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APRIL 2021 | OFFICIAL NEWSLETTER OF THE NIGERIA NATIONAL POLIOPLUS COMMITTEE | Contribute | Participate | Change

WORLD IMMUNIZATION WEEK

VACCINE BRINGS US CLOSER

Chairman's Address

World Vaccination Week 24-30th April

The practice of immunisation dates back hundreds of years. Buddhist monks drank snake venom to confer immunity to snake bite and variolation (smearing of a skin tear with cowpox to confer immunity to smallpox) was practiced in 17th century Ming dynasty China. Evidence exists that the Chinese employed smallpox inoculation as early as 1000 CE. It was practiced in Africa and Turkey as well, before it spread to Europe and the Americas. Edward Jenner's innovations, begun with his successful 1796 use of cowpox material to create immunity to smallpox, quickly made the practice widespread. This was the first scientific work on a vaccine and vaccination. His method underwent medical and technological changes over the next 200 years, and eventually resulted in the eradication of smallpox. Louis Pasteur's 1885 rabies vaccine was the next to make an impact on human disease. And then, at the dawn of bacteriology, developments rapidly followed. Antitoxins and vaccines against diphtheria, tetanus, anthrax, cholera, plague, typhoid, tuberculosis, and more were developed through the 1930s. The middle of the 20th century was an active time for vaccine research and development. Methods for growing viruses in the laboratory led to rapid discoveries and innovations, including the creation of vaccines for polio. Researchers targeted other common childhood diseases such as measles, mumps, and rubella, and vaccines for these diseases reduced the disease burden greatly in children.

Innovative techniques now drive vaccine research, with recombinant DNA technology and new delivery techniques leading scientists in new directions. Disease targets have expanded, and some vaccine research is beginning to focus on non-infectious conditions such as addiction and allergies. We already have a vaccine against cervical cancer.

But these advancements did not go without some sociocultural upheavals. Vaccine hesitancy and outright vaccine opposition is not a new tendency. It's as old as mass immunisation campaigns. When an epidemic of smallpox broke out in Boston USA in 1721 there were some segments of Bostonians who actively opposed the campaigns because of side effects which were in scale not dissimilar to what we are having in recent times with Covid-19 vaccines. The opposition to the mass campaign in Boston led to a violent incident. On a November day in 1721, a small bomb was hurled through the window of a local Boston Reverend named Cotton Mather. Attached to the explosive, which fortunately did not detonate, was the message: "Cotton Mather, you dog, dam you! I'll inoculate you with this; with a pox to you." This was not a religiously motivated act of terrorism, but a violent response to Reverend Mather's active promotion of smallpox inoculation.

It is rather very instructive that after exactly three centuries science has not been able to create vaccines without side effects. This is because, in my view, it is the immune response of each individual that determines what side effect they experience.

As we celebrate vaccine week 24 -30th April with the theme VACCINES BRING US CLOSER let us rededicate ourselves to promoting and advocating vaccination uptake and also advocating for resources to be made available for vaccine research, production and equitable distribution. This way, we will promote good quality of life and in particular continue to reduce infant, childhood and maternal mortality.

FROM EDITOR'S DESK

THE BIG IMPACT OF SIMPLE THINGS

I have always been impressed with the ability of simple things to achieve so much. Like in football, the simplest football is often the best football. And in language, the best prose is that which is written in simple, short and straightforward sentences. In healthcare, the simplest things which constitute primary healthcare tend to have the most significant impact. For example, Increased rates of handwashing have been shown to significantly reduce the spread of communicable diseases and introduction of simple barriers have been shown to have significant impact in reducing the spread of diseases like HIV/AIDS and COVID-19. Simple things thus seem to have the capacity to make great impact.

Let's go back to the beginning of the current global pandemic, as soon as we began to know enough about the means of transmission of the virus to realize that we could limit its spread by simply avoiding contact with infected persons. We knew that if we could prevent contact with an infected person by isolating for around 14 days, we could effectively limit the spread of the virus and it would die out. It seemed simple enough but we couldn't abide by those instructions. That led to the imposition of lockdowns and quarantines which had serious consequences on the health and economy of the entire world. Then we found out that we could limit the risk of infection by simply wearing face coverings. That also seemed simple enough. We could limit infection if everyone complied. We also found it difficult to abide by those simple terms and the disease continued to spread, causing death and suffering and the imposition of further public health restrictions which had a deleterious effect on the livelihoods of even more people. Finally, years of previous research on related viruses coupled with massive funding from both governmental and non-governmental bodies led to the development of effective vaccines that are capable of stopping the disease in its tracks if only enough of us would take them to create the herd immunity that would ensure that the virus dies off in the population. These were made available to us for free. All we just had to do was to present ourselves for vaccination when it was out turn. That also seemed really simple to do but it has proved anything but. Conspiracy theories and missteps by authorities have led to significant numbers of people rejecting or refusing the vaccine which means that we may not be able to achieve the required herd immunity necessary to wipe out the disease, at least not in enough time to prevent the mutation of the virus into more virulent strains.

Misinformation and a deficiency of trust appear to be at the heart of this latest failure of ours to take advantage of a simple solution. A lot of it is based on emotion, politics and plain old mischief. However, we just need to look back a little to see that vaccines, irrespective of some side effects have done and continue to do tremendous good in the world. Take polio as an example, there is no other way of explaining the rapid decline of over 99.9 percent in new infections in such a short time apart from the mass polio vaccinations that were carried out. The same thing is observed when we consider the decline in the rates of childhood illnesses even as the global population continues to grow, particularly in developing countries. Still, many of us would prefer to believe grandiose and complex conspiracy theories rather than follow simple instructions and derive the benefit of simple things.

That is why, in this month of April when we celebrate the vaccination week, I want to appeal to us to appreciate the beauty of simple things. What's more beautiful than two drops of a vaccine stopping a child from being crippled or killed or two painless jabs of a vaccine to prevent the incapacitation and death of the people we hold dear? Let's help improve our routine immunization coverage even as we continue to encourage our people to take the COVID-19 vaccine in order to help return us to simpler times.

Polio 2021 SIA as at 31st March 2021

S/No	Date of implementation	No of States	No of LGAs	No of Wards	Details	Target Population	Antigen	Remark
1	13-16 Mar 21	5 States (Zamfara, Niger, Sokoto, Bayelsa, 1st phase of Delta-20) and FCT -1 LGA	91	998	OBR1	8,502,826	nOPV2	Done
2	10-13 Apr 21	4 States (Zamfara, Niger, Sokoto, and FCT -1 LGA)	63	676	OBR2	6,571,533	nOPV2	Proposed
		Kebbi state	21	226	OBR1	1,688,246	nOPV2	Proposed
3	24th-27th Apr 21	Bayelsa and Delta States	28	321	OBR2	1,517,886	nOPV2	20 LGAs in Delta state
		Delta State	25	51	OBR1	413,407	nOPV2	5 LGAs
4	22nd -25th May 21	Kebbi state & Delta 5 LGAs	26	231	OBR2	2,101,653	nOPV2	(=>12 weeks after the last mOPV2 round (22nd 25th January 2021)
5	19th to 22nd June 2021	34 states +FCT (Minus Delta and Kebbi state)	728	9016	Nation wide SIA with bOPV	61,385,585	bOPV	Delayed in order to respond with nOPV2
6	3rd to 6th July	Kebbi and Delta bOPV			SIPDs	3,163,209	bOPV	Moved 1 wk because of sallah
7	14th – 17th August 21	11 States	228	2607	SIPDs in 11 HR states namely Borno, Sokoto, Zamfara, Niger, Katsina, Bayelsa, Kogi, Kwara, Lagos, Yobe, and Kaduna	24,180,130	bOPV	Proposed
8	23rd to 26th Oct 2021	6 (Borno, Sokoto, Zamfara, Niger, Katsina, and Bayelsa)	172	1,366	SIPDs in 6 HR states namely Borno, Sokoto, Zamfara, Niger, Katsina, and Bayelsa	12,306,234	bOPV	Proposed

Rotarian 'Gbenga Olayiwole
Editor, Poliostop

Polio Eradication: The Journey So far

The Nigeria Polio programme recorded a historic achievement in 2020- after four years of no wild polio virus detection in Nigeria, the Africa Regional Certification Commission for Polio Eradication (ARCC) confirmed interruption of WPV1 transmission and subsequently certified the Africa Region as free of WPV1 on 25 August 2020. Nigeria's WPV-free status was achieved through the persistent effort by the political leadership, national and international partnerships, effective community engagement, focused attention to improve surveillance and population immunity, dedicated healthcare workers, innovation and use of technology.

The programme continued to grapple with circulating Vaccine Derived Poliovirus type 2 (cVDPV2) outbreaks in 2020. However, a decline in intensity of transmission was noted: the number of cVDPV2 cases in 2018, 2019 and 2020 was 34, 18, and 8 respectively, representing a reduction of 76.5% between 2018 and 2020. Eight states recorded cVDPV2 outbreaks in 2020: Anambra, Bayelsa, Delta, Lagos, Niger, Sokoto, Zamfara and Bayelsa, compared to 31 in 2018.

Current national and global polio update as at the first week of April shows Nigeria with no case of circulating vaccine-derived poliovirus type 2 (cVDPV2) was reported in the previous week. There were eight cVDPV2 cases reported in 2020 and three in 2021.

Afghanistan: No wild poliovirus type 1 (WPV1) case was reported this week. There is one case reported in 2021 while the total number of cases in 2020 remains at 56. Five cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) were reported: four in Zabul and one in Badghis bringing the number of 2021 cases to 28. There were 308 cVDPV2 cases reported in 2020. Eight cVDPV2 positive environmental samples were reported: one each in Nangahar and Kabul and three each in Kandahar and Hilmand.

Pakistan: No wild poliovirus type 1 (WPV1) case was reported this week. There is one case reported in 2021. The total number of cases in 2020 remains at 84. Two WPV1 positive environmental samples were reported; one each in Sindh and Punjab. No cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) were reported this week. There have been six cases in 2021. The number of cases in 2020 remains at 135. Three cVDPV2 positive environmental samples were reported: one in Sindh and two in Balochistan.

Officially reported WPV1 and cVDPV cases as of April 8 2021

Total global WPV1 cases in 2021: 2 (compared with 39 for the same period in 2020)

Total global WPV1 cases in 2020: 140

Total global cVDPV cases in 2021: 48 (compared with 68 for the same period in 2020) Total global cVDPV cases in 2020: 1076

AMINU MUHAMMAD
NATIONAL PROGRAMME COORDINATOR

Countries gear up to kick all forms of polio out of Africa, once and for all

To rapidly and sustainably stop outbreaks of circulating vaccine-derived poliovirus type 2 (cVDPV2) in African countries, a modified vaccine, known as novel oral polio vaccine type 2 (nOPV2) is now being rolled out. Last year, on 25 August 2020, Africa made history with the African Region Certification Commission for Polio Eradication independently certifying that the Region was free of wild poliovirus. This is the second disease to be kicked out of Africa after smallpox more than 40 years ago.

This achievement is remarkable, considering that in the 1990s wild poliovirus paralysed more than 75,000 African children every single year – a situation that prompted Nelson Mandela in 1996, joined by Rotary International and other partners, to issue a stark call to action: Kick Polio Out of Africa!

All strains of wild poliovirus have now been interrupted in the continent. The last case of wild poliovirus was in August 2016. However, this tremendous progress remains an unfinished success story. Although Africa is free of wild poliovirus, countries continue to be affected by another form of the virus, known as circulating vaccine-derived poliovirus type 2 (cVDPV2). Such strains are rare, but can occur in under-immunized communities with limited access to safe water and sanitation.

Populations that are adequately immunized are protected from both wild and vaccine-derived strains of poliovirus. However, because of gaps in immunization coverage across Africa, 20 countries have been affected by cVDPV2 outbreaks since 2018. Now, intensified efforts are being launched to finish polio once and for all, to ensure no child in Africa will ever be paralysed by any strain of this virus.

The novel OPV2 vaccine has been in development since 2011, and in November 2020, WHO's Prequalification Team issued an emergency use listing (EUL) recommendation enabling initial roll-out in countries affected by cVDPV2 outbreaks. Soon after the issuance of the EUL, the WHO Regional Director for Africa, Dr Matshidiso Moeti, advocated to countries to use this additional tool to stop all forms of polio in Africa.

For nOPV2 to be deployed and used under the EUL, special readiness requirements and criteria need to be met. The Polio Rapid Response Team at WHO's Regional Office for Africa, in close coordination with other Global Polio Eradication Initiative partners, has been working intensely with countries and partners across the continent to respond to outbreaks of cVDPV2 and prepare for the roll out of nOPV2.

As countries in the Region gear up to roll out this new tool for outbreak response, with WHO's support they are developing supply, demand and deployment plans; ensuring expedited pathways for national regulatory approvals; enhancing surveillance and laboratory capacity; investing in meeting cold-chain capacity and vaccine management requirements; ensuring vaccine safety monitoring and follow-up mechanisms are in place; and developing communication plans and engaging communities to enhance understanding of the vaccine and risks posed by cVDPV2.

These preparations continue even amidst the COVID-19 pandemic, and the existing polio eradication infrastructure has been instrumental in preparing for the nOPV2 vaccine as well as more broadly supporting COVID-19 response efforts across the continent.

Years of extensive development and preparations are now about to pay off, as nOPV2 will now be utilized for outbreak response. "This is tremendous news for Africa's polio eradication effort, and in particular for Africa's children who are currently at risk of lifelong paralysis due to circulating vaccine-derived poliovirus," said Dr Moeti. "This tool can stop cVDPV2 but only if it reaches all at-risk children. We must apply the lessons from the decades of action to kick wild polio out of Africa. This will require the collective action of political leaders, traditional and religious leaders, public health experts, partners, donors, frontline health workers and of course parents and caregivers. Together, we can protect all African children from all forms of this virus."

Source: polioeradication.org

Egypt and UAE co-chair new EMRO ministerial subcommittee on polio

On Tuesday 16 March, the effort to eradicate polio got a major push from a new backer: the just-inaugurated Regional Subcommittee on Polio Eradication and Outbreaks.

The new regional subcommittee brings together ministers of health from Member States across the Eastern Mediterranean Region to tackle some of the persistent high-level challenges to polio eradication. Those include raising the visibility of polio eradication as a regional public health emergency and priority and mustering the political support and domestic financial support needed to finish the job.

During the inaugural meeting convened by the Regional Director, Dr Ahmed Al-Mandhari, two co-chairs were elected to drive the regional push: Egypt's Minister of Health and Population, H.E Dr Hala Zayed, and the Minister of Health and Prevention of the United Arab Emirates, H.E. Abdul Rahman Mohammed Al Oweis.

H.E. Abdul Rahman Mohammed Al Oweis was represented at the meeting by Dr Hussain Al Rand, the Assistant Undersecretary for Health Centres and Clinics and Public Health, United Arab Emirates. Both Member States flagged the urgency of the state of polio transmission in the last polio-endemic region at present, but also the opportunity to leverage greater regional coordination to achieve eradication.

Polio eradicators around the world know that ours is, in many ways, a grassroots programme: we use microplans to work through neighbourhoods door to door, household to household. But big-picture solidarity is needed to maximize the success of our ground-level efforts.

Wild poliovirus transmission has spread beyond core reservoirs of polio endemic Afghanistan and Pakistan, infecting 140 children in 2020. Outbreaks of circulating vaccine-derived poliovirus type 1 (cVDPV1) paralysed 29 children in Yemen. Type 2 outbreaks spread across the Region in 2020, paralysing 308 children in Afghanistan, 135 in Pakistan, 58 in Sudan and 14 in Somalia. At a time like this, moving forward as a region and as blocs, rather than on a country-by-country basis, is critical.

One of the issues identified by Member States as critical to stopping transmission is the movement of people across borders, and ensuring that surveillance and vaccination efforts target the increasing number of people who regularly cross borders across the region – whether they are moving as a consequence of conflict, environmental crises or economic necessity.

Interventions were made by Afghanistan, Egypt, the Islamic Republic of Iran, Iraq, Oman, Pakistan, Saudi Arabia and the United Arab Emirates. All statements reaffirmed strong support for the establishment of the subcommittee under the Regional Committee Resolution on polio eradication adopted in 2020.

Members of the subcommittee were unanimous in their commitment to engage in coordinated action and support of regional polio eradication efforts in four strategic areas. These include raising the visibility of the polio emergency in the Region, pushing for collective public health action, strengthening efforts to transition polio assets and infrastructure and advocating for the mobilization of national and international funding to achieve and sustain polio eradication.

A theme that ran through all Member States' interventions was the idea of maximizing the resources already in place – including the workers, the polio and EPI infrastructure a across the region, and the array of community leadership groups with which the polio programme has worked in past.

"Last year or the year before the year before there was a meeting in Muscat with religious leaders from different countries, and I think we need to capitalize on their support. We need to give them ownership," said Dr Ahmed Al Saidi, Minister of Health, Oman.

The COVID-19 pandemic has had an outsized impact on polio programmes across the region. The four-month pause in vaccination, from March-July 2020, gave the virus a window to spread almost unchecked. While we are immensely proud to have shouldered much of the COVID response burden, with GPEI infrastructure still supporting that response, this has come at a cost: nearly 80 million vaccination opportunities were lost.

"But we are moving forward, making up lost ground and, through this new Regional Subcommittee, leveraging the credibility that the polio programme has built through its pivot to COVID-19 and back again to polio," said Dr Hamid Jafari, Director of the regional polio programme and co-facilitator of the Regional Subcommittee.

That credibility is now the polio's most valuable asset: the proof that polio programmes are not just a means to battle polio, but sophisticated, fast-moving public health assets skilled in pandemic response.

The subcommittee will report its progress to WHO's governing bodies meetings, including the World Health Assembly and the Regional Committee for the Eastern Mediterranean.

The Secretariat, which is made up of the office of the Regional Director and members of the regional polio eradication programme from WHO's Eastern Mediterranean Region, will support the subcommittee to develop a programme of work based on the key outputs of the group.

Source: polioeradication.org

UNICEF, WHO, FG worry over Nigeria's low immunization coverage

The WHO, UNICEF and the Federal Government on Tuesday expressed worry over Nigeria's low routine immunization coverage, warning that without adequate awareness on the need for people to continue routine immunisation, especially that of polio, there is a possibility of polio resurfacing in the country. In his submission at a three-day media dialogue on routine immunisation, post-polio certification and COVID-19 vaccination" in Yola organised by the Federal Ministry of Information and Culture in collaboration with the United Nations Children's Fund, UNICEF, the Minister of Information and Culture, Alh. Lai Mohammed disclosed that Nigeria was at a critical point in ensuring access to and uptake of routine immunisation by children across the country.

According to him, the country's immunization challenge was compounded by the COVID-19 pandemic which has resulted in a lot of children being partially immunised or unimmunised, including against polio, even though the country has been certified wild polio free. "There is an urgent need to address the immunisation situation in Nigeria with attention to COVID-19 and its impact on routine immunisation and the rollout of the immunisation for COVID-19 itself." Represented by Mr Temitoye Falayi from the Ministry of Information, he called on media practitioners to promote messages on both preventions of COVID-19 and increase uptake of vaccination for under 5 children.

Speaking, the Communication for Development, Specialist, UNICEF, Mrs Elizabeth Onitolo said routine immunisation helps eliminate vaccine-preventable diseases ravaging the country.

Onitolo said: "No child must die of polio again in Nigeria; we sincerely plead with the media to help us out by creating awareness and sensitising the people on routine immunisation. She said polio could still resurface even after the country had been certified free of polio, hence the need for the media to increase awareness for people to embrace routine immunisation. She also stressed the need for the media to do more awareness to guide against the coming back of polio and prevent other childhood diseases in the country.

Speaking on COVID-19, Onitolo stated that many Nigerians were scared to get the COVID-19 vaccination as a result of misinformation. Onitolo also called on the media to help change the mindset of Nigerians and get vaccinated. She urged the media to help build confidence in the people to encourage them get vaccinated by reporting the importance and benefits of vaccination and immunisation. Corroborating her views, Dr Friday Igbinovia of the WHO urged the media to create more awareness on the importance of COVID-19 vaccines in the country. Igbinovia said that the COVID-19 vaccine was safe, effective and should be taken as everyone was at risk of getting infected especially, the weak, elderly and persons with chronic diseases.

He explained that vaccine helps the body to develop immunity to the COVID-19 virus emphasising that it does not cause any harm. He added that by taking the complete dose of the vaccine, the body would be able to fight the virus in the future. He said people should continue to obey national and state directives on avoidance of large gatherings and strict adherence to COVID-19 protocols to reduce the spread of the virus. Speaking, the Director, Planning, Research and Statistics, Ministry of Health, Adamawa, Dr Stephen John, urged the media to create more awareness for people to understand, shun rumours and continue to abide by the COVID-19 protocols. He said compliance to the protocols was key to defeating the spread of the virus in the state and country at large.

FAQs for Healthcare Workers

1. **How does each of the available Covid-19 vaccines work?**
There are several COVID-19 vaccine candidates; some have been approved for emergency use while others are still at different phases of clinical trials for possible approval. Different COVID-19 vaccine candidates are of various categories based on their mechanism of action:

- Inactivated or weakened virus vaccines, which use a form of the virus that has been inactivated or weakened so it does not cause disease, but still generates an immune response.
- Protein-based vaccines, which use harmless fragments of proteins or protein shells that mimic the COVID-19 virus to safely generate an immune response.
- Viral vector vaccines, which use a virus that has been genetically engineered so that it cannot cause disease but produces coronavirus proteins to safely generate an immune response.
- RNA and DNA vaccines, a cutting-edge approach that uses genetically engineered RNA or DNA to generate a protein that itself safely prompts an immune response.

2. **Are there COVID-19 vaccines made specifically for Africans?**
No. There are no COVID-19 vaccines made specifically for Africans. Ignore the rumor and misinformation about any COVID-19 vaccine made for Africa. Vaccines used in Africa are the same vaccines being used in America, Europe, and Asia.

3. **Should one wait for a particular COVID-19 vaccine?**
No. All available COVID-19 vaccines approved by WHO and certified by NAFDAC are safe for use.

4. **Where is the AstraZeneca COVID-19 vaccine supplied to Nigeria manufactured?**
The Oxford AstraZeneca is a COVID-19 vaccine developed by Oxford University and AstraZeneca pharmaceutical company. There are several brands of this vaccine depending on the manufacturer. The COVISHIELD brand which is currently being used in Nigeria is manufactured by the Serum Institute of India. The COVISHIELD brand is used in over 71 countries including UK, Canada, India, and Brazil.

5. **Is Oxford AstraZeneca vaccine in Nigeria safe for use?**
Yes, the available vaccines in country are safe for use. Before a vaccine is certified for use, it must receive approval from WHO. Here in Nigeria, in addition to WHO approval, all vaccines including COVID-19 vaccine are certified safe for use by NAFDAC. Even when in use, NAFDAC continues to monitor the vaccine to ensure it causes no harm.

6. **Does the vaccine contain a microchip?**
No. There is no evidence to support the claims that the COVID-19 vaccine contains a microchip (by WHO and NAFDAC).

7. **Will the vaccine alter my DNA?**
No. There is no evidence that the vaccine alters human DNA (by WHO and NAFDAC).The vaccine enters cells, but not the nucleus of the cells where DNA resides. It causes the cell to make protein to stimulate the immune system, then quickly breaks down without affecting the DNA.

8. **Why was COVID-19 vaccine developed within a short period?**
The COVID-19 vaccine was developed quicker than any other vaccine in medical history because of years of previous research on related viruses, faster ways to manufacture vaccines, enormous funding that allowed firms to run multiple trials in parallel, and regulators moving more quickly than normal

9. **Is it safe to get a COVID-19 vaccine if I have an underlying medical condition?**
Yes. COVID-19 vaccination is especially important for people with underlying medical conditions such as heart disease, lung disease, diabetes, cancer, etc. People with these conditions are more likely to get very sick from COVID-19.

10. **Do I need to be vaccinated if I am a COVID-19 survivor?**
Yes,you have to be vaccinated. Vaccination will prevent you from severe infection.

11. **Can I have the vaccine if I have symptoms of COVID-19?**
If you currently have COVID-19 symptoms, you should wait until you have recovered from the illness and have completed your isolation period before getting vaccinated.

12. **Can I have the vaccine if I am in quarantine?**
You should finish your ten-day quarantine period before receiving the vaccine.

13. **Should a patient diagnosed with COVID-19 shortly after the first dose receive the second scheduled dose?**
The vaccine begins to generate protective immunity 10 to 14 days after the first dose. The current recommendation is that people with infection should wait until they have recovered from the illness.

14. **Are there contraindications to COVID-19vaccine?**
Known history of severe allergic reaction (e.g., anaphylaxis) should consult healthcare provider before taking the vaccine.

15. **Is there life-threatening reaction following COVID-19 vaccination?**
It is rare, but it advised that you report to your healthcare provider if you observe any adverse reactions after vaccination.

16. **Is it compulsory to take the vaccine?**
It is recommended that every eligible person (18 years and above) be vaccinated. It is strongly recommended that health workers get vaccinated as they are more exposed to the COVID-19 during the discharge of their daily duties. An unvaccinated health worker poses a risk to themselves, families, colleagues, and clients.

17. **Can I stop COVID-19 protection measures after vaccination?**
No, you should continue to wear face mask, practice physical distancing & sanitize hands and frequently touched objects regularly after being vaccinated. The vaccine does not prevent infection but prevent the progression of infection to the development of the disease.

Fact sheet on Oxford AstraZeneca COVID-19 Vaccine for Health Workers

Vaccination remains one of the most important medical interventions for preventing illnesses, death and controlling pandemic. WHO has approved some vaccinesfor the control of the ongoing COVID-19 pandemic, including the Oxford AstraZeneca vaccine.

Oxford AstraZeneca vaccine

1. The Oxford AstraZeneca is a COVID-19 vaccine developed by Oxford University and AstraZeneca pharmaceutical company. There are several brands of this vaccine depending on the manufacturer. The COVISHIELD brand which is currently being used in Nigeria is manufactured by the Serum Institute of India.

2. The COVISHIELD brand is used in over 71 countries including UK, Canada, India, and Brazil.

3. It has 76% efficacy rate against symptomatic COVID-19 and 100% effective in stopping severe infection.

Vaccine Safety

4. The vaccine has been confirmed safe by World Health Organization (WHO), European Medicines Agency (EMA), US Food and Drug Administration (US FDA) and Nigeria's National Food and Drug Administration and Control (NAFDAC).

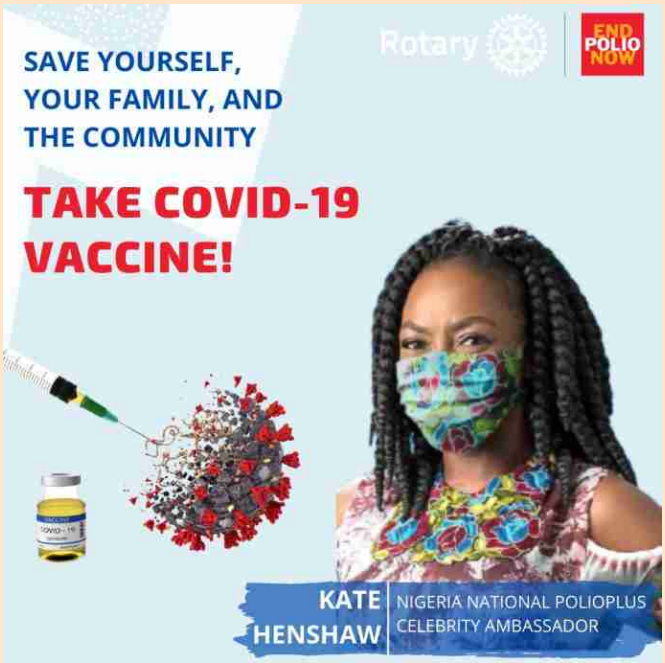
5. Investigations reveal that there is no evidence of a causal link between the vaccine and blood clot formation.

6. There is extensive data showing that the vaccine is safe and effective, and especially good at preventing severe illness and death from COVID-19.

7. **Side Effects:** Side effects are short term and include local pain around injection site, fever, headache, and other mild symptoms.

8. **Interval between doses:** WHO's Strategic Advisory Group of Experts on Immunization (SAGE) recommendation is that the two doses of the vaccine be given intramuscularly (0.5ml each) with an interval of 8 to 12 weeks (2-3 months).

9. **Mixing Vaccines:** WHO's Strategic Advisory Group of Experts on Immunization (SAGE) recommendation is that the same vaccine should be used for both doses.



Nigeria's Choice of Oxford/AstraZeneca vaccine

Dr. Faisal Shuaib, Executive Director/CEO NPHCDA

Nigeria is continuing in the process of administering roughly 4 million doses of the Oxford/AstraZeneca vaccine, beginning with our frontline health workers and vulnerable individuals. There has been no change to current plans or supply.

A huge number of countries around the world are administering the Oxford/AstraZeneca vaccine, including much of Europe, and United Kingdom which has administered the most doses of AstraZeneca globally. The World Health Organization, British and European health regulators all continue to advocate for the use of AstraZeneca.

AstraZeneca's strong effectiveness against COVID-19 has been demonstrated in clinical and human trials: it has been shown to be 76% effective at preventing COVID-19 and 100% effective at preventing severe disease and hospitalization. Nigeria's health authorities followed closely recent pronouncements from Europe's regulator, the EMA. The head of the EMA stated that, according to scientific knowledge, there is no evidence to support restricting the use of the vaccine in any population.

The NPHCDA's priority is the health and safety of the Nigerian people, and our decisions and advice are guided by best practice scientific evidence. We are confident in AstraZeneca's ability to save lives.

Vaccines save lives!

Emir of Argungun and Chairman NTLC, Alhaji Samaila Mohammed Mera vaccinating a child at the Flag Off ceremony of OBR in Kebbi State.

Meeting with the Deputy Governor of Kebbi state, Rotn Col Samaila Yombe Dabai, together with representatives of partner agencies

Supportive supervision of OBR2 round at Gada Abu Magaji in Tudun Wada ward of Gusau LGA

Presentation of Rotary materials to the Commissioner for Health Kebbi State by Amb. Aminu Muhammad

OUR ROTARY LEADERS LEADING BY EXAMPLE ...

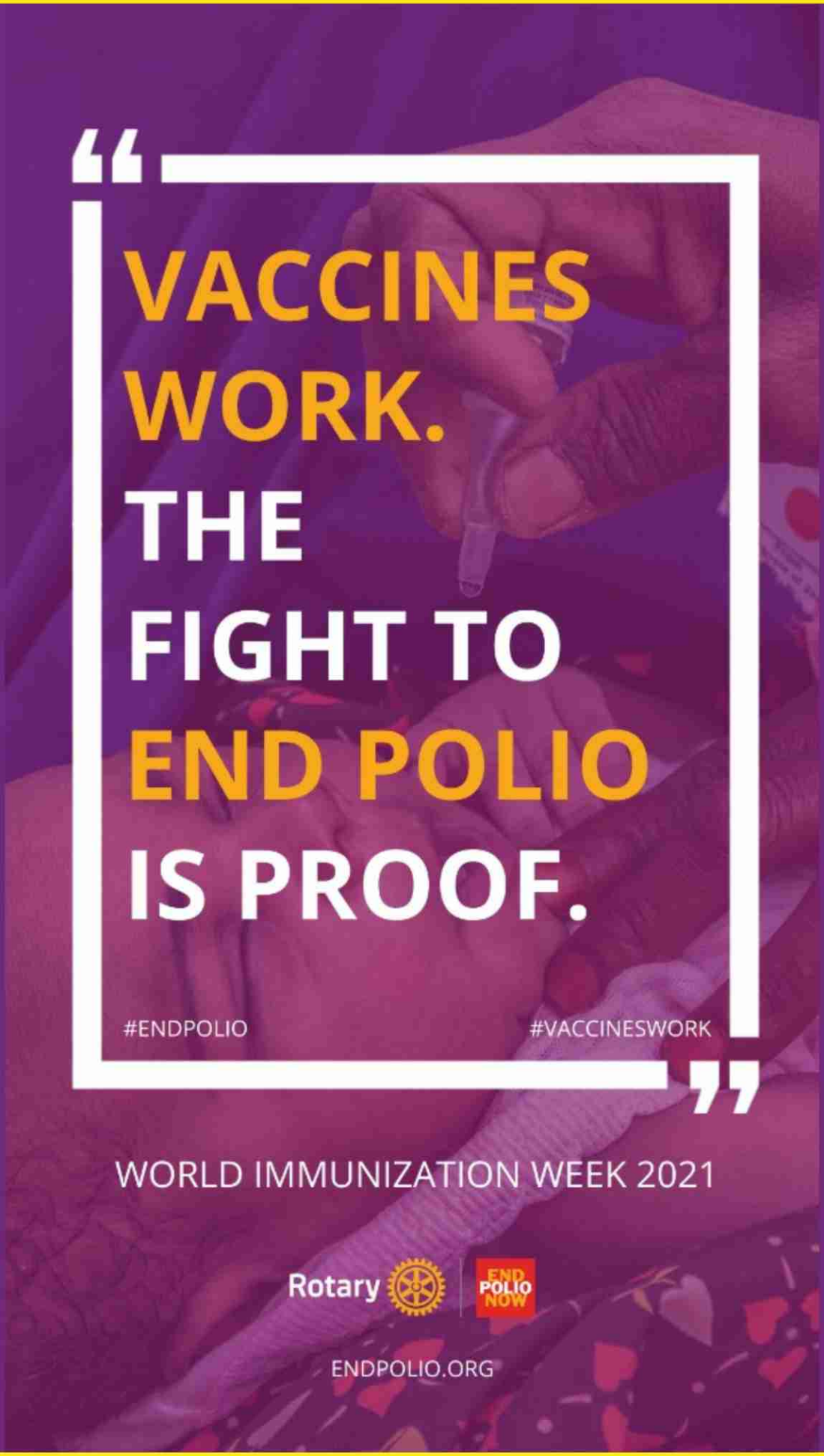
RI President Holger knaack

PRIP Jon.B. Mayiagbe

PRVIP Yinka Babalola

PDG Dr Tunji Funsho

From left - Dr Tunji Funsho, ALIBABA, PAG Lanre Kasim and DGE Remi Bello during the unveilling of ALIBABA Covid-19 billboard in Lagos



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