



## **NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY**

# **2013 NIGERIA POLIO ERADICATION EMERGENCY PLAN**

**February 2013  
Abuja**

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## Abbreviations

AFP	Acute Flaccid Paralysis
ALGON	Association of Local Governments of Nigeria
BCI	Boosting Childhood Immunity
BMGF	Bill and Melinda Gates Foundation
DDCI	Director Disease Control and Immunization, NPHCDA
CDC	Centers for Disease Control and Prevention, Atlanta
ED	Executive Director National Primary Health Care Development Agency
ERC	Expert Review Committee of Polio Eradication and Routine Immunization
EPI	Expanded Programme on Immunization
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FRR	Financial Resources Requirements
GAVI	Global Alliance of Vaccines and Immunization
HiLAT	High Level Advocacy Team
HR	High Risk
HROP	High Risk Operational Plan
HRS	High Risk States
HSS	Health Systems Strengthening
ICC	Inter-agency Coordination Committee
IPC	Inter-personal Communication
IPDs	Immunization Plus Days
IMB	Independent Monitoring Board
IWCS	Intensified Ward Communications Strategy
IPDS	Immunization Plus Days
LGA	Local Government Area

LTF	Local Government Task Force on Immunization
MSS	Mid-wives Service Scheme
NICS	National Immunization Coverage Survey
NMA	Nigeria Medical Association
NTL-PHC	Northern Traditional Leaders committee on Primary Health Care
NPHCDA	National Primary Health Care Development Agency
PEI	Polio Eradication Initiative
PTFoPE	Presidential Task Force on Polio Eradication
PMV	Patent Medicine Vendors
RI	Routine Immunization
RSA	Rapid Surveillance Assessment
SIAD	Short Interval Additional Dose
SIAS	Supplemental Immunization Activities
SURE	Subsidy Reinvestment and Empowerment Programme
SIACC	State Inter-Agency Coordination Committee
STF	State Task Force on Immunization
SIACC	State Inter-Agency Coordination Committee
TBAs	Traditional Birth Attendant

## 1. EXECUTIVE SUMMARY

In 2012, Nigeria's Presidential Task Force on Polio Eradication (PTFoPE) oversaw the implementation of the 2012 National Polio Eradication Emergency Plan. A significant number of technical innovations to improve the quality and coverage of polio eradication activities were adopted and implemented. Managerial innovations, including the adoption of a national PEI accountability Framework, deployment of additional technical support to the highest risk States, and the establishment of a National Polio Eradication Emergency Operations Centre were also implemented.

Nigeria continued to experience transmission of poliovirus in 2012. By end of 2012, 122 children were paralyzed by the wild poliovirus. This represented an almost doubling of confirmed cases as compared to 2011 when 62 children were paralyzed. During the first 2 quarters of 2012, wild poliovirus transmission occurred across most high-risk northern states. In Q3-4, transmission was increasingly restricted to the 3 states i.e. Kano, Kaduna and Katsina. Despite the increased number of cases in 2012, the genetic diversity of WPV circulating in Nigeria declined; with 6 WPV1 clusters and 2 WPV3 clusters detected in 2012 compared to 8 WPV1 clusters and 6 WPV3 clusters detected in 2011.

The efforts to improve SIA quality in 2012 yielded positive results, particularly in Q3-4 2012. The proportion of high risk LGAs that were accepted at 80% coverage by LQAs, increased from 35% during the May 2012 SIAs to 67% during the December 2012 SIAs. The trends in OPV status of non-polio AFP cases also indicated improving immunization status of children in Nigeria including in the polio high-risk states. The improving quality of SIAs as well as the improving population immunity in the high-risk states would appear to be consistent with the decline in number, geographic and genetic diversity of polio cases that were observed in the last 2 quarters of 2012.

The elaboration of the 2013 National Polio Eradication Emergency Plan (NPEEP) has been guided by the important lessons from 2012. The goal of 2013 NPEEP is to **achieve interruption of poliovirus transmission by end 2013**. Epidemiological milestones that will measure progress towards this goal include the reduction of number of new polio cases to zero in 9 of the 2012 polio-infected states<sup>1</sup> by end March 2013. By end June 2013, number of new polio cases should be reduced to zero in all states.

SIA improvement targets have been set in order to achieve the 2013 NPEEP goal and these are (a) 90% of all LGAs accepted at 80% coverage by LQAs by June 2013 and (b) In highest risks LGAs (107 + those containing hard to reach or borders settlements) 90% of the wards to achieve 90% coverage, by independent monitoring

The 2013 NPEEP has identified 6 strategic priorities (a) enhancing SIA quality, (b) implementation of special strategies to reach underserved populations, (c) adoption of special approaches for security challenges areas, (d) improving outbreak responses, (e) enhancing routine immunization and in-between round activities as well as (f) enhancing surveillance.

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<sup>1</sup> All 2012 polio-infected states except Kaduna, Kano, Katsina and Sokoto.

The 2013 NPEEP also includes 3 cross cutting priorities (a) intensifying communication and advocacy, (b) enhancing the use of innovations and (c) optimizing human resources.

The 2013 NPEEP prioritizes the need to improve SIA quality and reach all children in the areas that are the drivers of transmission in the country, i.e. the highest risk and consistently low performing LGAs and wards in endemic states. Four high risk states continue to significant numbers of LGAs with sub-optimal performance i.e. Kaduna, Kano, Katsina and Sokoto as well as two states with persistent security challenges i.e. Borno and Yobe will be prioritized in the implementation of the key 2013 NPEEP activities.

The low transmission season offers an important opportunity to reduce poliovirus transmission very significantly if high immunization coverage is achieved in the persistently poor performing areas. The following key activities will be prioritized in the low transmission season:

## Low season priorities

Priority	Description
1 Refine microplanning	<ul style="list-style-type: none"> <li>Scale up and refine house-based microplanning with social data in all <b>107 VHR LGAs</b></li> <li>Map HTR/border/nomadic settlements in 95 LGAs by <b>January</b> and all settlements reached with at least 3 doses of OPV by <b>June</b></li> <li>Complete GS mapping of 8 states and integrate into micro-plans by <b>March</b></li> </ul>
2 Strengthen team selection and training	<ul style="list-style-type: none"> <li>Revise SOP and training package to support improved team selection, management, and monitoring in place by <b>March</b> and scaled up in 107 VHR LGAs by <b>June</b></li> <li>Track all vaccinators in 40 LGAs in 8 states with GPS during IPDs by <b>April</b></li> </ul>
3 Access children in security compromised areas	<ul style="list-style-type: none"> <li>Strengthen mapping of security access by <b>February</b></li> <li>Pilot use of permanent vaccination teams in special areas (i.e., all major HFs, busy markets, transit points)</li> <li>Initiate SIAD in newly accessible areas (e) continued local stakeholder engagement</li> </ul>
4 Reduce non compliance	<ul style="list-style-type: none"> <li>Rapid review of VCM management structure to strengthen supervision by <b>February</b> to improve effectiveness and inform scale-up</li> <li>Develop and begin to implement LGA-specific strategy to enlist and mobilize religious leaders including integration of imams in microplans by <b>April</b></li> <li>Operations research on reasons for persistent, clustered non-compliance</li> </ul>
5 Intensify program management	<ul style="list-style-type: none"> <li>Sustained engagement with Executive Governors and VHR LGAs by Presidential Task Force &amp; Nigeria Governors' Forum</li> <li>Establish EOCs in Abuja and Kano, Katsina, Sokoto, Kaduna, and Borno by <b>April</b></li> <li>Optimize deployment of government and partner field staff to align with segmentation analysis of highest risk LGAs and wards by <b>February</b>, optimization completed by <b>April</b></li> <li>Ensure thorough and expedient response to outbreaks as outlined in the SOPE</li> </ul>

## 2. INTRODUCTION

In May 2012, the Sixty-fifth World Health Assembly declared the completion of poliovirus eradication a programmatic emergency for global public health and urged member states with poliovirus transmission to declare such transmission to be a national public health emergency. Nigeria had made progress in intensifying the polio eradication effort even prior to the 2012 WHA resolution. In March 2012, His Excellency the President of the Federal Republic of Nigeria launched the 2012 National Polio Eradication Emergency Plan (NPEEP) and accountability framework. The implementation of the 2012 NPEEP was closely monitored by a Presidential Task Force on Polio Eradication (PTFoPE) that met monthly and provided regular progress reports to His Excellency, the President.

The most important achievements during the implementation of the 2012 NPEEP included:

- Engagement and commitment of key Political leaders down to State and LGA level i.e. proportion of LGA chairmen in the polio high risk states that were actively engaged in PEI activities increased from 71% during Q1 2012 to 92% by Q4 2012;
- Sustained engagement and commitment of Traditional leaders, Religious leaders as well as Faith Based Organizations;
- Implementation of several technical and programmatic innovative approaches to improving quality of PEI activities;
- Successful introduction of national PEI accountability framework;
- Steady improvement in the quality of SIAs i.e. proportion of high risk LGAs that achieved at least 80% coverage (as demonstrated by LQAs) increased from 35% in May 2012 to 67% in December 2012;
- Decline in genetic diversity of poliovirus transmission, more marked in Q3-4 2012;

Common challenges noted during the implementation of the 2012 NPEEP included

- High level political support did not always translate into improved programme performance e.g. in Q4 2012, 100% of the Governors of the High Risk States had demonstrated personal commitment to polio eradication. During this same period (Q4 2012) the Governors did not meet with LGA chairmen to discuss how to achieve better PEI results in 18% of the High Risk states. Similarly, no meetings were held between Governor (or his representative) and Traditional Leaders in 27% of the high risk states in Q4 2012.
- Continued sub-optimal performance of vaccination teams in many high risk areas
- Persistent sub-optimal vaccination performance in underserved areas usually missed by health services e.g nomadic areas, hard-to-reach areas, scattered rural communities as well as border areas;
- Failure to mount timely and very high quality polio outbreak response activities;
- Persistent very low routine immunization coverage.

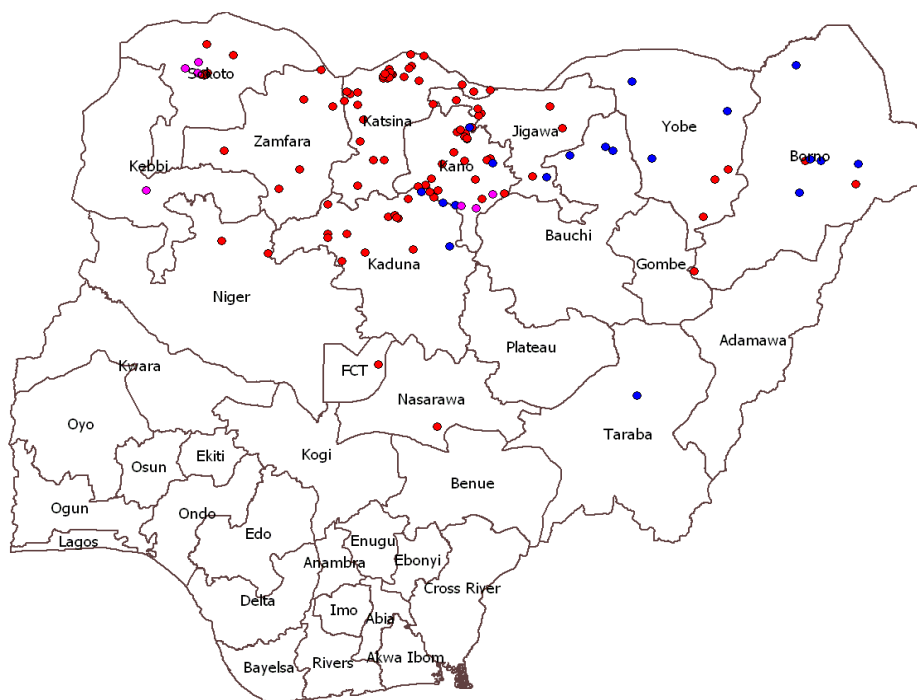
### **2.1. 2012 Poliovirus Epidemiology:**

Nigeria reported a total of 122 cases of polio with onset in 2012<sup>2</sup> due to wild poliovirus. This represented a doubling of cases from the 62 (47 WPV1 & 15 WPV3) reported in 2011. Most (103) of the 2012 cases are due to wild poliovirus type 1 (WPV1), with 19 due to wild poliovirus type 3.

A further 23 WPV isolates were obtained from environmental surveillance conducted in Nigeria in 2012. Of the isolates, 20 were WPV1, and 3 WPV3. Multiple isolates of cVDPV type 2 were also reported, 8 from cases or contacts, and 42 from environmental samples. The cVDPV case numbers were significantly reduced in comparison to 2011 (35). Despite the increase in WPV cases, genetic diversity in 2012 has declined, with 6 WPV1 clusters and 2 WPV3 clusters detected, down from 8 WPV1 and 6 WPV3 in 2011.

Thirteen states and 65 LGAs had confirmed polio cases in 2012. Of the 65 infected Local Government Areas (LGAs), 25 reported more than one case, and these 25 LGAs account for more than two-thirds of all reported cases. Some LGAs reported very significant numbers (just 2 LGAs, Katsina in Katsina State and Minjibir in Kano State, reported 22 cases in total, nearly 20% of all cases nationally).

**Figure 1.** The concentration of WPV1, WPV3, and cVDPV2 in endemic northern states in Nigeria, 2012.



In the first and second quarters of 2012, transmission was widespread in the endemic states of the north; in the third and fourth quarters, while case numbers remained high, transmission became more concentrated. In Q3 and Q4 2012, Katsina, Kano, and Kaduna accounted for 80% of all cases reported.

Cases continue to be very under-immunized relative to the general population; nearly a quarter of WPV and cVDPV cases were zero dose, and nearly half of all cases had less than 3 doses of OPV, compared to

<sup>2</sup> Data as of 8 February 2013



the national average for non-polio AFP cases of 1% and 8% respectively. WPV cases with zero or only one dose were very high as a proportion of all WPV cases in Kano (55%), Sokoto (50%), Katsina (40%), and Kaduna (33%). Cases are evenly split between males and females, and there is no difference in immunization status between the sexes. Consistent with previous years, the age groups with the highest incidence are those between 12 and 47 months of age, with the peak being in the 24 to 35 month age group (35% of all WPV cases). Cases below 12 months of age and over 60 months of age (9% and 6% of WPV cases respectively) are much less common.

#### **Genetic data:**

**Wild Poliovirus Type 1:** WPV1 isolates detected in 2012 in Nigeria are from six genetic clusters, in two genotypes. Within Genotype WEAf-B1, four clusters have been detected, N2, N5, N6, and N7, and from Genotype WEAf-B2, two clusters, L1 and L2.

There are two patterns of WPV1 circulation; the main pattern is of relatively distinct genetic 'zones'. The clusters do overlap geographically in the central area of the north (Kano, Kaduna, Katsina) but circulation in the north-west and north-east is essentially separate. The second pattern is of wide movement of virus which occurs relatively sporadically. The most diverse cluster, N6, demonstrates the greatest evidence of movement of viruses over long geographical distances.

**Wild Poliovirus Type 3:** The wild poliovirus type 3 isolates detected in 2012 are from two genetic clusters, termed F6 and F4. The pattern of transmission of WPV3 is essentially that of the cluster F6, which demonstrates both sustained local circulation, and extensive movement of virus. This cluster has a history of mobility, having moved from the north-west to the north-east in 2010/2011. In 2011 the cluster was mostly concentrated in the north-eastern states, but in 2012 it has also spread into north-central areas of Kano and Kaduna, and into Taraba. Further evidence of movement is provided by the Lagos environmental isolates which have common ancestors with isolates from Kano (environmental and case).

**Circulating Vaccine Derived Poliovirus Type 2:** Most cVDPV2 isolates have been detected in Sokoto, 3 from cases/contacts and 41 from the environment. These isolates are all closely related, although their closest relative is an environmental isolate from Kano in 2011. Three cases have been reported from Kano, all related to previous Kano circulation; additionally 2 environmental isolates were detected, one related to previous circulation and one related to the Sokoto transmission chain. The most recent isolates, from Kebbi, are orphans, the closest relatives are 2011 isolates from Kano.

## **2. 2 Implementation of PEI Strategies in 2012**

Several innovative strategies to enhance the quality of polio eradication activities were implemented in polio high risk states as part of the 2012 National Polio Eradication Emergency Plan. These strategies included (a) restructuring of vaccination teams and introduction of additional supervisory personnel (b) house-based micro-planning (c) special outreach to nomadic populations (d) introduction of concurrent monitoring (e) use of polio SIA dashboard and use of this to enhance accountability (f) use of GIS to

improve the quality of micro-planning and use of GPRS to track vaccination teams (g) recruitment of Volunteer Community Mobilizers in the highest risk settlements.

Implementation of the innovative strategies was greatly facilitated by recruitment and deployment of surge capacity technical staff in the highest risk states. Implementation of the innovative strategies and deployment of the technical surge capacity was completed in Q2-3 2012.

The quality of SIAs improved significantly particularly in Q3-4 2012. The proportion of high risk LGAs that were accepted at 80% coverage by LQAs, increased from 35% during the May 2012 SIAs to 67% during the December 2012 SIAs.

The decline in case numbers, genetic diversity, and geographic spread of WPV in Q4 2012 is related in time with programmatic improvements in delivering immunization during SIAs over the past 6 months, as evidenced by LQAS results in high risk LGAs. This suggests overall progress in reducing the large pockets of under-immunized children that fuel circulation and amplification of WPV.

It is however important to note that even with the overall improvement in quality of SIAs, significant number of children remained unvaccinated in a number of LGAs. Close to 10% of all the high risk LGAs that participated in the December 2012 IPDs had coverage adjudged to be less than 60%. In the LGAs with very low SIA coverage in December 2012, 53% of all children that remained unvaccinated were because vaccination teams visited their homes but did not make concerted effort to vaccinate all children belonging to that home; 25% remained unvaccinated because of refusal by their parents/carertakers to have their children vaccinated; 8% remained unvaccinated because vaccination teams did not visit their homes. Presenting the average reasons that children remained unvaccinated masks disparities between LGAs. In one rural LGA with significant number of scattered hard to reach settlements, 40% of the children that remained unvaccinated were because the vaccination teams did not visit their homes. It is also note worthy that non-compliance/refusals is now more prominent in urban than in rural settings.

Routine immunization coverage in 2012 was sub-optimal in Nigeria. By end December 2012, the national OPV3 coverage was reported to be 74. In the polio-infected states, the reported OPV3 coverage by end of December 2012 was 60% (range 34-87%). The reported OPV coverage in the settlements of the confirmed polio cases, as assessed during the outbreak investigations, was significantly much lower. Over 61% of all confirmed polio cases in 2012 had not received a single OPV dose during routine immunization session, 32% had received between 1-2 doses of OPV from routine immunization session and approximately 7% had received at least 3 doses of OPV during a routine immunization session.

Overall, the improvement in population immunity status, as noted from OPV status of Non-polio AFP cases noted in 2012, was a result of improving immunization coverage during SIAs and efforts to improve routine immunization in the highest risk areas were not as successful.

### **2.3. SIA Calendar for 2013**

In order to achieve the target of interruption of wild poliovirus transmission within 2013, Nigeria's Expert Review Committee recommended the following SIA schedule in 2013:

- Two national SIA rounds
- Six sub-national SIA rounds targeting the high risk States

The above calendar (dates of 2013 SIAs included in annex 9.2) will be complemented by outbreak response activities, as outlined in the revised Outbreak Standard Operating Procedures (SOP)<sup>3</sup>, whenever an outbreak is confirmed in any state in the Federation.

#### **2.4. Geographic Focus**

Consistent with previous years, in 2012 most circulation of virus, occurred in relatively restricted geographic areas in the endemic northern states. In these areas, virus circulation and amplification occurred because of inadequate levels of immunity in children less than five years of age due to significant community-wide pockets of under-immunized children. These under-immunized children provided opportunity for sustained transmission in one LGA or clusters of LGAs over significant periods of time, i.e. several months.

It is critical that the focus is put on improving SIA quality and reaching all children in the areas that are the drivers of transmission in the country, i.e. the highest risk and consistently low performing LGAs and wards in endemic states.

In December 2012, the polio eradication initiative in Nigeria, with technical assistance from Global Good Intellectual Ventures EMOD, the US Centres for Disease Control and WHO updated polio risk assessment using a harmonized risk assessment algorithm. This exercise identified 107 LGAs at very high risk in the polio-infected states (annex 9.1.). These areas are to be prioritized for special attention in 2013.

The epidemiology also indicates that the focus on high risk areas must be coupled with continued focus on migrant and mobile communities to reduce the risk of viral movement at the same time as immunity gaps are being closed in reservoir communities.

### **3. GOAL, TARGETS, AND MILESTONES**

#### **3.1. Goal**

The overall goal of the plan is to achieve interruption of poliovirus transmission by the end 2013.

#### **3.2. Targets**

**Target 1:** 90% of LGAs accepted at 80% coverage by LQAs by June 2013

**Target 2:** In highest risks LGAs (106 + those containing H2R/Borders settlements) 90% of the wards to achieve 90% coverage, by independent monitoring

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<sup>3</sup> Draft Standard Operating Procedures for response to polio cases in Nigeria, EOC, NPHCDA (Dec

### 3.3. Milestones

- Reduce the number of new WPV cases in most states to zero by the end of March 2013
- Reduce number of new WPV cases to zero in Kano, Katsina, Kaduna and Sokoto by end June 2013.
- 100% of the 107 high risk LGAs with updated and validated micro-plans, with inclusion of all underserved<sup>4</sup> communities, by end of Feb 2013
- 80% of the 107 high risk LGAs achieve at least 80% coverage as demonstrated by LQAs by April 2013.
- GIS mapping completed in 8 high-risk states by March 2013.
- Vaccinators in 20 LGAs in 8 states tracked with GPS during each IPD round by April 2013.
- Improved vaccinator selection, training and monitoring SOP implemented in all 107 VHR LGAs by June 2013.
- Implement LGA specific strategies to reduce non-compliance that include the mobilization of religious leaders by April 2013.
- Full functioning national and state level EOCs in 5 high-risk states by April 2013.

## 4. OVERSIGHT AND MANAGEMENT

Improving program management and operational execution is a major focus of the 2013 plan. The overall objective is to provide a governance framework that encourages evidence-based decision-making, enhanced situational awareness, early problem detection, and a coordinated response among partners to the evolving situation of polio in Nigeria.

### 4.1 National Level

The Federal Government of Nigeria will continue to:

- Ensure effective leadership and coordination of bodies established to enhance programme coordination for both polio eradication as well as the broader Immunization programme i.e. the Presidential Task Force on Polio Eradication (PTFoPE), the Inter-agency Coordination Committee (ICC) and the ICC Working Groups. The Federal Government will also provide leadership of the National Polio Eradication Emergency Operations Centre (EOC).
- Provide enabling environment for strong partnership with Traditional leaders, Religious Leaders, Community and Faith Based Organizations, Women Organizations, Professional Organizations as well as donor and technical partner agencies. These partnerships will be optimized to support the effective implementation of key aspects of the 2013 NPEEP at all levels, from Federal to community level.

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<sup>4</sup> Underserved communities refer to communities that have been missed by delivery of health services including immunization and surveillance e.g. nomadic communities, hard-to-reach communities, scattered and border communities.

- Support resource mobilization from domestic and international sources for timely and effective implementation of the 2013 NPEEP. Resources include financial, human and logistical/material resources.
- Lead activities aimed at monitoring the implementation of the 2013 NPEEP, priority setting as well as re-programming at regular intervals.
- Oversee advocacy efforts targeting the other tiers of Government (State and Local Government) to ensure full ownership of 2013 NPEEP priorities, strategies and activities by all key stakeholders.

The PTFoPE, NPHCDA and NTLC are vehicles to drive policy and implementation of the Federal Government's mandate.

#### **4.1.1. Presidential Task Force on Polio Eradication (PTFoPE)**

The PTFoPE is composed of: Minister of State for Health as chair, heads of technical partner agencies, commissioners for health from the poor performing and high priority states, Representatives of religious groups, traditional Leaders, and Non-Governmental Organizations (NGOs).

The PTFoPE provides overall oversight to the PEI program in Nigeria. The PTF will continue to monitor progress at the State and LGA level against the existing Abuja Commitments and Governor's Challenge through monthly meetings. A report card will be published on a quarterly basis indicating progress against the implementation of the Abuja Commitments.

#### **4.1.2. National Primary Health Care Development Agency (NPHCDA)**

The NPHCDA is the government agency responsible for implementing the polio programme across the entire country. Through the National Polio Eradication Operations Centre (EOC), the NPHCDA acts as secretariat of the Presidential Task force on Polio Eradication.

#### **4.1.3. Northern Traditional Leaders Committee on Primary Health Care (NTLC-PHC)**

The traditional leaders play a very important role in the PEI programme. They have been incorporated in all the taskforces from presidential to the LGA task force. Aside from this involvement in various task forces, the traditional authorities in northern Nigeria have an organization called the Northern Traditional Leaders committee on PHC (NTLC-PHC) whose mandate among others is to lead the process of achieving PEI and RI goals through the systematic involvement in activities for Polio eradication. They have established committees at Emirate and District levels that coordinate activities in the LGAs, wards and settlements. These committees are involved in micro-planning, vaccinator team selection, supervision of IPDS activities, resolution of non-compliance and promotion of community demand for vaccination services.

NTLC-PHC as well as the Religious Leaders, through established structures such as the Nigeria Inter-Faith Action Alliance (NIFAA) will be expected to participate in the national coordination committees (PTFoPE, ICC, ICC Working Groups) and thereby support planning, implementation and evaluation of priority activities in the 2013 NPEEP.

#### **4.1.4. Nigeria Governors Forum (NGF)**

The Nigeria Governors' Forum is a key member of the Presidential Task Force on Polio Eradication (PTFoPE). In 2012, the NGF adopted discussions on polio eradication as a standard agenda item during the monthly Governors' meeting. This contributed significantly to keeping Polio Eradication on the front banner regarding Governor's priorities. The NGF also took a decision to raise the profile of State Task Force on Immunization by ensuring that these Task Forces were chaired by Deputy Governors.

It is expected that during the very critical period of 2013, the NGF will continue to prioritize and support the intensified polio eradication effort.

#### **4.1.5. National Polio Eradication Operations Centre (EOC)**

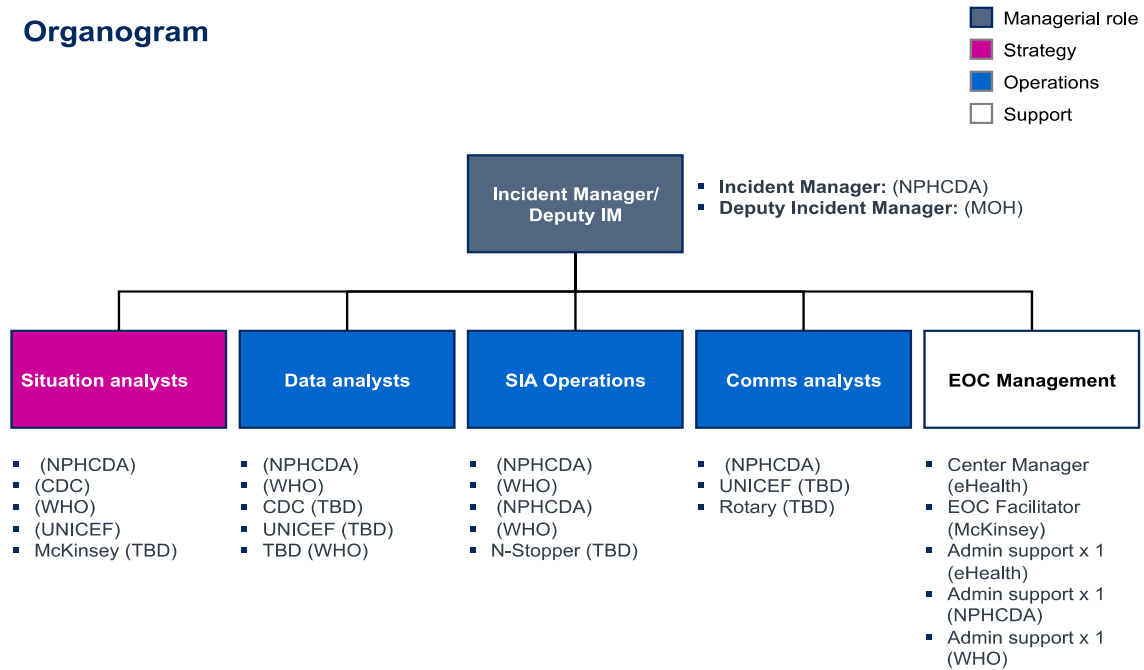
A significant change in the 2013 National Polio Eradication Emergency Plan, as compared to the 2012 NPEEP is the introduction of Emergency Operation Centers (EOCs) at the national level and in 5 high risk states. The EOCs are the operational/programme management areas of the Presidential and State Task Forces. The EOCs provide a setting where key government and partner staff can work together in the same physical location with the aim of improving information sharing, conducting joint planning and programming, and implementing new strategies to increase the effectiveness of the polio programme. The EOCs bring together senior, action-oriented national authorities with support from partners to make data-driven decisions that will address persistent gaps in programme implementation at all levels.

On October 23, 2012, the Presidential Task Force on Polio established an Emergency Operations Center at the national and in selected states to help manage PEI activities in Nigeria.

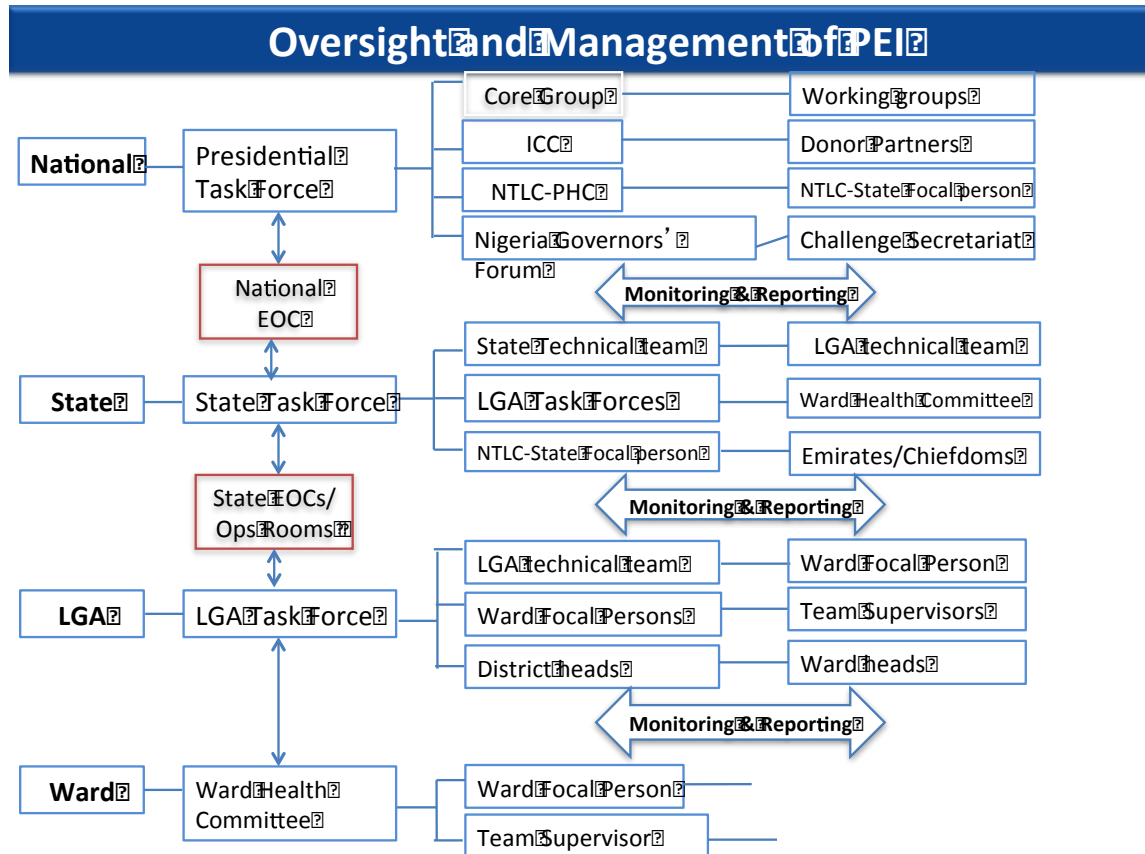
**Objectives:** This group is working to oversee implementation of policy and strategic orientation provided by the Presidential Task Force on Polio Eradication in Nigeria through (a) coordinating the key inputs and resources required for all operations, and (b) driving implementation and accountability across the states. The EOC will act as the overall secretariat of the PTF.

**Structure:** The national EOC will be Government-led and will draw its membership from relevant Government departments as well as international partner agencies. It is organized into working groups on strategy, situational awareness, operations and communication (Figure). The national EOC interfaces with the ICC working groups at the operational level.

## Organogram



**Reporting:** The EOC will report to the ED of NPHCDA on a daily basis and to the Minister of Health for State on a weekly basis.



#### 4.2 State Governments:

State Governments will continue to

- Ensure effective leadership and coordination of State Task Force on Immunization, the State Technical Team as well as State Technical Working Groups
- Provide leadership of the State Polio Eradication Emergency Operations Centre (EOC)<sup>5</sup> as well as State Operations Rooms.
- Support partnership with Traditional leaders, Religious Leaders, Community and Faith Based Organizations, Women Organizations, Professional Organizations as well as donor and technical partner agencies. These partnerships will be optimized to support the effective implementation of key aspects of the 2013 NPEEP at all levels, from State to community level.
- Support resource mobilization through timely release of counter-part funding as well as provision of human and material resources to complement those released from national level.
- Oversee monitoring the implementation of the 2013 NPEEP at State level as well as in the various LGAs, with particular focus on high risk LGAs.

<sup>5</sup>In 2013, State EOCs are expected to be established and made functional in 5 high risk states i.e. Borno, Kano, Kaduna, Katsina and Sokoto. The rest of the States are expected to continue to strengthen State Operations Rooms.



- Oversee advocacy efforts targeting LGAs to ensure full ownership of 2013 NPEEP priorities, strategies and activities by all key stake-holders including professional organizations (e.g. Nigerian Medical Association, Pharmaceutical Association of Nigeria and civil society organizations).

#### 4.2.1 State Task Forces

The State Task Forces on Immunization are chaired by Deputy Governors and are expected to meet regularly to review the progress in achieving PEI/RI targets in the States, identify remaining challenges as well as appropriate issues to address the remaining challenges. It is expected that in 2013, State Task Forces will continue to be an important forum to bring together key political leaders, Traditional and Religious leaders as well as health workers, to oversee the critical activities implemented at State level and in all LGAs, particularly the Very High Risk and High Risk LGAs.

#### 4.2.2. State EOCs/State Operations Rooms:

The State EOCs are the operational/programme management areas of the State Task Forces. In States that will not have EOCs established in 2013, this function is expected to be performed by State Operations Rooms. In January 2013, the first state EOC was launched in Kano. Additional EOCs will be set-up during the earlier part of the year in Katsina, Kaduna, Sokoto,(March 2013) and Borno (April). Similar to the national EOC, state-level EOCs will include membership from all partner agencies who co-locate and work together for maximum efficiency. In states where EOCs are not established STF's will be responsible for managing and implementing the polio programme.

**Objectives:** The terms of reference for the state EOCs/STFs are to develop and implement a state-wide plan for polio eradication and monitor implementation at the LGA level.

**Structure:** The states EOCs/STFs contain representatives from government and international partner agencies. They are organized into working groups on strategy, situational awareness, operations and communications (Figure).

**Reporting:** State EOCs/STFs will provide daily reports to the Executive Director/Chairman of their Primary Health Care Agencies; where these do not exist, such reports will be made to the Director of Public Health in the state Ministry of Health. On a weekly basis, the EOCs will report to the Deputy Governors with close collaboration of the Commissioner for Health.

**Role of state EOCs:** The state EOCs will customize the national program so as to address local challenges within the state. State EOCs will also be responsible for driving implementation across their LGAs and wards

**How the National and State EOCs/State Operations Rooms will work together:** To ensure systematic coordination, there will be clear "ownership" of the relationships with states at national level. As a result each member of the Operations committee at National EOC level will be responsible for a cluster of states. The Operations committee member (state custodian) will form a critical connecting point

between the national EOC and the states. Whilst this is the case states will continue to receive support via specific agency channels as required to drive impact.

### **4.3 Local Governments:**

Local Governments will ensure effective leadership and coordination of LGA Task Force on Immunization and the LGA Technical Team. The LGAs Governments are also expected to support partnership with influential community leaders including Traditional leaders, Religious Leaders, Community and Faith Based Organizations, Women Organizations as well as Professional Organizations. These partnerships will be optimized to support the effective implementation of key aspects of the 2013 NPEEP at all levels, from LGA to community level.

The LGAs are expected to support resource mobilization through timely release of counter-part funding as well as provision of human and material resources to complement those released from national and state level.

The LGAs are expected to oversee monitoring the implementation of the 2013 NPEEP at LGA and ward, with particular focus on high risk wards.

The LGAs will also oversee advocacy efforts targeting LGAs to ensure full ownership of 2013 NPEEP priorities, strategies and activities by all key stake-holders.

#### **4.3.1. LGA Task Force**

The LGA Task Forces on Immunization are chaired by LGA chairmen and meet at least once monthly to review the progress in achieving PEI/RI targets in LGAs, identify remaining challenges as well as appropriate issues to address the remaining challenges. It is expected that in 2013, LGA Task Forces will continue to be an important forum to bring together key political leaders, Traditional and Religious leaders as well as health workers, to oversee the critical activities implemented at LGA level and in all wards, particularly the Very High Risk and High Risk wards.

### **4.4 Independent Advisory bodies and Global Partners**

**4.4.1 GPEI Partners:** GPEI partners and donors are expected to support the national authorities to effectively implement the key activities included in the 2013 NPEEP. The GPEI partners are also expected to support resource mobilization.

**4.4.2. Expert Review Committee on Polio Eradication and Routine Immunization (ERC):** The ERC is expected to MEET 2-3 times a year to provide technical guidance on programme implementation in the area of improving SIA quality, strengthening routine immunization as well as strengthening surveillance activities.

**4.4.3. National Polio Expert Committee (NPEC):** The NPEC supports virological classification of AFP by meeting regularly to review and classify AFP cases with inadequate stool specimen.

## 5. STRATEGIC PRIORITIES

### 5.1. Enhancing SIA Quality

The main objective is to achieve high vaccination coverage during SIAs, attain population immunity and ultimately result in the interruption of poliovirus transmission. There are several key levers that will contribute to the improvement of SIAs and these will be implemented/accomplished by mid 2013 to achieve optimal success.

#### 5.1.1. Activities

##### 5.1.1.1. Improving performance of vaccination teams:

- **Team selection:** The guidelines for team selection will be revised to ensure that a rigorous process for team selection is in place across wards and disseminate these guidelines to ward selection committees. Additionally, states and LGAs will deploy capacity to supervise team selection at the ward-level, review their performance in the previous round and ensure that non performers are not selected again. A reporting mechanism will be put in place to hold LGAs accountable for effective team selection.
- **Team training:** The SIA training package will be revised, based on adult learning principles and deployed to teams across high risk states. LGAs will be asked to supplement and differentiate training based on the individual needs of the wards within their respective LGAs. An increased presence from LGA supervisors at training will further ensure high quality. The revised SOP and training package to support team selection, management and monitoring will be in place by March 2013 and will be scaled up to all 107 LGAs by June 2013.
- **Accountability:** The National will assist States and LGAs to develop performance indicators to monitor team performance and drop team members if performance is low. Concurrent monitoring will continue to be used to monitor team performance and ensure real time corrective action. The National EOCs will work with states/LGAs to test and implement strategies for improving team motivation and performance, including vaccinator recognition/reward programs.

##### 5.1.1.2. Improve quality of SIA pre-implementation and implementation activities

- **Household based micro-plans:** Develop quality standard for micro-plans and audit micro-plans in VHR LGAs and wards to all settlements are included in the micro-plan. All available data, including household data from the VCM settlements, nomad data, etc should be included in the micro-plans. There will be scaling up and refining of house-based micro planning with social data in all 107 LGAs by Mid 2013. Quality micro-plans should be used to guide the provision of adequate logistics for each vaccination team i.e. vaccine supply, cold chain and potent indelible markers.

- **Polio SIA Dashboard:** Continue use of dashboard system to monitor campaign performance at state and LGA levels and link with specific actions for non performance at pre-intra-and post campaign periods.
- **Broaden inter-sectoral collaboration:** Increase inter-sectoral collaboration for SIAs including departments of transportation, education, agriculture, education, defense, and NGOs and CBOs.
- **Adequate supply of pluses:** Provide adequate supply of other health interventions (e.g. other antigens, ORS, anti-malarials, environmental sanitation....etc) together with polio vaccine during IPDs. Supply of plus should be especially monitored in areas with entrenched resistance and persistent transmission. Increased focus should also be given to ensuring adequate functioning of fixed vaccination posts during IPDs.

#### 5.1.1.3. Improve SIA monitoring and operational Research

- **Improve quality of Enhanced Independent Monitoring (EIM) and LQAs:** Continue to improve the quality of EIM and LQAs through strengthening monitoring of monitors activities as well as through periodic audits.
- **Operational Research:** Conduct operational research to better understand reasons for chronically missed children.
- **Improved use of SIA monitoring data for action:** Closely monitor the implementation of mop up activities in areas of low performance based on LQA and IM. Consider use of separate teams to conduct the mop up vaccination. Conduct post mop-up evaluation to ensure high coverage.

#### 5.1.2.Targets, Milestones and Indicators:

- 100% of LGAs to have meeting of Ward Selection Committees (WSC) to review performance and selection of teams 2 weeks prior to implementation by March 2013
- 100% of the 107 high risk LGAs with updated and validated micro-plans, with inclusion of all underserved<sup>6</sup> communities, by end of March 2013
- 80% of the 107 high risk LGAs achieve at least 80% coverage as demonstrated by LQAs by April 2013.
- Improved vaccinator selection, training and monitoring SOP implemented in all 107 VHR LGAs by June 2013.
- Implement LGA specific strategies to reduce non-compliance that include the mobilization of religious leaders by April 2013.
- Full functioning national and state level EOCs in 5 high-risk states by April 2013.

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<sup>6</sup> Underserved communities refer to communities that have been missed by delivery of health services including immunization and surveillance e.g. nomadic communities, hard-to-reach communities, scattered and border communities.

## 5.2. Special Strategies to reach underserved populations

Special rounds and other tactics will be conducted to reach children who have been missed or who have never been reached with campaigns or health services. Underserved populations refer to those populations that have been demonstrated to have a higher likelihood of not receiving regular services i.e. nomadic and other migratory populations, populations living in hard-to-reach areas, scattered or border settlements.

In the past 12 months, most children with confirmed polio resided in rural, hard-to-reach settlements along the border areas between LGAs. Many cases have not received any dose of polio vaccine and are from communities that are not visited by vaccinator teams or whose parents refuse the vaccine. These border areas are also often in close proximity to major travel routes for nomadic herdsmen, whose children are chronically missed by the program. Furthermore, AFP cases were being systematically missed as indicated by discovery of many unreported cases.

### 5.2.1. Activities:

- **Complete landscape analysis:** Identify and map nomadic routes, hard to reach settlements and border areas in the northern high risk States.
- **Update existing microplans** with additional census data from these special rounds
- **Use the Short Interval Additional Dose (SIAD) strategy** to rapidly build immunity in communities that have not been reached before.
- **Ensure proper logistic support** for IPDs with emphasis on teams operating in hard-to-reach and border areas that have not been well covered
- **Cross Border activities: Increase collaboration and synchronization of PEI activities across international, interstate, inter-LGA and inter-ward borders.**
- **Establish permanent immunization posts:** Establish permanent immunization posts/teams in busy medical centres and markets to reach children from areas of difficult access.
- **Monitor quality of IPDs in these areas:** Special efforts will be conducted to monitor coverage in nomad and hard to reach areas
- **Strengthen surveillance among scattered, nomad and border communities**
- **Strengthen RI outreach:** Using information provided by landscape analysis, outreach to nomad communities will be included in the RI microplan in LGAs with high nomad populations.

### 5.2.2. Targets, Milestones and Indicators:

- Improvement in population immunity in all scattered and border settlements as measured by OPV status of non-polio AFP cases identified from these communities
- Decrease in number of unreported AFP cases detected in outreach sessions
- Improvement in campaign quality month over month for all 107 VHR LGAs states as measured by IM

## 5.3. Approaches in Security Challenges Areas

Flexibility is critical when working in areas where accessing all children during campaigns is not possible. Special approaches including the deployment of special permanent polio teams and in-between round activities will be undertaken in areas where it is difficult to access children during campaigns.

Many children remain persistently inaccessible during polio campaigns in Borno and Yobe due to insecurity. During campaigns conducted in October 2012, a total of 167,602 were not accessed in Borno and Yobe due to security challenges, while during the Nov 2012 campaign this number increased to 283,207 children. During the December 2012 campaigns, 164,740 children in these states could not be accessed by vaccination due to security challenges. In 2012, Borno reported a total of 8 cases and Yobe a total of 6, indicating the presence of virus in this key reservoir as result of low population immunity through SIAs and routine immunization. Some areas and populations are chronically missed, leading to a build-up of susceptible children where outbreaks can occur and spread to infect other areas given the high population mobility. Given the volatility of the security situation in this key reservoir, a priority for 2013 is to adopt new, flexible innovative approaches in Borno and Yobe in particular, that can be undertaken during and in-between campaigns to assist in increasing population immunity in the high-risk areas where inaccessibility and insecurity are a risk to the programme. Experience from other countries with similar challenges has shown progress in reaching children through flexible immunization approaches.

### 5.3.1. Activities

- **Mapping and security landscape analysis:** Create and update maps of security challenged areas and track trend analysis in terms of number of children inaccessible and the number of children from these areas missed or immunized.
- **Permanent polio teams:** Test the use of permanent polio teams (PPT), to be deployed to work and be paid on a monthly basis instead of being hired for the few days of a campaign, in the high risk areas. The teams would keep a low profile within their catchment area and would be recruited from within their local community in consultation with relevant community/local leaders. These teams can take responsibility for ensuring a pre-identified population is immunized over a specified period of time, rather than being bound by the campaign schedule. Permanent polio teams should also be deployed in busy market and transit sites.
- **Establish permanent immunization posts:** Establish permanent immunization posts/teams in busy medical centres, motor parks and markets to reach children from areas of difficult access.
- Conduct daily remote supervision by phone to local supervisors in security compromised areas.
- **Capitalizing on windows of opportunity:** Implement low profile campaigns in limited areas outside the campaign schedule whenever there is an opportunity to vaccinate children. As the situation allows, the programme will implement a short interval additional dose approach, with three passages undertaken 10 days apart. More teams should be added to the microplan to reduce the number of days for the activity. Microplans should be regularly updated and all necessary logistics, resources and support available for quick implementation.
- **Local stakeholder engagement:** Scale-up engagement of local stakeholders, such as FOMWAN, to help overcome issues of mistrust and suspicion at the local level.

### 5.3.2. Targets, Milestones and Indicators:

- Improvement in population immunity in all security challenged areas as measured by the Non-polio AFP rate.
- Increase in number of PPTs established
- Increase in number of SIADs (up to 3) implemented in security challenged LGAs

### 5.4. Improving Outbreak Response

Intensive efforts will be made to effectively respond to cases of laboratory –confirmed polio and to stop transmission in the areas where cases have been detected.

The timeliness and effectiveness and timeliness of outbreak response activities, both in polio-endemic states as well as polio-free states that experienced polio outbreaks in 2012 was in many cases sub-optimal.

In the past 12 months, several high-risk LGAs reported multiple chains of transmission over 2-6 month period indicating failure of the local response to stop transmission in that LGA. For example there were 12 cases reported from June through October in Katsina LGA and 9 cases reported from Minjibir from June through Dec. Other LGAs with extended outbreaks over several months include Batsari (5), Zaria (4), Barbura (3 cases), Kiru (3), and Zurmi (3).

The ability to control these outbreaks expediently will improve Nigeria’s progress toward eradication. Experience has shown the most impact can be achieved with rapid and intense response (3 rounds 10 days apart) to the first case at the local level. Experience has also shown that if an effective local response is not done, prolonged outbreaks are likely to occur with spread to neighboring LGAs. Intense efforts will be made to control local outbreaks in the coming months.

#### 5.4.1. Activities:

**5.4.1.1. Outbreak Response Standard Operating Procedures (SOP):** An SOP has been developed to provide clear guidelines on how to respond to outbreaks. This SOP will be implemented across states through training to States and LGAs.

- **Outbreak Investigation:** Ensure high quality investigation with a senior epidemiologist including capturing GPS coordinates for all WPV cases as soon as ITD results are available. Hot cases in high transmission zones should be investigated immediately and responded to according to the SOPs. Expanded case finding should be conducted if additional cases are detected during the initial 30 household case search. A social mobilization officer should be included in the outbreak investigation team to communicate to the community about polio transmission modes.
- **Monitoring outbreak response:** Support outbreak response at the national EOC level through the deployment of experienced personnel to support outbreak response activities and closely

monitor adherence to Outbreak Response SOP. Develop a roster of outbreak response teams to support implementation of outbreak SOPs.

- **Response to cVDPV:** Immediate response to cVDPV cases (LGA wide) with tOPV within 10 days followed by two rounds of tOPV in the LGA.

**5.4.1.2. Vaccine supply:** Maintain vaccine stockpile of 10 million doses (5 million bOPV and 5 million tOPV) for outbreak response.

#### 5.4.2. Targets, Milestones and Indicators

- All cases investigated within 24 hours of notification by end of February 2013
- All mop-up campaigns (3 rounds 10 days apart) conducted as outlined in outbreak SOP by end of Feb 2013
- No LGAs with > 2 cases of polio with onset of illness > 6 weeks apart after end march 2013

#### 5.5. Enhancing Routine Immunization and in-between round activities

Routine Immunization is the scheduled delivery of vaccinations through health systems, using static, mobile and outreach services. In-between round activities are conducted between scheduled IPD rounds to further increase population immunity.

In 2013 the polio program's efforts will focus on improving RI coverage in those LGAs and wards at risk of sustaining any poliovirus transmission. The rapid revitalizing of routine immunization service delivery is a huge undertaking and the Government of Nigeria will collaborate with the GPEI spearheading partners and development partners, including USAID, DFID, JICA, the European Union, Bill & Melinda Gates Foundation, Clinton Health Access Initiative in the development of a national immunization and accountability framework. This will include their active participation in the working groups of the Inter-Agency Coordinating Committee (ICC) to strengthen vaccine supply and management, monitoring and evaluation, training and social mobilization.

##### 5.5.1. Activities:

- **Review Terms of Reference:** Review terms of reference of WHO, UNICEF and CDC field workers to ensure up to 25% of staff time is earmarked to supporting RI activities. These include support for RI planning and reviews, monitoring of fixed and outreach immunization sessions, RI training of health workers, household and community engagement by VCMs, and vaccines and logistics support. Staff will be oriented and trained on their responsibilities before mid-2013 and performance indicators set and measured.
- **Engage in REW micro planning:** The highest risk LGAs will be supported to develop updated and realistic micro-plans aimed at ensuring regular and quality RI service delivery through fixed, mobile and outreach services. The aim is to ensure that in every ward at least one health facility is supported with the required personnel, cold chain as well as vaccines and consumables required to deliver quality RI services. The updated and revised IPDs micro-plans supplemented



by the GIS/GPS information will be used to determine areas for mobile and outreach services delivery.

- **Integrate RI Reporting:** Reporting of RI monitoring data integrated into polio status updates used at LGA, State and Presidential Task Force meetings, including an analysis of sessions planned vs held; cold chain and vaccine availability; etc.
- **Mobilize human resources:** On the supply side, to ensure that these services are revitalized, there is urgent need to mobilize the required human resources, including wherever necessary retired health workers and provide adequate logistics, including vaccines and cold chain, to support the accelerated routine immunization activities in the highest risk areas.
- **Increase demand and utilization:** To increase demand and utilization, linkages with traditional leaders, religious leaders, community opinion leaders and traditional birth attendants (TBAs) in mobilizing mothers and caretakers in the targeted high risk communities to consistently utilize routine immunization activities will be strengthened. In addition, the network of volunteer community mobilizers (VCMs), wherever they operate, and faith networks such as the FOMWAN will play a part in mobilizing mothers.
- **Engage in and leverage collaborative relationships:** Furthermore, during 2013, WHO, UNICEF and CDC will support 20 LGAs in 8 states to implement accelerated immunization outreach activities to address persistent transmission of cVDPVs. Additionally, WHO and UNICEF will collaborate with Kano state, the Dangote Foundation and the Bill & Melinda Gates Foundation in a three-year effort to revitalize routine immunization from 2013. The focus will be on improved tracking of vaccine supplies, support for data management, training and monitoring of immunization sessions, and intensification of social mobilization activities to increase demands for immunization services
- **Intensify In-Between round activities appropriately for the context:** Efforts will be to intensify appropriate in-between round activities (LIDs, BCI, SIAD, Market Strategy, Naming ceremonies, New-born strategy) based on whether the poor performing areas are in endemic or non-endemic states.
- **Build immunity in endemic areas:** In states with polio transmission in the last 6 months, the focus will be to quickly build population immunity through activities targeting special areas / communities with increasing susceptibility determined by consistently poor SIAs quality, surveillance data (non-polio AFP - OPV doses and persistent WPV transmission) and if the area is determined as an underserved area based on classification of being hard to reach, scattered border areas and nomadic populations, including seasonal farmers and fishermen etc.
- The activities in these areas will be tailored according to the specific peculiarities that make them not benefit from RI services. In the poor quality SIA and low OPV doses communities, additional vaccination activities will be planned between rounds covering wards. In the nomadic populations, the activities will focus on Boosting Child Immunity (BCI) whereby all routine immunization antigens will be given to these populations up to the age of 23 months. However, OPV will be given up to the age of 59 months. In areas with insecurity and migrant populations, Short Interval Additional Doses (SIAD) approach will be implemented when opportunity to reach the groups arises. At least, 3 OPV passages will be administered at a 10 - 14 days intervals.

- The market vaccination strategy and vaccination during local ceremonies, particularly naming ceremonies, will be intensified. The network of TBAs and VCM will notify their supervisors the list of pregnant women and information of planned naming ceremonies. As part of the celebrations, a vaccination team will be set up within the visible vicinity of the crowd attending the naming ceremony and will provide tOPV and pluses. For successful implementation, it will be vital that adequate pluses are provided with the teams to attract children in the true spirit of celebrating protection of a newborn from polio.
- **Implement Local Immunization Days (LIDs) in non-endemic areas:** In states without WPV transmission in the last 6 months, the main focus will be intensified implementation of LIDs. Since the focus is to reduce the number of un / under-immunized children, the RI coverage data from 2012, will be used to identify LGAs which will start implementing LIDs in the 1st half of 2013. The RI coverage data and accumulating number of un / under-immunized children by June 2013, will be used to determine the LGAs to implement LIDs in the 2nd half of the year. It is important to note that prioritized LGAs in either 1st or 2nd quarter will implement 3 sessions of LIDs to ensure the immunization of children.
- **Immunize newborns everywhere:** Furthermore, in both polio-free and areas with continued WPV transmission, newborns are to be tracked and immunized through MSS facilities. OPV is also to be pre-placed in delivery rooms to ensure administration of birth dose of OPV.

### 5.5.2 Targets, Milestones and Indicators

- At least 80% of the VHR LGAs have updated REW micro-plans by end of April 2013
- At least 80% of wards in the VHR LGAs have at least 1 routine immunization monitored per week by May 2013
- At least 80% of planned Fixed Routine Immunizations hold as planned by May 2013
- At least 80% OPV3 coverage by end August 2013

### 5.6. Enhancing Surveillance

Highest quality surveillance is critical to ensuring timely detection of poliovirus circulation, particularly as intensity of transmission becomes more and more restricted. To ensure that Nigeria is able to ensure timely detection of poliovirus circulation, and subsequently timely and effective response, surveillance sensitivity will be enhanced through both enhanced Acute Flaccid Paralysis (AFP) Surveillance and expanded environmental surveillance.

Nigeria has achieved and maintained target AFP surveillance performance (non-polio AFP rate of at least 2 per 100,000 under 15 year olds and at least 80% stool specimen adequacy) at national level and in the 36 States and Federal Capital Territory (FCT) for the last 4 years. Between January and November 2012, 93% of all the Local Government Areas (LGAs) in Nigeria achieved target AFP surveillance performance.

The proportion of orphan viruses being detected by the surveillance system is decreasing, suggesting that transmission is less often missed; however in 2012 there remain clear examples of serious gaps in detection of WPV and cVDPV2

This overall good surveillance performance however masks gaps at sub-national level. In 2012, genetic sequencing confirmed 14 orphan wild polioviruses in Nigeria i.e. wild polioviruses that had been circulating undetected for at least 1 year. Eleven of the detected orphan viruses were detected from AFP cases while 3 were detected from environmental surveillance samples. Intensive outreach to communities not usually reached by immunization and surveillance activities, including nomadic settlements, hard to reach and border areas, was conducted in 2012. During these outreaches, several unreported AFP cases were detected. In early 2013, an orphan wild poliovirus was confirmed in neighboring Niger republic that was genetically linked to wild poliovirus that was circulating in Kaduna state in Nigeria in 2011.

### **5.6.1. Activities:**

**5.6.1.1. Enhance the sensitivity of AFP Surveillance:** This will be achieved through the following specific activities:

- Conduct biannual review and update of AFP surveillance network to include both formal health facilities as well as community informants as reporting sites. LGAs with sub-optimal performance indicators should have increased focal sites, and community informants. Where Volunteer Community Mobilizers and Village Health Workers exists, their TORs should include active case surveillance.
- Implement regular capacity building of personnel involved in surveillance including surveillance focal points, DSNOs, state epidemiologists through supportive supervision, on-the-job training, peer exchanges and refresher training. Additionally, in LGAs where the surveillance review indicates a need, assistant DSNOs should be engaged.
- Implement targeted surveillance activities in under-served communities including nomadic communities as well as border and hard-to-reach areas
- Monitor quality of active surveillance and performance of the AFP surveillance network through supportive supervision, monthly and quarterly surveillance review meetings at LGA, State and national level as well as implementation of regular surveillance reviews (rapid surveillance review and where indicated international surveillance review)

**5.6.1.2. Expand Environmental Surveillance** This will be achieved through the following specific activities:

- Provide technical, logistical and financial support to sustain quality environmental surveillance activities in Kano, Sokoto and Lagos.
- Monitor the performance of the environmental surveillance sites quarterly and modify/expand as indicated

**5.6.1.3. National Polio Laboratory Activities:** This will be achieved through the following specific activities:

- Provide laboratory reagents, supplies and equipment
- Provide technical support, capacity building and accreditation visits
- Bi-annual technical meetings with National Polio Laboratory staff

**5.6.1.4. Polio sero-surveys:** Polio sero-surveys will be conducted periodically in several key states including Kano, Sokoto and Kebbi

**5.6.2. Targets, Milestones and Indicators**

- Sustain attainment of the 2 main AFP surveillance performance indicators in at national and state level
- Conduct at least 80% planned active surveillance activities (including to community informants)
- National Polio Laboratories maintain WHO accreditation

## 6. CROSS CUTTING PRIORITIES

### 6.1. Intensifying Communication and advocacy

Intensive efforts will be made to scale up communication and advocacy in the high risk areas to contribute to a reduction in the percentage of missed children and enhanced commitment at the LGA level.

'Child absent' remains the main reason for missed children, accounting for over 71% of the total number of missed children. Nationally, caregivers' refusal to vaccinate their children account for 23% of the total number of missed children during campaigns. No felt need by caregivers is reported as a significant reason for non-compliance. States like Kano, Katsina, Kaduna and Sokoto still continue to have a high proportion of unresolved non-compliance even after teams have gone back to revisit the refusing households. This correlates to the non-polio AFP data of un/under-immunized children, which shows that 28% of the AFP cases were un/under-immunized due to non-compliance. Experience has shown the significant impact can be achieved by developing locally appropriate communications plans that include targeted household and community engagement together with a solid media and visibility package. A national communications strategy has been developed based on recommendations from an international communication review. The priorities of reducing chronically missed children, including refusals, branding and visibility are based on key elements of that strategy.

#### 6.1.1. Activities

##### 6.1.1.1.Reducing chronically missed children and in particular non-compliance

- **Developing evidence based communication planning** in every high risk LGA to address the locally specific reasons for missed children.
- **LGA-specific strategy developed and implemented to enlist and mobilize religious leaders, including integration in microplans**
- Additional Volunteer Community Mobilizers (including Polio Survivors) and other community mobilizers (ie PPRINN, TSHIP, FOMWAN) deployed in the highest risk areas with particular emphasis on Kano, Katsina and Kaduna

**6.1.1.2. Branding, visibility and mass media promotion:** Develop long-term entertainment-education radio programming in local languages to highlight the benefits of immunization. These will be conducted with clear recognition and sensitivity of the local security situation.

#### 6.1.2. Targets, Milestones and Indicators

- Locally appropriate, issue specific communication plan in place in all high risk LGAs of Kano, Katsina and Kaduna by March 2013.
- VCM network optimized in Kano, Kaduna and Katsina in the highest risk settlements by March 2013

- Achieve >90% caregiver awareness in all high risk states
- Missed children due to actual non-compliance reduced to <1% in Kano, Katsina and Kaduna by end-2013.
- Religious leaders integrated in microplans in Kano, Kaduna and Katsina by April
- Nigeria polio eradication brand and IEC package in place by April 2013.
- Entertainment education package airing in 3 key states by mid-2013
- VCMs implementing polio communications activities and outreach during naming ceremonies in the participating settlements in Kano, Katsina and Kaduna by March 2013.
- Implement LGA specific strategies to reduce non-compliance that include the mobilization of religious leaders by April 2013.
- Focal points for religious leader engagement identified in Kano, Kaduna, Katsina and Sokoto by March 2013.
- IPC skills integrated in the updated training package by March and scaled up in all 107 High Risk LGAs by June.

## **6.2. Enhancing Innovations**

Utilize GIS technology to enhance data collection, interpretation, and programmatic response.

Due to an unreliable mapping of settlements, it is very difficult to implement and monitor many of the programme's initiatives including creation of microplans, team adherence to microplans, and immunization activities in border/HTR areas. GIS/GPS technology can help map out settlements and improve monitoring of immunization activities

### **6.2.1 Activities**

- Micro-planning – GIS-based Ward maps containing names and locations of all settlements and other points of interest (POIs) – health facilities, schools, markets, mosques/churches, etc. - will be provided to each Ward for use in the microplanning process. The maps also will contain specific layers identifying migrant communities and seasonal movements.
- Tracking – Vaccination teams will be tracked in selected LGAs (up to 30 each round) to evaluate geographical coverage and identify missed settlements. Tracks also provide effective feedback for improving team performance and supervision. Team tracks will be uploaded each day at the LGA level and the results shared with the LGA team. Tracks will simultaneously be transmitted to the EOC-Abuja for review by the EOC and dissemination to the State teams.
- AFP Surveillance - GIS maps showing locations of health facilities and other reporting sites will be used to ensure more effective planning and better coverage of surveillance catchment areas.
- Monitoring/Evaluation – GIS maps with population data can be used to select true randomized samples for monitoring processes such as LQAS and enhanced Independent Monitoring.
- Population Estimation – A GIS-based population estimation model that is under development will provide a powerful tool to estimate target populations, validate tally sheet totals, and support planning for IPDs, Routine Immunization activities and other public health efforts.

### **6.2.2. Targets, Milestones and Indicators**

- GIS mapping completed in eight states and fully integrated into microplanning process by March 2013;
- All vaccinators in 30 LGAs in 8 states routinely tracked during IPDs with GPS from April.

### **6.3. Optimizing human resources**

Continually ensuring human resources are of adequate quality and ensuring that the right quantity and quality are allocated to the highest risk LGAs and wards to achieve the greatest impact

2012 saw a huge increase in the number of field workers in the polio programme. WHO deployed more than 2,500 people at the state, LGA and ward levels to support improved campaign quality. UNICEF expanded its communications capacity in LGAs in the high risk states. 1827 Volunteer community mobilizers were deployed to the highest risk settlements, with further expansion in 2013. In order to maximize the impact of these individuals it is essential to deploy them into the highest risk LGAs and wards. Furthermore, there is an opportunity to put the highest performing individuals into these highest risk LGAs and wards as they are the most qualified and capable of managing the programme implementation. Emphasis will be placed on ensuring a one team, one plan approach at all levels of the programme.

#### **6.3.1. Activities:**

- Develop an analysis tool and dashboard to update the most critical LGAs and wards after each campaign and overlay the current human resource allocation
- Facilitate EOC discussions after each campaign to reward, remove or re-allocate field staff to best tackle the high risk areas.
- Facilitate a one-team approach at all levels and coordination around the development of one-plan.
- Support each agency to develop a system to track performance of their field staff to ensure that we have the right people in the jobs.
- Develop a set of rules, communications and incentives to support the new strategy of continual re-allocation of workers to make rewarding, removing and transferring of workers simple.

#### **6.3.2. Targets, Milestones and Indicators**

- Government and partner field staff deployment optimized by February to match highest risk ward and LGA analysis.
- Full functioning national and state level EOCs in 5 high risk states by April 2013.

## **Summary of low season priorities**

## Low season priorities

Priority	Description
1 Refine microplanning	<ul style="list-style-type: none"> <li>Scale up and refine house-based microplanning with social data in all <b>107 VHR LGAs</b></li> <li>Map HTR/border/nomadic settlements in 95 LGAs by <b>January</b> and all settlements reached with at least 3 doses of OPV by <b>June</b></li> <li>Complete GS mapping of 8 states and integrate into micro-plans by <b>March</b></li> </ul>
2 Strengthen team selection and training	<ul style="list-style-type: none"> <li>Revise SOP and training package to support improved team selection, management, and monitoring in place by <b>March</b> and scaled up in 107 VHR LGAs by <b>June</b></li> <li>Track all vaccinators in 40 LGAs in 8 states with GPS during IPDs by <b>April</b></li> </ul>
3 Access children in security compromised areas	<ul style="list-style-type: none"> <li>Strengthen mapping of security access by <b>February</b></li> <li>Pilot use of permanent vaccination teams in special areas (i.e., all major HFs, busy markets, transit points)</li> <li>Initiate SIAD in newly accessible areas (e) continued local stakeholder engagement</li> </ul>
4 Reduce non compliance	<ul style="list-style-type: none"> <li>Rapid review of VCM management structure to strengthen supervision by <b>February</b> to improve effectiveness and inform scale-up</li> <li>Develop and begin to implement LGA-specific strategy to enlist and mobilize religious leaders including integration of imams in microplans by <b>April</b></li> <li>Operations research on reasons for persistent, clustered non-compliance</li> </ul>
5 Intensify program management	<ul style="list-style-type: none"> <li>Sustained engagement with Executive Governors and VHR LGAs by Presidential Task Force &amp; Nigeria Governors' Forum</li> <li>Establish EOCs in Abuja and Kano, Katsina, Sokoto, Kaduna, and Borno by <b>April</b></li> <li>Optimize deployment of government and partner field staff to align with segmentation analysis of highest risk LGAs and wards by <b>February</b>, optimization completed by <b>April</b></li> <li>Ensure thorough and expedient response to outbreaks as outlined in the SOPE</li> </ul>

## 7. ACCOUNTABILITY

**7.1 Accountability mechanisms and rewards:** Increased accountability across all levels is needed to ensure campaigns and other activities are carried out with a high degree of quality.

The Accountability Framework is an evidence-based tool used to promote accountability, evaluate staff performance and increase inter-agency transparency. It is based on several key principles:

- I. **Promoting individual accountability at every level:** People have been hired to achieve specific terms of reference for the polio eradication programme. This framework helps to identify those who are performing and those who are not, and to consider rewards and consequences accordingly.
- II. **Rewards for strong performance:** The individuals who demonstrate strong performance should be recognized through a new reward programme. The programme will develop a standardized reward scheme to recognize top performers in wards, LGAs and states. Rewards can include public recognition, a congratulatory meeting with a senior leader, an award certificate, a mention in the media, enrollment in training of choice, etc. This scheme should be operational by the end March 2012
- III. **Consequences for weak performance:** All weak performance will be documented and reported to appropriate policy makers and stakeholders. Further, demonstrated weak performance will



be sanctioned (e.g., including warnings, withholding of allowances and/or disengagement from the programme).

- IV. Evidence based decision making:** Assessments of critical impediments, their solutions, staff performance and progress will be evidence based.
- V. Independent assessments every month:** The programme will conduct random independent assessments of critical impediments, solutions and performance at LGA and state levels throughout the year.
- VI. Feedback to all levels:** Constant feedback loops are critical to ensure a coordinated response and common understanding of challenges and progress. Feedback loops between wards, LGAs, state, Core Group and Presidential Task Force will be in place.

The Accountability Framework was instrumental in evaluating staff performance by Government and partners in 2012 with disciplinary actions taken on poor performing staff. In 2013, the additional use of an Indicator Dashboard will further increase transparency and rapidly monitor staff performance at all levels during each IPD round.

#### **7.2. Activities:**

**Develop, refine and implement the framework and indicator dashboard:** The LGA High Risk Operational Plans (HROP) serves as the foundation of the Accountability Framework. In addition, key performance indicators that can be accurately measured and regularly updated will form a dashboard to inform progress as illustrated below:

## State level Pre-campaign Indicators to monitor campaign quality

Nov-2012

Kaduna

State Indicator	3 Weeks to Implementation	2 Weeks to Implementation	1 Week to Implementation	3 Days to Implementation
Has the State Task Force met [HCH]	No	Yes	Yes	
Is the Schedule of Activities/Workplan finalized [WHO-SC]	No	Yes	Yes	
Has the HROP been reviewed [WHO-SC]	No	No	Yes	
Has the State team supervisory plan been done [SIO]	No	No	Yes	
Are state level counterpart funding available [DPHC]	No	No	Yes	
Are the state level Social Mobilization Activities being done as scheduled [SHE & UNICEF]	No	No	Yes	
Is the list of tasks for LGA taskforce prepared [SIO]	No	No	Yes	
Is the Training plan available [WHO-SC]	No	Yes	Yes	
Report of vaccine & Logistics distribution available [SCCO & UNICEF]			Yes	
Status of preparedness Report available [DPHC]			No	
Verification of LGA status of preparedness [WHO-SC]				

\* black boxes = indicator not collected at this point in time.

\*\* All indicators should have yes, no, and unknown as dropdown options.

**Identify the workers of interest:** Government and partners will submit the actual names of each cadre working at the different levels, particularly at LGA. The dashboard will contain the names of staff and those working in poor performing LGAs will be exposed for timely action to be taken in addition to periodic evaluations.

**Receive timely performance input:** During implementation, LIO /LGA facilitators working in perpetually poor performing LGA provide information of the daily IPD status in problematic wards during evening teleconference calls with the EOC, ED-NPHCDA and Chairman Presidential Task Force. GPEI partners (inside and outside Nigeria) can dial in to provide inputs on how to improve quality.

**Provide incentives:** Because of the transparency of the dashboard and the clarity of accountability in the framework, workers can receive awards as incentives to continue performing well. Conversely, workers can also receive sanctions in the instance of poor performance.

**Targets, Milestones and Indicators:**

- The EOC will integrate the State and National Indicators into the monthly Polio Accountability Report to the Presidential Task Force. It will also use additional measures such as IPDs EIM and LQAs outcomes, RI coverage, and reports from independent supervisors to complement the reports from states and will note any discrepancies.

**Dashboards:** Monitor key during the pre, intra and post-campaign periods through an integrated dashboard. Feedback will be provided to ensure a coordinated response and common understanding of challenges and progress. State EOCs will be expected to monitor LGA level indicators and implement corrective actions when necessary.

**Rewards and recognition:** Develop and test a reward and recognition program to incent strong performance and desired behavior for individuals across levels including vaccinators and local leaders. Weak performance will be documented and reported to appropriate policy makers and stake-holders. Weak performance at individual level will be accompanied by sanctions including warnings, withholding of allowances and/or disengagement from the programme.

## 8. MONITORING AND EVALUATION

### 8.1. Monitoring Process

Priority activities to improve quality of immunization services, particularly scheduled SIA activities, special rounds targeting underserved populations as well as outbreak response immunization activities will be monitored through the use of

- standard pre-implementation and implementation monitoring checklists and presentation of information in the polio SIA dash board
- Supportive supervision, including concurrent monitoring
- Enhanced Independent Monitoring
- LQAs
- Programme audits and reviews
- Special studies including polio sero-surveys

Specific activities that will be undertaken to monitor surveillance and polio laboratory activities will include

- Monthly review of standard surveillance and laboratory performance indicators
- Rapid surveillance appraisals, targeting areas with sub-optimal performance indicators
- Annual Laboratory Accreditation missions.

The information collected from the monitoring processes will be analysed by EOCs and State Operations rooms and regular monitoring reports prepared for use by

- Presidential and State Task Forces

- Quarterly PEI review meetings
- ERC and other technical oversight meetings ....etc

## **8.2. Targets, Milestones and Indicators**

8.2.1. SIAs

8.2.2. Service Delivery in underserved areas

8.2.3. Security Compromised Areas

8.2.4. Outbreak Response

8.2.5. Routine Immunization

8.2.6. Surveillance

8.2.7. Communication and advocacy

8.2.8. Innovations

8.2.9. Human Resources

## 9. ANNEXES

### 9.1 List of High Risk LGAs as of December 2012

State	Very High Risk LGAs	High Risk LGAs
Bauchi	Bauchi, ItasGadau (2 LGAs)	Alkareli, Dambam, Gamawa, Ganjuwa, Giarde, Jamare, Katagum, Misau, Shira, Toro (10 LGAs)
Borno	Bama, Bayo, Jere, Kaga, Kukawa, Mafa, Maiduguri (7 LGAs)	Abadam, Damboa, Guzamala, Konduga, Mongumo, Ngala, Ngazai, (7 LGAs)
FCT	Abuja Muncipal (1 LGA)	
Jigawa	Babura, Birninku, Dutse, Gwaram, Kazaure, Kiyawa, Maigatari, Miga, Sule-Tan, (9 LGAs)	Biriniwa, Guri, Hadeja, Jahun, Kafin Hausa, Kaugama, MalamMadori, Ringim, Taura (10 LGAs)
Kaduna	Birnin-G, Chikun, Igabi, Ikara, Kaduna-North, Kaduna-South, Kubau, Makarfi, Sabon-Ga, Zaria (10 LGAs)	Giwa, Kauru, Kudan, Soba (4 LGAs)
Kano	Bagwai, Bebeji, Bunkure, Dala, Dambatta, Dawakin Kudu, Fagge, Gabasawa, Garko, Gaya, Gezawa, Gwale, Kabo, Kano, Kibiya, Kiru, Kumbotso, Kura, Madobi, Minjibir, Nasarawa, RimimGado, Rogo, Sumaila, Takai, Tarauni, Tudun Wada, Ungogo, Wudil (29 LGAs)	Ajingi, Albasu, Bichi, DawakinTofa, Doguwa, GarumMallam, Gwarzo, Karaye, Kunchi, Makoda, Rano, Shanono, Tofa, Tsanyawa, Warawa (15 LGAs)
Katsina	Bakori, Batagarawa, Batsari, Baure, Dandume, Daura, Dutsin-M, Faskari, Funtua, Ingawa, Jibia, Kafur, Kaita, Kankara, Katsina-(K), Mai'Adua, Malumfashi, Mani, Mashi, Sandamu, Zango (21 LGAs)	Bindawa, Charanchi, Danja, Danmusa, Dutsi, Kankiya, Kurfi, Kusada, Musawa, Rimi, Sabuwa (11 LGAs)
Kebbi	Suru (1 LGA)	Aleiro, Augie, Birninke, Jega, Maiyama, Ngaski, Shanga, Yauri, Zuru (9 LGAs)
Nasarawa	Doma (1LGA)	
Niger	Mariga (1LGA)	Bosso, Mashegu, Wushishi (3 LGAs)
Sokoto	Gwadabaw, Illela, Kware, Rabah, Sokoto-North, Sokoto-South, Wamakko, Wurno (8 LGAs)	Bodinga, Dange-Shuni, Gada, Isa, Kebbe, Sabon-Birni, Shagari, Yabo (8 LGAs)
Taraba	Gassol, Wukari (2 LGAs)	
Yobe	Damaturu, Fune, Geidam, Gujba, Gulani, Nangere, Tarmuwa (7 LGAs)	Borsari, Fika, Karasuwa, Machina, Potiskum, Yunusari, Yusufari (7 LGAs)
Zamfara	Bukkuyum, Bungudu, Gummi, Gusau, Maradun, Maru, Shinkafi, Zurmi (8 LGAs)	Anka, Bakura, Kaura-Na, Talata-Mafara, Tsafe (5 LGAs)

## 9.2. Polio Eradication Key Dates

Month	Activity	Location
<b>January</b>		
12-15 Jan	Special Vaccination campaign	11 northern states
21-Jan	Orientation meeting for NID	Abuja
21-29 Jan	WHO Executive Board Meeting, including polio agenda item	Geneva
31-Jan	Presidential Taskforce Meeting	Presidential Villa
<b>February</b>		
2-5 Feb	National IPD	Nation-wide
mid-Feb	Finalization of NEAP	
21 Feb	Presidential Taskforce Meeting	
<b>March</b>		
2-5 Mar	National IPD	
After 18 <sup>th</sup>	ERC Meeting	TBC
26 March	Presidential Taskforce Meeting	EOC
	Gates Foundation Challenge (award)	
	Reporting on Abuja Commitments	
11-13 Mar	EPI Manager's Meeting IST West	Burkina Faso
<b>April</b>		
6-9	Revaccination in underserved communities	
9-11 April	SAGE meeting	Geneva
13-16 April	SIPD	HR states
24-25 April	Global Vaccine Summit	Abu Dhabi
25 April	Presidential Taskforce Meeting	
	African Vaccination Week	
<b>May</b>		
7-8 May	IMB Meeting	London
11-14	SIPDs	
	MNCH Week	
20-28 May	World Health Assembly	Geneva
23 May	Presidential Taskforce Meeting	
<b>June</b>		
15-18	SIPDS	

	Reporting on Abuja Commitments	
27 June	Presidential Taskforce meeting	
<b>July</b>		
6-9	SIPDS	
27 July	Presidential Taskforce Meeting	
<b>August</b>		
17-21	Measles campaign + OPV in Fixed Posts	
22	Presidential Taskforce Meeting	
<b>September</b>		
7-10	SIPDS	
26	Presidential Taskforce Meeting	
	IMB Meeting (?)	
	Reporting on Abuja Commitments	
<b>October</b>		
5-14	Men A + OPV Fixed Post	
12-15	SIPDS	
24-Oct	World Polio Day	
24 Oct	Presidential Taskforce Meeting	
	ERC	
<b>November</b>		
9-12	SIPDS	
	WHO AFRO RC Meeting	
	Communication Review meeting	
5-7 Nov	SAGE meeting	Geneva
21 Nov	Presidential Taskforce Meeting	
<b>December</b>		
14-17	Revaccination in underserved	
19 Dec	Presidential Taskforce Meeting	
	ARIC	
	Reporting on Abuja Commitments	

### 9.3. Polio Eradication Emergency Plan Implementation Schedule

Strategic Priority: Enhance SIA Quality														
Activity	Timeline												Responsible	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec		
Develop team selection brochure in Hausa	X													Kano EOC
Disseminate brochure to all 11 HR states		X												National EOC
Deploy supervisory capacity to monitor WSC meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	All partners
Develop WSC reporting mechanism	X													Kano EOC
Disseminate reporting tools to all 11 HR states		X												All partners
Revise SIA training package		X												National EOC
Disseminate training package to 11 HR states			X											National EOC
Customize training based on local needs			X	X	X	X	X	X	X					Wards
Develop team performance indicators				X									X	National EOC
Disseminate team performance					X									National EOC



indicators to states													
Identify best in class microplans		X											National EOC
Disseminate effective microplans to states		X											National EOC
Integrate settlements from special rounds into I{PS microplans		X											LGAs
Conduct microplan audits in VHR LGAs			X										States

## 9.3. Cont'd

Strategic Priority: Special Strategies to reach underserved populations													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Complete landscape analysis for 150 high priority LGAs		X	X										NSTOP
Complete landscape analysis remaining LGAs				X	X	X							NSTOP
Conduct special rounds (in-between rounds)	X		X	X									All partners
Update existing microplans		X	X	X	X	X							Ward teams
Use the Short Interval Additional Dose (SIAD) strategy													All partners
Ensure proper logistic support for IPDs	X	X	X	X	X	X	X	X	X	X	X	X	EOC
Establish permanent immunization posts in key LGAs Kano, Katsina, Kaduna				X	X	X							EOCs in each state
Establish permanent immunization posts in key LGAs other states							X	X	X				EOCs in each state
Monitor quality of IPDs in these areas:	X	X	X	X	X	X	X	X	X	X	X	X	WHO
Strengthen RI outreach:													NPHCDA

## 9.3. Cont'd

Strategic Priority: Security –compromised areas													
Activity													Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Conduct mapping of security compromised areas and situation analysis		X	X			X			X			X	All partners
Develop SOPs for PPTs		X											All partners
Identification, recruitment, and establishment of PPTs			X	X	X	X	X	X	X	X	X	X	NPHCDA
Conduct Short Interval Additional Dose strategy (as appropriate)													All partners
Identify markets, motor parks and busy medical centres for the establishment of permanent immunization posts			x										All state partners
Establish permanent immunization posts in key LGAs in the security compromised states (Borno and Yobe)				X	X	X							EOC/state team
Monitor quality of PPTs in the implementing areas					x	x	x	x	x	x	x	x	EOC/state team

9.3. Cont'd

Strategic Priority: Improved Outbreak Response													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Finalize SOP for outbreak response		X											EOC
Training on SOP guidelines - training package developed and disseminated		X											EOC
Stockpile of vaccine procured and in country		X											EOC
Documentation of outbreak response as outlined in SOP		X	X	X	X	X	X	X	X	X	X	X	State and local TF

## 9.3. Cont'd

Strategic Priority: Communication and Advocacy													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Launch entertainment education package in 3 key states						X							UNICEF
Finalize SOPs for engaging VCMs for newborn tracking and supporting polio immunization during naming ceremonies		X											UNICEF
VCMs implementing polio communications activities and outreach during naming ceremonies in the participating settlements in Kano, Katsina and Kaduna			X										UNICEF
Establish Nigeria polio eradication brand and IEC package				X									UNICEF
Expand VCM network in Kano, Kaduna and Katsina in the highest risk settlements			X										
Create evidence based communication plan in place in every high risk LGA in Kano, Katsina and Kaduna		X											LGAs

## Global partner contributions to support low season priorities

Partner	Priority	Description of efforts
BMGF	<ul style="list-style-type: none"> <li>Advocacy</li> <li>Operational support</li> <li>Resource mobilization</li> </ul>	<ul style="list-style-type: none"> <li>Co-chair visit in March</li> <li>Immunization Challenge 2013</li> <li>EOCs, eHealth, GIS/GPS scale up</li> </ul>
CDC	<ul style="list-style-type: none"> <li>Technical assistance</li> </ul>	<ul style="list-style-type: none"> <li>Additional staffing (e.g., EOC data management/dashboard)</li> <li>N-Stop work expanded and refocused</li> </ul>
Rotary	<ul style="list-style-type: none"> <li>Advocacy</li> <li>Community engagement</li> </ul>	<ul style="list-style-type: none"> <li>Local Rotary 'adoption' of high risk LGAs</li> <li>National and state political advocacy</li> </ul>
UNICEF	<ul style="list-style-type: none"> <li>Technical assistance</li> </ul>	<ul style="list-style-type: none"> <li>Mgmt. review of VCM network</li> <li>Surge optimization</li> <li>Operations research on N/C</li> <li>OPV stock management system</li> </ul>
WHO	<ul style="list-style-type: none"> <li>Technical assistance</li> </ul>	<ul style="list-style-type: none"> <li>Additional staffing and consultants support (including SMOs from India)</li> <li>Security planning</li> <li>Surge optimization</li> </ul>