Update on Nigeria Polio Transition Planning Process

NIGERIA
Transition Independent Monitoring Board
London
4 May 2017
Outline

• Background
• Transition planning update
• Next steps
• Challenges identified
• Support needed
Nigeria recently reclassified as Polio Endemic Country following the recent outbreak in Borno state of Nigeria after almost 2 years of being Polio Free

Currently implementing a robust outbreak response plan along side a country Polio Transition plan

Risks of Double transition in context with both GPEI and GAVI transitioning occurring within the same time frame
Transition Planning Update

✓ Governing and management team established

<table>
<thead>
<tr>
<th>S/N</th>
<th>Position/committee</th>
<th>Membership</th>
<th>Key function</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Inter-agency Coordination Committee (ICC)</td>
<td>Government and Partner Agencies <em>Chairled by the Honourable Minister of Health</em></td>
<td>• General oversight on Health Policy</td>
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<tr>
<td>2</td>
<td>National Polio Legacy Planning Committee (NPLPC) - Inaugurated 18 May 2016</td>
<td>Federal Ministries of Health; Finance; &amp; Budget and Planning; National Primary Health Care Development Agency (NPHCDA); and Partners <em>Chairled by the Executive Director, NPHCDA</em></td>
<td>• Provide policy direction and supervisory oversight on polio transition planning activities • Mobilize needed resources for implementation of legacy work plan • Review and approve/endorse all PT4 submissions.</td>
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<td>3</td>
<td>Polio Transition Technical Task Team (PT4) - Inaugurated 18 May 2016</td>
<td>NPHCDA and Partners <em>Chairled by the National Coordinator, Polio Legacy Planning</em> PT4 Secretariat: NPHCDA; WHO; UNICEF; and CHAI</td>
<td>• Finalize mapping of all Polio assets in Nigeria • Develop a clear costed work and decision-making framework • Implement polio transition planning work plan in line with agreed time frames and provide regular updates</td>
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National Coordinator for Polio legacy was appointed in April 2016
The summary of the Personnel cost averages per annum across all the implementing Partners in Nigeria stands at $89,587,042. This covers functions across the 10 program areas and distributed across the 36+1 states as well as central level staffs. However, 98% of these personnel are located in the 11 Polio high risk states as shown below and account for about 70% of the total personnel cost.

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### Agency Details

<table>
<thead>
<tr>
<th>Agency</th>
<th>No of Personnel</th>
<th>Annual Standard cost, USD</th>
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<tbody>
<tr>
<td>CDC</td>
<td>6</td>
<td>$2,050,000.00</td>
</tr>
<tr>
<td>CGPP</td>
<td>1967</td>
<td>$954,580.00</td>
</tr>
<tr>
<td>NSTOP</td>
<td>241</td>
<td>$7,222,800.00</td>
</tr>
<tr>
<td>UNICEF</td>
<td>17927</td>
<td>$26,247,480.83</td>
</tr>
<tr>
<td>WHO</td>
<td>2908</td>
<td>$51,812,006.13</td>
</tr>
<tr>
<td>NPHCDA/FMOH</td>
<td>220</td>
<td>$1,300,175.84</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>23269</strong></td>
<td><strong>$89,587,042.79</strong></td>
</tr>
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</table>

* 121,413 personnel are recruited as Polio team members across country for every National Campaign with a personnel cost of $9 Million(Funded through WHO)
HR and Physical Assets Mapping

HR distribution by zone

- North Central Zone: 6%
- North Western Zone: 65%
- South Western Zone: 1%
- South South Zone: 0%
- South Eastern Zone: 28%
- North Eastern Zone: 0%

Large physical assets (Office presence in all Zones/States)

- NWZ
- NEZ
- NCZ
- SEZ
- SWZ
- SSZ

Map showing distribution of HR and physical assets in different zones:

- Central Office
- Zonal Offices (6)
- State Offices (37)
Polio Personnel by Level of Implementation/Partner

77.4% of all polio staff are located at the community level. 89.6% and 86.2% of UNICEF and CGPP personnel are at the community level, while NSTOP are at the LGA(District) and CDC at the Country Level. WHO staff spread mainly at the Ward(55.4%), LGA(17.3%) and State(14.3%) Levels.
Polio personnel contribution to other programs

- To document this contribution, a survey was conducted using the WHO ODK platform in December 2016.
- Personnel of WHO, UNICEF, and Govt were asked to fill a questionnaire stating their activity allotments in the field, qualifications, No. of years involved in PEI etc.
- 718 personnel responded to the survey mainly at National, state levels.
Staff time involvement by polio Sub-Functions

- Cold Chain Management
- Logistics
- Other Vaccine Management
- Central Support and Planning of Activities and Campaign
- Field Supervisors of Immunization
- Outbreak and Emergency Planning
- Security Planning
- Data Analysis and Reporting
- Monitoring and Evaluation
- Surveillance Officers
- Planning
- Lab Technicians and Testing
- Social Mobilizers
- Other types of Community Engagement
- Media, Communications and Advocacy
- Technical Expertise
- Training
- Financial Mobilization
- Resource Mobilization
- Research
- Partnership and Coordination
- General Management
- General Administration
- General Operations (e.g. drivers)

- 43%
- 38%
- 47%
- 54%
- 46%
- 15%
- 61%
- 37%
- 1%
- 47%
- 41%
- 19%
- 35%
- 61%
- 46%
- 23%
- 11%
- 11%
- 8%
Polio personnel Time spent on Non Polio programmes

- Routine Immunization: 88%
- Sanitation and Hygiene: 63%
- Maternal and Neonatal child Health: 63%
- HIV/AIDS: 11%
- TB & Malaria (ATM): 16%
- Disease Outbreak Response/IDSR: 74%
- Measles: 76%
- New Vaccines Introduction: 68%
- Crises/Humanitarian Support: 13%
- OTHERS: 13%

Source: PT4 Survey of National Polio Personnel (N=718)
MONITORING AND DATA MANAGEMENT

- **Accountability Framework**[11]

Lack of proper accountability has been cited as one of the major challenges in achieving polio eradication in Nigeria. An accountability framework was implemented in the Nigeria polio program by the WHO Nigeria Country Office in 2014. An analysis was done to determine the contribution of the accountability framework to improving staff performance in the Nigeria polio program.

It was also found that the accountability framework contributed to program implementation, as shown by a statistically significant change in the process indicators of both AFP surveillance and routine immunization.

- **Tracking Of Immunization Using GIS**[12]

In line with polio eradication activities, NPHCDA in collaboration with other partners enhanced use of new technologies to complement the current tools and processes for mapping, micro planning and tracking of teams in the drive to improve team performance.

Key among these technologies is the use of Geographic Information Systems (GIS) for tracking vaccinators during polio NIDs and analyzes data for the generation of geospatial products such as maps and charts relevant for taking informed decisions for effective program implementation.

The tracking of vaccination teams provided significant feedback during polio campaigns and enabled supervisors to evaluate performance of vaccination teams. The reports supported other polio program activities, such as review of micro plans and the deployment of other interventions, for increasing population immunity in northern Nigeria.

COMMUNICATION AND COMMUNITY ENGAGEMENT

- **Journalist Initiatives on Immunization Against Polio**[13]

The World Health Organization (WHO), seeing that journalists were a major group in the spreading the negative campaign in various media, decided to partner with them to counter the further spread of the negative messages. Pursuant to achieving the overall goal of polio eradication and after several consultations and sensitization of an initial group of journalists, the Journalists Initiatives on Immunization against Polio (JAP) was formed in 2007 by Nigerian journalists working for international, national, and local media companies to carry out communication initiatives.

- **Demand Generation Activities**[14]

Demand-side interventions have been shown by the World Health Organization and others to lead to significant gains in child vaccination coverage in low- and middle-income countries. To stimulate the population to request for OPV, demand creation interventions were introduced which included the provision of attractive benefits (hereafter, “pluses”) during immunization activities, the establishment of health camps, implementation of the nomadic Ardor (i.e., Fulani community leader) intervention, the Qur’anic schoolteacher package, and increasing media visibility at the state level.

DISEASE SURVEILLANCE
National Health Priorities identified

1. PHC Revitalization
   - Improve availability, quality and redistribution of human resources for health.
   - Strengthen logistics and supply cold chain management
   - Strengthen referral systems
   - Improve management support and oversight
   - Strengthen health facility infrastructural maintenance
   - Promote innovation and use of technology to improve health services
   - Improve community ownership and participations to improve demand for and quality of health services and ensure accountability through the Ward Development Committee (WDCs)

2. Expanded Program on Immunization/Routine Immunization
   - Increase and sustain routine immunization coverage for all antigens and reduce morbidity and mortality form VPDs
   - Reach the hard to reach LGAs/Communities
   - Sustain availability of bundled vaccines at service delivery sites
   - Introduce new and underutilized vaccines (PCV, Rotavirus, HPV and IPV) into the country’s immunization schedule
   - Strengthen health management information system (HMIS)
   - Strengthen the PHC system (through wards/community structure and participation
   - Improve budgeting and budget execution at Federal, State, LGA and ward levels
   - Sustain and expand the cold chain at all levels
   - Sustain interruption of WPV transmission and eradication of Polio
   - Measles mortality and morbidity reduction
   - Maternal and neonatal tetanus elimination

3. Disease Surveillance and Response/Emergencies
   - AFP Surveillance:
     - Case detection and reporting,
     - Sample collection, handling and transportation.
     - Laboratory network support and Quality assurance and control/QC.
     - Laboratory Certification, environmental surveillance.
     - Sero-surveillance
     - Community surveillance network.
     - Expanded support of these laboratory for other disease confirmation in terms of disease outbreaks
   - Accelerated disease control: Support surveillance for measles, Yellow Fever, cerebrospinal meningitis, Neonatal tetanus
   - IDSR current structure: strengthen reporting timeliness and quality, disease outbreak investigation and response.
   - Emergency response coordination
**Determining Transition Strategies**

2 day Polio Transition Simulation Exercise held & Transition Strategies identified

Participants included 74 participants from approximately 30 agencies and organizations representing key government agencies at Federal and state levels; partner agencies and stakeholders; and representatives from the Polio specialized laboratories; and from the Northern Traditional Leaders Committee.

**Outcomes from the simulation exercise**

- Criticality of polio functions as it affects directly or indirectly the National Health Priority areas documented.
- Opportunities for polio assets and functions to support the implementation of national health priorities identified.
- General transition strategies to ensure that polio assets and functions are leveraged to contribute to these health priorities suggested.
- Review of practicality of the recommended transition strategies and assessment of budgetary implications, towards addressing gaps ongoing.
Suggested transition strategies by thematic area

- Transfer responsibility for conduction essential polio function to Government
- Maintain Minimum assets and Structure
- Build Local Capacity to take over Management and Implementation while phasing out Polio program assets
- Transfer responsibility to an alternate implementing partner/New Organization
- Maintain Polio program and assets for other health Priorities
- Discontinue Polio function
- Discontinue Polio Function and Sunset assets
- Discontinue Assets/ Functions but ensure lessons learnt are integrated into other health programs

Legend:
- PHC
- EPI/RI
- Disease surveillance/Outbreak response
Linking GAVI transition With Polio Transition Plan
Once a GAVI country’s GNI per capita > US$1,580, it enters graduation and must step up its co-financing amounts over the next 5-7 years: 2012-2014 3 Year average was $2380.

Country enters graduation

- **Initial Self-Financing**: $0.20/dose co-financing for all Gavi vaccines
- **Preparatory Transition**: 15% annual increase in co-financing reqs. (based on antigen price)
- **Accelerated Phase 2**: Increasing country co-financing requirements over 5 years*
- **Transitioned Country**: Fully financing RI & NVI, with access to Gavi prices for 5 years post-transition

*May be extended to 7 years in certain cases (e.g. unexpected rebasing of Nigeria’s GDP)
GPEI Vs GAVI Transition

Example: Nigeria will need to pay ~ $147M per year for co-financed vaccines by 2022, for the current set of vaccines

Biggest Risk for GAVI transitioning is perceived effect on vaccine procurement and Cold chain Management.

Country engagement framework development meetings scheduled for Q2&Q3 2016. PT4 will be part of these engagement.

GAVI HSS grants utilization for system strengthening.
Country engagement framework

This will focus of about 6 main thematic areas focus or linking
PTP will be:

1. The plan is to have an integrated disease surveillance reporting in the country by 2020, coordinated by the Nigeria Centre for Disease control (NCDC).

2. Plan to fully transition from DVD-MT to DHIS2 by January 2019. DHIS2 has been rolled-out in the country in a phased manner in the country; and to be completed by Dec 2018.

3. The monthly DHIS2 reporting would cover the following areas: immunization coverage, utilization and surveillance;

4. Under the PHC revitalization, efforts are on-going to support expansion of laboratories / supplies of needed materials for basic diagnosis of some of the VPDs.
Next Steps

1. Business Case Development
   I. Interactive meetings with relevant stakeholders at subnational Levels (states and LGAs)
   II. Engagement of consulting Firm

2. Initiate and finalize alignment of polio transition plan with GAVI Transition plan through the Country engagement framework

3. Endorsement of the Business Case by the relevant Stakeholders.

4. Development of draft National Polio Transition Plan (PTP) with timeliness and robust M&E framework

5. Endorsement of the PTP by Government and Partners.
Challenges Identified

1. Outbreak of Wild Polio Virus in Borno state, Nigeria
   I. Destabilizing effect on the polio transition Agenda
   II. Prioritizing the OBR and its impact on transition planning personnel participation
2. Funding Gaps in Transition Plan Process
3. Communicating and finalizing transition strategies endorsement with specifics from Partners and Government department
4. Achieving consensus and buy-in amongst the three tiers of government in Nigeria
Support Needed

1. Support in engagement of consultant/Consulting Firm for business case development
2. Continued communication between GPEI/TMG/Regional and Nigeria Polio Transition team
3. Funding Support: Gaps in National Transition planning work plan
4. High level advocacy and engagement on Transition planning
THANK YOU