



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

# **2015 NIGERIA POLIO ERADICATION EMERGENCY PLAN**

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## Abbreviations

AFP	Acute Flaccid Paralysis
BCI	Boosting Childhood Immunity
BMGF	Bill and Melinda Gates Foundation
CDC	Centers for Disease Control and Prevention, Atlanta
cVDPV	circulating Vaccine Derived Poliovirus
DOPV	Directly observed polio vaccination
EOC	Emergency Operations Centre
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
HR	High Risk
HROP	High Risk Operational Plan
HRS	High Risk States
ICC	Inter-agency Coordination Committee
IDPs	Internally displaced populations
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
LQAS	Lot quality assurance sampling
LTF	Local Government Task Force on Immunization
NICS	National Immunization Coverage Survey
NPEEP	National polio eradication emergency plan
NTL-PHC	Northern Traditional Leaders committee on Primary Health Care
NPHCDA	National Primary Health Care Development Agency
OPV	Oral polio vaccine
PEI	Polio Eradication Initiative
PTFoPE	Presidential Task Force on Polio Eradication
RI	Routine Immunization
SIAD	Short Interval Additional Dose
SIA	Supplemental Immunization Activities
STF	State Task Force on Immunization
UNICEF	United Nations Children's Fund
VCM	Volunteer Community Mobilizer
WDC	Ward Development Committee
WFP	Ward focal person
WHO	World Health Organization
WPV	Wild polio virus

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## **EXECUTIVE SUMMARY**

2014 was a landmark year for Nigeria's polio eradication programme. Nigeria recorded historical progress towards the target of stopping transmission of wild poliovirus, reporting only 6 cases in 2 states in 2014 (as at 14 January 2015), compared to 53 cases in 9 states in 2013. At the same time, there have been no cases of WPV3 since November 2012. In 2014 wild poliovirus became even more geographically restricted to 2 states, including in 4 LGAs of Kano state and 1 LGA in Yobe which has continued to face security and access challenges. There has also been a significant reduction in the number of circulating genetic clusters from 8 in 2012 to only 1 in 2014 (N5). However, in 2014, Nigeria experienced an increased outbreak of cVDPV2 with 29 cases across five states (14 cases in Borno, 10 cases in Kano, 1 case in Katsina, 2 cases in Yobe and 2 cases in Jigawa), up from 5 cases in 2013.

The Nigeria's Presidential Task Force on Polio Eradication (PTFoPE) continued to oversee the implementation of the 2014 National Polio Eradication Emergency Plan with the National Emergency Operations Centre (EOC) providing technical leadership and coordinating Government and partner efforts at the central level, with the State EOCs or their equivalents at the State Level coordinating implementation at the state level. To ensure that the planned activities in the NPEEP were implemented with quality, the EOC continued to implement the accountability framework for all stakeholders at all levels.

The achievements in 2014 have been largely due to the improved quality of SIAs, with the proportion of LGAs achieving an estimated coverage of least 80% coverage as verified by LQAS increasing from 72% in December 2013, to 97% by December 2014. Quality improved as the result of a number of interventions and innovations which were implemented throughout 2014. These included the introduction of Directly Observed Polio Vaccination (dOPV) and scaled up outside household vaccination to address team performance and non-compliance issues; the accelerated introduction of IPV in Borno, Yobe and Kano states; the scaling up of health camps and demand creation interventions to address other felt needs of communities; increased focus on hard to reach populations during and in-between campaigns, including internally displaced populations (IDPs) from security compromised areas; and precision focus on the high risk LGAs.

In 2015, continued focus will be placed on sustaining the progress made in 2014, including the interruption of wild poliovirus. The goal will be to stop transmission of all polioviruses, including cVDPVs, with no cases after April 2015.

The 2015 NPEEP outlines strategic priorities that will be the areas of focus to ensure interruption of all polioviruses during the year. These include: (1) enhancing SIA quality in prioritized vulnerable areas; (2) special approaches for insecurity areas; (3) mounting timely and adequate polioviruses outbreak responses; (4) enhancing routine immunization; (5) intensifying surveillance; and (6) expanding household and community engagement approaches to build demand for polio and routine immunization. All strategies will be underpinned by strict adherence to the accountability framework which continues to guide the NPEEP.

## **1. INTRODUCTION AND CONTEXT OF THE PROGRAMME**

### **1.1. Context of Polio Eradication Efforts in 2015 – Looking towards a polio-free future**

2014 was a historic year for Nigeria's polio eradication programme. Nigeria made the most significant progress in the history of the polio eradication programme, intensifying efforts towards the target of stopping poliovirus transmission. Never before has Nigeria been so close to stopping transmission, with only 6 cases reported in 2014 (data as at 12 January 2015). The last case of wild poliovirus was reported on 23 July 2014 (as of 12 January 2015). The strong progress and achievements in 2014 were due to the continued commitment and leadership at the highest level of Government through the Presidential Task Force and the translation of the leadership vision and implementation of the identified 2014 NPEEP strategic priorities. The national and state EOCs continued to drive the programme, ensuring strong coordination of Government and partner efforts at all levels. The EOCs continued to provide strategic technical support to the programme, including close monitoring of performance. The most important achievements during the implementation of the 2014 NPEEP included:

- Significant reduction in the number of WPV1 cases, with 6 cases from 2 states in 2014, compared to a total of 53 cases in 9 states in 2013;
- Complete disappearance of WPV3 cases – no cases since 2012;
- Only one genetic cluster in circulation in Nigeria in 2014, compared to 8 in 2012;
- Improvement in the quality of IPDs with 97% of the LGAs by December 2014 achieving estimated coverage of at least 80% as verified by LQAS compared to 72% of LGAs in December 2013
- Accelerated introduction of IPV in Borno, Yobe and Kano to enhance population immunity with more than 3 million doses administered;
- Enhanced population immunity, with 97% of non-polio AFP cases reporting at least 3 doses of OPV;
- Scaling up of interventions and innovations, including DOPV, health camps and other demand creation approaches to reduce missed children;

Among the challenges in 2014 have been:

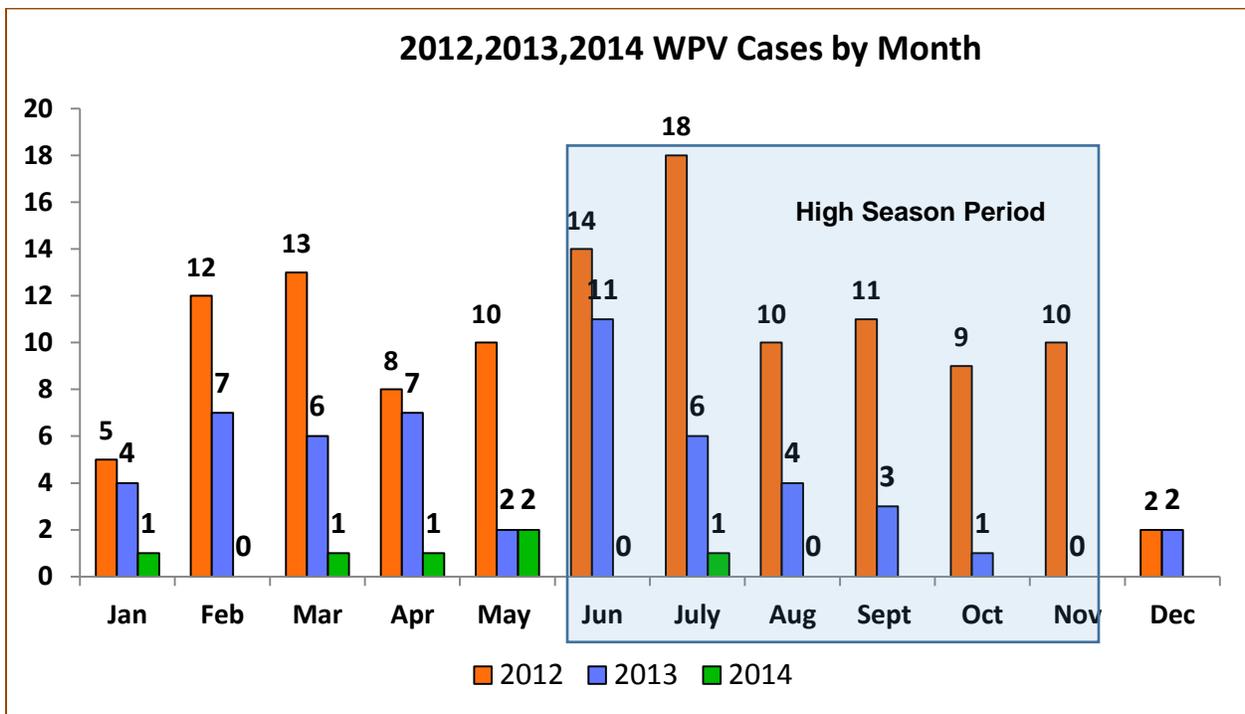
- Heterogeneous political support and commitment at the State and LGA levels, in particular, with late release of counterpart funding for implementation of planned activities in key states; securing consistent leadership and political commitment continues to be a challenge;
- Overcoming security challenges in Borno and Yobe to reach children during campaigns. Escalating insecurity has resulted in increased inaccessibility of children in the security compromised states in the North Eastern part of the country and significant population movements.
- Poor team performance due to team selection interference in several persistently poor performing Very High Risk LGAs
- Interrupting transmission in Kano - 5 of the 6 WPV1 cases nationally (83%) have been in Kano, and it is the last area of active WPV transmission. Sero-prevalence surveys conducted in

metropolitan Kano in October 2014 indicate significant gaps in population immunity despite the number of campaigns that have been conducted.

- Upsurge in cVDPVs in 2014, from 5 cases in 2013 to 29 cases in 2014.

### 1.2. Poliovirus Epidemiology

Over the past couple of years, the number of confirmed WPV cases in Nigeria has declined substantially, from a total of 122 cases in 2012, down to 53 cases in 2013. The goal of the 2014 NPEEP was to stop transmission of wild poliovirus. Nigeria made significant progress towards meeting that target reporting 6 cases in 2 States (as at 12 January 2015), with the last case reported on 24 July, 2014. It is also important to highlight that no WPV type 3 cases have been reported in Nigeria since November 2012. In 2014, there was continued geographical restriction of polioviruses to 5 LGAs in 2 states – Kano and Yobe, compared to 29 LGAs in 9 states in 2013. Kano remained as the last sanctuary with active transmission into the 3<sup>rd</sup> quarter of 2014. As shown in the chart below, as at 12 January, 2015, the latest case of wild poliovirus was reported on 24 July 2014. Importantly, only one case was reported during the high transmission season, unlike in previous years, where cases were at their highest.



There was an increase in the cVDPV outbreak in Nigeria in 2014. As of 12 January 2015, Nigeria reported 29 cases of cVDPV2 in 5 states in 2014 compared to 5 cases in 2 states in 2013. Borno (14 cases) and Kano (10 cases) reported 82% of the cVDPV cases in 2014.

In 2014, Nigeria expanded the number of environmental surveillance sites to supplement the surveillance system. Environmental surveillance detected 1 WPV1: Kaduna; and 54 cVDPV2: Kaduna 11, Kano 14, Katsina 2, Sokoto 12, Borno 13, Jigawa 1 and Yobe 1.

The decline in number of WPV cases was due to improvement in quality of polio SIAs rounds most of which were bOPV rounds during the beginning of the year with improved population immunity. Resultantly, there was a decline in zero dose WPV cases from 10% in 2013 to 0% in 2014. Similarly the number of children with at least 3 doses of OPV increased from 64% to 67%. There was also an improvement in the immunity profile of the non-polio AFP cases in 2014, with 97% of non-polio AFP cases reporting at least 3 doses of OPV.

### **1.3 Profile / characteristics of polio cases**

In 2014, the majority of the WPV cases (67%) were among children between 12 -35 months of age, with the remaining cases older than 35 months of age. The polio cases were young under-immunized children (67% had 1 – 3 OPV doses) of non-compliant families (83%) residing in rural villages (83%). The families of the children were poor and lowly educated (mostly koranic school education).

### **1.4 Genetic data:**

- Wild Poliovirus: The number of circulating genetic clusters in 2014 remained 1 (N5) from Genotype WEAf-B1, compared to 8 in 2012 (Genotype WEAf-B1:N2, N5, N6, and N7, and from Genotype WEAf-B2: L1 and L2; and WPV3 with 2 clusters: F4 and F6).
- Circulating Vaccine Derived Polioviruses: There are 29 cVDPV cases among AFP cases all belonging to N7B genetic cluster. Environmental surveillance has isolated 54 cVDPVs belonging to the cVDPV –A genetic cluster.

## **2. ACTIVITIES IMPLEMENTED IN 2014 TO BOOST POPULATION IMMUNITY**

### **2.1 Accelerated IPV introduction:**

One of the major milestones of Nigeria PEI programme was the accelerated introduction of inactivated polio vaccine (IPV) in mass vaccination campaign mode in all LGAs in Borno and Yobe States and 12 LGAs in Kano State. Approximately 3 million doses of IPV were administered between June – December 2014. IPV was given together with tOPV, and there was a resultant decline in the number of cVDPV including in the environment after the accelerated introduction of IPV in Borno State which had intense circulation of IPV in the beginning of 2014.

IPV was also administered in internally displaced persons (IDPs) camps to boost population immunity among children coming from insecurity areas that had not received adequate OPV doses during campaigns as their areas were inaccessible.

### **2.2 Mobile Outreach in Hard to Reach Areas**

The BMGF funded project with NPHCDA provided integrated immunization, maternal and child health care services as part of integrated mobile routine immunization. At the initiation of the project a baseline survey conducted in April 2014 with piloting in selected LGAs in May 2014. The full roll out of the project in 2311 hard to reach underserved settlements in 453 wards in 92 LGAs in 6 states of Borno, Yobe, Bauchi, Kaduna, Kano and Katsina was in June 2014. These states were selected because they had

ongoing transmission in the second half of 2013 and 48% of the ongoing WPV circulation was in the hard to reach areas. The baseline survey revealed relatively low population immunity in the hard to reach settlements.

Despite insecurity in Borno and Yobe States and logistics challenges since these are hard to reach areas, by December 2014, the project had administered 329,330 OPV doses to children 0 – 59 months, 199,155 children reached with Vitamin A, 184,776 children had been dewormed and anti-malarial prophylaxis administered to 174,615 pregnant women.

### **2.3 Routine immunization intensification in cVDPV and low population immunity**

To rapidly boost population immunity in 59 vulnerable and cVDPV transmission LGAs, routine immunization was intensified with financial support from BMGF. There was an increase in conducting fixed and outreach sessions to reach the unimmunized and under-immunized children.

By November 2014, there had been a 76% decline in number of unimmunized children from 237,759 by November 2013 to 55,721 unimmunized children.

### **2.4 Directly Observed Polio Vaccination (DOPV)**

The rationale for introducing DOPV was that some IPDs vaccination teams colluded with parents to just finger-mark the children without administering the 2 OPV drops in their mouth. This resulted in misleading the programme that children were being vaccinated when in reality they were not.

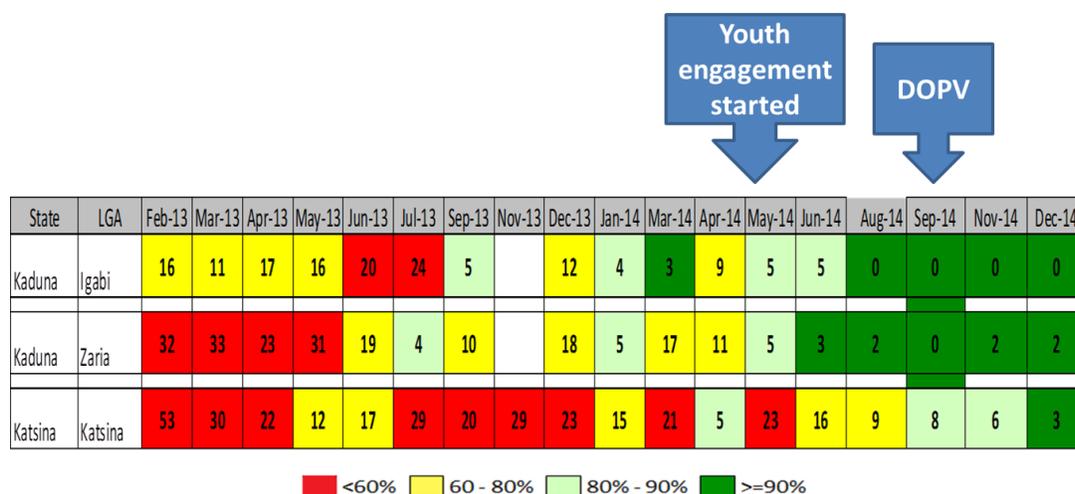
The DOPV approach was therefore to attract children to be vaccinated outside the household to be sure that the 2 OPV drops had been administered. After successful piloting in Bauchi State in August 2013 and endorsement of the strategy by the Expert Review Committee and the Independent Monitoring Board (IMB), the strategy was rolled out in the 61 VVHR and VHR LGAs (8 VVHR LGAs in metropolitan Kano did not participate due to insecurity) from September 2014 IPDs.

With the scaling-up of DOPV to 61 LGAs in September 2014, there was a 20% increase in LGAs that had been accepted by LQAS to have reached an estimated 90% coverage compared to the previous August 2014 IPDs round.

### **2.5 Systematic Youth Engagement**

In specific LGAs, persistent poor performance during IPDs was due to incidence of violence and intimidation of teams and actual attacks on vaccinators which eroded vaccination team confidence resulting in suboptimal performance. Among the notorious LGAs which had youths with “OPV resistance” were Zaria and Igabi LGAs in Kaduna, and Katsina LGA in Katsina State. These are also VVHR LGAs which were selected for DOPV. To ensure that teams could operate freely during outside vaccination, it was crucial that these youth be systematically oriented and engagement in the PEI activities.

With systematic engagement of youth coupled with DOPV in these LGAs, there was tremendous improvement in team performance which contributed to all 3 LGAs being accepted at 90% coverage by LQAs in December 2014, as shown in trends of LQAS coverage in figure below.



## 2.6 Transit Vaccinations: Markets, Motor parks, Highways, Hospitals, CMAM sites

Children on transit (highways and motor parks) and in transit places (markets, hospitals, nutrition centres) contribute to a good proportion of missed children during IPDs. Also, children in transit from areas with polioviruses circulation pose a great risk of exporting viruses to polio-free areas. Similarly the children going into polioviruses circulation areas have to be protected by being administered OPV doses. It is also important to note that within the polio endemic areas with WPV circulation in 2014, 83% of the cases were in rural areas mostly farming areas. Therefore, farmers with children coming to markets to sell produces posed a risk of “trading” WPV in markets and nutrition centres. It was therefore important to vaccinate children on transit and in transit places.

2.7 Transit vaccination activities were intensified mostly during the last quarter of 2014. There was variance in implementation of the transit vaccination activities across states as was monitored weekly by the States and National EOCs. Among states that performed well with transit vaccinations during the last 12 weeks of 2014 were market vaccinations (Borno with 87,581 OPV doses, Bauchi with 33,000 OPV doses); motor parks and highways vaccination (Kaduna with 4,721 OPV doses); hospital vaccinations in Kano with 11,271 OPV doses; and CMAM sites in all states involved in the project with 84,000 OPV doses administered

### International Border activities

Nigeria has 16 States, 60 LGAs and 201 wards along the international border. Prominent among these are states that share borders with Niger and Cameroon. Nigeria has a history of infecting other countries with wild and circulating viruses. On the hand, Nigeria has another history of importing viruses from neighbouring states. Cameroon had in 2014 an outbreak of WPV1 that spread across the country with two districts on the border with Taraba and Adamawa getting infected. The virus in Cameroon went further and infected Equatorial Guinea. It is on this premise that the programme in Nigeria focused on strengthening international border activities with the aim of improving immunity in the border LGAs All major crossing points along the international border where mapped with geo-coordinates obtained. Permanent border transit point vaccination teams were recruited and stationed at crucial crossing points and they immunize children coming and going outside Nigeria. The data generated is shared on a weekly basis at the national EOC. During SIAs interborder synchronization meetings are held and

attended by officials from the opposing sides and these meetings culminate into joint plans and synchronization of vaccination sessions by team from both countries.

## 2.8 Health Camps

Health camps continued to be implemented in areas with persistent non-compliance in the endemic states with provision of routine immunization services and other health interventions. Of note is that there was also targeted scaling up of health camps during specific interventions such as rolling out of accelerated IPV introduction in Borno, Yobe and Kano where health camps was the only podium for delivery of the vaccine with approximately 3 million IPV doses administered.

With the proven success of health camps in 2013, new partners joined to support implementation of health camps in selected states and LGAS in 2014.

## 2.9 Vaccinating in Security Compromised areas and Internally Displaced Persons (IDP) camps

In security compromised areas, despite the increase in insurgency in 2014 (almost 60% of the settlements could not be fully reached by December 2014 IPDs), the local innovations from 2013 continued to be implemented in areas with accessibility. Detailed monthly security risk assessments were done to identify areas where implementation was feasible. The figure below shows the number of OPV doses administered by innovation from May – December 2014

Intervention	# Doses	# Zero dose
<b>Hit and Run (Shortened IPDs Duration)</b>	1,851,249	10,429
<b>Permanent Health Teams</b>	462,299	7,640
<b>Firewalling</b>	180,863	3,816
<b>Market Transit Points</b>	51,830	960
<b>International Boder Transit</b>	27,311	90
<b>VCM Newborns</b>	3,380	3,380
<b>Total</b>	<b>2,576,932</b>	<b>26,315</b>

Additionally, the increased insurgency resulted in increased number of internally displaced persons (IDPS) in camps or assimilation into communities in the north eastern part of the country. Vaccination activities were conducted in the camps.

By December 2014, there were 48 registered IDP camps in 15 LGAs of 4 states: Adamawa, Borno, Gombe and Taraba. A total of 57,715 children aged 0 – 59 months were vaccinated with OPV and those who did not present a card to indicate that they had not received IPV were vaccinated with IPV. Of the 57,715 children that were vaccinated in IDPs, 1,592 (2.8%) had not received any OPV before indicating gaps in population immunity in the areas where the children came from and risk of spread of the polioviruses. The figure below shows the number of children vaccinated with tOPV in the different camps in the LGAs

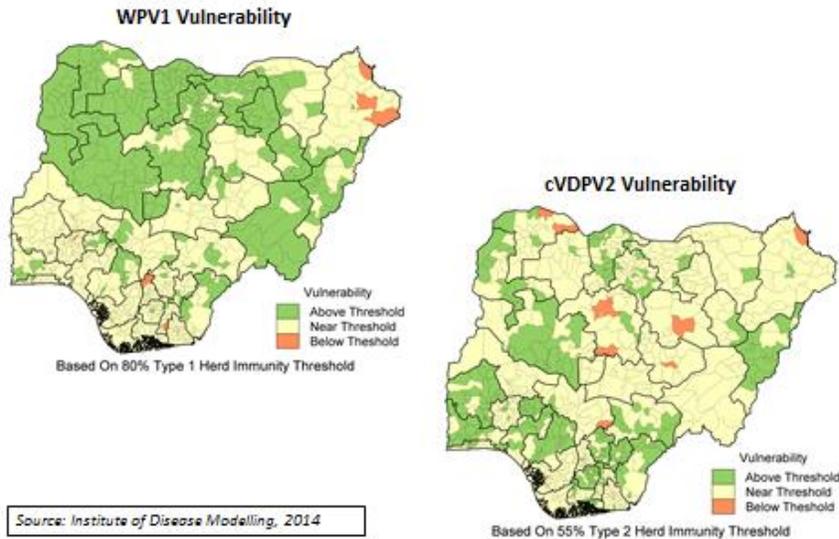
State	LGA	# IDP Camps	<5 children vaccinated	zero dose children
	Girei	1	2085	30
	Yola North	1	122	2
	Yola South	2	969	21
<b>Adamawa</b>	<b>3</b>	<b>4</b>	<b>3176</b>	<b>53</b>
	Askira-Uba	0	0	0
	Biu	2	659	7
	Jere	8	13632	330
	Konduga	1	425	0
	Maiduguri	13	38113	1048
<b>Borno</b>	<b>5</b>	<b>22</b>	<b>52829</b>	<b>1385</b>
	Akko	1	314	95
<b>GOMBE</b>	<b>1</b>	<b>1</b>	<b>314</b>	<b>95</b>
	Ardo Kola	5	186	15
	Bali	4	178	3
	Gassol	1	47	1
	Jalingo	5	432	15
	Wukari	5	529	25
	Zing	2	24	0
<b>Taraba</b>	<b>6</b>	<b>21</b>	<b>1396</b>	<b>59</b>
<b>Total</b>	<b>15</b>	<b>48</b>	<b>57715</b>	<b>1592</b>

### 3. REMAINING CHALLENGES FOR FOCUS IN 2015

#### 3.1 Population immunity gaps

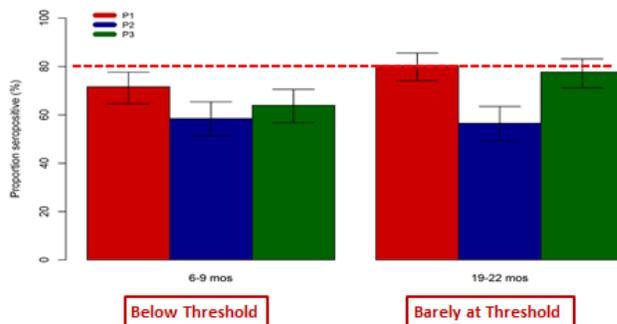
Although there has been geographical restriction of polio transmission in the country with only 2 out of 11 very high risk states infected with wild poliovirus in 2014, the population immunity still remains fragile with a real risk of re-infection into states that have not reported any cases. The figure below illustrates gaps in population immunity particularly to cVDPV type 2 across the states and vulnerability to WPV1 in Borno and Yobe states in the north east.

## Population immunity and Vulnerability, as of Dec 2014



The sero-prevalence survey undertaken in metropolitan Kano also reinforces that there remain significant immunity gaps.

### LGA Immunity Profile: Kano Seroprevalence 2014 – 6-9 month and 19-22 month old children



\*Survey conducted in October 2014 in metropolitan LGAs

Any continued transmission within the existing transmission zone or re-infection of any other area would be a great setback to the progress being made and would be a huge setback to the programme.

### 3.2 Continued WPV and cVDPV circulation

Kano remained the only sanctuary with break-through transmission of wild poliovirus into the 3<sup>rd</sup> quarter of 2014. In 2014, Nigeria experienced a significant increase in the number of cVDPVs in AFP cases and the environment, indicative of fragile population immunity in key areas. The breakthrough transmission in Kano with low sero-prevalence rates has been due to persistently poor performance during IPDs. Kano, too, has the highest number of unimmunized children based on routine immunization

data in 2014. Due to security challenges, Kano did not implement some of the new initiatives in the metropolitan LGAs, including DOPV, health camps and IPV. Kano is a commercial hub of northern Nigeria and beyond. During the dry season, farmers and traders from Northern states and beyond the borders, make long journeys to Kano to sell their farm produce and buy commodities. These long journeys across states have historically attributed to long range WPV transmissions from Kano to other states and beyond. cVDPVs in Jigawa and Katsina have been linked to those circulating in metropolitan Kano.

Transmission of cVDPV2s in AFP cases and the environment continued in Kaduna, Jigawa and Yobe States following the November 2014 campaign during which tOPV was used. This breakthrough transmission is a serious concern for 2015, posing a great threat to the programme

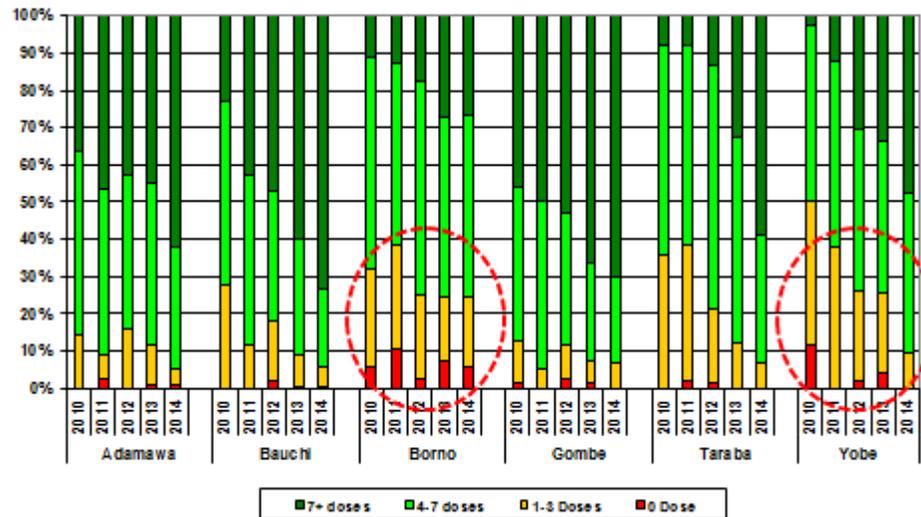
Movement of nomadic populations across the country poses another risk to spread of the circulating virus with risk of re-infecting other states. Just like the commercial traders, the beginning of the dry season (low polio transmission season) marks the commencement of nomads travel from the upper northern states to the north central part of the country in search of pasture. There are so many nomadic routes traversing the northern states of the country in all directions. The nomadic routes have also been historically associated with long-range transmission of polio virus in all direction in the northern part of the country, including the north-central states.

### **3.3 Inaccessibility in Security Compromised States and IDPs**

Although Borno and Yobe States implemented all scheduled polio campaigns, including the accelerated introduction of IPV, not all LGAs or wards within LGAs have completely and consistently been accessible to the vaccination teams. The number of inaccessible children continued to increase, particularly at the end of 2014 from 19% in January 2014 IPDs to 60% in December 2014 IPDs. Even in the accessible areas, quality is comprised within a context of overall insecurity. Insecurity has impacted campaign performance, resulting in Borno being the only high risk state that struggled to reach the target threshold of  $\geq 80\%$  LGAs achieving  $\geq 80\%$  coverage. Yobe is one of only 2 states which reported a case of wild poliovirus in 2014; and both Borno and Yobe states state have reported 55% of the total number of cVDPVs, mainly from inaccessible areas. Adequate and timely response to these polioviruses was hampered by insecurity. The continued circulation of polioviruses in Borno and Yobe pose a risk of polio spread to other states and beyond Nigeria. As shown in the chart below, the immunity profile of non-

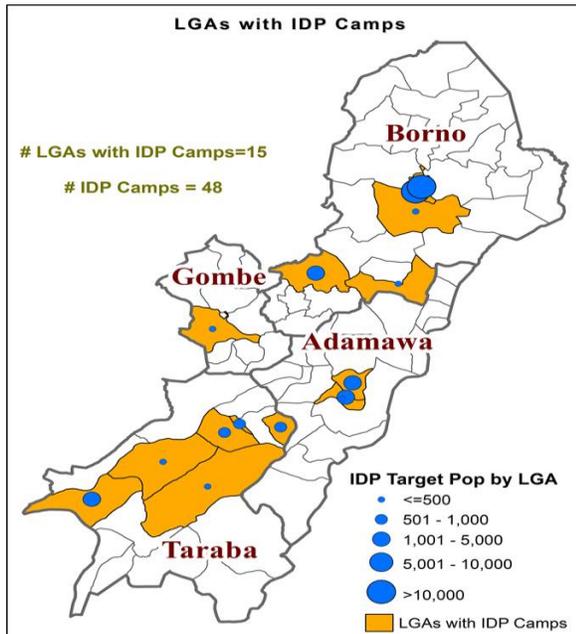
polio AFP cases in both Borno and Yobe is much lower compared with other high risk States in the north

**Negative impact of insecurity and inaccessibility:  
OPV doses of NPAFP Cases 6 - 59 months, by North Eastern States  
2010 - 2014**



eastern Zone.

The increase in insurgency in the north east of the country and tribal communal clashes in the north central part of the country has resulted in the displacement of families in to IDP camps and communities. The number of IDP camps continued to sprout in different parts of the country but mostly in the north eastern and north central (FCT, Nasarawa, Benue and Niger States) part of the country.



It is important to note that the continued movement into and out of these states with the fluctuating security situation poses a huge risk of re-infecting other states that have not reported cases in 2014.

### **3.4 Non-compliance**

Although several interventions have been implemented to address non-compliance with resultant reduction as a reason for missing children, there is still some persistent non-compliance in selected communities. It is important to note the paradox that although non-compliance accounted for about 10% as a reason for missed children in 2014, 83% of the total WPV cases in 2014 were from non-complaint families. Therefore, non-compliance still poses a threat to continued transmission of polioviruses in 2015.

Additionally, with the general elections in 2015, there could be political grievances against government programmes that could result into “political” non-compliance to OPV.

### **3.5 Surveillance gaps**

There have been improvements in AFP surveillance performance in 2014 compared to 2013 with more AFP cases detected (10,447) compared to 8,648 cases in 2013 which is a 21% increase in detection rate attributed to strengthening of reporting networks including informants, and further capacity building and engagement of the surge capacity in surveillance activities. Performance indicators show that the AFP surveillance system worked well, even in security-compromised areas. In 2014, Borno State reported 274 AFP cases compared to 182 cases in 2013 while Yobe State reported 230 AFP cases in 2014 compared to 152 cases in 2013 which represents a 51% increase in AFP cases detection in both states in 2014 compared to 2013. As of November 2014, 100% LGAs across Nigeria are reporting AFP cases, and 96% of LGAs are meeting the two main performance indicators (number of cases and stool collection), representing an improvement from 2013.

However, despite the progress, there were 34 AFP cases that were classified by the National Polio Expert Committee in 2014 as polio compatible and also genetic sequencing showed that some of the WPV and cVDPVs were orphan viruses that had been circulating undetected revealing surveillance gaps in the country that pose a threat of undetected polioviruses circulation.

These surveillance gaps have to be addressed in 2015 to timely detect any polioviruses circulation, so that timely and adequate mop-up response to the outbreaks be mounted. Additionally, the OPV doses of the AFP cases will be used to identify areas with population immunity gaps so that immunization activities be intensified to boost population immunity in the vulnerable areas.

## **4. GOAL, TARGETS, AND MILESTONES FOR 2015**

### **4.1. Goal**

The overall goal of the NPEEP 2015 is to achieve interruption of all poliovirus transmission by the end of 2015.

## 4.2. Targets

**Target 1:** Interruption of WPV transmission by 3<sup>rd</sup> quarter 2015

**Target 2:** Zero cVDPV cases in AFP and the environment by 2<sup>nd</sup> quarter 2015 and interruption of cVDPV transmission by end 2015

**Target 3:** No breakthrough WPV or cVDPV transmission from any outbreak in 2015

**Target 4:** At least 85% of VVHR LGAs estimated by LQAS to have achieved at least 80% coverage during 2015 IPDs rounds

**Target 5:** In highest risks LGAs, 90% of the wards to achieve 90% coverage, by independent monitoring during each round of 2015

**Target 6:** All children in IDP camps aged 0 – 59 months vaccinated with 4 tOPV doses (depending on length of stay in the camps); and all children 14 weeks – 11 months vaccinated with IPV

**Target 7:** Reduction of LGAs in the country not meeting both certification level surveillance performance indicators to less than 2% nationwide.

## 4.3. Major Milestones

- Micro-plans updated in all VVHR/VHR LGAs, LGAs with active WPV and cVDPV circulation, low population immunity and LGAs with population influx and IDP camps by March 2015
- The Borno and Yobe Strategic Operational Plan 2015 for security compromised areas finalized by February 2015 and implementation being closely monitored by March 2015.
- All states have developed and finalized polioviruses outbreak response plans by February 2015
- In security accessible areas, all outbreak mop-up responses to polioviruses detected by AFP or environmental surveillance conducted timely and adequate as per the GPEI / EOC guidelines, including the use of IPV where appropriate
- All very high risk and vulnerable LGAs have routine immunization strengthening plans by February 2015 and implementation closely monitored by the EOC every month by March 2015
- 90% of planned active AFP surveillance visits to prioritized sites conducted by June 2015
- Aggressive advocacy and engagement plan in place for Governors, LGA chairmen and key stakeholders for implementation after the national elections.

## 5. STRATEGIC PRIORITIES FOR 2015

The strategic priorities identified by the EOC after consultation with immunization partners and local stakeholders to achieve the set goal, targets and milestones include: (1) enhancing SIA quality in prioritized vulnerable areas; (2) implementing special approaches for security challenged areas; (3) mounting timely and adequate polio outbreak responses to all polioviruses; (4) enhancing routine immunization; (5) intensifying surveillance; and (6) expanding household and community engagement approaches to build demand for polio and routine immunization. All strategies will be underpinned by strict adherence to the accountability framework which continues to guide the NPEEP.

### 5.1 Enhancing SIA quality in prioritized vulnerable areas

#### Activities

**5.1.1 Deployment of stronger hands to weak performing areas:** Government and partners will review the performance of their state, LGA and ward staff and ensure that stronger hands are redeployed to weak performing LGAs which will result in quality implementation of planned activities. In view of the *emergency nature of the programme*, the review and re-deployment on LGA and ward staff will be done as the situation demands based on available poor performance data.

### **5.1.2 Identifying vulnerable areas**

In addition to very high risk LGAs categorization jointly conducted by the National EOC, WHO, CDC and Global Good done every 6 months, other analyses such as LQAs performance after each round and independent monitoring data will continue to determine the vulnerable LGAs. In 2015, the LQAs approach has been modified to collect information on the number of OPV doses received over time among the sampled children. This information will be used to determine which LGAs and settlements have had persistently poor performance and are hence vulnerable.

### **5.1.3 Improving team performance**

Poor team performance, which manifests as child absent and households not being visited during IPDs, has been the largest contributor to poor quality IPDs in 2014. To reverse the situation in 2015, the critical activities will include:

- **Ward selection committee meeting endorsement:** States and LGA Task Forces will review the appointment of ward focal persons in the very high risk persistently poor performing wards and will hold partner agencies accountable for their staff working in these wards. A responsible coordinator from a partner agency will oversee the selection process of teams in poor performing LGAs and wards. The programme will focus its energy on this thorny but elusive process of team selection and very senior programme officers from government and partners have been deployed to the wards to oversee the team selection process by enforcing accountability and transparency in the process. Senior partner agencies' staff will verify and validate that ALL ward selection meetings have been done and vaccination team members selected as per set National IPDs Guideline criteria.
- **Micro-planning revision and extension of enumeration:** Desk review of micro-plans of all LGAs will be conducted after each round after analysing tally-sheet, LQAs and independent monitoring data from the concluded IPDs. Extensive walk-throughs with enumeration and validation to revise micro-plans in identified poor performing LGAs from the desk review will be conducted before the following round of IPDs. However, in other LGAs, extensive walk-throughs will be conducted every 6 months.
- **Enhancing training quality:** In addition to the institutionalized audio-visual training materials, training modules for major components of the IPDs will be developed with participants and training manuals to ensure consistency of the trainings. Additionally, trainings at all levels will be conducted by senior programme officers, and particularly at ward levels the trainings will be led by the PHCC along with partners.

- **Enhancing supervision:** The national EOC will deploy senior management supervisory teams (MST) to states and the State EOCs / State Task Forces will deploy the MST, state level and partner agency staff to the identified high risk LGAs and wards based on the high risk operational plan for that particular round. In 2015, there will be stringent monitoring of the completed supervisory checklist submission by staff deployed by each agency to ensure adherence and accountability. The analysis of completed supervisory checklist by agency will be presented to the state EOC / state task force and National EOC after each round. The accountability framework will be implemented on government and agency staff that did not perform supervision to the expected level.
- **Improve SIA monitoring:** To enhance independent monitoring, the State EOCs and LGA Teams will select the areas / settlements for independent monitoring before deployment of monitors based on the high risk operational plan (poor performing, underserved etc.). To ensure quality data from independent monitors, government and partner agency staff will develop itineraries to monitor the independent monitors work. They will validate at least 20% of the independent monitors' data. Mock LQAs will continue to be implemented in selected LGAs and settlements during the IPDs in areas where independent monitoring reveals poor quality of IPDs for corrective measures / redoing before the end of the campaign. LQAs will be implemented after the round; and final LQAs verification will continue to take place after each round and where anomalies are found between the LQAs surveyor and LQAs verifier, the surveyor will be held accountable.
- **Enhancing the quality of cross border activities:** Continue collaboration, planning and synchronized implementation of PEI activities across international, interstate, inter-LGA and inter-ward borders.

**5.1.4 Targeted scaling up of proven innovations to reach chronically missed children and evaluation of impact:** Proven innovations that increased reach of chronically missed children in 2014 such as Directly Observed Polio vaccination (DOPV), transit point vaccinations (markets, motor parks, hospitals etc.) health camps, local entertainers and youth engagement will be scaled up in a *targeted* manner to further improve the quality of IPDs. Data will continue to be collected during each IPDs round and in-between rounds on the contribution of each intervention in reaching children, particularly chronically missed children. The impact of each intervention using the collected data will be finally evaluated by the end of the low transmission season in 2015.

#### **5.1.5 Targets, milestones and indicators**

- Categorization of VVHR/VHR LGAs for the 1<sup>st</sup> half of 2015 by the National EOC by February 2015
- Re-deployment of "stronger hands" to VVHR/VHR and weak performing LGAs and wards by Government and partners by March 2015
- Microplans updated in VVHR/VHR, active polioviruses transmission, population influx and IDPS LGAs and wards by March 2015
- Training modules for IPDs developed by April 2015

- Validation of LQAS and use of OPV data from LQAS to improve population immunity commenced by January 2015
- Synchronized international cross-border vaccination with neighbouring countries implemented by April 2015 IPDs
- Evaluation of impact of local IPDs innovations conducted by June 2015.

## 5.2 Implementing special approaches for security challenged areas and IDPs

### 5.2.1 Activities

- **Conduct monthly security risk assessments** to determine accessibility for PEI/EPI activities. These will continue to be conducted with the help of the security and intelligence officers who are part of the State EOCs / Task forces. The implementation of the planned IPDs will be geographically adjusted according to the prevailing security risk assessments.
- **Deploy National and state EOC personnel to security compromised areas:** In continuation of the strategies developed in 2014, officers from the operations group of the National EOC who constitute the Borno-Yobe strategic group will continue to provide field based technical support to the security compromised areas. However, this supportive supervision will be expanded to increasingly involve key actors in the Routine Immunization program.
- **Conduct “Catch-up” OPV contacts** in wards that did not participate in planned 2014 IPDs rounds to further improve population immunity in the targeted LGAs, wards and settlements. At least 4 catch-up rounds will be conducted in the low transmission season in 2014. This will be as contained in the detailed operational plan for Borno and to a lesser extent, Yobe. These catch-up campaigns will be prepared in close collaboration with the security agencies given the current situation of insecurity in many completely inaccessible LGAs. Primal importance will continue to be given to the safety of health workers.
- **Expansion of “Hit & Run”** to all wards with new WPV, cVDPVs or those with accessibility challenges that did not achieve high quality IPDs during “catch-up” immunization contacts.
- **Enhanced Routine Immunization services:** The implementation of Health Camps with attractive pluses during the IPV campaigns in Borno, Yobe and Kano has shed some light on the complex challenge of demand creation. While the latter is more innate and sustainable, there are arguments in favour of responding to expressed felt needs. The impressive coverage figures observed during the IPV campaigns using health camps as a vehicle lends credence to the superiority of this position. In 2015 the EOC plans to use this health camp model of providing “attractive pluses” and other integrated clinical services such as malaria diagnosis, treatment of common ailments, anti-helminthics and multi-vitamin supplementation to enhance Routine Immunization. This intervention will be used in a targeted way; they will be limited to health facilities operating within, near security compromised areas or places where the establishment of a traditional health camp may attract anti-vaccination elements and pose a risk to health workers and their clients during operations. A typical

LGA with only 50% accessibility would have these enhanced RI facilities identified and deployed in the “safe areas” in such a way that mothers and children in “unsafe areas” would be able to access them when they become aware of the availability of these desired health interventions. Using this model would invariably require the mobilization of huge resources to ensure continuous availability of vaccines, pluses and these services. Consequently, implementation must be at scale with the available resources from both government and development partners.

- **Establish and strengthen Routine Immunization services in IDP camps:** Although vaccinations are currently taking place in IDP camps, moving forward, deliberate steps would be taken to establish RI services in all existing and new camps. With vaccination cards given to all residents of the camp, this will be linked to other therapeutic services given.
- **Strengthen Permanent Health Teams** to wards and settlements with inaccessibility challenges and persistent non-compliance. Unlike the global roll-out of PHT of 2014, experience has shown that implementation of this strategy yields the highest dividends when it is used in areas where accessibility is of grave concern and non-compliance persists. Furthermore, there is a need for close supervision of the vaccinators in order to ensure that they consistently approach the focus households and that the set coverage targets are met. In 2015, there will be greater emphasis on holding the implementers of this strategy accountable for the gaps that have been identified so far. With geographical restriction of its scope to where higher level supervision is possible, then there would be greater confidence in the quality of the data.
- **Establish permanent vaccination sites at all major transit points.** Priority in establishing permanent vaccination sites will be given to Very High Risk LGAs as well as LGAs that were previously inaccessible to vaccinate children with OPV before reaching IDP camps or communities. Wherever feasible, trained health workers who can administer injectable antigens will be recruited so that all RI antigens can be given in addition to OPV. In areas with no capacity to deploy trained health workers to be included in the permanent vaccination sites, volunteers would be recruited and they would administer OPV and any other less demanding intervention available e.g. Vitamin A.
- **Establishing Health Camps and expanding Therapeutic feeding centres (OTP) / CMAM.** In the insecurity areas, the population has been deprived of many health services in addition to OPV. Providing comprehensive services such as antenatal care, screening for chronic disease and treatment of common ailments has pulled crowds to where health camps are operated. Indeed, in areas which were hitherto inaccessible, provision of these interventions has opened up populations to OPV vaccination. Interventions in these camps also include “pluses” such as multivitamins and household items. Additionally, there are reports of malnutrition due to lack of access to food. Therefore, as part of in-between round activities in the security compromised areas, health camps will be established; and OTP and Community Management of Acute Malnutrition (CMAM) centres expanded. These avenues will be used to increase uptake of OPV.
- **Enhancing AFP surveillance** in these areas in order to ensure that cases continue to be reported outside of the orthodox health infrastructure. There will be a conscious effort to increase the number of community-based informants who have regular meetings with DSNOs and facility based focal persons.

- **Scaling up engagement of local traditional, religious leaders and other influencers:** Scale-up engagement of local traditional and religious leaders plus stakeholders to help overcome issues of mistrust and suspicion at the local level.

### 5.2.2 Targets, Milestones and Indicators:

- Detailed Operational plan for security affected states of Borno and Yobe updated and implementation being closely monitored by end February 2015.
- Conduct 4 “Catch-up” OPV contacts in wards and LGAs that did not participate in planned IPDs rounds by June 2015
- Conduct 3 “Hit & Run” mop-ups to all wards with WPV and accessibility challenges that did not achieve high quality IPDs during “catch-up” contacts by May 2015
- Permanent Transit Vaccination intensified by March 2015
- Permanent Health Teams established in all wards with inaccessibility challenges and persistent non-compliance by January 2015 with monthly reporting of data
- Enhanced Routine Immunization established in security compromised, partially accessible or vulnerable LGAs
- Targeted Health Camps and CMAM sites established and expanded in poor performing wards and non-compliant sites by May 2015
- Routine immunization services set up in displaced camps; emphasis on weekly vaccination of eligible children with OPV and other vaccines by February 2015

### 5.3 Mounting timely and adequate outbreak responses to all polioviruses

Out of the 6 WPV outbreaks experienced in 2014, 5 mop-up responses were implemented in an appropriate and timely manner. However one WPV mop-up response was not undertaken in a comprehensive way due to insecurity in Yobe state. Additionally, the cVDPV outbreaks in Borno, particularly Damboa and Gwoza were not implemented due to insecurity. Furthermore, there was no consistency in the geographical scope and population targets of the mop-responses

Major outbreak response activities undertaken by the EOC were in strict adherence to the EOC-Outbreak Response Standard Operating Procedures (SOPs) and dashboard indicators (GPEI polio outbreak protocol). The support to NPHCDA outbreak response manager and EOC Outbreak Response team constituted in 2014, contributed to the timely response to outbreaks and ensured vaccines and operational funds were pre-positioned for timely response.

#### 5.3.1 Activities:

- **Appointment of senior outbreak response manager and team at national and states levels:** NPHCDA, National EOC and State Task Forces /EOCs including partners to update the list of effective senior managers of outbreak response and team members at all levels
- **Development of state outbreak response plans:** to ensure timely outbreak responses with responsible persons and mobilization of resources, all states in Nigeria will develop a specific state

outbreak response plan. The plans will also ensure that outbreak responses are conducted as per the GPEI guidelines with approximately 2 million children targeted

- **Timely Deployment of the National Outbreak Management Team:** All agencies to ensure that funds are set aside for timely dispatch of their respective outbreak team members to infected states within 24 hours of non-Sabin ITD notification.
- **Monitor and maintain the outbreak dashboard:** Monitor implementation of outbreak response based on the EOC's Outbreak SOPs and the Outbreak dashboard during every Wednesday EOC session as part of the agenda of the day. Improve the dashboard by installing reminders to reporting of outbreak activities done in the infected state.
- **Maintain pre-positioning of vaccines and operational funds for outbreak response:** Monitor vaccine stock levels in country through weekly presentation in the EOC by the National Logistics Working Group on availability and forecast for OPV
- **Use LQAs to monitor mop-up quality:** LQAs will continue to be conducted for each response to ensure quality. As set standards, the infected LGA should be accepted at 90% coverage as estimated by LQAs while the other LGAs should achieve at least 80% coverage as estimated by LQAs. If these expected levels are not met through LQAs or independent monitoring findings, the LGAs will continue mopping-up areas which contributed to the poor quality before deciding that the response is adequate.

### 5.3.2. Targets, Milestones and Indicators

- National and State Outbreak Response Managers and teams updated by the Government and partners by February 2015
- State Outbreak Plans developed and shared with National EOC by February 2015
- National Outbreak Management Team deployed to outbreak states within 24 hours of non-Sabin ITD notification
- The first response to all poliovirus outbreaks conducted within 2 weeks of non-Sabin notification and 3 responses completed within 2 months. Timeliness of the outbreak responses continue to be monitored based on the National EOC –Outbreak SOPs and the Outbreak dashboard on a weekly basis
- NPHCDA to ensure adequate stocks of vaccines at the National and Zonal strategic cold store (NSCS) to facilitate timely outbreak response from January 2015
- Vaccines and operational funds pre-positioned in outbreak-prone areas by February 2015
- LQAs and independent monitoring results (90% by LQAs for the infected LGA and 80% for the surrounding LGAs) used to determine quality of the outbreak response

### 5.4 Enhancing routine immunization

To ensure interruption of all polioviruses and sustain the gains, it is important that routine immunization is rapidly strengthened. Strengthening routine immunization is labour, material and financial intensive, so it is key that the efforts of the polio programme towards strengthening routine immunization should be targeted to areas that pose a great risk to interrupting transmission.

If the prioritized areas already have other routine immunization projects being funded and implemented such as RI Intensification for Vulnerable LGAs, Integrated Mobile Outreach for Hard to Reach Areas etc., then the role of the polio staff and EOCs is to ensure that activities are being carried out as planned and ensure weekly reporting of number of sessions carried out and children vaccinated to the National EOC.

#### **5.4.1 Activities**

- 5.4.1.1 Identify the priority areas for strengthening routine immunization: Vulnerable LGAs and wards with low population and large numbers of unimmunized / under-immunized children, categorized as VVHR or VHR, evidence of polioviruses circulation, and those with population influx and internally displaced persons in camps or assimilated in communities
- 5.4.1.2 EOC to share prioritized LGAs and wards with the NPHCDA'S RI working group and engage in discussions of the type of support that will be required by both parties
- 5.4.1.3 National EOC to advocate to State Task Forces / EOCs for state ownership and human, logistics and financial support to the identified LGAs as per developed routine immunization intensification plans
- 5.4.1.2 The polio field surge capacity by government all partners to work with traditional institutions to conduct walk-throughs micro-plans, micro-census, enumeration and verifications to establish almost accurate target populations for routine immunization. Also during walkthroughs determine areas for outreach sessions in agreement with the traditional leaders.
- 5.4.1.3 Polio infrastructure to support the planning and implementation of routine immunization sessions (fixed and outreach), logistics support to carry vaccines to – and from sessions where possible, supportive supervision; demand creation activities, enhancing routine immunization sessions by providing a minimal integrated package of MNCH services.
- 5.4.1.4 Government and partners to assist with printing data tools for proper collection of accurate RI data in the prioritized areas: registers, vaccination cards, vaccine management data tools, vaccination data reporting and monitoring
- 5.4.1.5 Government and partners to participate and monitor the fixed and outreach sessions carried out in these prioritized areas
- 5.4.1.6 Build on NPHCDA efforts to strengthen the RI information system to improve quality, timeliness, and completeness of routine immunization data through the DHIS2 and DVDMT reporting systems.
- 5.4.1.7 National and State EOC to weekly monitor from these LGAs the proportion of fixed and outreach sessions carried out, number of children vaccinated in the sessions, and vaccine availability / stock outs

#### **5.4.2 Targets, milestones and indicators**

- Priority LGAs / wards for strengthening RI identified and shared with State Task Forces / EOCs by February 2015
- Commencement of National EOC advocacy with state task forces / EOCs for human, material and financial support by March 2015
- Updated RI plans based on walk-through micro-plans data and sessions plans available by March 2015
- Data tools for capturing and monitoring routine immunizations performance available in priority LGAs by March 2015
- Polio surge capacity supporting and monitoring sessions by March 2015
- National and State EOCs / task forces commence weekly monitoring of RI performance by April 2015

### **5.5 Intensifying surveillance**

A very highly sensitive AFP surveillance system remains the gold standard indicator to ensure timely detection of poliovirus circulation and this will be critical in 2015 to verify if indeed Nigeria has interrupted transmission ad per set targets and milestones.

In 2015, the real focus with regards to strengthening surveillance will be at ward level. In continuation from 2014, geo-coordinates of active surveillance field visits to designated reporting sites, all AFP and polioviruses cases will continue to be taken and GIS mapped by ward level. This technique allows for a better visualization of the geographical distribution of AFP cases, WPVs, polio compatibles and cVDPVs by ward. The use of an integrated supervisory check list on a mobile device was introduced in 2014 to generate real time data on active surveillance activities. Its use in 2014 has provided useful information that has been used to strengthen surveillance weaknesses and validate implementation of planned surveillance activities and this technology will be further strengthened in 2015.

#### **5.5.1. Activities:**

##### **5.5.1.1. Enhance sensitivity of AFP Surveillance:**

- Update the AFP surveillance network of public and private health facilities as well as community informants and reporting sites every 6 months;
- Implement regular capacity building of personnel involved in surveillance including surveillance site focal points, DSNOs, state epidemiologists, surge capacity through supportive supervision, on-the-job training, peer exchanges and refresher training. Additionally, in LGAs where the surveillance review indicates a need, assistant DSNOs, informants will also be engaged and trained as well as sensitization of clinicians (of all categories).
- In under-served communities including nomadic communities as well as border and hard-to-reach areas, a network of informants (including Traditional leaders / Ardos) of nomadic populations will be identified as informants to be set up and regularly monitored to report cases. Regular meetings will be convened between the community based focal points and DSNOs/surveillance staff during which the activities of the community focal points will be documented, refresher training provided

to the community focal points and any outstanding performance recognized and rewarded. SMS reminders will be sent to the community focal points in between meetings.

- Monitor quality of active surveillance and performance of the AFP surveillance network through supportive supervision, monthly and quarterly surveillance review meetings at LGA, State, zonal and national level as well as implementation of regular surveillance reviews (Rapid Surveillance Assessment).
- Implement targeted surveillance activities to enhance surveillance in states with security challenges including: development of jingles and use of local radio stations, improving partnership with professional medical associations, CBOs and NGOs.
- Monitor implementation of RSA and ERC recommendations.
- *Provide a N1,000 reward to any vaccination team that reports a true AFP case during IPDs*

#### **5.5.1.2. Sustain and expand Environmental Surveillance**

- Support existing environmental surveillance activities in 10 states Kano, Sokoto, Lagos, FCT, Kaduna, Jigawa, Yobe, Katsina, Kebbi and Borno.
- Expand environmental surveillance to Adamawa State and additional very high risk states depending on poliovirus epidemiology
- Conduct quarterly supervision of all environmental surveillance sites.
- Conduct annual meeting of environmental surveillance system technical staff.

#### **5.5.1.3. Sustain performance and accreditation of the National Polio Laboratory Activities:**

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

#### **5.5.1.4. Conduct polio sero-surveys:**

- Finalize all sero-prevalence studies commenced in 2014
- Conduct additional sero-surveys depending on polio epidemiology and population immunity.

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

- Attainment of the 2 main AFP surveillance performance indicators at national, state level and LGA levels by June 2015
- 90% of all reported AFP and polioviruses verified and geo-coordinated by June 2015
- 5-10 % increase in community informants conducting AFP surveillance by June 2015.
- Conduct at least 80% planned monthly active surveillance activities (including to community informants) by June 2015
- At least 70% reduction in polio compatible cases by December 2015.
- Environmental surveillance expansion to Adamawa State by February 2015
- Sero-prevalence surveys conducted in Katsina, Borno and Yobe by April 2015
- National Polio Laboratories maintain WHO accreditation in 2015.

#### **5.6 Expanding household and community engagement approaches to build demand for polio and routine immunization**

Intensive efforts will be made to scale up household and community engagement approaches in the very high risk LGAs to reduce missed children and build demand for overall immunization – SIAs and routine. In 2014 more than 10000 Volunteer Community Mobilizers (VCMs) were deployed to support household engagement in the high risk LGAs. As well, 1500 FOMWAN women were engaged to further supplement community engagement in high risk areas. An important partnership was established with Daawa, a network of key religious leaders and institutions in 2014. Polio survivors, doctors, youth and religious focal persons were deployed to ensure the full engagement of local level religious leaders and key community stakeholders. To address the issue of child absent and non-compliance, community entertainers were deployed to support outside vaccination and DOPV in high risk areas, contributing important reductions in missed children. The entire communication network coupled with other demand creation initiatives such as the scaling up of health camps and attractive pluses have shown results in reducing missed children, including non-compliance. Additional social data collected in early 2014 showed overall high levels of acceptance for both polio vaccines and routine immunization. There remain however some gaps in knowledge and understanding about the importance of multiple doses and overall immunization which need to be addressed in 2015 through more emphasis on social and community mobilization through a wide range of stakeholders.

'Child absent' still remains the main reason for missed children across the programme. Non-compliance also continues to be a key challenge in some well-known priority areas. In 2014, 83% of the polio cases were from non-compliant families. As well, 24% of the cvDPV cases (n=29) were from non-compliant families. Given many parents refuse polio vaccination due to other felt needs, the programme has responded by providing health camps, expanding links to nutrition programmes, routine immunization and by providing attractive pluses. The programme will continue to ensure linkages with other high impact child survival interventions, including water and sanitation (WASH), nutrition, health camps, immunization during and in-between campaigns to create demand and build trust for immunization within communities. More emphasis in 2015 will be placed on building demand for routine immunization in the prioritized LGAs in between campaigns.

Experience has shown the significant impact can be achieved by developing locally appropriate communications plans that include targeted household and community engagement approaches during and in-between polio campaigns. In 2015, VCMs will continue to work at the household level supported by a community engagement approaches which will include a strong focus on the engagement of religious and traditional leaders for routine and SIAs. The integrated training package which includes IPC, routine immunization and key household practices will be fully rolled out across the VCM network to ensure mobilizers are fully equipped to engage with communities on issues beyond polio. Social data shows that children are missed during polio campaigns due to participation in local ceremonies. VCMs will track and immunize newborns and all under five children during and in-between campaigns, also taking advantage of traditional naming ceremonies as an additional opportunity to immunize missed children. VCMs will also support defaulter tracing and health education for routine immunization in their settlements. The network of Daawa members will be further engaged to ensure the full engagement of local religious leaders, particularly Jummat mosque imams in all wards within high risk LGAs for SIAs and routine immunization together with the Northern Traditional Leaders Committee and other religious

institutions. With increased focus at the community level, community-based organizations (CBOs), including youth groups will be identified to expand the network of community partners even further in the prioritized LGAs. Pro-immunization messages – from key influencers and using popular entertainment will continue to be distributed on a regular basis at household level and in viewing centres and new technologies putting polio within a broader health context of child survival. Efforts in 2015 will also focus on broader entertainment-education activities for all components of immunization guided by the social data.

By packaging the polio vaccination programme with a number of other health interventions parents are more likely to want to bring children to the centres and to agree to permit vaccination. The community network must be linked to the broader programmatic priorities in the high risk and security compromised areas, including health camps, outpatient therapeutic Programme (OTP) / CMAM, child health weeks and broader routine immunization.

### **5.6.1. Activities**

#### **5.6.1.1 Reducing chronically missed children**

- Developing evidence based communication plan in every high risk LGA, including a focus on activities in the high risk wards to address the locally specific reasons for missed children;
- Rigorous follow up on the register of all missed children during and in-between campaigns;
- All VCMs to immunize all children under-five during naming ceremonies during and in between campaigns
- **Local traditional, religious leaders and stakeholder engagement:** Scaling-up engagement of local traditional and religious leaders, including the Daawa Coordination Council members/Jummat mosque imams plus stakeholders to help overcome issues of mistrust and suspicion at the local level;
- Full engagement of local entertainers to support outside household vaccination, including DOPV;
- Mapping and engagement of new community-based partners and youth groups in the highest risk areas.

#### **5.6.1.2 Building demand for routine immunization**

- Full implementation of new integrated module for mobilizers, which includes routine immunization;
- Every VCM must be linked to the health facility in her catchment. All VCMs to track and immunize newborns and support defaulter tracking together with the relevant health facility staff. Every VCM to support key routine immunization activities during session days at the health facility, including health education.
- Every high risk LGA for polio to have a social mobilization plan in place for routine immunization which will be tracked by the EOC. Key components will include reinvigoration of WDCs, engagement of traditional and religious leaders and other key stakeholders;
- Entertainment-education package for Hausa media platforms to include routine immunization;

- Use of local entertainers to support the mobilization of caregivers to routine immunization sessions, including outreach sessions

### **5.6.1.3 Building political support for immunization among new leadership**

- Following national elections, a rigorous advocacy plan will be implemented based on the new context to ensure the full engagement of new LGA Chairmen and Governors in particular. This will include orientations of new Chairmen in prioritized states to ensure their full support for immunization. The High Level Immunization Action team will be reinvigorated to undertake one-on-one engagement with new Governors and other key political leaders.

## **6. POLIO SIA CALENDAR FOR 2015**

It is important that the momentum that led to the marked progress towards interrupting wild poliovirus transmission in 2014 be sustained with acceleration to achieving interruption of all types of polioviruses in the shortest possible time in 2015 within the context of the global polio endgame strategy. The Expert Review Committee (ERC) endorsed Nigeria's SIA schedule during its 29<sup>th</sup> ERC meeting in January 2015.

Quality will continue to be the overarching theme for 2015. Emphasis will continue to be placed on improving campaign quality with continued close monitoring of quality pre -; intra-; and post – IPDs activities. The monitoring will be done by a revised IPDs Dashboard that will look at quality issues than just achievement of milestone indices.

The number of IPDs in 2015 includes:

- 2 Nation-wide IPD rounds
- 6 Sub-National rounds

The choice of the antigens to be used for the rounds has been endorsed by the ERC but will take into consideration the evolving poliovirus epidemiology as the year unfolds. The EOC will ensure that the antigens to be used for the rounds are determined and orders placed on time to ensure availability of scarce polio vaccines.

The scheduled dates of 2015 IPDs are in Annex 2.

## **7. OVERSIGHT AND MANAGEMENT**

- **National, State, LGAs and Traditional Forums**

The enhanced functionality of the Presidential Task Force will continue to provide oversight to the PEI program in Nigeria. The PTF will continue to monitor progress at the State and LGA level through monthly meetings.

The National EOCs which is the operational/programme management secretariat of the Presidential and State Task Forces will continue to provide a setting where key government and partner staff will continue to work together with the aim of improving decision making, information sharing, conducting

joint planning and programming, and implementing new strategies to increase the effectiveness of the polio programme. The functions of the national EOC will be replicated by the State EOCs and State Task Forces of Immunization.

The LGA Task Forces on Immunization will 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 2015, 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.

2015 being an electioneering year will mean that there is critical need for stronger engagement of the traditional institutions if progress is to be maintained. 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, vaccinators 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 2015 NPEEP. In 2015 continued focus will be placed on the engagement of Daawa and FOMWAN members together with the NTLC.

- **Independent Advisory bodies and Global Partners**

**GPEI Partners:** GPEI partners and donors are expected to support the national authorities to effectively implement the key activities included in the 2015 NPEEP. The GPEI partners are also expected to support resource mobilization.

**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.

**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.

## **8. ACCOUNTABILITY**

**8.1 Accountability mechanisms and rewards:** Enforcement of accountability continues to underpin all aspects of Nigeria's polio eradication programme and has been the game changer since 2013. The EOC

will continue to ensure that all programme officers are held accountable while delivering on their assigned mandates. Increased accountability across all levels is needed to ensure campaigns and other activities are carried out with a high degree of quality. Programme officers in the high risk polio LGAs will also be held accountable for performance of routine immunization. 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:

- **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.
- **Rewards for strong performance:** The individuals who demonstrate strong performance should be recognized through a reward programme. The programme has developed a reward scheme to recognize top performers in wards, LGAs and states. This was piloted in 31/44 LGAs of Kano state during the December 2013 IPDs campaign. An award certificate was issued to winning LGAs. However, these rewards may include public recognition, a congratulatory meeting with a senior leader, a mention in the media, enrollment in training of choice, etc.
- **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).
- **Evidence based decision making:** Assessments of critical impediments, their solutions, staff performance and progress will be evidence based.
- **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.
- **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 will continue to be instrumental in evaluating staff performance by Government and partners with management actions taken based on staff performance.

## **9. MONITORING AND EVALUATION**

### **9.1. 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 dashboard
- 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 analyzed 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

## 10. ANNEXES

### 10.1 Annex 1: Provisional List of 41 Very Very High Risk (VVHR) LGAs in 2015 (EOC, February 2015)

State	Very High Risk LGAs
Bauchi	Bauchi Itas Gadau Ningi Toro
Jigawa	Birnin Kudu Dutse
Kaduna	Birnin Gwari, Chikun Giwa Igabi, Ikara, Kaduna-North, Makarfi Sabon Gari Zaria

<b>Kano</b>	<b>Ajingi</b> <b>Albasu</b> <b>Dambatta</b> <b>Dalla</b> <b>Fagge</b> <b>Gaya</b> <b>Gwale</b> <b>Kano Municipal</b> <b>Kibiya</b> <b>Kumbutso</b> <b>Kura</b> <b>Nasarawa</b> <b>Rano</b> <b>Sumaila</b> <b>Takai</b> <b>Tarauni</b> <b>Tudun Wada</b> <b>Ungogo</b> <b>Wudil</b>
<b>Katsina</b>	<b>Katsina,</b> <b>Funtua</b> <b>Mani</b>
<b>Sokoto</b>	<b>Sokoto North</b> <b>Sokoto – South</b> <b>Wamakko</b>
<b>Zamfara</b>	<b>Maru</b>

10.2 Annex 2: IPDs schedule, Antigens choice, Geographical scope and Major holidays, Nigeria 2015

S/No.	Dates in 2015	Antigen & Scope	Comment
1	24 - 27 January	<b>bOPV</b> (SIPDs)	
<b>IPV Introduction in Routine Immunization: 11 February</b>			
2	14 - 17 March	<b>tOPV</b> (NIPDs)	Taking into account general elections is on the 28 <sup>th</sup> March
<b>Easter: 3 - 6 April</b>			
3	25 - 28 April	<b>bOPV/tOPV</b> (NIPDs)	Taking into account general elections is on the 11 <sup>th</sup> April
*4	6 – 9 June	<b>bOPV</b> (SIPDs)	
<b>Ramadan: 18 June - 17 July</b>			
*5	25 - 28 July	<b>tOPV</b> (SIPDs)	
6	5 – 8 September	<b>bOPV</b> (SIPDs)	
<b>Eid Al Adha: 23 September</b>			
<b>Independence Day: 1 October</b>			
7	17 - 20 October	<b>tOPV</b> (SIPDs)	Depending on evolving poliovirus epidemiology
8	5 - 8 December	<b>bOPV</b> (SIPDs)	Depending on evolving poliovirus epidemiology

### 10.3. Annex 3: Polio Eradication Emergency Plan Strategic Priorities, Milestones and Timelines

Strategic Priority 1: Enhancing SIA quality in prioritized vulnerable areas													
Milestone / Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Categorization of VVHR/VHR LGAs for the 1 <sup>st</sup> half of 2015 by the National EOC by February 2015	X	X											EOC
Re-deployment of “stronger hands” to VVHR/VHR and weak performing LGAs and wards by Government and partners by March 2015			X				X						GOVT & PARTNERS
Microplans updated in VVHR/VHR, active polioviruses transmission, population influx and IDPS LGAs and wards by March 2015	X	X	X			X	X	X					STATE EOCS
Training modules for IPDs developed by April 2015				X									EOC
Validation of LQAS and use of OPV data from LQAS to improve population immunity commenced by January 2015	X		X	X		X	X		X	X		X	WHO
Synchronized international cross-border vaccination with neighbouring countries implemented by April 2015 IPDs				X		X	X		X	X		X	EOC
Evaluation of impact of local IPDs innovations conducted by June 2015.													GOVT & PARTNERS

<b>Strategic Priority 2: Implementing special approaches for security challenged areas and IDPs</b>													
Milestone /Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Detailed Operational plan for security affected states of Borno , Yobe (and Adamawa) updated and implementation being closely monitored by end February 2015.	X	X											STATE EOCs / STF
Conduct 4 “Catch-up” OPV contacts in wards and LGAs that did not participate in planned IPDs rounds by June2015	X	X	X	X	X	X							STATE EOCs
Conduct 3 “Hit & Run” mop-ups to all wards with WPV and accessibility challenges that did not achieve high quality IPDs during “catch-up” contacts by May 2015		X	X	X	X								STATE EOCs
Permanent Transit Vaccination intensified by March 2015			X	X	X	X	X	X	X	X	X	X	STATE EOCs
Permanent Health Teams established in all wards with inaccessibility challenges and persistent non-compliance by January 2015 with monthly reporting of data	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOCs
Enhanced Routine Immunization established in security compromised, partially accessible or vulnerable LGAs			X	X	X	X	X	X	X	X	X	X	STATE EOCs / STF
Targeted Health Camps and CMAM sites established and expanded in poor performing wards and non-compliant sites by May 2015					X	X	X	X	X	X	X	X	STATE EOCs / STF

Routine immunization services set up in displaced camps; emphasis on weekly vaccination of eligible children with OPV and other vaccines by February 2015		X	X	X	X	X	X	X	X	X	X	X	X	STATE EOCs / STF
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<b>Strategic Priority 3: Mounting timely and adequate outbreak responses to all polioviruses</b>														
Milestone / Activity	Timeline												Responsible	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
National and State Outbreak Response Managers and teams updated by the Government and partners by February 2015		X												NATIONAL & STATE EOCs
State Outbreak Plans developed and shared with National EOC by February 2015		X												STATE EOCs / STF
National Outbreak Management Team deployed to outbreak states within 24 hours of non-Sabin ITD notification	X	X	X	X	X	X	X	X	X	X	X	X	X	NATIONAL EOC
The first response to all poliovirus outbreaks conducted within 2 weeks of non-Sabin notification and 3 responses completed within 2 months. Timeliness of the outbreak responses continue to be monitored based on the National EOC – Outbreak SOPs and the Outbreak dashboard on a weekly basis	X	X	X	X	X	X	X	X	X	X	X	X	X	NATIONAL & STATE EOCs

NPHCDA to ensure adequate stocks of vaccines at the National and Zonal strategic cold store (NSCS) to facilitate timely outbreak response from January 2015	X	X	X	X	X	X	X	X	X	X	X	X	X	NPHCDA
Vaccines and operational funds pre-positioned in outbreak-prone areas by February 2015		X	X	X	X	X	X	X	X	X	X	X	X	NPHCDA
LQAs and independent monitoring results (90% by LQAS for the infected LGA and 80% for the surrounding LGAs) used to determine quality of the outbreak response	X	X	X	X	X	X	X	X	X	X	X	X	X	WHO

<b>Strategic Priority 4: Enhancing routine immunization</b>														
Milestone / Activity	Timeline												Responsible	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		
Priority LGAs / wards for strengthening RI identified and shared with State Task Forces / EOCs by February 2015		X												NATIONAL EOC
Commencement of National EOC advocacy with state task forces / EOCs for human, material and financial support by March 2015			X	X	X	X	X	X	X	X	X	X	X	NATIONAL EOC

Updated RI plans based on walk-through micro-plans data and sessions plans available by March 2015			X	X	X	X	X	X	X	X	X	X	STATE EOCs / STF
Data tools for capturing and monitoring routine immunizations performance available in priority LGAs by March 2015			X	X	X	X	X	X	X	X	X	X	NPHCDA / SPHCDA
Polio surge capacity supporting and monitoring sessions by March 2015			X	X	X	X	X	X	X	X	X	X	GOVT & PARTNERS
National and State EOCs / task forces commence weekly monitoring of RI performance by April 2015			X	X	X	X	X	X	X	X	X	X	NATIONAL EOC & STATE EOCs / STFS

<b>Strategic Priority 5: Intensifying surveillance</b>													
Milestone / Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Attainment of the 2 main AFP surveillance performance indicators at national, state level and LGA levels by June 2015	X	X	X	X	X	X	X	X	X	X	X	X	WHO & PARTNERS
90% of all reported AFP and polioviruses verified and geo-coordinated by June 2015							X	X	X	X	X	X	WHO
5-10 % increase in community informants conducting AFP surveillance by June 2015							X	X	X	X	X	X	WHO & PARTNERS
Conduct at least 80% planned monthly active surveillance activities (including to community													WHO

informants) by June 2015													
At least 70% reduction in polio compatible cases by July and December 2015.							X					X	WHO
Environmental surveillance expansion to Adamawa State by February 2015		X	X	X	X	X	X	X	X	X	X	X	WHO
Sero-prevalence surveys conducted in Katsina, Borno and Yobe by April 2015	X	X	X	X									WHO
National Polio Laboratories maintain WHO accreditation in 2015	X	X	X	X	X	X	X	X	X	X	X	X	WHO

