NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

2012 NIGERIA POLIO ERADICATION EMERGENCY PLAN

Draft compiled by

NPHCDA

Contents

Abbreviations

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

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

EXECUTIVE SUMMARY

The set back experienced in polio eradication in Nigeria in 2011 and persistent spread of wild poliovirus into 2012 is being treated as an emergency by the Nigerian national authorities right from the highest office in the land. Persistent transmission of poliovirus (both wild poliovirus as well as circulating vaccine derived poliovirus) is occurring in areas that have consistently failed to achieve high immunization coverage. Factors contributing to sub-optimal vaccination coverage in these areas include (a) poor local leadership and accountability; (b) sub-optimal macro and micro-planning; (c) poor motivation, performance and attitude of vaccination teams and supervisors as well as (d) sub-optimal acceptance and uptake of vaccination in some areas.

In 2011, Nigeria adopted a PEI emergency plan that was sub-optimally implemented in the highest risk areas. A careful review of the factors that led to sub-optimal implementation of the 2011 PEI Emergency Action Plan has been made and lessons learned applied during the preparation of the 2012 PEI emergency plan.

The main objective of the 2012 PEI Emergency plan is to achieve interruption of poliovirus transmission by the end of 2012. This goal is to be achieved by ensuring (a) implementation of highest quality SIAs, with specific focus on high risk States and LGAs (b) highest quality AFP surveillance quality is achieved in all states before end of 2012 and (c) routine OPV3 coverage in the highest risk LGAs is increased to at least 50% in all high risk LGAs.

The objectives of the 2012 PEI Emergency plan will be achieved by ensuring high quality implementation of priority activities in all States and Local Government Areas, particularly those at highest risk of continued poliovirus transmission through (a) strengthening leadership and accountability at all levels especially the operational level as well as (b) deploying additional well trained and motivated personnel in the highest risk areas.

The priority strategies and activities in the 2012 PEI Emergency Plan include

- Refining and improving basic strategies
- Improving performance and motivation of front line health workers and personnel
- Scaling up proven innovations
- Expanding partnerships and inter-sectoral collaboration

What is new in the 2012 PEI Emergency Plan?

- Much closer involvement of His Excellency the President of the Federal Republic of Nigeria through the recently established Presidential Task Force on Polio Eradication
- Closer linkages between the Presidential Task Force and State Task Forces
- Introduction of national PEI Accountability Framework with well defined indicators for use at all levels.
- Optimization of new technologies including GIS/GPS, SMS…etc.
- Systematic introduction of revisit strategy; Short Interval Additional Dose strategy in areas that have been consistently missed or where access may be a problem due to insecurity.
- Surge of technical capacity from Government and partners in the highest risk areas

1. INTRODUCTION

In 2010, the polio eradication efforts in Nigeria registered significant success as the country experienced a 95% decline in confirmed polio cases as compared to 2009. Improved quality and coverage of immunization activities that resulted from very strong involvement of Political, Traditional and Religious leaders down to the community level in the highest risk States and Local Government Areas (LGAs) contributed to this success.

The progress registered in 2010 was not sustained in 2011 as Nigeria experienced persistent transmission of all 3 serotypes of poliovirus, with a 3-fold in cases due to wild poliovirus as compared to 2010. Eight states experienced wild poliovirus transmission in 2011 [Borno, Jigawa, Kano, Katsina, Kebbi, Sokoto, Yobe and Zamfara] while 10 states experienced transmission of circulating vaccine derived poliovirus [Bauchi, Borno, Jigawa, Kano, Katsina, Niger, Plateau, Sokoto, Yobe and Zamfara].

In May 2011, the Federal Government of Nigeria developed a Polio Eradication Emergency Action Plan with a goal of intensifying polio eradication efforts. Implementation of this plan was sub-optimal, particularly in the highest risk areas. Some factors that contributed to the sub-optimal implementation of the 2011 PEI Emergency plan included insufficient buy-in by State and LGA authorities, insufficient human and financial resources, low accountability amongst programme implementers and stake-holders as well as increasing insecurity in several areas.

The failure to implement priority activities included in the 2011 Emergency action plan contributed to a decline in the quality and coverage of both immunization and surveillance activities in the highest risk states. The 22nd session of the Expert R eview Committee on Polio Eradication, and Routine Immunization in Nigeria (ERC) that met in Abuja in October 2011 noted that *"transmission of all poliovirus types is primarily being detected in known high risk LGAs, most of which demonstrate consistent problems in achieving high immunization coverage during IPDs"*.

Nigeria is determined to achieve interruption of poliovirus transmission within the shortest time possible. The Federal Government of Nigeria, with support of Global Polio Eradication Initiative (GPEI) partners has developed a Polio Eradication Emergency Plan for 2012 that has taken into account the important lessons from 2011. Extensive consultations during the development of the 2012 plan have been had with State and Local Government authorities as well as with GPEI partners. A bottom up approach with emergency plans developed by States and Local Government Areas contributing to the finalization of the 2012 national Polio Eradication Emergency Plan was adopted.

The main technical areas of focus of the 2012 PEI emergency plan include (a) enhancing SIA quality to reach all children, with specific focus on the chronically missed children (b) intensified advocacy, behavior change communication and mobilization at all levels (c) accelerating routine immunization delivery and (d) enhancing surveillance for poliovirus detection.

New implementation modalities have been put in place to ensure more effective implementation of the 2012 Polio Eradication Emergency Plan. On 1 March 2012, His Excellency President Goodluck Jonathan inaugurated a Presidential Task Force on Polio Eradication (PTFoPE). This Task Force, chaired by the Honorable Minister of State for Health, has membership drawn from the National Assembly, Nigeria Governors Forum, Northern Traditional Leaders Committee on Primary Health Care, States, Federal Ministry of Health and Partner Agencies. The Executive Director of the National Primary Health Care Development Agency (NPHCDA) is the secretary of the PTFoPE. The main goal of the PTFoPE is to provide leadership support to Nigeria's efforts to accelerate

interruption of poliovirus transmission in 2012. It is expected that the PTFoPE will support State and Local Government Task Forces to ensure timely and effective implementation of the 2012 PEI Emergency plan (discussed in more detail in chapter 3).

A national Polio Eradication Accountability Framework that will be monitored monthly by the PTFoPE has also been adopted to enhance full implementation of the 2012 PEI emergency plan by all stake-holders right from the national level down to the operational level (discussed in detail in chapter 8).

In September 2011, Executive Governors' recommitted themselves to the Abuja commitments and are already providing personal leadership to polio eradication activities in their states, including through regular meetings with LGA chairmen as well as Traditional leaders. The Leadership Challenge Award that is being supported by the Bill and Melinda Gates Foundation in close partnership with the Nigeria Governors' Forum (NGF) is a new opportunity that has been warmly received by all 36 Governors as well as the Honorable Minister of the FCT.

The Federal Government is also putting in place mechanisms to ensure closer linkage between the intensified polio eradication effort and other relevant Government initiatives including the MSS scheme, the Subsidy Reinvestment and Empowerment (SURE) Programme, the Midwives Services Scheme (MSS) and the GAVI supported Health Systems Strengthening programme. In October 2011, His Excellency President of the Federal Republic of Nigeria also announced an increase in the contribution by the Federal Republic of Nigeria to the operational costs of PEI from USD17m to USD30m per annum.

2. GOAL, SPECIFIC OBJECTIVES AND GEOGRAPHICAL FOCUS

The overall Goal of the plan is: To achieve interruption of poliovirus transmission by end 2012

Specific Objectives:

(1) Ensure implementation of high quality SIAs, with particular focus on high risk states and LGAs, sufficient to achieve interruption of poliovirus transmission by end 2012

(2) Achieve highest quality AFP surveillance as (demonstrated by standard AFP indicators, genetic sequence analysis and environmental surveillance) by end 2012

(3) Improve routine OPV3 coverage in the highest risk LGAs to at least 50% by end 2012

The above objectives will be achieved by ensuring high quality implementation of priority activities in all States and Local Government Areas, particularly those at highest risk of continued poliovirus transmission through (a) strengthening leadership and accountability at all levels especially the operational level as well as (b) deploying additional well trained and motivated personnel in the highest risk areas.

Geographical Focus

The plan will focus primarily on;

1. The **12 high risk states**, with particular focus on the persistently infected states.

2. **Local Government Areas (LGAs)** with evidence of increased vulnerability, historical evidence of persistent poliovirus transmission and other evidence of increased risk of transmission (indicators of low population immunity and/or sub-optimal surveillance)

Between 2006 and 2011, the Polio Eradication programme in Nigeria used a standard algorithm to determine risk status of LGAs using the following criteria (a) presence of confirmed WPV (b) presence of confirmed cVDPV (c) presence of zero dose AFP case (d) presence of wards with at least one missed settlement of more than 10% missed children from independent monitoring data during the 3 most recent SIA rounds and or (e) presence of more than 100 non-compliant households in any of the 3 most recent SIA rounds. In January 2012, 72 LGAs in the 12 HRS were classified as at very high risk using the traditional risk analysis methodology. These are summarized in appendix 10.1

In late 2011, the Global Good Intellectual Ventures EMOD Polio Team undertook a polio outbreak Vulnerability Assessment. In the northern states, a total of 79 LGAs were classified as very highly vulnerable LGAs. These LGAs are summarized in appendix 10. 1

An algorithm for risk analysis is currently being developed by CDC. It is expected that once this algorithm is introduced, a standard method of defining risk will be applied and uniformly used in the programme.

3. PEI GOVERNANCE IN NIGERIA

3.1. National level

Presidential Task Force on Polio Eradication (PTFoPE): The Presidential Task Force on Polio Eradication (PTFoPE) which was officially inaugurated by His Excellency President Goodluck Jonathan on 1st March 2012 has the overall objective of providing leadership support to Nigeria's efforts to accelerate interruption of poliovirus transmission by end of 2012. The PTFoPE is chaired by the Honourable Minister of State for Health and has membership drawn from the National Assembly (Chairman Senate Committee on Health, Chairman House Committee on Health), National Primary Health Care Development Agency, Federal Ministry of Health, Polio high risk and polio-free states, Northern Traditional Leaders Committee on Primary Health Care, Nigeria Inter-Faith Group, Nigeria Governors Forum and GPEI Partners.

The specific terms of reference of the PTFoPE are indicated in Annex 10.5. The PTFoPE is expected to meet monthly to review the progress in polio eradication with specific attention being given to the status of implementation of the 2012 PEI emergency plan. Key areas to be reviewed during the monthly meetings of PTFoPE include (a) reports on the Abuja Commitments (b) Status of funding for priority PEI activities including timing of funding release (c) quality of PEI activities (SIA, Surveillance, RI) particularly in the highest risk areas (d) actions undertaken to address sub-optimal programme performance (e) monthly reports on the national accountability framework from all 36 States and FCT

Following their meetings, the PTFoPE will be expected to (a) provide reports to Mr President with recommend actions required (b) provide feedback to Governors and Chairpersons of State PEI Task Forces (c) plan high level advocacy visits to areas with particular challenge (d) organize periodic meetings with State PEI task Forces

Inter-Agency Coordination Committee (ICC): The ICC is chaired by the Honorable Minister of Health and oversees all immunization activities in the country including polio eradication. Membership of the ICC is from the Federal Ministry of Health, National Primary Health Care Development Agency, NAFDAC and Partner Agencies including

ALGON. The ICC plays a very important role in ensuring seamless coordination of polio eradication activities with the broader immunization and PHC agenda in Nigeria. The ICC is expected to meet at least once monthly.

Core Group and ICC Working Groups: The Core Group is chaired by the CEO/ED of NPHCDA with members from NPHCDA, relevant ministries, international organizations, donors and civil society. Working groups including in the areas of operations, vaccines, logistics, monitoring and evaluation, routine immunization and social mobilization support the Core Group. Responsibilities of the Core Group include:

- Monitoring: the Core Group will ensure monitoring of implementation of the 2012 PEI emergency plan as well as monthly monitoring of the new State and LGA Accountability Framework
- Reporting: the Core Group will (a) ensure the necessary reports, including a report on the State and LGA Accountability Framework, are prepared for the Secretariat to transmit to the Presidential Task Force in a timely fashion (b) provide summary update from each meeting to the Task Force Chairman
- Advisory: the Core Group will identify specific challenges to polio eradication and recommend practical solutions to the Task Force
- Implementation: will facilitate the implementation and follow-up of the decisions of the Task Force
- Feedback and Information sharing: the CoreGroup will ensure information sharing mechanisms, including email lists to distribute pertinent and timely information about polio eradication to the National Task Force and relevant partners

3.2. State Level

State Task Force/State Inter-agency Coordination Committee (STF/SIACC): The STF/SIACC are established under the auspices of the Governor and should include membership from State Ministries, Departments and Agencies including Local Government, Health, Womens' Affairs, Education, Local Government Commission, National Orientation Agency; Civil Society including Traditional and Religious Leaders as well as partners.

The specific TOR of STF/SIACC are indicated in Annex 10.5. Similar to the PTFoPE, the STF/SIACC is expected to meet at least once monthly to review the overall status of Polio Eradication in the state with particular attention being given to the status of implementation of the 2012 PEI Emergency Plan in the highest risk areas. Key areas to be reviewed during the monthly meetings of STF/SIACC include (a) status of implementation of the Abuja Commitments (b) Status of funding for priority PEI activities including timing of funding release (c) quality of PEI activities (SIA, Surveillance, RI) particularly in the highest risk LGAs and wards (d) actions undertaken to address sub-optimal programme performance (e) monthly reports on the national accountability framework from all LGAs in the state

The STF/SIACC is expected to support the functioning of LGA Task Forces and provide required technical and/or advocacy support to LGAs with persistent sub-optimal performance. The State Task Forces are also expected to maintain a close functional relationship with the PTFoPE.

The State Technical Team serves as the secretariat of the STF/SIACC and are responsible for preparing all the background documentation for the STF/SIACC.

3.3. Local Government Area level

LGA Task Force: The LGA Task Force is expected to be chaired by the LGA Chairman with members drawn from senior members of the Local Government Council, councilors for health, District Head and members of the LGA Technical Team. The specific TOR of the LGA Task Force is shown in annex 10.5.

The LGA Task Force is responsible for ensuring that priority activities required to ensure high quality implementation of PEI activities in the LGA are fully implemented as recommended. Specific focus should be paid to the highest risk wards in the LGA.

LGA Task Forces are expected to provide regular feedback to State Task Force. Wherever required, the State Task Forces will organize capacity building for LGA Task Forces.

4. ENHANCING SIA QUALITY TO REACH ALL CHILDREN

The main objective of the 2012 PEI emergency plan activities related to SIAs is to achieve and sustain high quality SIAs that accelerate the attainment of population immunity that is consistently above the threshold required to achieve interruption of poliovirus transmission (both wild poliovirus and circulating vaccine derived poliovirus) by the end of 2012[1].

The 2012 priority activities to enhance SIA quality and ensure that all children are reached including the chronically missed children are in 3 main categories (a) reviewing and refining basic SIA strategies with emphasis on improving performance of vaccination teams (b) introducing and scaling up new and proven interventions/initiatives to characterize and reach chronically missed children and (c) identify and deploy additional human resources to highest risk areas in the country.

4.1. Review and refine basic SIA Strategies with focus on improving performance of vaccination teams

Priority activities include

- Improve ***micro-plans*** so that all settlements are identified and included in the micro-plan. This will be done through the use of Geographic Information System (**GIS)** to improve microplans and aid in team tracking during implementation. Satellite imagery through GIS will be employed in 8 states, with all settlements to be geo-coded. Microplans will be revised to include all settlements and hamlets. This project commenced in February in some parts of Jigawa and by March both Jigawa and Kano would have been reached.

- Ensure that we have well-trained and supervised ***vaccinator teams*** with revised team selection process, coupled with new and standardized vaccinator training. This is essential as there will be new expectations (hours in the field, line list missed children) of the teams. The 'B Team' type revisit strategy will also be initiated.

- Address problem of irrational team ***workloads***, team shortages and remuneration issues by restructuring team compositions, employing more teams and testing options tailored to different contexts (location, population, distance) in March round to inform new operational guidelines. Increased remuneration will be used to attract a better quality of workers. One **GPS** tracking device will be given to each vaccinator, with automatic data upload to a web server. This will auto-generate team-based alert to the LGA for evening review meetings during SIAs. LGAs will therefore get 'real time' information for corrective action

- Provide all vaccination teams with the required **logistics**, including adequate vaccines, vaccine carriers and adequate transportation to ensure that they are able to effectively perform the expected functions.

[1] EMOD Project, Global Good Intellectual Ventures Laboratory. Quarterly Immunity Projections for northern Nigeria States, February 2012.

Particular attention is to be given to teams operating in hard-to-reach and border areas, that have hitherto not been very well covered.

- Fix ***independent monitoring*** to help identify quality gaps more reliably. The independent monitoring guidelines will be revised to incorporate lessons learned in 2010-2011 as well as recommendations and best practices identified during recent international meeting on independent monitoring. Special attention will be given to selection, training and supervision of independent monitors. Special monitoring will be introduced in areas where children have not been well covered in the past, including border areas. LQAs will also be scaled up.

4.2. Introduce and Scale up new and proven interventions/initiatives to characterize and reach chronically missed children

In order to reach children who have been missed over several rounds of SIAs or who have never been reached due to the nomadic existence of their parents/ guardians, the plan will require that the following steps be taken;

- Finalize a ***tool*** to better characterize and identify children that are missed during each polio campaign. A first step to achieve this will be to identify LGAs with large nomadic populations by using stock route maps
- ***Scale up interventions to reach Fulani and nomadic populations***. Identify and map Fulani nomadic routes and locations in 14 Northern States and linking this group to the LGAs in the development of Micro-planning and implementation of campaigns to achieve greater accessibility of vaccines to the target Fulani age groups. An April-May timeline has been set for this activity to take off.
- Introduce a ***Short-Interval Additional Dose Strategy*** – deployed strategically to rapidly boost the immunity of children in special peculiar issues such as communities, geographic locations that have missed consecutive rounds/have never been reached and insecurity prone areas .

4.3. Identify and deploy additional human resources to highest risk areas

In order to more effectively support implementation of priority activities in the highest risk areas, appropriately skilled and motivated human resources will be identified and deployed.

- Additional senior and committed supervisors will be deployed to selected high risk LGAs during each IPD round.
- Increase the number of technical staff deployed at operational level (LGAs and wards)
- Increase the size of international STOP team deployed and introduce a national STOP team programme

5. INTENSIFIED ADVOCACY, BEHAVIOUR CHANGE COMMUNICATION AND MOBILIZATION AT ALL LEVELS

A major aspect of the Emergency program will be advocacy to secure increased support from policy makers and opinion molders as well as wider program communication. These will be aimed at;

- Countering ***resistance/ non-compliance.*** About half of the cases last year were associated with non-compliance. To this end, UNICEF will be deploying 957 community mobilizers in high risk settlements in

Kano, Sokoto and Kebbi States by March. A scale up this program is planned next for Zamfara and Jigawa states. The Mobilizers are expected to engage families, promote immunization and keep a line list of all children under the age of five.

- Initiate an outreach campaign to map, engage and mobilize ***religious leaders***_(imams, madrassa headmasters, etc.) in high risk areas. The major cause of non-compliance has been religious belief.

- Build awareness and political support of ***LGA Chairmen*** in collaboration with ALGON. This will ensure oversight of the program at the highest level. LGA Chairmen will be required to participate in supervision of SIAs and RI, coordination and physical attendance of daily review meetings during implementation in addition to release of funds for activities

- Strengthen the engagement and involvement of Faith-Based and Community Based organizations (FORMWAN..) in mobilizing communities particularly in the highest risk areas.

National advocacy teams will visit the high risk states for advocacy to State Governors, members of National and State legislatures and other top government officers. Advocacy kit and guidelines will be developed to support the states in advocacy to LGAs.

6. ACCELERATING ROUTINE IMMUNIZATION DELIVERY

Efforts will be targeted towards improving RI coverage particularly in those LGAs at highest risk for continued WPV circulation. Potential interventions will include:

- The highest risk LGAs will be supported to develop evidence based micro-plans to improve routine immunization service delivery through fixed, mobile and outreach services. A rapid participatory review of the critical barriers to consistent delivery and uptake of routine immunization in these areas will be conducted as first step and the findings used to prepare cost-effective routine immunization acceleration activities in these areas.

- Mobilize the required human resources, including wherever necessary retired health workers and provide adequate logistics, including vaccines and cold chain, to support the accelerated routine immunization activities in the highest risk areas.

- Strengthen linkages with Traditional Birth Attendants in mobilizing mothers and caretakers in the targeted high risk communities to consistently utilize routine immunization activities.

- Strengthen linkages with Traditional leaders in supporting accelerated routine immunization activities in the targeted areas.

- Conduct of three rounds of ***LIDs*** between May & November in LGAs with particularly low RI coverage

- Initiation of outreach effort in 10-15 LGAs, focused primarily in Kano and Jigawa, with persistent ***cVDPV transmission***. This project will be coordinated by NPHCDA, State and LGA immunization teams, WHO, UNICEF and NGO partners.

- ***Newborn*** children are to be tracked and immunized through MSS facilities. OPV is also to be pre-placed in delivery rooms to ensure administration of birth dose of OPV.

- Implement outreach sessions targeting **nomadic and migratory populations** in line with the model of the Boosting Childhood Immunity Initiative (BCI) that was successfully implemented several years ago

7. ENHANCING SURVEILLANCE

Surveillance activities for the year will include;

- Priority surveillance training for clinicians and nurses
- Deployment of more community informants in all high risk LGAs
- Ensuring full functioning of secondary and tertiary hospitals in the surveillance network. This will be done through;
    - Identification of appropriate focal point to conduct active surveillance
    - Inclusion of all appropriate hospital departments in active surveillance
- Advocacy to States to ensure provision of funds for surveillance
- Rapid surveillance reviews in response to any 'orphan' virus.
- Monitoring of quarterly implementation of rapid surveillance assessment recommendations
- Increased environmental surveillance in Kano State and with expansion to Maiduguri and Sokoto

8. ENSURING ACCOUNTABILITY

The Accountability Framework is a tool to help raise population immunity to above the critical threshold required to achieve interruption of persistent transmission in infected, high-risk and vulnerable LGAs by identifying the critical barriers and solutions to improved quality of PEI activities; and holding individuals responsible for delivering rapid improvement so that polio transmission can be stopped in 2012 in Nigeria.

9.1. Principles of the accountability framework include

- **Promoting individual accountability at every level**: People have been hired to achieve specific terms of reference for the polio eradication program. 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 new reward program. The programme will develop a standardized reward scheme to recognize top performers in wards, LGAs and states. Rewards can include public recognition, a congratulatory meeting with a senior leader, an award certificate, a mention in the media, enrollment in training of choice, etc. This scheme should be operational by the end March 2012
- **Consequences for weak performance**: All weak performance will be documented and reported to appropriate policy makers and stake-holders. Demonstrated weak performance will be

sanctioned. Weak performance at individual level will be accompanied by sanctions 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.

9.2. LGA High Risk Operational Plans (HROP) as Foundation of Accountability Framework

The key steps in developing LGA HROP that will serve as the basis for the accountability framework are shown in the table below:

Step	Action
1	The first step is for the state team to direct a full strategic assessment of the high-risk LGAs
2	The LGA teams should conduct this assessment, and based on evidence (IPDs, RI and surveillance data) and experience, determine the specific impediments to achieving high population immunity. These impediments may include • Leadership issues such as low involvement of the LGA Chairman, District and Village Heads or Ward Development Committees in planning and review • Funding issues such as the timely release of sufficient funds at every level • Personnel issues such as the quality of ward focal persons, supervisors and monitors; the selection of vaccinators; the seniority of community leaders • Population demographic issues such as low population immunity in neighbouring LGAs with heavy transport and trade routes, seasonal population movements; hard to reach areas • Operations issues such as quality of microplans, the completeness of settlement lists, the implementation of social mobilization and communication activities to address community concerns; the efforts to line-list and return to vaccinate non compliant and absent children; the rationality of vaccinator workloads; logistics and transport; the quality of cold chain; the quality of afternoon and evening review meetings etc
3	The LGA teams should identify up to four <u>core</u> impediments
4	The LGA teams should identify concrete, specific solutions to <u>each</u> impediment
5	The LGA Teams should identify the <u>individual responsible</u> to implement each solution along with a <u>timeline</u> for implementation. Note the individual may be a government, traditional leader or

	partner representative.
6	The State team collects these plans; and compiles them into a master priority plan by LGA
7	The master plan should identify where specific state support is required and identifies the individual responsible for that support
8	The State team develops a standard monitoring system to measure implementation of the LGA plans and sustainability of the improvements
9	The State team submits monitoring reports on an agreed day of each month to the polio Presidential Task Force / Core Group Secretariat , copied to the Executive Governor and Health Commissioners offices
10	The Core Group/ Presidential Task Force Secretariat creates a standard monthly report, including recommendations, and present this to the Presidential Task Force for polio eradication; which will take appropriate actions
11	Any new poliovirus (WPV and cVPDV) or other designation of an LGA as vulnerable should precipitate an immediate assessment as per the above, and entry of this LGA into the state and Presidential Task Force monitoring system
12	The State teams order a re-assessment of high-risk and vulnerable LGAs as per steps 1-8 above every four months.

9.3. Accountability Framework Indicators

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

Officer	Indicator	National Target	Verification
Chairman of Presidential Task Force	Meetings of the Presidential Task Force	At least 1 meeting per month	Task Force minutes
	Reports to H.E. Mr. President	1 report to H.E. President per month	Meeting report
	Direct actions taken by Task Force	> 2 direct actions per month (phone call, extraordinary meeting, LGA visit/review)	Task Force Reports
CEO/Exec Director, NPHCDA	Core Group submission of Accountability Report to Task Force	Accountability Report submitted monthly	Task Force minutes
	Timeliness of IPDs schedule and scope	IPD dates/ scope decided >1 month before activity	Memo to States
	Timeliness of funding release for IPDs	As per IPDs guidelines	Bank Statements
	Notification of polioviruses to state teams so states can begin immediate investigation	100% of new polioviruses notified within 24 hours to state team	Secretariat to track notifications to States
	NPHCDA supervisors dispatched for IPDs	90% of NPHCDA senior supervisors arrive at least 7 days prior to each IPD	Tracking reports from Ops Room
	State and LGA teams receive feedback on IPDs from NPHCDA supervisors	90% of NPHCDA supervisors send reports within 7 days every IPD	ED/CEO tracking
NPHCDA, WHO, UNICEF supervisors	Improvement in outcomes in LGAs supervised by NPHCDA, WHO and UNICEF	>90% of supervisors complete their terms of reference and	Supervisor reports
WHO Country Rep.	Release of funds in advance of IPDS	>90% of HR States receive funds xx days in advance of every IPD	WHO reports
UNICEF Country Rep	Release of funds in advance of IPDS	>90% of HR States receive funds xx days in advance of every IPD	UNICEF reports

Officer	Indicator	National Target	Verification
The Executive Governor	Operational State Task Force exists and is sustained	12/12 High Risk States from February 2012 and all States by end Quarter 2 and sustained	Minutes from Task Force Meetings
	Visible, personal leadership on PE demonstrated by Exec. Governor every quarter	12 HR states in Q 1 and sustained; 80% of remaining Governors and FCT in Q. 2 and sustained	State team reports
	Executive Governor meets with LGAs every quarter	12 HR states in Q 1 and sustained; 80% of remaining Governors in Q. 2 and sustained	Minutes from meetings
	Executive Governor meets with Traditional Leaders every quarter	12 HR states in Q 1 and sustained; 80% of remaining Governors in Q. 2 and sustained	Minutes from meetings
State Task Force Chairman	State Task Force is functional	At least one monthly meeting to review PEI status in the State	Minutes of meeting with clear action points to address identified challenges
	Planned funds released for IPDs on time	12/12 HR States release full funds > xx days in advance of IPDs by end Q 1 and sustain through 2012/2013.	Operations room reports
State Immunization Officer	Compilation of LGA reports and submission to Core Group/ Exec Gov and Health Commissioner	Monthly	Core Group receipt of reports
	Assistance provided to LGAs as per their own assessments for Accountability Report	Monthly	As per the assistance provided

9. MONITORING AND EVALUATION

The 2012 PEI Emergency Plan will be monitored very closely each month at LGA, State and National level using the following major indicators

- Proportion of planned activities that have actually been implemented as planned (see annex 10.3)
- Process indicators of the 2010-2012 Global Polio Eradication Strategic Plan

- Operational Targets set by the 19th-22nd Expert Review Committee meetings
- National PEI Accountability Framework Indicators (see chapter 9)
- Abuja Commitments Indicators.

Special technical teams will be established at both national and state level will be set up to prepare monthly status reports of the implementation of the 2012 PEI Emergency Plan.

ANNEXES

Annex 10.1 High Risk LGAs

2011-2012 Polio Infected States		
State	**LGAs at high risk (traditional methodology)**	**Vulnerable LGAs (Global Good Analysis, Dec 2011)**
Bauchi	Very High Risk: Bauchi, Ningi, Toro, Katagum, Darazo, Ganjuwa, Alkareli, Shira	Very Vulnerable: Bauchi, Ningi, Toro, Gamawa, Katagum, Alkaleri, Shira, Ganjuwa, Darazo, Misau, Dambam, Tafawa, Giade
Borno	Very High Risk: Marte, Kukawa, Maiduguri, Bama, Damboa, Jere, Abadam, Konduga,	Very Vulnerable: Maiduguri, Jere, Damboa, Gwoza
Jigawa	Very High Risk: Ringim, Guri, Babura, Roni, B/Kudu, Dutse, Gumel, Gwiwa, Yankwashi	Very Vulnerable:
Kaduna	Very High Risk: Zaria, Igabi, Markafi, Kubau, Lere, Kaduna South, Soba, Kaduna North	Very Vulnerable: Zaria, Kaduna South, Igabi, Sabon Gari, Soba, Giwa, Kaduna North, Chikun, Birnin Gwari, Lere
Kano	Very High Risk: Kumbotso, D/Tofa, Gezawa, Bichi, Nasarawa, D/Kudu, Gaya, Rogo	Very Vulnerable: Nasarawa, Ungogo, Kano, Gwale, Kumbotso, Kiru, Sumaila, D/Tofa, Dala, Takai, D/Kudu, Bunkure, Bichi, Fagge, Wudil, Gaya, Minjibir, Gezawa, Zaria, Dambatta, Makoda, Tarauni, T/Wada, Gwarzo, Gabasawa, Bebeji
Katsina	Very High Risk: Jibia, Mani	Very Vulnerable: Katsina, Daura, Mai Adua, Funtua, Batsari, Mani, Batagarawa, Kankara, Kaita, Ingawa, Kafur, Kankiya, Dutsin Ma, Bindawa, Zango
Kebbi	Very High Risk: Aliero, B/Kebbi, Gwandu, Bagudo, Jega	Very Vulnerable:
Niger	Very High Risk: Bida	Very Vulnerable:
Plateau	Very High Risk: Shendam	Very Vulnerable:
Sokoto	Very High Risk: Wamako, Isa, Ilella, S/Birni, Sokoto North, Sokoto South, Gwabadawa, Kware, D/Shuni, Yabo	Very Vulnerable:
Yobe	Very High Risk: Bursari, Jakusko, Karasuwa, Nguru, Nangere, Tarmua, Gujba	Very Vulnerable: Fune
Zamfara	Very High Risk LGAs: Gumi, Shinkafi, T/Mafara, Bukuyyum, Bakura,	Very Vulnerable: Gusau, Maru, Maradun, Bukuyyum, Zurmi, Tsafe, Kaura Namoda,

Annex 10.2 PEI Key Dates

Date	Activity	Particulars
February: 18-21	NIPDs	36 States and FCT
28-29	Meeting on 2012 PEI Emergency Plan	NPHCDA and Partners
March: 1	Presidential Inauguration of Presidential Task Force on Polio Eradication (PTFoPE)	State House
1st Mar	1st meeting of Presidential Task Force on PE	FMOH
6th Mar	Polio Emergency Situation Centre Established	NPHCDA
15-16th Mar	Debriefing of Feb NIPDs and dissemination of 2012 Emergency Plan	
28-29th Mar	23rd ERC Meeting	Abuja
31 Mar-3 Apr	NIPDs	
April 12	Presidential Task Force on PEI meeting	
May 12-15	SIPDs (Scope and Antigen to be determined)	High Risk States
May (TBD)	Maternal, Neonatal Child Health Week	36 States and FCT
29-30th May	Debriefing meeting and 1st National Review of implementation of 2012 PEI Emergency Plan	
31st May	Presidential Task Force on PEI meeting	
June 21st	Presidential Task Force on PEI meeting	
30 June-3 July	SIPDs (Scope and Antigen to be determined)	High Risk States
19th July	Presidential Task Force on PEI meeting	
Aug 11-14	SIPDs (Scope and Antigen to be determined)	High Risk States
28 Aug	Debriefing meeting and 2nd National Review of implementation of 2012 PEI Emergency Plan	
30 Aug	Presidential Task Force on PEI meeting	
Sept 27th	Presidential Task Force on PEI meeting	

1. Interval of at least 6 weeks between any 2 rounds.
2. Proposed schedule for PTFoPE meetings included
3. Dates for ERC meetings after 23th ERC as well as mop up activities not included.

Annex 10.2 PEI Key Dates (Cont'd)

Date	Activity	Particulars
Oct 6-9	SIPDs (Scope and Antigen to be determined)	High Risk States
18 Oct	Presidential Task Force on PEI meeting	
Nov (TBD)	Maternal, Neonatal Child Health Week	36 States and FCT
22 Nov	Presidential Task Force on PEI meeting	
Dec 1-4	SIPDs (Scope and Antigen to be determined)	High Risk States
18 Dec	Debriefing meeting and 3rd National Review of implementation of 2012 PEI Emergency Plan	
19 Dec	Presidential Task Force on PEI meeting	

Updated time-line of activities will be disseminated each month. A comprehensive schedule of all immunization activities (including routine immunization, new vaccine introduction as well as accelerated control of vaccine diseases) will also be prepared and circulated to all States, Partners and Stake-holders regularly.

Annex 10.3 PEI Emergency Plan Implementation Schedule

Enhancing SIA Quality to reach all children especially the chronically missed children

Thematic Area: Enhancing SIA Quality												
Objective: High Quality SIAs that boost population immunity beyond level required for interruption of transmission by end 2012												
Activity	**Timelines**											**Responsible**
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1. Improve micro-plan quality & ensure rational team work-load		x	x	x								NPHCDA, States, LGAs, Partners
2. Scale up GIS/GPS to improve micro-plan and team tracking		x	x	x	x							NPHCDA, Partners
3. Selection and deployment of senior supervisors		x	x	x	x	x	x	x	x	x	x	NPHCDA, States, Partners
4. Improve team selection, training, supervision		x	x	x	x	x	x	x	x	x	x	States, LGAs, Partners
5. Introduce systematic "revisit strategy"			x									NPHCDA
6. Improve SIA independent monitoring and scale up LQAs		x	x	x	x	x	x	x	x	x	x	NPHCDA, Partners
7. Revise and disseminate IPDs operational guidelines			x									NPHCDA, Partners
8. Update and disseminate IPDs training DVD			x	x								NPHCDA, Partners
9. Scale up technical support in highest risk areas		x	x	x	x	x	x	x	x	x	x	NPHCDA, Partners
10. Timely provision of adequate quantities of OPV	x	x	x	x	x	x	x	x	x	x	x	NPHCDA, Partners
11. Provision of adequate cold chain (including vaccine carriers)				x	x	x	x					NPHCDA, Partners
12. Timely provision of SIA operational funds	x	x	x	x	x	x	x	x	x	x	x	NPHCDA, States, Partners
13. Systematically investigate chronically missed children			x	x	x							NPHCDA, States, Partners
14. Scale up interventions to reach nomads/migrants					X	X	X	X	X	X	x	NPHCDA, States, Partners
15. Introduce SIAD strategy in missed/hard to reach areas					X	X	X	X	X	X	x	NPHCDA, States, Partners
16. Establish permanent vaccinational at international borders			X	X	X	X	X	X	X	X	x	NPHCDA, Fed Min of Interior
17. Establish clear linkages with FGoN initiatives (MSS, SURE)					X	X	X	X	X	X	x	NPHCDA, FMOH

Annex 10.3 PEI Emergency Plan Implementation Schedule (cont'd)

Intensified Advocacy, Behaviour Change Communication and Mobilization at all levels

Thematic Area: Intensified advocacy, Behaviour Change Communication and Mobilization at all levels												
Objectives: (a) Ensure that 80% of High Risk States and LGAs achieve Quarterly Abuja commitments (b) 80% LGAs implement > 80% social mobilization activities in the Emergency Plan												
Activity	**Timelines**											**Responsible**
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1. Development of LGA Specific Advocacy Kits		X										NSMWG
2. Sensitization of Legislators from HR States			X	X	X							PTFoPE, STFs
3. Increase HiLAT visit to HR States			X	X	X	X	X	X	X	X	x	PTFoPE, STFs
4. Sensitization meetings with ALGON		X			X			X			x	NSMWG
5. Link Polio-free torch campaign to high risk LGAs	X	X	X	X	X	X	X	X	X	X	x	NSMWG
6.Official engagement of Min of Religious Affairs, Min of Women..		x			x			x			x	NSMWG
7. Optimize the BMGF supported Leadership Challenge	x	x	x	x	x	x	x	x	x	x	x	NGF
8. Quarterly Reporting of Abuja Commitments	x	x	x	x	x	x	x	x	x	x	x	NSMWG
9. Line-list, map, engage and mobilize Religious Leaders in HRAs	x	x	x	x	x	x	x	x	x	x	x	NSMWG
10. Scale up com mobilizers (Kano, Sokoto, Kebbi, Zamfara, Jigawa)		x	x	x	x	x	x	x	x	x	x	UNICEF
11. Implement national media campaign			x	x	x	x	x	x				NSMWG
12. Update Majigi file and guidelines		x										NSMWG
13. Increase visibility of campaign using posters, media, mobilizers					x	x	x	x	x	x	x	NSMWG
14. Promote birth registration of new borns				x	x	x	x	x				NPHCDA, Nat Population Comm.
15. Line-listing and reorientation of town announcers			x	x	x							NSMWG
16. Line listing of gate-keepers like Fulani community leaders			x	x	x							NSMWG
17. Conduct IPC skilles training for team members			x	x	x							NSMWG

Annex 10.3 PEI Emergency Plan Implementation Schedule (Cont'd)

Accelerating Routine Immunization Delivery

Thematic Area: Accelerating Routine Immunization Service Delivery												
Objectives: (a) achieve at least 50% OPV coverage in all high risk LGAs												
Activity	**Timelines**											**Responsible**
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1. TBAs and PMVs engaged to support RI service provision		x	x	x	x	x	x	x	x	x	x	MCH/TBA Coordinator
2. Clustering of TBAs and PMVs around a Health Facility to provide RI		x	x									MCH/TBA Coordinator
3. Train TBAs and PMV on RI			x									ZTOs, States, LGAs, Partners
4. Sensitization and training of midwives			x	x								ZTOs, States, LGAs, Partners
5. Conduct rapid diagnosis of low coverage in high risk states/LGAs		x	x									NPHCDA, States, Partners
6. Prepositioning of OPV in all post natal/lying in rooms			x	x	x	x	x	x	x	x	x	States, LGAs
7. Intensified outreach in cVDPV infected LGAs					x	x	x	x	x	x	x	NPHCDA, States, LGAs, Partners
8. Newborn tracking through settlement heads			x	x	x	x	x	x	x	x	x	NTLC, States, LGAs
9. Plan outreach session to all major markets					x	x	x	x	x	x	x	ZTOs, States, LGAs, Partners
10. Monitor and support effective implementation of 1,2,3 strategy			x	x	x	x	x	x	x	x	x	NPHCDA, States, LGAs, Partners
11. Intensify RI outreach to migrants and hard-to-reach areas (BCI)				x	x	x	x	x	x	x	x	NPHCDA, States, LGAs, Partners
12. Ensure adequate and timely vaccine supply	x	x	x	x	x	x	x	x	x	x	x	NPHCDA, Partners
13. Implement cold chain preventive maintenance and replacement			x	x	x	x	x	x	x	x	x	NLWG, States, LGAs

Annex 10.3 PEI Emergency Plan Implementation Schedule

Enhancing Surveillance

Thematic Area: Achieve highest quality AFP surveillance by end 2012												
Objectives: (a) 90% LGAs meet 2 main surveillance indicators (b) Zero orphan virus detection												
Activity	**Timelines**											**Responsible**
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1. Advocacy to states to provide adequate resources for surveillance		x	x	x	x	x	x	x	x	x	x	NPHCDA
2. Set up Toll Free number for AFP reporting				x								NPHCDA, Partners
3. Introduce incentive for vaccination teams reporting AFP cases			x	x	x	x	x	x	x	x	x	NPHCDA, BMGF
4. Conduct sensitization for Professional bodies (NMA, NANN & MW)				x				x				NPHCDA, Partners
5. Conduct national/international surveillance review				x								NPHCDA, Partners
6. Quarterly monitoring of Rapid Surveillance Assesment (RSA) Recs.		x			x			x			x	NPHCDA, States, Partners
7. Increase collection frequency of Environmental samples in Kano	x	x	x	x	x	x	x	x	x	x	x	NPHCDA, Partners
8. Expand Environmental surveillance to 2 new states (Borno, Sokoto)			x	x	x	x	x	x	x	x	x	NPHCDA, Partners
9. Conduct additional sero-prevalence study in new area								x	x	x	x	NPHCDA, Partners
10. Increase community informers border areas and HTR areas			x	x	x	x	x	x	x	x	x	States, LGAs
11. Prepare and implement training package for clinicians			x	x	x	x						NPHCDA, Partners, States
12. Stengthen supervision in LGAs with sub-optimal indicators			x	x	x	x	x	x	x	x	x	States, LGAs
13. Implement RSA in response to any orphan virus			x	x	x	x	x	x	x	x	x	NPHCDA, Partners, States

Annex 10.4. PEI Emergency Plan Milestones

Time-line	Key Milestone	Who Responsible
March	Inauguration of Presidential Task Force	Chairman PTFoPE
	Strengthen functioning of ICC, Core Group and Working Groups	ED NPHCDA
	Meeting between Presidential and State Task Forces	Chairman PTFoPE
	Field test new IPDs team structure, revisit strategy, SIAD . . .	DDCI, NPHCDA
April	Finalize 2012 PEI Emergency Plan Budget and begin Res. Mob.	ICC Finance WG
	IPDs guidelines updated to reflect revised IPDs standards	NPHCDA
	Harmonized Risk Assessment Algorithm introduced	CDC, Global Good, WHO
End June	$\geq$ 80% LGAs in High Risk States (HRS) achieve 90% coverage in at least 1 IPD round	States
End Sept	$\geq$ 90% LGAs in the HRS achieve 90% coverage in 2 IPDs	States
End Dec	$\geq$ 90% LGAs in the HRS achieve 90% coverage in at least 4 IPDs	States

Monthly milestones, March-December 2012

- Monthly Report on Status of Implementation of 2012 PEI Emergency Plan presented to Presidential Task Force on PEI as well as to PEI State Task Forces.
- Report on each IPD Round with priority action points by the Polio Eradication Emergency Centre.

Quarterly Milestones [End March, End June, End September, End December 2012]

- Quarterly Reports of Status of Implementation of the Abuja Commitments
- Quarterly Joint Federal Government-States Review of Implementation of the 2012 PEI Emergency Plan

Annex 10.5 Terms of Reference of PEI Task Forces

Presidential Task Force on Polio Eradication (PTFoPE)

(1) To provide leadership support to Nigeria effort to accelerate activities aimed at achieving interruption of poliovirus transmission in 2012.

(2) To review monthly status of Polio Eradication in Nigeria, the status of implementation of the 2012 PEI Emergency Plan (with specific focus on the highest risk areas) and direct appropriate action.

(3) To monitor compliance with the national PEI accountability framework through monthly reports from all 36 States and the FCT

(4) To mobilize States, LGAs, Partners, Traditional and Religious Leaders, Civil Society, the media and the general public to ensure high quality and funded PEI activities.

(5) To report to His Excellency Mr President on the progress, challenges and corrective actions being taken to stop polio in Nigeria

State Task Force/Inter-Agency Coordination Committee (STF/SIACC)

(1) To ensure effective leadership and coordination of all immunization activities in the State.

(2) To endorse an annual immunization plan for the State as well as the 2012 Polio Eradication emergency Plan.

(3) To undertake monthly review of the status of implementation of the annual immunization plan and the 2012 Polio Eradication Emergency Plan in the state, with specific focus in the highest risk areas, and direct appropriate action.

(4) To support LGA authorities to ensure that LGA Immunization Task Forces are properly constituted and function as recommended.

(5) To approve budgets for immunization and polio eradication activities, advocate for timely and adequate resource allocation and ensure judicious use of all allocated resources.

(6) To provide regular feedback to His Excellency the Governor and seek his intervention wherever appropriate.

LGA Task Force/Inter-Agency Coordination Committee

(1) To ensure effective leadership and coordination of all immunization activities in the LGA.

(2) To prepare an annual LGA immunization plan with incorporation of appropriate priority activities from the 2012 PEI Emergency Plan.

(3) To undertake monthly review of the status of implementation of the annual LGA immunization plan, with specific focus in the highest risk wards, and implement appropriate action.

(4) To support Ward Development Committees to implement recommended polio eradication/immunization activities in the respective wards.

(5) To ensure timely provision of expected LGA funding for priority Polio Eradication/Immunization activities.

(6) To provide regular feedback to State Task Force.