NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

2016 NIGERIA POLIO ERADICATION EMERGENCY PLAN

December 2015, Abuja

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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
LGA	Local Government Area
LQAS	Lot quality assurance sampling
LTF	Local Government Task Force on Immunization
NCC	National Certification Committee
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
SIAs	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

2015 was a landmark year for Nigeria's polio eradication programme. On 25 September 2015, Nigeria was officially removed from the list of polio endemic countries by WHO following historical progress in interruption of WPV transmission for over 12 months. In 2015, there were no reported WPV cases compared to 6 cases in 2 states (Kano and Yobe) in 2014. At the same time, there have been no cases of WPV3 since November 2012. A significant reduction in cVDPV cases was recorded with only 1 confirmed cVDPV type 2 from the Federal Capital Territory (FCT) in May 2015, compared 30 cases across five states (Borno, Kano, Katsina, Yobe and Jigawa) in 2014. There were 2 cVDPV2 positive samples recorded from Kamacha river environmental site in Kaduna state in January and March 2015, compared to 54 cVDPV positive samples in 2014 from 7 states. One iVDPV2 was recorded in Osun State in September 2015.

The Government of Nigeria continued to oversee the implementation of the 2015 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, and the State EOCs or their equivalents coordinating implementation at the state level. To ensure that 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 2015 have been largely due to the improved quality of SIAs. The proportion of LGAs achieving an estimated coverage of least 80% coverage, as verified by LQAS, was 97% in 2015. Quality improved as the result of continued implementation of interventions and innovations to reach missed children in 2015. These included timely use of data to identify and target vulnerable populations; scale up of Directly Observed Polio Vaccination (dOPV) to address team performance and non-compliance; scale up of health camps and demand creation interventions to address 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. Additionally, IPV introduction was scaled up in all states in 2015.

In 2016, it is imperative that the program builds on the success in interruption of transmission to building resilience across all states towards certification. The program will have to be protected from financial risk associated with national and global funding-reprioritization following Nigeria's removal from the list of polio endemic countries, until certification is attained. Additionally, the program will continue to address the outstanding 2015 challenges that include immunity gaps among the most vulnerable populations, inaccessibility in security compromised areas, non-compliance and surveillance gaps at ward level.

The 2016 NPEEP outlines key strategic priorities to ensure interruption of polioviruses is sustained: (1) building resilience towards certification; (2) enhancing SIA quality in prioritized vulnerable areas; (3) special approaches for insecurity areas; (4) ensuring robust outbreak preparedness and response across all states; (5) enhancing routine immunization; (6) sustaining certification standard surveillance; (7) withdrawal of tOPV; and (8) polio legacy planning. All priorities will be underpinned by strict adherence to the accountability framework which will continue to guide the NPEEP.

FOREWORD

The unique milestone achieved in the Nigeria Polio Eradication Programme in the last 2 years has placed Nigeria on the brink of successfully interrupting the Polio Virus; a key landmark on the path to eradication. The success so far has essentially been the outcome of careful deliberations, thorough planning and meticulous implementation; of which the Nigeria Polio Eradication Emergency Plan (NPEEP) has been the centre core each year.

Focused leadership and unprecedented political commitment have been critical factors that have resulted in the highest levels of implementation of the NPEEP each year. The accountability framework and the scaling up of local strategies within the broader NPEEP have accorded the recorded successes: with no confirmed transmission of wild poliovirus since 24 July 2014, 90% reduction of WPV from 53 cases in 2013 to 6 cases in 2014 to zero case in 2015, geographical restriction of WPV spread from 9 states in 2013 to 2 states in 2014; and 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 and also 97% December 2015.

Other areas where significant process has been made based on the implementation of the NPEEP over the years include:

- Improved IPDs quality in persistent poor performing LGAs / Ward through the use of innovations such as Directly Observed Polio Vaccination (DOPV) and scaling up outside-household vaccination and use of health camps.
- Increased reach in security compromised areas through the accelerated introduction of IPV in Borno and Yobe states despite the security challenges
- Timely and quality outbreak responses in high risk states except Borno and Yobe where security challenges are significant.
- In-between round activities to further increase population immunity and reduce the threat of the polio virus importation
- Enhanced surveillance and deployment of technological Innovations in the high risk states.
- Intensified household and community engagement to build demand.

It is in a bid to further consolidate on these initiatives and ensure the interruption of the WPV transmission this year that the 2016 NPEEP has been developed. This plan serves to provide detailed guidance on strategies for the 'end game' as Nigeria drives towards interruption and eradication of the WPV. The 2016 NPEEP takes into consideration successful innovations from the previous plans and adapts new thinking to tackle emerging peculiarity and the accommodation of new tool such as the Injectable Polio Vaccine (IPV).

The 2016 NPEEP which was developed by the National Primary Health Care Development Agency (NPHCDA) EOC; focuses essentially on eight (8) strategic priorities: (1) Building resilience towards certification; (2) Enhancing SIAs quality in prioritized vulnerable areas; (3) Implementing special approaches for security challenged areas and IDPs; (4) Mounting timely and adequate outbreak response; (5) Enhancing routine immunization; (6) Intensifying surveillance; (7) Withdrawal of tOPV; and (8) Polio legacy planning.

It is the expectation of the Government of Nigeria that all Partner Agencies would key fully into the 2015 NPEEP and continue to collaboration closely through the Emergency Operation Centre (EOC) of the NPHCDA in order to assure the successful eradication of the Wild Polio Virus from Nigeria.

Dr. Ado J. G. Muhammad *(OON)*
Executive Director/CEO; NPHCDA

1. INTRODUCTION AND CONTEXT OF THE PROGRAMME

1.1. Context of Polio Eradication Efforts in 2016 – looking towards certification of polio

2015 was a historic year for Nigeria's polio eradication programme. Nigeria achieved interruption of wild polio virus transmission with no confirmed wild polio virus (WPV) in 2015 compared to 6 cases in 2 states (Kano and Yobe) in 2014. The last case of WPV was reported on 24 July 2014 in Kano. The strong progress and achievements in 2015 were due to the high level political commitment and leadership and the translation of the leadership vision and implementation of the identified 2015 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 2015 NPEEP included:

- Removal of Nigeria from the list of polio endemic countries following interruption of WPV transmission for over 12 months;
- Complete disappearance of WPV3 – no case since 2012;
- Reduction in number of cVDPV cases from 30 in 2014 to 1 in 2015, as at 15 December 2015;
- Maintaining the quality of IPDs with 97% of the LGAs in the 11 high risk states achieving estimated coverage of at least 80% by December 2015 as verified by LQAS. 97% of LGAs in these high risk states achieved above 80% coverage in December 2014;
- Scaling up of interventions and innovations, including DOPV, health camps and other demand creation approaches to reduce missed children;
- Nationwide introduction of IPV into routine immunization schedule to enhance population immunity;
- Enhanced population immunity countrywide, with 96% of non-polio AFP cases reporting at least 3 doses of OPV by week 49 in 2015;
- Increased surveillance sensitivity with non-polio AFP detection rate at 17.3 per 100,000 population in week 49 2015 compared to 13.3 in same period in December 2014; and stool adequacy at 98% in 2015 compared to 97% in 2014. The proportion of LGAs meeting both indicators increased from 97% in 2014 to 99% in 2015.
- Timely and robust response to outbreaks, meeting required standards: cVDPV, VDPV, compatibles, environmental isolates.
- Initiation of legacy planning process for mapping of assets and decision making; switch planning; and laboratory containment within the context of the Polio End Game Strategy.

Among the challenges in 2015 have been:

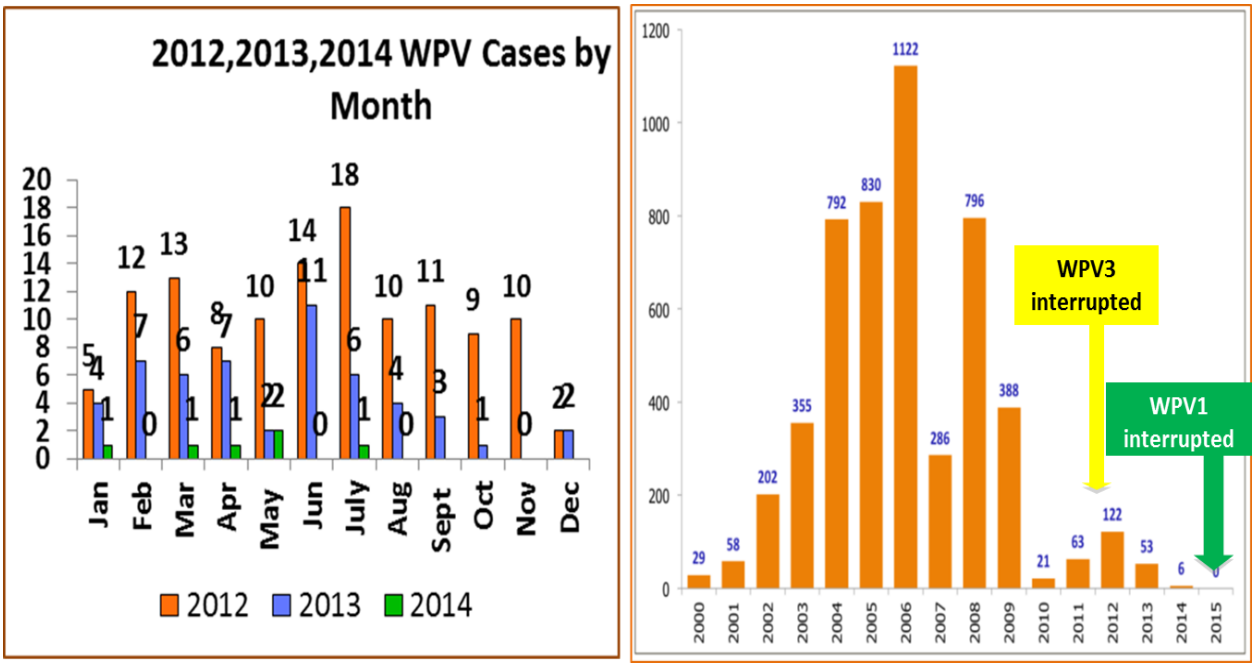
- Overcoming security challenges in Borno and Yobe to reach children during campaigns. Escalating insecurity has resulted in increased inaccessibility of children in the security compromised states in the North Eastern part of the country, significant population movements and displacements.

- Heterogeneous political support and commitment at the State and LGA levels, in particular, with late or no release of counterpart funding for implementation of planned activities in key states; securing consistent leadership and political commitment continues to be a challenge.
- Persistent health worker strikes that hindered smooth implementation of activities in some states. Prolonged health worker strikes have interrupted routine service delivery and contributed to increased risk of VDPV outbreaks.
- Persistent population immunity gaps particularly in the central and southern states, including some pockets in the northern part of the country.

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 53 cases in 2013, down to 6 cases in 2014 and to 0 cases in 2015. The goal of the 2015 NPEEP was to stop transmission of wild poliovirus. Nigeria made significant progress towards meeting that target resulting in removal of the country from the list of endemic countries on 25 September 2015.

Figure 1: Confirmed WPV cases, Nigeria, 2000-2015



There was a 95.4% decrease in the number of cVDPVs from 30 cases in 5 states during 2014 to 1 case in 2015 reported from 1 state. A reduction in **e**nvironmental cVDPV was recorded from 54 in 7 states to 2 in 1 state (Kamacha River in Zaria LGA of Kaduna state) on 20th January and 4th March 2015.

The interruption of WPV 1 in 2015 was due to improvements in the quality of polio SIAs most of which were tOPV rounds resulting in enhanced population immunity.

1.3 Genetic data:

- Circulating Vaccine Derived Polioviruses: There was 1 cVDPV case among an AFP case belonging to XX genetic cluster. Environmental surveillance isolated 2 cVDPVs belonging to the cVDPV –A genetic cluster.

2. ACTIVITIES IMPLEMENTED IN 2015 TO BOOST POPULATION IMMUNITY

2.1 IPV introduction in routine immunization

Inactivated polio vaccine (IPV) was introduced nationwide in 2015 in two phases, as part of the Polio End Game Strategic Plan. The northern states (19 plus FCT) introduced IPV in February – March while the southern states (17) introduced in June 2015. 2 southern states (Delta and Rivers), had delayed introduction in October due to prolonged health worker strikes.

The accelerated introduction of IPV to promote per contact immunogenicity in the security compromised states and IDP camps, through mass vaccination campaigns in June – December 2014 in all LGAs in Borno and Yobe States and 12 vulnerable LGAs in Kano State, provided a good experience for the national scale up.

2.2 Routine immunization intensification in cVDPV and low population immunity LGAs

To rapidly boost population immunity in 59 vulnerable and cVDPV transmission prone 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.

2.3 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 in 2,311 hard to reach underserved settlements in 453 wards in 92 LGAs in 6 states of Borno, Yobe, Bauchi, Kaduna, Kano and Katsina. These states were initially selected in 2014 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. A baseline survey prior to initiation of the project 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 November 2015, the project had administered 596,833 OPV doses to children 0 – 59 months, 300,075 children had been reached with Vitamin A, 270,858 children had been dewormed and anti-malarial prophylaxis administered to 73,634 pregnant women.

2.4 Boosting population immunity in 46 vulnerable LGAs using polio infrastructure

Special focus was given to 46 very very high risk (VVHR) LGAs in six states (Kano, Kaduna, Katsina, Sokoto, Jigawa and Bauchi), through use of polio infrastructure to support activities to boost population immunity. Plans were closely monitored, performance tracked and review meetings held with the

respective LGAs to assess performance. By September 2015, 19 of the 46 VVHR LGAs (41%) had achieved at least 10% increase in routine immunization coverage compared to 2014; 76% of the LGAs achieved >80% coverage compared to 63% of the same LGAs for the same period in 2014.

2.5 Directly Observed Polio Vaccination (DOPV)

The DOPV approach continued to be an effective approach for attracting children to be vaccinated outside the household to be sure that the 2 OPV drops are 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 from September 2014 IPDs. 8 VVHR metropolitan LGAs in Kano that did not participate in DOPV in 2014 implemented the approach for the first time during the October 2015 IPDs. Other areas where the strategy was introduced in 2015 included Adamawa, Taraba and FCT.

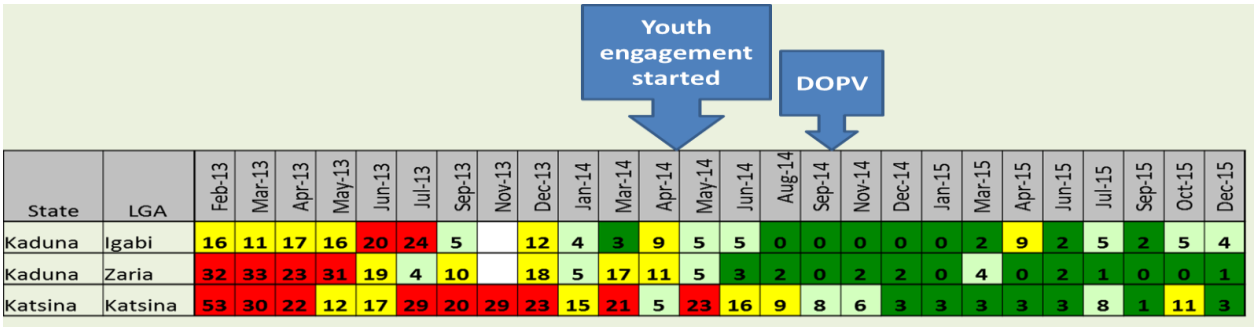
With the scaling-up of DOPV to 69 LGAs in 2015, there was a 77% increase in LGAs that had been accepted by LQAS to have reached an estimated 90% coverage compared to 73% in 2014. Specifically in Kano metropolitan LGAs, a marked increase in LGAs achieving >90% coverage was observed from 89% during the September IPDs to 100% during the October IPDs.

2.6 Systematic Youth Engagement

In specific LGAs, persistent poor performance during IPDs in 2013 and 2014 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 80% coverage by LQAs in December 2015, as shown in trends of LQAS coverage in figure 2.

Figure 2: LGA performance during IPDs, 2013-2015



State	LGA	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Sep-13	Nov-13	Dec-13	Jan-14	Mar-14	Apr-14	May-14	Jun-14	Aug-14	Sep-14	Nov-14	Dec-14	Jan-15	Mar-15	Apr-15	Jun-15	Jul-15	Sep-15	Oct-15	Dec-15
Kaduna	Igabi	16	11	17	16	20	24	5		12	4	3	9	5	5	0	0	0	0	0	2	9	2	5	2	5	4
Kaduna	Zaria	32	33	23	31	19	4	10		18	5	17	11	5	3	2	0	2	2	0	4	0	2	1	0	0	1
Katsina	Katsina	53	30	22	12	17	29	20	29	23	15	21	5	23	16	9	8	6	3	3	3	3	3	8	1	11	3

2.7 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. Farmers with children coming to markets to sell produces pose a risk of "trading" polioviruses in markets and nutrition centers. It was therefore important to vaccinate children on transit and in transit places.

Transit vaccination activities were intensified in 2015. 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 in 2015 were market vaccinations in Borno with 377,735 children immunized with OPV and Adamawa with 107,246 children immunized with OPV; hospital vaccinations with 16,604 children in Borno and 27,879 in Yobe immunized with OPV; and nomadic vaccinations with 60,038 children immunized with OPV in Yobe.

2.8 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 polioviruses. On the other hand, Nigeria has another history of importing viruses from neighboring states. Although Cameroon did not have an outbreak in 2015, border vaccinations are still ongoing to curb the risk of importation in case of any outbreak. This has also helped to increase population immunity in communities along the border.

All major crossing points along the international borders were 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, inter-border 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.

2.9 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 and IPDs. In 2015, about 3,300 health camps were implemented across the 11 high-risk states during each IPD. Nearly 1 million children are immunized at health camps during each IPD.

As recommended by the ERC a descriptive review of health camps was undertaken to further understand the added value of health camps in building trust in immunization. In polio high-risk states, mobile health camps have greatly improved the community's trust of health care workers, through the free provision of primary health care services and free treatment of common diseases. In some communities, the house-to-house polio vaccination campaign was made possible by the institution of mobile health camps, making the interruption of polio transmission possible. There was a strong consensus amongst all respondents and focus group participants that health camps have succeeded in building trust between communities and healthcare workers and should be perpetuated and considered

for the delivery of other or alternate health services (such as routine IPV, antenatal care, and management of chronic diseases). The predominant utility ascribed to health camps by the focus group participants was the building of trust between health care providers and the community, in order to grow community demand for health services. This group of stakeholders also felt that health camps were highly demanded by the communities. The community interviews validated this finding.

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

In security-compromised areas, despite the increase in insurgency in 2015 (almost 64% of the settlements could not be fully reached during the October 2015 IPDs), the local innovations 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 January – December 2015.

Table 1: Children vaccinated through special interventions in security compromised areas, 2015

Interventions	Borno	Yobe	Taraba	Adamawa	Total	Type of vaccine
Fire walling	46,555	58,387			104,942	bOPV/tOPV
PHT	458,448	630,617		46,684	1,135,749	
Market/transit	387,155	21,575	114,138	118,241	641,109	
IBPT		27,751	76,052	74,638	178,441	bOPV/tOPV
Hit & Run	58,401	1,528,001		56,495	1,642,897	tOPV
IDPs	347,343	9,064	23,974	39,213	419,594	bOPV
Hospital	28,537	31,427			59,964	bOPV
Nomadic		62,937			62,937	bOPV
Cross Border				11,080	11,080	tOPV
Total	**1,326,439**	**2,369,759**	**214,164**	**346,351**	**4,256,713**	

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

By November 2015, there were 61 registered IDP camps in 29 LGAs of 7 states: Adamawa, Borno, Gombe, Benue, Yobe, Plateau and Taraba. A total of 419,594 children aged 0 – 59 months were vaccinated with OPV from Week 1 – Week 49 of 2015 and those who did not present a card to indicate that they had received IPV were vaccinated with IPV.

Of the 422,675 children that were vaccinated in IDPs, 8,297 (2.0%) 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 table below shows the number of children vaccinated with tOPV in the different camps in the LGAs.

Table 2: Children vaccinated in IDP camps in northern Nigeria, Week 01 – 49 2015

LGA/State	IDP camp (wk 01 - 49)	Cumulative doses Admin	Cumulative Zero Dose	Cumulative IPV Doses	AFP Cases reported
Fufore	2	7271	60	407	0
Girei	3	17061	50	0	0
Yola North	1	1512	13	0	0
Yola South	2	13369	57	0	0
Adamawa	8	39213	180	407	0
Jere	15	152624	2306	2854	2
Maiduguri	10	169451	1429	3725	5
Konduga		15154	614	4118	3
Dikwa		7783	1931	2749	0
Gwoza		2331	709	0	0
Borno	25	347343	6989	13446	10
AKKO	1	452	59	1	0
FUNAKAYE		610	114	0	0
KWAMI		178	45	0	0
NAFADA		340	84	0	0
YAMALTU D.		670	95	1	0
Gombe	1	2250	397	2	0
Ardo Kola	4	4542	106	0	0
Bali	3	1667	32	0	0
Donga	1	1855	23	0	0
Gassol	1	647	27	0	0
Jalingo	5	4842	110	0	0
Karim Lamido	1	61	3	0	0
Wukari	5	9695	186	0	0
Zing	1	665	33	0	0
Taraba	20	23974	520	0	0
Damaturu	2	5184	129	2	0
Geidam	1	3880	30	1	0
Yobe	3	9064	159	3	0
Logo	3	98	0	0	0
Ukum	1	269	25	0	0
Benue	4	367	25	0	
Jos South		129	0	237	0
Kanam		266	23	72	1
Quaan Pan		69	4	62	0
Plateau		464	27	371	1
Total	61	422,675	8,297	14,229	11

3. REMAINING CHALLENGES FOR FOCUS IN 2016

3.1 Misinterpretation of polio virus interruption and risk of complacency

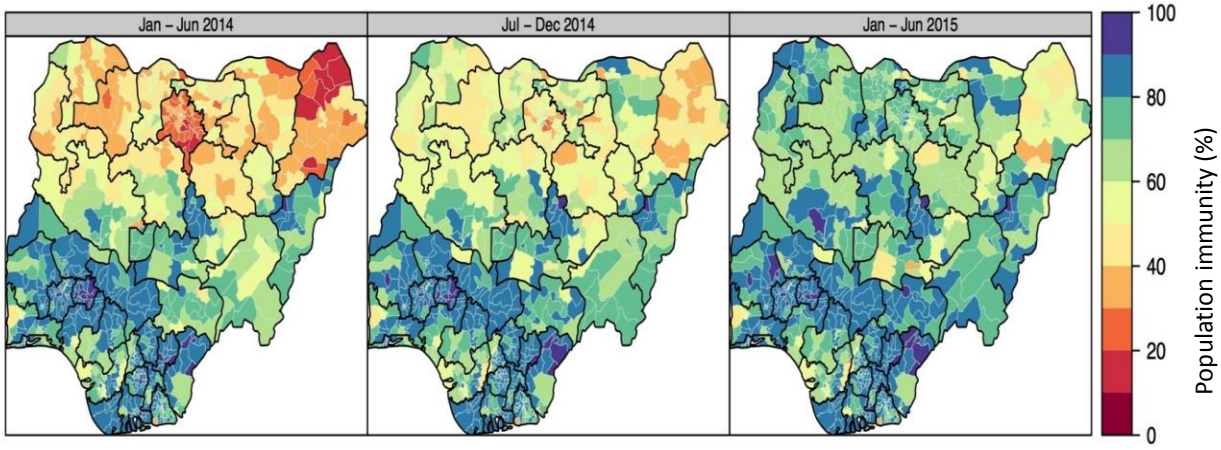
The removal of Nigeria from the list of polio endemic countries has been misinterpreted by many parties to mean that polio virus has been eradicated from Nigeria. This is creating a sense of complacency that the "job is finished" resulting in a new wave of challenges: wavering political support, reduced counterpart funding, reduced donor support by systematic scaling down of funding and 'fatigue', non-compliance in some communities and 'fatigue'.

3.2 Population immunity gaps and continued risk of VDPV

Although interruption of transmission has been achieved for over a year, the population immunity still remains fragile with a real risk of re-emergence of the virus (wild or vaccine derived) due to population immunity gaps. Figure 3 illustrates gaps in population immunity to cVDPV type 2 across the states, noting higher vulnerability in Borno and Yobe states in the North-East.

Gaps in population immunity in the southern states, contributed by prolonged interruptions in service provision due to health worker strikes in some states, complacency and sub optimal coverage in SIAs, also pose a risk for VDPV outbreaks.

Figure 3: Population immunity profile to cVDPV, Nigeria, 2014-2015

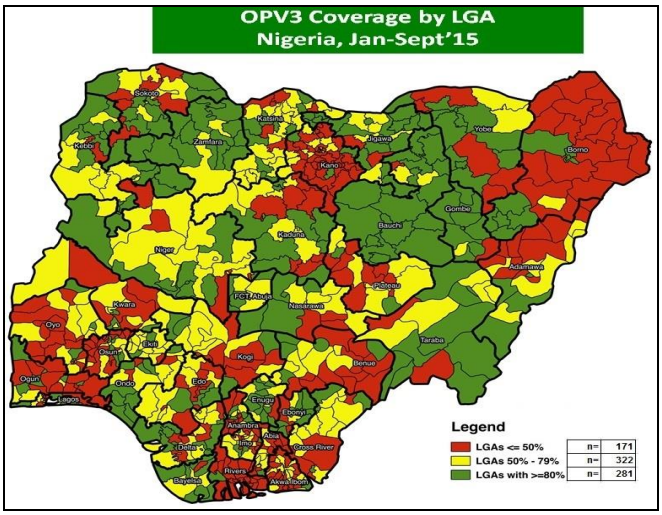


Source: Vaccine Epidemiology Research Group, Imperial College London

The sero-prevalence survey undertaken in Katsina in 2015 also reinforces that there remain significant immunity gaps.

Based on administrative data from the DVD-MT, out of the 774 LGAs: 171 (22.1%) have OPV3 coverage less than 50%; 322 (41.6%) have their OPV3 coverage between 50 and 79.9%, and 281 (36.3%) have 80% or more OPV3 coverage (Figure 4). The risk for cVDPV2 outbreaks is still therefore present as only 36.3% of LGAs have coverage greater than 80%. Comparing the data for the same period with Penta 3 coverage, there is a wide discrepancy, demonstrating missed opportunities during the vaccination sessions and the challenge of supportive supervision. Furthermore immunity profile for OPV3 coverage of non-polio AFP cases in 2015 depicts low coverage in the following states: Abia (74%), Anambra (74%), Lagos (74%), Akwa-Ibom (74%), Rivers (73%), just to mention a few.

Figure 4: Routine OPV3 Coverage by LGA, Nigeria, January-September 2015



Transmission of cVDPV2 in AFP cases and the environment continued in Kaduna State in the first half of 2015 following SIPDs in late 2014 and NIPDs in March and April 2015 during which tOPV was used. The cVDPV case in FCT in May 2015 was genetically linked to circulation in Kaduna According to earlier reports, two different cVDPV2 strains were detected in Zaria environmental samples. A cVDPV2 that emerged in August 2014 in Zaria LGA, Kaduna, and was detected in a sample collected in the 20th January 2015, is the same strain that caused the 16th May 2015 AFP case in FCT. The second cVDPV2 from the environment on 4th March 2015, was the last detection in Nigeria of the old persistent cVDPV2 strain. The break through transmission of cVDPV2 and possible continued circulation is a concern that needs to be closely followed. Any continued transmission or re-infection of any other area would be a great setback to the progress made and would be a huge setback 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, not all LGAs or wards within LGAs have completely and consistently been accessible to the vaccination teams. The number of inaccessible settlements has remained stagnant in 2015 ranging from 60% – 67% in Borno state and 15% - 20% in Yobe state between January 2015 and November 2015. Even in the accessible areas, quality is comprised within a context of overall insecurity. Despite the insecurity having an impact on campaign performance, Borno and Yobe states have managed to achieve the target threshold of >= 80% LGAs achieving >=80% coverage. It is important to note that neither of these states has reported any

poliovirus in 2015 but surveillance activities have been intensified to ensure that no polioviruses are concealed due to the ongoing insecurity. 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 eastern zone.

The increase in insurgence in the northeastern part 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 northeastern 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 transmitting polioviruses.

Figure 4:

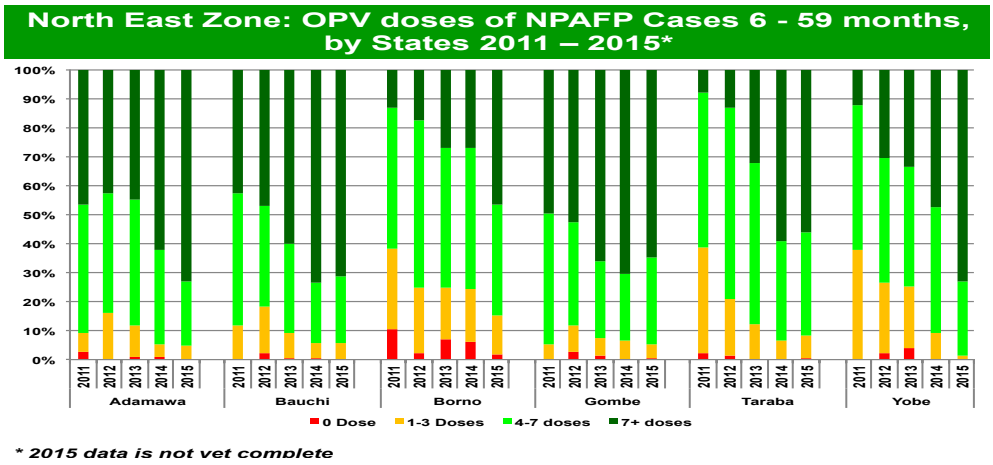
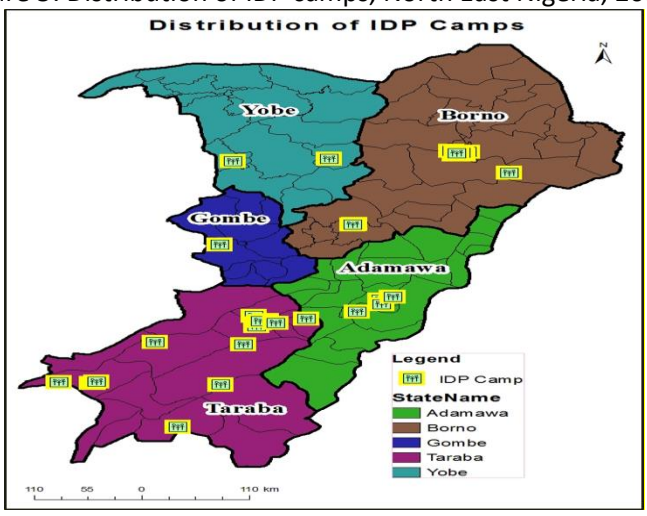


Figure 5: Distribution of IDP camps, North East Nigeria, 2015



3.4 Non-compliance

Non-compliance continues to be a key challenge in some well-known priority areas, including in areas which have been affected by insecurity. Given many parents refuse polio vaccination due to other felt needs and mistrust, the programme will continue to respond to these issues 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 2016 will be placed on building demand for routine immunization in the prioritized LGAs in between campaigns.

3.5 Surveillance gaps

There have been improvements in AFP surveillance performance in 2015 compared to 2014 with more AFP cases detected – 12,294 compared to 10,507 cases in 2014 which is a 15% increase in detection rate attributed to strengthening of reporting networks including community 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 2015, Borno State reported 329 AFP cases compared to 274 cases in 2014 while Yobe State reported 299 AFP cases in 2015 compared to 230 cases in 2014 which represents a 20% increase in AFP cases detection in both states in 2015 compared to 2014. As of October 2015, 100% LGAs across Nigeria are reporting AFP cases, and 99% of LGAs are meeting the two main performance indicators (number of cases and stool collection), representing an improvement from 2014.

A reduction in the number of AFP cases classified as polio compatible by the National Polio Expert Committee was recorded from 34 cases in 2014 to 23 cases in 2015. Despite the progress, this indicates there are still surveillance gaps that need to be addressed. These include existence of silent wards in some LGAs, some stakeholders (clinicians and informants) expected to report cases are still not well informed of surveillance processes, limited geographical accessibility for field activities in some areas in the north east and southern parts of the country due to insecurity and inadequate documentation of surveillance activities in many states.

These surveillance gaps have to be addressed in 2016 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 2016

4.1. Goal

The overall goal of the NPEEP 2016 is to sustain interruption of all poliovirus transmission and build the momentum towards certification.

4.2. Targets

Target 1: Sustain polio free (WPV, cVDPV) status until December 2016
Target 2: Switch from tOPV to bOPV on April 18 2016
Target 3: 50% reduction in number of unimmunized children in VVHR LGAs
Target 4: Completion of phase 1 Laboratory containment
Target 5: Country documentation of polio-free status completed by December 2016 using AFRO template
Target 6: Legacy Transition Plan completed and approved by December 2016

4.3. Major Milestones

- Aggressive advocacy and engagement plan in place for Governors, LGA chairmen and key stakeholders such as donors
- Micro-plans reviewed and updated in all VVHR/VHR LGAs, low population immunity and LGAs with population influx and IDP camps by June 2016
- The Borno and Yobe Strategic Operational Plan 2016 for security compromised areas finalized by February 2016 and implementation being closely monitored by March 2016
- All states have conducted trainings, developed and finalized polioviruses outbreak response plans by February 2016
- 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
- Development of a detailed analysis of States and LGAs with immunity gaps in all the southern zones with detailed high risk operational plans to address the gaps in place.
- All very high risk and vulnerable LGAs have routine immunization strengthening plans by February 2016 and implementation closely monitored by the EOC every month
- External surveillance review completed by June 2016
- Expansion of environmental surveillance to at least one state in the South South/ South East zones.
- 90% of planned active AFP surveillance visits to prioritized sites conducted by June 2016
- tOPV withdrawn and bOPV introduced into the national routine immunization schedule by April 18 2016.
- Mapping of polio assets completed by February 2016
- Finalization of transition plan by December 2016

5. STRATEGIC PRIORITIES FOR 2016

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) building resilience towards certification; (2) enhancing SIA quality in prioritized vulnerable areas; (3) special approaches for insecurity areas; (4) mounting timely and adequate polioviruses outbreak responses; (5) enhancing routine immunization; (6) intensifying surveillance and tracking documentation deliverables towards certification; (7) withdrawal of tOPV; and (8) polio legacy planning. All strategies will be underpinned by strict adherence to the accountability framework which continues to guide the NPEEP.

5.1 Building resilience towards certification

Within the evolving context in Nigeria, a new and nuanced message framework will be developed for all key audiences – political leaders, donors, community influencers, programme officers, frontline workers and communities themselves. The President of Nigeria has committed to reinvigorating the Presidential Taskforce to ensure strong political commitment through to 2017 for both polio and routine immunization. A revised 'commitment' dashboard with updated indicators for state and LGA leadership will be tracked at the Presidential and Governor levels to enhance accountability. The High Level Advocacy Team (HiLAT) will hone in on those areas where there are gaps in political commitment, including release of counterpart funds. Public accountability will be key in this process, by involving the national media and other key stakeholders. Dashboards and gaps in political commitment will be made public through ongoing media dialogue and discussion.

In 2016, resource mobilization and donor engagement will be critical to ensure that the Financial Resource Requirements (FRR) gaps are filled to sustain the gains as well as to ensure donor partners are supporting the EOC advocacy agenda. Special focus will be placed on having regular interactions with existing in-country Ambassadors and donor technical teams, as well as other emerging donors. Where possible this could also include field trips to experience first-hand the use of polio funds. The EOC will also look for all possible opportunities to recognize and appreciate the support of its donors.

Increased efforts will be made to focus on ensuring operational excellence of the existing platforms for household and community engagement in the very high risk LGAs to reduce missed children and build demand for overall immunization – SIAs and routine. In 2015 more than 12,000 Volunteer Community Mobilizers (VCMs) were deployed to support household engagement in the high risk LGAs. As well, 1500 FOMWAN female mobilizers were engaged to further supplement community engagement in high risk areas. An important partnership was established with Daawa Coordination Council, a network of key religious leaders and institutions in 2015. The Northern Traditional Leaders Committee (NTLC) continued to play a key role at all levels to facilitate trust. 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 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 2016, especially in a context where there are no polio cases. Working closely with the data team, there will be more rigorous attention to delving deeper into the reasons for missed children, including through special investigations in areas with chronically missed children. In 2016, more emphasis will be placed on social and community mobilization through a wide range of stakeholders to highlight risk and reiterate the need for all immunization. Additional social data will be collected to identify key gaps, including special investigations in areas with chronically missed children and through periodic polling in communities.

Experience has shown that 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 2016, 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 continue to 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. Emphasis will be placed on motivating communities for all immunization.

Positive immunization messages engaging key influencers and using popular entertainment feature prominently in the 2016 approach through community influencers, viewing centers and using new technologies (Bluetooth pairing and sharing) putting polio within a broader health context of child survival. Efforts in 2016 will also focus on broader entertainment-education activities for all components of immunization guided by the social data. This includes strong community engagement and mobilization through local channels in order to motivate and inspire communities. The new message framework will guide programming across these platforms to create a positive environment for immunization at the community level. To work closely with community gate keepers in order to mobilize the citizenry to embrace immunization

Emphasis in 2016 will also be placed on motivating the front line workers. In the past there have been some attempts to recognize and appreciate those workers that are doing a good job. However this has not been systematic and consistent. In 2016 a more systematic approach to appreciating good performance will be implemented through public recognition will be initiated by the National EOC. Trainings and evening review meetings must be institutionalized as opportunities for recognition and motivation. The national EOC will develop guidelines/SOPs for capitalizing on these opportunities.

Activities

5.1.1 Changing the narrative

- Revise message framework for all key stakeholders – political leaders, Traditional/ religious/ community leaders, donors, frontline workers, communities, etc
- Entertainment-education packages for Hausa media platforms to reflect the revised programme narrative and include routine immunization; these platforms will be scaled up further in 2016 supported by proactive media engagement.

5.1.2 Narrowing the gaps – efforts to reduce chronically missed children

- Undertake special investigations following each polio campaign to understand in more detail the reasons for chronically missed children;
- Develop revised message framework to support household and community engagement approaches.
- Develop 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, especially the insights from the special investigation;
- Rigorous follow up on the register of all missed children during and in-between campaigns;
- Engage local traditional, religious leaders and stakeholder: scaling-up engagement of local traditional and religious leaders, including the Daawa Coordination Council members/Jummat mosque imams plus stakeholders to ensure communities understand the risk of polio and the need to immunize their children. The NTLC will be reinvigorated to ensure traditional leaders at all levels understand the new context and message framework.

5.1.3 Building demand for routine immunization

- Full implementation of new VCM data registers which include RI and maternal health tracking; Every VCM must be linked to the health facility in her catchment. All VCMs to track and immunize new-borns and support defaulter tracking together with the relevant health facility staff. Every VCM to support the mobilization of households on 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;

5.1.4 Ensuring strong political support for immunization

- Reinvigorate the Presidential Taskforce to focus on polio and routine immunization

- Closely monitor new 'commitment' dashboard and share with HE The President and Governors to track release of counterpart funds and key indicators of political commitment;
- HiLAT to follow up on the areas where there are gaps highlighted by the 'commitment' dashboard through one-on-one engagement;
- Organize roundtable platforms at national and state level to bring together key stakeholders to understand the new 'era' of polio eradication efforts in Nigeria and to create a momentum through to 2017.
- Engage national and state media proactively to ensure editorial content reflects the new message framework and supports efforts to enhance political commitment.

5.1.5 Strengthening engagement with donors

- Donor landscape mapping within Nigeria, including donors who currently do not support polio eradication;
- Bi-annual meetings with heads of donor governments to take place to ensure they are kept updated of the latest programme developments and risks; this will also provide a platform to recognize and appreciate donor support;
- Organize periodic donor field trips so their representatives see their funds in action;
- Organize international media visits/field trips from key donor countries to document use of their funds in action;
- Engagement of new donors to help transition polio assets by working closely with the government.

5.1.6 Motivating the frontline health workers

- National recognition scheme for frontline workers to be developed, including criteria for selection;
- Public recognition of well performing frontline workers to take place quarterly at national, state and LGA level;
- SOPs to be developed to guide field staff on the use of trainings and review meetings as opportunities for motivation and recognition in a more systematic way;

5.1.7 Targets, milestones and indicators

- Revised message framework in place by January 2016;
- Revised Abuja Commitment indicators finalized by January 2016 to be tracked quarterly at the Presidential Taskforce meetings;
- Two donor interactions held in 2016;
- Special investigation tool finalized by mid-January and undertaken in areas with high missed children after every campaign;
- SOPs for motivation of front-line workers by February of 2016;
- Entertainment packages for radio and other programming reflect the new message framework by March 2016;

5.2 Enhancing SIA quality in prioritized vulnerable areas

Activities

5.2.1 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 continued 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.

5.2.2 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 was 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.

5.2.3 Improving team performance

Poor team performance, which manifests as child absent and households not being visited during IPDs, was one of the largest contributors to poor quality IPDs in 2015. To continue to address the situation in 2016, 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. This new micro planning process was extended to potential polio sanctuaries of Adamawa, Taraba, Benue, Plateau and a limited scope introduced in Kogi and FCT.

- ***Introduction of some new innovations in southern states***: In 2016, all Southern States will commence the use of new tally sheets and basic household enumeration tools during SIAs. The current team composition of 6 persons per team will be split into 3 person team made up of 1) a team supervisor 2) a Vaccinator 3) a community leader

- ***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 2016, 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. Mock LQAs will also be introduced in all Southern States in 2016

- ***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.

5.2.4 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 2015 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 2016.

5.2.5 Targets, milestones and indicators

- Categorization of VVHR/VHR LGAs for the 1st half of 2016 by the National EOC by February 2016
- Re-deployment of "stronger hands" to VVHR/VHR and weak performing LGAs and wards by Government and partners by March 2016
- Micro plans updated in VVHR/VHR, active polioviruses transmission, population influx and IDPS LGAs and wards by March 2016
- Validation of LQAS and use of OPV data from LQAS to improve population immunity commenced by January 2016
- Synchronized international cross-border vaccination with neighboring countries implemented by April 2016 IPDs
- Evaluation of impact of local IPDs innovations conducted by March 2016.

5.3 Implementing special approaches for security challenged areas and IDPs

5.3.1 Activities

- **Fortnightly 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. Moving forward, inputs from LGA chairmen, traditional and religious leaders would also be sought; these will provide local context to the security situation. Experience of the last few months indicates that while whole swathes of LGAs may not be accessible due to insecurity, the latter group of individuals provide reliable information around how a few settlements or wards could be systematically approached for limited PEI activities. The implementation of the planned IPDs will be geographically adjusted according to the prevailing security risk assessments.

- **Deployment of National and state EOC personnel:** In continuation of the strategies developed in 2014 and 2015, officers from the operations group of the National EOC who constitute the Northeast 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.

5.3.2 Borno State

In 2015, there were 5 fully accessible LGAs, 9 partially accessible LGAs, and 13 inaccessible LGAs during scheduled SIAs in Borno state (Refer to Annex 3 for Map of Accessibility in Borno for IPDs in 2015).

The strategic priorities for Borno in 2016 include:

5.3.2.1 Vaccination in Recently Accessible Territories (VRAT)

As the military continues to make transient gains in different LGAs and wards with insecurity, the programme has trained and prepositioned human resources, logistics, vaccines and other materials required to mount a hit and run exercise. This would be done in collaboration with NEMA and the Military, riding on the back of security provided by the institutions, to carry out a campaign within 48 hours of obtaining information that territories are safe. For this information to become readily available, there is a need for constant interaction between the EOC, NEMA and the Military to provide real time information on the accessibility of these areas. This is necessary to ensure that the programme keys into the operations of NEMA, which typically involves the transportation of food and medical supplies to the communities that have been under the control of the insurgents. This campaign is feasible because in most of the previously occupied LGAs and wards, most of the population is concentrated in the LGA Headquarters such that access to eligible children becomes feasible by such an action.

5.3.2.2 Vaccination in Partially Accessible Territories (VPAT)

As a result of the campaign by the Nigerian Army, there has been a conscious shift in the accessibility of small areas due to the tactical movement of insurgents from areas previously occupied. While the Army may have deliberately liberated some of these territories, tactical withdrawal by insurgents has also made some areas accessible so that a whole LGA that was previously occupied now has some sections that are deemed passable for goods and services by LGA Chairmen and UNICEF Local Access Security Facilitators. The aforementioned people indicate that some of these partially accessible territories are suitable for well-defined, highly mobile teams to operate in. These teams would be structured like the hit and run teams, however, the number of personnel, vaccines and logistics required would depend on the size of the target population. The plan would be for the nucleus of these teams to be formed by very competent and experienced health workers drawn from the metropolitan LGAs but supported by health workers from the host LGAs. For these teams to be successful they would require reliable intelligence on the security situation of the LGA, experienced logisticians, reliable cold chain equipment, and appropriate transportation. Although VPAT operations commenced in 2015, they would be intensified in 2016 as the landscape of accessibility evolves.

5.3.2.3 Hit and Run Campaigns

Hit and run IPV/OPV campaign has been planned for Kala Balge and Gwoza LGAs that did not partake in the IPV/OPV campaign in 2015 due to insecurity. This is necessary to address concerns of low population immunity. It is also important to note that only one ward which was accessible in Dikwa LGA participated in the IPV/OPV 2014 campaign. Consequently, these LGAs would be prioritized for hit and run activities once there are reports that they have become fully or partially accessible. This hit and run would be contingent on the relative time of scheduled IPDs campaigns and when the areas become fully or partially available.

5.3.2.4 Catch-Up Contacts for LGAs and Wards that have missed IPDs between 2013 and 2015

Some LGAs and wards have consistently missed IPDs rounds due to persistent insecurity. These LGAs have been catalogued and as there are plans to conduct IPDs between December 2015 and June 2016, catch up campaigns would be conducted in the affected LGAs regardless of participation in any of the scheduled IPDs. bOPV campaigns and an expanded age group for vaccination would also be planned for so as to cover older children who may have exceeded the target age group for OPV during the period under consideration.

5.3.2.5 Enhanced Health Services

The implementation of Health Camps with attractive pluses during the IPV campaigns in Borno, Yobe, Sokoto, Kaduna and Kano shed some light on the complex challenge of demand creation. While the latter is more innate and sustainable, there were arguments in favor of responding to expressed felt needs. The impressive coverage figures observed during the IPV campaigns using health camps as a vehicle strengthened this position. In 2015 the EOC used this health camp model of providing "attractive pluses" and other integrated clinical services such as malaria diagnosis, treatment of common ailments, anti-helminthics, multi-vitamin supplementation and CMAM to enhance Routine Immunization. This intervention was used in a targeted way; they were limited to health facilities operating near security compromised areas or places where the establishment of a traditional health camps may attract anti-vaccination elements and pose a risk to health workers and their clients during operations. A typical LGA with only 50% accessibility had these enhanced RI facilities identified and deployed in the "safe areas" in such a way that mothers and children in relatively "unsafe areas" accessed them when they became aware of the availability of these desired health interventions.

Building on the 2015 Emergency Plan and 29th ERC Recommendation to establish health facilities where enhanced health services would be provided, the EOC was able to provide enhanced comprehensive services in 67 health facilities identified based on the criteria that they are situated near security compromised communities, thereby making them available for some populations trapped in inaccessible areas to attend. The range of services provided includes MNCH, CMAM, treatment of common ailments, first aid, and provision of pluses such as milk and sugar, OPV and other RI antigens.

5.3.2.6 Establish and strengthen Routine Immunization services in IDP camps

Although vaccinations are currently taking place in most existing IDP camps, moving forward, deliberate steps would be taken to establish RI services in new camps. With vaccination cards given to all residents of the camp, this will be linked to other therapeutic services given.

5.3.2.7 Strengthen Permanent Health Teams to wards and settlements with inaccessibility challenges and persistent non-compliance

Experience has shown that implementation of this strategy yields the highest dividends when it is used in areas where accessibility is of moderate concern and non-compliance persists. However, 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 2016, 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.

5.3.2.8 Scale up permanent vaccination sites at all major transit points.

In 2015, priority was given to establishing permanent vaccination sites in Very High Risk LGAs as well as LGAs that were previously inaccessible to vaccinate children with OPV. In 2016, we would continue to identify and train health workers who can administer injectable antigens so that all RI antigens can be given in addition to OPV. In areas with no capacity to deploy trained health workers, volunteers would be recruited and they would administer OPV and any intervention that doesn't require specialized skills e.g. Vitamin A.

5.3.2.9 Establishing Health Camps and expanding Therapeutic feeding centres (OTP) / CMAM

In the insecure 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 during IPDs. Indeed, in areas which where hitherto inaccessible, provision of this interventions has opened up populations to OPV vaccination. Additionally, many children have been found to be malnourished due to lack of access to food during occupation of their communities by insurgents. Therefore, as part of in-between round activities in the security compromised areas, IDP camps and host communities, Community Management of Acute Malnutrition (CMAM) centers would continue to be used as an opportunity to provide OPV and immunization.

5.3.2.10. Enhancing AFP surveillance

The focus will be on improving strategies that would enable AFP reporting from inaccessible settlements and IDP camps where they occur. The intention is to ensure that cases continue to be reported outside of the orthodox health infrastructure. In 2016, depending on the landscape of insecurity, there will be increased recruitment of community-based organizations, individuals, informants (herbalists, bone setters, traditional birth attendants, Patent Medicine vendors), faith-based organizations, and to help report AFP cases. As the accessibility increases, DSNOs will be involved in VRAT and VPAT activities described above. Thus, as territories become available community informants' structure will be improved upon and set up where it had been disrupted, health staff will be organized and trained with provision of management tools as well as community case search cases of AFP that may have been missed would be prioritized. There will be a continuous effort to increase the number of meetings between DSNOs, health facility based focal persons and informants.

5.3.2.11. Scaling up engagement of Local Government Chairmen, traditional, religious leaders and other influencers

There will be a scale-up of engaging local traditional and religious leaders plus other stakeholders to help overcome issues of mistrust and suspicion at the local level. Following up on the Kano PEI/RI retreat with Borno LGA Chairmen, the latter would be increasingly involved in planning meetings for interventions that improve access and delivery of PEI activities. A monthly meeting with these

stakeholders will be routinely held until such a time when access to vulnerable children reaches a threshold.

5.3.3 Yobe State

In 2015, there were 10 fully accessible LGAs, 5 partially accessible LGAs, and 2 inaccessible LGAs during scheduled SIAs in Yobe state. The same strategies used in Borno state would be used in the security compromised LGAs of Yobe state. This is based on considerations that the insecurity in LGAs and wards arise from activities of insurgents in wards bordering LGA such as Damboa in Borno state. Insurgents operate within a circumscribed area that covers these inaccessible areas in Yobe state. This makes it impossible for the movement of humans, goods and services in these areas. However, the ongoing activities of the Nigerian Army has made the security situation fluid and very dynamic thereby creating the avenue for the programme to seize every opportunity to implement VPAT while making sure the state is adequately prepared to undertake VRAT.

5.3.4 Adamawa and Taraba States

In 2015, Management Support Teams (MSTs) were deployed to support the programme especially in Adamawa and Taraba states. Also, 71 personnel from the federal government and partner agencies were deployed to both states for 3 months (August 2015 – October 2015) to support with SIAs, routine immunization and surveillance activities. Directly Observed Polio Vaccination (DOPV) was implemented in 7 LGAs in Taraba and 3 LGAs in Taraba during the catch-up campaigns. Border vaccinations were also strengthened between both states and Cameroon and Chad with 36 international border points in 9 LGAs in Adamawa and 4 LGAs in Taraba state.

Although three rounds of catch-up IPD campaigns have been conducted recently in the two states, there is a risk of importation from Cameroon. Also, populations fleeing from insurgents in the security compromised and inaccessible areas of Borno and Yobe states relocate to neighboring Adamawa and Taraba states. The routine immunization and OPV doses of NPAFP cases indicate that there is sub-optimal population immunity which puts the two states at risk of outbreak of polioviruses if introduced. It is therefore crucial that the programme takes adequate steps to curb any risk of importation and to build population immunity. Consequently, LIDs would be conducted to boost population immunity especially among children under-1 year of age until such a time that the risk of importation is reduced. LIDs are to be synchronized with currently scheduled IPDs starting from the December 2015 IPDs.
In order to improve the quality of LIDs in these two states, MSTs will be deployed to supervise and report on the conduct of these activities.

5.3.5 Northwestern States

Some states in the northwestern region of Nigeria have been consistently affected with insecurity ranging from challenges such as armed robbery to cattle rustling. This has affected few wards and LGAs in states such as Bauchi (Toro, Darazo, and Ganjuwa LGAs), Kano (Tudun Wada LGA), Kaduna (Birnin Gwari, Igabi, Chikun, and Giwa LGAs), Katsina (Batsari and Jibia LGAs), and Zamfara (Maradun, Bungudu, Maru, and Birni Magaji) and consequently affected the implementation of planned SIAs activities. Details of the affected wards and actions taken can be found in Annex 7.

Targets, Milestones and Indicators:

- Detailed Operational plan for security affected states of Borno and Yobe updated and implementation being closely monitored by end December 2015.
- Conduct 4 "Catch-up" OPV contacts in wards and LGAs that did not participate in planned IPDs rounds by December 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 July 2016
- Permanent Transit Vaccination intensified by end January 2016
- Deployment of Permanent Health Teams reviewed and strengthened with strong supervisory component all wards with inaccessibility challenges and persistent non-compliance by January 2016 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 March 2016
- Routine immunization services set up in new IDP camps, emphasis on weekly vaccination of eligible children with OPV and other vaccines by January 2016

5.4 Mounting timely and adequate outbreak responses to all polioviruses

Outbreak responses to the cVDPV case and positive environmental samples in 2015 were mounted timely and appropriately. 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.

Training was conducted for state outbreak response teams for all states in six phases for the six geo-political zones during 2015.

Each state will be expected to reinforce a robust outbreak response mechanism to respond to any case of polio (Importation of WPV), any cVDPVs from AFP cases or environmental surveillance or any polio compatibles in 2016. Outbreak responses shall be conducted in strict adherence to National Outbreak response protocol.

5.4.1 Activities:

- **Constitution of outbreak response manager and team at state 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.

5.4.2. Targets, Milestones and Indicators

- State Outbreak Response Managers trained and teams updated by the Government and partners by February 2016
- State Outbreak Plans developed and shared with National EOC by February 2016
- 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.

5.5 Enhancing routine immunization

To ensure sustained interruption of all polioviruses, it is important that routine immunization is rapidly strengthened. Strengthening routine immunization is labor, 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.

5.5.1 Activities

5.5.1.1 Identify 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

5.5.1.2 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

5.5.1.3 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

5.5.1.4 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.

5.5.1.5 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.

5.5.1.6 Government an 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

5.5.1.7 Government and partners to participate and monitor the fixed and outreach sessions carried out in these prioritized areas

5.5.1.8 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.

5.5.1.9 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

5.5.2 Targets, milestones and indicators

- Priority LGAs / wards for strengthening RI identified and shared with State Task Forces / EOCs by February 2016
- Commencement of National EOC advocacy with state task forces / EOCs for human, material and financial support by March 2016

- Updated RI plans based on walk-through micro-plans data and sessions plans available by March 2016
- Data tools for capturing and monitoring routine immunizations performance available in priority LGAs by March 2016
- Polio surge capacity supporting and monitoring sessions by March 2016
- National and State EOCs / task forces commence weekly monitoring of RI performance by April 2016

5.6 Intensifying surveillance and tracking of documentation towards certification in 2017

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 2016 to verify if indeed Nigeria will sustain interruption of transmission as per set targets and milestones.

In 2016, 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 will be sustained. Its use in the past years 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 2016, amongst other issues to capture real-time data on activities of DSNOs which is critical in building resilience in surveillance especially at the operational level

5.6.1. Activities:

5.6.1.1. 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;
- Advocate to the new political leadership at all levels for support to surveillance especially in terms of logistics support for DSNOs
- Implement regular capacity building of personnel involved in surveillance including surveillance site focal points, DSNOs, State Epidemiologists, surge capacity and others involved in surveillance through supportive supervision, on-the-job training, peer exchanges and refresher trainings. 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 though 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 to be conducted in high risk states and other states based on risk analysis).
- Implement targeted surveillance activities to enhance surveillance in states with security challenges including: review of informants networks with additional engagements and sensitization/trainings, review of network of focal persons with additional engagements with training of network, review network of DSNOs with additional engagements and trainings with provision of management tools, development of jingles and use of local radio stations, improving partnership with professional medical associations, CBOs and NGOs.
- Monitor implementation of rapid surveillance assessment (RSA) and ERC recommendations.
- Provide a N1,000 reward to any vaccination team that reports a true AFP case during IPDs nation-wide
- Continue to provide N 1,000 to any person who reports a true AFP case in Kano state.
- Provide surveillance management tools and surveillance guidelines at all levels (IEC materials will be provided to complement what is available at state levels).
- Improve the sensitivity of AFP surveillance through collection of contact samples from all AFP cases from Adamawa, Borno and Yobe states and from all inadequate AFP cases from other states and FCT.
- Finalize phase I laboratory containment of poliovirus (wild and VDPV) and continue to update the inventory of laboratories with poliovirus and potentially infectious materials.
- Investigate and respond to polio compatible cases as per the new guidelines.
- Expand current surveillance system by at least 10 % (increase focal sites from the existing non-focal sites by Dec 2016).

5.6.1.2. Sustain and Expand Environmental Surveillance

- Support existing environmental surveillance activities in 10 states Kano, Sokoto, Lagos, FCT, Kaduna, Jigawa, Yobe, Katsina, Kebbi, Borno and Adamawa.
- Expand environmental surveillance to 1-2 additional high risk states by September 2016 (vulnerable states) depending on poliovirus epidemiology
- Expand environmental surveillance sites to one-two states in the southern states by June 2016 based on risk analysis and capacity of the lab to handle additional samples.
- Conduct quarterly supervision of all environmental surveillance sites.
- Conduct annual meeting of environmental surveillance system technical staff.

5.6.1.3. 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.

- Maiduguri polio lab supported and moved to the new building.
- Modular lab at University of Ibadan polio installed and functioning well.

5.6.1.4. Conduct polio sero-surveys:

- Finalize all sero-prevalence studies commenced in 2015
- Conduct additional sero-surveys depending on polio epidemiology and population immunity. (Within operational limits consider both facility- based /community- based SPS by December 2016).

5.6.2. Targets, Milestones and Indicators

- Attainment of the 2 main AFP surveillance performance indicators at national, state level and LGA levels by June 2016
- 90% of all reported AFP and polioviruses verified and geo-coordinated by June 2016.
- 5-10% increase in community informants conducting AFP surveillance by June 2016.
- Conduct at least 80% planned monthly active surveillance activities (including to community informants) by June 2016
- At least 70% reduction in polio compatible cases by December 2016.
- Environmental surveillance expansion to a southern State by May 2016
- Sero-prevalence surveys conducted in Borno and Yobe by March 2016.
- National Polio Laboratories maintain WHO accreditation in 2016.

5.7 tOPV withdrawal

In line with the global switch from tOPV to bOPV, Nigeria has scheduled the switch date for 18 April 2016. A National Switch Committee was set up under the leadership of the National EOC in 2015 to oversee the preparations. A Switch Plan was finalized and costed and all States were formally notified of the schedule in 2015.

5.7.1. Activities

- Finalize and print training materials for the switch
- Designate Switch Support Teams at state level
- Distribute bOPV to state and LGA levels
- Conduct sensitization meetings with key stakeholders
- Conduct training sessions for health workers
- Withdrawal and disposal of tOPV
- Conduct national validation of the switch

5.7.2. Targets, Milestones and Indicators

- Switch date implemented on 18 April 2016
- Withdrawal and disposal of tOPV by 30 April 2016
- National validation on 1-14 May 2016

5.8 Legacy Planning

In March 2015, Nigeria initiated the legacy planning process and set up a Legacy Planning Working Group with a secretariat in the National EOC, while it was assumed that the process will start in 2016. This earlier planning will enable the country better prepare for transitioning the polio assets into high priority interventions and broader public health goals. Since the inception of the Working Group, meetings of the technical working Group as well as with donors /partners have taken place and ongoing until the final mapping is done for decision making.

5.8.1 Activities

- Mapping the polio assets with all stakeholders
- Organisation of meetings, surveys/ interviews at all levels with stakeholders: partners, ICC, HSPC, all cadres of frontline workers, NTLC, States and Federal Government.
- Monthly Legacy technical working group meetings
- Quarterly ICC/partners debriefing meetings
- Documentation of best practices and lessons learned targeting different stakeholders

5.8.2 Targets, Milestones and Indicators

- Assets mapping finalized by February 2016
- Dissemination of mapped assets for partners endorsement by April 2016
- Final legacy plan by December 2016

6. POLIO SIA CALENDAR FOR 2016

It is important that the momentum that led to the marked progress towards interrupting wild poliovirus transmission in 2015 be sustained towards maintaining interruption of all types of polioviruses in 2016 within the context of the global polio endgame strategy. The Expert Review Committee (ERC) endorsed Nigeria's SIA schedule during its 30th ERC meeting in August 2015.

The number of IPDs in 2016 includes:

- 2 Nation-wide IPD rounds
- 3 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.

Quality will continue to be the overarching theme for 2016. Emphasis will continue to be placed on improving campaign quality with continued close monitoring of quality pre -; intra-; and post – IPDs activities.

The scheduled dates of 2016 IPDs are in Annex 2.

7. OVERSIGHT AND MANAGEMENT

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

The re-invigorated functionality of the Presidential Task Force (PTF) will provide oversight to the PEI program in Nigeria. The PTF will monitor progress at the State and LGA level through monthly meetings.

The National EOC, 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 2016, 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.

Traditional leaders play a very important role in the PEI programme. They have been incorporated in all the taskforces from presidential to the LGA task force. Aside from this involvement in various task forces, the traditional authorities in northern Nigeria have an organization called the Northern Traditional Leaders committee on PHC (NTLC-PHC) whose mandate among others is to lead the process of achieving PEI and RI goals through the systematic involvement in activities for Polio eradication. They have established committees at Emirate and District levels that coordinate activities in the LGAs, wards and settlements. These committees are involved in micro planning, vaccinator team selection, supervision of IPDS activities, resolution of non-compliance and promotion of community demand for vaccination services. NTLC-PHC as well as the religious leaders though established structures such as the Nigeria Inter-Faith Action Alliance (NIFAA) will be expected to participate in the national coordination committees (PTFoPE, ICC, and ICC Working Groups) and thereby support planning, implementation and evaluation of priority activities in the 2016 NPEEP. In 2016, 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 2016 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. Table 3 highlights the management actions taken by Government and partners in 2015.

Table 3: Accountability Framework actions by Agency, Nigeria, September 2015

NPHCDA 2015 Accountability Framework Actions as at 31 July	
Action	**Number**
Commendation	352
Sanction	253
Total	**615**

UNICEF 2015 Accountability Framework Actions as at 30 September	
Action	**Number**
Commendation	135
Sanction	591
Termination	267
Redeployment	163
Total	**1156**

WHO Accountability Framework Actions Quarter ended 30 Sep 2015	
Action	**Number**
Appreciation Letter	178
Verbal Commendation	1437
Discussion to Improve	422
Verbal Warning	52
Written Warning	19
Contract non-renewal	0
Total	**2108**

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: List of Very Very High Risk and Very High Risk LGAs, EOC December 2015

Zone	State	LGA	*Rank*	HR Status categorization
VVHR LGAs (17)				
NWZ	Kano	Tarauni	1	VVHR
SWZ	Osun	Ife East	2	VVHR
SSZ	Rivers	Ahoada East	3	VVHR
NCZ	Benue	Guma	4	VVHR
NCZ	Kwara	Ilorin South	5	VVHR
SWZ	Osun	Irewole	6	VVHR
SSZ	Rivers	Gokana	7	VVHR
NWZ	Katsina	Katsina	8	VVHR
SWZ	Lagos	Surulere	9	VVHR
SSZ	Rivers	Akuku Toru	10	VVHR
SEZ	Anambra	Awka South	11	VVHR
SSZ	Edo	Orhionmwon	12	VVHR
SEZ	Enugu	Igbo-Eze-North	13	VVHR
SWZ	Lagos	Mushin	14	VVHR
SWZ	Osun	Ejigbo	15	VVHR
SWZ	Oyo	Egbeda	16	VVHR
SWZ	Oyo	Ona Ara	17	VVHR
VHR LGAs (29)				
NCZ	Benue	Gwer East	18	VHR
NCZ	Benue	Ukum	19	VHR
NWZ	Kaduna	Igabi	20	VHR
SWZ	Lagos	Alimosho	21	VHR
SWZ	Osun	Ife South	22	VHR
SSZ	Rivers	Oyigbo	23	VHR
SSZ	Rivers	Port-Harcourt	24	VHR
SEZ	Ebonyi	Onicha	25	VHR
NWZ	Kano	Nassarawa	26	VHR
NWZ	Kano	Ungongo	27	VHR
SWZ	Lagos	Apapa	28	VHR
SWZ	Lagos	Ifako/Ijaye	29	VHR
SWZ	Lagos	Kosofe	30	VHR
SWZ	Osun	Ilesha West	31	VHR
SWZ	Oyo	Iseyin	32	VHR
SWZ	Oyo	Oyo West	33	VHR
SSZ	Rivers	Asari-Toru	34	VHR
SSZ	Cross River	Calabar South	35	VHR

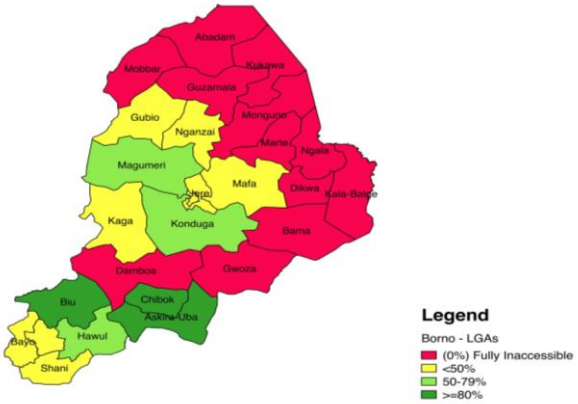
Zone	State	LGA	*Rank*	HR Status categorization
SSZ	Cross River	Obubra	36	VHR
SSZ	Delta	Burutu	37	VHR
SSZ	Delta	Ughelli South	38	VHR
SSZ	Edo	Esan West	39	VHR
NCZ	Fct, Abuja	Municipal Area Council	40	VHR
NCZ	Kogi	Dekina	41	VHR
SWZ	Lagos	Amuwo Odofin	42	VHR
SWZ	Osun	Ila	43	VHR
SSZ	Rivers	Obio/Akpor	44	VHR
SSZ	Rivers	Okrika	45	VHR
NWZ	Zamfara	Tsafe	46	VHR

*** 44 LGAs in Borno and Yobe states considered as special due to insecurity**

10.2 Annex 2: IPDs schedule, Antigens choice, Geographical scope and Major holidays, Nigeria 2016

ERC Approved SIAs Calendar for 2016			
S/No.	Dates	Antigen & Scope	Comment
1	23 - 26 January	tOPV (SIPDs)	
2	27 Feb – 1st March	tOPV (NIPDs)	
3	19 – 22 March	tOPV (NIPDs)	
Easter: 25 – 28 March			
18 April Switch Day (from tOPV to bOPV)			
4	14 – 17 May	bOPV (SIPDs)	
Ramadan: June 6 - 5 July			
5	15 – 18 October	bOPV (SIPDs)	
Eid El Kabir: 13 September			
Independence Day: 1 October			

10.3 Annex 3: Map of Accessibility in Borno state for IPDs, October 2015



10.4 Annex 4: Draft Chronogram for preparation of country documentation in 2016

Activity	Dec	Jan	Feb	Mar	Apri	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Distribution of country documentation template	x												
Discussion of template by EOC		x			x			x			x		
Drafting of country documentation using template		x	x	x	x								
Review draft country documentation by EOC, NCC, NPEC						x							
Review of complete final draft country documentation by EOC, NCC, NPEC									x				
Updating of country documentation										x	x	x	x
Sensitization/advocacy of labs with inventory retaining infectious materials on destruction of un needed materials and containment		x	x	x	x								
Complete State level documentation		x	x	x									
Complete LGA level documentation		x	x	x	x								
Complete H/F level documentation (Focal sites)		x	x	x	x								
Complete Non focal site documentation		x	x	x	x	x	x	x	x	x			
External surveillance review					x								
Elaboration of action plans to implementation external surveillance review recommendations						x	x						
Implementation of External review recommendations						x	x	x	x	x	x	x	x
EOC field visits on implementation of Ext Suv Assessment Recommendations								x	x	x	x	x	x
Field visit of Polio committee members (NCC/NPEC)			x	x		x				x	x		