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2014 NIGERIA POLIO ERADICATION EMERGENCY PLAN

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Table of Contents

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
ED	Executive Director National Primary Health Care Development Agency
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
HSS	Health Systems Strengthening
ICC	Inter-agency Coordination Committee
IPC	Inter-personal Communication
IPDs	Immunization Plus Days
IMB	Independent Monitoring Board
IWCS	Intensified Ward Communications Strategy
IPDS	Immunization Plus Days
LGA	Local Government Area
LTF	Local Government Task Force on Immunization
NICS	National Immunization Coverage Survey
NMA	Nigeria Medial Association
NTL-PHC	Northern Traditional Leaders committee on Primary Health Care
NPHCDA	National Primary Health Care Development Agency
PEI	Polio Eradication Initiative
PTFoPE	Presidential Task Force on Polio Eradication
RI	Routine Immunization
RSA	Rapid Surveillance Assessment
SIAD	Short Interval Additional Dose
SIAs	Supplemental Immunization Activities
SIACC	State Inter-Agency Coordination Committee
STF	State Task Force on Immunization
SIACC	State Inter-Agency Coordination Committee
TBAs	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. EXECUTIVE SUMMARY

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

Nigeria recorded tremendous achievements in 2013 with at least 58% reduction in the number of WPV1 cases compared to 2012. There has been no case of WPV3 in 2013 with the last WPV3 case in November 2012. Overall there has also been a 50% reduction in the number of infected LGA in 2013 compared to 2012 with the geographical restriction of cases to 4 states (Borno, Yobe, Kano and Bauchi) accounting for 84% of the total cases in 2013.

Within these states, Borno and Yobe, which are security compromised, account for 54% of the polio cases since a significant number of LGAs could not be accessed due to insecurity.
There has also been an 80% reduction in the number of circulating genetic clusters from 8 in 2012 to only 2 in 2013 (N5A and N7B). The circulation of cVDPVs has also been marked reduced (75% reduction) from 8 cases in 3 North West states to only 3 cases in Borno State which is a security compromised state with problems of inaccessibility

The improvements in the polio eradication efforts have been due to the improved quality of SIAs in 2013 with the proportion of LGAs achieving an LQAS estimated coverage of at least 80% increasing from 64% to around 74% by September 2013.

The goal of the 2014 NPEEP is to achieve interruption of polio transmission by December 2014 with no new cases reported by end June 2014.

To achieve these milestones, the SIAs quality has to improve with 80% of LGAs achieving at least 80% coverage (LQAs estimates) by March 2014. In the very high risk LGAs, 80% of all LGAs accepted at 80% coverage by LQAs by June 2014; and 90% of the underserved wards achieving at least 90% coverage by independent monitoring data.

The 2014 NPEEP has identified strategic priorities that will be the areas of focus during the low transmission period and the rest of 2014 to ensure interruption by December 2014. These include: (a) improving IPDs quality in persistent poor performing LGAs / Wards; (b) increasing reach of children with OPV in the security compromised areas; (c) rapidly containing circulation in the breakthrough polio

transmission zones; (d) mounting timely and adequate polio outbreak responses; (e) reaching underserved populations; (f) intensifying surveillance; (g) expanding technologies / innovations to further improve micro-planning and team performance; (h) intensifying communication and demand creation; (i) Boosting child immunity in-between rounds and in polio-free states; (j) optimizing human resources and stricter implementation of the accountability framework

2. INTRODUCTION

2.1. Context of Polio Eradication Efforts in 2013

Nigeria made significant progress in intensifying the polio eradication efforts in 2013 due to the continued commitment and leadership at the highest level in Government through the Presidential Task Force and the translation of the leadership vision and implementation of the identified 2013 NPEEP Strategic Priorities through EOC's enhanced coordination of Government and partners efforts at the central and state levels.

The most important achievements during the implementation of the 2013 NPEEP included:

- Engagement and commitment of key Political, traditional and religious leaders from the central level down to State and LGA level through task forces at all levels
- Strong EOC drive, coordination and close monitoring of programme performance
- Implementation of several technical and programmatic innovative approaches to improving quality of PEI activities
- Improvement in the quality of IPDs with 74% of the LGAs estimated by LQAS to have reached at least 80% coverage compared to 67% in 2012
- Marked reduction (at least 56%) in WPV1 cases compared to 2012
- Disappearance of WPV3 with no case in 2013
- 80% reduction of circulating genetic clusters
- Geographical WPV restriction (60% reduction of WPV infected endemic states and 50% reduction in infected LGAs) in 2013 compared to 2012
- About 63% reduction of cVDPV cases from 8 in 3 states in 2012 to 3 cases in 1 state (Borno)

The major challenges to achieving interruption in 2013 have been:

- Heterogeneous political support and commitment at the State and LGA levels, in particular, with late release of counterpart funding for implementation of planned activities
- Insecurity resulting in killing of vaccinations team members (Kano and Borno) and inaccessibility of children in the security compromised states in the North Eastern part of the country
- Poor team performance due to team selection interference in several persistently poor performing Very High Risk LGAs
- Localized non-compliance which was exacerbated by anti-OPV campaigns / messages by institutions of higher learning and religious clerics
- Delays to mount timely and adequate polio outbreak response due to global shortage of vaccines and unavailability of operational funds

2.2. Poliovirus Epidemiology

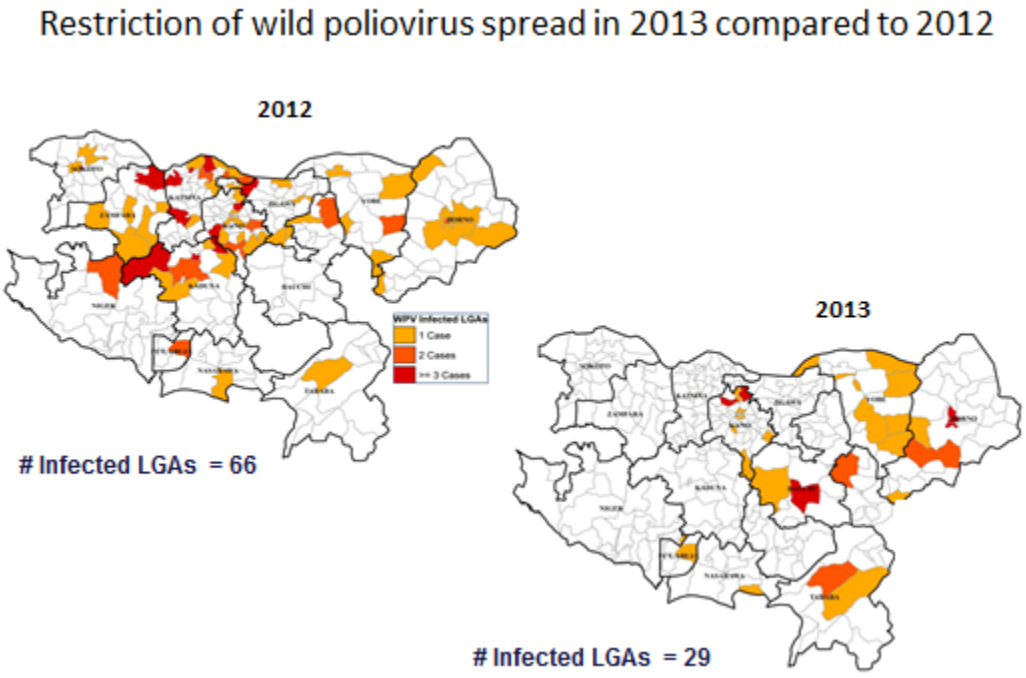
The number of confirmed WPV cases in Nigeria declined substantially between 2012 and 2013, from 122 to 50 cases between January and December representing a marked reduction of 58% compared to same period in 2012. No WPV type 3 has been reported in 2013 with the last case in November 2012. In 2013, there was geographical restriction and shift of poliovirus transmission to the northeastern states, with the majority of cases (84%) occurring in 4 states: Borno (16 cases), Kano (14 cases), Yobe (7 cases), and

Bauchi (6 cases) . The number of infected LGAs reporting cases in 2013 compared to 2012 dropped from 58 to 29 (50% reduction). Of the 29 infected LGAs, only 7 LGAs had multiple cases with 27 cases accounting for 54% of the cases (figure 1 below)

As of December 31, 2013, 3 cVDPV2 cases were reported in 2013 Borno State compared to 8 cases in 3 States in 2012 representing a 63% reduction in cases.

Environmental surveillance detected 3 WPV1: Kano (1) and Sokoto (2); and 13 cVDPV2: Sokoto 9, Kano 2 and Borno 2.

Like in previous years, the majority of WPV cases in 2013 (almost half) were among 12 -35 months of age. However, there was a slight shift in the other age groups with 12% of infected children below 12 months compared to 6% in 2013. Also, 12% of the infected children were above 59 months of age compared to 9% in 2012. In terms of population immunity among WPV cases, there was a decline in zero dose cases from 23% in 2012 to 10% in 2013. Similarly the number of children with at least 3 OPV doses increased from 52% to 66%. In the non-polio AFP cases, population immunity was better with 1% being zero doses and 83% having received at least 3 OPV doses.



Genetic data:

- **Wild Poliovirus:** The number of circulating genetic clusters in 2013 remained 2(N5 and N7) both from Genotype WEAF-B1, compared to 8 in 2012 (Genotype WEAF-B1:N2, N5, N6, and N7, and from Genotype WEAF-B2: L1 and L2; and WPV3 with 2 clusters: F4 and F6).

- **Circulating Vaccine Derived Polioviruses:**

There are 3 cVDPV cases in Borno State among AFP cases all belonging to N7B genetic cluster. Environmental surveillance has isolated 18 cVDPVs (9 in Sokoto, 2 in Kano and 7 in Borno) belonging to the cVDPV –A genetic cluster. However the Sokoto isolates are a separate cluster related to the persistent Nigeria cVDPV circulation.

- **WPV and cVDPV genomic sequence for orphans**

  Genetic diversity (reflected by the number of genetic clusters) is used to assess both viral diversity and surveillance sensitivity. Six clusters identified in 2012 were not detected in 2013. Genetic divergence in polio cases equaling 1.5% (VP1 nucleotide identity) from previously identified cases indicate more than one year of undetected "orphan" virus circulation. Of the 112 WPV cases detected from January-September in 2012, 13 (13%) had greater than 1.5% genetic diversity from known isolates. Of the 51 cases detected in 2013, 8 (16%) had over 1.5% divergence including 3 cases in Borno, 2 in Kano, 1 case in Bauchi, Gombe, and the Federal Capital Territory. The numbers of orphan viruses that have circulated without detection for more than a year are indicative of gaps in surveillance

Profile / characteristics of polio cases

The majority of polio cases were young children of poor, lowly educated families living in hard to reach areas and non-compliant urban slums as shown in the table below:

Figure 2: Characteristics of polio cases in 2013

Age	**< 36 months**	**66%**
	60+ months	**11%**
Residence / Location	**Hard to reach and rural**	**48%**
	Urban slums	**31%**
Nomadic	**From nomadic family**	**2%**
	Proximity to nomadic settlement	**38%**
Travel History	**Child travel**	**8%**
	No travel	**87%**
Economic Status	**Poor**	**73%**
Educational status	**Koranic school & none**	**Mother 77%**
	Koranic school & none	**Father 52%**

2. 2 Status of Implementation of 2013 NPEEP strategies towards interrupting poliovirus circulation

The 2013 NPEEP identified 6 strategic priorities (a) enhancing SIA quality, (b) implementation of special strategies to reach underserved populations, (c) adoption of special approaches for security challenges

areas, (d) improving outbreak responses, (e) enhancing routine immunization and in-between round activities as well as (f) enhancing surveillance. The NPEEP also included 3 cross cutting priorities (a) intensifying communication and advocacy, (b) enhancing the use of innovations and (c) optimizing human resources.

At the national level, statistical modeling and lot quality assurance sampling (LQAS) data are used to define high risk LGAs and wards to prioritize interventions. The list is updated every six months and used extensively by National and state EOCs to target resources to improve campaign quality. Through this analysis, the program identified a number of persistently poor performing LGAs, particularly in the transmission zones of Bauchi, Kaduna, Kano, Katsina, Taraba, and Yobe.

Enhancing SIA quality: Among the main activities that contributed towards improving quality were:

- **Enforcing Accountability at all levels:** This has been the main game changer in the programme. Sanctions and rewards were enforced by the Polio Emergency operations center. It was a departure from the past were laxity and indolence was rife
- **Focused oversight, coordination and supportive supervision in EOC identified very very high risk (VVHR) LGAs, very high risk (VHR) LGAs and persistently poor performing LGAs/Wards.** High-Risk Operational Plans were developed and funds made available to ensure that the impediments affecting quality were addressed. Additional management support teams (MSTs) were deployed to the LGAs of focus to strengthen supervision. In the selected 5 states, EOC were fully established and functional with decision-making abilities based on performance data analysis from previous rounds.
- **Continued revision of micro planning in very very high risk (VVHR) LGAs, very high risk (VHR) LGAs and re-infected non-endemic states in the middle belt.** Micro planning reviews conducted in all the 11 HR States using information from tally sheet analysis and walk-throughs. Revised workload rationalizations were done with additional teams re-deployed.
- **Focused training and team selection:** New training methodology using pictorials was more practical emphasizing on team performance. These had greatly improved team performance in the traditional poor performing LGAs. Systematic engagement of WFPs and Community leaders in accountability especially team selection, noncompliance resolutions and general team performance improvements. Poor team selection has been the bane of the programme accounting for the very poor quality issues. This was addressed by making sure that ward selection committee made more active by ensuring that the selection process is not left at the whims and caprices of the Ward Focal persons. A responsible coordinator from a partner agency will now oversee the selection process of vaccination teams in poor performing LGAs and wards. The programme is focusing 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.

Special strategies to reach underserved populations

There was focus of activities done in the underserved populations with the January and June IPDs focusing in the hard to reach, scattered populations and along borders, migrant populations and nomads.
In addition, enumeration was done in these underserved areas that led to inclusion of missed settlements and hamlets into the micro-plans.

Special approaches for security challenges areas

After the killing of vaccinators in Borno and Kano States, the 2 states suspended the IPDs in March 2013 resulting in approximately 8 million children not being accessible. By May 2013, a State of Emergency was declared in Borno, Yobe and Adamawa States that led to increase in accessibility to almost 30%. The affected states with the help of EOCs started to implement innovations to reach children in these inaccessible areas. The innovations included:

- **Hit & Run:** This innovation focused on wards with WPVs that had not been accessible before. Instead of a normal 4-days IPDs, the strategy condensed implementation to 1 – 2 days with extra teams deployed.
- **Permanent Health Teams:** Derived from the Permanent Polio Teams in other security affected countries such as Afghanistan whereby discreetly elderly women were trained and provided with potent OPV vaccines and other minor health interventions. This innovation was focusing on communities with inaccessibility and non-compliance
- **Firewalling or wall fencing:** The focus was on LGAs bordering Yobe and Borno, which had explosive polio outbreaks to avoid the virus spreading over to neighboring states and countries. Vaccinations were given at crossing points using fixed posts and also in bordering communities as part of intensified outreach services.

Improving outbreak responses

The outbreaks were mostly importations from the endemic states to the North Central (FCT and Nasarawa) and North East (Gombe and Taraba). In 2013, the outbreaks in FCT, Nasarawa and Gombe did not have any break-through transmission while Taraba State had. Among the activities that were done to improve quality of mop-ups were:

- Dissemination of the revised EOC – Outbreak Response SOPs taking into account recent GPEI guidelines
- Deployment of inter-agency outbreak response team led by a senior NPHCDA outbreak response manager to infected state to coordinate and oversee responses since June 2013
- Pre-positioning of vaccines and operational funds to ensure timely and quality adequate response in Sept 2013
- Revision and updating of micro-plans and enumeration with work-load rationalization from August 2013, with verification in Sept - Oct 2013.This led to realistic workloads assigned to teams in high population density areas
- Finalized recruitment of surge capacity in these states in July 2013 with capability to support walk-through micro-plans development; timely and quality outbreak responses as per GPEI guideline

Enhancing routine immunization and in-between round activities

The focus was mostly in polio-free southern states and middle-belt states that were at risk of poliovirus importation and in LGAs in the endemic high-risk states that had low population immunity.

In the southern and middle-belt states, LGAs with an accumulated cohort of more than 2,500 unimmunized children by December 2012, were selected to conduct 3 series of weekly periodic intensification of routine immunization activities at least 4 weeks apart between September and November 2013 using tOPV and other antigens.

In the LGAs within the endemic states with cVDPV, a BMGF funded project targeted 20 LGAs was implemented. Additionally, 39 LGAs in endemic states with large numbers of unimmunized children were selected for implementation of activities to accelerate reducing number of unimmunized children.

Where these activities were implemented, there was a significant reduction in number of unimmunized children with increase in population immunity.

Other in-between round activities, included international cross-border immunization activities with Cameroun, Niger, Chad and Benin Republic to avoid exportations to neighboring countries; using other existing opportunities such as integration of OPV with other non-polio SIAs such as Measles and Meningitis; and taking advantage of the other interventions that provide opportunities to incorporate OPV such as community management of acute malnutrition (CMAM) and out-patient therapeutic programmes (OTPs) in the northern endemic states.

Enhancing AFP and Environmental Surveillance

Among the activities conducted in 2013 were expansion of informants in the weak performing LGAs as part of the surveillance network, increase in the WHO surge capacity working on surveillance, conducting rapid surveillance assessments (RSAs) in poor performing states and LGAs. A non-Polio Acute Flaccid Paralysis (NPAFP) rate of ≥2 cases per 100,000 children aged< 15 years and a ≥80% adequate stool specimen collection are indicators of quality AFP surveillance. In 2013, both indicators were met in the highest risk states with respectively 8.8 and 86.5%.

Environmental surveillance in Nigeria expanded considerably in 2013 with Kaduna and FCT included. One of the important milestones has been extension of environmental surveillance to Maiduguri in Borno State. Currently twenty sites report, including sites in Borno (4), Kaduna (2), Kano (3), Lagos (5), Sokoto (4), and the FCT (2). Between January and September 30, 2013, three confirmed environmental cases of WPV1 were detected including one in Kano and two in Sokoto.

Ibadan and Maiduguri National Polio Laboratories have been fully accredited by WHO in 2013

Intensifying communication and advocacy

There was significant programme shift in communication and advocacy strategies from city fanfare to the community level activities. To address anti-polio sentiments and violence targeting polio workers

early in 2013, the program intensified social and community mobilization activities providing opportunities for community leaders to engage in the response and become advocates for the program's success. The program also supported the establishment of health camps to provide primary care services during SIAs to address unmet health needs particularly in communities where non-compliance is high. The engagement of polio survivors to resolve non-compliant household was also a game changer as significant hard lined non-compliant communities were converted. Over 1000 members of the Polio Survivor's Association are working to enhance community engagement, particularly given the low risk perception among communities where non-compliance remains high. Religious leaders have been mapped according to sect in the high risk LGAs, and 200 focal points are engaging with local mallams and koranic school teachers to further enhance support within communities. There currently ongoing efforts to ensure that community leaders at the settlements are fully engaged (Mai-anguans). Some LGAs enlisted the support of "doctors against polio" who are local physicians who advocate for the program in the worst performing areas of the LGA.

The program expanded the recruitment of Voluntary Community Mobilizers (VCMs) to conduct social and communication outreach activities prior to vaccination campaigns, identify newborns and immunize zero dose children in-between rounds. The program also developed pro-polio CDs and launched an aggressive Bluetooth campaign to address anti-polio sentiment and counter anti-polio messages in selected areas with high non-compliance. To enhance overall campaign management, the national program is deploying interagency Management Support Teams (MST) to enhance management at the sub-LGA level and supervise SIA activities. Monitoring and accountability officers are also being used to monitor funding expenditures and increase accountability at the local level.

Enhancing the use of technological innovations

In line with polio eradication activities, NPHCDA in collaboration with other partners enhanced use of new technologies to complement the current tools and processes for mapping, micro planning and tracking of teams in the drive to improve team performance. Key among these technologies is the use of Geographic Information Systems (GIS) for tracking vaccinators during polio NIDs and analyzes data for the generation of geospatial products such as maps and charts relevant for taking informed decisions for effective program implementation.

In 2013, several activities were conducted using these new enhanced technologies focusing on the use of GIS maps in micro planning, tracking vaccination team movements during IPDs, analyzing and generation of maps, charts and graphs in relation to identifying inaccessible areas especially in security compromised states, monitoring WPV transmission and AFP surveillance. To ensure the quality of the underlying geospatial datasets used in the generation of these products, extensive field data collection and map correction was done which enabled the expansion of the number of tracking LGAs to 40 by July 2013. In addition, A3 micro planning maps have been produced and distributed to all the 8 GIS states in December 2013 for use in micro planning for IPDs. Furthermore, the GIS team in WHO office, Abuja worked with the GIS team at WHO HQ and developed a map template for Borno specifically focusing on

the LQAS coverage by round, inaccessibility at ward level, AFP case distribution. This template will be replicated for Kano, Zamfara and Yobe states and the products will be updated on monthly basis.

2.3. SIA Calendar for 2014

It is important that the momentum that led to the marked progress towards interrupting wild poliovirus transmission in 2013 be sustained with acceleration to achieving interruption in the shortest possible time in 2014.

To have consensus on the scope and number of IPDs rounds in 2014, the Government of Nigeria held a consultative meeting with the Global Polio Eradication Initiative (GPEI) spearheading partners in Abuja on 25 November 2013 which was followed up by endorsement by the 26th Expert Review Committee (ERC) which was held from 26 – 27 November 2013. The theme for 2014 will be improving quality with close monitoring of quality pre -; intra-; and post – IPDs activity. The monitoring will be done by a revised IPDs Dashboard that will look at quality issues than just achievement of milestone indices. The activities to be adequately implemented with quality between IPDs rounds are in Annex 1

The IPDs schedule for 2014 includes:

- 2 Nation-wide IPDs round
- 7 Sub-national IPDs (which will include conducting special rounds for underserved, child health weeks etc.)

The choice of the antigens to be used for the rounds will take into consideration the evolving WPV and cVDPV epidemiology. The EOC will ensure that the antigens to be used for the rounds are determined and orders placed on time to ensure availability of scarce polio vaccines.

The scheduled dates of 2014 IPDs are in Annex 2

2.4. Geographic Focus for 2014

Although there has been geographical restriction of polio transmission in the country with only 4 out of 11 very high risk states infected in 2013, the population immunity is frail with a real risk of re-infection of states that have not reported any cases in 2013. Re-infection of these states would be a great setback to the progress being made and the country may fail to achieve interruption in 2014 and beyond.

The geographical focus for the 2014 National Polio Eradication Emergency Plan takes into consideration the goal that polio transmission should be interrupted in 2014, noting the existing risks and threat which include:

- **Population immunity**

It is important to note that during the 3rd quarter of 2013, only 2 IPDs were conducted in July and September 2013 covering all the 11 very high-risk endemic states. This followed a significant disruption

in the program in the 2nd quarter when vaccinators were murdered in Borno and Kano, leading to the cancellation of the March campaign, and a downturn in quality until July. In the 4th quarter of 2013, only the December 2013 IPDs was a house-to-house IPD rounds covering all the 11 very high-risk states. Although the November round was IPDs in 8 States, the other SIAs were integrated with measles and meningitis (October and November, respectively) in 3 out of the 11 very high risk states and as such fixed posts were used with significantly less number of children reached with OPV.

For example, using LQAs estimates, in the September 2013 House-to-House IPDs 26% of the LGAs had less than 80% coverage and this increased to 31% during the November campaign but improved marginally (29%) during the December 2013 IPDs campaign. Thus, some of the very high-risk states have not maintained the desired population immunity by the 4th quarter of 2013.

Additionally in 2013, there has been heterogeneity of IPDs quality resulting in fragility of population immunity. Analysis of IPDs performance reveal that there are still persistently poor performing LGAs, with some having declining performance in the North West Zone that have not reported any WPVs in 2013. For example in Zamfara, the proportion of LGAs accepted at 90% by LQAS declined from 83% in April 2013 to 50% by September 2013. For a similar period, there has also been an increase in proportion of LGAs in North Western states (Kebbi, Kaduna, Jigawa) that have been rejected at 80%. In Sokoto, the proportion of LGAs rejected at 60% has remained around 10% for most of the IPDs rounds since April with still 5% of the LGA rejected at 60% during the September IPDs round.

The 4th quarter 2013 recent Global Goods risk analysis also revealed the fragility of the population immunity in the northern States despite some very high risk states not reporting cases in 2013. Its modeling of Type 1 herd immunity in the 10th percentile (i.e., worst performing) LGAs indicate that Borno (48%), Yobe (58%), Zamfara (64%), Kano (71%), Sokoto (72%), Kaduna (76%), Jigawa (80%), Katsina (80%) and Bauchi (83%) are either well below or just close to thresholds needed to prevent narrow transmission. Only Niger and Kebbi seem to be well above thresholds in the 10th percentile LGAs to prevent transmission as this point. Due to the heterogeneity of population immunity among LGAs within states, it is important that the 11 very high risk states be adequately covered with IPDs during the December round.

Sero-prevalence studies conducted in Kano State from September to October 2013, revealed that while the sero-prevalence rates remained similar for children 36 – 47 months of age comparing 2011 and 2013 (type 1 from 91% in 2011 to 93% in 2013; type 2 from 87% in 2011 to 85% in 2013; type 3 from 85% in 2011 to 87% in 2013), there was a significant drop in sero-prevalence levels among infants of 6 -9 months of age (type 1 from 81% in 2011 to 59% in 2013; type 2 from 75% in 2011 to 41% in 2013; and type 3 from 73% in 2011 to 51% in 2013). The drop in sero-prevalence among infants 6-9 months of age constitutes an ideal environment for epidemic transmission of wild poliovirus type 1 and epidemic transmission of cVDPV2.

- **Continued WPV and cVDPV circulation**

With this fragile population immunity in 2013, the continued transmission of WPVs in Bauchi State and Kano State, in particularly, as late as October 2013 poses a great threat to re-infection of the states in North West and North East. The breakthrough transmission in Kano with low sero-prevalence rates has been due to persistently poor performance during IPDs as the proportion of LGAS accepted at 90% by LQAS have not reached above 35% in all rounds in 2013. Kano, too, has the highest number of unimmunized children based on routine immunization data in 2013. Kano is a commercial hub of northern Nigeria and beyond. During the dry season, farmers and traders from Northern states and beyond the borders, make long journeys to Kano to sell their farm produce and buy commodities. These long journeys across states have in the past attributed to long range WPV transmissions from Kano to other states and beyond.

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.
The detection of wild poliovirus in environmental samples from Sokoto state in 2013 highlights the need to ensure continued focus on improving quality and sustaining intensity of polio eradication activities in all the high-risk northern states, even those that did not have any confirmed WPV detected by AFP surveillance. In these states, enhancing population immunity through implementation of very high quality SIAs, intensifying routine immunization as well as closing surveillance gaps will be emphasized.

- **Security compromised states / areas with inaccessibility**

Borno State has not been able to conduct all the planned rounds in 2013 due to inaccessibility caused by insecurity while Yobe State has not conducted quality rounds due to security concerns. While there's been progress in getting the program restarted after the cancellation of the round in March, some 480,000 children of a target population of 1.6 million under five in Borno state could not be immunized in September. In November 2013 IPDs, 2 LGAs (Dikwa and Kaga) out of 27 LGAs did not participate. Among the 25 LGAs that participated, 5 LGAs did not have all the wards within the LGA participating. The continued circulation of polio in Borno and Yobe States and the isolation of VDPVs in the recently established environmental surveillance samples from Maiduguri in October 2013 pose a risk of polio spread to the states and beyond Nigeria. It is important to note that there is continued movement into and out of these states with the fluctuating security situation, which poses a huge risk to re-infect other states that have not reported cases in 2013.

- **Surveillance gaps**

Furthermore, although there has been improvements in AFP surveillance performance in 2013 compared to 2012 with more AFP cases detected compared to previous years, strengthening of reporting networks including informants, and further capacity building and engagement of the surge

capacity in surveillance activities. However, despite the progress, there has been detection of orphan viruses and classification of compatible cases, which reveal surveillance gaps in Katsina, Kano, Niger, Taraba, and Cross River states. Therefore there is the need to increase population immunity in very high risk states to deal with any undetected polio circulation.

In 2013, there was detection of poliovirus from environmental samples in high risk state (Sokoto) that did not have any poliovirus confirmed from AFP surveillance.

It is, therefore, important that the country increases population immunity in the very high risk states during the low transmission season through conducting adequate number of OPV rounds that cover the very high risk states to avoid any re-infection that could be disastrous to the programme and threaten achieving interruption in 2014. It is important to note the goal of 2014 is to achieve interruption (zero cases after June 2014) and not to reduce number of cases, so the population immunity has to be increased in a large enough geographical area to avoid any single breakthrough transmission in the low transmission period.

3. GOAL, TARGETS, AND MILESTONES

3.1. Goal

The overall goal of the NPEEP 2014 plan is to achieve interruption of poliovirus transmission by the end 2014.

3.2. Targets

Target 1: Zero new WPV cases with onset after June 2014

Target 2: 80% of LGAs accepted at 80% coverage by LQAs by June 2014

Target 3: In highest risks LGAs, 90% of the wards to achieve 90% coverage, by independent monitoring by June 2014

Target 4: Sustained control of cVDPVs thru June 2014 and interruption of persistent cVDPV transmission by end 2014

Target 5: No breakthrough WPV or cVDPD transmission following importation of poliovirus to polio-free States

3.3. Milestones

- 80% of the very high risks LGAs achieve at least 80% coverage as demonstrated by LQAs by April 2014.
- 100% of the micro-plans updated in all high risk states with incorporation of GIS information, where mapping has been concluded, by March 2014
- 100% of the micro-plans updated in outbreak prone states with timely implementation of the mop-ups by April 2014.Updating of micro plans shall be a regular and routine exercise
- Security compromised states with inaccessibility issues conduct at least 4 IPDs in all LGAs by May 2014

- Operational plan for security affected states of Borno and Yobe finalized and implementation being closely monitored by March 2014.
- Vaccinators in 60 LGAs of states tracked with GPS during each IPD round by April 2014.
- Documented vaccinator selection, training using visual - pictorials and documented teams in all VHR LGAs by June March 2014.
- 100% implementation of the new team composition structure in all states by March 2014
- 100% implementation of demand creation activities targeting non-compliant areas in all persistently poor performing wards in very high risk LGAs by March 2014
- Full functioning Yobe State EOC by April 2014.
- 100% implementation of timely outbreak response for all WPV/cVDPV viruses detected by AFP or environmental surveillance in polio free states 3 series of periodic intensification of routine immunization activities (PIRI / LIDs) conducted in LGAs with large number of unimmunized children in polio free states in the southern part of the country and Middle-belt states to avoid importation by November 2014
- Establish hard-to-reach and underserved mobile outreach health services in 2,000 communities in Kano, Bauchi, Borno and Yobe and achieve >80% coverage with >3 doses of OPV in under-5s in these communities by December 2014.

OVERSIGHTS AND MANAGEMENT

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

4.1 National Level

The Federal Government of Nigeria will continue to:

- Ensure effective leadership and coordination of bodies established to enhance programme coordination for both polio eradication as well as the broader Immunization programme i.e. the Presidential Task Force on Polio Eradication (PTFoPE), the Inter-agency Coordination Committee (ICC) and the ICC Working Groups. The Federal Government will also continue to provide leadership of the National Polio Eradication Emergency Operations Centre (EOC), the implementing organ for polio eradication activities.
- Provide enabling environment for strong partnership with Traditional leaders, Religious Leaders, Community and Faith Based Organizations, Women Organizations, Professional Organizations as well as donor and technical partner agencies. These partnerships will be optimized to support the effective implementation of key aspects of the 2014 NPEEP at all levels, from Federal to community level.
- Support resource mobilization from domestic and international sources for timely and effective implementation of the 2014 NPEEP. Resources include financial, human and logistical/material resources.

- Lead activities aimed at monitoring the implementation of the 2014 NPEEP, priority setting as well as re-programming at regular intervals.
- Oversee advocacy efforts targeting the other tiers of Government (State and Local Government) to ensure full ownership of 2014 NPEEP priorities, strategies and activities by all key stakeholders.

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

4.1.1. Presidential Task Force on Polio Eradication (PTFoPE)

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

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

4.1.2. National Primary Health Care Development Agency (NPHCDA)

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

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

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

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

4.1.4. Nigeria Governors Forum (NGF)

The Nigeria Governors' Forum is a member of the Presidential Task Force on Polio Eradication (PTFoPE). In 2012, the NGF adopted discussions on polio eradication as a standard agenda item during the monthly Governors' meeting. This contributed significantly to keeping Polio Eradication on the front

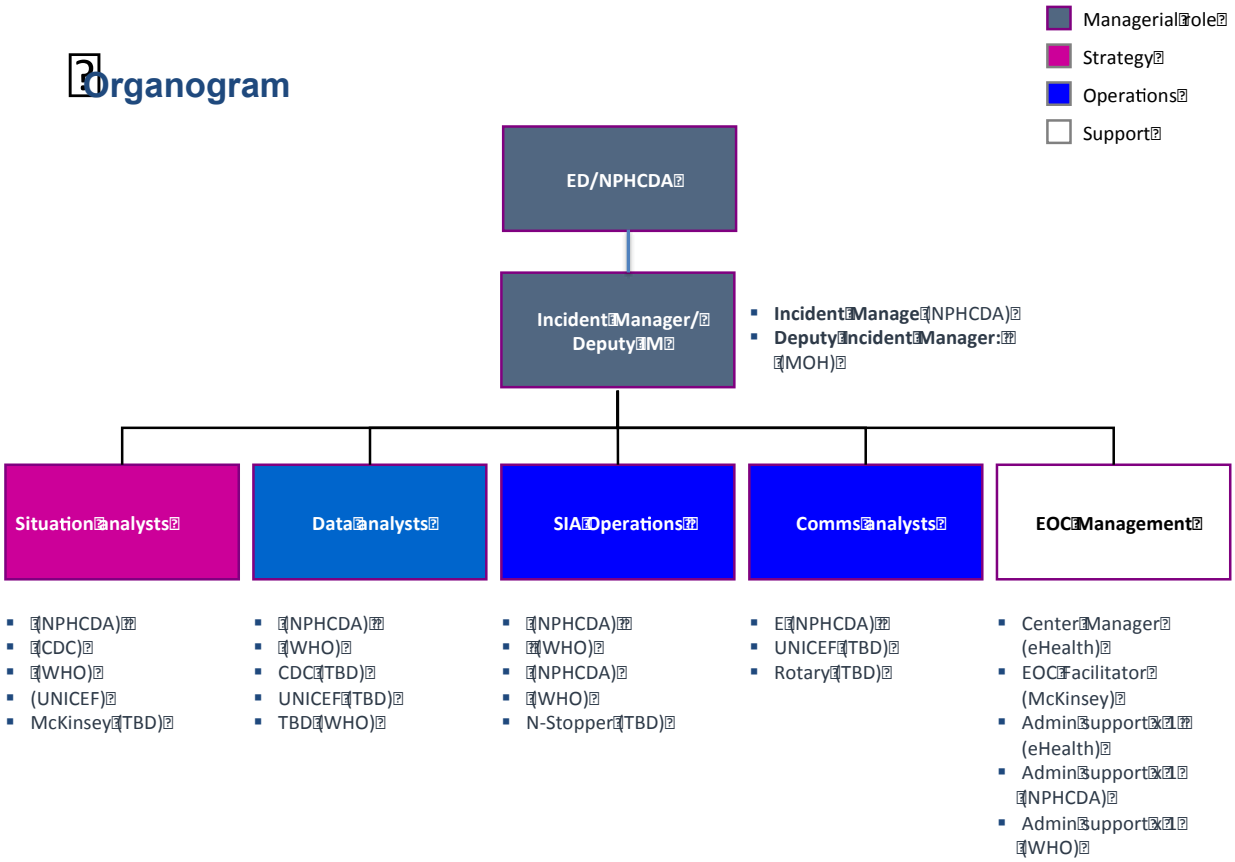
banner regarding Governor's priorities. The NGF also took a decision to raise the profile of State Task Force on Immunization by ensuring that Deputy Governors chaired these Task Forces.
It is expected that during the very critical period of 2014, the NGF will continue to prioritize and support the intensified polio eradication effort.

4.1.5. National Polio Eradication Operations Centre (EOC)

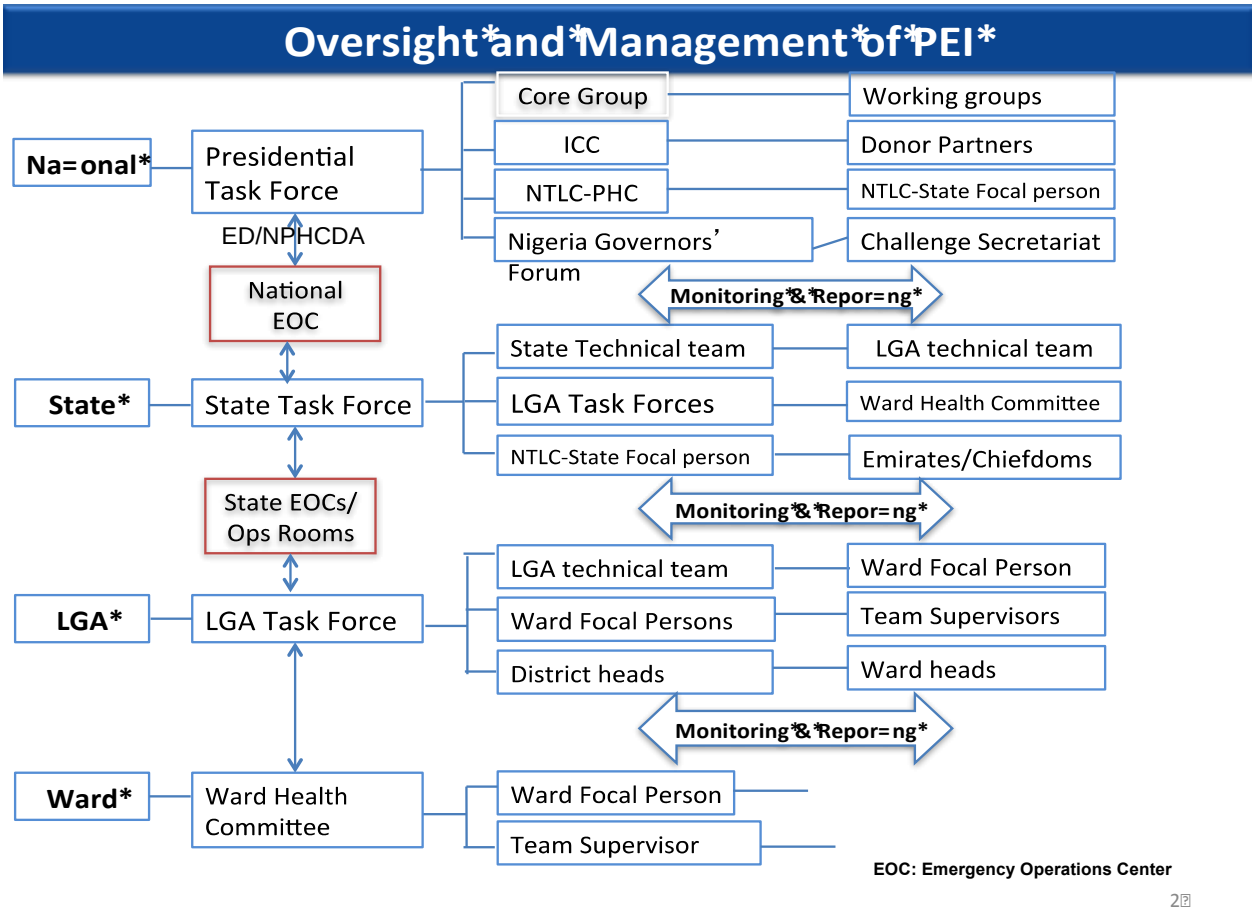
A significant change in the 2013 National Polio Eradication Emergency Plan, as compared to the 2012 NPEEP is the introduction of Emergency Operation Centers (EOCs) at the national level and in 5 high-risk states. The EOCs are the operational/programme management areas of the Presidential and State Task Forces. The EOCs provide a setting where key government and partner staff can work together in the same physical location with the aim of improving decision making, information sharing, conducting joint planning and programming, and implementing new strategies to increase the effectiveness of the polio programme. The EOCs bring together senior, action-oriented national authorities with support from partners to make data-driven decisions that will address persistent gaps in programme implementation at all levels.
On October 23, 2012, the Presidential Task Force on Polio established an Emergency Operations Center at the national and in selected states to help manage PEI activities in Nigeria.

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

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



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



4.2 State Governments

State Governments will continue to:

- Ensure effective leadership and coordination of State Task Force on Immunization, the State Technical Team as well as State Technical Working Groups
- Provide leadership of the State Polio Eradication Emergency Operations Centre (EOC)[1]as well as State Operations Rooms.
- Support partnership with Traditional leaders, Religious Leaders, Community and Faith Based Organizations, Women Organizations, Professional Organizations as well as donor and technical partner agencies. These partnerships will be optimized to support the effective implementation of key aspects of the 2014 NPEEP at all levels, from State to community level.
- Support resource mobilization through timely release of counter-part funding as well as provision of human and material resources to complement those released from national level.
- Oversee monitoring the implementation of the 2014 NPEEP at State level as well as in the various LGAs, with particular focus on high risk LGAs.

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- Oversee advocacy efforts targeting LGAs to ensure full ownership of 2014 NPEEP priorities, strategies and activities by all key stake-holders including professional organizations (e.g. Nigerian Medical Association, Pharmaceutical Association of Nigeria and civil society organizations).

4.2.1 State Task Forces

The State Task Forces on Immunization are chaired by Deputy Governors and are expected to meet regularly to review the progress in achieving PEI/RI targets in the States, identify remaining challenges as well as appropriate issues to address the remaining challenges. It is expected that in 2014, State Task Forces will continue to be an important forum to bring together key political leaders, Traditional and Religious leaders as well as health workers, to oversee the critical activities implemented at State level and in all LGAs, particularly the Very High Risk and High Risk LGAs.

4.2.2. State EOCs/State Operations Rooms

The State EOCs are the operational/programme management areas of the State Task Forces. In States without EOCs, this function is to be performed by State Operations Rooms. In January 2013, the first state EOC was launched in Kano. Additional EOCs were set up during the year in Katsina, Kaduna, Sokoto, and Borno Similar to the national EOC, state-level EOCs will include membership from all partner agencies who co-locate and work together for maximum efficiency. In states where EOCs are not established state teams will be responsible for managing and implementing the polio programme.

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

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

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

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

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

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

4.3 Local Governments

Local Governments will ensure effective leadership and coordination of LGA Task Force on Immunization and the LGA Technical Team. The LGAs Governments are also expected to support partnership with influential community leaders including Traditional leaders, Religious Leaders, Community and Faith Based Organizations, Women Organizations as well as Professional Organizations. These partnerships will be optimized to support the effective implementation of key aspects of the 2014 NPEEP at all levels, from LGA to community level.

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

The LGAs are expected to oversee monitoring the implementation of the 2014 NPEEP at LGA and ward, with particular focus on high-risk wards.

The LGAs will also oversee advocacy efforts targeting LGAs to ensure full ownership of 2014 NPEEP priorities, strategies and activities by all key stakeholders.

4.3.1. LGA Task Force

The LGA Task Forces on Immunization are chaired by LGA Chairmen and meet at least once monthly to review the progress in achieving PEI/RI targets in LGAs, identify remaining challenges as well as appropriate issues to address the remaining challenges. It is expected that in 2014, LGA Task Forces will continue to be an important forum to bring together key political leaders, Traditional and Religious leaders as well as health workers, to oversee the critical activities implemented at LGA level and in all wards, particularly the Very High Risk and High Risk wards.

4.4 Independent Advisory bodies and Global Partners

4.4.1 GPEI Partners: GPEI partners and donors are expected to support the national authorities to effectively implement the key activities included in the 2014 NPEEP. The GPEI partners are also expected to support resource mobilization.

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

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

5. STRATEGIC PRIORITIES FOR NPEEP 2014

The strategic priorities identified by the EOC after consultation with immunization partners and local stakeholders include: (a) improving IPDs quality in persistent poor performing LGAs / Wards; (b) increasing reach of children with OPV in the security compromised areas; (c) rapidly containing circulation in the breakthrough polio transmission zones; (d) mounting timely and adequate polio outbreak responses; (e) Reaching children in underserved populations (f) intensifying surveillance; (g) expanding technologies / innovations to further improve micro-planning and team performance; (h) intensifying communication and demand creation; (i) Boosting child immunity in-between rounds and in polio-free states; (j) optimizing human resources and stricter implementation of the accountability framework

5.1 Improving IPDs quality in persistent poor performing LGAs / Wards

Improving IPDs quality will be key to achieving interruption of wild poliovirus by December 2014. It is important that all critical activities are implemented with quality and closely monitored using the polio dashboard that will be revised to monitor quality of implemented activities. The National IPDs Guideline provides the necessary milestones that have to be achieved to improve the quality of IPDs rounds. The current tool used to monitor the level of preparedness milestones is the EOC IPDs Dashboard.

To avoid re-inventing the wheel, it is important to identify some key IPDs dashboard indicators that did not improve with time and continued to affect the quality of IPDs rounds in 2013. These included: timeliness of release of counterpart funding by State and LGAs, untimely availability of social mobilization and logistics funds which meant that planned activities could not be implemented on time due to lack of resources. Additionally, while dashboard reports did not show much problems but anecdotal and field supervisory reports during IPDs implementation indicated issues with processes such as team selection by ward selection committees, quality of training, team composition and quality of micro-plans.

It is also clear is that the IPDs rounds improved with time comparing the proportion of persistently poor performing LGAs that had LQAs rejected at 80% and that improvement could be associated with intensification of prioritized innovations / approaches implementation with time in these LGAs (prioritization and focus of resources in persistently poor performing LGAs, intensifying supervision, staggering, provision of demand creation packages, etc.)

Implementation of the accountability framework on government and partners, including stakeholders, will be crucial for improving quality of IPDs in 2014.

5.1.1. Activities

5.1.1.1. Improving team performance

Poor team performance, which manifests as child absent and households not being visited during IPDs, has been the largest contributor to poor quality of IPDs in 2013. To reverse the situation in 2014, the critical activities will include:

5.1.1.1.1 New team restructuring: It is important the teams be re-structured to improve efficiency and also tackle the issues of child absent and households not being visited. As such, the 4 member House-to-

House team composition has been revised from having one vaccinator, **one recorder**, one supervisor and one community leader to a 3 member team comprising of one vaccinator, one supervisor (who will also do recording) and one community leader. The smaller team will be allocated less number of households (from 150 to 120 in urban areas and from 80 to 60 in rural areas). The new team will have reduced workload and improve efficiency. This will ensure that the teams visit all assigned households, have time to ask the 6 key questions to avoid missing children in houses and also a smaller geographical area to ensure that revisits are done.

5.1.1.1.2 Ward selection committee meeting endorsement: Ward focal persons and agency staff working at the LGA should take an active role in ward selection committee processes to improve team selection. States and LGA Task Force 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. The new ward focal points will be oriented by LGA teams on ward selection issues and composition of the committee. A responsible coordinator from a partner agency will oversee the selection process of teams in poor performing LGAs and wards. The programme is focusing 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 ward selection meetings have been done and vaccination team members selected as per set National IPDs Guideline criteria. Additionally, the dropping of Group Supervisors in late 2013 and the new change of the team composition from a 3-technical vaccination team to 2 take place in early 2014 (drop the recorder), will increase the pool from which to select good team members in 2014.

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

5.1.1.1.4 Decentralization of National EOC activities from Abuja to the states, LGAs and Wards: Members of the National EOC will in line with models used in 2013, spend more time in poor performing states to provide technical support to LGAs and wards. This will involve intensive monitoring of work plans, and implementation of the NPEEP in a way that ensures that agreed activities and timelines are adhered to.

5.1.1.1.5 Micro-planning revision and extension of enumeration: Extensive walk-throughs to revise micro-plans in very high risk and persistently poor performing LGAs will be conducted before each round of IPDs. However, in other LGAs, it would be conducted every **6 months** with updating based on IPDS performance data.
Enumeration in hard to reach, scattered settlements, nomadic populations and border areas will be expanded to areas where the activities have not been completed.

5.1.1.1.6 Enhancing training quality: The new training methodology using visual aids / pictorials will be expanded to all LGAs in very high risk states by March 2014. Where applicable, the stall-methodology will be used. There would be a reduction in the number of tally-sheet analyses for workload rationalization in specific wards / settlements after every IPDs round.
Most significant is the fact that training at the ward level will no longer be delegated; senior programme officers led by the PHCC along with partners will oversee training directly ward levels. Major quality issues were due to delegation of training less technical staff at the ward levels. We shall continue to fix team selection and training issues at the operational level by this oversight function.

There should be fewer categories of participants per training venue to ensure that adequate time is allocated for trainings, which would result in better focused training per venue. Critical is the issue of OPV management and accountability; particularly at vaccination team level, vaccination distribution point and ward level will be emphasized. Logistics Working Group at State and LGA level will be held accountable for OPV management modules.

5.1.1.1.7 Timely social mobilization funds and demand creation packages availability: while UNICEF may have released the social mobilization funds on time, the funds have not been "deliberately" released timely by the State Government to LGAs, and from LGAs to planned activities in non-compliant wards. To ensure that the processes for timely release of funds are addressed, it will be important that state proposals for new funding requirements and funds liquidations from previous rounds are timely submitted to UNICEF. Part of the problem is due to late retirement of funds expended by the state/LGAs. Quarterly fund release to states should be encouraged.
Budgets for funds to support other *demand creation packages* such as: pluses, polio survivors groups, koranic school teachers, mallams sensitizations, health camps etc. for persistently poor performing wards should be timely submitted to LGAs Task Forces, State Task Forces or State EOCs, and national EOC at least 3 weeks before the IPDs round for mobilization of resources.

5.1.1.1.8 Logistics funds availability: While the funds used for ensuring functional cold chain (fueling generators to freezing ice-packs) has not been a big problem i.e. there has been no problems with OPV-VVM stages during IPDs rounds based on intra-campaign data, the component of logistics funds that is used for mobility of teams have not been transparently provided by ward focal persons during implementation resulting in teams not having enough logistics to hire appropriate transport. The partners supervising the LGAs will be monitoring during campaigns using the revised checklist and report at evening meetings and feedback what proportion of teams reported having received adequate logistics funds for their daily movements and accountability of ward focal persons.

5.1.1.1.9 Timeliness of release of counterpart funding: There has been no improvement in this indicator in 2013. The priority in 2014 will be to monitor and document the amounts released for continued high level advocacy to the State Governors and Commissioners of Health.

5.1.1.1.10 IPDs Dashboard Monitoring: There will be a shift from the dashboard use to monitor timeliness of implementation of milestones to quality of implementation of the milestones. As a result

the dashboard will be reviewed by the National EOC. Additionally, there will be stricter monitoring of the revised dashboard indicators so that activities are conducted as planned with accountability measures taken at all levels.

5.1.1.1.11 Improve SIA monitoring (EIM and LQAS) and operational Research: To ensure quality data from independent monitors, the agency staff will develop independent monitors deployment schedule to wards and settlements, strictly supervise and monitor adherence to the plan. The state / LGA team will validate at least 10% of the independent monitors' data.

LQAs verification will continue to take place after each round and where anomalies are found between the surveyor and verifier data, the surveyor will be held accountable.

5.1.1.1.12 Pre- / Post-campaign review meetings: The analyzed LQAs performance data is available at national level and shared 5-6 days after the IPDs which is supplemented by the EIM data few days later. This allows for a meaningful review meeting to be conducted within 2 weeks of finalizing the IPDs round. The National and State EOCs / State Technical Teams and LGA Technical Teams will prepare analysis of critical performance indicators and ensure that review meetings with influential stakeholders are conducted pre-/post – each IPDs to ensure that all impediments from previous rounds are addressed before subsequent rounds. Additionally, these review meetings will ensure that accountability issues are thoroughly discussed and provide an opportunity to give rewards for good performing teams and sanctions for poor performing teams.

5.1.2. Targets, Milestones and Indicators:

- 100% implementation of the new vaccination team structure by March 2014
- Completed re-deployment of Government and partners staff based on competence by February 2014
- 100% revision of micro-plans with incorporation of GIS maps information and enumeration by April 2014 IPDs
- 100% trainings for vaccination teams using pictorials / visual – aides by February 2013 IPDs
- Timely deployment of MST for adequate supervision based on new formula by February 2013
- Full provision of SOCMOB human resource and planned demand creation commodities by February 2014
- Completed revision of the IPDs Dashboard by January 2014

5.2. Increased reach in security-compromised areas

One of the major setbacks towards efforts to halt transmission in 2013 was insecurity resulting in the killing of vaccinators in Borno and Kano States. The deteriorating security situation led to suspension of IPDs activities in March 2013 with close to 8 million children not being vaccinated with OPV of which about 1.6 million were from Borno State. Despite that both states resumed IPDs activities in April 2013, by June 2013, there were still about 939,000 children inaccessible in Borno in 131 out of 306 wards involving 6714 settlements out of a total 11742 settlements in the state. The June 2013 IPDs were conducted in only 12 out of 27 LGAs. By October 2013, there was an increase in access with about

488,000 children still not accessible in 85 wards in close to 3,000 settlements and IPDs were conducted in 22 out of the 27 LGAs in the state. The inaccessibility resulted in a huge polio outbreak in Borno and Yobe in the first half of year.

To curtail the spread of the outbreak, innovations to reach children in the security inaccessible areas were commenced in June 2013 and they included conducting Permanent Health Teams a modification of the Polio Permanent Teams in Afghanistan which has similar security challenges; Hit & Run strategy where increased number of teams vaccinated children in 1-2 days instead of the traditional 4 days IPDs; and Fire-walling where children were vaccinated as they were crossing over from the security compromised states to neighbouring states or countries. Additionally, there was intensification of outreach activities for tOPV and other antigens as part of strengthening routine immunization services in the bordering wards of these security compromised states.

5.2.1. Activities

5.2.1.1 Conduct monthly security risk assessments to determine accessibility for PEI/EPI activities. These will continue to be conducted with the help of the security and intelligence officers who are part of the State Task forces. The implementation of the planned IPDs will be geographically adjusted according the prevailing security risk assessments.

5.2.1.2 5.2.1.2 Finalize operational plan for Borno and Yobe: This operational plan, which will be updated after 6 months, will have clear goals, appropriate strategies according to risk situation of each LGA in these states as well as well laid out monitoring mechanism. The plan will also be flexible to allow for rapid changes wherever these may be necessary.

5.2.1.3 **Ensure the deployment of both National and state EOC personnel:** In continuation of the strategies developed in 2013, officers from the operations group of the National EOC who constitute the Borno-Yobe strategy group will continue to provide field based technical support to the security compromised areas.

5.2.1.4 **Conduct "Catch-up" OPV contacts** in wards that did not participate in planned 2013 IPDs rounds to further improve population immunity in the targeted LGAs, wards and settlements. At least 4 catch-up rounds will be conducted in the low transmission season in 2014. This is shown in the attached six-months operational plan.

5.2.1.5 **Expansion of "Hit & Run"** to all wards with new WPV or cVDPVs with accessibility challenges that did not achieve high quality IPDs during "catch-up" contacts.

5.2.1.6 **Expansion of Permanent Health Teams** to wards and settlements with inaccessibility challenges and persistent non-compliance.

5.2.1.7 **Expansion of Fire-walling innovations** to all LGAs on the borders of Borno and Yobe; and also LGAs in Adamawa, Gombe, Bauchi and Jigawa States which share borders with Borno and Yobe

States. As the WPV get more and more geographically restricted to some inaccessible wards, the program will expand the firewalling to surround wards bordering these areas with limited access; this is to ensure that immunity levels reach levels that can prevent narrow transmission within the security compromised areas.

5.2.1.8 **Establish permanent vaccination sites at all major border transit points**. Priority in establishing permanent vaccination sites will be given to Very High Risk LGAs as well as LGAs that were previously inaccessible. Wherever feasible, trained health workers who can administer injectable antigens will be recruited so that all RI antigens can be given in addition to OPV. In areas with no capacity to deploy trained health workers to be included in the permanent vaccination sites, volunteers would be recruited and they would administer OPV and any other less demanding intervention available e.g Vitamin A.

5.2.1.9 **Establishing Health Camps and expanding Outpatient Therapeutic Programme (OTP) / CMAM.** In the insecurity areas, the population has been deprived of many health services in addition to OPV. Providing comprehensive services such as antenatal care, screening for chronic disease and treatment of common ailments has pulled crowds to where health camps are operated. Indeed, in areas which where hitherto inaccessible, provision of this interventions has opened up populations to OPV vaccination. Interventions in these camps also include "pluses" such as multivitamins and household items. Additionally, there are unconfirmed reports of malnutrition due to lack of access to food. Therefore, as part of in-between round activities in the security compromised areas, health camps will be established; and OTP and Community Management of Acute Malnutrition (CMAM) centres expanded. These avenues will be used to increase uptake of OPV.

5.2.1.10 **Establishment of Hard-to-Reach Initiative:** These will be implemented as part of strengthened outreach to remote areas with reasonable access. In particular, the activities will be conducted as a modified Boosting Child Immunity in areas that are difficult to reach due to terrain, flooding etc. These will be week long activities targeting some 2000 communities in Kano, Bauchi, Borno and Yobe states.

5.2.1.11 Enhance AFP surveillance in these areas in order to ensure that cases continue to be reported outside of the orthodox health infrastructure. There will be a conscious effort to increase the number of community-based informants who have regular meetings with DSNOs and facility based focal persons.

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

5.2.2. Targets, Milestones and Indicators:

- Operational plan for security affected states of Borno and Yobe finalized and implementation being closely monitored by March 2014.
- Conduct 4 “Catch-up” OPV contacts in wards that did not participate in planned IPDs rounds by May 2014
- Conduct 3 “Hit & Run” mop-ups to all wards with WPV and accessibility challenges that did not achieve high quality IPDs during “catch-up” contacts by May 2013
- Permanent Health Teams established in all wards with inaccessibility challenges and persistent non-compliance by January 2014 with monthly reporting of data
- Fire-walling established in all LGAs on the borders of Borno and Yobe by March 2014 with monthly reporting of coverage data
- Health Camps and CMAM sites established and expanded to reflect the number of poor performing wards and non-compliant sites by May 2014
- Child Health Weeks established in specified LGAs in Borno, Yobe, Kano and Bauchi by June 2014

5.3 Rapidly containing circulation in the breakthrough polio transmission zones

Although there were 50 WPV1 cases reported in 29 LGAs in 2013, slightly above half (27 cases) were reported in 7 LGAs in 4 states. In Borno (7 in Maiduguri, 6 in Jere, 2 in Damboa), Kano (4 in Bauchi and 3 in Dambatta), Bauchi (5 in Bauchi LGA) and Taraba (2 in Gassol). The other 22 LGAs did not have break-through transmissions.

It is therefore important that during the low transmission period, activities are conducted to knock out any remaining circulation.

In the last 6 months of 2013, as of 1 December 2013, out of the 14 WPV cases, 9 (64%) were from Kano State with Borno (3), Bauchi and Taraba States had one case each. The majority of the cases in Kano were in the Bichi (northern Kano LGAs Cluster of Bichi, Dambatta and Makoda), the central Kano Metropolitan LGA Cluster (Nasarawa, Kumbutso) and Southern Kano (Doguwa LGA). The LGAs in the northern axis and Southern axis of Kano border Katsina and Kaduna LGAs that had the largest number of cases in 2012.

It is therefore important that, as part of the low transmission season priorities, conduct high quality IPDs in infected LGAs and surrounding LGAs of the transmission zones to avoid breakthrough transmission.

5.3.1. Activities

5.3.1.1 Revision of micro-plans and enumeration: Prioritize revision of micro-plans through walk-throughs, validation of plans and workload rationalization in the infected LGAs and surrounding LGAs in the infected states by February 2014.

5.3.1.2 **Establish Permanent Vaccination Teams:** Conduct rigorous selection of vaccination teams members with oversight by the State Technical Teams /State EOC to ensure that the team

members meet the set criteria. Concentrate training in these LGA with all appropriate training materials. Once trained, the selected vaccination team members should be registered with identification cards, so that as Permanent Vaccination Teams they can be retained for subsequent rounds till the end of the low transmission season in 2014.

5.3.1.3 **Implementation of ward level dashboard:** To ensure that pre-, intra-; and post – implementation activities are monitored at the ward level for quality, the dashboard for these LGAs will be modified to the ward level. The State and National EOC will be focus on ensuring that corrective measures including accountability are implemented at the ward level.

5.3.1.4 **Intensified supervision**: Depending on the IPDs performance of these LGAs in the rolling 4 past rounds, Management Support Teams (MSTs) comprising of senior supervisors from the national level (NPHCDA and partners) and State level will be timely deployed to the LGA for further deployment to the specific wards at least a week before implementation. The new formula for deploying the MST will be: if the ward >10% missed children in 3 – 4 IPDs, then 3 MSTs will be deployed; and if the ward had 1-2 rounds >10% missed children then 2 MSTs will be deployed.

5.3.1.5 **Full provision of SOCMOB human resource and demand creation commodities:** It may be difficult to guarantee provision of community mobilization to full capacity (PSGs, mallams, koranic school teachers etc.), including the spectrum of demand creation commodities by the LGA counterpart funding. As such for these LGAs and wards, in addition to the amounts the LGA will provide, the state supported by NPHCDA and partners will support timely availability of these requirements.

5.3.1.6 **Conduct post-IPDs mop-ups based on independent monitoring and LQAS performance:** The data from the intensified deployment of supervisors, implementation checklists, concurrent monitoring, in-process monitoring and LQAS will be used to ensure that mop-ups are conducted until the IPDs round is of high quality.

5.3.2 Targets, milestones and indicators

- Revision of micro-plans and enumeration completed by January 2014
- Permanent Vaccination Teams operational from February 2014
- Ward level dashboard functional from January 2014 IPDs
- Timely deploy planned adequate MST for adequate supervision based on new formula by November 2013
- Full provision of SOCMOB human resource and planned demand creation commodities by January 2014 IPDs
- Conduct post-IPDs mop-ups based on LQAS performance from January 2014 IPDs

5.4 Outbreak response to WPV and cVDPV

The continued WPV circulation in the very high-risk endemic states resulted in infection of previously polio free states. The polio free states that were infected in 2013 included FCT (1 case), Nasarawa (1 case), Gombe (2 cases) and Taraba 3 cases. Some of the oubtreaks were a result of spillover transmission from outbreaks in these states from 4th quarter of 2012. A reasonable proportion of these outbreaks however happened through importations from the very high risk states such as Katsina, Kano, Jigawa and Yobe States.

The continued transmission from late 2012 in some states was a result of the poor quality of mop-up responses. As a result, walk-through microplans had to be done in the states with workload rationalization. It was necessary that these activities be conducted although they delayed the mop-up response timeliness. Out of the 6 outbreaks, 4 mop-up responses were not on time, the 2 delayed responses being in Gombe State.

In addition to micro planning, there were shortages of vaccines globally to meet the mop-up responses requirements and funding was not readily available at state and LGA levels to timely conduct the mop-ups.

Among the major activities that were done by the EOC were to finalize the EOC-Outbreak Response Standard Operating Procedures (SOPs) to ensure adherence to the GPEI polio outbreak protocol; ensure that walk-through micro-plans were conducted in outbreak states in preparation of any outbreak that may happen (but not all LGAs in these states have been completed); a NPHCDA outbreak response manager and EOC Outbreak Response team were constituted that timely reacts to outbreaks; vaccines and operational funds were pre-positioned to timely response to outbreaks

5.4.1 Activities

Most of the outbreak activities in 2014 will continue to build up on the foundation laid in 2013

5.4.1.1 Finalization of walk-through micro-plans: Complete walk-through micro-plans in the remaining LGAs in the outbreak prone states for readiness and timely implementation of mop-up responses

5.4.1.2 Outbreak dashboard: Monitor implementation of outbreak response based on the EOC – Outbreak SOPs and the Outbreak dashboard 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

5.4.1.3 Maintain pre-positioning of vaccines and operational funds for outbreak response: Monitor vaccine stock levels through weekly presentation in the EOC by the National Logistics Working Group on availability and forecast for OPV

5.4.1.4 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

5.4.1.5 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 before deciding that the response is adequate.

5.4.2. Targets, Milestones and Indicators

- Completed walk-through micro-plans and enumeration by March 2014
- Timeliness of outbreak response continue to be monitored based on the EOC –Outbreak SOPs and the Outbreak dashboard
- Vaccines and operational funds pre-positioned in outbreak-prone areas by January 2014
- National Outbreak Management Team deployed to outbreak states within 24 hours of non-Sabin ITD notification
- LQAs and independent monitoring results (90% by LQAS for the infected LGA and 80% for the surrounding LGAs) used to determine areas which have to continue mopping-up before deciding that a response is adequate
- No LGAs with > 2 cases of polio with onset of illness > 6 weeks apart after March 2014

5.5. Special Strategies to reach underserved populations

Reaching underserved populations continues to be an important priority in 2014. Underserved populations refer to those populations that have been demonstrated to have a higher likelihood of not receiving regular services i.e. nomadic and other migratory populations, populations living in hard-to-reach areas, scattered or border settlements. It is likely these populations serve as a hidden reservoir of WPV and contribute to movement of virus across state and international borders. Surveillance in these communities is challenging and efforts are ongoing to improve detection and reporting from these areas.

5.5.1. Activities:

- **Enumeration of high risk LGAs:** The enumeration exercise has not yet been conducted in selected high risk LGAs, particularly in Borno, Yobe, and Kano states. Special efforts will be used to conduct a “hit and run” enumeration exercise when the security situation is permissive. In addition, selected LGAs along known high risk transit routes for nomadic communities will be targeted for enumeration in the first 3 months of 2014 (e.g. along Benue and Niger rivers). Ongoing consultation with state teams will help define other high risk LGAs for outreach efforts
- **Outreach during outbreak response:** As part of overall efforts to improve outbreak response, special efforts will be made to conduct outreach in communities with WPV outbreaks. If cases occur in a ward or LGA without a previous enumeration exercise, all settlements will be enumerated as part of the first round in outbreak response. Monitoring will be used to ensure settlements continue to be reached during follow-up response rounds.
- **Outreach during IPDs;** The SOP to reach these communities during IPDs is part of the national guidelines and will continue to be used in the IPD planning process. Special teams and logistic

support will be highlighted in the High Risk Operational Plans in LGAs/Wards where a large number of these settlements exist.

- **Update existing micro-plans**: Community leaders will continue to be engaged in IPD planning to identify new settlements and ensure all underserved included in the micro-plan and are reached during IPDs. On a monthly basis, SMS reminders will be sent to ward level focal points asking about movement or establishment of new communities in high risk areas for inclusion in micro-plans.
- **Ensure proper logistic support:** LGAs will continue to provide adequate support for outreach to hard-to-reach and border areas that have not been well covered.
- **Cross Border activities:** Continue collaboration and synchronization of PEI activities across international, interstate, inter-LGA and inter-ward borders.
- **Monitor quality of IPDs in these areas:** Special efforts will continue to monitor coverage in nomad and hard to reach areas after the enumeration exercise.
- **Evaluation of continued IPDs coverage in underserved settlements:** Targeted post-enumeration evaluation will be conducted in settlements with high number of zero-dose children. This strategy was piloted in 50 settlements in April 2013. OPV will be offered during the process of enumerations.
- **Strengthen surveillance among scattered, nomad and border communities:** Community-based focal points will be identified and included in the WHO network of AFP informants and be sent monthly SMS reminders to report children with AFP. Regular meetings with these focal points will also be held to obtain real-time feedback on surveillance activities in their areas. DSNOs will be provided logistics and transportation support to investigate AFP cases identified during outreach activities.
- **Strengthen RI outreach:** Using information provided by landscape analysis, outreach to nomad communities will be included in the RI microplan in LGAs with high nomad populations. Mobile teams will be supported to conduct outreach in areas with large number of zero-dose children.
- As part of the accelerated use of IPV in the security compromised areas of Borno and Yobe, a joint task force will be set up between the polio and RI programs to develop strategies and processes required to not only introduce IPV in these two states but also ensure the successful introduction of the vaccine in the last quarter of 2014 as per the agreed RI timeline.

5.5.2. Targets, Milestones and Indicators:

- Improvement in population immunity in all scattered and border settlements as measured by OPV status of non-polio AFP cases identified from these communities
- Decrease in number of unreported AFP cases detected to zero in outreach sessions
- Ensure > 80% of AFP cases identified during outreach exercises are properly investigated and classified.
- Improvement in campaign quality month over month for all underserved communities as measured by EIM

5.6. In-between round activities to further increase population immunity and reduce threat of importation of poliovirus

Implementation of in-between rounds activities in 2013 in the endemic states and polio-free states at risk of polio importation further improved population immunity to accelerate interruption of wild poliovirus transmission and cVDPV. During 2013, with BMGF funding, WHO, UNICEF and CDC supported 17 LGAs in 8 states to implement accelerated immunization outreach activities to address persistent transmission of cVDPVs which have had positive impact in restricting spread of cVDPVs in 2013 with large reductions in number of unimmunized children in the specific LGAs. Additionally, WHO and UNICEF collaborated with Kano state, the Dangote Foundation and the Bill & Melinda Gates Foundation in a three-year effort to revitalize routine immunization from 2013.

Also, the in-between round activities were used to increase population immunity by taking opportunity of the various non-polio SIAs that were conducted in the 4th quarter of 2013 (measles, meningitis and yellow fever SIAs) to add OPV. In some notorious non-compliant communities, integration increased uptake of OPV. In the polio-free states, period intensification of routine immunization (PIRI) in the form of LGA Immunization Days (LIDs) were conducted in areas where data revealed accumulation of unimmunized children that were susceptible to be infected. By the end of 2013, there was significant reduction (>50%) in areas where LIDs were conducted. In the endemic states, additional OPV doses were administered in Out-patient Therapeutic Programmes, which were integrated with nutrition services as part of Community Management of Acute Malnutrition (CMAM).
Additionally, international cross-border activities were conducted with neighboring countries (Benin, Cameroun, Chad and Niger Republic) to limit local spread of poliovirus from Nigeria. Outbreak responses were also conducted in-between rounds to quickly mop-up any confirmed circulations.

Furthermore, the in-between round activities included efforts to improve quality of IPDs. These included updating of micro-plans, modifying training methodology and re-deployment of stronger hands to poor performing areas.

5.6.1. Activities:

- **Continue collaborative efforts to improve routine immunization in VHR LGAs and those with high number of un-immunized children:** The focus will be on improved tracking of vaccine supplies, support for data management, timely microplan (including session plans), updating training and monitoring of immunization sessions, and intensification of social mobilization activities to increase demands for immunization services. In addition to the on-going collaborative efforts in cVDPV project LGAs and the Kano Tripartite Project, 39 LGAs will be supported to reduce unimmunized children in selected polio endemic states.
- **Intensify activities to increase population immunity and avoid exportation and importation of polio viruses:**
    - **Conduct synchronized cross-border activities with neighbouring states**

- **Integration with non-polio SIAs: Meningitis and Yellow Fever in the 2nd quarter and 4th quarter of 2014**
- **Expansion of OTP / CMAM sites**
- **Reaching remote and hard to reach areas / migratory communities**: In these populations, the activities will focus on Boosting Child Immunity (BCI) whereby all routine immunization antigens will be given to these populations up to the age of 23 months. However, OPV will be given up to the age of 59 months. Additionally, in underserved remote settlements in states with continued transmission in 2014 (Kano, Bauchi, Borno and Yobe), integrated mobile outreach services to approximately 2000 communities will be provided with support from BMGF. At least, 3 OPV passages will be administered as part of outreach, together with RI/basic maternal and child health services.

- **Implement Local Immunization Days (LIDs) in non-endemic areas:** In states without WPV transmission in the last 6 months, the main focus will be intensified implementation of LIDs. Since the focus is to reduce the number of un / under-immunized children, the RI coverage data from 2013, will be used to identify LGAS which will start implementing LIDs in the 1st half of 2013. The RI coverage data and accumulating number of un / under-immunized children by June 2014, will be used to determine the LGAs to implement LIDs in the 2nd half of the year. It is important to note that prioritized LGAs in either 1st or 2nd quarter will implement 3 sessions of LIDs to ensure the immunization of children.
- **Immunize newborns everywhere:** Furthermore, in both polio-free and areas with continued WPV transmission, newborns are to be tracked and immunized through MSS facilities. OPV is also to be pre-placed in delivery rooms to ensure administration of birth dose of OPV. Additionally, the network of TBAs and VCM will notify their supervisors the list of pregnant women and information of planned naming ceremonies. As part of the celebrations, a vaccination team will be set up within the visible vicinity of the crowd attending the naming ceremony and will provide tOPV and pluses. For successful implementation, it will be vital that adequate pluses are provided with the teams to attract children in the true spirit of celebrating protection of a newborn from polio.

5.6.2 Targets, Milestones and Indicators

- Marked reduction (at least 30%) in number of unimmunized children in very high risk LGAs, cVDPV project and 39 selected LGAs by June 2014
- Conduct all synchronized cross- border activities with neighbouring states
- OPV integrated in measles "keep-up" re-vaccination exercise by March 2014
- OPV integrated with non-polio SIAs: Meningitis (phase 4 states: Kwara, Kogi, Benue) and Yellow Fever SIAs in the 2nd quarter and 4th quarter of 2014
- OTP / CMAM sites expanded by 25% of current number of sites by April 2014
- Integrated mobile outreach to remote and hard to reach areas / migratory communities established by April 2014: In these populations, the activities will focus on Boosting Child Immunity
- 3 series of Local Immunization Days (LIDs) / PIRI conducted in non-endemic LGAs with large number of unimmunized children by November 2014
- Data of number of newborns immunized in naming ceremonies, other traditional and religious celebrations; and delivery places (TBAs, hospitals / health facilities) shared by Communication Team in EOC very week to monitor performance.

5.7. Enhancing Surveillance

A very highly Sensitive AFP surveillance system remains the gold standard indicator to ensure timely detection of poliovirus circulation. Nigeria has achieved and maintained target AFP surveillance performance (non-polio AFP rate of at least 2 per 100,000 of under 15 year olds and at least 80% stool specimen adequacy) at national level and in the 36 States and Federal Capital Territory (FCT) for the last 4 years. Between January and November 2013, 89 % (target=80%) of all the Local Government Areas (LGAs) in Nigeria achieved target AFP surveillance performance with the non- Polio Enterovirus isolation rate of 17.4 % (target at least 10%).

In 2013 (Jan-November), 33 polio compatible cases (with clustering in three States of Kano, Kaduna and Katsina) were classified by the National Polio Expert Committee (NPEC). The number of orphan viruses detected was 8 compared to 14 in 2012. Three cVDPV2 have been identified from AFP cases in Nigeria in 2013. In neighbouring countries, one cVDPV2 was reported in Niger Republic and two in neighbouring districts in Cameroon found to be genetically linked to cVDPV isolated from the environment in Kano and a WPV1 in Borno state in 2013. Environmental surveillance sampling isolated 3 WPV1 and 13 cVDPV2 (9 in Sokoto, 2 in Kano, and 2 in Borno) in 2013.

Security challenges especially in the sates of Borno and Yobe continue to threaten the optimal performance of surveillance. Such challenges include closure of health facilities, restriction on the conduct of supportive supervision and Active case search, fear to conduct community and clinician sensitization, DSNOs afraid to move to polio laboratory with samples, inability to conduct outbreak investigation & response (3 WPV pending investigation); and partner agencies not being able to support some key field activities in some LGAs.

Surveillance gaps were observed in 76 LGAs spread across all the geo-political zones in the country. Field activities like IPDs, Rapid Surveillance Assessments and supportive supervisory visits revealed unreported AFP cases in some sites. Intensive outreach to communities not usually reached by

immunization and surveillance activities, including nomadic settlements, hard to reach and border areas were continued in 2013. During these outreaches, unreported AFP cases were detected and investigated so as to harmonize with the AFP surveillance database.
Geo-coordinates of AFP and WPV cases and GIS mapping of verified AFP cases was initiated from July 2013. This technique allows for a better visualization of the geographical distribution of AFP cases, WPVs, polio compatibles and cVDPVs.

5.7.1. Activities:

5.7.1.1. Enhance sensitivity of AFP Surveillance:

- Update AFP surveillance network every 6 months for public and private health facilities as well as community informants as reporting sites.
- Review Volunteer Community Mobilizers (VCMs) and Village Health Workers' TORs to include active case search and reporting for AFP in communities, conduct training and monitor reporting of AFP cases.
- Implement regular capacity building of personnel involved in surveillance including surveillance site focal points, DSNOs, state epidemiologists, surge capacity through supportive supervision, on-the-job training, peer exchanges and refresher training. Additionally, in LGAs where the surveillance review indicates a need, assistant DSNOs, informants will also be engaged and trained as well as sensitization of clinicians (of all categories).
- In under-served communities including nomadic communities as well as border and hard-to-reach areas, a network of informants (including TLs / 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).
- Implement targeted surveillance activities in to enhance surveillance in states with security challenges including: development of jingles and use of local radio stations, improving partnership with professional medical associations, CBOs and NGOs.
- Monitor implementation of RSA and ERC recommendations
- Surveillance management SOPs with accountability framework will be implemented and monitored
- Scale up the collection of Geo-Coordinates on: AFP cases, reporting sites and community informants. This information is to be used for action.

5.7.1.2. Sustain and expand Environmental Surveillance

- Support existing environmental surveillance activities in Kano, Sokoto, Lagos, FCT, Kaduna and Borno.
- Expand environmental surveillance to additional very high risk states (2-3) and to polio free states (1-2)
- Monitor the performance of the environmental surveillance sites quarterly and modify/expand, particularly for silent sites.
- Bi-annual meeting of environmental surveillance system technical staff.

5.7.1.3. Sustain performance and accreditation of the National Polio Laboratory Activities:

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

5.7.1.4. Conduct polio sero-surveys:

- Polio sero-surveys will be conducted in Kebbi and Katsina.

5.7.2. Targets, Milestones and Indicators

- 5-10 % increase in community informants, Ardos and VCMs conducting AFP surveillance by June 2014
- Conduct at least 80% planned monthly active surveillance activities (including to community informants)
- Attainment of the 2 main AFP surveillance performance indicators at national and state level.
- At least 50% reduction in polio compatible cases and orphan viruses by June 2014
- Environmental surveillance expansion as planned by September 2014
- National Polio Laboratories maintain WHO accreditation in 2014

6. CROSS CUTTING PRIORITIES

6.1. Intensifying household and community engagement to build demand

The communication network has shown results in reducing missed children, including non-compliance Intensive efforts will be made to scale up household and community engagement approaches in the very high risk LGAs to reduce missed children and build demand for immunization. In 2013 more than 8000 Volunteer Community Mobilizers (VCMs) were deployed to support household engagement in the high risk LGAs. As well polio survivors, doctors and religious focal persons were deployed to ensure the full engagement of local level religious leaders and key community stakeholders. .

'Child absent' still remains the main reason for missed children, accounting for over 70% of the total number of missed children. Nationally, caregivers' refusal to vaccinate their children accounts for 15% of

the total number of missed children during campaigns. No felt need by caregivers is reported as a significant reason for non-compliance. States like Kano, Katsina, Kaduna and Sokoto still continue to have a high proportion of unresolved non-compliance even after teams have gone back to revisit the refusing households. Given many parents refuse polio vaccination due to other felt needs, the programme has responded by providing health camps, expanding links to nutrition **programmes**, routine immunization and by providing attractive pluses. The programme will continue to ensure linkages with other high impact child survival interventions, including water and sanitation (WASH), nutrition, health camps, immunization during and in-between campaigns to create demand and build trust for immunization within communities. Emphasis will also be laid on engageing community based organisations, using local media for message delivery and increasing the IPC skills of health workers.

Experience has shown the significant impact can be achieved by developing locally appropriate communications plans that include targeted household and community engagement approaches during and in-between polio campaigns. In 2014, VCMs, and PSG will continue to work at the household level supported by a community engagement approach, which will include a strong focus on the engagement of religious and traditional leaders. Social data shows that children are missed during polio campaigns due to participation in local ceremonies. VCMs will track and immunize newborns and zero-dose children during and in-between campaigns, also taking advantage of traditional naming ceremonies as an additional opportunity to immunize missed children. The network will be further expanded to include members of the Daawah Coordination Council together with the Northern Traditional Leaders Committee and other religious institutions. With increased focus at the community level, community-based organizations (CBOs), including youth groups will be identified to expand the network of community partners even further in the prioritized LGAs. Pro-OPV messages will continue to be distributed on a regular basis at household level at through viewing centres and new technologies putting polio within a broader health context of child survival.

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

6.1.1. Activities

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

- Developing evidence based communication plan in every high risk LGA, including a focus on activities in the high-risk wards to address the locally specific reasons for missed children.
- Additional Volunteer Community Mobilizers (including Polio Survivors) and other community mobilizers (i.e FOMWAN) deployed in the highest risk areas with particular emphasis on Kano, Bauchi, Borno and Yobe as necessary.

- **Local traditional, religious leaders and stakeholder engagement**: Scale-up engagement of local traditional and religious leaders, including the Daawah Coordination Council members plus stakeholders to help overcome issues of mistrust and suspicion at the local level.
- Mapping of new community-based partners and youth groups in the highest risk areas.
- Introduction of polling approach to enhance social data collection and analysis within the programme.

6.1.2. Targets, Milestones and Indicators

- Locally appropriate, issue specific communication plan in place in all high risk LGAs of Kano, Bauchi, Borno and Yobe by March 2014.
- VCM network optimized in Kano, Kaduna and Katsina in the highest risk settlements by March 2014.
- Achieve >90% caregiver awareness in all very high risk LGAs
- Missed children due to actual non-compliance reduced to <1% in prioritized LGAs of Kano, Katsina and Kaduna by end-2014.
- Religious leaders integrated in microplans in Kano, Kaduna and Katsina by April 2014.
- VCMs implementing polio communications activities and outreach during naming ceremonies in the participating settlements in Kano, Bauchi, Borno, Yobe by March 2014.
- Implement LGA specific strategies to reduce non-compliance that include the mobilization of religious leaders by April 2013.
- Mapping of religious leaders by sect updated quarterly in the very high risk LGAs.
- One poll implemented in the prioritized states by March 2014.

6.2. Enhancing use of Technological Innovations

One of the challenges to missing children was that some settlements were not included in the settlement master-list and hence were not part of the daily implementation micro-plans and therefore not visited by teams. Most of the areas not captured were small settlements and hamlets in the outskirts of the major settlements.

Additionally, even when the settlements were on the daily implementation plan, some settlements and hamlets were not visited by vaccination teams due to poor team performance.

In 2013, GIS /GPS technology was used to improve the quality of micro-planning by incorporating settlements in the GIS ward maps onto the hand-drawn maps done during walk-through micro-planning and enumeration exercise. Also, vaccination teams tracking system (VTS) was used to track teams through Global Positioning System (GPS) tracking using underlying geospatial data sets of wards, settlement points and satellite imagery. The VTS process includes several components and focuses primarily on the vaccination days of the polio campaign to visualize in real time if the settlements – urban areas, small settlements and hamlets were covered. Team tracks are uploaded each day from the

tracking phones to a laptop at the LGA level and then transferred to the EOC dashboard through MiFi and shared with the LGA team, State EOC, State Technical Teams and National EOC.

Where the teams did not cover all settlements, feedback was provided to the LGA / ward team to ensure that the vaccination teams are re-deployed to vaccinate children in the missed or poorly covered settlements.

The successful tracking of vaccination teams and the use of these tracks through the VTS for computing geographic coverage for all settlement types depend a lot on the underlying geospatial datasets built into the Nigeria Gold Database. Extensive map correction which involved field data collection to ensure all settlements in the 8 GIS states are captured and included in the database was accomplished and 80% of the GIS maps were available. In addition, **t**he VTS dashboard has been enhanced with new features such as the missed or partially covered settlement validation workflow and mop up efficiency report.

For monitoring and evaluation, GIS maps with population data can be used to select true randomized samples for monitoring processes such as LQAS and enhanced Independent Monitoring. The Geographic coverage results from the VTS, which show areas covered by vaccinators at LGA, ward and settlement levels could also be used to reward teams with high level of coverage during SIAs. To ensure accountability of teams at ward level, the same coverage results could be used to sanction poor performing teams.

6.2.1 Activities

- Mapping of Kaduna – map Kaduna state to provide ward and settlement level geospatial data suitable for tracking vaccinators during IPDs
- Maps availability – fast-track printing of the GIS maps so that they are available for micro-planning in the already mapped very high risk states
- Micro planning – incorporate GIS-based Ward maps in updating micro-plans in the very high risk states. The plans should also be used to strengthen routine immunization delivery with social mapping
- Tracking – expand VTS tracking of teams in very high risk states from 40 VVHR & VHR LGAs to 60 LGAs
- Population Estimation – A GIS-based population estimation model that is under development will provide a powerful tool to estimate target populations, validate tally sheet totals, and support planning for IPDs, Routine Immunization activities and other public health efforts.

6.2.2. Targets, Milestones and Indicators

- GIS maps printed, available and incorporated into revised micro-plans for all LGAs in Kano State for the January 2014 IPDs
- GIS maps for micro planning printed and available in the remaining states and fully integrated into micro-planning process by April 2014.

- VTS expanded to 50 VVHR & VHR LGAs by February 2014, 60 LGAs in March 2014, 70 LGAs in May 2014 and 80 LGAs in April 2014
- GIS mapping in Borno and Yobe completed by first quarter 2014
- GIS mapping of Kaduna completed in December 2013 and tracking of vaccinators commenced by first quarter of2014
- Missed/Partially covered settlement report incorporated into mop up activities and in-between round activities by first quarter of 2014
- A2 ward level micro planning maps printed, laminated and distributed to all wards in the GIS states by the first quarter of 2014

6.3. Optimizing human resources

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

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

6.3.1. Activities:

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

6.3.2. Targets, Milestones and Indicators

- Government and partner field staff deployment optimized by February to match highest risk ward and LGA analysis.
- Fully functional national and state level EOCs in 6 high-risk states by April 2014.

Summary of low season priorities December 2013 – May 2014

For the programme to achieve interruption in the next six months, some low season strategies and activities will be prioritized and pursued with all aggression. These low season priorities hold the key to early interruption of the wild polio virus from the remaining sanctuaries in 2014

The low season priorities shall include:

Security compromised Areas

- Conduct monthly security risk assessments to determine accessibility for PEI/EPI activities
- Conduct 3 "catch-up" OPV contacts in wards that did not participate in planned IPDs rounds by December 2013.
- Expansion of Hit and Run, Permanent Health Teams and Fire-Walling by December 2013

Continued Transmission Areas

- Conduct high quality IPDs in infected LGAs and surrounding LGAs in transmission zones through:
- Expansion of visual – aides training for vaccination teams, timely deployment of MSTs, full provision of SOCMOB human resource and conduct post-IPDs mop-ups based on LQAS performance from November 2013 IPDs.

Outbreak Response

- Monitoring based on the EOC –Outbreak SOPs and the Outbreak dashboard.
- Maintain pre-positioning of vaccines and operational funds for outbreak response.
- Deployment of the National Outbreak Management Team to infected states within 24 hours of ITD notification.
- Use LQAs and monitoring findings to determine mop-up areas.

Persistent Poor Performing LGAs/wards

- Revision of micro-plans and establish Permanent Vaccination Teams by January 2014 IPDs.
- Engagement of youth groups by February 2014 IPDs
- Incorporate night vaccination in settlements with high proportions of child absent
- Increase GIS tracking from 40 to 60 LGAs by December 2013 IPDs
- Reward team performance in improving LGAs by December 2013 IPDs

Implementing Accountability Framework

- Linking human resource database (government and partners) with dashboard monitoring for stricter accountability framework and sanctioning by December 2013 IPDs.
- Rewarding good performing teams in improving LGAs by December 2013 IPDs
- Evaluation and re-deployment of government and partners agencies' strong hands to weak performing areas by January 2013 IPDs

7. ACCOUNTABILITY

7.1 Accountability mechanisms and rewards: Enforcement of accountability has been the game changer in 2013 and 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.

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 new 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. This scheme would be scaled up and fully operational by March 2014.
- **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 was instrumental in evaluating staff performance by Government and partners in 2012 with disciplinary actions taken on poor performing staff. In 2013, the additional use of an Indicator Dashboard further increased transparency and rapid monitoring of staff performance at all levels during each IPD round. These activities will continue during 2014.

7.2. Activities:

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

Identify the workers of interest: Government and partners have submitted the actual names of each cadre working at the different levels, particularly at LGA. The dashboard contains the names of staff and

those working in poor performing LGAs will be exposed for timely action to be taken in addition to periodic evaluations.

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

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

Targets, Milestones and Indicators:

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

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

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

8. MONITORING AND EVALUATION

8.1. Monitoring Process

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

- Standard pre-implementation and implementation monitoring checklists and presentation of information in the polio SIA 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

9. ANNEXES

9.1. List of High Risk LGAs as of January 2014

State	Very High Risk LGAs	High Risk LGAs
Bauchi	Bauchi	Gamawa, Katagum, Misau, Ningi, Shira Tafawa-Balewa, Ganjuwa, Toro and Darazo
Kaduna	Birnin Gwari, Igabi, Ikara, Kaduna-North, Zaria	Giwa, Sabon Gari, Ikara, Kudan, Soba and Makarfi
Kano	Dambatta, Bichi, Nassarawa, Kumbotso, Garum Mallam, Makoda, Doguwa, Ungogo, Tudun wada, Minjibir	Dawakin Kudu, Gaya, Bunkure Fagge, Kiru, KMC, Tsanyawa, Bebeji, Dawakin Tofa, Gwale Madobi, Takai, Dala, Gezawa, Rimin Gado, Garko, Kabo, Kibiya, Kunchi, Rogo, Sumaila, Tofa, Wudil
Katsina	Katsina, Funtua	Daura, Mani, Batsari, Dutsin Ma, Bakori, Jibia
Kebbi	None	Arewa Dandi, Gwandu, Ngaski, Jega
Niger		Mariga
Sokoto	Sokoto-North, Sokoto-South	Ilela, Bodinga, Dange-Shuni, Kware, Rabah, Shagari, Wamako, Wurno, Gwadabawa, Sabon Birni
Zamfara	Gusau,	Bukkuyum, Gummi, Maru, Maradun, Talata-Marafa

9.2. Annex 2: Polio Eradication SIAs in 2014

No.	SIAs Schedule 2014	Dates
1	SNIDs (BOPV)	January 25 - 28
2	NIDs (bOPV)	March 1- 4
3	SNIDs (bOPV)	April 12 - 15
	Easter (April 19 - 22)	
4	SNIDs (bOPV)	May 24 - 27
5	Undeserved + Child Health Week (bopv)	June 21 - 24
	Ramadan (29 June - 27 July)	
	Micro-planning (July 3 - 26)	
6	SNIDs (bOPV)	August 9 - 12
7	SNIDs (bOPV)	September 20- 23
	Eid Mubarak (October 4 - 5)	
8	SINDs bOPV)	November 1 -4
9	Undeserved + Child Health Week	December 13 -16

9.3. Polio Eradication Emergency Plan Implementation Schedule, 2014

Strategic Priority 1: **Improving IPDs quality in persistent poor performing LGAs / Wards**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
New team restructuring	X	X											NPHCDA
Micro-planning revision and extension of enumeration	X	X	X				X	X					WHO / NSTOP
Ward selection committee meeting endorsement													PARTNERS
Deployment of stronger hands to weak performing areas	X	X					X	X					NPHCDA & PARTNERS
Enhancing training quality													WHO
Timely social mobilization funds and demand creation packages availability	X	X		X	X	X			X		X	X	UNICEF
Logistics funds availability	X	X		X	X	X			X		X	X	UNICEF
Timeliness of release of counterpart funding	X	X		X	X	X			X		X	X	NPHCDA
IPDs Dashboard Monitoring	X	X		X	X	X			X		X	X	EOC
Improve SIA monitoring (EIM and LQAS)	X		X	X	X	X			X		X	X	WHO &PARTNERS
Pre- / Post-campaign review meetings	X		X	X	X	X			X		X	X	EOC

Strategic Priority 2: **Increased reach in security compromised areas**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Conduct monthly security risk assessments	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOC
Expansion of Permanent Health Teams	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOC
Conduct "Catch-up" OPV contacts	X	X	X	X	X	X							STATE EOC
Expansion of "Hit & Run"	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOC
Expansion of Fire-walling innovations	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOC
Establishing Health Camps and expanding Outpatient	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOC
Therapeutic Programme (OTP) / CMAM	X	X	X	X	X	X	X	X	X	X	X	X	STATE EOC
Establishment of Child Health Weeks			X	X	X	X	X	X	X	X	X	X	BMGF / EOC

Strategic Priority 3: **Rapidly containing circulation in the breakthrough polio transmission zones**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Revision of micro-plans and enumeration	X	X	X										WHO / NSTOP
Establish Permanent Vaccination			X	X	X	X							STATE EOC

Teams													
Implementation of ward level dashboard	X	X	X	X	X	X							CDC / WHO
Intensified supervision	X	X	X	X	X	X							EOC
Full provision of SOCMOB human resource and demand creation commodities	X	X	X	X	X	X							NPHCDA/ UNICEF / WHO/ ROTARY
Conduct post-IPDs mop-ups based on independent monitoring and LQAS performance	X	X	X	X	X	X							STATE EOC

Strategic Priority 4: **Timely and quality outbreak response**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Finalization of walk-through micro-plans	X	X	X										WHO / NSTOP
Outbreak dashboard	X	X	X	X	X	X	X	X	X	X	X	X	EOC
Maintain pre-positioning of vaccines and operational funds for outbreak response	X			X			X			X			EOC
Deployment of the National Outbreak Management Team	X	X	X	X	X	X	X	X	X	X	X	X	EOC
Use LQAs to monitor mop-up quality	X	X	X	X	X	X	X	X	X	X	X	X	WHO

9.3. Cont'd

Strategic Priority 5: **Increase reach in underserved populations**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Enumeration of high risk LGAs	X	X	X	X	X	X	X	X	X	X	X	X	NSTOP / WHO
Outreach during IPDs	X		X	X	X	X		X	X		X	X	NSTOP / WHO
Outreach during outbreak response	X	X	X	X	X	X	X	X	X	X	X	X	NSTOP / WHO
Update existing micro-plans													NSTOP / WHO
Ensure proper logistic support	X		X	X	X	X		X	X		X	X	UNICEF
Cross Border activities	X	X							X	X			WHO
Monitor quality of IPDs in these areas	X		X	X	X	X		X	X		X	X	WHO
Evaluation of continued IPDs coverage in underserved settlements				X			X			X	X		NSTOP / WHO
Strengthen surveillance among scattered, nomad and border communities	X	X	X	X	X	X	X	X	X	X	X	X	WHO
Strengthen RI outreach	X	X	X	X	X	X	X	X	X	X	X	X	BMGF/UNICEF/WHO

Strategic Priority 6: **In-between round activities to further increase population immunity and reduce threat of poliovirus importation**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Strengthen coordination of PEI activities with projects providing RI antigens	X	X	X	X	X	X	X	X	X	X	X	X	EOC
Conduct synchronized cross-border activities with neighbouring states	X	X							X	X			EOC
Integrate OPV in planned non-polio SIAs									X				EOC
Expand OTPs / CMAM in very high risk states	X	X	X	X	X	X	X	X	X	X	X	X	UNICEF
Increase mobile outreach to remote and hard to reach areas / migratory communities			X	X	X	X	X	X	X	X	X	X	BMGF/UNICEF/WHO
Implement PIRI /Local Immunization Days (LIDs) in non-endemic areas with large number of unimmunized children/ large proportion of zero doses								X	X	X			WHO / NPHCDA
Immunize newborns in naming ceremonies, TBAs and maternity wards / delivery places	X	X	X	X	X	X	X	X	X	X	X	X	UNICEF

Strategic Priority 7: **Enhancing Surveillance**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Enhance sensitivity of AFP Surveillance by increasing informants and variety of reporting personnel	X	X	X	X	X	X	X	X	X	X	X	X	WHO
Expand use of GIS technology to improve accuracy of geographical location of AFP/WPV, cVDPV cases	X	X	X	X	X	X	X	X	X	X	X	X	WHO
Sustain and expand Environmental Surveillance			X	X					X				WHO
Sustain of the National Polio Laboratory Activities	X	X	X	X	X	X	X	X	X	X	X	X	WHO
Conduct accreditation									X	X			WHO
Conduct polio sero-surveys			X	X					X	X			WHO / NPHCDA

Strategic Priority 8: **Intensifying household and community engagement to build demand**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
Local traditional, religious leaders and stakeholder engagement	X	X	X	X	X	X	X	X	X	X	X	X	NPHCDA /UNICEF
Develop evidence based communication plan in every high	X	X	X										NPHCDA / UNICEF

risk LGA													
Recruit additional Volunteer Community Mobilizers	X	X	X										UNICEF
Map new community-based partners and youth groups in the highest risk areas	X	X	X	X			X			X			UNICEF
Introduce polling approach to enhance social data collection and analysis	X	X	X										UNICEF
Provide demand creation commodities, particularly unfelt needs	X		X	X	X	X		X	X		X	X	UNICEF / WHO/ NPHCDA
Expand use of health camps	X		X	X	X	X		X	X		X	X	UNICEF / WHO/NPHCDA

Strategic Priority 9: **Enhancing Technological Innovations**													
Activity	Timeline												Responsible
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	
GIS mapping of Kaduna State	X	X											E-HEALTH
GIS mapping of Borno and Yobe States			X										
Printing of the GIS maps completed for very high risk states	X	X	X	X									E-HEALTH
Micro-planning with fully incorporated GIS-based Ward maps	X	X	X	X			X	X					WHO

Tracking – expand VTS tracking of teams in very high risk states	X		X	X	X	X		X	X		X	X	E-HEALTH / WHO
Estimate settlements' population using a GIS-based population estimation model		X		X			X			X			E-HEALTH / WHO

Global partner contributions to support low season priorities

Partner	Priority	Description of efforts
BMGF	▪ Advocacy ▪ Operational support ▪ Resource mobilization	▪ Co-chair visit in March ▪ Immunization Challenge 2013 ▪ EOCs, eHealth, GIS/GPS scale up
CDC	▪ Technical assistance	▪ Additional staffing (e.g., EOC data management/dashboard) ▪ N-Stop work expanded and refocused
Rotary	▪ Advocacy ▪ Community engagement	▪ Local Rotary 'adoption' of high risk LGAs ▪ National and state political advocacy
UNICEF	▪ Technical assistance	▪ Mgmt. review of VCM network ▪ Surge optimization ▪ Operations research on N/C ▪ OPV stock management system
WHO	▪ Technical assistance	▪ Additional staffing and consultants support (including SMOs from India) ▪ Security planning ▪ Surge optimization

6 MONTHS OPERATIONAL PLAN FOR BORNO STATE NOV 2013- MAY 2014

Supplemental Immunization Activities

S/No	LGA		Security Category of Wards	Target Population		# of rounds missed Feb-Dec 2013 including mop ups in July, Aug and Nov and Oct IMC	# of" catch up" planned	# of additional doses planned	# of doses given and strategies as of Nov '13	Total doses required Nov '13- April '14 (Catch up + Additional)	Timeline and Strategies foe passages	Additional dates for Doses in 2014	No of "catch up" completed in 2014	Indicators: Proportion of SIA activities conducted as per time and scope	Responsible: Incident Manager Borno Child Survival Opeerations Centre	Budget
1	**Kukawa**	Alagarno	MEDIUM	13499	Cluster A 9	9		6		3+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
	10 wards				wards						Dec 14-17 (IPDs)	Feb 15 & 16 (HR)				
		Baga	MEDIUM	1414		9					PHT	Mar 1-4 (IPDs)	1			
		Barwati	MEDIUM	1010		9						March 22 & 23 (HR)	1			
		Bundur	MEDIUM	3417		9						Apr 12-15 (IPDs)	1			
		Dogoshi	MEDIUM	1212		9						May 3 & 4 (HR)	1			
		Doro	MEDIUM	3114		9							1			
		Kauwa	MEDIUM	1294		9							1			
		Kekeno	MEDIUM	21076		9							1			
		Yoyo	MEDIUM	2966		9							1			
		Kukawa	LOW	2525	Cluster B 1 ward	9				1+3	Dec 14-17 (IPDs)	Jan 25-28 (IPDs)	1			
											PHT	Mar 1-4 (IPDs)				
												Apr 12-15 (IPDs)				
2	**Dikwa**	Afuye	HIGH	2027	Cluster A 10	12	3	6	0	3+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	0			
	10 wards				wards						Dec 14-17 (IPDs)	Feb 15 & 16 (HR)				
		Boboshe	HIGH	5033		12					Dec 28 & 29 (HR)	Mar 1-4 (IPDs)	0			
		Dikwa	HIGH	2807		12						March 22 & 23 (HR)	0			
		Gajibo	HIGH	2087		12						Apr 12-15 (IPDs)	0			
		M. Kaza	HIGH	1877		12						May 3 & 4 (HR)	0			
		M. Maja	HIGH	1807		12							0			
		Margata	HIGH	2964		12							0			
		Muliye	HIGH	2840		12							0			

		Ngudoram	HIGH	2762		12							0			
		Ufaye	HIGH	2564		12							0			
						12										
				26767		12										
3	**Bama**	Abbaram	HIGH	2632	Cluster A	10	3	6	2 (Partial HR)	3+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
	14 wards	Amchaka	HIGH	8907	11 wards	12					Dec 14-17 (IPDs)	Feb 15 & 16 (HR)	0			
		Andara	HIGH	10100		12					Dec 28 & 29 (HR)	Mar 1-4 (IPDs)	0			
		Banki	HIGH	10701		12						March 22 & 23 (HR)	0			
		Bogomari	HIGH	2915		12						Apr 12-15 (IPDs)	0			
		Darajamal	HIGH	8700		12						May 3 & 4 (HR)	0			
		Goniri	HIGH	2249		12							0			
		Gulumba	HIGH	2825		12							0			
		Kumshe	HIGH	2490		12							0			
		Yabiri	HIGH	3837		12							0			
		Zageri	HIGH	2410		12							0			
		Soye	MEDIUM	4476	Cluster B	10	3	5		3+5	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
					1 ward						Dec 14-17 (IPDs)	Feb 15 & 16 (HR)				
											Dec 28 & 29 (HR)	Mar 1-4 (IPDs)				
											PHT	March 22 & 23 (HR)				
												Apr 12-15 (IPDs)				
		Kasugula	LOW	2427	Cluster C	8				1+3	Dec 14-17 (IPDs)	Jan 25-28 (IPDs)	1			
		Shehuri	LOW	3566	2 wards	8					PHT	Mar 1-4 (IPDs)	1			
												Apr 12-15 (IPDs)				
				68236												
4	**Gubio**	Ardimini	MEDIUM	1883	Cluster A	7	3	5	2 (full IPDs)	1+5	Dec 14-17 (IPDs)	Jan 25-28 (IPDs)	1			
	10 wards	Dabira	MEDIUM	5759	10 wards	7					PHT	Feb 15 & 16 (HR)	1			
		Felo	MEDIUM	2170		7						Mar 1-4 (IPDs)	1			
		Gamawu	MEDIUM	6068		7						March 22 & 23 (HR)	1			
		Gazabure	MEDIUM	2494		7						Apr 12-15 (IPDs)	1			
		Gobio 1	MEDIUM	1223		7							1			
		Gobio 2	MEDIUM	4830		7							1			
		Kingowa	MEDIUM	2158		7							1			
		Ngetra	MEDIUM	5863		7							1			
		Zowo	MEDIUM	6165		7							1			
				38613												
5	**Monguno**	Damakuli	HIGH	1010	Cluster A	10	3	6	2 (full IPDs)	1+6	Dec 14-17 (IPDs)	Jan 25-28 (IPDs)	1			

	12 wards	Kaguram Mintar Mofio Sure Wulo Yele	HIGH HIGH HIGH HIGH HIGH HIGH	1412 1258 1551 938 1332 1192	7 wards	9 9 10 10 9 10						Feb 15 & 16 (HR) Mar 1-4 (IPDs) March 22 & 23 (HR) Apr 12-15 (IPDs) May 3 & 4 (HR)	1 1 1 1 1 1			
		Zulum	MEDIUM	2289	Cluster B 1 ward	10		5		1+5	Dec 14-17 (IPDs) PHT	Jan 25-28 (IPDs) Feb 15 & 16 (HR) Mar 1-4 (IPDs) March 22 & 23 (HR) Apr 12-15 (IPDs)	1			
		Kumalia Mandala Mongonu Ngurno	LOW LOW LOW LOW	1560 1229 12727 1266 **27764**	Cluster C 4 wards	9 9 9 8		3		1+3	Dec 14-17 (IPDs) PHT	Jan 25-28 (IPDs) Mar 1-4 (IPDs) Apr 12-15 (IPDs)	1 1 1 1			
6	**Ngala** 11 wards	Fuye Gamboru A Gamboru B Gamboru C Logumane Ndufu Ngala Shehuri Wulgo Wulgo Warshele	Medium Medium Medium Medium Medium Medium MEDIUM MEDIUM MEDIUM MEDIUM MEDIUM	14830 2873 4700 3494 6716 5017 3512 5380 7152 2868 3375 **59917**	Cluster A 11 wards	10 10 10 10 9 10 10 9 9 9 9	3	6	1 (IPDs)	2+6	Nov 30- Dec 1 (HR) Dec 14-17 (IPDs) PHT	Jan 25-28 (IPDs) Feb 15 & 16 (HR) Mar 1-4 (IPDs) March 22 & 23 (HR) Apr 12-15 (IPDs) May 3 & 4 (HR)	1 1 1 1 1 1 1 1 1 1 1			
7	**Kaga*** 15 wards	Fai Mainok Ngamdu	High High High	1498 4004 716	Cluster A 3 wards	10 11 8	3	6	2 (Partial HR)	2+6	Nov 30- Dec 1 (HR) Dec 14-17 (IPDs)	Jan 25-28 (IPDs) Feb 15 & 16 (HR) Mar 1-4 (IPDs) March 22 & 23 (HR) Apr 12-15 (IPDs) May 3 & 4 (HR)	0 0 1			
		Benisheikh	Medium	1514	Cluster	6				2+5	Nov 30- Dec 1	Jan 25-28 (IPDs)	1			

					B						(HR)					
					12						Dec 14-17					
		Borgozo	Medium	970	wards	7					(IPDs)	Feb 15 & 16 (HR)	1			
		Dogoma	Medium	784		6					PHT	Mar 1-4 (IPDs)	1			
												March 22 & 23				
		Dongo	Medium	1838		6						(HR)	1			
		Galangi	Medium	1122		6						Apr 12-15 (IPDs)	1			
		Guwo	Medium	1414		6							1			
		Karagawaru	Medium	1118		6							1			
		Marguba	Medium	1349		6							1			
		Shettimari	Medium	1695		6							1			
		Tobolo	Medium	2017		8							1			
		Wajiro	Medium	1616		8							1			
		Wassaram	Medium	1095		7							1			
				22750												
					Cluster						Nov 30- Dec 1					
8	Damboa*	Ajigin A'	HIGH	3912	A	12	3	6		2+6	(HR)	Jan 25-28 (IPDs)	0			
					4						Dec 14-17					
	10 wards	Ajigin B'	HIGH	7221	wards	13					(IPDs)	Feb 15 & 16 (HR)	0			
		Azir Multe	HIGH	6185		8						Mar 1-4 (IPDs)	1			
												March 22 & 23				
		Bego	HIGH	5364		6						(HR)	1			
												Apr 12-15 (IPDs)				
												May 3 & 4 (HR)				
		Damboa			Cluster						Nov 30- Dec 1					
		Central	MEDIUM	5634	B	7		3		2+3	(HR)	Jan 25-28 (IPDs)	1			
					5						Dec 14-17					
		Kafa Mafi	MEDIUM	6294	wards	12					(IPDs)	Mar 1-4 (IPDs)	0			
		Mulgo Kopchi	MEDIUM	5292		8					PHT	Apr 12-15 (IPDs)	1			
		Nzuda														
		Wuyaram	MEDIUM	7656		7							1			
		Wawa														
		Korode	MEDIUM	3173		8							1			
					Cluster						Dec 14-17					
		Gumsuri	LOW	7798	C	8				1+3	(IPDs)	Jan 25-28 (IPDs)	1			
					1 ward						PHT	Mar 1-4 (IPDs)				
				58528								Apr 12-15 (IPDs)				
											Nov 30- Dec 1					
9	Gwoza			69835		3	3	5		2+5	(HR)	Jan 25-28 (IPDs)				
											Dec 14-17					
	Kala/Balge			15366							(IPDs)	Feb 15 & 16 (HR)				
	Konduga			39570								Mar 1-4 (IPDs)				
												March 22 & 23				
	Mafa			26163								(HR)				
	Magumeri			35442								Apr 12-15 (IPDs)				
	Marte			57971												

10	**MMC***	Bolori II	HIGH	8088	Cluster A	9	0	6	1 (IPDs)	2+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
	15 wards	Gamboru	HIGH	8107		2					Dec 14-17 (IPDs)	Feb 15 & 16 (HR)	1			
		Gwange III	HIGH	4034		2					PHT	Mar 1-4 (IPDs)	1			
		Lamisula	HIGH	34589		2						March 22 & 23 (HR)	1			
		Mafoni	HIGH	6222		2						Apr 12-15 (IPDs)	1			
		Maisandari	HIGH	4268		2						May 3 & 4 (HR)	1			
		Bulabulin	MEDIUM	4712	Cluster A 3 wards	2	0	6	1 IPDs	2+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
		Gwange II	MEDIUM	7116		2					Dec 14-17 (IPDs)	Feb 15 & 16 (HR)	1			
		Hausari	MEDIUM	2694		2					PHT	Mar 1-4 (IPDs)	1			
		Limanti	MEDIUM	19990		2						March 22 & 23 (HR)	1			
												Apr 12-15 (IPDs)	1			
												May 3 & 4 (HR)	1			
		Bolori I	LOW	11422	B 12 wards	1	0	5		2+5	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
		Fezzan	LOW	601		2					Dec 14-17 (IPDs)	Feb 15 & 16 (HR)	1			
		Gwange I	LOW	2936		2					PHTs	Mar 1-4 (IPDs)	1			
		Shehuri North	LOW	4693		2						March 22 & 23 (HR)	1			
		Shehuri South	LOW	12330		2						Apr 12-15 (IPDs)	1			
11	**Jere***	Alau	HIGH	2077	Cluster A 5 wards	2	0	6	1 (IPDs)	2+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
	12 wards	Dusuma	HIGH	3255		3					Dec 14-17 (IPDs)	Feb 15 & 16 (HR)	1			
		Galtimari	HIGH	6663		3					PHT	Mar 1-4 (IPDs)	1			
		Gongulong	HIGH	3012		2						March 22 & 23 (HR)	1			
		Old Maiduguri	HIGH	7286		2						Apr 12-15 (IPDs)	1			
												May 3 & 4 (HR)	1			
		Dala	Medium	2335	Cluster B 6 wards	2	0	6		2+6	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			
		Maimusari	MEDIUM	4142		2					Dec 14-17 (IPDs)	Feb 15 & 16 (HR)	1			
		Gomari	MEDIUM	3344		2					PHTs	Mar 1-4 (IPDs)	1			
		Khadammari	Medium	4996		2						March 22 & 23 (HR)	1			
		Mashamari	MEDIUM	11288		2						Apr 12-15 (IPDs)	1			
		Tuba	Medium	1961		2						May 3 & 4 (HR)	1			
		Mairi	LOW	3020	Cluster C	2	0	5		2+5	Nov 30- Dec 1 (HR)	Jan 25-28 (IPDs)	1			

				53380	1 ward						Dec 14-17 (IPDs) PHTs	Feb 15 & 16 (HR) Mar 1-4 (IPDs) March 22 & 23 (HR) Apr 12-15 (IPDs) May 3 & 4 (HR)				

* = WPV

LGAs

	Accessibility
Cluster - High Risk wards	>80%
Cluster - Medium risk wards	50-79%
Cluster - Low Risk wards	>80%

Vaccination Team
-OPV
-ORS
-Antihelminthic
Paracetamol * 8 tabs

YOBE STATE

Low Season Transmission: Six Months OPERATIONAL PLAN

Low Season Priority	LGA/Ward	Target Audience	Objective(s)	Activity (Include scope)	Time frame	Process Indicator	Expected Outcome	Responsible	Budget Estimate (N)
Reach chronically missed children in security compromised areas	1. Gujba LGA (Bunigari, Gujba, Buniyadi, Goniri and Dadingel wards) 2. Gulani LGA (Bara ward) 3. Damaturu (Bindigari/ Pawari, Nayinawa, Damaturu Central) 4. Potiskum (Dogo nini, Hausawa Asibiti, Bolewa B) 5. Fune (Ngelzarma B, Damagum B, Daura A) 6. Geidam LGA (Balle, Ma'anna, Asheikri 1, Asheikri 2 & Hausari)	Policy makers, informants, youth Groups, traditional rulers, security agent and influencial leaders	To review the security situation in security compromised wards	To conduct a monthly ward security risk assessments to determine accessibility for PEI/EPI activities	1st week of every month	availabilty of monthly risk assessment report	Guide the programme on safe PEI activitiy in the wards	LIO	1,260,000.00
	1. Gulani LGA (Bara ward) 2. Fune (Ngelzarma B, Damagum B, Daura A)	under five population (0-5 years)	To reach under five population with OPV in the security compromised areas	Expansion of Permanent Health Teams by January 2014 (16 teams)	06th of jan, 2014	No of egilible children immunized and number of new PHT establised	Reduced the number of unummunised children	LIO/ LGA F	**5,760,000.00**
	Nguru, Bade, Jakusko, Nangere, Fika, Gulani, Gujba, Damaturu, Tarmuawa and Geidam LGAs	under five population (0-5 years)	to reach eligible children with RI and OPV	Expansion of Fire walling in the inaccessible wards	30th of jan, 2014	No of egilible children immunized and number of LGAs implemeting wall fenching	Reduced the number of unummunised children	LIO	**11,424,000.00**
	1. Gujba LGA (Bunigari, Gujba, Buniyadi, Goniri and Dadingel wards) 2. Gulani LGA (Bara ward) 3. Damaturu (Bindigari/ Pawari, Nayinawa, Damaturu Central) 4. Potiskum (Dogo nini, Hausawa Asibiti, Bolewa B) 5. Fune (Ngelzarma B, Damagum B, Daura A) 6. Geidam LGA	youth groups, CBOs, community leaders and other stakeholders	To increase community awareness , acceptance and demand for immunization services through engagement of stakeholders	systematic engagement of Youth groups, CBOs and community leaders to provide support for PEI activities	December 2013 to February 2014	number of stakeholders engaged in community awareness, acceptance and demands creation for immunization services	increase coverage of immunization services in the LGAs.	LIO	210,000.00

Improve quality IPDs and generate demand for in infected LGAs and surrounding LGAs		ward selection committee members	To ensure selection of team members based on guidelines	Review and empower ward selection committee	2 weeks to every implemenetation	List of nominated team members and minutes of meeting of ward selection committee	good quality team members	LIO	3,720,000.00
		Vaccination teams	To improve performance of vaccination teams	Conduct high quality ward level training using revised training module.	one week to implementation	training reports and list of attendance	improved team performance	STF	0.00
		ward focal person and team supervisor	To include all settlements in the microplan	Desk review and updating of microplan	after every IPDs round	updated microplan and master list of settlements	all settlements included in the microplan reached	WFP	4,450,000.00
	Machina, Yunusari, Damaturu, Bade, Geidam and Gujba LGAs	ward focal person,team supervisor and traditional leader	To have regular update of Masterlist of settlements	Conduct of physical work through microplan	every six months	updated microplan and master list of settlements	all settlements included in the microplan reached	WFP/ LGAF	2,480,000.00
		LGA Council members	To ensure timely availability of funds	advocacy to LGA councils for early and timely release of funds for social mobilition activities	Every round	availability of funds	timely availability of funds	PHCC	225,000.00
		high risk settlements	To reduce the number of missed children to < 10%	conduct analysis of LQAS Data and investigate reasons why children were missed and also to guide the conduct of immediate mop-up/ revaccination	every round	report of LQAs analysis and investigation	Reduction in missed children to 10%	LGA F/Cluster consultant	0.00
		Non compliance HH	To reduce missed children due to non compliance	Scale up in-between round activities (SIAD), 1 phase/ LGA/	by March 2014	No. of Phases of SIAD conducted	Reduction in missed children due non compliance	Health Educator	14,034,700.00

		Non compliance HH	To reduce missed children due to non compliance	Establishment of Health Camps in the 6 LGAs, 2/ ward (62 wards)	by March 2014	No. of health Camps established	Reduction in missed children due non compliance	Health Educator	15,500,000.00
		Non compliance HH	To reduce missed children due to non compliance	Recruitment of 20 VCMs for Machina, Yunusari, Bade respectively	by March 2014	No. of VCMs recruited	Reduction in missed children due non compliance	Health Educator	4,140,000.00
			To reduce missed children due to non compliance	provision of attractive adult and children pluses	by April 2014	Availability of attractive pluses	Reduction in missed children due non compliance	Health Educator	9,476,790.00
		non compliance HH	To reduce missed children due to non compliance	full engagement of Youth group, ardos, religious focal persons	30th of January, 2014	Number of Youth group, ardos, religious focal persons engaged	Reduction in missed children due non compliance	Health Educator	120,000.00
Accountability	All the 17 LGAs	vaccination teams	To encourage healthy competition among teams	recognition and rewarding good performing teams in improving LGA by awarding certificate of merit	January 30	number of teams rewarded	improvement in teams performance	PHCC	2,992,000.00
Improving AFP surveillance performance	Fika, Jakusko & Machina	Surveillance focal persons	To improve AFP case detection and reporting in poor performing LGAs	Prioritizing conduct of active case search for AFP Case in focal sites and health facilities in the 3 LGAs	30th of January, 2014	no of active case search conducted	improvement in AFP case detection	cluster consultant, LGA F, DSNO	0.00
		Clinicians	To improve AFP case detection and reporting in poor performing LGAs	conduct sensitization of clinicians (2 Major Health Facilities/ month)	30th of January	no of clinicians sensitized	improvement in AFP case detection	cluster consultant, LGA F, DSNO	360,000.00
		informants	To improve	re-orientation	Feb-14	no of	improvement	cluster	171,600.00

			AFP case detection and reporting in poor performing LGAs	of informants on case reporting		informants trained or re-oriented	in AFP case detection	consultant, LGA F, DSNO	
		health care workers	To improve AFP case detection and reporting in poor performing LGAs	increase supervisory visits to focal site and health facilities	Feb-14	no of supervisory visits conducted	improvement in AFP case detection	cluster consultant, LGA F, DSNO	0.00
		Health care workers	To improve AFP case detection and reporting in poor performing LGAs	Health Care workers sensitization (1/month)	Feb-14	No. of sensitizations conducted	improvement in AFP case detection	cluster consultant, LGA F, DSNO	540,000.00
		State/ LGA authorities	To improve AFP case detection and reporting in poor performing LGAs	Establishment State Management Support Team (MST)	January 30	MST established	Improved performance in AFP Surveillance	State Epidemiologist & SC	0.00
							Total		**76,864,090.00**