23rd Meeting of the Expert Review Committee (ERC) on Polio Eradication Initiative & Routine Immunization

Major Findings & Recommendations

Signed:

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Major Findings:

As the ERC met to scrutinize a draft *'2012 Nigeria Polio Eradication Emergency Plan'*, both **the number and geographical extent of polio cases in the country are increasing**. As of end-March 2012, nearly double the number of cases have been reported and states infected compared with the same point in 2011. As alarmingly, survey (LQAS) data suggest that the coverage being achieved in the Immunization Plus Days (IPDs) is stagnant or at best improving very slowly in key localities. **In four infected states, ≤65% of children have received ≥4 doses of OPV** (NPAFP data), despite dozens of campaigns having been conducted since they were born: Borno (62%), Kano (64%), Sokoto (65%), Yobe (63%). In Borno 11% of children are still '0-dose'.

At the same time, **the already low quality and coverage of routine immunization services is deteriorating**. As the ERC met, 55% more Nigerian infants were not vaccinated with DPT3 in 2011 compared with 2010 and the central store had a stock-out of 4 of the 8 core childhood vaccines! 2.7 million Nigerian infants were completely unvaccinated in 2011.

Despite the declaration of polio as a national emergency by H.E. the President, Mr Jonathan Goodluck, **in the first quarter of 2012 only half of the 12 infected or recurrently re-infected northern states even convened a State Polio Task Force** to ensure gaps in IPD quality and coverage were addressed.

Simply put, the programme is continuing to miss both places and populations.

There are only 5 more IPDs planned between now and end-2012, the national target for interrupting all poliovirus transmission. Achieving that goal on time requires truly embracing and operating as an 'emergency programme' with much *faster* identification and rectification of problems in campaign operations, *focused* application of resources in the worst-performing areas, and *full accountability* of national authorities and partner agencies to perform their assigned tasks.

Encouragingly, there is very compelling evidence that Nigeria now has all of the tools and tactics necessary to achieve rapidly a huge jump in IPD quality. Excellent studies conducted since the ERC last met in October 2011 demonstrate that in the poor performing areas 'non-compliance' and 'absence of a vaccination team' accounted for 45% and 32% of missed children - much higher proportions than typically reported. Furthermore, the solutions to these problems now exist. Where properly applied, hard data prove the *Intensified Ward Communication Strategy* (IWCS) reconciled nearly all of the non-compliance that had been encountered. The proposal to structure the current 6-person *vaccination team strategy* into 2 teams of 3 people could rapidly help address the problem of insufficient teams. The systematic application of the new *microplanning* templates and processes, supplemented with GIS mapping in priority LGAs, could rapidly solve the nagging problem of missed places. *Special population strategies*, such as that being piloted for the nomadic population, prove that these very important populations can be reached.

The new National Emergency Plan is very promising. It addresses all of the major chronic operational and communications challenges the programme has

faced with approaches that have been proven at the pilot scale. Optimizing the proposed Polio Eradication Accountability Framework of the Presidential Task Force on Polio Eradication, as well as the function of State Task Forces, will be essential to the scale-up these pilot approaches, ensure the Plan's full application as an emergency intervention, reward those showing true leadership of the 'emergency approach', and sanction those who stand in its way.

Major Recommendations:

1. **Immediately Build a Nation-wide Sense of Emergency, Led by the H.E. the President & the Governors of the Persistently Infected States:** while authorities at the Federal level and in some states have embraced the sense of polio eradication as an emergency, this is not pervasive. A huge transformation in attitude is needed to move immediately from a 'business as usual' approach to an emergency approach.
    a. *Plan Launch:* the 'transformation' could begin with H.E. the President and the Governors of key states launching the finalized national emergency plan and communicating its importance directly to key LGA chairmen by 15 April 2012.
    b. *Massive Awareness Campaign:* in advance of the May 2012 Immunization-Plus Day (IPD), a massive public awareness campaign could build on the President's launch to communicate the emergency to all of the people of Nigeria because their children are now the only ones in Africa being paralyzed by polio, which can be rapidly stopped by vaccinating their children in all of the upcoming IPDs.

2. **Refine the 2012 National Polio Eradication Emergency Plan by 1 April 2012:** the Plan is strong, but would benefit from adjustments, particularly:
    a. *Ensuring a State-level Performance/Operations Focus:* NPHCDA should edit the Plan to ensure that each state can immediately understand 'what's different' and how to incorporate these new approaches into its state & LGA-level operations.
    b. *Situation Analysis:* there should be a specific section that clearly identifies the areas which have never achieved key IPD performance targets and prioritizes these for action (e.g. beginning the worst performing LGAs within the persistent-transmission states that have yet to achieve even 65-70% coverage with $\geq$4 OPV doses!).
    c. *Enhancing SIA Operations:* this section should be restructured into 4 key sections which highlight the 3-4 major activities that will be 'done differently' in each of the following areas: (a) improved microplans; (b) enhanced vaccinator team performance; (c) special population strategies (incl nomadic, migrant, mobile and other relevant groups); (d) surge support (human resources).
    d. *Intensified Communications:* this section should clearly identify its targets and the different strategic approaches for each. At the critical, community level,

the focus should be on expanding and intensifying the promising work to identify and resolve non-compliance, starting with the worst-performing states and LGAs. This should be coupled with additional work to understand and address the other social reasons for missing children (e.g. low awareness).

3. **Finalize the Emergency Plan With the 8 Priority Northern States, and Develop Plans for its Implementation & Roll-out, by 15 April 2012:** while there has been consultation with key states, partners and some LGAs, the ultimate success of the plan would be greatly enhanced by

   a. *Formal Consultation & Finalization with Priority States:* prior to finalization of the Plan, senior Ministry and NPHCDA officials should travel to and formally consult with each of the priority northern states (at least Borno, Kano, Sokoto), and ideally the worst-performing LGAs within them, to ensure their explicit understanding of, and buy-in to, the expectations on States and LGAs as laid out in Annex 10.3.

   b. *Clear Assignment of Roles & Responsibilities:* the success of the plan depends on each person, authority and agency at each level understanding their assigned roles & responsibilities. These should be more clearly assigned within the Plan or as part of each State and agency-specific operational plan.

   c. *Establishing Clear, Common Coordination Mechanisms:* the problems arising from the current division of labour by area of work (e.g. operations/logistics, social mobilization, special strategies) must be fixed for the 'emergency approach' to work, especially in the worst performing areas. There must be a single, strong government and partner coordination mechanism at each level to run the entire programme as a single, coordinated activity in each geographical area. This must be explicit in the operational plans.

4. **Give Real-Time Urgency to the Work of the Presidential Task Force & Accountability Framework and the State Level Task Forces:** to stop transmission with the 5 IPDs between now and end-2012, the primary purpose of the Task Forces and Framework must be to ensure that (a) no poor-performing LGA conducts an IPD unless it has properly prepared, and (b) that all poor-performing LGAs improve from round to round. This could be achieved by:

   a. *Link Meetings to IPDs:* instead of meeting monthly, the Task Force should plan to meet 10 days before each IPD to ensure that preparations have been done properly in the worst-performing LGAs, and 2 weeks after to assess whether there has been improvement.

   b. *Focus on the Worst-Performing LGAs in Worst-Performing States:* with its current process, the Presidential Task Force risks being overwhelmed with information and assessments, the majority of which may not affect the 2012 goal. For the May campaign the Presidential Task Force should begin with a focus on the 'Worst-Performing LGAs in the Worst-Performing States' and expand as appropriate/feasible with each subsequent round. Relatively well-performing States can deal with most of their LGAs through State Task Forces.

c. *Establish Standard Performance Indicators for LGA Preparedness & Performance:* a simple set of 5-7 indicators should be used to measure if an LGA is prepared for a campaign, with another set of 5-7 indicators to measure the performance of key campaign processes.

d. *Publicly Delay a Campaign if the LGA is not Prepared:* if a previously identified poor-performing LGA does not meet the preparedness indicators for an IPD, the State Governor should be immediately informed, a national enquiry should be initiated, and immediate corrective action taken. The Presidential Task Force should also recommend to the State that the flag-off in that LGA be delayed, for at most 7 days, while corrective action is taken. H.E. the President should be informed when this occurs in the highest-priority 'worst performing' states/LGAs.

5. **Concentrate First and Most Heavily on the 'Worst Performing' States & LGAs:** the concept of 'high risk' is itself at risk of losing meaning in the context of the Nigeria eradication programme.

   In reality, the main problem for the programme is chronic poor IPD performance in areas with persistent transmission (e.g. Kano, Borno, Sokoto) and areas with recurrent re-infection (i.e. the other, 'high risk' northern states). It is essential to understand this distinction as a basis for prioritizing areas for the rapid scale-up of the 'emergency approach'.

   At this stage the programme should categorize States and LGAs first by IPD performance, giving highest priority to those with persistent transmission, followed by those with recurrent re-infection. Clearly the greatest focus must be on the *Worst Performing States* (currently Borno, Kano, Sokoto, Yobe) and the *Worst Performing LGAs* within them.

   NPHCDA should ensure by 15 April 2012 completion of the work to categorize the northern states and their LGAs by their level of performance (worst to best) for programme planning purposes and for oversight/evaluation by the Presidential Task Force. The standard IPD process indicators used for defining worst performing areas should also be the basis for those monitored by the Task Forces. The epidemiology data should guide whether areas are defined as 'persistent transmission' or 'recurrently re-infected'.

   Beginning with the May 2012 IPD, all partners should support the Federal and State governments by concentrating resources and efforts on the Worst-Performing LGAs within the Worst Performing States. Ideally, partner operations would be fully scaled up in additional northern infected/re-infected States by the time of the subsequent IPD and at latest by September 2012.

6. **Use the Scale-up of the Polio Emergency Approach to Improve Routine Immunization Services:** urgent action is needed if the country is to protect its children from vaccine-preventable diseases and to be prepared for the introduction of pentavalent and pneumococcal conjugate vaccine and the 'polio endgame'. In other countries where polio technical assistance has been extended to the sub-district/sub-LGA level (as is planned in Nigeria), that capacity has been used to double routine immunization coverage during the period of the most intense

eradication activities (e.g. as was done in the states Bihar and western Uttar Pradesh in India).

As states, LGAs and partner agencies scale-up their technical assistance and attention to the worst-performing LGAs, specific attention should be given to:

a. *Microplanning:* using the new polio/IPD microplans to update routine immunization microplans as a basis for strengthening service delivery;

b. *Monitoring:* using the technical assistance to monitor the proportion of routine sessions that are planned vs conducted (as well as key barriers such as vaccine availability);

c. *Social Mobilization:* using the enhanced social mobilization & communications capacity and IWCS to specifically promote routine immunization and generate stronger community demand in areas where service delivery and vaccine availability is assured.