Joint appraisal report

Country	Nigeria
Reporting period	*January – December 2014*
cMYP period	*2011 – 2015*
Fiscal period	*January – December 2014*
Graduation date	*1st January 2022*

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. Gavi grant portfolio overview

The Federal Government and Development Partners, through more efficient partner coordination, have instituted a multifaceted approach to sustainably strengthen the EPI.

The country's comprehensive EPI Multi Year Plan (cMYP 2011-2015) articulated a long-term, strategic approach for redressing challenges in the immunization system in a holistic manner. In 2013, the National Routine Immunization Strategic Plan 2013-2015 (NRISP) was developed to express Nigeria's goals, objectives, and strategies to effectively meet the aims of the National Strategic Health Development Plan 2010-2015 (NSHDP) and elaborate on the RI component of the cMYP 2011-2015. On the basis of the NRISP, an operational plan was developed for 2014. The cMYP 2016-2020 is currently being developed and outlines the key activities planned in the next years.

The Inter-Agency Coordinating Committee (ICC) approved the 2014 operational plan. The total expenditure on immunization for 2014 was USD534,679,641 out of which Federal Government providedUSD190.9m(36%) and Gavi provided USD60.2m (11%). The contribution from Gavi was not a new disbursement, but a carry over of the HSS / ISS/ new vaccines introduction balances from the HSS 1 re-programming. Government percentage contribution to immunization expenditure has been on a marginal increase of 2% from 34% in 2011 to 36% in 2014 while Gavi contribution to immunization expenditure in Nigeria increased from 2.5% in 2011 to 11.2% in 2014.

Gavi's grant portfolio in Nigeria for 2014 covers the following:

- New vaccines introduction support: pentavalent vaccine support, pneumococcal conjugate vaccine introduction; and inactivated polio vaccine (IPV) introduction
- HSS / ISS cash support
- Meningococcal conjugate vaccine Type A campaign support
- Yellow fever campaigns (were planned for but postponed due to global vaccine shortage)
- INS support

With nationwide introduction completed by end 2013, Gavi support for pentavalent vaccines and devices continued through 2014. In December 2014, eleven (11) States introduced pneumococcal conjugate vaccine (PCV) as part of a 3-phase introduction plan. Gavi provided vaccines, devices and an introduction grant. The planned introduction of IPV was delayed till 2015 as a result the PCV introduction that was on-going during the last quarter of 2014 and the late completion of the VIG release processes.

The Gavi HSS Phase 1 funds were reprogrammed to address five (5) strategic areas including:

1. Demand creation and accountability,
2. Capacity building for frontline health workers and EPI managers,
3. Strengthening the NHMIS to ensure data quality, data analysis and utilization for informed decision making as well as programme monitoring and management,
4. Improved cold chain capacity and vaccine logistics at States/LGAs/health facilities level to improve storage of, and access to quality vaccines.

5. Addressing equity in availability and access to immunization services through targeted outreach services funded by ISS.

The Inter-Agency Coordinating (ICC) meeting held on 27th March 2014, approved the 2014 HSS and ISS activities work-plan. But, with the "put on hold" order from Gavi secretariat following the 2013 / 2014 provisional Gavi audit report, only a limited number of activities with regards training of PHC workers, procurement, maintenance and repairs of cold chain equipment, distribution of vaccines and devices, support to outreach services, were agreed upon for implementation as priority activities, thereby reducing the scope of the HSS implementation in 2014.

Nigeria benefitted from a special injection safety (INS) grant for procurement of devices for routine vaccination with the traditional vaccines.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- The reported number of children vaccinated with three doses of pentavalent increased from 5,890,585 to 6,389,932 between 2013 and 2014 leading to an increase in the country's official coverage estimate from 65% to 70%.
- The number ofpenta3 unimmunized children dropped by 25% from 1,092,323 in 2013 to 812,042 in 2014
- The phase four Men A campaign was conducted in 2014 with a reported coverage of 104%. These results will be validated with a planned post campaign survey.
- Pneumococcal conjugate vaccine was introduced into EPI schedule in 11 States in December 2014.
- Very high coverage was achieved with the Tetanus Toxoid campaign covering 6 States and 61 LGAs. In all, 2,746,212 (115%) women were reached.
- National cold chain capacity increased by 221,000 litres.
- Three (3) post campaign surveys were conducted, in line with IRC recommendations, to validate results of the 2013 measles, MenA and Yellow fever campaigns. National coverage from the surveys conducted in 2014 was as follows: measles (74.5%), MenA (88%) and yellow fever (76.75%).
- Utilization of the 2014 Gavi grant and usage of the polio infrastructure in the country to support RI in 2014 also contributed to the current achievements in PEI in Nigeria.

Challenges (Priority Ones)

- Most of the HSS / ISS activities proposed for implementation in 2014 as per the 2014 Gavi HSS work-plan approved by ICC were not implemented as a result of the 'Put on Hold' notice from Gavi Head-quarters following the 2013/2014 Gavi audit exercise. Following the 'Put on Hold' notice, Gavi Secretariat approved a few priority activities from the work-plan for implementation. There was also delays in the implementation of the approved priority activities especially at the initial stage due to the delay in the completion of the MOU between GoN and UNICEF / Gavi.
- There was delay in the introduction of PCV due to late receipt of decision letter from Gavi, late receipt of Vaccine Introduction Grant for PCV, delay in the signing of LOA between GON, UNICEF and WHO enabling them to act as 'pass-through'.
- Delay in retirement of ISS funds from state level.
- Non-implementation of Accountability Framework in Nigeria (AFRIN) Guidelines
- Insecurity in some parts of the country limiting ability to render immunization services
- Health worker strikes in various States affected programme implementation
- Denominator Issues with resultant gaps in planning and inconsistencies in RI coverage

- Global yellow fever vaccine supply shortage resulted in delayed or cancelled campaigns
- Inability to conduct National Immunization Coverage Survey in 2014 due to lack of funds
- Non-establishment of ward development committees (WDCs) in about 60% of wards; and non-functional committees in 20% of the wards that WDC was formed.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

The top priority areas of action for 2016 are:

1. Continue to strengthen the supply chain and logistics system with a goal of 100% visibility of stock and stock availability at LGA / HF by end 2016. Key actions:
   a. Integrate existing logistics management information systems (LMIS) with the visibility Analytics Network (VAN).
   b. Construct cold houses at the national level and operationalize three (3) hubs in Kano, Lagos and Abuja.
   c. Scale-up of push plus survey at health facility in Rapid pro / U-Report
2. Improve immunization advocacy, awareness, and involvement of community members.
   a. High-level advocacy at all levels for adequate and timely financing of immunization services (e.g. FMoH & NPHCDA to Federal Ministry of Finance to capture immunization services requirement in the Mid-Term Sector Strategy); and
   b. Activate community volunteers and structures to track newborns and defaulters for vaccination, in collaboration with their local health facilities (e.g. through WDC and VDC members such as TBAs, barbers, village/district heads, other traditional and religious leaders).
3. Strengthen use and quality of data / information at all levels:
   a. Conducting micro-census in areas where there is extreme deviation in the projected population or coverage far above 100% to improve denominator accuracy;
   b. Regular conduct of quarterly review meetings with all states plus FCT; and
   c. Regular conduct of DQS / LQAs and evaluation surveys; and timely implementation of recommendations.
4. Robust and high quality introduction of new vaccines & strategies
   a. Roll out of PCV to the remaining additional 16 phase 3 states, plus Rivers; and
   b. Focus on SWITCH from tOPV to bOPV in April 2016.
5. Improve on governance and accountability:
   a. Reactivation of PHC structures and technical coordinating committees at all levels for improved service delivery and management of Gavi grants;
   b. Rapid resolution of the "Put-on-Hold" impasse that is limiting funding flow;
   c. Update and implementation of accountability framework (AFRIN) guidelines at all levels;
   d. Hiring of State Accountants / consultants to manage retirement of funds at state level
   e. Timely availability of funds following decision letter; and
   f. Ensure regular Cash Audit exercise (at least once in every 1year).

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

- Renewal for
  - DPT-HepB-Hib (Pentavalent) nationwide, with revised targets. No change in presentation
  - Continuation of PCV for 21 states and complete introduction in the remaining 16 states.
  - IPV nationwide with change in presentation
  - Yellow Fever campaigns (2016-2020)
- The country plans to submit the following applications for the introduction of:
  - Rota vaccine
  - HPV demonstration project
  - Men AfriVac vaccine into the routine EPI schedule

Health systems strengthening support

- Extension of the time frame for implementation of the reprogrammed HSS/ISS phase 1 from June 2015 to December2015.
- There is a provisional approval of USD 83,904,305.7 for the Gavi Health System Strengthening (HSS) phase 2programme (July 2014 – June 2019) for the country by the IRC. The country is still awaiting the Decision Letter from the Gavi secretariat for the HSS phase 2-programme support.

1.4. Brief description of joint appraisal process

The process of development of the Gavi Joint Appraisal Report (JAR) for Gavi activities implemented in the country in 2014started with the exchange of calls, e-mails and teleconference between the Gavi focal persons at the Gavi secretariat and the Gavi desk officers at NPHCDA. The Gavi desk at the Agency was properly briefed on how to plan and conduct a joint Appraisal in the country. Relevant documents including the JAR guidelines and reporting templates were received from the Gavi secretariat.

The initial information gathered from the Gavi secretariat by the Gavi Desk at NPHCDA was shared with other Partners in the New Vaccine Strategic Team (NVST) meetings who also participated in some of the tele-conference during the JAR workshop planning process. The NVST members and other selected programme officers from the relevant MDAs formed the JAR Secretariat.
Several planning meetings were held before the JAR workshop that took place on the 6th – 7th of August 2015. During the planning meeting held on Monday 8thJune 2015, the team agreed to adopt the category A country approach for the conduct of the Joint appraisal in the country, which involves the participation of all immunization stakeholders in a 2-days joint appraisal workshop. The NVST acting as the JAR secretariat made recommendations on the proposed membership of the JAR secretariat, JAR Workshop and activities timeline to the Core Group and ICC for approval.

There were inputs at the Core Group and ICC meetings to strengthen and guide the composition and operations of the JAR secretariat and JAR committee members. The final JAR committee composition as approved by the ICC had membership from the Federal Ministries of Health, Finance, National Primary Health Care Development Agency (NPHCDA), National Planning Commission, National Population Commission; and representatives from the State Primary Health Care Boards and Local Government PHC Coordinators. Other JAR committee members were selected from WHO (National & IST), UNICEF (national & regional office), CHAI, BMGF, DFATD Canada, USAID, DFID, CDC, IVAC, JICA, Herfon, Save the Children, Solina Health, EU-SIGN and Gavi secretariat.

The activities timeline that was approved to guide the process of the joint appraisal report development is summarized in the table below:

Activity	Dates
Twice weekly planning meetings (JAR secretariat members)	Jun- Aug
Presentation of the composition of secretariat, JAR members and timeline to RIWG	09/06/15
Presentation of JAR work-plan, secretariat and committee members to Core Group	12/06/15
Presentation of JAR work-plan, secretariat and committee members to ICC	26/06/15
Continuation of the twice weekly meetings to pre-populate the JAR template	26/06-26/07
Presentation of draft populated template to JAR Team/Core Group	26/07/15
Arrival for the Graduation and JAR workshops	4/08/15
Gavi Graduation Workshop	5/08/15
Joint Appraisal Report (JAR) workshop	06-07/08/15
Harmonization of the JAR workshop report	10-14/08/15
Disseminate of draft report to JAR secretariat members for final comments	15-17/08/15
Update on the JAR workshop to the ICC	17/08/15

Disseminate of draft report to JAR committee and Core Group members for final inputs before Core Group meeting	17-20/08/15
Presentation of Draft Report to the Core Group	21/08/15
Finalization of the JAR report by the JAR Secretariat	24/08/15
Disseminate Draft Report to ICC members	25/08/15
ICC meeting for the approval of the final document	1st Week in Sept2015

As indicated on the timeline above, the secretariat team met twice weekly to plan and pre-populate the JAR reporting template before the main JAR workshop. The pre-populated template was circulated to all the JAR committee members before the workshop. The JAR workshop took place on the 6th and 7th of August 2015 as scheduled with all the expected participants in attendance; and was very successful.

Members of the JAR secretariat and selected members of the JAR committee met severally after the workshop to finalize the work done by the different working groups during the workshop. The final draft of the joint appraisal report was submitted to the Core Group and then ICC for approval before submission to the Gavi secretariat.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

Nigeria is the most populous country in Africa with an estimated projected population of about 187,008,875 people in 2015[1]and an estimated 7,458,349 live births per year. The country operates a federal system of government comprising of Federal, State and the Local Government Areas (LGAs). The provision of health care in the public system is tiered in accordance with the three levels of government. The private healthcare system provides care for a substantial proportion of the population.

The Federal Government of Nigeria maintains a policy to provide immunization services free to all against vaccine preventable diseases (VPDs). Through the Immunization Programme, housed in the NPHCDA, it provides overall policy guidelines and procures vaccines and devices for routine immunization. Operational management and service delivery are vested at State and LGA levels.

An Inter-Agency Coordinating Committee (ICC) has been established to co-ordinate the work of the agency and donors supporting immunization and vaccines. The Honourable Minister of Health chairs the ICC and other members include the Honourable Minister of State for Health, Permanent Secretary (FMOH), Director Health Planning, Research and Statistics (FMOH), Director Public Health (FMOH),Director General NAFDAC, Senior Special Assistant to the President on MDGs, WHO, UNICEF, USAID, Rotary International (Polio Plus),DFID,EU Delegation, DFATD Canada, Embassy of Japan, World Bank, CHAN, MSF, Red Cross, Bill& Melinda Gate Foundation, Clinton Health Access Initiative (CHAI),HERFON, CDC, Gavi and IVAC. The secretariat is the office of the CEO, NPHCDA. ICC endorses the Gavi work plan for implementation. The ICC works through the Core Group, which is mandated to integrate inputs from the functional working groups and provide routine oversight.

At the State level, functional oversight for immunization is vested in the State Primary Health Care Agency or Boards (where they exist) or State Ministry of Health (SMOH); while at the LGA level, the Primary Health Care Coordinator (PHCC) heads the immunization team.

The comprehensive EPI multi-year plan (cMYP 2010-2015) articulated a long-term, strategic approach for redressing challenges in the immunization system in a holistic manner. The 5-years plan was developed within the context of the Global Immunization Vision and Strategies (GIVS) to align with

[1] National population Commission, 2015

national health priorities as contained in the National Strategic Health Development Plan (NSHDP) 2010-2015. The National Routine Immunization Strategic Plan (NRISP) 2013-2015 was developed in 2013 to express Nigeria's goals, objectives, and strategies to effectively meet the aims of the National Strategic Health Development Plan 2010-2015 and elaborate on the RI component of the comprehensive multi-year plan (cMYP) 2011-2015. This strategic plan presents a road map for achieving vaccination of all children in accordance with global and regional goals. The national target of 80% coverage has been elusive for some time now, meaning that huge numbers of unimmunized children have accumulated, posing a threat to the health of the population, and causing outbreaks of diseases with epidemic potential.

As reported in the APR, the total expenditure on immunization for 2014 was USD 534,679,641. The Federal Government provided USD 190,904,231 USD (36%) and Gavi provided USD 60,251,250 (11%) (though this was not new disbursement from Gavi, but carry over of the HSS / ISS/ new vaccines introduction balances from the HSS 1 re-programming). The Federal Government contribution to immunization expenditure has been on a marginal increase of 2% from 34% in 2011 to 36% in 2014. The total government expenditure reported does not include the State and LGA expenditure on immunization, which covers human resources and other operational expenses. Gavi contribution to immunization expenditure in Nigeria increased from 2.5% in 2011 to 11.2% in 2014. Other contributions to the total expenditure in 2014 were from WHO (37%), UNICEF (15%) and CHAI (1%).

EVMA was conducted in 2014 and it showed significant progress at all levels as a result of implementation of the improvement activities identified by the 2010 EVMA. The assessment has helped the programme to identify key strengths and remaining challenges in the vaccine management performance. Based on the findings, an EVM Improvement plan was developed to address major challenges while sustaining the high performance.

National Health Act, which provides a framework for the regulation, development and management of the Health system and sets standards for rendering health services in Nigeria was signed into law. Efforts are on going to operationalize the Act.

The other factors/events during the year that had direct effect on the Gavi grant included:

- Rebasing GNI in April had dramatic effect on Nigeria's economic classification;
- More focused polio activities with a view to interrupting transmission;
- Finances and human resources was diverted to fight Ebola Outbreak in Nigeria in 2014;
- Lead up to elections at both state and federal levels impacted on budgets and financial release;
- Insecurity in some parts of northern Nigeria affected the service delivery; and
- 'Put on Hold' order from Gavi secretariat on the implementation of all proposed HSS/ISS activities in 2014.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

Programmatic performance and challenges

DPT-HepB-Hib (*Pentavalent) Vaccine*

By 2014, all States had introduced Pentavalent vaccine. The 2014 Country official estimate for penta3 coverage was 70 % against WHO-UNICEF estimate for Nigeria of 66%. Nigeria received 17,865,330 doses of Pentavalent vaccines in 2014 decision letter, which was less than required. Post Introduction Evaluation was conducted for Penta phase 3 states, which found improved knowledge of the vaccine and the cold chain system was functioning appropriately in the majority of states. However, health workers' knowledge of AEFI is still low.

MenAfriVac

Phase 4 of the MenAfriVac campaign was conducted as planned in October/November 2014. The set target for the campaign was 95% coverage, but the achieved administrative coverage was 104% with 3% wastage rate. The high administrative coverage could have been due to thehigh demand for MenAvaccine by persons outside the target age group.

Yellow Fever

Global yellow fever vaccine shortage affected the implementation of planned yellow fever campaigns in the country. The country has received only 10 million doses of yellow fever against the 62 million doses committed by Gavi. The country is expecting a new Decision Letter from Gavi secretariat with regards the 52 million doses of yellow fever vaccines yet to be delivered to the country for yellow fever campaigns in the remaining states.

PCV Introduction:

Introduction of pneumococcal conjugate vaccine (PCV 10) into EPI schedule for Phase 1 states commenced in December 2014.A readiness assessment was conducted by WHO prior to the introduction, looking at the placement of PCV 10 stickers on cold chain equipment and knowledge of health workers on PCV 10. Nigeria received 3,774,400 doses of PCV for twelve (12) states against the planned 4million doses in the decision letter.

PCV introduction was delayed from September till December 2014 due to the late release of vaccine introduction grant (VIG).PCV phase 1 introduction was planned for twelve (12) states, but the introduction in Rivers state has been delayed as a result of protracted health workers strike.

Supportive Supervision was conducted from the national level to the PCV Phase I states to ascertain the level of implementation and also address bottlenecks.

Lessons learnt from the introduction include:

- Modification of the training techniques with increased participation and facilitated study of manuals helped to maintain quality of training at all levels
- Time lag between training and introduction of vaccine should be shortened to maintain quality
- Extensive social mobilization prior to introduction is important to increase demand
- Inclusion of more private providers of RI during training to increase access

PCV phase 2 introduction is planned for October 2015 in nine (9) states; and the introduction in the remaining16 phase 3 states is planned for January 2016.

Monitoring and evaluation, surveillance and data quality:

Data Quality Assessment for 2013 data was conducted in 2014 with a verification factor of 96%. The monthly review meeting of health facility in charge and Local Immunization Officers (LIOs) at the LGA and States respectively also provides a forum for data quality checks.

National Immunization Coverage Survey (NICS) was planned for 2014, but was not conducted as a result of lack of funds.

Vaccine management:

A stock performance management dashboard was developed and introduced to improve on the stock visibility at LGA. This has led to the improved stock sufficiency at LGA level from 43% to above 80%.

Co-financing for new and under-used vaccines

Co-financing requirement for Pentavalent and PCV was USD 9,195,000 in 2014. No delays were recorded in the co-financing of new and under used vaccines and no records of GoN defaulting.

Key challenges

- There was significant delays in the implementation of the Gavi HSS 2014 work plan (including new vaccines introduction) as a result of the 'Put on Hold' notice from Gavi secretariat following the 2013/2014 CPA provisional report. There was delay in the signing of LOA between GON, UNICEF and WHO enabling them to act as 'pass-through' for the transfer of funds and implementation of the selected priority activities in 2014. WHO handled funds for some of the PCV & IPV vaccines introduction activities, while UNICEF handled funds for the approved priority HSS activities and remaining PCV & IPV introduction activities. The delay in the completion of the LOA also contributed to the delay in the receipt of decision letter and VIG for PCV and IPV introduction, which led to the re-scheduling of PCV introduction from September 2014 to December 2014; and IPV introduction from Q4 2014 to Q1 2015.
- WDC is an integral part of systems development and yet to be established in about 60% of wards, while about 20% of the WDCs formed are non-functional. The WDC support was not provided for in 2014 with resultant Less than optimum community ownership and engagement for planning, resource mobilization, defaulter tracing and co-management of the HF
- Most states / LGAs micro plans not always involving the communities and most times not always implemented. Again, equity and gender Issues not usually well articulated in the State plan to bridge the gap e.g. between the urban – rural, socio-economic quintiles etc.
- Inadequate funding (budgeting and releases) for RI services e.g. cold chain, outreach services, supervision, especially at sub-national levels. In addition, there is slow utilization of the ISS funds available to the states to bridge the gaps in these services due to the delay in the retirement of funds given to the states. This has resulted in the non-implementation of these proposed activities that would have contributed to the improvement in the immunization outcomes.
- Inadequate human resources for Routine Immunization (RI) and mal-distribution particularly at Service delivery level. Most of the health workers prefer to be posted to the urban health facilities thereby reducing the number of health workers available at the rural area for PHC services delivery (including immunization).
- Frequent and prolonged health worker strikes in many States affected programme implementation as observed in the delay in the introduction of PCV in Rivers state. This would result in the non-rendering of immunization services in the areas affected by the strike actions and subsequently an increased pool of un-immunized children.
- Non Implementation of Accountability Framework (AFRIN) guidelines to ensure efficiency and value for investment by government and partners in immunization services. There is need to have regular feedback on accountability to assess value for money spent.
- Weak partner coordination especially at States / LGAs levels, resulting in the implementation of parallel programmes and duplication of activities.
- Inadequate Supportive Supervision from National/States/LGAs to HFs. Opportunities for quick interventions and on-the-job- trainings are therefore lost.
- Inconsistency between different sources of immunization data remains a challenge, coupled with challenges with data management at all levels and denominator issues.
- Limited or non-use of data for decision making especially at operational levels. This could contribute to delayed and missed opportunities for quick intervention(s).
- Insecurity in some parts of northern Nigeria limits the ability to deliver immunization services in affected areas.
- Global yellow fever vaccine shortage resulted in delayed / cancelled campaigns in the country. There is still uncertainty in the supply of yellow fever vaccine for campaigns (10 million doses of the 62 million doses committed have been received for phases 1, 2, 3).
- A nation-wide stock out of yellow fever vaccine occurred in Quarter 3 of 2014, as a result of VVM7 used on the vaccine instead of VVM14. 876,000 doses of the yellow fever vaccine was affected.
- Shipment of biological E manufactured DPT-HepB-HiB arrived Nigeria in VVM stage 2; it was subsequently discovered that VVM 7 was used instead of VVM 14.

Financial performance and challenges

A total of USD 40,881,757 was received as support for new vaccine introduction and campaigns in the country out of which USD 24,394,039 was utilized (60%). These funds were used to implement activities contained in the approved work plan.

Activities already funded through the HSS grant were not duplicated in the VIG and campaign funds.

3.1.2. NVS renewal request / Future plans and priorities

Renewal of request for Currently approved vaccines:

1.Renewal of DPT-HepB-Hib (*Pentavalent) Vaccine*

During the application for Pentavalent introduction, the country revised its routine immunization targets using the coverage from WHO/UNICEF estimates, DQS, NICS and NDHS as indicators. These coverage rates have gradually increased over the years. Based on the cMYP 2016-2020 projections, the coverage targets for currently approved new vaccines are detailed in the table below.

Antigen	2014	2015	2016	2017	2018	2019	2020
Penta	82	87	90	94	94	94	95
Growth in Penta target		5	9	0	0	0	0
PCV	-	38	90	94	94	94	95
IPV	-		90	94	94	94	95

2. Renewal of Pneumococcal Vaccine:
   PCV phase 2introduction is planned for September / October 2015 in nine (9) states and Rivers state (as the health workers strike has now been called off). PCV phase 3 introduction in the remaining 16 states is planned for January 2016.

3. Renewal of IPV:
   By end of 2015, IPV will have been introduced in all the states including Rivers. The vaccines received in 2015 were 5-dose vial with VVM on the cap; and there is plan to change from 5 to 10 dose vial as captured in the forecasting for 2016 vaccines.

New applications and immunization programme priorities

The country has plans to submit applications to Gavi within the next one (1) year for the following:

- Introduction of Rota vaccine and MenAfriVac into the routine EPI schedule
- HPV demo project in two states – Nasarawa and Ebonyi.

Other programme priorities include:

- Introduction of PCV 10 into the Phase II and Phase III States
- "Switch", replacing b-OPV instead of t-OPV into the Routine Immunization in April 2016
- Finalizing the cMYP 2016-2020
- Intensifying supportive supervision at all levels
- Conducting Immunization coverage surveys

Expanding cold chain capacity to introduce Rota vaccine and MenAfriVac:

In drafting its new cMYP (2016 – 2020), the country in collaboration with in-country partners reviewed the programme performance, analyzed its capacity, global priorities and set forth the following priority areas over the next 5 years:

- Increasing and sustaining routine immunization coverage for all antigens; and reducing morbidity and mortality from VPDs.
- Reaching the hard-to- reach LGAs / communities

- Sustaining availability of bundled vaccines at service delivery sites
- Introducing new and underutilized vaccines (PCV, Rotavirus, HPV, IPV, Men A routine and second dose measles into the country's immunization schedule)
- To sustain and expand the cold-chain at all levels
- To sustain interruption of wild polio virus transmission and high quality AFP surveillance and eradicate polio in the country
- Measles morbidity and mortality reduction
- Maternal and neonatal tetanus elimination
- Strengthening health management information system (HMIS); and conduct national immunization coverage surveys.
- To strengthen the PHC system (through wards / community structures & participation)
- Improving budgeting and budget execution at federal, states, LGA and ward levels.
- Community engagement, participation and social mobilization for demand creation.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

Programmatic performance and challenges

Nigeria received HSS phase 1 support of USD 44,703,365 in 2008. In 2012, based on the recommendation of the Large Country Task Team on Nigeria, the outstanding funds from the HSS and previous ISS grant were reprogrammed for a total of USD 50,813,946 due to slow implementation. The reprogrammed HSS/ISS grant was initially approved for implementation till December 2013; but was later extended till June 2014 due to the late release of funds to the country in 2013.

The 2014 HSS work-plan was approved during the second ICC meeting held on 27th March 2014. Plans were on-going for the implementation of the approved activities by ICC, when a 'Put on Hold' notice was received from Gavi secretariat following the 2013 / 2014 provisional Gavi audit report.

Following a visit by the Gavi team during 2nd quarter of 2014, an approval was received from Gavi Headquarters for the implementation of a few selected priority activities from the 2014 work-plan that was approved by the ICC in March 2014.However, newly identified priorities that were not in the initial ICC approved work-plan were included in the Gavi-approved priority activities for implementation in 2014.An approval was later received from Gavi HQ for the transfer of funds to UNICEF for the implementation of the selected priority activities. There was further delay in the implementation of the selected priority activities due to the delay in the completion of the MOU between GoN and UNICEF / Gavi.

The following activities were implemented under the HSS/ISS grant:

Strengthening of the cold chain system

- *Procurement of cold chain equipment*:
  - Procurement of1,656 solar direct drive (SDD) refrigerators with 2-year preventive maintenance cover. The total cost of ownership included maintenance and training of technicians and CCOs was factored in. 1,589 (96%) of the procured SDD fridges were successfully installed in wards with large population across 36 states and the FCT, equipping 16.6% of wards in Nigeria. Procurement of six 40-cubic-metrewalk-incold rooms (WICRs), 30,566 vaccine carriers, 6,000 fridge tags and 41 Remote Temperature Monitoring Devices was completed.
  - Procurement of 31 incinerators is currently in process. POs issued to two suppliers and site inspections are ongoing. Installation should begin in four weeks pending the outcome of the site inspections
- Repair of broken down solar refrigerators:
  - 1,143 solar refrigerators were repaired (out of 1254 planned for repairs across 21 states). This exercise included maintenance training for technicians and health workers. (Detailed table in Annex G)

- *Trainings at all levels on SDD maintenance and operations*:
  - International training: 9 (of 10 planned) national technicians were trained in Luxembourg
  - National training: 74 state technicians (2 per state) and 37 state cold chain officers (1 per state) were trained in 2 batches in Abuja. Also refrigerator 21 instates
  - State training: A centralized supplemental training was provided for health workers in-charge of facilities that received SDD fridges in each state, on basic operations of the SDD fridges.
- These trainings have helped increase the critical mass of workers with technical capacity to operate and maintain SDD fridges in Nigeria. *Management support to PIT: This includes program management and coordination support over 11 months for the procurement and deployment of 1,656 SDD refrigerators across 36 states and the FCT.*
- *Vaccine stock performance management system (dashboard)*: This is anexcel based tool that provides a quick snapshot of the vaccine inventory by antigen stock levels and allocation. It is designed to provide data visibility on stock levels from the LGA up to the national level. Funds have been disbursed for data plans & PUSH training/supervision

Immunization Support Services:
Disbursement of ISS to states for service delivery is still ongoing; and only 27% of the funds have so far been disbursed due to delayed retirement from states.

Maternal Neonatal Tetanus Elimination (MNTE)
MNTE round1 campaign was conducted in 61 LGAs in 6Phase 1 states, namely; Ekiti, Ondo, Osun, Imo, Enugu and Ebonyi. Target population was 2,389,836 women of childbearing age and a total of 2,746,212 persons (115%) were reached. Data tools, namely; TT Cards, tally sheets and summary sheets were printedand distributed to the states involved in the round 1 MNTE campaign.

Post Campaign Coverage Surveys
- Measles post campaign coverage survey was conducted nationwide with exception of Borno state because of insecurity. The average measles coverage from the survey was 74.5%.
- Yellow fever post campaign coverage survey was conducted with a national coverage of 76.75%.
- Phase 3 MenA Campaign coverage survey was conducted in 8States (Kebbi, Taraba, Adamawa, Plateau, Nasarawa, Kaduna, FCT and Niger),which reported an average coverage of 88%.

The following activities commenced before the 'put-on-hold' notice:

HMIS: Funds for 75% of activities of the activities of the NHMIS had been released to the DPRS/FMOH before the 'put-on-hold' notice. This afforded 100% implementation of the following activities in the 14 penta phase 1 states.
- Procurement, printing and distribution of computers and printing of NHMIS data collection and reporting tools
- Training of Facility M&E officers on NHMIS tools
- Training of LGA M&E & State Officers on the DHIS for management.

Quarterly mentoring support to LGAs on electronic data capture and management was only 50% implemented. However, funds for data quality and data use trainings were not released, as they were not on the priority list.

Outstanding Activities on the priority list:
- Procurement of SMS-capable fridge-tags: there was no WHO-prequalified product at time of procurement
- 4% of the 1,656 SDD fridges procured are outstanding for installation
- Procurement of laptops and printers for the states (UNICEF provided desktop computer for all cold stores at national zonal and state level for the Navision deployment, which could be utilized for other activities).
- Training of health workers on Integrated PHC service delivery: There were several competing activities including planning for PCV and IPV Introduction.

- Recruitment of Gavi-funded State Accountants: Delays due to administrative bottlenecks.
- MNTE: support for the second round campaign

Challenges:

- UNICEF's procurement procedures switching financial management mid-stream came with a learning curve that led to some delays in implementation.
- Security challenges in the North East and health workers strikes delayed the installation of SDD refrigerators in some states.
- Competing activities hampered the implementation of other activities that were deferred as a result of the "Put on hold" e.g. the training of health workers on PHC took a lower priority than training for PCV and IPV introduction.
- Inadequate Staff compliment and mal-distribution particularly at the HF level
- Lack of funding impeded the planned formation, activation and reactivation of WDCs to foster community engagement.

Financial performance and challenges

As mentioned above under section 3.1, due to the "Put on hold" notice by Gavi, fund management for the HSS/ISS grant was temporarily transferred to UNICEF for priority activities. The total budget for the HSS/ISS priority activities was USD 15,425,942.46, of which USD 7,096,631.69(46%) has been spent. Details are in Annex F.

3.2.2. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve and sustain coverage and equity in access to immunization. See guidance document for more details]

The reprogrammed HSS/ISS grant had the following objectives:

Objective 1: **Demand Creation and accountability in new vaccine introduction states** through the reactivation/establishment of Ward development committees: Demand creation is one of the strategic focus of the NRISP (2013-2015) and cMYP (2011-2015). Lack of demand and trust in services has been a weakness of the programme, particularly in the north where health-seeking behavior remains an issue.

Although the intent was to strengthen demand creation, no related activities were included in the priority list. Greater focus has been on social mobilization and less on community engagement and ownership.

Key partners that supported the Government on demand creation include Global Fund, T-SHIP, PRRINN-MNCH, UNICEF, WHO, other CSOs and FBOs. These complementary activities were not national in scope but oriented more towards the northern part of the country where the need was highest. Emerging data, however, suggests a regression in progress in some southern states (increasing number of unimmunized children). Attention therefore should also be given to raising demand in other parts of the country.

Objective 2: **Building capacity of frontline health workers and EPI managers** to strengthen human resource for health through training on integrated PHC service delivery: One of the factors affecting immunization service delivery is the capacity and availability of health workers. The planned activities strengthen the capacity to deliver immunization services within the context of the PHC system, rather than as a vertical service. This contributes to improving service quality and coverage.

Objective 3: **To strengthen the NHMIS to ensure data quality, data analysis and utilization for informed decision making** as well as programme monitoring and management: This enables appropriate decision making regarding the performance and equity in coverage of the immunization program. The Gavi support complemented the country policy of a single integrated but decentralized

data management system put in place to address issues of multiple reporting systems.

The support enhanced the coordination role of the FMOH as it provided platform for aligning other ongoing initiatives on harmonized database by the Global Fund, WHO,UNFPA, MEASURE Evaluation, PRINN-MNCH and PATHS 2. The enhanced coordination has raised the completeness of reporting system from less than 10% in late 2012 to 65% by the end of 2014.

Objective 4: Improve access to quality vaccines and adequate storage at States/LGAs/health facilities level in phase 1 and 2 new vaccine introduction states:

The non-availability of vaccines and frequent vaccine stock-outs has been repeatedly identified as a bottleneck to improving the immunization coverage. The activities in this objective area, which include expanding the capacity and improving the maintenance of the cold chain system, as highlighted in section 3.2.1. above, are contributing to improve and sustain coverage by ensuring that vaccines are available in adequate quantity at the service delivery points and for outreach activities.

The support from Gavi is complemented by support from other partners and the government in strengthening the cold chain system through the facilitation of the Logistics Working group. UNICEF continued to provide technical support for Vaccine Security and Logistics through the engagement of consultants to build capacity for both state & LGA CCOs and assist in the management of supply chain performance metrics. JICA procured 400 solar battery powered fridges through UNICEF and Kano state procured 208 SSDs, along with commissioning five10-cubic-meter cold rooms. Kogi also procured 20 SDDs, 22 ILRs, 504 giostyles. Niger procured one 40 cbm WICR and 60 ILRs. Ondo procured 22 ILRs. CHAI & eHealth have implemented pilots of the PUSH system of vaccine distribution directly to health facilities in Kano & Lagos, which needs to be scaled up to all States

The Logistics Working Group has described the vision of Logistics management information system in terms of supply chain visibility for the country. This is being actualized through implementation of Navision, (which is a live ERP) and the stock management dashboard at the national and state levels. However the Country needs funding to integrate the dashboard into Navision to have visibility at LGA level.

Immunization Service Support (ISS): improves immunization services at service delivery level with particular emphasis on conducting outreach services, community link activities and ensuring the availability of vaccines/devices at the facility level.

Partners supported the GoN in RI intensification in poor performing and disadvantaged areas to address inequity. Projects like identification and intensification of routine immunization in very high risk LGAs, Hard to Reach LGAs/Communities. The Slum Project in Lagos State also specifically addresses the immunization and other PHC activities.

The MOU signed between Kano State, BMGF and Dangote Foundation and between Bauchi State, USAID, BMGF and Dangote Foundation is geared towards collaboration for improving routine immunization. While DF and BMGF contribute funds to the common RI basket, the contribution of USAID is technical especially in the areas of data management, supportive supervision, monitoring and evaluation, capacity building and community engagement.

The HSS has been able to address some of the challenges existing prior to introduction of new vaccines as implementation of some key HSS activities such as printing of data tools, procurement of Direct solar drive, and training of cold chain officers averted delay in introduction of IPV in some states.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

[Indicate request for a new tranche of HSS funds (and the associated amount) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming. Also describe future HSS application plans]

The country is proposing a discussion with the Gavi secretariat on the way forward for an extension of the HSS phase 1 re-programming to complete the implementation of activities that were in the 2014 ICC approved work-plan (Annex), but not included in the priority list that was approved by Gavi in 2014.

A 'no objection' approval has been received from Gavi to use the in country-unspent funds to pre-fund PCV phases, MNTE campaign and pre-implementation social mobilization activities for 2015 measles campaign. Approval to pre-fund PCV phase 3 is pending.

The country submitted request for support from Gavi for the HSS phase 2 (July 2014 –June 2019) in Q1 2014,and provisional approved by the IRC was received; but still awaiting decision letter. Country is proposing the commencement of the HSS2 programme from January 2016 to December 2020.

3.3. Graduation plan implementation*(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document]
The graduation workshop took place on 5th August 2015. The graduation from Gavi support is starting on 1st January 2017 and actual graduation on the 1st January 2022.

The graduation guidelines and principles have been adopted and taken into consideration in the process of development of the cMYP (2016 – 2020) that is about to be finalized.

3.4. Financial management of all cash grants

[Comment on all bolded areas listed in the table in this section of the guidance document]

WHO and UNICEF managed all Gavi cash grants in 2014. The breakdown of Gavi cash support utilization in the country is outlined in the table below.

Amounts in USD	Agency	Disbursed/ carried over	Utilized	Balance
HSS/ISS	UNICEF	15,425,942.46	7,096,631.69	8,329,310.77
	NPHCDA	5,979,018.05	-	5,979,018.05
	FMOH	3,727,053.00	2,647,368.00	1,073,684.00
PCV VIG Phase 1	UNICEF	302,627.00	162,230.00	140,397.00
	WHO	1,480,487.00	1,253,322.00	227,165.00
IPV VIG	UNICEF	5,569,473.33	2,522,240.57	3,047,232.76
Men A Campaign funds	UNICEF	8,142,028.00	5,418,315.46	2,723,712.54
	WHO	10,695,768.00	8,993,517.00	1,702,251.00
Total		**51,322,396.84**	**28,093,624.72**	**23,222,771.12**

The NPHCDA has a dedicated GaviISS account in a commercial bank. The signatories to the account as approved by the ICC are:

- Executive Director NPHCDA
- Chairman Rotary International

There is also a dedicated Gavi HSS account whose signatories are:

- Executive Director NPHCDA
- Director Finance and Accounts NPHCDA
- Director PRS, FMOH
- UNICEF Country Rep/WHO Country Rep

At least three of the signatories should sign for funds release i.e. the Executive Director NPHCDA, the FMOH and one of the partners.

All funds are drawn directly from the national level for all activities. Each beneficiary submits a work-plan in line with activities in the Proposal, which is approved by the Inter-Agency Coordinating Committee. When there are changes in activity plans by an implementer, an approval is sought from the ICC.

Once approval of work plan has been given and endorsed by the Honourable Minister of Health, the concerned agency or department applies for the approved fund and this is paid from the account. If the request is in local currency, the bank is instructed to convert the amount using the apex bank prevailing exchange rate.

The NPHCDA also has an internal audit department, which goes through all submissions to ensure compliance with approved disbursement guidelines.

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organizations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
Develop and implement micro plans detailed with involvement of communities, conduct LIDs (RI intensification, underserved) in underperforming and hard to reach wards and LGAs including displaced populations and conflict-affected areas.	Government / WHO / UNICEF	All Year	Gavi & other Partners
Reactivate / establish / support functionality of WDCs for demand creation at ward / community levels	Government & Partners	2016 - 2018	Government, Gavi& other Partners
Engage the private sector in routine immunization – (expansion of the MOU signed with private facilities providing RI and explore innovative strategies to sustain them)	NPHCDA / States / Partners (CHAI)	All year	Government (national, States& LGAs)& Partners
Train health workers at operational level on integrated PHC service delivery	Government & Partners	2016 - 2018	Government & Gavi
High Level advocacy to policy makers at all levels (National, State and LGAs, workers unions, Labour ministries etc).	IVAC & Government	All Year	Government & Gavi
Regular sensitization of Governors and LGA chairman on the impact of immunization and lives saved through vaccination.	Government / IVAC / UNICEF	All Year	Government & Gavi

Advocate to Hon. Minister of Finance to capture funding for immunization services and vaccine costs as priority project in Mid-Term Sector Strategy (MTSS).	NPHCDA	Quarter 3 (every year)	Not required
Advocate to States / LGAs to increase budgeting / release of funds for RI services, recruit / train / pay health workers HWs	NPHCDA / SPHCDA/Bs / LGA Chairmen / Partners	All Year	Government, CHAI& other Partners
Strengthen vaccine financing task force	Government, UNICEF& CHAI	All Year	Not required
Train FMoH / NPHCDA / state officers to improve financial management of grant support	Gavi Partners / consultants	2015 / 2016	Gavi
Early release of Decision letters and timely release of funds after approvals	Gavi	2 Weeks	Gavi
Timely release of funds by implementing partners after approvals	WHO / UNICEF	2 Weeks	Gavi
Scale up of push plus survey at HF in Rapid pro/ U-report	UNICEF / NPHCDA	All year	Gavi & Government
Develop last mile real time monitoring compatible with Navision Operationalization of the 3 hubs	NPHCDA / States / UNICEF / CHAI	2016	Gavi and Partners
Assure robust and high quality roll out of PCV in 16 phase 3 states	NPHCDA, WHO, UNICEF, CHAI & other Partners	2016	Government, Gavi & other Partners
Ensure a successful tOPV to bOPV switch	EOC, NPHCDA, WHO, UNICEF, CHAI & other partners	2016	NPHCDA & other Partners
Construct cold houses at the national level and operationalized three (3) hubs in Kano, Lagos and Abuja	UNICEF / NPHCDA	2016-2017	Gavi
Provide three (3) additional trucks for vaccine transportation	NPHCDA / UNICEF	2015-2016	Gavi
Integrate existing logistics management information systems (LMIS) with the Visibility Analytics Network (VAN)	NPHCDA, UNICEF& CHAI	All Year	Gavi
Reactivate technical coordinating committee comprising EPI and HSS stakeholders for operational management of Gavi grant	FMoH / NPHCDA / States	2015 / 2016	Not required
Use population data from Polio walk through micro plans, where ever it exists,	Government / WHO / UNICEF	All Year	Not required
Conduct micro census in areas where there is extreme deviation in the projected population or coverage far above 100%	Government & WHO	All Year	Gavi & Partners
DHIS2 scale up	CDC & Government	2015 - 2018	CDC & Funders
Regular DQS and Evaluation Surveys and implementation of recommendations	Government & UNICEF	Yearly	Government, Gavi & Partners

Update and implement the AFRIN Guidelines & tie salaries of Gavi consultants for retirement	Government / IVAC / other Partners	All Year	Government & Gavi
Finalize and implement Polio legacy transition plan.	EOC	2015 - 2018	WHO / UNICEF / GPEI
Hire state accountants and resident consultants to manage retirement of funds at state level	Government / States / Partners	All Year	Gavi
Conduct regular audit (at least every 1 or 2 years) and complete the audit processes in a timely manner	Government / Gavi	Every 1 or 2 years	Government & Gavi

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

[Comment on technical assistance received and the responsibilities of the different agencies, which provided the support. See guidance document for more details]

NPHCDA received technical assistance for training, planning, monitoring, development of proposals, and strategic documents like the cMYP, JRF, preparation of annual progress reports for Gavi grants, introduction of new vaccines, campaigns, from the various in-country partners including UNICEF, WHO, CHAI, CDC, IVAC, USAID, JICA, DFATD Canada, World Bank etc.

4.2 Future needs

[Comment on all bolded areas listed in the table in this section of the guidance document]

5. Technical support needed in implementation of Gavi grants for the following areas:

Area	Activities	Type of Assistance	Duration	Funding status	Partners
Programme monitoring and evaluation	An officer to monitor the implementation of Gavi grant, coordinate with all implementing partners	Long term Consultant to support NPHCDA Gavi Desk& Partners	Till the Gavi grant ends	Currently Not Funded	WHO / NPHCDA/ FMoH
Health information systems and data management including data quality	Development of data quality improvement plan and the implementation of the plan	Long term Consultant	Till the Gavi grant ends	Currently Not Funded	WHO / UNICEF / FMoH / NPHCDA
Fiscal advocacy and costing / financial sustainability with regard to graduation	To develop a comprehensive advocacy plan for immunization	Consultant	6 Months	Currently Not Funded	IVAC / NPHCDA
Financial management (better understanding of implementation of the grant)	Training on Gavi financial regulations and proper management of Gavi grant as per guidelines	Assistance at Regular Intervals	Short Term	Not Needed	Gavi
Logistics and cold chain a)Vaccines & Devices	Integrating stock management systems into Navision (Last mile Integration)	Institutional Support or Consultancy	Short Term	Partial Funding available from BMGF	UNICEF
b) Cold Rooms	Architect to review the 3 Hub Designs & Cold Houses	Consultant	Short Term	No Funding	UNICEF

Advocacy, Communication and Social Mobilization for demand creation and community engagement for immunization services	Support development of a communication strategy	Consultant	Short Term	Not Funded	UNICEF / NPHCDA
Long term assistance for improving immunization services in Nigeria, including strategies to reach the unreached	The existing workforce supporting the country in Immunization including Polio Legacy	Staff	Medium to Long term	Gaps from 2016	WHO, UNICEF, CHAI, IVAC, NPHCDA
Capacity building of LGA and state immunization officers	Develop a cadre of competent mid-level managers	Consultant	Medium to long term	Not funded	WHO / UNICEF/ NPHCDA
Development of the Gavi graduation planning and process	Develop Gavi graduation plan and process	Staff / consultant	Short to medium term	Not funded	NPHCDA / WHO/ UNICEF

ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS

(MAX. 1 PAGE)

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:
Issues raised during debrief of joint appraisal findings to national coordination mechanism:
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager:

6. ANNEXES

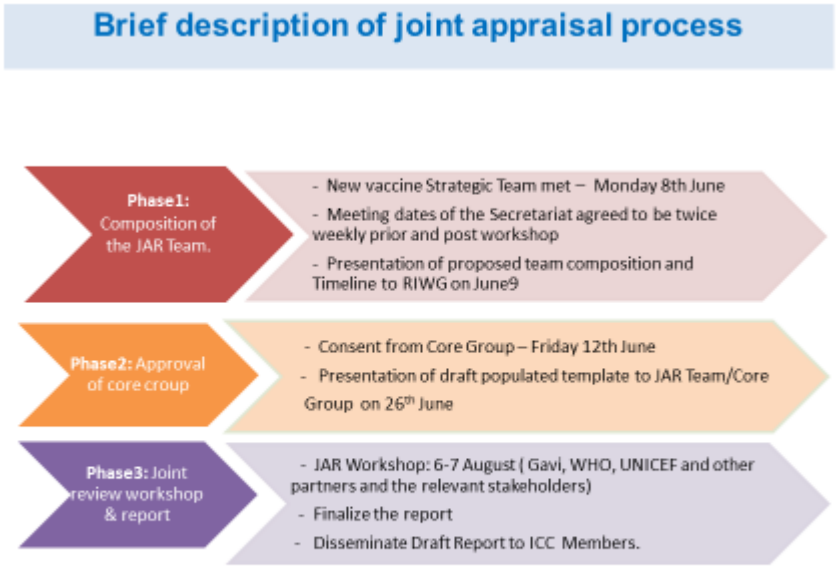
[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat).

- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)



- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date							
1.2 Date of reprogramming approved by IRC, if any							
1.3 Total grant amount (US$)			USD 52,348,501				
1.4 Grant duration			One year				
1.5 Implementation year			Month/year – month/year				
(US$ in million)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
1.6 Grant approved as per Decision Letter		21,439,754	1,165,238	0	0	12,402,439	
1.7 Disbursement of tranches							
1.8 Annual expenditure		0	9,267,669	2,495,772	5,372,499	7,411,757	12,660,661

1.9 Delays in implementation (yes/no), with reasons	Yes, Due to the 'Put on Hold' order, delay in the signing of MOU with partners implementing the priority activities, competing on-going activities and in a few instances delay in receipt of Decision letter.
1.10 Previous HSS grants (duration and amount approved)	Nigeria Gavi HSS (Phase 1) proposal was approved in 2008 for a total sum of USD 44,703,365 for the period of 2007 – 2010.

1.11 List HSS grant objectives

- **Objective 1:** Demand Creation and accountability in new vaccine introduction states;
- **Objective 2**: Building capacity of frontline health workers and EPI managers;
- **Objective 3:** To strengthen the NHMIS to ensure data quality, data analysis and utilization for informed decision making as well as programme monitoring and management.
- **Objective 4:** Improve access to quality vaccines and adequate storage at States/LGAs/health facilities level in phase 1 and 2 new vaccine introduction states
- **ISS**

1.12 Amount and scope of reprogramming (if relevant)

- **Objective 1:** Demand Creation and accountability in new vaccine introduction states;
  Budget: USD 4,008,194.
- **Objective 2**: Building capacity of frontline health workers and EPI managers;
  Budget: USD 7,800,585
- **Objective 3:** To strengthen the NHMIS to ensure data quality, data analysis and utilization for informed decision making as well as programme monitoring and management.
  Budget: USD 7,171,755
- **Objective 4:** Improve access to quality vaccines and adequate storage at States/LGAs/health facilities level in phase 1 and 2 new vaccine introduction states
  Budget: USD 21,368,430
- **ISS:**
  Budget: USD 11,561,200
- **Total: USD 52,348,501**

Annex E. Best practices (OPTIONAL)

1. Introduction of dashboard to improve visibility of vaccine status at national state and LGA levels:

There has been an increased stock visibility through the use of stock performance management dashboard at national and state with the resultant reduction in the reported vaccine stock outs at LGA level.

2. Use of Direct Solar Drive for vaccine storage at the ward level:

The procurement of the additional cold chain equipment (SDDs) has contributed to an increase in the national and sub national cold chain capacity by 1,757,300 litres.

3. Capacity of local technicians built on maintenance of the SDD

Vaccine handling and cold chain equipment maintenance has improved following the Vaccine Management Training of cold chain officers & technicians.

4. Introduction of real time supportive supervision including integrating community survey during RI supportive supervision:

Each cadre of surge staff carries out supportive supervision to a specified number of health facilities monthly, monitor immunization sessions (both fixed and outreaches) and offers on the job training. Real time feedback is provided.

ANNEX F. Detailed financial implementation for HSS/ISS

S/No.	Activity	Received	Committed	Balance	Comment
A. Priority Activities Already Approved by ICC for implementation before end of June 2014 :					
1	Training of health workers on Integrated PHC services delivery	$4,071,787.62	$0.00	$4,071,787.62	**Pending**
2	Procurement of remaining cold chain equipment (lot numbers 2013; 2-9)	$2,867,941.90	$2,438,907.00	$429,034.90	
3	Training of cold chain officers / HWs on cold chain maintenance and repairs	$1,769,876.19	$505,852.00	$1,264,024.19	
4	Management support to PIT through Solina Health	$424,750.00	$424,750.00	$0.00	Completed
Sub Total		**$9,134,355.71**	**$3,369,509.00**	$5,764,846.71	
B. Other Priority Activities proposed and already approved by ICC from the Unspent ISS Funds:					
5	Continuous disbursement of ISS to States for Service delivery including outreach services	$1,523,809.52	$301,972.00	$1,221,837.52	Ongoing
6	Operational funds to NSCS for cold chain maintenance and transportation of vaccines from national through zonal and state cold stores.	$1,864,355.89	$1,788,959.00	$75,396.89	Ongoing
7	Stock performance management dashboard	$374,285.71	$76,739.00	$297,546.71	Activity completed, partners were leverage to scale up across all states. The balance of funds is proposed for reprogramming to expend to cover LGA level.
8	Payment of state Accountants	$513,417.00	$53,144.00	$460,273.00	Funds commented for the recruitment process
Sub Total		**$4,275,868**	**$2,220,814**	$2,055,054.12	
C. MNTE Campaign - preparatory phase activities (from ISS funds)					
9	National TOT for micro planning	$49,752.28	$0.00	$49,752.28	The activities were conducted leveraging MenA funds. Outstanding funds proposed to be used for the second round.
10	State level micro planning training	$5,405.34	$0.00	$5,405.34	
11	LGA level micro planning training	$24,061.00	$0.00	$24,061.00	
12	Implementation materials-State level	$241,472.32	$49,630.00	$191,842.32	Balance is proposed for the second round.
Sub Total		**$320,690.94**	**$49,630.00**	$271,060.94	
D. Coverage Surveys (from ISS funds)					
13	Measles Post Campaign Coverage Survey	$447,500.00	$333,122.00	$114,378.00	Activity completed and the balance is proposed for reprogramming.
14	MenA post campaign Coverage Survey NGN 49,769,136 @ 160.5 per US$	$310,088.00	$221,096.00	$88,992.00	Activity completed and the balance is proposed for reprogramming. .
15	YF post campaign coverage survey NGN 32,560,844 @ 160.5 per US$	$202,871.00	$167,892.00	$34,979.00	Activity completed and the balance is proposed for reprogramming.
Sub Total		**$960,459.00**	**$722,110.00**	$238,349.00	
Total Programme Funds		**$14,691,373.77**	**$6,362,063.00**	$8,329,310.77	
Programme Support Costs (Recovery Costs) 5%		**$734,568.69**	**$734,568.69**	$0.00	
GRAND TOTAL		**$15,425,942.46**	**$7,096,631.69**	$8,329,310.77	

Annex G. Repair of solar refrigerators in 21 states

State	Number of faulty solars	Training Completed	Number of Solar repaired	Completion
Adamawa	24	Completed	24	100%
Bauchi	27	Completed	27	100%
Benue	101	Completed	92	91%
Borno	53	Completed	53	100%
Ekiti	29	Completed	25	86%
FCT	6	Completed	6	100%
Jigawa	32	Completed	29	91%
Kaduna	32	Completed	25	78%
Kano	64	Completed	18	28%
Katsina	34	Completed	34	100%
Kebbi	402	Completed	402	100%
Kogi	34	Completed	34	100%
Nasarawa	46	Completed	4	9%
Niger	48	Completed	48	100%
Ogun	38	Completed	38	100%
Osun	36	Completed	36	100%
Oyo	61	Completed	61	100%
Plateau	25	Completed	25	100%
Sokoto	50	Completed	50	100%
Taraba	62	Completed	62	100%
Yobe	50	Completed	50	100%
Grand Total	**1254**		**1143**	**91%**