Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analyzed, and explained where relevant.

Country	NIGERIA
Reporting period	*January to December 2015*
Fiscal period	*January to December 2015*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*NA*
Comprehensive Multi Year Plan (cMYP) duration	*2016 – 2020*
National Health Strategic Plan (NHSP) duration	*2010 – 2015*

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *PCV in existing presentation*	*Extension*	*2017-2020*	*7,530,268*	*7,078,452*	*US$ 53,668,500*
NVS – Penta in existing presentation	Extension	2017-2020	7,530,268	7,078,452	US$ 19,250,500
NVS – IPV in existing presentation	Renewal	*2017*	*5,185,086*		*US$ 7,638,000*

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	Rota introduction	*2016*	*2018*
	MenA introduction	*2016*	*2017*
	HPV Demo	*2016*	*2017*
	HPV (nationwide)	*2017*	*2019*
	Measles 2nd dose	*2017*	*2018*
	Revision of HSS2	Qtr 4 2016 – Qtr 1 2017	

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

The total population of Nigeria in 2015 was projected to be 186,458,724 (2006 census projection) with 7,458,349 and 7,197,307 of these being live births and surviving infants respectively. Access to Routine vaccines were provided, to protect these surviving infants and women against Poliomyelitis, Tuberculosis, Hepatitis B virus, Haemophilus Influenza type-b, Diphtheria, Pertussis, Tetanus, Measles, Yellow Fever and just recently, pneumococcal diseases.

Leadership, governance and Programme management:

In 2015, elections were conducted in the country from February to April, which led to a change in leadership at the Federal and most State Governments. The new government was sworn-in on the 29th of May 2015 with the resumption of federal cabinet Ministers in November 2015. During this period, the Permanent Secretary, Federal Ministry of Health chaired the meetings of the Inter-agency Coordinating Committee (ICC). The ICC met six (6) times in 2015, and some of the key decisions taken included the following: advocacy to Governors of States with identified challenges, approval of the MenA proposals campaigns and introduction into RI for submission to Gavi and provisional approval of the cMYP (2016 – 2020) before the final approval on 5th January 2016. Some of the major bottlenecks noted by the ICC in the implementation of immunization activities included inconsistencies in use of population statistics between EPI and other health programs and also quality of available data for decision making as was observed during the planning for measles campaigns.

The National Technical Advisory Group (NITAG) was constituted and inaugurated in August 2015. SIVAC provided technical assistance for the NITAG inauguration. NITAG has since inauguration met twice and has also put together a green book that details its strategic roles and responsibilities.
The National Immunization Financing Task Team (NIFT) was constituted in 2015 to coordinate advocacy efforts of partners and CSOs for sustainable immunization financing in view of the Gavi transition. NIFT has been able to hold several stakeholders meeting on sustainable immunization financing in view of the Gavi transition. In particular, it was able to stop the National Assembly to go ahead with its planned budget cut on immunization. Other achievements include the engagement of a consultant to study the profitability of local vaccines production.

Bureaucratic challenges exists at the States between the leadership of the State Primary Health Care Development Agency (SPHCDAs) and the State Ministries of Health in the implementation of Primary Health Care Under One Roof (PHCUOR) by the SPHCDAs as enshrined in the national PHC reform approved at the 54th National Council of Health. Advocacy visit from the National Government and Partners have solved this challenge in some of the States in 2015 (e.g. Sokoto and Rivers State). The SPHCDAs is responsible for the planning and implementation of the Reach Every Ward RI strategy at the subnational levels. One (1) PHC per ward is contributing to improve the infrastructures needed at the lower level for RI service delivery.

The following targets under programme management were not achieved in 2015: establishment / reactivation of WDCs in the remaining 60% of wards hiring of states accountants / resident consultants to manage retirement of funds at state level and conduct of micro census in areas with extreme deviation from the projected population due the non-commencement of the HSS2 programme implementation and the "Put-on-Hold" impasse from Gavi as a result of the delayed conclusion of the audit exercise.

Coverage and equity:

There has been an improvement in the administrative coverage data and official estimates from the DVD-MT platform. The 2015 administrative Penta3 coverage was 96%, which exceeded the set

target of 87% for the country. Available data shows an improvement in the Penta3 and IPV administrative coverage in most of the Northern states and other hard to reach areas. The administrative coverage for PCV3 in the twelve phase 1 states was 97% as at December 2015. Findings from the coverage cluster survey incorporated within routine immunization supportive supervision (RISS) showed 68% of the children as fully immunized children, 23% partially immunized and 9% not immunized.

At the LGA level, the administrative coverage varied and ranged from <50% to >95%, about 145 LGAs (18%) had Penta3 coverage below 80%. Majority of these suboptimal performing LGAs are in states affected by insurgency and prolonged health workers strike (e.g. Borno, Kogi and Rivers). There is also an improvement in the completeness and timeliness of reporting on the DHIS2 platform. Completeness improved from 42% in December 2014 to 66% in December 2015; and 71% in April 2016; while timeliness improved from 32% in Dec 2014 to 66% in December 2015 and 62% in April 2016. Completeness and timeliness on the DVD-MT platform was sustained above 90%. There is an observed wide discrepancy between the different sources of data in the country (DHIS, DVD-MT/Survey data). Possible reasons for these discrepancies and way forward to improve data quality in the country are discussed under “other factors” and programme management.

To address inequity in coverage, NPHCDA and partners implemented the following activities: supportive supervision to the identified low performing States / LGAs, implementation of integrated immunization services (through the “Hard to Reach project” in 6 States, RI intensification in 12 Polio High Risk (HR) States, and 3 rounds of Local Immunization Days in Rivers, Edo and Oyo states). Twelve (12) LGAs in Borno State were not accessible due to ongoing insurgency.

The implementation of these activities have contributed to the reduction in the number of un-immunized children from 389,096 at the end of 2nd quarter to 224,041 at the end of 3rd quarter and just about 39,470 at the end of the 4th quarter. There was also reduction in the number of cases and deaths from vaccine preventable diseases. No case of MenA meningitis and WPV was recorded in 2015. A total of 203 measles outbreaks with 1,688 cases were recorded in 2015 compared to the 112 outbreaks with 617 cases so far recorded in the country in 2016. The efforts of the government and partners on Polio eradication have also paid off in the delisting of Nigeria in 2015 from Poliovirus countries. No case of WPV was recorded in 2015. However, as at the time of writing this report two (2) case of WPV has been recorded in the country in Borno State. Response efforts are on going on the polio outbreak in the country.

Immunization financing:

The total immunization expenditure for vaccines and devices procurement for routine, NPSIAs and SIA-Polio in 2015 was $ 92,288.668.16 (this amount excludes funds for direct procurement of new vaccines by Gavi). The total sum of $ 9,102,287.16 was from the GON, $ 22,094,922.93 from WB Loan, $ 55,391,458.07 from JICA and $ 5,700,000.00 from UNICEF. Detail is shown on table 1.

Table 1: 2015 Immunization Procurement Value – Cost from Cost estimates

FUNDING SOURCE	AGENCY	ROUTINE	NPSIAs	SIA –POLIO	PROCUREMENT METHOD
NPHCDA (2014 carryover-funds available in UNICEF)	GoN	$5,541,788.47			Procurement services
NPHCDA (Jan 2015 (Routine immunization deposit	GoN	$2,727,768.69			Procurement services
WB - (Routine Immunization)	WB Loan	$17,608,233.43			Procurement services
WB - (2015 Measles campaign - 12,660,300 doses)	WB Loan		$3,608,185.50		
JICA LOAN (POLIO)	JICA			$55,391,458.07	Procurement services
NPHCDA (Meningitis AYCW)	GoN		$832,730.00		Procurement services
UNICEF - BMGF - IPV-10	UNICEF			$5,700,000.00	Programme
UNICEF - WB (buffer)	WB			$878,504.00	Procurement services
TOTAL BY ACTIVITY		$25,877,790.59	$4,440,915.50	$61,969,962.07	

Most of the government funds went towards the procurement of traditional routine immunization vaccines, injection devices, safety boxes and co-financing for the new vaccines. The change in leadership caused delays in approval of budgets and release of funds for operational activities at federal and subnational levels. However, the country also met its co-financing obligations for Penta and PCV (about 80% of the co-financing fund in 2015 and 100% in 2016 came from the World Bank).

Notwithstanding the rebasing of the economy in 2014, the country has witnessed a gradual decline in its economy due to insurgency in the North Eastern part of the country and militant activities in the Oil rich Niger Delta region. These calls for improved prioritization of domestic government expenditures to ensure immunization (as a highly cost-effective intervention) is fully funded. The drop in the international price of crude oil, which is the country's main source of income, has also affected the remittances of the federal government to the States. The reduction in State resources caused most of them to defer on payment of staff salaries, which in turn resorted to strike actions with adverse effects on immunization services particularly in the public sector.

Other system components (immunization service delivery, reporting etc):

This huge commitment to protect the vulnerable members of its citizens against diseases that are preventable through vaccination is presently being enhanced by the current administration resolve to revitalize Primary Health Care in the country through the deliberate effort to rehabilitate one Primary Health Care center in each of the 9557 wards in the country to provide comprehensive primary health services. This measure is geared towards strengthening the reaching every ward strategy of delivering routine immunization to reach every eligible child and women and achieving the quest for universal health coverage in line with the Global Vaccine Action Plan (2011-2020) to reach all persons whoever, whatever or wherever they live.

Based on findings from external PIE reports, surveys and RISS, efforts are being made to address challenges that lead to poor data quality such as discrepancies in denominator, multiplicity of data tools and the need for regular supportive supervision. The DHIS2 rollout is some States is already

showing a progressive increase in the completeness of reporting from 42% in December 2014 to 71% in April 2016. There are also efforts to institute periodic data quality audit (e.g. DQS etc.) and validation exercises, ensure effective and regular Integrated Supportive Supervision (ISS), harmonize survey activities and ensure timely feedback of findings and recommendations. A committee has been set up with the NPHCDA, National Population Commission (NPoPC), the National Bureau of Statistics (NBS) and Partners as members to resolve the issue of denominators in the health information system and make appropriate recommendations to the ICC for intervention to improve data quality (including surveys).

Other factors / events:

Other achievements in 2015 included improved better communication to improve harmonization of individual work plan and the development of the 2016-2020 comprehensive multi year plan (cMYP: 2016-2020), which was approved by the ICC on the 5th of January 2016.

3. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section

3.1. New and underused vaccines (NVS) support

3.1.1. Grant performance, lessons and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

a. Programmatic performance and Challenges

- ***Performance of each Gavi-supported vaccine programme against approved targets:***

Table 2: Nigeria 2015 Target against Coverage

	Penta3	PCV	IPV	Measles
Target	94%	42%	87%	91%
Administrative (JRF)	96%	97%	86%	96%
Official (JRF)	74%	73%	44%	71%
WUENIC	56%	13%	-	54%

There is an observed wide discrepancy in the reported data between the administrative coverage, official estimates, Wuneic estimates and even survey reports mainly due to denominator issues, inadequate / multiplicity of data tools, inadequate supportive supervision at all levels and attitude of the health workers. Availability of vaccination cards and cadre of personnel used during the survey exercises also have impact on the quality of survey report(s). Steps taken to address data quality in the country is discussed in the later section.

Summary information on VPDs and new vaccine surveillance data is provided in the table 3 on page 9.

- ***Results from equity analyses***

From DHIS 2013 in-equity in immunization was observed in two key areas – socio-economic & geographical areas. Children in families in the poorest quintile are five times less likely to be vaccinated compared to children in the richest quintile. In geographical equity huge disparities exist between and within states, a child in the South East zone is more likely to be vaccinated five times than a child in the North West zone.

The following interventions were carried out in 2015 / 2016 to address in-equity;

- Supportive supervision to States / LGAs with low immunization performance,
- Implementation of integrated immunization services through the "Hard to Reach project" in 124 LGAs in Bauchi, Borno, Kano, Yobe, Kaduna & Katsina states;
- Routine immunization intensification in Polio High Risk (HR) LGAs in 12 states: Adamawa, Borno, Gombe, Katsina, Kebbi, Sokoto, Yobe, Jigawa, Zamfara, Kaduna, Taraba & FCT; and
- Local Immunization Days (LIDs) in Rivers, Edo and Oyo states. Routine Immunization intensification has been implemented in 72 instead of 84 LGAs (12 LGAs were not accessible in Borno state due to ongoing insurgency).
- Based on the monthly RI feedback, the Minister of Health, ED- NPHCDA and Partners have advocated to Governors of States with poor RI performance; and there is an observed steady improvement from some of those States (e.g. Rivers, Kogi, Lagos, Akwa Ibom, Delta). Efforts are ongoing to address the issues in the remaining eight (8) identified States.
- The 3rd ICC meeting held on 23rd June 2016 has directed the mapping of all the hard-to-reach LGAs / wards / communities in the country by the RIWG; and recommendations for long-term systematic solutions to address persistent immunization equity gaps in those areas. Updates on the hard-to reach areas by States and possible recommendations for interventions to be re-presented during the 5th ICC meeting in October 2016.
- Few States are also implementing newborn / defaulter tracking strategies, tracking of pregnant women in relation to continuum of care (e.g. Ondo, Bauchi, Kano).

The implementation of these activities have contributed to the reduction in the number of un-immunized children from 389,096 at the end of June 2015 to just about 39,470 at the end of December 2015; reduction in the number of cases and deaths from other vaccine preventable diseases (measles, meningitis and sustained zero WPV status in 2015).

The in-country HSS team with representatives from all immunization stakeholders will follow usual consultative approach / workshops to decide on the way forward for the Gavi HSS phase 1 re-

programming unspent fund and the Gavi HSS phase 2 programme in the country. The HSS team would forward the revised plan to the Gavi Secretariat after approval by the ICC in Qtr 4 of 2016.

- ***Progress in the implementation of new vaccines introductions and campaigns in 2015:***

i. IPV: The introduction of IPV into routine immunization commenced in February 2015 and stretched till September 2015 (against the initial plan to complete introduction in all states by April 2015). This was due to prolonged health workers strike action in most states arising from unpaid salaries; and also delay in the delivery of data tools to the States. The country received a total of 6, 799, 545 doses of IPV; and 3,804,587 out of the 4,423.938 infants were immunized. The administrative coverage for IPV at the national level in the targeted States in 2015 was 86%, against the target of 87%. About 307 LGAs (39%) reported coverage less than 80%. The IPV low coverage in some states was due to the stock-out experienced as a result of global shortage. Efforts are ongoing to source and procure adequate quantity of the vaccine.

ii. PCV: The target of 42% set for PCV as shown in table 3 above was for the 21 Phase 1 & 2 States that were supposed to introduce PCV in 2015. However, at the end of 2015 only eleven (11) of the twelve (12) phase 1 states completed introduction of PCV in 2015 with an administrative coverage of 97%. The country received 6,073, 800 doses of PCV. About 1,334,613 infants were vaccinated with the 1st dose, 1,187,543 received the second dose and 1,018,521 received the third dose (drop-out rate of 23%, against a set target of 8%). This high drop-out for PCV is as a result of the following: introduction in only 11 states (compared with a nationwide utilization of Penta), the states introduced at different times of the year and the stock out of PCV that occurred in some states (Kogi and Ebonyi). We expect that the drop-out rate for PCV and Penta will be the same when PCV is fully introduced nationwide.

Pre-introduction activities for the nine (9) phase 2 states started in September / October 2015 for introduction in January 2016. This was against the initial plan for the remaining phase 2 states to introduce in quarter 4 of 2015. The lateness in the declaration of balances from Gavi funds in-country which was a prerequisite for the approval of the Gavi no objection letter contributed to the delay in the PCV phase 2 introduction.

The plans to reduce drop-outs includes infant registration by settlement, defaulter tracking (using village health workers / CHEWs, village / ward development committee members, polio infrastructure etc) and house to house sensitization. Pilot plan to send SMS reminders to the parents and caregivers on the due dates of vaccination(s) is on-going.

The balance of 2014 PCV VIG were used in 2015 for pre introduction activities (see Table 3).

iii. Pentavalent vaccine: The 2015 cumulative national administrative Penta3 coverage was 96%, which exceeded the set target of 87% for the country. The country's official estimate as reported on he JRF was 74% (based on RISS cumulative survey findings and DQS correction factor); while the wuneic estimate was 56% (based on the Nutritional Survey). The country received a total of

26,948,570 doses of Penta vaccines in 2015. About 6, 934,550 infants were immunized with the 1st dose, 6,491,805 with 2nd dose and 5,973,183 with the 3rd dose. A drop-out rate of 13.8% was recorded (just below the set target of 14%).

iv. Measles campaign: The first phase of the measles vaccination campaign exercise was carried out in November 2015 in the nineteen (19) northern states (including FCT). The campaign targeted children aged 9 months to 59 months old. Pre-campaign activities that were carried out included; micro planning, training, advocacy and social mobilization. A total of 24,472,534 children were targeted during the first round campaign and 24,069,024 (i.e. 98%) were vaccinated. The second phase in the remaining seventeen (17) southern states in January 2016 targeted 14,567,117 children and 19,102,223 (i.e.131%) were vaccinated. Nationally, 39,039,651 children were targeted and 43,171,247 (i.e. 111%) were vaccinated. However, the post campaign survey showed 84.5% coverage, possibly due to poor card retention.

The campaign has contributed to an observed slight decrease in the number of cases measles during the year. A total of 203 measles outbreaks with 1,688 cases were recorded in 2015 compared to the 112 outbreaks with 617 cases so far recorded in the country in 2016. Refer table 3 on page 9.

The initial delay to agree on the target population for the campaign led to the delay in the commencement of the first phase of the campaign and extension of the phase 2 to quarter 1 of 2016. Others included health workers strike in some States, inadequate logistics for the hard-to-reach areas, inadequate State / LGAs counter-part funding due to dwindling economy and insecurity in the north east and some other parts of the country due to insurgency and kidnapping.

- ***Status of strengthening surveillance systems:***

There is on-going surveillance for PMB, Rotavirus, measles, polio, NNT and YF in the country. Overall assessment of IDSR in relation to all VPDs reporting / investigation in 2015 was good. External Surveillance Review held on 15th – 26th August by Global Polio Partners concluded that there is strong surveillance structure with well-trained workforce in the country and that in States visited, except for Borno and in other inaccessible areas, AFP case detection is likely sufficient to detect circulation of CVDPV2 and WPV1. Summary of the VPDs and new vaccines surveillance in 2015 is shown in the table on page 9.

Successes recorded in VPD surveillance in 2015 include: sustained improvement in the tracking of disease trends, improved response to epidemics (e.g. polio and measles) and improved timeliness and completeness of reporting. AEFI surveillance is institutionalized in Nigeria and currently reported on both the DVD-MT / DHIS2 platforms (though AEFI was not recorded on DHIS2 platform in 2015). A total of 6,645 cases of AEFI were reported on the DVD-MT platform.

Major challenges to the VPD surveillance in the country include: insecurity (especially in the north east and Niger Delta where some areas are inaccessible), recurrent / prolonged health workers strikes, Inadequate active case search/supervision (due to inadequate funding especially at subnational levels), limited involvement of private health facilities in surveillance, frequent stock out in most lab

supplies and basic equipment across all the NVS sites, poor documentation and archiving and persistent 25 underperforming LGAs for IDSR and new vaccine surveillance. There is also the challenge of under-reporting of AEFI from the States possibly for fear of being punished (and none on the DHIS2 in 2015); and insufficient AEFI reporting tools were experienced in 2015, AEFI cases reported in 2015 were also not specific to the new vaccines introduced.

Table 3: VPDs and new vaccines surveillance (Jan 2014- June 2016)

Indicators / Parameters	2014 (Jan - Dec)	2015 (Jan - Dec)	2016 (Jan -Jun)
a. Measles:			
Target Population	180,049,323	186,458,724	191,843,149
Total reported cases of Measles	9,302	14,963	13,883
No of cases confirmed by epidemiological link		4,363	4,976
Measles cases confirmed by final classification	902	1258	1076
No of confirmed outbreaks / cases	121 (607 cases)	203 (1,688 cases)	112 (617 cases)
No of affected States / LGAs	20 (103 LGAs)	23 (in 174 LGAs)	23 (108 LGAs)
Measles incidence (Target < 6 per million / year)	25/million	42.4/million	44.9/million
Proportion of cases from whom specimen was collected	75%	80%	74%
Laboratory results made available	55%	62%	60%
% Measles IgM positives	15.40%	14.80%	16.40%
Annualized detection rates of suspected Measles cases per 100,000 population	5.2	8.1	14.5
Annualized detection rate of non - measles febrile rash illness	2.7	3.8	5.5
% LGAs with at least one case with blood specimen / year	84%	93%	89%
b. AFP Surveillance:			
AFP cases (1/100,000)	858	885	914
Annualized AFP detection rate	13	15.7	10.6
Annualized non-polio AFP rate	12.6	15.7	10.6
Non-polio Enterovirus (Npent) rate	11.7	10.1	10.6
Confirmed WPV1 cases	6	0	2
Confirmed cVDPV	29	1	1
c. Neonatal Tetanus (NNT):			
LGAs/States that reported	66 LGAs in 18 states	79 LGAS in 23 States	33 LGAs in 14 States
No. of NNT cases reported	104	124	38
d. Yellow Fever:			
No of LGAs / states reporting	177 LGAs in 32 States	281 LGAs in 35 States	175 LGAs in 32 States
Total suspected cases reported	406	715	328
Cases confirmed by lab (IgM positive)	0	0	0
Cases confirmed by Epi-link	0	0	0
% LGAs reporting at least 1 suspected case (target > 80%)	25%	38%	25%
% cases investigated within 7 days of onsets	76%	66%	71%
% cases investigated with blood specimen	100%	100%	100%
e. New vaccine surveillance (PBM & Rota virus):			

	2014 (Jan – Dec)	2015 (Jan – Dec)	2016 (Jan – Jun)
i. For PBM (All 5 sites reporting):			
Number of suspected cases enrolled into sites (LP done)	719	720	357
Hib b positive	1	13	1
S1 pneumoniae	7	88	38
N1 meningococci	5	30	2
Total confirmed cases	13	131	41
ii. For Rota virus surveillance (2 sites - Enugu & Ilorin):			
Total cases enrolled	641	710	522
Cases that tested positive for Rota virus	251	309	218
Proportion positive cases (%)	39.1	43.5	41.8

Current ongoing strategies by NPHCDA, States and Partners to close the observed surveillance gaps include: focus on poor performing states / LGAs / Wards, strengthening of surveillance in underserved populations including IDP camps and at border areas, special strategies to address security compromised areas (including use of media jingles, IEC materials, engagement of assistant DSNOs and community informants etc); and expansion of reporting network to include traditional leaders and private clinics. Others include capacity building of surveillance personnel at all levels, improving documentation and archiving of data (reproduction and re-distribution of data tools to all the states in Qtr 1 2016), provision of logistics and technical support to national labs; and establishment of specific and long-term tracking of all areas / populations where mOPV2 is used to monitor for future VDPV2 emergence.

- ***Compliance with data quality and survey requirements:***

Currently routine immunization data is being reported on the DVD-MT and the DHIS2 platforms in all the States (except Borno that is yet to report on the DHIS2 platform). However, issues with data quality still persist and these include: discrepancy in reported data between the two administrative platforms (DHIS2 & DVD-MT), >100% reported administrative coverage for some in some States, negative dropout rate and negative unimmunized). There is a wide discrepancy in the reported data between the administrative coverage, official estimates, Wuneic estimates and even coverage survey data.

The possible reasons for the observed data issues would include the following: inappropriate denominator, inadequate / multiplicity of data tools, weak routine immunization supportive supervision (scope, quality and use of data for action); and attitude of the health workers. Availability of vaccination cards and the use of personnel with no immunization background for immunization survey exercises also have impact on the quality of coverage survey report(s).

There are ongoing efforts to address these data quality challenges. National Data Quality Self-assessment (DQS) is being conducted on an annual basis and findings us to guide interventions. Community survey was included in the 2015 DQS as part of measures to validate the administrative data. Community Cluster Survey is also incorporated into the monthly RISS exercise and reported monthly on the ODK platform. Quarterly reviews are also being conducted at the National level with the State Immunization Officers (SIOs) and M&Es. States are also being encouraged to conduct

quarterly data self-assessments. Regular (monthly) review meetings are held at the State level with the Local Immunization Officers (LIOs). There is ongoing DHIS2 training / roll out in the country supported by BMGF through CDC (training was completed in 8 States in 2015 and on-going in 10 States this year). Walk-through micro-plan and GIS mapping have also been conducted in some states. National census is planned for 2017 / 2018, and this would possibly address some denominator issues).

The National immunization coverage survey (NICS) was incorporated within the Multiple Indicator Coverage Survey (MICS). The combined MICS / NICS exercise was initially planned for 3rd quarter 2015, but later rescheduled for Q1 2016 and now Q3 2016. Pre-survey activities are currently ongoing. The National Nutritional Status Survey in 2015 showed DPT3 coverage of 56%.

b. **Key implementation bottlenecks and corrective actions:**

Vaccine management still remains an issue especially at the States, LGAs and health facilities levels. This is evident by the stock-out experienced and vaccines found in stage 3 (e.g. 396,580 doses of Penta in nine (9) States in 2015). The States and the doses involved include: Akwa Ibom (63,580), Delta (20,340), Edo (92,210), Rivers (129,620), Ondo (31,860), Oyo (7,290) and Ekiti / Ogun / Osun (51,680). This was mainly attributed to the health workers strike action during the year that lasted between four (4) to eleven (11) months in some States.

As part of the implementation of the EVMA improvement plan, the country introduced the vaccine stock management dashboard to monitor vaccine stock at the national and state levels. Based on the analysis of the information on the dashboard, appropriate and timely actions are taken. Even-though there have been great steps towards stock visibility; there is little utilization information visible in the system. Other challenges include: implementation of the continuous temperature monitoring (especially response to alerts), storage capacity (plans for the 3 HUB not fast tracked at national and capacity gaps at the ward level), funding for distribution, vaccine management (prevention of freezing); and irregular supportive supervision. An update on the status of implementation of the EVMA is planned for September 2016 together with the strengthening of the State Logistics Working Groups (SLWGs). No additional technical assistance is required with regards the EVMA implementation.

Other challenges in cold chain management experienced include: irregular power supply, insufficient quantity and quality of human resource for vaccine management, poor visibility into vaccine utilization and stock performance at service delivery points. Comparison of vaccine utilization and children immunized is not available or used especially at the sub-national levels. This problem would be addressed with full implementation of the Visibility and Analytics Network Project.

With the salaries not being paid it has been extremely difficult to implement some of the planned activities. Delays in the payment of health workers salaries have resulted in recurrent and prolonged health workers strike actions, and this disrupted immunization activities in 2015. The Hon Minister of Health advocated to the Nigeria Governor's Forum (NGF) and have also made personal contacts with some of the Governors of the worst hit States on the need for the payment of health workers to be

given priority attention at the States. Bailout funds were also released from the Federal Government to the States to enable them pay outstanding salaries. Efforts are also ongoing to involve more private health facilities in the provision of immunization services.

There is no funding for demand promotion and communication for routine immunization activities in all the states. Funding even from partners is usually limited to social mobilization activities for campaigns and new vaccine introduction(s), which weaken continuity of demand creation activities for routine immunization. In addition, there is limited technical assistance (communication experts) at the state level to support state and community communication teams resulting in limited focus on demand generation for routine immunization.

Insecurity: The issues of Boko Haram in the north east zone, militancy in the south south zone and kidnapping especially in some parts of south east / south south zones also affected routine immunization program implementation in 2015. This is due to the fact that some of the LGAs / communities in those areas are not accessible – (e.g. 12 LGAs in Borno State cannot be accessed for the RI intensification support, likewise most riverine areas in Bayelsa, Rivers and Delta States).

c. Financial performance and challenges:

Currently, WHO and UNICEF are managing the vaccine introduction grant (VIG) in the country due to the Gavi cash audit exercise on NPHCDA for the period 2010 – 2015 that is yet to be concluded. Draft report of the audit exercise was received and country response forwarded to Gavi, awaiting finalization of the audit exercise report. The delayed conclusion of the extended cash programme audit exercise also contributed to the slow implementation of activities and inability to commence the implementation of the HSS2 programme in the country. About sixty (60%) percent of the planned activities were carried out in 2015. The remaining 40% of activities could not be implemented because of competing activities in 2015; and so rescheduled for implementation in 2016.

The sustainability of the additional improvements observed in the States supported for the hard to reach projects and RI intensification projects should donor-funding decline would be a challenge, as the country will be entering Gavi graduation from January 2017. The RI intensification projects, Hard-to-reach projects and LIDs contributed to improvement in immunization coverage and reduction in the number of un-immunized children in the targeted States / LGAs / communities. .

d. Overall Programmatic / financial capacity to manage NVS grants:

Lessons have been learnt from the just concluded Gavi Cash Audit exercise. NPHCDA is already implementing some of the recommendations of the audit exercise. As soon as Gavi audit issues with the NPHCDA are resolved, NPHCDA has the capacity to manage the grants, though this is to be evaluated by a program capacity assessment planned for October 2016. Existing capacity of relevant officers in the various departments of NPHCDA can be further improved through trainings. However, a fiduciary agent should be installed to work with the Agency.

Conclusions: Achievement was made in the implementation of planned activities, though there are still gaps that are yet to be addressed; and efforts are ongoing to address some of these gaps. Some of the bottlenecks will be addressed in the Gavi HSS2 reprogramming.

3.1.2. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

Renewal of requests for currently approved vaccines:

Based on the newly approved cMYP 2016-2020, the coverage target for current Gavi supported vaccines are shown in Table 4: below:

Antigen	2016	2017	2018	2019	2020
Penta	90	94	94	94	95
Growth in Penta target	9	0	0	0	0
PCV	90	94	94	94	95
IPV	90	94	94	94	95

PCV introduction is planned for completion nationwide by end of third quarter 2016 in the remaining 16 phase 3 states.

Currently, the country is using the 2-dose PCV and 5-dose IPV presentations, but the country is willing to change to the 4-dose PCV and 10-dose IPV presentations as soon as they are available in 2018; because of the advantage of reduced cold chain storage space.

The country has applied to Gavi to introduce MenA and Rota into her EPI schedule in 2017 and 2018 respectively. The application have been reviewed by IRC and recommended for approval. Clarification on the issues raised by the IRC have been addressed by the country and submitted to Gavi. The application is pending audit resolution. In addition, IRC has recommended for approval the HPV Demo and MenA Catch-up Campaign in 2017.

Based on the cMYP 2016 – 2020, the current priorities for the country's EPI program include:

- Increase and sustain routine immunization coverage for all antigens;
- Reduce morbidity and mortality from all VPDs (measles and tetanus inclusive);
- Improve RI services to reach the hard-to- reach LGAs / communities;
- Sustain availability of bundled vaccines at service delivery sites;
- Strengthen Health Management Information System (this include data quality);
- Introduce new and underutilized vaccines (MenA, Rotavirus and HPV) into the country's immunization schedule;
- Strengthen the PHC system (through wards / community structures & participation);
- Improve budgeting and budget execution at Federal, States, LGA and ward levels;
- Sustain and expand the cold-chain at all levels; and
- Sustain interruption of wild polio virus transmission and eradicate polio in the country.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

The current HSS / ISS funds in-country aligns adequately to the system bottlenecks and have significantly contributed to improve coverage and equity. It has also strengthened the programmatic systemic and financial capacities of the country. With the current dwindling of the nations economy, support from Gavi and other immunization has been very helpful to the programme. Complimentary and added value of the Gavi HSS 1 progarmme support to the country include the following:

- Cold chain expansion (through the procurement of 1,656 SDDs and other cold chain devices)
- Training of health workers on integrated PHC and data quality has contributed to some improvement at the service delivery point.
- Support for the establishment and reactivation of WDCs also contributed to improvement of ownership and participation of community members if the delivery of services
- ISS support to the States / LGAs for outreaches, cold chain maintenance at the LGA / HFs, and supportive supervision.

Provisional approval was given for the Gavi HSS 2 programme in Qtr 1 2014; but Decision Letter was not given because the HSS 1 is yet to be fully utilized and also the fact that the Gavi cash audit exercise that that started during Qtr 4 2013 is yet to be concluded. A lot has happened within the immunization space of the country that the country needs to make some adjustments to the earlier submitted HSS2 proposal. The basis for the planned change to the HSS 2 proposal include the following:

- The current administration is committed and resolved to revitalize Primary Health Care in the country through the deliberate effort to rehabilitate one Primary Health Care center in each of the 9557 wards in the country to provide comprehensive primary health services.
- There is also currently two (2) cases of polio in the country at a time there is huge gap in the polio funding, therefore additional burden to respond to the outbreaks that were not planned for.
- Gaps in the data quality
- Inadequate cold chain capacity / poor maintenance of CCE especially at the subnational levels

- The country is commencing graduation from Gavi Support from January 2017. The National Immunization Financing Task Team (NIFT) was constituted in 2015 to coordinate advocacy efforts of partners and CSOs for sustainable immunization financing in view of the Gavi transition.

These gaps need to be addressed. Hence, the in-country HSS team is planning to follow usual consultative approach / workshops to decide on the way forward for the Gavi HSS 1 re-programming unspent fund and the Gavi HSS 2 programme in the country to meet these needs. The Secretariat would forward the revised proposal to the Gavi headquarters after approval by the ICC in Qtr 4 2016.

3.2.2. Grant Performance and Challenges:

This section covers an analysis of both the programmatic and financial aspects of HSS grant performance and related implementation challenges.

Programmatic Performance and Challenges

In the 2014 JAR, the country reported the process that led to the reprogramming of HSS 1 to cover 15 priority activities; and the development of MoU between the GoN and UNICEF/Gavi for the disbursement of the funds to support the activities.

In the reporting year, the HSS / ISS grant was used to strengthen logistics, commodity management system at the national, zonal, state and LGA levels; and ensure routine immunization service delivery in 8 States. It addressed issues on accessibility in relation to the availability of immunization and PHC services in remote areas as it funded outreaches in 2,111 wards. The following activities were 100% completed:-

- MNTE Campaign (round 2) in 61 high risk LGAs in 6 States (Imo, Ebonyi, Enugu, Ondo, Osun and Ekiti): This was initially planned for 2014, then rescheduled for 2015 and eventually implemented in March 2016due to non-availability of funds. A total of 2,375,070 women out of the 2,505,336 targeted (i.e. 94.8%) were vaccinated.
- Measles, MenA and Yellow fever post campaign coverage surveys:
- Vaccine stock performance management dashboard up to the State level;
- Management support to SDDs Project Implementation Team through Solina Health;
- Procurement and distribution of 30,568 vaccine carriers; and procurement / distribution / installation of 6 walk-in cold rooms; fridgetag-2 in all LGAs and “Beyond wireless” devices in all states, zonal and national cold stores to monitor vaccine temperature and give instant alerts;
- Rollout of NAVISION / VAN for tracking and analysis of vaccine stock performance at the National, Zonal and State cold stores; and
- Training of seventy-four (74) cold chain technicians and 37 cold chain officers from 36 state and the FCT on “Beyond wireless”; and also training of 925 LCCOs on cold chain maintenance and repairs. These trainings have contributed to an improvement in the management of the cold chain equipment at the subnational levels with resultant reduction in the vaccines and devices stock-outs VVM stage 3 reporting. There is also an improvement in the functionality of the CCE at the LGAs / service delivery points.

Ongoing activities include the

- Improvement of zonal cold stores capacity to hold state buffer requirements;
- Commencement of planning for the 3 Hubs in Abuja, Kano and Lagos;
- Last mile cold chain saturation about 69% in line with the 1 CCE per ward policy;
- Operational funds to the NSCS for cold chain maintenance and transportation of vaccines from national through zonal and state cold stores: and
- Continuous disbursement of ISS to states for service delivery including outreach services: So far, only 8 out of 36 and the FCT have accessed the Gavi ISS funds. The fund is still available for any states to access in 2016 upon retirement. Challenges in the access to funds include delay in the retirement of expended funds by states and cumbersome UN processes of retirement.

Other activities carried out to strengthen the cold chain system that were not Gavi supported are as listed:

i. Procurement, distribution and installation of 1,200 25L cold boxes, 2 walk-in cold rooms (UNICEF Funded) and 400 battery driven solar fridges funded by JICA.
ii. Procurement and installation of 208 and 160 SDDs in Kano and Bauchi respectively. Donation of SDDs by Partners (EU-SIGN 27 in Yobe; MNCH2 85 in Kaduna, 20 in Kogi, 1 WICR and 22 ice-lined refrigerators in Niger, 22 ice-lined refrigerators in Ondo.
iii. The Solina Health provided management support to the project implementation team on the procurement and installation of SDDs.
iv. The Coca Cola Company Nigeria Limited collaborated in the provision of preventive maintenance of CCE in Lagos.

Identified bottlenecks to the implementation of key activities mentioned in section 3.1.1 above are

i. Insecurity in some parts of the country;
ii. Delay in payment of salaries with resultant strike actions by health workers in most States;
iii. Delay / non-retirement of ISS funds by states / cumbersome UN processes of retirement; and
iv. Inadequate funding for demand creation for routine immunization by most States / LGAs.

Activities proposed to address these bottlenecks includes

i. Special strategies such as hit and run and collaboration with the military authorities in security compromised areas;
II. Sustained advocacy to political leadership at the States / LGAs and other stakeholders to address issues of delayed payment of salaries to avoid health workers strike action(s); and Improved funding for immunization service delivery.
III. To address the issue of delayed / non-retirement of Gavi ISS funds, priority would be given to the recruitment of State accountants who are charged with financial responsibilities / RI consultants, implementation of the communiqué of the consultative meeting with stakeholders on ISS fund utilization held in November 2013; and implementation of the revised Gavi guidelines on the Gavi fund utilization, which the State / LGA officers were trained during Qtr1 2014. The NPHCDA State Coordinators would support the State Accountants and Consultants to address the issue of delayed / no-retirement of Gavi ISS funds at the States.

The country will conduct MICS/NICS in the last quarter of 2016 and the findings will be used to address data quality and equity issues.

The balances of HSS / ISS balances is shown on table 5, page 17.

Table 5: Balance of HSS/ISS Funds in 2015

Area of Support	Agency	Amount (USD)			Comments
		Balance 2014	Utilized 2015	Balance 2015	
HSS	UNICEF	4,629,672.78	1,029,054.91	3,600,617.87	These are provisional figures pending final payments of all commitments
	NPHCDA	3,444,191.81	0	3,450,517.15	Increase in balance is due to $ 6,325.34 bank interest accrual
	FMOH	1,073,684.00	0	1,073,684.00	Amount at the FMoH was in a Naira account: Balance as at 29/06/2015 was N216,128,096.28. Amount transferred to CBN TSA account.
	WHO	344,260.74	317,383.74	26,877.00	2014 balance was from PCV VIG (phase 1)
ISS	UNICEF	3,699637.99	1,375,848.99	2,323,789.00	These are provisional figures pending final payments of all commitments
	NPHCDA	4,497,746.52	1,936,785.79	2,560,960.53	Interest income in 2015 was $ 27,963.74 therefore bringing total amount in 2015 to $ 4,525,710.26. Amount utilized in 2015 was for payment of SDD supplied by Domestic SAR

Poor utilization of the Gavi funds has been a major challenge with the HSS grant. Implementation of the proposed activities under item 'iii' above would greatly improve the utilization rates of the Gavi ISS funds at the States / LGAs.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

About 2.4m USD of the HSS funds in country was utilized in 2015. The slow rate of utilization is due mainly to non-retirement of funds by States. Delay in reaching consensus on the content and procedure for the integrated PHC training for health workers delayed its implementation. The recruitment of State Accountants that was agreed in the prioritized activities was not carried out thereby impeding the retirement process; efforts would be made to recruit the accountants before the end of the year.

The in-country HSS team with representatives from all immunization stakeholders will follow usual consultative approach / workshops to decide on the way forward for the Gavi HSS phase 1 re-programming unspent fund and the Gavi HSS phase 2 programme in the country. The HSS team would forward the revised plan to the Gavi Secretariat after approval by the ICC in Qtr 4 of 2016.

3.3. Transition planning *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

A Transition/Graduation Workshop was held in Abuja (August 2015) where the Gavi Secretariat updated the country and all RI partners in country of the June 2015 Board decision on the Eligibility, Transition and Co-financing policy. Under the revised transition/graduation policy of Gavi, Nigeria will enter the five-year graduation process on 1 January 2017 and will have transitioned out from Gavi support by 1 January 2022. Upon graduation on 1 January 2022, Nigeria will need to pay approximately US$164m for currently approved vaccines introduced with Gavi support (penta, PCV, Rota, YF & Men A); and about US$200 million (if traditional vaccines are included).

A transition assessment is planned for Q3/4 of 2016 to help the country appropriately prepare for the accelerated transition phase that begins on 1 January 2017. Gavi will have a tailored approach for the transition assessment and planning process. Additional mitigation measures will be discussed at various governance structures as and when needed.

In preparation towards a smooth transition, the country constituted the National Immunization Financing Task Team (NIFT) to coordinate advocacy efforts of Government, partners and CSOs towards meeting the national immunization financial needs. The leadership provided by NPHCDA through NIFT inspired the active participation of non-health actors particularly CSOs under the coalitions NMA, Partnership for Advocacy in Child and Family Health (PACFaH), SOLINA Health, Vaccine Network and Women Advocates for Vaccine Access (WAVA). The NIFT was tasked to provide a comprehensive National transition plan which included activities it had already undertaken with other stakeholders, institutional capacity assessment plan for example local vaccines production Financial capacity assessment and the planned risk assessment provided by CHAI and building consensus on bridging funding gap. Gavi would also support the review of the developed country transition plan after full assessment.

High-level advocacy visits were made to raise awareness, engage a wider audience and ensure that key stakeholders in the Legislature, Ministry of Finance, the private sector and general public were aware of the huge funding gap. Immunization budget is being given priority attention in the MTSS at the Federal Ministry of Finance. NIFT has been able to hold several stakeholders meeting on sustainable immunization financing in view of the Gavi transition. In particular, it was able to stop the National Assembly to go ahead with its planned budget cut on immunization in 2015/2016. Other achievements include the engagement of a consultant to study the profitability of local vaccines production. Community level advocacy focused on sustained Community dialogue with Village Heads and targeted women groups. The cMYP (2016-2020) provided the evidence of the country's immunization financial needs which was very useful in the harmonization of advocacy messages. For long-term sustainability, consultations and engagement of stakeholders is ongoing on the possibility of local vaccine production.

Polio Legacy

In 2015 the country initiated activities geared toward polio transition planning which included the establishment of the Polio Legacy Technical task team and the inauguration of the Polio Legacy Planning Committee in May 2016. These bodies have finalized the costing of a work plan and drawn up a timeline for its activities, which will need to be supported taking advantage of any future reprogramming. Asset mapping and documentation of lessons learned are ongoing. However, two (2) cases of WPV have been reported in Borno during the process of compiling this report; and response

efforts are on-going. This has an effect on the entire transition polio legacy planning. The task team is readjusting the plan to accommodate the current outbreak.

3.4. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

Table 6: Financial management of all cash Grants

Programme support	Agency	Balance (2014)	Disbursed (2015)	Utilized 2015	Balance (2015)	% Utilization	Comment(s)
HSS/ISS	UNICEF	8,329,310.77	0	2,404,903.90	5,924,406.87	28.9	
	NPHCDA	7,941,938.33	0	1,964,749.53	6,011,477.88		The $ 34,289.08 observed difference is due to the interest income on the ISS & HSS accounts in 2015. Amount utilized in 2015 was for Dometic SDD ($1,954,929.06) & WHT ($9,820.47). Note: Additional $1,133,728 was disbursed to unicef in January 2016 for MNTE campaign (Annex 2). So, current balance of $ 4,877,749.88. Account in CBN TSA
	FMOH	1,073,684	0	0	1,073,684		N216,128,096.28 in Eco Bank transferred to CBN TSA Acct. (Refer annex 3).
	WHO	0	0	0	0	0	
PCV VIG Phase 1	UNICEF	140,397.00	0	89,346.96	51,050.04	63.6	
	WHO	344,260.74	0.00	317,383.74	26,877.00	98	$ 1,584,121 was received in 2014 and $ 344,260,74 rolled over to 2015. Funds were used for PCV Phase 2
PCV VIG Phase 2	UNICEF	0	0	0	0	0	
	WHO	0	0	0			Used balance of PCV phase 1 and Men A campaign to support PCV phase 2 to the tune of $ 756,399.00
IPV VIG	UNICEF	3,047,232.76	0	50,385.73	2,996,847.03	1.7	
	UNICEF	2,723,712.54	0	1,036,309.81	1,687,402.73	38	Funds used for incinerators

Men A Campaign funds	WHO	2,543,893.00	0.00	1,743,893.00	800,000.00	93	$ 11,444,472 was received in 2014 and $ 2,543,893 rolled over to 2015. Part of the balance was used for PCV Phase 2 and Measles campaign
Measles	UNICEF		6,487,444.76	6,199,013.30	288,431.46	95.6	
	WHO		13,321,683.00	7,866,856.00	5,454,827.00	59	
Total		**26,144,429.14**	**19,809,127.76**	**21,672,841.97**	**24,315,004.01**		The $ 34,289.08 observed difference is due to the interest income on the NPHCDA ISS & HSS accounts in 2015.

Financial statements / Analysis from NPHCDA and WHO are attached as annexes 1a & 1b. Transfer from NPHCDA to UNICEF is attached as annex 2 and financial statement from FMOH as annex 3.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritized strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Key recommended actions in the 2015 Joint Appraisal Report (JAR) to achieve sustained coverage and equity included the following: High level advocacy at all levels to policy makers, establishment / reactivation of WDCs in the remaining 60% of the wards in the country, timely availability of funds following decision letter(s), rapid resolution of the "Put-on-Hold" impasse, implementation of the AFRIN guidelines, Hiring of states accountants / resident consultants to manage retirement of funds at state level, regular cash audit exercise and conducting micro census in areas where there is extreme deviation in the projected population or coverage far above 100%. The status of implementation of some of the 2015 priority activities is shown on table 7 below;

Table 7: Status of implementation of some of the 2015 priority activities is shown on table 7 below.

Prioritized strategic actions from previous joint appraisal / HLRP process	Current status
1. Implementation of the AFRIN Guidelines & tie salaries of Gavi consultants to the retirement expected from states of assignment	Ongoing
2. Hiring of State Accountants / resident consultants to manage retirement of funds at state level	Not done
3. Train FMoH / NPHCDA / state officers to improve financial management of grant support	Not Done.
4. 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.	Done. Intensification of RI was carried out in 72 polio high risk LGAs in 12 states in northern Nigeria. The hard to reach project is still ongoing in 67 LGAs in 4 States to deliver vaccines in hard to reach areas.

5. Train health workers at operational level on integrated PHC service delivery	Not done in 2015 but carried over to 2016 as IMCI+ (National and Zonal planning meetings conducted)
6. Rapid resolution of the "Put-on-Hold" impasse that is limiting funding flow	Ongoing but slow

5. PRIORITISED COUNTRY NEEDS[1]

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

Prioritized needs and strategic actions	**Associated timeline for completing the actions**	**Does this TA?*** *(yes/no)* / type of assistance
RI Data Quality improvement: - Review / streamline/ update HMIS & data tools (linked with DHIS2 RI module) - Use GIS maps and local denominators to improve accuracy of REW micro-plans & local RI denominators - Institutionalize data triangulation techniques in all States (e.g. using subnational estimates using surveys) - Use polio assets to build out better surveillance for all VPDs including meningitis and rotavirus diarrhoea - Training of national and State level managers/ - Supportive supervision, improving on DQS and quality of surveys etc).	DHIS2 roll out to be completed by Dec 2017. GIS mapping / walk-through micro-plan in some selected states (ongoing). Training of National and state level managers to be completed by end 2016. Provision of data tools / SS (all year).	Yes. In the training of National and State level EPI Managers and staggered training of LGA and HF level Personnel
Develop and implement micro plans to improve coverage and equity in underserved / underperforming / hard to reach wards / communities (including displaced populations and conflict-with <80%: - Sustained advocacy to States/ LGAs - RI intensification - Hard to reach projects - LIDs	All year	No
Sustained advocacy for availability of bundled vaccines and funding for immunization services at all levels	All year	No
Strengthen the PHC system to increase demand creation for RI (through wards / community structures & participation and PHCUOR reform)	All year	Yes. Using the consultants already on ground in-country
Reprogramming of the Gavi HSS2 programme proposal / Review of the cMYP (2016 - 2020) to reflect current realities.	October - December 2016	Yes. Internal / External TA to review the documents.
Hire State Accountants / resident RI consultants to manage retirement of funds at state level and implement Gavi financial guidelines	October - December 2016	Yes. Consultants well versed in Gavi financial management systems to train hired accountants.
Capacity building of FMoH / NPHCDA / state officers to improve financial management of grant support	Jan - March 2017	No

Train health workers at operational level on IMCI	October 2016 - April 2017	No
Rapid resolution of the "Put-on-Hold" impasse that is limiting funding flow	ASAP	
Expansion and maintenance of CCE at all levels	All year	No
Introduce new and underutilized vaccines (MenA, Rotavirus & HPV) into the country's immunization schedule	MenA 2017, Rota 2018 & HPV 2019	No
Provide PPM for all current investments	Dec-17	Yes
Strengthen vaccine performance dashboard to inform PUSH in non-PUSH implementing states and increase visibility into vaccine utilization and stock performance at service delivery points	Dec-17	No
Implement VAN and instituting performance tracking using KPIs/	2018	Yes. Consultant for VAN to support NPHCDA
3-hub expansion for storage	2018	No
Develop Gavi transition plan. - RIWG engaged in polio legacy / transition plan development	Immediate	No
Sustain interruption of wild polio virus transmission and polio eradication in the country.	All year	No
Improve the quality of Supportive Supervision (SS) and increase Government leadership to SS	All year	No

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	Partners jointly developed the first draft JA report. Draft report was presented to the ICC members for endorsement on 16th August 2016. It was agreed at the meeting that the most recent draft copy of the JA report be re-circulated to all members immediately after the meeting. Joint comment / feedback from ICC members was to be communicated to the ICC Secretariat on or before 22nd August 2016. The ICC Secretariat was to ensure that all comments from Partners were in-cooperated into the JA report and sent back to all ICC members on or before 29th August. The updated report was re-circulated to ICC members for their comments and / or approval on 31st August 2016. An e-mail conveying approval from ICC members for the submission of the revised final JA report was received in the evening of Wednesday 7th September 2016; and the document submitted on Thursday 8th September 2016. A copy of the email confirming ICC members approval for submission and a scan copy of the attendance at

	the ICC meeting held on 16th Aug 2016 are attached as annexes 4 & 5. Minutes of the 4th ICC meeting held on 16th August 2016 that the JA report was presented for approval is attached as annex 6.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	Issues raised by Partners at the ICC meeting are attached as annex 7.
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	Issues raised by the Gavi Senior Country Manager are also attached as annex 8.

7. ANNEXES

This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

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

The process of development of the Gavi joint Appraisal Report (JAR) for Gavi activities implemented in 2015 started with the exchange of calls and e-mails between the Gavi focal person at Gavi Secretariat and the Gavi Desk at NPHCDA. The Gavi Desk officer at NPHCDA and Partners were properly briefed on planning and conduct of the 2016 JAR in the country. Relevant documents including the revised JAR guidelines and reporting templates were received from the Gavi Secretariat.

Members of the National Routine Immunization Working Group (NRIWG) and other relevant programme officers from NPHCDA and other relevant MDAs and Partners formed JAR the secretariat. The ICC approved the composition of the Jar secretariat and committee members. The approved JAR committee composition had membership from the Federal Ministries of Health, Finance, National Primary Health Care Development Agency, National Planning Commission and representatives from the States / LGAs. Other JAR committee members were selected from WHO, UNICEF (National & Regional), CHAI, BMGF, IVAC, DFATD Canada, DFID, USAID, CDC, Save the Children, EU-Sign and Gavi Headquarters.

The secretariat agreed to engage all immunization stakeholders in the country in a 2-days joint appraisal workshop. Several planning meetings were held before the JAR workshop on 19th and 20th July 2016.

The secretariat members also met severally after the workshop to finalize the work done by the different working groups during the workshop. The final draft 2016 Joint Appraisal Report to be presented to the ICC on 16th August for final approval before submission to Gavi Secretariat.

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result