Joint Appraisal report 2017

The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal report.

Country	NIGERIA
Full Joint Appraisal or Joint Appraisal update	Joint Appraisal Update
Date and location of Joint Appraisal meeting	22nd August 2017/Abuja
Participants / affiliation[1]	Government and Partners
Reporting period	January - December 2016
Fiscal period[2]	January - December 2016
Comprehensive Multi Year Plan (cMYP) duration	2016 - 2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
NVS - Routine	IPV		2018	6,222,318	US$	US$ 7,663,000
NVS - Routine	PCV 10-4		2018	6,619,487	US$	US$ 18,608,500
NVS - Routine	Pentavalent		2018	6,619,487	US$	US$ 1,976,000

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$
Duration of HSS grant (from…to…)	
Year / period for which the HSS renewal (next tranche) is requested	
Amount of HSS renewal request	US$

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

(next tranche)	

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Total amount of CCEOP grant	US$	
Duration of CCEOP grant (from…to…)		
Year / period for which the CCEOP renewal (next tranche) is requested		
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$
	Partner resources	US$
	Gavi HSS resources[3]	US$

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

	Programme	**Expected application year**	**Expected introduction year**
Indicative interest to introduce new vaccines or request HSS support from Gavi	*Rota introduction*	*Already applied (2016)*	*Q4 2018 for 9 phase 1 states; 2019 and beyond for remaining states*
	MenA introduction	*Already applied (2016)*	*Q1 2018 subject to NGI-TAG recommendation*
	HPV (nationwide)	*2018*	*18 States 2021; 19 States in 2022*
	Revision of HSS2	2018	*2018*

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.
[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

The total population of Nigeria in 2016 was projected to be 191,843,149 (2006 census projection) with 7,673,726 and 7,098,197 live births and surviving infants respectively. Routine vaccines were provided in adequate quantities to all states, to protect these infants against Poliomyelitis, Tuberculosis, Hepatitis B virus, Haemophilus Influenza type-b, Diphtheria, Pertussis, Tetanus (including women of child-bearing age), Measles, Yellow Fever and pneumococcal diseases.

Macroeconomic Situation

In 2016, the country entered its first full year of economic recession, as global oil prices reached its lowest ebb in 13 years. Consequently, government revenue collapsed leading to shrunken fiscal space and reduction in government expenditure, especially to the health sector and between 2015 and 2016, government health spending as a share of the total government budget declined from 6% to 4%. Due to the decrease in federal government revenue, transfer of funds to the state level has reduced drastically, resulting in lack of funds at subnational levels. The table below shows the trends in revenue allocation from the Federation Account for the period January 2015 to June, 2017:

Table 1: Trends in revenue allocation from the Federation Account (January 2015 - June 2017)

Year	Projected Annual Revenue (=N='billion)	Actual Distributable Revenue (=N='billion)
2015	5,557	3,995
2016	4,304	2,902
2017	6,785	1,452
Total	**16,646**	**8,349**

Source: Fiscal Account Reports (2015 – June, 2017) – Office of Accountant General of the Federation

From the table above, 72% and 67% of planned revenue was realized in 2015 and 2016, respectively. While only 21% of planned revenue for 2017 was realized as at June, 2017. Given that a significant factor affecting the reduced revenues is the oil price decline and lower oil production, the country's economic growth prospects will depend on its ability to diversify its economy. Projections from the IMF and Government of Nigeria show a modest outlook for economic growth in the short/medium term. In fact, in per capita terms, GDP growth is negative for the next five years, indicating that Nigeria's growth rate is not fast enough to keep up with its population. For clarity, it is important to place in context, the immunization financial resource requirement within the overall health sector capital appropriation, from where the annual immunization allocation is drawn. Table 2 compares the health sector capital appropriation with the financial resource requirements for vaccines and devices in the same years.

Table 2: Health Sector Capital Appropriation Vs. Financial resource Requirements for vaccines

Year	Health Sector Capital Appropriation (US$)	Financial resource Requirement for Vaccines & Devices (US$)
2015	95,501,143	210,567,352
2016	182,327,476	177,876,033
Total	**277,828,619**	**388,443,385**
Source: Annual vaccine forecast by LWG/NPHCDA Logistics department for 2015 & 2016		

From the above, it could be seen that the financial resource requirement for vaccines and devices alone is nearly double the entire federal government capital budget to the health sector. Thus, the FGON is not in a position to finance vaccines with government-sourced resources. The tables below show the federal government appropriation, releases and utilization as well as loans obtained during the period 2015 to June, 2017.

Table 3: Federal government appropriation, releases, loans and utilization (2015 - June 2017)

Year	Federal Budget Allocation to immunization (Naira)	Funds released (Naira)	Budget execution/expenditure (Naira)
2015	**5,183,498,159**	**5,183,498,159**	**4,215,404,341**
2016	**12,879,680,000**	**12,879,680.000**	**12,879,680,000**
2017	**12,513,914,801**	**0.00**	**0.00**

Table 4: World Bank Loan and Dollar Equivalent of Appropriation for vaccines & Polio operational costs

Year	World Bank Loans (US$)	FGoN Appropriation (US$)
2015	**200,000,000**	**24,943,221**
2016	**125,000,000**	**42,932,267**

The deterioration of the Nigerian Currency (Naira) against major international currencies has given further blow to immunization financing in the country since vaccines and cold chain equipment are priced in USD. The naira has fallen by almost 100% between 2015 and 2017.

Leadership, Governance and Programme management:

The current administration is committed to revitalizing PHC, eradicating Polio and ensuring accountability in the implementation of all health programmes. This commitment by the FGoN to better position the entire health system has culminated in the change of leadership at the NPHCDA. The current leadership of the NPHCDA has as its vision to close out Polio, strengthen RI, revitalize PHC, and strengthen governance and accountability. There has been increased coordination for SIAs e.g. the National measles technical coordinating working group, and the declaration of emergency on Routine Immunization leading to the formation of the National Routine Immunization Emergency Coordination Center (NERICC).

At all levels of Government (Federal, State and LGA) there is a renewed commitment to improve implementation of effective Immunization services which is in line with the vision of NPHCDA. The initiative to rehabilitate 10,000 functional PHCs under the PHC revitalization effort of the federal government, started with the rehabilitation of 109 PHCs, one per senatorial districts of the country. In view of the expected transition from Gavi support in 2021, the country is developing strategies to strengthen Immunization and PHC services in which proposals are being made to Gavi to consider flexibilities in extension of country transition and increase in the HSS ceiling. To ensure a seamless transition, the NPHCDA with support from partners, conducted a mapping of Gavi support to Nigeria from 2001 – 2016, and identified the risk areas that would be majorly affected on graduation. These risk areas form the basis for the priority areas which will guide the country towards a sustainable transition.

The comprehensive multi-year plan (cMYP 2016 - 2020) was approved by the ICC in January 2016. It was updated in May 2017 in line with the national objective of PHC revitalization, data quality improvement and Cold Chain rehabilitation and expansion at all levels including CCEOP and 3 hub plan development. Funding is currently not available for the construction of the 3 Hub which is expected to take about three to four years to complete upon commencement. However, the possibility of using funds from world bank assistance will be pursued. The required funding is about 25m USD to construct the 3 Hub. In October 2016, the review of the National Immunization Policy (NIP) commenced. A draft is available which will be presented to the National Council of Health in its next meeting.

Although there was improvement in accessibility in the North-Eastern part of the country, in Borno state, two LGAs (Abadam & Marte) are inaccessible due to security issues with an estimated 13,264 (2006 projected census figure) under one children in these LGAs not reached with health services including immunization. Of the remaining 25 LGAs in Borno 23 are partially accessible. In August 2016, Nigeria reported four cases of Wild Poliovirus (WPV1) from three Local Government Areas (LGAs) in Borno state after close to two years of not detecting any cases. Circulating Vaccine Derived Poliovirus type 2 (cVDPV2) was isolated from an environmental sample in Borno and a healthy contact child of an AFP case in Sokoto state. Monovalent OPV type 2 (mOPV2) was used to respond to the outbreaks. In May 2017, 550,300 doses of IPV were used to respond to cVDPV2 isolated from environmental samples in Sokoto state. This quantity of IPV was recently replaced by the EOMG which has plans to provide the country with additional 116,000 doses of IPV for supplementary activities in Borno and Yobe states, targeting children coming from areas that are currently inaccessible.

In 2016 a total of 17,135 cases of measles were reported (Lab. Confirmed: 1707, Epi linkage: 5939, clinically confirmed 9489). 56% were zero dose and 64% from northern Nigeria while 36% were from the southern part of the country.

Figure 1: Age Distribution of 2016 Confirmed Measles cases

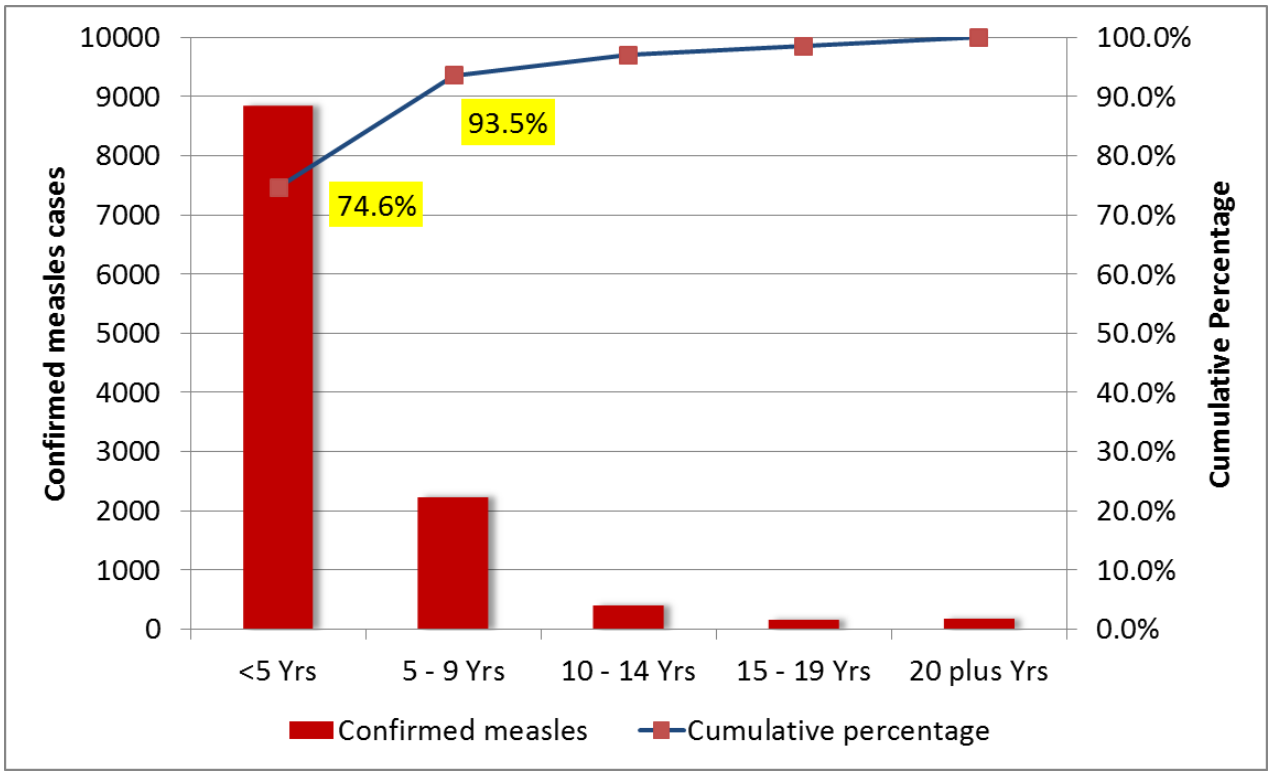


Table 5: Number of confirmed measles case by state 2015/2016

State	2015				2016			
	# lab confirmed	# Epi-linked	# clinically confirmed	Total confirmed	# lab confirmed	# Epi-linked	# clinically confirmed	Total confirmed
Adamawa	24	157	11	192	62	81	124	267
Bauchi	28	65	1529	1622	39	0	604	643
Benue	64	0	34	98	38	0	25	63
Borno	27	41	88	156	118	414	1560	2092
FCT, Abuja	32	0	150	182	28	0	208	236
Gombe	58	132	609	799	64	49	223	336
Jigawa	96	420	83	599	71	1035	95	1201
Kaduna	162	136	115	413	56	3	93	152
Kano	298	819	337	1454	166	1551	338	2055
Katsina	143	2239	91	2473	87	868	137	1092
Kebbi	48	53	221	322	273	200	273	746
Kogi	16	0	14	30	53	0	9	62
Kwara	11	0	11	22	46	0	9	55
Nasarawa	72	0	113	185	47	0	15	62
Niger	46	0	157	203	75	0	88	163
Plateau	51	0	277	328	12	0	79	91
Sokoto	4	154	94	252	65	1101	45	1211
Taraba	74	56	212	342	82	30	46	158
Yobe	26	41	175	242	115	193	3001	3309
Zamfara	31	82	24	137	17	406	23	446
Total North	**1,311**	**4,395**	**4,345**	**10,051**	**1,514**	**5,931**	**6,995**	**14,440**
Abia	4	0	146	150	13	0	168	181
Akwa Ibom	0	0	90	90	2	0	169	171
Anambra	11	18	188	217	11	0	227	238
Bayelsa	0	0	42	42	9	0	49	58
Cross River	5	0	75	80	8	0	99	107
Delta	1	0	143	144	30	0	118	148
Ebonyi	3	0	84	87	6	0	146	152
Edo	2	0	87	89	6	0	103	109
Ekiti	3	0	186	189	10	0	249	259
Enugu	5	1	157	163	9	8	139	156
Imo	4	0	98	102	2	0	129	131
Lagos	4	0	131	135	24	0	58	82
Ogun	9	0	152	161	7	0	119	126
Ondo	3	0	79	82	2	0	121	123
Osun	1	0	132	133	4	0	104	108
Oyo	28	0	352	380	46	0	365	411
Rivers	5	0	138	143	4	0	131	135
Total South	**88**	**19**	**2,280**	**2,387**	**193**	**8**	**2,494**	**2,695**
GRAND TOTAL	**1,399**	**4,414**	**6,625**	**12,438**	**1,707**	**5,939**	**9,489**	**17,135**

The states of Borno Adamawa, and Yobe experienced an unexpected upsurge in measles cases between June and September of 2016 due to the successful liberation of settlements and LGAs by the military and extensive migration. For example, in Borno, among 1320 reported suspected cases in 25 of 27 LGAs; 132 (10.0%) had blood specimens tested. Among these, 68 (51.5%) were IgM positive for measles, and another 16(12.1%) had equivocal results. Lab confirmed cases were identified in 17 LGAs. In Adamawa, among 99 reported suspected cases in 15 of 21 LGAs, 84 (84.8%) had blood specimens tested. Among these, 35 (41.7%) were IgM positive for measles, and another 13 (15.5%) had equivocal results. Lab confirmed cases were identified in 7 LGAs, with equivocal only cases in one additional LGA. In Yobe, among 2376 reported

suspected cases in 16 of 17 LGAs, 128 (5.4%) had blood specimens tested. Among these, 86 (67.2%) were IgM positive for measles, and another 8 (6.3%) had equivocal results. Lab confirmed cases were identified in 13 LGAs.
The Measles outbreak response vaccination was conducted in 46 'high-risk' LGAs between Jan and Feb 2017, targeting children aged 6 months - 10 years. Result of the coverage survey (Card + History) was 85.6% in Adamawa, 92.5% in Borno and 87.8% in Yobe.

Between December, 2016 and June, 2017, a total of 14,518[5] suspected cases of CSM with 1,166 deaths (CFR= 8%) were reported from 25 States with Zamfara, Sokoto, Katsina and Kebbi States which share borders with Niger Republic mostly affected. *Neisseria meningitides* sero-group C was the predominant (80.6%) cause of meningitis amongst those who tested positive. There was delay in responding to the outbreaks using the appropriate vaccine due to lack of in-country stock and the rigorous process of accessing the vaccines from ICG.

In view of the expected transition from Gavi support in 2021, the country is developing strategies to strengthen Immunization and PHC services in which proposals are being made to Gavi to consider flexibilities in extension of country transition and increase in the HSS ceiling. The strategy also includes higher government commitment to RI, financial management strengthening, donor and partner harmonization to a single plan led by NPHCDA, flexibilities for vaccine introduction and Technical Assistance at other levels.

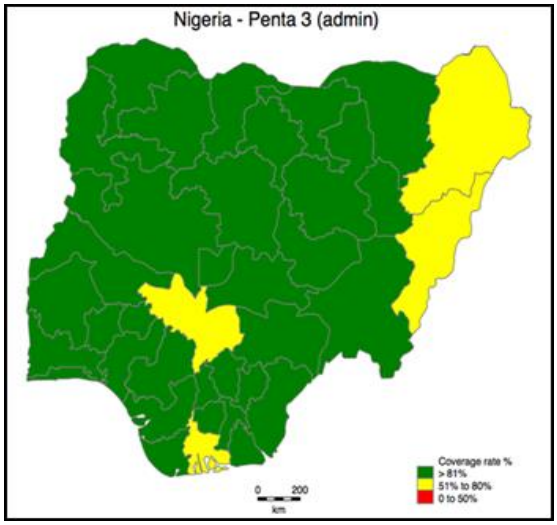
3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

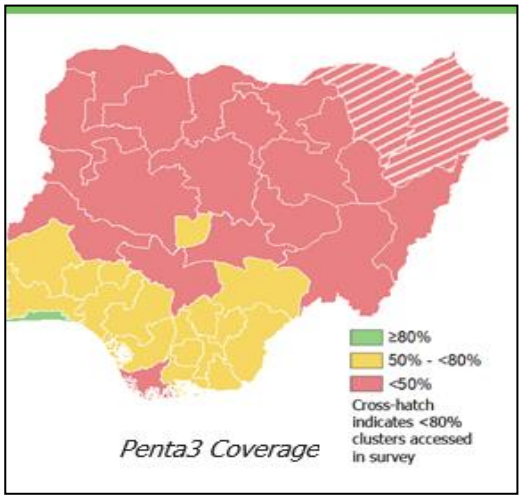
Coverage

The administrative data shows marked increase in the national penta3 coverage from 89% in 2013 to 105% in 2016 (JRF 2016). In 2016, all except 4 states reported administrative penta3 coverage of ≥80%. The 2016 National Immunization Coverage Survey (NICS) showed penta3 coverage of 33% with all states having coverage less than 80% except Lagos state *(see reasons for discrepancy in section 3.3).* The WHO-UNICEF estimates show a less drastic increase of penta3 coverage from 46% in 2013 to 49% in 2016.

Nigeria Penta 3 coverage by state – DVD-MT Jan – Dec

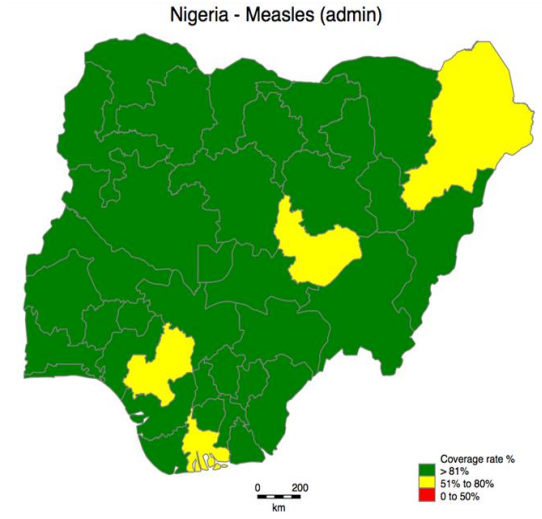


Nigeria Penta 3 coverage by state – 2016

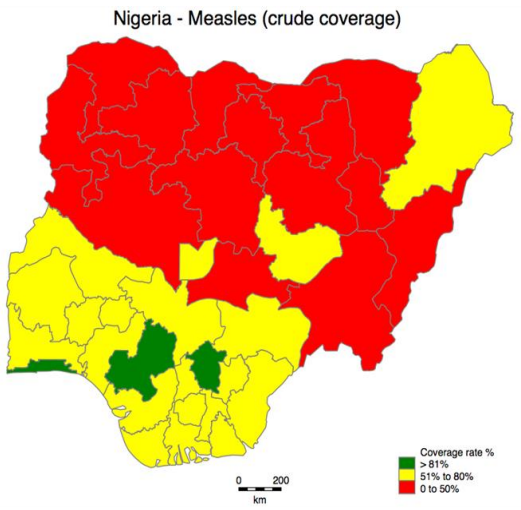


[5] CSM outbreak report 2017

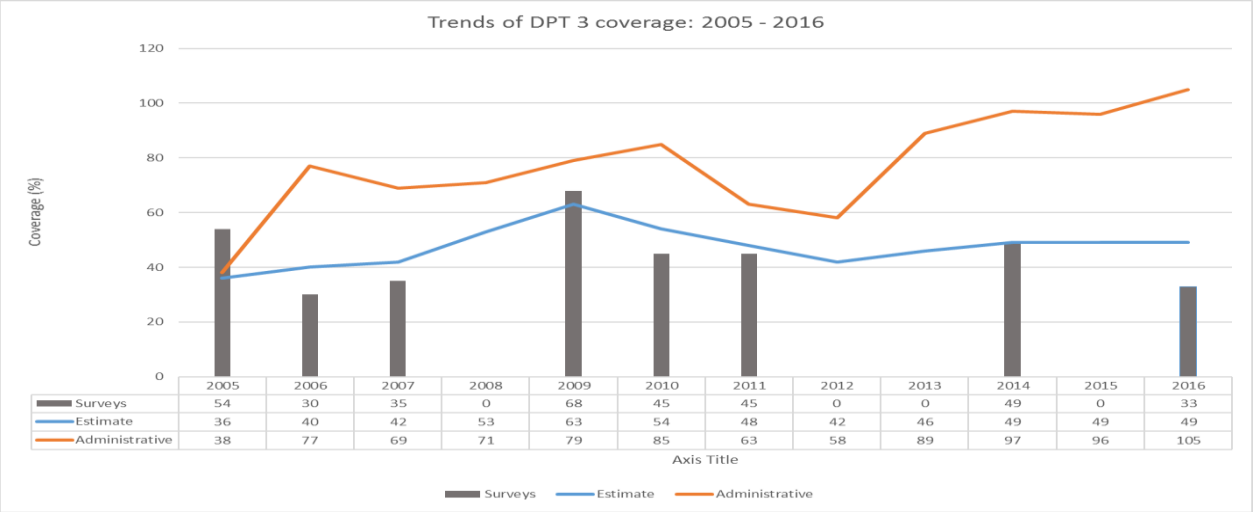
Nigeria Measles (admin coverage)



Nigeria Measles (Crude coverage)



Trends of DPT3 coverage: 2005 -2016

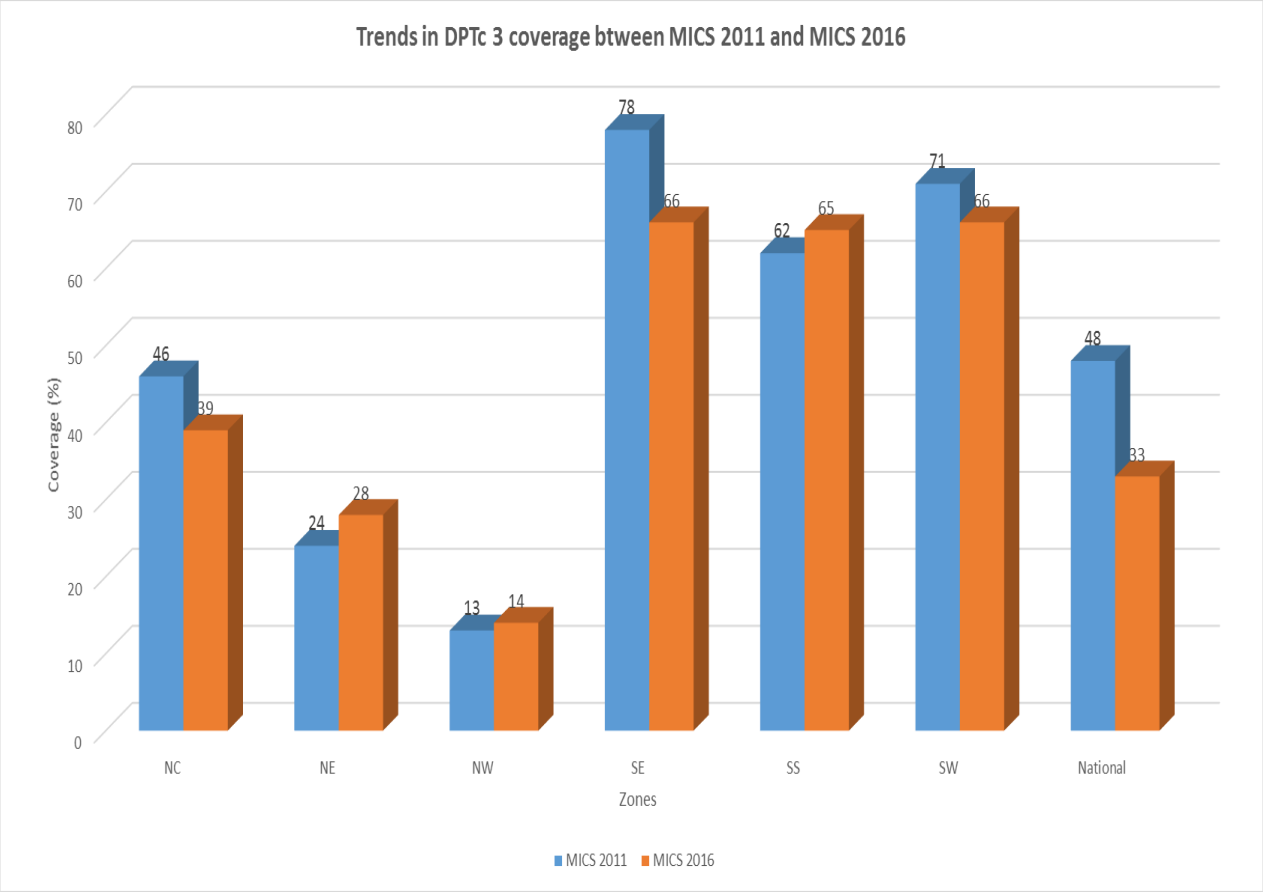


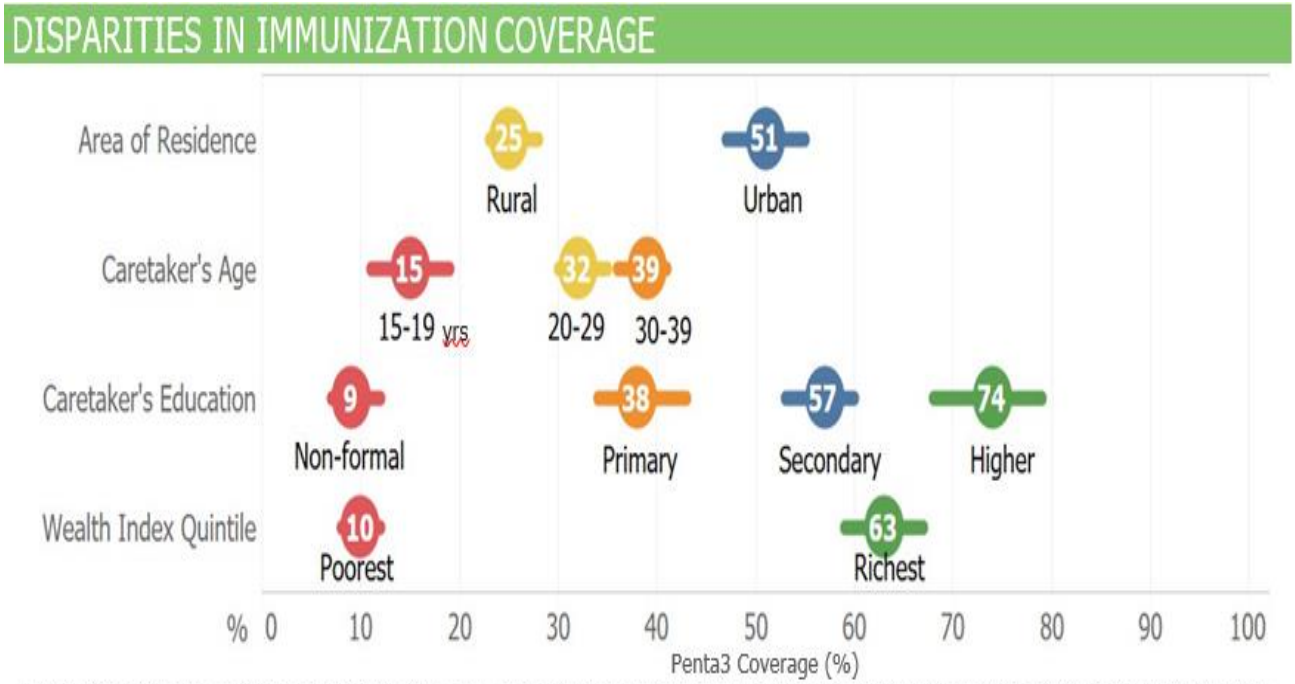
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Surveys	54	30	35	0	68	45	45	0	0	49	0	33
Estimate	36	40	42	53	63	54	48	42	46	49	49	49
Administrative	38	77	69	71	79	85	63	58	89	97	96	105

Equity:

Using Penta 3 coverage as an indicator with reference to MICS 2011 and 2016, It was observed that Penta 3 performances although not up to the set target for reference year was lower in the Northern part of the country compared to the southern part. The north west and north-east zone has the lowest coverage of

14% and 28% respectively. Families in higher economic quintile had better coverage than those in lower economic quintile. The MIC/NICS 2016 report show that children of women with higher educational qualifications and age received more vaccination than those of lower educational and socioeconomic status. A reduction in the coverage in previously high performing zones such as the South East and South West has also been observed from the 2016 MICS/NICS survey. Low immunization coverage persists in riverine and mountainous areas and amidst migrant populations and security challenged areas e.g. An equity assessment is currently being conducted and findings will inform actions to be taken to redress inequity. The government declared emergency on Routine Immunization with the formation of the National Routine Immunization Emergency Coordination Center (NERICC) to support states rapidly increase routine immunization coverage and reduce inequities.





Note: Penta3 crude coverage (%) represented by circles. Bars represent upper and lower bounds of two-sided 95% confidence interval. Wealth index quintile shows the poorest 20% and richest 20% of population.

3.2. Key drivers of low coverage/equity

Health Workforce

The decline in the country's revenues over the last couple of years has adversely impacted the remittances of the federal government to the states. The reduction in State resources has in turn resulted in significant budgetary constraints so much so that most of the states have defaulted on paying staff salaries. This has resulted in frequent and prolonged health worker strikes that adversely affected delivery of health services and in some cases delays in introduction of new vaccines. 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 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 inadequate and inequitable distribution of health workers which has adversely impacted on delivery of immunization services. This has been exacerbated by high staff turnover in the rural areas on account of the rural urban migration and in turn resulted in frequent staff shortages for rural and peri-urban areas. The country's National HRH Policy which was adopted in 2015 seeks to address some of the challenges faced through re-organization, alignment and re-orientation of the human resources management and development systems to ensure efficiency and effectiveness in health service delivery. There are also ongoing efforts to increase PHC workforce through the mandatory one year posting of midwives to PHC Centers. The National Health Act 2014 has earmarked 10% of the Basic Health Care Provision fund for the development of human resources for primary health care. The Act has also prescribed the rights of health care personnel.

Demand Generation/Demand for vaccination

Demand generation for routine immunization has remained a critical challenge to achieving coverage and equity. Aside from the MOU states (Kano, Sokoto, Kaduna, Bauchi, Yobe, Borno), funding for demand promotion and communication for routine immunization activities is negligible in the states. In the MOU states, funding for demand generation activities such as WDC meetings, engagement of traditional rulers and other community influencers creates awareness for RI. In the other states, funding is usually narrowed to social mobilization activities for campaigns and new vaccine introduction(s), with minimal continuity of demand creation activities for routine immunization. There is limited involvement and engagement of community structures (Traditional and Religious Leaders, women and Youth Groups as well as community based organizations CBOs) in demand creation for RI. In addition, there is limited technical assistance (communication experts) at the state level to support state and community communication teams resulting in in-adequate focus on demand generation for routine immunization.

During the campaigns, there is one-on-one interface between the caregivers and trusted community members engaged as VCMs and other community mobilizers (TBAs, etc) to build trust and increase acceptance and demand for immunization services. These trusted community members were also trained by the communications consultants to line list new borns, track defaulters and unimmunized eligible children (under one year). As the country gradually closes out polio, there will be leverage on the communication structures and strategies that were used to create awareness and generate demand during the polio eradication campaign to strengthen the demand for routine immunization uptake at the health facility and reduce drop outs.

Social mobilization interventions tailored to specific geographical locations to address specifically identified demand generation issues will be identified, while implementing strategies to sustain and improve uptake in the average and high performing states. Such interventions include leveraging on the emerging new technologies and mobile telecommunication platforms for increased messaging on the benefits of routine immunization to elicit uptake of services amongst caregivers in urban and semi urban areas.

Supply Chain

Some supply chain management challenges persist as revealed by the findings from the new vaccine deep dive assessments conducted in 25 states in Q4 2016. Between January and September 2016, more than 30 percent of LGAs stores in 9 states were not adequately stocked with all antigens while the number of states stores adequately stocked with Penta, PCV and IPV were nine, eight and one respectively. This was because of global shortage (for IPV) and ad-hoc nature of distribution at sub state levels. To address the challenge of distribution, in January 2017, the country outsourced deliveries from national stores to the states. Direct delivery of vaccines to the health facilities is happening in Kano, sokoto, Bauchi, yobe, Borno, lagos and Niger, and keep buffer stock at the LGA level. Efforts are still ongoing to scale up direct deliveries to health facilities in the remaining 29 state and the FCT. Fifteen of the states have been categorized into three phases for this purpose. Phase 1 states (Osun, Taraba, Imo, Ebonyi, Jigawa); Phase 2 (Anambra, Benue, Ondo, Nasarawa, Kwara); Phase 3 (Rivers, Delta, FCT, Edo, Zamfara).

Other challenges include poor implementation of temperature monitoring and control systems (especially response to alerts); storage capacity insufficiencies – 48% capacity gaps at national and 59% of wards do not have CCEs, operational inefficiencies – poor utilization of existing storage capacities at the zones), inadequate funding for distribution, weak vaccine accountability and management - poor visibility into vaccine utilization and stock performance at service delivery points - systems, poor maintenance of CCE and buildings and irregular supportive supervision. An update on the status of implementation of the 2014 EVM improvement plan (which started mid-2015) was conducted in September 2016 and the result showed an average of 65%, 20%, 44%, 54%, 34% achievement rates at the national, zonal, state, LGA and facility

levels respectively. Since then NPHCDA started driving and tracking the implementation of the EVM improvement plans through the strengthening State Logistics Working Groups (SLWGs).

Other challenges experienced in cold chain management include: irregular power supply, insufficient and non-optimal equipment, quantity and quality of human resource for vaccine management.

Gender Related Barriers

The low proportion of female health workers for Northern Nigeria contributes to driving low uptake of health services including immunization in Northern Nigeria. Although nurses and JCHEWs in Nigeria are predominantly female, the North East and North West have the lowest density of nurses and midwives e.g. 7.7/100,000 population in Jigawa[6]

Leadership, management and coordination:

NPHCDA had an Acting Executive Director for over six months and lacked a board of directors for over one year. There was therefore no effective oversight over the activities of NPHCDA nor was NPHCDA able to make key decisions that required board approval.

The ICC held meetings regularly and met more frequently than the minimum 4 times a year that is stipulated in the TORs. The PCA report noted that the ICC has not been very effective as a mechanism for oversight due to inadequate internal processes and procedures at the ICC Secretariat. These led to poor quality of board papers, communication and uninformed decision making which in turn results in the high level of dissatisfaction among ICC members as revealed during the PCA.

Coordination between the NPHCDA and other Ministries was sub- optimal in the year under review and the resultant effect of this was seen in delayed release of funds for immunization and increased missed opportunities to leverage other ministries activities e.g. Education to increase immunization. In recent times, with the re- energized leadership there is an increase in collaboration between the NPHCDA and other ministries. More needs to be done to strengthen the partnership between the NPHCDA and the Ministry of Education to ensure immunization is made compulsory In line with the Nigeria Child Rights Act 2003 which provides that every parent/caregivers or person having the care and custody of a child less than 2 years shall ensure that the child is provided with full immunization.

While the national ICC and its working groups have been functional in the year under review, at the states, corresponding coordinating structures e.g. the Routine Immunization Working Groups, Logistics Working Groups, State Task Force for Immunization are lacking or non-functional in more than 50% of states. This lack of coordination for Immunization activities at sub national levels is a key driver of sub-optimal RI performance in states. Supervision of immunization activities is weak especially at sub national levels.

The Nigeria Immunization Technical Advisory Group (NIG-TAG) met only once in 2016. Disease working groups were setup during this meeting and they are expected to provide technical advice on key matters under review before they are presented to the ICC. Only the CSM working group could meet twice but did not make recommendations.

Public Financial Management

The country obtained additional financing facility from the World Bank to finance routine vaccine procurement (including co-financing for Penta and PCV) and operational funds for polio. In addition, 9.8bn naira was made available from the federal budget to finance polio operational costs.

There was a 6-month delay in the country's budgetary processes leading to late passage of the 2016 annual appropriation act and thus caused the delay in the release of funds. The downturn in the economy

[6] 2012 Nigeria healthcare workforce profile, p.16

witnessed in 2016 severely constrained the ability of subnational governments to pay salaries of workers leading to intermittent industrial action by health workers.

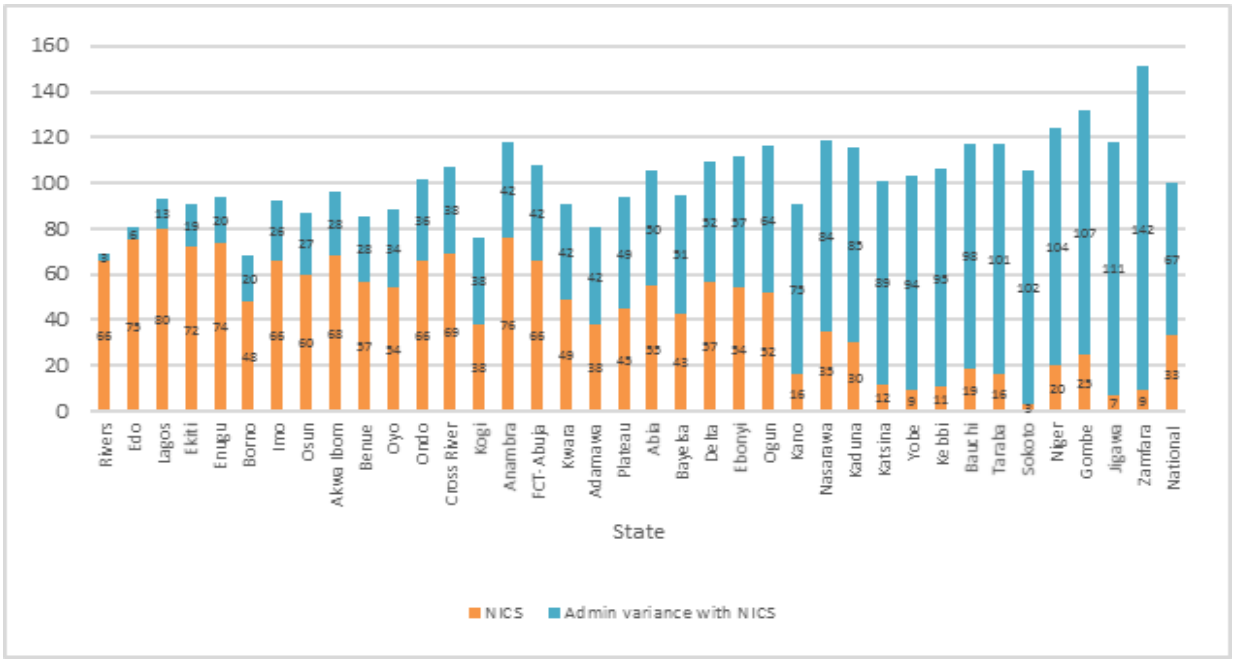
Funding for immunization and health generally varied from state to state, with those having RI MOU with partners (Sokoto, Kaduna, Kano, Bauchi, Borno, Yobe) tended to have a more regular release of RI funds from the MOU basket fund in addition to funds made available from other partners for RI services at the state and LGA level.

At the federal level, government is working assiduously to strengthen public financial management system by engaging reputable international consulting firms (i.e. KPMG and McKinsey) to review the planning, HR, budgeting, Procurement, disbursement and financial reporting processes and procedures at the NPHCDA for greater efficiency and effectiveness.

3.3. Data

The results of the combined Multiple Indicator Coverage Survey (MICS) and National Immunization coverage survey (NICS) conducted in 2016 (for cohorts born in 2015) show a National Penta 3 coverage of 33% against an administrative coverage of 105%. This shows a disparity of 72% between the two sources of data which is more than the acceptable 10%

Penta 3- Difference between survey and administrative coverage



All states except Edo and Rivers have more than 10% difference between administrative and survey data. The possible reasons for the observed data quality issues include the following:

i) inappropriate denominator,
ii) inadequate / multiplicity of data tools,
iii) emphasis on reaching targets with associated increased incentives to report to target rather than report accurate data,
iv) poor data generation and compilation by HCWs due to lack of knowledge on the use of some data tools e.g. the Immunization register, tally sheets and vaccine management tools,
v) weak routine immunization supportive supervision (both in scope, quality and use of data for action)

vi) attitude of the health workers towards data generation and reporting,
vii) lack of adequate human resource at the service delivery points
viii) frequent transfer/movement of skilled health personnel
ix) data not used for decision making
x) poor forecasting at the subnational level
xi) lack of feedback to community
xii) lack of training especially around data management

Efforts and innovations aimed at addressing data quality issues include the following;

1. A team comprising of NPHCDA and partners was set up to develop a data quality improvement plan in 2016;
2. The Federal Ministry of Health commissioned a multi-stakeholder committee with membership drawn from the FMOH, Federal Ministry of Budget & National Planning, NPHCDA, National Population Commission, WHO, UNICEF, UNFPA and BMGF. The Committee was given the mandate to harmonize existing population data sets (2006 Census, GIS mapping, Walk -through micro-plan) and make recommendations on for use in the different zones in the country.
3. Walk-through micro-plan was conducted in 17 southern states while the GIS mapping was conducted in all 19 northern states respectively. The program will leverage on the measles campaign micro-planning to conduct realistic RI micro-planning. The National census is planned for 2018, and will possibly address some denominator issues currently faced.
4. Additional efforts to address data quality issues include the scale up of the DHIS 2 RI module to capture immunization data on the national platform which has been rolled out in 28 states and the FCT. The 8 remaining states including: Kebbi, Zamfara, Jigawa, Katsina, Adamawa, Gombe, Yobe and Borno will be completed before December 2017
5. Conduct of monthly data validation meetings prior to data entry at the LGA levels in some states.
6. Additionally, there has been on the job, data quality trainings aimed at minimizing data entry errors/falsification at the Health Facility level in Kano and Niger states with plans to expand to additional states. Bauchi and Sokoto are doing regular DQAs and have formed Data quality committees to review/monitor data quality at the LGA level, on the job hands-on training and provide mentorship

To continue to address the challenges of stock visibility, the country transitioned from the Excel based vaccine stock management dashboard used to monitor vaccine stock to NAV a warehouse management system – was deployed at the national, zonal and state store to set a foundation for greater use of data by EPI managers . In 2016, to improve the visualization of stock performance, the VSPM dashboard was integrated into NAV to form the integrated NAV dashboard. Based on the routine analysis of the data on the dashboard, appropriate and timely actions are taken. There are ongoing pilots of an LGA level stock management tool in 3 states within the background of the data visibility and analytics network (VAN) initiative that will result in integration of NAV with DHIS2 and other stock management application within the Nigerian iSC ecosystems. Additionally, there is now visibility into facility stock utilization in all 7 states conducting vaccine direct deliveries to the facilities

Even-though there have been great steps towards stock visibility; there is little utilization information visible in the system. Comparison of vaccine utilization and children immunized is not used especially at the sub-national levels. These challenges are being addressed with the implementation of VAN initiative. The objective is to improve visibility, analysis, and utilization of data to improve vaccines cold chain and logistics systems. This will result in increased stock adequacy, safety and potency of administered vaccines. The implementation of VAN is an integrated approach combining people, processes, policies, and technology

and commenced with the introduction of the integrated NAV dashboard, to provide data visibility into state and LGA stock levels to inform stock accountability. This initiative is coordinated by the government and partners through the Interagency VAN Project Management Unit. Additionally, the planned integration of NAV with DHIS2 and the lower level (LGA and facility) tools, will provide end-to-end visibility and accountability.

3.4. Role and engagement of different stakeholders in the immunisation system

Inter-agency Coordination Committee (ICC)

The ICC chaired by the Honourable Minister of Health is the highest decision-making body on EPI in Nigeria. The table below provides an overview of the status of GAVI's requirements for the ICC, based on GAVI's self-assessment tool for National coordination forum.

Table 6: ICC's performance based on Gavi's Requirement

Key: **Green**: Done. **Yellow**: Partially done: **Red**: Not done

S/N	Area	Requirement	Status	Comments
1.1	ICC membership	Membership should include senior-level leaders who can make decisions on behalf of their organisations, represent the full range of voices needed to coordinate on high-level, strategic issues of the EPI programme, and whenever possible, strive for gender balance, equity and inclusiveness in participation amongst the stakeholder groups.		The ICC is chaired by the Honourable Minister of Health. Members include Minister of State for Health, ED NPHCDA, and decision-making representatives of other relevant Ministries, CSOs, donor and development agencies. The Nigerian Center for Disease Control is yet to join the ICC.
2.1	Strategic planning of EPI programme	Participate in the development of comprehensive strategic plan, including setting and aligning on specific goals and targets (where relevant)		The ICC worked with the CORE GROUP and relevant stakeholders to develop an updated 2016-2020 Country Multi Year Plan (CMYP) for immunization.
3.1	Programme Financing:	Review and approve Gavi grant applications (includes HSIS support), renewals and Partnership Engagement Framework (PEF) submissions of partners for 2018 and ensure alignment with national strategic and operational plans and a focus on sustainable coverage and equity		In 2016, the ICC reviewed and approved the (CEF). Joint Appraisal. The ICC also reviewed and approved the New Vaccines Renewals and the measles campaign requests to Gavi.
3.2		Ensure a broad and participatory process in grant application development		Relevant stakeholders are always involved in development of grant applications
3.3		Create long-term visibility on funding for EPI across domestic and donor sources in support of the national strategic plan, and near-term visibility on government budget and donor grant disbursements		The ICC encourages and facilitates financial transparency in the health sector. All relevant stakeholders actively participated in the development of the FRR

3.4		Advocate to government and partners to mobilize greater resources for EPI and facilitate dialogue among them to shape a resource mobilization plan		
3.5		Participate in development of grant proposals and renewals (for non-Gavi stakeholders) in alignment with national strategic and operational plans		
4.1	Coordination	Create transparency on programmatic coordination among key stakeholders		
4.2		Define structure/organisation of operational/technical coordination forum and ensure processes exist for major bottlenecks to surface to the ICC		The Core Group chaired by the ED, NPHCDA provides technical/operational support to the ICC
4.3		Create transparency and linkages with coordination bodies for the broader health sector and those related to EPI		
5.1	Operational Planning and Performance Oversight	Review and endorse operational plans and budgets for HSIS support		The ICC endorses the annual immunization work plan and budget for the ministry of Health/NPHCDA
5.2		Oversee progress of Gavi investments based on discussion and approval of Joint Appraisal and if possible based on insights from the EPI team and operational/ technical Coordination Forums		The ICC provides oversight to Gavi's investments in the country. It also provides advice and approves the JA.
5.3		Review and input into annual EPI work plan aligned with strategic goals.		The annual EPI work plans were approved by the Core group and ICC
5.4		Oversee performance of the EPI programme, including regular review of performance indicators and implementation status of annual work plan, with a focus on tracking and assessing progress against coverage and equity goals		Quarterly review meetings with states were held to assess progress of implementation of work plans. Reports were shared with ICC showing that 80% of the annual operational plan for EPI was implemented
5.5		Raise critical issues impeding progress of the EPI programme to relevant government stakeholders		
5.6		Review findings and recommendations from EPI review, PCA and other assessments (including regular review of management capacity of the EPI team) and translate into actions		
5.7		Oversee progress of key PEF activities (including discussion and approval of PEF functions and PEF milestones) based on		

		insights from the EPI team and operational/ technical coordination for a		
6.1	Information dissemination	Share information highly relevant to the EPI programme, ICC members, and the Gavi Alliance		
6.2	Governance of ICC	Draft formal TORs, adhere to meeting frequency and timing and follow quorum and decision-making procedure as defined in the TOR		
6.3		Take appropriate minutes for each meeting and share with all members within defined timelines		
6.4		Have a devoted ICC secretariat		

Civil society: Civil society organizations, faith-based groups and religious leaders were involved, to a variable extent, in the planning and execution of RI programs in the country. CSOs representatives on the ICC, the National Immunization Financing Task Team (NIFT), the NGI-TAG and the national routine immunization working group support technical coordination and strategic and tactical decision-making on RI operations in the country.

On their own, CSOs have played a prominent role in raising awareness about impending funding gaps for immunization consequent upon the country's transition from Gavi support. Organizations and coalitions such as the Women Advocates for Vaccine Access (WAVA), the Health Sector Reform Coalition (HSRC), the Partnership for Advocacy in Child & Family Health (PACFaH) have executed singly and collectively, a range of advocacy activities aimed at building a critical mass of influential officials and individuals who can push for or take specific actions on sustainable financing for immunization. National activities are linked with state level advocacy through advocacy training workshops, African vaccination week events, direct advocacy interventions and social media engagements. The outcome of these are increased awareness and engagement of influential individuals like the Senate Committee Chair on Health Services, Sen Ohuabunwa, Mrs. Toyin Saraki, wife of the Senate President and Dr. Zainab Bagudu, wife of the Kebbi state governor, who have all made public calls for immunization financing. For example, all three have lead 1-hour twitter chats on vaccine financing. The hashtags #VaccinesWork, #NigFundVaccines and #VaccineGoodOh are three of the most commonly used to tag discussion on sustainable immunization financing. Furthermore, CSOs under the HSRC submitted a shadow budget to the public hearing for the 2017 budget, where they requested for increased funding for immunization and other health programs. Coalitions like WAVA, PACFaH and NIFT collectively convened at least three separate retreats on financing for the health sector and immunization, for members of the legislature in Uyo and Owerri, where consensus was reached on implementing the financing provisions of the 2014 National Health Act, which allocates at least 1% of the consolidated revenue funds (estimated at 50 billion naira in 2016). The media is increasingly being engaged in immunization financing and the need for sustainability. For example, a media search for mentions on "immunization financing and need for sustainability" yielded 95 hits. There is however more to be done in getting the media houses engaged more in putting out investigative, analytic and human interest pieces on routine immunization rather than just reporting on events related to immunization.

NPHCDA and partners continued to engage with traditional and religious leaders through the Northern Traditional and Religious Leaders Council (NTLC) and to mobilize communities primarily for polio, but

secondarily for RI and SIAs. Organizations belonging to the Gavi CSO platform also play a role in community mobilization and service delivery. Overall, there are CSOs involved in a range of activities such as advocacy, mobilization, service delivery and accountability at both national and sub national level. Communities are being engaged via Ward Development Committees, religious leaders, women's groups and traditional leaders. The objectives of the engagement range from increasing demand for immunization, to addressing non-compliance and encouraging community participation in accountability for service delivery. CSOs experience challenges relating to funding of activities, low political will at the lower levels and complacency among parents. There is however great variability in the scope and nature of their activities, which are highly dependent on donor support. Furthermore, there is no mechanism to comprehensively track the contributions of CSOs. A common lexicon, standard matrices and a central reporting mechanism are needed to better document the coverage and impact of their activities in immunization. A CSO reporting framework to address this gap is being developed at the global level; the framework is not yet to be finalized.

Other donors:

Other donors' active in the RI space include national, bilateral and multilateral donors. The most prominent national donor is the Dangote Foundation, which has partnered with the Bill and Melinda Gates Foundation, USAID (2 states – Sokoto and Bauchi) and the governments of 6 northern states under the RI MOU arrangement, to fund RI system strengthening. A transition and sustainability model is built into the MOUs to have donor funds decline gradually while government's contribution increases to replace the donor funds. The MOU funding arrangement varies with States. Kano has just signed an RI MOU Child Health addendum (after 4 years implementation) which will run through 2017 – 2020. Borno, Kaduna, Sokoto and Yobe states will run until 2019, while Bauchi is in their final 4th year of implementation.

Besides the MOUs, the Bill and Melinda Gates Foundation supports RI strengthening and fiscal advocacy through partners and grantees. The World Bank funds NSHIP programs in three states, the UK's DFID supports the MNCH2 project in 5 northern states, EU funds the EU SIGN project working in 24 states. The USG through CDC and USAID NSTOP and other immunization support activities in country. Other donors are helping to strengthen RI systems and program with most partner support going to the northern states. A major funding decline is expected as polio eradication activities wind down. The polio transition team estimates that about 91m dollars in assets (Human & physical) will be at risk of being lost with the polio enterprise after eradication. A mapping of partner and donor activities in RI is provided in Table 7 below.

Table 7: Mapping of RI Partners in Nigeria, 2016

Donor	Implementing organization	Name of current project	Project activities	Number of states	Duration of funding
CDC	AFENET-NSTOP	RI Strengthening of RI in polio high risk states	• Training of State, LGA and Health facility personnel, • HF supportive supervision, • Community dialogue, • VPD surveillance, • Data Management and provision of laptops to LGAs for RI data management, • RI data Monitoring, • Monthly review meetings, • Quarterly micro plan update, • RI coverage surveys and assessments, • Printing and distribution of polio AFP cards, Support pre, intra and post campaign activities, • Deployment of MSTs during polio and non-polio SIAs, and • Partnership and collaboration with NPHCDA and partners	**12 states** Adamawa, Bauchi, Borno, Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, Taraba, Yobe, Zamfara	2014 – unknown end date
CDC	AFENET-NSTOP	RI intensification in Adamawa and Taraba	Same as above	**2 states** Adamawa and Taraba	2012 – unknown end date
CDC	AFENET-NSTOP	Underserved settlement (nomadic and hard to reach settlements) Enumeration	• Enumeration of new nomadic and underserved settlements, • Update of REW microplans to capture identified missed/new settlements and • Vaccination with OPV	**12 states** (same as above)	2012- unknown end date
CDC	AFENET-NSTOP	DHIS2 project	• Training of State, LGA and Health facility personnel, • HF supportive supervision and DHIS2 scale up,	**17 states**	2014-2020

			• Data Management, provision of laptops to LGAs for RI data management, and printing and distribution of RI data tools, • RI data Monitoring, • Monthly review meetings, partnership and collaboration with NPHCDA and partner	Kano, Enugu, Bauchi, Akwa Ibom, Oyo, Nasarawa, Taraba, Niger, Sokoto, Osun, Abia, Plateau, Imo, Delta, Rivers, Kaduna, Kwara	
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
BMGF	CHAI	Nigeria Immunization Strengthening: improving coverage and equity at national level and in six states	• Support the development of a robust Gavi application for Rotavirus Vaccine Introduction and support the implementation of Nigeria's rotavirus vaccine introduction • Improve EPI training coordination through functional PHC training units and immunization training working groups • Design and implement innovative training approaches which allow for increased knowledge retention and improved practice for HCWs and EPI Managers • Establish training quality control measures for standardizing training guidelines, content for all cadres of health workers, delivery methods, and assessments. • • Strengthen the functioning of ICC and its technical working groups • Support the development and implementation of the country multi-year plan. • Support for the Federal government, 6 focus state governments and their local governments in budgeting, resource mapping and tracking of expenditures. • Support the FMOH/NPHCDA to develop a GAVI transition plan.	**6 states** Kano, Rivers, Nassarawa, Niger, Lagos and Yobe	2015-2019

			• Support program performance reviews to track program performance • Design and implement on the job data use trainings to strengthen data quality • Institute monthly data spot checks and quarterly routine data quality assessments to ensure data consistency. • Increase community participation in RI demand creation in Kano, Lagos and Niger States. • Optimize cold chain planning, resourcing and implementation • Develop or strengthen systems for managing and tracking cold chain maintenance needs • Support scale-up of improved temperature monitoring and control systems which have been shown to be appropriate and effective at higher levels in the cold chain. • Expand the reach of improved stock management systems and vaccine distribution systems. • Support development of plans to identify and transition Polio assets and infrastructures to strengthen Routine Immunization		
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
BMGF	CHAI	Accelerate the speed and efficiency of the introduction of new vaccines (PCV & IPV)	• Ensure PCV and IPV are successfully introduced in a timely manner into the routine immunization schedule • Document and share lessons learned from vaccine introductions • Provide key monitoring data to ensure smooth roll out and optimal uptake	36 states and FCT	2013-2017

			• Strengthen capacity of EPI Managers to manage introduction of new vaccines		
International Initiative for impact evaluation (3ie)	DCL	Formative study on Vaccine Indicator and Reminder (VIR) band to improve vaccination initiation and completion in Nigeria	• Social mobilization and engagement of community members for VIR band and immunization. • Training of TBAs and facility-based health workers on VIR band use and communication on importance of immunization timeliness and completeness. • Provision and activation of VIR bands by health workers in the health facilities.	**1 state** Kebbi	2016-2018
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
International Initiative for impact evaluation (3ie)	DCL	Formative study on Vaccine Indicator and Reminder (VIR) band to improve vaccination initiation and completion in Nigeria	• Conduct baseline and end line community acceptability study • Conduct baseline and end line Household survey • Observation of health workers activating VIR band • Monitoring of on-going service delivery	**1 state** Kebbi	2016-2018
GSK, Save the Children	DCL	The effectiveness of using a reminder bracelet to improve timeliness and completeness of childhood vaccinations in Nigeria: A cluster randomized control trial	• Engagement with National and State level policy and immunization managers • Pre-pilot test to check validity and HW understanding of the tools • PHC facility mapping • Baseline and endline survey to obtain estimates of vaccination timeliness, completion and Pentavalent 3 coverage • Qualitative interviews with PHC managers, RI service providers, caregivers, community members on perception	**1 state** Nassarawa	2017-2018

			and attitudes of community towards vaccination and bracelet
			• Training of health workers on how to use bracelet
			• Enrolment & follow up
			  o Sensitization for parents/caregivers on the bracelets and the importance of timely and complete immunization
			  o Deployment and roll out of bracelets to intervention facilities, participant and non-participant observations
			• Monthly data collection and ongoing mentoring for facility staff providing bracelets
			• Data analysis, write up and dissemination of finding.		

Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
European Union	Conseil Sante, HPI, SOFRECO (Consortium)	EU-SIGN	• Strengthening Governance through establishment of PHCUOR/SPHCB/As at the states and LGAs. • Supplies and repairs of CCE (DDSRs etc), 29 4WD Hilux, 136 Computers. • Construction/renovation of 46 HFs/CS across the 24 EU states. • Information and research to inform policies and actions	**24 states** Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, Zamfara, Bauchi, Gombe, Yobe, FCT, Kogi, Kwara, Plateau, Ebonyi, Anambra, Abia, Akwa Ibom, Rivers, Cross Rivers, Edo, Lagos, Ogun and Osun	2011-2018
BMGF	IVAC	Strengthening Training on EPI and PHC in Nigeria (STEP-IN)	• Engagement meetings with relevant stakeholders at the national and state level • Training Needs Assessment in the three states • Curriculum review and adaptation	**3 states** Bauchi, Niger and Rivers	2016- 2017

			• Training of core training from the three states		
Gavi	IVAC	Primary Health Care Reform-Primary Health Care Under One Roof (PHCUOR)	• Co-review Imo SPHCDA law with NPHCDA • Host Imo SPHCDA orientation workshop • Support Imo SPHCDA and stakeholders to develop a draft 2017 costed work plan	**2 states** FCT Imo	2016-2016
Gavi	IVAC	Accountability Framework for Routine Immunization in Nigeria (AFRIN) pilot study	• Design workshops with State, LGA, and ward officials on appropriate format for reporting tools that are easily accessible by community. • Monthly submission of the REW monitoring tool by health facilities to the LGA's • Reactivation of Ward Development Committees (WDCs) • Monthly feedback meetings with WDC • State review meeting with stakeholders • Project update meeting with the Honorable Commissioner of Health in the state • Baseline and end line assessments • Dissemination of findings to stakeholders.	**1 state** Niger	2014-2016
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
BMGF	IVAC	Fiscal Advocacy for Immunization in Nigeria through Advocacy Networks, Coordination and Evidence (FaINANCE)	• **National Immunization Financing Task Tam (NIFT)** o Bimonthly Coordination Meeting o Stakeholders analysis o National stakeholders' engagement through advocacy visits, roundtable meetings and retreats o technical assistance to NPHCDA on production of Quarterly Vaccine Financing Outlook and Sustainable Immunization Financing (SIF) Transition Plan	**14 states** FCT, Adamawa, Bauchi, Kano, Abia, Ebonyi, Enugu, Akwa Ibom, Rivers, Lagos, Ogun, Kebbi, Kwara and Kaduna	2016-2017

			○ Budget advocacy • **Women Advocates for Vaccine Access (WAVA)** ○ Recruitment of CSOs to join the WAVA network ○ Training workshop for CSOs on immunization advocacy ○ Production of IEC materials on the health and economic values of vaccines ○ Small grants to WAVA-CSOs for RI advocacy ○ Budget tracking ○ Publication of quarterly WAVA Newsletter ○ Inaugurate Champions for Sustainable Immunization Financing Advocacy ○ Media advocacy for unhindered access to vaccines including social media • **Research** ○ Baseline survey on data needs of advocates for immunization advocacy ○ Perception Study on sustainable immunization financing ○ End line survey on data needs of advocates for immunization advocacy		
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
USAID	Maternal Child Survival Programme (MCSP)	MCSP-RI Strengthening	• Technical support in RI components • Capacity building of RI staff at State , LGA and HF levels	**2 states** Bauchi and Sokoto	2014-2018

DFID/UKAID	Palladium and other consortium members (Axios, Options, Mannion Danion, Marie Stope and FHI)	Maternal, Newborn and Child Health	• Strategic planning (including budget, planning, policy development and implementation, health care financing, organizational capacity development) • Integrated RMNCH service delivery including immunization, quality of care, healthy timing and spacing of pregnancy, • Integrated supportive supervision, • Capacity building, • Advocacy and accountability, • Vaccine, logistics and drugs supply, • Health facility renovation and supply of equipment, • Outreach services, • Operational research, • Data management, and • Demand creation	**6 states** Jigawa, Kaduna, Kano, Katsina, Yobe and Zamfara	2014-2019
Global Affairs Canada	World Health Organization (WHO)	Sustaining Polio Eradication Through Strengthened Routine Immunization	• Conduct trainings for routine immunization • Conduct three rounds of intensified routine immunization activities • Provide supervisory support for intensified routine immunization activities • Expand household and community engagement approaches to build demand for polio and routine immunization. • Facilitate government led polio transition planning consultative meetings •	Oyo, Lagos, Ogun, Edo, Rivers, Ebonyi ,Ekiti, Enugu, Delta,Anambra,Ondo, Abia, Akwa Ibon, Bayelsa, Osun	2016-2020

US foundations: Good Ventures, Give Well.	New Incentives (All Babies Are Equal Initiative)	Cash Transfers for Routine Immunizations	• Provide small cash transfers to mothers that bring their children to RI visits (to compensate for transport costs).	**2 states in the North TBD.**	2017-2019
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
USAID	Family Health & Youth Empowerment organization (FAHYE)	Core Group Partners project	• Support the conduct of outreach RI sessions in supported health facilities, VVHRW and border areas of focal LGAs	**1 state** Katsina	2014 - 2017
	HealthCare & Education Support Initiative (HESI)		• Support the conduct of Fixed RI sessions in supported health facilities of focal LGAs • Conduct supportive supervision for fixed and outreach RI sessions in project intervention areas, VVHRW and Border areas • Demand creation and Social mobilization activities to strengthen RI support (Compound meeting, Community dialogue, Majalisa sensitization)		2014 - 2017
Glaxo SmithKline	None*	Health workers capacity building project	• Train frontline health workers on REW microplanning, New Vaccine administration, AEFI and Injection safety, and DHIS RI module	**3 states** Kaduna Lagos Gombe	2015 - 2018
BMGF	Solina Group	Northern Nigerian States Routine Immunization Strengthening	• Planning and Management, Service Delivery, Vaccine Supply Chain, RI Supportive supervision and Data Management, Demand Creation through community engagement and Building an effective and transparent financial management system	**8 states** Kano, Bauchi, Kaduna, Sokoto, Borno, Yobe, Katsina and Zamfara	2013-2018

UNICEF funds, Gavi, BMGF, Rotary international, WB, US Natcom, UK committee UNICEF.	Federal and state governments	Access to essential immunization services	• Ensure availability of bundled vaccines at the national and decentralized levels, conduct social mobilization and provide technical, logistic and financial support to immunized children and women.	**All states**	2013-2017; 2018-2022
Donor	**Implementing organization**	**Name of current project**	**Project activities**	**Number of states**	**Duration of funding**
WHO funds, Gavi, BMGF, Canada	Federal and state governments	Technical support to Implementation and monitoring of the global vaccine action plan	• Support the country in developing and implementing national multi-year plan and annual implementation plans, including micro-planning for immunization, with a focus on under-vaccinated and unvaccinated populations	**All states**	2016-2017 (WHO has biennual workplan agreements with government)
BMGF	• WHO, Unicef, • CHAI, • Solina Group, IVAC, • CHIGARI Foundation, • dRPC, and	Routine immunization system strengthening and support for introduction of new vaccines	All RI and PEI work stream (Planning and Management, Service Delivery, Vaccine Logistics and Supply Chain, Data Management, Demand Creation - advocacy and communication)	National level, 6 MOU states and 4 BMGF focal states and others	2009 – 2020

	• Others				
Gavi	Federal and state governments	Introduction of Pentavalent vaccine in RI	Immunizing under 12 months infants	**All states**	2012-2020
	Federal and state governments	Introduction of Pneumococcal conjugated vaccine in RI			2014-2020
	Federal and state governments	Introduction of Inactivated Polio vaccine in RI			2015-2018

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

I. Achievements against agreed targets

Table 8: Nigeria 2016 Coverage against Target

	Penta3	PCV	IPV	Measles
Country Target	90%	90%	90%	95%
Administrative	105%	83%	93%	104%
Official (JRF)	45%	29%	74%	43%
WUENIC	49%	26%	49%	51%
MICS*	33%			42%

***PCV/IPV not assessed**

Using the administrative coverage data for 2016, the coverage targets for the new vaccines were achieved except for PCV, whose introduction in 16 states was completed in the Q3 of 2016. The coverage variance with the WUENIC/survey has been discussed in section 3.3.

II. Overall implementation progress

New Vaccine Support

i. **IPV:** following the introduction of IPV in 2015, the administrative coverage was 93%, against the set target of 90% for the country. This was much more than from the 2016 WUNEIC estimates of 49%

ii. **PCV:** Phased PCV introduction in the 16 phase 3 states was also completed in Q3 of 2016. This was however associated with challenges that included inadequate cold chain equipments, poor maintenance of CCE, inadequate data tool for reporting, poor supportive supervision to health facilities with most visits reported to be conducted by partners. The administrative(JRF) coverage for PCV in 2016 was 83% against the set target of 90%.

iii. **Penta:** The administrative coverage for Penta3 105% in 2016 against the set target of 90% with Penta 1-Penta 3 drop-out rate of 7%. The 2016 MICS/NICS coverage of 33% was however recorded.

Measles

MCV1 administrative coverage for 2016 was 104% against the set target of 90%, however the 2016 MICS/NICS coverage was 41.7%. The first phase of the measles vaccination campaign exercise was carried out in November 2015 in the nineteen (19) northern states (including FCT) and the second phase was held in January 2016 in the Southern States of the country. A total of 39,039,651 children aged 9 months – 59 months were targeted for the campaign and 43,171,457 were vaccinated recording a National administrative coverage of 111%. The breakdown of numbers vaccinated in the North and South were 24,069,024(98%) and 19,102,223 (131%) respectively. This was above the set target of 95%, Post measles campaign coverage survey showed coverages below the reported administrative coverage in all states as shown in table 9 below.

Table 9: Measles Administrative Vs Survey Coverage by State 2016

State	Admin Coverage	Survey Coverage	State	Admin Coverage	Survey Coverage
Adamawa	106	86	Abia	129	92
Bauchi	99	80	Akwa-Ibom	108	86
Benue	107	83	Anambra	149	91
Brono	103	82	Bayelsa	121	72
FCT	119	78	Cross-River	102	92
Gombe	103	78	Delta	114	84
Jigawa	102	94	Ebonyi	132	88
Kaduna	96	84	Edo	97	80
Kano	105	84	Ekiti	97	94
Katsina	96	78	Enugu	103	93
Kebbi	102	80	Imo	126	95
Kogi	105	82	Lagos	188	88
Kwara	106	76	Ogun	122	75
Nassarawa	91	82	Ondo	103	88
Niger	106	94	Osun	120	86
Plateau	108	88	Oyo	171	83
Sokoto	78	73	Rivers	116	86
Taraba	111	92			
Yobe	110	84			
Zamfara	92	73			

HSS/ISS

The HSS/ISS funds for 2016 were used to strengthen and support service delivery in all states. Activities conducted included the following:

- MNTE Campaign in the SW States of Ekiti, Ondo and Osun (March and Sept 2016) and SE States of Ebonyi, Enugu and Imo.

- Training of health workers on integrated PHC service delivery

- Disbursed ISS funds to states for service delivery including outreach services.

CCEOP

The draft CCEOP document is currently being developed for submission to Gavi.

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

WHO and UNICEF are still managing Gavi grants on behalf of the Government of Nigeria since unresolved audit issues of the period of 2010 – 2015. Draft report of the audit exercise was received and country's response forwarded to Gavi, awaiting finalization of the audit exercise report. By the end of 2016, about thirty percent of the resources available for the year were utilized (Table 10). 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.

Table 10: Balance of HSS/ISS funds with NPHCDA/FMOH

Bank Name	Account No.	Account Name	Prog	Currency	Account bal. before closure	CBN TSA Account No.	STATUS / Comment
First Bank Nigeria	2023500877	NPHCDA/GAVI ISS DRAWDOWN ACCOUNT	ISS	Naira	30,353,438.03	20165661077	Account closed and funds moved to CBN. Cash credit reflected in submitted bank statement
United Bank of Africa (UBA)	1011319990	NPHCDA/GAVI HSS	HSS	Naira	15,079,359.59	20165661077	Account closed and funds moved to CBN. Cash credit reflected in submitted bank statement
First Bank Nigeria	2020251051	NPHCDA/GAVI HSS	HSS	Naira	9,339,250.46	??	Account closed and funds moved to CBN. **NOT** reflected in CBN bank statement. NPHCDA taken steps to write to Acct General on missing credit of funds, response pending.
Eco bank Nigeria	2202000432	DHDR Office FMOH			216,128,096.28	??	Account closed and funds moved to CBN. No evidence of funds in CBN, Bank statements not provided. FMOH taken steps to write to Acct General to credit funds, response pending.
		Total Naira Accounts			**270,900,144.36**		
United Bank of Africa (UBA)	3000616888	NPHCDA/GAVI HSS	HSS	USD	3,437,642.74	??	Account closed and funds moved to CBN. CBN bank statements pending. Action pending
First Bank Nigeria	2023113660	NPHCDA/GAVI - ISS DOMICILIARY	ISS	USD	1,422,750.07	??	Account closed and funds moved to CBN. CBN bank statements pending. Action pending
First Bank Nigeria	2020251068	NPHCDA/GAVI HSS	HSS	USD	18,344.45	??	Account closed and funds moved to CBN. CBN bank statements pending. Action pending.
					4,878,737.26		

UNICEF - Statement of account of Gavi grants in US$ as at 31st July 2017								
Area of support	**Grant number**	**Valid to date**	**Propose of fund**	**Total funds received**	**Funds utilized**	**Balance as at 31th July 2017**	**% utilization**	**Comments**
HSS/ISS	SC140635	31/12/2018	Support Immunization programme, Donor notification disbursement of funds dated 24 July 2014.	15,771,115.13	11,820,375.23	3,950,739.90	75%	Reprogramming was agreed between NPHCDA, Gavi and UNICEF on 12 October 2016 to accelerate the utilization of grant. -Decision letter (vaccines, devices and operations) was received from GAVI on 14th July 2017 on the MVC. This letter has authorized UNICEF to use in country funds (GAVI funds) to commence preparation for the MVC. GAVI had approved the use of 2,391,146 USD by UNICEF from in country GAVI HSS/ISS Grant.
IPV-VIG	SC 150090	31/12/2018	Vaccine Introduction Grant for Inactivated Polio Vaccine	5,569,473.33	4,434,426.51	1,135,046.82	80%	C4D, Printing material and Post Introduction Evaluation.
MenA	SC140784	31/12/2018	Meningococcal vaccination Campaign	5,944,788.57	5,749,202.42	195,586.15	97%	To be used during the preparedness of next CSM season
	SC110540	31/12/2018	Meningococcal vaccination Campaign	6,558,225.89	6,124,049.39	434,176.50	93%	To be used during the preparedness of next CSM season
Measles	SC 150606	31/12/2018	Measles SIAs	6,487,444.76	6,416,054.85	71,389.91	99%	Routine immunization intensification to the state with low measles coverage and measles outbreak
	SC 130571	31/12/2018	Nigeria- Social mobilization and logistic for Measles and YF SIAs	6,541,513.71	6,217,714.05	323,799.66	95%	measles outbreak
PCV - VIG	SC140824	expired	Vaccine Introduction Grant phase1 Pneumococcal Conjugate vaccine (PCV)	302,626.67	287,407.23	15,219.44	95%	Fund was fully spent before expired date, however, with the new exchange rate of Naira, the fund came back to the grant after payment of supplies.
PCV-VIG	SC140581	expired	Pentavalent Vaccine Support	4,588,997.54	4,554,608.81	34,388.73	99%	Fund was fully spent before expired date, however, with the new exchange rate of Naira, the fund came back to the grant after payment of supplies.
	Total			**51,764,185.60**	**5,603,838.49**	**6,160,347.11**		

Balance of funds with WHO as at Dec 2016

Area of Support	Agency	Balance (2015)	Fund Received (2016)	Funds Available (2016)	Utilized 2016	Balance (2016)	% utilization (2016)	Comment
PCV VIG Phase 1	WHO	0.00	2,015,539.00	2,015,539.00	1,394,258.00	621,281.00	69.18	Reprogrammed for MLM
PCV VIG Phase 2	WHO	0.00	0	0	0	0	0.00	Used balance of phase 1 and Men A campaign
Men A Campaign fund	WHO	1,407,731.00	0.00	1,407,731.00	3,266.00	1,404,465.00	0.23	
Measles	WHO	7,068,468.00	-	7,068,468.00	3,984,925.00	3,083,543.00	56.38	Reprogrammed for measles SIAs 2017

With the slow absorption of Gavi funds managed by UNICEF, an agreement was reached between Gavi, NPHCDA and UNICEF to re-programme all available Gavi grants with UNICEF.

The major issues arising from the cash management audit include poor planning, budgeting, procurement and fund disbursement system. Also internal control was seen to be weak culminating in violation of public procurement Act and poor documentation of the financial transactions. Consequently, the new Management at NPHCDA is focused on governance reform including enthroning the culture of accountability, transparency and value for money in the utilisation of available resources.

The Agency is in the process of redefining the roles/responsibilities of Staff in the finance function and the implementation of appropriate accounting software for enhanced efficiency and effectiveness of the financial management and reporting systems. For example, McKinsey and KPMG International have been engaged to support the current reform effort.

4.3. Sustainability and (if applicable) transition planning

Of the 1,017,495,128 naira appropriated for routine immunization, only 617,495,128 naira was released. The country obtained additional financing facility from the World Bank to finance routine vaccine procurement (including co-financing for Penta and PCV) and operational funds for polio.

National Immunization Financing Task Team (NIFT)

The National Immunization Financing Task Team (NIFT) was set up by the NPHCDA Board in 2015 to improve coordination on immunization financing and vaccine security, among government, partners, CSOs and the private sector. Its goal is to assure sustainable immunization financing by 2022 and long-term vaccine security in Nigeria. In addition to multi-Stakeholder engagements and meetings, the NIFT carried out the following activities;

Advocacy

- Hosted Advocacy Subcommittee workshop on Sustainable Immunization Financing (SIF) Transition Plan in February, 2016
- Co-hosted with Sabin Institute the Anglophone Peer review workshop in Abuja on SIF in April 2016 as follow up – broad participation included NASS and private sector. Followed up participation in Sabin Institute SIF colloquium in July at Nepal 2016.
- Hosted Uyo Legislative retreat on health financing, NHAct, and immunization in October, 2016. The focus was on advocacy for the Basic Health Care Fund, a pathway to achieving the Abuja Declaration of 15% of national budget to health. The major outcome from this discussion was a consensus among participants that government should be held accountable for increasing by 1% every year, the proportion of national budget going to health till 15% is achieved.
- Active participation at National Assembly public hearing on 2017 budget. Advocacy activities are timed to coincide with the budget cycle but there are challenges with delays in the budget timelines. The newly established Primary Health Care Revitalization Support Group of the National Assembly presents an opportunity for CSOs to engage better with the National Assembly on PHC and immunization advocacy.

Immunization trust fund

A legislative drafting committee has been set up to develop a legislation on immunization trust fund. Discussions center on the scope of the trust fund - whether vaccine only or PHC more broadly

Local vaccine production

NIFT is advocating for the government to put in place an enabling environment to foster private sector investment in local vaccine production. They are seeking funds to procure the services of an international consultant who can produce a Policy Framework for Local Vaccine Production and a Bankable Business Case. The Business Case is to inform investment decisions by interested parties.

Gavi Transition

Gavi's objective is to provide catalytic support while encouraging countries to take full responsibility of providing vaccines and commodities as well as sustainably strengthening the primary health care system in general and routine immunization system. Nigeria as a country, that has been benefitting from Gavi support for over 10 years is expected to transit by 2022 as a result of the rebased economy.

In 2016, Nigeria received support for co-financed new vaccines (PCV, Penta and IPV) from Gavi which will decrease over time while the country pays for the gap. The country met its co-financing obligations for

2016. In addition, Gavi also supported supplemental immunization activities/campaigns, immunization system strengthening and health system strengthening activities.

In view of the Gavi transition, the country commenced planning to close-up these gaps. Specifically, the NPHCDA with support from partners, conducted a mapping of Gavi support to Nigeria from 2001 – 2016, and tried to identify the risk areas that would be majorly affected on graduation. These risk areas will form the basis for the priority areas which will guide the country towards a sustainable transition. The areas were basic concepts to the analysis used to develop the country's strategy to chart a new direction were grouped into 4 key categories for successful graduation and include: Evidence based decision making, Immunization demand and delivery, Access to timely and affordable supply, and Financial sustainability. This further provided additional immunization towards transition and beyond.

Polio Transition

In line with the fourth objective of the GPEI Polio Eradication Endgame Strategic Plan (2013-2018), Nigeria's Polio Transition Planning process is geared towards developing a national Plan which ensures that once containment of the Polio is attained, assets from the PEI program continue to benefit and sustain other health programmes and national health priorities, while also maintaining a Polio-free country. Nigeria initiated its Polio Transition Planning process by inaugurating the National Polio Transition Planning Committee (NPTPC) and the Polio Transition Technical Task Team (PT4) as the governing and implementing bodies respectively, in May 2016.

Since then, the country has achieved key milestones towards developing a national Polio Transition plan including the completion of asset mapping - which aligned assets, their level of involvement in Polio functions and non-Polio activities, and the associated costs; and the documentation of the Best Practices of the PEI program. The process has also identified three (3) national health priorities namely: PHC Revitalization, EPI/RI and Disease Surveillance/Outbreak Response.

A simulation exercise with wide stakeholder engagement was held in September 2016, which assessed the criticality of Polio assets and functions to Polio activities, and to the successes of non-Polio activities including RI, MNCH, Measles/New vaccines and Disease Surveillance/Outbreak Response; and proposed strategies for transitioning these assets and functions to support and strengthen the three (3) health priority areas. The activity's risk assessment determined the risk of absence of GPEI funding to Disease Surveillance/Outbreak response at 82.9%; PHC Revitalization at 54%; and EPI/RI at 29%. However, the projected risks are escalated for all the priority areas, and especially for EPI/RI, when cognizance is taken of the effects of simultaneous developments in other programs/initiatives, including the Gavi graduation. There are ongoing efforts to align Polio Transition Planning process with the Gavi Transition Plan to identify high, medium and low risk priorities that will inform decision-making and planning.

The 2016 isolation and outbreak of WPV in Borno and the response of heightened efforts to contain the outbreak reinforces the need to ensure the country's preparedness for transition in the absence of GPEI funding and when Polio is eradicated, while not detracting from ongoing eradication efforts. This includes assessing the absorptive capacity of relevant government agencies, restructuring of health frameworks, and addressing policy and funding gaps. Towards this end, the country is currently in the process of developing a business case which will allow transition strategies, and roles and responsibilities to be clearly defined.

4.4. Technical Assistance (TA)

To support the implementation of activities on Immunisation in country, Gavi is providing technical assistance through WHO, UNICEF, CDC, IVAC and CSO/CRS. The support received in 2016 contributed to the improvement of immunisation programme. During the reporting year, Gavi-funded a case study of Targeted Country Assistance (TCA), six (6) key findings and recommendations were made to address issues. These are stated below.

Key Finding 1. There is poor quality of immunization data in the country, which impedes the TCA from being planned effectively.

- Recommendation 1. Re-direct TA funding to intensify data-related TA to improve quality of country's immunization data.

Key Finding 2. There have been funding delays and excessive donor dependence. Delays in funding for immunization: the release of budgetary provision and donor pledged funds commonly challenge immunization plans and activities.

- Recommendation 2. All stakeholders should review together and harmonize funding processes to reduce funding delays.
- Recommendation 3. TA to focus on strengthening NPHCDA institutional capacity rather than capacity filling by partners. NPHCDA to also increase coordination of partner led TA efforts.

Key Finding 3. TCA/PEF is in its nascent phase and stakeholders are in the process of fully understanding their roles.

- Recommendation 4. Review and enhance TCA planning and JA process for improved efficiency of especially the management of post meeting report.

Key Finding 4. The structure for the TCA planning process has been established but is lacking in some important details.

- Recommendation 5. Gavi should include mechanisms for partner updates and feedbacks to country on the TAs that the partners provide and the milestones achieved.
- Recommendation 6. Gavi should strengthen transparency in TCA by including mechanisms for transparency between partners and the EPI team.
- Recommendation 7. Improve the alignment of the TA with the country's perceived (real) needs beyond those identified through the TCA process.

Key Finding 5. Partner TA delivery activities are concentrated mainly at the national level and less so at the subnational level where TA is more needed.

- Recommendation 8. Gavi should re-focus to increase partner TA activities determinately to the subnational level.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. 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 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). - Design and implement innovative approach to incentivize data accuracy - Implement data quality and use trainings in states with the largest discrepancy between admin and survey coverage data	A data quality improvement plan has been developed and awaiting roll out. In addition to this, part of the efforts to improve RI data quality, was an on-the job mentoring of health workers to improve their data management skills which was implemented in Kano and Niger state in 2016. The activity is ongoing in Rivers and Nasarawa state. Five sentinel sites for PBM (UNTH Enugu, UITH Ilorin, ATBU Bauchi, ULTH Lagos, UBTH Benin) and two sentinel sites for rotavirus (UNTH Enugu, UITH Ilorin) have been created with support from the GPEI funds. Two more sentinel sites for rota have been planned to be created in September 2017 in ATBU Bauchi and ABUTH Zaria. Training haven provided for the site coordinators, Laboratory focal points and data managers in existing sentinel sites, together with logistics support for their operations. NHIS supplementary form has been developed to capture additional RI indicators on the DHIS2 platform. GIS Technology has been used to determine population estimates for the northern states, whilst walk-through micro-plan has been used for the southern states.
2. 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	The National Emergency Routine Immunization Coordination Centre was inaugurated in July 4th 2017 and has developed a comprehensive plan to improve coverage and equity within 18 months of its creation.
3. Sustained advocacy for availability of bundled vaccines and funding for immunization services at all levels	The country has been committed to providing adequate bundled vaccines to state in a timely manner. Advocacy visits have been carried out to

	states on the provision of funding for immunization services.
4.) Strengthen the PHC system to increase demand creation for RI (through wards / community structures & participation and PHCUOR reform	The Federal government has launched the PHC Revitalization initiative with plans to rehabilitate 10,000 PHCs across the country, starting with an initial 109 facilities, one in each of the senatorial district of the country. There is an ongoing plan to operationalize the CHIPS programme, to bring PHC services to the very doorstep of people in the communities.
5. Reprogramming of the Gavi HSS2 programme proposal / Review of the cMYP (2016 - 2020) to reflect current realities.	cMYP (2016 – 2020) has been reviewed. The HSS2 reprogramming is still pending
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being priorities in the new action plan (section 6 below).

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for next year:

The National Routine Immunization Emergency Coordination Center has developed a work plan for supporting improvement in coverage and equity with particular focus to the poorly performing states and LGAs. Implementation of the work plan has commenced in 2017 but will continue through 2018. Measles catch-up campaign targeting children 6 – 59 months will be implemented in phases starting with the very high-risk states in North West (October 2017) and North East (November 2017). The states in North Central will implement in February 2018 and Southern states in March 2018.

Yellow Fever campaign will be conducted in 3 states (Benue, Taraba and Plateau) in April 2018 using available 15m doses. The remaining phase 2 states (Anambra, Imo, Delta and Adamawa) states will conduct the yellow fever campaign in October 2018, if vaccines are available.

Introduction of Men A into routine immunization in 2018 will be guided by the NGI-TAG recommendation. In the Immunization strategy being presented to Gavi, the country seeks for flexibility to be able to develop and submit the proposal to Gavi in 2018 for phased introduction of HPV in 2021 and 2022.

The Immunization coverage target set for countries in the WHO African Regional Office is 95% for the year 2018. However, in consideration of the MICS/NICS Survey result of 33% national penta3 coverage, with states recording varying coverages, Nigeria is aiming towards 80% national coverage in 2018 and 85% in 2019 which will be stabilized till 2025. This is informed by the need to encourage improvement in coverage

in high performing states like Lagos that recorded 80% coverage in the MICS/NICS and eleven[7] other states that had 60% to 76% coverage. This is also bearing in mind that the country recorded 78% administrative coverage on the DHIS2 platform in 2016 and all states are moving onto the platform by January 2018. The 80% coverage set for 2018 is for the purpose of vaccine forecasting and will accommodate availability of vaccines on all the proposed initiatives. States will be grouped into specific coverage targets based on the 2016 MICS/NICS result.

The NPHCDA in collaboration with partners is putting in place measures to implement the data quality improvement plan in 2018 so as to improve RI data quality and reduce to acceptable level, the disparity between administrative and survey coverages.it is also iIncreasing the human resources in DCI by providing capacity building of identified persons that will be task-shifting from other department to the Department of Disease Control and Immunization of the agency. NPHCDA and partners have signed an MOU to implement an "Immunization Service Delivery Accountability" approach, which aims to address data accuracy/quality and reduce pressure on the health care worker to falsely report to targets. This accountability mechanism will ensure every manager and partner supports the health care worker to report data accurately, as any falsification found at LGA/health facility level includes both government and partner staff in those locations being held responsible.

Key finding 1	**Poor data quality, with variation of more than 10% noted between administrative and survey data; Weak linkage between actual surveillance and coverage data; serious disparity between admin and survey data**
Agreed country actions	Implement data quality improvement plan including Annual Desk Review
Associated timeline	2018 - 2019
Technical assistance needs	- Support to expand electronic data capture from the health facility level to enhance real-time data review, use and accountability (TA Support from WHO, CDC/NSTOP, CHAI, IVAC) - support for implementation of prioritized strategies in the DQIP including health facility level micro-planning (TA Support from WHO, CDC/NSTOP, CHAI, IVAC, JSI) - on-the-job trainings for data quality and use in states with the largest discrepancy between admin and survey coverage data. (TA Support from WHO, CDC/NSTOP, CHAI, IVAC) - design and implementation of innovative approach to improve data accuracy at health facility level (TA Support from WHO, CDC/NSTOP, CHAI, IVAC, JSI) -Triangulation of immunization data with surveillance and logistics data, through a well co-ordinated integration of EPI data within the HMIS that would consider coverage, stock and surveillance data for the long-term integration (TA Support from WHO, NSTOP, CHAI, IVAC, JSI) -TA support to Pilot and implement a strategy for "no targets" in prioritized states as a programmatic strategy to address key denominator challenge and pressure on reporting to targets—learning lessons from polio.

[7] Anambra, Edo, Enugu, Ekiti, Cross River, Akwa Ibom, FCT, Imo, Rivers, Ondo & Osun

Key finding 2	Poor stock records at all levels of the Supply Chain which impedes vaccine accountability; Inappropriate and Insufficient Cold Chain Equipment at all levels of the supply chain which affects vaccine potency
Agreed country actions	-Revise existing vaccine and devices data collection framework -Disseminate using new learning approaches and on the job-mentoring -Get buy-in of state and local governments to enforce accountability structures and provision of data tools -Establish data performance matrix to track state/LGA/HF level performance Submit CCEOP application -Construct the 3 Hubs -Develop and implement a framework for sustainable vaccine delivery to the last mile
Associated timeline	2018 – 2019
Technical assistance needs	-Technical assistance will be required to support: - vaccine and devices utilization assessment (TA Support from UNICEF, CHAI) - establishing a system to track and monitor cold chain equipment performance vaccines and devices utilization (TA Support from UNICEF, CHAI) - development of a sustainable last mile vaccine delivery framework (TA Support from UNICEF, CHAI, JSI)
Key finding 3	Need to strengthen institutional capacity to manage EPI at national and sub-national level to improve performance
Agreed country actions	-Ensure full implementation of recommendations from the ongoing NPHCDA organization assessment - Institutionalize ongoing strategic initiatives to strengthen EPI management at the NPHCDA and state/LGA levels (NERICC, SERICC, JSI)
Associated timeline	2018 and ongoing
Technical assistance needs	Technical support for the implementation of the NERICC and state level work plans including incorporation of the findings from the equity assessment into the work plans (All RI Partners)). TA support from CHAI, JSI (already supporting Sokoto through MCSP)
Key finding 4	Caregiver mistrust and fear; Inadequate awareness on RI services as against SIAs; Poor demand for Services
Agreed country actions	One on one interface with caregiver by trusted community members engaged as VCMs, CHIPS and other community mobilizers (TBAs, etc.) and engagement of traditional rulers and other community influencers regularly to builds trust and increase acceptance and demand for immunization services. Leveraging on the emerging new technologies and mobile telecommunication platforms and community channels for increased messaging on the benefits of routine immunization to elicit uptake of services by care givers.

	Leverage on the communication structures and strategies that were used to create awareness and generate demand during the polio eradication campaign to strengthen the culture of routine immunization uptake at the health facility. Improve demand for service as a catalyst for improving coverage through the deep engagement of community structures and linking them with PHC Train and mentor health care workers on Train and mentor health care workers on Inter-Personal Communication and Counselling (IPCC) techniques to address poor attitude of health workers at service delivery level.
Associated timeline	Continuous engagement
Technical assistance needs	Communication Consultants deployed to the states to develop and implement social mobilization plans that will engage the community structures with relevant messages (TA Support from UNICEF, JSI) TA to develop and implement communication strategies that will use mobile telecommunication technologies and community channels for intensive messaging to improve awareness and uptake of RI services (TA Support from UNICEF, IVAC) TA for partners to implement robust community engagement interventions (TA Support from UNICEF)
Key finding 5	Poor coverage and equity
Agreed country actions	Improve coverage and equity (Finalise a costed strategy development) Conduct deep dive into the root causes of poor coverage in the priority states
Associated timeline	Flexibility request to GAVI board by end of Sept 2017 March 2018- Final strategy submitted Deep dive (immediately)
Technical assistance needs	TA for developing the strategy (All RI Partners) (TA Support from UNICEF including JSI, CDC/NSTOP) TA to conduct the qualitative assessment, robust analysis and disseminate findings (CHAI, IVAC, CDC/NSTOP)
Key Findings 6	Poor card availability and retention (Challenges with home based records)
Agreed Country Actions	Strengthen home based records - Increase availability of child health card and retention, test and introduce innovations like vaccine reminder bands and bracelets to improve uptake and serve as wearable vaccination records
Associated timeline	Immediately, 2018 to 2019
TA assistance needs	TA to review the current home-based records and implement the findings of the NICS 2016 (IVAC, DCL)
Key Findings 7	Increasing resource for immunization and financial sustainability: Lack of clarity about sustainability and effectiveness of the different strategies for increasing resources for immunization; Challenges with commencing implementation of the different strategies for increasing resources for immunization like the Basic Health Care Provision Fund (BHCPF), Immunization Trust Fund; weak advocacy for sustainable resource mobilization at the subnational level

Agreed Country Actions	1. Development of estimates of how the different resource mobilization strategies are realistically expected to yield 2. Immediately initiate strong, targeted advocacy on key strategies like BHCPF, Immunization Trust Fund, etc to the Senate, National Assembly, Governor's Forum and other major stakeholders to ensure the funds are included in the 2018 budget. 3. Advocacy and TA for creation of institutional mechanisms to increase fiscal space for health and immunization at the sub-national level.
Associated timeline	Activity 1 – November 2017 Activity 2 - tbd Activity 3 – Q1 2018; advocacy on going thereafter
TA assistance needs	1. TA for devising workable initiatives for the operationalization of the BHCPF, Trust fund (World Bank) 2. Strengthen national capacity in the areas of forecasting, costing and budgeting of annual and multi-year immunization plans. (World Bank) 3. Advocacy for new initiatives that will encourage government political will and funding for health /immunization. (TA support from IVAC) (World Bank) 4. TA to strengthen national capacity to report on immunization expenditures through JRF using the NHA/SHA methodology (World Bank), support vaccine introduction, surveillance, and evaluation 5. TA to strengthen national and subnational capacity for budget tracking and accountability (TA support from IVAC)

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

The 2017 Joint appraisal report was developed with guidance template and other relevant documents received from the Gavi secretariat. The process of development of the JA Report (JAR) for Gavi activities implemented in 2016 started with a planning meeting of the JAR secretariat to discuss the modalities of developing a quality report. At the meeting, members received proper guidance on the development process and the guidance documents from Gavi were shared with members. The JA report template was shared with members to populate with information.

Eight meetings were had by members and at each meeting members reviewed information provided to the document. At the end of each meeting of the JAR secretariat, the draft report was circulated to a wider stakeholder for comments and inputs. This continued until the report had been well populated and was taken into a one-day Joint appraisal workshop. The JA workshop was held in Abuja on the 22nd of August 2017. Participation at the workshop cut across government and partners and included the Federal Ministry of Health, the Ministry of Budget and National Planning, the NPHCDA, WHO, UNICEF, World Bank, CDC/NSTOP, CHAI, BMGF, MCSP, IVAC, SOLINA Group, DFID and Gavi Headquarters.

During the one-day workshop, participants were divided into six groups to provided further inputs and comments to the draft JA report and also identify areas of the Immunization systems that require technical assistance, working off information from the draft report. The six groups and sections of the draft report reviewed were:

Sn	Groups	Sections reviewed

1	Leadership, program management & coordination	2.0, 3.1, 3.2, 3.4, 4.4, 5.0
2	Financial Management & Sustainability	2.0, 3.1, 3.2, 4.3, 4.4, 5.0
3	Supply Chain Management and CCEOP	2.0, 3.1, 3.2, 3.3, 4.4, 5.0
4	Data management/ disease surveillance	2.0, 3.1, 3.2, 3.3, 4.4, 5.0
5	Programme implementation (NVS, HSIS)	2.0, 3.1, 3.2, 4.1 4.2, 4.4, 5.0
6	Demand Promotion and Community Engagement	2.0, 3.1, 3.2, 3.4, 4.4, 5.0

The JAR secretariat met twice after the workshop on 23rd and 24th August 2017 to harmonize the work done by the different working groups during the workshop. The harmonized draft report was shared with the core group in its meeting of 25th August 2017 for further guidance and approval for onward submission to the ICC.

The final draft of the 2017 Joint Appraisal Report was presented to the ICC on 5th September 2017 for final approval before submission to the Gavi Secretariat. In attendance at the Meeting was the Honourable Minister, Professor Isaac Adewole (ICC Chair), Dr. Faisal Shuiab (ED-NPHCDA), Dr. Odutolu (WB), Dr. Rex Mpazanger (WHO),Dr. Fiona Braka (WHO), Dr. Sanjana Bhardwaj (UNICEF), Moji Rhodes (CHAI), Chris Lewis (DFID), Joseph Monehin (USAID), (IVAC), and Yusuf Yusufari (BMGF). After the presentation, the ICC decided that the draft report should be shared with members for comments with deadline for feedback on 7th September 2017.

8. ANNEX

Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	✓		
Financial Reports			
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
End of year stock level report	✓		
Campaign reports	✓		
Immunisation financing and expenditure information	✓		
Data quality and survey reporting	✓		
Annual desk review			
Data quality improvement plan (DQIP)	✓		
If yes to DQIP, reporting on progress against it			

In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)	✓		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	✓		
Post Introduction Evaluation (PIE)	✓		
Measles-rubella 5-year plan			✓
Operational plan for the immunisation program			
HSS end of grant evaluation report			
HPV specific reports			✓
Transition Plan			

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.
