Joint Appraisal report 2019

Country	NIGERIA
Full JA or JA update[1]	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	16 &17 September 2019, Abuja
Participants / affiliation[2]	Government & Partners (see annex attached)
Reporting period	January 2018 – August 2019
Fiscal period[3]	January – December 2018
Comprehensive Multi Year Plan (cMYP) duration	2016 – 2020 (NSIPSS 2018-2028)[4]
Gavi transition / co-financing group	*accelerated transition*

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ■	No ☐	
Does the vaccine renewal request include a switch request?	Yes ☐	No ■	N/A ☐
HSS renewal request	Yes ☐	No ☐	N/A ■
CCEOP renewal request	Yes ☐	No ☐	N/A ■

2. GAVI GRANT PORTFOLIO

Existing vaccine support

Introduced / Campaign	Date	2018 Coverage (WUENIC) by dose	2019 Target		Approx. Value $
			%	Children	
IPV Routine	Feb 2015	57% (IPV1)	57%	4,497,334	58,653,396
Measles Campaign	Oct 2013	65% (MCV1)	80%	6,643,318	44,702,117
Measles Campaign	Nov 2015				
Measles Campaign	Nov 2017				
MenA Campaign	Dec 2011	N/A	33%	2,603,720	84,373,279
MenA Campaign	Dec 2012				
MenA Campaign	Nov 2013				
MenA Campaign	Nov 2014				
MenA Routine	Aug 2019				
Penta Routine	June 2012	70% (DTP1)	74%	5,838,644	147,094,827

[1] Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, https://www.gavi.org/support/process/apply/report-renew/

[2] If taking too much space, the list of participants may also be provided as an annex.

[3] If the country reporting period deviates from the fiscal period, please provide a short explanation.

[4] NSIPSS: a ten-year national strategy for immunization and PHC system strengthening

		57% (DTP3)			
PCV Routine	Dec 2014	57% (PCV3)	74%	5,838,644	238,488,899
Yellow Fever Routine	Jan 2005	65%	N/A	N/A	113,803,587
Yellow Fever Campaign	Dec 2013				
Yellow Fever Campaign	Jan 2018				

Existing financial support

Grant	Channel	Period	First disb-ursement	Cumulative financing status @ July 2019				Compliance	
				Comm.	Appr.	Disb.	Util	Fin	Audit
HSS	WHO/ UNICEF		2008	159,558,507	96,7755,695	30,297,040			
INS	WHO/ UNICEF		2008	12,630,270	12,630,270	12,610,218			
ISS	WHO/ UNICEF		2001	44,162,306	44,162,306	44,162,306			
Measles Follow-Up Ops cost	WHO/ UNICEF		2017	25,714,045	25,714,045	25,210,153			
Measles SIA Ops cost	WHO/ UNICEF		2013	37,207,046	37,207,046	37,207,046			
MenA Mini Catch-Up Ops cost	WHO/ UNICEF		2019	15,932,071	15,932,071	14,409,590			
MenA Ops cost	WHO/ UNICEF		2011	43,505,648	43,505,648	43,505,648			
Product Switch Grants	WHO/ UNICEF		2018	2,049,376	2,049,376	1,718,203			
Vaccine Introduction Grants	WHO/ UNICEF		2003	24,952,677	24,952,677	23,234,600			
Yellow Fever Ops cost	WHO/ UNICEF		2013	48,607,277	37,959,252	26,153,979			
Comments									

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[5]

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	Rota vaccine	2019	2020
	HPV	2020	2021

Grant Performance Framework – latest reporting, for period 2018

Intermediate results indicator	Target	Actual
N/A	N/A	N/A
Comments		
• National level GPF has been negotiated with the new HSS approval this year but not yet due for reporting as the implementation hasn't started and the GPF indicators need to be put on the portal. • In addition, 8 states are working on specific GPFs which will be put on the portal, once finalized.		

PEF Targeted Country Assistance: Core and Expanded Partners at [2018/2019]

	Year	Funding (US$m)			Staff in-post	Milestones met
		Appr.	Disb.	Util.		
TOTAL CORE	**2018**	**3.6**	**3.6**	**3.6**	**7/7**	**11/13**
	2019	**5.8**	**4.7**	**N/A**	**12/16**	**23/25**
UNICEF	2018	0.9	0 .9	0.9	4/4	4/5
	2019	3	2.2	0.6	9/11	14/14
WHO	2018	1.4	1.4	1.4	3/3	1/1
	2019	1.4	1.1	0	3/5	5/5
WB	2018	0.5	0.5	0.5	NA	2/2
	2019	0.5	0.5	NA	NA	2/2
CDC	2018	0.8	0.8	0.8	NA	4/5
	2019	0.9	0.9	NA	NA	2/5
JHU	2018	0.1				-
PATH	2018	0.03				0/1
	2019	NA				-
CHAI	2018	NA				-
	2019	0.9				1/3
CRS	2018	0.3				3/3
	2019	NA				-
University of Oslo	2018	0.02				-
	2019	0.02				-
ARC	2018	0.2				4/5
	2019	NA				-
ICA (2x)	2018					-

[5] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.
Countries are encouraged to highlight in subsequent sections, and in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

	2019	0.2		-
Rocque Advisory	2018	0.1		1/1
	2019	NA		-
Solina	2019	0.09		-
HSCL	2018	NA		-
	2019	0.6		-
Sydani Initiative	2018	NA		-
	2019	0.2		-

3. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

Political environment

The 2019 elections brought continuity in governance at the national level and in most states. As part of sustaining momentum of leadership commitment at all levels, the NPHCDA has engaged new Governors and Executive Secretaries/Executive Directors in most states[6]. Government priority for sustaining revitalization of PHC and strengthened immunization in 2019 was evident by the enactment of the new National Health Insurance Act of 2019, the launch of the National Strategic Health Development Plan (NSHDP) II 2018 to 2022 and the disbursement of the Basic Health Care Provision Fund (BHCPF) to 15 states and the FCT.

Economy and finance

Nigeria achieved relative macroeconomic stability with half year 2019 cumulative gross domestic product (GDP) growth rate of 2.02%, largely driven by improvement in non-oil sector[7]. However, the Federal Government of Nigeria (FGoN) revenue projection for 2019 remains largely unreliable. The actual pro rata revenue for Jan-June recorded 30% negative variance as against the 45% negative variance recorded for the 2018 fiscal year[8]. Despite the shortfall in revenue in 2018, releases for Immunisation during the year stood at 99.54% at the National level; thus. lending credence to the FGoN commitment to Immunisation Financing. Nevertheless, there was late release of funds due to instability in the budget cycle.

The government has signed a law increasing the minimum wage from N18,000 to N30,000 per month, yet, varied ability by states to pay poses a risk of industrial action.

Immunisation and PHC

The under-five, (132/1000LB) and infant mortality (67/1000LB) rates are very high. Over fifty percent (57%) of pregnant women have had at least four ANC visits and 43% delivered by skilled birth attendant, however very wide disparity exists across the geographic and socio-economic strata in the country.[9] Immunisation coverage remains suboptimal despite marginal increases during the past five years (e.g. estimated increase of Penta3 coverage increased from 38% to 50% (NDHS 2013 vs 2018). The trends in state-level vaccination coverage (based on data from NDHS 2013 and 2018) suggests improved coverage in the Northern states and a decline in some Southern States. Beginning in November 2018, there was a significant population from displaced persons migrating from recently liberated, previously inaccessible areas, contributing to several outbreaks including measles, yellow fever, meningitis and circulating Vaccine Derived Polio Virus type 2 (cVDPV2), cholera and Lassa fever.

[6] ED executive brief notes to the Governors meetings, 2018/19
[7] National Bureau of Statistics
[8] Draft 2020 – 2022 Medium Term Fiscal Framework (MTFF), Federal Ministry of Finance, Budget and National Planning
[9] NDHS preliminary report 2018:

The declaration of Routine Immunisation as a Public Health Emergency in June 2017 and subsequent intensification of activities in 18 low performing states is translating into improvement in quality of immunisation services in these priority states. The implementation of the Optimised Integrated Routine Immunisation Sessions (OIRIS) approach is assessed through periodic conduct of the Routine Immunisation-Lots Quality Assurance Sampling (RI-LQAS). The recent result shows an increase in the number of LGAs with acceptable score from 11 (3%) in Q4 of 2017 to 172 (46%) in Q2 of 2019 across the 378 targeted LGAs. These achievements notwithstanding, there are persisting factors such as inadequate number of skilled staff, low financing and insecurity that contribute to sub-optimal immunisation performance. Furthermore, the District Health Information System 2 (DHIS2) and the RI Short Message Service (SMS) is used to track the conduct of daily fixed sessions which is a key pillar of the OIRIS approach.

A declaration of State of public health concern on Maternal and Child Deaths was made on April 8th, 2019 with a decision to establish a National Coordination Centre to provide oversight on RMNCAH + N activities at the Primary Health Care level. Following this declaration, the national emergency maternal and child health intervention centre (NEMCHIC) was established to promote awareness and ensure effective emergency response to maternal and child mortality that addresses the delays to care through an integrated approach. The creation of NEMCHIC saw the need to replace the RI LQAS with the Programme Assessment for Performance Management and Action (PAPA-LQAS) which incorporate some other RMNCH+N indicators, namely ANC attendance and skilled birth attendance tracking.

Gavi and partners continue to support the NPHCDA to improve immunisation coverage and equity. In February 2019, the Gavi Board approved the following applications for implementation: Phase I HSS, Measles, Yellow Fever and Meningitis Supplementary Immunisation Activities (SIAs), the Cold Chain Equipment and Optimisation Platform (CCEOP) and introduction of Measles Second Dose in Routine Immunisation.

The Government also endorsed the Accountability Framework for the implementation of the Nigeria Strategy for Immunisation and PHC Systems Strengthening 2018 – 2028.

Polio Transition

Nigeria has successfully interrupted Wild Polio Virus (WPV) transmission, having gone 36 months without a case of WPV. The country is preparing for submission of certification documents for assessment by the Africa and Global Certification Committees. The country is in the process of finalizing a business case on polio transition from which a polio transition plan will be developed where the government will gradually take over the funding and management of responsibilities of polio resources including human resources, intangible assets, and tangible assets that will be used to strengthen disease surveillance/outbreak response, EPI, and PHC revitalization over the next 5 years (2019-2023).

The WHO has commenced the polo-ramp down process that would result in a steep decline in staffing in Nigeria from more than 2000 personnel in 2019 to 140 personnel in 2023. Other GPEI partners are also planning transition of resources.

Potential future issues (risks)

Table 1: Potential Risks and Mitigation Plans

SN	Thematic Area	Risks	Mitigation Plan	Responsible
1	Service delivery	• Security threats, armed banditry and kidnaping in some LGAs across the states will deter conduct of sessions (fixed and outreach). • Persistent work to rule by health workers could continue if the approved minimum wage is not implemented by states. • Dependence of states/LGAs on the use of adhoc/casual staff who cannot be held accountable.	1. Dialogue with leaders of the bandit groups to allow health workers to conduct sessions and ensure provision of vaccines through both RI and SIAs. Use of local leaders, community informants, and civilian joint taskforce/military to reach insecure areas. 2. Advocacy to state government, Governors forum, Ministries of Health and CSOs at all levels for recruitment of skilled health workers and ensure adherence to accountability, release of budget line for RI and PHC , leveraging lessons learnt from MOU states and the basket funds for the Gavi supported 8 states and the World Bank supported states. 3. An assessment of the health workforce including adhoc/casual staff	1. State government 2. NPHCDA, Donors & Partners 3. State/National
2	Demand Generation	Insufficient funds for community mobilization for RI sessions that hinged on the Polio campaigns following ramp down of polio program	1. identify essential cost drivers (start off and operational activities) for the CE approach for sustainability. 2. Gather and document lessons learned from states who have been implementing CEF for 1+ years, and perspectives on what can be improved going forward 3. Expand on the implementation of the community engagement framework to other states.	SPHCDAs, NPHCDA and partners
3	VPDs outbreak and surveillance	Persistent outbreak of vaccine-preventable diseases e.g. measles, Yellow fever, cVDPV etc. • Frequent outbreaks due to low routine immunization coverage and low quality SIAs • Weak AEFI Surveillance and response contributes to vaccine hesitancy.	1. use the outbreaks information for sensitization of leaders and health workers on RI for improved coverage. 2. Strengthen collaboration with NCDC and improve use of VPD surveillance data to identify high risk areas to inform targeted RI intensification and preventive campaigns, and to monitor and evaluate RI program and health system strengthening effectiveness, even in areas of high coverage 3. Strengthen community-based surveillance using e-surveillance.	NPHCDA and other relevant MDAs

4	Data management	Shortage/stock out of data tools may occur due to national shedding the responsibility of data tool printing to states Continued sub-optimal data quality	1. Conduct state level monthly inventory on the quantity of data tools available at HFs and LGAs 2. Advocate to states to approve and release annual budget for immunization inclusive of line item for the printing of data tools specified by the national 3. Implement data quality and use support and DQIP 4. Implement accountability framework for data falsification	SPHCDAs, NPHCDA and partners
5	Finance	• Misalignment in national budget cycle and vaccine budget/financing cycle • Risk of irregular payment of health workers' salary in some states of the federation which may arise from the recent wage increase	1. Coordination between NPHCDA, Ministries of Health, Budget & planning and finance to mitigate potential delays in funding release due to separate funding cycles. 2. The NPHCDA and partnership to ensure early development of strategic plans for EPI program to fit into the MTEF calendar. 3. Vaccine Forecasting process to be concluded early (between April and May) every year to meet up with timelines for development of MTEF 4. Legislative advocacy to ensure timely release and front-loading of funding for next year. 5. Strengthen planning process starting with the forecast process. 6. Engagement of the Governors forum towards ensuring adequate budgetary provisions for regular payment of health workers salaries; 7. Scale up of the PBF mechanism in which health facilities are granted autonomy to develop their own business plans with incentives to motivate the workers.	NPHCDA, Partners
6	Cross cutting	• Major change in policy e.g., Primary Healthcare Under One Roof (PHCUOR) with varying levels of adoption at the state level, which could affect coordination within the PHC • Funding risks that may arise from the new directive of funding from Federal to LGAs, and potential impact on PHCUOR, transparency of financing at HF level	1. Advocacy to leadership in the states to implement PHCUOR 2. Advocacy to the States /ALGON on the impact of LGA autonomy and advocacy to the LGAs/Director PHCs on the need for increased coordination across the different services provided under the PHC	NPHCDA/Partners NPHCDA/SPHCDA/Partners

4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

4.1. Coverage and equity of immunisation

Coverage and Equity

Although opportunities to accelerate gains remain, preliminary results from the 2018 Nigeria DHS suggest marginal improvements at the national level in access and utilization of immunization services for infants in the 2017 birth cohort from levels observed 5–10 years ago. Evidence from the preliminary results of the Nigeria Demographic Health Survey (NDHS) 2018, shows Penta3 coverage of 50%, an increase from 38% from NDHS 2013. Among the 2017 birth cohort, two-thirds of infants received BCG vaccine and first dose of Penta vaccine; half of infants received a third dose of Penta vaccine; and about half of infants received a dose of measles containing vaccine compared to two-in-five infants five years earlier. Unfortunately, vaccination against polio virus through routine immunization (both OPV and IPV) appears to continue to lag far behind necessary levels. Finally, and most importantly, the percentage of infants who reportedly received no vaccinations appears to have declined to the lowest levels ever observed in Nigeria. Results suggest notable gains in the North East Zone likely driven by changes in Bauchi, Borno, Gombe, and Yobe.

The preliminary results also suggest these gains are particularly pronounced among infants born into socioeconomically disadvantaged conditions. In fact, a first look suggests access to, and utilization of immunization services may have doubled among the poorest households on average during the past five years, and that the gap between richest and poorest has narrowed on average. Current WUENIC estimates suggests penta3 coverage of 57% (Figure 1), a value above 43% estimated within the Nigeria Strategy for Immunisation and Primary Health Care Systems Strengthening (NSIPSS), 2018 – 2028.

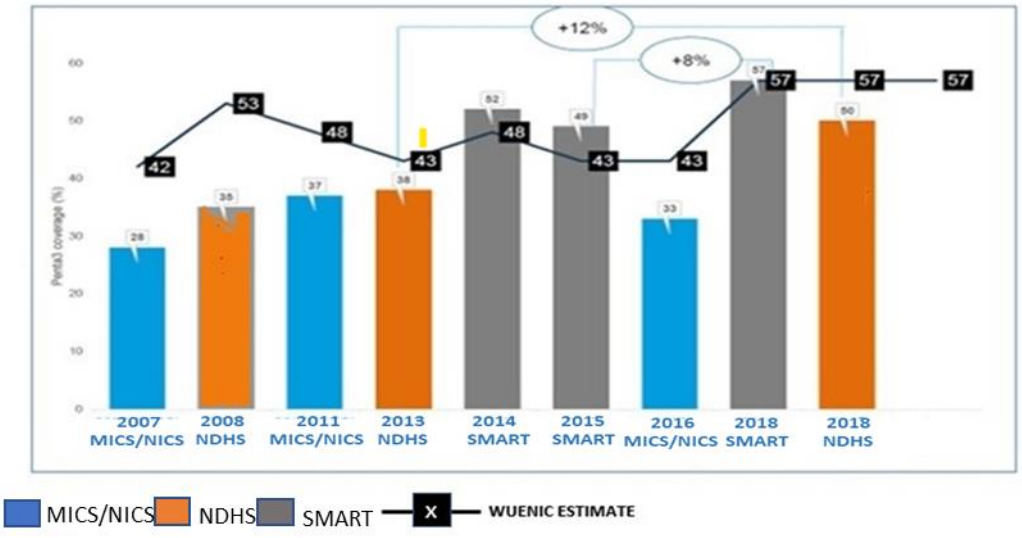


Figure 1: Trend of Penta3 coverages for multiple surveys and WUENIC in Nigeria, 2007 - 2018

Equity analysis of utilisation of immunisation services show that over the past five years, there is no disparity between gender, while variations in Penta3 coverage exist based on residence, mother's education and wealth. The trends as shown in Figure 2 below show progress made in bridging increases in Penta3 coverage for each equity barrier, despite the persisting gaps. The findings of the NDHS 2018 show that the infants of mothers with no formal education are three times less likely to be reached with Penta 3 dose compared to those with secondary education. In addition, the rich are 3.5 times more likely than the poor to be vaccinated with Penta3 dose.

Although geographic differences in access and utilization of immunization services remain, particularly between the north and south (e.g., North West and North East have lower immunization coverage compared to the South East and the South West zones), preliminary results suggest gains across all regions. Gains appear particularly pronounced with regards to access in the North East and North West. In addition, observed differences between regions appear to be narrowing with a distributional shift. For example, the absolute difference in estimated coverage for Penta1 between regions with the highest and lowest Penta1 coverage levels in the 2018 DHS decreased to 20% compared to that observed in 2008 and 2013.

There are also disparities in immunization coverage across geographical regions. Using the penta3 coverage as indicator, the North West (29.1%) and North East (37.2%) have lower immunization coverage compared to the South East (83.1%) and the South West (73.8%) zones[10].

Low immunization coverage has also been recorded in identified hard to reach areas, underserved communities with very difficult terrain, security compromised areas and urban slums.[11]

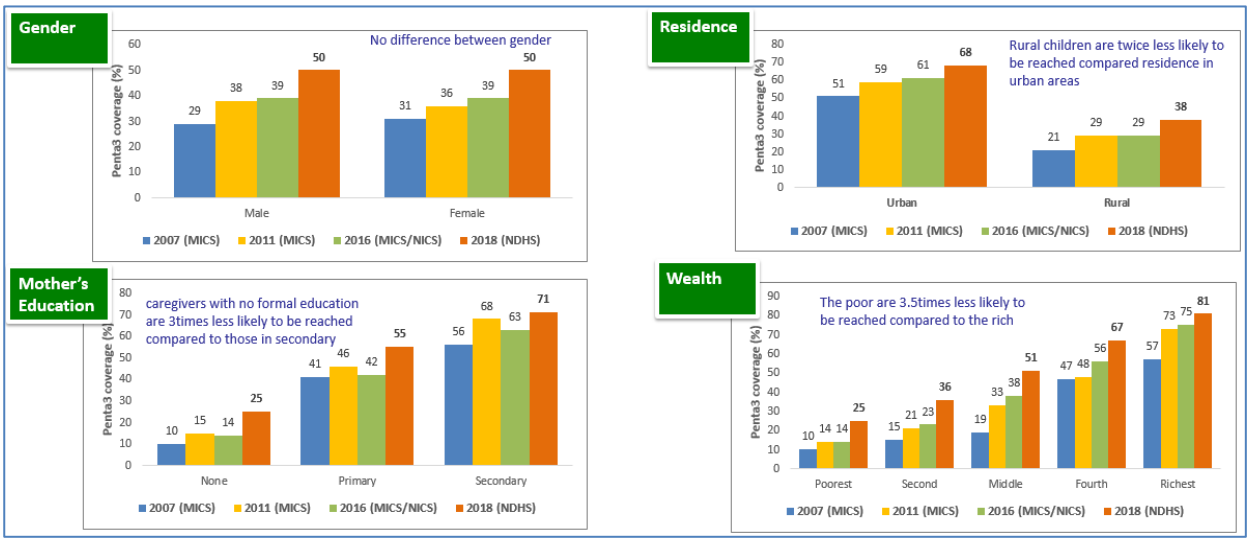


Figure 2: Penta3 Coverage trend by gender, residence, mother's education and wealth, per surveys in Nigeria, 2007 – 2018. Results for the 2018 NDHS are preliminary.

Though administrative data for 2018 is indicative of improved access and utilisation for immunisation services, WUENIC and survey estimates suggest the contrary. Based on WUENIC estimates none of the routine antigens achieved at least 85% coverage as shown in the Table 2 below.

Table 2: Routine Immunisation Coverage for selected antigens from DHIS2, WUENIC and official estimates, 2018

Antigen	HMIS/DHIS2	WUENIC 2018	Official Estimate
BCG	*81%*	53%	75%

OPV3	*80%*	57%	58%
Penta1	*87%*	70%	72%
Penta3	*80%*	57%	58%
PCV3	*80%*	57%	58%
IPV	*79%*	57%	N/A
Measles	*75%*	65%	63%
Yellow fever	*73%*	65%	61%

Coverage at Sub-national level

In view of the limitations of the administrative data elaborated above, subnational analysis of immunisation coverage is largely informed by the recent surveys and quality using the RI-LQAS, recently modified to PAPA, to accommodate variables for maternal and other child health interventions.

The 2018 preliminary NDHS report (2017-birth cohort) showed that 29 of 36 states and the FCT have Penta3 coverage less than 80%. Access to immunisation services varied from 17% in Zamfara to 97% in Lagos whiles utilisation of services also ranged from 7.2% in Sokoto to 93% in Ekiti. A comparison of the NDHS results in 2013 with 2018, show that Penta3 coverage declined in 10 states of which seven were in the South. Routine analysis of the DHIS2 data confirm a similar trend. The results suggest that prior to establishment of NERICC, multiple routine interventions in the northern parts of the country, supported with huge investments in PHC and RI as well as polio resources may have contributed to the increases observed. Figure 3 details trends of Penta3 coverage NDHS 2013 and 2018.

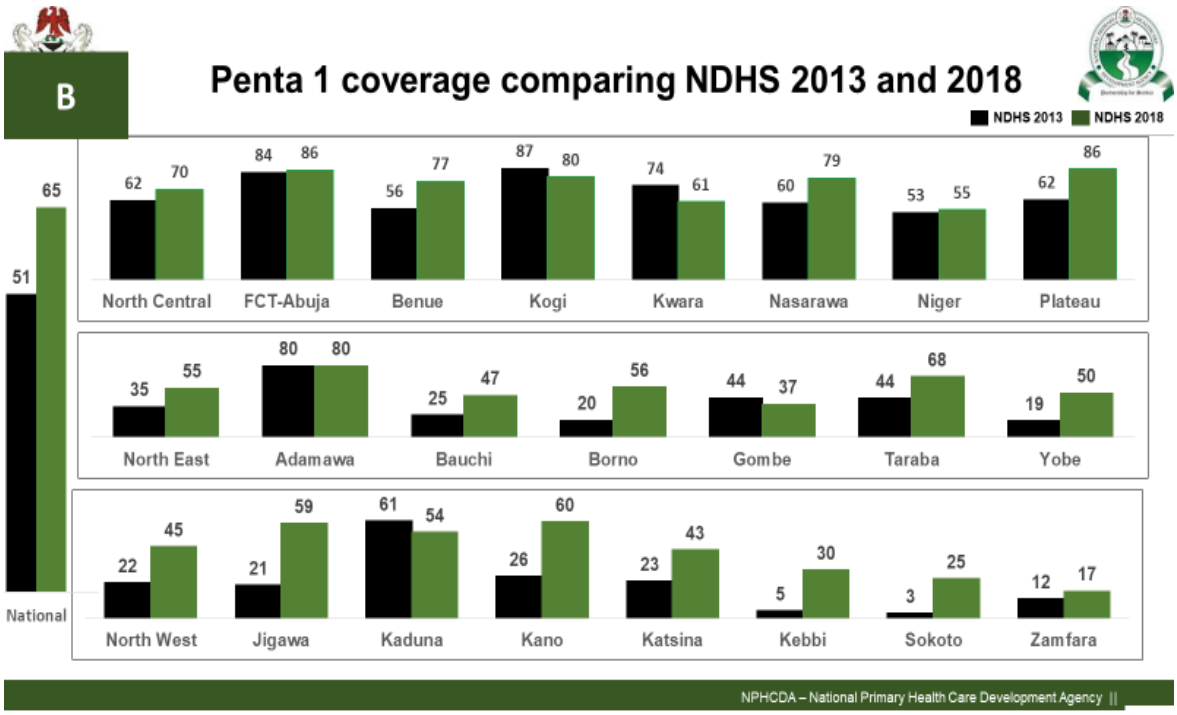
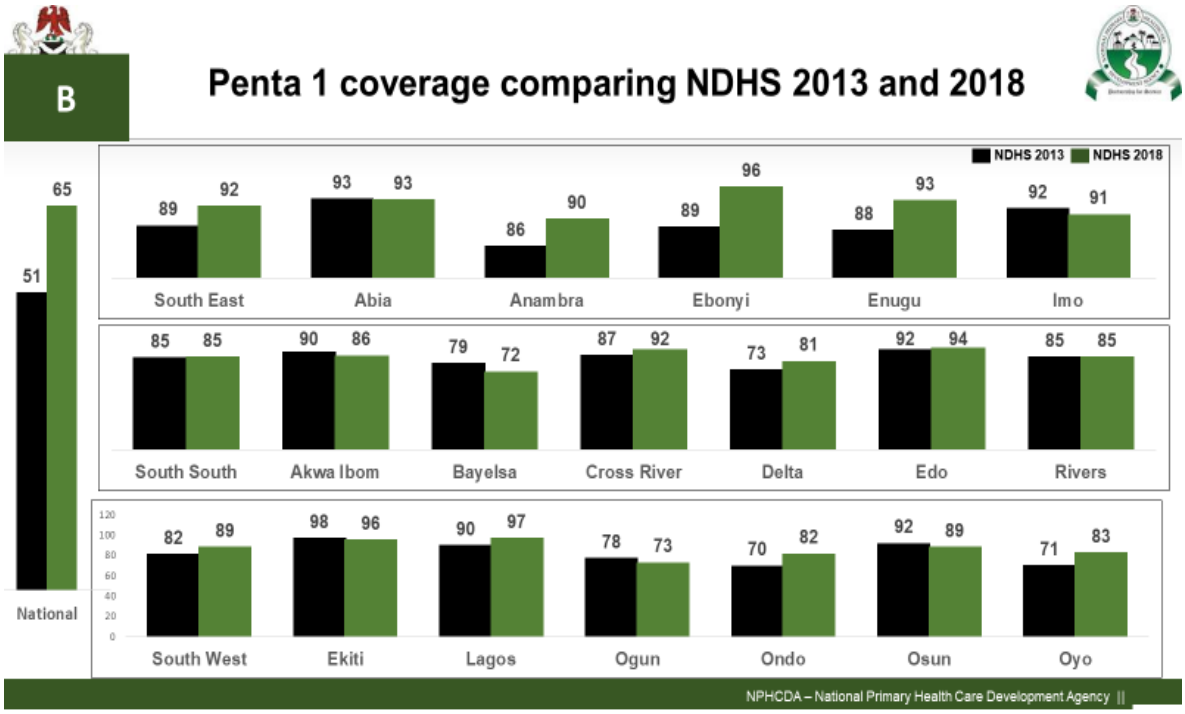
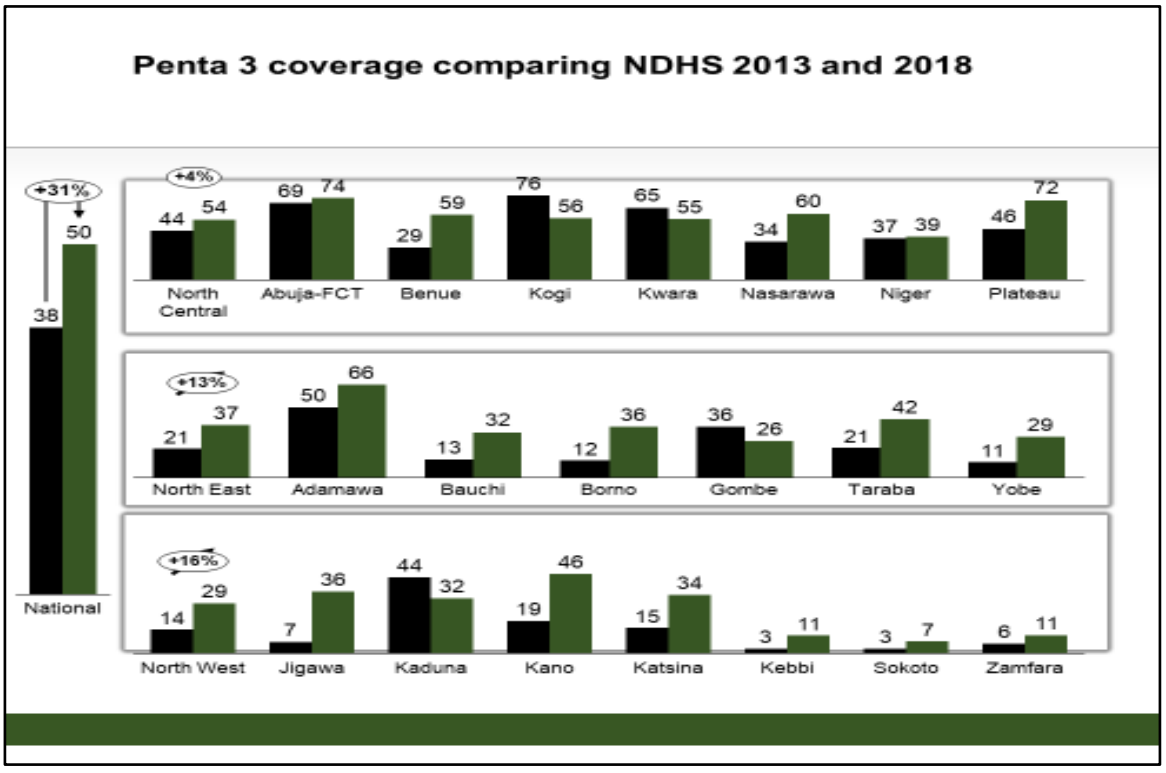


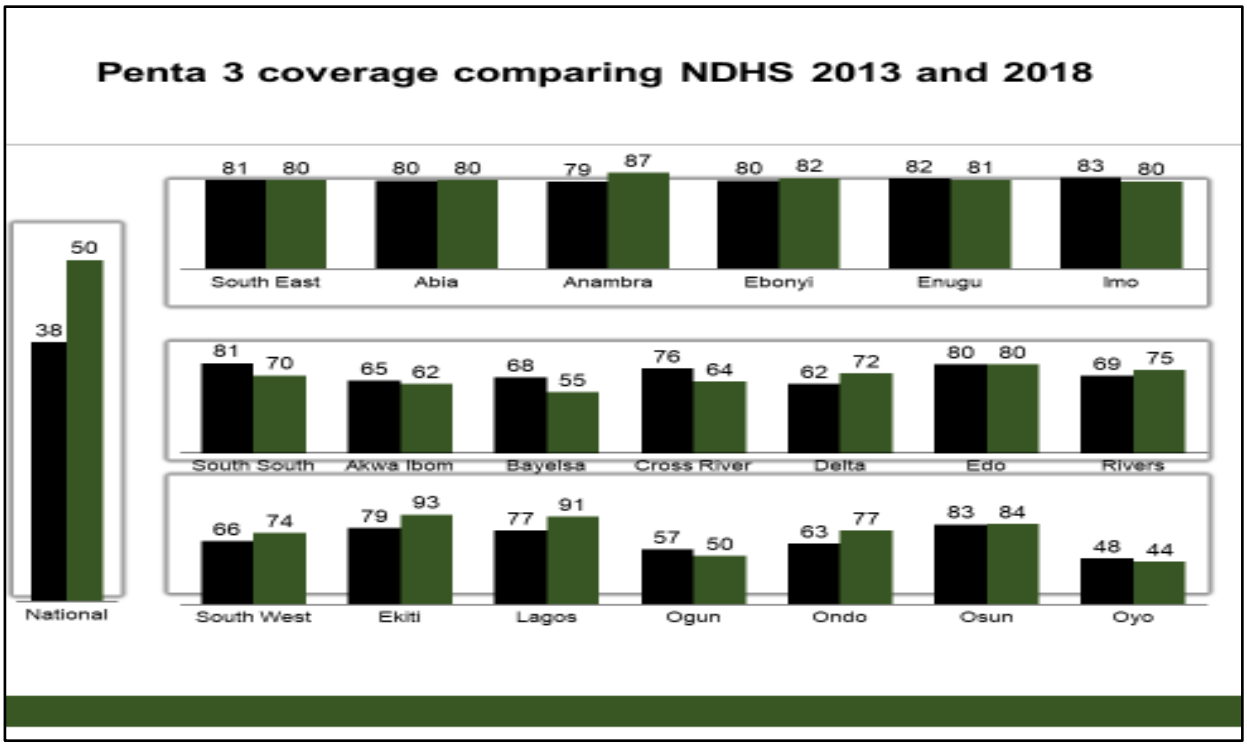
Figure 3: Trends of Penta1 coverage NDHS 2013 and 2018



Figures 4: Trends of Penta1 coverage NDHS 2013 and 2018



Figures 5: Trends of Penta3 coverage NDHS 2013 and 2018



Figures 6: Trends of Penta3 coverage NDHS 2013 and 2018

Notwithstanding the observed increase in Penta3 coverage in most Northern states, coverage of specific routine antigens in the NDHS report of 2018, reflect significantly high immunity gaps in most of the states as evidence by Figure 7 below. There is observed variance in coverage in doses administered at the same time. This could be attributed to quality of services and data.

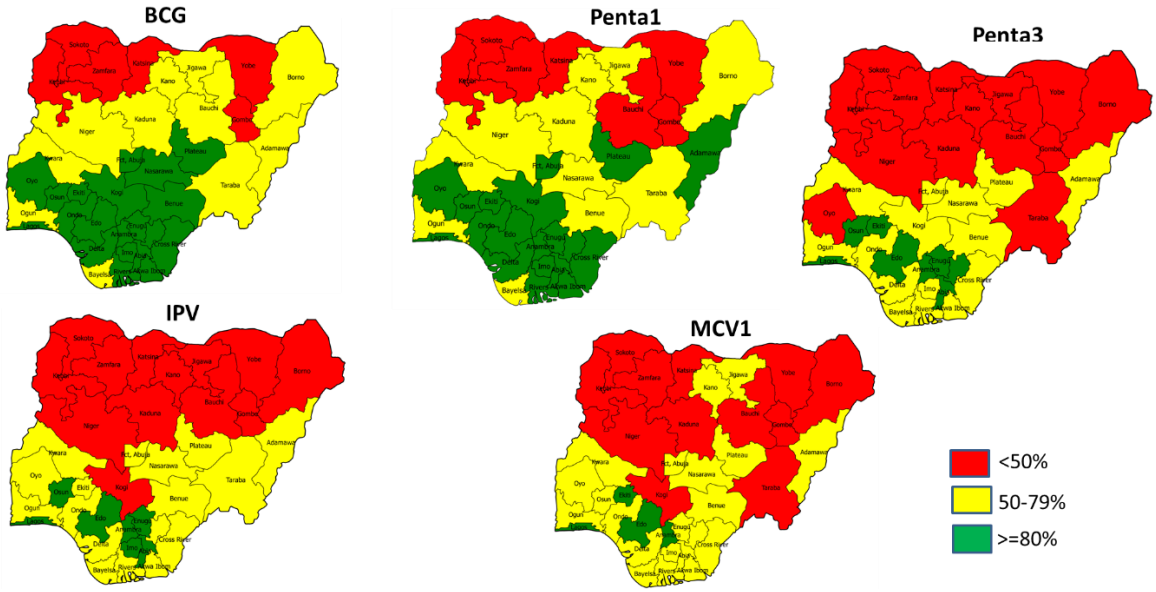


Figure 7: Map showing coverage of antigens, NDHS 2018

In view of the gaps in coverage, the NPHCDA with the support of partners sustained the implementation of the Optimised Integrated Routine Immunised sessions (OIRIS) approach, a strategy developed in response to the June 2017 declaration of routine immunisation as a public health emergency in Nigeria. The following activities were

conducted in 2018 to further increase routine immunisation coverage in the 18 low performing states mostly in the Northern part of the country:

1. The Executive Director of NPHCDA made 6 briefings on PHC and Immunisation to the Governors Forum to garner support and commitment of the states to prioritise PHC and Immunisation. In addition, the ED had engagement with the National Economic Council. Further advocacy presentations were made by the ED to the Presidential Task Force on Immunisation and PHC.
2. NERICC conducted high level advocacy visits using the platform of the Optimised Integrated Routine Immunization Session (OIRIS) visits to: a) strengthen coordination capacity at all levels through SERICCs and LERICCs b) advocate for release of funds for RI activities, c) conduct field visits to monitor and provide support to frontline health workers, and d) encourage the implementation of the accountability framework.
3. Quarterly review meeting with Executive Secretaries of State Primary Health Care Development Agencies to address management and coordination issues.
4. Conducted the annual EPI Review meeting with State teams to guide programme implementation
5. Conducted a mini-EPI review program to assess the EPI program in three states, which will be used to guide future National EPI reviews
6. Conducted two engagement meetings with selected Low performing LGAs post LQAS to review performance and jointly develop action plans that are tracked for improvement
7. Engaged 18 states and FCT to review coordination platforms and action plans to improve immunisation coverage.
8. Piloted and scaled up SMS real time reporting on sessions conducted in 18 high risk states, with weekly review of the data and corrections at state/ LGA and health facility level. Reporting on SMS has gone from 40% to 80% on average each week by September 2019.
9. Strengthened the implementation of RI service delivery through
    a. Review of the REW tools and processes to include elements of community engagement, nomads, and other hard to reach populations
    b. Effective continuous learning approaches e.g., peer-led learning and videos on RI-related areas
    c. Review of RISS the checklist to include community engagement component for monitoring implementation of CE strategy in the state and finalized the SOP
    d. Working with the national EOC to strengthen the RI components of the polio campaigns through RI intensification activities in 20 states

The trend of RI-LQAS conducted bi-annually for the 36 states and the Federal Capital Territory (FCT) is depicted in Figure 6 below. The number of LGAs with acceptable scores of qualities increased from 111 (14%) in Q2 of 2018 to 252 (33%) in Q2 of 2019, hence a corresponding decline in the number of LGAs that failed over the same period.

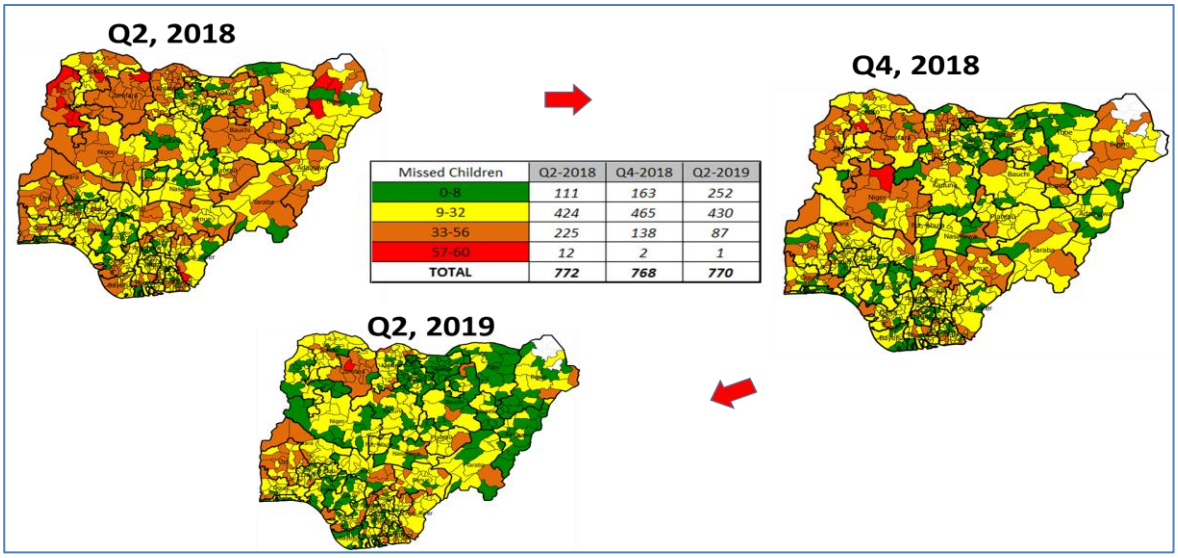


Figure 8: RI-LQAS results for 36 states and FCT, Q2 2018 to Q2 2019.

In the 18 low performing states of which only one, Bayelsa is in the South, a remarkable increase in quality of immunisation was noted over the period. The quarterly RI-LQAS (now known as PAPA-LQAS) conducted from the 18 low performing states shown significant increase of LGAs passing the lot from 21/379 (5.5%) in Q1 of 2018 to 172/377 (45.6%) in Q2 2019. The observed increase is attributed to the intensity of focus in implementation of the OIRIS approach in the states focusing on increasing number of outreach and fixed sessions, conducting regular supportive supervision at all levels, integration of commodities and services, implementation of the community engagement in some states, and ensuring accountability with respect to data utilisation for decision making, monitoring actionable recommendations to overcome barriers, and financial accountability.

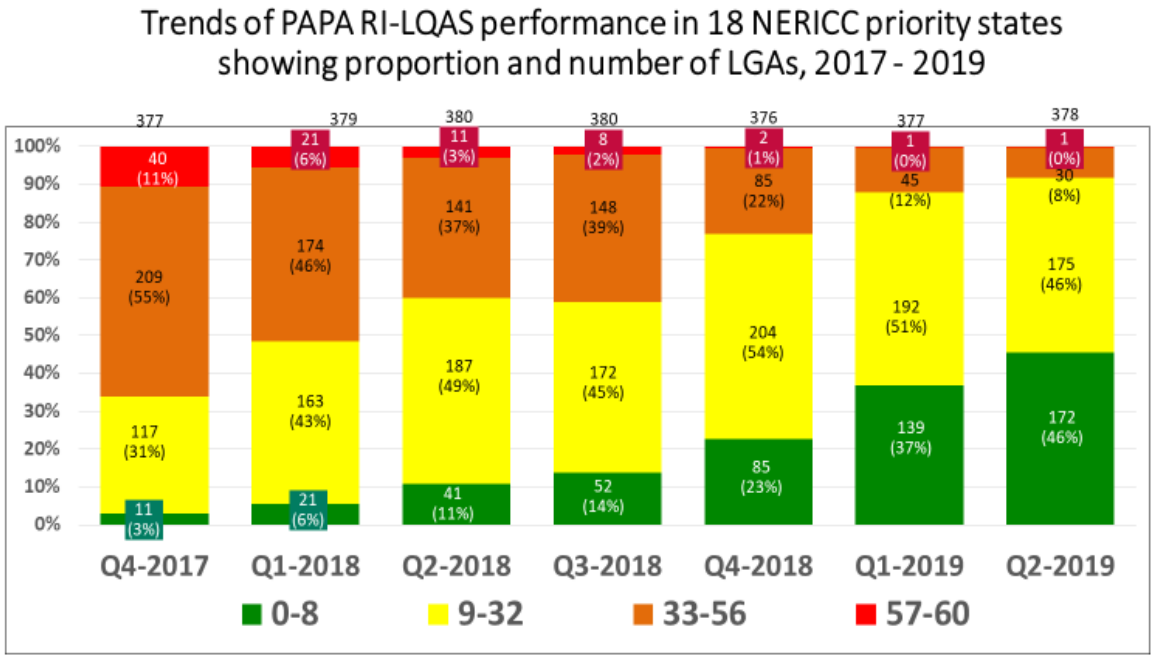


Figure 9: Results from LQAS show an increasing number of lots with passing scores suggesting improvements in programme performance in the 18 priority states between Q4 2017 and Q1 2019

Despite the focus on intensification of OIRIS approach, a desire for a rapid increase in sustaining high quality of routine immunisation uptake alongside observed increases in the number of LGAs with passing LQAS scores, the number of LGAs that have consistently maintained three consecutive score of acceptable level quality over the period remains below desired levels (e.g. increased from three (3) LGAs in Q2 of 2018 to 48 in Q2 of 2019 with sustained three quarters of acceptable scores). In addition to recognizing the achievements among these LGAs, a deep dive engagements with these LGAs has identified the following as drivers for sustaining quality over time: high quality operational plans, high level of commitment of the LGA Chairmen, availability of motivated human resource, institutionalisation of accountability; and regular monitoring and supervision of activities, as well as data utilisation.

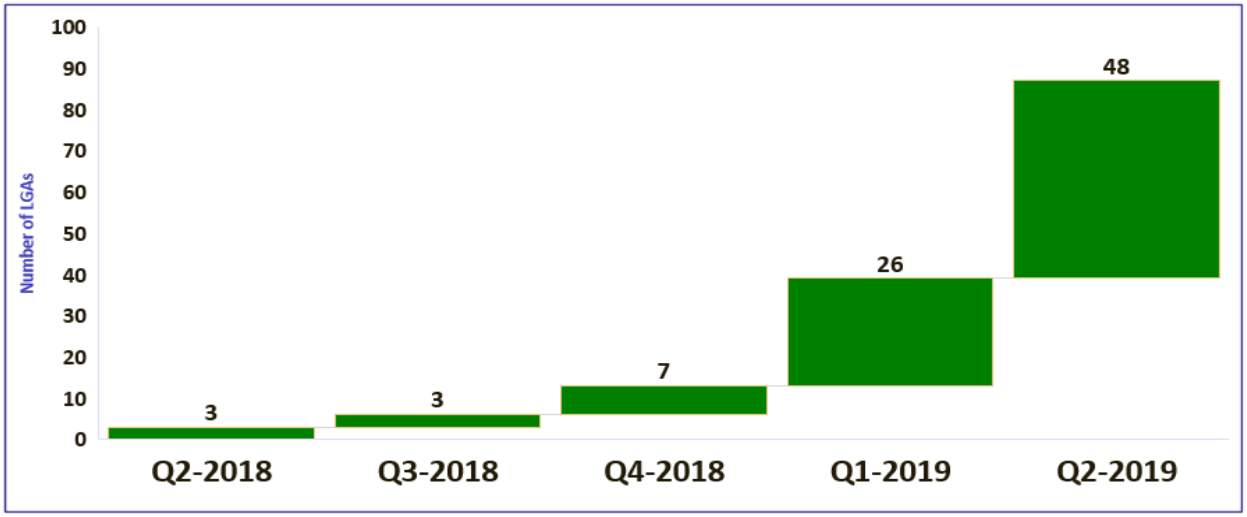


Figure 10: Trend of LQAS with at least 3 consecutive acceptable scores for RI-LQAS, Q2 2018 to Q2 – 2019.

Factor accounting for sub-optimal RI performance include:

- increasing insurgency in North East, especially Borno and Yobe, that resulted in destruction of cold chain equipment and vaccines and displacement of persons.
- persisting challenges in addressing security posed by militants/bandit involved mostly in kidnapping of health workers and other civilian is interrupting provision of services in some LGAs in Zamfara, Katsina, Benue, Kaduna and Ondo states.
- repeated national strikes by health worker due to demand for increase in salary.
- insufficient number of, and inequitable distribution of health workers –particularly in the hard to reach and rural areas; and general suboptimal health infrastructure and functionality across the country, particularly in the Northern part of the country.
- inadequate financing of operational plans mainly at the HF level,
- limited coordination in mapping out and use of available funding from other sources e.g. Saving One Million Lives (SMOL) to improve coverage.
- delayed release of budgeted funds to conduct sessions at peripheral levels,
- inappropriate health worker attitude,
- sub-optimal integration of services, and poor linkages to broader health systems and development approaches
- weak infrastructure
- vaccines stock out at the health facility level
- The demand-related issues include lack of awareness, mother's literacy level, weak mobilization, and vaccine hesitancy.
- Lack of TA and implementation of proven strategies to reach urban slums

Coverage: Absolute numbers of un- or under-immunised children

A crude estimate from the NDHS, 2018, reveals a total of 3.4 million unimmunized children in Nigeria with Kano state having the highest number of unimmunised children of 290,225 children (8.3%) as shown in Figure 9 below.

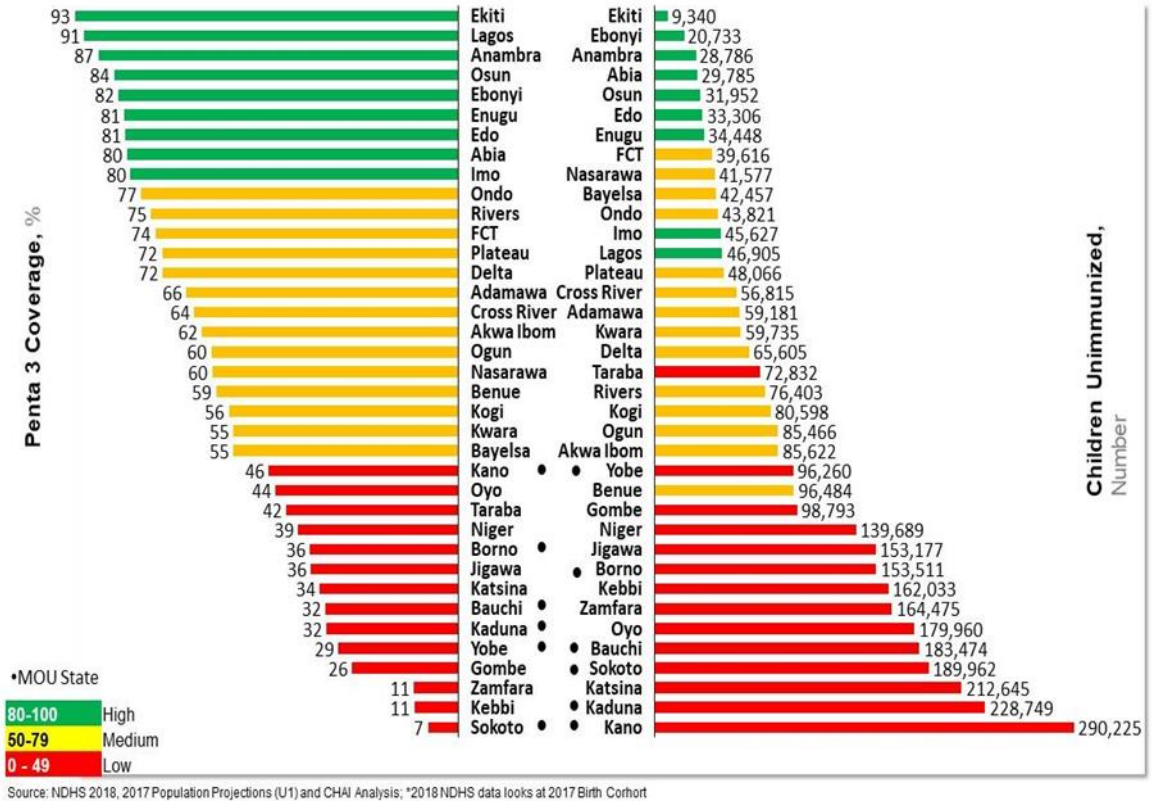


Figure 11: Penta3 coverage and unimmunised children per state, NDHS, 2018

VPD Surveillance, Outbreaks and Response

The weak immunisation system (low RI coverage and sub-optimal quality SIAs) has resulted in multiple VPD outbreaks of measles, yellow fever, meningitis and circulating Vaccine Derived Polio Virus type 2 (cVDPV2) in Nigeria.

Measles

Considering the low uptake of routine doses of measles vaccine (NNHS 2018), the burden of measles remains very high. In 2018, a total of 1610 measles cases were confirmed across all the states, with the highest number from Katsina (299), Kano (116), Borno (114) and Kebbi (98). As of June 2019, annualised rate of measles incidence was 93/million inhabitants with over 19,638 confirmed cases of which 52% were in Borno. Katsina (245), Borno (163) and Jigawa (123), remained as states with the highest number of confirmed measles cases. A higher burden, 57%, of confirmed cases affected children 12 – 59 months and 40% of all cases were zero dose. Thus, the number of LGAs with outbreaks have increased from 107 in 2017, to 126 in June 2019[12].

In 2018/19 reactive vaccination have been conducted in 38 wards in 22 LGAs in Yobe, Ogun, Benue, Borno and Lagos reaching over 1.5 million children of varying target age groups ranging from 6 months to 10 years.

The expected increases in outbreak of measles is evidenced by the spatial spread of confirmed cases on MCV1 coverage as reported in the NDHS2018, shown in figure 10 below: In view of the suspected build-up of susceptible, planned measles SIAs is to be conducted in the northern zones of the country in Q3, 2019.

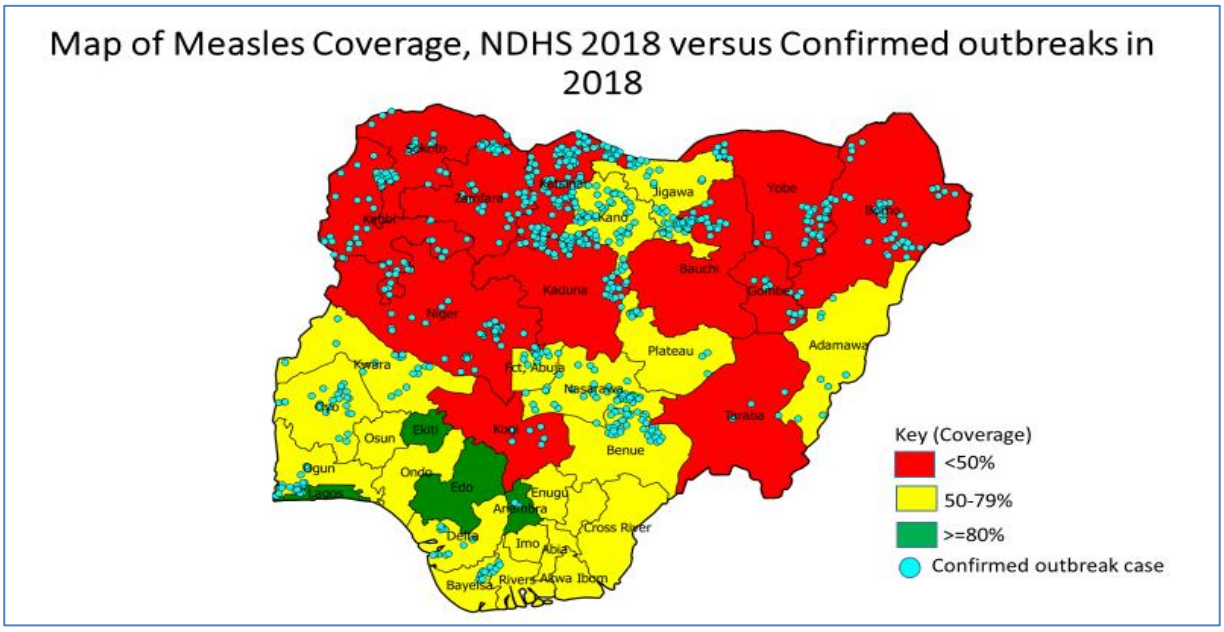


Figure 12. NDHS 2018 Measles RI coverage vs measles outbreaks by state in 2018

In 2018, a total of 1610 confirmed measles cases across all the states, with the highest number from Katsina (299), Kano (116), Borno (114) and Kebbi (98). The number of confirmed measles cases as at first half of 2019 is 19,638, which slightly higher than what was reported the year 2018. Katsina (245), Borno (163) and Jigawa (123), remained as states with the highest number of confirmed measles cases.

In 2019 plans for the conduct of Measles campaign in the Northern states and introduction of Measles Second dose in the southern states are ongoing.

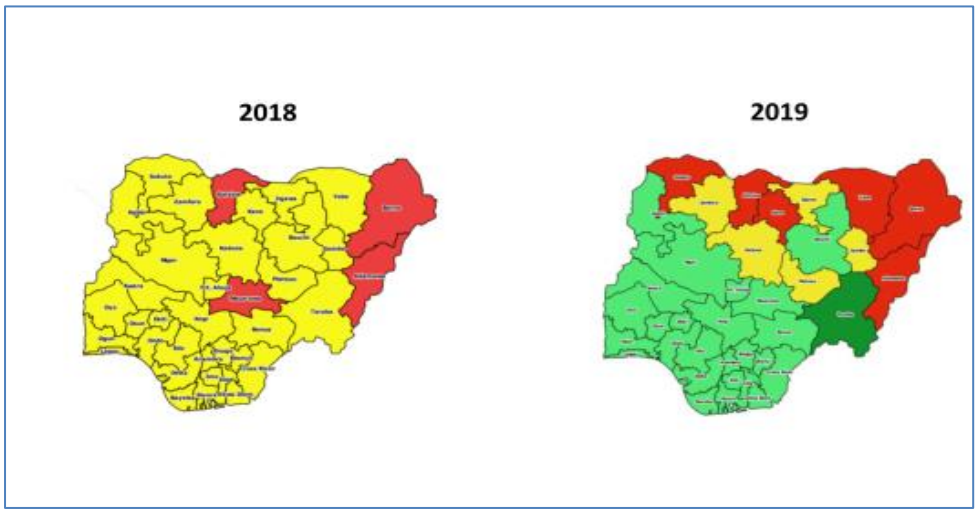


Figure 13: Measles incidence rate per million population by states 2018 & 2019 (Jan-July)

LEGEND		# States 2018	# States 2019
	<1 Measles Incidence Rate Per million	0	1
	1 - 25 Measles Incidence Rate Per million	33	25
	26 - 50 Measles Incidence Rate Per	-	5
	> 50 Measles Incidence Rate Per million	4	6
	Non Reporting States	0	0
TOTAL REPORTING States		37	37

Table 3: Legend for figure 13

Rubella

A total of 4,652 blood samples were tested for Rubella in 2019 (Jan-Jul) and 950 (20%) were positive compared to 329 (8%) out of the 3,971 samples in 2018. With the 2017 national Congenital rubella Syndrome (CRS) retrospective desk review conducted in the six geo-political zones,1544 cases were identified with 290 clinically confirmed. Additionally, cardiac complication was found to be the most common at 45% followed by hearing impairment at 28%. The proportion of suspect cases that were clinically confirmed varied from 14% in the NW/NE zone to 45% in SW. Due to the increased number of cases, Nigeria has taken a bold step to establish CRS sentinel surveillance sites across different geopolitical zones in 2019-2020.

Yellow Fever

Outbreaks of Yellow Fever in Nigeria continue to occur, yet response continue to delay due to delays in confirmation of suspected cases, and limited availability of yellow fever vaccines globally. Surveillance gaps persist, as only Nasarawa and Kebbi states in the country meet standards for investigation of cases. In 2018, 94 (64%) of the 147 presumptive yellow fever cases were confirmed by the regional reference laboratory. States with probable IgM positive cases in 2018 were Benue, FCT, Kogi, Kwara, Nasarawa, Borno, Jigawa, Katsina, Kebbi, Sokoto, Zamfara, Abia, Anambra, Ebonyi, Enugu, Imo, Delta, Edo, Rivers, Ekiti, Lagos, Ogun, Ondo and Osun. Edo, Kebbi and FCT had 73% of all the probable IgM positive cases reported in 2018.

In 2019 (Jan-Jul), 31 (41%) of the 76 presumptive yellow fever cases were confirmed by the regional reference laboratory. Case fatality (CFR) is 1.3% States with probable IgM positive cases are Benue, FCT, Bauchi, Gombe, Katsina, Kebbi, Sokoto, Anambra, Ebonyi, Enugu, Imo, Delta, Edo, Ogun, Ondo, Osun and Oyo. Edo and Ebonyi constitute 49% of all probable IgM positive cases between January and July 2019

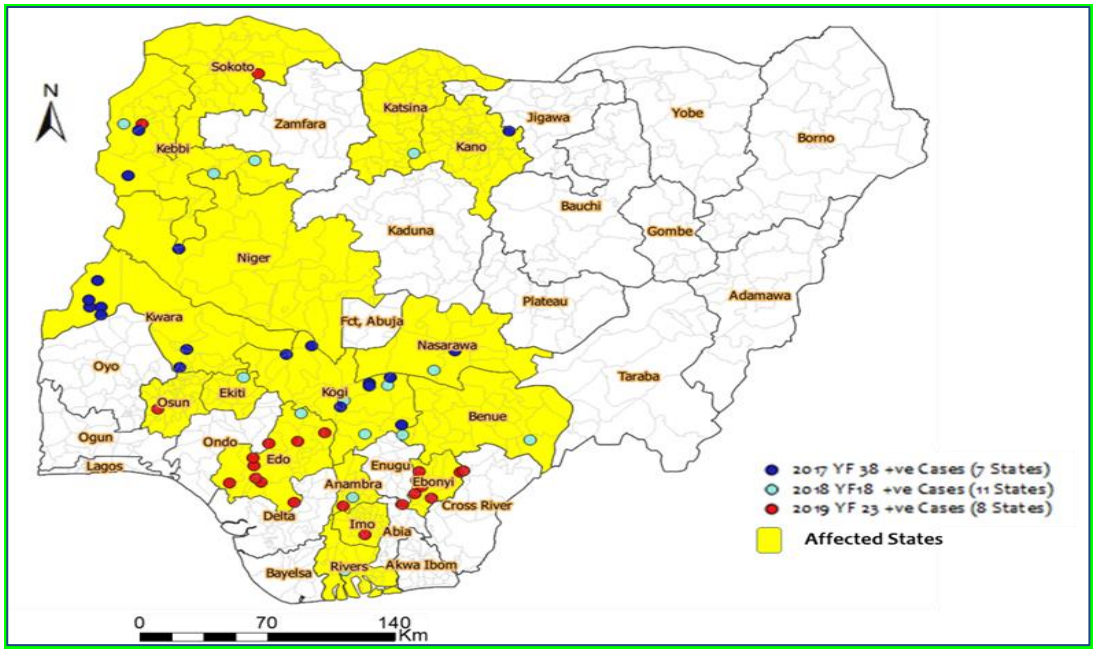


Figure 14: Distribution of confirmed cases of Yellow Fever in Nigeria, 2017 to 2019

Cerebrospinal Meningitis:

From 1st October 2018 to 12th May 2019, 905 suspected cases have been reported from 15 states namely Ebonyi, Cross River, Bayelsa, Ondo, Kwara, Niger, Kebbi, Sokoto, Zamfara, Katsina, Kano, Jigawa, Bauchi, Plateau and Yobe. One hundred and ten (110) samples were positive for bacterial meningitis. Neisseria *meningitides serogroup* C (NmC) accounted for 31.8% (35) of the positive cases. So far, 65 deaths (CFR=7.2%) have been recorded among all suspected cases.

In 2018 reactive campaigns were conducted targeting persons aged 1-29 years in Katsina reaching 78,936 persons, Sokoto (one ward in one LGA) reaching 44,167 persons and Zamfara 7 wards in 5 LGAs reaching 125,622 persons. Results of the Post Campaign Coverage Survey (PCCS) shows 81%, 70% and 70% coverage for Zamfara, Sokoto, and Katsina respectively. Reasons for low performance include low awareness, weak coordination at the state level, and vaccination posts were not easily accessible

State	Year	No. of LGAs	No. of wards	No. vaccinated
Katsina	2018	4	4	78,936
Sokoto	2018	1	1	44,167
Zamfara	2018	5	7	125,622
Katsina	2019	1	1	12,648
Katsina	2019	1	2	25,406
		12	15	286,779

Table 4: Reactive vaccination to meningitis outbreaks 2018 – June 2019

In January 2019 an outbreak of meningitis occurred in Kagaare ward, Sandamu LGA in Katsina state, 12,648 persons aged 2 to 29 years were reached. In May 2019 reactive campaign was conducted in Karfi and Na'alma in Malumfashi LGA in Katsina state reaching 25,406 persons. PCCS was not conducted due to funding constraints. The NPHCDA plans to conduct Men A campaign in the 4th quarter of 2019 in 25 states.

Nigeria introduced MenA vaccine into its RI schedule in August 2019 to improve herd immunity of children against NmA.

Cholera

Nigeria is endemic for cholera with cases being reported throughout the year. Over the years, there have been periods of low case notifications interspersed with high number of cases being reported for a single year. Poor WASH conditions, particularly open defecation and shallow/ uncovered wells have been known to be the main driving force for spread of the disease in Nigeria.

Also, widespread devastation of normal health care infrastructure due to prolonged armed conflicts especially in the North East region has exposed large swaths of populations in communities including internally displaced persons (IDPs) to infectious diseases, one of which is cholera.

There have been regular outbreaks with more than 20,000 cases between 1991 – 2018.

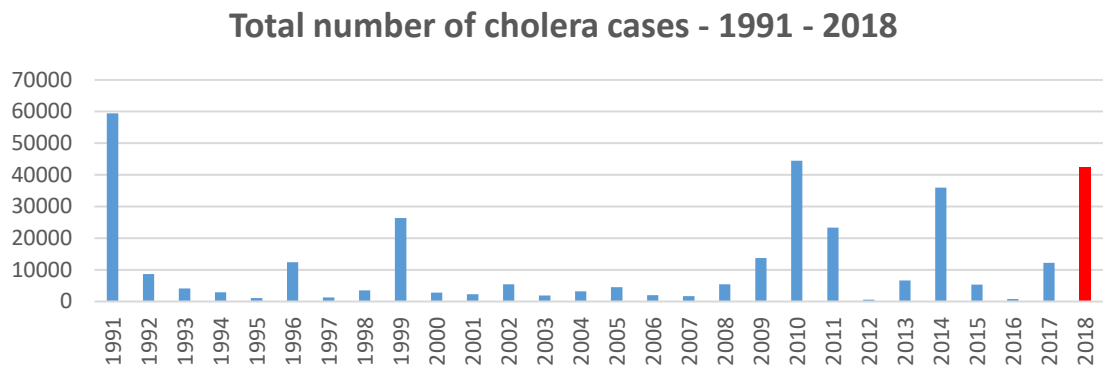


Figure 14: Cholera cases (1991 – 2018)

In Nigeria the mainstay of cholera control and prevention has been WASH interventions, surveillance, risk communication and case management strengthened by coordination among stakeholders.

However, in September 2017, in addition to the aforementioned, Oral Cholera Vaccination was conducted in Borno State in response to cholera outbreak in Muna IDPs Camp. This intervention quickly led to the containment of the outbreak in the State.

Since then, Oral Cholera Vaccination campaign has become adopted as an effective tool and integrated as part of multi-sectoral intervention strategies in the prevention and containment of cholera outbreaks in Nigeria.

Maternal and Neonatal Tetanus Elimination

The country completed MNTE validation of South East zone in 2017 and South West Zone in June 2019. However, Nigeria is far from reaching elimination target due the following: low reporting rate of NNT cases (39% of LGAs), 57% of mothers with at least 4 times visits to antenatal care, 43% of pregnant women delivered by skilled attendance, and 62% rate of protection at birth (PAB)[13]. Even though there was no state that reported 30 and above cases of NNT, Kebbi, Sokoto, Katsina, Kano, Bauchi, Gombe, Borno, Adamawa, Kogi, Edo, Delta, Bayelsa, Imo, Ebonyi, Cross Rivers and FCT reported 10 to 30 NNT cases. The health systems bottlenecks continue to impede on progress for MNT elimination in Nigeria. The country plans to finalize MNTE sustainability plan for the SE and SW zones. Additionally, conduct the recommended Td SIAs in 136 high risk LGAs across 16 northern states.

Strengthening RI through SIAs

[13] NDHS 2018

- With the SIA platform, the Cold Chain Officers (CCOs) have the opportunity to update their cold chain inventory, identify gaps, conduct repairs and maintenance. Procurement of Cold Chain Equipment (CCE) is captured in the SIA operational cost, this goes a long way in bridging identified CCE gaps.
    - Conducting AEFI training with each campaign provides opportunity to build the capacity of HCW and strengthen AEFI reporting system for RI
    - AEFI training is done prior to every campaign
- IEC materials for SIAs provide pertinent information to improve uptake of RI
- Trainings focused on both campaign and routine immunization.
- Strong partnership with media fostered during campaigns would be sustained and utilized to strengthen RI in the area of media coverage and positive reporting.
- House-to-house mobilizers and VCMs used for the campaigns also assist in mobilizing caregivers for routine immunization.
- SIAs provide a platform for procuring incinerators, which will be used for RI.
- Development of micro plans with GIS mapping for SIAs gives an opportunity to update settlement listing and demographics, which RI uses for the planning of sessions.
- SIAs provided opportunity for zero-dose children to be vaccinated.

4.2. Key drivers of sustainable coverage and equity

Health Work Force:
Inadequate health workforce remains a major challenge in primary health care including immunization service delivery across all states in the country. This is compounded by the lopsided distribution of health workers that favour more Health workers in urban than rural and hard to reach areas. A significant number of healthcare workers are volunteers/ casual workers especially at LGA and HF level e.g. over 60% in Katsina. Inadequate motivation of health workers and the lack of accountability especially for volunteer health workers, promote prolong absences from work.

To address this, varying measures have been employed within states and LGAs. This includes staff auditing, redistribution of personnel, adhoc engagement of volunteer frontline health workers and personnel recruitment. In Bauchi and Cross River State, the Workload Indicator of staffing needs was also conducted [14] [15]. The Federal government has continued with schemes such as the Modified Basic Midwife service scheme as a stop gap measure that deploys basic midwives to primary health care facilities for a period of one year[16]. The N power scheme also provides a veritable source of health manpower through the GoN Social Investment Program. In 2018, a total of 1, 181, basic Midwives were deployed to 1000 rural Health facilities across the country and 33,211, N power staff were recruited and are currently undergoing training. This number added to the second batch of 16,067 adds up to 44,277 additional staff engaged to support service delivery at Health facility level. With the launch of the Basic Health Care Provision Fund in March 2019, money earmarked for development of human resources for primary health care will now be gradually deployed to address these gaps.

However, there is a need to implement some other strategies to further strengthen the health workforce and to improve the RI service provision. States need to be supported to use the outcomes of their staff mapping and auditing to implement the National Task Shifting Policy; redistribution of staff where applicable and conducting recruitment of staff. It is worthy to note that states can leverage incoming resources like the BHCPF to recruit more health workers.

[14] Estimating Frontline Health workforce needed for primary health care service delivery in Bauchi State Nigeria

[15] Study on Frontline Health workers staffing needs for primary healthcare centers in Cross Rivers state
[16] NPHCDA

States also need to develop and implement accountability systems for health workers. NPHCDA also needs to support states with the right framework/ guidelines for engagement of volunteers and whether they can be transitioned to HCWs while planning for hire of accredited HCWs.

States also need to seek indigenous approaches to increase production of HCWs. Communities to nominate and train HCWs. This includes implementing community led approaches to increase the number of community members who attend training institutions to become HCWs and institute a framework that ensures they can serve in their communities for an agreed period of time.

NPHCDA can support states through advocacy to increase absorption of qualified HCWs into the health workforce; explore other recruitment mechanisms to be explored by states and review the MSS program with a view to identify and promote long term retention.

SPHCDA can also consider generating evidences on HRH issues to inform advocacy to State Government e.g. Workload analysis. These can include but not limited to inadequate HCWs, anecdotal evidence that HCW who train in training schools in the North return to other locations to work rather than work in the regions where they trained. Also, Healthcare workers training curricula need to be revised to capture current realities and prepare health workers for working in the community. States should also consider community midwifery approaches and community incentives to ensure HCWs remain in areas of greatest need to work

Service Delivery and Demand generation:

Service Delivery

Since the last Joint Appraisal, service quality challenges have persisted but are being mitigated with finalisation of the development and full roll out of the Optimised Integrated Routine Immunisation Sessions (OIRIS) approach in January 2018 in the 18 low performing states mostly in Northern Nigeria. The OIRIS approach, hinges on four key pillars (increased frequency of RI sessions, integration with other health services, community engagement to push for demand for RI, and supportive supervision) with ownership and accountability at all levels., has had an impact evidenced by the observed increased in the number of LGAs with acceptable scores, elaborated in section 4.1 above supported by:

- Increased number of tertiary, secondary and urban health facilities conducting daily fixed sessions; while rural health facilities conducts 2 fix sessions and at least 2 outreach sessions in a week
- Integration of other services and commodities during the conduct of sessions to optimise opportunities for other child survival interventions
- 10/18 states conduct full complement of the community engagement strategy by ensuring that the traditional leadership in the settlements within the states ensure line listing of new-borns and children under one, reconciling line-listed registers with the immunisation registers at the health facility and defaulter tracking.
- Encouraging increasing frequency in the conduct of supportive supervision from national, state and LGAs to the respective lower levels and using that opportunity to generate political and management commitment to bridge the gaps in routine immunisation
- Implementation of data amnesty policy and institutionalisation of accountability for data falsification at all levels. In addition, management teams at lower levels are supporting the opening of health facility accounts to ensure effective utilisation of funds disbursed for immunisation activities.
- Rolled out of the engagement with low performing LGAs for which 105 and 43 LGAs were separately engaged in December 2018 and April 2019 respectively.
- Regular monitoring of action points that creates enabling environment to resolve barriers to coverage improvement at all levels. This is done through NERICC, SERICC and LERICC structures.

- Support the sustenance of special interventions such as RI Intensification for low performing and hard to reach LGAs, Reach Every Settlement and Reach Inaccessible Children in security compromised areas in Borno.

In addition to the above, the country also successfully implemented the switch from PCV10-2dose to PCV10-4dose vails in April 2019, and further introduced the MenA in routine immunisation in August 2019. These new vaccine introduction activities enabled the following:

- Update of the EPI schedule with MenA administered at 9months
- Training of over 70,000 health professionals including state and LGA teams as well as health providers to improve on the quality of conduct of sessions, vaccine storage, handling and administration, data recording, analysis and monitoring as well as surveillance especially on Adverse Events Following Immunisation.

Demand generation

The 2016/2017 MICS/NICS results showed lack of knowledge (42%) and mistrust and fears (22%) as major reasons for non-vaccination. Evidence from the RI-LQAS from 2018 to Q2, 2019 PAPA LQAS also showed that the top reason for which children were partially vaccinated or unvaccinated was that caregiver claim they were unable to take children for vaccination. Other major reasons were vaccine not available, unaware of the need for immunisation and unaware of EPI schedule[17]. The NSIPSS noted two key mitigating strategies for engaging communities and driving demand for immunization and PHC. The CE strategy and the Community Health Influencers Promoters and Services (CHIPS).

The CE strategy was launched in 2017 to promote community participation in RI through the involvement of traditional institutions and Community Resource Groups (CRGs). The strategy involves

- line-listing of new-borns,
- reconciliation of community line-list with health facility registers to identify and
- tracking of defaulters.

From the last JA in 2018, an additional four states (Gombe, Jigawa, Bayelsa and Plateau) commenced full implementation of the Community Engagement strategy making a total of 10 states. Expansion to the other states is limited by availability of funding required to cover the cost of training of traditional leaders and community engagement focal persons as well as tools during the inception phase. In 2019, NERICC rolled out standardized CE monitoring and reporting tools at ward and LGA levels in April 2019. State CE focal persons and health educators were trained on use of the tools and the CE reporting structure. 10 states have commenced reporting of CE activities. As at August 2019, 14,435 settlement heads across six states (Bauchi, Borno, Kano, Kaduna, Sokoto and Yobe) line-listed under 1 children, 13,632 attended reconciliation meetings and 11,136 tracked defaulters.

However, in states where it's been implemented, on-going challenges include weak ownership by traditional leaders as well as sub-optimal monitoring and reporting of activities.

The CHIPS Programme is structured to stimulate and support households in communities to seek and obtain PHC services through various delivery platforms, namely: the health facility, outreaches and home services using volunteer CHIPS agents. CHIPS agents are also tasked with conducting home visits to provide education to caregivers on child health services including immunization. CHIPS has been rolled out in three states; Nasarawa, Niger and Jigawa, and plans are underway to scale up the programme in the remaining states.

Key barriers affecting service delivery and demand generation are:

- inadequacy of micro plans due to unreliable denominator

[17] RI-LQAS Q1 2018 to Q2 2019; slides on reasons for partially vaccinated or unvaccinated children

- inadequate health workers to conduct sessions;
- low health worker motivation, inadequate supervision and accountability,
- inappropriate attitude leading to non-conduct of planned sessions and lack of accountability,
- stock out of vaccine and devices at service delivery points due to limited logistics support for last mile distribution,
- knowledge gaps amongst service providers leading to missed opportunity for vaccination and high dropout rates partly due to weak Inter-personal Communication (IPC) skills.
- Lack of incentives to health workers and in some states, salaries not paid on time.

Gender-related barriers faced by caregivers

Gender related socio-cultural norms have been clearly identified as obstacles to access immunization services. This include:

- A mini EPI review conducted in 2019 revealed that caregivers (mothers) especially in northern Nigeria are unable to take eligible children for vaccination due to hesitance of husbands to grant permission, as culturally required. This is largely caused by inadequate knowledge of the importance and benefit of immunization by the husbands[18]**.** Additionally, the traditional practice of women not being allowed to leave their homes until 40 days after child delivery has also been a big obstacle for initiating and continuing infant vaccination. The CE strategy is currently been strengthened to include RI messaging at religious houses specifically targeting heads of households to give standing permission to caregivers to access RI
- Lack of education and economic dependency as it affects women is also a barrier to immunization access especially in northern Nigeria. A broader approach beyond the health sector is required, current efforts by the government to encourage girl-child education should play a role

The current CE strategy is being strengthened to include RI messaging at mosque/churches specifically targeting heads of households. There is evidence from Bauchi and Sokoto that trusted community voices that have normative contact with new-borns and head of households within the first week of life are effective in conveying key RI messages, referral and immunization uptake.
The strategy being implemented in 10 states engaged the traditional leadership to enable an interaction to discuss barriers including traditional practices that avert uptake of vaccination by children.

Data/Information system:
Routine immunization (RI) data in Nigeria is available via administrative sources and Surveys. Currently, RI data is collected through District Health Information System, version 2 (DHIS2) as the only recognized electronic platform in the country's National Health Management Information System (NHIMS). The platform supports real-time data reporting, promotes government ownership and accountability. All health facilities offering routine immunization send monthly reports, which are entered into DHIS2 by LGA Officers. The DHIS2 RI Module was recently rolled out nationwide. Reporting has increased to over 80% and it enables officials at all levels to easily access RI data, and use a continuous work in progress.

Having fully transitioned to the DHIS2 platform in 2018, completeness of the National Health Management Information system (NHMIS) report increased from 65% in 2016 to 76% in 2018 and a similar trend of 59% to 69% over the same period was observed for timeliness of report submission.

Recently, the RI Short Message Service (SMS) daily reporting tool was scaled up to 18 NERICC priority states to complement DHIS2 monthly reports. The RI SMS tool ensures RI data is available on the SMS/DHIS2 instance immediately after sessions are conducted which makes data available real time for making informed decisions. RI data is analysed weekly and disseminated at all levels. Issues affecting routine immunization service delivery are

[18] Mini EPI review report, 2019

identified and followed up with relevant authorities and LGAs. Furthermore, weekly data analysis of RI SMS data and monthly analysis of the DHIS2 RI data at NERICC has improved the use of data to drive action.

Despite improvements in the implementation process of DHIS2 RI Module in-country, there are still challenges at the national and subnational levels. At the national level, the main challenge is the considerable discrepancy between administrative and survey RI data. The 2016-2017 Multi-Indicator Cluster Survey/National Immunization Cluster Survey (MICS/NICS) reported that Nigeria's northern states account for the lowest coverages both overall and for individual antigens, leaving a large proportion of children susceptible to vaccine-preventable diseases. At the same time, administrative coverage rates often exceed 100% in these states. The occurrence of major outbreaks of vaccine-preventable diseases across these states support the survey findings. These discrepancies in coverage are due to over-reporting of administrative RI data that is largely driven by known issues such as data entry errors, incomplete listing of RI-providing HFs, inaccurate population estimates across the country and non-compliance with accountability measures from states to LGAs and HFs.

Preliminary findings of DHIS2 RI Module evaluation highlighted some of the challenges that affect smooth implementation of DHIS2 in-country:

- Logistic/technical challenges
    - Inadequate maintenance/replacement of laptops used for data entry and dashboard review by Local Government Immunization Officers (LIOs)
    - Unreliable electricity for charging laptops and poor network coverage, particularly in security compromised areas
    - Frequent stock-outs of data tools at HF and LGA levels affecting completeness and timeliness of reports
    - Inability to store data tools in a safe, dry place in some facilities
    - Inaccurate health facility lists provided on the DHIS2 platform leading to low completeness rates
- Inadequate HR for data management
    - Low staff capacity to complete RI forms accurately (turnover, lack of trainings for new staff, infrequent refresher trainings)
    - Burden of completing multiple forms while attending to patients is often too much for the limited number of HWs available
    - Low motivation among state-level DHIS2 focal persons due to funding constraints
- Suboptimal conduct of data quality improvement interventions and use of data for action
    - LGA level data validation meetings have been noted to improve accuracy of data reported across all tools when it is conducted per guidelines, however, these meetings are not holding as planned due to funding related issues and non-attendance of key stakeholders
    - States do not comply with standard process for data validation
    - Pressure on health workers and LGA officials to meet targets may promote data falsification
    - Feedback on reported data is inconsistent, and sometimes used in a punitive rather than constructive or supportive manner causing staff to feel pressured rather than motivated

To address issues with population estimates (denominator), the polio EOC and NERICC data teams triangulated denominators across various sources using projected census population, GIS estimate and Walk-through Micro-plan for 25 states and recommended GIS estimates for the remaining 12 states (mostly Northern states). However, there was insignificant change in the number of LGAs reporting >100% coverage; from 123 LGAs in 2016 to 111 LGAs in 2018 as shown in figure 15 below. Additionally, despite the change in operational denominators, the 2018 national coverage was 90% and state-level coverage was >100% in some Northern states.

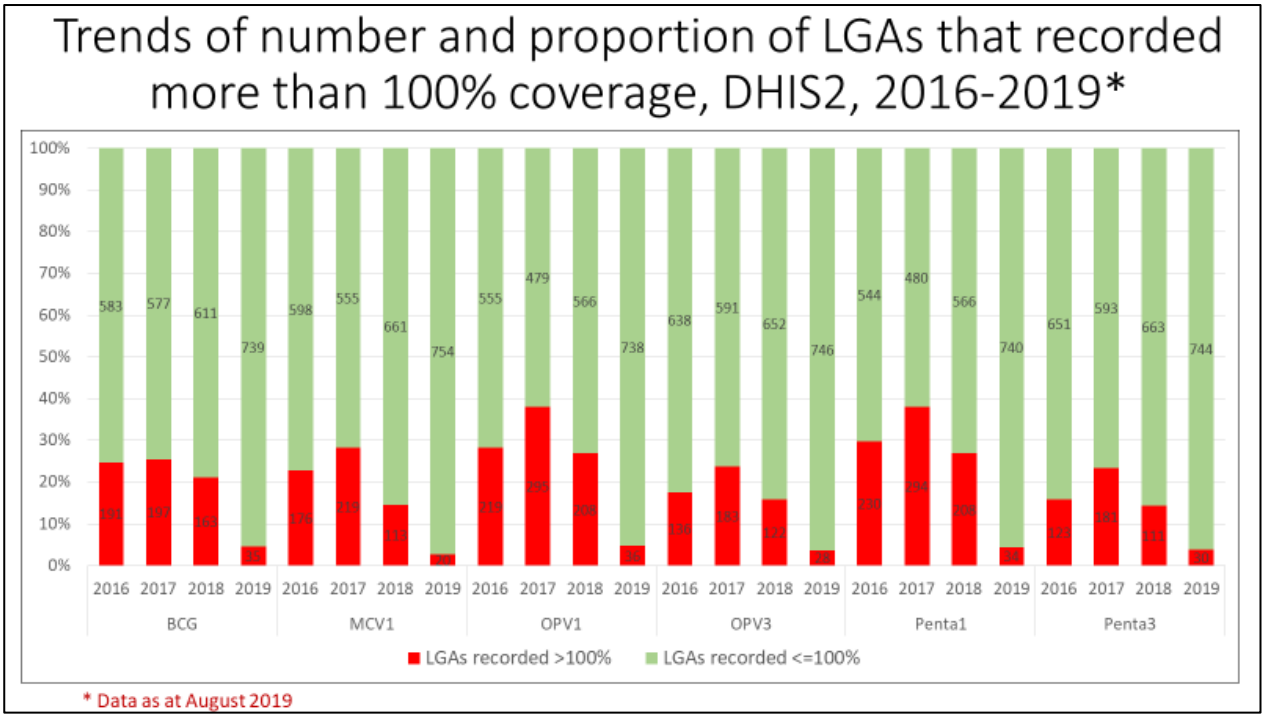


Figure 15: Trends of number and proportion of LGAs recording above 100% RI coverage

Recent efforts to improve the DHIS2 platform include; an assessment of DHIS2 by Gavi through University of Oslo, implementation of validation rules and compulsory data elements. Furthermore, the health facility registry (HFR)/master facility list was launched by Honourable Minister of Health in May 2019, and although this is still in progress, it will be linked to DHIS2 once completed. The HFR has been rolled out in Abia and Niger States with a plan to scale-up to all states in the country.

The quarterly RI LQAS assessment was broadened to become Programme Assessment, Performance management and Action LQAS (PAPA-LQAS) in January 2019 to include MNCH indicators. These assessments measure the quality of RI, ANC and skilled birth attendance across states and provide data for rapid decision making and improvements. There was an increase in the number of LGAs with acceptable scores from 111 (14%) in Q2, 2018 to 252 (33%) in Q2, 2019 across all LGAs. These achievements notwithstanding, there are persisting factors such as inadequate skilled staff, low financing and insecurity that contribute to sub-optimal immunisation performance. Other routinely conducted surveys include NDHS, NICS/MICS and NNHS which provide useful data to validate the quality of administrative data.

There are variances in coverage rates across surveys particularly between NDHS, NICS/MICS and NNHS surveys. This is driven by differences in methodology where NNHS is likely to sample more urban settlements with higher coverage than other surveys. This limits comparison across the surveys. Nevertheless, there is need to include other data sources such as community-based data (e.g. new-born line lists), supportive supervision, surveillance and SIA data in routine analyses to improve programmatic decision making.

Despite improvements in vaccination coverages and investments in cold chain to ensure quality of vaccines used for immunization, outbreaks of VPDs are still recorded across the country. More triangulation of vaccination coverage and disease outbreak data to better understand underlying issues are needed. AEFI surveillance and reporting is also sub-optimal and requires more attention.

The availability and retention of home-based vaccination records appears to have improved based on the preliminary 2018 NDHS data, meaning that much more of what is understood about programme performance is based on documented evidence compared to a decade ago (e.g. current HBR ownership at national level was around 25-30% during the period 2007 to 2013 and was around 40% for the 2017 cohort). While there is evidence of modest improvements in the distribution and retention of home-based records in Nigeria, there is opportunity for much more improvement. Unfortunately, the availability of home-based records (and therefore documented evidence of vaccination) is lowest among the most marginalized in Nigeria for whom coverage and equity issues are most critical.

As noted elsewhere, as attention is shifted towards understanding variations in programme performance at LGA and ward levels, the ability to do so using data from the routine administrative recording and reporting system continues to be challenged, though we are hopeful there are improvements. A review of state-specific plots of reported LGA administrative vaccination coverage for 2018 alongside recent survey results highlight that many areas continue to report unreasonable administrative coverage. There are differences across states with regards to the magnitude of variation as shown in the figures below.

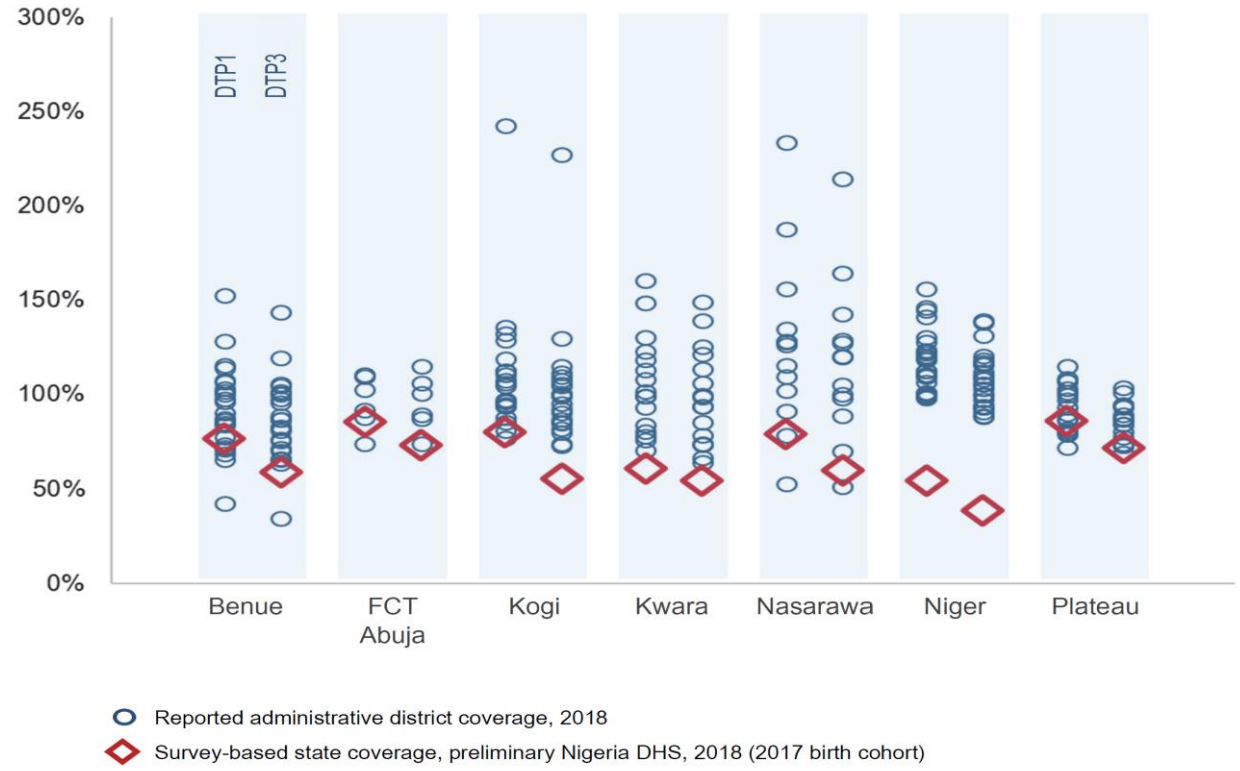


Figure 16: State-specific plot of reported LGA administrative vaccination coverage for 2018 alongside survey-based vaccination coverage for the 1st and 3rd dose of Penta vaccines, North Central zone

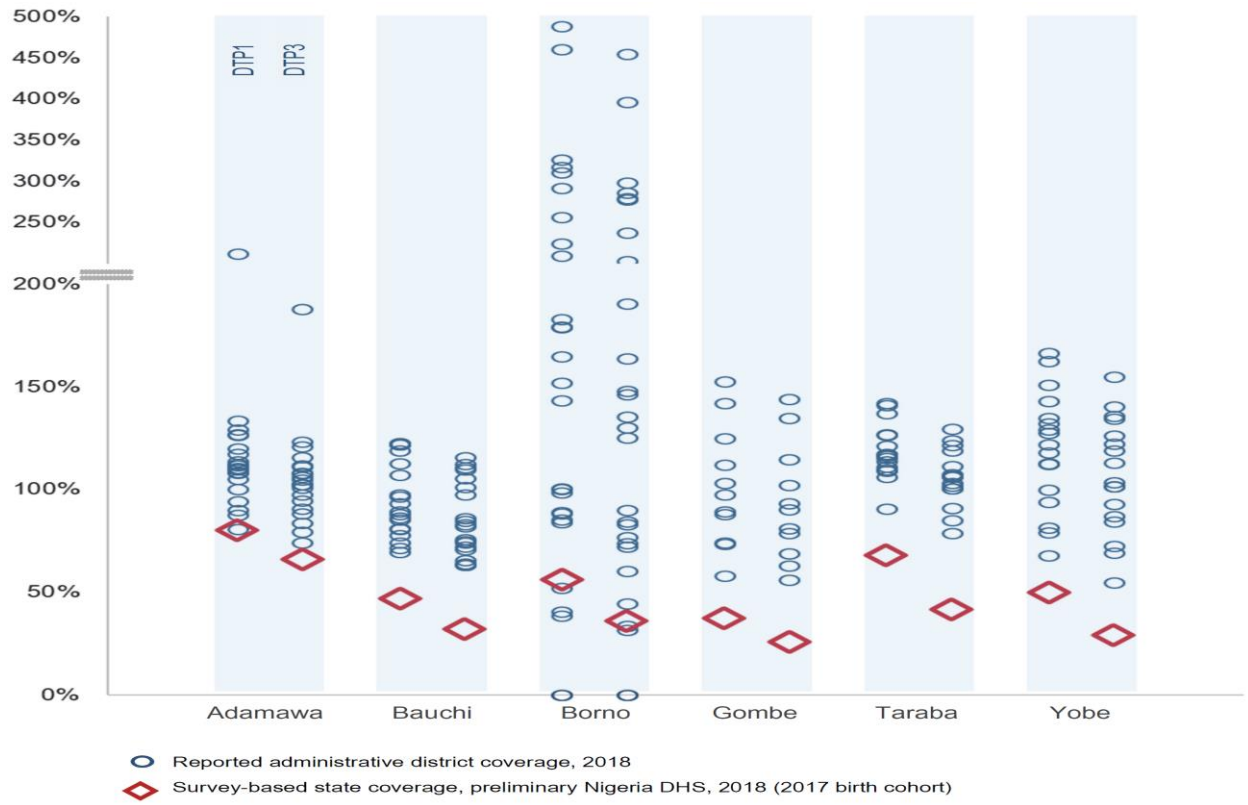


Figure 17: State-specific plot of reported LGA administrative vaccination coverage for 2018 alongside survey-based vaccination coverage for the 1st and 3rd dose of Penta vaccines, North East zone

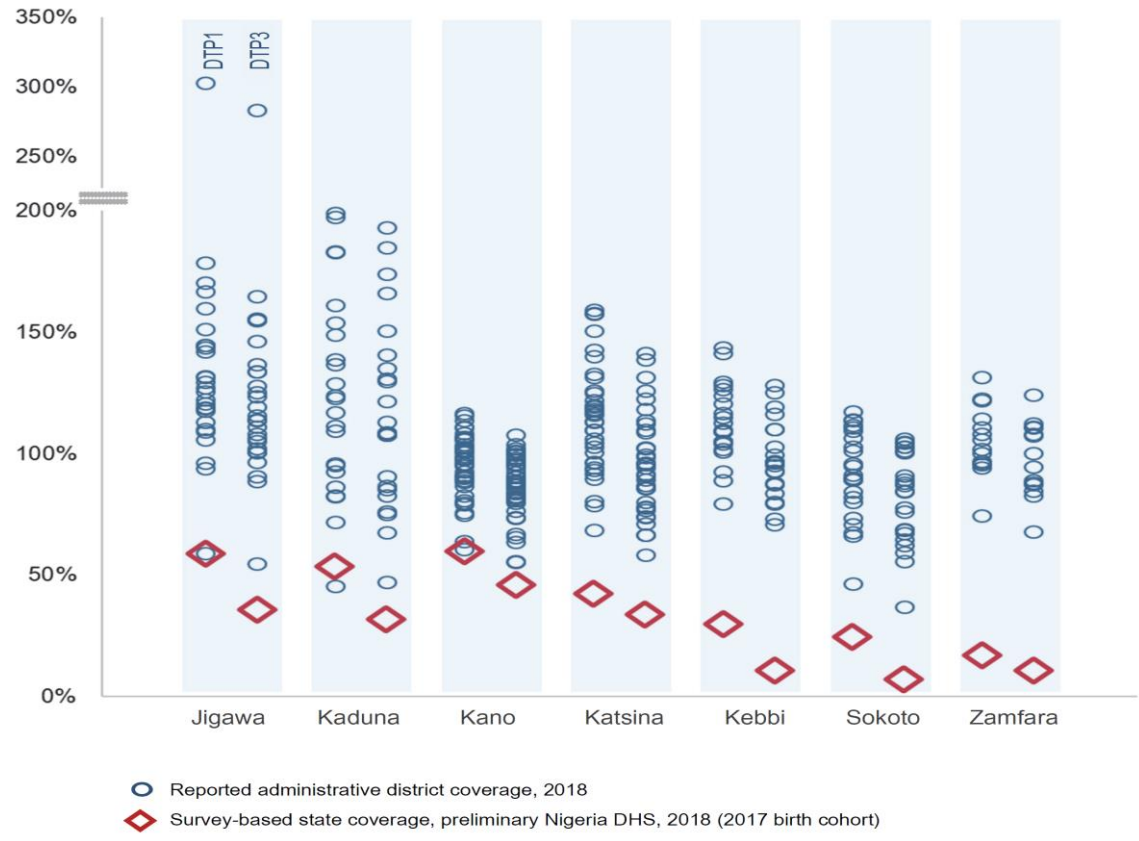
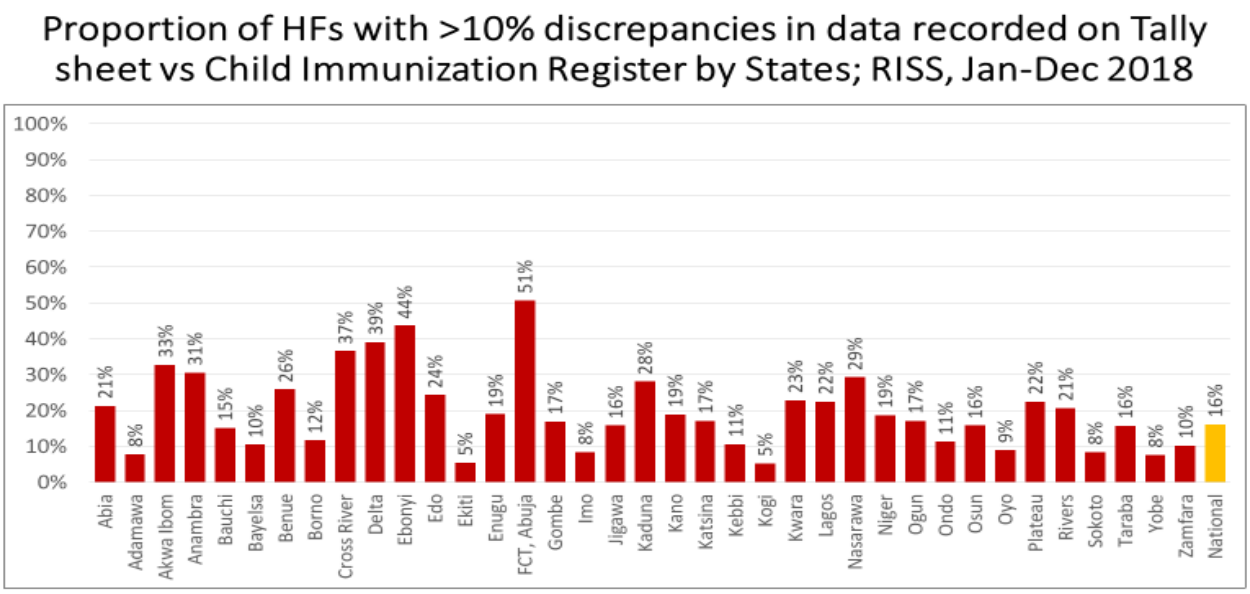


Figure 18: State-specific plot of reported LGA administrative vaccination coverage for 2018 alongside survey-based vaccination coverage for the 1st and 3rd dose of Penta vaccines, North West zone



Averagely 16% of the HFs in the country had >10% discrepancies in data reported on Tally sheet and Child Immunization Register

In addition, a review of results from supportive supervisory visits that include checks of discrepancies in the number of children vaccinated between facility tally sheets and child immunization registers highlights ongoing problems at the facility level.

These challenges in administrative data highlighted above are no doubt due in part to problems with recording and reporting practices impacting the numerator data as well as suboptimal microplanning target population exercises and known challenges with census data at subnational levels that impact denominator data.

The possible reasons for the observed data quality issues include the following:

- Inappropriate target population estimates (i.e. denominator)
- Inadequate/multiplicity of data tools that are not well fit to meet end user needs
- Weak routine immunization supportive supervision and mentoring at sub-national levels (both in scope, quality and use of data for action)
- Inappropriate attitude of the health workers towards data recording and reporting
- Falsification of number of children immunized to meet assigned performance targets, and subsequent alteration of vaccines utilization data
- Data recording errors resulting from manual entry and aggregation
- Incomplete data entry on DHIS2 platform (especially vaccine stock availability and utilization data)
- Late reporting of immunization data

Current efforts and innovations aimed at addressing data quality issues include:

- Revision of Data Quality Improvement Plan (DQIP) and development of a six-month priority plan intended to serve as a quick win in addressing RI data quality issues in the country
- Post PAPA-LQAS Action Plan development and implementation
- Strengthen the use of routine immunization data for making informed decisions at all levels;
    - Weekly analysis and dissemination of SMS data at NERICC and follow up to states to address gaps and disseminate findings to LGAs and HFs

- Daily SMS dashboard review in most LGAs. Data is used to follow up with HFs on non-conduct of planned sessions and children immunized
- Routine triangulation of administrative and survey data at the National level
- Inclusion of feedback sessions on data management and use during OIRIS visits to states
- Routine feedback on RI performance to sub-national levels through DHIS2 monthly reports at relevant meetings e.g. NERICC, NPHCDA-PRS Top Management Meeting with Partners, etc.

- Revision of operational denominator for effective programmatic decision making by NERICC data team
- Development and implementation of GEEKS (Growing Expertise in E-health Knowledge and Skills) project among NPHCDA PRS national M&E officers. This project is designed to address capacity gaps in data analysis, data quality and use and dissemination of feedback to sub-national levels.
- Intensified supportive supervision and mentoring visits by PRS to states with a focus on the conduct of Data Quality Self Assessments (DQSAs) comparing source documents in health facilities with reported data on electronic platforms (DHIS2 and SMS)
- Conduct of data validation meetings and supportive supervision in some States and LGAs

Supply Chain

Integration of vaccines with other PHC supply chain

The NPHCDA made progress on the integration of vaccines with other health supply chains across 2 areas;

1. ***Supply chain design to support PHC revitalization road map***: Following the launching of the 10,000 PHC revitalization, an initiative of the Federal Government of Nigeria, there was a need to clearly define its supply chain component. The Federal Ministry of Health (FMoH) through NSCIP, NPHCDA and their partners collaborated to develop a strategic document that provides a road map for the supply chain management of PHC commodities including vaccines. The document developed was titled "The supply chain design to support PHC revitalization in Nigeria". The document has been approved by the Honourable Minister of Health for printing, public adoption and dissemination of which plans are underway.

2. ***Integrated National Stock Status Report:*** In the period under review, the NSCIP initiated the harmonization of logistics management information system (LMIS) data from the 5 key health programs; reproductive health, Malaria, Tuberculosis, HIV/AIDS and immunization. Program officers meet quarterly to submit their respective program data for harmonization into a single report known as the Integrated National Stock Status Report (NSSR). Each report contains information on; the quarterly stock of health commodities in-country, in-coming health commodities shipments, key challenges affecting each program and recommendations to address them. Six meetings were successfully held between Q1 2018 to Q3 2019.

3. ***State Engagement Meeting and State-Specific Forecasting:*** This forecast for 2020 done in July 2019 was preceded by a state engagement meeting. During this meeting, consumption data, physical stock count feedback and other challenges affecting the states were extensively discussed after which solutions were proffered and specific utilization work-plans developed per state to use up the near-expiry as well as vaccines in VVM Stage 2. During the forecast harmonization/finalization process, the drop-out rates for PCV and Penta across the cascade of care were taken into consideration (i.e. Penta 1, 2 & 3 and PCV 1, 2 & 3).

4. Global vaccines supply and in-country demands:

In view of the re-current global shortage of vaccines and limited global production and strain on vaccine resources due to multiple outbreaks, peculiar to IPV and YF, the increasing volume of outbreaks in-country poses a major challenge on vaccine availability to meet RI needs. In the wake of these outbreaks, there is always pressure on the use of RI vaccines for outbreak responses and the shipment of outbreak vaccines are not always immediate. This has been witnessed on IPV, YF and MCV. Due to capacity constraints and frequent outbreaks, this has led to frequent shipments. Coupled with paucity of funds, these frequent shipments could also lead to vaccine stock out.

Gavi Supply Chain Fundamentals

1. **Management Coordination and Human Resources:**

- Vaccine Management Training was conducted in 11 northern states with cascades to the LGA level.

- Gavi STEP training was also conducted where 18 participants from national, zonal and state level officers successfully completed the training that was anchored by African Resource Centre (ARC). A one-week training on Supply Chain Management was also organised by ARC for some more NPHCDA staff.

- NPHCDA Leadership Academy: 2 staff of the DL&HC were enrolled in this training being hosted by different development partners.

2. **Optimised Equipment:** The Cold Chain Equipment Optimization Platform (CCEOP) application was concluded and approved by IRC in January 2019.

Prior to the approval, the nationwide Cold chain inventory assessment (CCIA) was conducted in October 2018 using the WHO IRP Tool. The Facility Readiness Assessment for the Operational Deployment Plan (ODP) was carried out in May 2019. Cost estimate has been approved by NPHCDA for the 1st Tranche of the deployments for Priority 1 sites. The deployment of the CCEs was prioritised in two phases (2019 – 2021 & 2022 – 2025).

3. **Data for Management:** four additional staff from the zones were deployed to the NPHCDA Headquarters to support the data team and are being trained on the tool and processes for the NISCmis (National Immunization Supply Chain Management Information System) by the system administrators.

4. **Immunization Supply Chain Design:** The national level system is being re-designed to a 3-Hub system whereby national stores are located at 3 strategic points across the country – Abuja, Lagos and Kano. These hubs are to directly receive incoming shipment of vaccines and supplies for efficient distribution of same to the states. Each hub is expected to cover 2 zones. Plan is also on the way for the installation of 500 cm^3 Walk-In-Cold House at NSCS, Abuja.

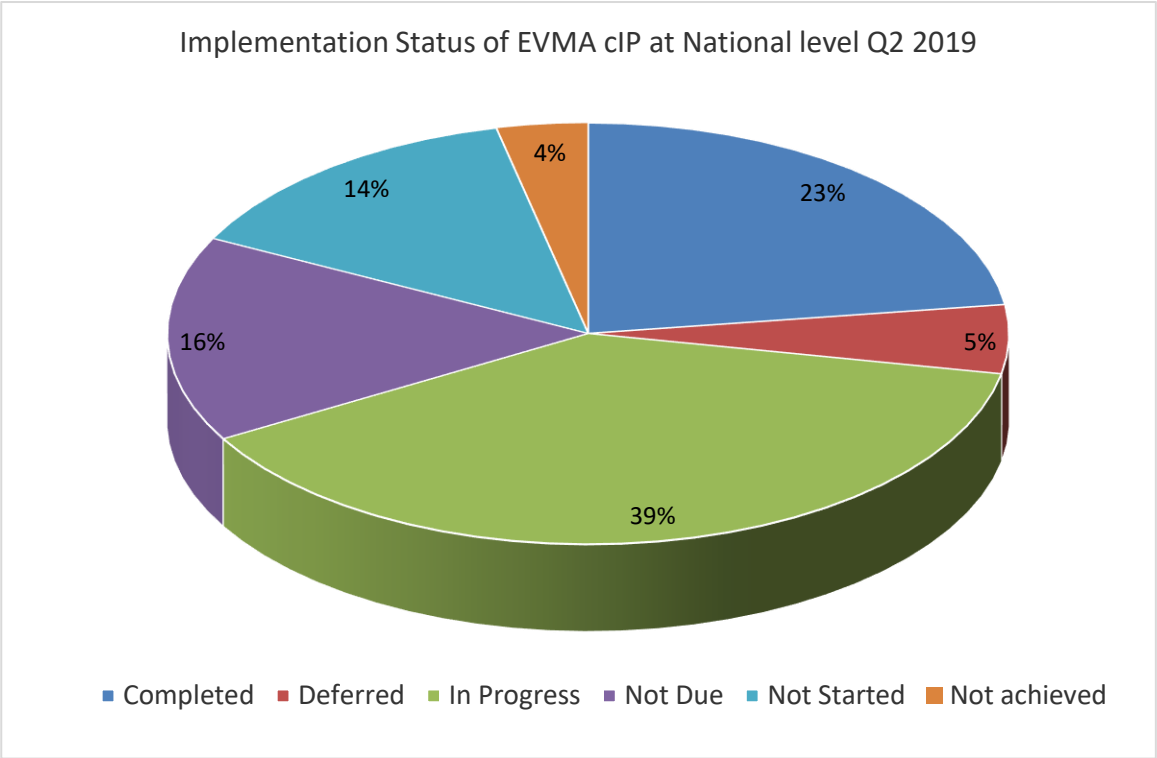
5. **Continuous Improvement Processes:** National, Zonal and State-specific EVM cIPs were developed following the conduct of EVM assessment across the country in 2017. Progress of implementation of the cIPs is summarized below.

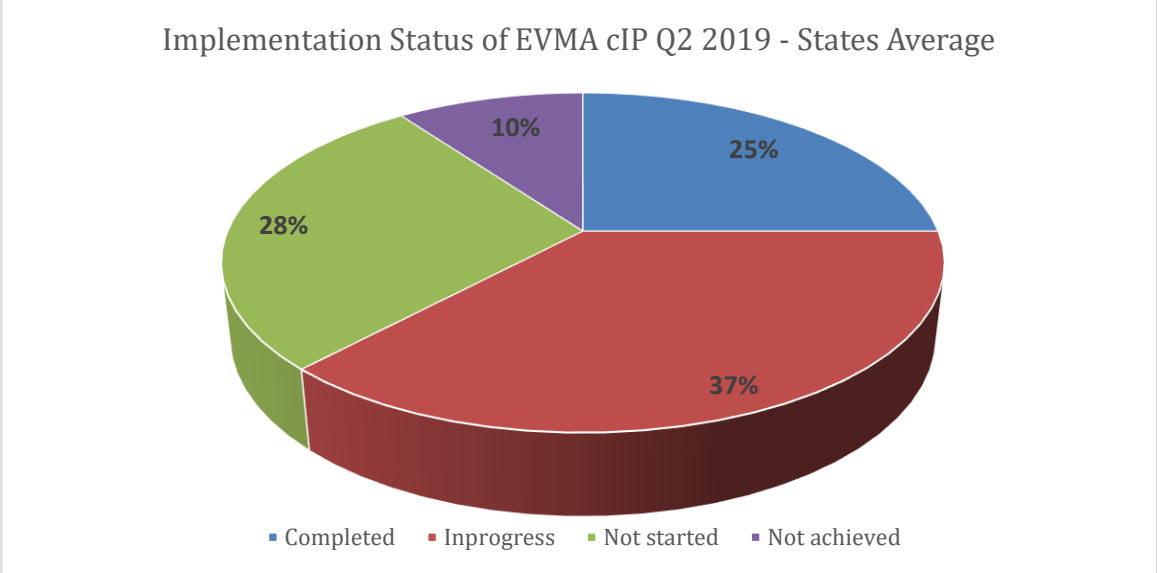
- **<u>Status of cIP Implementation across the levels - National and States</u>**

Following the 2017 EVMA, a comprehensive state specific continuous improvement plan was developed to be implemented between 2018-2020, with involvement of all stakeholders. Each state/level conducted a series of advocacy for funding and integration of the costed activities into the state's budget for various sources of funding to ensure gaps identified in the 2017 EVMA are addressed.

So far, there is low level of implementation of the cIP generally and there is need to double efforts as 2020 approaches.

At the National level, some progress has been made on implementation of the 2019 annual EVM cIP. As of July 2019, 22.8% of activities are fully completed; 47.37% are in progress, 12.28 are not due; 8.77% have not started and 7.02% have been deferred.





At the state level, the level of implementation varied with the level of commitment to funding specific activities for the immunization supply chain.

On the average only 25% of planned activities as at 2019 have been completed; 37% are in progress, 28% have not started and 10% of activities have not been achieved. There is clear improvement in the implementation of activities (above 50% completion rate) in the MoU states (apart from Sokoto and Kaduna). However, states like Adamawa and Jigawa (Non-MoU) recorded significant improvement due to high level of commitment by the state.

Leadership, management and coordination

The Inter-Agency Coordination Committee and the Core Group led by the leadership of the FMoH and NPHCDA respectively remain functional with the support of all immunisation partners. The ICC and Core Group maintain oversight implementation of the NISPSS as well as monitoring accountability of all stakeholders. The term of the Nigeria Immunisation Technical Advisory Group (NGI-TAG) ended in April 2019 and new members have been pencilled for inauguration. The technical working groups comprising National Technical Coordinating Committee (NTCC), the National Emergency Routine Immunisation Coordination Centre (NERICC), the National Logistic Working Groups (NLWGs) and the National Technical Committee on HMIS with the respective sub working groups continued their functions. Similar structures of the technical groups exist in the states. Despite their functionality, coordination across the working groups is sub-optimal. Thus, resources and technical capacities are not fully utilised across the working groups, particularly in improving the efficiency of programme plans.

Key drivers to improve on leadership, management and coordination include:

- Strengthen functionality of State Task Force on Immunisation and PHC.
- Improve monitoring on efficiency of Technical Working Groups (SLWG, SERICC/RIWGs and LERICCs)
- Establish a joint National Technical Coordination Team to address cross-cutting technical issues of the immunisation and PHC programme.
- Increase mentorship and support to the states
- Define the type of support NPHCDA will give to states to increase their ability to build and sustain systems beyond the emergency
- Strengthen existing coordination structures at the state and LGA and define clear plan to strengthen sub-optimally performing groups at sub-national levels
- Clearly define roles and responsibilities for national, state and LGA level coordination structures and support sub-national level to plan and implement

The coordination and leadership of the NERICC has resulted in a lot of gains in the RI program in the last two years. However, NERICC was set up to be a short-medium term intervention. Thus, it is important to plan for the transition and sustainability of the coordination provided by NERICC when it ends:

- Have a clear timeline and criteria for transitioning program out of an emergency mode and into systems building and long-term sustainability mode
- Options to be considered in defining the criteria include a high national coverage (>70%) sustained for two years; states achieving NSIPSS targets consistently for a few years and performance of other PHC indicators

Also, very key to strengthening the leadership and management is through full implementation of the Accountability Framework at both National and State levels. Some of the steps towards achieving this include:

- States need to be engaged on the accountability framework, ensure coordination between Gavi, NPHCDA on the state engagements on the accountability framework
- Institute program accountability measures and performance management
- Develop and institute standards of practice

Other critical aspects: PHC Systems' Strengthening and Integration

The push towards PHC integration has been one of the key drivers for sustainable coverage and equity. Within the last one year, the Government of Nigeria through the NPHCDA has strengthened the implementation of PHC Under One Roof (PHCUOR). All 37 states are now implementing PHCUOR, but at various levels of maturity as evidenced by the PHUOR Score Card 4.

To improve equity, access and quality of PHC services, 4000 health facilities have been revitalized with plans ongoing to scale up completion to 10,000 health facilities. These newly revitalized health facilities are yet to be fully functional in line with the recently revised standards for assessing PHC functionality (Minimal Service Package). Additionally, there are no monitoring mechanisms to analyse and establish the status of previously awarded PHC facilities.

In addition to the PHCUOR and revitalization efforts, the NPHCDA inaugurated the National Emergency Maternal and Child Health Intervention Centre (NEMCHIC). The NEMCHIC follows the model of the NERICC with a multidisciplinary team consisting of government and partners from different programs to identify and resolve gaps affecting maternal, new-born and child health in PHCs in an integrated approach. Complementing these efforts is the ongoing work by the Community Health Influencers, Promotion and Services (CHIPS). Recent advances include the inauguration of CHIPS Programme in Nasarawa state on February 6th, 2018 by the President H.E Muhammadu Buhari and presidential mandate to roll out to the 36 states plus FCT. Since then 580 CHIPS Agents have been selected and are currently providing services in Nasarawa state, CHIPS Personnel have been selected in Niger states and all other states have been engaged and are in the pre-implementation phase of the programme.

The Basic Health Care Provision Fund (BHCPF) has been rolled out and is currently on track with 16 states having received their first tranche of funds through the NPHCDA gateway. All the states have formed contributory health insurance schemes however some 21 states still lag in fulfilling the criteria put forward.

To further improve PHC Systems, the government has developed and approached the implementation of a PHC Systems Strengthening accountability framework. This framework identifies key indicators to be used to track performance of the government, donors and partners in the health systems.

Other ongoing efforts include the establishment of a quarterly round table management review meeting with executive secretaries from all 37 states and the FCT. Through these quarterly meetings, the ED NPHCDA advocates for increased prioritization of PHC and immunization activities. The Task Force on Immunization was also expanded to include primary health care. The taskforce, now called the Task Force on Immunization and PHC forms a coordination body chaired by the Deputy Governor.

4.3. Immunisation financing

Availability of timely and accurate information for planning/budgeting:

Nigeria operates a 3-year rolling plan - Medium Term Expenditure Framework (MTEF) in which all expenditure projections including health/immunization financing requirements are captured. The MTEF forms the basis for the annual budget preparation. In 2018, the sum of N12.14bn (US$ 39.8m) was included in the annual appropriation for vaccine procurement and operational cost for immunization out of which 99.54%, N12.08bn (US$39.62m) was released. However, owing to instability in the nation's budget cycle, the amount approved for the 2018 fiscal year did not come until the 3rd quarter 2018 (24th September). Therefore, the 2018 appropriation was used to finance immunization activities from September 2018 to June 2019.At sub-national level however, there is no effective integrated approach for coordination of immunization financing amongst the states. Therefore, prioritization of immunization activities/ financing seems to differ from state to state.

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY										
2018 IMMUNIZATION BUDGET PERFORMANCE AS AT 30/06/2019										
S/N	CODE	PROJECT NAME	APPROPRIATION; AMOUNT (N)	APPROPRIATION (US$)	TOTAL RELEASES (N)	RELEASES (US$)	EXPENDITURE (N)	EXPENDITURE (US$)	UNSPENT BALANCE (N)	% PERFORMANCE
1	NPHCDA-ERGP25112666	PROCUREMENT OF ROUTINE IMMUNIZATION VACCINES, DEVICES AND OPERATIONAL COST	8,895,468,504.00	29,165,470.50	8,895,468,504.00	29,165,470.50	8,895,468,504.00	29,165,470.50		100
2	NPHCDA-ERGP25112672	POLIO ERADICATION INITIATIVE (PEI)	1,204,190,831.00	3,948,166.66	1,204,190,831.00	3,948,166.66	1,204,190,831.00	3,948,166.66	-	100
3	NPHCDA-ERGP25112677	PROCUREMENT OF NON- POLIO SIA VACCINE AND DEVICES OPERATION	540,000,000.00	1,770,491.80	540,000,000.00	1,770,491.80	540,000,000.00	1,770,491.80	-	100
4	NPHCDA-ERGP25112679	PROCUREMENT OF OUTBREAK (EMERGENCY) RESPONSE VACCINE, DEVICES AND OPERATIONAL COST	1,500,000,000.00	4,918,032.79	1,444,089,343.22	4,734,719.16	1,444,001,700.00	4,734,431.80	87,643.22	96.27
		Total	**12,139,659,335.00**	**39,802,161.75**	**12,083,748,678.22**	**39,618,848.13**	**12,083,661,035.00**	**39,618,560.77**	**87,643.22**	**99.54**

Allocation of resources in national health budget: Owing to the size of financial resource requirement for immunisation, and the persistent shortfall in federally collected revenue, it has been difficult for governments, to make adequate provision for immunisation financing in the annual appropriation.

The 2018 and 2019 vaccine procurement expenditure for RI and SIAs is as follows:

2018 and 2019 Vaccine Procurement Expenditures

DATE	PROGRAMME/ PROJECT	SOURCE OF FUNDING				
		FGON BUDGET US$	STATE BUDGET US$	WORLD BANK LOAN US$	GAVI US$	TOTAL US$
2019	RI	$5,057,901.00	$0.00	$63,582,899.53	$48,572,358.00	$117,213,158.53
2019	SIA	$0.00	$0.00	$15,746,806.61	$57,519,391.00	$73,266,197.61
	Total	**$5,057,901.00**	**$0.00**	**$79,329,706.14**	**$106,091,749.00**	**$190,479,356.14**
2018	RI	$6,401,474.99	$0.00	$36,354,726.67	$108,849,660.00	$151,605,861.66
2018	SIA	$0.00	$0.00	$27,208,698.06	$47,643,921.10	$74,852,619.16
	Total	**$6,401,474.99**	**$0.00**	**$63,563,424.73**	**$156,493,581.10**	**$226,458,480.82**

In order to improve country ownership and enhance sustainable immunization financing from domestic budgetary resources, the partnership has developed an accountability framework, which provides for steady increase in government contribution towards vaccine procurement such that by 2028, the nation will achieve 100% vaccine financing from internal/domestic resources. On the strength of this, the country has started to achieve significant improvement in resource allocation for vaccine procurement from 2019 and if sustained the country will be on track to achieving the goal of self and sustainable financing for vaccine procurement beyond the transition period.

Timely disbursement and execution of resources; The instability in the budget calendar and falling revenue does not allow for timely release of approved budget from year to year. For instance, the 2019 appropriation was approved on 27th May 2019, but no releases were made as at end of August 2019. Consequently, part of 2018 budget and World Bank additional financing facility and Gavi Funds was used to finance 2019 vaccine procurement and other immunization activities. In addition, other donor funding has been used to supplement polio operations.

Adequate Reporting: In Nigeria, the annual statutory audit is a constitutional requirement for all government funded Projects, Programs and activities. The Government fiscal cycle runs from 1st January to 31st December but unfortunately, the instability in the budget cycle made it impossible to align the annual budget performance report with the Government financial reporting cycle, which is January 1 to December 31 of any particular year. In this context, the budget year runs from June of one year to May of the following year, causing undue overlap of fund disbursement from year to year, thus, creating inconsistency between the annual statutory audit report of a year and corresponding budget performance report for that year. However, given the current cordial relationship between

legislature and executive arm of government in the country, there are indications that moving forward, the annual budget will be passed in time for a January 1 start date and December 31 end date, thus, stabilising the budget cycle.

At the National level, a robust accountability framework has been developed comprising of some high-level indicators that would hold both government and partners accountable for their commitment towards both financial and programmatic attainment in the immunization space. In all, there are 32 indicators spread across five domains vis the core, health financing, governance, programmatic, data quality and vaccine accountability. These indicators will form the basis for high-level annual relief by both government and Gavi at the end of every year. In order to ensure that the accountability framework will be implemented comprehensively, the task team will need to be strengthened to comprise all relevant programmatic and financial stakeholders. In order to achieve full benefits of the new investments in immunization by both government and Gavi, there is a need to develop state specific accountability framework across all the states and FCT to enhance their ability to meet their commitment and also improve efficiency and effectiveness of immunization service delivery in the country. In addition, national should work with the state to set up advocacy groups emphasizing the importance of state financial contributions to immunization and PHC operations.

5. PERFORMANCE OF GAVI SUPPORT

5.1. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

Objective 1: Leadership, Management and Coordination	
Objective of the HSS grant (as per the HSS proposal or PSR)	To build the leadership and governance capacity and institutionalize accountability for policy makers at federal, states and local levels for evidence-based policies and strategic planning
Priority geographies / population groups or constraints to C&E addressed by the objective	The strategic priorities and interventions will strengthen the Health system across the National level and the eight(8), (*Taraba, Zamfara, Kebbi, Jigawa, Gombe, Katsina, Niger and Bayelsa*) HSS states that have been classified as low performing by the recent NICS/MICS survey and the most current scorecard on PHCUOR
% activities conducted / budget utilisation	Not applicable as the country is unable to estimate the denominator for this computation. Funds used for under-listed activities were reprogrammed from left-over funds of the 2013 HSS and funds returned by the FGON to Gavi following the Gavi audit. Funds from the HSS proposal covering 2019-2023 are not yet available for activities in this section due to delays in budget negotiation.
Major activities implemented & **Review of implementation progress** including key successes & outcomes / activities not implemented or delayed / financial absorption	• Conduct of External Audit for NPHCDA
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[12]	• HRH review; • use of evidence-based tools to support recruitment and equitable distribution of HW e.g. WISN tool; • explore other short-term measure to increase staffing while working on longer term measures; • Development of transition pathway and incentives for states to move out of the emergency mode and sustain improvements; • Support SPHCDA to develop and implement a transition plan for full implementation of PHCUOR using the scorecard 4 as a baseline at the National level

	• Support the development of a state specific PHC and immunization financing plans (forecasting, costing and development of virtual basket) • Procurement of 2 computers per state, automation and deployment of SOPs for financial management systems at the sub-national level and deployment • Implementation of mechanisms for rapid evidence-based learning o Facilitation of collaborative associations with Universities, research institutes and other institutes of higher education to document good practices and lessons learned from the implementation of strategies and interventions outlined in the NSIPSS o Identification of healthcare workers and PHCs as entities with best practices and creation of a platform for sharing with peers [19] o The institution of state-level programme review processes and appraisals (EPI review, annual joint appraisals with key stakeholders, amongst others) with oversight from the national level o Roll-out of data-driven performance management system at National, state and LGA levels[20]
Objective 2: Service Delivery	
Objective of the HSS grant (as per the HSS proposal or PSR)	To improve coverage and equity for immunization and PHC service delivery
Priority geographies / population groups or constraints to C&E addressed by the objective	• Improved microplanning at health facilities with community participation • Intensify conduct of immunization session. States with suboptimal coverage and low RI performance selected for Gavi support include Taraba, Gombe, Katsina, Kebbi, Bayelsa, Zamfara, Niger and Jigawa • Implement tailored interventions to reduce high number of unimmunized children and missed opportunities for vaccination. States targeted for tailored interventions to reduced high number of unimmunized children in urban slums include: Lagos, Rivers, Benue, Oyo, Kogi, Ogun, Plateau, Delta and Adamawa
% activities conducted / budget utilisation	Not applicable as the country is unable to estimate the denominator for this computation. Funds used for under-listed activities were reprogrammed from left-over funds of the 2013 HSS and funds returned by the FGON to Gavi following the Gavi audit. Funds from the HSS proposal covering 2019-2023 are not yet available for activities in this section due to delays in budget negotiation.
Major activities implemented & **Review of implementation progress** including key successes & outcomes / activities not implemented or delayed / financial absorption	• Switch from PCV 2-dose to PCV 4-dose vials • MenAfriVac introduction • Measles and Yellow Fever outbreak responses

[19] *Community-based health Research, Innovative-training and Services Programme (CRISP) of the NPHCDA: Strategy Document page 7*

[20] *Further details and costs included in "Objective 4: Data management and Surveillance"*

Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[12]	1. Development of GIS-based REW micro-plan in 8 low performing states - 1.1: Conduct sensitization meetings with the LGA focal persons - 1.2: Conduct sensitization with the health facilities - 1.3: Engage with communities on REW micro-plan development - 1.4: Monitor and evaluate REW micro-plan development - 1.5: Conduct validation of REW micro-plan 2. Conduct outreaches and mobile sessions in the urban slums specifically in the 9 states with high number of unimmunized children - 2.1: Develop immunization session plans including, outreaches and mobile session for urban slums in line with REW micro-plan - 2.2 Conduct immunization sessions according to plan - 2.3 Monitor the conduct of immunization session via supportive supervision - 2.4 Institute extended hours and weekend vaccinations in high volume facilities - TA to assess the barriers in each urban context as this differs from place to place and allows for more tailored approaches in community engagement, communications and other interventions that must accompany the service delivery interventions 3. Implement strategies to reduce missed opportunities for vaccination in states with high number of unimmunized children - 3.1: Conduct sensitization on missed opportunity for vaccination - 3.2: Develop and implement plan to minimize MOV 4. Conduct of RI supportive supervision/ on-the-job mentoring by the LGA and State officials to the health facilities - 4.1 Orientation of state and LGA supervisors on supportive supervision - 4.2 Develop supportive supervision plans - 4.3 Conduct of supportive supervision according to plan - 4.4 Print supportive supervision checklists (and flowcharts) - 4.5 Develop mentoring agreements and conduct needs-based mentoring 5. Support periodic intensification of immunization through the conduct of PIRI, LIDs in states with low RI performance following performance reviews 6. Conduct PIRI in areas with low RI performance following assessment in coordination with polio IPDs
Objective 3: Demand generation	
Objective of the HSS grant (as per the HSS proposal or PSR)	To improve demand creation and institutionalize revised community engagement strategy for immunization and PHC
Priority geographies / population groups or constraints to C&E addressed by the objective	The strategic Interventions have been tailored to address demand side issues affecting uptake of routine immunization such as lack of awareness, mistrust or fear, and lack of time. This is evidenced by low Penta 3 coverage and high number of unimmunized children as shown below[21]: • Lagos with 80% coverage and 85, 432 unimmunized • Oyo with 54% coverage and 122,208 unimmunized Bayelsa, Kebbi, Jigawa, Taraba, Katsina, Zamfara, Niger, Gombe, Oyo, Lagos with less than 50% coverage and high number of unimmunized

[21] NICS/MICS 2015/2016

% activities conducted / budget utilisation	Not applicable as the country is unable to estimate the denominator for this computation. Funds used for under-listed activities were reprogrammed from left-over funds of the 2013 HSS and funds returned by the FGON to Gavi following the Gavi audit. Funds from the HSS proposal covering 2019-2023 are not yet available for activities in this section due to delays in budget negotiation.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	The CE strategy has been fully implemented in 10 of the 18 NERICC focus states (6 MoU states, Gombe, Jigawa, Bayelsa, Plateau). 4 of the 8 outstanding states (Adamawa, Katsina, Kebbi and Niger) are being prioritized for roll-out in Q4, 2019 using Gavi support, 2 states (Zamfara and Taraba) will be funded using Gavi HSS funds in 2020 while the last 2 states (Nasarawa and Kogi states) have no funding. Line listing of new borns, reconciliation meetings and tracking of defaulters have begun in the 10 implementing states, however, there is a weak implementation of the strategy in some places as a result of weak ownership by traditional leaders as well as weak monitoring and reporting of activities. • In order to expand implementation of the Strategy, a CE "how to" guide for the strategy was developed and launched by the Northern Traditional Leaders Council in November 2018. Thereafter the strategy was launched in Jigawa and Gombe states where it is being fully implemented. There is ongoing effort to expand the strategy to 6 more States – Zamfara, Katsina, Kebbi, and adopt for implementation in specific areas in the southern States. • Capacity building of CE focal persons and State health educators of the 18 priority states on the the CE strategy, particularly emphasizing the role of all stakeholders, communication and reporting channels and the harmonized monitoring and evaluation framework. • Implementation of ACSM activities as part of PCV switch and MenA introduction. These included contribution to the training manual and training of state personnel at the NTOT, development and dissemination of IEC materials and communication messages; posters, flyers, FAQs, jingles and public service announcements on radio.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[22]	1. Roll-out of Community engagement strategy for RI and PHC services I. Sensitization and training of traditional and religious leaders (Emirates, Sultanate, Chiefdoms, District, village and settlement head) and SPHCDAs on implementation of CE strategy II. Production and distribution of CE tools (CE toolkit, tickler boxes, defaulter tracking registers, line list for community leaders, summary forms for CEFPs) III. Appointment and training of State, LGA and Ward CE focal persons, health facility workers, and all community resource persons to drive implementation

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	IV. Implement annual non-monetary rewards systems for religious and traditional leaders as recognition for good performance 2. Scale up of CHIPS Program in selected states for community level demand creation I. Engagement and State level planning with established State implementation teams. II. Selection and training of CHIPS in IPC and mobilization skills 3. Advocacy to key political, policy decision makers (NGF, NA, Speakers) and civil society organizations at all level of governance for timely release of funds for Immunization and PHC services I. Develop and disseminate customized and data-driven advocacy kits and policy briefs for engagement of stakeholders across all levels 4. Engagement with civil society organizations at all levels for redressing inequities, increase uptake, voice, accountability, branding and social marketing for immunization I. Engagement and orientation of CSOs on current demand generation strategies II. Tracking of performance of CSOs for improved accountability 5. Generation, monitoring and analysis of routine qualitative and quantitative data for demand generation activities I. Quantitative methods through evaluation of RI-LQAS, review of community survey component of routine immunization supportive supervision checklist, rapid appraisal surveys, rapid audience assessment, tracking use of material, media coverage etc II. Qualitative methods through focused group discussions, community groups and key informant interviews, direct observations, mystery clients etc that will further elucidate demand side issues.
Objective 4: Data Management and Surveillance	
Objective of the HSS grant (as per the HSS proposal or PSR)	To strengthen the health management information system and the integrated surveillance systems for enhanced prevention, detection, diagnosis and control of diseases, with improved data quality for decision making
Priority geographies / population groups or constraints to C&E addressed by the objective	• Weak data collection, reporting, suboptimal data quality, data use and data falsification; • RI data not linked with SCL and other key immunization data sources • Inaccurate population figures for data analysis and use • Harmonization of case-based surveillance and laboratory data • Delays in confirmatory testing due to limited laboratory capacity and frequent reagents stock outs
% activities conducted / budget utilisation	Not applicable as the country is unable to estimate the denominator for this computation. Funds used for under-listed activities were reprogrammed from left-over funds of the 2013 HSS and funds returned by the FGON to Gavi following the Gavi audit. Funds from the HSS proposal covering 2019-2023 are not yet available for activities in this section due to delays in budget negotiation.

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	• Support printing of data tools • support scale up of RI SMS reporting to 18 NERICC priority states • Conduct of 7 rounds of quarterly PAPA LQAS since Q1, 2018 • Conduct of quarterly OIRIS visits to 18 NERICC priority states • Conduct of intensified data quality focused supportive supervision activities in some states • HF list update on DHIS2 • Nationwide training • Evaluation of DHIS2Different data tools have been printed for 2019 and being distributed.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[23]	1. Implementation of strong accountability measures at all levels and capacity building of HWs to address behavioural aspects of data quality 2. Scale up of Real-time SMS reporting all states across the country 3. Revision of operational denominator for effective programmatic decision making by NERICC/NEOC data team in collaboration with partners and relevant agencies including the National Population Commission 4. Conduct of data validation meetings at the LGA level 5. Improve RI data collection, quality and the use of data for action 6. Harmonize RI data tools to reduce the use of excessive tools in health facilities 7. Printing of RI data tools (VM tools, Child health cards, RI Job Aids, immunization registers, tally sheets, NHMIS summary, Community data tools), 8. Conduct monthly review meetings at state and LGA levels to discuss routine immunization data quality issues and use available data for action 9. Conduct of Surveys to assess programme performance and quality of administrative data (SMART, MICS and NICS) 10. Conduct supportive supervision to LGAs and Health Facilities to address data quality issues 11. Develop capacity of frontline health care workers to collect accurate information 12. Conduct Data Quality Self Assessments 13. Build capacity of EPI managers on data triangulation, enhancing their ability to spot data manipulation 14. Engage in Directly observed data entry in poor performing locations 15. Operationalization of the DQIP 16. Conduct of operations research on improving immunization uptake and understanding the dynamics of data quality 17. Conduct population estimate studies / assessments to address denominator issues 18. Conduct walk-through households' enumeration, 19. GIS Population estimates 20. conduct validation of already conducted household enumeration 21. Continuous triangulation of the data to derive best denominator for immunization program

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	22. Introduce electronic data transmission and immunization registry to capture individual immunization record 23. Purchase mobile devices for 28,000 plus facilities 24. Deploy mobile reporting Apps to 28,000 RI Health Facilities across the country 25. Deploy an app for reporting data using SMS in 14,000 Health Facilities 26. Deploy electronic vaccine registry in all 28,000 Health Facilities 27. Expansion of network of laboratories for measles and rubella to include South-east & South -south zones and strengthen laboratory management towards WHO accreditation of the network of laboratories including NCDC National Reference Laboratory and increase laboratory capacity and reduce reagent stock out rate. 28. Purchase of ELISA washer, reader, incubator for 2 additional network labs 29. RT-PCR equipment for NCDC National Reference laboratory 30. Procurement of Measles and rubella test kits 31. Purchase of Consumables and other supplies for serology and molecular diagnostics laboratory for Measles and Rubella 32. Train DSNO and HCWs on specimen collection, packaging, and management 33. Conduct nationwide intra-state and inter-sate specimen transport workshop and cascading trainings to community level 34. Build capacity for data management among network of public health laboratories, in order to integrate laboratory data with surveillance data 35. Train community informants and LGA Disease Surveillance Notification Officers (DSNOs) for VPDs case base and AEFI outbreak investigation and response 36. Conduct nationwide workshop on surveillance and laboratory data harmonization and case classification for Measles and yellow fever and cascading trainings to community levels 37. Establish TWG for yellow fever, Measles and Rubella 38. Carry out nationwide workshop on data management, cleaning, case investigation, and summary/presentation of data 39. Conduct IT training at NRL and network of laboratories for diagnostic information management system 40. Carry out workshop and implementation training & ability of NCDC/NRL to have diagnostic data from network of laboratories
Objective 5: Human Resources for Health	
Objective of the HSS grant (as per the HSS proposal or PSR)	To improve capacity and optimize distribution of frontline health workers and EPI managers for RI and PHC
Priority geographies / population groups or constraints to C&E addressed by the objective	Kebbi, Jigawa, Katsina, Zamfara, Gombe, Taraba and Bayelsa. These are states with low coverage and high % of unimmunized children. The selected activities will address the following challenges in the states: a. Inadequate number of staff b. Mal distribution of staff c. Improving the skill mix d. Improving skills of health workers e. High turnover of trained staff Improved Quality of care, increased service utilization and access will be achieved.
% activities conducted / budget utilisation	Not applicable as the country is unable to estimate the denominator for this computation. Funds used for under-listed activities were reprogrammed from

	left-over funds of the 2013 HSS and funds returned by the FGON to Gavi following the Gavi audit. Funds from the HSS proposal covering 2019-2023 are not yet available for activities in this section due to delays in budget negotiation.
Major activities implemented & **Review of implementation progress** including key successes & outcomes / activities not implemented or delayed / financial absorption	• Task-shifting programme of the NPHCDA (phase 1-3) • Recruitment and payment of SERICC TAs • Salary augmentation (performance bonus) for SERICC Programme Managers
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[24]	1. To get accurate number, distribution and mix of HRH for PHC of each state this will be used for planning tracking and advocacy to policy makers in the states. It will further generate evidence on HRH gap required for quality service delivery in line with Ward Minimum Health Care Package. 1.1. Identify and engage a consultant to develop, and implement a HRH assessment framework with report working with NPHCDA and partners. 1.2. Planning meetings/workshop to train field assessors on collation of HRH inventories, field assessments and field verification 1.3. HRH profiling and assessment of health training Institutions in state by trained assessors (5 days 1.4. National Dissemination meeting 1.5. Review and update pre-service training curriculum for immunization and other PHC services in collaborations with regulatory bodies 2. Advocacy to policy makers for recruitment of more qualified health workers, better pay and incentives (e.g. rural posting allowance) 2.1. Leverage on existing forums (Nigeria Governors Forum-NGF, Honourable Commissioners for Health, Executive Secretaries of State PHCBs, Nigeria Governors Wives, National Council on Health) 2.2. Development of Advocacy kit for HRH 2.3. Development of framework to guide states for deployment and incentivizing of PHC Workers 2.4. Routine Update on National HRH Profiling (bi- annual) 3. Innovative cost-effective approaches for capacity building of health workers (e.g. CRISP strategy, teach to reach, etc.) 3.1. Development of Program Curriculum to support Capacity building of States and LGAs implementing the CRISP Strategy 3.2. Capacity building 7 priority states for Training of CHIPS Personnel (CHIPS Agents & CEFP)

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	3.3. Conduct Middle Level Management Training on Immunization for SIOs and LIOs 3.4. Training of Health Workers on IMCI plus REW including follow up after training workers 3.5. Training of Health Workers on Basic Guides on Immunization 3.6. Training of tutors of Health Training Institutions on current issues in line with updated curriculum 3.7. Development of audio-visual training resources for addressing identified skill gaps 4. Phased need base implementation of task shifting/sharing policy by state 4.1. Support State to adapt task shifting/ sharing policy and hold meetings with professional groups on the task shifting policy 4.2. Capacity building on AEFI surveillance for health workers 5. Improve Health Workers performance through performance management mechanism 5.1. Engage TA to develop performance management framework and tools in collaboration with stakeholders 5.2. TA to develop HRH pathways for volunteers, casual workers **5.3.** Orientation of old and new staff on job descriptions and performance management **5.4.** Establish mechanism for continuous assessment of staff performance gap and corrective learning, as well as a functional and sustainable reward and sanction system as a means of incentivizing performance
Objective 6: Supply Chain	
Objective of the HSS grant (as per the HSS proposal or PSR)	To ensure availability of 100% bundled vaccines and other PHC commodities of the right quality and quantity at the right time at the last mile (service delivery point).
Priority geographies / population groups or constraints to C&E addressed by the objective	• Human resources deficit in terms of number and required skill sets to manage the supply chain • Lack of pre-service training in tertiary institution curriculum leading to suboptimal vaccine management • Inadequate storage capacity at the point of service delivery • Lack of visibility on stock availability and consumption at the last mile • Additional vaccine requirements due to increased demand generation activities are not communicated timely to the DL&HC • Excessively high vaccine wastage exacerbated by lack of clarity on wastage drivers across state/LGA/HF levels • Lack of state ownership of the EVM Improvement Plans, vaccine accountability and maintenance of CCE leading to weak implementation • Dependence of vaccine distribution to the last mile on out-of-pocket expenses of health care workers
% activities conducted / budget utilisation	100% of the $27 million released from the HSS funds (2019-2023) for CCE procurement has been utilized.
Major activities implemented &	• Physical Vaccine Stock Count • CCE inventory assessment • State Engagement on vaccine management and accountability

Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	State specific forecast 2018 and 2019 • Approval of the Application • Facility Readiness Assessment of the ODP • Establishment and inauguration of the PMT for CCEOP implementation • Procurement of CCE as part of CCEOP phase 1 (from HSS 2019-2023) • Follow the Vaccines • Wastage Rate Study
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[25]	- Conduct 2020 supervisory EVMA to assess status of implementation of the continuous Improvement Plan for 2017 EVMA - Leverage the EVM2.0 on boarding to conduct targeted assessment and utilize it monitor progress of cIP implementation - Conduct a Rapid HR Needs assessment and Training Needs assessment on the workforce gaps across all supply chain levels - Develop, print and disseminate clear Job descriptions/Schedules for all levels of the supply chain - Conduct regular training for SC managers and healthcare workers including online and international trainings - Conduct regular supportive supervision and provide on-the-Job mentoring during supportive supervision including annual supervisory EVMA - Strengthen the national information system in a holistic manner by improving the following areas; **Environment:** - Reviewing and updating the stock data policy - Developing a process to assess, track and ensure data integrity as part of the supervisory visit - Implement maturity model to track progress - Review and update the supply chain indicators, data tools and analytics processes **Technical Capacity:** - Strengthen the capacity to perform supply data analytics - Implement a supply chain and demand management process to identify stock risky situations proactively - **Enablers:** minor changes to NISCmis - Identify the technical requirements for the eLMIS to comply with newly defined user-requirements - Develop plan to transition management of the eLMIS to NPHCDA

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	- Identify the best last mile LMIS technology solution for the country linked to other efforts outside of immunization (e.g. NSCIP) - Carry out wastage rate study - Train EPI managers and Health Care Workers (HCWs) on vaccines accountability (including analytics and use of data for action) and management frameworks, , with follow up systesm of mentoring/support provided that connects vaccine accountability, excess wastage data, RI coverage of vaccinated for age (LQAS/survey) - Monitor utilization of last mile LMIS solution - Deploy appropriate last mile LMIS technology solution for the country - Maintenance and hosting of LMIS technology - Introduce barcode technology - Print and supply adequate data management tools - Monitor utilization of last mile LMIS solution - System design changes are being implemented in process and infrastructural areas: ***Infrastructure:*** The vaccine distribution system is being re-designed at both the National and Service Delivery levels. At the National level, Storage capacity expansion is being implemented along the line of construction of three (3) Megastores to serve as Hubs for Storage and distribution of vaccines to the states. The Hubs will be in Abuja, Kano and Lagos. Activities planned for the first two years of the HSS are: - Acquire land for construction of Hub in Abuja - Construct and equip Lagos, Abuja and Kano Hubs At the service delivery level, the country plans to have at least one functional CCE in each ward, with enough capacity to cater for immunization activities in the ward. The application on the CCEOP is aimed at bridging current existing gaps in the wards and providing for replacement of obsolete or soon to be obsolete CCE. *Process:* At the National level, the three Hubs will distribute vaccines directly to the States (each covering States in two zones). The zonal stores will thus be eliminated as a node in the distribution line. A system for direct delivery of vaccines from the State cold stores to the Health Facilities that have CCE is being instituted. Deliveries will be made to identified Health Facilities that have functional cold chain equipment. Facilities without CC will draw their supplies from the nearest facilities with functional CCE. Activities in this area in the next two years include: - Conduct additional analysis to inform implementation of end-to-end system design vision including bundling the cost of distribution with vaccine procurement - Develop an implementation plan based on the above analysis aligned with construction of the 3 hubs and CCEOP implementation Gradually scaling up the direct delivery system from the current seven implementing states to cover all the States - Operationalise 3 Hubs - Complete procurement and deployment of CCEOP equipment

	- Continue to monitor and supervise stock management

- The penta3 coverage baseline was 33% in 2016/2017 MICS/NICS, though there was no MICS/NICS in 2018, but the SMART Survey conducted in 2018 was 57% coverage for Penta3 and NDHS was 50% in the same year.
- Though there was no active HSS in 2018, however there was support from partners to implement OIRIS and Gavi supported some activities in 2019 from the cash in country. The programme introduced RILQAS to assess programme performance for corrective measures. It was noted that the performance of RI has progressed in a linear line with consistent increase in the proportion of sampled children that were appropriately immunized (from 36% in Q4 2017 to 74% in Q2 in 2019). There was an improvement seen from the RI LQAS between districts in the 18 interventions states as compared to other non-intervention states.
- Gavi support in the form of HSS is not yet active, however improvements have been observed in the areas where prioritised activities are supported. It is too early to assess the financial absorption and implementation rate of the Gavi supported activities; however, this can conveniently be assessed when HSS disbursement commences.
- There was reprioritization meeting done to look at the NERICC (RI) activities, HSS workplan vis a vis the World Bank Multi-Phase Approach (MPA) funding.
- The country did not receive any performance-based funding from Gavi.
- There was some interface between the other donor for alignment and complementarity, however this needs to be strengthened beyond the period of proposal development to ensure alignment during implementation.
- BMGF and Dangote Foundation are supporting 6 states in the form of MOU, in which the state governments are funding the operational cost of the immunization program and technical assistance provided by other partners including UNICEF, WHO, USAID, CDC/AFENET and others.
- The private sector provides immunization services in urban areas, but there are challenges related to charges for services and reporting to the respective LGAs and states.

5.2. Performance of vaccine support

Vaccine-related issues which may have been highlighted for the vaccine renewals

- **Funding for distribution**: Unavailability of operational fund for appropriate distribution of bundled vaccines
- **Inadequate vaccine storage capacity**: As a result of the inadequate storage capacity at the national cold stores, shipments in-country are staggered. Additionally, vaccine arrivals are divided into shipment bits that can be reasonably managed by the available capacity in the country.
- **Weak visibility into last mile stocks**: - while the country's stock management visibility has evolved over time, the current logistics management tool (NISCmis) has not yet provided visibility in the stock management and availability at the last mile/service delivery point.
- **Stock out antigens**: there have been reports of stock out of some antigens at the LGA and health facility levels as result of in-country shortages warranted by hitches in procurement financials. There were also stock out of 2ml Auto-Disable syringes across all levels.

Wastage Study: The study has commenced with data collection completed in 329 facilities that conducted 1784 fixed and outreach sessions across the first 14 states. While field data collection is ongoing in the additional 10 states, final report of the study will be disseminated in December 2019.

New Vaccine Introduction and Switches

- Following the NGI-TAG recommendations, the 2019 new vaccine introduction plan, included the PCV Switch, Men A and MCV2 introduction into Routine immunization.

- The country switched from the use of the PCV10 2 dose vial to the PCV10 4 dose vial. The process provided an opportunity for refresher training for health workers on other aspects of routine immunization and has been concluded in all 36 states and FCT. The switch process was rescheduled due to the general elections. There was a staggered switch process as a result of varying stock levels of PCV10 2 dose vial in different states. Special arrangements were made for areas with security challenges especially as regards training schedules.
- The MenA vaccine has been introduced country wide into the routine immunization schedule with a successful launch on the 9th of August. 2019.
- The country plans to introduce Rota vaccine in 2020. The initial proposal has been updated awaiting the review of initial NGI-TAG recommendation
- The country is billed to submit a proposal for HPV introduction in 2020 for introduction in 2021.
- The country is in the process to introduce a second dose of measles vaccine in Southern States in November 2019 and in Northern States in Q1 of 2020.

NVS introductions and switches in vaccine presentation

As stated in the NSIPSS, Nigeria planned to introduce and has introduced a couple of vaccines as shown in the table 5 below:

S/N	Vaccine	Scope	2019				2020				2021
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1	Men A (RI)	Nation-wide	Starting Jan								
2	Men A (Follow-up campaign)	Nation-wide		Jun							
3	Meningitis Vaccine (ACWY)	Phased									Starting Jan
4	Rota	Phased				High		Mid		Low	
5	Measles second dose	Phased				Starting Oct					
6	HPV	Phased							Starting Sept		

Table 5: NVS introductions and switches in vaccine presentation

Campaigns/SIAs

Measles

In 2017/18 measles follow-up campaign was conducted in phases countrywide reaching 40,044,875 million children 9 – 59 months with a post campaign coverage survey of 87.5% that ranged from 72% in Borno to 97% in FCT. Only FCT, Plateau, Anambra, Ekiti and Jigawa states met the 95% target per post campaign survey results.

Yellow Fever

In 2018, the country reported a total of 18 confirmed Yellow Fever cases from 11 states. These states were Anambra, Benue, Edo, Ekiti, FCT, Katsina, Kebbi, Kogi, Nasarawa, Rivers and Zamfara. As at August 2019, the total number of confirmed Yellow fever cases reported rose to 23 from eight states and they are from Anambra, Ebonyi, Edo, Imo, Kebbi, Ondo, Osun and Sokoto States). Ebonyi and Edo States reported 7 and 9 confirmed cases respectively, which signifies the highest in 2019.

In 2018, six preventive yellow fever campaigns and five reactive campaigns were conducted, vaccinating a total of 19,088,213 and 4,913,491 respectively. In 2019, five reactive campaigns were carried out vaccinating a total of 2,357,743. See table 6 below.

State	Year	Preventive campaign	Reactive vaccination campaign	Target Population	Number Vaccinated	PCCS
BORNO	2018	2018		496,730	525,720	Not done
DELTA	2019		2019	442,697	431,074	Pending
EDO	2019		2019	506,766	434,451	Pending
Edo	2018		2018	1,444,355	1,774,192	Pending
FCT	2018	2018		2,143,967	2,251,651	96.1%
KATSINA	2018		2018	154,132	202,462	83.0%
KEBBI	2018	2018		2,571,510	2,537,684	68.7%
Kebbi	2018		2018	1,490,618	1,525,308	89.0%
NIGER	2018	2018		4,388,449	4,344,490	78.1%
Niger	2018		2018	1,118,814	1,219,507	90.0%
ONDO	2019		2019	1,401,815	1,189,553	Pending
PLATEAU	2018	2018		5,093,800	4,833,258	93.6%
SOKOTO	2018	2018		4,618,164	4,595,410	62.2%
Sokoto	2018		2018	193,961	192,021	87.0%
Benue	2019		2019	278,882	302,665	Pending

Table 6: Result Yellow fever preventive and reactive campaigns

Update of the situation analysis for measles and rubella:

Measles

In 2018, there were a total of 697 suspected measles outbreaks of which 189 were confirmed. The total number of suspected measles cases involved were 6,554 As at January to July 2019, A total of 28,302 suspected measles cases were reported from 907 LGAs in 36 States plus FCT. The proportion of LGAs that have investigated at least a measles case with blood specimen was 90% (698). The proportion of suspected measles cases for which blood sample was collected was 29% (8227). The non-measles febrile rash rate was 5.9/100,000 population and the Measles incidence was 93/1,000,000 inhabitants.

In 2019 (Jan-Jul) there were 165 confirmed Measles outbreaks from 28 states and 146 LGAs. The number of confirmed cases involved was 907. Three states (Borno, Katsina and Yobe accounted for 43% (392/907) of the total outbreak confirmed cases in 2019.

Rubella

A total of 4,652 blood samples were tested for Rubella in 2019 (Jan-Jul) and 950 (20%) were positive compared to 329 (8%) positive cases out of the 3,971 samples processed in 2018. There is currently no adequate data on Congenital Rubella Surveillance (CRS) in Nigeria hence the difficulty in assessing the burden of the disease, including the severity, mortality and economic impact. In addition, the current surveillance and public health programs in Nigeria do not address the issue of rubella. A number of small studies have documented CRS in Nigeria. These studies have identified children presenting with congenital cataract or congenital heart defects (Duke, 2015; Sadoh, 2016; Otaigbe, 2012) mainly through clinical diagnosis without laboratory confirmation. One study, with laboratory confirmation, evaluated 78 cases with congenital cataract, 40 were under 1 year of age, and 12 of those underwent antibody testing, two cases were rubella IgM positive and seven cases of rubella IgG positive (Musa,2018), the limited sample estimating 75% of cataracts are associated with CRS. This notwithstanding however, the country has reached advanced stage in preparations to for the take-off of CRS surveillance within 2019.

Polio

Nigeria has gone three years without WPV. However, there have been over 200 VDPV2s in 2018-2019. As part of increasing individual immunity and intensifying RI coverage for polio vaccines with IPV which if high enough will limit

the number of VDPV2s, GAVI provided Nigeria with 2,6million doses of IPV, which were used as fractional doses for ~12million children across 20 states.

Cholera

In addition to WASH interventions, surveillance, risk communication and case management, Cholera vaccination was introduced in 2017 for prevention and control in the country. A number of campaigns have been conducted since then using OCV with outcomes detailed in the table 7 below

State	LGA	Name	Target	Date Round 1	No of Doses Administrated	% Cov	Target	Date Round 2	No of Doses Administrated	%Cov
Borno	LGA 1a	Maiduguri Municipal Council	323,875	Nov 28 – Dec 2, 2018	369,418	114.1	359,640	March 1 – 6, 2017	369,841	102.8
Borno	LGA 2	Jere	399,367	Nov 28 – Dec 2, 2018	374,782	93.8	374,782	March 1 – 6, 2018	394,533	105.3
Borno	LGA 3	Ngala	142,640	Nov 28 – Dec 2, 2018	138,382	97.0	152,640	March 1 – 6, 2019	152,640	100.0
Borno	LGA 1b	Kal-Balge	51,680	Nov 28 – Dec 2, 2018	51,680	100.0				
Zamfara	LGA 4	Gummi	286,552	Dec 3 – 7, 2018	265,860	92.8	286,552	Feb 9 – 13, 2019	265,860	92.8
Yobe	LGA 5	Gulani	162,550	Nov 26 – Dec 1, 2018	143,000	88.0	164005	Jan 27 – 31, 2019	149980	91.4
Adamawa	LGA 6	Fufore	280,432	Feb 20 – 22 & Feb 25-26, 2019	280,331	100.0				
Adamawa	LGA 7	Michika	216,197	March 30 – April 3, 2019	197,788	91.5				
Kebbi	LGA 8	Argungu	247,402	April 1 – 5, 2019	275,297	111.3				
Yobe	LGA 9	Damaturu	88,014	March 2 – 6, 2019	88,251	100.3				
Borno	LGA 10	Bama	394,503	March 1 – 6, 2019	401,817	101.9				
	TOTALS		2,593,212		2,586,606		1,337,619		1,332,854	

Table 7: Results of oral cholera vaccination campaigns

5.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

5.4. Financial management performance

Gavi HSS grants are domiciled in two accounts with the FGoN/ NPHCDA denominated in Naira and USD
The utilisation rate for the USD account is 86.02% and that for the Naira account is 39.76%. In pursuance to the recommendations to the 2016 Audit report expenditure on these accounts depends on approvals from GAVI.

The average burn rate for the GAVI grant domiciled with UNICEF is 74.98% and 51.6% for the WHO Grants. This is because most of the funds are schedule for use in the last quarter of 2019 for planned SIAs.
The summaries of the Grant utilization for all accounts are shown in the tables below.

FGoN/NPHCDA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY-GAVI (10302-2-503315)

ANALYSIS OF GAVI FUND BALANCE IN THE TSA ACCOUNT-USD AS AT 31ST AUGUST, 2019

S/N	DESCRIPTION	TRANSACTION DATE	AMOUNT (USD)		
			INFLOW	PAYMENTS	BALANCE
	OPENING BALANCE				-
1	GAVI HSS-FBN (as transferred by commercial bank)	18/01/2018	18,329.45		18,329.45
2	GAVI HSS-UBA (as transferred by commercial bank)	18/01/2018	3,437,642.74		3,455,972.19
3	Payment (B Medical Systems with charges)	26/06/2018-19/09/2018		454,909.44	3,001,062.75
4	GAVI ISS-FBN (as transferred by commercial bank)	28/09/2018	1,422,750.07		4,423,812.82
5	Transfer to UNICEF	04/02/2019		3,700,000.00	723,812.82
6	Charges on Transaction	05/02/2019		8.00	723,804.82
7	Support for Staff to Harvard School of Public Health, Boston. USA	27/05/2019		41,784.00	682,020.82
8	Charges on Transaction	29/05/2019		48.00	**681,972.82**
	Total		**4,878,722.26**	**4,196,749.44**	
	% Utilization			***86.02***	

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY-GAVI (0020165661077)

ANALYSIS OF NPHCDA GAVI NAIRA TSA FUND BALANCE FOR THE PERIOD 1ST JANUARY 2018 TO 11TH SEPTEMBER, 2019

S/N	DESCRIPTION	TRANSACTION DATE	AMOUNT (NGN)		
			INFLOWS	PAYMENTS	BALANCE
1	**OPENING BALANCE**	01/01/2018	-	-	**45,432,692.62**
2	NEXIA AGBO ABEL & CO-60% Audit Fee	11/07/2018		7,371,944.01	38,060,748.61
3	GAVI HSS-FBN (as transferred by commercial bank)	14/08/2018	9,339,197.96		47,399,946.57
4	NEXIA AGBO ABEL & CO-Balance of 40% Audit Fee	09/11/2018		4,915,335.00	42,484,611.57
5	Remita charges on transactions	09/11/2018		210.00	42,484,401.57
6	Balance mopped up from FMoH	05/04/2019	216,128,096.28		258,612,497.85
7	TA's Salary (April 2019)	30/04/2019		3,700,000.00	254,912,497.85
8	SERICC TA's Salary, April'18-March'19	31/05/2019		47,800,000.00	207,112,497.85
9	Remita charges on transactions	31/05/2019		5,040.00	207,107,457.85
10	TA's Salary (May 2019)	14/06/2019		3,000,000.00	204,107,457.85
11	TA's Salary (June 2019)	10/07/2019		3,700,000.00	200,407,457.85
12	SERICC PMs AND DPMs FOR GAVI SUPPORTED STATES. Q3 2017-Q1 2019	24/07/2019		15,415,000.00	184,992,457.85
13	TA's Salary (July 2019)	31/07/2019		3,700,000.00	181,292,457.85
14	TA's Salary (July 2019)	11/09/2019		2,900,000.00	178,392,457.85
15	Q2-Q4 2018 Pay Bonus Arrears to GAVI funded SERICC Tas	11/09/2019		15,970,000.00	162,422,457.85
			225,467,294.24	**89,607,529.01**	
	% Utilisation			*39.74*	

UNICEF financial utilization analysis report summary on Gavi funds

S/n	Area of support	Grant number	Valid to date	Total Funds Received ($)	Total Amount Expended (30Aug2019	Balance as at 30Aug 2019 ($)	% Utilisation	Remarks…
1	HSS/ISS	SC140635	31/12/2019	15,771,115.13	15,728,511.77	42,603.36	99.73	2018 Cold Chain Inventory & Assessment (CCIA)
	Sub-Total (HSS/ISS)			**15,771,115.13**	**15,728,511.77**	**42,603.36**	**99.73**	
2	IPV-VIG	SC150090	31/12/2019	5,569,473.33	5,540,511.01	28,962.32	99.48	RI Data Tool (tied up and not enough)
	Sub-Total (IPV-VIG)			**5,569,473.33**	**5,540,511.01**	**28,962.32**	**99.48**	
3	MenA	SC140784	31/12/2019	5,944,788.57	5,761,037.87	183,750.70	96.91	Men A Campaign
4		SC110540	31/12/2019	6,558,225.89	6,251,118.39	307,107.50	95.32	Men A Campaign
5		SI090020	31/12/2019	556,758.00	532,177.93	24,580.07	95.59	Men A - C4D
	Sub-Total (Men A)			**13,059,772.46**	**12,544,334.19**	**515,438.27**	**96.05**	
6		SC150606	31/12/2019	6,487,444.76	6,221,562.21	265,882.55	95.90	Implementation of Measles Supplementary Vaccination
7		SC130571	31/12/2019	6,541,513.71	6,507,947.25	33,566.46	99.49	Measles TCA - Consultants; Follow the Vaccines Assessment (FtVA)
89		SC170402	30/06/2019	50,000.00	49,785.89	214.11	99.57	Measles TCA - Consultants
10	Measles	SC180480	30/05/2020	142,219.44	-	142,219.44	-	Measles SIA
	Sub-Total (Measles)			**13,221,177.91**	**12,779,295.35**	**441,882.56**	**96.66**	
11		SC180061	31/12/2019	1,080,617.59	151,761.85	928,855.74	14.04	Contribution to 500cbm WICR for Abuja Hub; 4 Foster WICRs 9 Inciner8 incinerators
12	Yellow Fever	SC180792		4,076,289.52	3,355,214.66	721,074.86	82.31	2020 Vaccines and Devices Forecast; State Engagements and …
	Sub-Total (Yellow Fever)			**5,156,907.11**	**3,506,976.51**	**1,649,930.60**	**68.01**	
13	TCA	SC180268	30/06/2019	867,649.00	855,608.77	12,040.23	98.61	TCA -
	Sub-Total (TCA)			**867,649.00**	**855,608.77**	**12,040.23**	**98.61**	
14	PCV Switch	SC181058	18/11/2019	506,052.38	501,587.40	4,464.98	99.12	PCV Switch (Communication)
	Sub-Total (PCV Sitch)			**506,052.38**	**501,587.40**	**4,464.98**	**99.12**	
	Sub Total Previous Grants			**54,152,147.32**	**51,456,825.00**	**2,695,322.32**	**95.02**	
	2019 Gavi Grants - UNICEF							
15		SC190063	15/01/2020	7,915,507.62	6,623.54	7,908,884.08	0.08	Men A catch-up campaign (Logistics etc); NERICC WorkPlan and Data Tools
16	Men A campaign & RI	SC190179	4/3/2020	1,170,014.29	375,227.24	794,787.05	32.07	Support the introduction of MenA Vaccine into RI
	Sub-Total (Men A)			**9,085,521.91**	**381,850.78**	**8,703,671.13**	**4.20**	
17	TCA	SC190114	30/6/2020	2,011,657.13	1,052,749.63	958,907.50	52.33	GAVI's Partners' Engagement Framework (PEF) 2019-2020 TCA
	Sub-Total (TCA)			**2,011,657.13**	**1,052,749.63**	**958,907.50**	**52.33**	
18	Yellow Fever Campaign	SC190329	20.05.2020	3,819,240.35	247,968.60	3,571,271.75	6.49	Campaign will be conducted Q4 2019
	Sub-Total (Yellow Fever)			**3,819,240.35**	**247,968.60**	**3,571,271.75**	**6.49**	
19	Measles Second Dose	SC190330	20.05.2020	784,516.19	12,879.19	771,637.00	1.64	Put on hold by Gavi
20	Measles SIAs	Sc190331	20.05.2020	1,017,974.76	140,028.59	877,946.17	13.76	Campaign will be conducted Q4 2019
21	Measles OBR (MRI)	SC190107	31.12.2020	220,243.00	8,722.00	211,521.00	3.96	Fund from MRI: Measles OBR in Borno, Reactive campaign conducted awaiting change of funding source
	Sub-Total (Measles)			**2,022,733.95**	**161,629.78**	**1,861,104.17**	**7.99**	
	Sub Total 2019 Grants			**16,939,153.34**	**1,844,198.79**	**15,094,954.55**	**10.89**	
	GRAND TOTAL			**71,091,300.66**	**53,301,023.79**	**17,790,276.87**	**74.98**	

Gavi Funds – WHO

		WHO financial utilization analysis report summary on Gavi funds					
S/N	**Award Number**	**Activity**	**Expiry date**	**Allocated Amount**	**Amount disbursed/ Encumbered**	**Balance**	**utilization rate**
	2018/19						
	MenA						
1	58513	Men A Campaign/IDSR training	31-Dec-18	1,179,481	1,179,481	-	
2	68735	MenAfriVac Vaccination Catch Up (NERICC support)	31-Dec-19	2,100,000	955,958	1,144,042	
3	68736	MenAfriVac (MenA) Vaccine - New Vaccine introduction	30-Jun-20	3,835,699	3,263,021	572,678	
4	68649	Men A Campaign	30-Jun-20	7,698,307	2,059,153	5,639,154	
				14,813,487	**7,457,613**	**7,355,874**	**50.3%**
	TCA						
		Gavi TCA 2018/19	30-Jun-19	1,297,000	1,296,998	2	**100.0%**
		Gavi TCA 2019/2020	30-Jun-20	1,010,343	51,321	959,022	**5.1%**
				2,307,343	**1,348,319**	**959,024**	**58.4%**
	Yellow Fever						
7	68060	Yellow Fever Campaign	31-Aug-20	4,125,143	3,510,919	614,224	
8	68950	Yellow fever ops costs 2019	31-Mar-20	4,585,441	538,031	4,047,410	
				8,710,584	**4,048,950**	**4,661,634**	**46.5%**
	Switch						
9	68168	PCV Swtitch	31-Aug-20	1,186,848	1,051,600	135,248	
				1,186,848	**1,051,600**	**135,248**	**88.6%**
	Measles						
10	68954	Measles follow-up campaign ops costs 2019	15-Mar-20	8,441,632	965,997	7,475,635	
11	68953	MCV2 VIG 2019 and 2020	31-Mar-20	3,169,786	380,480	2,789,306	
12	66460	Meases SIA/Surveillance	31-Mar-20	10,347,671	9,996,193	351,478	
				21,959,089	**11,342,670**	**10,616,419**	**51.7%**
		Total		**48,977,350**	**25,249,152**	**23,728,199**	**51.6%**

Gavi Funds – CDC

CDC financial utilization analysis report summary on Gavi funds						
SN	Activity	Expiry Date	Allocated Amount	Amount Disbursed	Balance	Utilization Rate
1	Supported the planned introduction of MCV2 rollout in Nigeria. This activity is ongoing in alignment with the country's schedule for the MCV2 rollout	June 2018-September 2019	$327,000.00	$ 242,265.83	$ 84,734.17	74%
2	Deployed CDC staff to provide technical assistance for 30 days each to ensure high quality preparation, implementation and monitoring for measles follow up SIA conducted in November 2018	June 2018-September 2019	$ 26,160.00	$ 26,160.00	$ -	100%
3	Increased training, mentoring, and supervision of SMS texting for RI and supported a portion (10-15%) of the SMS project	June 2018-September 2019	$109,000.00	$ 109,001.88	$ (1.88)	100%

	that included collecting real time RI data					
4	Supported the establishment of surveillance of congenital rubella syndrome (CRS) in Nigeria by supporting the development of a national surveillance protocol and the establishment of sentinel sites in NIgeria where data on cases can be collected and the burden of the disease can be identified. The Government postponed the rollout due to competing priorities. The activity will re-commence fully in October 2019	June 2018-September 2019	$ 65,400.00	$ 23,665.07	$ 41,734.93	36%

5.5. Transition plan monitoring (applicable if country is in accelerated transition phase)

Based on the KPMG report, the NPHCDA commenced the system redesign towards strengthening the finance and accounts, procurement, and internal audit processes. This includes the redefinition of tasks, processes and procedures for greater transparency and accountability in financial resource management.

However, the key components of the entire system reform is the implementation of an integrated financial management software that will link budget and planning, procurement, inventory management, financial reporting, and internal audits. This component is yet to be actualized owing to low government budgetary allocation. Considerations for such a system will be based on global best practices and cost.

Following a rebasing of the Nigerian economy in 2014, the country entered into an accelerated transition phase, with a planned graduation in 2021 from Gavi support. However, due to the fluctuations in the Nigeria economy and low immunization outcomes (Penta 3 coverage of 33% in the 2016/2017 MICS/NICS), Nigeria in close collaboration with other government stakeholders, donors and partners developed the Nigeria Strategy for Immunization and PHC System Strengthening (NSIPSS) in 2018, a 10-years strategy (2018-2028) in a bid to request for an extension of Gavi transition timelines to 2028.
The Gavi board and the Federal Government of Nigeria jointly approved the NSIPSS, thus extending the Gavi transition timeline till 2028, and committed $1.03 billion and $1.9 billion respectively to support vaccine financing and health system strengthening from 2018 to 2028. After the approval of the NSIPSS, the country applied for, and secured approval for the following proposals:

- Health System Strengthening (HSS) Cash support for National and 8 Gavi-focus states
- Cold Chain Equipment Optimization Platform (CCEOP)
- Measles second dose introduction
- Measles SIA
- Yellow Fever SIA

Implementation progress of planned activities and bottlenecks

Rate of execution of due activities outlined in the NSIPSS has been slow, due to delays in the availability of HSS funds for the activities. The country is in the process of finalizing budget negotiations for the non-CCE areas of the HSS and expects to commence full-scale implementation of transition activities once funds are available. Despite this challenge, the country has been able to leverage left-over funds from 2013 Gavi HSS as well as funds from other donors and partners (BMGF, US-CDC, WHO, UNICEF) to fund critical immunization activities to drive improvements

in the immunization programme. However, the country has made significant progress in improving amount of funds available from the government budgetary sources for vaccines procurement. In 2019 budget, for the first time ever, over 40% of counterpart funds for co-financed vaccines were included in the federal budget through the Service Wide Votes, with a high probability of 100% funds release. Regarding the CCEOP, the country has commenced deployment of CCE as part of the CCEOP phase 1 operational deployment plan.

Implementation of other approved proposals (Measles second dose introduction, Measles SIA and YF SIA) has not commenced, but we are on track to successfully implement them as planned. Gavi funds have been disbursed and are available for these activities, though the country is facing some challenges with timely availability of government counterpart funds.

Adherence to deadlines and the transition plan

There has not been any significant change to Gavi approved transition plan. However, there have been some modifications made to the timelines for introduction of new vaccines: MenA introduction was planned for Q4 2018 but was introduced in Q3 2019. Also, the introduction of Rota vaccine which was planned for 2019 has now been moved to 2020. There is also a high likelihood that the country may not adhere to the HPV introduction timeline of 2020.

5.6. Technical Assistance (TA) (progress on ongoing TCA plan)

The delivery of Technical Assistant to improve coverage and equity are spread at National and Sub-national levels and involves both core and expanded partners. TA needs are provided by Government and assigned to core partners based on core competences. Expanded partners are also engaged on merits for other priority request by the NPHCDA.

WHO

Progress on Milestones:

All key milestones were met as per the TCA plan for 2018/19

Leadership Coordination and Management

- Supported the leadership, coordination and management of the immunisation programme in the country through high level engagements, advise, and advocacy for priority at the higher levels (ICC, Presidential Task Force on Immunisation, Core Group, Steering Committee, NERICC, NTCC and NLWG)

Improvement in Coverage and Equity

- Technical support was provided to develop and implement coverage and equity plans that contributed in the observed increase in LGAs with acceptable RI-LQAS results, from 21 in Q1 2018 to 172 in Q2 2019.
- Monitoring technical performance of SERICCs in line with the key indicators of the OIRIS approach.
- Supported the technical elements for MCV, fractional IPV the engagement of 105 low performing LGAs in 2018 and 43 low performing states resulting in at least 20% increase in the number of LGAs from both engagements that recorded acceptable score for quality of RI in Q1 and Q2 2019.
- Completed the Phase 2 training for 18 state teams; 372 LGA teams; 12000 RI providers.
- Supported the development of applications for Measles, Meningitis, Yellow Fever, Measles Second Dose and CCEOP.
- Leveraging on polio resources, technical support was provided to state and LGAs (where applicable) to improve and monitor the implementation of coverage improvement plans. The support is prioritised for the 18 low performing states
-

Data Improvement

- Provided technical guidance for the conduct of RI-LQAS to monitor quality of routine immunisation in the 18 low performing states.
- Provided guidance for the update of the DQIP and development of the SMS reporting proposal.
- Monitoring risk of VPDs through surveillance and providing technical guidance in responding to outbreaks (measles, yellow fever, meningitis and cholera)
- Provided regular guidance on development of technical guidelines for the introduction of MenA and switch from PCV10-2 dose to 4dose vail, as well as facilitating trainings at all levels. Developed protocols for the conduct of NICS
- Supported the review and development of technical elements for the SMS proposal
- Conducted stakeholders' meetings on developing the action plan for the implementation of the DHIS2 assessment.
- .

New Vaccine Introduction

- Shared technical positions and references to guide the deliberations and decisions of the NGI-TAG in respect of proposed recommendations for MSD, fractional IPV and HPV.

Provided regular guidance on development of technical guidelines for the introduction of MenA and switch from PCV10-4dose vail, as well as facilitating trainings at all levels VPD and AEFI Surveillance

- Provided technical guidance for the update of the AEFI and IDSR guidelines.
- Strengthened the capacity for AEFI surveillance through training of the National Expect Committee on AEFI on Causality Analysis and 102 State level officers from all states in the South- South, South East and Norther Central zones.

SIAs

- Provided technical support in the development plans for the implementation of coverage improvement plans. The support is prioritised for the 18 low performing states. SIAs including development of guidelines
- Conducted post campaigns survey for outbreaks and SIAs
- Guide the submission of ICG proposals for Yellow Fever outbreaks
- Support coordination and planning for Oral Cholera Vaccination.

Vaccines, Supplies and Logistics

- Supported forecasting of vaccines
- Development of CCEOP
- Development of the DIP for the CCEOP
- Supported design and review of the outcome of the physical count exercise

Progress of TCA 2019/2020

- All TAs at national level are on-board
- The selection of 8 TAs for the 8 Gavi Focus states is expected to be completed by October 2019
- The implementation of the WINS workshop for two states is planned in Q1 2020.

Challenges in implementing the TCA plan:

- Intermittent interruptions of implementation of activities based on multiple external review process required from the NPCHDA by Gavi.
- Fragmented coordination platforms on technical issues.

Existing TCAs that should be maintained

- Existing TCA supporting leadership, management and coordination, supporting development and monitoring of quality operational plans for improvement of coverage and equity; supporting functionality of national advisory and expert groups (NGI-TAG, NEC-AEFI etc), Data Systems design, analysis, and feedback (PAPA, RISS, SMS, MICS/NICS); Implementation of DQIP. In addition, monitoring quality of VPD Surveillance as well as strengthening IDSR systems; Support development of plans for the conduct of high quality SIAs (measles, yellow fever, meningitis)
- Strengthening technical capacities of states through 8 SERICCs with the provision of support for the development of state specific improvement plans, monitoring performance and development quality improvement interventions.

Proposed new TCA:

- Technical Assistants for the implementation and monitoring of EVMA and iSC recommendations at National (NLWG) and one each for the 8 priority states
- Funds for implementation of 2019/20 activities outlined in the iSC Road map e.g. supportive supervision to all levels, EVM 2.0 Onboarding, Targeted EVMA, development of cIPs, NLWG end of year review meeting.
- TA to conduct EPI Capacity Needs Assessment
- TA to conduct Workload Indicator of Staffing Needs (WISN)

UNICEF

UNICEF is providing technical support to NPHCDA at national as well as subnational level in immunization system strengthening, new vaccines introduction and supplemental immunization activities and specifically:

- Advocacy, communication and social mobilization (ACSM)
- Immunization supply chain for routine immunization

Most of the 2018 TCA milestones have been completed and the 2019 milestones are on track.

UNICEF is providing technical support in the following areas:

- **LMC**
- In leadership, coordination and management at national and state level through NERICC and SERICC as well as in the communication and national logistics working groups.

- **Service delivery:**
- UNICEF continued to support activities at national and subnational levels, targeting the low performing LGAs.
- Financially supported the 2019 Q2 Engagement of Lowest Performing LGAs (as identified using the most recent LQAS) where status was reviewed and LGAs were supported to develop/re-adjust their RI micro plans to address current issues.
- At the subnational level, UNICEF provided both technical and financial support for planning & implementation of outreach services in 63 Hard to reach & Riverrine wards in 13 LGAs of Lagos State.
- Supported implementation of recommended routine immunisation activities which includes Routine Immunization Intensified Supportive Supervision (RISS) "Operation Rubdugu" in 12 low Performing LGAs of Katsina State identified from the 2018 Q4 RI-LQAS result
- Supported integrated MNCH outreaches across 628 marginalized communities of Faskari and Kankara LGAs of Katsina State reaching 5,562 children with Penta 3 and 4,420 with Measles vaccinations.
- UNICEF supported RI expansion to partially accessible LGAs of Borno and Yobe State in collaboration with the military.

- **Demand generation/Advocacy communication and social mobilization (ACSM)**
    - Supporting in the rolling out of the communication strategy and currently 10 states have rolled out the strategy.
    - Community Engagement Consultants hired and supporting community mobilization activities as well as SERRIC's in six States (Kano, Katsna, Niger, Sokoto, Bauchi, Borno and Kaduna) to improve RI indices.

- Capacity building of RI and other health service providers on effective inter-personal communication (IPC) and delivery of key messages.
- In collaboration with NPHCDA and other partner in communication supported the development and implementation of communication strategies to the SIAs and in response to outbreaks (measles, Meningitis and yellow fever).
- UNICEF recruited one consultant per state (37) to support the new vaccines introduction and SIAs in 2019.

- **Immunization supply chain**
- Recruitment of a technical National Officers to support the CCEOP PMT Secretariat – in progress, the cadre is expected to be on board by November 2019
- Recruitment of Zonal VSL Consultant (State Supervisor) for South-south Zonal Cold Store in progress and will be on board by October 2019.
- Cold Chain Logistics Consultants for 6 Geo-political zones – recruitment with Unicef is in progress and will be completed by November 2019
- Recruitment of the CCEOP Specialist to support NPHCDA with the implementation of the CCEOP is in progress and the cadre will be on board by October 2019.
- Provided a TCA for the implementation of the 2019 physical stock count of immunization supplies, state engagement and state forecast for 2020, and these activities were successfully implemented.
- Recruited a consultant who supported the implementation of the ODP development plan necessary for CCE deployment.

- **SIAs**
  - Supporting the GoN in implementing recommended Td SIAs
  - Supported GoN in conducting a risk assessment for the northern states which identified 136 high risk LGAs across 16 northern states.
  - UNICEF is also mobilizing funds for the conduct of recommended 3 rounds of Td SIAs in these LGAs
  - In collaboration with NPHCDA and other partner in communication also supported the development and implementation of communication strategies to the SIAs and in response to outbreaks (measles, Meningitis and yellow fever).

Challenges

- Delayed in implementation of some planned activities because of competing priorities.
- Priorities changed at national and/or state level and activities delayed or cancelled.

Current TCA to continue:

- Support the national and state level in strengthening the NERICC and SERICC efforts.
- Support the implementation of the communication strategy in the states already rolled out as well as in the remaining states.
- Support the 8 Gavi supported states in developing the proposal and implementation and continuous monitoring.
- Communication support in the non-polio SIAs as well as outbreak response activities.

The NLWG will require technical assistance in the coming year on 3 priorities;

- Consultant for finalization of iSC Road map.
- Consultant for development of SOP for long term PPM.
- Funds for implementation of 2019/20 activities outlined in the iSC Road map e.g. VMT, data war room for the establishment of the NISCmis and capacity building of the data team, the annual physical stock count in preparation for the forecast and outcome from the wastage rate study.

World Bank

Support provided through TCA 2018/2019

- Coordinated advocacy on investing in health

- The World Bank team with support from other partners, organized a retreat for chairpersons and vice chairpersons of health-related committees of the Ninth Legislative Assembly. The program which was attended by all the parliamentarians and the two Ministers of health, agreed on priority health legislative items; committed to upholding govt commitments under Gavi principles of engagement and accountability framework, and resolved to prioritize health in appropriations in the next four cycles.
- Partnered with ThisDay Newspaper to engage in policy dialogue to increase financing for primary healthcare and immunization
- Provided a technical brief to the chair, senate health committee to participate in high-level panel discussion on immunization in fragile states in Kigali Rwanda/March 2019
- Developed and disseminated lessons from BHCPF as a tool for increased funding of primary healthcare through the MDTF newsletter - an avenue to reach a wider range of policy makers and development practitioners.

- Support to strengthening the linkage between policy, planning and the budget.
- The World Bank team provided substantial technical support to NPHCDA in developing the financing indicators of the Accountability Framework;
- Working with NPHCDA to set up the vaccine financing working group;
- Supporting the government to develop the draft annual vaccine financing plan;
- Supporting the government by working with UNICEF and NPHCDA to estimate the gap for vaccine financing (and include this as part of the new World Bank operation/MPA).
- The Bank has also worked with the government to ensure that cost requirements of Gavi transition are incorporated into government medium term planning - medium-term sector strategy (MTSS), the medium-term expenditure framework (MTEF) and the medium-term budgeting framework (MTBF).

- Additional Support provided outside the TCA
- Nigeria is ranked 152 out of 157 countries in the World Bank's human capital index. The results indicate that a child born in Nigeria will be 32 percent as productive as she could be if she enjoyed complete education and full health. To address the human capital crises, the World Bank is supporting the government of Nigeria through several work streams to improve health in general and immunization specifically towards reducing under-five mortality by half by 2030.
    - Polio support operations: Now in its 3rd additional financing, this project has supported the procurement of Polio and RI vaccines; Support to polio operations; Expansion of storage capacity at the Lagos Hub; Strengthening of logistics operations; and immunization management strengthening, including TA support at the national and sub-national levels
    - The Nigeria States Health Investment Project (NSHIP): Seeks to increase the delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities. NSHIP has shown that utilization and quality of health services (including immunization services), increase
    - The Accelerating Nutrition results in Nigeria (ANRiN): Focuses on increasing the utilization of quality, cost-effective nutrition services in 12 high burden states in the next 5years. The project targets children under 5yrs of age and their mothers and adolescents.
    - The Multiphase programmatic approach (MPA): Currently being developed, this project is a joint commitment between the Governments of Nigeria and the World Bank to drastically reduce under-five mortality in the next ten years. The first phase (2019 -2023), is focused on increasing access to immunization, maternal and childcare and malaria services. This project will fill the gap in government vaccine financing, while ensuring that the government transitions from IDA to full funding from budgetary resources by 2028.

- Proposed new TCA areas
    - Continue to provide support to vaccine financing planning, including technical support to vaccine financing group and monitoring of accountability framework indicators
    - Work with Government to develop a web-based dashboard for tracking vaccine financing
    - The World Bank will also continue to strengthen the budgeting and planning process.
    - Continuous engagement with the MPA team and advocacy to government to ensure.
    - Note: The World Bank received funds in June 2019 for this year. Next year's engagement is likely to focus on continuing to support and monitor progress on vaccine financing, but will also focus on building capacity for the roll-out of the Basic Health Care Provision Fund – the main mechanism that will finance immunization service delivery in the future. The specifics of the TCA support will be determined in collaboration with NPHCDA and partners in the coming months.

CDC

CDC-GAVI TCA for 2018/2019 activities: Most key milestones were met according to the TCA plan for 2018/19

- Technical Assistance
    - Increased awareness for, and supported the planned introduction of MCV2 rollout in Nigeria
    - Employed a consultant via WHO mechanism to support the development of the MCV2 introduction proposal to GAVI.
    - Deployed CDC staff to provide technical assistance for 30 days each to ensure high quality preparation, implementation and monitoring for measles follow up SIA conducted in November 2018
    - Supported a mini epi review conducted in Gombe, Jigawa and Bayelsa. Findings indicated a huge gap in demand generation and community engagement. The findings are contributing to the development of state planning activities
- Training
    - Conducted training and provided mentorship for health facility and LGA level staff by the state and national level supervisors. Corrective action in the form of retraining and mentorship has resulted in an increase in the number of fixed and outreach RI sessions conducted by health facilities
- Data
    - Utilized a portion (10-15%) of Gavi's funds to support the SMS project that included collecting real time RI data and now scaled up to 18 states
    - Supported the establishment of surveillance of congenital rubella syndrome (CRS) in Nigeria by supporting the development of a national surveillance protocol and identifying states for CRS sites for the reporting and collection of rubella data. States proposed are Lagos, Kano, Enugu and Plateau
- Challenges
    - Competing national priorities prevented the full implementation of the CRS and was delayed by a couple of months. New date for implementation is scheduled in October 2019

- Additional non-Gavi TCA and non-HSS funds:
    - LMC
- In leadership, coordination and management at national and state level through NERICC and SERICC as well as in the data, service delivery and communication-working group.
- CDC/ AFENET staff are serving as deputy PMs in some states
    - Data Management
- Provided 8% balance for roll out of SMS texting in 18 states (~$600,000). Assigned 3 full time staff to support back end and analysis for weekly SMS reporting
- Supported write up and proposal to develop app and apply for additional resources for SMS project
- DHIS officers placed in several states, and assigned ~ 10 full time DHIS staff to work with PRS and NERICC and national level to manage DHIS2 monthly data with state and LGA officers including analysis, reporting and DQUSS
- On-going one-year training/ mentoring (GEEKs) of data staff in PRS to improve health management information system at state and national level

- Financial and technical funding of PAPA-LQAs in 6 states
- Conducted DHIS2 evaluation in 12 states with dissemination and program planning by states
- Conducted micro-census for denominator in Wurno ward, Sokoto State
- Supported DQIP review and 6-month data improvement plan
    - Service Delivery:
        - Technical and financial support for REW micro plan, men A introduction, MCV2 introduction, OIRIS
    - Demand Generation:
        - Implementation and assessment of Sokoto state demand generation activities

Progress on 2019/2020 activities: Activities are ongoing

- TA provided from CDC HQ and Nigeria to support the MCV2 rollout in the South and SIA campaigns in the North, both scheduled for the fall of 2019
- Consultants and management support teams are ready for deployment once the date for MCV2 rollout and SIA campaigns are finalized
- Recruitment of data management and epidemiologist consultants to support NCDC in strengthening the national measles, rubella and yellow fever surveillance and lab network are underway
- Support for the strengthening of specimen processing and testing for meningitis disease in high risk states for epidemic response and to strengthen culture and molecular testing capacity at the national level –ongoing
- Hired 2 consultants (Kano and Katsina) to support the preparation of both states for the measles SIA in both states in preparation for the MCV2 introduction next year
- Awaiting date of MCV2 introduction and measles SIA dates in order to deploy consultants for remaining states
- Challenges:
    - Ongoing deliberations around the MCV2 rollout and SIA dates given the funding challenges the country experienced in the past months, hence there is a hold on deploying the consultants. They have been identified and awaiting deployment 6 weeks prior to start of campaign
    - Competing priorities at the state level, resulting in the dates for the SIAs being delayed

Proposed new TCA requested

- TA to support data improvement and conduct of enumeration using micro census as done for wurno ward (well favored). Will help with validating denominator data through other process due to the rigor.
- TA to improve VPD surveillance, including continued support to establish measles, rubella, yellow fever lab network
- TA to support measles SIAs at end of 2020/2021, including epidemiologic analysis, modeling and support for Gavi application
- TA to scale up Congenital Rubella Syndrome surveillance, currently being implemented in only 4-5 facilities nationwide
- TA to support assessment of CEF
- TA to build NPHCDA's capacity for strengthening data architecture and management for non-polio SIAs and vaccine introduction

Clinton Health Access Initiative (CHAI)

Supply Chain

CHAI is supporting the FGoN working with stakeholders at National and State level to conduct a vaccines wastage study the purpose of which is to ascertain the state-specific wastage rates and the potential determinants in 24 states in Nigeria. The study was phased with 14 states in Phase 1 and 10 states in Phase 2.

- The result of the assessment is expected to:
    - Provide better understanding of vial presentation for the country.
    - Support the NITAG selection of vaccines for the EPI Schedule.
    - Improve forecasting and maximize cost savings in the procurement of vaccines in the country.
    - Improve service delivery

- Reduce vaccines wastages.

- The assessment has so far been completed in the phase 1 states, while the phase 2 states is on-going and is expected to be completed by 30th October 2019. Following this, a dissemination meeting will be organised where states can share lessons learned and plan for the implementation of the study recommendations.
  .

NEW TCA Needs:

- Support the implementation of the recommendations from the result of the wastage study in the initial 24 states
- Conduct the study in the remaining 13 states
- Provide technical support to the NLWG on the implementation of the CCEOP
- Support the capacity building of HCWs on Maintenance and temperature monitoring practices.

Supplementary Immunization Activities (SIAs)

CHAI is providing Technical support to the National Technical Coordination Committee on specific data requirements which includes determining the best mechanism to be used for data collection and collation at the national level and continuously provide data evidence throughout the campaign to promote the use of data for action. CHAI has provided two technical consultants who support the data operations at the NTCC and CHAI's specific support to the NTCC has been:

2018 Yellow Fever SIA

- Provided Data support for the Yellow Fever Reactive campaign which took place in Niger, Plateau, FCT, Borno, Sokoto and Kebbi state in December 2018. Specific support was provided pre, during and post implementation through data collation, analysis, interpretation in the following:
- Tracking the readiness at National and State level through the Readiness Assessment Dashboard
- Tracking missed children using the Intra campaign Dashboard.
- Supported the redesigning of the micro plan template and processes including Analysis
- Collated and analysed daily Call-in data (Analysis of Coverage by ward, LGA, states and Vaccines used)
- Analysis of Tally sheet and End-process data, for final administrate coverage and missed clients.
- Review of Post-campaign Coverage Survey done by National Bureau of statistics
- Documentation of campaign implementation processes.

2019 Yellow Fever, Measles, Men A and MNTE SIAs

- Harmonisation of Micro plan - As part of the country's effort to transit to an integrated system and in view of the upcoming 2019 SIAs (Yellow fever, Measles, MenA, Measles second dose and MNTE)
- Harmonisation of all data tools including initial field testing/pilot of the revised tools
- Tracking the readiness at National and State level through the Readiness Assessment Dashboard for the planned four SIAs in 2019
- Customization of Call in Data Template for the planned four SIAs in 2019 for all implementing states
- Customization of the state readiness dashboard for the planed four SIAs in 2019 for all implementing states
- Extrapolation of target population
- Support the planning and implementation at state level through interface with the state liaison officers
- Training of State Data Managers from 36 States and the FCT to build capacity on data collation analysis and use. The training also introduced them to the newly integrated data tools and also to get their feedbacks on identified gaps.

NEW TCA Needs

Transition the processes of data management to State level through the continuity of the capacity building program and providing short term consultants to enhance the capacity building process.

Technical Assistance for the implementation of Financial Commitments in Nigeria's Gavi Transition Plan

CHAI has provided technical assistance to the National Government for the implementation of financial commitments laid out in the commitment letter and NSIPSS, to ensure continued availability and timely release of funds for immunization activities – specifically vaccines

CHAI was engaged to work with NPHCDA, Ministry of Finance, Budget & Planning, (MoBFP), Budget Office of the Federation and the National Assembly across 3 key areas:

i. **Forecasting & Budgeting** - Forecasting and costing of vaccines and operational costs as well as capacity building in these areas at NPHCDA/MoH
ii. **Advocacy** - Promote awareness, political ownership and buy-in from high-level stakeholders
iii. **Coordination** - Ensuring identified funding needs are reflected in FGoN budget, and provide necessary support for the timely release of funds

Key Milestones:

- Provided technical support on forecasting and budgeting for vaccines and operational costs for the 2019 Budget and for vaccines & devices for the 2020 – 2022 FGON Medium Term Expenditure Framework (MTEF)
- Provided technical support to NPHCDA towards the establishment of a Vaccines Financing Committee. Continuously provide technical and secretariat support to the committee.
- Developed a Vaccines Financing Process Map for the Vaccines Financing committee to improve visibility into the processes that cover Budget preparation, Approval and Implementation.
- Provided technical support to NPHCDA in its engagement with MoBFP and National Assembly for an increase in budgetary allocation for vaccines; to ensure FGoN fulfills vaccines financing needs including Gavi co-financing requirements, as outlined in the NSIPSS. This included the development of advocacy tools and facilitation of meetings etc.
- Supported Budget office with necessary data and tools to operationalize the Service Wide Vote for vaccines in the 2019 & 2020 FGoN Budget.
- Promoted awareness, political ownership and buy-in from high-level stakeholders for immunization financing at the Presidency, MoBFP and Budget office
- Ensured annual budgetary process for 2019 & 2020 made adequate provision for all vaccines (Gavi & traditional vaccines)
- Worked with NPHCDA and UNICEF to ensure funding requests are submitted to MoBFP in advance and worked with NPHCDA to follow up on the payment with the various MDAs, which led to the timely release of funds for vaccines in the 2019 budget.
- Ongoing support to Budget office and NPHCDA to incorporate NSIPSS into key government policies such as Nigeria's Aid Transition Plan, to aid sustainability
- Collaborated with NPHCDAs Department of Advocacy and Communications to develop an immunization financing advocacy newsletter which was disseminated to key stakeholders at the Presidency, NASS, MoBFP and Budget office.
- Provided support to VF Committee for the development of the 2020 Vaccines Financing Plan – ONGOING

Additional Support provided outside the TCA:

- Provided support towards the development of the financial components of the NSIPSS Accountability Framework and sign-off by MoBFP, MoH and Budget office
- Provided analytical support to NPHCDA in developing financials for World Bank funding for 2019 – 2023(MPA)
- Worked with NPHCDA to develop a 2019 – 2023 Vaccines Financing outlook document and Vaccines Financing tracker. This will aid visibility and tracking of Vaccines Financing,

JHU

TA support ended July 2018; all milestones met

Advocacy

Provided one full time TA support advocacy support to NERICC on the development and execution of advocacy and communications interventions and support to the states

Data quality

- Supported the development of the national Data Quality Improvement Plan
- Conducted a desk review of lessons learned from data quality improvement efforts in the country, produced a report.
- Undertook a diagnostic intervention on data quality improvement with the objectives were to describe the immunization data quality issues at different levels in different settings, determine the direct and indirect correlates of weak data quality in different settings, recommend tailored solutions:
    - The diagnostic intervention conducted in six states (one in each geopolitical zone) Kebbi, Gombe, Nasarawa, Ekiti, Delta and Imo state.
    - Result of first phase states shared with NPHCDA, state-specific reports shared with states

Challenges

Health worker strike in May 2018 affected the prospective data collection, study was unable to obtain one full month of service delivery.

Proposed new TCA areas – CSO platform coordination to improve demand generation, support of NERICC advocacy and communication team to roll out demand generation interventions.

Additional Support provided outside the TCA (2-3 Sentences): Provide TA to NERICC's advocacy and communication's team. Supported the sensitization of RI providers and traditional leaders on community engagement strategy in 14 LGAs in Kebbi state

SYDANI INITIATIVE

Sydani Initiative for International Development was engaged to provide technical support at National as well as State level on strengthening routine immunisation and strengthening the primary health care (PHC) system and promoting effective and efficient implementation of Gavi-supported activities. In addition to ongoing broader capacity-building TA to liaise between Gavi and supported government agencies (NPHCDA, NCDC), a grant monitoring officer recently commenced support on monitoring the implementation of activities under Gavi grants to support RI and PHC programmes, strengthening financial accountability and compliance with Gavi grant standards and requirements for grant management and reporting.

Progress against milestones – Not due for reporting.

Summary of Progress

- Supported the FGoN in the development of the Programme Support Rationale (PSR) and HSS budget for Gavi HSS support 2019-2023
- Supported the successful conduct of the in-country Independent Review Committee (IRC) in 2019, and also assisted in the development of country response's to IRC clarifications
- Successful finalization and endorsement of the joint Accountability Framework between Gavi and Nigeria
- Supported analysis of coverage targets and projections for the state-specific forecasting
- Successful engagement of states to kick-start the development of state specific HSS proposals
- Continued support to NPHCDA on RI and PHC system strengthening
- Support to the NCDC on development of HSS budget for Gavi support
- Continued support to the NCDC in the development of proposal for yellow fever diagnostic support
- Sustained liaison between Gavi and agencies (NPHCDA and NCDC) on Gavi-supported programmes

Challenges

- Periodic delays in implementation of planned activities due to competing government priorities
- Intermittent conflict of activities leading to delays or cancellations due to siloed planning and weak coordination across immunization activities

ICA

Activity

Support the country at national and state level on effective implementation of Gavi supported programmes including measles, yellow fever, MenA campaigns, introduction of new vaccines (MCV2 and MenA), routine immunisation and primary health care system (PHC) strengthening.

Summary on the progress in delivering technical assistance.

1. Continue supporting the implementation of Gavi's strategy of support to the GoN for strengthening immunisation and PHCs including the participation on the orientation and field work for the Gavi's MoU States.
2. Participated in strategic meetings of the National Emergency Routine Immunization Coordination Centre (NERICC) and other technical working groups such as the National NPSIAs Technical Coordinating Committee in line with the operationalization of the National Strategy for Immunization and PHC System Strategy (NSIPSS).
3. Facilitated the development of harmonised and integrated workplan detailing Gavi activities to support immunisation (measles, yellow fever, meningitis, CCEOP and routine) and the primary health care system in Nigeria.
4. Oversee all Gavi efforts for the control of measles elimination, control of yellow fever and, control of type A meningitis, implementation of the CCEOP and for routine immunisation in the country.
5. Continue serving as the liaison person between NERICC and NTCC for the linkage between routine immunisation, vaccine introduction and campaigns.
6. Continue supporting the GoN to respond effectively and efficiently to emerging vaccine preventable disease threat mainly measles in Oyo and Ogun States and the Yellow Fever Outbreak in Edo, Ebonyi and Bauchi States
7. Supported the conduct of the wastage study on behalf of Gavi and represent Gavi at related critical meetings with the National Logistics Working Group (NLWG)
8. Provided regular timely reports to Gavi Secretariat.

9. Continue providing strategic advisory support to the Director of Disease Control and Immunization when required

Highlight progress and challenges in implementing the TCA plan.

- The agency programmes are highly verticalized and the competition is at the pic between the programme managers.

CRS

- CSO support

University of Oslo

- Conducted DHIS 2 Rapid Assessment

Rocque Advisory

- Provide Gavi with a high-level initial view of funds channelling options which may be applicable to Gavi funds, and which may then be assessed in detail by the Programme Capacity Assessment (PCA).

HSCL

- Physical stock count

Conducted a physical count of doses and devices and the retrieval of expired doses in Nigeria's North-Central zone down to the health facility level.

- TA to states

Provide programmatic support and fiscal space analysis in four states for the development of state specific PSRs and programme design.

PATH

- Support the decision making for HPV national introductions in collaboration with WHO and partners

ARC

- Provide support to and facilitate the workshop phase of the Strategic Training Executive Programme (STEP) training in Lagos and Abuja

JSI

Proposed TA request

- Provide TA to support Urban Immunization Assessment, strategy development and TA to enable GoN scale up the strategy at the subnational levels in cities with high unimmunized children (Ibadan, Kaduna, FCT, Kano, Port-Harcourt, Gombe)
- TA to develop approach and guidelines on using GIS for RI microplanning building on lessons learned from Bauchi, Sokoto, kano, Kaduna
- Support the roll out and implementation of the community engagement strategy in the 8 Gavi targeted states.
- TA to improve data quality and use at state and LGA levels in targeted states

6. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

SN	Prioritised actions from previous Joint Appraisal	Current status

1	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 build trust and increase acceptance and demand for immunization services.	The Community Engagement Framework of the OIRIS is being implemented in the 10 low RI performing states to increase demand for RI. The CHIPS programme has undergone a lot of planning and is being rolled-out. Implementation of CHIPS had begun in Nasarawa State with selection of CHIPS personnel ongoing. Training and plans at State, LGA and ward levels is ongoing for roll-out in more states. One on one interface between traditional barbers, community leaders and caregivers in all 18 NERICC states to provide key messages on immunization and refer for vaccination of new-born. Interaction with the traditional leaders/Mainguwa's to record infants in name-based register in MOU states
2	Engagement of traditional rulers and other community influencers regularly to build trust and increase acceptance and demand for immunization services.	The Community Engagement Strategy is being implemented in 10 low RI performing states to increase demand for RI. The strategy involves a collaboration between health workers and traditional leaders to identify and immunize all children eligible for routine immunization in the community with the assistance of community volunteers such as traditional barbers, VCMs and TBAs. The CES is scheduled to be rolled out in the remining eight priority states between 2019 and 2020 leveraging on lessons that will be learned from states currently implementing.
3	Adequate provision made in the annual appropriation for Immunization funding. Enactment of Immunization trust fund. Timely payment of states/LGAs co financing.	• The annual FGoN appropriation for vaccine was increased from 1.8% to 28% of the total requirement in 2019. This is also expected to increase progressively to 100% by 2028 in line with the approved NSIPSS Accountability Framework. • The idea of establishing a Trust Fund for Immunisation has been overtaken by the new understanding of financing Immunisation entirely from the annual budget, as the most sustainable path to follow. At the moment, the National Health Act is the only platform that provides for 25% co-financing by State for all projects/programmes to be financed through the Basic Health Care Provision Funds (BHCPF). However, the implementation modalities for the BHCPF are still being worked out. In addition, engagements of the 8 Gavi focal states are ongoing for the implementation of the Gavi HSS Fund, in which the benefiting States will be required to make co financing payments.
4	Availability and implementation of accountability framework.	The national level NSIPSS Accountability Framework was finalized and signed by all parties in May 2019 and

		the implementation phase has since commenced. For instance, the 2020 vaccine financing plan has been developed in accordance with the tenets of the Accountability Frame. In addition the FMoF/Budget and Planning has fully embraced the AF requirement in the development of the 2020 -2022 Medium Term Expenditure Framework and the 2020 Annual Proposal.
5	• Availability of functional finance working group and active finance committee. • Full operationalization of NPHCDA's redesigned financial management processes • Clear systems established for transparent fund disbursement, retirement and audits of the financial management system at sub-national levels	• A finance working group/active finance committee that aligns both Government, Donors and Partners investments in Immunisation does not exist. However, the implementation of NSIPPS AF has given rise to the Accountability and Vaccine Financing Task Team that currently looks into mobilizing resources for vaccine procurement. • The operationalization of the NPHCDA Financial Management system/process redesign has commenced. The Finance and Accounts, Internal Audit, and Procurement functions have been redefined and all relevant staff reoriented. However, the implementation of an integrated financial management software that links planning and budgeting, finance and accounts, procurement and inventory management and internal audit system has not been achieved. But there is ongoing effort at engaging a suitable vendor to handle this aspect subject to availability of fund. The Framework for the implementation of BHCPF has embedded in it transparent processes for fund disbursement, utilization and financial reporting mechanism for the States and LGAs.
6	EVM supervisory visits to all levels. As part of the supportive supervision and to ensure that the states are on track with implementation of the state specific cIP, the country plans to conduct an annual EVM supportive supervisory visit. This activity will triangulate information from the data analysis using the EVM tool and the 2017 EVMA to determine progress. The quarterly supportive supervision visits will also be conducted, and the two activities will complement each other.	The planned EVM supervisory visit was stepped down to pave way for the introduction of EVMA 2.0 next year. Next Steps: - On-boarding of the EVM 2.0 and consequently conduct of supervisory EVM using the new tool in Q1 2020. - Monitoring the status of the cIP workplan implementation at various levels of the iSC (national, zonal & states) using targeted EVMA 2.0 assessment
7	Physical stock count. This will be done immediately before the forecast. It is meant to provide accurate data to inform procurement quantities.	The physical stock count of immunization supplies was conducted in June 2019 using independent vendors.
8	State-specific Engagement on vaccine accountability	State engagement meeting with relevant stakeholders conducted in June 2019 on findings from physical stock

	State-Specific Forecast	count, status of EVM cIP, SLWG Strengthening and other vaccine accountability issues 2020 vaccine forecast has been completed and is under review by UNICEF SD
9	Wastage rate study to determine the national wastage and to ensure state specific interventions to wastage in the system.	The wastage study has concluded with data analysis ongoing for the first 14 states. While field data collection is ongoing in the additional 10 states, final report of the study will be disseminated in December 2019.
10	Hubs: Construction of the Lagos Hub, rehabilitation/renovation of the Kano and Abuja Hubs. This is expected to increase the available national storage capacity to accommodate the new vaccines introductions coming up in 2019.	The civil works contract for Lagos Store will be awarded in September 2019 while discussions are ongoing for Gavi funding support for Abuja and Kano Hubs. National level to State level distribution is outsourced.
11	Follow the Vaccines (FtV): As part of the vaccine accountability being put on place, the FtV will be conducted. This will also provide evidence as to how bundled vaccines are managed through the system and improvement plans will be developed to address gaps identified.	The field assessment is ongoing and is expected to be completed by March 2020. Recommendations will feed into the state cIP.
12	Cold Chain Equipment Optimization Platform: Contingent on approval from Gavi, Nigeria will implement the operational deployment plan of the CCEOP. This will be a multiyear activity with the first phase expected to kick start in 2019	The CCEOP PMT has been inaugurated and is developing a detailed microplan based on the ODP submitted for the deployment of the first tranche of the CCE (2,975).
13	Strengthening of DHIS 2 reporting - Centralized coordination of data tools production - Decentralized distribution - Strengthen logistics management systems to monitor, report and track data tools	An assessment of the HMIS and DHIS2 was conducted. Following this a stakeholders meeting has reviewed the recommendations of the report and drawn up and action plan.
	Adopt a nationally agreed denominator based on immunization program performance	There is an approved operation denominator in use to monitor the program on the DHIS2 platform
14	Strengthen review mechanisms at national and sub-national levels - Increase use of process indicators at all levels for real time decision making and action. - Improve outputs and quality of review meetings	Process indicators are regularly tracked using data from OIRIS, SMS reporting, RISS checklists, RI- LQAS and feedback shared with all levels for action. There is a regular review of action points from meetings conducted at NERICC and the 18 priority states

15	Implement on – the – job capacity building for improved data management	On the job training is provided to health workers during the supportive supervision by LGAs and States, especially in the 18 priority States.
16	Polio transition plan	**A** business case document for polio transition is being developed. Once finalized, it will guide the development of a transition plan for polio
17	Adequate and available human resource for immunization and PHC	All states are at varying stage of implementation of the PHCUOR to ensure that the SPHCDAs manage the human resource for primary health care.
18	Improved immunization coverage	There is marginal improvement of immunisation coverage, evident by penta3 coverage of 50%, NDHS 2018. Coverage improvement measures were implemented through the OIRIS approach and intensifying advocacy with the states for sustained resource for the implementation of existing REW micro-plans.

	Additional significant IRC / HLRP recommendations (if applicable)	Current status
1	HSS • Refine and articulate strategies for urban slums, hard to reach, and other communities; and for involvement of private sector including CSOs/CBOs; • Develop ToRs, with input from GAVI Secretariat, for TA to be recruited under TCA • Develop chronogram for Phase 2 to ensure the timely development of State plans for IRC review	• The final PSR was updated to include strategies to reach urban slums, hard to reach settlements and involvement of the private sector. The 8 focus states are in the process of developing operational plans to address these special populations • Lead by Government ToRs for TAs were developed and agreed upon at Core Groups • Chronogram was developed; First Engagement with the 8 states conducted in August 2019; States are developing plans expected to be reviewed in 2019
2	**CCEOP** Establish Data System (ideally using DHIS2) to track implementation of CCEOP and performance of CCE using monthly 30DTR alarm data so that inventory remains live – and removes need for another inventory exercise • Consider longer supply intervals, especially for remote health facilities, to reduce logistic costs	Upon the installation of the 1st tranche of CCEOP devices, there are plans to train end-users on the use of the 30DTRs and institutionalize temperature monitoring and reporting which will be linked to the maintenance needs to optimise the CCE performance and update the cold chain inventory. The maximum storage duration for service point/facility was increased to 1.25 months in the application package (for FIC) prior to the approval. Further recommendation will be incorporated into discussions for scaling up the last mile distribution as well as LGAs' CCEOP support.

3	**YF SIA** In consultation with WHO and EYE, consider fractional dose to more rapidly protect country	The country is considering seeking guidance from NGI-TAG when re-inaugurated by the newly appointed Federal Minister of Health
4	**MEASLES** • Undertake more detailed and timely epidemiological analysis of outbreaks to guide the program, including assessment of implied vaccine efficacy; • Use MCV2 introduction to catch-up immunisation of older children; • No upper age limit for MCV (School Entry check and update); and SIAs for Northern States and Introduction of MCV2 for the Southern States	• Surveillance on measles remain optimal, and feedback is regularly provided to respond to outbreaks. IDM modelling was conducted in 2019 to access the risk of outbreaks. • Preparations for the MCV2 introduction is advanced, delayed schedule as well as intensification period have been developed to reach children 9 – 23months • This is yet to be considered in the second National Policy on Immunisation • This is being implemented as planned.
5	**MEASLES/ YF** • Joint delivery in States where both interventions are planned	An integrated planning is being rolled out in states that are implementing joint SIAs (Measles, Yellow Fever and MenA).
6	**CROSS CUTTING** • Emphasis on the need to plan and budget for mitigating activities on risks, audit and assurance; • Introduction of a country-level mechanism to monitor domestic financing committed and disbursed by the FGoN to complement the Gavi investment; and • Initiate an exercise to map all resources for HSS (WB, GFATM, BMGF and others) going to Federal, State and LGA levels indicating the complementarity of all support.	Two TAs have just been engaged by Gavi this September 2019 to support the implementation of these IRC recommendations

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 7 below).

7. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year and requested modifications to Gavi support:

Vaccine Supply and Logistics

1. Implementation of the CCEOP

2. Conduct of the EVMA2.0 and implementation of the recommendations
3. System redesign
4. Vaccine forecasting exercise
5. Vaccine Management Training
6. Finalization and implementation of the iSC roadmap
7. Strengthen the existing incineration of immunisation waste
8. Review of LMIS
9. TA to Support Development of iSC Roadmap (Year 2)
10. Eight State and 1 National iSC Technical Assistants as immunization supply chain and logistics officers at National and 8 priority States who are expected to deliver data for management, supply chain leadership-capacity building and mentorship, supportive supervision and SLWG strengthening.
11. LMIS Consultant to work on the NISCmis infrastructure (to handle where we are and the transition)

SIAs

1. Conduct of measles SIAs targeted at the most at risk states
2. Conduct of YF risk assessment and reprioritization of states. Conduct of YF SIA targeted at the most at risk states
3. Conduct MNTE in identified 136 high risk LGAs in 16 Northern States.
4. MNTE validation survey in the south-south zone
5. Implementation of MNTE sustainability plan south-western and southern eastern zone.

Service Delivery and Demand generation

1. REW microplanning using GIS (house-to-house enumeration, involvement of communities in micro-plan development)
2. OIRIS implementation and intensification of supportive supervision in low performing LGAs
3. Special interventions in security compromised areas, and in areas with high numbers of unimmunised children (conduct PIRI/RI intensification, urban slum vaccination, missed opportunities for vaccination etc.)
4. Conduct EPI capacity assessment and implement capacity building strategies to address gaps
5. Conduct qualitative and quantitative assessments (KAP survey) to develop communication strategies for immunization and PHC and evaluate the operationalization of the CEF in implementing states.
6. Expanding the implementation of the community engagement framework to other states, while ensuring robust supervision and routine collection of quality monitoring data from the states
7. Commence periodic triangulation of Community Engagement data with service delivery data for enhanced program coordination
8. Commence documentation of lessons learnt from CE implementation to aid scale-up
9. Revitalize the functionality of the state taskforce on immunization
10. Scale up the utilization of Workload Indicators of Staffing Needs (WISN) to address inadequate and mal distribution of staff.
11. Scale up of the name-based records of target population piloted in MOU states and support reconciliation of data with HF records.
12. Technical assistance needed for implementing service delivery strategies eg REW microplanning and OIRIS, capacity building and use of GIS for microplanning
13. Technical assistance needed for designing, implementing and monitoring tailored interventions to address high number of unimmunized children as well as reduce missed opportunities eg urban slum vaccination strategies, MOV strategies etc

New Vaccine Introduction

1. Submission of revised application for Rota and introduction of Rotavirus vaccine in 2020
2. Development and submission of application for HPV vaccine introduction

Data Management

1. Implement the Data Quality Improvement Plan (DQIP)
2. Conduct MICS/NICS in Q2 2020
3. Strengthen DHIS2 platform
4. Scale up SMS reporting to other states and upgrade to use of tablets instead of personal cell phones in few states with good GSM network as a pilot.
5. Conduct an operational study to identify key drivers for data falsification and design strategies to change behaviours on data falsification
6. TA Support for DHIS 2 infrastructure management
7. TA support for completion of population estimate studies; GIS, walk through, data triangulation
8. TA support for deployment of electronic immunization registry and use of electronic platforms (mobile app etc.) for data reporting
9. TA support for improving RI data quality

VPD and AEFI surveillance

1. Use of outbreak information for sensitization of leaders and health workers on immunization
2. Strengthen capacity of states to ensure early detection, investigation and response for VPDs
3. Capacity building for AEFI
4. Strengthen laboratory capacity to respond to VPDs outbreaks
5. Strengthen community-based surveillance

Immunization Financing

1. Continue to explore innovative sources of financing for immunization including greater involvement of sub-national government and the possibilities of leveraging on the National Health Insurance/State health Insurance in view of the enormity of the financial resources that would be required to be met by government post-transition
2. Technical assistance to develop and implement an accountability framework for the states in order to align the focus of the states with the ongoing national commitments to immunization and PHC financing
3. Technical support towards implementation of a financial management solution to enhance the ability of NPHCDA to continue to track and manage the resources provided by government and donors.
4. Engagement of the Governors forum towards ensuring adequate budgetary provisions for regular payment of health workers salaries
5. Expand scope for engagement/advocacy to the legislative and executive arms at the national and subnational levels to ensure timely release and front-loading of funding for next year.
6. Strengthen the scale up of the PBF mechanism in which health facilities are granted autonomy to develop their own business plans with incentives to motivate workers.
7. Establishment of a unified and functional committee of all finance desk officers/managers across government, donors and implementing partners to conduct quarterly review of the financial status of EPI programs/projects
8. TA to conduct training on automated financial management system and coordinate the development of a state specific PHC and immunization financing plans
9. TA needed to support the implementation of high-quality performance management strategies to improve HCW motivation and establish mechanisms for continuous assessment of staff performance

PHC System Strengthening

1. Set up coordination structures to improve synergy between the management of routine immunization and Primary Health Care structures in all the states
2. Improve the monitoring and execution of PHC revitalization activities

3. Streamline the multiple PHC funding pools to improve the efficiency in fund mobilization and utilization for PHC
   States to develop and implement one PHC plan
1. Operationalize a structured capacity building plan/continuous mentoring for PHC managers and frontline providers
2. TA needed to support NPHCDA and SPHCDAs in development and roll-out of organizational strengthening strategies towards the actualization of PHCUOR
3. TA need will include consultancy fee for the period of engagement for a period of 6 months to develop and implement the HRH assessment framework

This table draws from the previous JA sections, summarizing key findings and agreed actions, as well as indicating required resources and support, such as associated needs for technical assistance[26].

Key finding / Action 1	The creation of NERICC to rapidly revamp the low Penta 3 coverage of 33% (NICS/MICS 2016/2017). The adoption and implementation of the OIRIS approach by NERICC has contributed to a significant improvement in RI. Quality LQAS conducted in the 18 low RI performing states show an improvement in the proportion of LGAs passing lots from 3% in Q4 2017 to 46% in Q2 2019 The NDHS 2013 (38%) Vs 2018 (50%) shows an improvement (12%) in coverage, however still sub-optimal. Recently, there has been increase in coverage in majority of the low performing states while marginal decline has been observed in some medium and high performing states.
Current response	• Coordination of immunization by NERICC, SERICC, LERICC and implementation of OIRIS in 18 priority states with recent extension to 6 additional states in the south at the national level
Agreed country actions	• conduct EPI Capacity Needs Assessment • Urban Immunization Assessment, strategy development • scale up the strategy at the subnational levels in cities with high unimmunized children (Ibadan, Kaduna, FCT, Kano, Port-Harcourt, Gombe) • develop approach and guidelines on using GIS for RI microplanning building on lessons learned from Bauchi, Sokoto, kano, Kaduna • roll out and implement community engagement strategy in the Gavi targeted states.
Expected outputs / results	• EPI Capacity Needs Assessment conducted • Urban Immunization Assessment and strategy developed • urban immunization strategy scaled up at the subnational levels in cities with high unimmunized children (Ibadan, Kaduna, FCT, Kano, Port-Harcourt, Gombe) • approach and guidelines for using GIS for RI microplanning developed • community engagement strategy rolled out and implemented in the Gavi targeted states.
Associated timeline	2019/2020
Required resources / support and TA	• TA to conduct EPI Capacity Needs Assessment • Provide TA to support Urban Immunization Assessment, strategy development

[26] The needs indicated in the JA will inform the TCA planning. However, when specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. The TA menu of support is available as reference guide.

	• TA to enable GoN scale up the strategy at the subnational levels in cities with high unimmunized children (Ibadan, Kaduna, FCT, Kano, Port-Harcourt, Gombe) • TA to develop approach and guidelines on using GIS for RI microplanning building on lessons learned from Bauchi, Sokoto, kano, Kaduna • Support the roll out and implementation of the community engagement strategy in the Gavi targeted states.
Key finding / Action 2	The implementation of the community engagement strategy has contributed to significant improvement in coverage in some of the low performing (Yobe, Kano, Jigawa. However, there are persisting challenges in some states to systematically implement the strategy and sustain the gains
Current response	Implementation of community engagement strategy in 18 states
Agreed country actions	• Explore other means of motivating VCMs (aside monetary incentives) to continue community mobilization following the ramp down of polio program • Integration of community mobilization for RI with other PHC programs at community level (e.g.WASH, Nutrition e.t.c) • Seek alternative sustainable funding for community mobilization and CES roll-out • Sustain community engagement through durbars and meetings. • Engage religious leaders to disseminate RI messages in prayer houses targeting heads of households and female Islamic schools (targeting caregivers) • Expand on the implementation of the community engagement framework to other states. • identify essential cost drivers (start off and operational activities) for the CE approach for sustainability. • Gather and document lessons learned from states who have been implementing CEF for 1+ years, and perspectives on what can be improved going forward • Expand on the implementation of the community engagement framework to other states.
Expected outputs / results	CE implementation expanded to other states
Associated timeline	2019/2020
Required resources / support and TA	
Key finding / Action 3	Investments have been made in strengthening capacities for IDSR and AEFI surveillance. This notwithstanding, there are gaps in sensitivities of the surveillance systems to respond to VPDs outbreaks including delayed field investigation, handling and transport of sample and laboratory confirmation.
Current response	
Agreed country actions	• use the outbreaks information for sensitization of leaders and health workers on RI for improved coverage. • Improve laboratory capacity for timely diagnosis and case confirmation to inform prompt action in case of outbreaks • Strengthen community-based surveillance using e-surveillance. • Support rapid response teams to respond to frequent outbreaks in a timely manner • Strengthen collaboration with NCDC and improve use of VPD surveillance data to identify high risk areas to inform targeted RI intensification and preventive campaigns, and to monitor and evaluate RI program and health system strengthening effectiveness, even in areas of high coverage. • build the capacity of health workers in implementation of the IDSR in collaboration with NCDC for early detection of and response to outbreaks • Strengthen community-based surveillance using e-surveillance.
Expected outputs / results	Early detection and response to outbreaks Early detection and response to AEFI
Associated timeline	2019/2020

Required resources / support and TA	TA to improve VPD surveillance TA to improve HWs knowledge and skills in AEFI surveillance
Key finding / Action 4	Suboptimal quality of data, inappropriate denominator and non-finalization/implementation of the DQIP
Current response	Use of triangulated population estimates (GIS estimates, census estimates and house to house enumeration) in 25 states and use of GIS estimates in 12 states
Agreed country actions	• Behavioural change communication of health care workers on delivery of quality health services and producing quality data • Strengthen DHIS2 implementation in-country • Regular update of the master facilities list on DHIS2 • Enhance DHIS2 storage capacity and backend maintenance • Training/mentoring, re-training and on-the-job training of frontline health workers and managers on the use of DHIS2 • Scale up of Real time SMS reporting phase 1b and phase 2 in all states in the country a. Procure android mobile phones for data reporting from the health facility b. Training of all healthcare workers on SMS reporting c. Printing of RI SMS job aid • Transition the processes to data management to State level through the continuity of the capacity building program • Review of existing operational denominators using desk reviews and assessments across all states and FCT (e.g GIS estimates, house to house enumeration etc.) • Update of GIS population estimates in all the states + FCT • Conduct Household enumeration every 3-5 years engaging communities to improve microplanning activities leading to improved operational target populations
Expected outputs / results	Improved data quality, standardize denominator for operational use at subnational levels Reliable and consistent numerator data
Associated timeline	2019/2020
Required resources / support and TA	• support development and delivery of strategy on behavioural change communication of health care workers on delivery of quality health services • Support for DHIS 2 infrastructure management • Provide short term consultants to enhance the capacity building process. • TA support for completion of population estimate studies; GIS, walk through, data triangulation • TA support for deployment of electronic immunization registry and use of electronic platforms (mobile app etc.) for data reporting • TA to support data improvement and conduct of enumeration using micro census • TA to improve data quality and use at state level in targeted states TA to finalize the adoption of a national denominator • Conduct enumeration and walk through data to determine appropriate denominator
Key finding /Action 5	The country is currently rolling out strategies e.g. NLMIS for iSC; physical stock count; follow the vaccine; wastage rate study and deployment of vaccine accountability officers for polio SIAs to improve vaccine management and availability at the last mile. Despite this, there are still challenges with vaccine management practices at the subnational levels and the LMIS
Current response	• cIP Implementation across the levels - National and States

	• Continuous Improvement Processes: National, Zonal and State-specific EVM cIPs were developed following the conduct of EVM assessment across the country in 2017. Progress of implementation of the cIPs is summarized below. • Immunization Supply Chain Design: The national level system is being re-designed to a 3-Hub system whereby national stores are located at 3 strategic points across the country – Abuja, Lagos and Kano.
Agreed country actions	• Development of iSC Roadmap (Year 2) • implementation and monitoring of EVM cIP and ISC2 recommendations at national and selected states • Technical Assistants for the implementation and monitoring of EVMA and iSC recommendations at National (NLWG) and one each for the 8 priority states • LMIS Consultant to work on the NISCmis infrastructure (to handle where we are and the transition) • Consultant for finalization of iSC Road map. • Consultant for development of SOP for long term PPM. • Funds for implementation of 2019/20 activities outlined in the iSC Road map e.g. VMT, data war room for the establishment of the NISCmis and capacity building of the data team, the annual physical stock count in preparation for the forecast and outcome from the wastage rate study, supportive supervision to all levels, EVM 2.0 Onboarding, Targeted EVMA, development of cIPs, NLWG end of year review meeting. • Support the capacity building of HCWs on Maintenance and temperature monitoring practices. • Support the implementation of the recommendations from the result of the wastage study in the initial 24 states • Conduct the study in the remaining 13 states • Provide technical support to the NLWG on the implementation of the CCEOP • Support the capacity building of HCWs on Maintenance and temperature monitoring practices.
Expected outputs / results	• Vaccine management improved • Potent vaccine delivered • Vaccine wastage rate reduced • Capacity of HWs improved in vaccine and CC management • The supply chain fully redesigned
Associated timeline	2019/2020
Required resources / support and TA	• TA to support development of iSC Roadmap (Year 2) • TA to support the implementation and monitoring of EVM cIP and ISC2 recommendations at national and selected states • Technical Assistants for the implementation and monitoring of EVMA and iSC recommendations at National (NLWG) and one each for the 8 priority states • LMIS Consultant to work on the NISCmis infrastructure (to handle where we are and the transition) • Consultant for finalization of iSC Road map.

	• Consultant for development of SOP for long term PPM. • Funds for implementation of 2019/20 activities outlined in the iSC Road map e.g. VMT, data war room for the establishment of the NISCmis and capacity building of the data team, the annual physical stock count in preparation for the forecast and outcome from the wastage rate supportive supervision to all levels, EVM 2.0 Onboarding, Targeted EVMA, development of cIPs, NLWG end of year review meeting. • Support the capacity building of HCWs on Maintenance and temperature monitoring practices. • Support the implementation of the recommendations from the result of the wastage study in the initial 24 states • Conduct the study in the remaining 13 states • implementation of the CCEOP • build the capacity of HCWs on Maintenance and temperature monitoring practices.
Key finding / Action 6	• The NPHCDA has started the development of a unified tracking system for EPI funds/expenditure from all sources (donor, partners and government). However, inadequate funding challenge is affecting its early completion and roll out. • Low financing of operational plans at lowest levels (states and LGAs) • Very weak implementation of the accountability framework to guide investments in EPI at state level may potentially hamper transparency and accountability in the management of resources at that level • Inadequate funds for implementation of an integrated financial management software to link budget and planning, procurement, inventory management, finance and accounts, internal audits and personnel management function within the NPHCDA financial management system
Current response	The NPHCDA has started the development of a unified tracking system for EPI funds/expenditure from all sources (donor, partners and government).
Agreed country actions	• Prompt engagement of the respective states' authorities • Need for financial support for development and implementation of an appropriate, integrated financial management solution • Technical support towards implementation of the financial management solution to enhance the ability of NPHCDA to continue to manage the resources provided by government and donors. • Establishment of a functional committee of all finance desk officers/managers across government, donors and implementing partners to conduct quarterly review of the financial status of EPI programs/projects
Expected outputs / results	Availability of AF at the state level Availability of an integrated financial management software Implementation of an integrated financial management solution
Associated timeline	2019/2020
Required resources / support and TA	• TA to facilitate accountability framework development by the states • financial support for development and implementation of an appropriate, integrated financial management solution • TA to implement financial management solution to enhance the ability of NPHCDA to continue to manage the resources provided by government and donors
Key finding / Action 7	Strengthen the integration of immunization and PHC system
Current response	CHIPs
Agreed country actions	• Set up coordination structures to integrate PHC and immunization • Operationalize CHIPs in all states • Develop an integrated microplanning tools in priority states • Conducted integrated PHC microplanning in the priority states and LGAs

Expected outputs / results	• PHC integration structure set up and functional in all states to improve synergy between immunization and other PHC services • CHIPs operationalized in all states • Integrated microplanning, supportive supervision, monitoring and services provision implemented
Associated timeline	2019-2021
Required resources / support and TA	• TA on PHC Systems Strengthening and Integration • TA to provide technical support to the states • TA to develop PHC microplanning tools
Key finding / Action 8	Weak use of data for decision making
Current response	• Strengthening review mechanisms at national and sub-national levels • Data Quality and Use Supportive Supervision (DQUSS), Routine Immunization Supportive Supervision (RISS)
Agreed country actions	• Strengthen data review meetings at State and LGA levels and demonstrate data use • Strengthen data validation meetings at LGA level • Conduct national Bi-annual data review meeting • Support states in production and dissemination of quarterly bulletins on RI performance • Conduct monthly supportive supervisory visits to all HFs including reporting on the ODK and encourage data use for action at all levels • Conduct national biannual and state quarterly DQS/DQA to LGA and health facilities • Conduct quarterly RI Lots Quality Assurance Sampling (LQAS) in all states
Expected outputs / results	• Improve outputs and quality of review meetings • Improve capacity of subnational officers on data management and use • Funding for on the job capacity building
Associated timeline	2019/2020
Required resources / support and TA	• Funding data management reviews at national, state and LGA levels • TA to revise structure and content of review meetings

Based on the above action plan, please outline any specific technology or innovation demand that can be fulfilled by private sector entities or new innovative entrepreneurs.

- GIS mapping of areas for microplanning which could be conducted by private sector.
- Enumeration of target population to address denominator challenges and for easy mobilization

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

The 2019 Joint appraisal report was a full appraisal and was developed with guidance template and other relevant documents received from the Gavi secretariat. The appraisal covered immunization and PHC activities supported by Gavi and other development partners from January 2019 uptill August 2019.

This year's joint appraisal started with a meeting on the 19th August 2019 that engaged all stakeholders. The engagement meeting had three (3) objectives which were:

- To provide a forum for members of the JAR working groups to meet and know themselves

- To familiarize members with the JAR development approach
- To provide guidance on the JAR template and reporting guidelines

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 also shared with members to populate with the required information and members of the various working group were introduced to the group leads. Each working group were introduced to the section(s) to be populated and were asked to start work without delay in providing the required information, adhering strictly to the guidelines while doing so. Seven (7) working groups were identified to work on the Joint appraisal. These were: programme coordination and sustainability, Financial management, vaccines supply chain management and CCEOP, data management, disease surveillance, programme implementation and demand generation

Aside from the separate meetings of each of the working groups, joint meetings by all working groups were held on five (5) different occasions. These meetings provided the opportunity for members to share ideas, provide comments and inputs to the draft appraisal. At the end of each meeting of the JAR secretariat, the draft report was re-circulated to a wider stakeholder for comments and inputs. This continued until the report had been properly and well populated.

The outcome was taken into a 2-day pre-JAR meeting on 11th and 12th September 2019 at the Barcelona Hotel. The objectives of the 2-day meeting was to:

- To identify the gaps from the draft JAR
- To finalize the JAR for recirculation to the all the stakeholders before the final workshop.
- To finalize the agenda for the 2 days JAR workshop

The draft report generated from the 2-day pre-JAR meeting was then taken into a 2-day Joint appraisal workshop which was held on the 16th and 19th September 2019 at the Barcelona Hotels. Participation at the workshop cuts across government and partners both within and outside the country, and included the Federal Ministry of Health, the Ministry of Budget and National Planning, the NPHCDA, WHO, UNICEF, World Bank, USAID, US-CDC, CHAI, BMGF, IVAC, SOLINA Group, AFENET, NCDC, Canada High commission, JSI, and Gavi.

At the JA workshop, participants were divided into 9 working groups as shown below, to review key sections of the document and to most especially identify challenges under the key thematic areas and to make recommendations for TA support as appropriate and or needed.

1. Leadership, Management, Coordination and Human Resources for Health
2. Service Delivery and New Vaccines Introduction
3. Demand Generation and Community Engagement
4. Supply Chain and Logistics
5. Data Management
6. SIAs and Disease Surveillance
7. PHC System Strengthening
8. Finance and Accountability
9. Technical Assistance Support

The JAR secretariat met five times after the workshop to harmonize the work done by the different working groups during the workshop and to update the document with comments and inputs received.

The harmonized draft report was shared with the core group in its meeting of 22nd November 2019 for further guidance and approval for onward submission to the ICC.

Joint Appraisal (full JA)

The final draft of the 2019 Joint Appraisal Report was presented to the ICC in its meeting of 2nd of December 2019, where the draft was endorsed and approval given for its submission to Gavi.

9. ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
End of year stock level report (due 31 March) *	yes		
Grant Performance Framework (GPF) * reporting against all due indicators	yes		
Financial Reports *			
Periodic financial reports			
Annual financial statement			
Annual financial audit report	Yes (SDD report)		
Campaign reports *			
Supplementary Immunisation Activity technical report	Yes		
Campaign coverage survey report	Yes		
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review	Yes		
Data improvement plan (DIP)	Yes		
Progress report on data improvement plan implementation			
In-depth data assessment (conducted in the last five years)	Yes		
Nationally representative coverage survey (conducted in the last five years)	Yes		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	Yes		
CCEOP: updated CCE inventory	Yes		
Post Introduction Evaluation (PIE) (specify vaccines):			NA
Measles & rubella situation analysis and 5 year plan	Yes		
Operational plan for the immunisation programme	Yes		
HSS end of grant evaluation report			NA
HPV demonstration programme evaluations			NA
Coverage Survey			NA
Costing analysis			NA
Adolescent Health Assessment report			NA
Reporting by partners on TCA			

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.

ACTIVITY	DESCRIPTION
Vaccine Management Training	Vaccine Management Training in 4 zones (NC, SE, SS and SW zones plus Gombe and Kebbi) including 3 people (LZTO, SCCO and SLO) from each of the 11 previous states (in NE and NW zones).
EVMA2.0	EVMA2.0 Onboarding and Assessment *- Site selection will be based on at least 1 high performing and 1 low performing LGA, as per the 2017 EVMA results, from 36 states + FCT and 2 health facilities from each of the selected LGAs*
	EVMA2.0 continuous improvement plan (cIP) harmonization meeting *- This will follow the planned assessment above. The objective of the meeting is to harmonize the site-specific cIP generated by the EVMA2.0 platform*
	Supportive supervisory EVMA in all states yielded 217 sites corresponding to 1 national, 6 zonal, 36 + 1 states, 8 satellite, 55 LGAs and 110 HFs. *- Site selection will be by prioritisation of NERICC states (2 LGAs per state and 2 HFs per LGA) and non-NERICC states (1 LGA per state and 2 HFs per LGA)*
Physical Stock count	Vaccines, devices (diluents and consumables), safety boxes and data tools count at national, 6 zonal, 36+1 state, 21 satellite, 774 LGAs, ~10,000 HFs and any other vaccine storage points
	Quality assurance provided by NLWG and State representatives including national ToT; zonal ToT and field validation *-This will be carried out between April and May 2020 before the vaccine forecast.*
2021 Vaccines and Devices Forecast	State engagement meeting *-This will be carried out in June 2020 before the vaccine forecast. The meeting will disseminate the findings of the Physical Stock Count and aim to address the identified gaps and issues; review the 2020 forecast performance and other emerging supply chain issues; as well as review the trend of vaccine consumption/utilization for the previous year.*
	State-specific and national vaccines and devices forecast for 36 states + FCT with other health commodities *-The meeting in June 2020 will review the planned assumptions and develop the 2021 forecast*
	Vaccines and Devices Forecast Consolidation Meeting *-NLWG will continue to consolidate the different state templates, assumptions, program inputs etc and make presentation(s) to the Core Group before sharing with external stakeholders*
	Bi-annual Review of Vaccine and Devices Forecast *-This meeting will be conducted every 6 months (June/Nov) to review the performance of the 2020 forecast being implemented and make any necessary adjustment(s).*
	Health Commodities Forecast Harmonization Meeting *in collaboration with FMoH (NSCIP) – by end of November*
CCEOP implementation	State engagement meeting on state specific CCEOP project operationalisation NLWG facilitation of state engagement meetings clustered per zone
	CCEOP project operationalisation by the Project Management Team (PMT) Including post-installation health facility assessments, in samples of health facilities, as part of CCE commissioning process
	Technical and financial support to operationalisation of State Maintenance Units Conduct CCE Technicians trainings and procurement of tool kits
	Desk Review: CCEOP Operational Deployment Plan revalidation Health Facility Readiness Assessments for the Phase 1 _Tranche 2 of CCE deployments
	CCEOP phase 2 ODP Health Facility Readiness Assessments

	CCEOP project implementation monitoring and evaluation Cold Chain Inventory (CCI) update conducted after initial support phase
Targeted Supportive Supervision	Quarterly supportive supervision by NLWG to low-performing iSC states based on the EVMA performance
System Redesign	Finalize the 3-Hub construction
	Conduct additional analysis to inform implementation of the end-to-end system design vision of the NPHCDA
	Define integration opportunities within and beyond NPHCDA
	Develop an implementation plan based on the above analysis aligned with construction of the hubs & CCE OP implementation
Program Planning and performance monitoring	NLWG end-of-year review by the first week of December 2019
Human Resources	Salaries for 6 zonal immunisation supply chain (iSC) specialists to support programme implementation & 1 NOB to support the CCEOP PMT secretariat
Temperature Monitoring and Control (TMC)	Deployment of TMC systems at sub-national levels (LGAs and HFs), informed by deployment of RTMDs with CCEOP procurements, and capacity building of HCWs on revised TMC systems
iSC2 mission: Immunisation SC system strengthening	Implementation of recommendations for iSC2 mission System Design operationalisation
iSC2 mission: Immunisation SC system strengthening	Implementation of recommendations for iSC2 mission LMIS improvement Strengthen the national information system in a holistic manner by improving the following areas; **Environment:** - Reviewing and updating the stock data policy - Developing a process to assess, track and ensure data integrity as part of the supervisory visit - Implement maturity model to track progress - Review and update the supply chain indicators, data tools and analytics processes **Technical Capacity:** - Strengthen the capacity to perform supply data analytics - Implement a supply chain and demand management process to identify stock risky situations proactively - Implement a peer review/peer-led learning within/among national and zonal officers **Enablers:** - Include minor changes to NISCmis - Identify the technical requirements for the eLMIS to comply with newly defined user-requirements - Develop plan to transition management of the eLMIS to NPHCDA - Identify the best last mile LMIS technology solution for the country linked to other efforts outside of immunization (e.g. NSCIP)
Capacity Building	Human Resources Assessment (HRA), Training Needs Analysis (TNA) and informed capacity building of iSC and PHC

Waste Management	Strengthening Waste Management Systems - *Finalization of assessment of existing incinerators and development of a rehabilitation plan*
	End-to-end procurement of 18 incinerators
	Explore opportunities for innovative state-specific waste management systems e.g. PPP, hybrid model
	Procurement of protective wear and handling equipment for waste handlers
Targeted measles SIA nationwide	Conduct of measles SIA targeted at the most at risk states
Yellow fever preventive campaign	Conduct of YF risk assessment and reprioritization of states. Conduct of YF SIA targeted at the most at risk states
MNTE	SIAs to be conducted in identified 136 high risk LGAs in 16 Northern States. MNTE validation survey in the south-south zone Implementation of MNTE sustainability plan south-western and southern, eastern zone.
Outbreak response	Continuous response to outbreak as epidemiology evolves.

Annex

Status of implementation of EVMA recommendations in states

SN	State	Completed	In progress	Not started	Not Achieved
1	Abia	20%	32%	48%	0%
2	Adamawa	61%	22%	11%	6%
3	Akwa Ibom	0%	25%	75%	0.00%
4	Anambra	9%	18%	64%	9%
5	Bauchi	64%	36%	0%	0%
6	Bayelsa	29%	67%	5%	0.00%
7	Benue	23%	26%	46%	5.00%
8	Borno	68%	18%	15%	0.00%
9	C/River	21%	37%	11%	31.58%
10	Delta	7%	17%	48%	27.59%
11	Ebonyi	6%	56%	39%	0%
12	Edo	29%	43%	29%	0.00%
13	Ekiti	0%	41%	41%	18.18%
14	Enugu	5%	42%	32%	21.05%
15	FCT	37%	26%	24%	13.00%
16	Gombe	29%	24%	43%	4.76%
17	Imo	0%	41%	44%	14.71%
18	Jigawa	60%	40%	0%	0.00%
19	Kaduna	46%	38%	16%	0.00%
20	Kano	82%	9%	9%	0.00%
21	Katsina	30%	51%	19%	0.00%
22	Kebbi	46%	38.5%	15.5%	0.00%
23	Kogi	15%	26%	44%	15.00%
24	Kwara	0%	10%	75%	15.00%
25	Lagos	57%	24%	19%	0%
26	Nasarawa	7%	55%	32%	6.00%
27	Niger	46%	31%	23%	0.00%
28	Ogun	23%	23%	38%	15%
29	Ondo	29%	43%	21%	7%
30	Osun	54%	24%	5%	17%
31	Oyo	47%	27%	27%	0.00%
32	Plateau	26%	56%	18%	0.00%
33	Rivers	16%	71%	13%	0.00%
34	Sokoto	50%	50%	0%	0.00%
35	Taraba	15%	50%	35%	0.00%
36	Yobe	83%	17%	0%	0.00%
37	Zamfara	32%	56%	12%	0.00%

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