2020 MULTI STAKEHOLDER DIALOGUE REPORT

Immunization Planning in light of COVID-19

NOVEMBER 27, 2020

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

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1 Country situation pre-COVID-19 (end of 2019/early 2020; pre-COVID-19)

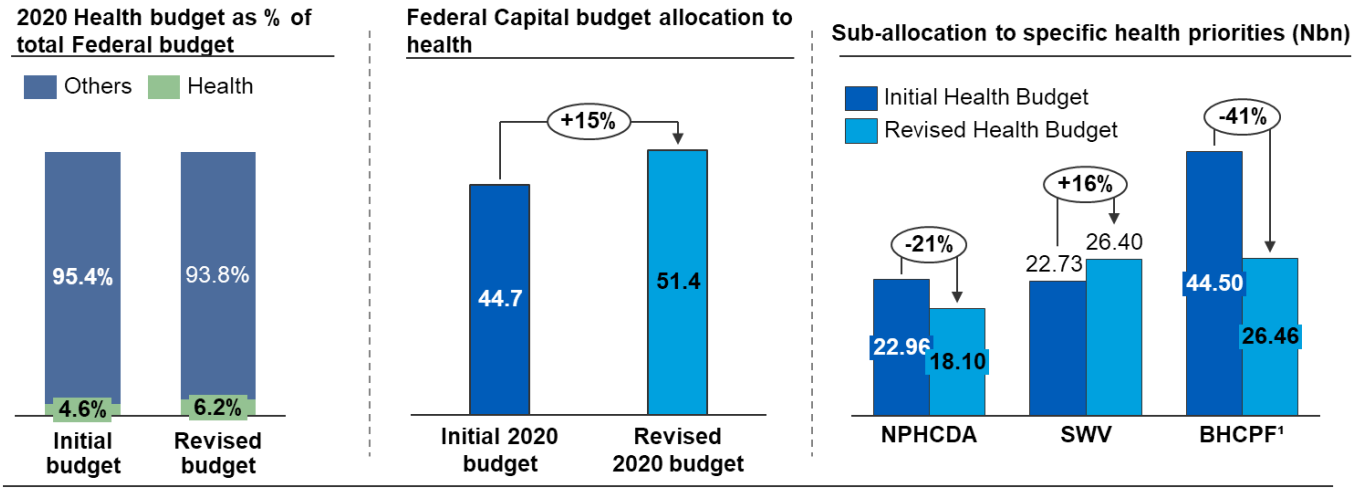
1.1 Country context

Contextual Information			
PEF Tier: Tier 1			
Indicator Name	Year	Source	Value
GNI per capita	2019	World Bank	2,090
Nurses/Midwives per 1000 population	2018	WHO - GHO	12
Population	2020	NPoPC 2006	217,855,875
Surviving Infants	2020	NPoPC 2006	8,278,523
Under 5 mortality (per 1000)	2018	UNICEF	120

Gavi has included Nigeria in the list of fragile countries in 2020-2021, however, the Board-approved country strategy supersedes access to Fragility, Emergencies, Refugees (FER) flexibilities.

Political context and commitment of the government to immunisation *(Provide brief summary ~100 words)*

Nigeria's Federal government is led by an administration that is in its second term in office, having come into power in 2015. This offers the benefit of the continuity of policies and relative political stability. In 2019, 372.7 billion naira was appropriated for health, representing a decrease of 29.4% when compared to the 2018 health budget of 528.14 billion naira. In the current year 2020, 464 billion naira was allocated to health, representing an upward movement of 24.5% when compared with the amount allocated in 2019[1]. In 2019, the Government demonstrated its commitment to immunization by releasing 100% (NGN 21,250,424,823) of the budgeted funds for vaccines procurement. Furthermore, during the revision of the 2020 budget to reflect COVID19 realities, and despite the negative economic impact of the COVID19 pandemic, the government increased funding for vaccines procurement to cushion foreign exchange losses due to devaluation of the Naira, and also raised capital allocation to the health sector by 15% as shown in the charts below.



- Overall, due to the Covid19 pandemic, the FGoN revised the national budget, which resulted in an increase of health budget from 4.6% to 6.2%
- The capital budget for health was increased from N44.7b to N51.4b to address COVID19 response financing needs
- While capital budgets for NPHCDA and the BHCPF were reduced, the Service Wide Votes (SWV) earmarked for vaccine financing was increased from N22.7b to N26.4b to cushion the negative impact of weakening of the Naira against the dollar

Recent changes in the country context and potential risks in 2021 *(Provide brief summary ~100 words)*

[1] Budget office of the federation

1.1.1 COVID-19 and disruption of PHC Services

In February 2020, Nigeria recorded its index COVID-19 case and has since recorded a total of 68,303 cases, with 64,291 (91%) recoveries and 1,179 (1.7%) fatalities (as of December 3).
In response to the pandemic, the government; set up a Presidential Task Force (PTF) on COVID 19, activated a multisectoral Emergency Operations Centre (EOC) led by the Nigeria Centre for Disease Control (NCDC) in close coordination with the State public health EOCs (PHEOC), and established measures to curtail the spread, including a 4-week partial lockdown in Lagos, Ogun and the FCT. There was another 4 weeks nationwide lockdown and closing of international borders from March through September.
However, the pandemic had a negative impact on all sectors in the country, with the Health care and Economic Sector most affected.
Nigeria recorded disruptions in operations of the PHC programs, including coordination meetings, work plan implementation performance, commodity supplies, delivery of key PHC services at fixed and outreach sessions, and supervisory visits. Consequently, there were observed declines in the uptake of key maternal and child health services including immunization. The pandemic also caused a major disruption in the schedule of National Supplementary Immunization Activities (SIAs), with planned campaigns postponed to curtail the spread of the virus. The pandemic also affected the disease surveillance and response efforts.
Similarly, the impact of the pandemic on the economy resulted in a 6.1% decline in GDP between 2019 and 2020. This economic downturn poses a further threat to the already shrinking fiscal space for health and resourcing for priority health program activities in the country.
In a bid to increase uptake of health services, the NPHCDA conducted trainings for health workers and sensitized communities on COVID-19 and continuity of PHC services while rolling out the Integrated Medical Outreach program (IMOP) in all 36 states and FCT, aimed at intensifying RI, IMCI, Nutrition, and Maternal health services over 3 rounds in Q4 2020. Sixty-eight LGAs in seven states were also supported by UNICEF to conduct routine immunization intensification efforts in the 3rd and 4th quarters of 2020.

1.1.2 Polio Eradication and Wild PolioVirus Certification

Nigeria- and consequently, Africa - received its polio-free certification from the **African Regional Certification Committee (ARCC) on Polio** on August 25, 2020 after more than 48 months since the last record of a WPV1 isolate in the last frontier, Borno state.

Also, the country began to interrupt the ongoing pockets of circulating Vaccine Derived Polio Virus (cVDPV2) outbreaks. Across the states in the country, between 2019 and 2020, multiple cVDPV2 isolates were identified. States with reports of vaccine-derived poliovirus have conducted response campaigns and are awaiting commencement of the revised polio SIA campaign from the National EOC, while intensifying surveillance activities to curb the spread of Polio and sustain the WPV-free status.

1.2 Performance of vaccine support (end of 2019/early 2020; pre-COVID-19)

1.2.1 Vaccines introduced and forecasted to be introduced

2.1.1 - Toutine Introductions

Vaccine	Introduction Date	2018 Covera	2019 Covera	2019 Target	2020 Target
YF	Jan-05	54	54	66	80
Penta	Jun-12	56	57	74	84
PCV	Dec-14	55	57	74	84
IPV	Feb-15	53	53	57	73
Men A	Aug-19		22.3	66	80
MCV2	Jan-19	54	54	50	80

2.1.2 - Forecasted routine & Campaign introductions

Vaccine	Type	Sub-Type	Status	CP Date	Phase
Men A	Campaign	Catch-up	Applied	2019-11-15	2
ROTA	Routine		Approved	2021-03-31	1
ROTA	Routine		Approved	2021-03-31	2
Measles	Campaign	Follow-up	Applied	2021-12-31	1
HPV	Routine		Forecasted	2023-12-31	N/A
HPV	Campaign	Follow-up	Forecasted	2023-12-31	N/A
MEASLES	Campaign	Follow-up	Forecasted	2024-12-31	1
MEASLES	Campaign	1st D	Forecasted	2027-12-31	N/A
MR	Campaign	Catch-up	Forecasted	2027-12-31	N/A
MR	Campaign	Follow-up	Forecasted	2030-12-31	1

1.2.2 Performance against Alliance Key Performance Indicators (KPIs)

Indicator	Source Name	Year	Value	Previous Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	9	0	▲
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	57	56	▲
Drop-out rate between Penta1 and Penta3	WUENIC	2019	12.3	13.8	▲
Difference in Penta3 coverage between children of urban and rural residences	Survey	2017	29.5	0	▼
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2017	56.4	53.1	▼
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2017	61.8	48	▼
EVM	EVM	2017	69	67.3	▲
# of Underimmunised Children	Calculated	2019	3046943.02	3069860.2	▲

1.2.3 Trends and district equity

Indicator	Source Name	Year	Value	Previous Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	9	0	▲
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	57	56	▲
Drop-out rate between Penta1 and Penta3	WUENIC	2019	12.3	13.8	▲
Difference in Penta3 coverage between children of urban and rural residences	Survey	2017	29.5	0	▼
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2017	56.4	53.1	▼
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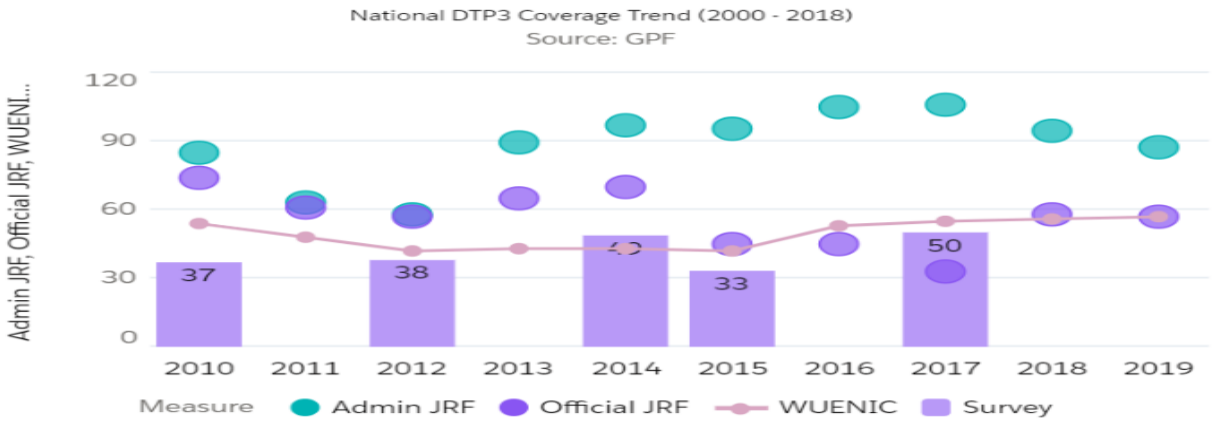
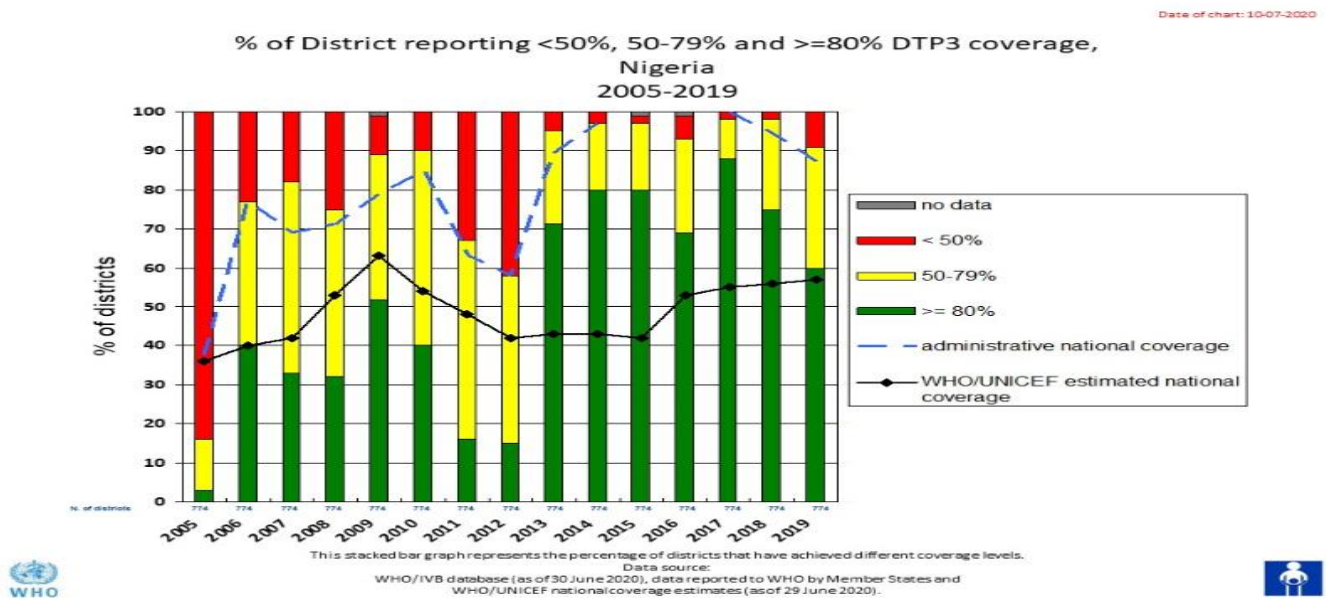




1.2.4 Progress against indicators and targets achievement

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change*
PNEUMO	Admin (JRF**)	Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	7,304,474	-5%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	6,820,990	-4%
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	7,326,684	-6%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	6,830,033	-5%
MCV	Admin (JRF)	Number of children in the target population who received the second recommended dose of measles containing vaccine (routine) (MCV 2)	708,187	NA
	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	6,289,531	-15%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	6,542,698	-7%
All others	EVMA Reports	Effective Vaccine Management Score (composite score)	NA	NA
	JRF	There was no stock-out at national and LGA level for all GAVI-supported vaccines during period under review	No	NA
	Admin (JRF) & Survey	Percentage point difference between Penta 3 national administrative coverage and survey point estimate	37	-18%

1.2.5 Overview of New Vaccine Support (NVS)

NVS Support	2003-2018 (US$)	2019 (US$)	2020 (US$)	Grand Total (US$)
Measles SIA	22,604,288			22,604,288
Meningitis A - campaign	56,057,711			56,057,711
Penta	145,916,719	4,626,530	-337,087	150,206,162
Pneumo	224,168,622	21,188,391	15,941,835	261,298,848
Yellow Fever	39,711,793			39,711,793
Yellow Fever - campaign	46,351,179	30,731,615	50,747,169	127,829,963
IPV	38,708,639	23,863,627	17,424,310	79,996,576
Meningitis A - mini catch-up campaign	22,057,844		3,376,516	25,434,360
Meningitis A	6,257,724		1,661,578	7,919,302
Injection Safety Devices	4,617,324	5,867,425	5,754,522	16,239,271
Measles-Follow-up campaign	11,458,257	8,043,026	-288,995	19,212,287
Measles 1st and 2nd dose		4,362,751	-72,379	4,290,372
Total	617,910,100	98,683,365	94,207,468	810,800,934

1.2.6 Overview of cash grant support

NVS Support	2002-2018 (US$)	2019 (US$)	2020 (US$)	Grand Total (US$)
Health systems strengthening	30,297,040	25,403,318	18,462,317	74,162,675
INS	12,610,218			12,610,218
ISS	44,162,306			44,162,306
Measles SIA - Operational costs	37,207,046			37,207,046
Meningitis A - operational costs	43,505,648			43,505,648
YF - Operational costs	17,749,298	8,404,681		26,153,979
Meningitis A - mini catch-up op.costs		14,409,590		14,409,590
Measles-Follow-up campaign op.costs	15,699,648	9,954,802		25,654,450
Vaccine Introduction Grant	14,176,839	9,057,761		23,234,600
Product Switch Grant	1,718,203			1,718,203
CCEOP		22,999,223	-193	22,999,030
Yellow Fever Diagnostics			159,128	159,128
Total	217,126,246	90,229,375	18,621,252	325,976,873

1.2.7 Overview of other Gavi support

E.g VIGs, OPS, PBF, switch grants, transition grants etc. (as applicable)

Support	Start Date	End Date	Recipient	Grant Value (US$)	Disbursed (US$)	Expenditure (US$)	Cash balance (US$)	Status Update/ Need for NCE
IPV VIG	2014	2020	UNICEF	5,847,947	5,847,947	5847922.26	25	Close
Measles SIA Ops costs	2015	2020	UNICEF	6,811,817	6,811,817	6,805,382.42	6,434.58	Mop up and close
Measles follow-up ops costs	2017	2020	UNICEF	5,830,070.50	5,830,070.50	9,161,686.19	370,164	4 Grants - 1 closed; 3 NCE
Measles follow-up ops costs	2017	2020	WHO	19,824,379	19,824,379	15947426.6	3876952.4	

Measles 1&2 VIG	2019	2020	UNICEF	823,742	823,742	403,851	419,891	NA (NCE approved till 2021)
Measles 1&2 VIG	2019	2020	WHO	3,169,806	3,169,806	896,936	2,272,850	Apply for NCE
MenA Ops costs	2011	2014	UNICEF	8,003,578	8,003,578	13,776,118.92	39,814.40	
MenA Ops costs	2011	2014	WHO	26,424,410	26,424,410	26424410		Closed
MenA (catchup) Ops costs	2019	2019	UNICEF	8,311,283	8,311,283	7,015,062	1,296,221	NCE 2021 - approved
MenA (catchup) Ops costs	2019	2019	WHO	9,798,307	9,798,307	7811618	1986689	NA
MenA VIG	2019	2019	UNICEF	1,228,514.70	1,228,514.70	1,228,334.48	180.22	Close
MenA VIG	2019	2019	WHO	3,835,698.55	3,835,698.55	3472835	362863.55	NA
PCV Switch	2018	2020	UNICEF	531,355	531,355	531,218.21	136.79	Close
PCV Switch	2018	2020	WHO	1,186,848	1,186,848	866988	319860	NA
PCV VIG	2015	2020	UNICEF	317,758	317,758	263,119.52	54638.479999 9999	Closed
YF Ops costs	2016	2020	UNICEF	13,821,426.35	13,821,426.35	9,247,187	4,574,239	4 Grants (3 fully utilised; 1 NCE)
YF Ops costs	2016	2020	WHO	16,859,923	16,859,923	11,08 5,524	7,0 24,557	5 Grants (2 expires in 2021)
YF Diagnostics	2020	2020	UNICEF SD / NCDC	239,544	221,827.59			1.2
			Total	132,866,407.10	132,848,690.69	120,785,620	22,605,515	

1.2.8 Performance of Gavi vaccines support

Provide a succinct analysis of the performance of Gavi's vaccines support in 2019/early 2020; pre-COVID-19 ~200 words

Overall, the support from GAVI was received on time during the reporting period. This resulted in a robust and seamless supply chain for vaccines for Nigeria. No stock outs for the GAVI supported vaccines were experienced during the reporting period. The vaccines were received on time and this resulted in improved service delivery. The support from GAVI has helped galvanize political will, strengthen health systems, create credible and predictable vaccine availability in Nigeria. The seamless support from GAVI catapulted the Government of Nigeria's Vaccine Accountability & Financing. The support has helped Nigeria to secure the much-needed strong political commitment to immunisation, access to affordable vaccines and efficient financial management

There was a slight delay in 2019 in funds disbursement for devices due to ERP switches at GAVI but this was immediately rectified to ensure that no stock outs were experienced.

The support from GAVI has resulted in long-term success and ensuring immunisation programmes are sustainable.

1.3 Overview of HSS grant implementation (end of 2019/early 2020; pre-COVID-19)

HSS (CCE) implementation summary (as of 13 October 2020)

Support	Start Date	End Date	Recipient	Grant Value (US$)	Disbursed (US$)	Expenditure (US$)	Cash balance (US$)	Status Update
CCEOP	2019	2019	UNICEF SD	22,999,223	22,999,030.35	13,413,668.38	9,585,361.97	All committed, 58% of invoice submitted.
HSS – CCE	2019	2020	UNICEF SD	25,403,318.32	25,403,318.32	22,963,316.77	2,013,493.68	All committed, 90% with invoice
HSS COVID reallocation	2020	2020	UNICEF	417,279	417,279	45,225	372,054.42	
HSS COVID reallocation	2020	2020	UNICEF SD	10,709,962.89	10,709,962.89			No feedback on level of expenditure
HSS COVID reallocation	2020	2020	WHO	554,198	554,198	118,127	436,071	21% utilization
HSS supply chain	2020	2021	UNICEF	4,729,259.64	4,729,259.64	50,857.317	4,678,402.32	In addition to expenditure, $ 210,868.75 has been committed.
HSS supply chain	2020	2021	WHO	722,617.29	722,617.29	2,753	719,864	N/A
HSS NERICC 2020	2020	2021	UNICEF	1,397,450	1,397,450	260,000	1,137,450	22.8% utilization
HSS NERICC 2020	2020	2021	WHO	1,329,000	1,329,000	591,066	737,934	N/A
Total				68,335,858.14	68,335,665.49	37,185,013	20,014,182	

1.3.1 HSS key milestones achieved in 2019/early 2020 pre-COVID 19)

	Process Indicators			Intermediate Results		
	Indicator name	Value	Rel. % change	Indicator name	Value	Rel. % change
OBJ-NA	Level of completion of Abuja and Kano supply chain hubs	NA	NA	% of states that achieved projected coverage for Penta 3	NA	NA
	Proportion of annual forecast harmonization workshop conducted with at least three public health programs	100	NA	CCE inventory update	100	NA
	Proportion of Gavi-focus states engaged	100	NA	Percent of districts reporting VPD surveillance data	100	NA
	Proportion of HCWs trained on basic Guide for Routine immunization	NA	NA	Percent of health facilities offering immunisation services	100	NA
	Proportion of health facilities that received android phones for real-time electronic data entry	NA	NA	Percent of outreach sessions conducted against planned	92	NA
	Proportion of health workers trained on Vaccine Management	NA	NA	Percent of supervision sessions from province/state to district level conducted	100	NA
	Proportion of LGAs who were trained on MLM	NA	NA	Proportion of states with optimized REW microplan	3	NA
	Proportion of planned monthly OIRIS visits to states conducted	67	NA	Proportion of states with progressive improvement in score from the PHCUOR annual scorecard	62	NA
	Proportion of planned national EPI review meetings conducted	0	NA			
	Proportion of planned NERICC meetings held	100	NA			
	Proportion of planned quarterly LQAS conducted	75	NA			
	Proportion of planned semi-annual NERICC engagement (RI performance review) workshop with low performing LGAs conducted	50	NA			
	Proportion of Quarterly programme management reviews with ES's, PMs, DPMs and TA's in 18 low performing states	100	NA			
	Proportion of states implementing the community engagement (CE) strategy	100	NA			
	Proportion of vaccine storage facilities where physical stock count of vaccines was conducted	NA	NA			

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.

Value cell color is green if target has been >= 90% met, yellow if 70-90% met, and red < 70% met. There is no color when no target is set in GPF.

1.3.2 Performance of Gavi HSS support

Provide a succinct analysis of the performance of Gavi's HSS support in 2019/early 2020; pre-COVID-19 ~200 words

In January 2019, the IRC approved the HSS envelop of $127m to support national and state level HSS activities from 2019-2023 (5 years). Of the total approved amount for national level support, only the CCEOP component ($27m) was provided by Gavi in Q4 2019. Funding for all other components (NERICC and NLWG) was significantly delayed and was only approved and released in September 2020. Major reasons for the delays included extensive iterations during workplan/budget reviews and focus on COVID19 in 2020.

At the state level, the HSS support is yet to commence across the 8 Gavi-focus states. In April 2020, 6 out of the 8 states secured IRC approval, while the outstanding 2 states received IRC approval in November 2020. Currently, the estimated start time for the state-level HSS is Q1 2021, which is 2 years since the initial national level approval in 2019. This implies that states only have 3 years of Gavi HSS support, as opposed to the earlier plan of 5 years HSS support, thus reducing the duration of Gavi support which could have a negative impact on the states' ability to achieve set targets.

At the onset of the COVID-19 pandemic, Gavi worked closely with the country (NCDC, NPHCDA, PTF) to successfully reprogramme 10% of HSS funds towards support to Nigeria's efforts in fighting the pandemic. Though the country experienced some delays in receiving some of the COVID-19 supplies through UNICEF, the timely and swift support from Gavi was well received.

In summary, the overall performance of Gavi HSS support in the period under review is sub-optimal, especially at the national and state levels where extensive delays in availability of the approved funds have stifled implementation of activities earmarked for support by Gavi.

1.4 Compliance, absorption and other fiduciary risk matters (~200 words)

- Comments on financial absorption as of [date]:

The financial absorption as at November 2020 for both UNICEF and WHO was satisfactory, bearing in mind the events of the year (COVID-19 Pandemic). Funds domiciled at UNICEF and WHO has consumption rate of over 70% respectively. Most of the disbursements were made in the latter half of the year.

- Compliance with financial reporting requirements (periodic/annual financial reports, audits):

Financial reporting requirements (biannual and annual) were met. However, grants that needed to be reprogrammed received more attention and had to be reviewed more frequently than the basic requirement. Gavi Grants domiciled in UNICEF and WHO are audited within the audit cycle of each Organisation and not separately.

- Compliance with counter-part funding for on-going SIAs (MSD):

Compliance to the allocation and release of government counterpart fund for implementation of ongoing SIAs varied from the activity and the level of governance. Most States met their obligations by providing the required essentials e.g. provision of AEFI kits, before they could conduct the activity. Where the Government was not able to meet up with all the required counterpart funding for e.g. 2019 Measles SIA (19 Northern States and FCT) and 2019 Men A Catch-up campaign (in 25 high risk States), an approval was given for Gavi 'in country funds' to be used to offset the shortfall at the national level. Also, the campaigns were integrated in States that conducted both Men A and Measles to enable cost sharing for logistics, ACSM and personnel; and the strategy gave the desired result.

- Compliance with programmatic reporting requirements (GPF):

The country has fully updated the Grant Performance Framework for the required reporting period:

- Other financial management and fiduciary risk comments:

There was a slow implementation at the beginning of the year as many activities had to be postponed to the 3rd and 4th quarter of 2020 due to COVID-19. This resulted in the inundation the last half of the year having more activities with little or no time to effectively plan.

Hurried processing of fund disbursement: Implementing Partners not adhering to the required timelines for requesting for fund disbursement from both UNICEF and WHO.
Reports show that grants received this year (2020) had very low consumption rate compared to older grants, most probably due to the emerging priorities, after the pandemic which disrupted workplans. This may lead t

Issues of over budgeting as a fiduciary risk as it promotes inefficiency; late release of funds to Implementing Partners thereby causing some Partners to find the resources to start the activity and get reimbursed after the activity.

Depreciation of naira enabling the Gavi Funds to do more than originally planned for and the need for re-programming of the left-over funds.

UNICEF's Financial Utilisation Analysis Report

Financial Utilization Report of Gavi Funds in US$: UNICEF as at 30th November 2020

S/N	Area of Support	Grant/Award Number	Expiry date	All. Amt (Total received with PSC)	Amount disbursed/ Encumbered	Balance	Utilization Rate (%)	Specific Activities/Achievements (that may be highlighted)	Comments
	MenA								
1	Men A campaign	SC190063	31-Dec-21	8,311,289	7,015,062	1,296,221	84.4%	Supported integrated Measles/Men A catch-up campaign in 19 out of the planned 25 endemic states targeting children born after the phased catch-up	Balance of $1.6m was reprogrammed for for RI and
2	Men A introduction	SC190179	03-Apr-20	1,228,515	1,228,334	180	100.0%	Supported introduction of Men A into RI nationwide	Closed
3	MenA Vaccination Campaign	SC140784	31-Dec-20	6,242,028	6,231,033	10,995	99.8%	Supported Men A campaigns in 9 high risk states targeting persons aged 1-29 years with a Post Campaign Survey of 88% Balance of fund reprogrammed for VMT Q1 -Q3, 2020.	Recommended for closure
4	MenA Vaccination Campaign	SC110540	31-Dec-20	7,017,147	6,990,503	26,644	99.6%	Supported Men A campaigns in the 17 high-risk states targeting persons aged 1-29 years with a Post Campaign Coverage Survey of 88%. Balance reprogrammed for VMT	Fund to be mopped up and Recommended for closure
5	Men A - Communication Activities	SI090020	31-Dec-19	556,758	554,582	2,176	99.6%	Supported the conduct of Men A campaigns in the 25 high-risk states reaching a total of 83,864,852 persons aged 1-29 years with a Post Campaign Coverage Survey of 88%.	Closed
	Yellow Fever								
6	YF Preventive Mass Vaccination Campaign (Phase 2a)	SC180061	30-Nov-20	1,167,067	1,167,067	0	100.0%	Supported YF preventive campaign in Kogi, Kwara, Zamfara and selected LGAs in Borno with a Post Campaign Coverage Survey of 94%, 92%, 89% and 81% respectively	Recommended for closure
7	Yellow Fever Campaign	SC180792	31-Mar-20	4,280,104	4,270,766	9,338	99.8%	Supported YF preventive campaign in FCT, Plateau, Kebbi, Niger, Sokoto and selected LGAs in Borno states	Recommended for closure
8	Yellow Fever Campaign	SC190329	31-Dec-21	3,819,240	3,592,449	226,791	94.1%	Supported YFpreventive campaign in Katsina, Borno (16 wards in 3 LGAs), Ekiti and Rivers with a Post Campaign Coverage Survey of 83.8%, 78.4%, 91.1% respectively. Rivers result still pending	NCE (no cost extention) approved
9	Yellow Fever	SC 200680	28-Oct-20	4,555,015	216,905	4,338,110	4.8%	Currently supporting logistics, procurement of PPEs and ACSM for Phase 4 Yellow Fever campaign in Benue, Osun, Ondo, Oyo, Bauchi and Borno states	Extended???
10	Yellow Fever Diagnostics	UNICEF SD		221,828				Ongoing support directly to NCDC from UNICEF SD	Procurement through Supply Division.
	Measles								
11	Measles SIAs	SC150606	31-Dec-20	6,811,817	6,805,382	6,435	99.9%	Supported the 2015/2016 nationwide measles vaccination campaign reaching 43,171,247 children aged 9-59 months with a Post Campaign Coverage Survey of	Recommended for mop up and closure
12	Measles Second Dose	SC190330	20-May-21	823,742	403,851	419,891	49.0%	Supported MSD intro into RI in the southern states. Introduction MSD in the northern states is planned for Dec 2020.	
13	Nigeria- Measles and YF SIAs C4D	SC130571	31-Dec-19	6,997,180	6,935,100	62,080	99.1%	Supported logistics and ACSM component of 2013 Measles and Yellow Fever campaigns targeting children	Closed
14	Measles SIAs	SC180480	31-Dec-21	153,597	36,539	117,058	23.8%	Gavi Reprogramming decision: Support implementation of NPHCDA task shifting policy per NSIPSS	NCE approved
15	Measles SIAs	SC 190331	31-Dec-21	1,068,874	942,935	125,939	88.2%	Supported the ACSM component in the 2019 measles campaign in the 19 northern states and FCT with a	NCE approved
16	Measles OBR (MR)	SC190107	31-Dec-21	942,035	876,948	65,087	93.1%	Supported the measles outbreak response in Borno state reaching 1,238,181 children aged 9 months-9 years with a PCCS of 85.7%	NCE approved
	New Vaccine Intro and Switch								
17	IPV-VIG	SC150090	31-Dec-19	5,847,947	5,847,922	25	100.0%	Successful introduction of Inactivated Polio Vaccine (IPV) countrywide and balance reprogrammed to support	Closed
18	PCV Switch	SC181058	31-Mar-20	531,355	531,218	137	100.0%	PCV Switch - Communication activities for RI	Recommended for
19	PCV VIG	SC140824	30-Jun-16	317,758.00	263,119.52	54,638	82.8%	Successful introduction of PCV	Closed;expired in 201
	HSS/ISS								
20	Paid in by GoN in 2014 to support approved ISS Work Plan	SC140635	31-Dec-19	15,771,115	15,769,681	1,434	100.0%	Supported range of activities including Immunization System Support activities where funds directly disbursed to States for almost 3 years to support RI activities including Outreaches; capacity building on PHC/IMCI in 14 States and some VSI activities	Closed
21	HSS NERICC 2020	SC200732	29-Oct-21	1,471,000	-	1,471,000	0.0%	New NERICC grant for IMOP and MICS/NICS; mIMOP2 completed; activity partly prefunded from another grant and and fund still to be correctly charged.	Received Nov 2020. ***Change of Funding Source (CFS) needed.***
22	COEOP	UNICEF SD	UNICEF SD	22,999,030	13,413,668	9,585,362	58.3%	POs for 2065 COE and 343 COE issued to two suppliers. The part of consignments arrived and balance enroute. In addition to expenditure, the commitment made for issued POs so far is $ 8,883,250.47	
23	HSS – COE	UNICEF SD	UNICEF SD	25,403,318	22,963,317	2,013,494	90.4%	Under this project 2963 COE deployed and installed across 28 States. For few number of installation invoicing is going on.	Invoicing and payment are being concluded.Dependin
24	HSS supply chain	SC200542	18-Aug-21	4,729,260	50,857	4,678,402	1.1%	Vaccine Management Training completed, EVM2.0 onboarding completed. In addition to expenditure, $ 210,868.75 has been committed	CFS needed
25	HSS COVID reallocation	SC200374	15-Jun-21	417,279	45,225	372,054.42	10.8%	Epi & Surveillance - SORMAS in 2 state established, RCCE and coordination and oversight activities is going on. Sample transportation materia procurement will be done once PTF supply and distribution pillar conclude the gap analysis	In addition to actual expenditure, $29538.94 has been committed
26	HSS COVID reallocation	UNICEF SD	SD	10,709,963			0.0%	PPE procurement completed, Lab procurement is going on (approx 80% completed), local procurement of IPC supplied is being concluded, off-shore major portion of PPE procurement is in PO stage.	Procurement through Supply Division, deliveries in progress. It is only
	TCA								
27	TCA	SC180268	30-Jun-19	867,649	864,695	2,954	99.7%	TCA completed	Closed
28	Measles TCA - Consultants	SC170402	30-Jun-19	50,000	49,786	214	99.6%	Additional funds to support engagement of a national technical consultant for the 2017/2018 measles campaign. Campaign was conducted successfully reaching 40,044,875 children aged 9-59months with a PCCS of 87.5%	Closed
29	Gavi TCA	SC190114	31-Dec-20	2,011,657	1,575,163	436,495	78.3%		Recommend for NCE
	Grand Total			**145,323,581**	**108,842,110**	**35,323,153**	**74.8%**		

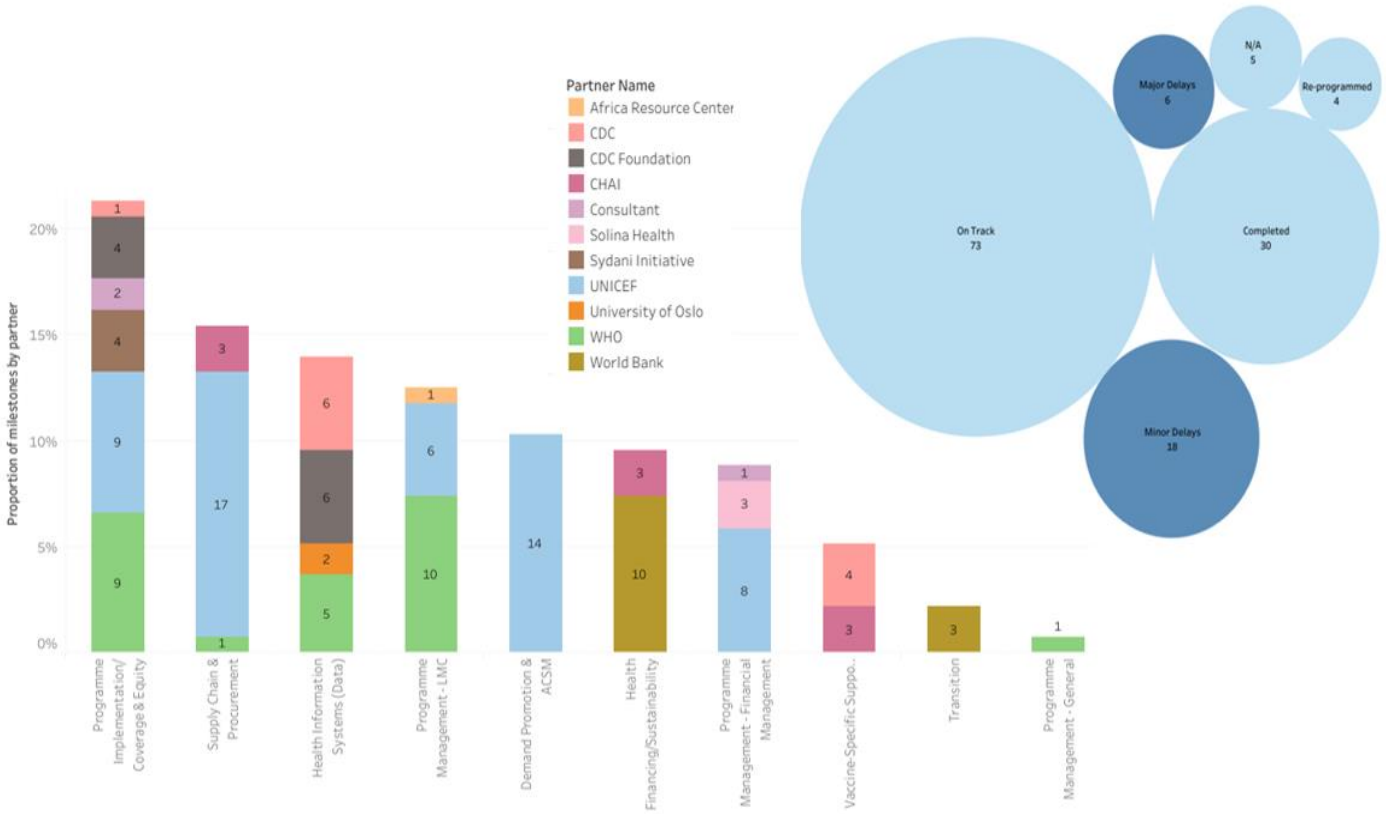
Financial Utilization Analysis Report Summary on Gavi funds - WHO Update

As at: 20-Nov-20

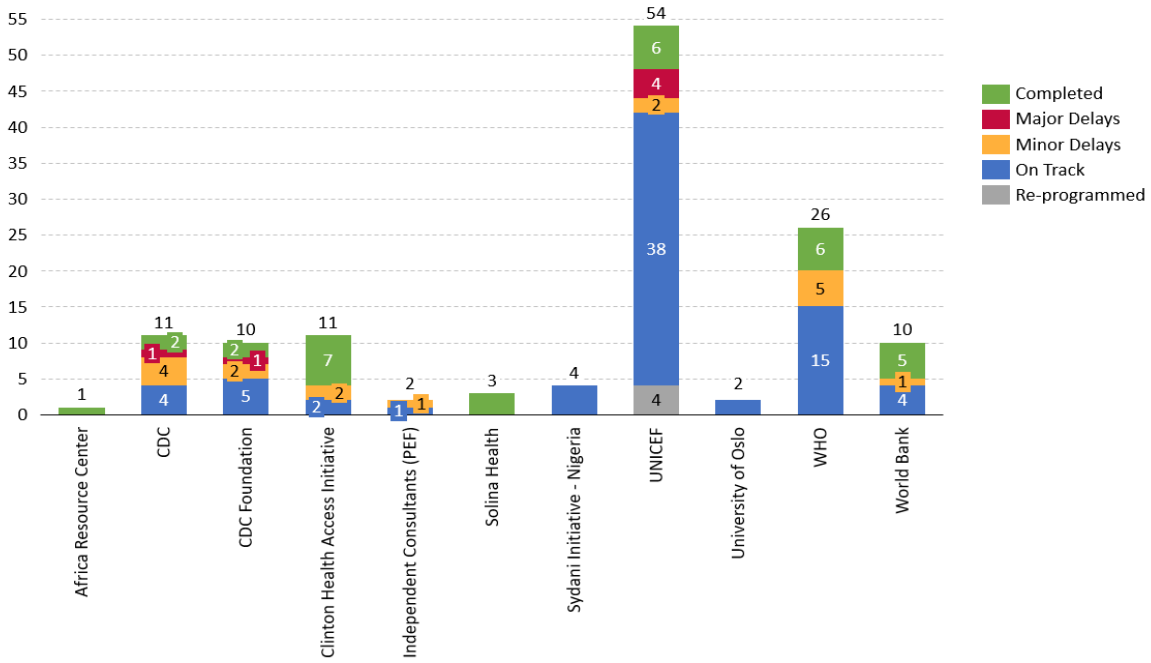
S/N	Area of Support	Grant/Award Number (where applicable)	Expiry date	Allocated Amount (Total Funds received)	Amount disbursed/ Encumbered	Balance	Utilization Rate (%)	Specific Activities/Achievements (that may be highlighted)	Remarks (if any)
	MenA								
1	Men A Campaign	68649	30-Jun-21	7,898,307	6,073,484	1,824,823	76.9%	Supported Men A catch-up campaigns and integrated measles/Men A campaign	Pending Ebonyi, Cross River and Oyo; Pending Post-campaign coverage survey (PCCS) activities
2	MenAfriVac Vaccination Catch Up (NERICC support)	68735	31-Jul-21	2,100,000	1,738,134	361,866	82.8%	implemented all approved NERICC activities in 2018 - 2019 (8 OIRIS visits, 2 Engagement with low performing LGAs, 7 rounds of LQAS conducted, Supported all meetings for NGITAG etc)	conduct of LQAS
3	NERICC programme support grant	70989	30-Jun-21	1,329,000	591,066	737,934	44.5%	Implemented round 1 IMOP	round 2 IMOP ongoing; LQAs and OIRIS visit pending
	Yellow Fever								
1	Yellow Fever Campaign	68080	31-Aug-21	4,125,143	4,065,006	60,137	98.5%	Supported Phase 3 Yellow Fever Preventive Mass Vaccination (PMVC) campaign	Pending PCCS in Anambra and River State
2	Yellow Fever Campaign	68950	31-Dec-20	4,585,441	4,096,994	488,447	89.3%	Supported Phase 3 Yellow Fever Preventive Mass Vaccination (PMVC) campaign	Pending PCCS in Anambra and River State. No cost extension for 6-12 months required
3	Nigeria YF reactive campaign in Bauchi and Gombe states	68916	31-Dec-20	123,114	123,114	-	100.0%	Over 266,000 people from 9 months - 44 years targeted and vaccinated in 3 LGAs (11 wards) in Bauchi and 3 LGAs (5 wards) in Gombe	Closed
4	Yellow Fever Campaign	71029	30-Jun-21	8,487,355	0	8,487,355	0.0%	Phase 4 Yellow Fever PMVC in 7 States	
	Switch								
1	PCV Switch	68168	31-Aug-21	1,188,848	868,988	319,860	73.0%	PCV switch succesfully implemented in all states. Annualised PCV coverage of 75% in August 2020	Pending is PIE
	Measles								
1	Measles follow-up campaign ops costs 2019	68954	31-Dec-20	8441831.8	5,300,378	3,141,254	62.8%	Measles follow-up campaigns in 19 Northern States	Meningitis A award pre-financed some measles activities during the integration of the measles and Meningitis A campaigns in the North, in 2019. No cost extension for 6-12 months required.
2	Measles SIAs	68480	31-Dec-20	10347671	10,056,269	291,402	97.2%		
3	Measles SIAs	67803	31-Mar-20	590,780	590,780	-	100.0%	88% of all children who were eligible for measles vaccination during the campaign were vaccinated. Five states (Anambra, Ekiti, FCT-Abuja, Jigawa and Plateau) achieved an estimated coverage of 95% and above	Closed
4	Measles Outbreak	68704	31-Dec-20	348,108	348,108	-	100.0%	Number of children vaccinated during the outbreak response immunization was 437,515 in phase 1 of the campaign. Over 800,000 children more were targeted for phase 2. The aggregated weighted coverage was 85.7%	Closed
5	MCV2 VIG 2019 and 2020	68953	31-Dec-20	3,189,786	898,936	2,272,850	28.3%	Phase 2 introduction completed in Nov 2019. Annualised coverage of 27% in August 2020	Phase 2 in 19 northern states ongoing; after which PIE will be conducted. No cost extension for 6-12 months required.
	New Vaccin Introduction								
1	MenAfriVac (MenA) Vaccine - New Vaccine introduction	68738	30-Jun-21	3,835,899	3,472,835	362,864	90.5%	MenA was succeffuly introduced country-wide. Current annualised coverage as of 50% as of August 2020	Post Introduction Introduction
	COVID-19								
1	OCR S GAVI COVID19 RESPONSE	70544	31-Dec-20	517942	110399	407543	21.3%	NPHCDA had completed the implementation of IPC training for PHC worker before receipt of funds. The Agency made a request to Gavi to have the funds reprogrammed to support coverage improvement activities (IMIOP). Gavi is yet to respond on the request.	Discussion on reprogramming required. No cost extension for 6-12 months required.
	TCA								
1	GAVI TCA activities 2019/2020	68755	31-Dec-20	89,718	89718	-	100%	Completed	Closed
2	TCA Technical Assistance 2019/2020	68755	31-Dec-20	940,825	940824	1	100%	Completed	Closed
3	GAVI TCA activities 2020/2021	70278	30-Jun-21	17,732	-	17,732	0%	Concept note developed but roll stalled due to COVID-19	Activity should be reprogrammed to support OIRIS visits
4	TCA Technical Assistance 2020/2021	70278	30-Jun-21	947,250	435,138	512,112	46%	funds not sufficient for the agreed TA. Gavi to supplement through next TA cycle or via HSS support	
	Grand Total			56,840,150	39,773,971	17,066,180	70%		

1.5 **Overview of PEF TCA progress:**

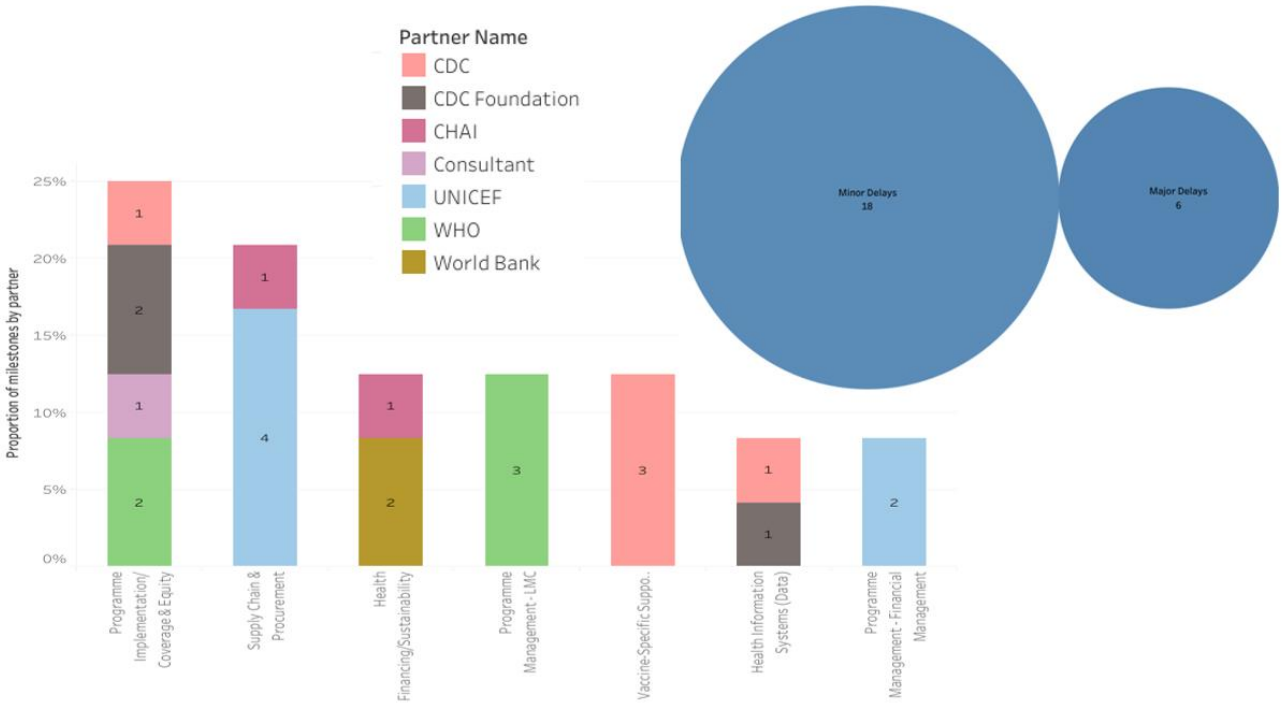
1) June 2019 – June 2020 TCA milestones reporting, per partner, per programmatic area, all milestones



The above figure gives an overview of TCA reporting in Nigeria from June 2019-2020, per programmatic area.
Milestones pertaining to coverage and equity made up more than 20% of the total milestones in this period, with WHO and UNICEF being the partners most involved in this programmatic area.
Overall, UNICEF was the partner with the highest number of milestones (and therefore activities) from June 2019-June 2020, spread across coverage & equity, supply chain, demand promotion and financial management.
An overview of performance per partner between June 2019- June 2020 is given in the below graph:



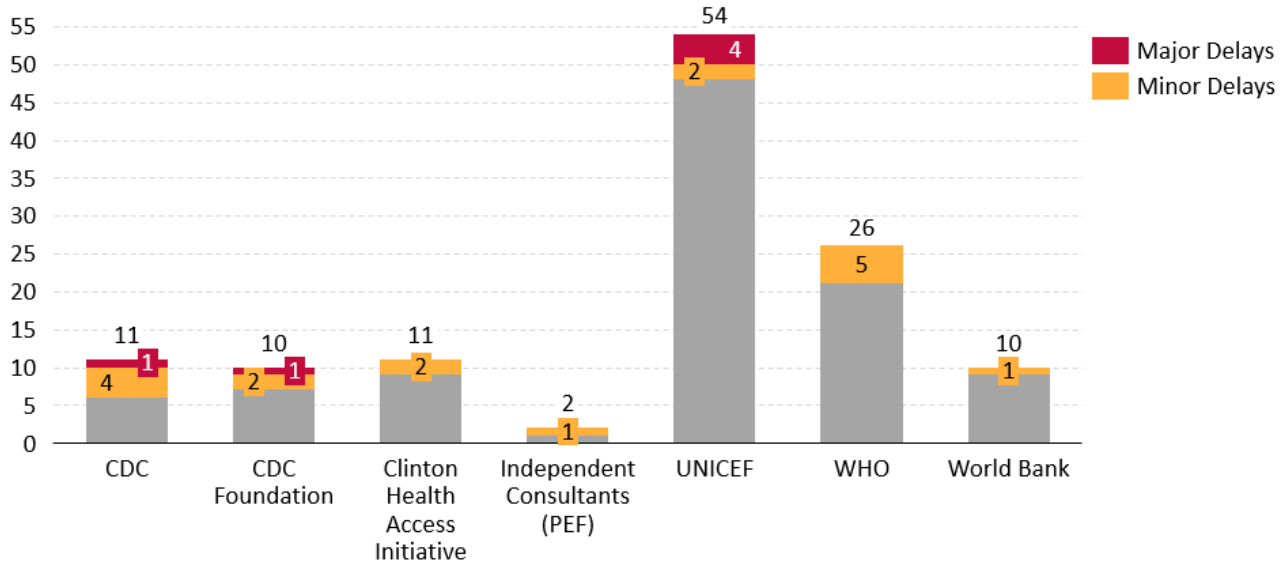
2) June 2019 – June 2020 TCA milestones reporting, per partner, per programmatic area, delayed milestones



Activities under the programmatic area of coverage and equity experienced the highest number of delays, for the period of June 2019- June 2020, in Nigeria. The delayed milestones under the programmatic area of 'Programme Implementation/Coverage & Equity' constituted 25% of the total number of delayed milestones.

The partners experiencing the highest number of delays are UNICEF (in supply chain and financial management related activities), CDC (in vaccine-specific support, health information systems and coverage and equity related activities) and WHO (in LMC and coverage and equity related activities.

The graph below reflects the number of delayed milestones per partner between June 2019-June 2020:



Details of TCA performance

Partner Name	Programmatic Area	Milestone Name	Activity	Status	Deadline
UNICEF	Supply Chain & Procurement	Draft CCEOP Operational deployment plan submitted for review	1. CCEOP implementation (a) Development of the Operational Deployment Plan (ODP) (b) Support to the coordination/ monitoring/evaluation of the CCEOP project implementation and updating of the project	Completed Not completed (This activity is on-going until phase 1 of the project is completed by the end of 2021.)	30/11/2019
UNICEF	Supply Chain & Procurement	Draft iSC Process Manual and SOPs submitted for review	Develop iSC policy document and SOPs	Completed (Final draft ready, to be edited by a consultant before printing)	30/11/2019
UNICEF	Supply Chain & Procurement	(a) Nationwide physical stock count completed ahead of 2020 Vaccine and Devices Forecast Exercise	Support state specific forecasting in line with the revised immunization coverage targets for states	Completed	30/11/2019
UNICEF	Supply Chain & Procurement	(a) 2020 State-specific forecast, for 36 states + FCT and national, completed (b) 2020 Shipment Plan for Vaccines and Devices completed	Support state specific forecasting in line with the revised immunization coverage targets for states	Completed	30/07/2020
UNICEF	Supply Chain & Procurement	EVMA2.0 Onboarding and Assessment completed	EVMA 2.0 Onboarding Conduct of National EVM Assessment	a. EVMA 2.0 Onboarding completed. Delayed to Q1 due to COVID-19	29/06/2020 Q 1 2021
WHO	Supply Chain & Procurement	EVM continuous Improvement plan (CIP) from various states consolidated and that of national developed.	Workshop for the review and consolidation of state specific cIPs and that of national level. Printing and dissemination of the consolidated cIPs	Not completed Delayed due to COVID-19	Q 1 2021
WHO	Supply Chain & Procurement	Quarterly EVM targeted assessments completed	Supervisory visits to selected sites using EVM 2.0 Generation of site-specific improvement plan	Not completed Delayed due to COVID-19	Q 1 2021
UNICEF	Supply Chain & Procurement	50% completion of CCEOP PMT workplans across implementing states (annualized)	11. Technical support for the CCEOP deployment and implementation	On Track a.Tranche 1 of the CCE deployment and installation completed by end of June 2020. b.Tranche 2 implementation is not completed. Deployment and installation will start by Jan 2021.	29/06/2020

UNICEF	Supply Chain & Procurement	Recruitment of TA to support 3 Hub operationalization completed	14. Support operationalization of 3-hubs (focus on Kano and Abuja hubs)	Not completed (due to delay in the construction).	29/11/2020
UNICEF	Supply Chain & Procurement	(a) Procurement and distribution of vaccines and devices in line with 2020 forecast (b) Forecast accuracy monitoring and evaluation (quarterly) (c) Internal Physical stock count ahead of 2021 forecast	Support state specific forecasting in line with the revised immunization coverage targets for states	Completed	30/06/2020
UNICEF	Supply Chain & Procurement	a.100% Procurement and distribution of vaccines and devices in line with 2019 forecast b.50% quarterly Forecast accuracy monitoring and evaluation completed	5. Support state specific forecasting in line with the revised immunization coverage targets for states	Completed	29/06/2020
UNICEF	Supply Chain & Procurement	50% completion of annualised National Logistics Working Group (NLWG) projects to be implemented at the state level	6. Technical liaisons between the NLWG and state logistics work groups (SLWGs), within zonal catchment areas, for implementation of annualized NLWG work plan at state level	Not completed Significant delays in implementation of the NLWG work plan at the state level because of the COVID-19 outbreak. Major activities delayed are – EVMA across the States, Independent physical vaccines stock count.	29/06/2020
UNICEF	Supply Chain & Procurement	Vaccine Management Training (VMT) completed at national level and in all states . VMT cascade training plan developed	8. Conduct of vaccine management training in all states. Targeted capacity building for NPHCDA/SPHCDA logisticians (national and subnational levels)	Completed 303 participants trained at National Vaccine Management Training of Trainers (VMT ToT) At Sub-national level (LGA and Health Facility staff) vaccine management training cascade wasdisrupted by COVID-19 outbreak. Howevethis activity was, completed in Q3 and a total of 63,296 HCW's were trained	29/06/2020
WHO	Supply Chain & Procurement	Temperature data for vaccines throughout the supply chain (including in-transit) gathered. Recommendations to avoid vaccines damages across supply chain levels based on the outcomes provided.	Procurement of study materials Trainings Data collection and analysis Supervision	Not completed Delayed due COVID-19	Q1 2020

UNICEF	Demand promotion and ACDM	MCV2 introduced, planned campaigns conducted	7. Communication support in the implementation SIAs (Men A, Measles and Yellow Fever campaigns) and New Vaccines Introduction (MCV2) in the northern states and rota vaccine introduction nationwide. Supports disease outbreak response and supervision of state-level community engagement for Routine Immunization.	on track	29/06/2020
UNICEF	Program management-LMC	1. 5% improvement in the proportion of LGAs having >80% children appropriately immunized for age in NERRIC Focus states. Collective accountability. (Baseline 45% of LGAs in priority states achieved >80%.	1. Provide day-to-day technical support to the NERICC and oversights to the sub national levels on routine immunization.	on track	29/06/2020
UNICEF	Programme Implementation/Coverage & Equity	All priority states supported in developing annual work plan and introducing rota vaccine	16. Provide technical support to the states in the NSIPSS implementation and improving RI coverage, conducting successful NPSIAs, and introducingnew vaccines	on track	29/06/2020
UNICEF	Programme Implementation/Coverage & Equity	All priority states supported in developing annual work plan and introducing rota vaccine	16. Provide technical support to the states in the NSIPSS implementation and improving RI coverage, conducting successful NPSIAs, and introducingnew vaccines	on track	29/06/2020
UNICEF	Demand generation and ACSM	Communication plans regularly updated in 13 high-risk statesRevised communication plans implemented in at least three states	3. Provide technical support and guidance in the formulation and management of programme communication strategies and plans of action for social and behavioural change in support of routine immunization program.	on track	29/06/2020
UNICEF	Demand generation-LMC	CE strategy 80% of LGAs in focus states implementing line listing	4. TA to support Community engagement strategy and conduct line-listing of newborns and eligible children in every settlement	on track	29/06/2020
CDC	Surveillance	1) Lab training completed for 14 national staff 2) Epidemiologist consultant hired 3) Lab information consultant hired 4) Outbreak response plans updated	Support NCDC in development of national surveillance and lab network for measles, rubella and yellow fever diagnostic testing to include: 1) Conduct lab training for lab staff to build their capacity on the testing for various vaccine preventable diseases to include measles, rubella, and yellow fever 2) 1 year Epidemiologist consultant to develop and refine protocols	1. Measles and rubella lab training completed; YF lab training delayed due to COVID-19 related ltravel restrictions affecting Atlanta-based CDC trainers . 2. Completed (Epi consultant hired)	06/30/2020

			for surveillance, including case investigation and classification and outbreak response for measles and yellow fever, and laboratory/ epi data harmonization including data cleaning, data management, and summary/presentation of data 3) 1 year information strategy support for laboratory information management system 4) Outbreak investigation for measles, rubella and yellow fever including CDC support to conduct root cause analysis of outbreaks.	3. Completed (lab consultant hired) 4. OBR plans on track	

Please provide any additional comments on the implementation of the TCA plan (e.g., progress in key areas, challenges, constraints, reallocations, no-cost extensions ~100 words per partner)

UNICEF implemented most of the TCA planned activities during the July 2019 to June 2020 period. Most of the activities in program management, coordination and leadership, coverage and equity, immunization supply chain including CCEOP installations and communication and demand generation were completed or on track. However, some activities were delayed because of covid-19 pandemic and competing priorities in the health system.
Examples:
a. Independent Physical stock counting (PSC) exercise by private vendors was delayed because of covid-19
b. National Vaccine Management Training was conducted as scheduled in January/February 2020. However, the cascade was delayed because of the Covid-19 but completed during the 3rd quarter.
c. Recruitment of TA to support 3 Hub operationalization delayed due to delay in construction of the hubs. UNICEF is now working with NPHCDA to start the upgrading of the building and procure the cold rooms.

Four activities were not implemented and cancelled because of non-recruitment of the staff mainly the finance specialist who was supposed to support the stakeholders in the capacity building of the national as well as state teams on financial management.

WHO provided technical support for the coordination, planning, and implementation of NERICC, NLWG, and SIA interventions during the reporting period July 2019/June 2020. These included implementation of two rounds of Optimised Integrated Routine Immunisation Sessions OIRIS visits, Engagement of 103 low performings LGAs, Review of coverage improvement plans with 18 medium and high performing states, and the conduct of 2 rounds of LQAs. In addition, WHO supported the review and development of the Data Quality Improvement Plan, the Gavi SMS project, development of new vaccine proposals (IPV2, Rota, and drafted HPV applications), and Measles, Yellow Fever and Meningitis proposal. WHO leveraged on the TA support and Polio assets to support the functionality of NGI-TAG, the National Expert Committee on AEFI as well as support for VPD surveillance. The delays in approval of the NERICC work plan coupled with the COVID-19 disruptions accounted for the inability to complete some planned phases of the approved activities e.g., ORIS round 4, the introduction of Measles Second Dose, and the Conduct of LQAS.

CDC coordinated lab training for measles and rubella testing in August/September of 2019. Yellow fever lab training planned for August 2019 was delayed due to unavailability of key trainers, and further delayed due to COVID-19. CDC hired two consultants hired in November/December 2019 to support NCDC's surveillance efforts. The consultants work closely with NCDC and CDC to 1) strengthen the outbreak response efforts for measles, rubella, and yellow fever, 2) update the outbreak response plans, and 3)

conduct root cause analysis of the disease areas to determine the reason for high disease burden and determine the best approach for a response. Specifically, the consultants have been instrumental in the analysis of measles, rubella, and yellow fever data to strengthen the response to outbreaks. They have helped improve the use of data to inform immunization program planning and evaluation of the effectiveness of the program activities, including SIAs. They have also strengthened the harmonization of lab and case-based surveillance data and supported the development of the national measles and rubella surveillance and outbreak investigation guidelines. Furthermore, they informed the review process of measles and surveillance data to strengthen and better harmonize the data reporting and visualization for regular surveillance updates.

In April through June 2020, the consultants contributed immensely to selecting the strategy for the 2021 SIAs and in the development of the GAVI proposal for the 2021 SIAs.

2 Programmatic Update and Planning

2.1 Indicative interest to introduce new vaccines support from Gavi

Indicative interest to introduce new vaccines support from Gavi	Programme	Expected application year	Expected introduction year
	Rotavirus Vaccine Introduction	Q4 2019	2021
	IPV 2	Q3 2020	2021
	HPV Vaccine	Q3 2020	2021
	COVID-19 Vaccine	Q4 2020	2021

2.2 Forecasted introductions and campaigns in 2021

Forecasted introductions and campaigns in 2021	Programme	Expected application year	Expected introduction year
	Rotavirus Vaccine Introduction	2020	2021
	HPV Vaccine	2020	2021

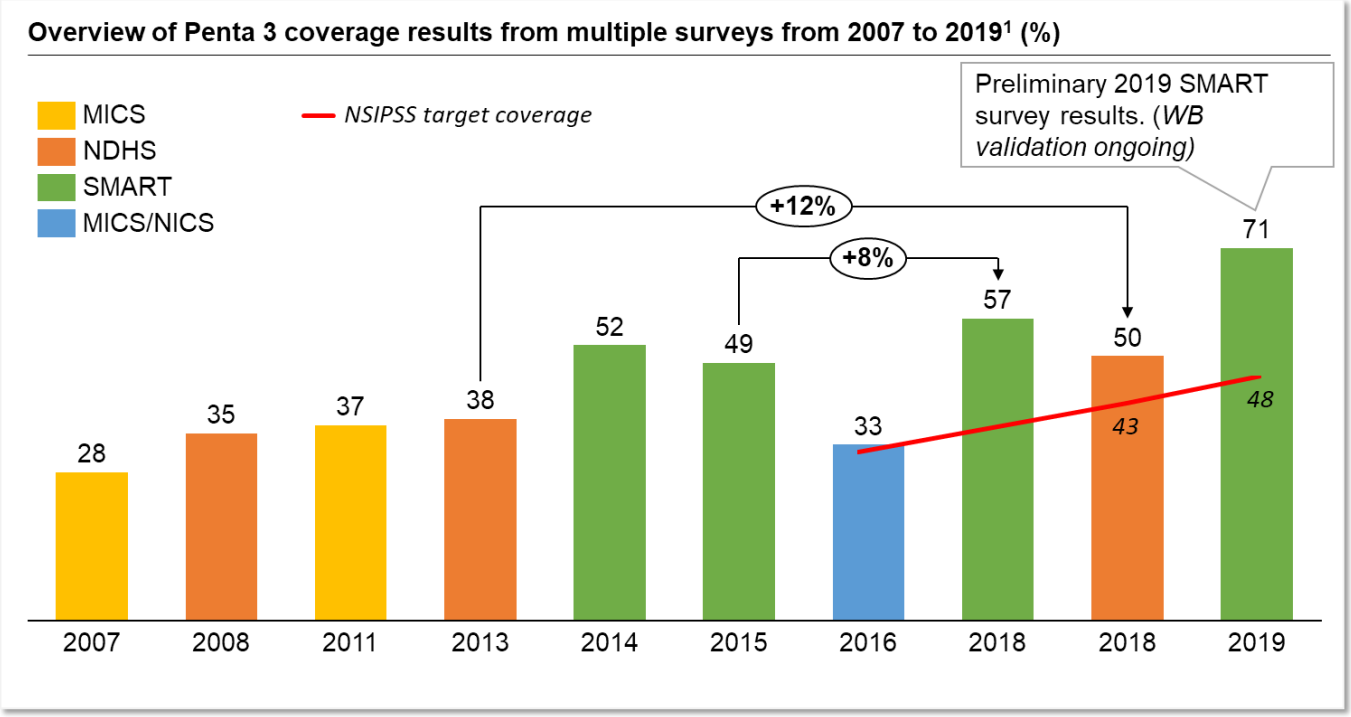
2.3 Data, innovation, zero dose, equity (Provide brief update of work done since 2019 JA and plans for 2020 ~200 words)

Questions for consideration:

- What are the current challenges with population data/programmatic target population? How can they be addressed?

At the moment, there are concerns on the reliability of the projected census figures to track RI performance in Nigeria because of disparity between survey and admin data and the recurrent VPDs outbreaks in states with >100% administrative coverage rate. The Core Group in early 2018 recommended that there was a need to generate a programmatic/operational target population. Consequently, NEOC and NERICC data teams triangulated denominators across various sources using projected census population, GIS estimate and Walk-through Micro-plan data for 25 states and recommended GIS estimates for the remaining 12 states (mostly Northern states) pending when national census will be conducted.
However, there still are concerns on the accuracy of these programmatic targets and this necessitated several efforts to conduct another enumeration in some LGAs and wards to arrive at the estimates that might be recommended for routine immunization programme monitoring. Examples of the current efforts include micro-census exercise that attempts to have a complete count of persons using high level precision tools to get reliable estimates. This effort was piloted in Magarya ward, Wurno LGA of Sokoto State in August of 2018 and the enumerated data was validated and triangulated with other population sources including walk-through micro plan and GIS estimates. The results were quite close to the GIS estimates for the enumerated area. It was subsequently agreed to broaden the scope to cover more wards in Wurno LGA of Sokoto and capture a state in the South of Nigeria to provide additional context. Planning is currently ongoing to conduct this in 5 wards in Wurno LGA of Sokoto and 5 wards in Ifedore LGA of Ondo States. This exercise will provide us with an opportunity to get the counts of all the persons in these areas. In addition, we will also get the estimates for under 1's and compare this with the other population estimates e.g 2016 walk-through, 2006 projected census estimates, GIS estimates and others. Furthermore, it could also give an insight on the reliability of some of our estimates e.g what proportion of the general population is under 1 and also if these proportions vary from place to place.

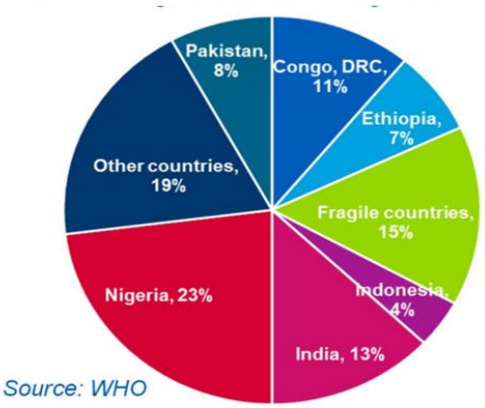
- Coverage estimates from reliable surveys (NDHS 2018)



From the results of the 2018 surveys, Nigeria surpassed the national coverage target set in the NSIPSS (43% Penta 3 coverage). There was 12% and 8% increase in Penta 3 coverage for the 2018 NDHS and SMART respectively, when compared to the previous survey results. While the NDHS result of 50% is less than the SMART result of 57%, both survey results indicate an overall positive trend in immunization coverage in the country

- What work is currently being undertaken to identify, reach and monitor zero-dose populations? What other/new strategies could be pursued?

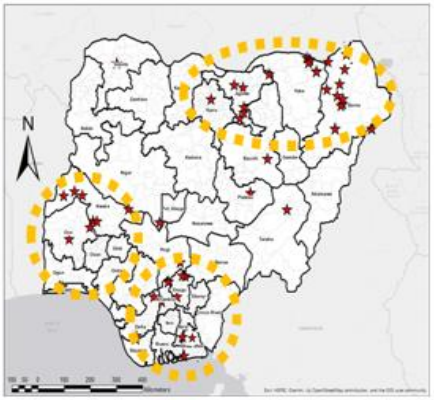
Identification of zero-dose populations



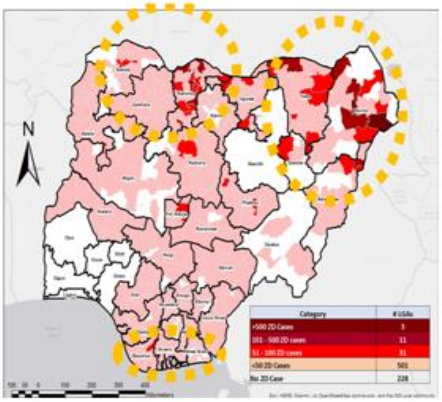
As the figure below refers, 81% of zero-dose children[2] are in 20 Gavi-supported countries including Nigeria. 10.6 million infants lack access to vaccination services, of which Nigeria records over 2 million zero-dose children. Social economic barriers can play a role in denying equitable access.

Looking at available various data source, it is evidence that certain parts of the country have higher proportion of zero-dose populations. As the Figures below show, Surveillance and LQAS data show high burden of zero dose children in states in North East zone and North West zone; Acute flaccid paralysis (AFP) and LQAS data shown high burden of zero dose in South West zone, North East zone and South South zone.

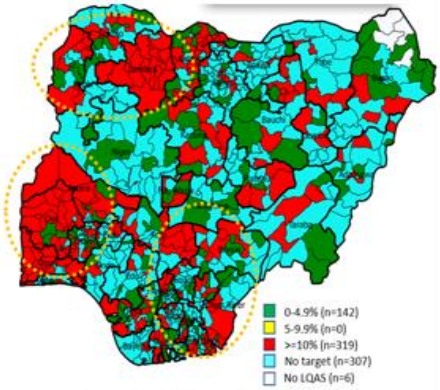
[2] Zero-dose children are those that have not received any routine vaccine. For operational purposes, Gavi defines zero-dose children based on lack of Penta 1. Under-immunised children are those who are missing their full course of vaccination.



AFP zero dosed children 6-59mnths, 2019



Distribution of zero dose measles cases, 2019



Proportion of children 9 – 11 months no dose of any antigen, Q2- LQAS 2019

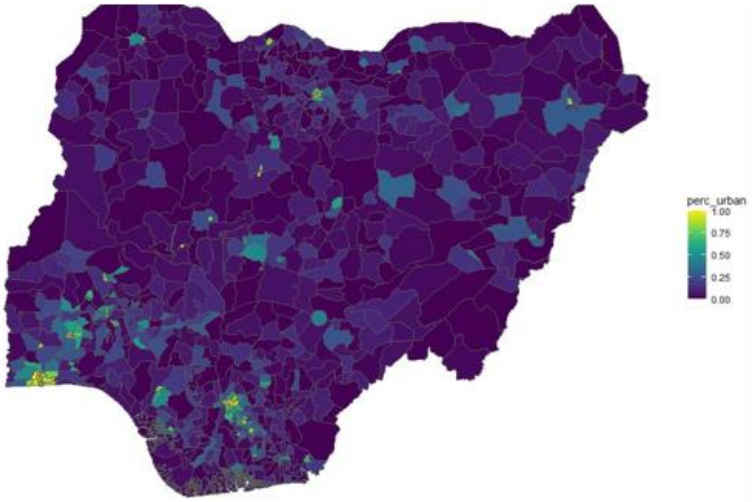
With regards to geographical settings, children in conflict, urban and other geographic settings are more likely to not receive their first dose of Penta there by increasing the likelihood of exposure to vaccine preventable diseases. 61% of the zero dose population live in geographic settings classified as 'other'. Consequently, there is a need to develop geographic sensitive strategies to reach zero dose populations thereby improve access to immunization services.

% of total zero dose in geographic settings

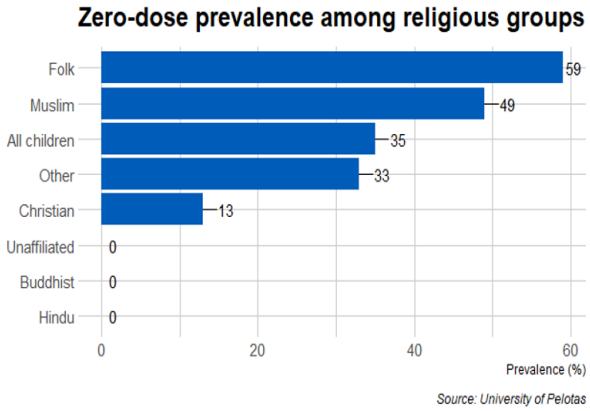
SETTING	% OF TOTAL SURVIVING INFANTS	% OF TOTAL ZERO DOSE
Urban	23	13
Slums	3	NA
Peri-urban	7	6
Remote	2	2
Conflict (narrow)	5	7
Conflict (broad)	20	21
Other	53	61

Note: 2019 IHME coverage. Analysis by WorldPop.

Definitions
Remote Rural: 3 or more hours away from city (population >50k)
Urban: Built Settlement + Density
Urban Slum: Urban + Accessibility
Conflict (narrow): 300 conflict deaths per 1m pop
Conflict (broad): 30 deaths per 1m pop

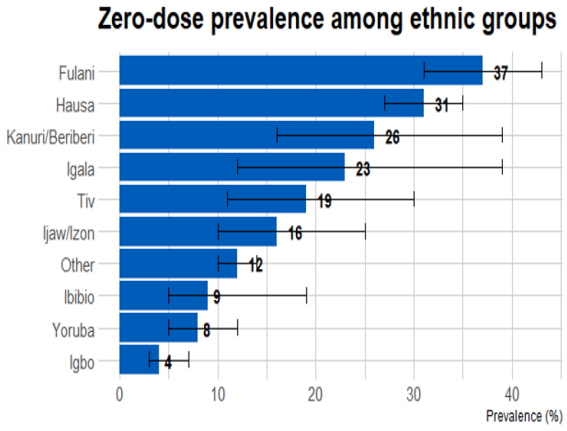


As a religiously diverse country, there are large differences in zero-dose prevalence in Nigeria as reference in the figure below.. Zero-dose prevalence was most prominent with folk (59%) and muslim (49%) populations compared to the national prevalence of 35%. With such great disparities across religious groups, further evidence is required to understand what factors undermine infants from accessing immunization services.



Source: University of Pelotas

With over 250 ethnic groups, Nigeria's Immunization program faces with a unique feat of reaching children from unique cultural settings, thereby interfering with ongoing efforts to reach every child. the Figure below shows that Fulani, Hausa and Kanuri/Beriberi populations record the highest zero dose prevalence compared to other ethnic groups. Notably, the high concentration of Fulani, Hausa and Kanuri/Beriberi communities are situated in the northeastern and northwestern regions of Nigeria, which also have higher proportions of zero-dose populations.



Due to the high vulnerability of zero-dose populations, there is a need for further review of available data (i.e. historical and real time SIA data) to understand who zero-dose and under-immunised children are, where they live and why they are not being reached holistically. This will require more concerted efforts disaggregating data to look at zero-dose populations.

Reaching zero-dose populations

In order to bridge the gaps in equity, Nigeria has developed approaches to reach vulnerable and under immunized populations such as Optimised Integrated Routine Immunization Session (OIRIS) and Integrated Medical Outreach Program (IMOP).

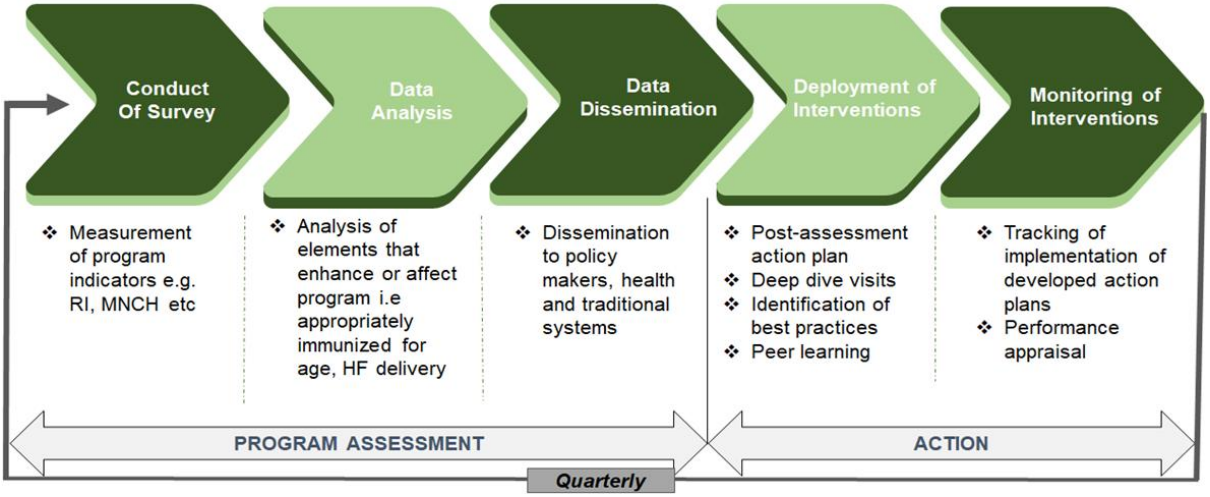
OIRIS strategy was deployed in the 18 poorest performing states to focus on increasing the number of sessions ensuring that daily sessions are conducted for all health facilities in urban, peri-urban areas. In addition, supportive supervision was intensified at all levels, institutionalization of integration through inclusion on other PHC commodities, services and supplies during sessions, implementation of community engagement Framework, improving on data visibility and accountability.

IMOP is focused on bridging gaps in PHC service provision especially reaching the unreached children in immunization in 409 lowest performing LGAs (53% of the LGAs in Nigeria). Three rounds are being implemented to rapidly improve RI and PHC outputs from October–December 2020 by prioritizing the provision of key PHC services to underserved populations through fixed, temporary fixed posts and mobile sessions.

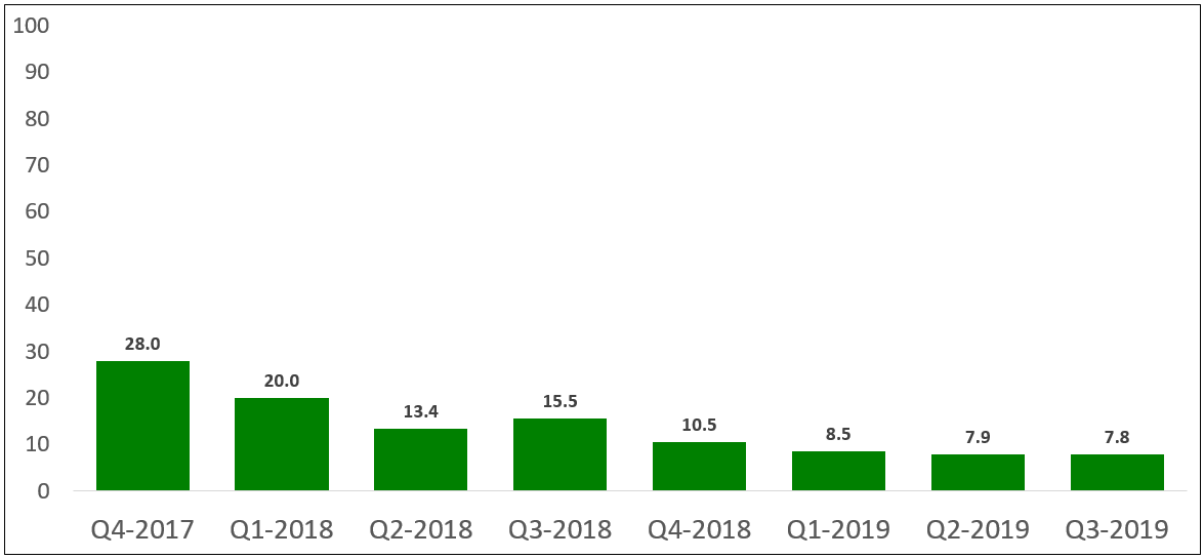
Existing innovative approaches such as OIRIS and IMOP have resulted in meaningful gains in access and utilization of immunizations services. However, there is a need to develop and implement dedicated strategies targeted at reach zero-dose populations

Monitoring zero-dose populations

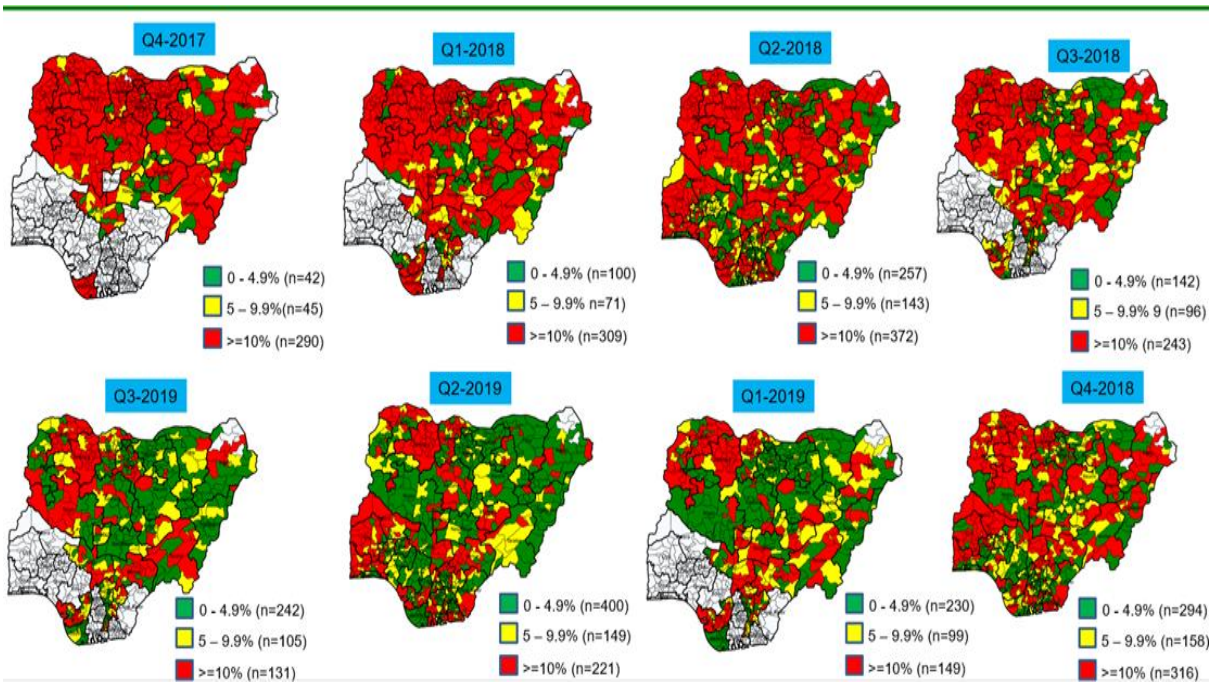
In order to monitor program progress, Nigeria has deployed Programme Assessment for Performance management and Action - Lots Quality Assurance Sampling (PAPA-LQAS). Since Q4 2017, quarterly RI programme performance assessments were conducted in the 18 lowest-performing states with the aim of identifying poor performing states for prompt interventions. This was done by conducting quarterly PAPA-LQAS for a more intensive programme implementation and monitoring. In addition, bi-annual PAPA-LQAS is also conducted in all the 36 states and FCT. PAPA is systematic 5 step approach to addressing program challenges through data monitoring for action as highlighted in the figure below:



Trends in the proportion of Zero dose population have shown steady decline from Q4, 2017 to Q3, 2019 from 28% to 7.8% (Figures x).



There have also been significant gains in reaching under-immunized children. PAPA-LQAS results shows steady progress in the quality of RI services based on proportion of LGAs passing a lot at 80%, from 3% of LGAs in Q4 2017 to 45% in Q3 2019. This may be attributed to increase of concerted efforts to improve access and update of RI services in Nigeria through interventions such as OIRIS, RI intensification, etc.



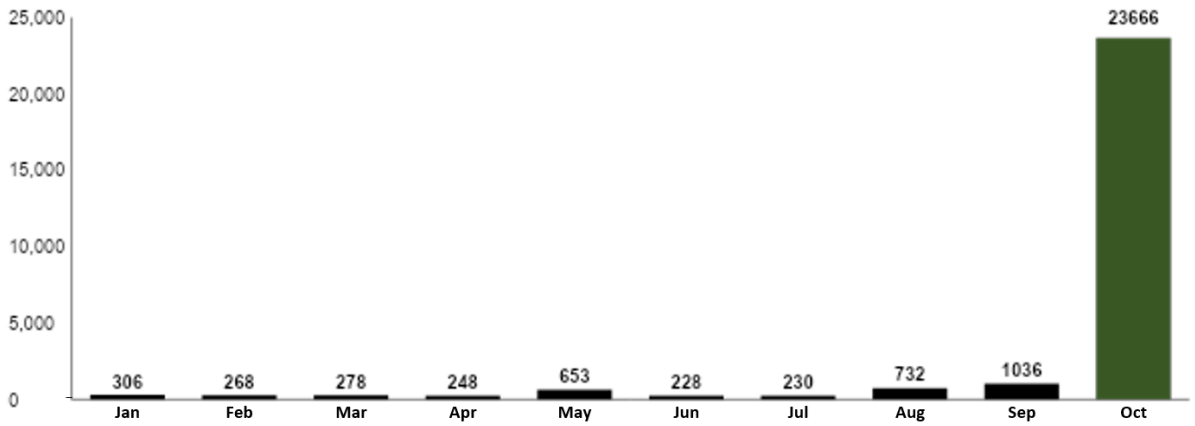


Figure 9: Monthly trends children 12-23 immunized with Penta 3 (DHIS2) versus Integrated Medical Outreach Programme (IMOP) conducted in 1 week in October 2020

Figure 9 above shows over 22,000 increase in monthly trends of children 12-23 months immunized for Penta3 within 1 week of IMOP implementation. Data is received from 333 out of the 409 LGAs.

Multiple interventions including Reaching Every Settlement, Reaching Hard to Reach, Routine Intensification among others have led to significant decline in the number of unimmunized populations. It must be mentioned that this does not discount access to some settlements in the states for which continued efforts are being availed to close the gap.

In moving forward, there is a need for specific strategies to further capture correct zero dose unimmunized children including;

- Conduct a risk assessment to assess, map and profile locations at the highest risk of zero cases
- Develop a risk profiling tool for IDP and riverine areas and focus specific strategies especially for places that have intermittent coverages for RI intensifications.
- Utilize the findings of the assessment to guide the development and monitoring of targeted strategies to reach zero dose populations

- What are the current challenges with immunisation coverage data? How can they be addressed?

Administrative data collected at health facilities and compiled by LGA Monitoring & Evaluation (M&E) Officers is often inaccurate, incomplete, and unreliable. This is further compounded by the fact that health workers who collect the primary data are not appropriately trained on how to use, interpret or manage data. The denominators of the coverage rate are often inaccurate because of poor population estimation, unrecorded population movements, or outdated Census figures. Also, the numerator of the coverage rate may be either inflated (e.g., doses are administered outside the recommended age range, poorly kept records, the total number of children immunized is falsely inflated to meet set targets, summation errors, etc.) or too low (e.g., inconsistent reporting, insecurity, poor internet services, etc.) Without reliable data, the country is unable to identify and assess evidence-based decisions that will improve access to quality health care. Additionally, accurate data is essential to lead to better plans and targeted budgets to channel funds into the specific areas that need most help.

To address the gap in data quality, the government and partners developed a mid-term strategy document, Data Quality Improvement Plan (DQIP) and has piloted a variety of initiatives to address some of these issues. NPHCDA worked with partners to develop a comprehensive six-month action plan to improve DHIS2 data quality. This followed the revision of the DQIP at the behest of the ED NPHCDA. Interventions from the DQIP were identified and prioritized to inform the development of the action plan. In Q1 2020, ED NPHCDA approved the action plan. Despite the development of quick win strategy to serve as a roadmap for improving data quality, implementation remains suboptimal. Due to the onset of COVID-19, the states have not yet been systematically engaged to understand their financial or programmatic expectations. As a next step, the agency plans to communicate and disseminate the DQIP to ensure optimal implementation before Q2 2021.

With the successful scale up of DHIS2 reporting platform across all the states and LGAs, routine immunization has drastically improved since data in the country has become accessible, visible, and available for decision making. However, the entry occurs at the LGA level following monthly submission from all health facilities within each LGA. The major challenges with this structure are that it delays action and reduces chances of identifying and correcting data quality issues at the operational level promptly. The proposed health facility data reporting system which will leverage on the mobile DHIS2 module technology for data capture will help to address some of the challenges associated with the aggregate data reporting at the LGA level. This system will provide visibility at operational level, eliminating LGA level aggregation and reporting as data will be entered directly by the routine immunization services providers, allowing prompt actions on data quality issues and use of data for decision making. This system will have a dashboard for viewing the indicators, a mobile phone/tablet (preferably android) and SIM card for data transmission from each health facility, a simple gateway equipment for collating and transferring data to the server and a job aid for guiding health workers in sending data will be developed and shared.

Despite ongoing initiatives to improve data quality, usability, and use, issues persist. Many studies in low and middle-income countries including Nigeria have shown that interventions, which encourage the

positive practice of health workers, improve the compliance of individual health systems actors with the broader system's health goals[3,4,5]. Some studies in Nigeria provide evidence linking poor data quality and use to structural and organization barriers, but do not emphasize the exact causes attributed to behavioural factors. As a result, these studies infer that deploying accountability measures, clarifying the data management functions of EPI managers and health workers across levels, and building their capacity is paramount for data quality improvements[6,7]. These studies do not provide substantial information on what drives health care workers to value, adopt, and own data tools and procedures. Consequently, there is a need to enrich the evidence base on the behavioural drivers for poor data quality, usability, and use from the perspective of health care workers.

Insights from the behavioural science perspective will help to determine key drivers of data quality, usability, and use at the LGA and HF levels as well as inform intervention design. NPHCDA in collaboration with AFENET and CHAI conducted longitudinal study to understand the drivers of RI and PHC data quality across eight states (i.e. Anambra, Ekiti, Bauchi, Sokoto, Kano, Yobe and Niger). Based on the outcomes of the study, the expectation is that new insights will inform the development of strategies. that may disrupt the beliefs, norms, and thought processes that give rise to certain data management practices alongside those that encourage such practices designed by aligning concepts gleaned with behavioural science literature and qualitative analysis.

Additionally, a behavioural component is currently being implemented by NPHCDA and AFENET with funding from BMGF aimed at addressing the challenge of wide disparity between data from administrative sources and surveys. Using the HCD approach, factors and norms affecting data quality across the different levels will be addressed using the B.J Foggs Behavioural Model targeting motivation, ability and triggers/prompts while considering sustainability. This approach seeks to motivate the health workers, simplify the activities related to data management at the facility and LGA, nullify barriers to generation of good quality data, explore norms around data quality and introduce prompts into the system that will regularly and systematically prompts the health workers to carry out simple behaviours and tasks to ensure good quality data. In this approach, data use is encouraged at all levels including the health facility where health workers capacity is built enough to independently review their service delivery data, make inferences and plan actions based on this for the next reporting month

- What tools/technologies are being used to collect and analyse data? What new tools/technologies/ strategies could be pursued?

Currently, RI data is collected through the District Health Information System, version 2 (DHIS2) as the only recognized electronic platform in the country's National Health Management Information System (NHMIS). The platform supports real-time data reporting, promotes government ownership and accountability. All health facilities offering routine immunization submit monthly reports, which are entered into DHIS2 by LGA Officers. The DHIS2 RI Module roll-out was concluded in 2018 which has contributed to improvement in reporting rates on the national instance of DHIS2 to over 80%. 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. The country is transitioning from the NHMIS version 2013 to 2019, which incorporates more RI data elements to be captured at the health facility level. The NPHCDA working with partner agencies through the NERICC structures also developed a system that allows health facilities to report their daily routine immunization sessions using SMS-based technology that makes the data to be accessible at National, State and LGA levels instantly. The system allows health facilities to be tracked and followed up to ensure data reported is verified and issues arising promptly resolved. The RI Short Message Service (SMS) daily reporting tool has been scaled up to all 18 NERICC high-priority states to complement DHIS2 monthly reports. The RI SMS tool ensures RI data is available

[3] MCHIP. (2012).Creating Stronger Incentives for High-Quality Health Care in Low- and Middle-Income Countries. Retrieved from https://www.mchip.net/sites/default/files/QoC and PBI_Full report_Final.pdf

[4] Ogundeji, Y. Can Performance Based Financing Improve Quality of Healthcare in Nigeria? http://afhea.org/docs/presetationspdfs/Yewande%20Ogundeji%20-%20Can%20RBF%20improve%20quality%20and%20access%20to%20care%20in%20Nigeria%20-%20Copy.pdf. 2016

[5] Florence M Nyangara, Tajrina Hai, Kirsten Zalisk, Lynda Ozor, Joy Ufere, Chinwoke Isiguzo, Ibrahim Ndaliman Abubakar, Assessment of data quality and reporting systems for underserved populations: the case of integrated community case management programs in Nigeria, Health Policy and Planning, Volume 33, Issue 4, May 2018, Pages 465–473, https://doi.org/10.1093/heapol/czy003

[6] Etamesor, S., Ottih, C., Salihu, I. N. & Okpani, A. I. Data for decision making: using a dashboard to strengthen routine immunisation in Nigeria. BMJ Glob. Heal. 3, e000807 (2018). Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6169671/

[7] Omoleke, S. A. & Tadesse, M. G. A pilot study of routine immunization data quality in bunza local government area: Causes and possible remedies. Pan Afr. Med. J. 27, (2017). Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5622826/

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 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.
The plan for roll-out of RI SMS system involves three phases, with each subsequent phase a technological advancement of the preceding phase. The transitions will be systematic, and this process started with SMS-based reporting and plans to gradually move to the app-based system with an integrated mechanism for collecting individual digital data, coupled with a tracking and reminder system is ongoing.

Effective RISS is one of the strategic interventions of the Optimized Integrated Routine Immunization Session (OIRIS), an approach that aims at revamping RI coverage, data quality inclusive. The intensified Routine Immunization Supportive Supervision (RISS) happens from the national to the states, states to the LGAs and LGAs to the health facilities. During such visits, issues on data quality are addressed and on-the-job mentoring provided to RI data officers at health facility levels. Information on RISS are reported real-time on the ODK platform for effective follow up on issues highlighted and this is being analysed monthly at all levels for appropriate urgent actions. While the use of RISS data for programming at the national level has significantly improved, use of RISS data at the subnational level remains suboptimal. To support states, strengthen the quality and use of RISS data, there is a need for the creation of dashboards and review of RISS database.
After the termination of the Logistics Management Information System on the NiSCMIS platform, the NLWG developed an ODK based LMIS as a stopgap measure for stock data management. Termination was due to high operational cost, technical issues and inadequate capacity transfer to the Government. The ODK LMIS has been deployed and provides weekly stock visibility across National, Zone, State and LGA levels for vaccines accountability and decision making for distribution where necessary. The ODK will be linked with the eLMIS. The NLWG is conducting weekly meetings with the Novel-T team to discuss information and features to be included in the eLMIS to be developed.
While there are plans to transition VPD surveillance data to SORMAS, consideration on how to integrate SORMAS with DHIS2 is also important. This will ensure optimizes governments decision making process. Considering the existing capacity of the DHIS2, there is a need to ensure that bandwidth expansion occurs for streamline integration.

- How is data currently being used to promote accountability? What other/new strategies could be pursued?

Nigeria has an accountability framework for routine immunization developed which also covers data quality. However, this framework has been fully operationalized. However, there are examples of a few states that have implemented elements of the framework to reward and sanction health staff which has yield some improvement. Nevertheless, strong political will obtained from the highest level of government is critical in ensuring accountability commitments are met especially at the sub-national levels. This is expected to yield demonstrated results when applied consistently.

Additionally, since 2017, NPHCDA working with donors and development partners (WHO, UNICEF, GAVI, BMGF, US-CDC, AFENET/NSTOP, USAID, CHAI, EU-SIGN, SOLINA and IVAC) has been tracking RI performance in all the thirty-six (36) states and FCT biannually, to monitor the impact of the RI interventions in all communities. This monitoring involves the use of routine administrative data on the DHIS2 and SMS platforms to engage poor performing states and LGAs; periodic assessment of RI programme performance using PAPA-LQAS (Programme Assessment for Performance management and Action - Lots Quality Assurance Sampling). Recently, quarterly RI programme performance assessment was conducted in the 18 lowest-performing states with the aim of identifying poor performing states for prompt interventions. This was done by conducting quarterly PAPA-LQAS for a more intensive programme implementation and monitoring. In addition, bi-annual PAPA-LQAS is also conducted in all the 36 states and FCT and the most recent one indicates a gradual improvement in the RI performance in the country. The PAPA-LQAS is independently conducted by the National Bureau of Statistics (NBS) with technical support from the World Health Organization (WHO). In addition to these assessments, AFENET has supported the states to develop quarterly scorecards to assess the performance of their LGAs using selected indicators that cut across Coverages, vaccine usage and data entry errors. This will be scaled up to incorporate other PHC indicators.

- What work is currently being done to promote health care and immunization equity? What other/new strategies could be pursued?

Although opportunities to accelerate gains remain very essential, results from NDHS 2018 suggest meaningful improvements in access and utilization of immunization services at the national and sub-national levels for infants in the 2017 birth cohort compared to levels observed 5–10 years ago. The NDHS 2018 result also suggest these gains are particularly pronounced among infants born into socioeconomically disadvantaged conditions. 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 still exist based on residence, mother's education, and wealth quintile. The trends as shown in Figure 1 below show progress made to improve Penta3 coverage for each equity barrier, despite the persisting gaps. However, 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 Pent 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. Generally, 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).

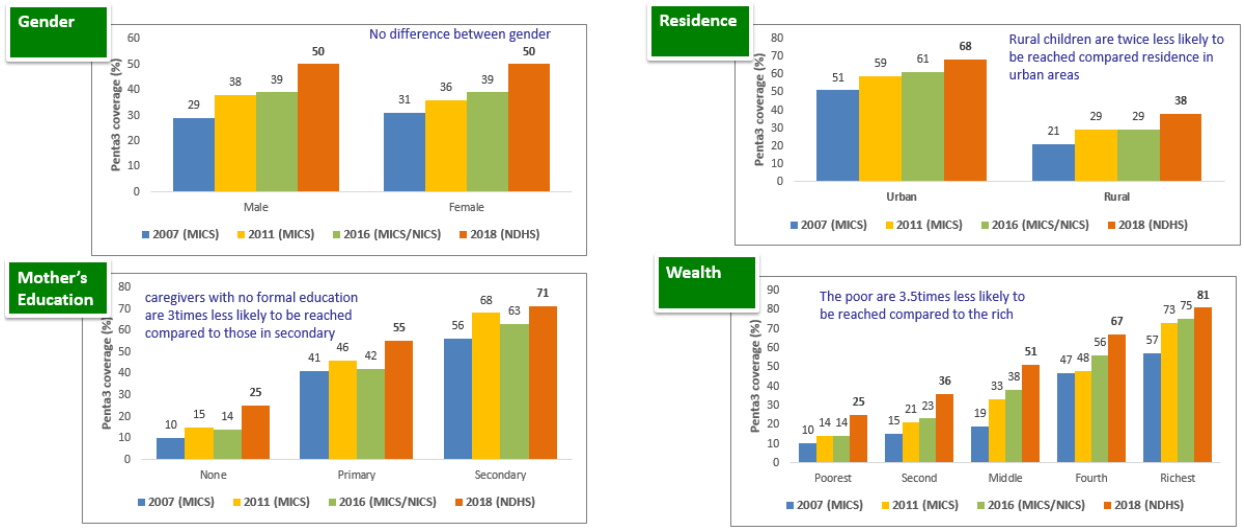


Figure 1: Penta3 Coverage trend by gender, residence, mother's education, and wealth, per surveys in Nigeria, 2007 – 2018

The implementation of the Optimised Integrated Routine Immunisation Sessions (OIRIS) approach which is regularly assessed through periodic conduct of the RI-LQAS helps to strengthen healthcare and immunization equity across various regions of the country. The RI-LQAS which is currently being replaced by the Programme Assessment for Performance Management and Action (PAPA-LQAS), incorporate some other RMNCH+N indicators. The PAPA-LQAS results as shown in figure 2 below indicates an increase in the number of LGAs with acceptable score from 11 (3%) in Q4 of 2017 to 172(46%) and 169(45%) in Q2 and Q3 of 2019 across the 378 targeted LGAs. These achievements notwithstanding, there are factors such as inadequate number of skilled staff, low financing and insecurity that contribute to sub-optimal immunisation performance inequity.

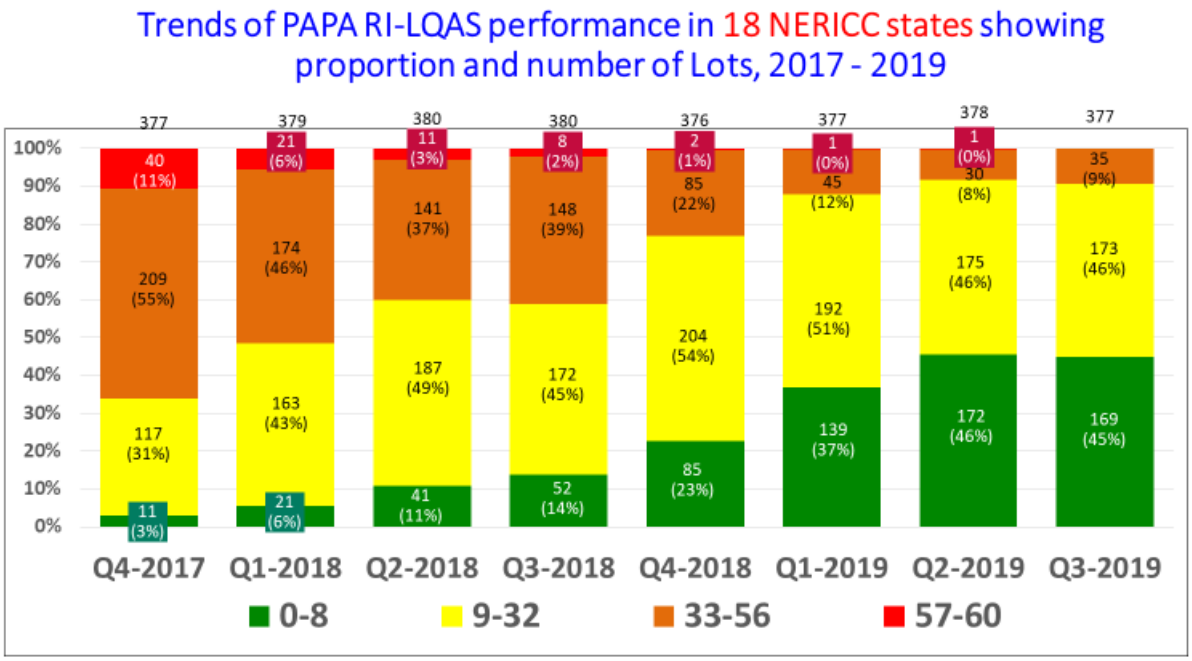


Figure 2: Results from LQAS show an increasing number of lots with passing scores suggesting improvements in programme performance in the 18 priority states between Q4 2017 and Q1 2019

Actions taken to redress inequity in security compromised areas such as Borno, Yobe and Adamawa include the Hard-to-Reach Project and Immunization at transit points and IDP Camps. In addition, there is an initiative to expand RI to partially accessible settlements with the support of civilian JTF and further explore polio vaccination strategies such as Reach Inaccessible Children (RIC) and Reach Every Settlement (RES). Other innovations include targeted and tailored strategies that are designed to meet the specific needs of the identified communities such as as the support for outreach/RI intensification to hard-to-reach areas and underserved communities across all HFs in LGAs sharing international borders in 7 states: Adamawa, Taraba, Borno, Jigawa, Yobe, Zamfara and Katsina and to Informal IDP camps and their host, increasing outreach and mobile services in often missed and hard to reach areas; task shifting among health care workers; increased community involvement; additional supervision to reach urban under-immunized areas; Implementation of demand generation projects and [BU1] strengthening strategies for demand generation that will increase education and awareness about the importance of vaccination, working with PPMV since they are the major care provide, and developing clear lines of responsibility for addressing the needs of new, urbanizing areas and setting up noncomp liant resolution committee in the wards to addressing pertinent issues in chronically noncompliant communities and households

- What additional TA is needed to implement 2021 activities to address issues identified above?

The technical assistance and activities that should be implemented to address issues highlighted above include but not limited to:

S/N	Key activities planned for 2021 that require TA	Required TA
1	Implementation of strong accountability measures at all levels and capacity building of HWs to address behavioural aspects of data quality	Continuation of existing TA
2	Revision of operational denominator for effective programmatic decision making by NERICC/NEOC data team in collaboration with relevant agencies including the National Population Commission	Continuation of existing TA
3	Conduct of data validation meetings at the LGA level	Continuation of existing TA
4	Improvement of timely recording of data using NYSC corps/ad hoc as prompts/triggers at the health facility	Continuation of existing TA
5	Harmonization of RI data tools to reduce the use of excessive tools in health facilities	Continuation of existing TA
6	Printing of RI data tools (VM tools, Child health cards, RI Job Aids, immunization registers, tally sheets, NHMIS summary, Community data tools),	Continuation of existing TA
7	Conduct of monthly review meetings at state and LGA levels to discuss routine immunization data quality issues and use available data for action	Continuation of existing TA
8	Conduct of surveys to assess programme performance and quality of administrative data (SMART, MICS and NICS)	Continuation of existing TA
9	Conduct supportive supervision to LGAs and Health Facilities to address data quality issues	Continuation of existing TA
10	Development of frontline healthcare workers capacity on how to collect accurate information	Continuation of existing TA
11	Institutionalization of award and sanction-based system. NPHCDA will be rewarding states with low variance between administrative data and future surveys, this will increase motivation to improve data quality	New TA
12	Conduct of Data Quality Self Assessments	Continuation of existing TA
13	Build capacity of EPI managers on data triangulation, enhancing their ability to spot data manipulation	Continuation of existing TA
14	Operationalization and sub-national domestication of the DQIP	Continuation of existing TA
15	Conduct of operations research on improving immunization uptake and understanding the dynamics of data quality	Continuation of existing TA
16	Conduct of LGA and ward levels enumeration studies in some selected states	Additional TA
17	Validation of already conducted household enumeration and conduct walk-through households' enumeration,	Continuation of existing TA
18	Implementation of GIS population estimates	Continuation of existing TA

19	Continuous triangulation of the data to derive best denominator for immunization program	Continuation of existing TA
20	Introduction of electronic data transmission and immunization registry to capture individual immunization record	Continuation of existing TA
21	Purchase of mobile devices for 28,000 plus facilities	Continuation of existing TA
22	Deployment of mobile reporting Apps to 28,000 RI Health Facilities across the country	Continuation of existing TA
23	Deployment of electronic vaccine registry in all 28,000 Health Facilities	Continuation of existing TA
24	Upgrade of DHIS2 bandwidth and routine technical assistance on DHIS2 optimization	New TA
25	Support states migration from old to new tools on the DHIS2 platform through regular HCWs capacity development and production of NHMIS and RI tools	New TA
26	Support the implementation of Health Facility Registry and interoperability of both HFR and DHIS2 platforms	New TA
27	Revision of operational denominator for effective programmatic decision making by NERICC/NEOC data teams in collaboration with relevant agencies including the National Population Commission	Continuation of existing TA

2.4 **HSS**

Provide brief update of work done since 2019 JA and plans for 2020 ~200 words)

- What is the status of HSS activities?

Thematic area	HSS planned activities	Status (2019-2020)	Comments
LMC	Conduct of yearly scorecard assessment		The conduct of the annual PHCUOR scorecard is ongoing
	Develop and disseminate financial management tutorials (online)		Not done
	Monthly feedback on RI and PHC Indicators from national to subnational levels		NPHCDA programme teams (NERICC, NEMCHIC, etc) provide these updates routinely
	Conduct Mid-Year EPI Review Meeting with the 36 States + FCT		Not done. Although through the NERICC platform, NPHCDA engages the state EPI managers (ES, SIO, PM) routinely
	Conduct Annual EPI Review Meeting and Workplan development with the 36 States + FCT		This was conducted in 2019, but not in 2020.
	Support regular conduct of NGITAG and ICC meetings		These meetings hold as required, though without Gavi funding support

	Quarterly meeting of the ED NPHCDA with SPHCDA leadership (ES, PHC directors, etc)		Ongoing
Service delivery	Conduct of RI supportive supervision/ on-the-job mentoring at state by the National		Ongoing
Demand	Engagement and orientation of CSOs on current demand generation strategies		Not done
	Printing of materials for advocacy for adequate resource allocation, timely release and tracking of budgeted funds for Immunization and PHC services		Ongoing
	Scale up immunization reminder innovations e.g SMS, bracelets, Voice messaging		Not done
Data	Deploy mobile reporting Apps to 28,000 RI HFs across the country		Not done
	Procurement of 28,000 android phones for all RI HFs for reporting		Not done, though efforts are underway to complete this
	Training of HCWs on use of mobile reporting apps		Not done
	Configuration of community data tools to the HMIS/DHIS		Not done
	National Bi-annual Data review meeting		Not done
HRH	Identify and engage a consultant to develop, and implement a HRH assessment framework with report working with NPHCDA and partners		Not done
	Review and update pre-service training curriculum for immunization and other PHC services in collaborations with regulatory bodies		Not done
	Routine Update of National HRH Profiling (bi- annual)		Not done
	Development of framework to guide states for deployment and incentivizing of PHC Workers		Not done
	Development of Advocacy kit for HRH		Not done
	Development of Program Curriculum to support Capacity building of States and LGAs implementing the CRISP Strategy		Not done
Supply chain	Conduct periodic cold chain inventory assessments to monitor implementation of CC expansion and rehabilitation plan		Conduct as required
	Conduct Temperature data study for vaccines throughout the supply chain (including in-transit)		Not fully operational

	To bridge funding gap for construction, outfitting and operationalisation of Lagos Hub		Not done
	Construction, outfitting and operationalisation of Abuja Hub		Support for 3-Hub system (Abuja and Kano) yet to commence. The process to involve vendor started
	Maintenance and hosting of LMIS technology		Support in procurement and deployment of LMIS ongoing with Novel-T
	Joint investment for CCEOP		Not applicable as the required funding has been covered by Nigeria through WB
	Procurement of cold chain equipment		The implementation of CCEOP Tranche 1 (HSS CCE) has been completed. 2,963 CCEs have been deployed and installed across 28 States under Tranche 1. The Tranche 2 Operational Deployment Plan (ODP) for 6,346 CCE has been completed. Procurement for tranche 2 is ongoing. Deployment and installation of tranche 2 CCE will commence across the 36 States plus FCT by beginning of Jan 2021 and planned to be completed by end of 2021.

2.5 **Immunisation supply chain and effective vaccine management**

(Provide brief update of work done since 2019 JA and plans for 2020 ~200 words)
Topics to discuss:

- What has been done in 2020 to improve vaccine management (inventory management, temperature monitoring)?

o Deployment of optimized refrigerators with RTMDs and bundled with 30-day temperature recorders (30 DTRs) for continuous temperature monitoring and logging under the CCEOP project implementation as well as optimizing other available temperature management systems leveraging national and state review systems with necessary actions taken to safeguard vaccines.

o Temperature mapping was conducted in 2018. The WICR/FR at the National Strategic cold stores have been mapped. Mapping of Cold chain equipment is conducted to identify temperature variations and to identify potential airflow issues that may be the cause of temperature variations. It is also recommended that temperature mapping should be conducted after major repairs and installation of a new cold chain equipment. ZCCO, VSL, NLWG members were trained on mapping. Vaccine Management training at National, State and LGA levels was delivered through a mix of effective physical and virtual training techniques and adult learning methodologies (voice-over video recordings, PPT presentations etc).

o Effective Vaccine Management Assessment (EVM2.0) onboarding and Standalone EVM assessments conducted at different levels in country with self-developed continuous improvement plans

o ODK- based LMIS was deployed for data visibility at National, Zones, States and LGAs to create stock visibility and contribute to vaccine accountability checks for availability, distribution, and programmatic decisions.

After the termination of NiSCMIS platform, the country as a stop-gap measures develop an ODK bases LMIS to create visibility at National, Zones, States and LGAs. On weekly basis this has contribute immensely to vaccine distribution and accountability.

o Information gathering for the development of an eLMIS system is currently ongoing through the engagement with Novel-T consultancy.

Gavi and NPHCDA went into discussion in August 2020 for an eLMIS solution for Nigeria through Novel-T Solution centred on the following:

- ❖ Scoping (concluded) - defines NPHCDA 's high level requirements on Stock Management, Cold Chain Management and Vaccine Ordering with the understanding that the real-time and accurate vaccine consumption tracking at the lowest levels (Health Facility) is considered as part of eRI solution scope.
- ❖ Prioritization- Agreement on a Minimum Viable Product (MVP)
- ❖ Research – Perform research and detailed analysis of the existing off-the-shelf solutions available and already in use in Nigeria
- ❖ Gap analysis – basically cross referencing earlier defined requirements with functionalities offered by identified off the shelf solutions
- ❖ Selection – select on the basis of a value criteria the best fit solution
- ❖ Enhance – add missing features to the selected solution so the final product can entirely match earlier defined requirements

o Development of Standard Operating Procedures for all levels for effective vaccine management based on EVMA 2.0, consultant required for further review and finalization before printing and dissemination
o Development of iSC Policy Document
o Regular insourced Physical Stock Count conducted by the vaccine handlers at all levels for vaccine accountability and distribution
o The NPHCDA's audit department conducts internal audits of NSCS vaccines and other commodities on a monthly basis

- What lessons have been learned from the CCE installations undertaken so far? What can be adapted to improve the rollout of subsequent installations? When are the next installations expected to begin/end?

The deployment of next batch of CCE to States are expected to start by December 2020 while installations will commence tentatively by January 2021
Lessons Learned from the HSS CCE installations that can be adopted to improve the rollout of subsequent installations:

S/N	Theme	Challenges	Mitigation Strategies
1	CCE ODP	-The Process of updating the inventory was cumbersome - When developing the deployment and installation timeline, various risks, such as- delay in MOU signing, erroneous deviation of sites, spontaneous security hurdles in the movement were not fully anticipated.	- Field inventory assessment was conducted - The service providers have been coordinated to develop a realistic development plan for the upcoming installations.
2	CCE Shipment & Distribution	Congestion at the port of entry caused delay in the clearing of the consignment. However, Shipping line provided the free demurrage terms for 45 days.	The clearing agents have been engaged to prepare the documentation in advance and the Quality Assurance & Strategic Planning Division will coordinate fast tracking of CCE clearance.
		Some States did not have designated storage points for CCE's received and this exposed the equipment & devices to the risk of damage from weather conditions	SPMT will identify and prepare appropriate Storage points before CCE's are deployed to the States

3	Coordination of project in States by State Project Management Teams (SPMT)	Poor monitoring of CCE deployment and installation by State PMTs due to lack of funds for SPMT for in-the-field monitoring	SPMT will follow-up virtually via phone calls with LIOs and HCWs where installations are being done
		Late reporting of progress of CCEOP implementation in States	Updating and troubleshooting the weekly installation progress report. – Follow-up with service provider on issues identified – Follow-up with SPMT to submit report and escalate issues to ES when necessary – NLWG coordinates with ES's on any pending or unresolved issues
		Deviations from agreed plan in the ODP viz last-minute changes of HFs and/or mounting due to recent dilapidation, incomplete renovations, and recent onset insecurity issues	Ensuring reallocations are to HFs within same ward or local government to minimize deviation cost
4	CCE installation assessment	Inability to conduct in-process/post-installation Inspection due to COVID-19 pandemic * The Post installation Inspection (PII) is being planned and will be conducted soon	– Engagement of State teams to ascertain the quality of CCE installations being carried out at health facilities – State teams will be coordinated to leverage on other activities such as the supportive supervisions to conduct in-field monitoring of CCE installation – 100% review by National Project Management Team (NPMT) of installation documentations including picture of the HFs and installation process – Monitoring of installed equipment via RTMD portal – Timely in-process/post-installation Inspection for the upcoming installation will be planned and conducted in adherence with the COVID-19 IPC protocols
5	Monitoring and implementation of Signed MoU	Non-implementation of State maintenance units due to: − Lack of funds − Lack of personnel and tools	– Ongoing advocacy to States and GAVI to fund and optimize state maintenance units – Ensuring the curative maintenance of CCEOP equipment are done by installation vendor when needed

- What has been done in 2020 to address wastage? What improvements have been made/need to be made to the implementation of the open vial policy, closed vial wastage, wastage study findings?

Following the identification of factors that drive wastages, active steps have been taken to minimize drivers of avoidable wastages. some of these include:

1. Revision of Data tools:

The NLWG has taken active steps to revise and simplify the data tools as non-documentation was identified as a barrier to effectively quantifying wastages as healthcare workers are often overburdened with multiple tools which oftentimes lead to non-reporting.

2. Non-Traditional Training approach

Working closely with the NERRIC, Non- traditional training approach has been adopted to improve HCWs knowledge specifically on Multidose vial policy using video and visual learning materials. During the last National Vaccines Management Training that was held in Lagos in January 2020 and later cascaded in the states, emphasis was placed on MDVP as a strategy to reduce avoidable wastages.

3. Improved Accountability and Stock Management

In 2020, as a strategy to minimize wastages and mitigate stock out during the COVID Pandemic, the DL&HC ensured that all stock distributed were as data driven as possible with periodic requests to the states to account for the doses received at intervals. Stock irregularities within states were also identified and addressed.

4. Improving HCWs knowledge on Vaccines Management

Also, in 2020, the NLWG undertook the development of multi-supply chain level SOPs and Job aids, aimed at further guiding HCWs on vaccines management practices prior to and during immunization sessions as a strategy to improve practices and reduce avoidable vaccine wastages

5. Community Engagement

Community engagement in session planning is being encouraged to ensure that all eligible clients attend planned sessions which will greatly reduce vaccine wastage through smaller-than-planned sessions and loss of vaccines in opened vials. This has also contributed to improved demand.

In addition to the actions that have been taken by the DL&HC and NLWG, there are activities that require further strengthening which is anticipated to further reduce avoidable vaccines wastages including:

1. **Increase demand for RI and Improve session planning** - Work closely with the NERRIC, Advocacy and Communication department and Non-Polio SIA team to improve demand for RI services in target states with low demand for RI services
2. **Institute systems that promote Supply chain data use to strengthen data availability, quality and track completeness** - Include procedures for vaccines utilization in the accountability framework for Vaccines management specifically around delineation of RI and SIAs vaccines and procedure for use. Additionally, integrate into existing supportive supervision structures the need for "on-the-session" supervision across states with focus on vaccine management practices.
3. **Institute accountability into vaccine management** - Introduce the RI data matrix (SMT) for use to EPI Managers at state and LGA level. This matrix collates per supply chain level key data points for vaccines management monthly e.g doses used, NOCI, Empty vial returned, stock balance etc
4.

- What has been done to improve iSC accountability? What is planned to continue improvements in the future?

The National Logistics Working Group (NLWG) continued with activities to strengthen the immunization supply chain (iSC) therefore enhancing accountability. These include the following,

a) State-Specific forecast: Despite the challenges brought by the pandemic, the virtual State specific forecast was carried out for 2021. This is to ensure vaccine availability according to state needs and enhance state ownership. This is expected to continue into succeeding years.
b) Follow the Vaccine (FtV): The FtV as part of the larger vaccine accountability framework seeks to gather information about storage and transit time for vaccines at all supply chain levels. In addition, it seeks to determine the appropriateness and completeness of the documentation process, stagnation and possible leakages in the system and to identify knowledge gaps in vaccine management practices at the various immunization Supply Chain (iSC) levels. The findings from the FtV will be used to develop recommendations and plans of action to improve vaccine stock management practices and accountability at all levels
c) Leadership - NPHCDA and its partners are interested in the growing body of education and training programs now available for supply chain and logistics professionals and the ways in which trained personnel have been used to make a difference in supply chain performance. Team members from the Department of Logistics & Health Commodities were nominated to go through internship

programs with the Clinton Health Access Initiative and the Africa Resource Centre. Logistics managers at National and State levels also participated in the Gavi STEP training.

d) Continuous Improvement - The Effective Vaccine Management (EVM) process benchmarks supply chain performance against best practices vaccine management. This has provided the much-needed oversight mechanisms for monitoring performance and recommend policy changes to improve supply chain performance. To date, Nigeria has achieved average scores below the desired threshold of 80%.

e) Effective use of logistics data -- Use of the ODK-LMIS vaccine stock management tool and dashboard to collect data and track stock performance. Regular review of the dashboard was adopted and has led to reduced stock outs, improved reporting and increased vaccine availability after 8 months of consistent use. There are plans for the Integration of the current ODK based LMIS into the new eLMIS in 2021

- What additional TA is needed to implement 2021 activities?

S/N	Key activities planned for 2021 that require TA	Required TA
1	Implementation of Cold Chain Equipment Optimization Platform (CCEOP): Phase 1, Tranche 2 and Phase 2	Continuation of existing TA
2	Development of an iSC 10-year road map following the completion of the iSC policy	New TA
3	Deployment and Management of an eLMIS for vaccines stock data management	New TA
4	iSC System re-design & mega-stores operationalization (3-hub)	New TA
5	Human Resource development, Knowledge Management institutionalization for iSC	New TA
6	Implementation of Vaccine Accountability Strategies and improvement for all levels	New TA
7	Pre-introduction preparation/Supply Chain and logistics for the COVID19 vaccine introduction	New TA
8	Implementation of identified action plan from the wastage study	New TA ▪ To enhance the Knowledge, Attitude and Practice of healthcare workers on drivers of wastage and promote behavioral change ▪ Improve efficiency of delivery of immunization through the institutionalization of Accountability into Vaccine Management

2.6 **Service delivery and demand**

Provide brief update of work done since 2019 JA and plans for 2020 ~200 words
Topics to discuss:

- What is being done to reinforce the basics (e.g. ensuring equitable access to health/EPI facilities with regular outreach/mobile services)? What is planned to continue improvements in the future?
- How are SIAs currently being leveraged to strengthen routine immunization and reaching zero-dose children? What is planned to continue improvements in the future?

During SIAs, fixed posts are required to remain functional on a daily basis. The expectation is that when vaccinators provide polio vaccine to eligible children during polio campaigns and are determined to be partially vaccinated, they can be directed to the closest health facility where they can catch up on their missed vaccines. WIth the circulating vaccine derived polio virus outbreaks in 2020, Nigeria's response has been swift, sometimes leveraging the outbreak response efforts to conduct RI intensification. This included the use of fractional inactivated polio vaccines for children in areas where monovalent oral polio vaccines have been provided. During these campaigns, the LGA saff use their RI data to determine areas with low RI coverage and strategically position vaccination teams in such areas that have a large number of eligible children with high dropout rates.

The country leverages the SIA resources to update cold chain inventory, identify gaps, and conduct repair and maintenance of CCEs. It also strengthens the AEFI surveillance, which includes the procurement of AEFI kits, availability of AEFI tool, and refresher training. Advocacy materials and kits used to promote the SIIAs are adapted as a fundamental part of RI Information generated.
Site mapping and cost implication for hard-to-reach communities during the SIAs is leveraged to reach zero dose children and to revise RI budget for efficient service delivery to those communities. Key topics to reinforce RI skills were included in the SIAs training schedule to build the capacity of RI service providers. Findings from the SIAs checklist are used to correct and plan outreach services, while data on sources of information used to determine appropriate channels to relay RI messages to the public. Strong partnerships with media fostered during SIA and this is utilized to strengthen RI in media coverage and positive reporting. The SIAs trained and used a large pool of high calibre supervisors. These supervisors are being used to support RI services in critical need. During SIAs vaccination teams are trained to evaluate child vaccination cards to ascertain the level of utilization of routine immunization services, defaulting children will then be mobilized by providing them with appropriate information and messages, the date, time, and place on next vaccination. Community-based announcers trained during the SIAs are encouraged to support community mobilization for routine immunization and this create demand and enhance routine immunization uptake.

- How has governance and accountability been improved recently (especially related to various funding streams; alignment, coordination and prioritization)? What is planned to continue improvements in the future?
- How can immunization be leveraged as a pacesetter for universal PHC?
- What has been done to improve HR capacity? What is planned to continue improvements in the future?
- What additional TA is needed to implement 2021 activities?

S/N	Key activities planned for 2021 that require TA	Required TA
1	Targeted strategies to address high number of unimmunized children ▪ Identification and mapping of zero dose children and implementation of strategies to vaccinate missed children ▪ Increase in the conduct of outreaches ▪ Local Immunization Days/ IMOP ▪ Scale up implementation of CHIPS program	▪ Continuing TA needed to support planning, implementation and monitoring of LIDs ▪ New TA needed to support mapping and identification of zero dose children ▪ New TA needed to support implementation and monitoring of the CHIPS program (New TA)

2	Implement the Optimised Integrated RMNCAH +N and RI Session (OIRIS) to identify and resolve issues on the field	Continuing TA needed for planning, implementation and monitoring of Optimised Integrated RMNCAH +N and RI Session (OIRIS)
3	Introduce planned new vaccines (*Rotavirus vaccine, COVID vaccine, IPV 2, HPV)* into the EPI schedule	Technical assistance needed for early planning, coordination, implementation of the planned new vaccine's introduction (Additional or Continuing)
4	▪ Provision of adequate PPEs to all RI rendering facilities ▪ Inclusion of behavioural trainings in planned capacity building ▪ Implementation of accountability framework across all levels (rewards and sanctions to promote compliance)	No TA needed
5	Strategies to increase demand for primary health services ▪ Scale up Community Engagement roll out to other 12 states ▪ Implementation of targeted social mobilization activities to increase demand especially in low performing states, LGAs and communities	▪ Continuing TA needed to scale up of community engagement strategies ▪ New TA – C4D Specialist to provide technical support to NERICC Communication working group on a full range of activities for social mobilization, accelerate demand generation strategies as well as take responsibility for other related functions.
6	Capacity Building ▪ Implement Mid-level Managers Training to strengthen capacity at national and subnational levels across the 36 states and FCT ▪ Implement innovative training methodologies to increase reach and improve knowledge and skills of health workers – Continuous learning on Immunization and PHC via e-learning approaches to improve health worker knowledge	New TA needed to support the planning, coordination and conduct of innovative capacity building approaches to improve knowledge and skills of health workers

2.7 **Immunisation & health financing at federal and state level**

(Provide brief update of work done since 2019 JA and plans for 2020 ~200 words)
Guiding questions:

- Is there any concern about the release of the last tranche of payment? Are there any concerns about 2021 co-financing and vaccine financing in general?

There is high expectation that the last tranche of funds for vaccine procurement will be released, though unexpected bureaucratic delays might result in late release. All required documentations to facilitate the release of the funds have been completed and the process of funds release from the Federal Ministry of Finance, Budget and National Planning to the Central Bank Account of the NPHCDA has reached advanced stages. All hands are on deck to ensure complete and timely release of the budgeted funds for vaccines financing from the 2020 budget.
Budgeting and planning have improved. The country's 3-year rolling plan – The medium-term expenditure framework (MTEF) continues to be the basis for annual planning. The MTEF has enabled Government to

link medium term plans to annual budgets for primary healthcare including immunization. Federal government share of the total annual vaccine financing from domestic budgetary resources has increase from 1.8% in 2018 to 28% and 33% in 2019 and 2020, respectively in line with the approved accountability frameworks. This is expected to improve further to 39% in 2021 in spite of the daunting economic challenges following the COVID 19 pandemic.. Financing for vaccines have been elevated above the sector specific budget of the health ministry and stabilized within the service wide votes, an effort by Govt to improve releases and predictability of financing for the lifesaving commodity. In the current year, 2020, Govt realigned the fiscal year to synching it with the calendar year.

The realignment means that the government now has a more stable and predictable budgeting cycle/calendar which will in turn promote efficiency and effectiveness of the entire budgetary system including the timeliness of budget execution. [CSO1] respectively. The BHCPF set up under the 2014 Health Act is a major platform by which the federal government directly provides financial resources to health facilities in the country. As at November 2020, BHCPF funds have been disbursed to Primary Health Care Boards of all 36 states and the Federal Capital Territory, while only 7 states have commenced funds disbursements to health facilities. Other states are expected to also start disbursements to health facilities in the coming months, as soon as all stipulated requirements are met.

At the federal level, timely release of vaccine budgets has always been an issue and was to be resolved through the Service Wide Votes. Even though overall approved releases have improved, last year has shown that timeliness is still an issue as 2019 funds were received by UNICEF SD in January 2020. In 2020, only NGN4.1 billion out of budgeted NGN26.4 billion has been received by UNICEF to date, while efforts are still ongoing to ensure complete release of the funds by January 31, 2020. Timely releases of funds is a concern if Nigeria is to reduce dependency on IDA for vaccines

Although, the responsibility for health is jointly borne by the 3 tiers of Govt in Nigeria, immunization and primary healthcare financing in state budgets remains a challenge probably because such expenditures have not been appropriately prioritized in many states. For the most part, data on sub-national level budgets and budget execution is very sparse and efforts at the state-level through development partners including Gavi, BMGF and WB, needs to be further upscaled and properly coordinated through appropriate deployment of TAs that will build the capacity of the respective states in this direction..

The shocks in the global oil market due to the impact of COVID has lowered the projections of government revenue in the short to medium term. In recognition of this constraint, Gavi has granted special flexibilities, freezing the co-financing requirement for Penta and PCV for the year 2021. The country will reflect this new concession in the vaccine financing plan, and adjust the milestones in the accountability framework over the medium term.

Technical assistance would be needed for country preparedness for introduction of the COVID-19 vaccine in 2021. In addition, continuing TA would be needed for improvements in vaccine forecasting and overall management. At the state-level, critical gaps exist in budgeting, planning, and overall coordination of PHC response. A steady and reliable TA support would enable institutionalization of the budgeting and planning functions, the operationalization of the accountability framework, and expenditure data tracking and analysis at the subnational level.

- What challenges are faced with domestic financing for health and immunisation services (state and federal level)? How can these be addressed?

Overall, there are issues with budgeting while at the State level, it has been observed that there is non-release or delayed release of funds, challenges with accountability (HCWs do not account for previous releases) and operational funding; inadequate budgeting resources for immunization and non-prioritization of immunization activities. Turning to the National level, there is delay with release stemming from documentation challenges.

- What steps are needed to update the 2021 vaccines forecast, taking into account the freeze of 2021 co-financing level for Penta and PCV, and resulting updates to the Accountability Framework? When will this be completed?
- Meeting of government and all stakeholders to propose adjustments to be made and review of milestones
- Outcomes to be used to update targets in Accountability Framework (during high level review meeting)

- Timelines will be most likely after MSD (specific date to be determined)

Response: The 2021 Forecast will be readjusted in Q2 2021 to ensure that the changes in consumption are captured and updated (in view of the current operating environment that is constricted by the pandemic). Additionally, this will guarantee that there are no stock outs experienced during the course of the year. The changes will be communicated to UNICEF Supply Division so that changes can also be made on the Provisional Plan including communication to the relevant suppliers for the antigens in question. Additional domestic resources will be required to fill the potential gap that may ensue after the recalibration. The updates to the Accountability Framework will be done at the in Q2 when the recalibration is complete.

- Is additional TA needed to implement 2021 activities? If yes, what kind of support is needed?

S/N	Key activities planned for 2021 that require TA	Required TA
1	Continued support on improving State specific forecasting process to ensure timeliness of development of vaccine financing plan	Timely triangulation of data from all sources (continuation)
2	Improving coordination, timeliness/visibility for State level expenditure data	New TA required
3	Operationalize accountability framework at State level	New TA required

2.8 Leadership, management and accountability

(Provide brief update of work done since 2019 JA and plans for 2020 ~200 words)
Guiding questions:

- What work has been to improve leadership, management and accountability?
    - Onboarding of new staff members
    - Leadership development Academy (LDA)
    - NPHCDA leadership Retreat and meetings with State ES's

- What work is planned to address these topics in 2021?

The NLWG has prioritized the need to build a pipeline of supply chain leaders and managers at national, zonal and state levels in 2021 through a blended capacity building, mentorship and learning approach leveraging internal and external learning opportunities.

- Is additional TA needed to implement 2021 activities? If yes, what kind of support is needed?
    - TA for HR & Knowledge Management & institutionalization for iSC (to conduct training needs assessment for the different cadre of Logistics staff and development of appropriate curriculum e.t.c.)

2.9 **Chronogram of 2021 activities (Provide an overview of 2021 activities for planning purposes ~200 words)**

Vaccine Security, Cold Chain and Logistics			
#	Activity	Details	Proposed timelines
1	Effective Vaccine Management Assessment (EVMA)	Full national EVMA	Q1, 2021
		EVMA continuous improvement plan development workshop Conduct quarterly EVMA	Q1, 2021 Q2, Q3, Q4
3	Supply Chain Analysis and System Design	Scale up exercise from 8 Gavi States to include Lagos and Kano States.	Q1
2	Independent Physical Stock Verification and Store Audit exercise	Vaccines, devices (diluents and consumables), safety boxes and data tools stock count at national, 6 zonal, 36+1 state, 21 satellite, 774 LGAs, ~10,000 HFs and any other vaccine storage points	Q2, 2021 (tentatively April 2021)
3	2022 Vaccines & Devices Forecast	State engagement meeting	Q2, 2021 (tentatively May 2021)
		State-specific and national vaccines and devices forecast for 36 states + FCT	Q2, 2021 (tentatively May 2021)
		Vaccines and Devices Forecast Consolidation Meeting	Q2, 2021 (tentatively May 2021)
		Bi-annual Review of Vaccine and Devices Forecast	June and November 2021
4	CCEOP project implementation	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	Q1 – Q4, 2021
5	Targeted supportive supervision	Supportive supervision by NLWG to recurrently low-performing states.	Q1 – Q4, 2021
6	System Redesign	Procurement and deployment of 500cbm WICR (for Abuja Hub)	Q1 – Q3, 2021
		Deployment (infrastructural upgrade of NSCS) in readiness for Abuja Hub	Q1 – Q2, 2021
		Construction and outfitting of Abuja, Kano and Lagos mega hubs	Q1 – Q4, 2021
		System design assessment is being done with Gavi support in 8 HSS Gavi supported states, Lagos and Kano	Q4 2020 –Q1 2021
		Direct Vaccine Delivery (PUSH Plus) scale-up	

7	Temperature Monitoring & Control	Revalidation and possible deployment of new TMC technologies and systems at national and zonal levels	Q1- Q4, 2021
		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	Q1- Q4, 2021
		Conduct Temperature Monitoring Study	Q1
8	Logistics Management Information System (LMIS) improvement	Procurement and deployment of *appropriate* LMIS technology for Nigeria	Q1
9	Capacity building	Capacity building of a core team of iSC staff at national, Hub/zone and state levels - Blended learning facilitated by external training bodies e.g. Imperial Health, Bull City Learning - Participate in external trainings and workshops e.g. Warehouse in a Box	Q1 – Q4, 2021
10	Waste Management	End-to-end procurement and deployment of 9 units of incinerators	STRENGTHEN
11	Vaccine Accountability	Physical stock count of vaccines and devices at national and zonal levels (insourced)	Q1 - Q4, 2021
12	Introduction of COVID 19 Vaccines		
13	Cold Chain Expansion	Procurement and deployment of 4 units of walk-in cold rooms	Q1, 2021
		Procurement and deployment of walk-in freezers at national and zonal levels for Covax	Q1, 2021
NERICC			
#	Activity	Details	Proposed timelines
	Operations, planning and project management	Annual EPI Review and workplan review/develop meeting with the 36 States and the FCT Gavi Joint Appraisal Report (JAR) Workshop with Partners	Q4 Q3
	Improving data quality and use for decision making	Quarterly programme management reviews with PMs, DPMs and TA's in 18 low performing states Conduct quarterly (1st and 3rd quarter) LQAS in 18 low performing states. Conduct LQAS in 31 states (12 low performing and 18 medium performing states) - 2nd and 4th quarter. Conduct quarterly LQAS in six medium performing states (Abia, Benue, Delta, Ebonyi, Enugu states & FCT) RIOs Monthly Review Meetings	

		Mid-level Manager's Planning / National/Zonal levels training	
	Coverage and equity	Support state and LGA implementation of OIRIS (6 states visited per month) Implementation of Integrated Medical Outreaches (IMO) in 36 + 1 States) Support the conduct of REW Microplan Development exercise Support the conduct of immunization in Urban Slums and underserved communities HepB birth dose and Tetanus vaccination improvement project in Kaduna and Enugu states Support RI Intensification activities in Prioritized LGAs NERICC engagement with low performing LGAs to improve RI performance Conduct of Coverage and Equity Assessment in 6 Selected states (1 per geopolitical Zone)	
	Data Quality Management	Production of balance of Data tools Strengthen Data review meetings at State National Biannual data review meeting Capacity building of NERICC, NLWG and PRS members on comprehensive data management Follow up with 36 states + FCT on implementation of action points Build capacity of 6 selected states, LGA and ward level officers on the conduct of ward level data validation Running and maintenance of the SMS reporting in 18 NERICC States National infrastructure for mobile reporting application Deploy mobile reporting Apps to 28,000 RI HFs across the country Procurement of 36,400 android phones (including 30% buffer) for all RI HFs for reporting Training of HCWs on use of mobile reporting appilcation Refresher training of SMS focal persons and other SERICC team members on RI SMS dashboard review Conduct of NICS/MICS 2020 Revision of SOPs/guidelines for conduct of data review meetings at LGA levels Strengthen DHIS storage infrastructures Printing and distribution of SMS and DHIS 2 Job-Aids Capacity building and mentorship programme of NPHCDA personnel on DHIS 2 Continuous update of GIS population estimates in all the states + FCT	

	Community Engagement	Senstization and training of traditional leaders in five NERICC low performing states (Jigawa, Gombe, Bayelsa, Plateau and Zamfara) Engaging faith-based institutions to strengthen demand for routine immunization as part of the Community Engagement Strategy Senstization and training of traditional leaders in NasarawaState Senstization and training of traditional leaders in Kogi State National Bi-Annual (Twice a Year) CES Review Meeting Airing of RI Radio Jingles across 36 States in at least 2 stations in every state Aring of public service announcement Printing of advocacy materials to support ED's advocacy efforts to immunization stakeholders monthly Engagement with civil society organizations Engage and train community resource persons to drive implementation of CE activities in the 10 NERICC states (Less MOU states, Jigawa and Gombe) Appointment and training of State, LGA and Ward CE focal persons to drive implementation in 10 states Training of RI service providers on community engagement strategy in 10 states NERICC supervision of sensitization of community engagement in 10 states Conduct assessment of the community engagement strategy in 6 MOU states	

2.1. Accountability Framework Progress

S/N	Theme	Level	Objectives	Indicator	Data sources	Target	Baseline	2020	Progress update & way forward
1	Core indicators	National	Use of Gavi support for the intended purpose whilst building capacity of NPHCDA /SPHCDA to ensure compliance to best financial management practices	Outcome of annual external audit and/or Gavi country programme audit	Final audit reports, programme audit reports, etc.	A	N/A	A	The Status for 2020 is not due While the report of 2019 external audit is not yet finalized
			Continued, timely co-financing of any newly introduced and of already introduced vaccines and monitoring the financial sustainability of transitional vaccines	Timeliness of release of funding for traditional and co-financed vaccines	UNICEF Supply Division report; Government Integrated Financial Management Information System (GIFMIS) report	A	A (2017)	A	The country is on track to achieve "A" for this indicator in 2020. The first tranche of vaccine funds (NGN12.3 billion) has been disbursed to FMoH and in the process of being transferred to UNICEF SD. The outstanding balance will be processed before the end of the year. It should be noted that vaccine financing requirements for 2019 was paid before the end of the same year
3	Health financing	National	Increased year-on-year health sector and immunisation budgetary commitments, increase in government expenditure on vaccines and immunization programmes, and a commitment to	Proportion oFGoN budget allocated to health at the federal level [FMoH+ Service Wide Votes allocated to Health (vaccine financing, BHCPF)]	Gazetted annual Appropriation Act of FGoN	10%	4.5% as @ 2018	6.0%	The current status is 6.2%

4a			sustain the enhanced programme once Gavi support ends.	Proportion of the approved health sector capital budget allocated to PHC at the Federal level (NPHCDA capital budget)	Gazetted annual Appropriation Act of FGoN	30%	27% as @2018	30%	The current status is 35%
4b				Proportion of the Consolidated Revenue Fund allocated to BHCPF	Gazetted annual Appropriation Act of FGoN	>=1%	1%	>=1%	Currently at 1% It should be noted that as a result of revenue contraction,1% resulted in a lower amount than expected before COVID-19
				Proportion of appropriated NPHCDA capital budget+ BHCPF funds + vaccines financing from service-wide votes released…	Government Integrated Financial Management Information System (GIFMIS) report	100%	81% as @ 2017	100%	In 2019, 100% of SWV was for vaccine financing, 41.2% of capital budget for NPHCDA while nothing was released for BHCPF as at Dec 10, 2019. In 2020, 46.4% of SWV for vaccine financing has been released to FMoH
5b				… and expended		100%	100% @2017	100%	Not due
6				Proportion of annual vaccine procurement expenditure released from government budgetary resources	GIFMIS report / UNICEF records	100%	1.8% as @ 2017	33%	Not due
7				Vaccine financing plan for the next year developed	Approved vaccine financing plan by ICC and	A	NA as @ 2018	A	Activity is off track. 2021 Financing plan was not ready by June

				and updated by end of June of the current year	endorsed by MB&NP				2020 *(deadline)* because it cannot be developed without vaccine forecast (which was not concluded at the scheduled time)
8	Financial management and institutional capacity building	National	Strengthen financial management capacity of relevant national and sub-national institutions	Proportion of jointly agreed financial control and management recommendations that have been fully implemented by NPHCDA (KPMG, PCA, NPHCDA)	PCA report NPHCDA annual report, annual audit report	100%	N/A	20%	Achieved 1 out of 5 qualitative indicators The country is making progress towards achieving set targets for this indicator: · Restructuring of the financial management system has been fully accomplished, while the training/capacity building plan is being finalized. · The bidding process for award of contract for the automation of the Agency's financial management system is ongoing The results of 2019 independent audit and PCA will be used to evaluate this indicator

9	Governance	States' performance	Ensure sustainable governance and improved coordination for PHC systems at National level	Proportion of states where repositioning of PHC has been fully implemented as stipulated in the PHCUOR policy	PHCUOR scorecard (National score for repositioning)	100%	47%	64%	Indicator is on track based on the preliminary results of the PHCUOR Scorecard 5
10			Leverage polio eradication resources to improve immunisation and broader PHC	Proportion of meetings of the Presidential Task Force on Polio Eradication where RI and PHC are agenda items	Agenda & Minutes of PToPE meetings	100%	66%	100%	Indicator is on track. The quarterly meeting of the Presidential Task Force on Polio Eradication has been merged with the National Economic Council, since the Vice President assumed the chairmanship of the PTFoPE and routine immunization and primary health care are included on the agenda and discussed at all NEC meetings.
11			Improve accountability and coordination of PHC programs at National and state levels	Proportion of partners and donors working on immunization and PHC that align their activities with NSIPSS/NPHCDA & SPHCDA strategic and annual operational plans	Annual operational plan for National and states	100%	NA as @ 2018	80%	Indicator is on track. The country has achieved full alignment in the Expanded Programme on Immunization (RI, Supply chain and SIAs), while efforts are being to improve alignment across other PHC activities at national and sub-national levels

12	Coverage	National average	Increased coverage for immunization and PHC services	Penta 3 coverage	Immunization coverage survey (NICS, SMART, NDHS, MICS, DHIS2)	84%	33% (2016)	55%	Data is not yet available. Nigeria has made progress based on the results of the 2018 NDHS and findings from quarterly RI LQAs The results of planned MICS/NICS survey in 2020 will be used to evaluate the 2019 values for these indicators
				IPV coverage		84%	NA	55%	
				MCV1 coverage		91%	41.7% *(2016)*	69%	
				ANC4 coverage		86%	49.1 (2016)	66%	
				SBA coverage		71%	43% (2016)	52.3 %	
		States' performance		Proportion of states that achieved projected coverage rates for the following vaccines: Penta 3		100%	N/A	55%	Data is not available. Nigeria has made progress based on the results of the 2018 NDHS The results of planned MICS/NICS survey in 2020 will be used to evaluate the 2019 values for these indicators
				IPV		100%		55%	
				MCV1		100%		55%	
				ANC4		100%		30%	
				SBA		100%		30%	
13	Data quality	National	Improved RI data quality at National and sub-national levels	Variance between DHIS2 and survey Penta 3 coverage	DHIS2, immunization coverage surveys (NICS, SMART, NDHS, MICS)	10%	72%	54.3 %	Data is not available. The country has made significant progress based on the results of the 2018 NDHS, even surpassing the 2019 targets for this indicator

									The results of planned MICS/NICS survey in 2020 will be used to evaluate the 2019 values for these indicators
		States' performance		Proportion of states with variance between DHIS2 and survey coverages within recommended values		100%	5%	20%	Data is not available. The country has made significant progress based on the results of the 2018 NDHS, even surpassing the 2019 targets for this indicator The results of planned MICS/NICS survey in 2020 will be used to evaluate the 2019 values for these indicators
14	Vaccine account-ability	National	Improved vaccine accountability by ensuring that vaccine wastage rates are within recommended values	Triangulated wastage rate of the following vaccines: Penta	Wastage rate study, DHIS2, immunization coverage surveys, report of physical vaccine stock count	25%	40%	35.0 %	Data is not available. Data from the listed sources are required to triangulate and evaluate this indicator as defined: § MICNICS 2020 survey data (planned for next year) Wastage study data (data analysis of a recently conducted study still ongoing)
				IPV		20%	30%	27.0 %	
				MCV1		30%	40%	37.0 %	
				PCV		10%	20%	17.0 %	
		States' performance		Proportion of states with triangulated wastage rate within recommende		100%	N/A	55%	Data is not available. Data from the listed sources are required to triangulate and evaluate this

				d values for Penta					indicator as defined: MICNICS 2020 survey data (planned for next year) Wastage study data (data analysis of a recently conducted study still ongoing)
				IPV		100%		55%	
				MCV1		100%		55%	
				PCV		100%		30%	

3 COVID-19 impact on immunisation (in 2020): current situation

3.1 COVID-19 cases and deaths (as of 2nd May 2021)

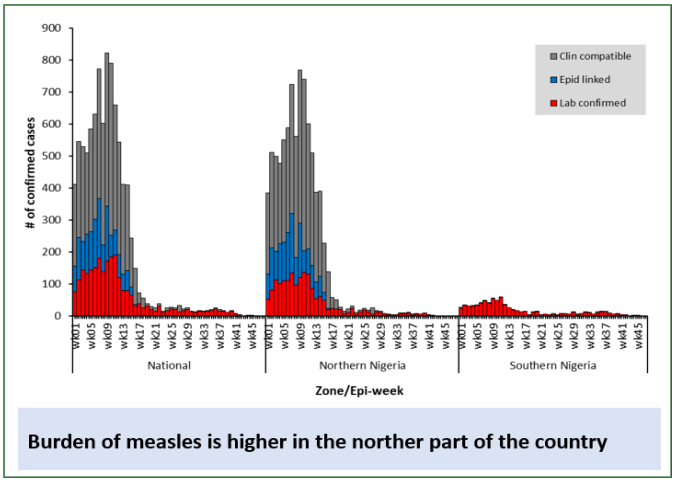
GENERAL FACT SHEET – DATA AS AT 2ND MAY 2021

Table 1: States with reported laboratory-confirmed COVID-19 cases, recoveries, deaths, samples tested and active cases.

STATE	CONFIRMED		RECOVERIES		DEATHS		ACTIVE CASES	TESTING	
	Total	Last Week	Total	Last Week	Total	Last Week		Total	Last Week
Abia	1,690	1	1,658	0	22	0	10	22,487	200
Adamawa	1,103	40	275	1	32	0	796	19,216	383
Akwa Ibom	1,864	14	1,830	36	14	0	20	18,911	110
Anambra	1,909	0	1,826	0	19	0	64	25,080	172
Bauchi	1,549	1	1,518	0	17	0	14	25,212	15
Bayelsa	886	0	855	0	26	0	5	17,604	21
Benue	1,188	0	591	0	22	0	575	16,808	64
Borno	1,337	0	1,200	0	38	0	99	20,449	23
Cross River	394	0	376	0	18	0	0	7,065	33
Delta	2,623	3	1,744	0	71	0	808	36,738	310
Ebonyi	2,030	0	1,965	0	32	0	33	15,719	110
Edo	4,902	4	4,714	5	185	0	3	44,876	1,923
Ekiti	872	2	856	5	11	0	5	16,869	244
Enugu	2,401	56	2,013	0	29	0	359	26,946	614
FCT	19,784	19	19,095	5	166	1	523	267,204	4,853
Gombe	2,034	0	1,986	0	44	0	4	43,715	167
Imo	1,657	0	1,592	0	37	0	28	37,512	676
Jigawa	528	1	492	7	16	0	20	10,074	224
Kaduna	9,061	21	8,981	11	65	0	15	94,664	6,280
Kano	3,961	7	3,824	6	110	0	27	96,653	1,159
Katsina	2,097	0	2,049	0	34	0	14	39,668	164
Kebbi	450	0	392	0	16	0	42	17,471	243
Kogi	5	0	3	0	2	0	0	4,619	1
Kwara	3,123	3	3,062	248	55	0	6	24,825	433
Lagos	58,494	203	56,990	0	439	0	1,065	487,246	15,414
Nasarawa	2,382	0	373	0	13	0	1,996	22,990	18
Niger	930	0	913	0	17	0	0	17,799	19
Ogun	4,678	31	4,591	20	49	0	38	72,273	680
Ondo	3,248	6	2,080	0	63	0	1,105	24,705	108
Osun	2,578	3	2,510	8	52	0	16	18,774	55
Oyo	6,852	2	6,721	0	124	0	7	59,975	763
Plateau	9,059	10	8,987	5	57	0	15	68,087	355
Rivers	7,114	16	7,006	55	101	0	7	187,080	3,462
Sokoto	775	0	747	0	28	0	0	18,809	4
Taraba	974	0	950	0	22	0	2	12,743	38
Yobe	409	19	375	23	9	0	25	17,668	2,752
Zamfara	240	0	221	0	8	0	11	7,919	69
Total	165,181	462	155,361	435	2,063	1	7,757	1,966,453	42,159

Source: NCDC covid-19 Situation Report

3.2 Disease Surveillance and Incidence



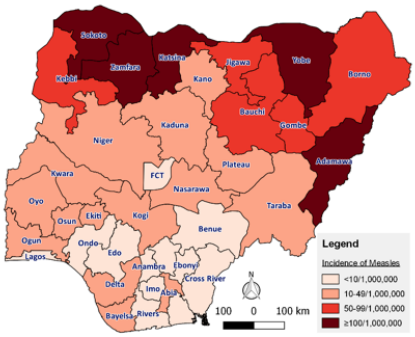
Burden of measles is higher in the norther part of the country

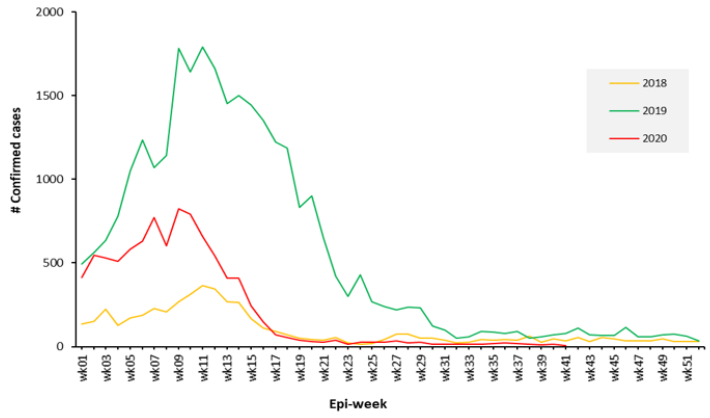
INDICATOR	MEASUREMENT
Suspected cases	14,352
Samples tested	7,688
Confirmed cases	9,234
Lab-confirmed	2,435
Epi linked	1,501
Clinically compatible	5,298
Deaths from all cases	55
Case fatality rate	0.6%

Summary of measles epidemiology, EW 01-45, 2020

Incidence of measles in Nigeria was 42/1,000,000 population

- North East – 101/1,000,000
- North West – 92/1,000,0009



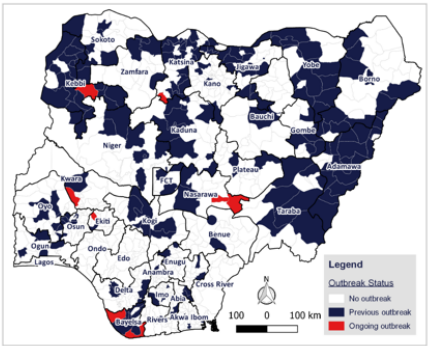


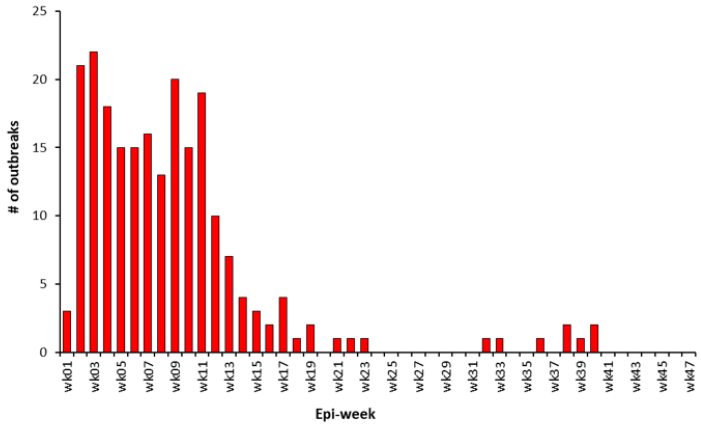
Peak period of measles incidence in Nigeria is in the 1st quarter of the year

Measles incidence by place & time, EW 01 - 45, 2020

77% of outbreaks occurred in the Northern part of the country

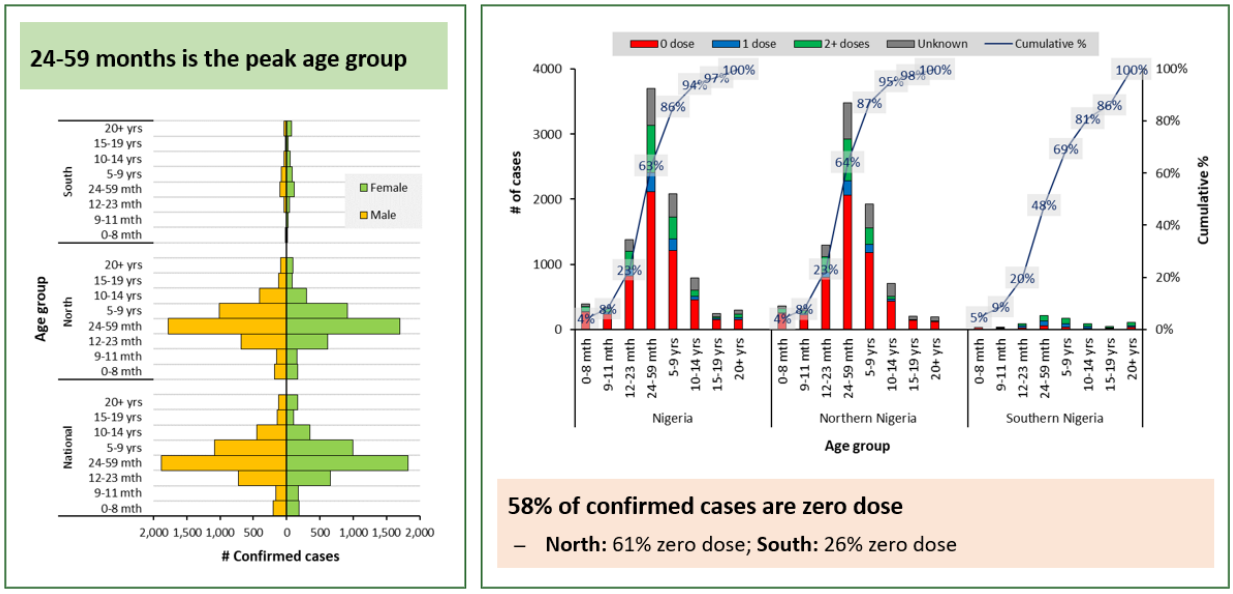
- North West: 40%; North East: 23%; North Central: 14%





Of the 221 measles outbreaks recorded this year, 89% were in the 1st quarter of the year

Measles Outbreak by place and time, EW 01-45, 2020



Measles outbreaks by place & time, EW 01 - 45, 2020

Surveillance Performance Indicator	Target	2019 (Jan – Oct)	2020 (Jan – Oct)	
Measles Incidence	< 1/1,000,000 pop.	132.0	42.3	▼
Non-measles febrile rash illness (NMFRI) rate	≥ 2/100,000 pop.	4.0	2.0	▼
Proportion of reported measles cases from whom blood specimen was collected	≥ 80%	31.9%	52.6%	▲
Proportion of LGAs that reported at least 1 measles case with blood specimen collected	≥ 80%	93.2%	89.4%	▼
Annualized rate of investigation (with blood specimens) of suspected measles cases	> 1/100,000 pop.	6.6	4.1	▼
Proportion of lab confirmed measles cases	< 10%	24.1%	35.1%	▲
Proportion of serum specimens arriving measles laboratory in good condition	≥ 90%	98.3%	84.4%	▼
Proportion of serum specimens arriving measles laboratory in good condition	≥ 80%	19.2%	17.3%	▼

Measles surveillance performance: 2019 vs 2020

3.3 Impact of COVID-19 on disease surveillance (~200 words)

Briefly describe the impact of COVID-19 on the sensitivity and specificity of vaccine preventable disease surveillance. Measles surveillance data are one option to illustrate that impact, including:

- Changes in the number of reported suspected measles cases
- Changes in the number or rate of discarded suspected measles cases
- Changes in the proportion of suspected measles cases that undergo laboratory testing

Surveillance data from other diseases can be used as well to highlight key areas of impact.

The index case of COVID-19 was confirmed on 27th February 2020 and since then measures were taken by the National Task Force on COVID-19 to limit the spread and rapidly identify cases and contacts for action. Some measures amongst others include total and partial lock down at the first instance, which later affected states as the number of cases increased.

The lock down effect resulted in fear amongst health workers to attend to patients and also patient's hesitancy to access health facilities for fear of being infected. Heightened attention on COVID -19 outbreak response activities led to disruption of surveillance for other priority diseases.

Burden of COVID-19 by state

As of 19th November 2020, at least 724,744 samples were tested, 65, 693 were confirmed across all the 36 states and Federal Capital Territory with a total of 1,169 deaths recorded. The confirmed cases ranged from 5 in Kogi State to 22,704 in Lagos State. Distribution of confirmed cases by states is as shown in Figure 1.

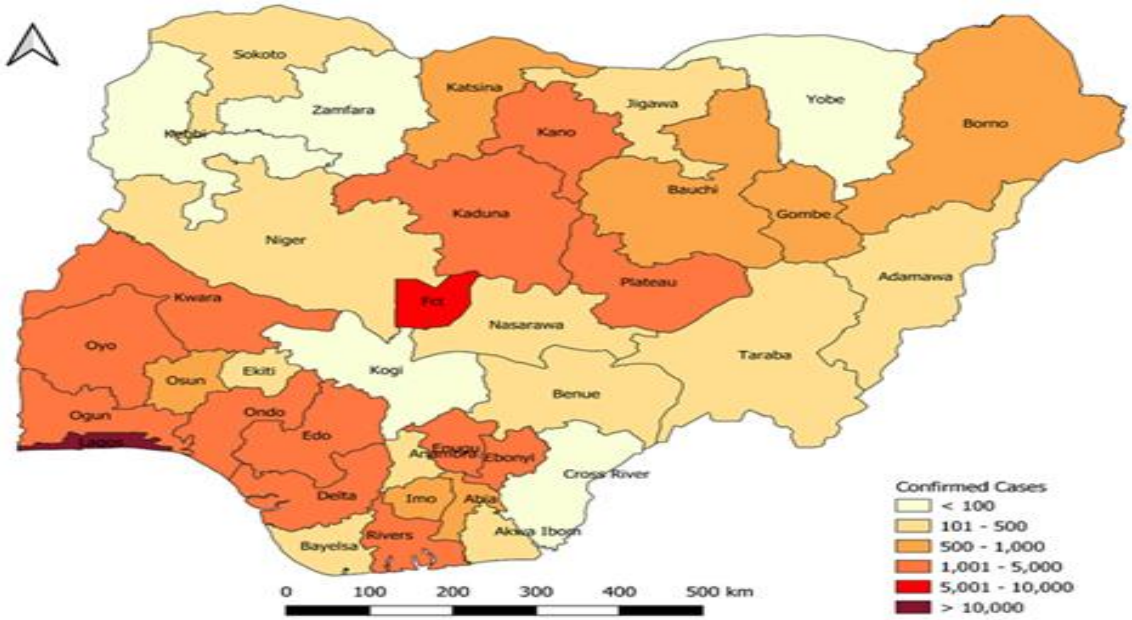
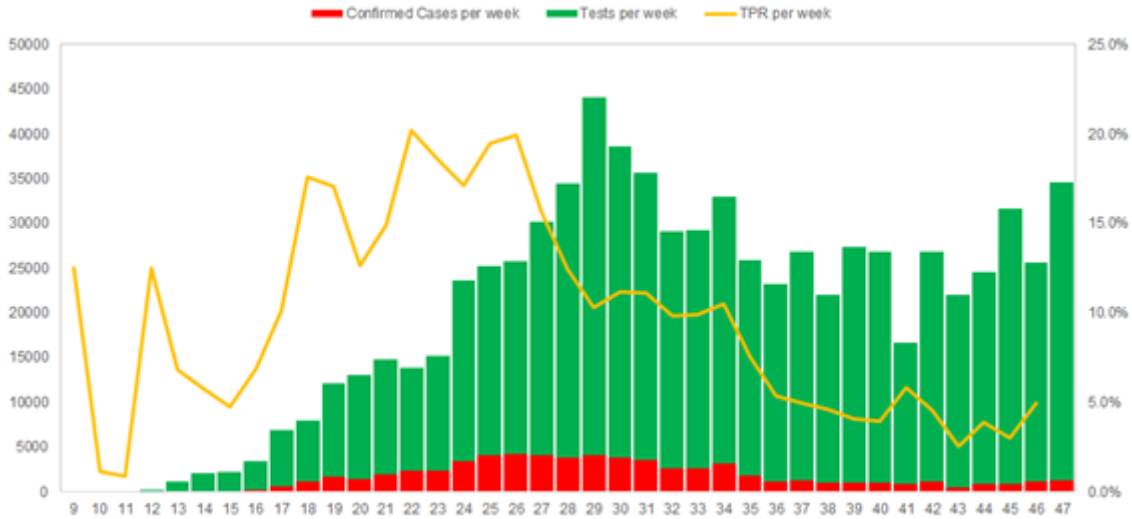


Figure 1 above shows spatial distribution of cases across the states



National Epicurve per week at 25th Nov 2020

Effects of COVID-19 on VPDs surveillance (January – October: 2019 compared with 2020)

There has been a significant reduction in surveillance for other VPDs due to the effect of covid -19 lockdown thereby leading to reduced access to health facilities or diversion of all health workers to covid -19 responses.

Measles surveillance

The total number of suspected measles cases reported between January and October was 36,379 in 2019 and 14,352 in 2020 representing a decline of 60.5%. The decline in suspected cases reported became more marked from March through April to May where reported cases were 3,872, 1,144 and 428 in 2020 compared to 8,916, 7,133 and 4,463 in 2019 respectively. (see Chart 2).

Also, there was a marked decline in the performance of the measles surveillance system with respect to non-measles febrile rash illness (NMFRI) rate. As at the end of October 2020, 20 states were yet to meet the target of 2 discarded cases per 100,000 population as compared to 11 states not meeting the target

as at this time in 2019 (see Chart 3). However, with respect to the proportion of suspected cases with blood specimen collected, the situation this year is similar to that of 2019 (see Chart 4).

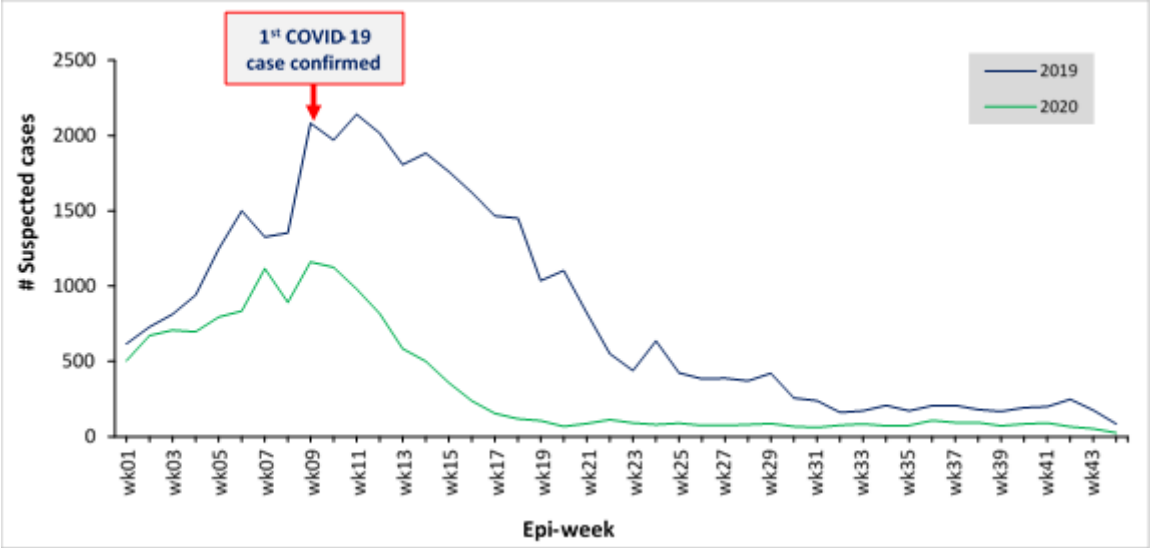


Chart 2: Trend of reported suspected measles cases, Jan – Oct, 2019 and 2020

Chart 3: NMFRI rate by state, Jan – Oct, 2019 and 2020

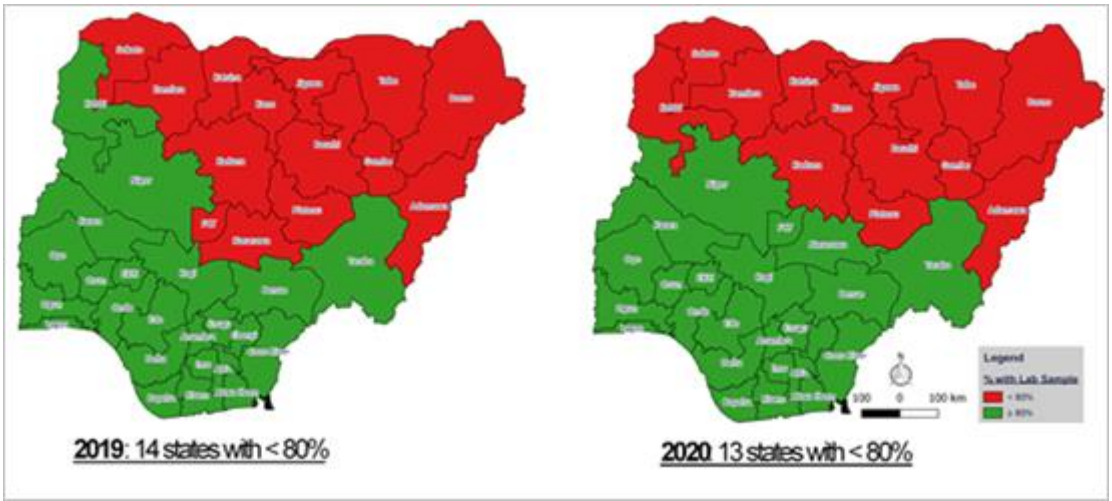


Chart 4: Proportion of suspected measles cases with blood specimen collected by state, Jan – Oct, 2019 and 2020

Yellow Fever (YF) Surveillance

The total number of suspected YF cases reported between January and October was 3873 in 2019 and 1,649 in 2020 representing a decline of 57.4%. Similar to measles surveillance, the decline in suspected YF case reported became more marked from March through May to July where reported cases were 146, 67 and 139 in 2020 compared to 287, 354 and 403 in 2019 respectively (see Chart 5). In terms of proportion

of suspected cases with blood specimens collected, the picture this year is also similar to that of 2019 with 3 and 4 states not meeting the target of 80% respectively (see Chart 6).

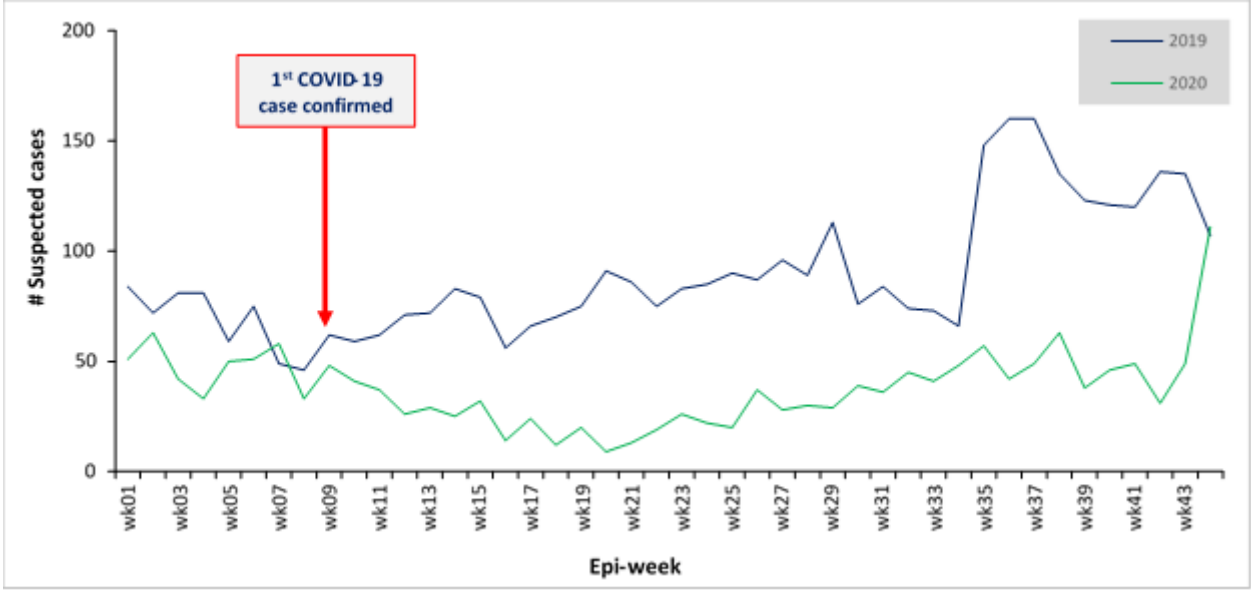


Chart 5: Trend of reported suspected measles cases, Jan – Oct, 2019 & 2020

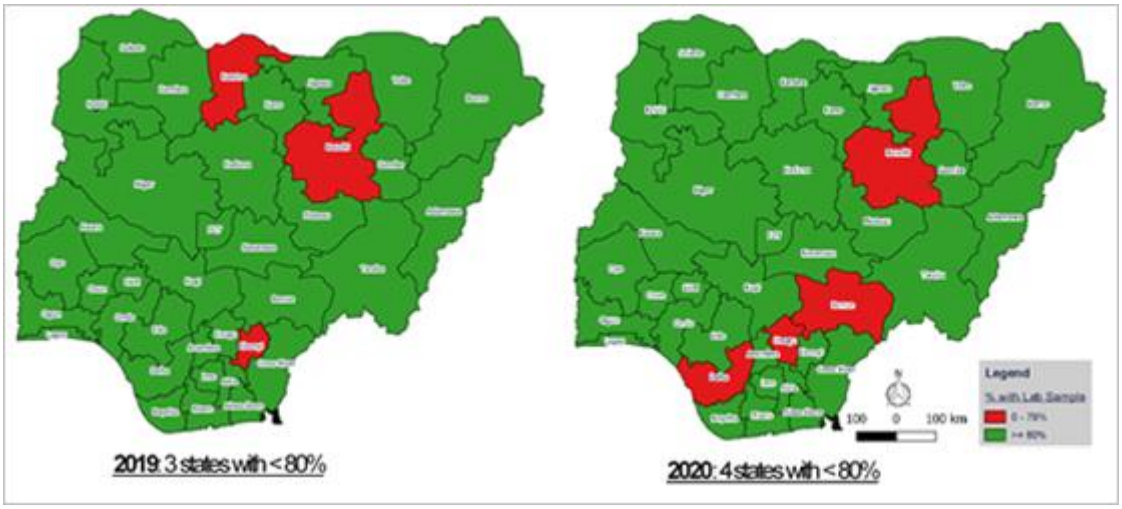


Chart 6: Proportion of suspected YF cases with blood specimen collected by state, Jan – Oct, 2019 and 2020

3.4 **Impact of COVID-19 on disease cases (~200 words)**

Briefly describe the impact of COVID-19 on vaccine preventable disease incidence. Since measles is the vaccine preventable disease most likely to have a rapid increase in incidence due to declines in immunization coverage associated with COVID-19, measles data can be used to illustrate this impact, including:

· Changes in the number or rate of confirmed measles cases

· Interpretation of changes in the number or rate of confirmed measles in light of changes in surveillance performance. For example, assessment of whether decreases in measles incidence are due to actual declines or decreased sensitivity of measles surveillance. Similar data for other diseases can be used as well.

Measles Incidence

Similar to the trend of suspected measles cases reported, there was a decline of 66.9% in the number of confirmed measles cases reported in 2019 (27,899) compared to 2020 (9,234). The decline was also more marked between march and May 2020 (see chart 7).

Given that the performance of the measles surveillance system from January to October was generally better in 2019 as compared to 2020 (see table 1), we can conclude that the burden of measles was under reported in Nigeria in 2020 possibly as a result of the impact of COVID-19 pandemic.

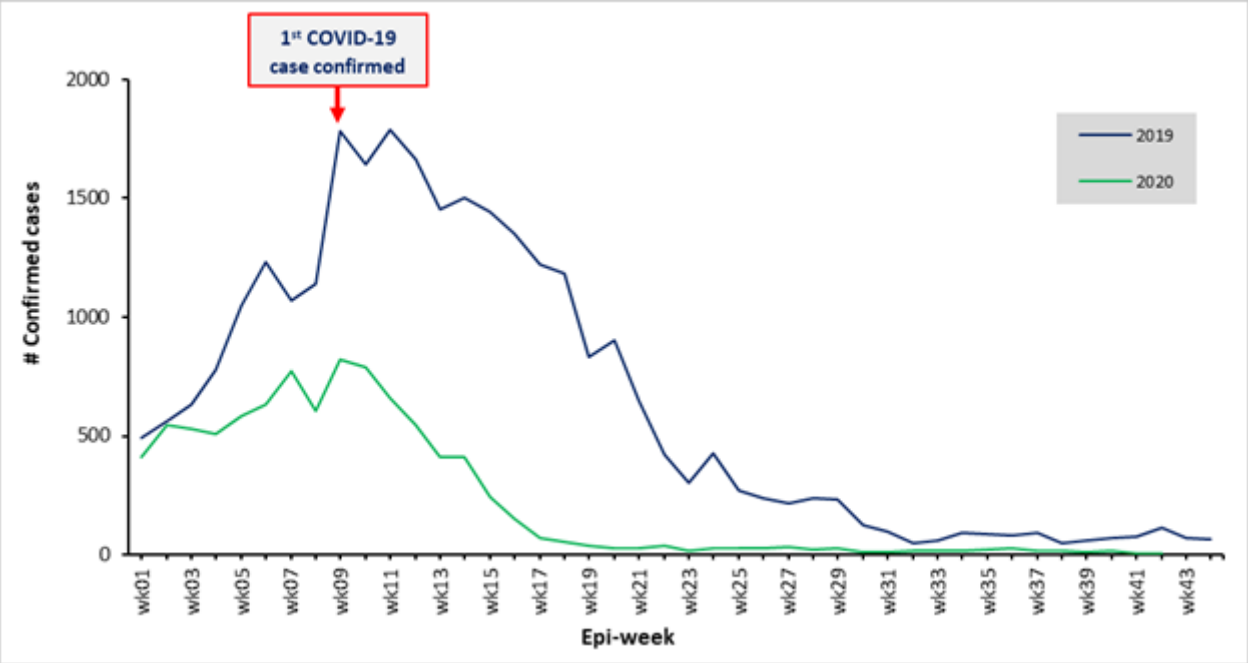


Chart 7: Trend of confirmed measles cases, Jan – Oct, 2019 and 2020

Table 1: Trend of measles surveillance performance indicators, Jan – Oct, 2019 – 2020

Surveillance Performance Indicator	Target	2019 (Jan – Oct)	2020 (Jan – Oct)
Measles Incidence	< 1/million population	132.0	42.3
Non-measles febrile rash illness (NMFRI) rate	≥ 2/100,000 population	4.0	2.0
Proportion of reported measles cases from whom blood specimen was collected	≥ 80%	31.9%	52.6%
Proportion of LGAs that reported at least 1 measles case with blood specimen collected	≥ 80%	93.2%	89.4%
Annualized rate of investigation (with blood specimens) of suspected measles cases	> 1/100,000 population	6.6	4.1
Proportion of lab confirmed measles cases	< 10%	24.1%	35.1%
Proportion of serum specimens arriving measles laboratory in good condition	≥ 90%	98.3%	84.4%

3.5 **Impact of COVID-19 on immunisation (~200 words)**

Briefly describe the impact that COVID-19 has had on your ability to effectively deliver immunisation services, including:

- Constraints on routine immunisation services (e.g.are health workers still carrying out immunisation services? What barriers do health workers face?)

Immunization service delivery suffered a setback during the periods of lockdown with a rising number of cases reported in all states across the country. The affectation of some health workers with Covid 19 combined with health workers anxiety was one of the contributing factors to low uptake especially in states where personal protective equipment such as facemask were not provided. Additionally, COVID-19 along with response to measles and yellow fever outbreaks caused delays in state-level planning and implementation of polio SIAs and cVDPV2 outbreak responses.

Other effects of the pandemic on immunization included temporary suspension of coordination meetings, delays in implementation of activities resulting in competing state-level activity implementation,reduction of funding for immunization and supervision, redeployment of staff to COVID-19 response and decline in immunization service delivery.

Supply chain interruption occurred due to international flight restriction, and initial in-country transport logistics interruptions, in-country delays in routine replenishments and low demand led to stock outs and overstock in some states

The effects are shown in the reduction of services and coverages as shown in the charts below.

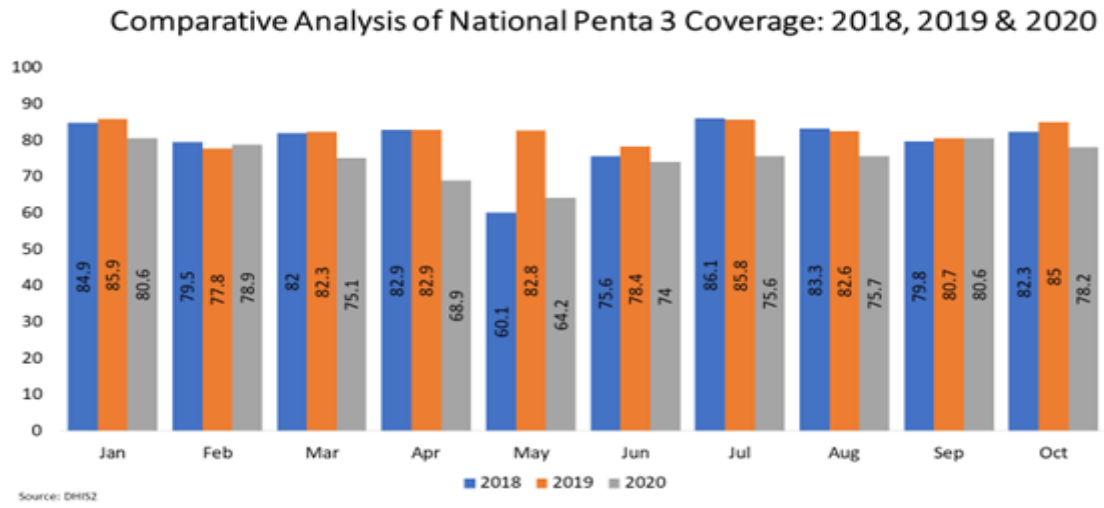


Figure xx shows the reversal in the penta 3 coverage from the month of june when normal services started

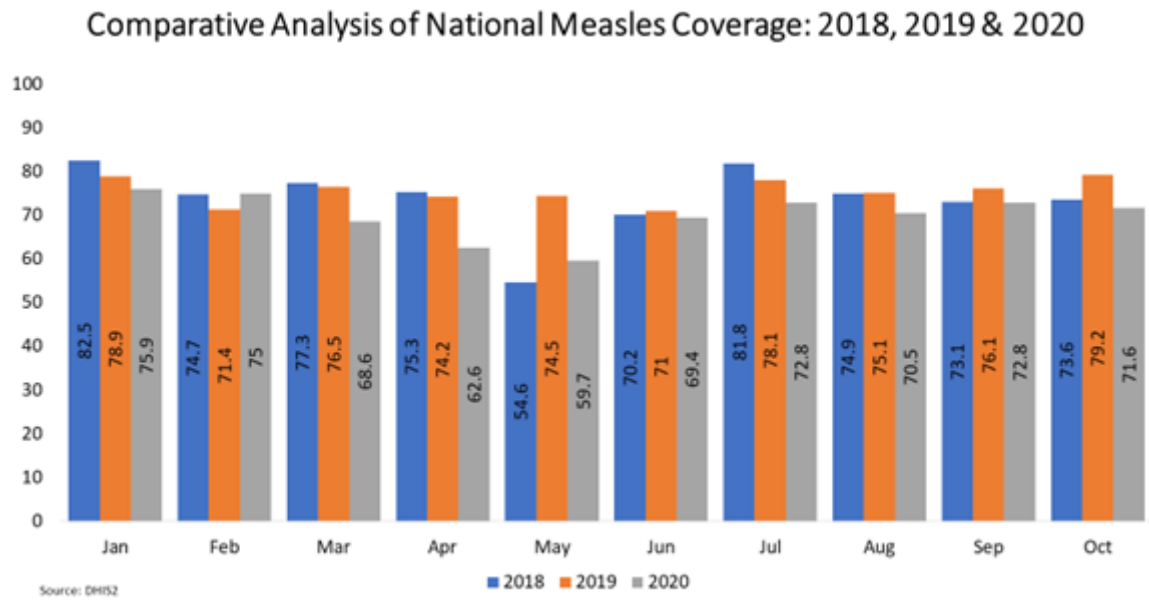


Figure xx shows rise in Measles vaccine coverages from the month of June.

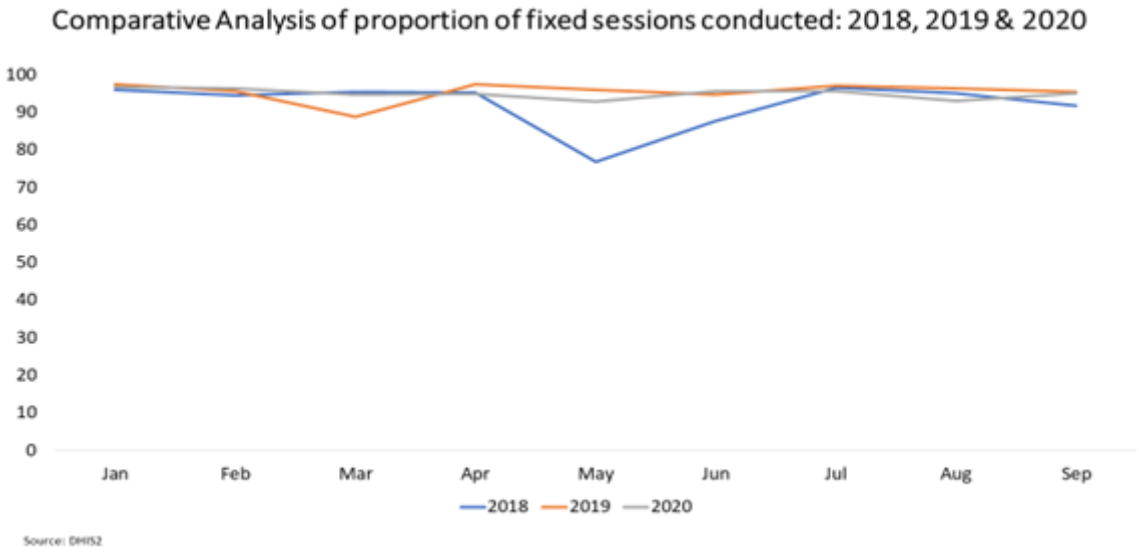


Figure above shows some reduction in number of fixed session during the peak of covid 19 infections and a gradual rise from the month of june
The NPHCDA promptly responded with a training package on Preparedness and response to covid 19, *two hundred and forty thousand* frontline health workers were trained to boost their morale and build their confidence to continue working in addition to the provision of PPEs (facemask) and veronica buckets and soap for hand washing.
Monitoring visits were initiated to ensure health facilities are fully functional and ensure health workers comply with the teachings from the training . In addition to the training, over *sixty thousand* community members were sensitized on covid 19 and measures to protect the family and the community in general.
Post training and engagement normal services resumed with infection prevention and control protocols adhered to, outreaches resumed. Some other measures put in place were; conversion of physical meetings to virtual meetings at National and subnational level, weekly coordination meetings between NERICC and State Immunization teams to strengthen coordination via zoom,advocacy for increased allocation of resources at all levels for routine Immunization, provision of PPEs for health workers and encouraged usage and reprioritization of the work plan to implement key activities to improve immunization and rescheduling of missed preventive and reactive campaigns.

- Impact of the pandemic that may have exacerbated gender related barriers to immunisation experienced by caregivers, adolescents and/or health workers.
- Impact on uptake, demand and community engagement (including impact of rumours or misinformation)
- Impact on any planned new vaccine introductions or campaigns
- Impact on vaccine stocks (e.g. restocking of vaccines and related supplies, risk of expiry, updating dose requirements, reallocating stocks internally within the country/districts to ensure equity of supply)

All coordinating platforms (NLWG, ZLWG and SLWG) continued to operate virtually promoting data review, and use for action. Specifically, the following initiatives were put in place to ensure availability and potency of stocks;

1. Use of chartered flights at high costs, with special waivers, to overcome international travel restrictions.
2. Cross-docking shipments of stocks to subnational stores.
3. Issuance of Movement Permits to vaccine distribution vendors and health care workers to ensure continuing distribution of vaccines from national to state stores.

4. Active stock monitoring and use of data for action using the ODK-based LMIS and the WHO SMT. Actions undertaken include retrieval and equitable redistributions of stocks to areas in need and shortfall as guided by evidence.
5. NERICC deployed a dashboard measuring the impact of COVID-19 on RI and primary health care service delivery. Key iSC indicators being monitored include vaccines with shelf life <6 months, vaccines in VVM stages II and beyond, and CCE downtime in states and LGAs.
6. Review of temperature data to determine functionality of CCE as well as the conditions of storage of stocks at national and subnational levels (up to health facilities leveraging the CCEOP equipment deployments).

- Impact on health and immunisation (incl. vaccines) financing (e.g. repercussions on the health/ immunisation/ vaccine budget; delays in budget disbursements relating to immunisation activities; intention of other donors to make additional funding available for health/ immunisation/ vaccines)

The Nigeria economy is vulnerable to fluctuations in the global oil market. The pandemic caused a sharp fall in oil prices, which significantly lowered export earnings for the country, cutting government revenue projections. The economy is expected to contract by over 3% of GDP in 2020. In response, Government revised the 2020 budget, increasing budgetary allocation to the health sector in response to the Covid 19 outbreak. The revised allocation to the health sector in 2020 represents over 30% increase over the 2019 budget. Current proposals for 2021 also show noticeable increases over the 2020 revised budget.

There was also effect on vaccine financing with increased freight costs, occasioned by the use of chartered flights for vaccine delivery. Normal international flights were suspended. This greatly reduced the funds available for vaccine procurement, However, the reviewed FGoN budget provided additional funds for vaccines. The German Development Bank, KfW has indicated readiness to provide additional 5Million Euros to support immunization activities to mitigate the effect of the pandemic.

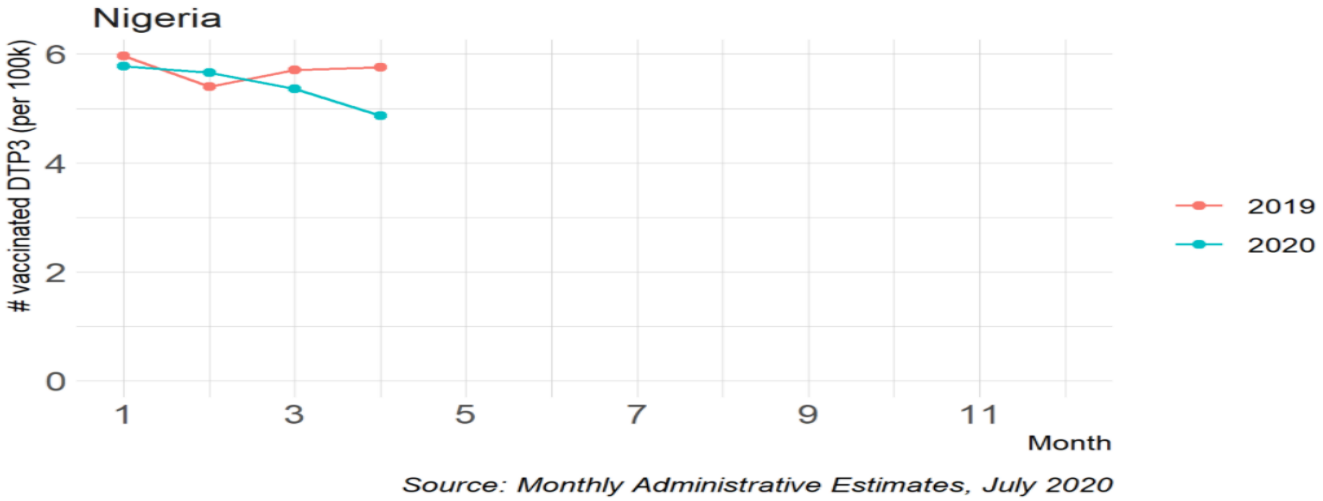
What has been the impact on the implementation of Gavi support (vaccines, HSIS, TCA, other), including financial absorption, stock management etc.?

NERICC'S inception, interventions were implemented across key thematic areas. These ranged from the setup of the emergency RI coordination centers across national, state and LGA levels and implementation of accountability framework, the cold chain equipment optimization plan implementation of the optimized integrated RI sessions and optimized RISS, conduct of quarterly RI LQAS and engagement of poor performing LGAs post LQAS amongst other priority interventions. While Nigeria was on course towards achieving the NSIPSS target of 84% Penta 3 coverage, the COVID19 pandemic threatened to reverse the gains as the increasing number of COVID 19 cases led to the implementation of COVID19 interventions to curb the spread and interrupt transmission.

Following the first case of COVID 19 in the country and with the increasing number of confirmed cases, the airports were shutdown followed by national and states lockdown and restriction of movements, social gatherings, and other commercial activities. These interventions negatively affected RI activities at all levels. Mostly affected was the re-allocation of RI funds for COVID 19 response across states, limited conduct of RI sessions and supportive supervision. Health care workers who provide routine services were also saddled with the responsibility of supporting COVID 19 response and that negatively affected their routine schedules. Demand for RI was poor due to rumours, fears, and mis-information about COVID 19 and its association with vaccines amongst caregivers. Access to immunization post was also a challenge for caregivers who were willing to take their wards for vaccination.

The growing rate of COVID 19 infection amongst HCWs also affected the provision of immunization services. Most planned new vaccine introductions like the measles second dose introduction in Northern states was stalled and that subsequently affected the planning and introduction of other vaccines like Rota planned for Q4 2020 amongst others. Planned SIAs like the measles and MeA SIAs campaigns could not be implemented.

On vaccines and logistics management, delays in delays in vaccine shipments and deliveries, from national to states and lower level affected vaccine availability at service delivery points with records of stock outs among HFs and where available there was a decline in consumption.



Source: Monthly Administrative Estimates, July 2020

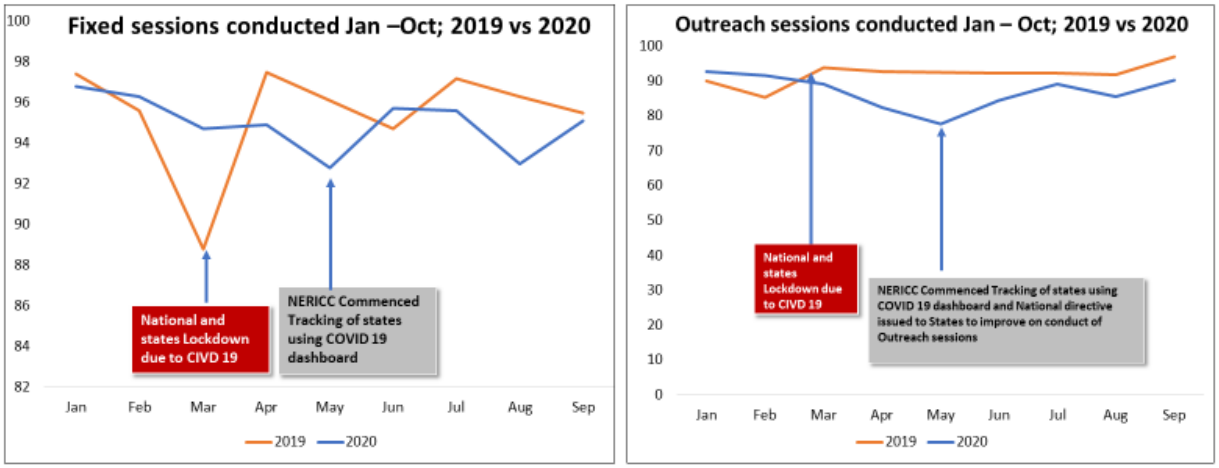
COVID 19 pandemic affected all thematic areas of NERICC operations as shown below in figure xx.

Governance and Coordination	Logistics and Vaccine Management	Service Delivery	Demand generation	Data management
• Challenges with physical engagements and internet connectivity • Reduced implementation of RI workplan • Reallocation of funds for COVID-19 response	• Vaccine deliveries and shipments delays • Decline in the consumption of available vaccines	• Limited conduct of outreach sessions • Reduce number of children vaccinated • Access issues due to lockdown • Decline in RI supportive supervision	• Fears, mis-information and rumors • PTF directive on "No gathering " affected CE activities	• Data quality improvement activities were stalled • Decline in Data quality supportive supervision

Figure xx: Thematic Areas affected by COVID 19 Pandemic

NPHCDA in its bid to mitigate against the impact of COVID19 and its interventions, converted its daily NERICC meetings to virtual meetings, developed and conducted a nationwide virtual training of HCWs on COVID 19 response and provision of immunization and PHC services amidst COVID 19 pandemic.
RI activities were also prioritized and COVID 19 dashboard developed to track the states and their status of implementation of prioritized activities. A national directive was issued for all states to improve on the conduct of their outreach sessions.
Impact of COVI9 on RI coverage indicators highlighted on Figures below

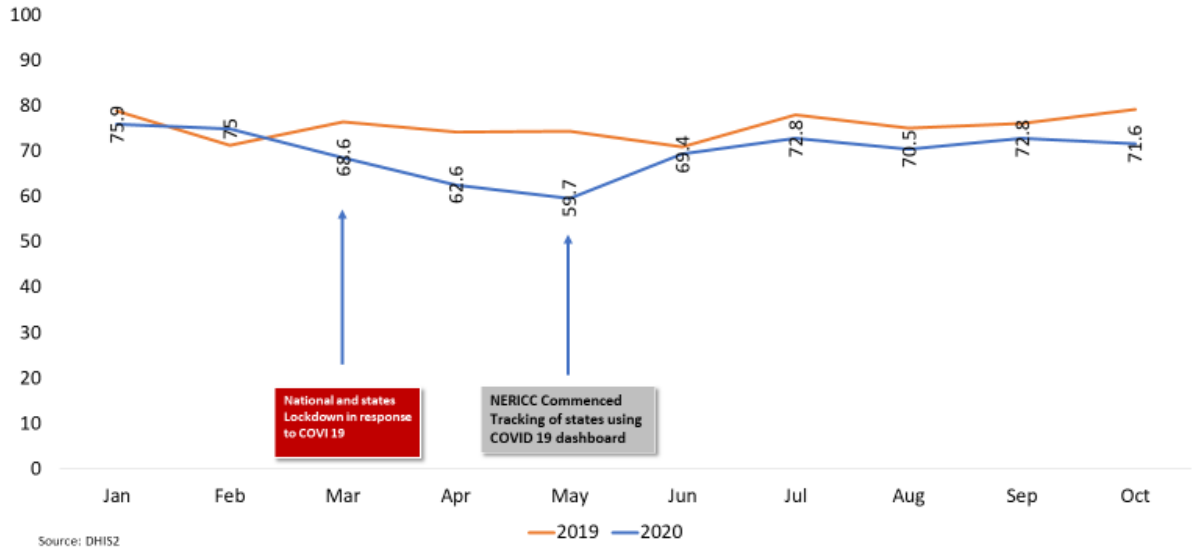
Proportion of Fixed and outreach sessions conducted January to October; 2019 vs 2020



- Conduct of fixed sessions not significantly affected as HFs were left open for the entire period
- Conduct of outreach sessions significantly declined due repurpose of funds for immunization for COVID response and Health workers misinterpretation of restriction of movement due to lockdown

Source: DHIS2 Downloaded Nov 11th 2020

National Measles Coverage: January – October 2019 vs 2020



Source: DHIS2

3.6 Impact of COVID on health expenditure and macroeconomic projections (~200 words)

Guiding questions:

- Has there been any impact of the COVID pandemic on 2020 budget execution? Budget reallocation / freeze? Vaccine financing? Other programme costs funding?

Currently, this is insufficient information on budget execution. The table below highlights budget reallocation:

S/NO	Budget Category	Original 2020 budget (billion Naira)	Revised 2020 budget (billion Naira)	Budget proposa 2021 (billion Naira)
1	Basic Health Care Provision Fund	44.50	25.56	35.03
2	FMOH recurrent + capital	396.5	414.5	546.98

3	SWV- Gavi immunization contribution	22.73	26.83	45.19
4	GF Counterpart funding	5.50	5.50	5.50
5	SWV- COVID-19 crisis intervention Fund	0	0.213	
6	COVID-19 crisis intervention Fund (incremental capital)	0	100.03	

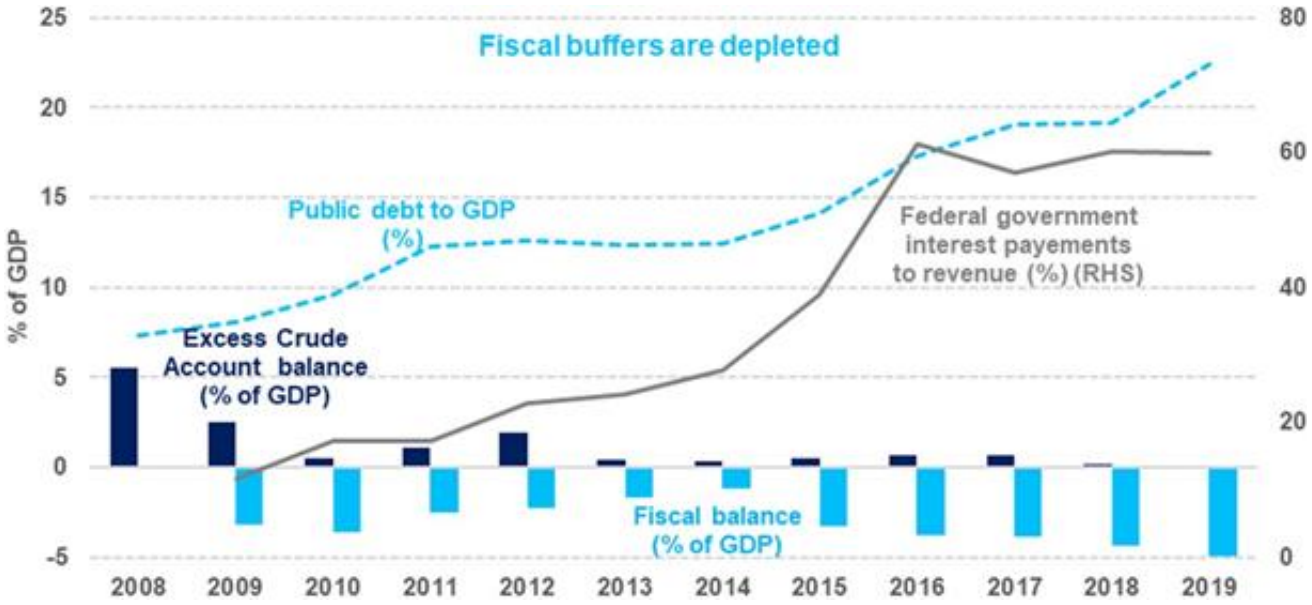
In terms of vaccine financing, annual budgets for vaccines are now earmarked in the service wide votes, thereby improving the predictability of releases. In addition, improvements have been made in planning and budgeting for vaccines, as a three year vaccine financing estimate is now incorporated explicitly in the MTEF to improve predictability of Government financing for vaccines. Noteworthy is the set up of vaccine financing and accountability task team with a focus on institutionalizing the budget planning and monitoring function for vaccines. Lastly, BHCPF has been elevated to first line charge/ a statutory transfer and public funding for primary healthcare and front-line service delivery, including immunization services.

- Is there any visibility on 2021 health budget already and potential impact on the immunisation budget? On the PHC budget?

The proposed budget proposal is as shown in the table above while 2021 debt is estimated to be 33.55% with the GGR as 7.13%.

- What are the IMF projections for Nigeria in terms of macro-fiscal status etc.?

According to the update from the World Bank Group on the Development in Nigeria in June 2020, public debt is still relatively low by international standards at around 20-25% of GDP. However, it is growing rapidly and because of the extraordinarily low levels of revenue, over 60% of the revenue from the Federal Government was geared towards servicing public debt in 2019 (likely to much higher in 2020). It is noteworthy to mention that the Excess Crude Account has been depleted and in recent years, the fiscal deficit has been systematically underestimated and monetized ex post. Hence, with the amended budget for COVID-19, the Government projected a more realistic larger deficit ex ante. Below is an illustration to this effect:



In a nutshell, Nigeria's economy is expected to contract this year possibly triggering the worst recession in four decades with the speed of recovery solely dependent on the response from Government's policy and the global outlook of the pandemic.

- Are there any national strategies being implemented or explored to secure and sustain funding for immunisation, for PHC? Any health tax discussion? Any domestic resource mobilisation advocacy strategy?

In swift response to the fiscal shock, the authorities amended the Federal budget for 2020 and was accompanied by a Fiscal Strategy Paper (FSP) 2020-22 that responds to the impact of COVID-19 on Nigeria's public finances. The new budget revises revenue expectations downward in line with the collapse of global oil prices and the deteriorating macroeconomic outlook. It cuts nonessential spending and reprioritizes expenditures toward the COVID-19 response; a new N500 billion COVID-19 intervention fund channels resources to emergency health priorities and public works programs designed to ease the impact of the economic downturn on the livelihoods of poor and vulnerable Nigerians. A more realistic budget deficit estimate allows for an additional N2.8 trillion in borrowing from domestic and external sources using market instruments. Many State Governments are also expected to revise their 2020 budgets

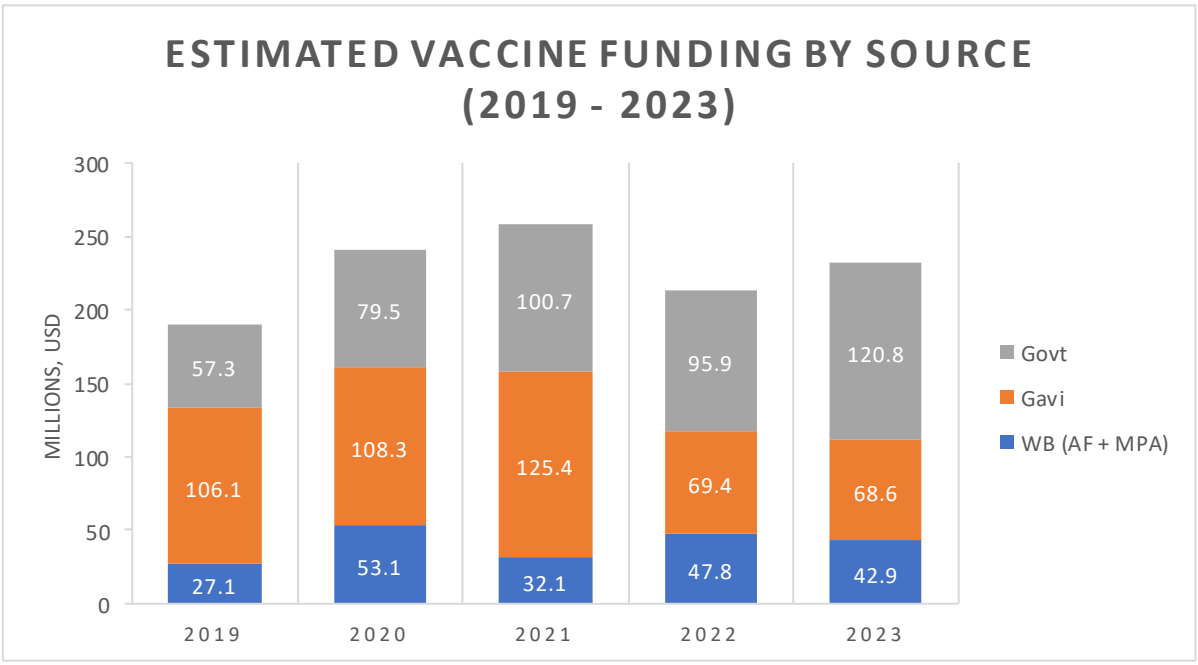
- How are expenditures under the response and recovery plan tracked at country level?

Expenditures are currently sub-optimal from the Government with limited pre-pooling arrangement. This means most of the health expenditure will be borne by households.
The following steps have been taken to constitute a recovery plan:

- Increased allocation to the health sector by the Government as highlighted in the table at section 3.7
- Advocacy and sustained engagement with MoF and Legislature to ensure vaccine financing is prioritized
- Securing of vaccine budget in service wide votes
- Augmentation of vaccine gap as a result of exchange rate loss by the Ministries of finance, budget and National planning
- MTEF process to provide a medium-term planning platform that will be used by the Government to anticipate vaccine expenditure
- Government has sought concessional assistance from international institutions and is working with the World Bank, African Development Bank and Islamic Development Bank to secure more budget support

- Discussion on regional analysis developed by the World Bank could be used to provide high level recommendation regarding domestic resource mobilisation etc

The forecast for 2021 and subsequent years may change. Currently, an estimate of **$415M** submitted by the NLWG for 2021 is being reviewed by the vaccine financing task team. $120.19m proposed in the 2021 Federal Govt budget with the major cost driver appearing to be the planned introduction of HPV and Rota in 2021. However, these new introductions are yet to be finalized.



- What are the Government/Partner/other stakeholder plans (projects, technical assistance, budgetary support, other)

- How are all actors coordinating and aligning to ensure efficient health expenditure in the current challenge?
- What is needed to be done to secure at vaccine financing (SWV and statutory budget, advocacy, etc)

3.7 Already agreed budget reallocations of HSS grant for COVID-19 response

Activity	COVID-19 activity	Amount reallocated (US$)	Status of implementation
A	Hygiene and infection control training for health workers	413,494	Not done. NPHCDA requested to use the funds for RI intensification activities
B	Infection control supplies	8,449,701	Procurement ongoing through UNICEF
C	Surveillance activities - Deployment of SORMAS in 2 States	158,863	UNICEF Completed and delivered
D	Laboratory testing materials	2,494,698	6/8 received, delivery in progress
E	Risk communication and community engagement	33,333	Not done. Approval secured to use the funds for IPC trainings.
F	Coordination and Oversight	111,428	Two of the TAs have been recruited and 2 others on recruitment process by UNICEF.

3.8 Already agreed modifications in Technical Assistance

- Support provided to CHAI Nigeria to assist the Presidential Task Force with the coordination of the response to the pandemic

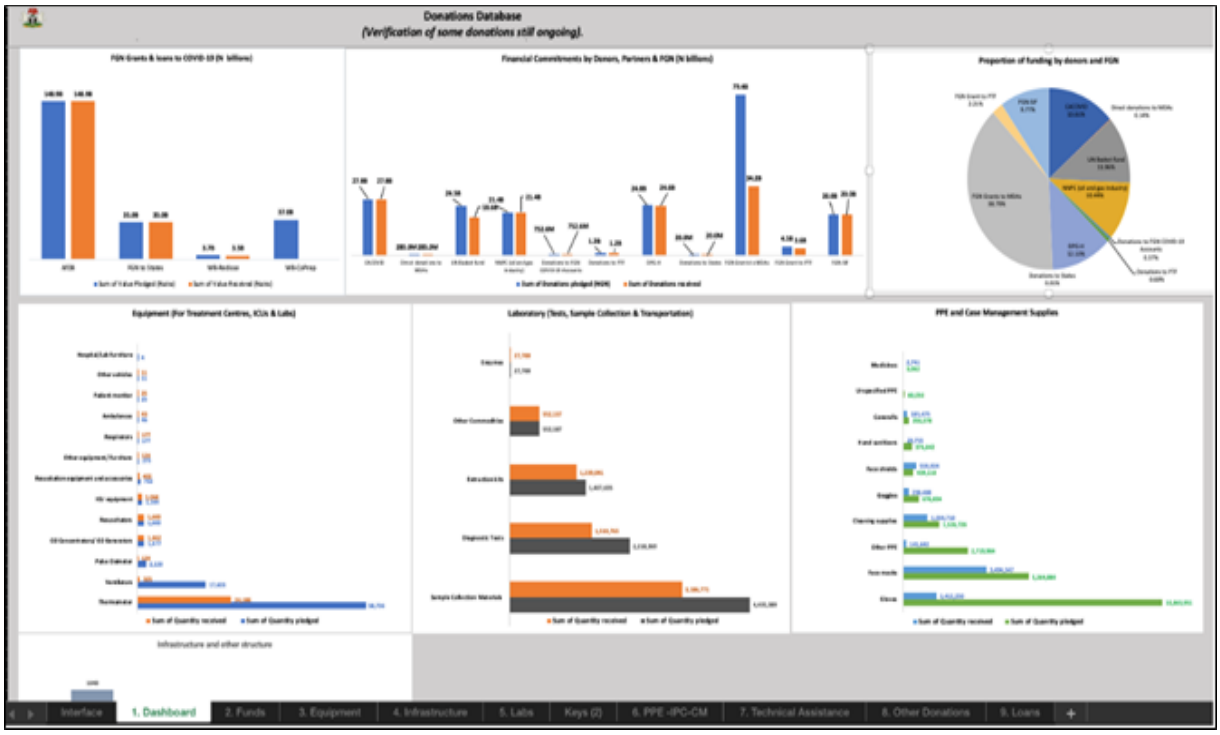
For the period June 2020 – November 2020, the Clinton Health Access Initiative (CHAI), under a Gavi-funded grant provided Technical Assistance (TA) to the Presidential Task Force (PTF) and Nigeria Governors' Forum (NGF) whom, according to the pandemic response plan, are responsible for coordinating the pandemic response at National and State levels respectively. Specifically, CHAI support focused on strengthening donor coordination and resource mobilization. During this period, CHAI provided technical assistance in the areas of scenario modelling, rigorous analysis, deployment of tools & templates to improve efficiency of the response, processes and optimize the resource mobilization and supply chain processes through ensuring data availability for decision making.

Key objectives under this work include:

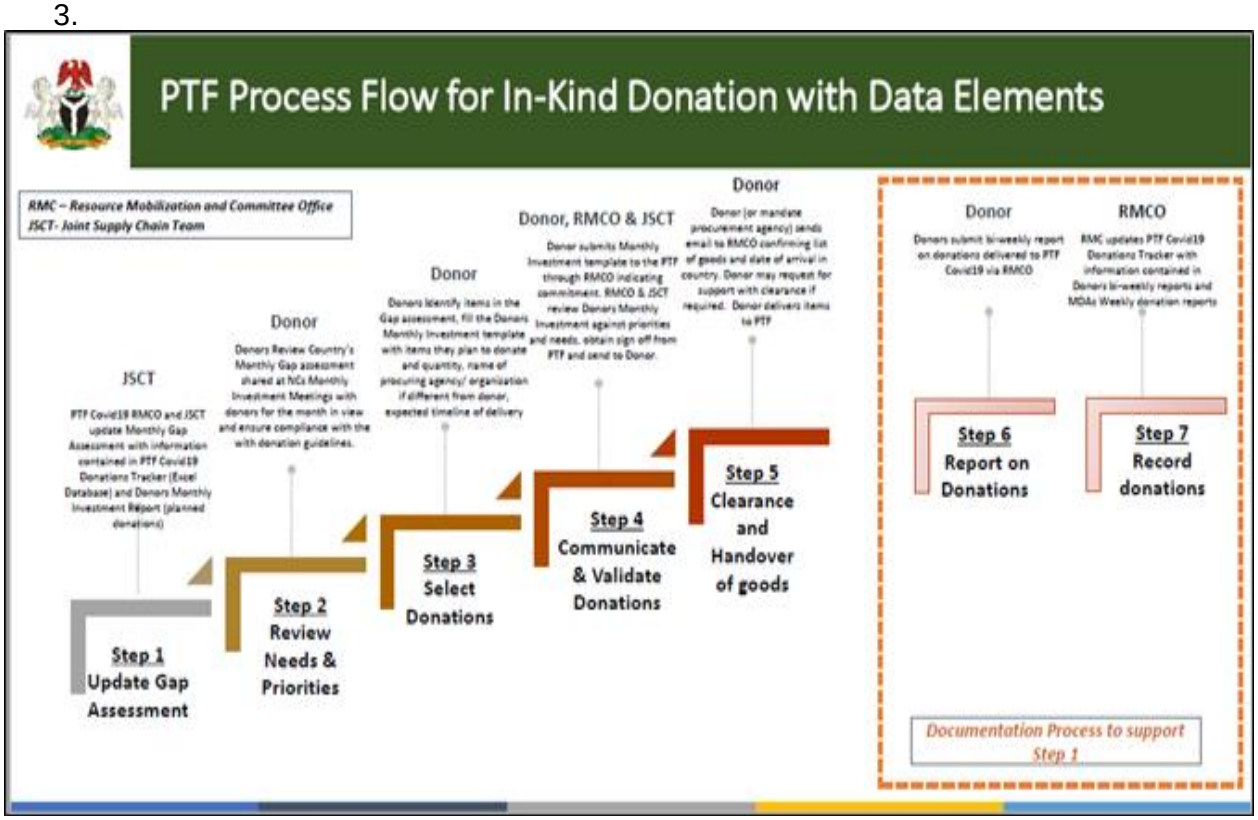
1. Strengthening Donor Coordination & Engagement at the National Level
2. Strengthening Resource Planning and Deployment at the National and State level
3. Strengthening coordination, planning and provide secretariat support as part of the COVID-19 National response (PTF and NGF)
4. Supporting strategic planning and coordinated action and promote cross state learnings through information sharing at the State Level

To ensure the achievement of the stated objectives, CHAI facilitated and promoted the achievement of the following:

1. Development of a dashboard to provide real-time visibility, coordination and tracking of donor resources for the COVID-19 response http://www.statehouse.gov.ng/covid19/
    - CHAI in June 2020 finalized the development of a donor investment dashboard (also known as a donations database) that captures and tracks all donations (financial and 'in-kind') made to the country through the PTF, MoH, OSGF and NCDC. In addition to the visibility the dashboard provides, it also serves as a repository for all donations across the seven (7) donation categories

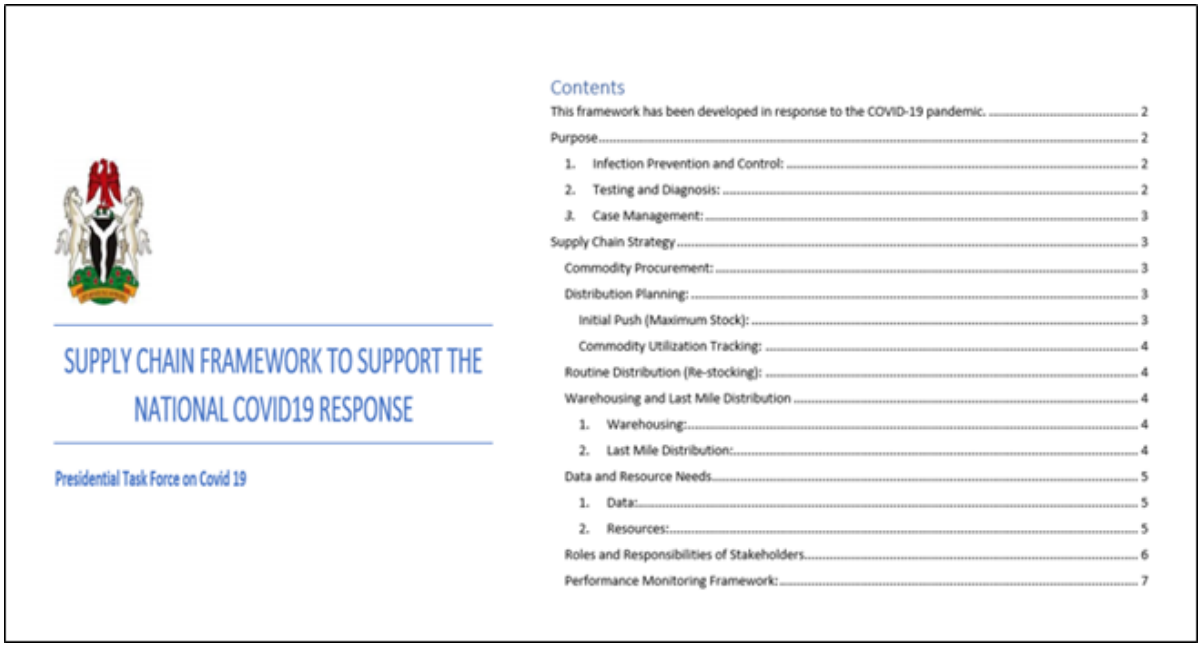


2. Development and dissemination of a donation process flow to aid advocacy for resource mobilization and provide coordination and guidance for donations. This publicly disseminated document detailed all steps required for donations.
3.



4. Development of a cost-effective supply chain plan to ensure equitable supply and distribution for COVID-19 commodities across all states.
    - CHAI in collaboration with members of the Joint supply chain team of the PTF supported the development of a guiding strategy document for supply and distribution activities to aid equitable and seamless distribution of COVID-19 commodities. This document provides the supply chain strategy for commodity procurement, distribution planning (initial push and commodities utilization tracking), restocking, warehousing and last-mile distribution, data &

resources, roles and responsibilities of stakeholders and performance monitoring framework.

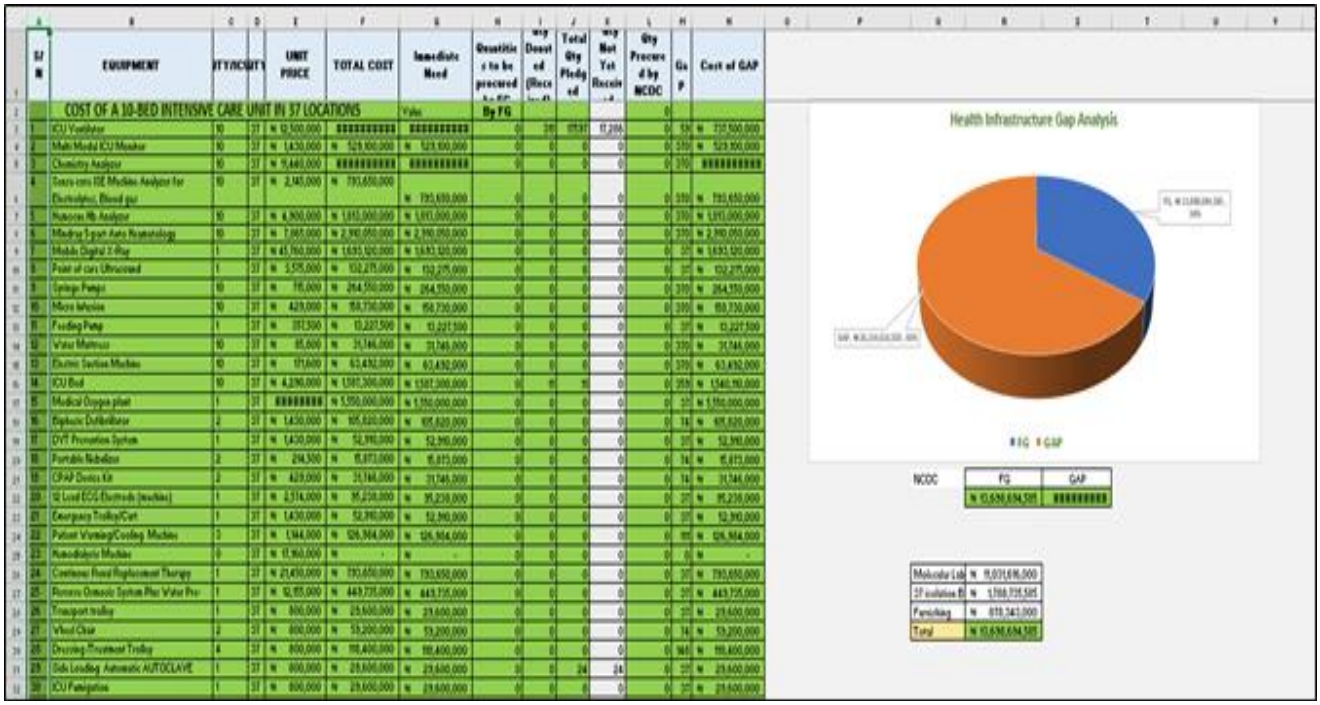


SUPPLY CHAIN FRAMEWORK TO SUPPORT THE NATIONAL COVID19 RESPONSE

Presidential Task Force on Covid 19

Contents

5. Country-wide needs assessment with routine updates to ensure real-time intelligence on the country's requirements to effectively respond to the pandemic.
    - CHAI building off initial work done by UNICEF and other technical partners developed and deployed the monthly gap assessment tool to enable the country effectively monitor and determine its 3-month and 6-month COVID-19 resource gaps/surpluses. This tool provides a visual representation of all resource gaps on essential commodities for COVID-19 response and thus serves as an advocacy and engagement tool to donors for continued investment for the country's response. Additionally, the tool analyzes the quantity of items pledged by donors versus those received in-country and is critical in creating a lean supply chain response system which effectively aligns demand and supply.



6. In collaboration with NCDC and JSCD, developed and reviewed the COVID-19 Commodities distribution schedule from July till November 2020.
    - CHAI in collaboration with members of the Joint supply chain team of the PTF supported the monthly review of the national distribution plan developed by the NCDC which allocates COVID-19 commodities (PPE's and IPC's materials, Oxygen concentrators, Ventilators and

respirators) to Tertiary, secondary and primary healthcare facilities across all states within the country with additional provision made for surveillance activities.

7. Monthly meetings between the FGoN and Donors to provide a two-way feedback mechanism across stakeholders.
    - CHAI supported the organizations of Donor Investment Meetings. The terms of reference for the Donor Investment Meeting included facilitating discussions amongst COVID-19 donors, partners and stakeholders on the country's effort towards the pandemic response including an assessment of country needs, available resources in-country, identified gaps in the response initiatives, and harnessing technical, financial & material resources to closing the gaps. Participants included GAVI, WHO, USAID, DFID, McKinsey & Company, US CDC, NNPC, Global Affairs Canada, IHS, CHAI, BMGF, UNICEF, UN One COVID-19 Basket Fund, CACOVID, Dangote Foundation, Federal Ministry of Health, eHealth Nigeria, OSGF, NCRC, the PTF.
8. Facilitated the review and costing of the 3-month roadmap of activities for the Resource Mobilization and Coordination Office (RMCO) and Joint Supply Chain & Distribution Team (JSCD) c. ₦37 million Naira ($97k)

- Sydani Initiative assisting NCDC and NPHCDA with COVID-19 response

Through re-purposing of the existing agreement with Gavi, Sydani Initiative provided technical support to the NCDC and NPHCDA in development and implementation of COVID19 response activities funded by Gavi. Key areas of support included:

1. HSS budget reprogramming: The Sydani team supported the NCDC and NPHCDA in review of the HSS budget to reprogramme 10% ($12.6m) of the approved HSS funds towards Nigeria's COVID19 response. As part of the process, the Sydani facilitated meetings of relevant stakeholders (NCDC, NPHCDA, WHO, UNICEF, WB and USCDC) to identify critical areas that require Gavi support in line with the NCDC's COVID19 Incidence Action Plan (IAP). Sydani worked with relevant stakeholders to develop the detailed budget using Gavi templates and facilitated the process of securing required approvals from FMOH.
2. Tracking implementation of Gavi-funded COVID19 activities: Sydani liaised with NCDC, UNICEF and WHO to ensure timely implementation of approved Gavi-funded activities and flagged identified bottlenecks to Gavi for speedy resolution
3. Development of budget proposals to other donors: Sydani supported the NCDC in the development of required budgets for proposals to donors including Africa Development Bank, Islamic Bank, etc

3.9 **Unspent funds and savings from Gavi support, available for re-allocation**

(Brief narrative & table referring to cash balances mentioned in tables 1.2 & 1.3. Considering that some activities have been cancelled, delayed or modified, this is an overview of funds available to be re-allocated.)

Cash balances in HSS CCE and CCEOP support through unicef:

1. **HSS CCE support through the supply division**- There is a balance of $2,013,493.68 in this support grant. However, invoicing and payment are being concluded. Depending on new invoices could be that commitments are not utilized and returned to available cash. The final balance is planned to procure the CCE.

2. **CCEOP support through the supply division of unicef**- The planned activities supported by this grant is on track. $13,413,668.38 has been spent and balance is $9,585,361.97
3. **HSS supply chain** - this support grant has a balance of $4,678,402.32. The planned activities for 2021 are EVMA in Q1/Q2, 2022 Bundled Vaccine forecasting, Physical Stock verification and Store Audit exercise, CCEOP project implementation, supply chain analysis and system redesign, LMIS improvement (supply maturity model workshop, procurement and deployment of incinerators, Procurement and deployment of 4 x WICRs.

Support	Recipient	Amount available for reallocation	Activity to receive reallocated funds	Amount needed to fund activity

3.10 **COVAX readiness**

(Brief narrative on preparations being made for the rollout of the COVAX vaccine and related support through the COVAX Facility)

The country has set up a Covid-19 Technical Working Group. The working group is an expansion of the existing new vaccine strategic task team (NVSTT). It is Chaired by the ED/CEO NPHCDA and its membership is drawn from a broad base of relevant stakeholders which include government and non-governmental organizations, the private sector, and developmental partners. The Technical working group has four subcommittees viz: planning, coordination, and service delivery; microplanning and surveillance; vaccine Security, Safety and Logistics as well as the risk communication and demand generation subcommittee. Each of the subcommittee is headed by a director of the agency. The subcommittees meet regularly to provide information on sections of the VIRAT/VRAF tool relevant to it, develop the National Deployment and Vaccination Plan, the covid-19 vaccination operational plan and the covid-19 workplan. The team is also populating the covax vaccine request application, the covax CCE request and indemnification of the manufacturer.

The current AEFI reporting system will be used for reporting any untoward effect during vaccination. The following are the steps lined up for the application of the Covid-19 vaccine:

- The GoN through the HMH has Signed the MoU with GAVI to facilitate access to the COVAX facility.
- Amendment of the current MoU with UNICEF Supply Division to include the procurement of COVID-19 vaccines will be made.
- The CCE inventory for Q3 has been updated and are being used to determine the CCE storage gaps that will be necessary for the Covid-19 vaccine storage. The cost implication of the CCE required is being determined.
- Approved GAVI template for application has being received and is being populated for vaccine needs will be submitted to GAVI on 7th Dec 2020.
- Application for procurement of the required CCE including the ultralow temperature freezers if needed (based on the candidate vaccine characteristics yet to be shared) will be submitted to GAVI with the cost implications.
- Forecasting scenarios with different dose vials using 3% TP for Health workers and 17% for the elderly and those with underlying ailment have been developed.
- Fundraising for the co-financing portion by NPHCDA (domestic resources + World Bank loan) i.e securing Government commitment.
- The application for waiver and process of registration of the Covid-19 vaccine from NAFDAC being the National Regulatory Authority since the vaccine may not have been registered in the country before now are being processed.
- Cost Estimates will be requested from UNICEF SD, reviewed and approved by NPHCDA.
- Placement of Purchase Orders by UNICEF SD followed by commencement of deliveries to the country (pre-alerts to be shared 2 weeks prior to the delivery)
- Port of entry and primary store which are Nnamdi Azikiwe International airport and NSCS respectively are identified.
- Clearing Agents have been identified for the Clearing of the vaccines and devices
- NAFDAC will sample the COVID- 19 vaccine for quality assurance on arrival.
- Distribution of the vaccine and devices using the existing iSC system.

4 Discussions on priorities, action plan and technical assistance needs; Roadmap for further re-allocation/planning

Based on the analysis of the current programmatic and financing status of your immunisation programme (captured in Sections 1 and 2), the questions below provide guidance for discussions on priorities, action plan and technical assistance needs for 2021.
This should result in an outline of your plans to reinforce/re-establish routine immunisation activities, catch-up on missed children, and potentially re-activate some of the planned new introductions and/or campaigns, in the context of the country epidemic response/recovery plans while taking into account the guidance provided by the Alliance.

The country is asked to:

- Define short/medium-term activities to maintain/restore routine immunisation and catch-up on coverage as needed. For these, a workplan and budget will be required.
- Define a roadmap for further re-allocating/planning of activities not captured here, considering the medium/long-term country recovery plan, domestic resources and those available from other development partners, lessons learned, and innovative approaches used to cope with the epidemic, and synergies with all relevant stakeholders, including CSOs, with the vision of "building back better".

The multi-stakeholder dialogue may consider the following questions, considering the latest programmatic guidance provided by the Alliance:

- TA needed to implement VPD Surveillance 2021 activities

S/N	Key activities planned for 2021 that require TA	Required TA
1	Supportive supervision on measles/rubella/yellow fever response activities	New TA Needed – Measles/Rubella surveillance and lab consultants
2	Trainings for state DSNOs and other staff involved in sample collection, packaging and transport to the laboratory	
3	Training of clinicians from Tertiary and secondary facilities to identify and report cases of VPDs	
4	Expansion of CRS sentinel surveillance	
5	RCA to identify underlying cause of VPDs outbreaks	
6	Transition of VPDs surveillance data to SORMAS	
	Training of DSNO on data management of surveillance of VPDs	

4.1 Short/medium-term activities to maintain/restore routine immunisation.

- COVID-19 recovery plan: does the country have a recovery plan which includes restoring essential health services including immunisation? If not, is the recovery plan being developed?
- Immunisation services: What strategies have been implemented at the service delivery points to re-activate immunisation services and to address any immunisation gaps resulting from COVID-19?
  - Are any additional strategies/delivery mechanisms planned (e.g. updated demand strategies, community outreach, PIRIs, new campaigns, etc.)?
  - If so, how are these measures incorporated into broader primary health care considerations and are they in line with WHO guidelines?

  - What plans exist regarding risk communication and community engagement in the response?
  - What lessons learned and/or innovative approaches to immunisation service delivery that were used to cope with the epidemic are worth broader adoption and scaling-up?
- Equity approach: What are the plans to ensure that underserved and missed communities, including zero-dose children, are prioritised within the country's recovery plan?
  - Does the plan consider any additional cohort of children or any new communities that might have missed immunisation due to COVID-19 and have strategies to address them?
  - Does the plan consider disproportionate impacts of the pandemic on women and girls or other vulnerable groups (including migrant, disabled, HIV+, LGBTQI communities) and propose gender responsive/transformative strategies to mitigate them?[8]
  - Does the plan consider new or strengthened partnerships to reach underserved communities, including CSOs?
  - What are the gaps in immunisation data and information that will limit the ability to identify missed children, track reaching those children, and monitor the effect of recovery strategies/service delivery mechanisms?
  - Does the recovery plan include activities to improve known gaps in immunisation data?
- Immunisation financing: Has sufficient funding been secured to ensure availability of vaccines, including the co-financing portion, and to enable continuous immunisation service delivery going forward? Please give a brief overview of the funding landscape for the immunisation program[9] and highlight any gaps in support. Describe efforts underway to close any financing gaps.

Yes. Vaccine financing is being provided through a mix of Budgetary allocations, credit facility funds (World Bank) and the Basic Health Care Provision Funds. The NSIPSS Accountability Framework is used as a guide for determination of required resources from each possible source to guarantee 100% availability of funds to meet the country's forecasted needs. The forecasted needs include co-financing obligations.

4.2 What support is required from Gavi for the planned short/medium-term response efforts?

- What are the key technical assistance needs to be funded through PEF TCA[10]?
  The specific TA needs for each thematic area have been provided above.
- Does the country anticipate requiring additional HSS flexibilities or support?
  - Need for flexibility is anticipated but not yet confirmed.
- Do any planned new vaccine introductions or campaigns need to be adjusted in light of the current situation? (Please confirm or indicate any changes in assumptions from section 1.1)
  - Planned vaccine introduction – Rota Introduction and IPV 2 introduction, will be refined considering the COVID context to make provision for virtual meetings and, IPC materials for physical gatherings where applicable.
- Is the country intending to apply for new vaccine support or a product/presentation switch[11] in next 6-24 months? If so, please mention for which vaccines/support.
  Yes, for HPV vaccine, and potentially a switch from IPV full dose to fractional dose
- Is the country interested in innovation initiatives[12] from the innovation catalogue[13] available to countries?
  - Yes

[8] Gavi's revised gender policy was launched on July 1, 2020 and can be downloaded here https://www.gavi.org/programmes-impact/programmatic-policies/gender-policy
[9] Including sources of funding.
[10] The TA needs mentioned in this report are a key input into the process to classify Gavi TA support (PEF TCA). The TA plan will however be subject to follow-up discussions and a separate approval process, which may require supplementary information to be provided.
[11] For information on available products/presentations, please refer to: https://www.gavi.org/news/document-library/detailed-product-profiles
[12] Definition of innovation: new products, practices or services that unlock more efficient and effective ways to accelerate Gavi mission.
[13] An innovation catalogue will be made available to countries in the coming weeks.

4.3 **Roadmap for further medium/long-term planning**

Please briefly outline your roadmap for developing a more detailed medium/long-term recovery plan to restore immunisation services and address any immunity gaps created by the COVID-19 pandemic. In your response, you can consider the following:

- Is there a need to conduct an assessment of the COVID-19 pandemic impact on immunisation services in order to best facilitate the development of a longer-term response plan?
  - Yes, this assessment has been conducted and findings highlighted above (section 3.5)
- What is the envisioned planning process, including efforts to engage communities in the development of the plans, to join broader health sector planning exercises, and to ensure harmonisation of support with all relevant bi-lateral and multi-lateral development partners?
  - The country will leverage existing platforms (NERICC, Core Group, etc) in ensuring planning is inclusive of all relevant stakeholders.
- Will a technical assistance plan be developed alongside the recovery plan? Will it be holistic and ensure support from all TA partners is harmonised?
  - Yes
- Finally, please note whether planning has already begun for a potential introduction of a COVID-19 vaccine (including the readiness assessment) if/when such vaccine becomes available?
  - Yes

Annex 1: List of PEF-TCA Activities with Major Delays in June 2019 - June 2020

Partner	Activity	Milestone
CDC	Support NCDC in development of national surveillance and lab network for measles, rubella and yellow fever diagnostic testing to include: 1) Conduct lab training for lab staff to build their capacity on the testing for various vaccine preventable diseases to include measles, rubella, and yellow fever 2) 1 year Epidemiologist consultant to develop and refine protocols for surveillance, including case investigation and classification and outbreak response for measles and yellow fever, and laboratory/ epi data harmonization including data cleaning, data management, and summary/presentation of data 3) 1 year information strategy support for laboratory information management system 4) Outbreak investigation for measles, rubella and yellow fever including CDC support to conduct root cause analysis of outbreaks.	1) Lab training completed for 14 national staff 2) Epidemiologist consultant hired 3) Lab information consutlant hired 4) Outbreak response plans updated
CDC Foundation	Leveraging findings from a targeted EPI program assessment in 3 states planned for January 2019, we will provide technical support for the planned introduction of MCV2 in Nigeria in 2019. This will include operations research to identify and mitigate barriers to uptake of second year of life (2YL) services (e.g. MCV2), and recording/reporting of vaccines doses delivered in 2YL; development and roll-out of training materials for 2YL, with emphasis on use of MCV2 as an opportunity to catch-up children on vaccinations that were missed during the first year of life; communications messaging to increase awareness and demand for MCV2	Assessment of materials conducted, and tools adapted as needed for in-country needs. Materials included in planning for phased MCV2 introduction.
UNICEF	Design and implement financial management strengthening strategies at federal, state and sub-state levels to improve efficiency of fund distribution and availability at the last mile	Financial management strategy developed
UNICEF	Design and implement financial management strengthening strategies at federal, state and sub-state levels to improve efficiency of fund distribution and availability at the last mile	NPHCDA and SPHCDA finance staff from 6 prioriy states trained in HACT modalities
UNICEF	10. Physical Stock Counting Exercise	Physical stock counting (PSC) exercise completed
UNICEF	6. Technical liaisons between the NLWG and SLWGs, within zonal catchment areas, for implementation of annualized NLWG work plan at state level	50% completion of annualised NLWG projects to be implemented at the state level

Annex 2: Overview of NVS support

	2012		2013		2014		2015		2016		2017		2018		2019		2020		Grand total		
	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Supplies	Freight	Total
Meningitis	11,006,413	646,878	12,181,252	497,826	20,062,113	881,170	1,691,351	35,613	180,093	8,576	5,530,772	50,898	389,348	6,481	30,821,087	632,974	1,762,857	112,926	83,625,286	2,873,342	86,498,628
Penta	16,351,536	394,252	22,056,718	297,592	28,792,505	396,048	30,108,570	321,945	31,701,346	274,457	12,857,055	213,257	2,122,875	28,648	1,143,675	16,605	3,085,335	43,828	148,219,615	1,986,632	150,206,247
Yellow Fever	3,516,626	371,405	15,942,640	597,973					20,284,821	1,057,900	4,178,416	114,080	22,968,792	808,297	31,100,163	656,474	35,025,044	1,362,155	133,016,502	4,968,284	137,984,786
Measles			9,746,267	656,602			11,563,655	637,764			6,179,125	320,833	4,728,897	229,402	9,867,572	386,710	1,726,549	63,621	43,812,065	2,294,932	46,106,997
PCV					13,396,399	140,856	25,345,213	236,517	100,336,980	638,162	67,721,300	468,626	15,673,340	46,507	14,156,880	49,974	23,036,040	52,035	259,666,152	1,632,677	261,298,829
IPV							13,235,396	287,003	7,231,414	198,655	6,914,512	133,206	10,373,314	284,167	23,503,186	224,556	17,326,595	129,735	78,584,417	1,257,322	79,841,739
OCV											3,352,107	250,982	5,941,259	347,753	2,490,037	58,125			11,783,403	656,860	12,440,263
Devices											2,765,148	124,893	2,081,735	140,520	4,973,117	544,294	1,917,780	210,508	11,737,781	1,020,215	12,757,996
CCEOP															13,292,765	121,703			13,292,765	121,703	13,414,468
YF Diagnostics																	9,747	8	9,747	8	9,755
Total	**30,874,575**	**1,412,535**	**59,926,877**	**2,049,993**	**62,251,017**	**1,418,074**	**81,944,185**	**1,518,842**	**159,734,654**	**2,177,750**	**109,498,435**	**1,676,775**	**64,279,560**	**1,891,775**	**131,348,482**	**2,691,415**	**83,889,947**	**1,974,816**	**783,747,732**	**16,811,975**	**800,559,708**

Annex 3: Attendance at the MSD workshop

Attendance			
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