[FEDERAL REPUBLIC OF NIGERIA]

2018 Programme Support Rationale

[Strategic period (2019 – 2023)]

The Programme Support Rationale (PSR) presents the rationale and objectives for the programming of Gavi support for the upcoming period, and - together with the online vaccine application(s) mentioned below - replaces the previous application forms used to request new support.

- The PSR is developed approximately once every five years based on and in alignment with the national health and immunisation strategic plan(s) and budgets.
- It incorporates the Joint Appraisal in the year of its review.
- **Stock levels and requests for vaccine renewals or product switches need to be reported on the Gavi Country Portal between late March and 15 May.**
- All required reporting has to be submitted on the country portal, as per the reporting guidelines.
- The PSR builds on robust analysis of country data and evidence of progress made (or persistent challenges) on the coverage and equity situation.
- In parallel to the PSR, the Gavi budgeting and planning template and Gavi grant performance framework (GPF) are completed to complement the objectives presented in the PSR. This should be reflected in the country's own operational budget and workplan.
- The Coordination Forum (ICC, HSCC or equivalent body) is required to endorse the PSR prior to final submission to Gavi.
- Signatures of both the Minister of Health and Minister of Finance or their delegated authority are required to endorse the final PSR before submission to Gavi.
- The PSR will be reviewed by members of the independent review committee (IRC) who will make a recommendation to Gavi on the full portfolio of support for the duration of the PSR, including any current support that needs to be renewed.
- Following the independent review there will be a period for countries to respond to any 'issues to be addressed' ahead of final Gavi approval and disbursement.
- **It is recommended that this process be initiated 15-18 months prior to expected grant disbursement.**
- **Vaccine applications are developed via Gavi's online country portal and submitted for review and approval 15 to 18 months before the planned vaccine launch or campaign.**
- On an annual basis the budget will be reviewed and updated to take into account implementation progress and any new information from the joint appraisal.

Visit Gavi's website (http://www.gavi.org/support/process/apply/) for available programmatic and process guidance to support the development of the PSR and vaccine applications. For a **list of mandatory documents** to be submitted together with this PSR, please refer to Annex 1 of the Application guidelines.

BACKGROUND

A. HSS development approach

- Following the approval of the NSIPPS by the Gavi Board in July 2018, the NPHCDA and partners rolled out key engagement processes to inform the development of the HSS. On 13th -17th August 2018, EPI review meeting was held with the 36 states and FCT to review state specific performance and outline state-specific priority interventions in 2019. Also the Joint Appraisal and the NSIPSS retreat that held on 19th – 21st and 24th – 26th of September 2018 respectively further provided botfh strategic and operational priorities for Immunisation and PHC strengthening. Prioritized strategies provided in this PSR took into consideration and built upon the work done during the above-mentioned workshops[1]
- The National team, working consistently with State and local teams, has all the requisite elements to define the strategies and interventions proposed in this PSR. However, the development of state specific plans requires further analysis and a process that is collaborative, transparent and bottom-up to ensure developed plans are tailored to state and sub-state context, as well as promote ownership and sustainability. Due to the urgent needs for vaccine support, cold chain equipment optimisation and federal-level management and coordination activities to boost immunization and PHC coverage and equity, the country is proposing a two-phase approach for the development of a realistic and targeted HSS plan that provides a solid foundation for sustainable immunization and PHC systems strengthening:
    - **Phase 1 (current phase):** National-level development of HSS plan with well-detailed breakdown of federal-level strategies and activities. In this phase, state-level plans are NOT detailed out, and the costing for the proposed state strategies are provided as a lump-sum. The lump-sum costing done by the national team is based on extensive understanding of state-level issues through frequent engagements (OIRIS), reports and follow-up with the state and LGA teams, especially in the 18 low-performing states.
    - **Phase 2**: National team will engage with prioritized states and state-level stakeholders to develop tailored interventions that will address state-specific issues. Appropriate details will be provided for all activities and the costing will be done at a granular level. Once completed, the tailored state plans will be shared with all relevant stakeholders and submitted to the Gavi review process for approval.

B. Rationale for selection of Gavi priority states

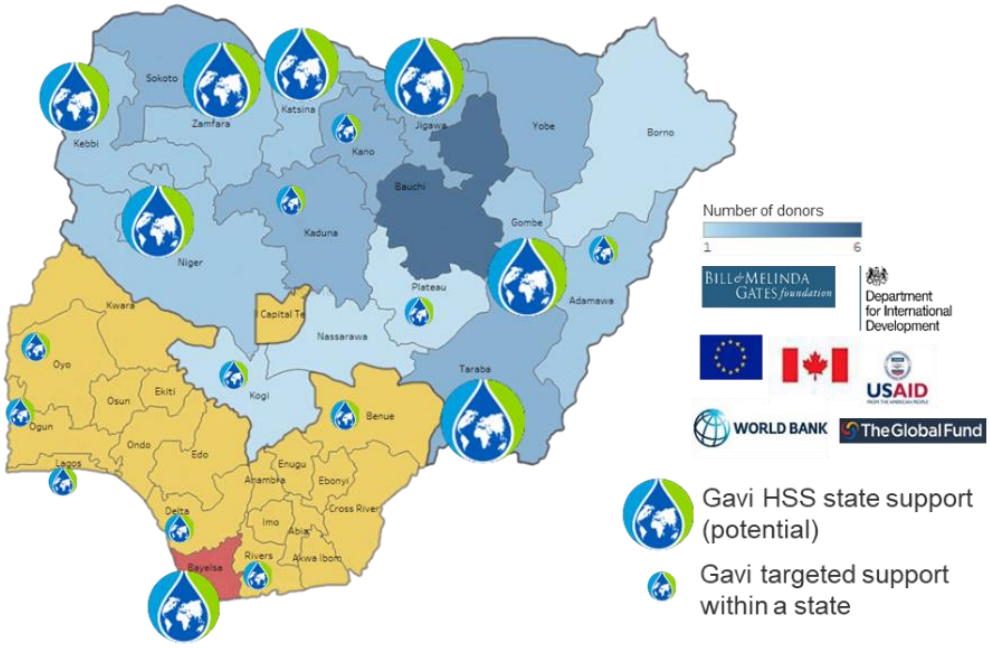
- Based on RI coverage[2] and the number of un/under - immunized children as per the NSIPSS in each state; and identified funding gap due to lack of donor support, some states (see figure below) have been prioritized for potential support from Gavi. The prioritization process also factored in operational data from NERICC and selected states are a sub-set of the 18 NERICC priority (low-performing) states. Focus is on States with low RI coverage, high number of under-immunised children, identified funding gaps and subpar political will to drive immunization activities
- In 8 prioritized States, Gavi will focus on strengthening overall RI and PHC programme, in coordination with other partners. While in other states, with high number of under-immunised (>85,000) children but relatively good coverage (e.g Lagos, Oyo), a more targeted approach (to be developed in phase 2 of the HSS plan development) will be used, based on further analysis

[1] See Annex 1: Mapping of prioritized strategies across the NSIPSS, JAR, NSIPSS retreat and HSS/PSR

[2] 2016 MICS/NICS survey

The scope of implementation of activities outlined in this PSR and costed in the HSS budget varies based on the potential impact of the activity. Some key activities will be implemented at the federal level to strengthen the capacity of the national team to effectively coordinate immunization and PHC programmes. At sub-national level, some activities will be implemented across the 8 Gavi-focus states, some across all 18 NERICC priority states; and other activities will cut across all 36 states and Federal Capital Territory

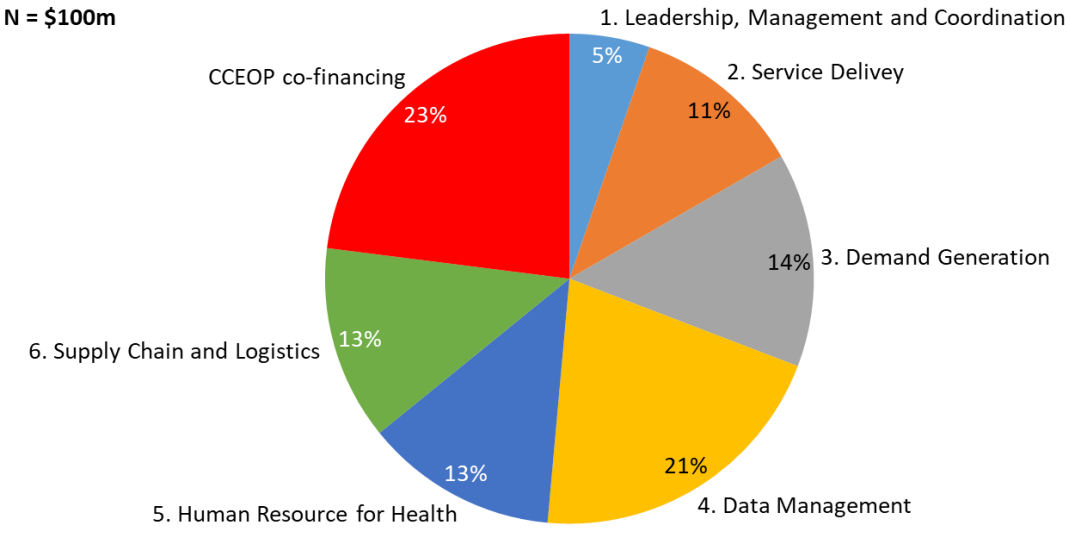
Figure B1. Geographic distribution of Gavi support (potential) across states



C. Breakdown of HSS budget by thematic area

The total budget ceiling for the HSS 2019-2023 is one hundred million US dollars ($100m). Twenty-three million USD ($23m) out of the total is allocated to co-financing of the CCEOP, and the outstanding seventy-seven million USD ($77m) is distributed across the six thematic areas as shown in the figure C1 below.

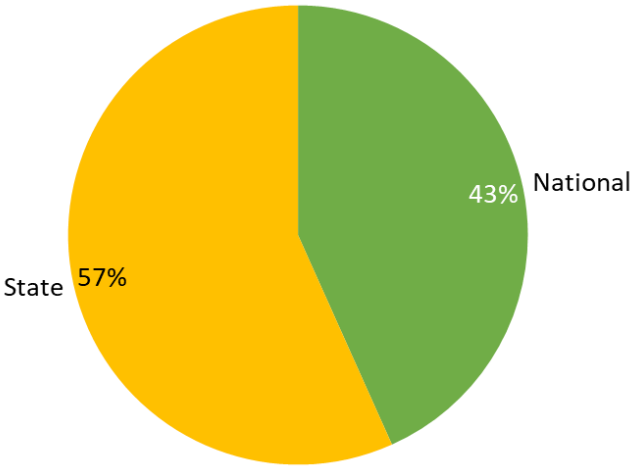
Figure C1. Proportion of the total HSS budget contributed by each thematic area



D. Breakdown of HSS budget by support-beneficiary (Federal vs State)

The chart below provides the distribution of HSS support across the Federal and State levels. The distribution represents the proportion of funds that are dedicated to supporting the respective levels, irrespective of which level receives the funds. *As an illustration: Procurement of electronic immunization data-capture devices is classified as a state-level beneficiary (fund recipient on the HSS excel template), though the activity will be implemented centrally by the Federal level and the funds will flow through the national level.*

Figure D1. Distribution of the HSS budget by beneficiary of Gavi-support



E. Justification for inclusion of HR costs in the HSS

The HSS does not include any payment of staff salaries or incentives. The HR costs in the HSS are in relation to per diems (DSA) for staff attending workshops, trainings and conducting supervision. These activities are particularly targeting States with low coverage in order to reduce inequities in coverage. The government will review options to fund these activities in the coming years.

Part A: Overview of portfolio of support

All grey boxes to be pre-filled by the Gavi Secretariat
All white boxes to be filled by Country

1. Vaccines: Projected country co-financing and Gavi support requested for current and new Gavi-funded vaccines

1.1. Co-financing for current Gavi-funded vaccines

Programme and type of support		Estimated projections[3]				
		2019	2020	2021	2022	2023
Pentavalent routine	Country co-financing (US$)	$17,305,685.61	$15,407,615.35	$16,956,097.38	$18,373,352.18	$20,043,928.01
	Gavi support (US$)	$ $4,541,076.61	$3,543,116.48	$3,376,633.34	$3,120,299.82	$2,844,514.23
PCV routine	Country co-financing (US$)	$ $39,323,491.94	$37,792,740.71	$44,331,130.79	$51,025,451.15	$58,772,031.24
	Gavi support (US$)	$35,804,766	$27,376,434	$25,326,261	$22,613,269	$19,651,810
IPV	Country co-financing (US$)	$0	$0	$20,681,646.00	$19,409,550	$20,394,378
	Gavi support (US$)	$7,526,516	$8,685,571	$0	$0	$0
a) Total Country co-financing for current vaccines (US$)		**$56,629,177.55**	**$53,200,356.06**	**$61,287,228.17**	**$69,398,803.33**	**$78,815,959.25**
b) Total Gavi support for current vaccines (US$)		**$40,345,842.61**	**$30,919,550.48**	**$28,702,894.34**	**$25,733,568.82**	**$22,496,324.23**
c) Total cost of current vaccines (a+b) (US$)		**$96,975,020.16**	**$84,119,906.54**	**$89,990,122.51**	**$95,132,372.15**	**$101,312,283.48**

1.2. Vaccine presentation and implementation dates: Country to complete all columns for each new vaccine introduction and campaign planned over the duration of the PSR and for which the country seeks support.

Programme and type of support	Preferred presentation[4]	Target submission date of request	Desired date for vaccines to arrive	Planned launch date	Support requested until[5]
Rota	5	Submitted/approved	September 2019	October 2019	2028
Men A	10	Submitted/approve	April 2019	June 2019	2028
HPV	2	October 2019	July 2020	September 2020	2028

[3] These estimates provide visibility to the total funding needs that a country should plan to complement the Gavi financing. These estimates are projections and may differ from actual commitments, which are calculated year-by-year and reflected in Gavi decision letters. The source of these estimates are the latest input received from country, with adjustments performed by the Gavi Secretariat (eg price updates, supply constraints, etc.)

[4] For vaccine presentations, please refer to the detailed product profiles available here: https://www.gavi.org/about/market-shaping/detailed-product-profiles/

[5] For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so. For campaigns the "support requested until" field will normally be the same or one calendar year from the launch date, but can be extended for a phased campaign.

Measles second dose(Southern)	10	October 2018	September 2019	October 2019 (Southern Zones)	2028
Measles Second dose (Northern)	10	October 2018	February 2020	March 2020 (Northern Zones)	2028
Men A Campaign	10	Submitted/approved	August 2019	Sept- Oct 2019	2019
Yellow Fever Prevention Campaign	10	October 2018	August - September 2019	October – December 2019	2021
Measles SIAs	10	October 2018	August 2019	Sept – Dec 2019 (Northern Zones)	2020
Measles SIAs	10	October 2018	November 2019	Jan – March 2020	2020
Fractional IPV Campaign	10	2019	December 2018	Jan -	2019

1.3. New vaccine support to be requested: For types of vaccine support and guidelines, please refer to http://www.gavi.org/support/process/apply/vaccine/)

Programme and type of support	Year	Year 1(2019)	Year 2 (2020)	Year 3 (2021)	Year 4(2022)	Year 5 (2023)
MEASLES SECOND DOSE ROUTINE	Population in the target age cohort (#)	,2,800,007*	6,700,000	7,015,000	7,243,853	7,480,000
	Target population to be vaccinated (first or only dose) (#)	1,400,000#	3,500,000	3,858,250	4,346,312	4,862,000
	Target population for last dose (#)	1,400,000#	3,500,000	3,858,250	4,346,312	4,862,000
	Estimated wastage rates[6]	40%	40%	35%	35%	30%
	Country co-financing (US$)	$	$	$	$	$
	Gavi support (US$)	$	$	$	$	$
MEASLES RUBELLA	Population in the target age cohort (#)	-	-	-	-	7,480,000
	Target population to be vaccinated (first or only dose) (#)	-	-	-	-	4,862,000
	Target population for last dose (#)	-	-	-	-	4,862,000
	Estimated wastage rates[7]	-	-	-	-	30%
	Country co-financing (US$)	$	$	$	$	$
	Gavi support (US$)	$	$	$	$	$
a) Total Country co-financing for new vaccines requested (US$)		$	$	$	$	$
b) Total Gavi support for new vaccines requested (US$)		$	$	$	$	$
c) Total cost of new vaccines requested (a+b) (US$)		**$**	**$**	**$**	**$**	**$**

[6] *For indicative wastage rates for preferred presentations (%), please refer to the detailed product profiles available here: https://www.gavi.org/about/market-shaping/detailed-product-profiles/*

[7] *For indicative wastage rates for preferred presentations (%), please refer to the detailed product profiles available here: https://www.gavi.org/about/market-shaping/detailed-product-profiles/*

***The MCV2 introduction plan targets all children aged 9 months to 23 months to give opportunity to all the children**					

1.4. Total cost and co-financing summary for vaccine support

a) Total Country co-financing for current and new vaccines requested (a+d) (US$)	**$**	**$**	**$**	**$**	**$**
b) Total Gavi support for current and new vaccines requested (b+e) (US$)	**$**	**$**	**$**	**$**	**$**
c) Total cost of current and new vaccines requested (g+h) (US$)	**$**	**$**	**$**	**$**	**$**

1.5 Request for vaccine presentation switches[8] for current support (if applicable)[9]: Please note that this requires further documentation containing cold chain capacity, stock levels of the current product, and a costed activity plan (to be submitted via the Country Portal, here: http://www.gavi.org/support/process/country-portal/ in the Supporting Documents section).

Current presentation	Desired new presentation	Desired switch month and year	Rationale for the switch in presentation including any anticipated impact on coverage and equity	Do you request a product switch grant in the vaccine renewal request on the country portal?
Men A	Men ACWY	January 2021	Men-ACWY has broadest coverage against serogroups within Nigeria and neighboring countries. It has co-formulation of 4 antigens in one dose with minimal wastage and it is the recommended presentation by NITAG	NO

2. Financial support requested

2.1. Country health and immunisation data and national health planning and budgeting cycle Country to complete table below

Country health and immunisation data - All figures in US$	**2017**	**2018**
Total government expenditures (past year)[10]	$43,272,131,147.54	Not applicable
Total government health expenditures (past year)	**Not available**	Not applicable

[8] *Gavi aims to meet country's preferences on vaccine presentation to the extent possible. When there is not enough supply of a desired product to meet country demand, Gavi will consider the rationale for the switch in order to prioritise supply between countries.*

[9] *For a detailed description of the vaccine product profiles, please see here: https://www.gavi.org/about/market-shaping/detailed-product-profiles/*

[10] *https://knoema.com/atlas/Nigeria/topics/Economy/Financial-Sector-General-Government-finance/General-government-total-expenditure; Exchange rate : NGN305 to 1 US dollar*

Immunisation budget (past & current year)	$37,823,337.43	**$42,401,326.52**

2.2. National health planning and budgeting cycle, and national planning cycle for immunisation

National cycles	From	To
Years of National Health Plan(NSHDP II)	2018	2022
Years of immunisation strategy (NSIPSS)	2018	2028
Start and end dates of fiscal period	Jan 1st	Dec 31

2.3. Currently active Gavi financial support (only grants already approved but not yet closed) Entire table prefilled by Gavi Sec (PO)

Type of support	Amount committed	Amount approved	Amount disbursed	Year(s) of support
HSS 1	*$15,80 II0,000*	*$11,343,375*	*$100,000*	2014-2018
IPV VIG	*$10,980*	*$568,989*	*$25,000*	2017-2019
Men A Ops for mass preventive Campaign	*$14,409,590*	*$14,409,590*	*$0*	2019

2.4. New financial support requested: Country to complete table below. For all types of vaccine support and guidelines, please refer to: http://www.gavi.org/support/process/apply/

Target start and end date for financial support:		Month & year Prefilled by Gavi Sec (PO)					
Please note the **country's total HSS ceiling** for the coming 5 years[11]: (US$ ceiling amount)		Indicative estimates					
		Year 1(2019)	Year 2 (2020)	Year 3 (2021)	Year 4 (2022)	Year 5 (2023	Total
Health Systems Strengthening support (HSS)							
Objective 1… (from Section 9)		777,917	1,334,222	1,334,222	1,054,222	774,222	5,274,806
Objective 2 … (from Section 9)		1,345,800	3,205,800	3,205,800	2,275,800	1,345,800	11,379,000
Objective 3… (from Section 9)		1,448,486	4,198,750	4,198,750	2,843,486	1,408,750	14,098,222
Objective 4 … (from Section 9)		4,292,867	5,398,131	5,398,131	3,638,131	1,878,131	20,605,389
Objective 5… (from Section 9)		1,578,204	3,732,589	3,732,589	2,460,000	1,230,000	12,733,382
Objective 6 … (from Section 9)		28,219,824	6,736,491	722,112	150,000	75,000	35,903,426
Total HSS (US$)							
Cold Chain Equipment Optimisation Platform (CCEOP)							
CCEOP Gavi joint investment[12]		11,918,993	7,847,159	7,100,541	5,019,456	3,245,924	35,132,074
CCEOP country joint investment[13]							
• National funds (Country co-financing is part of FGoN input into NSIPSS)							
• Gavi HSS (with this amount clearly budgeted for within the HSS ceiling to avoid double counting)		12,932,107	8,514,168	7,704,087	5,446,110	3,521,827	38,118,300
• Other partners							
Total CCEOP[14] (US$)		24,851,100	16,361,327	14,804,628	10,465,566	6,767,751	73,250,374
New vaccine support (vaccine introduction grants, or operational support for campaigns, or switch grants) (as per type of support requested in table 1.2)							
Measles second dose routine VIG	Live births[15]	2,800,007*	6,700,000	7,015,000	7,243,853	7,480,000	#
	Gavi Support (US$)[16]	$	$	$	$	$	$

[11] *If circumstances warrant, and the source of the CCEOP country joint-investment is Gavi HSS, this amount should be deducted from the HSS ceiling.*

[12] *CCEOP Gavi joint investment = 50% or 80% of the total amount for CCEOP, depending on the Gavi transition phase*

[13] *CCEOP country joint investment = 20% or 50% of the total amount for CCEOP, depending on the Gavi transition phase*

[14] *Total CCEOP = CCEOP country joint investment + CCEOP Gavi joint investment*

[15] *VIGs are calculated based on live births*

[16] *Please refer to what you have calculated in the Budgeting and Planning template and ensure consistency*

Measles follow-up campaign operational support	Population in the target age cohort[17]	24,471,357	18,117,689	#	#	#	#
	Gavi Support (US$)[18]	$	$	$	$	$	$
Yellow Fever PMVC 0perational Support	Population in the target age cohort[19]	21,165,611**	26,994,761	26,272,479			
	Gavi Support (US$)[20]	8,362,527	10,507,520	9,896,043			
Measles Rubella	Population in the target age cohort					7,480,000	
	Gavi Support (US$)					$	
Fractional IPV Campaign	Population in the target age cohort						
	Gavi Support (US$)						
Men ACWY	Population in the target age cohort					4,862,000	
	Gavi Support (US$)					Not determined	
Men A Ops	Population in the target age cohort[21]	34,942,924					
	Gavi Support (US$)	$					
Total Gavi support: VIGs, OPS, switches (estimate)							
Total HSIS support requested (US$)							

2.5. Data verification option for calculating HSS/Performance Based Funding (PBF) payments

Country to indicate one data verification mechanism among the proposed ones (please mark with an "X" in the relevant box. Please note that the selected option will be utilized for the whole duration of the HSS grant.

Use of country admin data	…	**Use of WHO/UNICEF estimates**	…	**Use of surveys**	**X**

[17] *Operational cost is calculated based on population in the target age cohort*

[18] *Please refer to what you have calculated in the Budgeting and Planning template and ensure consistency*

[19] *Operational cost is calculated based on population in the target age cohort*

[21] *Target population is children aged 1-5 years*

[21] *Target population is children aged 1-5 years*

Part B: Country immunisation system analysis & past performance review

Part B replaces the Joint Appraisal for this year and reviews the performance of the immunisation system, including a thorough analysis of immunisation coverage and equity and any constraints to improving sustainable and equitable coverage. It should focus on the evolution/trends observed over the past two to three years and particularly on changes since the last Joint Appraisal took place.

Information in this section will substantially draw from the recommended analysis on coverage and equity and other relevant programme aspects which can be found in the **Joint Appraisal analysis Guidance** (http://www.gavi.org/support/process/apply/report-renew/).

This section also describes the progress in grant implementation and improvements in the immunisation system. By complementing the data as reported via the country portal (e.g. the updated grant performance framework, financial reports, data quality assessment etc.), this section explains over and under achievement of goals and targets, associated implementation challenges and key lessons from the past reporting period.

→ ***This section is the basis for the identification of objectives, to be defined in Section D on future programming***

3. Coverage & equity situation

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In tables 3.1 and 3.2, identify trends in coverage and equity, across geographical areas, economic status, populations and communities, including urban slums, remote rural settings and conflict settings (consider population groups under-served by health systems, such as slum dwellers, nomads, ethnic or religious minorities, refugees, internally displaced populations or other mobile and migrant groups). Relevant information includes: overview of districts/communities which have the lowest coverage rates, the highest number of under-vaccinated children, disease burden: number and incidence of vaccine preventable diseases (VPD) cases as reported in surveillance systems in regions/ districts, etc.

Among data sources available, consider administrative data, coverage surveys, DHS/MICS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles. Please clearly reference the source(s) of the data used in this section.

→ ***This section is key to determine the target geographies and/or population groups for prioritising interventions***

→ ***Provide any relevant trend analysis or additional evidence available.***

→ ***Please also refer to the Guidance on gender related barriers to immunisation*** (https://www.gavi.org/support/process/apply/additional-guidance/#gender)

3.1. At the national level: (Include data source & year for each)

Coverage:
DTP3, MCV1

Please ensure data is in line with what you reported in the GPF

DTP3

Data source	2015	2016	2017
Admin	100%[22]	105%[23]	84.3%[24]
Official estimate	45%	45%	33%

[22] DVD-MT

[23] DVD-MT

[24] DHIS-2

	Survey	49%[25]	33%[26]	No survey
	WUENIC	42%	42%	42%

MCV 1 Coverage

Data source	2015	2016	2017
Admin	100%[27]	104%[28]	85.3[29]
Official estimate	43%	43%	42%
Survey	51%[30]	42%[31]	No survey
WUENIC	42%	42%	42%

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

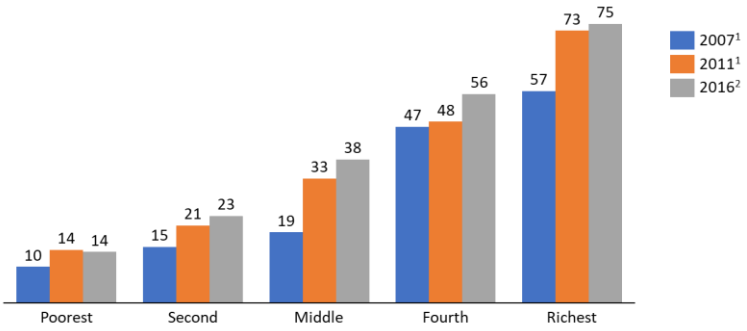
Nigeria has the highest number of unimmunized children in the world, estimated at 4.3 million children in 2018[32]. Due to challenges with accuracy of population numbers (denominators) used in determination of absolute number of unimmunized children, it is difficult to establish a trend for this data element.

Equity:
- Wealth (e.g. high/low quintiles)
- Education (e.g. un/educated)
- Gender
- Urban-rural
- Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of female caretakers with low socioeconomic status, etc.

Trends in DTP3 vaccination coverage by wealth quintiles

Figure 3.1.3 shows that from 2007 to 2016, vaccination coverage for children in the lowest quintile (poorest) has stagnated at 14%, in contrast to steady increase in coverage seen across all other wealth quintiles. The highest growth in vaccination coverage between 2011 and 2016 was seen in those within the fourth wealth quintile with an 8 percentage-points jump.

Figure 3.1.3. Trend in DTP3 vaccination coverage by wealth quintiles



Trends in DTP3 vaccination coverage by mother's education

It can be seen in figure 3.1.4 that in 2016, there was a general decline in immunization coverage irrespective of the mother's level of education. Children whose mothers had at least secondary education had the highest coverage rates, as compared to those whose mothers had no education with the least coverage rates.

Figure 3.1.4 Trend in DTP3 vaccination coverage by wealth mother's level of education

[25] 2015 SMART survey

[26] MICS/NICS 2016

[27] DVD-MT

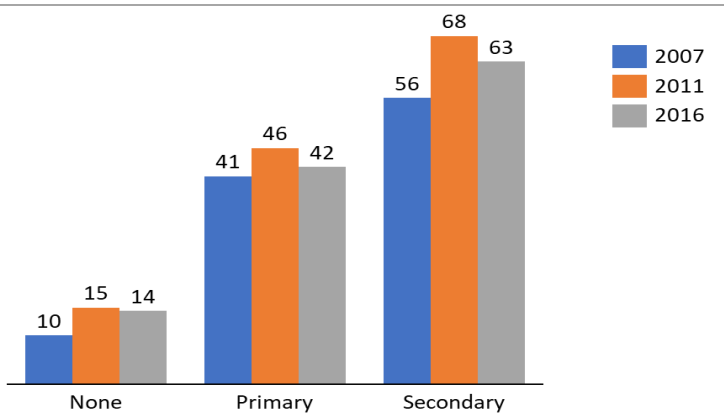
[28] DVD-MT

[29] DHIS-2

[30] 2015 SMART survey

[31] MICS/NICS

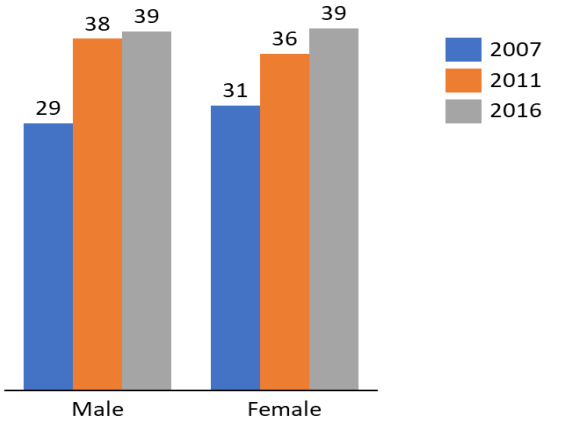
[32] NSIPSS pg. 14



Trends in DTP3 vaccination coverage by gender

Figure 3.1.5 shows that difference in vaccination coverage between male and female children is insignificant and both genders have seen a steady climb in vaccination coverage from 2007 to 2016.

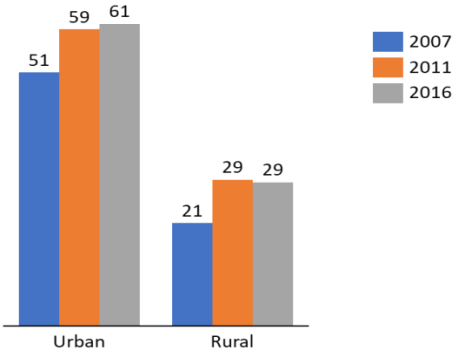
Figure 3.1.5. Trend in DTP3 vaccination coverage by gender



Trends in DTP3 vaccination coverage by urban-rural distribution

Figure 3.1.6 shows a steady improvement in vaccination coverage in urban areas, while coverage has stagnated in the rural areas. Due to the low coverage rate in rural areas, a lot of interventions are targeted at improving coverage rates in these areas.

Figure 3.1.6. Trend in DTP3 vaccination coverage by urban-rural distribution



Trends in DTP3 vaccination coverage by geo-political zones

The 36 states plus Federal Capital Territory (FTC) in Nigeria are divided into six geo-political zones. States within each zone have significant socio-ethnic

and cultural similarities. Figure 3.1.7 shows that the North-East and North-West zones have the lowest coverage rates between 2007 and 2016. Between 2011 and 2016, vaccination coverage in the South-East and South-West zones declined.

Figure 3.1.7. Trend in DTP3 vaccination coverage by geo-political zones

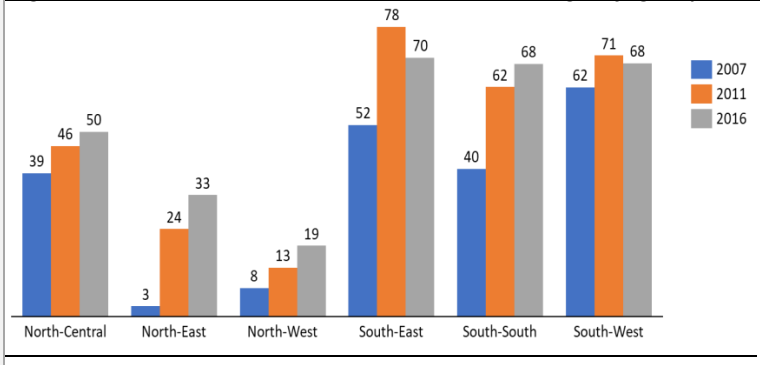
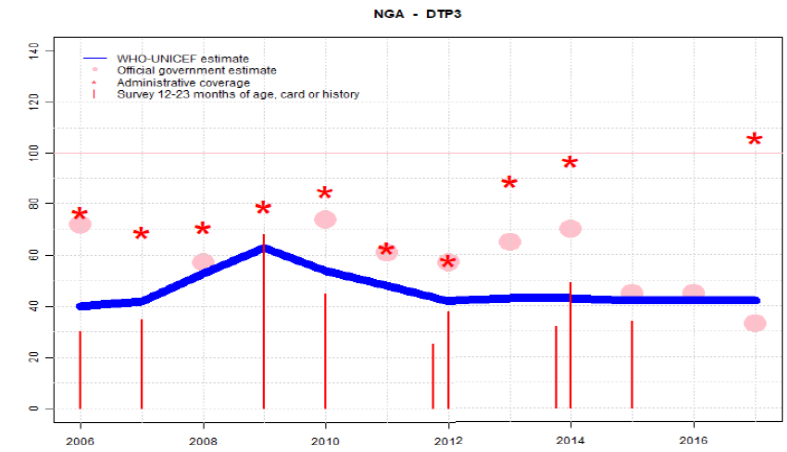


Figure 3.1.7. Trend in DTP3 vaccination coverage based on the WUENIC



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Estimate	40	42	53	63	54	48	42	43	43	42	42	42
Estimate GoC	•	•	•	•	•	•	•	•	•	•	•	•
Official	72	NA	57	NA	74	61	57	65	70	45	45	33
Administrative	77	69	71	79	85	63	58	89	97	NA	NA	106
Survey	30	35	NA	68	45	NA	*	NA	*	34	NA	NA

3.2. At the sub-national level identify the target areas and groups of low coverage and equity: (Include data source & year for each)

→ ***Identified target groups to be used in subsequent sections for tailored interventions***

Coverage by geographies/population group: DTP3	*E.g. 3 of 45 districts have DTP3 coverage less than 80%* *District 1: DTP3 coverage ~45%* *District 2: DTP3 coverage ~70%* *District 3: DTP3 coverage ~70%* Evidence from the 2016 MICS/NICS survey indicates that wide variations exist in RI performance across the country's zones with the South East and South West zones showing high RI performance, while the North East and North West show low-performance. This disparity is driven by several factors which include socio-economic status, culture, and personal beliefs of the care givers

Figure 3.2.1 DTP3 coverage by geopolitical zones (2016 MICS/NICS)

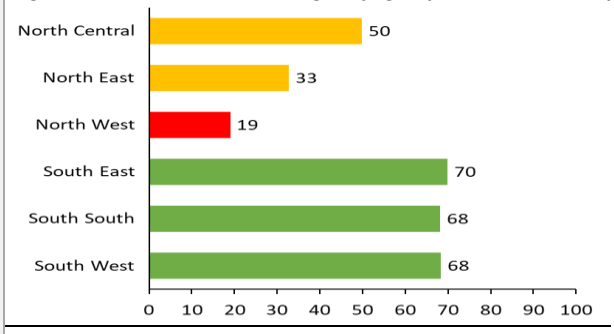
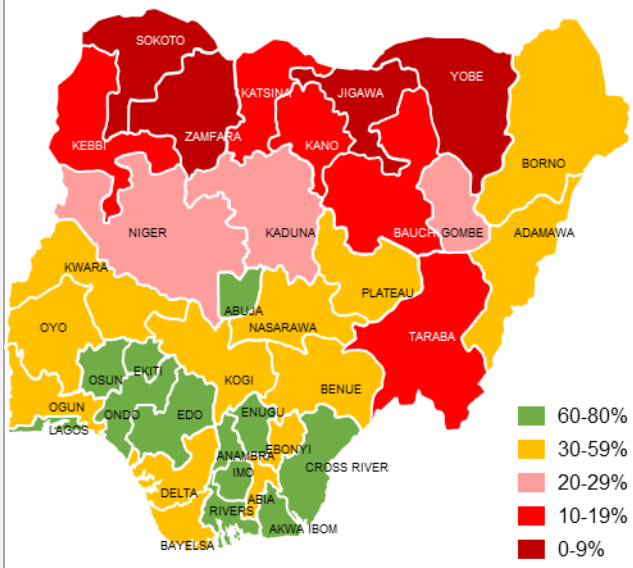


Figure 3.2.2 DTP3 coverage across states in Nigeria (2016 MICS/NICS)

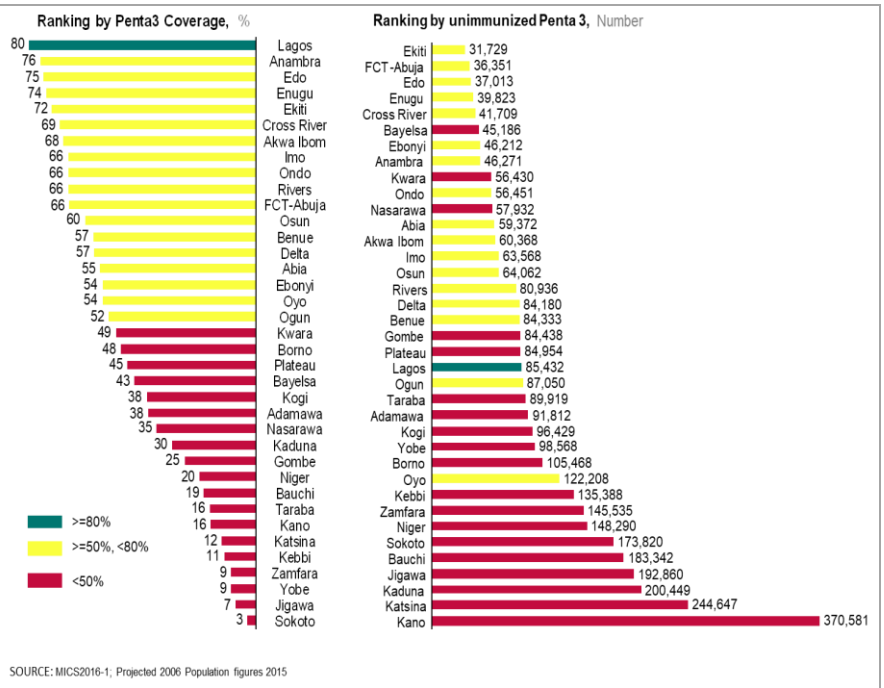


Coverage by geographies/population group:
Absolute numbers of un- or under-immunised children

E.g.
District 1: 5M under-immunised children
District 2: 1.2M under-immunised children
District 3: 2M under-immunised children

As a result of critical challenges with determining denominators (population figures), it is difficult to estimate the exact numbers of children who are unvaccinated by Local Government Areas. The figure 3.2.3 below shows the number of unimmunized in 2015 by states in comparison to the immunization coverage achieved by the states in the 2016 MICS/NICS survey. This shows that even high coverage states like Oyo, Ogun and Lagos, have more unimmunized children than some of the low coverage states, reinforcing the national spread of the low immunisation challenge. Thus, emphasis should be placed more on reaching unimmunized children than achieving target coverage. Analysis of Lagos state data has shown very high numbers of unimmunized children in urban slums in the state. Hence, the country has developed strategies targeted at improving immunization coverage in urban slums in this HSS proposal.

Figure 3.2.3. Comparison of states DTP3 (Penta 3) coverage and the number of under-immunized children in the state



Equity by geographies/population group:

- Wealth (e.g. high/low quintiles)
- Education (e.g. un/educated)
- Gender
- Urban-rural
- Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of female caretakers with low socioeconomic status, etc.

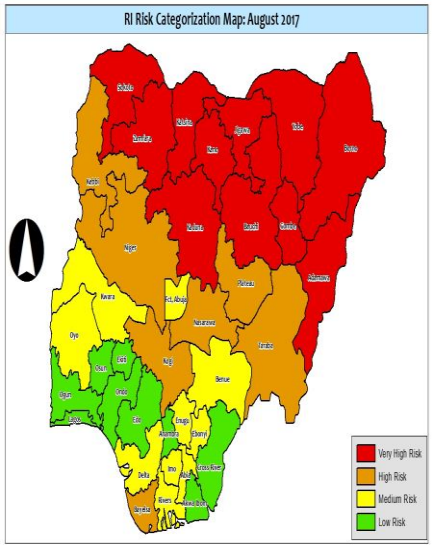
E.g.
Population group 1: Migrant population 5,000 in the region of xxx with low levels of DTP3 coverage (limited data available)
Population group 2: Urban area of xxx with the lowest DTP3 coverage of 60%

Available survey data sources do not provide sub-national level details on distribution of vaccination coverage rates by wealth, education, gender, urban-rural and cultural categorizations. Nevertheless, experience from working with the states has shown that these categorizations at sub-national levels show similar trends as at the national level

Further risk analysis of the burden of unimmunised children coupled with risk of polio, status of health system support for RI in the states, 18 states were considered as high priority for the country. These are presented in the map below

Figure 3.2.4 Categorization of states by NERICC[33]

[33] National Emergency Routine Immunisation Coordination Centre

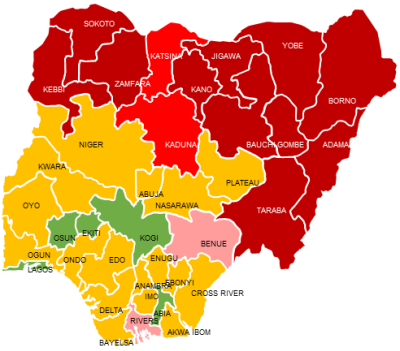


Very High Priority (11)	Sokoto, Jigawa, Kaduna, Kano and Kastina, Borno, Gombe, Bauchi, Adamawa, Yobe and Zamfara
High Priority (7)	Kebbi, Kogi, Taraba Nasarawa, Niger, Bayelsa and Plateau
Medium Priority (10)	Kwara, Benue, Imo, Ebonyi, FCT Oyo, Abia, Delta, Enugu & Rivers
Low Priority (9)	Edo, Akwa Ibom, Cross River, Ogun, Anambra, Osun, Lagos, Ondo and Ekiti

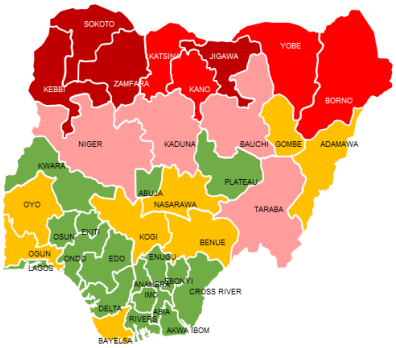
To further elaborate on sections 3.1. and 3.2 above, **countries are strongly encouraged to include heat maps or similar to show immunisation coverage trends over time** , and to reference the source of data, which may be added here. Examples of such analysis are available in the Joint Appraisal Analysis Guidance
(available here: http://www.gavi.org/support/process/apply/report-renew/)

Figure 3.2.5 Heat maps showing immunization coverage for Nigeria from 2007 to 2016.

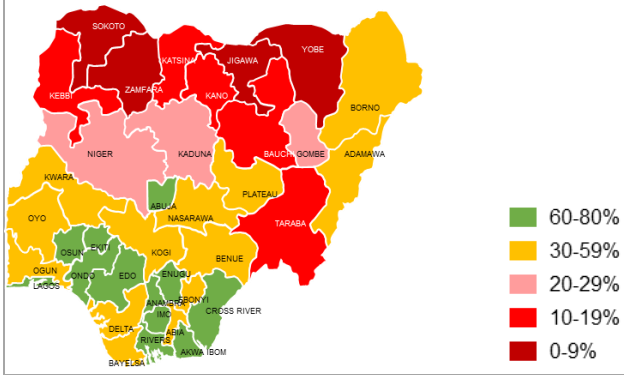
2007 MICS



2011 MICS



2016 MICS/NICS



3.3. Key drivers of sustainable coverage and equity at the national level

Please highlight the key health system and programmatic drivers of the levels of coverage and equity from the section above. To the extent possible, please list the barriers below by order of priorities with regards to coverage and equity bottlenecks, prioritising and ranking the 3-5 biggest issues. If any of these will not be supported by Gavi, indicate why and who will support it. Provide evidence and lessons learned from previous activities.

→ ***This prioritisation is to be reflected in Part D on objectives of requested Gavi support***

Up to 500 words

[Consider the following barriers: Health work force, Supply chain, Service delivery and demand generation, Gender-related barriers faced by caregivers[34], Leadership, management and coordination, Data quality, availability & use, or other critical aspects identified for example based on the cMYP, EPI reviews, EVMs, evaluation reports etc.]

1. Leadership, management and coordination
    - Low levels of commitment to financing operational plans for immunisation and PHC[35]
    - Weak synergy between management of immunization and management of Primary Health Care (PHC) structures
    - Non-implementation of existent accountability frameworks for immunization and PHC[36]
    - Sub-optimal use of data for evidenced-based strategic planning and program performance management
    - Weak mechanism for resource-mapping between Government, Donors, and NGOs
    - Lack of visibility and transparency into financial and technical support provided by partners and donors
    - Poor predictability in resource availability and allocation [37]
    - Weak financial management systems[38]
    - Weak systems for tracking functionality and effectiveness (regularity of meetings, attendance, follow-up on decisions taken and action plans) of coordinating fora (ICC, Core Group, Technical Working Groups/Top Management Teams (TMTs)
2. Service delivery
    - Weak national system for coordinating implementation of national policies and guidelines at sub-national levels
    - Poor access to quality health care due to weak infrastructure
    - High vaccine wastage and supply chain data not triangulated with service delivery data
    - Poor accountability and service quality
3. Demand generation
    - Weak community engagement structures (there is limited service structure linkage at ward level with the Local Government Areas (LGAs) and Health Facilities
    - Inadequate national strategy for demand generation for immunization and PHC

[34] *For additional programmatic guidance refer to https://www.gavi.org/support/process/apply/additional-guidance/#gender Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women often have limited access to health services and are unable to take their children to get vaccinated. Barriers include lack of education, lack of decision-making power, low socio-economic status, women unable to move freely outside their homes, inaccessibility of health facilities, negative interaction with health workers, lack of father's involvement in healthcare etc.*

[35] There is marked decline of health budget from 5.7% in 2015 to 3.9% in 2018 with resultant late releases of approved operational funds at all levels as well as co-financing obligations

[36] NSIPSS pg 27

[37] 2018 Joint Appraisal Report for Nigeria, pg 29

[38] NSIPSS pg 28

- Insufficient C4D experts at the national level

4. Data quality and surveillance
    - Sub-optimal implementation of the Data Quality Improvement Plan (DQIP)
    - Poor reliance on admin (DHIS2) data for decision-making due to significant data quality issues[39]
    - Unreliable target population numbers at all levels[40]
    - Weak infrastructure for real time data capturing and visibility
    - Weak logistics management information system
    - Admin data not used for action due to significant inaccuracies with reported data
5. Human resources for health
    - Inadequate number and capacity of staff
    - Inadequate supervisory and mentoring as well as capacity building mechanisms for staff
    - High turnover of trained staff
    - Absence of succession plans that incorporate capacity building along the hierarchy and ensure a seamless transition of functions when staff resign or are either promoted, redistributed or transferred
6. Supply chain management
    - Inadequate cold chain capacity
    - Weak Cold Chain Equipment (CCE) Maintenance and poor compliance to standards
    - Delay in implementing cold chain expansion plan
    - Inadequate funding for vaccine distribution to the last mile
    - High vaccine wastage
    - Supply chain data not triangulated with service delivery data

3.4. Key drivers of sustainable coverage and equity at the sub-national level

Please highlight the key health system and programmatic drivers of the levels of coverage and equity from the section above. To the extent possible, please list the barriers below by order of priorities with regards to coverage and equity bottlenecks, prioritising and ranking the 3-5 biggest issues. If any of these will not be supported by Gavi, indicate why and who will support this.

→ ***This prioritisation is to be reflected in Part D on objectives of requested Gavi support***

Up to 500 words

[Consider the following barriers: Health work force, Supply chain, Service delivery and demand generation, Gender-related barriers faced by caregivers, Leadership, management and coordination, Data quality, availability & use, or other critical aspects identified for example based on the cMYP, EPI reviews, EVMs, evaluation reports etc.]

1. Leadership, management and coordination
    - Poor political and financial commitment from state governments
    - Limited leadership and management skills for Primary Health Care at State and LGA
    - Weak coordination of platforms for evaluation of primary health care packages for various levels
    - Weak adherence to existing policies and protocols
    - Weak private sector engagement
    - Weak financial management capacities
    - Fragmentation of funding sources for Primary Health Care
    - Delays in release of operational funds for immunization and PHC in some states

[39] While the numerator is affected by poor recording and aggregation by health workers, the denominator has been defective due to lack of recent population census

[40] The last national census was conducted in 2006

2. Service delivery
    - Poor quality of development and implementation of Reach Every Ward (REW) micro plans
    - Weak support for regular conduct of supportive supervision from state to LGA and LGA to health facilities and little or no mentoring and on the job training taking place
    - Non-implementation of strategies to reduce missed opportunities for vaccination[41]
    - Insecurity and insurgency in northern parts of the country
    - High numbers of unimmunised children in urban slums
    - Weak system for follow-up and tracking immunization defaulters
3. Demand creation
    - Weak implementation of community engagement strategies
    - Inadequate linkage/communication between health facilities and communities on immunization services.
    - Lack of mechanism to provide feedback and dissemination of immunization information to the community.
    - Delays in commencement of the Community Health Influencers, Promoters and Services (CHIPS) programme
4. Data quality and surveillance
    - Poor attitude of health workers (weak commitment to accurate data reporting)
    - Challenges with estimation of reliable target population
    - Data falsification and padding
    - Multiplicity of data tools
    - Lack of equipment to support real time reporting and data visibility
5. Human resource for health
    - Weak commitment in recruiting required number of staff
    - Delay in payment of salaries of health workers
    - Inadequate number and limited skills of health workers
    - Poor staff performance management systems
    - Mal-distribution of staff
    - High turnover of existing staff coupled with erratic transfers of skilled staff
    - Heavy reliance on casual staff affecting system strengthen
6. Vaccine security and logistics management
    - Inadequate cold chain storage capacity at the service delivery level. Only about 47% of the 9565 wards in the country have functional CCE, thus limiting access to potent vaccines for immunization service delivery
    - High vaccine wastage rates in states
    - Non-adherence to vaccine accountability protocols
    - Weak support for planned maintenance of cold chain equipment
    - Poor temperature monitoring
    - Weak funding for last mile distribution of vaccines from State to LGA and LGA to Health facility.

[41] NSIPSS pg 32

4. National programme management

4.1. Immunisation financing

- **Availability of national health financing framework and medium-term and annual immunisation operational plans and budgets,** whether they are integrated into the wider national health plan/budget, and their relationship and consistency with microplanning processes
- **Allocation of sufficient resources in national health budgets for the immunisation programme/services,** including for Gavi and non-Gavi vaccines, (integrated) operational and service delivery costs. Discuss the extent to which the national health strategy incorporates these costs and any steps being taken to increase domestic resources for immunisation. If any co-financing defaults occurred in the last three years, describe any mitigation measures that have been implemented to avoid future defaults.
- **Timely disbursement and execution of resources:** the extent to which funds for immunisation-related activities (including vaccines and non-vaccine costs) are made available and executed in a timely fashion at all levels (e.g., national, province, district).
- **Adequate reporting** on immunisation financing and timely availability of reliable financing information to improve decision making.

Not exceeding 250 words

Nigeria's Fiscal Responsibility Act 2007 (amended in 2011) established a 3-year rolling plan, MTSS[42] and the MTEF[43] which projects government revenues, guides expenditures and serves as a basis for annual budgeting. The operationalization of both the MTSS and MTEF have however been very weak, leading to poor predictability in resource availability and allocation[44]. The weak linkage between the strategies and annual budgets as result of poor operationalization, continue to result in gross under-funding of health and immunization. This has led to a reliance on loans e.g. from the World Bank, and grants e.g. Gavi and the Global Polio Eradication Initiative (GPEI) which are off-budget to fund the immunization program and present a major risk for sustaining immunization financing in outer years, especially as transitions of both Gavi and GPEI support to Nigeria are in the works.

Allocation of financial resources has not met desired targets, and health budget as a total of Government allocation has declined since 2012 due to weak economy. In developing the NSIPSS, the Government has demonstrated commitment to ensuring effective mobilisation of internal funds to meets its obligations towards Gavi transition. Key sources include:

- Increasing Government funding for routine immunization and PHC[45]
- Contributions from state to fund cost of operations and vaccines
- BHCPF[46]
- Matching grants from donors (e.g. BMGF)
- Loans (World Bank)

Further, release of funds for immunization and PHC activities are usually delayed and inadequate leading to poor execution of planned activities. Reporting systems for PHC financing are weak and require significant strengthening.

[42] Medium Term Sector Strategy

[43] Medium-Term Expenditure Framework

[44] 2018 Joint Appraisal Report

[45] From 2015, the FGoN has increased funding to routine immunization from NGN5.2 billion to NGN13.3 billion, to cover the costs of vaccines/devices procurement for RI, non-Polio SIA, Polio, Hajj vaccines, as well as vaccines for disease outbreaks. Funding for the NPHCDA also increased from NGN2.1 to NGN23.9 billion over the same period for operational and other Primary Healthcare Center (PHC) related activities.

[46] Basic Health Care Provision Fund (1% of Consolidated Revenue Fund CRF)

4.2. Priority needs

4.2.1 Programme management: leadership and management capacity of the EPI team, functionality of the Coordination Forum (ICC, HSCC or equivalent body) and the national immunisation technical advisory group (NITAG or equivalent):

- **Challenges** related to structure, staffing and capabilities of the national/ regional EPI team (including implementation of annual operational plan for immunisation)
- **Engagement of different stakeholders** (including WHO, UNICEF, CSOs, donors) in the immunisation system
- **Effective functioning of the relevant Coordination Forum: To what extent does it meet Gavi requirements? If it does not, what are the steps needed to address these gaps?**

  (To be eligible for new Gavi vaccine or financial support, countries need to demonstrate a basic functionality of their coordination forum. Requirements are further described at http://www.gavi.org/support/process/apply/additional-guidance/ *under the heading 'Leadership, management and coordination')*
  Where a NITAG does not exist, Gavi recommends that countries include plans to establish one and briefly describe such plans here.

Not exceeding 250 words

Challenges related to structure, staffing and capabilities of the national EPI team

- At the national level, there is inadequate quantity of technical staff to support the EPI
- Weak capacity of staff to independently implement immunization programmes
- Inadequate reward and sanctions system

Engagement of different stakeholders and functionality of the coordination forums
The ICC: chaired by the Minister of Health, is comprised of key stakeholders: multinationals - WHO, Unicef; bilaterals, - USAID, US CDC, DFATD, NORAD, DFID, JICA, EU; donors - BMGF, Gavi; implementing partners – Solina, CHAI, IVAC and CSOs – Rotary International, HERFON. Although the ICC is scheduled to convene every quarter, these are not regular, and when needed, emergency meetings are called to decide on emergency immunisation activities.

The Core Group: chaired by the ED NPHCDA, has as members, heads of immunization programs for ICC member-organizations including technical implementing partners such MCSP/JSI. It meets monthly and reports to the ICC Chair. Enhanced Core Group meetings are however requested on a more frequent basis to support emergency activities that should be presented to the ICC.

NERICC/SERICCs/LERICCS: The NERICC centre has supported states and LGAs to establish SERICCs and LERICCs in 18 poor-performing states to coordinate RI activities at the subnational level and provide intensive program implementation support. Key challenges include the lack of well-trained personnel to support programmatic and managerial efforts, as well as insufficient operational funds available to implement plans at state and LGA levels. These gaps are more acute at the lower levels.

NITAG provides technical advice on policies, plans and strategies for introduction of new vaccines and vaccine delivery technologies for the future. The body is currently functional but needs to be strengthened to increase its functionality and effectiveness.

4.2.2 Vaccine management: Priority areas for improvement to manage risks to vaccine stocks, e.g. based upon recent audits or assessments

Not exceeding 250 words

- Provision of appropriately skilled staff for supply chain management
- Expand and extend cold and dry storage capacity for immunization commodities especially at the National and health facility levels (National is at <50% required capacity, only 47% of wards have CCE)
- Secure sustainable funding for vaccine distribution at sub-national level, in place of current practice that is heavily reliant on Health Workers resources to pull vaccines.
- Optimize temperature monitoring and response systems at all levels of the iSC in line with standard operating procedures
- Establish appropriate maintenance systems, at all iSC levels, and secure sustainable funding and technical expertise for long term implementation

- Institutionalize vaccine accountability and management systems including proper documentation of transactions, periodic physical stock count of bundled vaccines at all iSC levels, annual independent stock verification exercise and the Follow the Vaccine Initiative; ensure state specific availability of this information
- Expand iSC data visibility to the last mile (cold chain equipped health facilities)
- Ensure appropriate and timely disposal of biological wastes and sharps
- Develop a behavioral change communication strategy to address high vaccine wastage, that links with data quality improvement (e.g. cost of vaccines a HF gets each month; cost of high wastage based on vaccinated for age in LQAS/Surveys)

4.2.3 Financial Management: Priority areas to address financial management gaps

Not exceeding 250 words

The current financial management reform effort in NPHCDA is an essential prerequisite for attaining the highest level of probity, transparency and accountability in the management of scarce resources; and this is a necessary condition for restoration of stakeholders' hope and confidence in the ability of the Agency to deliver on its core mandates.

- Implementation of recommendations from KPMG financial management assessment
- Implementation of coaching, training and resistance management plans
- Intense supervision, monitoring and evaluation of staff performance
- Development and application of departmental accountability score cards
- Development and implementation of comprehensive rewards and sanctions protocols based on existing rules and regulations and international best practices

4.3. Polio transition planning (if applicable)

If transitioning out of immunisation programme support from other major sources, such as the Global Polio Eradication Initiative, briefly describe the transition plan. If none exists, describe plans to develop one and other preparatory actions.

Not exceeding 100 words

The GPEI-funded programme represents the single largest source of external technical assistance, personnel and infrastructure, and provides support for other health interventions, including immunisation and surveillance in Nigeria. The ongoing Polio Transition Planning process identified priorities in line with the national health plans and the GPEI's Polio Post-Certification strategy, which comprise strengthening PHC systems, RI and Disease Surveillance/Outbreak Response.

The transition plan includes mainstreaming Polio assets to support RI and mainstreaming Polio Eradication under an Integrated Health System[47]

Finalization and endorsement of the Country's Polio Business Case[48] is planned within coming months to inform the transition process.

[47] NSIPSS pages 67-68

[48] Four Business case scenarios are proposed in a phased manner:

Scenario_1 : Retention of partner salary scheme; transition of physical, human and intangible assets. Cost = $908,414,053

Scenario_2 : Transition of all assets using FMOH salary scale; cost = $730,249,210.

Scenario_3 : FMOH salary scale plus external funding to augment transitioned staff salaries. Cost = $901,232,114.

Scenario_4 : Transition of physical assets, transition of HR based on FMOH salaries, plus augmentation from external funding = $775,148,556.

An additional operationalization cost of $97,664,448 is envisaged.

5. Past performance of Gavi support, implementation challenges and lessons

Briefly comment on the performance of the vaccine support and health systems and immunisation strengthening support (HSS, Ops, VIGs, CCEOP, transition grants) received from Gavi

5.1. Programmatic performance of Gavi grants, in terms of:

- Achievements against agreed targets
- Overall implementation progress, lessons learned and best practices
- Progress and achievements specifically obtained with Gavi's HSS and CCEOP support
- Usage and results achieved with performance based funding (PBF)
- If applicable, implementation progress of transition plan, implementation bottlenecks and corrective actions

Not exceeding 500 words

Achievements against agreed targets[49]

Table below shows that while the administrative coverages for the listed vaccines were above the set targets, the official/survey coverage were far below the set targets, highlighting the significant challenges with the quality of admin data in the country

Table: Nigeria 2017 Coverage against Target

	Penta3	PCV3	IPV	Measles
Country Target (GPF)	90%	94%	94%	95%
Administrative (DHIS2)	84.3%	82%	72.8%	85.3%
Official (JRF)	33%	NA	NA	42%
WUENIC	49%	26%	49%	51%
MICS*	33%			42%

The reasons for this as shown by the MICS/NICS 2016 below:

[49] 2018 Joint Appraisal Report, page 32

S/N	Zone	Lack of awareness	Service delivery	Lack of time	Mistrust or fear
1	North Central	50%	26%	16%	14%
2	North East	39%	28%	17%	27%
3	North West	37%	22%	17%	32%
4	South West	39%	27%	18%	17%
5	South South	49%	24%	19%	12%
6	South East	47%	29%	26%	9%

Progress and achievements specifically obtained with Gavi's HSS and CCEOP support[50]

In 2017, the country did not apply for HSS support from Gavi. However, the balance from the old HSS grant support with UNICEF was used in 2017 to implement priority activities as shown in below

Table: Gavi HSS/ISS with UNICEF – 2017 Utilization in Dollars

Activity	Output	Amount
ISS	Continued the disbursement of ISS to States for service delivery including outreach services, vaccine collection from LGAs to the HFs, community announcements and supportive supervision at LGA and HF levels, (Osun, Edo, Ekiti, Ogun, Nassarawa, Sokoto, Jigawa, Plateau, Niger, Gombe, Cross River, Akwa Ibom and Delta). At total of 5,276 HFs in 298 LGAs benefited for 3 – 6 months depending on the State.	**$446,914.81**
HSS (PHC Training)	Training of health workers on Integrated PHC services delivery - completed the training of health workers on IMCI and EPI which commenced last year, in the 14 States.	**$603,731.76**
Vaccine Security and Logistics	● NAV dashboard training and training on WICR temperature mapping. ● Operational funds to NSCS for cold chain maintenance and transportation of vaccines from national through zonal and state cold stores. ● Stock performance management dashboard	**$398,445.89**
Non-Polio SIAs	● MNTE activities including the campaign in the SW, pre-validation activities in the SW, Post campaign surveys and Review Meetings ● Advocacy, communication and social mobilization activities for measles campaign including IEC materials development, production and distribution.	**$2,269,912.73**
Total		**$3,719,005.19**

[50] 2018 Joint Appraisal Report, pages 36-37

5.2. Financial management performance, in terms of:

- Financial absorption and utilisation rates
- Compliance with financial reporting and progress in addressing audit requirements
- Major issues arising from review engagements (e.g. Gavi cash programme audits, Gavi programme capacity assessments, annual external/internal audits, etc.) and the implementation status of any recommendations
- Financial management systems, including any modifications from previous arrangements

Not exceeding 500 words

Total amount:$ 15,771,115.13

Total Expenditure:$13,119,053.15

Balance as at September,2018: $2652061.98

Percentage utilization: 83.18%

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

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

Part C: Planning for future Gavi support[51]

6. Planning for future support: coordination, transparency and coherence

6.1. Alignment

How does Gavi support align with the country's national health and immunisation strategies including multi-year plans (e.g. cMYP)?

- Explicitly address how Gavi support will complement, both financially and programmatically, the achievement of objectives set out in the most recent strategic multi-year plan (cMYP).
- Given the immunisation strategies proposed in this PSR, explain and show how these will contribute to the national health strategy or if there are gaps, describe what needs to be done to address these.
- Describe the extent to which Gavi's support proposed in this PSR (in areas such as data, supply chain, etc.) will be implemented through national routine systems and processes or explain the steps that are being taken to achieve integration.

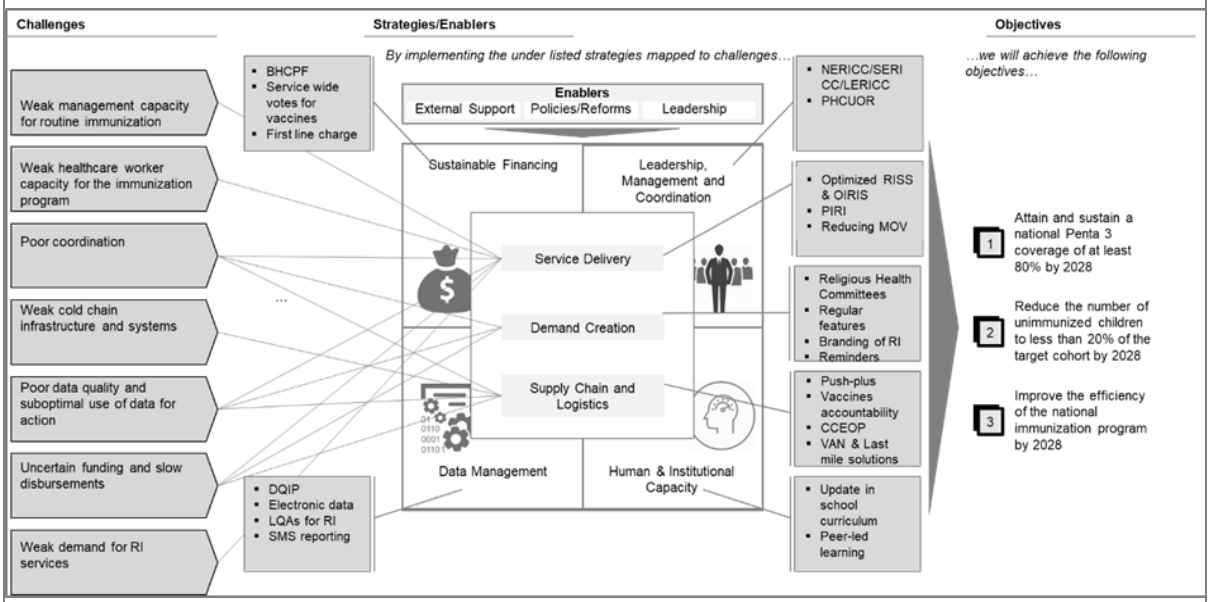
→ ***Include information on the Gavi budgeting & planning template to capture the gap analysis for requested Gavi support***

Not exceeding 250 words

How Gavi Support will complement NSIPSS

The support from GAVI will greatly complement the achievement of the objectives set out in both the NSIPSS and National Strategic Health Development Plan (NSHDP II) both financially and programmatically.

The intensified effort by the country to increase immunisation coverage focus on strategic interventions, within a theory of change that believes in identifying and tackling key causes of low and inequitable coverage, reducing waste, changing health worker behaviour and creating/strengthening enabling leadership, coordination and accountability systems at all levels, as the pathway to overcome existing challenges and lead Nigeria to achieve its immunisation and PHC objectives. This theory of change provided a framework for selecting and prioritising interventions, across the different thematic areas[52].



[51] *The duration of Gavi funding should be discussed in consultation with the Gavi Secretariat to align to the extent possible to a country's strategic period. For Measles Rubella the high-level plan with coherent and integrated measles and rubella disease control activities is expected to cover the next5 years, regardless of the duration of the national strategy.*

[52] *NSIPSS page 25*

The immunisation and system strengthening strategies proposed in the PSR will significantly contribute to the attainment of the goal of the NSHDP II most especially in the area of :

- Enabled Environment for the Attainment of Health Sector Goals
- Increased Utilization of Essential Package of Health Care Services
- Strengthened Health System for the Delivery of Essential Health Care Package (EHCP).

The Gavi support will address some of the areas identified in the prioritized states (7 states –Kebbi, Zamfara, Katsina, Jigawa, Gombe, Taraba and Niger states). The gaps in the remaining states will be addressed by leveraging other ongoing interventions (MoU[53], SOML, GF, GFF, BHCPF, etc) and support from the states and the federal government.

How NSIPSS Strategy aligns with NSHDP II

The NSIPSS which is in alignment with the NSHDP II also to be implemented within the same period. The NSIPSS aligns with the NSHDP II Strategic Objective "**To reduce neonatal and childhood mortality and promote optimal growth, protection and development of all new-borns and children under five years of age**" with emphasis on the need to "**strengthen routine child immunization including new antigens**" as a key intervention.

How Gavi support will be integrated through Routine Immunisation

The Gavi support is already aligned with the NSIPSS 2018-2028, through the Optimized, Integrated, Routine Immunisation Session (OIRIS) strategy which primarily focused on integration of routine immunisation and other PHC services. This strategy has already demonstrated effectiveness in improving coverage and it is equitably implemented with emphasis on areas with low coverage.

6.2. Complementarity, coherence and technical soundness

What steps were taken to ensure complementarity, coherence and technical soundness of Gavi's support across government and stakeholders?

- What role was played by the national coordination forum (ICC, HSCC or equivalent) and the national immunisation technical advisory group (NITAG) in the development of the PSR?

Not exceeding 250 words

Several meetings took place at the technical and policy levels during the development of this document. There were two main Lockdown meetings involving Core Group members and TMT members. The first meeting took place in Bolton White Hotel and involved FMOH, NPHCDA, all the technical working groups, Development partners (WHO, UNICEF, USAID, U.S. CDC, WB, BMGF etc) and other partners IVAC, MCSP/JSI, CHAI, Solina, AFENET etc. During the meeting, clarification was obtained on the status of the 2013 HSS support and this led to a conference call to Gavi team to clarify on the status of the 2013 HSS support.

The second lockdown meeting was a 4-day meeting in Barcelona hotel where the government's ministries, department representatives, NITAG Secretariat, Gavi team and our partners working in HSS and immunisation were in attendance to prioritize the interventions that need to be considered in the Gavi support. Recommendations and key justifications from the NITAG and ICC were added where applicable.

The PSR document was presented to the core group members and working group representatives on the 8th November 2018 for review. Following the core groups review, the document was updated to reflect comments from the core group prior to the ICC meeting. The document was presented at the ICC meeting on the 9th November 2018 during its emergency session for further review and inputs.

There were special sessions with the HSS teams from FMOH, WHO, CDC, CHAI and other development partners to further align on the ongoing Global Fund HSS for harmonization of activities and complementarities. Three key meetings took place,

i. The first meeting was at the NPHCDA headquarters with full participation of the Gavi country manager and partners on the alignment of resources to ensure complementarity. A key

[53] The MOU funding system has been implemented in six northern states in Nigeria (Kano, Kaduna, Bauchi, Sokoto, Yobe and Borno)

outcome from the meeting was the need to further meet with the FMOH HSS team and NACA Global Fund team for further alignment and complementarities.

ii. The 2nd planned joint consultation meeting took place on the 27th November 2018 at the Federal Ministry of Health Headquarters with RSSH, HSS and NACA/Global Fund technical teams at the Department of Health Planning Research and Statistics, room 1112, 11th floor FMOH. The teams discussed extensively on the 2 proposals and identified potentials areas around HMIS, HRH, Supply chain and surveillance that needed further alignment

The 3rd meeting took place on the 29th November 2018 at the NPHCDA conference room. During this meeting, the 2 proposals were discussed in detail by reviewing each activity and teams took decisions on the areas that need to be aligned. The Global fund thematic areas of PSM, HMIS and Laboratory were discussed side by side the prioritized activities in the Gavi HSS, at the end of the meeting the alignment across the surveillance, HMIS, HRH and supply chain on the PSR was achieved to avoid duplication and ensure complementarity. The entire surveillance component based on the consensus at the meeting was moved to laboratory component of the Global fund proposal. The team agreed to harmonise the HRH assessment and come up with a common framework for the country that will ensure the objectives of the FMOH and NPHCDA for PHC human resource for health are achieved.

Part D: Objectives of requested Gavi support

Section D details the new vaccine support and health system strengthening support requested for the upcoming 3-5 years, including strategic considerations and prioritized activities. Operational details are presented in the Gavi budgeting and planning template and performance measurement is presented in an updated **grant performance framework**.

If you plan to request new vaccine support (routine introductions and/or campaigns**) in the upcoming 3-5 years,** please fill in section 7 below.

I**f you plan vaccine routine introductions and/or campaigns in the next 18 months,** in addition, please fill in the relevant vaccine specific request, on the Country Portal, here: http://www.gavi.org/support/process/country-portal/

7. Strategic considerations supporting the requests for new vaccines (routine or campaigns)

This section presents information on future vaccine routine introductions and/or campaigns under consideration for Gavi support (including support for which the country may not be eligible yet). This does not represent a commitment from the country to introduce the vaccines listed below. High level information critical to advance planning and preparation should be outlined here.

Approximately 15-18 months ahead of the actual introduction in the routine programme or the campaign, the country will be required to fill in the relevant vaccine specific request, on the Country Portal to obtain Gavi approval. This vaccine-specific request to be submitted will include: evidence to confirm eligibility, operational plan, budget, and essential information to support grant implementation (e.g. procurement and co-financing terms, target population data).

7.1. Rationale

Describe the rationale for requesting each of the new vaccine supports, including the burden of disease. If already included in detail in the Introduction Plan or Plan of Action, please cite the sections only.

Not exceeding 500 words

The Country on the 2nd of November submitted joint application on 1. Measles Follow Up Campaign 2. Measles 2nd Dose and 3. Yellow Fever Preventive Mass Vaccination Campaign. For details refer to the Gavi Portal. Below is a rationale for the application.

MCV2 introduction rationale include among others;

- Provide an additional contact for measles vaccination
- Provide opportunity for children missed by RI & SIAs

  Integration with other child survival interventions as second year of life activities are addressed
- Huge cost savings from limiting the number of SIAs

Measles SIAs rationale include among others;

- The 2017/2018 MVC improved on previous follow up campaign and has resulted in a drop in measles cases around the country from 10,224 suspected cases including lab confirmed cases as at week 37 (September) in 2017 compared 407 suspected cases including lab confirmed as at week 37(September) of 2018.
- The campaign will improve the coverage in the Northern zones in preparation for MCV2 introduction and consolidate the herd immunity among the children.

The Yellow Fever SIAs rationale include among others;

- Persistently low population immunity levels from MICS/NICS - 27.2%, 60.1% and 39% for 2006, 2011 and 2016 respectively
- Resultant accumulation of susceptible populations – known trigger for outbreaks
- Multiple outbreaks since September, 2017 even amongst previously non high-risk states

- 47 confirmed cases from 22 LGAs in 11 states (Kwara, Kogi, Kano, Zamfara, Kebbi, Nasarawa, Niger, Katsina Edo, Ekiti and Rivers states) since September 2017

7.2. Financial Sustainability

Discuss the financing-related implications of the new vaccine support requested, particularly how the government intends to fund the additional co-financing obligations.

Not exceeding 250 words

The JAR 2018 report explained this in the introduction thus "Nigeria has a national plan that is backed by law (i.e. Fiscal Responsibility Act 2007), which makes provision for 3 year rolling plan, which is updated every year to capture all significant government programmes including: health, immunization and PHC[54]. The country has consistently met her co-financing obligation, even though the government revenue dipped in the last five years. The government has been able to bridge the funding gap arising from the shortfall in revenue with the world bank additional financing and other credit sources". Detailed explanation on this can be obtained in the JAR 2018 and NSIPSS under challenges and the mitigating strategies.

7.3. Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

Not exceeding 250 words

Although some progress has been made in reaching more children with life-saving vaccines, demand generation continue to remain a challenge to achieving sustainable immunization coverage and equity due to barriers and issues in the PHC systems. Large cohorts of children remain unimmunized and partially immunized, especially in the low performing states. Identified reasons by caregivers include:

1. **Lack of knowledge on routine immunization** (42%), including benefits, schedule, place and time of immunization (MICS/NICS 2017).
2. **Mistrust and fears about immunization** (22%) (MICS/NICS 2017). further compounded by anti-vaccination rumours and misconceptions also provided a fertile ground for refusal/hesitancy leading to low RI uptake.
3. **Poor attitude of health workers** has also been identified as another barrier to parents and caregivers bringing their children and wards to access immunization and other PHC services
4. **Inadequate skilled human resources in communication interventions** for improved access to and utilization of PHC services including immunization.
5. **Funding for the implementation of advocacy and communication interventions and community engagement** to increase awareness for RI continues to pose a challenge as most social mobilization and demand generation activities are prioritized only during immunization campaigns and new vaccine introductions, with minimal possibility of continuity for RI and other PHC services.
6. **Low prioritization of immunization at all levels of government and traditional institutions** has also resulted in poor involvement and participation of the community leaders and CBOs/NGOs in planning, demand creation, and implementation of routine immunization activities; and sub-optimal community enlightenment, health education and promotion of PHC services.
7. Poor quality of data at all levels

[54] 2018 Joint Appraisal Report, page 3

To address the issues the following advocacy, communication and community engagement strategies would be implemented:

1. Production of infographics, Information, Education and Communication (IEC) materials in pidgin and 3 major local languages to promote and disseminate targeted RI messages to increase awareness of caregivers on the benefits of immunization and importance of of the completion of immunization.
2. Broadcast of radio jingles on RI in all states enabled us to connect to a wider audience, as appropriate, in relation to KAP study findings
3. Conduct of traditional and new multi-media activities for increased awareness and access to RI and PHC information on NPHCDA social media platforms, in line with KAP findings
4. Intensified media engagements and advocacy visits to relevant stakeholders by NPHCDA and partners to garner support for RI as well as to promote and dispel misinformation.
5. Leveraging SIAs to provide RI messaging to caregivers through interpersonal contacts with community influencers and mobilizers who embark on house to house mobilization leveraging on the trust vested on them by caregivers to increase acceptance for RI and other PHC services.
6. Engagement of caregivers via social media and reminders (electronic & voice)
7. Revision and re-invigoration of the community Engagement strategy by NERICC to promote increased community participation in RI and PHC through the involvement of traditional institutions and trusted Community Resource Groups (CRGs) in the communities.

Gender-related barriers faced by caregivers are cultural norms and behaviours which include resistant husbands who do not grant permission for wives to take their children for immunization and other PHC services because of cultural dependency of women on husbands for decisions, including accessing health services for themselves and their children. This is most prevalent in the northern part of the country that constitutes the states with low RI coverage.

Another cultural barrier is that, women are not allowed to leave their homes until 40 days after child delivery. These have affected access to immunization services, leading to a high number of unimmunized children and affected new-born follow-up. Planned and ongoing efforts include engagement of heads of households at compound meetings and engagement of female health workers, men discussion groups (Majalisa).

7.4. Improving coverage and equity of routine immunisation

Explain how the proposed vaccine support will be used to improve the coverage and equity of routine immunisation, by detailing how the proposed activities and budget will contribute to overcoming key barriers.

Not exceeding 250 words

The proposed activities in the budget are among the key prioritized activities and are selected based on based on the evidence of improvements in states where they are deployed, as clearly reported by the RI-LQAS[55]. NSIPSS strategy was used as guide and leveraging on the ongoing innovations introduced by the National Emergency Routine Immunisation Coordination Centre (NERICC) which are demonstrating positive impact, the RI team will leverage on this opportunity to synergized and synchronized it effort toward improving RI, this opportunity will help to update cold chain inventories and upgrade the equipment and capacity, micro-planning, trainings, waste management, AEFI and enhancing the surveillance system as well as revision of policy documents, operational guideline and accountability framework. This will help in overcoming the key barriers.

[55] Routine Immunization Lot Quality Assurance Sampling

7.5. Synergies

Describe potential synergies across planned introductions or campaigns. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines in a year. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions.

Not exceeding 100 words

From 2019 to 2028, new vaccines such as Measles second dose, Men A introduction to routine, Measles SIA, Yellow fever SIA, will take place across the country at different times. Some will happen same quarter and activities will be synergised such as – updating cold chain inventories and upgrading the equipment and capacity, micro-planning, trainings, waste management, AEFI and enhancing the surveillance system as well as revision of policy documents, operational guideline and accountability framework. Staggering and phasing the implementation and strong accountability framework will be used to mitigate risks associated with multiple introductions.

8. Description of requested support for each new vaccine

More specific planning needs particular to certain vaccine support listed in table 1.2 are described here. Greater details on activities needed to prepare for the vaccine introduction and/or campaign (addressing the programmatic challenges and bottlenecks outlined above) should be reflected in the country's annual EPI work plan.

Exclude here vaccines that already approved by Gavi, even if not yet introduced.

Delete boxes below that are not relevant

HPV routine

Anticipated introduction date: September 2020

Describe the **broad strategy for introduction** (including target population, potential multi-age cohort vaccination in year 1, potential regional roll-out etc.).

The Country intention as documented in the NSIPSS is to introduce the vaccine into the RI programme in 2020.
The first year of introduction will be a catch-up year for children between 9-14 years and subsequent years will target a quarter of this cohort. The country planned to do a phased introduction to other regions starting in the third quarter 2020 as described in the NSIPSS document.

Year	2020	2021	2022	2023
Target Population	11,424,576	1,822,534	1,571,449	1,752,737

Describe the **steps to finalise the introduction** strategy and to engage key stakeholders

In 2019 the Country will develop application and detailed introduction plan and submit through the Gavi portal. During the development of the HPV application all the relevant stakeholders will be engaged.

Describe how the **future HSS investments** will strengthen the quality of the HPV introduction (e.g., through focus on critical demand generation, civil society engagement, adolescent health platforms for integrated service delivery, etc.)

HSS aim at strengthening the system and it cut across demand and other integrated services of which adolescent health is relevant in this context. Although the HPV introduction is an expanded cohort, the HPV introduction will leverage on the HSS investments particularly around demand generation, coordination, service delivery and data management to ensure a successful HPV introduction.

Technical Assistance: List the anticipated TA needs and timelines required to support this activity and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

TA will be needed to support the country in the introduction of the vaccine.

1. TA will be needed during the development of the application and the introduction plan – 3 Months
2. TA will be needed to support the coordination of all pre-implementation activities – 6 months
3. TA to support the introduction – 6 months

9. Programmatic description of priority HSS investments from Gavi

9.1. Objectives and priority activities for Gavi financial support

Given the target geographic and population groups identified and key national and sub-national bottlenecks determined in **Section B**, this section asks you to strategically consider these findings, and develop the **3-5 key objectives and specific activities within these to be supported by Gavi and the rationale for choosing these**. The link between data and evidence and proposed interventions must be clear. **The activities listed here are to be costed in Gavi's budgeting and planning template.**

The activities proposed must contribute to sustainable improvements in coverage and equity. For **Programming Guidance** for targeting interventions in each of Gavi's strategic focus areas (i) leadership, management and coordination, (ii) supply chain, (iii) data (iv) demand promotion, and (v) immunisation financing, please see the Gavi website here: http://www.gavi.org/support/process/apply/hss/

To apply for CCEOP support, include CCEOP as one of the activities under a supply chain objective. For countries in the accelerated transition stage, dedicate one objective to those activities specific to appropriate transition planning.

All objectives and interventions described in Section 9 require implementation at the national level and at the state level. The present PSR (and related planning and budgeting) provides details for the activities at the national level. Operationalization at the State level requires further analysis and planning to be conducted in the States, tailored to the different contexts: detailed operational plans and budget for each of the prioritized States will be provided in a subsequent phase of this application.

Objective 1: Leadership, Management and Coordination	To build the leadership and governance capacity and institutionalize accountability for policy makers at federal, states and local levels for evidence based policies and strategic planning
Timeframe:	2019 - 2023
Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective: → ***List to match those identified in Section B***	The strategic priorities and interventions will strengthen the Health system across the National level and the eight(8), (*Taraba, Zamfara, Kebbi, Jigawa, Gombe, Katsina, Niger and Bayelsa*) HSS states that have been classified as low performing by the recent NICS/MICS survey and the most current scorecard on PHCUOR
Describe the tailored interventions to address this constraint and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.	

• Full implementation of the PHCUOR policy
  ○ Ensure transfer of personnel from Ministry of Local Government to PHC Board
  ○ Design and provide staff with appropriate terms of reference for effective performance
  ○ Conduct capacity building and mentoring for all cadre of staff
  ○ Design and implement coordination framework to avoid duplicity of effort, ensure integration of PHC programmes at the sub-national levels with one plan, one management, one monitoring and evaluation framework for improved outcomes.
• To establish mechanisms to improve and sustain funding and accountability for immunization and PHC at National and sub-national levels)	

- Development of quality PHC financial work plans at the National and sub-national levels
- Plan and design financial frameworks for the implementation of immunization activities at the Sub-national level
- Ensuring financial control for checks and balances(Budget tracking and release)
- Monitoring financial compliance (strengthening internal audit, financial retirement processes and deployment of standardized tools)
- To ensure periodic financial reporting at all levels

- Improving organizational capacity to manage Routine immunization (NERICC,SERICC, LERICC) & PHC programmes at National and sub-national level
  - To enhance the capacity of programme managers and implementers at all levels that can ensure good coordination, planning and implementation of immunization activities for improved performance at all levels.

- Deployment of mechanisms for rapid evidence-based learning and building on good practices through a continuous learning process[56], with two complementary aspects:
  - Embedded operational research in routine management activities at all levels
  - Consolidation of a learning agenda for the country: this is critical task for the NPHCDA at national level, in a context where several interventions prioritized need further and continuous collection of evidence and lessons learned.

  This justifies the need for sustained supportive supervision from the national level: not only as a monitoring (and control) measure, but as a key learning activity, to learn from the specific contexts of the States, consolidate knowledge and continuously improve the strategies, especially on service delivery and demand to improve equity and coverage.

- Strengthening the functionality of advisory bodies (NITAG) in affordable, sustainable ways

To ensure regular quality meetings to provide advisory and regulatory decisions to guide implementation of immunization programmes

List approximately five (5) specific activities to be undertaken to achieve this objective:
→ ***Reflect these activities in the budget & planning template***

- Support SPHCDA to develop and implement a transition plan for full implementation of PHCUOR using the scorecard 4 as a baseline at the National level
- Support the development of a state specific PHC and immunization financing plans (forecasting, costing and development of virtual basket)
- Procurement of 2 computers per state , automation and deployment of SOPs for financial management systems at the sub-national level and deployment
- Implementation of mechanisms for rapid evidence-based learning
  - Facilitation of collaborative associations with Universities, research institutes and other institutes of higher education to document good practices and lessons learned from the implementation of strategies and interventions outlined in the NSIPSS
  - Identification of healthcare workers and PHCs as entities with best practices and creation of a platform for sharing with peers [57]
  - The institution of state-level programme review processes and appraisals (EPI review, annual joint appraisals with key stakeholders, amongst others) with oversight from the national level
  - Roll-out of data-driven performance management system at National, state and LGA levels[58]

[56] NSIPSS page 18, section 5.2.4

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

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

Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation. → ***Reflect these in the Grant Performance Framework***
Technical Assistance: List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)
-TA to conduct training on automated financial management system and coordinate the development of a state specific PHC and immunization financing plans - TA needed to support NPHCDA and SPHCDAs in development and roll-out of organizational strengthening strategies towards the actualization of PHCUOR
Financing: Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage. → ***Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs*** *(please refer to the Guidance on supporting countries' HR capacity, available here:* http://www.gavi.org/support/process/apply/additional-guidance/).
…

How much HSS budget is allocated to this objective: → ***Reflect the details in the budget and planning template***	**Years 1-2**	US$ 2,112,139
	Years 3-5	US$ 3,162,667

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key cost drivers	Inputs	Assumptions
Leadership, Management and coordinator	Improving accountability for immunization and PHC at National and sub-national levels) • Meeting of state officers in 8 states • Transport and Per Diem • One off purchase of computer • Hiring of consultant Improving organizational capacity to manage Routine immunization (NERICC, SERICC, and LERICC). & PHC programmes at National and sub-national level • Training fees • Per diem • Monthly Meeting with state level officers at subnational levels • Bi annual meetings • Transport • Per Diem	All invited officers from the eight states attend the meeting Conduct of monthly meetings at the sub-national level, conduct of bi annual review.

Objective 2: Service Delivery	To improve coverage and equity for immunization and PHC service delivery
Timeframe:	2019 - 2023

Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective: → ***List to match those identified in Section B***	→ Improved microplanning at health facilities with community participation → Intensify conduct of immunization session. States with poor coverage and poor RI performance selected for Gavi support include Taraba, Gombe, Katsina, Kebbi, Bayelsa, Zamfara, Niger and Jigawa → Implement tailored interventions to reduce high number of unimmunized children and missed opportunities for vaccination. States targeted for tailored interventions to reduced high number of unimmunized children in urban slums include: Lagos, Rivers, Benue, Oyo, Kogi, Ogun, Plateau, Delta and Adamawa

Describe the tailored interventions to address this constraint and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.

1. The identified interventions will provide opportunities for increased access and equity to integrated PHC services with support from national to the subnational levels. This will also strengthen the system to intensify RI periodically and reduce missed opportunities. Optimization of the Reach Every Ward (REW) strategy across 8 states to provide increased access and equity to integrated PHC services using Optimized Integrated Routine Immunization Session (OIRIS) approach. Key pillars of OIRIS include REW microplanning, optimize conduct of fixed, outreach and mobile session, integration of services, community engagement, supportive supervision, accountability[59]
2. Implement Missed Opportunities for Vaccination (MOV) in urban PHC facilities, secondary and tertiary health facilities (using lessons learned from existing efforts, such as Kano), increase routine screening for immunization and strengthen linkages between service delivery points. This intervention and tailored design will be implemented in selected health facilities in 8 states with the highest number of unimmunized children[60] including assessments to identify context specific barriers
3. RI Intensification/Periodic Intensification of RI/LIDs in locations with prolonged disruptions in RI services. Following performance reviews, this intervention will be implemented in selected states with poor performance to address backlog of unimmunized children from prolonged strike actions, and in crisis situation such as in IDP camps[61]

List approximately five (5) specific activities to be undertaken to achieve this objective:
→ ***Reflect these activities in the budget & planning template***

1. Development of GIS-based REW microplan in 8 low performing states
    - 1.1: Conduct sensitization meetings with the LGA focal persons
    - 1.2: Conduct sensitization with the health facilities
    - 1.3: Engage with communities on REW microplan development
    - 1.4: Monitor and evaluate REW microplan development
    - 1.5: Conduct validation of REW microplan
2. Conduct outreaches and mobile sessions in the urban slums specifically in the 9 states with high number of unimmunized children
    - 2.1: Develop immunization session plans including, outreaches and mobile session for urban slums in line with REW microplan
    - 2.2 Conduct immunization sessions according to plan
    - 2.3 Monitor the conduct of immunization session via supportive supervision
    - 2.4 Institute extended hours and weekend vaccinations in high volume facilities

[59] NSIPSS, pg 30

[60] NSIPSS, pg 32

[61] NSIPSS, pg 32

3. Implement strategies to reduce missed opportunities for vaccination in states with high number of unimmunized children
    - 3.1: Conduct sensitization on missed opportunity for vaccination
    - 3.2: Develop and implement plan to minimize MOV
4. Conduct of RI supportive supervision/ on-the-job mentoring by the LGA and State officials to the health facilities
    - 4.1 Orientation of state and LGA supervisors on supportive supervision
    - 4.2 Develop supportive supervision plans
    - 4.3 Conduct of supportive supervision according to plan
    - 4.4 Print supportive supervision checklists (and flowcharts)
    - 4.5 Develop mentoring agreements and conduct needs based mentoring
    -
5. Support periodic intensification of immunization through the conduct of PIRI, LIDs in states with low RI performance following performance reviews
    - 5.1 Conduct PIRI in areas with low RI performance following assessment in coordination with polio IPDs

Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation.

→ ***Reflect these in the Grant Performance Framework***

Technical Assistance: List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation.

→ *Reflect these in the Grant Performance Framework*

Indicator	Definition	Data Source	Reporting frequency	Baseline (2018)	Target Year (2019)	Target Year (2020)	Target Year (2021)	Target Year (2021)	Target Year (2021)
1. Proportion of states with optimized REW microplan	Number of states with optimized REW microplan/Total number of states	DHIS, REW microplan	Quarterly	Numerator = Denominator = 37 Percentage =	50%	60%	70%	80%	90%
2. Proportion of LGAs with optimized REW microplan	Number of LGAs with optimized REW microplan/Total number of states	DHIS, REW microplan	Quarterly	Numerator = Denominator = Percentage =	50%	60%	70%	80%	90%
3. Proportion of planned outreach sessions	*. Number of conducted outreach session/Number of planned*	DHIS	Quarterly	*Numerator = 0 Denominator= Percentag*	60%	70%	80%	*90%*	*100%*

conducted in selected states.	*outreaches session*			*e=0%*					
4. No. of districts conducting PIRI	*No. of targeted districts conducting PIRI/Total number of targeted districts for PIRI*	Reports	Annually	*Numerator = Denominator= Percentage=*	100%	100%	100%	*100%*	*100%*
5. % of states that achieved projected coverage for Penta 3	Number of states that achieved projected coverage for penta 3/ total number of states (based on individual state projection from NSIPSS)	DHIS Survey data	Annually	*Numerator = Denominator= Percentage =*					
6. Reduction in the proportion of unimmunized children	Target population – Number of children immunized	DHIS	Annually	*Numerator = Denominator= Percentage =*					
7. % of HFs that received at least 2 Supportive Supervision per quarter	Number of HFs that received supportive supervision / Total number of health facilities planned for supportive supervision	DHIS	Quarterly	*Numerator = 0 Denominator= Percentage =*	50%	60%	70%	*80%*	*90%*

Financing: Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage.

→ ***Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs*** *(please refer to the please refer to the Guidance on supporting countries' HR capacity, available here:* http://www.gavi.org/support/process/apply/additional-guidance/).

- Technical assistance needed for implementing service delivery strategies eg REW microplanning and OIRIS, capacity building and use of GIS for microplanning

• Technical assistance needed for designing, implementing and monitoring tailored interventions to address high number of unimmunized children as well as reduce missed opportunities eg urban slum vaccination strategies, MOV strategies etc		
How much HSS budget is allocated to this objective: → ***Reflect the details in the budget and planning template***	**Years 1-2**	US$ 4,551,600
	Years 3-5	US$ 6,827,400

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key cost drivers	Inputs	Assumptions
Service delivery	**Optimization of REW microplan.** ● Meetings with communities in 8 low performing states ● Transportation for the conduct of outreaches and mobile sessions ● Transportation for supportive supervision (lower level) ● Mentors identified and trained for follow up on need-based mentoring and coaching	REW microplanning will be conducted in all health facilities in the 8 low performing states .
	Missed opportunity for vaccination strategies ● Workshops/Sensitization on Missed opportunity vaccination in secondary, tertiary and urban PHCs in the 9 states with high unimmunized children	This intervention will be implemented in urban PHC facilities, secondary and tertiary health facilities, increase routine screening for immunization and strengthen linkages between service delivery points. This intervention will be implemented in selected health facilities in 9 states with the highest number of unimmunized children
	Intensification of supportive supervision across all levels	Supportive supervision will be conducted not only as a monitoring and control measure, but as a key learning activity for the national/State and LGA supervisors to mentor healthcare workers on the job and provide course correction.
	Periodic Intensification of Routine Immunization ● Transportation for the conduct of outreaches	This intervention will be implemented in selected states with poor performance to address backlog of unimmunized children from prolonged strike actions, and in crisis situation such as in IDP camps

Objective 3: Demand generation	To improve demand creation and institutionalize revised community engagement strategy for immunization and PHC
Timeframe:	2019 - 2023

Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective: → ***List to match those identified in Section B***	The strategic Interventions have been tailored to address demand side issues affecting uptake of routine immunization such as lack of awareness, mistrust or fear, and lack of time. This is evidenced by low Penta 3 coverage and high number of unimmunized children as shown below[62]: • Lagos with 80% coverage and 85, 432 unimmunized • Oyo with 54% coverage and 122,208 unimmunized • Bayelsa, Kebbi, Jigawa, Taraba, Katsina, Zamfara, Niger, Gombe, Oyo, Lagos with less than 50% coverage and high number of unimmunized

Describe the tailored interventions to address this constraint and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.

1. **Strengthen Community sensitization and mobilization through the enhanced Community engagement**
   This is aimed at promoting community participation in RI through the involvement of traditional institutions and Community Resource Persons (CRPs) in the communities. This strategy hinges on 3 pillars namely: Line listing of children under the age of 1 year by community head with support from community volunteers, reconciliation of line list with health facility worker at the health facility or outreach site, referrals and tracking of identified defaulters and left outs. This is currently ongoing In Kano, Sokoto, Kaduna, Bauchi, Yobe, Borno, Bayelsa. Preliminary success results show an increased proportion of caregivers for whom the community leader is the source of information for immunization. Through the implementation of the community engagement strategy, national traditional and religious institutions will be strengthened to take ownership and be accountable for improved health outcomes in their communities[63]. Supplementary Immunization Activities (SIAs) will also be leveraged to engage households on RI and ensure referrals for RI/PHC services

2. **Scale up of CHIPS Program**
   Based on the successes recorded in the Polio program with engagement of VCMs and other community resources persons, these have since been incorporated as a core component of CHIPS and will function to improve access, linkages and uptake of PHC services including immunization in rural and underserved communities. This is currently being rolled-out in Nasarawa, Kebbi, Jigawa and Niger states. Capacities of focal personnel in the departments of Community Health services as well as Advocacy and Communications will be strengthened to manage the scale-up and implementation of the CHIPS program in the priority states[64]

3. **Build capacity of health workers on Inter-Personal Communication, social behavioral change communication, and other demand creation activities**
   Job aids will be developed to assist health workers in conveying key RI messages to caregivers and the community about the diseases, prevention and the new vaccines[65]

4. **Advocacy to key political, policy decision makers for increased program support, budget and timely release of funds for Immunization and PHC services**
   High level advocacy will be conducted to Heads of MDAs, Nigeria Governor's Forum (NGF), National and State Legislatures as well as Association of Local Governments of Nigeria (ALGON)[66],

[62] *NICS/MICS 2015/2016*

[63] *NSIPSS, pg 39*

[64] *2018 Joint Appraisal report, pg 46*

[65] *2018 Joint Appraisal report, pg 53*

[66] *NSIPSS, pg 34*

linking with and leveraging on similar efforts by GPEI with NGF, ALGON, NTLC, Presidential Task Force on Immunization

5. **Intensified engagement with Civil Society Organizations (CSOs) at all level**
   CSOs' participation and engagement to support NPHCDA's drive are vital in the efforts of increasing coverage and equity especially boosting access to immunization and other PHC services in hard-to-reach communities. They will largely redress inequities, increase uptake, ensure accountability and fulfillment of commitments by policy makers, and support branding and social marketing for immunization and other PHC services[67]

6. **Generation of routine qualitative and quantitative data for demand generation activities**
   This is essential for Planning, evaluation and revision of implemented demand generation strategies[68]

7. **Intensify and sustain branding and social marketing of immunization**
   Branding is important for continuous and consistent portrayal and association of immunization with disease prevention benefits of immunization to children and the communities at large. Intensified social marketing through the use of Multi-media channels (Local, traditional and new media), traditional and new media activities will target an increased awareness, acceptance and uptake of immunization by all stakeholders including the 5-visits schedule for immunization completion. These will also focus on dispelling misconceptions as well as building trust and garnering support for RI[69]

List approximately five (5) specific activities to be undertaken to achieve this objective:
→ ***Reflect these activities in the budget & planning template***

1. **Roll-out of Community engagement strategy for RI and PHC services**
   I. Sensitization and training of traditional and religious leaders (Emirates, Sultanate, Chiefdoms, District, village and settlement head) and SPHCDAs on implementation of CE strategy
   II. Production and distribution of CE tools (CE toolkit, tickler boxes, defaulter tracking registers, line list for community leaders, summary forms for CEFPs)
   III. Appointment and training of State, LGA and Ward CE focal persons, health facility workers, and all community resource persons to drive implementation
   IV. Implement annual non-monetary rewards systems for religious and traditional leaders as recognition for good performance

2. **Scale up of CHIPS Program in selected states for community level demand creation**
   I. Engagement and State level planning with established State implementation teams.
   II. Selection and training of CHIPS in IPC and mobilization skills

3. **Advocacy to key political, policy decision makers (NGF, NA, Speakers) and civil society organizations at all level of governance for timely release of funds for Immunization and PHC services**
   I. Develop and disseminate customized and data-driven advocacy kits and policy briefs for engagement of stakeholders across all levels

4. **Engagement with civil society organizations at all levels for redressing inequities, increase uptake, voice, accountability, branding and social marketing for immunization**
   I. Engagement and orientation of CSOs on current demand generation strategies
   II. Tracking of performance of CSOs for improved accountability

5. **Generation, monitoring and analysis of routine qualitative and quantitative data for demand generation activities**

[67] *NSIPSS, pg 16*

[68] *NSIPSS, pg 38*

[69] *NSIPSS, pg 36*

I. Quantitative methods through evaluation of RI-LQAS, review of community survey component of routine immunization supportive supervision component, rapid appraisal survey, rapid audience assessment, tracking use of material, media coverage etc
II. Qualitative methods through focused group discussions, community groups and key informant interviews, direct observations, mystery clients ete

Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation.

→ ***Reflect these in the Grant Performance Framework***

Indicator	Definition	Data Source	Reporting frequency	Baseline (2018)	Target Year (2019)	Target Year (2020)	Target Year (2021)	Target Year (2022)	Target Year (2023)
1. Proportion of states implementing the community engagement (CE) strategy	Number of states who have commenced CE implementation/Total number of priority states	State CE summary reports	Monthly	10%	100%	100%	100%	100%	100%
2. Proportion of planned high level advocacy conducted to key political figures and policy makers	Number of advocacy visits conducted/Total number of planned visits	Reports	As required	-	100%	100%	100%	100%	100%
3. Proportion of health workers trained on IPC and SBCC skills	Number of health workers trained / Total number of targeted health workers	Reports	Annually	-	100%	100%	100%	100%	100%
4. Proportion of planned activities implemented by CSOs	Number of activities implemented/Total number of planned workplan activities	Reports	Monthly	-	70%%	90%	100%	*100%*	*100%*

Technical Assistance: List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

Deployment of Communication for Development (C4D) consultants for a 2-year duration to provide technical expertise to national and sub-national levels on:

- Planning, evaluation and revision of implemented demand generation strategies
- Roll-out of community engagement strategy
- Rebranding and social marketing of immunization
- Building capacity of health workers and other mobilization teams on demand generation skills

Financing: Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage. → ***Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs*** *(please refer to the please refer to the Guidance on supporting countries' HR capacity, available here:* http://www.gavi.org/support/process/apply/additional-guidance/).		
…		
How much HSS budget is allocated to this objective: → ***Reflect the details in the budget and planning template***	**Years 1-2**	US $ 5,647,236
	Years 3-5	US $ 8,450,986

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key cost drivers	Inputs	Assumptions
Roll-out of CE strategy	• Advocacy visit to high level traditional leaders • Training of 183,000 traditional leaders across all cadres, community volunteers, community engagement focal persons and health facility workers • Production and distribution of line list and CE manuals for all personnel in the traditional and health system sides	This will be implemented state-wide in Bayelsa, Kebbi, Jigawa, Taraba, Katsina, Zamfara, Niger, Gombe while in select LGAs/communities in Oyo and Lagos states to foster community ownership, accountability and improved uptake for R services
Rebranding and social marketing of immunization	• Engagement of media houses/consultant • Immunization logos and themed songs • Production of branded items • Pre-test of immunization brand	This will be implemented in all 10 priority states. This will target continuous awareness creation and improving public acceptance of immunization and other PHC activities through improved awareness

Objective 4: Data management and surveillance	To strengthen the health management information system and the integrated surveillance systems for enhanced prevention, detection, diagnosis and control of diseases, with improved data quality for decision making
Timeframe:	2019-2023
Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective: → ***List to match those identified in Section B***	→ Poor data collection, reporting, poor data quality, data use and data falsification; → RI data not linked with SCL → Inaccurate census population figures for programmatic decisions

	→ Harmonization of case-based surveillance and laboratory data → Delays in confirmatory testing due to limited laboratory capacity and frequent reagents stock outs

Describe the tailored interventions to address this constraint and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.

1. **Improve RI data collection, quality and the use of data for action**

Intervals between surveys are often long drawn and variable, and comparison between study results is challenging because of different methodologies. Surveys that currently provide immunization coverage include the Nigeria Demographic and Health Survey (NDHS), National Immunization Coverage Survey (NICS), Multiple Indicator Cluster Surveys (MICS) and the Standardized Monitoring and Assessment of Relief and Transition (SMART) survey. In the last decade, no survey type has been conducted more than twice (except SMART, which was implemented in 2014, 2015 and 2018). The last MICS/NICS, which provided baseline data for this strategy, was conducted in 2016. Therefore, changes to the programme and coverage since then can only be assumed

The Government of Nigeria plans to provide supervision and data audit support to the lower levels of the healthcare system to improve the accuracy of their recorded data. This process includes leading Data Quality Surveys (DQS) and Data Quality Self-Assessments (DQA) on a regular basis. A recent intervention is the revision of the DQS/DQA procedures to include use of child immunization registers at the health facility level, in order to reduce the discrepancies between the registers and tally sheets. The aim of this intervention is to use the data quality review meetings to build interest and capacity in data use data, and support both the NERICC and SERICCs to better structure their discussions and indicator review processes around RI data use for action.

Institution of quarterly RI Lot Quality Assurance Sampling Surveys (LQAS) and annual immunisation coverage survey to provide timely insights into programme performance and impact of deployed strategies on immunisation[70]

Finally, data analysis, interpretation and use will be strengthened at the national and state levels by providing partner-led capacity building and technical support for daily operations. Specifically, the PRS-NPHCDA data management staff at the national level (one per geo-political zone) will receive regular support to analyse the data reported on the DHIS2 platform (for both performance and process indicators of the RI system), interpret the findings, disseminate the results and recommendations to the national and state levels, and provide regular feedback and follow-up to states on the gaps noted. The same procedures will be completed to strengthen data timeliness, completeness and accuracy at all levels. Also, analysis and feedback will be provided to states regarding their implementation of the DHIS2 platform. These operations must be supported by NPHCDA's financial contributions to the logistics and infrastructure requirements of the project (e.g., server to support the national instance, recharge cards for phone credit, agency-owner laptops and phones, funds dedicated to state-level deployments, etc.)

[70] NSIPSS page 18, section 5.2.4

Regardless of their intentions, all the activities described above will not be effective if they are not followed by regular refresher trainings and supportive supervision (SS) at the state and LGA levels. The trainings address the issue of frequent staff turn-over, while the SS visits assess the accuracy of the data reported and the implementation of recommended actions. To date, both activities have lacked dedicated funding, thus curtailing numerous deployments. The introduction of Integrated Supportive Supervision (ISS) in 2018, with the corresponding harmonization of all data collection tools, is a first step. The proposal to conduct refresher trainings on the new revised 2018 data tools and DHIS2 analytics upgrade is another step. Both initiatives must be supported and expanded as resources allow.

2. Conduct population estimate studies / assessments to address denominator issues

The target population (denominator) currently used in Nigeria is extrapolated from the 2006 National Census enumeration, using a fixed growth rate for each state provided the National Population Commission. However, the accuracy of these estimates is in doubt, since they do not account for inter- and intra-state migration, which have significantly impacted the size of populations in certain communities. The calculation of an accurate denominator for estimation of administrative immunization coverage rates is a global issue, but particularly severe in Nigeria given the high number of states that reported immunization coverages rates above 100% in the last few years.

An inter-sectoral committee was set up in 2015, consisting of the NPHCDA, FMoH, National Bureau of Statistics and the National Population Commission. The purpose of the committee was to arrive at a more robust understanding of the denominator for immunization coverage rates using both the national GIS mapping estimates (calculated using satellite imagery) and the walk-through micro-plans (based on house-to-house enumeration of children younger than 15) for polio SIAs. In addition, the committee conducted a well-designed small-scale enumeration exercise in a few LGAs to help provide additional reference point for the micro plan and GIS estimate data.

To date, the walk-through enumeration has been conducted in 22 states, and these estimates are used for planning routine immunization and vaccination campaign activities. There are plans to conduct the same enumeration in the remaining 15 states. To validate these counts, the enumeration exercise may be repeated in a sample of wards using satellite images and field-based navigational tools. This additional step is resource-intensive, but produces detailed micro plans and avoids omissions or duplications. If the difference between the original and validation counts is less than 15% in the select wards, the original enumeration for the state can be considered to be accurate.

The GIS population estimation results and the walk-through enumeration results will be compared with Census data on a regular basis to triangulate the most precise denominator estimate possible in each state and the FCT. The country plans to update the GIS population estimates in all the 36 states and the FCT and to conduct the walk-through micro-planning every 3-5 years to reassess denominator estimates.

3. Introduce electronic data transmission and immunization registry to capture individual immunization record

A key intervention to address many of the data quality issues at the health facility level is the introduction of electronic data capture and reporting using the DHIS2 platform[71]. This platform embeds multiple validation rules and compulsory in its data entry interface, thus limiting the number of data entry errors at the HF level. In addition, Nigeria started electronic data capturing using the SMS in 18 poor performing states (selected based on their 2016-2017 MICS/NICS 2017 results), with a plan to scale up to the remaining 18 states and FCT in the coming years. This provides an additional form of data reporting, where SMS values are compared to those reported monthly on the DHIS2 platform, and any gaps are corrected at the state level.

Also, electronic immunization records may help track children from birth until completion of the vaccination schedule. Since the country has adopted DHIS2, the electronic vaccine registry will be uploaded on the platform's tracker module. Its purpose is to assign a unique ID to each child born, and track him/her at each encounter with the healthcare system to ensure completion of the vaccination schedule. The unique ID system allows healthcare workers to update the child's immunization record regardless of service delivery point.

4. **Training of surveillance officers on measles and rubella case-based surveillance and specimen collection and management.**

An evaluation of the national measles surveillance system was conducted in 2017. It identified major gaps in surveillance and laboratory capacity at all levels. The following tailored interventions were proposed:

- In order to ensure that the vaccine-preventable disease (VPD) and the adverse effects following immunization (AEFI) surveillance system is strengthened and meets all WHO requirements, HSS funds will support regular monitoring of sentinel sites, conduct review meetings at multiple levels, strengthen the capacity of healthcare workers at all levels on AEFI reporting and investigation, and conduct active case search regularly.
- Surveillance officers at all levels will receive refresher training on IDSR as well as case-based surveillance for measles, rubella and yellow fever. As part of the surveillance training, they will also receive a refresher on outbreak response principles.

5. **Harmonization of laboratory and surveillance data, and collaboration around the use of surveillance data between agencies.**

HSS funds could be used to increase the number of WHO-accredited measles and rubella testing laboratories in Nigeria, from three to six (one for each geo-political zone), and increase capacity at the national reference laboratory for confirmatory testing.

- A laboratory network for measles, rubella, and yellow fever will be created to ensure that all specimens are tested, that the data are harmonize with surveillance data at all levels, and that results can be forwarded to surveillance officers and healthcare workers for feedback to patients and the organization of response activities at the operational level.

[71] NSIPSS, pg 48

- A specimen transportation network will be further strengthened to ensure that surveillance officers know where to send specimens and know the procedures for correct sample collection and transportation

Specimen collection and management training will be conducted at all levels to ensure that specimens are collected and delivered correctly to the laboratories in a timely fashion

List approximately five (5) specific activities to be undertaken to achieve this objective:
→ ***Reflect these activities in the budget & planning template***

1. **Improve RI data collection, quality and the use of data for action**

   - Printing of RI data tools (VM tools, Child health cards, RI Job Aids, immunization registers, tally sheets, NHMIS summary, Community data tools),
   - Conduct monthly review meetings at state and LGA levels to discuss routine immunization data quality issues
   - Conduct of Surveys to assess programme performance and quality of administrative data (SMART, MICS and NICS)
   - Conduct supportive supervision to LGAs and Health Facilities to address data quality issues
   - Develop capacity of health care workers to collect accurate information
   - Introduce incentives for high data accuracy based on survey vs admin variance as well connecting vaccines with costs (per delivery each month; per quarter/year excess wastage based on vaccinated for age LQAS/survey data)
   - Conduct Data Quality Self Assessments
   - Build capacity of EPI managers on data triangulation, enhancing their ability to spot data manipulation
   - Engage in Directly observed data entry in poor performing locations

2. **Conduct population estimate studies / assessments to address denominator issues**

   - Conduct walk-through households enumeration,
   - GIS Population estimates
   - conduct validation of already conducted household enumeration
   - Continuous triangulation of the data to derive best denominator for immunization program

3. **Introduce electronic data transmission and immunization registry to capture individual immunization record**
   - Purchase mobile devices for 28,000 plus facilities
   - Deploy mobile reporting Apps to 28,000 RI Health Facilities across the country
   - Deploy an app for reporting data using SMS in 14,000 Health Facilities
   - Deploy electronic vaccine registry in all 28,000 Health Facilities

4. **Expansion of network of laboratories for measles and rubella to include South-east & South -south zones and strengthen laboratory management towards WHO accreditation of the network of laboratories including NCDC National Reference Laboratory and increase laboratory capacity and reduce reagent stock out rate.**
   - Purchase of ELISA washer, reader, incubator for 2 additional network labs
   - RT-PCR equipment for NCDC National Reference laboratory
   - Procurement of Measles and rubella test kits
   - Purchase of Consumables and other supplies for serology and molecular diagnostics laboratory for Measles and Rubella
   - Train DSNO and HCWs on specimen collection, packaging, and management

- Conduct nationwide intra-state and inter-sate specimen transport workshop and cascading trainings to community level

5. **Build capacity for data management among network of public health laboratories, in order to integrate laboratory data with surveillance data**
   - Train community informants and LGA Disease Surveillance Notification Officers (DSNOs) for VPDs case base and AEFI outbreak investigation and response
   - Conduct nationwide workshop on surveillance and laboratory data harmonization and case classification for Measles and yellow fever and cascading trainings to community levels
   - Establish TWG for yellow fever, Measles and Rubella
   - Carry out nationwide workshop on data management, cleaning, case investigation, and summary/presentation of data
   - Conduct IT training at NRL and network of laboratories for diagnostic information management system
   - Carry out workshop and implementation training & ability of NCDC/NRL to have diagnostic data from network of laboratories

Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation.

→ ***Reflect these in the Grant Performance Framework***

Indicator	Definition	Data Source	Reporting Frequency	Baseline (2018)	Target Year (2019)	Target Year (2020)	Target Year (2021)	Target Year (2022)	Target Year (2023)
% of states that have conducted monthly RI review meeting	Number of States that conducted monthly RI review meeting/ Total number of states	State Reports	Monthly	50%	60%	70%	80%	90%	100%
% states that demonstrate increased accuracy of RI data	Number of States or LGA with less than 10% difference between survey and admin/ Total number of states	DHIS2 Survey Report	Annually	10%	15%	20%	25%	30%	35%
% of HF with increase accuracy of data reporting	Number of HFs with consistent number of children given Penta 3 between SMS & DHIS2 / Total number of states	DHIS2 and SMS server	Monthly, Annually	10%	15%	20%	25%	30%	35%

Technical Assistance: List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

- Support for DHIS 2 infrastructure management
- TA support for completion of population estimate studies; GIS, walk through, data triangulation
- TA support for deployment of electronic immunization registry and use of electronic platforms (mobile app etc.) for data reporting
- TA support for laboratories strengthening laboratory management towards accreditation and specimen tracking system
- TA support for TA for integrated laboratory & surveillance data management

Financing: Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage.

→ ***Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs*** *(please refer to the please refer to the Guidance on supporting countries' HR capacity, available here:* http://www.gavi.org/support/process/apply/additional-guidance/).

Voluntary Community Mobilizers (VCMs) will be transited into CHIPS Agents to be used for demand generation for RI and PHC services

How much HSS budget is allocated to this objective: → ***Reflect the details in the budget and planning template2***	**Years 1-2**	US$ 9,690,997
	Years 3-5	US$ 10,914,392

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key cost drivers	Inputs	Assumptions

Health Information System	• Conduct of DQA and DQUSS monthly
	• Configuration of Systems
	  ○ SMS App
	  ○ Electronic immunization registry
	  ○ Community HMIS tool on DHIS2
	• Monthly review meetings
		Conduct of DQA, configuration system app, electronic immunization registry and community HMIS tool will contribute to strengthening the health management information system and improve data quality

Procurement	• Printing of RI data tools • Procurement of 28,000 android phones	• RI data tools will be updated and seed tools printed for nationwide dissemination and use • Android phones will be procured for 28,000 health facilities across the country for real-time entry of routine immunization data at service delivery points

Trainings, Refresher and cascading training, orientation of health workers on DHIS2, community HMIS tool, electronic data reporting	• Training Material
	  ○ Develop revised training materials on DHIS2
	  ○ Guideline and protocol for using the community HMIS tool
	  ○ Guideline and protocol for
	  ○ Development of guideline and protocol for electronic immunization registry
	• Printing.
	• Stationery.
	• Subsistence allowances
		As the country rolled out DHIS2 nationwide and some HCWs were trained over 3 years ago and some have rotated in / out , there is a need to conduct refresher trainings and update guidelines accordingly.

External professional services	• Vendor for development and deployment of electronic immunization registry • Technical assistance on conduct of surveys • Technical assistance for configuration of community HMIS tool • Technical assistance	• TA will be needed as we begin to introduce and implement e-registry. In addition, the bac

Management	• Conduct/ support surveys that will provide annual RI coverage data	• From NSIPSS, one survey or the other (SMART, NICs/ MICs, DHS) will be done annually and each will require input and where needed resources from the NPHCDA grant that will be targeted to the GAVI supported states.

Objective 5: Human Resources for Health	To improve capacity and optimize distribution of frontline health workers and EPI managers for RI and PHC
Timeframe:	2019 - 2023
Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective: → ***List to match those identified in Section B***	*Kebbi, Jigawa, Katsina, Zamfara, Gombe, Taraba and Bayelsa. These are states with low coverage and high % of unimmunized children.* *The selected activities will address the following challenges in the states:* *a. Inadequate number of staff* *b. Mal-distribution of staff* *c. Improving the skill mix* *d. Improving skills of health workers* *e. High turnover of trained staff* *Improved Quality of care, increased service utilization and access will be achieved.*
Describe the tailored interventions to address this constraint and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.	
1.Generate evidence for development of HRH strategies and improve production, recruitment, distribution and retention of health workers at national and sub-national levels)[72] 2. Advocacy to policy makers for recruitment of more qualified health workers, better pay and incentives (e.g. rural posting allowance) 3. Develop and implement innovative cost-effective approaches for capacity building of health workers, that link with existing efforts such as PHC TSU (e.g Community-based health Research, Innovative-training and Services Programme (CRISP) strategy[73], Teach to reach, innovative peer-to-peer learning exchange meetings, etc..) 4. Roll-out a phased need-based implementation of task-shifting/sharing policy by state	

[72] NSIPSS page 18, section 5.2.4

[73] The goal of CRISP strategy is to refocus community-based medical education programs in colleges of medicine/health Sciences, for the improvement of health indicators in host communities through PHC research, innovative training and provision of quality health services. See further details in the CRISP Strategy document

5. Improve Health Workers performance through performance management mechanism[74], with specific tactics for each sub national level: zones, states, LGAs, HFs).
The critical national and sub national capacities of PHC and RI managers will be improved. Also, availability of trained PHC staff will address challenges of quality of care, access and service utilization.

List approximately five (5) specific activities to be undertaken to achieve this objective:
→ ***Reflect these activities in the budget & planning template***

1. To get accurate number, distribution and mix of HRH for PHC of each state this will be used for planning tracking and advocacy to policy makers in the states. It will further generate evidence on HRH gap required for quality service delivery in line with Ward Minimum Health Care Package.
   1.1. Identify and engage a consultant to develop, and implement a HRH assessment framework with report working with NPHCDA and partners.
   1.2. Planning meetings/workshop to train field assessors on collation of HRH inventories, field assessments and field verification
   1.3. HRH profiling and assessment of health training Institutions in state by trained assessors (5 days
   1.4. National Dissemination meeting
   1.5. Review and update pre-service training curriculum for immunization and other PHC services in collaborations with regulatory bodies
2. Advocacy to policy makers for recruitment of more qualified health workers, better pay and incentives (e.g. rural posting allowance)
   2.1. Leverage on existing forums (Nigeria Governors Forum-NGF, Honourable Commissioners for Health, Executive Secretaries of State PHCBs, Nigeria Governors Wives, National Council on Health)
   2.2. Development of Advocacy kit for HRH
   2.3. Development of framework to guide states for deployment and incentivizing of PHC Workers
   2.4. Routine Update on National HRH Profiling (bi- annual)
3. Innovative cost-effective approaches for capacity building of health workers (e.g. CRISP strategy, Teach to reach, etc.)
   3.1. Development of Program Curriculum to support Capacity building of States and LGAs implementing the CRISP Strategy
   3.2. Capacity building 7 priority states for Training of CHIPS Personnel (CHIPS Agents & CEFP)
   3.3. Conduct Middle Level Management Training on Immunization for SIOs and LIOs
   3.4. Training of Health Workers on IMCI plus REW including follow up after training workers
   3.5. Training of Health Workers on Basic Guides on Immunization
   3.6. Training of tutors of Health Training Institutions on current issues in line with updated curriculum
   3.7. Development of audio-visual training resources for addressing identified skill gaps
4. Phased need base implementation of task shifting/sharing policy by state
   4.1. Support State to adapt task shifting/ sharing policy and hold meetings with professional groups on the task shifting policy
   4.2. Capacity building on AEFI surveillance for health workers
5. Improve Health Workers performance through performance management mechanism
   5.1. Engage TA to develop performance management framework and tools in collaboration with stakeholders
   5.2. Orientation of old and new staff on job descriptions and performance management

[74] NSIPSS, page 53, section vi

5.3. Establish mechanism for continuous assessment of staff performance gap and corrective learning, as well as a functional and sustainable reward and sanction system as a means of incentivizing performance

Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation.
→ ***Reflect these in the Grant Performance Framework***

Technical Assistance: List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

Gavi HSS TA for HRH

-TA need will include consultancy fee for the period of engagement for a period of 6 months to develop and implement the HRH assessment framework

- TA needed to support the implementation of high-quality performance management strategies to improve HCW motivation and establish mechanisms for continuous assessment of staff performance

-

Financing: Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage.
→ ***Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs*** *(please refer to the please refer to the Guidance on supporting countries' HR capacity, available here:* http://www.gavi.org/support/process/apply/additional-guidance/).

…

How much HSS budget is allocated to this objective: → ***Reflect the details in the budget and planning template***	**Years 1-2**	US$ 5,310,793
	Years 3-5	US$ 7,422,589

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key cost drivers	Inputs	Assumptions
HRH	**To get accurate number, distribution and mix of HRH for PHC** • Identify and engage a consultant • Planning meetings/workshop • HRH profiling and assessment of health training institutions • Review and update pre-service training curriculum	• HRH Profiling will be conducted to get accurate number and distribution of health workforce in Nigeria • Pre-services training curriculum will be reviewed and updated
	Advocacy to policy Makers • Leverage on existing forums • Development of Advocacy kit for HRH	• Advocacy to policy makers/ stakeholders in the states will be conducted to address

	• Development of framework to guide states • Routine Update on National HRH Profiling	issues relating to HRH.
	Innovative approaches for capacity building of health • Development of pre-service Program Curriculum • Capacity building in 8 priority states • Conduct Middle Level Management Training • Training of Health Workers on IMCI plus REW including follow up • Training of Health Workers on Basic Guides on Immunization • Training of tutors of Health Training Institutions • Development of audio-visual training resources • Capacity building on AEFI surveillance • Institute continuous vaccine education for HCWs through on the job, low cost peer mentoring approaches	• Trainings will be conducted to build capacity of frontline health workers in the 7 priority states.
	Phased need base implementation of task shifting/sharing policy • Support State to adapt task shifting/ sharing policy	• States will be supported on full implementation of task shifting/sharing policy
	Improve Health Workers performance through performance management mechanism • Engage TA to develop performance management framework and tools • Orientation of old and new staff • Instituted established mechanism for continuous assessment of staff	• Performance management framework and tools will be developed • Orientation of job description will conducted for both old and new staff

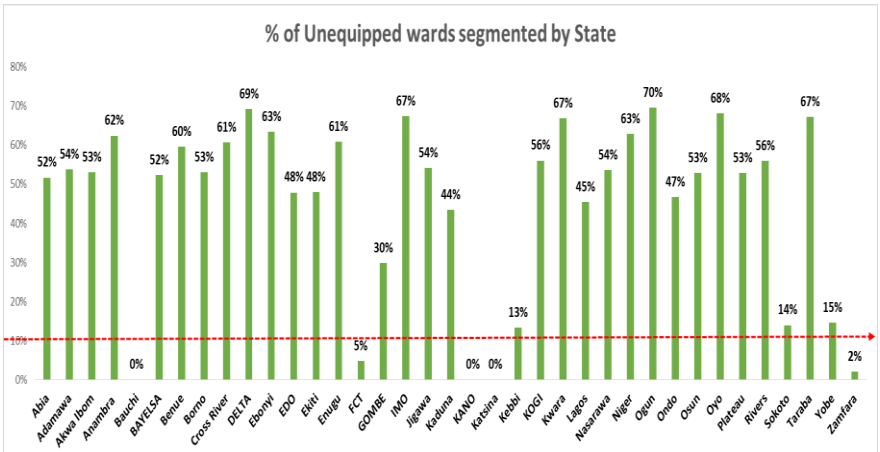
Please add additional objective boxes as necessary.

***Template for Supply Chain** (Applicable even if country is not applying for CCEOP):*	
Objective:	To ensure availability of 100% bundled vaccines and other PHC commodities of the right quality and quantity at the right time at the last mile (service delivery point).
Timeframe:	2019 - 2023
Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective: → ***List to match those identified in Section B***	→ Human resources deficit in terms of number and required skill sets to manage the supply chain → Inadequate storage capacity at the point of service delivery → Lack of visibility on stock availability at the last mile, → Excessively high vaccine wastage exacerbated by lack of clarity on wastage drivers across state/LGA/HF levels → Lack of state ownership of the EVM Improvement Plans leading to poor implementation → Dependence of vaccine distribution to the last mile on out-of-pocket expenses of health care workers

Describe the tailored intervention to address the particular supply chain constraints and provide evidence of efficacy of the intervention:

1. **Organizational re-design at the National level**
   Following an Organization Health Index, a Departmental Handbook was developed, which identified the various divisions within the Department of Logistics and Health Commodities, required staff, and job schedules. A Supply Chain Leadership Development (SCLD) Programme was instituted to rapidly build the capacity of the staff to perform their duties.
2. **Deployment of new and optimal cold chain technologies to meet national policy of 1 functional CCE per ward**

- To ensure equitable availability of vaccines at the point of service delivery, a National Policy of at least one CCE per Ward was adopted. While there has been some progress towards this goal, driven by support from global partners, notably Gavi, EU-SIGN and UNICEF, there is still a wide gap which the country is seeking to bridge through the Gavi CCEOP. Currently, only five states have up to 90% of their wards equipped.



- Availability of CCE in every ward has enabled implementation of the direct vaccine delivery strategy in MOU (kano, Bauchi, Yobe, Sokoto, Kaduna, and Borno) states with dramatic results in terms of reduction of vaccine stockout

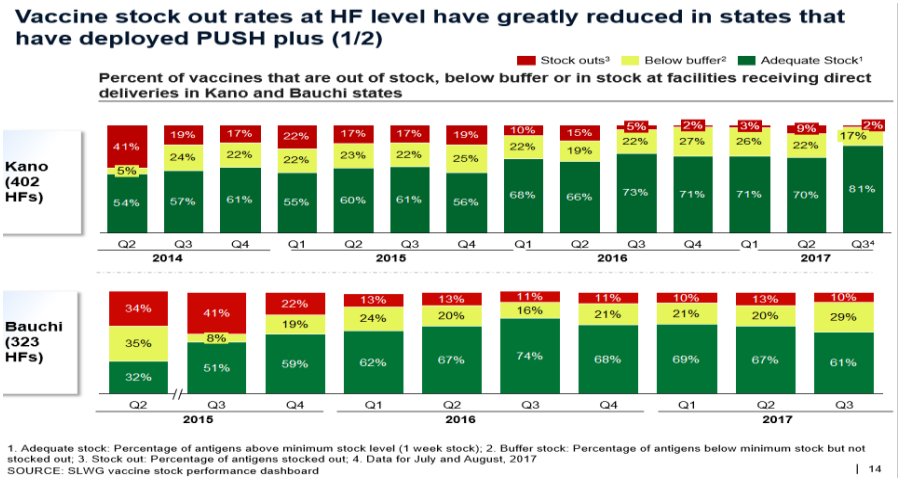
3. Ongoing implementation of data Visibility and Analytics Network project

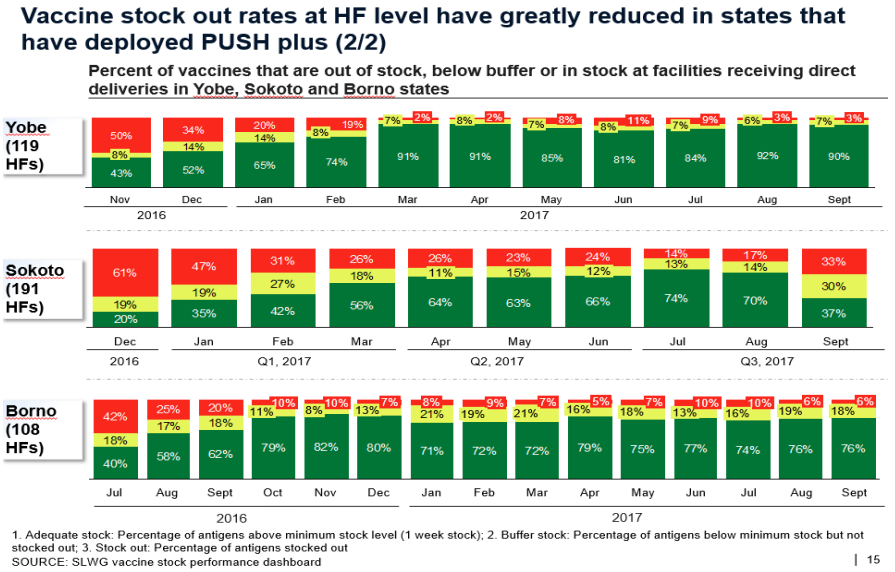
- The Visibility and Analytics Network project has greatly improved vaccine stock management processes. Stock allocation is now data-driven from National to sub-national levels and visibility improved on stock performance from national to LGA levels

4. Collaborative bottom-up approach to development of the EVM continuous

- Nigeria had a score of 52% in the first EVMA Assessment in 2010. This was a far cry from the accepted global standard of 80%. The second assessment showed improvements with a score of 67%, while the country scored 69% in a third assessment in 2017. Each assessment was followed by the development of an improvement plan, which was meant to address the identified gaps at the various levels of iSC. The low scores were attributed to a lack of ownership leading to poor implementation of the plans, which were developed at the National level. The development of the continuous improvement plan for the 2017 EVMA was therefore done with full participation of the States. The process is expected to ensure ownership for execution and funding by all relevant stakeholders at subnational levels

5. Implementation of Push Plus in MoU states which improved stock availability at the last mile in implementing states





- **Designed and implemented vaccine accountability management systems including empty vials retrieval (which is now being implemented by the states)** with full100% accountability for the vials (which has been handed over to the states); of all mOPV2 vials used in the polio outbreak response activities. Vaccine accountability also linked with data accuracy efforts, and with tracking cost of vaccines (e.g. per delivery, estimated cost of excess wastage per quarter or year (using vaccinated for age data from LQAS and surveys)

List priority activities for each of the five supply chain fundamentals:
Describe the activities related to supply chain fundamentals – for those planned in years1-2 and those planned in the outer years (3-5).
→ ***These activities should be linked to the latest EVM Improvement Plan and be reflected in the operational workplan & budget***

1. Continuous Improvement

- ***First two years (Years 1-2) :*** Conduct 2018 and 2019 supervisory EVMA to assess status of implementation of the continuous Improvement Plan for 2017 EVMA

- ***Outer years (Years 3-5):*** Conduct 2020 EVMA assessment and develop CIP

2. Management/Leadership

- ***First two years (Years 1-2):***
  - Conduct a Rapid HR Needs assessment and Training Needs assessment on the workforce gaps across all supply chain levels
  - Develop, print and disseminate clear Job descriptions/Schedules for all levels of the supply chain

- ***Outer years (Years 3-5)***
  - Conduct regular training for SC managers and healthcare workers including online and international trainings
  - Conduct regular supportive supervision and provide on-the-Job mentoring during supportive supervision including annual supervisory EVMA

3. Data for Management

- ***First two years (Years 1-2)***
  - Identify the best last mile LMIS technology solution for the country linked to other efforts outside of immunization (e.g. NSCIP)
  - Link Navision with DHIS2 and other last mile solutions within the LMIS ecosystem in Nigeria within the National Immunisation Supply Chain management information system (NISCmis)
  - Develop, print, distribute and disseminate SOP for interpretation of NISCmis analytics
  - Train EPI managers on interpretation of NISCmis analytics
  - Carry out wastage rate study
  - Train EPI managers and Health Care Workers (HCWs) on vaccines accountability (including analytics and use of data for action) and management frameworks, , with follow up systesm of mentoring/support provided that connects vaccine accountability, excess wastage data, RI coverage of vaccinated for age (LQAS/survey)
  - Monitor utilization of last mile LMIS solution

- ***Outer years (Years 3-5)***
  - Deploy appropriate last mile LMIS technology solution for the country
  - Maintenance and hosting of LMIS technology
  - Introduce barcode technology

- Print and supply adequate data management tools
- Monitor utilization of last mile LMIS solution

4. Cold Chain Equipment (including maintenance)

- How will the country ensure that aspects of maintaining the cold chain are addressed (e.g. preventive and corrective maintenance, monitoring functionality, technicians, financing for maintenance, spare part procurement etc.)?
- What is the frequency of preventative and corrective maintenance that the country commits to (supported by partners)?
- How will the country monitor the completion of preventive and corrective maintenance?
- Indicate the sources of funding for planned maintenance activities
- How will the country dispose of obsolete and irreparable equipment replaced by new equipment?

4. Cold Chain Equipment (including maintenance)

- How will the country ensure that aspects of maintaining the cold chain are addressed (e.g. preventive and corrective maintenance, monitoring functionality, technicians, financing for maintenance, spare part procurement etc.)?

a. Organization of maintenance

The NPHCDA took several initiatives in implementing its strategy of CCE maintenance. With support by the NLWG, considerable efforts were made by the DL&HC to develop, experiment, and scale up innovative approaches to CCE maintenance. Through the NLWG, guidelines and skills on CCE maintenance are currently being cascaded at state level through capacity building of SLWGs. The following examples show achievements by NPHCDA to institutionalize CCE maintenance.

4.1.1 Management

To promote better CCE management the NLWG supported the DL&HC in developing, printing and disseminating 12,000 approved copies of “Guidelines on Management of Planned Preventive Maintenance” to all levels of the iSC (Annex1). The target beneficiaries of these guidelines were all sites with an available CCE. Furthermore, through learning exchanges conducted in 4 northern RI MoU States on CCE maintenance, participating State Logistics Working Groups (SLWGs) are acquiring knowledge and skills on best practices of CCE management.

4.1.2 User maintenance

To implement the “user-based maintenance” of CCEs by health workers daily, weekly, and monthly, the DL&HC (supported by the NLWG) developed, printed and disseminated 15,000 posters on CCE maintenance by users.

4.1.3 Supportive supervision

To monitor and support CCE maintenance work performed by health workers, monthly supportive supervision of health facilities by CCOs will be reinforced. Supervision checklists are developed to monitor the quality of CCE maintenance carried out by health workers (Annex 3).

4.1.4 Expert based Maintenance

The NPHCDA uses outsourced experts to maintain and repair its cold rooms at the national and zonal stores. There are contracts that cover basic maintenance carried out for a fixed amount per quarter. Other contract clauses cover separate invoicing of major repairs.

- What is the frequency of preventative and corrective maintenance that the country commits to (supported by partners)?

User maintenance of CCE will be done on a daily, weekly, and monthly basis by Health workers who use the equipment. Specific tasks will be performed at set intervals.

SOPs for CCE maintenance at the National and Zonal levels guide preventive maintenance activities. Quarterly maintenance activities are handled by engaged private sector vendors.

At the service delivery level, Planned Preventive Maintenance Posters have been provided at the site of every Solar Direct Drive CCE to guide Health Workers on routine maintenance tasks.

As is the case with the National level, states are being encouraged to engage the services of maintenance vendors to handle corrective maintenance as they occur.

- How will the country monitor the completion of preventive and corrective maintenance?

Each maintenance activity is entered in a Maintenance Log placed at the equipment site. The contents of the maintenance Log are validated before the maintenance activity can be invoiced and paid for. Also, at the National level, Zonal and State levels, an installed Remote Temperature Monitoring Device (Beyond Wireless®) which remotely tracks and displays the functional status of equipment.

- Indicate the sources of funding for planned maintenance activities?

Looking at the updated IRP as at October 2018, and the 2019-2023 projections for equipment, approx. 11,000 CEs will require for routine maintenance over the next 10 years with an additional 6,937 with the approval of the CCEOP application making the total approx. 18,000 units. The budget estimated to facilitate and manage annual CCE maintenance is $2.700.000(at $150/equipment/annum). Extended warranty and long-term maintenance including spare parts will be paid for by the respective state governments with some states leveraging on the Saving One Million Lives funds initially while NPHCDA has conducted high level advocacy to state leadership to fund maintenance. Another source of funds for maintenance would be from the recently approved (by the National Assembly) Basic Healthcare Provision Fund (BHCPF), which will be made up of 1% of Nigeria's consolidated revenue. Fifteen percent of this fund is going directly to the health facilities and has been earmarked for maintenance of facilities, equipment and distribution (#13.8_ BHCPF: Implementing the NPHCDA Gateway_Pp5).

An estimated 1% of the newly procured CCE would require curative maintenance annually at a cost of approx. $50/ equipment (spare parts are being procured as part of the CCEOP application).

- How will the country dispose of obsolete and irreparable equipment replaced by new equipment?

- Quarterly update of the IRP offered the opportunity to identify CCEs that are non-PQS, beyond economic repairs, or have reached the end of their useful life. Lists of CCEs recommended for disposal will be compiled by states and submitted to national level through the SLWGs. The involvement of 'Facility Management Department of the Ministry of Works, and the State Primary Health Care Boards would facilitate the disposal processes in accordance with State laws and national guidelines as detailed in the PPM guidelines.

- ***Outer years (Years 3-5)***

5. System design (all countries should answer) *If the country is applying for CCEOP, also indicate how system design considerations impacted the choice of CCE for which the CCEOP support is requested.*

- ***First two years (Years 1-2)***
  - System design changes are being implemented in process and infrastructural areas: *Infrastructure:* The vaccine distribution system is being re-designed at both the National and Service Delivery levels. At the National level, Storage capacity expansion is being implemented along the line of construction of three (3) Megastores to serve as Hubs for Storage and distribution of vaccines to the states. The Hubs will be in Abuja, Kano and Lagos. Activities planned for the first two years of the HSS are:
    - Acquire land for construction of Hub in Abuja
    - Construct and equip Lagos, Abuja and Kano Hubs

At the service delivery level, the country plans to have at least one functional CCE in each ward, with enough capacity to cater for immunization activities in the ward. The application on the CCEOP is aimed at bridging current existing gaps in the wards and providing for replacement of obsolete or soon to be obsolete CCE.

Process: At the National level, the three Hubs will distribute vaccines directly to the States (each covering States in two zones). The zonal stores will thus be eliminated as a node in the distribution line.

A system for direct delivery of vaccines from the State cold stores to the Health Facilities that have CCE is being instituted. Deliveries will be made to identified Health Facilities that have functional cold chain equipment. Facilities without CC will draw their supplies from the nearest facilities with functional CCE.

Activities in this area in the next two years include:

- Gradually scaling up the direct delivery system from the current seven implementing states to cover all the States

- ***Outer years (Years 3-5):***
  - Operationalise 3 Hubs
  - Complete procurement and deployment of CCEOP equipment
  - Continue to monitor and supervise

Describe how the sustainability of these activities will be ensured in the future:

Sustainability will be ensured by Government's implementation of a dedicated fund for Immunisation with phased reduction of loan component of Immunisation financing at the rate of 10% per annum with a target of 100% government financing by 2028.

List indicators to monitor progress toward objective:

→ ***Reflect these in the Grant Performance Framework***

If requesting CCEOP support, include mandatory indicators (please refer to the programming guidance, here: http://www.gavi.org/support/process/apply/hss/)

- Continuous Improvement
  - **a.** Proportion of planned supervisory EVMAs conducted (Years 1 – 2)
  - **b.** Availability of EVMA Report and level specific cIP (Years 3 – 5)
- Management/Leadership
  - **a.** Availability of HR Development Plan (Years 1 – 2)
  - **b.** Proportion of planned activities capacity development activities implemented (Years 1–5)
- Data for Management
  - **a.** The best last mile LMIS technology solution identified and deployed (Years 1-2)
  - **b.** Full linkage of Navision with DHIS2 and other last mile solutions within the National Immunisation Supply Chain management information system (NISCmis) achieved (Years 1-2)
  - **c.** Proportion of EPI managers and Health Care Workers (HCWs) fully trained on vaccines accountability (including analytics and use of data for action) and management frameworks (Years 1-2)
  - **d.** Percentage LMIS technology uptime (Years 3-5)
- Cold Chain Equipment (including maintenance)
  - **a.** Proportion of wards and LGAs with adequate and functional CC capacity (Years 1 – 2)
  - **b.** Proportion of states with LTA for maintenance in place (Years 1 – 2)
  - **c.** Availability of report on mid-term cold chain inventory and assessment to assess progress of implementation of 5-year cold chain expansion, replacement and rehabilitation plan (Years 3 – 5)
- System Design
  - **a.** Fully Completed and Operational Lagos Hub (Years 1 – 2)

b. Fully Completed and Operational Abuja and kano Hubs (Years 3 – 5)

Detail TA needs required to support this activity and clarify how much is not covered by PEF/TCA.

1. TA for Review of the CCEOP (Year 1)
2. TA to Support Development of iSC Roadmap (Year 2)

How much HSS and CCEOP budget is allocated to this objective → ***Insert here same figures as in table 2.4. and also reflect these in the budget and planning template***	**Years 1-2**	US$ 11,956,314 + $23m (CCEOP)
	Years 3-5	US$ 947,112

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key Cost Drivers	Inputs	Assumptions
Management	3-Hub System • Acquire land and cost of the expansion of Abuja (NSCS) Store • Scale up appropriate vaccine delivery system (PUSH Plus) • Conduct annual vaccines and devices audit	Availability of means of transportation or cost and other consultancy costs
Training	• Deploy technical staff to the 3-hubs • Cost of training of new staff on state of art equipment in the hub • Build capacity of EPI managers and health care workers (HCW) on use of data for action	Officers will be trained continuously to safely store, manage vaccines and related supplies and data management
Procurement	• Provision of personnel protective equipment • Construct and equip Lagos Store • Upgrade/Renovate the Kano and Abuja Hub	Proper kitting of personnel to prevent work related hazard
Management	CCEOP • Deployment of new and optimal CCEs, spare parts and voltage regulators to equip wards and LGAs • Conduct periodic cold chain inventory assessments to monitor implementation of CC expansion and rehabilitation plan	Assume that Nigeria meets the requisite of GAVI and the availability of counterpart funding by the government of Nigeria
Training	• Integrate vaccine accountability and management systems - including CCE maintenance - into other EPI trainings e.g. Basic Guide • Cold chain maintenance training for national and state technicians	Equipment running and maintenance cost, spare parts will be procured to enable that technicians carry out maintenance

	• Maintenance of cold chain equipment across the 36+1 States of the country	and timely repairs to ensure CCE are maintained and are in a well-functioning state
Procurement	• Procurement of new and optimal CCEs, spare parts and voltage regulators to equip wards and LGAs • Procure and deploy comprehensive mechanical equipment and technicians for both preventive and curative maintenance of equipment • Provision of tool kit for maintenance	The program will procure functional solar CCE for use at health facilities, State and zonal stores
Management	EVM and Vaccine Waste Assessment • Conduct EVMA assessment and develop continuous improvement plan • Conduct supervisory EVMA • Conduct vaccine waste assessment • Harmonization of SLWGs and LMCUs under the PSMs-TWGs	Availability of both administrative and consultancy cost, and schedules of meeting with action plans that are realizable
Training	• Train assessors • Stationeries • Transport • Daily stipends	The assessment will include orientation, data collection, data processing and disseminate findings
Management	Forecast Meeting • Conduct annual forecast harmonization workshop for all public health programs • Co-develop and provide guidelines to distribution entities on distribution processes	Cost of workshop and consultancy services
Training	• Integrate NISCmis with the DHIS2 and NHLMIS	

Part E: Signatures – Endorsement of the Programme Support Rationale

Government signature form

The Government of Nigeria would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for the portfolio as outlined in this Programme Support Rationale (PSR):

The Government of Nigeria commits itself to the continued development of national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The Government of Nigeria will fulfill the co-financing commitments set out in this PSR as expressed in doses or the equivalent dollar amount in Part A above.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.[75]

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name		**Name**	
Date		**Date**	
Signature		**Signature**	

[75] *In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.*

ANNEXES

ANNEX 1: Mapping of prioritized strategies across the NSIPSS, JAR, NSIPSS retreat and HSS/PSR

Strategy captured Strategy not captured

Leadership, Management and Coordination			
NSIPSS prioritized strategies	**JAR**	**NSIPSS retreat**	**HSS/PSR**
Strengthening PHC management through Primary Health Care Under One Roof (PHCUOR)			
Improving coordination at national and sub-national levels			
Instituting an accountability framework for RI and PHC			
Improving organizational capacity to manage immunization and PHC programmes			
Strengthen financial management			
Service delivery			
NSIPSS prioritized strategies	**JAR**	**NSIPSS retreat**	**HSS/PSR**
Optimization of the Reach Every Ward (REW) strategy across all states (OIRIS)			
Reduction of Missed Opportunities for Vaccination (MOV) in urban PHC facilities, secondary and tertiary health facilities			
Strengthening RI and Integrated supportive Supervision (RISS) at national, state and LGA levels			
Periodic Intensification of RI in locations with prolonged disruptions in RI services			
Reach Every Settlement (RES), Reach Inaccessible Children (RIC) strategies in security compromised locations			
Regular reviews and evaluations e.g. quarterly and annual review			
Demand generation			
NSIPSS prioritized strategies	**JAR**	**NSIPSS retreat**	**HSS/PSR**
Strengthened community engagement through participatory planning and implementation of RI and PHC services (CES, CHIPS)			
Strengthening institutional capacity for demand creation by training service providers in communication and mobilization			
Strengthening partnerships through mobilizing key partners and stakeholders within and outside the healthcare sector			
Engaging political, social and civic leaders as well as CSO, professional organizations and relevant others			
Increase awareness and behavioural change towards immunization through branding, traditional and new media engagements			
Use of data for action			
Data Management			
NSIPSS prioritized strategies	**JAR**	**NSIPSS retreat**	**HSS/PSR**
Strengthen coordination structures for data reporting, warehousing and management			
Improve availability and use of data capture tools			
Introduce electronic vaccine registry to capture individual immunisation record			
Strengthen data quality audit, assurance and assessment mechanisms -RI LQAS, DQA/S			
Conduct annual surveys to provide timely and reliable information for decision making			
Conduct population estimate studies to address denominator issues			
Strengthen Operations research mechanisms			
Human Resource for Health			
NSIPSS prioritized strategies	**JAR**	**NSIPSS retreat**	**HSS/PSR**
Optimization of planning and policies for HRH			
Improve production, recruitment, distribution and retention of health workers at national and sub-national levels			

Improving attitude of health workers			
Innovative approaches for capacity building of health workers (CRISP strategy, teach to reach)			
Institutionalization of adequate performance management systems			
Supply chain and logistics			
NSIPSS prioritized strategies	**JAR**	**NSIPSS retreat**	**HSS/PSR**
Organizational re-design at the National level, development of a Supply Chain Leadership Development (SCLD) Programme.			
Deployment of new and optimal cold chain technologies to meet national policy of 1 functional CCE per ward			
Ongoing implementation of vaccine accountability framework Visibility and Analytics Network (VAN) project to improve stock visibility and use of data for stock-allocation at all levels			
Collaborative bottom-up approach to development of the EVM continuous improvement plan (EVM cIP)			
Scale up of Push Plus to improve stock availability at the last mile in implementing states			