GAVI Alliance

Annual Progress Report 2013

Submitted by

The Government of

Nigeria

Reporting on year: **2013**
Requesting for support year: **2015**
Date of submission: **16/05/2014**

Deadline for submission: 22/05/2014

Please submit the APR 2013 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2013**

Requesting for support year: **2015**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	Yellow Fever, 10 dose(s) per vial, LYOPHILISED	Yellow Fever, 10 dose(s) per vial, LYOPHILISED	2015
Preventive Campaign Support	Meningococcal type A, 10 dose(s) per vial, LYOPHILISED		2014

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	Yes	next tranche: N/A	N/A
HSS	Yes	next tranche of HSS Grant No	N/A
COS	Yes	Not applicable	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 is available here.

2. Signatures

2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of Nigeria hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Nigeria

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Prof. C.O Onyebuchi Chukwu	**Name**	Dr Ngozi Okonjo Iweala
Date		**Date**	
Signature		**Signature**	

<u>This report has been compiled by</u> (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr Ado J.G Muhammad	Executive Director/CEO	+2348033139090	dradojg@yahoo.com
Dr E.A Abanida	Director Disease Control & Immunization	+2348103686717	drabanida@gmail.com
Dr Mahmud M.Z	Chief Medical Officer, Head Routine Immunization & External Support Servicess	+2348122054336	drmahmudmz@yahoo.com
Dr Bassey Okposen	Chief Medical Officer, Head External Support Services	+2348032373794	basenokng@yahoo.com
Dr Obiora Ezebilo	Senior Medical Officer 1, External Support Services (GAVI Desk)	+2348036766888	angels4obi@yahoo.com
Dr Racheal Serunyenge	Medical Officer EPI (WHO)	+2348102210092	serunger@who.int
Dr Daniel Ali	Medical Officer EPI (WHO)	+2348034022393	alid@who.int
Dr Jeevan Makam	Medical Officer EPI (WHO)	+2348039795144	makamjeevank@who.int
Dr Daniel Agbor	EPI Team leader (UNICEF)	+2348134642882	jagbo@unicef.org
Dr Boubacar Dieng	Health Manager (UNICEF)	+2348035351850	bdieng@unicef.org
Dr Paul Adovehekpe	Health Specialist (UNICEF)	+2348035351850	padovohekpe@unicef.org
Gloria Nwulu	Health Specialist (UNICEF)	+2348035351009	gnwulu@unicef.org
Dr Murtala Bagana	Associate (CHAI)	+2348060341169	MBangana@clintonhealthacess.org
Anita Okemini	Associate (CHAI)	+2348132036948	aokemini@clintonhealthaccess.org
Mrs Wuraola Adebayo	Health Research Officer, FMOH	+2348055171424	wuradebayo@yahoo.com
Dr Ogochukwu Chukwujekwu	Health Economist (WHO)	+2348054021288	Chukwujekwuo@who.int

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

Nigeria is not reporting on CSO (Type A & B) fund utilisation in 2014

3. Table of Contents

This APR reports on Nigeria's activities between January – December 2013 and specifies the requests for the period of January – December 2015

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)			
	2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation
Total births	7,002,987	7,002,987	7,227,082	7,227,082	7,458,349	7,458,349
Total infants' deaths	420,179	420,179	361,354	361,354	261,042	261,042
Total surviving infants	6582808	6,582,808	6,865,728	6,865,728	7,197,307	7,197,307
Total pregnant women	8,753,733	8,722,121	9,033,853	9,033,853	9,322,936	9,322,936
Number of infants vaccinated (to be vaccinated) with BCG	5,462,329	6,614,771	5,926,207	6,865,728	6,488,763	7,197,307
BCG coverage	78 %	94 %	82 %	95 %	87 %	97 %
Number of infants vaccinated (to be vaccinated) with OPV3	5,134,590	6,076,321	5,629,897	6,522,442	6,261,657	6,981,388
OPV3 coverage	78 %	92 %	82 %	95 %	87 %	97 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,828,558	1,069,973	0	0	0	0
Number of infants vaccinated (to be vaccinated) with DTP3	1,645,702	972,169	0	0	0	0
DTP3 coverage	25 %	15 %	0 %	0 %	0 %	0 %
Wastage*[1]* rate in base-year and planned thereafter (%) for DTP	25	25	25	25	25	25
Wastage*[1]* factor in base-year and planned thereafter for DTP	1.33	1.33	1.33	1.33	1.33	1.33
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	3,873,729	5,413,227	6,385,127	6,385,127	6,693,495	693,455
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	3,873,729	4,918,416	6,385,127	6,385,127	6,261,657	5,973,183
DTP-HepB-Hib coverage	59 %	75 %	93 %	93 %	87 %	83 %
Wastage*[1]* rate in base-year and planned thereafter (%) *[2]*	25	25	25	25	25	25
Wastage*[1]* factor in base-year and planned thereafter (%)	1.33	1.33	1.33	1.33	1.33	1.33
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with Yellow Fever	5,134,590	5,658,051	5,629,897	5,658,051	6,261,657	6,261,651
Yellow Fever coverage	78 %	86 %	82 %	82 %	87 %	87 %
Wastage*[1]* rate in base-year and planned thereafter (%)	30	30	30	30	30	30

Wastage*[1]* factor in base-year and planned thereafter (%)	1.43	1.43	1.43	1.43	1.43	1.43
Maximum wastage rate value for Yellow Fever, 10 dose(s) per vial, LYOPHILISED	40 %	40 %	40 %	40 %	50 %	40 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Pneumococcal (PCV10)	0	0	3,819,800	611,795		6,477,576
Number of infants vaccinated (to be vaccinated) with 3 dose of Pneumococcal (PCV10)	0	0	3,819,800	360,279		5,397,980
Pneumococcal (PCV10) coverage	0 %	0 %	56 %	5 %		75 %
Wastage*[1]* rate in base-year and planned thereafter (%)	10	1	10	1		1
Wastage*[1]* factor in base-year and planned thereafter (%)	1.11	1.01	1.11	1.01		1.01
Maximum wastage rate value for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	10 %	10 %	10 %	10 %	0 %	10 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	5,134,590	6,581,099	5,629,897	6,581,099	6,261,657	6,581,099
Measles coverage	78 %	100 %	82 %	96 %	87 %	91 %
Pregnant women vaccinated with TT+	6,807,090	4,630,899	7,385,169	7,385,169	8,086,220	8,086,220
TT+ coverage	78 %	53 %	82 %	82 %	87 %	87 %
Vit A supplement to mothers within 6 weeks from delivery	45,194	0	49,302	0	53,410	0
Vit A supplement to infants after 6 months	2,214,560	0	2,415,883	2,415,883	2,617,206	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	10 %	9 %	0 %	0 %	0 %	0 %

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [(A B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

2 GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2013.** The numbers for 2014 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  No changes

- Justification for any changes in **surviving infants**

  No changes

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  The focus on vaccine availability, timely funding release, capacity building, intensified supportive supervision to poor performing States/LGAs, intensified routine immunization activities in low performing States/LGAs, accountability and data tool availability ensured the abilityto achieve the high target

- Justification for any changes in **wastage by vaccine**

  No changes

5.2. Immunisation achievements in 2013

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2013 and how these were addressed:

In 2013, the country experienced significant improvements in Routine Immunization outcomes. The coverage of DPT containing antigens increased from a baseline of 52% in December 2012 to 84% in December 2013. Other antigens with coverage above the target included: BCG (94%), OPV (87%), and Measles (94%). Antigens with coverage below target were YF (81%) and TT (53%). This coverage report is based on the 2013 administrative data. However, DQS was conducted with a correction factor of 95%.

Key Major activities / Achievements in 2013:

Several key activities were conducted in 2013 that contributed to the observed significant improvements in coverage rates; and these included the following:

1. Procurement of adequate quantity of required routine vaccines and timely distribution to the sub-national levels. these resulted in the availability of adequate vaccines at the health facilities and out reach sites for Routine Immunization.

2. New vaccine introduction: the completion of **DTP-HepB-Hib** introduction nationwide allowed for Cold Chain maintainance, refresher trainings and routine immunization data tools production / distribution to States/LGAs/Health facilities. These contributed to the improved coverage observed in 2013.

3. Formation and reactivation of 702 Ward Development Committees (WDCs). This contributed to the improvement in the community structure for the implementation of PHC with resultant increase in the demand for and quality of services (as shown by the WDC assessment survey conducted in Nov 2013).

4. Training and capacity building of health workers: There has not really been any major training for health workers and managers in the country since after the MLM training in 2009. The Penta Introduction in 2013

provided an oppputunity to train at least three (3) health workers per health facility offering RI. There was also training on DVD-MT, SMT and Vaccine Management. All the RI intensiifcation projects also had training component as one of the strategy. BMGF supported training activities in 56 LGAs; and CDC supported 100 LGAs. This has also significantly contributed to improvement in the service delivery.

5.Prioritizing 230 LGA's for focused intervention: Intensification of Routine Immunization activities in 230 poor performing or high priority LGAs in Polio Endemic States and LGAs with high number of un-immunized children in the Polio free states (including LIDs). E.g is the reduction in the number of un-immunized children seen in 17 cVDPV LGAs. This has contributed to very significant reduction in the number of WPVs in the country.

6. Intensification of supportive supervision: There was improved supportive supervision from the national level to poor performing states by the Hon. Minister for Health and the Executive Director and others (e.g of states visited included: Benue, Abia, Anambra, Bayelsa, Cross Rivers, Kano & Nasarawa States). This contributed to the improvement in services and immunization outcomes.

7. Conducted 8 rounds of stand alone Polio Supplemental Immunization Activities (6 SIPDs and 2 NIPDs); and reaching an average of 96% in all the rounds conducted. This has also contributed to the reduction in the number of WPVs in the country.

8. Conducted measles follow up campaign, reaching 30,579,666 children aged 9-59 months nationwide (with a national average of 105%). This contributed to the reduction in the number of cases, morbidity and mortality from measles.

9. Conducted MenAfriVac campagn in 8 states, namely; Adamawa, FCT, Kaduna, Kebbi, Nassarawa, Niger, Plateau and Taraba (with a national coverage of 102%). This contributed to the reduction in the number of cases, morbidity and mortality from measles.

Major Challenges experienced:

1. Denominator for Routine Immunization in Nigeria continues to be a major issue. This becomes pronounced with increasing administrative coverage as demonstrated in 2013. However NPHCDA and Partners are working with National Population Commission to address the issue.

2. Slow utilization of ISS funds by the states / LGAs (due to late / delayed retirements). This resulted in the delay in the disbursement of funds from the national to the states / LGAs. Available ISS funds in-country was therefore used for the pentavalent vaccine introduction in the country (since NIG was not available). This resulted in an insignificant balance in the country to carry out any of the major planned activities (ISS or HSS).

3. There was also delay in the submission of the External Audit Report for 2009 to 2012 and this led to the delay in the release of outstanding HSS balance from GAVI Sectretariat. When the External Audit Report was finally ready in April 2013, there was another issue related to a change in the HSS & ISS bank accounts due to the delay in obtaining the Hon Minister for Finance Signature for the new accounts. Outstanding HSS balance did not come from GAVI Headquarters till ending of October 2013; and because of the need for quality only a few of the major planned HSS activities for 2013 could be implemented between the October and December 2013 due to the short time. Most of the planned major HSS activities like procurement of cold chain equipment and training of health workers on integrated PHC could not be implemented in 2013 because of the limited time.

4. The delay in the release of part of the outstanding HSS funds led to the extension of the HSS phase 1 re-programming from December 2013 to June 2014 by GAVI to enable the implementation of the pending major HSS activities. The implementation of these activities in 2014 could not start on time because of the delay in the approval of the 2014 work-plan. The 2014 HSS work-plan was approved during the second ICC meeting on 27th March 2014. Plans were just being concluded for the implementation of the approved pending activities when we received a 'Put on Hold' notice from GAVI headquarters following the recent CPA provisional report.

5. Funds borrowed from the ISS account for other activities during the earlier part of 2013 was returned to the ISS account when the HSS part payment was made in October. However, about USD 11 million was expected to remain as unspent fund by ending of June 2014. After discussions with the GAVI Secretariat, a proposal was submitted to the ICC and approval obtained on the priority ISS activities that could be implemented with the expected unspent funds before the end of the phase 1 support in June 2014. 'No Objection' is still being awaited from the GAVI Secretariat before these reprogrammed ISS activities can be

implemented.

6. Another challenge was the poor involvement of the private sector in routine immunization activities. Memorandum of Understanding was signed with several Private Practitioners through the States Ministry of Health to make vaccines available at these private facilities. This has resulted in the improved participation of the private sector in the routine immunization activities.

7. Huge Security challenges especially in the north eastern states, namely; Adamawa, Borno and Yobe. This has slowed down (and sometimes hinder) the implementation of planned activities in these state. To protect staff against attacks in these states, indigenes were trained and utilized for vaccine service delivery. The country also utilized mobile teams, health camps and fire-walling mechanisms.

5.2.2. If targets were not reached, please comment on reasons for not reaching the targets:

The country was not able to reach the projected TT coverage target in 2013. This is more of a demand side issue. There is poor awareness about the TT vaccine. Only 3 states conducted more than 80% of community link activities; and there is no sponsorship for the implementation of proposed activities to improved the TT coverage in the identified states. There is need for improved sensitization activities.

Due to the late release of HSS funds in 2013 and the need for quality time for quality training, the training of health workers did not take place in 2013 (but postponed to 2014). So, the target of training about 7,000 health workers in 2013 was not met.

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
National Immunization Coverage Survey (NICS)	2010	52	48
National Health Demographic Survey	2008	35.6	35.3

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

From survey reports, the ratio is 1:1. There is no discrepancy between male and female.

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

The country is transiting towards the DHIS platform. The new data collection format when fully implemented would enable break down of coverage by gender.

5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)

There is wide discrepancies in immunization coverage from different data sources (administrative, DOS and

Community survey). In order to ensure data quality, Data Quality Self assessment (DQS) is conducted in the country annually. A community survey component was included in the just concluded DQS. It was observed that the proportion of children who were up to date with their immunization was 69% as against 84% administrative coverage. The NDHS coverage for 2013 was estimated at 38%. This discrepancy can be attributed to the fact that the 2013 survey covered children from age 12-23 months, and so this covered children born in 2012 when coverage in Nigeria was low (due to inadequate vaccine supply that year).

* Please note that the WHO UNICEF estimates for 2013 will only be available in July 2014 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

Nigeria has recently (February 2014) conducted a data quality self assessment in which the correction factor was 95%. The DQS was conducted to verify the routine immunization administrative data for 2013. It compares the information in the primary data tool (tally sheet) with that in the LGA summary sent to the state.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2011 to the present.

Several activities have been undertaken to improve data quality in the country. These include the following:

1. The establishment of the data harmonization committee with the mandate to ensure that all data for routine immunization was housed under the Nigerian government;

2.The decision by the government to transit to the DHIS 2 platform which would allow for data harmonization amongst programs under one platform. This move also led to data management training and timely provisionof data management tools;

3. Additionally, the country have instituted monthly data quality checks;

4. An annual DQS coordinated at the national (in collaboration with all immunization partners) to ensure improved data quality. Some states / LGAs currently conduct Data Quality Self Assessment (DQA);

5. Training of health workers during the penta introduction and the training on data management; and

6. Production and distribution of data capturing tools to the states, LGAs and health facilities (during the penta introduction between 2012 and 2013).

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

1. Complete transition to the DHIS. Revised DVD-MT;

2. Training and re-trainings of health workers on data capturing and use of data for actions;

3. Improvement in supportive supervision at all levels; and

4. Correction of the denominator factors through the on-going collaborations of the immunization partners with the national planning commission.

5. Sustained production and distribution of data capturing tools to the states / LGAs / Health facilities.

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 155	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2013	Source of funding						
		Country	GAVI	UNICEF	WHO	CDC	CHAI	EU
Traditional Vaccines*	28,539,102	28,539,102	0	0	0	0	0	0
New and underused Vaccines**	45,225,406	12,090,406	33,135,000	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	0	0	0	0	0	0	0	0
Cold Chain equipment	3,068,681	0	0	2,420,295	0	0	648,386	0
Personnel	4,249,868	1,514,337	286,451	1,271,499	0	0	1,177,581	0
Other routine recurrent costs	5,796,978	477,327	0	1,811,500	1,840,375	0	1,538,744	129,032
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	188,842,454	185,842,454	0	0	0	0	0	3,000,000
BMGF: Polio SIAs: 30,268,135 AFP Surveillance: 4,943,843 RI: 1,300,000 Polio Lab.: 126,096 Surge Capacity: 13,000,000 KFW: Polio SIAs: 18,789,099 CIDA: Polio SIAs: 9,709,780 RI: 150,000 DFID: Polio SIAs: 1,707,885 AFP Surveillance: 4,476,760 Surge Capacity: 3,303,374 AusAid: Polio SIAs:3,804,612 USAID: Polio SIAs: 3,000,000 Korea: AFP Surveillance: 934,579 GAVI : Routine EPI: 280,000 SWISS: MenafriVac: 211,382 UNF: Measles Surveillance: 595,000 and Measles SIAs: 947,000		0	0	0	0	0	0	0
Total Expenditures for Immunisation	275,722,489							
Total Government Health		228,463,626	33,421,451	5,503,294	1,840,375	0	3,364,711	3,129,032

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2014 and 2015

NA

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Implemented**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?
The aide memoire governing cash management of GAVI grants started in 2009 and was signed in August 2012	Yes

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

1. A detailed job description for the RI consultants has been developed
2. Regular review meetings with states and other stakeholders
3. Submission of work plans and budgets to ICC as the need arises
4. Training of NPHCDA/State/LGA finance staff on the GAVI financial guidelines
5. Revision of the procedures for allocating GAVI ISS funds to the states and LGAs
6. Maintenance of cash book fortransactions of all national level expenditures and disbursement tosub-national entities along with fully reconciled bank accounts
7. Signing of Aid Memoire
8. Completion and submission of ISS financial statements for years 2008 – 2012
9. GAVI Procurement Committee with membership from partners has been established and inaugurated.
10. Annual External Auditing of GAVI funds disbursed.

If none has been implemented, briefly state below why those requirements and conditions were not met.

NA

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2013? **6**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

The 2013 Annual Progress Report was presented at the 3rd ICC meeting which was chaired by the Honourable Minister of Health held in the conference room Federal Ministry of Health on Tuesday 13th May 2014. At this meeting the 2013 APR was among other things presented to the ICC and was unanimously endorsed for submission to GAVI.

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
HERFORN : Health Reform Foundation of Nigeria
CHAI: Clinton Health Access Initiative
ROTARY international
Red Cross Society

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI programme for 2014 to 2015

1. Logistics:

- Guarantee 100% adequacy of bundled quality vaccines for safe immunizations at all times.

- Revamp the sub-national levels (LGA and HFs) cold chain infrastructure functionality from 47% to 80% of EVM standards by end of 2014. This includes: Adequacy of bundled vaccines at all levels,Real-time stock data management, procurement of additional cold chain equipment, PQS adherence, Planned Preventive Cold chain maintenance, PPP for transport and Expand the use of incinerations for waste disposal.

2. Service delivery: Ensure that 100% of wards implement reach every ward strategy by June 2014. This includes: To Improve micro-planning process that is community linked, Increase fixed sessions, Increase outreach sessions, Private Provider's engagement, monitor AEFIs, VPD and emergencies insecurity inclusive.

3. Human Resources for Health (HRH): Strengthen EPI related capacity of frontline work-force in at least 80% of the service points by 2015. This includesOptimize EPI Workforce, Integrated training for frontline health workers, and Strengthening of supportive supervision.

4. Health Management Information Systems (HMIS): Improve the quality of all components (recording, reporting, core output analysis, use of data for action, archiving,demographic information) of the RI monitoring system to a minimum of 80% as measured by data quality self-assessments in the context of the NHMIS by 2015.This includes Data quality, National data management, Health facility data management and data feedback.

5. Community Participation and Ownership: Create demand for RI beyond behaviour change to social transformations by changing level of awareness from less than 50% to 80% by2015. This includes: Demand creation, Community engagement, Advocacy to political leadership

6. Leadership and Governance:

- Establish an accountability framework at all levels for RI that isimplemented by all stakeholders from January 2014 onwards.

- Eliminate delays in funding service delivery through increase and basket funding for RI in 80%of LGAs.

- Support efforts to bring primary health care delivery under one roof through implementation of functional SPHCDAs. This includes:Accountability, Operational funding, Basket funding, financing vaccines procurement, SPHCDA functionality and SPHCDA funding

7. Partnerships and Program Integration

- Support the roll-out of new vaccines (Penta., PCV, Rota, HPV, Td, MRV and IPV) in all states between 2013 to 2015.

- Continuously link polio campaigns and other health interventions in an integrated manner to strengthen the overall PHC system. This includes: New and Underutilized Vaccine Implementation, Polio Eradication Initiative and other interventions

8. AEFI training for phase 2states, Quarterly supportive supervision to PBM sentinel sites and capacity building of site coordinators

9. Research for RI: Conduct research directed at identifying strategies to improve RI and health systems and evaluate impact of health programs.

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
BCG	AD Syringes	GoN
Measles	AD Syringes	GoN
TT	AD Syringes	GoN
DTP-containing vaccine	AD Syringes	GoN and GAVI

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

We don’t have problems implementing it

Please explain in 2013 how sharps waste is being disposed of, problems encountered, etc.

Safety boxes are collected at health facility leveland disposed using the burn and bury method. We have also recently procured 41 incinerators through GAVI supportwhich have been installed in 12 states

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2013

	Amount US$	Amount local currency
Funds received during 2013 *(A)*	55,861,134	8,658,475,770
Remaining funds (carry over) from 2012 *(B)*	6,105,490	946,351,151
Total funds available in 2013 *(C=A+B)*	61,966,624	9,604,826,921
Total Expenditures in 2013 *(D)*	32,128,508	4,979,918,864
Balance carried over to 2014 *(E=C-D)*	29,838,116	4,624,908,057

6.1.1. Briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

A dedicated Bank Account is open for all GAVI Funds and managed from the National Primary Health Care Development Agency (NPHCDA) with signatories from NPHCDA, FMOH and UNICEF / Rotary International. An annual work-plan with budget is presented to the Inter Agency Coordinating Committee (ICC) chaired by the Hon Minister for Health for approval. Implementing Agencies and Departments execute this Work Plans and budgets in accordance with the terms and conditions specified in the Aid Memoire.

NPHCDA releases the ISS funds from the national account to the states Ministry of Health (SMOH) account by electronic transfers based on the approved budgets. The states in turn releases the funds to the LGAs for the specified activities at the LGAs / health facilities. Funds from the states to the LGAs was by cash, but this was changed in September 2013 after the national consultative meeting with the State Commissioners for Health (and some other State Officers). States now do electronic transfer to the LGAs.

The LGAs after implementation of planned activities retire back to the state and state retire to the national. This process of retirement from the states / LGAs to the national has been very slow. According to the national policy, reimbursement from National to the states are only possible when the retirement from the states is completed. The challenge include lack of capacity by state to assess ISS funds as when due (i.e. on a quarterly basis). This results in untimely retirement of funds disbursed to states for reimbursement there by leading to slow implementation of GAVI ISS funded activities. So, it is not an issue of delays in availability of funds for programme use, but delayed retirement resulting in delayed reimbursement. However, training on the retirement process was conducted for the states / LGAs finance officers in December 2013 / January 2014; and so, the process is expected to improve.

Please note that ISS funds have not been included in the National Health Sector Plans and Budget. ISS funds is used mostly for operational support to the states and LGAs to support immunization activities at the sub-national levels. Budget planning cycle of the states is not synchronized with that of the national.

Funds from the national for the payment of the RI Consultants are sent from the national to the zones for payment of the monthly transport allowances to the RI Consultants. Payments are made only after the GAVI Consultants have submitted their monthly reports to the national, state and zonal offices.

6.1.2. Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process

The ISS funds at the national are domiciled in commercial banks approvedby ICC.

ISS funds are transferred from the NPHCDA at the national by electronic transfer to State GAVI dedicated accounts based on the approved available budgets. The payment to the states from the national is made after every six (6) months. Based on the national policy, reimbursement from the national to the states are only possible after completion of the retirement processes from the state.

From the state Ministry of Health GAVI dedicated accounts funs are transferred to the LGAs. Before September, this used to be by cash payment, but has now been changed to electronic transfers after the

consultative meeting with the states. This has improved the payment and retirement process at that level.

At the LGA level, the fund is released to the in-charge of the health facilities and other LGA officers for the implementation of the planned activities. After implementation of the planned activities, retirements are made from the health facilities to the states and then the states to the NPHCDA zonal offices / headquarters.

In the new arrangements, auditors at the zonal offices look at the documents and recommend to the zonal coordinator who then passes the document to the NPHCDA headquarters. The Account / Audit Units at the headquarters do the final checking and then reimbursement made to the states concern.

The states are advised to retire after every three months so that there would be funds for the activities at the lower levels at all times. if states retire after 3 months, there is still 3 months funds to continue with the activities while processing the reimbursement of the first 3 months earlier retired.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2013

1. Payment of ISS operational funds to the states / LGAs: Fund (USD 1,505,070) was transfered to 19 States to support thefollowing activities: State cold chain maintenance 2.State supportive supervision 3. State social mobilization 4. LGA Cold chain maintenance5. LGA Supportive supervision 6. LGA Review meetings 7. LGA Vaccine collection 8.Health Facility Communityannouncement 9.Health Facility Outreach services 10. Health Facility Vaccine distribution.

2. Payment of transport allowance for RI GAVI consultant in each of the 36 states plus FCT.

3.Payment of activities for the phase 2 and 3 introduction of pentavalent vaccines in 23 states: NVI grant was not received on time and the ISS fund in-country during the early part of the year was used for the introduction of penta valent vaccines in the 23 states. The introduction provided opportunity of training of health workers, provision of data management tools etc. This contributed significantly to the improvement of immunization services and outcomes in 2013.

4. Payment of activities for the 2013 DQS exercise. this was useful for the determination of the verification factor and JRF Reporting.

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **No**

6.2. Detailed expenditure of ISS funds during the 2013 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2013 calendar year (Document Number 7) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **Yes**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 8).

6.3. Request for ISS reward

Request for ISS reward achievement in Nigeria is not applicable for 2013

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2013 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2013 vaccinations against approvals for 2013

	[A]	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
DTP-HepB-Hib	17,184,000	26,216,410	0	No
Pneumococcal (PCV10)	0	0	0	Not selected
Yellow Fever	7,774,400	1,000,000	4,023,800	Yes

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  The Nigeria government purchased excess doses of 11,074,410 DTP-HepB - Hib in 2013.

  There was carry over of Yellow fever doses from 2012 into 2013.

  3,750,600 doses of yellow fever was actually shipped in 2013 as opposed to the 7,774,400 in the decision letter.

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

  The country is in the process of deploying an Enterprise Resources Planning (ERP) system to track vaccine stock and stockmovements in real-time down to state level. This will allow for visibility ofstack levels and better timing of incoming vaccine shipments. VaccineManagement training has also been conducted down to state level staff is inprogress at present.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

Stock out was exprerienced in Benue and Nasarawa states

7.2. Introduction of a New Vaccine in 2013

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2013, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	Yes	01/06/2012
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Phases 2 and 3 were accelerated due to anticipated global shortage of DPT

Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID		
Phased introduction	Yes	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	NA

Yellow Fever, 10 dose(s) per vial, LYOPHILISED		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	The campaign was split into 2 because of vaccine availability

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **June 2014**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

The country conducted External PIE for phase I states (March 2013) and Internal PIE for phase II states (September 2013).There was no plan for external PIE for phase II and internal PIE for phase 3 states in 2013. Plans are underway for external PIE for all phase 3 states in June 2014.

Following the external PIE, a New Vaccines Strategic Group (NVSG) was constituted to implement the recommendations. A Plan of Action has been developed with time line for implementing the recommendations. (see document attached). The following recommendations from the PIE have been implemented: (1). All Phase 3 introducing states developed their **DTP-HepB-Hib**. Introduction plan, (2). The NPHCDA Operations room monitored the implementation of state specific plans, (3). Contract for printing of data tools for phase 3 states was awarded on time, (4) Phase 3 states conducted cold chain capacity assessment to determine gaps, and (5). An additional day will be added to **DTP-HepB-Hib** training at the Health facility level as recommended in the PIE.

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Yes**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

<?xml:namespace prefix = "o" />

PBM data was collected from Five (5) sites.

1. Site: LUTH(Lagos)

Specimen: CSF

Assay: Bacteriology

Technique: Latex

No/month: 23

No analyzed/year: 238

No of Isolates: Meningitis-0, HIB-0, Strep pneumonieae-2,strep group B-0, other strep-0

2. Site: UNTH(Enugu)

Specimen: CSF

Assay: ---

Technique: Culture

No/month: 4

No analyzed/year: 203

No of Isolates: Strep pneumonieae-2

3. Site: ESUTH(Enugu)

Specimen: CSF

Assay: Analysis and Culture

Technique: Latex& Binax

No/month: 1

No analyzed/year: 87

No of Isolates: **

4. Site: UITH (Ilorin)

Specimen: CSF

Assay: Analysis and Culture

Technique: Latex & Binax

No/month: 3

No analyzed/year: 104

No of Isolates: 1

5. Site: UTBU (Bauchi)

Specimen: CSF

Assay: Analysis and Culture

Technique: Latex & Binax

No/month: 3

No analyzed/year: 13

No of Isolates: 1(Neisseira Meningococcus)

ROTAVIRUS

Site: UNTH (Enugu)

Specimen: Stool

Assay: Serology

Technique: ELISA

No/month: 4

No analyzed/year: 793

Positive: 204 (51%)

Rota Serotypes: C/G12P(8)

Site: UITH (Ilorin)

Specimen: Stool

Assay: Serology

Technique: ELISA

No/month: 3

No analyzed/year: 13

Positive: 0

Rota Serotypes: *

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	4,311,474	668,278,470
Remaining funds (carry over) from 2012 (B)	0	0
Total funds available in 2013 (C=A+B)	4,311,474	668,278,470
Total Expenditures in 2013 (D)	4,311,474	668,278,470
Balance carried over to 2014 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

Conducted National State and LGA training for phase 3 cluster A and B states (16 states), conducted PIE in Penta phase II states, printing of data tools and IEC materials and carried out sensitization of key stakeholders.

Please describe any problem encountered and solutions in the implementation of the planned activities

DTP-HepB-Hib introduction in phase 3 states 3 states was done in 2 phases: phase 3a (July 2013) and phase 3b (December 2013) and this was as a result of excess DPT stock in country as at that time. The phasing was necessary to avoid wasting of DPT vaccines.

Please describe the activities that will be undertaken with any remaining balance of funds for 2014 onwards

NA

7.4. Report on country co-financing in 2013

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	9,548,432	11,074,417
Awarded Vaccine #2: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	0	0
Awarded Vaccine #3: Yellow Fever, 10 dose(s) per vial, LYOPHILISED	2,541,973	4,300,000

	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?	
Government	12467950	
Donor	28161558	
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2,455,952	
Awarded Vaccine #2: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	0	
Awarded Vaccine #3: Yellow Fever, 10 dose(s) per vial, LYOPHILISED	1,211,173	
	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	August	GoN
Awarded Vaccine #2: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	August	GoN
Awarded Vaccine #3: Yellow Fever, 10 dose(s) per vial, LYOPHILISED	August	GoN
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	High level advocacy is being done to the partners and presidency to ensure early release of funds taking into consideration the planned election in 2015	

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **No**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **November 2010**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **Yes**

If yes, provide details

TheEVM process is about entrenching good storage and distribution practices. Thepackage has been designed so that it can also be used both as an assessmenttool for the systematic analysis of strengths and weaknesses across the supplychain and also as a supervisory aid to monitor and support the long-termprogress of individual facilities.

Subsequentto the EVM Assessment conducted in 2011, an improvement plan was developedbased on the EVMA recommendations to systematically address weaknesses in thevaccine supply chain in Nigeria. Activities have been assigned to each tier ofthe supply chain. Although significant progress has been made, particularly atNational level, there are still some high priority activities that need to becarried out at all levels of the supply chain.

National LevelProgress:

Atthe National level, great progress has been made with several of theimprovement activities having been achieved (84%), partly achieved (9%) or inprogress (5%). Of concern is that there has been no progress on rehabilitationof the existing dry store with the fitment of organized shelving and theprovision of step ladders. The zonal stores, which are part of the nationalsupply chain tier, have made some progress, with five out of the six zonalstores having sufficient dry storage capacity, however only 2 out of the sixzonal stores have shelving. The remaining stores make use of pallets to storesyringes and safety boxes. Five out of six of the zonal stores have contingencyplans in place (with the remaining store in the process of developing one).Only 50% of these zonal stores provide Persona; Protective Equipment (PPE) tostaff working in cold rooms. A significant improvement in maintenance is noted,with a contract in place for preventative maintenance and emergency repairs.100% of the stores in the national supply tier (NSCS & Zonal stores) areserviced by this contract. Another improvement is the availability ofdistribution plans for all of the stores. Only 4 out of the 6 stores receiveregular supportive supervision from the next level.

State Level Progress

Improvementsat the state level have been less impressive, with only 53% of tasks achieved,22% partly achieved, 12% in progress and 12% not achieved. Dry storage areas atstate level is still concern, with 41% of states still lacking sufficientstorage capacity and 82% lacking adequate shelving. Personal ProtectiveEquipment for working in cold rooms has also not been provided in 76% of thestates. The accurate recording of wastage remains an issue. This needs to beraised with the Data Harmonization Committee for incorporation into datacollection tools and ultimately DHIS2. Temperature monitoring has improved,with a number of activities underway, including a temperature monitoring study.A number of state cold rooms have also had continuous temperature loggers withsms alert capability installed. Majority of states (76%) have developedcontingency plans which were introduced in the vaccine management training.Storage capacity is currently being addressed under the introduction plan ofthe new vaccines. Only 41% of state stores conduct regular preventativemaintenance; however maintenance guidelines are in the process of beingdeveloped and basic user maintenance was introduced as a module in the vaccinemanagement training undertaken in quarter 4 of 2013. 91% of the states havedeveloped distribution plans and share these with the LGAs. Job aids andfinalization of the existing SOPs is also in progress.

LGA Level Progress:

Improvementsat the LGA level have been steady, with 69% of tasks achieved, 21% in progressand only 10% not achieved. Again adequate, well organized dry storage capacityremains an issue. Supportive supervision has improved, with many states nowperforming supervisory visits on a routine basis. Vaccine storage capacityremains a challenge, but should be addressed with the plans to procure batteryand solar directive drives refrigerators for each ward. Planning for the statelevel vaccine management training (where the LGA level will be trained) isunderway, with a few states having confirmed their training dates. This shouldbe

finalized by April 2014.

Health Facility LevelProgress:

Atthe Health Facility level, 56% of tasks have been achieved, 19% partlyachieved, 10% in progress and 6% not achieved. One of the most notableachievements is the revision of the supportive supervision checklist to includemonitoring of vaccines and devices. The repair of solar refrigerators and thedevelopment of job aids is partly achieved. Training on vaccine management,development of planned preventative maintenance policies and vaccine disposalSOP are in progress and should be achieved shortly. A significant challenge hasbeen the renovation of health facilities and addressing the poor drainagesystems and other infrastructure inadequacies. On the positive side, 82% ofstates conduct supportive supervision at the LGA level.

Note:Data from Borno, Gombe & Jigawa was not available at the time of thisreport.

When is the next Effective Vaccine Management (EVM) assessment planned? **September 2014**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

7.6.1. Vaccine Delivery

Did you receive the approved amount of vaccine doses for Meningococcal type A Preventive Campaigns that GAVI communicated to you in its Decision Letter (DL)?

[A]	[B]	[C]
Total doses approved in DL	**Campaign start date**	**Total doses received (Please enter the arrival dates of each shipment and the number of doses of each shipment)**
22886000	02/11/2013	21878000 (6th October 10,952,000: 10th October 10,926,000

If numbers [A] and [C] above are different, what were the main problems encountered, if any?

No explanation

If the date(s) indicated in [C] are after [B] the campaign dates, what were the main problems encountered? What actions did you take to ensure the campaign was conducted as planned?

Not applicable

7.6.2. Programmatic Results of Meningococcal type A preventive campaigns

Geographical Area covered	Time period of the campaign	Total number of Target population	Achievement, i.e., vaccinated population	Administrative Coverage (%)	Survey Coverage (%)	Wastage rates	Total number of AEFI	Number of AEFI attributed to MenA vaccine
Eight States	2nd – 11th November 2013	22339165	22796829	102	95	11	14016	0

*If no survey is conducted, please provide estimated coverage by indepenent monitors

Has the campaign been conducted according to the plans in the approved proposal?" **No**

If the implementation deviates from the plans described in the approved proposal, please describe the reason.

The campaign phases and dates had to be changed basedon vaccine availability from suppliers

Has the campaign outcome met the target described in the approved proposal? (did not meet the target/exceed the target/met the target) If you did not meet/exceed the target, what have been the underlying reasons on this (under/over) achievement?

Target was met and exceeded

What lessons have you learned from the campaign?

- Planning and coordination at state and LGA levels need to be closely supervised by national level
- Early release of funds is essential to ensuring quality campaign (especially state funds)
- Late production and distribution of data tools and IEC materials led to inadequacy of these materials due to distribution problems

Logistics – Funds for team movement need to be augmented through advocacy to State and LGA policy makers

7.6.3. Fund utilsation of operational cost of Meningococcal type A preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
Planning	8618930	55606
Printing of data tools	166837660	1076372
Procurement of incinerators	305056740	1968108
Coverage survey	63926185	412427
Monitoring and supervision	136439990	880258
Total	**680879505**	**4392771**

7.7. Change of vaccine presentation

Nigeria does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2014

Renewal of multi-year vaccines support for Nigeria is not available in 2014

7.9. Request for continued support for vaccines for 2015 vaccination programme

In order to request NVS support for 2015 vaccination do the following

Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	200,000$		250,000$	
			<=	>	<=	>
DTP-HepB	HEPBHIB	2.00 %				
HPV bivalent	HPV	3.50 %				
HPV quadrivalent	HPV	3.50 %				
Measles second dose	MEASLES	14.00 %				
Meningococcal type A	MENINACONJUGATE	10.20 %				
MR	MR	13.20 %				
Pneumococcal (PCV10)	PNEUMO	3.00 %				
Pneumococcal (PCV13)	PNEUMO	6.00 %				
Rotavirus	ROTA	5.00 %				
Yellow Fever	YF	7.80 %				

Vaccine Antigens	VaccineTypes	500,000$		2,000,000$	
		<=	>	<=	>
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50 %	6.40 %		
HPV bivalent	HPV				
HPV quadrivalent	HPV				
Measles second dose	MEASLES				
Meningococcal type A	MENINACONJUGATE				
MR	MR				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Yellow Fever	YF				

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	6,582,808	6,865,728	7,197,307	20,645,843
	Number of children to be vaccinated with the first dose	Table 4	#	3,873,729	6,385,127	693,455	10,952,311
	Number of children to be vaccinated with the third dose	Table 4	#	3,873,729	6,385,127	5,973,183	16,232,039

	Immunisation coverage with the third dose	Table 4	%	58.85 %	93.00 %	82.99 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.33	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	11,826,880			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	11,826,880			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.26	0.68	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

NA

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

4

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2013	2014	2015
Minimum co-financing	0.23	0.26	0.30
Recommended co-financing as per APR 2012			0.30
Your co-financing	0.26	0.26	0.68

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

2014	2015

Number of vaccine doses	#	25,226,800	6,337,400
Number of AD syringes	#	21,662,200	4,629,500
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	238,300	50,925
Total value to be co-financed by GAVI	$	52,645,500	13,351,000

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2014	**2015**
Number of vaccine doses	#	3,590,300	3,020,700
Number of AD syringes	#	3,083,000	2,206,600
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	33,925	24,275
Total value to be co-financed by the Country [1]	$	7,492,500	6,363,500

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	12.46 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	3,873,729	6,385,127	795,507	5,589,620
B1	Number of children to be vaccinated with the third dose	*Table 4*	3,873,729	6,385,127	795,507	5,589,620
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	11,621,187	19,155,381	2,386,519	16,768,862
E	Estimated vaccine wastage factor	*Table 4*	1.33	1.33		
F	Number of doses needed including wastage	*D X E*		25,476,657	3,174,071	22,302,586
G	Vaccines buffer stock	*((D - D of previous year) x 0.333) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.333)*		3,340,160	416,142	2,924,018
H	Stock to be deducted	*H1 - F of previous year x 0.333*				
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*				
H2	Reported stock on January 1st	*Table 7.11.1*	0	11,826,880		
H3	Shipment plan	*UNICEF shipment report*		22,242,000		
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		28,817,000	3,590,235	25,226,765
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		24,745,096	3,082,927	21,662,169
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		272,197	33,913	238,284
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		55,472,725	6,911,202	48,561,523
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		1,113,530	138,732	974,798
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		1,361	170	1,191
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		3,550,255	442,317	3,107,938
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*		60,137,871	7,492,420	52,645,451
U	Total country co-financing	*I x country co-financing per dose (cc)*		7,492,420		
V	Country co-financing % of GAVI supported proportion	*U / T*		12.46 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2015		
			Total	Government	GAVI
A	**Country co-finance**	*V*	32.28 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	693,455	223,839	469,616
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	5,973,183	1,928,070	4,045,113
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	9,524,782	3,074,481	6,450,301
E	**Estimated vaccine wastage factor**	*Table 4*	1.33		
F	**Number of doses needed including wastage**	*D X E*	12,667,961	4,089,060	8,578,901
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.333) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.333)*	- 3,210,199	- 1,036,212	- 2,173,987
H	**Stock to be deducted**	*H1 - F of previous year x 0.333*	100,005	32,281	67,724
H1	**Calculated opening stock**	*H2 (2014) + H3 (2014) - F (2014)*	8,592,223	2,773,463	5,818,760
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*UNICEF shipment report*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	9,358,000	3,020,646	6,337,354
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	6,836,035	2,206,587	4,629,448
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	75,197	24,273	50,924
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	18,238,742	5,887,239	12,351,503
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	307,622	99,297	208,325
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	376	122	254
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	1,167,280	376,784	790,496
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	19,714,020	6,363,440	13,350,580
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	6,363,440		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	32.28 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.1: Specifications for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	6,582,808	6,865,728	7,197,307	20,645,843
	Number of children to be vaccinated with the first dose	Table 4	#	0	3,819,800	6,477,576	10,297,376
	Number of children to be vaccinated with the third dose	Table 4	#	0	3,819,800	5,397,980	9,217,780
	Immunisation coverage with the third dose	Table 4	%	0.00 %	55.64 %	75.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.11	1.11	1.01	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#				
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	0			
	Number of doses per vial	Parameter	#		2	2	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.69	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		3.00 %	3.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

NA

Co-financing tables for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2013	2014	2015
Minimum co-financing	0.00	0.20	0.23
Your co-financing	0.00	0.20	0.69

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2014	2015
Number of vaccine doses	#	15,001,300	17,382,600
Number of AD syringes	#	15,193,200	18,949,000
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	167,125	208,450
Total value to be co-financed by GAVI	$	53,080,000	61,190,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2014	2015
Number of vaccine doses	#	898,800	4,237,900
Number of AD syringes	#	910,300	4,619,800
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	10,025	50,825
Total value to be co-financed by the Country [1]	$	3,180,000	14,918,500

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID (part 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	5.65 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	0	3,819,800	215,908	3,603,892
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B x C*	0	11,459,400	647,724	10,811,676
E	Estimated vaccine wastage factor	*Table 4*	1.11	1.11		
F	Number of doses needed including wastage	*D X E*		12,719,935	718,974	12,000,961
G	Vaccines buffer stock	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		3,179,984	179,744	3,000,240
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Reported stock on January 1st	*Table 7.11.1*	0			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		15,900,000	898,722	15,001,278
J	Number of doses per vial	*Vaccine Parameter*		2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		16,103,323	910,214	15,193,109
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		177,137	10,013	167,124
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		53,916,900	3,047,564	50,869,336
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		724,650	40,960	683,690
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		886	51	835
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		1,617,507	91,427	1,526,080
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*		56,259,943	3,180,000	53,079,943
U	Total country co-financing	*I x country co-financing per dose (cc)*		3,180,000		
V	Country co-financing % of GAVI supported proportion	*U / T*		5.65 %		

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID (part 2)

		Formula	2015		
			Total	Government	GAVI
A	**Country co-finance**	*V*	19.60 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	6,477,576	1,269,675	5,207,901
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B x C*	19,432,728	3,809,024	15,623,704
E	**Estimated vaccine wastage factor**	*Table 4*	1.01		
F	**Number of doses needed including wastage**	*D X E*	19,627,056	3,847,114	15,779,942
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	1,993,332	390,715	1,602,617
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	21,620,400	4,237,831	17,382,569
J	**Number of doses per vial**	*Vaccine Parameter*	2		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	23,568,667	4,619,713	18,948,954
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	259,256	50,817	208,439
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	72,860,748	14,281,490	58,579,258
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	1,060,591	207,888	852,703
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	1,297	255	1,042
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	2,185,823	428,445	1,757,378
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	76,108,459	14,918,076	61,190,383
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	14,918,076		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	19.60 %		

Table 7.11.1: Specifications for Yellow Fever, 10 dose(s) per vial, LYOPHILISED

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	6,582,808	6,865,728	7,197,307	20,645,843
	Number of children to be vaccinated with the first dose	Table 4	#	5,134,590	5,629,897	6,261,651	17,026,138
	Number of doses per child	Parameter	#	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.43	1.43	1.43	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	1,177,000			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	1,709,647			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		1.11	1.88	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		7.80 %	7.80 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

NA

Co-financing tables for Yellow Fever, 10 dose(s) per vial, LYOPHILISED

Co-financing group	Intermediate

	2013	2014	2015
Minimum co-financing	0.34	1.11	1.16
Your co-financing	0.34	1.11	1.88

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2014	2015
Number of vaccine doses	#	585,700	- 5,906,500
Number of AD syringes	#	405,000	- 4,591,400
Number of re-constitution syringes	#	64,500	- 649,700
Number of safety boxes	#	5,175	- 57,650
Total value to be co-financed by GAVI	$	711,000	- 6,756,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

2014	2015

Number of vaccine doses	#	5,932,600	15,086,700
Number of AD syringes	#	4,102,200	11,727,800
Number of re-constitution syringes	#	652,600	1,659,600
Number of safety boxes	#	52,325	147,275
Total value to be co-financed by the Country [1]	$	7,203,000	17,259,000

Table 7.11.4: Calculation of requirements for Yellow Fever, 10 dose(s) per vial, LYOPHILISED (part 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	91.02 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	5,134,590	5,629,897	5,124,090	505,807
C	Number of doses per child	*Vaccine parameter (schedule)*	1	1		
D	Number of doses needed	*B x C*	5,134,590	5,629,897	5,124,090	505,807
E	Estimated vaccine wastage factor	*Table 4*	1.43	1.43		
F	Number of doses needed including wastage	*D X E*		8,050,753	7,327,449	723,304
G	Vaccines buffer stock	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		177,073	161,165	15,908
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Reported stock on January 1st	*Table 7.11.1*	0			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		6,518,200	5,932,585	585,615
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		4,507,056	4,102,129	404,927
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		717,002	652,585	64,417
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		57,465	52,303	5,162
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		7,130,911	6,490,248	640,663
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		202,818	184,597	18,221
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		2,869	2,612	257
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		288	263	25
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		556,212	506,241	49,971
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		20,598	18,748	1,850
T	Total fund needed	*(N+O+P+Q+R+S)*		7,913,696	7,202,705	710,991
U	Total country co-financing	*I x country co-financing per dose (cc)*		7,202,705		
V	Country co-financing % of GAVI supported proportion	*U / T*		91.02 %		

Table 7.11.4: Calculation of requirements for Yellow Fever, 10 dose(s) per vial, LYOPHILISED (part 2)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	164.34 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	6,261,651	10,290,418	- 4,028,767
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	6,261,651	10,290,418	- 4,028,767
E	Estimated vaccine wastage factor	*Table 4*	1.43		
F	Number of doses needed including wastage	*D X E*	8,954,161	14,715,297	- 5,761,136
G	Vaccines buffer stock	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	225,853	371,168	- 145,315
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Reported stock on January 1st	*Table 7.11.1*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	9,180,100	15,086,606	- 5,906,506
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	7,136,255	11,727,745	- 4,591,490
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	1,009,812	1,659,529	- 649,717
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	89,607	147,261	- 57,654
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	9,409,603	15,463,772	- 6,054,169
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	321,132	527,750	- 206,618
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	4,040	6,640	- 2,600
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	449	738	- 289
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	733,950	1,206,176	- 472,226
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	32,563	53,515	- 20,952
T	Total fund needed	*(N+O+P+Q+R+S)*	10,501,737	17,258,588	- 6,756,851
U	Total country co-financing	*I x country co-financing per dose (cc)*	17,258,588		
V	Country co-financing % of GAVI supported proportion	*U / T*	164.34 %		

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

   b. HSS implementation during January – April 2014 (interim reporting)

   c. Plans for 2015

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2014, the HSS reports are expected by GAVI Alliance by September 2014.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2013

   b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2013 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2013 and request of a new tranche

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **No**

If NO, please indicate the anticipated date for completion of the HSS grant.

End of June 2014

Please attach any studies or assessments related to or funded by the GAVI HSS grant.

Please attach data disaggregated by sex, rural/urban, district/state where available, particularly for immunisation coverage indicators. This is especially important if GAVI HSS grants are used to target specific populations and/or geographic areas in the country.

If CSOs were involved in the implementation of the HSS grant, please attach a list of the CSOs engaged in grant implementation, the funding received by CSOs from the GAVI HSS grant, and the activities that they have been involved in. If CSO involvement was included in the original proposal approved by GAVI but no funds were provided to CSOs, please explain why not.

In November 2013, NPHCDA and Partners carried out an assessment of the 499 Ward Development Committees (WDCs) formed through GAVI HSS support in 2010 to determine the functionality of the WDCs formed in the selected wards. About 80% of the WDCs formed are still functional and contributing to the increase in demand and improved services. Improvement was noticed in all the regions of the country. Copy of the detailed report is attached.

CSOs participated in the implementation of some of the HSS activities by providing support through their technical officers. Some of the CSOs providing support include CHAI, Rotary International and HERFON.

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

Please provide data sources for all data used in this report.

Please attach the latest reported National Results/M&E Framework for the health sector (with actual reported figures for the most recent year available in country).

9.1.1. Report on the use of HSS funds in **2013**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **No**

If yes, please indicate the amount of funding requested: US$

These funds should be sufficient to carry out HSS grant implementation through December 2015.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2008	2009	2010	2011	2012	2013
Original annual budgets	22098373	21439754	1165238			

(*as per the originally approved HSS proposal*)						
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)	22098490	0	0	0		12402439
Remaining funds (carry over) from previous year (*B*)	0	22098490	22098490	13026864	10432232	5059733
Total Funds available during the calendar year (*C=A+B*)	22098490	22098490	22098490	13026864	10432232	17462172
Total expenditure during the calendar year (*D*)			9267669	2495772	5372499	7411757
Balance carried forward to next calendar year (*E=C-D*)	22098490	22098490	13026864	10432232	5059733	11181531
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	11181531			
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	2570040779	2803247835	171989128			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)	2570054387					1937260971
Remaining funds (carry over) from previous year (*B*)		2889377567	3261737124	1936703870	1629514638	790330333
Total Funds available during the calendar year (*C=A+B*)	2570054387	2889377567	3261737124	1936703870	1629514638	272591305
Total expenditure during the calendar year (*D*)			1367907944	371046423	834187920	1157716507
Balance carried forward to next calendar year (*E=C-D*)	2570054387	2889377567	1922765126	1550959931	785624742	1746555267
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	1733137305			
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2008	2009	2010	2011	2012	2013
Opening on 1 January	116.3	130.75	147.6	148.67	156.2	155.27
Closing on 31 December	130.75	147.6	148.67	156.2	155.27	155

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2014 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements

at both the sub-national and national levels; and the overall role of the HSCC in this process.

The GAVI HSS fund is domiciled at UBA PLC Abuja, which is a commercial bank. It is a government account opened solely for the GAVI HSS grant. The signatories tothe account are as approved in an ICC meeting of Feb 28 2008 and these are:

A1. The Executive Director NPHCDA

A2. The Director of Finance and Accounts NPHCDA

B. The Director of Health Planning Research and Statistics Fed Min. of Health

C. WHO Country Rep in Nigeria/ Country Rep UNICEF Nigeria

The mandate is A B and C. It is not a cheque account and transfersare based on signed instructions.

The GAVI fund has been in same account since it was transferredfrom the GAVI Finance division in August 2008. Beneficiaries of this accountfor the reprogrammed HSS grant include:

The National Primary Health Care Development Agency (NPHCDA).

The Health Management Information Systems (HMIS) Unit of theDepartment of Health Planning, Research and Statistics of the FMoH.

Each beneficiary submits a work-plan in line with her objectives/Activities in the Proposal, which is approved by the Inter AgencyCoordinating Committee. All Funds are drawn directly from the National Level for all activities. Funds for HMIS are transferred to DPRS Project account, andthe signatories are the Director PRS and the Project Accountant.

The ICC oversees the implementation of the GAVI HSS grant. All the lead implementers of various objectives of the HSS grant have membership in theProject implementation committee. When there are changes in activity plans by an implementer, an approval is sought from the ICC. The committee reviews workplans of the various agencies and departments as needed and approves the release of funds for approved work plans. At the HPCC meeting, regular updatesof the HSS grant implementation are provided.

Once approval of work plan has been given and endorsed by the Honourable Minister of Health, the concerned agency or department applies for the approved fund and this is paid from theGAVI HSS account. If the request is in Local currency, the bank is instructed to convert the amount using the apex bank prevailing exchange rate.

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2013 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective 1: To constitute/ re-activate 702 Ward			

Development Committees in selected LGAs in Pentavalent vaccine introducing Phase 1			
Activity 1.1 Form/Reactivate and re-orientate Ward Development Committees in 702 Wards across the 14 Penta Phase_1 States by end 2013	Form/Reactivate and re-orientate Ward Development Committees in 702 Wards across the 14 Penta Phase_1 States by end 2013	100	Administrative reports
Activity 1.2: Develop, review/ update Ward Health Plan of 702 WDCs for sustaining community link to HFs by 3rd Qtr of 2013	Develop, review/ update Ward Health Plan of 702 WDCs for sustaining community link to HFs by 3rd Qtr of 2013	100	Administrative reports
Activity 1.3: Conduct monthly review meeting within the first year of formation of WDCs to institute sustainability and monitor the implementation of WHPs in 527 Wards (at least 75% by the end of 2013).	Conduct monthly review meeting within the first year of formation of WDCs to institute sustainability and monitor the implementation of WHPs in 527 Wards (at least 75% by the end of 2013).	100	Administrative reports
Activity 1.4: Monitor PHC activities including routine immunisation services at health facilities within their wards	Monitor PHC activities including routine immunisation services at health facilities within their wards	70	Administrative reports
Objective 2: To build human and institutional capacity for improved coverage in routine immunization by 2014			
2.1 Build the capacity of at least 50% of HWs on Integrated PHC service delivery in Phase 1 Penta. states by December 2014	Build the capacity of at least 50% of HWs on Integrated PHC service delivery in Phase 1 Penta. states by December 2014	0	
2.2 Train EPI Managers & vaccinators about Hib disease, storage, handling and safe vaccination with pentavalent vaccine in phase 2 penta states	Train EPI Managers & vaccinators about Hib disease, storage, handling and safe vaccination with pentavalent vaccine in phase 2 penta states	100	
2.3 Capacity building of LGA and state officials on adverse event reporting	Capacity building of LGA and state officials on adverse event reporting	0	
2.4 Determine the requirements essential for integrating pre-service training curricula targeting frontline health workers for immunization (by end of 2013)	Determine the requirements essential for integrating pre-service training curricula targeting frontline health workers for immunization (by end of 2013)	0	
Objective 3: To strengthen the NHMIS to ensure data quality, data analysis and utilization for informed decision making as well as programme monitoring and management in 300 LGAs by 2014			

Activity 3.1: Provision of data management tools and equipment in 14 phase one Penta States (HMIS minimum package)	Provision of data management tools and equipment in 14 phase one Penta States (HMIS minimum package)	100	
Activity 3.2: Training of health facility and LGA staff on paper based and electronic capture	Training of health facility and LGA staff on paper based and electronic capture	50	
Activity 3.3: Facilitate quarterly mentoring support to LGAs on electronic data capture by Consultants for 4 days	Facilitate quarterly mentoring support to LGAs on electronic data capture by Consultants for 4 days	50	
Activity 3.4 Institutionalize monitoring and supervision by building capacity on use of monitoring checklist and DQA tools as well as Enhance capacity to utilise data for informed decision making and generate information products (e.g. quarterly LGA health bulletins, annual State health profiles)	Institutionalize monitoring and supervision by building capacity on use of monitoring checklist and DQA tools as well as Enhance capacity to utilise data for informed decision making and generate information products (e.g. quarterly LGA health bulletins, annual State health profiles)	0	
Activity 3.5 Capacity building on Pedriatric Bacterial Meningitis (PBM) Surveillance	Capacity building on Pedriatric Bacterial Meningitis (PBM) Surveillance	0	
3.6 Setting up of 6 sentinel sites for Paediatric Bacterial Meningitis	Setting up of 6 sentinel sites for Paediatric Bacterial Meningitis	0	
3.7 Monitoring & Supervision	Monitoring & Supervision	50	Administrative report
Objective 4: To improve vaccine security and Logistics in phase 1 & 2 penta at States, LGAs and Ward levels			
4.1 To expand vaccine storage capacity in identified states, LGAs and HFs and improve vaccine distribution	Procure and install solar direct drives at LGA & HFs, Walk-In-Cold Rooms in 4 states and the NSCS, Vaccine carriers,	40	Project Implementation Team procurement documents
4.2 To improve vaccine management through provision of adequate training and improved cold chain monitoring	Procure and install temperature monitoring devices (SMS, Fridge Tags	40	Project Implementation Team procurement documents
4.3 To improve the capacity of HWs on cold chain maintenance and repairs	To improve the capacity of HWs on cold chain maintenance and repairs	20	Project Implementation Team procurement documents
4.4 To institute an efficient waste management disposal system in all states	Procure and install a 100kg capacity incinerators in 33 states including training on usage.	40	

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**

Objective 1: To constitute/ re-activate 702 Ward D	
Activity 1.1 Form/Reactivate and re-orientate War	735 WDCs were reactivated using the Participatory Learning Approach (PLA). A directory of the WDC members has been compiled for three zones and it is expected that this will be completed for all zones by the end of the second quarter of 2014.
Activity 1.2: Develop, review/ update Ward Health	The Ward Health Plans of the reactivated WDCs have been reviewed and updated. This was conducted as part of the PLA when the WDCs were being reactivated.
Activity 1.3: Conduct monthly review meeting withi	Based on the assessment carried out in the last quarter of 2013, the WDCs have conducted review meetings, most of them monthly; however, the lack of direct financial support for the review meetings has been a challenge.
Activity 1.4: Monitor PHC activities including rou	WDCs have made attempts to monitor activities at the health facilities within their wards, although this is not done comprehensively due to inadequacy of funds.
Objective 2: To build human and institutional capa	
2.1 Build the capacity of at least 50% of HWs on I	Approval has been obtained from the ICC for the training of 7000 health workers on integrated PHC service delivery. Awaiting no objection letter from GAVI for release of funds for the commencement of this activity in May 2014.
2.2 Train EPI Managers & vaccinators about Hib dis	A total of 30,830 health workers were trained in the phase 2 and 3 penta states with the vaccine introduction grant. The funds initially planned for this activity are being channeled to data management training in phase 2 and 3 states to be conducted in May 2014.
2.3 Capacity building of LGA and state officials o	AEFI training for Phase 1 Penta states will be conducted in May 2014.
2.4 Determine the requirements essential for integ	This is planned for May 2014.
Objective 3: To strengthen the NHMIS to ensure dat	The country was to procure 218 laptops however savings made from direct purchase was used to procure additional 282 laptops to make a total of 500 laptops. The laptops are in the process of being distributed to the LGA M&E officers.
Activity 3.2: Training of health facility and LGA	LGA M&E officers and the assistants as well as state program officers were trained on electronic data capture using DHIS 2. Paper based training will be concluded by May 2014
Activity 3.3: Facilitate quarterly mentoring suppo	255 LGAs have received 2 rounds of quarterly mentoring visits on DHIS 2 a third round will be conducted before end of June 2014.
Activity 3.4 Institutionalise monitoring and super	This has not commenced due to non-disbursement of funds from GAVI secretariat.
Activity 3.5 Capacity building on Pedriatric Bacte	This activity has been approved for implementation in 2014
3.6 Setting up of 6 sentinel sites for Paediatric	This activity has been approved for implementation in 2014
3.7 Monitoring & Supervision	Review meetings for PBM sites were conducted as planned. Supervisory visits for sentinel sites were also carried out. However supervisory visits on HMIS have not been implemented.
Objective 4: To improve vaccine security and Logis	
4.1 To expand vaccine storage capacity in identifi	The contract for procurement of Direct Solar Drive (1635) has been awarded and delivery and installation is being awaited.
.2 To improve vaccine management through provision	Training has been approved by the ICC. A no objection letter from GAVI is being awaited to commence training on cold chain management and equipment maintenance.
4.3 To improve the capacity of HWs on cold chain m	The proposal has been developed to conduct training after procurement of the cold chain equipment sometime in Sept 2014
4.4 To institute an efficient waste management dis	The procurement plan has been concluded and approved. GAVI CPA response has put on hold further procurement with GAVI funds.

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

There was a delay in the submission of the External Audit Report for 2009 to 2012 and this led to the delay in the release of outstanding HSS balance from GAVI Secretariat. When the External Audit Report was finally ready in April 2013, there was another issue related to a change in the HSS & ISS bank accounts due to the delay in obtaining the Hon Minister for Finance Signature for the new accounts. The outstanding HSS

balance was not received from GAVI Headquarters till ending of October 2013. As a result, only a few of the major planned HSS activities for 2013 could be implemented between October and December 2013, because of the need for quality Implementation. The delay in the release of the outstanding HSS funds led to the extension of the HSS phase 1 re-programming from December 2013 to June 2014 by GAVI to enable the implementation of the pending major HSS activities.

Major HSS activities planned for 2013, but could not be implemented because of the limited time, included the following: procurement of cold chain equipment, training of health workers on integrated PHC / cold chain management / data management; and monthly meetings / monitoring activities by the WDCs. The implementation of these activities in 2014 could not start on time because of the delay in the approval of the 2014 work-plan. The 2014 HSS work-plan was approved during the second ICC meeting on 27th March 2014. Plans were just being concluded for the implementation of the approved pending activities when we received a 'Put on Hold' notice from GAVI headquarters following the recent CPA provisional report. So, these activities are still yet to be implemented as at time of submission of this report.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

GAVI HSS grant was not used for human resource incentives during the period under review.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2012 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2013 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2009	2010	2011	2012	2013		
Proportion of WDCs formed/ reactivated and orientated				100					100	WDC survey 2013	
Proportion of WDCs whose WHPs were developed and reviewed				100					100		
% of WDCs that conduct at least 80% review meetings within the first year				100					100		
Proportion of health facilities that were visited on monthly basis				100					100		
Proportion of health workers in Penta. Phases 1 states trained on Penta introduction by March 2014				70					70		
Proportion of health workers in phase 2 states trained on penta vaccine by June 2013				70							Delays in implementation however training will be commenced in April 2014
Proportion of penta phase 2				100							

states using penta vaccine by April 2014											
Proportion of front line health institutions curriculum without immunization component											
Percentage of LGAs whose routine HMIS returns meet minimum requirement for data quality standard for informed decision making by 2014.	0								54	JAR/MTR 2013 report	
Percentage of LGAs in the phase 1 penta states having HMIS minimum package				100					100	Procureemnt report and distribution report	
Percentage of LGAs sending qualitative paper based data				0					0	the LGAs are no longer expected to send paper based reports	
Percentage of LGAs sending qualitative electronic data				41.3					41.3	NDHIS instance December 2013	
Percentage of LGAs reporting qualitative data to the state				41.3					41.3	NDHIS instance December 2013	
Number of functional PBM sites				0					0	This is planned for 2014	
Number of sentinel sites fully equiped				0					0	The provision of equipment for the sites will be done in 2014	
Proportion of LGAs and Wards/HFs with newly installed and functional SR that complied with PQS Standard											
Proportion of a set of spares available in the ratio of 1:10 units of equipment.											
Proportion of LGAs HF with installed and functional battery solar refrigerators.											
Proportion of LGAs and HFs with newly installed and functional SR that complied with PQS											

Standard											
Proportion of LGAs HF with installed and functional direct drive solar refrigerators											
Proportion of HFs with minimum requirements of VC for RI.											
Proportion of states with functional WICR.											
Proportion of vaccine stores with ability to monitor and prevent stock outs.											
Proportion of cold chain points reporting temperature alarms.											
Proportion of cold rooms functional TMD.											
Proportion of vaccine stores with job aids.											
Proportion of LGAs monthly meeting held with reports											
Propoprtion of trained health workers on cold chain											
Proportion of faulty refrigerators repaired by Q3 2013											

9.4. Programme implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

About 735 Ward Development Committees (WDCs) were reactivated in 2013 using Participatory learning and action tools (PLA). A directory of all WDCs is being developed; the directory is completed for South-south zone, north central zone and north east zone. The directory for the other three (3) zones are still in progress.

An assessment of all the 499 WDCs formed through GAVI support in 2010 was also carried out in November 2013. The assessment report showed there was significant improved demand creation and improved PHC services in the wards that the WDCs were formed. The WDCs contributed to the improved health and social impacts in the wards that the WDCs were formed. For instance, there was an increase in the cumulative DPT3 coverage, number of children immunized at the health facilities and the number of women attending ANC in all the six (6) regions (when compared to the wards that WDCs were not formed in 2010). The support contributed to the DPT3 coverage increase from 52% in 2012 to 84% in 2013. So, the additional WDCs formed in 2013 have also contributed to the improved health and social impacts in the wards that the WDCs were formed.

All the targeted LGAs / health facilities for phase 1 penta valent vaccine introduction were provided with computers for electronic data capture and data management tools. Training on DHIS has been conducted for the M&E officers in all the supported LGAs. These activities have contributed to the improvement in the data

quality / reporting notice in 2013 as well as the reporting level from the states and LGAs.

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

There was delay in the release of funds from GAVI HQ due to observed weaknesses in the accounting system. There was a delay in the submission of the external audit reports for the period 2010 to 2012. There was also a change in the HSS Bank Account and it took months before the honourable Minister of Finance signature could be gotten for the documents to GAVI Secretariat on the New Bank account numbers. These challenges contributed to the delay in the release of funds from GAVI which resulted in the limited implementation of planned activities in 2013.

When eventually part of the HSS funds was released in October 2013, there was very little time to implement most of the proposed HSS activities in 2013. There was also delay in the approval of the 2014 HSS work-plan and so the implementation of the rescheduled activities could not commence on time in 2014. The implementation of these approved HSS activities for Jan - June 2014 in the country are currently on hold. And the HSS phase 1 programming is suppose to end by June 2014.

CPA Team from GAVI Headquarters visited the country in December 2013 and completed their assignment in March 2014. Currently, there is a 'Hold On' order from GAVI Headquarters for the implementation of all the approved and pending activities because of the findings of the Draft Report from the CPA Team.

As solution for future improvement, efforts would be made to improve all financial disbursement and retirement processes to avoid future delays in the release of funds for proposed activities. The GAVI Desk at the NPHCDA would also ensure annual work-plans are developed and approval received during the last quarter of the year for the preceding year. In this way, approvals would be gotten on time to commence the implementation of all proposed activities from the very early part of the year.

Request / Appeal would also be made to GAVI Headquarters to ensure timely release of approved funds to ensure timely implementation of approved and pending activities. There is the need for GAVI Headquarters to fast track the CPA feedback process for continuation of activities implementation.

There is also the need for further extension of time by GAVI Secretariat to enable the completion of the implementation of the remaining proposed priority / pending HSS activities; and also proper evaluation at the end of the programme.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

The GAVI HSS funded activities are overseen at the national level by the Inter-agency coordinating committee(ICC). This body is also responsible for validation and overall monitoring of the GAVI activities.

There was plan for quarterly monitoring from the national to the states / LGAs but this was not very regular in 2013, because of lack of funds for a greater part of the year.

Regular updates on the GAVI grant implementation are also provided to the Health Partners Coordinating Committee (HPCC) that meets quarterly. The monitoring reports of the implementing agencies are used for routine monitoring of the activities carried out.

Routine Immunization consultants are also engaged (one per state plus FCT) to monitor and report on the implementation of GAVI activities at the states / LGAs levels.

In addition, external monitoring consultants are engaged to monitor specific activities like the training of health workers for penta valent vaccine introduction and the survey to assess the functionality of WDCs (conducted in 2013).

The outcome indicators are monitored using the routine HMIS tools, where possible or through the Nigeria DHS, multiple indicator cluster survey and other surveys as may be necessary.

There was a plan for end of programme evaluation, but yet to be done because of the extension of the programme to end of June 2014.

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual

sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

The GAVI HSS M&E is integrated with the country M&E system. Nigeria carried out its first annual health sector review in December 2010. The second review (for 2011) commenced in the first quarter of 2012 and was finally presented to stakeholders in Feb, 2013. The Mid term review of the National Strategic Health Development Plan was conducted in 2013 and the stakeholders meeting was held in December 2013. Activities implemented with GAVI HSS funds are reported along with existing reporting systems in the country.

GAVI HSS also utilizes the routine HMIS to report on key outcome or impact indicators like the antenatal care coverage or routine immunization coverage. Since objective 4 of the GAVI HSS is focused on strengthening the HMIS, this means the strengthened HMIS provides better data on GAVI activities. HMIS data reporting is web based; and so, indicators can be accessed real-time online.

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

The key stakeholders in the health sector, which include development partners (both bilateral agencies and multilateral agencies) and their subsidiary projects, various civil society organisations, are members of the Inter Agency Coordinating Committee (ICC),which oversee the implementation of the HSS proposal. As such, they review andvalidate what the implementing units have carried out and reported.

Key stakeholders in the health partners coordinating committee include development partners like WHO, UNICEF, UNFPA, DFID, and Rotary International as well as the Health Reform Foundation of Nigeria (HERFON), civil society organization, EU, USAID, CIDA, World Bank, CHAI, JICA

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

CSOs like the Christian Health Association of Nigeria (CHAN) and Rotary International as well as the Health Reform Foundation of Nigeria (HERFON) as stated above are members of the ICC that oversees the implementation of the HSS proposal. They review and validate what the implementing units have carried out and reported. No CSO is receiving direct funding for implementation of GAVI funded activities.

The specific roles of the CSOs are shown below:

Name Organization, Organization Type, Implementation Function

A. Christian Health Association of Nigeria (CHAN):

Faith Based Organization

1. Member of ICC and HPCC

2. Review and validate theimplementation

3. Endorses the APR before submission

B. Rotary International:

Non Governmental Organization

1. Memberof ICC and HPCC

2. Review and validate the implementation

3. Endorses the APR before submission

4. Signatory to the GAVI account

C. Health Reform Foundation of Nigeria (HERFON):

Civil Society Organization

1. Member of ICC, HPCC and PICC

2. Member of advisory committee

D. Clinton Health Access Initiative (CHAI):

International CSO

1. Review and validate the implementation

2. Endorses the APR before submission

3. Member of ICC

E. Other NGOs/Faith Based Organizations

Civil Society Organizations

1. Member of WDCs at the Community level.

2. Supervise and Monitor implementation of PHC activities at the Ward level

3. Ensure community ownership of PHC activity.

4. Mobilize community for health action.

5. Ensureaccountability and sustenance of PHC activity.

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

The management of HSS funds has beendescribed in the financial management section of 9.1 above. Fund management hasbeen effective overall.

Therewere delays in the release of funds for implementation of activities.[CDO-n1]

There are proposed changes in the area of retirementof GAVI funds [CDO-n2] and revision of TORof GAVI consultants

9.5. Planned HSS activities for 2014

Please use **Table 9.5** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
Procurement and installation of 100kg incinerators	yes	1386000	0	NA	NA	
Provision of electronic data	yes	143490	0	NA	NA	

management tools and equipment to 14 states						
Procurement of cold chain monitoring tools and training of CCO	yes	1140417	0	NA	NA	
Monthly WDC meetings and monitoring of HFs by the WDC	yes	271742	0	NA	NA	
Procurement of Cold Chain Equipment (DDSR and other CCE) and distribution to States	yes	16995643	0	NA	NA	
Quarterly supportive supervision to PBM sentinel sites	yes	25939	0	NA	NA	
Training of LGA and State accountants on GAVI financial guidelines	yes	1054839	929032	NA	NA	
Training of HWs on integrated PHC service delivery	yes	4275377	0	NA	NA	
Conduct mentoring support to LGAs on electronic data capture	yes	1012090	0	NA	NA	
Data management training for penta phase 1 states	yes	2325375	0	innially this activity was training on Penta introduction in phase 2 states, but was revised with ICC and GAVI approval	The initial activity was conducted using the vaccine introduction grant	
Training of CCO/HWs (national, States & LGAs) on cold chain maintainance and repairs	yes	1864370	0	NA	NA	
Monitoring of activities at the health facilities/Wards	yes	76645	0	NA	NA	
PHC under one roof consultative meeting	yes	167742	0	NA	NA	
Annual Progress Report preparatory meeting	yes	41290	16425	NA	NA	
Quarterly PBM , Rota quarterly meetings	yes	163616	0	NA	NA	
Conduct one day training a state level for state/LGA officers on AEFI	yes	81290	0	NA		

Workshop to determine requirements essential for integrating pre sevice training currilcula targeting frontline HWs	yes	181742	0	NA	NA	
Preparatory meeting with partners for submission of APR	yes	20645	0	NA	NA	
Setting up of 6 sentinel sites for PBM	yes	884621		NA	NA	
Development /Review/Update of Ward Health Plans (702)	yes	634065	0	NA	NA	
Evaluation for Penta phase 3 states (A&B)	yes	412903	0	NA	NA	
End of programme (HSS) review meeting with States	yes	529032	0	NA	NA	
Programme monitoring and management	yes	77806	0	NA	NA	
Conduct monitoring and evaluation of previous work plan in 1 state per zone	yes	26323	0	NA	NA	
PICC quarterly review meeting	yes	191032	0	NA	NA	
Biannual evaluation of reprogrammed GAVI project using existing Govt. monitoring structures and CSO	yes	191032	0	NA	NA	
Support WDC meetings	yes	124200	0	NA	NA	
Construct cold house at NSCS	yes	3139240	0	NA	NA	
Support the engagement of town announcers for sensitization of community members prior to outreach services in 960 wards	yes	73500	0	NA	NA	
Mid Level Management Training for EPI managers	yes	163046	0	NA	NA	
Provision of financial resources for RI GAVI Consultants	yes	416250	0	NA	NA	
Provide financial resources for state level	yes	55500	0	NA	NA	

Supportive supervision for two staff monthly						
Provide financial resources for LGA level supportive supervision for two staff monthly	yes	580500	0	NA	NA	
Provide financial resources for vaccine collection	yes	716250	0	NA	NA	
Provide financial resources for transport for outreach services	yes	1432500	0	NA	NA	
Provide financial resources for monitoring of RI activities	yes	200000	0	NA	NA	
Engagement of accountants at state level for improved financial management	yes	303493	0	NA	NA	
Procurement of equipment for GAVI desk in NPHCDA	yes	26580	0	NA	NA	
		41406125	945457			0

9.6. Planned HSS activities for 2015

Please use **Table 9.6** to outline planned activities for 2015. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Conduct Participatory learning activities to form / reactivate WDCs in 960 wards	Yes	560703	NA		
Training on DHIS 2 with integration of EPI database into the DHIS 2 (HMIS Database)	yes	121685	NA		
Provision of	yes	328481	NA		

computer equipment in 23 states (phase 2&3 states) in 360 LGAs					
Provision of Data Management Tools in health facilities in 36 states plus FCT	yes	950000	NA		
Mid-level management Training for EPI Managers at state / LGAs	Yes	1152708	NA		
Commission existing NHMIS Software consultant to provide mentoring support the LGAs on electronic data capture	Yes	493970	NA		
Commission state & LGAs M&E staff to provide supportive supervision to the LGAs / HFs	yes	9030	NA		
Train frontline health workers on integrated PHC service delivery including EPI	yes	1550000	NA		
Support the engagement of Town Announcers for community sensitization prior to outreach services in 960 wards	yes	73500	NA		
Support WDC Meetings for 18 months to institute sustainability and community ownership in 960 wards	yes	124200	NA		
Management costs to provide quality assurance of trainings		41400			
Management costs for technical expertise to support vaccines introduction and switch		138000			
Engagement of Accountants		303494			

at state level for improved financial management					
Conduct external Audit of HSS funds		55255			
Conduct community based assessment including KAP to ascertain the level of community knowledge		100000			
Provide financial resources for vaccine collection		716250			
Provide financial support for transport for outreaches services		1432500			
Provide financial resources for Routine Immunization consultants logistics		416250			
Provide financial resources for monitoring of RI activities		200000			
Provide financial resources for Routine Immunization consultants logistics		416250			
Provide financial resources for monitoring of RI activities		200000			
Conduct annual DQS assessmment		305662			
Conduct zonal EPI/PHC Reviews		332450			
Conduct LGA EPI/PHC Review		654924			
Conduct annual AEFI review meetings		70660			
Construct cold house at National cold store		3139240			
Construction of vaccines hups		3139240			
Establish cold chain maintenance contract for new CCEs at		37670			

national level					
Supportive supervision		17171			
Annual review of LMIS and development of work plan		67987			
Quartrely store mamnagement overheads		815480			
Outsourcing of vaccine distribution in Lagos and Kano states for 2 years		456646			
Provide server hosting and 4 servers for data bank at national		35783			
Conduct targeted advocacy visits for establishment of state primary health care boards in 10 states		72911			
Conduct of Baseline Assessment		151582			
Hiring of M&E specialist to support the GAVI Unit in programme management		46006			
Procurement of equipment for GAVI Desk in NPHCDA		26582			
Provide office equipment and furniture for the data bank at national		25040			
Conduct quarterly meetings between the Executive Secretaries of the SPHCBs and the NPHCDA / Partners for PHC service delivery		334176			
Operations Cost for GAVI Desk NPHCDA		36395			
Conduct of service availability and readiness assessment and DQRC development for monitoring of intermediate results and outcomes		660000			

annually					
Bi-annual verification of planned GAVI phase 2 interventions using existing government monitoring structure and external CSOs		47323			
		19856604			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
EU SIGN	1070000	6 years	Capacity building
Global Fund for AIDS, TB and Malaria	120000	5 years	facility rehabilitation, HMIS strengthening, community strengthening, logistics system harmonization
MDG Debt Relief Gains	3380000	5 years	Capacity building

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **No**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Administrative reports (DVDMT, monthly RI feed back)	Independent verifiers (DQS)	Denominator issues (population projections) , data not disaggregated by gender, insufficient data tools
HMIS reports	Surveys (DHS)	Wide disparities between administrative and survey results, in completeness of reports
Operational research (surveys)	Independent assessors	Inadequate funding for operational research

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

Reconciliation between the JRF and administrative reports because of the wide disparities between the different data sources has been a great challenge for the completion of the baseline data section. Capacity

building of key stakeholders on filling of the APR and support for regular evaluation would be very useful.

There will also be need for funding of operational research. This will help in obtaining useful information for the reports.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?2

Please attach:

1. The minutes from the HSCC meetings in 2014 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. TYPE A: Support to strengthen coordination and representation of CSOs

Nigeria **has NOT received GAVI TYPE A CSO support**

Nigeria is not reporting on GAVI TYPE A CSO support for 2013

10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

Nigeria **has NOT received GAVI TYPE B CSO support**

Nigeria is not reporting on GAVI TYPE B CSO support for 2013

11. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2013 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2013 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS *1*

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2013 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2013 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2013 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2013 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Annual Progress Report 20130001.pdf **File desc:** **Date/time :** 15/05/2014 10:27:13 **Size:** 7 MB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Annual Progress Report 20130001.pdf **File desc:** **Date/time :** 15/05/2014 10:31:46 **Size:** 7 MB
3	Signatures of members of ICC	2.2	✓	Attendance.pdf **File desc:** **Date/time :** 15/05/2014 10:53:02 **Size:** 3 MB
4	Minutes of ICC meeting in 2014 endorsing the APR 2013	5.7	✓	3rd ICC minutes.pdf **File desc:** **Date/time :** 15/05/2014 11:03:50 **Size:** 5 MB
5	Signatures of members of HSCC	2.3	✓	NA.docx **File desc:** ,,,, **Date/time :** 15/05/2014 02:17:59 **Size:** 12 KB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3	✓	NA.docx **File desc:** **Date/time :** 15/05/2014 02:23:17 **Size:** 12 KB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✓	NPHCDA GAVI ISS Domiciliary account 2014.jpg **File desc:** **Date/time :** 15/05/2014 11:35:40 **Size:** 382 KB
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3	✓	NA.docx **File desc:** **Date/time :** 15/05/2014 02:29:07 **Size:** 12 KB

9	Post Introduction Evaluation Report	7.2.2	✓	REPORT OF POST INTRODUCTION EVALUATION.docx **File desc:** **Date/time :** 15/05/2014 11:23:57 **Size:** 176 KB
10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	NA.docx **File desc:** **Date/time :** 15/05/2014 02:33:26 **Size:** 12 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1	✓	NA.docx **File desc:** **Date/time :** 15/05/2014 02:35:52 **Size:** 12 KB
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM_Nigeria_report_NVS_D3-09052011_draft.pdf **File desc:** **Date/time :** 06/05/2014 11:36:48 **Size:** 2 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM_Improvement_plan_21112012_(Autosaved).xlsx **File desc:** **Date/time :** 06/05/2014 11:38:00 **Size:** 107 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM IMPROVEMENT PLAN Narrative on update.pdf **File desc:** **Date/time :** 06/05/2014 11:39:36 **Size:** 175 KB
16	Valid cMYP if requesting extension of support	7.8	✗	NA1.docx **File desc:** ,, **Date/time :** 15/05/2014 02:41:07 **Size:** 12 KB

17	Valid cMYP costing tool if requesting extension of support	7.8	✗	No file loaded
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	No file loaded
19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	FBN AC NO 20202510680001.pdf **File desc:** **Date/time :** 15/05/2014 11:20:04 **Size:** 1 MB
20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	NA.docx **File desc:** ,, **Date/time :** 15/05/2014 02:43:54 **Size:** 12 KB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3	✓	NA.docx **File desc:** ,, **Date/time :** 15/05/2014 02:46:43 **Size:** 12 KB
22	HSS Health Sector review report	9.9.3	✓	NA.docx **File desc:** ,, **Date/time :** 15/05/2014 02:49:08 **Size:** 12 KB
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	No file loaded
24	Financial statement for CSO Type B	10.2.4	✗	No file loaded

	grant (Fiscal year 2013)			
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4	×	No file loaded
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2013 on (i) 1st January 2013 and (ii) 31st December 2013	0	✓	NA.docx **File desc:** ,,, **Date/time :** 15/05/2014 02:51:36 **Size:** 12 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	×	No file loaded
	Other		×	GAVI ISS 2014 SOA.jpg **File desc:** **Date/time :** 15/05/2014 11:31:27 **Size:** 245 KB