2022 Joint Appraisal

Section 1: Country situation: overview of performance of support & discussion on progress, challenges faced

A. Immunisation Programme Performance – Zero-dose, Routine immunisation coverage, Vaccine introductions, campaigns, and outbreak response

1. Learning Question: What progress has been made to reach zero-dose and under-immunised children with vaccinations?

Indicator(s):

- Absolute reduction in the number of zero-dose children (total number)
- Percentage change in number of zero-dose children (disaggregated by previous year, baseline year)
- Number of children reached with DTP1 in areas targeted for intervention
- Gap in coverage between DTP1 and the last dose of MCV in the national schedule (MCV1 or MCV2) - both nationally and in areas targeted for intervention
- DTP1-DTP3 Dropout

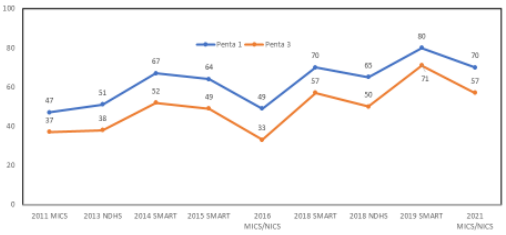
Penta 1 & Penta 3 National Coverage by source, 2011 - 2021

Source	Penta 1	Penta 3
2011 MICS	47%	37%
2013 NDHS	51%	38%
2014 SMART	67%	52%
2015 SMART	64%	49%
2016 MICS/NICS	49%	33%
2018 SMART	70%	57%
2018 NDHS	65%	50%
2019 SMART	80%	71%
2021 MICS/NICS	70%	57%

Zero Dose Overview

Indicator	Values
# of zero dose	5521110
# of zero dose targeted (2023 – 2025)	2208444
% of zero dose targeted	40%
# LGAs targeted	100
Change in zero dose in targeted LGAs (2018- 2021)	-18%

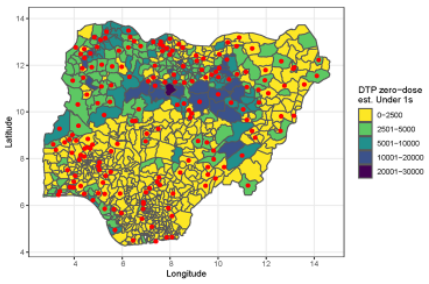
Trend of National Coverage by source, 2011 - 2021



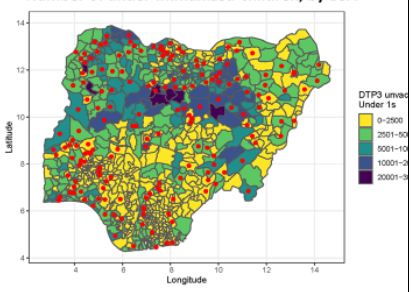
Subnational estimates of zero dose, 2021 MICS/NICS

Geospatial analysis was done to assess the characteristics of zero-dose and under-vaccinated children using cluster-based data of 2021 MICS/NICS survey. This is intended to estimate 'coldspots' and under-vaccinated areas with precision; assess potential outbreaks and evaluate national and subnational progress towards coverage targets.

Number of zero dose children, by LGA



Number of under-immunized children, by LGA



The red dots are centroids of LGAs which had at least one CVDPV2 outbreak in 2021

Country Comments (please consider the set of cross-cutting questions to structure comments):

The country has carried out targeted interventions aimed at increasing the uptake of RI while also making efforts in reaching zero-dose and under-immunized children.

Nigeria conducted a national survey of routine immunisation coverage among children in 2021. The summary of the survey findings shows

- First dose of pentavalent vaccine (Pents1/DTP1) = **70%**
- 3rd dose of pentavalent vaccines (Penta3/DTP3) = **57 %**
- Drop out between penta1 & penta3 doses = **21%**
- First dose of Measles vaccine (MCV1) = **60%**

Only **36%** of children aged 12-23 months received all recommended 1YL vaccines while **18%** never received any antigens before in Nigeria. Substantially, more children are fully vaccinated in the southern zone compared to the Northern zone (Southeast **57.3%** Vs Northeast **24.4%)**.

The 2021 MICS/NICS survey findings show that immunisation coverage varies dramatically across Nigeria and improvements are needed in most states. Two states (Ebonyi and Enugu) have estimated Penta 3 coverage of 90%. It also shows variation in terms of the proportion of children that received recommended 1YL vaccines between the poorest and richest in the country (**20.5%** vs **65.3%**). Children are less likely to have received 3 doses of pentavalent vaccines if they are from poor or rural families, child mothers less than 25 years of age or have a low educational level. The findings further showed that children in the richest quintile were more than twice as likely to have received Penta 3 than those in the poorest quintile.

Child health cards are important health records and are critical for evaluating the immunisation status of children. The 2021 MICS/NICS report indicated that about 56% of the children showed a child health card. The availability of child health cards varied across the states with Ebonyi recording 98% card rendition and as low as 16% in Sokoto State.

Key reasons for children not fully immunised by respondents given multiples reasons include

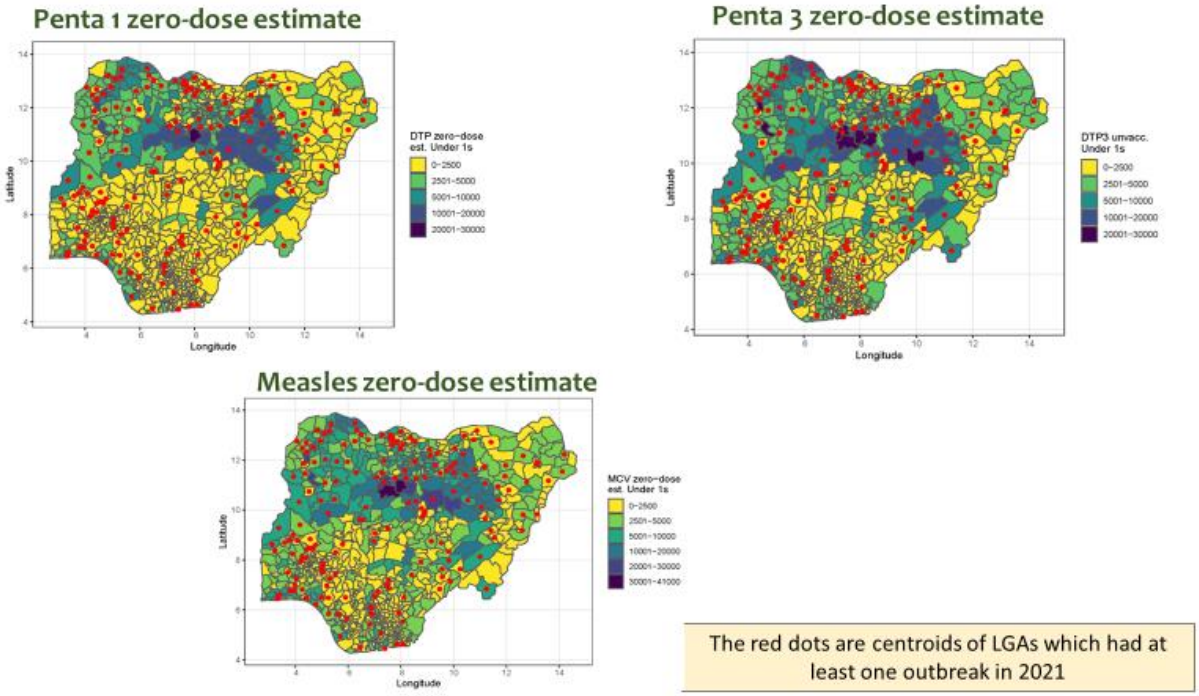
- 51% lack of knowledge or information.
- 19% measures service delivery issues
- 24% lack of time or other family issues and 26% mistrust or fear.

Percentage change in Zero Dose Children:

- The WUENIC report of 2020 showed that Nigeria recorded 2.5 million doses of zero-dose children while the report of 2021 showed a reduction of zero-dose children to 2.2million (a difference of 300,000 children).
- Nigeria has made an effort for the reduction of zero-dose children, initially identifying 145 prioritised zero-dose LGAs across 29 states. Eighty (80) of these 145 LGAs are fully accessible with a total of 1,703,048 under 1 year old. Seventy percent (1,199,682) of these are unimmunized. Sixty-five (65) of the LGAs are partially accessible with of total of 2,008,637 children. 1,445,124 (72%) of these children in these partially accessible LGAs

are unimmunized. The NPHCDA (NERICC) in 2021 conducted an engagement meeting with the 145 low performing LGAs that were prioritised across 29 states using the NDHS to ensure key Strategies are developed to strengthen the observed gaps in the Routine immunisation space with responsible persons and timelines. The aim was to prioritise wards, health facilities and settlements with the LGAs, identify LGA specific challenges affecting routine immunisation and proffer appropriate mitigation plans to improve RI performance of these LGAs. The LGAs developed a Zero Dose Reduction Operational plan (ZDROP).

- UNICEF and WHO supported the prioritised LGAs with the conduct of RI intensification focusing on zero-dose children and other integrated interventions for a period of one year aimed to increase uptake of RI vaccines in missed/underserved communities to reduce zero-dose children by 20% in the low performing LGA with a baseline of 61% zero dose children. The chart below shows the progress made in RI intensification conducted in the prioritised LGAs.



Progress made in reaching zero-dose and under-immunized children with vaccinations with a focus on the demand side are as follows:

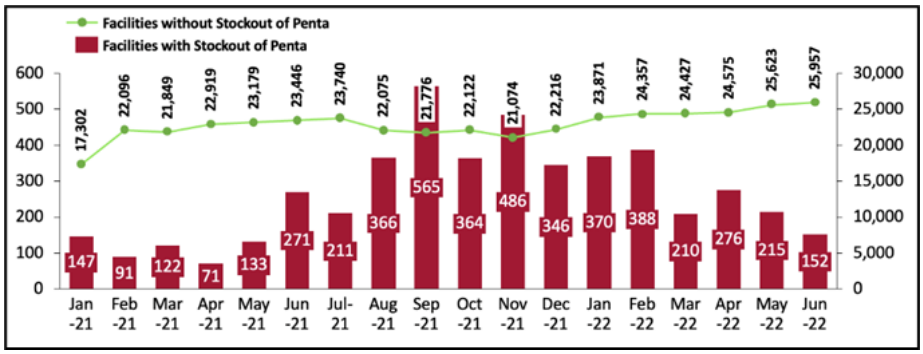
1. Sensitization of leadership and coordination structures at the national and sub-national levels in relation to zero dose and under-immunised children in Nigeria
2. The institutionalisation of community engagement strategy across the MoU states with a focus on service integration and tracking of zero dose children within facility perimeter, far/hard to reach and efforts to discover new areas that have never been reached
3. The institutionalisation of integrated community engagement strategy in Zamfara state and other pending four states

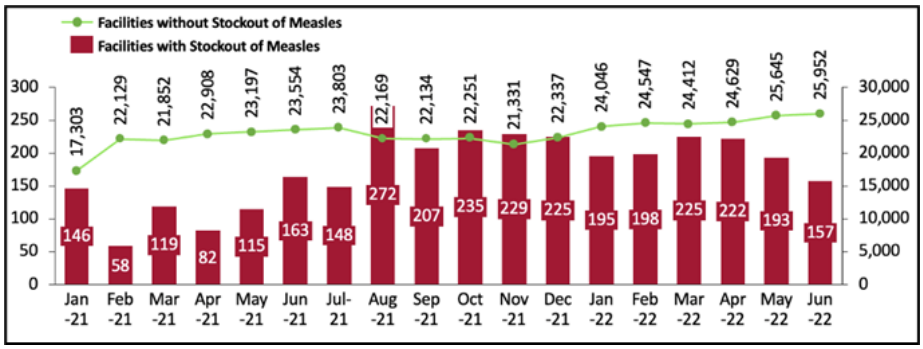
4. Leverage on the Rota vaccine introduction to engage religious and traditional institutions across the 18 northern states and the FCT in reaching zero dose and under-immunised children
5. The institutionalisation of Crisis Communication Centre at the national and sub-national levels for integrated communication messages (Covid-19, RI and other PHC services)
6. Integration of Covid-19 activities with RI and other PHC services
7. Airing of routine immunisation jingles (radio and TV) and public service announcements on the importance of routine immunization at the national and subnational levels
8. Dissemination of information, education, and communication materials on the importance of routine immunization across the 36 states and the FCT
9. ACSM targeted activities during the new vaccine introduction with activities at national and sub-national levels
10. Conduct of community dialogue and engagement meetings
11. Public sensitization and awareness creation on routine immunization at religious gatherings and public places
12. Tracking of newborns and unimmunized for vaccination through local barbers, Imams, and other key local leaders
13. Leveraging on ACSM-related funds during SIAs (Polio and Non-Polio) to improve routine immunization services
14. Social media engagement (engagement of influencers and bloggers) for public sensitization and awareness creation on routine immunization and zero dose concepts
15. Engagement of community resources groups, mobilizers, and volunteers to create demand for routine immunization as well as track and bring defaulters back to the system
16. Use of human-centred design approach in driving demand for routine immunization services

2. Learning Question: How well are vaccine stocks being managed?

Indicator(s):

- Number of health facilities that reported no stock-outs of DTP containing vaccine
- Number of health facilities that reported no stock-outs of Measles containing vaccine
- Closed vial wastage of DTP-containing vaccine





Country comments (please consider the set of cross-cutting questions to structure comments):

To ensure availability of potent vaccines for use the country through the NLWG has taken steps to ensure the efficient management of vaccines through the following interventions:

- Storage capacity expansion: at the National level, work has commenced on the construction of the Lagos Hub, one of the three Hubs to be constructed (in Abuja, Lagos, and Kano) to provide adequate storage space for vaccines and other health commodities. The Hub designs were done with the projected country population by 2040 in view. The country is also equipping at least one HF in each ward with a Cold chain equipment preferably Solar Direct Drive refrigerator, capable of storing the ward's vaccines needs for at least one month. Through the support of Gavi and the Government of Nigeria, implementation of the Gavi Cold Chain Equipment Optimization Platform (CCEOP) project has equipped 79% (7,556) of the wards in the country with at least one SDD refrigerator. The project continues with the ongoing distribution and installation of 2,445 equipment across the country. The plan is to procure a total of 12,753 CCE to address current and future cold chain capacity requirements up to 2028. The equipment will be deployed to extend services. Efforts are underway to mobilize resources for procurement of the remaining CCE that have not been covered on the CCEOP project.
- Temperature monitoring and control: To maintain vaccine quality, the temperature at which vaccines are stored is monitored throughout the supply chain. At lower levels of the supply chain (LGA and Health facilities), Fridge Tag 2 devices are used, whereas at National, Zones and State levels in addition to Fridge Tags remote temperature monitoring devices (RMTD) are used. For all CCEOP equipment additionally, RTMDs are used as well to monitor vaccine

storage temperature. These device temperature records are used to assess the quality of the vaccine supply chain, monitor the performance of cold chain equipment over time and demonstrate compliance with good storage practices. For in-transit temperature monitoring, freeze tags for RI are utilised as well as RTMDs for COVID-19 vaccines.

- Stock management and visibility: There is ongoing monitoring and tracking of vaccine utilization using the DHIS2 monthly, while vaccine stock visibility is currently achieved through the use of three main tools. For COVID-19 Vaccines, the country, with support from GAVI, has implemented the use of OpenLMIS for stock management of COVID-19 vaccines. This provides visibility for the management of COVID-19 vaccines from the National to the State level. The country also reports stock balance of COVID-19 vaccines using a Google sheet to capture the vaccine stock balance from LGA level to track the balance of dynamic expiry dates of COVID-19 vaccines. For all routine immunisation vaccines, the country currently uses an ODK-based stock reporting tool for the management and visibility of the vaccines; this is a stopgap before the roll-out of the broader OpenLMIS RI module for the management of all vaccines. The National Training of Trainers (NTOT) on the OpenLMIS RI module was concluded in the 2nd week of November 2022. The State cascade is slated to commence from the last week of November to the first week of December 2022.
- Reverse logistics and waste management: The reverse logistics is the process for retrieval of used and/or unusable vaccine vials, as well as used injection devices for the purposes of safety and accountability. This process decreases risk and completes the product life cycle. Used and unusable vials are retrieved from the Health Facilities to the State through the LGA's, filled safety boxes are similarly retrieved. Although this practice is more institutionalized in polio and non-polio SIAs, including COVID-19 vaccination across all the states, there has been some level of reverse logistics for RI vaccines, especially the 6 states with direct vaccine delivery systems. This is done to avert the potential health and environmental hazards. The preferred mode of waste destruction/elimination is through incineration and to boil, crush and bury. The Federal Government and partners have supported the country in the procurement of 137 incinerators, which are deployed across the 36 states plus the FCT. There are also 11 incinerators which are privately owned which sums up the incinerators in-country to 148. The waste management SOPs has been revised in 2021 and there is currently efforts to conduct another revision in Q2 2023, following the constitution of the waste management committee. State waste management officers were identified in all the 36 states and the FCT and were trained at national and zonal levels to carry out their responsibilities in coordination of waste management plans in their respective states. Gaps still exist in the absence of updated health care, including immunization waste management policy in the country and lack of waste management plans in each of the states. The NLWG, through the newly formed waste management task team, wishes to conduct nationwide waste management assessment and support states to come up with waste management plans, while also catalysing actions to review the health care waste management policy.

- Vaccine Accountability is a set of processes and procedures that ensure that vaccines are properly stored (right temperatures) and managed to ensure that they retain their viability and potency up till the point of administration. The process also ensures that quantities of vaccines deployed are fully accounted for in terms of the number of doses deployed triangulated with the number of clients vaccinated. The combination of storage space expansion (with optimised CCE), stock visibility, reverse logistics and proper accounting for retrieved vials form the country's vaccine accountability pillars. In each ward, there is an Immunization Ward Focal Person, who is charged with the responsibility for vaccine accountability in the ward. He/she sets the preference of maintaining the viability of the vaccine, being accountable for the vaccine received, and adhering to the requirements of the program required to maintain an active status in the program. Providers demonstrate accountability through monthly doses administered and inventory reports, site visits, and monthly temperature logs. States reports stock balance weekly via ODK LMIS (to cease when Open LMIS is fully deployed) and decision on stock performance. The COVID-19 stock balance and accountability is tracked three times a week to ensure no stock out as the country implement the SCALES strategy.
- Vaccine distribution from the National level to the states is outsourced to third-party logistics firms, with clear SOPs. Distribution of vaccine and other commodities from the state stores to the HFs is achieved through a mix of Pull and Push delivery systems depending on the states availability of dedicated funding for the vaccine delivery. Currently, 6 states of Kano, Kaduna, Borno, Bauchi, Sokoto, and Yobe are implementing a full last mile vaccine delivery system, with Lagos pushing vaccines to LGA levels and major apex health facilities. The 8 GAVI HSS states have dedicated funds for vaccine delivery and have since started some level of vaccine push/pull systems. This needs to be further revisited by the NLWG to provide adequate guidance to the states to ensure these states are implementing last mile delivery in line with the recommendations of the system design analyses conducted in the states. In addition, funding was recently secured through a World Bank IDA Credit to support a direct state-to-HFs delivery system in 20 states from 2023 - 2025 which will leverage the CCE in each ward to support equitable access to vaccines across the country. There is ongoing discussion with UNICEF HQ on DRIVE initiative to leverage private sector engagement or public-private partnership to deliver vaccines to the last mile.
- CCE maintenance: This is a major area of concern as it poses a risk to the realisation of the objectives of all the massive investments being made to support the immunization supply chain. This challenge is being addressed through systematic building of States' capacity to maintain their CCE and provision of maintenance toolkits through Gavi support. Additionally, all CCEOP equipment procured from 2020 have a 10 year warranty. NPHCDA has also secured the commitment of the manufacturers' representatives for CCE suppliers to continuously mentor the state technicians in the maintenance units. With support from GAVI, UNICEF has procured technician tool kits and distributed them to the 36 states and the FCT maintenance units. In addition, training for the technician from 36 states + FCT was conducted on the conduct of maintenance on CCE. Kano State has a floating assembly model following up on

the maintenance of all cold chain equipment in the state, which the country plans to adopt and up-scale.

Closed vial wastage of DTP-containing vaccine:

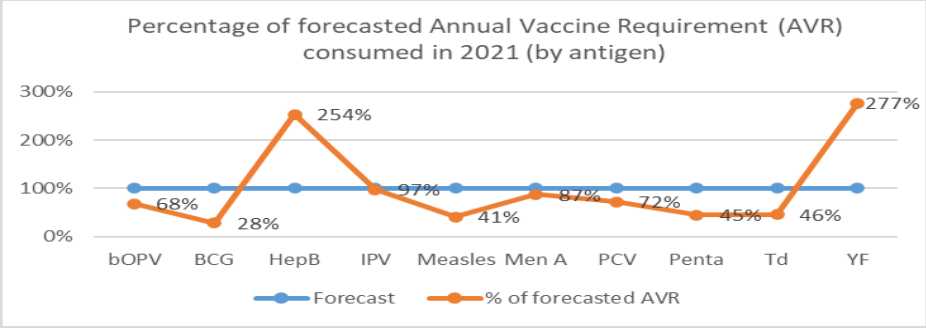
NPHCDA through the NLWG has put processes in place to ensure closed vial wastage is monitored. This is achieved using Vaccine management tools called the Loss and Adjustment Form. This form is used to track and monitor all forms of closed vial wastage to determine appropriate response strategies for storage and handling, since it is largely due to supply chain practices.

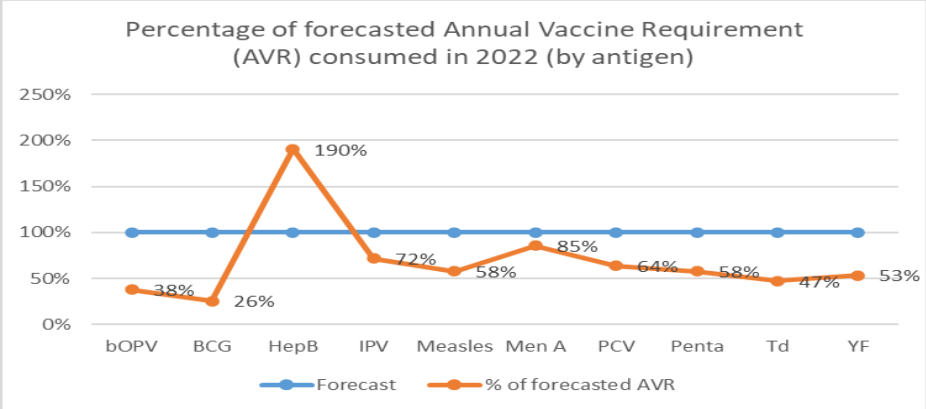
Despite the availability of the tool, there is little or no reporting of closed vaccine vial wastage. This non-reporting of closed vial wastage by iSC levels has really hampered the availability of data for decision-making. Hence, the NLWG will engage all stakeholders on the need for accurate reporting and archiving of closed vial wastage, which subsequent feedback and follow-up will be through their monthly data review meetings at the LGA levels and expanded NLWG meetings for the states and the NSCS. Also, the introduction and use of the OpenLMIS for managing all vaccines will help keep records of all adjustments electronically in vaccine quantities from closed vial wastages, thereby providing the data for decision making and vaccine accountability.

3. Learning Question: Are vaccines being consumed at rates that are in-line with approved forecasts? What are the key drivers of consumption compared to expectation (e.g., stockouts, increased coverage, wastage)?

Indicator(s):

- Percentage of forecasted Annual Vaccine Requirement (AVR) consumed in prior period (by antigen)





Country comments (please consider the set of cross-cutting questions to structure comments):

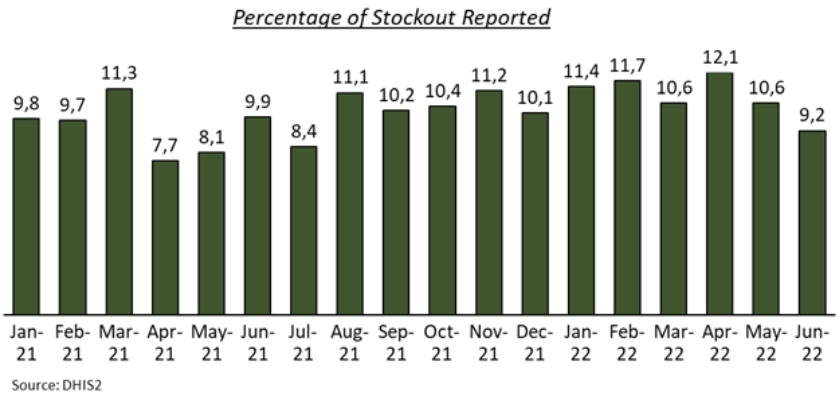
From the graphs depicted above and as experienced in-country, we have recorded lower percentages of forecasted vaccine requirement (AVR) consumed except for HepB and YF for 2021. While our state-specific forecasting process has been a rigorous one involving all the relevant partners and government stakeholders (ministries and departments) and has witnessed remarkable improvements over the years, we still experience significant challenges that affect vaccine stock availability and management down to the last mile while driving our consumption patterns.

In addition to the different interventions highlighted above to effectively manage our vaccines towards ensuring equity and improve coverage, various factors continue to drive/impact our consumption against expectation – the key ones are listed below:

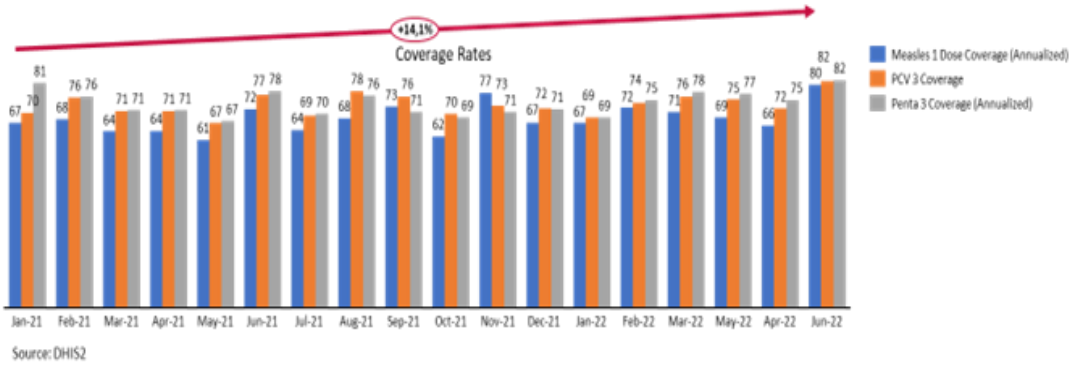
a) *Delayed Release of Government Funding:* Over the years and within the period under review, Nigeria has witnessed significant delays in the processing and release of the government traditional and counterpart funding for vaccines. These delays have resulted in the late arrival of vaccines for and within the quarters they were needed. Consequently, giving rise to inadequate stock in-country and stock out of different antigens such as bOPV, PCV, Td, Men.A and YF. These delayed arrivals, unfortunately, cannot be taken aback to be consumed within the lost periods (months, quarters, or years).

b) *Change of Forecasted Doses on Decision Letter:* Nigeria has continued to receive changes (mostly reductions) in the number of the quantified doses of the Gavi-funded antigens from the concluded figures communicated and shared by the country based on the country plans and priorities for the respective years using government-approved parameters (e.g., population figures, target coverages). In most cases, the country does not get the chance for a final engagement from Gavi on these numbers being arrived at before getting the decision letters or costing engagements through UNICEF. Hence, even if the country fully funds its calculated portion of the forecasted doses, there still wouldn't be enough vaccines in-country for vaccination as the pockets of resultant stock outs will not count for the eventual total consumption for a particular year.

c) *Stockouts:* As seen in the charts above and below, Nigeria has recorded stockouts across several antigens spanning months and impacting all the supply chain levels. Within Q1 and Q2 2022, Nigeria experienced stock out of bOPV, PCV, Td, MenA and YF. However, strategies like the R.I intensification (Zero dose Health Facility targeting) and Optimised integrated Routine Immunisation sessions (A week-long monthly activity) and introduction of daily fixed sessions were conducted to address missed children.



d) *Coverage:* Over the last one and a half years, Nigeria has recorded a steady and gradual increase in the administrative coverage of key immunization antigens – recording 14% compound growth between January 2021 and June 2022.



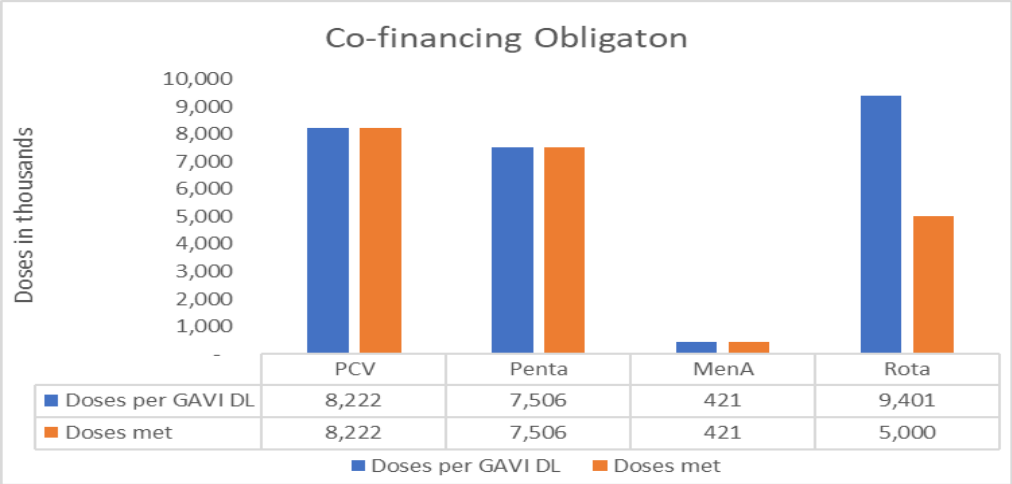
e) *Wastages:* Available administrative data has also shown that the wastage rates of key antigens are below the figures from the WHO Wastage Rate Calculator [1]. The country has since continued to implement the qualitative recommendations of the 2018 Wastage Study as part of the overall system-strengthening approaches and interventions of the immunisation supply chain.

The NLWG and the Department of Logistics and Health Commodities have continued to make progress in addressing the factors that contribute to vaccine wastage. In line with the country's NSIPPS 2.0 accountability framework, the country will pursue more wastage reduction strategies by tracking wastage specific data through the implementation of wastage rate calculator/session planning tool at lower levels. The goal is to optimize vaccine use and avoid unnecessary wastage while ensuring missed opportunities for vaccination are reduced and graduate our performance over six years. For open vial wastage, the country targets a 12% reduction (2% annually). Multiple levels of the supply chain will be evaluated periodically (bi-annually & annually) to monitor their graduation towards the target

4. Learning Question: Is the country complying with co-financing requirements in a timely manner?

Indicator(s):

Country co-financing obligation met in a timely manner



Country comments:

The country met its co-financing obligation, for the year 2021, although there was delay in fund release. The Country has also met its co-financing obligation in 2022. However, fund release and transfer to UNICEF did not happen until July and August 2022.

The FGoN made the following transfer to UNICEF SD in 2021 and 2022 for both co-financed and traditional vaccines:

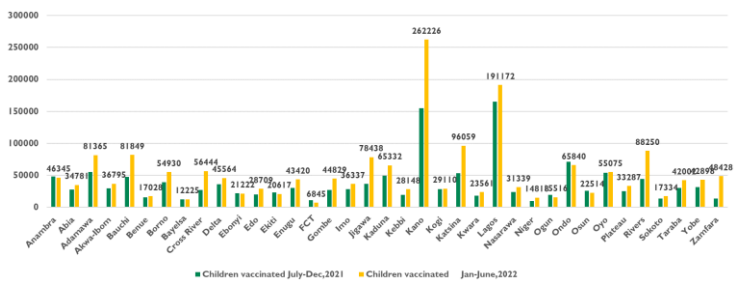
SN	Date	Amount (USD)
1	25 August 2022	49,412,872.01
2	22 July 2022	24,956,435.94
3	31 December 2021	32,715,589.49
4	11 June 2021	38,950,659.29

However, as part of effort at encouraging local vaccine production, the country signed MoU with Bio-Vaccines Nigeria Limited which empowers the company to commence importation of 50 per cent of certain traditional vaccines requirements with the aim of commencing local vaccine production in the country. In this context, the sum of USD5,888,802.53 was set aside in a dedicated Central Bank of Nigeria Account for that purpose but the company has not been able to commence importation due to regulatory requirements to be fulfilled.

5. Learning Question: If applicable, have new vaccines been introduced as planned and if not, why? Is coverage of recently introduced vaccines being scaled-up as expected?

Indicator(s):	Analysis on Number of children vaccinated in 2021 (July – Dec) & 2022 (Jan-June) Nigeria

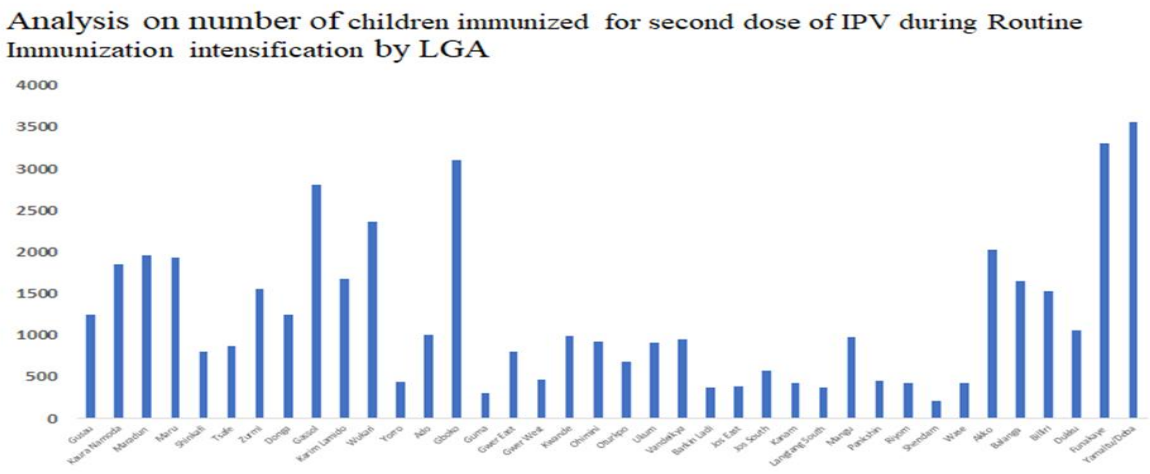
- Number of routine introductions completed over a number of targets set for the calendar year
- Coverage of recently introduced vaccines
- **In addition, forecasted routine introduction & campaign dates should be validated during the JA discussion**



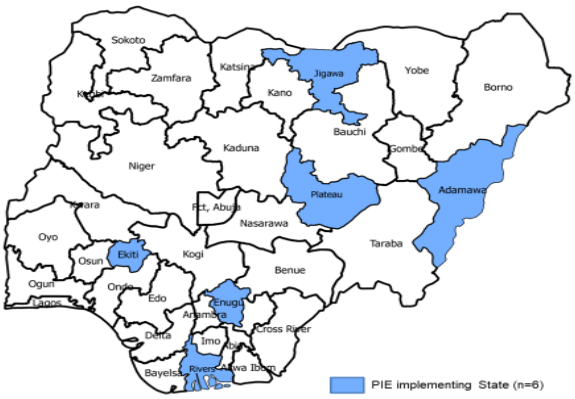
Country comments (please consider the set of cross-cutting questions to structure comments):

Inactivated polio vaccine (IPV) introduction into the national routine immunisation schedule is aimed at strengthening the routine immunisation system which is in line with the Polio Eradication and Endgame Strategic plan. It was introduced and launched in July 2021 across the 774 LGAs in the 36 states and FCT. 58,900 wards and health facilities health workers' knowledge and skills were built on routine immunisation, Data tools were revised for the introduction in the child health register, tally, and summary sheets on the age groups for the vaccination of 1st & 2nd dose in the routine immunisation calendar.

Post-introduction activities include monitoring and supervision of post-introduction IPV second dose activities by state and LGA level officers, and monitoring of ACSM activities at the state, LGA and ward levels, with fund availability and utilisation. Awareness was raised through the training of health workers on the second dose of IPV introduction. LGA and health facilities session plans were revised and included IPV second dose. First dose at six (6) weeks & second dose at fourteen (14) weeks of age. Integrated Routine Immunisation Intensification was conducted in 39 LGAs after IPV second dose introduction to improve the uptake of Routine immunisation vaccines (Penta1, IPV1&2, MCV1&2) to reduce zero dose children and boost the immunity of children against cVDPV in the communities.



Post Introduction Evaluation (PIE) was conducted for MCV2, MenA and IPV2 in six (6) selected states (Adamawa, Ekiti, Enugu, Jigawa, Plateau and River) across the country. A total of 196 checklists were administered including the national level check as shown below:



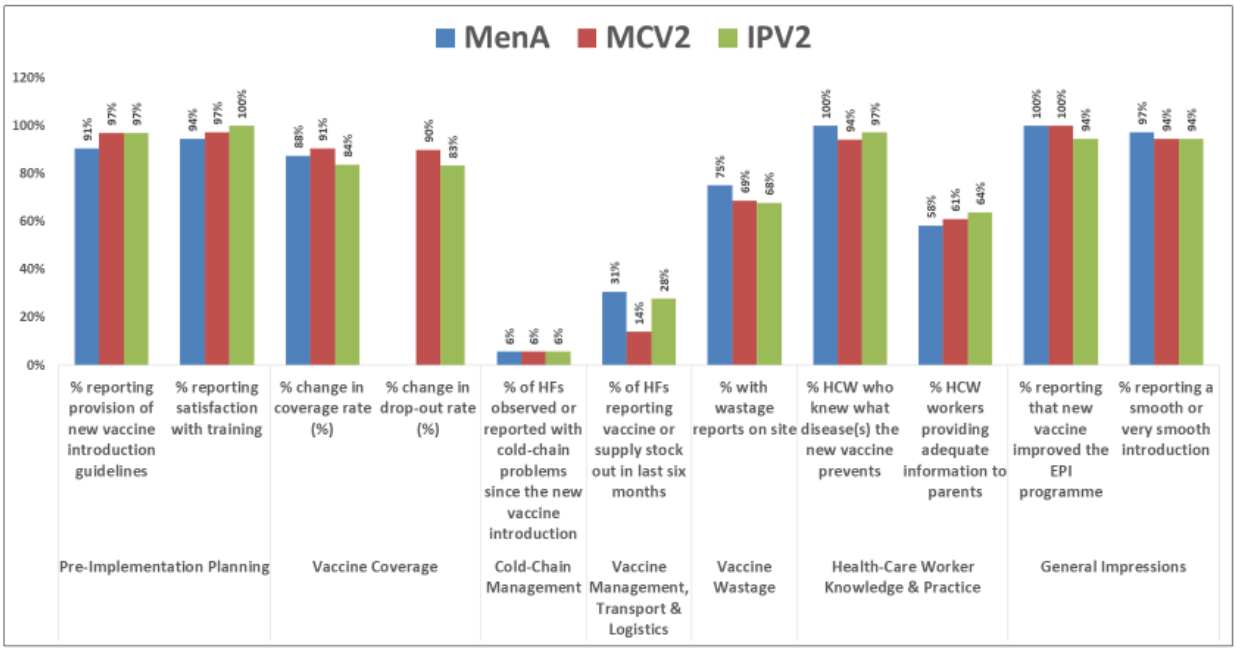
Number of Checklist submitted						
SN	State	HFs	Care Givers	LGA	State	Total
1	Adamawa	6	22	2	1	31
2	Ekiti	6	27	2	1	36
3	Enugu	7	23	2	1	33
4	Jigawa	5	20	2	1	28
5	Plateau	6	23	2	1	32
6	Rivers	6	26	2	1	35
	Total	**36**	**141**	**12**	**6**	**195**

Note: Total Checklists = 196 (Plus 1 National checklist)

Key indicators from the PIE focuses on

- Pre-implementation planning (provision of new vaccine introduction guidelines and reporting satisfaction with training).
- Vaccine coverage
- Cold Chain Management, transport, and logistics
- Vaccine wastage
- Monitoring and supervision
- Adverse Event Following Immunisation (AEFI)
- Health care worker knowledge and practice
- General Impression
- Observations at vaccination session
- Observation of vaccine storage area
- Waste Disposal

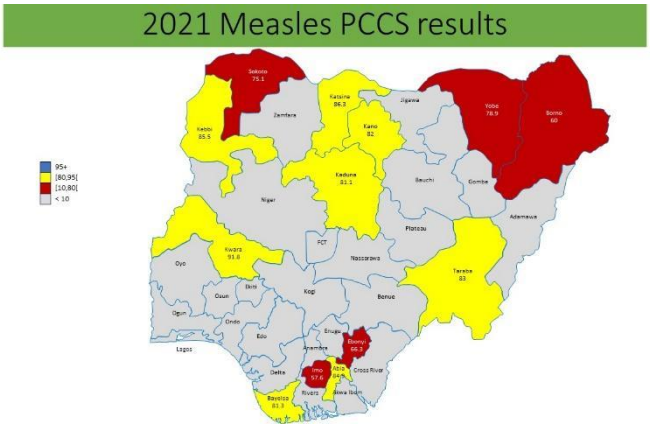
The administered 196 checklists enumerate the proportion of findings across the six (6) selected states as shown below:



6. Learning Question: If relevant, how effective have recent Gavi supported vaccination campaigns been?[1] Please highlight lessons learned which are applicable for routine immunisation and upcoming campaigns (e.g., timeliness of outbreak response, quality, campaign reach and link back to strengthening routine immunisation).

Indicator(s):

- Number of vaccination campaigns conducted (stratified by type of campaigns, including preventive, reactive, catch-up, follow-up, sub-national and national)
- Coverage of recent Gavi-

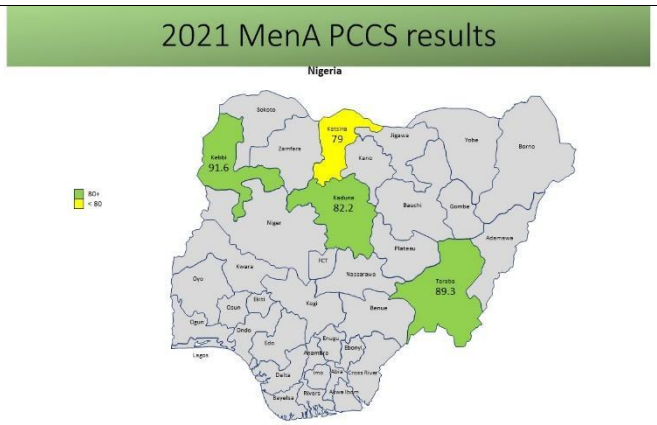


Though the target to attain herd immunity for measles is to achieve at least 95% PCCS, 8 States have coverage ranging between 80 and 94% while 5 States performed less than 80%.

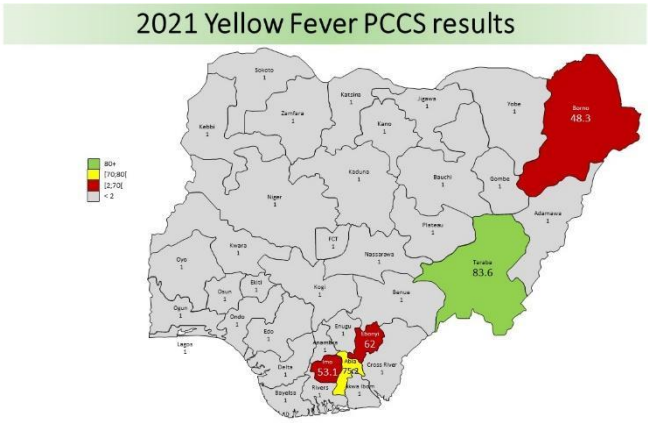
[1] Please reflect on those campaigns conducted since the last Joint Appraisal/Multi-Stakeholder Dialogue exercise.

supported campaigns, compared to target

- Number of reported outbreaks of vaccine-preventable diseases (for which GAVI supports with reactive campaigns)



Linking to the MenA mini catch-up campaign, targeting those children who missed the catch-up campaign in 2011-2014, it is targeted that at least 80% of the target will be reached based on independent survey using the vaccine efficacy at 90%. Three of the four targeted States attain more than 80%. Katsina State is the only state that scored 79% which is less than the score needed for attainment of herd immunity.



The yellow fever preventive mass vaccination campaign is implemented in phases to cover the entire country. For this phase, five States were covered. Borno, which is recurring with a targeted population of 500 thousand yearly is not considered here. In the remaining four States, one (Taraba) got the herd immunity over 80% while another one (Abia) PCCS Result ranged between 70 and 80% while the other two States (Imo and Ebonyi) performed less than 70%.

Country comments (please consider the set of cross-cutting questions to structure comments):

If relevant, how effective have recent Gavi-supported vaccination campaigns been?

During the last quarter of 2021, the country implemented Measles, Yellow Fever, and MenA integrated campaigns in 13 States. Namely, Kwara, Kebbi, Sokoto, Katsina, Kano, Kaduna, Borno, Yobe, Taraba, Bayelsa, Imo, Abia, and Ebonyi.

The measles vaccination carried out in the 13 states reached 16,203,500 children aged 9-59 months while the yellow fever vaccination was administered to 13,720,069 persons aged 9 months - 44 years in 5 states and the Men A targeting children aged 8-10 years reached 2,677,380 in 4 states.

In terms of campaign effectiveness, the integrated measles campaign yielded to the following results based on the post-campaign coverage survey conducted using the WHO international coverage standards. Though the States did not meet the set target of 95%, The PCCS showed good coverage in some weighted Enumeration Areas where 42% of EAs got above 95%, while 23% of EAs scored between 80 and 94%, and 35% of the EAs had less than 80%.

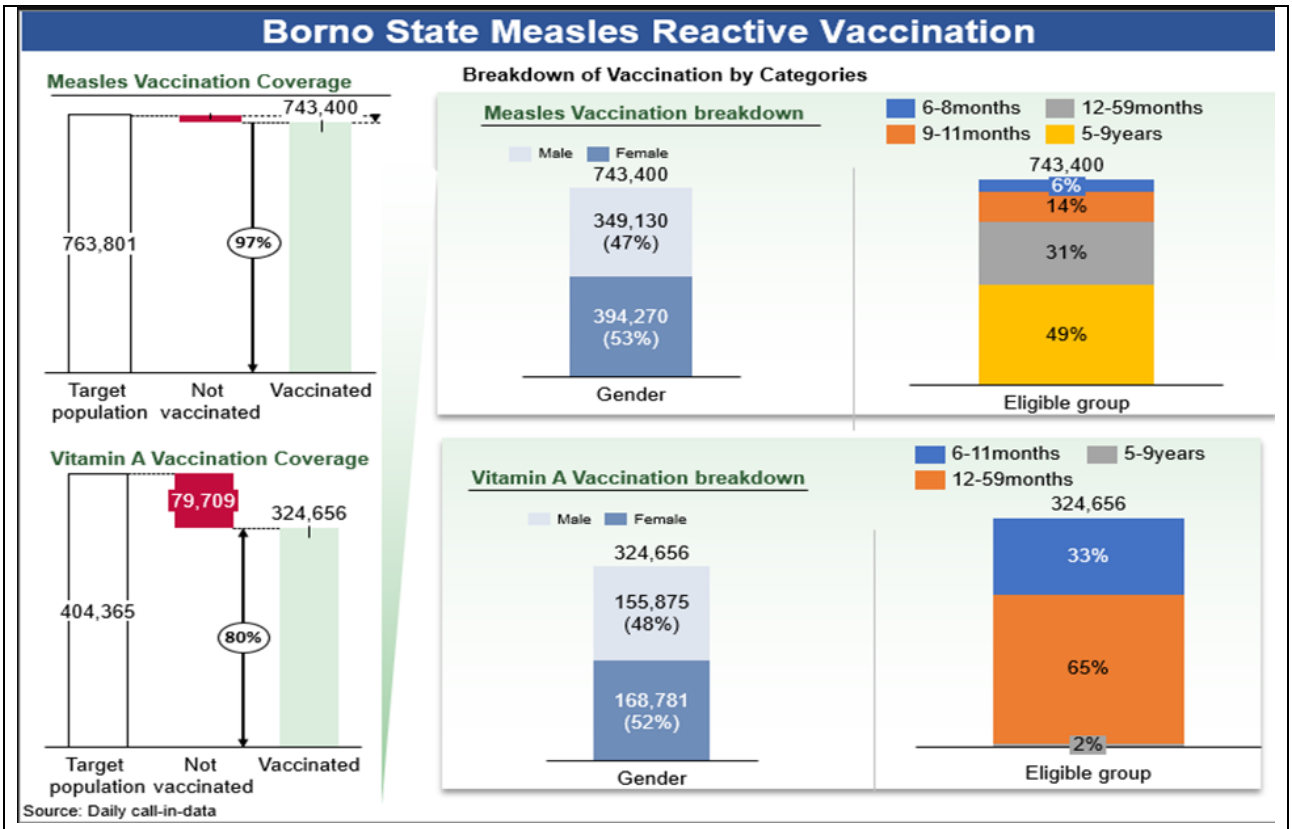
In the area of MenA, only four States implemented and three reached the targeted herd immunity of 80% and above (Kebbi: 92%, Kaduna: 82% and Taraba:89%) while Katsina reached 79%.

In the area of Yellow Fever which was implemented in 4 States (Imo, Abia, Ebonyi and Taraba) the following were achieved within the 40 EAs of each State. In summary 38% of those EAs reached 80% and above while 23% reached between 70 and 79% and, 39% reached less than 70%. All PCCS in the States did not show any significant gender disparity.

Measles zero dose. The PCCS showed that 37% of children (2,072,890 children) received measles vaccine for the first time during the SIAs in the 13 States (measles Zero-dose).

In 2021 measles outbreak response was conducted in 7 LGAs in Borno state targeting children 6 months – 9 years in 36 wards vaccinating 743,400 children with the measles vaccine.

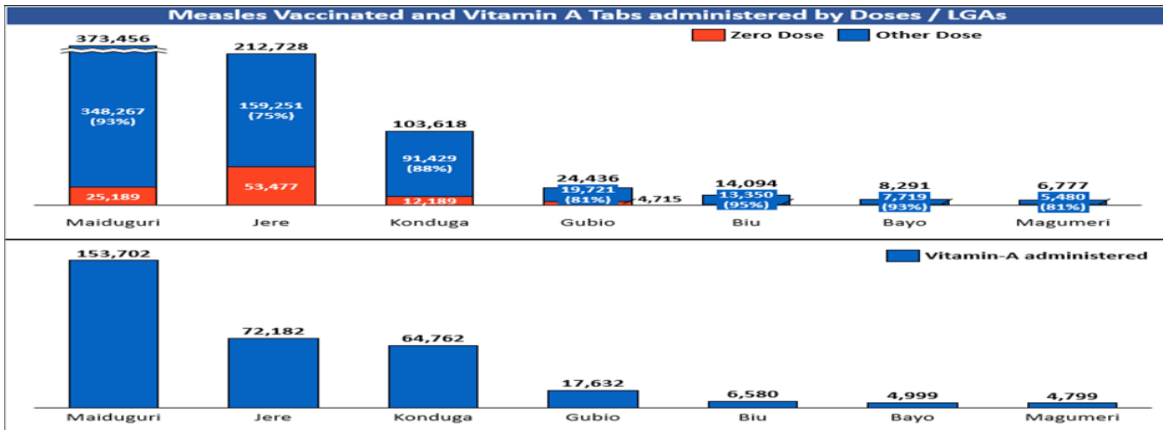
The graph below describes the distribution by Gender and Age groups reached by the reactive vaccination in Borno State.



Timeliness of the outbreak response.

In March 2021, Borno State recorded an outbreak of measles in 7 LGAs where a response was provided in April in less than 3 weeks. The intervention was carried out in due time for the following reasons:

- There was a leftover measles vaccine and devices in the State from the previous 2019 SIA
- UNICEF and WHO funded the operational cost for a quick and timely implementation of the reactive vaccination.
- A consensus was reached in country not to submit any proposal to the MRI-ICG based on the above



2022 preventive mass vaccination campaigns.

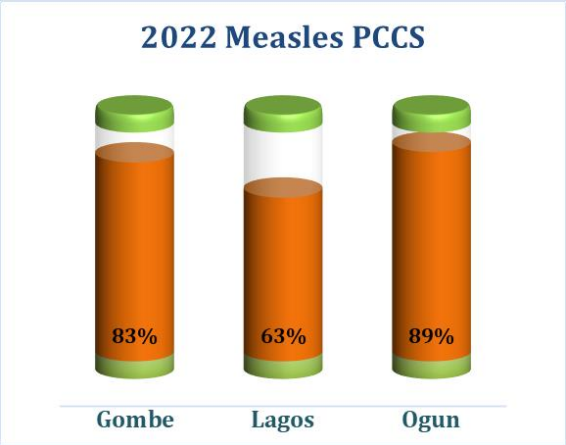
In June 2022, three subnational integrated campaigns (Measles, Yellow Fever, bOPV, MenA, Covid-19 Vitamin A, and RI) were implemented in Lagos, Ogun, and Gombe States.

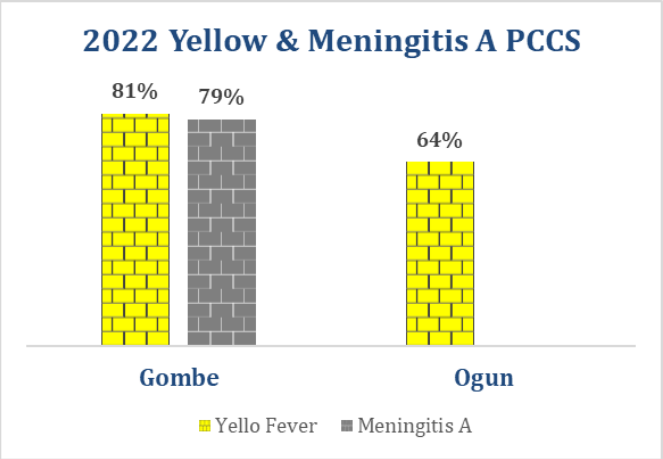
The integration was the first of its kind in the country supported by NPHCDA and Partners. It was done to maximise the use of limited resources and ensure equity in service delivery under the slogan of "one country, one team, one plan, and one budget."

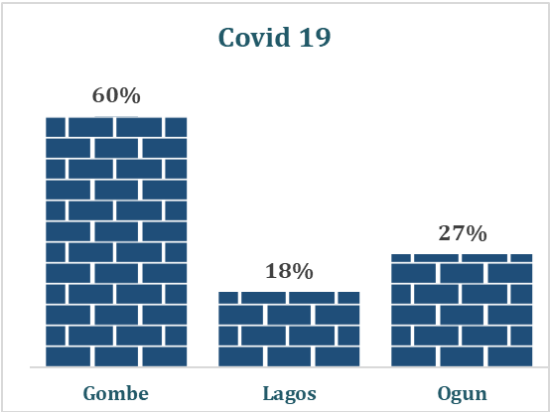
Lagos state implemented Measles SIA with Covid-19, bOPV, Vitamin A Supplementation, and routine immunization in two Zero-Dose LGAs.

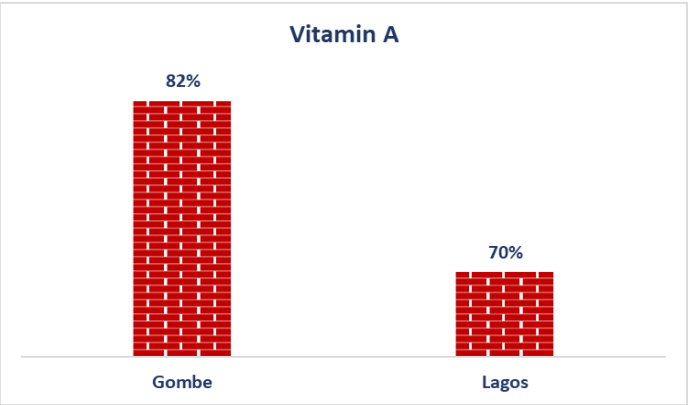
Ogun state integrated the Yellow Fever, bOPV, Measles, Covid-19 and RI while Gombe implemented the integrated campaign with Yellow Fever, Measles, Men A, bOPV, Vitamin A, Covid 19 and routine immunization.

A total of 6,281,891 children aged 9-59 months were reached with measles vaccine in the three states. 621,716 children aged 8-9 years were reached with Men A in Gombe state. 8,902,432 persons aged 9 months - 44 years were reached with yellow fever in Gombe and Ogun states. 3,731,309 children aged 0-59 months with b OPV, 5,052,795 aged 6-59 months with Vitamin A and 775,945 persons aged 18 years and above were vaccinated with Covid 19 vaccines during over a period of approximately 2 weeks of the campaign. Gombe and Ogun states won the best performing states in their zone. The PCCS results showed that 60% of the children received measles for the first time in the three States. The integration yielded positive results in Gombe and Ogun States. Below is the 2022 PCCS for the 3 states that integrated the SIAs







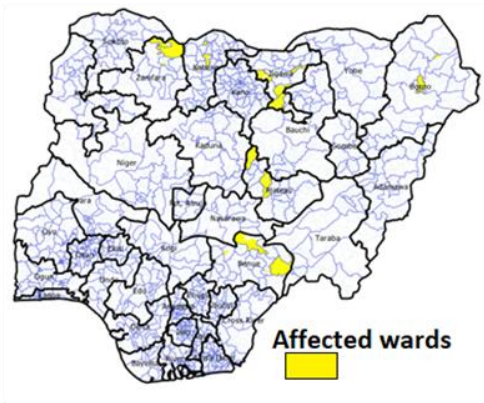


In terms of reaching the unimmunized children, 13 LGAs were identified as Zero dose LGAs in the three states (3 in Lagos, 3 in Ogun and 7 in Gombe) during the integrated SIAs over a period of approximately 2 weeks.

Below is a table showing the number of children reached with routine immunization antigens in those zero dose LGAs.

States	bOPV	IPV	HBV	Penta1	Penta2	Penta3	PCV	VitA
⊞ Gombe	14,695	5,637	1,810	4,949	1,761	1,583	7,816	21,205
⊞ Lagos	16,283	718	129	552	277	336	1,036	26,801
⊞ Ogun	9,106	486	299	377	203	352	898	0
Total	40,084	6,841	2,238	5,878	2,241	2,271	9,750	48,006

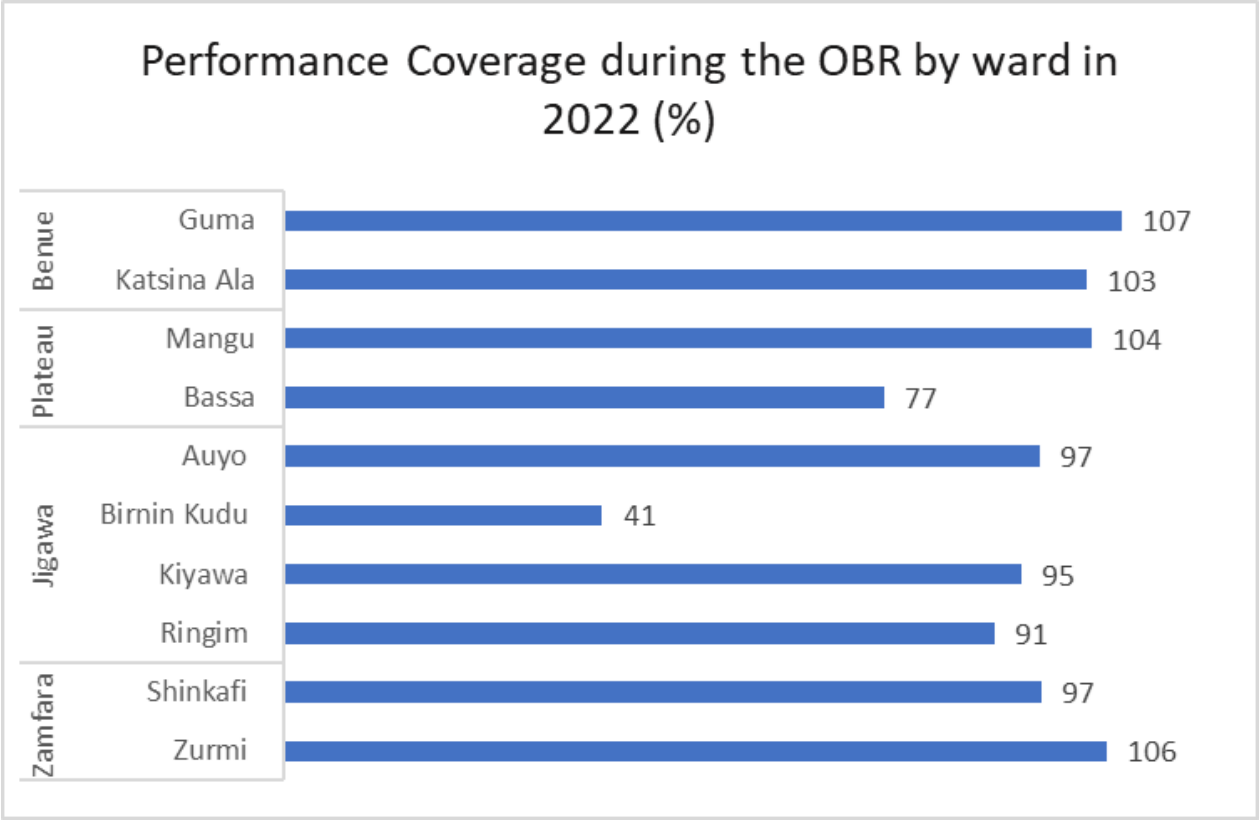
Outbreak Response in 2022



In 2022 UNICEF supported measles outbreak response conducted in 10 LGAs across 4 states namely: Jigawa (4 LGAs: 205,790), Zamfara (2 LGAs: 139,117), Plateau (2 LGAs: 115,130), Benue (2 LGAs:118,397) and Borno (12 wards in 4 LGAs: 258,412) reaching 836,846 children aged 9-59

months with measles and 253,373 children aged 6-59 months with Vitamin A in Borno (12 wards in 4 LGAs).

State	LGA	TP	Male	Female	9-11 Months	12-23 Months	24-59 Months	Total Daily Doses 9 - 59 Months	Coverage
Benue	Guma	50,746	25,180	25,180	10,685	19,756	24,102	54,543	107
	Katsina Ala	62,036	30,123	33,731	13,228	20,850	29,776	63,854	103
Plateau	Mangu	76,788	38,185	41,474	8,503	19,178	51,978	79,659	104
	Bassa	46,076	16,840	18,631	4,994	10,983	19,494	35,471	77
Jigawa	Auyo	35,454	16,149	18,223	8,945	12,024	13403	34,372	97
	Birnin Kudu	84,170	16,149	18,223	8,945	12,024	13403	34,372	41
	Kiyawa	46,443	20,634	23,320	12,701	16,366	14,887	43,954	95
	Ringim	51,826	22,231	25,042	9,047	13,508	24,718	47,273	91
Zamfara	Shinkafi	42,664	18,525	22,941	7,221	13,470	20,775	41,466	97
	Zurmi	92,413	46,447	51,204	13,090	24,879	59,682	97,651	106
	Total	**588,616**	**250,463**	**277,969**	**97,359**	**163,038**	**272,218**	**532,615**	



Timeliness of the outbreak response.

The 2022 Measles Outbreak

In week 2 of January 2022, States started reporting outbreaks of measles. It started from Katsina even though the State completed the preventive campaign in early December 2021. However, the outbreak was declared over within a short period of time which can be associated with the impact of the campaign. However, outbreaks continued in other States such as Zamfara, in three northern LGAs of the States which has serious security issue, Jigawa (4LGAs), Plateau (2 LGAs), and Benue (2 LGAs). Following an emergency stakeholder meeting between Government and Partners an Outbreak response was conducted in the affected LGAs in March. The lag time between the outbreak and the response was about 4-6 weeks.

Lessons learned from the 2021 -2022 Campaigns

1. Implementation of several health interventions previously affected by COVID-19 lockdown targeted through same health workers was a challenge, so harmonization of workplans from the national level while guiding lower levels on implementation should be the way forward.
2. COVID-19 vaccination rollout was a priority which affected other health programs including the campaigns, therefore integration of COVID-19 vaccination with other health programs should be encouraged.
3. All programmes that intend to integrate, must have all requirements (commodities, supplies, training, funding) on time before the process starts
4. Details of integration and indicators to track should be clearly spelt out at the planning phase to avoid last minute changes which could affect programme implementation.
5. Counterpart funds (National/States) must be released in timely manner to avoid delay in implementing all required activities.
6. Due to limited number of human resources and fast cold chain equipment, States were advised to stagger the implementation. It must be stated that, since 2015, no recruitment has occurred for the primary health care services. Going forward, if volunteers/unemployed personnel are not used/available, work with available limited human resource available while extending their implementation period should be considered.
7. The integration approach has led to an increase in RI coverage (Zero Dose LGAs) and daily COVID-19 uptake in the stream 1 states (Lagos, Ogun and Gombe)
8. Collaborative supervision amongst partners and government (Zones/states) enhances supervision and integration
9. Adaptation of vaccination to suit local context helped in reaching special populations (e.g., evening vaccination for farming/fishing communities)

Risks/Challenges and mitigation measures

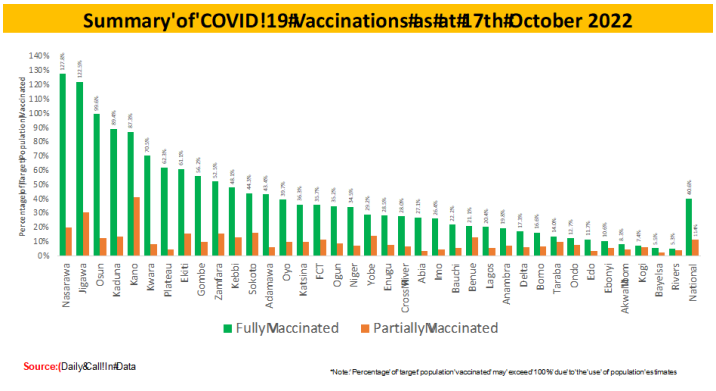
#	Challenges	Mitigation measures
1	Multiple change in campaign date because of the COVID-19 vaccination roll-out shortened the planning time for the NPSIAs	▪ Integration of SIAs with Covid 19 and other interventions

		▪ Strict adherence to readiness timelines in the readiness dashboard and decision matrix
2	Poor ownership of program outcomes	MOU with states to be signed to ensure accountability before commencement of implementation
3	Non-utilisation of all approved number of teams	States to submit detailed line list of vaccination team members to NPHCDA team for verification prior to implementation
4	Delay in the release of FG and State counterpart funds	Implementation will commence only in state with confirmation of release of counterpart funds
5	Delay in the disbursement of ACSM and logistics funds to LGA/ward levels	Funds must be disbursed to lower levels at least 2 weeks to implementation
6	Gaps in cold chain equipment (Fast Cold Chain Equipment)	Sourcing of equipment from neighbouring LGAs/States and Staggering of campaign implementation
7	Gaps in human resources	▪ Use of ad-hoc personnel and staggering of campaign implementation. ▪ Reduce the number of vaccination teams and extend the number of implementations
8	Industrial action	Campaigns to be conducted after industrial action
9	Dynamic nature of insecurity across some states can affect the SIA	The campaign will leverage polio program experiences e.g. use of cJTF and military in reaching vulnerable groups in security threat settings
10	Delay in the commencement of PCCS in 2021 due to delay in DCT because of the risk status of NBS	NBS to clear DCT ahead of time

7. Learning Question: How has the introduction of COVID-19 vaccine progressed?

Indicator(s):

- Reflect on current coverage levels of the adult population and key at risk population.
- Describe how the country plan to use opportunities for integrated delivery of COVID-19 vaccine with routine immunisation & other primary health care services



Country comments (please consider the set of cross-cutting questions to structure comments):

Reflect on current coverage levels of the adult population and key at-risk population.

The target population for COVID-19 vaccination in Nigeria is 18 years and above which is 111,776,503 nationwide. The priority groups (Key at-risk population) considered during the vaccination include the health care workers (2% of the population), other frontline workers (4%), people with comorbidities including the immunocompromised – hypertensives, diabetics, transplants, AIDS, cancers, autoimmune diseases, sickle cell diseases etc., the elderly - 50 years and above (22%). The country deployed different strategies during the COVID-19 vaccine introduction in line with the National Vaccine Deployment Plan (NVDP). As of 20th November 2022, the country has fully vaccinated 55,584,706 persons representing 49.7% of the eligible population while a total of 68,102,505 persons representing 60.9% of the eligible population who have had at least one dose of the COVID-19 vaccine.

The TEACH strategy was deployed to reach the priority groups at the beginning of the vaccine introduction. Other strategies were deployed, including the PSI-COVID, SCALES, Optimised SCALES 2.0 and SCALES 3.0 following an expansion of the vaccination scope to reach the broader target population in the different phases of vaccination as the pandemic evolved.

The Optimised SCALES 2.0 and SCALES 3.0 also put into consideration strategies to reach the special populations of concern such as refugees, the internally displaced persons (IDPs) and migrants to ensure the at-risk population are vaccinated while integrating COVID-19 vaccination with other PHC services including routine immunization and polio/non-polio supplementary immunization activities.

Describe how the country plan to use opportunities for integrated delivery of the COVID-19 vaccine with routine immunisation & other primary healthcare services

Nigeria has started implementing strategies to leverage on the COVID-19 vaccination to deliver other primary healthcare services including routine immunisation (RI). This commenced with the deployment of the Primary Health Care Integration with COVID-19 Vaccination (PSI-COVID) strategy in August 2021. This integration is not only to increase the PHC services coverage but also to strengthen all the elements of the PHC system. The country has also integrated the covid-19 vaccination with the Supplemental immunization campaign in Lagos, Ogun and Gombe states in June and July 2022.

Subsequent strategies (Optimised SCALES 2.0 and SCALES 3.0) built on the PSI-COVID strategy and were developed to strengthen the integration of COVID-19 vaccination with PHC services, including RI, riding on accountability and performance based payments to beneficiaries. The integration is being done at national and subnational levels along all the thematic areas as follows:

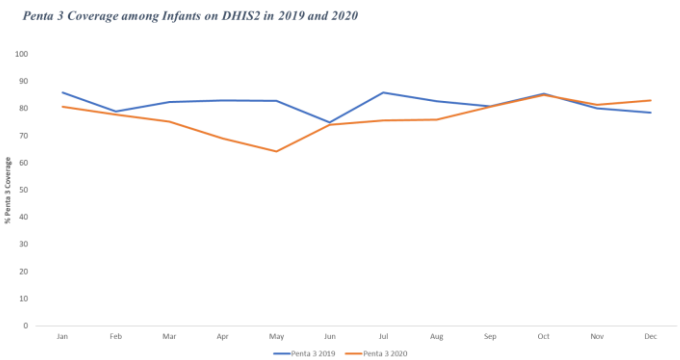
- **Leadership and coordination**: Harmonised coordination structures (for COVID-19 vaccination, RI, SIAs, and Vitamin A supplement) were established at the national and sub-national levels. These include the Strategy Group, Operations room at the national and state levels, State task force and coordination teams at the state level etc.

- **Service delivery**: At the service delivery points, the vaccination teams (fixed and mobile teams) provide integrated COVID-19 vaccination, RI services, vitamin A supplementation (VAS), ante-natal care, family planning, nutrition services and health checks (at all the fixed posts). Services were also integrated during NEMCHIC, SIAs and OBRs activities. This is possible and necessary because the available human resources were trained to implement all the interventions at the subnational, including the community level.
- **Logistics and supply:** There is harmonised logistics movement of vaccines and health commodities to the last mile. The reverse logistics was also harmonised for efficiency.
- **ACSM**: The advocacy, communication and social mobilization (demand generation) activities are integrated at the national and state levels including the airing of jingles, community engagements, media engagements etc with integrated messages. The CHIPs structures and other community structures are used to facilitate the integrated demand generation activities for service provisions.
- **Data management:** There is joint data reporting and feedback to all levels through the daily call-in-data as the data template was reviewed accordingly to accommodate RI. The EMID is currently being used for COVID-19 vaccination. The process of expanding it to accommodate RI and other PHC service data is in progress.
- **Training**: Training, retraining, and training updates for healthcare workers are harmonised across all thematic areas with an emphasis on the integration of service delivery. In addition, supervisors are encouraged to provide integrated on-the-job training during supportive supervisory visits.
- **Supportive supervision**: Supportive supervision with the objective to improve the quality of care and management is carried out with supervisors deployed from the national and subnational levels to support the implementation of all program activities across different levels. Accordingly, the ToR of the supervisors is regularly reviewed and updated to reflect integrated supervision thus optimizing every supervisory visit.

8. Learning Question: Trajectory and progress against targets set

- **How does the progress over the past year compare with your Theory of Change or programme objectives?**
- How has **COVID-19** and **COVID-19 vaccination** impacted your routine immunisation programme, what has been done to maintain and restore immunisation and what has been the impact of it (please include reference to trends in DTP3 and MCV1 coverage)?
- If there are **other factors** (e.g., government transitions, natural disasters, other disease outbreaks, etc.) which have led to disruptions in your immunisation programme over the last year, please also reflect on those.

Indicator(s):	

• Number of children who received DTP3 and the number of children who received MCV1 in the past year compared to the number who received those vaccines in 2019. Penta 3 coverage monitored monthly on the DHIS2 showed a decline in children that received the antigen in 2020 when compared to 2019	

Country comments (please consider the set of cross-cutting questions to structure comments):

How does the progress over the past year compare with your Theory of Change or programme objectives?

NPHCDA, in its 2021/2024 mid-term strategic plan, was to implement high-impact interventions that would lead to significant improvement in PHC services, including the delivery of RI. The plan was fully aligned with the innovative strategies and interventions that are contained in the 2018/28 NSIPSS and designed within the context of the current global Immunization Agenda 2030 (IA 2030) and the GAVI 2021-2025 (GAVI 5.0) agenda, which has the basic principle of leaving no one behind. The 2021/24 strategic plan also had an upward review of its goal and objectives with the ambitious target to achieve:

- National Penta 3 coverage of 90% by 2024
- Reduce the number of under-immunized children by 20% of the target cohort by 2024
- Reduce the number of Zero-dose children for Penta 1 by 35% by 2024
- Enhance sustainability of immunization program management, including improvement in the quality, equity, and coverage of immunization services

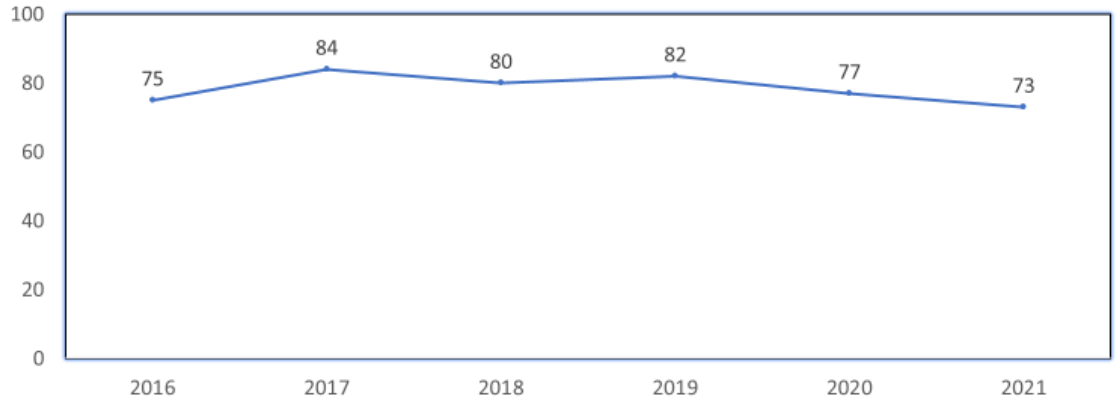
Against the ambitious target of 90% by 2024, Nigeria achieved 57% in the national coverage of Penta 3 vaccine in 2021 (MICS/NICS, 2021). This represents a 24 percentage point increase over the coverage of 33% of Penta 3 in 2016 (MICS/NICS, 2016). However, there is a slight increase in the number of unimmunized children from 18% in 2020 to 20% in 2021 (WUENIC Report, 2020 and 2021). A reduction in the number of zero-dose (Penta1) children from 2.5 million to 2.2 million (difference of 300,000 children) was achieved over the same period (WUENIC Report, 2020 and 2021).

How has COVID-19 and COVID-19 vaccination impacted your routine immunisation programme, what has been done to maintain and restore immunisation and what has been the impact of it (please include reference to trends in DTP3 and MCV1 coverage)?

The Impact of covid-19 on routine immunization was felt only in the first half of 2020. By 2021, the country implemented a mitigation plan which led to routine immunization returning to normal. The 57% Penta 3 coverage of the MICS/NICS 2021 alluded to this assertion. The DHIS2

data shown below from 2016 to 2021 also show the effectiveness of the mitigation measures taken to stem the impact of the pandemic on RI.

National Trend of Penta 3 Coverage, 2016 - 2021



- Significant improvement in reliability of admin coverage (not more than 100%) from 2016 till 2021 as evident above
- 9 points drop in Penta 3 coverage between 2019 and 2021 shows the minimal impact of COVID19 on RI

Source: DHIS2

Strategies such as the PSI-COVID was introduced in mid-July 2021 to integrate the delivery of PHC services with covid-19 vaccination at Primary Health care centres. Covid-19 vaccination was administered at temporary and outreach sites along with other vaccination.

B. Programme Management

Financial implementation of Gavi cash grants

Cash[2] Support Summary*

Overall live cash grant status

Programme	Approved (US$)	Disbursed (US$)	% Disbursed
CCEOP	25,554,010	25,553,817	100.0%
CDS	44,638,517	41,035,477	91.9%
HSS (2)	133,560,102	89,623,442	67.1%
HSS ZD	13,665,196	-	0%
IPV	7,984,939	7,975,785	99.9%
Measles	4,024,340	3,169,806	78.8%
MenA	57,744,937	54,556,475	94.5%
PCV	2,049,376	4,052,216	197.7%
Rota	4,260,941	4,236,188	99.4%
YF	45,742,687	45,742,687	100.0%
YF diag.	290,348	-	0%
Total	**339,515,393**	**275,945,893**	**81.3%**

[2] All HSIS grants (HSS, VIGs, OPS, Switch), EAF and CDS cash support as applicable for the period 2021.

Specific agreements signed

Grant	Recipient	Period - End-date	Status as of 2021 - 2022				Cash Bal	Compliance**	
			Grant Value	Disbursed	Expenditure	Utilisation		Fin. Rep	Audit
HSS - Surveillance	WHO	Dec 2023	3,122,491	1,089,133 2,033,358	1,823,382	54%	1,299,109	Yes	Yes
HSS – Open LMIS module installation & deployment for RI	CHAI	Sep 2023	1,791,870	801,110		60%			
HSS – 3 Hub	UNICEF	Dec 2023	6,382,636	6,382,636	303,934.59	4.7%	6,078,701.41	Yes	Yes
HSS – ZD Analysis	University of Southampton	Dec 2023	383,230	-					
HSS – TA NPHCDA vaccines financing	CHAI	Dec 2022	413,165	386,558		94%			
HSS - Phones	Airtel	-	2,053,000	-					
HSS – States (2020) - incl add'l assurance & prog support	UNICEF	Dec 2024	53,782,244	25,298,370	11,098,116.13	43.87%	14,200,253.87	Yes	Yes
CDS – EA (NPHCDA)	UNICEF	-	6,911,799	6,911,799	6,483,871.05	93.8%	427,927.95	Yes	Yes
CDS – EA	WHO	Dec 2022	6,538,012	4,871,251	4,840,133	99%	31, 118	Yes	Yes
CDS – EA: TA for COVID-19 vaccines delivery preparations & readiness	CHAI	Dec 2022	234,446	234,446		100%			
CDS – OpenLMIS COVID-19 Module	CHAI		1,312,934	503,353		94%			

CDS – EA	eHealth Af	Mar 2023	679,154	204,225.59	204,225.59	100%			
CDS – NBW (NPHCDA)	UNICEF	Dec 2023	13,070,166	13,070,166	11,148,799.9	85.3%	1,921,366.10	Yes	Yes
CDS - NBW	WHO	Dec 2023	13,944,816	12,097,614 1,847,122	11,695,304	97%	402,390	Yes	Yes
COVAX CCE	UNICEF-SD	-	2,554,787	2,214,717	1,477,286.57	66.7%	737,430.43	Yes	Yes
Measles F/U - C	WHO	Jun 2023	29,001,711	20,079,099	10,795,380	54%	9,283,719	Yes	Yes
Rota VIG (NPHCDA)	UNICEF	-	1,947,599	1,947,599	1,187,513.52	61%	760,085.48	Yes	Yes
Rota VIG	WHO	Jun 2023	2,288,589	2,288,589	2,036,481	89%	252,108	Yes	Yes
YF – OPC (NPHCDA)	UNICEF	-	6,578,076	6,578,076	1,335,325.93	15.5%	5,242,750.07	Yes	Yes
YF – OPC	WHO	Jan 2023	7,618,750	7,618,750	5,868,848	77%	1,749,902	Yes	Yes

*All amounts are in USD

**Comment below in case of non-compliance

9. Learning Question: How well is the country able to absorb Gavi funding and what are the drivers? (This should cover all funding including funds channelled through partners.)	
➢ Comment on the financial implementation progress of grants including but not limited to the utilisation rates. What are the key issues?	
Indicator(s): ● Percentage of grant funds utilised ● Amount of cash balance in-country	
Country comments:	

Grant	Recipient	Status as of 2021 - 2022			Drivers of Utilization
		Grant Value	Disbursements	Utilization	
HSS – OpenLMIS Module Installation & Deployment for RI	CHAI	1,791,870	801,110	60%	1. Staff Time 2. System Build and Development of the OpenLMIS RI & SIA Module & SIA 3. Training and Capacity building of HCWs 4. Logistics support for training
HSS - TA NPHCDA Vaccines Financing	CHAI	413,165	386,558	94%	1. Staff Time 2. Local Logistics
CDS – EA - TA for COVID-19 Vaccines Delivery Preparations and Readiness	CHAI	234,446	234,446	100%	1. Staff Time 2. Local Logistics
CDS – OpenLMIS COVID-19 Module	CHAI	1,312,934	503,353	94%	1. Staff Time 2. System Build and Development of the COVID-19 Module 3. Training and Capacity building of HCWs 4. Logistics support for training 5. Procurement of Laptops and Tablets for State and LGA cold chain officers
CDS – EA	eHealth Africa	679,154	204,225.59	100%	

UNICEF

Grant	Recipient	Period - End-date	Status as of 2021 - 2022				Cash Bal	Compliance**		Drivers of Utilization *Provide bullet point explanation for utilisation below 100%*
			Grant Value	Disb.	Expenditure	Utilisation		Fin. Rep	Audit	
HSS – 3 Hub	UNICEF	Dec-23	6,382,636	6,382,636	303,934.59	4.70%	6,078,701.41	Yes	Yes	1. Three hubs (Kano, Lagos & Abuja) operationalization assessment vendor contracting. 2. Infrastructure design works for construction.
HSS – States (2020) - incl add'l assurance & prog support	UNICEF	Dec-24	53,782,244	25,298,370	11,098,116.13	43.87%	14,200,253.87	Yes	Yes	1. Reactivation and operationalisation of RI and PHC coordination structuresBayelsa, Katsina, Jigawa, Kebbi, Zamfara, Niger, Gombe and Taraba. 2. Service deliver support for Penta1, Penta3 and skilled birth attendance. 3. Demand generation activities to empower communities and improve quality, access, and utilisation of integrated RI and PHC services, the programme supported the scale-up of evidence-based demand generation and community mobilisation activities in all 8 states. 4. Data management, HR, Procurement of logistics, supplies and commodities for 8 states.
CDS – EA (NPHCDA)	UNICEF	-	6,911,799	6,911,799	6,483,871.05	93.80%	427,927.95	Yes	Yes	1. Technical assistance to NPHCDA and SPHCDA for Covid-19 vaccine deployment. 2. Logistics, vaccine storage and shipping and social mobilization for Covid-19 vaccine deployment.
CDS – NBW (NPHCDA)	UNICEF	Dec-23	13,070,166	13,070,166	11,148,799.90	85.30%	1,921,366.10	Yes	Yes	1. Covid-19 harmonized micro planning exercise. 2. Vaccine shipping & Logistics, HW logistic allowances, and social mobilization for SCALES campaign for Covid-19 vaccine deployment. 3. Storage of Covid-19 vaccine at national level.
COVAX CCE	UNICEF-SD	-	2,554,787	2,214,717	1,477,286.57	66.70%	737,430.43	Yes	Yes	1. Procurement and deployment of 87 cold chain equipment, 1,455 cold boxes for national, zone and state stores.
Rota VIG (NPHCDA)	UNICEF	-	1,947,599	1,947,599	1,187,513.52	61%	760,085.48	Yes	Yes	1. Advocacy communication & social mobilization activities including HW training in all 774 LGAS in 37 states for Rota vaccine introduction. 2. Community dialogue with community leaders and health workers for sensitization of communities in 10,000 wards in 37 states. 3. RI intensification during the Rotal vaccine introduciton.
YF – OPC (NPHCDA)	UNICEF	-	6,578,076	6,578,076	1,335,325.93	15.50%	5,242,750.07	Yes	Yes	1. Training of HW for integrated campaign in 5 states. 2. Vaccination team Logistics, EMID recorder, vaccine transporation cost for YF campaign in 5 states as part of the integrated campaign.

WHO

Grant	Recipient	Period - End-dat	Status as of 2021 - 2022				Cash Bal	Compliance**		Drivers of Utilization *Provide bullet point explanation fo utilisation below 100%*
			Grant Value	Disb.	Expenditure	Utilisation		Fin. Rep	Audit	
HSS - Surveillance	WHO	Dec-23	3,122,491	1,089,133	1,823,382	54%	1,299,109	Yes	Yes	Supportive supervision in 23 CSM Laboratory
CDS – EA	WHO	Dec-22	6,538,012	4,871,251	4,840,133	99%	31, 118	Yes	Yes	Payment of COVID-19 Vaccination personnel for Scales 2.0
CDS - NBW	WHO	Dec-23	13,944,816	12,097,614	11,695,304	97%	402,390	Yes	Yes	Payment of COVID-19 Vaccination personnel for Scales 3.0
Measles F/U - C	WHO	Jun-23	29,001,711	20,079,099	10,795,380	54%	9,283,719	Yes	Yes	Payment of stipends to vaccination personnel
Rota VIG	WHO	Jun-23	2,288,589	2,288,589	2,036,481	89%	252,108	Yes	Yes	LGA and Ward Level implementation training for 77 LGAS and all 9551 wards
YF – OPC	WHO	Jan-23	7,618,750	7,618,750	5,868,848	77%	1,749,902	Yes	Yes	Payment of stipends to vaccination personnel

10. Learning Question: How well is the country resolving issues arising from assurance activities? What issues are left to solve and what is the path forward?

- What is the progress of Grant Management Requirements implementation?
- How has the country addressed recommendations arising from past audit recommendations (annual external audits + Gavi Programme Audit)?
- Comment on the improvements that have been made to financial management and risk assurance activities with the support of assurance providers (e.g., Fiscal Agents, Monitoring Agents, Financial Management Technical Assistance).
- Specifically, what actions have been taken to enable a larger % of Gavi funds to be channelled back through government systems?

Country comments:

Prior Gavi audit/KPMG Recommendations

To address the gaps in the NPHCDA financial management system identified in Prior Gavi audit and the subsequent recommendations by KPMG on modalities for addressing those weaknesses. The NPHCDA in collaboration with partners developed a comprehensive financial management capacity building plan for the Agency. The plan which is to be implemented in 2 phases over a 3 year period contains short term actions to be completed by the end of 2022 and series of wider reform actions to be implemented over 2023/2024.

The short term actions which have already been implemented include the computerization of the agencies finance and accounts, fixed assets, procurement, and inventory management systems using the flexible accounting software which is currently being used for world bank projects in the country. In addition, the KPMG is also currently supporting the NPHCDA in establishing an integrated programme coordination unit to manage all donor funded projects for optimal efficiency and effectiveness. To achieve this objective, the firm is also developing a comprehensive standard operating procedure (SOP) and manuals for the finance and accounts, procurement, asset management, risk management and grant sourcing functions as well as manual for the IPC. The broader reform actions to be implemented in 2023 and 2024 cover internal audit strengthening, broader staff capacity building, implementation of enterprise resource planning (ERP), policy reforms and anti-corruption and change management among other things.

2021 Gavi PCA Recommendation

The 2021 Gavi Programme Capacity Assessment identified some key weaknesses in programmatic processes and made far reaching accommodations towards addressing such gaps. The weaknesses were mainly found around Vaccine Supply Chain Management, Data management, service delivery, PEF TCA and the NSIPSS accountability framework implementation. However, there are on-going efforts at implementing some of the key recommendations from that assessment as highlighted below:

a) Vaccine Supply Chain Management:

i) The NLWG (NPHCDA) is responsible for overseeing the implementation of the 3-hubs architecture and has focal points that are responsible for regular progress tracking and reporting. Other efforts include:

- Establishment of a Project Management Team

- Construction commenced in Lagos Hub Contract awarded for Abuja Hub construction.
- Architectural designs and BOQ for Kano Hub under review prior to contract award
- Commencement of 3-Hub system redesign operationalization analysis

ii) NPHCDA has continuously ensure that the VVM status is always checked and recorded during the hand-over of vaccines deliveries/ receipts between storekeepers working across different tiers and levels of the health system. These have been achieved through:

- Continuous use of an ODK based LMIS for data visibility at the National, Zones, States and LGAs
- Deployment of OpenLMIS Covid-19 module
- Visibility for Vaccines (ViVa) online tool to support in-country stock management.
- Thrive 360 has been deployed for stock data triangulation (National & State) to inform decisions.

iii) To strengthen the vaccine forecast and documentation, the country has taken steps to strengthen the system through the.

- Conduct of annual vaccine forecast development based on agreed parameters.
- Shipment tracking triangulation with consumption to inform vaccine procurement.
- Use of supply planning tool for COVID-19 vaccine shipment planning
- Bi-annual forecast performance review

iv) To improve waste management and reverse logistics at all levels, NPHCDA and SPHCDA will develop and implement a comprehensive immunization waste management plan to improve disposal of waste across the supply chain. The country has also carried out the following activities as measures to continue to improve the waste management system. They include:

- Nationwide waste management training of State Immunization Waste management Officers
- Establishment of a national waste management committee with clear TORs

v) Conduct of annual audits to identify obsolete CCEs. Guidelines have been provided to states on the procedure for decommissioning CCEs and advocacy to set-up decommissioning committee.

b) Data Management

i) The NPHCDA has continued to adopt strategies to improve data quality with the DQIP and other data improvement programmes. The efforts in strengthening the data management system include:

- Development of DQIP
- Domestication of DQIP in six states
- Conduct of Data Quality Use Focused Supportive Supervision in few states.
- Incorporation of data quality tool on the DHIS2 national instance
- Conduct of quarterly Data Quality Assurance sampling in 6 MOU states and 8 HSS states
- Use of RMNCAH scorecard for decision making
- Conduct of monthly validation meeting for data improvement
- Development of RI/VPDs data triangulation dashboard

c) Service Delivery

Challenges in service delivery around planning& coordination, HRH, Access, and Demand generation have been incorporated in the development of workplans across these core areas. The recommendations from the past audit such as timely last mile delivery and improved access to vaccination has improved within the year under review.

d) PEF TCA

i) The TCA delivery approach has been re-designed to ensure that the designated activities are specific, measurable, accurate, relevant and include defined timelines. This objective will be further achieved with its alignment with the Accountability Framework.

ii) The TCA partners performance will be further validated on the reported deliverables to prior to these being reported by the partners via the Gavi PEF portal.

e) NSIPSS Accountability Framework

The definition, targets, milestones of some of the AF indicators have been refined for improved clarity of performance tracking and measurement. Some of the indicators have been decentralised for greater program ownership, commitment, and Accountability with two new indicators, and one zero dose indicator added.

In addition, the implication/action for all the indicators were refined to reflect specific actions to be taken if targets are not met.

The following assurance and accountability measures have been adopted by the country to ensure the appropriate utilisation and management of Gavi funds.

Assurance & Accountability	Current Status
Availability and Implementation of Accountability Framework	The NSIPSS Accountability framework has aided the tracking of vaccine financing and accountability in the country over the past three years. A comprehensive review of the AF was conducted in 2022 to ensure that indicators, targets, and measurement approaches better reflect the current realities in the country. The review would address challenges with effective implementation and utilization.
Implementation of Accountability Framework for routine immunization in Nigeria	The existence of an accountability framework for routine immunization has a significant impact on RI. This has been fully operationalized in the country. There are examples of states that have implemented sections of the framework to reward and sanction health workers which has improved accountability compliance. Nevertheless, with better political will from the government at the highest level the RI framework will be sustained if accountability commitments are met especially at the national level.
Funding for vaccine procurement is ring-fenced in the service-wide vote	Immunization funds for vaccine procurement through the Government are reserved in the service-wide vote domiciled in the Federal Ministry of Finance. All funds disbursement from the service-wide vote must be justified and approved by the ministry of finance.

Broader Government reforms for enhancing transparency and management of resources.	These include the implementation of the Treasury Single Account (TSA) at the Central Bank of Nigeria for enhanced visibility, efficiency, and transparency in the management of resources. Also, the implementation of the government-integrated financial management information system (GIFMIS) ensures real-time electronic payment systems end to end to vendors and service providers and other categories of payees. The use of the GIFMIS, TSA, and other e-payment systems have strengthened the use of allocated resources. The automation of the audit system and internal audit
Full operationalization of NPHCDA financial management capacity building plan in line with the Grant management requirements.	The plan is being implemented in two (2) phases comprising the short-term actions to be concluded by the end of 2022 and the wider reforms to be executed over three (3) years. A finance working group/active finance committee that aligns both Government, Donors and Partners' investments in Immunisation does not exist. However, the implementation of NSIPPS AF has given rise to the Accountability and Vaccine Financing Task Team that is currently looking into mobilising resources for vaccine procurement.
Clear systems established for transparent fund disbursement, retirement, and audits of the financial management system at sub-national levels???	The operationalization of the NPHCDA Financial Management system/process redesign has commenced. The Finance and Accounts, Internal Audit, and Procurement functions have been redefined and all relevant staff reoriented. However, the implementation of integrated financial management software that links planning and budgeting, finance and accounts, procurement and inventory management and internal audit system has not been achieved. But there is an ongoing effort at engaging a suitable vendor to handle this aspect subject to the availability of funds. The Framework for the implementation of BHCPF has embedded in its transparent processes for fund disbursement, utilization, and financial reporting mechanisms for the States and LGAs.

11. Learning Question: Please comment on any other financial management-related bottlenecks for implementation and compliance.		
#	Critical Challenges	Mitigation strategies in line with the Accountability Framework (AF)
1	Poor ownership, weak political commitment, and consequent low prioritization of immunization funding in the states and LGAs annual budgets	Leverage existing Government platforms e.g. the Governors forum, the National Economic Council, the conference of speakers of states houses of assembly, etc to advocate for Increased year-on-year health sector, PHC and immunization budgetary allocations
2	Delay in the release of funds for traditional and co-financed vaccines	NPHCDA, FMOH, Budget and National Planning to ensure 100% payment for vaccine requirements for the succeeding year received before 31 December of the current year.
3	Non-release of budgetary allocation for PHC at the sub-national level	Advocate for states and LGA 25% counterpart funding to complement >=1% of the FGoN Consolidated Revenue Fund allocated to BHCPF
4	Low capacity in the management of resources at the sub-national level	Strengthen financial management capacity at all levels through the tracking of implementation of financial management capacity building plans across the board for enhanced transparency and accountability in resource utilization
5	High out of pock expenditure on health at 72%	The revenue generated from out-of-pocket payments is high and should be properly documented and remitted at the sub-national level
6	The LGA Autonomy will affect the funding allocation to states and PHCUOR arrangement	Engage the Association of Local Government of Nigeria on the need to prioritize PHC and Immunization

12. Learning Question: Is the country effectively addressing gender related barriers (e.g. faced by caregivers or adolescents in accessing immunisation services and barriers faced by health workers in delivering immunisation services)?	
Indicator(s):	Graphs: *(Examples to be replaced with specific country versions)*

● Has the country implemented initiatives that remove or reduce gender-related barriers? Qualitative information	

Country comments:

The country is working vigorously to effectively address gender-related barriers in all health sub-sectors, including immunization.

The Coverage, Equity and Bottleneck Analysis (CEA) that was conducted in 2021 showed mixed pieces of evidence on the effect of the gender of a child on access to immunization. In terms of access to immunization services, there is no gender bias in all the reported coverage surveys. The 2018 NDHS report shows the percentage that was fully immunized with childhood vaccines was 31.5 % for males, while the female was 31.1%. The 2021 MIC/NICS report did not show any gender disparity in respect of access to immunization, as gender was not included in the demographic disparities, which included the maternal age, urban/rural, mother's education and wealth quintile.

Also, the qualitative evidence in the CEA report shows that there are strong pieces of anecdotal evidence that female-headed households have less access to immunization, which likely has cross-sectionality with household per capita income. This is common among Internally Displaced Persons (IDPs) families in insurgency-ravaged areas where many male heads of households are dead or missing. The findings that female-headed houses are often IDP families in north-eastern Nigeria show cross-sectionality of gender, insecurity, minority status and provision of services by the government. Programmatically, it was also established from anecdotal and empirical evidence that female health workers are preferable to males in population-related health interventions that involve entry into households, especially in the northern parts of the country. On the other hand, female health workers are prone to rape and other forms of abuse against the female gender during house-to-house public health interventions. Programmers are expected to show sensibilities in the deployment of health personnel in public health interventions.

Following the above, it was recommended that the health sector, through the NPHCDA, should share data on the negative effects of inequities in education and socioeconomic opportunities on the health and general well-being of mothers and children and the societal consequences with relevant sectors for the purpose of interventions. Accordingly, effective partnership, collaboration, and cooperation with the Ministries of Humanitarian Affairs, Education, Women Affairs, and the National Orientation Agency should be established to develop a joint project for addressing gender-related issues on health. These include female education, and women empowerment, particularly, economic, and financial inclusion initiatives.

The Agency has sensitized communities on the importance of immunization and the need to get the children effectively vaccinated. In addition, more female RI service providers have been trained and deployed to the immunization sub-sector which has yielded positive and tremendous results. The RI service providers have also been directed to provide RI services in an open space within the facility setting. This has also helped significantly in addressing the concerns of both female caregivers and their husbands.

Other efforts by the country aimed at addressing gender-related barriers include

1. Conduct of formative research on new vaccine introduction to explore possible gender barriers in relation to cultural norms, religious beliefs, and geographical differences in the country. This also

includes the conduct of monthly polling in assessing public perception on both RI and new vaccine introduction using various polling sources (telephone, U-report, LGA community) and the findings from the formative research and monthly polling will help develop communication messaging in addressing possible gender issues relating to the RI uptake and planned new vaccine introduction.

2. Early engagement of key stakeholders most especially at the community and household levels in addressing myths and beliefs associated with the girl child as a way of addressing gender barriers/issues in Nigeria
3. Engagement of community volunteers to dispel possible gender-related barriers to RI and new vaccine introduction in Nigeria
4. Use of existing community engagement structures for community dialogues on the importance of routine immunization

The 2021 MICS/NICS coverage survey identified progress as follows.

Considerable progress has been made in achieving universal education and closing the gender gap but gender disparities to the disadvantage of girls still exist in some countries. Further, girls still comprise most of the world's out-of-school population.

Percentage of children aged one year younger than the official primary school entry age at the beginning of the school year who are attending an early childhood education programme or primary school (adjusted net attendance rate).

Preventing adolescent pregnancy not only improves the health of adolescent girls but also provides them with opportunities to continue their education, preparing them for jobs and livelihoods, increasing their self-esteem and giving them more say in decisions that affect their lives. Yet, too often, adolescent girls lack access to appropriate sexual and reproductive health services, including modern methods of contraception.

Adolescent girls and boys are being engaged as civic participants in the decisions affecting their lives and communities. People's sense of security and freedom from the fear of crime influences how they move about those communities, access services and economic opportunities and participate in public life.

Adolescent girls and boys are likely to have different perceptions of personal safety due to different gender-based vulnerabilities to sexual violence and other crimes. Life satisfaction measures an individual's perceived level of well-being or how an individual feels about their life. Measuring adolescent girls' and boy's satisfaction with their lives can provide important insights into their mental health during a stage of life when gender norms consolidate, and girls and boys experience different risk factors for m

While the literacy amongst boys and men aged 15-49 years is 75%, literacy among girls and women of the same age is 61%.

Two-thirds (66%) of boys and men aged 15-49 years read a newspaper, listen to the radio, or watch television at least once a week, compared to half (54%) of girls and women of the same age.

Girls and women aged 15-49 years are more life-satisfied (6.3) than boys and men (5.4) of the same age group, irrespective of their sex, wealth quintile and marital status, and similarly their expectations about their lives will get better in one year.

C. Implementation of Technical Country Assistance (PEF-TCA)

13. Learning Question: Is the country implementing PEF TCA and COVAX TA as expected? Please explain how the TCA has helped to support the achievement of the country's objectives.

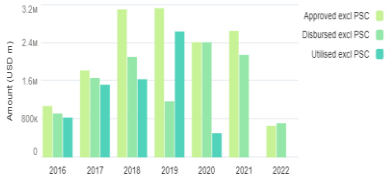
Indicator(s):

- Country analysis on partner performance as per work plans

Graphs:

(Examples to be replaced with specific country versions)

Year	Approved excl PSC	Disbursed excl PSC	Utilised excl PSC
2016	$1,077,849	$920,953	$834,135
2017	$1,823,216	$1,666,390	$1,534,042
2018	$3,104,880	$2,108,660	$1,638,787
2019	$3,129,892	$1,176,234	$2,641,104
2020	$2,414,138	$2,414,138	$507,557
2021	$2,652,460	$2,150,440	$0
2022	$662,143	$716,813	$0



Row Labels	Completed	Major Delays	Minor Delays	On Track	Re-programmed	Unreported	Grand Total	Achievement
COVAX Technical Assistance	**10**	**0**	**0**	**0**	**0**	**0**	**10**	
Target Country Assistance	**16**	**4**	**6**	**15**	**0**	**0**	**41**	
Grand Total	**26**	**4**	**6**	**15**	**0**	**0**	**51**	

Section 2: Looking forward: Summary of key discussion points and follow up actions for 2023 and beyond.

Briefly summarise the **key discussion points**, including **identified needs** and **follow up actions** resulting from the Joint Appraisal review and dialogue.

This may include

Service delivery, ACSM and Covid-19

Thematic area	Key Challenge	What is being done (key interventions)	Priority Interventions	Future Needs (TA Support)
Planning and Coordination	1. Poor integrated microplanning and implementation 2. Suboptimal coordination of partners at subnational level (implementation of parallel activities) 3. Poor ownership of RI-PHC programs in about 70% of states 4. Poor implementation of accountability at State and LGA level 5. Poor utilization of coordinating structures at subnational levels	1. Desk review of micro plan development 2. Pilot of GMT for microplanning 3. Integrated micro plan template for RI, Polio and NPSIA 4. Partners coordination forum 5. Integrated workplan development 6. Implementation of PHCUOR	1. Update existing micro plan template to capture all PHC services 2.Train HCWs on integrated PHC micro plan development 3. Conduct integrated PHC Micro plan development process 4. Scale up GMT 5. Integration of PHC coordination platforms at state and LGA levels (SEMCHICC, SERICC/RIWG, EOC, SLWG etc)	TA for Zero dose Funding support

HRH	1. Inadequate & poorly motivated HRH to deliver quality services 2. Inadequate & poorly motivated HRH to deliver quality services: Volunteers constitute about 40% of RI service providers in 80% of states Less than 30% of HFs in 60% of states have full complement of the health workforce 3. Irregular/non- payment of HWs salaries in some states 4. Inadequate technical capacity of HWs and transfer of skills 5. Difficulty to hold Volunteers accountable due to weak engagement process 6. Frequent staff/volunteer transfers/turnover/maldistribution 7. Inadequate knowledge on RI and other PHC services amongst some volunteer RI service providers	1. Profiling of HRH by state 2. High level advocacy 3. Peer-led learning 4. On the site training of health workers during supportive supervisory visits	1. Conduct of evidence based targeted advocacy 2. Build capacity (training, mentoring, supervision) of HCWs and volunteers 3. Conduct structured capacity building for Health Workers on RI and other PHC services 4. Develop a framework (identify, train, deploy, transfer and eventual absorption) for volunteer HW engagement 5. Biannual profiling of HRH at HF across all LGAs	
Funding	1. Funding gaps in 70% of states affected conduct of key activities to strengthen the program 2. Repurposing RI related funds for other activities in 30% of states 3. Majority of the states have not release approved budget for RI 4. Inadequate budgeting and non-release and utilization/repurposing of funds	1. Mapping of existing funding sources at national level	1. Map out funding sources at subnational level 2. Develop integrated costed AOP with govt. and partners and ensure timely submission 3.Advocate for budget line for RI and PHC services and release 4. Build capacity of states on budgeting and development of AOP	

Access	1. Poor conduct of outreach and mobile sessions 2. Insecurity 3. Poor integration with other PHC activities 4. MOV implementation 5. Gender barriers (non-empowerment of women financially and in decision making) 6. No/irregularities in logistics support for last mile delivery of vaccines resulting to frequent vaccines stock-out	1. Funding of outreaches in some states 2. Conduct of RI Intensification activities in select LGA 3. Integration of RI during SIAs (Polio, Non-Polio, COVID19) 4. OIRIS implementation in select states 5. Irregular distribution of vaccines to the last mile (Frequent vaccine stock out).	1. Budget and fund for conduct of one outreach session per week per HF and at least one integrated mobile session per month per LGA. (For non-prioritised LGAs) 2. Implement routine RI intensification activities for prioritized LGAs 3. Intensify quarterly visits to prioritised OIRIS states. 4. Develop strategy to intensify MOV in prioritized Health facilities 5. State to prioritized and empowered trained woman HCWs in PHC services. 6.Institutionalised and track last mile delivery to ensure vaccine availability	TA for resources to meet the minimum number of sessions
Supervision	1. Suboptimal conduct of supportive supervision 2. Lack of data driven supervision	1. Supportive supervision conducted at convenience	1.Build capacity of State & LGA team on optimised integrated supportive supervision and mentorship 2. Transfer skills and capacity of state on the conduct of monthly OIRIS visits to LGAs	TA for resources to finance OIRIS visits
Demand Generation	1. Sub-optimal implementation of integrated community engagement strategy that was rolled out in 9 out of 18 states 2. Poor communities' ownership and participation in immunization to create demand for RI services in most states 3. Non provision of incentives for community leaders	1. Implementation of integrated community engagement strategy in Zamfara state 2. Conduct of ACSM related activities during new vaccines introduction 3. Development and deployment of integrated RI messaging for demand generation	1. Scale up integrated CE to other 11 NERICC priority states (7 states completed) 2.Implementation of incentivized integrated community engagement strategy in Adamawa, Katsina, and Niger states	TA for resources to fund monthly engagement and reconciliation meetings and stipends for community member participation

COVID19	1. Suboptimal ownership of COVID 19 Vaccination activities at subnational level 2. Demand (Hesitancy, Low risk perception) 3. Delay in approval and release of funds	1. Partner mapping for available resources 2. Implementation of SCALES 3.0 3. Accountability based payments 4. Integration of COVID with RI	1. Integration of COVID with RI 2. Routinising COVID vaccination 3. Strengthen accountability by performance-based incentives	Continue with existing TA support

Plans to Improve Data Management in Nigeria

Thematic area	Overarching gaps/challenge	What is being done	What is working	Priority Interventions
Accountability Framework	Challenges with reliability of data sources used for the routine tracking of governance and health financing indicators	· Reliance on informal means of verification · Appropriation bills, scorecard and annual expenditure, minutes of the meeting are used as major means of verification		Development of KM Tool: · Online Data Repository System to collate means of verification for governance and health financing indicators · Development of automated dashboard for quarterly tracking of governance and health financing indicators

Data quality and use	Suboptimal data quality and use at the LGA and Health Facility levels	· Development of DQIP · Domestication of DQIP in six states · Conduct of Data Quality Use Focused Supportive Supervision in few states · Incorporation of data quality tool on the DHIS2 national instance · Conduct of quarterly Data Quality Assurance sampling in 6 MOU states and 8 HSS states · Use of RMNCAH scorecard for decision making · Conduct of monthly validation meeting for data improvement · Development of RI/VPDs data triangulation dashboard	· Domestication of DQIP using behavioral and technical approaches · Training of State and LGA Workers on how to conduct Data Quality Focused Supportive Supervision	· Review DQIP to reflect EMID, HFR, LMIS etc. · Scale up of SMS reporting in the remaining states · Pilot of COVID19 EMID system to capture individual child immunization record · Build capacity of frontline healthcare workers and EPI managers on data management and triangulation, enhancing their ability to spot data manipulation, to collect accurate information · Scale up of DQIP domestication using behavioral and technical approaches · Capacity building of national and subnational officers on the use of DHIS2 - Data quality tool · Optimization of quarterly data quality assurance sampling · Linking conduct of state and LGA data validation meeting and review meetings to AF dashboard · Integration of RI/VPDs data triangulation dashboard on the DHIS2, MSDAT and SORMAS

DHIS2 operations at national and subnational level	· Irregular funding of DHIS2 database hosting · Inadequate bandwidth on DHSI2 national instance · Capacity gap among government staff on management of the DHIS2 backend	FMoH recently got one year support from partners/donors on DHIS2 database hosting	TA support from HISP on front and backend maintenance of DHIS2 platform	· Creation of budget line for annual hosting of DHIS2 and bandwidth expansion · Capacity building of the government staff (FMoH and NPHCDA) on management of DHIS2 backend · Provision of ICT infrastructure at subnational level (Laptops, internet connectivity etc.)
Health Facility Registry	· Incomplete HF listing of DHIS2 platform · Suboptimal functionality of HFR-DHIS2 interoperability	· Development of HFR and MFL database · Completion of HFR data collection process across 36 states and FCT. · Completion of HFR validation in 7 states (Adamawa, kano, Bayelsa, Ebonyi, F C T)	· Capacity building of State HMIS officer on the HFR data validation process	· Completion of HFR validation in the remaining 29 states. · Interoperability of all Digital Health applications e.g., DHIS2, LMIS, HFR etc.
Governance of HIS at all levels	· Inadequate data tools · Weak coordination at the state level on HIS · Irregular review of NMHIS data tools	· Production of seedstock of data tools · Sharing electronic copy of data tools with states	· Coordination of HMIS at the national level	· Implementation of clear accountability framework on production of data tools and HIS coordination at subnational level

Population denominator	· Inaccurate population denominator	· Triangulation of different population data sources · Projection of annual population using growth rate	· Data Triangulation of different population sources	· Strengthen Civil Registration and Vital Statistics · Scale up of geospatial Micro planning toolkit · Household enumeration
Identification and quantification of zero dose/under-immunized children	· Inability to accurately identify and track the Zero-dose	· Using geospatial modelling approach to determine Zero-dose and under immunized children	· Utilization of geospatial modelling approach and survey data to identify and quantify	· Continued usage of geospatial modelling approach to determine zero-dose and under immunized children until a better method is identified · Quantification of zero-dose and under immunized children through robust micro planning processes · Use of GIS to estimate target population for HF and community levels · Conduct of cluster-based survey (LQAS 2.0) to monitor annual reduction in number of zero dose children in 100 targeted LGAs

Finance and programme management

Thematic area	Challenges	Key/priority Interventions	TA Need
Finance	Low prioritization of health, primary healthcare, and immunization funding in the states and LGA's annual appropriation and non-release of budgetary allocation for PHC at the sub-national level	-Develop an advocacy plan showing activities, timelines and responsible persons based on scientific evidence of the associated social, political, and economic benefits - Perform regular budget expenditure analysis and develop a budget tracking system - Develop and implement state accountability framework.	TA support required
	Delay in the release of funds for traditional and co-financed vaccines	- Implement multiyear planning for vaccine financing - Continued advocacy - Rigorous implementation of the AF indicator on the VF plan which stipulates that funds for vaccine financing should be available on a preceding-year basis.	TA support required
	Delay in financing of Technical Country Assistance for RI and COVID-19	Advocacy from the office of DCI to Gavi for timely financing of TCA	TA support required
	Poor financial management capacity in the management of resources at the sub-national level	- Develop framework for financial management capacity building across states and LGA - Funding for the implementation of the financial management capacity building framework should be included in the budget - Publishing of financial report to the public - Advocate for funds to be available at the SPHCB to be made available to the PHC	TA support required

	High out of pocket expenditure on health at 72%	- Advocate to relevant authorities to ensure full implementation of the NHIA act to broaden the NHI base towards improving access and equity in healthcare delivery in Nigeria	TA support required
	Potential risk to sustainable immunization financing (increasing vaccines budget due to NVI, increasing coverage, and increasing share of co-financing responsibilities, shrinking fiscal space caused by low revenue base and donor transition)	-Meet with the DG Budget/Ministry of Finance to identify the best mechanism to ensure sustainable vaccine financing	TA support required
Programme management	Poor integration of programmes, projects and activities	- Develop comprehensive framework for the development of annual plan with focus on efficiency, elimination of duplication in programme execution and waste	
	Inappropriate definition of project objectives and goals	- Project programmes and activity objectives properly aligned with the interest of the population to promote ownership and commitment.	
	Poor alignment of donor funds with government investment and programmatic priorities	- Develop partners mapping framework showing donor funds for various programmes	
	Weak technical capacity in programme execution, monitoring and evaluation and impact measurement	- Develop capacity building curriculum of programme management e.g MLM training - Draw lessons on financial management and capacity building ongoing in Gavi 8 priority states	

	Low research and innovation in the design of programmes	-Design and implementation of programmatic strategies based on outcome of research and innovation - Leverage Gavi learning Hub for innovations and best practices to refine program design	
	Poor community participation in the design of programmes, project, and activities	Design framework for bottom up approach to programmes design and implementation	

Non Polio Campaigns

Challenges	What is being done	Priority intervention for next year	TA need
Poor ownership of program outcome by subnational level	• Signing of MOU by states • Use of readiness assessment and decision matrix	• MOUs to be introduced from planning phase • MOUs to be signed with Governors • Signing off readiness by government and partners at all levels	**National:** • Planning and coordination • Training • ACSM • Logistics • Operations • Data management • PCCS consultant **State level:** • STA • SBC • AFENET • Zero dose FPs per LGA
Non-involvement of the states in the pre-planning phase (proposal development) of the campaign	• Yet to commence engagement of States	• Involvement of States in pre-planning phase • Stakeholders meeting to get endorsement of proposal before submission	
Over ambitious integration of different antigens and programs of different age groups	• Progressive integration from non-Polio SIA antigens to other programs • Integrating zero dose LGAs	• Consider integration of programs with similar age targets • Realistic integration considering the available HR as well as logistics	

Integration of programs with funding not at par	• Separate funding sources for integrated programs	• Harmonized costed annual workplan developed for all planned integration	• PCCS
Delay in the release of operational funds	• No release of funds no implementation	• No release of funds no implementation across all levels	
Delay in procurement and distributions of data tools and IEC materials	• Centralization of production	• Decentralization of production to state level	
Last minute changes to programme implementation	• Documented as lessons learnt	• Ensure proper planning for multiple implementation	
Gap in HR and fast CCE	• Verification of HR list close to campaign implementation • Staggering of campaign	• Update HR list at State level and submit 3 months before implementation • Team allocation based on available HR in State and extending implementation period	
Prepositioning of resources at subnational level before finalization of requirements at national level	• Prepositioning of resources as per approved budget without consideration of available HR at subnational level	• Resources prepositioning should be done after verification of available HR at subnational level and approval by NPHCDA	

Nationwide campaign reaching same cohort of children already reached by previous SIA/ RI	• Statewide campaign • Implementation of Zero dose reduction plan in the prioritized LGAs that falls within implementing States • Engagement with all Zero dose reduction plan stakeholders in all 9 States implementing in streams 2 &3, 2022 implementation • Real time tracking of vaccination in Zero dose LGAs/wards/settlements using Power BI	• Targeted campaigns focusing on high and medium risk LGAs • Sustain and strengthen the Zero dose reduction plan to reach more children	

Immunization supply chain logistics

Overarching Gaps/Challenges	What is being done	Priority interventions	TA Need
Delayed implementation of the 3-Hub system redesign has sustained longstanding inefficiencies vis-à-vis managing multiple incoming shipments (>200/year)	▪ Establishment of PMT ▪ Construction commenced in Lagos Hub Contract awarded for Abuja Hub construction ▪ Architectural designs and BOQ for Kano Hub under review prior to contract award ▪ Commencement of 3-Hub system redesign operationalization analysis	▪ Expedite the process for contracting Kano construction ▪ Expansion of land for Abuja Hub ▪ Monitoring of Lagos Hub construction milestones ▪ Implementation of recommendations from operationalization analysis	TA needed to project manage the system redesign (including 3-Hubs implementation)
Delayed implementation of Last Mile Delivery	▪ Last mile delivery being implemented in 6 states. ▪ Establishment of LMD task team at national and has since commence work towards upscaling LMD in phases starting in Q1 2023 ▪ Secured kick-off funding from WB IMPACT project	▪ Finalize costed plans for upscaling LMD ▪ Upscale last mile delivery in non-implementing states, leveraging on existing sources of funds ▪ Mobilize additional resources to support LMD, with emphasis on ZD settlements	TA support required

Lack of functional eLMIS for RI stock visibility and vaccine accountability	▪ Continuous use of an ODK based LMIS for data visibility at the National, Zones, States and LGAs ▪ Deployment of OpenLMIS Covid-19 module ▪ Visibility for Vaccines (ViVa) online tool to support in-country stock management ▪ Thrive 360 has been deployed for stock data triangulation (National & State) to inform decisions	▪ Finalize development and deployment of OpenLMIS RI and SIA modules up to LGA level. ▪ To scope the requirement and costs for achieving stock visibility at Health facility level ▪ Mobilize resources for interoperability of OpenLMIS and EMID to ensure last mile visibility	
Decommissioning of obsolete CCE's	▪ Provided guidelines to States on the procedure for decommissioning CCEs ▪ Advocacy to States to set-up decommissioning committee	▪ Comprehensive Cold chain inventory assessment to Identify obsolete CCEs ▪ Scale-up Advocacy to States to Inspect and approve the removal of obsolete CCEs by the Authorized Decommissioning Committee ▪ Provide guidance to States on the decommissioning and disposal costing	.
Absence of comprehensive cold chain equipment inventory	▪ Quarterly submission of inventory data by States	▪ Training on the web-based IRP ▪ Comprehensive National cold chain inventory assessment	TA support required
Inadequate monitoring of implementation of cIPs	▪ Review of cIP monitoring templates	▪ Conduct quarterly supervisory EVMA	TA support required
Lack of Country specific vaccine wastage data	▪ Use of WHO wastage of rate calculator at National level	▪ Cascade training on the scale up of the use of WHO wastage rate calculator ▪ Systematic tracking of wastage rate to ensure adherence to NSIPSS AF	TA support required

Absence of immunization waste management plan	▪ Nationwide waste management training of State Immunization Waste management Officers ▪ Establishment of a national waste management committee with clear TORs	▪ Development of Comprehensive immunization waste management plan	·
Lack of periodic forecast review	▪ Conduct of annual vaccine forecast development based on agreed parameters ▪ Shipment tracking triangulation with consumption to inform vaccine procurement ▪ Use of supply planning tool for COVID-19 vaccine shipment planning	▪ Bi-annual forecast performance review	·