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Nigeria Case Study Report

Evaluation of the technical assistance provided through the Gavi Partners' Engagement Framework

Baseline Assessment

July 2017

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Acronyms and Abbreviations

Acronym	Description
APR	Annual Progress Report
B&MGF	Bill and Melinda Gates Foundation
BP	Business Plan
CDC	Center for Disease Control and Prevention
CHAI	Clinton Health Access International
CIDA	Canadian International Development Agency
cMYP	Comprehensive Multi Year Plan
CSO	Civil Society Organizations
DFID	Department for International Development
EPI	Expanded Program on Immunization
FMoH	Federal Ministry of Health
HSCC	Health Sector Coordinating Committee
HSS	Health System Strengthening
ICC	Interagency Coordinating Committee
JA	Joint Appraisal
JAP	Joint Appraisal Process
JAR	Joint Appraisal Report
JHU-IVAC	Johns Hopkins University – International Vaccine Access
JICA	Japan International Cooperation Agency
KII	Key Informant Interview
MDA	Ministries Department and Agencies
MoH	Ministry of Health
NCDC	Nigerian Center for Diseases Control
NGO	Non-governmental Organization
NIFT	National Immunization Financing Task Team

NPHCDA	National Primary Health Care Development agency
PCV	Pneumococcal Conjugate Vaccine
PEF	PEF Partners' Engagement Framework
RI	Routine Immunization
SFA	Strategic Focus Area
SIA	Supplemental Immunization Activities
SIO	State Immunization Officer
SPHCDA	State Primary Health Care Development Agency
TA	Technical Assistance
TCA	Targeted Country Assistance
UNFPA	United Nation Population Fund
UNICEF	United Nations Children's Emergency Fund
UNDP	United Nations Development Program
WB	World Bank
WHO	World Health Organization

1. Executive Summary

This report presents findings from a case study of Gavi-funded Targeted Country Assistance (TCA) in Nigeria. This case study is a component of the larger prospective evaluation of TCA across the 20 Tier 1 and Tier 2 countries that are supported by Gavi-funded Partners to bolster the implementation of their national immunization programs. Using intensive interviews, document reviews, and observations, the Evaluation team explored the planning and implementation of the 2016 TCA cycle (2015 JA - implementation of the 2016 TCA activities through March 2017) as well as the planning for 2017 TCA activities in Nigeria and identified key successes and challenges. Data collection for this case study was conducted between November 2016 and March 2017.

Below is a summary of the key findings and recommendations for this case study.

- **Key Finding 1.** There is poor quality of immunization data in the country, which impedes the TCA from being planned effectively.
  - **Recommendation 1.** Re-direct TA funding to intensify data-related TA to improve quality of country's immunization data, including funding of activities in the Data Improvement Plan.
- **Key Finding 2.** There have been funding delays and excessive donor dependence.
  - **Recommendation 2.** All stakeholders should review together and harmonize funding processes to reduce funding delays.

1. **Key Finding 3.** TCA/PEF is in its nascent phase and stakeholders are in the process of fully understanding their roles.
   - **Recommendation 3.** Review and enhance TCA planning and JA process for improved efficiency of especially the management of post meeting report.

- **Key Finding 4.** The structure for the TCA planning process has been established but is lacking in some important details.
  - **Recommendation 4.** Gavi should include mechanisms for partner updates and feedbacks to country on the TAs that the partners provide and the milestones achieved.
  - **Recommendation 5.** Gavi should strengthen transparency in TCA by including mechanisms for transparency between partners and the EPI team.
  - **Recommendation 6**. Improve the alignment of the TA with the country's perceived (real) needs beyond those identified through the TCA process.
- **Key Finding 5.** Partner TA delivery activities are concentrated mainly at the national level and less so at the subnational level where TA is needed.
  - **Recommendation 7.** Gavi should re-focus to increase partner TA activities determinately to the subnational level.

2. Introduction

This report presents findings from a case study of Gavi-funded Targeted Country Assistance (TCA) in Nigeria. This case study is a component of the larger prospective evaluation of TCA across the 20 Tier 1 and Tier 2 countries that are supported by Gavi-funded Partners to bolster the implementation of their national immunization programs. This case study was conducted by Dr. Dele Abegunda in partnership with Deloitte Consulting.

Overview of Case Study Approach

The purpose of this case study is to supplement the Gavi Baseline Assessment of the Targeted Country Assistance (TCA) within the Partner Engagement Framework (PEF). Nigeria was selected as one of four case study countries that will be followed throughout the five year evaluation of the PEF-TCA, alongside Afghanistan, the Democratic Republic of Congo, and Ethiopia, based on the criteria noted in Box 1.

Box 1. Selection criteria for case study countries:

- Tier 1 country
- Diversity of TA providers
- Diversity of TA activities & programmatic areas
- Regional representation
- Security
- Feasibilitv

This report provides a background on the immunization landscape of Nigeria, including the TA needs, and a summary of the key insights gained on some of the unique aspects of the TCA process in the Nigeria during the 2016 TCA cycle.

As with the broader TCA evaluation, this case study employed a mixed methods approach. Information used in this analysis is based on an extensive document review (see Appendix A); interviews with 18 stakeholders from TCA implementing Partners, MOH, and the Gavi Secretariat (see Appendix B); In-person observations of three Routine Immunization review meetings; and responses to an 360° online survey from respondents in Nigeria.

Background and Country context

Nigeria is the most populous country in Africa, and 7th most populous nation in the world, with an estimated 182 million inhabitants according to the National Population Commission of Nigeria. Nigeria is a federal republic, with its capital in Abuja considered the Federal Capital Territory (FCT), and surrounded by 36 states. These states are further segmented into 774 local government areas (LGAs).

Immunization Landscape

According to the 2013-2015 National Routine Immunization Strategic Plan, key issues hindering public health services, including immunization, includes poor primary and secondary education, gender inequality, natural disasters, and difficult-to-reach populations. This is exacerbated by systemic challenges, such as security challenges and extreme data quality challenges.

Nigeria's health care system includes private and public players, with different governmental levels responsible for different pieces, however quality issues undermine health coverage and accessibility throughout the country. For children under five, vaccine preventable deaths count for roughly 40% of deaths.[1]

The National Primary Health Care Development Agency (NPHCDA) is mandated to provide policy direction and support to states and local government areas (LGA) for the implementation of primary health care including immunization , supporting the States and LGAs in the implementation of primary care policies, strategies and plans and providing feedback for the subsequent years. The NPHCDA develops the comprehensive multiyear plan (cMYP), annual plans and organizes the quarterly and annual review meetings including the Joint Appraisal (JA) process.

Within NPHCDA, the Department of Disease Control and Immunization has three divisions, with various immunization-related responsibilities: 1. Routine Immunization (RI); 2. Supplemental Immunization Activities (SIAs), which conducts mainly immunization campaigns; and 3. Disease Control and Outbreak response.

Figure 2. Country ranking of unimmunized children, CDC

Rank	Country	Number Unimmunized
1	India	7,225,120
2	Nigeria	3,048,560
3	Indonesia	1,574,350
4	Ethiopia	1,194,130
5	Pakistan	883,600
6	DRC	764,400
7	Philippines	458,600
8	Afghanistan	409,700
9	Chad	342,420
10	South Africa	281,680

Source:https://www.cdc.gov/globalhealth/immunization/stories/child-immunization-drc.htm

In Nigeria primary health care delivery, in which immunization delivery is berthed, is the responsibility of the LGAs with the States providing technical support to the LGAs. National planning and RI review meetings are held where there are exchanges of information on activities in the states. The following year's plan is developed following the annual review. These plans are shared with the Routine Immunization Working Group (RIWG) which is one of four working groups that also consider the plans before higher level deliberation by a core group. This core group consists of the team leads of all the partners and other organizations. The three other working groups that deliberate on the report before the core group are: the logistic working group, the Monitoring and Evaluation (M&E) working group and the Advocacy Working group. Partners are members of all working groups. The RI plans are shared and discussed with all the working groups and then presented for deliberation to a core working group which is headed by the Executive Director of NPHCDA and subsequently passed on to the Inter-Agency Coordinating Committee (ICC) which is headed by the Honorable Minister for Health. This apical committee consists of the heads of the Partners as members. ICC approval of the plan gives the plan an authentic and authoritative seal as the implementation plan to guide all the stakeholders.

[1] NPHCDA bottleneck analysis 2012.

National immunization and HSS priorities

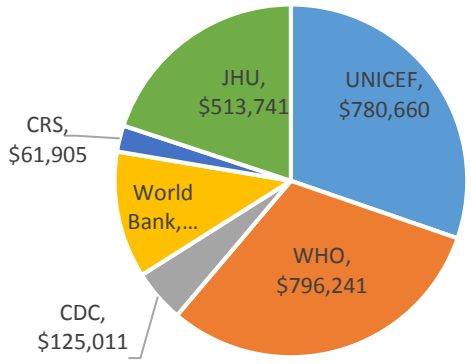
The goals of the NPHCDA are to provide immunization services to reduce the burden from vaccine-preventable diseases and often creates the entry point for primary health care delivery in communities in Nigeria.[2]

The objectives are to ensure that infants are fully immunized against vaccine preventable diseases before attaining 12 months of age; ensure that the routine immunization components of bundled vaccines, cold chain and logistics, human resource development with the operational finances are securely in place; develop a strategic framework which delineates the roles and responsibilities of the federal, state, LGA and wards, as well as the private sector and development partners; and to develop a comprehensive, timely and complete reporting system with necessary feedback mechanisms.[3]

Gavi Support

In 2016, Gavi provided support to the Nigeria EPI (transferred to Partners) through a Vaccine Introduction Grant and New Vaccine Support (NVS) grants for Penta, Pneumo, Yellow Fever, and IPV.[4] In addition, Gavi funded UNICEF, WHO, CDC, World Bank, Johns Hopkins University (JHU), and Catholic Relief Services (CRS) to provide technical support to the EPI. The 2016 TCA Plan allocated a total of $2.57M to these six Partners, with about 30% of the funding going to UNICEF and WHO each. UNICEF and WHO are primary partners that collaborate with the NPHCDA in all aspects of the national immunization program through the provision of technical assistance and also as donors. The other Gavi-funded Partners have more limited scopes of support for the EPI. JHU focuses on strengthening advocacy; the World Bank supports financing, and CDC supports data and surveillance as well as costing for an HPV demo project. While CRS was written into the 2016 TCA Plan, funding had not been disbursed to this organization at time of data collection for this case study. Therefore, CRS is not included within this assessment.

Figure 1. Allocation of TCA Funding by Partner - $2.6M



- *Source: 2016 TCA Plan*

Other non-Gavi funded Partners include the Clinton Health Access Initiative (CHAI), the Maternal and Child Survival Program (MCSP), European Union Support to Immunization Governance in Nigeria (EU – SIGN), Johns Hopkins University- International Vaccine Access Center (JHU-IVAC), SOLINA-Health Nigeria, Glaxo Smith Kline (GSK), African Field Epidemiology Network (AFENET), and the Nigerian Center for Disease Control (NCDC). The Bill and Melinda Gates Foundation (BMGF) is another major donor for the EPI.

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[2] Federal Ministry of Health Nigeria: Comprehensive Multi-Year Plan 2011-2015: The National Programme on Immunization. In. Abuja, Naigeria: Federal Ministry of Health Nigeria,; 2011.
[3] National Primary Health Care Development Agency: Nigerian National Routine Immunization Strategic Plan(2013-2015). In. Abuja: National Primary Health Care Development Agency.; 2013
[4] Gavi. All Countries – Commitments and Disbursements. Retrieved from http://www.gavi.org/country/nigeria

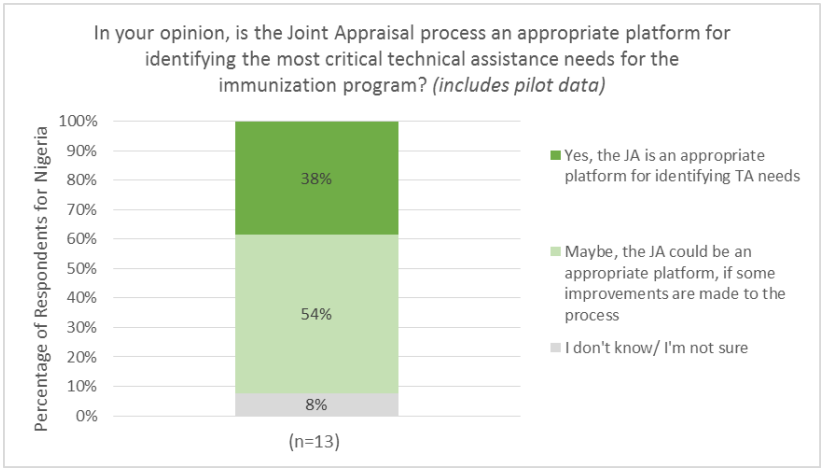
3. Domain 1: TCA Planning

JA Process in country

The Gavi Audit affected the Joint Appraisal and planning in 2016.

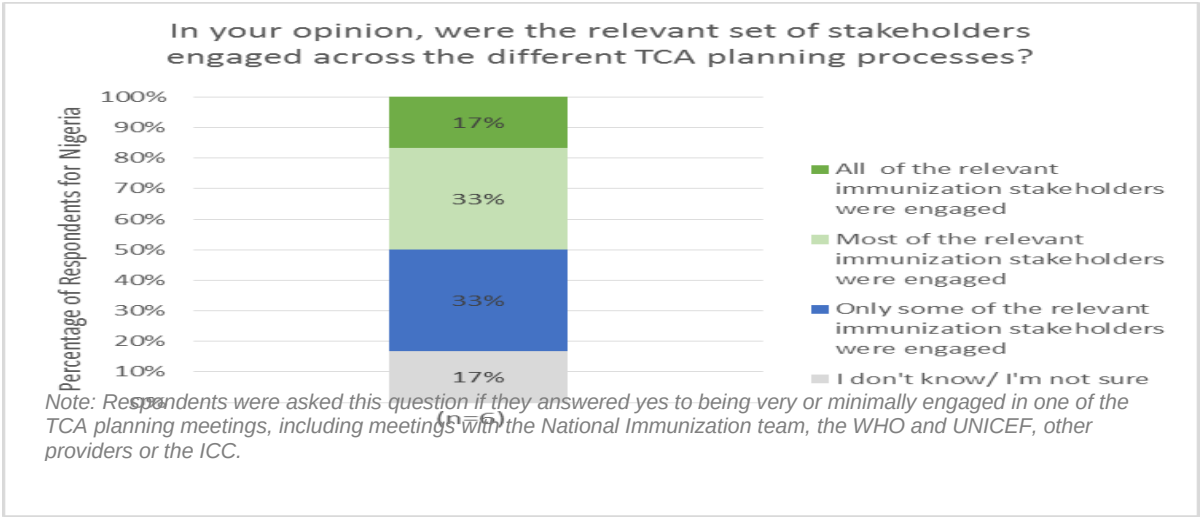
The concurrent Gavi Audit slowed down the 2016 JA process because activities that were related to the process were "laid on hold" for the completion of the audit. There is consensus among all the partners and the country NPI team however, that the 2016 review meeting improved compared with the 2015 meeting in terms of content (the range of NPI issues challenges and identified needs that were brought onto the discussion table) and the level of engagement by all participating stakeholders. There was general agreement that the country NPI team provided technically robust engagement and leadership, as expected, in defining and prioritizing the program's TA needs. There were suggestion though, that the two-day allotted for the meeting was insufficient for a robust and deep deliberation that the issues raised deserved. The country NPI team which was the convener, seemed to be too busy with managing the overall process, that there was no time to really "push back". Generating and finalizing the meeting report became somehow difficult and fairly poorly produced.

Figure 2. Stakeholder perspective on appropriateness of JA platform



The Joint Appraisal may be improved by increased efficiency of the process, mainly around the management of the report finalization, post Joint Appraisal meeting.

Delays in processing the JA report and subsequent submission to Gavi detracts from the desired outcome of PEF as the country advances in transitioning out of Gavi funding. This remains an area that the partners can concentrate the TA on by supporting the country to rehearse the process to reduce delays and move to fully synchronizing funding.



Note: Respondents were asked this question if they answered yes to being very or minimally engaged in one of the TCA planning meetings, including meetings with the National Immunization team, the WHO and UNICEF, other providers or the ICC.

Partner Engagement and Coordination

There is a strong consensus that Partners are actively engaged in coordinating TA planning and implementation, and TA is appropriately split between implementing Partners in a way that leverages their comparative advantage.

Partners have recognized areas of comparative advantages (See table 1). WHO's comparative advantage was recognized in interviews to lie in its convening power and UNICEF's perceived comparative advantage lies in its strength with cold chain, vaccine supplies, logistics and communications. JHU-IVAC is recognized for evidence gathering for advocacy among other functions such as a recent health economic studies on immunization in Nigeria. This analysis is regarded as a reference point for advocacy towards increased funding for immunization at policy level in Nigeria. Immunization data management and research are in CDC's comparative advantage.

"Each organization has its specialty, because they have some global mandate which they have over time, grown to know how to achieve. UNICEF global mandate is about logistics and social mobilization." – EPI

Although BMGF is not considered a partner in the sense that they are a donor to, rather than a reciepent of, Gavi funding, it is useful to mention that they also specialize in capacity building, gap filling and implementation in this space. Thier forte lies with their connection with high level of governance in Nigeria.

4. Domain 2: TCA Delivery

TA models that have been used under PEF are categorized as: activities that relate to capacity building (e.g. training, mentoring); advisory, by providing expert advice or consultation for a specific programmatic area, for instance, an expert to assist in program design or to contribute to the investment and sustainability plan [9]; or direct implementation or management support in a gap-filling capacity to carry out tasks in lieu of country staff to conduct for instance, an outbreak investigation or equity assessment.

Partners provided TA mixes covering the capacity building, advisory, gap filling, embedded staffing and Partner support to provide TAs (See Table 2 below). WHO and UNICEF provide TA across all the delivery models including embedding staff in all the States of the federation, a comparative advantage for immunization program implementation at the subnational level. All the partners organizations which were involved in this evaluation provide capacity building TA. Majority provide advisory TA while gap-filling and embedded staffing were the least employed TA delivery models.

Table 2. Partner TCA Delivery Models

Partner	Capacity Building	Advisory	Gap filling	Embedded Staff	Partner support
A. Partners funded under TCA					
WHO	√	√	√	√	
UNICEF	√	√	√	√	√
JHU-IVAC	√				
NCDC	√	√			
B. Partners not funder under TCA					
BMGF	√	√	√		√
CHAI	√				
CDC	√	√			

Factors affecting TA Effectiveness

Effectiveness is regarded as the level to which the planning processes result in a TA plan that is aligned with the specified goals and needs of the national immunization program, leveraging on the comparative advantages of partners. To this end, the TA plans are developed within the JA process where country TA needs are prioritized and are aligned with the goals of the immunization program in principle. This inherently guarantees the effectiveness of the TA process. However, beyond the issues around the TCA to Nigeria that have already been discussed previously, seemingly exogenous factors that may indirectly influence the quality and the effectiveness of TA in Nigeria include the following:

Limited capacity for uptake of TA

The country team's capacity to take advantage of the TA provided through the partners is somewhat limited. Although, there is sufficient quality technical capacity, managerial and operational capacities of the program is deemed insufficient for effective implementation of the large scale of the national immunization program in Nigeria. This view which was held mainly by the partners is however incongruous with those of the country's NPI team. The country team feels that the real issue is the limited installed human resources to undertake all the work required to cover the Nigerian expansive immunization landscape in Nigeria. While top country team managers are demonstrably highly experienced and technically sound, staff management and incessant staff redeployment result in middle (operational) level country team managers turnover and new staff learning on the job. While this may not limit the capacity of the NPI to uptake the TAs provided; it certainly enlarges the scope of the needed TA.

> "There is of course the issue capacity at all levels, managerial capacity. Capacity to manage a good immunization program is weak at all levels. Skills mix of staff providing quality care that also attracts people to the facility to access services is weak." - Partner

To this end, the TA need is at some variance to the type of needs that partners have been aligned to provide by the contracts with Gavi. In addition, the country NPI already felt excluded in the agreement between the partners and Gavi. These pose the partners as more of third party supervisors and agent of Gavi rather than partners in the full sense of it. The resultant effect is that the Country NPI team tends to collaborate with the partners in bid to satisfy Gavi's condition for her continuous support. There are some undertones of subtle resentment of the intermediary role of the partner's from the Country NPI team that were pieced in the interviews. This notwithstanding, the country team has expressed appreciation for the contribution of the partners in certain areas of NPI, for instance, in the introduction of new vaccines.

Strategy-effectiveness mismatch

According to a partner, an estimated "60% to 70% of the grants under the TCA/PEF strategy to increase capacity, and sustainably enhance Routine Immunization, go to learning through participatory processes, trainings, meetings and workshops". However learning science informs that only about 10% of learning is obtainable through these means, about 20% is learned from collaboration with peers. This implies that the TCA/PEF strategies and TA models may be targeting only about 20% workplace learning and capacity building learning space with 60% to 70% of the funding.

> "I would say close to 60% -70% of the funds go to training or workshops. But if you look at learning science, regardless of culture or location one learns seventy percent on the job, about twenty percent through collaboration with peers and 10% learning is obtained from theoretical training and in workshops. So we are putting most of our money in the ten percent issue and we are not putting our time resources effort in strengthening on the job types of effort." - Partner

A goal in the change from the BP to the new PEF, is to emphasize TA delivery models that move away from trainings and workshops, as was in the BP approach, to include, in addition to training and meetings, advisory, staff embedding, staff in-filling TA activities. Given that PEF is in its nascent stage, its convenient implementation in the operational terrain of meetings and workshops, may yet limit its desired impact. An incidental value that the partners' TA brings to the NPI according to NPI interviewees is the additional hands that the partners bring on to the NPI work at the national level and possibly at the subnational level.

Weak primary health care infrastructure

Related to the above is the weak state of the country's primary health care infrastructure within which the NPI is situated. This is particularly so in the northern regions where RI coverage have been consistently lower than the country's averages for years. The country's RI is designed to be delivered at the primary care level at the primary care facilities. Perennial challenges plague the primary care system to weaken the delivery of vaccines and routine immunization to the huge population.

Funding delays

Funding and delays in the release of available funds for RI remain critical to immunization programs in Nigeria in the future. Though government contributed only about 10% of the total of $92.3 million total expenditure to immunization in 2015 as co-financing, delays in approval of budgets and release of funds for operational activities at federal and subnational levels, have characterized the funding scenario and are likely to remain in the near future. Change in governance caused the delay in the release funds in 2015 although the country met its co-financing obligations for Penta and Pneumococcal Conjugate Vaccine (PCV) (about 80% of the co-financing fund in 2015 and 100% in 2016 came from the World Bank) [5]. The ongoing recession and economic downturn that the country is experiencing, remain threats to the future funding of NPI as also the transitioning to full self-funding will shift the funding burden directly to the country. The funding areas supported by the Gavi TCA risks becoming underfunded as the transition completes.

Though the Ministry of Finance is presently carried along with regards to (involved in) the planning and budgeting of the NPI in Nigeria and in the annual progress reports (APRs) in which the minister of finance is a core signatory, bureaucratic delays in the inter-ministerial collaboration have tended to delay the necessary signatures for the timely release of scheduled government funds.

Low level of data quality continues to plague the country in posing challenges to forecasting and delivering on country needs

One of the greatest challenges continuously mentioned by interview and survey respondents surrounds the issue of data quality, and the availability of accurate data. This affects a recurring circle of TA planning, delivery, and monitoring and evaluation. It's difficult to plan for EPI needs and deliver on those needs without accurate data. It's difficult to secure funding without data to reinforce a business case for funding. It's difficult to monitor and evaluate the success of TA and immunization activities without access to reliable data to inform reporting.

Coordination between Partners and NPI in TA Delivery

While there is good coordination among partners, there is limited coordination with the NPI.
The coordinating role of the NPI can be viewed as effective to the extent to which coordination at the JA meetings and workshops is possible. However, coordination is weak among the partners, and at the subnational level. In addition, the overall coordination within the TCA may have been stronger, more robust and more effective had the NPI had a stronger role or/and been included in the Gavi–partners coordinating framework.

The partner coordination provided by the NPI is mainly limited to the coordination in the series of JA process meetings and workshops in which the NPI provide strong leadership. TA coordination has therefore been mainly felt at the national level where most partners operated to provide TA, although the attitude of the NPI staff at the meetings raises some concerns about the strength of their leadership and coordination or level of importance and priority that they have placed on the meetings. There is also little evidence of inter-Partner coordination (coordination among the partners) beyond the interactions that is possible at the planning meetings. Lastly, there are TA monitoring mechanisms within the contractual framework between Gavi and the partners. These presumably, include reporting and accounting for pre-agreed milestones and expected deliverables. There are however, no other obvious monitoring mechanisms or processes beyond this. The NPI is also not privy to outcomes of this Gavi coordinating and monitoring processes with the partners.

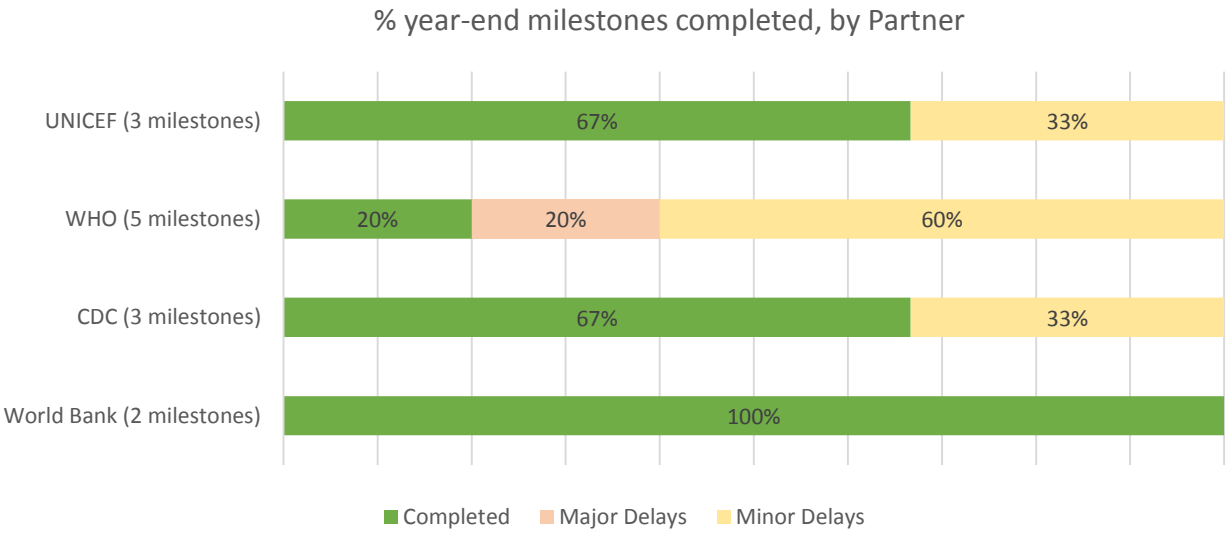
"I know that the partners have regular meetings. But since I am not a party to the meetings, it is uncertain that they have not met before the JA meetings. I don't know if they are coordinated. All I know is that interests matters most and every organization has their interests. WHO and UNICEF must serve their interests, USAID must serve the American peoples interest. JAPA will serve the Japanese interest. So to the extent that here are common interest is the extent that collaboration can to be seen amongst them - the partners." - NPI

I think at the National level, the coordination…the attempt at coordination is better. I don't think it's as strong at the state level. I think it can be better because there is always one Partner doing something that nobody was ever aware of or … there are platforms for these kind of discussions, coordination and so that we don't duplicate activities." – Subnational level Partner

Milestone Reporting

The Core TCA Partners submitted progress reports to the Gavi Secretariat on the status of their TCA activities. As of the year-end milestone report, about 54% of Partners' milestones were reported as "completed". Where explanations were provided, delays were attributed to hold ups in approval of activities due to the audit or activities have been be scheduled to begin after the milestone report timeline.

Figure 4. Status of year-end milestones



Only one stakeholder from Nigeria responded to the 360 online survey questions about the accuracy of the milestone reports submitted by Partners, limiting ability to draw any insights about stakeholders' perspectivs on the accuracy of the milestone reports. A review of the milestone report does reveal some inconsistencies in the reported status of the milestons compared when compared with the reporter comments. Table 3 provides some examples of such discrepancies.

Table 3. Sample of incongruent milestone reports

Milestone	Reported status	Reporter Comment
HPV costing completed	Completed	Country not conducting HPV demo project. No further engagement for GID.
Outbreak investigation report shared with government	Minor delays	Responding to polio and measles outbreaks has delayed government's ability to collaborate on the outbreak investigation currently planned for early 2017
Risk Assessment conducted for each state; outbreak investigation report shared with governmen	Completed	A risk assessment analysis has been conducted for each LGA in each state

The milestones in Table 2 above are one Core Partner's milestones. This Partner's interviewees had noted that their TCA efforts in Nigeria were quite limited in 2016 as a result of the MOH decision to

postpone the introduction of HPV. However, the milestone reports do not reflect this change in course for this Partner's activities.

5. Overall Conclusion and Recommendation

In conclusion, this assessment indicates that, although the PEF has been well established to support the country transition towards independent immunization program implementation, there remain some aspects that can be improved to achieve greater efficiency and effectiveness. These are challenges that directly relate to the delivery and implementation of TCA on the one hand, and exogenous (indirectly related) factors such as funding and immunization data quality, upon which Gavi may only have limited direct influence.

Level of Priority	Recommendations
Study further and take action as needed	❖ **Key Finding 1. There is poor quality of immunization data in the country, which impedes the TCA from being planned effectively.** Although, country has taken steps to address this challenge, considering the limited time remaining to conclude the Gavi transition, TCA activities should be refocused and reinforced to support the country to significantly overcome this challenge before the end of the Gavi transition. ➢ **Recommendation 1. Re-direct TA funding to intensify data-related TA to improve quality of country's immunization data, including funding of activities in the Data Improvement Plan.** Working with the relevant partners, collaboration with the national population commission and the census bureau should be intensified to resolve immunization data challenges for high quality data assurance. ❖ **Key Finding 2. There have been funding delays and excessive donor dependence.** Delays in funding for immunization: the release of budgetary provision and donor pledged funds commonly challenge immunization plans and activities. ➢ **Recommendation 2. All stakeholders should review together and harmonize funding processes to reduce funding delays.** Gavi should engage the benefit of its influence in the country to engage all stakeholders including especially the ministry of health, ministry of finance, the legislatures to fashion a common understanding of the immunization funding cycle and schedule and to be committed to achieving the no-delay goals of funding.
Act Now	❖ **Key Finding 3.** TCA/PEF is in its nascent phase and stakeholders are in the process of fully understanding their roles. ➢ **Recommendation 3. Review and enhance TCA planning and JA process for improved efficiency of especially the management of post meeting report.** Delays in processing the JA report and subsequent submission to Gavi detracts from the desired outcome of PEF as the country advances in transitioning out of Gavi funding. This remains an area that the partners can concentrate the TA on by supporting the country to rehearse the process to reduce delays and move to fully synchronizing funding.

- **Key Finding 4. The structure for the TCA planning process has been established but is lacking in some important details.** Although the TCA PEF has been well established according to the underlying principles of relevance, transparency and accountability, the process remains short of the goals in certain respects. While transparency and accountability between country team or the partners and the Gavi secretariat is sufficiently robust, they are not nearly as robust between the partners and the country team.
  - **Recommendation 4. Gavi should include mechanisms for partner updates and feedbacks to country on the TAs that the partners provide and the milestones achieved.** Partners are accountable mostly to the donor (Gavi) and have limited mechanisms for accountability to the country on the TA activities that these partners provide. Gavi should take a closer look at the mechanism to strengthen accountability and transparency in PEF and to increase leadership and ownership by the country team. Feedback on partners milestones should be included the summaries and documentations in preparation for the JA meeting and on the agenda of the JA meetings.
  - **Recommendation 5. Gavi should strengthen transparency in TCA by including mechanisms for transparency between partners and the EPI team.** Transparency is presently fostered between the partners and Gavi on the one hand and the country and Gavi on the other. The mechanisms to foster transparency between the providers and the country team is presently weak, undermining the sense of ownership on the part of the country team. Transparency in the TCA planning and TA is a key principle of the new PEF but should be significantly improved by motivating more documentation of the activities of the partners to the country NPI partners and down to the subnational levels.
  - **Recommendation 6. Improve the alignment of the TA with the country's perceived (real) needs beyond those identified through the TCA process.** While the TA are targeted towards improving the technical capacity of the NPI, there is sufficient technical capacity within the NPI in Nigeria. The main challenge is that the available human resource and operational capacity are hardly sufficient to implement immunization program of such scale as in Nigeria. The EPI team feels they need more in this area rather than support to build technical and managerial capacity. Country felt needs should be synchronized well with the donor perceived need. This can be achieved by steering the JA meetings more like a brokerage meeting where the country NPI team table their perceived need and the partners table perceived TA. In addition, the country NPI team, the partners and Gavi should have a set aside meeting to discuss and agree on the important needs as perceived by all stakeholders and how these needs are to be addressed.
- **Key Finding 5. Partner TA delivery activities are concentrated mainly at the national level and less so at the subnational level, where TA is needed.** Partners are mainly located in Abuja the capital city and the limitation in staffing in the partner organizations, bring a default situation where most of the TA activities are delivered at the national level whereas support is needed most at the subnational level where immunization is directly delivered. This leaves a gap in the delivery of TA on the country's immunization landscape

	➢ **Recommendation 7. Gavi should re-focus to increase partner TA activities determinately to the subnational level.** An emphasis on the staff-filling and embedding TA models is more appropriate to the needs and challenges at the subnational level. Partners should collaborate with those that already have established statewide structure to piggyback TA deliveries to the subnational level.

Appendix A. List of Stakeholder interviewed

Organization		Name
NPHCDA	Director Logistics	Mustafa Mahmud
NPHCDA	Head NPSIA	Nneka Onwu
NPHCDA	CMO/RI	Okposen Bassey
NPHCDA	Principal Scientist	Taiwo Adebesin
Former NPHCDA	Former Director - NPHCDA	Dr. Emmanuel Abanida
Johns Hopkins	Team Leader in IVAC	Dr Chizoba Wonodi
UNICEF	Chief of Health	Dr John Egbe Agbor
UNICEF	Immunization Manager	Dr Modibo Kassogue
UNICEF	Communications for Development Officer	Margaret Soyemi
WHO	EPI Prog Mgmt (NPSIA) budget	Yared Yehualashet
WHO	Routine immunization desk officer	Dr. Daniel Ali Ichaba
WHO	RI Officer	Dr Rachel Seruyange
BMGF	Associate Program Officer	E.A. Durham
BMGF	Senior Program Officer for Vaccine Delivery	Jenny Sequeira
BMGF	Senior Program Officer for Vaccine Delivery	Yusuf Yusufari
UNICEF	Immunization Specialist	Charles Nwosisi
UNICEF	Health Specialist on Immunization and Nutrition Program	Dr. Ifeyinwa Anyanyo
CHAI	Director for Vaccines and Cold Chain	Garba Abdu

Appendix B. List of Documents reviewed

Full reference for Document
Federal Ministry of Health Nigeria: Comprehensive Multi-Year Plan 2006-2010: The National Programme on Immunization. In. Abuja, Naigeria: Federal Ministry of Health Nigeria,; 2006.
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Appendix C. List of Meetings/Events observed

Event	Description	Event sponsor/organizer	Date of event	Place of event (city)
Routine Immunization Bi Monthly Review Meeting	Routine Immunization Bi Monthly Review Meeting	NPHCDA	12./09/2016	Abuja
RI planning meeting	Planning Meeting for the End of year EPI review (northern and southern States)	NPHCDA	01/17/2017	Abuja
RI Annual Review meeting	Review meeting, Northern States.	UNICEF/NPHCDA	12/18-19/2017	Abuja