



**Federal Republic of Nigeria**

**Federal Ministry of Health**

**National Primary Health Care Development Agency**



**National Routine Immunization Strategic Plan**

**2013-2015**



**Intensifying Reaching Every Ward through Accountability**





## Members of the Drafting Committee

1.	Dr. M. Z. Mahmud	NPHCDA
2.	Pharm. Yau Inuwa	NPHCDA
3.	Dr. Vincent Orinda	UNICEF
4.	Dr. Aboubacar Kampo	UNICEF
5.	Dr. John Agbor	UNICEF
6.	Dr. Daniel Ali	WHO
7.	Dr. Hashim el-Moussad	CDC
8.	Alh. Garba Abdu	CHAI
9.	Ms. Anita Okemini	CHAI
10.	Mr. Omair Azam	CHAI
11.	Dr. David Olayemi	SCI
12.	Dr. (Miss) Olayinka Adekugbe	SCI
13.	Dr. Chizoba Wonodi	IVAC
14.	Mr. Daniel Erchick	IVAC



# Abbreviations & Acronyms



AD	Auto-Disable	EVM	Effective Vaccine Management assessment
AEFI	Adverse Events Following Immunization		Assessment 2011
AFP	Acute Flaccid Paralysis	FCT	Federal Capital Territory
APR	GAVI Annual Progress Report	FGoN	Federal Government of Nigeria
BCG	Bacille Calmette Guerin	FMOH	Federal Ministry of Health
BGSP	Basic Guide for Service Providers	FP	Fixed Post
BMGF	Bill & Melinda Gates Foundation	GAVI	GAVI Alliance
CCA	Cold Chain Assessment	GIS	Geographic Information System
CCE	Cold Chain Equipment	H2H	House-to-House
CCEM	Cold Chain Equipment Manager	HCW	Health Care Worker
CCO	Cold Chain Officer	HEFRON	Health Reform Foundation of Nigeria
CDC	Centers for Disease Control and Prevention	Hep B	Hepatitis B
CF	Correction Factor	HF's	Health Facilities
CHAI	Clinton Health Access Initiative	Hib	Haemophilus Influenza Type b
CHPBN	Community Health Practitioners Board of Nigeria	HMIS	Health Management Information System
CME	Continuing Mandatory Education	HPV	Human Papilloma Virus
cMYP	Comprehensive Multi-Year Plan	HRH	Human Resources for Health
CSO	Civil Society Organization	HW	Health Worker
DFID	Department for International Development, United Kingdom	IBD	Invasive Bacterial Disease
DHIS	District Health Information System	ICC	Inter-agency Coordinating Committee
DPT	Diphtheria Pertussis Tetanus	ICH	Institute of Child Health
DPT3	Diphtheria Pertussis Tetanus 3rd dose	IEC	Information Education and Communication
DQS	Data Quality Self-assessment	IPC	Interpersonal Communication
DVD MT	District Vaccine and Devices Monitoring Tool	IPDs	Immunization Plus Days
ED	Executive Director	IRPT	Inventory Replacement and Planning Tool
EPI	Expanded Program on Immunization	IVAC	International Vaccine Access Center
EPR	Emergency Preparedness and Response	JHU	Johns Hopkins University
ERC	Expert Review Committee	KPI	Key Performance Indicator
EVM	Effective Vaccine Management	LARI	Landscape Analysis of Routine Immunization in Nigeria
		LB	Live Birth
		LCCO	Local Cold Chain Officer



# Abbreviations & Acronyms



LGA	Local Government Area	PHCUOR	Primary Health Care Under One Roof
LIDs	Local Immunization Days	PPM	Planned Preventive Maintenance
LIOs	Local Immunization Officers	PPMVs	Private Patent Medicine Vendors
M&E	Monitoring and Evaluation	PPP	Public Private Partnership
MDAs	Ministries Departments and Agencies	PQS	Performance, Quality, and Safety
MDGs	Millennium Development Goals	PRRINN/ MNCH	Program to Revitalize Routine Immunization in Northern Nigeria
MDVP	Multi Dose Vial Policy	REW	Reach Every Ward
MLM	Mid-level Management	RI	Routine Immunization
MNCH	Maternal Neonatal Child Health	SCCO	State Cold Chain Officer
MNCHW	Maternal Neonatal Child Health Week	SCI	Save the Children International
MoUs	Memorandum of Understanding	SIA	Supplemental Immunization Activities
NDHS	National Demographic Health Survey	SIOs	State Immunization Officers
NGOs	Non-governmental Organizations	SMS	Short Message Service
NHMIS	National Health Management Information System	SMT	Stock Management Tool
NICS	National Immunization Coverage Survey	SOML	Save One Million Lives
NLWG	National Logistics Working Group	SOPs	Standard Operating Procedures
NRIS	National Routine Immunization Strategy	SPHCDA	State Primary Health Care Development Agency
NPHCDA	National Primary Health Care Development Agency	TBAs	Traditional Birth Attendants
NPI	National Program on Immunization	TBD	To Be Determined
NSHDP	National Strategic Health Development Plan	Td	Tetanus and fractional Diphtheria
NUVI	New and Underutilized Vaccines Introduction	ToT	Training of Trainers
OPV	Oral Polio Vaccine	TT	Tetanus Toxoid
OR	Outreach	TWG	Training Working Group
PBM	Pediatric Bacterial Meningitis	UCI	Universal Childhood Immunization
PCN	Pharmacist Council of Nigeria	UNICEF	United Nations Children's Fund
PCV	Pneumococcal Conjugate Vaccines	UNTH	University of Nigeria Teaching Hospital
PEI	Polio Eradication Initiative	VCM	Volunteer Community Mobilizers
PHC	Primary Health Care	W/VDCs	Ward/Village Development Committees
PIE	Post-introduction Evaluation for Pentavalent vaccine	WHO	World Health Organization
		WPV	Wild Polio Virus
		WUENIC	WHO UNICEF Joint Estimates of National Immunization Coverage



# Table of Contents



FOREWORD.....	10
ACKNOWLEDGEMENT .....	11
EXECUTIVE SUMMARY.....	12
ABOUT THE NRISP .....	13
Why do we need a NRISP?.....	13
What is the NRISP? .....	13
How was the NRISP developed?.....	14
What are the responsibilities of national government, states, and LGAs? .....	14
How will the plan be implemented?.....	14
INTRODUCTION .....	16
Socio-demography .....	16
Health care system .....	16
Expanded program on immunization.....	17
MAJOR CAUSES OF POOR RI PERFORMANCE.....	18
Ineffective supply chain and logistics.....	18
Poor service delivery and missed opportunities .....	18
Inadequate human resources .....	19
Poor data quality.....	19
Weak demand for RI services.....	20
Lack of funding and financing delays.....	20
Lack of accountability .....	20
Unintended consequences of PEI and poor integration.....	20
Lessons Learned.....	20
Achieving and maintaining coverage high – Sustainability.....	20
Vaccine security and cold chain logistics:.....	20
REW and MLM Trainings.....	20
Quality of data.....	21
Operational funding .....	21
New and underutilized vaccine introduction .....	21



# Table of Contents



ABOUT THE STRATEGIC FRAMEWORK.....	22
Strategic principles.....	22
Strategic focus.....	22
Reaching Every Ward.....	22
Accountability Framework.....	22
Back to the Basics: Health System Strengthening.....	22
STRATEGIC FRAMEWORK.....	23
Impact.....	23
Goal.....	23
Objectives.....	23
Priority Areas and Key Activities.....	23
1. Logistics.....	23
2. Service delivery.....	25
3. Human Resources for Health (HRH).....	26
4. Health Management Information Systems (HMIS).....	27
5. Community Participation and Ownership.....	28
6. Leadership and Governance.....	28
7. Partnerships and Program Integration.....	29
8. Research for RI.....	30
IMPLEMENTATION OF STRATEGIES.....	31
Phase 1: Low hanging fruits (Quick wins).....	31
Phase 2: Black diamond.....	32
Phase 3: Nice-to-haves.....	32
Phase 4: Back burners.....	32
MONITORING & EVALUATION.....	33
The Monitoring and Evaluation process:.....	33
Approach to data collection.....	34
Operationalizing M&E.....	34
Key Performance indicators.....	35



# Table of Contents



LOGFRAME .....	37
BUDGET.....	43
Priority Area 1 Logistics – US\$231,599,732 .....	43
Priority Area 2 Service Delivery – US\$55,164,712 .....	43
Priority Area 3 Human Resources for Health – US\$59,295,566.....	43
Priority Area 4 Health Management Information Systems – US\$34,344,102 .....	43
Priority Area 5 Community Participation and Ownership – US\$59,289,712 .....	44
Leadership and Governance – US\$944,957 .....	44
Partnership and Integration – US\$198,480,440 .....	44
Operational Research – US\$2,919,250.....	44
APPENDIX .....	49
Lafia Retreat Conclusions.....	49
WHO supervision model .....	50
Operational Scheme of Accountability Framework .....	51
Accountability framework indicators.....	52
Sanctions and Rewards .....	57
Budget and funding responsibilities.....	60



# CALL TO ACTION FOR ACCOUNTABILITY IN PROVIDING QUALITY IMMUNIZATION SERVICES



We, as responsible opinion leaders and policy makers, duly recognize the urgent need to curb the high rate of childhood deaths, disabilities and illnesses by rapidly scaling up maternal, new-born and child health interventions in line with Nigeria's Saving One Million Lives Initiative and the Millennium Development Goals 4 and 5.

We consider it unacceptable that in 2012, about a million children were estimated to have died before their 5th birthday. It is unfortunate that most of these deaths are preventable and 40% of these deaths were caused by diseases that can be prevented by vaccination – such as pneumonia, measles, diarrhoea, diphtheria, pertussis, meningitis and tetanus. Equally disheartening is that 122 children were paralyzed by wild poliovirus in the same year.

While appreciating the immense health and economic values of vaccines, and acknowledging that immunization is one of the most cost-effective public health interventions available, we are concerned by the failure in 2012 to vaccinate (with 3rd dose of DPT) an estimated 3.2 million of the 6.8 million children born that year.

Conscious of the fact that government has made tremendous efforts to strengthen the Routine Immunization Program, the progress made is far from the desired goal of protecting every child from the risk of contracting vaccine-preventable disease. The multiple, systemic challenges and inability by key stakeholders to fulfil their respective roles and responsibilities is partly responsible.

We are therefore pleased that the Nigerian government and partners have articulated two critical documents – a three-year Routine Immunization Strategic Plan (RISP) for

2013-2015 and an Accountability Framework for Routine Immunization in Nigeria (AFRIN), which lays out a road map to rapidly overcome the bottlenecks and fundamentally transform the routine immunization (RI) system.

These documents represent a set of bold, ambitious, yet attainable, goals that will enable the RI program to protect more people. They call for all stakeholders to fully commit to the RI plan and enshrine accountability across all levels and processes.

We therefore, COMMIT OURSELVES to

- I. **Improving delivery of RI services** in a collective, organized manner to reduce the number of unimmunized children in our localities.
- II. **Mobilizing the resources needed** to provide high-quality immunization services using the **Reaching Every Ward (REW) strategy**.
- III. Using **AFRIN to guide all our actions** as they relate to our expected roles and responsibilities, while abiding by the consequences of our actions and/or inactions as enshrined in the AFRIN.

And on this note CALL UPON

- I. **All stakeholders** at national, state, LGA and community levels to **adopt the AFRIN** as a working tool to guide the affairs of all our immunization activities.
- II. **All stakeholders** to ensure and assure **shared accountability and responsibilities** for all our actions and/or inactions as enshrined in the AFRIN.

S/N	NAMES	SIGNATURE
1	Dr Muhammad Ali Pate, Hon Minister of State for Health, Federal Ministry of Health, Abuja	
2	Rep. of State's Taskforce on Immunization: Prof. Angela Oyo-Ita, Hon. Comm. for Health, Cross Rivers State	
3	Chief Nwabueze Okafor, Hon. Chairman Enugu South LGA, National President ALGON, Abuja	
4	HE, Alh. Saad Abubakar, Sultan of Sokoto & Co-Chair Nigeria Interfaith Action Association (NIFAA)	
5	Pastor Ayo Oritsejafor, CAN President and Co-chairman Nigeria Interfaith Action Association (NIFAA)	
6	Alh Buba Shehu Bulkachuwa, 106 Matsango Gabas, Azare, Katagum LGA, Bauchi State (Father)	
7	Mrs Kunbi Adeleye, Akopo Estate, Egbeda LGA, Oyo State (Caregiver)	
8	Mrs Ngozi Okehe, No. 5, Ikembara Street, Independent Layout, Enugu, Enugu State (Mother)	



# FOREWORD



The NPHCDA's mandate is to provide technical support for the effective implementation of primary health care (PHC) by states and local governments. Immunization is an important component of the agency's work, but to perform effectively, it must procure and distribute potent vaccines to all states and local government areas (LGAs) to cover the population of infants. Yet RI, which underpins any meaningful and sustainable achievement in disease eradication or control, has received little attention. The quest to achieve the United Nations Millennium Development Goals (MDG) 4 and 5 is also of great importance; consequently, careful and purposeful attention to RI has been identified as a means to achieve our goals.

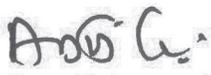
The National Routine Immunization Strategic Plan 2013-2015 (NRISP) was developed to express Nigeria's goals, objectives, and strategies to effectively meet the aims of the National Strategic Health Development Plan 2010-2015 (NSHDP). This document will elaborate on the RI component of the comprehensive Multi-Year Plan 2011-2015 (cMYP), which is also aligned to the NSHDP. The NRISP builds on the outcomes of the retreat for developing a strategic framework for RI that was held in Lafia, Nasarawa on 14-16 February 2013. The document took into consideration the National Immunization Policy and the Saving of One Million Lives Initiative (SOMLI), as well as other directives and recommendations from recent high-level forums and meetings convened to address the recent setbacks and challenges for RI in the country.

This strategic plan presents a road map for achieving vaccination of all children in accordance with global and regional goals. The national target of 80% coverage has been elusive for some time now, meaning that huge numbers of unimmunized children have accumulated, posing a threat to the health of the population, and causing outbreaks of diseases with epidemic potential.

Let me conclude by appreciating our partners who have supported this process. It has not been an easy journey, but with their support, we have embarked on a pathway necessary to making Nigerians healthy. This is what the National Primary Health Care Development Agency (NPHCDA) and Nigerian government stand for, and we remain committed to working with our partners to ensure that this strategic plan is fully implemented.

**Dr. Ado Jimada Gana Muhammad**

Executive Director, National Primary Health Care Development Agency





# ACKNOWLEDGEMENT



This strategic plan was developed by stakeholders from a wide range of backgrounds and expertise in routine immunization. With a common goal of reducing morbidity and mortality from vaccine-preventable diseases in Nigeria over the next three years and beyond, these stakeholders have focused their attention on successful strategies that will achieve the stated goal.

**Federal Ministry of Health**

**National Primary Health Care Development Agency**

*and*

**Bill & Melinda Gates Foundation**

**U. S. Centers for Disease Control**

**Clinton Health Access Initiative**

**DFID supported PATHS2 and PRRINN/MNCH Programs**

**EU-Support for Immunization Governance in Nigeria**

**GAVI Alliance**

**Health Reform Foundation of Nigeria**

**Johns Hopkins International Vaccine Access Center**

**Save the Children International**

**United Nations Children's Fund**

**USAID supported TSHIP Program**

**World Health Organization**

*All these and others not mentioned in this document are appreciated. We also acknowledge all sources of our data and information provided in this document.*

**Dr. Emmanuel Abanida**

Director Disease Control and Immunization



# EXECUTIVE SUMMARY



This National Routine Immunization Strategic Plan (NRISP) lays out key goals and objectives for Nigeria's routine immunization (RI) system, and details the strategies that will allow the country to achieve its aims, while recognizing important challenges.

NRISP is not a standalone document, instead it was developed to fit within the National Strategic Health Development Plan 2010-2015 (NSHDP) and expand upon the comprehensive Multi-Year Plan 2011-2015 (cMYP). The NRISP will also operate within and alongside Nigeria's Saving One Million Lives Initiative (SOML) and other efforts to meet the MDGs. As highlighted in these initiatives, the NRISP is guided by a set of core principles, namely: accountability, efficiency, equity, ownership, integration, sustainability, and transparency.

Within the NRISP, the Strategic Framework enumerates strategies to improve the country's RI system. Three strategic focal areas have been identified to concentrate efforts to improve the system in practice; these strategies are already in place to varying extents and are recognizable by stakeholders at all levels in Nigeria. They are: Reaching Every Ward (REW), Accountability for RI Framework (AFRIN), and Health System Strengthening.

The Strategic Framework's strategies are categorized into RI system areas, and outputs, indicators, and responsible parties have been developed for each. A monitoring and evaluation (M&E) process describes a regular reporting structure inclusive of relevant stakeholders, and seeks to ensure that data are available in a timely manner and used in decision making. A system of rewards and sanctions are also suggested to improve accountability.

The NRISP aims to clarify the roles and responsibilities for different levels of government in the execution of the RI system. The National Primary Health Care Development Agency (NPHCDA) and partners are responsible for providing policy direction, mobilizing resources to fill gaps, building capacity, providing supportive supervision, and conducting M&E of the RI program. Implementation of this strategic plan and accountability framework will fall on the shoulders of states and local government areas (LGAs). The expectation is that State Primary Health Care Development Agencies (SPHCDA) will guide LGAs, and LGAs will in turn support health facilities (HFs).

Consequent upon the above, the total budget to implement this plan for the period July 2013 to December 2015 estimated at USD 642,038,476 has been shared among the three tiers of governments. Therefore, 69% will be the responsibility of the federal, 15% that of the states, and 16% will be borne by the local governments. This averages USD 35.41 per child born in Nigeria over the next two and a half years.

Finally, the NRISP was developed through a consultative process that included stakeholders from all levels of government and various facets of society. Commitments were made on behalf of MoH, NPHCDA, states, and other important institutions to take up and implement these recommendations for the unanimously agreed upon purpose of this strategy: protecting the health of Nigeria's children through equitable provision of RI.



# ABOUT THE NATIONAL ROUTINE IMMUNIZATION STRATEGIC PLAN (NRISP)



## What is the NRISP?

The proposed impact of the NRISP is to contribute significantly to the reduction of infant and childhood mortality by half from present levels by 2015. Following on this, the goal of this NRISP is to reduce the number of unimmunized children through the attainment of at least 87% sustained national coverage in which not less than 90% of the local government areas (LGAs) reach at least 80% of infants with all scheduled routine antigens by 2015.

To attain its goal over the period 2013-2015, the NRISP lays out key goals, objectives, and strategies for Nigeria's RI system, along with an implementation and monitoring and evaluation (M&E) plan, while recognizing important challenges and lessons learned from past efforts in Nigeria.

Within the NRISP, the Strategic Framework enumerates strategies to improve the country's RI system. Three strategic focal areas have been identified to concentrate efforts to improve the system in practice; these strategies are already in place to varying extents and are recognizable by stakeholders at all levels in Nigeria. They are: Reaching Every Ward (REW), Accountability for RI Framework (AFRIN), and Health System Strengthening.

Specifically, the NRIP's priority objectives are designed to:

1. Revamp sub-national level cold chain infrastructure
2. Guarantee all vaccines are bundled
3. Ensure all wards implement REW
4. Strengthen EPI related capacity of frontline workforce
5. Improve data quality
6. Establish an accountability framework
7. Eliminate funding delays and increase funding for RI
8. Support the roll out of new vaccines
9. Continuously link Polio Eradication Initiative (PEI) and other primary health care (PHC) initiatives
10. Support ongoing effort to bring PHC under one roof
11. Create demand for RI
12. Conduct research for RI

Implementation of the NRISP relies on AFRIN, which delineates roles and responsibilities and prescribes sanctions and rewards for stakeholders in the RI system. To jumpstart the implementation process, the NRISP suggests a set of flexible "quick-wins," or strategies with clear, immediate roll-out plans.

## Why do we need the NRISP?

Although the current National Strategic Health Development Plan 2010-2015 (NSHDP) and comprehensive Multi-Year Plan 2011-2015 (cMYP) provide plans for the entire health system and Expanded Program on Immunization (EPI) respectively, the existing challenges for Nigeria's routine immunization (RI) system demand specific focus. Further, some recommendations made in the NSHDP or cMYP need to be revisited, for example the "1, 2, 3" immunization schedule strategy (one fixed session a week, two outreaches a month, and three supervisory visits a month); evidence has shown that this strategy is insufficient and more sessions are needed to reach every child.

Need for the NRISP is also seen in the numbers of unimmunized children – in 2012, 3.2 million children remained unreached with DPT3. Given that 54% of Nigerians live below poverty line, and out of pocket expenditure constitutes 64.5% of the total health expenditure, drastically scaling up the reach of vaccinations will be crucial to saving lives and alleviating poverty.

Against this backdrop, the call for greater attention to RI has recently been amplified through several forums, including the National Vaccine Summit (April 2012); the 5th ICC (November 2012); the Roundtable on Accountability in RI, (November 2012); and the Ministerial dialogue (December 2012). The RI retreat that took place in Lafia, Nasarawa State (February 2013) established a platform for stakeholders drawn from all levels to endorse and contribute to the development of this three-year NRISP.

Some challenges for RI highlighted in Lafia meeting include:

1. Increasing number of unimmunized children (from 2.5 million children in 2011 to 3.2 million children in 2012).
2. Increasing number of states (43% or 16/37 states & FCT) recorded less than 50% coverage in year 2012 compared to only 8 states in 2011.



# ABOUT THE NRISP



3. Huge disparities in immunization coverage within and between states/regions and between the rich and poor.
4. Increasing trend of disease outbreaks (measles, polio, meningitis, pertussis, and diphtheria).
5. In addition, the need to mobilize resources to meet the rising immunization costs was noted.

## How was the NRISP developed?

### *Lafia Retreat*

In February 2013, stakeholders met in Lafia, Nasarawa State to discuss the poor state of affairs in RI, review the existing program and brainstorm the way forward. This interaction brought to light many problems facing immunization as elaborated in the situational analysis. The meeting identified key priorities for the next three years and the manner in which solutions should be applied. The Lafia Retreat and the conclusions agreed upon there were major driving forces in the development of this NRISP.

### *Zonal workshops*

The NRISP was developed out of a consultative process between representatives from national government, states, LGAs, community representatives and international partners. Workshops held in each of six geo-political zones gave state and LGA leaders an opportunity to provide suggestions and feedback on a draft of the NRISP and contribute details about the challenges and potential solutions for strengthening RI unique to their localities. During this process, states expressed their general satisfaction with the NRISP and made commitments to adopt and implement the NRISP once finalized.

### *Guiding documents*

NRISP recommendations are guided by, and map closely to, the NSHDP and cMYP. Other key analyses informing the framework are the National Immunization Policy, NPHCDA Strategic Plan: 2013-2016, WHO Post-introduction Evaluation for Pentavalent vaccine (PIE) 2013, Polio Eradication Initiative (PEI) Emergency Plan 2012, AFRIN, Landscape Analysis of Routine Immunization (LARI) study, and several independent logistics and cold chain assessments, among others. The NRISP was also shaped by plans under the Nigeria's Save One Million Lives (SOML) Initiative and other efforts working towards the Millennial Development Goals (MDGs).

## What are the responsibilities of national government, states and LGAs?

The responsibility of the national level (Federal Ministry of Health, NPHCDA, and partners) is to provide policy direction, mobilize needed resources (to fill gaps), build capacity, provide supportive supervision, and monitor and evaluate all immunization and PHC services.

Actual implementation and provision of infrastructure and manpower is vested at states and LGAs levels. The expectation is that the states, through their SPHCDA or SPHCDBs, will provide funding and logistics support to manage the vaccines and devices supplied at the national level, monitor and provide supportive supervision for implementation at the LGA level, and ensure adequate quality standards are maintained by providers.

The local governments will continue to engage the appropriate personnel to run the health facilities (within their control), while ensuring that budgetary lines are provided for maintaining the infrastructure for storage and effective fixed and outreach immunization services. Therefore, the success of this plan is very much dependent on the level of buy-in and commitment from the states and LGAs.

Further responsibilities, including those for communities and development partners, are listed in the AFRIN.

## How will the plan be implemented?

The NRISP clearly identifies evidenced-based strategic recommendations for states and LGAs, to adopt as needed. Each focus area has clearly defined roles and responsibilities, associated activities, and outputs to be monitored. The proposed M&E process will ensure that data is available in a timely fashion to guide evidence-based decision making, guarantee a quarterly reporting structure to ensure all relevant stakeholders are well informed on indicators, and most importantly, provide the basis for shared accountability and responsibility.

To fully achieve accountability, the NRISP incorporates the AFRIN as a guide to operationalization of RI activities. AFRIN has the following broad objectives:

1. Define roles and responsibilities across the immunization delivery system
2. Encourage shared responsibility among stakeholders for the different system processes



# ABOUT THE NRISP



3. Create a system to track performance, milestones, and data trends
4. Involve the political leaders for buy in at state and LGA levels
5. Raise awareness of all stakeholders on available immunization services in the communities

The implementation process is such that for each thematic RI area there is a set of core indicators linked to individuals and at different levels (National, state, LGA, health worker and partners) that will be tracked and measured. Added to this, is the institutionalization of rewards and/or sanctions across board.



# INTRODUCTION



## Socio-demography

Nigeria is a federal republic comprising 36 states and a Federal Capital Territory (FCT). Within these states are 774 local government areas (LGAs) and 9,565 wards. The states are grouped into six geo-political zones; South South, South East, South West, North East, North West, and North Central.

The population of Nigeria was estimated to be 170 million in 2012<sup>1</sup>, with an estimated birth cohort of 6.8 million children, which is expected to rise to 183 million with a birth cohort of 7.3 million by 2015<sup>2</sup>. Gross domestic product (GDP) growth in Nigeria was estimated to be 6.6% in 2012<sup>3</sup>, yet in 2010 the percentage of the population living below the national poverty line was 62.6%<sup>4</sup>, highlighting a disparity between macroeconomic growth and the majority of the population's standard of living.

Nigeria shares many of the social and economic problems associated with developing countries. The percentage of the population living below the national poverty line has reached an estimated 54.4% – a significant increase from 28.1% in the 1980s. In contrast, the national economy has been growing in the last three years – GDP reached an annual average growth rate of 8.2% in May 2011.

The total annual expenditure of the health sector accounts for 5.6% of GDP and about 4.4% of total government spending<sup>5</sup>. Household out-of-pocket expenditure as a proportion of total health expenditure averaged 64.5% between 1998 and 2002, which is very high. It is estimated that on average, health care consumes more than half of total household expenditure in about 4% of cases and over a quarter of total household expenditure in 12% of cases<sup>6</sup>.

Important challenges hindering the delivery of public health services and development in Nigeria include inadequate quality of primary and secondary education, inequality among genders, natural disasters (e.g. flooding), and a number of hard-to-reach populations, such as nomadic populations and riverine fishing communities. Strategies must be employed to specifically target these hard-to-reach populations or they will continue to be underserved.

Finally, Nigeria is currently experiencing security challenges in the form of militants in the south and insurgents in the

north. In 2012 and 2013, attacks killed several health workers engaged in vaccination in the north. Security will remain an important issue in coming years.

## Health care system

Nigeria's health care system consists of both public and private sectors. The public health care system is mirrored on the three levels of government with the national government responsible for tertiary care, state government responsible for secondary care, and LGAs responsible for primary care.

Although the quality of health services, coverage, and accessibility still present major challenges, there have been drops in the infant mortality rate (from 127 per 1,000 live births in 1990 to 78 per 1,000 live births in 2011) and in the under-five mortality rates (from 214 per 1,000 live births in 1990 to 124 per 1,000 live births in 2011).<sup>7</sup> While both rates are declining, Nigeria is falling short in achieving Millennial Development Goal (MDG) 4, to reduce mortality among children under the age of 5 by two-thirds from 1990 to 2015<sup>8</sup> (Figure 1). On the current trajectory, the country will reach an under-five mortality rate of approximately 80 per 1,000 live births by 2015 – still falling short of the MDGs.<sup>9</sup>

Vaccine-preventable deaths, such as pneumonia, diarrhea, and measles, account for about 40% of all deaths among children under-five in Nigeria (Figure 2).<sup>10</sup> Other significant causes of death were malaria and neonatal causes.

## Trends in infant and child mortality from 1993-2008, Nigeria

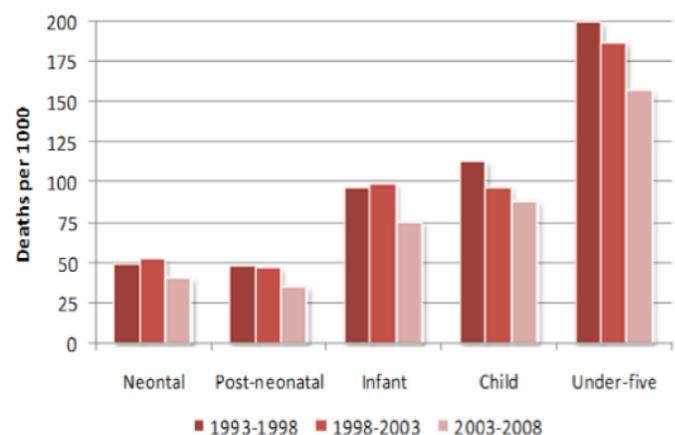


Figure 1: Under-five mortality rates from 1993-2008.<sup>11</sup>

<sup>1</sup>Population Council, Country Profile for Nigeria

<sup>2</sup>Analysis conducted using World Development Indicators from the World Bank

<sup>3</sup>Nigeria Economic Report, World Bank, May 2013

<sup>4</sup>World Development Indicators from the World Bank

<sup>5</sup>Analysis conducted using World Development Indicators from the World Bank (?)

<sup>6</sup>Nigeria Economic Report, World Bank, May 2013

<sup>7</sup>WHO Global Health Observatory Data Repository

<sup>8</sup>MDGs, United Nations

<sup>9</sup>Analysis using Global Health Observatory Data Repository

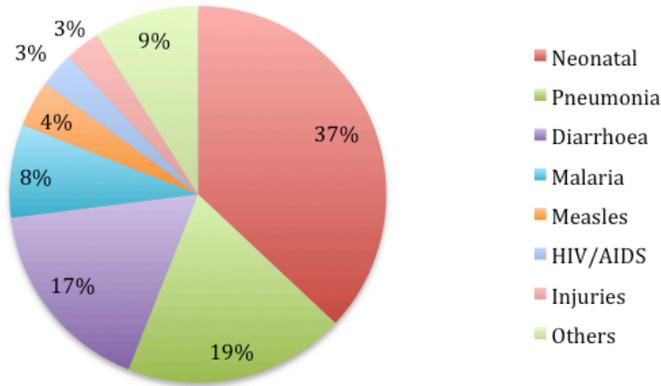
<sup>10</sup>NPHCDA bottleneck analysis 2012.



# INTRODUCTION



**Causes of death in Nigerian children under-five years of age (2010)**

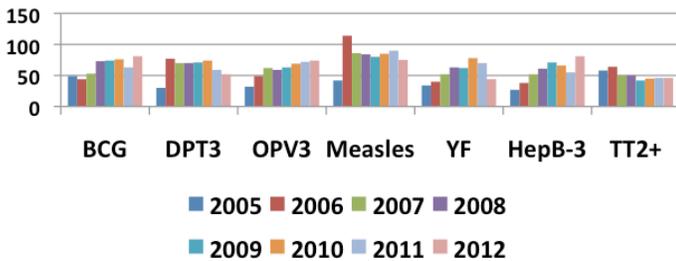


**Figure 2:** Causes of child (under-five years old) mortality in Nigeria (2010).<sup>12</sup>

## Expanded program on immunization

In recent years, Nigeria's coverage of DPT3, a key indicator of a country's performance of routine immunization (RI), has fallen from 74% in 2010 to 52% in 2012 (Figure 3). Fluctuations have also been observed in the coverage of other antigens administered in the country.

**Immunization coverage for select antigens from 2009-2012**



**Figure 3:** Cumulative RI coverage for RI antigens, 2005-2012<sup>13</sup>

Referencing Figure 3 above, there has been a steady rise in OPV3 coverage but not sufficient to interrupt transmission, as 122 cases of wild poliovirus (WPV) were reported in 2012.

Evidence from the National Immunization Coverage Survey (NICS) indicates that variations exist in RI performance across the country's zones with the South West and South East zones showing higher RI performance, and the North West and North East showing low-performance. This disparity ultimately impacts national RI coverage over time (Figure 4).

<sup>11</sup>NDHS 2008

<sup>12</sup>NPHCDA 2013

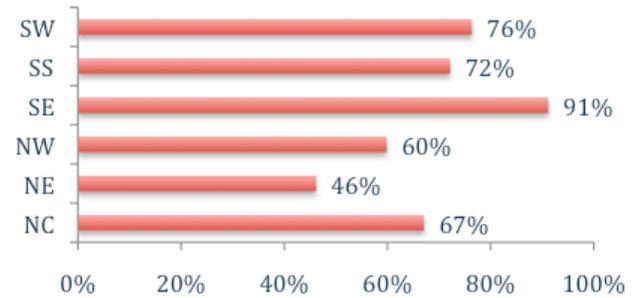
<sup>13</sup>NPHCDA 2013 Administrative Data

<sup>14</sup>Nigeria National Immunization Coverage Survey 2010.

<sup>15</sup>RI and logistics feedback, NPHCDA April 2013

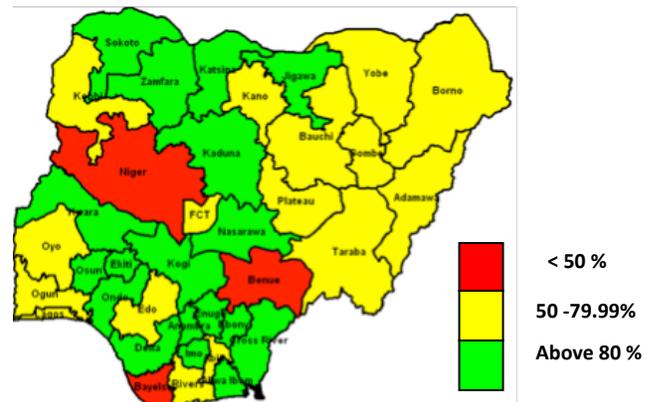
<sup>16</sup>NPHCDA Administrative Data 2013

**Immunization coverage by zone**



**Figure 4:** Immunization coverage rates by zone in 2010 (NICS 2010).<sup>14</sup>

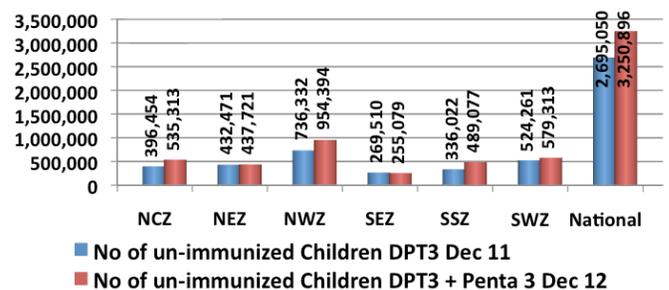
In 2012, only about 50% of Nigerian states had more than 80% immunization coverage (Figure 5).



**Figure 5:** DPT3 coverage by state 2013.<sup>15</sup>

The recent drop in immunization coverage in Nigeria – from 69% in 2010 to 52% in 2012 – has left more than 3.2 million children at the age of 12 months unimmunized (Figure 6), adding to the existing large pool of susceptible under-fives, which could lead to outbreaks of vaccine-preventable disease across the country.

**Number of unimmunized (DPT3/Penta3) children by zones**



**Figure 6:** Number of unimmunized (DPT3/Penta3) children by zones, December 2011, 2012.<sup>16</sup>



# MAJOR CAUSES OF POOR RI PERFORMANCE



Recent studies have identified a number of factors as contributing to the poor RI performance observed in Nigeria. These are:

- Ineffective supply chain and logistics
- Poor service delivery
- Inadequate human resources
- Poor data quality
- Weak demand
- Funding constraints
- A lack of accountability/weak governance
- Unintended consequences of Polio Eradication Initiative (PEI)

## Ineffective supply chain and logistics

During 2012, vaccine supply (particularly for DPT and yellow fever) was inconsistent due to reduced or limited global production. Barriers for delivery of immunization services were identified as vaccine stock-out, bundling vaccines, and cold chain equipment failures compounded with unavailability of regular transport and finance.

The current vaccine forecasting process applies a top-down approach that is based on Census projected target population estimates. However, as a result of migration and unreliable census data, the census-determined target population often differs from the actual target population, creating a mismatch between demand and actual vaccine requirement. On the supply side, global vaccine production shortages result in scarcity, which in combination with poor forecasting leads to reduced vaccine coverage. This imbalance between the demand and supply of vaccines results in vaccine stock-outs in some states and excess in others.

The 2012 vaccine audit<sup>17</sup> identified a number of other issues at various levels of the supply chain that impact immunization coverage. These include:

- Absence of distribution plans
- Failure to follow annual distribution plans
- Mismatch between quantity of vaccines issued and program needs

<sup>17</sup>Routine Immunization Program of Nigeria; Vaccine Audit Report 2012

<sup>18</sup>Nigeria EVM assessment report 2011

<sup>19</sup>Nigeria EVM assessment report 2011

<sup>20</sup>Cold chain capacity assessment in 20 states, 2012

<sup>21</sup>Cold chain capacity assessment in 20 states, 2012

- Persistent vaccine shortages at health facilities (HFs) despite adequate supplies at the national level

Logistics and supply chain infrastructure issues also play a role in poor RI performance. In the EVM assessment, 81% of LGAs and 54% of HFs<sup>18</sup> did not have vehicles for vaccine distribution and outreach sessions, impacting the flow of vaccines to reach the health facility (HF) level and making hard-to-reach target populations more difficult to access. The same assessment found that 96% of HFs<sup>19</sup> visited had no refrigerators for vaccine storage, which severely impacts vaccine inventory at the HF level.

The Cold Chain Assessment (CCA) 2012 showed that an alarming 43% of cold chain equipment (CCE) at LGA and HF levels is non-functional<sup>20</sup>, resulting in reduced storage capacity and compromising vaccine potency; however, the assessment revealed that 75% of the non-functional equipment was repairable. The national policy of at least one solar fridge in every ward was not implemented countrywide – only 12% of wards<sup>21</sup> surveyed had at least one HF with an operational solar refrigerator. This further highlights the need for substantial cold chain procurement, as well as a planned preventative maintenance policy for the country.

Finally, there is inadequate knowledge among health workers regarding multi-dose vial policy, as only 38% of health workers at HFs know how to apply it correctly, according to the Nigeria Vaccine Wastage Study.<sup>22</sup> The same study reported that 35%<sup>23</sup> of LGAs mentioned exposure to high temperatures as a reason for vaccine wastage. Coupled with the fact that only 25% of LGAs collected vaccine wastage data from HFs, it is clear that the issue of vaccine security is a substantial barrier to improving RI coverage in Nigeria.

## Poor service delivery and missed opportunities

There are many missed opportunities for vaccination due to planned sessions not being carried out and non-integration of RI services with other maternal, newborn and child health (MNCH) services. In 2008, it was reported that 35% of pregnant mothers delivered at HFs<sup>24</sup>, yet some of these facilities still do not offer vaccination services.

In 2012, only 80% of nationally planned fixed sessions and 74% of outreach sessions were conducted. This was an improvement from 2011, when only 27% and 24% of states conducted more than 80% of fixed and outreach sessions

<sup>22</sup>Nigeria Vaccine Wastage Study 2011

<sup>23</sup>Nigeria Vaccine Wastage Study 2011

<sup>24</sup>National Demographic Health Survey 2008



# MAJOR CAUSES OF POOR RI PERFORMANCE



respectively. However, at the national level, there is no clear relationship between outreach sessions and RI coverage. In Figure 7, plotting the monthly number of outreach sessions against RI coverage yields a correlation factor of 0.42.

The Nigeria Vaccine Wastage Study showed:

- 59% of health workers knew that a vial is to be opened for any eligible infant
- 54% of workers only opened vials on designated session days during a month – this misinformation results in mothers being turned away and instructed to return on alternative dates, which is unlikely
- 40% of health workers knew the national policy that all children under that age of 5 are eligible for vaccination<sup>27</sup>

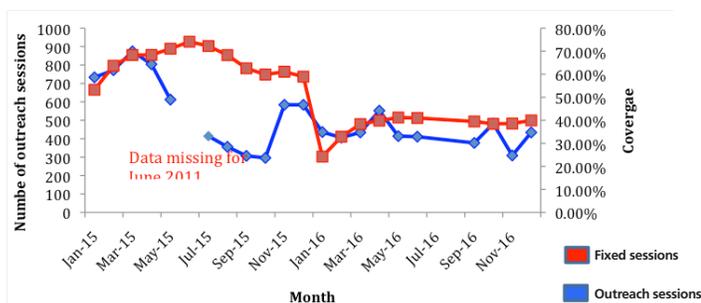


Figure 7: Number of national outreach sessions vs. national RI DPT3 coverage.<sup>28</sup>

## Inadequate human resources

Human resource inadequacies constitute another challenge for RI in Nigeria. The RI system suffers from inadequate manpower relative to need, high turnover, and weak capacity at the HF level. Insufficient hiring on the part of LGAs, as well as inequitable distribution of staff between urban and rural areas, has created significant staffing gaps in many HFs<sup>29</sup>. A further challenge to HR is a lack of training and supportive supervision for health workers. In the Vaccine Wastage Study, only 6% of facilities reported receiving a supervisory visit in the previous three months<sup>30</sup>.

An added challenge is the misalignment of accountability in the RI system. States have two separate bodies involved in PHC delivery. LGAs that recruit, train, and pay health workers, and State Ministries of Health (SMOHs) that set policy and program objectives and conduct monitoring and evaluation (M&E). SMOHs do not directly supervise LGA staff, and

therefore do not hold LGA staff accountable for performance. The Local Government Service Commission is tasked with oversight of LGAs, yet it often lacks technical capacity and commitment to carry out adequate supervision. This disconnect can lead to poor commitment and performance among LGA staff in the PHC system.

## Poor data quality

Quality of immunization data at LGA and HF level remains a challenge that impedes the ability to make data-driven decisions. In the WHO Post-introduction Evaluation (PIE) 2013, for example, only 36% of HFs recorded prior doses of DPT in registers, and only 56% reported updating registers with information from a child's immunization card. Furthermore, only 48% of local immunization officers (LIOs) could explain anomalies in monitoring charts at their sites<sup>31</sup>.

This practice highlights the capacity gaps that exist at all levels, possibly due to high attrition rates of health workers, limited availability of relevant training, or the misalignment between the individuals that are trained and the roles they perform. The absence of data collection tools at facilities can result in poor data capturing and delayed introduction of new vaccines, as documented in the WHO PIE 2013. The lack of regular data feedback from LGAs to HFs compounds the problems as facility workers have little awareness of and opportunities to improve the quality of the data they collect.

Nigeria usually conducts a national data quality self-assessment (DQS) in Q1 each year. Figure 8 shows that the correction factor for 2012 was 0.98<sup>32</sup>, meaning that precision of the reported coverage for all antigens was 98% correct. Nonetheless, there is a need for continual improvement in RI data quality, completeness, and reporting. Also, use of data to spur action in LGAs and HFs must become institutionalized.

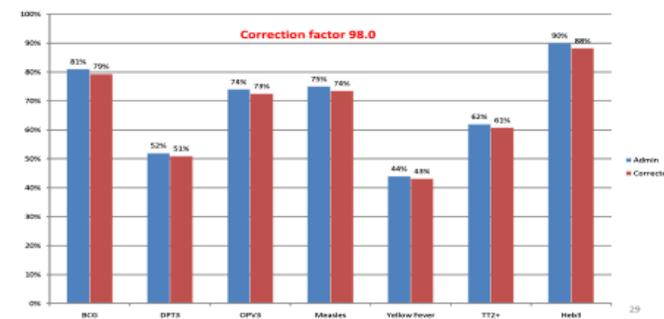


Figure 8: Correction factor for reported antigens, Nigeria DQS 2013

<sup>28</sup>Nigeria Vaccine Wastage Study 2011

<sup>29</sup>Analysis using DVD-MT

<sup>30</sup>Landscape Analysis of Routine Immunization in Nigeria: Identifying Barriers and Prioritizing Intervention, 2012

<sup>31</sup>Nigeria Vaccine Wastage Study 2011

<sup>32</sup>Post-introduction evaluation (PIE) of Pentavalent vaccine in Phase 1 states, WHO 2013 NPHCDA 2013 DQS Assessment Report



# MAJOR CAUSES OF POOR RI PERFORMANCE



## Weak demand for RI services

Nigeria has RI demand challenges, particularly in the northern states where the population's demand for immunization is low – as of April 2013, there were 466,047 unimmunized children (DPT3/Penta3) in the three Northern zones compared to 222,352 unimmunized children in the three Southern zones.<sup>33</sup> While demand alone does not entirely explain the disparity between the North and South, it is a significant factor. Some of the causes for low demand include:

- Poor attitude and skillset of health workers
- Poor community involvement in planning and implementation of RI services
- Social and cultural barriers to access (lack of knowledge about potential benefits of vaccinations)
- Lack of partner involvement in communications-related activities
- Lack of funding for sustained communications interventions

## Lack of funding and financing delays

Funding for RI is a major issue across all levels. The recent vaccine audit report indicated 76% of states and 65% of LGAs assessed did not have funds available for vaccine distribution<sup>34</sup>. This limited availability of funds results in fluctuations in the supply of vaccines and devices to service delivery points, thus impacting on the RI coverage. Weak financial management and lack of fiscal oversight also compound the situation.

At the national level, the timely release of adequate funding for vaccine procurement is crucial to avoiding any delay in delivery; yet disbursement can be affected due to budgetary approval delays. Thus, even though funds for procurement might be available, irregular disbursement can impact the vaccine supply chain with a detrimental effect on immunization coverage.

## Lack of accountability

Undefined roles and responsibilities within the RI system greatly impact ownership and accountability. The overall health system is managed in silos, with unclear linkages across the different levels of government (federal, zonal, state, LGA,

and ward) that play a role in the delivery of PHC in Nigeria. Limited feedback and accountability for outcomes at and between levels means there is little incentive to improve the current state of RI in the country. Nigeria will benefit from the deployment of an accountability framework that will lead to results-based performance monitoring, redefining of roles and responsibilities, alignment of resources, and transparent reporting and data management.

## Unintended consequences of PEI and poor integration

The global drive to eradicate polio has resulted in polio eradication activities being executed in tandem, and sometimes in competition with, RI programs. Supplemental Immunization Activities (SIAs) for polio also occur multiple times per year. Rather than being integrated with RI programs, polio programs tend to attract resources away from other immunization activities – having significant impact on the success of RI programs, particularly in low-resource states and LGAs.

## Lessons Learned

### *Achieving and maintaining high coverage - sustainability*

The performance of RI in Nigeria has varied significantly over time. High coverage of >80% was observed from 1988-1990, followed by a coverage drop to <25% in the 1990s. Recent performance has also been undulating (74%, 59%, and 54% for 2010, 2011, and 2012 respectively). This has been largely due to the weak PHC system, and has resulted in the need to strengthen governance issues for sustainability.

### *Vaccine security and cold chain logistics:*

Security of vaccines and supplies is at the heart of building lasting trust with communities and improving the RI system. The PUSH-PULL system of vaccines and commodities distribution has left gaps in supply adequacy, especially at HF levels (expected to PULL from LGAs) with adequacy reaching as low as 30%. The government and partners do not give adequate attention to the supply chain or the cold chain equipment in terms of a well-planned maintenance system.

### *REW and MLM Trainings*

An important milestone for RI delivery in Nigeria was the adoption of the Reaching Every District (RED) strategic document produced by WHO in 2003, and implemented

<sup>33</sup>NPHCDA Administrative Data 2013

<sup>34</sup>Routine Immunization Program of Nigeria; Vaccine Audit Report 2012



# MAJOR CAUSES OF POOR RI PERFORMANCE



as the Reaching Every Ward (REW) strategy in Nigeria in 2004. REW, which is client-centered, focuses on the ward at the operational level and was aimed at providing regular, effective, quality, and sustainable RI in every political ward to improve coverage and guarantee equitable access to immunization for every target age group. Unfortunately not all wards were effectively covered.

In addition to REW training, NPHCDA and partners successfully organized national and zonal level trainings for mid-level managers (MLM) in 2008 and 2009 respectively. Unfortunately these trainings could not be extended due to paucity of funds to every state and LGA manager, which is critical to improving RI. Additionally, the national RI program was not able to evaluate the contributions or impact of MLM on service provision as planned because for same reason above.

## ***Quality of data***

The effective use of accurate, reliable, and timely data is paramount to managing the immunization program. Tied to quality surveillance, data allows for easy identification of poor performing areas. Data quality self-assessment (DQS) introduction in 2008 provided an important platform that has continually improved the quality (precision) of reported administrative data for RI. This has resulted in improvements in terms of completeness, quality, and timeliness. The correction factor for administrative data rose from 74% in 2007 to 96% in 2011.

There are several aspects of the monitoring system that need improvement: archiving, recording practices, use of data to spur action, accurately defining the population, and tracking indicators. Improving these areas could lend credence to the quality of numerators and denominators and have far reaching implications for planning (forecasting vaccines, distribution, session plans, storage space, etc.), and improving the performance of the immunization system.

## ***Operational funding***

Providing a regular source of funding for RI operations in the recurrent budget of states and LGAs will improve sustainability of services. However, over the years, governments have been relying on partners to a large extent, and in the recent past, pooled funds from state and LGAs have been established and made available for vaccine logistics.

## ***New and underutilized vaccine introduction***

The introduction of new vaccines often brings an opportunity for new data tools, trainings, cold chain expansion, IEC materials, and surveillance strengthening – as well as the potential to re-engineer the immunization system. However, the nation's ability to reap these gains is limited due to challenges with data tools and poor supervision of training at lower levels.



# ABOUT THE STRATEGIC FRAMEWORK



The Strategic Framework serves as a guide for implementation of strategies presented in this NRISP. The Strategic Framework is not intended to be comprehensive for all levels of government; instead, it outlines the priority areas and strategies. States, LGAs, HFs, communities, and partners should adopt and adapt relevant strategies to their specific needs.

## Strategic Principles

**Accountability:** All stakeholders should be ready and willing to undertake their responsibilities, while at the same time accepting the consequences of their actions or lack thereof. Efforts will be made to determine accountability mechanisms for RI wide publicity, broad acceptance, and full implementation.

**Efficiency:** While calling for greater investments in immunization, the strategy will ensure duplications are minimized, and resources – human, financial, and material – are allocated efficiently.

**Equity:** In delivering immunization services, equity to access and utilization will be the fundamental guiding principle across all communities. Gender, socio-economic status, or culture should not constitute barriers. This Strategic Framework will take special considerations for communities that are hard-to-reach, poor, and sparsely populated.

**Integration:** The immunization program will be delivered in alignment with other PHC interventions, from planning through implementation, to monitoring and evaluation. The immunization system will work towards the vision of Primary Health Care Under One Roof (PHCUOR).

**Ownership:** Better engagements of subnational governments, partners, and the local community will be undertaken through planning, implementation, and monitoring and evaluations. Community ownership will be encouraged in a manner that will empower ward/village development committees (W/VDCs) to be involved in the RI system.

**Sustainability:** Sustainable funding and mechanisms for regular operation of the health system need to be pursued.

**Transparency:** Transparency will be a core guiding principle of implementation to ensure high ethical standards and accountability to the wider community.

## Strategic Focus

Problems facing RI are complex, and one strategy will not address every challenge. Too many strategies, however, could overburden and overwhelm individuals and institutions involved in implementation. Although this plan lays out a

large set of strategies within the RI system building blocks, three approaches are highlighted as essential areas of focus. These are Reaching Every Ward (REW), Accountability Framework for RI in Nigeria (AFRIN), and Back to the Basics: Health System Strengthening. Together these strategies seek to ensure that vaccines are transported to where they are needed, actors within this system understand and adhere to their responsibilities, and integrated services are delivered to every corner of the country.

## Reaching Every Ward

There are five main components of the REW strategy, which aim to integrate comprehensive delivery of maternal child and newborn health interventions. Currently, the REW strategy has been introduced, but implementation has been superficial.

REW components:

- i. Planning and management of resources (human, material and financial)
- ii. Reaching target populations
- iii. Linking services with communities
- iv. Supportive supervision (regular on-site teaching, feedback, and follow-up with staff)
- v. Monitoring to spur action (self-monitoring feedback and tools)

## Accountability Framework for RI in Nigeria

When implemented, AFRIN will allow for: goal-directed expenditure, result-based performance monitoring, re-defined roles and responsibilities, synergistic alignment of resources, transparent reporting and data management, and mutual consensus on pre-determined consequences for falling short of articulated targets. AFRIN is composed of cross-cutting system components – planning, forecasting and procurement, logistics, cold chain management, demand creation, service delivery, and data management – viewed through the lens of who is responsible for governance, human resources, and implementation at the federal, state and LGA levels. The framework provides clarity on roles and responsibilities where previously there were overlaps and gaps.

## Back to the Basics: Health System Strengthening

Strengthening health systems includes, but is not limited to, improving cold chain and transport, bundling vaccines, and improving data quality. Delivery of vaccines from the national level to the LGA and HF levels functions primarily by being pushed downward, making a well-operating health system essential.



# STRATEGIC FRAMEWORK



## Impact

The impact of implementing the Strategic Framework is projected to contribute to the 50% reduction in infant and childhood mortality by 2015 (presently, 143/1000LB, reduced to 75/1000LB by 2015).

## Goal

The goal is to reduce the number of unimmunized children by attaining at least 87% sustained national immunization coverage in which no fewer than 90% of the LGAs reach at least 80% of infants with all scheduled routine antigens by 2015.

## Objectives

1. Guarantee 100% adequacy of bundled quality vaccines for safe immunizations at all times
2. Increase sub-national level (LGA and HFs) cold chain infrastructure functionality from 47% to 80% of EVM standards by end 2014
3. Ensure that 100% of wards fully implement the REW strategy by June 2014
4. Strengthen EPI related capacity of frontline workforce in at least 80% of the service points by 2015
5. Improve the quality of all components (recording, reporting, core output analysis, use of data to spur action, archiving, demographic information) of the RI monitoring system to a minimum of 80% as measured by DQS in the context of the NHMIS by 2015
6. Create demand for RI, moving beyond behavior change to social transformations by increasing awareness from less than 50% to 80% by 2015
7. Establish an RI accountability framework at all levels that is implemented by all stakeholders in January 2014 onwards
8. Support the roll out of new vaccines (Penta, PCV, Rota, HPV, Td, MRV) in all states from 2013 to 2015
9. Continuously integrate polio campaigns and other health interventions that strengthen the overall PHC system
10. Conduct research directed at identifying strategies to improve RI and health systems and evaluate impact of health programs

<sup>39</sup>Vaccine audit report 2012

## Priority Areas and Key Activities

### 1. Logistics

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

*Increase sub-national level (LGA and HFs) cold chain infrastructure functionality from 47% to 80% of EVM standards by end 2014*

#### 2.1 Adequacy of bundled vaccines at all levels:

*Synchronize vaccine and device procurement and delivery:* Currently, vaccines and devices are transported from the national to the HF level separately through different systems. To eliminate mismatches that lead to missed opportunities, vaccines and devices should be bundled at the national level for all antigens. Given that vaccines and injection devices have different procurement lead times, it would be essential to ensure their procurement is synchronized. For these procurements to guarantee sufficient buffer stocks, this plan is proposing that procurement of vaccines should be undertaken twice a year and devices once a year along with their buffer stocks of 25% and 50% respectively. The first tranche of vaccines should be ordered in September/October and the second tranche in March/April to fit into fiscal cycle of availability of funds. Devices will be procured for each year during June of the previous year, as they take longer to clear from the ports. Depot warehousing for these devices will be sited in Lagos at the SWZ cold store. The buffers for vaccines and devices will be as follows:

- National level, 6 weeks buffer of vaccines and 12 weeks buffer for injection devices
- State level, 3 weeks buffer of vaccines and 6 weeks buffer for injection devices
- LGA level, 1 week buffer of vaccines and 3 weeks buffer of injection devices

*Tie distribution to coverage performance:* To ensure that Nigeria provides accurate needs for vaccines and injection devices, procurement is based on forecasting of target populations. Studies have shown that when vaccines and commodities are adequate at the national level, the major issue is periodic stock-outs at the lower levels, especially at HF<sup>35</sup> levels. At the same time, it has been observed that some LGAs are overstocked while others are understocked. At the LGA and HF levels, evidence of RI coverage above 100% (Administrative Data) clearly points to underestimation of target populations.



# STRATEGIC FRAMEWORK



To address this challenge, the request by LGAs for vaccines and commodities will be based on the target population, and previous and expected coverage. The HF needs will be based on consumption patterns. Each PHC facility should estimate vaccine and injection device needs based on utilization/wastage and reasonable assumptions of catchment area population. These estimates will be aggregated and rolled out to LGAs, states, zones, and national levels for planning. Mid-year will be the appropriate time period for this process (to be extrapolated for the entire year and measured in subsequent months) and will require careful planning and capacity building to achieve. The approach will be bottom-up with appropriate training on needs estimation.

**1.2 Real-time stock data management:** Adequate stock management knowledge and practice is central to consistent product availability. Vaccine utilization data, as currently captured using the stock management tool (SMT) with Dropbox augmentation, has not been able to address the need for real-time inventory data for decision making. Across states and LGAs, reporting practices are varied and delays frequent, due to use of poorly managed paper forms and inconsistent reporting frequencies at the lower levels of government.

Stock management could be enhanced through standardization of reporting tools and integration of new technologies (e.g. computerized or SMS-based systems) at state and LGA levels. At the national level, a comprehensive system should be developed to reflect stock levels across the country. An automated two-way, real-time data reporting system could be established for the nation's supplies, logistics, and cold chain systems, utilizing computers at the zonal, state, and LGA levels, while rapid SMS could be used at the HF levels. In addition, a procurement dashboard with related KPIs as well as a set of procurement standard operating procedures (SOPs) could be developed to track the quantities of antigens and supplies at all levels.

This system would be linked to the District Health Information System (DHIS) 2.2 that is the current national health management information policy. Capacity of relevant staff will be built on the various facets of logistics management, ranging from bottom-up forecasting, stock management, inventories, and temperature monitoring and vaccine management. SOPs and visual aids for frontline staff will be reviewed, produced, and made available.

**1.3 Cold chain equipment:** Keeping vaccines cool until administration requires an optimal distribution of cold chain

equipment (CCE), including traditional fridges (e.g. ice-lined fridges (ILRs)) and new technologies, such as solar fridges. The Q3 2011 cold assessment, which surveyed 17 states, reported that less than 20% of sites had access to the required eight hours of electrical power from the grid per day. Solar, direct-drive, battery-power fridges, and other new technologies (e.g. temperature tags) should be installed to fill these gaps. The optimal mix of technologies will depend upon performance, lifespan, and price (including installation, training, and operational costs). Per the national policy, every political ward should be provided with a solar refrigerator at minimum.

**1.4 PQS adherence:** The 2012 Cold Chain Assessment found that 27% of the country's cold chain equipment did not meet WHO's PQS standards. HFs, with serious storage capacity constraints, sometimes fill these gaps with non-PQS equipment, introducing risk of vaccine failure. NPHCDA should educate stakeholders on the advantages of acquiring PQS equipment for vaccine storage and assist in replacing non-PQS equipment. Sanctions for sites continuing to rely on non-PQS equipment should be applied through the AFRIN.

**1.5 Planned preventive cold chain maintenance:** Beyond procurement, a system of planned preventive maintenance (PPM) is needed to guide the use and maintenance of CCE. The 2010 EVM report and 2011 Cold Chain Assessment cited PPM as a major issue, finding a respective 32% and 41% of assessed equipment to be non-functional. To improve PPM, a national guideline will be developed. States will be required to create a new cadre of cold chain technicians (CCT) under the CCO, which will increase capacity for preventive maintenance and repairs. Before implementation begins, the NPHCDA should conduct a cost-benefit analysis of outsourcing PPM and cold chain equipment management (CCEM) versus undertaking this task alone to ensure that resources are used most efficiently.

**1.6 PPP for transport:** Nigeria's geographical size, relatively poor road infrastructure, and the large distances between many LGA stores and HFs make transportation of vaccines a huge task. The vaccine supply chain functions on a PUSH-PULL system; however, neither direction is currently at sufficient capacity to efficiently transport vaccines across the country. Developing Public-Private Partnerships (PPP) for transport – examples of which include NURTW, PATHs, and Riders for Health – could improve the delivery of vaccines and personnel to HFs. Special considerations may need to be taken to reach facilities in riverine/remote areas or nomadic populations.



# STRATEGIC FRAMEWORK



**1.7 Expand use of incineration for waste disposal:** Nigeria's revised National Immunization Policy<sup>36</sup> clearly outlines the importance of injection safety, use of auto-disable (AD) syringes and safety boxes, and safe waste management. WHO's PIE 2013 found that waste management in Nigeria was a challenge, with only 33% of HFs using closed-off waste disposal sites and many others using open-air disposal pits<sup>37</sup>. Promotion and enforcement of use of incinerators by states and LGAs, especially in riverine areas, will enhance the ability of HFs to dispose of waste properly.

## 2. Service delivery

*Ensure that 100% of wards fully implement the REW strategy by June 2014*

### 2.1 Improve micro-planning process that is community linked:

Micro-plans are an important tool for achieving sustained, high RI coverage. In many LGAs and HFs, poor population data leads to inaccurate immunization coverage rates, which in turn misrepresent the performance of the health system. To borrow from the PEI experiment, detailed micro-plans with micro-census and walk-through are to be carried out by all HFs in all LGAs to properly identify and clearly capture the target communities. For States in the North that have GIS-based maps, this should be further utilized by the affected LGAs in drawing up HF-based micro-plans. Once the exercise is completed, uncovered areas will be identified and states and LGAs will design appropriate mobile services linked to HFs.

With a complete population map of the country, areas with low coverage can be targeted with additional resources. Micro-planning encompasses both fixed and outreach sessions, and communities should be actively involved in the planning and implementation of immunization services. LIOs are encouraged to analyze data from fixed and outreach sessions to gather information on the number and location of unimmunized children.

**2.2 Increase fixed sessions:** Many Nigerian states follow what is referred to as a "1-2-3" strategy: one fixed immunization session per week, two outreach services per month, and three supportive supervisory visits per month (from the LGA to lower levels). This strategy is applied rigidly in most states, LGAs, and HFs without adjusting sessions or resource availability based on actual demand. The "1-2-3" strategy should be reviewed and fixed vaccination sessions increased as appropriate. Highly populated urban areas, where health

facilities receive daily deliveries, are encouraged to carry out daily sessions. In non-urban areas, the frequency of immunization sessions should be adjusted based on micro-plans that take into account accurate estimates of the catchment population. States and LGAs will need to provide additional resources to support the increase in sessions.

**2.3 Increase outreach sessions:** Outreach and mobile immunization services are intended for populations that are hard-to-reach or otherwise fall outside of the range of the RI system. Current methodology for planning and conducting outreach sessions follows the same structure as for fixed sessions; two outreaches per month are conducted in most HFs. Instead, HFs should plan for an appropriate number of outreach sessions per month based on the needs of their catchment area and available resources. Where the catchment area is large or dispersed, and beyond the capacity of the HF, the LGA or state should provide additional resources to ensure that gaps are filled and communities are served with outreach teams. Increased focus should be placed on using market day vaccinations, local immunization days (LIDs), and MNCH weeks to deliver catch-up sessions, with particular focus on LGAs with low coverage. Immunization data will be reviewed monthly to identify and focus on areas with huge numbers of unimmunized children ranking states and the LGAs. Within LGAs, those facility catchment areas with highest numbers of unimmunized children will be targeted by inter-state supportive supervision teams, adapting the most appropriate mix of interventions to raise coverage in these areas.

In addition, street children may constitute the bulk of unimmunized in some states. Partnering with faith based organizations, NGOs, and social workers, immunization services could be extended to this category to further reduce the inequalities in coverage.

**2.4 Private Providers engagement:** Over 85% of Nigeria's immunization services are provided by public sector providers<sup>38</sup>. Increasing private sector provision of RI services has been suggested as an avenue for reaching a segment of the children who remain unimmunized. In 2012, the national government signed a MOU with the private providers in three states (Kwara, Niger, and Nasarawa), detailing a commitment from these providers to offer safe and effective immunization services and participate in a data reporting system. In return, the government promised to provide capacity building, data tools, vaccine supplies, and storage capacity. Similar MOUs could be instituted for private providers in other states.

<sup>36</sup>National Immunization Policy (2009 revised)

<sup>37</sup>Post-introduction evaluation (PIE) of Pentavalent vaccine in Phase 1 states, WHO 2013

<sup>38</sup>NICS 2010



# STRATEGIC FRAMEWORK



**2.5 Monitor AEFIs:** Current systems and practices for identification and reporting of adverse events following immunization (AEFI) in Nigeria are undeveloped and underutilized. Challenges include lack of knowledge of AEFI identification and AEFI reporting processes among health workers and managers, absence of AEFI reporting forms and kits at HFs, and reluctance of health workers to report AEFIs for fear of reprimand. Improving the AEFI system will require training and equipping HFs across the country, and supportive supervision to develop a culture of practice that encourages reporting AEFIs.

**2.6 VPD emergencies insecurity inclusive:** The context in which RI service delivery will take place over the next few years requires that the program is adequately prepared to deal with certain internal and external threats in the wider environment. Due to the huge numbers of susceptible children that have accumulated over the years, outbreaks of diseases of epidemic potential may be more common than expected. During the 2012/2013 dry season, an extensive measles outbreak was detected in 477 LGAs. Containing the outbreak became a major competing challenge that tended to divert resources away from RI. Similarly, huge displacements of populations occurred in 2012 due to natural floods, which affected half of the states. In security challenged areas, people continue their exodus to safe havens carrying with them infectious diseases. Nasarawa State, which was previously freed from polio, became re-infected with the virus from Borno State.

Therefore, it is very important that vaccines and response commodities are stockpiled at the zonal stores to reduce response time in the event of an emergency. These emergency vaccines will include measles, yellow fever, meningitis, pertussis, and diphtheria. A minimum of 10% of annual requirements needs to be pre-positioned. In security challenged areas and disaster zones, collaboration with security and rescue agencies, including local vigilante groups, will be needed to deliver the vaccinations. Therefore states and LGAs must have well-funded and functional Emergency Preparedness and Response (EPR) committees as per national policy.

### 3. Human Resources for Health (HRH)

*Strengthen EPI related capacity of frontline workforce in at least 80% of the service points by 2015*

**3.1 Optimize EPI Workforce:** HFs are largely staffed by community health or extension workers with few nurses and even fewer doctors at the local level. The optimum

requirements are specified in the ward minimum health care package. Often, staff workers are inequitably distributed, with more senior staff located in urban areas, leaving rural areas underserved. States and LGAs should endeavor to encourage or incentivize staff to work in rural or remote areas. Occasionally, to address shortages, temporary staffing arrangements of task shifting and/or task sharing methods could be employed pending full staffing of the facilities. Temporary staff may also be obtained from the pool of retired health workers and existing employment schemes.

**3.2 Integrated training:** Health workers in PHC facilities frequently have limited basic training. In combination with inadequate numbers of staff, poor training contributes to low standards of care. Health worker attitudes towards patients are also a commonly reported concern, which can have a negative impact not only on the quality of care provided but also demand and community trust in RI and PHC facilities.

Training is provided to health workers for different components of the immunization program and to varying degrees. Trainings will now be offered as an integrated package to combine material and better utilize training time. Modules on various topics will be developed and put together as volumes or manuals. During the less busy period of the year, managers and service providers will be called for training at designated centers located in each training institution. The feasibility of outsourcing training will be considered, as well as innovative training methods, such as self-directed learning and m-Learning.

Resource persons will be drawn from NPHCDA, partners, and core trainers' schemes already in progress. REW, data management, cold chain and vaccine management, planned preventive maintenance, interpersonal skills, new vaccines, and AEFI trainings will be combined as an integrated package for managers (MLM) or service providers (BGSP). Specialized courses on vaccinology and advanced logistics supplies chain management will be offered on a professional basis to a select few serving as specialists.

NPHCDA in liaison with regulatory bodies (e.g. CHPBN, NMDC, PCN) will update training curriculum of pre- and in-service institutions in which immunization training will be domiciled. The government shall ensure training in relevant areas for health workers, specifically partnering with their regulatory agencies in Continuous Mandatory Education (CME) activities and programs.



# STRATEGIC FRAMEWORK



With respect to MLM and service providers' trainings that are pending, NPHCDA and partners (through the training working group) will conduct rapid training needs assessment for the two levels (mid-managers and service providers) in order to ascertain training needs. Based on this assessment, the adapted MLM modules will be used to complete the cascade training to some states and all LGAs (depending on needs), while using the revised basic guide to re-train frontline (old and new) health workers in a cascaded manner. Trainings on social mobilization and communication processes will prioritize and integrate the private sector (RI focal persons from the private sector) involved in RI service delivery and community volunteers. Towards this end, NPHCDA and partners will mobilize the needed resources (government and partners) to conduct trainings phased over the three-year period.

**3.3 Strengthen supportive supervision:** Supportive supervision is consistently a missing link in the implementation of public health programs in Nigeria. Evidence from several programs, PRRINN-MNCH for example, shows that effective supportive supervision can improve immunization coverage and strengthen delivery of other services in the local health system<sup>39</sup>. When HFs are properly supervised, with emphasis on improving staff technical skills through integrated PHC trainings, improvements are seen in service quality that, in turn, boosts demand for vaccines.

This plan seeks to strengthen current mechanisms for supportive supervision by integrating RI with other components of PHC, regularizing it using standardized checklists and outlining mechanisms for feedback and follow-up. Emphasis will be placed on skill improvement for the staff to ensure provision of quality services. It will require an assessment of the performance of the EPI and EPI staff, and provision of feedback and necessary remedies, inclusive of on-the-job training. Each supervisory team will be expected to carry out a debriefing to facility staff at the end of each visit. It is recommended that the national level should undertake supportive supervision at least once every two months; states once a month; and LGAs three times a month. Evaluation mechanisms will be put in place to ensure that feedback is received on support supervision to ensure that lessons learned inform improvements.

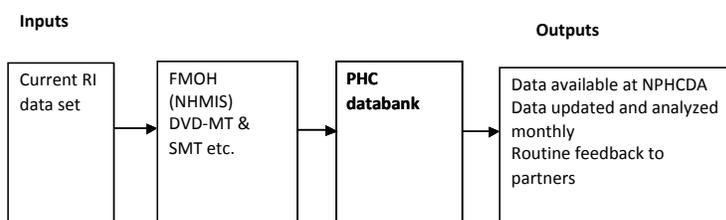
## 4. Health Management Information Systems (HMIS)

*Improve the quality of all components (recording, reporting, core output analysis, use of data to spur action, archiving, demographic information) of the RI monitoring system to a minimum of 80% as measured by DQS in the context of the NHMIS by 2015*

**4.1 Data quality:** Data quality is crucial to improvement of immunization coverage and health systems. A strong data management system will allow for accurate measurement of coverage, evidence-based decision making and need-based adjustments in resources, targeting of underserved areas, and early identification of obstacles to prevent vaccine stock-outs and ultimately disease outbreaks. Training and ongoing supportive supervision of data management staff are priority interventions to improve data quality in states, LGAs, and HFs. Crucial to data quality is the data collection process at the local level by the RI Focal Persons.

DQs have had positive impacts on the reported coverage data in all previous exercises. Other components such as core output analysis, recording, archiving, and use of data of action have remained poor and therefore the practice of annual DQS entrenched nationally will be institutionalized at the subnational levels. Specifically, states and LGAs will be encouraged to conduct bi-annual internal DQS (prior to the national one) as an important tool to improve RI coverage data and monitoring systems. Beyond this, subsequent national DQS would aim to implement all recommendations from the DQS in a systematic manner through regular follow-ups. Additionally, national immunization coverage surveys will be conducted every three years to provide a source of validated data intermittently with the next one planned in 2014.

**4.2 National data management:** RI system data is currently housed by partners, leading to calls for the development of a PHC data bank hosted and managed by the NPHCDA. In the short-term, the data bank will pull data from other depositories, but will eventually become Nigeria's primary source of RI data. The data bank will be built on a software platform that is real-time and readily available, an example of which is operating in the District Health Information System (DHIS) supported by FHI 360.



<sup>39</sup>Improving access to essential care through Integrated Supportive Supervision in Katsina State; PRRINN 2011



# STRATEGIC FRAMEWORK



**4.3 Health facility data management:** Lack of data tools, data management protocols, and skilled data collectors at HFs have hindered proper data management. This is an issue that has the potential to create delays for new vaccine introduction. The WHO PIE 2013 revealed that data tool challenges delayed pentavalent vaccine introduction in some Phase 1 states by approximately two months. Funding and distribution responsibilities for data tool seed stock remains with NPHCDA and the remaining tools with the states and LGAs. Simplifying and improving data tools are other areas that will be explored.

**4.4 Data feedback:** Results of analyses on data collected from states, LGAs, and HFs should be fed back to institutions and staff responsible for RI and PHC systems. Each level of government should institute regular processes for RI data review and feedback. Data should also be used in the planning process to adapt operations to each specific locality. The system would utilize dashboards/scorecards to provide feedback at monthly meetings and dialogue sessions in the states and LGAs.

## 5. Community Participation and Ownership

*Create demand for RI, moving beyond behavior change to social transformations by increasing awareness from less than 50% to 80% by 2015*

**5.1 Demand creation:** Demand for RI and other preventative PHC services is underwhelming, particularly in northern Nigeria. Myths and misinformation are present in some northern communities, and have led to vaccine refusal. In an effort to improve demand, evidence-based communication plans and programs will be developed to deliver positive messages on the value of vaccines. This approach will incorporate targeted messaging to health workers, community organizations, traditional leaders, religious leaders, and media, among others. Immunization weeks will be celebrated annually to further draw people's attention to the benefits of immunization. In particular, to be socially marketed, immunization will be branded as life-long protection wherever you go in terms of value (trust, reliability etc.).

**5.2 Community engagement:** Involving communities in the planning and implementation processes (e.g. community meetings, advocacy meetings, community representation) will serve as a means of increasing community knowledge, trust in health systems, and demand for RI services.

Community engagement may look at partnerships with other sectors, such as the private industry, NGOs, academic institutions, school children, and media, etc., to promote RI. Efforts should strive to reach and engage a wide audience, perhaps through grassroots organizations (e.g. National Orientation Agency, Civil Defence Corps, Boys Scouts, CBOs, Peace builders) or key community leaders (traditional and religious). Special community staff or volunteer representatives have been suggested as possible opportunities to involve communities. Health education programs focused on preventative health care and immunization should be considered as another option.

**5.3 Advocacy to political leadership:** Political leadership, especially at the state and LGA level, has been shown to tremendously impact the strength of RI and PHC systems. Advocacy targeted to governors, legislators, and LGA chairmen to raise awareness of the need for RI and increase the political benefit of support for RI, will go a long way towards achieving the system-wide changes (e.g. implementation of SPHCDA) and substantial financial support needed to significantly improve RI and PHC delivery.

## 6. Leadership and Governance

*Establish an RI accountability framework at all levels that is implemented by all stakeholders in January 2014 onwards*

*Eliminate delays in funding delivery through basket funding and increase funding for RI in 80% of LGAs*

*Support efforts to bring primary health care delivery under one roof through implementation of functional SPHCDA*

### Accountability

**6.1 Roles and responsibilities:** Recent studies have identified lack of accountability in RI and health systems as a major impediment to high immunization coverage in Nigeria<sup>40</sup>. In 2012, government and donor partners developed the AFRIN<sup>41</sup>. AFRIN aims to clarify roles and responsibilities, increase transparency, establish a system of monitoring and evaluation, and pre-determine sanctions and rewards for individuals and organizations based on performance. To increase their relevance, AFRIN strategies will be integrated within existing health programs and build upon M&E systems at the national and state levels. The national AFRIN will be adapted for implementation at the state level in at least three states over the span of the NIS.

<sup>40</sup>LARI

<sup>41</sup>AFRIN Narrative



# STRATEGIC FRAMEWORK



## Financing

**6.2 Operational Funding:** Funding responsibilities for each level of government have not always been widely understood. Too often funding earmarked or disbursed for RI by state and local governments is insufficient to meet the basic functions of the RI system, which impact service delivery, logistics, HMIS, HRH, and more. Activities that are often overlooked but still form crucial parts of a functioning RI system, such as monitoring and evaluation and community involvement, should have designated funding to guarantee financial needs are met. States and LGAs should raise the status of RI and PHC by including these areas as specific line items in their recurrent budgets.

**6.3 Basket funding:** Delays and lack of transparency in financing systems for immunization disrupt health service delivery across levels of the Nigerian government. In 2009, Zamfara State piloted an intervention referred to as a “basket fund” where RI funds are pooled and transferred to LGAs through regular, direct transparent disbursements each month. Donor partners responsible for funding RI services may also contribute oversight by serving as signatories to the basket fund. A WHO and the UK’s Department for International Development (DFID) review recommended this intervention for use in other states in Nigeria. Today the Zamfara fund is fully operational and an integral part of state policy<sup>42</sup>. Similar initiatives have sprung up in Borno, Jigawa, and Kano states. A top-down approach (e.g., advocacy to the National Governors’ Forum) will be needed to ensure widespread uptake of the fund across Nigeria.

**6.4 Financing vaccines procurement:** NPHCDA and development partners are committed to ensuring all vaccine and device needs are provided. To avoid stock-out of products, Nigeria receives a lump sum first charge funding from the government. To improve efficiency, SOPs on forecasting and procurement will be developed, alongside a transparent tracking system to allow all stakeholders access to the most up-to-date information. This tracking tool will provide a transparent, accurate, and detailed system for tracking the procurement of vaccines for Nigeria.

### State Primary Health Care Development Agencies (SPHCDA)

**6.5 SPHCDA functionality:** PHCUOR calls for consolidating all PHC management and implementation under the SPHCDA. This means responsibilities for staffing and PHC operations

will be ceded to the agencies. Many states have begun to establish their agencies, but the emerging structures have yet to attain full functionality as described by the National Council on Health. Establishment of functional SPHCDA is the responsibility of each state and under this strategy the national government is responsible for continuing to provide technical assistance throughout this process. Standard guidelines will be circulated widely and the frequency of sensitization meetings with policy makers will be increased. To achieve sustainable immunization, these agencies would be supported to become fully functional in all states.

**6.6 SPHCDA funding:** Responsibilities for various components of PHC delivery in Nigeria is borne by an array of individuals and institutions at the national, state, and local levels. The fragmentation of this system has resulted in poor accountability, wasteful duplication, and critical gaps, and has eroded community confidence and PHC service utilization and demand. In 2011, the National Council on Health adopted guidelines for the integrated management of PHC level services. The model is particularly relevant now with the imminent passage and anticipated implementation of the National Health Bill, which stipulates PHC funds will be accessed only through the SPHCDA.

## 7. Partnerships and Program Integration

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

*Continuously integrate polio campaigns and other health interventions that strengthen the overall PHC system*

### New and Underutilized Vaccine Implementation

**7.1 EPI development:** Nigeria’s EPI program is experiencing rapid expansion driven by the ongoing introduction of pentavalent vaccine and pending introduction of the pneumococcal conjugate vaccine (PCV). Using a phased approach, 14 states introduced pentavalent in June 2012, 7 states introduced in February 2013, and the remaining 16 states plan to introduce in Q3 2013. Pentavalent introduction has set the stage for future introductions, including PCV (expected in 2014 due to global supply constraints), and later rotavirus, measles rubella (MR), tetanus diphtheria (TD), and human papilloma virus (HPV) vaccines. As gains in PEI bring the nation closer to eradication, preparations for smooth end-game strategy using Inactivated Polio Vaccines will be necessary within this strategic plan period.

<sup>42</sup>Innovative & Sustainable Financing Mechanism in Health:

A case study of the “Basket fund” in Zamfara State, Nigeria; PRRINN 2011



# STRATEGIC FRAMEWORK



Introduction of pentavalent vaccine and PCV alone is estimated to increase the cost per DPT3-immunized child in Nigeria from \$47.1 to \$64.2<sup>43</sup>. Financing new vaccine introduction requires high-level political commitment and coordinated donor support to ensure successful roll out and sustainability of the new service. Further, there is continued need to support state and local governments in strengthening service delivery, logistics (EVM assessments), human resources, surveillance (disease/AEFI/laboratory), and other key areas to adjust for the burden new vaccines add to the RI system.

## Polio Eradication Initiative and other interventions

**7.2 PEI program integration:** Integrating RI into broader health systems and other primary health care programs, such as PEI, has been an important focus in Nigeria for many years, and is one of the guiding principles of global immunization efforts<sup>44</sup>. Strategies to leverage the PEI program and other supplementary immunization activities to strengthen delivery and uptake of RI services, present a range of opportunities, including reducing fragmentation of services, increasing efficiency and cost-effectiveness of health programs, and advancing towards a strong, sustainable health system.

Nigeria's PEI Emergency Plan 2012 recommends that high-risk polio LGAs be targeted for intensified RI activities. In these high-risk areas, PEI serves as an entry point for the provision of RI services. At present, most integration is focused on fixed posts. Unfortunately, inadequate coordination, weak mobilization, and poor data management threaten current efforts. Solutions might include re-orientation/training of health workers to promote RI during polio campaigns, enlistment of community leaders as advocates for RI, or designation of polio resources (human, material, and funding) to strengthen RI and PHC.

Efforts should also be taken to avoid any negative effects of the PEI on RI and PHC. Focusing on polio may mean fewer resources are available for PHC services. An example of a less obvious challenge might be that health care workers begin to expect financial incentives for their PHC responsibilities, as these incentives are sometimes provided for PEI activities. Interactions between the PEI and PHC will likely differ by region and state. Management negotiations are key to succeeding in this regard.

Other interventions like the Midwives Services Scheme (MSS), Subsidy Re-investment Program (SURE-P), and SOML have the potential to positively influence RI and deliberate efforts to leverage these opportunities are advocated in this plan.

## 8. Research for RI

*Conduct research directed at identifying strategies to improve RI and health systems and evaluate impact of health programs*

In the course of this plan, certain operational research studies will be conducted. Key areas of concern are determining appropriate baselines for indicators and impact evaluation of novel strategies/activities (e.g. PPP for transport, school children as RI ambassadors, dashboards and scorecards, vaccine push system, etc.). Special surveys, including the national immunization coverage survey, will be conducted in 2014 to help validate accurate coverage. Post-introduction evaluation and sero-prevalence studies will be important to further guide new vaccine introduction and document effectiveness of these vaccines.

<sup>43</sup>2011-2015 cMYP costing tool

<sup>44</sup>Global Vaccine Action Plan



# IMPLEMENTATION OF STRATEGIES

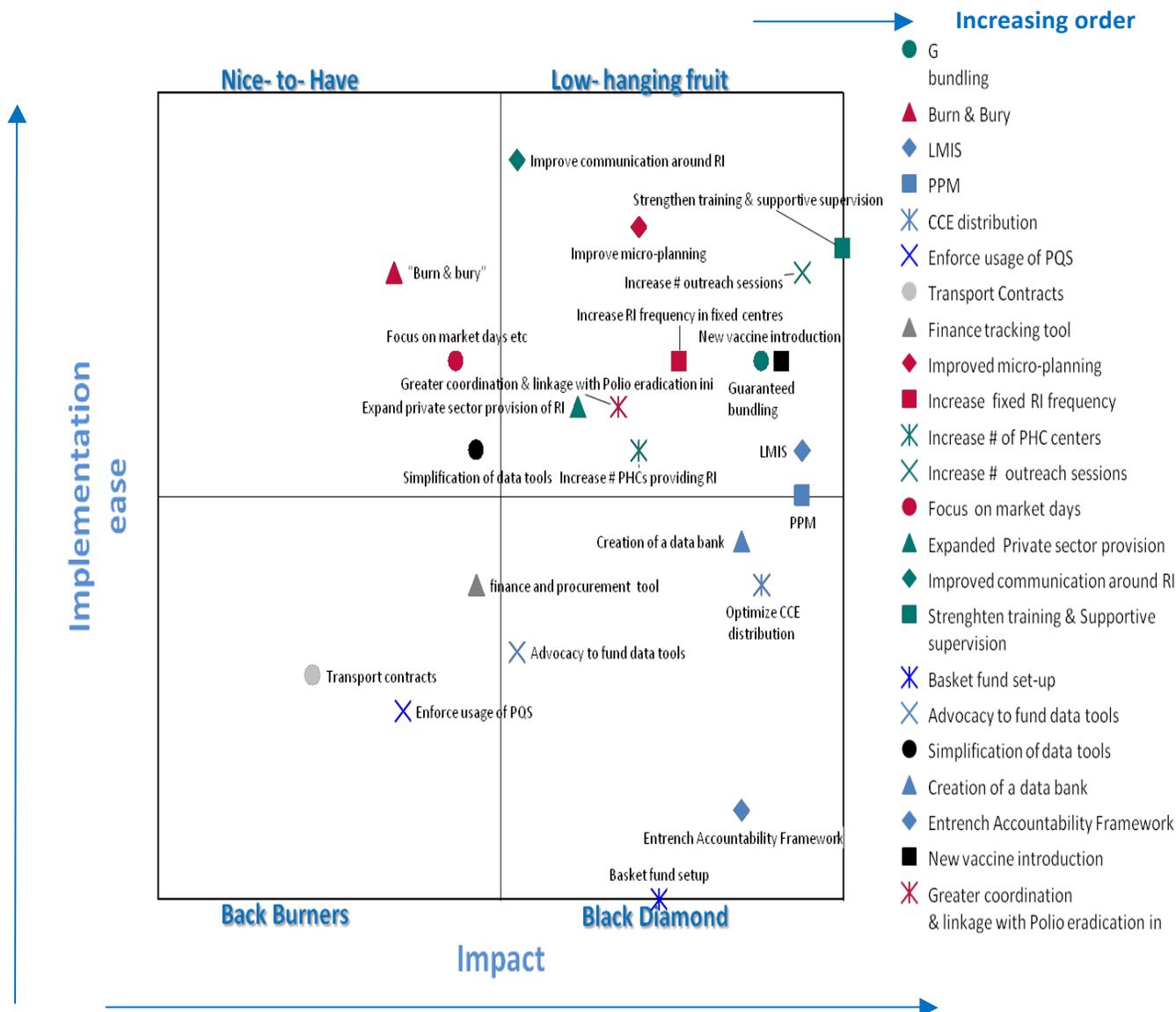


Figure 9: Assessment of implementation strategies by RI Working Group

This NRISP outlines 29 strategies for phased implementation. The strategies have been divided into four major categories, based on the ease of implementing the project and also the impact that the project will have on the vaccines system. The four categories are (Figure 9):

- Phase 1: Low-hanging fruits
- Phase 2: Black diamond
- Phase 3: Nice-to-haves
- Phase 4: Back burners

## Phase 1: Low hanging fruits (Quick wins)

It is recommended that strategies in this quadrant be addressed first. These strategies have huge impact and are relatively easy to accomplish. Identified strategies in this quadrant include:

- Improved communication around RI and community involvement
- Strengthened training and supportive supervision
- Redistribution of staff
- Improved micro-planning
- Increased RI frequency



- New vaccine introduction
- Guaranteed bundling
- Use of transportation contracts
- Health Management Information System (HMIS)
- Advocacy to fund data tools
- Greater coordination with PEI
- Private sector engagement for RI service delivery
- Maintenance contracts

### Phase 2: Black diamond

Though difficult to accomplish, strategies in this segment will have a huge impact if achieved. For this reason, strategies in this segment should be addressed after the low-hanging fruits have been accomplished. Strategies include:

- Planned Preventive Maintenance (PPM)
- Creation of data bank
- Optimized CCE distribution
- Advocacy to fund data tools
- Entrench accountability framework
- Basket fund set-up

### Phase 3: Nice-to-haves

These are strategies that, though easy to accomplish, have less of an impact than other identified strategies. These strategies should be addressed in phase 3 of the project:

- Enforcing optimal waste management
- Focusing on outreach sessions
- Simplification of data tools

### Phase 4: Back burners

These strategies should be addressed last because not only are they difficult to address, but they also have lower impact compared to other strategies. Strategies identified as occupying this section of the quadrant include:

- Establishment of a finance and procurement tool
- Enforcement of performance, quality, safety (PQS)
- Use of transportation contracts



# MONITORING & EVALUATION



An important component of this strategic plan will be monitoring and evaluation (M&E) of identified activities, outputs, and outcomes. The proposed M&E process will ensure that data is available in a timely fashion to guide evidence-based decision making and will provide a regular reporting structure to keep relevant stakeholders informed on all indicators. This process will also form the basis of the accountability framework. The M&E structure will be based on the following core principles:

- Provide data that meets the reporting requirements of the NPHCDA and other relevant stakeholders
- Identify appropriate tools and methods for data collection to ensure timeliness of reporting
- Allow for third-party independent assessments of the M&E process to reduce bias and provide an impartial appraisal
- Define clear roles and responsibilities for data collection, analysis, and usage to ensure accountability
- Outline a data dissemination process that allows all stakeholders to easily access data and make decisions based on the data

In addressing these core principles, this section of the document will outline the:

- Monitoring and evaluation matrix
- Key outcome performance indicators, output, and activity indicators
- Approach to data collection

## The Monitoring and Evaluation process:

### Step 1: Develop a log frame that outlines key objectives, outcomes, outputs, and activities for the year

The log frame will outline key outcomes, objectives, outputs, and activities. This requires input from all stakeholders, but the process will be kick-started by the head of RI at the NPHCDA. The log frame will be used to create work plans for each team and also to set performance indicators. Each working group will be responsible for finalizing their respective portions of the log frame.

### Step 2: Determine KPIs

Set key performance indicators for all outcomes, outputs, and activities. Metrics should be measurable, specific, and relevant to what is being measured. The head of M&E at the NPHCDA, supported by the head of RI at the NPHCDA, will be responsible for this process.

### Step 3: Set baselines and targets for all indicators

Determine baselines and targets for the metrics. Baselines should equate to values from the last month of the previous calendar year, while targets should be ambitious but take into account baseline values. This process will be kick-started by the head of M&E at the NPHCDA, supported by the head of RI at the NPHCDA.

### Step 4: Develop a tracking sheet and dashboard

Develop data tracking sheets and dashboards that will contain information such as definition of data, who is responsible for collecting data, etc. The M&E group will lead this step.

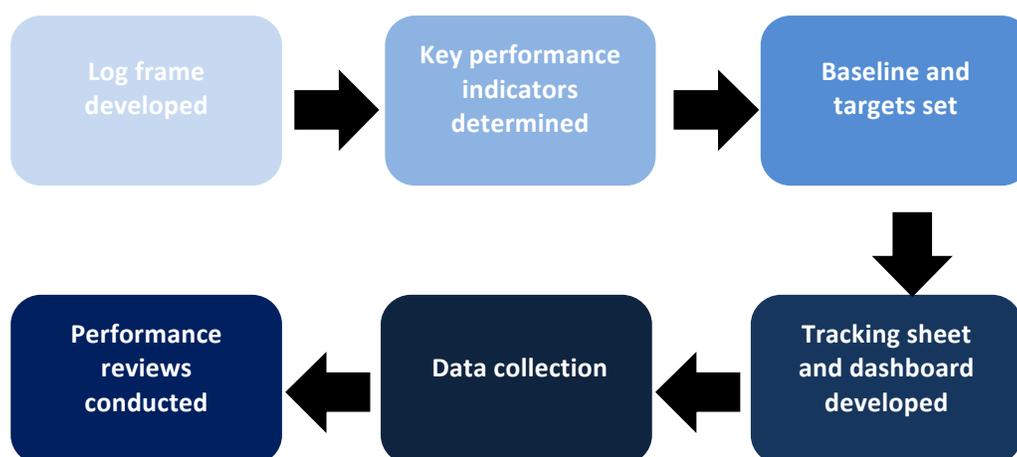


Figure 10: Monitoring and evaluation process



# MONITORING & EVALUATION



## Step 5: Implement data collection

The head of M&E will work with the M&E group to be certain that data is being collected on a fortnightly basis at minimum.

## Step 6: Conduct performance reviews

*Monthly reviews:* Discussions on performance based on tracked metrics should be institutionalized. These reviews present an opportunity to discuss indicators that have shown improvements and those that have not. Identify clear action items during these meetings and set deadlines for activities.

The M&E process will roll out from November of the previous year to January of the following year, though performance reviews will occur on a monthly basis. A suggested timeframe is outlined below.

*Quarterly PHC reviews:* In addition to the above monthly performance reviews, the immunization performance will be evaluated during the established integrated system of PHC monitoring of ward minimum health care package. This quarterly review process is part of the monitoring mechanism of the NSHDP.

## Approach to data collection

Routine and already institutionalized methods of data collection will be used in addition to new innovative

methods. The major instruments for data collection will be the District Vaccine and Devices Monitoring Tool (DVD MT), Stock Management Tool (SMT), Finance and Procurement tracking tool (once this has been established), post-training surveys, and internal tracking tools for output metrics.

As highlighted in the table above, responsibility for data collection will depend on the metric. For example, a metric measuring vaccine stock-out will be collected by both the M&E team and the national cold chain officer who heads the logistics team. Ultimately, the M&E head will be responsible for ensuring that all data is appropriately registered in the dashboard. In the short term, the head of M&E will work closely with partners to collect this data using WHO-housed tools such as the DVD MT. In the long term, however, the aim is to computerize data collection from the LGA level, wherein LGA staff directly input data into software that can then be viewed by states and the NPHCDA.

## Operationalizing M&E

Successful implementation of projects or programs is often dependent upon funding for M&E. Global best practices recommend assigning 10 to 15% of operational funding to M&E.

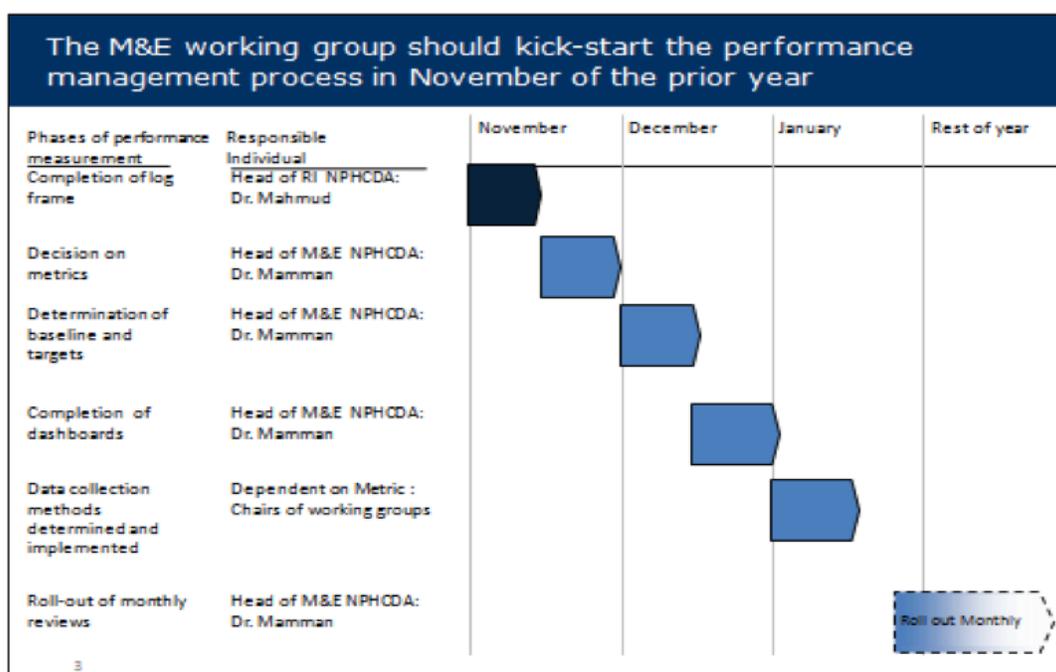


Figure 11: Activity schedule of the M&E working group



# MONITORING & EVALUATION



## Key Performance Indicators

Objectives	Metrics	Definition	Baseline	Target			Frequency	Responsibility for tracking	Source
				2013	2014	2015			
1	State level supply adequacy	Proportion of states with stocks below minimum stock levels for the target population	27% (DPT containing Ag)	10%	5%	0%	Monthly	M&E team + logistics team	SMT
	LGA level Supply adequacy	Proportion of LGAs with stocks below minimum stock levels for the target population	24% (DPT containing Ag)	10%	5%	0%	Monthly	M&E team + logistics team	SMT
	% of HF's (public and Private) with bundled vaccines	Number of HF's with bundled vaccines/Total number of facilities providing RI	TBD	100%	100%	100%	Monthly	M&E team + logistics team	VM 1
	Vaccine wastage rates	Total number of vaccines doses used minus Total number of children immunized)/ total number of doses used	12% (DPT containing)	10%	10%	10%	Monthly	M&E team + logistics team	SMT
2	Proportion of LGAs with functional CCE in their wards	Number of LGAs with functional CCE in their wards/Total number of LGAs(774)	25%	40%	80%	90%	Quarterly	M&E team + logistics team	IRP
	Median down time of non-functional CCE from January 2014	Median number of weeks it takes to repair non-functional equipment	TBD	TBD	2weeks	1 week	Quarterly	M&E team + logistics team	IRP
3	Number of unimmunized children	Total annual target population minus Total annual No of children immunized with DPT3	3,250,896	1,534,518	1,286,903	952,666	Monthly	M&E team	DVD_MT
	Immunization coverage	Number of children who receive vaccination/ target population	52% DPT	78%	82%	87%	Monthly	M&E team	DVD_MT
	Proportion of planned fixed session conducted	Number of planned outreach sessions held/ Total number of planned outreach sessions	73%	79%	85%	90%	Monthly	M&E team + social mobilization team	DVD_MT
	Proportion of planned outreach session conducted	Number of planned outreach sessions held/ Total number of planned outreach sessions	71%	78%	84%	90%	Monthly	M&E team + social mobilization team	DVD_MT
	Drop-out rates	Number immunized with DPT1 minus Number immunized DPT3/Number immunized DPT1	12%	8%	7%	4%	Monthly	M&E team	DVD_MT
4	Proportion of health facilities with at least one HW having EPI related training in the year	Number of RI HF's with at least a trained (EPI) HW in the year/ total number of HF's conducting RI in that year	TBD	25%	50%	80%	Quarterly	M&E team + training working group	Survey
	Proportion of trained Healthworkers with adequate skills of RI delivery	number of HWs trained observed with right skills during supervision/Total number of trained HWs met during supervision	TBD	50%	85%	90%	monthly	M&E team + training working group	monthly supervisory checklist



# MONITORING & EVALUATION



## Key Performance Indicators

Objectives	Metrics	Definition	Baseline	Target			Frequency	Responsibility for tracking	Source
				2013	2014	2015			
5	Proportion of health facilities with complete data report	Number of health facilities with complete data report / total number of health facilities	89%	95%	100%	100%	Monthly	M&E team	DVD_MT
	Proportion of health facilities that report on timely basis	Number of health facilities reporting data on time / total number of health facilities	TBD	90%	100%	100%	Monthly	M&E team	DVD_MT
6	Proportion of ALGON members sensitized	Number of ALGON members attending sensitization meetings	0	25%	75%	100%	Bi-annual	M&E team	Meeting reports
	Proportion of WDCs formed and functional	Number of functional WDCs/Total number of wards	TBD	TBD	TBD	TBD	Monthly	M&E team	WDC data base
7	Proportion of States that have achieved at least 80% of AFRIN core indicators	Number of States with at least 80% AFRIN core indicators achieved/Total number of States	0	0%	70%	100%	Quarterly	M&E team	TBD
	Proportion of HF's receiving funding from the LGA monthly	No of HF's with fund/Total number of HF's reporting	TBD	20%	40%	80%	Monthly	M&E team	LGA monthly LIO and HF i/c meetings
	Proportion of states with functional SPHCDAs	Number of states with SPHCDAs/Total number of States	59%	70%	92%	100%	Monthly	M & E team	PRS Department
8	Penta Coverage	Number of children who receive vaccination/ target population	TBD	75%	78%	87%	Monthly	M&E team + new vaccines task force	DVD_MT
	PCV coverage	Number of children who receive vaccination/ target population	0	0	27%	87%	Monthly	M&E team + new vaccines task force	DVD_MT
9	Proportion of infants vaccinated during campaigns	Number of infants vaccinated with RI antigens during campaign/total number of infants targeted during campaign	TBD	TBD	TBD	TBD	Quarterly	M&E team	Campaign tally sheet
10	Number of operational researches conducted	Number innovative operational research carried out	0		2	2	Biannually	RI working group, Operations research unit	Research data



# LOGFRAME



1.0 Priority Area: Logistics																
Strategic objectives 1) To guarantee 100% adequacy of bundled quality vaccines for safe immunization at all times 2) To revamp sub-national level(LGA and HFs) cold chain infrastructure functionality from 47% to 80% of EVM standards by the end of 2014																
KPI/Core Indicator: 1. % of HFs (public and Private) with bundled vaccines 2. Proportion of LGAs with functional CCE in their wards																
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
1.1	Create a system that ensures adequacy of bundled vaccines at all levels (procurement system for 100% bundling of vaccines and devices; 25% rolling buffer stock for all antigens; 50% rolling buffer stock for devices; clearing and warehousing for devices; insurance of all stocks at warehouses and in transit, distribution)	State level distribution plans for vaccines and devices developed and tied to coverage	X	X	X	X	X	X	X	X	X	X	Quantity of bundled vaccines delivered to the LGAs and HFs	VM 2	States logistics working group	GAVI, UNICEF
1.2	Build real-time stocks data management system (real-time stocks available centrally - use of computer application softwares)	Stock management tool developed and tested		X	X	X	X	X	X	X	X	X	Use of new stock management tool	Realtime stocks tracking	National logistics working group	UNICEF, PATHS, DFID, CHAI
1.3	Expand use of solar fridges and introduce New technology for CCE management (Introduce new - DDSR/Dual, increase Battery SR, CCEs management technology e.g. PATHS CCEM tool, continuous temp logs, fridge tags etc)	Procurement plan for CCE developed		X	X	X	X	X	X	X	X	X	Quantity and types of new equipment installed at LGA and HF levels	Distribution plan and certification (installation report)	National logistics working group	GAVI, UNICEF, EU, DFID, JICA and PATHS
1.4	Enforce/advocate usage of Product Quality and Safety (PQS) equipment and replacement of non PQS compliant equipment (awareness of PQS equipment by States/LGAs/MDGs conditional grant scheme )	WHO PQS catalogue shared with the states and LGAs	X	X									Quantity of WHO PQS product information catalogue shared to States/LGAs	Acknowledgement letters	National logistics working group	UNICEF, WHO
1.5	Establish Planned Preventive Maintenance system (Create and implement maintenance contracts; establish PPM by production of guidelines and training on it)	Planned preventive maintenance guidelines reviewed, adopted and approved	X	X	X	X	X	X	X	X	X	X	Quantity of Planned preventive maintenance manual shared to States and personnel trained	PPM equipment logbook in use	National/States logistics working group	UNICEF, Fed Ministry of science and Technology, CHAI
1.6	PPP transport options (Assess, and trial of PPP distributions via a via current public schemes e.g. NURTW, PRRINN Jg model, Riders for Health, canoe drivers association etc)	Concept and proposals on partnership articulated	X	X									Quantity of bundled vaccines delivered to the LGAs and HFs by PPP arrangement	MoUs signed with States and LGAs	State logistics working group	UNICEF, DFID- PRRINN, Mckinsey
1.7	Expand use of incineration for waste disposal	Advocacy plan developed to target States and partner's			X	X	X	X	X	X	X	X	Quantity of incinerators procured and installed	Map of incinerator locations	State logistics working group	John Snow, GAVI, GBF
2.0 Priority Area: Service delivery																
Strategic Objective: Ensure that 100% of wards implement the REW strategy by June 2014																
KPI/Core Indicator: 1. DPT3 coverage Proportion of planned/outreach fixed sessions conducted																
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
2.1	Micro plan development (Detailed plans with micro-census and walk-through carried out by all HFs and LGAs)	Revised RI Micro plans developed by LGAs and HFs	X	X	X	X	X	X	X	X	X	X	Comprehensive Micro plans for all communities and linked to HFs	line-list of LGAs with revised MP	States, LGAs supportedn by RIWG	WHO ,DFID,BMGF,GAVI,CDC
2.2	Conduct more vaccination sessions at HFs to cater for community needs based on revised Microplan	Increase in fixed sessions conducted	X	X	X	X	X	X	X	X	X	X	Increased immunization coverage	HF Monthly RI reports	States, LGAs supported by RIWG	WHO ,DFID,BMGF,GAVI
2.3	Conduct more vaccination sessions through outreach vaccination services for distant and hard to reach areas	Increase outreach sessions conducted	X	X	X	X	X	X	X	X	X	X	Increased immunization coverage	HF Monthly RI reports	RI working group NPHCDA	WHO ,DFID,BMGF,GAVI
2.4	Conduct more vaccination sessions through strong and sustainable Private Provider engagement	MoU with Private providers developed and signed	X	X	X	X	X	X	X	X	X	X	Increased Immunization coverage	HF Monthly RI reports	RI working group NPHCDA	WHO ,DFID,BMGF,GAVI
2.5	Improve AEFI surveillance systems (training of HWs on detection and reporting, availability of reporting/investigation forms, AEFI kits and supervision)	Avaiability of filled AEFI forms	X	X	X	X	X	X	X	X	X	X	AEFI committee reports	Avaiability of filled AEFI forms	Surveillance team NPHCDA	WHO ,DFID,BMGF,GAVI
2.6	Strengthen EPR to outbreaks, internally displaced populations and security challenged areas (IDSR, stock piling, pre-positioning of commodities and supplies, Rescue teams)	Early warning systems in place/LGA EPR committees functional	X	X	X	X	X	X	X	X	X	X	Report of active response during emergencies	LGA monthly report	RI working group NPHCDA	WHO, DFID, BMGF, GAVI, NEMA



# LOGFRAME



3.0 Priority Area: HRH																	
Strategic Objective: To strengthen EPI-related capacity of frontline workforce in at least 80% of service delivery points by 2015																	
KPI/Core Indicator: Proportion of health facilities with at least one trained HW in the year																	
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
3.1	Optimize distribution of EPI workforce (increase #s in rural areas, make temporary staffing arrangements from pool of retired/unemployed HWs, Taskshifting & task sharing etc.)	EPI work staff audit	X	X	X	X	X	X	X	X	X	X	X	Availability HRH plan & placement	HF postings	LGA EPI team	WHO, CHAI
3.2.1	Complete basic guide and MLM training to frontline HWs and EPI managers (integrated REW, data management, EVM, PPM, AEFIs, Surveillance, etc trainings.)	Training plans developed	X	X	X	X								Number of Health workers trained on EPI	Training reports	Training working group /States/LGAs	WHO
3.2.2	Outsource EPI trainings to health training institutions (integrated REW, data management, PPM, AEFIs, SIAs, )	Map of potential institutions		X	X		X	X	X	X	X	X	X	Number of Health workers trained on EPI/institutions/streams	Graduands record	Training working group/States	WHO, CHAI, HERFON, PATHS2,
3.2.3	Collaboration with professional health regulatory bodies (PCN, MDCN, NMCN, CPBN etc) on continuous mandatory education for EPI	Advocacy plans and visits conducted				X	X	X	X	X	X	X	X	EPI incorporated into CME curriculum	Annual report	NPHCDA	WHO, CHAI, HERFON, PATHS2,
3.3	Strengthen supportive supervision (Integrate RI into other components of PHC, use standardized checklists, outline mechanism for feedback, etc.)	Supportive supervision checklists revised and schedules outlined	X	X	X	X	X	X	X	X	X	X	X	List of HF's supervised	Supervision reports	RI working group/States/LGAs	All partners

4.0 Priority Area : HMIS																	
Strategic Objective: To improve the quality of all components of the RI monitoring system to a minimum of 80% as measured by DQS in the context of the NHMIS by 2015																	
KPI/Core Indicator: 1. Proportion of health facilities with complete data report      2. Proportion of HF's reporting timely																	
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
4.1	Conduct data quality surveys (regular conduct of data quality self assessment (DQS) National - once annually, States biannually and LGAs quarterly to improve other components of data - recording practices, archiving, use for action, core indicators analysis and demography to satisfactory standards)	DQS surveys conducted	X	X	X	X	X	X	X	X	X	X	X	DQS data	DQS Report	M&E working group and RI working group	WHO, UNICEF, CHAI, CDC, DFID supported program, USAID supported programs
4.2	Create PHC data bank (PHC data bank at the NPHCDA for repository of all information on PHC statistics, human resource, capacity building, infrastructure and software)	Functional data bank at the NPHCDA established			X	X	X	X	X	X	X	X	X	Availability of harmonized, regular and up to date data for EPI in the context of HMIS	data bank report	M&E working group and RI working group	WHO, UNICEF, CHAI, CDC, DFID supported program, USAID supported programs
4.3	Provide sufficient data tools that are harmonized to conform to NHMIS format at HF levels	Availability of data tools at HF's	X	X	X	X	X	X	X	X	X	X	X	HF Monthly RI reports	supportive supervision report	M&E working group and RI working group	WHO, UNICEF, CHAI, CDC, DFID supported program, USAID supported programs
4.4	RI data review and feedback on a monthly basis in states and LGAs (LIOs/HF i/cs, DSNOs, harmonization meetings, PHC quarterly reviews)	Schedule of planned meetings	X	X	X	X	X	X	X	X	X	X	X	Monthly State/LGA RI reports	Reports of meetings	M&E working group and RI working group	WHO, UNICEF, CHAI, CDC, DFID supported program, USAID supported programs



# LOGFRAME



5.0 Priority Area: Community Participation & Ownership																	
Strategic Objective: To create demand for RI beyond behavioral change communication to social transformations by changing level of awareness from <50% to 80% by 2015																	
KPI/Core Indicator:1. Proportion of WDCs formed and functional																	
2. Number of care givers that respond positively to RI Radio messages																	
ID	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
5.1	Demand creation (Targeted messaging around RI to relevant stakeholders-flyers,banners, billboards,jingles; hosting of annual immunization weeks-Media engagements.)	Message development & pre-testing of new RI brand	X	X	X	X	X	X	X	X	X	X	X	Quantity of IEC materials and frequency of print & electronic media engagement	Media clips and footages	Social mobilization team NPHCDA	UNICEF, WHO, CHAI,CDC, EU, DFID supported program,USAID supported programs
5.2	Community engagement (engagement of community structures- WDCs, TLs, RLs, CBOs,NOA, civil defence, vigilantes, School children, Boys scout, Peace builders corps etc- meetings, announcements, distribution of IEC materials, trainings)	Proportion of WDCs formed and functional	X	X	X	X	X	X	X	X	X	X	X	Activity reports	Directory of community groups	Social mobilization team NPHCDA	UNICEF, WHO, CHAI,CDC, EU, DFID supported program,USAID supported programs
5.3	Advocacy to political leadership (Target Governors, Legislators, LGA chairmen, etc.)	Advocacy plans and kits		X		X		X		X		X	Advocacy report	Attendance list	Social mobilization team NPHCDA	All partners	
6.0 Priority Area: Leadership & Governance																	
Strategic Objective: 1) To establish an accountability framework at all levels for RI that is implemented by all stake holders from January 2014 onwards 2) To eliminate delays in funding delivery through basket funds and increase funding for RI in 80% of LGAs 3) To support efforts to bring PHC delivery under one roof through implementation of functional SPHCDA																	
KPI/Core Indicator:1. Proportion of States that have achieved at least 80% of AFRIN core indicators.																	
2.Proportion of HF's receiving funding from the LGA monthly																	
ID	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
6.1	Implement AFRIN at all levels (Launching, sharing of AFRIN, Sensitization meetings, feedbacks - dashboards and scorecards)	Copies of printed AFRIN document and its distribution		X	X	X	X	X	X	X	X	X	X	Monthly dashboard indicators	Database of performance	RI working group and M&E working group	All partners
6.2	Operational funding for RI (through specific line items in recurrent budgets) - advocacies to legislature and MoLGA	State/LGAs with line budgets for RI				X	X	X	X	X	X	X	list of LGAs with funds released monthly	Fund release certificates	State and LGA PHC teams	All partners	
6.3	Basket fund setup (based on Zamfara case study)	Proportion of states holding coordination meetings					X	X	X	X	X	X	List of States with established basket funds	Minutes of coordination meetings and disbursements	RI working group	All partners	
6.4	Financial and procurement tracking tool setup (giving all stakeholders access to up-to-date information)	Tracking tool developed and operational			X	X	X	X	X	X	X	X	RI funding statements at ICCs (national and states)	Minutes of ICCs	ICC finance committee	All partners	
6.5	Accelerate establishment of functional SPHCDA (dissemination of guidelines/advocacies for legislation and funding)	Number of guidelines shared	X	X	X	X	X	X	X	X	X	X	States with functional SPHCDA	Laws establishing agencies	RI working group	All partners	



# LOGFRAME



7.0 Priority Area: Partnerships and Program Integration																	
Strategic Objective: 1.To support the roll out of new vaccines in all states from 2013 to 2015. 2. To continuously link Polio campaigns and other health interventions in an integrated manner that strengthens the overall PHC system																	
KPI/Core Indicator: Coverage of at least 87% for Penta nationally by 2015																	
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
7.1.1	Roll out of Penta-valent and Pneumococcal conjugate vaccines	States introduction work plan		X	X	X	X	X	X	X	X	X	X	Coverage of Penta/PCV amongst states	RI monthly performance report	RI working group	WHO, UNICEF, DFID, BMGF, GAVI
7.1.2	Establishment of sentinel sites for IBD and rota virus surveillance	Assessment reports		X	X	X	X	X	X	X	X	X	X	Burden of disease data	Laboratory performance indicators	M&E working group	WHO, BMGF, MenAfrican
7.1.3	HPV demonstration project	Reactivate existing Nigeria Vaccine Access Plan	X		X	X	X	X	X	X	X	X	X	Coverage of HPV at target sites	Project Report	SIA working group	WHO, UNICEF
7.1.4	Policy switch in vaccine types (OPV to IPV, TT to Td, MV to MRV)	Desk/Literature reviews conducted		X			X			X				Position paper from ICC	National Immunization Policy	RI working group	WHO, UNICEF
7.2	PEI and other PHC program integration (Training of HCWs to promote RI during Polio campaigns, enlisting community leaders as RI advocates, Refinement of TORs, Data tools, resources from MSS & SURE-P etc.)	Field guide reviewed reflecting new TORs	X	X	X	X	X	X	X	X	X	X	X	Proportion of infants vaccinated during campaigns	SIA reports	EOC	WHO, UNICEF, DFID, BMGF, GAVI

8.0 Priority Area: Research for RI																	
Strategic Objective: To conduct research directed at identifying strategies to improve RI and health systems and evaluate impact of health programs																	
KPI/Core Indicator: 1. Number of operational researches conducted																	
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
8.1	Operational research to be carried out to determine baselines for indicators TBD	Assessments and pilots conducted	X	X										Baseline assessment	Reports	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC
8.2	Impact evaluation of novel strategies (school children as RI ambassadors, dashboards and scorecards, vaccine push system etc) to be carried out	Research protocols developed		X	X	X	X							Scale-up of good innovations	Reports	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME
8.3	Conduct National Immunization Coverage Survey	Launching of tender		X		X	X							Report of survey	Dissemination meeting	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME
8.4	Conduct post-introduction Evaluation of New vaccines	PIE Plan						X					X	Report of PIE	Dissemination meeting	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME
8.5	Sero-prevalence studies especially for HPV and fractional IPV	Research protocols developed				X				X			X	Report of study	Dissemination meeting	RI working group, Surveillance group and Operational Research unit	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME



# LOGFRAME



7.0 Priority Area: Partnerships and Program Integration																	
Strategic Objective: 1.To support the roll out of new vaccines in all states from 2013 to 2015. 2. To continuously link Polio campaigns and other health interventions in an integrated manner that strengthens the overall PHC system																	
KPI/Core Indicator: Coverage of at least 87% for Penta nationally by 2015																	
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
7.1.1	Roll out of Penta-valent and Pneumococcal conjugate vaccines	States introduction work plan		X	X	X	X	X	X	X	X	X	X	Coverage of Penta/PCV amongst states	RI monthly performance report	RI working group	WHO, UNICEF, DFID, BMGF, GAVI
7.1.2	Establishment of sentinel sites for IBD and rota virus surveillance	Assessment reports		X	X	X	X	X	X	X	X	X	X	Burden of disease data	Laboratory performance indicators	M&E working group	WHO, BMGF, MenAfrican
7.1.3	HPV demonstration project	Reactivate existing Nigeria Vaccine Access Plan	X		X	X	X	X	X	X	X	X	X	Coverage of HPV at target sites	Project Report	SIA working group	WHO, UNICEF
7.1.4	Policy switch in vaccine types (OPV to IPV, TT to Td, MV to MRV)	Desk/Literature reviews conducted		X			X			X				Position paper from ICC	National Immunization Policy	RI working group	WHO, UNICEF
7.2	PEI and other PHC program integration (Training of HCWs to promote RI during Polio campaigns, enlisting community leaders as RI advocates, Refinement of TORs, Data tools, resources from MSS & SURE-P etc.)	Field guide reviewed reflecting new TORs	X	X	X	X	X	X	X	X	X	X	X	Proportion of infants vaccinated during campaigns	SIA reports	EOC	WHO, UNICEF, DFID, BMGF, GAVI

8.0 Priority Area: Research for RI																	
Strategic Objective: To conduct research directed at identifying strategies to improve RI and health systems and evaluate impact of health programs																	
KPI/Core Indicator: 1. Number of operational researches conducted																	
	Key Activities	Process Indicators	2013		2014				2015				Output/Deliverable	Means of verification	Responsible	Supporting Partners	
			Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4					
8.1	Operational research to be carried out to determine baselines for indicators TBD	Assessments and pilots conducted	X	X										Baseline assessment	Reports	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC
8.2	Impact evaluation of novel strategies (school children as RI ambassadors, dashboards and scorecards, vaccine push system etc) to be carried out	Research protocols developed		X	X	X	X							Scale-up of good innovations	Reports	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME
8.3	Conduct National Immunization Coverage Survey	Launching of tender		X		X	X							Report of survey	Dissemination meeting	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME
8.4	Conduct post-introduction Evaluation of New vaccines	PIE Plan							X				X	Report of PIE	Dissemination meeting	RI working group	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME
8.5	Sero-prevalence studies especially for HPV and fractional IPV	Research protocols developed				X				X			X	Report of study	Dissemination meeting	RI working group, Surveillance group and Operational Research unit	WHO, UNICEF, DFID, BMGF, GAVI, CHAI, IVAC, CDC, WB-DIME



# LOGFRAME



1.0 Priority Area: Logistics	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
2.0 Priority Area: Service delivery	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
3.0 Priority Area: HRH	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
4.0 Priority Area : HMIS	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
5.0 Priority Area: Community Participation & Ownership	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
6.0 Priority Area: Leadership & Governance	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
7.0 Priority Area: Partnerships and Program Integration	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>
8.0 Priority Area: Research for RI	<ol style="list-style-type: none"> <li>1. Child Health issue remain a priority agenda of the Government of Nigeria</li> <li>2. Enabling environment remain in place to achieve continue to achieve peacefull co-existance and economic prosperity</li> <li>3. Goverments spending on health will be sustained &amp; continue to increase</li> <li>4. strong Development Partner's commitment to supporting Government to achieve it's health target</li> </ol>



# BUDGET



The total budget to implement this plan for the period of July 2013 to December 2015 is estimated at USD 642,038,476. Logistics and partnership represent 36% and 31% respectively and entails essential procurement and distribution of bundled vaccines, cold chain, waste management, and the introduction of new and underused vaccines and integration with PEI. The major cost drivers are cold chain supply and vaccines. Of total budget, 69% will be the responsibility of the national level and 31% for the subnational level. Furthermore all funds are assumed unsecured in view of the timing of the plan. This plan therefore requires strong resource mobilization efforts by all to ensure success.

### Priority Area 1: Logistics – USD 231,599,732

Representing 36% of the total budget estimate, this component will include the procurement, storage, and distribution of bundled vaccines to the facilities to ensure an uninterrupted supply of vaccines and injection material at the point of delivery. Cold chain equipment will also be procured for all levels of the system to ensure vaccines are stored at the appropriate conditions. New vaccines are included under this budget line as the country moves towards introduction of Pentavalent and PCV. Further investments are anticipated for waste management, including the procurement of incinerators to be located at strategic points within the system.

### Priority Area 2: Service Delivery – USD 55,164,712

The service delivery component will consider the roll out of the REW approach through implementation of all of its components to ensure that more vaccination sessions are held at each ward, support the integration of private sector into immunization, and surveillance of adverse effects to immunization and disease. Preparation and response to vaccine preventable disease outbreaks has been included under this component.

### Priority Area 3: Human Resources for Health – USD 59,295,566

This component will focus on building and strengthening the capacity of health workers to deliver and manage immunization services at all levels. A complete MLM program will be rolled out at all levels for frontline managers. The plan also suggests domestication of training into training institutions and stronger collaboration with professional regulatory bodies in the country. Building capacity would require stronger and more consistent supportive supervision, which has been built into the plan and budget.

### Priority Area 4: Health Management Information Systems – USD 34,344,102

Sufficient data tools will be provided to HFs and higher levels to ensure efficient data collection, recording, and reporting. Regular review meetings with the teams will be instituted in support of the overall PHC review processes. National DQS will be conducted annually and LGA DQS will be conducted quarterly to improve recording practices, archiving, use of data to spur action, core indicators analysis, and demography. A PHC data bank at NPHCDA for repository of all information on PHC statistics, human resource, capacity building,

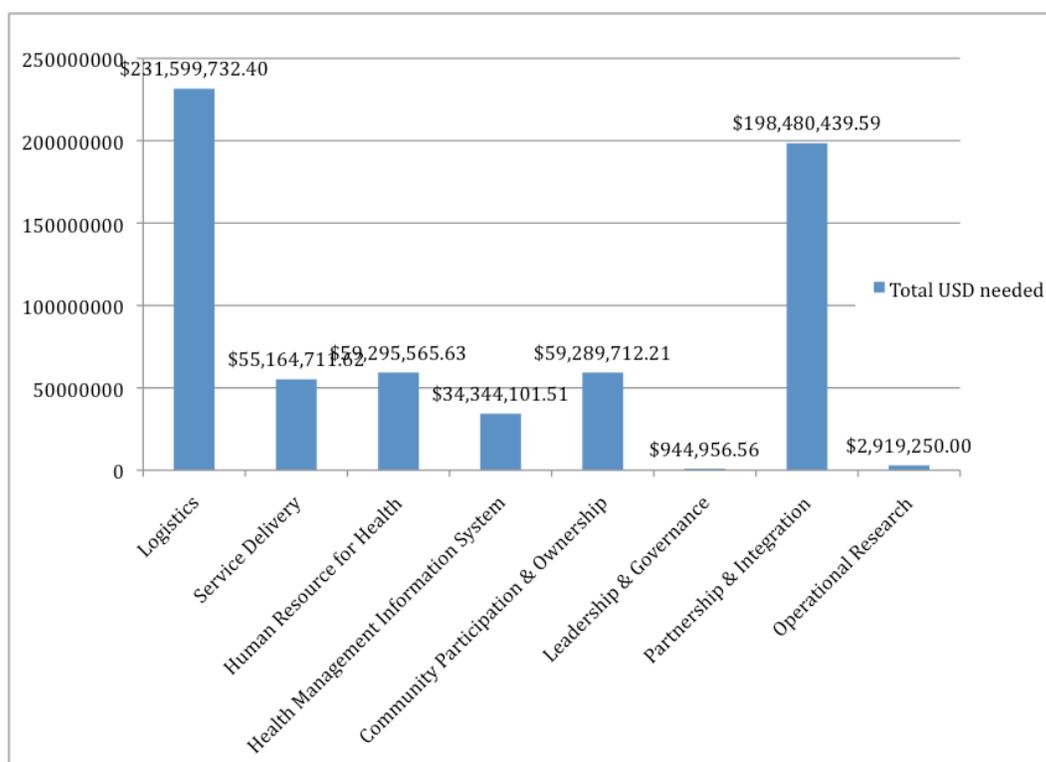


Figure 11: Distribution of costs by priority areas



# BUDGET



infrastructure, and software will be created.

## Priority Area 5: Community Participation and Ownership – USD 59,289,712

To improve demand creation, targeted messaging around RI to relevant stakeholders will be intensified. A mix of strategies has been budgeted, including visual, print media, flyers, banners, billboards, jingles, and support to the hosting of annual immunization weeks. Community structures will be engaged (WDCs, TLs, RLs, CBOs, NOA, civil defense, vigilantes, School children, Boys Scout, Peace builders corps) through meetings, announcements, distribution of IEC materials, and trainings, to enable them to own the program and ensure that communities use the available services. Advocacy meetings and visits to political leadership (Target Governors, Legislators, LGA chairmen, etc.) will be intensified and held on a regular basis.

## Leadership and Governance – USD 944,957

The budget considered the implementation of AFRIN at all levels including a launch, sharing of AFRIN, sensitization meetings, and feedback consisting of dashboards and scorecards. Advocacy efforts targeting the legislature and MoLGA will be held to get their support on the provision of operational funding for RI through specific line items in recurrent budgets. State teams will visit Zamfara State to learn about the Basket Fund and later advocate for its set-up in various states. A financial and procurement tracking tool will be set up to ensure that all stakeholders have access to up-to-date information. The budget considers the dissemination of guidelines/advocacies for legislation and funding to accelerate the establishment of functional SPHCDA.

## Partnership and Integration – USD 198,480,440

This is the second largest budget component (31%) and includes the roll out of Pentavalent and pneumococcal conjugate vaccines (PCV), including the establishment of sentinel sites for IBD and Rotavirus surveillance and the HPV demonstration project. Budgets have been included to ensure vaccine procurement for a switch in vaccine types (OPV to IPV, TT to Td, MV to MRV). Integration with the PEI program would include the training of HCWs to promote RI during polio campaigns, enlisting community leaders as RI advocates, refinement of TORs, data tools, and support to one staff in each facility during campaigns for routine activities.

## Operational Research – USD 2,919,250

An operational research is planned to be carried out to determine baselines for indicators as well as possible impact of new interventions. One national Immunization Coverage Survey and post-introduction Evaluation of New Vaccines will be conducted. A Sero-prevalence study on HPV and fractional IPV will also be conducted.

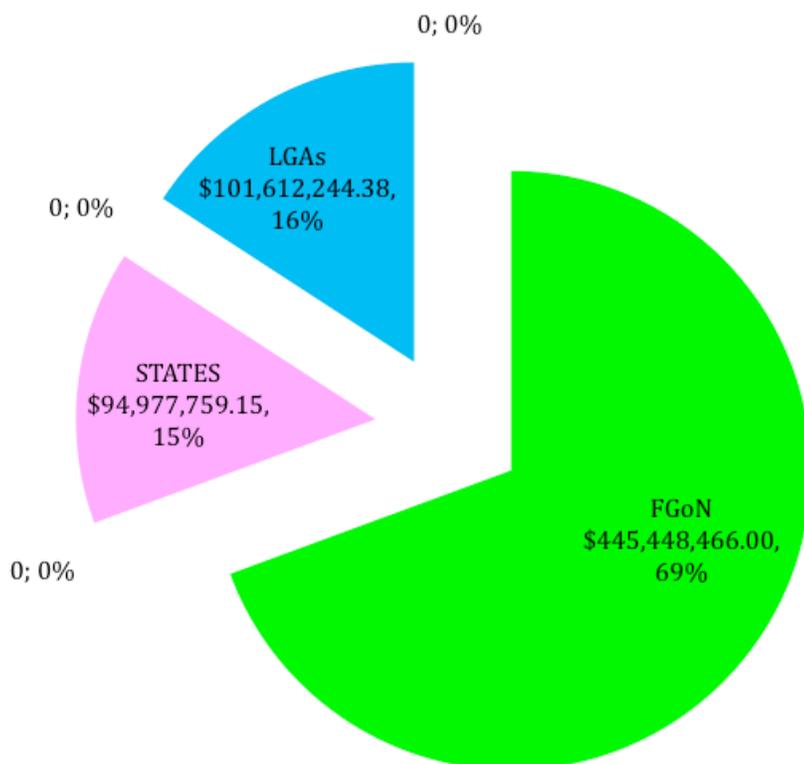


Figure 12: Funding Responsibilities by levels of governments



# BUDGET



Key Activities	Description of costs	2013	2014	2015	2013-2015
Create a system that ensures adequacy of bundled vaccines at all levels (procurement system for 100% bundling of vaccines and devices; 25% rolling buffer stock for all antigens; 50% rolling buffer stock for devices; clearing and warehousing for devices; insurance of all stocks at warehouses and in transit, distribution)	Antigens and devices procurement	\$21,201,092	\$49,530,040	\$58,895,371	\$129,626,503
Build real-time stocks data management system (real-time stocks available centrally - use of computer application softwares)	Procurement of consultancy, computers and software, training	\$142,516	\$75,422	\$80,016	\$297,954
Expand use of solar fridges and introduce new technology for CCE management (Introduce new - DDSR/Dual, increase Battery SR, CCEs management technology, e.g. PATHS CCEM tool, continuous temp logs, fridge tags, etc.)	Procurement with installation	\$20,091,173	\$32,924,205	\$31,281,863	\$84,297,241
Enforce/advocate usage of Product Quality and Safety (PQS) equipment and replacement of non PQS compliant equipment (awareness of PQS equipment by States/LGAs/MDGs conditional grant scheme )	Production of PQS	\$17,500	\$0	\$0	\$17,500
Establish Planned Preventive Maintenance system (Create and implement maintenance contracts; establish PPM by production of guidelines and training)	Procurement of maintenance contract, replacement parts, guidelines, training	\$2,026,528	\$3,279,647	\$3,090,452	\$8,396,627
PPP transport options (Assess, and trial of PPP distributions via current public schemes e.g. NURTW, PRRINN Jg model, Riders for Health, canoe drivers association etc)	Consultancy cost	\$23,373	\$0	\$0	\$23,373
Expand use of incineration for waste disposal	Procurement and installation	\$1,630,178	\$2,440,178	\$4,870,178	\$8,940,534
<b>GRAND TOTAL AREA 1 - LOGISTICS</b>	<b>\$45,132,360</b>	<b>\$88,249,492</b>	<b>\$98,217,880</b>	<b>\$231,599,732</b>	
Micro-plan development (Detailed plans with micro-census and walk-through carried out by all HFs and LGAs)	Trainings, personnel, transport	\$2,368,887	\$2,276,668	\$0	\$4,645,555
Conduct more vaccination sessions at HFs to cater to community needs based on revised Micro-plan	Imprest	\$2,570,625	\$5,141,250	\$2,570,625	\$10,282,500
Conduct more vaccination sessions through outreach vaccination services for distant and hard-to-reach areas	Meetings and local run	\$4,284,375	\$8,568,750	\$4,284,375	\$17,137,500
Conduct more vaccination sessions through strong and sustainable Private Provider engagement	State level meetings and local run	\$685,247	\$660,619	\$55,546	\$1,401,412



# BUDGET



Improve AEFI surveillance systems (training of HWs on detection and reporting, availability of reporting/investigation forms, AEFI kits and supervision)	Training, forms, kits, personnel	\$1,601,859	\$640,745	\$1,601,859	\$3,844,463
Strengthen EPR to outbreaks, internally displaced populations and security challenged areas (IDSR, stock piling, pre-positioning of commodities and supplies, rescue teams)	Training, procurement, personnel	\$3,485,754	\$6,805,612	\$7,561,916	\$17,853,282
<b>GRAND TOTAL AREA 2 - SERVICE DELIVERY</b>		<b>\$14,996,747</b>	<b>\$24,093,644</b>	<b>\$55,164,712</b>	
Optimize distribution of EPI workforce (increase numbers in rural areas, make temporary staffing arrangements from pool of retired/unemployed HWs, task shifting and task sharing, etc.)	Salaries, rural posting allowances	\$0	\$0	\$0	\$0
Complete basic guide and MLM training to frontline HWs and EPI managers (integrated REW, data management, EVM, PPM, AEFIs, Surveillance, etc.)	Training	\$4,626,704	\$13,392,426	\$11,112,501	\$29,131,631
Domesticate EPI trainings at health training institutions (integrated REW, data management, PPM, AEFIs, SIAs)	Meetings, Consultancy	\$124,485	\$225,000	\$236,985	\$586,470
Collaborate with professional health regulatory bodies (PCN, MDCN, NMCN, CPBN, etc.) on continuous mandatory education for EPI	Meetings	\$5,580	\$2,790	\$1,395	\$9,765
Strengthen supportive supervision (Integrate RI into other components of PHC, use standardized checklists, outline mechanism for feedback, etc.)	Transport, Personnel	\$5,913,540	\$11,827,080	\$11,827,080	\$29,567,700
<b>GRAND TOTAL AREA 3 - HUMAN RESOURCES FOR HEALTH</b>		<b>\$10,670,309</b>	<b>\$25,447,296</b>	<b>\$59,295,566</b>	
Conduct data quality surveys (regular conduct of data quality self assessment (DQS) National - once annually, States biannually, and LGAs quarterly to improve other components of data-recording practices, archiving, data use to spur action, core indicators analysis and demography to satisfactory standards)	Training, transport, personnel	\$2,716,275	\$2,903,775	\$2,716,771	\$8,336,821
Create PHC data bank (PHC data bank at the NPHCDA for repository of all information on PHC statistics, human resource, capacity building, infrastructure, and software)	Procurement of infrastructure, computers, softwares, personnel, consultancy, transport, meetings	\$1,008,206	\$175,000	\$579,456	\$1,762,662
Provide sufficient data tools that are harmonized to conform to NHMIS format at HF levels	Procurement of data tools	\$1,678,872	\$1,678,872	\$1,678,872	\$5,036,616
RI data review and feedback on a monthly basis in states and LGAs(LIOs/HF i/cs, DSNOs, harmonization meetings, PHC quarterly reviews)	Meetings	\$11,411,709	\$3,898,147	\$3,898,147	\$19,208,003
<b>GRAND TOTAL AREA 4 - HEALTH MANAGEMENT INFORMATION SYSTEM</b>		<b>\$16,815,062</b>	<b>\$8,655,794</b>	<b>\$34,344,102</b>	



# BUDGET



Create demand (targeted messaging around RI to relevant stakeholders - flyers, banners, billboards, jingles; hosting of annual immunization weeks; media engagements.)	IEC materials procurement/Media engagement	\$10,190,969	\$18,660,063	\$18,660,063	\$47,511,095
Engage community (engagement of community structures - WDCs, TLs, RLs, CBOs, NOA, civil defence, vigilantes, school children, Boy Scouts, Peace builders corps, etc.- meetings, announcements, distribution of IEC materials, trainings)	Meetings and trainings	\$1,451,723	\$2,226,234	\$7,486,696	\$11,164,653
Advocate to political leadership (Target Governors, Legislators, LGA chairmen, etc.)	Meetings, advocacy kits	\$181,506	\$247,119	\$185,339	\$613,964
<b>GRAND TOTAL AREA 5 - COMMUNITY PARTICIPATION AND OWNERSHIP</b>	<b>\$11,824,198</b>	<b>\$21,133,416</b>	<b>\$26,332,098</b>	<b>\$59,289,712</b>	
Implement AFRIN at all levels (launching, sharing of AFRIN, sensitization meetings, feedback, dashboards, and scorecards)	Meetings, trainings, technical assistance	\$476,973	\$63,178	\$63,178	\$603,329
Establish operational funding for RI (through specific line items in recurrent budgets) - advocacy to legislature and MoLGA	Meetings, Advocacy kits	\$21,394	\$31,379	\$0	\$52,773
Set up basket fund (based on Zamfara case study)	Meetings and experiential learning (personnel/transport)	\$75,330	\$0	\$0	\$75,330
Set up financial and procurement tracking tool (giving all stakeholders access to up-to-date information)		\$31,250	\$0	\$0	\$31,250
Accelerate establishment of functional SPHCDA (dissemination of guidelines/advocacy for legislation and funding)	Advocacy, meetings, transports, personnel	\$34,488	\$96,212	\$51,575	\$182,275
<b>GRAND TOTAL AREA 6 - LEADERSHIP AND GOVERNANCE</b>	<b>\$639,435</b>	<b>\$190,769</b>	<b>\$114,753</b>	<b>\$944,957</b>	
Roll out Pentavalent and Pneumococcal conjugate vaccines	Assess readiness(personnel, transport), procurement of data tools, IEC materials, training	\$34,021,387	\$34,045,762	\$11,913,188	\$79,980,337
Establishment of sentinel sites for IBD and rota virus surveillance	Surveillance costings	\$959,234	\$959,233	\$959,234	\$2,877,701
HPV demonstration project	Procurement cost	\$6,851,250	\$0	\$0	\$6,851,250
Accommodate policy switch in vaccine types (OPV to IPV, TT to Td, MV to MRV)	Additional procurement costs	\$0	\$0	\$89,979,485	\$89,979,485
Integrate PEI program (training of HCWs to promote RI during Polio campaigns, enlisting community leaders as RI advocates, refinement of TORs, data tools, etc.)	Personnel cost for fixed HWs	\$2,291,667	\$8,250,000	\$8,250,000	\$18,791,667
<b>GRAND TOTAL AREA 7 - PARTNERSHIP AND INTEGRATION</b>	<b>\$44,123,538</b>	<b>\$43,254,995</b>	<b>\$111,101,907</b>	<b>\$198,480,440</b>	



# BUDGET



Perform operational research to determine baselines for indicators TBD		\$0	\$0	\$0	\$0
Perform operational research on possible impact of new interventions (school children as RI ambassadors, KAP studies, dashboards and scorecards, vaccine push system, etc.) to be carried out	Lump sum to pilot new interventions	\$1,000,000	\$0	\$0	\$1,000,000
Conduct National Immunization Coverage Survey		\$0	\$1,125,000	\$0	\$1,125,000
Conduct post-introduction Evaluation of New vaccines	Penta Phase 1 (14 states) & Phase 2(7 states)= 5 people/state	\$239,400	\$182,400	\$91,200	\$513,000
Sero-prevalence studies especially for HPV and fractional IPV		\$0	\$281,250	\$0	\$281,250
<b>GRAND TOTAL AREA 8 - OPERATIONAL RESEARCH</b>	<b>\$1,239,400</b>	<b>\$1,588,650</b>	<b>\$91,200</b>	<b>\$2,919,250</b>	
<b>GRAND TOTAL</b>	<b>\$145,441,049</b>	<b>\$212,614,056</b>	<b>\$283,983,366</b>	<b>\$642,038,471</b>	



# APPENDIX



## Lafia Retreat Conclusions

1. It is a national priority that RI is revitalized, so that every child receives all vaccinations at the right age
2. Increase access to immunization to reduce the number of un-immunized children. A child should be immunized at any given opportunity
3. Explore innovative approaches that may include participation of the private sector, CSO, TBA, PPMVs e.tc.
4. To enhance co-ordination and synergy of stakeholders at every level. The government should be in the “driver’s seat” while partners are to support RI activities
5. Improve community, traditional and religious leaders’ participation in RI activities
6. Encourage regular supportive supervision, training and joint quarterly monitoring in an effort to revitalize RI
7. Address poor vaccine security especially at LGA and HF levels
8. To ensure vaccine security, we need to improve and expand cold chain infrastructure
9. Forecasting should be based on validated catchment populations, timely procurement, storage and distribution. There is need for a good monitoring system of adequate bundled vaccines at LGA and health facility levels
10. There should be improvement in data management especially at LGA and health facility levels
11. The convergence of PEI and RI is highly recommended so that resources available for polio should be used to strengthen RI
12. The accountability framework must inform our actions at every level. Reporting of progress made on achievements of accountability and actions taken is to be done quarterly. Incentives should include awards and recognition to the best-performing LGAs, in addition to national and state recognition of individuals and organizations (from the private sector, traditional/religious leaders, CSOs, etc.) that significantly contribute to RI and PEI
13. There should be a dissemination meeting with the states for adequate buy-in
14. In order to achieve the above the following were prioritized:
  - i. Improve logistics
  - ii. Reduce unimmunized children
  - iii. Improve data quality
  - iv. Support introduction of new vaccines
  - v. Demand creation for services
  - vi. Link with PEI



# APPENDIX



## WHO supervision model

### Setting up/ (or Review) supportive supervision system

- Training a core set of supervisors
- Creating checklists and recording forms
- Ensuring appropriate resources are available – vehicles, per diem, areas for collaboration with other programmes.

### Planning several supervisory visits

- Where: using data to decide priority supervision sites
- When: schedule supervision visits using a work plan
- What subjects to train: identify training needs and skills that need updating

### Conducting Supportive Supervision

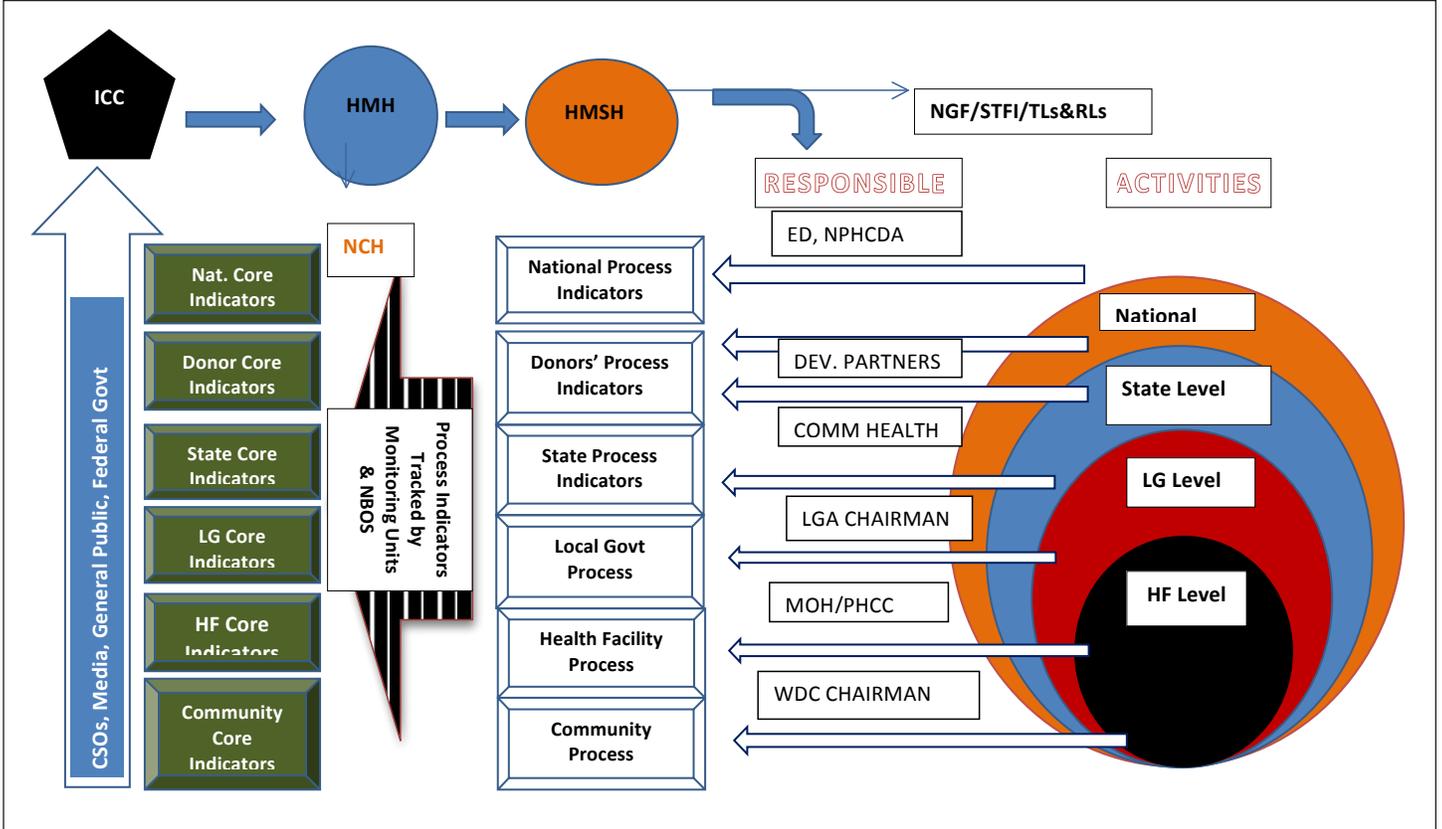
- Observation
- Use of data
- Problem solving
- On the job training
- Recording observations and feedback

### Follow – Up

- Follow up on agreed actions by supervisors and supervised staff
- Regular data analysis
- Feedback to all stakeholders

# APPENDIX

## Operational Scheme of Accountability Framework





# APPENDIX



## Accountability framework Indicators

### CORE INDICATORS FOR ROUTINE IMMUNIZATION ACCOUNTABILITY IN NIGERIA

S/No	LEVEL	OPERATIONAL AREA	INDICATORS	DENOMINATOR	BASELINE	MINIMUM TARGETS			METHOD OF VERIFICATION	RESPONSIBILITY	FREQUENCY	PRIORITY RANKING
						2013	2014	2015				
1	NATIONAL	COLD CHAIN MGT	% of zonal cold stores that are fully functional	Total number of zonal cold stores	TBD	100	100	100	Survey Reports	NPHCDA	Monthly	high
2	NATIONAL	VACCINES & LOGISTICS	# of states (plus FCT) with no vaccine stock out of any antigen	Total number of states	TBD	37	37	37	Vaccine inventory logs	NPHCDA/SMOHs	Monthly	high
3	NATIONAL	VACCINES & LOGISTICS	# of states (plus FCT) with no AD Syringe stock out	Total number of states	TBD	37	37	37	AD Syringe Inventory Logs	NPHCDA/SMOHs	Monthly	high
4	NATIONAL	VACCINES & LOGISTICS	# of states (plus FCT) bundling AD Syringes and Vaccines <b>prior</b> to distribution to LGAs	Total number of states	TBD	37	37	37	Bundling status reports	NPHCDA/SMOHs	Monthly	low
5	NATIONAL	VACCINES & LOGISTICS	% supply adequacy rate	Total number of vaccines requested	TBD	100	100	100	State Request Data/ Distribution logs	NPHCDA	Monthly	high
6	NATIONAL	VACCINES & LOGISTICS	% of Vaccines procured distributed to states	Total number of vaccines procured	TBD	100	100	100	Logs/Reports	NPHCDA	Monthly	low
7	NATIONAL	LOGISTICS	Number of months delay between fund release by Govt and vaccine delivery	NA	4 mnths or <	2	2	2	Vaccine delivery logs & Paid invoice records	RI Donor Partners	Annually	high
8	NATIONAL	FORECASTING & PROCUREMENT	% of forecasted Vaccines Procured within 4 months of request	Total number of vaccines forecasted based on state requests	TBD	100	100	100	Procurement Records	UNICEF	Annually	high
9	NATIONAL	PLANNING	National Annual Plan for RI developed and disseminated	NA	Y/N	Y	Y	Y	National RI Plan available at all levels	NPHCDA	Annually	high
10	NATIONAL	PLANNING	# of states (plus FCT) with EPI plans	Total number of states	TBD	37	37	37	State EPI Plans available	NPHCDA/SMOHs	Annually	low
11	NATIONAL	PLANNING	# of states (plus FCT) conducting monthly review meetings	Total number of states	TBD	37	37	37	State meeting records/minutes	NPHCDA/SMOHs	Monthly	low
12	NATIONAL	PLANNING	Proportion of milestones as defined by the National RI Strategic Plan, achieved within the specified intervals	Total number of milestones to be achieved within review interval	TBD	70	80	90	Reports, Logs, Document Review	NPHCDA	Annually	high
13	NATIONAL	SERVICE DELIVERY	% of planned supervisory visits to states undertaken using ISS checklist	Total number of planned supervisory visits	TBD	80	90	100	Reports	NPHCDA	Quarterly	high
14	NATIONAL	DATA MANAGEMENT	Proportion of monthly RI reports analyzed and disseminated	Total number of LGA RI Monthly reports	TBD	70	80	90	Analysis of Monthly RI Report available at all levels	NPHCDA	Monthly	medium
15	NATIONAL	DATA MANAGEMENT	% DPT3 national coverage achieved	Total number of DPT3 eligible children	TBD	78	82	87	Coverage Data	NPHCDA	Quarterly	high
16	NATIONAL	DATA MANAGEMENT	Proportion of donor technical support resources for use by Govt that are integrated into the existing RI system, rather than being parallel implementing units.	Total number of Donor Technical Support Resources approved for use by Govt	TBD	70	85	95	RI programming reports at all levels	RI Donor Partners	Annually	medium
17	NATIONAL	GOVERNANCE	National Immunization Policy document reviewed and/or updated	NA	Y/N	Y	Y	Y	Review Certifications /Updated policy available	NPHCDA	Every 2 yrs	low
18	NATIONAL	GOVERNANCE	% of budgeted donor partner RI funds released in a timely manner.	Total budgeted Donor funds for RI programming in-country	TBD	75	85	95	Financial Records	RI Donor Partners	Annually	high
19	NATIONAL	GOVERNANCE	% of ICC meetings attended by donor partners	Total number of ICC meetings held	TBD	50	75	100	ICC Meeting minutes/ Sign in sheets	RI Donor Partners	Annually	medium
20	NATIONAL	GOVERNANCE	% of partner workplan objectives that are aligned with RI component of IHP + compact (NSHDP)	Total number of Donor workplan objectives for RI	TBD	65	80	90	Donor RI workplans	RI Donor Partners	Annually	medium
21	NATIONAL	GOVERNANCE	Proportion of donor RI funds committed to priorities identified in the RI Strategic plan	Total budgeted Donor funds for RI programming in-country	TBD	65	80	90	Donor RI funding records	RI Donor Partners	Annually	high



# APPENDIX



## Accountability framework Indicators

### CORE INDICATORS FOR ROUTINE IMMUNIZATION ACCOUNTABILITY IN NIGERIA

S/No	LEVEL	OPERATIONAL AREA	INDICATORS	DENOMINATOR	BASELINE	MINIMUM TARGETS			METHOD OF VERIFICATION	RESPONSIBILITY	FREQUENCY	PRIORITY RANKINGS
						2013	2014	2015				
1	STATE	COLD CHAIN MGT	State Cold Store is fully functional and capacity adequate	NA	Y/N	100	100	100	Logs/Reports	SIO, CCO	Monthly	high
2	STATE	COLD CHAIN MGT	% of approved RI facilities state-wide with functional cold chain equipment	Total number of approved RI facilities in state	TBD	80	90	100	Survey Reports	SIO, CCO	Quarterly	medium
3	STATE	VACCINES & LOGISTICS	% of Distributed Vaccines bundled with injection supplies	Total number of distributed vaccine doses	TBD	85	95	100	Distribution Logs/inventory data	SIO, CCO	Monthly	high
4	STATE	VACCINES & LOGISTICS	% of LGAs with no AD syringe stock-out	Total number of LGAs	TBD	100	100	100	Inventory Log	SIO	Monthly	high
5	STATE	VACCINES & LOGISTICS	% of LGAs with no vaccine stock out of any antigen	Total number of LGAs	TBD	100	100	100	Stock level logs/reports	SIO	Quarterly	high
6	STATE	LOGISTICS	% supply adequacy rate	Number of vaccines requested	TBD	100	100	100	State Request Data/ Distribution logs	SIO	Monthly	high
7	STATE	FORECASTING	% of LGA Forecasting data submitted to HQ timely per protocol	Total number of LGAs	TBD	85	95	100	Forecasting reports	SIO	Quarterly	medium
8	STATE	PLANNING	State annual EPI plan developed and disseminated	NA	Y/N	Y	Y	Y	Annual Plan available at Sub -State levels	SIO, DPHC	Annually	high
9	STATE	PLANNING	% of LGAs with updated Micro-plan	Total number of LGAs	TBD	70	80	90	LGA Microplans	SIO	Quarterly	medium
10	STATE	SERVICE DELIVERY	% of approved RI facilities with the required minimum level of staff	Total number of approved RI facilities	TBD	80	90	100	Survey Reports	SIO, DPHC	Quarterly	medium
11	STATE	SERVICE DELIVERY	% of LGAs with at least one staff trained on immunization in previous year	Total number of LGAs	TBD	80	90	100	LGA Training Reports	SIO, DPHC	Annually	high
12	STATE	SERVICE DELIVERY	% of new fixed sites providing RI	Total number of RI fixed sites	TBD	10	20	30	Reports	SIO	Quarterly	medium
13	STATE	SERVICE DELIVERY	% Coverage achieved for DPT3	Total number of eligible children	TBD	65	75	85	Coverage Data	SIO	Monthly	high
14	STATE	SERVICE DELIVERY	% of LGAs with DPT3 coverage below 78%	Total number of LGAs	TBD	35	25	15	Coverage Data	SIO	Monthly & Yearly	high
15	STATE	DATA MANAGEMENT	Proportion of needs assessments and/or program evaluations by partners with beneficiary or end user input		TBD	70	85	95	Needs Assessments and Program Evaluation Reports	Donor Partners	Semi - Annually	low
16	STATE	DATA MANAGEMENT	% of EPI Managers & Health workers trained on Data management	Total number of EPI Mgrs and Health Workers	TBD	65	75	90	Training Records	SIO, DPHC, NPHCDA	Annually	low
17	STATE	DATA MANAGEMENT	Proportion of LGAs that have 90% completion of monthly RI reports submitted	Total number of LGAs	TBD	70	80	90	Monthly RI Reports	SIO, DPHC	Monthly	low
18	STATE	DATA MANAGEMENT	% of LGAs Conducting Monthly Data Quality Checks (DQC)	Total number of LGAs	TBD	70	80	90	DQC Data	SIO, DPHC	Monthly	low
19	STATE	DATA MANAGEMENT	Proportion of reporting requirements (indicators) that are harmonized for multiple partners	Total number of Reporting Tools required by donors	TBD	3 or >	5 or >	7 or >	Donor reporting tools utilized at state level	Donor Partners	Quarterly	high
20	STATE	GOVERNANCE	Proportion of Monthly RI Review meetings held with HCH and DPs in attendance	Number of RI Review Meetings planned per month (1)	TBD	6	9	12	Meeting Minutes/Reports	HCH, DPHC	Monthly	medium
21	STATE	GOVERNANCE	% of LGAs receiving timely funds for logistics	Total number of LGAs	TBD	80	90	100	Financial Records	SIO, DPHC	Quarterly	high
22	STATE	GOVERNANCE	Proportion of partner activities that are harmonized and jointly-funded	Total number of donor funded RI activities	TBD	3 or >	5 or >	7 or >	Program records	Donor Partners	Semi-Annually	high
23	STATE	GOVERNANCE	Proportion of quarterly RI operational targets achieved by partners assigned	Total number RI operational targets assigned to partners	TBD	70	85	90	State RI Monthly meeting minutes, Operational Reports	Donor Partners	Quarterly	high
24	STATE	GOVERNANCE	Proportion of budgeted RI partner funds released in a timely manner	Total budgeted RI partner funds	TBD	75	85	95	Financial Records	Donor Partners	Semi-Annually	high



# APPENDIX



## Accountability framework Indicators

### CORE INDICATORS FOR ROUTINE IMMUNIZATION ACCOUNTABILITY IN NIGERIA

S/No	LEVEL	OPERATIONAL AREA	INDICATORS	DENOMINATOR	BASE-LINE	MINIMUM TARGETS			METHOD OF VERIFICATION	RESPONSI- BILITY	FREQUENC Y	PRIORITY RANKING
						2013	2014	2015				
1	LGA	COLD CHAIN MGT	% of approved RI facilities LGA-wide with an updated Cold Chain Preventive Maintenance Log and Report	Total number of approved RI facilities per LGA	TBD	80	90	100	Logs/Reports	LG Chair, CCO	Quarterly	Medium
2	LGA	COLD CHAIN MGT	% of approved RI facilities LGA-wide with functional cold chain equipment of adequate capacity	Total number of approved RI facilities per LGA	TBD	80	90	100	Survey Reports	LIO, HOD-HEALTH, CCO	Quarterly	High
3	LGA	FORECASTING	% of HFs with vaccine requirement submitted at least one month before next quarter	Total number of HFs	TBD	85	95	100	Forecasting reports	LIO	Quarterly	Medium
4	LGA	LOGISTICS	% of Vaccines received distributed to HFs	Total number of vaccines received	TBD	90	95	100	State Request Data/ Distribution logs	LIO, HOD-HEALTH	Quarterly	Medium
5	LGA	VACCINES	% of HF with no vaccine stock out in any antigen	Total number of HFs	TBD	100	100	100	Vaccine Management Records at LGA	LIO, HOD-HEALTH	Monthly	Medium
6	LGA	PLANNING	Proportion of HFs with updated microplans	Total number of HFs	TBD	70	80	90	Available HFs Microplans	LIO	Quarterly	Medium
7	LGA	SERVICE DELIVERY	% of new fixed sites providing RI	Total number of fixed RI sites	TBD	10	20	30	Reports	LIO, HOD-HEALTH	Annually	Medium
8	LGA	SERVICE DELIVERY	% Coverage achieved for DPT3	Total number of eligible children	TBD	80	85	90	Coverage Data	LIO	Monthly	High
9	LGA	SERVICE DELIVERY	% No. of HFs with at least one staff trained in RI during previous year	Total number of HFs	TBD	80	90	100	Training Data at State level	LIO, HOD-HEALTH	Annually	Medium
10	LGA	SERVICE DELIVERY	% of HFs with at least one supportive supervisory visit per qtr conducted by LGA	Total number of HFs	TBD	70	80	90	Reports	LIO	Quarterly	High
11	LGA	DATA MANAGEMENT	Proportion of needs assessments and/or program evaluation by partners with beneficiary or end user input	Total number of needs assessments and program evaluations completed	TBD	70	85	95	Needs Assessments and Program Evaluation Reports	Donor Partners	Semi - Annually	Low
12	LGA	DATA MANAGEMENT	% of monthly RI reports received by LGA from HFs	Total number of HFs	TBD	70	80	90	Monthly RI Reports	LIO	Monthly	Low
13	LGA	GOVERNANCE	Proportion of Monthly RI Review meetings held with LG Chairmen, LGA/EPI Teams and WDCs in attendance	Number of meetings planned per quarter (3)	TBD	2	3	3	Meeting Minutes/ Reports	LG CHAIR	Quarterly	High
14	LGA	GOVERNANCE	Proportion of supervisory visits jointly undertaken by partners and Government at LG/HF level	Total number of missions undertaken	TBD	50	75	100	Reports	LIO	Quarterly	High
15	LGA	GOVERNANCE	Proportion of quarterly RI operational targets achieved by partners assigned	Total number RI operational targets assigned to partners	TBD	70	85	90	State RI Monthly meeting minutes, Operational Reports	Donor Partners	Quarterly	High
16	LGA	GOVERNANCE	Proportion of budgeted RI partner funds released in a timely manner	Total budgeted RI partner funds	TBD	75	85	95	Financial Records	Donor Partners	Semi-Annually	High
17	LGA	FINANCE	% of HFs received timely funds for logistics, outreach & mobile services	Total number of HFs	TBD	80	90	100	Financial Records	LIO, LGA Chair	Quarterly	High



# APPENDIX



## Accountability framework Indicators

### CORE INDICATORS FOR ROUTINE IMMUNIZATION ACCOUNTABILITY IN NIGERIA

S/N	LEVEL	OPERATIONAL AREA	INDICATORS	DENOMINATOR	BASE-LINE	MINIMUM TARGETS			METHOD OF VERIFICATION	RESPONSIBILITY	FREQUENCY	PRIORITY RANKING
						2013	2014	2015				
1	HEALTH FACILITY	Cold chain management	% of days in a month where daily temperature logs are updated per protocol	Total number of days in month of review	TBD	85	90	100	Temperature logs	MOH/PHCC/LIO	Monthly	High
2	HEALTH FACILITY	Cold chain management	Have functional cold chain equipment of adequate capacity (Y/N)	NA	TBD	Y	Y	Y	Observation	MOH/PHCC/LIO		High
3	HEALTH FACILITY	Vaccine and logistics	Zero stock-out of any antigen in the last month (Y/N)	NA	TBD	Y	Y	Y	Vaccine stock register	MOH/PHCC/LIO	Monthly	High
4	HEALTH FACILITY	Vaccine and logistics	Zero stock-out of AD syringe in the last month (Y/N)	NA	TBD	Y	Y	Y	Vaccine stock register	MOH/PHCC/LIO	Monthly	High
5	HEALTH FACILITY	Vaccine and logistics	Submitting monthly vaccine utilization report to LGA (Y/N)	NA	TBD	Y	Y	Y	Report available	MOH/PHCC/LIO	Monthly	Med
6	HEALTH FACILITY	Forecasting	% of Catchment Area Forecasting data submitted to LGA on time per protocol	Total number of catchment areas	TBD	75	85	95	Forecasting reports	MOH/PHCC/LIO /LIO	Quarterly	Med
7	HEALTH FACILITY	Planning	REW microplan reviewed and updated in the last quarter (Y/N)	NA	TBD	Y	Y	Y	REW HF Performance Monitoring Tool	MOH/PHCC/LIO	Quarterly	High
8	HEALTH FACILITY	Planning	WDC participating in planning (Y/N)	NA	TBD	Y	Y	Y	Monthly RI Reports	MOH/PHCC/LIO	Quarterly	Med
9	HEALTH FACILITY	Service delivery	Proportion of planned fixed session conducted	Total number of planned fixed sessions	TBD	90	95	100	Monthly RI Reports	MOH/PHCC/LIO	Monthly	High
10	HEALTH FACILITY	Service delivery	Proportion of planned outreach session conducted	Total number of planned outreach sessions	TBD	80	90	90	Monthly RI Reports	MOH/PHCC/LIO	Monthly	High
11	HEALTH FACILITY	Service delivery	% DPT3 coverage achieved	Total number of eligible children	TBD	80	85	90	Coverage Data	MOH/PHCC/LIO	Monthly	High
12	HEALTH FACILITY	Service delivery	At least one personnel trained in immunization in the last year (Y/N)	NA	TBD	Y	Y	Y	REW HF Performance Monitoring Tool	MOH/PHCC/LIO	Yearly	Low
13	HEALTH FACILITY	Service delivery	At least one planned supportive supervisory visits conducted	Total number of planned visits per quarter	TBD	2	3	3	REW HF Performance Monitoring Tool	MOH/PHCC/LIO	Quarterly	High
14	HEALTH FACILITY	Service delivery	DPT1* coverage rate	NA	TBD	85	90	95	Monthly RI Reports	MOH/PHCC/LIO	Quarterly	Med
15	HEALTH FACILITY	Service delivery	DPT1 to DPT3 dropout rate	NA	TBD	15	10	5	Monthly RI Reports	MOH/PHCC/LIO	Quarterly	Med
16	HEALTH FACILITY	Service delivery	DPT1 to measles dropout rate	NA	TBD	15	10	5	Monthly RI Reports	MOH/PHCC/LIO	Quarterly	Med
17	HEALTH FACILITY	Service delivery	% of target population fully immunized	Total Number of eligible children	TBD	65	75	85	Monthly RI Reports	MOH/PHCC/LIO	Yearly	Low
18	HEALTH FACILITY	Demand creation	% of home visits planned conducted	Total number of home visits planned	TBD	80	90	100	Monthly RI Reports	MOH/PHCC/LIO	Quarterly	Med
19	HEALTH FACILITY	Demand creation	% of DC activities WDCs were supported to carry out	Total number of DC activities planned	TBD	80	90	100	Financial Reports	MOH/PHCC/LIO	Quarterly	High
20	HEALTH FACILITY	Demand creation	% increase in health facility patient visits over previous quarter	Total number of patient visits	TBD	10	20	30	REW HF Performance Monitoring Tool	WDC Chair	Quarterly	High
21	HEALTH FACILITY	Demand creation	% of planned monthly WDC meeting conducted	Total number of WDC meetings planned	TBD	70	80	90	REW HF Performance Monitoring Tool	WDC Chair	Quarterly	High



# APPENDIX



## Accountability framework Indicators

### CORE INDICATORS FOR ROUTINE IMMUNIZATION ACCOUNTABILITY IN NIGERIA

S/N	LEVEL	OPERATIONAL AREA	INDICATORS	DENOMINATOR	BASE-LINE	MINIMUM TARGETS			METHOD OF VERIFICATION	RESPONSIBILITY	FREQUENCY	PRIORITY RANKING
						2013	2014	2015				
21	HEALTH FACILITY	Demand creation	% of planned monthly WDC meeting conducted	Total number of WDC meetings planned	TBD	70	80	90	REW HF Performance Monitoring Tool	WDC Chair	Quarterly	High
22	HEALTH FACILITY	Data management	# of months/quarter where data monitoring chart is updated	Number of months per quarter (3)	TBD	2	3	3	REW HF Performance Monitoring Tool	MOH/PHCC/LIO	Quarterly	Med
23	HEALTH FACILITY	Data management	# of months/quarter where data analysis table is updated	Number of months per quarter (3)	TBD	2	3	3	REW HF Performance Monitoring Tool	MOH/PHCC/LIO	Quarterly	Med
24	HEALTH FACILITY	Data management	% of monthly RI reports submitted to LGA on time	Number of months per quarter (3)	TBD	80	90	100	Reports	MOH/PHCC/LIO	Quarterly	High
25	HEALTH FACILITY	Financing	Disbursement of funds for all planned outreach sessions in the last quarter (Y/N)	Total number of planned outreach sessions per quarter	TBD	Y	Y	Y	Financial reports	MOH/PHCC/LIO	Quarterly	High



# APPENDIX



## Sanctions and Rewards

Staff Sanctions Matrix					
	Method	Process / Definition	Monitoring team	Guidelines and tools	Enforcement
Redirection for Individual staff members	Step 1 - Written warning	If activities assigned are not carried out and/or targets not achieved in the first reporting cycle, a written warning will be given	National :M& E working group, Direct supervisor	Standardized template for the written warning will be developed	National: Enforced by the ED and the M&E working group
			State: M& E personnel where available and direct supervisor		State: Commissioner of Health via direct supervisor
			Local Government: Local government chairman and Direct supervisor		Local: Local government chairman via direct supervisor
			Facility: LIO, WDCs and direct supervisor		Facility : Director of PHC
	Step 2 - Surcharge	If activities assigned are not carried out and/or targets not achieved by the 2nd consecutive reporting cycle, a designated deduction is made from cited individual's monthly pay commensurate with the lapses identified.	National :M& E working group, Direct supervisor	The same standard for the calculation of wages to be surcharged should be applied for all affected staff	National: Enforced by the ED and the M&E working group
			State: M& E personnel where available and direct supervisor		State: Commissioner of Health via direct supervisor
			Local Government: Local government chairman and Direct supervisor		Local: Local government chairman via direct supervisor
			Facility: LIOs, WDCs and direct supervisor		Facility : Director of PHC
	Step 3 - Demotion/refused promotion	If activities assigned are not carried out and/or targets not achieved by the 3rd consecutive reporting cycle, the cited individual will receive a demotion from current position	National :M& E working group, Direct supervisor	Individual can only be demoted by one level	National: Enforced by the ED and the M&E working group
			State: M& E personnel where available and direct supervisor	Individual will be allowed to appeal case before the demotion is put into place	State: Commissioner of Health via direct supervisor
			Local Government: Local government chairman and Direct supervisor		Local: Local government chairman via direct supervisor
			Facility: LIO, WDCs and direct supervisor		Facility : Director of PHC
	Step 4 - Termination	In cases in where the performance target continues in a downward trend due to consistent lapses in assigned activities, observed in a fourth consecutive reporting cycle , the cited staff member will be terminated	National :M& E working group, Direct supervisor	The threshold performance level warranting termination should be set by direct supervisor and clearly communicated to subordinate staff at or before step 2 of the disciplinary process.	National: Enforced by the ED and the M&E working group
			State: M& E personnel where available and direct supervisor		State: Commissioner of Health via direct supervisor
			Local Government: Local government chairman and Direct supervisor		Local: Local government chairman via direct supervisor
			Facility: LIO, WDCs and direct supervisor		Facility : Director of PHC

Appeal Process: Cited individuals will have 10 business days for the release date of the Process Indicator & Performance report, to provide additional evidence and/or documentation to rebut the citation. The monitoring units can, after due consideration, uphold or rescind citation as appropriate.



# APPENDIX



## Sanctions and Rewards

Organizational Sanctions - Public Reporting					
	Method	Process / Definition	Monitoring team	Guidelines and tools	Enforcement
Sanctions	Step 1 - Reprimand at the ICC/ State and LG RI Meetings	Federal, State and LG MDAs as well as Donor Partners failing to meet targets for the first time in a reporting cycle, will get an official reprimand by the ICC which will be captured in the minutes.	National : Selected CSOs & ICC	NA	National: Minister of health, Partners, CSO's
			State: M& E personnel where available and direct supervisor		State: Governor, Health Commissioners, Partners CSO's
			Local Government: Local government chairman and Direct supervisor		Local: Local government chairman, CSO'S
			Facility: LIO, WDCs and direct supervisor		Facility : Director of PHC and CSO's
Sanctions	Step 2 - Performance Improvement Plan demanded by ICC/State and LG RI Meetings	Federal, State and LG MDAs as well as Donor Partners failing to meet targets for the second consecutive time in a reporting cycle, will be required to draft and submit an organizational Performance Improvement Plan for ICC approval and monitored implementation	National : Selected CSOs & ICC	NA	National: Minister of health, ED, Partners and CSO's
			State: state level CSOs		State: Commissioner of health, CSO's
			Local Government: CBOs, LG level CSOs		Local: Local government chairman, CSO'S
			Facility: WDCs		Facility : Director of PHC and CSO's
Sanctions	Step 3 - Naming and Shaming in the Media	Federal, State and LG MDAs as well as Donor Partners failing to meet targets for the third consecutive time in a reporting cycle, will have their poor performance shared with print and electronic media houses for onward dissemination to the general public	National : Selected CSOs & ICC	The correspondence will name both individuals and departments responsible for failure to achieve targets	National: Minister of health, ED, chosen CSO's
			State: state level CSOs	The enforcement team will be responsible for sending out document to the appropriate media outlet	State: Commissioner of health, CSO's
			Local Government: CBOs, LG level CSOs		Local: Local government chairman, CSO'S
			Facility: WDCs		Facility : Director of PHC and CSO's

**The organizational Sanctions apply to the core indicators only.**



# APPENDIX



## Sanctions and Rewards

Staff Reward Matrix			
Method	Process / Definition	Guidelines and tools	Enforcement
Verbal encouragement	If target is achieved in first reporting cycle verbal encouragement should be given	Verbal encouragement or praise must be documented	National: Enforced by the ED and the M&E working group
			State: Commissioner of health via direct supervisor
			Local: Local government chairman via direct supervisor
			Facility : Director of PHC
Written acknowledgement of efforts	If target is achieved and maintained for 3 consecutive reporting cycles then written acknowledgements should be given	Letters of commendation should be framed or laminated before presentation	National: Enforced by the ED and the M&E working group
			State: Commissioner of health via direct supervisor
			Local: Local government chairman via direct supervisor
			Facility : Director of PHC
Naming and faming	If target is exceeded a report will be sent out to the media highlighting the wins and individuals responsible for ensuring that these wins were accomplished	The correspondence will name both individuals and departments responsible for success. The enforcement team will be responsible for sending out document to the necessary media personnel	National: Enforced by the ED and the M&E working group
			State: Commissioner of health via direct supervisor
			Local: Local government chairman via direct supervisor
			Facility : Director of PHC
Accelerated promotion	If target is exceeded by a specified percentage the individual will be fast tracked for a promotion which will include a pay rise	The standard for qualifying for fast-tracked promotion should be pre-determined and applied fairly to all eligible staff	National: Enforced by the ED and the M&E working group
			State: Commissioner of health via direct supervisor
			Local: Local government chairman via direct supervisor
			Facility : Director of PHC
Awards	If target is exceeded and comes top all the time, the individual will be fast tracked for a promotion which will include a pay rise and given special recognition in terms of an award	Special ceremony is organised yearly to recognize these individuals where presents depending on available resources is presented to the recipients	National: Enforced by the Minister of Health and ED
			State: Governor and Commissioner of health via direct supervisor
			Local: Local government chairman via direct supervisor
			Facility : Director of PHC and community leaders



# APPENDIX



## Budget and funding responsibilities

1.0 Priority Area: Logistics									
Strategic objective 1) To guarantee 100% adequacy of bundled quality vaccines for safe immunization at all times									
Strategic objective 2) To revamp sub-national level(LGA and HFs) cold chain infrastructure functionality from 47% to 80% of EVM standards by the end of 2014									
KPI/Core Indicator: 1. % of HFs (public and Private) with bundled vaccines 2. Proportion of LGAs with functional CCE in their wa				Funding Responsibilities in 2013-2015					
Key Activities	Responsible	Description of cost	National		State		LGAs		
			Grand totalUSD	Grand total N	Grand totalUSD	Grand total N	Grand totalUSD	Grand total N	
1.1	Create a system that ensures adequacy of bundled vaccines at all levels (procurement system for 100% bundling of vaccines and devices; 25% rolling buffer stock for all antigens; 50% rolling buffer stock for devices; clearing and warehousing for devices; insurance of all stocks at warehouses and in transit, distribution)	States logistics working group	Antigens and devices procurement	\$129,626,503.34	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
1.2	Build real-time stocks data management system (real-time stocks available centrally - use of computer application softwares)	National logistics working group	Procurement of consultancy, computers and software, training	\$0.00	N 47,672,500.00	\$0.00	N 0.00	\$0.00	N 0.00
1.3	Expand use of solar fridges and introduce New technology for CCE management (Introduce new - DDSR/Dual, increase Battery SR, CCEs management technology e.g. PATHS CCEM tool, continuous temp logs, fridge tags etc)	National logistics working group	procurement with installation	\$20,488,072.50	N 0.00	\$63,809,167.50	N 0.00	\$0.00	N 0.00
1.4	Enforce/advocate usage of Product Quality and Safety (PQS) equipment and replacement of non PQS compliant equipment (awareness of PQS equipment by States/LGAs/MDGs conditional grant scheme )	National logistics working group	Production of PQS	\$0.00	N 2,800,000.00	\$0.00	N 0.00	\$0.00	N 0.00
1.5	Establish Planned Preventive Maintenance system (Create and implement maintenance contracts; establish PPM by production of guidelines and training on it)	National/States logistics working group	Procurement of maintenance contract, replacement parts, guidelines, training	\$8,250,800.00	N 23,332,500.00	\$0.00	N 0.00	\$0.00	N 0.00
1.6	PPP transport options (Assess, and trial of PPP distributions via current public schemes e.g. NURTW, PRRINN Jg model, Riders for Health, canoe drivers association etc)	State logistics working group	Consultancy cost	\$0.00	N 3,739,600.00	\$0.00	N 0.00	\$0.00	N 0.00
1.7	Expand use of incineration for waste disposal	State logistics working group	Procurement and installation	\$8,910,000.00	N 4,885,650.00	\$0.00	N 0.00	\$0.00	N 0.00
GRAND TOTAL AREA 1				\$167,275,375.84	N 82,430,250.00	\$63,809,167.50	N 0.00	\$0.00	N 0.00



# APPENDIX



## Budget and funding responsibilities

2.0 Priority Area: Service delivery				National		State		LGAs		
Strategic Objective: Ensure that 100% of wards implement the REW strategy by June 2014				\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00	
		Key Activities	Responsible	Description of cost						
	2.1	Micro plan development (Detailed plans with micro-census and walk-through carried out by all HFs and LGAs)	States, LGAs supported by RIWG	Trainings, personnel, transport	\$0.00	N 14,755,000.00	\$0.00	N 366,300,000.00	\$0.00	N 362,233,800.00
	2.2	Conduct more vaccination sessions at HFs to cater for community needs based on revised Microplan	LGAs	Imprest	\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 1,645,200,000.00
	2.3	Conduct more vaccination sessions through outreach vaccination services for distant and hard to reach areas	RI working group NPHCDA	Meetings and local run	\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 2,742,000,000.00
	2.4	Conduct more vaccination sessions through strong and sustainable Private Provider engagement	RI working group NPHCDA	State level meetings and local run	\$0.00	N 26,662,200.00	\$0.00	N 3,940,500.00	\$0.00	N 193,623,300.00
	2.5	Improve AEFI surveillance systems (training of HWs on detection and reporting, availability of reporting/investigation forms, AEFI kits and supervision)	Surveillance team NPHCDA	training, forms, kits, personnel	\$0.00	N 0.00	\$0.00	N 307,557,000.00	\$0.00	N 307,557,000.00
	2.6	Strengthen EPR to outbreaks, internally displaced populations and security challenged areas (IDSR, stock piling, pre-positioning of commodities and supplies, Rescue teams)	RI working group NPHCDA	training, procurement, personnel	\$16,355,469.12	N 100,500,000.00	\$0.00	N 139,150,000.00	\$0.00	N 0.00
GRAND TOTAL AREA 2					\$16,355,469.12	N 141,917,200.00	\$0.00	N 816,947,500.00	\$0.00	N 5,250,614,100.00
3.0 Priority Area: HRH				National		State		LGAs		
Strategic Objective: To strengthen EPI-related capacity of frontline workforce in at least 80% of service delivery points by 2015				\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00	
		Key Activities	Responsible	Description of cost						
	3.1	Optimize distribution of EPI workforce (increase #s in rural areas, make temporary staffing arrangements from pool of retired/unemployed HWs, Taskshifting & task sharing etc.)	LGA EPI team	Salaries, rural posting allowances	\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
	3.2.1	Complete basic guide and MLM training to frontline HWs and EPI managers (integrated REW, data management, EVM, PPM, AEFIs, Surveillance, etc trainings.)	Training working group/States/LGAs	training	\$0.00	N 4,661,060,900.00	\$0.00	N 0.00	\$0.00	N 0.00
	3.2.2	Domesticcate EPI trainings at health training institutions (integrated REW, data management, PPM, AEFIs, SIAs, )	Training working group/States	Meetings, Consultancy	\$0.00	N 93,835,200.00	\$0.00	N 0.00	\$0.00	N 0.00
	3.2.3	Collaboration with professional health regulatory bodies (PCN,MDCN,NMCN,CPBN etc) on continuous mandatory education for EPI	NPHCDA	Meetings	\$0.00	N 1,562,400.00	\$0.00	N 0.00	\$0.00	N 0.00
	3.3	Strengthen supportive supervision (Integrate RI into other components of PHC, use standardized checklists, outline mechanism for feedback, etc.)	RI working group/States/LGAs	Transport, Personnel	\$0.00	N 281,880,000.00	\$0.00	N 1,523,232,000.00	\$0.00	N 2,925,720,000.00
GRAND TOTAL AREA 3					\$0.00	N 5,038,338,500.00	\$0.00	N 1,523,232,000.00	\$0.00	N 2,925,720,000.00



# APPENDIX



## Budget and funding responsibilities

4.0 Priority Area : HMIS										
Strategic Objective: To improve the quality of all components of the RI monitoring system to a minimum of 80% as measured by DQS in the context of the NHMIS by 2015										
				National		State		LGAs		
		Key Activities	Responsible	Description of cost	\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
	4.1	Conduct data quality surveys (regular conduct of data quality self assessment (DQS) National - once annually, States biannually and LGAs quarterly to improve other components of data - recording practices, archiving, use for action, core indicators analysis and demography to satisfactory standards)	M&E working group and RI working group	Training, transport, personnel	\$0.00	N 30,079,350.00	\$0.00	N 345,987,000.00	\$0.00	N 957,825,000.00
	4.2	Create PHC data bank (PHC data bank at the NPHCDA for repository of all information on PHC statistics, human resource, capacity building, infrastructure and software)	M&E working group and RI working group	Procurement of infrastructure, computers, softwares, personnel, consultancy, transport, meetings	\$0.00	N 282,026,000.00	\$0.00	N 0.00	\$0.00	N 0.00
	4.3	Provide sufficient data tools that are harmonized to conform to NHMIS format at HF levels	M&E working group and RI working group	Procurement of data tools	\$0.00	N 537,238,928.00	\$0.00	N 268,619,464.00	\$0.00	N 0.00
	4.4	RI data review and feedback on a monthly basis in states and LGAs(LIOs/HF i/cs, DSNOs, harmonization meetings, PHC quarterly reviews)	M&E working group and RI working group	meetings	\$0.00	N 51,670,500.00	\$0.00	N 970,510,000.00	\$0.00	N 2,051,100,000.00
GRAND TOTAL AREA 4					\$0.00	N 901,014,778.00	\$0.00	N 1,585,116,464.00	\$0.00	N 3,008,925,000.00
5.0 Priority Area: Community Participation & Ownership										
Strategic Objective: To create demand for RI beyond behavioral change communication to social transformations by changing level of awareness from <50% to 80% by 2015										
				National		State		LGAs		
		Key Activities	Responsible	Description of cost	\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
	5.1	Demand creation (Targeted messaging around RI to relevant stakeholders- flyers,banners, billboards,jingles; hosting of annual immunization weeks-Media engagements.)	Social mobilization team NPHCDA	IEC materials procurement/Media engagement	\$0.00	N 2,091,000,000.00	\$0.00	N 879,075,000.00	\$0.00	N 4,631,700,000.00
	5.2	Community engagement (engagement of community structures-WDCs, TIs, RIs, CBOs,NOA, civil defence, vigilantes, School children, Boys scout, Peace builders corps etc- meetings, announcements, distribution of IEC materials, trainings)	Social mobilization team NPHCDA	Meetings and trainings	\$0.00	N 1,221,001,604.00	\$0.00	N 124,343,100.00	\$0.00	N 441,000,000.00
	5.3	Advocacy to political leadership (Target Governors, Legislators, LGA chairmen, etc)	Social mobilization team NPHCDA	meetings, advocacy kits	\$0.00	N 98,234,250.00	\$0.00	N 0.00	\$0.00	N 0.00
GRAND TOTAL AREA 5					\$0.00	N 3,410,235,854.00	\$0.00	N 1,003,418,100.00	\$0.00	N 5,072,700,000.00



## Budget and funding responsibilities

### 6.0 Priority Area: Leadership & Governance

Strategic Objective: 1) To establish an accountability framework at all levels for RI that is implemented by all stake holders from January 2014 onwards 2) To eliminate delays in funding delivery through basket funds and increase funding for RI in 80% of LGAs 3) To support efforts to bring PHC delivery under one roof through implementation of functional SPHCDA

		Key Activities	Responsible	Description of cost	National		State		LGAs	
					\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
6.1		Implement AFRIN at all levels (Launching, sharing of AFRIN, Sensitization meetings, feedbacks - dashboards and scorecards)	RI working group and M&E working group	Meetings, trainings, technical assistance	\$0.00	N 50,324,650.00	\$0.00	N 46,207,800.00	\$0.00	N 0.00
6.2		Operational funding for RI (through specific line items in recurrent budgets) - advocacies to legislature and MoLGA	State and LGA PHC teams	Meetings, Advocacy kits	\$0.00	N 8,443,400.00	\$0.00	N 0.00	\$0.00	N 0.00
6.3		Basket fund setup (based on Zamfara case study)	RI working group	Meetings and experiential learning (personnel/transport)	\$0.00	N 0.00	\$0.00	N 12,052,800.00	\$0.00	N 0.00
6.4		Financial and procurement tracking tool setup (giving all stakeholders access to up-to-date information)	ICC finance committee		\$0.00	N 5,000,000.00	\$0.00	N 0.00	\$0.00	N 0.00
6.5		Accelerate establishment of functional SPHCDA (dissemination of guidelines/advocacies for legislation and funding)	RI working group	Advocacy, meetings, transports, personnel	\$0.00	N 29,164,400.00	\$0.00	N 0.00	\$0.00	N 0.00
GRAND TOTAL AREA 6					\$0.00	N 92,932,450.00	\$0.00	N 58,260,600.00	\$0.00	N 0.00

### 7.0 Priority Area: Partnerships and Program Integration

Strategic Objective: 1. To support the roll out of new vaccines in all states from 2013 to 2015. 2. To continuously link Polio campaigns and other health interventions in an integrated manner that strengthens the overall PHC system

		Key Activities	Responsible	Description of cost	National		State		LGAs	
					\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
7.1.1		Roll out of Penta-valent and Pneumococcal conjugate vaccines	RI working group	Assess readiness (personnel, transport), procurement of data tools, IEC materials, training	\$0.00	N 12,796,853,850.00	\$0.00	N 0.00	\$0.00	N 0.00
7.1.2		Establishment of sentinel sites for IBD and rota virus surveillance	M&E working group	surveillance costings	\$0.00	N 460,432,182.00	\$0.00	N 0.00	\$0.00	N 0.00
7.1.3		HPV demonstration project	SIA working group	Procurement cost	\$6,851,250.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
7.1.4		Policy switch in vaccine types (OPV to IPV, TT to Td, MV to MRV)	RI working group	additional procurement costs	\$89,979,485.22	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
7.2		PEI program integration (Training of HCWs to promote RI during Polio campaigns, enlisting community leaders as RI advocates, Refinement of TORs, Data tools etc.)	EOC	Personnel cost for fixed HWs	\$0.00	N 3,006,666,666.67	\$0.00	N 0.00	\$0.00	N 0.00
GRAND TOTAL AREA 7					\$96,830,735.22	N 16,263,952,698.67	\$0.00	N 0.00	\$0.00	N 0.00



## Budget and funding responsibilities

8.0 Priority Area: Research for RI										
Strategic Objective: To conduct research directed at identifying strategies to improve RI and health systems and evaluate impact of health programs										
				National		State		LGAs		
		Key Activities	Responsible	Description of cost	\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
	8.1	Operational research to be carried out to determine baselines for indicators TBD	RI working group		\$0.00	N 0.00	\$0.00	N 0.00	\$0.00	N 0.00
	8.2	Operational research on possible Impact of new interventions (KAP, School children as RI ambassadors, dashboards and scorecards, vaccine push system etc) to be carried out	RI working group	Lump sum to pilot new interventions	\$0.00	N 160,000,000.00	\$0.00	N 0.00	\$0.00	N 0.00
	8.3	Conduct National Immunization Coverage Survey	RI working group		\$0.00	N 180,000,000.00	\$0.00	N 0.00	\$0.00	N 0.00
	8.4	Conduct post-introduction Evaluation of New vaccines	RI working group	Penta Phase 1 (14 states) & Phase 2(7 states)= 5 people/state	\$0.00	N 82,080,000.00	\$0.00	N 0.00	\$0.00	N 0.00
	8.5	Sero-prevalence studies especially for HPV and fractional IPV	RI working group, Surveillance group and Operational Research unit		\$0.00	N 45,000,000.00	\$0.00	N 0.00	\$0.00	N 0.00
<b>GRAND TOTAL AREA 8</b>					\$0.00	N 467,080,000.00	\$0.00	N 0.00	\$0.00	N 0.00
<b>GRAND TOTAL</b>					\$280,461,580.18	N 26,397,901,730.67	\$63,809,167.50	N 4,986,974,664.00	\$0.00	N 16,257,959,100.00



National RI Strategic Plan: Total expenditure by state and priority area											
			1.0 Logistics	2.0 Service delivery	3.0 HRH	4.0 HMIS	5.0 Community Participation & Ownership	6.0 Leadership & Governance	7.0 Partnerships and Program Integration	8.0 Research for RI	Grand total
FGoN & Partners	USD		\$167,275,375.84	\$16,355,469.12	\$0.00	\$0.00	\$0.00	\$0.00	\$96,830,735.22	\$0.00	\$280,461,580.18
	NGN		82,430,250.00NGN	141,917,200.00NGN	5,038,338,500.00NGN	901,014,778.00NGN	3,410,235,854.00NGN	92,932,450.00NGN	16,263,952,698.67NGN	467,080,000.00NGN	26,397,901,730.67NGN
Abia	USD	1.80%	1148565.015	0	0	0	0	0	0	0	1148565.015
	NGN		0	130218565.2	91784016	94728446.35	129660925.8	1048690.8	0	0	447440644.2
Adamawa	USD	3.01%	\$1,920,655.94	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,920,655.94
	NGN		0.00NGN	166,881,761.86NGN	125,136,295.20NGN	129,253,873.07NGN	167,673,054.81NGN	1,753,644.06NGN	0.00NGN	0.00NGN	590,698,629.00NGN
Akwa Ibom	USD	1.59%	\$1,014,565.76	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,014,565.76
	NGN		0.00NGN	223,539,090.66NGN	141,540,760.80NGN	145,861,244.28NGN	219,369,617.79NGN	926,343.54NGN	0.00NGN	0.00NGN	731,237,057.07NGN
Anambra	USD	4.35%	\$2,775,698.79	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,775,698.79
	NGN		0.00NGN	177,828,858.36NGN	145,547,604.00NGN	150,494,433.68NGN	181,118,857.35NGN	2,534,336.10NGN	0.00NGN	0.00NGN	657,524,089.49NGN
Bauchi	USD	3.03%	\$1,933,417.78	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,933,417.78
	NGN		0.00NGN	160,219,353.03NGN	121,637,505.60NGN	125,659,293.86NGN	161,279,228.43NGN	1,765,296.18NGN	0.00NGN	0.00NGN	570,560,677.10NGN
Bayelsa	USD	0.68%	\$433,902.34	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$433,902.34
	NGN		0.00NGN	59,636,568.23NGN	40,492,893.60NGN	41,770,719.46NGN	59,072,053.08NGN	396,172.08NGN	0.00NGN	0.00NGN	201,368,406.45NGN
Benue	USD	3.53%	\$2,252,463.61	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,252,463.61
	NGN		0.00NGN	184,781,485.52NGN	140,663,973.60NGN	145,319,683.68NGN	186,079,848.93NGN	2,056,599.18NGN	0.00NGN	0.00NGN	658,901,590.91NGN
Borno	USD	1.39%	\$886,947.43	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$886,947.43
	NGN		0.00NGN	194,602,002.34NGN	123,280,552.80NGN	127,044,601.35NGN	190,984,741.59NGN	809,822.34NGN	0.00NGN	0.00NGN	636,721,720.42NGN
Cross River	USD	2.15%	\$1,371,897.10	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,371,897.10
	NGN		0.00NGN	139,903,679.78NGN	100,918,764.00NGN	104,187,956.48NGN	139,767,399.15NGN	1,252,602.90NGN	0.00NGN	0.00NGN	486,030,402.31NGN
Delta	USD	2.66%	\$1,697,323.86	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,697,323.86
	NGN		0.00NGN	191,325,638.93NGN	135,018,727.20NGN	139,352,375.44NGN	190,539,131.46NGN	1,549,731.96NGN	0.00NGN	0.00NGN	657,785,604.99NGN
Ebonyi	USD	1.66%	1059232.181	0	0	0	0	0	0	0	1,059,232.18
	NGN		0.00NGN	101,771,645.38NGN	74,437,747.20NGN	76,862,873.30NGN	101,878,100.46NGN	967,125.96NGN	0.00NGN	0.00NGN	355,917,492.30NGN
Edo	USD	2.70%	\$1,722,847.52	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,722,847.52
	NGN		0.00NGN	144,396,891.03NGN	109,296,540.00NGN	112,906,097.03NGN	145,286,198.70NGN	1,573,036.20NGN	0.00NGN	0.00NGN	513,458,762.96NGN
Ekiti	USD	1.34%	\$855,042.84	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$855,042.84
	NGN		0.00NGN	119,634,808.37NGN	80,973,712.80NGN	83,525,308.12NGN	118,450,692.54NGN	780,692.04NGN	0.00NGN	0.00NGN	403,365,213.87NGN



National RI Strategic Plan: Total expenditure by state and priority area											
			1.0 Logistics	2.0 Service delivery	3.0 HRH	4.0 HMIS	5.0 Community Participation & Ownership	6.0 Leadership & Governance	7.0 Partnerships and Program Integration	8.0 Research for RI	Grand total
Enugu	USD	2.54%	\$1,620,752.85	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,620,752.85
	NGN		0.00NGN	136,263,976.70NGN	103,055,932.80NGN	106,458,308.19NGN	137,086,219.74NGN	1,479,819.24NGN	0.00NGN	0.00NGN	484,344,256.67NGN
FCT	USD	1.92%	\$1,225,136.02	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,225,136.02
	NGN		0.00NGN	56,640,181.98NGN	52,066,670.40NGN	53,903,851.11NGN	58,832,687.52NGN	1,118,603.52NGN	0.00NGN	0.00NGN	222,561,994.53NGN
Gombe	USD	1.55%	\$989,042.10	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$989,042.10
	NGN		0	87,221,406.47NGN	65,155,320.00NGN	67,296,040.19NGN	87,585,320.55NGN	903,039.30NGN	0.00NGN	0.00NGN	308,161,126.51NGN
Imo	USD	3.91%	\$2,494,938.45	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,494,938.45
	NGN		0.00NGN	215,189,079.34NGN	161,665,999.20NGN	166,989,536.24NGN	216,270,877.71NGN	2,277,989.46NGN	0.00NGN	0.00NGN	762,393,481.95NGN
Jigawa	USD	1.80%	\$1,148,565.02	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,148,565.02
	NGN		0.00NGN	197,951,487.09NGN	129,525,804.00NGN	133,543,578.85NGN	195,098,755.80NGN	1,048,690.80NGN	0.00NGN	0.00NGN	657,168,316.54NGN
Kaduna	USD	4.57%	\$2,916,078.95	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,916,078.95
	NGN		0.00NGN	193,277,739.52NGN	156,505,586.40NGN	161,804,894.90NGN	196,515,397.17NGN	2,662,509.42NGN	0.00NGN	0.00NGN	710,766,127.41NGN
Kano	USD	3.46%	\$2,207,797.20	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,207,797.20
	NGN		0.00NGN	326,501,264.38NGN	218,884,723.20NGN	225,751,969.65NGN	322,847,626.26NGN	2,015,816.76NGN	0.00NGN	0.00NGN	1,096,001,400.25NGN
Katsina	USD	4.38%	\$2,794,841.54	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,794,841.54
	NGN		0.00NGN	266,284,259.49NGN	195,156,669.60NGN	201,519,908.62NGN	266,641,242.78NGN	2,551,814.28NGN	0.00NGN	0.00NGN	932,153,894.77NGN
Kebbi	USD	1.21%	\$772,090.93	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$772,090.93
	NGN		0.00NGN	152,176,706.86NGN	97,718,119.20NGN	100,721,776.71NGN	149,611,529.01NGN	704,953.26NGN	0.00NGN	0.00NGN	500,933,085.04NGN
Kogi	USD	3.15%	\$2,009,988.78	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,009,988.78
	NGN		0.00NGN	168,025,488.36NGN	127,268,820.00NGN	131,473,036.12NGN	169,077,840.15NGN	1,835,208.90NGN	0.00NGN	0.00NGN	597,680,393.53NGN
Kwara	USD	2.17%	\$1,384,658.93	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,384,658.93
	NGN		0.00NGN	126,415,472.62NGN	93,616,538.40NGN	96,681,774.77NGN	126,779,062.77NGN	1,264,255.02NGN	0.00NGN	0.00NGN	444,757,103.58NGN
Lagos	USD	6.59%	\$4,205,024.14	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$4,205,024.14
	NGN		0.00NGN	189,302,684.03NGN	175,864,564.80NGN	182,089,439.98NGN	197,000,912.79NGN	3,839,373.54NGN	0.00NGN	0.00NGN	748,096,975.14NGN
Nasarawa	USD	2.66%	\$1,697,323.86	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,697,323.86
	NGN		0.00NGN	109,941,120.38NGN	89,670,067.20NGN	92,714,037.94NGN	111,912,281.46NGN	1,549,731.96NGN	0.00NGN	0.00NGN	405,787,238.94NGN
Niger	USD	3.91%	\$2,494,938.45	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,494,938.45
	NGN		0.00NGN	201,537,482.68NGN	154,059,127.20NGN	159,166,331.24NGN	203,081,857.71NGN	2,277,989.46NGN	0.00NGN	0.00NGN	720,122,788.29NGN
Ogun	USD	4.45%	\$2,839,507.95	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,839,507.95
	NGN		0.00NGN	171,820,007.53NGN	143,267,400.00NGN	148,167,947.65NGN	175,527,765.45NGN	2,592,596.70NGN	0.00NGN	0.00NGN	641,375,717.33NGN



National RI Strategic Plan: Total expenditure by state and priority area											
			1.0 Logistics	2.0 Service delivery	3.0 HRH	4.0 HMIS	5.0 Community Participation & Ownership	6.0 Leadership & Governance	7.0 Partnerships and Program Integration	8.0 Research for RI	Grand total
Ondo	USD	2.37%	\$1,512,277.27	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,512,277.27
	NGN		0.00NGN	141,700,964.28NGN	104,269,874.40NGN	107,675,212.70NGN	141,974,918.97NGN	1,380,776.22NGN	0.00NGN	0.00NGN	497,001,746.57NGN
Osun	USD	3.20%	\$2,041,893.36	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,041,893.36
	NGN		0.00NGN	229,866,147.08NGN	162,261,360.00NGN	167,470,016.85NGN	228,930,139.20NGN	1,864,339.20NGN	0.00NGN	0.00NGN	790,392,002.33NGN
Oyo	USD	3.62%	\$2,309,891.86	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,309,891.86
	NGN		0.00NGN	253,249,660.16NGN	179,776,670.40NGN	185,561,421.00NGN	252,420,755.22NGN	2,109,033.72NGN	0.00NGN	0.00NGN	873,117,540.50NGN
Plateau	USD	2.58%	\$1,646,276.52	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,646,276.52
	NGN		0.00NGN	136,590,755.70NGN	103,665,225.60NGN	107,092,354.77NGN	137,487,586.98NGN	1,503,123.48NGN	0.00NGN	0.00NGN	486,339,046.53NGN
Rivers	USD	1.39%	\$886,947.43	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$886,947.43
	NGN		0.00NGN	167,298,809.02NGN	108,066,808.80NGN	111,398,191.35NGN	164,606,701.59NGN	809,822.34NGN	0.00NGN	0.00NGN	552,180,333.10NGN
Sokoto	USD	2.09%	\$1,333,611.60	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,333,611.60
	NGN		0.00NGN	173,017,441.52NGN	118,729,432.80NGN	122,494,006.60NGN	171,630,628.29NGN	1,217,646.54NGN	0.00NGN	0.00NGN	587,089,155.75NGN
Taraba	USD	3.06%	\$1,952,560.53	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,952,560.53
	NGN		0.00NGN	133,686,305.37NGN	107,173,303.20NGN	110,789,311.30NGN	135,709,483.86NGN	1,782,774.36NGN	0.00NGN	0.00NGN	489,141,178.09NGN
Yobe	USD	1.51%	\$963,518.43	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$963,518.43
	NGN		0.00NGN	127,849,417.45NGN	87,366,643.20NGN	90,131,608.61NGN	126,751,013.31NGN	879,735.06NGN	0.00NGN	0.00NGN	432,978,417.63NGN
Zamfara	USD	2.04%	\$1,301,707.02	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,301,707.02
	NGN			111,701,844.21NGN	84,029,464.80NGN	86,797,918.37NGN	112,285,599.24NGN	1,188,516.24NGN	0.00NGN	0.00NGN	396,003,342.86NGN
Total	USD		\$231,097,305.17	\$16,355,469.12	\$0.00	\$0.00	\$0.00	\$0.00	\$96,830,735.22	\$0.00	\$344,283,509.52
	NGN		82,430,250.00NGN		9,487,887,718.40NGN		9,487,061,907.62NGN		16,263,952,698.67NGN	467,080,000.00NGN	47,645,458,685.51NGN

