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National Primary Health Care Development Agency

***Proposal for the Establishment of
Nigeria Immunization Technical Advisory Group (NGI-TAG)***

to

Dr Khaliru Alhassan, Honourable Minister of Health

from

Dr. Ado J. G. Muhammad, OON

Executive Director, NPHCDA

March 2014

Background

Nigeria is a federal constitutional republic comprising of 36 states and a Federal Capital Territory (FCT). Each state is subdivided into local government areas (LGA) and across the country are 774 LGAs and 9,565 wards with over 25,500 public health facilities offering routine immunization (RI). The population of the Nigeria is estimated to be over 175 million this year¹, with an estimated under-1 birth cohort of approximately 7 million children, which is expected to increase to 183 million with a birth cohort of 7.3 million by 2015².

The healthcare systems in the country consists of both private and public health facilities with the private sector represented at each tier of government (federal, state and LGA) into tertiary, secondary and primary respectively. Although the quality of healthcare services, accessibility and coverage still present significant challenges, there have been drops in the infant mortality rate from 127 to 78 per 1,000 live births and in the under-5 mortality rates from 214 to 124 per 1,000 live births in the same period between 1990 and 2011³, over 40% of these deaths are vaccine-preventable from diseases like pneumonia, diarrhea, and measles. At this rate of decline, Nigeria is falling short in achieving Millennium Development Goal (MDG) 4 & 5 to reduce mortality by two-thirds by the end of 2015⁴.

Strengthening and expanding the reach of routine immunization programs and encouraging accelerated introduction of new vaccines in addition to promoting innovative technologies in the vaccine space has a positive correlation in improving vaccine coverage. This has the potential of providing effective means of reducing mortality associated with these vaccine-preventable diseases. There are many vaccines on the way to be introduced in Nigeria (IPV, PCV, Rota etc.) and several technologies are available on global scale for combating vaccine-preventable diseases and maintaining the potency of these vaccine. As the country continues to build on these achievements by to take advantage of these new vaccines and available evidence based innovative approaches, the need to optimize the National Immunization Programs becomes more imperative. Technical expertise in continually assessing country needs and the appropriateness of these technologies is therefore a pre-requisite for any informed decision in strengthening immunization programs and policies. Hitherto recommendations on both context and contents of Nigeria EPI are in view through the WHO technical advice and opinion of the SAGE. In addition, the Global Vaccine Action Plan endorsed by Ministries of Health at the 65th World Health Assembly has as its first goals and strategic objectives, a monitoring indicator.

This strategic framework which the country endorsed allows for individuals and communities, governments and health professionals the primary responsibility of exploiting new opportunities and confronting the challenges that this decade of vaccines (2011-2020) brings⁵. It is against this background that the establishment of the National Immunization Technical Advisory Group (NITAG), an independent expert advisory committee free of political or personal interests is required to provide adept and

¹ International Futures, Country Profile – Nigeria: http://www.ifs.du.edu/ifs/frm_CountryProfile.aspx?Country=NG

² Analysis conducted using World Development Indicators from the World Bank

³ WHO Global Health Observatory Data Repository

⁴ Federal Republic Of Nigeria, National Routine Immunization Strategic Plan 2013 - 2015

⁵ Global Vaccine Action Plan (2011-2020) http://www.who.int/immunization/global_vaccine_action_plan/GVAP_doc_2011_2020/en/

rigorous scientific recommendations to NPHCDA and Federal Ministry of Health (FMoH) to guide policy makers and program managers in the area of immunization.

The general objective of the technical advisory group is to provide guidance for making evidence-based immunization related policy decisions, including choices of new vaccines and technologies and make recommendations towards improvement of existing programs and schedules. The NGI-TAG will serve to promote;

- the adoption of policies based on national priorities,
- help resist pressure from interest groups
- reinforce the credibility of national vaccine and immunization policies
- enhance the ability to secure government or donor funding
- encourage a comprehensive approach that considers the health of vulnerable and under-served populations
- encourage the work of existing committees/ governing structure in the immunization landscape

NGI-TAG with this mandate will play a technical advisory role for the development of vaccine recommendations and will not perform an implementing, supervisory, coordinating or regulatory activity.

Situation Analysis of Immunization in Nigeria

Nigeria states are politically grouped into 6 zones with remarkable disparities in health and socio-economic indices including immunization coverages; the South-South, the South-East, the South-West, the North-East, the North-West and the North-Central zones. The country generally shares many of the social and economic challenges facing developing countries with significant proportion of the population living below poverty line.

Nigeria's immunization coverage has fluctuated significantly over the last 25 years since the introduction of Expanded Program on Immunization (EPI), driven in part by the political landscape and poor management. Principally due to massive vaccines stock-outs between 2011 and 2012, immunization coverage rates took a dip by May of 2012 {*BCG (60%), Polio (59%), Measles (42%) and DPT (41%)*}. This decline was a reflection of systemic problems in the country's vaccine and primary healthcare landscape and could be attributed to several factors such as; chronic vaccine supply challenges, weak PHC system, poor government funding, lack of political commitment and accountability, poor coordination of partners and committees in the vaccine space, and emphasis on polio campaigns over routine immunization in the country. However in recent years, following pentavalent vaccine introduction, DPT3 antigen coverage has improved from 52% in Dec. 2012 to 84% in Dec. 2013⁶ and supply adequacy of various antigens have significantly improved.

In order to sustain these achievements, guard against threats from lack of vaccines and ensure that policies and plans for routine immunization are country-driven and owned, establishment of Nigeria

⁶ RI & Logistic Monthly Feedback, NPHCDA December 2013

Immunization Technical Advisory Group (NGI-TAG) has become imperative. Furthermore, the recently launched National Routine Immunization Strategic Plan (NRISP) which outlines specific strategies; Reaching Every Ward (REW) through accountability and Health System Strengthening (HSS) has placed a greater responsibility on the country to mobilize resources and fulfill its commitment towards the objectives of the Global Vaccine Action Plan (GVAP).

DPT3 coverage gaps persist between Nigeria and other African countries, and typically within the countries and therefore, reaching underserved populations which carry a heavier disease burden will be especially challenging during the decade. As the economy and population of the country continue to grow, so will the potential to fund immunization and enhance the number of health workers, as well as their knowledge and skills. This will entail increase oversights and decision-making process around vaccines and immunization programs are in place – formation of NITAG will therefore help government to strengthen immunization systems as an integral part of a well-functioning health system.

Current Decision-Making Process for Immunization Program in Nigeria

a. Structure of the Agency and relation with the Inter-agency Coordinating Committee (ICC)

Government through National Primary Health Care Development Agency (NPHCDA) takes lead on decisions on immunization in Nigeria with support from development partners, particularly, WHO, UNICEF, CHAI, CDC, IVAC, DFID, USAID, BMGF, EU and SCI. Decisions with respect to regulation and control of importation and manufacturing of vaccines are guided by the National Agency for Food and Drugs Administration and Control (NAFDAC). Committees such as the Inter-Agency Coordination Committee (ICC) provides a coordinating platform for implementation and resource mobilization, the National Polio Expert Review Committee (ERC) provides advice on technical direction regarding the Global Polio Eradication Initiative; Core Group, Routine Immunization Working Group (RIWG), National Logistics Working Group (NLWG), Training Working Group (TWG), Social Mobilization Working Group (SMWG), Monitoring and Evaluation Working Group (MEWG) etc. implement activities as planned by the Agency or ICC advice on specific components of the immunization programs.

The NPHCDA initiates decision making by constituting a task team that works very closely with partners, to carry-out a situation analysis and provide recommendations and next steps. This is then followed by a wider discussion with major stakeholders as the case may be (including Nigerian Academy of Science Advisory Committee on Vaccines and Immunization), and development partners. The task team then presents recommendations as agreed in the working group to the ICC chaired by the Honorable Minister of Health before final decision is taken.

The NPHCDA staff and her technical partners/advisers work closely, and from time to time, give feedback on the national immunization programs during meetings of technical groups, sub-committees and task forces and decisions in most instances are accepted by Government, after getting buy-in at ICC chaired by the Honorable Minister of Health.

The composition and mandate of existing committees and groups on immunization are addressed in the sections below.

b. Existing Immunization Committees

Committees and groups are set up by GoN (NPHCDA/or FMOH) through policy/administrative instructions and follow-up. These committees include;

1. **Inter-Agency Coordinating Committee (ICC):** The ICC was set up since 2004 as a coordinating body for immunization governance in Nigeria to rebuild trust especially on the tail of the then polio controversy. The roles and responsibilities of the committee have however extended beyond that of polio eradication, and now encompass programmes supporting routine immunization, and other non-polio disease control initiatives. Thus, the ICC responsibilities includes:
 - Coordinating decision-making and information sharing extend to all immunization activities/programmes undertaken by the Federal Government of Nigeria.
 - Coordination role for the activities of partners and external donor activities when working at sub-national level with states and LGAs.

The ICC through the Honorable Minister of Health of the Federal Republic of Nigeria as the Chair draws her membership from diverse interest groups from; Ministry of Health, Federal Ministry of Health, ED/CEO of NPHCDA, WHO, UNICEF, USAID, Rotary International (Polio Plus), DFID, CHAI, EU, ALGON, diplomatic missions (Japan, Norway and Canada), World Bank, Red Cross, and Coca Cola Nigeria etc. The ICC meetings are organized on a monthly basis especially on the last Thursday of the month and minutes are circulated within 48 hours after the meeting.

2. **The Core Group:** Chaired by the ED/CEO of NPHCDA has the mandate of integrating the inputs from the functional working groups and providing routine oversight on behalf of the ICC. The Core Group will report to the Chairman of the ICC, and through him, to the ICC members drawn from various partner agencies. Team Leaders of the working groups are also members of the Core Group. The responsibilities of the group amongst others include:
 - To review and recommend to the ICC, proposals, budgets or other matters developed by the functional subgroups for approval
 - To monitor and supervise the planning and implementation of all immunization activities in Nigeria.
3. **Working Groups (Operations; Social Mobilization; Logistics; Training; Monitoring & Evaluation; Routine Immunization, etc.)** are intended to be action-oriented, identifying key strategic and operational issues in immunization and working to resolve them in a timely manner. The working groups work closely with partner agencies as members, and will provide support to national, the State governments in their efforts to promote immunization programmes at State and LGA levels.

In times of emergencies, like disease outbreaks, vaccine stock-outs or transmission of WPV, the working groups work round the clock daily to ensure evidence-based actions are taken in a timely manner. All working groups formally report to the Core Group, through the Chairperson or Leader of the Working Group.

4. Expert Review Committee (ERC) is an expert advisory group on polio eradication that meets about 2 or 3 times a year (more often if necessary) to review the progress of the Polio Eradication Initiative in Nigeria, and provides policy guidance and advice on strategic direction, for consideration by the government, and its partners. The ERC is composed of both national and international experts in polio eradication and immunization programs.

c. **Limitations of the existing committees in the policy decision-making process**

The ICC and other working groups reviews and endorses plans for routine immunization, introduction of new vaccines and supplementary immunization activities. These plans are usually synthesized and prepared by the department of Disease Control & Immunization of the NPHCDA with support from partner agencies. These plans focus essentially on the programmatic aspects and even though some technical information is provided as background these committees do not use a standardized process to collect the best available evidence. Expert opinions tend to prevail in the decision rather than use of verified evidence. In addition the decision is not solely national as partners and external parties' opinion have also their say.

NITAG Added Value

NITAG does not implement activities or supervise immunization programmes, but instead provides technical advice on policy analysis and strategy formulation for all vaccine-preventable diseases, and guides the national authority on identifying and monitoring important data and the latest scientific immunization recommendations and advancements. NITAG's advice is generated from a transparent and exhaustive process of collecting and analysing the evidence needed to take a decision, from a scientific and context-specific perspective.

Literature Review (NITAG all over the world)

While for many years at both global and the country levels, the focus of immunization programs has been on infants and limited number of traditional vaccines, the vaccine world has evolved with new demands and expectations of global and national policy makers, donors, other interested partners parties and public.

Whereas developing countries have for long struggled with vaccine funding problems and limited ability to optimize coverage with standard immunization programs, even industrialized nations today face problems involving financing and delivery of expanded vaccines programs.

NITAGs are both technical resource and deliberative body to empower the national authorities and policy makers to make evidence-based decisions. A well balanced and institutionalized group can aid a national program to resist pressure from any interest or lobby group including but not only that of industry and anti-immunization groups. This protection function is important, because without it pressure from these groups could result in program changes that are not well justified in the local context and harmful. A major advantage of NITAGs is the credibility of the process by which major policy decisions are made. This in turn adds credibility to the national immunization program by its rigor, transparency and informed/evidence-based process used in arriving at decisions. In addition, standing NITAGs will facilitate more comprehensive and cohesive country immunization program perspective. NITAGs may have broader mandate, which help consolidate programs and have more comprehensive and integrated approach in terms of interventions and target population. The mandates may include recommending national immunization policies and strategies that take into account the local epidemiologic and social contexts; and possibly to advice on implementation strategies to be adopted by national immunization programs and monitoring of program impact⁷.

Many countries across all regions of the world have established National Immunization Technical Advisory Committees. These committees provide information to national governments that is used to make evidence-based decisions regarding vaccine and Immunization policy. Nevertheless, many differences between committees exist including their legal basis, size and scope of membership, scope of work, role of the Ministry of Health on the committee, existence of conflict of interest policies, and ultimate role in the decision-making process. Compared to the wealth of information on Immunization and vaccine, there is paucity of published information on National Immunization Technical Group (NITAGs). All the available literatures support a NITAGs set-up based on federal government-sanctioned creation. Two basic models exist, namely ministerial or executive branch decree and a legislative act. The former is by far more common with only the United States, United Kingdom, South Korea and Sri Lanka indicating the existence of a law authorizing committee creation

The vast majority of NITAGs are operating under specific mandates or terms of reference. Ten out of fifteen committees reviewed reported that their mandate is limited to vaccine and immunizations while five have broader mandates to work in other areas of communicable disease control. The broadest mandate reported is that of China, which included in addition recommendations on other communicable diseases, design and implementation of education and research studies, vaccine preventable diseases surveillance policy, outbreak response, and programmatic issues such as vaccine supply. Within the realm of vaccines and immunization, all NITAGs specifically reported that their role include developing recommendations on new vaccines introduction and schedule. Other common activities include related to high risk groups, vaccine formulation, research priorities and implications of adverse events. Other less common topics include vaccine logistics, coverage, supply and regulation, SIAs (E.g. Polio Eradication), vaccine and immunization programme financing and surveillance, Additional activities include responding to questions from key groups or public and educational efforts related to vaccines immunization.

⁷ National Immunization technical Advisory Groups (NITAGs): Guidance for their establishment and establishment and strengthening (vaccine 28s 2010 A18-A25 www.elsevier.com/locate/vaccine)

The process of committee member nomination is diverse. The broadest recruitment process is used by countries like the US and UK, which advertises nationally and accept nomination from any source. In France, nominations come through the general medical community, in some countries members are selected based on positions allocated to the central government or professional organizations. Regardless of nomination process, Ministry of Health (MoH) representatives play a central role on almost all committees either by virtue of holding the position of chairperson or secretary, holding various fixed positions or acting as the committee secretariat. Expertise represented on the committee is primarily medical or public health and includes paediatrics, family practitioner, infectious disease experts, vaccinologist or immunologist, and even economists. Community representation was included in four countries: a consumer representative in South Korea, and the US, a consumer expert in Australia and a "lay person" in UK. Appointment to committees varies from 2 years to unlimited. The most common duration is 4 years, and usually reappointment is allowed. Korea with lowest appointment of two years does not allow reappointment nor does US. The total number of official committee members that vote or participate in consensus decision varies from 5 in Honduras (All Paediatricians) and 10 in Oman to 33 in India and 38 in Sri Lanka. The median number is 19 though in some cases the size is augmented to a large degree by numerous ex-officio and liaison members. Most committees include ex officio or liaison members that may participate but not vote. They usually include government representatives from EPI or programs related to disease control, regulatory affairs and in one case government vaccine producer. Others include WHO and UNICEF representatives. The roles of ex-officio and liaison members differ between committees. Except in one case of government vaccine producer, pharmaceutical companies do not have formal representation or voting rights in committees, however, industry representatives are allowed to attend meetings and present information when necessary.

Most countries report regularly scheduled NITAG meetings ranging from 1 to 8 times per year, and in all cases but two countries also reported ad hoc meetings to address urgent issues (most recently the influenza H1N1 pandemic). China and Thailand reported that meetings are scheduled only ad hoc. The number of meetings per year, however, may not measure the work or efficiency of particular NITAG since meeting duration is variable, in some cases as short as half day. Among the 12 NITAGs reporting this information, meetings are open to the public only in two countries (South Korea and US). However, four other countries indicated that specified members of the public could attend with a formal invitation. The meeting agenda determines which topics the NITAG will discuss and thus is an important instrument in determining eventual policy. 11 countries identify who determines the agenda and in most cases this includes the MOH either solely or in part. Less frequently, NITAGs solicit or allow agenda items from private health care providers, WHO, professional organizations and the public.

The majority of NITAGs make use of working groups to assemble data for presentation to the full committee. These may be permanent, temporary but for a prescribed duration or adhoc working group membership consisting in most cases of NITAG members usually as chairpersons. Other working group members may include government officials, liaison officers, ex-officio or invited experts. Most countries do not report a codified and systematic process for collecting and evaluating data for decision-making. Some countries identify specific epidemiological criteria that are considered for example when considering new vaccine recommendation, the most common of which is mortality attributable to the

disease prevented by the vaccine. Many countries reported that they rely more and more frequently on local data. Economic evaluation data are considered by all committees with the exception of Australia and Canada (where a separate advisory committee evaluates economic issues). However, only the UK's committee uses specific cost-effectiveness cut-offs for making recommendations on including vaccines in the public vaccination schedule. Five countries reported that their committee considers financial sustainability when reviewing evidence (Iran, Korea, Oman, Sri Lanka and Switzerland). The Sri Lankan committee reports that it doesn't recommend a vaccine unless it is certain that the country can sustain financing regardless of the availability of partner such as the Gavi. The other four committees do not report how financial sustainability issues affect committee recommendations. In general countries use all sources of data available to them including peer-review articles, findings from other NITAGs, WHO documents, regional data (for example Oman shares data with other gulf countries), and local data. Beyond the use of data and publications from WHO, six countries reported on the influence of WHO recommendations for final committee decisions. In three instances (Honduras, Oman and Switzerland) the committee to date has supported all WHO global recommendations, three countries (South Africa, Thailand and the US) have modified WHO global recommendations to the local national circumstances. Twelve NITAGs indicate process by which final recommendations are made and in seven cases this is by consensus and in five by voting, usually by majority vote.

NITAGs recommendations may have considerable implications for vaccines sales and thus, most of the included manuscripts emphasized that committee members must be independent of pharmaceutical industry influence. Eleven of 13 countries reporting this information have some formal conflicts of interest policy, but three of these indicate no written declaration is required; India and Sri Lanka have no formal policy. The consequences to committee members when they report conflict of interest vary by country. For example, depending on the level of conflict, members of the Australian NITAG might participate and vote, participate but not vote, attend the meeting but remain silent or barred from the meeting. The UK as well reported a relative nuanced policy, based on whether personal (such as stock ownership), or non-personal (such as involvement in a study through academic institution and whether the conflict is specific or not to the vaccine in question).

In most cases, committee recommendations are advisory and not legally binding. However, in five countries the committees have some form of legal responsibility for determining some or all policy related to topics under their mandate. In Iran for example the government is obliged to implement committee recommendations, although no law requires this. In Oman and Sri Lanka, the government is legally obliged to implement recommendations. Recommendations from the UK also carry legal weight but a recommendation may be made only if economic data are convincing. The US NITAG recommendations are advisory in most instances with exception of vaccine for children act, which regulates financing of vaccine for low income children, where committee decisions determine which vaccines will be funded.

Some countries specifically state that not all recommendations are followed such as South Korea and Thailand where budget limitations are the major reasons. Other countries such as Honduras and

Switzerland reported that decisions do not carry legal force but to date have implemented all recommendations⁸.

Establishment of NITAG

The membership of NITAG shall be multi-disciplinary taking into consideration geographical spread with at least two (2) members from each zone. The selection shall be based on recommendation by the Executive Director, NPHCDA and ratified by the Honorable Minister of Health. Appointed members shall complete a declaration of interest form and swear a confidentiality oath administered by the Minister of Health.

MEMBERSHIP

The membership of the NITAG shall comprise of Core members (15), non-Core members: liaison-members (5), and Ex-Officio members (5). The chairman who shall be appointed by the Honourable Minister of Health (HMH) on the advice of the Chief Executive of the NPHCDA shall be a reputable expert and also serve as the spokes-person of the group. The membership shall be in two categories of **core** (15 nos) and **non-core** (10 nos) membership.

1. Core NITAG Members

The core members shall be fifteen in all. Members should be credible experts who serve in their own capacity and who do not represent the interests of any particular group, institution or stakeholder. Selected members shall refrain from promoting the policies, views and products of the organization for which they work. As such their advice is independent from any influence. The core members will be the only ones allowed to decide on the final set of recommendations.

It is proposed that at least one or two experts should be drawn from the following disciplines;

- i. Public Health Specialists (2)
- ii. Infectious Disease Experts/Microbiologists (2)
- iii. Paediatricians (2)
- iv. Immunologist/Vaccinologist (1)
- v. Pharmacist/Toxicologists (1)
- vi. Gynaecologist (1)
- vii. Pathologist (1)
- viii. Medical Epidemiologist (1)
- ix. Medical Bio-Statistician (1)
- x. Social Anthropologist (1)

⁸ Informing decisions makers: Experience and process of 15 national Immunization Technical Advisory Groups – Elsevier Medical Journal (Vaccine 28S 2010, A1-A5) www.elsevier.com/locate/vaccine

- xi. Health Economist (1)
- xii. Communication expert (1)

2. Non-core Members

- a. Liaison-members: In all there shall be 5 non-core members drawn from professional associations and key development partners/stakeholders. Their role is to contribute to the discussion and to help provide technical or social-cultural background information or needed evidence. They should not be directly involved in deciding on the final set of recommendations.
- b. Ex-Officio members

In all there shall be 5 ex-officio members representing the various tiers of government in the country. They will be drawn from the Federal Ministry of Health (2), States Ministries of Health (2), and Local government health authorities (1).

b. Terms of Reference for the NGI-TAG

The terms of reference for Nigerian Immunization Technical Advisory Group shall among others include the following;

- Provide guidance to ministries, departments and agencies in the formulation of technical policies, plans and strategies for introduction of new vaccines and vaccine delivery technologies for the future.
- Advice on the operational/implementation framework most appropriate following on the recommendations for introducing any vaccine product
- Guide and provide evidence based recommendations for the development of immunization related national policies and best practices.
- Advise on strategies to assess the coverage and effectiveness of the vaccination programs
- Any other term of reference that may become apparent in the future as directed by the Minister of Health

c. Duration of Appointment and Re-appointment

The tenure of office of the core members including the Chairman shall be for a period of three years and renewable for another term only. Core members who have served their maximum tenure of six years are not eligible for re-appointment. Procedures for membership renewal and replacement will be further described in the NGI-TAG internal procedures guidelines

d. Termination of Appointment

The following will guide reason for termination of appointment of core members:-

- i. failure to attend 3 consecutive meetings
- ii. change in affiliation resulting in conflict of interests
- iii. breach of code of conduct guiding the proceedings as enshrined in the internal procedures manual of the committee
- iv. voluntary resignation by a member

Procedures and Rules of the Committee

There shall be quarterly scheduled meetings annually. The quorum for any meeting shall be formed by at least 11 core members. These shall be closed meetings with clear communication at least a month in advance to members. At least one of these meetings shall be open to the public on invitation. Emergency meetings may be called to address urgent issues before a scheduled meeting.

The secretariat shall take minutes of the meeting and share with the NGI-TAG members within a week after the meeting. The approved minutes, decision of the meeting and recommendations shall be forwarded to the HMH through the ED/CEO NPHCDA. The Minister of Health may decide to publish the recommendations of the committee through gazette, bulletins, media (print and electronic including web-based media) etc. for public consumption.

Decisions and recommendations shall be made through consensus. If consensus is not reached on a particular issue a decision shall be taken by a simple majority vote of the Core members through secret ballot.

Secretariat of the Committee

NPHCDA shall be the technical secretariat of the committee as constituted by the Executive Director of the agency. The Nigerian Academy of Sciences and a competent management firm shall provide technical support to the secretariat at the discretion of the management of the NPHCDA. All meetings organized by the committee, secretariat, or working groups that may be formed will not be paid monthly salaries, but rather paid a sitting allowance as applicable in the financial regulations of government whenever they meet. Thus, NPHCDA will be responsible for organizing these meetings as directed by the NGI-TAG Chairman. Issues and meeting agenda may also be recommended/suggested/tailed by any stakeholder(s) as part of contribution to ongoing NGI-TAG agenda/debate, or ab-initio issue, related to immunization.

The modus operandi of the committee shall be in accordance with the internal procedures and rules of the committee as agreed after inauguration and orientation training.

BUDGET

There shall be a costed work-plan with an annual budget for the scheduled and emergency meetings and the secretarial support provided by the government through an existing structure of NPHCDA immunization department.

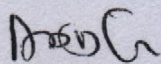
This budget should be an integral part of the budget of the NPHCDA

ADMINISTRATIVE REQUIREMENT

There shall be administrative and institutional framework to support the establishment of NITAG. The procedure shall utilize the existing statutory mandate establishing NPHCDA

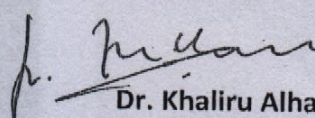
- The full deliberation and decision reached on this establishment shall form the basis for the HMH to constitute and inaugurate the NGITAG. This will form the basis for the Minister to spell out the process for its inauguration.
- Annexed is the list of nominated members for Honourable Minister's kind approval.

Endorsed to HMH by



Dr. Ado J. G. Muhammad, OON
Executive Director/CEO
NPHCDA

Approved by



Dr. Khaliru Alhassan
Hon. Minister of Health
Federal Republic of Nigeria

**MEMBERSHIP OF NIGERIAN IMMUNIZATION TECHNICAL ADVISORY GROUP
(NGITAG)**

S/N	Specialization	No.	Name	Designation
1	Medical Epidemiologist	1	Prof. Umaru Shehu FAS	Chairman
2	Public health	2	Prof. Obehi Okojie Dr. Kabir Mustapha	Member
3	Infectious Disease Expert/Medical Microbiologist	2	Prof. Habib A. Garba Prof. Uche Ozumba	Member
4	Immunologist/Vaccinologist	1	Dr. Idris N. Muhammad	Member
5	Pharmacist/toxicologist	1	Prof. Fola Tayo	Member
6	Paediatricians	2	Prof. Adebisi Olowu Dr. Dorothy O. E	Member
7	Gynaecologist	1	Dr. Mairo Hassan	Member
8	Pathologist	1	Prof. Abdullahi Muhammed	Member
9	Social Anthropologist	1	Mr. Atata Geff	Member
10	Health Economist	1		Member
11	Communication Expert	1	Dr. Dale Ogunbayo	Member
12	Medical Statistician	1	Dr. Azuogu b. Ndubueze	Member
13	Non-core members	5	Dr. Ben Anyene WHO UNICEF CDC Dr. David Tswana	
	Ex- Officio members	5	FMoH (2) SMoH (2) Mr. Christopher Lebara	

The Health Economist will be filled at a later date when become available.