

Global Vaccine Action Plan

Secretariat Annual Report 2016

Priority Country report on progress towards GVAP-RVAP goals

NIGERIA

A. Progress towards achievement of GVAP goals

1. Summary

The summary table below describes the current situation in Nigeria regarding achieving the GVAP goals. Data used to assess progress towards achievement of GVAP goals are included in the annex.

Area	Indicator	Nigeria
9. NITAG	NITAG established?	Yes, inaugurated in August 2015

2. Country ownership of the immunization program

2.1 Immunization policy decision-making capacity

The main decision-making and coordinating body for the immunization program in Nigeria is the ICC, which is chaired by the Minister of Health and includes senior-level officials from the Federal Ministry of Health (FMOH) and around 18 development partners and bilateral organizations. The ICC, which meets every two months, endorses the GAVI work plan, makes decisions about new vaccine introductions and other key program decisions. The technical arm of the ICC is called the Core Group, which is chaired by the Executive Director of the parastatal organization that manages the immunization program – the National Primary Health Care Development Agency (NPHCDA) – and includes EPI team leaders from different immunization stakeholders and partners in the country. The Core Group, which meets once a month, provides direction to and oversight of various technical working groups, and makes recommendations based on their input and analysis, which must then be approved by the ICC.

Among the technical working groups – which include logistics, social mobilization, M&E and finance – is the Routine Immunization Working Group, which is chaired by the director of

routine immunization at the NPHCDA and whose members are immunization program officers and experts from different stakeholder and partner organizations. The states – which are responsible, along with local government authorities (LGAs), for the delivery of health services in the country and implementation of health programs – also each have their own working groups (e.g., routine immunization and logistics).

The functioning of the ICC and regularity of meetings have improved considerably in the past few years and the committee is reportedly held in high esteem by the Government.

A NITAG has recently been established, with support from WHO, CHAI and SIVAC, and its inaugural meeting held in August 2015. Unlike the ICC and Core Group, its 10-12 members are independent of the immunization program and include pediatricians, microbiologists and other experts from academia, research institutes and the private sector. A number of partner organizations, including WHO, UNICEF and CHAI, participate as observers. Unlike the ICC, the NITAG will have solely an advisory – not a decision-making role. Its impact on decision-making for the immunization program, as well as its role vis-à-vis that of the ICC's Routine Immunization Working Group, has yet to be determined. It should also be noted that decisions have already been made about most vaccine introductions currently supported by GAVI (e.g., rotavirus, meningitis A, HPV).

The Nigeria Government's decision-making capacity and implementation of the immunization program is complicated by the fact that the program – along with several other components of the primary health care program – is managed not by the Federal Ministry of Health, but by the NPHCDA, which is a separate, parastatal organization. However, a number of key activities related to immunization, such as disease surveillance and supportive supervision, fall under the responsibility of the FMOH. In some cases, the NPHCDA and FMOH have parallel systems, causing confusion and duplication of effort. There are, for example, separate supervision checklists for each agency and two health information systems – the HMIS run by the FMOH and the immunization program's vaccination monitoring system run by the NPHCDA. Each system uses a different platform (the DHIS2 in the case of the HMIS and the DVT-MT in the case of the EPI's system) and different population data for their denominators. Key primary health care programs, including malaria control, nutrition and family planning, are still under the FMOH, complicating the delivery of integrated health services and such activities as intensified vaccination activities that provide other MCH interventions. As another example, disease surveillance officers are under the FMOH at the state level, while those at the LGA level report to the local PHCDA.

2.3 Human resource situation

Immunization program staff in Nigeria consist of a national EPI team at the NPHCDA, EPI teams in each of the country's 37 states, and LGA immunization officers (LIOs) in each of the 774 LGAs. There are also surveillance officers at each level. There have been MLM and other trainings for these staff in recent years, although turnover and transfers are common.

To supplement this staff, partners have been supporting a contingent of more than 11,000 persons funded through the polio eradication program, including 408 WHO staff, 2,070 “surge staff” and more than 8,600 social mobilizers who work for UNICEF.¹ The EPI has come to rely on these staff for not just polio activities (AFP surveillance and polio SIAs), but

¹ Internal WHO briefing note for the 2016 joint appraisal.

also for measles control, disease surveillance, and improvements to the routine immunization program. As part of the polio transition, polio program funds (apart from funds for SIAs) will be cut by more than half between 2016 and 2019 – likely resulting in a substantial reduction in this supplemental workforce.

At the operational level, most vaccinations given in the public sector are administered by nurses or midwives or – especially in the under-served North – by community health extension workers (CHEWs). These are facility-based, salaried health workers with secondary school education and a year or so of training, who focus on providing preventive health services, including in the community. In addition, an estimated 15% of vaccinations are provided by nurses and midwives working in private health facilities.²

As in many countries, the number of health workers in the public sector is inadequate in many parts of the country, due to insufficient funding at the state level (health worker salaries are paid out of state budgets) and a high rate of staff transfers. In addition, most health workers prefer to work in urban vs. rural areas, resulting in an imbalanced distribution in which more than 70% work in urban areas, and with greater concentrations in the South than in the North. This leaves many rural areas, especially in Northern states, with vastly insufficient numbers of health workers to serve the population. The skills level of many health staff is also considered to be low.

Making matters worse are frequent and prolonged health worker strikes – often lasting 4-6 months – in a number of states, especially those that have not paid their health workers for months, due to either state bankruptcies or the freezing of salaries of civil servants, as part of a “verification” process mandated by the new President to determine who actually works for the state and to weed out “ghost workers”.

To increase the health workforce, in alignment with the Government’s plan to make PHC services accessible to all, the federal government began two initiatives in the past five years. The Midwives Service Scheme (MSS) involves recruiting 8,000 qualified midwives as well as CHEWs to work in PHC facilities in under-served areas, while the SURE-P-MCH program also recruits and deploys midwives and CHEWs, as well as 5,000 village health workers, using results-based incentives. However, these initiatives are funded by the MDG debt relief funding or savings from reductions in the petroleum subsidy and both have been affected by the country’s worsening economy. The state of Kano, for instance, has had to lay off 600 midwives hired through the MSS due to the decline in the state’s revenues. Recruitment of SURE-P-MCH health workers has also reportedly been put on hold in many areas.

B. Partner support to address remaining challenges to meet the GVAP goals and targets

As in other countries, development partners have played a key role in Nigeria’s efforts to eradicate polio – by helping to build a robust AFP/polio surveillance system and conduct polio vaccination campaigns, as well as to control other epidemic-prone diseases (measles, yellow fever, meningitis A) through case-based disease surveillance and vaccination campaigns. The more than 11,000 health workers supported by WHO and UNICEF with policy eradication program funds have been critical to these efforts, as well as to helping with improvements to the routine immunization program. Technical and financial support from

² cMYP.

partners, including GAVI funding, has also played an important role in the country's successful introduction of three new vaccines in the past four years.

Below we highlight three areas of partner support that are addressing key issues that have been discussed above.

Expansion of the cold chain system and improving vaccine management

The ability of health facilities to provide immunization services on a weekly or more frequent basis has been hampered in the past by inadequate cold chain capacity at state and LGA stores and a lack of refrigerators in many health centers. This problem has been compounded by inadequate vaccine stock management, resulting in frequent stockouts of vaccines at sub-national levels. In the PCV/IPV post-introduction evaluation, for instance, 36% of health facilities visited reports stockouts of vaccines (BCG, IPV, yellow fever) in the past six months.

To address this problem, a major activity of partners in the past several years has been to strengthen the cold chain system and vaccine management, using funds from the GAVI HSS grant and other partner support. Two sub-national hubs were established to store and distribute vaccine and devices, in addition to the central stores in Abuja. In the past few years, more than 1,600 solar direct drive (SDD) refrigerators have been procured and installed in health facilities in wards with large populations, as well as other cold chain equipment. There has also been a series of national and state-level trainings in cold chain maintenance and operations for cold officers and technicians. To address the issue of vaccine management and to prevent unnecessary local stockouts, partners (WHO, UNICEF and CHAI), worked with the Government to set up a vaccine stock management “dashboard” in 2015. This is an Excel-based tool that provides a snapshot of the vaccine inventory at all levels of the system, based on weekly reports sent By LGAs to the states, which are then passed on to the National Logistics Working Group. The dashboard has greatly increased the ability of the national and state logistics personnel to monitor vaccine stock levels at the lower levels on a weekly basis and to act accordingly. According to one source, many LGAs that were chronically under-supplied with several vaccines in the past have not experienced a single stockout during the first half of 2016.³

Ensuring sustainable financing for routine immunization

As described above, a lack of funds for operational costs at the local level has been a key bottleneck in improving immunization coverage rates in Nigeria. A major reason for the lack of funds is that such expenditures are not included in the states' recurrent budgets – which are guaranteed – but are instead often included under *ad hoc*, unprotected budgets. To ensure more adequate funding for routine immunization activities, the Gates Foundation and the local Dangote Foundation have entered into three-year agreements with two Northern states, Kano and Bauchi, which require the states to include all operational costs for routine immunization in their recurrent budgets. Each state has also set up a routine immunization basket into which the state funds are placed, along with contributions from both foundations. The share of the budget paid by the foundations is 75% in the first year (and includes capital costs for refrigerators to ensure that at least one health facility per ward is able to store vaccines), and 50% in the second year. By year 3, the states will cover all costs. The

³ Internal WHO briefing note for the 2016 joint appraisal.

partners, which also include USAID, are providing technical support under this initiative in microplanning, data management, supportive supervision, M&E and community engagement.⁴ The plan is to establish similar agreements and routine immunization basket funding in four additional Northern states.

Development of a single, integrated data management system for immunization program data

As mentioned above, there are currently two parallel systems for collecting immunization data – the EPI's system in the NPHCDA that uses the DVD-MT platform, and the FMOH's HMIS, which uses the DHIS2 platform. Each system at present uses different population data and produces different coverage estimates. Partners, including CDC, are assisting the Government to improve the immunization component of the HMIS in the aim of creating a single immunization data management system (the DVD-MT system will be phased out over time).

⁴ Joint Appraisal report 2015.

ANNEXES

- Planning and management:
 - Stockout events 2015: none
 - cMYP: 2011-2015
 - Annual Plan: Yes
- Country decision making: NITAG recently established