Facilitating Participatory Development

PACFaH@Scale
Many Advocates, One Voice

PAS JULY 2020

ACTIVITY REPORT

TABLE OF CONTENT

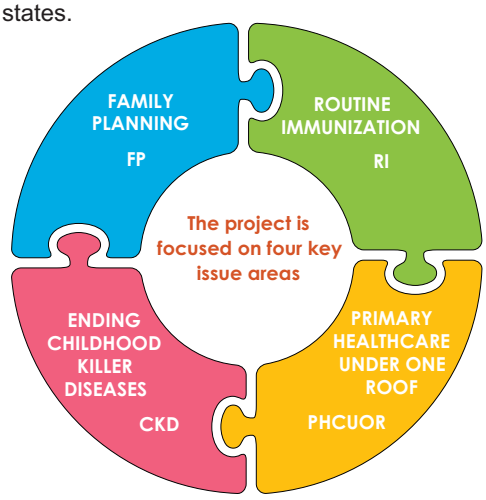
LIST OF TABLES

INTRODUCTION

1.0 INTRODUCTION

The Partnership for Advocacy in Child and Family Health at Scale (PACFaH@Scale), or simply, PAS, is a BMGF reinvestment health/social accountability project which aims to advocate to the executives and legislatures at federal, states and LGA levels to fulfill their service and social compacts with the citizens, fulfill promises made and implement policies, laws and regulations that have positive health impacts on the people. Key message in the advocacies is to demand for increased and sustained funding of primary health care (PHC) and health.

PAS is being implemented at National and in Kaduna, Niger, Kano, Anambra, Enugu, Taraba, and Lagos states.



PAS partners are supported by the development Research and Projects Centre (dRPC), to implement the project, mobilize CSO partners, media constituencies; build champions within the executive; and educate the legislature to fulfill their constitutional role at the national and state levels.

PAS NATIONAL PARTNERS
The PAS national level partners include;

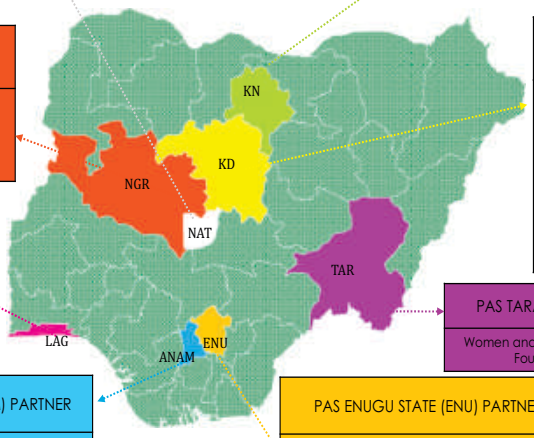
Association for the Advancement Family Planning (AAFP-PAS)
Society of Gynaecology and Obstetrics of Nigeria (SOGON-PAS)
National Council of Women Societies (NCWS-PAS)
Medical Women Association of Nigeria (MWAN-PAS)
Pharmaceutical Society of Nigeria (PSN-PAS)
National Institute for Democratic & Legal Studies (NILDS)
National Institute for Policy & Strategic Studies (NIPSS)
National Orientation Agency (NOA)
Society for Public Health Professionals of Nigeria (SPHPN-PAS)
Nigeria Inter-Religious Council

KANO STATE (KN) LEAD PARTNERS
The PAS project in Kano is implemented by five partners;

Women in Media (WIM-PAS)
National Association of Nigeria Nurses and Midwives (NANNM-PAS)
Federation of Muslim Women Associations of Nigeria (FOMWAN-PAS)
Medical Women Association of Nigeria (MWAN-PAS)
Accountability Mechanism for MNCH in Kano State (AMMKaS)

PAS NIGER STATE (NGR) PARTNERS
In Niger state the PAS project is being implemented three partners;

Centre for Communication and Reproductive Health Services (CCRHS-PAS)
Federation of Muslim Women Associations of Nigeria (FOMWAN-PAS)
Network of Muslim Leaders in Health



PAS KADUNA STATE (KD) COALITION
The PAS project in Kaduna state is implemented by six PAS partners;

Global Initiative for Women and Children (GIWAC-PAS)
National Association of Nigeria Nurses and Midwives (NANNM-PAS)
Planned Parenthood Federation of Nigeria (PPFN-PAS)
Maintaining Family Care and Empowerment Initiative Group (MAFAHSU-PAS)
Initiative for Integrated Grassroot Empowerment and Support (IIGES-PAS)
Interfaith Mediation Centre (IMC-PAS)

PAS LAGOS STATE (LAG) PARTNER
In Lagos state the PAS project is being implemented by The Alumni Association of the National Institute AANI-PAS

Alumni Association of National Institute (AANI-PAS)

PAS TARABA STATE (TAR) PARTNER

Women and Children Health Empowerment Foundation (WACHEF-PAS)

PAS ANAMBRA STATE (ANAM) PARTNER

South Saharan Social Development Organization (SSSDO-PAS)

PAS ENUGU STATE (ENU) PARTNER

South Saharan Social Development Organization (SSSDO-PAS)

2.0 ROUTINE IMMUNIZATION (RI)

2.1 KANO STATE

DEVELOPMENT OF PEOPLE'S SCORECARDS FOR ROUTINE IMMUNIZATION FOR 2020 HALF YEAR IN KANO STATE

MWAN-PAS in the month under review conducted half yearly People's scorecard on RI and developed issue brief on the Implementation of RI CIP. The Scorecard checklist was administered on Program Manager SERICC; EOC Desk Officer; Deputy Director Ministry of Planning and Budget MoP&B, Final Account Unit. The checklist and verbal discussion were conducted on 18th -20th June 2020 and the Budget Desk Review was conducted from 21st -22nd June 2020. The review was done through 12th-17th July 2020. Findings are being finalized for a peer review validation. PAS partners are achieving the outcome of supporting increased accountability in the utilization of RI funds through existing platforms.

SUPPORTIVE SUPERVISION TO LOW RI PERFORMING LGAS – TOFA AND TARAUNI LGAS:

Sequel to the SERICC findings on the DHIS 2 data reports and SMS reports. Some LGAs have very low immunization performance due to high number of dropouts and unimmunized children. The LGAs classified as category 4 (poor access poor utilization stage) with worst performance RI antigens such as Penta, Hepatitis, Yellow Fever, and Measles. To address the issue, SERICC constituted a team and it to conduct a supervision visit to the LGAs in order to find the reason for the Low coverage in all antigens for the second quarter of 2020 and workout modalities to curb the threat and mentor the LGA teams.

The SERICC committee consisting of representatives from the State Primary Health Care Management Board (SPHCMB); Women in Media Communication Initiative (WIM-PAS); Medical Women Association of Nigeria (MWAN-PAS); United Nations Children's Fund (UNICEF); National Primary Healthcare Development Agency, visited the PHC office at Tofa and Tarauni LGAs on 20th and 21st July 2020.

The LGA teams presented their RI data analysis for the 2020 second quarter and identified lockdown order, non-compliance by the private health facilities (Tarauni), non-conduct of outreaches, and closure of private health facilities as the factors responsible for low RI coverage in the LGAs. Health facility assessment was also carried out at Unguwa Uku Health Facility were data tools were examining. For the field visit 11 children were surveyed from 10 households and it was found that 7 are appropriately immunized, 3 are partially immunized and 1 child is fully immunized. During the visit the following issues were recognized; Problem of non-compliance by private health facilities, they do not report data to LGA, they do not attend monthly RI meeting and they have poor management of RI data as such proper action from the state is required.

> "PAS partners are achieving the outcome of supporting increased accountability in the utilization of RI funds through existing platforms."

The LGA team revisited their mitigation plan to assign responsibilities to the activities recognized. The RIO is also not submitting summary of LGA data to the zone regularly and there is poor conduct of LERICC meeting.

PAS partners are achieving the intermediate outcome of increased CSO coalition network conducting technical reviews and increased representation of CSOs on RI Task force Committees where applicable.

PARTICIPATION IN SOCIAL MOBILIZATION AND COMMUNITY ENGAGEMENT TECHNICAL WORKING GROUP MEETING (SM&CEWG) – 11TH JULY 2020 by KANO PAS PARTNER

The objectives of the meeting were to discuss the possible ways through which the group can leverage on the forth coming SMC&MNCHW in improving RI uptake across the state. May CE data was presented to the group, the data was discussed and the following issues were identified; increase in number of ward heads not attending reconciliation meeting and decrease in the number of CE supervisory visits by both LGACEFPs and WCEFPs. The group was tasked to come up with possible ways through which the state can leverage on the forth coming SMC&MNCHW and scale up RI consumption across the state, the issue was presented and discussed at group level and action points were agreed upon.

Observations were made around re-structuring of Kano Emirate council committee on health for effective implementation of community engagements. Some of the issues raised includes: committee set by state ministry of health to spearhead the restructuring process and issue of leadership tenure in the emirate. follow up meeting was held on Monday 13th July, 2020 to discuss the development of advocacy tools for advocacy visit to all the Emirates in Kano. PAS partners are achieving the intermediate outcome of increased CSO coalition network conducting technical reviews and increased representation of CSOs on RI Task force Committees and TWGs where applicable.

PARTICIPATION IN SERICC VISIT TO TOFA LGA - MONDAY 20TH JULY 2020

In line with its mandate of Identifying program bottlenecks and barriers to high Routine Immunization coverage as well as designing strategies to address these barriers to increase coverage, the State emergency routine immunization coordination center (SERICC) through the M&EWG conducted a deep dive analysis to assess, monitor and evaluate RI performance across all LGAs in order to provide feedback and technical guidance on the way forward to these LGAs.

This analysis was conducted based on these selected performance indicators: Dropout rate, Penta 3 coverage, Supportive supervision visits conducted, Number of unimmunized children, Percentage of Fixed Sessions Conducted and

Percentage of Outreach Sessions Conducted

Objective of meeting was to provide Technical Guidance to mitigate the current situation at the LGAs based on some performance indicators and produce a mitigation plan that will help in handling the issue of low RI coverage. All LGA team members participate at the meeting; the team has the mandate of ensuring smooth execution of RI and other PHC services at LGA level. The members of the team also supervise immunization activities at ward levels.

The state team that visited the LGA consists of Government staff and partners supporting immunization activities in the state at the LGA: PHCC, DPHCC, CCO, RIO, LIO, Health Educator, LGA CEFP, LGA M&E, WHO LGAF, M&A (EOC), UNICEF LGAF and District Head Scribe. state level: SPCHMB, NPHCDA, UNICEF, MWAN PAS and WIM PAS.

The adopted for Methodology during the visit consists of a presentation by the LGA team, visit to the LGA cold store to check availability of vaccines / review of LGA data tools, Health Facility Visit, Field Survey and an advocacy visit to the District Head office. The visit was aimed at assessing the LGAs RI performance and provides technical assistance to the LGA team. The meeting began with an introduction of team members by the SERICC Team Lead Malam Jibrin, he stated that SERICC used DHIS2 data to search for LGAs with issues which shows the LGA was in Category 4 (poor access, poor utilization) that needs an urgent intervention.

Issues identified include; High dropout rate, Low coverage, Poor utilization and poor access, Monthly coverage of all antigens are below 80% across the LGA as follows; BCG-74.0, HBV-67.0, OPV-72, PENTA3-72, IPV-74, PCV-73, MEASLES 58, YELLOW FEVER 59 and Td2 37.9

Penta 1-3 dropout rate was 20% lowest from the 44 LGAs in the state this was due to Negative attitudes of some WTO's towards RI services, Inadequate supportive supervision by the LGA teams, Data inconsistency in some health facilities, believe in traditions that injection may be of harm to their children and Poor attendances of reconciliation meeting by WTO's and ward supervisors

Mitigation Plan/ Way forward identified include Inviting WTOs/RIFP and CEFP for a meeting, Sanction poor performing WTOs, developing ward level data analysis tools, LGA team supportive supervision must be maintained, WCEFP's been present at every RI session (FS&OS), Organizing community mobilization, developing a tool to calculate number of unimmunized and targeted coverage, Regular checking of time book at health facilities and Intensifying supportive supervision

HEALTH FACILITY 1 (LENGEN PHC):
The facility has good clients flow at the facility with good and updated records. Only minimal errors were identified in their child register and VM1A&B which were instantly corrected. OTJ mentoring was done by the SERICC team to the service provider and the rest of staff available during the visit. The gaps identified were lack of constant supervision to the facility by the LGA team, lack of proper tracking of defaulters and referred for immunization services

COMMUNITY SURVEY (CS) Hf1:
The CS was conducted with recorded data as follows; Number of houses visited=2, 5 houses with no eligible children, 6 houses full immunized, 2 houses appropriately immunized and, 7 houses partially immunized. The 7 partially immunized children in the two houses were counseled and referred back to the facility to continue with their immunization. Outcome of the CS revealed LGA team have more understanding of their roles and responsibilities, Demand and utilization of services improved and LGA RI performance assessed and major issues identified

Conclusions/ Recommendation
The activity was conducted with a success, all planned sub activities have taken place and the purpose for the visit was

SERICC Supportive Supervision Team at the Tofa District Head's Palace

SERICC Supportive Supervision Team at one of the Health Facilities in Tofa

achieved. However, the following were recommended: The District head to call all lengel traditional leaders for a meeting on the 23rd July 2020 to discuss way ford with regards to the belief injection is harmful to their children, SERICC need to initiate an unscheduled visit to LERICC and LGA monthly RI meetings, SPHCMB to train its staff on safe keeping of data tools and need for a feedback mechanism to the traditional leaders on RI and other PHC services

Next Step to be taken include;
LGA team to revisit its action plan to assign responsibility to each identified activity, LGA team followed up with a meeting to take place at the district head office with traditional leaders of lengel, M&E officer and RIO should be sending data to the National four times in a month, CET to filter LGAs with CE issues and triangulate with DhiS data, Plan CE spots checks in identified LGAs with issues.

Fast track the re-structuring of KECCOH to improve CE coordination, Use state flag up avenue in passing high level messages to caregivers, Use state technical supervisors in ensuring that all SMC teams track and refer unimmunized children to HF for immunization, Update existing jingles to capture and emphasize RI messages in SMC jingles and Contacting state health educator on the status of KECCOH restructuring committee.

PARTICIPATION IN SERICC MONITORING VISIT TO TARAUNI LGA - TUESDAY 21ST JULY 2020
In line with its mandate of Identifying program bottlenecks and barriers to high Routine Immunization coverage as well as designing strategies to address these barriers to increase coverage, the State emergency routine immunization coordination center (SERICC) through the M&EWG had conducted a deep dive analysis to assess, monitor and evaluate RI performance across all LGAs in order to provide feedback and technical guidance on the way forward to these LGAs. This analysis was conducted based on these selected performance indicators: Dropout rate, Penta 3 coverage, Supportive supervision visits conducted, Number of unimmunized children, Percentage of Fixed Sessions Conducted and Percentage of Outreach Sessions Conducted

The Objective of the visit is to evaluate RI performance of the LGA, provide Technical Guidance to mitigate the current situation at the LGAs based on some performance indicators and produce a mitigation plan that will help in handling the issue of low RI coverage. All LGA team members participate at the meeting; the team has the mandate of ensuring smooth execution of RI and other PHC services at LGA level. The members of the team also supervise immunization activities at ward levels. The state team that visited the LGA consists of Government staff and partners supporting immunization activities in the state. LGA team consist of PHCC, DPHCC, CCO, RIO, LIO, Health Educator, LGA CEFP, LGA M&E, WHO LGAF, M&A (EOC), UNICEF LGAF and District Head Scribe, STATE team include SPCHMB, NPHCDA, UNICEF, MWAN PAS and WIM PAS staff

The visit was conducted successfully as planned; it started with a speech by the SERICC team lead who stated the objectives of the visit and the expected result to be achieved. The visit also consists of a presentation by the LGA team, Health Facility Visit, Field Survey and an advocacy visit to the District Head office.

The visit was aimed at assessing the LGAs RI performance and provides technical assistance to the LGA team. The meeting began with an introduction of team members by the SERICC Team Lead Malam Jibrin, he stated that the SERICC used DHIS2 data to search LGAs with issues which shows the LGA is in Category 4 (poor access poor utilization) that needs an urgent intervention.

On the other hand the LGA team presented their RI data analysis for the 2020 second quarter and identified lockdown order, non-compliance by the private health facilities, non-conduct of outreaches, and closure of private health facilities as the factors responsible for low RI coverage in the LGA. The team also presented the appropriate action identified as mitigation to the issues.

2.2 Mitigation Plan					
S/N	**ISSUES/PROBLEMS IDENTIFIED**	**ROOT CAUSE**	**ACTIVITIES TO BE CONDUCTED**	**RESPONSIBLE PERSON**	**TIMELINE**
1	Some Of The Planned Sessions Not Conducted Across The Facilities	Covid 19	Ensure All The Planned Sessions Are Conducted Under Close Supervision	LIO	Quarter 3_2020
2	Closure Of Some Private Facilities And Govt. House Clinic	Covid 19 Lock Down	Advocacy To Facilities Management To Ensure All Session Planned Are Conducted	SERICC/PHIMA	July 2020
3	High Penta 3 Dor Across Most Of The Facilities(Only 3 Achieved <10% Dor)	Some Clients Defaulted Due To Covid 19 Lock Down	Intensify Defaulter Tracking And Demand Creation	RI In Charges	July 2020
4	In Adequate Supervision	Competing Activities and Modification of Supervision Due to Covid 19 Lock Down	Intensify Supportive Supervision	PHCC	From 1 St July 2020
5	Some RI Service Providers Had No Mobility to Access the Facility	Restriction of Movement During Covid19 Lockdown	Regular Checking of Time Book to Monitor the Staff Movement, Since The Lock Down Is Relieved	PHCC	From 1 St July 2020

Advocacy to private health facilities to ensure full resumption of RI Sessions, Conduct of activities to increase demand creation, Regular checking of time book at health facilities and Intensifying supportive supervision. Health facility assessment was also carried out at Unguwa Uku Health Facility where data tools were examined. For the field visit 11 children were surveyed from 10 households and it is found that 7 are appropriately immunized, 3 are partially immunized and 1 child is fully immunized. After the presentation, field survey, facility assessment and the advocacy visit to the District Head office the SERICC team identified some key issues that need an urgent attention to improve the coverage in the LGA.

these include: Problem of non-compliance by private health facilities, they do not report data to LGA, they do not attend monthly RI meeting and they have poor management of RI data as such proper action from the state is required, LGA team revisiting their mitigation plan to assign responsibilities to the activities recognized, RIO is not submitting the summary of LGA data to the zone regularly and poor or non-conduct of LERICC meeting. Outcome is CSO led recommendations now supporting state's strategy

2.2 NIGER STATE

CCRHS-PAS PROPOSED SUPPORT TO THE SPHCDA FOR SERICC

In the month under review, PAS partner in Niger state (CCHRS-PAS) proposed support to 25 Local Immunization Officers (LIO) and 15 state primary healthcare board technical staff to enable them attend on-line virtual SERRIC meetings to make contributions as regard emerging issues, challenges, solutions and recommendations for RI. SERICC meeting haven't held since the last meeting in April 2020. This move was to support the implementation of the RI strategy within the platform.

FINALIZATION OF THE MID YEAR 2020 RI PEOPLE'S SCORECARD

CCRHS-PAS is currently finalizing the data collection for the half year People's scorecard for routine immunization for Niger state. This will then undergo peer review validation prior to its release.

The objective of the routine immunization scorecard assessment is to identified areas of strength, gaps/weaknesses and challenges in the state RI implementation, and make recommendations to guide the state in targeting support for improvement. PAS partners are achieving the outcome of supporting increased accountability in the utilization of RI funds through existing platforms.

2.3 LAGOS STATE

In the month under review (July 2020), PAS partners (AANI-PAS) concluded work on the production of RI people's scorecard for mid-year (Jan-June 2020)

The goal of the mid-year routine immunization scorecard assessment is to assess the level of RI implementation in Lagos state and to serve as advocacy tool to help stakeholders, and managers drive the change needed.

The objective of the routine immunization scorecard assessment is to identified areas of strength, gaps/weaknesses and challenges in the state RI implementation, and make recommendations to guide the state in targeting support for improvement

Key finding from the RI assessments Revealed that LGAs achieved greater than 80% scheduled for both fixed RI session and outreach RI session conducted, vaccine stock out and timely release for routine immunization finances

Further finding also revealed Existence of costed implementation plan for RI, existence of RI budget line, RI task force meeting, full implementation of community engagement in the state, functioning of cold chain equipment, lesser dropout rate (10%) for Penta 1 and Penta 3 in the previous month and existence of monitoring chart accurately and visibly display.

The People's scorecard is being readied for peer reviewed validation. PAS partners are achieving the outcome of supporting increased accountability in the utilization of RI funds through existing platforms.

2.4 NATIONAL LEVEL

In the month under review (July 2020), PAS National level partners MWAN-PAS and NCWS-PAS continues active representation at the National Emergency Routine Immunization Coordination Centre. PAS partners are gathering data to produce update reports on RI focusing on emerging issues, problems and successes at national level.

2.5 RI ACTIVITY SUMMARY TABLE

PAS Geographies	Number of on-going activities	Number of activities completed	Number of new activities initiated in July
National	3	2	0
Kaduna	2	6	1
Kano	3	4	2
Niger	2	1	1
Lagos	1	3	0

3.0 FAMILY PLANNING (FP)

3.1 KADUNA STATE

WEBINAR ON FP FUNDING IN KADUNA STATE: EMERGING ISSUES IN THE FACE OF REDISTRIBUTION OF THE 2020 HEALTH BUDGET FOR COVID-19

PAS partner in Kaduna state (NANNM-PAS, GIWAC-PAS, IIGES-PAS, MAFAHSU-PAS, PPFN-PAS) hosted a webinar on the 29th July 2020 on FP funding in Kaduna. The webinar commenced at 11am with Mrs Christy Bawa (moderator) introducing the topic and background on the issues to be discussed and later on, introduced the panelist.

Dr Illiyasu (Director-Public Health, KDSPHCDA) gave the background on FP funding in Kaduna State. Hajiya Nafisa explained that one of the major impacts of COVID-19 on FP in Kaduna is the decline in access to FP products. She notes that in Jan 2020 180,000 women accessed FP services, post Covid 19 only about 40,000 women accessed FP services. Another impact are increased in family planning unmet need and high rate of unplanned pregnancy due to the lockdown.

Dr Saied Tafida, PhD (BMGF Goalkeeper 2019 and Lead, Follow Taxes) gave an update on family planning budget tracking in Kaduna state. He stated that government should avoid late releases of funds for family activities so that the state can best make used of FP financing in Kaduna state. Dr Illiyasu explained that adequate equipment is needed to be provided to healthcare workers so that we don't lose even more women who will be in need of Family planning services.

Mr Iliya Kure (Secretary, FHANI Kaduna state) explained that the next steps for CSOs in Kaduna state are to ensure that adequate attentions is given to family planning financing and service delivery in the state' in the state, he further stated that the Governor is being very forthcoming and they are being invited for dialogue with government agencies to give recommendations on how best to financing family planning in the state.

This webinar was held as a policy dialogue on government's FP performance in Kaduna state, outcome was increased commitment in support of timely allocations and releases of funds.

3.2 KANO STATE

KANO STATE FAMILY PLANNING PEOPLE'S SCORECARD ASSESSMENT

In July, Kano state PAS partner (WIM-PAS, MWAN-PAS, FOMWAN-PAS, AmKaSS-PAS, NANNM-PAS) concluded work and produced a people's scorecard on mid-year FP activities implementation in the state.

The objectives of the FP people's scorecard are to assess the level of performance of FP activities implementation from January to June 2020 according to the Six thematic areas (Demand generation and behavior change communication, Service delivery, Supplies and commodities, Policy and environment, Financing and Supervision, monitoring, and coordination) of Family planning or Child birth spacing in Kano State as indicated in the Kano State CIP and the FMoH Blueprint.

The adopted methodology for the assessment is Data collection, Data entry and analysis. key finding from the assessment revealed Existence of a functional RH/FP Technical Working Group, Publication of FP Mid- and End-of-year budget performance, Existence and participation of 3 or more CSOs in technical working group meetings, Quarterly trainings of logistics management and coordination unit (LMCU) officers at LGA on contraceptive logistics management system, and Existence of Bimonthly review meetings with LGA FP supervisors to facilitate the distribution of FP commodities conducted.

Further finding revealed existence of 6 or more State and community-level FP champions, at least 2 targeted state multimedia FP advocacy and demand generation campaigns aired in the past quarter, 3 or more new access points for FP service provision where FP outreaches are conducted in the past quarter, >75% of the health facilities in the state (both public & private) offering family planning service and 50-100% of health facilities have integrated FP counselling and service provision integrated into other health services.

MWAN –PAS PARTICIPATION IN RMNCH+N TECHNICAL WORKING GROUP

MWAN PAS participated in RMNCH planned activity for new model of Group Anti Natal Care that will improve women and child health through reduction of Maternal and Child Death. MWAN PAS contributed immensely to the discussion especially around how RI will be improved through this model and how pregnant women will be sensitize on protecting their children from CKDs during the Group ANC sessions.
However, At the End of the workshops next steps for implementing the model were identified as follows: -
Training of State Trainers, Selection of the Health facilities for the pilot and Training of the Healthcare workers (service providers)

> "in Jan 2020 180,000 women accessed FP services, post Covid 19 only about 40,000 women accessed FP services."

PARTICIPATION IN GROUP ANC STAKEHOLDER ORIENTATION WORKSHOP - TUESDAY 7TH AND WEDNESDAY 8TH JULY 2020

In the month of July 2020 Kano partners MWAN-PAS and WIM-PAS participated in group ANC stakeholders' orientation workshop. The meeting aimed was is to provide technical support to the Government to adapt, implement and sustain model for G-ANC at PHC facilities across the State. In Kano State 69% of pregnant women attend ANC but 87% of them deliver at home. With G-ANC women are

more likely to deliver in health facilities and received RMNCH interventions for mother and child.

The model is expected to bring increase in uptake of RI among women attending G-ANC, facility delivery, Postnatal care, malaria surveillance, maternal and child nutrition among others. G-ANC model will be piloted in 10 LGAs in Kano State, in each selected LGA three facilities will be used for the pilot. Moreover, 8 out of the 10 LGAs were selected at the meeting to be among the pilot LGAs. The LGAs selected are the ones with issues in either high rate of maternal mortality or low RI coverage.

Furthermore, a presentation was made on Community Health Influencers and Promoters services (CHIPS) program. The program aimed at strengthening the community component of Primary Health Care services by harmonizing and integrating all community based activities at settlement levels. The overall goal of the CHIPS is to reduce maternal and child morbidity by creating demand for and improving access to and equitable coverage with essential primary healthcare services.

According to the presentation CHIPS agent mainly female were selected based on a certain criteria and will work in their communities to help improve access to primary healthcare and support community distribution of misoprostol, DT Amoxicillin as first line treatment for Pneumonia and ORS-Zinc as treatment for childhood Diarrhea diseases among others.

Outcome:
At the end participants were able to understand the concept of G-ANC and CHIPS intervention, MDAs made commitments to support the implementation of the Model and Some of the model's methods were domesticated to suite the situation in Kano State.

Conclusions/ Recommendation
The two-day activity was conducted successfully as planned, with good attendance from the invited participants across Kano State Ministry of Health and her MDAs, development partners and CSOs. The good attendance helps the workshop in achieving its objectives and identifying the next steps to be taken towards implementing the G-ANC Model across the state. However, it will be of importance for PAS project to track the implementation of the pilot model for the role it will play towards increasing RI coverage and reduce infections of CKDs.

Next Steps
At the End of the workshops next steps for implementing the model were identified as follows: -

Training of Trainers, Selection of the Health facilities for the pilot and Training of the Healthcare workers (service providers).

3.3 NIGER STATE

DEVELOPMENT OF HALF YEAR FP FUNDING SCORECARD

CCRHS-PAS in the month of July collected data for the FP budget in the state, following up with emerging issues highlighted from the Child Spacing Action Working Group meeting which CCRHS-PAS facilitated. This will form part of the emerging issues updates from the states issue brief. This is aimed at improving allocations and timely releases of FP funding in fulfilment of Niger state governments 'commitments to FP.

FAMILY PLANNING WEBINAR PLANNED IN NIGER STATE

CCRHS-PAS and the network of Muslim leaders in health-PAS commenced plans for a webinar on funding child spacing and maternal health in the context of covid-19; the experience of Niger state. This webinar will feature the Niger state director community health, SPHCDA, the director economic corporation and development, the FP coordinator amongst other civil society partners. This will serve as an opportunity to engage and proffer solutions to the government on emerging issues as well as advocate for timely releases of FP funds.

3.4 LAGOS STATE

AANI-PAS CONCLUDE THE DEVELOPMENT OF THE FP PEOPLE'S SCORECARD FOR JAN-JUNE 2020

AANI-PAS collected data for the development of the FP people's scorecard. Findings from this scorecard will be put through a peer review process for the validation. This is aimed at improving allocations and timely releases of FP funding in fulfilment of Lagos state governments 'commitments to FP

3.5 NATIONAL LEVEL

SOGON-PAS PARTICIPATES ON NRHTWG; LEADS ADVOCACY SUBCOMMITTEE

In the month of July 2020, two NRHTWG meetings have held virtually (6/7th July 2020) & (22nd July 2020) with SOGON-PAS actively participating. The meetings were held to discuss updates on Covid-19 response through a consideration of the impact and mitigation on Reproductive and Maternal Health to ensure sustained and effective service delivery.

The first meeting focused on the Adolescent Friendly Sexual and Reproductive Health and Rights services in the draft Adolescent Health and Development Policy. At this meeting stakeholders reviewed the draft document to observe its appropriateness and gaps in the SRH national policy while offering recommendations. Partners also worked on indicators for the subsequent assessment of the policy in the long term. The second meeting focused on improving sexual and reproductive health services in humanitarian settings during Covid-19 pandemic. The FMOH is keen on sustaining reproductive health services nationwide through this pandemic period.

3.6 FP ACTIVITY SUMMARY TABLE

PAS Geographies	Number of on-going activities	Number of activities completed	Number of new activities initiated in June
National	3	0	0
Kaduna	3	4	1
Kano	3	5	0
Niger	2	1	1
Lagos	0	3	0

4.0 ENDING CHILDHOOD KILLER DISEASES (CKD)

4.1 NIGER STATE

CCRHS PAS SUPPORTS INNAUGURATION OF CKD TECHNICAL WORKING GROUP

In July 2020, PAS partner in Niger state (CCRHS-PAS) in collaboration with the state primary healthcare board & state ministry of health inaugurated the CKD technical working group. The inauguration was done by the permanent secretary ministry of health who represented the commissioner for health. PAS partners aimed to strengthen coalitions in support of eliminating CKD.

The objective of the CKD technical working group are:

- To build capacity for program management and service delivery on CKD
- To provide technical assistance to Ward Focal Facilities in developing plans of operation for implementation of PHC_CKD service delivery channels.
- To conduct partners and resource mapping and financial gap analysis on CKD
- To build strategic alliances and linkages with DMA, SCHIS, SPHCDA and HMB on CKD service support
- To provide technical support in conducting social mobilization activities for PHCs on CKD
- To maintain an updated mapping of partners, activities, and resources engaged in the implementation of CKD in Niger State
- To monitor the ongoing implementation of scale-up interventions on CKD by holding joint program progress and performance reviews with participation from major implementing stakeholders
- To provide a platform for frequent and transparent information and knowledge sharing by facilitating regular monitoring, evaluation, programmatic, and other progress reports by scale-up partners
- To develop recommendations to improve scale-up plan implementation based on the results of joint performance reviews and analysis of regular monitoring and evaluation reports provided by scale-up partners
- To identify needs and gaps for CKD scale-up implementation and identify and engage potential partners and/or resources to fill these gaps
- To advocate for additional public- and private-sector investment in scale-up interventions in the state for CKD
- To providing technical support to conducting regular supervision, monitoring and evaluation on CKD interventions in the state
- Meet at least last Thursday's of every month and report to the SPHCDA on a monthly basis.

Composition of the CKD technical working group includes:

ED, SPHCDA	1	Chairman
Dir. Public Health, SMOH	1	Co-Chairman
DG, DMA	1	Executive Member
EMD, HMB	1	Executive Member
ES, SHIA	1	Executive Member
Director Pharmaceutical Services	1	Member
Dir. Medical Services & Training, SMOH	1	Member
Dir. Community Health Services, SPHCDA	1	Member
Dir. PRS, SPHCDA	1	Member
Dir. Immunization, SPHCDA	1	Member
PM, SERICC	1	Member
State IMCI Coordinator	1	Secretary
State SOML Program Manager	1	Member
State HMIS Officer	1	Member
M&E Officer, SPHCDA	1	Member
Assistant M&E Officer, SPHCDA	1	Member
Representatives of LGA PHC Directors (zonal representation)	6	Member
Partners	2	Member
CSO Coalition on Maternal and Newborn Child Health in Niger State (COMiN)	2	Member
Niger PAS Partners	2	Member

NEXT STEP

- Platform to operate within the scope of the ToR and always report to the MoH through the Chair or Co-Chair to report to the Hon Commissioner
- Meetings to be held by every last Thursday of every month – Co-chair to be reached on this
- Monthly meetings to be held by the platform – PAS team to meet with the Co-chair on the date of the first meeting
- ToR to include creating CSO advocacy group advocacy course to stakeholders on CKD funding allocation and releases.
- The group to form CIP committee on CKD – Process to kick start in the first meeting in 3rd Week of July
- Platform charged to do their best and intermittently update the Hon. Commissioner MoH – To be done either by the Chair or Co-chair
- The Co-Chair to meet with dRPC-PAS to deliberate on the way forward – 2nd Week of July,
- The next meeting date of the platform to be communicated to other members via the newly opened whatsapp platform for the CKD

4.2 CKD ACTIVITY SUMMARY TABLE			
PAS Geographies	Number of on-going activities	Number of activities completed	Number of new activities initiated in June
Kaduna	1	0	0
Kano	1	0	0
Niger	1	1	1

5.0 PRIMARY HEALTH CARE UNDERONE ROOF (PHCUOR)

5.1 KANO STATE MWAN-PAS FINALISE PHCUOR 2020 MID-YEAR PEOPLE'S SCORECARD

In July 2020, PAS partners in Kano state (WIM-PAS, MWAN-PAS, NANNM-PAS, AmKaSS-PAS & FOMWAN-PAS) concluded work on the development of PCHUOR people's card.

The Objectives of PHCUOR peoples Scorecard assessment is to identify areas of strengths, best practices, gaps/weaknesses and challenges in the state, level of improvement between last year's and this year bi-annual assessment, make recommendations to guide the State and partners in targeting support for improvement, produce a scorecard as an advocacy tool for engaging policy makers including State Governor as well as other PHCUOR actors to improve political commitment and funding for effective Primary Health Care (PHC) implementation to enhance rapid achievement of Universal Health Coverage (UHC) and disseminate a report that provides a guide to the state in requesting technical support from NPHCDA and partners to improve their performance

Key finding at the SPHCB revealed that the State scores (100%) in Legislation, System Development, Human resource, Operational Guidelines, Office Set up and Accountability & Transparency, the lowest performing being Governance & Ownership and Funding sources and Structure scoring (67%). At the LGAs, the State scored 100% best in Legislation, Minimum Service Package, System Development, Human Resource, Operational Guidelines and office set up. the lowest performing pillars been Repositioning scoring (67.0%).

At the health facility level, the state scored best in Governance & Ownership, Community Engagement, Infrastructure, Cold Chain & Logistics, Data tools, data quality and Financial support (100%) and lowest in Human resource for Health (75%).

The State scored 92% overall in implementation of PHCUOR, scoring best in Legislation, system development domain, Operational Guidelines, Office Set up and Accountability and Transparency (100%) and has the lowest score in Re-positioning (77%).

Observed strengths from the kano state PHCUOR people's scorecard shows Availability of a gazette law and regulations, Presence of dedicative management team, Presence of dedicative Governing board.

Adoption and Costing of MSP with classification of different health facility type, Equipped offices at the State and sub-State levels. Existence of State Strategic Health Development Plan for PHC component based on the MSP document developed by the SPHCB.

Observed Weaknesses revealed PHC staff benefits are not administered by Kano SPHCMB, non-evidence of HRH committee, department or unit to address staff needs, The PHC department, staff, programs and funds in the SMoH have not been moved to the SPHCB and non-availability of PHCUOR implementation manual at the SPHCB

5.2 NATIONAL LEVEL- PAS PARTNERS ASSESS PHCUOR SCORECARD 5 METHODOLOGY AND CSO INVOLVEMENT

PAS is engaging with the National Primary Healthcare Development Agency (NPHCDA) to disseminate the recently concluded PHCUOR score card 5 assessment

In July 2020, PAS conducted a research on PHCUOR scorecard assessment and civil society involvement. The purpose of the research on PHCUOR scorecard assessment and Civil Society Organization participation is to determine whether there were successive modification to the PHCUOR scorecard assessment methodology from in inception (2012) to date, determine whether civil society organizations were involve in PHCUOR scorecard 1 in 2012 to scorecard 4 in 2018, examine whether the PHCUOR scorecard assessment objective varies from scorecard 1 to scorecard 5, determine whether the PHCUOR scorecard 5 assessment conducted in 2019 was the first CSO are participating in the scorecard and lastly determine the composition of the PHCUOR scorecard data assessors by sectoral representation from scorecard 1 to scorecard 5 in 2019

Key informant interview and Desk reviews were adopted for this research. Key informant interviewed during this research work include Mr. Niyi EKisola, the Desk officer PHCUOR NPHCDA, Mrs. Tosin Dare, Health Systems Support Division of NPHCDA and a Dr Charles Mamman, a retired director from NPHCDA. Desk reviews were conducted on scorecard 2, scorecard 3, scorecard 4 and scorecard 5

Finding from the Desk review and key informant interviewed revealed that What is common to all Scorecards is that it was done in all 36 states including the FCT regardless of whether there is an already established SPHCB at that time. The assessment still happens in all states.

However, there are differences in the questionnaire and its application and interpretation of results. For every scorecard, there is an improvement. For example, in Scorecard 2 (2014) scorecard 1 was modified from existing checklist to full assessment tool and a scorecard. In scorecard 3 (2015) the assessment tool used in scorecard 2 had to be revised to increase sensitivity and expanded to include a qualitative questionnaire for better understanding of the implementation process in the States.

The 2018 PHCUOR Scorecard 4 Assessment tool was a modified and improved version of the previous scorecard tools: large number of questions were substantially reduced to fewer but critical

questions, which enhanced the sensitivity of detecting gaps in the implementation of PHCUOR. Each question had a score and each pillar was weighted to reflect its importance in the functionality of the SPHCBs.

The final assessment tool in scorecard 4 was coded on to an android enabled platform - the Open Data Kit (ODK) to enhance data collection processes including tool administration, data uploading to a central server for analysis and data quality assurance. To ascertain the reliability and validity of the Scorecard 4 tool, a pretest exercise was carried out in the FCT using the android phones by a team of PHC TMT members led by the NPHCDA. Some of the questions were observed to be insensitive or improperly framed. The tool was further revised by the team in line with lessons learnt/feedback from the pretest exercise.

In 2019 Scorecard 4 tool was revised for Scorecard 5 assessment to reflect new thinking and recommendations from the Scorecard 4 report. The review enabled revision and addition of questions to eight out of the nine PHCUOR pillars: 15 questions were added and three questions were modified. To enhance the sensitivity of the tool, each question was allotted a score while each of the nine pillars was weighted according to its relevance. The reviewed Scorecard 5 tool was abridged for the sub-state levels, and to enable corroboration across the levels (State, LGHA, health facilities).

The tool was designed in a manner that answers from the LGHA and health facilities' questionnaire can be used to validate state level answers. For example: PHCUOR state tool: Is there a State PHC Annual Operational Plan (AOP) with budget incorporating all LGHA Annual Operational Plans? PHCUOR LGHA tool: Is there a LGHA PHC Annual Operational Plan? PHCUOR health facility tool: does the facility have an Annual Operational Plan?

If the state level answers 'yes' to the sample question above, the response from the LGHAs and facilities are expected to be 'yes'. However, in a situation where the state level answers 'yes', and any of the other levels answer 'no', the state automatically scores nothing for that question.

Further finding revealed that the objective of PHCUOR scorecard assessment from scorecard 1 in 2012 to scorecard 5 in 2019 is to identify specific areas within the PHCUOR framework in which state need further support, generate evidence for use in advocacy to governmental and non-governmental stakeholders on PHC reform, promote peer review and learning mechanism among the States, lastly the PHCUOR scorecard assessment objective is to assess the implementation status of the PHCUOR policy in all thirty six state and FCT

Process step methodology were also reviewed from five step process methodology (revision of assessment tool, training of data collectors, data collection, data analysis and report writing) in scorecard 2 (2014) and scorecard 3 (2015) to ten process step methodology (process step added include quality control, pretesting of assessment tool, data validation and entry, coding of assessment tool and review) in scorecard 4 (2018) and scorecard 5 (2019)

Finding also revealed that civil society organization like HERFON, IVAC, PRRINN-MNCH, have been participating in PHCUOR scorecard assessment since inception (2012), Scorecard 3 and scorecard 4 witness increased involvement of civil society organizations in PHCUOR scorecard assessment.

5.3 PHCUOR ACTIVITY SUMMARY TABLE

PAS Geographies	Number of on- going activities	Number of activities completed	Number of new activities initiated in June
National	2	0	1
Kaduna	1	0	0
Kano	1	2	0
Niger	2	0	0

6.0 PAS PARTNERS ACCOUNTABILITY PLATFORM REPRESENTATION

PAS PARTNERS RI PLATFROM REPRESENTATION SUMMARY

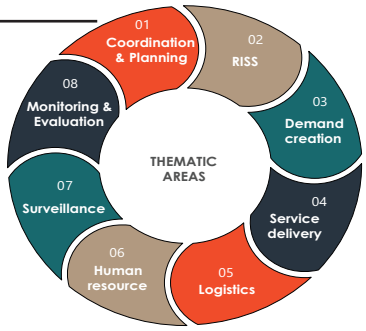
LOCATION	JUNE 2020	
	Total	Attended
Kaduna	15	13
Kano	11	11
Lagos	2	2
Niger	0	0
National	15	9

National Emergency Routine Immunization Coordination Centre (NERICC) meetings are held to improve coordination of immunization programs in Nigeria. The Expanded NERICC meetings include State Emergency National Routine Immunization Coordination Centre (SERICC), State Immunization Officers (SIOs), State Emergency Maternal and Child Intervention Centre (SEMCHIC), Reproductive Maternal New born & Child Adolescent Health +Nutrition (RMNCH+N), and National Primary Health Care Development Agency (NPHCDA) State Coordinators. SERICC meetings are held to improving the immunization coverage at the State level.

During this reporting period of June 2020, PAS-CSOs at the National and State levels played significant roles across the RI platforms; held government accountable at local, state and federal levels, and provided technical inputs. The key issues discussed and contributions of the PAS sub-grantees were disaggregated by national and states below.

NERICC PLATFORM

In July 2020, PAS-CSO; Medical Women Association of Nigeria (MWAN-PAS) participated and contributed actively in 9 NERICC meetings. Discussions and updates are centred around 8 thematic areas:



The key issues discussed and contributions of the PAS sub-grantee at NERICC meetings are below.

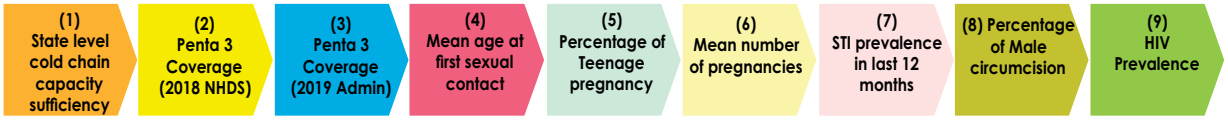
Summary of LGAs' Performance

Performance analysis of the 774 LGAs in Nigeria showed that 72 LGAs are very poor performing, 686 are poor performing LGAs, and 16 good performing LGAs. The proportion of planned fixed sessions conducted in 725 LGAs was very good, while the proportion conducted in 43 LGAs was poor and 6 LGAs were very poor in achieving planned fixed sessions. Similarly, 608 LGAs conducted good percentage of planned outreach sessions, 114 LGAs had poor proportions and 52 LGAs had very poor proportions of planned outreach sessions conducted. Plans to engage state facilitators in supervising sessions in the poor and very poor performing states was proposed to boosted the performance.

Human Papilloma Virus (HPV) Vaccine Introduction

New Vaccine Strategic Task Team provided an update on plans for introduction of HPV vaccine. A phased approach with clearly defined requisite criteria will be used for the HPV introduction to ensure equitable phasing seen below:

The first phase will start in March 2021 across 20 States (Katsina, Jigawa, Kano, Bauchi, Plateau, Adamawa, Taraba, Benue, Nasarawa, FCT, Oyo, Ogun, Lagos, Osun, Anambra, Imo, Delta, Rivers, Akwa-Ibom, and Abia). States selected in the 1st phase increased from 18 to 21 and budget cut down from $26 million to $19million, with a shortfall of $10million. Being a new vaccine, training will be physical to allow for hands-on. At meeting with EOC, the two budgets will be presented with $2million and $7million dollar gaps, and to consider strategies to close the gap of any of the two budgets eventually approved. The 2nd phase will start in September 2021 across the 16 remaining States. The estimated budget for the Operational Cost of introduction is 19,216,915 Million USD. The operational costs will cover; vaccination personnel allowance, training budget, supervision, monitoring & evaluation, transport, and logistics, social mobilization, surveillance and coverage survey, data tools and other printing materials, payment mechanism and others. All proposal documents for HPV have been sent to the PM for review and further submission. Next Steps are; update chronogram with approved dates, obtain all necessary approval and signature for submission, and submit proposal.



6.0 PAS PARTNERS ACCOUNTABILITY PLATFORM REPRESENTATION

Weekly Updates on SMS Reporting and RI Service Delivery

The SMS routine immunization (RI) data for 18 NERICC priority states from 14,047 HFs was analysed for weeks 25 to 27 (15th June to 5th July 2020). Compared to week 26 (35,821), total SMS received in week 27 (32,382) dropped by 10%. 92.7% of messages received were good and synchronized messages (30,020), 2.3% were wrongly formatted (730), and 5% of the messages were from phone numbers that were not configured (1,606). In week 28 (6th July to 12th July 2020), there was an increase in the number of messages received (36,433) compared to the 3 previous weeks, with 92.5% good and synchronized messages (33,703), 2.5% wrong format messages (918) and 5% of the messages from phone numbers not configured (1,761). There was further improvement in week 29 (13 to 19th July 2020), with 39,298 messages received. 93.1% were good and synchronized messages (36,598), 2.4% wrong format messages (938) and 4.5% of the messages from phone numbers not configured (1,723).

Reporting rate was calculated using number of health facility that reported conduct of either fixed or outreach session during the reporting week divided by total number of expected health facilities. Compared to week 26 (9197) and week 25 (8372), there was a drop in the number of health facilities that reported in week 27 (7943). In week 28, there was an increase in the number of health facilities that reported (9667). Reports across 18 NERICC priority states for selected antigens; BCG, Measles, Penta 1 and Penta 3 were compared. Measles vaccination persistently low in Taraba, Sokoto, Bauchi and Kaduna states, overall Penta 2 vaccination was <50%, lowest in Bayelsa and Taraba states. Penta 3 vaccination also lowest in the same states. Generally poor reporting in week 26 (56%), except for Nasarawa and Gombe.

Since week 23, Kano has had >80% of HF reporting. Niger, Bayelsa, Plateau and Kogi states were poor in percentage of HF reporting conduct of fixed sessions in week 26. Only Kano and Yobe reported >50% outreach sessions. Overall reporting of outreaches was 32%. Overall average was 57%, least so far.

In the North Central Zone, there was a steady decline in the reporting rate from week 25, 26 to 27 across all states except Nasarawa State (103, 304, 452 for all the respective weeks). Kogi State (364, 478, 396), Niger State (469, 495, 295), and Plateau State (458, 459, 382) experienced a drop for all the respective weeks.

The North-West Zone also experienced a steady decline in the reporting rates in all the States; Kano (1072, 1106, 1029), Sokoto (460, 470, 376), Zamfara (410, 476, 422), Katsina (1059, 1075, 926), Kaduna (703, 837, 703), Kebbi (455, 469 and 391), and Jigawa (520, 552, 496) for weeks 25, 26 and 27 respectively.

There was a decline in the number of health facilities that reported in States in North Eastern Zone; Adamawa (422, 493, 383), Bauchi (753, 761, 566), Yobe (263, 314, 274), and Taraba (271, 265, 207) for weeks 25, 26 and 27 respectively.

Bayelsa State in South-South Zone experienced increase in the number of health facilities (53, 62, 71) that reported for weeks 25, 26 and 27 respectively.

Overall reporting rate based on either fixed or outreach sessions improved by 10% point from 55% in week 25 to 65% in week 26. This increase was in all states except Taraba state. Taraba, Niger, Plateau, Nasarawa and Bayelsa states had reporting rates of fixed or outreach sessions of <50%. Kano, Sokoto, Yobe and Jigawa states had >80% reporting rates. However, the overall reporting rate based on the conduct of either fixed or outreach sessions was 56% in week 27 which was low compared to 65% in week 26. There was increase in subsequent weeks; 69% in week 28, and 70% in Week 29. 76% of planned fixed and 57% of outreach sessions were conducted in week 27 while 99% and 82% of planned and outreach sessions respectively were conducted in week 28. There was a drop in week 29; 85% and 74% of planned fixed and outreach sessions were conducted. Decline in reporting rate based on conduct of either fixed or outreach sessions was noted in most States except Bayelsa and Gombe in week 27. Week 28 showed an increase in reporting rate based on the conduct of either fixed or outreach session in all states. However, week 29 report showed decrease in reporting rate based on conduct of either fixed or outreach sessions in Kano, Gombe, Jigawa, Sokoto, Kebbi, Taraba and Plateau States. Baylesa, Niger, Plateau, Taraba, and Kogi States had less than 50% reporting rate based on conduct of either fixed or outreach session in week 27 and 28. Niger and Bayelsa States had < 50% reporting rates based on conduct of either fixed or outreach sessions in week 29. Less than 50% of health facilities in Borno, Niger and Plateau reported the conduct of fixed sessions in the last 27 weeks. Only Kano had a reporting rate that is greater than 80% based on the conduct of either fixed or outreach sessions in week 27. There was an improvement in week 28, with 7 States; Kano, Yobe, Gombe, Sokoto, Jigawa, Zamfara, and Kebbi having greater than 80% reporting rates. In week 29, only 4 States; Kano, Yobe, Gombe and Zamfara had > 80% reporting rates.

> “The North-West Zone also experienced a steady decline in the reporting rates in all the States”

In week 26, 378 out of 386 LGAs (97.9%) reported, and 209 out of the 378 LGAs had over 80% of HFs reporting. In 15 states, 45 LGAs had 100% of their HFs reporting daily session plans. Nasarawa and Bayelsa states were least performing with reporting rates of 40% and 29% respectively in week 26. 377 out of 386 LGAs (97.6%) reported in week 27, 28 and 29, with 183 of this 377 LGAs having over 80% of HFs reporting in week 27, and 150 of 377 LGAs having over 80% of HFs reporting in week 28. In week 29, 221 out of 377 LGAs had over 80% of HFs reporting. In week 27, 38 LGAs in 10 states had 100% of HFs reporting their weekly session plan and 32 LGAs in 11 States had 100% of HFs

reporting their weekly session plan in week 28. While 58 LGAs in 15 States had 100% of HFs reporting their weekly session plan in week 29.

Baylesa and Niger were the least performing states with reporting rates of 34% and 28% respectively in week 27; 33% and 42% respectively in week 28, and 34% and 45% reporting rates respectively in week 29. There was a decline in conduct of both fixed and outreach session in most States when compared to Week 26. All states except Katsina and Nasarawa conducted above 80% of either planned fixed or outreach sessions in week 28. In week 29, only Gombe and Yobe States conducted at least 90% of planned fixed and outreach sessions. There was a decline in the number of children vaccinated with selected antigens in most States in week 27 compared with week 26. Similarly, there was a decline in the number of children vaccinated with selected antigens in most states in week 29 compared with week 28.

There was reduction in supervised planned fixed and outreach sessions conducted across most states in week 26. Only Kebbi State had more than 50% of fixed and outreach sessions supervised in week 27, 28 and 29. While only 13% of fixed sessions were supervised in Gombe State, and no outreach session was supervised in Bayelsa State in week 27. An improvement was observed with 10% of outreach sessions in Bayelsa and Nasarawa States supervised in week 28. Less than 30% of target population were vaccinated with BCG, Penta 1 & 3 and Measles in Bayelsa State in the last 4 weeks. In week 29, less than 60% of HFs in all LGAs in Bayelsa State reported weekly session plan.

There was consistent report of vaccines stock-out during the conduct of sessions in Jigawa, Niger and Kaduna States. Overall, there was >70% wastage rate of Penta 3 vaccine, 50% BCG wastage and >40% for Measles vaccine. All states except Nasarawa had >40% measles wastage rate in week 27. Analysis of the BCG wastage rate for fixed and outreach sessions by State, showed that 11 states had wastage rates that were greater than 70% threshold in week 27 and 28. In week 29, only Niger, Nasarawa and Gombe States had > 70% threshold for BCG wastage rate, and all States exceeded 40% threshold for Measles wastage rate. Highest BCG wastage rates were noted in Sokoto state and all states except for Niger had >40% wastage for measles.

Some of the challenges identified during the review include; poor SMS dashboard review in Niger and Bauchi States; persistent stock out of vaccines during the conduct of sessions in some HFs in Jigawa, Kaduna, Niger and Sokoto States; decline in conduct of fixed and outreach sessions across most States; poor report of weekly sessions plan across all the LGAs in Bayelsa State; persistently low numbers of children vaccinated with BCG in Kaduna and Taraba States at fixed and outreach sessions; and decrease in number of children vaccinated during the conduct of fixed and outreach sessions across most States. It was recommended that NERICC leadership will follow-up with State Desk officers during Wednesday weekly engagement meeting with the States, to proffer solutions. Feedback on SMS reporting will be discussed with States during Wednesday weekly meetings. State Desk Officers will also follow with State teams to address poor conduct of sessions, suboptimal RI performance and stock out of antigens and give feedback to NERRIC.

Feedback from States on SMS reporting and challenges with SMS reporting

Feedback from Taraba, Jigawa, Niger, Bayelsa, Bauchi, Plateau, Kaduna, Sokoto States on SMS reporting showed that Nasarawa, Bauchi, and Taraba had poor SMS dashboard review in week 26. Healthcare workers in Bauchi State feel unsafe attending to clients due to inadequate PPEs, and clients also avoid health facilities for fear of contracting COVID-19 from healthcare workers. In Niger State, all Antigens are currently available but some CCOs failed to collect vaccines from the LGAs and reported vaccine stock-out. NGSERICC intend to identify defaulting CCOs and applying appropriate accountability measures. Conflicting activities in Sokoto State including implementation of SMC and Q3 2020 REW MP desk review across 23 LGAs contribute to low reporting observed. In addition, reports of stock-out are false alarm and as a result of typical error. In Bayelsa State, lack of funds to conduct RI activities, lack of recharge cards to follow up with the LGAs regularly and data bundles for downloading SMS Data for analysis are some of the factors contributing to late and inadequate reporting. Also, the general public avoids health facilities for fear of contracting COVID-19, and there are cases of absentee healthcare workers due to lack of PPEs. Bayelsa also report wastage because health workers open multi-dose vials even for a small number of persons to avoid MOVs.

Implementation of National Immunisation Coverage Survey (NICS)/Multiple Indicator Cluster Survey (MICS)

MICS/NICS were scheduled for this year. Government and partners have agreed to conduct NICS/MICS, streamline timelines and brief NICS global team. The Nigeria Bureau of Statistics (NBS) will share the revised budget and timeliness with UNICEF for harmonization and approval. The Steering committee will review the budget to include cost of PPE, sanitizers etc for protection against Covid-19. The revised budget will be shared with all partners before presentation to EOC. UNICEF representative advised the reuse of some equipment used in the last exercise in order to cut down cost. Budgets for NICS/MICS and NICS alone will be prepared in readiness for whichever one will be approved eventually. A stakeholders' meeting has been held and another scheduled to provide update on NICS/MICS, and to streamline timelines.

Appreciation Day

To mark the 3rd year anniversary of NERICC, the NERICC team took time out to appreciate members for the general progress achieved in the past 3 years of dedicated work and laudable accomplished projects such as Nigeria being certified 'polio free', and improved RI coverage. It was recommended and a team constituted to tell the NERRIC story in a document that will be circulate widely for the public to read. Every member was encouraged to say one or two things regarding what they have learnt

and any suggestions they want to share with the team. Despite the challenges of insecurity, bad roads and ill-health, members were grateful for opportunity to learn greatly over the years and improve in their work deliverables. The Executive Director and Director (DCI)/PM NPHCDA were appreciated for their leadership style, patience, dedication, and guidance for new members. The teamwork, dedication to work and punctuality of members were acknowledged.

National Data Project

Poor data quality, and non-use of data for action at health facility level are widely acknowledged problems affecting RI reporting. Key strategy to address many of the data-related issues is the introduction of SMS/electronic data capture at HF level. SMS texting was rolled out in 18 NERICC priority states as a strategy for improving data quality. Health facilities send reports daily after conduct of sessions. The proposed tool for phase two of national data project is DHIS2 Mobile App, that will be operationalized and scaled up. National Data Project was deployed to address identified gaps in routine immunization data quality. The justifications for the project are; (1) 34%-point discrepancy in Penta 3 coverage between survey and administrative data above acceptable 10% threshold. (2) Current RI SMS reporting in 18 States has improved the use of data to drive decisions at all levels while providing timely interventions to identified challenges. (3) Improved timeliness of reporting in majority of health facilities with good reporting rates have been consistently maintained at over 80% pre-COVID19. (4) Reporting at the point of services delivery has reduced possibilities of data falsification and therefore, there is need to scale up point of service reporting across all 36 States.

Progress made so far were the approval of the National Data Project proposal by GAVI, mobile device specification finalized with network provider (Airtel), engagement of key stakeholders on the operationalization of the proposed strategy, development of operational plan and identification of pilots' states. The project will be operationalized in 4 categories: Pre-implementation phase, Pilot phase, Post pilot phase, and Scale-up phase.

Health Facilities Updating

There was a need to update and revamp all the health facilities in 36 States and FCT, but due to the Covid-19 pandemic only 21 States were able to be updated.

Health Facility Registry

The process of Health Facility registry implementation is in two phases. 23 states have completed phase 1 and 2 of the health facility registry. However, Kebbi State have done only phase 1, its remaining phase 2 which was suspended due to COVID-19 Pandemic. While the remaining 13 States have not done any of the phases. The 13 States that have not yet done phase 1 and phase 2 are; Akwa Ibom, Bauchi, Bayelsa, Borno, Ebonyi, Gombe, Jigawa, Kogi, Kwara, Osun, Rivers, Taraba and Zamfara).

ACSM SMS Intervention to Healthcare Workers (HWs) for Improved RI Services Uptake

Currently, the Nigeria disease burden for COVID-19 is at 38,344 cases (NCDC website, 23rd July 2020). Provision of routine health services have been greatly affected in Nigeria due to (1) initial lockdown restricting movement of health workers and caregivers, and (2) rumours, myths, and misinformation on Covid-19. This has resulted in decline in RI services provision (HF RISS visits: March-3,617, April – 2,900 and May-2,256) (NERICC RISS data), and decline in the demand for RI services. Mitigation measures taken to improve PHC services include; conduct of NPHCDA COVID-19 training across the 36 States and FCT, and development of dashboard for assessment of impact of Covid-19 on RI and PHC services.

SMS service targeting health workers will be developed to constantly remind and guide HWs with accurate information for improved service provision. The aim of the SMS intervention is to reinforce key issues in RI/PHC services delivery for improved RI services uptake. The objectives include; (1) promote adherence to COVID-19 NCDC IPC guidelines by health workers during service provision; (2) improve prompt reporting and documentation of AEFI by HWs; and (3) remind health workers on the importance of providing RI 6- key messages during service delivery. The estimated budget for SMS intervention is N1,742,400 ($4468).

Three COVID-19 messages that will be disseminated during the intervention are:

- All Health Workers/Service providers are expected to resume all services on the conduct of fixed and outreaches including ANC in all health facilities providing RI services.
- All Health Workers must practice COVID-19 transmission precautions at health facilities and ensure that NCDC guidelines on COVID-19 IPC are observed as advised.
- COVID-19 is a highly infectious disease. Its key symptoms are fever, cough, and difficulty in breathing. Symptoms appear within 2-14 days after exposure. Reports any suspected case to LGA DSNOs and State COVID- Task force team for sample collection, testing and isolation of confirmed cases.

An assessment will be conducted to assess the outcome of SMS intervention targeting HWs. The data elements that will be assessed for each objective of the intervention are;

Objective 1: 10% of HWs per state will be interviewed on the quality of SMS content and RISS checklist on IPC. The indicators for assessment of this objective are; proportion of HWs ensuring the practice of IPC; proportion of HWs that received SMS; proportion of HWs that testified usefulness of SMS messages has impacted their service delivery most (Qualitative Assessment).

Objective 2: AEFI line list from the AEFIDB; AEFI reporting during RISS. The indicator for assessment of this objective is AEFI reporting rate.

Objective 3: Immunization status of children surveyed during RISS. The indicator for assessment of this objective are; proportions of immunized children 3 months interval before/ with interventions from RISS visits; percentage of caregivers confirming reminders given by HWs during exit interviews.

The timeline for the implementation of the intervention and assessment include; Approved Budget and release of funds - July; Commencement of Bulk SMS to HWs, and establishment of feedback mechanism to address key issues arising from disseminated key messages – August; Motivating & reinforcing key issues in RI services provision by HWs - September 20; Rapid assessment to monitor the effectiveness of SMS to HWs - October 28; Presentation to NERICC on the monitoring of SMS to HWs and End of SMS Strategy targeting HWs - December. About 22,000 phone numbers of HWs from 18 NERICC states are available on the RI SMS server as used for the budgeting. Overall Cost in Naira of sending SMS to 22,000 HWs is N1, 201,200.

Feedbacks from Review Meeting with States on Identified Challenges with SMS Reporting

Bayelsa: Non-payment of salary and arrears affected the conduct of RI sessions. Supportive supervision has not taken place in the state due to inadequate funding and the terrain of the state. Weekly SMS is submitted by health workers using out-of-pocket fund, so the state could not enforce the submission of daily and weekly reports by HFs. Staff transfer and reshuffling also affect the observed capacity for SMS reporting in some LGAs/HFs. Plans are in place to support HFs with some funds for SMS reporting and conduct of outreach sessions.

Niger: State recently conducted deep-dive analysis to understand the root cause of poor SMS reporting. The result of this deep-dive analysis was used to categorize LGAs into average, poor and very poor. The list of health facilities on SMS platform is unreliable. Due to Covid-19, HFs report weekly session plan but do not conduct the sessions. In a situation where the planned weekly sessions were conducted, some health facilities could not report using the SMS server due to network issues. Stock-out of vaccines during sessions was attributed to the Push system. Lastly, there was a salary cut which may be responsible for poor attitude to work among HCWs.

Kogi: Some LGAs and HFs have capacity gap on SMS reporting, and are not using job aid. HFs use personal fund to transport vaccines to vaccination sites. The State will use the ongoing Vaccine Management training to sensitize the health workers on the importance of sending SMS immediately after an activity is performed. Also, the State will use August FIPV implementation to refresh the HF officers on how to send reports of weekly sessions plans and conduct. The State will appeal to UNICEF for the release the proposed funds for outreach activities in very poor wards, and review the phone numbers of HF immunization officers and update them especially in health facilities where there were recent transfers.

Taraba: Insecurity in Taraba State including community crisis, kidnapping, and banditry in some LGAs affected the conduct of RI sessions. Most secondary health facilities could not conduct daily sessions due to lack of funds for RI related activities. The State recently received one-month support from SOML and has included support for SMS reporting in the new Gavi approved support. Other challenges were inaccurate HFs list on SMS platform, and backend issues on data summation.

Plateau: Covid-19 affected conduct of both fixed and outreach sessions, and there is a knowledge gap on use of SMS platform. In addition, there is a shortage of human resources for health in the state, and no fund for supportive supervision. Most of the RIOs in the state are new, and there is a plan for virtual training of the new RIOs in the coming weeks. The report of weekly sessions conducted from some HFs could not deliver to SMS server due to network issues, and the HF list on SMS platform is inaccurate.

Kaduna: Poor vaccines forecasting was responsible for stock out during RI sessions. Another challenge is the failure of healthcare workers to report weekly session plan. Attitude of healthcare workers also contributed to vaccines stock-out and poor SMS reporting.

Actions Points

- TAs SERICC will provide regular support to state on SMS reporting and ensure SMS data are used for programme planning.
- States will share maximum of 2 slides on the mitigation plans latest by COB on Tuesday 28th July 2020
- States will organize refresher training for the affected healthcare workers
-
- States will compile and share list of functional HFs with NERICC data team.
- NERICC data team will address SMS backend-related issues.
- NPHCDA leadership will advocate to state governors on HCWs salary review.

State of Preparedness of States for Introduction of New Vaccines

> “Attitude of healthcare workers also contributed to vaccines stock-out and poor SMS reporting”

A tabular presentation on the storage capacity in zones and NSCS's available capacity for national storage of new vaccines, and plans for storage expansion was shared by Department of logistics and health commodities. At the National level, additional storage space is needed at the national cold store. Zonal stores will continue to serve as trans-ducting storage contingencies. The ongoing plans for the NSCS to procure 500CM3 of walk-in-cold rooms would provide all the required storage capacity at the national level. Arrangement is ongoing to cater for the redesigned Hubs. At the national level, there is not enough cold chain capacity for new vaccines,

however, the three hubs will cater for this. The three hubs would also cater for zonal stores with no available capacity for new vaccines as the zonal stores would only be used as contingency plan. Few states like Ogun State requires storage space and are in the process of procuring Walk-in cold rooms.

The country is implementing the Cold Chain Equipment Optimization Platform (CCEOP), with the plan for the procurement of about 12,753 cold chain equipment, out of which 2,963CCE have been installed in Tranche 1. The Tranche 2 installation of 6,346 CCEs will commence before the end of the year 2020, and will provide adequate storage capacity at the LGA and HF levels. The CCEOP is covering expansion, rehabilitation and extension at the lower levels (LGAs and HFs) to ensure vaccines, including new vaccines to be introduced, are stored optimally. The goal is to achieve 100% of wards and LGAs with full/adequate capacity at the end of the Tranche 2 CCEOP deployment which were expected to be installed between Oct 2020 to Mar 2021.

New Vaccine Introduction and NPSIA 2020/2021 timelines
The timeline for activities listed in the chronogram are: (1) IMOP Implementation: July – October 2020, (2) MCV2 (Measles Conjugate Vaccine) Introduction: July – September 2020, (3) Rotavirus introduction (pre-implementation activities, Launch, phase 1 and phase 2): July – Oct, 2020, (4) IPV2 and HPV Introduction (Pre implementation activities from Aug 2020 – Feb 2021) and Launch Nationwide: March 2021, (5) Men A SIA (Supplementary Immunization Activities): December 2020 and March 2021 in selected states, (6) MVC (Measles Vaccine Campaign): Sep - Oct 2020, Feb- Mar 2021, and Sept - Oct 202 in some selected states, (7) MNTE (Maternal Neonatal Tetanus Elimination) for selected states: Sept - Oct 2020, Feb - Mar 2021, and June - July 2021, (8) YF (Yellow Fever) for selected states: Sept - Nov 2020 and April - May 2021. Three scenarios were presented for MCV2 involving 409 LGAs. The logistics team should advise on using and availability of data tools to grade state performance.

Assessment of Impact of Covid-19 on RI and other PHC services in the states
The impact of Covid-19 on RI and other PHC services in the states was assessed based on the 8 thematic areas - coordination and planning, service delivery, surveillance, RISS, logistics, M&E, demand creation, and human resources. In the North Central Zone, all parameters were <50% except for surveillance and M&E. Only RISS and demand creation met the cut-off of 80% in the North East Zone, while only demand creation met the cut-off in North West Zone. In the South-South Zone, all parameters were less than 50%, and none of the indicators met the cut-off. The South West Zone met the cut-off only in surveillance. Lagos State improved due to funds support from SOMIL for outreaches, especially for hard-to-reach areas, and WHO providing partial support for feeding and stipends. Impending massive retirement of experienced HW was raised, National promised to follow up with the Lagos State governor to ensure prompt replacement when that happens. In the South East Zone, none of the indicators met the cut-off mark, except Ebonyi that met cut-off for 4 parameters

Modified Integrated Medical Outreach Program (mI-MOP)
Covid-19 disrupted operations across all work streams. NPHCDA and partners are planning a Modified Integrated Medical Outreach Program (mI-MOP) to strengthen immunization and PHC services during Covid-19. A three-pronged approach was proposed; fixed post, temporary-fixed post and a mobile post across the 409 LGAs involved. Fixed post will run usual service using the staff at the facility. All health facilities will be open throughout the days of implementation. Community mobilisers will work in communities to mobilise clients to fixed posts. Provision of commodities as incentives at fixed post during implementation days. There will be integration of services at fixed posts- ITNs, CMAM, ANC, Delivery, PN4, Vit A supplementation, IMCS, FP and screening for other medical conditions (hypertension, diabetes etc). Referral services will be conduct to designated referral Centres. Immunization target group will be 0-23months. Temporary fixed post will have 1 vaccinator, 1 MCH officer, 1 community and 1 youth leader for crowd control, 1 town announcer, 1 community mobilizer, and 1 recorder. Mobile post will have 1 vaccinator, 1 MCH officer, and 1 recorder. The town announcer and community mobilizer from the ward will support mobilization efforts.

With regards to the requirement of face mask for proposed mI-MOP, the estimated cost of masks for HWs alone is 230,373,150 and for children and mother is 2,168,040,000, making a total of 2,398,413.150. However, NERRIC will seek guidance from CMC if masks should be procured for only HWs or for HWs, Children and their caregivers. UNICEF will align with national and provide support to LGAs not chosen for mI-MOP.

RISS Data by States
The number of RISS visits conducted at HF level reported by states have dropped by over 50% from Jan-May 2020, since the outbreak of Covid-19. RISS community survey reports by states showed that the commonest reasons for children being unimmunised/poorly immunised were caregiver's ignorance about immunisation or the NPI schedule, AEFI/fear of injections, and security challenges/unrest. Only 13 states submitted the June 2020 RISS reports/updates.

HFs routine immunisation supportive supervision have been low since march, however it improved from June to week 27. 2,424 HFs had 69% completeness of report, while 2,970 data (53%) were discarded.

Zonal report: The North East had highest supervisory visits, outreach sessions have increased, with 77% of sessions implemented. In the South West, Lagos had 64% micro availability plan implemented. Reasons for non-implementation include; lack of vaccines, logistics, non-accessibility, Covid-19 pandemic, and lockdown. Funding have increased from 10% to 20%. Vaccine and RI-related commodities were stocked out; HBV - 23%, BCG - 14%, data tools stock out, AFI - 25%, VMA1&B - 22%, stock out of syringes - 42%, and vaccination card - 14%. LGAs with vaccine stock out had dropped from 112 to 96 LGAs. HPV vaccine stock out

fell from 30% to 23%, and Penta vaccine stock outs in LGAs reduced from 5 to 1.

Temperature monitoring of cold chain: All states are doing well except for Delta with 50% functional capacity, while Delta and Enugu did not submit reports. Vaccine stock out occurred more in states with poor vaccine distribution system or push e.g. Kaduna, and Kogi. Edo, Nasarawa and Ogun states had 100% cold chain functionality, and Benue had 80%.

Data tools- updated vaccine management tools: VMA1a and b were available in 92% of all states' HFs, except for Kogi with greater than 70% of HFs where the tools were unavailable.

KAP of HWs on immunization: 87% of healthcare workers knew the immunization target, 92% knew the correct vaccination site, 91% knew how to correctly vaccinate, and 97% of HWs provide clients with the 6 key messages on vaccination. HWs that were trained over 1 year ago had knowledge gap in the target of immunization, while those with no training had 11% knowledge. Community linkage was 100% in 6 states, Kogi had the least at 67%. Delta State had 100% of HFs having meetings with community leaders, Plateau was least with 58%, Edo 0%, and the general average was 41%. HFs defaulter tracking was 100% in Niger, Nasarawa, Kogi and Bayelsa States, Edo and Ogun were 60%, Plateau was the least while the average was 95%.

Peer-led training was 0% in Edo and Enugu State, the national average was 58%. The general exit interview average was less than 90%. The caregivers' decision on RI is usually made by the mother in the South and the father in the North. Nationally it is the Father. Feedback showed that caregivers reported 99% satisfaction with RI Services, only 20% reported AF after last vaccine. Out of 18,672 children sampled, 81% were properly vaccinated, 15% partially immunized and 47% unimmunized. There was 96% card retention.

Discarded data: All (100%) the data from Anambra, Imo and Ondo were discarded. 55% of government data, 51% of CDC data, 50% of CHAI data, 50% UNICEF data and 50% of WHO data submitted were discarded. Concern over non-documentation of RISS by some states was expressed, while those who document, do so incorrectly. Suggestions to reduce amount of discarded data include training and retraining by data team. AEFI 6 key messages were reviewed.

North West Zone: Only one indicator was met in the zone. Kaduna State has no data for RISS. In Kebbi State, each SERRIC member was given 40,000 Naira each to go to LGAs. Every desk officer was expected to be accountable. NIOs and LIOs were supported to do supportive supervision, while LG SMS focal person was supported for supportive supervision and data entry. In the area of service delivery, RI providers in Kebbi State were paid directly for outreaches, which was increased from 2 to 4 per month. Community engagement strategies helped to support tracking of defaulters and retrieved data from focal Persons in 21 LGAs. Kebbi State has serious HR challenges. In 618 HFs conducting RI, some have only 1 healthcare worker providing all interventions. The healthcare workers were overworked, and some facilities were locked up because there is no healthcare worker to provide services. The Kebbi State DSNO is fully engaged in Covid-19 activities, so was unable to provide data to GAVI team. There is measles outbreak, with 81 cases in one month in 18 LGAs. The Kebbi Commissioner of Health and Permanent Secretary met to provide PPE for HWs in PHCs. The State intend to use SMS data to take actions and ensure accountability at HF, and LGA levels, and desk officer. The monthly zoom meetings have 40 participants supported by WHO.

Kano State planned to increase SMS data from 40% to 70%. Jigawa State had problem with RISS, resolved issues at LGA and State levels through 'jarkalafiya'. The State government provision of logistic and stipends to HWs was poor, which affected the conduct and supervision of outreaches. There are serious problems with HR, lots of casual workers were engaged and given stipends to reach nomads. There was no support for the conduct of planned RISS, and 27 LGAs lack funds and still awaiting release of funds captured in state budget. In Sokoto State, quarter 3 vaccines were received but BCG, IPV OPV were insufficient. Coordination and planning meetings were held twice weekly to address poor supervision of community outreach. The involvement of the Sokoto sultanate council in mobilizing villages and settlements improved demand creation. The M&E was optimized through field and HF supervision. Zamfara State has good coordination by ES and EOC, which meets three times per week for SERRIC meetings. Also, there is good coverage in spite of insecurity. However, Zamfara State had some challenges such as RISS and HR problems. In last 1-2yrs there were lots of retirement without replacement, so community volunteers were engaged and received stipends from SOMIL.

There is poor logistics support. The SERICC team is awaiting response to proposal to state PHCB, WHO, UNICEF and CDC. WHO supported training of midwives but HF lack tracking systems especially general hospitals. NPHCDA provided CCE to all 225 wards for daily sessions. ORIS strategy integrates all interventions at PHC but was affected by lack of adequate HWs, especially ANC. The monthly oversight visit by ES helped to improve HF delivery. The restriction on outreaches has now been lifted, so there is need for support to conduct outreaches and fixed sessions at secondary and tertiary facilities. The team is currently expecting distribution of PPE from donors for Covid-19.

> "Kano State planned to increase SMS data from 40% to 70%"

South East Zone: In Abia State, 7 LGAs were below 50% performance, inter phasing with RIOs will improve performance. Surveillance is good. Abia State is awaiting assistance from UNICEF, SOMIL and other partners., and expect national to follow up. Enugu State's coordination and planning meetings were now more regular. However, service delivery dropped due to lockdown but fixed sessions

continued even though patient turnout was low. Surveillance was poor due to lack of desk officer, so all information was sourced from disease surveillance officer in the SMoH. The cold chain system is functional but distribution of vaccines to HFs was poor due to out of pocket financing. This was also due to lack of funds and partner or government support for logistics. The M&E was affected by lack of funds. Only UNICEF supports RI activities in Enugu State. There is a severe HR problem and no partner will support ad-hoc HR recruitment. Demand creation has improved through increasing community awareness. The Programme Manager suggested liaising with national Pharmacist to help with vaccine cold store. Imo State was the best performing state in the south east zone, 5 indicators met target. The coordination meeting is held physically on weekly basis. RISS was not funded, so routine supportive supervision was conducted in nearby LGAs. The State CCO collects vaccines using out of pocket money, which becomes difficult due to non-payment of salary. The budget submitted to SOMIL was not approved. M&E was affected by lack of monthly summary vaccine utilization data tool in most LGAs. The HR was affected by lack of PPE for HWs which hindered the conduct of outreaches and fixed sessions.

Update on Call Centre
Template for financial resource mapping in states will provide information and visibility on available resources, identify gaps in resource mobilization, and identify potential funding sources for mobilizing funds. Thematic areas that will be addressed are: program management and coordination, service delivery, data management and M&E, demand creation, supply chain, and other activities.

Vaccine management tools review
The National Logistics Working Group (NLWG) reviewed the following tools: VMIA, VM1B, and VM2. Columns for Name of HF and ward were removed, leaving only LGA and state. Columns for minimum and maximum temperatures were added in VM2 to help track HF temperature monitoring. Column for 'CCM' was changed to 'CCM/Freeze indicator'. 'Arrival brought forward (B/F) surplus deficit return' cell was moved from bottom to top of form, so that the HW would have thought it through before commencing vaccination session. 'check at issue' was changed to 'checked by issuing officer', 'check at receipt' was changed to 'checked by issuing officer'.

DHIS Vaccine utilization summary form was removed and replaced by VM2. Opened and closed vial wastage rate calculation formula was amended. Updated VM2 was adapted to include DHIS2 vaccine utilization tool details. Vaccine delivery/injection equipment ledger and Vaccine requisition form-requisition issue/receipt were reviewed.

Feedback from states after interventions to resolve challenges with RI

South-South Zone: Surveillance, logistics and demand creation were the indicators that made the cut off. Akwa Ibom achieved 6 out of 8 indicators, after improved follow-up by national, and additional funds sourced by the SIO for their activities. Akwa Ibom had ongoing coordination meetings. Cross River has a more regular coordination/ SERICC meetings with good attendance by HODs. The work-plan was harmonized, and awaiting disbursement of funds. Demand creation in Cross River is still poor due to lack of funds for outreaches and poor HR due to fear of coronavirus. Service delivery was ongoing at the HFs and vaccine delivery to HFs from the LGAs has improved. RISS was still poor due to poor funding, and no supportive supervision was conducted. Edo state has no funds for supportive supervision but the ES fixed 2 Hilux vans to assist. Coordination and planning meetings were regular but no funds for SMS reporting and data entry. Immunization task force has been suspended due to forthcoming elections, however program officer and HODs working together to improve performance.

In Delta State, performance was less than the pass mark though improving. Delta State did not meet any of the indicators cut-off. Committee has not been inaugurated. Commissioner of Health and out-gone chairman met with ED and board chairman, LIOs and RI working committee on the way forward. The State has not accessed UNICEF funds, and has not received a zoom license from national. Rivers State has recently received license and are yet to begin zoom meetings. Also, the State was unable to load data. Ongoing sensitization will improve demand creation.

North Central Zone: Benue State team was inaugurated in Oct 2019, and taskforce was inaugurated in all 33 LGAs. The Deputy governor was interested in RI and was very supportive, attends monthly task force meetings, and was responsible for the success achieved so far. He provided laptops for SERICC secretariat and sponsored zoom meetings. Only PHC board supports SERICC and RI activities making it difficult to meet indicators but SERICC had meetings with LGA desk officers, LGA immunization officers and directors of LGA health activities. APIN has promised support of monthly meetings. The Deputy governor has promised to improve service delivery by recruiting more workers. The RISS was not doing well due to lack of funds, and only few HFs conduct outreaches.

The ES is still pushing for the release of promised SOMIL funds for June. The State team requested that National should follow up with state government to lift embargo on employment. Benue State was doing well in surveillance, all 23 LGA surveillance officers reported. The State have functional cold chain but no funds to push vaccines to the HFs. The Commissioner of Health promised to buy new refrigerators for cold room. The M&E department still have problems due to lack of data tools. WHO helped photocopy some forms for January and February which have been exhausted. UNICEF is not producing data tools, so there is request for the National support. Demand creation was poor but immunization on-going at the HFs but one worker per HF. RISS was not carried out due to lack of funds from SOMIL and PHC board as previously promised. UNICEF promised support with 3.8 million for 71 poorly performing wards, but yet to be released. M&E was ongoing, and reports from DHIS were analysed per LGA on the platform. Coordination meeting initially

held 3 times weekly, was now inconsistent due to lack of funds and out of pocket expenses was not possible due to salary cut.

Coordination meetings in Niger State were irregular due to lack of funds for phone data, so currently leveraging WHO meetings. All partners promised to help with data through service providers. Service delivery was affected by Covid-19 but fixed sessions and outreaches are still ongoing. HR issues was still a challenge and there are problems with accountability and transparency. Niger State appealed to National to help with transfer of workers salary from State PHC to LGA for improved accountability. Surveillance is good as a result of strong support from the ED, TA and State coordinator for NPHCDA. RISS was down due to lack of funds though SOMIL tried to help. M&E was good because data tools are adequate and properly filled. Demand creation increased following adequate provision of PPE for HW and training. The programme manager promised to follow up on HR problems. Dashboard on assessment of Covid-19 impact on RI and PHC services was created.
FCT was the least performing with only 3 out of 8 indicators meeting the cut-off marks; logistics, demand creation and surveillance.

“Coordination meetings in Niger State were irregular due to lack of funds for phone data”

South East Zone: Only surveillance and demand creation met the cut-off.

Contributions from dRPC-PAS CSO

- Children <6yr were not recommended to wear masks, so removing cost of masks for children might reduce total cost of masks for mIMOP.
- Contributed to finalizing SMS messages to HWs, adverse events and intervention by caregiver
- To address persistent vaccine stock out in some HFs in some states, it was recommended that the national should assist states to get funds from the governors to facilitate transportation of vaccines from cold stores to the HFs or make vehicles available to enable this. Also, national should identify HW responsible for vaccine transportation from whom feedback could be required.
- To avoid high rate of discarded data, training and retraining of HWs on the correct use of the data tools was proposed. Also, we suggested that data tool mostly affected should be identified and properly address the issue.

STATE EMERGENCY ROUTINE IMMUNIZATION COORDINATION CENTRE (SERICC)

KADUNA STATE

PAS-CSO – the National Association of Nigeria Nurses and Midwives (NANNM-PAS) attended 13 SERICC meetings for the month of July 2020. Some of the issues discussed and contributions include;

Distribution of vaccines: With regards to stock-out, LWG reported arrival of Q3 vaccines receipt from the National via the NW Zone. The DVD of received stock will be hasten in order not to create a gap. There was a shortfall of some vaccines in the Q3 supply. The specific vaccines and quantity will be ascertained.

Data tools for the assessment of Covid-19 impact on PGC Services in the State is almost ready. The CEWG reported progress towards Measles campaign and held meetings with Traditional Leaders and other stakeholders. Week 1-28 daily RI Sessions Evaluation report was shared. 273 health facilities out of 295 conducted daily sessions. Coverage rates are lower in the month across selected antigens comparing operational target with projected census figures. There is high negative dropout in 9/23 LGAs. 8 out of 23 LGAs conducted more RI sessions for fixed and outreach than planned.

The Covid-19 pandemic affected PHC operations, resources & service uptake. The level of impact is easing off as lockdown is partially lifted. Full recovery is possible but will be gradual.

RI Data Tools: AEFI details was not submitted for the update of the form. AEFI content will be made available for inclusion in subsequent production. PM & MGF RI Consultant will follow up concerning data tools printing so as to expedite No Objection approval.

NANNM-PAS observed that Pneumonia in under-5s was captured as treated with antibiotics against Amoxicillin DT. Observation upheld & DPM 3 will pull out those treated with Amoxicillin DT.

Challenges identified include; data quality issues on SMS reporting from 40 HFs of 18 LGAs, and stock-out of some antigens. The LWG indicated that supply is on the way. Also, there are security compromised communities in Chikun LGA. The security compromised communities were not in IDP camp, so organizing an RI session for them was not feasible.

NANNM-PAS Contribution: We proposed that State team should locate the location of the displaced communities. Programme Officers should track the approval process to ensure planned activities were not left out.

Next Steps

- Desk Officers of affected LGAs should identify factor(s) responsible for data quality issues.
- The M&E WG will liaise with the LGA to find out whether security compromised communities are in the IDP camp.
- Follow up with the National will be intensified
- Desk Officers of Soba & Kaura LGAs should follow up to identify cause of Zero SMS Reporting
- SIO/Desk Officers should find out why some facilities are not conducting daily RI Sessions
- Weekly LERICC meeting minutes should be shared with SERICC
- OIRIS visits should focus on affected facilities
- Disseminate findings of Covid-19 assessment to stakeholders
- Community Engagement activities should be intensified

Local Emergency Routine Immunization Coordination Centre (LERICC)

ZARIA LGA, KADUNA STATE

In Zaria LGA, Kaduna State, PAS-CSO – MAFAHSU/PAS attended 4 LERICC meetings for the month of July 2020. Some of the issues discussed and contributions include;
Monthly review meeting and RI data validation

> “There was consistently low NHMIS reporting rate”

There was consistently low NHMIS reporting rate of less than 80%, stockout of yellow fever and HBV vaccine across the LGA, and data discrepancies between OPD register, General attendance register, ANC, RI register, and the NHMIS monthly summary. Some HFs conducted only one session per week, and Four HFs reported unofficial outreaches. There was some improvement in completeness of SMS report in week 29 compared to week 30, although 11 HFs did not send the complete report.




Recommendations/ contributions from MAFAHSU-PAS

- MAFAHSU/PAS advised that some staff should be trained on issues identified as weak areas.
- Supervisors should rectify any simple issues instantly and report the complex ones to the LGHA management.
- MAFAHSU/PAS recommended that M&E, NHMISO, and WFPs should identify and visit
- private HFs that are functional and not reporting the LGA.
- Also, LCCO should plan to retrieve yellow fever vaccine and HBV from those APEX facilities with excess to those that are highly in need.
- It was further suggested that all the program managers should sit during monthly data validation and compare the report submitted to them with M&E/NHMIS before upload it to the server.
- HFs that do not conduct daily session should conduct more than one session considering their target population.
- RI providers should report only outreach session that was approved officially by KSPHCDA.
- WFPs should notify the HFs under their ward about settlements that should be served with outreach sessions.
- MAFAHSU/PAS suggested that RIOs/HMISO should identify and follow-up facilities sending RI SMS to the server on planned sessions only without children immunized.

NIGER STATE

No SERICC meeting was held in Niger State for the month of July 2020.

KANO STATE

11 SERICC meetings were planned and conducted in Kano State during this reporting period of July 2020. PAS-CSOs - Medical Women Association of Nigeria (MWAN-PAS), and Women in Media Communication Initiative (WIM -PAS) participated in all meetings. Some of the key issues discussed and contributions for the month include;

SERICC Team Visit to Makoda LGA

To address the issue of low RI coverage in Makoda LGA, SERICC conducted a deep dive analysis to assess the RI performance in the LGA. A visit aimed at evaluating RI performance was made to the LGA, to provide technical guidance and mitigate the current situation. The following performance indicators were assessed; Dropout rate, Penta 3 coverage; Supportive supervision visits conducted; Number of unimmunized children; Percentage of fixed sessions conducted; and Percentage of outreach sessions. Makoda LGA has low performance in 5 out 6 indicators. Key findings of the visit were weak community engagement structure, poor performance of the health workers, inadequate monitoring and supervision of RI activities, poor knowledge of the TOR and deliverables of line officers by the LGA team and individuals, far distance of health workers residences to the LGA, and lack of teamwork. Some proactive measures taken by the LGA team include: advocacy to the LGA leadership to address transport issues faced by health workers during Covid-19 pandemic; and development of a mitigation plan.

Action Points include; (1) a committee was formed to develop a guideline on how to conduct SERICC supervision visit, and (2) M&E WG should include surveillance data into the monthly feedback report.

SERICC LGA Visit

SERICC resolved to either invite or visit LGAs with key issues regarding RI. The LGAs are:

1. Albasu, Nasarawa, Minjibir and Tarauni LGAs with monthly coverage of selected antigens below 50% in 8 out of 10 selected antigens.
2. Dala and Nasarawa LGAs had high number of unimmunized children by antigen.
3. Tarauni, Bichi, Tsanyawa and Bagwai LGAs had high Penta dropout rate.
4. Fagge, Nasarawa, Tarauni and Kano Municipal had low supportive supervision visits conducted by the LGA
5. Takai LGA did not report data for supervision conducted.

SERICC will visit Tarauni and Nasarawa LGAs, while Albasu, Bichi, Bagwai, Dala, Kano Municipal, Minjibir, Tofa, Tsanyawa and Takia LGAs will be invited to the Board Headquarters.

Action Points include; (1) SERICC will visit Tofa, Tarauni and Nasarawa; (2) All Health facilities should send their weekly session plan according to the days planned for MNCHW; and (3) Invitation letters should be sent to the LGAs to be invited by SERICC.

Unimmunized Children and Target Population for RI MNCHW

MNCHW is a period when the backlogs of unimmunized children are moped up; It is a catch-up campaign for RI and other child killer diseases. The percentage coverage at LGAs and health facilities are calculated by putting the number of children vaccinated during MNCHW divided by Total Population. LGAs should provide feedback report to SERICC with the number of children immunized and coverage after the implementation.

Action Point: SERICC will share presentation of unimmunized and target population for RI MNCHW with RIOs

> “No SERICC meeting was held in Niger State for the month of July”

Preliminary Report on Impact Assessment of Covid-19 on PHC Services

Since the first case of Covid-19 virus was reported in Kano state on April 11, 2020, the number of cases rapidly rose to over 1000 within two months. This brought the need to conduct an assessment to understand the impact of Covid-19 on RI and PHC services.

The assessment aimed to determine the effect of Covid-19 pandemic on key program indicators, understand stakeholders' perception of Covid-19 related factors affecting PHC programs, and to inform tailored interventions. The overall goal was

to assess the impact of Covid-19 pandemic in Kano state RI and PHC service. It assessed the functionality across 6 thematic areas: leadership and government, services delivery, monitoring evaluation/ supportive supervision, community engagement, supply chain and logistics management, and financial management.

There was a notable decrease in number of HFs offering essential PHC services since March 2020 and there was a significant reduction in the uptake of all essential services from April 2020.

Preliminary findings on reasons for the decline in PHC services are: (I) Complete/partial closure of some facilities, (II) Delayed and/or non-conduct of services due to unavailability of health workers as a result of limited availability of commercial vehicles during the lockdown, (III) Lack of testing kits for PMTCT services, and (IV) Data reporting error from some facilities and LGA M&E officers. The data obtained from DHIS2 will be further validated by the reports from the state DFR and detailed information from the state M&E officer.

Next Steps

- State supervisor will provide feedback to SERICC on LGAs with issues for week 27 SMS Report, and filter and share defaulting health facilities by zones.
- State supervisor will provide feedback on defaulting health facilities to SERICC.
- Committee will analyse and identify LGAs performing below target for SERICC intervention.
- Provide update on the impact assessment of Covid-19 on PHC
- M&E WG should identify the low performing LGAs using the DHIS2 June report.
- Print and paste list of low performing LGAs on SERICC notice board
- Development schedule of LGAs for SERICC visits and for invitation to SERICC
- Share SMS report with the RIOs
- Invitation letters should be sent to Albasu, Minjibir, Dala, KMC, Tsanyawa, Bichi, Bagwai,Fagge & Takai LGAs.
- Share presentation of unimmunized and target population for RI MNCHW with RIOs
- Send a reminder to RIOs and M&E to send their ODK to National Server
- Remind senior supervisors to fill the National ODK on supervision
- TA should share the prioritize activities for Q1&Q2 with Sec
- SEC should share the approved 2020 work plan
- Participants in the SERICC virtual meetings that goes on and off will not be included in the attendances' sheets.
- State supervisors should follow up with LGAs having issues
- Share monthly zonal RI review meeting posting with the state supervisors and report back to SERICC for data analysis.

LAGOS STATE

PAS-CSO – Alumni Association of the National Institute (AANI) attended the Lagos State SERICC (RITWG review) meetings held twice a month for the month of July 2020. Some of the issues discussed and contributions include;

Lagos State Q2 2020 RI Performance Review

The RI workplan was reviewed and categorized as done, on-going, and not done. 54 indicators were reviewed from the key thematic areas on the workplan. 72% (39) of the planned Q2 2020 activities on the state work plan were completed, 26% (14) were not done and 2% (1) was ongoing. 33% of the planned coordination thematic area activities were not carried out in the last quarter. There was 100% availability of all antigens. No stock out was reported across Lagos State, LGAs or HF. There was increase in RISS visits to HFs and consistent monthly review of RI activities despite the pandemic.

Key challenges in this quarter were shortage of health personnel, competing State priorities which affected funding, data discrepancies across different data tools/sources, overwhelmed healthcare workers in Q2, healthcare workers were infected with Covid-19 and in isolation, and PHCs were shut down due to Covid-19 infection.

State Level Report

Lagos State June 2020 RI feedback showed that cumulatively the state conducted 5423 out of planned fixed sessions of 5383 (98%), 140 were not conducted. This was due to public holidays and the non-conduction of RI in some facilities as a result of Covid-19. 961 out of 1126 planned outreach sessions were conducted. Badagry conducted only 32% of her planned RI outreach sessions and Mushin LGA did not plan nor conduct any RI outreach sessions. This was due to the impact of Covid-19 on this LGA, as they refused to release health workers from Covid-19 related activities. Also, this was due to lack of funds for stipends and transportation for the mobilisers. The cumulative Penta 3 coverage for Lagos State for June 2020 was 63%, and the dropout rate was 13%.

RI performance summary in Lagos for June 2020 showed a general improvement across board in all indices compared to May 2020 and April 2020 of the last quarter. However, in comparison to the same period in 2019 the program showed a decline which is due to the negative impact of Covid-19 on RI program. This pattern was also seen for pregnant women assessing ANC. The state still recorded a higher number of children vaccinated based on the hardcopy of the LGA summary than the DHIS, the nationally recognized data platform. Other challenges faced by the state includes irregular RI sessions conducted due to lack of funds, lack of Penta 3 charts at the HF in the state, lack of ownership of the PHC by the community members, and inadequate information on RI on social and mainstream media. There were low demand creation activities through community dialogue and linkages. Ojo and Lagos-mainland LGAs did not conducted any demand creation activity. Oshodi, Kosoofe and Ikorodu LGAs recorded low performance. Also, there has been no support for defaulter tracing and community linkages activities.

Vaccine Management/ Cold chain and logistics update

58% of the health facilities currently have functional CCE (4% increase), 18% of HFs currently have faulty CCE (2% increase), and 24% of the existing HFs do not have active cold chain equipment (5% decrease). 42 SDD were distributed to 10 LGAs, more will be distributed in the second tranche across all LGAs. Across Lagos State, there are 757 cold boxes, 4502 Giostyles and 1964 RUSH. Temperature monitoring across all LGAs were fine except for Alimosho LGA where heat excursion was recorded at Akinyele and Ikola ward. Also, cold excursion was recorded at Akinogun wards.

Wastage rate (Penta) across Lagos State did not exceed 25%. All LGAs have sufficient vaccine stock except for Apapa LGA that is on a reorder point for OPV which has been issued. The State was very low on IPV (stage II), on reorder point for Penta and Hep B. Generally, third quarter supply is needed.

Support from Partner

UNICEF plans to conduct Vaccine Management training virtually. CHAI will conduct a data assessment for improved data quality and accountability framework.

Performance Review for Two Local Government Areas

Kosofe LGA has 13 public HFs and 39 private HFs conducting RI, with a population of 1,087,573 in 21 wards. Coverage for BCG was 41%, Penta- 45%, IPV- 45%, Measles – 52%, and TT2 was 28%. Dropout rate was 7%, Fixed sessions held was 100% and outreach sessions held was 64%. Kosofe LGA has an overall low coverage compared to the target population of 21,732, which was compounded by the ongoing Covid-19 pandemic prompting the shutdown of some facilities. 50% of the planned RISS was held, and 3 AEFI was reported. With regards to capacity building through peer led learning, 18 HF conducted and 28 did not conduct any peer learning. Vaccine wastage rate for all antigen was below acceptable rate.

> “Key challenges in this quarter were shortage of health personnel, competing State priorities which affected funding, data discrepancies across different data tools/sources, overwhelmed healthcare workers in Q2”

Lagos Island LGA has a population of 518,830 and 18 wards. There are 16 Public HFs and 10 Private HFs conducting RI. Coverage for BCG was 54%, Penta 3 - 61%, IPV - 61%, Measles- 40%, and TT2 was 29%. Dropout rate was 10%, Fixed sessions held was 100%, and outreach sessions held was 95%. All antigen coverages were below expected national target with a cumulative number of immunized children in Lagos Island below national target. RI

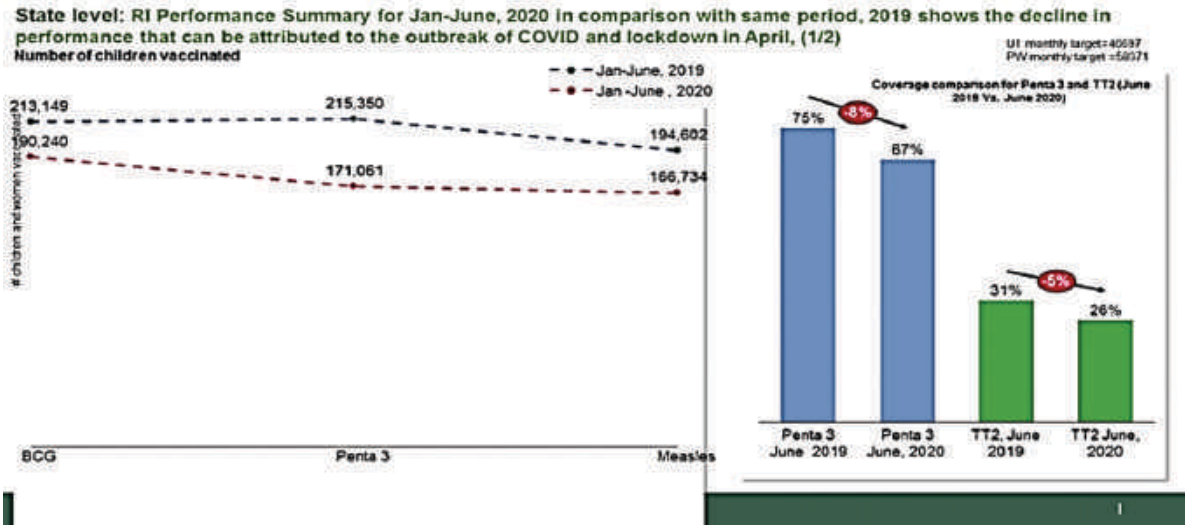
performance analysis showed elevated cumulative unimmunized children (0- 11months). 15 of the planned RISS were conducted with 24 not conducted. Peer led learning for capacity building were held in 8 HFs (Public) while 10 HFs (private) did not conduct any.1 AEFI was reported, and Vaccine wastage rate was below the acceptable.

Some of the challenges that affected performance were; lack of utility vehicle to enhance effective supervision of RI services (fixed and outreaches), delay/non reporting due to Covid-19 pandemic especially private health facilities, unreliable estimated population data, incessant changing of trained private hospitals health workers, and reduced number of caregivers assessing health facilities due to Covid-19.

Proposed way forward include; provision of adequate fund for outreaches due to increase in transportation which has affected service utilization; LGA/LCDAs should take ownership of outreach sessions; strategies to mitigate the impact of Covid-19 on RI should be proposed; intensify community mobilization and acceptance of PHC services; State and LGA team should increase the conduct of RISS to health facility level; and adequate provision of funds for outreach mobilization.

Contributions from AANI

AANI raised the issue of continuous delay in the setting up of the Finance technical working group which was moved forward. The delay was because the Commissioner of Health needed to head the working group and his commitment is required which could not be secured at this time due to Covid-19. Another issue raised was the reported data for TTS for the month of June which was unduly high and suspicious. It was agreed that the State Immunisation Officer will review and make corrections. Lastly improvement in the data reported was observed, it has less discrepancies compared to previous quarter. It was recommended that efforts should be put into intensifying the data harmonization meeting so as to reduce data discrepancies across data tools/sources.



7.0 PAS COLLABORATION WITH BMGF GRANTEES & CAPACITY BUILDING SUPPORT TO SUBGRANTEES

KANO STATE	PAS NGOs WIM-PAS and MWAN-PAS collaborated with other BMGF grantees CHAI and Solina to conduct the monitoring visit to RI low performing LGAs Tofa and Taraumi. MWAN-PAS supported the Group ANC Stakeholder Orientation Workshop held on Tuesday 7th and Wednesday 8th July 2020 which was supported by CHAI.
KADUNA STATE	PAS NGOs collaborated with the 2019 BMGF Goalkeepers to engage with Kaduna state government virtually to discuss the funding issues and the emerging issues in the face of the redistribution of the 2020 health budget for covid-19.
NIGER STATE	Niger PAS collaborated in the validation of the draft 1 BHCPF indicators organised by BMGF Grantee E4A, this was for the tracking of BHCPF implementation in Niger State.

The following are a list of knowledge products produced by dRPC-PAS and PAS subgrantees in July 2020;

dRPC-PAS	Implications of covid-19 on the 2020 revised Routine Immunization budget at the national and in PAS states.
KANO STATE	Kano 2020 Revised Health Budget Performance Analysis.

9.0 REFERENCES

1. Comparative analysis of the reviewed 2020 health budget allocations.
2. Emerging Issues at the national and subnational levels.
3. Status update on the routine immunization budget for national and in PAS states.
4. Monthly narrative report for Kaduna state.
5. Monthly narrative report for Kano state.
6. Monthly narrative report for Niger state.
7. Monthly narrative report for Lagos state.

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