Nigeria MNCH Country Summary, March 2017

Country - Selected Demographic and Health Indicators for Country					
Indicator	**Data**	**Indicator**	**Data**	**Indicator**	**Data**
Population[2]	182,202,000	TFR (births per woman)[1]	5.5	DTP3[1]	38%
Live births/year[2]	7,133,000	CPR (modern methods)[1]	9.8%	Care seeking for pneumonia[1]	34.5%
MMR (per100,000 live births)[1]	576	ANC +4[1]	51.1%	Care seeking for diarrhea [1]	28.9%
NMR (per 1,000 live births)[1]	37	SBA (Ages 14-49)[1]	61%	Stunting (height for age <5)[1]	37%
U5MR (per 1,000 live births)[1]	128	IPTP3[3]	19%	HIV prevalence or Other[1]	4.1 %

Sources: [1] Nigeria DHS 2013; [2] Countdown to 2015, The 2015 Report: Nigeria; [3] Nigeria MIS, 2015.

Strategic Objectives

- To improve quality of facility-based MNH/PPFP services, and of community facility-based child health services.
- To improve health information systems to monitor service delivery and health outcomes.
- To increase use of lifesaving innovations.

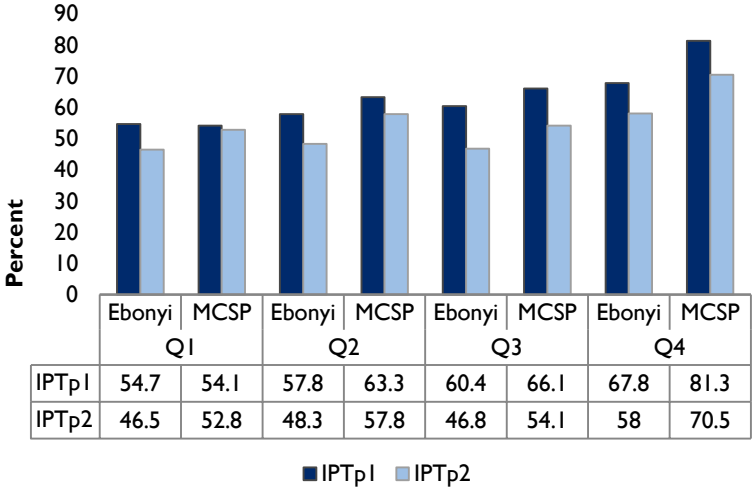
Program Dates	October 1, 2014 – December 31, 2018			
Financial Status	Expenditures thru PY2 [redacted]; PY3 Budget [redacted]; Total [redacted]			
Geographic Scope	Ebonyi and Kogi States			
Geographic Presence	**No. of provinces (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**	**Projected Population by 2016 (SMOH)**

	2 states (5.5%)	Kogi: 21 LGAs (100%) Ebonyi: 13 LGAs (100%)	Phases I and II: 240 facilities (24%)	Kogi: 4,405,625 Ebonyi: 2,637,001
Technical Interventions	 PRIMARY: Maternal Health, Newborn Health, Child Health, Reproductive Health (Postpartum Family Planning) CROSS-CUTTING: Adolescent Sexual and Reproductive Health; Gender, Health Systems Strengthening, Quality Improvement			

Key Accomplishments

MCSP/Nigeria's maternal, newborn and child health (MNCH) program focuses on improving the quality and utilization of MNCH services in public and private facilities in Kogi and Ebonyi states. MCSP aims to contribute to a reduction in maternal and neonatal mortality and increase utilization of quality emergency obstetric and newborn care (EmONC) services by pregnant women, mothers and their newborns. MCSP also aims to contribute to reductions in under-five mortality by increasing access to integrated, high-quality curative child health services. MCSP is supporting improvements in quality of routine care as well, such as supporting antenatal care (ANC) services. As shown in Figure 1, the percentage of pregnant women receiving IPTp1 and IPTp2 from MCSP supported facilities was higher than the average for the entire Ebonyi state according to routine service statistic data from DHIS2.

Figure 1. IPTp1 and IPTp2 in Ebonyi state and in MCSP supported health facilities, October 2016 to September 2017



	Ebonyi Q1	MCSP Q1	Ebonyi Q2	MCSP Q2	Ebonyi Q3	MCSP Q3	Ebonyi Q4	MCSP Q4
IPTp1	54.7	54.1	57.8	63.3	60.4	66.1	67.8	81.3
IPTp2	46.5	52.8	48.3	57.8	46.8	54.1	58	70.5

Maternal, Newborn and Child Health: MCSP's MNCH program empowered over 1,498 health care workers across 120 facilities with lifesaving skills to provide evidence-based basic emergency obstetrics and newborn care (BEmONC) to pregnant women, postpartum women and newborns. Health care workers gained new or improved skills to perform clinical procedures such as active management of the third stage of labor screening and management of pre-eclampsia/eclampsia, use of partograph, manual removal of the placenta, prevention, diagnosis and treatment of postpartum hemorrhage, and newborn resuscitation. Some immediate outcomes of the training were successful removal of placenta for patients with retained placenta and increase in number of newborns with birth asphyxia that were successfully resuscitated. To date, out of 216 babies not breathing at birth, 211 (98%) were successfully resuscitated.

With MCSP support, the national Essential Newborn Care Course training materials, Nigeria Every Newborn Action Plan and the National Strategy for Scale-up of Chlorhexidine in Nigeria were finalized. Newborn resuscitation corners were established in 48 facilities in the program states, KMC spaces were established in 8 health facilities in Ebonyi State and 12 PUMANI bubble continuous positive airway pressure (bCPAP) machines were placed in six facilities as an innovative technology for saving preterm newborns with respiratory distress.

Monthly follow-up training visits were conducted to program facilities by MCSP staff and professional associations to ensure that skills learned during trainings were being applied in service delivery. In addition, a total of 28 core staff from the State Ministry of Health (SMOH), local government area (LGA), and professional associations were trained on the use of the newly approved integrated supportive supervision tools by the Federal Ministry of Health (FMOH) to mentor and supervise health care workers in hospital and primary health care facilities to ensure quality of maternal and newborn service delivery in both states.

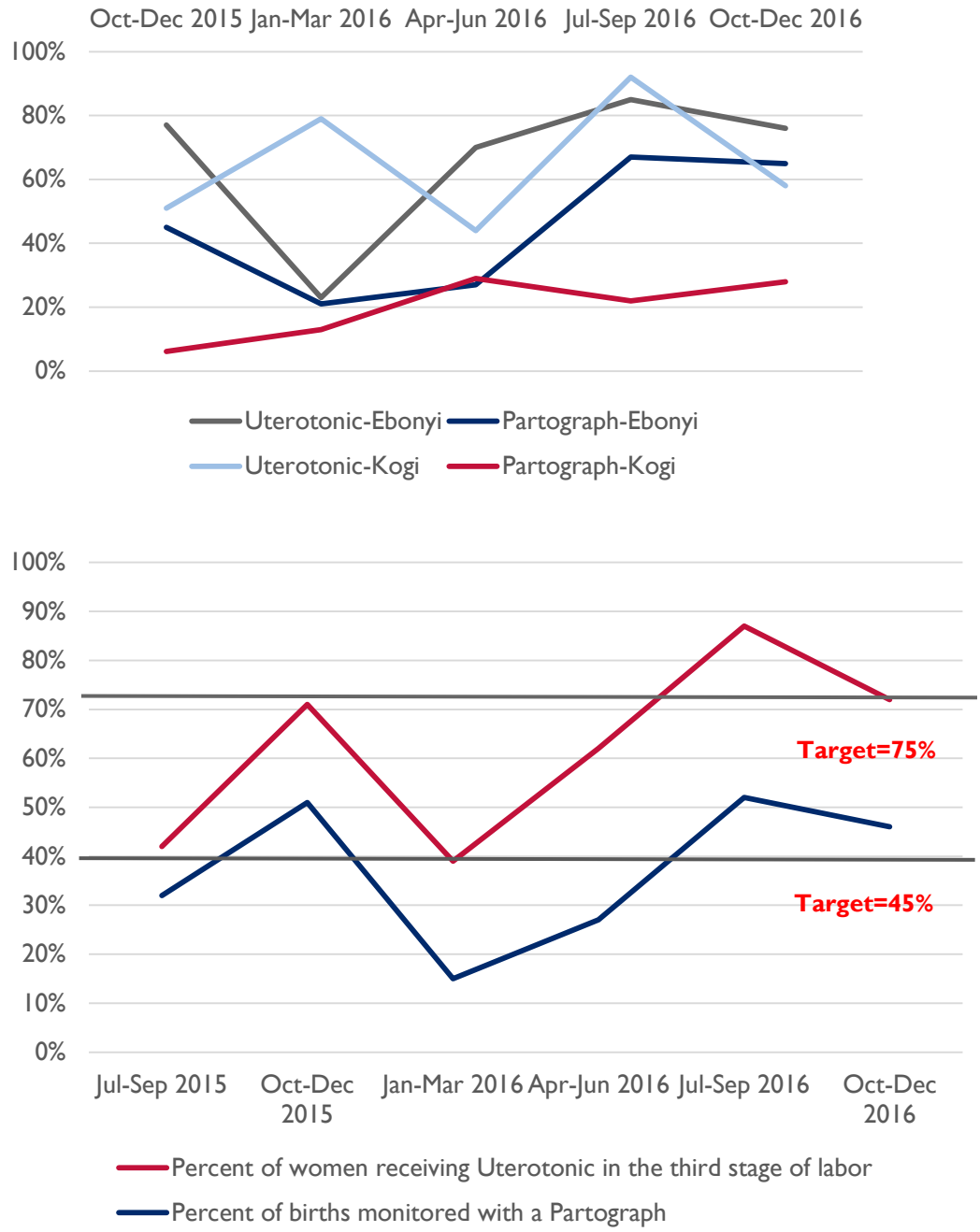
MCSP expedited policy change so community based lay providers can give the recommended antibiotic to sick children with pneumonia. There was an impasse among stakeholders so MCSP supported a mapping and analysis of perceived barriers, and opportunities to increase access to treatment of pneumonia, which can be fatal if untreated. MCSP proposed and helped the Honorable Minister, FMOH, to convene a round table harmonization meeting with key stakeholders to align the three policy documents (Essential Medicines List and standard treatment guidelines, National iCCM Implementation Guidelines and Task Shifting and Task Sharing Policy) to reflect consistent guidance and mandate the use of Amoxicillin Dispersible Tablet (AMX DT) as a first line medicine for children under five at community level by community-oriented resource persons, including private patent medical vendors. The meeting resulted in a revised policy that will be implemented at the state level, creating an enabling environment for MCSP to introduce iCCM at the community level in Kogi and Ebonyi states.

Further, MCSP began integrating gender into mainstream MNCH services in Ebonyi and Kogi states with about 80 health care workers from 39 facilities already oriented toward being gender sensitive in providing health care services in the states. The trained service providers are now more mindful of gender barriers that could affect the uptake of quality maternal, newborn, child and adolescent health and how to offer respectful and dignified care. They can mitigate disrespect and abuse during childbirth, and promote male involvement in RMNCAH as well as shared-decision making for women and their partners.

Quality Improvement: MCSP raised greater awareness toward institutionalizing and operationalizing quality improvement approaches in Ebonyi and Kogi states leading to the creation of quality improvement teams at facility, LGA, and state levels. MCSP also mobilized efforts toward the development of a quality of care national framework for Nigeria with a draft concept table for the framework agreed upon at the third technical working group (TWG)/stakeholders meeting on MNH quality of care.

To monitor quality of labor and delivery care, MCSP tracked the percentage of deliveries monitored by the use of the partograph in the program states as well as provision of an uterotonic immediately after birth to prevent postpartum hemorrhage. Figure 2 shows variation in the trends of using uterotonic for the third stage of labor for the program states. It should be noted that MCSP depends on the DHIS2 to track and report routine service statistics, and there were a series of strikes by health care workers in the two program states during the reporting year, particularly from January to April 2016. During the strikes, health care providers were not providing services to patients because the facilities were closed down for services due to salaries arrears. Therefore, services were stalled in all health facilities, and data were not entered into DHIS2 when due. Lack of partographs was also a constraint in many facilities to achieving higher partograph use.

Fig. 2: Percent of births monitored with a partograph and women who received a uterotonic at the third stage of labor – by state (Oct 15 – Sep16)



Reproductive Health (Postpartum Family Planning [PPFP]): MCSP supported 22 health facilities and trained 53 health workers from these facilities to initiate PPIUD services in PY2. Further, MCSP trained 16 PPIUD service providers as PP-LARC trainers and to scale up PPIUD and postpartum implants services. There were 763 new acceptors of PPFP methods during the period in program-supported sites. MCSP also supported the review of national FP training materials in line with the new WHO medical eligibility criteria, and printed and disseminated a series of FP brochures, posters, job aids and guidelines to enhance learning and knowledge sharing. To ensure that trained providers are practicing their new PPIUD insertion techniques with the appropriate instruments, MCSP distributed essential PPFP equipment including PPIUD insertion kits to trained providers to support the right technique for the immediate postpartum IUD insertion. MCSP conducted post-training follow-up with 52 trained health care workers to ensure training is translated to

services and that the transfer of knowledge and skill to other staff at their facilities is happening. To strengthen quality of PPFP services, regular monthly supportive supervision visits and mentoring were conducted to all the MCSP supported FP health facilities during which service delivery gaps identified were addressed through on-the-job training. To ensure compliance with USAID legislative policy requirements, trained service providers were oriented on the USAID FP and abortion legislative requirements followed by quarterly compliance monitoring, where no compliance issues were identified. The MCSP Program Director was appointed as the new chairman of the Reproductive Health TWG in recognition of his and MCSP's role in reproductive health in Nigeria.

Adolescent Sexual and Reproductive Health (ASRH): MCSP facilitated the formation and inauguration of ASRH TWGs in Ebonyi and Kogi as platforms to drive ASRH in the states. Additionally, MCSP set up four adolescent corners in four health facilities to offer adolescent and youth-friendly services and demonstrate the need for provision and scale-up of ASRH services in the states. Data collection was completed for Phase 1 of a formative research activity to inform future plans and interventions for adolescent and youth-friendly health services in Ebonyi and Kogi. A data analysis and report writing meeting has been held to identify the themes of the report, which is expected to be finalized by end of March 2017.

Learning: MCSP advanced implementation of the program's ambitious learning agenda, receiving approval for concept notes and research plans to and initiated or completed several learning activities in Nigeria. The approved learning activities include: (1) a quality of care study to examine the quality routine antenatal care, family planning and delivery care services, which was completed; (2) a study on bCPAP introduction to assess feasibility and acceptability of use of the PUMANI bCPAP in select facilities, as well as service provider compliance with operating procedures, (3) an evaluation of a low-dose high- frequency (LDHF) approach to healthcare worker training to provide evidence for the shifting from group-based training to different model, (4) a study about care-seeking during infancy and postpartum period in Nigeria; (5) implementation research to improve reproductive health for adolescent mothers; (6) a knowledge, practices and coverage household survey that will explore child health care seeking; and (7) a qualitative, formative study on care seeking for sick children that will inform the community engagement and demand creation approaches for child health activities; and (8) quality of care study in 40 health facilities in Ebonyi and Kogi to assess the factors related to quality of care for RMNCH in health facilities supported by MCSP.

Pre-Service Education: MCSP harmonized and finalized performance standards based on the Standards-Based Management and Recognition (SBM-R®) approach tools for improving quality of education and training received at schools of technology and health science in Ebonyi and Kogi. The tool will be used to identify gaps in PSE in 13 institutions in Ebonyi and Kogi States and to implement interventions that will bridge the gaps identified to improve the RMNCH skills of new providers entering the workforce from the start.

Capacity Building for Using Data for Decision Making: In an effort to strengthen data in the program states, MCSP trained nearly 150 health providers and officers to measure indicators and use data for decision-making. Further, MCSP supported tracking and reporting in the national labor and delivery register for the application of chlorhexidine in Ebonyi and Kogi states as well as trained 28 health officials to use the new national integrated supportive supervision tools.

Partnership and Collaboration: MCSP continued its partnership with four professional associations: PAN/NISONM, SOGON, and NANNM in PY3. This included enhancing the involvement and participation of the associations in activities targeted at improving MNH in Nigeria and particularly in Ebonyi and Kogi states. SOGON and PAN/NISONM started implementing voluntary obstetric scheme and volunteer pediatric service scheme respectively, and both schemes are helping to extend quality MNCH services to rural and underserved communities. Similarly, following sustained advocacy, the governments of Ebonyi and Kogi states demonstrated increased political will to improve MNCH service delivery in the states by initiating MNCH-related projects and increasing funding.

Challenges

In PY3, the program encountered some challenges that significantly affected the planned work, including prolonged strikes by health workers, stakeholder refusal to adopt new stances, slow engagement by SMOH, security challenges in program zones and the effects of the current economic recession in Nigeria. Throughout the program year, MCSP remained focused on working around these challenges as best as possible, including getting a formal commitment from the SMOH for improved support of RMNCH and training providers where possible around strikes.

Way Forward

MCSP Nigeria's MNH and child health activities have merged, creating an integrated MNCH program that will better serve the populations of Kogi and Ebonyi states. Having covered an appreciable ground in improving the capacity of frontline health workers in both states, and planning additional step-down trainings in more facilities, MCSP will focus on supporting the states to set up structures to strengthen the health system and improve the quality of care. The national quality of care framework for Nigeria will be developed and ratified in 2017. MCSP will also provide post-training support and mentoring to trained health care workers and help in establishing and entrenching an integrated supportive supervision system across the states. Child health activities will focus on building Kogi and Ebonyi States capacity to introduce and expand iCCM and IMCI implementation, while ensuring high service quality through supportive supervision led by the state and partners. The program will continue to progress on the learning agenda and operations research to promote learning and test acceptability and feasibility of new innovations in Nigeria. MCSP will also continue to advocate to Nigerian governments at local, state and federal levels to improve delivery of quality MNCH services through appropriate policy implementation, and particularly at the facility level through timely procurement of critical equipment and lifesaving commodities. Additionally, USAID has requested that MCSP expand upon activities related to treatment of possible severe bacterial infection (PSBI) and bCPAP. With the endorsement of the new simplified antibiotic regimen from FMOH, MCSP will support the introduction of PSBI treatment across all LGAs within Kogi and Ebonyi States. For bCPAP, MCSP will collaborate with USAID's Center for Accelerating Innovation and Impact (CII) and Dalberg Group on the development of a national bCPAP action plan in order to guide national scale-up of bCPAP in Nigeria. PY3 workplan addendums for these two expanded activities are under development and will be submitted to USAID for review and approval soon.

Selected Program Indicators	Cumulative Target to PY3-Q1	Achievement (inception to PY3/Q1)
Number of people trained in MNH (HBB, HMS, KMC, ENC, RMC) through USG supported program	435	949
Number of people trained in BEmONC	100	327
Number of people trained on FP/RH with USG funds	460	327
Number of ANC visits supervised by skilled providers from USG assisted facilities	275,500	93,609
Number of pregnant women that attended antenatal clinic for at least 4 times	53,500	29,493
Number of deliveries by skilled birth attendants	31,000	20,065
Percent of women receiving immediate postpartum uterotonic drugs in the third stage of labor	75%	61%
Couple years of protection in MCSP program	36,950	30,943
Number of postpartum counseling visits for FP/RH as a result of USG support	3,500	7,056
Percent of babies for whom Chlorhexidine was applied to the umbilical cord at birth at health facilities	18%	25%

Nigeria RI Country Summary, March 2017

MCSP/Kate Holt.

Selected Demographic and Health Indicators for Nigeria			
Indicator	**National**	**Bauchi**	**Sokoto**
Population[1]	182,202,000[1]	6,530,875[2]	5,071,150[3]
Live births/year[1]	7,133,000[1]	1,431[4]	1,151[4]
DTP3[2]	38.2%[4]	12.5%[4]	2.6%[4]
NMR(per 1,000 live births) [2]	37[6]	43[7]	44[7]
U5MR(per 1,000 live births) [2]	128[6]	160[7]	185[7]

[1]Countdown to 2015, The 2015 Report: Nigeria. [2]Bauchi State Team Report of SNIPDS, September 2016. [3]SPHCDA, 2016.[4]2013 Nigeria Demographic and Health Survey (NDHS). [5]Percentage of children <1 yr. fully immunized. Source: Card + recall. Social Audit on Primary Health Care Millennium Development Goals. Bauchi State Scorecard, 2009-2013. NEHSI, CIET, DFATD Canada. [6]Rates for five-year period preceding the survey. Source:2013 NDHS [7]Zonal data for the 10-year period preceding the survey (state data not available). 2013 NDHS.

Strategic Objectives

- Support State-led and State-owned efforts to achieve >80% RI coverage in every ward of Bauchi State by the end of December 2017, and in Sokoto State by the end of December 2018.
- Support State-led and State-owned efforts to expand the availability and quality of RI services by providing technical assistance in the areas of capacity building and training, supportive supervision, monitoring and use of data, supply/cold chain, and community engagement.
- Promote the transition of all responsibility for sustaining and building on these gains to Bauchi by January 2018, and to Sokoto by January 2019, by improving capacity to promote, deliver, and monitor RI services at state, Local Government Area (LGA), health facility, and community levels.

Program Dates	Sept 1, 2014 – March 15, 2019
Financial Status	*This program budget aligns with Government of Nigeria budget cycles which are by calendar year.* Expenditures through Dec. 2016 = [redacted]; 2017 Budget = [redacted]; Total = [redacted]
Geographic Scope	National and in, Bauchi and Sokoto states

	No. of States (%)	No. of Local Government Authorities (LGAs) (%)	No. of facilities/communities (%)
Geographic Presence	2 of 36 total states (5.5%) Population:9,853,084 (Bauchi & Sokoto states)	National: 43/774 (5.6%) Bauchi: 20/20 (100%) Sokoto: 23/23 (100%) Number of wards (%) National: 547/ 9,572 (5.7%) Bauchi: 323/323 (100%) Sokoto: 224/224 (100%)	Bauchi: 987/1,077 (92%) Sokoto: 482/785 (61%) Both: 1,469/1,844* (78%) * *Bauchi and Sokoto only*
Technical Interventions	 PRIMARY: Immunization. CROSS-CUTTING: Community Health, Civil Society Engagement, HSS, Digital Health, SBCC.		

Key Accomplishments

In 2015, USAID/Nigeria adopted new operating principles to respond to the highly political nature of many of the country's development challenges. These principles require that the Government of Nigeria take the lead in delivering essential, dependable, and high-quality health services to the Nigerian people; that USAID's partnership be conditional upon the government's demonstrated political and financial commitment to doing so; and that USAID's investments be designed through a systems strengthening lens. MCSP/Nigeria Routine Immunization (RI) is the first MCSP program and USAID Nigeria implementing partner to fully operationalize these new principles.

MCSP/Nigeria provides strategic technical support at the national level (in Abuja), and at scale across all of Bauchi state's 20 Local Government Areas (LGAs) and Sokoto's 23 LGAs. In Bauchi and Sokoto, the State Primary Health Care Development Agencies (SPHCDAs) are using an innovative approach to strengthen RI services and reduce childhood illness and death. This approach is based on a common partnership framework, and implemented under a memorandum of understanding (MOU) between each SPHCDA, the Bill & Melinda Gates Foundation (BMGF), the Dangote Foundation, and USAID/Nigeria. The goal of these quadripartite MOUs is to support state governments to dramatically and sustainably increase RI coverage by the end of 2017 in Bauchi and the end of 2018 in Sokoto.

MCSP/Nigeria RI has been supporting MOU implementation in Bauchi since January 2015 and in Sokoto since October 2015. The program's accomplishments since PY1 at state and national level are described below.

State Level Support

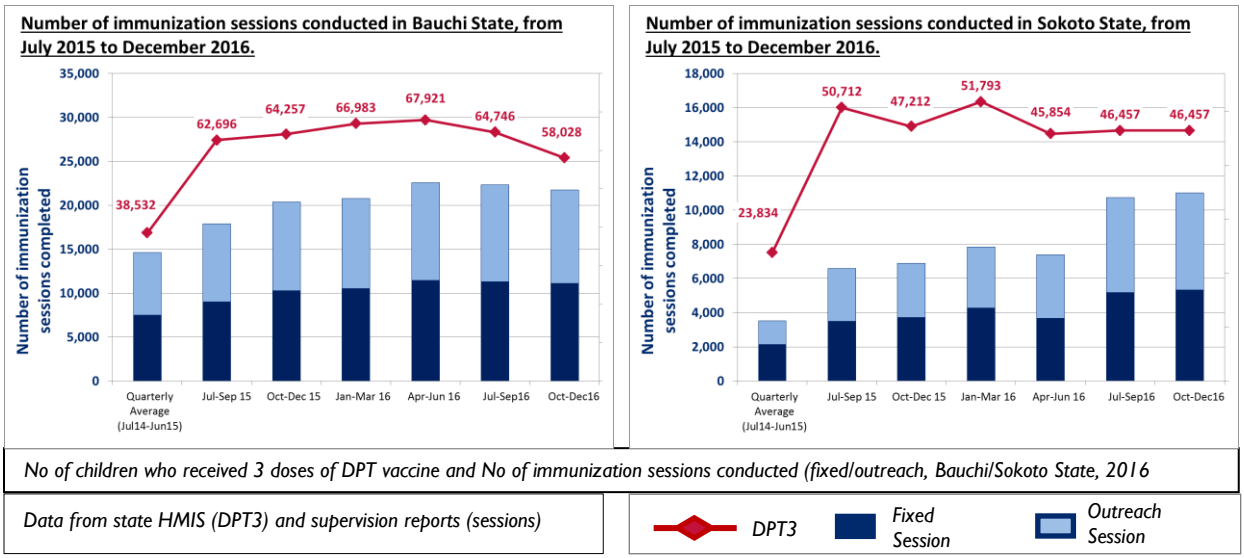
Both Bauchi and Sokoto states have recorded important progress in contributing to reduced vaccine-preventable childhood morbidity and mortality. Achievements by MOU thematic area are highlighted below.

***Strengthening governance and partner coordination*:** MCSP PY2 marked the milestone launch and first year of Sokoto's quadripartite RI MOU and the second full year of Bauchi's implementation. Both state governments are demonstrating indications of improved commitment to and capacity for RI program management and coordination, and RI MOU implementing partners are largely collaborating effectively under the leadership of state-led teams. LGA-level coordination, planning, and review mechanisms are less strong in Sokoto, and the program and other RI MOU partners are supporting the SPHCDA to improve. The direct disbursement and consistent availability of MOU funding at operational levels has helped better ensure that routine activities like monthly review meetings, supportive supervision, and outreach sessions are conducted as planned. Both the Bauchi and Sokoto SPHCDAs have fully disbursed the funds they committed to their respective RI MOU Basket Funds for the year. Also, they are using financial tracking tools (developed with support from BMGF, Solina Health, and MCSP) to track the disbursement to and use of

basket funds by LGAs and individual health facilities. As of January 2017, Sokoto government has deposited 100% of the financial commitment for 2017 in to the basket.

Expanding availability of and access to services: Both states have reported improved performance in the coverage of diphtheria-pertussis-tetanus (DPT3) containing vaccine since their respective baselines. In 2016, 99 percent of an estimated 261,235 infants targeted in Bauchi (compared to 59 percent at baseline) and 94 percent of an estimated 202,846 infants targeted in Sokoto (compared to 47 percent at baseline) received all three doses of DPT-containing vaccine. Increased vaccine stock availability in health facilities, increased numbers of health facilities providing RI services in both Bauchi and Sokoto, increased numbers of RI sessions provided by some health facilities, and increased frequency of supportive supervision--due partly to regular RI MOU Basket Fund disbursements--all likely contributed to this improvement. Enhanced community engagement may also have driven increased community demand for and use of RI services in Bauchi, in particular. MCSP has also initiated plans to support both states to use GIS tools and to further enhance community engagement to ensure that catchment area maps are capturing settlements and children that may have otherwise been missed in micro planning activities. Accurate maps and population estimates at the operational levels are critical to identifying and targeting health facility catchment areas, identifying harder-to-reach communities, determining how to reach more children with these services and ultimately improving equitable vaccination coverage.

In both Bauchi and Sokoto more health facilities were providing significantly more RI services at the end of calendar year 2016, compared to their respective baselines. Bauchi expanded the number of health facilities offering RI services from 958 health facilities to 987 and targeted its stronger-performing and higher-yielding facilities for additional support to increase their performance--ultimately, 100 health facilities were assisted to boost the number and size of their monthly fixed and outreach RI sessions with support from BSPHCDA, MCSP and other MOU implementing partners and this led to more immunization sessions conducted and significantly more children being immunized. In its first year of MOU implementation, Sokoto took a slightly different approach, focused primarily on strengthening the existing 487 health facilities that were already providing at least one RI session per month in the state, but the total number of sites offering services also increased.



***Building local capacity to deliver quality services*:** From supportive supervision and monthly data review meetings to on-site training and peer-to-peer mentoring, MCSP has supported diverse, state-led approaches to capacity strengthening at all levels of the health system. In 2016, 10,666 people in Bauchi and Sokoto states received MCSP-supported training on RI topics, including the Reaching Every Ward (REW) approach. In Bauchi, for example, MCSP provided mentoring support during REW training and monitoring in 615 health facilities across all 20 of the state's LGAs. REW training sessions targeted LGA management and health

facility staff, and were primarily organized in small, participatory groups using practical, on-the-job training and hands-on demonstrations.

Improving vaccine security, cold chain, and logistics: 99 percent of Bauchi's 323 satellite cold store facilities (versus 23 percent at baseline) had functional cold chain equipment at the end of 2016. Fifty-two non-functioning units were replaced during the year. Similarly 94 percent (versus 26 percent at baseline) of Sokoto's 244 wards had functional cold chain equipment at the end of December, 2016. The Sokoto SPHCDA procured and installed 143 new items of cold chain equipment in 177 wards and an additional 34 units were added with support from EU-SIGN. In Sokoto, 94 percent of wards had functional CCE at the end of 2016. Moreover, both Bauchi and Sokoto had fully rolled out a "push" system for vaccine delivery (through public-private partnership) and a vaccine stock monitoring dashboard to help better respond to vaccine stock-outs and cold chain breakdowns.

Improving routine data quality and use: Tackling data quality issues has been a priority for program support. Discrepancies between the two RI data reporting streams (DHIS-2 and DVD-MT) persist, despite ongoing technical and capacity-building support from the SPHCDA and all RI MOU partners. MCSP is working closely with other partners to help address these challenges, including through support to the National Primary Health Care Development Agency (NPHCDA) to develop an RI data quality improvement plan. When finalized, this plan will be adopted by the 36 states for RI data quality improvement. Additionally, MCSP continues to support Bauchi and Sokoto states to fully transition to and use the DHIS-2; to conduct data quality self-assessments, and use the findings to develop data quality action plans; and to develop (with the aim to institutionalize) a performance recognition framework that emphasizes rewards for good practices over hitting targets. More than 3,900 health workers in Bauchi and 1,350 in Sokoto received program-supported training on RI data management during calendar year 2016.

Strengthening community-facility linkages: The launch of Bauchi's first-ever Community Engagement Strategy (CES) for RI helped drive momentum for another important milestone: the inauguration of Bauchi's State Emirate Committee on Health (BASECOH). The Committee was established to help sensitize and mobilize communities to demand, access, and use RI services, and to monitor vaccine demand and supply at the community level in line with the CES. MCSP supported health facilities providing RI services to conduct review meetings with communities through their village and ward development committees. These meetings provided feedback to communities and generated their input on RI session planning, session monitoring and child tracking.

National Level Support

Informing national policy development and implementation: At the national level, MCSP shares experiences and lessons learned from MOU implementation in Bauchi and Sokoto and contributes technical expertise to EPI and other program reviews. National policies and tools drafted with the program's support include Nigeria's comprehensive Multi-Year Plan (cMYP) for Immunization, 2016-2020, 2016 EPI Workplan, Basic Guide for Routine Immunization Service Providers, Guidelines on Strengthening RI Services, and updated terms of reference for State Logistics Working Groups. As a member of the National Primary Health Care Development Agency's (NPHCDA's) National RI Working Group, MCSP also contributed in late 2016 to planning for the next Multiple Indicator Cluster Survey and National Indicator Cluster Survey, and work has also begun at the national level to update the Mid-Level Manager (MLM) and Immunization in Practice (IIP) training modules with program support.

Supporting new vaccine introduction: MCSP provides national- and state-level technical support to help strengthen the RI systems that are critical to the successful introduction of new vaccines. During calendar year 2016, the program provided planning, implementation, and monitoring support for the phased, nationwide rollout of pneumococcal conjugate vaccine (PCV) and contributed technically to development of a successful Gavi application for the introduction of rotavirus vaccine in 2018. MCSP also played a role in the global "switch" from trivalent to bivalent oral polio vaccine (tOPV to bPOV) in April 2016, which was an important milestone in the longstanding global effort to eradicate polio. MCSP supported the NPHCDA to

form State OPV Switch Committees in signal states in preparation for this deadline, and to recall all unused trivalent OPV from vaccines stores and health facilities. At the state level, program support included serving on the Bauchi and Sokoto "switch" committees and supervising activities at every stage of implementation, up to the final disposal of all retrieved tOPV in each state.

Challenges

Although there have been significant MOU achievements, challenges to successful RI implementation, monitoring, and evaluation persist. The provision of RI services continues to be inadequate in both states, but particularly in Sokoto, where still only 61 percent of the government health facilities are providing RI services (compared to 53 percent at baseline). Sokoto was able to achieve its annual RI MOU target of 92 percent DPT3 coverage by the end of December 2016, but until more of its health facilities are regularly offering RI services, this coverage will remain fragile. Another common problem is the lack of child immunization cards in some LGAs and of newborn, left-out, and dropout tracking and reporting mechanisms that contribute to missed opportunities for immunization. Knowledge about how some community structures function and how to engage them for RI continues to be weak among some MOU partners and community representatives. To address this, MCSP is working with the SPHCDAs to strengthen ward and village development committees, implement strategies for community engagement and continue efforts to reach newborns and unimmunized children with RI services in each state.

Data quality issues also continue. Despite capacity-building support from the SPHCDA, MCSP, and other RI MOU partners, discrepancies between the two RI reporting platforms [DHIS-2 and DVD-MT] make data use difficult. The fact that the two data reporting streams are managed and owned by two different groups — DVD-MT by WHO, and DHIS-2 by the Government and its LGA M&E Officers—is a key contributor to the duplication of effort and poor quality of the data available for management purposes. Falsification of data because of pressure to reach targets is another contributing factor. MCSP is working closely with partners to help address data management and quality issues. This includes supporting Bauchi and Sokoto to build their capacity to use the DHIS-2, and ontributing to the development and institutionalization of state-owned performance recognition frameworks that are used to reward good *practices* rather than impressive, but short-lived *results*.

Way Forward

As Bauchi begins to prepare for its final year of full MOU implementation in 2017, partners will assist the SPHCDA to incorporate an exit strategy into its 2017 Harmonized Annual RI MOU Workplan. This likely will not involve partners' complete withdrawal from Bauchi after the formal MOU ends in December 2017, but more limited, targeted, and coordinated financial and technical assistance in the future.

MCSP has been working closely with the two SPHCDAs, USAID/Nigeria, BMGF, and Solina to develop a state-owned and -led learning agenda that will be fully rolled out in both states in 2017. Operational studies are planned that will explore new ways of mapping communities using GIS technology, mobilizing traditional barbers to identify newborns, and using a digital health platform to register, track and send reminder and motivational messages to families that increase their use of available RI and other RMNCH services. The iterative processes and learning occurring as part of the MOU planning, coordination, financing and review mechanisms also will be analyzed and documented through a health governance lens.

Sustained government ownership and political commitment to RI financing will become increasingly important leading up to 2020, when Nigeria will no longer qualify for Gavi co-financing of its vaccines. The new financing mechanisms established through each state's MOU have been critical to ensuring the consistency of program functions that sustain RI (e.g., supportive supervision, outreach sessions, and review meetings). Although there are encouraging signs that improved RI governance will be sustained after the end of each state's MOU, increased advocacy, community and civil society engagement, and mechanisms that promote and reward local investment in RI will become increasingly important as the current quadrapartite funding strategy winds down in 2017 and 2018.

PY2 Performance Indicators (December 31, 2016)		
Country PMP Indicators	**National**	
Number of (national) policies drafted with USG (MCSP) support *(Includes cMYP 2016-2020, Basic Guide for RI Service Providers, Guidelines on Strengthening RI Services, and updated terms of reference for State Logistics Working Groups)*	4	
Percentage of children less than 12 months of age who received DPT3/ vaccine in areas supported by MCSP (2016)	**Bauchi**	**Sokoto**
	99%	94%
Number of people trained in child health and nutrition through USG supported health area programs	7,792	2,825
New vaccines introduced with MCSP support *(PCV, tOPV → bOPV "switch")*	2	2
Percentage of health facilities receiving RI basket funds on a monthly basis	99%	100%
Percentage of Wards with functional solar Cold Chain Equipment	99%	94%