GUIDANCE FOR DEVELOPING A NATIONAL IMMUNIZATION STRATEGY (NIS)

IA2030

World Health Organization

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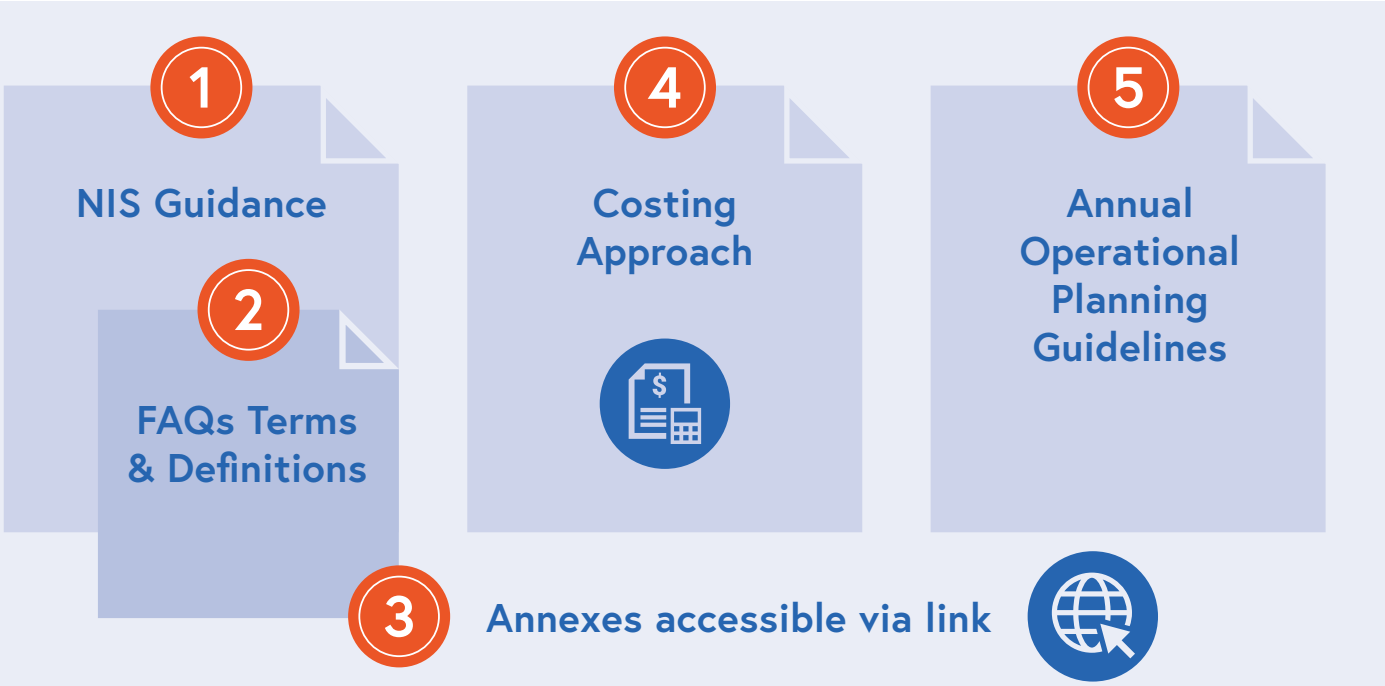
ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AEFI	Adverse events following immunization
AOP	Annual operational planning
BeSD	Behavioural and Social drivers
CDS	Communicable disease surveillance
CEA	coverage and equity assessment
cIP	Continuous improvement plan
CSO	Civil Society Organization
EPI	Expanded Programme on Immunization
EVM	Effective Vaccine management
FAQ	Frequently asked questions
GAVI	Gavi, the Vaccine Alliance
HMIS	Health Management Information Systems
HR	Human Resources
HSCC	Health sector coordination committee
HSSP	Health sector strategic plan
IA2030	Immunization Agenda 2030
ICC	Inter-agency coordination committee
M&E	Monitoring and evaluation
MCH	Maternal and child health
ME&A	Monitoring, evaluation and action
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Nongovernmental organization
NIP	National immunization programme
NIS	National immunization strategy
NITAG	National immunization technical advisory group
NLWG	National logistics working group
PHC	Primary Health Care
RITAG	Regional Immunization Technical Advisory Group
SAGE	Strategic Advisory Group of Experts
SD	service delivery
ToC	Theory of change
ToRs	Terms of reference
TWG	Technical working group
UHC	Universal health coverage
UNICEF	United Nations Children's Fund
VPOP	Vaccine prioritisation and portfolio optimization
WHO	World Health Organization

INTRODUCTION

This document forms part of a **package of guidance and tools** for countries that taken together provide:



1. **NIS Guidelines:** a step-by-step guide for country stakeholders on how to develop an NIS available at https://www.who.int/teams/immunization-vaccines-and-biologicals/vaccine-access/planning-and-financing/nis
2. **NIS FAQs:** further details and descriptions, including definitions of key concepts and terms available at https://www.who.int/teams/immunization-vaccines-and-biologicals/vaccine-access/planning-and-financing/nis
3. **NIS Costing Approach (NIS.COST):** Web-based decision-support platform for costing, budgeting, and financing analysis of National Immunization Strategies. Available at https://niscost.org/en
4. **Annual Operational Planning (AOP) guidelines:** guidance and tools to support the transition from the NIS into actionable tasks available at https://immunizationeconomics.org/unicef-national-planning-and-budgeting

The National Immunization Strategy (NIS) streamlined planning process that focuses on a strategic period of 5 years. Specifically, the NIS defines:

1. The immunization **vision** to be achieved over the long term (generally 10 years).
2. Specific **objectives** to be achieved at the end of the strategic period (5 years). These are measureable intermediate outcomes along the way to achieving the vision.
3. Priority **strategies, a costed set of interventions based on the available immunization fiscal space** to achieve the objectives, as well as the measures to mitigate against risks associated with the selected interventions.

The NIS is intended for use (e.g. to prioritise and plan future work, advocacy and resource mobilisation) by the following key stakeholders at the national level:

- country-level decision-makers at all levels (national and subnational) in the health sector and other government sectors, including the Ministry of Finance (MoF);
- national immunization programme (NIP) managers and other relevant programme focal points (e.g. supply chain and logistics manager, primary health care, vaccine preventable diseases surveillance, demand generation);
- immunization partners at the national, regional and global levels (e.g. WHO, UNICEF) and local and international nongovernmental organizations (NGOs) and civil society organizations (CSOs);
- policy-making bodies at national and subnational levels, such as the National Immunization Technical Advisory Group (NITAG); and
- entities that oversee and coordinate immunization and health interventions at national/ sub-national levels (e.g. Interagency Coordination Committee (ICC) and the Health Sector Coordination Committee (HSCC)).

How to use this NIS guidance

This document is a 2026 update of the first edition of the NIS guidance published in 2020. It is designed as a practical resource to support country decision-makers at each stage of developing a national immunization strategy, outlining key stakeholders to involve, roles and responsibilities, and the intended impact.

The NIS guidance follows seven steps of NIS development (Table 1). For each step, the guidance describes:

- the **process** for completing the step, including possible **roles and responsibilities** across a team;
- how the step contributes to developing the **content of the NIS** and reminders for **efficient integration** with the Health Sector Strategic Plan (HSSP);
- a recommended set of **tools and resources** (with relevant links);
- **best practice tips** gathered from country experiences that will continue to be collected over time.

This guidance is not intended to be prescriptive as to what a country should do. Rather, it provides examples and the general direction on how an NIS can be developed most effectively. The following chapters provide guidance on which steps can be undertaken in parallel, recognising that the process is iterative and may require revisiting and refining earlier stages as the strategy develops.

Table 1. The 7 steps of NIS development

1. Preparation

Development of a **workplan** for developing (or updating) the NIS, including a **stakeholder engagement** plan and ToRs for Steering Committee and key teams/ working groups. Collection of documents for situation analysis.

Output: NIS planning complete and documentation available.

2. Situation Analysis

Review of existing documents related to immunization and the health system (e.g. plans, reports, reviews, assessments, surveys) to identify and prioritise critical programme barriers, strengths and evidence gaps.

Output: Consolidated situation analysis report.

3. Strategy Development

Using the consolidated situation analysis, the development of the strategy can begin by asking where do we want to go and why and how do we get there. The answers to these question should address the barriers to high coverage and equity identified during Step 2. They will support the setting of the **NIS vision and objectives**, while ensuring alignment with and a clear understanding of national health sector priorities. Part of the strategy development stage is identifying the **key opportunities and obstacles for achieving the objectives**, for example, political, social or economic factors, based on which, interventions will be identified to either capitalise on these opportunities or mitigate against factors that could threaten the achievement of the objectives.

Output: NIS vision and consolidated 5 years objectives with interventions to achieve them.

4. M&E Framework

The monitoring and evaluation (M&E) framework will be used to **measure progress on NIS implementation** and to take corrective action when needed. Assigning specific and measurable indicators is of critical importance, as is assigning accountability for achieving the indicators.

Output: Monitoring and Evaluation Framework.

5. Resource estimates

Once the interventions to achieve objectives have been identified, the NIS development team will **estimate the resource requirements** for implementing them using **NIS.COST**

Output: Resource requirements for the NIS.

6. Budget dialogue

Dialogue around NIS budget requirements will need to happen both with the government and external health partners, and, if sufficient resources are available, may involve scaling back the roadmap to align with a realistic expectation of committed resources.

Output: Consolidated budget for the NIS.

7. Approval and endorsement

With steps 1-6 completed the final NIS document is **endorsed** by the relevant in country stakeholders and any legal act or regulations needed to approve the NIS document and transform it into a governance tool are considered.

Output: Final version of NIS document with budget estimates.

Step 1. Preparation

Objective: Prepare for a successful NIS development process	
When to initiate?	• The process is typically triggered by a new national strategy development cycle, by the need to review or update the NIS, or by other specific country needs. • Anticipate the need for an **Expanded Programme on Immunization (EPI) Review as the foundation of a programme's strategic planning process** (as a pre-step, the EPI or other programme evaluation is not accounted for in the NIS timelines below). • Plan a full year in advance and reflect the process in workplans of relevant stakeholders at the beginning of the NIS development year.
Who should initiate?	• The EPI manager takes the initiative to plan the NIS development well in advance, although a formal request is typically mandated by the Minister of Health. • Planning occurs with Ministry of Health (MoH) planning and budgeting and service delivery (PHC/family/MC health) departments and the relevant country coordination forum, such as the ICC, HSCC, or immunization technical working group (TWG).
How to prepare the development of the NIS?	• **Put the NIS team in place**, giving equal consideration to capacity needs for both programmatic content and financial costing and budget negotiations. Leverage existing structures and mechanisms to the extent that this is possible. • **Develop a project plan for NIS development**, aligning it with the process and consultation approach for developing the NIS content. • Consider how best to **reach key stakeholders and build buy-in** (i.e. through workshops or meetings at subnational level) with representatives from different levels of the immunization programme (including the NITAG); Maternal, newborn and child health programmes; MoH planning/budgeting and PHC/SD teams; National logistics working group (NLWG), health promotion and communications, MoF; Ministry of Women or Gender; Ministry of Education; development partners; immunization and health sector representatives; humanitarian agencies; civil society, including women's groups and primary health care (PHC) agents; academia and research institutions. • **Prepare situation analysis** (see more in Step 2).
What to prepare?	• Key appointments (by the MoH) made to individuals or task teams to undertake NIS development and governance roles (a Steering Committee can be created from an existing senior-level coordinating mechanism). • Develop a NIS workplan and timeline. • Consider developing a stakeholder engagement plan. • Consider mapping of ongoing relevant national work that needs to be reflected or considered in the development of the NIS. • Strongly recommended to consider alignment with HSSP cycles and annual budget processes. • Prepare terms of reference (ToRs) that define clear roles and responsibilities for completing the NIS, including expected inputs and outputs for members and/or structures across the NIS development team as well as the decision-making process. • Plan and secure additional capacity or technical support as needed. • Collect all the key country documentation needed for situation analysis (see Annex 2 for recommended list) including key financial information for subsequent costing.

Objective: Prepare for a successful NIS development process	
Entry point for **integration** with the HSSP	• Check the timing for the development of the national HSSP and align the development of the NIS to facilitate its integration into the HSSP. If there is an additional level of management between the MoH and the NIP (e.g. the Maternal, neonatal, child and adolescent health (MCAH) department) the timeline for development of the MCH strategy should also be taken into account when determining the NIS development period. • Ensure involvement of planning officers who oversee the HSSP strategy development and/or mid-level department (e.g. MCH) to serve on the NIS development team.
Coverage and equity	• From the very early planning phase, consider how diverse voices will be represented in the NIS development team. • For analysis of gender and socio-cultural barriers to be meaningfully integrated into the NIS, the NIS team needs to include a health (preferably immunization) expert who is also well-versed in gender dynamics. • Ensure that processes such as consultations or deliberations are mindful of gender and other power dynamics in order to ensure equal participation, and opportunity to influence, by all actors, including women's organizations, and that all voices and perspectives are gathered/considered.
Duration	*1–2 months* *A situation analysis (Step 2) and stakeholder engagement could start before Step 1 is final and may influence how NIS planning takes shape (i.e. technical task teams needed).*
Outputs	1. Confirmation of the NIS development team, including securing additional external assistance with local expertise. 2. Temporary structures (e.g. Steering Committee, Planning Committee) established with ToRs. 3. A well-defined project plan, including methodology, and activities for each of the development steps with timelines. 4. Stakeholder engagement plan for NIS development. 5. Comprehensive collection of documents and data for the situation analysis.
Tools and resources	ToRs: an MoH standard format may be available. If not, **Annex 1** provides suggestions on how to develop the ToRs for the NIS development team.

1A. Setting up an effective NIS development team

The first step in developing the NIS is to select and appoint the NIS development team. While the size, scale and arrangement of the NIS team will vary by country, the following considerations can guide the best approach:

- In addition to key stakeholders from the immunization programme, from the very start of the process the team should include representatives from the MoH Planning and Budgeting departments to ensure close alignment to overall national mechanisms for planning and budgeting.
- Use and leverage existing structures, technical working groups and other coordinating bodies (e.g. ICC, HSCC, NITAG, national/sub-national logistics working groups, etc.) to the extent that this is possible.
- While short-term consultancy support may be considered, selecting local experts and using national organizations for additional capacity is preferable to relying on international consultants.
- The size of any NIS structure/committee should be manageable. If too small, it might be over-burdened with work or perceived as exclusive. If too large, it might be unwieldy and progress slowly.
- The project will depend on continued regular support from key stakeholders in the NIP, including at subnational and district levels, as well as from other government departments. These resources can be brought in when needed during the process.

Functions within a NIS development team

- **The NIS Task manager/Coordinator** is responsible for the successful planning, coordination and monitoring of the project, ensuring that a quality product is delivered on time. The Task manager/Coordinator must have the required technical knowledge about the NIP and the seniority to serve effectively as the overall coordinator.
- **The NIS Content producer** prepares materials for the working groups and the respective stakeholders to support substantive discussions. They summarize outputs of consultations and document decisions made and write the various sections of the NIS document. The Content producer should have a good understanding of the NIP, its current situation and main barriers, and be able to facilitate technical discussions. Introducing complementary finance and budgeting expertise as part of the NIS development team is also recommended.
- **NIS Steering Committee** is an advisory body made up of senior stakeholders or experts and can be located within an existing representational governance mechanism. Its role is to guide at the technical and strategic level as well as provide high-level supervision to the development of the NIS from start to completion. Steering Committee members may be drawn from the following list of key stakeholders:

- focal point(s) of the immunization programme, including from subnational levels;
- focal point(s) of the Health Sector Planning / Service Delivery, PHC, MCH or equivalent Department and the MoH, from the Department of Women or Gender, and from the Health Promotion Department or Advocacy and Social Mobilisation;
- focal point(s) of the NITAG or equivalent;
- focal point(s) of broader teams within the MoH such as communicable disease surveillance (CDS), malaria programme, disease control programme, MNCAH and National Logistics Working Groups;
- decision-makers from the MoH department responsible for the Immunization Programme (e.g. the MCH Division);
- focal point(s) of the Ministry of Finance, including the contact for health budgeting;
- focal point(s) of the Ministry of Education;
- representatives of key development partners, including technical agencies and donors;
- representatives of civil society, including women's groups;
- representatives of communities benefiting from vaccination;
- representatives of the private sector;
- stakeholders beyond the immunization and health sectors, such as those dealing with education and information technology.

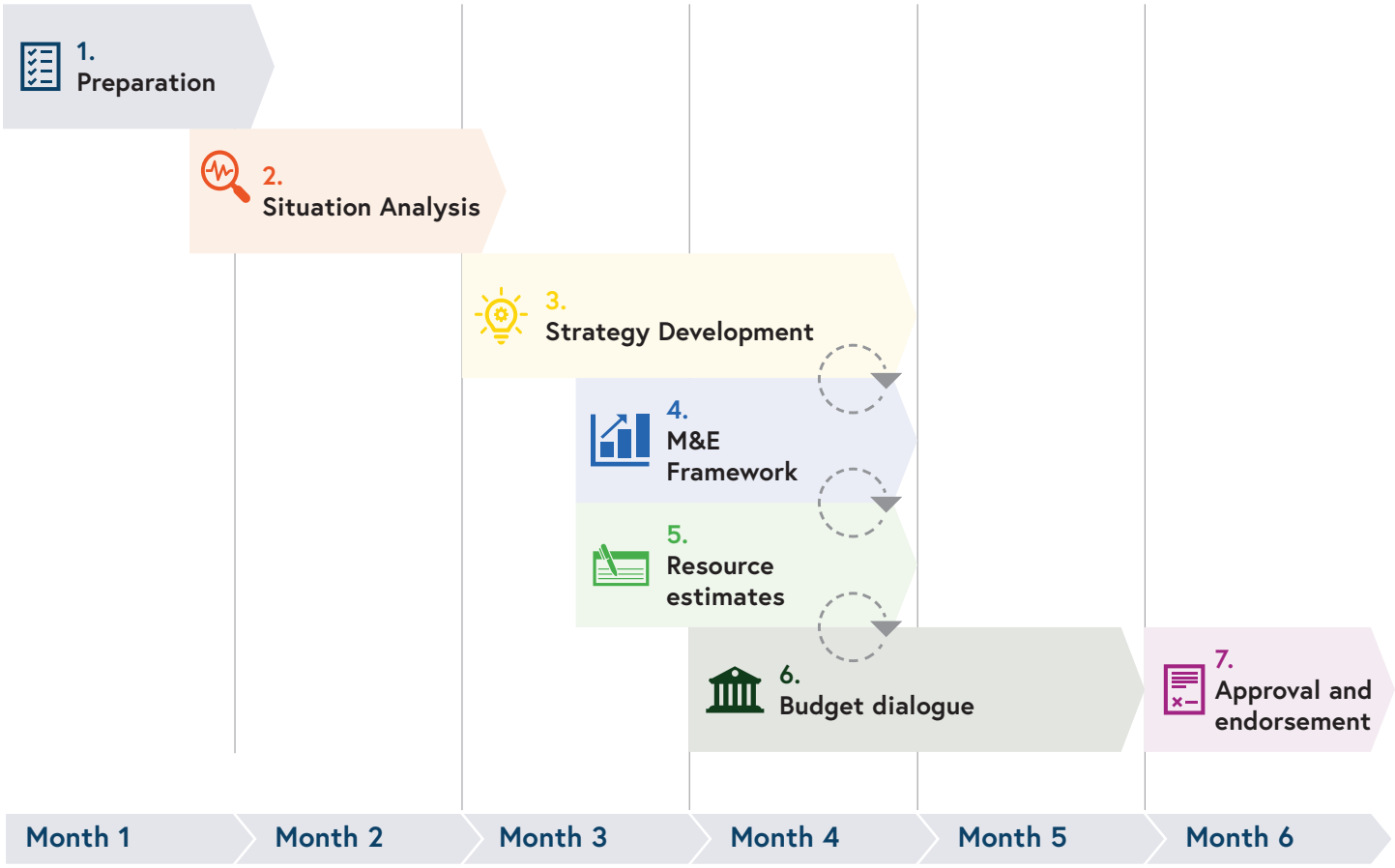
- **Immunization technical working groups (TWGs)** exist in most countries as thematic technical bodies that can be called upon and/or reinforced as needed to lead the development of NIS content in their respective work area. TWG members are technical experts and/or representatives of the main agencies, organizations and institutions working in immunization focus areas. These TWGs should engage, as early as possible, with budget staff to ensure that the programmatic work is developed alongside financial estimation.

1B. Establishing the NIS timeline

It is important to design realistic project timelines according to the country context and planning schedules. It is important to consider formal government processes, timeline for approval of the NIS by the Minister of Health, and budget approval processes. Consider already planned activities the NIP and key stakeholders lead that may impact this timeline. Engaging across stakeholders takes time and effort and should be included in the planning process. Based on the estimated duration for each step, the NIS development should target no more than six months from initiation to endorsement (**Figure 1**).

A situation analysis is a fundamental step and a key instrument for programme reviews and strategic planning. It provides a thorough, comprehensive and objective assessment aimed at evaluating national immunization programmes in order to guide future priorities. Compiling information from both available, already existing documents and discussions with key stakeholders is important to prepare for this step.

Figure 1. Target timetable for the development of the NIS



Best practice tips for Step 1: NIS preparation

- A memo signed by the Minister of Health can feature as the official launching of the process.
- Government appointments to the NIS development team can help hold members accountable for their assigned tasks.
- Careful planning, advocacy and orientation for NIS team members to ensure they commit to the NIS exercise will help make the process more efficient.
- Governments are encouraged to engage local consultants (preferable to international ones) and direct them through the process.
- Ensure constructive, inclusive and transparent communication across different team components (coordinators, committees and technical working groups). ToRs can help explain how information will be shared and at what frequency.
- Bear in mind that it will take time to have people appointed to the NIS team before work can commence, and time will be needed for the document to be reviewed and approved at national and subnational levels.
- Country timelines and procedures for budget negotiations and allocations should be reflected in the overall timeline for the development of the NIS.
- Securing early engagement from senior members of the MoH Budgeting/Financing Department will save time.
- Including women-led and youth-led CSOs will play a critical role in increasing demand and reaching zero-dose children, adolescents and communities.
- Set up an online document repository for the NIS team members. A Gantt chart showing the project schedule would also be useful.

Step 2. Situation analysis

Objective: Understand and evaluate the current immunization situation to inform future directions	
Who prepares the situation analysis?	**1. Task manager/Coordinator:** √ collects available, relevant resources to be reviewed (e.g. EPI review report, EVM report, supply chain continuous improvement plan, surveillance review, equity assessment, BeSD, etc.) √ plans and organizes consultations (e.g. meetings, online survey, etc.); **2. Content producer:** √ before consultations, conducts a desk review and prepares discussion materials; √ helps to identify the area of focus and key questions for TWGs; √ summarizes the understanding of the current situation and prepares discussions with the Steering Committee. **3. Technical Working Group(s):** √ designs and plans consultation meetings; √ develops a questionnaire for individual interviews with key stakeholders, if needed; √ considers results from any previous national reviews for incorporation into the situation analysis; √ conducts in-depth analyses in their respective areas in response to questions asked by the Content producer/Steering Committee. **4. Steering Committee:** √ may recommend or sign off on individuals to be consulted and facilitate invitations; √ reviews and aligns the conclusions of the situation analysis; √ supports the workshop on prioritizatio°n of findings.
Who should be consulted?	*Refer to stakeholder analysis/mind-mapping below* • Immunization programme managers at both national and subnational levels • Members of the NITAG • National Logistics Working Group • The Health Sector Planning Department • Technical Directorates responsible for asset management/maintenance • Other departments in the MoH (e.g. human resources, health management information system, health promotion, procurement system and management, training institutions, etc.) whose collaboration will be key to achieving the objectives; and also the relevant department from the Ministry of Women or Gender (if one exists) • MoF, MoH Budget Department, Treasury, Fiscal Commission (as relevant) • Ministry of Territorial Administration or other with designation for overseas resource allocation at the devolved (district) level • Main health development partners that support the country • Civil society, including women's groups, professional associations and representatives of communities • Humanitarian organizations that deliver services in fragile or conflict settings • Other organizations, religious groups, private sector, armed forces, as relevant.
How should analysis and consultation take place?	1. Understand what recent assessments have been conducted to inform this exercise, consider recent plans in place (e.g. supply chain continuous improvement plan (cIP)) and recent joint appraisals. To inform the desk review, use conclusions from any relevant recent assessments, and particularly the most recent EPI Review. If an EPI review has not been conducted within the past 2 years, use the *WHO Guidance and Workbook for conducting a situation analysis* to complete this step. (here). 2. Draft a summary report for consultative meetings and workshops. 3. Hold consultative meetings with key stakeholders or solicit and incorporate written comments, using online consultative platforms. 4. Conduct workshop(s) to consolidate the findings of the situation analysis – these workshop can be combined with the development of the objectives and strategies (see Step 3).

Objective: Understand and evaluate the current immunization situation to inform future directions	
Entry point for **integration** with the HSSP	• Assess the Health Sector strategy (annual health sector performance review) to understand the main health system and delivery issues when reviewing immunization performance. • Analyse the overall strengths, weaknesses, opportunities and threats of the health system and incorporate the findings.
Coverage and equity	Work with country-based experts and stakeholders to assess potential barriers to equitable coverage due to, for example: • gender-related barriers • remote rural settings and nomadic and pastoralist populations • urban poor settings • poor households and poor segments of society (poorest quintile or decentile) • conflict-affected and fragile settings • refugees, internally displaced people and populations. *See: UNICEF Coverage and Equity Assessment Guidance* (here); *UNICEF Gender and Immunization Global Gender Analysis Tool* (here); *Immunization Supply Chain Interventions to address coverage and equity* (here)
Duration	1 month *Step 2 can start before Step 1 has been completed* *Step 3 can start as part of Step 2 consultations (workshops for strategies)*
Outputs	1. Summary of the current context systematically documented through a recent EPI Review or a desk review of other relevant assessments. 2. Lessons learned from past plans/strategies as discussed and agreed across stakeholders. 3. Shared understanding of the environment for the next strategic period.
Tools and resources	• WHO. *A guide for conducting an Expanded Programme on Immunization (EPI) Review* (here) • *WHO Guidance and Workbook for Conducting a Situation Analysis (here)* • *Effective Vaccine Management (EVM) assessment tool (here)* • *Why Gender Matters: Immunization Agenda 2030 (here)* • *UNICEF How to conduct a Coverage and Equity Assessment (CEA) of immunization services (here)* • *UNICEF: Quality Assurance Checklist for Gender Integration in Situation Analysis* • *UNICEF: Embedding Social and Behavioural Change (SBC) Approaches in National Immunization Strategy to Promote Demand and Uptake (here)* • *UNICEF: Immunization Supply Chain Interventions to Address Coverage & Equity (here)* • *WHO: How to develop a Continuous Improvement Plan (here)*

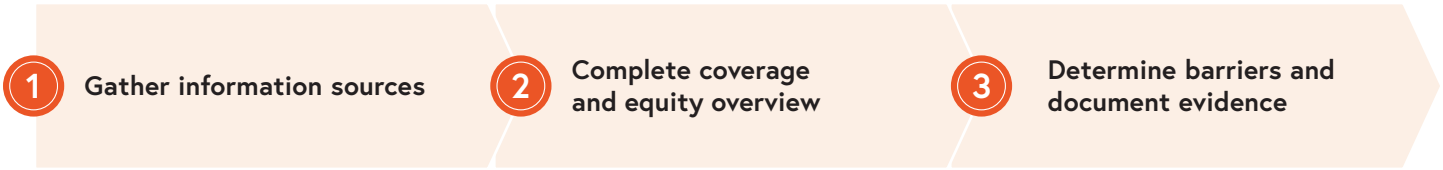
1. Initiatives that may provide relevant assessment include: Holistic Health Assessment (for a National Health Development Plan); Resource Mapping and Expenditure Tracking (RMET); the investment case for the Global Financing Facility; partner mapping for Gavi's Full Portfolio Planning; or the immunization module included in a World Bank Health Security Financing Assessment (HSFA).

2A. Understanding the immunization programme performance

WHO strongly recommends that an **EPI review**[2] (or equivalent) is is completed within the last two years before the immunization programme's strategic planning cycle in order to serve as the key reference for the NIS situation analysis. If such recent review exists, a separate situation analysis is not required, and the findings from the EPI review should serve as the basis for the NIS development. Ensure the findings reflect equity considerations, and consider including additional analysis, such as gender analysis or social and behavioural drivers of immunization analysis.

If an EPI review has not been conducted prior to the development of the NIS, the NIS content producer will need to undertake a situation analysis of existing information sources and data ahead of any stakeholder consultations. See ***WHO's Guidance and Workbook for Conducting a Situation Analysis*** (link) for a guidance on how to document evidence systematically.

There are three essential steps to conducting a systematic situation analysis, as follows:



1. **Gather relevant information sources** to serve as the evidence base for the assessment exercise. Documents recommended for review are listed in (see Annexes).

2. **Complete a quick overview of immunization coverage and equity**. By conducting this analysis and interpreting the trends in coverage and equity, the development team will understand the main achievements of, and challenges (potential barriers) to, the immunization programme.

3. Use the seven EPI categories to **determine a list of lines of enquiry**, and systematically document evidence that indicates why there might or might not be a barrier. Also document evidence in cases where data are, or are not, available. To support this step, the ***WHO's Guidance and Workbook for Conducting a Situation Analysis*** (link) provides a long list of lines of enquiry to be explored, grouped by the seven EPI categories.

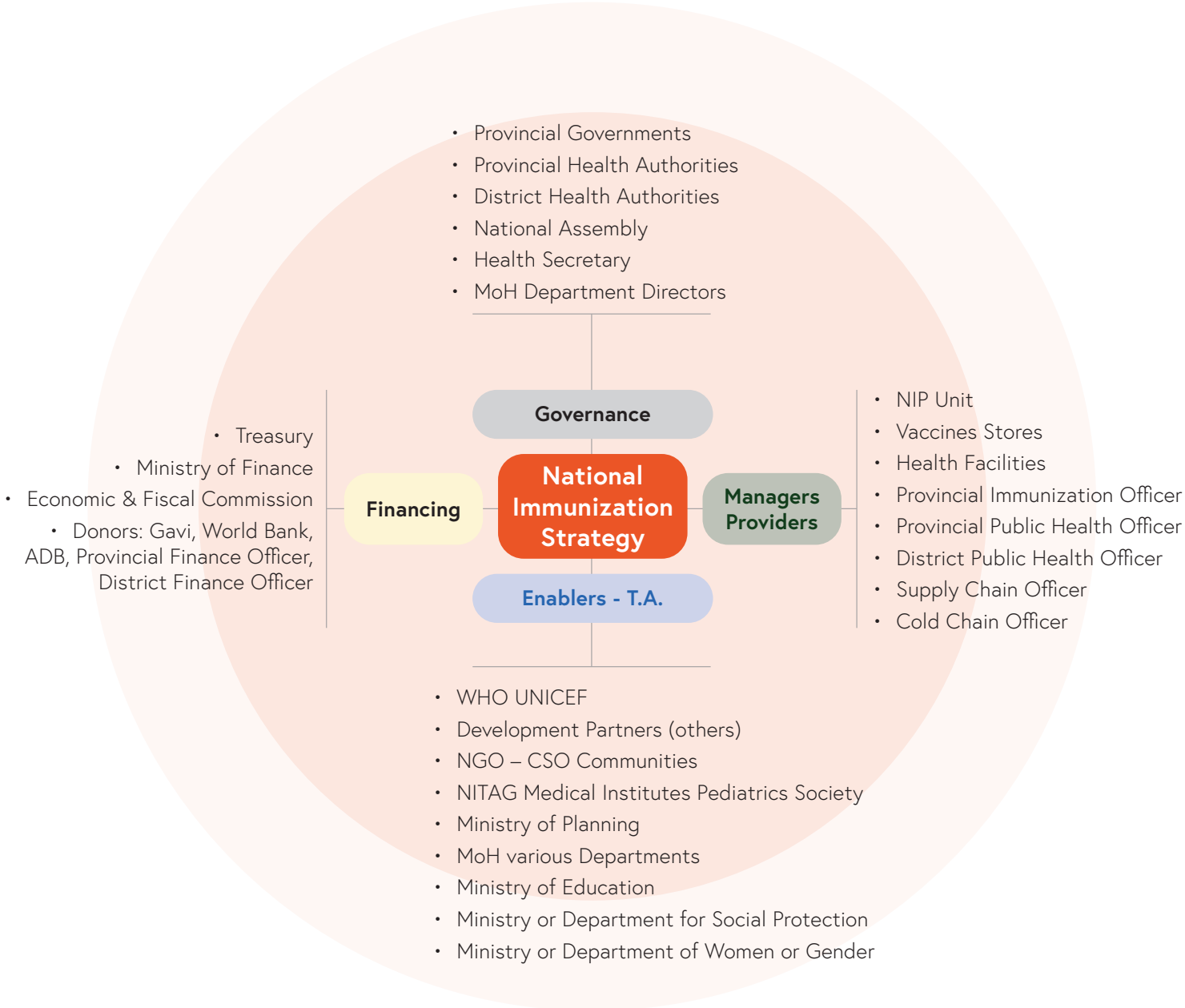
2. A guide for conducting an Expanded Programme on Immunization Review. Geneva: World Health Organization; 2017. https://apps.who.int/iris/bitstream/handle/10665/259960/WHO-IVB-17.17-eng.pdf?sequence=1

2B. Consultations with key informants

Prepare consultations with key informants – understand the partner landscape

In decentralized countries, these perspectives also need to be reviewed at subnational level where a local decision will be crucial for the endorsement and implementation of the NIS.

Figure 2. Illustrative stakeholder analysis



Once the available evidence has been reviewed, either through a recent EPI review (in the last 2 years) or a newly conducted situation analysis, the next step is to engage key stakeholders to contextualize the findings. Stakeholder consultations are essential to deepen the understanding of the evidence and clarifying any gaps. Discussions with sub-national authorities are crucial in understanding any sub-national differences. An important first step is a stakeholder mapping exercise. **Figure 2** outlines potential stakeholders to include in the consultation process. Once the landscape is well understood, plans for consultations can advance. These can take many different forms, including online surveys, key informant interviews (individual or group), workshops and/or meetings.

- **Understanding the findings from the situation analysis**
  - Discussions should explore whether the findings reflect operational realities, fill in any gaps or inconsistencies in the data and assess the extent of sub-national variation. Note if the findings from the stakeholder analysis differ from those in the published evidence, and explain and justify how these differences are interpreted and resolved.
  - Example questions include whether there are significant variations across socio-cultural groups, geographic areas, gender differences or special populations such as refugees and populations living in conflict-affected settings. Discussions should also explore, for categories or sub-categories where evidence is sparse or outdated, what additional insights can be documented based on stakeholder experience to help fill identified gaps.
- **Assessing progress against the previous national immunization strategic plan**
  - Discussions should explore the extent to which the previous immunization strategy was successfully implemented and whether its objectives achieved the intended outcomes.
  - Example questions include which objectives were financed, which were fully achieved, and which were only partially achieved; how was success measured; whether the targets were appropriate given the available resources and context. Discussions should also examine barriers to implementation, unmet objectives, and the underlying reasons for underperformance.
  - Clearly document objectives that were not fully achieved. If these objectives are to be retained in the next strategy, specify what changes (e.g. adjustments in resources, implementation approaches and monitoring mechanisms) are needed to improve the likelihood of achieving them.
- **Understanding the context**
  - Discussions should explore the evolving environment within which the immunization programme will operate over the next five years. This includes political, economic or social factors, both domestic and external, that may create opportunities or pose barriers to successful implementation of the NIS.
  - Example questions include assessing the level of immunization financing available; the proportion of financing that is domestic versus external; anticipated changes in funding; the broader macro-fiscal context; risks associated with donor transition or reduced external support; risks and resilience planning beyond fiscal constraints (e.g. climate change effects, pandemic preparedness, conflicts); the impact of decentralization on planning and budgeting; and opportunities for innovative financing or greater integration with primary health care.

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Best practice tips for Step 2: Situation analysis

- Systematically document the available evidence on immunization programme performance, and highlight research gaps.
- Ensure broad engagement across stakeholders in the situation analysis so that diverse views are captured and ownership is developed from the very early stages of NIS development.
- In decentralized countries, including subnational-level informants and decision-makers in the NIS development from the beginning is key for the endorsement and implementation of the NIS at subnational level.
- Evaluate with relevant stakeholders the key challenges encountered and the main drivers influencing the implementation of the objectives set out in the previous strategic plan.
- Review budgets spent against different interventions and objectives during the past period in order to guide thinking about the types of resources required for new strategies.
- Initiate fiscal space analysis and consider opportunities for optimisation of existing portfolio, including areas for prioritisation (priority groups/regions) and integration (either amongst immunsation activities or other MCH services).
- Identify gender-related barriers to immunization and ensure that these components are properly addressed in the situation analysis.
- Make sure to keep track of and organize the documentation used in the NIS development process for future reference, noting gaps and out-of-date materials.
- Use the iSC Toolkit to map the barriers and opportunities to address the coverage and equity in the supply chain.

Important note for the next four steps:

Once Step 2 is completed, the next four steps are **iterative**. The **strategy** and the **monitoring and evaluation (M&E) framework** first developed in Steps 3 and 4 will need to be revisited once the work on resourcing in Steps 5 and 6 is complete. This will ensure that the NIS captures the appropriate level of ambition, composed of realistic objectives that can be resourced within an expected budget envelope. To avoid a difficult and lengthy process across these four steps, it can be helpful to deal with financial considerations as early on as possible.

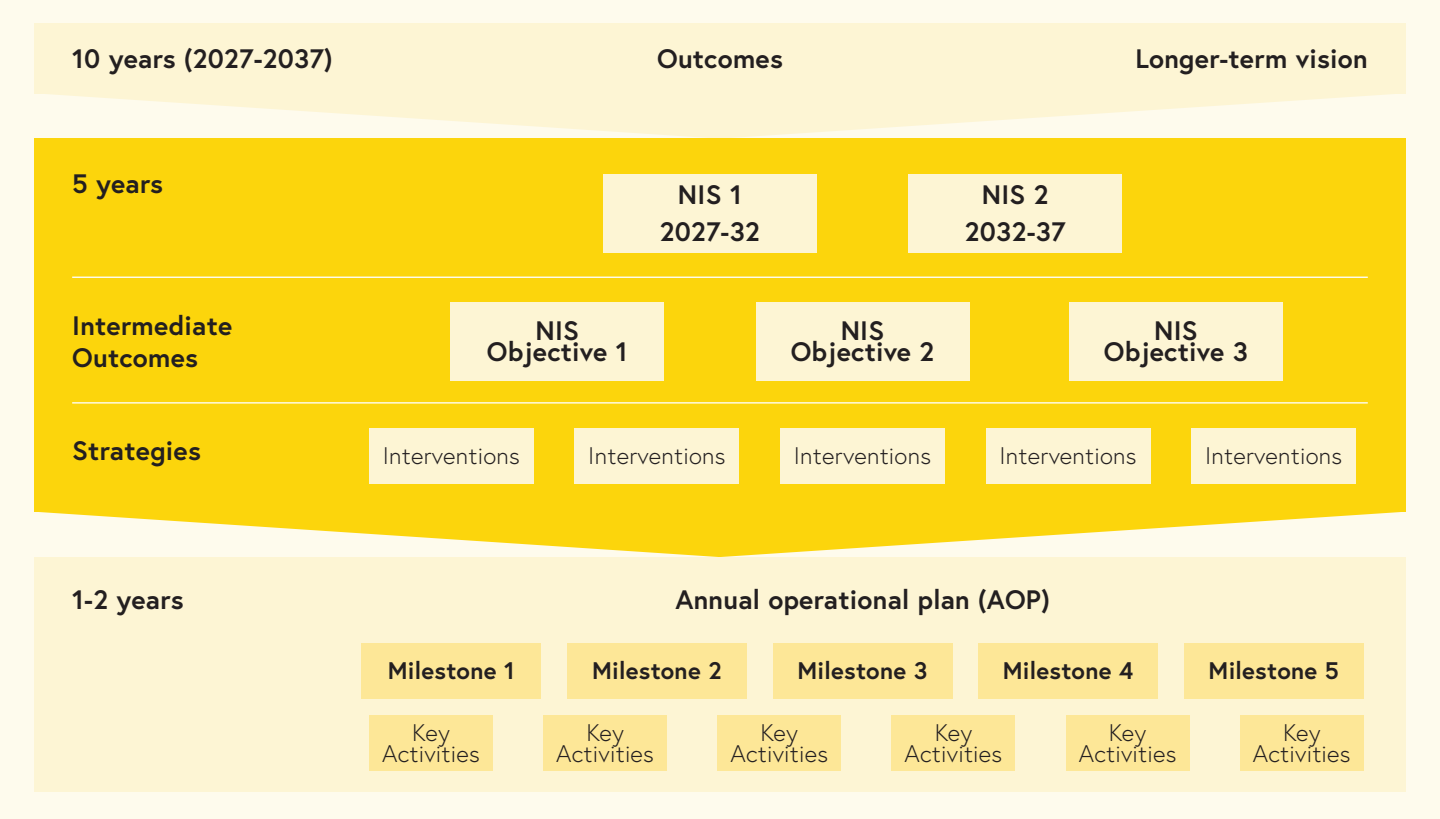
Step 3. Strategy Development

Objective: Set the vision (outcomes), objectives, and strategies	
Who does **what?**	**1. Task manager/Coordinator:** √ organizes the strategy development meetings, sets the meeting agenda and main outputs; √ manages the flow of information; √ prepares submission to the Steering Committee for review and approval. **2. Content producer:** √ helps define key questions for TWGs to identify strategies to achieve the objectives; √ records different scenarios for the strategy, corresponding assumptions, for and against; √ documents final strategies recommended by the TWGs and agreed to by the Steering Committee. **3. Technical Working Group(s):** √ identifies strategies to be taken in their respective work areas; √ works with other TWGs to see how the actions proposed by each TWG relate to the actions in other areas to address key barriers; √ matches the proposed strategy with the availability of resources and external factors to ascertain their feasibility; √ drafts proposal for Steering Committee review and approval. **4. Steering Committee:** √ assesses proposals and decides on the final strategy for the immunization programme to be negotiated with the MoH and MoF.
Who should be engaged?	• Following the stakeholder mapping and consultation plan from Steps 1 and 2, it is important to ensure that the NIS content builds on an inclusive dialogue with immunization stakeholders, health sector planners and focal points from other sectors.
How to develop the strategy	• Follow the agreed NIS workplan, including consultations (e.g. 1–2 workshop(s)) to prioritize proposals and build a strategy across these with coherent actions to commonly achieve the objectives. • Build scenarios to allow for comparison and consideration of trade-offs between options. • Present the scenarios to the Steering Committee for final decisions on the best strategies.
Entry point for **integration** with HSSP	Use the National HSSP as the key reference with which to align. If there is no HSSP, ensure that health sector planning focal points participate in the development of the NIS so that knowledge of the wider health sector is incorporated.
Coverage and equity	Ensure that the strategy development builds on the barriers to equitable coverage identified in the situation analysis (Step 2), with a clear focus on reducing or eliminating those barriers and advancing coverage and equity.
Duration	*Steps 3, 4, 5 and 6 are iterative and progress in parallel over a period of 3 months.* Step 3 is likely to take 1–2 months.
Output	A written NIS proposal, including long-term vision, objectives and strategies to achieve the objectives.
Tools and resources	• Vaccine prioritization and portfolio optimization (VPOP) toolkit (link) • NITAG resource center (link) • Gavi Programme Funding Guidelines (link) • Health Equity Assessment Toolkit (link).

3A. Preparing the strategic thinking

After having evaluated the current and past situation in Step 2, this step focuses on developing the content for the NIS, including the alignment to a **longer-term vision** (or goals) from national health plans and regional immunization strategies, identification of the **objectives** to be achieved by the end of the strategy period, a description of how to achieve them, and the changes (or **strategies**) needed to progress (Figure 3). The NIS is not intended to capture implementation details. The strategy should set clear directions and high-level interventions to guide implementation, and activities should be detailed in annual operational plans.

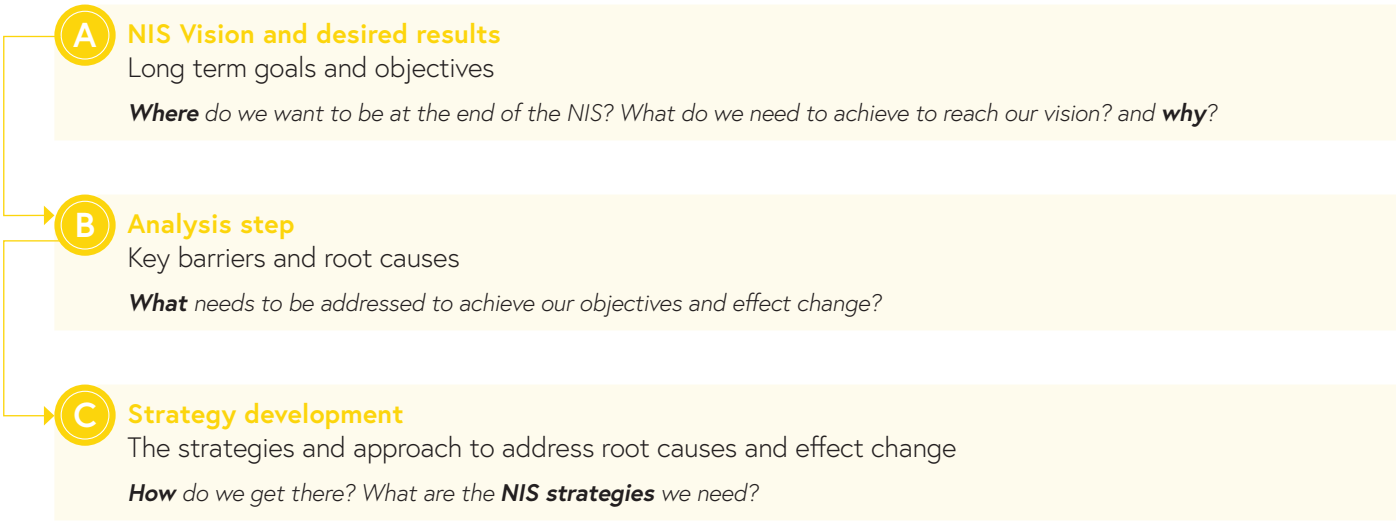
Figure 3. Relationship between vision, objectives, strategies and timelines



The NIS strategic thinking[3] begins by deciding "**where** do we want to go and **why**?" before determining "**what** should we address to achieve the objectives?" and finally designing **"how** do we get there" (**Figure 4**).

3. This type of logical progression is also captured by a **theory of change** approach that forms part of Gavi's application process. Gavi Theory of Change instructions. Geneva: Gavi, The Vaccine Alliance; May 2021 (https://www.gavi.org/sites/default/files/support/Theory_of_Change_Instructions.pdf, accessed 8 July 2021).

Figure 4. Steps in strategic thinking



Alignment with global and regional immunization strategy goals

IA2030 provides a long-term strategic framework that is intended to inspire and align the activities of community, country, regional and global stakeholders. The framework is composed of seven strategic priorities and four core principles, enabling regions and countries to identify the elements that are most relevant to their situation and enabling each strategic priority to be "weighted" according to its relative importance to a region or country.

3B. Setting and prioritizing NIS objectives

As intermediate outcomes, the NIS objectives need to capture sufficiently what is needed in order to advance towards the desired result, while reflecting available resources and capacity. Limiting the number of objectives, while ensuring each objective is clearly defined, measureable and achievable within the strategy framework, will help keep the NIS focused and prioritized. In order to set and prioritize NIS objectives:

- **Look for opportunities for integration within the broader health system:** Health workforce incentive plans, gender equity policies, health information system upgrades, poverty reduction strategies, quality improvement collaboratives to help increase demand for services, direct facility or performance based financing to improve performance of facility, community networks to improve organisation and monitoring of services, etc. will provide insights on how to optimize the NIS strategy. It is important to find opportunities to participate in the development of the health sector strategy to ensure that the immunization programme is appropriately represented in the resulting HSSP. Explore integration as a strategic means to deliver immunization across the life course, working with other health services to be delivered together – e.g. through the second year of life platform (reproductive health, nutrition, de-worming, etc.).

4. Some HSSPs contain immunization-specific objectives/targets that were developed at a different point in time or within a different context; therefore care must be taken when aligning the NIS objectives to them.

- **Find the key contributions needed from immunization:** The HSSP is a good starting point for understanding health sector priorities and the contribution of the NIS to the HSSP. As most HSSPs do not include details of the immunization programme, the contribution of the immunization programme should be combined with those of other health interventions (e.g. maternal and child health), to lead to optimization of resources leading to a broader health outcome.
- **Align with the broader national health sector strategic priorities** to increase the efficiency of the different immunization components (**Figure 5**). Vaccine-preventable disease (VPD) surveillance and immunization supply chain for instance, will be more efficient if it collaborates with different departments, including the Supply and logistics unit, epidemiology department, the laboratory network and the immunization programme.
- **Align with other plans and processes within the immunization programme** to ensure coherence and avoid duplication of efforts. Such examples include aligning with existing improvement initiatives, such as the continuous improvement plan (cIP) for EVM, and related strategies in areas such as digital health and information systems (e.g. digital platforms supporting immunization, integrated digital health plans).
- **Focus on advancing equity** by identifying and reaching zero-dose and under-immunized populations through tailored, context-specific approaches. This includes targeting fragile, remote, urban poor and mobile populations.
- **Gender-intentional strategies** as gender equality is a core principle of IA2030. Objectives should explicitly address gender-related barriers to immunization, and incorporate gender-intentional strategies across relevant system components. They should promote equitable access and should not reinforce harmful norms or increase unpaid labour burdens.

Integration with Primary Health Care

Immunisation is an integral part of PHC and PHC-oriented health services are recognized as the most inclusive, equitable and cost effective pathway towards Universal Health Coverage (UHC). Countries and Ministries of Health are responding to the reduction of external funding with approaches to improve the strategic allocation of resources and maximise their efficient use. Integration of immunisation programmes with PHC-oriented models of care will not only support Ministries of Health to increasing the equitable access to care but also contribute to the people-centeredness of services and reduce fragmentation of delivery and funding.

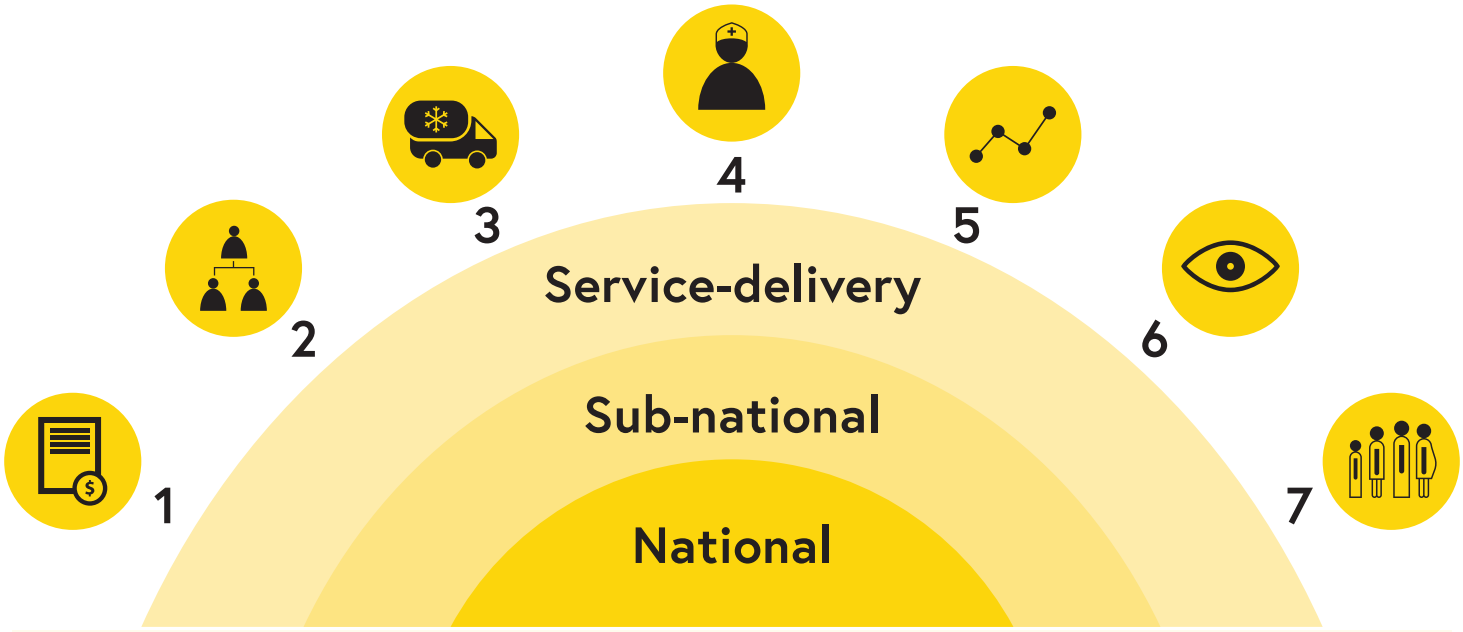
Integrating NIS objectives and activities with national health sector priorities especially primary health care contributes to more efficiency and mutual reinforcement, emphasizing the role of immunization in strengthening PHC systems and conversely, how robust PHC programmes can support immunization delivery. The Immunization for Primary Health Care Framework for Action highlights concrete practices, and opportunities such as to leverage immunization to contribute to robust and strengthened PHC. Examples include multisetoral collaboration towards a Health in All policy approach; integrated data generation to inform decision-making processes and integrated microplanning to identify missed out children and families for immunisation and other primary care interventions.

- Assess potential impact: To help focus the number of objectives, prioritize those most likely to have the greatest impact towards the intended results given funding availability. These will address the most significant challenges to ensuring successful outcomes.
- Consider time frame and sequencing along with the choice of objectives for each specific strategy period. There may be a chronological order in which activities need to be completed to reach the long-term outcome or desired result.
- Assess feasibility to ensure that objectives are achievable, not only within the NIS period but given the available capacity in terms of both human and financial resources. This point is further explored in Step 5 (Resource requirements), but having initial information up-front will help exclude objectives that are not achievable within given parameters.

5. Gavi-supported countries need to be aware of future funding scenarios and should prepare well in advance for possible transition from eligibility.

- Consider the evolving environment within which the immunization programme will operate over the next five years. The environment can be shaped by political, economic and social factors, both within the country and externally, which may create opportunities on barriers for successful implementation of the NIS. In particular, countries should account for changes in the funding landscape, including shifts in donor support and potential transition from Gavi eligibility, and plan in advance to ensure sustainable finacing and programme continuity.

Figure 5. Seven immunization system components will guide the NIS development and costing approach



1. Programme management and financing
- Policy & guidance
- Governance & accountability
- Planning & procurement
- Partner coordination
- Budgeting & financing

2. Human resources management
- HR planning
- Capacity-building
- Supervision & performance monitoring

3. Vaccine supply, quality and logistics
- Cold chain
- Supply management
- Transport
- Waste management

4. Service delivery
- HR & strategies
- Session quality
- Integration

5. Immunization coverage and AEFI monitoring
- HR & systems
- Recording & reporting
- Data quality
- Coverage monitoring & use
- AEFI monitoring

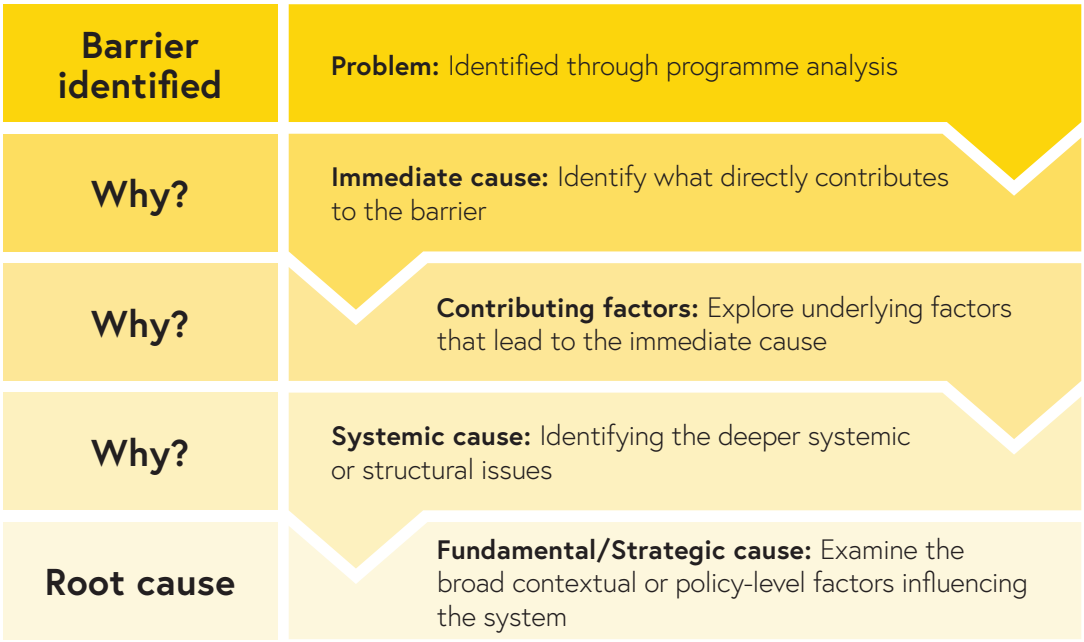
6. Disease surveillance
- HR & systems
- Detection & response
- Performance

7. Demand generation
- Thinking & feeling
- Social processes
- Practical issues
- Knowledge & attitudes

3C. Identifying key opportunities and barrier(s) and their root causes

Use the findings from Step 2 not only to describe what is happening, but also to understand why it is happening. By examining the evidence on barriers to achieving high and equitable coverage, identify the root causes that must be addressed to achieve sustainable change across the seven components of the immunization programme (Figure 5). A practical approach to identifying root causes is illustrated in Figure 6, which demonstrates how a series of why questions can trace a defined barrier (problem) from its immediate cause and contributing factors to the underlying systemic and fundamental (strategic) causes. Consider the appropriate level at which the barriers can be addressed (e.g. VPD surveillance is closely linked to the immunization programme but is often managed outside of the immunization system). Identify opportunities, such as political, economic and technological factors that could lead to reduction or elimination of the identified barriers.

Figure 6. Identifying root causes



3D. Defining NIS strategies to address root causes and effect change

The next step is to decide what **key changes** are needed in the immunization programme to capitalize on opportunities and address root causes of the barriers identified. Coherent actions, or **key interventions**, from all immunization components can be designed to combine with each other to create solutions to enable the improvements to happen.

- **Consultation and engagement:** To ensure the successful design of strategies, it is important that EPI managers at central and local levels, as well as representatives from the health-facility level and from the communities benefiting from immunization, participate directly in the development of the strategies and propose key interventions needed at their respective levels.
- **Financial considerations:** When thinking through the strategies, it will be important to have information available on costs. This will help ensure that realistic strategies are being proposed..

Looking ahead to Steps 4 and 5, build a **prioritization structure** into the NIS so that it is easy to identify which activities are essential and which ones can be renegotiated. Document the process of determining trade-offs between options.

Vaccine prioritisation and optimisation (VPOP)

VPOP promotes a country owned, evidence-informed process for countries to maximize the health impact of their immunization programmes within available resources, adapted to their own context and optimally respond to financial constraints.

- **Vaccine prioritisation** allows countries to sequence decisions on vaccines that are **not yet introduced** determining which ones to introduce first based on impact, feasibility, and resources.
- **Vaccine optimisation** focuses on **maximising the impact of the existing immunization portfolio** by adjusting products, schedules, presentations, or target groups to maximize the impact, efficiency, and coverage of already introduced vaccines.

Why VPOP?

In the context of expanding range of vaccines and delivery options, and limited competing resources, it is essential to make evidence-informed, transparent, and documented strategic trade-offs decisions. Applying VPOP strengthens alignment between **technical recommendations, national priorities, and available resources**, and supports dialogue with ministries of finance and partners.

How VPOP informs NIS strategies?

Optimisation decisions typically inform **short-term strategies** to improve performance and efficiency of existing vaccines and delivery platforms. **Prioritisation decisions** inform **medium- to long-term strategic directions**, including new vaccine introductions or major portfolio shifts that may extend beyond a single NIS cycle.

Coordination between EPI and NITAG

Effective VPOP requires **close coordination between EPI**, which leads strategic planning, feasibility assessment and implementation, and the **NITAG**, which provides, evidence-based recommendations. Joint engagement helps ensure that recommendations are **contextualised, prioritised and operationalised** within the NIS.

Integrating VPOP outcomes into the NIS

The VPOP considerations should be fully embedded in the NIS process.

- During preparation (Step 1) reference any ongoing or planned prioritization/optimization work.
- In Step 2, review existing vaccine portfolio and build the evidence based needed for prioritization and optimization (e.g. disease burden, programme performance, financing trends, delivery constraints and equity gaps).
- Align strategic choices in Step 3 with the outcomes of the VPOP process.
- When designing the M&E framework in Step 4, develop indicators and milestones which would ensure VPOP iterations are part of regular monitoring.
- Use the VPOP outcomes to inform costing assumptions, prioritization of interventions, and scenario development in NIS.COST (Step 5) and use the documented trade-off discussions to justify sequencing of investments (Step 6).
- Ensure that major prioritization and optimization decisions are clearly reflected and endorsed as part of the final NIS (Step 7), and revisit VPOP outcomes as part of period annual reviews.

Resources available

VPOP toolkit

- Optimisation guidance: https://www.nitag-resource.org/training/building-and-strengthening-technical-competencies/vaccine-prioritization-and-portfolio
- WHO Vaccine Evidence Compendium: https://www.nitag-resource.org/compendium

Beyond VPOP, countries need to prioritise strategies and interventions of the NIS based on their own context, by assessing different options and choosing the most suitable ones based on available resources. Evidence-informed prioritisation of immunization services, in the broader context of PHC can ensure that health resources are spent efficiently and equitably.

Priority-setting should be guided by a core set of principles to ensure that the resulting decisions are fair, informed by evidence, and aligned with social values. These principles fall into two broad categories: substantive principles, which concern the criteria and values used to rank health priorities (the "what" of the decision), and procedural principles, which concern the process by which decisions are made (the "how" of decision-making).

Principles

Substantive

- **Efficiency –** Use available resources to maximise benefit and minimise harm (maximise population health). This requires defining overall health impact of an intervention or service. Efficiency is commonly assessed using cost-effectiveness analysis, which informs the decision maker about the extent of health gains given the resources used.
- **Equity –** Ensure that allocation decisions do not discriminate for or against individuals or populations based on characteristics such as race, ethnicity, gender, disability, or religion. Equity also means not worsening the situation of people who are disadvantaged by systematic disparities in health or the social determinants of health (such as income, education, rural versus urban, and racism) when allocating resources.
- **Social and economic impact –** Maximise broader, non-health impact associated with the intervention or health service, including contributions to productivity, educational attainment and poverty reduction and minimise unintended negative social and economic impact.
- **Feasibility –** Feasibility is the practicality of implementing the intervention with existing health system capacity.

Whenever multiple principles are used to allocate resources, there will be trade-offs. Reconciling such conflicts between the ethical principles is fundamental and should be done explicitly. There are four fundamental procedural principles during this process: transparency, participation and inclusion, evidence responsiveness and accountability.

Procedural

- **Transparency –** Publicly communicate decisions, decision-making processes and reasons supporting decisions in an accurate, honest, understandable and timely manner.
- **Participation and inclusion –** To the greatest extent possible, set priorities with the involvement and/or representation of those expected to be affected by such decisions. Enabling the participation and inclusion of those expected to be affected should aim to calibrate decisions to the extent to which the intervention or service is accepted, culturally appropriate and trusted by the communities it is intended to serve.
- **Evidence –** responsiveness Inform decisions with the best available evidence. Assess evidence against each principle of decision-making. Regularly review and revise decisions based on evolving data, such as evolving cost-effectiveness assessments and concerning which populations might benefit or are unfairly disadvantaged.
- **Accountability –** Be answerable for decisions and actions. Decisions should be made with clearly defined objectives and responsibilities, transparently communicated and based on reasons that can be understood by the affected communities.

A systematic approach helps ensure that trade-offs are explicitly considered and that decisions are aligned with national priorities, available resources, and programme goals. Table 2 outlines a practical process that can be used to compare options in a structured manner. This process builds on the principles of multi-criteria decision analysis while remaining adaptable to country contexts.

Table 2. A five-step process to prioritisation of choices

Component	Key questions to answer
1. Prioritisation decision	• What decision is needed and why? • Is it a comparison of different strategies? • Is it an introduction of new strategies not used before?
2. Understanding context	• What is the current situation? • Which options will you compare? • Who are the stakeholders that should be involved in decision-making?
3. Determining criteria for decision-making	• Which criteria will be used to make a decision? • Do the chosen criteria allow you to distinguish between the options? • Is it qualitative or quantitative comparison? • Does each criterion have equal weight?
4. Compiling evidence	• Do you have sufficient evidence collected for each criterion? • Are there any challenges with data quality of the evidence?
5. Selecting the appropriate option	• How do the options compare between each other? • Is there an option that performs better overall than the other options? • Is there an option that performs better for the criteria with highest weight? • What is the final decision? • What is the rationale behind making the decision?

Best practice tips for Step 3: Strategy development

- Ensure interventions are aimed to address the identified barriers to high and equitable coverage.
- Ensure there is capacity for strategic and innovative thinking within the NIS team so that stakeholders are pushed to think beyond the status quo drawing on different learning agendas.
- Ensure seamless coordination between service delivery and demand generation and community engagement, based on evidence.
- Expert facilitation will be required to help stakeholders explore new opportunities and reach agreement on the prioritization process, including trade-offs.
- Ensure NITAG's involvement is well planned to support recommendations on VPOP to be integrated in the NIS.
- Involve health sector planning focal points to leverage opportunities from the wider health sector.
- Involve subnational actors in the discussions and decision-making, especially where financing for immunization service delivery is the responsibility of subnational governments or institutions.
- Remember its iterative process and the strategy should be aligned with costing and budget dialogue.

Step 4. M&E framework

Objective: Develop the monitoring and evaluation framework for the NIS, with linkages to ownership and accountability	
Who does what?	**1. Task manager/Coordinator:** √ provides overall coordination for development of the monitoring and evaluation (M&E) framework; √ organizes consultations with the key NIS implementing agencies, including representatives from the subnational level and key stakeholders beyond the immunization programme. **2. Content producer:** √ participates in the development of the M&E framework, plans with the TWGs and documents the agreement reached between the implementing agencies. **3. Technical Working Group(s)/experts:** √ in consultation with the implementing agencies, develops the M&E framework and plans by leveraging, where possible, existing health-sector M&E processes. **4. Steering Committee:** √ reviews and endorses the M&E framework
Who should be engaged?	• Following the stakeholder mapping and consultation plan from Steps 1 and 2, it is important to ensure that the NIS content builds on an inclusive dialogue across immunization stakeholders, health-sector planners and focal points from other sectors.
How to develop the NIS M&E framework	1. Revisit the goals, objectives, and outcomes that were formulated in step 3. Formulate a theory of change that specifies how the selected interventions will lead to the desired intermediate outcomes and objectives. 2. Define indicators, data source, periodicity, milestones and targets to measure the progress across the results chain (inputs, processes and outcomes). 3. Agree on the mechanisms, frequency, and roles and responsibilities for regular review and corrective action.
Entry point for **integration** with HSSP	• Use national health sector M&E frameworks to identify key performance indicators for the NIS M&E framework to the extent that is possible. • Contact the Bureau of Statistics or the Planning Department of the Ministry of Health, public health institutes, academic institutions, or global partners supporting M&E to understand roles and responsibilities, and timelines, to shape and leverage the approach and process.
Coverage and equity	• Beyond the impact of the NIS on national level coverage, consider how it may affect specific populations, and plan to measure coverage not just at the national level, but also plan for disaggregation across geographies, ethnic and socio-economic groups. • Where relevant, disaggregate key performance indicators by sex to assess gender-related barriers and establish clear benchmarks and sex-disaggregated indicators of success. • Include indicators that track gender-related barriers to immunization, such as caregiver mobility, decision-making autonomy, and access to information leveraging the Gender and Immunization Measurement Framework to support standarisation, integration into national systems, and routine use of gender data for decision-making.
Duration	*Steps 3, 4, 5 and 6 are iterative and progress in parallel over a period of 3 months.* Step 4 is likely to take 4–6 weeks of the full 3 months.
Output	An agreed M&E framework for the NIS with linkages to ownership and accountability.

6. Key performance indicators should measure overall progress towards achieving NIS objectives and should be SMART (Specific, Measureable, Achievable, Relevant and Timebound)..

4A. What is an M&E framework and how can it help development and implementation of the NIS?

The Monitoring and Evaluation (M&E) framework is a structured plan that articulates in some detail what the NIS aims to achieve and describes how its progress and impact will be measured.

- **Monitoring**: The continuous, routine collection of data to track programme activities and outcomes and take corrective actions as needed.
- **Evaluation**: A periodic, deeper assessment to determine if the NIS progresses towards its broader goals. It also aims to explain why and how the NIS worked or failed to reach its objectives.

A good M&E framework builds a narrative around how the NIS intends to affect change. Typically, the interventions outlined in step 3 require resources and aim to optimize processes to strengthen the immunization system or support demand. This ought to improve coverage and/or equity and lead to reduction in disease burden, which in turn may have a positive economic and even political impact. That thinking is captured in the generic logical framework in Figure 7. It shows "things that can be monitored", classified logically on the causal pathway or a results chain from required inputs to desired impact.

Figure 7. Logical Framework for immunization – not exhaustive

Outcomes should be disaggregated by sex

Resources / inputs	Processes	Outputs	Outcomes	Impact
• Vaccines • Financial resources • Human Resources • Facilities • Equipment	• (Micro)planning • Service delivery strategies • Messaging and communication • Community engagement • Integration with PHC & broader MNCAH services	• Service availability (access) • Service Quality • Demand, attitudes toward vaccination	• Coverage • Equity	• Outbreaks • Morbidity and mortality • Economic impact • Political impact

The detailed narrative of how an intervention is supposed to work is sometimes referred to as the "theory of change (ToC)". An example of a ToC could be as simple as this statement:

> *"If we equip 500 remote locations with solar refrigerators (input),* ***then*** *fixed site vaccination services can be organised in these communities (process), which will* ***lead to*** *better availability in rural areas (output). This will* ***lead to*** *higher coverage and more equity between rural and urban areas, and less vaccine preventable disease outbreaks in rural areas. This in turn will* ***contribute to*** *rural development and improved trust in government services."*

The ToC thus describes how the selected interventions will address the identified root causes to lead to better outcomes, and it follows the logical model above from left to right. "Upstream" indicators (inputs, processes and output) are more actionable than outcomes or impact indicators. Inversely, this logic can also start with a problem statement about poor outcomes and help think about the root causes identified in Step 3 for underperformance in a more rigorous way, reading the table from right to left. In the above example, the thinking might be that:

> *"There are too many outbreaks of measles* ***because*** *coverage is too low in rural areas. This is* ***because*** *people there do not have access to routine immunization services,* ***because*** *the lack of electricity means that no vaccines can be stored in facilities and no fixed site service can be provided."*

Some of these statements could be questioned. What if human resources rather than refrigerators are the real bottleneck for rural service provision? And what if the real root-causes relate to demand or quality, rather than to access? Building the M&E framework highlights the underlying assumptions in the strategy and doing it in parallel with the strategy development can improve the rigour of that process. As noted in step 3, identifying root causes and selecting appropriate interventions is also a data-driven process for which evidence is needed.

4B. Select and define indicators and their sources

The M&E framework should include enough indicators to measure progress across the results chain, without creating a disproportionate amount of work for the people who will collect the required data. Ideally, most data are already available through the Health Management Information System (HMIS) or other routine sources. When essential data are lacking, they could either be added to the HMIS or collected though periodic surveys at the start and endpoints of the NIS. There is no correct number of indicators, but a relatively short list of about 10 to 15 might work best to maintain focus. To assess whether the framework has enough indicators, ask whether they will be able to inform the following questions:

- Were the planned resources made available? E.g. track the number of procured refrigerators.
- Were the NIS interventions implemented as intended? E.g. track the facilities that were equipped with a solar refrigerator.
- Did this lead to improved access? E.g. track the number of fixed-site sessions held or estimate the number of people having access to routine services within 30-minute travel time.
- Did better access lead to higher coverage or more equity? E.g. monitor the level or trends in coverage, disaggregated by rural and urban area.
- Did higher coverage lead to better disease control? E.g. track outbreaks or incidence in areas with improved access.

Once they have been selected, each indicator needs to be defined. Table 3 has a suggested list of attributes.

A note on context: Important resources like financing or human resources might be outside of the control of the immunization programme, i.e. their ownership may lie elsewhere. That makes the related indicators less actionable, but it is still important to capture this context as it drives success or failure of the programme.

Table 3. Indicator meta-data

Description	Name of the indicator, with its purpose and interpretation.
Calculation	What is in the numerator and denominator?
Source	The routine facility reporting system / HMIS, a periodic survey or assessment (household survey or facility survey), surveillance system, other.
Owner	Who is accountable for the status of this indicator? Ownership can be either at the national or subnational level.
Baseline	The value of the indicator at the beginning of the strategic period, before its interventions are implemented.
Target and milestones	What would success look like for each indicator, by the end of the strategic period and ideally at a mid-point? Targets can be defined as an absolute level (e.g. 90% coverage), or relative to a baseline, e.g. 50% less "zero-dose children".

4C. Operationalise the framework through M&E and action cycles

The NIS M&E Framework should facilitate monitoring, evaluation and action (ME&A) cycles at national, subnational and health facility levels (Figure 8).

At the national level, annual reviews should be held to check if the implementation of the NIS is on track and to identify potential actions for course correction. In addition to reviewing overall progress, it is important to assess the most significant bottlenecks affecting implementation. What should happen at the given time point according to the strategy, what is actually occurring, where the largest gaps exist, what factors are causing these gaps, and what actions can be taken to address them? Assess implementation bottlenecks across several key areas, including:

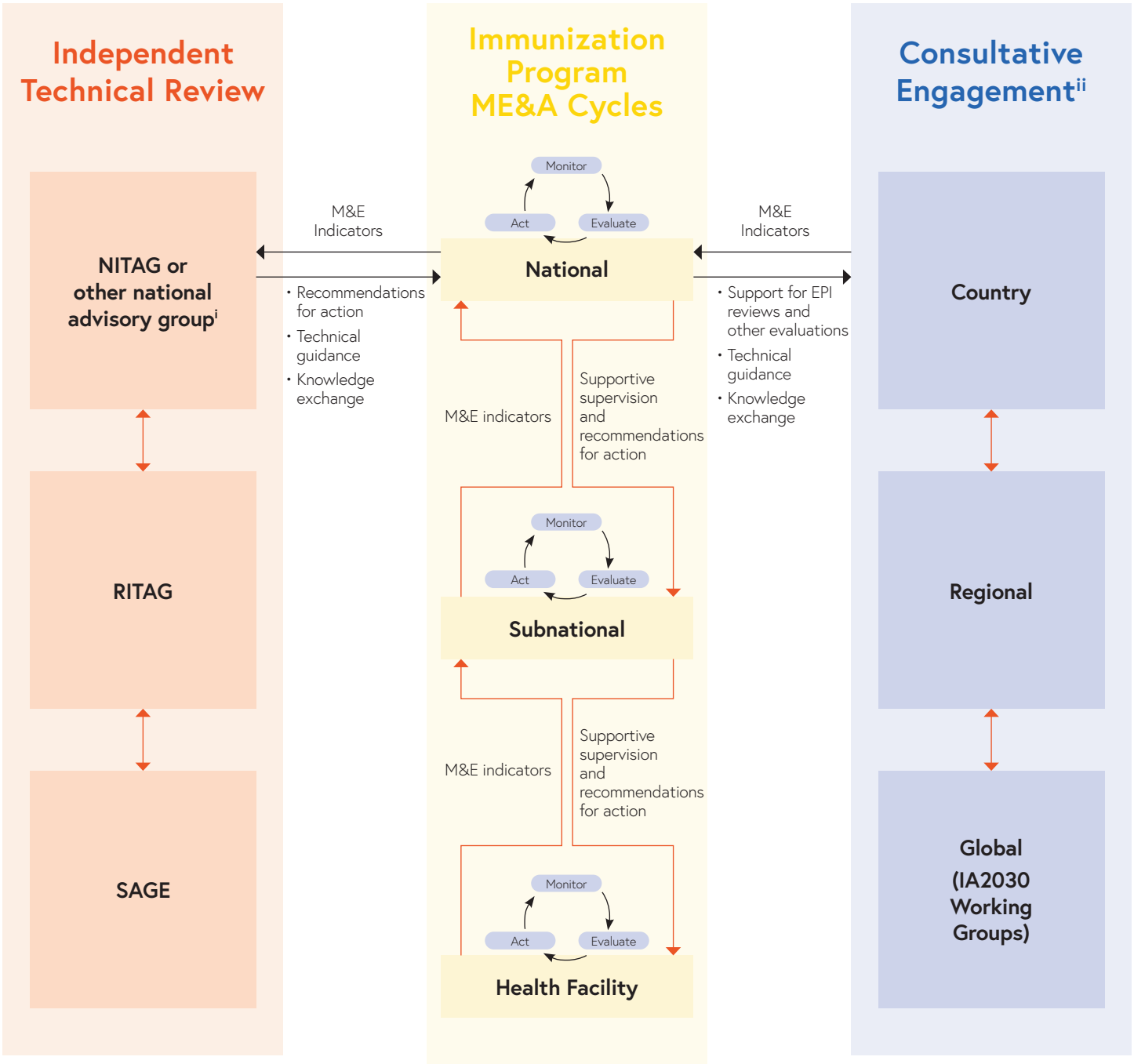
- **Policy, governance and planning**: Review and discuss whether relevant policy updates have been adopted and communicated clearly, whether NIS objectives have been translated into annual operational plans, whether coordination meetings across different levels of the system are occurring as planned, and whether roles and responsibilities among stakeholders are clearly defined and understood.
- **Financing and resources**: Review and discuss whether resources are sufficient and reaching the right level, by assessing whether the immunization budget has been fully allocated and disbursed, whether sub-national levels receive funds on time, and whether partner funds are aligned with the national priorities.
- **Workforce capacity**: Review and discuss whether health workers have the skills and time to deliver services and implement NIS interventions. Areas of discussion could focus on training needs, frequency and quality of supportive supervision, and staff time availability.
- **Data**: Do the existing systems provide all the data that are required at a sufficient data quality for decision making?

Furthermore, periodic programme assessments provide an opportunity for more in-depth evaluation, including root cause analysis, and to update NIS goals and interventions as needed.

Subnational and health facility: Relevant key performance indicators at national level should be linked to actionable indicators at subnational and health facility levels. Targets and milestones should be based on the context, opportunities and challenges at these levels and progress should be tracked continuously. Health facilities and actors at subnational level should receive timely information (recommendations and action points) from progress reviews at national level and be empowered (receive the resources and decision-making power) to implement the required corrective actions.

Countries may opt to undertake different types of costing exercises. These will vary from costing the NIS strategy alone and costing the NIS strategy along with the EPI programme as a whole. The NIS Guidance and associated NIS.COST approach are designed to capture costs and estimated resources for the NIS alone. If a country chooses to cost the full programme, the following guidance will support an assessment of the costs of routine immunization services "How to Cost Immunization Programs".

Figure 8. Information flow for Monitoring, Evaluation & Action (ME&A) Cycles for NIS implementation



i. The **NITAG** or other relevant technical advisory group can be engaged to support with formal independent technical review of progress towards NIS millestones and targets and provide recommendations for actions. Regional Immunization Technical Advisory Groups (RTTAGs) provide support to NITAGs to regulatory monitor progress and systematically identify emerging priorities.

ii. **Consultative** engagement with civil society organizations (CSOs), PHC, other departments within the MoH, implementing partners, and IA2030 global working groups can support additional periodic exercises of in-depth evaluation or reviews (e.g., EPI Reviews) of technical or functional areas to provide technical guidance, knowledge exchange, and recommendations for actions.

Best practice tips for Step 4: M&E framework development

- Design the M&E framework in a participatory manner using a multisectoral approach to engage with all implementing stakeholders, including those at subnational levels, and optimize ownership and accountability.
- Leverage the country's existing mechanisms for evaluating government programmes. In some countries, the NITAG or the ICC can play a role in overseeing M&E progress reviews for the NIS.
- Use historical data to define baseline and inform target-setting. Use existing reporting systems, where possible, such as digital systems for automated reporting, dashboards, and harmonized indicator tracking (e.g. Global Digital Health Monitor).
- Consider approaches to strengthen the quality and use of data at all levels. Set guidance for data collection, monitoring and progress reporting.
- Conduct annual review of the process to identify any bottlenecks and course-correct.
- Institutionalize accountability by attributing the role of a focal point for an action to a specific position (e.g. public health officer) rather than a work entity (e.g. public health office).
- Link M&E results to the allocation of resources.
- Refer to the Immunization Agenda 2030 country-level indicator options for strategic areas of immunization programme performance. Countries may be guided by the menu of indicators (presented in Annex 1 to the IA2030 Framework for Action) and can define and select those indicators mapped to the specific NIS objectives.

7. IA2030 Framework for Action and Annex 1, the IA2030 M&E Framework are available to download from the IA2030 website: https://www.immunizationagenda2030.org/framework-for-action

Step 5. Resource estimates

Objective: Estimate the resource requirements for NIS	
Who does **what**?	**1. Task manager/Coordinator:** √ organizes the collection of information needed for costing, including securing authorization by the MoF and MoH as needed. **2. Content producer:** √ supports the collection of data for resource requirement estimates and the calculation of total resource requirements, including the needs for maintaining routine immunization activities as included in previous years' budgets and for implementing the NIS interventions. **3. Technical Working Group(s)/Health economist expert:** √ apply the NIS COST application to estimate the resource requirement for the actions included in the selected strategies; √ a health economist can be very useful for developing estimates of resource requirements working with the technical groups to ratify data sources and estimation methods. **4. Steering Committee:** √ defines what kind of resource requirement information is crucial for the budget dialogue and health-sector planning; √ facilitates sharing of costing data from respective agencies.
Who should be engaged?	• From the MoH Budget Department, usually a health economist. • The MoF, Treasury, Fiscal Commission and others with immunization funding. • WHO, UNICEF, Gavi, World Bank, Asian Development Bank, etc. • Provincial finance officers
How to estimate resource requirements	• Understand the level of detail needed to estimate the feasibility of the strategies in preparation for the budget dialogue. • Work to fill any knowledge gaps in cost data. • Use the NIS.COST application to guide the process and estimate the costs.
Entry point for **integration** with HSSP	• Work with the Planning and Budgeting departments of the MoH and other relevant ministries with budgets for immunization (e.g. Education). • Solicit and follow guidance from the MoH planning and budgeting officials on how to estimate costs. • Discuss with HSS and financing experts from partner organizations and other stakeholders how to strengthen PHC as the platform for the immunization system.
Duration	*Steps 3, 4, 5 and 6 are iterative and progress in parallel over a period of 3 months.* Step 5 is likely to take 4–6 weeks of the full 3 months.
Output	Estimate of the total resource requirement for implementing the NIS and routine immunization activities. Estimate of any funding gap once the budget envelope for the NIS is estimated.
Tools and Resources	NIS.COST[8]

8. https://niscost.org/en

5A. Estimating the funding needs for the implementation of the strategies

The NIS should be a feasible plan based on a **realistic expectation of available resources**. Available resources include those resources currently available to the immunization programme plus the additional resources that can be mobilized, based on the projected fiscal space and external funding opportunities for health including primary care services and immunization over the timeframe of the NIS strategic period. To support realistic planning, countries should distinguish between the total resource requirements (costs) of the NIS, the financing expected from domestic sources, the financing expected from external partners, and any remaining funding gap. This helps ensure that the NIS is not only technically sound but also financially feasible.

For the expectation of available resources to be realistic, countries can use macro-economic data at the national level and data showing historical immunization budget and expenditure trends in order to project the increase in immunization budget that could potentially be attained. Where feasible, this analysis should also consider the affordability of the NIS over time, including expected growth in government health expenditure, potential efficiencies proposed in the strategy in prioritisation/integration, competing priorities that could reduce resource availability, and the recurrent cost implications of new investments (such as human resources, cold chain maintenance, and service delivery expansion). This assessment of resource needs and financing expectations should inform the prioritization and sequencing of interventions and provide a foundation for the subsequent budget dialogue (Step 6).

5B. Using the NIS costing approach

UNICEF has developed an **NIS resource requirement application** called NIS.COST. The tool is available as a web-based NIS.Cost application designed to support standardized costing, budgeting, and financing analysis. It enables countries to estimate resource requirements, compare costs with available financing, and generate multi-year budget proejctions within a standardized framework. The application supports scenario analysis and financing analysis and is governed through stablished multi-agency mechanisms to ensure methodological consistency, data integrity and alignment with country planning nad budgeting processes. The instructions on the use of the application are integrated within the application. Underlying principles include:

1. NIS.COST is closely linked with the **interventions proposed in the NIS**. Hence, it is the strategies (and their main interventions) as presented in the NIS document that will be entered into the roadmap module of the NIS. The associated costs of these activities and interventions are estimated and presented for each of the years covered by the NIS strategic period. The Interventions and activities within the NIS roadmap should be further tagged by EPI categorization, priority of the activity relative to the attainment of the strategic objective, activity type – whether routine, replacement or new, the administrative level of implementation and whether or not the activity will share costs/ resources with other immunization and health systems interventions. Other customized categories and tags could also be applied to indicate Gavi categorization and any country-specific categorization.

9. Resch S, Menzies N, Portnoy A, Clarke-Deelder E, O'Keeffe L, Suharlim C, Brenzel L., "How to cost immunization programs: a practical guide on primary data collection and analysis." 2020. Cambridge, MA: immunizationeconomics.org/ Harvard T.H. Chan School of Public Health.

2. The MoH budget for immunization should be established at the onset of the costing process, alongside an assessment of the projected fiscal space for health and services including immunization. Historical data on budget allocations and expenditures should be entered into the budget module of the application to inform baseline trends. This enables the estimated future resource requirements of the NIS to be assessed against both past expenditure patterns and the expected trajectory of available domestic resources, supporting a more realistic and affordable costing of the strategy.

3. Importantly, the NIS.COST supports the **prioritization of the interventions** as "low", "medium" and "high", which is critical for informing implementation sequencing and subsequent budget dialogue (Step 6).

- **High priority** interventions are those **essential** to achieving NIS strategic objectives and should be accommodated within the **expected resource envelope**, based on confirmed or highly probable financing.
- **Medium priority** interventions **contribute** to strategic objectives but are contingent on the availability of **additional or uncertain resources**. These may be sequenced, scaled, or deferred depending on affordability over the NIS period.
- **Low priority** interventions are not required for initial implementation and have no identified financing. These may be deferred to outer years and represent a pipeline of activities to be implemented if additional resources become available.

  The prioritization tagging should be used to inform phased implementation and financing scenarios, enabling assessment of trade-offs, alignment with realistic financing projections, and structured budget dialogue.

4. Costing within NIS.COST is conducted using a standardized structure that requires specification of costing method , investment type (capital or recurrent), data source, and classification of costs. Estimates are typically based on quantities and unit costs, ensuring transparency of assumptions. All inputs should be supported by clearly identified data sources (e.g., government budgets, procurement data, or validated estimates) to strengthen credibility. The application also enables standard cost classification, currency conversion, and inflation adjustments to support consistent multi-year analysis and comparability across interventions.

5. **Shared costs** that benefit other parts of the health system (e.g., human resources, transport, infrastructure) or shared across multiple interventions (e.g. PHC) should be identified within NIS.COST. Two types of shared costs should be considered:

- **Shared costs within NIS interventions**: Where multiple interventions rely on the same resources, these should be clearly identified to avoid **double counting**. Costs should be estimated once and appropriately allocated across interventions as needed.
- **Shared health systems costs across Primary Health Care**: With immunization being an integral part of PHC, efforts should be undertaken to identify costs that contribute to improved access to primary care services such as facility based health workers, financial management- logistics- and information systems). The immunization-attributable share of

10. Shared resources that are those that benefit other parts of the health system than immunization. Important shared costs are human resources, buildings and vehicles.

these costs should be estimated, where feasible, using appropriate assumptions. Where immunization relies on shared system resources but does not directly contribute to their financing, these costs should be identified but not included in the NIS costing.

In all cases, countries are encouraged to indicate the expected financing source or budget holder for shared resources, particularly where these fall outside the direct control of the immunization programme. Where NIS interventions depend on substantial shared resources, their implications should be explicitly considered and addressed in the budget dialogue (Step 6). Furthermore, cost estimates should not be interpreted as fixed resource requirements, but as projections based on available data and assumptions. Given the dynamic nature of programme implementation, including changes in strategies, prices, and resource availability, estimates should be periodically reviewed and refined as part of ongoing planning and financing discussions.

Best practice tips for Step 5: Resource requirements

- This step may require additional technical expertise, including health economics and financing analysis, to ensure robust costing and affordability assessments.
- Collaborate closely with the health planning and budgeting authorities (including Ministry of Finance where relevant) to ensure outputs from the NIS costing, financing and budget modules are aligned with national budget structures and can inform resource allocation decisions.
- Use the costing process to make explicit the trade-offs and prioritization decisions underpinning the NIS, including sequencing of interventions under constrained resource scenarios. Where applicable, draw on complementary prioritization processes (e.g. VPOP) to inform these decisions.
- When using the NIS as a resource mobilization tool, ensure budget estimates are realistic and grounded; overly ambitious totals or large funding gaps can undermine credibility and make implementation more difficult.
- Present results in a format that clearly distinguishes costs, available financing, and funding gaps over time, to support structured budget dialogue (Step 6).
- NIS costing provides high-level, strategic estimates and should be complemented by more detailed costing during annual operational planning (AOP); however, where countries have applied in ingredients-based approach for costing, the level of detail generated (e.g. quantities, unit costs, and input categories) can be readily disaggregated and exported to inform costed AOPs and implementation planning.

Step 6. Budget dialogue

Objective: Finalize the strategy based on a realistic assessment of the available and potential resources from both domestic and external sources, and align priorities with the expected resource envelope	
Who does **what**?	**1. Task manager/Coordinator:** √ with the support of the Steering Committee, maps all possible (governmental and external) funding sources for the NIP; √ organizes and leads the budget dialogue meetings with the key stakeholders, using outputs from NIS.COST, for the respective funding sources; √ ensures alignment of the NIS with national planning and budgeting processes and timelines. **2. Content producer:** √ prepares the strategy propositions with corresponding resource requirements including prioritized and costed strategies and where relevant, alternative implementation and financing scenarios; √ supports the development of evidence-based investment messages for discussions with the key stakeholders of the main funding sources for immunization. **3. Technical Working Group(s)/Health economist:** √ provides technical support during the revision of strategy options based on budget dialogue outcomes; √ may be consulted during revisions of the strategy options to assess affordability, analyzing trade-offs and supporting the identification of the most efficient allocation of available resources under different financing scenarios; √ ensures costing assumptions and revisions remain technically sound and consistent. **4. Steering Committee:** √ supports the task manager/coordinator to identify the main stakeholders for financing the NIS and facilitates coordination across agencies; √ supports resource mobilization for the NIS through their respective networks; √ provides strategic guidance to ensure alignment between NIS priorities, financing opportunities, and partner processes.
Who should be engaged?	• The MoH immunization, planning, and budget departments, including a health economist. • The MoF, Treasury, Fiscal commission, or other ministries with immunization funding. • Subnational authorities (e.g. provincial or district finance officers). • WHO, UNICEF, Gavi, World Bank, Asian Development Bank, etc. • Other relevant stakeholders involved in health financing and planning processes as appropriate to the country context.
How to defend the budget during a dialogue process	1. Prepare tailored arguments on the value of the investment aimed at different stakeholders – i.e. the Minister of Health, Minister of Finance or external funders. 2. Articulate clearly the value of investments, including expected programme outcomes, efficiency considerations, equity considerations, and implications of underfunding. 3. On the basis of this dialogue, revise the strategies and update resource estimates ensuring alignment with available and expected financing. 4. Pursue additional advocacy efforts, including identifying additional and new sources for immunization financing.

Objective: Finalize the strategy based on a realistic assessment of the available and potential resources from both domestic and external sources, and align priorities with the expected resource envelope	
Entry point for **integration** with HSSP	In some countries, budget negotiations take place before parliamentary approval, while in others, parliamentary process may still influence government budget allocations. The development of the NIS and its budget should ideally align with and integrated into national budgeting processes for health. It is essential to understand the timing, structure and decision points of national budget processes in order to identify appropriate entry points for engagement. Understanding how the MoH negotiates with the MoF, Treasury and relevant parliamentary committees is an essential first step. This includes identifying when budget ceilings are set, when sector proposals are developed, and when negotiations occur. Ensure that immunization investments can be effectively incorporated into health sector strategic plans, medium-term expenditure frameworks and annual budget allocations.
Duration	*Steps 3, 4, 5 and 6 are iterative and progress in parallel over a period of 3 months.* The duration of Step 6 depends on the dialogue cycles.
Output	1. Stakeholder-specific investment messages and materials to support budget dialogue and resource mobilization. 2. A revised NIS aligned with available and expected financing, including prioritized and sequenced interventions. 3. Identified financing sources, confirmed resource commitments, and residual funding gaps to inform other domestic budgeting processes and external resource mobilization.
Tools and resources	• Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016: Chapter 8 (here). • Responding to the health financing emergency: Immediate measures and longer-term shifts (2026) (here) • Bishai, David, Logan Brenzel, and William Padula (eds), Handbook of Applied Health Economics in Vaccines, Handbooks in Health Economic Evaluation (Oxford, 2023; online edn, Oxford Academic, 20 Apr. 2023) (here)

6A. Defending the NIS in a budget dialogue

Following the resource estimation of Step 5, the NIS team is now equipped with information on incremental costs associated with proposed improvements and strategic changes, alongside available and expected financing, funding gaps, and prioritized and sequenced interventions over the strategic period. This enables the budget dialogue to focus on the additional investments required to achieve improved programme performance and outcomes, and to articulate a clear investment strategy aligned with available and potential financing. This provides a structured basis for engagement with key stakeholders.

- **Focus on the changes needed:** In the absence of major macro-economic shifts, baseline funding levels may remain stable. Budget dialogue should therefore focus on the incremental resources required to implement priority interventions and achieve the desired improvements, considering expected fiscal space and financing constraints.

- **Protect core immunization functions:** Clearly identify and defend a core, sustainable financing envelope required to maintain routine immunization services. This is particularly important in contexts where resources (e.g. financial, human) may be reallocated during changes in funding landscape, emergencies or competing health priorities.

- **Target the appropriate financing stakeholders:** As a core public health programme, immunization should be primarily financed through domestic resources, including government budgets and, where applicable, social health insurance, complemented by external financing. Budget dialogue should therefore engage the Ministry of Health, Ministry of Finance, relevant subnational authorities, and key external partners including multilateral and bilateral agencies, with a clear understanding of their respective roles in financing.
- **Tailor the investment messaging:** The value of investment in the NIS should be articulated using evidence-based arguments, including expected health outcomes, efficiency considerations, and the implications of underfunding. Messages should be adapted to different stakeholders, recognizing that decision-making criteria may include affordability, fiscal impact, and alignment with national priorities.

6B. Revising the NIS based on budget dialogue

If the proposed NIS cannot be fully financed as initially presented, it should be revised to reflect the outcome of budget discussions and the available and expected resource envelope. The prioritization of interventions, as captured in the NIS.COST application, should guide this process. Interventions with lower priority and high resource requirements may need to be deferred, scaled, or removed to ensure alignment with available financing.

Critical to this step is a transparent and structured assessment of trade-offs, ensuring that decisions reflect both technical priorities and financing constraints. This includes evaluating how different combinations of interventions affect programme outcomes, efficiency, and affordability. For example, countries may need to assess trade-offs between introducing new vaccines and strengthening service delivery to improve coverage of existing vaccines.

Prioritization should be operationalized through the development of alternative, costed scenarios (a built in function of NIS.COST) starting from an ideal scenario and progressively adjusting to reflect realistic financing conditions. Where resources are insufficient to implement all proposed strategies, countries should define the sequencing of interventions by identifying what is implemented first, what is deferred, and what is contingent on additional financing..

This process ensures that the final NIS reflects a feasible, prioritized, and phased implementation plan, aligned with available resources and informed by explicit prioritization criteria and evidence-based decisions.

6C. Pursuing further advocacy efforts

The NIS provides a strong foundation for ongoing resource mobilization efforts, supporting engagement with both domestic and external financing processes. The analysis underpinning the NIS, including costing, prioritization, and financing gaps generated through NIS.COST, can be used to inform targeted engagement with key stakeholders.

For Gavi-eligible countries, the NIS serves as a key input into funding applications and broader financing dialogue with partners. More broadly, countries are encouraged to align resource mobilization efforts with national budget processes, partner funding cycles, and relevant financing mechanisms to maximize effectiveness and reduce duplication.

Some countries may choose to include an advocacy or resource mobilization strategy within the NIS, outlining how to tailor messages to different stakeholders, communicate expected results, and leverage evidence to support financing decisions. This can support engagement with both existing and potential financing sources, including new financing partners where relevant.

Best practice tips for Step 6: Budget dialogue

- Initiate budget dialogue early and align engagement with national budget cycles and key decision points, including preparation of medium-term expenditure frameworks and annual budgets.
- Use NIS.COST outputs to clearly present costs, available financing, funding gaps, and prioritized scenarios, ensuring transparency in assumptions and trade-offs.
- Distinguish clearly between confirmed financing, probable resources, and unfunded priorities to support realistic budget planning and decision-making.
- Frame discussions around incremental investments and expected improvements in programme performance and outcomes, rather than total programme costs alone.
- Engage both technical and financial decision-makers, particularly Ministry of Finance and planning authorities, to ensure alignment with resource allocation processes.
- Document resource commitments and agreed financing responsibilities to support follow-up actions, integration into budgeting process, and accountability.
- When presenting prioritized scenarios under constrained resources, make explicit the equity and gender implications of different funding choices, including the impact on reaching zero-dose children and underserved populations.

Step 7. Approval and endorsement

Objective: Launch the NIS endorsed by the government	
Who does **what**?	**1. Task manager/coordinator:** √ requests government endorsement of the final NIS document; √ disseminates the final endorsed version of the NIS document to all stakeholders and development partners. **2. Content producer:** √ adapts the final NIS document to the government's document template in preparation for endorsement by the government. **3. Technical Working Group(s):** √ supports the Content producer to develop the document or government. **4. Steering Committee:** √ facilitates the endorsement of the NIS by the government.
Who should be engaged?	• Relevant MoH/government staff.
How to have the NIS endorsed	• Understand who needs to endorse and approve the NIS within the government. • Follow the national approval process.
Entry point for **integration** with HSSP	As part of the government endorsement process, ensure that the NIS becomes fully integrated and embedded into the HSSP and PHC operating plans (including essential services package).
Duration	1 to 2 months
Output	Final NIS document endorsed by the MoH or other relevant (health) institutions, and an operational budget approved.

Once the NIS technical content is finalized, it should be reviewed and endorsed by the Minister of Health. Highlighting the importance of this step is crucial, as delays in its implementation can occur if authorities are not fully aware of its significance. Finalising the NIS ensures it can serve as a key advocacy tool, supporting engagement across the health sector, with partners and donors.

Post-approval: implementing and operationalizing the NIS

Once the NIS has been endorsed, it is important to ensure that the strategy will be put into action. Implementing and operationalizing the NIS involves four steps:

- **Dissemination** to all subnational levels and other stakeholders involved in the process – including policy-makers, the MoF, health partners, donors, CSOs and national programme managers – will help increase acceptance and advocacy for the new strategy. A national launch event or ceremony could also serve to communicate the main goals and targets of the NIS.

- **Continued integration into the health-sector planning** through joint activities between immunization and other health priorities. Arrange discussions between groups (from either the immunization or non-immunization sectors) that may benefit from working together (i.e. have similar intervention locations or community outreach programmes). Once confirmed, joint planning and resource-sharing may follow.

- **An annual operational plan** needs to be developed for every year covered by the NIS in order to translate the strategy into specific actions and activities. For the first year, this process should start in parallel to NIS development, or as soon as the NIS has been approved by the government, to ensure consistency. Refer to the "Annual Operational Plan for immunization services: Guidelines for development or optimization" for further guidance on how to plan and conduct and an AOP.[11]

- **The M&E framework** will be used to review progress against NIS objectives at regular (at least annual) intervals by the relevant national bodies. M&E review meetings facilitate discussions on past achievements and challenges and identify ways to improve the next year's plan. The stakeholders in immunization services delivery – including local authorities, surveillance staff, the private sector, NGOs and CSOs (in particular women's groups) – should be active participants in this review and planning process. Adjustments to the strategy and the costing should be made periodically based on the M&E outcomes to ensure full implementation by the end of the period.

11. https://immunizationeconomics.org/unicef-national-planning-and-budgeting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