

# **SECOND GAVI EVALUATION**

**GAVI ALLIANCE**

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**SUPPORTING PAPER 4.3:**

**NIGERIA COUNTRY STUDY REPORT**

Submitted by:

**CEPA LLP**

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## ACRONYMS AND ABBREVIATIONS

AD	Auto Disable (syringes)
APRs	Annual Progress Reports
BCG	Bacillus Calmette-Guérin (vaccine against tuberculosis)
CBOs	Community-Based Organizations
CEPA	Cambridge Economic Policy Associates
cMYP	comprehensive Multi-Year Plan
CSM	Cerebrospinal Meningitis
CSO	Civil Society Organisations
DFID	Department for International Development
DP	Development Partners
DQA	Data Quality Audit
DQS	Data Quality Self-assessment
DTP(3)	(Third dose of) Diphtheria, Pertussis, Tetanus
EU	European Union
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FMOF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
HIS	Health Information Systems
HMIS	Health Management Information Systems
HPCC	Health Partner Co-ordinating Committee
HSF	Health Systems Forum
HSRP	Health Sector Reform Program
HSS	Health System Strengthening
ICC	Inter-Agency Co-ordinating Committee
INS	Injection Safety Support
IPDs	Immunisation Plus Days
IRC	Independent Review Committee
ISS	Immunisation Services Support
JICA	Japanese International Cooperation Agency
LGA	Local Government Areas
MDG(/DRG)	Millennium Development Goals (/Debt Relief Grants)
MMIS	Making Medical Injections Safer
MNT	Maternal and Neonatal Tetanus
MOF	Ministry of Finance
MOH	Ministry of Health

NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NPC	National Planning Commission
NPHCDA	National Primary Health Care Development Agency
NPI	National Program on Immunisation
NSCS	National Strategic Cold Store
NVS	New and underused Vaccine Support
OPV(3)	(Third dose of) Oral Polio Vaccine
PCV	Pneumococcal Conjugate Vaccine
PEI	Polio Eradication Initiative
PEPFAR	(United States) President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PPP	Public Private Partnership
PRIME	Partnership to Reinforce Immunisation Efficiency
PRRINN	Partnership for Reviving Routine Immunisation in Northern Nigeria
SG	(GAVI) Strategic Goal
SMOH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SSA	Sub-Saharan Africa
TSHIP	Targeted States High Impact Project
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VPD	Vaccine Preventable Disease
WFP	Ward Focal Person
WHO	World Health Organisation

## EXECUTIVE SUMMARY

This is an executive summary of the Country Evaluation Report for Nigeria, undertaken as a part of the GAVI second evaluation. The report has been prepared by CEPA, in association with Hanovia Medical Ltd (country-based partners).

The report provides contextual information on Nigeria in terms of its health and immunisation sector, and assesses the results and value add of GAVI programs in the country. The key conclusions are based on evidence gathered during a field visit to Nigeria in the week of 12 April, and desk research.

GAVI has played an important role in increasing focus on the routine immunisation sector in the country, following deterioration in performance after donors left the sector in the late 1990s, and within the overall context of relatively greater emphasis on polio immunisation. There have been key areas of results as well as added value of GAVI support, however there have been a few issues as well that have impacted the sector as a whole. The following are our overall judgements on the performance of GAVI across the four SGs, as well as areas where it has added value:

- **Health System Strengthening (SG1):** Nigeria has received support under the Injection Safety Support (INS), Health System Strengthening (HSS), and Immunisation Services Support (ISS) programs, with all forms of support currently ongoing.

Stakeholders felt that INS support thus far has been a success. Although injection safety policies were in place before support began, GAVI has contributed to the actual uptake of auto-disable (AD) syringes and safety boxes for routine immunisation, in particular by ensuring predictable supply. There was also a high degree of optimism regarding the sustainability of usage and funding of safety kit. However, waste management remains a challenge, with very limited capacity of incinerators.

The implementation of HSS support in Nigeria has been substantially delayed. The delays were felt by most stakeholders to reflect primarily internal institutional issues, although the requirement of GAVI for HSS to be led by the Federal Ministry of Health (FMOH) as against the National Programme on Immunisation (NPI) department has caused some confusion. As a result of these delays it is too early to comment on the impact of HSS funding. Stakeholders noted that while GAVI HSS funding will focus on similar health system bottlenecks as other initiatives, its specific value add is its focus on delivery at the ward level as well as its flexible approach.

There have also been delays in implementation of ISS funds. In this case the delays reflect the complex implementation process which results from the high degree of autonomy granted to the states. However, this program is highly valued by stakeholders, especially at the state level. It is perceived to have catalysed improvements in planning and budgeting capacity, data quality and accountability. It was suggested that ISS funding has also encouraged greater levels of funding from some state governments for their immunisation systems (although we do not have data to verify this directly).

- **Vaccine Support (SG2):** GAVI has funded the supply of Yellow Fever vaccine in Nigeria since 2003, and the support has been very positively received. Vaccines have

been delivered regularly, although uptake has been restricted in some areas by a lack of demand.

However the recent rejection of Nigeria's application for Pentavalent vaccine and Pneumococcal Conjugate Vaccine (PCV) support has had several adverse impacts. It has impacted planning and budgeting for the government-funded DTP and HepB vaccines (in anticipation of receipt of the pentavalent vaccine), and diverted scarce resources from other much-needed areas (as the government had allocated funds for the corresponding co-financing requirements), amongst other issues. Many government stakeholders expressed disappointment at this decision and indicated that GAVI had not been forthcoming on the reasons for this decline in support.

- **Financing (SG3):** The federal government views were mostly positive on the financial sustainability of GAVI's support – given that total GAVI funding to Nigeria is relatively small in comparison to the government health budget and the support received from other donors.<sup>1</sup> The relatively high prices of the new vaccines (Pentavalent and PCV) were noted, and it was acknowledged that Nigeria would find it difficult to fund these vaccines today without GAVI's support.

In general there was a lesser degree of optimism from state representatives – an issue which is important in the context of sustainability of ISS funding in particular. However, as noted above, ISS support is considered to have improved state level planning and budgeting processes, and thus is expected to contribute to greater sustainability in the long run. Funding for injection safety is expected to continue, but the problems resulting from the recent NVS application may have knock-on effects on Nigeria's ability to meet its co-financing requirements.

- **Added value as a global Public Private Partnership (PPP) (SG4):** Our discussions indicated that GAVI's multi-stakeholder partnership model, in terms of the participation of WHO and UNICEF at the country level, works well. It was expressed by some stakeholders that having a GAVI 'focal person' or greater interaction from the Secretariat would be beneficial.

GAVI has served as an advocate for immunisation in a variety of settings (including internal technical group meetings and regional gatherings).

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<sup>1</sup> Nigeria is one of the GAVI-eligible countries that funds the Hepatitis B vaccine on its own.

# **1. INTRODUCTION**

## **1.1. Background and purpose**

This is the Country Evaluation Report for Nigeria, developed as part of the Second Evaluation of the GAVI Alliance. The report is prepared by CEPA<sup>2</sup> in partnership with local country-based consultants, Hanovia Medical Ltd.

The purpose of the report is to provide an evaluation of the results and value add of GAVI in Nigeria, drawing on country stakeholder perspectives.

## **1.2. Methodology**

This report has been informed by the following sources of evidence:

- Analysis of country level data on health and immunisation. Annex A presents the data.
- A review of the relevant literature, including country reports, academic papers, country and state health plans, GAVI documentation, etc. A complete bibliography is provided in Annex B.
- Interviews with relevant country stakeholders during a field trip to Nigeria in the week of 12<sup>th</sup> April 2010. A full list of consultees is provided in Annex C.
- Interviews with State-level stakeholders in Federal Capital Territory (FCT), Lagos and Sokoto, carried out during the field trip. These states were selected primarily to ensure a balance of opinions from historically strong-performing states (FCT and Lagos) and weaker-performing states (Sokoto). A more detailed explanation of the selection of States for detailed study, as well as the feedback during the visit is provided in Annex D.

## **1.3. Structure of the report**

The report is structured as follows:

- Section 2 provides a background/ context to the country evaluation in terms of an overview of the key political and economic developments, as well as a situational report of the health sector in the country.
- Section 3 synthesises the history and current state of the country's immunisation sector.
- Section 4 provides an overview of GAVI support to Nigeria to date.
- Section 5 provides an assessment of GAVI's support for system strengthening programs in the country (Strategic Goal 1<sup>3</sup>).

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<sup>2</sup> A Consortium led by CEPA ([www.cepa.co.uk](http://www.cepa.co.uk)) has been appointed by the GAVI Alliance to undertake its second evaluation.

<sup>3</sup> SG1 programs cover Immunisation Services Support (ISS), Injection Safety Support (INS), Civil Society Organisations support (CSO), and Health System Strengthening support (HSS).

- Section 6 provides an assessment of GAVI's support for vaccines in country (Strategic Goal 2).
- Section 7 presents a discussion on the sustainability of GAVI funding in Nigeria (Strategic Goal 3).
- Section 8 reviews the effectiveness of GAVI structures and processes in country (Strategic Goal 4).
- Section 9 brings together the analysis and assessment in the previous sections to present a summary evaluation of GAVI's results and value added in Nigeria.

## **2. OVERVIEW OF COUNTRY CONTEXT**

### **2.1. Background: demographic, social, economic and political profile**

With an estimated 140m people, Nigeria holds close to 20% of the population in Sub-Saharan Africa (SSA) and approximately one-sixth of Africa's population, making it the most populous country on the continent. The country is very diverse with more than 250 ethnic groups, 500 indigenous languages, and diverse religions. The country's population is largely young: the median age is 18.7 years and about 45% of the population is under the age of 15.

Administratively, it is organized as a federation with: a federal government; 36 states plus the Federal Capital Territory of Abuja (FCT); and 774 local government areas (LGA) sub-divided into 9,555 wards. There are six geo-political zones: North-West, North-Central, North-East, South-West, South-South, and South-East.

Despite the large revenues generated from oil wealth and natural resources, Nigeria is one of the poorest countries in the world with a Gross Domestic Product (GDP) per capita in 2008 of only US\$1,161. Approximately 54% of the population live on less than one dollar per day. Nigeria's annual economic growth rate from 2000 through 2006 averaged 2.5%. The economy largely relies on the oil and gas sector, which accounts for 99% of export revenues, 85% of the government budget revenue, and 52% of GDP. Agriculture, mining, light industry, and banking sectors also contribute significantly to GDP.

### **2.2. Background to the health sector**

This section provides a brief summary of the health sector in Nigeria. More details can be found in Annex A.

#### **2.2.1. Structure of the health sector**

The health sector comprises of public, private for-profit, nongovernmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), and traditional health care providers.

##### *Public providers*

The public health system operates on three tiers similar to the tiers of government – federal, state, and local. Roles and responsibilities for each tier are poorly defined. At the federal level, the FMOH headed by the Honourable Minister of Health take responsibility for policy development and tertiary health care provision. At state level, state ministries of health headed by Commissioner of Health take responsibility for secondary health care provision while at LGA level, departments of health are responsible for primary health care provision.

##### *Private providers*

Thirty-eight percent of registered health facilities in the FMOH database are privately owned, of which about 75% are primary care and 25% are secondary care facilities. Private facilities account for one-third of primary care facilities. Together with FBO facilities, private facilities are reported

to provide 80% of health services to Nigerians and hence constitute an important partner in expanding coverage of key health services.

### 2.2.2. Health sector policy and financing

The Nigerian health sector is guided by the Revised National Health Policy, launched in 2004, and the Health Sector Reform Program (HSRP), also launched in 2004. The latter was conceived in response to worsening health performance indices, and is primarily aimed at improving oversight and management in the sector.

#### *Expenditure and financing*

The level of health spending in Nigeria is relatively low, at around \$50 per capita. Over the period 2000 to 2006 Nigeria spent less than 5% of GDP on health.

Health care is financed from government budget, health insurance (social and private), external funding and private out-of-pocket spending. Household out-of-pocket expenditure is the largest source of health care financing in Nigeria, at 65.9% of total health expenditure. The government accounts for a further 26.1% (federal 12.4%, state 7.4%, and local government 6.4%).

#### *Key health indicators*

Three decades of political instability and economic crisis have led to deterioration in national health indicators. The maternal mortality ratio of 1,100 per 100,000 live births (NHSA 2008) is one of the highest in the world. Infant mortality is 75 per 1,000 live births and under-five mortality is 157 per 1,000 live births (NDHS 2008). Approximately 1 million children under five die every year from preventable diseases such as malaria, diarrhoea, and pneumonia (NHSA 2008).

### 2.2.3. Key health sector donors

Several donors are in operation in Nigeria (see Table 2.1).

*Table 2.1: Key health sector partners in Nigeria*

Health Partner	Sector	Selected area(s) of Support	Scope of Support
World Bank		Health Systems Development Project; HIV/AIDS Program	All states
WHO		Immunisation; Reproductive Health/ Family Planning; HIV/AIDS; Information Systems	All states
UNICEF		Immunisation; HIV/AIDS	All states
USAID		Immunisation; RH/FP; HIV/AIDS	Selected states
DFID		Health system strengthening; Routine immunisation; HIV/AIDS	All states
JICA		Immunisation; Roll Back Malaria	Federal level
European Union		Immunisation; HIV/AIDS	Selected states

*Source: Nigeria World Bank Health Systems Development Project -II: Project Appraisal Document (2007)*

### **3. IMMUNISATION SECTOR**

This section provides a brief summary of the immunisation sector in Nigeria. More details can be found in Annex A.

#### **3.1. Policy developments, key actors, funding and support**

The national immunisation policy states that government will provide immunisation services and potent vaccines, free to all populations at risk of vaccine preventable diseases (VPDs). In addition, all States have immunisation specific strategic plans covering the period up to 2015.

The National Primary Health Care Development Agency (NPHCDA) directly oversees routine and supplemental immunisation management in Nigeria, a responsibility it has held since it absorbed the National Program of Immunisation (NPI) in 2007. Through the interagency coordinating committee (ICC), this responsibility is coordinated with development partners engaged in the Polio Eradication Initiative (PEI). The ICC is chaired by the Minister of Health.

The National Planning Commission (NPC) is the statutory entry point and clearing house for all donor support in Nigeria and records data on grants to immunisation services. With the NPC being the first port of call, the Ministry of Finance (MOF) has a limited role.

At the LGA level, immunisation services are overseen by Primary Health Care (PHC) coordinators. They are responsible for maintaining the link between the NPHCDA, State Ministries of Health (SMOH) and the community.

##### **3.1.1. Funding and support for the immunisation sector**

The three tiers of government contribute about 90% of financial resources for routine immunisation at the health facilities. Various donors provide additional support, including:

- From 2001-09 the European Union (EU) provided technical and financial support for routine immunisation to 23 selected states under its PRIME (Partnership to Reinforce Immunisation Efficiency) initiative.
- DFID supports the five-year Partnership for Reviving Routine Immunisation in Northern Nigeria (PRRINN) which covers four of the northern states.
- USAID supports routine immunisation through the Targeted States High Impact Project (TSHIP), a five-year project in two states (Sokoto and Bauchi) in northern Nigeria.

#### **3.2. Performance of immunisation sector**

Overall, 23% of children aged 12-23 months are fully vaccinated, an increase from 13% in 2003. However, 29% of children have not received any vaccinations. Children in urban areas (38%) are more than twice as likely as rural children (16%) to be fully vaccinated. The proportion of children fully-immunised ranges from a high of 43% in the South West and South East to a low of 6% in the North West.

Routine immunisation has to an extent been compromised by Nigeria's strong recent focus on the Polio Eradication Initiative.

#### 4. OVERVIEW OF GAVI SUPPORT IN NIGERIA<sup>4</sup>

Nigeria has received GAVI support across four programs – Immunisation Services Support (ISS), Injection Safety Support (INS), Health System Strengthening (HSS), and New and underused Vaccines Support (NVS) for the yellow fever vaccine. ISS support has been provided since 2001, INS is ongoing and covers the period 2008-10, HSS support began in 2008, and NVS has been provided since 2003.

Over the period 2001-10, the total approved support amounts to US\$132.4m, of which \$83.2m has so far been disbursed. As shown in Figure 4.1 below, disbursements fell significantly short of approvals in 2007 (and to a lesser extent in 2008 and 2009). This was primarily due to a shortfall in disbursement of ISS funds (see Section 5 below for details). In addition, there has been a delay in the disbursement of 2010 HSS funds, although this appears to have been resolved and it is likely that these funds will be disbursed in 2010.

Figure 4.1: Nigeria - GAVI approvals and disbursements data (\$m)<sup>5</sup>

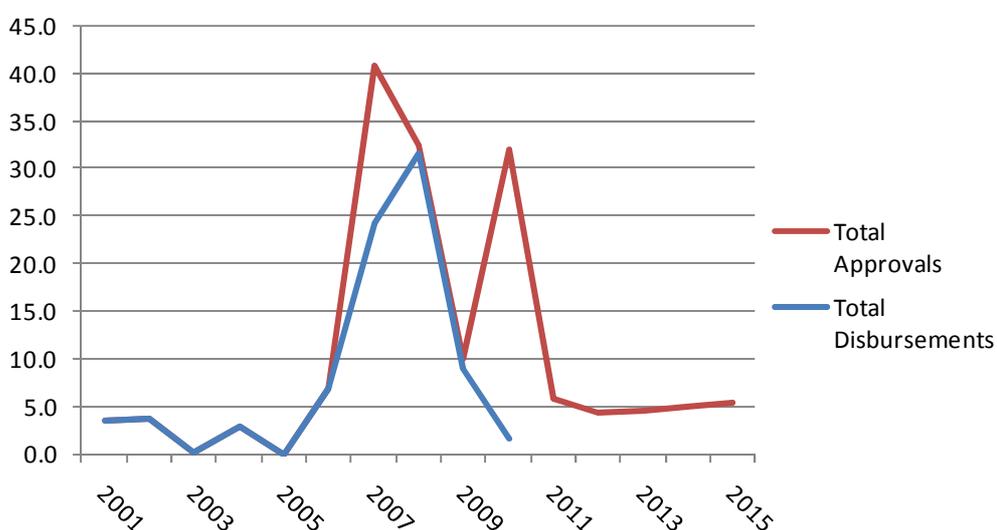


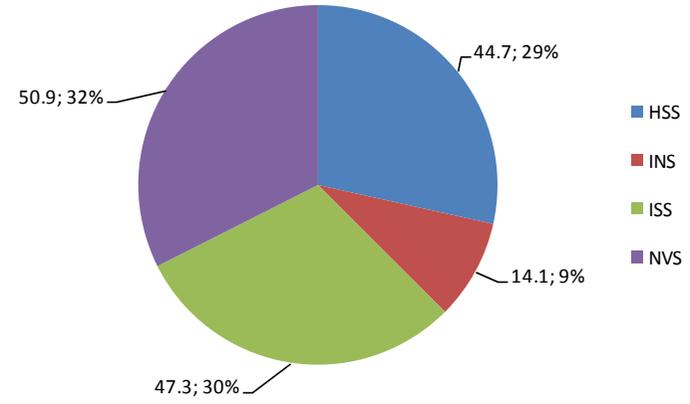
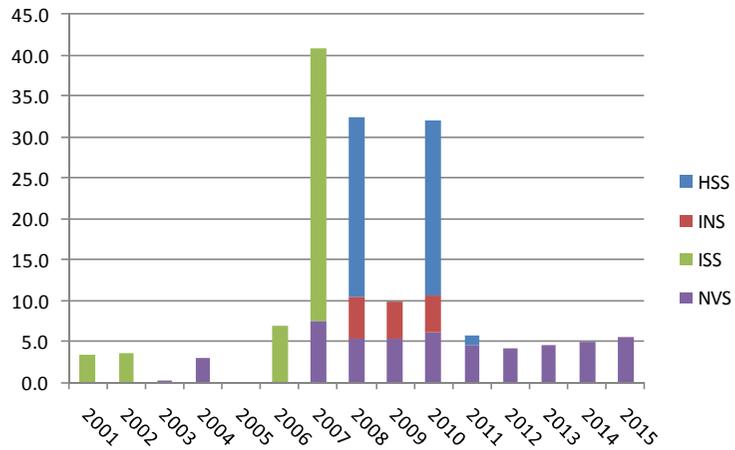
Figure 4.2 and below shows the breakdown of approved and disbursed funds respectively, across years and by GAVI program. Total approved funds up to 2015 are split quite evenly between the NVS, ISS and HSS windows. However, reflecting the fact that 2010 HSS funds have yet to be disbursed and NVS funding has been approved up to 2015, the majority of disbursements so far (37%) are accounted for by ISS.

<sup>4</sup> Figures sourced from "CEPA - GAVI Phase I & II consolidated approvals & disbursements" spreadsheet, received from the GAVI Secretariat.

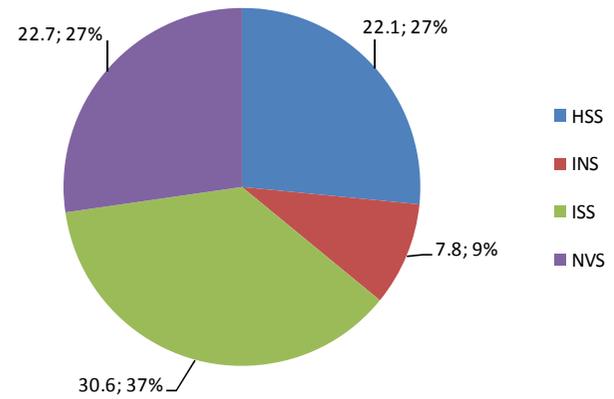
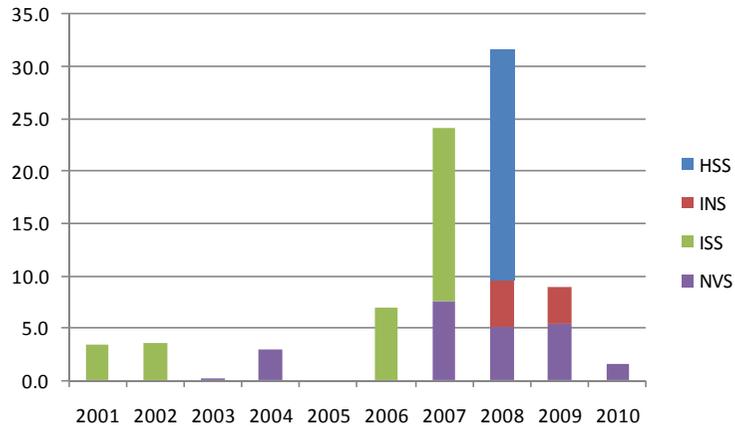
<sup>5</sup> Where lines overlap, disbursements are equal to approvals

Figure 4.2: GAVI approvals and disbursements data 2001-15 (\$m)

Approvals



Disbursements



## 5. ASSESSMENT OF GAVI SYSTEM STRENGTHENING SUPPORT (SG 1)

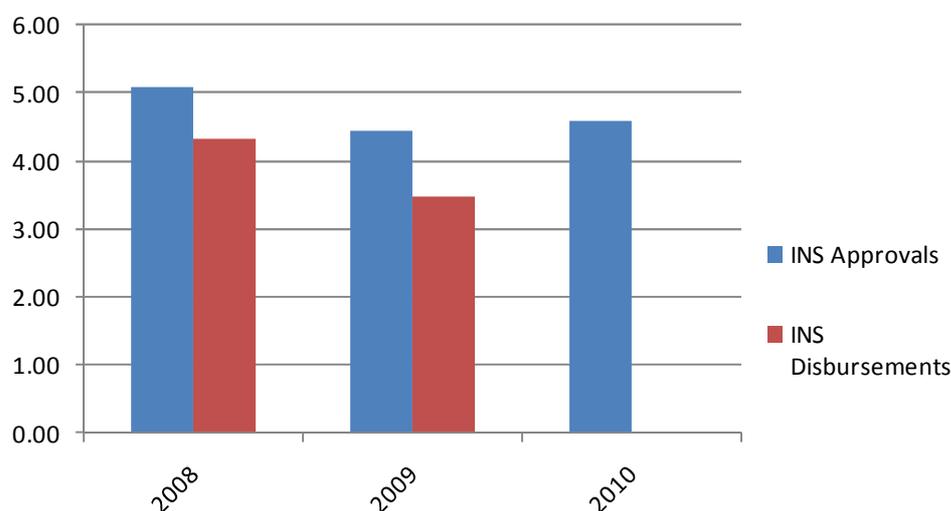
GAVI's first goal (Strategic Goal 1 – SG1) is to contribute to strengthening the capacity of country health systems to deliver immunisation and other health services in a sustainable manner. This goal covers the following GAVI programs: Health System Strengthening (HSS), Immunisation Services Support (ISS), Injection Safety Support (INS), and Civil Society Organisations (CSO).

This section provides a description of the support received from GAVI as well as an assessment of the results and value add, for the programs relevant for Nigeria.

### 5.1. Assessment of GAVI INS support

Nigeria has received in-kind INS support amounting to US\$7.8m during the period 2008-09, and a further \$4.6m has been approved for 2010 (see Figure 5.1).<sup>6</sup>

Figure 5.1: GAVI INS: approvals and disbursements (US\$m)



#### 5.1.1. Description of INS application, approval and implementation process

Nigeria's first attempt at accessing INS support in 2002 was unsuccessful due to incomplete documentation (NPHCDA 2008). A second application was submitted in 2006 and underwent a review by the Independent Review Committee (IRC) in November 2006. This application also resulted in a request for re-submission, since the application was for cash (rather than in-kind) support and it was perceived that existing supply channels and processes for safety equipment were lacking. A subsequent application for in-kind support was finally approved for the period 2008-10.

Feedback during the field visit indicated that the INS support is being effectively delivered, with no issues of stock outs, etc being reported.

<sup>6</sup> In both 2008 and 2009 the amount disbursed was around \$1m lower than the amount approved. This probably represents differences in the price or quantity of materials procured as compared with approvals. We did not explore this in the field visit, and no interviewee offered any comments on the matter.

### 5.1.2. Results and value add of INS support

Nigeria's injection safety policy specified AD syringe use before INS began; however, there was minimal uptake in the routine immunisation sector. The primary impact of INS support has been in facilitating uptake in line with existing policy.

#### *Introduction and use of safety kit*

Interviewees agreed that GAVI support has increased the use of safety equipment in the form of AD syringes and safety boxes for routine immunisation. Prior to support, Nigeria's injection safety policy was not adopted on a widespread basis; this policy has since been strengthened, and AD syringe use is now established.<sup>7</sup>

The NPHCDA reports that supply of equipment is very reliable under GAVI support, and both Sokoto and Lagos states reported safety kit usage of close to 100%. One exception to this occurred in the first quarter of 2010, when Lagos state experienced a delay in supply of supplies for BCG injections. This led to the (temporary) use of disposable syringes – though syringes were not re-used between children.

#### *Sustainability of funding of safety kit*

There was a high degree of optimism from the federal government regarding sustainability of funding for safety kit. The state government representatives we met also expressed commitment to supporting usage. A UNICEF representative noted that the strengthening of government level planning for the continued funding and use of safety kit represents a significant positive step.

#### *Safe disposal/waste management*

Waste management in most areas at the point of delivery is limited to the use of safety boxes, and GAVI has contributed to the uptake of these.

However, there remain some challenges to safe disposal in Nigeria. The availability of high temperature incinerators is limited, especially outside urban areas, and this issue has received little attention from immunisation managers.

As a result the “burn and bury” approach (where appropriate) has been a longstanding feature of official injection safety policy. Again, it was suggested that GAVI support has been able to catalyse the actual implementation of this policy, and facilities generally have the procedures and staff in place to carry out this method.

#### *Safety practices in broader country health systems other than immunisation*

The curative sector has not progressed as far as the routine immunisation sector in introducing AD syringes and safety boxes, except in a few focal health sites targeted by the US President's Emergency Plan For AIDS Relief (PEPFAR).

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<sup>7</sup> We received mixed reports regarding local production capacity for AD syringes. Government representatives were not aware of any local manufacturers, however a representative of the USAID MMIS program suggested that such capacity is emerging.

FCT officials noted that in addition to the GAVI INS support, GAVI’s bundled approach for vaccine support is crucial in supporting uptake, and this maybe a decisive factor differentiating the two sectors.

### *GAVI value add*

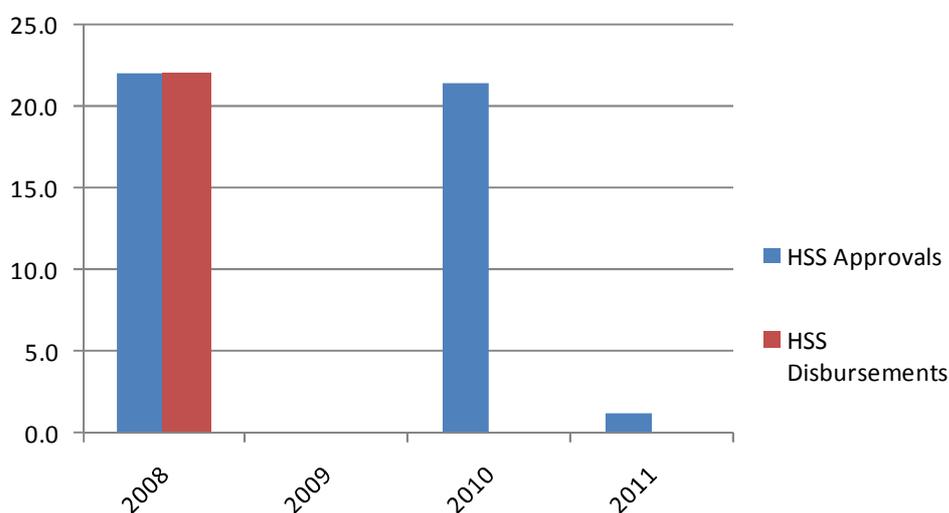
The key value add of GAVI INS support has been in terms of facilitating the uptake of AD syringes in Nigeria. As mentioned above, there has been a stated policy for use of safety equipment in immunisation for a while, but it wasn’t until GAVI INS support that the policy was actually implemented. GAVI’s provision of safety supplies (as distinct from cash-based support) is also perceived to have resulted in greater predictability of supply than would otherwise have been the case.

It must be noted, however, that other initiatives, in particular USAID’s Making Medical Injections Safer (MMIS), had made initial progress in this area prior to the introduction of GAVI support (although in the curative sector). Not all of the gains in uptake of safety kit can be attributed to GAVI.

## **5.2. Assessment of GAVI HSS support**

A total of US\$44.7m has been approved for Nigeria under the GAVI HSS window for 2008-11 (see Figure 5.2 below). The first tranche of \$22.1m was disbursed in 2008; however, given delays on the part of the Nigerian government in implementing the funds, no funding was disbursed in 2009.

*Figure 5.2: HSS - GAVI approvals and disbursements data (\$m)*



### **5.2.1. Description of HSS application, approval and implementation process**

The application, approval and implementation process for HSS funding in Nigeria has been lengthy. Table 5.1 summarises the main developments.

Table 5.1: Timeline of events in HSS application process

Date	Event	Details
July 2006	Proposal preparation begins	<ul style="list-style-type: none"> <li>The NPI took the lead role at this stage</li> <li>Proposal committee included the FMOH, parastatals and Development Partners</li> </ul>
March 2007	New guidelines issued	GAVI stipulates that the FMOH should take the lead role
May 2007	Original submission deadline	Application delayed by new GAVI stipulations
Oct. 2007	Revised submission deadline	Application submitted successfully
Feb. 2008	Application approved	GAVI approved ISS support of \$44.7m over 2008-10
Aug. 2008	First disbursements by GAVI	First tranche of \$22.1m disbursed
2009-10	<i>Institutional delays</i>	<i>See discussion below</i>
April 2010	Commencement of use of funds by government	Government approval for the use of funds provided; implementation expected to commence shortly

The delay in the implementation of the HSS funds by the Nigerian government was caused by a number of internal procedural and institutional delays, which arose due to three main factors:

- *Complex institutional mechanism for delivery.* Implementation responsibility was shared between three bodies: NPHCDA, and the departments of Planning, Research & Statistics, and Food & Drugs within the FMOH.
  - The complexities of these three separate bodies working together caused delays to the proposal development process. The consensus view among interviewees was that the tripartite delivery mechanism had not worked well, and would need to be reconsidered in future.
  - In addition, GAVI's new stipulation that the FMOH should hold the lead role has appears to have caused some confusion and delays. Previously the department with responsibility for immunisation acted as the main point of contact with GAVI.
- *Delays due to efforts to harmonise donor support in Nigeria.* A process was set up to try to coordinate the health systems support of the various donors active in this area and it was decided that once this process was completed the use of GAVI HSS funds could commence.<sup>8</sup> However there were many delays in this harmonising process.
- *Lack of political leadership.* Frequent changes in the leadership of the FMOH have resulted in a lack of continuity. At certain times the degree of leadership and focus required to help take the support forward has therefore been missing.

These issues combined to delay the use of HSS support by almost two years, although we understand that final approval for use of funds was granted in April 2010.

<sup>8</sup> Two bodies were tasked with overseeing the harmonisation process: the Health Systems Forum (HSF), comprising government departments and donors; and the Health Partners Coordination Committee (HPCC), comprising mainly donor partners.

### 5.2.2. Results of HSS support

It is too early to comment on any results achieved through GAVI HSS funding in Nigeria as funds are just being put to use. In addition attribution of results to GAVI will be difficult as the scale of GAVI HSS funding is small in comparison to government (and other donor) funding for health system strengthening. Also, while the GAVI HSS funding will aim to tackle some of the key health system bottlenecks in the country, these are also being addressed by the government and other donors and it may be difficult to isolate the specific impact of GAVI support. However, the importance of GAVI HSS funding was highlighted by all stakeholders – recognising clearly the extent of demand in Nigeria in comparison to the available resources.

As per the proposal, GAVI HSS support will focus on three main bottlenecks:

- Capacity building for service delivery (e.g. rehabilitation of primary health care centres, etc), which is the responsibility of the NPHCDA;
- Development of a harmonised logistics and supply system, which is anchored by the Department of Food and Drugs, FMOH; and
- Health Management Information Systems (HMIS), which is the responsibility of the Department of Planning, FMOH.

The institutional responsibility for the implementation of each of these areas is based on the focus and comparative advantage of different departments within the FMOH. The expected impacts are improvements in each of these areas, ultimately leading to a better health system in the country and corresponding impacts on improved mortality and morbidity.

### 5.2.3. HSS value add

We comment on the value add of HSS support in terms of the following:

- The GAVI approach of providing support and the benefits viewed by the Nigerian stakeholders; and
- The potential for impact in comparison with other types of HSS support.

#### *GAVI approach in comparison with other donor support*

Discussions with the Nigerian government suggested the following areas of positive value add of GAVI support:

- The GAVI approach of providing flexible cash to be used as per the priorities of the government is extremely valued. This helps align the support more closely with the government plans and structures.
- As against the disease-related HSS support provided by the Global Fund, the government views the more broad-based sector wide approach of GAVI as more beneficial.
- It was commented that GAVI's processes for proposal approval and fund disbursement were relatively efficient. This point was made especially in the context of World Bank support.

In addition, the following areas were highlighted where other donor support compares more favourably:

- GAVI support is much smaller than other HSS support from donors.
- GAVI support is being provided from 2008 to 2011 only (with the majority of support coming in 2008-10). In comparison, World Bank support covers up to 10 years (from 2003 to 2012), and the Global Fund started a four year program in 2009.

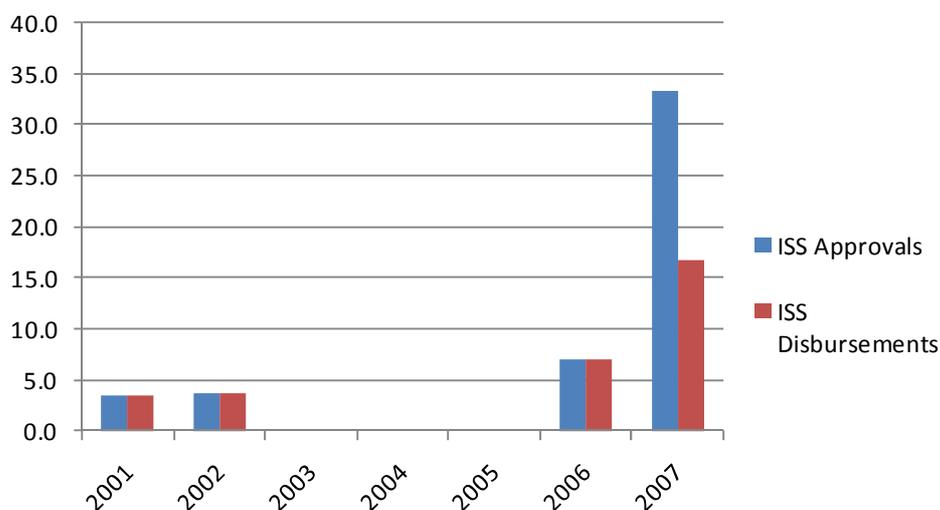
#### *Potential for impact through GAVI support*

While GAVI HSS funding is being used to address bottlenecks that are also receiving funding from other sources, it was highlighted that as against other forms of support, GAVI HSS support is targeted at the ward level (i.e. the lowest level of delivery). Support from others, though targeted at specific constraints, is delivered at a higher level. This was considered by several interviewees to be a key element of GAVI value add.

### **5.3. Assessment of GAVI ISS support**

Since the inception of GAVI support Nigeria has received a total of \$30.6m for immunisation activities (see Figure 5.3 below). This funding is comprised of initial disbursements of \$14m over 2001/2 and 2006, followed by a reward payment of \$16.7m in 2007.

*Figure 5.3: ISS - GAVI approvals and disbursements data (\$m)*



The initial payments represent the full amount approved; however, disbursements in 2007 amounted to only half of the \$33.4m approved funding.

#### **5.3.1. Description of ISS application, approval and implementation process**

Nigeria began accessing GAVI ISS support in 2001, and drew down on the initial approval until 2006. It subsequently became eligible for reward funding in 2007. However, problems were identified in the first DQA (see Box 5.1).

*Box 5.1: Note on DQA and DQS*

The Data Quality Audit (DQA) is designed to assist countries receiving GAVI support to improve the quality of their information systems for immunisation data. Nigeria's first DQA, in 2004, raised many questions. This was seen within Nigeria as a wake-up call, and the second DQA in 2006 noted an improvement in the data. Since 2008, Nigeria has conducted yearly Data Quality Self-assessments (DQS), using government and ISS funds.

One interviewee commented on the lack of robustness of the approach, suggesting that the sample size (a total of four randomly selected LGAs – one each from four states) may typically be too small to draw conclusions.

The federal structure of Nigeria, with a high degree of autonomy granted to the states, creates complexity in the implementation process. All states and LGAs are entitled to apply for resources from GAVI ISS funds managed at the federal level, and all three states considered as part of this report have accessed funds. There has historically been poor access by states for these funds, due to limited capacity for proposal drafting and delays in use of previously disbursed funds. Revised guidelines were therefore introduced in 2009 to encourage and facilitate states to submit proposals. These have been positively received by the States, though the revision did entail a period in which ISS funding to states was put on hold.

ISS funds are implemented at the very periphery of the health system. Measures for oversight and accountability are therefore particularly important. The importance and success of GAVI in this area are discussed in the section below on value add.

### **5.3.2. Results of ISS support**

This section summarises the main results of ISS support, including:

- uses of funds;
- analysis of data on ISS funding and impact on the DTP3 coverage rate;
- impact of and perceptions regarding the 'flexible cash' aspect of ISS support; and
- impact of and perceptions regarding the performance based nature of ISS support.

#### *Use of ISS funds*

GAVI ISS funds are tied to the implementation of activities contained in state-level strategic plans. The current guidelines regarding activities to be funded are summarised in Figure 5.4 below.

Figure 5.4: Activities covered by ISS funds<sup>9</sup>

State level	LGA level	Ward/Health facility level
<ul style="list-style-type: none"> <li>• Supportive supervision</li> <li>• Vaccine distribution to LGA cold stores</li> <li>• Routine cold chain maintenance</li> <li>• Social mobilisation</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive supervision</li> <li>• Monthly review meetings and data reviews</li> <li>• Routine maintenance of cold chain equipment (not fuelling)</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive supervision</li> <li>• Activities of Ward Focal Persons (WFPs)</li> <li>• Vaccine distribution and data collection</li> <li>• Outreaches and community link activities</li> </ul>

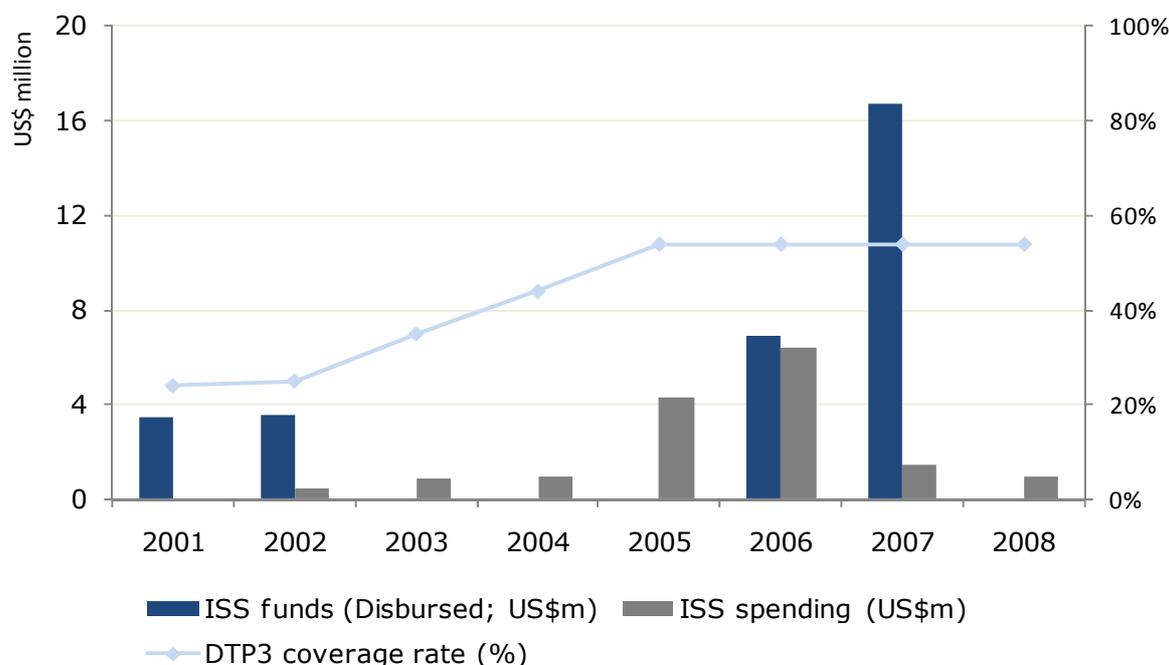
Part of Nigeria’s initial ISS funds were expended for the purchase of injection safety materials for the 2005 and 2006 measles campaigns and the pilot Immunisation Plus Days (IPDs). As can be seen in Figure 5.4 there is now a wider menu of choices for states. Of these options, outreach services were considered the most important element in FCT, Lagos and Sokoto.

Some states do not see application for ISS funding as a priority. The FCT, for example, has been less proactive since immunisation services are well funded by the relevant levels of government.

#### ISS funding and impact on DTP3 coverage rate

Figure 5.5 presents Nigeria’s DTP3 coverage rate over time against yearly ISS disbursements.<sup>10</sup> The data do not suggest any link between ISS disbursements and the DTP3 coverage rate in Nigeria – however stakeholders interviewed did indicate the importance of ISS funding for strengthening immunisation systems in the country.

Figure 5.5: DTP3 coverage, ISS disbursements from GAVI and use of funds by the government, 2000-08



<sup>9</sup> Source: State plans for routine immunisation strengthening and state representatives.

<sup>10</sup> The source for coverage rates is WHO/UNICEF, given the problems identified in Nigeria’s DQA.

### *Flexible cash'*

National level stakeholders viewed the flexible nature of ISS support positively. In addition, the fact that ISS funds could be spent widely through the immunisation sector has helped to strengthen system-wide strategic planning in Nigeria.

Some flexibility in the use of funds is certainly lost between disbursement of funds from GAVI to Nigeria, and the use of those funds by states. At the state level, however, the guidelines regarding use of ISS funds are actually perceived to be relatively strict. But the overall ethos of flexibility is at least partly preserved even at the state level, as states can apply for funding from a menu of choices. In addition, feedback from the federal government suggested that they could provide funding for additional areas to the States – although the States had not yet indicated any additional areas for support.

### *Reward based funding*

The rewards-based approach employed in ISS funding was generally viewed as useful by many stakeholders, especially at the national level. However:

- The incentives created through this reward-based approach are not transferred to the States, which are primarily responsible for the implementation of the ISS funds. While the rewards are calculated at the national level and concomitant funds are disbursed by GAVI to the federal government, there is no direct link between the funding provided by the federal government and improvements in coverage rates by the States.
- Better performing states are often those with higher levels of resources, and are hence less inclined to bid aggressively for ISS funding. As a result the states with the most access to ISS funds may be the poorest performing states in terms of coverage rates.

Some interviewees expressed more fundamental concerns with reward based funding. They noted that linking funding to performance requires accurate and reliable data on coverage rates and the data quality in Nigeria may not be sufficient in this respect (see Box 5.1 above on the DQA). Also, it was noted that performance based approaches require considerable additional funding to support the monitoring process – for example, one interviewee cited an example of performance-related funding in Cambodia, where the monitoring and evaluation requirements took up 20% of the total budget.

### **5.3.3. GAVI ISS value add**

Feedback from stakeholders suggests that GAVI ISS has added value in a number of ways in Nigeria:

- **Improved planning and budgeting by States.** We understand that prior to GAVI ISS funding, and also in the early years of GAVI ISS support, there was no credible system for States to access funds from the federal government. Disbursements were more ad hoc in nature and were not set within a broader framework for immunisation system strengthening. With the progression of GAVI ISS support, these systems have improved. States now have to develop a plan for their immunisation systems, with a corresponding budget, in order to apply for funds from the federal government. The federal

government has appointed ‘GAVI consultants’ to help states develop these plans and proposals. The capacity of the States to develop proposals has improved over time – and this was noted as one of the key value additions of GAVI ISS support in Nigeria.

- **Improved accountability by the States.** The federal government requires the states to provide a full account of the use of funds before disbursing the next tranche of ISS funds. This requirement has improved overall accountability amongst the states. The federal government noted that as they need to report to GAVI on the use of funds (through the Annual Progress Report (APR)) they need to ensure appropriate accountability of funds by the States.
- **Better quality of data.** The failure of the first DQA in 2004 was an important wake up call for Nigeria. Stakeholders view that the DQA and DQS have helped improve data quality in Nigeria. In requiring the states to apply for ISS funding, the NPHCDA has passed down incentives to states to improve their data capacity.
- **Additional funding for immunisation systems by state governments.** While we do not have data to support this, feedback from federal and state level stakeholders suggested that some states governments have been encouraged to provide greater amounts of funding for immunisation systems strengthening given the increased focus through the availability of GAVI ISS funding.

Thus GAVI ISS funding has added value in Nigeria in a number of different ways, over and above its direct intended purpose. While all these improvements cannot be attributed to ISS funding alone, it has played a pivotal role in encouraging these developments.

#### **5.4. GAVI CSO support**

Nigeria has not applied for GAVI Type A CSO support, and is not one of the pilot countries eligible for Type B support.

Feedback from the government indicated that they had shared information with the CSOs on the GAVI support, however they had not expressed much interest in applying for this support. However the lack of demand for this support may also stem from the limited high level forums for major stakeholders to discuss or review health sector issues at the national or sub-national level. CEPA did not get a chance to meet with any CSOs during the field visit to comment further on their views.

## 6. ASSESSMENT OF GAVI VACCINE SUPPORT TO NIGERIA (SG 2)

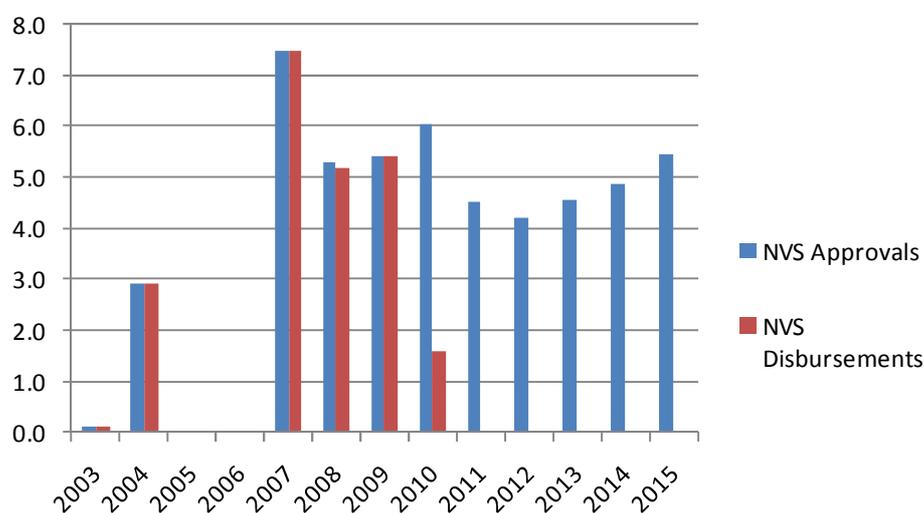
GAVI's second strategic goal is to: 'accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security'.

This section provides a description of the support received from GAVI as well as an assessment of the results and value add for Nigeria.

### 6.1. Description of GAVI support for vaccines<sup>11</sup>

Nigeria has been receiving NVS support from GAVI since 2003. Total support worth \$22.7m has been disbursed between 2003 and 2009, with a further \$38.1m worth of Yellow Fever vaccines approved for 2010-15. Figure 6.1 shows approvals and disbursements made under this window across the years of support.

Figure 6.1: NVS - GAVI approvals and disbursements data (\$m)



#### 6.1.1. Description of application, approval and implementation process

In June 2003, GAVI granted approval to support Nigeria with Yellow Fever vaccine. We understand that Yellow Fever was on the routine immunisation schedule before GAVI support began in 2003, although its availability was irregular.

The support was temporarily discontinued in January 2005 due to Nigeria's reluctance to introduce AD syringes for routine immunisation. In June 2006, a fresh application was made for reinstatement of the support following which GAVI gave approval for support worth \$7.5m in 2007 and a further \$40.4m over 2008-15. Nigeria will start co-financing as from 2011.

<sup>11</sup> Note that Hepatitis B vaccine was introduced on to the routine immunisation schedule in 2003, and is fully funded by the Nigerian government.

## 6.2. Results and value add of GAVI NVS support

### *Vaccine delivery*

The availability of the yellow fever vaccine was reported as good, with no incidences of stock outs. No stock outs were reported in Lagos or Sokoto, and stock out rates for Yellow Fever have been generally lower than for Hep B. However, this was tempered by relatively low uptake in some areas (including FCT). Public demand is stronger for BCG, for example, and one interviewee suggested that demand creation and local advocacy in support of the Yellow Fever vaccine needs to be improved.

### *Planning*

Interviewees felt that GAVI's NVS support (in common with other programs, in particular ISS) has catalysed improvements in planning and internal processes. Comprehensive Multi Year Plans (cMYP) are considered to have improved in quality, since it is known that they will support NVS applications.

## 6.3. Nigeria's application for Pentavalent and PCV

For a long time Nigeria did not apply for support for the Hib or Pentavalent vaccines from GAVI, due to its ongoing focus on eliminating polio in the country. Finally, in 2009, it decided to apply for support for Pentavalent from GAVI, along with support for the PCV vaccine. However while at first Nigeria received conditional support for both proposals, it has now been asked to 're-submit' an application, and effectively its applications have been rejected.

Table 6.1 summarises the application process for the Pentavalent vaccine and PCV based on feedback from country stakeholders.

*Table 6.1: Summary of applications for introduction of Pentavalent and Pneumococcal vaccines*

Date	Result	Conditions
July 2009	Conditional approval	<ul style="list-style-type: none"><li>• Additional investment required in cold chain capacity</li><li>• More detailed planning required regarding sustainability</li></ul>
October 2009	Resubmission <sup>12</sup>	Further requirements unclear

We received strong negative feedback regarding the process and outcome of these applications. Following the July 2009 conditional approval, the NPHCDA felt the required changes were well-understood. As a result the revised cMYP was widely considered to have met the necessary conditions, and plans were made on the assumption that vaccine support would begin in April 2010.

All interviewees said the reason for second request for resubmission was unclear: there can be no doubt that this decision has caused some confusion. Country stakeholders also noted that the planned changes to the requirements for new vaccine approvals by GAVI (for example, an increase in the threshold level of the DTP3 coverage rate to 70% and the use of WHO-UNICEF

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<sup>12</sup> To be interpreted as: an additional application is required, but not an outright rejection

best estimates as against administrative data) would limit the chances for funding in the near future.

Feedback from stakeholders indicated that this rejection of Nigeria's applications for the new vaccines has had a number of negative impacts:

- Inefficient use of **investment capital**.
  - GAVI's July 2009 conditional approval resulted in over N1bn of government funds being made available in order to meet the specified requirements, particularly in the area of cold chain capacity.
  - This has diverted spending from other areas (e.g. funding to tackle measles) and will result in a degree of over-capacity (though not all of the additional capacity will be wasted).
  - Cold storage capacity is typically depreciated over five years, so even the delay so far of six months is relatively significant.
- Inefficient use of **political capital**.
  - NPHCDA representatives reported that they had to lobby hard to secure the required N0.6bn cofinancing from the federal Government.
  - This funding, earmarked for the current spending round, would be highly unlikely to be released again in the next spending round.
  - Furthermore, with the NPHCDA's credibility diminished, its ability to secure future funding in support of GAVI initiatives or for further investments is jeopardised.
- Inefficient **procurement of substitute vaccines**.
  - Given that the planned introduction of the Pentavalent vaccine in April 2010 did not go ahead, Nigeria has had to make arrangements to procure its DTP vaccines separately.
  - We understand from UNICEF officials that procurement requests are typically made 14 months in advance, and Nigeria constitutes 60-80% of total DTP vaccine demand in SSA (since only four African countries do not currently use the Pentavalent vaccine). It is consequently a major challenge to secure sufficient stocks in time.

## 7. SUSTAINABILITY OF GAVI FUNDING AT THE COUNTRY LEVEL (SG 3)

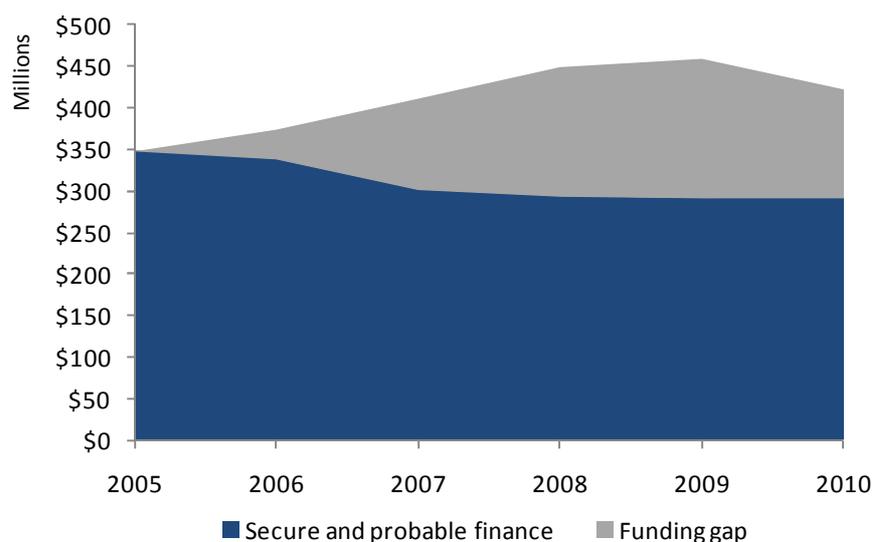
GAVI's third goal relates to financing of its programs, and is to 'increase the predictability and sustainability of long-term financing for national immunisation programs'. The focus of the country-level evaluation is to analyse to what extent GAVI has promoted and increased the sustainability of immunisation funding in the country.

Nigeria's federal structure means the states have significant responsibility for delivery and indeed funding. While sustainability of funding for vaccines is primarily a country-level issue, sustainability of funding for systems strengthening is relevant at the state level.

### 7.1. Review of country cMYPs

Nigeria's initial cMYP, beginning in 2005, incorporated increased expenditure between 2005 and 2010 (see Figure 7.1 below). While sources of finance in the baseline year and the first forecast year were close to the full amount of expected expenditure, for Years 3-6 there was an anticipated funding gap of around 30% of expenditure.

Figure 7.1: Estimated funding gap (2005-10)



A revised cMYP, covering 2009-14, was submitted in support of the Pentavalent and PCV NVS application. Baseline indicators for 2008 showed total immunisation expenditure of \$235m (\$132m on campaigns and \$103m on routine immunisation), and total shared costs of \$197m. The total of \$434m is slightly below the \$448m planned expenditure in the first cMYP.

The total secured financing from government and Development Partners (DP) for this cMYP amounts to \$715m. With probable financing amounting to \$974m there exists a funding gap of \$425m, around 20% of the total budget – lower than in the earlier cMYP. This funding gap comprises costs for vaccines and injection equipment; personnel; transport; logistics (vehicles, cold chain and other equipment); and other recurrent costs.

## 7.2. Stakeholder views on the sustainability of GAVI funding

### *Federal level*

At the federal government level, views were mostly positive on the financial sustainability of GAVI's support – given that total GAVI funding to Nigeria is relatively small in comparison to the government health budget and the support received from other donors.<sup>13</sup> Many government stakeholders alluded to the financial sustainability of INS funding, once GAVI support was terminated. Furthermore, the introduction of budget lines for activities funded under ISS, combined with the improved reporting on the use of funds, suggested better planning for immunisation financing.

The relatively high prices of the new vaccines (Pentavalent and PCV) were noted, and it was acknowledged that Nigeria would find it difficult to fund these vaccines today without GAVI's support.

In addition, the recent experience with the applications for these new vaccines (see Section 6 for details), has implications for Nigeria's ability to meet its co-financing requirements in the future. While stakeholders generally appreciated GAVI's pragmatic approach to cofinancing (and some expressed the view that GAVI's requirements in this area are a good incentive to plan and think about future financing at an early stage), the NPHCDA noted the problems it would face in requesting for funds to meet GAVI's co-financing requirements in future years.

### *State level*

As noted previously, state process with respect to planning and budgeting have been improved as a consequence of GAVI support (in particular ISS support – see Section 5.3). Such improvements have positive implications for sustainability. Furthermore, having seen the successes of INS support, in particular, some area councils in FCT are beginning to release further funds for continuing activity.

However, there were signs of potential difficulties for states in terms of sustainability. Interviewees – particularly in Sokoto – indicated that opportunities greatly exceeded available funding. All states felt that continued and predictable GAVI support would be important in meeting ongoing funding needs.<sup>14</sup>

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<sup>13</sup> Nigeria is one of the GAVI-eligible countries that funds the Hepatitis B vaccine on its own.

<sup>14</sup> An earlier requirement by the federal government for 10% counterpart funding from states to access ISS funds met with significant resistance from the states.

## **8. GAVI'S STRUCTURES AND PROCESSES IN NIGERIA (SG 4)**

This section summarises views on the institutional structures that are relevant for GAVI (the ICC and Health Partners Coordinating Committee (HPCC)) and the functioning of the alliance at the national level. It also comments on GAVI's advocacy role for immunisation in Nigeria.

### **8.1. Institutional structures**

#### *ICC*

The ICC is comprised of all key health sector stakeholders, though it is focused on the immunisation sector. The ICC itself is concerned primarily with policy issues, while the Core Group underneath it (and the Routine Immunisation Technical Group beneath that) is focused on technical issues.

Many interviewees commented that oversight and support from the ICC had not been as much as expected. The committee has not met as often as planned: it has met only three times since 2007 due to frequent unavailability of the Federal Minister of Health who chairs this meeting. The Finance Working Group of this Committee has not met since 2005. The Core Group however meets more regularly and is fairly active.

#### *HPCC*

The HPCC also includes key health sector stakeholders. Its technical arm, the Health Systems Forum (HSF), was reactivated in 2006 to oversee the submission of the GAVI HSS proposal among other functions.

It was suggested that there is room to improve the functioning of the HPCC.

### **8.2. Stakeholder views on the 'Alliance' model at the country level**

Discussions with the Government indicated that they view the support of GAVI partners – WHO and UNICEF – as very useful. Discussions with the partners suggested they support the government in accessing and implementing GAVI funds. Partners view themselves as an inherent part of the Alliance and there is a strong feeling of partnership among stakeholders.

It was expressed by some stakeholders that having a GAVI 'focal person' or greater interaction from the Secretariat would be beneficial. For example, greater communication regarding proposal results could have averted significant confusion in the case of the Pentavalent and Pneumococcal vaccine application.

### **8.3. Advocacy**

GAVI was considered by a number of stakeholders as synonymous with routine immunisation. GAVI has helped to focus attention on immunisation, with the result that it is very much on the government's agenda. GAVI's presence is felt in various ways, from meetings of the core technical groups under the ICC and HPCC to a peer pressure effect that has been observed at regional gatherings.

## 9. CONCLUSIONS

This section brings together the findings on results and value add across GAVI programs in Nigeria. Table 9.1 below consolidates the evidence from our analysis on areas where GAVI has demonstrated relatively better or weaker performance across its four Strategic Goals.

Table 9.1: Performance of GAVI programs in Nigeria

Strategic Goal	Positive results/value add	Weaker results/value add
SG1: Health system strengthening	<ul style="list-style-type: none"> <li>• INS led to wider adoption/uptake of AD syringes than was the case previously, despite the existence of a policy on the use of safety equipment.</li> <li>• High usage of safety kit supported by reliability of supply.</li> <li>• General optimism on sustainable funding for safety kit.</li> <li>• Availability of ISS funding has led to an improved focus on immunisation system strengthening – which was not previously receiving sufficient attention/funds. Some state governments are also now allocating more funds to immunisation systems.</li> <li>• Flexibility in use of ISS and HSS funds is well-received by all stakeholders.</li> <li>• Process requiring states to apply for ISS funds has helped catalyse major improvements in planning, budgeting and accountability.</li> <li>• The issue of data quality has received more attention in Nigeria, given the outcome of the first DQA as well as the link with reward funding.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited capacity for waste management of injection safety material.</li> <li>• Delays in implementation of GAVI HSS support.</li> <li>• Incentives created by the ISS reward-based system do not flow down to the state level directly.</li> <li>• Some consultees were sceptical as to whether the data was good enough to support reward-based funding.</li> </ul>
SG2: Vaccine support	<ul style="list-style-type: none"> <li>• Regular supply of yellow fever vaccine has supported uptake.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of demand has partly limited uptake of Yellow Fever vaccine in certain areas.</li> <li>• Confusion regarding the approval process has resulted in negative consequences, as investments, political decisions and procurement decisions were made on the basis of impending Pentavalent and PCV support.</li> </ul>

Strategic Goal	Positive results/value add	Weaker results/value add
SG3: Financing	<ul style="list-style-type: none"> <li>• General improvements observed in immunisation planning and budgeting.</li> <li>• High degree of optimism regarding continued provision of injection safety kit.</li> </ul>	<ul style="list-style-type: none"> <li>• Recent experience with Pentavalent and PCV applications has implications for Nigeria's ability to meet future co-financing requirements.</li> </ul>
SG4: Added value as a global Public Private Partnership (PPP)	<ul style="list-style-type: none"> <li>• Partnership model at the country level appears to work well, with high level of involvement of WHO and UNICEF in GAVI-related activities.</li> <li>• GAVI funding has helped raise the profile of immunisation in the country.</li> </ul>	<ul style="list-style-type: none"> <li>• Limited oversight and support from the ICC and HPCC, which meet irregularly</li> <li>• Limited interaction with GAVI Secretariat/ lack of a GAVI 'focal point' has impeded effective communication</li> </ul>

## ANNEX A: BACKGROUND INFORMATION ON NIGERIA'S IMMUNISATION SECTOR

This annex provides some additional background information on Nigeria's immunisation sector.

### *Role of key actors*

The NPHCDA is the key nodal agency for immunisation in Nigeria. Its head office is in Abuja and its 6 zonal sub-units are distributed in Nigeria's geo-political zones. It provides technical support to states either directly or through zonal technical officers assigned to states. Its core functions include vaccine distribution; training of immunisation service personnel; supervision, monitoring and evaluation. The Zonal offices are principally concerned with providing linkage between the head office and States; providing technical support, monitoring and evaluation. With the notable exception of GAVI funding, states do not receive funding for immunisation from the NPHCDA.

Other key players in Nigeria's immunisation sector are summarised in Table A1.1 below.

*Table A1.1: Key role players in the management and delivery of immunisation services in Nigeria*

Institution	Focus	Immunisation delivery strategy	Cost elements supported
<b>Federal Government</b>			
NPHCDA	Overall national responsibility for governance and oversight	Routine, Polio & Campaigns	All aspects of immunisation including human resources, procurement of CSM vaccines and clearing of all vaccines, cold chain & logistics, social mobilization, program management
MDGs Office	Financial resources	Routine, Polio & Campaigns	Routine vaccines, bridge financing for Polio, HR capacity building, campaigns
NPC	Point of entry for donors; coordination of grants		
FMOF	Coordination of concessionary loans		
<b>States and Local Governments</b>			
State Governments (SMOH/SPHCDA)	Overall State responsibility for governance and oversight	Routine, Polio & Campaigns	Human resources, vaccines, cold chain & logistics, social mobilization, program management
Local Governments	Overall LGA responsibility for governance and oversight	Routine, Polio & Campaigns	Human resources, vaccines, cold chain & logistics, social mobilization, program management
<b>Development Partners</b>			

Institution	Focus	Immunisation delivery strategy	Cost elements supported
Various	Planning, monitoring & evaluation, training, surveillance &	Routine, Polio & Campaigns	Human resources, vaccines, cold chain & logistics, social mobilization, program management

Source: NPHCDA 2010

### Routine immunisation schedule in Nigeria

Table A1.2: Routine immunisation schedule

Vaccines / Supplements	No. of Doses	Age	Minimum interval between doses
BCG	1	At birth or as soon as possible	
OPV	4	At birth, 6,10 and 14 week of age	4weeks
DPT	3	At 6,10 and 14 weeks of age	4weeks
Hepatitis B	3	At birth, 6 and 14 weeks of age	4weeks
Measles	1	At 9 months of age	
Yellow Fever	1	At 9 months of age	
Vitamin A	2	At 6months and 12 months of age	6 months
Tetanus Toxoid	5	Women of Child bearing Age/ early Pregnancy	TT1 @ 1 <sup>st</sup> Contact TT2 at least 4wks after TT1, TT3 at least 6mths after TT2 TT4 at least 1yr after TT3, TT5 at least 1yr after TT4

Source: NPHCDA (2009) Nigeria cMYP 2009- 2014

Modifications of this schedule are proposed upon introduction of Pentavalent and pneumococcal conjugate vaccines. CSM is administered in an annual campaign in susceptible areas in the north, to age groups which vary according to the quantity of vaccine supplied. The immunisation policy also provides guidelines on injection safety standards and practices, surveillance systems, advocacy/social Mobilisation and partner coordination.

### Immunisation funding

Resource requirements for PEI, measles, meningitis, tetanus and yellow fever are shared by government and DPs in varying proportions. At the federal level, 42% of total costs are estimated to be expended for routine immunisation, 46% for supplemental immunisation and 12% for surveillance. Vaccine procurement and delivery accounted for as much as 46% of total expenditure. Government provides 80-90% of funds routine vaccines procurement and GAVI provides the balance (NPHCDA 2008). Other immunisation program specific costs include personnel costs; injection supplies; cold chain equipment and maintenance; transportation; training; social mobilization; coordination and data management. Key cost elements directly

related to the delivery of immunisation services in the NPHCDA 2009 budget are presented in Table A1.3 below.

*Table A1.3: Immunisation specific costs elements identified in NPHCDA 2009 budget*

S/no	Cost element	Budget (Nm)
1	Procurement of bundled vaccines	75
2	Polio eradication	250
3	Polio and measles immunisation in high risk States	1,500
4	Implementation of MNT and Tetanus Eradication Initiative	250
5	Procurement of bundled vaccines for routine and polio immunisation	3,000
6	MDGs/DRG projects	7,500
	<b>Total</b>	<b>12,575</b>

*Coverage rates*

*Table A1.4: Routine Immunisation Coverage rates (%)*

State	BCG	DTP3	OPV3	All Vaccines
National	49.7	35.4	38.7	22.7
FCT	84.7	75.9	65.2	55.4
Lagos	84.6	73.6	60.9	52.8
Sokoto	4.5	2.0	10.9	1.0

*Source: DHS 2008*

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## ANNEX C: LIST OF CONSULTEES

### National level consultees

Table C.1: National Level Consultees

Stakeholder category	Organisation	Position	Person
Government	FMOH	Dir. Health Planning and Research	Dr. Mohammed Lecky
		Head PPP Unit/Chair, Project Implementation Coordinating Committee, HSDPII	Dr. Tolu Fakeye
		Dept. Health Planning, Research & Statistics	Dr. Tosin Solanke
		Medical Officer FMOH	Dr. George Davidson
		ED./CEO NPHCDA	Dr. Muhammad Ali Pate
		Dir. Immunisation NPHCDA	Dr. Abanida
		Asst. Dir. Immunisation NPHCDA	Dr. Nuhu Adamu
		Asst. Dir./ GAVI Desk Officer NPHCDA	Dr. Joseph Oteri
Other Donor Organisations	DFID	Health Advisor	Ebere Anyachukwu
	UNICEF	Health Manager/EPI Team Leader	Dr. Boubacar Dieng
		SIA Officer (Health Specialist)	Dr. Paul Adovohekpe
		Health Specialist	Dr. Jane Bammeke
		Vaccine Security & Logistics	Mr. Fred Willis
	USAID	Senior Health Advisor	Dr. John Quinley
		MCH Program Manager	Dr. Folake Olayinka
	WHO	WHO Representative	
		EPI Team Leader	Dr. Alex Gasasira
		Immunisation Unit Head	Dr. Patricia Tanifum
		Routine Immunisation Focal Person	Dr. Edward Dede
	World Bank		
	European Commission	EU-Project Office; Health	Dr. Anthony Ayeke
	USAID-AIDSTAR/JSI	Country Director	Dr. Abimbola O. Sowande
HCWM Advisor		Kelechi E. Amaefule	

## State level consultees

Table C.2: State Evaluation Consultees – FCT

Stakeholder category	Organisation	Position	Person
Government	FCT Health Secretariat	Deputy Dir. PHC	Dr. Mrs. H.S. Balarabe
		GAVI Consultant: FCT, Nasarawa, Niger states	Dr. Wale Okediran
		FCT Immunisation Officer	Dr. O.A. Obanewa
		Asst. Cold Chain Officer	Aliyu Lawal
		Chief Comm. Health Officer	Mrs. Lucy A. Agim

Table B.2: State Evaluation Consultees – Lagos

Stakeholder category	Organisation	Position	Person
Government	Lagos State MOH	IMCI/SCH Health Coordinator; LSMOH	Dr. A. A. Idowu
		IMNCH Officer	Dr. A.S. Olatunji
		Dir. FH&N; LSMOH	Dr. Jemilade Longe
		State Immunisation Officer; LSMOH	Mrs. O. O. Sessi
		Local Immunisation Officer, Ikorodu LGA	Mrs. S.I. Lawal
		GAVI Consultant: Lagos & Ogun states; NPHCDA	Dr. Frank Thorpe
		AD SW2; NPHCDA	Dr. N.U Onwu
		Local Immunisation Officer, Oshodi/Isolo LGA	Mrs .G.A Ayodele

Table B.3: State Evaluation Consultees – Sokoto

Stakeholder category	Organisation	Position	Person
Government	Sokoto State MOH	Hon. Comm. for Health	Dr. Mohammad Jabbi Kilgori
		Permanent Secretary	Pharm. Umar Attahiru
		Dir. Pry Health Care	Dr. A. M. Gandi
		State Immunisation Officer	Mohammad Lema Sani
		GAVI Consultant for Sokoto, Zamfara and Kebbi states	Yusuf Mohammad Argungu
		Sokoto-North Local Immunisation Officer	Ibrahim Umar
		Local Immunisation Officer	Umaru Buba

Stakeholder category	Organisation	Position	Person
		Asst. Local Immunisation Officer	Lawal Isiyaku
		DDPH/DIS	Garbe Kandi
Other Donor Organisations	USAID	TSHIP	Halima Abubakar
		TSHIP	Dr. Benson Ojile
	WHO	WHO-National Facilitator	Dr. Musa Yahaya

## ANNEX D: REPORT ON VISITS TO FCT, LAGOS AND SOKOTO STATES

### Executive Summary

Given the federal nature of Nigeria, with considerable diversity across States, our evaluation covered a review of GAVI support to select States. Three states – FCT, Lagos and Sokoto – were covered as part of the evaluation, including a mix of good and poor performing states in terms of their coverage rate. The objective was to understand their experience with GAVI funding. Consultations were carried out with state and local government immunisation program personnel and representatives of partner agencies operating at state level.

In terms of vaccine and injection safety support (provided directly by the federal government), no major issues were highlighted across all three states reviewed.

In terms of ISS funding however (which is more relevant at the State level), a number of GAVI's key points of value add were:

- Its demand driven approach permits the flexibility of applying GAVI ISS funds where they are most needed.
- By making the availability of state-level, immunisation-specific, fully costed plans a prerequisite for access to GAVI ISS funds, planning and budgeting processes are enhanced.
- GAVI funds crowded in the provision of funding by the government.
- GAVI funds use galvanized the development partners (notably WHO and UNICEF) to partner with states and the FCT in joint planning, implementation, monitoring and evaluation of immunisation activities.

GAVI funding has encouraged immunisation program managers at sub-national levels to successfully advocate for financial resources from their respective tiers of government for strengthening the cold chain system and capacity building of immunisation planning and management personnel and their service delivery counterparts.

### Introduction

The state visits were conducted from 14-16 April, 2010, to determine the extent to which GAVI has met its strategic goals at sub-national levels in Nigeria. States were selected primarily on the basis of:

- their **immunisation program performance** determined by vaccine coverage levels prior to accessing GAVI ISS support. In particular, two 'good' (Lagos and FCT) performing states and one 'poor' (Sokoto) performing state were selected.
- their **geographical spread**, including one state each in the south (Lagos) and north (Sokoto), and centre (FCT) of the country. The FCT is highly proximal to the national level agencies and development partners, while Sokoto is relatively distant.

The following sections are organised by state.

## **Federal Capital Territory (FCT)**

### **Background**

The Federal Capital Territory (FCT) is located at the geographical centre of Nigeria and has a population estimated at 0.8m (2006 census), likely an underestimate for a city with a large influx of people from across the country and beyond. The FCT has six Area Councils. These are the equivalent of LGAs in states. At the FCT-level, the Department of Health and Human Services oversees health care delivery through the secretary of health and human services. At the area councils, the health department oversees health through the PHC Coordinator. The FCT has one of the best immunisation services indicators in the country.

Administrative reporting for antigen coverage in the FCT averages 80% and 60-70% for DTP3 and OPV3 respectively in 2009. The FCT and its Area Councils provide the bulk of funding for immunisation services. Other support to the service includes GAVI and MDG for outreach services; UNICEF for capacity building and SIAs; and EU-PRIME for capacity building and cold chain equipment. Some Area Councils now have specific budget lines for RI services. While UNICEF funds its activities through a government account into which the FCT contributes its counterpart funding, WHO and EU fund their activities directly. WHO and UNICEF provide guidance to the FCT and its Area Councils for GAVI funds utilization.

### **Assessment of GAVI health system strengthening support (SG 1)**

#### *Assessment of GAVI INS support*

Quarterly vaccines supplies to the FCT from the National Strategic Cold Store are hundred percent bundled with AD syringes and disposable, reconstitution syringes. AD syringes foster the use of burn and bury sites for disposal of injection materials. Bury sites are considerably cheaper than incinerators though burning poses an environmental hazard. At the Family Planning Clinic in Abuja where an immunisation session was observed, a burn and bury site was in place from which the FCT waste disposal agency frequently collects its waste injection material for disposal.

#### *Assessment of GAVI ISS support*

The FCT received N2.1m in October 2009, the first tranche of a total of N8m approved funding. Logistics support for outreach services was identified as a priority in the FCT and flexibility in the ISS funds enabled it to be channelled to meet this purpose. The ISS funds are also applied to creating demand for immunisation services by sensitizing communities through their traditional rulers. Two health facilities in each of 62 wards (total 124 HFs) receive ISS support against a total of 178 facilities providing routine immunisation services in the FCT. The decision to disburse funds directly to health facilities was borne out of the need to achieve targets and is the result of lessons learned from previous experiences where funds disbursed through Area Councils did not reach the facilities where they are needed the most.

The ISS support has provided the basis to reinforce political commitment to provide funds for outreach services in the FCT and its Area Councils. It also responsible for the new trend in budgeting for routine immunisation services in Area Councils. The condition that approval for

GAVI ISS support is tied to contents of immunisation program plans encourages and builds capacity for program planning in immunisation personnel in the FCT.

### **Assessment of GAVI vaccine support to Nigeria (SG 2)**

The purchase of routine vaccines is the exclusive statutory responsibility of the federal level. Quarterly vaccines distribution to the FCT from the National Strategic Cold Store (NSCS) ensures there have been no vaccine stock-outs since April 2007. Availability of vaccines has led to increasing coverage rates, e.g. DTP3 coverage from administrative data increased from 66% to 83% between December 2006 and December 2009. Yellow Fever vaccines for travellers are provided from routine vaccine stock but stock-outs have not occurred due to the ease of replenishing stock from the NSCS.

### **Cross-cutting issues**

The country's federal structure which grants autonomy to the different tiers of government implies that the FCT has limited influence on immunisation program management at its Area Councils. To ensure efficient utilization of the ISS funds for improving immunisation coverage, the FCT bypasses its Area Councils and directly grants the support to health facilities. WHO and UNICEF strengthen poor human capacity for financial management that exists at this level.

### **Summary and conclusions**

GAVI INS, ISS and NVS have contributed to enhancing immunisation service delivery in the FCT. Improved injection safety and regular vaccine availability are among direct benefits from this support. Flexibility of the funds enables provision of much-needed logistics for outreach services and demand creation. Finally, availability of the funds has been responsible for increasing political commitment to funding and budgeting for routine immunisation services.

## **Lagos state**

### **Background**

Lagos State is located in South Western Nigeria. It is home to Lagos, one of the world's ten largest cities, which has a population estimated at 12-15m, grows at an annual rate of 6%, and attracts people from other parts of Nigeria, the West African sub-region and beyond. There are twenty LGAs in the state. It is Nigeria's most prosperous state, but socio economic indices of its inhabitants vary widely.

The State ministry of health oversee the state's health care delivery through the commissioner for health. At the LGA level, the PHC Coordinator is responsible for health services delivery. The federal system of government confers autonomy to state and local governments.

Lagos state is one of the good performing states based on its immunisation service indicators. Coverage for the fully immunized child is more than double the national average of 22.7% at 52.8%. The state and local governments fund their immunisation services along with support from GAVI, WHO and UNICEF. WHO gives a monthly support of N240,000 towards the local immunisation officers' meeting; UNICEF supports the Reach Every Ward strategy and GAVI funds are being used for training and supportive supervision in the state. The ward is an administrative unit within the LGA. Each LGA comprises approximately 10 wards.

### **Assessment of GAVI health system strengthening support (SG 1)**

#### *Assessment of GAVI INS support*

The state receives quarterly routine vaccines from the NSCS. The vaccines are 100% bundled with AD syringes and have been consistently available except for a recent stock-out in BCG syringes that has necessitated the use of disposable syringes. This stock-out was confirmed to be a result of non-distribution of BCG syringes from the NSCS in the last quarter and the NPHCDA is taking steps to procure the item.

#### *Assessment of GAVI ISS support*

Lagos state received ISS funds in 2006 and 2007, and the funds were reportedly well utilized. The process of guidelines development for GAVI funds disbursement that occurred in 2008 hindered disbursement that year. Thereafter, the state developed and submitted its routine immunisation plan based on which approval was granted for GAVI ISS support. The state received the first tranche of disbursement approved in 2009 in the sum of N4.5m. The funds were expended on supportive supervision and N100,000 was used for training immunisation service delivery personnel in the state. The GAVI ISS supports the state's capacity building exercise which extends to two health workers per selected private health facilities delivering immunisation services in the state. The GAVI ISS is especially valuable for providing logistics support for outreach services to hard-to-reach, riverine communities in the state. The funds were also used to procure vaccine carriers and facilitate transportation for LGA officials to attend stakeholders' meetings.

The state acknowledges that reporting on use of funds is essential. GAVI funds, by virtue of its financial accountability requirements, promote health workers to be accountable for funds expended on immunisation service delivery.

### **Assessment of GAVI vaccine support to Nigeria (SG 2)**

The state receives quarterly supply of routine vaccines, including Yellow Fever vaccines, from the NSCS and there have been no vaccine stock-outs since 2007. Regular vaccine availability is contributory to sustained high coverage rates in the state.

### **Sustainability of GAVI funding at the state level (SG 3)**

The state acknowledges that GAVI ISS funds are useful in filling funding gaps for routine immunisation services in the state. The state officials are, however, mindful that external funding, including GAVI, are often unpredictable and eventually cease. They report that the state provides substantial funding for its immunisation services stating that N17m was spent on outreach services in 2008. Local governments also support their immunisation services.

### **Summary and conclusions**

GAVI INS, ISS, and NVS to Lagos state have been useful towards improving immunisation services in the state. GAVI ISS support is especially valuable for bridging funding gaps for routine immunisation services in the state.

## **Sokoto state**

### **Background**

Sokoto state lies in North Western Nigeria with an estimated total population of 3.6m (2006 census) of mostly poor, uneducated people who largely reside in rural areas. It has 23 LGAs, 120 health districts and 538 health facilities including two tertiary health institutions. The secondary and PHC HF's are evenly distributed across the state. Health care infrastructure, equipment, logistics and personnel are inadequate. Measles remains a major cause of childhood mortality. The state runs the Free Medicare Program to improve health service delivery for children under-five years and pregnant women.

State ministries of health oversee the state's health care delivery through the state commissioner for health. At the LGA level, the PHC Coordinator is responsible for health services delivery. The federal system of government confers autonomy to state and local governments.

In Sokoto State, neonatal mortality rate is 80 per 1,000 live births and under-five mortality rate is 25 per 1,000 live births.

Sokoto state is one of the states with the poorest immunisation indicators in the country with coverage of 1% for the fully immunized child in 2008 (NDHS 2008). The onset of GAVI support to the state in 2007 has brought about consistent improvements in coverage rates. Administrative reporting shows astonishing increase in coverage rates to 83% and 75% for DPT3 and OPV3 respectively in 2009. Yellow fever coverage was 63% in the same period.

The state recognizes the following key constraints to efficient immunisation service delivery:

- inadequate logistics for outreach services;
- negative attitude from the public to immunisation services;
- poor capacity and high attrition rates for immunisation personnel; and
- unreliable electricity supply for vaccine storage

To strengthen political commitment, the state set up state and LGA task forces comprising state commissioners; special advisers to the governor; religious leaders; traditional rulers; and representatives of development partner agencies charged with facilitating necessary support and social mobilization for immunisation services at state and LGA levels.

The state and local governments provide the bulk of funding for logistics for routine immunisation services. GAVI, UNICEF, WHO, EU-PRIME provide various support for immunisation services and a Partner Coordination Forum and Private Health Facilities Forum streamline all external support. The state focuses its support towards strengthening cold stores, vaccine distribution, outreach services and logistics.

### **Assessment of GAVI health system strengthening support (SG 1)**

#### *Assessment of GAVI INS support*

Vaccines supplied to the state from the NSCS have been 100% bundled with AD syringes since 2007. Prior to this, use of AD syringes for immunisation was less than 100%. The use of AD

syringes re-enforces the concept of ‘one syringe for one injection’ in the minds of the service delivery personnel. It also fosters the use of ‘burn and bury’ sites for disposal of injection materials. The state officials report the state’s willingness to fund procurement of AD syringes at the termination of GAVI INS support.

#### *Assessment of GAVI ISS support*

Funds were first accessed in the state in 2003 at which time the state and 4 LGAs were beneficiaries. By 2005, the state and all LGAs began to benefit from the fund, although the bulk of funding for immunisation services is still provided by the state and LGAs. The GAVI ISS support is received quarterly and is expended by the state and LGAs for maintaining cold chain systems; social mobilization; supportive supervision; and logistics for vaccine distribution. It also supports two health facilities in each ward to conduct outreach services. These activities were selected to conform to NPHCDA guidelines for utilizing these funds. The recently deployed state GAVI consultant ensures the funds are efficiently utilized. The GAVI ISS is contributory to the increasing coverage in the state.

Overall improvement in immunisation service delivery has brought about better data collection and administrative reporting in the state. At the health facility where an immunisation session was observed, the HW demonstrated clear understanding about how to enter immunisation data into relevant record books. The condition that approval for GAVI ISS support is tied to contents of immunisation program plans encourages and builds capacity for program planning in immunisation personnel in Sokoto state.

#### **Assessment of GAVI vaccine support to Nigeria (SG 2)**

The state receives quarterly supply of routine vaccines, including Yellow Fever vaccines, from the NSCS and there have been no vaccine stock-outs since 2007. Regular vaccine availability is contributory to marked improvements in coverage rates.

#### **Sustainability of GAVI funding at the state level (SG 3)**

GAVI support has contributed in fostering improved political commitment to funding immunisation services in the state. More funds are now consistently made available to the immunisation program at state and LGA levels. The states officials, in conveying the state’s willingness to fund procurement of AD syringes upon termination of GAVI INS support, report that the SMOH has a Sustainability Unit that ensures continuity and widespread deployment of successful, terminated development partner-supported programs.

#### **GAVI’s structures and processes in Nigeria (SG 4)**

The state officials are of the opinion that the presence of physical GAVI representation will drive better utilization of the state’s GAVI support.

#### **Cross-cutting issues**

The WHO representative reports on the inadequacy of disposable syringes for reconstituting vaccines and inadequate quantities of vaccine diluents. Even though these items (except diluents

for Yellow Fever vaccines) are procured with federal government funds, their inadequacy has the potential to disrupt immunisation services that GAVI supports.

To strengthen the state's capacity to achieve MDGs, NPHCDA employed MDG funds to deploy 96 midwives to strengthen maternal health service delivery in the state. This provides much needed human capacity for health services delivery which has the potential to translate to further improvements in immunisation services in the state.

### **Conclusions**

GAVI INS, ISS and NVS have contributed significantly to consistent improvements in immunisation indices in Sokoto state. The GAVI support strengthens political commitment for better planning, budgeting and increased allocation of funds to immunisation.