GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Nigeria Desk Study

Final Version – August 2009

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Submitted by

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Summary of key findings, conclusions and recommendations

GAVI HSS support to Nigeria is significant with over $US44 million being committed over 3 years. The proposal approach was highly country driven with the Federal MoH together with the Nigerian National Primary Health Development Agency being responsible for leading the design process and ensuring the effective participation of their various partners.

Recent analytical work on the Nigerian health system has highlighted a number of important areas connected with the effective provision of health services that are not currently being addressed adequately with the available resources. GAVI HSS funding in Nigeria is responding to these areas through a number of specific objectives:

- To re-vitalise the Ward Development Committees in 960 wards (in about 100 local government areas LGAs covering 20 million people)
- To rehabilitate and equip 960 health facilities (1/ward) to deliver PHC minimum health package;
- To train and retrain PHC workers in those 960 wards on managerial capacity, and technical skills for integrated service delivery by 2010;
- To strengthen the NHMIS for programme monitoring and management in 100 LGAs by 2010;
- To strengthen the logistics system and infrastructure at the National/State/LGA/Ward levels by the end of 2010.

Nigeria's proposal for Health System Strengthening support was approved after clarifications in 2007. The GAVI HSS funding has been programmed to implement activities intended to support the achievement of the five main objectives outlined above. Given the existing lack of resources of all kinds in the sector, there can be a high degree of confidence that GAVI HSS funds represent necessary and additional resources for the sector.

Responsibilities for primary health care in Nigeria are divided between the Federal MoH and the National Primary Health Care Development Agency (NPHCDA). There appears to have been a turf war between the two organisations that has delayed the start of the HSS programme. At the heart of the dispute seems to be the issue of where the HSS money should be deposited and who should control it: - in a FMOH account or in a NPHCDA account.

Successive Ministers of Health have failed to sign-off on the proposed work plan. Sign-off was only achieved after the current Minister was approached by the GAVI Secretariat at the recent World Health Assembly and asked to do so. However, implementation has yet to begin.

It is recommended that the GAVI Secretariat undertake an urgent review of the situation in Nigeria to establish what needs to be done to get the programme started.

It is recommended to undertake an end of HSS Assessment to see what the key lessons to be learned are, given the large size of the HSS grant, the long delays in commencing work and the particular challenges of working in Nigeria in terms of its population, federal structure and on-going issues around management and governance.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of a Deeper Desk Study of the GAVI HSS support to Nigeria carried out in July 2009 as part of the GAVI HSS Evaluation Study. The evaluation conducted 11 In-depth case studies in the following GAVI HSS recipient countries, Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. This current study is one of an additional 10 countries that were also studied, which did not involve country visits, but simply a review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 2.

1.2 Brief conceptual framework of the Evaluation

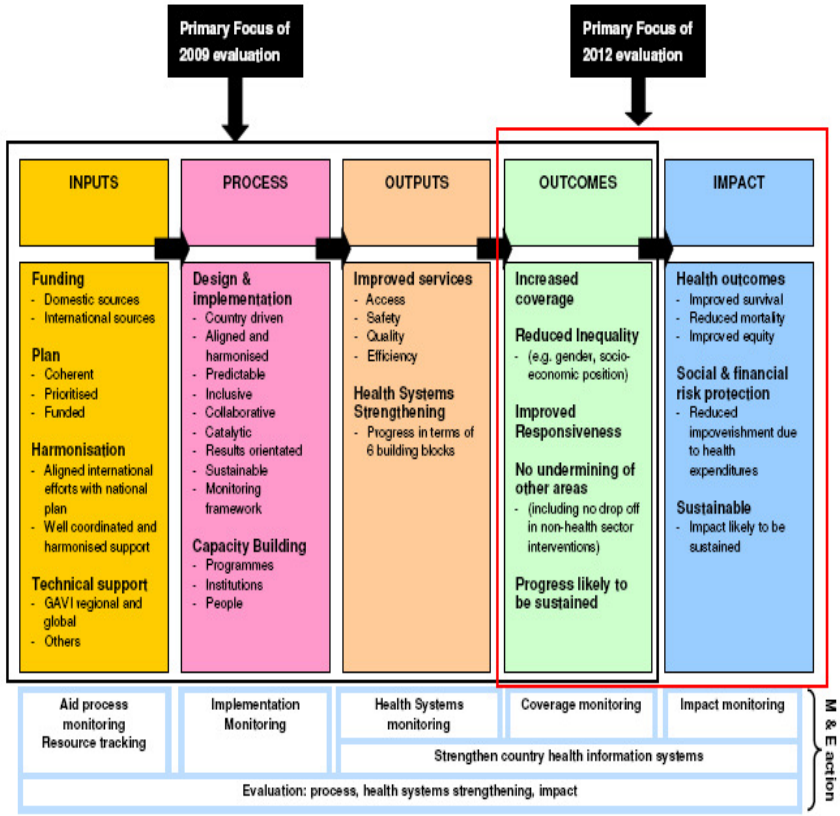
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation –the first one ever conducted on the GAVI HSS component- will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant

implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Nigeria Deeper Desk Study

The Nigeria Deeper Desk Study used a combination of document review and telephone interview in order to gain insight into how GAVI HSS funding has support health system strengthening more generally in the country. Both the document review and interviews took place in June 2009. Annex 1 provides a list of resources used for the Nigeria desk study. Unfortunately, for a variety of reasons, GAVI HSS work has not yet begun in Nigeria. For that reason, there was no reporting on the programme in the 2008 APR.

2 The GAVI HSS proposal – inputs, outputs and progress to date

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion 2010 On purpose this section will be mainly descriptive, while the assessment of the meaning of these findings in relation to GAVI principles and to the questions of the evaluation study will be done in section 4 in order to avoid repetition.

2.1 HSS proposal design

Nigeria is the most populous country in Africa with a population of approximately 140 million people (Census, 2006). The population is predominantly young with approximately 45% under 15 years of age, 20% under 5 years, while women of child bearing age (15-49 years) account for 22% of the total population. With a per capita GNI of US$640, Nigeria has about 57% of its population living below $1 per day.

The performance of Nigeria's health system declined appreciably in the closing decade of the last century resulting in poor health outcomes. Recent assessments have shown some improvements: the maternal mortality ratio has declined from 948/100,000 in 2003 to 800/100,000 in 2006. However, the under five mortality rate has shown only a marginal improvement from 230/1000 live births in 1990 to 194/1000 live births in 2005 and the infant mortality rate improved from 120/1000 live births in 1990 to 100/1000 live births in 2005 UNICEF State of the world children 2007). There was a substantial improvement in the DPT3 coverage from 37.5% in 2005, to 77% in 2006. (JRF 2005 & 2006) as a result of a combination of Immunization Plus Days (IPDs) and the acceleration of the Reach Every Ward (REW) initiative.

In spite of these advances, the health system still faces major challenges such as inadequate funding, a shortage and poor distribution of human resource for health, general infrastructure decay, a lack of a harmonized and efficient logistics system and a weak national health management information system combined with inefficient health programme management.

Barriers to Accessing Health Services

Recent analytical work on the Nigerian health system has highlighted a number of important areas connected with the effective provision of health services that are not currently being addressed adequately with the available resources. GAVI HSS funding is being targeted at a number of these areas which include:

General Health System issues

- Inadequate funding of health care services at all levels;
- Inadequate number and inequitable distribution of skilled manpower;
- Poor knowledge, attitude and managerial skills among health workers;
- Inadequate storage facilities and transport logistics at the LGA and ward levels;
- Poor maintenance culture at the LGA and State levels;
- Lack of update of pre-service training curricula with new innovations in the health sector and absence of systematic in-service training;
- Weak National Health Management Information Systems;
- Most health facilities do not meet the minimum requirement in terms of equipment and essential health commodities.

The **Goal** of the GAVI HSS programme is to strengthen the National health system and reposition it to deliver effective, efficient and sustainable health services.

The **General objective** is:

- To develop the Ward Health System in 960 wards (covering about 100 local government areas and approximately 20 million people) to deliver PHC services based on a minimum health care package by 2010.

Specific objectives include:

- To re-vitalise the Ward Development Committees in 960 wards;
- To rehabilitate and equip 960 health facilities (1/ward) to deliver PHC minimum health package;
- To train and retrain PHC workers in those 960 wards on managerial capacity, and technical skills for integrated service delivery by 2010;
- To strengthen the NHMIS for programme monitoring and management in 100 LGAs by 2010;
- To strengthen the logistics system and infrastructure at the National/State/LGA/Ward levels by the end of 2010.

Activities to be funded by GAVI HSS in Nigeria in support of the five specific objectives outlined above are included below in Table 1.

Table 1 GAVI HSS Interventions & Budget

Area for support	Year 1	Year 2	Year 3	TOTAL COSTS
	2008	2009	2010	
Activity costs	**US$**	**US$**	**US$**	**US$**
Objective 1: **To re-vitalise the Ward Development Committees in 960 wards**				
Activity 1.1 Reactivate and re-orientate Ward Development Committees in 960 Wards over 2 years	166,476	166,476	0	332,952
Activity 1.2: Develop a Ward Health Plan (WHPs), 2008- 2010, in 960 wards over 2 years	2,177,143	2,177,143	0	4,354,286
Activity 1.3: Implement Ward Health Plans (WHPs) based on micro-planning in 960 Wards over 2 years.	0	0	0	0
Objective 2: **To rehabilitate and equip 960 health facilities (1/ward) to deliver PHC minimum health package**				
Activity 2.1 Rehabilitate 960 existing PHC facilities, one per ward over 2 years	5,714,286	5,714,285	0	11,428,571
Activity 2.2: Equip 960 existing PHC facilities with minimum equipment package one per Ward over 2 years	3,809,524	3,809,524	0	7,619,048
Activity 2.3 Provide seed stock of essential drugs to 960 existing PHC facilities, over 2 years	1,904,762	1,904,762	0	3,809,524
Objective 3: To train PHC workers in those 960 wards in management, and the technical skills for integrated service delivery by 2010.				

Activity 3.1: Training and re-training of all PHC workers in 960 wards on integrated service delivery, managerial and team building skills and resource mobilization. (Each training activity will be institution-based and for 2weeks)	4,853,333	4,853,333	0	9,706,667
Activity 3.2: Providing monitoring and supportive supervision of trained PHC workers	213,333	213,333	213,333	**640,000**
Objective 4: **To strengthen the NHMIS for programme monitoring and management in 100 LGAs by 2010**				
Activity 4.1: Provision of data management tools and equipment in the LGAs covering the target wards	87,301	87,302	0	174,603
Activity 4.2: Facilitate data flow using ward focal persons	457,143	457,143	457,143	1,371,429
Activity 4.3: Training of 2(HF service provider per ward) and 2 staff from the LGA (774) on quality assurance and data management	121,690	121,690	0	243,381
Activity 4.4: To conduct monitoring and supportive supervisory visits to strengthen NHMIS programme implementation at all levels:				
4.4.1: 2 Officers per zone (2 X 6 persons) to conduct supervision of M & E activities quarterly at state level for 3 days	59,048	59,048	59,048	177,143
4.4.2: 5 State Officers per State (37 X 5 persons) to conduct supportive supervision to LGAs – quarterly for a period of 5 days	264,285	264,286	264,286	792,857
4.4.3: 2 LGA officers to conduct supportive supervision - monthly for 5 days	95,238	95,238	95,238	285,714
Objective 5: To strengthen the logistics system and infrastructure at the national /State /LGA /Ward levels by the end of 2010				

Activity 5.1: Development of a harmonized logistic system for all health commodities in the country by: 5.1.1: Establishing a core group to review existing systems and to develop a draft manual to harmonize them 5.1.2: Convening a Stakeholders meeting /workshop to consider and approve the harmonized manual for the logistics of health commodity system (one person per state and 20 national officers including partner agencies for 2 days)	54,524 12,579	0 0	0 0	54,524 12,579
Activity 5.2: Develop an architectural design to serve as prototype storage facility in line with international specifications to be adopted by the states and LGAs for the harmonised logistics system. (to be outsourced)	7,937	0	0	7,937
Activity 5.3: Training of LGA logistic personnel, 2/LGA (1548) on the harmonized logistics system	480,794	0	0	**480,794**
Activity 5.4: Training and provision of maintenance kits, 2 per state and FCT (74).	**64,365**	**0**	**0**	**64,365**
Activity 5.5: Provision of solar refrigerators for storage of vaccines in 960 Wards over 2 years	1,440,000	1,440,000	0	2,880,000
Activity 5.6 Provision of maintenance support for solar refrigerators	76,190	76,190	76,190	228,571
TOTAL COSTS	**22,098,373**	**21,439,754**	**1,165,238**	**44,703,365**

Source: GAVI HSS Application

Use of GAVI HSS Funding

The GAVI HSS funding has been programmed to implement activities intended to support the achievement of the five main objectives outlined above. Given the existing lack of resources of all kinds in the sector, there can be a high degree of confidence that GAVI HSS funds represent necessary and additional resources for the sector.

Nigeria's proposal for Health System Strengthening support was approved after clarifications in 2007. Clarifications were requested by the IRC in a number of areas: banking details; costing issues; errors in indicators; recent assessments of PHC in Nigeria; and the identification of the 100 LGAs involved. The GAVI HSS funds for the first year activities were received in August 2008. A one year Plan of Action was developed and presented to the GAVI mission that visited the country by the then acting Minister of Health in August 2008.

2008 was a very challenging year for the Federal Ministry of Health; there was a rapid turnover of officials at the highest level including two Ministers of Health, a Permanent Secretary and several key directors. A substantive Minister was appointed in December 2008.

Responsibilities for primary health care in Nigeria are divided between the Federal MoH and the National Primary Health Care Development Agency (NPHCDA). There appears to have been a turf war between the two organisations that has delayed the start of the HSS programme. At the heart of the dispute seems to be the issue of where the HSS money should be deposited and who should control it: in a FMOH account or in a NPHCDA account. Successive Ministers of Health have failed to sign-off on the proposed work plan. Sign-off was only achieved after the current Minister was approached by the GAVI Secretariat at the recent World Health Assembly and asked to do so. However, implementation has yet to begin.

2.2 HSS application and approval processes

The GAVI HSS proposal was drafted by a committee established by the Federal Minister of Health and included representatives drawn from the FMoH, FMoF, Health Planning and Research Department (FMoH), National Primary Health Care Development Agency, WHO, UNICEF, World Bank, EU, USAID and a number of CSOs. State and local governments were also approached for their comments and inputs as was a representative of the private sector. The draft proposal was then reviewed by the Health Sector Forum (HSF) and was formally endorsed by the Health Partners Coordinating Committee (HPCC) prior to submission.
See Table 1 overleaf for more information around the milestones within the application and approval process.

Box 1. Key dates in the Nigeria HSS proposal

July 2006	Minister of Health establishes the HSS proposal drafting committee
Jan 2007	ICC approved the timeline proposed by the drafting committee
Feb 2007	HSF Reviewed the initial draft and recommended that the FMOH should assume leadership of the drafting committee with support from all the HSF partner agencies in line with GAVI guidelines.
Feb 2007	FMOH assumes leadership of the drafting committee
Feb 2007	Inputs received from USAID, Washington DC
Mar 2007	Committee had a one week retreat with the support of WHO and first draft was produced
Mar 2007	Draft proposal reviewed at HPCC and endorsed for submission to GAVI after corrections and input by HSF
Mar 2007	Review of first draft at WHO regional workshop in Ouagadougou. Need for further inputs identified and submission date changed to October 2007
Jul 2007	Drafting committee held a ten day retreat with technical assistance from a health systems consultant
Sep 16th 2007	Committee reviewed draft proposal and distributed draft to HSF for review on the 21st of September 2007
Sep 21st 2007	HSF reviewed the proposal and made further comments and observations
Sep 24th 2007	Sub-group of the drafting committee had a 5 day sitting (sic) and incorporated comments and observations of the HSF into the proposal document for review in their next meeting
Sep 28th 2007	Final review of draft by HSF
Oct 2nd 2007	Endorsement of the HSS proposal by the Ministers of Health and Finance.
Oct 5th 2007	Submission of the proposal to GAVI Secretariat.
Nov 11th 2007	IRC Approval (with clarifications)
Nov 28th 2007	GAVI Board Approval
Aug 2008	GAVI HSS funding received for 1st year of activities

A health systems consultant was involved in drafting the proposal, but the $50,000 earmarked for this purpose was not requested. As shown above, the proposal was formally

approved in just under two months following its submission, however funding was received some nine months later.

2.3 HSS Start up measures

No activities or start-up measures were undertaken in the period covered by the 2008 APR beyond the development of a Year 1 action plan which has yet to be approved.

2.4 Annual Progress Reporting (APR) on HSS

The HSS section of the 2008 APR was left blank as no implementation had happened in that period.

Result indicators

The Nigeria GAVI HSS proposal contains six outcome/impact indicators – see Table 2. below. Given the nature of the interventions being supported by GAVI HSS, this set of indicators should adequately reflect progress made in the target areas as a result of HSS funding.

Table 2 Outcome & Impact Indicators

Indicator	Data Source	Baseline Value	Target by 2010
1. National DTP3 coverage (%)	NICS (2006)	36.3%	80%
2. Number / % of LGAs achieving ≥80% DTP3 coverage	JRF 2006	310(40%)	620(80%)
3. Under five mortality rate (per 1000)	UNICEF report 2007	194/1000	185/1000
4.Proportion of births attended by skilled Health personnel	NDHS(2003)	36.3%	60%
5.Antenatal care up take/proportion of women attending antenatal clinic	UNICEF report 2007	58%	70%
6.T.T 2+ coverage	UNICEF report 2007	51%	65%

Similarly, the six output indicators selected and included in Table 3 below should reasonably reflect the progress being made in implementing the HSS programme.

Table 3 Output Indicators

Indicator	Data collection
1.Percentage of rehabilitated existing PHC facilities	This data is collected through administrative reports and surveys
2. Percentage of existing PH facilities fully equipped	This data is collected through administrative reports and surveys
3. Proportion of PHC workers trained	This data is collected through administrative reports and surveys
4. Percentage of wards with installed solar refrigerators.	This data is collected through administrative reports and surveys
5 Percentage of LGAs provided with data management tools and equipment in the LGAs of the target wards.	This data is collected through administrative reports and surveys
6. Proportion of supervisory visit conducted by LGA to Health facilities.	This data is collected through monitoring and supervisory reports.

Source: GAVI HSS proposal

There is little doubt that the requirements for developing an annual performance report to GAVI will put considerable additional pressure on the MoH as it does in most countries. Given the very poor state of the health system in Nigeria, it would seem sensible to look at ways in which the reporting requirements of individual funding agencies such as GAVI could be minimised. This may achieved through incorporating the GAVI requirements into existing reporting arrangements and would help enable the senior management team within the MoH to focus on the quality and delivery of health services in Nigeria.

2.5 HSS progress to date

No progress reported in 2008 APR.

2.6 End of HSS Assessment

Given the large size of the HSS grant, the long delays in commencing work and the particular challenges of working in Nigeria in terms of its population, federal structure and on-going

issues around management and governance, it would seem appropriate to undertake an end of HSS Assessment to see what the key lessons to be learned are.

2.7 Support systems for GAVI HSS

Key informants in Nigeria indicated that much of the technical support required for developing the GAVI HSS proposal has come from the Nigerian National Primary Health Development Agency, the Federal body responsible for organising Primary Health Care in Nigeria.

As the HSS work has still not begun, it is not possible to identify where the support to implementation and the development of the annual reports will come from.

3 Alignment of HSS with GAVI principles

This section will attempt to analyse the extent to which the Liberia HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?

3.1 Country Driven

The Federal MoH together with the Nigerian National Primary Health Development Agency were responsible for leading the design process and ensuring the effective participation of their various partners. Whilst there have been inputs from a wide range of international partners including WHO and UNICEF, there seems little doubt that the proposal design process has been country driven.

3.2 Is GAVI HSS aligned?

In this section we consider several dimensions of alignment as discussed in the evaluation study guidelines: Alignment with broader development policies such as the PRSP and the national health plans and priorities; alignment with planning and reporting systems; alignment with budget and financial management systems.

3.2.1 Alignment with broader development and health policies

The emphasis on supporting primary health care at the ward level through improving access to and utilization of PHC services; increasing the technical and managerial capacity of PHC workers to deliver quality health service; improving data management and use of data for planning, programme monitoring and decision making; and creating an effective and efficient health commodity procurement and distribution system is consistent with existing National Health plans and the PRSP.

3.2.2 Alignment with budget and reporting cycles

Nigeria's financial year runs from January – December enabling alignment with the GAVI planning and budget cycles. In terms of alignment with budget and financial management procedures, GAVI HSS resources, are "on plan" but they are not "on budget". Nigerian public financial management rules require any unspent funds included in the budgets of Federal Ministries/Agencies to be returned to a General Fund at the end of the financial year.

GAVI HSS funds are managed and reported on separately and have their own bank accounts which are operated by the FMoH and State Governments. The GAVI HSS programme does use the existing MoH Health Information System for reporting purposes although the GAVI APR report is developed separately.

3.3 Is GAVI HSS Harmonised?

The Federal Minister of Health has decided to harmonise all health systems strengthening work in Nigeria. All HSS funding should be reflected in the harmonised FMOH annual work plan. Given that the new Minister has taken up his position fairly recently and the GAVI HSS programme has not yet begun, it is impossible to make any judgements at this stage on the level of harmonisation.

3.4 Is GAVI HSS funding predictable?

Table 4 provides a breakdown of receipts and disbursals by year.

Table 4 GAVI HSS Funds: Receipts and Disbursal

	Year		
	2008	**2009**	**2010**
Approved Funds ($US)	22,098,373	21,439,754	1,,165,238
Date the Funds Arrived	August 2008		
Amount Spent ($US)	0		
Balance ($US)	22,098,373		
Amount Requested ($US)			

Source: GAVI 2009 APR

As previously mentioned, there has been a significant delay in putting the HSS programme into operation. GAVI will be undertaking a Financial Management Assessment in Nigeria from 11th to 23rd of August to assess the FM capacity.

3.5 Is GAVI HSS accountable, inclusive and collaborative?

Whilst the process of developing the HSS proposal was undoubtedly inclusive and collaborative, the lack of progress since then and the failure to begin implementing the HSS programme despite the approval of the proposal and the receipt of the first tranche of funding in August 2008, points to some significant problems with the management and governance arrangements. It is recommended that the GAVI Secretariat undertake an urgent review of the situation in Nigeria to establish what needs to be done to get the programme started.

3.6 Does GAVI HSS have a catalytic effect?

It is impossible to determine at this very early stage of implementation.

3.7 Is GAVI HSS Results Oriented?

As mentioned earlier in Section 2.4 the programme indicators should serve to adequately reflect progress made in the target areas as a result of HSS funding.

However, the lengthy delays in the commencement of the large Nigerian HSS programme suggests that perhaps the GAVI Secretariat needs to be able to respond more quickly to situations which are hindering effective programme implementation.

3.8 GAVI HSS sustainability issues

Nigeria is a poor country. There is much to be done in order to build an effective and sustainable economy and health system. Much of the GAVI HSS support is directed at rehabilitating and re-equipping health infrastructure, training and supervision. This is likely to have a substantial impact on the performance of the health system at the ward and LGA levels.

3.9 Does HSS funding help improved equity

The 960 wards selected for GAVI HSS support were chosen on the basis of their DPT3 coverage levels. A mix of high and low coverage wards were chosen. It can be reasonably inferred that the some of the poorest wards will have the lowest DPT3 coverage as they will be the hardest to reach and the most difficult to provide services for. Given the huge unmet health needs across Nigeria, and the high levels of poverty, it could be argued that a specific poverty focus is not necessary. Most people in most places in Nigeria will be poor and in need of effective healthcare. The emphasis on improving the training and skills of primary health care workers should help to ensure that the poorest and least served populations in Nigeria benefit from the HSS funding.

Annex 1 List of people interviewed

Dr Muhammad Pate, CEO, National Primary Health Care Development Agency

Dr. Joseph Oteri: GAVI Desk Officer, National Primary Health Care Development Agency

Annex 2 List of Documents reviewed

Nigeria GAVI HSS Proposal

Nigeria GAVI 2008 APR

Poverty Reduction Strategy Paper, 2005

Annex 3 Summary GAVI HSS Evaluation Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such as way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be **complemented by the results of 6 on-going GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.

Annex 4 Typology of areas for HSS support

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA ($50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	*Internal process*	IRC-HSS
IRC recommendations	*Internal process*	IRC-HSS
Decision on proposals	*Internal process*	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring