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Mid-term Evaluation of 'Strengthening the Nigerian Health System towards Achieving Universal Health Coverage (HSS)' Programme

FINAL REPORT

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Team:
Dr Lucilla Magherini, M&E expert
Dr Giovanni Cascone, Public health expert/Team leader

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LIST OF ABBREVIATIONS

Acronym/abbreviation	Meaning
AFP	Acute Flaccid Paralysis
ALGON	Association of Local Governments of Nigeria
AOP	Annual Operational Plan
ASHIA	Anambra State Health Insurance Agency
BHCPF	Basic Health Care Provision Fund
CMAM	Community-based Management of Acute Malnutrition
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organisations
cVDPV	circulating Vaccine Derived Polio Virus
DAC	Development Assistance Committee
DFATD	Department of Foreign Affairs and Trade Canada
DFID	Department for International Development
DHIS	District Health Information System
DHPRS	Department of Health Planning Research and Statistics
DPG-H	Development Partners Group on Health
DQA	Data Quality Assurance
DQA	Data Quality Assessment
DQAF	Data Quality Assessment Framework
DVD-MT	District Vaccine Device Monitoring Tool
EDF	European Development Fund
EOC	Emergency Operation Centre
EPHS	Essential Package of Health Services
EPR	Epidemic Preparedness and Response
EQ	Evaluation Question
ERGP	Economic Recovery and Growth Plan
ET	Evaluation Team
EU	European Union
EUD	European Union Delegation
FCT	Federal Capital Territory
FG	Focus Group
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
GAP	Gender Action Plan
GDP	Gross Domestic Product
GF	Gates Foundation
GFATM	Global Fund against AIDS Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GPEI	Global Polio Eradication Initiative
HCF	Health Care Financing
HDCC	Health Data Consultative Committee
HDGC	Health Data Governance Council
HFEI	Healthcare Financing Equity and Investment
HIS	Health information System
HIUOR	Health Insurance Under One Roof
HR	Human Resource
HRH	Human Resource for Health
HSS	Health System Strengthening
ICC	Interagency Coordinating Committee
ICD	International Classification of Diseases
ICT	Information Communication Technology

Acronym/abbreviation	Meaning
IPD	Immunisation Plus Day
IDSR	Integrated Disease Surveillance and Response
IPD	Immunisation Plus Day
IPV	Inactivated Polio Virus
ISS	Integrated Supportive Supervision
KfW	Kreditanstalt für Wiederaufbau
KII	Key Informant Interview
LGA	Local Government Area
LGHIS	Local Government Health Information System
LQAS	Lot Quality Assessment Sampling
M&E	Monitoring & Evaluation
MCH	Mother and Child Health
MDG	Millennium Development Goals
MFBNP	Ministry of Finance, Budget and National Planning
MFL	Master Facility List
MMR	Maternal Mortality Ratio
MNCH	Maternal New-born and Child Health
MOH	Ministry of Health
MoU	Memorandum of Understanding
MS	Member States
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NAO	National Authorising Officer
NCC	National Polio Committees
NCD	Non-Communicable Diseases
NCDC	Nigeria Centre for Disease Control
NEPC	National Polio Expert Committee
NGO	Non-Governmental Organisation
NGP	National Gender Policy
NHA	National Health Act
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NICS	National Immunisation Coverage Survey
NID	National Immunisation Day
NIP	National Indicative Programme
NMEP	National Malaria Elimination Programme
NNMSAP	National Multisectoral Action Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP2	National Strategic Health Development Plan (Second)
NTF	National Task Force
NTLCP	National Tuberculosis and Leprosy Control Programme
ODA	Official Development Assistance
OOP	Out of Pocket
OPV	Oral Polio Vaccine
OR	Operational Research
PHC	Primary Health Care
PHCDA	Primary Health Care Development Agency
PSC	Programme Steering Committee
PTFoPE	Presidential Task Force on Polio Eradication
RES	Reaching Every Settlement
RIC	Reaching Inaccessible Children
ROM	Result Oriented Monitoring

Acronym/abbreviation	Meaning
RRT	Rapid Response Team
SCI	Service Coverage Index
SDG	Sustainable Development Goals
SIA	Supplementary Immunisation Activities
SOP	Standard Operating Procedures
STDs	Sexually Transmitted Diseases
SWAP	Sector Wide Approach Programme
TA	Technical Assistance
THE	Total Health Expenditures
TOR	Term Of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
USAID	United State Agency for International Development
WB	World Bank
WHO	World Health Organisation
WPV	Wild Polio Virus
WR	Workforce Registry

1 INTRODUCTION

This is the Final Report for the mid-term evaluation of the Programme "Strengthening the Nigerian Health System towards Achieving Universal Health Coverage". The contents and the logic of this Programme that is the object of this evaluation are summarised in the table below:

Table 1 : General summary of the programme evaluated

- Strengthening the Nigerian Health System towards Achieving Universal Health Coverage - Start: 09/03/2017 - End: 08/08/2021 - Total budget (EU contribution): EURO 21 million Decision title : EU Support to the Health Sector in Nigeria Phase 1 (EU budget EURO 70M) • Component 1 (implemented by United Nations International Children's Emergency Fund (UNICEF), corresponding to specific objectives 1, 2 and 3, and not part of this evaluation) • Component 2, implemented by WHO (funds were channelled directly by the EU to WHO) • Component 3, implemented by WHO (funds were channelled directly by the EU to WHO)

The Programme strategy for components 2 and 3, which are the components to be evaluated, was based on the following:

Table 2 : General summary of the programme evaluated (Please note that Part 2.15 below contains, in tables 7 and 8, all the results, targets and indicators as stipulated in the Amendment 1)

PROGRAMME STRATEGY Component 2: support of 15 million EURO Under this Component, the expected result is: - Result 4 – Maintain polio-free status in non-polio infected states. Main activities of the intervention under this Component are: - Planning and execution of the highest quality polio SIAs in polio priority states. - Implementation of special strategies/innovations to reach children chronically missed with polio vaccine in polio priority states.
Component 3: support of 5.6 million EURO Under this Component, the expected results are: - Result 5 – Quality of Health and Nutrition Information and its use for decision-making is strengthened. - Result 6 – By 2020, improvement of local institutional capacity at state level to plan and prepare cost budgets and provide full narrative and financial reporting for the health sector including nutrition. Main activities of the intervention under this component are: - Support the Ministry of Health to improve health information data quality through a participatory process. - Support for coordination of actors in health information through the relevant technical working group at national level and in the selected states. - Support the building of the capacity of the Federal Ministry of Health Research and Statistics Division and the state Monitoring and Evaluation/Health Information

System (M&E/HIS) units on the analysis of health information, both from routine systems and from surveys.
- Support to the government for the implementation of sustainable risk protection mechanisms for health and monitoring of the level of coverage of risk protection schemes at various levels of the health system.
- Support to the government to conduct annual health accounts estimation as well as other expenditure tracking processes.
- Analyse information from these processes in '5 above' alongside health outcomes data to assess efficiency of health spending.

Both components of the Programme have implemented strategies that are in support to the implementation of Universal Health Coverage. In other words, the Programme has shown a certain degree of flexibility, which has allowed to shift from a "MDG (Millennium Development Goals) - related" logic to a "SDG (Sustainable Development Goals) related" Programme logic. This has been possible thanks to the flexibility of the adopted instrument and thanks to the capacity to stir this transition in the right direction shown by WHO and Nigerian stakeholders.
The project has been developed within the framework of supporting the health sector reforms in Nigeria by facing key issues that hamper health sector reforms in Nigeria:

- poor data management,
- inadequate financing,
- vaccine-preventable disease outbreaks and in particular polio.

The project aims to solve the main problems identified by following the principles of the sector-wide approach. It aims to strengthen the health system with a view to achieving Universal Health Coverage and the international goal of polio eradication.
The project components, strengthening global health systems for Universal Coverage and polio eradication, are complementary and together will have a synergistic impact.
The polio component targets accessible areas in 18 polio priority states. In fact, persistent Wild Polio outbreak is both a cause and driver of poor governance and performance of the health system.
The health system strengthening component addressing health information for decision-making and health financing system targets federal and state levels in the states of Sokoto and Anambra.
The Programme seeks to support the effective implementation of key established laws (Health Act), policies (National Health Policy), plans (National Strategic Health Development Plan NSHDP2) and it aims at ensuring that institutional capacity to effectively manage the anticipated health sector reform is in place.
The Programme also aims at enabling Civil Society and the public in general, to exercise its role of watchdog on polio eradication efforts and health system strengthening. A well mobilised Civil Society is critical, as proved by several experiences in Nigeria and elsewhere, to push the government to initiate desired reforms and move towards increased accountability in governance.
The key pillars of interventions under this project – polio eradication and health systems strengthening - are complementary and mutually reinforcing. The health systems strengthening interventions target institutions within the health sector; however, its effects benefit the entire population of Nigeria, with the vulnerable and poor benefitting from the improvements in the health financing landscape.

1.1 Implementation of the evaluation mission

The following experts composed the evaluation team: Dr Giovanni Cascone (team leader), Dr Lucilla Magherini (team member).
The team started the assignment on 13/04/2021 with an inception phase and a desk phase. An Inception Report was submitted on 20/04/2021.
The field phase took place from distance due to the restrictions given by the COVID-19 pandemic.
At the end of the field phase the evaluation team delivered an Intermediary Report. The presentation of preliminary findings in a debriefing session took place on 21/06/2021. Comments from the Reference Group have been taken into consideration in the preparation of this draft final report.
The evaluation finished with a presentation of the Final Report during a dissemination session.

Mission objectives and deliverables

The focus of the evaluation is on the assessment of achievements, the quality and the results of actions in the context of an evolving cooperation policy with an increasing emphasis on result-oriented approaches and the contribution towards the implementation of the SDGs.
From this perspective, the evaluation should look for evidence of why, whether or how these results are linked to the European Union (EU) intervention and seek to identify the factors driving or hindering progress.
The evaluation has to provide an understanding of the cause-and-effect links between inputs and activities, and outputs, outcomes and impacts. Evaluations will serve accountability, decision-making, learning and management purposes.

The main objectives of this evaluation are to provide the relevant services of the European Union, the interested stakeholders and the wider public with relevant information including:

- To produce an overall independent assessment of the past performance of the Programme (Components 2 and 3), paying particular attention to its results measured against its expected objectives and the reasons underpinning such results.
- To document key lessons learned, best practice, conclusions and related recommendations in order to improve current and future Actions in line with the SDG 3.8 of advancing universal health coverage.

Each planned activity corresponds to planned deliverables as per the following table:

Table 3 : Schedule of the assignment

	Deliverables	Time of submission
Inception phase Desk phase	Inception Note	20/04/2021
Field phase	Debriefing with the Reference Group Intermediary Report	Held on 21/06/20
Synthesis phase	Draft Final Report Draft Executive Summary Final Report and Executive Summary Presentation of draft final report to Reference group	30/06/2021 24/08/2021
Final debriefing	Slide presentation	31/08/2021

1.2 Methodology and approach

The evaluation has focused on the following specific evaluation criteria of relevance, effectiveness, efficiency, sustainability (standard Development Assistance Committee (DAC) criteria) as indicated by ToR.

Table 4 : DAC criteria

- **Relevance** - is the extent to which the objectives of a policy or an intervention are consistent with the beneficiaries' needs, and EU policies and priorities.
- **Effectiveness** - is the extent to which the development intervention's objectives were achieved or are expected to be achieved.
- **Efficiency** - is the measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.
- **Sustainability** - is the continuation, or probable continuation, of benefits from a development intervention after major development assistance has been completed.

In addition, the evaluation has assessed specific evaluation criteria:
The coherence of the intervention with other interventions in a country, sector or institution.
The active interaction of the Programme with key stakeholders.
The EU added value (the extent to which the Programme brings additional benefits to what would have resulted from Member States' and other development partners active in the health sector interventions).
Cross-cutting issues such as gender equality, human rights, environmental sustainability, and good governance will also be taken into consideration.
The consistency of visibility activities undertaken by the Programme.

The evaluation is answering specific questions regarding these criteria.
The set of evaluation questions answered by the evaluation team is comprehensive of those given in the Terms of Reference with the addition of 4 questions proposed by the Evaluation Team.
Data and information as a result of the desk review and those that have been collected during the Field Phase (through meetings and questionnaires with the key stakeholders and beneficiaries) have been also utilised for concrete recommendations for possible future interventions.
All relevant information has been collected following the two MATRIXES:

- evaluation questions,
- the matrix of the log frame.

1.2.1 Questionnaire

A Questionnaire has also been utilised to collect information from Key Informants in 18 states about Component 2 only. It is an online questionnaire, which utilises the platform "Survey Monkey". It has been prepared during the Desk Phase in consultation with EUD and submitted on 31/05/2021, upon authorisation of the Executive Secretary/CEO of NPHCDA, to 56 relevant staff in the 18 targeted by the Programme. This tool allowed the Evaluation Team (ET) to reach a number of interviewees that could not have been reached otherwise. The final analysis considers all information collected from both, the questionnaire and the scheduled meetings. The final analysis will integrate data from the questionnaire and from the zoom interviews and the Final Report will use narrative information to clarify and explain the findings. The online survey tool will allow the ET to perform cross tabulation in order to compare each group of respondents' answers.

For component 3, which is concerned only with two states (Anambra and Sokoto), we have interviewed almost all the relevant key informants. These interviews have been guided by a set of specific written questions that are relevant to the different groups of Key Informants (HIS, health insurance, financing) interviewed. An analysis of answers to the Questionnaire is presented in the paragraph 2.17.

1.2.2 Interviews

During the Field Phase the Evaluation Team has utilised the virtual format for meetings that was experienced previously, namely during the Inception Phase and Desk Phase but also by the Consultants in previous assignments.
Utilisation of online communication tools (Zoom and WhatsApp mainly) has ensured all the planned contacts with stakeholders and key informants. Traditional channels of communications such as email have been also utilised.
The Evaluation Team was already familiar with the utilisation of these technologies in a similar situation, furthermore, we have found that the key informants in all the states were also familiar with the proposed technologies, and well equipped and connected. This has ensured the operations even from distance.

The total number of meetings and interviews performed with Key Informants on ZOOM has been 35 of which:

- 23 in Abuja,
- 10 in the 8 states out of the 18 targeted by Component 2,
- 2 in the two states (Anambra and Sokoto) targeted by Component 3.

The sample of 8 states where Key Informants were interviewed has been selected in accordance with geographical and high risks criteria in collaboration with WHO and NPHCDA.

The total number of Key Informants participating to meetings has been around 85 persons.
It should be noted that by no other means the ET could have reached such a large number of persons during the limited time of the Field Phase.
All details on participants to the meetings and interviews are given in the attached schedule (Annex F).

1.2.3 Distance communication challenges

All the communication challenges have been satisfactorily overcome.
The difficulties encountered during implementation of Field Phase were well foreseen in our methodology and they were all linked to the impossibility of travelling to Nigeria due to pandemic restrictions. The methodology presented in PROMAN offer took already into consideration this possibility. Consequently, it has foreseen a plan for distance working with utilisation of up-to-date technology for distance communication in real time (i.e. WhatsApp and ZOOM platforms) and a sound utilisation of the email. In addition, it was foreseen the possibility of mobilising some local experts in case they were needed for collecting first-hand information. However, thanks to the collaboration of WHO management and local staff, NPHCDA senior and local staff, NHIS federal and local staff and other relevant stakeholders, the Evaluation Team has overcome all the difficulties deriving from distance working:

1) Exhaustive documentation on Programme implementation and health strategies of Nigeria was timely provided,
2) The participation to Zoom meetings of federal and states staff of WHO and MoH, but also of the international partners, was excellent. Subsequently the mobilisation of local experts for data collection was not deemed necessary.

The utilisation of WhatsApp, ZOOM and email has been proved as highly effective since all Key Informants resulted to be well equipped and acquainted with these conditions. Consequently, there has been no need for mobilisation of local experts.
As a matter of fact, the efficient use of mentioned communication tools and the collaboration and the openness of Key Informants have made possible to interview a much higher number of relevant staff than what would have been possible during the extremely limited time of the mission. Furthermore, we have been able to reach people in areas where we will never have had the chance of travelling.
In addition, the above-mentioned Questionnaire for Component 2 has allowed us to reach a number of interviewees that we would not have been able to reach otherwise.

1.2.4 Structure of the report

This final report has been structured in compliance with relevant indications given in the ToR. We would like to remind here that the evaluation questions marked with "a" were presented in the ToR while the evaluation questions marked with "b" were proposed by the Evaluation Team and validated by the Reference Group.
The project's approach to issues has been considered as well. Attention has been paid to the recommendations made in previous review/monitoring visits, internal and external reviews.

1.3 Overall context of the health sector in Nigeria

Nigeria presents a lot of health care services challenges: its size, its growing population-estimated more than 200 million in 2020[1] - the presence of about 300 ethnic groups with more than 500 languages brings large social, cultural, economic and geographical diversities. As a result, disease patterns, health resource availability and health outcomes very largely in the country. Moreover, recent insurgency activities caused serious harm in social infrastructure and health development achievements especially in the North Eastern Region, one of the most socio-economically deprived zones.

Nigeria is a federal system with a federal government, 36 states and the Federal Capital Territory (FCT), and 774 local government areas (LGAs). Nigeria comprises a mixed health care system with a public service and a growing private health sector with health services provided by non-governmental organizations and private-for-profit providers, traditional medicine providers and alternative health practitioners. Public sector healthcare is the responsibility of the three tiers of government with different authorities assigned to the three levels of government, mostly autonomous in terms of management and financing. The federal government is mainly responsible for tertiary-level health services, state governments are responsible for secondary health care services and local governments are responsible for primary health care services. Besides, various programmes and parastatal agencies, generally based at the federal level with state correspondent administrations, are responsible for PHC services. Moreover, the FMOH is responsible for the development and implementation of specific public health programmes, such as National AIDS and STDs Control Programme (NASCP), National Malaria Elimination Programme (NMEP), National Tuberculosis and Leprosy Control Programme (NTLCP).

Nigerian Constitution and the National Health Act (NHAct)[2] state the right to health care for all Nigerians. The NHAct outlines priorities and strategic objectives for the health sector and provides the overall legal framework for the development and implementation of the National Health Policy. The 2016 National Health Policy - later elaborated into the revised Second

[1] data.un.org Nigeria
[2] Nigeria's National Health Act 2014 (NHA 2014), signed into law on October 31, 2014

National Strategic Health Development Plan 2018-2022, NHSDP II[3] - provides an implementation framework to incorporate the requirements of the NHAct and the Sustainable Development Goals to operationalise the National Health Policies. The principles of Universal Health Coverage are stated in the National Health Policy as follows: "To strengthen Nigeria's health system, particularly the Primary Health Care subsystem, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health-care services to all Nigerians".

Nigeria governments - federal and states - have invested in recent decades in the development and implementation of various health sector reform programmes with the specific goal to develop a modern, efficient and effective healthcare delivery system. Under the current national development agenda, Vision 20:2020[4], the health sector is expected to get investments in human capital development through strengthening of primary health care and expansion of secondary health care services in every Local Government Area (LGA). The Economic Recovery and Growth Plan (ERGP) 2017-2020 whose overall objectives are to restore growth, invest in people, and build a globally competitive economy has specified a number of health sector policy objectives. Those objectives have been stated in the NSHDP II and include: i) the improvement, availability, accessibility, affordability and quality of health services; ii) expand healthcare coverage to all Local Governments; iii) provide sustainable financing for the health care sector; iv) reduce infant and maternal mortality rates. Nigeria commitment to attain globally agreed Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) is reflected in the 2016 revised NHPDP II; priority is given to increase access to Primary Health Care (PHC) and to financial risk protection.

According to World Bank (WB) estimates, life expectancy at birth in Nigeria is about 60.87 years, 59 years for males and 63 years for females. Although the rate in the Country has been increasing since 2000, it has also been consistently below both the regional and the global figures and continues to be among the lowest in Africa as well as in the world.

Though some decline in maternal and childhood mortality has been observed since 2003, the rate has remained elevated, and Nigeria is one of the countries in Sub-Saharan Africa where maternal mortality persists, despite strategies like the promotion of institutional deliveries, training and the deployment of new skilled health workers. The 2018 Nigeria Demographic and Health Surveys (NDHS) published a national MMR of 512 deaths per 100,000 live births for the seven-year period before the survey[5]. However, studies have shown that the levels of maternal mortality may vary within the country as some states show a higher level of maternal mortality compared to the national average[6].
Besides, regional disparities exist in the country with maternal mortality rate of North East and North West zones being almost 10 and 6 times higher than that of the South West zone. Childhood mortality remains a major social and public health problem in Nigeria: neonatal mortality rate was 32.9 deaths per 1000 live births and under five mortality rate 100.2 deaths per 1000 live births in 2017[7].

From an epidemiological point of view malaria remains one of the main causes of morbidity and mortality in Nigeria and is a risk for 97% of Nigeria's population. The remaining 3% of the population live in the malaria-free highlands. There are an estimated 100 million malaria cases

[3] Federal Government of Nigeria, Federal Ministry of Health, "Second National Strategic Health Development Plan 2018-2022", 2018
[4] Federal Government of Nigeria, National Planning Commission, "Nigeria Vision 20:2020", December 2009
[5] "Nigeria 2018 Demographic and Health Survey Key Findings" National Population Commission (NPC) [Nigeria] and ICF. 2019.
[6] "Maternal Mortality Ratio in Selected Rural Communities in Kebbi State, Northwest Nigeria", Usman Gulumbe, Olatunji Alabi, Olusola A. Omisakin, Semeeh Omoleke, BMC Pregnancy Childbirth, 2018, 18: 503.
[7] UNICEF. Levels and trends in child mortality; 2018: https://data.unicef.org/wp-content/uploads/2018/09/UN-IGME-Child-Mortality-Report-2018.pdf.

and over 300,000 deaths per year in Nigeria. Malaria also contributes to an estimated 11% of maternal mortality.
Nigeria is the most populous country in Sub-Saharan Africa and has the second highest number of HIV-infected persons in the world, and the highest number of annual AIDS-related deaths[8].The HIV epidemic in Nigeria affects populations of all age groups and geographic locations. The 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS)[9] reported HIV prevalence was 1.3% among adults 15 – 49 years, with a higher prevalence among women 1.7% compared to males 0.8%. Also, NAIIS reported 8 new infections per 10,000 population. HIV care and treatment programmes have been highly donor-dependent and largely implemented in public hospitals. In addition, the country is ranked seventh among the 30 high TB burden countries and second in Africa. The problem of TB in Nigeria has been made worse by the issues of drug-resistant TB and HIV/AIDS epidemic. It is estimated that 407,000 people in Nigeria have TB each year.

Although communicable diseases continue to be the primary cause of death in Nigeria, the country is currently facing an increase in the burden of Non-Communicable Diseases (NCD) with premature mortality from NCDs estimated at 22%. According to the 2018 WHO country profile, NCDs accounted for an estimated 29% of all deaths in Nigeria with cardiovascular diseases as the primary cause of NCD-related death (11%) followed by cancers (4%), chronic respiratory diseases (2%) and diabetes (1%). Nigeria's Federal Ministry of Health in collaboration with WHO has recently launched (2019) the first National Multi-sectoral Action Plan (NNMSAP) for the Prevention and Control of Non-communicable Diseases.

1.3.1 Health financing

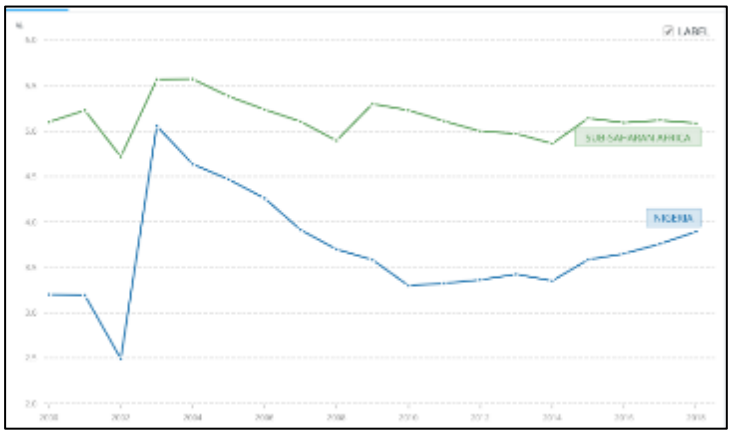
Health financing mechanisms in Nigeria includes government budget collected by general tax revenue, direct out-of-pocket payments, a social health insurance scheme for the formal sector implemented by the National health insurance and funding from donors. Revenues are collected and administered centrally: the Federal Government collects national revenues that are afterward shared among the three layers of the government in accordance with the established allocation formula.

The National Health Financing Policy has been developed in 2006. The policy aimed at promoting equity and access to quality and affordable health care, besides ensuring efficiency and accountability through a sustainable financing system[10]. The National Health Act, first proposed in 2004 and signed into law in 2014, provides a legal framework for the regulation, development, and management of the Nigerian National Health System and set its standards. Together with the revised National Health Policy (NHP) these provide the basis whose ultimate goal is to guarantee access to health services for all, particularly for vulnerable populations, in the country, i.e. to guarantee universal health coverage (UHC). The Act seeks to remove financial barriers particularly for the poor and vulnerable in accessing primary healthcare. It represents the first attempt to provide legislative clarification and funding sources to support PHC. It includes provisions for a Basic Health Care Provision Fund.

According to the World Bank report "Nigeria Health Financing System Assessment"[11] Nigeria spend less on health if compared with other Sub-Saharan countries (see graph 1).

[8] UNAIDS. UNAIDS DATA 2018. (2018).
9 Nigeria 2018 Hiv/Aids Indicator And Impact Survey
[10] Federal Republic of Nigeria, "National Health Financing Policy", 2006
[11] World Bank, "Nigeria Health Financing System Assessment", 2018

Graph 1 : Current health expenditures (% of GDP) Nigeria, Sub-Saharan Africa)



Source: World Health Organization Global Health Expenditure database (apps.who.int/nha/database)

Nigeria has conducted NHAs since 1998. The latest NHA was released by the FMOH in 2020 and covers health expenditure figures by 2018. It reveals that the households constitute the main source of financing healthcare in Nigeria, although Out Of Pocket (OOP) expenditures as a share of Total Health Expenditures (THE) decreased slightly from 74.8% in 2017 to 69.4% in 2018[11]. This creates an important barrier to accessing health services leaving a large proportion of the population at risk of economic failure.
Government funded health expenditures was 0.6 percent as a share of Gross Domestic Product (GDP) in 2016 and remained the same proportion according to the 2018 National Health Account (NHA)[12.] THE as a share of the GDP decreased slightly in 2018 in comparison with 2017 from 3.9% to 3.6%; this figure is below the target of 5% indicated by the 2010 World Health Report (see Table 5).

Table 5 : Health Financing Key Performance Indicators 2015 - 2018

Indicator	2015	2016	2017	2018
Resource Mobilization				
THE as share of GDP	3.6	3.8	3.9%	3.6%
Per-capita THE (US Dollar)	96	77	73	72.7
Per-capita OOP (US Dollar)	68	55	55	50.5
Per-capita government expenditure (US Dollar)	13	10	12.4	11.9
Government-funded health expenditure[13] as a share of GDP (%)	0.6%	0.6%	0.5%	0.6%
OOP as share of as share of THE	71.4%	71.5%	74.8%	69.4%

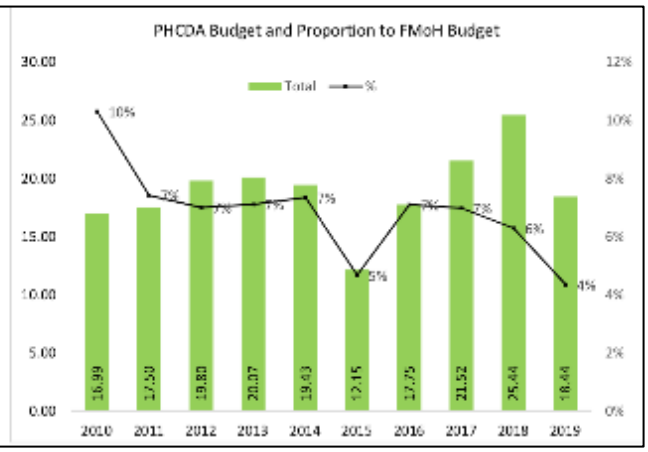
Source: adapted from Federal Ministry of Health Nigeria « National Health Account 2018 », September 2020

The majority of spending happens at the central level and is focused on tertiary and secondary hospitals. Primary health care is particularly concerned as spending is skewed towards curative care, especially in tertiary and secondary hospital settings, with little focus on low-cost high-impact areas of prevention, public health, and primary health care (see graph 2). Primary Health Care Development Agency (PHCDA) budget, as a proportion of the FMOH, has dropped from 6.3% in 2018 to 4.3% in 2019, the lowest allocation since the last 10 years.

[12] Federal Ministry of Health Nigeria « National Health Account 2018 », September 2020
[13] Refers to all revenues of government financing schemes including i) transfers from government domestic revenue (allocated to health purposes), ii) transfers distributed by government from foreign origin and iii). social insurance contributions

Graph 2 : Trend of PHCDA budget allocation and proportion of FMOH budget

Year	Total	%
2010	16.99	10.3
2011	17.50	7.4
2012	19.80	7.0
2013	20.07	7.1
2014	19.43	7.3
2015	12.15	4.7
2016	17.75	7.1
2017	21.52	7.0
2018	25.44	6.3
2019	18.44	4.3



Source: Ministry of Budget and National Planning, 2019

The National Health Insurance System (NHIS) was introduced in Nigeria in 2005 to guarantee accessibility to healthcare for Nigerians. Since its inception, only those employed in federal formal sector, which constitutes <5% of the working population of Nigeria have been enrolled by NHIS. The plan to expand the coverage of the insurance scheme to the informal sector, comprising most Nigerians – including the poorest and sickest individuals – still has to be developed and most of Nigerians continue to pay out-of-pocket for their health care expenditures.

1.4 International partners support to the health sector

Nigeria is a low-middle-income country, but it is also high in the ranking of fragile states. The support of the international community to the Health Sector of Nigeria has continued to be strong in recent years, especially in terms of grants. This is also due to the need for support in order to face emergencies (i.e. epidemic of Polio, COVID-19 pandemic and major insecurity factors).
An informal platform for coordination of international partners that support the health sector in Nigeria does exist and it meets regularly with the aim of exchanging information, coordinate different interventions, developing synergies and avoid overlapping.
The intervention of different international partners usually has Steering Committees chaired by government authorities, which is also the case for this Programme to be evaluated.

1.4.1 EU support to the Nigerian health sector

The European Union has been consistently supporting the health sector of Nigeria during the past 20 years. We recall here below the list or projects/programmes that have benefitted (totally or partially) the health sector of Nigeria during the past 10 years:

- EU SUPPORT TO THE UNITED NATIONS "ONE UN RESPONSE PLAN TO COVID-19 IN NIGERIA"
  - Source of funds: EU Emergency Trust Fund for Stability and Addressing Root Causes of Irregular Migration and Displaced Persons in Africa (ABAC Ref. T05-EUTF-SAH-NG-09-01)
  - Decision date: 17/04/2020 (end of written procedures)
  - Total budget: EUR 50 M (EU contribution)

- EU NIGER DELTA SUPPORT PROGRAMME (NDSP) – COMPONENTS 3&4 – WATER AND SANITATION, MICRO PROJECTS
  - Source of funds: 10th EDF (CRIS ref: 2011/022-910)

  - Decision date: 20/12/2011; FA signature date: 29/10/2012
  - Total budget: 377,855,000 EUR (EU - Components 3 & 4- 101,000,000 EUR)

- WATER SUPPLY & SANITATION SECTOR REFORM PROGRAMME PHASE II (WSSSRP II)
  - Source of funds: 10th EDF (CRIS ref: 2012/022-740)
  - Decision date: 20/12/2011; (FA signature: 26/06/2011)
  - Total budget: EUR 94 M (EU – 80 MEUR; counterpart – 14 MEUR)

- EU SUPPORT TO IMMUNISATION GOVERNANCE IN NIGERIA (EU-SIGN)
  - Source of funds: 10th EDF (CRIS ref: 2010/022-101)
  - Decision date: 21/12/2010 (FA signature: 07/03/2011)
  - Total budget: EUR 144.1 M (EU – EUR 63.5 M; Others – EUR 75.3 M ; FGN – EUR 5.3 M)

- EU SUPPORT IN RESPONSE, RECOVERY AND RESILIENCE IN BORNO STATE (13 Contracts)
  - Source of funds: 11th EDF (FED 2017/040-165)
  - Decision date: 24/03/2017
  - Total budget: EUR 153 M (including a EUR 20 M contribution from the EUTF)

- BUILDING RESILIENCE IN BORNO
  - Source of funds: 11th EDF (FED 2017/040-165) FED/2017/388-850)
  - Decision date: 24/03/2017
  - Total budget: EUR 15 M

- RESTORING AND STRENGTHENING HEALTH SERVICES IN BORNO
  - Source of funds: 11th EDF
  - Decision date: 24/03/2017
  - Total Budget: EUR 7,182,182 M

- HIGH IMPACT, EASY-TO-SCALE UP, COMPREHENSIVE HEALTH, NUTRITION, WASH AND LIVELIHOOD PACKAGE IN BORNO STATE
  - Source of funds: 11th EDF (contract not decision)
  - Contract no: (FED/2017/388-999)
  - Decision date: 24/03/2017; Contract signature Date – 14/12/2017
  - Total budget: EUR 14 M (EU contribution)

- *Humanitarian Dialogue* COVID-19 CRISIS RESPONSE: PEACEMAKING IN THE FACE OF A GLOBAL PANDEMIC
  - Source of funds: IcSP
  - Decision date: 08/04/2020
  - Total budget: EUR 200,000

<u>The total amount of invested funds invested in the above projects/programmes is of EUR 432.5 M.</u>
In addition, it has to be considered that a number of regional projects/programmes financed by the EU are partially financing interventions in favour of the health sector of Nigeria. Namely:

- A WEST AFRICAN RESPONSE TO EBOLA (AWARE)
  - Source of funds: 11th EDF (CRIS ref: 2014/37785)
  - Decision date: 28/11/2014

  - Total budget: EUR 30.4 M (EU – EUR 28 M; Others – EUR 2.4 M) Implementation period: 3 years (2014 – 2017) Implementing agency: Various Geographical region: West Africa

- SUPPORT TO THE REGIONAL CENTRE FOR DISEASE SURVEILLANCE AND CONTROL IN THE ECOWAS ZONE (ECOWAS-RCDSC)
  - Source of funds: 11th EDF (CRIS ref: 2017/40214)
  - Decision date: 17/10/2017
  - Total budget: EUR 9 M (EU - EUR 9 M; Others - EUR 1.1 M)

- ENABLING EFFECTIVE AND CONFLICT-SENSITIVE RESPONSES TO COVID-19 TO PROTECT SOCIAL COHESION IN FRAGILE CONTEXTS IN AFRICA
  - Source of funds: IcSP
  - Decision date:
  - Total budget: EUR 2,1 M

1.4.2 Member States

Germany

GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit) is currently co-financing and managing two regional programmes that are also concerned with supporting the health sector of Nigeria, namely: (i) support to regional surveillance systems for infectious diseases and (ii) regional programme against the pandemic of COVID19.

KfW (Kreditanstalt für Wiederaufbau) has financed in the past 15 years the polio eradication programme in Nigeria with a total amount of 200 mil through contracts with WHO and UNICEF, which have been terminated at the end of 2020.
Other multilateral programmes concerned with the health sector are directly supported by the Ministry of Cooperation from headquarters.

Hungary

Hungary is financing in so far small projects in Sokoto in support of Christian communities that works for IDP (internally displaced people). Furthermore, it is planning a bigger project in Abuja Federal Capital region, which may replicate the approach of CORE (project financed by United State Agency for International Development, USAID) in support of PHC with involvement of community volunteers, local and religious leaders. It is due to start in 2022.

United Kingdom

The UK has been one of the 28 member states of the EU formally until 31/01/2020 though the transition phase terminated on 31/12/2020.

The UK has been supporting the Nigerian health sector regularly from decades, it currently has the following projects in place:

- Centrally managed programmes (i.e. neglected disease as trypanosomiasis and reproductive health and family planning) via multilateral channels as WHO, those right now have been downsized in budget.
- Country managed programmes have also suffered from budget cuts and they are implemented through a contracting out strategy via lead consortium. In the last 10 years there were 5 of these programmes

A new programme designed as a continuation of those programmes, called the LAFYIA programme, started last year in 5 states with focus on health system strengthening and in improving governance on health financing with the aim of providing equitable access to services. This has a budget of 234 million pounds where 20 % of that budget is allocated to supply of health commodities; but with Official Development Assistance (ODA) budget review it should be scaled down. A COVID-19 dimension was also introduced.

The support of national malaria prevention programme, about 54 million pounds, supposed to end 2024 is also scaling down. It is managed by malaria consortium as leading agency and implemented in 6 states with high burden for malaria.
There is also a project in nutrition via UNICEF for provision of ready to use food to minorities in the states of Borno.

1.4.3 Other partners supporting the health sector:

We are giving hereinafter a synthetic description of interventions of the international partners, which focus on synergies and complementarities with the EU action and also on similarities or innovation in the implementation approach. Subsequently the paragraph cannot be considered as exhaustive of all partners' current and previous interventions.

Canada

Canada has financed for five years the polio eradication programme of WHO (GPEI) with a total amount of 20 million Canadian dollars. The contribution has terminated in 2020 and they have never participated in the Programme Steering Committee (PSC). They are thinking of supporting the polio transition plan, but there is concern about the government capability of supporting the transition. Other areas of engagement in Nigeria are on sex reproductive rights, particularly in the north of Nigeria, for access to social norms and behaviour changes and enabling women in making decision on their sexual behaviour. Support has been also given to human resources enhancing the ability of MOH in order to develop a Human Resource (HR) strategy and build capacity on planning for HR for health at state and LGA level. Canada has also joined the Basket under the Memorandum of Understanding (MoU) stipulated by Gates Foundation in Bauchi state (3 million Canadian dollars over 3 years). Funds have also been released in favour of an emergency plan for the pandemic of COVID-19.

USA

There are a number of American agencies involved for many years in the support of the health sector and the USA is a major donor to the sector. Most interventions have been and are focusing on Polio eradication, HIV/AIDS and other infectious diseases, including the establishing of relevant surveillance systems. This is regularly done through project approach and mainly implemented by international agencies. The focus on strengthening PHC services and related human resources has been mainly developed through the implementation of mentioned activities. There has been no focus so far on supporting the implementation of National Health Insurance (NHIS).

JAPAN

JICA has been intervening in the health sector in Nigeria with projects aiming at strengthening laboratory system in the fight to reducing the burden of infectious diseases, instead previous supports to polio eradication were stopped 2 years ago. The Agency is currently running grants aid and 1 Technical Assistance (TA) project and the major focus is on the construction of a reference laboratory for the NCDC (National Centre for Disease Control) and on supporting

the laboratory network in Nigeria as JICA currently supports about 8/10 NCDC labs in the country.
There are ongoing plans and discussions for future support to the implementation of UHC, which will be eventually decided next year.

GATES Foundation

Gates Foundation (GF) in Nigeria since 2012, first with family planning. Then expanded to polio to routine immunisation, Mother and Child Health (MCH) nutrition and health system strengthening and health financing. Country office relatively new. Lots of support before from Seattle, after 2017 an office was established in Nigeria. PHC is the entry point for all programmes, they work with grantees and partners.
The total amount of investment in the health sector is currently around 90 million US$ a year. Across national and state level, support NCDC to FMOH to NHI scheme at state level in 10 states to NPHCDA via investment in priority areas. The foundation gives grants and works with grantees, which can be local or international (United Nations, UN) partners. The bulk of investments is via grantees.
The Foundation works closely with WHO on polio eradication and most of staff in WHO are paid by foundation. GF is funding a campaign for new vaccines that are scaled up in Nigeria and Afghanistan.
MOU were signed with governors in 6 states to commit resources in a basket fund to support PHC (initially was on immunisation): the GF puts initially 80% of the money and government 20% (depending on states). The MoU stipulates on a gradual inversion of the contribution. This mechanism finances annual operational plan (AOP). Other partners are supporting the initiative though with different financial approaches.

World Bank

Nigeria as low-middle-income country can still benefit from loans, but there are some grants example (i.e. the TA to Basic health care provision fund worth 20 million US$). The grants are not always given on TA, for instance for COPRA (COVID-19) it was given directly to government to implementing measures against the pandemic.

The World Bank in Nigeria is about to terminate several projects focusing on MCH, PHC, malaria and immunisation coverage for a total value of 500 million US dollars. These are loans negotiated at Federal level though the funds go directly to states.
The polio eradication project (though UNICEF) has ended last month after several consecutive rounds.

In terms of health security: regional system surveillance project 3 years following Ebola to strengthen the system and surveillance. There is also currently one project to respond to COVID-19 of about 140 million US$, 90 million to the state and the rest at federal level.
WB has also invested heavily on provision funds to BHCPF (Basic Health Care Provision Fund) in various aspects of it to stimulate the government to make a contribution, but unfortunately it was stopped in 2019. The manual was revised but WB is still doubtful about the accountability model designed at state level.

A comprehensive new project called IMPACT is about to start. It is worth 650 million US$ with implementation in 12 states.

2 ANSWERED QUESTIONS & FINDINGS

The Evaluation Matrix, as presented in the Inception Note, has been one of the tools developed during the planning of this evaluation in compliance with what has been indicated by the ToR of the assignment. It has included the evaluation questions and the plans for collecting information to answer questions and it has guided the analysis since it brings all the sources together to address the questions. The Evaluation Matrix has guided the collection and analysis of information and the writing of this report. The Evaluation Matrix includes: the questions to be answered; the criteria or indicators on which the answers will be based; information sources and analysis methods.
Here below the key findings, the measure of indicators and the overall judgement for each question are presented.

2.1 Relevance: Evaluation Question 1a

EQ 1a: Does the intervention match the needs of national and local partners?

2.1.1 Measurement of the indicators

What objectives, results and activities of the Programme are (or not are) the same as the priority objectives, results and activities found in the policy and strategy documents.

The degree of consistency of Programme objectives and results with the national health policy agenda and the states agenda is high. In addition, the objective concerning Polio eradication, is well aligned with regional priorities and recommendations.

2.1.2 Key Findings

The overall objective of the Programme was to support the health systems strengthening efforts in Nigeria towards achieving Universal Health Coverage and improved health outcomes through improved data analysis and information dissemination capabilities, health expenditure estimation, reduction in financial barriers to health care and to increase and sustain herd immunity against polio in polio priority states.

Regarding the national level, the National Strategic Development Plan (NSHDP2) – 2018 to 2022 is based on five strategic pillars.

FIVE STRATEGIC PILLARS

Strategic Pillar 1: Enabled environment for attainment of sector outcomes
Strategic Pillar 2: Increased utilization of EPHS
Strategic Pillar 3: Strengthened health system for delivery of the EPHS
Strategic Pillar 4: Protection from health emergencies and risks
Strategic Pillar 5: Predictable financing and risk protection

- Within Strategic pillar 2 (Increased utilization of the Essential Package of Health Services EPHS) is targeting communicable diseases as priority area 5 but also Strategic Pillar 4 (protection from health emergencies and risk) is targeting public health emergencies preparedness and response.
- **The intervention under Component 2** is fully consistent with these strategies.
- Within Strategic pillar 3 (Strengthened health system for delivery of the EPHS), the NSHDP2 is targeting the improvement of Health Information System as priority area 12.
- **The intervention under Component 3** is fully consistent with this strategy.

- Within strategic pillar 5 (Predictable financing and risk protection); the NSHDP2 is targeting the improvement of Health Financing as priority area 15.
- **The intervention under Component 3** is fully consistent with this strategy.

Regarding the local level:

- There is no doubt that the intervention targeting polio eradication in 18 states (Component 2) fully met the priorities of these states, but also national and regional priorities.
- The intervention targeting in two states the improvement of HIS and the health financing system, including health insurance, (Component 3) corresponds to high states' priorities and to the logic of establishing pilot projects that can be eventually generalised nationwide.

The "National Health Policy, 2016" of the government of Nigeria gives priority to "Prevention and Control of Communicable Diseases" under which the main goal is to significantly reduce the burden of communicable diseases in Nigeria in line with the targets of the third sustainable development goal. Within this policy, one of the objectives is to achieve the eradication of Polio in Nigeria. This goal is recalled within the objective of strengthening the national alert and response capacity for epidemics and other public health emergencies.

The Component 2 of the Programme is fully aligned with these objectives and it has certainly been instrumental to the achievements of optimal results in this regard. It has to be noted that Polio eradication is a priority since the outbreaks of wild Poliovirus in 2012 and it also became a strong priority at regional level.

The same policy document defines the improvement of HIS as a priority as one of its goals is: "To institutionalize an integrated and sustainable health information system for decision-making at all levels in Nigeria". The following relevant initiatives are also recommended by the "National Health Act" and they have been implemented by **Component 3** of the Programme:

- Ensure adequate resource allocation for health information system at all levels.
- Strengthen mechanisms to ensure accuracy, timeliness and completeness of health data reporting from both public and private health facilities.
- Build capacity on routine data collection, analysis and interpretation for decision-making.
- Strengthen coordination mechanisms and platforms for effective collaboration, harmonization and integration of data collection, reporting and management systems both state and non-state actors to ensure adequate and complete information for decision-making.
- Strengthen mechanisms for translating health evidence into policy, decision-making and resource allocation.
- Strengthen and integrate existing surveillance systems and registries into the overall health information system.
- Strengthen data infrastructure including Information and Communication Technology (ICT) infrastructure at all levels.
- Strengthen mechanisms to ensure data protection, confidentiality and security in line with the provisions of the National Health Act 2014.
- Establish a national health observatory for appropriate knowledge management.

It has to be noted also that one of the objectives of this policy document is to "significantly improve the nutritional status of the Nigerian population", which is well captured by additional activities of the Programme that were stipulated by the Addendum to WHO contract (see Logframe Matrix in Par 2.15, table 8).

With regard to health financing the document identifies the following goals: "Ensure adequate and sustainable funding that will be efficiently and equitably used to provide quality health services and ensure financial risk protection in access to health services for all Nigerians, particularly to the poor and most vulnerable". While the related objectives are indicated as:

- To strengthen the institutional environment for sustainable financing and ensure accountability in the health sector,
- To guarantee financial access to a minimum package of health services through mandatory health insurance for all Nigerians,
- To strengthen domestic mobilisation of adequate resources to sustain funding for health.

The Component 3 of the Programme is fully aligned with these objectives and it has certainly been instrumental to the achievements of results to this regard.

Furthermore, it has to be noted that the "National Health Act 2014" has stipulated for the establishment, function and coordination of National Health Management Information System (NHMIS) and also for the establishment of a National Health Insurance Scheme.
Both components have been also designed to contribute to the achievement of the government health sector policy objectives under the Universal Health Coverage through improved financial capability of the government to achieve sector policy objectives, improved health sector governance and improved health service delivery.
The implementation of Universal Health Coverage was directed towards ensuring the achievement of the health system goals of better health outcomes, sustained health financing and responsive health system by ensuring that all Nigerian have equitable access to affordable health care.

Technical assistance to main federal and states partners was provided in the above-mentioned key result areas and the Programme has filled crucial and urgent financial gaps for key public health areas that would otherwise not have been covered by the government of Nigeria.
Last but not the least all these political initiatives are perfectly in line with the presidential declaration made at the end of the Summit on Universal Health Coverage in Abuja on the 10th of March 2014. In fact, the President has strongly and formally recommended on that occasion "the government of Nigeria at all levels (federal, state and local government) to significantly progress towards achieving Universal Health Coverage in Nigeria". He consequently set up a number of more specific recommendations.

2.1.3 Overall Judgement

The objectives and results of the Programme are definitely consistent and aligned with government sector policy agenda and with national and local health care needs as it appears from relevant policy documents, staff interviews and actions initiated by the government of Nigeria during the assessed period.

Overall, the Programme has supported the process towards achievement of UHC in Nigeria.
Furthermore, the Programme has filled a financial gap for a key public health area that would otherwise not have been covered by the government of Nigeria.

2.2 Effectiveness: Evaluation Question 1b

EQ 1b: To what extent planned objectives/ results have been achieved in accordance with planned schedule?

2.2.1 Measurement of the indicators

OVI identified for objectives and results in the logframe

A detailed explanation of indicators is provided in the section above, but it is also in the paragraph 2.16.

2.2.2 Key Findings

Objectives and results in the logframe have been almost achieved for both components.

For component 2:

The expected target for the objective of "Maintain polio-free status in non-polio infected states" the indicator "No indigenous poliovirus cases (Wild Polio Virus, WPV/ circulating vaccine derived polio virus, cVDPV) in the country from Acute Flaccid Paralysis (AFP) or environmental samples during and after the grant period" was partially achieved, as cVDPV is still circulating in Nigeria. In fact, 22 cases of cVDPV occurred in 2020 against a target of zero.
The expected target for the objective of "Reduce the proportion of missed children" has been partially achieved: the indicator "Proportion of LGAs with < 5% missed children in all SIAs round" had a target of "all LGAs with < 5% of missed children shows that in 2020, all LGAs 98% had less than 5% of missed children (data are partial for 2020). This is due to difficulties in accessing unsecured and compromised areas.

The expected target for the objective "Increased and sustained herd immunity against poliovirus in polio high risk states", the indicator "Proportion of LGAs in high-risk states that have achieved >90% LQAS in three consecutive SIAs" shows that the objective is partially achieved, as it was 86% in 2020 against the target of 90%.The indicator "Proportion of LGAs that has achieved 80% coverage for IPV" has been partially achieved showing a coverage for IPV in 2020 of 69.5%.

The expected objective "Highest quality polio Supplementary Immunisation Activities (SIA) activities, including micro-planning, implementation of activities and supervision" has been partially achieved as the indicator "proportion of high-risk settlements that are supervised by Management support team during SIAs (National Immunisation Day, NID round) shows a proportion of 39% of settlements against a target of 80%.

For component 3:

The expected result for objective "Improved resource allocation for health priorities" whose indicator is % of government expenditure on health with a target of 15% by 2020, some improvements have been noticed in Anambra state, but no major improvements have been observed at federal level.
For result "Reduction in financial barriers to health care access" whose indicator is "proportion of Nigerian covered by any risk-pooling mechanisms" and whose target is 30% by 2020, no major improvements have been observed as insurance coverage remains very low, estimated as below 5% of the population, even in Anambra and Sokoto.
Fore result "Improved capacity for tracking and reporting on UHC" whose indicator is "Federal and State MoH able to generate UHC Service Coverage Index (SCI)" with a target defined as

"at least each state should have 50% of data on UHC SCI", we have observed that the National Health Observatory has been established, and plans rolled out, although in 2020 have been disrupted by a pandemic. Major improvements have been noticed as per data collection in Anambra and Sokoto states though there are still delays in reaching the target.
As per result "Data from health management information systems used for policy and planning" whose indicator is "Percentage of Federal and state plans and strategies that are based on routine HMIS data to improve coverage and quality of high-impact interventions" and whose target is "100% by 2020", the ET found that operational plans based on a review process were performed in Sokoto and Anambra regularly in 2019, 2020 and 2021 and are also available for 2020 at Federal level. Joint Annual review reports have been also produced at Federal level for 2018, 2019 and 2020. Outcomes in Anambra and Sokoto were also of timely reported, planned and budgeted.
For result "improved availability of health expenditures data for policy and planning", whose indicator is "Number of policy briefs on financing developed in support of review and planning processes" with a defined indicator of "4 by 2020 (at least 1 per year)", the ET observed that review reports were timely performed in Anambra and Sokoto. However some delays occurred in 2020 because of COVID-19 pandemic.
For result "Improved availability of information on health services use and health outcomes" whose indicator is "Number of bulletins and health statistics briefs developed from HMIS data" and whose target is "4 by 2020 (at least 1 per year)", the ET found major improvements in Anambra and Sokoto states with the exception of data for the private sector. In addition, 6 health information bulletins were also produced and disseminated.
As per result "Data on health expenditures routinely collected and reported" whose indicator is "Number of health accounts estimations conducted" and whose target is "6 by 2020 (cumulative)", the ET observed that In Anambra and Sokoto NHA estimations were performed but not completed as yet for 2020.
As per result "Quality of data assessed regularly, at least once per year, using internationally agreed data quality criteria" whose indicator is "Number of planned data quality assessments conducted using internationally agreed quality criteria such as the Data Quality Assessment (DQA) Framework (DQAF)" and whose target is "at least 1 round of DQA per year", the ET found that in Anambra and Sokoto DQA reports were produced every year.

2.2.3 Overall Judgement

Objectives and results in the logframe have been almost achieved for both components.

For component 2 Objectives and results in the logframe have been almost achieved. cVDPV still circulating in Nigeria, whereas no cases of WPV have been notified in the Programme's target states as well as in the whole country. Nigeria has been certified "polio free" in August 2020. In some states still the proportion of high-risk settlements that are supervised by Management support team does not reach the target of 80%.

For component 3, no major changes have been observed as per the % of government expenditure on health. Similarly, no major changes have been observed as per the proportion of Nigerians covered by any risk-pooling mechanisms. The 2 target states achieved the result of "Percentage of Federal and state plans and strategies that are based on routine HMIS data to improve coverage and quality of high-impact interventions". Similarly, the 2 target states were able to produce bulletins and health statistics briefs developed from HMIS data. Policy briefs on financing have been timely developed in support of review and planning processes, although some delay has been observed due to the COVID-19 pandemic.

2.3 Effectiveness: Evaluation Question 2a

EQ 2a: What has been the Staff allocation to the Action and cooperation with the Ministry of Health (MoH) staff at both State and Federal levels?

2.3.1 Measurement of the indicators

Type /Number of staff allocated to the Action to MoH at State and Federal level.
Cooperation arrangements effectively implemented compared to planned cooperation arrangements.

For component 2 more than 400 000 staff have been mainly contracted by WHO with temporary contracts. Project management and coordination unit have been established within government departments but the number of staff from the government side is unchanged. However, it is difficult to clearly assess the number of staff allocated to polio eradication from the government side and therefore difficult to assess its exact contribution.
For component 3 an adequate number of new staff (not exact data are available) has been recruited by the government, particularly in HIS Data Centre, HIAgencies, MOH unit on budgeting & financing.

2.3.2 Key Findings

Number of staff allocated to the action for both components have been adequate in order to achieve the expected results.

As far as **component 2** is concerned, the Programme cooperates mainly with NPHCDA, where staff allocation is unchanged. For conducting activities under component 2 more 400 000 staff have been mainly contracted by WHO with temporary contracts for implementing extensive training and educational activities; these are volunteers and community health workers all trained by WHO and consequently certified by government management support team. It is difficult to clearly assess the number of staff allocated to polio eradication activities from the government side and therefore difficult to assess its exact contribution. The government has deployed staff on vaccination and surveillance activities through the leadership of the NPHCDA and the Emergency Operation Centre (EOC) SIAs, via a pre-campaign, implementation and post-campaign activities.

As per component 3 the Programme cooperated with the MOH since the beginning of baseline assessment on situation analysis on Health System Strengthening activities. Following a participatory approach, Federal and State level Department of Health Planning Research and Statistics (DHPRS) have been contributing to the implementation but also involved in all the discussions, decisions, advocacy, needs assessments and activity planning. MoH staff in Anambra and Sokoto received comprehensive trainings as per HMIS and Health Financing. A number of new staff has been recruited by the two states, and trained by the Programme, particularly in HIS Data Centre, HIAgencies, MoH unit on budgeting & financing. Government officers have been trained at the National level in Anambra and Sokoto states to elaborate health accounts. Staff of the state Ministry of Health have been trained on the use of One Health Tool and STATA to ensure sustainability and use of data for decision-making in the states. Although apparently a formal cooperation agreement with MOHs does not seem to exist, there is an agreement for joint production of AOPs.

2.3.3 Overall Judgement

The staff allocation during Programme implementation has been satisfactory for both components with the exception of some disruptions due to the COVID-19 pandemic. Cooperation mechanisms with the government are different for each component as component 2 mainly cooperates with NPHCDA and component 3 with MOH. On an overall the Programme has worked effectively towards the achievement of the planned objectives for the 2 components.

For component 2, although project management and coordination unit have been established within government departments, the bulk of the production cost in terms of human resources is still within the implementer hands, that is WHO, and not within the government. The accelerated transition plan proposed by WHO shows data on available GPEI-funded staff and how it declines over the years. Yet, key informants assessed as insufficient the financial and human resources that government will devote to polio eradication after the end of the Programme.

For component 3 in particular, the cooperation between Programme implementer and government of Nigeria appears clear as new staff has been recruited and training provided to SMOH on HIS and on health financing tools in Anambra and Sokoto states.

2.4 Effectiveness: Evaluation Question 3a

EQ 3a: What Internal implementation procedures, capacity and skills, internal mechanisms for coordination are in place?

2.4.1 Measurement of the indicators

Coordination procedures and mechanisms
Procedures and mechanisms applied compared with planned procedures and mechanisms

Coordination procedures and mechanisms applied comply with what was originally planned. The coordinating structure is clear for both components. Even if counterparts are different for the two components (per component 2 main counterpart is the NPHCDA whereas component 3 has two counterparts: the director of planning and the national insurance agency), there is a "de facto" coordination between WHO and beneficiaries for each of the 2 Programme's components.

For component 2: the already existing polio coordination mechanism - within the framework of the GPEI structure – via the Inter-Agency Coordinating Committee (ICCs) and through a polio EOC ensures harmonization of activities and effective coordination of all immunization activities. The EOC ensures strong coordination of government and partner efforts at all administrative levels of the country with close monitoring of performance. At state level the Inter-agency Coordination Committee comprises members from state Ministries, Departments and Agencies including local government, Health, Women's Affairs, Education, local government Commission and traditional and religious leaders. This committee is responsible for ensuring that high quality implementation of PEI activities in the LGA are implemented as planned. The presence of the government institutions in coordination meetings has been recorded in reports as an indication of the government high involvement in the Programme.

For component 3: quarterly Health Partners' meetings have been held in Anambra and Sokoto states regularly. The Partner's Forum has established government leadership of the system, provided direction and effective coordination of health activities. These meetings have ensured joint planning and implementation of activities, as well as monitoring and review. HFEI

Units established in the DHPRS MOH of Anambra and Sokoto are functional and provide leadership and coordination function for health financing in the states. Additional technical staff have been reorganised and trained to support the HFEI Unit in both states that provides harmonization between government and partners in the states.

2.4.2 Key Findings

The level of internal coordination mechanisms for Programme implementation procedure is high for both components as WHO applies its consolidated procedures in implementing the Programme. A joint WHO-UNICEF Project Steering Committee (PSC) for the whole EU funded Action, including component 1 implemented by UNICEF – comprising the EUD, WHO, UNICEF, FMOH, NPHCDA, Ministry of Budget and National Planning, and MoH representatives from supported states - was held in 2018, 2019, and 2020 has ensured effective management to monitor the progress of project implementation and ownership. The ET could access the minutes of PSCs of 2018 and 2019 where Programme's progresses in implementation, discussion and approved plans for the rest of the year are reported. It should be noted that this large steering committee is supposed to cover the entire coordination of the 3 components of the Programme. From discussions with key informants, the ET could appreciate that a coordination structure organised for each component, with clearly defined roles and responsibilities for each component, would have worked more effectively in accomplishing goals. As per components 2 and 3, WHO has been a successful coordinating driving force at federal and national level, while we can appreciate that the government of Nigeria has effectively provided stewardship. The application of this type of "model" allowed an effective implementation of the planned activities for both components.
Opinions from international partners interviewed mentioned the need for more synergies among donors and the need for more involvement of local government in coordinating activities.

For component 2: the evaluation team could assess the existing level of coordination but could not completely evaluate the interconnections among the different level of the polio eradication model in the country. From document reviews and interviews, it appears that the Programme acted in an environment of well-defined role and responsibility at all levels of the government. The implementing mechanisms of WHO have operated as "coaching", finding a favourable ground among government counterparts where ownership of the Programme is very high at all levels of the health system. The surveillance structure is coordinated at national, zonal, state, LGA and health facility levels. The National Polio Committees (NCC), National Task Force (NTF) and National Polio Expert Committee (NEPC) in the country are functional and meet at least every quarter. These committees guide the entire polio eradication initiative programme with WHO providing a decentralized coordination for technical and managerial public health functions through its coordination offices located at state, LGA level and in some cases closer to some of the most affected/risky communities. The coordination efforts worked effectively, though with some challenges, in states where security is an issue: innovative approaches such as the 'Reaching Inaccessible Children' (RIC) 'and 'Reaching Every Settlement' (RES) were used to access areas with security challenges and to reach some of the population trapped under insurgents in the North East, in coordination with the Military and Civilian Joint Task Force (cJTF).

For component 3: the Healthcare Financing Equity and Investment (HFEI) Units established in the DHPRS MOH of Anambra and Sokoto have ensured coordination for health financing in the states. In addition, there are coordination mechanisms between federal and states levels for each subcomponent. However, some of the activities have been disrupted by the pandemic. The Partner's Forum has provided support in incorporating government leadership that ensured effective coordination of activities.

2.4.3 Overall Judgement

The Programme shows a sufficient level of coordination mechanisms and implementation procedures in place for both components. WHO has been a successful driving force in coordination at federal and national level, which has contributed to activities effectiveness and the government of Nigeria has effectively provided stewardship. The structure of the coordination is clear and works effectively from federal to state and LGA level. The joint WHO-UNICEF PSC established for the whole EU funded action, that is supposed to cover the entire coordination of the 3 components of the Programme, is considered by key informants as too large, although the polio component is coordinated by the ICC on immunization. Coordination structures organised for each component, with clearly defined roles and responsibilities for each component, would have worked more effectively in accomplishing goals.

2.5 Effectiveness: Evaluation Question 4a

EQ 4a: What reporting relations and the performance of the management and its ability to monitor and capacity to adapt to changing conditions are in place?

2.5.1 Measurement of the indicators

Planned reporting chain (who is reporting to whom, periodicity of reporting)
Observed reporting according to planned reporting
Adaptations /changes based on evidence

PSCs minutes have been produced and dispatched among partners for each year, although the ET could not access the 2017 and 2020 ones. Technical progress reports from WHO have been timely provided to EUD once a year as planned; the 2020 period is included in the 2019 which may generate some problems in understanding precisely progresses attributable to each of the 2 years considered. Adaptation has been made particularly for component 2: WHO Polio infrastructure logistics and infrastructures have been deployed from February 2020 in support of the response to the COVID-19 outbreak, in particular for training and surveillance including contact tracing.

2.5.2 Key Findings

The Programme shows a defined reporting chain among all stakeholders. Technical reporting and relevant feedback of activities have been timely provided by WHO to the EUD: trends in the performance indicators are reported over time for both components together with accurate management of implementation, degree of achievement of results and difficulties faced.

The EUD has performed one monitoring mission in Anambra state and the report is available. No Result Oriented Monitoring (ROM) missions have been undertaken during the Programme implementation. The management of the Programme implemented by WHO - that applies its consolidated structure for both component – is facilitated by the extensive collaboration with the government of Nigeria that provides a supporting environment for implementing activities. In particular, **for component 2**, WHO has worked in synergy with the National Emergency Routine Immunisation Coordination Centre and supported national efforts by complementing human and financial resources and by introducing innovative approach such as microplanning and mapping high risk and nomadic population, such as the Reaching Every Settlement (RES), Reaching Inaccessible Children (RIC) and other so defined Special Interventions. In addition, WHO has provided laboratories, logistics and enhanced mechanisms for coordination.

Visibility measures which were planned in the Action document, have been also implemented for both components and detailed in each technical progress report with description of the digital and printed material.
COVID-19 pandemic has affected all operations; contingencies plans have been put in place especially for Component 2 where infrastructure and logistics have been adapted to support COVID-19 outbreak and response.

2.5.3 Overall Judgement

The level of existing internal mechanisms for Programme implementation procedures and reporting can be assessed as adequate for both components. PSC have been held and minutes distributed among partners as planned. Technical progress reports providing relevant feedback of activities and trends in the performance indicators are duly reported over time for both components as planned. The EUD has performed one monitoring mission in Anambra state and the report is available. No ROM missions have been undertaken during the Programme implementation. Adaptation has been noticed for component 2 where WHO Polio infrastructure logistics and infrastructures have been supporting COVID-19 response to the outbreak since February 2020.

2.6 Effectiveness: Evaluation Question 5a

EQ 5a: How effective is the Programme support or not in pushing for the Health Insurance agenda in the country? (As of 2019 only 5% of the population is actually covered by Health Insurance).

2.6.1 Measurement of the indicators

Programme's activities implemented that aim to increase the number of people covered by health insurance

These have been mainly directed to assisting on the drafting of the new Health Insurance Bill and to the National Assembly Committees on Health in order to make health insurance mandatory through the Health Insurance Act. Capacity building activities to strengthen state Health Insurance Agency have been performed, but it should be noted that a "new" rebranded HIA is in place since the second half of 2020.

Percentage of population covered by Health Insurance in the country:
The Programme fixed a target of 30% of the outcome "Proportion Nigerians covered by any risk-pooling mechanisms". However, it appears that it is about 4.5 % for Federal level.

2.6.2 Key Findings

The Programme, **through component 3**, has conducted a number of activities in support of the implementation of the Health Insurance in the country.
Technical Assistance has been provided for the drafting of the new Health Insurance Act that, at the moment of the mid-term evaluation, is waiting to be signed by the President.
The Programme has also provided technical guidance to the National Health Insurance Scheme (NHIS) and to the National Assembly Committees on Health in order to make health insurance mandatory through the Health Insurance Act.
Capacity building activities to strengthen state Health Insurance Agency have been performed.
The enrolment policies and procedures have been updated and the "Adoption Model" of the Anambra State Health Insurance Agency (ASHIA) for the poor is under implementation in Anambra and led to increase in enrolment 100% of all population enrolled in the informal

Sector. ASHIA also received support in developing communication packages for disseminating information and for community mobilization on health insurance.
Operational Researches were conducted on Health Insurance and on Financial Risk Protection: research on State Health Insurance Typologies in Nigeria and research on the Status of Implementation of State Health Insurance Schemes, performed in collaboration with the NHIS and State Health Insurance Agencies. Results from these studies have been used to produce a Scorecard to check State Health Insurance progresses. The Scorecard is updated monthly by the NHIS and shared with the Nigerian Governors Forum.
Another study on the demand side for Health Insurance by Nigerians in the Informal Sector has been produced in collaboration with NHIS to support expansion of the informal sector coverage.
A short video has been produced to raise awareness and to encourage resource mobilization for UHC. The video aims at motivating policy makers, politicians, and the private sector on reaching UHC. Support has been given to the Legislative Network for Universal Health Coverage for the development of the first-ever Legislative Health Agenda which was adopted and validated by state legislators during the 3rd Legislative Summit for UHC in Nigeria held in November 2019 and in 2021. WHO also provided technical support for the national Health Insurance Strategic Retreat in 2019 and to the following development of the Health Insurance Under One Roof (HIUOR), which is a national coordination framework for health insurance in Nigeria.
The Programme has provided support for Health account study and key health financing analytics to government Officers who have been trained in Anambra, and Sokoto states to conduct NHA studies.
The Programme has also provided technical assistance for the linkage of the Nigerian Social (Poverty) Register and Social Safety Net intervention of the federal government of Nigeria to Health Insurance.

2.6.3 Overall Judgement

Various activities under component 3 of the Programme have led to improvements in the consistency of legal frameworks and capacity of the Insurance Agency these activities were designed consistently with the drafting of the new National Health Act (see above). The enrolment policies and procedures have been updated and the "Adoption Model" of the ASHIA for the poor is under implementation in Anambra and led to increase in enrolment 100% of all population enrolled in the informal Sector. However, concrete results of the enrolment policies have still to come.

2.7 Efficiency: Evaluation Question 6a

EQ 6a: How cost efficient is the action to achieve the expected results?

2.7.1 Measurement of the indicators

Set targets within the indicated timeframe in the log frame
The study of documents mentioned as verification sources in the log frame and relevant "triangulations" with Key Informants showed the timely achievement of targets for Polio eradication (Component 2). However, for Component 3, there are some delays in achievement of targets (due partially to disruption generated by the Covid-19 pandemic).

Cost comparison with similar interventions.
As for Component 2 similar WHO interventions appears as slightly less expensive. Instead, it is very difficult to make comparison with similar intervention as per Component 3 in Nigeria.

2.7.2 Key Findings

For component 2:
The results have been completely achieved and Nigeria has been declared polio free in August 2020 though still there is a residual incidence of cVDPV cases (decreased from 141 in 2018 to 22 in 2020). However, it is very difficult to consider the cost efficiency of the EU Programme separately from inputs of other donors. This is a contribution to a long-time well-established programme of WHO. The WHO polio eradication programme has spent during the past 10 years an average of 100 million US dollars per year. This includes the contribution of the EU Programme, which eventually has represented, during the past 4 years, around 7% of the total amount spent by WHO on behalf of the government of Nigeria. Therefore it is almost impossible to consider the impact of EU financial support as separate from inputs of other donors.
In terms of cost of the intervention ensured by the international community it has also to be considered that the epidemic has been declared a high regional priority and there was strong pressure for a WHO led intervention by the Africa Union member states. In general terms there are non-existing comparisons that can be done with similar programmes in Nigeria though comparisons have been made in recent years with similar intervention in other countries. A study made by KfW (2014) showed that the cost of polio eradication campaign in Nigeria has been slightly higher than similar interventions, made by WHO, in countries like Pakistan and Afghanistan. It seems from our investigations that these differences persist unchanged though an explanation of their reasons remain obscure to the Evaluation Team.

For component 3:
The expected results have been partially achieved, mainly as a consequence of the COVID-19 pandemic that has disrupted a number of activities (mainly training activities, data collection and meetings). With regard to health insurance, it has to be specified that, while the capacity-building activities have been extensive and effective in supporting the definition of clear legal framework and procedures (especially with regard to enrolment), weaknesses in extending the coverage still persist (not even 5% in so far) as a consequence of both (i) delays in fixing the legal framework and (ii) delays in deploying enough financial resources.
With regard to the cost efficiency of this component, there are no comparisons with previous EU projects in Nigeria in recent years though there are synergies and complementarity developed with other similar interventions of international partners. The costs are aligned with standard costs for similar technical assistance activities for training and capacity building implemented by UN agencies. Furthermore, this modality appears to be the most frequently utilised by all international partners in Nigeria. It is understood that it is due to specific conditions of fragility from which the country suffers. However it may be appropriate to explore the feasibility of other modalities for future interventions.

2.7.3 Overall Judgement

The efficiency of Component 2, having taken into consideration its complete integration into a well-established WHO programme, is fully satisfactory.
The efficiency of Component 3 appears to be mixed with some reservations linked to the subcomponent on health insurance. Delays due to the Covid-19 pandemic have been also noted.

2.8 Efficiency: Evaluation Question 7a

EQ 7a: How efficient has been the mapping of allocation of resources to health during the period?

2.8.1 Measurement of the indicators

Measures to create additional fiscal space for health care.
No measures for increasing fiscal space for health are so far in place.

Percentage of increase of health expenditures at state and federal level.
Furthermore, it has to be noticed that the last available NHA account is for 2018 with no tangible signs of increasing of share of state and federal expenditures for health.

2.8.2 Key Findings

There is no evidence of increased fiscal space for health during the period to be assessed. All the policy documents studied by the ET do contain neither specific timeframe nor budgeting indications.
Furthermore, it appears as the budgeting process is still working at both federal and state's level, on a historical basis. This method does not ensure any relevant and consistent increase of the budgets.
There is also an evident difficulty in producing NHA timely (last officially produced is the 2018).
However, the political debate on the above-mentioned issues is currently intense and it has been developed at the highest institutional level. The attendance by the ET to the 4th Annual Legislative Summit (May 23 – 25, 2021) has given the opportunity to notice that the issues are high in the agenda of the government of Nigeria and there is the concrete possibility that some relevant actions to prioritise the investments in health in the government agenda will be taken in the very near future (i.e. introduction and/or increase of so-called sin-taxes dedicated to support the health sector). These findings were also confirmed during the interview with the Chairman of the Committee on Health of the Senate and the Parliament.
A concrete positive sign in the right direction could be seen in the revamping of the BHCPF (blocked in 2019 after two years of functioning) in the financial year 2022.
We shall recall here that the BHCPF is constituted by 1% treasury consolidated revenues, contributions from international donors and contributions from private entities.

Basic Health Care Provision Fund - BHCPF

Overall objectives of the BHCPF: to ensure the provision of a Basic Minimum Package of Health Services (BMPHS) to all Nigerians and strengthen the PHC system.

This is to be achieved (based on the NHAct 2014) by:

- Disbursement of 50% of the BHCPF through the National Health Insurance Scheme (NHIS) via a pathway to be called the NHIS Gateway, which would purchase health services based on the BMPHS from providers nationwide.
- Disbursement of 45% of BHCPF through the National Primary Health Care Development Agency (NPHCDA Gateway) for the provision of essential drugs, vaccines and consumables for eligible primary health care facilities (20%), the provision and maintenance of facilities, laboratory, equipment and transport for eligible primary healthcare facilities (15%) and the development of Human Resources for Primary Health Care (10%);
- The utilization of 5% for the provision of Emergency Medical Treatment (EMT Gateway).

For component 2: it has to be recalled that the WHO polio eradication programme of WHO is phasing out thanks to the declaration of Nigeria as polio-free country in 2020. A transition plan has been prepared by the WHO and it is still under discussion with major stakeholders. It is foreseen that the investment will be reduced by more than 50% in 2021 and more than 60% in

2022. The Plan is based on the parallel integration of polio vaccination activities into the routine immunization programme of the government of Nigeria and the parallel strengthening of the surveillance system. However, there is so far no formal guarantee on the capacity of Nigerian government to replace even a reduced contribution and to finance the improvement of the two above-mentioned key activities. There are serious doubts about the capacity of strengthening the surveillance system, especially with regard to a possible future outbreak of Polio.

For component 3: The allocation of resources to HIS has made the District Health Information System (DHIS) 2 fully operational with exception of private facilities that are not yet in compliance with collection and transmission of relevant data. There are doubts about the possibility of continuing funding of the utilisation of volunteers that have been extremely useful for the integration of nutrition programme data into the system. Additional budget resources are also needed for the financing of newly established routine activities and the extension of internet access.
Regarding health financing, the resources allocated have permitted the establishment and functioning of a relevant "budgeting/financing unit" within states' MOH, which has been fully staffed by the state MOH. The employment of staff is secured though additional budget resources are needed to guarantee the functioning of the unit.
Regarding the Health Insurance Scheme the State Agencies, in the two targeted states, have been made fully operational thanks to resources allocated to capacity building and recruitment of new Agency staff. Instead, no consistent and relevant measures have been taken in so far, neither at federal nor at states level, in addition to the envisaged revamp of the BHCPF (Basic Health Care Provision Fund) to increase allocations dedicated to the extension of health insurance coverage especially among the poor section of the population.

2.8.3 Overall Judgement

With regard to Component 2, it would be difficult to give a separate (from the WHO programme) judgement on the efficiency of the support given by the EU Programme.
With regard to Component 3, allocation of resources, during implementation of Programme activities appears to be satisfactory.

2.9 Sustainability: Evaluation Question 8a

EQ 8a: What are the governing mechanisms of the Action in place and involvement of the government including mechanisms for the government to take over the action and continue by the end of the action?

2.9.1 Measurement of the indicators

Total Health Expenditure (THE) as % of GDP and OOP as % of THE.
Further increase of OOP is expected in the short-medium term as THE is increasing and the share of government expenditures is not increasing.

Training activities and support to infrastructure strengthening (communication, hardware and software)
All activities related to training (both components) and infrastructures strengthening (component 3) have been completed with only some delays due to the disruptions generated by the pandemic.

2.9.2 Key Findings

The Action has been governed, in accordance with the stipulation in the Financing Agreement by a Programme Steering Committee that it has been meeting once a year, as 2018, and

chaired by the NPHCDA. All relevant stakeholders at federal and state level were participating to the sessions and presenting their reports on progresses and challenges and their plans for the yearly plans.
At state level the Programme activities were integrated into state AOP as a result of their participation to the planning and budgeting exercises and this is particularly evident for Component 3.
As a matter of fact government mechanisms to take over Programme activities have been relying on both, federal and state level, on integrating Programme activities into AOP. The Programme has also contributed to sharpening and making more effective this mechanism. However, the sustainability of such mechanisms should at first be reflected into an increase of government's investments in the health sector, especially towards improvements of PHC delivery services, which so far has not always been the case.
In this regard it has been noticed that the THE have increased during this period and a further increase is foreseen in the medium term due to both (i) effects of the pandemic of COVID-19 and (ii) the increase of the population (fertility rate is stable at around 3.5% with no signs of decline). In the same period no major changes have been noticed with regard to a very high proportion of OOP expenditures as no major increase in government share of THE has been noticed (see par 1.3 - health financing). In addition, the level of enrolment into the National Health Insurance Scheme remains below 5%, therefore far from the target of 30% identified for 2020.

For component 2: WHO is phasing out its polio eradication programme. The WHO transition plan raises the issue of integrating polio vaccination into the routine immunization programme. However there is no guarantee that government budget could effectively support this integration of services.

For component 3: Anambra state appears to be ready to add new budget increase as 2022 while Sokoto is more relying on the MOU with Gates Foundation. More specifically:
AOPs are regularly produced and their budget has been progressively increased (especially in Anambra) to recruit new staff dedicated to HIS (Data Centres), MOH/planning and budgeting unit.
With regard to HIS, the DHIS2 has been made operational eventually with a satisfactory and regular flow of information from bottom up. Concerns persist with regard to proper data collection at facility level in the private sector.
With regard to health insurance the State Health Insurance Agencies were adequately strengthened in terms of capacity and some mechanisms for enrolment were put in place though the coverage is still around 5% population.

2.9.3 Overall Judgement

Mixed governance improvements as there are no evidence of sufficient financial support for government support to maintain these improvements.
Component 2: WHO the transition plan is still under discussion. The weakness of current routine immunization raises concerns, the same can be said for a routine surveillance system.
Component 3: working mechanisms in place in the two pilot states though their concerns on budget allocations that can entirely guarantee the functioning of newly established units and services.

2.10 Sustainability: Evaluation Question 9a

EQ 9a: How has this Programme improved health services delivery in Nigeria and how is WHO ensuring the government of Nigeria's capacity to take over the Programme (sustainability, ownership, etc.)?

2.10.1 Measurement of the indicators

Data on service delivery
Available data cannot prove any impact on regular services delivery.

Number and type of new services established and services strengthened.
The NHIMS, the states' NHIS and the state MOH/directorate of planning have certainly been strengthened and their capacities upgraded.

Total Health Expenditure (THE) as % of GDP and state's budget increase.
No major evidence of increase of government share of THE at any level though THE is expected to increase.

2.10.2 Key Findings

For component 2: it has introduced improvements in key areas of intervention, particularly applying special interventions to improve access to children in insecure areas during supplemental and routine immunization activities.
The capacity of fighting against the resurgence of Polio has certainly been strengthened. The success of the campaign in the 18 concerned states has been guaranteed by huge amount of training performed by WHO to permanent MOH staff and to more than 400,000 community volunteers. Unfortunately, these people were recruited on a temporary basis for the purpose of the vaccination campaign and with the end of the emergency they are progressively terminating their contract. In other words, a great part of the process of capacity building will not leave trace in the permanent structure of the MOH. There is no guarantee that the MoH could properly continue a regular vaccination process or face a new outbreak with its scarce permanent resources.

For component 3: the upgrading of the HIS in two target states is evident as the upgrading of budgeting and planning capacities and the capacities of NHIS Agencies.
Instead, there is no evidence of improving of the delivery services though none could have expected a direct impact on delivery services in such a short time. That may be generated later, assuming that state budgets will be increased consistently, for which there are no clear evidence. In fact, there is no evidence for increase of government share of THE.
The upgrading of the HIS in two target states is evident and it will indirectly contribute to the upgrading of the delivery services assuming that the decision makers will utilise the relevant information collected.
This Component has also provided relevant technical assistance in the area of health insurance at both federal and state level. At federal level the Programme has supplied a strategic technical assistance that has been instrumental in the design of the new insurance law that is now just at the signature of the President. At state level technical assistance provided by the Programme has insured consistency and it has been also instrumental in creating the conditions for the future acceleration in the implementation of the scheme by building relevant capacity in the State Health Insurance Agency (especially with regard to enrolment procedures).
Relevant capacity has been also built within the state MOH/directorate of planning with the establishment and training of the new unit on budgeting and planning.

The sustainability of the activities implemented by the Programme is completely relying on a consistent increase in the recurrent expenditures of the health budget in the two states. WHO has strongly advocated for that, though there is still no evidence that the needed increase will be allocated.

2.10.3 Overall Judgement

Mixed governance improvement as detailed below.

For component 2: Services related to polio eradication have certainly been improved, while WHO' transition plan is still under discussion. Furthermore, the weakness of current routine immunization programme, which shall take over Polio vaccination, raises concerns. The same can be said for routine surveillance systems.

For component 3: Working mechanisms in place in the two pilot states. However, measures implemented and planned for the takeover of Programme components are weak. Despite some budgetary increases (especially in Anambra), there is still excessive reliance on donors' interventions and underestimation of the inefficiency of PHC network. There have been declarations at the highest level at state and federal level, on relevant budget increase for 2022, but official budgets are still in the process of being elaborated.

2.11 Sustainability: Evaluation Question 2b

EQ 2b: To what extent the Civil Society interacts with the Programme and plays a role to contribute to health reforms and health system strengthening?

2.11.1 Measurement of the indicators

Number of CSOs involved in the Programme.
There was no formal involvement of CSOs in the Programme implementation neither at federal level nor state level.

2.11.2 Key Findings

There is no evidence of any systematic and extensive intervention of federal or national Non-Governmental Organisations.
(NGO) and/or other Civil Society Organisations (CSO) in the implementation of the Programme.
Furthermore, there is no major evidence of a systematic contribution from the CSOs in support of the process of strengthening and reforming the Nigerian health.
However, there are two interesting types of interventions of the CSOs that have been noted and deserve to be recalled here:

- a major involvement of community organisations and individuals at very local level has been promoted and implemented by the Programme. The involvement of volunteers at community level has been extensive for education and training on polio eradication (more than 400,000 persons have participated on a voluntary basis with just little reimbursement for food and transportation), community volunteers have been also recruited for data collection for the HIS and nutrition education **(Component 3).** There is a risk for the termination of this involvement once WHO will stop paying «motivations» (the little reimbursements) to them.
- At a different level, the 'adoption scheme' for enrolment of a poor segment of the population within the health insurance scheme that has been experimented successfully in Anambra shows an interesting and positive involvement of civil society.

The financial support given by Rotary of Nigeria and other associations of Nigerians from overseas with regard to health initiatives complementary or not was noted and also seems to have a great potential as the two above-mentioned initiatives.

2.11.3 Overall Judgement

While there was no formal involvement of CSOs in the implementation of the Programme, there have been interesting examples of interactions with civil society have been noted, some of them directly generated by the Programme. The findings of the mission drive to the conclusion that there is room for extending and improving the involvement of civil society in support of the health sector.

2.12 Coherence: Evaluation Question 10a

EQ 10a: How has the expected results materialised and what are the facilitating and contrasting factors?

2.12.1 Measurement of the indicators

Number of facilitating/contrasting factors for expected results
The ET identified a certain number of factors that have facilitated the achievement of expected results.

For component 2 the awareness creation campaigns by community leaders have been determinant for increasing immunisation coverage. The influence of religious leaders in advocacy and education for polio vaccination has been a key factor in contrasting community misbeliefs and misconceptions against vaccination: the provision of accurate and complete information has proven to be highly effective.

For component 3 the major contrasting factor has been the COVID-19 pandemic that has generated disruptions and delays to some of the planned activities.

2.12.2 Key Findings

On the policy and strategic level the Programme has materialised its result mainly by being coherent with the EUs Agenda for Change, SDGs, with Nigeria Vision 20:2020 and with the 11th EDF National Indicative Programme (NIP) 2014-2020. The Programme is also coherent with the NSHDP II and shows a high degree of coherence with the strategy for the achievement of the Universal Health Coverage. The Programme is therefore aligned with external policy commitments as per vertical coherence.
The action works in parallel with the EU Support to Immunisation Governance in Nigeria project, and with the EU-Maternal Newborn and Child Health (MNCH) project in Kebbi, Bauchi and Adamawa States. The Programme also appears complementary with other immunisation and health systems strengthening actions funded by the EU. The Programme is therefore also aligned with interventions implemented by other actors, as per horizontal coherence. In addition, the government of Nigeria shows a high level of commitment that is appreciated as a facilitating factor in considering both components.
The sole major contrasting factor was due to the COVID-19 pandemic that has prevented results of component 3 from being completely achieved. Details on results affected by the pandemic can be found in Par 2.15 below (table 8). The major obstacle created by the pandemic seemed to be linked to travel restrictions and of training session in presence, which could not apparently be replaced by other tools/means. The reason why a NCE (no-cost extension) was not formally requested remains obscure to the Evaluation Team.

2.12.3 Overall Judgement

The objectives of the Programme were coherent with national and local health care needs as it appears from relevant documents, staff interviews and actions initiated by the government of Nigeria during the assessed period. The Programme works in parallel with other actors' interventions in the same context and is also complementary with other immunisation and health systems strengthening actions funded by the EU through other partners. The Programme is coherent with the EUs Agenda for Change, SDGs, Nigerian vision 20:2020 and the 11th EDF NIP (2014-2020), which focuses on Health, Nutrition and Resilience. The Programme is also coherent with the NSHDP II and with the corresponding states' Plans national health policy agenda and shows a high degree of coherence with the strategy for the achievement of the Universal Health Coverage.
The coherence of the Programme is satisfactory. The objectives of the Programme were in great part achieved with the positive impact of some facilitating factors and limited impact on results of component3 of the sole contrasting factors due to the COVID-19 pandemic.

2.13 Cross cutting issues: Evaluation Question 3b

EQ 3b: To what extent are the cross-cutting issues (i.e. gender, community empowerment and social inclusion) addressed in the Programme?

2.13.1 Measurement of the indicators

Programme activities aiming at increasing women inclusion
Programme activities aiming at increasing inclusion of marginalised group and community empowerment

Although the specific issue of gender equality has only been considered to a limited extent, we can confirm that activities of the Programme include implicitly the dimension of women inclusion and community empowerment. In particular, for component 2 as per woman to woman activities in conducting household immunization. In addition, specific educational and advocacy activities that imply the involvement of the communities and religious leaders have also been conducted in implementing component 2. For component 3 gender disaggregated data collection tools have been included in the health information systems. The enrolment of poor segments of the population in the insurance scheme such as the Anambra adoption model was also adopted in implementing component 3.

2.13.2 Key Findings

In terms of general policy objectives, the Programme addresses specific objectives sensitive to the socio-cultural aspects of the area in which activities are managed. In Nigeria a number of policy documents have been designed to promote women's empowerment and to improve access to health services. Nigeria first developed a National Policy on Women in 2000 with the goal of this policy to ensure that the values contained in the 1999 Constitution were effectively enforced and that gender perspectives were addressed into all policies and programmes. The National Gender Policy (NGP, 2006) - implemented by all the ministries, departments, and agencies, at all levels of government - comprises legal equality for men and women and remove all barriers to the social, economic, and political empowerment of women. Vision 20:2020 also gives consideration to the gender issue as the key economic policies of the country. Since adoption of these policies, several actions have been taken in the country to set a target to increase women's access to education, health and social services.

For component 2: the Programme addresses specific objectives sensitive to the socio-cultural aspects of the area in which activities are managed. For example, in some communities of

northern Nigeria, the Programme adopts woman to woman strategy and organises women to conduct household immunisation. In order to monitor the implementation impact of the gender-specific objectives, surveillance data and national routine immunization surveys such as the National Immunisation Coverage Survey (NICS), are available to facilitate data analysis and sex disaggregation to produce gender statistics. Activities directed to increase community empowerment involving community leaders and volunteers have been also implemented systematically for component 2.

For component 3: the Programme has included, in order to strengthen the health information systems, appropriate mechanisms for including sex disaggregation in routine health facility information and gender disaggregated data collection tools to generate appropriate gender related analysis and statistics.

2.13.3 Overall Judgement

Although we cannot specifically find Programme's document that makes particular reference to gender issues, interviews with main stakeholders have highlighted that all the various activities of the Programme have been carried out with a participatory approach and with equitable participation of female and male stakeholders.
In Nigeria a number of policy documents have been designed to promote women's empowerment and to improve access to health services. Although not in the primary focus of the interventions, the Programme includes activities that involve women and community during the implementation of activities. The Programme contributes towards the ultimate goal of gender equality and supports government health policies when considering both components. The Programme therefore contributes to the achievement of the EU Gender Action Plan (GAP) objectives for 2016-2020. However, because Programme's indicators are not specifically articulated directly to be gender sensitive, it is not possible to quantify those achievements.

2.14 EU added value: Evaluation Question 4b

EQ 4b: To what extent the Programme brings additional benefits to what would have resulted from Member States and other development partners active in the health sector interventions?

2.14.1 Measurement of the indicators

Percentage of financial contribution of EU intervention
Percentage of financial contribution of Member States

The EU financial contribution to polio eradication has been equal to 6 or 7% of the total cost of Polio eradication programme. It has been similar to the contribution of Germany and much higher of those of the other Member States.
The EU contribution to the subcomponents supported by Component 3 is difficult to be compared as percentage MS contributions as there are very limited examples of similar interventions financed by MS.

2.14.2 Key Findings.

For component 2: the financial contribution of the EU is equal to those of other Member States (MS), namely Germany (its contribution has been by an average of 5 million euros a year in recent years) and the UK (with an even larger amount of contribution though on the way out from the EU since 2018). The contribution of this EU Programme to WHO polio eradication programme can be estimated as equal to 6 or 7% of total yearly cost of it. However, the participation of the EU to polio eradication programme appears as an inescapable duty in light

also of regional priorities and the support given by the EU, of which the Programme represents the second phase, has also a political added value in terms of advocacy among the donors' community and also in terms of political dialogue at regional level.

For component 3: it appears to be unique in comparison with other interventions of MS, it covers areas not covered by other interventions or partially covered by other interventions, with the only exception of the UK (which was a member state at that time). This component gives the possibility of opening and strengthening an intense dialogue on policies and strategies for the health sector of Nigeria at a level that is not attainable by MS in light of the type and size of their interventions.

2.14.3 Overall Judgement

For component 2: the EU added value appears to be mainly political, namely in terms of response and advocacy to a regional call for Polio eradication as the financial contribution of the EU is equal to 6 or 7% of the total cost of WHO programme to an already well-established WHO programme.

For component 3: certainly, as a more positive weight and added value in terms of the unicity and size of the interventions (in comparison with MS) in key areas that are priorities for the government of Nigeria and therefore it also facilitates the policy dialogue.

2.15 Evaluation of achievements within logframe Matrix

The Evaluation Team has also assessed the original Matrix that has been presented in the ToR taking into account the corrections made with Addendum to WHO contract signed on the 24/03/2020.
This Matrix was produced with the aim of evaluating the achievement of indicators stipulated in the logframe of the Programme. The logic of this Matrix has guided the verification of indicators related to achievement of objectives, results and outcomes of both, components 2 and 3. The quantitative analysis has been based upon the verification of data coming from the sources defined in the log frame. The access to the documents that represents the sources of verification has been crucial to the success of the assessment.
Hereinafter we present the major findings as they appeared from the examination of relevant sources of verification and further verified/confirmed through "triangulations" performed during a great number of relevant interviews. The findings are presented in form of comments in each row of the logframe.

<u>With regard to Component 2:</u>

The large majority of targets for results, outputs and outcomes were achieved more than satisfactory. Some results have not been achieved, in particular:

- 22 cases of cVDPV have been reported in 2020. Technical progress reports of 2019-2020 indicate that investigations conducted shows these cases mainly have affected young children (<5 yrs) belonging to "poor background, inadequately vaccinated, from families with limited or no education and living in rural areas".
- The minimal proportion of LGAs that has not achieved the target of having < 5% missed children in all SIAs, is due to noncompliance attitude, whose main reasons - as it appears in progress reports - were linked to "no-felt need, too many rounds, Oral Polio Vaccine (OPV) safety and contradictory religious belief". However, demand creation interventions - using milk packages, health camps, etc. - allowed to reach children that would have been otherwise missed. In addition, various episodes of armed banditry, kidnapping, religious and ethnic conflicts occurred, especially in states located in the north of Nigeria, that have hampered the access to children eligible for vaccination. The

utilisation of community informants for surveillance and vaccination and the engagement of the military have allowed to reach these children.

Table 6 : Log-frame component 2: results

Expected results	Indicators and targets	Preliminary judgement on achieved results
Achieve and maintain polio-free status in Nigeria	No indigenous poliovirus cases (WPV/cVDPV) in the country from AFP or environmental samples during and after the grant period TARGET: 0 WPV and CVDPV	Nigeria has been declared free polio state in August 2020. Poliovirus cases ((WPV/cVDPV) in the country from human or environmental in 2020: WPV=0;cVDPV=22
Reduce the proportion of missed children	Proportion of LGAs with< 5% missed children in all SIAs TARGET: ALL LGAs <5% missed children	In 2020: outside household: 97.6%, inside household 98.5%
Increased and sustained herd immunity against poliovirus in polio high risk states	Proportion of LGAs in high-risk states that have achieved >90%LQAS in three consecutive SIAs TARGET: 90% Proportion of LGAs that have achieved 80% coverage for IPV (Inactivated polio Virus) TARGET: 80%	Proportion of LGAs in high-risk states that have achieved >90% LQAS in three consecutive SIAs in 2020: 86% Proportion of LGAs that have achieved 80% coverage for IPV in 2020: 69,5
Highest quality polio SIA activities, including micro-planning, implementation of activities and supervision	Proportion of high-risk settlements that are supervised by Management support team during SIAs TARGET: 80%	Proportion of high-risk settlements that are supervised by Management support team during SIAs: 39% of the settlements are in high-risk states as of March 2020

With regard to Component 3:

The large majority of targets for results, outputs and outcomes were achieved more than satisfactory. The non-achievements of a number of targets are mainly due the following reasons:

- With regard to the targets related to NHIS coverage: at first it should be said that the targets were over-ambitious especially in consideration of the lack of a consistent legal framework both at federal and state level and the lack of a subsequent consistent financial commitment from the government in order to support the process. Similar process, even in smaller countries and countries with less complex institutional set-up, takes time to be agreed and implemented. Probably also the political willingness to accelerate the process, especially on the financial side, has been overestimated. Nevertheless, it as to be reminded that Programme activities has been very instrumental to the realisation of legal and procedural relevant processes during the period. Last but not least, the preparation of the new insurance law that is about to be signed by the President of the republic.
- With regard to other targets, the non-achievement is strictly related to disruption generated by the pandemic. A number of relevant activities (i.e. training, data collection) could not be performed or they were delayed because of heavy restriction imposed.

Table 7 : Log-frame component 3: results

Expected results	Indicators and targets	Preliminary judgement on achieved results
Improved resources allocation for health priorities	% of government expenditure on health * TARGET: 15% by 2020	Improvements noticed in Anambra state. No major improvements at federal level.
Reduction in financial barriers to health care access	Proportion of Nigerian covered by any risk-pooling mechanisms TARGET: 30% by 2020	No major improvement as insurance coverage remains very low (in general is estimated as below 5% of the population, even in Anambra and Sokoto)
Improved capacity for tracking and reporting on UHC	Federal and state MoH able to generate UHC Service Coverage index TARGET: At least each state should have 50% of data on UHC SCI	National Health Observatory established and plans rolled out in 2020 have been disrupted by a pandemic. Major improvements in data collection noticed in Anambra and Sokoto states though still delays in reaching target.
Data from health management information systems used for policy and planning	Percentage of Federal and state plans and strategies that are based on routine HMIS data to improve coverage and quality of high-impact interventions* TARGET: 100% by 2020	AOP based on a review process were performed in Sokoto and Anambra regularly in 2019, 2020 and 2021. Also, available for 2020 for Federal. Joint Annual review reports have been also made Federal for 2018, 2019 and 2020. Outcomes in Anambra and Sokoto were also good in terms of timely reporting, planning and budgeting.
Improved availability of health expenditures data for policy and planning	Number of policy briefs on financing developed in support of review and planning processes TARGET: 4 by 2020 (at least 1 per year)	Reviews reports were timely performed in Anambra and Sokoto with some delays due to a pandemic in 2020
Improved availability of information on health services use and health outcomes	Number of bulletins and health statistics briefs developed from HMIS data TARGET: 4 by 2020 (at least 1 per year)	Major improvements noticed in Anambra and Sokoto states with the exception of data for the private sector. 6 health information bulletins were produced and disseminated
Data on health expenditures routinely collected and reported	Number of health accounts estimations conducted TARGET: 6 by 2020 (cumulative)	In Anambra and Sokoto NHA estimations were made but not completed as yet for 2020.
Quality of data assessed regularly, at least once per year, using internationally agreed data quality criteria.	Number of planned data quality assessments conducted using internationally agreed quality criteria such as the (DQAF) TARGET: at least 1 round of DQA per year	In Anambra and Sokoto DQA reports were produced every year

Table 8 : Component 3, subcomponent on HIMS targets

Health Information Management System (HIMS)								
Outcome	Indicators/ Milestone	Baseline 2017			Target 2018	Target 2019	Target 2020	comments
		Anambra	Sokoto	Federal				
Agreed Policy and Strategy for HIS operational in the state	HIS Policy and Strategy in place	0	0	1 (but outdated and needs review and update)		1	3	Not achieved in 2020 but just finished at federal level in 2021 and subsequently adopted in the 2 states
	HIS cost operational Plan developed	0	0	0	2 (achieved)	3 (achieved)	3 (Achieved)	
Effective routine (HMIS) data management structure, plan and process in the state according to the national HIS Policy or SOP	Number of facilities reporting	665	770		At least 900 HF reporting in Anambra and 800 in Sokoto state (achieved in 725 health facilities in Anambra; 825 in Sokoto)	At least 950 HF reporting routinely in Anambra, 830 in Sokoto (achieved)	At least 1000 HF reporting routinely in Anambra, 830 in Sokoto	activity collapsed due to COVID-19
Health Data Governance Platforms for functional	Number of resolutions made by the HDGC based on submission by the HDCC	0	0	0	At least 1 (2 achieved)	At least 1 (done)	At least 1	done- Functional at all every level
	Number of HDCC meetings that held	0	1	0	4 (6 achieved)	At least 6 (10 achieved)	At least 6	Achieved for quarterly activity
HIS Platforms for coordination and management of LGHIS operational in the states	Number Integrated Health Data Management Team meeting	0	0		At least 8 per state (achieved In Anambra and Sokoto)	At least 8 per state (Achieved In Anambra and Sokoto)	At least 4 per state	achieved In Anambra and Sokoto: all 21 LGAs in Anambra and 23 Sokoto conducting monthly LGA Integrated data validation meetings as at Nov 2019 but disrupted by a pandemic in mid-2020
Effective institutional and human capacity for data analysis, dissemination in state and LG levels	Number of staff trained on HMIS/DHIS 2	25	30		100	300	1000	in total more than 1200 HCW trained in both states on revised NHMIS as 2020
	Number of health bulletins circulated per annum	0	0		4 (6 achieved)	4 (4 achieved)	6	only 2 achieved as a pandemic has disrupted activities
Institutional reporting of hospital deaths through the DHIS 2	Number of Health Facilities reporting hospital deaths routinely on the DHIS	0	0		20	30 (largely achieved)	50	largely achieved
Improved quality or (CREDO SIA "of") routine health data	Number of health facilities visited for Data Quality Reviews	NA	NA		At least 120 (102 achieved)	120 (59 achieve)	120	Partially achieved as partially disrupted by a pandemic. DQA in Sokoto in August 2020
Improved capacity of LGA and health facility staff on data management	Number of health facilities visited for ISS	NA	NA		100 (102 achieved)	120 (Achieved)	120	partially achieved as results of disruption generated by pandemic
SMOH with functional linked dashboard for data analysis	Dashboard functional at state levels	0	0,5	0	2 (Achieved In Anambra and Sokoto)	2 Achieved In (Anambra and Sokoto)	2	Achieved In Anambra and Sokoto
State Master Facility List and updated database	Availability of updated Master facility	0	0	0	2 (Achieved In Anambra	2 (Achieved In Anambra	2	Achieved In Anambra and Sokoto

Health Information Management System (HIMS)								
Outcome	Indicators/ Milestone	Baseline 2017			Target 2018	Target 2019	Target 2020	comments
		Anambra	Sokoto	Federal				
of health facilities available	list/database; update through physical mapping of facilities and completion of provided checklist				and Sokoto)	and Sokoto)		
	Health facility registry for continues update of MFL functional	0	0	0	2 (0)	2 (2 achieved)	2	Achieved In Anambra and Sokoto
Effective framework for data analysis, dissemination and use	Availability of SOP/TOR for the DOC desk officers	0	0	0	2 (2 achieved)	2 (2 achieved)	2 (2 achieved)	
	Number of HIS officers and stakeholders trained in data analysis	21		33	50 (113 achieved)	100 (achieved)	100 (.)	achieved: more than 500 health workers trained to use service delivery level curriculum for state, LGA and health facility staff
	Number of health facilities with standard template for data analysis	0		0	100 (60 achieved)	200 (partially achieved)	300	completely done in Anambra and Sokoto state
Guidance developed for more effective use of technology for data management and improved health services	National Digital Health Policy developed	0		0	0		1	achieved
	Updated National Digital Health Strategy developed	0		0	1 (but outdated)		1	achieved
Institutionalisation of ICD standards	Governance structure for ICD standards adoption and coordination developed	0		0	0		1	Not achieved in 2020. However ongoing. Meeting scheduled between the NPC DG, WHO WR and FMOH DHPRS to discuss proposed approach and endorse jointly. (Training completed for a core group on Strategy development, CRVS, death registration and certification using ICD-11.)
	Capacity building for ICD implementation	0		0	0		At least 100 health workers trained	Achieved for about half. Activities are ongoing though waiting for establishment of the governance structure - CRVS Steering committee and TWG.
Operational Research conducted to improve planning and policy making	OR on barriers to access to health services conduced in Sokoto state			0			1	(NOT achieved but planned for Q1 & 2 2020. Resumed plan, ToR for that done)
	OR on effective private sector engagement conduced in Anambra state	0					1	(Same as above)
Institutional Health Research System Capacity development	Situation analysis of the country research for health system capacity conducted	0		0	0		1	(Not finished as process for policy and Strategy developed was disrupted by COVID-19)
	National Research for Health System Strategy developed	0		0	0		1	Not yet - Country team prioritized revision of the National Health Research Policy in view of the pandemic and other experiences
	Publications from the National Research System capacity development	0		0	0		At least 3 publications	Not yet - A manuscript is ready for publication. Three others are still drafts

Human Resources for Health Information System							
Outcome	Outcome indicator	Baseline 2017		Target 2018	Target 2019	Target 2020	comments
		Anambra	Sokoto				
HRH policy, Strategy and Operational plans and guidelines in place	HRH Policy and Strategy in place	0	0	1	1	1	(Not yet - Planned for Q3 2020. Disrupted by COVID-19. Ongoing plan to support that now- both state Commissioners for Health have sent their request letters for support to the WR)
HRH division fully functional with ICT equipment furniture and fittings in place	Equipment procured, installed and commissioned	0	0	2 (achieved)			(All procurement accomplished in 2018)
Reliable web-based database-Human Resources for Health Registry functional	Web-based functional HRH Registry at SMOH	0	0	1	1 (2 achieved)	1 (achieved)	
	Number of senior government staff trained on the use of HRH Registry for HRH management	0	0	30	30	40 (	No senior staff trained in 2020. But it has to be noticed that the Commissioner and Permanent Secretary use the HRH Information system for planning all the time)
HRH management decision-making, policy making and funding based on output from the HRHIS	Number of HRH management decisions based on data on Registry	0	0	1	1	1	(Fully achieved. To be noticed that the Governor of Sokoto state lifted the embargo on employment last year after the Commissioner presented to him the health workforce situation based on the registry. Recruitment of health workers is still ongoing in Sokoto state. IN Anambra, the redistribution of staff (although limited) was as a result of the data from the registry showing that a high number of health workers were retiring from service.)
Integrated Disease Surveillance and Response							
Improved surveillance capacity	Governance for IDSR established	0	0				No target set but the standard governance structures was established in both states – EPR and RRT and have been functional. RRT established in some hot spot LGAs in Sokoto. These structures helped the state's initial planning and response to COVID-19. Also IDSR Operational Plans developed in both states in 2020
	Skills transfer to health care workers on surveillance	Less than 200	Less than 200				No target set but about 2000 health workers trained in Anambra and Sokoto state on IDSR during the period
	Increased data representativeness on IDSR	170 focal sites (based on only polio)	120 focal sites (based on only polio)			.	Data representativeness improved with over 700 reporting sites on IDSR in Anambra and Sokoto state each

Human Resources for Health Information System							
Outcome	Outcome indicator	Baseline 2017		Target 2018	Target 2019	Target 2020	comments
		Anambra	Sokoto				
Nutrition Data Management							
Improved decision-making on child Nutrition	Capacity building of health workers on Nutrition data management	NA	NA			.	State Nutrition teams and all LGA and Health facilities' nutrition focal persons built on CMAM and CMAM data management. One referral system built, and pathway identified and agreed. Ongoing periodic improved referral Documentation tools printed and distributed. Capacity review meetings enhance the ability of health staff
	Improve representativeness of Nutrition data to guide decision making	Less than 5 LGAs reporting Nutrition data	NA			.	Over 17 LGAs out of 21 in Anambra reporting as at Dec 2020. Reporting sites increased by over 300% in Anambra state. Sokoto not computed yet. Data been used as advocacy tools to the Commissioners for Health to increase the number of CMAM sites per state to increase access to services

Table 9 : Component 3 – subcomponent on health care financing

Health Care Financing						
Outcome	Outcome indicator	Baseline 2017	Target 2018	Target 2019	Target 2020 +	comments
Approved HCF policy, Strategy operational in the states	HCF Policy and Strategy in place	0	2 (achieved)	2 (achieved)	2 (achieved)	
HCF activities are coordinated by the HCF unit in MOH	HCF units are established and functioning	1	2 (achieved)	2 (Units are operational)	2	units are operational
Strengthened and integrated health financing coordination platforms	Number of coordination meetings held by HCF TWG	0	At least 4 (achieved)	At least 4 (platforms functioning)	At least 4	platforms functioning
HCF baselines studies and core analytics reports produced	Number of studies conducted	0	5 (achieved)	At least 2 (achieved)	At least 3	activities disrupted by pandemic
Health personnel trained on HF and Management	Number of health personnel trained	0	100 (110 achieved)	100 (achieved)	50 (achieved)	
Annual health accounts reports produced	Annual health accounts reports in place	1	3 (achieved)	3 (draft produced)	3	activities are running late
Annual budget and outcomes analysis conducted	Annual budget and outcomes analysis produced	0	0	2 (Achieved)	2	disrupted by the pandemic
Investment case for health developed and used for resource mobilisation	Number of states with Investment Case for health	0	2 (achieved)	2 (achieved)	2	achieved with delay due to pandemic
Processes for data transfer and upload to the health accounts software from government financial management information system automated	Number of states with functional automated financial management systems.	0	2 (achieved in Anambra and Sokoto)	2 (operational)	2	operational
Operations research on health financial risk protection conducted	Report of operations research available to inform policy and practice	0	0	1 (not achieved)	2 (not achieved)	
state level score cards based on health expenditure and health service information to inform state level annual reviews developed	Health financing score card in place	0	1 (achieved in Sokoto and Anambra)	1 (fully operational)	2	fully operational

2.16 Analysis of Questionnaire

The online questionnaire, which utilises the platform "Survey Monkey" has been utilised to collect information from Key Informants in 18 states about Component 2 only. This tool allowed the ET to reach a number of interviewees that could not have been reached otherwise.

A total of 58 questionnaires were administered to Key Informants in 8 states selected according to geographical and high-risk criteria.
36 questionnaires were filled and returned, giving a response rate of 62%. All questionnaires were correctly filled and therefore all were used.
The majority of respondents, 94.29 %, was above 40 years of age and 5.71% below 40; male respondents were 94.29 %, and female 5.71%. As per level of education, the 57.14% of respondents have a master's degree, the 20% A Doctorate, 20% a bachelor's degree and 2.86% have attended secondary/technical college.
29 questions were asked, 5 of which related to personal details; 24 questions constituted the core of the questionnaire, with 22 close end and 2 open questions. The questionnaire was developed based on the main different components of the issues to be investigated and consequently validated through a pilot test performed by the ET. The main purpose of the questionnaire has been to confirm the results and triangulate findings from EQ and interviews.

Table 10 below shows the questions for which answers were required.

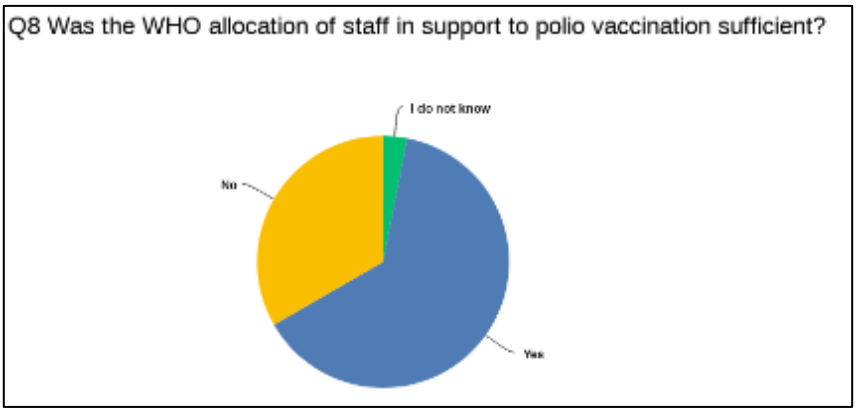
Table 10 : List of questions sent with online questionnaire using Survey Monkey online tool

QUESTIONS (questions from 1 to 5 were on personal details about age, gender and level of education)				
	Question	YES	NO	I don't know
6	Is the Polio eradication Programme supported by WHO meeting any health priority of your state?			
7	Has the Polio eradication Programme filled a financial/human resources gap for polio vaccination that would otherwise not have been covered by government?			
8	Was the WHO allocation of staff in support to polio vaccination sufficient?			
9	Was WHO coordination role effective?			
10	Has WHO intervention on polio vaccination introduced any important and relevant changes?			
11	If the answer to the previous question is YES, do you think that the government (either federal or state) will be able to maintain those changes?			
12	Has the ability to monitor polio vaccination improved?			
13	Has the level of coordination for polio vaccination improved?			
14	Has the level of surveillance reporting improved?			
15	Has WHO intervention been decisive (crucial) in the achievement of vaccination targets?			
16	Has WHO intervention helped in planning the allocation of resources (human and physical)?			
17	Has WHO intervention improved the monitoring of the vaccination campaigns?			
18	Has your local capacity improved after the intervention?			
19	Could you continue in the future the vaccination campaign with the same level of quality and efficiency?			
20	Have CSOs been involved in the vaccination campaign?			
21	There was any specific activity targeting the mobilisation of mothers during the campaign?			
22	Has the Programme prioritised the relevant health policy and strategy documents of Nigeria?			
23	Has the Programme been effective in improving regular mechanisms of review of performances against defined priorities in the country?			
24	Will the government be able to take over the management of this Action?			
25	Has the Programme improved health services delivery in Nigeria?			
26	Has the government an adequate level of Programme ownership?			
27	Has the Programme contributed to promote the Health Insurance agenda in the country?			
28	What are the mechanisms that the government is putting in place to ensure sustainability after the end of the Programme?	Open question		
29	What innovating element do you think is present in this Programme?	Open question		

All respondents answered that the Polio eradication Programme supported by WHO has met the health priority of their state (Q6) and prioritised the relevant health policy and strategy

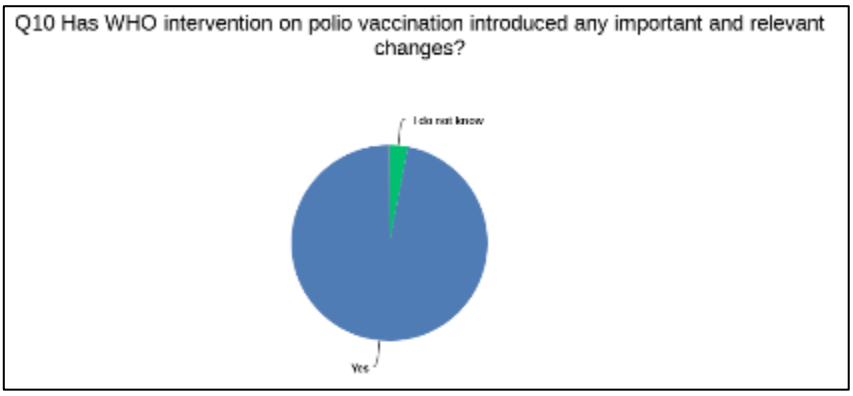
documents of Nigeria (Q22); 94% answered that Polio eradication Programme has filled a financial/human resources gap for polio vaccination that would otherwise not have been covered by government (Q7). However, only 33.3 % answered that WHO allocation of staff in support to polio vaccination was not sufficient (Q8) (3.03% answered "I don't know).

Graph 3 : Q8 of questionnaire



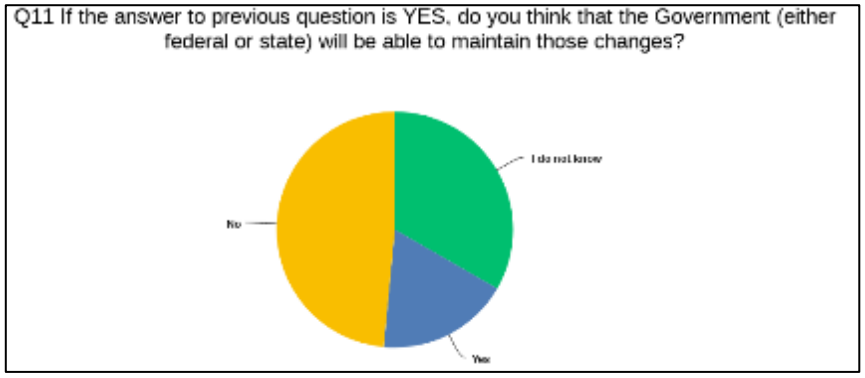
The 93.94% said that WHO coordination role was effective in the Programme (Q9). The majority (97%) answered that WHO intervention has been crucial in the achievement of vaccination targets (Q15) and 90% think that WHO intervention has helped in planning the allocation of resources (human and financial) (Q16). The majority (97%) of respondents answered that WHO intervention has helped the monitoring of vaccination campaign (Q17).

Graph 4 : Q10 of questionnaire



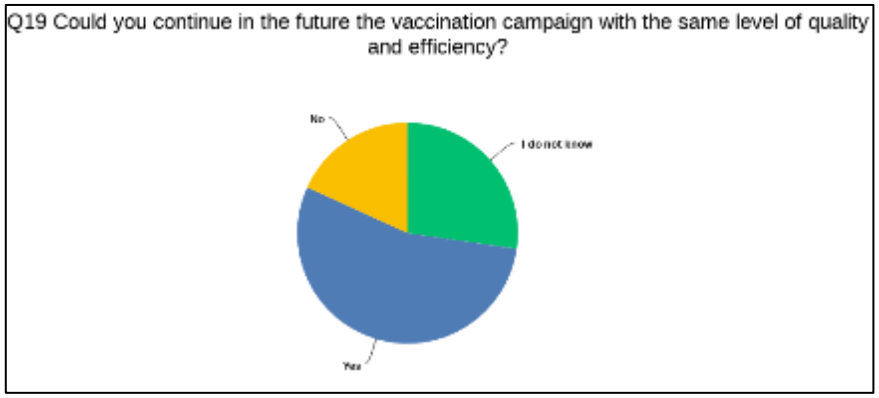
Almost 97% answered that WHO intervention on polio vaccination introduced important and relevant changes (Q10), and the following Q11 question shows that 48.48% think that the government will not be able to maintain those changes, whereas the 18.18% said yes.

Graph 5 : Q11 of questionnaire



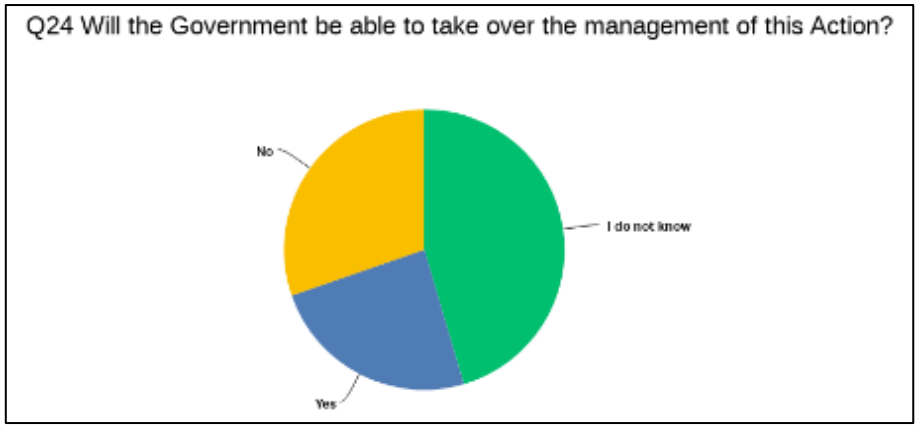
This is confirmed by Q19 where almost 19% said that they "[..] cannot continue in the future the vaccination campaign with the same level of quality and efficiency".

Graph 6 : Q19 of questionnaire



Triangulation with Q24 shows that 30% answered that the government will not be able to take over the management of the Programme's action, 24% answered yes and 45 % said they don't know.

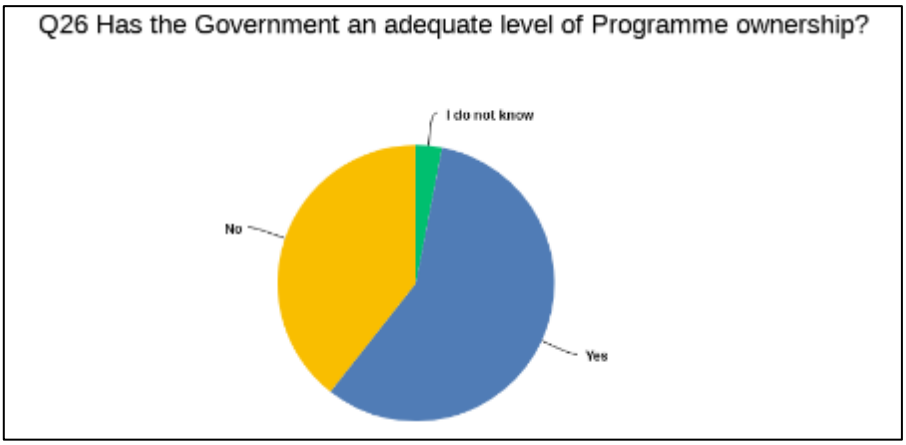
Graph 7 : Q24 of questionnaire



The majority (96.7%) of respondents think that the ability to monitor polio vaccination has improved (Q12) as well as the level of coordination (Q13). All respondents think that the level of surveillance reporting has improved (Q14) as well as local capacity, after the intervention (Q18).
The 90% of respondents said that the Programme has been effective in improving regular mechanisms of review of performances against defined priorities in the country (Q23). Almost

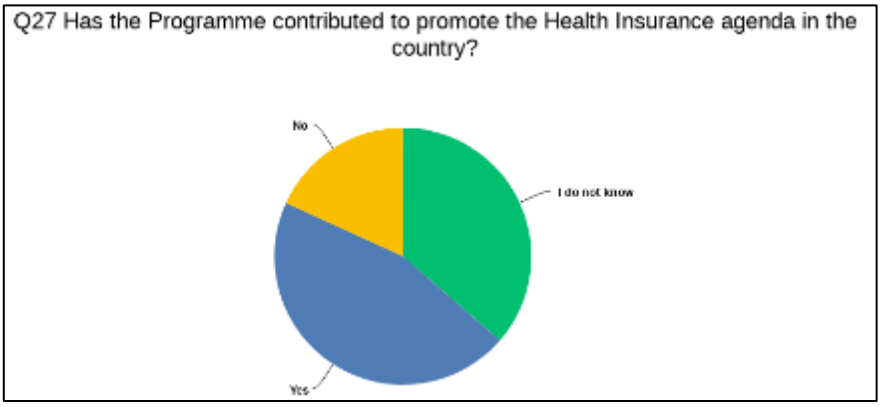
90% answered that the Programme has improved health service delivery in the country (Q25). On Q26, reports on the level of government ownership, slightly more than 50% considers it as adequate, whereas almost 40% answered no.

Graph 8 : Q26 of questionnaire



Questionnaire confirms that CSO and women have been involved in the vaccination campaigns (almost 90%) (Q20 and Q21)
As per Q27, almost half of respondents declared that the Programme has contributed to promote the Health Insurance agenda in the country, however, almost 40% of respondents answered that they don't know.

Graph 9 : Q27 of questionnaire



Q28 was an open question asking "What are the mechanisms that the government is putting in place to ensure sustainability after the end of the Programme?" Main mechanisms mentioned in answers were:

- *"Access to BHCPF will permit sustainable health service financing and PHC". Ownership and improve health service uptake".*
- *"Absorption of UN staff into routine immunisation programme/ Use of Polio structure. And Legacy at state and local government level".*
- *"Establishment of coordinating bodies for polio coordination in the state".*
- *"Engagement with Traditional and Religious institutions, community involvement".*
- *"Inclusion of some activities in the annual operational plan, budgeting and funding for some activities".*

Q29 was the second open question asking "What innovating element do you think is present in this Programme?" Main innovative elements mentioned were:

- *"Accountability"*
- *"Transparency"*
- *"Training and re-training of government and partners supporting polio/ Continuous capacity building/ Supportive supervision and evaluation of activities".*
- *"Community engagement strategy/ Involvement of Traditional and Religious leaders".*
- *"Special intervention teams/ Vaccination in accessible areas/ Microplanning (innovative and improved efficiency and accountability)".*
- *"Use of technical working groups, data driven action, dashboards".*
- *"Strong international and local political commitments/Extensive resource mobilisation and partnerships".*

2.17 Conclusions

The online survey tool has allowed the ET to perform cross tabulation in order to compare each group of respondent's answers and to confirm the findings from EQ and interviews. Questionnaire confirms the relevance of the Programme and its effectiveness in the achievement of vaccination targets; in addition answers show that the Programme has introduced relevant changes and innovative mechanisms that have been crucial for completing activities. Particular innovative elements have been the strategy involving the community but also religious leaders; these elements have been mentioned a number of times in answers. It also appears that the Programme has filled a financial and human resources gap for polio vaccination that would otherwise not be covered by the government. However, concerns as per sustainability can be noticed among respondents' answers. Some of the mechanisms that the government is putting in place to ensure sustainability - according to respondents- include the absorption of WHO staff in routine immunization and the development of a state strategic health development plan. The analysis of answers confirms the findings obtained by the study of relevant documentation and Key Informants interviews.

We shall also add consideration with regard to the Question 27. At first, we shall recall that this questionnaire is dedicated to assessing the perception of component 2 implementation and only one - Sokoto - out of the 18 states where the Questionnaire was submitted was also targeted by Component 3). We wanted nevertheless to check if in these states there was any perception regarding the Component 3 of the Programme (of which Health Insurance was an important part). Question and answers do not imply any judgement on improvement of the population coverage by NHIS. This issue is treated instead under Evaluation Questions

3 OVERALL ASSESSMENT

The FA for this Programme well captured the priorities of the health sector of Nigeria as they were stated in the most relevant policy documents.
The Programme appears consistent and synergetic, truly relevant to the health policies and strategies of the government of Nigeria and aligned with them. It also supports the regional priority for polio eradication.

There is enough evidence for a sufficient positive judgement of the Programme also in terms of effectiveness and efficacy of their implementation though there are some reservations with regard to general coordination of the Programme. To this regard we should also take into considerations the following factors: (i) the objective difficulties of coordinating two components so differently designed, (ii) the overambitious target for NHIS coverage and (iii) the difficulties created by the pandemic of COVID-19.

Despite the mentioned positive outcomes, doubts have been raised on the sustainability of activities that are in great majorities relying on the support of international partners and the technical assistance of international agencies (i.e. UNICEF, WHO). Despite all the advocacy efforts there is currently no evidence of an increased fiscal space in support of the health sector. A flag should be raised against the persistence of the current massive mechanism of aid that generates some counterproductive effects in terms of absolute reliance on foreign aid and delays in taking the political responsibility for prioritising investments and expenditures in the health sector.

We have also noticed the attainment of most Key Indicators that were indicated in the log frame of the Programme. The work done by WHO management in detailing all the targets for different outputs and outcomes was definitely remarkable, as well as the availability of sources of verification (relevant extensive documentation). However, delays in the attainment of targets were found regarding Component 3 due to the disruption generated by pandemic on its activities. There is currently an estimation for about € 900,000 of the funds allocated for Component 3 that will remain unspent due to this disruption. To this regard we have taken notice of a request for a no-cost extension of Component 3 made by the Commissioners of Anambra and Sokoto, by FMOH and by the CEO of National Health Insurance Agency.

Visibility of the Programme: the WHO has guaranteed consistently an important visibility to the EU funding of the Programme. The Evaluation Team has taken stock of relevant materials (i.e., logo, leaflets, regularly updated website) where the support of the EU has been well highlighted and shared with the community and general public, especially with regard to the Component 2 of the Programme. Activities under Component 3, which have been impacting directing the top and mid management more than the public, have been also consistently highlighting the support of the EU. The latter has been well also proved by relevant staff interviewed. For instance, this has also been proved during meetings with the highest level of the hierarchy as the 2 Commissioners for health and Chairman of Health Committee of the Senate have expressed high appreciation for the support of the EU and also given suggestions for future collaboration.

Communication: The Evaluation Team is fully satisfied of the channel of communication established with the Reference Group that has allowed the full implementation of the schedule of interviews and meeting planned by the Evaluation Team during the Desk Phase. The participation to interviews and meetings of the Key Informants has been excellent with a high level of openness and collaboration. The tools utilised for distance communication (ZOOM and WhatsApp) have been proved of being effective in all states and also the Key Informants have shown a strong familiarity with the utilisation of these tools.

Documentation: A relevant and extensive documentation has been collected, especially during the desk phase, thanks to the collaboration of major stakeholders of the Programme. The list of documents, attentively reviewed by the Team, is presented in Annex C of this report.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 Lessons learned

Here below we present the major lessons learned in terms of strengths and weaknesses in the implementation of the 2 components.

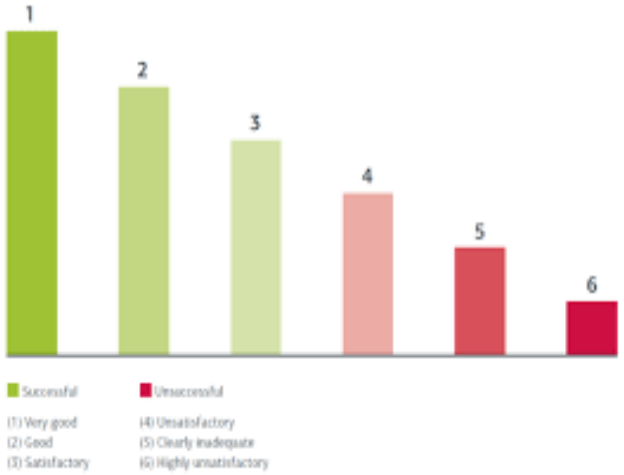
Table 11 : Strengths and weaknesses

Strengths Component 2	Weaknesses Component 2
• The involvement of traditional leaders and the community in the vaccination campaign has been quite relevant and could be extended to other activities. • The visibility of EU Programme has been quite high, especially in comparison with the size of EU contribution to the WHO eradication programme. • The attainment of almost all key targets as indicated in the logframe of the Programme. • The Programme has implemented a number of successful special Interventions to increase access to children in insecure areas • The widespread presence of WHO up to LGA and in some case ward level has facilitated implementation and supported coordination of activities	• The "Transition phase" proposed by WHO has not yet been approved though WHO has started already to phase out. • Doubts on the capacity of PHC to integrate the task of polio vaccination and surveillance into the routine mechanisms. • No guarantee that the "motivation" mechanisms for volunteers and communities will be adopted by government authorities. • If insecurity continues, access to eligible children for vaccination and surveillance will be hampered.
Strengths Component 3	**Weaknesses Component 3**
• The support to health reform agenda has been consistent for the whole period and aligned to all different corrections made by administration. • A high-level technical assistance that has supported consistent progresses, though slow, in determining the legal/procedural framework for NHIS. • Sufficient visibility guaranteed to the EU Programme by WHO (awareness of all key stakeholders both at state and federal level). • Satisfactory capacity building at state level for HIS, planning/budgeting unit at MOH and in the state Health Insurance agency. • Relevant experiments of involving the private sector in financing the coverage NHIS of poor segments of the population (Adoption model). • The introduction of mobile technology for enrolment into the NHIS has been proved as effective and deserve to be replicated.	• The strengthening of PHC delivery services (supply side) does not go in parallel with the offer of enrolment into the insurance scheme. • Motivation mechanisms for data collection and education (i.e. nutrition programme) have no guarantee of continuation after the end of the Programme. • No guarantee of appropriate financing from state MOH budget to the maintaining and strengthening of services developed through capacity building i.e. HIS, Planning/budgeting unit, NHIS agency). • No decision taken as yet on increasing of fiscal space for health nor for adequate increase of existing budget lines of MOH at state level. • Delays on upgrading of legal frameworks and availability of financial resources have produced no tangible progress in coverage by NHIS

4.2 Conclusions

All the DAC evaluation criteria have been in general met in a satisfactory manner with one exception. At the end of the evaluation process a score has been assigned to each one in accordance with the graph below.

Graph 10 : DAC criteria score card



Source: KfW evaluation criteria

1. **RELEVANCE:** good relevance with regard to priorities stipulated by strategy and policy documents for the health sector and good aligned with them. All the findings related to Evaluation Questions No. 1a are confirming this conclusion. SCORE: 2

2. **EFFECTIVENESS**: sufficient effectiveness with respect to the results that have been achieved almost entirely for both components. This conclusion is based on findings and judgements related to Evaluation Questions No. 1b, 2a, 3a, 4a, 5a. SCORE: 3

3. **EFFICIENCY**: a sufficient degree of efficiency has been shown during implementation of the Programme. This conclusion is based on findings and judgements related to Evaluation Questions No. 6a, 7a and from an attentive assessment of the achievement of targets mentioned in the Programme logframe. SCORE: 3

4. **SUSTAINIBILITY:** serious concerns with regard to sustainability of activities implemented by the Programme and their continuation by the government of Nigeria. The findings from Evaluation Questions No. 8a, 9a and related judgements lead to above conclusion. SCORE: 5

5. **CROSS-CUTTING ISSUES**: sufficient as the Programme does not target specific cross-cutting issues but includes activities that involve women and community during implementation of activities. Cross-cutting issues were checked across all Evaluation Questions and specifically in relation to Evaluation Question No. 3b. SCORE: 3

6. **COHERENCE:** good as the objectives of the Programme were in great part achieved with limited impact on results of component 3 due to the sole contrasting factor of COVID-19 pandemic. Findings and judgements related to Evaluation Question No.10a are supporting this conclusion. SCORE: 2

7. **EU ADDED VALUE**: Limited specific added value for Component 2 while Component 3 appears to contain a stronger and peculiar technical added value. Findings and judgement related to Evaluation Question No. 4b are supporting this conclusion. SCORE: 3

8. **VISIBILITY:** Excellent visibility for Component 2 while Component 3 had a satisfactory visibility among mid and upper management concerned staff only. This conclusion is based on a specific analysis of visibility activities, which is presented in Chapter 3. SCORE: 2

4.3 Recommendations

Based on the findings and related judgements of the evaluation mission the Evaluation Team is proposing hereinafter several recommendations. To this regard we shall recall that this exercise was supposed to be a mid-term evaluation consequently ET was supposed to produce mainly recommendations for the completion of the Programme, beside a number of recommendations for future interventions of the EU in the health sector in Nigeria. However, due to a series of unforeseen delays (i.e. the impact of the COVID-19 pandemic), the evaluation has taken place only during the last semester of Programme implementation. Therefore, the following recommendations, with the exception of the first one, are related to future actions to be eventually undertaken by the European Union. They should all be considered equally relevant with the only caution that they have been generated by observations made during a specific assignment not from a thorough health sector review.
The following recommendations have been also drafted with the aim of improving the compliance of EU future actions to DAC criteria; especially with regard to criteria 1, 2, 3, 4 and 7, which appear as the ones that need to be strengthened the most.

- The no cost extension for 6 or 8 months for Component 3 should be considered by the EU Delegation. This consideration is based on the special conditions determined by the pandemic, and the urgency to allow the completion of activities (crucial for the sustainability of the Programme) disrupted by the pandemic[14]. Recommendation relevant to criteria 1 and 4.

- The results achieved in Anambra and Sokoto states by Component 3 should be capitalised. Future Actions should consider the replication of best practises for capacity building on HIS, NHIS and health financing established by this Programme (see par. on lessons learned and logframe matrix). Recommendation relevant to criteria 2 and 7.

- For future interventions it should be considered by the EU Delegation that management/governance (see findings of EQs) of similar programmes can be strengthened. Programmes with three very different components, two implementing contracts and different national stakeholders would be better governed and managed by 3 different PSC or by one PSC with 3 strong sub-committees and better defined ToR for each one. Such a different approach will also contribute to strengthening synergies and ownership. Recommendation relevant to criteria 3 and 4.

- The EU policy dialogue should be strengthened in order to pursue a stronger political commitment in favour of health sector. An appropriate advocacy for prioritizing health expenditures within government budget (including but not only the creation of fiscal space) and consequently minimising the risk of delegating it to international agencies shall be applied. The added value of EU Actions will also be enhanced by such an effort. Recommendation relevant to criteria 1 and 7.

[14] The Evaluation Team understand the difficulties to implement this recommendation as at the time of finalising the evaluation report the programme and financial agreement have expired, but this recommendation was originally considered before the end of the programme and is still relevant and important.

- The progressive reduction of such a dependency can be obtained through the development of a consistent SWAP (Sector Wide Approach Programme) approach at state level, which could strengthen existing synergies and better support PHC services.

- The support to BHCPF (see EQ 7a, page 34), or, as an alternative, to Gates Foundation approach of MoU with states (for details see par 1.4.3, page 23), should be considered as appropriate implementation mechanisms. Recommendation relevant to criteria 1, 2 and 4.

- Future interventions should give priority to strengthen PHC service delivery in a sustainable way, namely by advocating and supporting government increase of share of health expenditures. This type of interventions should consider implementing activities that go directly in support of LGAs. Recommendation relevant to criteria 1, 2, 3 and 4.

- A future support to PHC, including polio vaccination campaign, should consider that the involvement of the community and religious leaders have been crucial for the Programme, particularly in reaching missed children and in enlightening to women the importance of children access to immunizations. Recommendation relevant to criteria 2 and 3.

- Further interventions in favour of vaccination and surveillance under EDF should be considered for support only if integrated into the PHC system as part of routine programmes for immunization and surveillance. In parallel emergency interventions should be considered separately. Recommendation relevant to criteria 2, 3 and 4.

- EU further support to the implementation of the National Health Insurance Scheme should be considered. However, due to the complexity of the exercises and the different challenges ahead, it is also suggested to mobilize a preliminary independent review of the ongoing reform. This shall focus on the challenges and proposed solutions for both the supply and demand sides in addition to the challenges for guaranteeing the coverage of the poorer segment of population. Recommendation relevant to criteria 1, 2 and 4.

- In any case the implementation of financing "motivation" mechanisms for routine tasks should be avoided, instead support to the establishment of local government/states incentives systems based on performance should be considered, not to mention upgrading of salary scale and timely payments of salaries. Recommendation relevant to criteria 2 and 4.