Nigeria Governors' Immunization Leadership Challenge

Evaluation Report

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Contents

Glossary of terms

AC	Abuja Commitments
AFP	Acute Flaccid Paralysis
BMGF	Bill and Melinda Gates Foundation
CDC	Centre for Disease Control
DFID	Department for International Development
DPT	Diphtheria Pertussis Tetanus
HR	High Risk
IPDs	Immunization Plus Days
LGA	Local Government Area
LIO	Local Immunization Officer
LQAS	Lot Quality Assurance Sampling
NGF	Nigeria Governors' Forum
LR	Low Risk
NPHCDA	National Primary Healthcare Development Agency
OPV	Oral Polio Vaccine
PEI	Polio Eradication Initiative
PHC	Primary Health Centre
RI	Routine Immunization
USAID	United States Agency for International Development
WHO	World Health Organization
WPV	Wild Polio Virus

I. Executive Summary

This review is a process evaluation of the Nigeria Governors' Immunization Leadership Challenge carried out with the objectives to:

i. Assess the extent to which the Challenge influenced political commitment to polio eradication and routine immunization goals amongst State Governors;
ii. Determine whether or not such political commitment translated into local actions taken by senior government officials;
iii. Understand, to the extent possible, how these changes in political commitment and action translate into states' performance against polio and routine immunization outcome goals.

The retrospective analysis included a desk review and analysis of quantitative data related to the polio program and its performance from 2011 to 2012, qualitative interviews of key stakeholders and analysis of media coverage of the Challenge. The Challenge, implemented between January and December 2012, measured changes in political commitment to the polio and routine immunization programs through 4 subgroups of programmatic indicators focusing on leadership, commitment, ownership and program results.

Findings from this evaluation show that there was significant improvement in leadership and commitment among state governors between 2011 and 2012, during the Challenge period. Although performance was variable between states, average performance in leadership, commitment, and results indicators improved. For example, the proportion of governors who met with LGA chairmen to discuss polio/RI rose from 30 percent to 57 percent between 2011 and 2012. More interestingly, measures of political commitment increased more significantly among governors of High Risk (HR)[1] states, who were the primary targets of the Challenge. As such, by 2012, political leadership and commitment were strongest in the HR states.

Respondents in the qualitative interviews largely believe that the Leadership Challenge played a strong role in stimulating increased political commitment among governors. However, because the period of the Challenge overlapped with other interventions aimed at increasing political commitment (such as the President's role modeling, focus by international community, and a highly engaged Governors' forum), it is difficult to tease out how much of the change in leadership and commitment is attributable to the Challenge alone.

Knowledge of the Challenge was quite high among state officials (health commissioners, executives of state Ministries of Health and Primary Health Care Development Boards). Many also reported that their commitment to polio was strengthened during the Challenge, mostly due to pressure from the governors. However, a few complained of being properly engaged rather late in the year.

[1] HR states are the 11 states classified by WHO/CDC and NPHCDA as high risk for polio.

Although performance against indicators measuring leadership and commitment improved remarkably, only modest improvements in program results were recorded, particularly among HR states. Our findings suggest two main reasons for why large increases in leadership, commitment and ownership did not correspond with comparably significant increases in program results over the same time period – a lack of real commitment at the frontlines (LGA level) and poor demand for vaccines due to misinformation in some communities in the HR states. It is noteworthy that neither of these factors was a direct target of the Challenge.

Respondents generally believed that the Challenge was implemented appropriately, but had a few suggestions:

- Targeting the Challenge at state governors was most appropriate, as they make the major funding decisions at the state level and have significant influence on other sub-state stakeholders, including LGA chairmen. However, they recommend inclusion of other state-level and LGA officials as co-targets of the Challenge, alongside Governors in future.
- The Challenge indicators were mostly appropriate for its purpose. However, a couple of respondents recommended an indicator for polio program funding that is easier to measure and the data easier to collect.
- The promise of recognition by Mr. Bill Gates, Co-Chair, BMGF was a far more compelling incentive for state governors than the financial reward. However, LGAs, who have much smaller operating budgets, may find the financial incentive more compelling. As such, the Challenge should emphasize non-monetary over monetary rewards when targeting governors.

Based on findings from this evaluation, we offer the following suggestions towards future interventions like the Leadership Challenge:

1. Some of the indicators need to be reviewed to include more precise and sensitive indicators that would better represent the likelihood of results performance. For example, beyond release of funds for immunization broadly, a more sensitive indicator would be amount of funds reaching end users for downstream activities such as vaccine transportation to facilities.
2. Future interventions like this should target governors, engaging them through the NGF or other relevant forum where peers can pressure one another. Also, in order to ensure that any effects are cascaded down to frontline stakeholders and results are achieved, technical personnel (health commissioners, Heads of Primary Health Care Development Boards etc) need to be engaged in a more systematic way and earlier on in the implementation process.

II. Introduction

The 2012 Nigeria Governors' Immunization Leadership Challenge (Challenge) came about from a visit by Mr. Bill Gates to Nigeria in September 2011, when all 36 State Governors re-affirmed their adoption of the 2009 Abuja Commitments to polio eradication. To encourage Governors to fulfill these commitments, the Bill & Melinda Gates Foundation (BMGF), in collaboration with the Nigeria Governors' Forum (NGF), announced the 2012 Governor's Immunization Leadership Challenge. Through the Challenge, seven states were selected for awards in two categories:

i. One winning state with the best performance in 12 pre-defined indicators was selected from each of the six geopolitical zones in the country.
ii. One state with the overall most improved performance in the same indicators from 2011 to 2012 was also selected for an award in the 'most improved' category.

BMGF incorporated two types of performance rewards for winning states into the Leadership Challenge:

i. The Governor in each winning state will receive personal recognition by Mr. Bill Gates, Co-Chair, BMGF.

   In addition, a $500,000 grant will be awarded to each winning state for a priority project to be selected by the state but with a focus on health-related Millennium Development Goals to be selected by the state. Winning states that were willing to contribute $250,000 would receive an additional matching grant of $250,000 from BMGF to make a total of $1 million available for the state's priority projects.

i. Objectives of the evaluation

BMGF engaged Solina Health to conduct an independent evaluation of the Leadership Challenge. The process evaluation of the 2012 Challenge, which took place between February and May 2013, aims to:

i. Understand to what extent the Immunization Leadership Challenge influenced political commitment to polio eradication and routine immunization goals among Governors.
ii. Understand perceptions about whether or not such political commitment translated into local actions taken by senior government officials (Health Commissioners, PHC Directors, etc.) to improve polio and RI performance
iii. Understand, to the extent possible, how these changes in political commitment and action translate into states' performance against polio and routine immunization outcome goals, and to understand the factors external to the Challenge that influence such performance.

This evaluation is neither to assess states' performance in Polio Eradication Initiative (PEI), routine immunization (RI) or other efforts, nor to select winning states in the Challenge.

III. Methodology

1. Study design

The evaluation was conducted as a **retrospective analysis** that sought to identify trends in political leadership, ownership and commitment and polio program results from 2011 (pre-Challenge) through 2012 (Challenge period). To achieve its objectives, the analysis included 3 core components:

i. Desk review and analysis of quantitative program data, quarterly Abuja Commitment (AC) and polio program results data for 2011 and 2012, Leadership Challenge (Challenge) data for 2012.
ii. Qualitative interviews of key immunization stakeholders at the National, state and LGA levels.
iii. Review and analysis of media coverage of the Challenge, PEI and RI during the period of the Challenge.

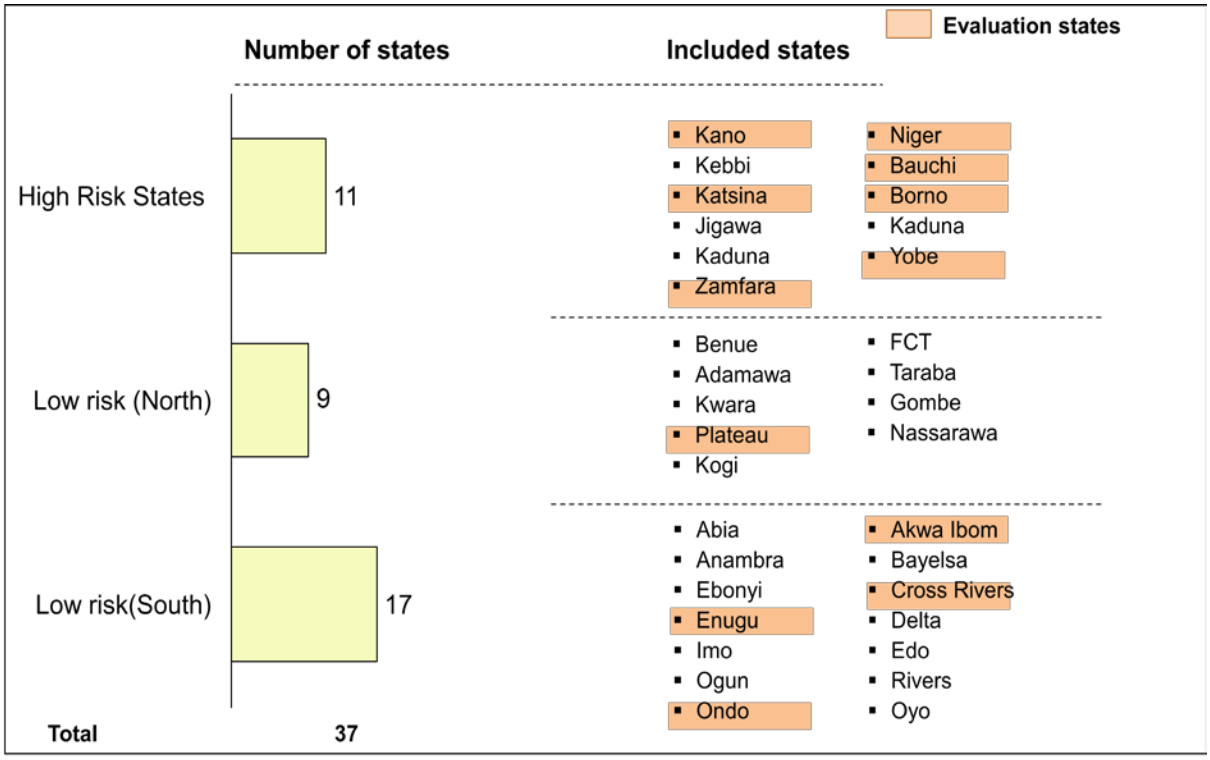
2. Selection of evaluation states, LGAs and respondents

Although the Challenge was implemented nationally, the polio program outcomes targeted by the Challenge were most relevant in the High Risk states and those states with the highest polio burden. As such, selection of states, LGAs and interview respondents for the qualitative interviews and media analysis was based on preliminary analysis of polio risk and program performance. States were categorized as High Risk (HR) states (n=11), Low Risk (LR) Northern states (n=9); and Low Risk Southern (n=17) states. This classification is based on polio risk classification of states by WHO, CDC and NPHCDA. Twelve (12) evaluation states were then purposively selected to maximize relevant insights as follows:

i. Polio incidence: 7 polio affected states were selected alongside 5 polio non-affected states for comparison.
ii. Geo-political representation: 8 states in the north and 4 states in the south were selected, ensuring at least 1 state per geo-political zone.
iii. Performance in Challenge indicators in Q1 to Q3 of 2012: 4 high performing (>16 points), 4 mid-performing (11-16 points) and 4 poor performing (<11 points) were selected to reflect the spectrum of performance.

The purposeful selection of 7 HR and 5 LR states ensured that while on the one hand, there was adequate information to form a perspective on the HR states (where certain Challenge outcomes were most pertinent), there was also sufficient data from LR states for meaningful comparison. Two Local Government Authorities (LGAs) were selected in each state for the evaluation exercise based on risk ratings (CDC-Global Good combined risk scores as of September 2012, Polio cases in 2011-2012 and 2012 DPT coverage). Appendix 1 shows the list of LGAs selected in each state, and their risk ratings.

Figure 1 – Distribution of Leadership Challenge evaluation states.



Interview respondents were selected among immunization stakeholders from the three tiers of government and other partners as follows:

i. National level key opinion leaders from the Federal Ministry of Health, Presidential Task Force on Polio Eradication, National Primary Health Care Development Agency (NPHCDA), Nigeria Governors' Forum (NGF), and Development Partner institutions (WHO, UNICEF, DFID, USAID, Rotary International)

ii. State level stakeholders including State Governors, Deputy Governors, Health Commissioners, State Immunization Officers, and State-level polio eradication partners (WHO, UNICEF)

iii. LGA level interviewees included LGA Chairmen from selected LGAs, Local Immunization Officers (LIOs), and traditional leaders

A total of 114 interviews were conducted for the evaluation as shown in table 1. For the media analysis, a media consultant was engaged to conduct national and state level interviews based on a database of national and state-focused (for the 12 evaluation states) media outlets including television, radio, and newspapers.

Table 1 – Profile and distribution of interviews for qualitative interviews

Stakeholder	National	High Risk States	Low Risk States	Total
Governors / Deputy Governors	NA	8	2	10
National Officials	11	NA	NA	11
State Officials	NA	24	19	43
State Partners	NA	5	4	9
LGA Chairmen	NA	10	6	16
LGA Officials	NA	15	10	25
Total	11	62	41	114

3. **Data collection and analysis**

i. Quantitative data analysis

Abuja Commitment (AC) and Leadership Challenge (Challenge) indicator data was obtained from WHO and NPHCDA Monitoring & Evaluation Working Group; program documents and additional data were obtained from BMGF; further background and contextual information was obtained through interviews with NGF. AC indicator scores were based on self reported data only while Challenge scores reflected submitted evidence of actual performance. Appendix 1 shows the data sources and scoring methodology for the Challenge indicators. The maximum achievable score for LR states was 54 points, while HR states could score up to a maximum of 67 points. Actual total scores for each state were converted to a percentage of the maximum achievable points for inter-state comparability. Likewise, for the core value analysis – assessing the four indicator categories of leadership, commitment, ownership and results – indicator scores were converted to percentages of total achievable scores for each core value.

ii. Qualitative interviews

Semi-structured interview guides were used for different categories of respondents. The qualitative data was analyzed using a thematic approach, whereby key themes were identified and findings analyzed along those themes. Findings were compared for the three main categories of respondents – state governors/deputy governors, national level stakeholders and state/LGA stakeholders. It is important to note that although BMGF provided input in the development of interview tools, the analysis was carried out independently of the Foundation. The analysis and findings are strictly as determined by the Solina Health team. Because only one of the three LR northern states was included as an evaluation state, stratified analysis of the interviews was done with just two strata – HR and LR states.

For the media analysis, a media-specific interview guide and data collection template was used for interview of stakeholders selected from a database of national and state-focused (for the 12 evaluation states) media outlets, including television, radio and newspapers.

IV. Findings

The findings of this evaluation are presented in four sections:

- The first section describes the indicators measured for the Challenge, and the distribution of scores among states.
- In the second section, we have presented performance and changes in leadership, commitment and program ownership, the factors driving these changes, as well as the perceived effects of the Challenge on these trends.
- In the third section, we have discussed performance in program results and presented the relationships observed between leadership, commitment, ownership and program results. This section also discusses reasons for the observed changes in results performance and perceived effects of the Challenge on polio and RI programs.
- In the final section, we have presented findings on the design and implementation of the Challenge itself, including perceptions on the target population, indicators, incentives and implementation.

1. Overall Leadership Challenge Performance

a. Overview of Leadership Challenge indicators

Performance of states in the Leadership Challenge was assessed based on scores in 4 subgroups of programmatic indicators that measure leadership, commitment, ownership and program results. Figure 2 shows the indicators and maximum achievable scores for each subgroup.

Figure 2 – Leadership Challenge indicators and maximum achievable scores

	Indicator	Threshold	Maximum achievable score
Leadership	• Meeting between Governor and LGA chairmen to discuss priority actions to improve RI/polio	• > or = 1 meeting per quarter	4
	• Governor meeting with Traditional leaders	• > or = 1 meeting per quarter	4
	• Proportion of LGAs where daily IPDs review meetings are chaired by a high level LGA official	• >=90% LGAs in each IPDs	4
Commitment	• Personal involvement of Governor in public event on immunization	• > or = 1 meeting per quarter	4
	• State task force meeting on polio/RI	• > or = 1 meeting per quarter	4
Ownership	• Evidences of monthly budget release for RI	• > or = 1 meeting per quarter	12
	• Evidences of monthly planning and review meeting on RI	• > or = 1 meeting per quarter	12
Results	• Two LQAS (Lot Quality Assurance Sampling) conducted.	• >=90% coverage after each IPD	2 or 7[1]
	• Proportion of wards with >10% missed children	• <=10%	2 or 7[1]
	• % LGAs that meet the 2 core AFP surveillance indicators	• 90% at the end of the review period	2 or 7[1]
	• Oral Polio vaccine status of non-polio AFP cases (% >3 doses of OPV)	• 90% with >3 doses by the end of the review period	4
	• %improvement in immunization coverage over the 1year award period	• >=90% DPT3 coverage or 5% increase	4

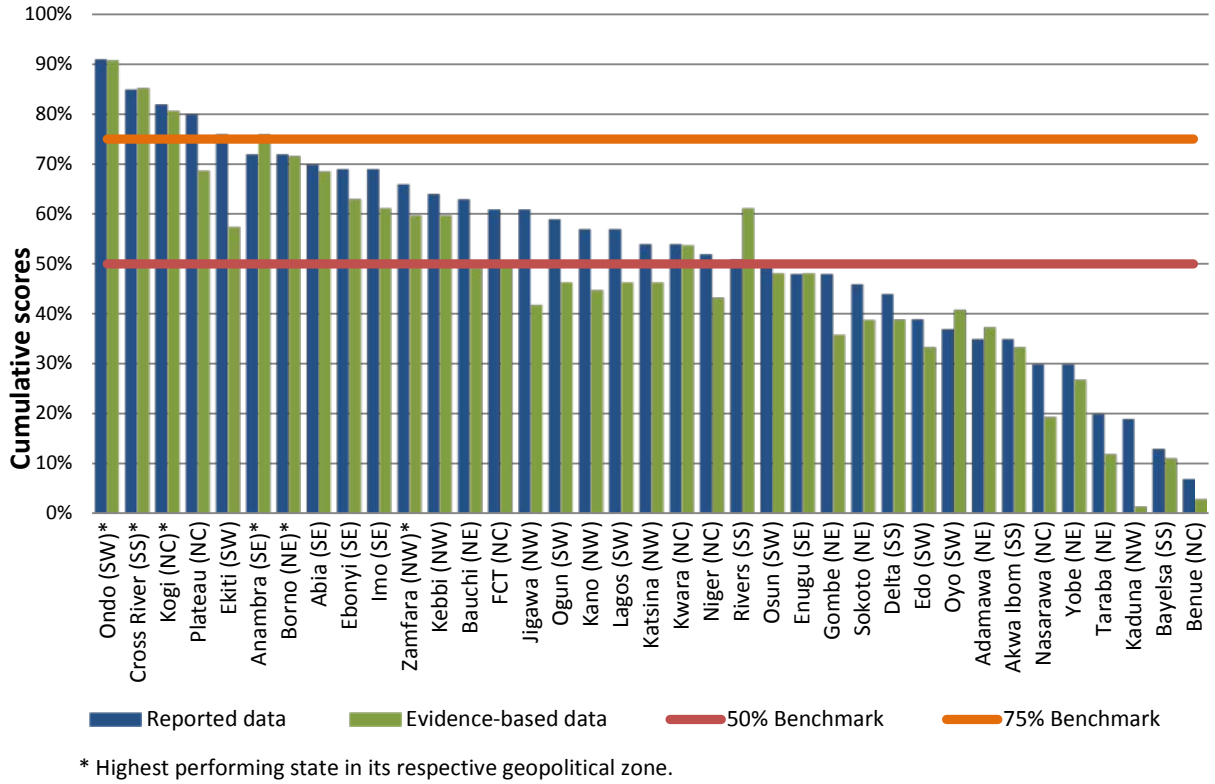
1. High risk states can score up to 7 while low risk states can score a maximum of 2 points

For the three indicators related to the implementation of polio immunization campaigns (proportion of LGAs where daily IPDs review meetings are chaired by a high level LGA official, LQAS sampling conducted after IPDs, and percent wards with >10 percent missed children), maximum achievable scores varied based on the number of polio campaigns conducted by state throughout the year (7 for HR states versus 2 for LR states). However, scores were adjusted statistically to make scores achieved directly comparable across states. Ownership indicators, where all states could score up to 24 points, had the most effect on overall performance.

b. Overall Leadership Challenge performance

Performance varied widely between states, ranging from 3 percent in the poorest performing state to 91 percent in the highest scorer. LR southern states (n=17) generally performed best as a category with an average score of 53 percent. HR northern states (N=11) scored an average of 44 percent while LR northern states (N=9) scored 40 percent on average as a group. The distribution of states' performance in both the self-reported and evidence-based data is shown in figure 3.

Figure 3 - Performance against maximum total score by state

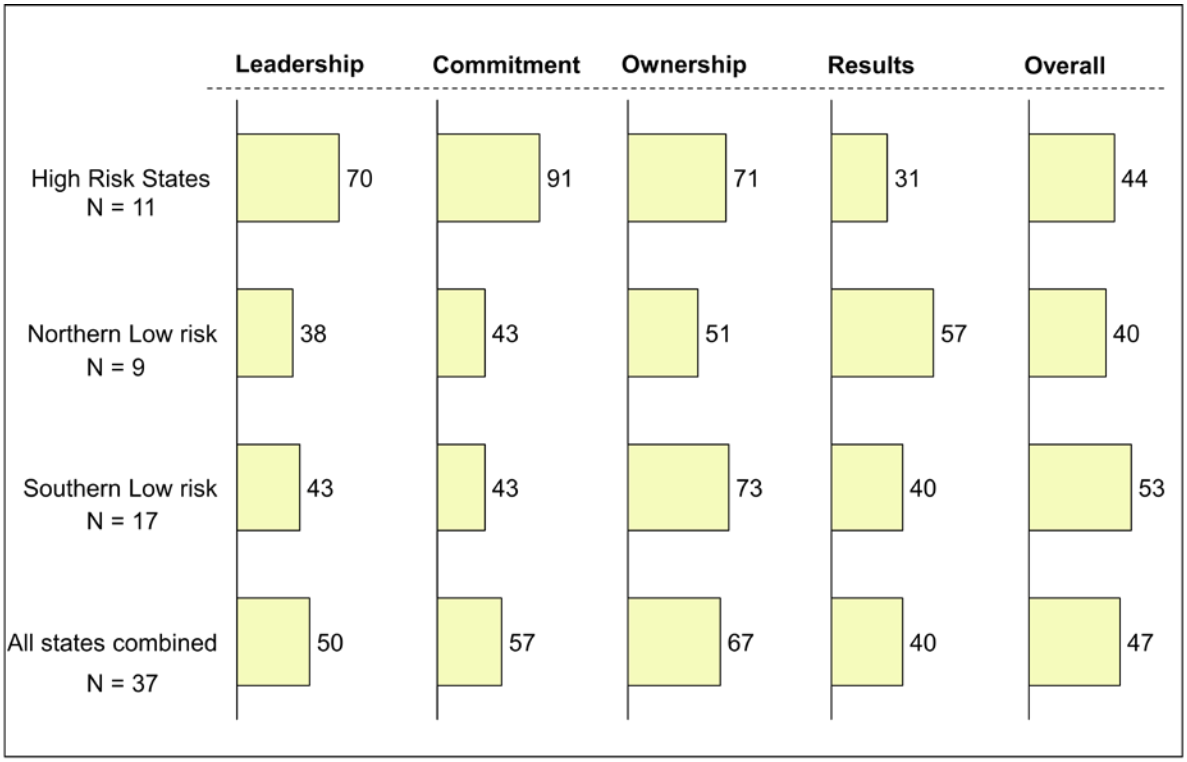


* Highest performing state in its respective geopolitical zone.

In the subgroup of indicators that measured leadership, commitment, ownership and results, the average scores among the categories of states were 50 percent, 57 percent, 67 percent and 40 percent respectively. The scores of the different categories of states in the different subgroups of indicators are shown in figure 4 below.

Southern LR states scored higher overall, mostly driven by more consistent funding commitments reflected in the ownership scores.

Figure 4 – Breakdown of scores for each category of states



SOURCE: 2012 Leadership Challenge Scores

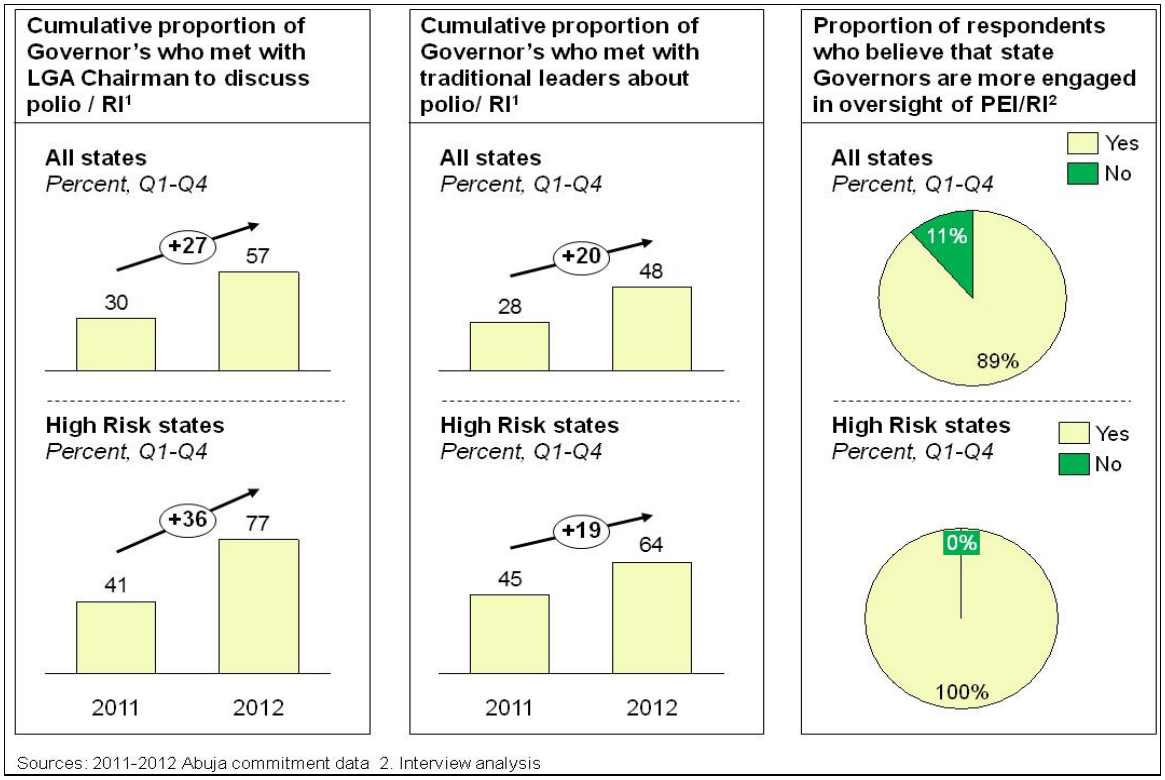
2. **Political Commitment, Leadership and Program Ownership**

a.Change in Leadership and Commitment

There was significant increase in polio program leadership among state governors from 2011 to 2012. Furthermore the increase in political leadership among governors increased even more significantly among HR states. Figure 5 below shows the change in leadership indicator performance among governors from 2011 to 2012, as measured by AC data. **Although commitment also increased among governors nationwide between 2011 and 2012, the improvements were significantly more marked in HR states** (figure 6)**.**

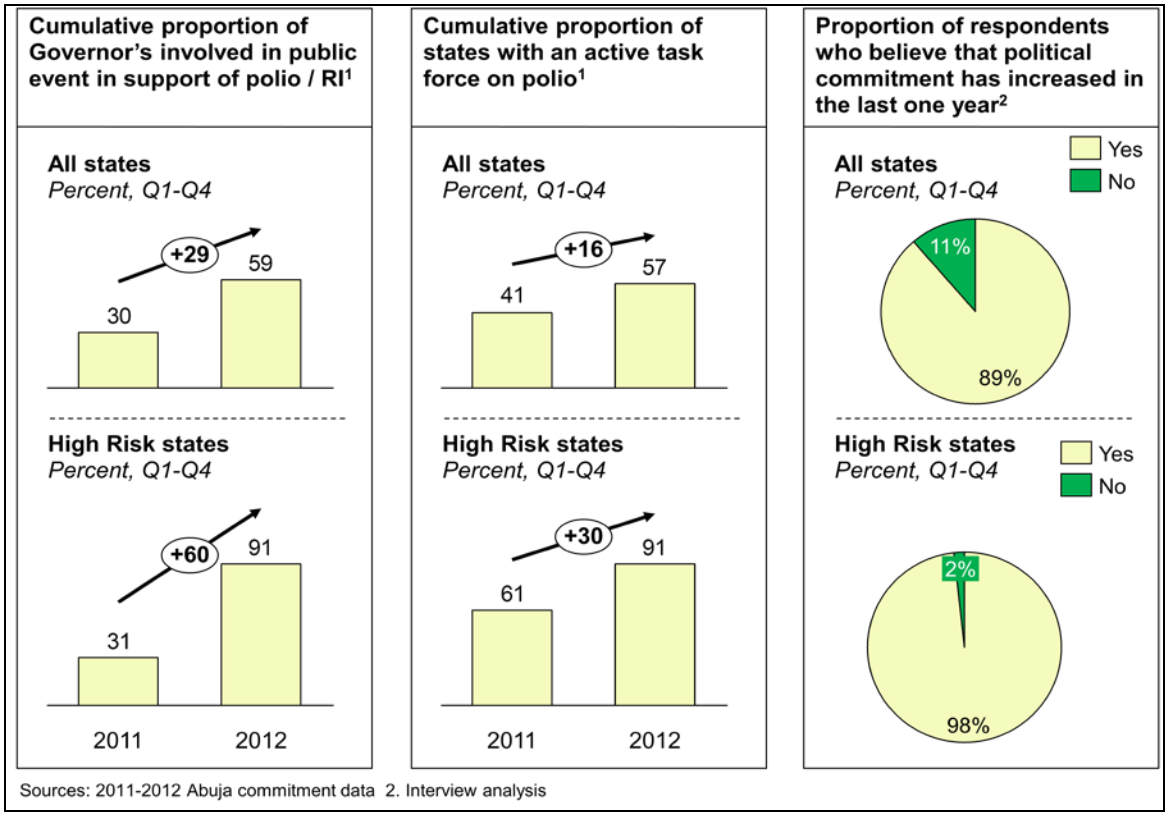
In the qualitative interviews, respondents overwhelmingly expressed the perception that governors' commitment had increased in their states from 2011 to 2012. In keeping with the quantitative findings, perceptions of an increase in commitment appeared to be more significant in HR states.

Figure 5 – Actual and perceived changes in leadership among Governors, 2011-2012



Note: The proportion of state governors satisfying each indicator was determined for each quarter, and the cumulative proportion is the average of the proportions for all 4 quarters in each year.

Figure 6 – Actual and perceived changes in commitment among Governors, 2011-2012



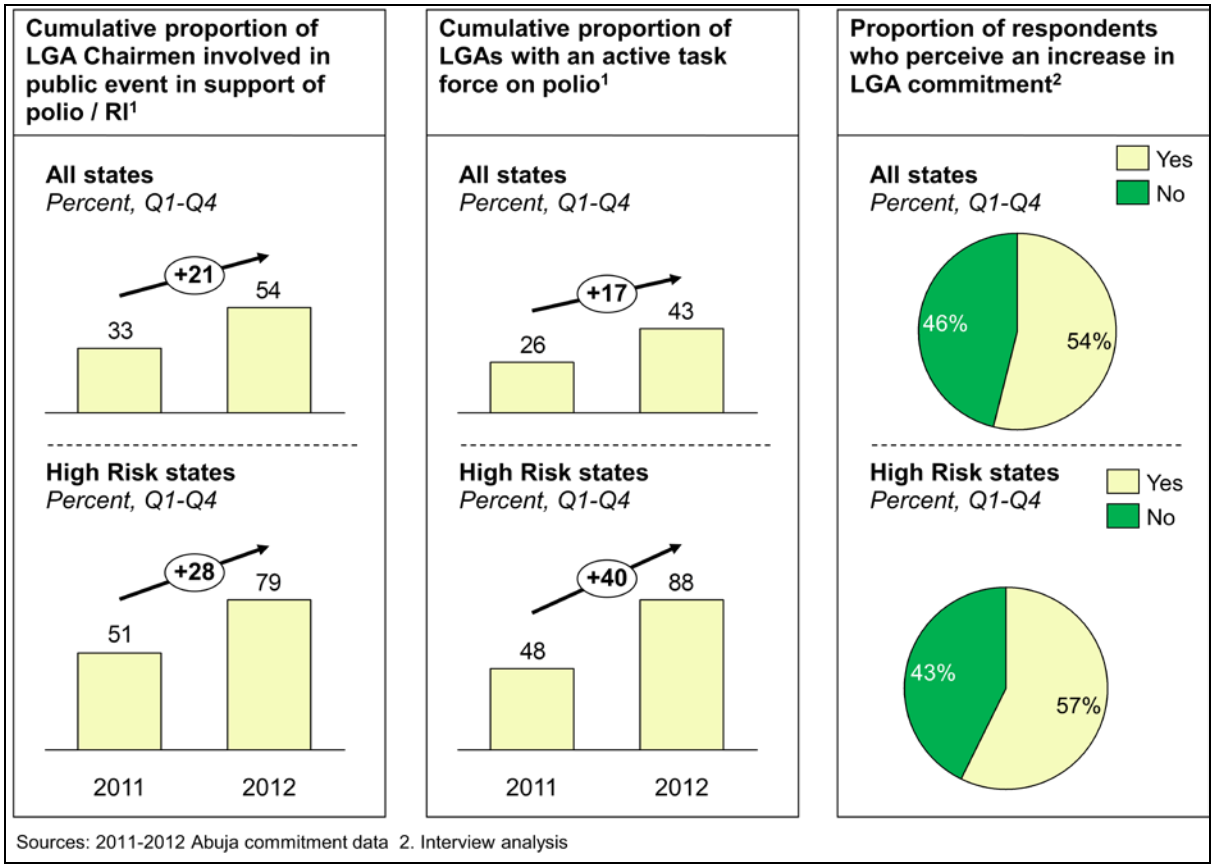
Note: The proportion of state governors satisfying each indicator was determined for each quarter, and the cumulative proportion is the average of the proportions for all 4 quarters in each year.

- *"We have noticed an unprecedented level of commitment from the government; they are doing their best in terms of realizing this goal by setting up task forces and charged the responsibility of regulating these task forces to the deputy governor who is active in his activities. We are not saying all is completely well, but there are definitely improvements in commitments..." - State level Development Partner*

- *"The Governor shows true commitment by attending flag-offs and increasing the funding." - State Official*

Although improvements in commitment was more modest among LGAs, improvements in commitment at the LGA level were stronger in LGAs in HR states compared to LGAs in LR states, as shown in figure 7.

Figure 7 – Actual and perceived changes in LGA-level commitment, 2011-2012



Note: The proportion of state governors satisfying each indicator was determined for each quarter, and the cumulative proportion is the average of the proportions for all 4 quarters in each year.

As such, by 2012, leadership and commitment were strongest in the HR states. **Among LR states, Southern LR states performed better than Northern LR states.** This trend was consistent across indicators for both leadership and commitment as shown in appendix 3.

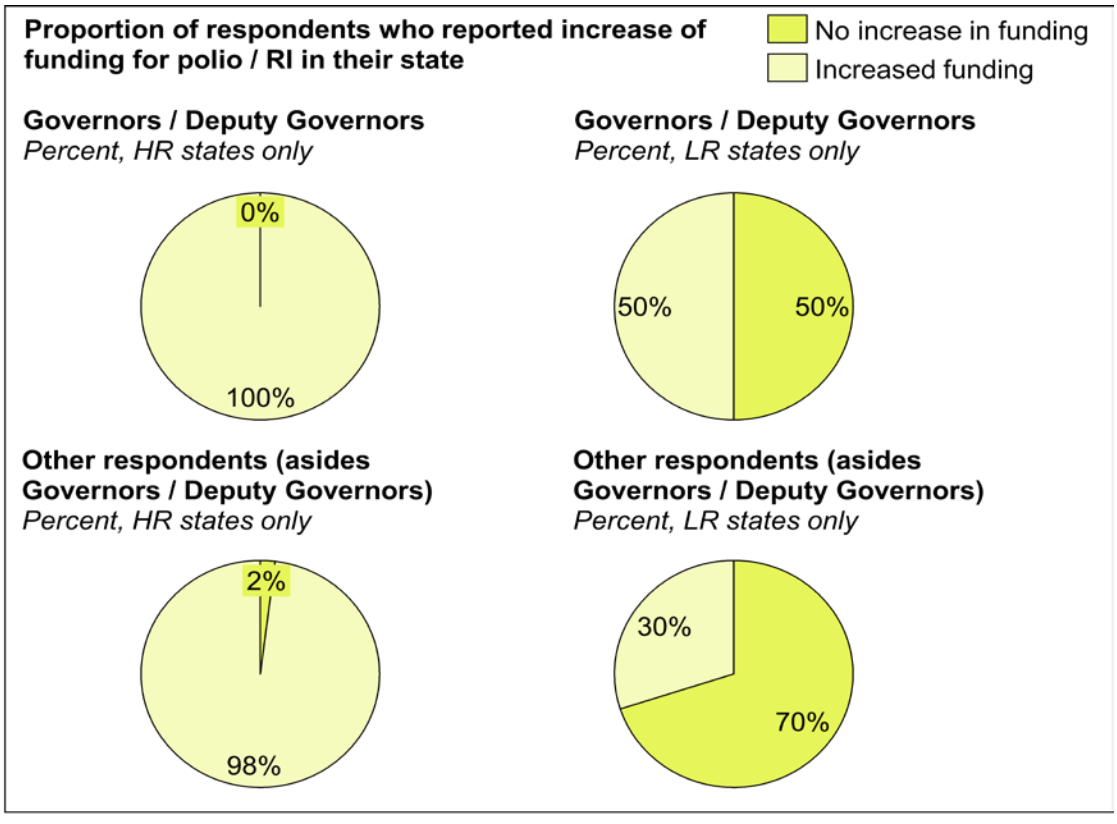
In 2012, the average score for leadership was highest for HR (70 percent), followed by Southern LR (43 percent) and Northern LR (38 percent) states. Performance in commitment followed a similar pattern, as shown above in figure 4.

b. Program Ownership

Since no data measuring ownership – through indicators capturing immunization planning and release of funds – was collected for ownership in 2011, only the 2012 Challenge data was analyzed for ownership. **In 2012, ownership was highest in southern LR states, while HR states in the north scored significantly higher than LR states in the north.**

Qualitative interview respondents expressed a perception of increased ownership across all evaluation states, with 76 percent of respondents reporting a perceived increase in funding for polio and RI in their states in the past year (broken down by respondent group in figure 8). However, perceptions of increased ownership in HR states were significantly higher than in LR states, in contrast to the quantitative Challenge indicator performance (figure 4).

Figure 8 – Perceptions of increased ownership among interview respondents



Sources: Leadership Challenge interviews

- *"The governors have taken it upon themselves to launch several campaigns at state and LGA level for the eradication of polio and put some funds towards it." - National level development partner*

- *"Yes funding is available; funds are distributed from one (pool) basket to all functioning units. We monitor the movements of funds, from request to disbursement, to sending to utilization; hence misappropriation of funds is minimized." - HR State Governor*

c.Factors driving the changes in Leadership and Commitment

Interview respondents proffered several reasons for the increased political leadership and commitment among governors. The most commonly cites reasons include:

i. ***Leadership and commitment from the President.*** Many state governors, particularly the 23 governors from the President's ruling political party during 2012, look to the President as their role model and follow his directions. Mr. President has been quite engaged in polio eradication: He set up a Presidential Task Force on Polio Eradication chaired by a cabinet minister and has received monthly briefings on polio since March 2012. In addition, the President has participated in high profile public events with local and international stakeholders (including Mr. Bill Gates). Many governors have treated this level of engagement at the top as an indication of what is important to the current government.

- *"When the President is serious about something, you have to be serious about it as a governor too…the President has shown us that he wants polio out and we also owe our people that mandate." - Northern Governor*

- *"Mr President demonstrated his seriousness by setting up a high level task force with highest level political backing and headed by the Minister of State…that is enough to send a message to everyone to get on board." - National Official*

- *"...Additionally, there is pressure from the President to perform well and contribute to the eradication of Polio." - State Official*

ii. **Pressure from international community.** The general context of increased focus on polio by the international community translates to pressure among governors.

- *"When you are told the world is looking at you because just three countries out of the several other countries in the world still have this Challenge then it becomes not a problem for a particular state but for everybody- it is one for all, all for one…." - National Official*

iii. **A very engaged NGF that better informs its members**. The Nigeria Governors' Forum has prioritized polio and made it a permanent agenda item in its monthly meetings. This has served as an informal peer review / peer pressure mechanism to influence governors to prioritize polio.

- *"The NGF has done a lot. Polio now has a standing place on the Forum's meeting agenda." - Development Partner*

- *"There is more unity among the governors in their commitment to polio. They know polio is very mobile and the fact that you have it in Sokoto today does not mean it cannot surface in Benue or Lagos tomorrow…" - National Official*

iv. **The Immunization Leadership Challenge**

The Leadership Challenge increased the awareness and focus of state governors on polio, and resulted in increased commitment.

- *"Priority of Polio has definitely increased in the last year because of this Leadership Challenge." - Southern Governor*

- *"This prioritization is as a result of a combination of factors such the presidential taskforce that is very functional and also the international partners' involvement through their direct visits, and interventions like the Leadership Challenge." - Development Partner*

v. **Involvement of traditional institutions**, such as the traditional and religious leaders in polio eradication activities is particularly relevant to increased commitment at the LGA levels.

- *"The change is because of the full involvement of the traditional rulers." - LGA Official*

d. Perceived effect of the Leadership Challenge on Leadership & Commitment

i. Awareness of the Challenge among governors

Awareness of the Leadership Challenge was high among state governors generally. However, few could give details of how it works, including the indicators, or even the specific grant award amount.

- *"I am aware of the Challenge and getting briefing from my commissioner regularly, but I cannot tell you the specifics off the top of my head." - Northern Governor*

- *"I would not know the details but what I know is that it draws a lot of attention in our (NGF) meetings…" - Southern Governor*

ii. Awareness of Challenge among other stakeholders

State officials (health commissioners, executives of state Ministries of Health and Primary Health Care Development Boards) were generally aware of the Challenge and reported that their commitment to polio was strengthened during the Challenge, mostly due to pressure from the governors. However, some complained of being properly engaged late in the year.

- *"There are 12 indicators which border on leadership, the output and the impact. Some of them are the number of task force meetings, non-AFP surveillance and the number of missed children. This information was given to me by the Executive Governor when I assumed office and has helped me to prioritize polio appropriately." - Southern State Health Commissioner*

- *"I think the NGF needs to directly reach out to those working below the Governor. The Governor is busy and cannot take time to fully brief us on what to do. It was not until [NGF staff] met with us recently that I got the details, and now it is too late to push my state to do well." – State Ministry of Health Official, HR State*

- *"The Challenge was introduced in January 2012 by Mr Bill Gates who was very concerned about Nigeria harboring WPV cases. The governors were told that the best performing state would win an amount of money to implement a health care program. Some of the indicators are: the Governor's commitment including public performances and innovations in the state, AFP detection rate and surveillance." - State Health Commissioner, HR State*

- *"I receive information about the state's performance from the NGF. Dr Giwa liaises with the SMOH." - State Health Official, Southern State*

Few LGA stakeholders had any knowledge of the Challenge. This was true both in HR and LR states. However, the few who knew about the Challenge said it had increased their overall knowledge and interest regarding polio and RI. It is important to note, however, that the Challenge did not specifically target LGA officials.

- *"{Leadership} Challenge? I am hearing this for the first time. But Polio campaigns, we support in my LGA and we have a lot of Challenges we are facing." - LGA Chairman*

- *"Yes, my knowledge has tremendously increased, I used to be quite ignorant about (polio) until the Challenge came; we are now very motivated towards it, it is of utmost importance in our work." - LGA Chairman*

iii. Prioritization of polio

In 9 out of the 12 evaluation states, respondents reported marked improvement in commitment by governors as a result of the Challenge, when asked specifically about the effect of the Challenge on prioritization of polio. Notably, all 3 states where respondents did not report improvements related to the Challenge were LR states, which suggests that HR states were more responsive to the Challenge. As already reported above, the Challenge had a significantly less remarkable effect on prioritization of polio at LGA level.

- *"Yes, the governors were not so bothered about this in the past, but ever since the advocacy of the (Leadership) Challenge amongst other things, their commitment has changed." - Traditional Ruler*

- *"The Challenge really helped put us together to make Polio eradication a permanent agenda. We were all properly re-educated about the disease and the Challenge and charged with responsibilities in the program which has motivated the governors very much." - State Official*

- *"The Challenge has done very well in this case. With the Challenge now, as opposed to before where at meetings states are complaining that their governments are not forthcoming, state governments are sitting up more and stepping up to the plate to ensure the success of the program, whereas, usually they would be adamant." - State Official*

- *"Well, I believe the Challenge has contributed... What we are seeing is a reflection of the leadership Challenge; with the level of commitment we believe we are going to interrupt transmission this year." - Development Partner*

- *"In this state our LGA chairmen are 'harder to reach' than the hard to reach communities." - LIO*

- *"I do not discuss polio or even health with the governor. When I see him, I discuss political matters and business." - LGA Chairman*

3. **Program results**

There was a modest improvement in program results performance from 2011 to 2012 in all categories of states except for Southern LR, as shown in figure 9. Since LQAS was only conducted in HR states in 2011, LQAS indicator scores were excluded from aggregate results data to allow an accurate comparison of performance in both years. Figure 10 shows, separately, the trends in LQAS in the HR states between 2011 and 2012. Performance in 2012 was best in the northern LR states (57 percent), followed by the southern LR states (40 percent), while HR states performed worst (31 percent). This is particularly noteworthy as the bulk of results indicators are PEI related indicators. This is also despite the high performance of HR states in leadership and commitment indicators. After stagnant LQAS performance during 2011, however, LQAS scores steadily improved in HR states during 2012.

Figure 9 – Change in program results performance between 2011 and 2012

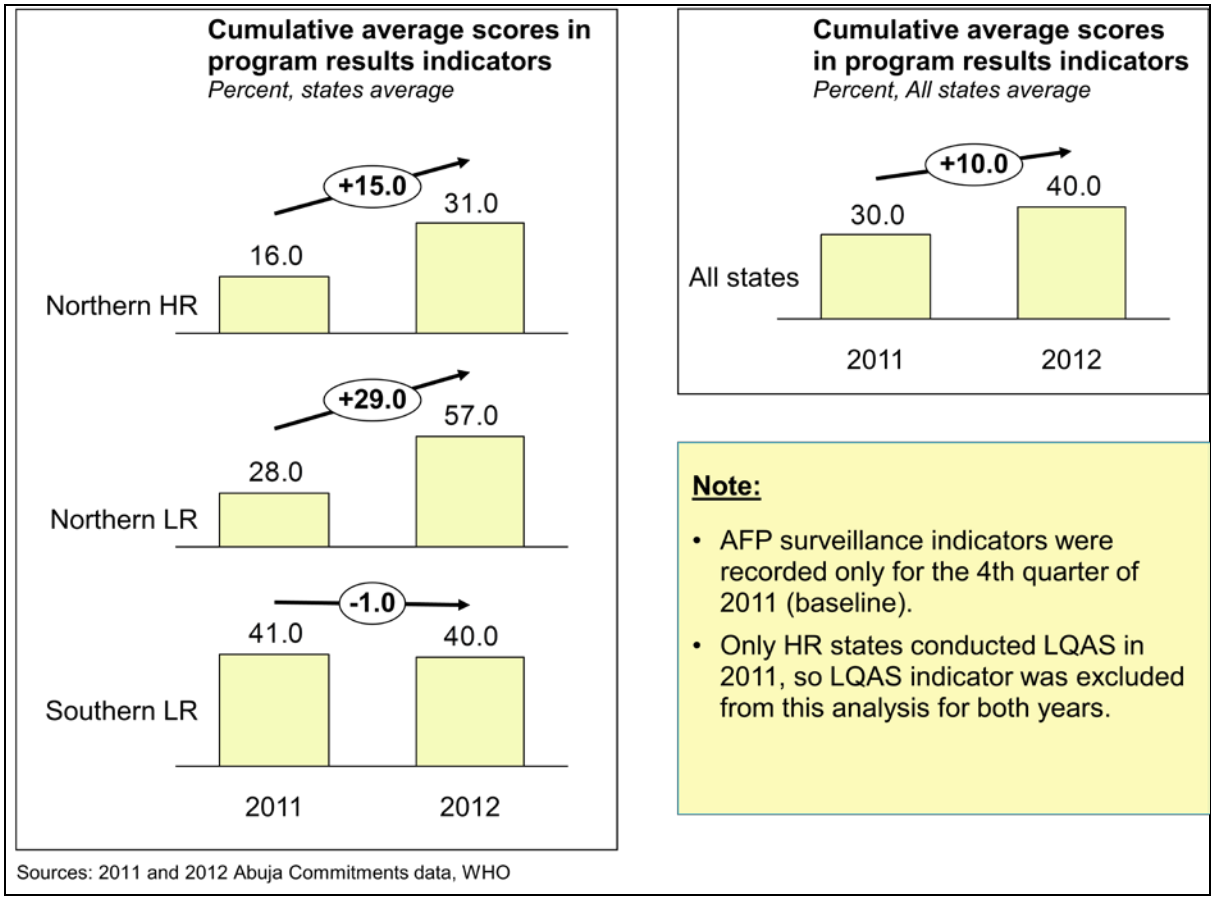
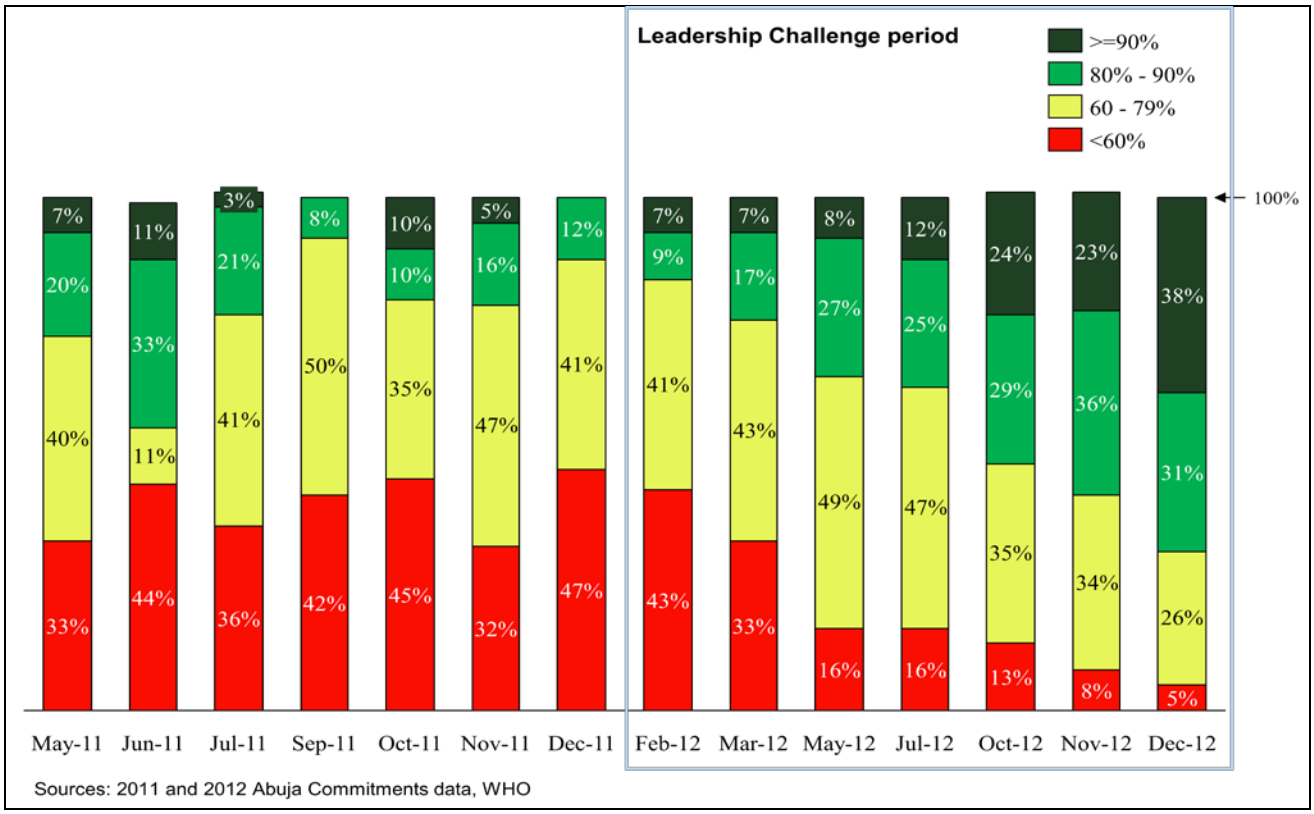


Figure 10 – Trends in LQAS data among 11 High Risk states between 2011 and 2012



Although a few interview respondents did not believe that polio programs had improved in their states, the majority, particularly in HR states, felt that the polio program improved in the past year, but the increase in number of polio cases in 2012 was a result of improved surveillance systems.

- *"The number of missed children has reduced and non compliance has gone down from 50% to 20%. Our RI is becoming better because of our mobilization and health education." - LGA Official, HR state*

- *"There is improvement in coverage rates from 50% to 60-70%, there are those LGAs with 90% but talking about average, I would say 60-70%." - Deputy Governor, HR state*

- *"The reason we are seeing more cases in some states is because all hands are now on deck, and we have better surveillance." - Governor, HR state*

a. **Factors driving change in program results**

In the quantitative analysis, progress against indicators measuring leadership and commitment was greater than progress against program results indicators between 2011 and 2012. In other words, large shifts in leadership and commitment were accompanied by only modest improvements in program results. One possible explanation that emerged from the interviews is that the Challenge may have been successful in driving change in parts of the program system that relate to political commitment, whereas program results are harder to influence as they depend on a broader set of factors than those directly addressed by the Challenge.

For example, there appeared to be inadequate trickle down of the increased commitment at the state level to LGAs, particularly in HR states. Interview respondents had mixed opinions regarding the trickle down, with only 58 percent of interviewees in HR states and 63 percent of those interviewees in LR states believed that the governors commitment translated to increased commitment at the lower levels. Those respondents who believe that commitment trickled down attributed this to the influence of the governors, while those who believed it did not trickle down attributed the failure to inadequate information at the implementation levels. i.e., although governors were committed, the information that frontline technical officers need to achieve the Challenge objectives was not provided to them in a structured and adequate manner.

- *"Going down the structure commitment levels fall; at the local levels dedication wanes at different levels again depending on the different LGAs." - State level development Partner*

- *"Yes it (priority) has increased and this is because of the involvement of the governors…, even the LGA chairman. They have become more involved ..." - LGA official*

- *"The problem at the implementation level is that officials were not properly informed of their involvement/ roles in the program and the stakes involved. We required a detailed explanation of all our respective duties." - State Official*

b. Relationship between performance in leadership, commitment and ownership, and programmatic results

Overall, progress against indicators measuring leadership and commitment is significantly greater than progress against results. In other words, the huge shifts in leadership and commitment were accompanied by only modest improvements in results indicators during 2012. Respondents gave a number of reasons for the weaker performance of states in the results indicators, even despite fairly impressive leadership and commitment performance. The most commonly cited reasons were:

1. **Lack of actual commitment at the LGA levels, despite improvements in commitment indicator performance**

Stakeholders in both HR and LR states expressed the belief that poor commitment at LGA level is a major barrier to polio and RI performance in their states. Many political leaders and technical personnel in LGAs are completely unaware of the importance of the polio program in their LGAs; and even when they are aware, many, particularly in LR states, do not consider polio a priority for their LGA in any way. Many respondents believe that where there has been high motivation and commitment by governors, the motivation has rarely trickled down to LGAs. Paradoxically, these perceptions are inconsistent with the improved LGA commitment indicator performance shown in figure 7.

- *"Lack of commitment at the Local Government level and insufficient supplies (stock-outs) are the major problems." - Development Partner*

- *“You can stop by any LGA when you are travelling and ask the LGA chairman about polio, he does not know what you are talking about, polio means nothing to him. The LGA chairmen are not interested in the polio situation." - (National Official)*

2. **Ignorance and misinformation in communities** – a number of respondents believe that demand issues arising from misinformation and inadequate education of the population regarding polio continues to pose a threat to the success of the program. This was identified as a problem only in HR states.

- *"Circulation of false information by Professor Kaita has threatened to harm the program, but we are doing everything to contain the situation including expanding the polio campaigns." - Northern Governor*

- *"...ignorance of the people about Polio and RI as a result of the illiteracy and the political problems that occurred three years ago where some local governments declared immunization as unacceptable, are the main factors affecting the state performance." - Northern State Official*

- *"The lack of commitment of the community is a problem because they are not fully knowledgeable about the disease and the program but now with the awareness campaigns we are making headway in these communities." LGA Chairman*

c. Perceived effect of Challenge on performance of Polio/RI Program Results

Although there are mixed opinions on the effect of the Challenge on polio programs in states, there is broad agreement that a lack of translation of political commitment to LGAs and other frontline stakeholders is a widespread barrier to improved performance, as already previously highlighted in this report.

- *“There have been mixed achievements between the Polio and RI as a result of the Leadership Challenge; ...and while Polio eradication for the most part is making progress, (especially because it is a line item for the government and is part of their agenda), the same cannot be said for RI.” - National Official*

- *"The Leadership Challenge has 'roused the consciousness' of the people to do the things they are supposed to do. It however did not result in any concrete programmatic results." - State Official*

- *"Although the key state officials are now deliberately fulfilling every activity and performance indicator of the Leadership Challenge, the Challenge cannot have been said to have directly affected program performance." - State Development Partner*

- *"Political commitments have not translated into operational commitments i.e. supervision, selecting the best teams etc." - National Official*

Overall, when considering the potential role of the Challenge in driving change in leadership, commitment and ownership versus program results, assessment of the quantitative and qualitative results of the evaluation suggest:

i. The Challenge may have been a successful contributor – amongst the other program inputs at play during that timeframe – toward generating commitment and leadership support;
ii. The Challenge may also have contributed to improved program results, albeit more modestly, from 2011 to 2012;
iii. Improvements in program results are subject to a number of factors that are outside the scope and influence of an intervention like the Challenge, such as commitment at the LGA levels; demand for vaccines due to misinformation; among others.

4. Perceived relevance and appropriateness of the Challenge

The evaluation sought to understand the appropriateness of the Leadership Challenge design and implementation from the perspectives of the stakeholders, particularly along three dimensions – the target population, indicators, incentives, and implementation approach.

a. Target population

Almost everyone interviewed agreed that the state governors are the most appropriate target group for the Leadership Challenge. This is because governors make the major funding decisions at the state level and have significant influence on other sub-state stakeholders, including LGA chairmen.

- *"I think bringing it to the Governors Forum was the best decision; because it had the drive. I think that was the best thing that the BMGF could have done." - Southern Governor*

- *"The leadership Challenge rightly focuses on the governors, mostly motivating the governors to identify with the war against Polio; and specify the responsibilities that they should appear publicly to advance the program, they should financially, support all the RI and Polio immunization campaigns that are taking place in the state." - State Official*

- *"At the state level, there are may be 3 or 4 key people that really have direct influence on the LGAs when it comes to the leadership Challenge. First is the governor, second is the commissioner for Local government because that commissioner has over-sight functions, he approves their funding and so on..." - Development Partner*

- *"I think the governors are the people to handle the Challenge, because for every project you need funds and they are the people who handle the funds …" - Development Partner*

However, many interview respondents in both HR and LR states strongly recommend inclusion of other state-level and LGA officials as direct targets of the Challenge in future.

- *"Yes it is important to target the governor and the executive members of the state. It will also do BMGF and the program good to involve the LGAs because they are at the grass root and will be able to certify whether the RI is being done or not... So I believe all LGAs must be Challenged continuously and encourage the LG chairmen and their councils and the traditional rulers to participate." - Northern Governor*

- *Yes I would say it should have a complete involvement of stake holders such as the traditional institutions, the political office holders, the civil servants, the business community and all the political parties at all levels so that it can be a general affair." - Northern Deputy Governor*

- *"We should involve the Emirs including the LGA chairmen for their moral to be boosted and they should be the targets." - LIO*

- *"The other appropriate target audience of the Leadership Challenge should have been the LGA Chairmen. The interest in the contest (the prize money) would have been higher at their level." - State Official*

b. Indicators

Most respondents interviewed believe that the Challenge indicators were appropriate for its purpose. However, a couple of respondents recommended an indicator for polio program funding that is easier to measure and the data easier to collect.

- "*Those indicators were well thought over, and it measures impact and not just output." - State Official*

- *"Apart from the coverage survey and increased financing for Polio indicator which is not easily measurable, the indicators were appropriate and adequate." - Development Partner*

c. Rewards

There was an overwhelming perception among respondents that the promise of recognition by Mr. Gates was a far more compelling incentive for state governors than the financial reward. This view was consistent among governors, deputy governors and state level officials interviewed, as well as the majority of LGA stakeholders, and in both HR and LR states. The common rationale is that while the $500,000 is a relatively small amount of money to incentivize governors, official recognition for good performance by BMGF would serve as political capital. However, LGAs, who have much smaller operating budgets, may find the financial incentive more compelling.

- *"Yes, but we are more concerned with the honor of winning such a prestigious title rather than the money attached. Irrespective of this money, our efforts to save our people from sickness and disease should not relent but to be rewarded for these efforts is gratifying as well." - Northern Deputy Governor*

- *"I would say the recognition is the more attractive incentive for Governors, the money is not as significant as being internationally recognized for your efforts in such a matter of global importance." - Development Partner*

- *"The recognition of the governor would even be better; it is higher rather than the money. You can even translate the money to drugs and supplies instead of money; it will be much better." - Southern Governor*

- *"As a governor we don't exactly need monetary benefits, what would really be incentive would be the vaccines and drugs for the Challenge offered for free as a reward for our progress in the Challenge." - Northern Governor*

- "*The money is more important because the certificate is just for the Governor alone but the money will go a long way in improving the state." - LGA Official*

d.**Implementation**

Most respondents expressed the belief that the Challenge was implemented appropriately overall. However, a few recurring suggestions for improvement in the implementation came up during the interviews. Several respondents believe the Challenge should emphasize non monetary incentives (i.e. the BMGF recognition in this case) over any monetary gifts. While money is good, it is difficult to award an amount that is large enough to truly motivate the governors, who already control large state budgets. In addition, several respondents suggested the inclusion of other officials in the reward schemes. While many mentioned the need to also incentivize health commissioners and other members of the state health team, a few mentioned the deputy governors as appropriate beneficiaries alongside the governors. This would likely ensure that the excitement and commitment among the governors is translated to implementers in the states and LGAs.

- *"The Challenge was appropriate and served the purpose for which it was established, which is to increase political will. However, the money doesn't mean anything to the Governors. It is the recognition they look forward to." - Development Partner*

- *"I would say its design is appropriate; the only change I would want is to consider the appearance of the deputy governor. He should also be recognized as instrumental for the program running." - State Official*

In addition, some respondents believe that the Challenge was implemented in a way that did not allow governors to take full ownership of their state programs. Setting the indicators, rewards, deliverables and timelines tended to give the governors a sense of the need for compliance rather than being in the driver's seat of their state programs.

- *"We want to do it in a way that is best for Nigeria rather than having an artificial deadline we keep missing and having to say we failed." - Development Partner*

- *"The Challenge does not allow for ownership by the Governors. They should be allowed to set their own indicators and assess one another at the NGF meetings. Expand the scope and make it more technical. Don't overload them." - State Official*

V. Discussion and Recommendations

Although the fieldwork for this evaluation commenced far into the implementation of the 2012 Leadership Challenge, the combination of a retrospective analysis of the AC and Challenge indicator data and qualitative interviews in selected states provides a fairly robust basis for making informed inferences regarding the process and perceived effects of the Challenge.

The Challenge took place in the context of already elevated political commitment among governors. A number of activities aimed at increasing state political commitment to polio took place immediately before and during the Challenge period. These include the visit of Mr. Gates and reaffirmation of all 36 governors to the Abuja Commitments in September 2011, and the establishment up of a cabinet Minister-led Presidential task force on polio in March 2012.

As such, while it is clear that the Challenge contributed significantly to increased commitment among governors observed between 2011 and 2012, it is important to note that other related events likely amplified the building momentum. Furthermore, several factors that influenced political commitment are highly related to the Challenge and therefore difficult to tease apart in the attribution of impact (e.g., high profile visits by Mr. Gates).

From the findings of this evaluation, however, it is apparent that the Leadership Challenge was instrumental to unlocking increased leadership and commitment among governors. The governors were the primary targets of the Challenge, and rightly so, and the Challenge was quite successful at influencing them. Furthermore, while the perceived effect was not uniform in all states, the HR states, where the polio outcomes of the Challenge were most relevant, appeared to have responded the most.

It is difficult to definitively explain why there was poor correlation between changes in political commitment and changes in program results. One reason widely stated by respondents was the lack of translation of the commitment of the governors to lower levels. Although the governors were engaged actively through the NGF (an approach which worked effectively), the communication of the importance and expectations from the Challenge down through state administrative and LGA levels was left to the governors for the most part. For example, it was not until about mid-way through the program year (June 2012) that deliberate attempts were made to engage health commissioners as part of the Challenge, with a workshop held in Abuja. Unfortunately, the governors themselves did not have the technical detail or wherewithal to provide the necessary information to the actual implementers in the field on how to drive improvements in program outcomes.

A second plausible explanation for the lack of translation is that the core value indicators used to measure Challenge performance were not sensitive enough to correlate closely with results. The indicators measured too far up in the theory of change and might only influence results via some other mechanisms that may not have been directly captured by the indicators. For example, presence of an active task force (measured by evidence of meetings) may be inadequate to achieve impact unless there is adequate follow through on identified issues and solutions implemented in a timely way.

A third potential reason is the perception among governors and other stakeholders that the main focus of the Challenge was the leadership and commitment indicator performance, as those were more closely related to direct actions of the governors. As such, the governors did not focus much on results. This may explain why the HR states, who knew they were targets of the intervention, paid more attention and scored high in leadership, commitment and ownership indicators but did not do as well in results indicators.

A number of recommendations for any future editions or iterations of the Leadership Challenge come out of the lessons learned from this evaluation:

1. The Challenge indicators need to be reviewed for opportunities to include more precise and sensitive indicators that would better represent the likelihood of results performance. For example, beyond release of funds for immunization broadly, a more sensitive indicator would be amount of funds reaching end users for downstream activities such as vaccine transportation to facilities. While funds may be released by the state, it is not uncommon for much of the funds to be absorbed by bureaucracy and 'supervision' activities. Measuring farther along the theory of change in this way would ensure that any increase in leadership or commitment truly translates to action on the ground and ultimately, improved program results.

2. Future interventions like this should continue to target governors and to engage them through the NGF or other relevant forum where peers can pressure one another. However, in order to ensure that any effects are cascaded down to frontline stakeholders and results are achieved, there is a need to more systematically engage state technical personnel and health system leaders including health commissioners, permanent secretaries, State Primary Health Care Development Boards and LGA officials. This could be achieved, for example, by carrying them along to give them a sense of co-ownership and empowerment from the kickoff of the Challenge. Also, some of these officials could be included in the incentive system, e.g., by rewarding 'state teams' led by the state governors.

VI. Appendices

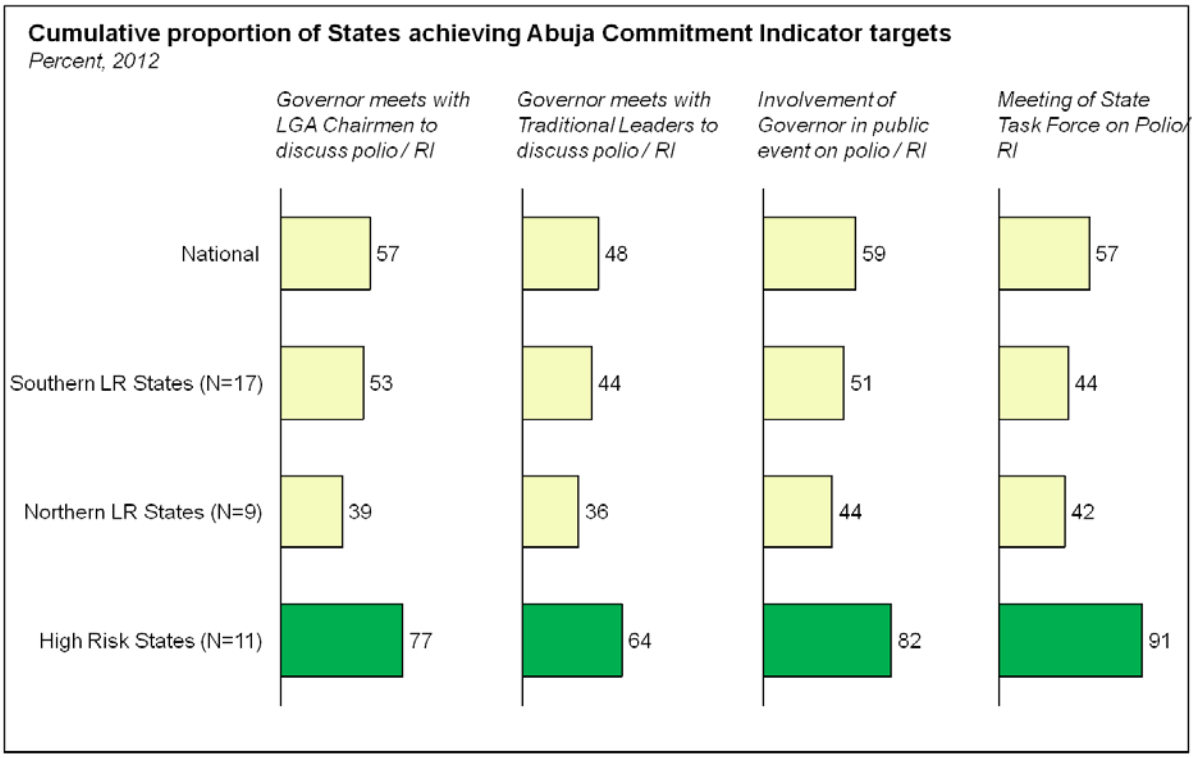
Appendix 1 – Survey states, LGAs and their risk ratings

State	LGA	Risk Ranking
Niger	Borgu	High
	Bida	Medium
Plateau	Jos North	High
	Shendam	Medium
Borno	Maiduguri	High
	Magumeri	Medium
Yobe	Gulani	High
	Borsari	Medium
Bauchi	Gamawa	High
	Warji	Medium
Zamfara	Bukkuyum	High
	Bungudu	Medium
Kano	Dawakin kudu	High
	Gaya	Medium
Katsina	Katsina	High
	Mashi	Medium
Enugu	Udi	Low
	Aninri	Low
Cross river	Bakassi	Medium
	Akamkpa	Low
Akwa Ibom	Owan west	Medium
	Etsako central	Low
Ondo	Ilaje	Medium
	Irele	Low

Appendix 2 – Leadership Challenge indicators and scoring grid

No.	Category	Indicator	Data Source	Scoring (Annual total per indicator)
1	**Process:** Adherence to State-Level Abuja Commitments	Personal involvement of HE Governor in public event in support of polio (e.g. meeting with key stakeholders, Immunization Plus Days (IPDs) flag off, Polio Awareness Days) each quarter	1. Abuja Commitments Monitoring by NPHCDA 2. Evidence submitted by states	1 point for fulfilling at least one activity per quarter (4 total)
2		At least one meeting between Governor with LGA chairmen to discuss priority actions to improve polio and routine immunization each quarter		1 point for fulfilling at least one activity per quarter (4 total)
3		At least one meeting between Governor with traditional leaders to review their involvement in polio and routine immunization each quarter		1 point for fulfilling at least one activity per quarter (4 total)
4		At least one meeting of the State Task Force or similar high-level oversight committee established by the Governor to oversee polio and routine immunization activities each quarter		1 point for fulfilling at least one activity per quarter (4 total)
5	**Process:** Adherence to LGA-Level Abuja Commitments	Proportion of LGAs where daily IPDs review meetings are chaired by a high level LGA official, i.e., LGA chairman or LGA HOD/PHC Dept.	Abuja Commitments Monitoring by NPHCDA	1 point earned per quarter in which >90 percent LGAs meet the indicator (4 total: HR (HR)* states) (1 total: Non-HR* states)
6	**Process**: RI Planning & Budgeting	Monthly evidence of state budgeted release of funding for routine immunization	Evidence submitted by states	1 point per month (12 total)
7		Monthly evidence of review and planning on routine immunization in State Task Force or equivalent planning meeting	Evidence submitted by states	1 point per month (12 total)
8	**Outcome:** Immunization Plus Days (IPDs) Performance	Proportion of Wards reporting >10 percent missed children during IPDs	IPDs Independent Monitoring	Northern states/zones: 1 point per SIA conducted each quarter in which ≤15 percent wards report >10 percent missed children (2-7 total) Southern states/zones: 1 point per SIA conducted each quarter in which ≤10 percent wards report >10 percent missed children (2 total)
9		Proportion of LGAs accepted at >90 percent LQAS coverage during IPDs	LQAs monitoring independently conducted by WHO	1 point for every SIA conducted each quarter in which 100 percent LGAs accepted at >90 percent LQAS coverage
10	**Outcome**: Polio Surveillance Performance	OPV status of non-polio Acute Flaccid Paralysis (NPAFP) cases: ≥3 doses	AFP Surveillance Data: NNAFP OPV doses	1 point if ≥90 percent of NPAFP cases receive ≥3 doses during each quarter (4 total)
11		LGAs meeting both Acute Flaccid Paralysis (AFP) surveillance indicators	AFP Surveillance Data: Non-polio AFP rate and stool adequacy rate	1 point for maintaining ≥90 percent during each quarter (4 total)
12	**Outcome:** RI Coverage	percent improvement in routine immunization coverage over the 1-year award period	Administrative measles coverage data	1 point for ≥90 percent coverage during 12-month review period (1 total)
Maximum cumulative annual score				*HR (HR)* States (7 IPDs/year)* = ***67*** *Non- HR (non-HR)* States (2 IPDs/year)* = ***54***

Appendix 3 – State level Leadership and Commitment indicator performance



Sources: Abuja commitment data

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