THE HUMAN CAPITAL OPPORTUNITIES FOR PROSPERITY AND EQUITY- PRIMARY HEALTHCARE PROVISION STRENGTHENING (HOPE-PHC) PROJECT

PROGRAM OPERATIONS MANUAL

JUNE 2025

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THE HUMAN CAPITAL OPPORTUNITIES FOR PROSPERITY AND EQUITY-PRIMARY HEALTHCARE PROVISION STRENGTHENING (HOPE-PHC) PROGRAM

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About this Manual

Toward a Unified and Accountable Health Sector: Implementing the Sector-Wide Approach through HOPE-PHC

Nigeria's health sector has long been challenged by fragmentation in planning, financing, and service delivery. These challenges have undermined the efficiency and impact of government and donor investments, resulting in persistent gaps in health outcomes and system performance across states. Recognizing the need for a coordinated, transparent, and results-focused reform, the Federal Government of Nigeria and its partners have committed to a Sector-Wide Approach (SWAp) to health sector strengthening.

The SWAp is not a program in itself—it is a unifying framework. It is a way of working that brings together federal and state governments, development partners, and implementing actors around shared priorities, harmonized financing, and a single results framework. The aim is to reduce duplication, improve resource alignment, and ensure that every actor is held accountable to a common set of goals and standards.

The HOPE-Primary Health Care (HOPE-PHC) Program is among the first major initiatives being implemented under the SWAp in Nigeria. Focused on revitalizing health care service delivery across participating states, HOPE-PHC is designed not only to deliver essential health services more effectively, but also to demonstrate how the SWAp can work in practice—through aligned financing, clear institutional responsibilities, robust performance monitoring, and state-driven implementation.

This Program Operations Manual serves as a critical tool for implementing HOPE-PHC in line with the SWAp principles. It is intended for use by all stakeholders, from high-level decision-makers to the operational teams charged with daily program implementation. The manual outlines standard operating procedures, institutional arrangements, program indicators, financial processes, and compliance measures. It provides clear, detailed guidance to ensure consistent execution across all participating states.

The sections that follow reflect extensive consultation and co-design with stakeholders across government and development partners. They aim to support states in delivering results while modeling the systems and processes that will guide broader sector-wide reforms.

To reinforce this shared commitment, the next section presents the SWAp Compact, signed by federal and state governments and by development partners. The compact affirms collective accountability for implementation and sets the foundation for collaboration under the Sector-Wide Approach.

Dr Muntaqa Umar Sadiq
National Program Coordinator
FMOH&SW SWAp Coordinating Office

Signed SWAp Compact

FEDERAL REPUBLIC OF NIGERIA
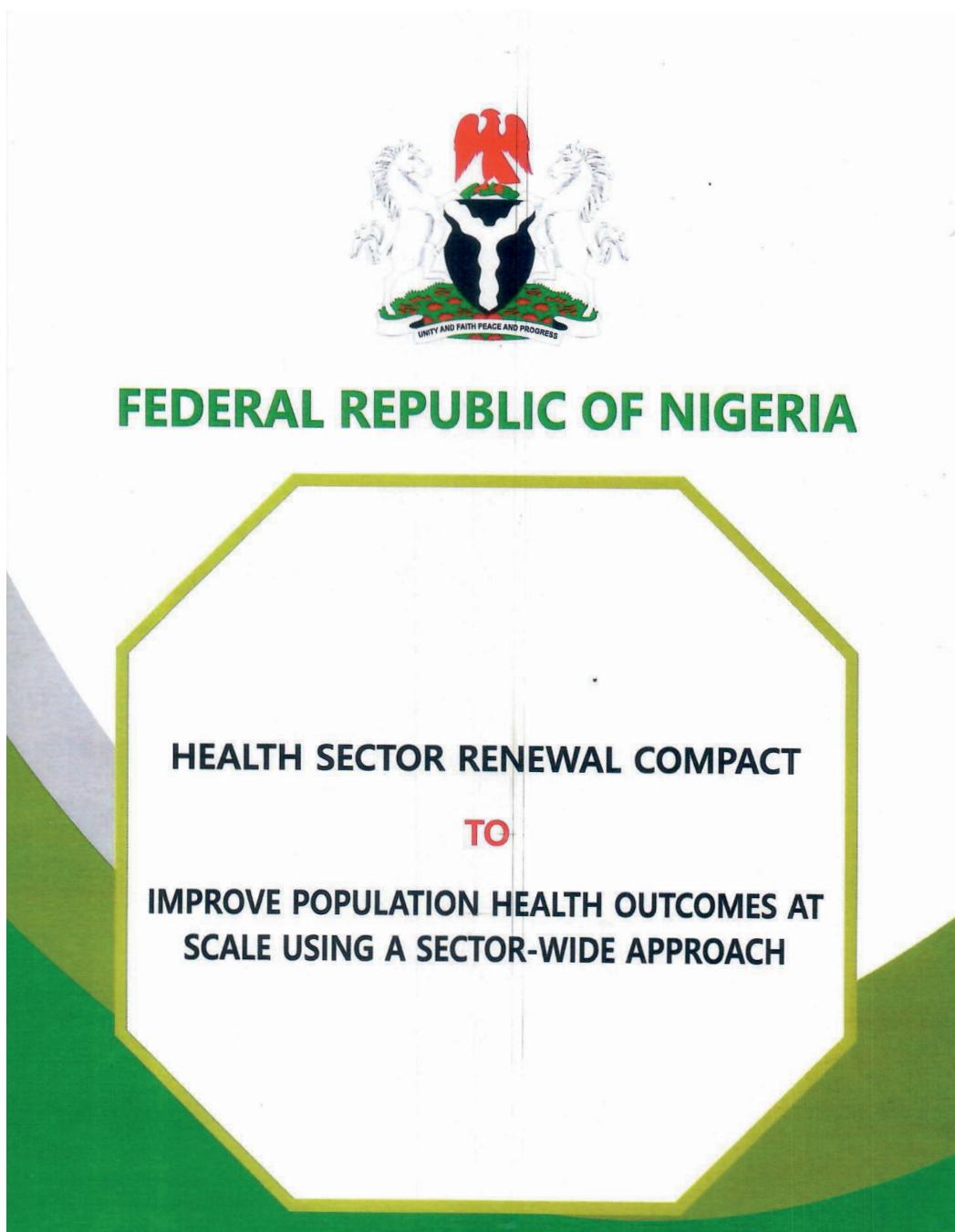
HEALTH SECTOR RENEWAL COMPACT

TO

IMPROVE POPULATION HEALTH OUTCOMES AT SCALE USING A SECTOR-WIDE APPROACH

S/N	STATE	NAME	SIGNATURE
1.	Abia	ALEX C. OTTI, OFR	
2.	Adamawa	Ahmadu Umaru Fintiri	
3.	Akwa Ibom	Sen. Dr Akan Eyakenyi — D. Gov	
4.	Anambra	CHUKWUMA CHARLES SOLUDO	
5.	Bauchi	Sen Bala Mohd Cari	
6.	Bayelsa	SEN LAWRENCE EWHRUDJAKPO	
7.	Benue	Rev. Dr Aba Hyacinth	
8.	Borno	Umar Usman Kadafur	
9.	Cross River	SEN BASSEY E. OTU	
10.	Delta	RT Hon. (RSGR) SHERIFF F.O. OBOREVWORI	
11.	Ebonyi	F.O DWIFWRY	
12.	Edo	GODWIN N. OBASEKI GOVERNOR EDO STATE	
13.	Ekiti	Biodun Oyebanji	
14.	Enugu		
15.	Gombe	Muhammad Inuwa Yahaya	

S/N	STATE	NAME	SIGNATURE
16.	Imo	Hope Uzodimma	
17.	Jigawa	Umar A. Namadi	
18.	Kaduna	DR HADIZA S. BALARABE	
19.	Kano	Abba K. Yusuf	
20.	Katsina	Dikko Umaru Radda	
21.	Kebbi	Dr. Nasir Idris	
22.	Kogi	Ahmed Usman Ododo	
23.	Kwara	Abdulrahaman Abdulrazaq	
24.	Lagos	BABAJIDE SANWO-olu	
25.	Nasarawa	DR E.A. AKABE	
26.	Niger	Mohammed Umaru Bago	
27.	Ogun	Dapo Abiodun	
28.	Ondo	Lucky O. Aiyedatiwa	
29.	Osun	Sen A. Adeleke	
30.	Oyo	Oluseyi Makinde	
31.	Plateau	BARR. CALEB MUTFWANG	
32.	Rivers	SIR Siminalayi Fubara	

S/N	STATE	NAME	SIGNATURE
33.	Sokoto	AHMED ALIYU Sokoto	
34.	Taraba	DR AGBU KEFAS	
35.	Yobe	Mai Mala Buni	
36.	Zamfara	Hon Mani Mal Mummuni	
37.	FCT	Ezenwo Nyesom Wike	

S/N	DEVELOPMENT PARTNERS	NAME	SIGNATURE/DATE
1.	World Health Organization (WHO)	DR WALTER KAZADI MULOMBO	12/12 2023
2.	World Bank	SHUBHAM CHAUDHURI	13/12/23
3.	United Nations Children's Fund (UNICEF)	CRISTIAN MUNDUATE	
4.	United Nations Population Fund (UNFPA)	Dr Gifty Addico Resident Representative	
5.	Bill and Melinda Gates Foundation (BMGF)	UCHE AMADNNU	
6.	UK Foreign, Commonwealth and Development Office (FCDO)	CYNTHIA ROWE	13/12/23
7.	Embassy of Norway	SVEIN BAERA	12.23
8.	GFATM (The Global Fund)	PETER SANDS	
9.	Susan T. Buffett Foundation	for Prof Samuel Finkle	
10	African Development Bank		
11	Global Affairs Canada	Djifa AHADU	12/12/23
12	Aliko Dangote Foundation	Zouera Youssoufou	13/2/23

WE, THE UNDERSIGNED, met in Abuja this 12th day of December 2023 on the World's Universal Health Coverage Day under the theme *"Health for All: Time for Action"*.

1) **RECOGNIZING** that health is the key to human capital accumulation; and a healthy, economically productive population, growing at a sustainable pace, supported by a health system that caters for all, is essential to Nigeria's socioeconomic development.

2) **RECOGNIZING** that the key challenges to achieving our national health objectives include constrained governance systems and structures with limited accountability, inadequate, inefficient, and inequitable health care financing, shortage, and mal distribution of human resources for health, limited availability of quality health commodities, insufficient citizens' and community engagement, and hyper fragmented, poorly coordinated external development assistance.

3) **RECOGNIZING** that the National Health Act (2014) created a National Health System comprising the Federal Ministry of Health, Ministries of Health in the 36 States and Federal Capital Territory (FCT), Local Governments, private sector, and community actors, and that the Coordinating Minister of Health and Social Welfare is mandated to pursue reforms of the National Health System.

4) **ACKNOWLEDGING** the approval of His Excellency, President of the Federal Republic of Nigeria, Bola Ahmed Tinubu, GCFR, for the implementation of Nigeria's Health Sector Renewal Initiative using a Sector-Wide Approach to improve population health outcomes.

5) **APPRECIATING** the consultations with Nigeria Governors' Forum, National Economic Council, and approval of the Sector-Wide approach by the 64th National Council on Health recently held in Ekiti with participation of the Federal Government and all 36 States and FCT.

6) ALIGNING our objectives with the priorities in the Nigerian National Strategic Health Development Plan (NSHDP) and the Renewed Hope Health Sector Blueprint's pillars (Effective Governance, Efficient, Equitable and Quality Health System, Unlocking Value Chains and Health Security) to improve governance, accountability, and relentless focus on results.

7) ADOPTING a more coordinated approach between Federal Government, State Governments, FCT, and all Development Partners, to achieving the desired improvement in the health of all Nigerians at scale.

8) COMMITTING to the redesign of the Basic Health Care Provision Fund, comprising at least 1% of the Consolidated Revenue Fund, provided by the National Health Act (2014), as the foundational basis of the sector-wide approach, to:
    a. Ensure more equitable, allocation of resources to the poorest and most disadvantaged persons and populations.
    b. Mobilize additional development partner (multilateral, bilateral, philanthropic, and private sector) financial resources to a common pool or aligned in parallel with the sector-wide approach.
    c. Doubling the number of fully functional Primary Healthcare Centers (PHCs) receiving Decentralized Facility Financing for infrastructural upgrades, and operational costs to ensure delivery of high quality essential Primary Health Care package including routine immunization, delivery, Family Planning, Antenatal Care(ANC), Postnatal Care, and meet the Basic Emergency Obstetric and Newborn Services (BEmONC) criteria, from 8,809 to 17,618 PHCs by 2027 in 36 States and the FCT.
    d. Link PHCs to a Secondary Care facility providing Comprehensive Emergency Obstetric and Newborn Care (CEmONC).
    e. Link PHCs to referral Secondary Care facility providing CEmONC through progressive development of a National Emergency and Medical Ambulance System.
    f. Refine the Vulnerable Group Fund (VGF) and optimize risk pools to strategically purchase highest impact benefit package to improve health outcomes with a focus on financial protection for critical reproductive, maternal, newborn, child, adolescent health, and nutrition services to reduce morbidity and preventable deaths.
    g. Take collective action towards achieving Universal Health Coverage by expanding health insurance coverage, ensuring healthy and viable risk pools through effective governance, and establishing an enabling environment for better public and private sector collaboration.
    h. Complement BHCPF financing with public health interventions to reduce the burden of Communicable and Non- Communicable Diseases including malaria, tuberculosis, and HIV/AIDS, increase access to sexual and reproductive health care services, and to strengthen systems and improve health security.

i. Ensure "best-buy" investments in community health models to serve as a critical entry point to public health services in a people-centered health system, including as a first step retraining of up to 120,000 frontline health workers as collaborative effort between Federal, State Governments, and key development partners to be followed by enhanced deployment.

j. Make transparent to all Government, Non-Governmental Partners, CSOs, and Citizens, the resources allocated, released, and results achieved.

9) **COMMITTING** all State Governments and FCT to complement the Federal Government by undertaking the following key policy actions:

a. Increasing budget allocation and timely releases of funds for primary health care services, immunization, family planning, and public health, and make those allocations and releases public.

b. Verifiably fulfilling jointly agreed counterpart obligations, in cash or in-kind, in support of the BHCPF, to State Primary Health Care Development Agencies and State Health Insurance Authorities and streamlining processes for disbursement and accounting for such transfers.

c. Collaborate in exploring innovative financing options, to expand universal health coverage especially for poorest Nigerians, potentially including health taxes, surcharges, and first charge from the VAT pool.

d. Training and retaining qualified health workforce dedicated to service delivery at community levels, primary health centers and hospitals.

e. Ensuring presentation and consideration of routine data on health outputs and intermediate outcomes on a quarterly basis in State executive councils, Nigeria Governors' Forum, and relevant National Economic Council meetings.

f. Participating in community health campaigns and engaging traditional and religious leaders in the States.

10) **COMMITTING to** the establishment of a joint coordination and monitoring mechanism in the Sector-Wide approach, establishing a common database of all health development partner engagements with the Federal Government and all 36 States and FCT, a results scorecard to transparently chart progress on a regular basis (at least annual, semi-annual) and hold each other accountable in bi-directional ways, to achieve desired results or course-correct.

11) **ENDORSING** the preparation and presentation of an annual report of the State of Health of Nigerians and the National Health System, as provided in the

National Health Act, to the President, National Assembly, Federal Executive Council, and the National Economic Council, and the hosting of a National annual joint review of performance along the benchmarks set out in the sector-wide indicators framework; and

12) **CALLING** on all health development partners to fully support the sector-wide approach; develop its coordinating secretariat; align behind Government's priorities supporting national ownership; strengthen and use national institutions and systems where possible; and reorient all technical and financial assistance, in a nationally coordinated manner, to the front ends of service delivery rather than process and activity orientation.

SIGNED in Abuja, Nigeria on 12th December 2023

BY
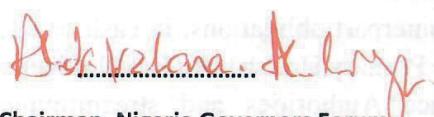
Chairman, Nigeria Governors Forum   **Coordinating Minister of Health**
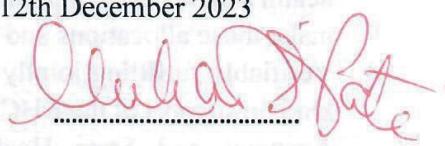
Executive Summary

Implementing Nigeria's Sector-Wide Approach through the HOPE-PHC Program

The SWAp aligns federal and state governments and partners under a unified results framework. At the heart of the SWAp is a commitment by the federal and state governments, alongside development partners, to work under a unified health strategy. This approach replaces fragmented interventions with a harmonized framework guided by a single results agenda. It is anchored in the Nigeria Health Sector Renewal Investment Initiative (NHSRII), launched in 2023, and solidified through a national compact signed by all 36 states and the FCT.

This Program Operations Manual (POM) guides the implementation of the HOPE-PHC program, acts as an operational model for Nigeria's Sector-Wide Approach (SWAp), and serves as the framework through which SWAp principles are put into practice. The Human Capital Opportunities for Prosperity and Equality – Primary Health Care Provision Strengthening (HOPE-PHC) program represents a bold and transformative step in Nigeria's efforts to reform its health sector. Designed as a flagship operational model for the SWAp, HOPE-PHC embodies a new way of working—one that prioritizes alignment, accountability, and results.

HOPE-PHC delivers on the SWAp through improved health services delivery, systems strengthening, and results-based financing. The HOPE-PHC program is the first national investment to fully operationalize the SWAp. It focuses on strengthening primary health care (PHC) service delivery, improving the quality and utilization of essential services, and enhancing the resilience of the health system. It will be implemented in eligible states that commit to the shared principles of the compact and meet readiness criteria.

Core Features of HOPE-PHC

- National Scope, State-Led Implementation: The program will operate across Nigeria's 774 LGAs, with resources channeled through state-level implementing agencies, reinforcing the decentralized nature of Nigeria's health system.

- Results-Based Financing: Over 90% of the committed financing is tied to Disbursement-Linked Indicators (DLIs) that incentivize improved health outcomes and system performance.

- Investment Support: An Investment Project Financing (IPF) component supports capacity building, technical assistance, digital transformation, and strategic purchasing reforms.

The program's key result areas (KRAs) reflect its strategic priorities—improving service quality, expanding access, and strengthening resilience—and include the following:

- KRA 1: Improving Quality of Services: Investments in BEmONC/CEmONC facilities, climate-resilient infrastructure, and essential RMNCAH-N commodities.

- KRA 2: Improving Utilization of Essential Services: Expanded insurance coverage, strengthened community-based service delivery, and subsidized maternal and child health services.

- KRA 3: Improving Resilience: Enhanced emergency preparedness, climate adaptation, and integrated health data systems.

This manual is a reference guide for operationalizing the program at all levels. This Program Operations Manual (POM) provides clear, detailed guidance to federal and state implementers, program staff, and partners on:

- Roles and institutional arrangements at national, state, and LGA levels

- Fund flow, financial management, and procurement procedures

- Monitoring and verification systems, including DLIs and the Independent Verification Agency (IVA)

- Environmental and social safeguards

- Technical assistance coordination, digital integration, and research priorities

The POM is aligned with World Bank documentation and provides technical direction for implementation. The manual draws directly from the World Bank's Program Appraisal Document and financing agreements and should be used as an implementation reference throughout the program cycle. For government stakeholders, it highlights the operational steps required to fulfill compact commitments. For technical teams, it provides the standard operating procedures necessary to deliver results.

HOPE-PHC sets the blueprint for broader reform success through coordinated action and shared accountability. By aligning all actors under a single results framework and harmonizing funding streams, HOPE-PHC aims to not only improve health outcomes but also serve as a scalable blueprint for broader health sector reform. Its success depends on political commitment, technical rigor, and a shared focus on accountability.

How to Use This Manual: Summary of Chapters

Chapter 1: The Health Sector in Nigeria and Adopting a Sector-wide Approach

Introduces the rationale for sector reform, highlighting challenges in financing, outcomes, and governance. Explains the origins and core principles of the SWAp and NHSRII.

Chapter 2: The HOPE-PHC Program

Describes the program's objectives, scope, activities, financing instruments, and key result areas. Explains how HOPE-PHC implements the SWAp in practice.

Chapter 3: Institutional and Implementation Arrangements

Outlines federal, state, and local responsibilities for program implementation. Provides a framework for coordination and supervision.

Chapter 4: Performance-Based Incentives for the Program's Components which will Disburse Against Achievement of Results

Details the DLI framework, verification protocols, and incentive structure. Guides implementers on performance targets and disbursement conditions.

Chapter 5: Overall Result Framework, Monitoring, Evaluation, and Reporting Systems

Explains the program's M&E system, including annual reviews, reporting tools, and evaluation strategy. Supports accountability and learning.

Chapter 6: Communication Strategy

Describes stakeholder engagement and messaging strategies. Provides tools to ensure transparency, promote behavior change, and build public trust.

Chapter 7: Financial Management and Procurement

Provides operational guidance for budgeting, accounting, disbursement, and procurement. Ensures compliance with fiduciary standards.

Chapter 8: Environment and Social Safeguards

Outlines policies, mitigation plans, and grievance mechanisms to manage environmental and social risks. Includes all guidance related to the Grievance Redress Mechanism for HOPE-PHC. Aligns with World Bank safeguards.

Chapter 9: Strengthening Evidence-Based Policy Formulation and Research Agenda

Presents a learning agenda and evaluation priorities to support adaptive program implementation. Encourages use of research in decision-making.

Chapter 10: Technical Assistance Pooling and Technical Capacity Building to Deliver on DLIs

Describes the Joint TA platform and pooling mechanism. Guides the delivery of capacity-building support aligned with national priorities.

Chapter 11: Complementarities between the HOPE-PHC Program and the HOPE-GOV Program

Clarifies the relationship between HOPE-PHC and governance reforms under HOPE-GOV. Reinforces policy alignment and institutional accountability.

Chapter 12: Design and Approval of CEmONC Empanelment and Reimbursement Strategy

Details the framework for empaneling and reimbursing hospitals for emergency obstetric and newborn care. Sets criteria and processes.

Chapter 13: Financing Access to Essential Health Services for Vulnerable and Poor Nigerian

Provides operational guidance on financial access to essentials health services for vulnerable Nigerians.

Chapter 14: Scaling Health Workforce Through the Community Based Health Worker (CBHW) Program

Outlines the implementation timeliness, supervision and performance management and incentives for the CBHW program .

Chapter 15: Maternal Mortality Reduction Innovation Initiative (MAMII) Guide

Provides operational guidance for MAMII, targeting high-burden areas with targeted maternal and newborn health interventions.

Chapter 16: RESMAT Implementation Framework

Lays out the framework for emergency medical transport systems in rural areas. Supports referral efficiency and reduces maternal mortality.

Contents

Abbreviations

ACTs	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
AOP	Annual Operational Plan
APA	Annual Performance Assessment
AWP&B	Annual Work Plan and Budget
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
BHCPF MOC	Basic Health Care Provision Fund Ministerial Oversight Committee
BHCPF SOC	Basic Health Care Provision Fund State Oversight Committee
BHCPP	Basic Health Care Provision Program
BMGF	Gates Foundation
BPP	Bureau of Public Procurement
CBN	Central Bank of Nigeria
CDD	Community-Driven Development
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CEMTO	Community Emergency Medical Transport Triage Officer
CHEWs	Community Health Extension Workers
CHWs	Community Health Workers
CIFF	Children's Investment Fund Foundation
CMHSW	Coordinating Minister of Health and Social Welfare
CPF	Country Partnership Framework
CRI	Corporate Results Indicator
CRIBS	Climate Resilient Infrastructure for Basic Services
DFF	Direct Facility Financing
DHIS2	District Health Information System 2
DHPRS	Department of Health Planning, Research, and Statistics
DIME	Development Impact Evaluation
DLI	Disbursement-linked Indicator
DLR	Disbursement-linked Result
DMA	Drug Management Agency
DP	Development Partner
DPG-Health	Development Partners Group for Health
EC	Eligibility Criteria
EDGE	Excellence in Design for Greater Efficiency
EFCC	Economic and Financial Crimes Commission
EMS	Emergency Medical Services
EMT	Emergency Medical Transport
EPR	Emergency Preparedness and Response Plan

ESS2	Environment and Social Safeguards; 2
ESSA	Environmental and Social Systems Assessment
ESSMAP	Environmental and Social Safeguard Management Action Plan
FARAH	Financial Accounting, Reporting and Auditing Handbook
FASTR	Frequent Assessments and Systems Tools for Resilience
FCDO	Foreign, Commonwealth and Development Office
FCT	Federal Capital Territory
FHWs	Frontline Health Workers
FM	Financial Management
FMBEP	Federal Ministry of Budget and Economic Planning
FMOH&SW	Federal Ministry of Health and Social Welfare
FP	Family Planning
FPFMD	Federal Project Financial Management Department
FPM	Financial Procedures Manual
FRP	Fund Release Policy
FSA	Fiduciary System Assessment
GAVI	Gavi, the Vaccine Alliance
GDP	Gross Domestic Product
GFF	Global Financing Facility
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCI	Human Capital Index
HIV	Human Immunodeficiency Virus
HMB	Hospitals Management Board
HMSH	Honourable Minister of State for Health
HNP	Health, Nutrition and Population
HOPE	Human Capital Opportunities for Prosperity and Equality
HOPE-BED	Human Capital Opportunities for Prosperity and Equality—Education
HOPE-GOV	Human Capital Opportunities for Prosperity and Equality—Governance
HOPE-PHC	Human Capital Opportunities for Prosperity and Equality—Primary Health Care Provision Strengthening Program
HRH	Human Resources for Health
IBRD	International Bank of Reconstruction and Development
ICPC	Independent Corrupt Practices Commission
IDA	International Development Association
IFSA	Integrated Fiduciary Systems Assessment
IPF	Investment Project Financing
IVA	Independent Verification Agency
JCHEWS	Junior Community Health Extension Workers
JICA	Japan International Cooperation Agency
KRA	Key Result Area
LAD	Large Anonymous Donor
LARC	Long-Acting Reversible Contraceptive
LGA	Local Government Area
M&E	Monitoring and Evaluation
MAMII	Maternal Mortality Action Innovation Initiative

MDAs	Ministries, Departments and Agencies
MDTF	Multi-donor Trust Fund
MERL	Monitoring, Evaluation, Research, and Learning
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MMS	Multiple Micronutrient Supplements
MOC	Ministerial Oversight Committee
NCDs	Non-Communicable Diseases
NCDC	Nigeria Centre for Disease and Control and Prevention
ND-GAIN	Notre Dame Global Adaptation Index
NDC	Nationally Determined Contribution
NDHS	National Demographic and Health Survey
NEMSAS	National Emergency Services and Ambulance Scheme
NHIA	National Health Insurance Authority
NHSRII	Nigeria Health Sector Renewal Investment Initiative
NIE	National Implementing Entity
NISP	National Implementation Support Plan
NPCU	National Program Coordination Unit
NPCU/SCO	National Program Coordination Unit/SWAp Coordinating Office
NPHCDA	National Primary Health Care Development Agency
NSC	National SWAp Steering Committee
NURTW	National Union of Road Transport Workers
OAGF	Office of the Accountant General of the Federation
OAuGF	Office of the Auditor General for the Federation
PAD	Program Appraisal Document
PAP	Program Action Plan
PCU	Program Coordination Unit
PDO	Program Development Objective
PEF	Program Expenditure Framework
PFM	Public Financial Management
PFMU	Program Financial Management Unit
PforR	Program for Results
PHCs	Primary Health Care Centers
PMIS	Program Management Information System
PMT	Proxy Means Testing
PMU	Program Management Unit
POM	Program Operations Manual
PPR	Pandemic Preparedness and Response
PPSD	Program Procurement Strategy Document
PSH	Permanent Secretary for Health
PV	Payment Voucher
PVAC	Presidential Initiative for Unlocking the Healthcare Value Chain
RESMAT	Rural Emergency Service and Medical Transport
RMNCAH-N	Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition

SCO	SWAp Coordinating Office
SDGs	Sustainable Development Goals
SDR	Special Drawing Rights
SEMSAS	State Emergency Medical Services and Ambulance System
SHMB	State Health Management Board
SIE	State Implementing Entities
SMOH	State Ministry of Health
SOC	State Oversight Committee
SOE	Statement of Expenditures
SOML	Saving One Million Lives
SOP	Standard Operating Procedures
SORT	Systematic Operations Risk
SPHCDA	State Primary Health Care Development Agency
SSC	SWAp Steering Committee
SSHIA	State Social Health Insurance Agency
SWAp	Sector-wide Approach
TA	Technical Assistance
ToR	Terms of Reference
TWG	Technical Working Group
UHC	Universal Health Coverage
UNCITRAL	United Nations Commission on International Trade Law
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USSD	Unstructured Supplementary Service Data
VGF	Vulnerable Group Fund
VVF	Vesico-Vaginal Fistula
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WHO	World Health Organization

Figures & Tables

01

THE HEALTH SECTOR IN NIGERIA AND ADOPTING A SECTOR-WIDE APPROACH

Chapter 1 - The Health Sector in Nigeria and Adopting a Sector-wide Approach

1.1   The Health Sector in Nigeria

1.1.1   Nigeria's Human Capital Crisis and Failure to Thrive

Nigeria is among the largest economies in Africa, with a gross domestic product (GDP) of approximately US$363 billion in 2023, but over 40 percent of the population lives in poverty (World Bank, 2023)[1]. Nigeria's key development constraints include insufficient

01 improving economic governance and gaining trust in public systems by boosting government investments in human capital development programs,

02 expanding social assistance, and

03 improving opportunities for the masses.

Figure 1.1 Pathway to resolving Nigeria's human capital crisis

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1- World Bank. Nigeria Economic Update. 2023

economic diversification, non-inclusive growth, and poor investment in human capital hinged on poorly developed health and social systems. Pathways for development in Nigeria include improving economic governance and gaining trust in public systems by boosting government investments in human capital development programs, expanding social assistance, and improving opportunities for the masses (Figure 1.1) .

The human capital crisis in Nigeria has hindered demographic transition with human capital index of 0.36, which implies a child born today is expected to achieve only 36 percent of their potential productivity by age 18. This falls below the Sub-Saharan African average of 40 percent, as well as regional comparators such as South Africa (43 percent), Ghana (45 percent), and Kenya (55 percent) (World Bank, 2023)[2]. If Nigerians were to reach their full educational and health potential, the country's per-capita GDP could be 2-8 times higher.

1.1.2 Health Sector Burden and Challenges in Nigeria

The health sector indices in Nigeria are some of the worst globally. Life expectancy at birth is 54 years, under-five mortality is the second highest globally at 114 per 1,000 live births, and maternal mortality is third-highest in the world at over 1,000 per 100,000 live births (UNICEF, 2021)[3]. These numbers translate to over 800,000 deaths among children under five and about 80,000 maternal deaths each year. Nigeria, therefore, accounts for one out of six child deaths and one out of four maternal deaths globally (WHO, 2019)[4]. Thirty-seven percent of under-five deaths, in Nigeria, occurs within the first 28 days of life, raking Nigeria second globally in neonatal death. The prevalence of stunting among
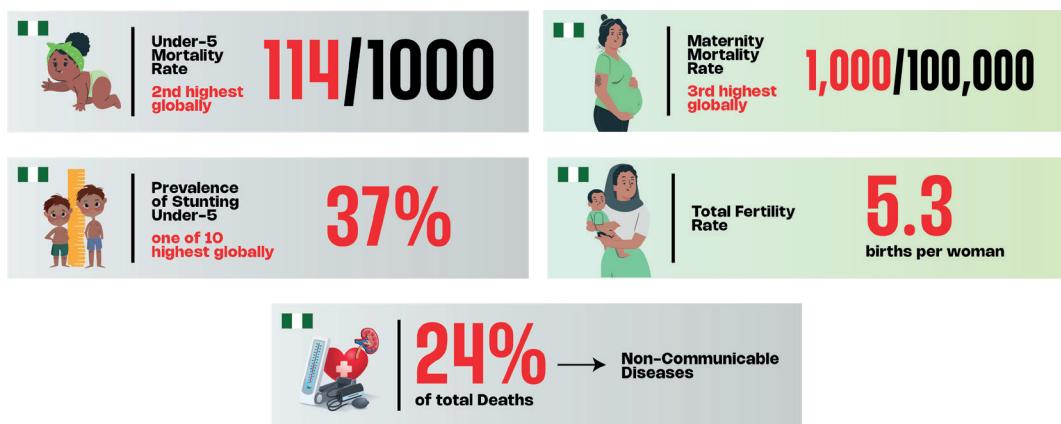
Figure 1.2 Health Sector Indices in Nigeria

children under five is 37 percent, one of the ten highest rates in the world (UNICEF, 2021)[3], with long-term implications for human development. The total fertility rate is also very high at 5.3 births per woman (WHO, 2019)[4] and has only marginally reduced from levels three decades ago. Non-communicable diseases (NCDs) are becoming a growing burden accounting for 24 percent of total deaths in Nigeria and posing a challenge for human capital development at large (figure 1.2).

2- World Bank. Economic Outlook, Africa. 2023

3 - UNICEF. Nigeria Country Profile. 2021

4 - WHO. Examining Maternal and Child Health in Sub-Saharan Africa. 2019

5- NBS. Nigeria Demographic and Health Survey. 2018

The poor health outcomes are linked predominantly to shortcomings in access to essential health services and to poor quality of care. Medical oxygen is a life-saving essential medicine used to treat patients at all levels of the healthcare system from intensive care, newborn and child health care, anaesthetic and surgical cases to outpatient services. In Nigeria, an estimated 625,000 deaths occur annually from diseases associated with hypoxaemia16. However, reliable data about the hypoxaemia burden and oxygen need for different disease conditions is largely lacking. Notably, hypoxaemia is prevalent among hospitalized children in Nigeria, increasing the odds of death by six-fold in neonates and eight-fold in under-five children17. Since 2008, skilled birth attendance at delivery has improved marginally, from 39 percent to 43 percent in 2018 according to the demographic and health survey (NBS, 2018)[5]. Childhood immunization coverage remains a significant challenge, with diphtheria, pertussis, and tetanus Pentavalent vaccine (DPT-3/Penta-3) coverage estimated at 57 percent (NBS 2018)[5].

As of 2020, Nigeria had the largest number of zero-dose children in the world, with the estimated number of zero- or missed-dose children increasing to 3.1 million from 3.0 million the previous year (UNICEF, 2021)[3]. These poor health outcomes demonstrate Nigerians' low utilization of health services due to a myriad of structural and social
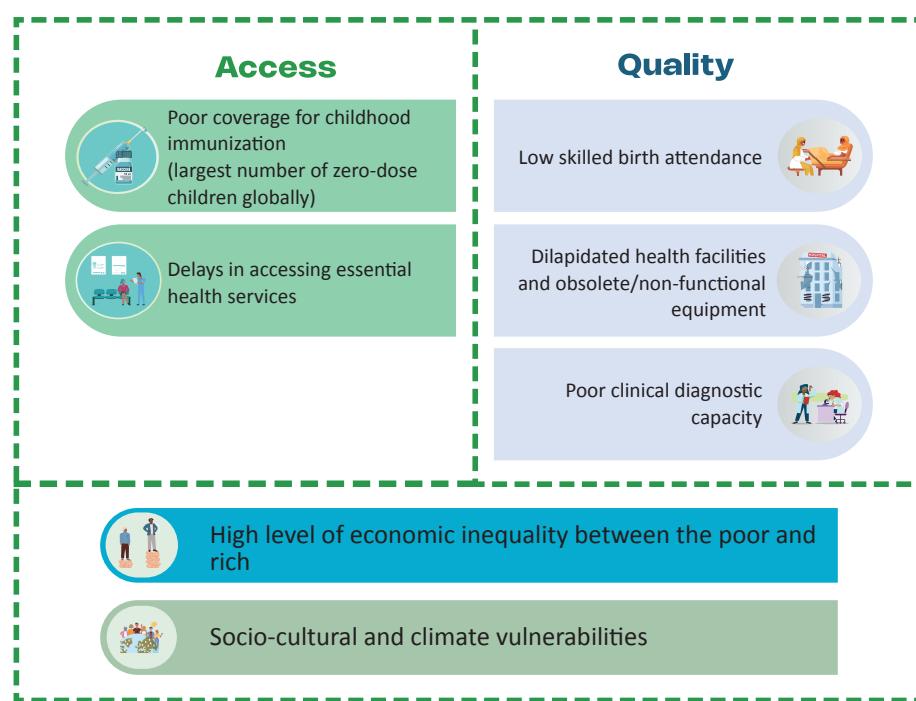
Figure 1.3 Health System Challenges in Nigeria

factors. Nigeria's healthcare services quality remains suboptimal and compares poorly with its peers. The lack of recent data on the quality of health services shows the gap in tracking this significant component of service delivery. The last national health service quality review was done in 2013 with the availability of essential equipment within health centers in Nigeria at 33 percent, compared to 89 percent in Tanzania and 84 percent

5- NBS. Nigeria Demographic and Health Survey. 2018

3 - UNICEF. Nigeria Country Profile. 2021

16 - Federal Ministry of Health. National Policy on Medical Oxygen in Health Facilities. Published online 2017

17 - Graham H, Bakare AA, Ayede AI, et al. Hypoxaemia in hospitalised children and neonates: A prospective cohort study in Nigerian secondary-level hospitals. EClinicalMedicine. 2019;16:51-63. doi:10.1016/j.eclinm.2019.10.009

in Kenya (Nigeria SDI 2013)[6]. Clinical competence is similarly weak: only 43 percent of clinical conditions in Nigeria are accurately diagnosed, compared to 69 percent in Tanzania and 67 percent in Kenya (World Bank, 2015)[7]. A national assessment of maternal deaths and near misses at hospitals identified gaps in service availability for maternal health as well. This assessment found that more than 90 per cent of mothers arrived at the health facility in critical condition. Despite this, in 50% of cases more than 60 minutes passed between diagnosis and critical intervention, and in 21.9 per cent of cases, this period was more than four hours. Shortages in human resources for health (HRH) and health infrastructure, along with a chronically weak supply chain and poor referral systems, intensify these service delivery challenges (World Bank, 2015)[7].

In a country with high income inequality, challenges in access to care and quality of care are greater for the poorest Nigerians. A child born into the poorest wealth quintile is over three times more likely to die before the age of five than a child born into the richest wealth quintile. At the same time, nearly every Nigerian State, including the richest, has a higher rate of under-five mortality than expected at their income level (measured by state gross national income per capita and compared with other nations at the same economic level) (NDS 2018). If Nigeria's second-richest wealth quintile was a country (with a population over 40 million), its under-five mortality rate would rank among the ten highest globally and far behind the target set out in the Sustainable Development
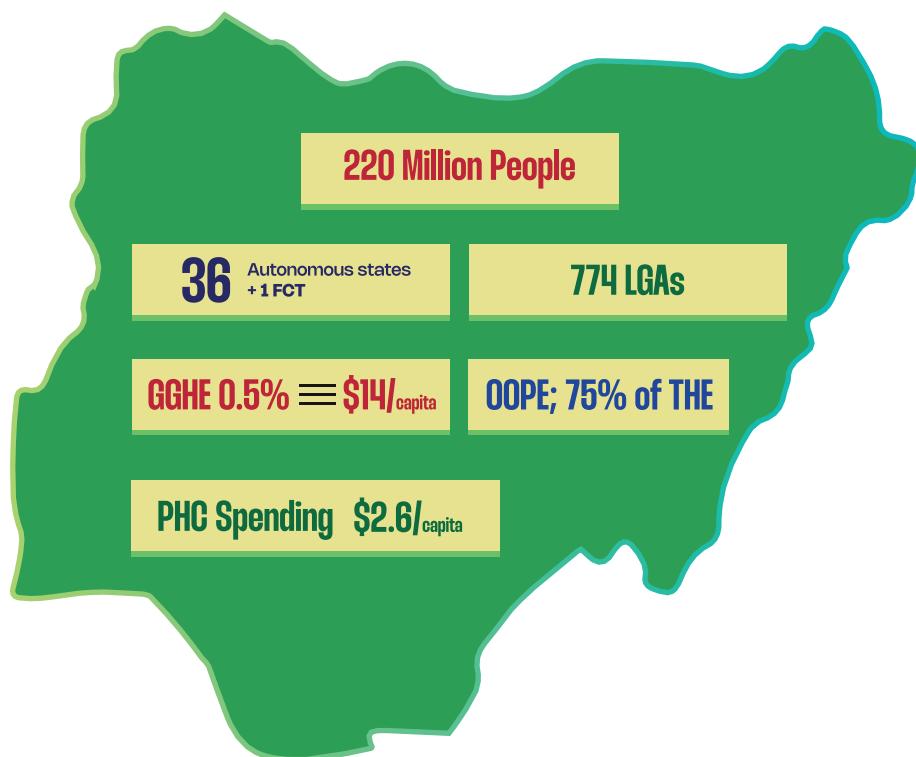
Figure 1.4 Fiscal federalism and health sector financing in Nigeria

6 - World Bank. Nigeria Health Service Delivery Indices. 2019

7 - World Bank. Service Delivery Update: SSA. 2015

8 - https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.13450

9 - Ononokpono DN, Odimegwu CO. Determinants of maternal health care utilization in Nigeria: a multilevel approach. Pan Afr Med J. African Field Epidemiology Network. 2014;17:2.

Goals (SDGs).

Socio-cultural and climate vulnerability differences between the north and south of Nigeria has created inequities that are accentuated in the health sector and resultant health outcomes. The states in northern Nigeria are more impacted when compared to their southern counterparts[10], for example, a woman living in North East Nigeria is ten times more likely to die during childbirth than a woman living in the South West. The climate, geographic terrain, and socio-cultural differences in these regions influence the availability of safe and climate-resilient health facilities, the distance to health facilities, the availability of skilled health workforce, and sociocultural behaviours which influences the utilization of essential health services. As such, women in the north are less likely to give birth at health facilities,[9] and many live far from health centers which are plagued by severe shortages of health workers compared to the south of Nigeria.

Climate change further threatens Nigeria's health system and jeopardizes health outcomes as effects have been linked to exacerbated transmission of water and vector-borne diseases in the country. Nigeria's vulnerabilities to extreme heat, floods, and drought have influenced the transmission of malaria, the leading cause of under-five mortality in the country, [10] food insecurity contributing to burgeoning rates of stunting and wasting in children under five, and flooding, which is debilitating the country's health facilities and further limit access to health services. For example, severe floods in 2022 destroyed 30 medical facilities in the hardest-hit state of Jigawa alone. [11]

1.1.3   Nigerian Government Health Spending

As a diverse federation of 36 autonomous states and 220 million people, federal-state coordination is a challenge. Nigeria's constitution provides for a vertical revenue-sharing formula across federal, state, and local governments and centrally-controlled special funds. Particularly for the health sector, the role of each level of government is not clearly defined, consequently creating accountability challenges, which translate to inadequate prioritization of public health spending, especially at the state level. This has resulted in federal fiscal dominance and in financially weak states, where budget execution is poor and there is no national oversight system to modulate failure and poor performance. Consequently, federal government health expenditure as a share of GDP ranks the lowest in the world, at 0.5 percent (World Bank, 2019)[12]. This translates to about US$14 per capita, of which less than 20 percent (US$2.62 per capita) (World Bank, 2019)[12] is allocated to primary and essential healthcare. Such fragmented financing—marked by multiple, poorly coordinated funding streams—has significant implications, including duplication of efforts, inefficient resource allocation, and weakened accountability structures. It undermines strategic planning and reduces purchasing power, thus diminishing the overall effectiveness and sustainability of healthcare interventions.

This low level of health financing severely limits the country's ambition to achieve universal health coverage (UHC). While global estimates of the cost of providing an

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10. FMOH&SW. Nigeria Climate Change and Health Vulnerability and Adaptation Assessment Report. 2024

11 - Abdulrakib Abdulrahim et al. A catastrophic flood in Nigeria, its impact on health facilities and exacerbations of infectious diseases. PAMJ - One Health. 2022;9(21). 10.11604/pamj-oh.2022.9.21.38023.

12 - R Hafez; World Bank. Nigeria Health Financing System Assessment. 2019

essential health service package in countries at Nigeria's income level fall between US$70 and US$80 per capita (WHO, 2021)[13], Nigeria costs her basic primary care package at about US$10 per capita (NHA, 2021)[14]. The low government health spending is pushing
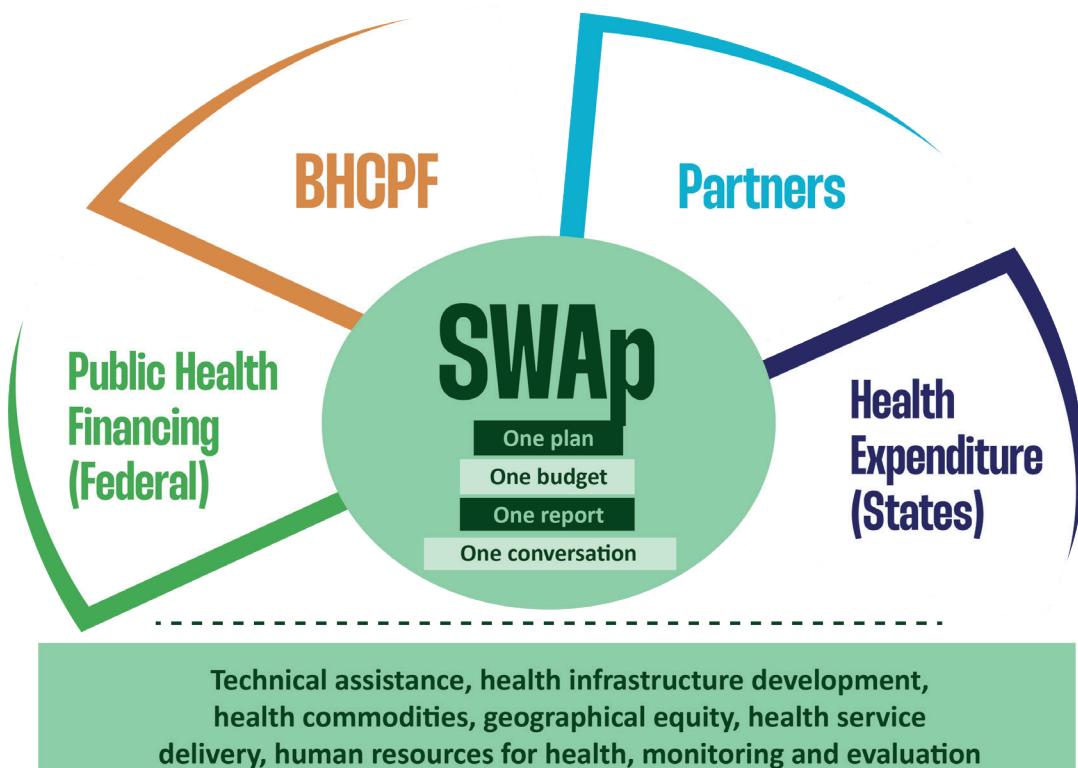
Figure 1.5 Sector-wide Approach in Nigeria

Nigeria's household out-of-pocket expenditures to account for almost 75 percent of total health spending and the fourth-highest share in the world (NHA, 2021)[14]. The government has used conditional fiscal transfers through the Basic Healthcare Provision Fund (BHCPF) in the health sector to transfer resources and influence public spending on essential health services since 2018 achieving mixed results partly due to continued financial fragmentation and coordination challenges.

1.1.4   Digital Data and Technology in the Health Sector

Nigeria's health sector currently suffers from fragmented, paper-based, and poorly standardized digital data systems, with limited interoperability across over 40,000 health facilities—many of which still lack basic digital infrastructure. The use of electronic health records is sparse and inconsistent, hampering effective patient care, public health decision-making, and efficient insurance processing. In response, the government launched the Nigeria Digital in Health Initiative (NDHI) in 2024 to create a unified, interoperable digital health architecture (Nigeria Digital Health Architecture, NDHA) that includes core building blocks such as health registries, a Health Information Exchange (HIE), and a Shared Health Record. These systems aim to improve data access and quality, enable seamless service

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13 - WHO. Scaling up Action Against Non-communicable Diseases. 2021

14 - WHO. Nigeria Health Account. 2021

delivery, and support innovations like AI-driven tools and personal health apps. In the short term, NDHI seeks to establish technical standards and pilot digital integration; in the long term, it aims to transform the health system into a scalable, patient-centric, and data-driven ecosystem. The National Health Insurance Authority (NHIA) will benefit through digital health claims exchange platforms that improve claims management, enhance transparency, and reduce inefficiencies.

1.2   Adopting a Sector-Wide Approach

1.2.1   A Sector-wide Management Approach for Promoting Health Sector Development

The BHCPF design has shown promises of addressing significant health sector challenges and promoting equitable health sector development to close the gap between the weakest and wealthier states and collectively push the system towards universal health coverage (UHC). However, implementing the BHCPF has been challenging as the amount in the fund is insufficient to affect the necessary changes. Although health financing limitations prevail, external development assistance in Nigeria has risen over the years, now accounting for about 10 percent of Nigeria's total health spending. However, its impact represents less than the sum of its contributions due to significant fragmentation, inefficiencies, and parallel procedures. There are many multilateral, bilateral, and philanthropic international and domestic development partners in the health sector, with a complex array of inputs (financing, technical assistance (TA), and commodities), geographical distribution (focus states and federal government), sectoral priorities, thematic preferences, and institutional arrangements (monitoring and evaluation (M&E) frameworks, financial management (FM) practices, and authorizing structures). This fragmented approach has undermined the impact of this significant financing in the sector.
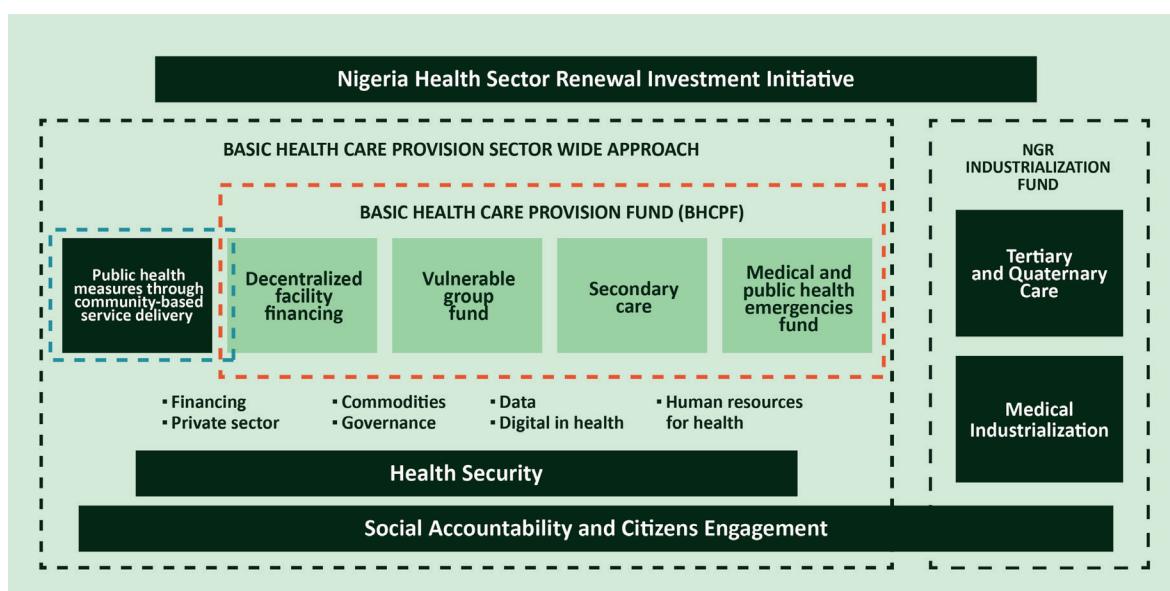
Figure 1.6 Relationship between HOPE-PHC and NHSRII

Under the new leadership of President Bola Ahmed Tinubu and a Renewed HOPE-PHC vision being steered by the Coordinating Minister of Health and Social Welfare, Professor Ali Pate, the BHCPF redesign as part of a broader Nigeria Health Sector Renewal Investment Initiative (NHSRII) will be a key financing vehicle for the broader Basic Healthcare Provision Program (BHCPP). The BHCPP will be implemented using a sector-wide approach (SWAp) to effectively integrate all public, development partners, and private sector resources to improve coordination and reduce inefficiencies in the health sector. The approach will address the current fragmentation in the system and pool government financing with available funding from all stakeholders to increase alignment and improve efficiency in health systems financing and service delivery. Taking a sector-wide approach implies shifts in the ways of doing business and in the partnership between the Government of Nigeria and its health development partners.

The approach will align the government at all levels and its partners around a "one plan, one budget, one M&E" framework, driving a single, nationally led conversation and harmonized actions aimed at achieving Nigeria's health sector aspirations, notably on reducing maternal newborn and child mortality. The adoption of a SWAp, inauguration of a SWAp coordinating office and appointment of a National Program Coordinator by the President demonstrate a concerted effort to bolster the sector's capacity to deliver on the Renewed HOPE-PHC Agenda, to improve accountability across all levels of government, and to increase health service availability and access to all Nigerians regardless of socio-economic status. Endorsement of the SWAp means that both the government and development partners, including the World Bank, will be striving to operate in a more aligned and integrated manner, adjusting their procedures where policies allow.

1.2.2 Nigeria Health Sector Renewal Investment Initiative and the 2023 National Compact on Improving Health Sector Outcomes

The NHSRII is the anchor reform to be supported through Nigeria's new health sector-wide approach (SWAp) to improve coordination and accelerate the implementation of critical reforms and policies in the health sector. The NHSRII is an ambitious and transformative initiative launched on World UHC Day in December 2023 with the aim of improving Nigeria's health outcomes and economic potential by drastically reducing maternal and under-five mortality rates.

The BHCPP, driven by the BHCPF, is an integral pillar of the NHSRII. By investing in service readiness, frontline health workers (FHWs), and evidence-based interventions, the BHCPP aims to unlock Nigeria's human capital potential. Overall, the NHSRII presents a call to action for all levels of government and donor community to build a robust coalition to support Nigeria for saving lives, boosting its human capital, and building a platform for health sector development by improving the efficiency and impact of its public and development financing.

Following the compact signing by all orders of government in Nigeria and development partners, the SWAp was established by the FMOH&SW in 2023. Partners have started

aligning their resources with the priorities outlined in the SWAp compact and are members of the thematic technical working groups set up to actualize the approach. Several partners have started processing agreements to align their financing with the SWAp, with some partners already completing the process and committing resources for the NHSRII. A SWAp should also provide the leverage to deepen federal–state dialogue for additional domestic resource mobilization and better accountability for results. The SWAp also aims to provide the leverage to deepen federal–state dialogue for additional domestic resource mobilization and better accountability for results. Through the NHSRII Compact, the 36 State Governments and FCT committed to complement the Federal Government by undertaking increasing budget allocation and timely releases of funds for primary health care services, immunization, family planning, and public health, and make those allocations and releases public. Thus, as part of the accountability and transparency, the CMHSW holds quarterly dialogues with the state commissioners to hold each other accountable in bi-directional ways, to achieve desired results along the benchmarks set out in the sector-wide indicators framework.

The NHSRII incorporates lessons from past reform experiences to inject fresh hope into Nigeria's health sector using a design that corrects previous errors in management. The operating environment is also appropriate as there is an unprecedented level of stakeholder alignment around health reform, evidenced by the federal compact signed by all states, the Federal Government of Nigeria (FGN), and donor partners. This approach is expected to de-fragment the local and external assistance to health sector development and overcome inefficiencies that have plagued the sector in the past.

In addition to macro-level shifts, the initiatives include several important service delivery innovations in a HOPE-PHC provisioning program which have not been part of previous reform efforts. These include purchasing Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services and investing in digital health platforms, expanding community health service delivery and commodity security and focusing on the complementarities of supply- and demand-side efforts and different levels of care. In May 2025, the National Primary Health Care Development Agency (NPHCDA) deployed Performance and Financial Management Officers (PFMOs) to each Local Government Area (LGA) in Nigeria to strengthen accountability, enhance transparency, and improve health outcomes in Primary Health Care (PHC) facilities. These officers provide essential

management support, informed by lessons from the Nigeria State Health Investment Project (NSHIP), where PHCs were identified as having low management capacity. PFMOs will support the health system to track performance indicators, facilitate community engagement, and ensure transparent, effective use of Basic Healthcare Provision Fund (BHCPF) resources. By addressing managerial gaps, PFMOs play a critical role in achieving sustainable improvements in service delivery and financial oversight within Nigeria's primary healthcare system and supporting the objectives of HOPE-PHC and the SWAp.

The NPHCDA is further streamlining the role of community health workers through a redesigned Community-Based Health Worker (CBHW) program. This program will formalize and streamline the roles of community health workers across Nigeria to support the delivery of quality health services.

Providing joint platforms for planning, delivery, monitoring, and accountability will drive efficiency, transparency, and accountability for health spending and key inputs and processes. By aligning development partner financing with the government's own resources, the HOPE-PHC Program will foster convergence around a common set of results in building a resilient and sustainable primary healthcare system, and should better ensure sustainability of the investments being made with this financing. The HOPE-PHC Program is also consistent with the National Strategic Health Development Plan II (2018–2022), Medium-Term National Development Plan 2021–2025, and Agenda 2050.

02

THE HOPE-PHC PROGRAM

Chapter 2 - The HOPE-PHC Program

The HOPE-PHC Program

Transforming Nigeria's health system will require embracing a "business unusual" approach. Strengthening primary healthcare is not only about enhancing service delivery but also about instituting significant changes in the governance of the health sector. Recognizing this dual need, the government requested financing from the World Bank for a series of interdependent programs: the program described in this chapter- Human Capital Opportunities for Prosperity and Equality—Primary Healthcare Provision Strengthening Program (HOPE-PHC Program, P504693), along with the crosscutting HOPE-GOVernance (HOPE-GOV; P181476) and HOPE Basic Education (HOPE-BED; P507001). The HOPE-PHC program focuses on primary healthcare service delivery and is designed to contribute to reorganizing primary healthcare and prioritizing cost-effective interventions in Nigeria. This will improve access to good-quality, essential health services, laying a solid foundation for a more robust and resilient health system in Nigeria.
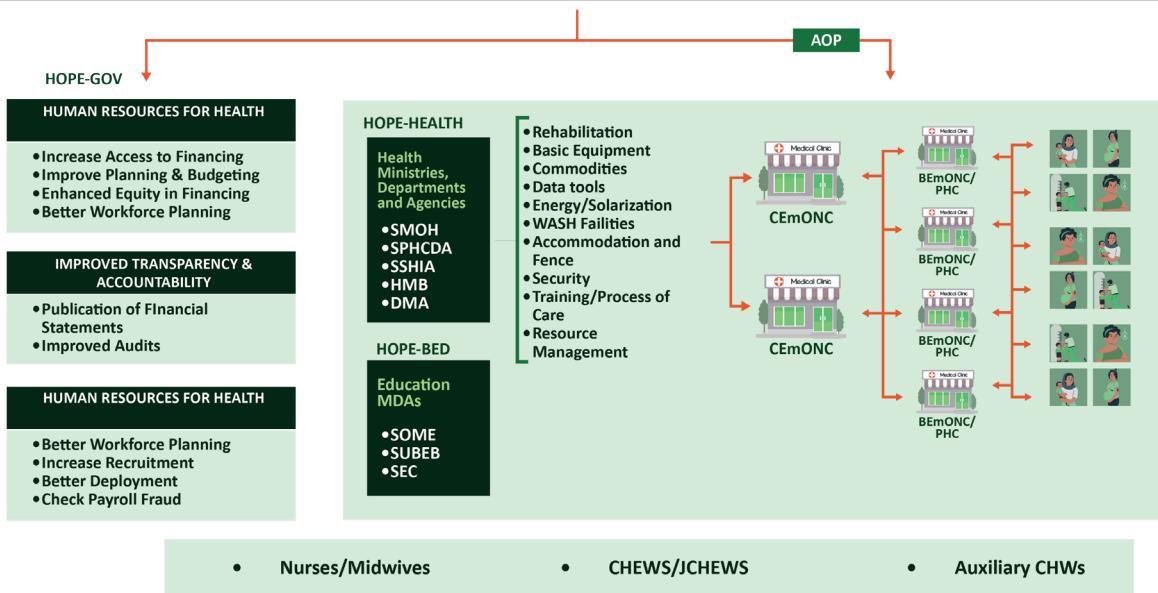
Figure 2.1 Relationship between HOPE-GOV, HOPE-PHC, HOPE-BED

2.1. Program Description

The HOPE-PHC program provides a platform for a health SWAp, leveraging significant additional resources to support a critical agenda. The BHCPP's essential benefit package prioritizes cost-effective services, focusing on reproductive health, maternal care and nutrition, childhood illnesses, screening and treatment of TB and HIV, and priority NCD screening. The HOPE-PHC program incorporates the interventions of the BHCPP with a discrete package of promotive, preventive, and simple curative interventions delivered at the community level, complementing facility-based primary healthcare services.

Achieving this goal will require careful consideration of the pace of the planned scale-up and service priorities. To consolidate investments, the BHCPP initially proposes to:

- expand Primary Health Centers (PHCs) from one per ward to a population-responsive distribution of two per ward, on average, with a total of over 17,600 [15] nationwide; and

- support the implementation of BEmONC and CEmONC care, including one CEmONC facility per Local Government Area (LGA), for a total of 774, and an equitable distribution of Tier 2 facilities [16]

- leverage the opportunity to strengthen emergency medical response in rural areas by addressing transportation barriers

- strengthen the health workforce, by investing in training curricula, addressing personnel gaps and improving competency and skills.

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15 - BEmONC facilities constitute 30 to 40 percent of PHCs.

16 - This indicates facilities that meet adaptive service readiness criteria by Nigerian Minimum Standards for Primary Healthcare, including servicing a population of 10-20,000 Nigerians having been equipped, amongst other things, with good infrastructure, at least two delivery rooms, an in-patient ward, maternity ward, laboratory, and pharmacy and four nurses/midwives, four Community Health Extension Workers and six Junior Community Health Extension Workers

- scale up digital health to create an integrated ecosystem and support the development of a digital backbone, ensuring interoperability and data exchange.

Adopting a SWAp demonstrates a concerted effort of the FMOH&SW to bolster institutional capacity in the health sector, including in the National Primary Health Care
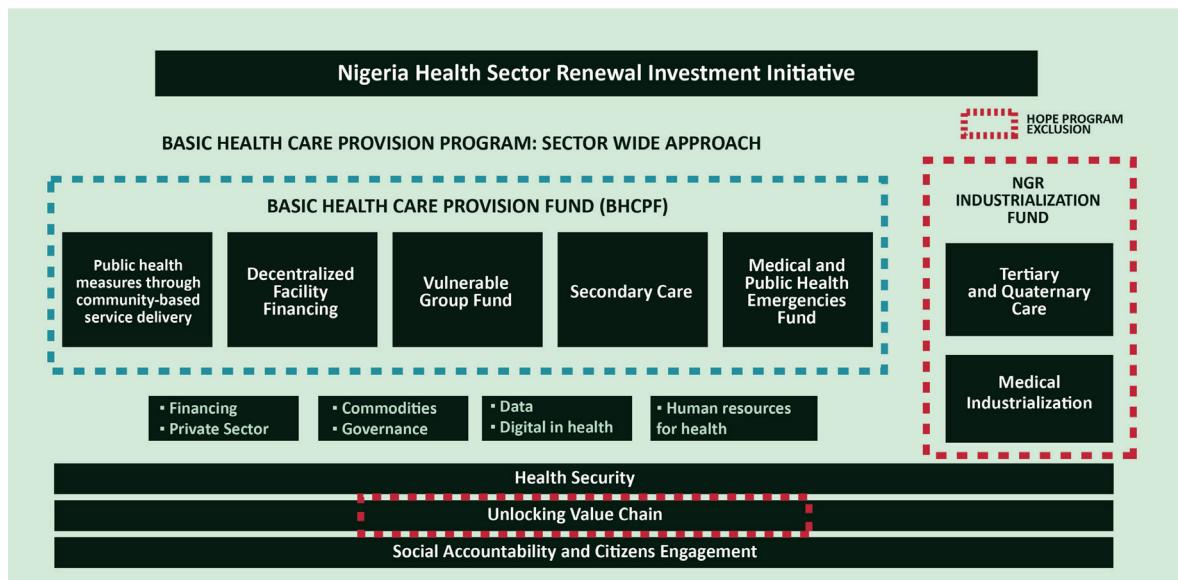
Figure 2.2 HOPE-PHC program

Development Agency (NPHCDA), the National Health Insurance Authority (NHIA), the National Centre for Disease Control (NCDC), the National Emergency Medical Service and Ambulance System (NEMSAS), and their respective state counterparts. The BHCPP acknowledges the accountability challenges that span multiple levels—federal to state, state to LGA, and state to provider—and are actively being addressed to ensure a robust and responsive health system under the SWAp framework.

2.1.1   Program Scope, Area, and Beneficiaries

The HOPE-PHC program will support all critical activities of the BHCPP under the NHSRII spanning community-based health services, primary healthcare delivery, vulnerable group/special intervention financing for select secondary services and medical and public health emergency preparedness and response (EPR) systems, operationalizing a service delivery model that mirrors the "hub-and-spoke" structure of Nigeria's healthcare system. In addition, the program will also ensure a climate-resilient health system and the introduction of a digital architecture for the health sector in Nigeria. Results are incentivized by the disbursement of financing which is linked to specific indicators' results under the BHCPP (the "Program for Results, or PforR, in the World Bank) and complemented by financing which disburses against expenditures (an "Investment Project Financing (IPF) component" in World Bank terminology) that focuses on supporting program implementation of key health reforms, especially in underperforming states, prioritizing their catch-up with their counterparts on demand- and supply-side

The HOPE-PHC Program will include

a. Primary healthcare service readiness, availability, and quality in the NPHCDA and its counterpart State Primary Health Care Development Agencies (SPHCDAs) to optimize selected PHC facilities to receive direct financing facility (DFF) for service delivery as guided under the BHCPF reform.

b. Strategic purchasing for maternal and child health, administered by the NHIA and the State Social Health Insurance Agencies (SSHIAs) through general hospitals managed by the State Ministries of Health (SMOH) and/or Hospitals Management Board (HMB)

c. Health security functions delivered by the Nigeria Centre for Disease Control and Prevention (NCDC) and improvements in emergency preparedness and response programs by the SMOH

d. National Emergency Services and Ambulance Dispatch program managed by NEMSAS and SEMSASs

e. Digital-in-health architecture and infrastructure to strengthen health information systems, HRH, GIS mapping of health facilities, and managing the national health insurance programs, among others, to be delivered by the FMOH&SW and SMOHs

f. Financing for essential health commodities, which will be procured at the federal level and available at the primary level across all states' PHC initiatives on the demand and supply side in underperforming states especially prioritizing innovations in maternal and childcare

The program is expected to be implemented in all states that meet the eligibility criteria and provided on a grant basis to the states for the benefit of all Nigerians. A summary of the main program areas and incentive framework for the federal, states, and LGA governments is presented in the schema below.

	Federal Government (supported by development partners)	State Government and LGA
BEmONC & CEmONC	Revitalize 327 Primary Health Centers and 48 CEmONC facilities, prioritizing MAMII LGAs.	Revitalize minimum of 2,500 PHCs per year and 3-5 CEmONC health facilities for every 1 upgraded by the federal government. Provide security and maintenance for equipment and infrastructure in revitalized health facilities.
Health Workforce	Provide time-limited salary support for newly recruited 2,550 SBAs and ~6,000 CHWs across 10 priority states. Re-train 120,000 frontline health workers over 4 years.	Recruit and deploy 4-6 SBAs and ~54k CHWs mapped to BHCPF facilities and communities across all states.
Essential Commodities	Provide seed stock of ~20 essential RMNCAH commodities to BEmONC health facilities, prioritizing MAMII LGAs.	Ensure sustainability of supply of essential MNH and FP commodities to BEmONC and CEmONC facilities, towards eliminating stockouts.
Financial Protection	Reimburse obstetric complications and provide free caesarean sections at NHIA-accredited CEmONC facilities.	Explore ways to sustain free caesarean sections in each state.
Service Delivery	Provide TA for implementation of Maternal and Neonatal Mortality Reduction Initiative (MAMII), starting with 172 prioritized LGAs.	Lead implementation of MAMII, including: • Enumeration and tracking of all pregnant women; • Facilitation of ANC and perinatal standard of care; • Linkage to CEmONC; • Emergency transportation
Financing	Provide Federal BHCPF contribution. Facilitate performance-based payments to states and LGAs for achievement of HOPE-HEALTH DLIs.	Pay state/LGAs counterpart payments in cash +/- kind. Invest upfront to achieve HOPE DLIs

Cross cutting
Citizen Engagement and Feedback
Ongoing Performace Management and Accountability

Figure 2.3 Incentive Framework for Federal, States, and LGAs to implement a sector program

2.1.2   Program Activities and Boundaries

The HOPE-PHC Program is grounded in the NHSRII. However, it is limited to primary care provisioning and health system resilience interventions to drastically reduce maternal and under-five mortality in Nigeria. The HOPE-PHC program will finance activities which are aligned with the BHCPP (described in table 2.1), which is an integral pillar of the NHSRII, with clearly defined boundaries that are clearly described in the components of the program. The HOPE-PHC program does not include financing for the Presidential Initiative for Unlocking Healthcare Value Chain (Nigeria Healthcare Industrialization Program), which will be delivered through a dedicated pool of funds and private sector partnerships to fast-track Nigeria's ambitions in tertiary healthcare and local manufacturing.

2.2 Program Rating

The World Bank currently rates the program highly satisfactory, as it fully aligns with the BHCPP to improve the outcome of the primary healthcare provisioning in Nigeria. The full alignment between program objectives and Nigeria's current strategy to address the developmental problems in the health sector and contribute to the solution to improving population health and crashing maternal and child mortality in Nigeria makes the program rating so.

The program outcome ratings will be reviewed during intermittent support missions which will be conducted jointly with other development partners to reduce the burden on government and more readily identify and exploit synergies. At program completion, the World Bank program task team and the government of Nigeria through the NPCU/SCO will review the overall performance based on the World Bank approved rating system described in table 2.2 below.

Table 2.1: World Bank Program Rating System

Highly satisfactory	There are no shortcomings in the program implementation and achievement of objectives while program efficiency and relevance remain high.
Satisfactory	There are minor shortcomings in the program implementation and achievement of objectives while program efficiency and relevance remain high.
Moderately satisfactory	There are moderate shortcomings in the program implementation and achievement of objectives while program efficiency and relevance remain high.
Moderately unsatisfactory	There are significant shortcomings in the program implementation and achievement of objectives; program efficiency, or relevance has been compromised
Unsatisfactory	There are major shortcomings in the program implementation and achievement of objectives, program efficiency and relevance have been compromised.

| Highly unsatisfactory | There are severe shortcomings in the program implementation and achievement of objectives, program efficiency and relevance have been compromised. |

2.3. Program Development Objectives

The Program Development Objective (PDO) is "to improve utilization of quality essential healthcare services and health system resilience in the Federal Republic of Nigeria."

2.4. Key Result Areas

The HOPE-PHC program is designed around three key results areas (KRA):

1. Improving quality of services

2. Improving utilization of essential services and

3. Improving the resilience of the health system.

2.4.1   KRA 1: Improving Quality of Services (US$177.5 million external funding committed: US$155.7 million IDA and US$21.8 million GFF and Nigeria Joint Financing Grant[18])

The KRA will support the improvement of service delivery by expanding the availability of BEmONC and CEmONC facilities that meet minimum criteria to deliver essential primary healthcare services and secondary obstetric newborn and child healthcare. The HOPE-PHC Program interventions under this results area allow for a progressive increase in the number of well-staffed, well-equipped, and climate-resilient PHC, BEmONC and CEmONC facilities in under-served and rural areas.

The KRA will help ensure the availability of lifesaving commodities in the required amounts in health facilities, including family planning supplies, which are essential to reduce neonatal, child and maternal mortality, as they decrease the number of high-risk births, increase birth spacing, delay first births and provide preventive and curative services for common childhood illnesses. In addition, effective RMNCAH-N services require the availability of other commodities, such as oxytocics, antimalarials, antibiotics, rapid diagnostics, nutrition commodities, and vaccines. By incentivizing federal government expenditure on quality family planning commodities, the HOPE-PHC Program will ensure that domestic resources are guaranteed in the budget to allow for uninterrupted access to lifesaving commodities and will support facilities in addressing stockouts by measuring the availability of tracer commodities across the priority RMNCAH-N continuum.

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18. [The GFF and Nigeria Joint Financing Grant includes funding from the GFF, FCDO, and CIFF with potential for expansion through additional partners]

2.4.2 KRA 2: Improving Utilization of Essential Services (US$272.5 million external funding committed: of which IDA US$239.0 million IDA; US$33.5 million GFF and Nigeria Joint Financing Grant[18])

The KRA will support the NHIA in facilitating the enrolment of beneficiary populations by SSHIAs. The government made health insurance mandatory in 2022 through the revision of the NHIA Act, but full implementation will require significant financing to ensure financial risk protection for targeted beneficiaries. SSHIAs will be incentivized to adopt enhanced identification and enrolment protocols and report enrolment figures to the NHIA. The IPF component of the program will make specific investments into the SSHIAs' operations.

Global experience has highlighted community health workers' (CHWs) strategic role in delivering health services, especially when mistrust exists between service users and the formal health system. The KRA leverages CHWs to provide critical frontline services, such as:

a. providing micronutrient supplements or small-quantity lipid-based supplements to prevent malnutrition in pregnant women and children

b. monitoring growth and screening for acutely malnourished children

c. identifying and following up with pregnant women and postpartum women including their newborns and referring them to receive multiple micronutrient supplements (MMS)

d. treating childhood illnesses, such as diarrhea, rapid breathing, and fever through the use of Integrated Community Case Management; and

e. conducting health education on measures to prevent infant and child mortality and under-nutrition, including the use of toilets, safe drinking water, and handwashing with soap at critical times.

The CHWs can also link beneficiaries to available Emergency Medical Services (EMS) in the community, allowing for quick referrals to primary/BEmONC and secondary/ CEmONC facilities. The HOPE-PHC Program leverages HOPE-GOV (see HOPE-GOV operations manual) which focuses on upstream governance interventions to address gaps in financing, policy, and legal frameworks for health and education reforms. HOPE-GOV specifically addresses the availability of CHWs at the PHC level.

The KRA will reduce the financial barriers which contribute to maternal, newborn and child mortality as well as stillbirth prevention by ensuring free access to hospitalizations for emergency obstetric, neonatal and pediatric care for pregnant women, newborns and children. In Nigeria, significant socioeconomic inequalities exist in RMNCAH-N services. The 2018 National Demographic and Health Survey (NDHS) showed that only 12 percent of deliveries in the poorest wealth quintile had skilled birth attendants, compared to 87 percent in the wealthiest quintile. Moreover, fewer than 3 percent of pregnant women utilize CEmONC services for delivery. There is a critical need to provide public financing for catastrophic but cost-effective maternal, newborn, and child health interventions by

ensuring the reimbursement to facilities for the cost of services utilized by the beneficiary population.

This KRA will support the roll out of priority interventions to improve the quality and utilization of maternal, newborn and child health services at the PHC level. These priority interventions are listed in the benefit package agreed by the NPHCDA and NHIA in the revised BHCPF guidelines and address family planning, antenatal care (ANC), safe delivery, postnatal care, nutrition services, treatment and prevention of pneumonia and diarrhea, and malaria treatment for children under five. Increasing the utilization of EMS among pregnant women and newborns is crucial, as delays in accessing appropriate healthcare in the case of pregnancy complications and poorly managed deliveries have been linked to high maternal mortality, stillbirths and neonatal complications. This results area will also enhance the utilization of quick and prompt EMS, referral, and transport of complicated deliveries in community/BEmONC facilities requiring CEmONC care and advanced neonatal care for newborns and facilitate the scale-up of a digitally enabled ambulatory dispatch service to improve sustainability and response times for ambulatory health services more generally.

2.4.3. KRA 3: Improving Resilience of the Health System (US$75.0 million external funding committed: US$65.8 million IDA; US$9.2 million GFF and Nigeria Joint Financing Grant[18])

This KRA will seek to increase the equitable allocation and disbursement of the BHCPF. Given the notable disparities in the utilization of health services between urban and rural areas, with rural residents, especially in the North West and North East geopolitical zones, facing the highest risk of under-five, newborn, and maternal mortality, prioritizing the deployment of scarce resources to such areas can secure rapid improvements in health outcomes. A responsive revised BHCPF guideline that incorporates this targeted approach will increase access to essential healthcare services and improve the chances of survival for vulnerable populations with the revision of the BHCPF required for the first disbursements of World Bank financing (a "prior result") under the HOPE-PHC Program.

Enhancing the health system's resilience against shocks such as disease outbreaks, climate emergencies, and other humanitarian crises is critical to safeguarding access to and delivering essential health services. The KRA will support the further improvement of preparedness and response structures for the containment of emergencies and shocks to the health system by ensuring that states are better prepared to mitigate health system vulnerabilities by developing and implementing multi-year EPR plans. In addition, it will support the development and implementation of a costed national climate and health adaptation plan to be adopted by subnational entities and incentivize implementation of these plans at both the national and state levels by linking disbursements to system and standards for state EPR programs.

Finally, this KRA will support the development of an integrated, interoperable health data ecosystem to support evidence-based improvements in value (efficiency, quality,

Figure 2.4 HOPE-PHC Theory of Change

Challenges

- Infrastructure, HRH, and equipment shortages
- Poor referral systems and delays in emergency referral/transport of pregnant women
- Persistent stock outs of high-priority tracer commodities
- Poor funding for FP
- Inequitable access and utilization of essential services.
- Low care-seeking behavior, exacerbated by financial and geographic barriers
- Poor emergency medical transport for obstetric and newborn complications
- Limited preparedness for disease outbreaks
- Poor climate and health adaptation
- Poor governance and resource allocation

Building climate resilient health systems

Results Areas & Activities

Results Area 1: Improving Quality of Essential Services
- PHCs equipped to proide services in line with QoC standards and climate resilient measures
- CEmONC facilities meet readiness and empanelment standards
- FG increases FP expenditure
- High-priority tracer commodities procured and made available

Results Area 2: Improving Utilization of Essential Services
- Expand health insurance coverage for poor aand vulnerable population
- Expand community health services delivery systems
- Increase in CEmONC and neonatal services
- Provide EMS for obstetric and neonatal complications
- Social & behavioral change

Results Area 3: Improving Resilience of Health System
- Increased disbursement in line with BHCPF guidelines
- Establish standard EPR programs
- Develop and implement National climate & adaptation plan
- Stronger digital foundation

Building climate resilient health systems

Outputs & Intermediate Outcomes

- Improved quality of RMNCAH-N services provided at selected, service-ready PHC and secondary facilities, including better climate resiliency (DLIs 1.1 and 1.2)
- Increased federal expenditure on FP (DLI 2.1)
- Increased availability of tracer commodities (DLI 2.2)

- More equitable access to essential health services (DLI 3 & DLI 4)
- Increased utilization of essential services (DLIs 3, 4, 6.1, 6.2, 6.3)
- Increased utilization of CEmONC and neonatal services (DLI 5)
- Availability and Increased utilization of EMS for obsteric and neonatal complications (DLI 7)

- Increased use of EPR standards across states (DLI 8)
- Availability and increased use of climate and health adaptation plan (DLI 9)
- Improved governance and resources allocation (DLI 10)
- National digital, health architecture developed, costed and activities (DLI 11)

Outcomes/Impact

- Improved quality of essential services
- Increased utilization & resilience of essential services

Higher-Level Outcomes

HIGHER LEVELS OF HUMAN CAPITAL

LIVES SAVED: UNDER-5 & MATERNAL MORTALITY SIGNIFICANTLY REDUCED

BETTER AND MORE EQUITABLE HEALTH OUTCOMES

Figure 2.4 HOPE-PHC Theory of Change

access, and health outcomes) for patients and providers. Learning from other countries and customizing solutions to fit the Nigerian context, this results area aims to lay a robust digital foundation by strengthening national standards, regulations, rules, and business processes for creating and maintaining a national health data space through a distributed enterprise architecture approach, and to facilitate the adoption and effective functioning of the health data ecosystem at the state level by integrating individual private, public, and program-specific health information systems.

Figure 2.3 below outlines a theory of change that connects critical health sector challenges in Nigeria to the HOPE-PHC Program's results areas, activities, outputs, intermediate outcomes, and impact. The schema also shows the disbursement-linked indicators (DLIs) which define and incentivize expected results. These results are linked to over 90 percent of the overall program financing and to activities undertaken by both the federal and state governments to drive progress toward program impact. The arrows in the schema represent the intended synergistic impact of the HOPE-PHC Program design, with key focus areas for the BHCPP encompassing (i) interventions to strengthen the supply side, including quality improvements; (ii) measures to improve and strengthen demand for and utilization of essential services at the community, primary, and secondary levels; and (iii) steps to strengthen resilience.

The expected outcome is increased coverage of good-quality essential health services, with the ultimate impact of substantially reducing mortality rates. This outcome relies on sustained political commitment, broader government initiatives, economic stability, and continued development partner support for the SWAp modality. The key assumption underlying the PforR design is that a combined approach of financing, TA and coordinated leadership not only incentivizes the program results but enables their attainment.

2.5 Instruments Used in Delivering the Program

Given the complex institutional federal system, there is explicit interest in shifting the focus from inputs to results, with a stronger emphasis on accountability for results. In addition, there is a need to incentivize government ownership and accountability and accelerate the implementation of critical reforms and policies in the health sector, all of which support the NHSRII's goal of serving as an anchor for a SWAp.

Given the national scope, and the impetus to aligning with the SWAp principles, the World Bank package of financing will largely disburse against results, rather than specific expenditures. However, some of this financing will be made available for specific costs through an Investment Project Financing (IPF) component which will enable the National Program Coordinating Unit (NPCU) to carry out targeted TA and procurement. The IPF will service critical consultancies to address states' capacity needs, targeted support to lagging states, and ensure government capacity is in place to ensure that inputs are well-designed, and that sufficient quality assurance is provided, including on the verification of the results. As such, the HOPE-PHC Program provides financing which supports both results-based and investment approaches

Furthermore, this design recognizes the need to make more efficient use of limited resources in a context where tying financing to results can be used to incentivize improvements in performance leveraging state and local government autonomy to attain the agreed results, boosting accountability. The design also aligns development assistance for health with government priorities by strengthening mechanisms to manage communications and funding flows from development partners.

2.5.1 Investment Financing Component

The investment financing component of the HOPE-PHC (US$45.01 million of the total external financing made available to date) will provide targeted financing in key areas of program implementation. This component of the program will be the responsibility of selected national-level institutions that will support state governments to achieve program results and sustainably strengthen state government capacities. Activities to be financed include the establishment of a Maternal Mortality Action Innovation Initiative (MaMII); the design, procurement, and deployment of a federated digital-in- health enterprise architecture; a joint TA coordination platform; operationalization of the public health fellows' program; hiring of an independent verification agency (IVA) to verify attainment of the disbursement-linked results; and critical TA and capacity building activities. The TA has two components:

1. Strengthening Systems and Capacities.

The largest part of this component will focus on establishing platforms for service delivery and supporting all participating state governments to strengthen their systems and capacities to enable them to achieve the HOPE-PHC Program results (the disbursement-

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7 - Attention will be paid to avoiding the fragmentation of IT-enabled platforms and encouraging consolidation while developing digital innovations.

linked results, or DLRs).

a. Operationalization of the Maternal Mortality Action Innovation Initiative (MAMII). MAMII "investments" focus primarily on strengthening primary healthcare in high-burden, lagging, and climate-vulnerable states, allowing them to address legacy issues and invest to "prime the pump." These service delivery innovations would aim to expand the coverage and quality of services at the population level, emphasising underserved rural populations (see annex 15). The MAMII will support public and private sector innovations that support interventions critical to ending preventable maternal, newborn, and child deaths and prevent stillbirths. This includes strengthening midwifery; improving access to emergency obstetric and newborn care; expanding maternal and perinatal death surveillance and response; and enhancing the prevention and management of obstetric fistula and other obstetric morbidities. A core focus will be the integrated management of childhood illnesses—such as pneumonia, diarrhea, malaria, and neonatal infections—delivered through both community-based and primary healthcare platforms. This includes training for CHWs, provision of child-appropriate medicines, early recognition and referral systems, and digital tracking of case outcomes. These interventions, supported under MAMII, will be tailored to the needs of high-burden, underserved, and climate-vulnerable areas. These will be complemented by enhanced digital technologies, clinical protocols, and capacity building to improve early diagnosis, treatment adherence, and referral systems for child health care. The MAMII will be managed through a competitive process, to be established by the NPCU. The World Bank and financing partners will review the process before its operationalization. Given the link between climate change and maternal, neonatal, and child health conditions in Nigeria, the initiative will prioritize proposals explicitly focused on climate-vulnerable areas with measures to address the additional disease burden from climate change

b. Design, procurement, and deployment of a federated digital-in-health enterprise architecture. The NHSRII reforms include plans to bring about a digital transformation in the health sector by digitizing most information systems, including the electronic human resource management information system, the electronic national health insurance system, and the electronic health records systems. The TA will support enhanced digital capacity, including Technical Advice[7] and consultancies for defining regulatory frameworks and acquiring hardware and software. However, this is bearing in mind major challenges with the servers for DHIS2 and issues with interoperability and maintenance across DHIS2 and other key national data systems. One key challenge in the current NHMIS is the lack of a harmonized digital approach to maintaining the Nigeria health facility registry and the links between that registry, the DHIS2, and the various program-level facility master lists at state and national level for BHCPF and other initiatives. The HOPE-PHC Program will support the FMOH&SW and its agencies to achieve an interoperable platform to systematically exchange data. In addition, the National Digital Transformation Office shall be supported in undertaking a feasibility study

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8 - https://statehouse.gov.ng/news/president-tinubu-approves-establishment-of-national-health-fellows-programme/

and establishing requirements for an enterprise data-sharing protocol. Based on the study's results, a system for interoperability and data governance will be financed. Furthermore, any professional and consulting charges required to fund the design, building, and implementation of the data-sharing architecture will be financed by the HOPE-PHC Program, including consultancies to support platforms to undertake: (i) improved management of medicine stocks and supply chains; (ii) introduction of advanced digital learning tools to upskill CHWs; (iii) digital platforms for the management of emergency transportation for pregnant women and vulnerable patients; (iv) expansion of the existing information technology (IT) application for Application Programming Interface for digital-in-health functions; (v) strengthening of the health sector digitalization strategy; (vi) an increase birth registration using e-CRVS systems, with National Identification Number issued, and children enrolled in national health insurance; and (vii) a health claims exhcange.

c. A platform for coordinated TA to support implementation. This is a collaborative approach aimed at strengthening Nigeria's health sector through coordinated TA and funding. The platform will enhance health systems by streamlining TA efforts from development partners and aligning resources with national health priorities across Nigeria's 36 states and the FCT. Supported activities will include the deployment of needs-based, demand-driven TA and TA for climate activities.

d. Strengthening strategic purchasing and regulatory functions of NHIA. This financing will be used to provide TA to establish a more robust strategic purchasing platform for the NHIA. Many key institutional building blocks and operational documents require updating or development at the NHIA, including (i) provider empanelment guidelines; (ii) a tariff schedule based on a costing exercise; (iii) a claims management manual; (iv) a medical audit manual; (v) a fraud control manual; (vi) a grievance redress manual; (vii) a functional call centre for beneficiary feedback; (viii) beneficiary communication guidelines; and (ix) contract templates for providers and third-party administrators. These building blocks are best developed at the NHIA as "public goods" for operationalization by SSHIAs, rather than each SSHIA attempting to develop its own approach, which would result in inefficiency and fragmentation.

e. Platform to support implementation of National Health Fellowship Program. The NHSRII reforms include the establishment of the National Health Fellows Program,[8] with young Nigerian fellows engaged across all 774 LGAs. The support will include (i) the Health Fellowship Program trainings (ii) monitoring and evaluation (iii) where government budget shortfalls occur, the IPF component may cover the wages and salaries of the health fellows. The fellows will receive mentorship and training on best practices within the Nigerian public health space to hone their leadership skills. Upon graduation, the fellows will be positioned to have a career in the health sector, with the President having declared that the initial set of fellows will be hired into the public sector. The NPCU will work with state government and development partners to identify career paths for subsequent sets of fellows. Through these

pathways, the fellows will provide a generation of future leaders capable of transforming the health sector and improving health outcomes in Nigeria.

2. Strengthening Program Coordination and Verification of Results.

The component will focus on program management, IVA functions, and the learning agenda. and will provide support for:

a. Hiring of an IVA for Independent Verification of Program Results. The financing will be used to procure the consultancy services of an IVA responsible for the implementation of the verification protocol and reporting to the NPCU/SCO on the HOPE-PHC Program results. The IVA will be engaged by the Federal Ministry of Budget and Economic Planning (FMBEP). The role of the IVA is to provide an independent, credible, and coherent analysis of state and federal government performance and earnings under the HOPE-PHC Program using agreed-upon data sources and earnings calculations. This is specified in the performance monitoring section of the HOPE-PHC PAD.

b. Program Monitoring and Evaluation and Learning, including Data Quality Assessments and publication of the annual State of Health Reports and Performance Ranking. The NPCU/SCO will put in place a robust program M&E system to select the right tools to monitor program activities and ensure comprehensive data collection on all results and DLIs and disbursement-linked results (DLRs), including through internal checks and balances to ensure continuous availability of credible data sources for verification. An M&E Specialist in the NPCU/SCO will assist the HOPE-PHC Program Manager to implement and coordinate these activities. The component will cover the costs of consultancy services to implement the annual State of Health Report. Furthermore, the HOPE-PHC Program incorporates a strong emphasis on the learning agenda to support the HOPE-PHC Program in adapting and enable peer learning and knowledge dissemination. The NPCU will employ this financing to implement a program of peer learning and knowledge dissemination to support the attainment of Program results. Thus, the knowledge and learning agenda provides support for state peer learning forums and periodic exchanges among state health commissioners, with a view to tapping into the tacit knowledge that exists within state governments and facilitating peer learning among states. In addition, the learning agenda will support South-South learning through exchange visits to countries with long experience with the SWAp, countries with experience using intergovernmental fiscal transfers as part of fiscal federalism, and/or countries who implement SWAp-like tools (e.g. TWGs, joint missions, JARs, and/or pooled funds).

c. Support NPCU/SCO program communications, stakeholder engagement, and SWAp coordination. The NPCU/SCO will receive support in providing effective coordination of stakeholders across the three tiers of government, as well as stakeholder management and aid coordination in the context of the SWAp. The NPCU/SCO

will support the Ministry of Health Department of Health Planning, Research, and Statistics (DHPRS) to collect and analyse relevant data. It will, with the DHPRS, coordinate with national and state entities. This coordination will ensure results remain on track, and that issues are identified and addressed early and rigorously. NPCU/SCO and, when necessary, escalate issues for corrective action to achieve the program's aspirations, reporting regularly to the CMHSW/NSC. The NPCU/SCO will work to coordinate the strategic communications activities to be implemented by relevant agencies, including the NHIA, NPHCDA, NCDC, and NEMSAS. The HOPE-PHC Program will implement activities with all stakeholders to enable regular dialogue and information sharing throughout its lifecycle. The communication strategy aims to reinforce the accountability framework underpinning the HOPE-PHC Program. The HOPE-PHC Program's stakeholder engagement and program communication will support activities such as a people's voice survey, advocacy for the State of Health Report, and communicating and working with states on the HOPE-PHC Program communications plan. The results of the people's voice survey will be used to inform the following directly: improvements in the delivery of services under the program; performance in the health system more broadly; and a communications strategy that will bolster service delivery, staff morale, strengthen public awareness of the health system, and support the advocacy campaign for the State of Health Report. Specialists will be hired within the NPCU/SCO, in addition to seconded FMOH&SW staff, on specific areas of program management.

2.5.2 Financing Results (DLI) Component

The HOPE-PHC Program will disburse based on the achievement of 11 indicators (known as Disbursement-linked Indicators, or DLIs) identified and pre-agreed with the World Bank and health development partners. For each DLI, yearly targets (disbursement-linked results, or DLRs) are defined, against which a "price" will be paid. Each DLI price represents a combination of strategic importance, ambition, and feasibility of achieving the DLRs, but not the cost of achieving them. Prior results will be non-scalable. From Year 1, most results will be scalable, and any time the results are met fully or partially, disbursement will be made in proportion to the achievement of the DLR. The HOPE-PHC program will incentivize the achievement of DLIs by linking to data sources and standardized measurement approaches, ensuring scalability, and adopting continuous rather than periodic verification cycles.

For more details on each of the DLIs, see Chapter 4 of this manual. However, Table 2.3 below presents a summary of DLIs under HOPE-PHC.

Table 2.2: Summary of DLIs under the HOPE-PHC Program

DLI	DLI IDA Amount (US$ m)	DLI Grant Amount (US$ m)	DLI Unit	Scalable	Time-Bound
Key Results Area 1: Improving Quality of Services					

DLI 1: Improved service readiness	DLR 1.1: Improved primary healthcare facility readiness, quality, and climate resilience in Participating States (percentage)	53.95	7.55	States	Yes	Yes
	DLR 1.2: Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (number)	50.88	7.12	States	Yes	Yes
DLI 2: Increased availability of essential commodities	DLR 2.1: Federal expenditure on quality family planning commodities increased (percentage)	21.93	3.07	Federal	Yes	Yes
	DLR 2.2: Frontline availability of tracer products improved in Participating States (percentage)	28.95	4.05	States	Yes	Yes
Key Results Area 2: Improving Utilization of Essential Services						
DLI 3: Increased enrolment of poor and vulnerable populations	DLR 3.1: Financial protection for poor and vulnerable populations increased in Participating States (number)	35.09	4.91	States	Yes	Yes
DLI 4: Enhanced community delivery of health services	DLR 4.1: Women and children who receive tracer essential health services in the community increased in Participating States (number)	43.68	6.14	States	Yes	No
DLI 5: Increased utilization of priority secondary care services	DLR 5.1: Secondary Facility Quality of Care for CEmONCs (Prior Result)	2.19	0.31	Federal	No	Yes
	DLR 5.2: Women and neonates receiving CEmONC and neonatal services and/or vesico-vaginal fistula surgeries (number)	61.40	8.60	Federal	Yes	No
DLI 6: Increased Primary Healthcare utilization of priority services	DLR 6.1: Deliveries with skilled birth attendant present increased in Participating States (percentage)	30.70	4.30	States	Yes	No
	DLR 6.2: Introduction of MMS for pregnant women during antenatal care in Participating States (percentage)	17.54	2.46	States	Yes	No

	DLR 6.3: Increase in Penta 3 coverage in Participating States (percentage)	30.70	4.30	States	Yes	No
DLI 7: Increased utilization of emergency medical services	DLR 7.1: Patients with obstetric and neonatal complications transported through emergency medical transport to selected facilities using the digitized EMS dispatch system (number) in Participating States (number)	17.54	2.46	States	Yes	No
Key Results Area #3: Improving Resilience of the Health System						
DLI 8: Improved allocation and disbursement of BHCPF funds	DLR 8.1: Governance for improved resource allocation and performance (Prior Result)	2.19	0.31	Federal	No	Yes
	DLR 8.2: Participating States receiving funds in compliance with allocation formula in revised guidelines (number)	8.77	1.23	States	No	Yes
DLI 9: Enhanced pandemic preparedness and response (PPR) through deployment of EPR plans	DLR 9.1-9.4: System and standards for state EPR programs are established (number)	13.16	1.84	States	Yes	Yes
DLI 10: Improved climate resilience	DLR 10.1-10.4: Climate and health adaptation plan developed, costed, and validated (number)	26.32	3.68	States	Yes	Yes
DLI 11: Stronger digital foundation	DLR 9.1: National enterprise architecture developed, costed, and adopted (Prior Result)	2.19	0.31	Federal	No	Yes
	DLI 9.2: Participating States adopting national enterprise architecture and integrating core health functions (number)	13.16	1.84	States	No	Yes
TOTAL		460.53	64.47			

2.6   Program Cost and Financing

The HOPE-PHC program financing totals US$570.01 million, comprising a US$500 million credit line from the International Development Association (IDA) and US70.01 million grant financing. The Global Financing Facility (GFF) multi- donor trust fund for Women, Children, and Adolescents is a country-led multistakeholder partnership housed at the World Bank that supports investments to scale up coverage of essential health services at the community and primary care levels, enhance service quality and resilience, and

support health system redesign and innovation. The GFF will contribute US$50.00 million of the total grant financing to disbursement-linked indicators (DLIs) supporting primary healthcare service delivery capacity, improvements in health policy, financing and public financial management (PFM), and increased utilization of primary healthcare services. In addition, the amounts of US$10.67 million from the Children's Investment Fund Foundation (CIFF) and US$9.35 million from the United Kingdom Foreign Commonwealth and Development Office (UK-FCDO) will be co-mingled with the GFF grant and expand the total grant from the GFF via the GFF MTDF joint financing window.

If additional financing is made available to expand the scale of the HOPE-PHC Program, the Program can readily be restructured to accommodate these resources. They would ideally be provided through the GFF Joint Financing option, or via a World Bank-administered trust fund.

Table 2.3: Describes HOPE-PHC program financing

Source	Program Amount (US$ millions)	IPF amount	% Of IPF Total
IDA Credit	460.51	39.47	87.67%
GFF	46.05	3.95	8.77%
GFF Nigeria Joint Financing (CIFF)	9.83	0.84	1.87%
GFF Nigeria Joint Financing (FCDO)	8.60	0.74	1.63%
Total Program Financing	525.0	45.01	100

2.7　Eligibility Criteria (EC) for States

The annual eligibility criteria for States are intended to strengthen interdependencies between governance actions under HOPE-GOV, such as enhanced preparation and transparency of the essential elements of the budget cycle and sectoral planning through the Annual Operational Plans. Participation in HOPE-PHC will be contingent upon States' involvement in HOPE-GOV, as demonstrated by the achievement of the annual EC. HOPE-GOV EC builds on EC initially introduced by the States' Fiscal Transparency, Accountability and Sustainability program and are already being practiced in all 36 states and the Federal Capital Territory (FCT).

HOPE-GOV EC includes annual preparation and publication of the budget prepared per the Chart of Accounts and approved by the State Assembly; annual preparation and publication of audited financial statements per International Public Sector Accounting Standards (IPSAS); and annual publication of quarterly budget implementation reports on primary healthcare within 30 days of the end of the quarter. For access to HOPE-PHC financing, additional criteria will include the preparation of sectoral Annual Operational Plans that translate the BHCPP into short-term operational plans, maintenance of BHCPF State Oversight Committees and implementation of Funds Release Policies that guarantee re-investment of proceeds from attainment of the disbursement-linked results in the

health sector.

Table 2.4 States' Eligibility Criteria (EC) for HOPE-PHC

	Year 1 – 2025	Year 2 – 2026	Year 3 - 2027	Year 4 - 2028
EC-GOV	Participation in and achievement of the Annual EC for HOPE-GOV	Participation in and achievement of the Annual EC for HOPE-GOV	Participation in and achievement of the Annual EC for HOPE-GOV	Participation in and achievement of the Annual EC for HOPE-GOV
EC-1	State Annual Operational Plan that aligns with the goals of the sector-wide approach as articulated in the signed health compact is approved by the SWAp Coordinating Office (SCO).	State Annual Operational Plan that aligns with the goals of the sector-wide approach as articulated in the signed health compact is approved by the SCO.	State Annual Operational Plan that aligns with the goals of the sector-wide approach as articulated in the signed health compact is approved by the SCO.	State Annual Operational Plan that aligns with the goals of the sector-wide approach as articulated in the signed health compact is approved by the SCO.
EC-2	State revises the terms of reference and composition of the BHCPF State Oversight Committee.	The State maintains the composition and functioning of the State Oversight Committee in accordance with the revised terms of reference.	The State maintains the composition and functioning of the State Oversight Committee in accordance with the revised terms of reference.	The State maintains the composition and functioning of the State Oversight Committee in accordance with the revised terms of reference.
EC-3	State adopts and signs Funds Release Policy for management of PforR earnings.			

2.8   Effectiveness Conditions for the Operationalization of the Program

The implementation arrangements for the HOPE-PHC program will be fully streamlined into existing government structures at the federal and state government levels. The underlisted are necessary conditions for the program's World Bank financing to become effective (i.e., able to begin to disburse).

- The establishment of a National Steering Committee (NSC) headed by the Coordinating Minister of Health and Social Welfare (other membership discussed in Chapter 3)

- Notification of the World Bank and agreement on the appointment of a national program coordinator (NPC) for the NPCU/SCO

- Notification of the World Bank and issuance of its "No Objection" on the appointment of fiduciary staff (accountant and procurement officers)

- Notification of the World Bank and issuance of its "No Objection" by the World Bank to the constitution of NPCU with other relevant staff

- Expansion of the membership of the BHCPF SOCs to accommodate the HOPE-PHC institutional arrangement (as oversight of state-level implementation will be through the BHCPF State Oversight Committees (SOCs).

- The submission of a Program Operations Manual (POM) to the World Bank and other financing partners for concurrence on the POM

- Opening of appropriate accounts with the Central Bank of Nigeria (CBN) for the NPCU

03

INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

Chapter 3 - Institutional And Implementation Arrangements

3.1 Overview of Program Implementation and Institutional Arrangements

The Program implementation arrangements flow from the following principles:

a. Aligns national and state-level priorities toward improved health outcomes through the Annual Operational Plan (AOP)[17] process.

b. Supports an ambitious, expansive, and complex reform agenda and the sector-wide approach, a fundamentally new approach to aligning stakeholders with the government's plan.

c. Relies on existing institutions and the sustainable benefits of strengthening the institutions

d. Recognizes the complexity of Nigeria's federal context, which presents unique challenges concerning the allocation of roles and responsibilities in the health sector

e. Incorporates lessons from previous health system strengthening reform efforts in Nigeria such as a need for clearer roles and strengthened institutional frameworks,

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17 - An AOP is an annual translation of the nation/state strategic plan that outlines: Key health priorities (national and state); Activities needed to achieve the set target on the priorities (incl. timeline and owners) over a calendar year; TA deployed/required to achieve the targets; Cost to implement each activity, incl. source of funds (DP, govt.); Gaps in resources to achieve priorities

f. Builds capacity and platforms for facilitating coordination across all tiers of government by establishing technical working groups to engage a range of stakeholders.

Taking the above into consideration, the implementation arrangements agreed for the Program are distributed across four levels viz,

1. Federal Level:

    i. Joint Inter-Ministerial Steering Committee: The Federal Steering Committee (FSC) is supported by HOPE-GOV NPCU and is domiciled in the Federal Ministry of Budget and Economic Planning (FMBEP).

    ii. National SWAp Steering Committee (NSC) at the FMOH&SW: The BHCPF Ministerial Oversight Committee will serve as the NSC. Membership will be expanded as determined by the Coordinating Minister of Health and Social Welfare (membership details are described in Table 3.1)

    iii. National Program Coordination Unit/SWAp Coordinating Office at the FMOH&SW: NPCU/SCO: Coordination Unit for the Program (the National Program Coordination Unit or NPCU) within the SWAp Coordination Office.

    iv. Implementing Agencies: NPHCDA, NHIA, NEMSAS, NCDC

As part of a SWAp network governance architecture, an NPCU/SCO, domiciled in the Office of the CMHSW and governed by an NSC, has been established as the management unit for the NHSRII.
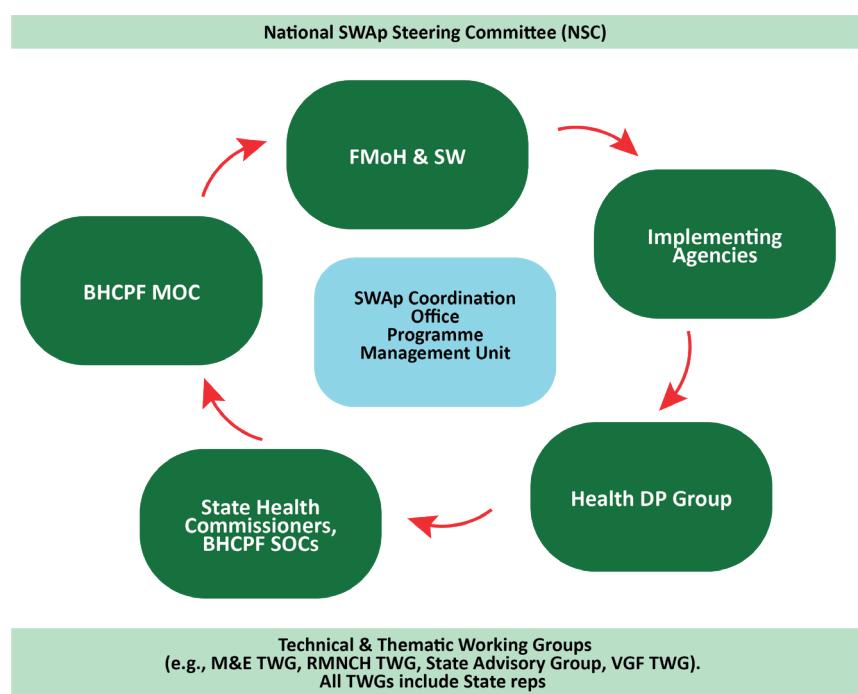
Figure 3.1 Nigeria Health SWAp Arrangement

2. State Level:

   i. The expanded BHCPF State Oversight Committee (SOC): The State Ministry of Health, under the leadership of the Commissioner for Health as the Chair of the expanded BHCPF SOC will lead state-level policy reform, service delivery improvement, and sector coordination. Implementing Agencies: SPHCB/A, SSHIA, SEMSAS. No separate management unit for the HOPE-PHC Program will be established at the sub-national level.

Consequently, the HOPE-PHC institutional arrangement will leverage the NSC, BHCPF and SWAp governance architecture at the federal and state levels.
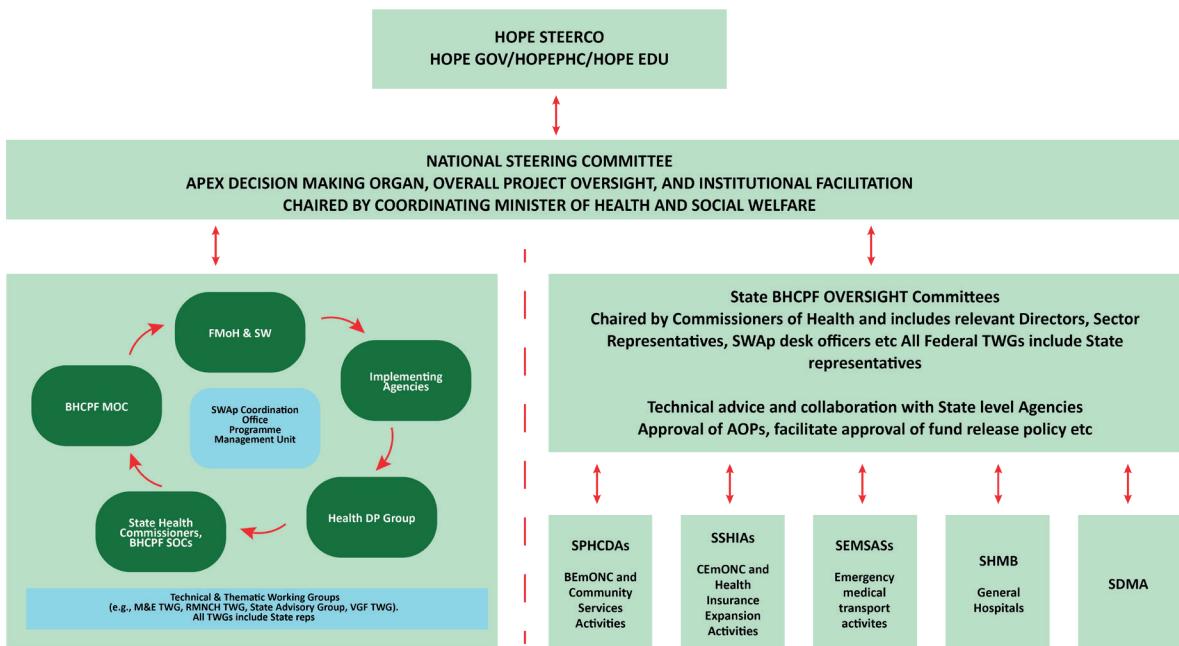
Figure 3.2 HOPE-PHC Implementation Arrangement

Table 3.1 Responsible entities and their roles and responsibilities

RESPONSIBLE ENTITY	COMPOSITION	ROLES AND RESPONSIBILITIES	ACCOUNTABILITIES
HOPE INTERDEPENDENT SERIES OF PROGRAMS NATIONAL STEERING COMMITTEE "Joint inter-ministerial steering committee at the federal level {the "National Steering Committee"}	• Co-chaired by Coordinating Minister of Health & Social Welfare, Minister of Budget & Economic Planning, and Minister of Education. • Also include the minister responsible for finance and any other relevant ministries, departments, agencies, and organizations as decided by the co-chairs.	• Responsible for providing high-level guidance, advice, and strategic oversight on the HOPE series of operations, with functions as further detailed in the Operations Manual. • Guardian of rules for the HOPE SOP. • Adoption of government-wide Human Capital Development (HCD) policies. • Setting and achieving of HCD reforms agenda.	• Realization of HOPE Standard Operating Procedures (ISOPs) contribution to the HCD vision of the Government of Nigeria.

| NATIONAL SWAP STEERING COMMITTEE

"Steering committee at the federal level (the National SWAp Steering Committee, NSC) responsible for providing strategic sectoral oversight	• NSC will be chaired by the Coordinating Minister of Health and Social Welfare (CMHSW) **Members shall comprise the following:** • The Honourable Minister of State for Health (HMSH), • The Permanent Secretary for Health (PSH), • Representatives of Ministry of Finance & Ministry of Budget and Economic Planning, • Relevant heads of agencies of the FMOH&SW (NPHCDA, NHIA, NCDC, Secretary BHCPF Ministerial Oversight Committee (MOC), Chair NEMT), • Directors at the Federal Ministry of Health including Family Health, Public Health, and Planning, Research, and Statistics, Chair of the committee of health commissioners in the federation, • Representative of the SPHCDA/B, • Representative of the SSHIAs, • Members of the Development Partners Group for Health (DPG-Health) who have contributed financial resources to the SWAp (BMGF, CIFF, Global Affairs Canada, FCDO, GAVI, JICA, LAD, GFF/WB as of May 2025)	**A. PROGRAM OVERSIGHT AND POLICY GUIDANCE:** a. Provide oversight and policy guidance for achieving NHSRII objectives, including the HOPE-PHC PDOs b. Oversee program coordination and implementation progress of the SWAp NHSRII indicators and HOPE-PHC results framework (including the DLIs) c. Approve the annual work plans and procurement plans of the NHSRII Programs & HOPE-PHC Program d. Review submissions/ requests from relevant stakeholders, e.g. from subnational entities and LGAs **B. ADHERENCE TO SWAP Behaviours & TWG CODE OF CONDUCT:** e. Oversee alignment to SWAp principles. f. Oversee governance charter of all TWGs, formalising their role and commitment as part of a SWAp TWGs g. Provide formal approval for changes in TWG mandate, TORs, or membership h. Review TWG attendance and progress against work plan output i. Review /approve content of TWG output to inform policy direction **C. FINANCIAL / FIDUCIARY REVIEW AND MANAGEMENT:** j. Provide approval for any budgetary and TA needs k. Review technical and financial/audit performance	• The investments and other programs are aligned with national priorities and state demands as articulated in the NHSRII.

	• Others as nominated by the CMHSW. • The NPCU National Coordinator shall be the Secretary of the NSC	l. D. REPORTING REQUIREMENTS m. The NSC will meet every quarter to consider the quarterly reports to be provided by the National Program Coordination Unit NPCU/SCO. n. Quarterly reports will include but are not limited to the following: status of implementation of actions outlined in the Financial Management Program Action Plan; Fiduciary Risk and Mitigation Measures outlined in the FSA. o. The quarterly reports will be sent to all members of the NSC at least five days prior to any meeting.	
NPCU/SCO Coordination unit for the program (the National Program Coordination Unit or NPCU) within the SWAp Coordination Office	• A National Coordinator shall head the NPCU • Include specialists in program management, procurement, financial management, environmental and social matters, communications, and other specialists all with qualifications, experience and ethics, and subject to the terms of reference acceptable to the World Bank	• Day-to-day operations and overall coordination of the program • Planning, budgeting, and reporting. • Serving as the secretariat of the National SWAp Steering Committee (NSC) • Monitoring and coordinating program implementation in line with guidance from the NSC • Implementing the program with responsibilities including but not limited to financial management, procurement, environmental and social, monitoring and evaluation, and communications	• Attaining the PDO-level and intermediate-level indicators

| STATE BHCPF OVERSIGHT COMMITTEE.

Based on a revised terms of reference and composition of the State BHCPF Oversight Committee (the State Oversight Committee or SOC) will accommodate membership from the State Ministry of Finance; Budget and Planning; office of the state accountant General, state SWAp desk Officer and any other entity. | • Chaired by the Commissioner of Health responsible for the state health system
• Membership includes technical experts from relevant state departments
• Includes state-based DPG-health members
• Meets at least quarterly | • Coordination between state government and NPCU.
• Technical approval for State AOPs.
• Responsible for providing technical oversight and implementation monitoring to ensure that critical actions are on track towards the achieving of the DLIs in participating states as applicable, all as further specified in the institutional arrangement section of the BHCPF manual
• Day-to-day operations and overall coordination of the program
• Planning, budgeting, and reporting | • Ensuring that the investments conform to national standards.
• Monitoring and evaluation of program indicators |

3.2 Federal Implementation and Institutional Arrangements:

COORDINATION OF THE HOPE SERIES OF PROGRAMS AT THE FEDERAL LEVEL: The HOPE-GOV NPCU will host a Joint Inter-Ministerial Steering Committee within the FMBEP. It will work in collaboration with the following Institutions – (i) Federal Ministry of Health and Social Welfare and its agencies and counterparts at the federal, state and local government levels; (ii) Federal Ministry of Education (FMoE), its agencies and counterparts at the federal, state and local government levels; (iii) Federal Ministry of Finance (FMoF), and its counterparts at the state level; (iv) State Ministries of Budget and Economic Planning (SMoBEP); (v) Universal Basic Education Commission (UBEC) and Universal Basic Education Boards at the state level; and (vi)NPCU/SCO, Basic Health Care Provision Fund (BHCPF) MOC, and all gateways and institutions participating in the BHCPF. The HOPE-GOV NPCU will liaise with the Program Coordinator of the NPCU/SCO to ensure the inter-ministerial committee meets regularly and its affairs are conducted in line with its TOR.

3.2.1. National SWAp Steering Committee (NSC)

The NSC, chaired by the Coordinating Minister of Health and Social Welfare, will be the highest body and is responsible for providing overall program coordination and policy guidance, including monitoring and evaluation of performance, and for overseeing program implementation progress of the HOPE-PHC Program by the National Program Coordinating Unit/SWAp Coordinating Office (NPCU/SCO) for and on behalf of the

Government of Nigeria. The NSC will also include a representative of funding/donor organization/agency under the HOPE-PHC program. Specifically, the committee will be responsible for:

1. The NSC endorses the Program Operations Manual (this document), as well as overall annual work plans and procurement plans of the SWAp Program.

2. The NSC will meet quarterly to review program performance, endorses annual plans, and consider reports and submissions from participating states and stakeholders. These quarterly governance meetings will be embedded within the broader Sector-Wide Approach (SWAp) and BHCPF governance framework, ensuring alignment, coordination, and accountability across federal and state actors.

3. The NSC shall be responsible for providing strategic sectoral oversight with functions, composition and resources as detailed in Table 3.1

4. The NPCU/SCO Program Coordinator shall be the Member Secretary of the NSC who shall, in this capacity, prepare the agenda, related NSC meeting documentation and present the same to the Chair and the Members of the NSC for their consideration and approval.

5. The NSC will meet every quarter to consider the quarterly reports to be provided by the National Program Coordination Unit NPCU/SCO.

3.2.2. National Program Coordination Unit (NPCU/SCO)

The NPCU functions will be incorporated into the SCO of the FMOH&SW. The NPCU/SCO will manage and coordinate the implementation of the HOPE-PHC Program and other resources pooled through SWAp which are disbursed by the SCO.

The NPCU/SCO for the HOPE-PHC Program will oversee day-to-day implementation and will be responsible for coordinating HOPE-PHC Program activities in the FMOH&SW.

The key functions of the NPCU/SCO are:

Program management and coordination

- oversee day-to-day coordination and implementation of NHSRII programs including coordinating HOPE-PHC program activities

- Serve as a secretariat for the NSC and one-stop shop for SWAp activities including managing SWAp TWGs

- Ensure development and implementation of approved work plans of NHSRII grants and programs (including HOPE-PHC program)

- Periodic program performance reviews with the active participation of the state entities implementing the results areas.

- Coordinate, harmonise and integrate the activities of NPCU/SCO with those of FMOH&SW Departments and Agencies providing support to States participating in the Programme
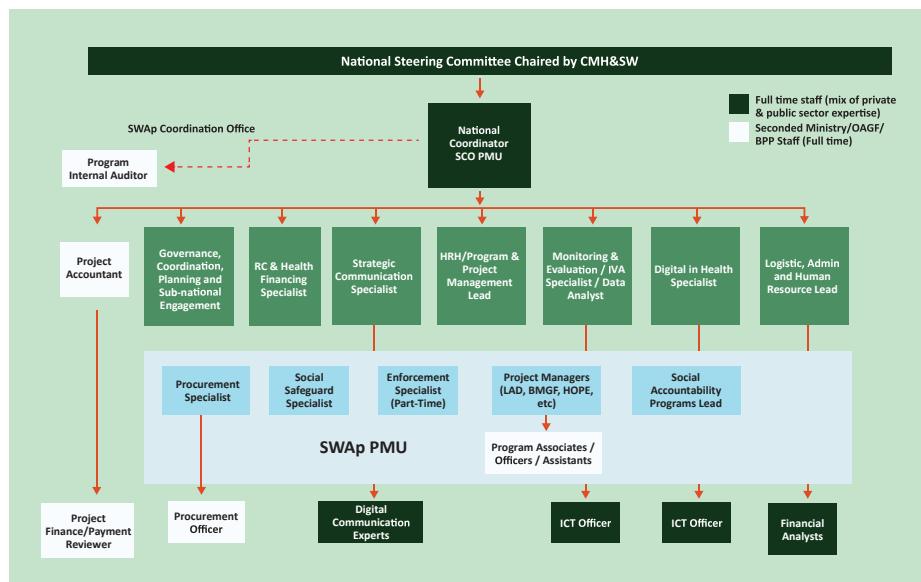
Figure 3.3 Federal program coordination unit (NPCU/SCO)

- Analyse overall program performance through the development and deployment of the state of the nation health report, monitor results as well as identify program-related gaps and how TA can address them

- Approve AOPs prepared by states and other implementing entities and monitor the implementation of the same

- Manage capacity assessments for states and deploy needed TA through the TWGs for, and implementing TA required to build capacities for program implementation

- Interface with the financiers contributing to HOPE-PHC and NHSRII programs/ projects, e.g., the World Bank's supervision and implementation support team

Monitoring and evaluation

- Develop and implement an overall M&E framework and quarterly (alongside states) and joint annual reviews for the NHSRII and HOPE-PHC results including the verification protocol for the DLRs and oversight for the activities of the IVA(s) in all the participating states and across all results areas

- Working with the Department of Health Research Planning & Statistics, ensure the timely collection of high-quality data and publication of the State of Health Report.

- Conduct periodic monitoring and evaluation visits to implementing entities and states, ensuring visits observe progress across all the result areas.

- Contract, Supervise, and Manage the IVA process and leverage the output of National Health Fellows and Public Financial Management Officers (PFMOs).

- Ensure the implementation and quality of M&E activities for the overall program while the individual state performance assessments are carried out by the IVA.

- Establish a quality assurance system to oversee the quality of the IVA and the compliance with the verification process.

- Prepare quarterly reports which will include the status of implementation of actions outlined in the financial management program action plan, fiduciary risk and mitigation measures outlined in the Fiduciary System Assessment (FSA).

- Lead SWAp program communications and outreach activities in accordance with the program's Communication Outreach Strategy.

- Support the DHPRS to carry out thematic studies to support sector policy improvements.

Financial / fiduciary management

The fiduciary arrangements will be managed by staff seconded to the NPCU/SCO from the OAGF and the Bureau of Public Procurement (BPP)

- Provide financial management of the program

- Provide accounting and financial reporting for the NHSRII and HOPE-PHC Program

- Ensure the efficient funds flow, disbursement, and all fiduciary arrangements of the proceeds of the program to the intended beneficiaries/recipients, as well as other sundry financial and procurement processes of the NHSRII and HOPE-PHC PforR, when and where necessary.

- Oversee disbursements to states and participating entities per payments based upon attainment of the respective DLRs

- Facilitate technical and financial/audit processes

- Establish and operate a Complaints Handling Mechanism to deal with appeals related to Procurements by expanding BHCPF SOCs and their implementing agencies

- Oversee DLR verification including engagement of IVA

- Disburse annual performance-based incentives to the states based on the Annual Performance Assessment (APA) from the IVA.

Resource coordination

- Drive and plan the SWAp expenditure program, resource mapping, gap analysis, adherence to tracking tools; work with partners to continually strengthen alignment of non-pooled funds

- Coordinate funds (TA pool) and ensure streamlined and efficient management of TA within the framework of the NHSRII

- Support initiatives by Development Partners (DPs) to pool or commingle funds with each other and with govt to strengthen government systems

- Develop training and capacity building program of participating institutions to support and build capacities of stakeholders in the States, including capacity for financing, budget, and resource coordination.

State engagement

- Coordinate with the states and provide support for various state-level activities (AOPs, State quarterly dialogues etc.) to ensure co-ownership of the SWAp with the States and the Federal Government

- Provide input on state engagement mechanisms; seek views from and represent the perspectives of states to ensure the sector-wide approach effectively serves states

- Develop CEmONC State partnership framework

- Manage National Health Fellows Program

- Issue and roll out citizens engagement guidelines to all state implementing agencies

Adherence to SWAp behaviours & TWG code of conduct

- Oversee alignment to SWAp principles of One Plan, One Report, One Budget and One Conversation

- Provide support to and facilitate the operations of all TWGs, and review the content of TWG output to inform policy direction

- Coordinate and manage joint missions, joint annual reviews etc.

- Reviews TWG participation and progress against each TWG's workplan output

Digital in Health and Strategic Communication

- Develop and implement the Digital in Health Program

- Develop and execute strategic communication plans for NHSRII and SWAp

Environment and social safeguards

- Ensure compliance with the Environmental and Social Systems Assessment (ESSA) requirements, Procurement Action Plan (PAP), procurement and fiduciary management guidelines, and other requirements of World Bank financing-, including the development of the half-yearly monitoring report

- Establish and operate a Grievance Redress Mechanism (GRM) to address citizen's grievances

- **Any other work as directed by the NSC and/or the National Program Coordinator (NPC) from time to time.**

The NPCU/SCO, headed by a National Program Coordinator (NPC) recruited from either the public or private sector and reporting to the CMHSW, has the following functions:

i.   steer day-to-day program activities.

ii. serve as the National Secretariat/delivery unit, based in the Office of the Coordinating Minister, as the secretariat for the NSC and as the counterpart for external financiers, including the World Bank.

iii. work under the overall guidance of the CMHSW, HMSH, and Permanent Secretary for Health. While the actual implementation of the HOPE-PHC program will be the responsibility of states, relevant entities such as NHIA, NPHCDA, NEMSAS, NCDC, FMOH&SW departments such as DHPRS and Department of Family Health, and BHCPF MOC will provide general oversight, technical support, supervision, M&E, and resource management, as required for states' engagement.

The NPC will be supported by the following operational staff of NPCU/SCO described in figure 3.3 above. The ToRs for the staff to be deployed were reviewed and agreed with the World Bank as a requirement for this World Bank-assisted program and are referenced in the annex. The NSC will also review the performance of the NPCU/SCO after six months and then annually.

3.3   State Implementation and Institutional Arrangement

At the state level, the State Ministry of Health, under the leadership of the Commissioner of Health, will lead state-level policy reform, service delivery improvement, and sector coordination while actual implementation takes place through the gateways (SPHCDA/B, SSHIA, SEMSAS) and the State Hospitals Management Board (HMB). The SMOH can participate in the actual implementation if a similar arrangement is obtainable in the state.

3.3.1   Expanded BHCPF State Oversight Committees (BHCPF SOCs)

The current membership and functions of the BHCPF SOCs will be expanded in all states to include oversight of the HOPE-PHC activities in addition to the current oversight of the BHCPF Federal Government grants. Membership of the committee shall be revised to include representation from the key state Ministries, Departments, and Agencies (MDAs) responsible for achieving the disbursement-linked results to be detailed in this POM.

The expanded BHCPF SOC, in addition to current membership, will include

- Representatives of commissioners of the state-level ministries of Finance, Budget & Planning, Local Government and Chieftaincy Affairs, Social Development and Women Affairs,

- state accountant generals,

- the state civil service commission, as well as any other institutions with responsibility for relevant subsectors regarding the overall program objectives of addressing the multi-sectoral dimensions of addressing maternal, newborn and child health.

- The State Commissioner for Health will assign a SWAp focal person to coordinate the implementation of the HOPE-PHC program across the KRAs and the coordination of the TA activities at the state level.

The BHCPF SOC will approve the Annual Operational Plans (Program annual work plan and budget prepared by all state stakeholders referenced in Annex 2) and monitor and

evaluate the performance of state-level program results. States will be responsible for achieving the program results and thus will be leading the implementation of the PforR component. The expanded BHCPF SOC will also review the state's results in the Annual Performance Assessment by the IVA, and take remedial action if the state is unable to achieve the Eligibility Criteria and the DLRs.

FUNCTIONS OF EXPANDED BHCPF SOC: BHCPF SOCs shall provide technical support for the overall planning, design, implementation, and supervision of the state aspects of the NHSRII. The primary responsibilities of the BHCPF SOC include:

a. Planning and budgeting for investments for the program period as articulated in the AOPs.

b. Recruitment of experts/consultants to support the design and implementation of investments.

c. Preparation of Performance Improvement Action Plans (PIAPs) and Policy, Institutional, and Regulatory (PIR) reforms to improve the efficiency and efficacy of sector operations in Nigeria, derived from the results of state capacity assessments and the DLI results.

d. Prepare/review conceptual and detailed designs for each investment based on data collected by conducting community consultations, field surveys, safeguards assessments and management

e. Improve institutional operations and monitoring through the Program Management Information System (PMIS) as advised by NPCU/SOC.

f. Conduct training programs to enhance the capacities of all stakeholders in consultation and coordination with NPCU/SCO.

g. Establish and service Grievance Redressal Mechanisms and document the grievances received and how soon they have been resolved.

h. Establish Citizens' feedback systems and communicate established guidelines developed by NPCU/SCO.

i. Submit quarterly progress reports to NPCU/SCO with details of physical and financial progress.

j. Ensure timely audit of annual financial statements and dissemination of certified audited Annual Financial Statements (AFS).

k. Any other work as directed by the NPCU/SCO

The SMOH DHPRS, as the Member/Secretary of the BHCPF SOC, shall, in this capacity, prepare the agenda and other related BHCPF SOC meeting documentation and present the same to the Chair and the Members of the SOC for their consideration and approval.

The State SWAp Desk Officer based in the SMOH shall work closely with the DHPRS and the planning officers of the health sector to develop the AOPs to be approved by the

BHCPF SOC. The SWAp Desk Officers are required to coordinate the implementation of the Program across the Key Results Areas and the coordination of the TA activities at the state level and communicate progress using the extant civil service rules in the state.

The BHCPF SOC should issue all administrative decisions/directives to support program implementation within 15 days of submission of the request from the relevant stakeholders, and/or beneficiaries of the program.

3.3.2 State SWAp Desk Officer

The State SWAp desk officers will be appointed by the Honorable Commissioners of Health to monitor program implementation across all program components at the state level. The SWAp desk officers will track and report program implementation to the BHCPF SOCs and NPCU/SCO periodically. It is recommended that HCHs appoint officers who are level 12 to level 16 as state desk officers so these officers can report to the HCHs through the extant civil service rules in the states.

3.3.3 Implementing Entities

The implementing entities at the state level are distributed across sector institutions, parastatal bodies, etc. and may vary from state to state. Some of the key sector institutions engaged in implementation at the State level are:

i. State Ministries of Health (SMOHs).

ii. State Social Health Insurance Agencies (SSHIAs).

iii. State Primary Healthcare Development Agency (SPHCDA).

iv. State Hospital Management Board (SHMB).

v. State Emergency Management and Ambulance Services (SEMSAS)

3.3.4 State Digital-in-Health Focal Persons

State Digital Health Focal Persons (SDIHFP) will serve as the primary coordinators for digital health initiatives within their respective states, acting as critical liaisons between state health authorities and the National Digital Health Transformation Office (NDHTO), a unit in the SCO/PVAC. These individuals will be responsible for aligning state-level digital health activities with the national digital health architecture (NDHA), supporting the implementation of the Nigeria Digital in Health Initiative (NDHI), and facilitating the adoption of standards-based, interoperable systems across public and private health facilities. Ideal candidates will possess a strong background in health informatics, public health, ICT, or related fields, with proven experience managing digital health projects or health information systems. Key responsibilities include coordinating stakeholder engagement, overseeing system integration efforts, monitoring digital infrastructure readiness, and ensuring compliance with national data protection and interoperability

standards. Through their leadership, State Focal Persons will drive the digital transformation of the health sector at subnational levels, ensuring that digital solutions are effectively implemented, adapted to local contexts, and sustainably maintained.

3.4   Management Information Systems for Digital-in-Health in the NPCU/SCO

The Digital Lead (Advisor) within the NPCU/SCO will champion and support the design, development, implementation and monitoring of all digital tools and management information systems as it relates to all 11 DLIs. This will be guided by existing data standards and Nigeria Digital Health Architecture Framework.

These standards and architecture would be jointly reviewed by representatives from FMOH&SW, SMOH, development partners, private sector and other stakeholders.

This would pilot a national harmonised information system for all levels of government that supports integrated monitoring, reporting, and evaluation of the SWAp program through the deployment of the necessary infrastructure, management modalities, and programs. This system will be tailored explicitly to inform decision-making in policy formulation, planning, and resource allocation in Nigeria's health sector, and will build upon existing systems where feasible. The financing will additionally support the NPCU/SCO in building the capacity of its M&E, procuring required hardware and software for the system's operation, and piloting the system in selected states.

3.5   Indicative Program Action Steps

Some action steps for the program are described in Table 3.2 below. This table may be used as a template for the complete Program Action Plan to be developed and updated throughout the duration of the program. The complete Program Action Plan will include steps from all strategic areas, including activities detailed in the NDHA, the M&E plan, and others.

Table 3.2 Indicative Program Action Plan

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Develop Program Operations Manual (POM) and publish on the Ministry website	Other	NA	NPCU/SCO	Other	At effectiveness.	Finalized Program Operations Manual developed in agreement with the World Bank and published.

Develop digital dispatch system for rural emergency service and maternal transport	Environmental and Social Systems	NA	NPCU/SCO and NEMSAS	Other	Within one year of effectiveness	Finalized Rural Emergency Service and Maternal Transport Digital Dispatch system developed
Develop referral pathways and communication on GBV prevention and management to be integrated into retraining curricula for front-line workers.	Environmental and Social Systems	NA	NPCU/SCO and FMOWA	Other	Within one year of effectiveness	Referral pathways developed and integration of GBV prevention and management in curricula.
Undertake environmental screening of designs for the rehabilitation of facilities to ensure that the rehabilitation activities filter out substantial or high-risk civil works and proposed actions	Environmental and Social Systems	NA	Federal Ministry of Health and NPCU/SCO	Other	Prior to commencement of rehabilitation works	Environmental screening checklist satisfactory to the World Bank developed for use before rehabilitation works
Develop e-waste and health care waste management strategies for managing e-waste and healthcare waste resulting from the program.	Environmental and Social Systems	NA	NPCU/SCO	Other	Within one year of effectiveness	Health care e-waste management plan developed and disseminated to health care facilities.
Deployment of key financial management, procurement and safeguards personnel, with TOR acceptable to the International Development Association (IDA)	Fiduciary Systems	NA	NPCU/SCO	Other	At effectiveness	Terms of Reference, Curriculum Vitae and Appointment Letter for each designated officer

Prepare and implement a comprehensive Procurement Capacity Development Plan for the implementing agencies based on a need assessment.	Fiduciary Systems	NA	NPCU/SCO	Other	Within 90 days of effectiveness	Capacity development plan developed
Conduct clinics to strengthen procurement institutions and systems through capacity building.	Fiduciary Systems	NA	NPCU/SCO	Other	Throughout the Program implementation	Annual training reports
Ensure that individuals or firms debarred or suspended by the World Bank are not awarded a contract by verifying the same prior to award under the program.	Fiduciary Systems	NA	NPCU/SCO	Other	Throughout the Program implementation	Annual reports *TOR for audit firms will include the requirement to assess on random basis whether any contract has been awarded to a suspended or debarred firm and no parties debarred or suspended by the Bank shall benefit from the program funds.*
Development and adoption of standardized framework agreements for procurement of recurring items.	Fiduciary Systems	NA	NPCU/SCO	Other	Within six months from effectiveness.	Standard Framework Agreement and procurement package templates
Carry out program procurement performance and value for money audit by an Independent Agency/Consultant (Third Party) using the terms of reference agreed by the World Bank.	Fiduciary Systems	NA	NPCU/SCO	Other	Once at mid-term review (MTR) and once at program closure.	Value for Money audit report

Establish service standards with implementing agencies to ensure timely for the release of Program funds.	Fiduciary Systems	NA	NPCU/SCO	Other	At effectiveness	Fund Release Policy
Engagement of IVA with technical and audit skill to review the achievement of DLIs and release of funds to the implementing agencies by the Government in conjunction with HOPE-GOV NPCU/SCO	Fiduciary Systems	NA	NPCU/SCO	Other	2 months after Program effectiveness.	Engagement of IVA by implementing agencies.
Submit report on fraud and corruption allegations. Where there are no such allegations or complaints, a statement to that effect shall be included in the submission.	Fiduciary Systems	NA	NPCU/SCO and Implementing agencies	Other	Bi-annually after effectiveness	Bi-annual report
Strengthening of ICPC's Anti-Corruption and Transparency Unit (ACTU) at FMOH&SW and strengthening reporting linkages to the Economic and Financial Crimes Commission (EFCC).	Fiduciary Systems	NA	NPCU/SCO	Other	Throughout the Program implementation	Semi-annual summary reports
Submit PEF-based Program financial and IPF interim financial reports.	Fiduciary Systems	NA	NPCU/SCO	Other	Throughout the Program implementation	Annual report and updated expenditure framework

Focused training of fiduciary staff in implementing agencies to strengthen financial management and reporting.	Fiduciary Systems	NA	NPCU/ SCO and implementing agencies	Other	Within 90 days of effectiveness	FM Training Report package that includes an agenda, training manual
Capacity training on risk-based internal audit for internal auditors.	Fiduciary Systems	NA	NPCU/ SCO and implementing agencies	Other	Within 18 months of effectiveness	Annual report
Government shall strengthen Maternal, Perinatal, and Child Deaths Surveillance and Response (MPCDSR) system	Technical	NA	NPCU/ SCO, DFH-FMOH&SW and NPHCDA	Other	Throughout the Program implementation	Annual PDSR Assessment / Report

3.6   Administration and Controls

The Administrative and Control Protocol provides robust administration and control mechanisms that enhance accountability, transparency, and effective management throughout the program. The section provides clarity on responsibilities and processes, enabling program teams and stakeholders to maintain oversight and mitigate potential risks that may arise. This document also clearly outlines roles and responsibilities for units within the NPCU/SCO described later in this chapter of the POM. All reporting under the program will meet the requirements of the financiers while adhering to the "One Report" principle of the SWAp.

Reporting Protocol

Ensure timely and accurate reporting of all program activities, progress, and financials to facilitate effective decision-making and accountability.

Frequency of Reports

- Quarterly financial and performance reports by the program accountant.

- Annual summary report for stakeholders and program governance entities.

Types of Reports

- Progress Reports: Detailing milestones, timelines, challenges, and risk mitigation.

- Financial Reports: Budget utilization, cost variances, and financial projections.

- Compliance Reports: Ensure adherence to local and international regulatory frameworks.

Approval Process

All reports are to be drafted by the respective implementing agencies for final review by the implementing entities executive directors or equivalent. This is to be then submitted to the implementing entities boards or stakeholders (where applicable) for ratification before forwarding to the NPCU/SCO.

Distribution

Reports must be shared with key stakeholders, including donors, government agencies, and partners involved in the program, through secure platforms (e.g., printed reports, encrypted emails, and shared drives).

Communication Protocol (Letters and Emails)

This establishes a formal communication channel for effective program management and documentation.

Official Channels

- All formal communication must be through program-authorized email addresses and letterheads.

- Use of standardized templates for letters and emails.

Letter/Email Protocols

- Subject Line: Indicate the purpose (e.g., "Recruitment Request – Implementing Agency Team").

- Content: Concise and to the point, with clear action items.

- Approval for Official Correspondence: All official letters and emails must be approved by the NPCU/SCO or lead of the respective Implementing Agency (IA) before dissemination.

Archiving

Maintain a digital repository for all outgoing and incoming letters and emails for at least 5 years following the completion of the program.

Recruitment Protocol

The NPCU/SCO will adhere to a recruitment procedure described below to maintain transparency, fairness, and competency in the recruitment process for program staff.

Recruitment Phases

Job Description Development: Each role must have a clear job description, approved by the NPC NPCU/SCO.

Selection Process

- Advertisement: Use official platforms (websites, social media, etc.) to announce job openings

- Review of applications by a minimum of three (3) recruitment committee members.

- Interviews to be conducted based on a pre-determined scoring matrix approved by the NPCU/SCO.

- Approvals: Final hiring decisions must be approved by the NPC of the NPCU/SCO.

Operational Costs and Budgeting for PIUs

This provides a framework for budgeting and managing operational costs to ensure efficient resource utilization.

Budget Preparation

- Each IA should prepare an annual budget covering personnel, office supplies, travel, and other relevant operational expenses.

- The budget should align with the overall program financial plan and be approved by the program's budget committee.

Cost Controls

- Implement spending limits for each expense category (e.g., travel, workshops).

- Regular audits (quarterly) to ensure expenditures align with approved budgets.

Reimbursement and Advances

- Set clear policies for reimbursement of travel and project-related expenses, with receipts and supporting documents mandatory.

- Cash advances must be authorized by the finance department and reconciled within 15 days.

04

PERFORMANCE-BASED INCENTIVES FOR THE PROGRAM'S COMPONENTS WHICH WILL DISBURSE AGAINST ACHIEVEMENT OF RESULTS

Chapter 4 - Performance-Based Incentives for the Program's Components which will Disburse Against Achievement of Results

4.1   DLI Matrix

The HOPE-PHC design is founded on a Program-for-Result financing (PforR) structure, which pushes certain desired results across all implementing entities and provides incentives for achieving these results, i.e., incentives and payouts are linked to expected results. These desired results are often annual and are termed disbursement- linked results (DLR); however, these results are tied to higher-themed priorities, whose progress is measured year on year, called DLIs (described in Chapter 2). The DLIs are grouped into KRAs which are fully aligned with the program development objectives

The list below shows the DLIs grouped into the KRAs together with the total amount of funds which will be disbursed when the specific results (DLRs) are met (sometimes referred to as the "price" of each)

- **Key Result Area 1: Improving Quality of Services (US$177.5M)**

  - DLI 1: Improved Service Readiness (US$119.5M)

  - DLI 2: Increased Availability of Essential Commodities (US$58.0M)

- **Key Result Area 2: Improving Utilization of Essential Services (US$272.5M)**

  - DLI 3: Increased Enrolment of Poor and Vulnerable Populations (US$40.0M)

  - DLI 4: Enhanced Community Delivery of Health Services (US$50.0M)

  - DLI 5: Increased Utilization of Priority Secondary Care Services (US$72.5M)

  - DLI 6: Increased PHC Utilization of Priority Services (US$90.0M)

  - DLI 7: Increased Utilization of Emergency Medical Services (US$20.0M)

- **Key Result Area 3: Improving Resilience of the Health System (US$75.0M)**

  - DLI 8: Improved Allocation and Disbursement of BHCPF Funds (US$12.5M)

  - DLI 9: Enhanced Pandemic Preparedness and Response through Deployment of EPR Plans (US$15.0M)

  - DLI 10: Improved Climate Resilience (US$30.0M)

  - DLI 11: Stronger Digital Foundation (US$17.5M)

The table below reviews the DLIs and DLRs for the HOPE-PHC Program and the incentives tied to achieving the results.

HOPE-PHC DLI Matrix

Table 4.1 HOPE-PHC DLI Matrix

Key Result Area 1	Improving Quality of Services (US$177.5 million)
DLI 1	Improved Service Readiness
Total Allocated (US$ m)	119.50

DLI 1.1	Improved primary health care facility readiness, quality, and climate resilience (Percentage)			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Percentage	61.50	
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	0			
Prior Result	-			
Result to be achieved in Yr 1	25% of 2,000 of BHCPF-supported level 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience. In addition, digital connectivity and speed must be considered especially for priority LGAs		6.15	US$12,300 per facility meeting the BHCPF level 2 BEmONC standard per ward up to a total of US$7.5million to be shared by allocating 90% reward to SPHCDAs of states with representative level 2 PHCs and 10% reward to NPHCDA
Result to be achieved in Yr 2	50% of 2,000 BHCPF-supported level 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience. In addition, digital connectivity and speed must be considered especially for priority LGAs		12.30	US$12,300 per facility meeting the BHCPF level 2 BEmONC standard per ward up to a total of US$12.00 million to be shared by allocating 90% reward to SPHCDAs of states with representative level 2 PHCs and 10% reward to NPHCDA
Result to be achieved in Yr 3	75% of 2,000 of BHCPF-supported level 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience. In addition, digital connectivity and speed must be considered especially for priority LGAs		18.45	US$12,300 per facility meeting the BHCPF level 2 standard per ward up to a total of US$18.00million to be shared by allocating 90% reward to SPHCDAs of states with representative level 2 PHCs and 10% reward to NPHCDA
Result to be achieved in Yr 4	100% of 2,000 of BHCPF-supported level 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience. In addition, digital connectivity and speed must be considered especially for priority LGAs		24.60	US$12,300 per facility meeting the BHCPF level 2 standard per ward up to a total of US$24.00 million to be shared by allocating 90% reward to SPHCDAs of states with representative level 2 PHCs and 10% reward to NPHCDA

DLI 1.2	Increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (Number)			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	58.00	
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	0			
Prior Result	-			
Result to be achieved in Yr 1	100 certified CEmONC facilities empanelled according to the NHIA guidelines that maintain the empanelment requirements and have implemented climate resilience measures. (See full list of facilities in annex 9)		3.46	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SMOH/HMB/Implementing MDA of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 2	200 additional facilities to add up to 300 certified CEmONC facilities empanelled according to the NHIA guidelines that maintain the empanelment requirements and have implemented climate resilience measures. (See full list of facilities in annex 9)		10.39	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SMOH/HMB/Implementing MDA of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 3	200 additional facilities to add up to 500 certified CEmONC facilities empanelled according to the NHIA guidelines that maintain the empanelment requirements and have implemented climate resilience measures. (See full list of facilities in annex 9)		17.32	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SMOH/HMB/Implementing MDA of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 4	274 additional facilities to add up to 774 certified CEmONC facilities empanelled according to the NHIA guidelines that maintain the empanelment requirements and have implemented climate resilience measures. (See full list of facilities in annex 9)		26.82	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SMOH/HMB/Implementing MDA of participating states and 2.5% reward to NHIA
DLI 2	Increased availability of essential commodities.			
Total Allocated (US$ m)	58.00			
DLI 2.1	Federal level expenditure on quality family planning commodities increased			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount

Outcome	Yes (up to annual cap)	Percentage	25.00	
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result	-			
Result to be achieved in Yr 1	6 percentage points increase over the 2024 baseline		5	US$0.83m per cent point annual increase federal level expenditure on quality FP commodities on the 2024 baseline to a maximum of $5m. Reward to be distributed to agencies proportionally to their initial investment in family planning commodity financing.
Result to be achieved in Yr 2	12 percentage points increase over the 2024 baseline		5	US$0.83m per cent point annual increase federal level expenditure on quality FP commodities on the 2025 result to a maximum of $5m. Reward to be distributed to agencies proportionally to their initial investment in family planning commodity financing.
Result to be achieved in Yr 3	21 percentage points increase over the 2024 baseline		7.5	US$0.83m per cent point annual increase federal level expenditure on quality FP commodities on the 2026 result to a maximum of $7.5m. Reward to be distributed to agencies proportionally to their initial investment in family planning commodity financing.
Result to be achieved in Yr 4	30 percentage points increase over the 2024 baseline		7.5	US$0.83m per cent point annual increase federal level expenditure on quality FP commodities on the 2027 result to a maximum of $7.5m. Reward to be distributed to agencies proportionally to their initial investment in family planning commodity financing.
DLI 2.2	Front-line availability of tracer products improved			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Percentage	33.00	
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result	-			

Result to be achieved in Yr 1	Up to 25% of 2,000 BHCPF supported level 2 (PHC + BEmONC) facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position. Real time LMIS using digital platforms as recommended by the NDHA is encouraged	3.3	US$6,600 per facility validated to have at least 5 of 6 tracer commodities above the minimum stock level on the realtime LMIS platform to be shared by allocating SPHCDAs (45%)/SDMAs (45%) of participating states and FMOH&SW (5%), NPHCDA (5%) at the federal level
Result to be achieved in Yr 2	Up to 50% of 2,000 BHCPF supported level 2 (PHC + BEmONC) facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position. Real time LMIS using digital platforms as recommended by the NDHA is encouraged	6.6	US$6,600 per facility validated to have at least 5 of 6 tracer commodities above the minimum stock level on the realtime LMIS platform to be shared by allocating SPHCDAs (45%)/SDMAs (45%) of participating states and FMOH&SW (5%), NPHCDA (5%) at the federal level
Result to be achieved in Yr 3	Up to 75% of 2,000 BHCPF supported level 2 (PHC + BEmONC) facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position. Real time LMIS using digital platforms as recommended by the NDHA is encouraged	9.9	US$6,600 per facility validated to have at least 5 of 6 tracer commodities above the minimum stock level on the realtime LMIS platform to be shared by allocating SPHCDAs (45%)/SDMAs (45%) of participating states and FMOH&SW (5%), NPHCDA (5%) at the federal level
Result to be achieved in Yr 4	Up to 100% of 2,000 BHCPF supported level 2 (PHC + BEmONC) facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position. Real time LMIS using digital platforms as recommended by the NDHA is encouraged	13.2	US$6,600 per facility validated to have at least 5 of 6 tracer commodities above the minimum stock level on the realtime LMIS platform to be shared by allocating SPHCDAs (45%)/SDMAs (45%) of participating states and FMOH&SW (5%), NPHCDA (5%) at the federal level

Key Result Area 2	Improving Utilization of Essential Services (US$272.5 million overall - US$238.9 million IDA, US$33.5 million Grant)			
DLI 3	Increased enrolment of poor and vulnerable populations.			
Total Allocated (US$ m)	40.00			
DLI 3	Financial protection for poor and vulnerable populations increased			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	40.00	7.02
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	1,800,000			

18 - Community outreach services include micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification/follow-up of pregnant women and referral to receive MMS, treatment of any childhood illness (Integrated Community Case Management – for diarrhea, fast breathing, fever)

Prior Result	-		
Result to be achieved in Yr 1	20 percent increase from the previous year in the number of eligible population with NIN (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs. Up to 2,520,000 enrolees on a digital enrolment and claims management platforms adhering to the NDHA standards and processes	5.63	US$8 per eligible health insurance enrolment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 2	20 percent increase from the previous year in the number of eligible population with NIN (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs. Up to 3,528,000 enrolees on a digital enrolment and claims management platforms adhering to the NDHA standards and processes	7.88	US$8 per eligible health insurance enrolment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 3	20 percent increase from the previous year in the number of eligible population with NIN (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs. Up to 4,939,200 enrolees on a digital enrolment and claims management platforms adhering to the NDHA standards and processes	9.04	US$8 per eligible health insurance enrolment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 4	20 percent increase from the previous year in the number of eligible population with NIN (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs. Up to 6,914,880 enrolees on a digital enrolment and claims management platforms adhering to the NDHA standards and processes	15.45	US$8 per eligible health insurance enrolment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA

DLI 4	Enhanced community delivery of health services.		
Total Allocated (US$ m)	50.00		
DLI 4	Women and children who receive tracer essential health services delivered by CBHW in the community		
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	50.00	8.77
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				

Prior Result	-		
Result to be achieved in Yr 1	5,000,000 service encounters for tracer essential health services [18] delivered by community based health workers in the community on the eCHIS and claims management platforms adhering to standards and processes set by the NDHA	5.00	US$1 per CHW-client contact in the communities on the DHIS2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 2	10,000,000 service encounters for tracer essential health services delivered by community based health workers in the community on the eCHIS and claims management platforms adhering to standards and processes set by the NDHA	10.00	US$1 per CHW-client contact in the communities on the DHIS2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 3	15,000,000 service encounters for tracer essential health services delivered by community based health workers in the community on the eCHIS and claims management platforms adhering to standards and processes set by the NDHA	15.00	US$1 per CHW-client contact in the communities on the DHIS2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 4	20,000,000 service encounters for tracer essential health services delivered by community based health workers in the community on the eCHIS and claims management platforms adhering to standards and processes set by the NDHA	20.00	US$1 per CHW-client contact in the communities on the DHIS2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA

DLI 5	Increased utilization of priority secondary care services.			
Total Allocated (US$ m)	72.50			
DLI 5.1	Secondary Facility Quality of Care for CEmONCs			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Prior Result	No	Guideline/ Report	2.50	0.44
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result	The design and approval of a CEmONC empanelment and reimbursement strategy by the NHIA for SSHIAs (annex 14)		2.50	One-time payment of US$2.5m following the achievement of the DLI to the NHIA
DLI 5.2	Women and neonates receiving CEmONC and/or neonatal services and/or VVF surgeries (Number)			

Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	70.00	12.28
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result				
Result to be achieved in Yr 1	50,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		4.38	US$87.50 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 4.37m for CEMONC services in an accredited CEmONC facility
Result to be achieved in Yr 2	150,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		13.13	US$87.50 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 13.12m for CEMONC services in an accredited CEmONc facility
Result to be achieved in Yr 3	250,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		21.87	US$87.50 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 21.87m for CEMONC services in an accredited CEmONC facility
Result to be achieved in Yr 4	350,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		30.62	US$87.50 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 30.45m for CEMONC services in an accredited CEmONC facility
DLI 6	Increased PHC utilization of priority services.			
Total Allocated (US$ m)	90.00			
DLI 6.1	Deliveries with skilled birth attendant present increased			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Percentage	35.00	6.14
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	46			
Prior Result				
Result to be achieved in Yr 1	Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years			Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years

Result to be achieved in Yr 2	2.5 percentage points increase over the 2024 baseline result on the number of deliveries with a skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)		17.5	US$118,243 per percentage point increase per state for the proportions of deliveries with SBA present over the previous survey data result to a maximum of $17.5m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 3	Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years			Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years
Result to be achieved in Yr 4	2.5 percentage points increase over the 2026 result on the of number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)		17.5	US$118,243 per percentage point increase per state for the number of deliveries with SBA presents over the previous survey data result to a maximum of $17.5m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
DLI 6.2	Introduction of MMS supplementation for pregnant women during ANC visits			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Percentage	20.00	3.50
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	25			
Prior Result				
Result to be achieved in Yr 1	Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years			Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years
Result to be achieved in Yr 2	6 percentage point increase over the 2024 baseline in the percentage of pregnant women using MMS supplementation for not less than 180 days (1 tablet per day) from the 2024 baseline		10.00	US$45,045 per percentage point increase in pregnant women receiving supplementation dosage of at least 180 tablets to a maximum of US$10.00m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 3	Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years			Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years

Result to be achieved in Yr 4	6 percentage point increase over the 2024 baseline in the percentage of pregnant women using MMS supplementation for not less than 180 days from the 2024 baseline		10.00	US$45,045 per percentage point increase in pregnant women receiving supplementation dosage of at least 180 tablets to a maximum of US$10.00m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
DLI 6.3	**Increase in Penta 3 coverage**			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Percentage	35.00	6.14
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	53			
Prior Result				
Result to be achieved in Yr 1	Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years			Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years
Result to be achieved in Yr 2	4 percentage point increase in Penta 3 coverage over the 2024 baseline based on survey data		17.50	US$118,243 per percentage point increase in Penta 3 immunization based on survey data to be shared by allocating 90% reward to SPHCDAs of participating states and 10% reward to NPHCDA
Result to be achieved in Yr 3	Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years			Survey data will be used for reimbursement for this DLI. Surveys will be conducted every 2 years
Result to be achieved in Yr 4	4 percentage point increase in Penta 3 coverage based on the 2026 survey results		17.50	US$118,243 per percentage point increase in Penta 3 immunization based in survey data to be shared by allocating 90% reward to SPHCDAs of participating states and 10% reward to NPHCDA
DLI 7	**Increased utilization of EMS**			
Total Allocated (US$ m)	**20.00**			
DLI 7	**Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system**			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	20.00	3.50

Period	Value	Allocated Amount (US$ m)	Formula
Baseline			
Prior Result			
Result to be achieved in Yr 1	10,000 patients with obstetric and neonatal complications were transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system. Use of digital platforms as recommended by the NDHA is encouraged	0.50	US$50 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Result to be achieved in Yr 2	50,000 patients with obstetric and neonatal complications were transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system. Use of digital platforms as recommended by the NDHA is encouraged	2.50	US$50 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Result to be achieved in Yr 3	100,000 patients with obstetric and neonatal complications were transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system. Use of digital platforms as recommended by the NDHA is encouraged	5.00	US$50 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Result to be achieved in Yr 4	240,000 patients with obstetric and neonatal complications were transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system. Use of digital platforms as recommended by the NDHA is encouraged	12.00	US$50 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS

Key Result Area 3	Improving Resilience of the Health System (US$75 million overall - US$65.8 million IDA, US$9.2 million Grant)		
DLI 8	Improved allocation and disbursement of BHCPF funds		
Total Allocated (US$ m)	12.50		
DLI 8.1	Governance for improved resource allocation and performance (Prior Result)		

Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Prior Result	No	Guideline/ Report	2.50	0.44

Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result	The design and approval of a revised and approved BHCPF 2.0 guidelines reflecting equity and climate resilience (climate vulnerability included as a criterion in resource allocation, specific guidelines for climate-resilient infrastructure, and addressing the impacts of climate change on climate-sensitive diseases and PHC service delivery, emphasis on climate-vulnerable states)		2.50	One-time payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to the BHCPF MOC Secretariat, 20% to the NPHCDA, 20% to the NHIS, 20% to the NEMSAS, and 20% to the NCDC
DLI 8.2	**States receiving funds in compliance with the allocation formula in the revised guidelines**			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	No	Number	10.00	1.75
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result				
Result to be achieved in Yr 1	The Government of Nigeria's adherence to the allocation formula contained in the revised BHCPF guidelines meets the equity and climate resilience guidelines		2.50	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to the BHCPF MOC Secretariat, 20% to the NPHCDA, 20% to the NHIA, 20% to the NEMSAS, and 20% to the NCDC
Result to be achieved in Yr 2	The Government of Nigeria adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines		2.50	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to the BHCPF MOC Secretariat, 20% to the NPHCDA, 20% to the NHIS, 20% to the NEMSAS, and 20% to the NCDC
Result to be achieved in Yr 3	The Government of Nigeria adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines		2.50	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to the BHCPF MOC Secretariat, 20% to the NPHCDA, 20% to the NHIA, 20% to the NEMSAS, and 20% to the NCDC

Result to be achieved in Yr 4	The Government of Nigeria adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines	2.50	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to the BHCPF MOC Secretariat, 20% to the NPHCDA, 20% to the NHIA, 20% to the NEMSAS, and 20% to the NCDC
DLI 9	**Enhanced pandemic preparedness and response through deployment of EPR Plans**		
Total Allocated (US$ m)	15.00		
DLI 9	**System and standards for state Emergency Preparedness and Response (EPR) programs established and implemented**		

Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	15.00	2.63
Period	Value		Allocated Amount (US$ m)	Formula
Baseline	0			
Prior Result	-			
Result to be achieved in Yr 1	NCDC establishes and disseminates templates for all 36+1 states EPR program plans based on public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		1.00	One-time payment of maximum of $1.0m to NCDC on achievement of the result
Result to be achieved in Yr 2	All 36+1 states have developed and costed state EPR program plans addressing key public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		2.75	US$74,323 per 36+1 state per costed EPR Plan developed; 97.5% Reward to states; 2.5% Reward to NCDC
Result to be achieved in Yr 3	All 36+1 states have implemented up to 50% of their state EPR program plans addressing key public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		3.75	$101,351 at 50% implementation per state; 97.5% Reward to states; 2.5% Reward to NCDC
Result to be achieved in Yr 4	All 36+1 states have implemented up to 80% of their state EPR program plans addressing key public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		7.50	$202,703 at 80% implementation; 97.5% Reward to states; 2.5% Reward to NCDC
DLI 10	**Improved Climate Resilience**			
Total Allocated (US$ m)	30.00			
DLI 10	**Climate and health adaptation plan developed, costed, validated, and implemented**			

Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	30.00	5.26
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result				
Result to be achieved in Yr 1	Development of the National climate and health adaptation plan including costing, a template for state climate and health implementation plans, and guidance for state implementation plans.		1.00	One-time payment of US$1.0m following the achievement of the DLI to be shared by allocating 75% reward to FMOH&SW, 25% reward to National Council on Climate Change in Nigeria (NCCC)
Result to be achieved in Yr 2	All 36+1 states have developed and costed state climate and health implementation plans addressing key climate and health and health system risks and vulnerabilities, adhering with the guidelines in the National Climate and Health Adaptation Plan		5.70	US$154,054 per 36+1 state climate and health adaptation plan developed; 97.5% reward to states; 2.5% reward to FMOH&SW
Result to be achieved in Yr 3	All 36+1 states have implemented up to 50% of each state's climate and health adaptation plans addressing key climate and health system risks and vulnerabilities		7.75	$209,459 per state at 50% implementation; 97.5% reward to states; 2.5% reward to FMOH&SW
Result to be achieved in Yr 4	All 36+1 states have implemented up to 80% of each state's climate and health adaptation plans addressing key climate and health systems risks and vulnerabilities		15.55	$420,270 at 80% implementation; 97.5% reward to states; 2.5% reward to FMOH&SW
DLI 11	**Stronger Digital Foundation**			
Total Allocated (US$ m)	**17.50**			
DLI 9.1	**National enterprise architecture developed, costed, and adopted**			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	No	Compliance	2.50	0.44
Period	Value		Allocated Amount (US$ m)	Formula
Baseline				
Prior Result	Design and approval of a national enterprise architecture for digital health by FMOH&SW, NPCU/SCO and PVAC		2.50	One-time payment of US$2.5m following the achievement of the DLI to the NPCU/SCO

DLI 9.2	States adopt national enterprise architecture for digital health and integrate core health functions			
Type of DLI	Scalability	Unit of Measure	Total Allocated (US$ m)	As % of Total financing Amount
Outcome	Yes	Number	15.00	2.63
Period	Value		Allocated Amount (US$)	Formula
Baseline	0			
Prior Result				
Result to be achieved in Yr 1	All 36+1 states adopt digital in health through • The selection of a Digital Health Focal Person within Level 9-11 • The mapping of existing EHR systems and infrastructure across each state. • A phased plan with annual targets of which and how the mapped information systems will be linked to the national health information exchange (at least 2 information systems per year should be linked to the HIE) • The development of a phased plan with annual targets for NIN number usage and NIN registration point initiation • Continuous engagement with stakeholders at the subnational • The development of state-specific implementation plans in collaboration with Stakeholders, SMOH and the Office of the Hon. Commissioner of Health etc. • The coordination of implementation frameworks for state-specific implementation plans. • Population of Health Facility registry and Healthcare worker registry with weekly updates. This includes both public and private facilities and public and private healthcare workers. • Adoption and integration with the National Facility registry and Healthcare worker registry in the national health information exchange • The support for technical enablement and capacity building to integrate systems and institutionalize digital health at the sub-national level.		1.68	Payment of US$45,404 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the FMOH&SW

	• The implementation of a health data governance plan for the State, in alignment with national health data governance and data protection plans • Confirmation from the State Health Commissioner that the State's health information and digital health plans are aligned with the national efforts to adopt and integrate the National Digital Enterprise Architecture.		
Result to be achieved in Yr 2	All 36+1 States adopt and integrate into the national enterprise architecture for digital-in-health framework and integrate at least 1 of the bundle of functions on the list of core health system functions. This will be done by 36+1 States achieving the following: • Updates the health worker and health facility registry as per the update mechanism agreed with the Federal government • Implements the year 2 activities for their NIN integration plans • For each of the 2 identified information systems, ensure that minimum cybersecurity standards are met • For each of the 2 identified information systems, link them to the national health information exchange • For each of the 2 identified information systems, exchange data about at least 90% of patient-visits within 48 hours of them occurring • Holds health data meetings as planned in the health data governance plan	3.33	Payment of US$90,000 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the FMOH&SW
Result to be achieved in Yr 3	All 36+1 States adopt and integrate into the national enterprise architecture for digital-in-health framework and integrate at least 1 of the bundle of functions on the list of core health system functions. This will be done by 36+1 States achieving the following:	3.33	Payment of US$90,000 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the FMOH&SW

	• Implements the year 3 activities for their NIN integration plans • For each of the 2 identified information systems, ensure that minimum cybersecurity standards are met • For each of the 2 identified information systems, link them to the national health information exchange • For each of the 2 identified information systems, exchange data about at least 90% of patient-visits within 48 hours of them occurring • Holds health data meetings as planned in the health data governance plan		
Result to be achieved in Yr 4	All 36+1 States adopt and integrate into the national enterprise architecture for digital-in-health framework and integrate at least 1 of the bundle of functions on the list of core health system functions. This will be done by 36+1 States achieving the following: • Updates the health worker and health facility registry as per the update mechanism agreed with the Federal government • Implements the year 3 activities for their NIN integration plans • For each of the 2 identified information systems, ensure that minimum cybersecurity standards are met • For each of the 2 identified information systems, link them to the national health information exchange • For each of the 2 identified information systems, exchange data about at least 90% of patient-visits within 48 hours of them occurring • Holds health data meetings as planned in the health data governance plan	3.33	Payment of US$90,000 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the FMOH&SW

4.2 Verification Protocol at a Glance

The appointed IVA will verify the attainment of the DLRs in Table 4.1 on a rolling basis. This section provides an overview of the verification protocols for each DLI under the HOPE-PHC program. A full, detailed description of the verification protocols for each DLI is included in Section 4.3.

4.2.1 DLI 1: Improved service readiness

DLI	1.1: Improved PHC facility readiness, quality, and climate resilience (percentage)
Definition	The DLI will incentivize and verify the percentage of BHCPF-supported Tier 2(PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience.
Description	The NPHCDA has tiered BHCPF facilities based on the quality and complement of services available at the health facilities. According to the NPHCDA, Tier 2 PHC facilities will offer 24-hour PHC services plus basic emergency obstetric and neonatal care (BEmONC). For the HOPE-PHC Program, 2000 facilities will be targeted for revitalization under DLI 1.1. (Full list of selected 2000 PHC/BEmONC facilities provided in Annex 12).
Data source/Agency	NPHCDA Health Facility Assessment Reports (Potential Linkage to the DHIS2)
Verification Entity	IVA
Procedure	
Baseline	
Y1	The IVA will visit 100% of all NPHCDA-accredited Tier 2/BEmONC facilities in the first year and inspect the premises for compliance against the NPHCDA checklist.

Facilities must meet at least a 75% score of the checklist to be eligible and recommended for DLR payout

Payment/disbursement will not be recommended unless at least 75% of the climate resilient measures for key climate shocks, identified in the UNICEF Climate Resilient Infrastructure for Basic Services (CRIBS) checklist, are implemented

The IVA will check for discordance in the NPHCDA assessment reports and their findings during field inspections, and discordance of assessment more than 5% must be flagged and reported in the IVA report

BHCPF tier 2 facilities that fall below the 75% mark on verification by the IVA will have 90 days to take remedial action and request a re-verification

Discordant Assessment Reports between the NPHCDA and the IVA in greater than 10 per cent of the verified facilities will require the IVA assessment for all PHC facilities on the NPHCDA report to have achieved the DLR |
Y2	The IVA will visit 5% or more of previously accredited BEmONC facilities in each state and 100% of newly accredited BEmONC facilities to inspect for compliance and non-discordance between field assessment by the IVA and the NPHCDA report
Y3	As in year 2
Y4	As in year 3
DLI	1.2: Increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (number)

Definition	The DLI will incentivize and verify the number of CEmONC facilities that are empaneled according to the NHIA empanelment guidelines, maintain the empanelment requirements, and have implemented climate resilience measures. The DLI will also ensure the certification criteria, energy efficiency, and climate resilience measures are part of the empanelment requirements for the NHIA. This will be done through pre-assessments (e.g. the climate resilient infrastructure for basic services (CRIBS) tool among others) which may be modified during program implementation.
Description	The SMOH/HMB/Relevant implementing MDAs in the states will refurbish, upscale and optimize 774 CEmONC facilities to reach at least one functional facility per LGA. The NPCU/SCO will support the optimization efforts of the states in a framework to be agreed upon by the NPCU/SCO and states. The full list of preselected facilities to be upgraded is attached in annex 9 of this POM. Following this optimization of the secondary health facilities, the NHIA will inspect and empanel facilities that meet their accreditation guidelines which will have been developed under the related Prior Result (DLI 5.1). The refurbishment will include key structural elements of quality (water source, toilets, mother-newborn intensive care units, surgical theatres, bed numbers, visibly posted schedule of free services, equipment, commodities and medicines, human resources, health information system) and implementation of climate resilience measures. Climate resilience will be measured based on NHIA accreditation criteria. The NHIA empanelment will be renewed on an annual basis.
Data source/Agency	NHIA Facility Empanelment Record (Potential Linkage to the DHIS2)
Verification Entity	IVA
Procedure	
Baseline	
Y1	NHIA provides a certified list of empanelled CEmONC facilities based on their assessment, submitted at least 30 days before the IVA's scheduled assessment. IVA compares this NHIA list with the preselected facilities in Annex 9 of the POM to identify priority CEmONC facilities. All facilities on the NHIA list are assessed by IVA using the DLI 5.1 checklist to confirm structural readiness, climate resilience, and achievement of the certification criteria. A subset of empanelment criteria is reviewed, and facilities must meet 100% of the assessed criteria to qualify as newly or continuously empanelled. IVA checks for discrepancies between its field findings and the NHIA list using the NHIA checklist; any discrepancy greater than 5% is flagged and reported.
Y2	The IVA will go to all additional facilities reported by NHIA to have been empanelled and check for compliance against the checklist; AND visit or verify by phone a random sample of 10% or more of all previously empanelled facilities in each state to ensure that they are still in compliance with previously empanelled facilities.
Y3	As in year 2
Y4	As in year 3

4.2.2   DLI 2: Increased availability of essential commodities

DLI	2.1 Federal expenditure on quality family planning commodities increased (percentage)
Definition	The DLI will incentivize and verify annual increases in domestic spending on contraceptive commodities to reach 30% of the forecasted total need by the end of the program.
Description	The Government of Nigeria will match donor and IDA contributions of US$25 million over the life of the Program with US$12.5 million of spending on contraceptive commodities from a baseline of US $0. This would result in the GoN spending 15% of total contraceptive requirements from domestic non-IDA resources by the program's final year.
Data source/Agency	Budget Execution Reports from the OAGF (Federal, States)
Verification Entity	IVA
Procedure	
Baseline	
Y1	IVA will review expenditure data from state and national budget execution reports to verify the achievement of domestic spending on contraceptive commodities.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3
DLI	2.2 Front-line availability of tracer products improved (percentage)
Definition	The DLI will incentivize and verify the number of Tier 2 (PHC + BEmONC) NHSRII-service- ready facilities (DLI 1.1 above) with a minimum of five of six commodities available.
Description	The NPHCDA has recommended the availability of a basket of tracer commodities and medicines to improve the quality and service readiness at the PHC level. Under the program, the earlier identified Tier 2 BHCPF facilities in 1.1 above will be assessed for the availability of the benchmarked minimum stock of tracer commodities that the SPHCDAs will report to the NPHCDA. There are multiple programs at the federal level, including the NPHCDA, providing essential medicines to primary healthcare facilities and the NPHCDA. The six tracer commodities are (i) oxytocin, (ii) Multiple Micronutrient Supplements (MMS), (iii) Artemisinin-based Combination Therapy (ACTs), (iv) Human Immunodeficiency Virus (HIV) rapid test kits, (v) pentavalent vaccine, and (vi) a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC).
Data source/Agency	Annual Health Facility Readiness Assessment, SPHCDA Essential Commodity Reports, and DHIS2
Verification Entity	IVA
Procedure	
Baseline	
Y1	IVA will verify this DLI using multiple data sources, including NPHCDA annual health facility assessments, procurement and CMS stock records, SPHCDA commodity reports, and DHIS2 data. (i) Procurement and delivery data for tracer commodities will be reviewed in each state, and (ii) IVA will confirm distribution arrangements between federal programs and NPHCDA for supplying essential commodities to facilities. (iii) Stock levels at federal, state, and facility levels will be reviewed, with facility data triangulated against service delivery data. (iv) Spot checks conducted for facilities with inconsistent stock reports and for 5% of facilities with adequate reported stock per state.

Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.3 DLI 3: Increased enrolment of poor and vulnerable populations

DLI	3 Financial protection for poor and vulnerable populations increased (number)
Definition	The DLI will incentivize and verify the progress in the number of poor and vulnerable persons covered by health insurance under the NHIA gateway in the BHCPP.
Description	The BHCPF's coverage of the poor and vulnerable has perennially remained under 2 million people. The BHCPP plans to scale the number of eligible citizens (poor and vulnerable) enrolled in the BHCPF's NHIA gateway by the SSHIAs. The SSHIAs should have a data system that is fully interoperable with the NHIA portal to facilitate engagement with the NHIA.
Data source/Agency	NHIA Portal
Verification Entity	IVA
Procedure	
Baseline	
Y1	•IVA will review the electronically generated achievement report provided by the NHIA •IVA will cross-check figures against the SSHIA portal/data available at the state level • IVA will apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys. IVA may also opt to cross-check records with unique identification numbers or national identity numbers. •Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.4 DLI 4: Enhanced community delivery of health services

DLI	4 Women and children who receive tracer essential health services in the community increased (number)
Definition	The DLI will incentivize and verify tracer priority health services delivered by health workers in the community.
Description	Priority health services provided at home and within communities are important entry points for delivering essential health services in settings where access is poor. The DLI will incentivize the number of household visits made by CHWs to deliver critical services, including (i) Provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring, and screening for acutely malnourished children (ii) identification/follow-up of pregnant women and referral to receive multiple micronutrient supplementation (iii) treatment of any common childhood illnesses (Integrated Community Management – for diarrhea, pneumonia (identified by community health workers as fast breathing) and; fever in line with the IMCI guidelines

Data source/Agency	CHMIS or independent data feed to DHIS2
Verification Entity	IVA
Procedure	
Baseline	
Y1	•Baseline will be established by the NPHCDA using administrative data on the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program •The IVA will review and compute annual records from the CHMIS or MIS for the CHW program provided by the NPHCDA for the indicators listed above •IVA will use FASTR and, where available, survey data to confirm the validity of CHMIS •Each percentage point discordance above 10% as detected by the IVA will be deducted from the total maximum eligible disbursement. •IVA will conduct small-scale surveys, household visits, and telephone verification based on primary records especially in states/LGAs/wards with anomalous data trends.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.5 DLI 5: Increased utilization of priority secondary care services.

DLI	5.1: Secondary Facility Quality of Care for CEmONCs (prior result)
Definition	The DLI will incentivize and verify the design and approval of a CEmONC empanelment and reimbursement strategy for the BHCPP. (See annex 14) The attainment of this DLI is supported by the investment financing support for MAMII.
Description	Description: As part of the BHCPP strategy to reduce maternal and U5 mortality, contracting service providers and payment for basic and comprehensive care for mothers and children are necessary. In this regard, the NHIA has developed operational documents (annex 14) for the contracting and payment of CEmONC service providers that detail the following i.the package list of CEmONC services eligible for reimbursement ii.the tariff schedule corresponding to each eligible package iii.standard operating procedures for claim submission, review, and payment iv.identification of key entities and development of MOUs involved (NHIA, TPAs, etc.) v.the key performance indicators for claims management, and vi.the definition of empanelment criteria for CEmONC facilities by the NHIA (including climate resilience)
Data source/Agency	NHIA
Verification Entity	IVA
Procedure	
Baseline	NHIA will share the relevant document(s) to NPCU/SCO and IVA for review. Disbursement will depend on validation against confirmation that the document includes the required elements.
Y1	
Y2	
Y3	

Y4	
DLI	**5.2 Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (number)**
Definition	The DLI will incentivize and verify the number of women and neonates using CEmONC services from NHIA-empanelled public or private health facilities. The attainment of this DLI is supported by the investment financing support for MAMII.
Description	The NHIA will develop a framework for contracting and paying for CEmONC services under the BHCPP (DLI 5.1; annex 14). This framework will include a benefit package of eligible CEmONC services including obstetric care, neonatal care packages, and VVF surgeries. The DLI will verify "paid claims" by the NHIA and not submitted claims. To ensure a relatively equitable share of service coverage, no individual reporting state can account for more than 1.25 times its share of the annual births forecast using the most recent NDHS survey and the 2006 population census data. In addition, at least 50% of the target met yearly should be for CEmONC child delivery.
Data source/Agency	NHIA Portal
Verification Entity	IVA
Procedure	
Baseline	
Y1	NHIA will share electronic claims data generated from the NHIA portal not less than 30 days before the review period.
	IVA will confirm that facility is on the empanelled list, service provided is on the eligible list, and that date of payment occurred during the relevant period
	Where there are discrepancies, the IVA may request unique identification numbers/NIN of beneficiaries to further review available claims data
	Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.6   DLI 6: Increased PHC utilization of priority services.

DLI	**6.1: Deliveries with skilled birth attendant present increased (proportion)**
Definition	The DLI will incentivize and verify the increase in the number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA). The attainment of this DLI is supported by the investment financing support for MAMII.
Description	Skilled birth delivery remains persistently low. The BHCPP will promote demand- and supply-side strategies to ensure there is an incentive for pregnant women to give birth with a skilled provider present.
Data source/Agency	Survey data
Verification Entity	IVA
Procedure	
Baseline	Baseline will be established using the 2023/2024 NDHS by the NPHCDA and IVA
Y1	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
Y2	As in year 1

Y3	As in year 2
Y4	As in year 3
DLI	**6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)**
Definition	The DLI will incentivize and verify the number of women receiving MMS during antenatal visits
Description	Maternal nutrition service is defined as the distribution of at least a 180- day supply (one bottle) of multiple micronutrient supplements (MMS) to a pregnant woman aged 15-49 years at least once during any ANC service or contact with a health worker at community level.
Data source/Agency	Survey data
Verification Entity	IVA
Procedure	
Baseline	baseline will be established using the administrative data from DHIS2 by the NPHCDA and IVA
Y1	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3
DLI	**6.3: Increase in Penta 3 coverage (number)**
Definition	The DLI will incentivize and verify the percentage of children immunized with Penta 3 vaccine
Description	This is the proportion of children aged 12-23 months who received DPT- HepB-Hib vaccination (3 doses)
Data source/Agency	Survey Data
Verification Entity	IVA
Procedure	
Baseline	The baseline will be established using the 2023 NDHS by the NPHCDA and IVA
Y1	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to NSC. Surveys will be conducted annually.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.7 DLI 7: Increased utilization of EMS

DLI	**7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number).**
Definition	The DLI will incentivize and verify the transport of pregnant women and neonates to level 2 (PHC BEmONC) facilities or empanelled CEmONC facilities using the digitized EMS dispatch system

Description	The DLI will support the scale-up of a digital dispatch platform on the national emergency transport gateway of the BHCPF, encompassing both the use of community transport and the ambulance transport system targeting pregnant women and neonates. The DLI will improve the effectiveness and efficiency of the EMT gateways of the BHCPF and track performance indices preventing first- and second-order delays in accessing essential health services at BEmONC/ CEmONC centers.
Data source/Agency	NEMSAS Electronic dispatch database
Verification Entity	IVA
Procedure	
Baseline	
Y1	NEMSAS will generate an electronic report from its digital platform database showing the total number of transfers from the rural ambulance service program.
	IVA will cross-check figures from NEMSAS against SEMSAS portal/data available at the state level
	IVA will also apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys
	IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals
	Each percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.8   DLI 8: Improved allocation and disbursement of BHCPF funds

DLI	8.1: Governance for improved resource allocation and performance (prior result)
Definition	This DLI will incentivize and verify the revision and approval of the BHCPF 2.0 guidelines reflecting equity and climate resilience
Description	The BHCPP aims to sharpen the incentive for closing the gap between the best-performing and under-performing states by prioritizing resources for the least- performing and the vulnerable states. This prior result will reimburse the Government upon revision and approval of BHCPF guidelines by the BHCPF MOC Secretariat. The revised guidelines will identify the allocation formula by which BHCPF funds are disbursed to states. The formula will give due consideration to state variation in RMNCAH-N burden, poverty headcount, climate vulnerability, and other relevant factors as determined by BHCPF MOC Secretariat Data
Data source/Agency	BHCPF MOC Secretariat
Verification Entity	IVA
Procedure	
Baseline	BHCPF MOC Secretariat will share the relevant document(s) to the NPCU/SCO and IVA for review. Disbursement will depend on validation against confirmation that the document includes all required elements.
Y1	

Y2	
Y3	
Y4	
DLI	8.2: States receiving funds in compliance with the allocation formula in revised guidelines (number)
Definition	The DLI will incentivize and disburse against the adherence to the allocation formula contained in the revised BHCPF guidelines, reflecting RMNCAH+N burden, poverty headcount and climate vulnerability
Description	This DLI will disburse based on a review of BHCPF MOC Secretariat documents that will determine/confirm the adherence to the allocation formula contained in the revised BHCPF guidelines prevailing at the time of verification.
Data source/Agency	BHCPF MOC Secretariat
Verification Entity	IVA
Procedure	
Baseline	
Y1	IVA to review minutes of quarterly BHCPF MOC meetings to confirm adherence to the revised prevailing guidelines concerning state-wise allocations

IVA to confirm payments are made in a timely fashion |
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.2.9 DLI 9: Enhanced pandemic preparedness and response (PPR) through deployment of EPR Plans

DLI	9: System and standards for state EPR programs are established and implemented (number)
Definition	This DLI will disburse when states develop and implement a multi-year EPR plan encompassing disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies.
Description	Subnational action and prioritization of emergency preparedness and response systems are poor, predisposing the country to recurring seasonal outbreaks that severely impact the health system. The DLI will incentivize the strengthening of subnational EPR by encouraging states to develop peacetime plans to improve emergency response and health security.

The NCDC will provide TA to states in developing a multi-year EPR plan that meets specified standards as determined by the NCDC following risk profiling and multi-hazard assessment of states, including disease outbreaks, climate shocks, natural disasters, and other emergencies. Emergency preparedness and response is to climate shocks, which are estimated to comprise at least 50% of health emergencies in Nigeria, is expected to be a significant proportion of the plans. Following development of these plans, the NCDC will also provide technical support and guidance to states for the implementation of the state- specific EPR plans. The NCDC will also prepare a guide for milestone achievement on the implementation of the EPR plans. |
Data source/Agency	NCDC Subnational Assessments
Verification Entity	IVA
Procedure	

Baseline	
Y1	NCDC to submit a validated EPR plan template to the NPCU/SCO and IVA for review.
	IVA to review template plan for completeness and full implementation within three years of program implementation
Y2	NCDC to prepare and submit an annual report to the NPCU/SCO on the state of states on the EPR program
	IVA to verify from NCDC report the states that have prepared and validated EPR plan that meets the predetermined standards
	States to compile evidence of completion of planned activities. NCDC will monitor states on implementation and provide evidence to the IVA .
	States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities
	IVA will review compiled evidence and ensure it meets standards
	IVA will visit all states that have submitted plans for disbursement to confirm the NCDC report
Y3	As in year 2
Y4	As in year 3

4.2.10 DLI 10: Improved Climate Resilience

DLI	10: Climate and health adaptation plan developed, costed, validated, and implemented.
Definition	The DLI will incentivize and verify the development of the National climate and Health Adaptation plan for states, which will include costs and be followed by implementation.
Description	The Federal Ministry of Health and Social Welfare has developed a National Climate and Health Vulnerability & Adaptation Assessment for the health sector in Nigeria and a national adaptation plan outlining time-bound actions throughout the health system aimed at addressing climate health vulnerabilities and threats identified in the National Climate and Health Vulnerability & Adaptation Assessment. The national plan should include a template and guidance for state implementation plans. States will need to adopt the plan, develop state-level implementation plans, cost the plans per the local context, and validate the costed plan with the FMOH&SW. Implementation of the costed plans must be prioritized and scaled. The DLI will reward states for developing and implementing climate and health adaptation plans to build climate resilience in the sector.
Data source/Agency	Climate Office, FMOH&SW Assessment Reports
Verification Entity	IVA
Procedure	
Baseline	
Y1	FMOH&SW Climate Office will submit a validated climate and health adaptation plan (CHAIP) to the NPCU/SCO and IVA for review including a template and guidelines for the development of state climate and health implementation plans.
	The IVA will review the plan for its completeness

Y2	IVA will verify from the FMOH&SW Climate Office report the states that have prepared and validated CHAIP that meets the predetermined standards
	IVA will recommend for disbursement when states prepare and validate their climate and health adaptation plan with the FMOH&SW Climate Office.
	States will compile evidence of completion of CHAIP activities. FMOH&SW Climate Office will monitor states' implementation CHAIPs and provide compiled evidence to the IVA.
	States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities
	IVA will review compiled evidence and ensure it meets standards
	IVA will visit all states that have submitted plans for disbursement to confirm the FMOH&SW Climate Office report
Y3	As in year 2
Y4	As in year 3

4.2.11 DLI 11: Stronger digital foundation

DLI	11.1: National enterprise architecture developed, costed, and adopted
Definition	The DLI will incentivize and verify the development of an integrated, interoperable health data ecosystem to support evidence-based improvements in value (efficiency, quality, access, and health outcomes) for patients and providers. The program shall support the FMOH&SW and its agencies in laying the foundations for an interoperable platform to systematically exchange data to enhance system functions.
Description	Description: The development, costing and adoption of a digital architecture by the states leverages the digital transformation for the health system as part of the BHCPP, SWAp and PVAC. The architecture will support a bundle of digital services cutting across Electronic Health Records, Service Delivery, A community health worker platform, Monitoring and Evaluation, Quality of Care, Health Insurance Management, Public Health Event Surveillance and Reporting, EMT and Ambulance Dispatch System, and others as prioritized by the NPCU/SCO and PVAC.
	The digital-in-health enterprise architecture platform will facilitate the transition from a paper-based system to a digital one and promote digital interoperability among health information systems to reduce data hyper-fragmentation and duplication. Additionally, the architecture will establish guidelines for national standards, regulations, and business processes regarding integration for states upon costing and alignment by stakeholders to include FMOH&SW, Development Partners, Private sector and SMOH.
Data source/Agency	NPCU/SCO
Verification Entity	IVA
Procedure	
Baseline	
Y1	The NPCU/SCO will submit a validated digital-in-health enterprise architecture template to the IVA for review
	The IVA may not recommend the architecture for disbursement upon review and assessment of incompleteness of the architecture.
	Disbursement will depend on validation against confirmation that the Architecture includes the required elements

Y2	
Y3	
Y4	
DLI	11.2: States adopting national enterprise architecture and integrating core health functions
Definition	The DLI will monitor and encourage states to adopt the national enterprise architecture and integrate digital health functions. By merging private, public, and program-specific health information systems, the DLI will support the adoption and effective functioning of the health data ecosystem at the state level.
Description	
Data source/Agency	Committee on Digital-in-Health Transformation in Nigeria Assessment Reports
Verification Entity	IVA
Procedure	
Baseline	
Y1	The committee on digital-in-health transformation in Nigeria will prepare and submit an annual report to the NPCU/SCO on the state of states on the digital-in-health agenda for Nigeria The IVA will verify which states have been prepared for the digital-in-health agenda using the Committee on Digital-in-Health Transformation in Nigeria Report The IVA will recommend for disbursement when states integrate a core health function defined in DLI 11.1 Committee on Digital-in-Health Transformation in Nigeria will monitor states on their integration of core digital health functions and will provide to the IVA a list of the states that have fully integrated core digital health functions defined in the system architecture IVA will visit states to confirm the report
Y2	As in year 1
Y3	As in year 2
Y4	As in year 3

4.3   Detailed Verification Protocols by DLI

The appointed IVA will verify the attainment of the DLRs in Table 4.1 on a rolling basis. This will allow achieved results from implementing entities to be processed on a needs basis and push states and national implementing entities towards delivering on targets all year round.

The descriptions herewith provide a full guide for implementing entities and the IVA on verifying results from the HOPE-PHC program.

4.3.1   DLI 1: Improved service readiness

DLI 1.1: Improved PHC facility readiness, quality, and climate resilience (percentage)

The DLI will incentivize and verify the percentage of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness

assessment that includes measures of structural and process quality, solar power, and climate resilience.

Scalability: Yes

Description: The NPHCDA has tiered BHCPF facilities based on the quality and complement of services available at the health facilities. According to the NPHCDA, Tier 2 PHC facilities will offer 24-hour PHC services plus basic emergency obstetric and neonatal care (BEmONC). For the HOPE-PHC Program, 2000 facilities will be targeted for revitalization under DLI 1.1. (Full list of selected 2000 PHC/BEmONC facilities provided in Annex 12). The NPHCDA will work with the states to select the facilities using the following criteria:

Approach for Selection of Facilities for Project HOPE-PHC
Target 2000 facilities to be selected for routine performance measurement which will inform state PforR disbursements

Decision	Considerations
Distribution of PHCs across states	• Allocate 2 facilities per LGA in each state (i.e. 2*774 = 1,548 PHCs) • Balance of a (452 PHCs) distributed across states - One additional facility for 58% of LGAs in each state
Health facility selection (for DLIs at facility level)	• All selected PHCs to be BHCPF Facilities benefitting from DFF • Selection of 1,548 facilities (2 per LGA) is based on high PHC service utilization (DHIS 2)-1 high volume PHC in the urban area and 1 high volume PHC in the rural area. • Selection of the remaining 452 PHCs to be determined based on population and burden of disease (MAMII LGAs zero dose LGAs etc.)

Figure 4.1: Approach for selection of facilities for HOPE-PHC

Mode of Verification of Functional Level 2 PHCs (BEmONC)

Infrastructure Requirements	• Access to reliable power and/or backup solar power
	• Presence of functional toilets (water closet and/or squat toilet with water supply)
	• Availability of clean water supply
	• Availability of at least 2 of the following:
	  • Light coloured walls that reduce heat absorption
	  • Sizable doors and windows that allow for cross ventilation and cooling
	  • Solarized refrigerator/cold chain equipment
	  • Solarized borehole
	  • Drainage and flood management (including barriers, water management, raised floors, raised access routes)
	  • Planted trees, flowers and/or shrubs

HRH and Staff Accommodation	• Either a minimum of 4 SBAs[1] if on-site accommodation is available OR • If no on-site accommodation, then minimum of 6 SBAs

1 - SBAs – Skilled birth attendants include Midwives, Nurses, CHEWs or JCHEWs with Modified Life Saving Skills Training

Figure 4.2: Mode of Verification of Functional Level 2 PHCs (BEmONC)

DLI 1.1 will incentivize only the 2000 Tier 2 BHCPF facilities that meet a score of 75% on the health facility readiness assessment that will be developed by NPHCDA before program effectiveness and conducted annually. The assessment tool, which will be designed and utilized by the IVA, will include components assessing structural quality (water source, toilets, blueprint for bed numbers and layout, commodities, medicines, equipment, health information system and human resources). Accredited facilities must be assessed biannually for re-accreditation. To achieve DLI 1.1, PHC facilities may require refurbishments, and the following are expected expenditure lines:

Table 4.2 Guidelines for climate-resilient primary healthcare facilities

Intervention	Description
1. Infrastructure adaptation-related interventions	
Strengthening Buildings	-Rehabilitation/strengthening of the facilities' wall, floor, ceiling, and roof. (Including painting)
	-Rehabilitation of the PHC's windows and doors to improve ventilation and cooling.
	-Drainage and flood management (including barriers, water management, raised floors, raised access routes)
	-Solar reflective painting
Water management	-Solarized 'deep' borehole ranging from 75-120m depth with solar pump and panels.
	-Installation of 5,000-litre water tank on steel towers up to 4m high, PPR Pipes and taps for water storage and distribution.
Energy security	-Provision of 5KVA / 48V hybrid inverter system including Battery and solar panels
	-Provision of solarized cold chain equipment
2. Service Delivery of adaptation-related interventions	
Heat Stress Management	-Planting of horticulture/trees
3. Community Engagement-related interventions	
Community Participation	-Engaging communities in planning and implementing climate resilience measures.

A credible assessment tool will include content on each of the aforementioned areas.

Data Verification Source: NPHCDA Health Facility Assessment Reports (Potential Linkage to the DHIS2)

Data Verification Entity: IVA Result Verification Protocol

- The IVA will visit 100% of all NPHCDA-accredited Tier 2/BEmONC facilities in the first year and inspect the premises for compliance against the NPHCDA checklist.

- Facilities must meet at least a 75% score of the checklist to be eligible and recommended for DLR payout

- Payment/disbursement will not be recommended unless at least 75% of the climate resilient measures for key climate shocks, identified in the UNICEF Climate

Resilient Infrastructure for Basic Services (CRIBS) checklist, are implemented

- The IVA will check for discordance in the NPHCDA assessment reports and their findings during field inspections, and discordance of assessment more than 5% must be flagged and reported in the IVA report

- BHCPF tier 2 facilities that fall below the 75% mark on verification by the IVA will have 90 days to take remedial action and request a re-verification

- Discordant Assessment Reports between the NPHCDA and the IVA in greater than 10 per cent of the verified facilities will require the IVA assessment for all PHC facilities on the NPHCDA report to have achieved the DLR

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

- In subsequent years, the IVA will visit 5% or more of previously accredited BEmONC facilities in each state and 100% of newly accredited BEmONC facilities to inspect for compliance and non-discordance between field assessment by the IVA and the NPHCDA report

DLI 1.2: Increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (number)

The DLI will incentivize and verify the number of CEmONC facilities that (a) are empaneled according to the NHIA empanelment guidelines, (b) maintain the empanelment requirements, and (c) have implemented climate resilience measures. The DLI will also ensure the certification criteria, energy efficiency benchmarks, and climate resilience measures are part of the empanelment requirements for the NHIA. This will be done through pre-assessments (e.g. the climate resilient infrastructure for basic services (CRIBS) tool among others) which may be modified during program implementation.

Scalability: Yes

Description: The SMOH, HMB, or relevant implementing MDAs in the states will refurbish, upscale and optimize 774 CEmONC facilities to achieve at least one functional facility per LGA. The NPCU/SCO will support the optimization efforts of the states based on a framework to be agreed upon by the NPCU/SCO and states.

The full list of preselected facilities to be upgraded is attached in annex 9 of this POM. Following this optimization of the secondary health facilities, the NHIA will inspect and empanel facilities that meet their accreditation guidelines, which will have been developed under the related Prior Result (DLI 5.1). The refurbishment will include key structural elements of quality (water source, toilets, mother-newborn intensive care units, surgical theatres, bed numbers, visibly posted schedule of free services, equipment, commodities and medicines, human resources, health information system) and implementation of climate resilience measures. Climate resilience will be measured based on NHIA

accreditation criteria. The NHIA empanelment will be renewed on an annual basis.

Data Verification Source: NHIA Facility Empanelment Record (Potential Linkage to the DHIS2)

Data Verification Entity: IVA Result Verification Protocol

- The NHIA will provide, on an annual basis, the certified and empanelled CEmONC care facility list based on their assessment, not later than 30 days before the scheduled IVA assessment

- The IVA will compare the list from the NHIA to the preselected facility list in annex 9 of this POM to determine prioritized CEmONC facilities on the NHIA empanelment list.

- The IVA will assess all CEmONC facilities reported by the NHIA in its CEmONC care facility list in the first year and use the checklist of criteria developed as a prior result (DLI 5.1) to ensure that the requirements for structural readiness and climate resilience have been met (75% of measures assessed to be needed), and the certification criteria as defined above has been achieved.

- A selection of empanelment criteria will be checked. Facilities must meet 100% of the assessed criteria to be verified as newly empanelled and to be verified as continuously compliant if previously empanelled.

- The IVA will check for a discordance in the NHIA CEmONC certified facility list and their findings using the NHIA checklist during field inspections. Discordance of assessment more than 5% must be flagged and reported in the IVA report

- For facilities that fall below the 100% mark on verification, 90 days will be given to take remedial action and request re-verification

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

- In subsequent years, the IVA will go to all additional facilities reported by NHIA to have been empanelled and check for compliance against the checklist; AND visit or verify by phone a random sample of 10% or more of all previously empanelled facilities in each state to ensure that they are still in compliance with previously empanelled facilities.

- Discordant Assessment between the NHIA and the IVA greater than 10 percent of the verified facilities in subsequent years will require the IVA assessment for all previously certified CEmONC facilities on the NHIA list

Climate Resilience Framework for BEmONC and CEmONC Facilities

General Infrastructure	• Flooding
	  • Are there drainage measures in place that can quickly and effectively move water away from the site?
	    • Building
	    • Access road to facility is secured (i.e. leveled up)
	• Extreme heat
	  • Are there measures in place to manage facility temperature, including (following options in dropdown for multiple selection) (extreme heat specific):
	    • Roofs painted with white solar reflective paint
	    • False ceilings
	    • Trees providing shading and wind protection for the building
	    • Good air circulation/ventilation
	    • Low energy/solarized cooling system covering patient areas? (e.g. solarized/low energy fans)
	  • Note for further consideration - do staff have training on response to high heat stress?
	• Windstorm
	  • If roof been damaged by winds/storms
	    • Has it been reinforced? (based on the engineering designed solution)
	  • If windows been damaged by winds/storms
	    • Have they been repaired and/or reinforced (based on the engineering designed solution)
	  • If significant exposure to windstorms exists:
	    • Is there a perimeter wall, which can help to protect the facility from high wind and provide security? (note: to be integrated into assessment section on perimeter wall)

Water	• Access to at least one source needs to exist
	  • Has facility been upgraded to have resilient and reliable access to water main?
	    • If yes, no need to evaluate further down.
	  • If the borehole had reduced water production at any point in the last 5 years or since construction:
	    • Has an engineer measured the depth of the bore hole, and/or has the borehole depth been increased by at least 20 meters below the current water table during dry season
	  • Does the facility have an elevated water-tank? Prompt: the water tank should be at least 3m high if flooding is prevalent hazard, is it anchored against high wind, if this is prevalent hazard)
	  • Is the Borehole protected from contamination during flooding?

(flood specific)
- Do you have a solar pump that draws water into the facility? (note: the solar pump is an important part of a sustainable water access solution for a facility dependent on a borehole for water access)
  - If yes; is the solar pump functional? (yes/no)
  - Is it securely installed (protected against relevant hazards and theft)

Sanitation
- If the toilets have ever been inoperable or inaccessible due to flooding over the past
  - have they been elevated from the ground?
  - Does the facility have a schedule for emptying latrines in advance of the flood season to avoid overflows?

Waste
- Is the waste storage area safe and in accordance with national guidelines?
- In case of frequent flood exposure:
  - Does the facility have waste pits protected during moderate flood events?

Energy
- Does your facility have adequate power to meet its energy needs (Prompt: check the inverter to clarify if at least a 5KVA/48V functional hybrid inverter system including battery and solar panels)
- Do you have functional solarized cold chain equipment that can sustain required temperature during extended power break (more than 48hours)?

In addition to the inverter, relaible power supply means,
- connection to the national grid: is it functional during the identified hazards
- Main/Back-up Solar: Are they properly anchored to withstand wind and protect againt theft?
- Back-up Generator: does it have a secured fuel storage and is the area elevated incase of flood?

Figure 4.3: Climate Resilience Framework for BEmONC and CEmONC Facilities

4.3.2:   Increased availability of essential commodities

DLI 2.1: Federal expenditure on quality family planning commodities increased (percentage)

The DLI will incentivize and verify annual increases in domestic spending on contraceptive commodities to reach 30% of the forecasted total need by the end of the program.

Scalability: Yes

Description: The Government of Nigeria will match donor and IDA contributions of US$25 million over the life of the Program with US$12.5 million of spending on contraceptive commodities from a baseline of US $0. This would result in the GoN spending 15% of total contraceptive requirements from domestic non-IDA resources by the program's final year.

Data Verification Source: Budget Execution Reports from the OAGF (Federal, States) Data Verification Entity: IVA

Result Verification Protocol

- The IVA will review expenditure data from state and national budget execution reports annually to verify the achievement of domestic spending on contraceptive commodities.

- If expenditures fall below the targeted amount for any year, the DLI disbursement will be prorated against the spending level provided a minimum increase of 20% of the target increase has been met. For example, if an increase of $1 million is the target, a minimum of US$200,000 in domestic spending must be in evidence to scale disbursement proportional to actual achievement.

- Irrespective of target achievements each year, the target for the subsequent year remains fixed.

- Achievement of the DLR will be reviewed by the World Bank and GFF Task Teams. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

DLI 2.2: Front-line availability of tracer products improved (percentage)

The DLI will incentivize and verify the number of Tier 2 (PHC + BEmONC) NHSRII-service-ready facilities (described in DLI 1.1 above) with a minimum of five of six commodities available.

Scalability: Yes

Description: The NPHCDA has recommended the availability of a basket of tracer commodities and medicines to improve quality and service readiness at the PHC level. Under the program, the earlier-identified Tier 2 BHCPF facilities (in DLI 1.1, above) will be assessed for the availability of the benchmarked minimum stock of tracer commodities that the SPHCDAs will report to the NPHCDA. There are multiple programs at the federal level, including the NPHCDA, providing essential medicines to primary healthcare facilities

and the NPHCDA. The six tracer commodities are (i) oxytocin, (ii) Multiple Micronutrient Supplements (MMS), (iii) Artemisinin-based Combination Therapy (ACTs), (iv) Human Immunodeficiency Virus (HIV) rapid test kits, (v) pentavalent vaccine, and (vi) a minimum of three modern contraceptive methods including at least one long- acting reversible contraceptive (LARC).

The NPHCDA will set the annual minimum stock position by commodity or threshold and the essential medicines score annually.

Data Verification Source: Annual Health Facility Readiness Assessment, SPHCDA Essential Commodity Reports, and DHIS2 Data Verification Entity: IVA

Result Verification Protocol

The verification of this DLI will utilize multiple data sources to validate the annual health facility assessments that will be conducted by the NPHCDA. Procurement records, CMS stock records and positions, SPHCDAs essential commodity reports, and DHIS2 will also be used to verify the reported achievement of this indicator.

- The IVA will review procurement and delivery data by state for the tracer commodities

- The IVA will confirm the sharing arrangement between all federal-level programs and the NPHCDA, providing essential tracer commodities to participating health facilities

- The IVA will note stock positions at federal and state central medical stores, and report stocks at the facility level.

- Facility-level stock positions will be triangulated with the respective services delivered reported in the annual facility readiness survey and DHIS2 to ensure coherence

- The IVA may opt to do spot checks of facilities that do not report rational stock positions; and will visit 5% of identified Tier 2 PHC facilities that have reported adequate stock per state.

- Facility visits that result in discordant verification from reported data will be labelled as High Risk. All High-Risk facilities will have repeat visits within six months of the first visit; this will not be part of the 5% pool.

- Facilities that meet the requirement for the minimum threshold will qualify as successfully verified and labelled as Low Risk. Low-risk facilities will be randomly selected in the 5% pool the following year.

- Discordant Assessment Reports between the NPHCDA and the IVA, greater than 10 per cent of the verified facilities, will require the IVA assessment for all PHC facilities on the NPHCDA report to have achieved the DLR

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.3   DLI 3: Increased enrolment of poor and vulnerable populations

Financial protection for poor and vulnerable populations increased (number)

The DLI will incentivize and verify the progress in the number of poor and vulnerable persons covered by health insurance under the NHIA gateway in the BHCPP.

Scalability: Yes

Description: The BHCPF's coverage of the poor and vulnerable has perennially remained under 2 million people. The BHCPP plans to scale the number of eligible citizens (poor and vulnerable) enrolled in the BHCPF's NHIA gateway by the SSHIAs. The SSHIAs should have a data system that is fully interoperable with the NHIA portal to facilitate engagement with the NHIA. As a part of this DLI, NIN registration will be made possible at SSHIAs, NHIA, and CEMONC facilities.

Data Verification Source: NHIA Portal Data Verification Entity: IVA

Result Verification Protocol

- The IVA will review the achievement report provided by the NHIA, which shows a breakdown of the total number of enrolees per state in each period.

- The IVA will only accept electronically generated reports from the NHIA portal showing real-time data on the summaries of health insurance enrolment in Nigeria

- The IVA will cross-check figures against the SSHIA portal/data available at the state level in consultation with the NPCU/SCO and state SWAp Desk Officer.

- The IVA will also apply a stratified random sampling method (state, urban/rural, age distribution, sex, others as deemed necessary at the time of review by the IVA with approval from the NPCU/SCO) to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys to ensure the figure reported in the NHIA portal for the selected SSHIAs and selected period corresponds to what is seen from the NHIA records

- The IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals

- Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 7% discordance will result in (7-5) = 2% deduction of the total eligible disbursement)

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.4 DLI 4: Enhanced community delivery of health services

Women and children who receive tracer essential health services in the community increased (number)

The DLI will incentivize and verifytracer priority health services delivered by health workers in the community.

Scalability: Yes

Description: Priority health services provided at home and within communities are important entry points for delivering essential health services in settings where access is poor. The DLI will incentivize the number of household visits made by CHWs to deliver critical services, including

- Provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring, and screening for acutely malnourished children

- identification/follow-up of pregnant women and referral to receive multiple micronutrient supplementation

- treatment of any common childhood illnesses (Integrated Community Management – for diarrhea, pneumonia (identified by community health workers as fast breathing) and; fever in line with the IMCI guidelines

The DLI will be measured on the community health management information system linked to the DHIS2 and the claims management platform, and the following will be tracked.

i.Number of children with Growth Monitoring Cards

ii.Children (6-59 months) who received micronutrient powders,

iii.Number of pregnant women attending ANC revisited by a community health worker and received MMS

iv.Pregnant women identified and referred for ANC (new)

Data Verification Source: CHMIS or independent data feed to DHIS2 Data Verification Entity: IVA

Result Verification Protocol

- The baseline will be established by the NPHCDA using administrative data on the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program

- The IVA will review and compute annual records from the CHMIS or MIS for the CHW program provided by the NPHCDA for the indicators listed above

- The IVA will use FASTR and, where available, survey data to confirm the validity of CHMIS

- Each percentage point discordance above 10% as detected by the IVA will be

deducted from the total maximum eligible disbursement. (e.g., 15% discordance will result in (15-10) =5% deduction of the total eligible disbursement)

- The IVA will conduct small-scale surveys, household visits, and telephone verification based on primary records especially in states/LGAs/wards with anomalous data trends. Anomalies could include beneficiaries outside the age range, out-of-ward beneficiaries, etc.

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.5 DLI 5: Increased utilization of priority secondary care services.

DLI 5.1: Secondary Facility Quality of Care for CEmONCs (prior result)

The DLI will incentivize and verify the design and approval of a CEmONC empanelment and reimbursement strategy for the BHCPP. (See annex 14) The attainment of this DLI is supported by the investment financing support for MAMII.

Scalability: No

Description: As part of the BHCPP strategy to reduce maternal and U5 mortality, contracting service providers and payment for basic and comprehensive care for mothers and children are necessary. In this regard, the NHIA has developed operational documents (annex 14) for the contracting and payment of CEmONC service providers that detail the following

- the package list of CEmONC services eligible for reimbursement

- the tariff schedule corresponding to each eligible package

- standard operating procedures for claim submission, review, and payment

- identification of key entities and development of MOUs involved (NHIA, TPAs, etc.)

- the key performance indicators for claims management, and

- the definition of empanelment criteria for CEmONC facilities by the NHIA (including climate resilience)

Data Verification Source: NHIA Data Verification Entity: IVA Result Verification Protocol

- The NHIA will share the relevant document(s) to the NPCU/SCO and IVA for review

- Disbursement will depend on validation against confirmation that the document includes the above elements

- Payout for the achievement of the prior result is subject to review and agreement of the World Bank Task team

DLI 5.2: Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (number)

The DLI will incentivize and verify the number of women and neonates using CEmONC services from NHIA-empanelled public or private health facilities. The attainment of this DLI is supported by the investment financing support for MAMII.

Scalability: Yes

Description: The NHIA will develop a framework for contracting and paying for CEmONC services under the BHCPP (DLI 5.1; annex 14). This framework will include a benefit package of eligible CEmONC services including

- Obstetric care

- neonatal care packages, and

- VVF surgeries

The DLI will verify "paid claims" by the NHIA and not submitted claims. To ensure a relatively equitable share of service coverage, no individual reporting state can account for more than 1.25 times its share of the annual births forecast using the most recent NDHS survey and the 2006 population census data (that is, any reimbursement above 1.25 times the state annual births forecast will not be eligible to count towards DLI disbursement). In addition, at least 50% of the target met yearly should be for CEmONC child delivery. As such, reimbursed claims for non-CEmONC child delivery services (e.g., VVF, etc.) exceeding 50% of the target will not be eligible for DLI payment".

Data Verification Source: NHIA Portal Data Verification Entity: IVA

Result Verification Protocol

- The NHIA will share electronic claims data generated from the NHIA portal not less than 30 days before the review period. The data must include

  - date of patient admission

  - Indication for CEmONC care/diagnosis

  - CEmONC/VVF service package provided

  - Name of the empaneled CEmONC facility where the service was provided

  - date of claim submission

  - date of claim payment

  - telephone contact of beneficiary

  - Age and sex of beneficiary

- The IVA will confirm that the facility is on the empanelled list, the service provided is on the eligible list, and that the date of payment occurred during the relevant period

- The IVA will also apply a stratified random sampling method (state urban/rural,

age distribution, sex, and others as deemed necessary at the time of review by the IVA with approval from the NPCU/SCO) to verify at least one percent of all claims listed in each report, via field visits and telephonic surveys to ensure the figure reported in the NHIA portal for the selected SSHIAs and selected period corresponds to what is seen from the NHIA records

- Where there are discrepancies, the IVA with approval from the NPCU/SCO may request the NHIA to provide unique identification numbers/NIN of beneficiaries to further review available claims data where telephonic surveys and field visits have not excluded all discrepancies

- Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 7% discordance will result in (7-5) = 2% deduction of the total eligible disbursement)

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.6 DLI 6: Increased PHC utilization of priority services.

DLI 6.1: Deliveries with skilled birth attendant present increased (proportion)

The DLI will incentivize and verify the increase in the number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA). The attainment of this DLI is supported by the investment financing support for MAMII.

Scalability: Yes

Description: Skilled birth delivery remains persistently low. The BHCPP will promote demand- and supply-side strategies to ensure there is an incentive for pregnant women to give birth with a skilled provider present.

Data Verification Source: Survey Data Verification Entity: IVA Result Verification Protocol

- The baseline will be established using the 2023/2024 NDHS by the NPHCDA and IVA

- Achievement of DLR will be validated through review of the results of household or small-scale surveys whose methodology is acceptable to the NSC

- The surveys will be conducted annually

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

DLI 6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)

The DLI will incentivize and verify the number of women receiving MMS during antenatal visits

Scalability: Yes

Description: Maternal nutrition service is defined as the distribution of at least a 180-day supply (one bottle) of multiple micronutrient supplements (MMS) to a pregnant woman aged 15-49 years at least once during any ANC service or contact with a health worker at community level.

Data Verification Source: Survey Data Verification Entity: IVA Result Verification Protocol

- The baseline will be established using the administrative data from DHIS2 by the NPHCDA and IVA

- Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC

- The surveys will be conducted annually

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

DLI 6.3: Increase in Penta 3 coverage (number)

The DLI will incentivize and verify the percentage of children immunized with Penta 3 vaccine

Scalability: Yes

Description: This is the proportion of children aged 12-23 months who received DPT-HepB-Hib vaccination (3 doses)

Data Verification Source: Survey Data Verification Entity: IVA Result Verification Protocol

- The baseline will be established using the 2023 NDHS by the NPHCDA and IVA

- Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC

- The surveys will be conducted annually

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.7 DLI 7: Increased utilization of EMS

Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number).

The DLI will incentivize and verify the transport of pregnant women and neonates to level 2 (PHC BEmONC) facilities or empanelled CEmONC facilities using the digitized EMS dispatch system. Use of digital platforms as recommended by the NDHA is encouraged.

Scalability: Yes

Description: The DLI will support the scale-up of a digital dispatch platform on the national emergency transport gateway of the BHCPF, encompassing both the use of community transport and the ambulance transport system targeting pregnant women and neonates. The DLI will improve the effectiveness and efficiency of the EMT gateways of the BHCPF and track performance indices preventing first- and second-order delays in accessing essential health services at BEmONC/CEmONC centers.

The report generated by NEMSAS will capture the following:

- Date of event

- Response time from the call for transfer

- Telephone number of the contact, beneficiary, or notifier

- Type and name of the selected facility

Name of the pregnant woman and neonate

Data Verification Source: NEMSAS Electronic dispatch database Data Verification Entity: IVA

Result Verification Protocol

- NEMSAS will generate an electronic report from its digital platform database showing the total number of transfers from the rural ambulance service program (see annex)

- The IVA will only accept electronically generated reports from the NEMSAS digital dispatch portal showing real-time data on the summaries of ambulance dispatch in Nigeria

- The IVA will review the result achieved from the NEMSAS digital platform database showing the number of pregnant women and children that were transported through facilitation by a digital process per state in the review period

- The IVA will cross-check figures from NEMSAS against the SEMSAS portal/data available at the state level in consultation with the NPCU/SCO and state IEs.

- The IVA will also apply a stratified random sampling method (state, urban/rural age, distribution, sex, others as deemed necessary at the time of review by the IVA with approval from the NPCU/SCO) to verify at least one per cent of all

enrolees listed in each report, via field visits and telephonic surveys to ensure the figure reported in the NEMSAS dispatch entries for the selected SEMSASs and selected period correspond

- The IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals

- The IVA will recommend disbursement upon satisfactory verification of the presented record from NEMSAS

- Each percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 7% discordance will result in (7-5) = 2% deduction of the total eligible disbursement)

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.8 DLI 8: Improved allocation and disbursement of BHCPF funds

DLI 8.1: Governance for improved resource allocation and performance (prior result)

This DLI will incentivize and verify the revision and approval of the BHCPF 2.0 guidelines reflecting equity and climate resilience

Scalability: No

Description: The BHCPP aims to sharpen the incentive for closing the gap between the best-performing and under-performing states by prioritizing resources for the least-performing and the vulnerable states. This prior result will reimburse the Government upon revision and approval of BHCPF guidelines by the BHCPF MOC Secretariat. The revised guidelines will identify the allocation formula by which BHCPF funds are disbursed to states. The formula will give due consideration to state variation in;

- RMNCAH-N burden

- poverty headcount

- climate vulnerability

- other relevant factors as determined by BHCPF MOC Secretariat Data Verification Source: BHCPF MOC Secretariat

Data Verification Entity: IVA Result Verification Protocol

- The BHCPF MOC Secretariat will share the relevant document(s) to the NPCU/ SCO and IVA for review

- Disbursement will depend on validation against confirmation that the document includes the above elements

- Payout for the achievement of the prior result is subject to review and agreement of the World Bank Task team

DLI 8.2: States receiving funds in compliance with the allocation formula in revised guidelines (number)

The DLI will incentivize and disburse against adherence to the allocation formula contained in the revised BHCPF guidelines, reflecting RMNCAH+N burden, poverty headcount and climate vulnerability

Scalability: No

Description: This DLI will disburse based on a review of BHCPF MOC Secretariat documents that will determine/confirm adherence to the allocation formula contained in the revised BHCPF guidelines prevailing at the time of verification.

Data Verification Source: BHCPF MOC Secretariat Data Verification Entity: IVA

Result Verification Protocol

- The IVA will review the minutes of quarterly BHCPF MOC meetings to confirm adherence to the revised prevailing guidelines concerning state-wise allocations

- The IVA will also confirm payments are made in a timely fashion and recommend for disbursement on achievement of the DLR

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.9   DLI 9: Enhanced Pandemic Preparedness and Response (PPR) through deployment of EPR Plans

System and standards for state EPR programs are established and implemented (number)

This DLI will disburse when states develop and implement a multi-year EPR plan encompassing disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies.

Scalability: Yes

Description: Subnational action and prioritization of emergency preparedness and response systems are poor, predisposing the country to recurring seasonal outbreaks that severely impact the health system. The DLI will incentivize the strengthening of subnational EPR by encouraging states to develop peacetime plans to improve emergency response and health security. The plans will address the following

- use of seasonal, multi-hazard risk calendars to support responsive risk response and risk profiling

- a significant focus on climate shocks which are estimated to comprise at least 50 percent of health emergencies

- responsibility chains for shock response coordination (EPR committees and S-PHEOCs)

- health security and EPR trainings and capacity development for subnational health workforce

- shock response simulations

- heath security and public health event reporting

- contact tracing, community surveillance, and epi-tracking systems

- commodity stockpiling and quantification to respond to shocks

- preparations for maintaining essential health service delivery during shocks

- developing and monitoring of early warning signs for health service delivery disruptions

- Laboratory diagnosis, sample management, and testing capacity development for pathogens of public health significance

- Climate-adaptive measures (e.g., early warning systems for heatwaves and floods)

The NCDC will provide TA to states in developing a multi-year EPR plan that meets specified standards as determined by the NCDC following risk profiling and multi-hazard assessment of states, including disease outbreaks, climate shocks, natural disasters, and other emergencies. Emergency preparedness and response is to climate shocks, which are estimated to comprise at least 50% of health emergencies in Nigeria, is expected to be a significant proportion of the plans. Following development of these plans, the NCDC will also provide technical support and guidance to states for the implementation of the state- specific EPR plans. The NCDC will also prepare a guide for milestone achievement on the implementation of the EPR plans.

Data Verification Source: NCDC Subnational Assessments Data Verification Entity: IVA

Result Verification Protocol

For year 1:

- The NCDC will submit a validated EPR plan template to the NPCU/SCO and IVA for review, including guidelines for the status of review for implementation

- The IVA will review the template plan for its completeness and full implementation within three years of program implementation

- The IVA may not recommend the plan for disbursement upon review and assessment of incompleteness of the template plan for states

- Development and approval of this plan is a prerequisite for further disbursement in years 2-4

For years 2-4:

- The NCDC will prepare and submit an annual report to the NPCU/SCO on the

state of states on the EPR program

- The IVA will verify from the NCDC report the states that they have prepared and validated EPR plan that meets the predetermined standards set by the NCDC for the development of subnational EPR plans

- Verification of completed EPR plans will include confirmation that a substantial percentage of activities in the plans are related to climate change and health emergency preparedness and response. Substantial is estimated to be between at least 25-50% of activities.

- The IVA will recommend disbursement when states prepare and validate their multi-year EPR plans with the NCDC. The completion and validation of these plans is a pre-requisite for subsequent disbursements of implementation.

- States will compile evidence (reports, photographs, and other documentation) of completion of activities in their EPR plans. The NCDC will monitor states on the implementation of validated multi-year EPR plans and provide the compiled evidence to the IVA .

- States are eligible for two disbursements on implementation of their validated multi-year EPR plan: one when they have completed implementation of 50% (implementation disbursement milestone 1) of the activities in their plans and one when they have completed implementation of 80% (implementation disbursement milestone 2) of the activities in their validated multi-year EPR plan.

- The IVA will review the compiled evidence and ensure it meets standards of completeness based on the developed plans.

- The IVA will visit all states that have submitted plans for disbursement during the verification cycle to confirm the NCDC report on the status of implementation of the multi-year state EPR plans. Confirmation will involve physical confirmation of completion, interviews, checking of original records, and other forms of in-person verification.

- The IVA will recommend for disbursement upon satisfactory confirmation that states meet the implementation milestones for two separate disbursement points: completion of 50% of activities in the validated multi-year EPR plan and then 80% of activities in the validated multi-year EPR plan. These are two subsequent disbursements. Confirmation that states meet the implementation milestones is defined as physical verification that the reported 50% of activities (implementation completion milestone 1) or 80% of activities (implementation completion milestone 2) were completed. If physical verification does not confirm that the reported percentage of activities was completed, based on the documentation submission by the states, the state will not receive the disbursement at that time. Any discordance of assessment must be flagged and reported in the IVA report. States that fall below the 100% mark on verification, 90 days will be given to take remedial action and request re-verification.

- Verification of completed EPR plans will include confirmation that a substantial percentage of activities implemented in the plans are related to climate change and health emergency preparedness and response. Substantial is estimated to be between at least 25-50% of activities and should be in proportion to the number of climate and health emergency preparedness and response activities in the validated plans.

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.10   DLI 10: Improved Climate Resilience

Climate and health adaptation plan developed, costed, validated, and implemented.

The DLI will incentivize and verify the development of the National climate and Health Adaptation plan for states, which will include costs and be followed by implementation.

Scalability: Yes

Description: The Federal Ministry of Health and Social Welfare has developed a National Climate and Health Vulnerability & Adaptation Assessment for the health sector in Nigeria and a national adaptation plan outlining time-bound actions throughout the health system aimed at addressing climate health vulnerabilities and threats identified in the National Climate and Health Vulnerability & Adaptation Assessment. The national plan should include a template and guidance for state implementation plans. States will need to adopt the plan, develop state-level implementation plans, cost the plans per the local context, and validate the costed plan with the FMOH&SW. Implementation of the costed plans must be prioritized and scaled. The DLI will reward states for developing and implementing climate and health adaptation plans to build climate resilience in the sector.

Data Verification Source: Climate Office, FMOH&SW Assessment Reports Data Verification Entity: IVA

Result Verification Protocol For year 1:

- The FMOH&SW Climate Office will submit a validated climate and health adaptation plan to the NPCU/SCO and IVA for review including a template and guidelines for the development of state climate and health implementation plans.

- The IVA will review the plan for its completeness and inclusion of a template and guidelines for the development of state climate and health implementation plans.

- The IVA may not recommend the national plan for disbursement upon review and assessment of not including guidelines and a template for climate and health implementation plans for states.

- Development and approval of this plan is a prerequisite for further disbursement in years 2-4

For years 2-4:

- The IVA will verify from the FMOH&SW Climate Office report the states that they have prepared and validated climate and health adaptation implementation plan that meets the predetermined standards set in the state climate and health implementation plan guidance and template in the HNAP. The IVA will review the completed state climate and health adaptation implementation plan against these standards.

- The IVA will recommend for disbursement when states prepare and validate their climate and health adaptation plan with the FMOH&SW Climate Office. Preparation and validation of the completed state climate and health implementation plan is a prerequisite for subsequent disbursements.

- States will compile evidence (reports, photographs, and other documentation) of completion of activities in their climate and health adaptation implementation plans. The FMOH&SW Climate Office will monitor states' implementation of validated climate and health adaptation plans and provide the compiled, monitored evidence to the IVA.

- The IVA will review the compiled evidence and ensure it meets standards of completeness based on the developed plans.

- States are eligible for two disbursements on implementation of their plans: one when they have completed implementation of 50% (implementation disbursement milestone 1) of the activities in their plans and one when they have completed implementation of 80% (implementation disbursement milestone 2) i of the activities in their validated multi-year climate and health adaptation plan.

- The IVA will visit all states that have submitted plans for disbursement during the verification cycle to confirm the FMOH&SW Climate Office report on the status of implementation of the multi-year state climate and health adaptation plans. Confirmation will involve physical confirmation of completion, interviews, checking of original records, and other forms of in-person verification. The IVA will recommend for disbursement upon confirmation that states meet the implementation milestones for two separate disbursement points: completion of 50% of activities in the validated state climate and health implementation plan and then 80% of activities in the validated state climate and health implementation plan. These are two subsequent disbursements. Confirmation that states meet the implementation milestones is defined as physical verification that the reported 50% of activities (implementation completion milestone 1) or reported 80% of activities (implementation completion milestone 2) were completed. If physical verification does not confirm that the reported percentage of activities was completed, based on the documentation submission by the states, the state will not receive the disbursement at that time. Any discordance of assessment

must be flagged and reported in the IVA report. States that fall below the 100% mark on verification, 90 days will be given to take remedial action and request re-verification.

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.3.11 DLI 11: Stronger digital foundation

DLI 11.1 National enterprise architecture developed, costed, and adopted

The DLI will incentivize and verify the development of an integrated, interoperable health data ecosystem to support evidence-based improvements in value (efficiency, quality, access, and health outcomes) for patients and providers. The program shall support the FMOH&SW and its agencies in laying the foundations for an interoperable platform to systematically exchange data to enhance system functions.

Scalability: No

Description: The development, costing and adoption of a digital architecture by the states leverages the digital transformation for the health system as part of the BHCPP, SWAp and PVAC. The architecture will support a bundle of digital services cutting across

- Electronic Health Records
- Service Delivery
- A community health worker platform
- Monitoring and Evaluation
- Quality of Care
- Health Insurance Management
- Public Health Event Surveillance and Reporting
- EMT and Ambulance Dispatch System
- others as prioritized by the NPCU/SCO and PVAC

The digital-in-health enterprise architecture platform will facilitate the transition from a paper-based system to a digital one and promote digital interoperability among health information systems to reduce data hyper-fragmentation and duplication. Additionally, the architecture will establish guidelines for national standards, regulations, and business processes regarding integration for states upon costing and alignment by stakeholders to include FMOH&SW, Development Partners, Private sector and SMOH.

Data Verification Source: NPCU/SCO Data Verification Entity: IVA Result Verification Protocol

- The NPCU/SCO will submit a validated digital-in-health enterprise architecture template to the IVA for review
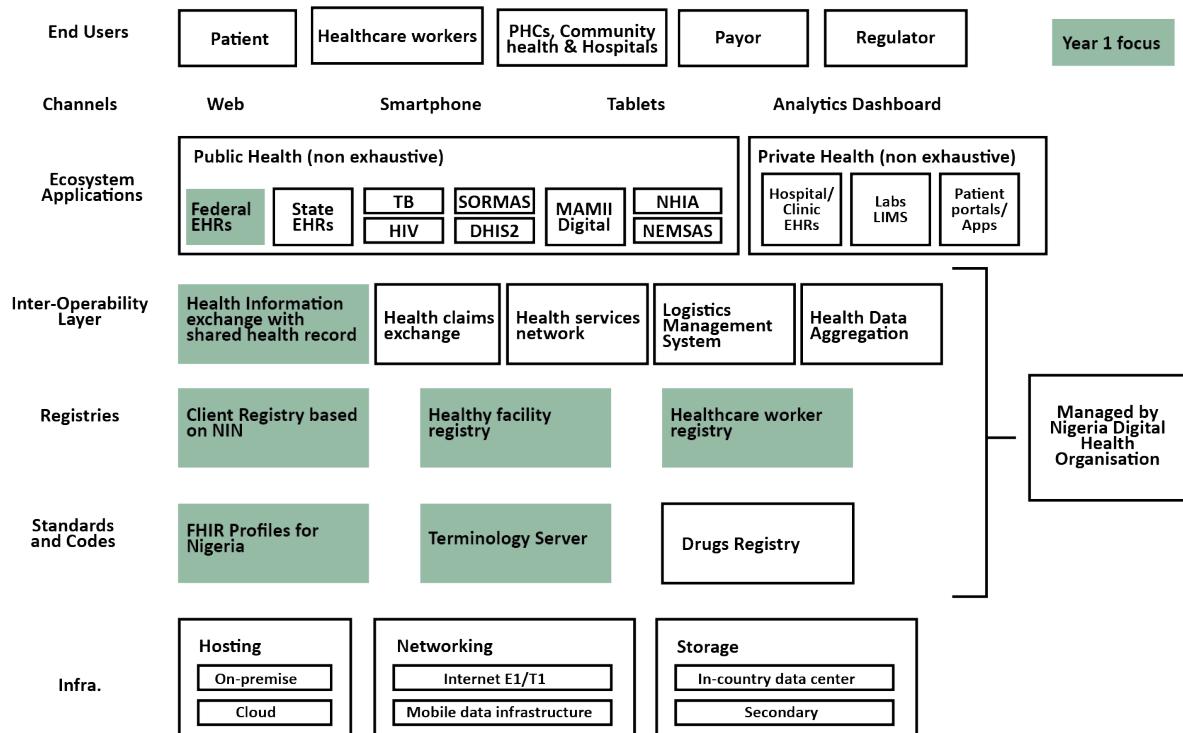
Figure 4.4: NHSRII summarized digital framework
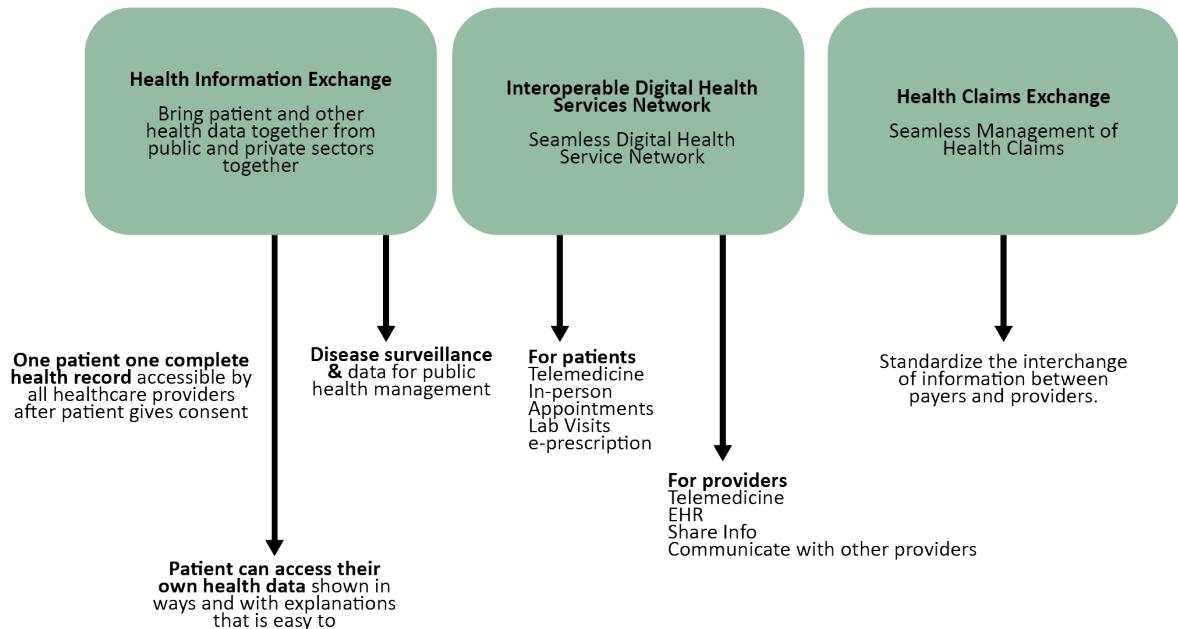
Figure 4.5: Applications of the NHSRII digital framework

- The IVA may not recommend the architecture for disbursement upon review and assessment of incompleteness of the architecture.

- Disbursement will depend on validation against confirmation that the Architecture includes the above elements

- Payout for the achievement of the prior result is subject to review and agreement of the World Bank Task Team

DLI 11.2: States adopting national enterprise architecture and integrating core health functions

The DLI will monitor and encourage states to adopt the national enterprise architecture and integrate digital health functions. By merging private, public, and program-specific health information systems, the DLI will support the adoption and effective functioning of the health data ecosystem at the state level.

Scalability: Yes

Description: States will integrate into the interoperable systems that feed into the national health data ecosystem at the federal level integrating individual private, public, and program-specific health information systems. To identify each state's capacity, the following are imperative.

- Conduct Digital Health and PHC Infrastructure Assessments, evaluating existing data systems and states' readiness, focusing on existing health data systems, governance structures, and IT capabilities.

- These assessments would also articulate service delivery mechanisms and governance structures at the State and LGA levels.

- Map health system functions critical to HOPE-PHC, such as patient management and referral systems, against DLI 11 requirements.

- Categorize states based on readiness for integration into the national enterprise architecture for digital health and prioritize states with high PHC needs.

The adoption of DLI 11 across all states requires a structured, phased, and collaborative approach that aligns with the National Health Sector Renewal Investment Initiative (NHSRII) and the broader objectives of the national enterprise architecture for digital health.

Objectives and key actions for the approach are detailed in the table below

Objective	Key actions
1.Strategic Alignment and Stakeholder Engagement	
Establish alignment between state-level goals, NHSRII and HOPE-PHC priorities	Organize and conduct national and state-level consultative workshops to align stakeholders, including policymakers, healthcare administrators, and IT specialists, on DLI 11 adoption.
	Integrate the goals of HOPE-PHC, focusing on reorganization and prioritization of cost-effective PHC interventions, into the DLI 11 adoption roadmap.
	Develop a memorandum of understanding (MoU) to define the roles of the Federal Ministry of Health & Social Work (FMOH&SW), state governments, and technical partners in achieving shared objectives.
2.Baseline Assessment and Gap Analysis	
Identify each state's current capacity and infrastructure gaps.	Conduct Digital Health and PHC Infrastructure Assessments, evaluating existing data systems, and states' readiness, focusing on existing health data systems, governance structures, and IT capabilities.
	These assessments would also articulate service delivery mechanisms and governance structures at the State and LGA levels.
	Map health system functions critical to HOPE-PHC, such as patient management and referral systems, against DLI 11 requirements.
	Categorize states based on readiness for integration into the national enterprise architecture for digital health and prioritize states with high PHC needs.
	Conduct Digital Health and PHC Infrastructure Assessments, evaluating existing data systems, and states' readiness, focusing on existing health data systems, governance structures, and IT capabilities.
	These assessments would also articulate service delivery mechanisms and governance structures at the State and LGA levels.
	Map health system functions critical to HOPE-PHC, such as patient management and referral systems, against DLI 11 requirements.
	Categorize states based on readiness for integration into the national enterprise architecture for digital health and prioritize states with high PHC needs.
3.Development of State-Specific Implementation Plans	
Create tailored adoption strategies for each state	Design state-specific roadmaps that include the integration of at least four core health system functions, prioritizing those that enhance PHC efficiency and accessibility.
	Ensure plans align with the National Health Care Digital Enterprise Architecture Framework and include interoperability standards.
	Establish a state-level digital health governance committee to oversee implementation and ensure adherence to timelines whilst meeting NHSRII and HOPE-PHC targets
	Ensure plans align with HOPE-PHC's focus on reorganizing PHC service delivery and improving access to essential health services
4.Capacity Building and Technical Enablement	

Develop the technical and operational capacity required to implement DLI 11 and support PHC priorities.	Train PHC workers, IT personnel, and decision-makers on the interoperable health data ecosystem, emphasizing functions that enhance PHC service delivery.
	Deploy technical assistance teams to support system integration and troubleshooting.
	Collaborate with academic institutions and training centers to institutionalize digital health skill-building programs.
	Provide hands-on technical assistance for system integration and on-the-job training for frontline health workers.
5.Infrastructure Development and System Integration	
Build and integrate infrastructure to support DLI 11 and improve PHC service delivery.	Deploy ICT infrastructure tailored for PHC facilities, such as data aggregation systems, servers housing patient registries, and referral tracking tools.
	Integrate core health system functions (e.g., service delivery monitoring, inventory management, and data analytics) with existing PHC processes under HOPE-PHC.
	Ensure seamless compliance and integration with the national enterprise architecture for digital health to enable interoperability across State and Federal systems.
6.Monitoring, Evaluation, and Feedback Mechanisms	
Continuously track progress and refine implementation strategies for DLI 11 and PHC integration.	Develop a Digital Health and PHC Dashboard to monitor real-time progress on DLI 11 adoption and HOPE-PHC outcomes, such as service accessibility and patient outcomes.
	Conduct biannual performance reviews to assess the integration of DLI 11 and HOPE-PHC interventions at State and LGA levels.
	Collect feedback from stakeholders to address challenges and refine implementation strategies.
7.Incentive and Sustainability Framework	
Encourage compliance and ensure the long-term sustainability of DLI 11 and HOPE-PHC initiatives.	Link disbursements under DLI 11 to measurable milestones, such as PHC service delivery improvements and integration of interoperable systems.
	Establish partnerships with private sector players through the Nigeria Health Care Industrialization Program to mobilize resources for PHC infrastructure and services.
	Develop sustainability plans to maintain digital and PHC infrastructure through revenue models, such as cost-sharing or public-private partnerships (PPPs)

Data Verification Source: Committee on Digital-in-Health Transformation in Nigeria Assessment Reports

Data Verification Entity: IVA Result Verification Protocol

The committee on digital-in-health transformation in Nigeria will prepare and submit an annual report to the NPCU/SCO on the state of states on the digital-in-health agenda for Nigeria

- The IVA will verify which states have been prepared for the digital-in-health agenda using the Committee on Digital-in-Health Transformation in Nigeria Report

- The IVA will recommend for disbursement when states integrate a core health

function defined in DLI 11.1

- The Committee on Digital-in-Health Transformation in Nigeria will monitor states on their integration of core digital health functions and will provide to the IVA a list of the states that have fully integrated core digital health functions defined in the system architecture

- The IVA will visit a randomized sample of states (not less than 100%) to confirm the committee on Digital-in-Health Transformation in Nigeria Report

- The IVA will recommend for disbursement upon satisfactory confirmation that states fully integrated into the national architecture the core health function in review

- Achievement of the DLR will be reviewed by the World Bank Task Team and the GFF. Payout for the achievement of the DLR is subject to the agreement of the World Bank Task team

4.4   Summary of Yearly Results

Baseline/Prior Result

DLI	Data source	Procedure
5.1: Secondary Facility Quality of Care for CEmONCs (prior result)	NHIA	NHIA will share the relevant document(s) to NPCU/SCO and IVA for review. Disbursement will depend on validation against confirmation that the document includes the required elements.
6.1: Deliveries with skilled birth attendant present increased (proportion)	Survey data	Baseline will be established using the 2023/2024 NDHS by the NPHCDA and IVA
6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)	Survey data	baseline will be established using the administrative data from DHIS2 by the NPHCDA and IVA
6.3: Increase in Penta 3 coverage (number)	Survey Data	The baseline will be established using the 2023 NDHS by the NPHCDA and IVA
8.1: Governance for improved resource allocation and performance (prior result)	BHCPF MOC Secretariat	BHCPF MOC Secretariat will share the relevant document(s) to the NPCU/SCO and IVA for review. Disbursement will depend on validation against confirmation that the document includes all required elements.

Year 1

DLI	Data source	Procedure
1.1: Improved PHC facility readiness, quality, and climate resilience (percentage)	NPHCDA Health Facility Assessment Reports (Potential Linkage to the DHIS2)	• The IVA will visit 100% of all NPHCDA-accredited Tier 2/ BEmONC facilities in the first year and inspect the premises for compliance against the NPHCDA checklist. • Facilities must meet at least a 75% score of the checklist to be eligible and recommended for DLR payout • Payment/disbursement will not be recommended unless at least 75% of the climate resilient measures for key climate shocks, identified in the UNICEF Climate Resilient Infrastructure for Basic Services (CRIBS) checklist, are implemented • The IVA will check for discordance in the NPHCDA assessment reports and their findings during field inspections, and discordance of assessment more than 5% must be flagged and reported in the IVA report • BHCPF tier 2 facilities that fall below the 75% mark on verification by the IVA will have 90 days to take remedial action and request a re-verification • Discordant Assessment Reports between the NPHCDA and the IVA in greater than 10 per cent of the verified facilities will require the IVA assessment for all PHC facilities on the NPHCDA report to have achieved the DLR
1.2: Increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (number)	NHIA Facility Empanelment Record (Potential Linkage to the DHIS2)	• NHIA provides a certified list of empanelled CEmONC facilities based on their assessment, submitted at least 30 days before the IVA's scheduled assessment. • IVA compares this NHIA list with the preselected facilities in Annex 9 of the POM to identify priority CEmONC facilities. • All facilities on the NHIA list are assessed by IVA using the DLI 5.1 checklist to confirm structural readiness, climate resilience, and achievement of the certification criteria. • A subset of empanelment criteria is reviewed, and facilities must meet 100% of the assessed criteria to qualify as newly or continuously empanelled. • IVA checks for discrepancies between its field findings and the NHIA list using the NHIA checklist; any discrepancy greater than 5% is flagged and reported. • Facilities that do not meet the 100% threshold are given 90 days to make corrections and request re-verification.
2.1 Federal expenditure on quality family planning commodities increased (percentage)	Budget Execution Reports from the OAGF (Federal, States)	IVA will review expenditure data from state and national budget execution reports to verify the achievement of domestic spending on contraceptive commodities.

2.2 Front-line availability of tracer products improved (percentage)	Annual Health Facility Readiness Assessment, SPHCDA Essential Commodity Reports, and DHIS2	IVA will verify this DLI using multiple data sources, including NPHCDA annual health facility assessments, procurement and CMS stock records, SPHCDA commodity reports, and DHIS2 data. (i) Procurement and delivery data for tracer commodities will be reviewed in each state, and (ii) IVA will confirm distribution arrangements between federal programs and NPHCDA for supplying essential commodities to facilities. (iii) Stock levels at federal, state, and facility levels will be reviewed, with facility data triangulated against service delivery data. (iv) Spot checks conducted for facilities with inconsistent stock reports and for 5% of facilities with adequate reported stock per state.
3 Financial protection for poor and vulnerable populations increased (number)	NHIA Portal	• IVA will review the electronically generated achievement report provided by the NHIA • IVA will cross-check figures against the SSHIA portal/data available at the state level • IVA will apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys. IVA may also opt to cross-check records with unique identification numbers or national identity numbers. • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement
4 Women and children who receive tracer essential health services in the community increased (number)	CHMIS or independent data feed to DHIS2	• Baseline will be established by the NPHCDA using administrative data on the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program • The IVA will review and compute annual records from the CHMIS or MIS for the CHW program provided by the NPHCDA for the indicators listed above • IVA will use FASTR and, where available, survey data to confirm the validity of CHMIS • Each percentage point discordance above 10% as detected by the IVA will be deducted from the total maximum eligible disbursement. • IVA will conduct small-scale surveys, household visits, and telephone verification based on primary records especially in states/LGAs/wards with anomalous data trends.
5.2 Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (number)	NHIA Portal	• NHIA will share electronic claims data generated from the NHIA portal not less than 30 days before the review period. • IVA will confirm that facility is on the empanelled list, service provided is on the eligible list, and that date of payment occurred during the relevant period • IVA will also apply a stratified random sampling method to verify at least one percent of all claims listed in each report, via field visits and telephonic surveys • Where there are discrepancies, the IVA may request unique identification numbers/NIN of beneficiaries to further review available claims data • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.

6.1: Deliveries with skilled birth attendant present increased (proportion)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.3: Increase in Penta 3 coverage (number)	Survey Data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to NSC. Surveys will be conducted annually.
7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number).	NEMSAS Electronic dispatch database	• NEMSAS will generate an electronic report from its digital platform database showing the total number of transfers from the rural ambulance service program. • IVA will cross-check figures from NEMSAS against SEMSAS portal/data available at the state level • IVA will also apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys • IVA will also apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys • IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals • Each percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
8.1: Governance for improved resource allocation and performance (prior result)	BHCPF MOC Secretariat	
8.2: States receiving funds in compliance with the allocation formula in revised guidelines (number)	BHCPF MOC Secretariat	• IVA to review minutes of quarterly BHCPF MOC meetings to confirm adherence to the revised prevailing guidelines concerning state-wise allocations • IVA to confirm payments are made in a timely fashion
9 System and standards for state EPR programs are established and implemented (number)	NCDC Subnational Assessments	• NCDC to submit a validated EPR plan template to the NPCU/SCO and IVA for review. • IVA to review template plan for completeness and full implementation within three years of program implementation
10 Climate and health adaptation plan developed, costed, validated, and implemented.	Climate Office, FMOH&SW Assessment Reports	• FMOH&SW Climate Office will submit a validated climate and health adaptation plan (CHAIP) to the NPCU/SCO and IVA for review including a template and guidelines for the development of state climate and health implementation plans. • The IVA will review the plan for its completeness

11.1: National enterprise architecture developed, costed, and adopted	NPCU/SCO	• The NPCU/SCO will submit a validated digital-in-health enterprise architecture template to the IVA for review • The IVA may not recommend the architecture for disbursement upon review and assessment of incompleteness of the architecture. • Disbursement will depend on validation against confirmation that the Architecture includes the required elements
11.2: States adopting national enterprise architecture and integrating core health functions	Committee on Digital-in-Health Transformation in Nigeria Assessment Reports	• The committee on digital-in-health transformation in Nigeria will prepare and submit an annual report to the NPCU/SCO on the state of states on the digital-in-health agenda for Nigeria • The IVA will verify which states have been prepared for the digital-in-health agenda using the Committee on Digital-in-Health Transformation in Nigeria Report • The IVA will recommend for disbursement when states integrate a core health function defined in DLI 11.1 • Committee on Digital-in-Health Transformation in Nigeria will monitor states on their integration of core digital health functions and will provide to the IVA a list of the states that have fully integrated core digital health functions defined in the system architecture • IVA will visit states to confirm the report

Year 2

DLI	Data source	Procedure
1.1: Improved PHC facility readiness, quality, and climate resilience (percentage)	NPHCDA Health Facility Assessment Reports (Potential Linkage to the DHIS2)	The IVA will visit 5% or more of previously accredited BEmONC facilities in each state and 100% of newly accredited BEmONC facilities to inspect for compliance and non-discordance between field assessment by the IVA and the NPHCDA report
1.2: Increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (number)	NHIA Facility Empanelment Record (Potential Linkage to the DHIS2)	The IVA will go to all additional facilities reported by NHIA to have been empanelled and check for compliance against the checklist; AND visit or verify by phone a random sample of 10% or more of all previously empanelled facilities in each state to ensure that they are still in compliance with previously empanelled facilities.
2.1 Federal expenditure on quality family planning commodities increased (percentage)	Budget Execution Reports from the OAGF (Federal, States)	IVA will review expenditure data from state and national budget execution reports to verify the achievement of domestic spending on contraceptive commodities.

2.2 Front-line availability of tracer products improved (percentage)	Annual Health Facility Readiness Assessment, SPHCDA Essential Commodity Reports, and DHIS2	IVA will verify this DLI using multiple data sources, including NPHCDA annual health facility assessments, procurement and CMS stock records, SPHCDA commodity reports, and DHIS2 data. (i) Procurement and delivery data for tracer commodities will be reviewed in each state, and (ii) IVA will confirm distribution arrangements between federal programs and NPHCDA for supplying essential commodities to facilities. (iii) Stock levels at federal, state, and facility levels will be reviewed, with facility data triangulated against service delivery data. (iv) Spot checks conducted for facilities with inconsistent stock reports and for 5% of facilities with adequate reported stock per state.
3 Financial protection for poor and vulnerable populations increased (number)	NHIA Portal	• IVA will review the electronically generated achievement report provided by the NHIA • IVA will cross-check figures against the SSHIA portal/data available at the state level • IVA will apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys. IVA may also opt to cross-check records with unique identification numbers or national identity numbers. • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement
4 Women and children who receive tracer essential health services in the community increased (number)	CHMIS or independent data feed to DHIS2	• Baseline will be established by the NPHCDA using administrative data on the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program • The IVA will review and compute annual records from the CHMIS or MIS for the CHW program provided by the NPHCDA for the indicators listed above • IVA will use FASTR and, where available, survey data to confirm the validity of CHMIS • Each percentage point discordance above 10% as detected by the IVA will be deducted from the total maximum eligible disbursement. • IVA will conduct small-scale surveys, household visits, and telephone verification based on primary records especially in states/LGAs/wards with anomalous data trends.
5.2 Women and neonates receiving CEmONC and neonatal services and/ or VVF surgeries (number)	NHIA Portal	• NHIA will share electronic claims data generated from the NHIA portal not less than 30 days before the review period. • IVA will confirm that facility is on the empanelled list, service provided is on the eligible list, and that date of payment occurred during the relevant period • IVA will also apply a stratified random sampling method to verify at least one percent of all claims listed in each report, via field visits and telephonic surveys • Where there are discrepancies, the IVA may request unique identification numbers/NIN of beneficiaries to further review available claims data • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.

6.1: Deliveries with skilled birth attendant present increased (proportion)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.3: Increase in Penta 3 coverage (number)	Survey Data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to NSC. Surveys will be conducted annually.
7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number).	NEMSAS Electronic dispatch database	• NEMSAS will generate an electronic report from its digital platform database showing the total number of transfers from the rural ambulance service program. • IVA will cross-check figures from NEMSAS against SEMSAS portal/data available at the state level • IVA will also apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys • IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals • Each percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
8.2: States receiving funds in compliance with the allocation formula in revised guidelines (number)	BHCPF MOC Secretariat	• IVA to review minutes of quarterly BHCPF MOC meetings to confirm adherence to the revised prevailing guidelines concerning state-wise allocations • IVA to confirm payments are made in a timely fashion
9 System and standards for state EPR programs are established and implemented (number)	NCDC Subnational Assessments	• NCDC to prepare and submit an annual report to the NPCU/SCO on the state of states on the EPR program • IVA to verify from NCDC report the states that have prepared and validated EPR plan that meets the predetermined standards • States to compile evidence of completion of planned activities. NCDC will monitor states on implementation and provide evidence to the IVA . • States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities • IVA will review compiled evidence and ensure it meets standards IVA will visit all states that have submitted plans for disbursement to confirm the NCDC report

DLI	Data source	Procedure
10 Climate and health adaptation plan developed, costed, validated, and implemented.	Climate Office, FMOH&SW Assessment Reports	• IVA will verify from the FMOH&SW Climate Office report the states that have prepared and validated CHAIP that meets the predetermined standards • IVA will recommend for disbursement when states prepare and validate their climate and health adaptation plan with the FMOH&SW Climate Office. • States will compile evidence of completion of CHAIP activities. FMOH&SW Climate Office will monitor states' implementation CHAIPs and provide compiled evidence to the IVA. • States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities • IVA will review compiled evidence and ensure it meets standards • IVA will visit all states that have submitted plans for disbursement to confirm the FMOH&SW Climate Office report
11.2: States adopting national enterprise architecture and integrating core health functions	Committee on Digital-in-Health Transformation in Nigeria Assessment Reports	• The committee on digital-in-health transformation in Nigeria will prepare and submit an annual report to the NPCU/SCO on the state of states on the digital-in-health agenda for Nigeria • The IVA will verify which states have been prepared for the digital-in-health agenda using the Committee on Digital-in-Health Transformation in Nigeria Report • The IVA will recommend for disbursement when states integrate a core health function defined in DLI 11.1 • Committee on Digital-in-Health Transformation in Nigeria will monitor states on their integration of core digital health functions and will provide to the IVA a list of the states that have fully integrated core digital health functions defined in the system architecture • IVA will visit states to confirm the report

Year 3

DLI	Data source	Procedure
1.1: Improved PHC facility readiness, quality, and climate resilience (percentage)	NPHCDA Health Facility Assessment Reports (Potential Linkage to the DHIS2)	The IVA will visit 5% or more of previously accredited BEmONC facilities in each state and 100% of newly accredited BEmONC facilities to inspect for compliance and non-discordance between field assessment by the IVA and the NPHCDA report
1.2: Increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (number)	NHIA Facility Empanelment Record (Potential Linkage to the DHIS2)	The IVA will go to all additional facilities reported by NHIA to have been empanelled and check for compliance against the checklist; AND visit or verify by phone a random sample of 10% or more of all previously empanelled facilities in each state to ensure that they are still in compliance with previously empanelled facilities.

2.1 Federal expenditure on quality family planning commodities increased (percentage)	Budget Execution Reports from the OAGF (Federal, States)	IVA will review expenditure data from state and national budget execution reports to verify the achievement of domestic spending on contraceptive commodities.
2.2 Front-line availability of tracer products improved (percentage)	Annual Health Facility Readiness Assessment, SPHCDA Essential Commodity Reports, and DHIS2	IVA will verify this DLI using multiple data sources, including NPHCDA annual health facility assessments, procurement and CMS stock records, SPHCDA commodity reports, and DHIS2 data. (i) Procurement and delivery data for tracer commodities will be reviewed in each state, and (ii) IVA will confirm distribution arrangements between federal programs and NPHCDA for supplying essential commodities to facilities. (iii) Stock levels at federal, state, and facility levels will be reviewed, with facility data triangulated against service delivery data. (iv) Spot checks conducted for facilities with inconsistent stock reports and for 5% of facilities with adequate reported stock per state.
3 Financial protection for poor and vulnerable populations increased (number)	NHIA Portal	• IVA will review the electronically generated achievement report provided by the NHIA • IVA will cross-check figures against the SSHIA portal/data available at the state level • IVA will apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys. IVA may also opt to cross-check records with unique identification numbers or national identity numbers. • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement
4 Women and children who receive tracer essential health services in the community increased (number)	CHMIS or independent data feed to DHIS2	• Baseline will be established by the NPHCDA using administrative data on the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program • The IVA will review and compute annual records from the CHMIS or MIS for the CHW program provided by the NPHCDA for the indicators listed above • IVA will use FASTR and, where available, survey data to confirm the validity of CHMIS • Each percentage point discordance above 10% as detected by the IVA will be deducted from the total maximum eligible disbursement. • IVA will conduct small-scale surveys, household visits, and telephone verification based on primary records especially in states/LGAs/wards with anomalous data trends.

5.2 Women and neonates receiving CEmONC and neonatal services and/ or VVF surgeries (number)	NHIA Portal	• NHIA will share electronic claims data generated from the NHIA portal not less than 30 days before the review period. • IVA will confirm that facility is on the empanelled list, service provided is on the eligible list, and that date of payment occurred during the relevant period • IVA will also apply a stratified random sampling method to verify at least one percent of all claims listed in each report, via field visits and telephonic surveys • Where there are discrepancies, the IVA may request unique identification numbers/NIN of beneficiaries to further review available claims data • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
6.1: Deliveries with skilled birth attendant present increased (proportion)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.3: Increase in Penta 3 coverage (number)	Survey Data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to NSC. Surveys will be conducted annually.
7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number).	NEMSAS Electronic dispatch database	• NEMSAS will generate an electronic report from its digital platform database showing the total number of transfers from the rural ambulance service program. • IVA will cross-check figures from NEMSAS against SEMSAS portal/data available at the state level • IVA will also apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys • IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals • Each percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
8.2: States receiving funds in compliance with the allocation formula in revised guidelines (number)	BHCPF MOC Secretariat	• IVA to review minutes of quarterly BHCPF MOC meetings to confirm adherence to the revised prevailing guidelines concerning state-wise allocations • IVA to confirm payments are made in a timely fashion

9 System and standards for state EPR programs are established and implemented (number)	NCDC Subnational Assessments	• NCDC to prepare and submit an annual report to the NPCU/SCO on the state of states on the EPR program • IVA to verify from NCDC report the states that have prepared and validated EPR plan that meets the predetermined standards • States to compile evidence of completion of planned activities. NCDC will monitor states on implementation and provide evidence to the IVA . • States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities • IVA will review compiled evidence and ensure it meets standards IVA will visit all states that have submitted plans for disbursement to confirm the NCDC report
10 Climate and health adaptation plan developed, costed, validated, and implemented.	Climate Office, FMOH&SW Assessment Reports	• IVA will verify from the FMOH&SW Climate Office report the states that have prepared and validated CHAIP that meets the predetermined standards • IVA will recommend for disbursement when states prepare and validate their climate and health adaptation plan with the FMOH&SW Climate Office. • States will compile evidence of completion of CHAIP activities. FMOH&SW Climate Office will monitor states' implementation CHAIPs and provide compiled evidence to the IVA. • States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities • IVA will review compiled evidence and ensure it meets standards • IVA will visit all states that have submitted plans for disbursement to confirm the FMOH&SW Climate Office report
11.2: States adopting national enterprise architecture and integrating core health functions	Committee on Digital-in-Health Transformation in Nigeria Assessment Reports	• The committee on digital-in-health transformation in Nigeria will prepare and submit an annual report to the NPCU/SCO on the state of states on the digital-in-health agenda for Nigeria • The IVA will verify which states have been prepared for the digital-in-health agenda using the Committee on Digital-in-Health Transformation in Nigeria Report • The IVA will recommend for disbursement when states integrate a core health function defined in DLI 11.1 • Committee on Digital-in-Health Transformation in Nigeria will monitor states on their integration of core digital health functions and will provide to the IVA a list of the states that have fully integrated core digital health functions defined in the system architecture • IVA will visit states to confirm the report

Year 4

Name	Data source	Procedure
1.1: Improved PHC facility readiness, quality, and climate resilience (percentage)	NPHCDA Health Facility Assessment Reports (Potential Linkage to DHIS2)	The IVA will visit 5% or more of previously accredited BEmONC facilities in each state and 100% of newly accredited BEmONC facilities to inspect for compliance and non-discordance between field assessment by the IVA and the NPHCDA report
1.2: Increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (number)	NHIA Facility Empanelment Record (Potential Linkage to the DHIS2)	The IVA will go to all additional facilities reported by NHIA to have been empanelled and check for compliance against the checklist; AND visit or verify by phone a random sample of 10% or more of all previously empanelled facilities in each state to ensure that they are still in compliance with previously empanelled facilities.
2.1 Federal expenditure on quality family planning commodities increased (percentage)	Budget Execution Reports from the OAGF (Federal, States)	IVA will review expenditure data from state and national budget execution reports to verify the achievement of domestic spending on contraceptive commodities.
2.2 Front-line availability of tracer products improved (percentage)	Annual Health Facility Readiness Assessment, SPHCDA Essential Commodity Reports, and DHIS2	IVA will verify this DLI using multiple data sources, including NPHCDA annual health facility assessments, procurement and CMS stock records, SPHCDA commodity reports, and DHIS2 data. (i) Procurement and delivery data for tracer commodities will be reviewed in each state, and (ii) IVA will confirm distribution arrangements between federal programs and NPHCDA for supplying essential commodities to facilities. (iii) Stock levels at federal, state, and facility levels will be reviewed, with facility data triangulated against service delivery data. (iv) Spot checks conducted for facilities with inconsistent stock reports and for 5% of facilities with adequate reported stock per state.
3 Financial protection for poor and vulnerable populations increased (number)	NHIA Portal	• IVA will review the electronically generated achievement report provided by the NHIA • IVA will cross-check figures against the SSHIA portal/data available at the state level • IVA will apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys. IVA may also opt to cross-check records with unique identification numbers or national identity numbers. • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement
4 Women and children who receive tracer essential health services in the community increased (number)	CHMIS or independent data feed to DHIS2	• Baseline will be established by the NPHCDA using administrative data on the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program • The IVA will review and compute annual records from the CHMIS or MIS for the CHW program provided by the NPHCDA for the indicators listed above • IVA will use FASTR and, where available, survey data to confirm the validity of CHMIS

		• Each percentage point discordance above 10% as detected by the IVA will be deducted from the total maximum eligible disbursement.
		• IVA will conduct small-scale surveys, household visits, and telephone verification based on primary records especially in states/LGAs/wards with anomalous data trends.
5.2 Women and neonates receiving CEmONC and neonatal services and/ or VVF surgeries (number)	NHIA Portal	• NHIA will share electronic claims data generated from the NHIA portal not less than 30 days before the review period. • IVA will confirm that facility is on the empanelled list, service provided is on the eligible list, and that date of payment occurred during the relevant period • IVA will also apply a stratified random sampling method to verify at least one percent of all claims listed in each report, via field visits and telephonic surveys • Where there are discrepancies, the IVA may request unique identification numbers/NIN of beneficiaries to further review available claims data • Each one percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.
6.1: Deliveries with skilled birth attendant present increased (proportion)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)	Survey data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to the NSC. Surveys will be conducted annually.
6.3: Increase in Penta 3 coverage (number)	Survey Data	Achievement of DLR will be validated with results from small-scale household surveys whose methodology is acceptable to NSC. Surveys will be conducted annually.
7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number).	NEMSAS Electronic dispatch database	• NEMSAS will generate an electronic report from its digital platform database showing the total number of transfers from the rural ambulance service program. • IVA will cross-check figures from NEMSAS against SEMSAS portal/data available at the state level • IVA will also apply a stratified random sampling method to verify at least one per cent of all enrolees listed in each report, via field visits and telephonic surveys • IVA may also opt to cross-check records with unique identification numbers or national identity numbers to ensure accurate reporting of unique individuals • Each percentage point discordance above 5% as detected by the IVA will be deducted from the total maximum eligible disbursement.

8.2: States receiving funds in compliance with the allocation formula in revised guidelines (number)	BHCPF MOC Secretariat	• IVA to review minutes of quarterly BHCPF MOC meetings to confirm adherence to the revised prevailing guidelines concerning state-wise allocations • IVA to confirm payments are made in a timely fashion
9 System and standards for state EPR programs are established and implemented (number)	NCDC Subnational Assessments	• NCDC to prepare and submit an annual report to the NPCU/SCO on the state of states on the EPR program • IVA to verify from NCDC report the states that have prepared and validated EPR plan that meets the predetermined standards • States to compile evidence of completion of planned activities. NCDC will monitor states on implementation and provide evidence to the IVA . • States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities • IVA will review compiled evidence and ensure it meets standards IVA will visit all states that have submitted plans for disbursement to confirm the NCDC report
10 Climate and health adaptation plan developed, costed, validated, and implemented.	Climate Office, FMOH&SW Assessment Reports	• IVA will verify from the FMOH&SW Climate Office report the states that have prepared and validated CHAIP that meets the predetermined standards • IVA will recommend for disbursement when states prepare and validate their climate and health adaptation plan with the FMOH&SW Climate Office. • States will compile evidence of completion of CHAIP activities. FMOH&SW Climate Office will monitor states' implementation CHAIPs and provide compiled evidence to the IVA. • States are eligible for two disbursements on EPR plan implementation: one at completion of 50% of planned activities and one at completion of 80% of activities • IVA will review compiled evidence and ensure it meets standards • IVA will visit all states that have submitted plans for disbursement to confirm the FMOH&SW Climate Office report
11.2: States adopting national enterprise architecture and integrating core health functions	Committee on Digital-in-Health Transformation in Nigeria Assessment Reports	• The committee on digital-in-health transformation in Nigeria will prepare and submit an annual report to the NPCU/SCO on the state of states on the digital-in-health agenda for Nigeria • The IVA will verify which states have been prepared for the digital-in-health agenda using the Committee on Digital-in-Health Transformation in Nigeria Report • The IVA will recommend for disbursement when states integrate a core health function defined in DLI 11.1 • Committee on Digital-in-Health Transformation in Nigeria will monitor states on their integration of core digital health functions and will provide to the IVA a list of the states that have fully integrated core digital health functions defined in the system architecture • IVA will visit states to confirm the report

4.5   Suggested interventions for achieving the DLIs

The DLIs should be achieved in a context-specific approach tailored to each state. Nevertheless, some interventions are likely to have a high impact on progress towards achieving these objectives. Table 4.3 describes recommended interventions for states to achieve the DLIs.

Table 4.3: Suggested Interventions to achieve the DLIs by state

HOPE-PHC DLIs	Description	Suggested initiative to achieve DLIs
DLI 1.1:		
Improved primary health care facility readiness, quality, and climate resilience (Percentage)	25% of 2,000 of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience	•Define the standards •Understand facility-specific needs and gaps to meet readiness standard. •Commit resources for climate-responsive infrastructural upgrade of PHC facilities using both available (IMPACT, BHCPF, state/LGA budget), and domestically-mobilized resources (CSR from organized private sector, constituency projects from parliamentarians, philanthropists, capitation, partner, etc.), HRH, service availability etc. •Provide certification to facilities that meet minimum standards
DLI 1.2: Increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (number)	CEmONC facilities are empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures	•Define the standards •Understand facility-specific needs and gaps to meet readiness standards. •Commit resources for the climate-responsive infrastructural upgrade of CEmONC facilities using both available (HOPE, IMPACT, state budget), and domestically-mobilized resources (CSR from organized private sector, constituency projects from parliamentarians, philanthropists, capitation, partners, etc.), HRH, service availability, etc. •Provide certification to facilities that meet minimum standards

DLI 2.2: Front-line availability of tracer** products improved (percentage)	Up to a maximum of 10pp increase in the number of Tier 2 (PHC + BEmONC) NHSRII-service-ready facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position. The tracer commodities include oxytocin, Multiple Micronutrient Supplements (MMS), Artemisinin-based Combination Therapy (ACTs), Human Immunodeficiency Virus (HIV) rapid test kits, pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC) (see annex 15)	•Strengthen the supply chain of essential commodities through a functioning DRF •quantification •availability of skilled logisticians at facility level •improved accountability systems (LMIS) •strengthen coordination through vertical programs
DLI 3: Financial protection for poor and vulnerable populations increased (Number)	20 percent increase from the previous year in the number of eligible population (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs.	•Allocate more resources (release of equity contributions, expanding to informal sectors, etc.) •Devise means of reaching the most vulnerable and innovative methods to ease enrollment, e.g. covering the VVF patients, enhancing community engagement and continuous enrollee sensitization and verification, ease of NIN registration, engaging community health volunteers to mobilize vulnerable persons
DLI 4: Women and children who receive tracer essential health services in the community increased (number)	5 percent increase from the previous year in the number of tracer essential health services delivered by community based health workers in the community.	•Design a comprehensive need-based community outreach program with the right skills mix to underserved settlements. •Strengthen/Set up systems to integrate data from outreach to the facility's monthly data flow to DHIS2
		•Make provisions for resources to procure commodities
DLI 6.1: Deliveries with skilled birth attendant present increased (number)	2.5% increase over the 2024 baseline on the number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)	Innovative approaches to improve SBA including: •Improved facility readiness for SBA (infrastructure, equipment, HWs available 24/7, security, etc.) •Capacity building of HWs for quality SBA •Demand generation (TBA referral, community structures) •Expanding SBA service points to empaneled private facilities, maternity homes, etc. •Strengthening data systems (capturing and uploading to DHIS2) •Increase uptake of ANC services

DLI 6.2: Introduction of MMS supplementation for pregnant women during ANC visits (number)	Pregnant women receive MMS supplementation for not less than 180 days	•Inclusion of MMS and procurement into states' free MCH packages, DRF, etc. for distribution at facility- and outreach-based ANC visits •Strengthen data systems for reporting and documentation
DLI 6.3: Increase in Penta 3 coverage (Number)	% of children immunized with Penta 3 vaccine	•Implement state-specific zero-dose under-immunised reduction strategy
DLI 7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number)	Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to tier 2 BEmONC or empaneled CEmONC facilities using the digitized EMS dispatch system	•Accelerate the establishment of SEMSAS according to BHCPF guidelines to aid referrals
DLI 9: System and standards for state EPR programs are established. (Numbers)	This DLI will disburse when states develop and implement a multi-year EPR plan encompassing disease outbreaks, climate shocks, natural disasters and other humanitarian emergencies.	Domesticate and implement a multi-year EPR plan encompassing disease outbreaks, climate shocks, natural disasters and other humanitarian emergencies
DLI 10: National Climate and Health Adaptation Plan developed, costed, validated, and implemented	This DLI will be disbursed with the development of the National Climate and Health Adaptation Plan, which will include the cost followed by implementation	Domesticate, cost, and implement a National Climate and Health Adaptation Plan
DLI 9.2: States adopt national enterprise architecture and integrate core health functions	This DLI will be disbursed against the adoption of the National ICT digital-in-health enterprise architecture by states	Domesticate the national ICT digital-in-health enterprise architecture

4.5   Focus on Quality

Integrating a quality-of-care approach into the delivery of HOPE-PHC requires embedding quality improvement as a continuous and integral component of program design and implementation. Quality should be viewed not merely as an outcome but as a systematic and iterative process that informs decision-making at every stage of the program. This includes establishing clear quality standards, routinely assessing facilities to understand gaps, and using these assessments to inform targeted improvements. Continuous monitoring, regular feedback, and adaptive management practices will further support sustained quality enhancement. Through this ongoing process-oriented approach, the program ensures that quality remains central to achieving its objectives and improving overall health outcomes.

05

OVERALL RESULT FRAMEWORK, MONITORING, EVALUATION, AND REPORTING SYSTEMS

Chapter 5 - Overall Result Framework, Monitoring, Evaluation, and Reporting Systems

This chapter reviews the HOPE-PHC program results framework including guidelines for the monitoring, evaluation, and program reporting systems. The chapter documents how program processes, outputs and outcomes will be measured objectively to assess progress and impact. A detailed monitoring, evaluation, research and learning (MERL) strategy and plan is established in this chapter to guide how program staff and stakeholders track progress and measure the impact of the interventions during and over the program's lifetime. The chapter also provides a guide on capturing early lessons as Nigeria implements a sector-wide approach in health for the first time.

The MERL systems established under the program will be critical inputs to the research and knowledge management agenda for which the NPCU/SCO is engaging with the World Bank's HNP and DIME teams, as well as other development partners as needed, for the program's learning agendas and impact evaluation.

5.1   Monitoring and Evaluation Plan

The HOPE-PHC Program's M&E framework will rely on multiple data sources, and will focus on supporting and strengthening existing information systems. The HOPE-PHC program monitoring will take place across the federal, state, health facility, and community levels and will be anchored by the NPCU/SCO's M&E Technical Working Group (TWG). The NPCU/SCO will support the development of a monitoring and evaluation plan for the program. The plan will include reporting templates for all implementing entities. The NPCU/SCO in collaboration with the Department of Health Research, Planning, and Statistics will work with the national implementing entities to develop national M&E plans and reporting templates. The national implementing entities will develop state reporting templates (draft template in annex) which will be submitted to the NPCU/SCO for aggregation. The NPCU/SCO will work with all stakeholders to build an aggregated reporting template for states covering all sector work programs. Each implementing agency under the program will be expected to maintain timely, updated reporting formats and records pertaining to interventions for which they hold accountability.

The NPCU/SCO, FMOH&SW will report all program-related data to stakeholders, including the financiers and the public. The NPCU/SCO will ensure availability of competent M&E specialists within their core team to support this function. The M&E officers of the NPCCU/SCO and the State SOCs and IAs will be tasked with continuous review of quality, completeness and timeliness of data recording and reporting at each level of reporting and higher levels of data aggregation to minimise risks arising from misreporting or incorrect collation of data. Any willful misreporting of performance will invite remedial measures and sanctions amounting to the cancellation of credit allocated to the particular result from the overall credit allocated to the state.

5.1.1   Use of Administrative Data

The program will use administrative data and desk records from national administrative databases. The use and quality of administrative data will be scaled nationwide through digital-in-health systems, which are upscaled under the NHSRII. At the state level, M&E processes will draw on administrative data from the District Health Information System 2 (DHIS2). Quality assessment and supportive supervision checklists, health facility reports, and essential medicine assessment reports will also form some of the administrative data used for progress monitoring and DLI achievement verification. Administrative data will be validated using sample-based verification approaches, especially for facility readiness, commodity stock, and other relevant indicators, particularly where there is a risk of gaming. Using rigorous data quality assessment processes, innovative methods will be used to derive quality-adjusted DHIS2 estimates of service contact coverage, including service coverage estimations for high-volume services, to enable more regular and frequent monitoring of coverage and service utilization trends at national and state levels in-between in-person surveys and to inform program learning and course correction.

The biases and limitations of using administrative data will be balanced with survey data for validation.

5.1.2   Use of Surveys

National surveys will also be conducted to triangulate and validate results from administrative data. The program will adopt the results from the 2023-24 NDHS as baseline. The NPCU/SCO and the Department of Health Planning, Research, and Statistics will coordinate partners who will conduct a mini survey at midterm implementation and a full NDHS in 2028 at the end of the program. The NPCU/SCO will ensure that methodology used in the NDHS, and mini surveys is suitably based on solid scientific grounds and acceptable to the World Bank and other partners. Other national surveys may also be used provided their methodology is acceptable to the NSC.

5.2   Mid-Year Supervisory Reports

The program design strongly focuses on data generation and its correct management. Data on indicators for the results monitoring framework will be used to track implementation progress towards the achievement of the program objectives. The NPCU/SCO will prepare mid-year supervisory reports using updates from national implementing entities and field mission report financiers via the World Bank task team. The quarterly reports presented to the NSC will also be part of the supervisory reports. This report will help identify implementation bottlenecks and their timely, evidence-based resolution and will be made available to the NSC no later than July 30 every year.

5.3   Annual National Health Program Reports

The national implementing entities will produce national program reports on the implementation of the SWAp and will specifically reference implementation progress on the DLIs which are being captured by the national implementing entities. The national program reports must be submitted to the NPCU/SCO not later than 30 days before the close of the calendar year to allow for review by the IVA toward processing rewards and incentives for the achievement of disbursement-linked results.

The following national implementing entities' program reporting units are expected to submit reports to the NPCU/SCO

- FMOH&SW (Planning, Research and Statistics; Climate Adaptation and Health; Digital Health; Family Health and Hospital Service)

- NCDC

- NEMSAS

- NPHCDA

- NHIA

- BHCPF MOC Secretariat

5.4   Joint Annual Reviews and State of Health Report

The NPCU/SCO, working with FMOH&SW Department of Health Planning, Research, and Statistics, will be responsible for developing and publishing the joint annual review and the State of Health Report, which will cover the implementation of Nigeria's health sector SWAp. The report will feature a state performance index to support the equitable and needs-based allocation of the BHCPF and broader data-driven decision-making. The NPCU/SCO will appoint a national consultant (firm) to track and work with all implementing entities to deliver the national program reports. The consultant will also collate and aggregate the State of Health Report, considering the whole health sector and noting progress on all activities within the sector.

The Annual State of Health Report, supported by the IPF component of the program must be finalised and delivered not later than 90 days from the end of the review period.

5.5   Research and Learning Agenda

The NHSRI's ambitions and subsequent design of HOPE-PHC aim to concurrently tackle multiple, persistent, and underlying challenges to improving Nigeria's health outcomes at scale. A prospective research and learning agenda will be essential to (1) examine and refine the assumptions, interdependencies, and uncertainties in the program's design for optimization, (2) facilitate quick adjustments and adaptive learning during implementation, and (3) ensure the program's impact and resulting barriers and enablers to achieving systems-level change are systematically captured to inform future health systems reform in Nigeria and beyond.

The research and learning agenda will be led by the NPCU/SCO and the Department of Health Planning, Research, and Statistics with support from technical partners, the TA Pooled fund and the World Bank's Health, Nutrition & Population Global Practice (HNP) and DIME (Development Impact Group) teams. At a high level, this is expected to include a multi-pronged approach to (1) adaptive performance monitoring to inform ongoing learning and course correction throughout program implementation, (2) embedded implementation research that will unpack key aspects of the program's design and theory of change and test-and-scale potential high impact innovations to maximize impact, and (3) an independent impact evaluation. Specific learning questions and study designs will be co-created early in the program's effectiveness and the content here is meant to be illustrative. (For full text on research agenda and priorities, see chapter 9 of this document).

5.6   Independent Verification Agent and Verification of Results

The HOPE-GOV NPCU will jointly recruit a third-party Independent Verification Agency

(IVA), on terms of reference acceptable to the World Bank referenced in Annex 6. The IVA will verify the achievement of DLRs per the approved verification protocol and work closely with the National Bureau of Statistics, M&E experts at the Federal Ministry of Budget and Economic Planning (FMBEP), the NPCU, and FMOH&SW NPCU/SCO. The IVA will be tasked to verify the achievement of the DLI targets based on data reported by the implementing agencies and other information sources identified in the protocol. The IVA procurement will be an eligible expenditure under the HOPE-PHC; however, the procurement process will be done under HOPE-GOV within sixty days of the program's effectiveness. (See Annex 6 for IVA TOR)

5.6.1   The IVA Arrangements

- The FMoBEP and the FMoH&SW will jointly hire the IVA to undertake the verification assignments for both the HOPE-GOV and HOPE-PHC programs in accordance with the agreed-upon methodology.

- The IVA will work under the supervision of the National Bureau of Statistics (NBS), based on the terms of reference and the technical and operational criteria approved by the World Bank.

- The IVA will be operationally accountable to the National SWAp Steering Committee for the verification report regarding HOPE-PHC.

- The IVA will conduct the APA, from data collection to assessment to the issuance of individual verification reports to each participating state (with copies to the NPCU/SCO and WB), and the consolidated verification report(s) to the NPCU/SCO and WB. NPCU/SCO NPCU/SCO.

- The IVA will evaluate how well states have met the DLRs based on APA guidelines and DLI verification protocols. This process is expected to involve both a central desk review and on-site visits for physical verification. The IVA will define the specific activities involved.

- In the process of the APA, the IVA may request data and input from other government and non-government entities related to the states' achievements of the DLRs. The IVA reserves the right to reach a conclusion that differs from the one suggested by the state implementing agencies.

- The IVA will formally submit the Consolidated Verification Report to the NPCU/SCO. Upon verification, the NPCU/SCO will communicate the achievement of DLIs and corresponding DLI values to the World Bank, along with supporting documents.

- The IVA reports the APAs' results to the NPCU/SCO, which will share these results to the World Bank for agreement and disbursement.

- The IVA's performance will undergo an annual formal review by a committee that includes representatives from the FMoH&SW, FMoBEP, and the World Bank. Performance indicators will consist of: (i) the timely execution of the IVA's scope of

work; (ii) accurate analysis of state performance and earnings based on the criteria and processes; and (iii) financial integrity as demonstrated in the IVA's external audit report.

5.6.2   The Annual Performance Assessment (APA) Guidelines

The achievement of the EC and DLRs will be evaluated binarily on a national implementing entity and state-by-state basis and denoted as achieved/passed or not achieved/failed. The appointed joint IVA with the government's HOPE-GOV Program will carry out the assessment on a rolling basis via the annual performance assessments (APAs), employing the DLI verification protocol contained in chapter 4 of this POM. The APA guidelines and DLI Verification Protocols may require refinement during program implementation to tackle systemic issues that arise in conducting the APAs.

Proposed formal revisions should originate from the IVA or NPCU/SCO, be submitted to the World Bank for review and approval and be promptly distributed to all states before the beginning of the calendar or fiscal year when the updated guidelines and protocols will take effect.

The verification protocol for the EC and each DLR comprises 1) a detailed definition/ description of the DLR, including definitions of key terms; 2) the state data source to be used by the IVA for assessing DLR achievement; 3) the procedure the IVA will use to determine whether the state has achieved (pass) or not achieved (fail) the EC or DLR. It is important to note the following:

- The detailed definition/description of the DLR in the verification protocol is not meant to be comprehensive regarding what a law contains or how a system should function. Rather, it describes the minimum content, function, and performance expected to achieve the DLR.

- This protocol does not exhaustively record the IVA's data sources and data requirements. The IVA reserves the right to request any additional information or data from states that may be required to form an opinion.

- This protocol does not exhaustively record the procedures that the IVA will use to assess states' achievements of the DLRs. The IVA reserves the right to undertake additional procedures or amend the procedures to form an opinion.

The APA guidelines include

1.   Timing and Definitions

The 2025 Annual Performance Assessment (APA) evaluates states' performance based on DLRs for the year 2025, which is the year being assessed. This assessment will be done on a rolling basis (quarterly or bi-annually depending on request to the World Bank and issuance of its "No Objection" to proceed with the assessment). This pattern continues for future assessments. "Year" refers to the fiscal year (unless stated otherwise), which is the same as the calendar year, running from January 1 to December 31. "Year-end" refers

to December 31. The schedule for the APAs is outlined in the table below. In Year 1 (2025), the APA will take place after assessing program effectiveness. In Year 4 (2029), the APA will occur from April to July 2029, utilizing the audited financial statements of FY 28 as the basis for the DLR assessment.

Table 5.1: PforR Annual Cycle

Program Evaluation and Disbursements	Year 1 (2025)	Year 2 (2026)	Year 3 (2027)	Year 4 (2028)	Year 5 (2029)
Performance period being assessed/year under assessment	Jan – Dec 25	Jan – Dec 26	Jan – Dec 27	Jan – Dec 28	
Interim Annual Performance Assessment period for the IVA and external audit firm	Jan – Jun 25	Jan – Jun 26	Jan – Jun 27	Jan – Jun 28	
Interim Verification report submitted by the IVA to the NPCU/SCO and WB	Aug – 25	Aug – 26	Aug – 27	Aug – 28	
Final Annual Performance Assessment period for the IVA and external audit firm	Jul – Dec 25	Jul – Dec 26	Jul – Dec 27	Jul – Dec 28	
Final Verification report submitted by the IVA to the NPCU/SCO and WB	Nov – 25	Nov – 26	Nov – 27	Nov – 28	
Disbursement of performance-based grants to states	Dec – 25	Dec – 26	Dec – 27	Dec – 28	

2. Templates

The NPCU/SCO, along with other implementing agencies and partners, plans to distribute several guidelines, templates, and tools to assist states in building capacity to meet various DLRs. These resources are also provided to the IVA. While states are encouraged to utilize these templates to evaluate their level of achievement for each DLR, they are not required to do so. In such instances, the IVA assessment should rely on the definitions and descriptions of the DLR outlined in the verification protocol.

3. Online Publication on State Official Website(s)

State official websites encompass the State Government site, the Office of the Auditor General for States, and relevant State ministries' websites, such as Finance, Budgets, and Economic Planning, as well as the State House of Assembly's site. All information that must be published on the state's official website(s) by specific dates should remain on the site permanently. The IVA will conduct periodic checks—at least quarterly—throughout the program's duration. The following guidance is provided to states:

- All state-provided information on websites should be time-stamped to indicate the publication date and time

- All information that needs to be published on the state websites must be clearly marked and easily accessible to visitors. Links to these online publications and databases should be prominently displayed on the homepages of each site.

- To download all evidence from the official state website(s), the states must provide IVA with the links and specific web pages.

4. Use of interim/unaudited year-end figures

Some DLRs will be assessed based on interim/unaudited year-end figures provided by the States' Accountant General's Office. Those DLRs will be reassessed using published audited figures during the next APA. If the updated results (pass/fail) differ based on the audited balances, any amounts due to the States at the end of the subsequent APA will be adjusted accordingly to reflect the updated results. In year 4, i.e., 2028 APA, those DLRs that were assessed on interim/unaudited year-end figures will be assessed using published audited figures, as there are no further APA and subsequent disbursements where adjustments can be made.

5. Treatment of cash and accrual accounting

States using cash accounting will be expected to produce annual and year-end figures on a cash basis, and states that have moved to accrual accounting will be expected to produce annual and year-end figures on an accrual basis. Where a state presents interim and audited financial statements prepared using the accrual basis, the IVA will base its calculations and analysis on the accrued balances rather than on cash flows. The IVA will also independently validate all accrued balances included in the year-end figures submitted to it, ensuring their appropriateness after year-end. If a state transitions from cash to accrual accounting during the program, the IVA's comparative analysis will consider the cash position in the first year of accrual accounting and then use the accrual position in subsequent years.

5.6.3 The APA Process and Outputs

The IVA will conduct an interim APA and a final APA in each year of assessment. At the end of each APA (interim and final), the IVA is expected to produce the following:

1. Annual Performance Assessment Reports for All Implementing Entities sent to each implementing entity and individual states, with copies to the NPCU/SCO and the World Bank. Each report will contain the following information:

   - Description of the work done by the IVA on each DLR and the areas of difficulty in confirming the state's performance.

   - A binary assessment of each DLR: pass or fail.

   - For the final APA, make any changes to the interim assessment on DLRs using the audited financial statements rather than the interim year-end figures.

   - Reasons for the state's failure to meet the DLR include identifying which required elements were met and which were not.

2. Consolidated Verification Reports: This will be a compendium report for the NPCU/ SCO and the World Bank, covering all participating states. The report will contain the following information:

- Description of the work done by the IVA and the external firm for the APA

- A binary assessment of each DLR (pass or fail) for every state.

- The final Verification Report must include adjustments to the interim assessment of DLRs according to audited financial statements, rather than relying on interim year-end figures for each state.

- Insights gained and suggestions for the upcoming APA, including any proposed updates to the APA guidelines and DLI verification processes.

In addition to these reports, the IVA will retain documentary evidence (either in electronic or hard copy) to confirm that all checks in the verification protocol have been carried out.

5.6.4   Addressing potential challenges that may arise during the APA process

This section outlines possible issues that may occur during the APA process, along with suggested solutions for addressing them:

1. Delays caused by states providing verification data late:

   - The IVA will issue a thorough information request to the national implementing entities and states, outlining the deadlines for submitting the data needed for the APA. While the deadlines may differ, implementing entities and states are generally required to submit the information within four weeks of receiving the request.

   - To ensure fairness, the IVA typically grants extensions to the deadlines for all states collectively, rather than for individual states. Keep in mind that such extensions will only be approved in exceptional circumstances.

   - The IVA will determine if DLRs have been met, relying on the information available by the specified deadline.

2. Instances of deceptive reporting by states: The IVA will promptly notify the NPCU/SCO of any signs of coordinated efforts by participating states to fraudulently report data concerning DLR achievement. The NPCU/SCO will share this information with the World Bank.

5.6.5   Using APA Results for M&E and Communications

The performance of each implementing entity and state—meaning their achievement of the EC and DLRs evaluated in the APAs—will be available on the HOPE-PHC public website/web portal to enhance transparency and accountability and to encourage peer learning and constructive competition. The IVA may also release APA performance results.

5.6.6   PforR Annual Performance-Based Funding Determination

The total PforR funding disbursement for an implementing entity or state will be calculated by the IVA and agreed by the World Bank. This calculation includes the following adjustments, if relevant:

- Resulting from either over or underpayments from the prior year due to the IVA assessing audited financial statements in the final APA, rather than using interim financial statements during the interim APA process.

- If an implementing entity/state was "overpaid" last year and does not qualify for PforR financing this year to offset the amount, the general rule is that the implementing entity/state must still reimburse the Bank via the FGN according to the applicable terms of the Subsidiary Grant Agreement.

- For implementing entities and states that are receiving benefits from other Bank-funded performance-based financing operations, the Bank will lower the payment amount associated with DLRs for which the state has previously received performance-based financing from those other projects. The HOPE-PHC Financing Agreement contains a covenant addressing this issue.

The total disbursement for PforR financing in each performance year will equal the combined total of PforR financing disbursements for all states meeting the eligibility criteria in the assessed year. Should states collectively fall short of expected performance, surplus funds will be carried over to the next year. However, this carryover does not apply to individual states. Conversely, if states collectively exceed performance expectations, disbursements will align with the full financing amount available, as long as they remain within the overall limit pooled resources for the PforR component.

5.7   Borrowers' Mid-term Review

The NPCU/SCO will prepare a midterm review for the HOPE-PHC program, documenting program milestones (initial outputs and achieved outcomes), progress towards achieving the results framework, intervention areas, and reporting on the IPF component of the program. The mid-term review will be a joint exercise engaging partners supporting the Program, and prepared in collaboration with the World Bank task team at the end of period two and the commencement of period 3 of the program. This will be combined with the Joint Annual Review for that period.

Table 5.2 HOPE-PHC period definition

Period	Period Definition
Prior Results	Prior Result
Period 1	CY2025
Period 2	CY2026
Period 3	CY2027
Period 4	CY2028

5.8   Borrowers' Implementation and Completion Report

The Implementation Completion and Results reports (ICRs) are an integral part of the World Bank's drive to increase development effectiveness through a continuous process of self-evaluation, lesson learning and application, sharing of knowledge, and being accountable for results. The lessons learned from ICRs improve the quality and effectiveness of Bank loans/credits, especially for follow-on operations. At the same time, borrower/stakeholder participation in the ICR process enhances later designs, preparation, and implementation.

For the HOPE-PHC program, an Intensive Learning ICR (ILI) is proposed with the same structure and content as the core ICR but more extensive analysis and lesson learning based on the findings of a stakeholder workshop (to gather information, discuss the experience, and derive lessons). The ILI will be concise and focus on effectiveness issues, their resolution, factors affecting performance, and the results and outcomes of interventions in the context of objectives. This will allow the NPCU/SCO to capture all early lessons and the full impact of the implementation of the health SWAp and follow feedback from all stakeholders on experience towards complete alignment of the system.

The NPC NPCU/SCO will organise and oversee the preparation of the ICR and will also be the formal contact with the World Bank and co-financiers during the preparation and review of the World Bank ICR. World Bank procedures require that ICRs be completed shortly after an operation is completed and circulated to the Board no later than six months after its closing date, but there are significant advantages to earlier preparation and submission of ICRs.

5.9   Results Framework

Table 5.3 PDO Indicators by Outcomes

Baseline	Period 1	Period 2	Period 3	Closing Period
Resilience				
Percentage of PHC facilities achieving service readiness assessment criteria (Percentage) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	25	50	75	100
National climate and health adaptation plan developed, costed, validated, and implemented (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	5	20	30	37
Utilization of Quality Essential Services				

Table 5.4 Intermediate Indicators by Results Areas

Baseline	Period 1	Period 2	Period 3	Closing Period
Improving utilization of quality essential services				
Financial protection for poor and vulnerable populations increased (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028

1,800.000	2,520,000	3,528,000	4,939,200	6,914,880
Increase in Penta 3 coverage (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
53	55	57	59	61
Percentage increase in patient experience score (Percentage)				
Nov/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
47.70	50	55	65	75
Introduction of MMS supplementation for pregnant women during ANC visits (Percentage) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
25	28	31	34	37
Percent of received complaints resolved within defined timelines using established feedback channels (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	80	80	80	80
Percent of received complaints resolved within defined timelines using established feedback channels (adolescents) (Percentage)				
Jun/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	80	80	80	80
Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (VVF surgeries ≤ 30% of the total share of reimbursed services) (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	50,000	150,000	250,000	350,000
People reached with digitally enabled health services (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,000,000	3,000,000	6,000,000	10,000,000
People reached with digitally enabled health services - Female (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	500,000	1,500,000	3,000,000	5,000,000
Number of people receiving quality HNP services (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	10,000,000	20,000,000	30,000,000	40,000,000
Number of children under 5 receiving quality HNP services (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0				
Number of adolescents receiving quality HNP services (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,000,000	3,000,000	6,000,000	10,000,000
Improving resilience of the health system				
People benefiting from climate resilient infrastructure (Number of people) CRI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	2,000,000	7,000,000	1,400,0000	20,000,000
People benefiting from climate resilient infrastructure - Female (Number of people) CRI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,200,000	4,000,000	8,000,000	12,000,000
People benefiting from climate resilient infrastructure - Youth (Number of people) CRI				

Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	600,000	2,100,000	4,200,000	6,000,000
Federal expenditure on quality family planning commodities increased (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	6	12	21	30
Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	100	300	500	774
Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	10,000	50,000	100,000	240,000
Front-line availability of tracer products improved (Percentage) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	25	50	75	100
Proportion of Tier 2 BEmONC facilities achieving minimum quality of care score (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	50	60	70	80

Table 5.5 Disbursement-linked Indicators (DLI)

Baseline	Prior Results	Period 1	Period 2	Period 3	Period 4
1. Proportion of births attended by a skilled provider (Percentage)					
43		0	50	0	54
0.00	0.00	0.00	17,500,000.00	0.00	17,500,000.00
DLI allocation		35,000,000.00	As a % of Total DLI Allocation		6.67%
2. Women and children who receive tracer essential health services in the community increased (Number)					
0		5,000,000	10,000,000	15,000,000	20,000,000
0.00	0.00	5,000,000.00	10,000,000.00	15,000,000.00	20,000,000.00
DLI allocation		50,000,000.00	As a % of Total DLI Allocation		9.52%
3. Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number)					
0		10,000	50,000	100,000	240,000
0.00	0.00	500,000.00	2,500,000.00	5,000,000.00	12,000,000.00
DLI allocation		20,000,000.00	As a % of Total DLI Allocation		3.81%
4. Introduction of MMS supplementation for pregnant women during ANC visits (Percentage)					
25	28	31	31	0	37
0.00	0.00	0.00	10,000,000.00	0.00	10,000,000.00
DLI allocation		20,000,000.00	As a % of Total DLI Allocation		3.81%
5. Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (VVF surgeries ≤ 30% of the total share of reimbursed services) (Number)					
0	CEMoNC Strategy	50,000	150,000	250,000	350,000

0.00	2,500,000.00	4,375,000.00	13,125,000.00	21,875,000.00	30,625,000.00
DLI allocation	72,500,000.00	As a % of Total DLI Allocation	13.81%		

6. Increase in Penta 3 coverage (Number)

53		0	57	0	61
0.00	0.00	0.00	17,500,000.00	0.00	17,500,000.00
DLI allocation	35,000,000.00	As a % of Total DLI Allocation	6.67%		

7. Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (Number)

0		100	300	500	774
0.00	0.00	3,464,000.00	10,396,000.00	17,320,000.00	26,820,000.00
DLI allocation	58,000,000.00	As a % of Total DLI Allocation	9.05%		

8. Front-line availability of tracer products improved (Percentage)

0		25	50	75	100
0.00	0.00	3,300,000.00	6,600,000.00	9,900,000.00	13,200,000.00
DLI allocation	33,000,000.00	As a % of Total DLI Allocation	6.29%		

9. National climate and health adaptation plan developed, costed, validated, and implemented (Number)

0		National Plan Developed	37	37	37
0.00	0.00	1,000,000.00	5,700,000.00	7,750,000.00	15,550,000.00
DLI allocation	30,000,000.00	As a % of Total DLI Allocation	5.71%		

10. Financial protection for poor and vulnerable populations increased (Number)

1,800.000		2,520,000	3,528,000	4,939,200	6,914,880
0.00	0.00	5,630,631.00	7,882,883.00	11,036,036.00	15,450,450.00
DLI allocation	40,000,000.00	As a % of Total DLI Allocation	7.62%		

11. Percentage of PHC facilities achieving service readiness assessment criteria (Percentage)

0		25	50	75	100
0.00	0.00	6,150,000.00	12,300,000.00	18,450,000.00	24,600,000.00
DLI allocation	61,500,000.00	As a % of Total DLI Allocation	9.71%		

12. Federal expenditure on quality family planning commodities increased (Percentage)

0		6	12	21	30
0.00	0.00	5,000,000.00	5,000,000.00	7,500,000.00	7,500,000.00
DLI allocation	25,000,000.00	As a % of Total DLI Allocation	4.76%		

13. States receiving funds in compliance with allocation formula in revised guidelines (number)

0	Guidelines Developed	37	37	37	37
0.00	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00
DLI allocation	12,500,000.00	As a % of Total DLI Allocation	2.38%		

14. System and standards for state EPR programs are established. (Numbers)

0	National Standards Developed	37	37	37	
0.00	0.00	1,000,000.00	2,750,000.00	3,750,000.00	7,500,000.00
DLI allocation	15,000,000.00	As a % of Total DLI Allocation	2.86%		

15. States adopting National enterprise architecture and integrate core health functions

0	National Health Enterprise Architecture	37	37	37	37
0.00	2,500,000.00	3,750,000.00	3,750,000.00	3,750,000.00	3,750,000.00
DLI allocation		17,500,000.00	As a % of Total DLI Allocation		3.33%

06
COMMUNICATION STRATEGY

Chapter 6 - Communication Strategy

Communications Strategy for the HOPE-PHC Program

Effective communication is a cornerstone for the success of the HOPE-PHC Program. The aim of the communications strategy is to reinforce the HOPE-PHC Program's accountability framework by enhancing stakeholder engagement, and ensuring effective dissemination of information to all relevant parties. Communications for the HOPE-PHC program will be managed by the National Program Coordinator of the NPCU/SCO and supported by a full-time, technically competent staff, either seconded from the FMOH&SW or competitively recruited from the private sector, including a Communications Specialist.

In addition, states and local governments will establish a communication structure through their respective MDAs.

A comprehensive communications strategy ensures that key stakeholders, including government bodies, healthcare providers, donors, and the public, are well-informed, engaged, and motivated to support the program's agenda and goals. This will also be in adherence to the FPIC principle (Free, Prior, and Informed Consent) of the states'

community members as outlined in the objectives of ESS 7 of the Environmental and Social Framework (Further details on this can be found in the World Bank's Environmental and Social Framework document).

The objectives of the communication strategy are:

- Increase public knowledge and understanding of the program's objectives, benefits, and potential impact on improving health lives for all Nigerians

- Foster meaningful engagement with all stakeholders, including the FMOH&SW, the national implementing entities, state implementing entities, donors & development partners, service providers, and local communities.

- Promote positive behavioural change in the national healthcare systems through targeted campaigns and supply of informational resources.

- Enhance program visibility as a leading initiative in improving national health outcomes led by the FMOH&SW

- Foster trust and transparency to ensure open and honest communication, providing updates on progress, challenges, and successes.

6.1 Stakeholder Definition and Program Roles in Communication

Program communications will target a diverse range of audiences. Key messaging will be tailored for each target audience in alignment with their concerns, priorities, authorities/ jurisdiction, and interests. Communications at relevant levels will be structured to be both stakeholder/beneficiary-centered rather than institution-centred, and messages will be developed to effectively instil behaviour change in stakeholders at their various institutional levels to promote effective and efficient health system management and performance.

At the community level, the program will work with the LGA-Level institutions, ward development committees, traditional rulers, religious and spiritual leaders to address community-specific information needs. This will enable the flow of information from the community to the local, state, and federal levels, and vice-versa. The following stakeholders have been identified as having relevant interest in the outcomes of the program implementation:

6.1.1 Internal Stakeholders

The following listed are internal/government stakeholders for the HOPE-PHC Program

- **Federal Ministry of Health and Social Welfare (FMOH&SW)**

The FMOH&SW includes the ministry led by the Coordinating Minister, Federal Ministry of Health and Social Welfare and all departments. The FMOH&SW hosts the NPCU for the HOPE-PHC program. The National SWAp Steering Committee is also housed under the office of the Coordinating Minister within the (FMOH&SW)

World Bank's Environmental and Social Framework https://www.worldbank.org/en/projects-operations/environmental-and-social-framework

- **Federal Ministry of Budget and Planning (FMBP)**

The FMBP includes the ministry led by the Minister of Budget and Economic Planning and all departments. The FMBP hosts the NPCU for the HOPE-GOV Program.

- **National Program Coordination Unit/ SWAp Coordinating Office (NPCU/SCO)**

The NPCU/SCO, led by the national program coordinator, is the national program management unit for the health sector-wide program. The SCO has several technical officers supporting the implementation and structuring of the overall health SWAp in Nigeria of which the HOPE-PHC program is a component.

- **BHCPF Ministerial Oversight Committee (BHCPF MOC) and Secretariat**

The BHCPF MOC, chaired by the coordinating minister of health, oversees the implementation of the BHCPF and is the highest coordinating committee for PHC provisioning in Nigeria. It is supported by a secretariat headed by a secretary with technical staff supporting the BHCPF operations. Through the NPCU/SCO serving as the secretariat of the National SWAp Steering Committee, the MOC works with the SWAp Office as an alternative entry to the Steering Committee.

- **National Health Insurance Authority (NHIA)**

The NHIA is the national entity for the enrolment and regulation of health insurance in Nigeria. The NHIA manages social health insurance management in Nigeria and is the national implementing entity for several DLIs on the HOPE-PHC program with a significant role in the verification of some results.

- **National Primary Health Care Development Agency (NPHCDA)**

The NPHCDA is the national entity for primary healthcare services in Nigeria. The NPHCDA manages the State-PHCDAs and regulates primary healthcare service delivery. The NPHCDA is a national implementing entity for several DLIs on the HOPE-PHC program, and it has a significant role in the verification of some results.

- **National Emergency Medical Services and Ambulance System (NEMSAS)**

The NEMSAS is the national ambulance/dispatch system for primary care emergencies and referrals funded through the BHCPF. The NEMSAS is a national implementing entity a DLI on the HOPE-PHC program with a significant role in the verification of some results.

- **Nigeria Centre for Disease Control and Prevention (NCDC)**

The NCDC is Nigeria's health security and emergency preparedness and response agency with the mandate to ensure emergency preparedness and response structures at the national level and support state structures and response during public health alerts/ events. The NCDC is a national implementing entity for a DLI on the HOPE-PHC program with significant roles in the verification of some results.

- **BHCPF State Oversight Committees (BHCPF SOCs)**

The BHCPF SOCs, chaired by the State health commissioners, oversee the implementation of the BHCPF at the state level and are the highest coordinating

committee for PHC provisioning at the state level. They are supported by a BHCPF desk officer providing support to the BHCPF operations at that level, and the State SWAp Desk Officers overseeing the SWAP/ HOPE-PHC project in the states

- **State Ministry of Health (SMOH)**

The State Ministry of Health is the overarching institution at the state level responsible for the delivery of state components of all DLIs on the HOPE-PHC program under the leadership of the health commissioners. The SMOH will also coordinate the efforts of the respective agencies under its structure including the following:

- **State Primary Healthcare Development Agencies (SPHCDA)**

The SPHCDAs are the subnational entities for primary healthcare services in each state in Nigeria. The SPHCDAs manage primary healthcare service delivery at the state level. The SPHCDAs will implement several DLIs on the HOPE-PHC program with significant roles in achieving results.

- **State Supported Health Insurance Agencies (SSHIA)**

The SSHIAs are the subnational entity for the direct enrolment of vulnerable population groups and management of social health insurance at the state level. The SSHIAs will implement several DLIs on the HOPE-PHC program with significant roles in achieving results.

- **Health Records Officers Registration Board of Nigeria (HRORBN)**

    The HRORBN plays a regulatory and capacity-building role by ensuring the professional standards of health information officers. The board is involved in training, certifying, and regulating health records personnel, which is crucial for maintaining data quality and integrity in digital health systems.

- **National Identity Management Commission (NIMC)**

    NIMC's role is central to patient identification through the integration of the National Identification Number (NIN) into health systems. This facilitates the creation of unique health records and supports interoperability and tracking across different care settings.

- **National Population Commission (NPopC)**

    The NPopC contributes to the NDHA by providing demographic data critical for planning, patient registration, and health service delivery. It supports civil registration and vital statistics (CRVS) systems that can be integrated with digital health platforms for more accurate population health metrics.

- **Federal Ministry of Communications, Innovation and Digital Economy (formerly Ministry of ICT)**

    This ministry is a key partner in setting national ICT standards and infrastructure

development. It supports digital connectivity, data governance policies, and cybersecurity frameworks—all essential for the implementation of a secure and scalable NDHA.

6.1.2 External Stakeholders:

Development Partners:

The Development Partners are international development-inclined organizations and registered members of the diplomatic community with bilateral relationship/goals with the Federal Republic of Nigeria to improve outcomes towards attaining the Sustainable Development Goals. They include grant-and-loan-providing organizations that are keyed into the Nigeria health SWAp process either through the HOPE-PHC program or through other funding lines providing resources for the implementation of the health sector program in Nigeria.

- **Citizens and General Public**

All Nigerians, resident and abroad, and registered residents of the Federal Republic of Nigeria.

- **Civil Society Organizations & Faith-Based Organisations**

These are non-profit organizations and religious institutions with a mandate to promote inclusion, transparency and accountability in the health sector. They champion citizen's engagement and enlightenment in providing a shared understanding of government programs and reforms.

- **Media**

Media institutions across all channels (TV, online, radio, print etc.) with the independence of public engagement, possessing technologies, expertise, and personnel to ensure mass media messaging of the HOPE-PHC program.

- **Academic and Research Institutions**

These are academic institutions working under the NUC-accredited universities, teaching hospitals, and research institutions, as well as independent researchers working on scientific exploration of the design, evidence and implementation science, data, governance, and policy components of the HOPE-PHC program.

- **The Private Sector**

This includes all for-profit organizations that contribute directly or indirectly to the health sector in Nigeria. In particular, this includes the Private sector start-up community, who have particular relevance to designing and scaling patient-centric solutions like mobile health apps, digital diagnostics, and health data platforms.

- **Mobile Network Operators (MNOs)**

MNOs are critical for enabling digital connectivity, especially in rural and underserved areas. They support data transmission for digital health systems and are expected to

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13 - Program Champions are identifiable and passionate individuals on the SWAp agenda in Nigeria.

partner in expanding last-mile internet access, which is foundational for the functioning of the NDHA.

- **Digital health training companies**

These companies are recognized for their role in building human resource capacity across the health system. They offer specialized training to health workers and IT staff, helping to bridge skill gaps necessary for effective deployment and maintenance of digital health systems.

- **Chief Medical Directors (CMDs) at tertiary hospitals**

CMDs are key institutional leaders responsible for ensuring digital health integration within tertiary facilities. The document notes their role in driving institutional buy-in, facilitating infrastructure readiness, and overseeing compliance with national digital health policies.

- **Frontline health workers**

These workers are central users of digital tools for service delivery, patient recordkeeping, and data entry. Their engagement is crucial for usability testing, feedback on system performance, and the success of any digital solution at the point of care.

- **Patient advocacy groups (e.g., PLHIV groups)**

Such groups to foster awareness, address concerns about privacy and digital inclusion, and promote trust in digital health solutions. These groups can help ensure that marginalized populations are not left behind and can act as feedback channels for system improvement.

6.2 The Roles and Responsibilities of NPCU/SCO in Communications

- The NPCU/SCO will coordinate strategic communications activities, collect, and analyse relevant data, and ensure effective stakeholder management. The NPCU will be supported by a Communications Specialist.

- The Communications Specialist, will develop and implement the communications plan, manage media relations, and oversee the production of communication materials.

- THE NPCU/SCO will develop a state/subnational communication guideline to support state-level rollout of the communication agenda

- State-level communication will be led through a committee under the leadership of State Health Commissioners, including SPHCDA, SSHIA,and BHCPF MOC alignment with the overall strategy and project objective.

- A communications agency will be recruited to support in the development and operationalization of strategic project communications and a behaviour change communications strategy.

6.3   Key Messaging

For effective targeting of upstream/downstream communications, the program will identify and segment primary, secondary, and tertiary audiences, which will be defined in a communications update prepared by the communication for HOPE-PHC (as a program and associated services).

6.3.1   Upstream Communications

This will be used to inform and sensitize all policy makers (internal stakeholders and parliamentarians), development partners, Civil Society Organizations (CSOs), and others on the program objectives and strategies for delivering the program. The program team will engage champions[13] identified through client beneficiary referrals at community, state, and federal levels on the successful implementation of the SWAp programs in Nigeria.

6.3.2   Public/Consumer Communication

This will be used to inform intended beneficiaries about the program's components and sub-components and measures to ensure accountability and transparency of the program.

1. Overarching program goals: Communicate the HOPE-PHC program's goals, agenda, and expected outcomes, emphasizing improvements in health access, service delivery, and system performance.

2. Accountability and Transparency: Highlight the mechanisms that ensure accountability and transparency in the program's implementation. This will be executed mainly through established partnerships with relevant government stakeholders and development partners.

3. Service Utilisation: Explain the package of healthcare interventions deployed for citizens' benefit, the intended beneficiaries of these interventions, and the places where these services can be obtained. This is done in collaboration with states to ensure proper linkages.

4. Stakeholder Engagement: Describe the importance of stakeholder engagement and the role of various stakeholders in achieving the program's objectives. This will be executed mainly through clear communication across various established Grievance Redress Mechanism (GRM) platforms for program implementation.

5. Success Stories: Share success stories and best practices from the program to build trust and encourage participation and sustained program impact. These success stories will be developed by the NPCU/SCO and disseminated across all implementing entities and platforms on the SWAp programs.

Messaging will focus on how the HOPE-PHC Program will improve the healthcare system in Nigeria, optimize service delivery to ensure access to all Nigerians, effectively

control disease, and improve health outcomes for the country. It will emphasize the government's commitment to improving healthcare access and quality at all levels and provide updates on milestones, impact/success stories from beneficiaries, and statistical impacts on national healthcare delivery. Mass messaging on preventive health care, the necessity of vaccination, maternal and child health, sanitation and hygiene practices, and disease management will also be implemented across all levels of implementation.

6.4   Communication Channels

The program will adopt various channels for communications as appropriate for each specific audience. Adopted channels and tools for communication will consider the cultural context, geographical context, literacy level, language, age, and physical ability or disability of its audience to ensure an effective and understandable flow of information. Some of the communication channels to be adopted include:

- Digital Platforms: Use of necessary social media, official websites, and email newsletters to disseminate information and updates.

- Traditional Mass Media: print media, radio, television, out of home to reach a broad audience.

- Workshops and Forums: The NPCU/SCO will organise peer learning forums, periodic exchanges among national and state implementing entities, and information dissemination/advocacy workshops during the implementation of the HOPE-PHC program. These fora will incorporate strategic high-level discussions with relevant stakeholders in the health and development sector to foster further partnerships for further expansion and sustained progress of the program outcomes. At state and local levels, these workshops will also engage with professional associations and the health workforce that contribute to the broader development outcomes for healthcare using practical discussion tools to convey relevant messaging to instil sustained knowledge and understanding.

- Community Channels: Townhall meetings, drama, proclamations, town halls, community dialogues, face-to-face interactions, community mobilization/sensitization (roadshows etc.).

- IEC Materials: These are for informing and educating stakeholders through direct/indirect messaging on materials such as fliers, banners, brochures, wearables (e.g. caps, shirts, hijabs etc.).

- Spokesmanship: In addition to the use of these channels, spokespersons will be identified across the internal stakeholders to serve as mouthpieces for HOPE-PHC. They are expected to have been cleared and trained to appear in the media and speak on behalf of their respective institutions.

6.4.1   Internal Communications

The internal and corporate communications for the HOPE-PHC program will enhance the image and credibility of the program, staff commitment to the achievement of program goals, work ethic and culture for all program staff, and the overall program dynamic within the HOPE-PHC program and across with other programs of the Federal Republic of Nigeria. Program staff will adhere to the program structure defined in the institutional arrangement section of the manual and address superiors and subordinates with full corporate regards in line with the civil service guidelines.

6.4.2   External Communications

External communications will support the design of corporate communication strategies. The communications and strategy specialist will lead these strategies to publicize activities and enhance a positive image for the NPCU/SCO. The HOPE-PHC website will be the first call for external communications with links for federal, state, local government, and community activities under the SWAp program. Mass communication will also be employed, including traditional and new media materials and channels. Communication strategies will be updated as necessary by the communications and strategy specialist with approval from the national program coordination of the NPCU/SCO, and strategies will be refined based on situation assessments, M&E indicators, research findings, communication audits, and/or needs assessments, and participatory stakeholders' appraisals.

6.4.3   Social Behavioural Change Communications Strategy (SBCCS)

Enhancing the quality of health facilities and services is insufficient to guarantee the uptake and utilization of essential health services. Quality improvements must be paired with initiatives that increase demand. To increase demand for health services, social behaviour change campaigns will be employed to enhance understanding of SWAp programs particularly on reproductive, maternal and child health, nutrition and improved dietary practices, vaccination for children under five, the minimum package of health services, and the public right to healthcare. The NPCU/SCO for the HOPE-PHC Program will oversee the implementation of the SBCCS and will be responsible for coordinating HOPE-PHC Program activities in the FMOH&SW. One of its key functions will be to work with the national implementing entities and states to develop and implement the SBCCS plan for the program.

6.5   Mechanisms for Establishing Partnerships

The NPCU/SCO will work to coordinate the strategic communications with all relevant implementing agencies, including the NHIA, NPHCDA, NCDC, and NEMSAS and their state counterparts as well as external stakeholders that can contribute to the impact of the program, to ensure the development of appropriate materials for SWAp funding

organizations to sustain their continuous partnership. The HOPE-PHC program will implement activities with all stakeholders to enable regular dialogue and information sharing throughout its lifecycle. Routine and predictable communications with funding partners will reinforce the accountability framework underpinning the HOPE-PHC Program as Nigeria's PHC provisioning SWAp agenda. The program's stakeholder engagement and communications plan prepared by the NPCU/SCO will support activities such as a stakeholder perception survey and advocacy for the State of Health Report as part of the strategy for improving partnerships. The results of the stakeholder perception survey, advocacy for domestic resource mobilization, and advocacy and socialization for of the State of Health Report as part of the strategy for improving partnerships at large will be used to generate critical insights on improving reporting systems, test the alignment of stakeholders to the overall program, and assess how implementation can be further adjusted to ensure continuous support from relevant stakeholders and strengthen public awareness to improve social accountability in the health sector.

6.6   Feedback Mechanisms

The NPCU/SCO must establish a feedback mechanism to gather feedback from stakeholders and the public to continuously improve the project strategy and implementation, identify gaps and address issues of concern. To further promote understanding of social accountability and build trust in government systems, the HOPE-PHC Program will ensure that a GRM is in place and incorporated into the Stakeholder Engagement Plan and will develop referral pathways within three months of effectiveness.

The GRM must be deeply embedded in communities to ensure proper coverage across the country, using appropriate methods, technologies and community structures (e.g. ward development committees, traditional women associations, SMS/social media, community-based organisations etc.). Its effectiveness will be measured by community awareness, accessibility, response time, resolution rates, and stakeholder feedback.

6.7   Monitoring and Evaluation

The NPCU/SCO will establish key performance indicators (KPIs) to measure the effectiveness of the communications strategies adopted across local, state, and federal levels of implementation, particularly as is linked to the project objective of HOPE-PHC. All implementing entities will provide regular reports on the progress of the communications activities to the NPCU/SCO. The NPCU/SCO will conduct stakeholders' perception surveys at least annually to guide the implementation and planning of the communications strategy. It is the overarching responsibility of the NPCU/ SCO to ensure that all stakeholders are well-informed, engaged, and supportive of the HOPE-PHC program, ultimately contributing to its success.

6.8   Establishing HOPE-PHC as a Leading Initiative in Improving National Health Outcomes Led by the FMOH&SW

The NPCU/SCO communication specialist will lead the crafting of corporate identity(-ies) consistent with the messaging style and visual expression for the HOPE-PHC program. The specialist will also support the overall messaging strategies in the health sector which will be domesticated nationwide to strengthen program adoption and delivery.

07

FINANCIAL MANAGEMENT AND PROCUREMENT

Chapter 7 - Financial Management and Procurement

This chapter discusses the public financial management arrangement and permissible procurement guidelines under the HOPE-PHC program. The guidelines will assist program implementing units across all levels, especially accounting and procurement officials, to understand and implement according to the eligible program expenditure base and follow appropriate guidelines in the implementation of the program in accordance with the laws of the Federal Republic of Nigeria in keeping with the creditors' guide from the World Bank. It will also assist contractors, auditors, and other stakeholders in understanding the financial management processes and procurement guides adopted for the implementation of the HOPE-PHC program.
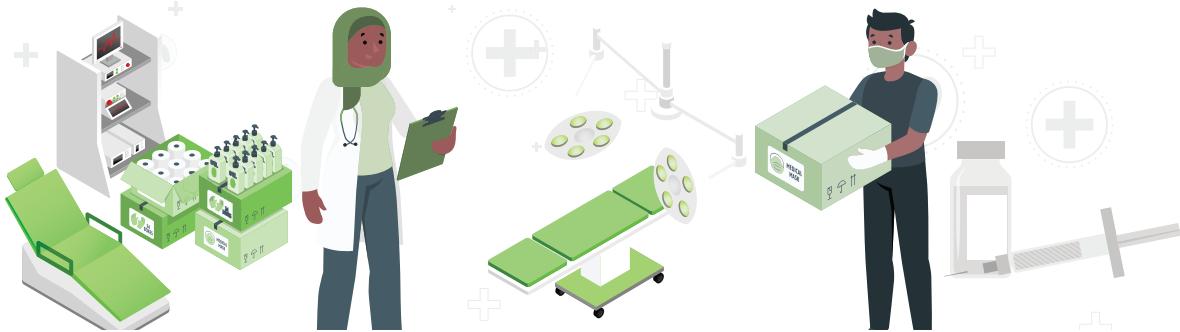
7.1   Financial Management

7.1.1   Objectives of Financial Management

The HOPE-PHC Financial Management program will work towards the following objectives:

1. Ensure that funds are used only for their intended purposes efficiently and economically in alignment with the program fund release policy, which has been

signed by all relevant stakeholders.

2. Ensure that funds are properly managed and flow smoothly, adequately, regularly, and predictably to meet the program objectives in a coordinated approach.

3. Enable the preparation of accurate, reliable, and timely financial reports for the program.

4. Enable the appointed program managers to monitor the program's implementation efficiently.

5. Safeguard the program assets and resources.

The following are necessary features of a strong public financial management system for the HOPE-PHC program:

- NPCU/SCO should have an adequate number and mix of skilled and experienced staff, including at least one qualified accountant from the FPFMD of the OAGF and a procurement officer from the Bureau of Public Procurement.

- The internal control system should ensure an orderly and efficient payment and procurement process, as well as proper recording and safeguarding of assets and resources.

- The accounting system should support the program's requests for funding and meet its reporting obligations to IDA and the other financiers of the HOPE-PHC program.

- The system should be capable of providing financial data to measure performance when linked to the program's output.

- An independent, qualified external auditor with TOR acceptable to the World Bank should be appointed to review the program's financial statements and internal controls.

7.1.2 Institutional Roles and Responsibilities

Responsibility for establishing and maintaining acceptable financial management (FM) arrangements under the HOPE-PHC program lies with the Federal Project Financial Management Department (FPFMD) of the Office of the Accountant General of the Federation (OAGF), within the Federal Ministry of Finance. As part of this arrangement, the FPFMD will assign a trained public finance management accountant to the NPCU/ SCO at the federal level. At the national level, each Implementing Entity will appoint its own program accountant and maintain financial records and reporting functions through its Project Financial Management Unit (PFMU). Similarly, each participating state will operate its own PFMU to manage and report on eligible expenditures and advances. These reports will be submitted to the NPCU/SCO as required.

The FPFMD and PFMUs serve as multi-donor, multi-project financial management platforms established jointly by the Government of Nigeria and the World Bank. These

platforms also support other World Bank–financed operations across Nigeria and will be fully applicable to the HOPE-PHC program.

The FPFMD and PFMUs will be responsible for the following:

- Maintaining books of account, financial records, and internal controls for the HOPE-PHC program;

- Ensuring adequate internal audit arrangements and activities;

- Managing efficient and effective disbursement processes;

- ensuring adequacy and reliability of the program's financial management arrangements

- preparing budgets, providing financial reports, and ensuring compliance with financial management requirements of the World Bank and the Federal Republic of Nigeria.

The head of the FPFMD/PFMU units/ designated program financial management specialist will be accountable for the above-listed responsibilities and will be assisted by support accounting officers and cashiers on the HOPE-PHC Program.

The program's FM system must be fully computerized. The World Bank's generic Financial Procedures Manual (FPM) will be adapted for the HOPE-PHC program.

Program financial statements will be audited in accordance with International Standards on Auditing (ISA)using Terms of Reference acceptable to IDA. These audits will also include a Technical Audit.

This approach to the financial management arrangement and responsibilities facilitates additional pooled contributions to the SWAp, whether disbursed directly to the SCO or through other pooled channels, using the same fiduciary systems described herein.

7.1.3   Financial Management Team Composition

At the federal level and in each state, the financial management (FM) team should include a qualified Program Financial Management Specialist, a Program Internal Auditor, accounting technicians, and a cashier. These personnel will undergo initial training and periodic refresher training throughout the program's implementation period.

All staff assigned to the FPFMD and PFMUs must be well-versed in World Bank financial management procedures. Key personnel responsible for managing program funds must be both experienced and qualified to operate the World Bank's client connection platform and related accounting tools. FM team members tasked with oversight—particularly those involved in monitoring and quality assurance—should be drawn from the FPFMD within the Office of the Accountant General of the Federation (OAGF). This requirement also applies at the state level.

The appointment of key financial management staff shall be carried out by the Accountant-General of the Federation and the respective State Accountants-General,

ensuring that qualified personnel are in place across all implementing entities.

7.1.4   Financial Management Assessment and Mitigation Measures

All implementing entities must undergo a financial management assessment in accordance with the Financial Management Manual and the AFTFM Financial Management Assessment and Risk Rating Principles.

Inherent risks identified during the assessment must be mitigated by setting up PFMUs and appointing skilled accountants from the FPFMD of the OAGF, which features robust controls (internal and external) for its staff when delivering duties. PFMUs must be set up across all implementing agencies and participating states for the program through joint efforts of the government of Nigeria and the World Bank. Also, the PFMUs must obtain adequate experience managing financial flows to multiple levels and be given additional training. Additional mitigation measures include the use of transparent procurement processes in selecting of contractors to implement of sub-awards, computerised accounting systems, and independent and effective internal audit and risk management functions. With these mitigation measures in place, the residual FM risk in the program is not substantial.

The Financial Procedures Manual will detail an internal controls framework and risk management strategy for the Program. Regular reporting arrangements and supervision plans will ensure that the program's implementation is closely monitored and that appropriate remedial actions are taken expeditiously.

At review periods, the FM risks will be re-assessed and updated as appropriate during program implementation.

7.1.5   Internal Controls

Adequate internal controls are in place at both PFMUs and FPFMD but will be strengthened further. The control features at both PFMUs and FPFMD include a robust FM procedures manual; relevantly qualified staff who are well-trained in World Bank procedures and requirements, including procurement; segregation of functions/duties; and highly independent and well-trained internal auditors. The capacity of the internal auditors will be built using a risk-based internal audit approach involving risk mapping. Each State Accountant-General and the Accountant General for the Federation appoint the FM staff. The program internal auditor at the NPCU/SCO will prepare quarterly internal audit reports. Additional controls in the form of an enhanced accountability framework will be implemented to mitigate the risk of misuse of funds for irrelevant soft expenditures, which may include unnecessary trainings, travels, workshops, study tours, etc. The enhanced accountability framework is included in Annex 3.

The fund release policy addresses risk mitigation measures applicable to the use of DLI incentives outside the health sector. All state governors must sign it as part of the program's eligibility and effectiveness condition. This manual and the fund release policy

also provide guidance on eligible expenditures.

7.1.6   Financial Reporting

The HOPE-PHC program maintains a comprehensive financial reporting system to ensure transparency, timely decision-making, and compliance with World Bank and national requirements. The NPCU/SCO is responsible for preparing Interim Financial Reports (IFRs) and consolidated financial statements, while financial data is generated and submitted by the FPFMD and PFMUs across federal and state levels. Two World Bank publications outline the indicative formats for the reports: (a) Financial Monitoring Reports: Guidelines to Borrowers for quarterly FMRs, and (b) Financial Accounting, Reporting and Auditing Handbook (FARAH) for monthly and annual reports.

The NPCU/SCO will prepare the program financial statements which will be audited by an independent audit firm engaged by the NPCU/SCO with the TOR acceptable to IDA. The NPCU/SCO will prepare an audit report and management letter to be submitted to IDA within six months of the end of the government fiscal year. Regular periodic returns will be made to the Federal and State Accountants General for consolidation in the government accounts.

The following entities have essential reporting responsibilities in the program:

Table 7.1: Responsibilities of reporting entities

Reporting Entity	Responsibilities
NPCU/SCO	Prepare and consolidate IFRs and audited statements; submit to IDA
FPFMD and PFMUs	Generate and submit periodic reports to NPCU/SCO
NIEs and SCO (States)	Submit quarterly financial monitoring reports to NPCU for consolidation

Reporting Schedule and Requirements

The FPFMD and PFMU will prepare and submit the following reports to the Program Coordinator of the NPCU/SCO on a monthly/quarterly basis.

Table 7.2: Monthly FM reports

Report	Comments
A Bank Reconciliation Statement for each bank account.	One for each bank account
Monthly Statement of Cash Position	For program funds from all sources, taking into consideration significant reconciling items
Monthly Statement of Expenditure	Classified by program components and disbursement categories; including a budget comparison or variance analysis.
Statement of Sources and Uses of Funds	By Credit Category/Project Activity, showing IDA and Counterpart Funds separately.
Cash flow projections for the following quarter	
Statement of Actual and Budgeted Expenditures	

Income and Expenditure Statement	
Balance Sheet	

The NPCU/SCO will prepare Interim Financial Reports (IFRs) for each calendar semester and submit them to IDA within 45 days after the end of each calendar semester (by February 15 for Semester 1 and by August 14 for Semester 2). The formats of IFRs have been developed at appraisal and agreed upon at Negotiation and are provided in annex 1 to this POM. On a semester basis, the FPFMU/PFMU will also prepare the following reports for submission to the Program Coordinator of the NPCU/SCO. The documents will also be submitted to IDA.

Table 7.3: Semester FM reports

Report	Comments
Financial Reports	•Include a statement showing for the period and cumulatively (program life or year to date) inflows by sources and outflows by main expenditure classifications; beginning and ending cash balances of the program; and supporting schedules comparing actual and planned expenditures. •Also include cash forecasts for the next two quarters.
Physical Progress Reports	•Include narrative information and output indicators (agreed upon during program preparation) linking financial information with physical progress and highlighting issues that require attention.
Procurement Reports	•Includes information on the procurement of goods, work, and related services, the selection of consultants, and on compliance with agreed procurement methods. •Compare procurement performance against the plan agreed upon at negotiations or subsequently updated and highlighting key procurement issues such as staffing and building borrower capacity
SOE Withdrawal Schedule	•This will list individual withdrawal applications relating to disbursements by the SOE Method, by reference number, date, and amount. •Each PFMU will submit a copy of the quarterly semester Program Financial Monitoring Reports to the NPCU/SCO, who will also submit the same to the SPMC. •Also, the NIEs and the SCO will forward copies of their quarterly Program Financial Monitoring Reports to the NPCU for consolidation. •The NPCU/SCO will submit the consolidated semester reports (IFR) to the World Bank.

The annual program financial statements, prepared by the FPFMD/PFMU, will include

similar statements as shown in the semester report requirements. In addition, the schedules of debtors, advances, cash and bank balances, local and foreign creditors, funds received from IDA, fixed assets, and statements of expenditure and financing should be included.

- A Statement of Sources and Uses of Funds (by credit category/by activity showing IDA and counterpart funds separately).

- Statement of Cash Position for Program Funds from all sources.

- Statements reconciling the balances on the various bank accounts (including IDA Special Account) to the bank balances shown on the Statement of Sources and Uses of Funds.

- SOE withdrawal schedules listing individual withdrawal applications relating to disbursements by the SOE Method, by reference number, date, and amount.

- Notes to the Financial Statements. The PFMU will submit a copy of the Program financial statements to the BHCPF SOC. The BHCPF SOCs will forward a copy of the financial statement to the NPCU/SCO for consolidation.

7.1.7 Risk Mitigation and Governance

In addition to the fund release policy, FM Governance and anti-corruption (GAC)-related risks in the program will be managed by a specialist who will ensure GAC-related complaints are tracked and investigated through handling mechanisms which have been pre-established; CSOs will also contribute to the overall accountability framework in the program, ensuring oversight for transparency and accountability on the program implementation at community level.

7.1.8 Audit (Internal and External)

7.1.8.1 Method of Auditing

Both pre- and post-payment audits will be conducted to ensure internal controls in the program. Pre-payment audit is a process where payment vouchers (PVs) are audited before payments are effected. Post-payment audit is a process of PV reviews after the payment has been effected.

7.1.8.2 External Control and Audit

The annual financial statements of the program across the national and states levels will be audited by the Office of the Auditor General for the Federation and an independent external audit firm recruited based on a ToRs acceptable to IDA. The ToR will include provision for the auditor to provide a special opinion on the expenditures incurred on civil works, renovations and upgrades, trainings, workshops, and study tours, identifying any expenditure that is considered ineligible or not aligned with the fund release policy.

The auditor will express an opinion on the annual financial statements in compliance with International Standards on Auditing. In addition to the audit report, the external auditors will also prepare a Management Letter, which will be submitted with a copy of the audited financial statements to IDA no later than six months after the end of each financial year.

7.1.9 Financial Management Implementation Support Plan

FM supervision will be consistent with a risk-based approach and involve collaboration with the World Bank's FM and procurement teams. The supervision intensity will be based initially on the FM risk rating specified in the PAD, and subsequently on the updated FM risk rating during implementation of the program. Flexibility, including virtual supervision, alternative arrangements for field visits, and remote supervision through GPS-enabled technology, will also be considered. Given the substantial residual risk rating, on-site supervision will occur twice a year. The on-site review will cover all aspects of FM, including internal control systems, the overall fiduciary control environment, and tracing transactions from the bidding process to disbursements and SOE review.

Additional supervision activities will include desk review of semester IFRs, quarterly internal audit reports, audited Annual Financial Statements and management letters, as well as timely follow up of issues that arise and updating the FM rating in the Implementation Status Report (ISR) and the Portfolio and Risk Management (PRIMA) system. The World Bank project team will also support in monitoring the timely implementation of the action plan and the achievement of DLI results..

7.2 Budgeting, Accounting, and Disbursement

7.2.1 Planning and Budgeting Procedures

7.2.1.1 Budget Preparation

Budget preparation will follow the federal or state government procedures, as appropriate. On an annual basis, the designated Program Accountant/Financial Management Specialist (in consultation with key members of the implementing unit) will prepare the budget for the fiscal year. Detailed procedures for planning and budgeting are documented in the FPM. A Standing Budget Committee should be constituted, which will be headed by the NPM while PA serves as his Secretariat for corresponding to all concerned units. The functions of the Budget Committee secretariat are to receive the Annual Work Plan and Budget of all units to collate them into one document. A Joint session will be held by all units with NPC to review the plan and budget and ensure it is realistic and reasonable before being transmitted by NPC to TTL.

7.2.1.2 Cash Budget Preparation

The cash budget should include the figures for the year, analysed by quarter. The cash budget for each quarter will reflect the detailed specifications for program activities,

schedules (including procurement plan), and expenditure on program activities scheduled respectively for the quarter. (Guidance on budget preparation is available in the World Bank publication entitled Financial Monitoring Reports: Guidelines for Borrowers.) The annual cash budget will be sent to the World Bank's Task Team Leader no later than 31 October in order to obtain the World Bank's "No Objection". The accounting staff's capacity to fulfil the program's budgeting needs must be updated regularly.

7.2.2   Advances: Use and Retirement

The national implementing entities and participating states are eligible for credit advances on the HOPE-PHC program. However, all PFMUs/FPFMD must ensure that all advances granted are retired with adequate documentation for forwarding to the World Bank for reimbursement as SOEs. Also, the government's no-retirement policy on advances does not apply; advances spent on ineligible expenditures, and the inadequate understanding of the World Bank FM requirements may also result in the return of advances. All granted expenses are expected to be retired within two (2) weeks after the assignment has been completed. This is to provide evidence for accountability.

To mitigate the risks arising from these issues, adequate procedures for handling advances against expenses, including remedial actions in the event of default, will be as described in the Financial Procedures Manual (FPM). An indicative checklist of appropriate supporting documents for incurred eligible expenditures that have been incurred will be developed and included in the FPM. Where an officer has failed to retire the statement of expenses on two previous trips, such an officer does not qualify for no further cash advances until all previous expenses are fully retired and approved in line with the World Bank FPM.

7.2.3   Disbursement Arrangements

The program will use the report-based disbursement procedures at effectiveness. The independent verification agent will prepare disbursement reports based on the review of DLIs and the achievement of those DLIs as per the verification protocol for the DLIs. Disbursements will be based on a review of the report submitted to the IDA by the IVA and acceptable results will be authorised for payment. For the approved and allowable advance under the program, disbursement will be done on a transaction basis where the national implementing entities and states that qualify for an advance will develop and provide a work plan to the IDA.

Only approved plans will be authorised for disbursement by the IDA. When program implementation begins, the calendar semester IFRs produced within the program will be reviewed by the World Bank with the expectation that adequate information is provided on the utilisation of the advanced funds. For the IPF component of the program, the NPCU/SCO and IAs will develop a work plan at effectiveness. Disbursements will be on a transaction basis; however, following implementation with timely and satisfactory IFRs, the borrower may request conversion to a report-based disbursement process. In such

a case, the World Bank program team will undertake a review to determine if the IPF component is eligible for report-based disbursements.

Details of the disbursement arrangement will be in the Disbursement Letter and as applicable in the World Bank's FPM.

Issues of inadequate documentation for incurred expenditures and poor-quality IFRs flagged in the FM and external audit reports during the implementation of the HOPE-PHC program implementation can result in the switch to transaction-based disbursement procedures and not report-based disbursement at effectiveness. A flexible disbursement ceiling will be applicable for national, and state implementing entities. This ceiling will be derived from the approved Annual Operational Plans and budget specifics and linked to the HOPE-PHC program. The ceiling will be reviewed annually and revised based on expenditure forecasts for each financial year until conditions are suitable to return to a report-based disbursement approach.

All states must abide by and adopt the fund release policy (Annex 8). The NSC reserves the authority to remove states that do not abide by the fund release policy from the program.

7.2.4   PforR Disbursement Arrangements

Annual disbursements for performance-based financing will occur only after the Bank decides to disburse. This decision follows the receipt of evidence showing that states have met the Program EC and DLRs through the APA process, as verified by the IVA, and includes any necessary adjustments. The Bank will formally notify the NPCU/
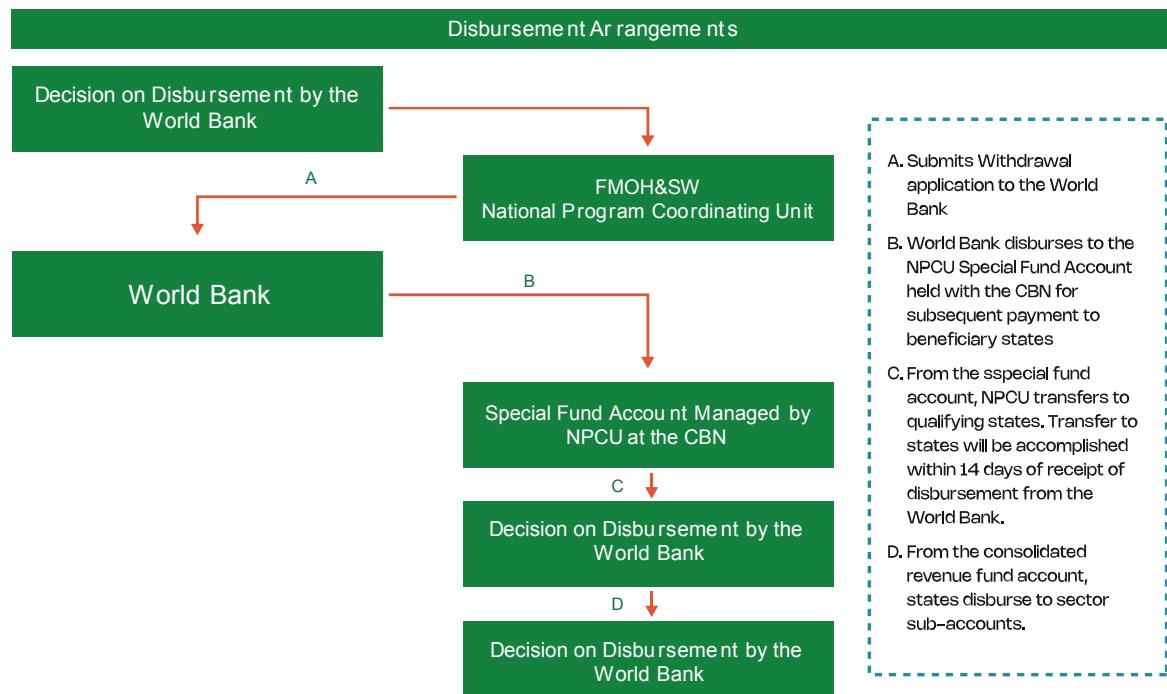
Figure 7.1 Disbursement arrangements

SCO and participating states of this disbursement decision. States can only access PforR/ performance-based financing after signing the Subsidiary Grant Agreement (SGA). This SGA is a legal contract between the federal government, acting as the borrower, and the states that are the beneficiaries. States that have not signed the SGA will have their PforR/ performance-based financing payments withheld until the agreement is finalized.

The flow of funds arrangement is triggered by the Bank's concurrence with the verification. See figure 7.1 below and figure 7.2 for and alternate disbursement arrangement for co-financing organizations/agencies using a named donor agency.

- Upon receiving the decision to disburse from the World Bank, the NPCU/SCO will

1. IVA verifies results achieved and prepare report

2. IVA sends report to NPCU

3. NPCU reviews report and sends to WB

4. WB sends report to JICA

5. WB reviews report and clears, after which notifies the NPCU to submit WA

6. NPCU submits WA

7. WB/JICA disburse to NPCU through the special Funds Account opened separately and held with Central Bank of Nigeria

8. NPCU exchanges USD/JPY to Naira at CBN prevailing exchange rate on the day of transaction.

9. NPCU transfers to qualifying states within 14 days of disbursement by WB and JICA

10. Auditor reviews Financial Statements

11. Issues audit report and management letter by June 30th to NPCU.

12. NPCU sends audit report and management letter to WB and JICA

13. At closure, NPCU/WB reconcile the disbursement throughout project life.

14. WB/JICA seek for refund if necessary (where total contributions from the borrower is less than total contributions from WB/JICA contributions throughout the project life)

Figure 7.2 Disbursement arrangement for co-financing

submit a Withdrawal Application (WA) to the World Bank using the World Bank's standard disbursement forms through the e-disbursement functionality in the World Bank's Client Connection system

- The IDA credit proceeds will be disbursed to the federal government's Special Fund Account, which serves as a sub-account of the federal TSA held with the CBN and managed by the Secretariat at the FMOH&SW as the program's NPCU/SCO

- The NPCU/SCO will make disbursements to national implementing entities and individual states from the Special Fund Account to the Consolidated Revenue Fund accounts of the national implementing entities and state governments strictly in accordance with the decision to disburse made by the Bank

- Funds should be transferred to the national implementing entity/individual states' accounts within 14 days of receiving the IDA credit proceeds for the PforR component into the Special Fund Account held with the CBN

- If a decision to disburse is delayed by over four weeks for all implementing entities/participating states due to disputes or verification issues concerning the achievement of Disbursement Linked Indicators (DLRs), disbursements should continue for the subset of implementing entities/states where the Bank has decided to disburse. This approach prevents delays in the regular annual Program-for-Results (PforR) cycle timelines. The arrangement for the flow of funds, following the decision to disburse for these national implementing entities/states, will remain consistent with what was previously outlined.Prior results (DLIs 5.1, 8.1, and 9.1) are expected to be achieved before the HOPE-PHC Program's legal agreements are signed. Combined with the achievement of prior results, estimated at US$7.5 million, the total disbursement upon effectiveness is expected to be US$62.5 million (not more than 30 per cent of IDA financing), within the PforR's allowed threshold. There will be an advance equivalent of up to 30 per cent of the total value of DLI 1.1, 1.2 and 5.2, totalling US$55 million. The advance is necessary to implement activities to achieve DLIs in the initial years, benefitting activities with longer lead times (such as capital investments). When the DLIs are achieved, the advance amount will be deducted (recovered) from the amount due to be disbursed and will be available again on a rolling basis, as requested by the government.

7.2.5   Funds Flow and Banking

According to the financial agreement, the HOPE-PHC program funding will consist of government funding and IDA credit for achieved and verified results. All program funds will be used in line with the Financing Agreement, Fund Release Policy, and the World Bank FM procedures.

IDA will disburse the credit to the Designated Accounts opened with the Central Bank of Nigeria at the Federal and State levels 10 which will be managed by FPCU/FPFMD, National Implementing Entities (NIEs)/PFMUs and State Implementing Entities (SIEs)/PFMUs at the Federal and State levels respectively.

The specific banking arrangements are as follows:

NPCU/SCO

Account Type	Currency	Purpose / Use
Designated Account (DA)	USD	Receives initial deposit and replenishments from IDA Held at the Central Bank of Nigeria.
Current (Draw-down) Account	NGN	Receives drawdowns from the DA for incurred eligible NPCU/SCO expenditures Will maintain near-zero balance post-payment

National Implementing Entities (NIEs)

Account Type	Currency	Purpose / Use
Designated Account (DA)	USD	Receives advances, replenishments, and DLI earnings from IDA.
Current Draw-down Account	NGN	Receives drawdowns from the DA for incurred eligible expenditures Will maintain near-zero balance post-payment
Current Program Counterpart Account	NGN	Where applicable Receives parallel fund contributions from government for planned expenditures
Current Program Interest Account (IDA)	NGN	Holds interest earned on IDA funds for planned expenditures.
Current Program Interest Account (Counterpart)	NGN	Holds interest on parallel fund contributions from the government.

State Implementing Entities (SIEs)

Account Type	Currency	Purpose / Use
Designated Account (DA)	USD	Receives advances, replenishments, and DLI earnings from IDA.
Current (Draw-down) Account	NGN	Receives drawdowns from the DA for incurred eligible expenditures and fund release policy Will maintain near-zero balance post-payment
Current Program Counterpart Account	NGN	Where applicable Receives parallel fund contributions from government for planned expenditures
Current Program Interest Account (IDA)	NGN	Holds interest earned on IDA funds for planned expenditures.
Current Program Interest Account (Counterpart)	NGN	Holds interest on parallel fund contributions from the government.
Earned Incentives Usage	NGN	Must be used only for activities in the approved Annual Operational Plan "No Objection" from World Bank Task Team Lead.

Incentive Sharing Mechanism	NGN	Up to 20% of earned incentives may be shared as productivity allowances to key officers driving performance
		Subject to "No Objection" from World Bank Task Team Lead.

7.2.6 Cash Management and Petty Cash

The NPCU/SCO shall maintain petty cash of not more than N500,000.00 only monthly, to cater for the payment, purchases, and reimbursement not exceeding N50,000.00 to be paid out of the petty cash. A register should be maintained for all the payments made from petty cash. A proper book of account must be maintained for the petty cash movement to record serial receipts and disbursement in a way that the balance outstanding can be ascertained at any point in time.

7.2.7 Signatory and Authorization Arrangements

7.2.7.1 Bank Account Signatories

All payments must be jointly signed by one signatory from each of two designated panels: Panel A and Panel B. Each panel may designate a maximum of two officials (Table 7.1). These dual signatory rules apply at both the federal (NPCU/SCO) and state program coordinating units (SPCUs).

Monthly bank reconciliations will be conducted by the Program Accountant. Designated officials must review all reconciliations, and any discrepancies must be investigated promptly.

Table 7.4 Signatories to Program Accounts

	Panel A	Panel B
Main Signatory	NPCU/SCO	Program Accountant
Alternate	Director, Health Planning Research and Statistics	Director, FPFMD

7.2.7.2 Authorisation and Approval Limits

Authorisation and approval limits shall be in line with the Program Financial Manual.

7.2.7.3 Delegation of Authority

Where an authorizing officer has delegated his powers to a subordinate officer, he remains responsible for the efficient performance of the delegated authority.

An officer may not make payment against a voucher unless:

a. It is properly signed, authorized, and approved for payment by the appointed signatories.

20 - Guidebook for Setting-up and Operating the Framework Agreement available at https://documents1.worldbank.org/curated/en/958921624026529503/pdf/Guidebook-for-Setting-up-and-Operating-Framework-Agreements.pdf

b. It bears the appropriate classification and accounts code.

c. All computations have been adequately checked and confirmed as accurate.

7.2.8 Accounting Arrangements

The program will adopt a cash basis of accounting for IDA funds. A computerized accounting system will be used, leveraging the flexible accounting software currently deployed at the FPFMD and PFMUs. This system will be expanded to accommodate HOPE-PHC program activities. Annual financial statements will be prepared in accordance with applicable International Public Sector Accounting Standards (IPSAS). All accounting procedures and internal controls are outlined in the Financial Procedures Manual (FPM), which will serve as a living document subject to periodic review and updates. Relevant training will be provided to FPFMD and PFMU staff to ensure effective use of the system and compliance with program requirements.

7.2.9 Books of Accounts and List of Accounting Codes

NPCU/SCO will maintain adequate and appropriate books of accounts. The books of accounts to be maintained for HOPE-PHC will include cash books, ledgers, journal vouchers, a fixed asset register, an advance register and a contract register, a cheques issued register, a general ledger, a vote book, an IDA credit drawdown register, a register of Statement of Expenditures (SOEs), and store records.

At the PFMU, a fixed asset register will be prepared, regularly updated, and checked. A contract register will also be maintained for all contracts with contractors, consultants, and suppliers. A quarterly Contract Status Report will also be prepared. Control procedures over fixed assets and contracts with contractors, suppliers, and consultants for Federal and State levels will be documented in the FPM.

The books of accounts will be maintained on a computerised system. A list of account codes (Chart of Accounts) for the program will be drawn up. This shall match the classification of expenditures and sources and application of funds to be indicated in the Financing Agreement. The chart of accounts should be developed so that program costs can be directly linked to specific work activities and program outputs.

The books of accounts to be used for the program will be opened, and a Chart of Accounts will be completed in accordance with the standard provision in the Financing Agreement for maintaining books of accounts for the program.

The PFMU will be responsible for preparing and submitting consolidated applications for withdrawal to the World Bank, as appropriate. The Financial Procedures Manual documents proper procedures and controls to ensure that disbursements and funds flow are carried out efficiently and effectively.

The PFMU will maintain a cumulative record of drawdown in the credit that will be reconciled monthly with a disbursement summary provided by the World Bank.

The Program Financial Management Specialist in the NPCU/SCO will be responsible for all the program's financial transactions. He/she will also render implementation assistance to the FPFMD/PFMU on loan drawdown, with emphasis on the use of Statements of Expenditures (SOEs) and the operation of special accounts.

7.3   Procurement Management

Procurement under the HOPE-PHC program shall be conducted in accordance with the following:

- World Bank Procurement Regulations for IPF Borrowers (February 2025),
- Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants (July 1, 2016),
- The provisions of the HOPE-PHC Financing Agreement.

7.3.1   Procurement Strategy and Planning

Procurement activities under the PforR component will be carried out by all federal and state-level implementing entities. These must align with the Eligible Expenditure Framework in the program fund release policy and with the World Bank Procurement Regulations. They must also follow competitive procurement procedures for activities above the program's established threshold.

Procurement is a critical activity in program implementation. Delays in procurement are the primary cause of implementation delays and even program failures. Delayed procurement may drastically reduce the time available for the execution.

To facilitate program implementation, a procurement plan is to be drawn by the NPCU/SCO in accordance with the IPF component of the program with targets to be achieved in the most effective, economical, and timely manner. Implementing entities will also be required to draw up procurement plans for advances requested on the program, ensure all expenditure using resources obtained from the program are aligned eligible expenditures, and follow the World Bank Procurement Regulations for borrowers in a manner approved by the World Bank.

The NPCU/SCO and all implementing entities in the program shall update the Procurement Plan annually or as needed throughout the duration of the program and shall implement the Procurement Plan in the manner approved by the World Bank. Each update to the Procurement Plan requires issuance of a "No Objection" of the World Bank.

Procurement activities carried out without an approved procurement plan are considered ineligible expenditures and not financed by program funds. In addition, a framework agreement will be developed for repititive items (goods and services recurrently used by Implementing Agencies) in accordance to the Guidebook for Setting-up and Operating the Framework Agreement prepared by the World Bank[20]

23 - Guidebook for Setting up and Operating Framework Agreements available at https://documents1.worldbank.org/curated/en/958921624026529503/pdf/Guidebook-for-Setting-up-and-Operating-Framework-Agreements.pdf

7.3.2 Procurement Responsibilities

Procurement responsibilities under the IPF component will be led by the NPCU/SCO at the Federal Ministry of Health and Social Welfare (FMOH&SW). The categories of procurement include goods, non-consulting services, and consulting services. Procurement of works is not anticipated under the Technical Assistance (TA) component.

Specific consulting assignments will include:

- The deployment of the federated digital-in-health architecture,

- Engagement of an Independent Verification Agent (IVA) firm by the FMBEP,

- Consultants to support capacity strengthening of the NPCU/SCO,

The NPCU/SCO may also engage consultants or firms for specific TA to support states in achieving DLRs.

As required by the Procurement Framework, the program will prepare a Program Procurement Strategy Document (PPSD). The PPSD will guide the preparation of the first 18-month Procurement Plan and subsequent annual plans. The program Procurement Plan for the IPF component and advances must be developed and submitted for approval.

For each contract to be financed by the credit, the different procurement methods, or consultant selection methods, estimated costs, prior review requirements, and time frame are agreed between the Recipient and the World Bank in the Procurement Plan.

The Procurement Plans for the IPF component of the program and advances can be updated, as necessary and in agreement with the World Bank, at least annually to reflect the program's actual implementation needs and improvements in institutional capacity.

Advance procurement of key TA activities will be critical.

All procurement actions for the program will be the combined responsibility of the Procurement Staff across all implementing entities and the relevant technical teams of NPCU/SCO. The NPCU/SCO procurement unit will play a central role in overseeing and monitoring the execution of all procurement plans to ensure compliance with the approved procedures and timelines. The NPCU/SCO Procurement Unit will consist of a Procurement Specialist; other procurement staff may be hired as needed to assist the Procurement Specialist.

To activate the procurement procedures, the procurement specialist will prepare an initiation memo, which the National and State Coordinators, NPCU/SCO. Following approval, the documentation process shall commence, and following documentation, the program coordinator shall authorise the procurement provided documentation is complete and due process has been followed. Incomplete documentation or failure to follow due process by the procurement units should be returned without action to the procurement specialist.

7.3.3 Staffing of the Procurement Unit

The procurement unit shall consist and be led by a procurement specialist who is supported by two procurement assistants.

7.3.4 Procurement Unit

The Procurement Unit shall perform the following functions:

- Supervise the procurement activities of the program.

- Ensure procurement procedures as contained in the procurement manual approved by the IDA are followed in all procurement activities.

- Understand and use procurement documents including the World Bank's procurement regulations for IPF borrowers, the Project Implementation Manual (PIM), procurement plan, standard procurement documents (SPDs), request for proposals (RFPs) and other relevant templates in procurement processes

- Ensure that all contracts are delivered per the standards and specifications of the contracts and that all engineering components of the program, particularly the maintenance and the rehabilitation of infrastructure, are implemented per relevant program procurement documents.

- Conduct market research for all the items to be procured for the program.

- Prepare procurement plans and progress reports for inclusion in the Financial Monitoring Report to be submitted to IDA.

- Provide technical assistance and support to the program team in preparing budgets/ plans.

- Prepare bid documents, provide instructions for bidders on procedures for submission of bids or proposals, and liaise with the user departments or subject experts to prepare technical specifications for materials or terms of reference for services to be procured.

- Provide professional guidance to the bid evaluation committee members.

- Follow up on contract recommendations and awards, source price quotations from suppliers, and ensure insurance cover for all assets and imports.

- Provide appropriate materials to the World Bank for issuance of its "No Objection" on all procurement activities.

- Keep adequate records of procurement activities in the NPCU/SCO.

- Organise and coordinate procurement workshops and training for the NPCU/ SCO.

- Work with the user department with regard to contract administration. A contract management plan should be adopted for each contract to ensure that the terms and conditions of the contracts are adhered to.

- Ensure that the Procurement Plan is uploaded and approved in STEP (Systematic Tracking of Exchanges in Procurement) and that all procurement activities are implemented following the Procurement Plan. Where an activity is post-review, all documents related to the procurement process of said activity shall be uploaded to STEP regularly and as when due.

- Ensure the standardized framework agreements for procurement of recurring items are followed[23].

7.3.5 Eligible Expenditures

WORKS

- Office Partitioning
- Civil works including renovations and retrofitting of climate-resilient structures (not including new building)

GOODS

- Medical equipment
- Health facility furniture
- Program vehicle(s)
- Computers
- Software (licenses) for GIS, Database Management, Image Treatment, Word Processing, Spreadsheets, etc.
- Accessories
- Communication equipment
- Office equipment
- Stationery

SERVICES

- Remuneration and allowance (HRH)
- Consultancy services (individual, firm)
- Health insurance payments

7.4 Procurement Methods and Thresholds

Table 7.5 Thresholds for Procurement Methods and Prior Review

No.	Expenditure Category	Contract Value Threshold** (USD)	Procurement Method	Prior review requirement

1	Goods and Non-Consulting Services	≥5,000,000	International Competitive Bidding (ICB)	All contracts
		150,000 ≥ and < 5,000,000	National Competitive Bidding (NCB)	All contracts > 1,500,000
		<150,000	Shopping / Request for Quotations	None
		All values	Direct Contracting	All contracts
2	Works	≥20,000,000	International Competitive Bidding (ICB)	All contracts
		250,000 ≥ and < 20,000,000	National Competitive Bidding (NCB)	All contracts > 5,000,000
		<500,000	Shopping / Request for Quotations	None
3	Consulting Services (Firms)	≥500,000	QCBS, International	All contracts
		200,000≥ and < 500,000	QCBS, National	None
		< 200,000	CQS	TOR only
	Consulting Services (Individuals)	≥ 200,000	Individual Consultant Selection (IC)	All contracts
		< 200,000	Individual Consultant Selection (IC)	TOR only (except procurement consultants)
	Consulting Services (Firms and Individuals)	All values	Single Source Selection (SSS)	All contracts
4	Training, Workshops, Study Tours	All values	Based on Annual Work Plan & Budget	As per approved Annual Work Plan

**These thresholds are for the purposes of the initial procurement plan. The thresholds will be revised periodically based on re-assessment of risks.

7.4.1   Procurement of Goods, Works, and Services

7.4.1.1   Request for Quotation

The Request for Quotation (shopping) method may be used for procurement of the following:

1. Readily available off-the-shelf goods that cannot be grouped

2. Commodities with standard specifications where the contract is valued below 150,000 USD equivalent

3. Small/minor Civil works values to USD500,000

This is in line with Section XII of the World Bank Procurement Regulations for IPF Borrowers and the "Guidance on Shopping Memorandum" issued by IDA, June 9, 2000.

Procurement via request for quotation will proceed according to the following steps:

Table 7.6: Steps for Procurement via request for quotation

Phase	Step
Preparation	1.Develop a vendor database with a clear audit trail of how vendors were selected.
	2.Subject experts in the user department prepare specifications and drawings based on the Bill of Quantity (BOQ) or lump sum.
	3.Procurement Specialist (PS) initiates the procurement action and submits it to the National Program Coordinator (NPC) for approval.
Quotation Solicitation	4.PS sends a Request for Quotation to at least three firms selected from the program's vendor database.
Evaluation	5.NPC sets up an evaluation committee, including the Procurement Specialist as secretary or member.
	6.Evaluation Committee evaluates received quotations strictly based on the pre-disclosed evaluation criteria, avoiding any discretionary or extraneous criteria.
	7.Procurement Specialist prepares the Bid Evaluation Report and submits it to the NPC for approval.
Award Notification	8.Issue a Notification of Award to the most advantageous evaluated bidder.
Contract Finalization	9.Sign the contract with the selected vendor.

7.4.1.2   International Competitive Bidding (Prior Review)

The goods to be procured are generally standard off-the-shelf and low-value goods, which may not exceed the National Competitive Bidding (NCB) threshold. Any procurement of goods that fall within the International Competitive Bidding (ICB) threshold shall use the World Bank standard procurement documents[21]

All contracts whose values are within the Thresholds of International Competitive Bidding (ICB) or Request for Bids – International are subject to Prior Review by the World Bank.

Procurement via ICB follows these steps:

Table 7.7: Steps for Procurement via ICB

Phase	Step
Preparation	1.Procurement Specialist and subject experts in the user department prepare specifications, BoQ, and drawings
	2.Procurement Specialist (PS) submits specifications, BoQ, and drawings to the National Program Coordinator (NPC) for approval.
Quotation Solicitation	3.Advertise the Invitation for Bids (IFB) on public notice boards, in the Tenders' Journal, in at least one widely circulated national newspaper, and on the World Bank and UNDB online portals
Evaluation	4.Conduct public bid opening
	5.NPC constitutes the Evaluation Committee
	6.Evaluation Committee reviews bids based on pre-disclosed evaluation criteria
	7.Submit Bid Evaluation Report to NPC for approval
Award notification	8.Issue Notification of Intention to Award Contract to all evaluated bidders, observe standstill period for debriefings to unsuccessful bidders and resolution of all petitions concerning the bidding process

	9.Send Bid Evaluation Report to NPCU/SCO consultant and to the World Bank for clearance and "No Objection"
	10.Send contract award notification to selected bidder
Contract finalization	11.Sign contract

7.4.1.3   National Competitive Bidding

National Competitive bidding is subject to post review. NCB procurement will take place through the following steps:

Table 7.8: Steps for Procurement via NCB

Phase	Step
Preparation	Procurement Specialist prepares SPDs, specifications and BOQs in liaison with Technical/User departments
	PS submits SPDs, specifications, and BOQs to Program Coordinator for approval
	Sends to NPCU/SCO /Procurement Consultants/Specialist for review
	Reviewed documents are sent to the World Bank for issuance of its "No Objection"
Advertisement	Advertisement carried in at least 2 (two) national dailies and in the Federal or State Tenders Journal
Bid Opening	Public Bid Opening
Evaluation	Program Coordinator constitutes the Evaluation Committee
	Evaluation Committee evaluates bids/proposals based on pre-disclosed evaluation criteria b
	Procurement Specialist prepares a Bid Evaluation Report
	Procurement Specialist submits Bid Evaluation Report to Program Coordinator for approval
	The Implementing Entity submits the Bid Evaluation Report to the NPCU/SCO for review
	The NPCU/SCO sends the reviewed Bid Evaluation Report (with comments) to the World Bank for issuance of its "No Objection"
Award Notification	Notification Intention to Award Contract to all evaluated bidders/proposers â with standstill period for debriefings to unsuccessful bidders/proposers and resolutions of all petitions concerning the bidding process
	Notification of contract award
Contracting	Signing of contract

7.4.2   Procurement of Consulting Services

Consultants shall be selected using either Direct Selection, Quality and Cost-based Selection (QCBS), Consultant Qualification Selection (CQS), Fixed Budget Selection (FBS), or Least Cost Selection methods.

Requests for Expressions of Interest, consultant shortlists, and the World Bank's standard Request for Proposals or Requests for CVs shall be prepared and issued in accordance with the procedures outlined in Sections VII and XII of the World Bank Procurement Regulations for IPF Borrowers

All procurement of consulting services under the HOPE-PHC program should follow the World Bank Procurement Regulations. Specifically:

- Shortlists for contracts below USD 500,000 may comprise only national consultants, per paragraph 7.25.

- Selection for services requiring hiring of research institutes, universities, and public training institutions, as well as hiring of individuals from these entities, shall follow paragraph 3.23.

- Selection of NGOs shall comply with paragraph 7.29.

- Selection of consultants for studies, data collection, training, and M&E shall follow paragraphs 1.13(b–e) and 3.16 of the Consultant Guidelines.

7.4.2.1   Preparation of Terms of Reference (TOR)

The NPCU/SCO, in collaboration with the responsible technical officers for each component, shall prepare or finalize Terms of Reference (TORs) and shortlists for all consultancy assignments.

Where a selection is subject to prior and post review before being issued to consultants, all TORs shall be submitted to the World Bank for its "No Objection".

7.4.2.2   Shortlisting

When preparing the shortlist, the NPCU/SCO shall give priority to firms that demonstrate both interest and appropriate qualifications. The shortlist must reflect a wide geographic distribution and include no fewer than five (5) and no more than eight (8) eligible firms. Per paragraph 7.16 of the World Bank Procurement Regulations for IPF Borrowers, the shortlist must consist only of firms that have expressed interest and possess the relevant experience, management, and organizational capacity required for the assignment.

During the "No Objection" process, the World Bank may request changes to the number of firms on the list. Once the Bank has issued its "No Objection" to the shortlist, the NPCU/SCO may not add or remove any firm without the Bank's explicit approval.

The final version of the shortlist shall be shared with all firms that expressed interest and with any firm that specifically requests a copy.

7.4.2.3   Quality and Cost-based Selection (QCBS) Procedures

Quality and Cost-Based Selection (QCBS) is a competitive process used to select a consulting firm based on both the quality of its proposal and the cost of its services. It is appropriate when the scope of work is well-defined and staff time, costs, and other inputs

can be estimated with reasonable accuracy.

For the engagement of firms through QCBS procedures, the RFP shall include (a) a Letter of Invitation, (b) Information to Consultants, (c) the TOR, and (d) the Proposed Contract.

QCBS will consist of the following steps:

Phase	Step
Planning and Preparation	1. Prepare REOI and TOR
	2. Submit REOI and TOR for World Bank review
	3. Receive the World Bank's "No Objection" on REOI and TOR
	4. Advertise EOI in appropriate media
	5. Submission of EOI by interested/potential consultants
Shortlisting	6. Create an Evaluation Committee
	7. Shortlist a minimum of five (5) and not more than eight (8) eligible firms
	8. Submit shortlist and RFP to the World Bank
	9. Receive the World Bank's "No Objection" on shortlist and RFP
Proposal Submission and Evaluation	10. Issue RFP to shortlisted consultants
	11. Receive proposals from consultants
	12. Opening and evaluation of technical proposals
	13. Submit technical evaluation report to the World Bank
	14. Receive the World Bank's "No Objection" on technical evaluation
	15. Opening of financial proposal
	16. Prepare and submit a Combined Technical and Financial Evaluation Report for World Bank review
	17. Receive 'No Objection' on Combined Technical and Financial Evaluation Report
Award and Contracting	18. Notification of Intention to Award Contract followed by standstill period
	19. Contract negotiation
	20. Submit Minutes of Negotiation and Draft Contract to the World Bank and receive 'No Objection'
	21. Notify selected service provider of award
	22. Signing of contract
	23. Send signed contract to the World Bank
Contract Implementation	24. Contract Management

7.4.2.4 Consultant Qualification (CQ)

The CQ method is appropriate for small assignments or emergency situations in which preparing and evaluating competitive proposals is not justified.

CQ selection will consist of the following steps:

Planning and Preparation	1.Prepare Request for Expression of Interest (attaching the TOR) and share to at least three qualified firms, who shall be requested to provide information about their relevant experience and qualifications. (Advertisement of REOIs is not mandatory)

Shortlisting	2.Evaluate the submitted EOIs and select the firm with the best qualifications and relevant experience.
Proposal Submission and Evaluation	3.Invite the firm to submit technical and financial proposals for negotiation
Award and Contracting	4.Issue Notification of award upon successful negotiation
	5.Contract signing
Contract Implementation	6.Acceptance of the first draft or interim report
	7.Acceptance of first report

7.4.3   Procurement of Individual Consultants

Individual Consultants (ICs) will be engaged for assignments that do not require a team of experts, do not need additional home office support, and that require individuals with outstanding qualifications and relevant experience.

The following individual consultants will be required under HOPE-PHC program:

- Financial audit

- Monitoring, Evaluation, and Health System Assessment Specialist

- Health Financing Specialist

- Stakeholder Engagement Specialist

- Strategic Communications Specialist

- Environment and Safety Adviser

- Climate and Health Adaptation Adviser

- Social Safeguards and GRM Specialist

- Digital Health Adviser

- Research Adviser

- Program Officer

7.4.3.1   Selection Methods for Individual Consultants

The method of selection for ICs depends on the complexity of the assignment, the availability of qualified individuals, and the urgency of the task. The following methods may be used:

Table 7.9: Method of Selection for Individual Consultants

Method	When to Use	Steps
Open Competitive Selection	There is knowledge of experienced and qualified individuals or their availability, The service is complex and there is potential benefit from broader advertising	1. Advertise a Request for Expression of Interest (REOI) 2. Evaluate submitted CVs 3. Select the most suitable candidate among only those applicants who responded to the advertised REOI

Limited Competitive Selection	There is knowledge of qualified and available individuals	1.Request CVs from at least three qualified individuals with comparable profiles
		2.Evaluate submitted CVs
		3.Select the most suitable candidate
Direct Selection	Tasks are a continuation of previous work carried out by the individual	1. Identify and engage the individual directly
	Assignment is under 6 month	2. Provide documented justification for selection
	Task is urgent	
	Candidate has exceptional relevantexperience and qualifications	

Steps in Engaging an Individual Consultant

1. Preparation of Terms of Reference (TOR)

2. Selection based on the appropriate method (Open, Limited, or Direct)

3. Shortlisting (if applicable)

4. Evaluation of candidates

5. Notification of award

6. Delivery and review of interim report (where required)

7. Delivery and acceptance of final report

7.4.4 Community-Driven Development

The program supports Community-Driven Development (CDD), which is defined as the participation of local community groups or institutions, and/ or NGOs and the private sector to increase utilization of local know-how and materials, including labour-intensive and other appropriate technologies. The procurement procedures, specifications and contract packaging may be suitably simplified and adapted to reflect these considerations, provided these are consistent with the principles of economy, efficiency, and social equity. The Community-Driven Development (CDD) procurement manual will be developed separately and will be an Annex to be used as part of the POM.

7.5 General procedures for procurement

7.5.1 Advertising

A General Procurement Notice (GPN) is mandatory. It must be published in the UN Development Business or Development Gateway and in at least a national newspaper as provided under the procurement regulations for IPF Borrowers Guidelines. The GPN shall show all International Competitive Bidding (ICB) for goods and works contracts and all International Consulting Services. In addition, a Specific Procurement Notice (SPN) is required for all goods and works to be procured under ICB and Expressions of Interest (EOI) for all consulting services that fall within open competitive thresholds as shown

in the appropriate threshold as in the Procurement Plan. All NCB procurement packages for goods and works must be advertised in at least one national daily, and the federal or state tender journal. In addition, all QCBS and ICB procurements shall be advertised in UN Development Business and at least a national newspaper as provided under the procurement regulations for IPF Borrowers.

7.5.2   Bids/Proposal Evaluation and Evaluation Committee

Bid evaluation will be carried out by an ad hoc evaluation committee member whom the NPC shall nominate via memo. The evaluation committee will comprise at least the following members:

 i.   Procurement Specialist (PS) as member/secretary

 ii.   Representative of the user departments

 iii.   Technical experts

Membership shall comprise a minimum of three and a maximum of five persons, including the Procurement Specialist, and always an odd number. The members of the committee will appoint the chairman on a simple majority vote. The evaluation committee will make decisions collectively. Prior to bid evaluation, the evaluation committee will prepare detailed evaluation criteria, each with their respective scores; these criteria shall be only a clarification of the original criteria included in the RFP. In no case may the original criteria of the RFP be modified. In all cases, the evaluation shall respect strictly the dispositions and criteria indicated in the RFP.

Each committee member will be provided with a copy of the proposals or bids and will assign a score for each of the designated review criteria for all the proposals/bids. The committee will meet to review the scores assigned by each evaluator. All decisions of the evaluation committee shall be taken at simple majority.

For QCBS, the evaluation of the proposals shall be carried out in two stages: first, the technical and then the financial. Evaluators of technical proposals shall not have access to the financial proposals until the technical evaluation, including the World Bank's "No Objection" to the result is concluded. Until the World Bank has issued its "No Objection" on the result of the technical evaluation, no communication or information will be exchanged with the firms.

Once the technical evaluation is completed and the corresponding "No Objection" has been issued by the World Bank, the NPCU/SCO shall notify those consultants whose proposals did not meet the minimum qualifying mark or were considered non-responsive to the RFP and TOR, indicating that their financial proposals have remained unopened. The NPCU/SCO shall simultaneously notify all consultants that have secured the minimum qualifying mark of the date and time set for opening the financial proposals. The opening date shall not be sooner than two weeks after the notification date.

The financial proposals shall be opened publicly in the presence of representatives of

the bidders who choose to attend. The consultant's name, technical scores, and proposed prices shall be read aloud and recorded when the financial proposals are opened. A copy of the minutes of the bid opening shall be promptly sent to the World Bank and circulated to the firms. The Procurement Specialist of the program shall prepare the minutes of the public bid opening.

7.5.3   Publications of Results and Debriefing

Online (DG Market, UN Development Business, or Client Connection) publication of contract awards will be required for all ICB, NCB, Direct Contracting and the Selection of Consultants for contracts exceeding a value of US$500,000.

In addition, where prequalification has taken place the list of pre-qualified bidders will be published.

Regarding prior review to ICB and large-value consulting contracts, the recipient must ensure online (DG Market, UN Development Business, or World Bank external website) publication of contract awards as soon as the World Bank has issued its "No Objection" notice to the recommended award.

Regarding Direct Contracting and NCB, contract awards can be published in aggregate form every quarter and in local newspapers. All consultants competing for an assignment involving the submission of separate technical and financial proposals, irrespective of the estimated contract value, should be informed of the result of the technical evaluation (number of points that each firm received) before the opening of the financial proposals. The NPCU/SCO will be required to offer debriefings to unsuccessful bidders and consultants should the individual firms request such a debriefing.

7.5.4   Negotiations

Negotiations shall include detailed discussions on the Terms of Reference (TOR), proposed methodology, staffing arrangements, client inputs, and any special conditions of the contract. These discussions must not substantially modify the original TOR, the contract terms, the quality or cost of the final product, or any other parameter that could impact the relevance of the proposal evaluation.

Negotiating Quality and Cost-Based Selection (QCBS) and Fixed Budget Selection (FBS) Contracts

For Quality and Cost-Based Selection (QCBS) and Fixed Budget Selection (FBS), financial negotiations shall be strictly limited to clarifying the consultant's tax liability in the country (if applicable) and how this is addressed in the contract. Unit rates for person-months and reimbursables shall not be subject to negotiation, as they were already evaluated during the selection process. Any reduction in the proposed price must reflect a corresponding reduction in the scope of work or level of effort. Under no circumstances should the negotiated contract price exceed the originally offered price.

Negotiating Consultant Qualification Selection (CQA) Contracts

For contracts awarded using Consultant Qualification Selection (CQS), all aspects of the

financial offer—including unit prices—may be negotiated in accordance with the terms outlined in the issued RFP's appendix. The finalized TOR and agreed work plan must be incorporated into the "Description of Services" section of the contract.

Substitution of key staff should not be permitted unless both parties agree that such substitution is unavoidable due to undue delays in contract issuance or is necessary to meet assignment objectives. Any substituted key staff must possess qualifications equal to or superior to those originally proposed.

The initial draft contract shall be submitted for the World Bank's "No Objection" before signature prior to signing, in accordance with the applicable prior review thresholds.

7.5.5   Review of Procurement Process by the World Bank

Each contract for goods, works, non-consulting services and consulting services shall be in accordance with the thresholds approved in the Procurement Plan. The Procurement Plan and other prior review documents must be communicated to the World Bank for review and approval before any action is initiated.

7.5.6   Operating Costs

Operating costs under the HOPE-PHC program will be procured in accordance with the administrative procedures of each Implementing Agency, provided these procedures are deemed acceptable by the World Bank. Payment for services related to operational costs shall be paid directly to the account of the service provider. Travel advances shall be paid directly to the account of each individual traveller.

Operating costs include:

- Office rental expenses
- Maintenance and insurance of vehicles and equipment
- Fuel
- Office supplies
- Utilities
- Communication expenses
- Consumables
- Bank charges
- Advertising expenses
- Travel
- Per diems

Accommodation and salaries of support staff, but excluding salaries of consultants and civil servants

7.6 Monitoring, Capacity Building, and Supervision of Procurement

7.6.1 Record Keeping and Reporting

All records used to award contracts, including bid notification, register to buy and receipt of bids, bid opening minutes, bid evaluation reports and all correspondence related to bid evaluation, communication sent to/with the World Bank in the process, bid securities, and approval of invitation/evaluation of bids will be retained by respective units and uploaded in the World Bank's Systematic Tracking of Exchanges in Procurement (STEP) system regularly.

7.6.2 Procurement Capacity Assessment

The World Bank shall assess the capacity of the FMOH&SW NPCU/SCO to implement procurement actions for the program. The assessment will examine the following:

- The record-keeping and document management system is adequate for implementing a World Bank-financed program.

- Availability of a dedicated program team that is adequately trained and qualified in WB procurement regulations for implementation of a World Bank-financed program.

- Complaint resolution system. There are clear procedures for complaints and settlement of disputes clearly provided by the Bureau of Public Procurement (BPP).

- Contract management and administration. The team has adequate knowledge of program management and administration of WB-financed programs.

7.6.3 Procurement Action Plan

The Procurement Action Plan (PAP) presents the supportive measures required for hitch-free procurement in the HOPE-PHC program. The following actions have been included in the PAP to facilitate procurement of goods and services:

a. recruitment of an experienced procurement consultant to increase available capacity,

b. adoption of the World Bank Procurement Regulations for IPF Borrowers of July 2016 for efficient implementation of the program,

c. training of relevant program staff on World Bank procurement procedures continuously during project implementation,

d. conduct contract management training for relevant program staff, and

e. adoption of World Bank's Standard Bidding Documents and Request for Proposals.

Table 7.10 Procurement Action Plan

Action	Responsibility	Due Date	Remarks

Assignment of a procurement officer/ selection of procurement consultants	FMOH&SW	Three months after effectiveness	Done at federal level and selection of procurement consultants at the state level
Training of procurement officer and key relevant officers	World Bank/ FMOH&SW	Before effectiveness and during program implementation	Continuous
Procurement tracking system (STEP)	World Bank/ FMOH&SW	Upon effectiveness	
Establishment of procurement complaint online database and hotline	FMOH&SW	No later than six months after effectiveness	
Establish an electronic filing system for program records	FMOH&SW	No later than six months after effectiveness	
Adopt the World Bank's procurement manual as part of the POM 11	FMOH&SW	No later than six months after effectiveness	Done

7.6.4   Supervision and Post Reviews

In addition to the prior review supervision to be carried out from World Bank offices, the capacity assessment of the Implementing Agency has recommended at least two supervision missions a year to visit the field to carry out post review of procurement actions. The procurement post-reviews should cover at least 20 percent of contracts subject to post-review. In addition, Financial Management post reviews of in-country trainings will be conducted from time to time to review the selection of institutions, facilitators, courses, contents of training, justifications thereof, and costs incurred.

7.6.5   Training and Capacity Building

An amount equivalent to 1% of the total program budget will be allocated to capacity-building activities aimed at strengthening management and staff skills within the NPCU/SCO. All trainings and workshops will be implemented in line with the HOPE-PHC Annual Work Plan and Budget, which is subject to annual review. The Annual Work Plan and Budget should specify each of the following:

- the training and workshops required,
- the personnel to be trained,
- the institutions which will conduct the training, and
- the duration of the proposed training.

In addition to the Annual Work Plan and Budget, the NPCU/SCO shall submit an annual training plan to the World Bank for its "No Objection" prior to implementation. The training plan must include the name and duty of each trainee, the unit and total cost of each training activity, and the relevance of the training to the objectives of the program.

08
ENVIRONMENTAL AND SOCIAL SAFEGUARDS
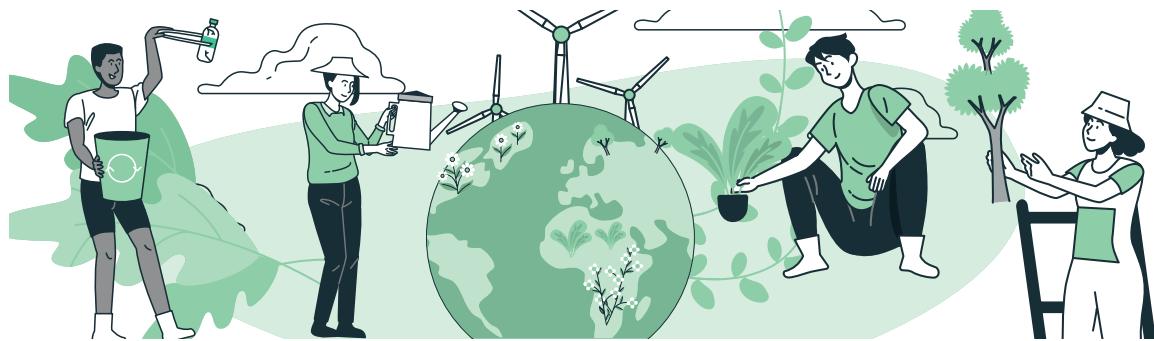
Chapter 8 - Environmental and Social Safeguards

8.1   Environment and Social Safeguards Assessment and Planning

To comply with PforR Policy, an Environmental and Social Systems Assessment (ESSA) was conducted with support from the World Bank to review the existing systems for E&S management and assess how these systems perform in practice across all tiers of Government.

The ESSA evaluates the acceptability of the Borrower's (Nigeria's) systems (laws, regulations, standards, and procedures) against the six core principles of the Program for Results Policy and recommends actions to address the gaps and to enhance performance during Program implementation. It also includes a review of due diligence practices, performance track record, budget, and institutional capacity of implementing agencies across all tiers of Government regarding E&S management.

| A Promote E&S Sustainability, avoid, minimize, mitigate adverse impacts and promote informes-decision making | B Avoid, minimize and mitigate against adverse impacts on natural habitats and physical cultural resources | Protect public and worker safely against the potential risks associated with:

(i) construction and/operations of facilities or other operational practices under the PforR program
(ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the PforR Program; and
(iii) reconstruction or rehabilitation of infastructure located in areas prone to natural hazards | Manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimun restoring, their livelihoods and living standards | Give due consideration to the cultural appropriateness of, and equitable access to PforR Program benefits, giving special attention to the rights and interests of the Indegenous Peoples and to the needs or concernsn of vulnerable groups | Avoid exacerbating social conflict, especially in fragile states, post-conflict area or areas subject to territorial disputes |

Fig. 8.1 The six Core Principles of the Environmental and Social Safeguards of the World Bank

The World Bank led the ESSA through a review of program materials and available technical literature. This literature includes policies, regulations, guidelines, and examples of due diligence and design documents, interviews, and extensive consultations with government staff, non-governmental organizations, regulatory agencies, private sector organizations, and sector experts associated with the health sector in Nigeria. The analysis determined the range of E&S risks and benefits associated with the HOPE-PHC Program based on the DLIs and the IPF component and recommendations are discussed below. The HOPE-PHC Program will generate both E&S risks and benefits.

8.2   Environmental and Social Impact of Implementation of HOPE-PHC

The HOPE-PHC Program does not involve new construction works, and program activities are not likely to require significant changes to the government's overall environmental systems.

The HOPE-PHC Program is generally assessed a moderate risk because some facilities are being rehabilitated to strengthen the health system. The environmental and social risks of the IPF component are rated low based on the scope of the component.
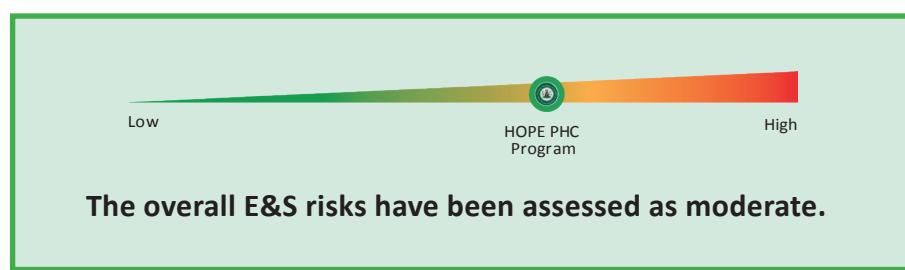
Figure 8.2 HOPE-PHC environment and social risk

8.2.1   Environmental Risks

The HOPE-PHC Program includes some activities expected to have an environmental impact. Rehabilitation and refurbishment activities will be conducted to achieve a score of 75 per cent on the health facility readiness assessment in DLI 1.1 and to ensure that

CEmONC facilities demonstrate service readiness, climate resilience, and energy efficiency in DLI 1.2. Implementation could involve rehabilitating facilities—for example, WASH facilities—that may be exposed to natural disasters, such as floods. The rehabilitation process entails a risk of adverse environmental impacts, including occupational hazards, health and safety risks, and solid waste, noise, and air pollution.

The emergency medical transport system in DLI 7 will increase the number of vehicles transporting patients during emergencies and the number of patients transported to primary or secondary healthcare facilities. This will result in increased fossil fuel consumption, leading to increased CO_2 emissions and air pollution from transportation. Moreover, the digitised system that will be employed in emergency transportation could, in the long run, result in e-waste. Generation of waste from electrical and electronic equipment, or e-waste, is also expected due to the increased use of information and communications technology to facilitate digital health transformation in DLI 9.1 and states' adoption of digital health infrastructure to achieve DLI 9.2.

8.2.2   Environmental Benefits

The HOPE-PHC program will deliver some direct and indirect environmental benefits. Direct environmental benefits will accrue from achieving DLI 1.1, which focuses on the percentage of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75 per cent on the health facility readiness assessment and includes measures of structural and process quality, solar power, and climate resilience. Environmental benefits will also be a direct result of achieving DLI 1.2, which aims for an increase in refurbished and empanelled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency.

Activities to achieve DLI 9, which strengthens EPR at the subnational level, will also yield environmental benefits.

8.2.3   Social Risks

The HOPE-PHC program is associated with some social risks. The refurbishment and rehabilitation of medical facilities under DLI 1.1 and DLI 1.2 could potentially affect the health and safety of workers involved in the rehabilitation works. The workers may be exposed to pollution caused by dust and noise at the work site. There could also be an influx of workers into the communities where rehabilitation work will occur, and there could be cases of sexual abuse and harassment, drug abuse, and other social problems. There is the potential for discrimination against women and other vulnerable groups, and ethnic considerations. This discrimination could occur in the provision of tracer essential health services by CHWs (DLI 4), provision of health insurance under the NHIA gateway (DLI 3), provision of CEmONC, neonatal and under-five services and/or VVF surgeries (DLI 5.2), distribution of MMS supplementation for pregnant women during ANC visits (DLI 6.2), and provision of emergency medical transportation for patients with obstetric and neonatal complications (DLI7).

Social conflict as envisaged by the ESSA, especially regarding armed conflict, does not apply to this program. Nevertheless, discrimination along the lines of ethnicity and religion of community health workers and the additional health workforce recruitment under HOPE-GOV, provision of family planning services and some other tracer essential health services, provision of emergency transportation for patients with neonatal complications, and distribution of MMS supplementation for pregnant women could result in complaints, grievances, social unrest, and demonstrations among communities that feel left out or cheated.

8.2.4   Social Benefits

The HOPE-PHC program will result in many social benefits from achieving the DLIs. These benefits include enhanced health outcomes, reduced infant and maternal mortality rates, increased life expectancy, enhanced economic development, and poverty reduction, given that more people will be healthy enough to work and contribute to economic development. Specifically, the refurbishment and staffing of primary healthcare facilities to readiness in accordance with the assessment tool (DLI 1.1) and the refurbishment and empanelling of CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (DLI 1.2) will facilitate the availability of water sources, toilets, mother–newborn intensive care units, pediatric inpatient units, surgical theatres, and equipment. This will help to enhance health outcomes, reduce stillbirth, newborn, child and maternal mortality rates, and increase life expectancy. Improving the quality of healthcare services in Nigeria's healthcare facilities will help ensure equitable access to healthcare, which will facilitate the realisation of some health-related SDGs.

Moreover, the rehabilitation of health facilities will lead to:

- Increased employment for locals who may be engaged in menial jobs.

- The rehabilitation may lead to an influx of workers into communities, enhancing the local economy.

- Health workers will also be recruited for primary healthcare facilities, thus creating employment opportunities for unemployed health workers, and enhancing their income and well-being.

- In addition, activities under DLI 2 will facilitate the provision of contraceptives, tracer commodities, and medicines to women and children. Tracer commodities include oxytocin, MMS, pediatric and adult formulations of ACTs, HIV rapid test kits, Pentavalent vaccine, pediatric formulation of Amoxicillin, and a minimum of three modern contraceptive methods, including at least one LARC. The provision of these commodities will reduce the incidence of malaria, especially during pregnancy; reduce mother-to-child transmission of HIV; enhance the health of mothers and children, reduce newborn, child and maternal mortality rates; and enhance life expectancy.

- Increased insurance coverage through linkages with the NHIA gateway (DLI 3) will

increase child enrolment in the NHIA. Increased insurance coverage will help ensure access to health services, especially among the poor, as it will protect them from increased healthcare costs. This will help to ensure improved health outcomes and quality of life. 12

- In addition, the provision of tracer health services (DL4) through CHWs, including micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification of and follow-up with pregnant women and referral to receive MMS, and treatment of childhood illnesses, among others, will enhance the health of women and children, reduce newborn, child and maternal mortality rates, and increase life expectancy

- Skilled birth attendance during delivery in primary healthcare centres (DLI 6.1) will help to ensure that women can deliver babies in the presence of skilled professionals, thus reducing stillbirths, newborn and maternal mortality rates. Moreover, because children under five and pregnant and lactating women (PLW) are particularly vulnerable to micronutrient deficiencies, providing MMS for pregnant women in DLI 6.2 will help prevent micronutrient deficiency in pregnant mothers and their babies, increasing the chances of delivering healthy babies with high immunity against diseases that threaten the lives of infants

- The provision of MMS will also help ensure babies' normal functioning and growth as well as the health of their mothers. In addition, the provision of Penta 3 vaccination in DLI 6.3 will help to ensure that children aged 12 to 23 months are maximally protected against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B and Haemophilus influenzae type b (Hib), thereby substantially reducing infant mortality rates. Provision of age appropriate formulations of medicines for the management of common childhood illnesses including malaria, pneumonia and diarrhoea.

- Digitising the health system in DLI 11 (digital-in-health enterprise in health architecture) offers many benefits to primary and general healthcare. For example, it will help policymakers make informed decisions about resource allocation and thereby reduce healthcare costs and free up resources for other important healthcare services.

8.2.5 Climate Change and Health Risks

The HOPE-PHC Program comprises some activities and interventions that are expected to address the climate-health threats and impacts. Refurbishment activities and delivery of climate-resilient, innovative, sustainable solutions for the health system/centres would be conducted to achieve a score of 75 per cent on the health facility readiness assessment in DLI 1.1. This will also ensure that CEmONC facilities demonstrate service readiness, energy efficiency and climate resilience in DLI 1.2. Implementation could involve rehabilitation of facilities such as WASH, energy, and some other health infrastructure that may be exposed

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12 - Institute of Medicine (US) Committee on the Consequences of Uninsurance. Coverage Matters: Insurance and Health Care. Washington (DC): National Academies Press (US); 2001. 1, Why Health Insurance Matters. Available from: https://www.ncbi.nlm. nih.gov/books/NBK223643/

to extreme weather and adverse climate events such as floods, drought and wildfire. However, the rehabilitation process itself carries the risk of adverse environmental and climate-health impacts, such as air pollution, which must be monitored and addressed.

8.3 Integrating Mitigating Measures in the HOPE Program Implementation

Following the identification of environmental and social risks, the E&S management system in place to manage the identified risks was assessed. The assessment was done using the following criteria: strengths of the system, or where it functions effectively and efficiently and is consistent with Bank Policy and Directive for Program-for-Results Financing; inconsistencies and gaps between the principles espoused in Bank Policy and Directive for Program-for-Results Financing and capacity constraints; actions to strengthen the existing system. Information from this analysis, identification of gaps and opportunities/actions, was used to inform the recommendations and Program Action Plan (PAP).

Given the environmental impact of this program, some recommendations are made as follows:

a. Undertake environmental and social screening (See Annex 8) of designs for the rehabilitation of facilities to ensure that the rehabilitation activities under some DLIs especially DLI 1 filter out substantial or high-risk civil works and proposed actions.

b. Strengthening the E&S capacity under the program is needed. To facilitate this, E&S specialists should be recruited for the Program.

c. E-waste and healthcare waste management strategies should also be developed to facilitate their management. The requirements for e-waste and healthcare waste control should be included in the bidding document under HOPE-PHC PforR.

d. There is a need to develop an environmental management strategy or manual and OHS guidelines for primary health care centers.

Given the identified social issues, the following recommendations are made:

a. Ensure that the provision of MMS for women, provision of tracer essential health services, and provision of emergency transportation to patients with obstetric and neonatal complications are carried out transparently to avoid bias and avoid ethnic or religious considerations.

b. Carry out Program outreach campaigns and citizen engagement activities to adequately target rural, marginalized, and vulnerable populations, especially in the provision of MMS for women, tracer essential health services, and emergency transportation to patients with obstetric and neonatal complications.

c. Strengthen the grievance mechanism in the health sector to ensure that complaints from different stakeholders are well addressed.

d. Strengthen provisions on gender-based violence (GBV) prevention and response,

including clear protocols for identifying, reporting, and addressing instances of GBV within the program.

e. Ensure beneficiaries who may experience various forms of GBV because of cash transfer intervention will access services from community- based /NGO GBV service providers and the PHCs.

f. Specific communication on GBV prevention should be rolled-out as part of the outreach activities for the Program.

Following the recommendations, the breakdown of actions to be included in the Program Action Plan (PAP) with indicative timeline, responsibility for implementation and indicators for measuring the completion of such actions are detailed in the Table below.

Table 8.1   Environmental and Social Safeguard Management Action Plan (ESSMAP)

s/n	Action Description	Due Date	Responsible Party	Completion Measurement
1	Engage an Environmental Officer that will support the Program in developing e-waste and health care waste management strategies. For managing e-waste and healthcare waste result from the program	Within one year of effectiveness.	Federal Ministry of Health and NPCO/SCO	Environmental officer engaged with responsibilities provided in the Program Operational Manual (POM) E-waste and healthcare waste management strategy document.
2	Develop Code of Conduct, Traffic Management and Occupational Health and Safety Plans for managing traffic related risks from increased emergency patients transport.	Within one year of effectiveness	Federal Ministry of Health and NPCO/SCO	Finalized Code of Conduct and Occupational Health and Safety Plans reports.
3	Engage a Social/GBV Officer to support the Program in i. Developing referral pathways and communication on GBV prevention and management. This will be integrated into retraining curricula for front line workers. ii. Strengthening the grievance management mechanism for the Health Sector to ensure timely follow ups on tracking and escalation. iii. Carrying out Program outreach campaigns and citizen engagement activities to adequately target rural, marginalized, and vulnerable populations	Within one year of effectiveness	NPCU/FMOWA	Social Officer engaged with responsibilities provided in the POM. Referral pathways developed and integration of GBV prevention and management in curricula. Detailed grievance mechanism procedures is publicized on the websites of the Federal, State and other relevant health agencies; (ii) the availability of the GM to beneficiaries and (iii) annual reports on GM implementation Outreach program guide and record of outreach activities.

4	Undertake environmental and Social screening of designs for the rehabilitation of facilities to ensure that the rehabilitation activities filter out substantial or high-risk civil works and proposed actions	Prior to commencement of rehabilitation works	Federal Ministry of Health and NPCO/SCO	Environmental and Social screening checklist satisfactory to the World Bank developed for use before rehabilitation works
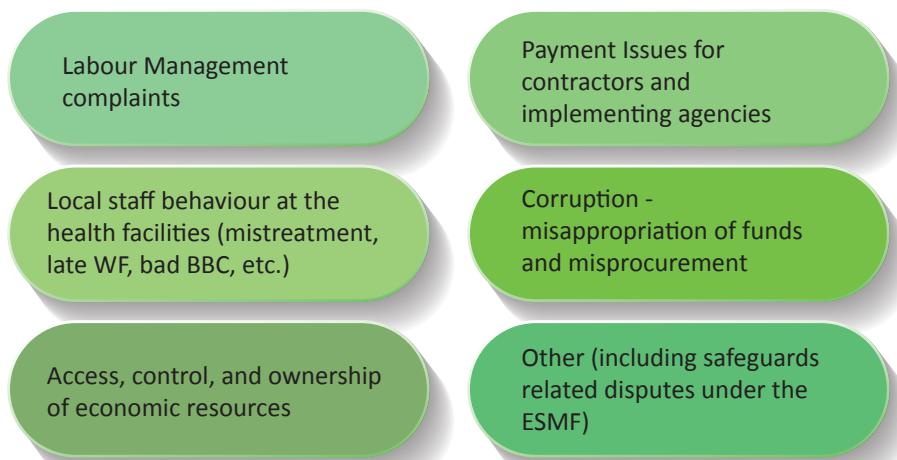
Figure 8.3 HOPE-PHC: Triggers of grievance/complaints

8.3.1   Labour Management Plan

The Labour Management Plan (LMP) will cover private entities such as consultants for IVAs and M&E that may provide operations services but are not covered by the public service rules in their entirety. The NPCU/SCO must prepare an LMP to address the risks associated with such entities. The program has committed in its ESCP to adopt the LMP as specified in the E&S standards no later than three months after the effective date, but before engaging program staff and thereafter implement the LMP throughout the program implementation. The NPCU/SCO and all implementing entities will adopt, and enforce the LMP including, among other things, provisions on working conditions, management of workers' relationships, occupational health and safety (OHS) (including personal protective equipment, and emergency preparedness and response), code of conduct (including relating to Sexual Exploitation Abuse and Sexual Harassment), forced labour, child labour, grievance arrangements for program staff will need to be developed and applied as a requirement for contracted workers such as Independent Verification Agencies (IVAs) or Monitoring and Evaluation (M&E) consultants, and others in consistency with ESSA.

Also, the program will adopt and implement OHS as an annex to the LMP to mitigate risks to the human population and the environment because of transportation of goods and program personnel, e-wastes from procurement of electronic and solar equipment, and minor labour-related risks. Under the Technical Assistance (TA) program, two categories of

workers are expected to be employed: direct workers and contracted workers. The direct workers, mostly government employees, will be subject to the public service rules. On the other hand, the contracted workers (e.g., IVAs) will be governed by mutually agreed terms of engagement/employment/contract, including all relevant codes of conduct and labour management procedures. The LMP will include information on OHS, the Code of Conduct for preventing sexual exploitation, abuse, and sexual harassment, as well as grievance mechanisms to address other potential risks related to labour and working conditions.

These procedures will include OHS procedures and a grievance mechanism for labour disputes including

- Program staffs will be provided with clear and understandable information and documentation regarding their terms and conditions of employment

- The information and documentation will set out their rights under national labour and employment law (which will include any applicable collective agreements), including their rights related to hours of work, wages, overtime, compensation, and benefits, as well as those arising from the requirements of this ESS

- This information and documentation will be provided at the beginning of the working relationship and when any material changes to the terms or conditions of employment occur

- Program staff will be paid regularly as national law and labour management procedures require

- Deductions from payment of wages will only be made as allowed by national law or the labour management procedures, and program staff will be informed of the conditions under which such deductions will be made

- Program staff will be provided adequate weekly rest periods, annual holidays, sick leave, maternity leave, and family leave, as required by national law and labour management procedures.

8.4   Stakeholder Engagement

A Stakeholder Engagement Plan (SEP) must be developed, finalised, disclosed, and adopted by the NPCU/SCO and all implementing entities under the program. The program activities will be screened further for any other potential environmental and social activities using an environmental and social screening checklist that will be developed during program implementation for all implementing entities.

The program will maintain active stakeholder engagement throughout implementation to foster ownership, gather feedback, and enhance program performance.

Consultations will allow stakeholders to express concerns about program activities, risks, and mitigation measures, with responses integrated into program decisions. Engagement methods include focus group discussions (FGDs), community meetings, call-in radio programs, written feedback, questionnaires, and public document dissemination

at federal, state, and local levels. Efforts will accommodate low literacy levels in rural areas by allowing adequate time for responses.

Traditional and religious leaders, along with trusted community members, will serve as key advocates for program outcomes. However, safeguards will be in place to prevent undue influence or exclusion. All public meetings will be documented, including attendees, discussions, conclusions and next steps. A monitoring mechanism will track the consultation process.

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8.5   Grievance Redress Mechanism

The HOPE-PHC program will have a Grievance Redress Mechanism (GRM) which is a structured system of process and procedures designed to receive, assess and resolve complaints, queries, or clarifications related to the program. The GRM is a proactive alternative dispute resolution arrangement which shall ensure that all issues arising during overall implementation are effectively addressed to improve program outcomes

A well-functioning GRM provides project teams with valuable insights into the effectiveness of social risk mitigation measures and serves as an early warning system for identifying and resolving concerns. Program-specific GRMs offer key advantages, including:

- Proximity to the affected community, facilitating direct engagement.

- Customization to the program's expected impacts; and

- The ability to provide timely resolutions and, when necessary, systemic corrective measures.

Stakeholder concerns handled through the GRM may be categorized as grievances, complaints, feedback, or functionally equivalent terms.

8.5.1   Key Steps in Establishing a GRM:

- Conduct a risk-based assessment of potential grievances, disputes, or conflicts that may arise during program preparation and implementation.

- Identify the existing capacity for grievance redress and develop an action plan to strengthen it. Where necessary, establish new mechanisms at the program level and allocate dedicated resources to support their implementation.

GRMs are designed to be accessible, transparent, and effective, prioritizing collaboration, dialogue, joint fact-finding, negotiation, and problem-solving. They serve as the first line of response to stakeholder concerns that proactive engagement efforts have not fully addressed.

8.5.2   Typical Grievance Redress Process

The grievance redress process will start with receipt/registration of the grievance(s) to be addressed for reference purposes and to enable progress updates on the cases. Thus, Grievances can be submitted through multiple channels, including in-person visits, hotlines, social media, written communications, and suggestion/complaint boxes. Upon receipt, grievances will be acknowledged, and complainants will be informed of the next steps in the resolution process.

- The official receiving the complaint will ensure that each complaint has an individual reference number and is appropriately tracked in the program's GRM platform, and passed to the appropriate unit/team for action

- All recorded actions/responses/resolution measures to grievances must be completed on the program's GRM platform and tickets closed for fully resolved grievances

- Each grievance will be assessed to determine its eligibility based on program scope, relevance, and the nature of the complaint. Eligible grievances will be categorized for appropriate handling, while ineligible grievances will be documented with an explanation provided to the complainant.

- All unresolved grievances must be escalated to a higher level and actions must be fully communicated to the complainer. The response time will depend on the issue to be addressed, but it should be addressed

- Periodic reports of grievance and resolution measures must be collated summarizing the number of grievances received, types of issues reported, resolution status, and trends over time. Quarterly reports to be submitted to the World Bank by the NPCU/SCO in line with the Environment and Social Safeguards; 2 (ESS2) for accountability and improvement of the GR system

- All grievances will be logged in a Grievance Register/Logbook or the MIS GRM module, detailing the complainant's information (where applicable), nature of the grievance, date of submission, and actions taken. Proper documentation ensures transparency, tracking, and monitoring of grievances throughout the resolution process.

- The Grievance Redress Committees (GRCs) at different levels will assess and address grievances promptly. Resolutions may include corrective action, mediation, or referrals to relevant authorities. Complainants will be regularly updated on progress and final decisions.

8.5.3   GRM Channels

The program GRM will have multiple channels available at all levels of implementation:

- In person at all levels via paper forms and the MIS GRM module: physical submission of grievances at all levels. Complaints will be documented using log books and

complaint forms through the MIS module for tracking purpose

- Hotlines at the state level - each state GRM focal person shall manage a phone line for receiving and responding to complaints to ensure timely engagement with complainants GRM Social media accounts (e.g., Facebook, X, WhatsApp) – shall be established to be managed by the NPCU/SCO safeguard specialists to ensure prompt response to grievances and concerns

- Letters/emails/written communication will be accepted at all levels. These will be logged and reviewed in line with GRM protocols

- Suggestion/Complaint boxes will be installed at Focal points within program implementing levels, and health facilities. These will be regularly checked and submitted grievances will be documented for appropriate action

These multiple grievance channels are designed to enhance accessibility, encourage stakeholder engagement, and ensure efficient grievance resolution throughout the program's implementation.

8.5.4 Expectations when Grievances Arise

When grievances are presented, the following are expected from the program management/channel of grievance resolution by the aggrieved person:

- Acknowledgement of the problem and concerns

- An honest response to questions/issues brought forward

- An apology, adequate compensation where relevant; and

- Modification of the conduct that caused the grievance and other fair remedies.

- Corrective actions to address issues and fair remedies to restore the confidence of service providers

Stakeholders also expect to be heard. Therefore, non-state actors and government officials must reassure beneficiaries that they can freely voice their concerns and that grievances will be addressed without fear of retaliation. To support this, non-governmental organizations (NGOs) are encouraged to collaborate with host communities in facilitating non-judicial, dialogue-based approaches for resolving grievances.

8.5.5 Grievance Resolution Process

To ensure a structured and effective grievance redress process, the following steps will be implemented:

During the initial stages of program implementation, affected persons will receive copies of the grievance procedures, outlining how grievances can be submitted and addressed.

Complaints will be formally registered to ensure proper tracking and follow-up. This will allow program teams to provide timely updates on the status of grievances.

Timely Response & Resolution:

- The timeframe for resolving grievances will depend on the complexity of the issue but should be handled efficiently.

- Affected persons will submit grievances using a designated Grievance Form, which will be reviewed by the GRC/FP. The GRC/FP will act on the complaint within a window period of 48 hrs to 28 days of all grievances and 24 hrs to 7 days for high priority grievances.

- If the complainant is not satisfied with the resolution, they may escalate the grievance to a designated office in the Proxy Means Testing (PMT) . The PMT must act on the appeal within 15 working days of its submission.

- Every effort will be made to resolve grievances amicably. However, if the complainant remains dissatisfied, they may seek further redress through formal legal mechanisms.

Recognizing that formal legal processes can be lengthy and contentious, an informal grievance redress mechanism will be established within the PMT of the program. This mechanism will operate through a committee comprising representatives such as:

- Local government administrative heads,

- Community or village chiefs,

- NGOs and Community-Based Organizations (CBOs), and

- Other relevant government agencies.

For sub-projects implemented by Non-State Actors (NSAs), each NSA must develop a grievance mechanism that aligns with the PMTs requirements and is acceptable to both the PMT and the task team.

The GRM aims to resolve disputes promptly, minimizing the need for legal action, which can be time-consuming. Grievance handling will begin at the community level through trained GRCs. If unresolved, complaints will be escalated to the LGA, State Coordinating Office (SCO), and NPMT until a satisfactory resolution is reached.

Efforts will focus on resolving grievances locally whenever possible. A grievance log will be maintained, with records shared with relevant authorities. Additionally, grievances will be reviewed quarterly during implementation to identify and address systemic issues.

8.5.6   GRM Focal Persons

The Social Safeguards Specialists are the GRM focal persons at all levels of implementation; their roles and responsibilities will be as follows:

- Manage the hotline to receive and resolve complaints and supervise complaints arising from states. They will also be responsible for collating monthly reports from states and providing regular reporting to the World Bank on the status of the GRM.

- The State SWAp Desk Officers/FPs will be managing the state hotline to receive and resolve complaints and supervise complaints from local community members. They will also be responsible for providing regular monthly reports on grievances arising in their states, per the guidance in the GRM Manual.

- The GRM lead will coordinate with SCO GRM focal points to handle grievances, train SCO, LGHA, and HF GRCs, and support the implementation of a GBV-sensitive GRM. They will ensure timely feedback to complainants, track and document grievances, and oversee grievance uptake channels.

- Additionally, they will review SCO reports, produce quarterly reports for the Bank team, support the development of GRM documents, activity plans, and monitoring indicators, and ensure GRM structures and communication strategies are well-resourced and accessible. Regular meetings, proper documentation, and a structured implementation timeline will be maintained to enhance grievance resolution across implementing states.

8.5.7   GBV and SEA/SH-related Complaints

Grievance mechanism models for SEA/SH

The 3 models for the design of the GBV as prescribed by the World Bank GMs for SEA/SH Interim Technical Notes include:

Model 1: Adapt overall program grievance mechanism to allow for the uptake of SEA/SH allegations;

Model 2: Link program grievance mechanism to an existing intermediary [The intermediary can be an existing government gender-based violence (GBV) service provider or an NGO that is a GBV service provider] to handle SEA/SH allegations; and

Model 3: Outsource SEA/SH allegation management to a third party.
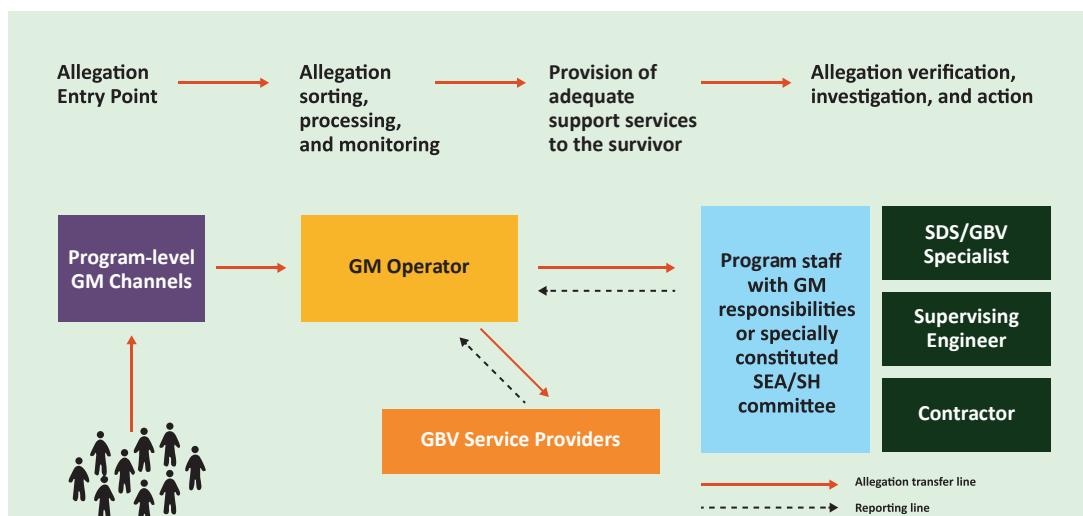

Figure 8.4 Grievance Mechanism Models

The program would adopt Model 1.

Model 1--Adapt the overall program grievance mechanism to allow for the uptake of SEA/SH allegations

Under this model, SEA/SH allegations can be reported, just like any other program-related grievance, using a regular program-level GM channel, Survivors can also use the GMs set-up by NGO firms. Any parallel grievance mechanisms operated by the NGO firms should include processes to refer complaints to the program-level grievance mechanism, in order to ensure an accurate understanding of the program's complaints throughout program implementation. The GM operator—the person in charge of sorting, processing, and monitoring grievances—logs the SEA/SH allegations, acknowledges their receipt, and takes two key actions (see yellow box in figure 8.4).

STEP 1: The GM operator refers the survivor to relevant GBV service providers, identified in advance and according to pre-established and confidential referral procedures (see orange box in the above figure, which represents GBV service providers in various fields, including health and medical services, psychosocial support, and shelter). The GBV service providers accompany survivors throughout the process and play a critical role by updating them on the grievance management progress and on safety planning, especially when sanctions are envisaged or will soon be implemented. The service providers should enter an information-sharing protocol with the GM operator to close the case (see dotted lines in figure 8.4) (World Bank 2020: 37).

STEP 2: If the survivor gives consent, the second action for the GM operator is to communicate the allegation to program staff responsible for grievance matters. This might be, for example, a specially constituted SEA/SH grievance committee comprising representatives of the client, consultant, contractor (e.g. the NGO firm), and local service providers that is charged with monitoring SEA/SH response. The allegation is reviewed and a determination made regarding the likelihood of the allegation being linked to a program. If the allegation is likely to be linked to the program, the program implementation unit asks the contractor to take appropriate action. The new requirements in the standard procurement documents provide more teeth for the program implementation unit to ensure that the contractor takes disciplinary action against the alleged perpetrator and that this is communicated back to the survivor.

Given the highly stigmatized nature of the topic, caution should be taken when communicating with the community about reported SEA/SH incidents. Once an assessment of the safety and value of reporting to the community is complete, occasional reports can be generated, although this is not systematically recommended (see light dotted lines back to the community in figure 8.4).

To fulfil the role of addressing GBV and SEA/SH complaints,

- All staff and volunteers should be trained on GBV guiding principles in the GRM Manual and the specialised procedures for receiving and referring GBV- or SEA/SH-related complaints. This set of skills will help GRM staff and volunteers to support the

quality of the complaint mechanism while at the same time ensuring the adherence to GBV guiding principles and a survivor-centred approach, including the right to safety, respect, and confidentiality of the complaint intake and management.

- Hotline operators should receive training on handling GBV-related complaints in line with the principles of confidentiality and the specialized procedures outlined in the GRM Manual.

- When receiving a grievance and throughout the intake process, the person receiving the complaint shall respect the complaint's wishes, choices, rights, and dignity.

- In the case of GBV or SEA/SH survivors, if they choose not to receive a referral, the officer or volunteer must seek their consent to share basic monitoring data for the survivor/complainant to file a complaint. The complainant must be provided with clear and simple information on how the system functions, the possible outcomes of filing a complaint, what the timelines are, what type of support can be provided, and any other information the complainant may require to be able to make an informed choice.

- For GBV or SEA/SH cases, it is important to ensure that access to the complaints processes is as easy and as safe as possible for the complainant/survivor and that they clearly understand the referral process.

8.6   Cultural and Religious Norms

Aligning the GRM with cultural and religious norms will enhance trust, promote inclusivity, and foster community ownership, ultimately improving grievance resolution and strengthening stakeholder confidence in the process.

All program activities must be aligned with local and religious norms in the context in which they will be implemented.

The GRM will be designed and implemented in a manner that respects and aligns with local cultural and religious norms to ensure accessibility, acceptance, and effectiveness. Recognizing the diverse social, religious, and traditional structures within communities, the GRM will adopt an inclusive, respectful, and culturally appropriate approach to grievance handling.

Main Focus area:

- The GRM will consider the integration of existing community-based dispute resolution mechanisms, ensuring they complement program's formal grievance redress procedures.

- The sensitive nature of some grievances, particularly those related to gender-based violence (GBV) and social exclusion, shall have designated safe and confidential reporting channels, with culturally appropriate support mechanisms in place.

- Traditional and religious leaders, women's groups, youth leaders, and community elders will be engaged to promote awareness of the GRM, encourage reporting,

and ensure fair grievance resolution without bias or exclusion.

- The GRM will provide multiple reporting options, including oral submissions for individuals with low literacy levels, and ensure that grievance procedures are communicated in local languages.

- Cultural barriers that may discourage grievance reporting, particularly for vulnerable groups, will be addressed through confidential and anonymous reporting mechanisms. The GRM will ensure that complainants feel safe and are protected from retaliation.

- Where grievances intersect with religious concerns, faith-based organizations and local religious institutions may be consulted to facilitate resolution in a manner that is respectful and acceptable to the community.

8.7   Climate Change and Health Nexus

The HOPE-PHC program activities and interventions essentially support climate change mitigation and adaptation. The installation of solar power and strengthening energy efficiency will enhance climate resilience in health facilities which will help reduce emissions and facilitate the achievement of Nigeria's 2060 zero-emission target. Achieving this DLI will improve Nigeria's ability to handle climate shocks, natural disasters, and other humanitarian emergencies and generate some climate co-benefits. In addition, developing and implementing a national climate and health adaptation strategy in DLI 10, which will help address climate change and vulnerabilities, will generate some climate co-benefits.

The Climate Change and Environmental Health (CCEH) Division, FMoH&SW in collaboration with NPCU/SCO will facilitate the assessment and delivery of the climate-health solutions/interventions. These roles are based on DLI 1.1, 1.2 and 10 and in line with the Health National Adaptation Plan (HNAP).

09

STRENGTHENING EVIDENCE-BASED POLICY FORMULATION AND RESEARCH AGENDA

Chapter 9 - Strengthening Evidence-Based Policy Formulation and Research Agenda

9.1　Strengthening Evidence-Based Policy Formulation

The purpose of government is to improve the wellbeing of the community in ways that may not be possible by individuals acting alone. However, policymakers can get it wrong, be ineffective, or fail to foresee unintended consequences, or not revisit policies when the environment/circumstances and assumptions change. There is often considerable debate about whether government action has led to an improvement and, if so, the extent of the gains. An evidence-based approach to policymaking is one way to improve policy development. It is built around the belief that better quality decisions will be made if the process is informed by robust evidence.

Evidence-based policymaking is a process that transparently uses rigorous and tested evidence in the design, implementation, and refinement of policy to meet designated policy objectives. Under the NHSRII and specifically under the HOPE-PHC program, evidence for policy change must address the following characteristics that seem emblematic of the present interest of the Government of Nigeria across all levels:

- evidence should be broad, tested, rigorous, and ideally capable of replication

- evidence should be robust and avoid common methodological pitfalls; and

- the entire process should be transparent and contestable.

The best available evidence should underpin policy decisions. The research agenda will be used to inform policy programs on both demand and supply-side of healthcare. The number of complex policy challenges on the horizon puts a premium on ensuring rigorous assessment of policy choices and evaluation of existing programs. For instance, in the human capital sphere there is often little settled evidence about what policy measures work best and there can be long lead times before results are fully evident making policy mistakes come at a significant cost.

This broader view recognizes that evidence and evaluation are relevant at every stage of the policy cycle, from identifying the policy problem, through assessing policy options, to ex-post evaluation (figure 9.1). Moreover, it can encompass an array of evidence and research methods (figure 9.2).
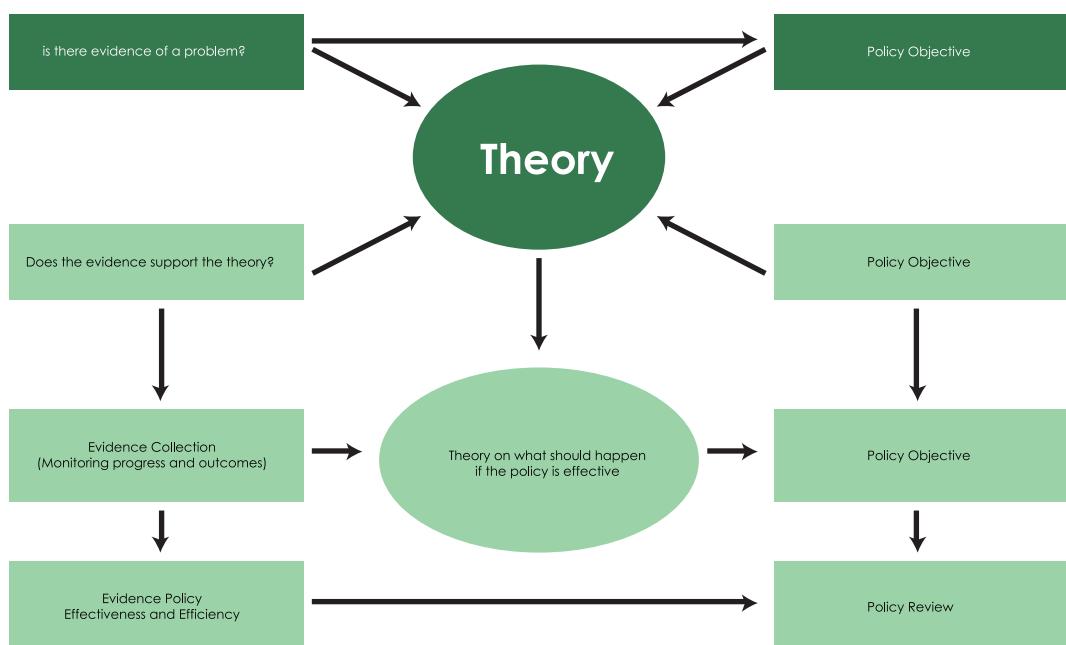

Figure 9.1: The role of Evidence in Policy Cycle

Figure 9.2 The types of evidence in evidence-based policy making

Under this view, what matters for public policy development is not only what works, but also how does it work, what are the broader ramifications, at what cost, and who benefits or loses? Fundamentally, evidence-based policy is about assessing whether a policy improves community wellbeing. To strengthen evidence-based policy formulation, the NPCU/SCO will foster a culture of evidence use, build capacity for data collection and analysis, and ensure that policy decisions are informed by rigorous research and data.

As part of its duty, the SCO will perform the following functions to ensure evidence-based policy making is institutionalized at the centre of high-level decision making:

1. Fostering a Culture of Evidence Use

2. Building Capacity for Data Collection and Analysis

3. Ensuring Evidence-Informed Decision-Making

4. Addressing Barriers to Evidence Use

9.2   Research Agenda

The HOPE-PHC program has a robust research agenda which will be executed by the NPCU/SCO and implementing entities with support from partners, including the World Bank's Development Impact Group (DIME) team. Stakeholders, including development partners, research organizations, and academic societies are invited to help identify additional critical research areas under the HOPE-PHC and NHSRII program of the renewed hope agenda. The prioritized research areas under the HOPE-PHC program are discussed below.

9.3   Priority Areas for Research on the HOPE-PHC Program

The priority areas of research have been carefully identified as areas where developmental research may influence policy review and reform. The list below describes priority areas and sub-themes. Researchers are encouraged to align their research topics to those listed below:

9.3.1   Strengthening Healthcare Systems and Service Delivery

1. Access to Quality Care

2. Investigate barriers to accessing antenatal, delivery, and postnatal care, including financial, geographical, and cultural barriers

3. Skilled Birth Attendants

4. Research strategies to attract and retain skilled health workers, particularly in remote areas (the LGAs that have been identified to contribute about 50% of all maternal mortality in Nigeria) and to assess the primary health system's

readiness to identify and transfer obstetric emergencies to facilities that provide comprehensive care.

5. Health Facility Infrastructure

6. Evaluate the adequacy and functionality of health facilities, focusing on the service menu and capacity across all levels, equipment, supplies, infrastructure, and climate resilience.

7. Data Collection and Monitoring

8. Evaluate the M&E systems, including MPDSR, for collecting and analyzing data on maternal and child health outcomes, including maternal mortality, morbidity, and child health indicators.

9. Health Insurance

10. Evaluate the scaleup of social health insurance coverage under the program and the quality and public perception of health insurance services.

11. Digital in Health

12. Evaluate the use of digital systems and their impact on health system management, efficiency of care and impact on greenhouse gas emissions.

13. Climate, Health, and System Resilience

14. Review the impact of climate and health interventions under the program and how these affect the overall health system resilience.

9.3.2   Addressing Maternal and Child Health Disparities

1. Nutrition

Investigate the effectiveness of nutrition interventions, such as micronutrient supplementation and food fortification in improving maternal and child health outcomes.

2. Family Planning

Research the effectiveness of family planning programs and financing in reducing unintended pregnancies and improving maternal and child health.

3. Infectious Diseases

Investigate the prevalence and impact of infectious diseases, such as HIV/AIDS, malaria, and tuberculosis, on maternal and child health.

4. Maternal Mental Health

Explore the prevalence and impact of maternal mental health conditions, such as depression and anxiety, on maternal and child health.

5. Postnatal Care

Focus on improving the quality and coverage of postnatal care for mothers and newborns, including breastfeeding support and newborn care.

6. Childhood Illnesses

Research the causes, prevention, and treatment of common childhood illnesses, such as pneumonia, diarrhea, and measles.

9.3.3   Promoting Evidence-Based Interventions

1. Socio-Cultural Factors

Investigate how cultural beliefs, practices, and norms influence maternal and child health behaviors and outcomes.

2. Poverty and Inequality

Explore the impact of poverty, socioeconomic status, incentives & rewards, and other social determinants on maternal and child health.

3. Access to Education and Empowerment

Research the role of women's education and empowerment in improving maternal and child health outcomes.

4. Specific Populations

Focus on the needs of marginalized populations, including those living in rural areas and the prioritized MAMII LGAs, ethnic minorities, and women with disabilities. Other groups under the HOPE-PHC programs can also be investigated for success or failure points for HOPE-PHC initiatives.

9.4   Performance Monitoring to Inform Ongoing Learning and Course Correction

A key aspect of the research and learning agenda will be fit-for-purpose, timely, and low-cost performance monitoring approaches that can be used to promote ongoing learning and course correction throughout program implementation. Building on the M&E plan described above, specific learning questions will be embedded within existing program monitoring to provide regular data and feedback to national and state stakeholders. Illustrative learning questions and data sources are found in the table below.

Table 9.1 Illustrative learning questions and data sources for the adaptive monitoring component of the learning agenda

Example learning question	Example data sources	Comparisons/ disaggregation
Is service utilization for key tracer services significantly improving over the program implementation period? How do focal facilities' performance compare to non-focal facilities' performance?	Facility-level monthly quality-adjusted DHIS2 DHIS2 data from 2020 to 2029	States; BHCPF tier 1 and tier 2 facilities; non-BHCPF public PHCs; Project HOPE-PHC supported facilities; facilities in MAMII focal LGAs

Is coverage trending in a positive or negative direction since the most recently available household survey? Since the introduction of key NHSRII design components (e.g., CHW program re-design, emergency transport scheme)?	Facility level monthly quality- adjusted DHIS2 data from 2020 to 2029	States; geographies impacted by NHSRII reform introductions
How does service utilization correlate with climate-induced or climate-related shocks (e.g., floods, droughts)?	Facility-level monthly quality-adjusted DHIS2 DHIS2 data from 2020 to 2029	States; geographies impacted by climate-induced shocks
How does the quality of data reported by PHC facilities change after digitalization measures are introduced?	Facility level monthly DHIS2 data from 2020 to 2029	Digitized PHCs; non-digitized PHCs
Is health facility readiness improving over time? How does health facility readiness in program-supported facilities compare with non-program supported facilities?	Rapid phone surveys with health facilities	States; BHCPF tier 1 and tier 2 facilities; non-BHCPF public PHCs; Project HOPE-PHC supported facilities; facilities in MAMII focal LGAs
How does service readiness in PHC facilities correlate with service utilization trends? Is this relationship different in geographies impacted by other NHSRII reform measures (e.g., CHW program re-design, emergency transport scheme)?	Facility level monthly quality- adjusted DHIS2 data from 2020 to 2029 and rapid phone surveys with health facilities	States; geographies impacted by NHSRII reform introductions

Existing data sources, broader M&E data use initiatives (e.g., DHIS2, MPDSR, FASTR, RMNCAEH+N scorecards), and novel open-source analytics tools (e.g., FASTR's data downloader and analytics platform) will be fully leveraged to ensure that this component of the learning agenda is sustainably embedded within country-owned systems and simultaneously strengthens data quality and performance monitoring competencies across stakeholders. Leveraging existing administrative data from DHIS2 will be a backbone of the adaptive performance monitoring component of the program and is uniquely supportive of answering key learning questions. Nigeria's DHIS2 system suffers from low reporting rates from private facilities and secondary and tertiary public facilities; however, reporting rates for public PHC facilities are relatively stable, all BHCPF facilities are required to report into the system as a part of their accreditation. Granular facility-level data with a long historical trend also enables data quality adjustments to be done on high-volume indicators. These features enable the use of DHIS2 data as a learning tool for NHSRII interventions. Triangulation with other gold-standard data sources, such as household surveys and independent verification data, will also be done to inform how data quality considerations will inform results interpretation.

9.5 Embedded Implementation Research to Test and Scale High-Impact Interventions

Another component of the program research and learning agenda will be implementation research to examine the delivery of key aspects of the program theory of change, unpack how these interventions are working (or not) and why, and devise remedial strategies needed to strengthen implementation for maximal impact. This may take various forms, such as formative work to identify critical implementation challenges and bottlenecks where interventions are performing poorly or to uncover essential enabling conditions where they are most successful (leveraging FASTR, routine monitoring data, or annual reviews to make these determinations); testing innovative implementation strategies for potential high impact interventions to identify optimal delivery mechanisms; exploratory work to understand the influence of context (and other critical factors) on implementation processes, to pinpoint specific adaptations needed for different settings, and to inform wider scale-up strategies to amplify the impact of effective interventions. Implementation Research (IR) topics will be selected to address the most significant implementation challenges faced by the program, aligning closely with both the planned focus of the impact evaluation as well as with analytical themes examined through rapid cycle approaches (FASTR) to ensure complementarity across these sets of activities. It is likely that the MAMII program design and implementation will provide a key anchoring platform to embed the IR agenda, with different MAMII focal states and LGAs providing a high-value opportunity to do comparative analysis on the roll out and scale up of MAMII-focused interventions in different contexts to understand key drivers of differential implementation outcomes.

Through a forward-looking approach, the implementation research will be embedded into ongoing program implementation processes by: 1) leveraging planned program implementation and monitoring activities to generate evidence about how and why (or why not) implementation is working, such that research activities are integrated into program processes and can inform decisions in real time 2) engaging program and service delivery decision-makers, implementers, and other key evidence users directly in the research process, particularly in research conceptualization (e.g., defining practice and policy relevant research questions) and in interpretation and use of the evidence to inform program or policy improvements. This approach will help ensure the feasibility, utility, and timeliness of IR activities.

9.5.1   Illustrative Implementation Research Learning Questions for HOPE-PHC

The following are samples of illustrative implementation research learning questions

1. How can the NHIA most effectively operationalize the new enhanced identification and enrollment protocols at SSHIA level? How feasible is this approach across settings? How can critical barriers to its roll out be overcome in different contexts?

2. How acceptable are CHW services at the frontline across diverse sub-populations of Nigeria? What factors influence this in different settings?

3. Which components of MAMII's client-centered service delivery approach are driving uptake of health services across MAMII-focal LGAs, why, and how? How does this vary based on context and implementation strength?

4. How well is the EMS reaching pregnant women,newborns, and children to ensure timely access to critical CEmONC and pediatric services—what are the pivotal influencing factors driving this outcome? What conditions are required to enable the scale-up of the digitally enabled ambulatory health service?

5. How feasible is the implementation of the revised BHCPF guidelines in geographic areas demonstrating greatest vulnerability among children under five and pregnant women (North West and North East zones)? What adaptations to the strategy may be needed in such contexts to ensure the resources channeled there are effectively increasing access to essential healthcare services?

To carry out this component of the research and learning agenda, the program will explore opportunities for partnering with federal- and state-level government research agencies and universities to conduct implementation research related to the delivery of priority SWAp interventions in Nigeria. The selected research institution(s) will also support the use of the IR findings by country stakeholders through tailored evidence translation activities, such as dissemination meetings, evidence dialogues, or sense-making consultative workshops; the research institution may enter into partnership with other specialized organizations to meet these and other technical needs.

9.5.2   Independent Impact Evaluation

The NPCU/SCO and the Department of Health Planning, Research, and Statistics with support from the World Bank, HNP and DIME teams will commission an independent impact evaluation for the program with a nested evaluation of program components. The WB DIME team will support the evaluation design. Nevertheless, the evaluation will address priority areas for the NPCU/SCO and the Department of Health Planning, Research, and Statistics.

9.6   Leveraging Digital Innovations

Under the HOPE-PHC program, the NPCU/SCO will carry out analysis of large microeconomic and social data sets and will utilize digital and computing power for more sophisticated modelling, experimentation, and econometric examination of micro and social policy impacts. The use of digital innovations will yield improvements in the ability of public systems to identify and quantify causal relationships. With the increasing availability of data from the NHMIS and other sources, a critical challenge is ensuring that analytical tools and evidence-generation practices align with contemporary data usage needs. Equally important is establishing a robust institutional framework capable of transparently and independently evaluating this evidence. The NPCU/SCO and implementing entities will facilitate comprehensive and large-scale data analysis, significantly enhancing the government's capacity for informed decision-making.

10

TECHNICAL ASSISTANCE POOLING AND TECHNICAL CAPACITY BUILDING TO DELIVER ON DLIS

Chapter 10 - Technical Assistance Pooling and Technical Capacity Building to Deliver on DLIs

This chapter will describe the structure of the implementation support and technical assistance required to deliver the interventions in NSHRII. It will specify what will be needed to deliver the DLRs, and the significance of additional support in allowing the HOPE-PHC program to close the gap between the States with the strongest and weakest health indicators. The Joint Health Sector Development Technical Assistance Fund (JHDTAF) manual, a stand-alone document, contains additional details on the Technical Assistance (TA) component and should be used in complementarity with the POM.

10.1 Mobilizing Technical Assistance to Address Training and Capacity Development Needs

The Government of Nigeria is adopting a sector-wide approach to implement the NHSRII, requiring all stakeholders to contribute to improving citizens' health by aligning with one national plan, one national budget and one set of results. This initiative aligns all stakeholders with one national plan, one national budget, and one set of results, ensuring a unified approach for improving health outcomes across the country. Central to this coordination is the SWAp Coordinating Office (SCO), located within the Federal Ministry of Health and Social Work (FMOH&SW). The SCO plays a pivotal role in managing and aligning efforts to implement the NHSRII through the 36+1 State Operational Plans.

A significant responsibility of the SCO is to harmonize technical assistance (TA) provided by various development partners (DPs) and agencies. Development partners are donor organizations and/or countries who provide development assistance for health in Nigeria.

This involves ensuring alignment and reducing fragmentation to enhance transparency, accountability, and efficiency in health sector interventions.

Currently, multiple development partners finance, contract or directly provide a wide array of Technical Assistance (TA), but these efforts are uncoordinated. To enable faster deployment, greater responsiveness and transparency, and improved accountability, pooling or alignment of technical assistance will be necessary. This initiative aims to harmonise technical assistance mechanisms and procedures, reducing fragmentation in externally funded development activities and minimizing the burden on health sector leadership through the establishment of a Joint Health Development Technical Assistance Fund (JHDTAF).

In addition to the technical, fiduciary, environmental, and social gaps identified through the Program's Appraisal by the World Bank, members of the development partners' group are encouraged to appraise the health SWAp to identify any additional risks and gaps that may require support during implementation. This support will cover all facets of the HOPE-PHC program. All partners are invited to contribute to the implementation support plans, adhering to the possible implementation support and financing arrangements described in the pooling options below.

Pooling Options for Technical Assistance

A review of various pooled technical assistance mechanisms implemented in multiple countries including Bangladesh, Botswana, Ethiopia, Mali, Mozambique, Tanzania, and Uganda identified three approaches to pooled TA; full pooling, mixed pooling, and loose pooling.

1. Full TA pooling is a model where development partners mix their financing for TA, procurement, strategic management, and control over the TA are carried out mainly by the NPCU/SCO on consultation with the participating development partners. This model entails the transfer of most TA resources and control to the NPCU/SCO who issue contracts to and directly manage TA personnel. This model was implemented in Ethiopia (2002 and 2018-2020). Although some perceive the results of this implementation to be mixed, donors and government in Ethiopia cite advantages of pooling TA, including that it:

    • places the government in control of resources, allowing flexibility of allocation on the basis of a set of priorities;

    • increases efficiency, in that the government does not have to deal with individual donors, and vice versa, and resources are managed from one pot;

    • encourages sectors and regions to use TA since the cost is not deducted from their budgets;

    • tends to drive harmonization because once funds are in a common pot, it makes sense to use a single set of guidelines for accounting, access, reporting and audit.

2. Mixed TA pooling, is a model where all health stakeholders (government,

development partners, civil society, and private sector) jointly oversee the TA, but the contracting is managed by one of the development partners providing financing. The functions of procurement and personnel administration are separated from the strategic management and control of the TA, such as its supervision, deployment, and performance assessment. This approach was implemented in Bangladesh, where an assessment indicates that the MOHFW made substantial progress in health outcomes and health systems strengthening. The SWAp facilitated the alignment of funding and technical support around national priorities, and improved the government's role in program design as well as in implementation and development partner coordination. Notable systemic improvements have taken place in the country's systems with regards to monitoring and evaluation, procurement, and service provision, which have improved functionality of health facilities to provide essential care. Implementation of the SWAp has, therefore, contributed to an accelerated improvement in key health outcomes in Bangladesh over the last 15 years. The health SWAp in Bangladesh offers an example of a successful adaptation of such an approach in a complex administrative structure. Based on the lessons learned from SWAp implementation in Bangladesh, its MOHFW needs to play a stronger stewardship and regulatory role to reap the full benefits of a SWAp in its subsequent programming.

3. Loose TA pooling is a model where the personnel and/or institutions providing TA directly provide in-house expertise, as from many UN Agencies, or the TA is contracted individually by one or more development partners, and the direction of the TA or institutions is shared between the government and development partners that contracted them. This is the least collaborative of the three approaches, and the current model in Nigeria.

10.2   Nigeria's Joint Pooling and Technical Assistance Model

Given the NHSRII and the health SWAp in Nigeria, a mixed TA pooling approach is adopted. In line with this approach, development partners are required to commit to financing and managing the joint pooling approach for technical assistance and support.

The NPCU/SCO will establish a Joint Health Development Technical Assistance Fund (JHDTAF) that will serve as a collaborative funding mechanism. This mechanism will oversee the allocation, financing, and procurement of technical assistance to support health system strengthening and improve service delivery in Nigeria. It will ensure that funds are efficiently managed, technical support is appropriately sourced, and resources are directed toward addressing critical gaps in healthcare infrastructure, workforce capacity, and service provision at national and subnational. The concept of the JHDTAF is based on the principles of pooled resources and collective efforts to address national/ subnational health priorities and issues. The aim is to progress from a loose to a mixed TA pooling approach, while gradually preparing to transition to a largely full TA pooling approach over time.

10.3   Objectives of the JHDTAF

The main objective of technical assistance funded and managed through the JHDTAF is to address key challenges in Nigeria's health sector by developing a coordinated framework, that aims to align TA efforts with demand and to ensure a results-focused approach, to harmonize TA provision across development partners, exploit synergies, and reduce the transaction costs of TA procurement.

This is therefore guided by the following secondary objectives:

- Strengthen the health system by supporting the implementation of policies to ensure the efficient delivery of health services

- Promote operational efficiencies by enhancing the quality and reach of health services, particularly in underserved areas

- Build capacity within local health institutions to enhance sustainability

- Drive innovation in the health sector

The JHDTAF will manage Pooled TA and coordinate Aligned TA supports. Pooled TA supports are jointly funded TA efforts from multiple DPs, that to be managed centrally within JHDTAF. Aligned TA are Independently funded by specific DPs but to be coordinated within JHDTAF.

10.4   Expected Outcomes of the JHDTAF

The work of the JHDTAF is expected to lead to the following outcomes:

- Improved transparency, efficiency, and equitable deployment of technical assistance across the country and within States, at Federal Ministry of health and across agencies

- Improved oversight on "quality" and responsiveness of technical assistance

- Increased ability for faster and more responsive technical assistance and support to the health sector

For additional details on the Technical Assistance (TA) component, kindly refer to the Joint Health Sector Development Technical Assistance Fund (JHDTAF) manual. This manual provides a comprehensive Standard Operating Procedure (SOP) outlining operational guidelines for:

- Pooled and aligned technical assistance

- Technical assistance requests and deployment

- Management and monitoring and evaluation (M&E)

- Fund management

The JHDTAF manual serves as a key reference guide for stakeholders, ensuring effective implementation of JHDTAF activities.

10.5 Governance and Mutual Accountability Structure of the JHDTAF Under the NHSRII

The governance arrangement and approval process for TA will be detailed in the TA Pool SOP document. Technical assistance needs are being documented across the health sector, scopes of work are being developed for the technical assistance needs, and presentations will be made to a Technical Advisory Committee.

The National SWAp Steering Committee (NSC), under the leadership of the CMHSW will mobilize all development partners (including those under the SWAp TWGs and others yet to commit to Nigeria's health sector SWAp) on the opportunity to provide continuous implementation support in the context of the BHCPP/HOPE-PHC program. The technical assistance supported by the Program will address the TA needs of national and subnational implementing entities to ensure alignment of efforts and the successful execution of all BHCPP and HOPE-PHC interventions.

The NPCU/SCO has the mandate to continuously expand the membership of technical working groups (TWG) and set up new TWGs as necessary to coordinate discussions, engagement, and planning across all development partners under the health SWAp. The TWGs are responsible for advising on sector-wide priorities (for example, the M&E TWG is tasked with creating sector-wide indicators and collecting inputs from relevant sub- groups, such as NHIA, NPHCDA, and Family Health). All SWAp TWGs will report their engagements and updates to the NSC, chaired by the CMHSW, and have specific terms of reference through which the NPCU/SCO will hold TWGs accountable.

Requests to the JHDTAF will cover the needs of all public health sector actors, including Federal Ministry of Health Directorates and Units, all Federal and National Agencies, and all States. Procedures have been established to:
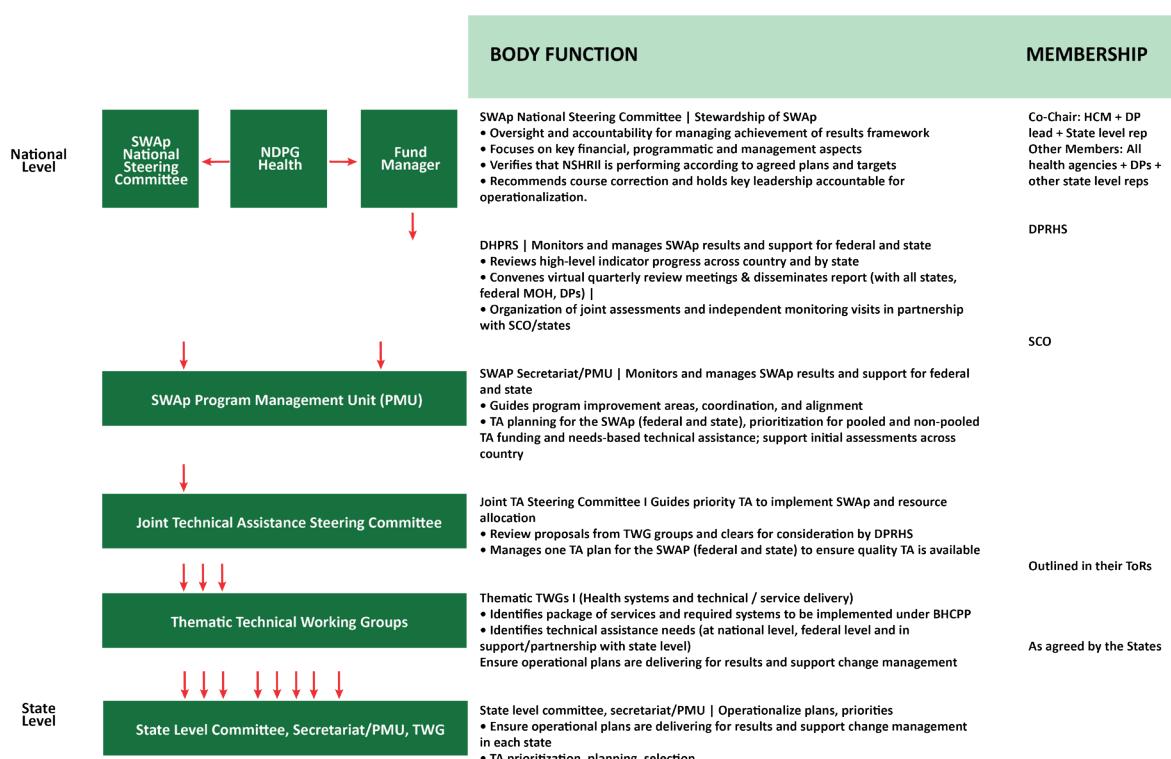
Figure 10.1: Proposed Governance Arrangement of JHDTAF (WIP)

- Set up databases of prospective TA personnel and institutions that are "pre-vetted" and can rapidly be deployed (similar to a retainer model)

- Determine eligibility criteria and other factors for "approval" of submitted SOWs and use of such resources.

- Conduct Performance Monitoring and Quality Control of Deployed Technical Assistance

- Identify a dedicated unit at the SCO-PMU to provide administrative support and coordination of all TA

Note: The points above cover pooled TA procedures and aligned TA (in-kind support, technical experts support, or parallel financing).

The table below shows some committed assistance that has been expressed by partners to the CMHSW and the NPCU/SCO in the context of the HOPE-PHC and the NHSRII as at May 2025.

Table 10.1 Role of Partners in Program Implementation

NAME	ROLE
Gates Foundation	TA
CIFF	Cofinancing /TA
FCDO	Cofinancing/TA
GAVI	TA
GFF	Cofinancing/TA
GIZ	TA
Global Affairs Canada	TA
GLOBAL FUND	TA
Japan International Cooperation Agency (JICA)	Cofinancing/TA
Large Anonymous Donor (LAD)	Cofinancing/TA
UNICEF/UNFPA/WHO	TA
US Centers for Disease Control (CDC)	TA
USAID	NDHS/State of Health Report/TA

The support provided through the pooled TA mechanism aims to facilitate coordination, monitor progress and outcomes, help identify and resolve roadblocks, strengthen performance management, improve equity, and enhance overall administrative efficiency for the NHSRII. It also largely supports attainment of the DLRs. In doing so, partners are invited to communicate core areas of strength to support implementation. The NPCU/ SCO will collate all expressed interest and share this with the CMHSW every six months. The NPCU/SCO is also expected to develop an annual implementation support report on all activities implemented that year and how the health SWAp has aligned the sector resources with the NHSRII (2024 report in Annex)

10.6 Technical Assistance Pooling Strategy

The NPCU/SCO will develop a National Implementation Support Plan from all TA requests from the national implementing entities and specific types of available TA financing or provision on offer from each DP. The NPCU/SCO will identify critical areas for additional support that may be missed from national implementing entities' requests and expressed interests from partners. The aggregation process for the National Implementation Support Plan (NISP) will prioritize the most critical requests from implementing entities, the most underperforming states, and the areas of most need. The NPCU/SCO, with the World Bank's "No Objection", will finalize the NISP to allocate resources from the program's investment financing to provide technical assistance for priority areas of program implementation that have not yet been mapped or received support from partners. This process will more efficiently deploy the resources available for TA support in the IPF component of the program (the TA support area report for 2024 is provided in annex 3).

The National Implementation Support Plan will be developed and published annually by the NPCU/SCO. It will show mapped commitments from named partners and implementation support plans that have not been funded. The plan will be used to proactively engage with and direct support from new and intending partners who have yet to commit to the SWAp.

11

COMPLEMENTARITIES BETWEEN THE HOPE HEALTH PROGRAM AND THE HOPE GOVERNANCE PROGRAM

Chapter 11 - Complementarities Between the HOPE-PHC Program and the HOPE Governance Program

The HOPE Program series comprises three interdependent operations strategically positioned to address different challenges while working towards the same development outcomes. While HOPE-PHC (Nigeria: Primary Healthcare Provision Strengthening Program: P504693/HOPE-PHC) and HOPE-Basic Education (HOPE for Quality Basic Education for All: P507001/HOPE-EDU) will focus on the quantity and quality of services delivered at the facility level. HOPE-Governance (HOPE-GOV) focuses on the critical crosscutting challenges and enabling factors related to both financial and human resource management.

Eligibility Criteria (EC) Into the HOPE-GOV Program

For each year of the HOPE-GOV Program, in order to be eligible to receive funds for achievement of the disbursement-linked results for that year, states need to achieve all of the HOPE-GOV annual Eligibility Criteria and also ensure and enhance the HOPE-GOV program segment for basic education and primary healthcare. The Eligibility Criteria set the ground for financial compliance and improve state appropriation for all of the HOPE operations including HOPE-PHC. The annual Eligibility Criteria comprise of three parts as shown in the table below: (1) Publication online on a timely basis the annual approved state budget in accordance with the national Chart of Accounts (with HOPE-GOV program segments for basic education and primary healthcare beginning with the FY26 budget); (2) Publication online of the HOPE-GOV annual audited financial statements prepared in accordance with IPSAS; and (3) Publication of HOPE-GOV timely quarterly budget implementation reports with detailed sections on basic education and primary healthcare.

Table 11.1   Eligibility Criteria Table into the HOPE-GOV Program

	Year 0: 2025 partial year	Year 1: 2025	Year 2: 2026	Year 3: 2027
EC-1	FY25 state budget, prepared under national Chart of Accounts, approved by the State Assembly and published online by January 31, 2025.	FY26 state budget, prepared under national Chart of Accounts with program segment for basic education and primary healthcare, approved by the State Assembly and published online by January 31, 2026.	FY27 state budget, prepared under national Chart of Accounts with program segment for basic education and primary healthcare, approved by the State Assembly and published online by January 31, 2027.	FY28 state budget, prepared under national Chart of Accounts with program segment for basic education and primary healthcare, approved by the State Assembly and published online by January 31, 2028.
EC-2	FY24 audited financial statement, prepared in accordance with IPSAS, submitted to the State Assembly and published by July 31, 2025.	FY25 audited financial statement, prepared in accordance with IPSAS, submitted to the State Assembly and published by July 31, 2026.	FY26 audited financial statement, prepared in accordance with IPSAS, submitted to the State Assembly and published by July 31, 2027.	FY27 audited financial statement, prepared in accordance with IPSAS, submitted to the State Assembly and published by July 31, 2028.
EC-3		FY25 quarterly budget implementation reports with detailed section on basic education and primary healthcare published on average within 30 days of quarter end.	FY26 quarterly budget implementation reports with detailed section on basic education and primary healthcare published on average within 30 days of quarter end.	FY27 quarterly budget implementation reports with detailed section on basic education and primary healthcare published on average within 30 days of quarter end.

The HOPE-GOV Program will support the full and sustained implsementation of strategic reforms in financial and human resource management enacted at the state level. The selected reforms are considered the most critical and impactful for strengthening the availability and efficient allocation of resources for basic education and primary healthcare transparency, accountability, and the appropriate use of allocated funds, as well as for the recruitment, deployment, and retention of adequate human resources for public institutions in these sectors. The HOPE-GOV program supports a subset of actions from the NHSRII, to be implemented from 2024 to 2028. These actions will mostly be undertaken at the sub-national (state and local government) level, with a few at the federal level.

The HOPE-GOV PDOs aim to support the Federal Republic of Nigeria in strengthening financial and human resource management in the basic education and primary healthcare sectors. Strengthening financial management is expected to enhance social contracts and citizens' trust in governments through strategic allocation and expenditure of resources

for basic education and primary health by increasing the availability and effectiveness of financing for these sectors, thereby boosting the efficiency of public expenditure. Consolidating human resource management will improve human capital outcomes by increasing the recruitment, deployment, and performance management of teachers and primary healthcare workers.

The HOPE-GOV Program will support Nigeria's states in addressing underlying governance weaknesses in the systems and procedures that constrain outcomes in primary healthcare, with a focus on improved financial resource allocation, efficiency in resource use, strengthened public financial management (PFM), improved sector fiscal transparency and accountability, and enhanced human resource management through results-based financing. Additionally, a US$20 million IPF component will finance TA structured around three results areas.

- Results Area 1: Increased availability and effectiveness of financing for basic education and primary healthcare service delivery. This results area will support the government in (i) enhancing states' access to UBE-IF resources; (ii) strengthening states' planning, budget preparation, and execution for basic education and primary healthcare; and (iii) improving budget-making at the local government tier through the adoption of the national chart of accounts at that level of government.

- Results Area 2: Enhanced transparency and accountability for basic education and primary healthcare financing. This results area will incentivize (i) the timely and consistent publication of citizen-friendly state basic education and primary healthcare budgets, budget implementation/execution reports, and transfers; (ii) the timely publication of financial and performance audits for the basic education and primary healthcare sectors; and (iii) improved transparency through the publication of procurement processes in the two sectors. These actions will help monitor the use of financial resources for their intended purposes.

- Results Area 3. Improved recruitment, deployment, and performance management of basic education teachers and primary healthcare workers by federal, state, and local governments. This results area will incentivize (i) the enhancement of state sector and workforce planning functions; (ii) the reduction of significant staffing gaps alongside improved deployment and management practices for basic education and primary healthcare workers; and (iii) the adoption of new or existing systems, such as the Central Bank of Nigeria's Bank Verification Number (BVN) system and National Identity Number platforms, to combat payroll fraud.

The HOPE-GOV program focuses on upstream activities with DLI 2 to DLI 6 focusing on primary health care and basic education services provision while DLI 1 only focuses on enhancing basic education financing. The table illustrates the DLIs under the HOPE-GOV program.

Table 11.2   Disbursement-Linked Indicator (DLI) Matrix of the HOPE-GOV Program

Disbursement -Linked Indicator	Total Financing Allocated (US millions)	Year 0	Year 1 – 2025	Year 2 - 2026	Year 3 – 2027
DLI 1: Enhanced access, and equity of UBEC financing of basic education		1.1. UBEC guidelines revised to: (i) enhance states' access approval and reporting process including publication of releases; (ii)) set rules for managing un-accessed funds	N/A	N/A	N/A
		N/A	1.2 UBEC funds are released to states in accordance with the revised guidelines.	1.2 UBEC funds are released to states in accordance with the revised guidelines.	1.2 UBEC funds are released to states in accordance with the revised guidelines.
DLR 1.1 value	7.50	4.50	N/A	N/A	N/A
DLR 1.2 value		N/A	$1.0	$1.0	$1.0
DLI 2: Strengthened state budget planning and execution for primary healthcare and basic education		2.1 State adopts comprehensive guidelines for preparation and submission of consolidated workplan for state basic education budget by March 31st, 2025	N/A	2.1 (i) Approved budget by Participating State based on annual workplan AND (ii) budget deviation for basic education < 20%.	2.1 (i) Approved budget by Participating State based on annual workplan AND (ii) budget deviation for basic education < 15%.
		2.2 State adopts comprehensive guidelines for preparation and submission of consolidated workplan for state primary health care budget by March 31st, 2025.	N/A	2.2 (i) Approved state budget based on annual PHC consolidated workplan AND (ii) budget deviation for primary healthcare < 20%.	2.2 (i) Approved state budget based on annual PHC consolidated workplan AND (ii) budget deviation for primary healthcare < 15%.
		2.3 Local governments adopt harmonized budget guidelines/ chart of accounts	2.3 Local governments publish FY25 budgets by February 28, 2026	2.3 Local governments publish FY26 budgets in line with the National Chart of Accounts by January 31, 2027	2.3 Local governments publish FY27 budgets in line with the National Chart of Accounts by January 31, 2028
DLR 2.1 value	$184.0				
DLR 2.2 value					
DLR 2.3 value					

DLI 3: Strengthened accountability and transparency for Federal funding for basic education and primary health care		N/A	3. UBEC and FMoHSW (through BHCPF MoC secretariat) publish online: (i) FY24 annual audited financial statements by May 31, 2025 AND (ii) Dates, amounts and recipients of all transfers made to subnational level on a quarterly basis within 15 days of the end of the quarter	3. UBEC and FMoHSW (through BHCPF MoC secretariat) publish online: (i) FY25 annual audited financial statements by May 31, 2026 AND (ii) Dates, amounts and recipients of all transfers made to subnational level on a quarterly basis within 15 days of the end of the quarter	3. UBEC and FMoHSW (through BHCPF MoC secretariat) publish online: (i) FY26 annual audited financial statements by May 31, 2027 AND (ii) Dates, amounts and recipients of all transfers made to subnational level on a quarterly basis within 15 days of the end of the quarter
DLR 3 value	$6.0	N/A	$2.0m	$2.0m	$2.0m
DLI 4: Strengthened accountability and transparency for basic education and primary health care funding at state level		4.1 Participating state publishes FY25 citizen budget for basic education and primary health by 28 February 2025	4.1 Participating state publishes FY26 citizen budget for basic education and primary health by 28 February 2026	4.1 Participating state publishes: (i) FY27 citizen budget for basic education and primary health by 28 February 2027 AND (ii) FY25 citizen performance audit report for basic education and primary health by 31 July 2026	4.1 Participating state publishes: (i) FY28 citizen budget for basic education and primary health by 28 February 2028 AND (ii) FY26 citizen performance audit report for basic education and primary health by 31 July 2027
		N/A	4.2 Financial and performance audits of basic education and primary health sub-sectors submitted to State Assembly and published by June 30, 2025.	4.2 Financial and performance audits of basic education and primary health sub-sectors submitted to State Assembly and published by June 30, 2026.	4.2 Financial and performance audits of basic education and primary health sub-sectors submitted to State Assembly and published by June 30, 2027.
		N/A	4.3 Publish contract award information for all procurements in the education and health sectors on a quarterly basis within 30 days of the end of the quarter in OCDS format on the online portal.	4.3 Publish contract award information for all procurements in the education and health sectors on a quarterly basis within 30 days of the end of the quarter in OCDS format on the online portal.	4.3 Publish contract award information for all procurements in the education and health sectors on a quarterly basis within 30 days of the end of the quarter in OCDS format on the online portal.
DLR 4.1 value	$66.0		N/A		
DLR 4.2 value		N/A			
DLR 4.3 value		N/A			

DLI 5: Increased numbers of teachers and health workers deployed		5.1 (i) Baseline exercise mapping the number and duty stations of basic education teachers across the Participating state and (ii) a multi-year costed teacher recruitment and deployment plan to address the staffing gap completed and published by March 31, 2025.	5.1 Participating state (i) publishes online report on actions taken and progress made in filling staffing gap and promoting equitable deployment by March 31, 2026 AND (ii) Meets basic or stretch target for gaps filled March 31, 2025:	5.1 Participating State (i) publishes online report on actions taken and progress made in filling staffing gap and promoting equitable deployment and (ii) meets basic target or stretch target for gaps filled as per Verification Protocol.	5.1 Participating State (i) publishes online report on actions taken and progress made in filling staffing gap and promoting equitable deployment; and (ii) meets basic target or stretch target for gaps filled as per Verification Protocol
		5.2 (i) Baseline exercise mapping number and duty stations of PHC workers in the Participating State and (ii) multi-year costed PHC worker recruitment plan to address staffing gap completed and published by March 31, 2025.	5.2 Participating State (i) publishes PHC staff gaps actions report; (ii) meets basic or stretch targets for gaps by March 31, 2026; and (iii) meets base target consisting of: (a) Staff in Level 2 Primary Health Care facilities (BEmONC) by 15%, (b) Community Health Workers (CHW) linked to Level 2 PHCs and deployed to communities by 15% as per Verification Protocol	5.2 Participating State (i) publishes PHC staff gaps actions report; (ii) meets basic or stretch targets for gaps by March 31, 2026; and (iii) meets base target: (a) Staff in Level 2 Primary Health Care facilities (BEmONC) by 15%, (b) Community Health Workers (CHW) linked to Level 2 PHCs and deployed to communities by 20% as per Verification Protocol	5.2 Participating State (i) publishes PHC staff gaps actions report; (ii) meets basic or stretch targets for gaps by March 31, 2026; and (iii) meets: base target: (i)Staff in Level 2 Primary Health Care facilities (BEmONC) by 15%, (ii) Community Health Workers (CHW) linked to Level 2 PHCs and deployed to communities by 15% as per the Verification Protocol
DLR 5.1 value	$189.50	$1 million per state	Basic: $1.2 million per state Stretch: $1.5 million	Basic: $1.3 million per state Stretch: $1.8 million	Basic: $1.3 million per state Stretch: $1.8 million
DLR 5.2 value		$1 million per state	Yes/No: $1.5 million	Yes/No: $1.8 million	Yes/No: $1.8 million

DLI 6: Improved payroll and performance management for teachers and health workers		N/A	6. Biometric capture and BVN data of 80 percent of BED and PHC workers in the public service completed and linked to payroll and identified ghost workers taken off the payroll.	N/A	N/A
DLR 6 value	$30.0				

The HOPE-PHC program aims to improve access to better-quality primary healthcare services. HOPE-GOV supports this outcome by strengthening upstream requirements for more effective service delivery, focusing on the efficient, effective, and accountable management of financial and human resources for the health sector. HOPE-GOV builds on the improved fiscal transparency and accountability results achieved under the States' Fiscal Transparency, Accountability and Sustainability (SFTAS) Program and will reinforce the institutionalization of the timely publication of core fiscal data, improved budget credibility, procurement transparency, and payroll integrity. HOPE-GOV deepens these reforms through a detailed and disaggregated focus on the primary healthcare sector, following the fiscal management chain from planning and budgeting to downstream implementation, reporting, and oversight.

While HOPE-PHC focuses on service delivery at the facility level, HOPE-GOV reinforces the institutional, financial, and human resource systems that enable effective and sustainable primary health care. The DLIs under HOPE-GOV are designed to unlock systemic constraints that directly affect the delivery and quality of PHC services—particularly financing availability, fiscal transparency, and health worker management.

The table below summarizes the HOPE-GOV Disbursement-Linked Indicators (DLIs) and describes how each one supports the objectives of HOPE-PHC:

Table 11.3   How the HOPE-GOV DLI supports the objectives of HOPE-PHC

HOPE-GOV DLI	Description	How It Supports HOPE-PHC
DLI 1: Enhance access to UBEC financing (education sector only)	Focuses on education only	No direct impact on HOPE-PHC
DLI 2: Strengthened state budget planning and execution for basic education and PHC	Requires states to develop costed annual investment/operational plans for PHC and improve execution rates	Enables states to align budgets with HOPE-PHC needs and improve the credibility and predictability of PHC funding
DLI 3: Strengthened accountability and transparency of federal transfers	Requires BHCPF releases and audits to be published within 30 days	Reinforces HOPE-PHC's financing base by ensuring transparency in BHCPF disbursements to PHC facilities
DLI 4: Strengthened accountability and transparency at state level	Requires publication of citizens' budgets, audits, and procurement info for PHC	Enables community monitoring and accountability for PHC funds and services

DLI 5: Increased recruitment and equitable deployment of PHC workers	Incentivizes states to map HR gaps, recruit, and equitably deploy PHC staff	Directly supports HOPE-PHC targets for workforce coverage and availability at PHC facilities
DLI 6: Improved payroll integrity and performance management	Promotes use of BVN/NIN for payroll cleansing and monitoring attendance	Ensures payroll efficiency and supports HR systems needed to manage PHC facility staff under HOPE-PHC

Together, these DLIs address upstream enablers of effective service delivery and reduce risks to the long-term sustainability of PHC reforms. States achieving results under HOPE-GOV will be better positioned to deliver on HOPE-PHC targets related to financing, staffing, facility functionality, and accountability.

The HOPEHOPE-GOV program will ensure sustained political commitment, broader government support, and structured funds flow mechanisms for primary healthcare while improving states' capacity to sufficiently build on existing gains. There are six DLIs under the three result areas (RAs). Each DLI has specific annual disbursement-linked results (DLRs) to be achieved by states for each program year. Each DLR has a specific amount of performance-based financing attached to its achievement per state per year. The Annual Performance Appraisals (APAs) will be carried out by the joint programs' independent verification agent (IVA) jointly commissioned by the FMBEP project coordination secretariat and the NPCU/SCO.

12

DESIGN AND APPROVAL OF CEmONC EMPANELMENT AND REIMBURSEMENT STRATEGY

Chapter 12 - Design and Approval of CEmONC Empanelment and Reimbursement Strategy

12.1 Empanelment criteria for CEmONC facilities

12.1.1 Identified as a Potential Facility for the Program

NHIA adopts differentiated approaches in identifying facilities for the CEmONC programme depending on the facility type. For a facility to be empanelled, it needs to have been identified in one of the following ways:

- Tertiary facilities: All federal facilities are considered for the CEmONC program

- Secondary facilities: NHIA engages the State Ministry of Health to nominate facilities to be considered for the CEmONC program

- Private facilities (including faith based): Facilities with high volumes of live births and maternal deaths are considered for the CEmONC program

For all the facilities, the following data are reviewed in the initial shortlisting of the facilities:

a. Number of deliveries (CS & vaginal)

b. Maternal and neonatal mortality rates

c. Obstetric emergencies

d. Neonatal complications

12.1.2 Meets Accreditation Criteria

Provides Basic Emergency Obstetric Care (BEmOC) Services: The facility should be capable of performing the seven signal functions of BEmOC, which include:

i. Administration of parenteral antibiotics for infections.

ii. Administration of parenteral uterotonics (e.g., oxytocin) to manage postpartum haemorrhage.

iii. Administration of parenteral anticonvulsants (e.g., magnesium sulfate) for pre-eclampsia and eclampsia.

iv. Manual removal of the placenta.

v. Removal of retained products of conception (following miscarriage or abortion).

vi. Assisted vaginal delivery (preferably with vacuum extraction).

vii. Basic neonatal resuscitation.

Accreditation for CEmONC related services: Facility should be accredited for and able to provide the following services:

i. Obstetrics & Gynaecology (including surgery, particularly Cesarean section)

ii. Safe blood transfusion

iii. Care for sick and low-birth weight newborns, including advanced resuscitation

iv. Paediatrics

v. Pharmacy

vi. Laboratory

Infrastructure and Facility Standards: The facility must have the necessary infrastructure, equipment, and supplies to perform the required CEmONC functions. This includes but not limited to:

i. Functional Operating Theater (for CEmONC).

- One set of Digital BP apparatus, Stethoscope, Adult Thermometer, Baby Thermometer, Baby Forehead Thermometer, Handheld Fetal Doppler, Fetoscope, Baby Weighing Scale, Measuring Tape for Four Labour Tables or at least two sets, Wall Clock.

- Availability of equipment & instruments for treatment procedures being undertaken in the facility

- Availability of equipment & instruments for diagnostic procedures being undertaken in the facility

- Avaialability of resuscitation instruments for Newborn and Mother

- Functional Surgical Operation bed and light

ii. Availability of essential drugs (antibiotics, uterotonics, anticonvulsants, anaesthesia).

iii. Equipment for assisted vaginal delivery, manual removal of the placenta and retained products.

iv. Blood transfusion services or access to safe blood transfusion.

v. Neonatal resuscitation equipment.

vi. Basic amenities like a regular water supply and waste management systems

Human Resource Requirements: Availability of skilled healthcare providers is crucial, including:

i. Obstetricians, Gynecologists, Anesthetists for CEmONC.

ii. Nurses and Midwives with appropriate training in emergency obstetric and newborn care.

iii. Equipment for assisted vaginal delivery, manual removal of the placenta and retained products.

iv. Trained support staff.

v. Adequate staffing levels to ensure 24/7 coverage.

12.1.3   Meets other empanelment requirements:

NHIA checks that facility meets all requirements listed below as defined in the NHIA operational guideline:

a. Legal and administrative requirements operations

b. Willingness to adhere to NHIA reporting (Monitoring and Evaluation) standards

c. Continuous quality improvement efforts

d. Acceptance of NHIA rates and billing requirements

e. Ability to receive referrals or further refer patients

f. Geographic and physical accessibility

g. Data management system

12.1.4   Passes facility readiness assessment (FRA) conducted by NHIA

a. Validate the capacity to capture patient encounter and service delivery data (required for claims management and health insurance enrolment)

b. Demonstrates empanelment requirement during scoping visit

12.1.5   Completes MOU signing

MoU signing between the facility, TPA and NHIA

12.2 Package List of CEmONC Services Eligible for Reimbursement

12.2.1   Background

The NHIA-financing access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) program aims to improve maternal and neonatal health outcomes b1y providing financial protection for women facing obstetric emergencies. As part of the implementation framework outlined in other documents, this document outlines the scope of conditions covered under the programme.

12.2.2   Services Covered

Within the NHIA-financing access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) program, six (6) major procedure categories are covered:

• Pre-Eclampsia (Mild to Severe)

• Eclampsia (in various stages)

• Obstructed Labour

- Caesarean Section

- Neonatal care services (Birth asphyxia, sepsis, jaundice, Preterm)

- Puerperal Sepsis

These six (6) procedures categories have been detailed into a comprehensive list of conditions are covered below:

Table 12.1 List of Conditions for the Six Procedure Categories

Conditions	ICD-10 Code
Pre-eclampsia (Mild to Moderate)	O.14.0
Pre-eclampsia (Severe Pre-eclampsia)	O14.1
Pre-eclampsia - HELLP (Haemolysis, Elevated Liver Enzymes and Low Platelets)	O14.2
Eclampsia in Pregnancy	O15.0
Eclampsia in Labour	O15.1
Eclampsia in the Puerperium	O15.2
Obstructed Labour	O66
Puerperal Sepsis	O85.0
Unspecified Abortion (Abortal Care)	O006
Antepartum Haemorrhage	O46.9
Post Partum Haemorrhage	O72
Delivery By Caesarean Section (Unspecified)	O82.9
Severe Birth Asphyxia	P21.0
Mild and Moderate Birth Asphyxia	P21.1
Sepsis of the Newborn	P36
Neonatal Jaundice	P59
Pre-term Delivery	O60
Ectopic Pregnancy	O00.9

12.3 Standard Operating Procedure for Claims Submission, Review and Payment

12.3.1   Purpose

The purpose of this SOP is to establish a standardized process for the efficient, accurate, and timely review and payment of healthcare claims.

12.3.2   Scope

Eligible claims include all medical, surgical, and pharmaceutical claims submitted by providers based on the NHIA tariffs for services rendered to beneficiaries.

12.3.3   Claims Documentation

Each healthcare facility must maintain accurate and verifiable patient records. The

provided patient form and claims form must be filled by the health facility for the purpose of reimbursement.

All claims must be based on the approved NHIA tariffs for the programme. The claims must include:

- Patient demographics and verification details (including National Identity Number (NIN))

- Diagnosis and treatment provided

- Itemized breakdown of services rendered

12.3.4 Claims Submission

- Each claim submission must include cover letter signed by the Medical Director of the facility or a designated representative.

- The health facility submits the claims forms alongside a signed cover letter to the assigned TPA copying NHIA cemonc@nhia.gov.ng

- The claims submission window by the healthcare facility is weekly for the previous week.

- TPAs receive, independently review, and reimburse claims.

12.3.5 TPA Claims Verification and Reporting

TPAs are required to submit reports regularly to NHIA in line with the facility claims submission schedule.

- TPA Information: Name, state coverage, and NHIA accreditation details.

- Claims Verification Summary: Total claims reviewed, approved, and rejected, with justifications.

- Service Utilization Validation: Cross-checking facility-reported figures with verified data.

- Program Beneficiary Insights: Number of women served and categorized service utilization.

- Fraud Detection & Compliance: Any detected fraudulent activities, inconsistencies, or facility non-compliance cases.

- Challenges and Recommendations: Observations, systemic challenges, and suggested process improvements

12.3.6 Payment

- NHIA front-loads TPAs with funds. This is to prevent any administrative and operational bottlenecks in disbursing funds to the healthcare facility when

needed.

- TPA disburses funds to facility within 14 days for verified claims.

- In the event that TPAs exhaust their funds, a reconciliation of accounts will occur with NHIA before processing another advance payment to the TPAs.

- TPAs receive, independently review, and reimburse claims.

12.3.7 Dispute Resolution

In case of any dispute among parties involved in the implementation of the program, the following steps should be taken:

- The affected parties are expected to attempt an internal resolution through designated focal persons.

- If unresolved, the aggrieved party should submit a formal written complaint to NHIA.

- NHIA reviews the case and recommends solutions

- NHIA issues a final decision on the dispute within a one-month period of the notification. Compliance with the resolution is mandatory for continued participation in the programme.

12.3.8 Data Quality Assurance

- TPAs must ensure beneficiaries have NIN before approving claims.

- NHIA will conduct random audits and validation checks to ensure TPA reported data aligns with facility records.

- Discrepancies or repeated non-compliance may lead to sanctions or suspension of TPA services within the program.

- Any party not complying with NHIA policies may be blacklisted from the programme.

12.4 Identification of third-party administrators (TPAS)

The selection of TPAs for the CEmONC programme has been informed by three (3) broad criteria:

12.4.1 Number of Private Enrollees

A significant number of private enrollees indicates the TPA possesses established operational capabilities for enrolment, healthcare provider relationship management, and claims processing, suggesting a readiness to handle the administrative demands of the CEMONC programme. Importantly, it demonstrates the capacity of the TPA to ensure

the enrolment of vulnerable groups, a core objective of the CEmONC intervention.

12.4.2 Financial Standing

A robust financial standing assures the NHIA that the TPA can securely manage the earmarked funds, meet financial obligations to healthcare providers promptly, and maintain programme stability. Sound financial management practices ensure accountability and prevent fund mismanagement. Additionally, a strong financial position ensures that the TPA is able to adapt to the geographical-spread imperatives of the CEmONC programme.

12.4.3 Risk Management practices

Strong risk management is crucial for protecting programme funds against fraud and abuse, ensuring the quality and safety of care provided during obstetric emergencies, and promoting efficient resource allocation. By proactively identifying and mitigating potential risks, the TPA can build trust, enhance the programme's credibility, and contribute to the long-term sustainability of the NHIA's intervention and trust amongst Nigerians by addressing issues like cost escalation and maintaining service quality

12.5 MOU Signing Process

12.5.1 Purpose

The purpose of signing Memoranda of Understanding (MOUs) between parties involved in the Financial Access to CEmONC intervention is to ensure clear roles and responsibilities, promoting efficiency, accountability, and proper documentation..

12.5.2 Scope

This process applies to NHIA Headquarters, NHIA State Offices, participating healthcare facilities, and Third-Party Administrators (TPAs).

12.5.3 Responsibilities

- NHIA: Finalization, legal vetting, and coordination of signatures. Distribution, record-keeping, and coordination between Legal department and State NHIA offices.

- NHIA State Offices: Coordination with facilities for signing and verification of documents.

- Healthcare Facilities: Reviewing and signing the MOU. TPA: Signing and returning the MOU to NHIA Legal.

- Director General (DG): Final endorsement of the MOU.

12.5.4   MOU Signing Process Flow

Finalization & Distribution

- NHIA Legal finalizes and vets the MOU.

- The finalized MOU is reviewed internally and

- NHIA emails the MOU to NHIA State Offices to print 3 copies.

Facility Signing & Verification

- The State NHIA shares the MOU with the facility during the onboarding session.

- The facility reviews and signs the MOU.

- The State NHIA verifies the signed MOU to ensure completeness and accuracy.

- Any discrepancies are addressed before submission to NHIA.

NHIA Review & Legal Processing

- NHIA cross-checks the MOU for completeness and records it for tracking and

- Forwards the MOU to NHIA Legal for further processing.

Third-Party Administrator (TPA) Signing

- NHIA Legal invites or dispatches the MOU to the TPA for signing.

- The TPA reviews and signs the MOU, then returns it to NHIA Legal.

Final NHIA Approval & Signing

- NHIA Legal signs and submits the signed MOU to the DG for final endorsement.

- The DG signs and returns the MOU to NHIA Legal.

Final Distribution & Record Keeping

- NHIA Legal keeps an official copy of the signed MOU.

- NHIA dispatches signed copies through NHIA State Offices to the respective facilities.

12.5.5   Compliance and Monitoring

- NHIA will maintain a database to track the status of MOUs.

- Any issues encountered should be reported to NHIA Legal for resolution

12.6 Key Performance Indicators for Claims Management

12.6.1   Framework for claims management

The Key Performance indicators for the claims management process are structured to measure the following desired objectives:

Quality: The NHIA conducts validation of claims to ensure that the right conditions are filed.

Accuracy: The NHIA assesses the claims submitted to ensure that data included in the claims form are accurate and is free from numerical errors.

Efficiency: The NHIA makes active effort to ensure that claims are submitted within the stipulated timeline, as defined within the framework for claims submission.

Dispute resolution: The NHIA ensures that complaints made are resolved and active steps are taken to prevent re-occurrences.

12.6.2   Key Performance Indicators for claims management

Claims Submission Timelines

a. % of claims submitted by providers in a timely manner.

Claims Processing Turnaround Time

a. Average number of working days from receipt of complete claim to final decision (approval/rejection).

Claims Validation and Rejection Rate

a. % of claims validated compared to claims submitted.

b. % of submitted claims rejected due to errors, incompleteness, or non- compliance.

Resubmission Rate

a. % of rejected claims successfully resubmitted and approved after correction.

Payment Timeliness

a. % of approved claims reimbursed within agreed payment window.

Dispute Resolution

a. Proportion of complaints made that are resolved.

b. Average number of days taken to resolve provider or TPA disputes related to claims.

Accuracy of Claims Documentation

a. % of claims submitted with complete, verifiable supporting documentation (e.g., case notes, discharge summary, consent forms).

b. % of claims submitted where re-imbursements requested were accurate.

TPA Verification Compliance

a. % of claims verified within timeline by TPAs, in line with standard operating procedures.

13

FINANCING ACCESS TO ESSENTIAL HEALTH SERVICES FOR VULNERABLE AND POOR NIGERIANS

Chapter 13 - Financing Access to Essential Health Services for Vulnerable and Poor Nigerians

13.1 Background

The NHIA, in line with the Health Sector Renewal Investment Initiative led by the Coordinating Minister for Health and Social Welfare has made equity a key pillar for financing access to health services. Accordingly, the NHIA through its equity programs is prioritizing targeting the poor and vulnerable persons with financial interventions.

This strategic direction is also in line with the NHIA Act; section 25 which stipulates the establishment of a Vulnerable Group Fund (VGF) to provide finance to subsidize the cost of provision of health care services to vulnerable persons in Nigeria (which according to section 59, includes the children under-5, pregnant women, the aged, physically and mentally challenged and the indigent as may be defined from time to time). Three programs are currently being implemented in this regard. These are the Basic Healthcare Provision Fund (BHCPF), the NHIA-financing access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) program, and the NHIA Fistula-Free Program.

1. The Basic Healthcare Provision Fund, through the NHIA gateway, aims to improve access to quality care and provide financial protection to vulnerable Nigerians. To implement the program, the NHIA works with states to provide a basic minimum package of care to all residents of Nigeria, as defined in the guidelines developed for the implementation of the Basic Health Care Provision Fund.

2. The NHIA-financing access to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) program aims to improve maternal and neonatal health outcomes by providing financial protection for women facing obstetric emergencies. As part

of the implementation framework outlined in other documents, this document outlines the criteria for potential beneficiaries of the program.

3. The Fistula-Free Program aims to address the immediate healthcare needs of vulnerable women facing Obstetric Fistula, while also ensuring long-term access to essential medical services through enrolment in the VGF/BHCPF.

13.2 Defining Vulnerability

Vulnerability in Nigeria is contextual and certain types of vulnerability are specific to geographies, gender, age, income, health status, or are multidimensional (including climate and conflict). As a result, it may be chronic or acute.

13.2.1   Chronic Vulnerability

While not the primary focus of the CEmONC intervention, it is important to distinguish chronic vulnerability for policy and system integration purposes. Chronic vulnerability in this context refers to the persistent, long-term conditions such as poverty, displacement, social marginalization, health related condition, or age-related exclusion that limit a person's ability to access healthcare services consistently.

These mechanisms for identifying the vulnerable are adapted to specific state contexts. For the BHCPF, the state health insurance agencies leverage these approaches to identify beneficiaries.

These include:

i.   Poverty and Socioeconomic Index: A multidimensional measure aligned with the national social register, used to identify poor households. The national social register, while being increasingly comprehensive, is limited by its static nature and infrequent updates. Hence, while a good starting point, is limited in targeting. Strengthening this iss a priority.

ii. Community-based Targeting: Involves engaging community structures to identify vulnerable individuals and households based on local context and social insight.

iii. NHIA-Specific Criteria – Focuses on predefined vulnerable groups such as the elderly, internally displaced persons (IDPs), persons living with disabilities, children under-5, pregnant women, as outlined in the NHIA Act, people living with certain diseases (e.g., HIV/AIDS, TB) and others prone to catastrophic health expenditure.

NHIA maternal initiative addressing chronic vulnerability

• The NHIA Fistula-Free Program is targeted at providing access to care for women suffering from a devastating obstetric complication – fistula. The women suffering from this condition are typically poor, isolated, socially excluded and often abandoned.

- For these women, no form of assessment is required and once they present or selfidentify, they are eligible for the program.

13.2.2   Acute Vulnerability

For women experiencing maternal morbidity and mortality during labour and delivery, the 72-hour perinatal period represents a time of heightened risk and vulnerability. In spite of the numerous maternal and child interventions, the leading causes of maternal death still occur during this crucial window.

To ensure that these vulnerable women have access to life-saving care within the period of heightened risk, we have defined below, the approach to identification of these vulnerable women eliminating potential "beneficiary identification bottlenecks".

NHIA maternal initiative addressing acute vulnerability

- The NHIA's the CEmONC program is specifically designed to address acute vulnerability—that is, the immediate, life-threatening risk faced by women experiencing severe obstetric complications. Recognizing and responding swiftly to these cases is essential to preventing maternal and neonatal mortality.

- In the context of the NHIA's maternal health initiatives, acute vulnerability refers to the urgent and severe risk of death or disability faced by women during obstetric emergencies especially when they are unable to access timely and appropriate care due to financial, geographic, or systemic barriers.

- To ensure a targeted and accountable response, the CEmONC program leverages the role of social workers at the healthcare facilities, who serve as the first point of identification for acutely vulnerable women. These social workers are embedded within the CEmONC multidisciplinary teams, where further social validation occurs while services are provided. This process ensures that the intervention reaches women who would otherwise be excluded from emergency care due to structural or financial constraints.

Finally, NHIA is developing a vulnerability mapping assessment tool that harmonizes the various tools of identification of chronic vulnerability across states and programs, drawing on all existing tools.

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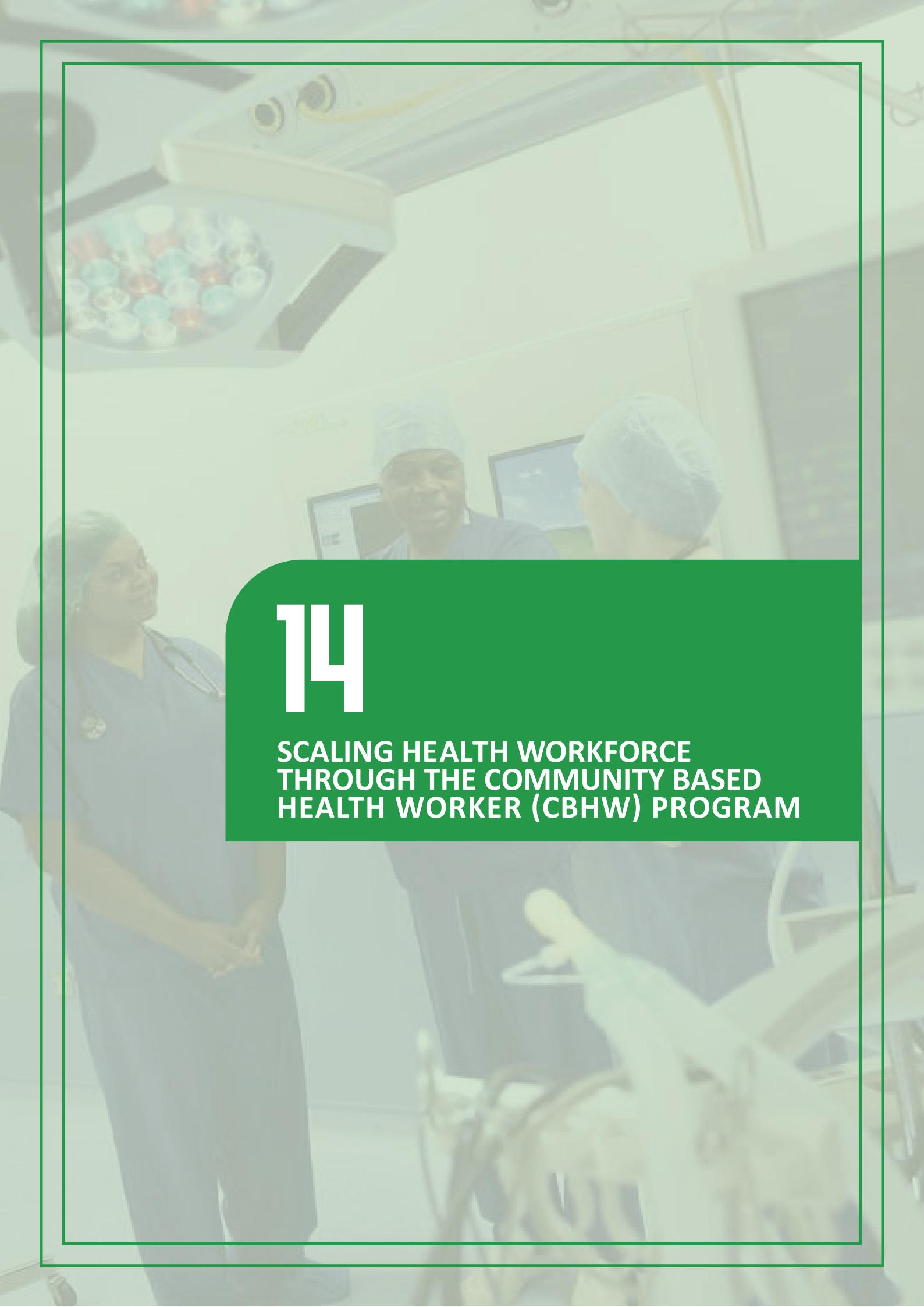
SCALING HEALTH WORKFORCE THROUGH THE COMMUNITY BASED HEALTH WORKER (CBHW) PROGRAM

Chapter 14 - Scaling Health Workforce Through the Community Based Health Worker (CBHW) Program

14.1   Program Rationale and Evolution

The delivery of community-based health services in Nigeria has been constrained by silo-ed responsibilities, insufficient frontline workforce, and lack of resources for service delivery at the frontlines. The Federal Government of Nigeria initiated the Community Health Influencers Promoters Services (CHIPS) program in 2018 to harmonize all previously existing Community-based health volunteer programs. However, such efforts have faced challenges such as weak supervision, inconsistent remuneration of volunteers and poor subnational engagement and buy-in.

As part of the Nigeria Health Sector Renewal Investment initiative{NHSRII} supported by a SWAp, the Community Based Health Worker (CBHW) program has been redesigned to improve on the Community Health Influencers Promoters Services (CHIPS) program. The CBHW is vital for Nigeria's UHC aspirations playing key role in health promotion, disease prevention, provision of basic services and demand generation because they link community members to health facilities. There is therefore an imperative to better structure, professionalize and implement the community-based health workforce model in a sustainable manner.

From the foregoing, Nigeria's evolving community level PHC landscape supports a hybrid model where **Junior Community Health Extension Workers (JCHEWs)** and

Auxiliary Community Health Workers (ACBHW) will be employed to provide a broad set of services1. With reference to the new guidelines, the two cadre of workers under the CBHW are as follows:

- Junior Community Health Extension Workers (JCHEWs) (see POM annex for definition).

- Auxiliary Community Health Workers (ACBHW) (see POM annex for definition).

14.2   Minimum Requirements Under the NHSRII

I. As part of the NHSRII, a minimum number of CBHWs per ward (outlined in the CBHW national guideline) will be recruited, trained, deployed, mentored, and supervised. The ratio of the JCHEWs to ACBHW to be engaged should be 1: 3 to ensure adequate supervision of the ACBHWs.

II. States can maintain or increase those numbers as required, this will be determined by the states based on the availability of either cadre and barriers to utilization of health care services (Hard-to-reach settlements, scattered settlements, non-functional or partially functional health facilities etc. availability of resources for efficient, effective, and sustainable implementation.

III. The selection of CBHWs should be a collaborative process that is community-driven with guidance and support from the local government health management team, CSOs, SPHCDA, and NPHCDA. The community mechanisms involved include community members, ward development committees, and existing traditional institutions.

IV. The NPHCDA is expected to concurrently ensure the engagement of unemployed CHEWs by State governments so that the revitalized Basic Health Care Provision Fund (BHCPF) PHCs will have adequate health workers to supervise the CBHWs and contend with the attendant increased demand for health care services. This will further support States to unlock additional financing available through HOPE GOV operations.

14.3   Cadre Differentiation

I. The state governments will be required to deploy skilled unemployed CBHWs (JCHEWs) to provide complex prevention, diagnosis and simple curative services while the less skilled and informally trained Auxiliary CBHWs (e.g CHIPS Personnel, Volunteer Community Mobilizers (VCMs)) should be upskilled to provide simple health promotive, preventive and basic curative services. The details on their selection criteria and scope of work are outlined in the CBHW national guidelines.

II. CBHWs will receive a salary in line with the state's salary structure and in consideration of differential renumeration based on the qualification and scope

of work between the two cadres. II.Governments would publicly recognize top CBHW performers (based on quality-of-service provided, data and feedback from Supervisors and the community) may wish to provide performance-based incentives and access to income-generating activities to CBHWs to improve their motivation and productivity.

14.4   Implementation Timelines and Phased Coverage

I. The National CBHW implementation strategy targets coverage across the 8,800 wards of the country within a 5-year period. Table 1 provides the roadmap for expanding CBHWs in the country with a recommended target of universal coverage by 2028. The proposal is frontloading incremental rate of 25% in the following 2 years (2025 – 2026) and 15% increase in the remaining two years (2027 – 2028). The strategy prioritizes CBHW coverage in the early periods in rural areas hence the recommendation is to have a more rapid annual increment in the rural areas, with 100% of rural populations reached with services by 2027 while the entire population will be reached with community-based services by 2028.

II. The MAMII LGAs comprising 172 LGAs in 33 states with highest burden of Maternal mortality have been prioritized for roll-out of CBHWs (Maternal Mortality Investment Initiative (MAMII). Furthermore, there is an overlap of these LGAs with the most burdened malnutrition LGAs across 21 states based on Cadre Harmonize data. The remaining high burdened malnutrition LGAs that aren't overlapping with the MAMII LGAs will also be prioritized for the CBHW roll-out LGAs across 33 states in the country with highest burden of Maternal mortality have been identified as MAMII LGAs

III. The entire national planning processes of this phased implementation framework is based on the recommendation of a blended model of the CBHWs with a mix of 3:1 (ACBHWs to JCHEW ratio). States can, therefore, begin with an appropriate mix starting from their current point and build up an optimum of having a predominantly JCHEW-led program.

Table 14.1 Phased coverage of CBHWs

National population targeted by CBHWs	Roadmap for CBHW Scale-up				
	2024	2025	2026	2027	2028
Rural areas (%)	30.0	60.0	85.0	100.0	100.0
Urban areas (%)	10.0	30.0	55.0	70.0	100.0
Total (%)	19.3	43.8	68.9	83.9	100.0

14.5   Supervision and Performance Management

I. Performance management of the CBHWs is crucial to ensure services are provided

as and when required, and to the level of quality expected to achieve results and make an impact on health outcomes. As such, the technical supervisors of the ACBHWs shall be the JCHEWs and where there are gaps, facility-based staff such as CHEWs and Community Health Officers (CHOs) will be required to step in. The JCHEWs in turn will be supervised by CHEWs, and the CHOs in the focal health facility.

II. Various methodologies will be used to intensively mentor the ACBHWs and the JCHEWs during the first 3 months of service delivery to ensure qualitative service delivery. Supervision (technical and non-technical) of both cadre of CBHWs will be conducted monthly subsequently.

III. The Ward Development Committees (WDCs) shall provide oversight in their respective communities and alongside other identified stakeholders provide non-technical supervision and implementation support. This Ward level Supervisors will provide feedback of their activities on a monthly basis to the BHCPF desk Officer at the LGA level on a monthly basis. The non-technical supervision includes monitoring commodity stock balance based on services provided (Commodities will be provided to each personnel in a bag for ease of transportation. The list is in the annex).

IV. The CBHWs will undergo 5-day in-person classroom and field training followed by structured mentoring and coaching sessions for 3 months to be anchored by the CBHW supervisors. Certificates of participation in the training will be issued when the mentoring and coaching session is successfully completed. To ensure proper monitoring and supervision, data collected by CBHWs will be linked to the Community-Based Health Information System (CBHMIS) instance of DHIS2 upon validation by Supervisors the national community-based health worker health
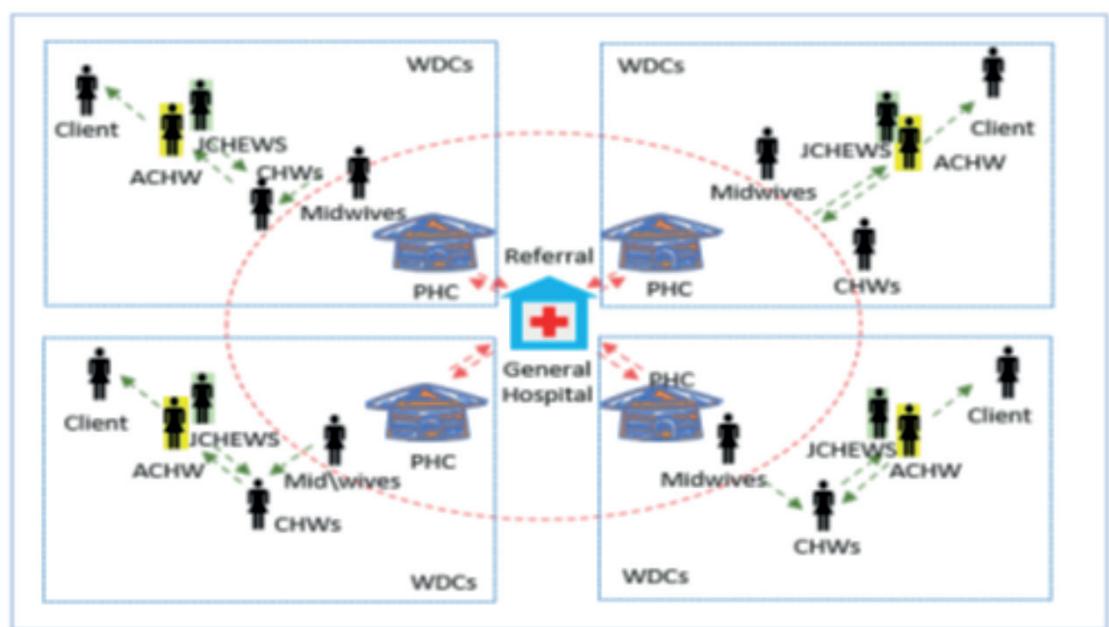
Figure 14.1 Community Referral System Managed by CHWs and Midwives

management system (CBHWHMIS) will be operationalized to provide real-time visibility to CBHW performance and coverage.

14.6 Incentives and State Engagement

1. To expedite the implementation of the CBHCW program, the NPHCDA will provide financial support to state governments that demonstrate the readiness and willingness to commence the program, as evidenced by their conduct of verification and mapping exercises of all available community health workers. This will be dependent on alignment of State's workplan with guidance given by NPHCDA and prioritization of high burdened Maternal mortality and malnutrition LGAs., with start-up funds. These start-up funds are designed to support the first two years of the program and will be dependent on state performance on results.

2. It is expected that thereafter, state governments would have fully absorbed the CBHWs into their health system and assume the payment of their remuneration. Upon integrating CBHWs into their systems, States will be able to unlock HOPE-GOV DLI 5.1 funds to scale-up CBHW program and sustain their remuneration.

3. These states will be required to submit a notification of interest to NPHCDA and will sign a memorandum of understanding (see Annex) to indicate agreement on the terms.

Table 14.2: List of CBHW commodities

Priority Areas	Service contents
Reproductive Health	A set of Family planning commodities (condoms. IUD, Pill, Beads etc)
Maternal Health	Misoprostol (Packs)
Newborn Care	Chlorhexidine Gel
Child Health	Lo-ORS
	Zinc Tab 20mg
	Paracetamol (Card)
	Amoxicillin (Dispersible) sachet
	ACT (Artemeter Lumefantrin)
	Malaria RDT Kits of 25 in a Kit
	Albendazole

Kitting and Equipment	Latex Gloves (100)
	Respiratory Timer
	MUAC Strips (per piece)
	Ankara (Bundle of 4 Yards Each)
	Masking Tape (Big)
	Measuring jug
	A big cup with a cover
	Towel (for tepid sponging demonstration) Spoon (Stainless)
	Notebooks
	Job Aids
	Scissors
	Apron
	Long Lasting Insecticidal Net (LLIN)
PPE	Liquid Soap (50cl Size)
	Facemasks
	Infrared thermometer
	Veronica buckets
	Hand sanitizers

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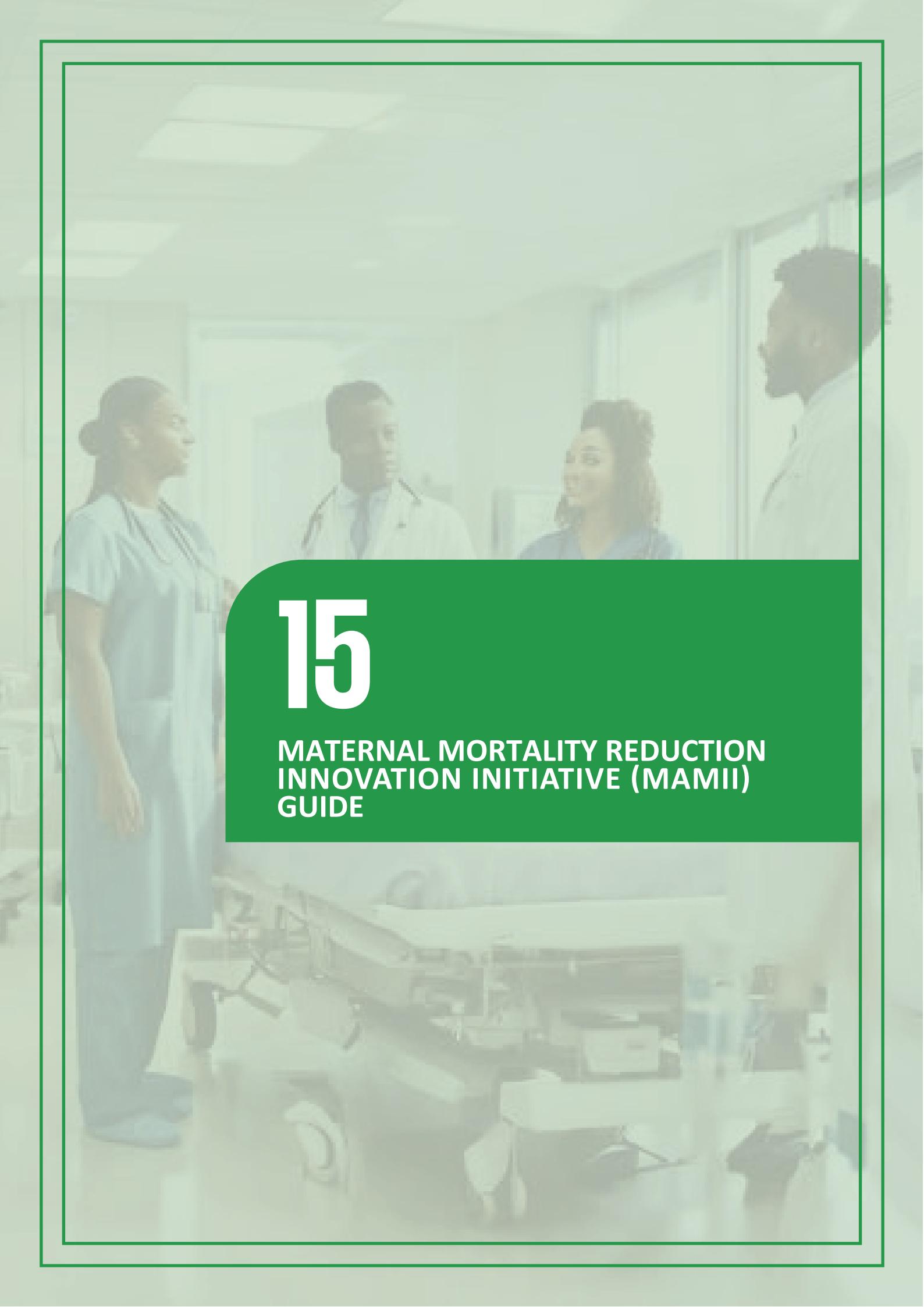
MATERNAL MORTALITY REDUCTION INNOVATION INITIATIVE (MAMII) GUIDE

Chapter 15 - Maternal Mortality Reduction Innovation Initiative (MAMII) Guide

15.1   Introduction

Nigeria's maternal and child health indicators have seen only marginal improvements between 1990 and 2023. Despite decades of intervention, maternal mortality remains critically high, with low skilled birth attendance (46% in 2023) and limited postnatal checks (43% in 2023). Contributing factors include poor quality of care largely due to weak health systems, equity of service delivery, and financial accessibility.

The Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII) launched in November 2024, aims to ensure that no area in Nigeria is at Stages I and II of the obstetric transition[20] by December 2026. This prioritized objective is in keeping with the national goal to reduce maternal mortality by 30% and increase health facility utilization by 60% by 2030. MAMII sets the stage for this vision in high-burden LGAs by introducing performance standards, accountability framework, and a roadmap for rapidly improving MNCH outcomes in Nigeria at scale. MAMII seeks to achieve increased access to and utilization of maternal, newborn and child health services and improved skilled birth attendance to significantly reduce maternal, neonatal and child deaths in these prioritized LGAs.

It is noteworthy that there are regions in Nigeria that are gradually shifting from a pattern of high maternal mortality to low maternal mortality, but progress is not uniform,

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20. Souza JP, Tuncalp O, Vogel JP, Bohren M, Widmer M, Oladapo OT, Say L, Gulmezoglu AM, Temmerman M. Obstetric transition: the pathway towards ending preventable maternal deaths. BJOG 2014; 121 (Suppl. 1): 1–4. In Stage I (MMR >1000 maternal deaths per 100 000 live births) most women experience a situation close to the natural history of pregnancy and childbirth, with very little – if anything at all – being done to reduce the risk of maternal mortality at the population level". In Stage II (MMR 999–300 maternal deaths per 100 000 live births) mortality and fertility remain very high, with a similar pattern of causes as in Stage I. However, a greater proportion of women start seeking care at health facilities".

is delayed and there are opportunities to course correct. The MAMII recognizes the variability and equity considerations on the path towards eliminating maternal mortality. Thus, this initiative takes these peculiarities into account by customizing strategies to make progress by deploying both geographical and targeted cost-effective interventions that could accelerate mortality reductions in the country. MAMII is a country-owned initiative that adopts a data-driven, context-specific sector wide approach with different stakeholders playing significant roles. The MAMII focuses on reaching the poorest and most vulnerable populations to address persistent inequities.

The MAMII addresses demand, access and quality of care issues as well as primary prevention. It strengthens overall collaboration across levels of government and across partners to remove barriers to accessing the health system together with rapid improvements in quality of care. The initiative focuses on guaranteeing the availability of basic infrastructure (including human resources for health), improving the quality of services received (including introducing innovations to make births safer), and implementation of maternal-mortality primary prevention measures including access to family planning, safe abortion, iron/MMS supplementation, and insecticide treated nets. Digitalization and deployment of Emergency Transport Systems (ETS) will be deployed for effective coordination of various stakeholders for MAMII initiative to achieve its goals. Digitalization is an essential element through which the MAMII initiative will achieve its goals, both in terms of supporting the supply side and demand side interventions, and by providing new ways to address gaps.

15.2   Priority Intervention LGAs

Extensive data analytics and maternal health assessments conducted identified 172 high-burden LGAs across Nigeria's six geopolitical zones, as follows: Northwest: 66 LGAs, Northeast: 51 LGAs, North-Central: 11 LGAs, South-South: 19 LGAs, Southeast: 13 LGAs, Southwest: 12 LGAs. These LGAs, with MMRs ranging from 300 to >1,000 maternal deaths per 100,000 live births (stages I and II of the obstetric transition), contribute 55% of national maternal mortality and account for 18% of under-five mortality (based on NDHS 2018).

All MAMII LGAs are guaranteed at least one certified BEmONC and one CEMONC addressing poor quality of EmONC services at health facilities. Health systems
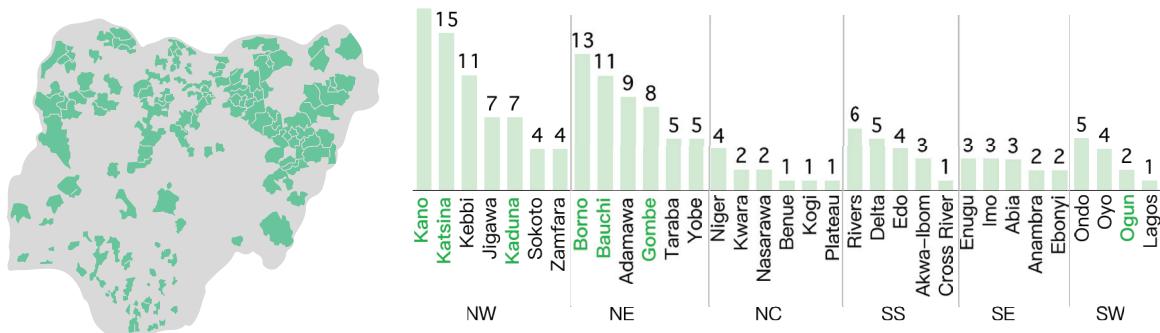

Figure 15.1 - Priority LGAs

| Delay in seeking care | Delay in reaching care | Delay in receiving care | Delay in taking responsibility | Delay in Coordination |

Figure 15.2 - 5 Delays in Accessing Healthcare

challenges in the prioritized LGAs include, severe facility readiness gaps, limited ability and accountability for quality of care, geographic and financial barriers to access, and socio-cultural barriers to maternal health-seeking. This is captured in the 5 delays shown below. A key intervention under MAMII for addressing these is ensuring facilities with the following attributes are available in each of the LGAs: Service availability 24/7; availability of skilled providers according to criteria set by the relevant entities; referral service to higher-level care through emergency transport systems (ETS); communications and digital tools; reliable electricity, water supply and clean toilets.

15.3   MAMII Interventions

By targeting these LGAs first, MAMII aims to make the biggest possible impact where the need is most urgent. The main added value of the Initiative is the intentionality in ensuring the combination of well-coordinated demand creation and service improvement activities. The MAMII strategic framework interventions and strategies for improving maternal, neonatal and child health and survival closely track the household-to-hospital continuum of care (HHCC) approach. By addressing each of the delays, but especially delays in seeking, reaching and receiving care, MAMII interventions encompass community engagement, physical and financial access, facility readiness, enablers, data intelligence and coordination.

15.3.1   Community Engagement, Stewardship, and Services:

To address prevention and the 1st delay, MAMII will engage at the community level through:

- Beneficiary Identification:

  - Identification and line-listing of every pregnant woman and provision of tailored services including caesarean section and treatment of obstetric complications (including fistula) at no cost to the woman

  - Pregnant women will be identified within the community through CHWs and TBAs; and followed up by the CHWs

  - At the government and faith-based health facilities by HCWs
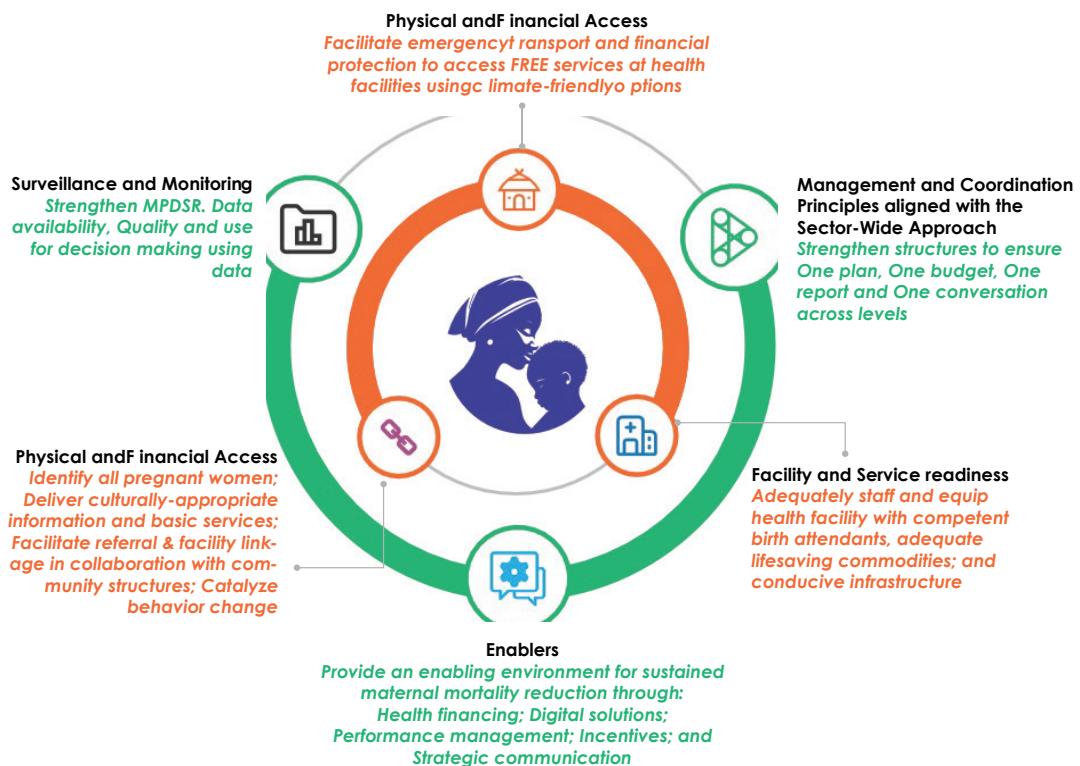
Figure 15.3 - MAMII Strategic Framework

- Locally customized interventions to strengthen community structure to address demand barriers and practices on maternal, newborn and child health.

- Health education and literacy campaigns for women in the community.

- Deployment of community health workers for proper birth plan and complication readiness. They will also ensure referrals and follow-ups.

- Engagement with Traditional Birth Attendants (TBAs) and faith-based health facilities. A transition plan will guide TBAs into becoming advocates for skilled care, companions during childbirth, or community mobilizers.

- Mobilization of community leadership structures. Forming community coalitions, direct engagement (e.g., workshops, door-to-door outreach), and capacity building of local groups to boost service uptake

- Ward Development Committees (WDCs) co-managing Primary Health Care (PHC) facilities, advocating for health resources, and mobilizing local solutions.

- Integrating National Health fellows (NHFs) into MAMII by training them to support PHCs at the LGA level and assist with community health education, logistics, care coordination, and social support.

Step 1
Identify all pregnant women in facilities and communities

In PHC: Use ANC registers to find women in facilities

In the community: Use CHWs to find women in communities

Step 2
Link woman to a dedicated care team of CHW and/or SBA

Refer to the mapped PHC

Step 3
Ensure the woman has the correct information and ability to seek care

CHWs conduct house-tohouse visits to provide health education, promotion, counselling and basic services; develop birth plans

Woman has transport support to access basic and emergency services at the facility

Step 4
Provide needed services directly to the woman (at the facility or in community)

- Routine ANC diagnostics including ultrasound and preventive ANC therapies
- Commodities at no cost
- 24hrs access to care by SBA
- Delivery, BEmONC andCEmONC
- Access to care by SBAs
- SRH

Step 5a
Follow woman at every stage of pregnancy to ensure smooth delivery

Track every woman. in case of a drop out, trace and return to care

In the event of complications, refer to mapped CEmONC center for emergency obstetric & newborn care at no cost to the woman

Step 5b
Provide post natal care (birth spacing, contraception & immunization)

In the event of death, ensure every death is notified, investigated and responded to

Figure 15.4 - MAMII Step-by-Step Approach to Improving the Maternity Journey

15.3.2 Physical and Financial Access:

To address delays in reaching care (including referral) due to geographic and financial barriers, MAMII will support investments into:

- Development of Emergency Transport Systems (ETS) for rapid response to the need of beneficiaries. NEMSAS will provide transport serial voucher for pregnant women to enable them to access the ETS when the need arises. This will address issues with the second delay of reaching health care.

- Functional referral system operationalization between BEmONC and CEmONC facilities to ensure transportation time is within 2 hours between referral points (HomeBEmONCCEmONC)

- For financial access, the NHIA will empanel CEMONC facilities, both secondary and tertiary, to offer free caesarian section for pregnant women in need.

- All women and children befitting from these services are entitled to subsequent enrolment by the NHIA as poor and vulnerable populations.

15.3.3 Facility Readiness

To address the 2nd and 3rd delays, MAMII will ensure the availability of facilities able to provide emergency obstetric and newborn care:

- Upgrading of health facilities

- BEmONC facilities will be upgraded to Level 2 functionality to offer twenty-four-hour services. They will be equipped (with staff, supplies, operating standards) to provide the seven signal functions, particularly interventions such as assisted vaginal delivery, newborn resuscitation, and management of obstetric complications.

Facility should also be able to support exclusive breastfeeding, kangaroo mother care, and provide oxygen therapy. For the implementation of MAMII activities EmONC facilities will be identified in the order shown below in figure 5.

- CEmONC facilities will be identified and supported through a unique partnership between the SCO and state governments. All identified facilities are required to have MOU certification which will be provided by the NHIA upon which they are empaneled to provide quality higher-level services including surgical interventions (e.g., free Caesarean sections, fistula repairs, etc), blood transfusions, and other specialist care, including CPAP, thermal care, phototherapy, IV fluids and nutrition for small and sick newborn, in addition to the BEmONC signal functions. NHIA empanelment criteria to attain MOU certification is shown below in Table 13.1.

- Provision of climate-resilient health services to address infrastructure challenges.

Table 15.1- NHIA CEmONC Facility Empanelment Criteria

1. Identified as a potential facility for the program	All federal facilities, nominated state facilities, and private (+ faith based) facilities with high volumes of live births and maternal death
2. Meets accreditation criteria	Provide full CEmONC signal functions; must have the necessary infrastructure, equipment, and supplies, including oxygen; skilled healthcare provider and trained support staff available 24/7;
3. Meets other empanelment requirements	Legal and administrative requirements operations; adherence to NHIA reporting standards; CQI efforts; Acceptance of NHIA rates and billing requirements; Ability to receive referrals or further refer patients; Geographic and physical accessibility; Data management system
4. Passes facility readiness assessment (FRA) conducted by NHIA	Validate the capacity to capture patient encounter and service delivery data; Demonstrates empanelment requirement during scoping visit
5. Completes MOU signing	MoU signing between the facility, TPA and NHIA

- Prepositioning and availability of essential maternal, newborn and child commodities/consumables, including oxygen, adult resuscitation/CPR, and equipment for small and sick newborn care.

- Standardized treatment protocols and operating procedures for EmONC

- Availability of WASH and waste disposal services

- Intensive training and capacity building for healthcare workers (see SBBC below)

- Implementation of effective Maternal & Perinatal Death Surveillance and Response (MPCDSR) in priority locations
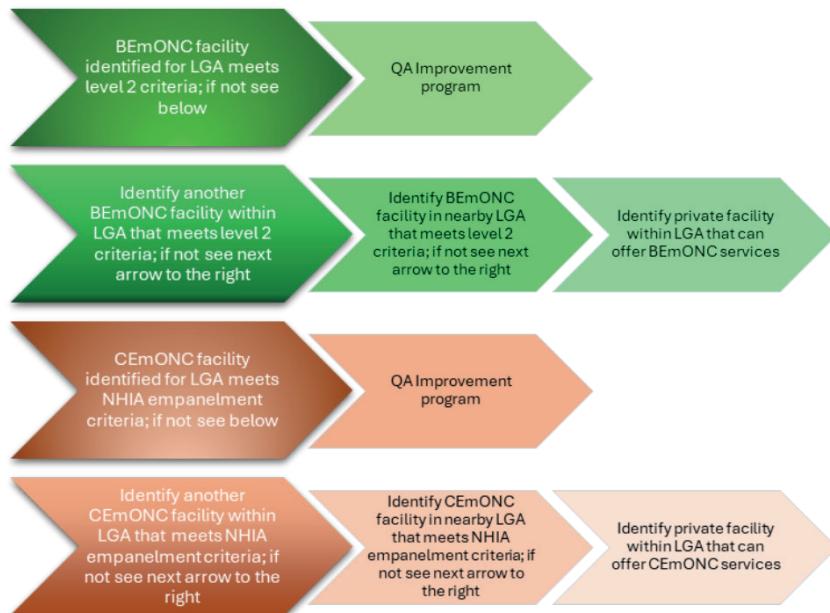
Figure 15.5 - State BEmONC and CEmONC Facility Identification

Service Readiness will address the 3rd and 4th delays by raising quality standards and accountability:

- In recognition of inadequate emphasis on the development of critical clinical skills for EmONC during pre- and in-service education, and poor retention of those skills over time, and to improve the quality of intrapartum care, the MAMII program will deploy a novel evidence-based health systems strengthening approach which can reduce facility-based neonatal and maternal deaths – the Safer Births Bundle of Care (SBBC) in all MAMII LGAs to . The roll out will be phased in line with facilities which meet the minimum criteria for introducing SBBC. The inclusion of LGAs beyond the MAMII LGAs will be scaled over time as effectiveness and scalability are demonstrated and as feasible, in consultation with state governments.

- SBBC comprises a CEmONC level bundle of innovative clinical devices; innovative learning tools and devices; appointment of a clinical champion; a learning station for low-dose high-frequency training; clear protocols for managing complications; generating a team-based culture; and robust audit and feedback supported by tools and assigned data collectors.

- The roll out of SBBC will consist of: (i) assessing (e.g., via Service Availability and Readiness Assessment, SARA) and selecting CEmONCs; (ii) appointing staff to required roles; conducting trainings; introducing tools, data collection, supervision and mentorship; and sustaining skills, equipment, knowledge and motivation.

Table 15.2- Safe Births Bundle of Care (SBBC) Roll Out

1. Pre-implementation activities	Induction and sensitization meetings at national and regional levels, as well as baseline facility readiness assessments; Harmonization of national guidelines with SBBC training content

2. Training cascade	SBBC Mentor/ National facilitators training, facility biomedical engineers training, facility champions training, and facility-based cascade training for healthcare providers
3. Implementation (mentorship)	series of post-facility training follow-ups, supportive supervision and monitoring for CQI visits
4. Sustainability activities	facility champions and labour ward in charge workshop, data collectors' workshop, routine supervision, facility champions refresher training, annual stakeholder meeting, and on-the-job refresher training

15.3.4   Enablers

Strengthening the enabling environment supports all of the five delays as well as prevention

- Deployment of POCUS to all women in MAMII LGAS: To enhance antenatal care quality and responsiveness, Point of Care Ultrasound (POCUS) will be deployed as a diagnostic aid to improve the early identification and referral of obstetric complications at the primary healthcare and community levels within MAMII LGAs. Key components and activities of POCUS deployment include Health Worker Training and Certification, Technology Access and Infrastructure, Integration with Antenatal Care (ANC) Protocols, Referral System Strengthening, and Monitoring, Learning, and Adaptation.

- Targeted Digital Communications: Digital tools ensuring two-way communications amongst beneficiaries, CHW/community members, and HCWs will be deployed under the MAMII. Motivational incentives to ensure sustained service delivery.

- Digital in Health interventions: Specific digital interventions are the following: HelloMama, eCHIS, logistics management information system, facility-level electronic health records, and eCRVS for birth registration. Each of these interventions will be linked to the national digital in health architecture ensuring that it contributes to the alignment and interoperability of health data in Nigeria.

- Partnership and Mentorship with High Volume Clinical Facility: To further improve provider competence, providers will be provided targeted educational updates to enhance their ability to provide essential standardized interventions. In this regard, at least one high volume clinical site per state is chosen and prepared as a demonstration site for "best practice", the high-volume clinical facility will service a network of MAMII BEmONC and CEmONC facilities.

15.3.5   Data Intelligence, Surveillance and Monitoring

Data will be utilized to support and enable each of the above areas. Monitoring, Evaluation, and Learning will be structured across five key thrusts to ensure performance

management and iteration

- Deep-dive diagnostics in the 172 LGAs: mixed-method consultations with communities and ethnography in LGAs with mainly demand-side gaps

- Further advanced analytics and modelling studies: use mathematical models to estimate and track the effects of different intervention mixes and use geostatistical models to track trends in mortality

- Strengthening MPDSR: targeted capacity strengthening for states and LGAs on MPDSR and routine data quality audits and spot checks for MPDSR

- Strengthening overall tracking of outputs and outcomes: RMNCH scorecard assessment, Mini-DHS survey, and Quarterly spot checks (facility assessments and community surveys)

- Getting to zero – Tracking the journey: Establish an electronic countdown dashboard tracking the reach and impact of each MAMII interventions/investments against maternal deaths

Enhancing the health system's resilience against shocks such as disease outbreaks, climate emergencies, and other humanitarian crises is critical to safeguarding access to and delivering essential health services. The MAMII will strengthen health security by supporting further improvement of preparedness and response structures for the containment of emergencies and shocks to the health system by ensuring that states are better prepared to mitigate health system vulnerabilities by developing and implementing multiyear emergency preparedness and response (EPR) plans.

A summary of MAMII activities is provided in the figure below while MAMII's theory of change is provided as an annex at the end of the document

15.4 Management and Coordination Principles

The Government of Nigeria is adopting a sector-wide approach (SWAp) to implement the Nigeria Health Sector Renewal Investment Initiative (NHSRII) in its totality including MAMII, requiring all stakeholders to contribute to improving citizens' health by aligning with one national plan, one national budget, one report, and one conversation.

Addressing the 5th delay, State-level policy reform, service delivery improvement, and sector coordination will be led by the State Ministry of Health, under the leadership of the Commissioner of Health. MAMII interventions in the 172 local government areas will be led by different government agencies at both national and state levels with very strong coordination within the state and between state and federal agencies. The state SWAp desk officer will monitor program implementation for the MAMII including its role of support across all HOPE DLIs at the state level and will facilitate coordination and collaboration with the MAMII Coordination team at the national level. The state SWAp Desk officer serves as the secretary of the MAMII task force team comprising of all relevant state level health MDAS including SSHIAs; SPHCDAs; SEMSAS; SHMB etc (see Table 15.3 and Figure 15.6).

Table 15.3 - Intervention and Responsible Agencies for MAMII

| Intervention	Responsible Agency	
	State	**National/Federal**
1. Deployment of community health workers	SPHCDAs	NPHCDA
2. PHC/BEmONC service readiness/ availability	SPHCDAs	NPHCDA/BHCPF
3. General Hospitals/CEmONC services readiness including private health facilities empanelment	SHMBs/SMOHs	FMOH-SCO/NHIA
4. Strategic purchasing for maternal and child health	SSHIAs	NHIA
5. Health security functions	SMOH	NCDC
6. Emergency Transport Systems and Ambulance Dispatch	SEMSAS	NEMSAS
7. Digital-in-health architecture and infrastructure	SMOHs	FMOH
8. Deployment of POCUS	SMOH	FMOH/PVAC
9. Climate readiness	SMOH {Climate focal persons}	FMOH
10. Governance	HCH/State SWAp focal persons	FMOH/NHIA/NPHCDA
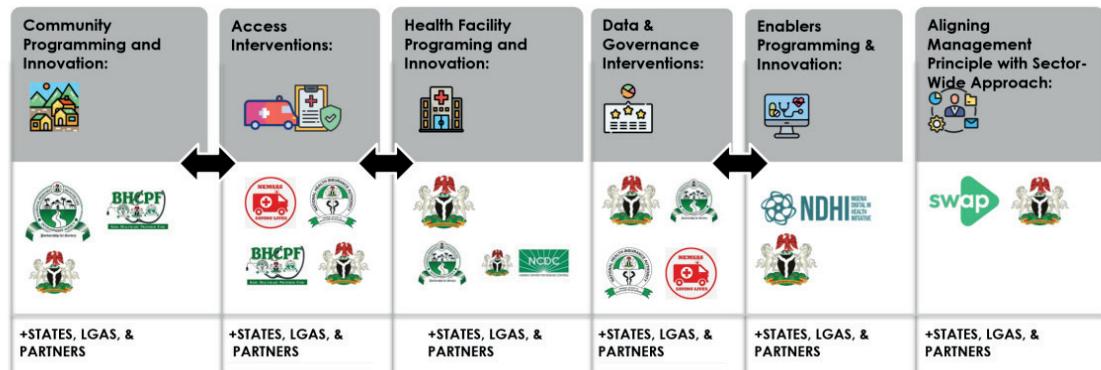
Figure 15.6 - Schematic Representation of MAMII Stakeholders

A significant responsibility of the SWAp Coordinating Office (SCO) is to harmonize technical assistance (TA) provided by various development partners (DPs) and agencies. This involves ensuring alignment and reducing fragmentation to enhance transparency, accountability, and efficiency in health sector interventions. This initiative aims to harmonise technical assistance mechanisms and procedures, reducing fragmentation in externally funded development activities and minimizing the burden on health sector leadership through the establishment of a Joint Health Development Technical Assistance Fund (JHDTAF). Given the NHSRII and the health SWAp in Nigeria, a mixed TA pooling approach is adopted in organizing development partners' support. In line with this approach, development partners are required to commit to financing and managing the

joint pooling approach for technical assistance and support. Table 4 below shows some committed assistance that has been expressed by partners to the CMHSW and the NPCU/SCO in the context of the HOPE-PHC and NHSRII. As partners express additional interest in contributing, their support is expected to be coordinated and harmonized through these mechanisms.

All states with a MAMII local government will reflect in their Annual Operational Plan all the MAMII interventions in the MAMII priority LGAs in their state.

Table 15.4: Development partners commitment

NAME	ROLE
Gates Foundation (BMGF)	TA
CIFF	Cofinancing /TA
FCDO	Cofinancing/TA
GAVI	TA
GIZ	TA
Global Affairs Canada	TA
GLOBAL FUND	TA
Japan International Cooperation Agency (JICA)	Cofinancing/TA
UNICEF/UNFPA/WHO	TA

Professional organizations and training institutions are pivotal to the effective implementation of MAMII by strengthening the health workforce and ensuring the quality and sustainability of maternal and newborn care services. Organizations such as the Society of Obstetricians and Gynaecologists of Nigeria (SOGON), National Association of Nigerian Nurses and Midwives (NANNM), and other allied professional bodies provide technical leadership, standard-setting, and advocacy for quality maternal, newborn, and child health services. They are expected to support the rollout of MAMII through the adoption of clinical protocols; facilitating continuous professional development; and contributions to capacity-building efforts such as mentorship, supportive supervision, and certification for interventions like the Safer Births Bundle of Care (SBBC) and Point-of-Care Ultrasound (POCUS).

Exponentially scaling up the availability of providers skilled in emergency obstetric and newborn care (EmONC) services in Nigeria is essential for the success of MAMII: Training institutions—including medical schools, nursing schools, and schools of health technology—are central to producing the skilled workforce required to deliver quality care in both Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC) facilities. They are also instrumental in integrating MAMII-relevant competencies into pre-service curricula, scaling up training programs, and partnering in implementation research, monitoring, and adaptation of best practices. Collectively, these entities ensure a pipeline of competent providers in the long term and reinforce standards that are crucial for achieving MAMII's goal of reducing maternal and neonatal mortality across Nigeria's high-burden LGAs and the country at large.

Table 15.5: MAMII Intervention Theory of Change

MAMII THEORY OF CHANGE			
Inputs ($$, infrastructure, equipment, supplies, HR, TA)	Activities	Outputs	Objectives
GON's adherence to the allocation formula contained in the revised BHCPF guidelines meets the equity and climate resilience guidelines (DLI 8.2) 2000 Tier 2 (PHC+BEmONC) BHCPF facilities targeted for revitalization: water source, toilets, blueprint for bed numbers and layout, commodities, medicines, equipment, health information system and human resources) -Rehabilitation/ strengthening of the facilities' wall, floor, ceiling, and roof. (Including painting) -Rehabilitation of the PHC's windows and doors to improve ventilation and cooling. -Drainage and flood management (including barriers, water management, raised floors, raised access routes) -Solar reflective painting -Solarized 'deep' borehole ranging from 75-120m depth with solar pump and panels. -Installation of 5,000-litre water tank on steel towers up to 4m high, PPR Pipes and taps for water storage and distribution.	Refurbishment and staffing of Tier 2 facilities to readiness in accordance with the assessment tool (DLI 1.1) Prepositioning and availability of essential maternal, newborn and child commodities/ consumables, including oxygen, adult resuscitation/CPR, and equipment for small and sick newborn care. POCUS will be deployed as a diagnostic aid to improve the early identification and referral of obstetric complications at the primary healthcare and community levels (incl Training and Certification, Technology Access and Infrastructure, Integration with ANC Protocols, Referral System Strengthening, and Monitoring, Learning, and Adaptation) SMOH/HMB/Relevant implementing MDAs in the states will refurbish, upscale and optimize 774 CEmONC facilities to reach at least one functional facility per LGA Approval of a CEmONC empanelment and reimbursement strategy for the BHCPP (DLI 5.1) Each eligible pregnant woman upon completion of her registration at the PHC receives a voucher with five detachable coupons (for three antenatal care visits, delivery and one postnatal care visit)	# Tier 2 facilities meet at least a 75% score Increase health facility utilization by 60% in high-burden LGAs by 2030 # Increased in refurbished & empaneled CEmONC facilities that meet 100% score for service readiness, climate resilience, and energy efficiency (DLI 1.2) # Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (DLI 5.2:) % increase in # skilled SBA deliveries in primary healthcare centres (DLI 6.1) # CEmONC implementing SBBC? # Tier 2 with a minimum of 5 of 6 commodities available (DLI 2.2) incl oxytocin & FP Reduced high-risk deliveries # patients with obstetric and neonatal complications were transported through EMT to selected facilities using the digitized EMS dispatch system (DLI 7)	Reduce stillbirth, newborn, maternal mortality rates Reduce maternal mortality rate by 30% in high-burden LGAs by 2030 Ensure that no area in Nigeria is at Stages I and II of the obstetric transition by end 2026

Provision of 5KVA / 48V hybrid inverter system including Battery and solar panels Provision of solarized cold chain equipment Planting of horticulture/trees Procurement of MamaNatalie, NeoNatalie Live, Mama Birthie, Moyo, Neobeat, Upright resuscitator & Penguin for SBBC facilities and training sites Consultants, training facilitators in SimBegin for roll-out of SBBC TA to develop Standardized treatment protocols and SOP for EmONCs Intensive training and capacity building for healthcare workers	Introduce SBBC in subset of LGA CEmONCs: Assess and select CEmONCs; appoint staff to required roles; conduct trainings; introduce tools, data collection, supervision, mentorship; maintain skills, equipment, knowledge and motivation. Provision of tracer health services (DL4) through CHWs, including identification of and follow-up with pregnant women and referral to receive MMS Implementation of maternal-mortality primary prevention measures including access to family planning, safe abortion, iron/MMS supplementation, and insecticide treated nets % increase in % pregnant women using MMS supplementation (DLI 6.2)		
Investing in infrastructure -- the availability of water sources, toilets, mother–newborn intensive care units, pediatric inpatient units, surgical theatres, and equipment. Procurement and distribution of and training on use of POCUS ITNs, IPT, FP, MMS	Domestic spending on contraceptive commodities to reach 30% of the forecasted total need by the end of the program (DLI 2.1) Digitalization (DLI 11) and Pregnant women registered during antenatal visits & in the communities by volunteers and Emergency Care Assistants		
GoN spending 15% of total contraceptive requirements from domestic non-IDA resources by the program's final year (DLI 2.1)	Registered pregnant woman receives a voucher for transportation costs for 5 round trips home-PHC, and for referrals from Tier 2 to CEmONC facility in case of complications		
Locally customized interventions to strengthen community structure to address demand barriers and practices on maternal and newborn health Health education and literacy campaigns for women in the community	Deployment of Emergency Transport Systems (ETS) CHWs link beneficiaries to available EMS in the community, allowing for quick referrals to primary/BEmONC and secondary/ CEmONC facilities.		

	Deployment of CHWs for proper birth plan and complication readiness. They will also ensure referrals and follow-ups.		
	Engagement with TBAs and faith-based health facilities. Transition plan will guide TBAs into becoming advocates for skilled care, companions during childbirth, or community mobilizers.		
	Mobilization of community leadership structures. Forming community coalitions, direct engagement (e.g., workshops, door-to-door outreach), and capacity building of local groups to boost service uptake		
	Deep-dive diagnostics in the 172 LGAs: mixed-method consultations with communities and ethnography in LGAs with mainly demand-side gaps		
	Further advanced analytics and modelling studies: use mathematical models to estimate and track the effects of different intervention mixes and use geostatistical models to track trends in mortality		
	Strengthening MPDSR: targeted capacity strengthening for states and LGAs on MPDSR and routine data quality audits and spot checks for MPDSR		
M&E Plan	Strengthening overall tracking of outputs and outcomes: RMNCH scorecard assessment, Mini-DHS survey, and Quarterly spot checks (facility assessments and community surveys)		
	Getting to zero – Tracking the journey: Establish an electronic countdown dashboard tracking the reach and impact of each MAMII interventions/investments against maternal deaths		

16

RURAL EMERGENCY SERVICE AND MEDICAL TRANSPORT (RESMAT) IMPLEMENTATION FRAMEWORK

Chapter 16 - Rural Emergency Service And Medical Transport (RESMAT) Implementation Framework

16.1 Background

A well-functioning pre-hospital and emergency care system is increasingly essential for Nigeria to confront the full range of urgent medical situations that impact its prospects to attain the Sustainable Development Goals by 2030. Nearly one-half of Nigeria's population of 213 million reside in rural areas where poverty is widespread, and access to quality health care is limited. Well over 40 percent of the country's population is under the age of 15, with children under five accounting for roughly 20 percent. Access to care is hindered by remote geography, poor roads, limited transport, financial constraints, and family preferences. A lack of properly equipped ambulances, adequately trained staff, reliable communication equipment, and poorly coordinated response between incidents and healthcare facilities present major shortcomings to the country's health systems. Coordinated and well-equipped ambulance services are therefore crucial for improving health outcomes and reducing preventable deaths in Nigeria's rural areas. (reference)

16.2 Reducing Maternal Mortality by Addressing "The Second Delay"

Maternal and child mortality rates remain among the most persistent national

Factors Affecting Service Utilisation

- Socioeconomic and cultural characteristic
- Accessibility of health facility
- Quality of EmOC Service

Delays

- Delay 1: Deciding to seek care
- Delay 2: Identifying and reaching facility
- Delay 3: receiving adequate and appropriate access to and utilisation of EmOC
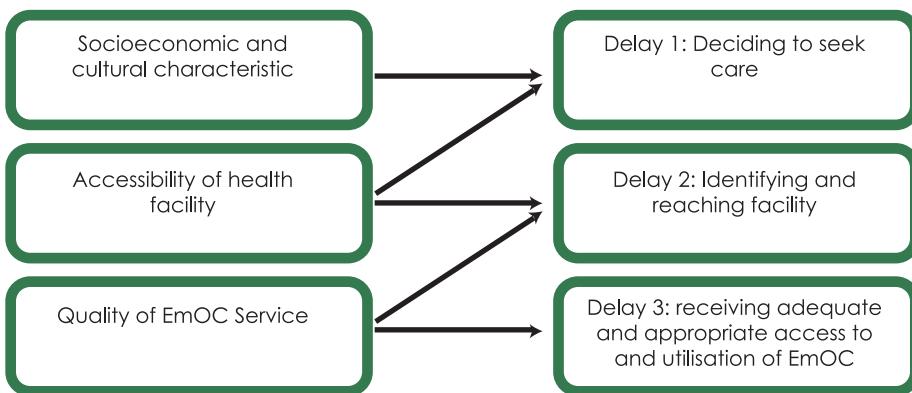
challenges. Nigeria has a maternal mortality rate (MMR) of 576 per 100,000 live births and an under-5 mortality rate (U5MR) of 95 per 1,000 live births, accounting for 10 percent of global under-five deaths. Nigeria's high MMR pose significant challenges to achieving the SDGs. Nigeria and India account for over one third of all estimated global maternal deaths in 2015, with an approximate 58,000 maternal deaths (19 percent) and 45,000 maternal deaths (15 percent), respectively. Most of the maternal deaths (80-85 percent) in developing nations including Nigeria can be attributed to direct obstetric causes (hemorrhage, sepsis, complications of abortion, hypertensive disorders). A major factor implicated in maternal mortality in Nigeria is the delay in reaching the point of care and delay in receiving quality care at the health facility.

The "three delays model" concept has proven to be a practical and widely accepted framework to account for the delay in management for obstetric emergencies and its role in maternal mortality. The model allows for evaluating the circumstances surrounding maternal deaths, which has proven useful in examining constraints to obstetric care and helping to understand ways to prevent maternal mortality. The model explores what, why and how maternal deaths occurred. The model comprises the delay in deciding to seek appropriate care by individuals, family, or both (Delay 1), delay in reaching an adequate health care facility (Delay 2) and delay in receiving adequate care when a facility is reached (Delay 3).

The application of the Three Delays Model to analyse maternal mortality highlights the considerable obstacles faced in accessing appropriate healthcare. Transportation barriers in rural Nigeria have profound implications on maternal and child health. Proximity to healthcare and access to affordable transport are key to addressing second delays. Addressing type 2 delays provides a strong justification for the availability of an ambulance service and having well-maintained roads[24]. Some of the hurdles that have been identified with Delay 2 include; the absence of healthcare facilities in the immediate area; long travel times from home to a healthcare facility, often requiring more than one hour to reach healthcare facility; the cost of transportation services; poor road condition or terrain; and visits to a traditional healer or traditional birth attendant first. Access to health facilities, including the distance to such facilities, is a critical factor influencing

24 - Paine, A., et al. (2023). Digital Healthcare Tools in Nigeria: Strengthening Public Health and Pandemic Preparedness—Insights from the COVID-19 Crisis. Telehealth and Medicine Today, 8, 445. https://doi.org/10.30953/thmt.v8.445

maternal, neonatal, and child health outcomes. Onyejose et al (2020), asserts that the strengthening and establishment and support for the implementation of an emergency transport scheme to convey pregnant women from their homes to health facilities for emergency obstetric care is necessary to address the second delay in Nigeria[25]. In many settings, women must pay out pocket fees, resulting in delays in accessing care, and levels of expenditure that push households into poverty . While some communities have transport plans and emergency transport schemes in place, there are still gaps in services, and other issues delaying access to first medical care.

Furthermore, some of the delays recognized under Delay 3 include delays in the necessary referrals of mothers from one healthcare facility to another due to the lack of emergency transport. For instance, the use of an ambulance might be constrained by fuel shortages or instances where ambulances are used for non-emergency purposes.

Strengthening the referral network to ensure that women with complications are promptly transferred from the community or health centre to an appropriate level of care and for follow-up, particularly of mother/baby pairs through supporting referral services is therefore also crucial.

Rural Emergency Service And Medical Transport (RESMAT) can provide a low-cost model that leverages existing resources within the community for improving maternal health outcomes. RESMAT builds upon local networks of volunteers, Local transporters and Health facilities using a mix of paper-based , phone call and USSD communication systems to communicate and coordinate emergency transportation for pregnant women and neonates in the community.

16.3 Strategic Objectives

1. To reduce infant, child, and maternal mortality by providing emergency care and transportation within the "golden hour" to those who need it.

2. To extend universal access to basic and advanced life support services to rural populations in Nigeria

3. To demonstrate National Emergency Medical Services and Ambulance System with state and local government collaboration mechanisms for strengthening Rural EMS delivery in selected LGAs in Nigeria.

The RESMAT initiative contributes directly to the goals of the Basic Health Care Provision Fund (BHCPF), particularly in ensuring equitable access to emergency maternal and neonatal services in underserved areas. It aligns with the World Bank's priorities on achieving Universal Health Coverage (UHC) and strengthening health systems for resilience, by addressing critical service delivery gaps and promoting effective public-private and community-level partnerships. Furthermore, RESMAT advances national commitments to reduce maternal and child mortality as outlined in the National Strategic Health Development Plan II (NSHDP II) and aligns with Sustainable Development Goals (SDGs) 3.1 and 3.2. RESMAT is fully aligned with the principles and procedures for operationalizing

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25 - Onyejose, Kenneth N., et al. "Sociocultural factors influencing maternal health outcomes in Nigeria." Sci. Res. J 7 (2019): 86-96.

the Basic Minimum Package of Health Services as contained in the National Health Act. Specifically:

- The implementation of the RESMAT will be prioritized for addressing rural emergencies and maternal transport during pregnancy thus driving reduction of crude mortality rates related to absence of effective, efficient, and timely medical emergency transport and reduction in maternal mortality related to the second delay i.e., delays in transportation and referral of obstetric cases and emergencies in the communities.

Table 16.1 - RESMAT Reviewed TOC and Indicators

RURAL EMERGENCY SERVICE AND AMBULANCE SYSTEM MONITROING AND EVALUATION FRAMEWORK							
Risk and Assumptions	**Specific objectives**	**Input**	**Acivities**	**Outputs**	**Indicators**	**Outcome**	**Goal**
Continuous provision of BHCPF		BHCPF -EMT Gateway fund	Conduct stakeholder meetings at national and sub-national levels	Stakeholder meetings at national and sub-national levels conducted	Number of states where stakeholder meeting was conducted	Increased demand and utilization of Rural Emergency Services and Maternal transportation systems.	Improved rural emergency services and maternal transport for pregnant women and neonates in rural communities across Nigeria
Increased partnership and community support to drive coverage		NHSRII - SWAP	Conduct advocacy visits to relevant stakeholders at State, Local Government, and community levels.	Advocacy visits to relevant stakeholders at State, Local Government, and community levels conducted	Number of states where advocacy for state-level leadership was conducted		
Active engagement of private operators and NURTW drivers		IMPACT Project			Percentage of states where local Government advocacy visits were conducted		
Availability of at least 2G network in selected communities		HOPE- PHC Project			Percentage of states where community-level advocacy		
Availability of functional LEVEL 2 PHCs across the Wards	To Drive demand generation through coordinated Advocacy and behavioral change communication activities		Develop and publication of RESMAT information on print media.	Publication of RESMAT information developed and published on newspapers	Number of RESMAT publications on print media		
Accessibility to hard-to-reach locations (difficult terrains)			Production and distribution of Information, Education, and Communication materials.	RESMAT Information, Education, and Communication materials produced and distributed	Number of states with distributed IEC materials		
Insecurity			Production and airing of radio programmes about RESMAT in various languages.	Radio programmes about RESMAT in various languages produced and broadcasted.	Number of states that have air RESMAT radio programmes		
Sociocultural beliefs			Production and air a television documentary about different aspects of RESMAT	Television documentary about different aspects of RESMAT produced and broadcasted	Number of states that have viewed RESMAT televised documentary		
Availability of Commercial drivers	To strengthen RESMAT governance for effective and efficient delivery of programme goals.		Collaborate with SEMSAS in all 15 states for RESMAT	SPHCDA is co-opted into state Emergency Medical Treatment Committees	Number of states to have established sysnergies between SEMSAS and SPHCDA		
			Train National and state-level programme implementation units for optimal performance	National and state-level programme implementation units trained	Number of programme implementation unit members trained		
	To strengthen the capacity of frontline rural health workers, tricycle operators, non – ambulatory private operators, and programme managers to ensure timely, quality, effective, and efficient Rural Emergency Service, and maternal transport in the states.		Train primary health care nurses, midwives, and community health extension workers on standard operating procedure for management of emergencies using the Community First Aid Response (CFAR) course	Train primary health care nurses, midwives, and community health extension workers trained	Number of Nurses, midwives and CHEWs trained	Improved quality of rural emergency service, obstetric care and transportation for delivery in high priority LGAs	
	To Ensure the availability of appropriate rural emergency transport by procuring, equipping, and distributing tricycles and Boat ambulances.		Procure , brand, distribute and utilize tricycle and boat ambulances equipped to GPS tracking capabilities	Tricycle and boat ambulances functional and utilised for emergency transportation in high priority LGAs	Number of Tricycle ambulances runs tracked and completed Number of Boat ambulances tracked and completed	Timely, effective, and efficient Rural emergency transport service	
	To Provide access to pre-hospital care and transportation for pregnant women high priority LGAs			Pregnant women in high priroty LGAs have access to pre-hospital transport	Number of pregnant women transported through RESMAT		
	To Provide access to pre-hospital care and transportation for neonates across high priority LGAs			Neonatal emergences in high prirotity LGAs have access to pre-hospital care and transportation	Number of neonatal emergencies transported through RESMAT		
	To optimize/strenthen RESMAT fiduciary, Monitoring, evaluation and learning processes		Conduct Quarterly, monthly, and weekly monitoring and exercises by the National , State and LGA M&E teams	Monitoring and evaluation exercises conducted	Number of Quarterly Monitoring Exercises conducted		
			Scale up and sustain functionality of National Integrated Emergency Medical Service software to support rural communication, dispatch and fiduciary functions	National Integrated Emergency Medical Service Software Scaled up	Number of digitall enabled emergency transport dispatches completed Number of RESMAT payment vouchers generated		

16.4 Governance And Implementation Framework.

RESMAT shall be coordinated through the State Emergency Medical Service and Ambulance system (SEMSAS) at the state level through Local Government SEMSAS officers deployed from the Local Government Health Authority. At the community level the Ward Development Committee (WDC) shall oversee governance and operations within the communities of its jurisdiction.

16.4.1 Operations Model

A. LGA-Wide Rural Ambulance Service Model:

The model describes an arrangement where ambulance service is purchased from a private sector operator to cover a catchment population. The operator will provide tricycle ambulances that can be deployed quickly, at low cost, with high safety standards. The ambulances will be equipped with basic life-saving equipment, and trained staff to provide emergency care service packages and manage emergencies during patient transportation. For operational purposes, each PHC will have 1 tricycle ambulances and a motorcycle for deployment of Community Emergency Responders.

B. Rural Transport for Maternity Services

The rural transport for maternity services model is a low-cost transport service utilized for maternity patients leveraging existing resources within the community. Usually, laypersons who are community members, particularly commercial transport drivers, are required to pool their vehicles. The selected individuals are also trained to provide basic first aid intervention. This model is driven by community participation. Using the existing HRH in the PHCs, all pregnant women in the community are identified and enrolled in the scheme.

C. Decentralized Community-based Model

The model is a hybrid of the LGA-wide Rural Ambulance Model and the rural transport for maternity services. Services are outsourced to both private operators and commercial transport operators for maternity services depending on location and catchment population. In this Model, the use of appropriate vehicles to transport patients and the need for care during transportation is a significant decision factor. Services are purchased from operators based on the available capacity to provide emergency services

16.4.2 Operational Flow

Using the decentralized community-based model, emergency medical service and medical transport for obstetrics and neonatal emergencies shall be provided using a USSD dispatch notification system to establish communication linkages between public and private emergency transport operators , Health Facilities and clients during obstetric and neonatal emergencies

Inter Facility Transfer

This level of response should be reserved for those circumstances when BEmONC facilities are unable to provide the necessitated quality and standard of Emergency care, Facilities then notifies a Community Emergency Medical Transport Triage officer (CEMTTO) to deploy an Emergency Transport Provider to transport client to the appropriate health facility.

16.4.3   Dispatch, Communications, and Information Systems

Delivering effective emergency medical services (EMS) in rural areas presents unique challenges due to limited resources, infrastructure, and connectivity. Establishing efficient dispatch, communication, and information systems tailored to these contexts is critical for ensuring timely responses to emergencies and improving patient outcomes.

A CEMTTO will serve as the nerve center for coordinating emergency responses. The CEMTTO shall be a woman with basic medical knowledge selected by the WDC to serve this purpose and she must be resident in the community, Rural areas suffer from poor and unavailable communication technologies, hindering seamless communication between dispatch centers and responders. To address this, feature phones will be used for implementation.
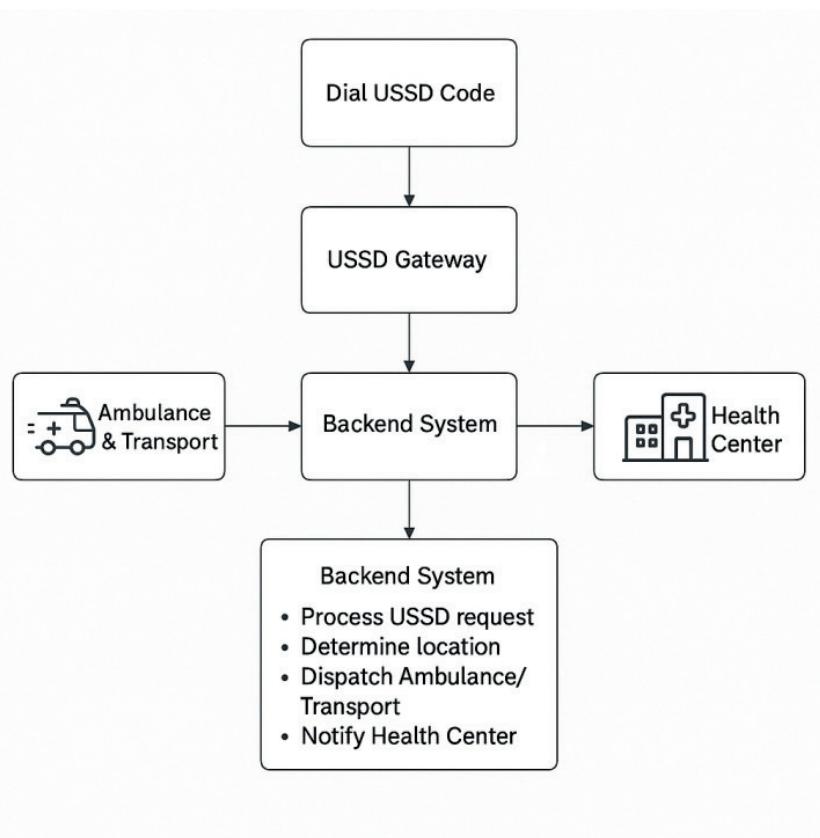

Figure 16.1 Digital Framework for Emergency Transport Dispatch

16.4.4   Reporting and Record Keeping

The NEMSAS and SEMSAS shall maintain accurate documentation of emergency responses, including beneficiary information, interventions performed, and transportation detail and case outcome..

16.4.5   Payment Mechanism

Emergency Transport Operators (including registered NURTW drivers and tricycle ambulance operators) will be reimbursed ₦10,000 per completed emergency transport trip. Payment is triggered through a USSD-generated digital coupon, issued by the receiving facility upon successful trip completion.

The payment system operates through the following steps:

1. Upon trip completion, the receiving health facility generates a digital coupon using the USSD platform.

2. The coupon is automatically recorded in the system's backend and linked to the specific trip and transport provider.

3. Digital payment vouchers are auto-generated and shared with both the NEMSAS Account Office and the transport provider for recordkeeping.

4. NEMSAS processes reimbursements to operators directly from the BHCPF–EMT programme account (BHCPF-EMT Gateway Funds).

This streamlined payment mechanism aims to ensure transparency, reduce delays, and support sustained community participation in emergency transport services.

Notes