

REPORT OF THE MID-TERM REVIEW OF NIGERIA RMNCAH+N STRATEGY (INVESTMENT CASE) 2017-2030

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Acronyms

ANC	Ante Natal Care
ANRiN	Accelerating Nutrition Results in Nigeria
AOPs	Annual Operational Plans
ARH	Adolescent Reproductive Health
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
CCM	Country Coordinating Mechanism
CHIP	Community Health Influencers, Promoters and Services
CMVAs	Contract Management and Verification Agencies
CPR	Contraceptive Prevalence Rate
CRVS	Civil registration and Vital Statistics
CSOs	Civil Society Organizations
DFH	Department of Family Health
DPs	Development Partners
DPG	Development Partners Group
DPRS	Department of Planning, Research and Statistics
ERGP	Economic and Recovery Growth Plan
FCDO	UK Foreign Commonwealth and Development Office
FCT	Federal Capital Territory
FCV	Fragile, Conflict and Violence
FMoH	Federal Ministry of Health
GAC	Global Affairs Canada
GAVI	Global Alliance for Vaccines and Immunization
HERFON	Health Reform Foundation of Nigeria
HUWE	Basic Health Care Provision Fund Project (HUWE Project)
IC	Investment Case
IVA	Independent Verification Agency
GFF	Global Finance Facility
LGAs	Local Government Areas
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Survey
MNCA	Maternal, Newborn, Child and Adolescent
MoH	Ministry of Health
MTR	Mid-Term Review
NCH	National Council of Health
NDHS	National Demographic and Health Survey
NDP	National Development Plan
NE	North East

NEMCHIC	National Emergency Maternal and Child Health Intervention Centre
NERICC	National Emergency Routine Immunization Coordination Centre
NHA	National Health Acts
NHIA	National Health Insurance Agency
NHSDP	National Health Strategic and Development Plan
NPC	National Planning Commission
NPHCDA	National Primary Health Care Development Agency
NSAs	Non-State Actors
NSHIP	Nigeria State Health Investment Project
NSHIP AF	Nigeria State Health Investment Project Additional Financing
PDO	Project Development Objective
PHC	Primary Health Care
PHSAN	Private Sector Health Alliance of Nigeria
PMVs	Private Medical Vendors
PPP	Public-Private Partnership
QoC	Quality of Care
RMNCAH-N	Reproductive, Maternal, Neo-natal, Child and Adolescent Health and Nutrition
RMNCAEH+N	Reproductive, Maternal, Neo-natal, Child, Adolescent, Elderly Health and Nutrition
RSSH	Resilient and Sustainable Systems for Health
RMET	Resource Mobilization and Expenditure Tracking
SDGs	Sustainable Development Goals
SEMA	Shaping Equitable Market Access
SFH	Society for Family Health
SHIAs	State Health Insurance Agencies
SMoH	State Ministry of Health
SP	Strategic Plan
SPHCDA	State Primary Health Care Development Agency(ies)
SRH	Sexual and Reproductive Health
U5MR	Under-5 Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WBG	World Bank Group
WHO	World Health Organization

Executive Summary

The Global Financing Facility (GFF) for Women, Children, and Adolescents assists countries in formulating Reproductive, Maternal, Neonatal, Child, and Adolescent Health plus Nutrition (RMNCAH+N) **Investment Case (IC)**. The RMNCAH-N IC document outlines prioritized and costed health system strategies or interventions aimed at advancing the health of women, children, and adolescents. Serving as a national blueprint for collaboration, the IC fosters partnership and engagement among governments (both national and subnational), development partners, the private sector, and civil society. The RMNCAH+N IC aims to align, coordinate, and mobilize resources from both domestic and external sources to enhance the effectiveness, efficiency, and equity of programs. The overarching objective is to establish a unified approach with "one country-led plan, one budget, and one monitoring and evaluation (M&E) framework" for RMNCAH-N at both national and subnational levels.

After nearly a decade, the GFF seeks to conduct a country-led evaluation of investment case processes and outcomes. This evaluation aims to generate evidence and insights into the design, implementation, and outcomes of the IC. The findings will be utilized to reinforce transparency and accountability in achieving measurable results. Furthermore, they will facilitate the dissemination and utilization of evidence to inform decision-making and drive improvement. The first evaluation in this series focuses on the mid-term review (MTR) of Nigeria's Investment Case.

The Investment Case for Nigeria was formulated based on the RMNCAH-N strategy. Stakeholders, under government leadership, particularly the Honorable Minister of Health and the Department of Family Health (DFH), developed, costed, and prioritized this strategy. Spanning the period 2017-2030, the Strategy is aligned with the National Health Strategic and Development Plan (NHSDP) II. The plan's premise was to revolutionize the Nigerian health system through a leapfrogging approach. Its overarching goal is "to reduce maternal, neonatal, child, and adolescent morbidity and mortality in Nigeria and promote universal access to comprehensive maternal and child health (MCH), sexual and reproductive health services for adolescents and adults throughout their life cycle." The plan encompasses six strategic objectives delineated in the results framework, with corresponding targets set for the indicators.

The Government of Nigeria, in collaboration with the Global Financing Facility (GFF) and other partners, supported the prioritization of Investment Case interventions through transformative, geographical, and programmatic approaches. Leveraging the National Health Act of 2014, the plan proposed interventions to operationalize the Basic Health Care Provision Fund (BHCPF) for maternal, newborn, and child health services within the Basic Minimum Package of Health Services (BMPHS) in three states. Additionally, it aimed to scale up RMNCAH-N services in areas of humanitarian crisis and emergency response in six states in the northeast. Furthermore, the plan sought to scale up health sector-specific nutrition services and pilot the provision of adolescent health in twelve targeted states, with the envisaged nationwide scale-up and expansion of BMPHS in all states and the Federal Capital Territory (FCT).

For the mid-term review, the review team conducted desk reviews of published and grey literature, including project reports, articles, survey reports, and progress trackers. Primary qualitative data was gathered through key informant interviews with stakeholders involved in RMNCAH+N strategy development and implementation of related interventions. The assessment adopted a systems approach, examining trends, systems/structures, and processes influencing the achievement of Investment Case objectives. Key areas for review included relevance and focus, impact, sustainability, scale-up, innovation, effectiveness and efficiency, capacity and coordination, strategy fit, operating environment, and organizational structure and function appropriateness.

The Investment Case proved highly relevant to RMNCAH-N outcomes for Nigeria, with the potential to contribute to Sustainable Development Goal (SDG) 3 and Universal Health Coverage. However, changes in the health sector, such as shifts in policy environments, frequent leadership changes, and attrition of senior government officials and project staff, alongside disruptions caused by the COVID-19 pandemic, impacted RMNCAH-N program implementation.

To provide context to the IC implementation, the mid-term review explored the strategy development process of the Federal Ministry of Health (FMOH) and the relationship between the NHSDP and sub-sectoral plans like the RMNCAH-N strategy. Additionally, it examined the linkage to the budget process and the appropriation and financing of prioritized activities. Notably, it was challenging to assess how well the IC and

its interventions were funded during the review period due to a lack of cost and **Implementation of RMNCAH-N activities across the country was not limited to the IC alone but basically derived from the NHSDP where the annual operating plans were developed and used for budgeting process.** Development partners and the private sectors implemented several projects and initiatives during the period. The three GFF supported projects were successfully implemented with two projects closed already. The HUWE project using the **GFF grant** was used to pilot the BHCPF in 3 states with decentralized funds to PHC facilities. It was catalytic in that it propelled and resulted in the first government appropriation for BHCPF. **From NPHCDA gateway,** quarterly disbursed funds to 8306 accredited PHC facilities, NPHCDA and SPHCDA provide supervision and capacity building. Within the period, NPHCDA launched multiple initiatives to strengthen PHC services in the country. **From NHIA gateway** 1.596 million poor and vulnerable people have been enrolled on the program and the accredited PHC facilities are paid capitation based on ₦12,000 premium.

At the midterm review, six years into implementation, positive trends were observed in health indices, although cautious optimism prevailed pending the 2023 demographic and health survey report. However, identified gaps and experiences from other low- and middle-income countries prompted recommendations for both the Nigerian government and the GFF.

Lessons learned highlighted the importance of sustained advocacy amid leadership changes, the necessity for rigorous monitoring, and outcome mapping to ensure fidelity to strategy implementation, and the catalytic role of GFF support in driving BHCPF adoption. Recommendations emphasized the need for improved alignment between health sector strategies and financing mechanisms, strengthened accountability mechanisms, and enhanced interagency collaboration.

Recommendations to the government of Nigeria included transitioning to program-based budgeting, enhancing accountability mechanisms for decentralized funding, and improving facility-level data quality. For the GFF, suggestions included anchoring country programs on ongoing health reforms, focusing on monitoring, evaluation, research, and learning activities, and supporting the rollout of sector-wide approaches for harmonization and alignment.

Future GFF investments were urged to continue supporting the Basic Health Care Provision Program (BHCPP), resource mobilization and expenditure tracking efforts, data infrastructure improvements, and sector-wide approach implementation. These recommendations aimed to address systemic challenges and capitalize on opportunities for enhancing healthcare delivery and achieving sustainable health outcomes in Nigeria.

1. Introduction

The Global Financing Facility (GFF) for Women, Children, and Adolescents provides support to countries in developing an Investment Case (IC). This serves as a prioritized and costed set of health system strategies or interventions aimed at accelerating progress in the health of women, children, and adolescents. The IC serves as a national document fostering partnership and engagement among governments (both national and subnational), development partners, the private sector, and civil society to address Reproductive, Maternal, Neonatal, Child, and Adolescent Health plus Nutrition (RMNCAH-N) issues. It aims to align, coordinate, and mobilize resources from both domestic and external sources to enhance the effectiveness, efficiency, and equity of programs. The overarching goal is to establish a unified approach with "one country-led plan, one budget, and one monitoring and evaluation (M&E) framework" for RMNCAH-N at both national and subnational levels.

The Principles Guideline and Resource¹ provided by the GFF explicitly outline the objectives of the Investment Case. It aims to create a shared understanding of the RMNCAH-N situation and health system performance at the country level, sharpen the focus on and prioritization of critical issues, reduce fragmentation and prevent duplication, strengthen political commitment, increase funding for IC priorities, and improve transparency and accountability for measurable results. The design of the Investment Case is country-led and typically falls into one of three categories: the national health strategic plan, the RMNCAH-N Strategy plan, or the Annual Operating Plan.

After nearly a decade, the GFF is interested in conducting a country-led evaluation of investment case processes and outcomes. The aim is to generate evidence and insights into the design, implementation, and outcomes of the IC, use the findings to strengthen transparency and accountability for measurable results, and facilitate the uptake and utilization of evidence to inform decision-making and improvement efforts.

¹ GFF (2023) *Country-led Investment Cases for Improved Health of Women, Children and Adolescents: Principle, Guidance and Resources*.

1.1 Description of the Nigerian RMNCAH-N Strategy/ Investment Case

The Investment Case for Nigeria was formulated based on the Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH-N) strategy. This comprehensive strategy, spanning from 2017 to 2030, was developed, costed, and prioritized by stakeholders under the government's leadership, particularly directed by the Honourable Minister of Health and the Department of Family Health (DFH). Aligned with the National Health Strategic and Development Plan (NHSDP) II², the primary aim of this strategy was to revolutionize the Nigerian health system through a paradigm shift, moving away from traditional approaches towards identifying and defining priorities and essential packages of services. This transformation involved leveraging technology, mobilizing private sector expertise, focusing on tangible results, and monitoring performance closely.

At the time, Nigeria was significantly underperforming compared to other lower middle-income countries and regional comparators in sub-Saharan Africa across various RMNCAH-N indicators. There seemed to be no clear path for Nigeria to achieve Sustainable Development Goal 3 and Universal Health Coverage (UHC). For instance, an alarming 714,000 Nigerian children under the age of five were dying annually, accounting for 26% of all under-five deaths in sub-Saharan Africa and 13% globally, despite Nigeria's population representing only 2.5% of the world's and 18% of Africa's total population³. Additionally, Nigeria ranked as the largest contributor to maternal deaths globally, with high levels of inequality in health outcomes and service utilization. This disparity was evident in the under-five mortality rate in the poorest wealth quintile households in Nigeria, which was the highest in West Africa. The plan aimed to address these disparities by reducing maternal, neonatal, child, and adolescent morbidity and mortality while promoting universal access to comprehensive maternal and child health (MCH), sexual and reproductive health services for individuals of all ages throughout their life cycle.

The Investment Case outlined six strategic objectives, each supported by a results framework and targets set for the indicators. Collaboratively, the Government of Nigeria, alongside the Global Financing Facility (GFF) and other partners, supported the prioritization of Investment

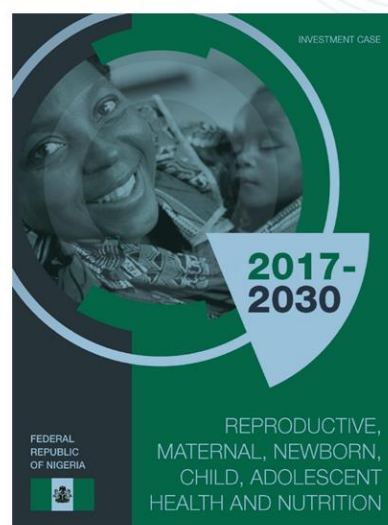
² FMOH – National Health Strategic and Development Plan II

³ Note that these indices were based on the 2013 NDHS but the Plan assessment will be based on 2018 data as baseline for the implementation of the IC

Case interventions using transformative, geographical, and programmatic approaches⁴. Leveraging the National Health Act of 2014, the plan proposed interventions to operationalize the Basic Health Care Provision Fund (BHCPF) for maternal, newborn, and child health services within the Basic Minimum Package of Health Services (BMPHS) in three states. Additionally, it aimed to scale up RMNCAH+N services in areas of humanitarian crisis and emergency response in six states in the northeast and pilot the provision of adolescent health in twelve targeted states. The plan also envisioned nationwide scale-up and expansion of BMPHS across all states and the Federal Capital Territory (FCT). These approaches were interconnected with the strengthening of Civil Registration and Vital Statistics (CRVS) and emphasized innovation and scaling up of innovations. It was anticipated that BHCPF and the National Health Act would support sustained domestic financing and attract larger donor financing, while improving the overall health system through output-based financing, strategic purchasing, expansion of pro-poor risk pools, public financial management reforms, and leveraging the potential of the private sector.

Figure 1: RMNCAH-N Strategy - Investment Case (IC) Design

- **Enabling Law and Policies** – Health Act of 2014 and the provision for BHCPF, PHC under One Roof, ERGP, NHSDP II,
- **Prioritization** – geographic, programmatic and adopting successful innovative approach as transformative initiative (based on findings from NSHIP Impact Evaluation)
- Special focus on the scaling up of NSHIP in the NE to address **humanitarian Crisis** (6 states)
- Pilot BHCPF implementation in three (3) States with findings to inform scale Up of **BHCPF**
- Accelerating Nutrition Results in Nigeria (ANRIN) 12 states
- Broadly the plan was to define priorities and essential package of services, leverage technology, focus on results, mobilize private



Strictly Confidential

Source: Authors

⁴ An approach to address key system constraints best implemented in phases and with provision from adaptive learning.

Expected results outlined ambitious goals, including a 50% reduction in maternal mortality ratio, infant mortality, and under-five mortality rates by 2021. Additionally, targets aimed to increase antenatal care coverage (to 8 visits), skilled birth attendance, postnatal care, and immunization coverage by 50%. However, it's notable that no specific targets were set for Vitamin A coverage or for reducing childhood wasting and stunting.

1.2 Mid Term Review of the Investment Case

The plan has been implemented over a span of approximately six years (2017-2023), encompassing a wide array of activities at both national and sub-national levels, funded by both government resources and contributions from development partners. Detailed specifics regarding these activities can be found in various sections of this report. Additionally, two out of the three projects financed or co-financed by the GFF, namely the Nigeria State Health Investment Project Additional Financing and the Basic Health Care Provision Fund (BHCPF) pilot, also known as the HUWE Project, were executed as planned and have since concluded. The Accelerating Nutrition Results in Nigeria (ANRIN) project, however, is still ongoing, with its closing date extended until December 2024. Commissioned by the GFF, this midterm review aims to assess the progress made in Nigeria regarding RMNCAH-N over the past six years. This review aligns with the global efforts of the GFF⁵ to: (i) generate evidence and insights into the design, implementation, and outcomes of investment cases across various countries; (ii) enhance transparency and accountability for achieving measurable results; and (iii) facilitate the utilization of findings and evidence to inform decision-making and drive improvement efforts, including potential course corrections and considerations for future expansion initiatives.

⁵ Draft Concept Note for Evaluation of IC processes and outcomes.

2. Methodology

For the midterm review, the evaluation team conducted desk reviews of published and grey literature, including project reports, published articles, survey reports, and progress trackers, among other sources. Additionally, primary qualitative data was gathered through key informant interviews with stakeholders involved in the development of the RMNCAH+N strategy and the implementation of related interventions. Although an initial list of respondents was generated, sample selection followed a snowball approach, and the number of respondents was increased as needed for further probing (cf. Annex 1 - the Matrix of Evaluation Questions, which was updated twice during the review).

The assessment employed a systems approach, drawing on methodologies outlined by Scoones (1998)⁶ and Kutzin (2008)⁷, to review the RMNCAH+N Strategy (IC). This involved examining trends, systems/structures, and processes that either facilitated or hindered the achievement of investment case objectives. The evaluation explored how health capabilities, operational and technical assets, financing, and activities relevant to RMNCAH+N performance were optimized in IC implementation. Additionally, guidelines from the Updated Investment Case Guidance Note, the draft Concept Note for Evaluation of IC Processes and Outcomes (GFF, 2022), and the GFF IC Decision Tree (2023) were utilized.

The areas of focus for the IC review included relevance and focus; impact, sustainability, scale-up, innovation, and adaptive learning; effectiveness and efficiency; influencing capacity and coordination; strategy fit and operating environment; and the appropriateness of organizational structure, function, and identity, among others. This approach provided insights into the design, implementation, and coordination of the IC, as well as institutional dynamics and processes during the review period. It allowed for the identification of tangible intended and unintended results achieved or unachieved, along with potential contributing factors based on existing institutional or program linkages and integration. Moreover, it

⁶ Scoones I (1998) Sustainable Rural Livelihoods: A Framework for Analysis IDS Working Paper 72.

⁷ Kutzin (2008) Links of Health Financing System to Policy Objectives, Other System Functions and Overall System Goals and Health Workers Access in underserved areas.

facilitated articulating strategic alignments and realignments for the IC at both national and sub-national levels.

In addition to institutional assessment, multi-stakeholder engagement processes were employed to set priority actions for addressing identified gaps. This involved utilizing key informant interviews and group discussions. Survey questionnaire guides, adjusted to study groups, focused on functional capacity areas of the IC, providing insights into operations, strategies, and mechanisms for enhancing delivery at national and subnational levels. These tools aimed to shed light on prevailing programs, operational situations, and outcomes related to RMNCAH+N program implementation and sustainability.

2.1 Framework for the MTR

An overview of the adapted framework for the IC mid-term review is presented in Figure 1. The conceptual framework explored the potential capacities that contributed to the results achieved, the resilience at the national and sub-national levels, and their effects on the IC. The results explored identified domains, assets and gaps using mixed methods, and findings presented by triangulating data. Based on the comment from the review of the inception report, we tried to include a quality-of-care domain, but available data were outdated, and the last health facility survey result was never approved nor published. It was beyond the scope of this review to collect primary data on quality-of-care. But interviewees repeatedly raised concerns about poor quality of care.

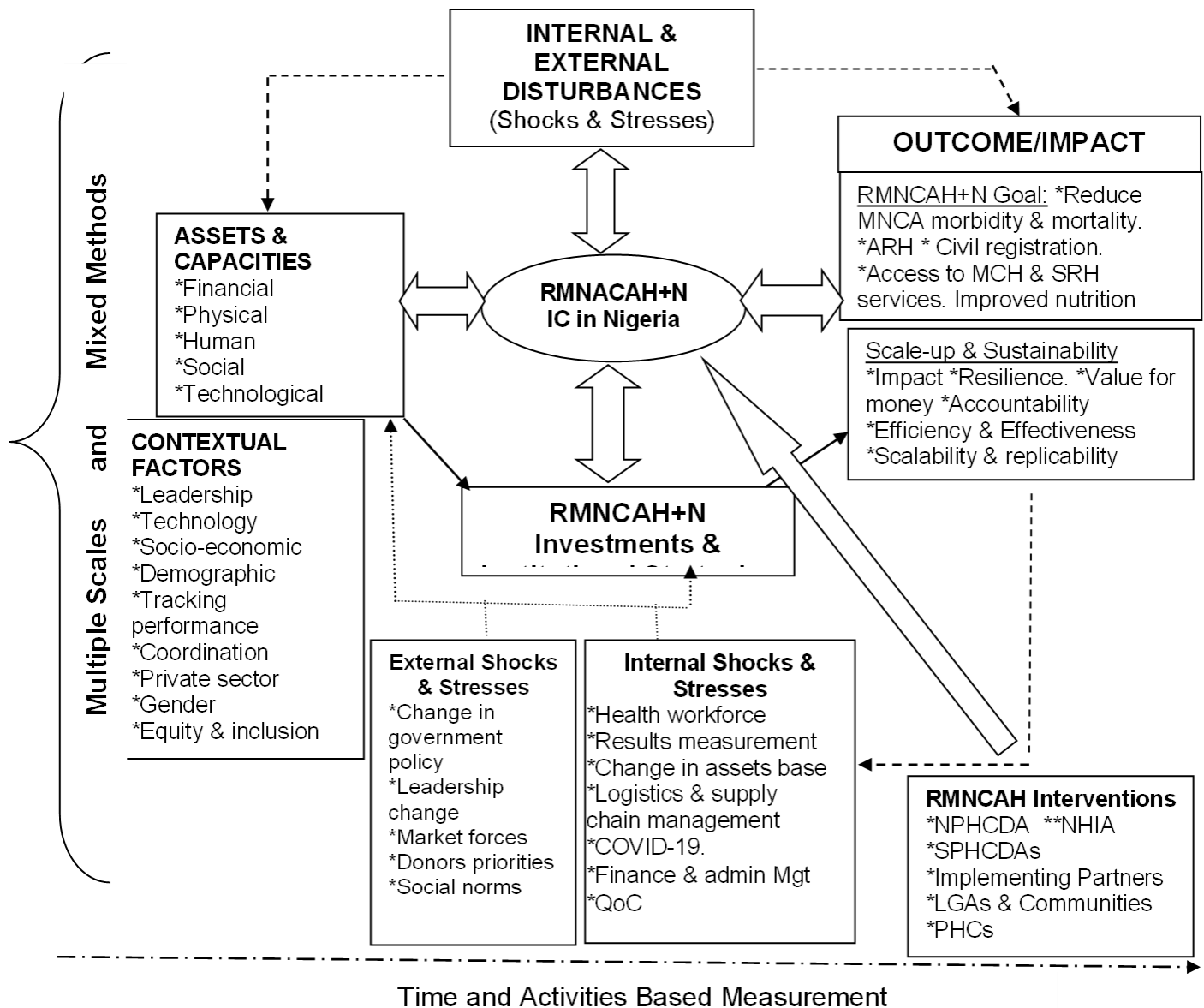


Figure 2: MTR Conceptual Framework Adapted from Scoones (1998) Sustainable Rural Livelihoods and Kutzin (2008) Links of Health Financing System to Policy Objectives, Other System Functions and Overall System Goals and Health Workers Access in underserved areas.

The methodology for the midterm review (MTR) of the RMNCAH+N strategy (IC) involved several key sub-tasks in its initial phase:

- a. Stakeholders' Engagement and Consensus Building Meetings, along with the Inception Meeting.
- b. Content Analysis, which entailed a thorough desk review of related project documentation and secondary analysis of available RMNCAH+N publications from both the Federal and States

- governments, as well as national and international development partners.
- c. Development of Stakeholders' Engagement Tools, which covered indicative areas of review.
 - d. IC MTR Field Data Collection, Documentation, and Reporting. This phase utilized a mixed research method involving both qualitative and quantitative approaches to data collection.
 - e. These sub-tasks collectively formed the foundation for the comprehensive assessment of the RMNCAH+N strategy, ensuring a rigorous evaluation process that incorporated diverse perspectives and sources of information.

2.2 Data Quality Assurance

Proactive measures were implemented to ensure effective data management, aiming to guarantee that the analysis data remained identical, harmonized, complete, reliable, accurate, and coherent throughout the process. Our MTR tools were deliberately designed to be concise and easily manageable for deployment. These measures were put in place to streamline the data collection and analysis process, enhancing efficiency and accuracy while facilitating the synthesis of findings.

2.3 Ethical Considerations

The IC review was guided by ethical considerations like informed consent, confidentiality, mutual respect, voluntary participation, and non-maleficence to ensure integrity of data.

3. Implementation Process

The engagement proceeded as outlined in the figure below, with some adjustments made along the way. Consultants discovered that the Department of Family Health (DFH) had already begun developing a new RMNCAEH-N strategy, which was in an advanced stage. Upon this discovery, the GFF IC mid-term review team agreed to support the consultants in this process, particularly in the realms of Monitoring and Evaluation and Costing of the new plan. Additionally, it was deemed essential for the team to contribute inputs based on some of the findings from the MTR.

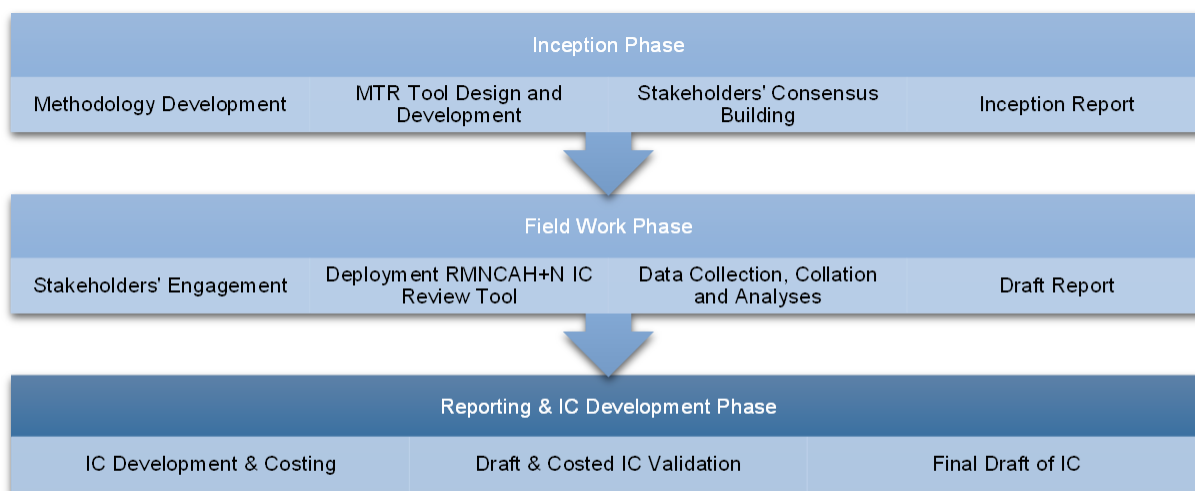


Figure 3: RMNCAH+N IC MTR Implementation Process

4. Relevance and Operating Environment for the Implementation of the IC

This section examines the relevance and focus of the Investment Case; partnerships and linkages for impact including harmonization and alignment; and changes in policy and implementation landscape between 2017 and 2023 and their effects on implementation of the Investment Case. It will also explore the effects of COVID-19 Pandemic on service disruption and the concomitant reallocation of resources.

4.1 Relevance and Focus

The IC was very relevant to RMNCAH-N results for Nigeria and could if well implemented contribute to attaining Sustainable Development Goal (SDG) 3 and Universal Health Coverage. It includes a set of

prioritized interventions; it was costed, and it focused on jumpstarting implementation of the National Health Act and piloting of BHCPF; addressing the health and humanitarian challenges of the NE; and putting nutrition on the agenda. As observed by one of the government representatives in the MTR data collection,

"The RMNCAH-N prioritization was apt and timely in assisting the country highlight the issues".

Our findings revealed that few stakeholders know about the strategy. Even some of the officials in the Department of Family Health (DFH) denied ever seeing nor using the plan. One respondent who was part of the development of the IC claimed that:

'Once the GFF grant, on the order of the then Minister of Health, was allocated to BHCPF, ANRIN and NSHIP NE, many stakeholders lost interest in the development and finalization of RMNCAH-N strategy. Secondly, some UN organizations were disappointed that they were not going to manage the fund'.

Although the finished product was shared electronically, it was never printed. Many stakeholders, particularly those from civil society and private sector partners, perceived the Investment Case as synonymous with the GFF grant and the interventions it funded. Additionally, frequent changes in leadership within the Ministry and the DFH added complexity to the situation. Consequently, there was a lack of significant ownership of the plan, as well as the anticipated buy-in from stakeholders for its implementation.

Despite this, RMNCAH-N activities were carried out in the country during the lifespan of the plan. However, there is no evidence to suggest a direct link between RMNCAH-N implementation and the IC, apart from activities supported by the GFF projects. The review revealed that over the years, Annual Operational Plans (AOPs) for RMNCAH-N were developed based on the NHSDP II⁸ (2018-2022), which promotes the integration of RMNCAH+N services and programs. These AOPs were used for budgeting and implementation guidance each year. Additionally, there were other

⁸ The RMNCAH-N (IC) 2017-2030 was developed from the NHSDP II (2018-2022) draft drawing from the RH and Nutrition components of the draft NHSDP document.

RMNCAH+N activities supported by development partners, the private sector, and civil society organizations, which were not limited to the scope of the IC.

4.2 Appropriateness of the IC for the Development of Partnerships for RMNCAH+N Implementation.

Before the development of the Investment Case, the Nigeria health sector witnessed the presence of multiple partnerships. However, these partnerships encountered challenges such as lack of coordination, duplication, fragmentation, and insufficient alignment and harmonization of efforts. Through the IC, the GFF supported the harmonization of efforts among development partners (DPs) by initiating processes to strengthen relevant RMNCAH-N coordination bodies and platforms.

As part of these efforts, the GFF publishes annual reports, including in-country assessments of various key areas, including the Country Platform. The 2020 report highlighted gaps in the coordination of RMNCAH-N activities, with functional Core Technical Committees (CTCs) existing at the national level but being weak or non-existent at the subnational level. In response, the GFF and other partners supported the Department of Family Health, Federal Ministry of Health, in establishing the Reproductive, Maternal, Neonatal, Child, Adolescent, and Elderly Health and Nutrition (RMNCAEH-N) Multi-Stakeholder Partnership Coordination Platform in 2020.

This platform serves as the substantive Country Coordinating Platform for all RMNCAEH-N issues, where matters are presented, discussed, and approved. It comprises state and non-state actors, including development partners, private sector groups, civil society organizations, and representatives of traditional leaders. The platform consists of four sub-committees:

- Leadership, Partnership, and Coordination.
- Advocacy, Resource Mobilization & Communication.
- Quality Technical Delivery.
- Accountability, Data & Knowledge Management.

While the main platform is scheduled to convene biannually, the subcommittees meet quarterly, albeit not very regularly, with the last meeting held over a year ago.

The establishment of this platform was approved by the National Council on Health (NCH), with all states urged to establish similar

bodies at the subnational level. Recognizing the importance of country leadership in the collaborative model of the GFF, the DFH requested support for leadership training, which was provided. Additionally, the GFF supplied a consultant to support the secretariat for a year at the national level to enhance leadership and governance capacity for RMNCAEH-N.

While the coordinating platform at the national level became functional, the existence of such platforms at the subnational levels was uncertain. As of the MTR, only 4 out of 36 states and the FCT had a coordinating platform similar to RMNCAEH-N at the subnational level. The emergence of these subnational platforms began as standalone technical working groups, tailored to the peculiarities and needs of the states. Over time, these four subnational platforms expanded to include other related RMNCAEH-N program areas.

The MTR also identified the presence of a functional Development Partners Group (DPG) for health in Nigeria, comprising multilateral and bilateral organizations. Partners were involved in the development of the IC and provided technical assistance (TAs) based on their programming areas and comparative advantages at the subnational levels. For instance, certain partners provided TAs in the pilot states for the BHCPF. Notable partners, including the World Bank, Bill and Melinda Gates Foundation, and the UK Foreign, Commonwealth, and Development Office (FCDO), supported the BHCPF pilot secretariat and provided technical assistance for the states and the ANRIN project. Other partners, such as PHSAN, PharmAccess, SOLINA, the Global Fund CCM, Global Affairs Canada (GAC), USAID, WHO, UNICEF, and UNFPA, were involved in RMNCAH-N implementation but were not directly linked to the Investment Case. The following chapter will detail the contributions of these groups to the RMNCAH-N space.

4.3 Changes in the Nigerian Landscape for RMNCAH-N Implementation

From 2017 to 2023, there were changes in the health sector that affected the implementation of RMNCAH-N programs in the country. These include changes in the policy environment, frequent changes in the leadership of the sector and attrition of senior government officials and project staff both at federal and state levels. On a positive note, following the enactment of the National Health Act in 2014, there was the first appropriation for the BHCPF in 2018 and every year after. Secondly, the National Health Insurance Authority (NHIA) Act of 2022 with provisions for mandatory health

The Government of Nigeria has set out a Strategic Vision for the Health Sector [2023-2026]

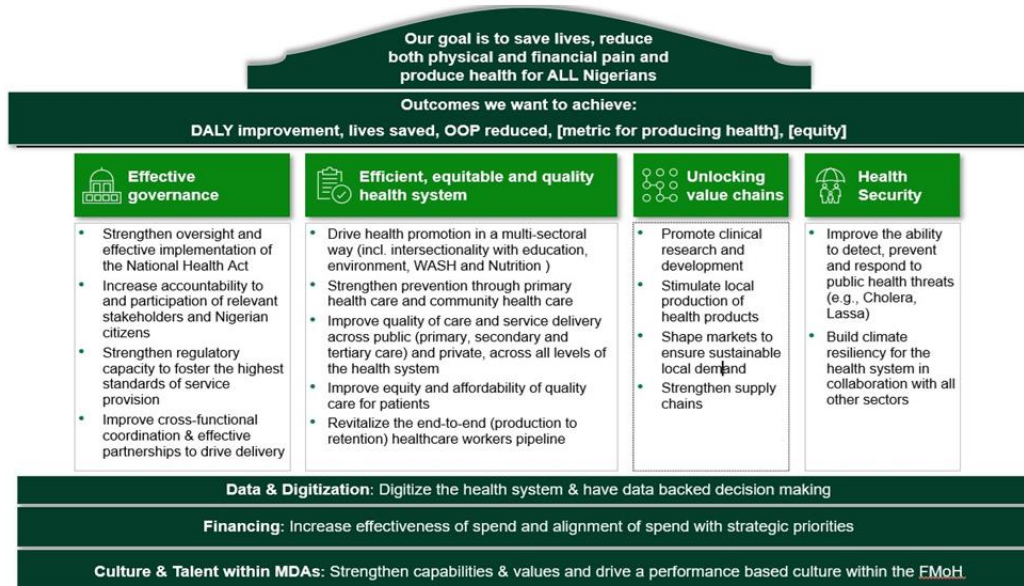


Figure 4: FMOH Presentation on Strategic Vision for the Health Sector (2023-2026)

insurance coverage for citizens was also passed into law and signed by the President of the country. Thirdly, there was the COVID-19 pandemic with severe disruption in service delivery and health financing architecture⁹.

Lastly, the Nigeria’s government under the Renewed Hope Agenda of the President Bola Ahmed Tinubu’s administration set out new Strategic Vision for the Health Sector 2023-2026 (Figure 4). Details of the drivers of the current health agenda in Nigeria include:

- Change from Economic Recovery and Growth Plan (ERGP) to National Development Plan (2021-2025).
- Revised National Health Strategic Development Plan (NHSDP)II -2023-2026
- Appropriation for BHCPF commenced in 2018, initially through service wide vote now to Statutory Transfers.
- Passage of Nigeria Health Insurance Authority (NHIA) Act with provision of mandatory health insurance (2022).

⁹ https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG11-3-Protecting-Essential-Services-in-Times-of-COVID-19.pdf

- Renewed Hope Agenda and Nigeria Health Sector Renewal Investment Program using Sector Wide Approach (see below schema showing the new health sector strategic vision and highlighted part on RMNCAH-N).

The Strategic Vision for the Health Sector will be guided by progress in key outcomes

	Save lives	Reduce physical pain	Reduce financial pain	Produce health	For ALL Nigerians	
This means	Less death	Improved quality of life Improved quality of care	Reduced out-of-pocket spend Increased and more effective government spend Reduced financial burden for the poor specifically	Reduced risk factors for communicable & non communicable diseases Reduced prevalence of noncommunicable and communicable diseases and reproductive/maternal, neonatal, child, adolescent, and nutritional (RMNCH+AN) conditions	All have access ...regardless of income group, there are good health outcomes	
Measured by	Mortality <ul style="list-style-type: none"> Life expectancy at birth Mortality rates <ul style="list-style-type: none"> Maternal Neonatal Under 5 Attributable to cardiovascular disease, cancer, diabetes, or chronic respiratory disease 	Quality of life <ul style="list-style-type: none"> DALYs (overall) Quality of care (QoC) <ul style="list-style-type: none"> HRH Density <ul style="list-style-type: none"> Medical doctors Nursing and midwifery personnel Community health workers Patient satisfaction rates with PHC services People voice survey scores Note: additional quality of care metrics to be added after QoC framework developed 	Health financing <ul style="list-style-type: none"> Population with impoverishing health expenditure Health insurance coverage Government health expenditure as a proportion of total health expenditure per capita 	Risk factors (Prevalence) <ul style="list-style-type: none"> Obesity Insufficient physical Activity Non-communicable diseases (Incidence) <ul style="list-style-type: none"> Cancer Cardiovascular diseases Diabetes and kidney diseases Communicable diseases (Incidence) <ul style="list-style-type: none"> Malaria Diarrheal diseases HIV TB Immunization <ul style="list-style-type: none"> Penta 3 coverage % of children 0-12 months fully immunized 	RMNCH+AN <ul style="list-style-type: none"> Contraceptive prevalence Antenatal care coverage Skilled birth attendance Postnatal care (newborn) Stunting and wasting Adolescent birth rate Health Security <ul style="list-style-type: none"> IHR¹ Score 7-1-7: early detection and response Local production: <ul style="list-style-type: none"> Net imports of generics and medical devices 	Access <ul style="list-style-type: none"> Health facility density and distribution Equity <ul style="list-style-type: none"> Coverage of essential health services Zero dose children Difference in [select outcomes]² between different regions and income groups

1. International Health Regulations (IHR) capacity and health emergency preparedness
2. Being determined

Source: SDGs Presidential Commitment WHO Other

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Figure 5: Strategic Vision for the Health Sector (2023-2026) with Highlights on RMNCAH-N

4.4 COVID-19 pandemic and disruption of Service

Like in other countries, COVID-19 pandemic had significant effects on the coverage of essential services both on the demand and supply sides. The lockdown, supply chain challenges, shocks to the financial system care, attrition/redeployment of health personnel, and redirecting financing to containing the virus had inimical effects on access to health. Nigeria experienced substantial and persistent disruptions to essential health services since the start of the COVID-19 pandemic especially in May 2021 to outpatient consultations. Institutional delivery and ANC4 were the most disrupted

reproductive, maternal, newborn, and child health services¹⁰. Specifically, as shown in the Figure 6 between April to July of 2020, out-patients department attendance fell by 14-21%, family planning and antenatal care fell by 10-15%, health facility delivery fell by 6-7% and vaccination of Penta 3 by 8-12%¹¹. Table 1 on the estimated impact of COVID-19 on essential services further highlights the nation’s experience during the pandemic. There is no data on fund flow from or to essential services during the COVID-19 pandemic.

Table 1: Estimated Impact of COVID-19 on Essential Services in Nigeria

	Number of Consultations (Outpatient attendance)	FP clients counselled	First Antenatal Visit (#)	Total deliveries	Third dose of Pentavalent vaccine (#)	BCG vaccination (#)
March 2020	-3.4	-1.2	-3.1	-0.6	-3.7***	2.4**
April 2020	-17.5***	-10.7***	-15.5***	-0.9	-12.3***	-5.7***
May 2020	-19.8***	-14.8***	-14.6***	-6.2***	-11.7***	-6.0***
June 2020	-14.7***	0.2	15.7***	-5.8**	-1.4	4.7***
July 2020 ¹	-21.3***	-9.6***	-13.9***	-6.5**	-7.4***	-5.3***

Source: Federal Ministry of Health of Nigeria

All the states except Adamawa state in Nigeria experienced disruptions to at least one essential health service compared to the pre-pandemic trends. Service-specific variations and disruptions were witnessed during the COVID-19 pandemic notably across the subnational levels to outpatient consultations. 20 states experienced major cumulative disruptions and another 8 states experienced minor disruptions to service volumes during the beginning of the pandemic.

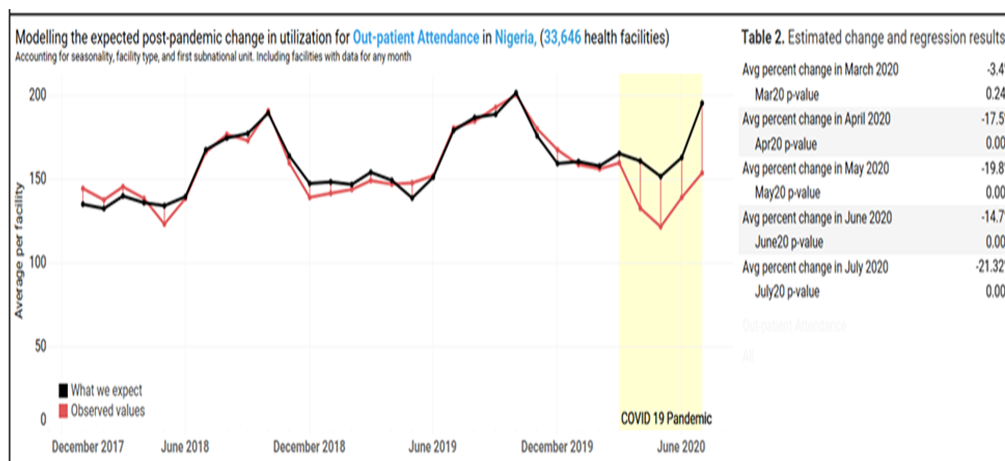
The following were the recorded service disruptions at the subnational level: Taraba state (9 services), Yobe state (8 services), Borno, and Delta states (6 services each), had the most services with major cumulative disruptions during the beginning of the pandemic. Abia, Adamawa, Benue, Cross River, Kaduna, and Kano states had no services with major cumulative disruptions from the beginning of the pandemic. However, States and LGAs in the North-East geopolitical zone and the south of the country

¹⁰ Federal Ministry of Health (2022) Monitoring and Improving Essential Health Service Provision in Nigeria. State Data Packet, March, 2022. With support from GFF

¹¹ https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-IG11-3-Protecting-Essential-Services-in-Times-of-COVID19.pdf

(South-East, South-West and South-South geo-political zones) experienced persistent major service disruptions¹².

Figure 6: Modelling of Post-Pandemic Changes in Out-Patient Attendance in Nigeria



Source: Federal Ministry of Health. See Ref. 11

Generally, GFF provided support during the pandemic period to maintain provision of essential health services. GFF supported virtual participation of the key stakeholders including DFH to participate in Service Delivery Learning Program (SDLP) to aid adaptation required especially at the level of health facilities for continuous provision of services in times of covid-19. Following the SDLP, GFF provided COVID-19 emergency grant which the DFH utilized to develop: (1) training guide on Guidelines for Maintaining Essential Health Services and Infection Prevention Control in COVID-19 Pandemic and other Infectious Epidemic; and (2) Policy Dialogue on Engaging Patent and Proprietary Medicine Vendors (PPMVs) in the Provision of Essential Health Services and commodities. In addition to the mEHS study, a follow-on study was conducted and findings shared with stakeholders to learn from high-performing local government areas (LGAs) through a positive deviance study (conducted in partnership with Exemplars in Global Health)¹³. This was done to enable the states to learn how others were able to recover their critical

¹² Ibid

¹³ Neill R, Peters MA, Bello S, *et al* What made primary health care resilient against COVID-19? A mixed-methods positive deviance study in Nigeria. *BMJ Global Health* 2023;**8**:e012700. <https://doi.org/10.1136/bmjgh-2023-012700>

health indicators during and after the pandemic, while making their health systems more resilient. For instance, all three GFF supported states used their financing to purchase IPC materials and improve service provision in BHCPF facilities through the NPHCDA Gateway. On the nutrition side, the Government responded quickly as well, with the development of the Nigeria Food and Nutrition Plan for COVID response. This prioritized the availability of nutrition commodities such as iron-folic acid, provision of IPC commodities to health facilities and nutrition-sensitive antenatal care under the Accelerating Nutrition Results in Nigeria (ANRiN) Project states.

Towards, the closure of NSHIP, the Government together with the task team decided to convert all health facility payments under the project to provide operational expenses rather than payments based on package of services rendered. These funds were used to procure PPE and to improve infection prevention and control measures in health facilities.

5. Effectiveness of the Planning and Budgeting for RMNCAH-N Outcomes

The mid-term review explored the strategy development process of the FMOH, and the relationship between the NHSDP and the sub-sectoral plans such as the RMNCAH-N strategy. The linkage to the budget process and how prioritized activities are appropriated for and financed were also of interest. Taking the NHSDP II development as example, the process was a guided bottom-up approach based on WHO One Health Framework.

- **Specifically, FMOH/DPRS develop national strategy framework based on situation analysis with five (5) pillars and 15 prioritized Intervention areas.** Guidance Note was also developed and sent to the states to guide the states to develop their framework with emphasis on states' own contexts to select strategic interventions.
- **Departments and Divisions with the FMOH, agencies of the Ministry and the state MOH** also use the framework and guidance note to make submissions to the plan.
- **Then the harmonization of the SP based on submissions from the states and MDAs.** The product is validated and approved by the National council on Health (NCH)

- **From the NHSDP, Annual Operating Plan (AOP) are developed (plus operating plan guideline for the states and MDAs) for budget proposal.** Based on “the budget envelop” from NPC – the budget proposal is based on historical needs and prioritization matrix. With regards to sub-sectoral strategic plans including RMNCAEH-N, they are supposed to derive or mirror the NHSDP. But usually not the case. The need for separate departmental SP is questionable as it looks like duplication and waste of funds. If sub-sectoral strategy plans are developed, they should cover the same period as the NHSDP. It was also gathered that the challenges to implementation and monitoring the plan are that (i) plans are not used, (ii) inadequate monitoring of implementation, (iii) Only about half of the states in the country are doing any form of performance appraisal, (iv) very weak regulation function, and (v) there is no sufficient guidance.

What happened between appropriation, the release of funds and implementation was beyond the scope of this MTR, and data related to cost and financing are not in the public domain to facilitate an appraisal. Hence it is difficult to know how well the IC and its prioritized interventions were funded in the period under review. Specifically, resource mapping and expenditure tracking studies are required to answer the questions about what is funded, the output and value for money. RMET is currently being conducted for the first time in Nigeria by Clinton Health Initiative (CHAI) with support from the GFF, this will be the first ever RMET to be conducted in Nigeria.

6. Impact and Sustainability

This section captures the findings on the implementation on RMNCAH-N activities in Nigeria within the period under review. It documents the scale up of the Basic Health Care Provision Fund after the initial pilot in three states. The GFF was instrumental with the piloting of the BHCPF in three (3) states, from where the intervention was scaled-up to the 36 states. The scale-up leveraged from the NSHIP model for the NPHCDA gateway¹⁴. This increased the readiness of the states for BHCPF implementation and scale-up. The appropriation for and the scale up of implementation of BHCPF to all 36 states and FCT was seen as a major achievement towards improving primary health care in the country.

As of June 2023, BHCPF has disbursed ₦103 billion to the health facilities in the country. The formation of State Health Insurance Agencies in 34 states plus FCT and the National Health Insurance Authority act were also seen as a major demand side shift to reduce demand side barriers and the potential to reduce out of pocket expenses. The consensus was that the BHCPF implementation has produced positive results, but there are still multiple challenges. It was too early to give an opinion on the SHIAs. This section provides some information on the program and activities implemented in the period by the multiple stakeholders on the government, development partners, and private sector sides, it documents the achievements of the projects under the GFF grant, present the outcome data currently available and list the current challenges and propose mitigating measures.

6.1 RMNCAH-N Initiatives-led by Government Agencies

Rapid scale up of Basic Healthcare Provision Fund from three (3) to 36 states plus FCT. GFF grant to Nigeria was used to pilot the BHCPF in 3 states with decentralized funds to PHC facilities. The purpose was to test run BHCPF in the states and learn from the process. Unfortunately, the learning was hindered by appropriation for the program in 2018 and the need to rapidly scale up the roll out of BHCPF. Respondents acknowledged the inherent challenges of capacity and inadequate financial management support but

¹⁴ <https://documents1.worldbank.org/curated/en/589301552969360031/pdf/NSHIP-IE-Report.pdf> (NSHIP Impact Evaluation Report, 2018)

believe that BHCPF has improved access to and utilization of PHC services. Some details below:

- **The Federal Ministry of Health (FMOH) leads the policy development and oversight for RMNCAH+N intervention in the country.**
- **From NPHCDA gateway**, quarterly disbursed funds to 8306 accredited PHC facilities, NPHCDA and SPHCDA provide supervision and capacity building. Within the period, NPHCDA launched multiple initiatives to strengthen PHC services in the country. These include PHC Revitalization, National Emergency Routine Immunization Coordination Centre (NERICC), National Emergency Maternal and Child Health Intervention Centre (NEMCHIC), and Community Health Influencers, Promoters and Services (CHIPS). NPHCDA also provided technical Support to SPHCDA, LGA Health Authorities and PHC facilities. It also served as coordinating unit for multiple donor projects on RMNCAH-N such as WB IMPACT, Global Fund RSSH, Gavi, WHO, UNICEF and BMGF. At the sub national level, all 36 states and FCT have functional SPHCDA and they coordinate PHC services including RMNCAH-N activities in the state. They also host development partners' projects in their states.
- **From NHIA gateway** 1.596 million poor and vulnerable people have been enrolled on the program and the accredited PHC facilities are paid capitation based on ₦12,000 premium. Other activities are assistance with improving quality of care, financial tracking, and programmatic reporting.
- **Other MDAs, in the case of nutrition, the Federal Ministry of Finance, Budget and National Planning, Federal Ministry of Health, Federal Ministry of Education, Federal Ministry of Agriculture and Rural Development,** Federal Ministry of Women Affairs, the National Social Safety Nets Coordination Office/National Cash Transfer Office, National Primary Health Care Development Agency; the State Ministries of Health and State Primary Health Care Development Agencies of implementing states, supported the Accelerating Nutrition Results in Nigeria (ANRiN) Implementation.

6.2 RMNCAH-N and Primary Health Care Contributions from Development Partners

The development partners' in-country provided support in the development of the IC. Bill and Melinda Gates Foundation, the World Bank/GFF, FCDO, Global Fund, USAID, WHO and other UN agencies provided considerable advocacy, financial and technical support for BHCPF implementation at federal and subnational levels. For instance, technical support were provided for the HUWE project in one of the states; in addition to the overall health policy support for RMNCAH-N. importantly, BMGF supported the IC with the financing of HUWE across the project state. Several other partners are also providing technical assistance to support implementation in states (USAID/HP+ - Osun, Abia, Niger, WHO - Edo, Abia, Niger, DFID/MNCH2 - Katsina, and Yobe).

Other activities that contributed to the RMNCAH+N achievements include:

- **UN agencies** – WHO, UNICEF and UNFPA had regular programming support to RMNCAH-N at the federal and state levels. UNICEF supports immunization and nutrition and UNFPA supports family planning. WHO aids the government in the areas of policies, guidelines and technical assistance in core RMNCAH-N and health financing.
- **World Bank** – IMPACT MPA-PDO of the MPA is to improve the utilization and quality of immunization plus (immunization, child, neonatal and maternal health) and malaria services in selected states. The project is financed under concessional terms through an IDA credit of \$650 million.
- **Gavi** provided vaccine support and supported health system and immunization strengthening to Nigeria. The support included newly introduced HPV vaccine roll out and efforts to reduce zero dose among children aged 0-23 months that have received first dose of DPT.
- **Global Fund** – through the RSSH grant supports health system strengthening with regards to human resources for health, emergency preparedness and response and have partnered successfully with supply of anti-malarial drugs in PHCs.
- **BMGF** supported several RMNCAH-N interventions through their implementing partners including being major financier of family planning, immunization, adolescent health, and maternal health.

- **FCDO** targeted policy windows where technical assistance could catalyze improvements in health financing through the Lafiya Project. They support family planning through the basket fund, service delivery in the North-East, and human resources for health.
- **Global Affairs Canada** majorly supported adolescent girls' health, gender and GBV.

6.3 RMNCAH-N and Primary Health Care Contributions from the Private Sector.

Partnership with the private sector also made significant contributions to the implementation of the plan. Some of these contributions are captured in the box 1. It is pertinent to however mention the use of vibrant Nigeria consultancy firms that served as Contract Management and Verification Agencies (CMVA) and Independent Verification Agency (IVA) in the implementation of the NSHIP AF in conflict zones in the Northeast of Nigeria. Their management inputs also built the capacity of the government functionaries in the six states. The Gombe State team, for example, alluded to the fact they have been able to sustain the program and their competence made them gain the confidence of the Governor who has continue to give adequate support to the health. The team was also one of the best performing states in ANRIN with multiple introductions of innovations. Nasarawa state participated in the first NSHIP project and it deplored the skills from the support of the private sector to jumpstart its participation in the ANRIN project. It is their hope that working with the NSA on ANRIN will ensure sustainability of nutrition program in the state. *These models in public private partnership need to be further studied for lessons learned towards better and greater PPP.*

Box 1: Private Sector Participation in RMNCAH-N Implementation (2017-2023)

Some private sector organizations also contributed to RMNCAH-N financing and service delivery. What was captured here was from group interviewed and available reports/websites.

Society for Family Health (SFH) has for decades program around family planning and reproductive health, maternal and child healthcare, health and social system strengthening and HIV and AIDS prevention and treatment.

Private Sector Health Alliance of Nigeria (PSHAN) focuses on PHC delivery in their project on Adopting Health Facility Project that targets 774 health facilities countrywide within 10 years. On the demand side, they are working with NHIA on a health insurance scheme – Shaping Equitable Market Access (SEMA) and nutrition.

PharmAccess supports insurance scheme across multiple in Kwara, Lagos and Delta States, quality improvement for maternal and child health interventions and SRH market survey and leveraging digital technology.

About 24 private sector groups and CSOs work as **Non-State Actors (NSAs)** on RMNCAH-N providing project management support, verification of health services, supply of nutritional commodities and capacity building for health workers.

Nigeria Health Watch, HERFON and other CSOs– information sharing, advocacy and regular workshops and conferences of RMNCAH-N Issues

Nigeria has thousands of private PHCs and hospitals providing RMNCAH-N services all over the country. There is also significant number of Nigerians that receive health care from private medical vendors (PMVs)

Source: Authors

6.4 GFF Grant supported Projects

Table 2 shows the performance, coverage, and the development objectives of GFF supported projects with the Investment Case. It highlights achievements related to the IC for the period under review.

Table 2: Performance of the GFF Supported Projects within the Investment Case

	BHCPF (HUWE) Project	ANRIN PROJECT	NSHIP AF
Co-Financing:	\$20 million from GFF	\$232 million from IDA and GFF	\$125 million from IDA and \$20 million from GFF
PDO	Establish the accreditation, verification, and payment mechanisms for the operationalization of the Basic Health Care Provision Fund in the participating states	Increase the utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls, and children under five years of age in select areas of Nigeria's territory.	To increase the delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities in the participating states.
Coverage	Three (3) states -(Abia, Niger, Osun states)	12 high malnutrition burden states - (Abia, Akwa Ibom, Gombe, Kaduna, Kano, Katsina, Kogi, Kwara, Nasarawa, Niger, Oyo, and Plateau states)	Six (6) States in the North-East of Nigeria (Adamawa, Bauchi, Borno, Gombe, , Taraba and Yobe States) to address humanitarian crisis in the NE
Strategies/ Innovations	Test running Direct Facility Financing (DFF); performance-based grants to providers using a "Fee-For-Service" approach; strengthening BHCPF national institutions and strengthening performance of state level implementation agencies.	Performance-based contracting of Non-State Actors; Use of Disbursement Linked Indicators, PHC and Community interventions, Integration of adolescent health and birth spacing services with nutrition services.	Performance based financing, performance of based contracting of private sector organizations (NSA) as CMVAs and IVA. Focus on PHC health system strengthening especially HF and Service delivery.
Digital Application	Nil	Web-based App for capturing data by the NSAs and PHCs	PBF Portal for warehousing and verification of service data
Outputs	Number of public PHC receiving operational expenses via DFF mechanism 898 exceeding targets of 800; Number of accredited facilities receiving payments for 'fee-for-Service (FFS) mechanism, - public and private 645 less than target of 1,000, OPD	(i) About 11,873,391 (7,157,044 children under five years and 4,722,347 women) beneficiaries - through NSA and PHC activities. (ii) Pilot integration of adolescent health and birth spacing services with nutrition services in Kaduna State.	(i)total beneficiaries of HNP services Penta 3 coverage from 27% in 2014 to 68.6% in 2020; SBA 22.2% in 2014 to 68% in 2020, Average HF quality of care score 41.9% in 2014 to 61.6% in 2020. Number of kids

	<p>visits/annum for the three states 1,181,776, Penta 3 coverage 68.7% (NB), SBA 79.47% (NB), Average health facility quality of care score 71.6% from baseline of 28%</p>	<p>(iii) Multisectoral co-convergence pilot in 3 Local Governments of one implementing state. – 1605 households homestead gardening, 20 girls in Income generating activity, WASH, 283 teachers and nurses trained to manage deworming. etc.</p>	<p>immunized per annum 327,228 in 2014 to 1.08 million in 2020.</p>
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6.5 Available Output/Outcome Data covering the Period under Review

This sub-section consists of findings from available data from surveys and analysis of information from key stakeholders on key RMNCAH-N outputs, outcomes, and finance.

Table 3 shows the domestic resources for health 2018-2022 in Billion Naira in aggregate terms of the total budget increase in the last three years but not in terms of as percentage of total budget. The total health budget as percentage over the period of the IC has been inconsistent at an average of 4.98% for the period 2018-2022; while the federal government's budgetary allocation to health has also averaged 8% over the last ten years. The country therefore has not been able to meet the Abuja Declaration on Health as set by the African Union countries in 2002 to allocate at least 15% of their budget each year to the health sector, known as the Abuja Declaration¹⁵.

Table 3: Domestic Health Resources 2018-2021 in Billion Naira from the Presidential Health Reform Committee Report, May 2023

Budget Components	2018	2019	2020	2021	2022
Capital	86.49	57.08	51.4	137.39	208.01
Recurrent	269.97	315.61	336.59	380.21	462.85
Statutory Transfer: BHCPF	55.15	51.21	26.45	35.02	54.05
Service-wide vote for healthcare	6.67	37.33	172	152	110.21
Total for health sector	418.28	461.23	586.94	704.86	835.12
Total budget size	9,120.33	8,916.96	10,810.80	14,570.74	17,126.87
Total health budget as %	4.59	5.17	5.43	4.84	4.88

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¹⁵ <https://www.afro.who.int/sites/default/files/2017-06/state-of-health-financing-afro.pdf>

Table 4 below shows the performance of the maternal health indicators from 2008 to 2018, which covers the period of the IC’s initial year. Although the actual performance of the country’s indices are not available due to the non-conclusion of the NDHS 2023, which is to provide the overview of the actual performance for the country. Table 4 therefore indicates a drop in MMR in 2018.

Table 4: Highlight of Maternal Health Indicators 2008 - 2023

Maternal Care Indicators	Rate/Ratio			
	2008	2013	2018	2023
Maternal Mortality	545	576	512	??
Total Fertility Rate	5.7	5.5	5.3	??
Contraceptive Prevalence Rate	13	15	17	??
ANC from skilled provider	58	61	67	??
Delivery by skilled provider	39	38	43	??
Delivery in a health facility	35	36	39	??
Unsafe abortion CFR	11	13	?	?

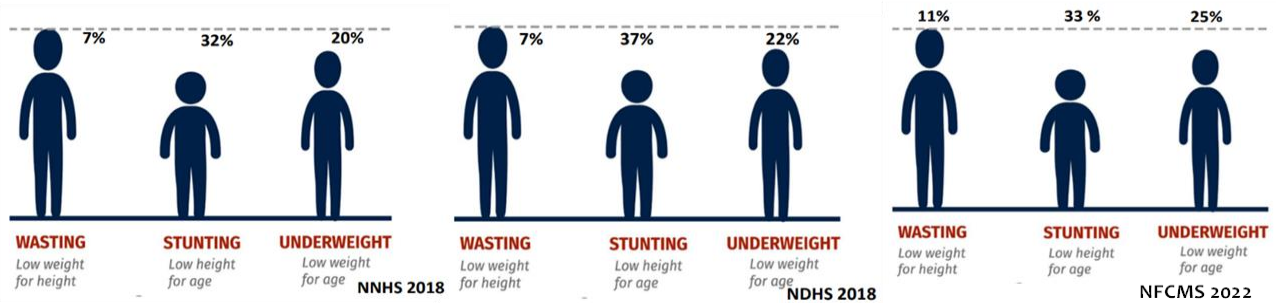
Sources: NDHS 2008 to 2023 and MICS 2021; 2023 NDHS is currently in process and may be considered as a more timely set of end-line indicators

Available data¹⁶ shows a marginal reduction in Maternal Mortality Ratio from 576 in 2013 to 512 deaths per 100,000 live births (NDHS, 2018). Same improvements are also recorded in Infant and Under-5 Mortality rates, while neonatal mortality rate however remained persistently high (Table 5). There were positive changes in total fertility rate, contraceptive use uptake, skilled birth attendance, penta-3 coverage as well as measles immunization coverage. In addition, the country is reported to have the second highest burden of stunted children in the world¹⁷.

¹⁶ NDHS, 2018, NNHS, 2018 and NFCMS, 2022

¹⁷ The State of Food Security and Nutrition in the World 2023. <https://www.fao.org/3/cc3017en/online/state-food-security-and-nutrition-2023/global-nutrition-targets-trends.html>. Accessed on February 12, 2024.

Diagram 7: Overview of the Performance of Nutrition Indices in Nigeria adapted from Multiple Sources



NDHS 2018 recorded that 37% of Nigerian children aged 6-59 months are stunted, 7% are wasted, 22% are underweight, 68% of children aged 6-59 months while 58% of women aged 15-49 are anemic. However, the Nigerian Nutrition and Health Survey (NNHS, 2018), and the National Food Consumption and Micronutrient Survey (NFCMS, 2022) posits marginal improvement in the nutrition indices. *See Figure 7 on overview of Nutrition Indices in Nigeria.* In relation to family Planning, MICS (2021) shows that 18.2% of women of reproductive age are using modern family planning methods at the national level, though FP uptake at sub-national levels ranges from 3.6% in Jigawa State to 36.6% in Lagos.

Table 5: Newborn & Child Health Indicators (NDHS 2008 – 2023 & MICS 2021)

Childhood Care Indicators	Rate /Ratio (NDHS)				MICS/NICS
	2008	2013	2018	2023	2021
Neonatal Mortality	40	37	39	??	34
Infant Mortality	75	69	67	??	63
Under 5 Mortality	157	128	132	??	102
Child Mortality	88	64	69	??	42
Vaccination coverage	23	25	31	??	44.2
Early Initiation of breast feeding	30	26.1	42	??	
Measles immunization	38	42	54	??	

Sources: NDHS 2008 to 2023 and MICS 2021; 2023 NDHS is currently in process and may be considered as a more timely set of end-line indicators

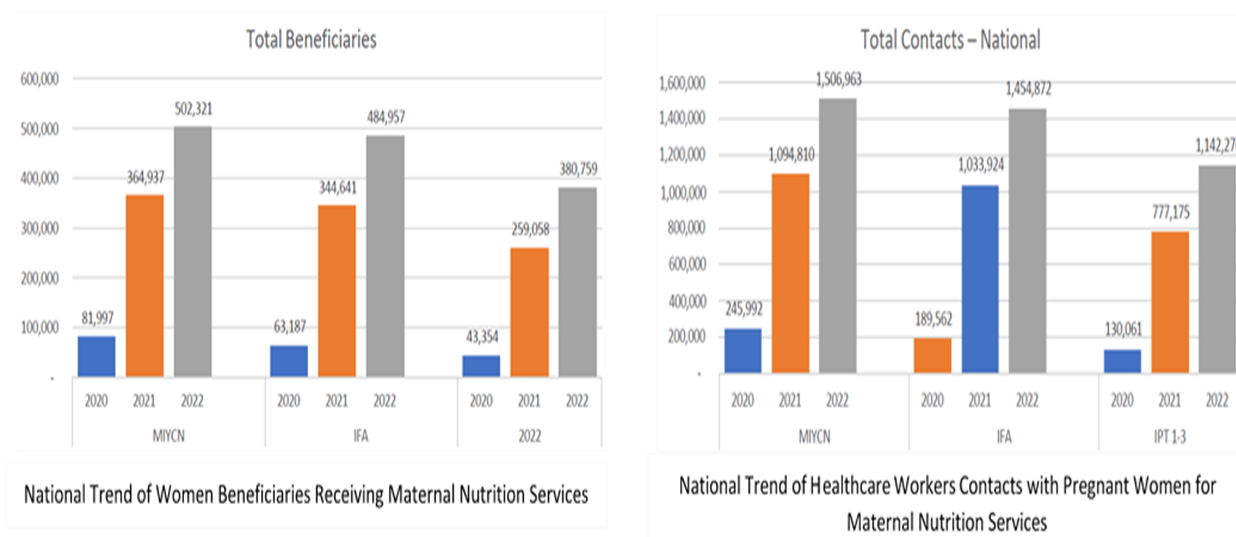
ANRIN Project achievement as at March 2023¹⁸ has maintained steady progress towards the Project Development Objective of *“increased utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under five years of age.* A total of 5,841,03 women and children have received basic nutrition services as against the end target of 4,260,143.00. This is made up of 4,255,848 children under five years of age and 1,585,189 pregnant women and adolescents that received services from the Basic Package of Nutrition Services delivered at community level as at December, 2022. Precisely, 456,012 women received maternal nutrition services at primary healthcare facilities. ANRIN project reached 129,034 children under-five with micronutrient powders representing 32 percent of the project’s cumulative target for 2022. In the same vein, 1,051,223 children received Zinc-ORS for the treatment of diarrhea being 106 percent of the target for 2022. 1,405,052 children under-five being 163 percent were dewormed at least twice; 2.6 million children under-five enrolled, given at least one service; and were eligible to receive follow-on services in the year 2023. More so, 220,050 women received at least 90 tablets of iron-folic acid during pregnancy, and 161,500 also received at least three doses of Sulfadoxine-Pyrimethamine for Malaria Prevention in Pregnancy. Twenty-one (21) of twenty-five (25) contracts with non-state actors (NSAs) were signed as at year ending 2022 for the ANRIN project implementation. As part of strengthening systems for the intervention delivery, 11 out of 12 states have active grievance redress mechanisms that detect, report and address project related grievances from communities and health facilities, and 11 out of 12 focal states had nutrition intervention mapping system developed and updated annually.

Besides, Ten (10) of twelve (12) State Primary Healthcare Development Agencies (SPHCDA) delivered 456,012 of maternal nutrition services in 2022 at the subnational level. – See *Figure 8 on Trends of Maternal Nutritional Services at the PHCs.* ANRIN supported the SPHCDA to roll-out integrated delivery campaigns to boost utilization towards

¹⁸ Accelerating Nutrition Results in Nigeria Project - P162069 (Credit No: 6269-NG) and the Global Financing Facility (TF0A7516-NG) Management Letter: Implementation Support Mission, November 21 – December 2, 2022 (Aide Memoire)

achieving the end target. This is in spite of the varied performance¹⁹ by the states as of November 2022.

Figure 8: Delivery of Maternal Nutrition Services at Primary Health Facilities under ANRIN Project



7. Interpretation of Results

Using the NDHS information for 2018, the available results are not enough to make any definitive judgment of the country’s performance on the health and well-being of women, children, and adolescents. It will be more appropriate to wait a few months down the line until the results of 2023 NDHS are released. The MICS of 2021 shows a positive trajectory for child health on the other hand. The MICS results seem to corroborate the narrative on implementation of the RMNCAH-N strategy, but this MTR cannot make a call at this point on effectiveness and efficiency of the strategy and whether it has equitable effect on population access to RMNCAH- N services.

7.1 Innovation and leapfrogging approach

One of the principles guiding the investment case was ‘innovation’ to improve coverage and delivery of quality RMNCAH + N health services. Notable home-grown innovative approaches were deployed within the period, especially by private sector organizations. For example, PHSAN is using Shaping Equitable Market Access (SEMA) to increase enrollment in

¹⁹ Performance varied across states, with six (6) out of the ten (10) states achieving over 80 percent of the set target, two over 50 percent and two below 50 percent

health insurance and PharmAccess is leveraging digital technology. Within the ANRIN, apart from leveraging technology for NSAs and PHCs to collect nutritional services data in all focus states, an innovation that focuses on the use of low-tech tool (Talking book) is in use to improve community health education. The tool provides high quality, learner-centered education for pregnant women, adolescent girls, and caregivers of under-5 children irrespective of their literacy level and language.

Service delivery challenge planned for in the Investment Case was not implemented due to delays in resolving mechanics of transferring funds to the successful organization before NSHIP AF closed. It was supposed to use competitive process to provide innovative service delivery models to serve populations in the remote and rural areas of the Northeast.

The Investment Case described leapfrogging approach as a sum of defining priorities and essential package of services; leveraging technology; mobilizing private sector skills; focusing on results; and tracking performance. Although, there is evidence of implementing some of the suggested activities, the available result has not shown radical transformations in health care in Nigeria'. This is due largely to the inability of the country to conduct its own NDHS to ascertain performance along the RMNCAH+N indicators. There is also poor-quality data from the DHS2, besides the impact of the COVID-19 pandemic that disrupted lots of projected actions.

7.2 Challenges of Implementation of RMNCAH-N Activities

Some of the challenges highlighted by respondents on the implementation of the IC and other RMNCAH+N activities in the country include:

- Non-involvement of subnational stakeholders including the private sector in RMNCAH-N strategy development,
- Weak capacity for health planning and management in the ministries of health at Federal and State levels.
- Lack of coordination at FMOH level (discordance between DPRS & DFH) and between MDAs, FMOH and the state MOH and Ministries of Health and development partners.
- **Fragmentation of RMNCAH-N interventions (vertical programs) due partly to misalignment of sector and subsectors action plans related to RMNCAH-N.**

- HRH and infrastructural challenges.
- Misalignment between partners interests and States priorities.
- Weak referral systems.
- Delivery not at scale and inequitable delivery of services and implementation coverage.
- **Lack of evidence to inform and improve RMNCAH-N implementation, learning and improvement agenda.**
 - Poor data quality, paucity, and usage both for design and in implementation.
 - Harmonizing data management platforms in DFH
 - Weak community information management systems.
 - Non-availability of clinical data.
 - Challenges of implementation and in acceptance of the last relevant health surveys.
- **Weak accountability mechanisms.**
 - Difficulty with health budget tracking.
 - Budget not program based.
 - Resource mapping and expenditure tracking – not in place.
 - Lack of / non-enforcement of accountability framework even when available.
- **Perverse incentives**

8. Lessons Learned

Below are some of the lessons learned from the mid-term review of the Nigeria Investment Case:

- i. **There was a lot of buy-in and support for the development of the Investment Case at the beginning of the process.** But with the frequent change of guards at the helm of the Federal and State Ministries of Health levels there were loss of momentum. Besides,

- some operational changes were made on Basic Health Care Provision Program that had negative effect on the program leading to inadequate focus on results. At such critical points, sustained advocacy and enlightenment of the new leadership is required for their buy-in.
- ii. **Formulating policies and developing strategic plans or investment case does not guarantee fidelity to its implementation and obtaining required results.** Findings from this mid-term review show that such strategy document at some point was not used to guide operation, there was no rigorous monitoring, and no outcome mapping. It was a case of 'aborted' planning cycle.
 - iii. **The initial GFF support for operationalization of direct facility financing in the Basic Health Care Provision Program (BHCPP) was catalytic towards the first parliamentary appropriation for the program.** The roll out of the BHCPF in the three project states was used as a proof of concept and a strong advocacy tool. It shows the alignment of external resources to ongoing country initiatives, foundational to building synergy for positive outcomes.
 - iv. **Prioritization of RMNCAH-N interventions requires follow through with budgetary provision, financial allocation and focus on implementation and monitoring by government and partners.** Apart from specific donor interventions, this mid-term review found no evidence of how government at national and subnational levels fund and preferentially implement prioritized interventions.
 - v. **MDAs at the federal level continue to work in silos;** interagency collaboration is required for effective implementation and shared accountability.
 - vi. **The formation of and GFF support for the RMNCAEH-N Multistakeholder Coordination Platform at the Department of Family FMOH provides good learning of how to support Country Platforms in other GFF countries.** With more embedded support, the platform can be nudged to meet regularly and learn to use data for decision making, cross correction and adaptive learning.

9. Conclusion and Recommendations

This section consists of concluding statements, recommendations for the federal government of Nigeria and GFF and highlight the limitation to the mid-term review of the RMNCAH-N strategy IC.

9.1 Conclusion

The preparation of the Nigerian RMNCAH-N Investment Case was country led and in accordance with the GFF guidelines. The design was relevant to the RMNCAH-N needs of the country, it was prioritized and costed. The implementation commenced in earnest especially with GFF funded projects but there was change of guards in the Federal Ministry of Health leadership and the IC was not referenced in subsequent implementation of activities in the country which was guided by the NHSDP II and its revised version in later years. At midterm review, there has been six years of implementation with vehicles such as the flagship program of government BHCPF and multiple government, development partners and private sector initiatives. There is an indication from the 2021 MICS that the indices are improving but we have taken a cautious approach and wait for the report of the 2023 demographic and health survey. However, based on our findings, identified gaps, experience from other low- and middle-income countries and the new vision for the health sector some recommendations and suggestions are made to both the government of Nigeria and the GFF.

9.2 Recommendations for the Federal Government of Nigeria

The Government of Nigeria recently expressed its political will to improve the health and well-being of women, children and adolescents as envisioned in the Renewed Hope Agenda and the Strategic Vision for the Health Sector (2023-2026). Another positive change is the agreement/signing of the compact for sector wide approach (SWAP) by the development partners which would ensure programmatic and financial alignment and reduce duplication and fragmentation which had otherwise been one of the banes of the sector. From the positive findings from this MTR, the reform will build on expansion of BHCPP and address systemic issues. The results of the ongoing demographic and health survey will be pivotal in providing guidance as to where to lay emphasis but from this mid-term review neonatal care, adolescent health and nutrition are critical areas

for programming. There is no new data to support it, but historically access to health care for Nigerians have been inequitable especially the rural/urban divide, north/south divide apart from income disparities. It is therefore apt that the new vision among other things proposes to improve equity and affordability of health care to patients. Going forward then, we make the following recommendations:

- i. **One of the observations from this MTR is that the strategic planning cycle abruptly ends with design and production of the plan as a document and not use in the budget process.** There is no follow through to link the plan with financing, implementation, monitoring and evaluation and results. The current input-based budgeting is in dissonance with the objective of focusing on results. Therefore, Nigeria may need to consider program-based budgeting to allow for systemic capturing of measurable results and accountability for results. It would enhance determination of effectiveness of interventions, efficiency of spending and demonstration of value for money. This presents an opportunity to leverage SWAP as the coordinating platform and strengthening the Annual Operating Plan process at the federal and state levels.
- ii. **With Decentralized Facility Financing (DFF) part of BHCPP, Nigeria has succeeded in decentralizing funding to PHC level.** One of the current challenges of the program is how to account for the transferred funds and ensure funds are not diverted for purposes unintended. This would require extensive strengthening of the public financial management system to the facility level. Judging from the fact that the BHCPP will double to close to twenty thousand facilities this year, building an electronic platform would strengthen accountability and bring confidence into the system in this new era of SWAP where partners would want to follow their money.
- iii. **Consideration should also be given to strengthening of facility-level data quality and improvement tools (such as the PFM for BHCPF gateways, claims management, and HMIS reporting)** as a vehicle for results-based monitoring and improvement. With complementing robust electronic health management information system (HMIS) and PFM system in place, accountability would be strengthened.

- iv. **The National Health Insurance Authority (NHIA) gateway of the BHCPP was able to enroll about 1.5 million and it is envisaged that the Vulnerable Group Fund will also increase insurance coverage to indigent Nigerians.** Thus, reducing financial barriers to accessing healthcare. This provides an opportunity for the government to operationalize the NHIA Act to reduce demand side barriers for RMNCAH-N services.

- v. **Government in collaboration with development partners should as a matter of urgency prioritize and implement the following suggested activities/interventions:**
 - a. Institute leadership training program for all cadres of leaders in the health sector and engage with the agencies with governance team to design and implement interventions to strengthen governance in the health sector.
 - b. Support innovative approaches in training, retention and incentivizing health workers and continue to supplement with community interventions where needed.
 - c. Sustain focuses on newborn care, adolescent health, nutrition and improving quality of care in general.
 - d. Build a culture of adaptive learning and use data for decision making.
 - e. Harmonize RMNCAH-N program and align external funding to RMNCAH-N within the Multi-Stakeholder Coordination Platform using the newly introduced SWAP.

9.3 Recommendations for GFF and Suggested Focus for Future Investments.

From the findings of this midterm review of the IC, we make the following recommendations directly addressed to GFF:

- i. **Premising the country Strategic Plan or RMNCAH-N Strategy as the investment Case did not work out as envisaged for Nigeria.** In this case, the plans are prepared to tick boxes and just move on with business as usual. The underlying systemic and behavioral issues cannot be singlehandedly managed by GFF. It will require a whole government approach to put in the required accountability framework and

enforcement of extant laws to compel or encourage positive change. GFF should look for alternatives in the elaboration of GFF country programs. Importantly, this presents an opportunity to either adopt or leverage other existing and functioning platforms including the DPG, and the emerging SWAP and its implementation units for RMNCAH-N implementation.

- ii. **In line with GFF vision, GFF grant was catalytic with its support for BHCPF Huwe Project enabled implementation of BHCPF in Abia, Niger and Osun States which became a strong advocacy tool to parliament,** and it catalyzed first appropriation for scale up BHCPF. This is a positive result. Secondly, funding ANRIN has put Nutrition in the front burner in Nigeria. Similarly, investment in the NE improved indices and strengthened health system in the region especially compared to the Northwest. Therefore, future investment case for Nigeria should focus on health sector reforms for example the current Sector Wide Approach (SWAP).
- iii. **Nigeria is a big country, hence future support could be directed towards monitoring, evaluation, research and learning (MERL) activities** starting with few states as pilot where progress and success could be easily demonstrated – with interventions that are taken to scale, designed to benefit from adaptive learning/demonstrable evidence, and plausibility of developing a blueprint for scale up for government.

There are still some low hanging fruits for GFF future investment as below:

- i. **Continue support for BHCPP – especially in TA for extension of public financial management system to the health facility level and deploying digital technology in support.** This is urgent and it will contribute largely to building transparency and accountability and investors (government and DP) confidence.
- ii. **Support for regular Resource Mobilization and Expenditure Tracking (RMET) is more than ever urgent and necessary in line with the government’s new program on sector wide approach.** Now it is difficult to find cost and financial data in the sector – some of the issues responsible for that are “cultural resistance” but capacity is also weak.

- iii. **Support the creation of 'Data Center' to improve the performance of HMIS in the country.** The DPRS has developed a concept note for creation of the center to be domiciled in a university or similar institution. The idea is novel, and it is worth exploring,
- iv. **Support the roll out of SWAP for harmonization and alignment through the work of Alignment Working Group**

10. Limitation of this Mid-term Review

This midterm review assumed that implementation RMNCAH-N activities in Nigeria 2017 - 2023 was based on the same premises, principles, and goals of the Investment Case. Secondly, some activities were implemented as planned for the IC especially the GFF funded projects. However, the mid-term review was limited fundamentally because there is no culture of evaluating plans and by the following factors:

- i. The MTR was bedeviled by lack of accurate record keeping, absence of vital documents such as annual operating plan, annual implementation report, monitoring report etc. Even for the NHSDP II, its monitoring was based on the Joint Annual Appraisal using tools that is virtually incapable of capturing results and learning lessons.
- ii. Both at state and federal levels, there has been a lot of attrition of officers due to retirement, posting to other programs and change of government.
- iii. This report has mostly been descriptive because of the lack of data on output and outcome indicators. There is a dearth of cost and financial data at all levels.
- iv. There were challenges of recall (memory) from some officials and some handover notes contained no meaningful information.
- v. In terms of logistics, travel to the states was restricted for the consultants. Although virtual meetings were used for some interviews Internet connection was a challenge especially for some states.

Annex 1: Matrix of Evaluation Questions and Data Sources

Question/Sub Question (if any)	Measure(s) or indicator(s)	Data Sources	Data collection method	Stakeholders /Informants	Analysis and assessment
Relevance & Focus					
To what extent is the IC relevant in contributing to RMNCAH+N results achievement as a sub component of the NHSDP to the national development priorities?	<ul style="list-style-type: none"> • Strategic objectives and targets of the IC. • Supported priorities identified in the IC. • Harmonization & Alignment • Feasibility of the plan 	<ul style="list-style-type: none"> • NDHS • Multiple Indicator Cluster Survey (MICS) 2021 • National Immunization Coverage Survey (NICS) 2021 • Project partners and stakeholders reports 	<ul style="list-style-type: none"> • Desk review • Structured interviews • Surveys 	<ul style="list-style-type: none"> • Representatives of RMNCAH+N stakeholders. • National and subnational coordination platforms. • Projects staff and technical specialist 	<ul style="list-style-type: none"> • Identification and prioritization of relevant RMNCAH+N related plans & policies. • Triangulation based on different data sources and evidence-based priority needs.
<p>Did the IC develop appropriate partnerships and linkages for high impact, evidence-based, cost-effective, and gender-sensitive response?</p> <p>What are the changes in the landscape that should be addressed in future RMNCAH+N for relevance and sustainability²⁰?</p>	<ul style="list-style-type: none"> • Partnerships developed to sustainably improve RMNCAH+N services linked to services specified in the National Health Act, through the Basic Healthcare Provision Fund (BHCPF) based on Basic Minimum Package of Health Services (BMPHS)²¹ 	<ul style="list-style-type: none"> • RMNCAH+N documents and progress reports. • RMNCAH+N partners and stakeholders feedback. 	<ul style="list-style-type: none"> • Desk review • Stakeholders engagement meeting outcomes. • Structured interviews. 	<ul style="list-style-type: none"> • Representatives of implementing partner & organizations • Representatives of constituents • RMNCAH+N project teams. 	<ul style="list-style-type: none"> • Analysis of the IC design and implementation in meeting RMNCAH+N goal(s) from inception till date. • Assess measures taken for deepening and sustaining IC results.

²⁰ Appropriation of funds for RMNCAH+N modeling after BHCPF approach

²¹ BMGF and FCDO involvement in BHCPF pilot

Question/Sub Question (if any)	Measure(s) or indicator(s)	Data Sources	Data collection method	Stakeholders /Informants	Analysis and assessment
	<ul style="list-style-type: none"> Project partners²² effectively working on RMNCAH+N themes beyond the IC life 				
Impact, Sustainability, Scale-up, Innovation and Adaptive Learning					
What are the results and critical reflections shaping decisions towards optimizing and sustaining RMNCAH+N IC from design to implementation in Nigeria? ²³	National and subnational empirical evidences generated for decision making and planning.	<ul style="list-style-type: none"> NDHS MICS NICS DHIS Project partners and stakeholders reports RMNCAH+N documents and progress reports. RMNCAH+N partners and stakeholders feedback. 	<ul style="list-style-type: none"> Desk review Stakeholders engagement meeting outcomes. Structured interviews. Surveys 	<ul style="list-style-type: none"> Representatives of RMNCAH+N stakeholders. National and subnational coordination platforms. Projects staff and technical specialist 	<ul style="list-style-type: none"> Triangulation based on different data sources for scalable and replicable actions based on lessons learned.
How is data used for the design, implementation, improvements, and scale-up of RMNCAH+N services for maternal, newborn, and child health, family planning, and ARH	RMNCAH+N learning and decisions based on verifiable data.	<ul style="list-style-type: none"> Project partners and stakeholders reports RMNCAH+N documents and progress reports. RMNCAH+N partners and stakeholders' feedback. 	<ul style="list-style-type: none"> Stakeholders engagement meeting outcomes. Structured interviews. 	<ul style="list-style-type: none"> Representatives of implementing partner & organizations National and subnational coordination platforms. Representatives of constituents 	<ul style="list-style-type: none"> Identification of relevant RMNCAH+N related plans & policies. Triangulation based on different data sources.

²² Other partners (PSHAN, PharmAccess, SOLINA, CCM, UNICEF, UNFPA, GAC, etc) involved in RMNCAH+N implementation, but not directly linked to the IC.

²³ Use quantitative data from secondary sources for its description

Question/Sub Question (if any)	Measure(s) or indicator(s)	Data Sources	Data collection method	Stakeholders /Informants	Analysis and assessment
and GBV services in the healthcare?				<ul style="list-style-type: none"> • RMNCAH+N project teams - staff and technical specialist 	
Effectiveness of the IC					
How are RMNCAH+N IC approaches and investment connected to opportunities for health systems resilience, and response to RMNCAH+N and GBV services at national and subnational levels through legislative engagement, and community-driven advocacy and social mobilization work?	RMNCAH+N response leveraging support for service delivery at all levels from the health systems and other sectors.	<ul style="list-style-type: none"> • Project partners and stakeholders reports • RMNCAH+N documents and progress reports. • RMNCAH+N partners and stakeholders' feedback. 	<ul style="list-style-type: none"> • Desk review • Stakeholders engagement meeting outcomes. • Structured interviews. 	<ul style="list-style-type: none"> • Representatives of implementing partner & organizations • National and subnational coordination platforms. • Projects staff and technical specialist • Representatives of constituents • RMNCAH+N project teams. 	<ul style="list-style-type: none"> • Identification of relevant RMNCAH+N related plans & policies. • Triangulation of related data sets.
Influencing Capacity, and Coordination					
What mechanisms exist at the national and sub-national levels to enhance multi-stakeholder coordination of the RMNCAH+N IC development and implementation for sustainable health agenda setting, influencing and creating change in	Mechanisms and platforms supported to enhance IC quality delivery.	<ul style="list-style-type: none"> • Project partners and stakeholders reports • RMNCAH+N documents and progress reports. • RMNCAH+N partners and stakeholders' feedback. 	<ul style="list-style-type: none"> • Desk review • Stakeholders engagement meeting outcomes. • Structured interviews. • Surveys 	<ul style="list-style-type: none"> • Representatives of implementing partner & organizations • National and subnational coordination platforms. • Representatives of constituents • RMNCAH+N project teams. 	<ul style="list-style-type: none"> • Review of RMNCAH+N plans, policies, and decisions. • Triangulation based on different data sources.

Question/Sub Question (if any)	Measure(s) or indicator(s)	Data Sources	Data collection method	Stakeholders /Informants	Analysis and assessment
policies and practices across in the health sector especially on issues affecting girls, women, and other vulnerable populations?					
Strategy Fit and Operating Environment (Plan for the current investment and the future)					
What priorities should RMNCAH+N IC build upon to optimize results and sustain impact that maximizes the available health workforce and resources for appropriate deployment, fit for purpose, and ready for the strategy realignment?	Appropriateness of the options for future RMNCAH+N interventions.	<ul style="list-style-type: none"> • NDHS • MICS • NICS • Project partners and stakeholders reports • RMNCAH+N documents and progress reports. • RMNCAH+N partners and stakeholders' feedback. 	<ul style="list-style-type: none"> • Desk review • Stakeholders engagement meeting outcomes. • Structured interviews. • Surveys 	<ul style="list-style-type: none"> • Representatives of implementing partner & organizations • National and subnational coordination platforms. • Projects staff and technical specialist • Representatives of constituents • RMNCAH+N project teams. 	<ul style="list-style-type: none"> • Outcomes of relevant RMNCAH+N stakeholders' inputs. • Triangulation of related data sets.
Address the implementation approaches of NSHIP ICR, ANRiN, BHCPF pilot, NHIA, NPHCDA, SPHCDA, NEMCHI, SEMCHICS					
How has leapfrogging and the prioritization approaches worked		Project reports, ISR, ICR	Interviews	World Bank TTLs, Project coordinators at	Outcomes of the projects in the NE, BHCPF pilot and ANRIN

Question/Sub Question (if any)	Measure(s) or indicator(s)	Data Sources	Data collection method	Stakeholders /Informants	Analysis and assessment
out in the final analysis?				national and subnational levels	

Annex 2: RMNCAH+N Investment Case FY 2017 – 2030 Mid-Term Review Questionnaire

Welcome – Explain purpose of the interview

Thank you for agreeing to speak with us. My name is (NAME) and colleague's name is (NAME), and I will be talking to you on the RMNCAH+N Investment Case (IC) in Nigeria. The RMNCAH+N IC is the same as the Nigerian RMNCAH+N strategy.

The World Bank and GFF supported the Government of Nigeria (GoN) in developing the RMNCAH+N Strategy (Investment Case) in 2017 to cover the period of 2017-2030. World Bank /GFF financed implementation of some parts of the strategy through multiple projects including NSHIP AF in the Northeast, the HUWE project and ANRiN. Project activities have been completed in the first two projects, while ANRiN is still operational. To plan its next financial support for Nigeria, GFF in consultation with the World Bank and the GoN have agreed to a midterm review (MTR) of the IC with a view to assessing the achievements, and challenges from design to implementation, with a view to bringing out lessons learned and updating the IC based on current realities.

The purpose of this interview is to learn more about your experience and recommendation(s) on how the RMNCAH+N Investment Case in Nigeria has achieved its purpose and how the IC will serve and achieve its mission. The outcome of this interview will be used for reviewing RMNCAH+N IC only. This team appreciates your time and responses. Every response will be held with utmost confidentiality. Please, remember that we want to know what you think and feel and that there are no right or wrong answers.

Indicative line of questioning includes:

A. Relevance and Focus

1. How would you describe the RMNCAH+N IC especially the understanding of the Country's Investment Case vision, purpose and values in Nigeria? *Probe to know if the RMNCAH+N IC exists. Ask to know the stage at which RMNCAH+N IC was known: at the stage of strategy development – design, implementation etc.; RMNCAH+N IC within one year of implementation; RMNCAH+N IC within one to three years of implementation; RMNCAH+N IC over three years of implementation.*
2. Describe the aspects of the RMNCAH+N IC you have been supporting or implementing. *Please provide information on specific RMNCAH+N IC projects being supported or implemented*
3. What do you see as the gap in the current strategy and what in your opinion are the challenges to implementing the plan? What lessons have you learned?

4. As a result of changes in the landscape, how should RMNCAH+N IC be adapted for future relevance in the areas of funding, programming, accountability, expansion, learning etc.?

B. Impact, Sustainability, Scale-Up, Innovation and Adaptive Learning

1. *What results has Nigeria achieved in the last 7 years in RMNCAH+N in your opinion? Explore to know the progress made in RMNCAH+N, and the contribution of the respondent's organization to this success?*
2. *What results and critical reflections do you use either on a continuous or periodic basis to inform decisions that optimizes RMNCAH+N implementation and effectiveness in expected, unexpected, and changing circumstances in Nigeria?*
3. *How do you use RMNCAH+N data for the design, implementation, and improvements of programs for maternal, new-born, and child health services, family planning, and reproductive health care and GBV?*
4. *What should RMNCAH+N IC do differently to continue and/or scale-up its operations in terms of approaches to work and delivery of services?*

C. Effectiveness and Efficiency

1. *How has RMNCAH+N IC program approaches and investment connected to opportunities for health systems resilience, elimination of gender-based violence and right-based outcomes at: (1) national level policy and legislative engagement; (2) sub-national level policy and program implementation; and (3) community-driven advocacy and social mobilization work?*

D. Influencing Capacity, and Coordination (multi-stakeholders coordination platform)

1. *How has RMNCAH+N IC differently engaged to set sustainable health agenda, as well as influence and create change in policies and practices across in the health sector especially on issues affecting girls, women, and other vulnerable populations?*
2. *What mechanisms exist at the national and sub-national levels to enhance multi-stakeholder participation and coordination of the RMNCAH+N IC development and implementation in Nigeria? Explore the existence of the Technical Working Groups, Sector-Wide Approach (SWAp) mechanism structure, Interagency coordinating committees (ICCs), National country platform, stakeholders health forums, sub-national led mechanisms or any other such related coordinating mechanism*
3. *How does the RMNCAH+N coordination at the subnational level support national-level efforts on RMNCAH+N IC development and implementation? Probe to know if the annual work plans aligned to the RMNCAH+N IC are*

developed; health service delivery data reported accurately and timely; progress reports submitted, and service delivery gaps at the subnational level?

E. Strategy Fit and Operating Environment (Plan for current investment & the Future)

- 1. What top 5 priorities should RMNCAH+N IC build upon to optimize results and sustain impact?*
- 2. What should RMNCAH+N IC do henceforth to maximize the available health workforce, and ensure it is appropriately developed, fit for purpose, and ready for the strategy realignment?*

F. General Questions

- 3. In what areas has RMNCAH+N strategy work not achieved the desired expectations and results, and why? Please explain what the RMNCAH+N strategy should do differently*

Any other comments?

Thank You!

Annex 3: Project Implementation Units (PIUs) Discussion Guide

Thank you for agreeing to meet with our team from the Global Financing Facility (GFF) who are on a mission to review the implementation and results from the 2017-2030 RMNCAH- Strategy (Investment Case) for Nigeria. The purpose of the MTR is to generate evidence and learning on the design, implementation and the outcomes and assist in strengthening transparency and accountability for achievement of measurable results. Lastly, the exercise is also to generate knowledge and encourage adaptive learning. This interview is to globally look at National Health and Strategic Development Plan II and the revised version in general and the role of DPRS in the implementation of the plan and how the sub-sectoral plans derive from the NHSDP or feed into it. We have three sections in this interaction which are basically on Strategic Planning, Data management and health financing.

ANRiN Project Design, Implementation, Monitoring, and Outcome:

- a. Briefly describe the process of design of ANRiN project. How is it linked with either the NSHDP II or RMNCAEH+N Strategy?
- b. How do you monitor the implementation of the ANRiN project, and what are the key achievements, and challenges encountered – How were the challenges resolved?
- c. What are the lessons learned from the governance and coordination of the ANRiN Project so far?
- d. What are your perspectives on deepening and/or scaling-up performance-based nutrition interventions in Nigeria through the public-private sector collaboration?
- e. What plans are in place for sustaining the various ANRiN achievement through sector-wide approach beyond the federal appropriation? Is there any plan for harmonization and alignment of donors/development partners financing nutrition?

Thank you!

Annex 4: Department of Planning, Research and Statistics (DPRS) Discussion Guide

Thank you for agreeing to meet with our team from the Global Financing Facility (GFF) who are on a mission to review the implementation and results from the 2017-2030 RMNCAH- Strategy (Investment Case) for Nigeria. The purpose of the MTR is to generate evidence and learning on the design, implementation and the outcomes and assist in strengthening transparency and accountability for achievement of measurable results. Lastly, the exercise is also to generate knowledge and encourage adaptive learning. This interview is to globally look at National Health and Strategic Development Plan II and the revised version in general and the role of DPRS in the implementation of the plan and how the sub-sectoral plans derive from the NHSDP or feed into it. We have three sections in this interaction which are basically on Strategic Planning, Data management and health financing.

1. Strategic Planning – Design, Implementation, monitoring, and outcome:

- a. Briefly describe the process of design of NHSDP II. How is it linked with either the ERGP or the new NDP?
- b. How did you decide on the core principles for the plan, programs, and priority areas?
- c. What is the role of your department in the implementation of the plan?
- d. Is there an Annual Operational Plan for each year of implementation?
- e. How do you link the plan with the budget of the Ministry? Is the budget program-based budgeting? If not, what is the budget premised on?
- f. How are you monitoring the implementation of the NHSDP and what are the key indicators?
- g. Is there any template for the sub-sectoral strategy plans? In your assessment are those sub sectoral plans aligned with the NSHDP? (Especially with regards to RMNCAH-N Strategy)
- h. What are your overall experience and reflections on the planning and execution of plans in the Ministry of Health?
- i. How does your department interact with state level DPRS on this subject matter?

2. Data Management and Data Use for Decision Making:

There has been various allusion or doubts on the quality and completeness of data from NHMIS/DHIS2:

- a. In your opinion, where are we now in the process of laying this perception to rest? What are the recorded successes and subsisting challenges?
- b. What support do you need to improve data quality, data analysis and reporting?
- c. What plans do you have for improving Data Use?
- d. Technology Adoption for Data Management in Health (Digital Health Support), any progress in this wise?
- e. HMIS and population surveys, how does Nigeria plan to use the two approaches to monitor and evaluate its program and promote adaptive learning?

3. Health Financing:

- a. What plans are in place for financing the various programs of government beyond the federal appropriation?
- b. Is there any plan for harmonization and alignment of donors/development partners financing?
- c. Do you have recent NHA and RMET studies for the period 2017 – 2023 in the country?