INVESTMENT CASE

2017-2030

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT HEALTH AND NUTRITION

FEDERAL REPUBLIC OF NIGERIA

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FOREWORD

The Federal Government of Nigeria (FGoN) is committed to improving the health status of Nigerians, especially the vulnerable and underserved populations. Nigeria holds the Reproductive, Maternal, New-born, Child, Adolescent Health Plus Nutrition agenda (RMNCAH+N) as a top priority for her human capital development.

However, progress made over the last decades to improve the health indices for women, children and adolescents is inadequate. The Federal Ministry of Health (FMOH) therefore, in an innovative manner, is embarking on strategic approaches to achieve the UN Sustainable Development Goals (SDG) for Nigerian women, children and adolescents and improve the performance of the health sector through enhanced accountability and strengthened cooperation between the public and private sectors as well as the civil society organizations (CSO).

The RMNCAH + N Investment Case was developed by the RMNCAH+N sub-group of the NSHDP II Technical Working Group (TWG) to operationalize the Global Financing Facility and accelerate results for women, children and adolescents in Nigeria. The membership of the group include: Officials of the Federal Ministry of Health (FMOH); Line Ministries; Departments and Agencies (MDAs); State/FCT; National and International Development Partners; Organised Private Sector and other relevant stakeholders.

This Investment Case lays out a strategy that focuses on results and not inputs and is actively pro-poor. It targets initially the rural population where most maternal and perinatal deaths occur and offers delivery of free healthcare services to mothers and children at the service delivery points (SDPs), along with strategic purchasing mechanism to increase efficiency.

Delivery of high-impact Basic Minimum Package of Healthcare Services (BMPHS) to Nigerian women, children and adolescents at the primary health care level is a bold step towards achieving Universal Health Coverage and improving dramatically the health and nutritional status of the poor and underserved Nigerians.

A carefully laid out monitoring and evaluation framework has been developed to track the progress and measure results on the set goals, objectives and targets of the investment case; enable informed decision making by policy makers; assess the health status of RMNCAH population and for accountability purposes.

I have no doubt that the targeted goals and objectives are achievable *if* we all join hands to ensure that the programme is well funded and implemented.

PROF. ISAAC F. ADEWOLE, FAS, DSC (HONS)

HONOURABLE MINISTER OF HEALTH

ACKNOWLEDGEMENT

The Federal Ministry of Health appreciates the enormous work done by the RMNCAH + N Subgroup of the National Strategic Health Development Plan II (NSHDP II) Technical Working Group, Departments, Organizations, Development Partners and everyone who invested time, technical and financial support to the development of this National Reproductive, Maternal, New-born, Child, Adolescent Health and Nutrition (RMNCAH + N) Investment Case. It is evident that huge intellectual, academic, innovative and technological skills were deployed in the development of this document.

Our special thanks go to the GFF Secretariat, World Bank Group, WHO, UNICEF, USAID, HERFON and all stakeholders who have contributed invaluably to this work.

We also acknowledge the technical assistance from the GFF consultants, who worked relentlessly with the Ministry in collaboration with other Partners to facilitate the development of this document.

Finally, I wish to commend the Co-Chairs of the GFF Country Platform Dr. Adebimpe Adebiyi, mni (Director, Family Health Department and Dr. Akin Oyemakinde (Director. Department of Health Planning Research and Statistics) and their officers for their doggedness and resilience towards ensuring the finalization of this document.

MR. CLEMENT OSARENOMA UWAIFO, FCA, MBA.

PERMANENT SECRETARY

ACRONYMS

AAFB	Acid and Alcohol Fast Bacilli
ACTs	Artemisinin-based Combination Therapy
AIDS	Acquired Immune Deficiency syndrome
AMTSL	Active Management of Third Stage Labour
ANC	Antenatal Care
ANC4	Ante-Natal Care – 4th visit
ART	Anti-Retroviral Treatment
AYF	Adolescent and Youth Friendly
AYFHS	Adolescent and Youth Friendly Health Services
BCG	Bacillus Calmette Guerin
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
BoD	Burden of Disease
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CRF	Consolidated Revenue Fund
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organizations
DLI	Disbursement Linked Indicators
DHS	Demographic Health Survey
DPT	Diphtheria Pertussis Tetanus
DPT3	Diphtheria Pertussis Tetanus – 3rd dose
EmONC	Emergency Obstetric and Newborn Care
ERGP	Economic Recovery and Growth Plan
FCT	Federal Capital Territory

FGM	Female Genital Mutilation
FGoN	Federal Government of Nigeria
FP	Family Planning
GBoD	Global Burden of Disease
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoN	Government of Nigeria
HERFON	Health Reform Foundation of Nigeria
HIV	Human Immunodeficiency Virus
HNLSS	Harmonized Nigeria Living Standard Survey
HNP	Health Nutrition and Population
IC	Investment Case
IDA	International Development Association
IDP	Internally Displaced People
IHME	Institute of Health Metrics and Evaluation
IMNCH	Integrated Maternal, New-born and Child Health
IPT	Intermittent Preventive Treatment
IRMNCAH	Integrated Reproductive, Maternal, New-born and Child Adolescent Health
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
IV	Intravenous
LGA	Local Government Area
LMIC	Low and Medium Income Countries
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies

MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, New-born and Child Health
MNCH2	Maternal, New-born, and Child Health Programme 2
Mcpr	Modern Contraceptive Prevalence Rate
MSoHF	Management Secretariat of the HealthCare Fund
MSS	Midwives Service Scheme
NARHS	National HIV/AIDS & Reproductive Health Survey
NCDs	Non-communicable diseases
NDHS	Nigeria Demographic and Health Survey
NE	North East
NHAct	National Health Act
NHFS	National Health Facility Survey
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NITEL	Nigeria Telecommunications
NNHS	National Nutrition and Health Survey
NPHCDA	National Primary Health Care Development Agency
NPOPC	National Population Commission
NSHDP	National Strategic Health Development Plan
NSHIP	Nigeria State Health Investment project
NSHIP-AF	Nigeria State Health Investment project - Additional Financing
NSPANN	National Strategic Plan of Action for Nutrition in Nigeria
OIC	Officer in Charge
OOP	Out of Pocket
ORS	Oral Rehydration Solution

ORT	Oral Rehydration Therapy
PBF	Performance Based Financing
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCUOR	Primary Health Care under One Roof
PIT	
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PTB	Pulmonary Tuberculosis
RMNCAH+N	Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition
RBF	Result Based Financing
RPBA	Recovery and Peace Building Assessment
SDGs	Sustainable Development Goals
SDI	Service Delivery Indicator
SDP	Service Delivery Points
SHC	Secondary Health Care
SMART	Standardized Measurement and Assessment of Relief and Transition
SP	Sulphadoxine-Pyrimethamine
SPHCDA	State Primary Health Care Development Agency
SPROM	Spontaneous Premature Rupture of Membranes
SRH	Sexual and Reproductive Health
SSA	Sub Saharan Africa
SSHIS	State Social Health Insurance Scheme
STD	Sexually Transmitted Diseses
TFR	Total Fertility Rate
TFR	Total fertility Rate
TMSoF	The Management Secretariat of the Fund

TWG	Technical Working Group
U5MR	Under Five Mortality Rate
USD	United State Dollar
UHC	Universal health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Despite the unprecedented progress recorded in Maternal, Neonatal and Child health outcomes globally in the past decade, many low and medium income countries (LMICs), particularly those in sub Saharan African do not have smart, scaled and sustainable financing mechanism to meet the Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH +N) related SDG Targets in 2030. The Situation analysis conducted revealed a high RMNCAH + N health burden with unacceptably high mortality and morbidity rates for mothers, neonates, children and adolescents. This necessitated the multi-stakeholder development of a costed GFF IC in line with international standards using the One-Health tool and in collaboration with the World Bank.

Modest Progress on RMNCAH+N: RMNCAH +N outcomes and health service delivery have improved only modestly over the last 25 years in Nigeria. The poor, in particular, experience unacceptably bad health outcomes and suffer from limited use of key services. Poor health, nutrition, and fertility outcomes are a serious impediment to Nigeria's economic development and are unlikely to be alleviated simply by GDP growth. Almost two/thirds of the burden of disease in Nigeria is accounted for by illnesses affecting women and children. Strengthening RMNCAH+N services is, therefore, an urgent development necessity.

Constrained Resources, Widespread Poverty, and Increasing Inequality: The slow progress on RMNCAH+N has to be understood in the current context the country is facing. Government revenues have declined as a result of oil price reductions and economic growth has faltered significantly. Thus, public resources are severely constrained. In addition, poverty reduction (e.g. declines in poverty headcount) has been sluggish and inequality has worsened over the last few years. Thus protecting the poor and vulnerable has become even more pressing and these groups should get the first call on public resources invested in the health sector.

The Problem is NOT Just Inputs: Nigeria has an extensive system of public health care facilities and a large number of skilled health workers (the number of health workers per population is almost twice the average for sub-Saharan Africa). Efforts over the last few decades to increase physical access to care have largely been successful but have not substantially improved utilization. The major demand side issues are financial barriers and low perceived (and actual) quality of care. The supply side issues arise from: (i) lack of operating budget at the health facility level; (ii) inadequate management and supervision; (iii) weak governance and accountability; and (iv) an inability to work effectively with the private sector that provides much of the curative care.

The North East Requires Special and Urgent Attention: Besides suffering from some of the worst health, nutrition, and fertility outcomes in all Nigeria, the North East warrants special and urgent attention because of on-going insecurity, impending famine, a health system that has been terribly damaged by years of insurgency, and worsening poverty (it is the only part of the country where poverty is increasing).

Over the Next 5 Years FGON will Significantly Strengthen RMNCAH+N Services: This investment case sets out the FGON's commitments, priorities, and strategies in RMNCAH+N over the next five years. The goals of the FGON are to reduce; (i) under-5 and infant mortality rates; (ii) the maternal mortality ratio; (iii) stunting rates; and (iv) the total fertility rate. The specific, measurable, objective indicators will be: improvements in: The modern contraceptive prevalence rate; HIV testing among pregnant women; Antenatal care; Skilled birth attendance; Postnatal care; Immunization and Vitamin A coverage; Out-patient visits to skilled providers by children; Growth monitoring and Improved quality of care measured by an index derived from the results of health facility surveys. The goals and output indicators will be independently measured using household and health facility surveys that are already being carried out on a routine basis. Targets will be based on Nigerian and Global experience rather than on aspirations.

In order for the GoN to achieve the targets outlined, it needs to mobilise domestic resources with a main focus on RMNCAH +N. This can be through the National Health Act, which can transform the health sector as it represents a commitment to improving primary health care, substantially strengthen RMNCAH+N, and set the stage for Universal Health Coverage (UHC). If implemented as it is written, the Basic Health Care Provision Fund (BHCPF) can contribute new domestic resources initially worth about 56.8 Billion Naira according to the 2018 budget (approximately US$ 157 million) per year. The other is through strengthening the States in the North East through performance based financing (PBF).

A Strong Urge to Innovate and Work with the Private Sector: Given the slow progress over the last two decades, business as usual is an unattractive option. Thus, the FGON intends to deploy bold innovations such as results-based financing (RBF), inter-fiscal transfer and leverage private sector expertise. These approaches build on initial successes in Nigeria and elsewhere and will be carefully monitored and adapted during implementation.

Given the Resource Constraints the FGON will use a Phased Approach to implement identified prioritized interventions: Due to the scarce resources, available, there is critical need to prioritize investments for RMNCAH + N and **FMOH will use a phased approach to implement the identified interventions.** The five phases will span from the quick deployment of the Minimum package of Activities in the North East, to the delivery of the National Basic Minimum Package of services initially in three states and then to the entire country, with the delivery of a package of high impact Nutrition services in 12 select States.

The investment case lays out a strategy that is actively pro-poor in that it:

1. Access to care is low; targets initially rural areas where skilled birth attendance is low (32.9% vs. 67.1% in urban areas), where most of the poor live and the largest group of underserved are (over 70% of those women without skilled attendance live in rural areas);
2. Poverty levels are high; targets services for mothers and children (70% of Nigerian women are living below poverty line) and ensures maternal services are really free at the point of care.

3. The strategy focus is on **results** not inputs and uses fee-for-service to increase efficiency.

In conclusion, the Investment plan for RMNCAH and Nutrition as envisioned, will dramatically bring results to health sector in Nigeria if properly implemented. It is therefore, a collective responsibility for the government of Nigeria and all stakeholders involved in women, children and adolescent healthcare delivery - donors, developmental partners, implementing partners, civil society organizations, technical agencies, private sector (non-profit and for profit), to partner harmoniously and effectively support the implementation of this plan in the next thirteen years.

CHAPTER ONE: SITUATION ANALYSIS

1.1 INTRODUCTION

Despite substantial reduction in global maternal and child mortality rates in the last two decades, Nigeria's maternal mortality rate remains significantly high: At 576 deaths for every 100,000 live births[1], Nigeria's maternal mortality rate accounts for 14% of the global burden of maternal deaths--second only to India. This represents approximately 40,000 maternal deaths per year. Under-5 mortality rate is 120 per 1,000 live births[2] and Nigeria experiences over 800,000 deaths among under-five children annually, 30% of which is attributable to new-born deaths.[3] Mortality rates for children, infants and neonates are higher than the latest average estimates for the Sub-Saharan Africa region: 120, 70 and 39 per 1,000 live births respectively.[4] [5]

1.1.1 Childhood malnutrition rates remain poor and have in fact worsened in the last two decades: Nigeria is home to the highest number of stunted children in the continent and ranks second globally with more than 10 million stunted children. The 2016-17 Nigeria Multiple Indicator Cluster Survey (MICS) reported 44% of children under five as being stunted, which represents a 16% worsening from 2013. MICS 2016 presents the rate of wasting among under-five children to be 11% and, 32% as underweight[6] with malnutrition being the underlying cause of 53% of deaths.

1.1.2 In recognition of the above the Nigeria RMNCAH Investment case developed as a sub component of the NHSDP 11 presents an opportunity for the GON to fast track rapid improvements in RMNCAH + N indices: This IC sets out to do the following (i) it lays out the background and context of the challenges of RMNCAH in Nigeria; (ii) it establishes the objectives of the investment case and how the progress will be tracked; (iii) lays out a prioritized and phased approach to addressing the challenge; and (iv) it proposes a financing strategy for the prioritized investments. The Nigeria RMNCAH+N IC presents how Development Partners, technical agencies and the private sector can align behind a common framework led by the Government of Nigeria to finance a prioritized set of interventions with the best chance of rapidly improving health outcomes and at the same driving economic growth; the financing plan for this IC is based on a realistic and pragmatic assessment of current and estimated resource flows.

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[1] Nigeria Demographic Health Survey, 2013 report

[2] Nigeria Multiple Indicator Cluster Survey, 2016-17 report

[3] Newborn Health in the context of integrated Maternal, Newborn and Child Health Strategy, 2011

[4] Nigeria Multiple Indicator Cluster Survey, 2016-17 report

[5] United Nations Children's Fund (UNICEF). (2011). At a glance: Nigeria. Retrieved from http://www.unicef.org/infobycountry/nigeria_statistics.html

[6] National Population Commission [Nigeria] and ICF Macro. 2013. Nigeria Demographic and Health Survey (NDHS) 2013. Abuja, Nigeria: National Population Commission and ICF Macro.

1.2 COUNTRY CONTEXT

1.2.1 The Nigerian economy experienced relatively healthy economic growth rates over the past decade but this trend has been broken by the oil shock: Nigeria is the most populous country with the largest economy in Africa. With an estimated population of over 180 million people in 2016, Nigeria accounts for almost half of West Africa's population. Oil accounts for more than two-thirds of the country's fiscal revenues and about 90 % of foreign exchange receipts. For a decade, since 2003, Nigeria had achieved strong growth, averaging over 6 % a year. Growth was mainly driven by the non-oil-sector (agriculture and services), private consumption and factor accumulation (capital mostly) with only minor contribution from productivity gains. Since the onset of the oil price shock in mid-2014, growth declined from 6.3% in 2014 to 2.8% in 2015. Revenue accruing to the Federal budget fell to 7.2% of GDP in 2015 and was among the weakest revenue mobilization efforts in the world[7]. In 2016, the economy registered negative growth in the first three quarters, with GDP contracting by -2.24% (year-on-year) in the third quarter and by the end of the year, the economy was contracted by 1.5%. The deterioration in the economy though triggered by the oil price shock, became compounded by drop in oil production attributable to militant activities in the Niger Delta. It is important to note that the ensuing fiscal constraints have had serious consequences for much needed investments especially in the social sectors including health.

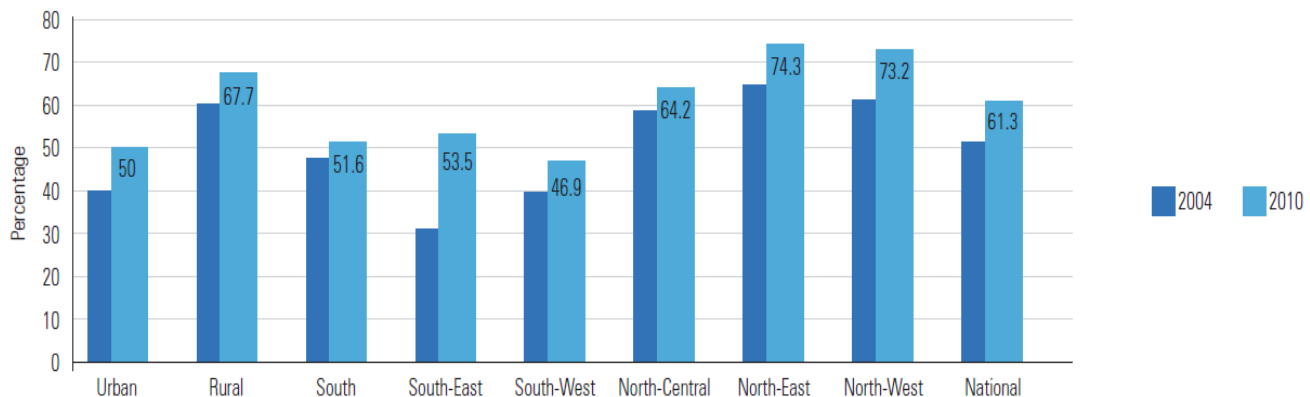
1.2.2 Slow progress on poverty reduction threatens development: Poverty rates remain high in Nigeria with the National Bureau of Statistics reporting an absolute poverty incidence per capita of 62.6% (HNLSS, 2009/2010) with about 112 million Nigerians living below poverty line[8]. Between 2004 and 2010, poverty incidence measured by headcount ratio, worsened in all geo-political zones, with the rural areas being more affected (see figure below)[9]. It is instructive to note that children of mothers in rural areas in Nigeria were having significantly higher risk of dying before the age of five years compared to their counterparts in the urban areas. Also there is a significant rural-urban difference in income distribution impact women particularly the 54 million of Nigeria's 80.2 million women that live and work in rural areas, and provide 60-70 percent of the rural labor force. In Nigeria, an increase in rural poverty has translated not only to increased female poverty but also to poor health outcomes for their children.

[7] IMF (October 2016). World Economic Outlook: Subdued Demand, Symptoms and Remedies.

[8] National Bureau of Statistics, 2014. Review of 2009/10 absolute poverty rates across Nigeria.

[9] Soucat et al. Accelerating the AFDB's response to the youth unemployment crisis in Africa. Africa Economy Brief 2013; 4 (1

Figure 1: Poverty prevalence in Nigeria by zones and location, 2004 and 2010



Source: NBS Poverty Profile, 2010

1.2.3 The GoN released in early March 2017 the Economic Recovery and Growth Plan (ERGP) which unveils a road map for Nigeria's economic recovery, growth and sustainable development: The core vision of the ERGP is one of sustained inclusive growth. It outlines an urgent need to drive structural economic transformation with an emphasis on improving both public and private sector efficiency. The aim is to increase national productivity and achieve sustainable diversification of production, to significantly grow the economy and achieve maximum welfare for the citizens, beginning with food and energy security. Actions articulated in the ERGP are focused on the need to restore macroeconomic resilience and growth; enhance engagement in the conflict-affected North East; advance structural reforms for private sector-led, non-oil growth; and increase opportunities for youth, women, and the poor, particularly in marginalized areas[10].

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[10]The World Bank- Performance and Learning Review of the Country Partnership Strategy for the Republic of Nigeria for the period FY14-FY16. August 2016.

Y Soucat et al. Accelerating the AFDB's response to the youth unemployment crisis in Africa. Africa Economy Brief 2013; 4 (1

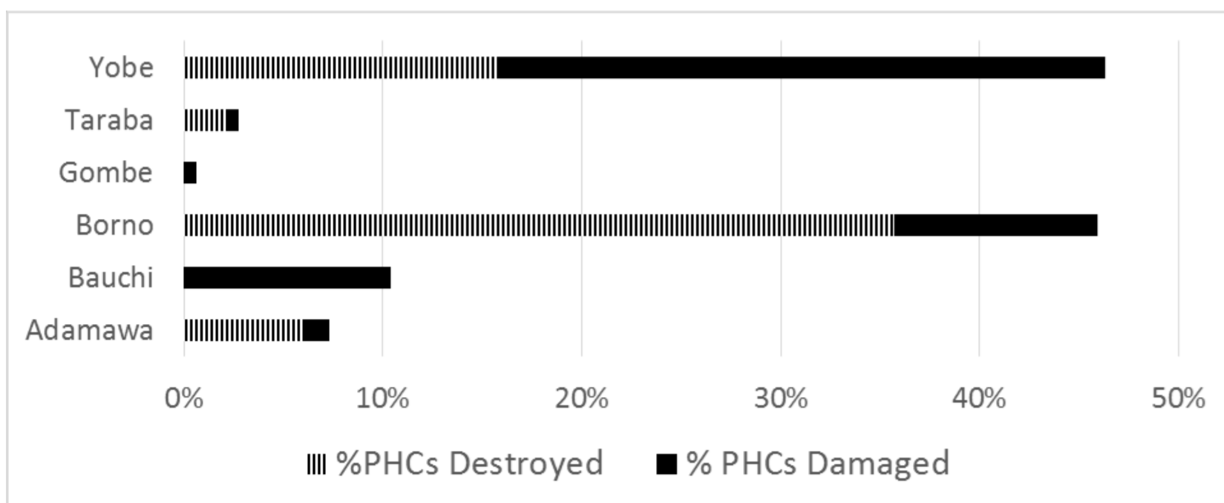
1.3 HUMANITARIAN CRISIS IN NORTH-EASTERN NIGERIA

1.3.1 ***The North East geopolitical zone of Nigeria is facing an humanitarian crisis brought about by insurgency: The humanitarian crisis in North Eastern Nigeria is a major impediment to development in the region and has resulted in a population in dire need of basic humanitarian assistance particularly quality healthcare services. Prior to the insurgency, the NE has been characterized by poor health conditions, poor access and utilization of health services as depicted by the under-five mortality rates (U5MR) of 115 per 1000 as compared to 67 per 1,000 in the South West zones of Nigeria[11]; Stunting rates also show a similar pattern of disparity with rates as high as 58.5% in the North West and 19.4% in the South West. Health Service delivery is also substantially poor as illustrated by poor DPT3 immunization coverage in 2016 of 28% in the NE compared to 66% in the South West. The insurgency has further worsened conditions and prevented any substantial improvement in health conditions*.**

1.3.2 The Recovery and Peace Building Assessment (RPBA) findings on Health Services in the North East paints a grim outlook: The RPBA found that about fifteen million people have been affected by the Boko Haram insurgency in the North-East since 2009; over 2 million people have been displaced; 20,000 lives have been lost and about 20% of health facilities were damaged or destroyed in the six NE states (see figure below). Currently, the insurgency has caused more damage to the health system, particularly the primary health care (PHC) system, and prevented substantial improvement in health conditions. In some areas, particularly parts of Yobe and Borno, the insurgents deliberately targeted and damaged health facilities, threatened health workers and made away with equipment and drugs such that healthcare services in some LGAs have come to a complete halt. Consequently, the deplorable state of health service delivery in the NE States is an emergency and is particularly detrimental to RMNCAH results. As such, addressing the urgent RMNCAH needs of the affected population is one of the three key priorities of the government of Nigeria.

[11] Nigeria Multiple Indicator Cluster Survey, 2016-17 report

Figure 2: Proportion of PHCs damaged or destroyed by State



1.4 SECTORAL AND INSTITUTIONAL CONTEXT: THE HEALTHCARE SERVICE DELIVERY SYSTEM

1.4.1 The GON has reiterated its commitment to making progress towards Universal Health Coverage by focusing on Primary Health Care & providing access to financial risk mechanisms: The National Primary Healthcare Development Agency(NPHCDA) was established as a parastatal of the FMOH with the mandate to develop National primary healthcare policy which in turn is implemented by the State primary healthcare Development Agencies (SPHCDA). There are ongoing reforms to ensure that the management of the PHC system is consolidated under the management of the SPHCDA at the state level under the PHCUOR concept to ensure a central point of accountability for PHC services in the state. To address inequitable financing the GON established the NHIS in 1999 and it began implementation in 2005 with the aim of providing accessible, affordable & qualitative healthcare for Nigerians. The NHIS is currently supporting states to set up SSHIS, which allows for the establishment of pro poor risk pools at the state level.

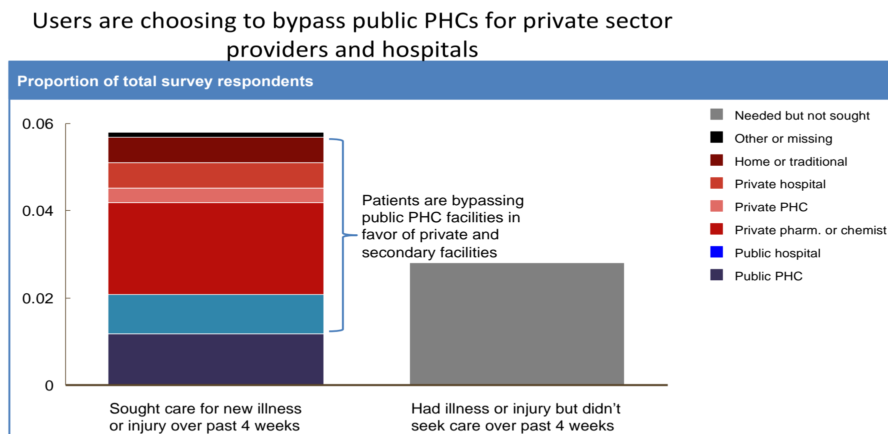
1.4.2The passage of the National Health Act signifies intention to accelerate efforts to move quickly towards UHC: In 2014 the GON signed into law the National Health Act which entitles all Nigerians to Basic Minimum package of Health Services and specifies the BHCPF as the principal funding vehicle. The BHCPF of the NHAct is funded by at least one per cent of the consolidated revenues of the Federal government. Fifty per cent of the funds are allocated through the NHIS gateway, 45% through the NPHCDA and the remaining 5% through the emergency gateway.

1.4.3The private health sector in Nigeria is large and vibrant: This constitutes about 38% of the health facilities in the country and provides about 60% of the health care services in the country[12]. In 2008 the DHS survey found that when Nigerians fall ill, they seek care from the private sector 65% of the time, with the poorest almost 72% of the time. In a survey done in 2013 by BMGF about 80% of patients are by passing primary public facilities in favour of private and secondary facilities. Private health sector capabilities, expertise, resources, reach and innovation can be

[12] Sustainable Healthcare System in Nigeria; Vision, Strategies and Challenegs. Vol 5 Issue 2. (Sept – Oct 2014)

leveraged to accelerate improvement in health outcomes in Nigeria. Involvement of the private sector in any path to inclusive health insurance system is beneficial and includes shared risks outside the public domain, improved quality of care and greater efficiency.

Figure 3: Survey on Use of Health Facilities in Nigeria

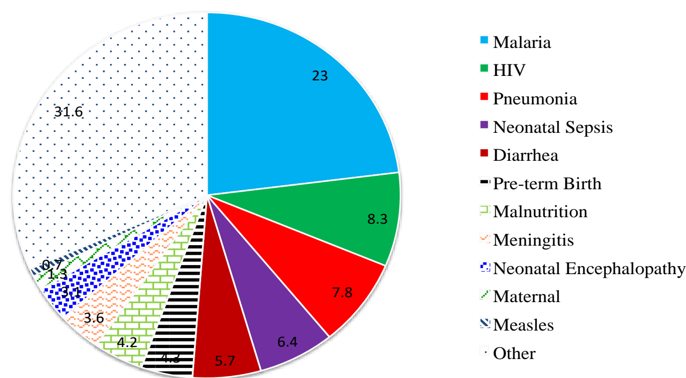


SOURCE: GHS, 2013
BMGF data analysis

1.5 SECTORAL AND INSTITUTIONAL CONTEXT: RMNCAH AND NUTRITION

1.5.1 RMNCAH causes account for about 2/3rds of the burden of disease in Nigeria[13].
The three risk factors that account for the most disease burden in Nigeria are childhood underweight, household air pollution from solid fuels, and alcohol use. Malaria, HIV/AIDS, and lower respiratory infections accounted for the top 3 DALYs in 2010.
Figure 4:

MNCH Causes Account for about 2/3rds of Burden of Disease (YLL)



Source: IHME GBD Study 2010

[13] IHME Global Burden of Disease Study 2010

1.5.2 Maternal Health: Nigeria's maternal mortality rate ranks amongst the highest in the world at 576 deaths per 100,000 live births (NDHS 2013) and the rate has not significantly changed since 2008. The proportion of births with skilled birth attendants has shown little improvement from 38.1% in 2013 to 43% in 2016 and facility-based deliveries has not improved either at 37.5%. The proportion of mothers who received postnatal check-up in 2013 was 40%, down to 37.1% in 2016 (MICS). Maternal deaths in Nigeria are mostly from *preventable and treatable complications*. Major causes of maternal deaths are haemorrhage (23%), infection (17%), malaria (11%), unsafe abortion (11%), obstructed labour (11%) and eclampsia (11%). The end-term evaluation of the National HIV Strategic Plan 2010-2015 reported that only 29% of HIV-positive pregnant women were on antiretroviral drugs in 2015.

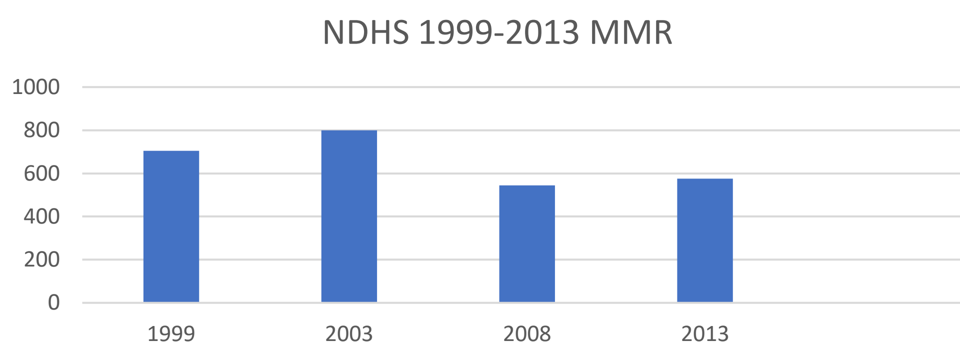


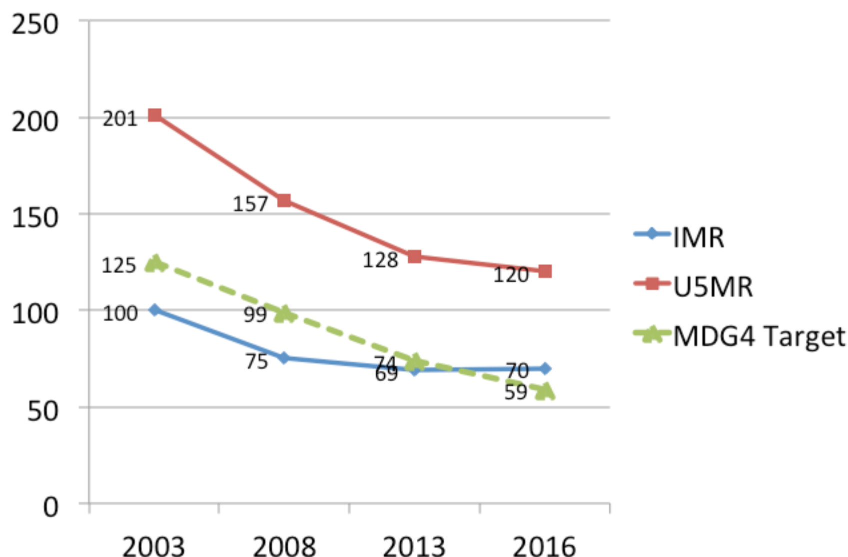
Figure 5: NDHS Maternal Mortality Rate

1.5.3 New-Born Health: Neonatal deaths account for 28%[14] of under-five deaths, with prematurity, asphyxia and infections[3] as the major causes of deaths. Infant mortality rate, as reported by the MICS has shown no change from 69/1,000 live births in 2013 (NDHS) to 70/1,000 live births in 2016. Stillbirth rate has remained high at 396/1.000 live births in 2013.

1.5.4 Child Health: The U-5 mortality declined from 126 deaths per 1000 live births in 2013 to 120 per 1000 live births in 2016, which is unacceptably high. The major causes of childhood mortality include malaria, pneumonia, diarrhoea, and vaccine-preventable diseases all complicated by malnutrition (NHP). At the current mortality levels, one in every 15 Nigerian children die in their first year of life, and one in every 8 do not survive their fifth birthday (NDHS). Although the indicators have improved, progress is too slow, and the rates are still unacceptably high compared to other countries in the region (NHP).

[14] TWG Sitan - referring to Sitan 2011

Figure 6: IMR & U5MR: 2003 - 2016



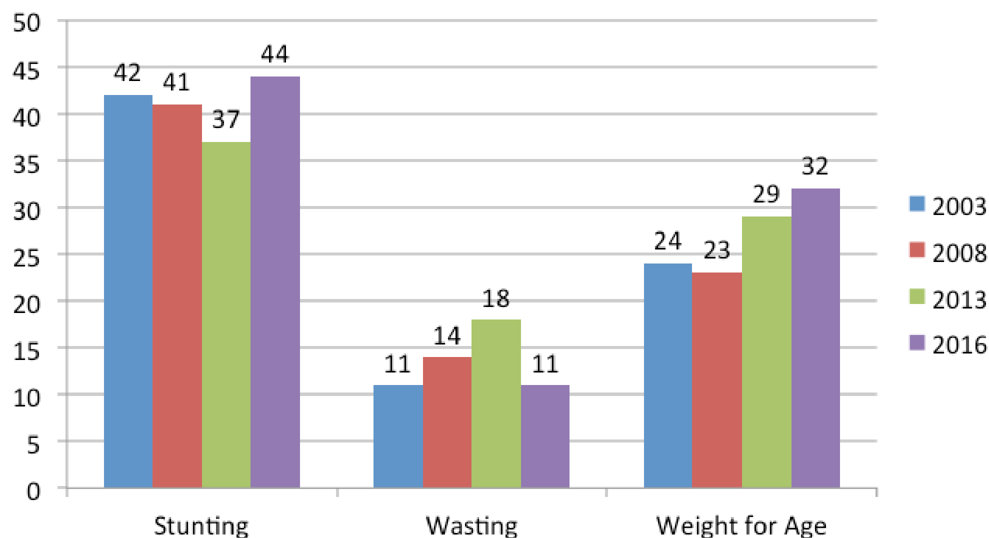
Sources: Nigerian Demographic and Health Surveys – NPopC and MICS 2016-17 NBS

1.5.5 Nutrition: Nutrition related conditions continue to be a problem of public health importance and remains a significant driver to RMNCAH disease burden in Nigeria. Childhood malnutrition worsened by some measures, with low weight for age increasing by 9% and stunting by 15 %. The national rate of acute malnutrition has decreased over the last few years from 18 % in 2013 to 7 % in 2015[15]. While this rate is below emergency thresholds, there are states and geo-political zones especially in the North, with acute malnutrition rates above WHO threshold of 10 %; these are the areas that are receiving considerable media attention. 7.2 percent of children suffer from acute malnutrition nationally, which translates into 11 million Nigerian children who will either die or not develop to their full potential. Stunting in the North East and North West *increased* consistently between 2008 and 2016 whereas the South West and South-East States recorded a decline. (Source NDHS 2008, 2013, NNHS 2015 and MICS 2016)). The 2008 NDHS showed that 22% of women are overweight or obese, with the frequency increasing with age, education and wealth and Diabetes causing half of the mortality in Nigeria.[16]

[15] NNHS 2015

[16] Ekpeyoung, CE, Udokang, NE, Akpan, EE, Samson, TK. (2012). Double burden, non-communicable diseases and risk factors in Sub Sharan Africa: The Nigerian Experience. European journal of sustainable development.

Figure 7: Child Nutritional Status 2003-16



Source: NDHS 2003, 2008, 2013 and MICS 2016-17

1.5.6 The current nutrition emergency in the North East is only the "tip of the iceberg", the most visible form of malnutrition. It is important to recognize that the emergency comes on top of the much more widespread and costly – in terms of lost productivity -- nutritional crisis of chronic malnutrition. While chronic malnutrition has remained constant since 2008, acute malnutrition has decreased over the last few years from a high of 18 percent in 2013 to 11% in 2016.

1.5.7 The "nutrition map" of Nigeria is highly uneven. Nine of the North East and North West states have rates of child stunting that exceed 50 percent, whereas some other states have rates of child stunting as low as 9 percent. As Figure XX demonstrates, the gap on stunting between the North and South is widening. Stunting in the North West has been consistently *increasing* between 2008 and 2015 whereas the states of the South West and South East have recorded consistent decreases.

1.5.8 Sexual Rights and Reproductive Health: Nigeria has a low modern Contraceptive Prevalence Rate (mCPR) of 13% (FP 2020, Mid-Term Review, 2016) which is below the SSA average of 24%; Unmet need for contraception remains high at 23% and a Total Fertility Rate (TFR) of 5.8 (MICS), has remained practically unchanged since 1990. The low mCPR, on one hand is attributable to high levels of out of pocket expenditures for primary healthcare which are most likely to affect the consumption of preventative health service like FP to a greater degree than curative services; on the other hand, the frequent contraceptive stock outs and lack of staff to offer quality contraceptive services limits access to FP counselling and a broad method mix that includes access to long acting contraception. Without a steep decline in

TFR in conjunction with other deliberate policy actions, Nigeria will not be able to harness the ***"Demographic Dividend"*.**

1.5.9 Adolescent Health: Nigeria has a very young population. Majority of the population are below the age of 25 years, with 22 % of the country's population between the ages of 10-19 years. Data shows that the average age of sexual debut is roughly 15 years of age among adolescent mothers in Nigeria (DHS 2003, 2008, 2013) , Similarly, the median age at birth has remained at 20 years for ages 25-49 (NDHS, 2013) and HIV testing has also consistently remained low. The national adolescent fertility rate in Nigeria is 120 births per 1,000 women aged 15–19 years (MICS). In the North West, it is as high as 176 births per 1000 women aged 15-19 years. The proportion of adolescents 15 to 19 years, who have begun childbearing, is 19.2% (31.4% in the NW and 5.9% in SW)[17], which may be related to early marriages.

1.5.10 State of Civil Registration and Vital Statistics (CRVS) in Nigeria: In 2001, only 28% of the estimated total five million births were registered in the country. Wide disparities exist between rural and urban areas as well as in the six geo-political zones across the country. As reported in NDHS 2013, the proportion of registered births was highest in the South-east and South-west (52% and 51%, respectively) and lowest in the North-west and North-east (20% each). The bottom line is that coverage of birth registration is low in Nigeria. Data also indicates that more children are registered in urban areas than rural communities and there is incomplete registration of these data due to challenges ranging from institutional, human resources, cultural and poor linkage with the health system. Birth registration also varies with socioeconomic status, as about 65% of registered births are found among families in the highest wealth quintile while only 7% of children are registered among families in the lowest wealth quintile. Registration of deaths is currently estimated at less than 5%. Clearly, the lack of an efficient CRVS system also hinders the registration of deaths and marriages. This is a constraint to optimal maternal and child health information, as well as monitoring of underage marriages.

[17] Nigeria Multiple Indicator Cluster Survey, 2016-17 report

1.6 HEALTH FINANCING FOR RMNCAH+N IN NIGERIA

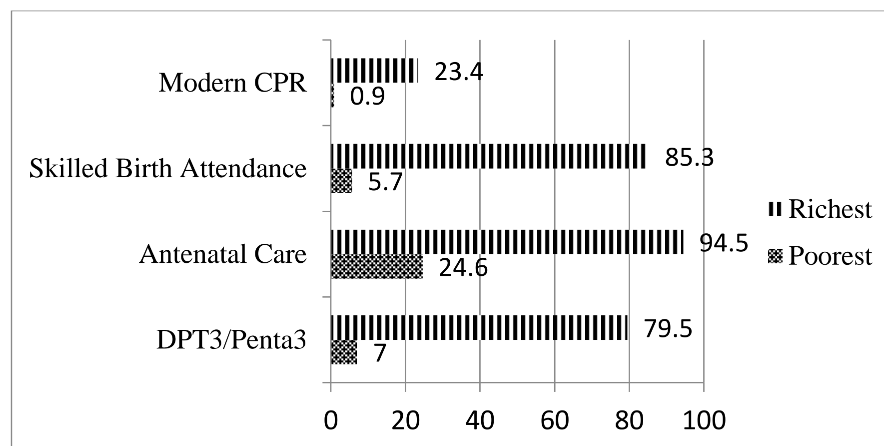
1.6.1 There is a significantly low public investment in health: The total Government Health Expenditure was 0.7% as a share of GDP and 2.2% as a share of government expenditures which amounts to just US$22 per capita- a figure which is well below regional, LMIC averages and is significantly below the recommended US$86 per capita LMIC required to deliver a limited set of key health services. Clearly the low prioritization of the sector means that there is scope to increase public spending on health and reduce out of pocket expenditures. In 2015 government revenues as a share of GDP rose from 0.9% in 2014 to 7.8% in 2015 however there was no commensurate increase in public financing for health as public expenditure on health as % of GDP remains at 1%. However, given the government's limited revenue potential, improving the efficiency of health sector spending especially through governance and accountability arrangements is also a key entry point.

1.6.2 There is a high out of pocket expenditure and publicly owned PHCs receive little or no funding: Nigerians pay a high share of their health expenditures, with 67 percent of such costs being paid out-of-pocket compared to 26 percent by the government and 7 percent by the development partners – this level of OOP is the highest in SSA. Furthermore, public PHCs receive little or no operating budget and frequently lack basic infrastructure, equipment and drugs. For instance, the 2016 National Health Facility Survey revealed that only a third of public PHCs received any form of cash grants to meet their operational costs resulting in poor attitude to work from demotivated health workers. The GON however is taking steps to correct this anomaly by prioritizing an accountable financing framework for PHC through the BHCPF.

1.7 CROSS-CUTTING DETERMINANTS OF RMNCAH + N SERVICE DELIVERY: EQUITY, GENDER AND HUMAN RIGHTS

1.7.1 Equity and RMNCAH+N outcomes: Maternal and child health outcomes are especially bad for the poorest two income quintiles. The poorest two income quintiles suffer from similarly poor H NP outcomes and have nearly a one in five chance of dying before their fifth birthday. Children from the poorest quintile are 3 times more likely to be stunted than children from the wealthiest quintile. Access to care is even more unequal with the wealthiest quintile 11 times more likely to be fully immunized or to have a skilled birth attendant than the poorest quintile. Furthermore, whilst the poverty rate in Nigeria fell by almost half in urban areas it barely declined in rural areas, where 50 percent of the population is currently living below the poverty line. Yet, it has been established that children of mothers in rural areas in Nigeria were having significantly higher risk of dying before the age of five years compared to their counterparts in the urban centers. Also, significant rural-urban differences in income distribution impact women, particularly the 54 million of Nigeria's 80.2 million women that live and work in rural areas, and provide 60-79 percent of the rural labor force (British Council, 2012). Therefore, increased rural poverty has translated into increased female poverty. As shown in figure 8 below, the differentials in access to, and utilization of, health services by income quintile are extreme.

Figure 8: Coverage of Key Health Interventions by Income Quintile – NDHS 2013



1.7.2 **Gender inequalities and inequities embedded in socio-cultural beliefs and practices also have far-reaching implications for RMNCAH +N and remain key drivers of poor RMNCAH and nutrition outcomes**: The Nigerian society is characterized by both diversity (ethnicity, religion, geographical regions) and growing disparities (urban versus rural status and socio-economic status). These influence the different experiences of women and girls, determining their chances of survival, education, the age at first marriage and childbirth, and the level of access to key RMNCAH + N services. Where women lack autonomy, mobility and financial resources, access to and utilization of timely and affordable healthcare is limited. In addition, evidence has shown that disrespect and Abuse (D&A) by service providers limits positive provider-client interactions, which stands out as a key indicator of poor quality of services and its prevalence limits the utilization of facility-based healthcare. An active approach in implementing gender-responsive interventions that targets the supply side (gender-sensitive health systems) as well as the demand side (community engagement to improve health seeking behavior, women's empowerment, male engagement) is needed for improved RMNCAH +N outcomes.

1.7.3 Access to health services is a fundamental human right for all. Nigeria is a signatory to the Child's Rights Act which positions access to health, nutrition and protection for all Nigerian children as a fundamental right. Furthermore, Violence Against Person's Prohibition Act (2015) prohibits any form of gender violence including female genital mutilation, and the National Commission of Women Act[18] gives both gender equal rights to access SRH information and services such as modern contraception, HIV testing and counseling and adolescent-friendly services.

[18] See National Commission for Women Act, Laws of the Federation of Nigeria, vol. xvi, 1990. Section 2 (b)

1.8 DEMOGRAPHIC DIVIDEND FOR ECONOMIC DEVELOPMENT IN NIGERIA

1.8.1 Nigeria is a pre-demographic dividend country with an incomplete demographic transition. The current population structure is skewed towards children, adolescents and youth who account currently for 43% of the population with a high dependency ratio. Focusing attention on creating a population structure with a larger share of workers and a smaller share of child dependence has a large pay off which has been partly attributed to the economic success of countries like South Korea and other south east asian countries. To achieve this, it is necessary to invest in RMNCAH + N, to ensure access to sexual and reproductive health and nutrition services, improved maternal and child outcomes, and empowerment of females starting from the early years, through adolescent to adulthood. This can decrease total fertility rates, improve chances of survival for young children, adolescents and youths who are expected to make up Nigeria's productive workforce as the demographic transition is completed. The magnitude of Nigeria's potential demographic dividend was recently quantified and it was estimated that Nigeria stands to benefit from per capita income increases of 30% or more by 2030 whilst an additional 32 million people will be lifted out of poverty. There is therefore, a compelling case to invest in RMNCAH + N for better health and economic outcomes in Nigeria.

The Demographic Dividend: Same population, different speeds!! Nigeria is NOT well placed to capture one

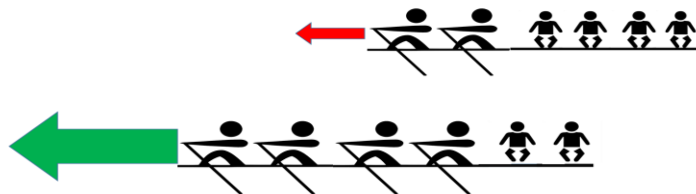


Figure 9: Demographic Dividend

CHAPTER TWO: LEAPFROGGING FOR RMNCAH+N RESULTS IN NIGERIA: PRE-REQUISITES

2.1 The Nigerian health system holds the potential for radical transformation when characterized by rapid and scaled improvement in RMNCAH+N outcomes. To unleash this potential Nigeria cannot afford to imitate the development trajectory of traditional health systems – it is too expensive and too slow! Without disruption in service delivery, financing models and demand models the results we yearn for will not be actualized in good time and at the scale we desire; thus, the concept of Leapfrogging which has already created enormous disruption in other industries is needed in the implementation of this IC. For instance, the country team recognizes the disruption in the Nigerian telecommunications industry where the industry-wide shift from fixed cable (NITEL) to mobile and wireless has redefined that industry.

2.2 Therefore, the goal of leapfrogging approach in this RMNCAH+N investment case is to ensure that similarly radical transformations in health care occurs in Nigeria through the deployment of high impact, low cost solutions in the shortest possible time. To achieve results this IC proposes six pre-requisites within a forward - looking, compelling and integrated sustainable RMNCAH agenda to attain the targets set in the NSHDP 11 (for 2022) and SDGs in the longer term (for 2030). These pre-requisites form the focus for action and introduce a paradigm shift from doing business as usual.

i. *Define Priorities and Essential package of services*
ii. *Leverage technology*
iii. *Mobilize private sector skills*
iv. *Focus on Results*
v. *Track performance*

Table1: Leapfrogging Prerequisites

Leapfrogging prerequisite	Description
Define Priorities and Essential package of services	The country team recognizes that the first step in implementing the RMNCAH+N Strategy in Nigeria is to define a compelling limited number of priorities that will leapfrog Nigeria's trajectory to improved RMNCAH+N results. To achieve Nigeria's UHC aspiration, essential health services across the full continuum of care for women, children and adolescents (needed by every family and community) are available to all without the challenge of out-of-pocket payments. To make this tangible, an explicit package of services must be linked to an explicit purchasing mechanism.
Leverage technology	Technology has enormous potential to provide high-impact, low-cost health care solutions.

Mobilize private sector skills	Integrating the private sector as a partner in public health delivery, particularly when facing challenges that touch on private sector activities can provide much needed resources in critical times.
Focus on Results	The Nigeria health system has largely underperformed. It is critical to offset high transaction costs and maintain a focus on efficiency through financing mechanisms to meet pre-defined results linked to a set of incentives rather than an overly fixation on inputs.
Track performance	A specific set of key performance indicators, mutually defined by key stakeholders to measure improvements in real time and track progress to ensure that programs meet critical milestones.

CHAPTER THREE: RMNCAH + N GOALS, OBJECTIVES AND TARGETS

3.1 The Vision of the 2017 National Health Policy is the attainment of Universal Coverage (UHC) for all Nigerians; the Mission is to provide stakeholders in health with a comprehensive framework for harnessing all resources for health development towards the achievement of UHC as encapsulated in the National Health Act in tandem with the SDGs.

3.2 The GoN has provided a strategic framework for achieving these objectives through the National Health Strategic Plan II (NSHDP II) 2017 -2025 to actualize the vision and mission of the National Health Policy. This RMNCAH+N investment case is a strategic pillar of the NHSDP 11 and it promotes the integration of reproductive, maternal, neonatal, child, adolescent health and Nutrition (RMNCAH+N) services and programs along the continuum of care and provide a framework for the equitable delivery of high quality integrated care across the life cycle.

3.3 **RMNCAH +N Goal:** *To reduce maternal, neonatal, child and adolescent morbidity and mortality in Nigeria and promote universal access to comprehensive MCH, sexual and reproductive health services for adolescents and adults throughout their life cycle.*

3.4 **RMNCAH +N Strategic Objectives:**

(i) Promote demand and increase access to sexual and reproductive health services

(ii) Reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after childbirth.

(iii) Reduce neonatal and childhood mortality by promoting optimal growth, protection and development of all newborns and children under five years of age.

(iv) Improve access to health information and services for all adolescents and youths.

(v) Improve the nutritional status of Nigerians throughout their life cycle with a particular focus on vulnerable groups especially children under five years, adolescents, and women of reproductive age.

(vi) Improve birth and death registration

3.5 **Targets:** The GFF aims at catalyzing country plans/investments on RMNCAH + N service delivery. The targets of the investment case align with the targets set in the National Health Plan (NSHDP II) based on the priority investments/interventions. The targets, with full cognizance of National and Global aspirations, are specific, measurable, achievable, realistic

and time bound and are suitable for adequate performance monitoring and evaluation of progress in RMNCAH + N service delivery.

Table 2: Targets/Expected Results for the Investment Case

Goal/Objective	Baseline NDHS 2013	Percentage Change	GoN target 2021	Data source
Sexual and Reproductive Health				
To Increase modern contraceptive prevalence rate (mCPR)	11%		43%	NDHS (2018, 2023)
Maternal and Newborn Health				
Reduction of MMR	576	50%	288 per 100,000 LBs	NDHS (2018, 2023)
Increase Antenatal care coverage (8 visits)	61%	50%		NDHS (2018, 2023)
Increase HIV testing among pregnant women				NDHS (2018, 2023)
Increase number of women who deliver in a facility	37%			NDHS (2018,2023)
Increase Skilled Birth Attendance by 50%	38%	50%	57%	NDHS (2018, 2023)
Increase provision of ITPp				NDHS (2018, 2023)
Increase postnatal care coverage	42%	50%	63%	NDHS (2018, 2023)
Reduce Neonatal MR	37/1000 LBs	50%	18/1000 LBs	NDHS (2018, 2023)
Child Health				
Reduce Infant MR	75/1000 LBs	50%	38/1000 LBs	NDHS (2018, 2023)

Increase growth monitoring for children Under 5	16%			NDHS (2018, 2023)
Reduce U5 MR	128/1000 LBs	50%	64/1000 LBs	NDHS (2018, 2023)
Immunization	25% (12-23mths)			NDHS (2018)
Adolescent Health				
Reduce Adolescent Maternal mortality		50% reduction		
Access to AYFHS		60% increase		
Nutrition				
Increase percentage of children exclusively breastfed, 1st 6moths of life			60%	NDHS (2018, 2023)
Reduction in childhood wasting (U5)	18%		Less than 10%	
Reduction in childhood stunting (U5)	37%		Less than 20%	
Vitamin A coverage	41%			NDHS (2018, 2023)
Reduction in proportion of women of reproductive age with anaemia		15% reduction		
Reduction of malnutrition in women of reproductive age	11%		Less than 5%	
CRVS				
Increase birth registration coverage	30%			
Increase death registration coverage	5%			

CHAPTER FOUR: PRIORITIZATION FOR RMNCAH + N INTERVENTIONS

4.1 RATIONALE FOR PRIORITIZATION

4.1.1 Resources are always finite and no government can provide all health services to meet all the needs of its population. Therefore, interventions that are *"High Impact, Evidence-*

4.1.2 *based, cost effective and gender-sensitive"* have been prioritized for the GFF RMNCAH and Nutrition Investment Case and will be delivered via the continuum of healthcare services from primary health care level up to the referral level.

4.1.3 The priority interventions for the RMNCAH and Nutrition Investment Case were identified through a series of prioritization process led by the Federal Ministry of Health in consultation with the Nigeria GFF country platform and other stakeholders including development partners (see chronology of prioritization process in the annex). The process was driven by the core objective of improving healthcare services as specified in the National Health Act, through the Basic Healthcare Provision Fund (BHCPF) which states inter alia *"all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS)"*. The process incorporated the core principles outlined earlier and leapfrogging Nigeria's RMNCAH+N indices to where it should rightly belong.

4.1.4 In line with the goals and guiding principles of the National Strategic Health Development Plan II and the IRMNCAH + N Strategy, priority was given to the most effective interventions that can be delivered at the lowest cost to the highest number of people, to yield the greatest health gains. Implementation of the RMNCAH + Nutrition components of the BMPHS will enhance service delivery in an equitable and gender-responsive manner to the poor and underserved in Nigeria.

4.1.5 Using this phased approach existing interventions that are currently being implemented and can easily be scaled up such as the NSHIP. The North East with its poor health indicators and rising poverty rates will greatly benefit from a rapid scale-up of the NSHIP in all the 6 North-Eastern states.

4.1.6 Investments were prioritized based on the criteria below:

Table 3: Prioritization Approach

PRIORITIZATION APPROACH	DESCRIPTION
Transformational initiative	An approach with the potential to address key system constraints and will require considerable resources & political commitment to achieve. Such transformational initiatives are best implemented in phases and will benefit from pilots to learn and demonstrate success.

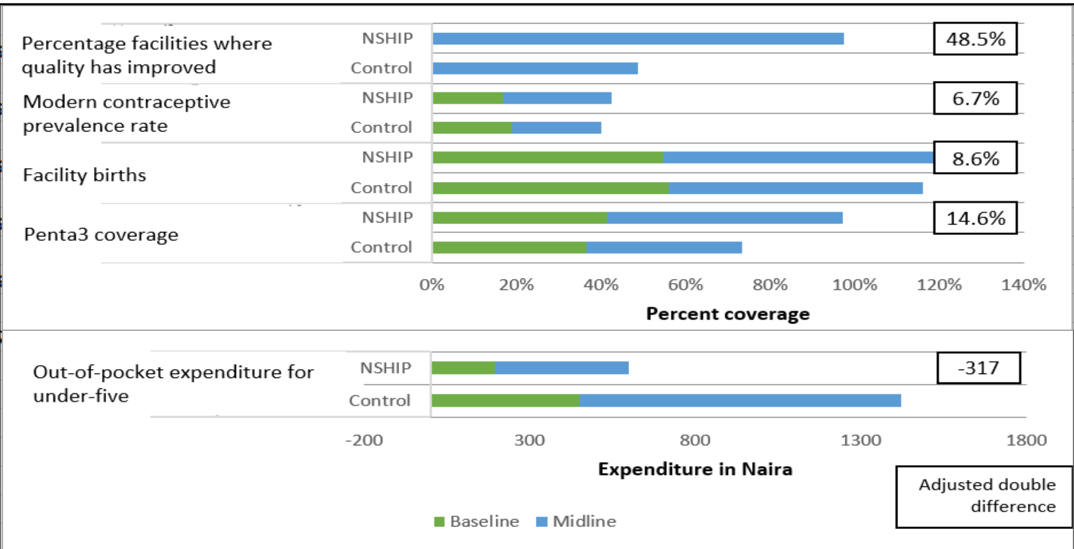
Geographical approach	This is based on prioritizing interventions in high burden geopolitical zones & allocating resources preferentially for such "worse off areas"
Programmatic approach	This is based on investing in a minimum essential package of services with the highest returns in investment.

4.2 PRIORITY RMNCAH + N INTERVENTION PACKAGES

4.2.1 *The provision of a Minimum Package of Activities (MPA) under The Nigeria State Health Investment Project (NSHIP)*

The Nigeria State Health Investment Project (NSHIP) addresses health system failures using a combination of result-based approaches to accelerate progress on health outcomes. NSHIP's objective is to increase the delivery and use of high impact maternal and child interventions in selected States – Adamawa. Nasarawa and Ondo. This is currently running in these States with additional financing for the other North-Eastern States. It builds on the principle of fiscal decentralization to support health system reforms both at primary and secondary levels. The Minimum Package of Activities (MPA) provided in the project contains thirteen (13) services out of twenty (20) that are pertinent to RMNCAH. It should be noted though that as soon as the funding source for the NSHIP expires all facilities will begin to deliver the Basic Minimum Package of Services (BMPHS) as provided for under the National Health Act. (Please refer to Annex for interventions in MPA and BMPHS).

Figure 10: Impact of NSHIP on Key Quality and Access measures



The provision of a Basic Minimum Package of Health Services (BMPHS) under the National Health Act

4.2.1.1 As stated earlier no country can possibly offer access to all available medical treatments and this provides a basis for defining a BMPHS. In view of the fiscal constraints it is essential that the package focuses on the most important BOD in the country. Thus the **“Basic Minimum Package of Health Services**" is a set of preventive, curative and rehabilitative interventions, published by the Federal Ministry of Health and legislated for under the National Health Act. It consists of nine (9) services, which comprises of 51 interventions of which address RMNCAH. (Please refer to Annex)

4.2.1.2 In line with the principles and core values of the RMNCAH +N GFF IC, the implementation of the BMPHS will kick-start primarily at the PHC level through a ‘proof of concept pilot in three selected states and subsequently scaled up to the entire nation. Successful implementation of the BMPHS will provide social health insurance, increased access, financial risk protection and increased utilization of healthcare services by the rural and underserved populace.

4.2.1.3 For improved coverage and delivery of quality RMNCAH + N services in the BMPHS, the FMOH will leverage on the capacity and expertise of the private sector and other relevant stakeholders to provide innovative service delivery models to serve populations at the remote and rural areas.

4.2.1.4 The National Health Act provides increased funding to implement the BMPHS through the Basic Health Care Provision Fund (BHCPF). The law stipulates not less than 1% of the consolidated revenue fund be used to finance the BHCPF. The table below highlights the critical linkages between the BHCPF and the vision of the Global Financing Facility for every woman every child. The significant domestic resources that will become available for RMNCAH+N in Nigeria through the BHCPF is aligned to the Smart, Scaled & Sustainable financing principles of the GFF.

Table 4: GFF Application to BHCPF

GFF PHILOSOPHY	DESCRIPTION	APPLICATION TO GON BHCPF
SMART FINANCING	Best buys: High Impact interventions	Basic Minimum Package of Health Services (BMPHS) that represents high impact low cost interventions.
SCALED FINANCING	Mobilize domestic financing, GFF TF, Donor resources	Basic Healthcare Provision Fund from at least 1% Consolidated Revenue Fund of the Federal Government, GFF TF, Donor resources. Generating efficiencies to close resource gap.

SUSTAINABLE FINANCING	Capturing the benefits of economic growth and taking to scale innovative Health Systems Strengthening approaches.	The nature of BHCPF and NHAct also supports sustained financing. Moreso the overall health systems strengthening lessons from NSHIP including Strategic purchasing; Expansion of pro poor risk pools; PFM reforms; harnessing the potential of the private sector etc. are approaches incorporated into the implementation of the BHCPF

4.2.2 ***Package of Nutrition services to rapidly address ongoing malnutrition crisis in Nigeria.***
Scaling up a package of well-proven interventions that have a strong evidence base, to have a direct and rapid impact on the Nutrition status in the country (see annex of proposed interventions). The coverage rates of most of these interventions in Nigeria remain very low. These are the "nutrition-specific" interventions that have a proximal link to nutritional impact and are typically implemented through the health sector.

4.2.3 ***Expanded Basic Minimum Package of Health Services (BMPHS) under the National Health Act.*** A sustainable evolving policy instrument should adapt as new evidence and capabilities emerge; in recognition of this fact is the anticipation of an expansion in the BMPHS in Nigeria. However, this will happen after the BMPHS as currently constituted has been scaled up to the entire country.

4.3 IMPLEMENTATION PLAN FOR PRIORITY GFF RMNCAH + N INVESTMENTS

In view of the huge RMNCAH + Nutrition health burden and the constricted fiscal space, the implementation of the priority RMNCAH + N interventions in the IC will be in five (5) phases outlined below. The timelines are shaped

Table 5: GFF PRIORITY RMNCAH+N INVESTMENTS IN NIGERIA: 2017 - 2030

PHASES	PRIORITY INVESTMENTS	GEOGRAPHICAL LOCATION	FUNDING SOURCES	TIMELINE
I.	Scaling up of RMNCAH services in areas of Humanitarian Crisis and Emergency Response (The Nigeria State Health	Six North Eastern Nigeria states	GFF + IDA	Jan 2017 – Jan 2022

	Investment Project - NSHIP) and Private sector innovations for service delivery in the North East. (Geographical Prioritization) Strengthen CRVS systems			
II.	Maternal, Newborn and Child Health Services (MNCH) within the BMPHS. (Transformational Initiative) Strengthen CRVS systems	Start up in three States	GFF + Domestic Resources	2018
III.	Nationwide Scale up of BMPHS (Programmatic Prioritization) Strengthen CRVS systems	36 STATES + FCT	Domestic Resources from BHCPF Statutory Allocation	Jan 2019 – Jan 2021
IV.	Scale up health sector specific nutrition services and pilot the provision of adolescent health services in targeted states (Geographical Prioritization)	Selected states – TBD	Domestic Resources +IDA	Jan 2018 – Jan 2023

V.	Expansion of services within the BMPHS (Programmatic Prioritization)	National – 36 States + FCT	Domestic Resources from BHCPF	Jan 2020 – Jan 2030

4.3.1 Phase One: Priority Investment I - Humanitarian Crisis and Emergency Response (North East Nigeria)

The Nigeria State Health Investment project (NSHIP) was developed to increase delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities through performance-based financing. NSHIP builds on the principle of fiscal decentralization to support health system reforms both at primary and secondary levels. The Minimum Package of Activities (MPA) provided in the project contains thirteen (13) services out of twenty (20) that are pertinent to RMNCAH (see Appendix).

The implementation of the NSHIP by NPHCDA is ongoing in the selected states of Adamawa, Ondo and Nasarawa States. Services purchased include antenatal visits, deliveries, Caesarean section (at secondary level), family planning, VCT, PMTCT, immunization, STIs etc. In recognition of the poor health outcomes compounded by the ongoing insurgency the expansion of the NSHIP to all the six North Eastern states it is critical so as to provide succor to the women and children who require these services the most.

4.3.1.1 Rationale for GFF investment:

This prioritized phase as proposed will be a sensible means for achieving the objectives of the GFF, specifically: (i) it focuses on strengthening RMNCAH; (ii) it does so in a part of the country where maternal and child health outcomes are lagging far behind; (iii) it responds to a Government request from the highest levels to meet a pressing need; (iv) it is associated with an IDA operation that uses innovative and results-based approaches; and (v) it has already benefited from extensive coordination and consultation with civil society and development partners and provides opportunities for both to be involved in implementation.

4.3.2 Phase Two: Priority Investment II – Start Up of Maternal, New-born and Child Health BMPHS

The delivery of the BMPHS will be piloted in the rural-poor communities of the three (3) selected States – Abia, Niger and Osun. The States were selected based on an eligibility criteria viz - Political economy/will, pre-existing service delivery monitoring systems, presence of a functional State Supported Health Insurance Scheme (SSHIS), State Primary Healthcare Development Agency (SPHCDA) and availability of partner support. These will enable disbursement of funds through the NHIS and NPHCDA “gateways”. The programme

will provide operation budget for identified primary healthcare facilities in the States and also guarantee the provision of the services, which will generate a **'proof of concept'.**

4.3.2.1 Rationale for GFF investment:

To ensure the right implementation structures are in place, the Federal Ministry of Health has decided to commence the implementation of the BHCPF in 2018 in three states of the federation: The need to demonstrate program effectiveness and to set up the necessary structures for nationwide implementation of the BHCPF which allows for lessons to be learnt and appropriate course correction made will be a strong rationale for leveraging the support of the GFF. The BHCPF mobilizes significant **domestic** resources for financing RMNCAH+N and supports Nigeria in its bid to close the resource gap. Through inter-fiscal transfer funds will flow from the Federal Government via State Institutions to frontline service delivery points and also ensures that additional domestic resources are utilized in a manner that it generates much needed efficiencies.

4.3.3 Phase Three: Priority Investment III - Nationwide Scale Up of the BMPHS (MNCH)

Lessons learnt from the startup phase will inform the scale up of the BMPHS to the 36 states of the federation and the Federal Capital Territory (FCT) using the 1% Consolidated Revenue Fund. It is hoped that success from phase 11 as supported by the GFF will help in supporting the GON to prioritize the BHCPF thus helping to mobilize substantial domestic resources to fund the BMPHS nationwide.

4.3.4 Phase Four: Priority Investment IV - Scale Up Health Sector Specific Nutrition and Adolescent Health Services

Malnutrition is holding back Nigeria's potential to compete in a global knowledge-based economy. It is therefore critical for Nigeria to address the ongoing malnutrition crisis with a laser sharp focus on implementing a set of proven high-impact nutrition interventions in the health sector aimed at reducing child stunting, anemia, iodine deficiency and other nutritional conditions that impinge on productivity and human capital. The GON will develop a programmatic approach to the malnutrition crisis in Nigeria using a multi-sectoral approach but will focus implementation on health sector interventions in the first instance.

4.3.5 Phase Five: Priority Investment V - Expansion of Services in the BMPHS

Based on the availability of funds, the services provided under the BMPHS will be expanded after the current package has been successfully scaled up to all 36+1 states in Nigeria.

4.4 INNOVATIVE PARTNERSHIP WITH THE PRIVATE SECTOR FOR PRIORITY INVESTMENTS

One of the principles guiding this investment case is 'innovation', and to improve coverage and delivery of quality RMNCAH + N health services, the FMOH leveraged on the capacity and expertise of the private sector, to provide innovative service delivery models to serve

populations at the remote and rural areas. The Service delivery challenge was a competitive process for identifying, showcasing and choosing the best suited innovations for scaling up RMNCAH plus Nutrition services in the GFF investment cases, especially in the North East.

4.4.1 **The Nigeria service delivery innovation challenge (NSDIC)** aims to Improve coverage and quality of RMNCAH service delivery, which thrives on international health principles such as global partnership and multi-sectoral collaboration, with the private sector inclusive. The RMNCAH+N investment case provides a timely entry point to source, refine and scale up selected innovations, especially in the North East through deployment of new service delivery approaches. The NSDIC is the product of the partnership between the Federal Ministry of Health, the Private Sector Health Alliance of Nigeria (PHN), the Healthcare Federation of Nigeria and the World Bank Group that resulted in a competitive and objective selection of best suited innovations to foster positive changes in RMNCAH service delivery in Nigeria.

4.4.2 The three top innovations selected to deliver RMNCAH services are:

4.4.2.1 TRANSFORM PROJECT – aims at eliminating:

a. Demand side challenges in RMNCAH healthcare delivery to the largely poor and vulnerable population through conditional cash transfers, payment vouchers and technical assistance to State Supported Health Insurance Schemes towards reducing out-of-pocket expenses.

b. Supply side challenges through improving the capacity and efficiency of the healthcare system to deliver quality services, using Safe Care monitoring standards for monitoring. The Transform Project in addition will strengthen drug revolving funds and the capacity of frontline health workers.

4.4.2.2 **CLINIPAK/VTR MOBILE – CLINIPAK** is a multi-media training application for continuous education/training of RMNCAH healthcare providers. It is an Android based mobile training application that supports multi-media training content including text, audio & video to support health workers with the continued training to improve their skills in delivering quality care, and engaging directly with patients around key messages relating to their conditions. **VTR MOBILE** is a point-of-care data capture and decision support tool that allows health workers to capture patient

health information and send the pertinent data points and information to remote servers through any of the available mobile networks.

4.4.2.3 RIDERS FOR HEALTH – an innovative transport system for mothers and children, particularly at the rural and hard -to-reach communities to reach the nearest Primary health centre or Secondary health facility. This is expected to tackle the challenge of '2ND delay', a major determinant on the 'road to maternal mortality'. Riders innovation is a managed transportation system consisting of motorcycles and ambulances and will ensure that pregnant women requiring obstetric care can get to their nearest health centre, for free and within the shortest possible time.

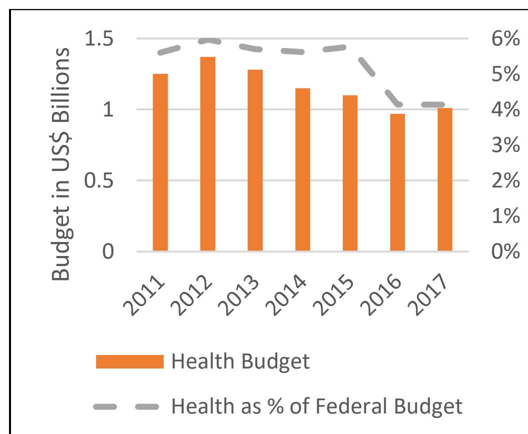
CHAPTER FIVE: FINANCING RMNCAH + N GFF INVESTMENT CASE

5.1 BACKGROUND

GOVERNMENT EXPENDITURE ON HEALTH IN NIGERIA IS AMONG THE LOWEST IN THE WORLD.

Nigeria's deteriorating macro fiscal stance has had severe implications in the health sector: The country experienced strong year-on-year economic growth until 2015 when it went into recession because of fiscal constraints due to reduction in oil prices. Current allocations to health as a percentage of total government expenditure, at 5% in 2014, are extremely low. In fact, out of 190 countries, Nigeria ranked at the bottom (180) in 2010 in terms of government contribution to health, below even resource-poor and conflict-affected African countries – this situation has not improved dramatically in 2016. Despite lagging performance in health as compared to our neighbours, the percentage of federal budget dedicated to health has declined over the last 2 years even as the total federal budget has increased. Yet, the country aims to become one of the top 20 global economies by 2020; for Nigeria to do this it needs to prioritize investments in human capital, which will be the nation's source of economic growth and innovation. This Investment case for expanding RMNCAH+N services provides a strategy for make those investments possible within a very short time.

Figure 11 Trends in Total Federal and Health Budget in Nigeria



5.1.1 As stated earlier in chapter one, responsibilities for health services are divided among the three tiers of government under Nigeria's federal system. The federal government (FGN) finances public sector tertiary services, state governments finance public sector secondary hospital services, and local government areas (LGAs) support public sector primary health care (PHC) services. However, this division of responsibilities is only approximate in that other tiers of government can intervene in health provision at levels that are the primary responsibility of another tier, as, for example, when state governments frequently compete with the FGN to build tertiary hospitals, or when the FGN and states invest in PHC.

5.1.2 More money is needed for health, but better use of funds is required: Health spending is low compared with peers with 4.2% of government budget going to health. Donor financing accounts for about 7% of total health expenditure and plays an important role in immunization and family planning. Due to limited pooling of resources most health spending is out of pocket. Of the limited financing that is available to the health sector, most of it goes to salaries; 81% of FMOH budget goes to salaries; 18% goes to capital projects.

5.1.3 Weak inter- governmental accounting makes it difficult to track finances and so leaves gaps as to who takes responsibility, thereby duplicating efforts for Primary health care. As it is generally considered to be a "concurrent area," meaning that all three tiers finance PHC services and projects - expectedly none of the entities end up funding PHC services, as they should. In recent years however reforms for the implementation of PHCUOR has supported efforts for states to set up their SPHCDAs.

5.1.4 Beyond the institutional architecture for improving governance at the PHC level is the implementation of the NHAct. This represents a major health financing reform with the greatest potential to fast track Nigeria's move toward Universal Health coverage. It will allow the GON to boost its current low contribution to health through the BHCPF. This is arguably Nigeria's most straightforward path to increasing financial resources for health.

5.2 FINANCING THE PRIORITY INVESTMENTS IN RMNCAH+N INVESTMENT CASE

5.2.1 Financing the priority investments in this RMNCAH+N IC will require a significant and sustained investment of not only financial but also managerial resources. The **Nigeria Health Financing Strategy** (which has been passed, but yet to be costed) will complement estimates in this IC. It outlines concretely plans for domestic resource mobilization in closing the resource gap for the health sector. The broad strategy to finance the IC will be mainly from GON's contribution either from its direct budgetary appropriations or its IDA allocations.

5.2.2 The implementation of the BHCPF is designed in a way to institutionalize incentives to address the accountability framework to improve RMNCAH+N outcomes in Nigeria: The NHAct was approved by the National Assembly in 2014, signed into law by the President and gazetted in late 2014. The NHAct stipulates that at least 1% of consolidated federal revenues be set aside to support the Basic Health Care Provision Fund (BHCPF). 50% of the funds are allocated to the National Health Insurance Scheme (NHIS) "gateway", 45% through the National Primary Health Care Development Agency (NPHCDA) "gateway", and 5% are set aside to deal with emergencies. The BHCPF can be used as a tool to increase the decision space of Nigerian state governments to quickly improve their health system performance through Inter-Governmental Fiscal Transfer (IGFT). The funds from the Consolidated Revenue Fund, which will be used to finance the BHCPF is modest - would have generated about N56.8 Billion (about $157 million) only in 2018.

5.2.3 The BHCPF will: (i) pay for prenatal, delivery, and post-natal care for all mothers in rural areas of Nigeria in accredited private and public facilities on a modified fee-for-service basis making such services free to the patient; (ii) provide operating budgets to PHC centers (PHCC's) in rural areas via electronic transfer to the individual facilities' bank account that are controlled by the officer-in-charge (OIC) and the Ward Development Committee; and (iii) set aside a small portion for dealing with emergencies, including disease outbreaks and road traffic accidents.

5.2.4 The Federal Government could strategically use incentives in the BHCPF to increase contributions and increased health outcomes from state & local governments, leverage donor funds, and mobilize private capital to fund the delivery of RMNCAH+N services in Nigeria. An innovative implementation strategy can further stimulate private sector investment, ensuring that the large available and active private health sector can meet the quality and volume demands associated with participating in an inclusive health system. As agreed during the TWG meetings partners are expected to align and rally around these common priority investments for efficiency and better results.

5.2.5 However, there is a realization that there is a need for pragmatism and a high absorptive capacity in ensuring efficient financing of the IC.

Table 6: Priority Investments

PRIORITY INVESTMENTS	COST	AVAILABLE FUNDS (millions USD)	FUNDING SOURCE	GAP
I. Scaling up of RMNCAH + N services in areas of Humanitarian Crisis and Emergency Response	TBD	130 20	IDA GFF	0
Strengthening CRVS systems	TBD	TBD	TBD	TBD
II. Maternal, Newborn and Child Health Services (MNCH) within the BMPHS.	TBD	20 0.98 2	GFF GoN (States) BMGF	TBD
Strengthening CRVS systems	TBD	TBD	TBD	TBD
III. Nationwide Scale up of BMPHS (Programmatic Prioritization)	TBD	100	BHCPF	TBD
Strengthen CRVS systems	TBD	TBD	TBD	TBD
IV. Scale up health sector specific nutrition services and pilot the provision of adolescent health services in targeted states (Geographical Prioritization)	TBD TBD	300 50 10	IDA IDA GFF	TBD TBD TBD
V. Expansion of services within the BMPHS.	TBD	1000	BHCPF	TBD

5.3 RESOURCE COSTING FOR GFF RMNCAH+N INVESTMENT CASE

The costing for the first two phases of the priority Investments will be based on the costing done for the Additional Financing (AF2) and the Basic Minimum Package of Health Services.

5.3.1 Minimum Package of Activities: the costing was based on a facility level, results based financing model for improving the quality and accessibility of key health services in communities. This model was demonstrated to be effective as part of the NSHIP pilot project. The PBF "fee" is a subsidy for this service and depending on content, total subsidies for curative care can be around 20-30% of available PBF budget. The combined subsidies of all services are modeled at $1.8 per capita per year for MPA.

Table 7: Minimum Package of Activities

SERVICE	BEFORE		AFTER					
	NSHIP-wide		Ondo		Adamawa		Nasarawa	
	Index	Fee	Index	fee	Index	fee	Index	fee
New outpatient consultation	1	$ 0.42	1	$ 0.42	1	$ 0.39	1	$ 0.39
New outpatient consultation by an indigent patient	3	$ 1.26	10	$ 4.20	10	$ 3.90	3	$ 1.17
Minor Surgery	10	$ 4.20	10	$ 4.20	7	$ 1.95	5	$ 1.95
Referred patient arrived at the Cottage Hospital	10	$ 4.20	10	$ 4.20	10	$ 3.90	10	$ 3.90
Completely vaccinated Child	15	$ 6.30	15	$ 6.30	15	$ 5.85	15	$ 5.85
Growth monitoring visit Child	0.7	$ 0.29	1.5	$ 0.63	1.5	$ 0.59	1.5	$ 0.59
2-5 Tetanus Vaccination of Pregnant Women	2	$ 0.84	2	$ 0.84	2	$ 0.78	2	$ 0.78
Postnatal Consultation	4	$ 1.68	4	$ 1.68	4	$ 1.56	4	$ 1.56
First ANC visit before 4 months pregnancy	5	$ 2.10	5	$ 2.10	5	$ 1.95	5	$ 1.95
ANC standard visit (2-4)	3	$ 1.26	3	$ 1.26	3	$ 1.17	3	$ 1.17
Second dose of SP provided to a pregnant woman	5	$ 2.10	5	$ 2.10	5	$ 1.95	5	$ 1.95
Normal delivery	30	$12.60	50	$21.00	30	$11.70	30	$11.70

FP: total of new and existing users of modern FP methods	10	$ 4.20	10	$ 4.20	8	$ 3.12	8	$ 3.12
FP: implants and IUDs	15	$ 6.30	15	$ 6.30	15	$ 5.85	15	$ 5.85
VCT/PMTCT/PIT	4	$ 1.68	1	$ 0.42	0.7	$ 0.39	1	$ 0.39
PMTCT: HIV+mothers and children treated acc protocol	40	$16. 80	40	$16. 80	40	$15.6 0	10	$ 3.90
STD treated	10	$ 4.20	10	$ 4.20	10	$ 3.90	5	$ 1.95
New AAFB+ PTB patient	75	$31. 50	75	$31. 50	75	$29.2 5	75	$29.2 5
PTB patient completed treatment and cured	20 0	$84. 00	20 0	$84. 00	20 0	$78.0 0	20 0	$78.0 0
Household visit per protocol	10	$ 4.20	3	$ 1.26	3	$ 1.17	3	$ 1.17

Services for the five (5) North East States

The rationale for high subsidy fee is that government policies in these States stress free MNCH services. This is to enable the health facilities procure necessary drugs/equipment/consumables to provide needed services. Strategic purchasing is likely taking place within the first quarter of 2018.

Table 8: MPA for 5 NE States

MPA Service	Cat1	Cat2	Cat3	Cat4	Cat5
New outpatient consultation	423	447	470	494	517
Minor Surgery	2,117	2,234	2,352	2,470	2,587
Referred patient arrived at the Cottage Hospital	5,927	6,257	6,586	6,915	7,245
Completely vaccinated Child	4,234	4,469	4,704	4,939	5,174
Growth monitoring visit Child 0-23 months	635	671	706	741	777
Growth monitoring visit Child 24-59 months	423	447	470	494	517
Admin of Vit A caps (6 monthly)	212	223	235	247	259
New case of acute malnutrition and/or ambulatory care acc to protocol for MAM	4,234	4,469	4,704	4,939	5,174
Suppl of Iron Folate to Pregnant Women	847	894	941	988	1,035
2-5 Tetanus Vaccination of Pregnant Women	847	894	941	988	1,035
Postnatal Consultation	1,694	1,788	1,882	1,976	2,070
First ANC visit before 4 months pregnancy	1,694	1,788	1,882	1,976	2,070
ANC standard visit (2-4)	1,270	1,340	1,411	1,482	1,552
Second dose of SP provided to a pregnant woman	1,694	1,788	1,882	1,976	2,070
Normal delivery	12,701	13,406	14,112	14,818	15,523
FP: total of new and existing users of modern FP methods	1,694	1,788	1,882	1,976	2,070
FP: implants and IUDs	10,584	11,172	11,760	12,348	12,936
VCT/PMTCT/PIT test	847	894	941	988	1,035
PMTCT: HIV+mothers and children treated acc protocol	16,934	17,875	18,816	19,757	20,698
STD treated	4,234	4,469	4,704	4,939	5,174
New AAFB+ PTB patient	31,752	33,516	35,280	37,044	38,808
PTB patient completed treatment and cured	63,504	67,032	70,560	74,088	77,616
Household visit per protocol	1,270	1,340	1,411	1,482	1,552
Individual psycho-social counselling services (new case)	3,387	3,575	3,763	3,951	4,139
Individual psycho-social support (follow-up visits)	2,117	2,234	2,352	2,470	2,587

5.3.2 Basic Minimum Package of Health Services: the target population was defined here based on the 2017 population projections and for each intervention the population in need was calculated. Thirdly using the 2013 NDHS **for each intervention, the current coverage level (the share of the target population *currently receiving* the intervention) was used to estimate service volume.** Unit cost for labour (based on professional type and treatment time (in minutes) per average case), dugs and consumables for each intervention and overheads (account for all costs that cannot be directly connected to services of individual patients) were calculated from different years based on availability[19].

Niger is the most populated pilot state at 5.7 million people (3.4 million in rural areas) followed by Osun (4.8 million total / 2.9 million rural) and Abia (3.8 million total / 2.3 million rural). Total cost at current coverage rates is estimated at USD 30 million per year for the three states. For baseline and target coverage for the States please refer to the annex.

[19] Costing of the Basic Minimum Package of Health Services (BMPHS) in Nigeria: World Bank Group – Health, Nutrition and Population (HNP) Global Practice July 2017.

At an average of 15,000 people per health facility, there are around 574 rural facilities in the three states. Administrative and start-up costs aside, covering marginal cost for the benefits package would amount to just under USD 12,000 per year, or USD 0.79 per capital, and leave approximately USD 6.3 million for capital improvements, which comes to over USD 5,000 per facility per year (NSHIP provided this amount for just the first year). Coverage and target indicators see annex.

Table 9: Resource allocation for marginal cost and facility upgrades

PILOT STATES, RURAL, FULL PACKAGE					
	Year 1	**Year 2**	**TOTAL**	**Per HF** (est. 574 PHCs)	**Per capita** (15,000 / HF)
PILOT BUDGET			$ 20,000,000		
NHIS	$ 6,858,227	$ 6,858,227	$ 13,716,454	$ 11,948 / year	$ 0.79
			$ 6,283,546		
NPHCDA	$ 3,141,773	$ 3,141,773	$ 6,283,546	$ 5,473 / year	
			$0		

Health Financing Gaps

Table 10: Health Financing Gap in the Next Two Years

Need Area	Financing Gap (₦ bn)	FGON (₦ bn)	Other Sources (₦ bn)
Polio Eradication & Immunization in Lagging States	**57.3**	10.8	46.5
Malaria bed nets & drugs	**55.2**	5.6	49.6
Family Planning	**23.9**	5.3	18.6
Mandated Health Insurance	**1**	1	0
BHCPF – National Health Act	**44.3**	38.1	6.2
Total		60.8	

5.3.3 Private Sector Innovative Challenge: There is a financing gap here as to how it will be initially funded and then sustained.

5.4 ROLE OF GFF TRUST FUND IN LEVERAGING ADDITIONAL RESOURCES FOR FINANCING RMNCAH+N IC

5.4.1 The GFF Trust Fund can be used to leverage existing funding from government and donors to address rapid scale up of RMNCAH interventions to improve the current dismal indices. There is a cross fertilization of priorities between these financing opportunities as they are pro-poor with a focus on vulnerable groups (women and children under five years of age) and prioritization of rural areas. Aligning these opportunities could potentially maximize coverage, enhance efficiency in utilization of resources and optimize the use of delivery platforms.

5.4.2 Development partners can help by aligning their programmes, and considering opportunities to support governments as they develop and scale up RMNCAH +N services. Complementary roles are essential to harmonizing investments, building synergies across programs with countries, and integrating it within a country plan. The DP can help increase accountability and advocate for Government commitments especially those within the Health Act, so provide funding to roll out the BHCPF. Those working in the various States can support the private sector to expand services in the areas that matter to government.

5.4.3 **Partnership arrangements:** A strategic partnership has been formed under the Nigeria GFF country platform. The country platform is a multi-stakeholder that supports efforts to facilitate the pooling of financial and technical resources to deliver the startup phase of the BHCPF in the three states as envisaged under the complementary financing of the GoN RMNCAH+N investment case supported by the GFF. This approach allows the GoN to better align and harmonize interventions around a common vision that aims to rapidly increase access to essential maternal and child health services in the country. It also avoids duplication of efforts and improve the efficient use of resources. It is instructive to note that the BMGF in alignment with this vision has already contributed the sum of 2M USD to the implementation of the BHCPF.

5.4.4 This investment case will leverage GFF TF resources for grant funding to fund priority investments I & II. These priority interventions explicitly focus on RMNCAH outcomes. For ***Priority investment I*** the GON will leverage on the existing NSHIP investments for half of the GFF TF grant resources. Thus, aligning the IC with the Nigeria State Health Investment Project (NSHIP) in the North East will help efforts to leverage resources for the provision of essential RMNCAH services needed to move the country forward in achieving the SDGs and facilitate quick recovery for a region suffering from the immediate consequences of insurgency.

5.4.5 This investment case will also leverage GFF TF resources for grant funding to fund ***Priority investments II***. This is with the realization that a successful implementation of the BHCPF will allow Nigeria to make available an explicit benefit package, will allow the poor and vulnerable to access quality and affordable health care, it will address known challenges in primary health care delivery and support efforts to introduce strategic purchasing mechanisms at scale.

CHAPTER SIX: MONITORING AND EVALUATION FRAMEWORK

6.0.1 The Nigeria RMNCAH Investment Case is a sub set of the NHSDP 11 and is supported by a results framework to measure and monitor progress on results, track efficiency and effectiveness, and identify deficiencies and propose improvement measures for needed course corrections. The NHSDP 11 results framework has been developed with baselines, five-year targets and sources of data. It is envisaged that Nigeria will continue to make the necessary critical investments in CRVS in the period of implementation to complement accurate data collation and monitoring.

6.0.2 It is essential that progress is measured against set targets in this Investment Case. The monitoring of the operationalization will be the responsibility of the Country platform in conjunction with the Health Sector Reform Coalition (Nigeria GFF CSOs working group). The secretariat will organize quarterly and annual review meeting to monitor progress and a web-based dashboard will be developed and utilized to visualize progress on the implementation of the various phases. There will be a mid-term evaluation of the implementation of this Investment Case to assess the extent of progress.

6.0.3 The results to be achieved with the implementation of the RMNCAH+N will be measured annually and targets will be based on the historical progress on these indicators in Nigeria and globally.

A. **Vaccination coverage among young children (Pentavalent3);**
B. **Contraceptive prevalence rate (modern methods);**
C. **Vitamin A supplementation among children 6 months to 5 years of age;**
D. **Skilled birth attendance;**
E. **HIV counseling and testing among women attending antenatal care;**
F. **Use of insecticide treated nets (ITNs) by children under five**
G. **Improved quality of care index at health center level.**

6.0.4 **Role of the DHIS2 & sources of data:** The DHIS 2 in Nigeria is still evolving and will not likely be able to fully provide information on the measurement of some of the indicators proposed in this Investment Case. As some of the proposed indicators will require population-based information while others need facility level data it is suggested that the proposed approach to monitor progress utilizes a combination of SMART population based survey for population based indicators and health facility surveys for quality of care indicators. This RMNCAH+N investment case will utilize the under listed data sources for its M & E assessment. Relying on existing surveys makes sense because they: (i) have a track record of quality; (ii) provide baseline data against which to assess progress; (iii) represent an efficient use of currently available resources; and (iv) cannot be easily manipulated. Thus, the NDHS 2013 will provide a baseline and another one scheduled for 2018 will measure impact level indicators.

1. **Household Surveys.** There are three major sources of household survey data in Nigeria that are broad in coverage and focus beyond single diseases or interventions, **NDHS, SMART, and MICS.**

2. **Nigeria Demographic Health Survey (NDHS).** Collects demographic, health service utilization, and basic health status information and is implemented by the National Population Commission (NpopC) with technical support from ICF Macro. The NDHS is conducted using a well standardized methodology and rigorous sampling and has been carried out on average a little less than every 5 years. Previous surveys were conducted in 1990, 1999, 2003, 2008 and most recently 2013. NDHS obtains the majority of its support from USAID.

3. **Standardized Monitoring and Assessment of Relief and Transitions (SMART) Survey.** The SMART survey was developed as an annual household survey to provide State level information on nutritional status and related information for children and women. It has expanded to meet the data needs of other Programs, primarily the SOML, to include information for basic reproductive and child health indicators. SMART surveys may be used to judge changes in skilled birth attendance and immunization coverage. It shall be designed to measure progress in utilization of key MNH services: (i) Availability, utilization and coverage of key maternal and neonatal health services especially for the poor; (ii) Reduction in inequities in access and health (related) expenditures; (iii) Quality of care, in public and private health facilities; and (iv) Changes in health seeking behaviour over time.

4. **Multiple Indicator Cluster Survey (MICS).** The MICS survey covers multiple aspects of health and health practices focusing on women and children. The National Bureau of Statistics (NBS) implements it, with technical support from UNICEF. Primary external partners are UNICEF, UNFPA and DFID. The MICS was conducted most recently in 2016 and provides zonal and urban-rural level estimates for key indicators.

5. **Service Delivery Indicator (SDI) Survey.** The SDI is a standard survey conducted through the World Bank to provide comparable data across countries. The focus of SDI is on service readiness (equipment and supplies at the facility), finance and budget at the facility level human resources at the health facility (HF), and service provider knowledge based on responses to vignettes.

6. **Service Availability and Readiness Assessment (SARA).** The SARA is a standard health facility (private and public facilities) survey for primary health care and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). The standard tools are adapted to each country. A Nigeria SARA is in the final planning phase with main donors GAVI and Global Fund.

7. **NSHIP Baseline Facility Survey.** As part of the baseline for the NSHIP impact evaluation a health facility survey was conducted in 6 States by NBS with technical assistance from the University of South Carolina. NBS experienced delays in completing the survey.

6.1 RESULTS FRAMEWORK

The results framework (see annex) will be used to monitor the indicators as outlined in the Investment case – Additional finacing of the NSHIP and the BHCPF. SMART and Household Survey will be used to monitor progress.

6.2 STRENGTHENING CRVS FOR A ROBUST RMNCAH DATABASE

6.2.1 A functional and effective CRVS system offers lots of benefits to development and governance at all levels especially in the health sector namely, health data & information; causes of death; infant, child and maternal mortality; fertility rates and trends; communicable and non-communicable diseases and emerging public health diseases such as HIV/AIDS, Tuberculosis, Cancer, Diabetes and Hypertension. In addition, birth and death data from civil registration systems can be used to determine population estimates in the interim years between population censuses, as well as for population projections.

6.2.2 To this end, the FMOH in collaboration with the CRVS department of the National Population Commission (NpopC) is leveraging on the Community Health Management Information System, to ensure continuous data generation on births, deaths and fertility at the community level. The objective is to develop a system of data collection that will ensure the appropriate capturing of data on births and deaths both in the community and facility level and onward migration into a National Birth Registry. The Ministry is currently working together with CRVS Department NpopC among other partners to develop sets of indicators for health interventions and means of collecting community health data.

6.2.3 Impact Evaluation of prioritized phases in the IC: In addition, relevant impact evaluations and regular surveys will be conducted to look at the effectiveness and impact of selected interventions and measure progress on service delivery improvements. It is unlikely to have a single Impact Evaluation (IE) designed to assess the impact of operationalization of the IC due to the phasing of the priority interventions. Subsequently, Impact Evaluation will be implemented to assess impact of the various prioritized areas highlighted in the IC thus the planned IE will rely on the implementing entities of the various phases to plan and fund such IEs. The Impact Evaluation shall at the minimum, consist of baseline surveys prior or at the time of commencing each of the different phases and an endline survey done at the period indicated in the IC. The Impact Evaluation shall generate lessons on the effectiveness of the IC. The country platform will be responsible for the building the narrative from the IE and disseminating evidence to stakeholders. Data from the impact evaluation will also be used to guide key advocacy engagements.

6.2.4 To further ensure accountability, Citizens' engagement will be enhanced. The social accountability technical working group will be reactivated and innovative approaches will be rolled out to receive citizens' feedback. Accountability will also be enhanced by establishing an independent review group/body to assess RMNCAH achievements on an annual basis by

triangulating service statistics and survey data. This will deliver a holistic picture of RMNCAH achievements by each county and at the national level.

6.2.5 Monitoring of implementation of the Investment Case will be done by the country platform on a quarterly and annual basis through review meetings. A web-based dashboard will be developed and utilized to visualize progress at national and county levels. Where they are implemented, performance-based financing will enhance recognition for well-performing states (counties), while biannual data quality audits and review meetings will be conducted to authenticate the reports posted on the dashboard.

6.2.6 The SDI was conducted in 12 States Nigeria in 2014. Findings were consistent across States with results from the first six States showing that an average of 36 percent providers accurately diagnosed conditions and 32 percent adhered to clinical guidelines when interviewed using a vignette. Only 17 percent adequately demonstrated knowledge for management of maternal/newborn complications. About 45 percent of facilities had essential drugs available and about 18 percent equipment and infrastructure required for basic services.

ANNEX I

Interventions under the BMPHS

		Interventions	Comments
BMPHS Ante-natal Care (ANC) interventions	1	ANC Visits	4 visits
	2	Tetanus toxoid	2 tetanus toxoid immunizations
	3	Syphilis screening and treatment	Rapid plasma reagent test and treatment of seropositive cases with Penicillin
	4	Hypertensive disease case management	Includes hypertension without proteinuria
	5	Management of Pre-eclampsia (Magnesium Sulphate)	Includes mild to severe pre-eclampsia
	6	Anaemia Treatment	Anaemia treatment
	7	Deworming (Pregnant women)	Hook worm treatment with anthelminthic
	8	Ante-natal corticosteroids	Steroids with suspected preterm labour
	9	Antibiotics for SPROM	Oral antibiotics
	10	IPT (Pregnant women)	Intermittent presumptive treatment
	11	Case management of malaria in Pregnant women	Diagnosis and treatment with Artesunate-based Combination Therapy
	12	PMTCT	1) HIV testing and counselling for all pregnant women 2) ART for mother and newborn 3) Infant feeding counselling
	13	Daily iron and folic acid supplementation in Pregnant women	Supplementation for pregnant women
	14	Haemoglobin screening and urinalysis	
	15	Induction of labour (beyond 41 weeks)	Induction of labour to prevent births at or beyond 41 completed weeks
	15	Labour and Delivery Management/Essential care for all women and immediate essential	Monitoring of labour progress (partograph), detection of complication, infection control (clean delivery), immediate drying and skin-to-skin contact, breast feeding initiation

BMPHS Labour and Delivery Care and Emergency Obstetric and Neonatal Care (EmONC) interventions		newborn care (Facility based deliveries)	
	17	Active management of 3rd stage of labour (AMTSL)	Controlled cord traction, oxytocics, fundal massage
	18	Pre-referral management of labour complications	Stabilization of women in labour to lower level health facilities with complications that require referral to a hospital
	19	Obstructed Labour	Assisted vaginal delivery (10% of obstructed cases) and C-section (90%)
	20	Magnesium Sulphate management of Eclampsia	Management of severe eclampsia
	21	Newborn resuscitation (clinic based deliveries)	Detection of breathing problems and resuscitation of newborn when required
	22	Newborn - treatment of local infections	Conjunctivitis, infection of the umbilical stump and other local infections
	23	Kangaroo mother care	For premature newborns
	24	Post-natal preventive care	Postnatal preventive care including 2 home visits
	25	Mastitis	Treatment of mastitis
	26	Post Partum Haemorrhage	Treatment for post-partum haemorrhage
	27	Maternal sepsis management	Treatment of sepsis within 42 days of delivery
	28	Newborn Sepsis - injectable antibiotics	Administration of intramuscular antibiotics for neonatal sepsis, meningitis or pneumonia
	29	Newborn Sepsis - Full supportive care	Hospital based management of sick newborn as an inpatient with supportive care
BMPHS children under-5 interventions	30	Vitamin A supplementation for treatment of xerophthalmia	Therapeutic doses of Vitamin A for treatment of xerophthalmia including night blindness, Bitot's spots, corneal xerosis, corneal ulceration and keratomalacia
	31	Management of mild and moderate diarrhoea with ORT	ORS
	32	Zinc for diarrheal treatment	Oral zinc
	33	Antibiotics for dysentery	

	34	Treatment of severe diarrhoea (children)	Treatment with IV Fluids
	35	Pneumonia treatment (children)	
	36	Treatment of severe malaria (children)	Diagnosis and treatment with Artesunate-based Combination Therapy
	37	Vitamin A for measles treatment (children)	Non-complicated measles with Vitamin A therapy
	38	Treatment of severe measles	At referral level
	39	Measles (2 doses)	2 doses
	40	Haemophilus influenzae type b (3 doses)	3 doses
	41	DPT (3 doses)	3 doses
	42	Pneumococcal (3 doses)	3 doses
	43	Polio (3 doses)	3 doses
	44	BCG (1 dose)	1 dose
BMPHS Malaria treatment and Non-Communicable Disease (NCD) screening and prevention	45	Malaria Treatment (population over 5)	Diagnosis and treatment with Artesunate-based combination drugs (ACTs)
	46	Screening for risk of Cardiovascular Disease and Diabetes	Blood glucose, Cholesterol, Urine analysis and counselling
Family Planning interventions	47	Pills	Combination (Estrogen + Progestagen) or only Progestagen
	48	Condoms	Male (95%) and Female (5%) 120 per year
	49	Injectables	
	50	IUCD	Copper-T 380-A IUD (10 years)
	51	Implants	

ANNEX II

Interventions under the Minimum Package of Activities

1	New outpatient consultation
2	Minor Surgery
3	Referred patient arrived at the Cottage Hospital
4	Completely vaccinated Child
5	Growth monitoring visit Child 0-23 months
6	Growth monitoring visit Child 24-59 months
7	Administration of Vit A caps (6 monthly)
8	New case of acute malnutrition and/or ambulatory care according to protocol for MAM
9	Supplemental Iron and Folate to Pregnant Women
10	2-5 Tetanus Vaccination of Pregnant Women
11	Postnatal Consultation
12	First ANC visit before 4 months pregnancy
13	ANC standard visit (2-4)
14	Second dose of SP provided to a pregnant woman
15	Normal delivery
16	FP: total of new and existing users of modern FP methods
17	FP: implants and IUDs
18	VCT/PMTCT/PIT test
19	PMTCT: HIV+mothers and children treated acc protocol
20	STD treated
21	New AAFB+ PTB patient
22	PTB patient completed treatment and cured
23	Household visit per protocol
24	Individual psycho-social counselling services (new case)
25	Individual psycho-social support (follow-up visits)

ANNEX III

Cost of Baseline Coverage, Pilot States

BASELINE COVERAGE					
	National	**Abia**	**Niger**	**Osun**	**TOTAL**
ANC	$54,964,623	$1,064,176	1,598,414	$1,356,095	$4,018,685
Delivery	$42,353,788	$820,016	1,231,681	$1,044,959	$3,096,656
PNC	$19,789,815	$383,153	575,503	$488,257	$1,446,913
Child	$205,692,112	$4,274,804	6,420,843	$5,447,448	$16,143,096
Adult malaria	$27,946,387	$541,073	812,702	$689,497	$2,043,273
NCD	$21,168,927	$409,854	615,609	$522,283	$1,547,745
FP	$23,314,761	$451,399	$678,011	$575,225	$1,704,636
TOTAL	**$395,230,414**	**$7,944,475**	**$11,932,763**	**$10,123,765**	**$30,001,003**
Immunization	$25,381,553	$491,415	$738,115	$626,217	$1,855,747
Malaria	$114,151,779	$2,210,104	$3,319,622	$2,816,370	$8,346,096
Nutrition	$64,892,789	$1,548,774	$2,326,290	$1,973,626	$5,848,691
Nutrition	$21,168,927	$409,854	$615,609	$522,283	$1,547,745

ANNEX IV

Cost of Target Coverage, Pilot States

TARGET COVERAGE					
	National	**Abia**	**Niger**	**Osun**	**TOTAL**
ANC	$67,036,784	$1,297,906	1,949,481	$1,653,941	$4,901,329
Delivery	$53,646,140	$1,038,648	1,560,071	$1,323,565	$3,922,285
PNC	$24,475,936	$473,881	711,779	$603,874	$1,789,534
Child	$253,871,325	$5,273,052	7,920,232	$6,719,531	$19,912,815
Adult malaria	$34,467,211	$667,323	1,002,333	$850,380	$2,520,036
NCD	$26,108,343	$505,486	759,251	$644,149	$1,908,886
FP	$26,046,232	$504,284	$757,444	$642,616	$1,904,345
TOTAL	**$485,651,971**	**$9,760,581**	**$14,660,592**	**$12,438,057**	**$36,859,230**
Immunization	$32,996,968	$638,858	$959,577	$814,106	$2,412,541
Malaria	$141,895,370	$2,747,251	$4,126,427	$3,500,864	$10,374,541
Nutrition	$78,551,915	$1,878,675	$2,821,808	$2,394,024	$7,094,508
Nutrition	$26,108,343	$505,486	$759,251	$644,149	$1,908,886

ANNEX V

Results Framework

Project Development Objective Indicators					
Status	Indicator Name	Unit of Measure		Baseline	End Target
	Number of children 0-12 months immunized with Pentavalent 3 vaccine per year in five states – (Sum of Borno, Bauchi, Gombe, Taraba and Yobe states).	Number	Value	180,145	284,442
			Date	2015	2020
			Comment	SMART	Househol d Survey
	Number of children 0-12 months immunized with Pentavalent 3 vaccine per year in three states – (Sum of Abia, Niger and Osun states).	Number	Value	298,763	397,931
			Date	2015	2020
			Comment	SMART	Househol d Survey
	Proportion of children (12-23) months with Pentavalent 3 vaccination (average in Borno, Bauchi, Gombe, Taraba and Yobe states).	Percentage	Value	20.92	29
			Date	2015	2020
			Comment	SMART	Househol d Survey
	Proportion of children (12-23) months with Pentavalent 3 vaccination (average in three states of Abia, Niger and Osun)	Percentage	Value	57	66.7
			Date	2015	2020
			Comment	SMART	Househol d Survey
	Number of births (deliveries) occurring in a health facility in three states (sum of Borno, Bauchi, Gombe, Taraba and Yobe states).	Number	Value	231,452	344,015
			Date	2015	2020
			Comment	SMART	Househol d Survey
	Number of births (deliveries) occurring in a health facility in three states (sum of Abia, Niger and Ondo)	Number	Value	367,668	442,694
			Date	2015	2020
			Comment	SMART	Househol d Survey
	Proportion of births attended by skilled health personnel (average of	Percentage	Value	28.7	37
			Date	2015	2020

	Borno, Bauchi, Gombe, Taraba and Yobe states).		Comment	SMART	Household Survey
	Proportion of births attended by skilled health personnel (average of Abia, Niger and Osun)	Percentage	Value	70	74.3
			Date	2015	2020
			Comment	SMART	Household Survey
	Average Health Facility Score – Structural Quality of Care (average of Borno, Bauchi, Gombe, Taraba and Yobe states).	Percentage	Value	38.9	53.9
			Date	31-Mar-2016	30-Jun-2020
			Comment	NHFS 2016	NHFS 2019
	Average Health Facility Score – Structural Quality of Care (average of Abia, Niger and Osun)	Percentage	Value	28	43.0
			Date	31-Mar-2016	30-Jun-2020
			Comment	NHFS 2016	NHFS 2019
	Number of outpatient visits per year, children (sum of Borno, Bauchi, Gombe, Taraba and Yobe states).	Number	Value	617,265	
			Date	2015	2020
			Comment	SMART	Household Survey
	Number of outpatient visits per year, children (sum of Abia, Niger and Osun)		Value	294,915	
			Date	2015	31-Jul-2020
		Number	Comment	SMART	Household Survey
	Number of beneficiaries of BMPHS with access to essential health services (out-patients + deliveries + family planning clients+ antenatal care visits)	Number	Value	1,740,856	XXXX
			Date	2015	2020
			Comment	SMART	Household Survey
	Female beneficiaries with access to essential health services	Percentage Sub Type Supplemental	Value	0.00	60.00
Intermediate Results Indicators					

Status	Indicator Name	Unit of Measure		Baseline	End Target
*Rural (SPHCDA)	Percentage of eligible PHCs enrolled for DFF payments	Percentage	Value	0	
			Date	Aug. 2018	31-Jul-2020
			Comment	TMSOF	
*Timeliness of payments (SPHCDA)	Number of public PHCs receiving operational expenses electronically on time	Number	Value	0	
			Date	Aug.2015	30-Jun-2020
			Comment	TMSOF	
*Timeliness of payments (SSHIS)	Number facilities receiving payments for services delivered electronically on time	Number	Value	0	
			Date	Aug.2015	30-Jun-2020
			Comment	TMSOF	
*Quality on SSHIS	Number of health facilities that underwent accreditation process	Number	Value	0	
			Date	Aug 2018	31-Jul-2020
			Comment	TMSOF	
*Accountability and citizen empowerment (SPHCDA)	Proportion of health facilities in the project area with functioning management committees having community representation	Percentage	Value	0	
			Date	Aug. 2018	31-Jul-2020
			Comment	TMSOF Verified supervisory checklist	
*Incentivizing quality in public PHCs (SPHCDA)	Percentage of eligible PHCs enrolled for DFF payments who qualify for BPF payments	Percentage	Value	0	
			Date	Aug. 2018	
			Comment	TMSOF	