

Nigeria Health Sector Renewal Investment Program

... towards a healthy and prosperous Nigeria Now !

- Discussion Draft, November 6, 2023

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

Introduction

- A Vision for Nigeria's Health Sector
- Framework for Nigeria Health Sector Renewal

Financing and Organization of Services

- Decentralized Facility Financing
- Operationalizing a Vulnerable Group Fund
- Strengthening Community Based Health Services
- Improving Quality of Care
- Harmonized TA support for BHCPF

Enabling Systems for Improved Outcomes

- Improving Commodity Security
- National Emergency Medical Service and Ambulance Scheme
- Digital in Health

Health Security

Governance, Financing and Accountability

- Defragmenting Sector Financing for Improved Efficiency
- Federal-State Partnership for Improved Ownership and Accountability
- Citizens Engagement and Social Accountability

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Introduction

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

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

Our goal is to save lives, reduce both physical and financial pain and produce health for ALL Nigerians

Outcomes we want to achieve:

DALY improvement, lives saved, OOP reduced, [metric for producing health], [equity]



Effective governance

- Strengthen oversight and effective implementation of the National Health Act
- Increase accountability to and participation of relevant stakeholders and Nigerian citizens
- Strengthen regulatory capacity to foster the highest standards of service provision
- Improve cross-functional coordination & effective partnerships to drive delivery



Efficient, equitable and quality health system

- Drive health promotion in a multi-sectoral way (incl. intersectionality with education, environment, WASH and Nutrition)
- Strengthen prevention through primary health care and community health care
- Improve quality of care and service delivery across public (primary, secondary and tertiary care) and private, across all levels of the health system
- Improve equity and affordability of quality care for patients
- Revitalize the end-to-end (production to retention) healthcare workers pipeline



Unlocking value chains

- Promote clinical research and development
- Stimulate local production of health products
- Shape markets to ensure sustainable local demand
- Strengthen supply chains



Health Security

- Improve the ability to detect, prevent and respond to public health threats (e.g., Cholera, Lassa)
- Build climate resiliency for the health system in collaboration with all other sectors

Data & Digitization: Digitize the health system & have data backed decision making

Financing: Increase effectiveness of spend and alignment of spend with strategic priorities

Culture & Talent within MDAs: Strengthen capabilities & values and drive a performance based culture within the EMoH

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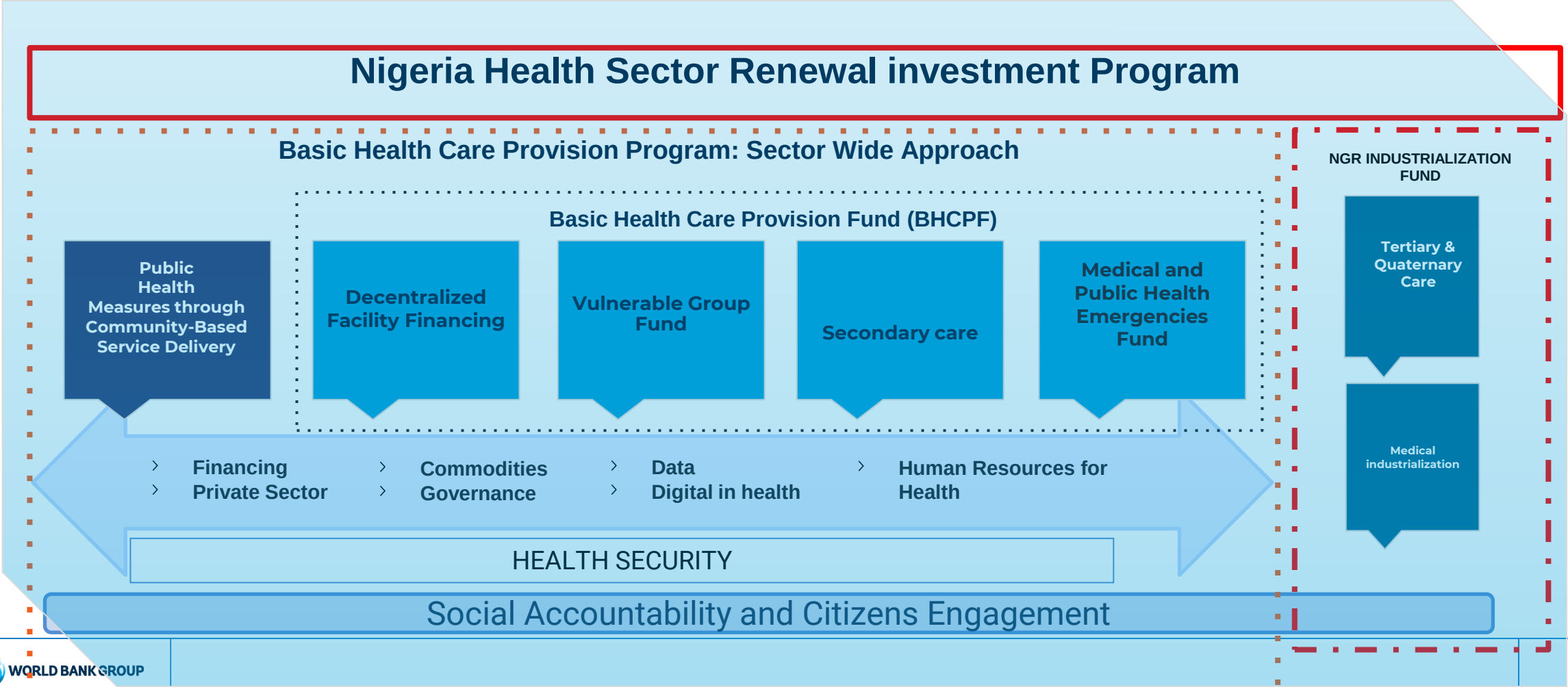
The Strategic Vision for the Health Sector will be guided by progress in key outcomes

	Save lives	Reduce physical pain	Reduce financial pain	Produce health		For ALL Nigerians
This means	Less death	Improved quality of life Improved quality of care	Reduced out-of-pocket spend Increased and more effective government spend Reduced financial burden for the poor specifically	Reduced risk factors for communicable & non-communicable diseases Reduced prevalence of non-communicable and communicable diseases and reproductive, maternal, neonatal, child, adolescent, and nutritional (RMNCH+AN) conditions		All have access ..regardless of income group, there are good health outcomes
Measured by	Mortality ● Life expectancy at birth • Mortality rates ● Maternal ● Neonatal ● Under 5 ● Attributable to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	Quality of life ● DALYs (overall) Quality of care (QoC) • HRH Density ● Medical doctors ● Nursing and midwifery personnel ● Community health workers ● Patient satisfaction rates with PHC services ● People voice survey scores ● Note: additional quality of care metrics to be added after QoC framework developed	Health financing ● Population with impoverishing health expenditure ● Health insurance coverage ● Government health expenditure as a proportion of total health expenditure per capita	Risk factors (Prevalence) ● Obesity ● Insufficient physical Activity Non-communicable diseases (Incidence) ● Cancer ● Cardiovascular diseases ● Diabetes and kidney diseases Communicable diseases (Incidence) ● Malaria ● Diarrheal diseases ● HIV ● TB Immunization ● Penta 3 coverage ● % of children 0-12 months fully immunized	RMNCH+AN ● Contraceptive prevalence ● Antenatal care coverage ● Skilled birth attendance ● Postnatal care (newborn) ● Stunting and wasting ● Adolescent birth rate Health Security: ● IHR¹ Score ● 7-1-7: early detection and response Local production: ● Net imports of generics and medical devices	Access ● Health facility density and distribution Equity ● Coverage of essential health services ● Zero dose children ● Difference in [select outcomes]² between different regions and income groups
						

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

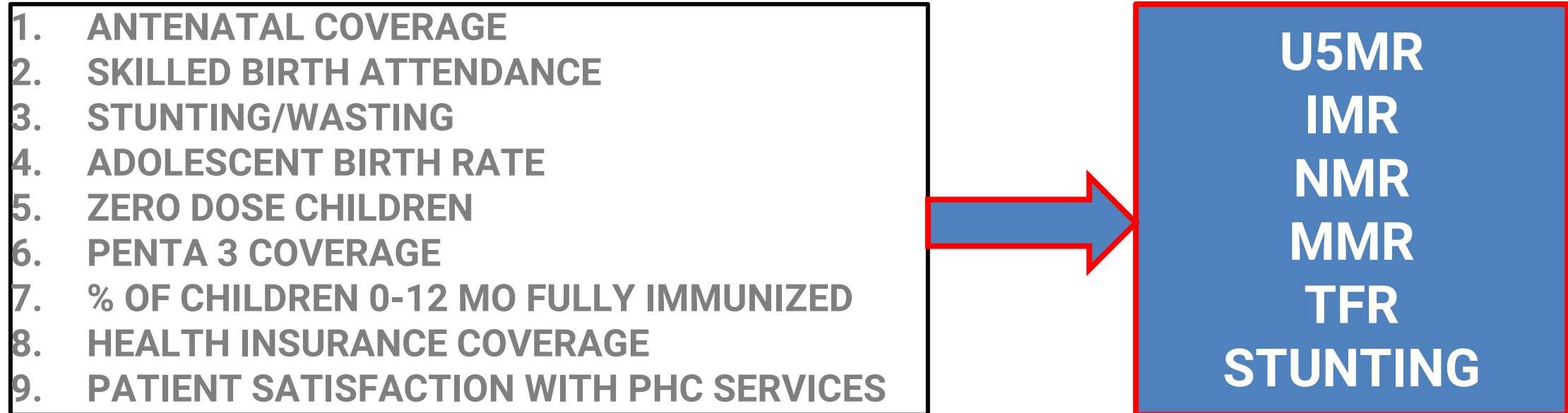
NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

The program comprises of the BASIC HEALTHCARE PROVISION PROGRAM and the HEALTHCARE INDUSTRIALIZATION PROGRAM. The BHCPP will be managed through a **sector wide program** via real or notional pooling of all available funds. The **Nigeria healthcare industrialization fund** will be a specially dedicated pool of funds to drive investment in the healthcare value chain.



THE NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM IS “BUSINESS UNUSUAL”

If Nigeria is to make progress, traditional “business-as-usual” models will not lead to progress in the following key areas.....



THE BASIC HEALTHCARE PROVISION PROGRAM OF THE NHS RIP ADDRESSES ALL OF THE ABOVE

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Financing and Organization of Services

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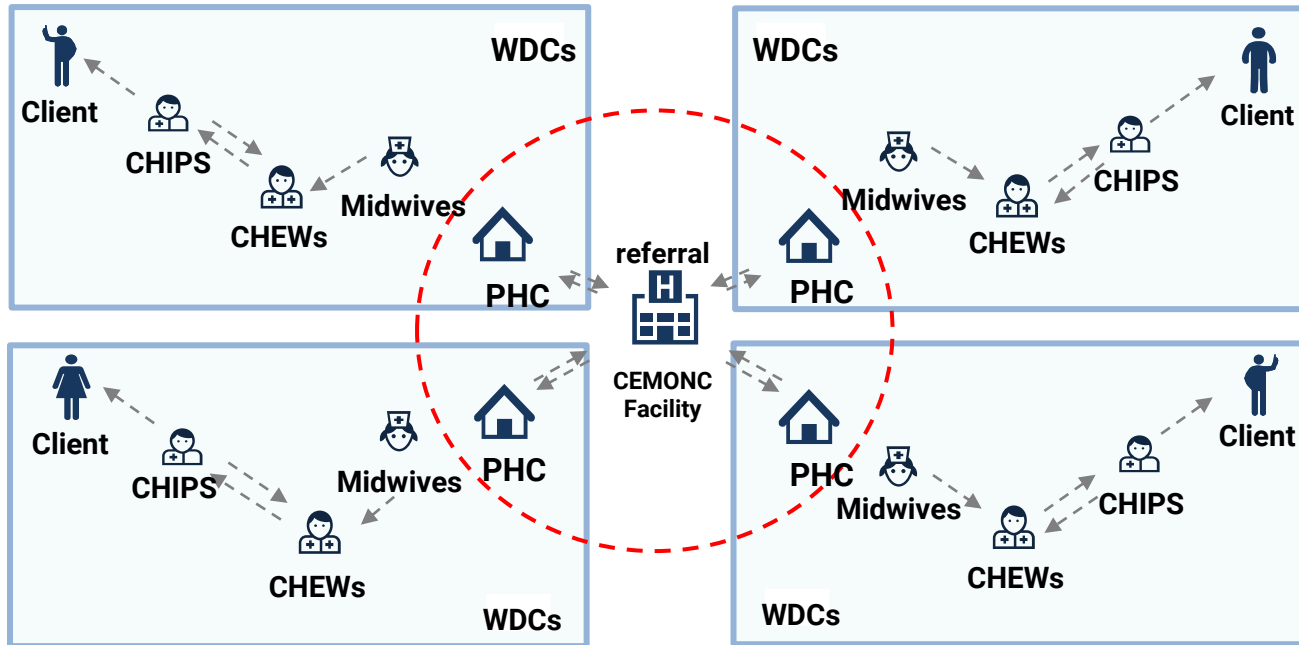
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Leveraging the instrument of **DECENTRALIZED FACILITY FINANCING**, the program will aim to improve the service readiness of 17,000 PHCs and 774 secondary facilities to deliver Universal Primary Healthcare {to be delivered free to beneficiaries}



The DFF package would include the following services below, targeting about 7m pregnancies and over 6m new births annually:

- ANC
- Child-Birth
- PNC
- FP
- IMCI*
- Nutrition
- NCD–screening {HYPERTENSION & DIABETES MELLITUS }

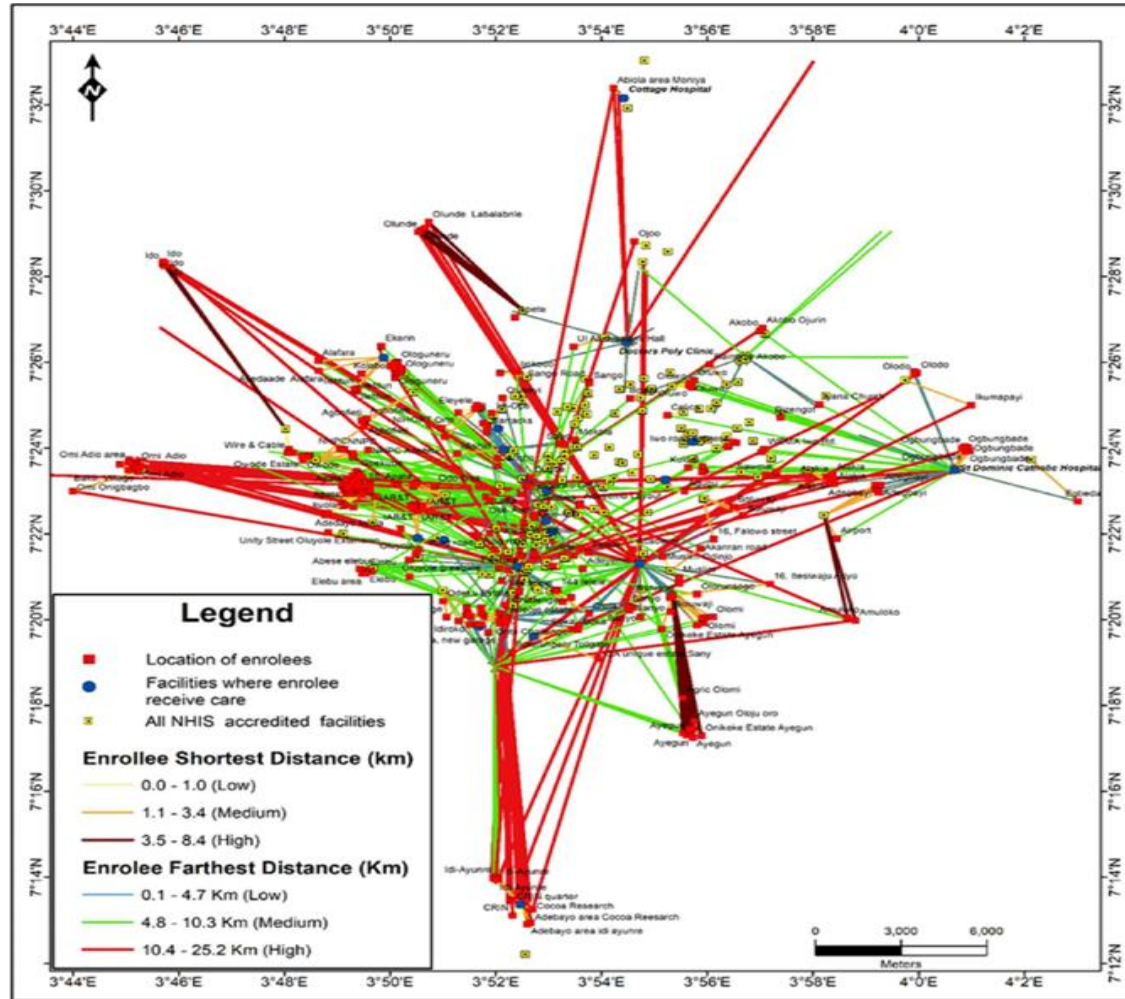
Success factors:

- Effective community Demand Creation interventions
- Strong accountability/governance structure and processes
- Quality data (routine service delivery and financial data)

FEATURES

1. Aspire to expand to at least 2 PHC per ward BEmONC ready/certified; at least 1 higher level facility or CEmONC using the hub and spoke model. Expansion will be driven by evidence, with locations of higher needs prioritized
2. The LGAs will be categorized into three tiers (lowest to highest) and equity calculations will be reflected in funds transferred to the PHCs
3. Investment fund for facility upgrade to meet minimum requirements for a functional PHC
4. Payment of bonuses to facilities for meeting periodic quality of care targets
5. Transportation for pregnant women
6. Health worker's incentives (additional payment to workers in rural/hard-to-reach communities)
7. Operations funds, made up of a fixed component and another that depends on the number of clients served. Ops funds will be increased to support facilities to engage healthcare workers on a need basis and buy essential commodities for the provision of a free package of healthcare services.
8. Funding to improve routine HMIS at facility level and TA support to facilities

Geospatial mapping will inform the additional public PHC, and also future expansion paths by subnational governments



- 1. ACCESS:** Healthcare facilities usually clustered around urban areas, while rural areas had few and scattered health facilities. The further away one travels, the sparser healthcare facilities become.
- 2. EQUITY:** Urban areas also have better availability of infrastructure, such as better road networks, as well as population density.
- 3. Stratify facilities** based on geospatial and poverty data.

The DFF arm reflects equity considerations

We recognize:

- Some facilities are in hard-to-reach locations
- Do not attract the right healthcare workers
- Coverage has been low
- Disease burden is higher
- Poverty is higher

To address this:

- Investment funds (one-off payment) will not be equal. Hard-to-reach locations with poor facilities will receive more funds.
- Transportation disbursement will use the ratio of 4:3:2
- Incentives will be paid to healthcare workers working in rural and hard-to-reach locations
- Operational funds will be a function of the number of persons reached. The table below summarizes the three categories and the possible amount each will receive for year 1.

S/N	Cost Item	Tier 1	Tier 2	Tier 3
1	Investment Fund	15,000,000.0	11,250,000.0	7,500,000.0
2	Transportation	4,800,000.0	3,600,000.0	2,400,000.0
3	Operations	4,800,000.0	4,800,000.0	4,800,000.0
4	Health Care workers incentives	1,080,000.0	540,000.0	-
	Total	25,680,000.0	20,190,000.0	14,700,000.0

Explainer for the figures in the table are estimates and for illustration purposes only

INVESTMENT FUND:

This is a one-off fund to upgrade the facilities. *Actual will be based on the gaps identified when facility gap analysis has been conducted.* Estimates are based on IMPACT project experience, which aims to make facilities functional and not necessarily level 2 PHC.

TRANSPORTATION:

Estimates informed based on what NEMSA currently pays (N2,500 per capita). Tier 1 will however get more, and facilities that serve more clients will also get more.

OPERATIONS FUND:

The estimate is based on what some facilities shared as the cost of running a PHC quarterly. The cost has two components: Fixed and variable cost. The fixed is about N250,000. *A more robust and country costing may to be conducted before commencement.*

BONUSES TO HEALTHCARE WORKERS in rural/hard-to-reach communities: This is estimated at N30,000 per HCW in a rural location.

DFF: ADDRESSING LEAKAGES AT THE FRONTLINES

The risk of increasing funds to facilities is corruption, LGAs, SPHCDA

Increasing Accountability in BHCPF 2.0

1. **WDCs:** Leverage their important supervisory role over the PHC system for accountability.
2. **Financial autonomy with performance incentive:** Linking performance with incentives to pay staff bonuses and make facility improvements.
3. **TA (PFMOs):** Hands-on support to PHCs on basic bookkeeping, capacity building of LGA finance focal persons and auditing of the fund, and sufficiency of supportive supervision by LGHA and State
4. **Independent Verification Arrangements & Leveraging technology to record and validate client data and PHC management**
5. **Use CSOs/NGOs:** Collaboration with entities such as BudgIT/ONE campaign have used technology tools such as social media and easy-to-understand infographics to explain the Nigerian budget to ordinary citizens, expose gaps in the data, and push the three tiers of government to provide more information about public finances and spending, including in the health sector.

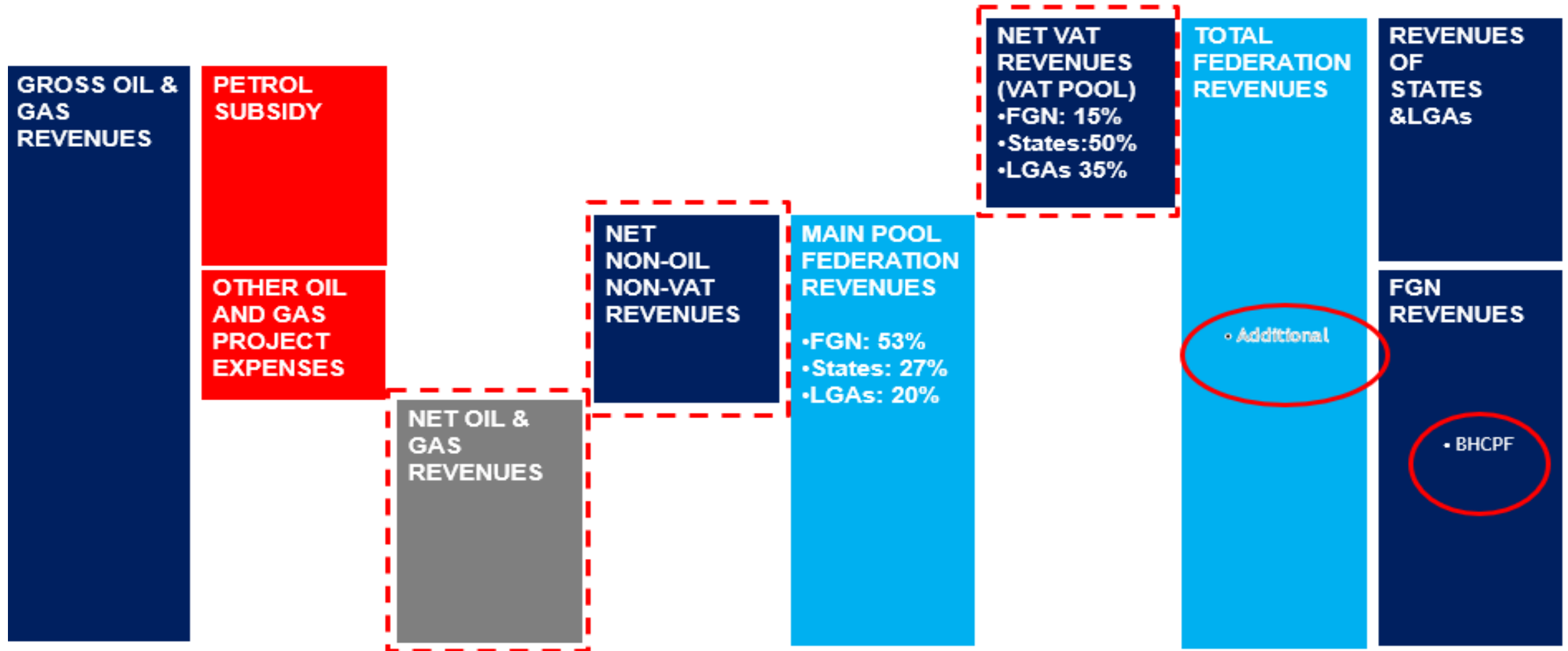
>>> REWARDS AND SANCTIONS as central to shifting institutional behaviour<<<

THE NHIA ACT OF 2022 PROVIDES AN OPPORTUNITY FOR PROGRESS, FURTHER PRIORITIZING THE POOR AND VULNERABLE

Consolidate existing funds to implement a more impactful arm.
FMOH implements the CHF. NHIA implements other extra budgetary initiatives all could be implemented under the SIF

A 640	2022 No. 17	National Health Insurance Authority Act, 2022
Establishment and sources of the Vulnerable Group Fund.	25.—	(1) There is established the Vulnerable Group Fund. (2) The sources for the Vulnerable Group Fund include— (a) Basic Health Care Provision Fund to the Authority ; (b) health insurance levy ; (c) Special Intervention Fund allocated by the Government and appropriated to the Vulnerable Group Fund ; (d) money that accrues to the Vulnerable Group Fund from investments made by the Council ; and (e) grants, donations, gifts and any other voluntary contribution made to the Vulnerable Group Fund. (3) The Council may by regulations review the sources of funding to keep pace with developments in the health insurance industry.

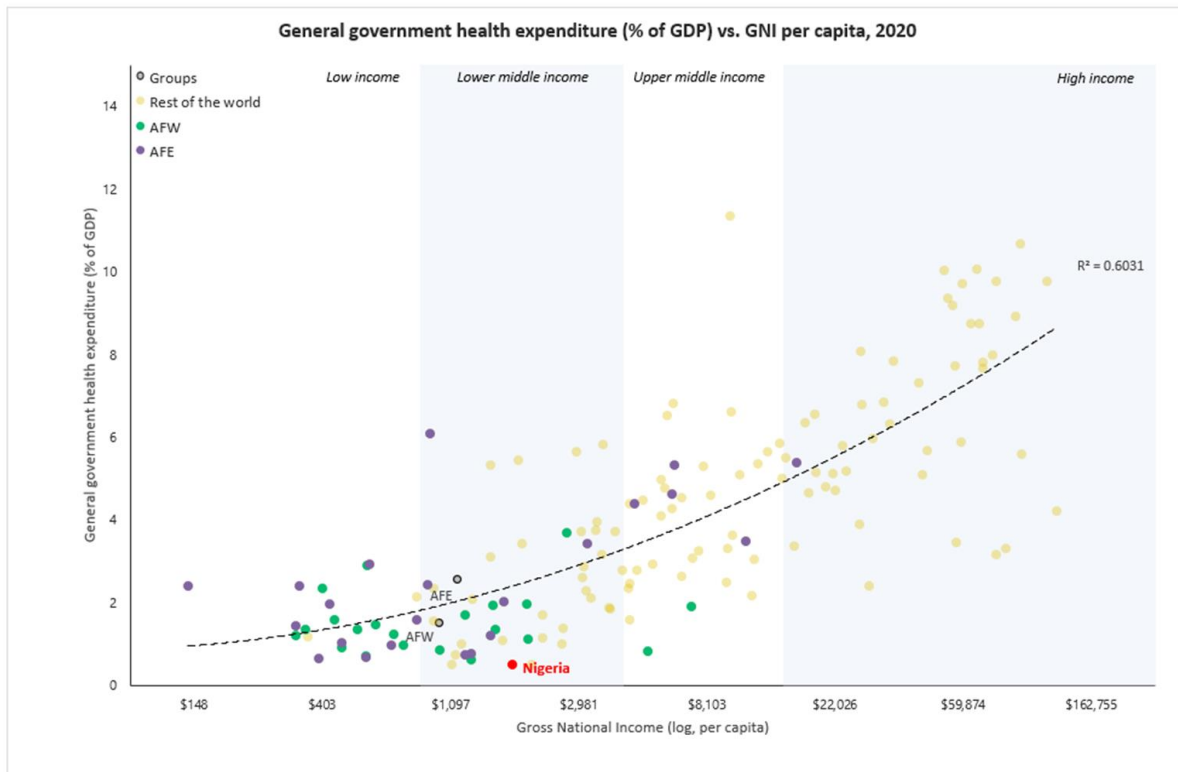
CRF FROM FG OWN REVENUES IS LIMITED



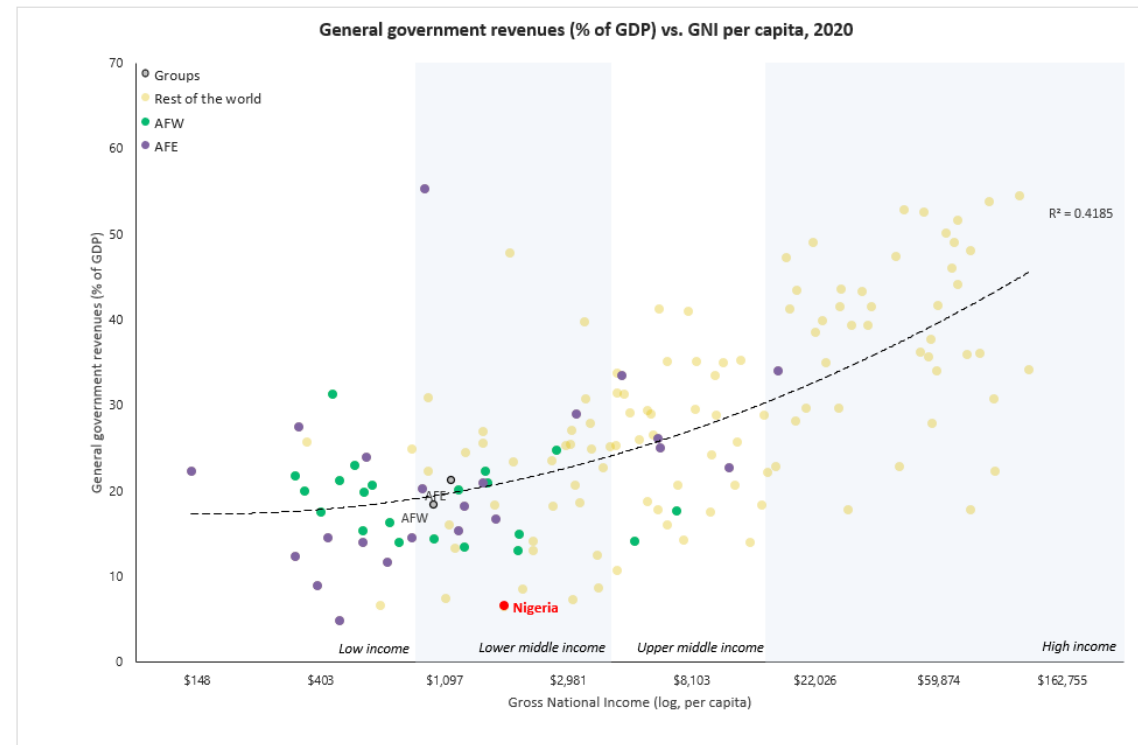
Source: OAGF.

AND NIGERIA'S GOVERNMENT HEALTH SPENDING AS % OF GDP THE LOWEST IN THE WORLD (0.5%) IS UNLIKELY TO EXCEED 1% IN NEXT 3 YEARS, AS REVENUE-TO-GDP ALSO AMONG LOWEST (7%)

Government health spending (% of GDP)



Government revenue (% of GDP)



NIGERIA NEEDS TO MAKE BOLD DECISIONS ON SCALE-UP OF NHI ON ITS PATHWAY TO UHC

SPRINT /MDR/

SCENARIO	BENEFIT PACKAGE	PROVIDER	PPM
SCENARIO FOUR	UMHC & CHILD ADMISSIONS + RTAS + CHF	PUBLIC PRIVATE	CASE BASED*
SCENARIO THREE	UMHC & CHILD ADMISSIONS + SELECTED NCDS	PUBLIC PRIVATE	CASE BASED
SCENARIO TWO	UMHC & CHILD ADMISSIONS	PUBLIC PRIVATE	CASE BASED
SCENARIO ONE	UNIVERSAL MATERNAL HEALTHCARE {UMHC}	PUBLIC PRIVATE	CASE BASED

NIGERIA HEALTH FACILITY DELIVERY (15 -24YRS) IS VERY LOW, WORSE IN RURAL AREAS AND NE, COMPOUNDED IN AREAS WITH LOW TRANSPORT AVAILABILITY AND AMONGST HIGHRISK PREGNANCIES

OVERALL FACILITY DELIVERY	33.72% {39% OVERALL}	
HEALTH FACILITY DELIVERY	SOUTHEAST ~ 77%	NORTHEAST ~ 16%
ANC VISITS	AT LEAST 4 ~ 52%	NO ANC ~ 28%
PLACE OF RESIDENCE	URBAN ~ 54%	RURAL ~ 26%
COMMUNITY TRANSPORT	HIGH ~ 60%	LOW ~ 20%
NUMBER OF CHILDREN BORN	1 ~ 42%	4-7 ~ 23%

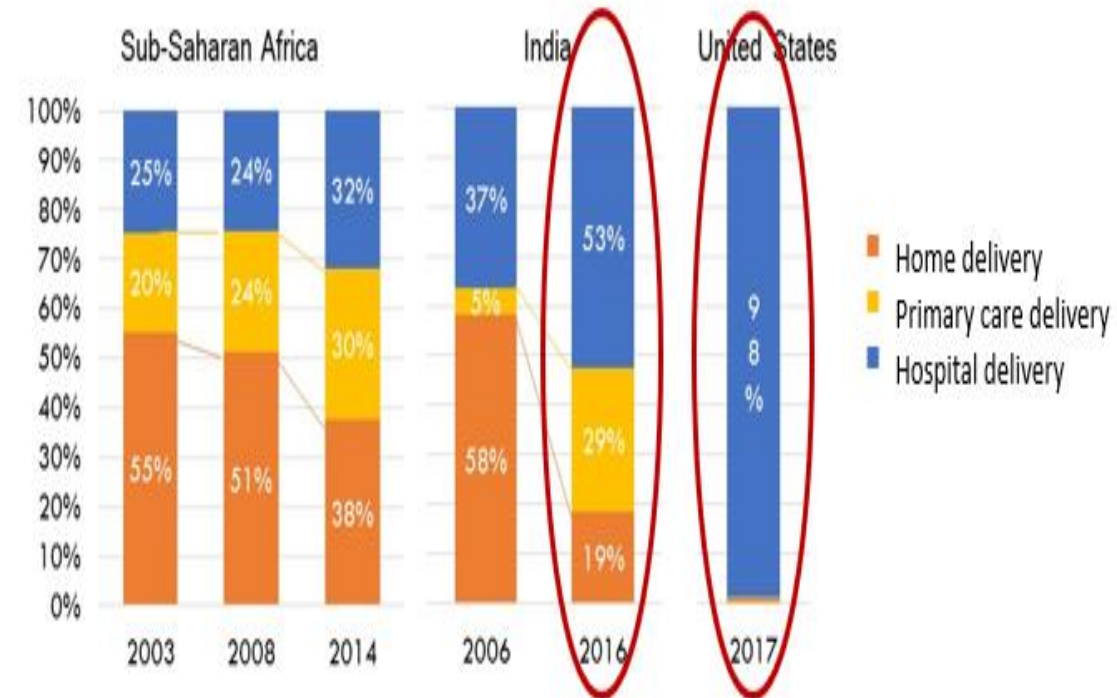
SERVICE READINESS IMPROVEMENTS WILL BE COMPLEMENTED BY FULL ACTIVATION OF THE VULNERABLE GROUP FUND FOR UNIVERSAL MATERNAL CARE AND CHILD HOSPITAL ADMISSIONS

SCENARIO ONE

UNIVERSAL MATERNAL HEALTHCARE purchased through CEmONC facilities:

- Provides financial protection to one of the most vulnerable populations
- Enrollees are self-identifying mitigating potential fraud and short-term challenges with national identity systems
- Shifting deliveries to higher level facilities which are better resourced with strong referral and can guarantee both comprehensive emergency obstetric care, as well as emergency newborn care quality
- Shift away from PHCs could lead to decreased case load, improved access and quality for antenatal and postnatal care and other services delivered at PHC level
- Hub- and spoke- approach will allow for full continuum of care from community-based interventions - education and counselling, other demand side interventions e.g. transport vouchers, CCT to at PHC level (ANC, PNC, FP) to higher level facilities

~30% of babies in LMICs are born at primary care clinics compared to 2% of babies in HIC (Gage 2019)



NIGERIA ACCOUNTS FOR A QUARTER OF ALL NEONATAL AND CHILD DEATHS IN SSA AND IS NOW THE COUNTRY WITH THE HIGHEST NUMBER OF UNDER-FIVE DEATHS IN THE WORLD

SCENARIO TWO

Based on the 2003 and 2018 Nigeria Demographic and Health Survey (NDHS) findings, Nigeria's under-five mortality rate declined over the 15 years from 201 per 1000 live births to 132 per 1000 live births.

However, the neonatal mortality rate only slightly declined, from 48 per 1000 live births in 2003 to 39 per 1000 live births in 2018.

The **North West zone has the highest under-five mortality rate at 187 per 1000 live births**, and the South West zone is lowest, at 62 per 1000 live births.

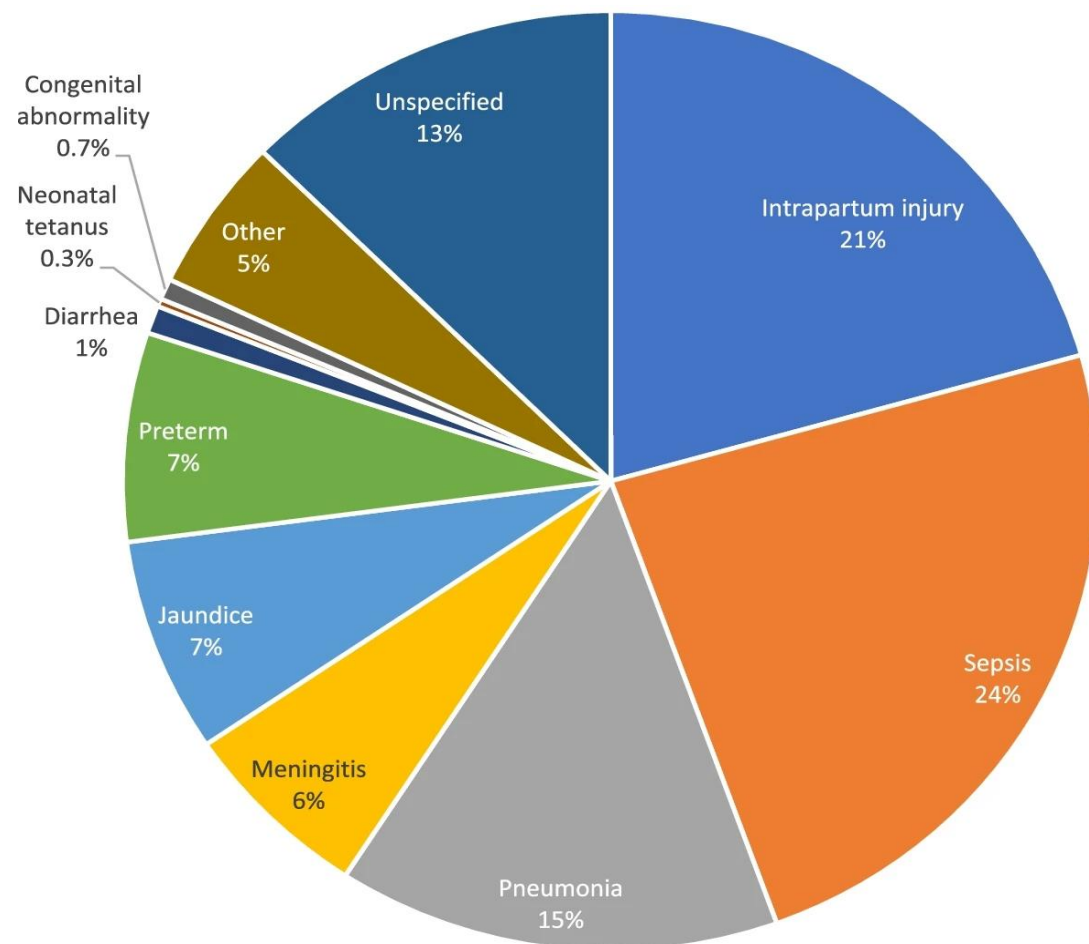
The **North West and North East** zones together accounted for 65 percent and 72 percent of the deaths in the neonates and children aged 1–59 months deaths.

DEMOGRAPHIC CHARACTERISTICS OF U5 DEATHS

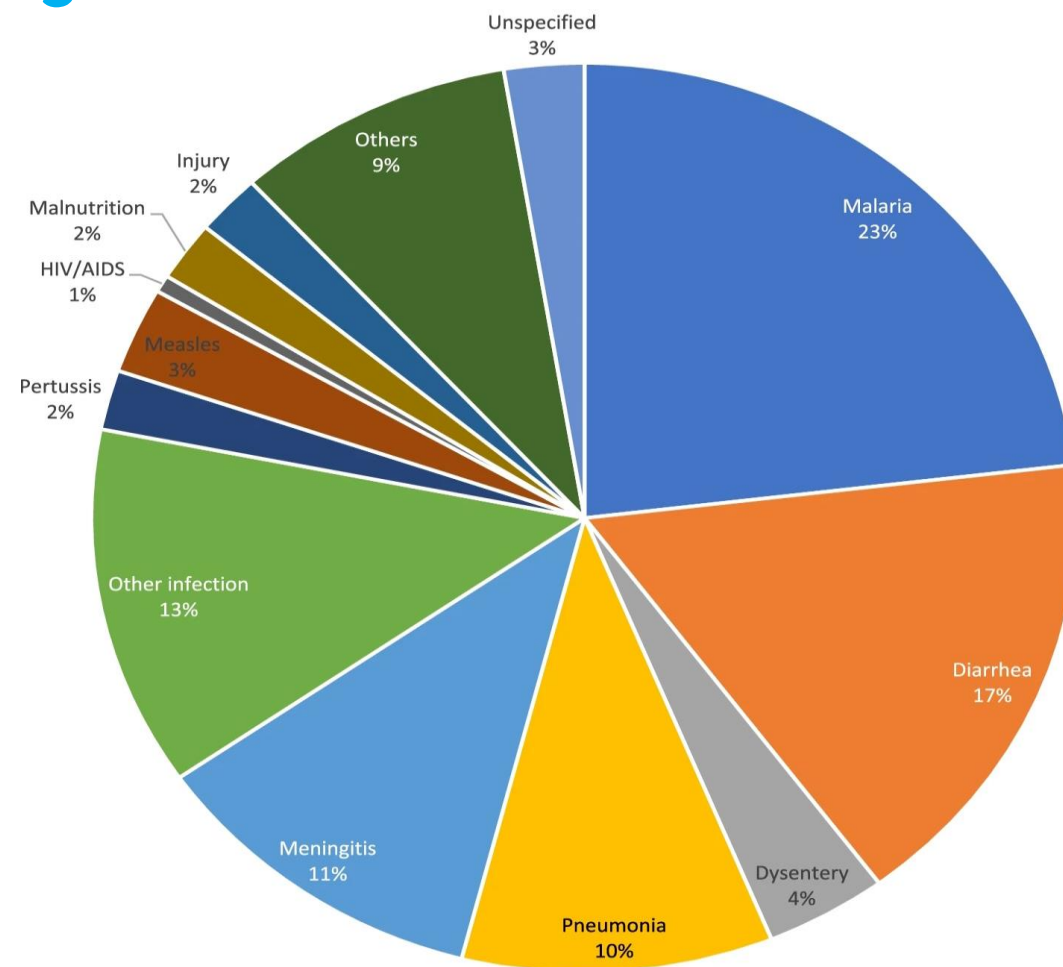
ZONE	% NN	% U5
NW	40	50
NE	26	23
NC	15	14
SW	5	3
SE	8	7
SS	7	5

THE NW AND NE SHOULD BE PRIORTIZED FOR SCENARIO TWO

Cause-specific neonatal mortality



Main causes of deaths in children aged 1–59 months



At the current coverage levels, a tier of Community Based Health Services could significantly boost coverage and deepen promotive, preventive and simple curative measures as a complement to the Basic Package of Health Services delivered at facility level

Create Demand for PHC Services

Improve health seeking behaviour of individuals and households

1. Conduct home visits to clients
2. Encourage clients to seek care (for ANC, sick school aged-children, sick adolescents, sick adult males & females, elderly) at PHCs
3. Mobilize communities for outreaches and campaign activities

Social Behaviour Change Communication

Interpersonal communication & counselling:

1. Pregnant women to attend ANC services
2. Improve dietary (MIYCN), adolescent nutrition and care practices
3. Encourage caregivers to take children under-5 for vaccination
4. Provide counselling and screening services for NCDs
5. Birth spacing

Public Health and Social Measures

1. Seasonal Malaria Chemoprophylaxis (Mass distribution of ACTs)
2. Mass distribution of LLINs
3. Improve WASH practices in households (sanitation, hygiene, food prep; Menstrual Hygiene Management)
3. Screening for and referral of suspected TB cases
4. Boost infection prevention and control measures
5. Community surveillance and notification

Preventive and Simple Curative MNCH services

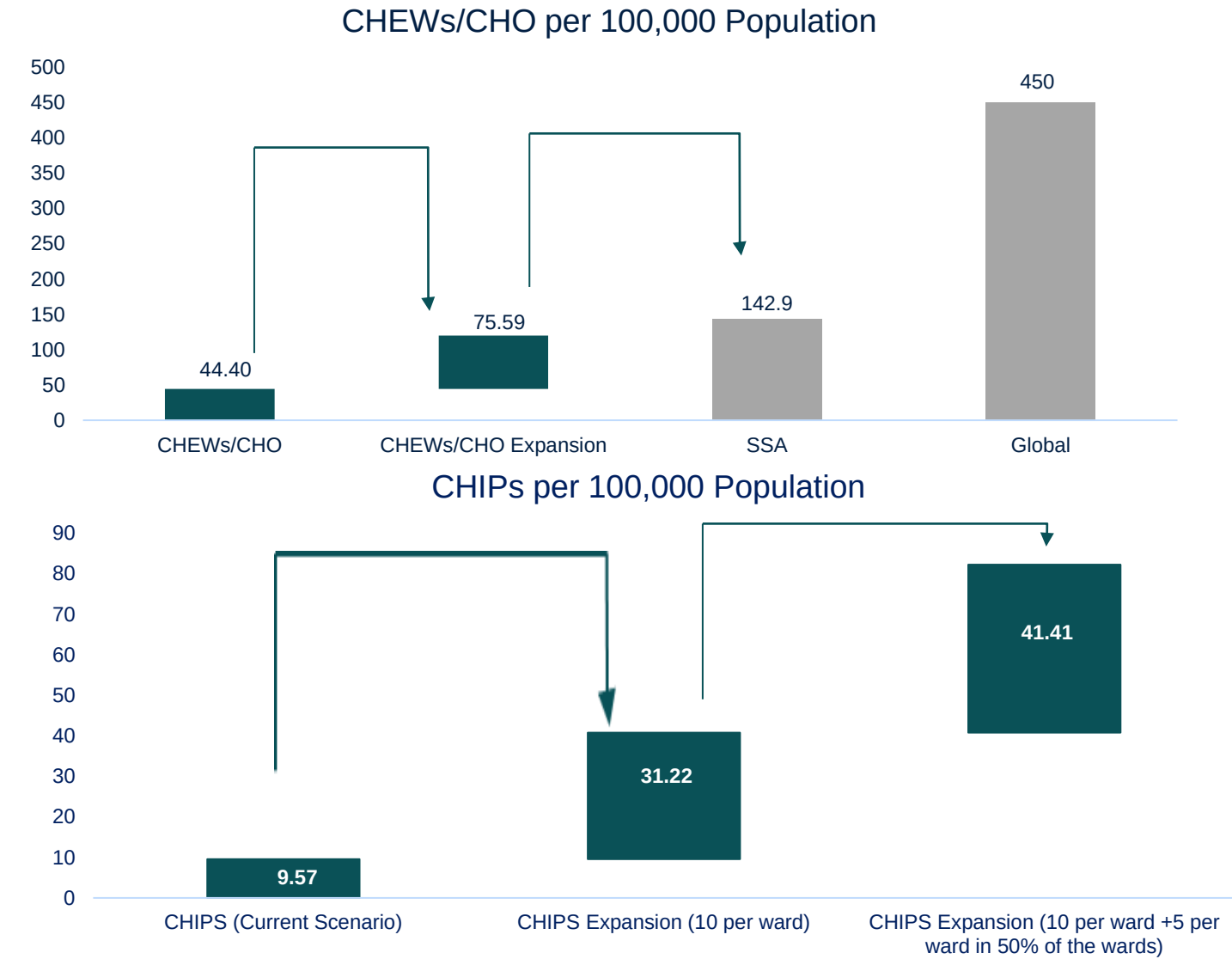
1. Use ICCM to treat basic cases of Malaria, Diarrhoea, fast breathing in children under-5
2. Administration of Zn/ORS, Albendazole to under-5 children
3. Administration of MMS to pregnant women & MNP to children under-5; Detection of malnutrition and referral
4. Short-acting contraceptives (Condoms, Mini pills, Combined Oral Contraceptive pills)
5. Administration of Chlorhexidine for cord care to new-borns
6. Administration of misoprostol to pregnant women during unavoidable home delivery to prevent PPH
7. First aid and trauma management

Referral & Follow-up Visits

1. Identify clients requiring care in health facilities (NCDs, TB, HIV, Hepatitis, FP/LARCS, etc.) and refer
2. Follow-up on clients receiving care in facilities to ensure they are improving otherwise encourage them to return to health facility for additional care
3. Refer community members as appropriate to receive care for NCDs, Mental health
- 4., and community-based treatment of cases with directly observed therapy (DOT)

Facility based services will be complemented by a phased and targeted approach to boosting demand creation, promotive, preventive and simple curative services at the frontlines

Minding the gap at frontlines



- CLARIFY ANATOMY OF FRONTLINE WORKFORCE**
- ⇒ Option 1: Retrain all existing Community Health Practitioners (CHPs)
 - ⇒ Option 2: Boost quantum of CHPs at the frontlines
 - ⇒ 2a: Absorption of existing CHPs (CHEWS)
 - ⇒ 2b: Strengthen CHIPS program as a **COMPLEMENT not SUBSTITUTE** to CHEWS (rationalize, standardize and certify competencies, upskill, improve remuneration, supervision, etc.) + expand the scope of work as a complement to other facility-based CHW PLUS mop-up existing unemployed CHWs
 - ⇒ Option 3: Alternative state preference: Engage private entities for service provision
- **Investment in production of Midwives and CHPs will be done as a parallel track and across board to ensure availability of appropriate HCW at facilities**

The options take into cognizance wide variability in HRH availability and distribution, and geographical access across states

KEY CONSIDERATIONS FOR STATE FLEXIBILITIES

- | | |
|--|---|
| <ol style="list-style-type: none">1. States that can demonstrate sufficient numbers and distribution of CHW2. States that can demonstrate sufficient numbers and distribution of CHPs but has significant populations in hard-to-reach areas3. States that cannot demonstrate sufficient numbers and distribution but can prove sufficient numbers of CHEWS in circulation additional CHW4. States that cannot demonstrate sufficient numbers and distribution and cannot prove sufficient numbers of CHEWS in circulation5. All states need to pursue concrete CHP production and sustainable financing plan | <ul style="list-style-type: none">⇒ Retrain only⇒ Contracting out⇒ Recruit and retrain additional CHEWS which may be complemented by CHIPS⇒ Enroll, upskill CHIPS to complement⇒ Link to states incentive framework and fiscal transfers and federal-state partnership MoUs |
|--|---|

For states operationalizing a rationalization of CHIPS

Skill set/competencies

- Skilled health workers are those who have had structured training for a period of time (usually at least 1 – 2 years).
- CHIPS will be upskilled by receiving 3 – 6 months training in the first instance with incremental periodic training over 1-2 years. *This does not make them equivalent to CHEWS*

Training and Career Advancement

- E-learning platforms will be created to serve as flexible learning opportunity for CHIPS Agents.
- Time bound competency-based tests will be carried out at certain intervals to ascertain quality of service each CHIPS Agent is providing
- After minimum training requirements achieved, facilitate linkages for career advancement

Recruitment and deployment

- Maintain minimum qualification and improve system and standards for recruitment
- Sustained financing for remuneration through subnational commitment as “match” to BHCPF allocation
- Clear scope of work/ job description that effectively links community to facility-based services

Remuneration

- The stipend will be increased to NGN35,000 in keeping with the economic realities and motivate them to do the desired scope of work
- Other state recognition systems [based on competency tests]; put more prestige into the system

Data management

- Need to fast track activation of Community-Based Health Information Management System (CBHMIS)
- Transition CHW personnel to electronic data reporting system

Moving from strictly structural quality measures to a combination of structure, process, and outcome quality measures

WE PROPOSE A COMPREHENSIVE APPROACH FOR OPERATIONALIZING QUALITY IMPROVEMENT FOR IMPACT

Structure → Process → Outcome



Structure

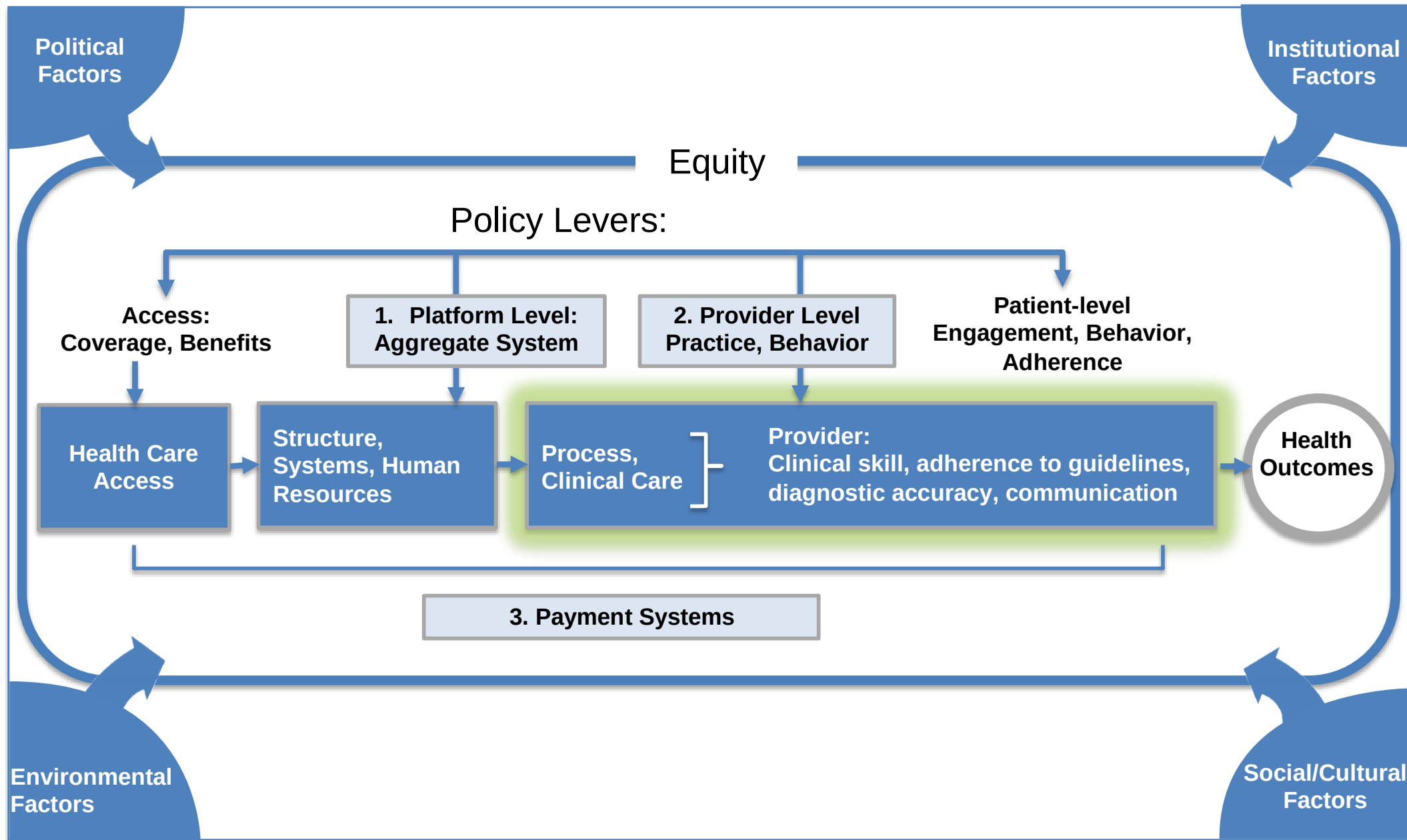
Physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods.

Process

Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations of healthcare visits.

Outcomes

Includes changes to health status, behavior, or knowledge as well as patient satisfaction and health-related quality of life.



Shift from **QUALITY OF CARE** broad focus on infrastructure to also include sharp focus on competency-based improvements in content/process of care



Structure

Physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods.



Process

Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations of healthcare visits.



Outcomes

Includes changes to health status, behavior, or knowledge as well as patient satisfaction and health-related quality of life.



1. Patient Exit Interviews

- Self-reported status; response bias; anchoring bias



2. Formal Testing-Licensing

- Single best answer questions; gaming



3. Claims/Administrative Data

- Non-clinical
- Patient level variation



4. Direct Observation

- Hawthorne effect



5. Medical Chart Abstraction

- The current standard, inaccurate and time consuming



6. Standardized Patient

- The gold standard but hard to reproduce



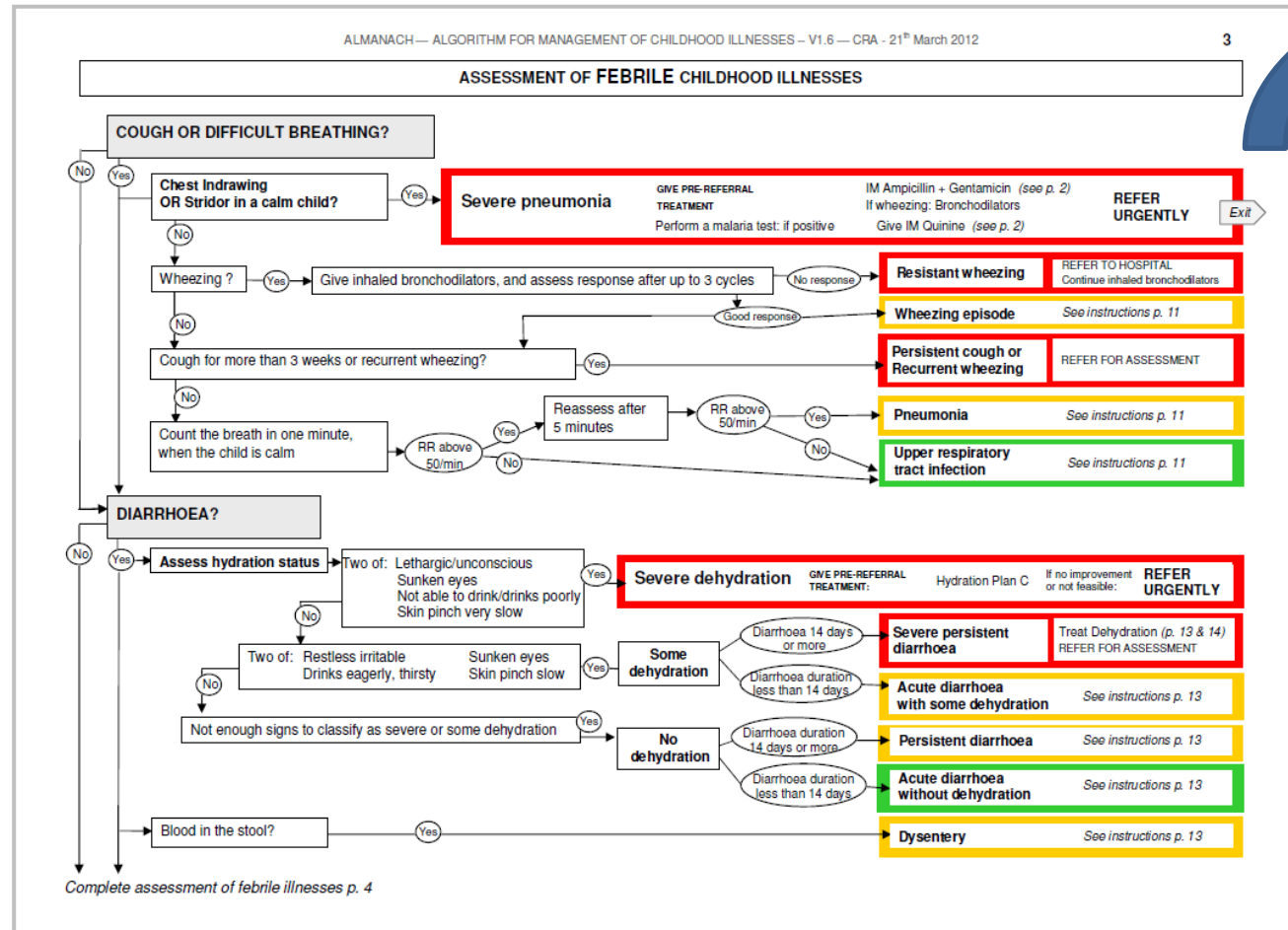
7. Simulations, vignettes

- Validated, lead to change; need to be used more



LEVERAGING EXISTING TOOLS TO IMPROVE QOC SUCH AS THE ALMANACH IN ADAMAWA

From paper to Android:



SUMMARY OF QOC MEASURES IN BHCPF2.0

STRUCTURE	PROCESS	OUTCOMES	DIGITAL TRANSFORMATION (LEVERAGING TECHNOLOGY FOR QOC):
NORMS & STANDARDS: BEMONC/CEMONC CERTIFICATION	1. Simulations/ 2. vignettes. 3. Decision making tools such as ALMANACH. 4. SAFE CARE methodology. 5. QOC based on case-based payments.	Patient satisfaction and patient experience surveys.	(Leveraging technology for QOC): Harmonization of all digital systems

HARMONIZED TA FOR BHCPF STATE SUPPORT

STANDARDIZED AND QUALITY ASSURED TA

PROGRAM OF WORK AGREED UNIVERSALLY AND WILL BE
DEMAND DRIVEN.

NO MORE ORPHAN STATES

KNOWLEDGE AND LEARNING DONE IN A COHERENT AND
ORGANIZED MANNER.

TRANSITION TO BHCPF 2.0 – DFF

BHCPF

1. **Allocation of Operational funds:** *Equal across all facilities.*
2. **Number of PHC facilities/ward:** *One*
3. **Facility assessment:** *Take off assessment Not linked to a standard criteria..*
4. **Package of services:** *Lack of clarity*
5. **Quality of care:** *Defined not enforced. Public PHCs are empaneled by NHIA regardless of available infrastructure.*
6. **Quantum of operational grants:** *N300K per quarter.*
7. **TA:** *Varying technical capacities to deliver on SP functions ~ reimbursements, quality framework*

BHCPF 2.0

1. **Allocation of Operational funds:** *Based on tier classification. Disadvantaged PHCs receives more.*
2. **Number of PHC facilities/ward:** *Two. Second facility chosen based on burden of disease and need.*
3. **Facility assessment:** *Facility must be either **BEMONC OR CEMONC**.*
4. **Package of services:** *UNIVERSAL BASIC PACKAGE OF SERVICES INCLUDING DELIVERIES*
5. **Quality of care:** *Performance incentives linked to quality.*
6. **Quantum of operational grants:** *N900K per quarter.*
7. **Referral network:** *Linkage with BEMONC and EMS gateway.*
8. **Facility upgrade:** *One-off investment (2 PHCs per ward and 1 CEMONC Facility per LGA)*
9. **ACCOUNTABILITY:**
 - A. **Part of the incentive framework will also include element of performance (IVA).**
 - B. *Provider reimbursements based on verifiable outcomes.*
 - C. *Strengthened Fiduciary framework*
10. **RESULTS FRAMEWORK:**
11. **TA:** *Harmonized TA program.*
12. *Leverage the CHIPS/CHEW to **generate demand, provide promotive, preventive and simple curative services***

TRANSITION TO BHCPF 2.0 {VGF}

BHCPF

1. **Beneficiary identification:** Different states are using different beneficiary identification and enrollment systems.
2. **Unclear Health Benefit package:** Lack of clarity on what the BMPHS is following the OM/guideline revision.
3. **Multiple Benefit packages:** BHCPF has introduced another benefit package into a crowded ecosystem of BP.
4. **Unclear Fiscal Sustainability Plan:** Are you enrolling the same beneficiaries or adding new beneficiaries ?
5. **Reimbursements** ~ FFS + CAPITATION
6. **TA:** Varying technical capacities to deliver on SP functions ~ reimbursements, quality framework

BHCPF 2.0

1. **No beneficiary identification.** Self-selection.
2. **Equity considerations:** Mostly the PVH will use.
3. **Empanelment with a Strong focus on Quality.**
 - A. **Empanelment based on Facility classification** ~ BEMONC/CEMONC
 - B. **Referral network** ~ tight linkage with BEMONC and EMS gateway
4. **Reimbursement:** *CASE BASED with focus on Quality.*
5. **ACCOUNTABILITY:**
 - A. Part of the incentive framework will also include element of performance (IVA).
 - B. Provider reimbursements based on verifiable outcomes.
 - C. Strengthened Fiduciary framework
6. **RESULTS FRAMEWORK:**
7. **TA:** Harmonized TA program.
8. *Leverage the CHIPS/CHEW to **generate demand.***

CBHS, DFF AND VGF PROVIDING THE RATIONALE FOR PROGRESS TOWARDS UHC

funding source

benefits

private

uncovered services (noncontracted)

private, out of pocket

copayment

social fund payroll tax
republican budget
transfers for "insured"

fully exempt

partially exempt

supplemental benefits: reduced
copayment, outpatient drugs

"uninsured"

budget: local
governments buy
universal coverage
for their populations

basic benefits package: free primary care from enrolled
family group practice, referral care with copayment, from
which defined population groups are fully or partially exempt

Mandatory Health Insurance Fund

service coverage (depth)

service coverage (depth)

0%

population coverage (breadth)

100%

03

Enabling Systems for Improved Outcomes

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

Introduction

A Vision for Nigeria's Health Sector
Framework for Nigeria Health Sector Renewal

Financing and Organization of Services

Decentralized Facility Financing
Operationalizing a Vulnerable Group Fund
Strengthening Community Based Health Services
Improving Quality of Care
Harmonized TA support for BHCPF

Enabling Systems for Improved Outcomes

Improving Commodity Security
National Emergency Medical Service and Ambulance Scheme
Digital in Health

Health Security

Governance, Financing and Accountability

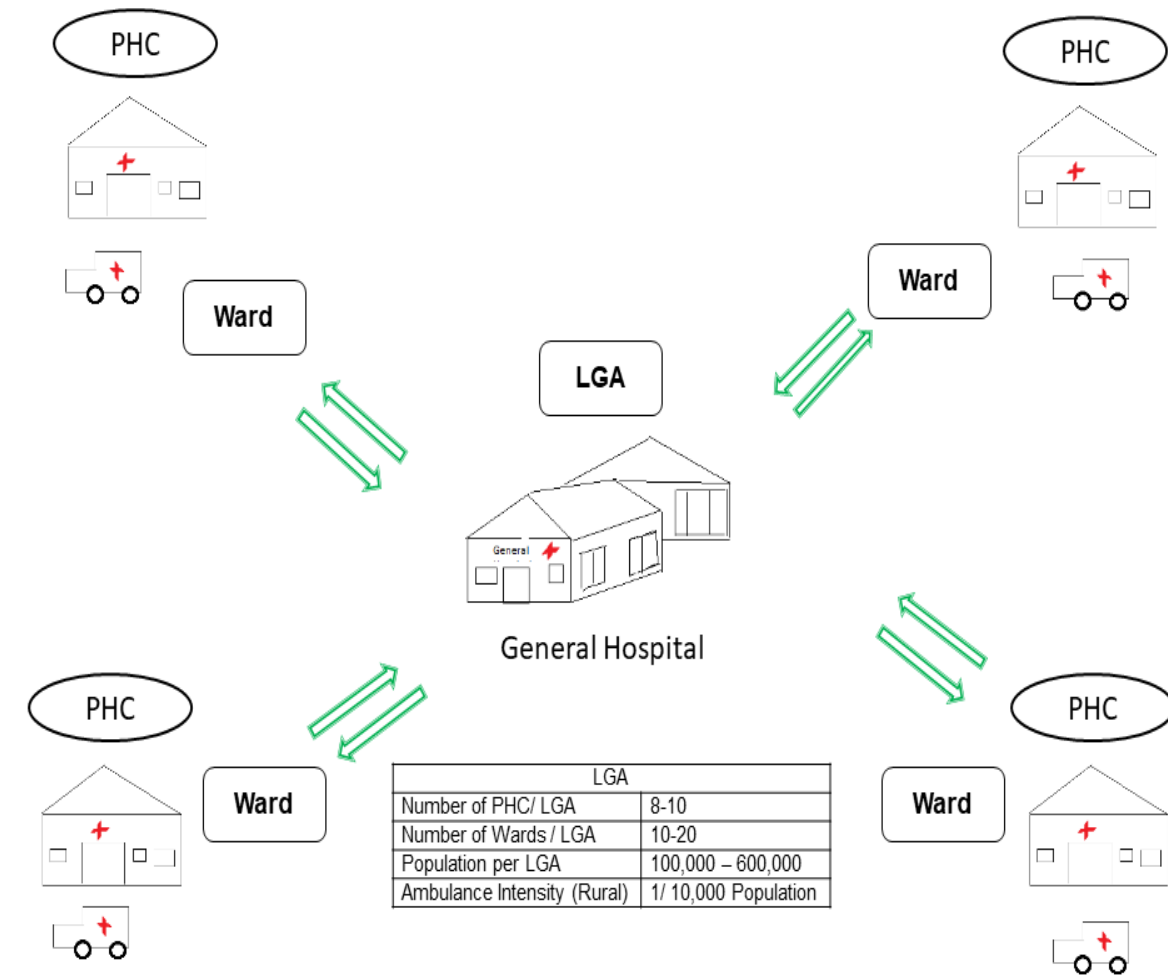
Defragmenting Sector Financing for Improved Efficiency
Federal-State Partnership for Improved Ownership and Accountability
Citizens Engagement and Social Accountability

The National Emergency and Ambulance Services Scheme will be leveraged to address the second delay in reaching health facilities for maternal care

New Rural EMS Program Arrangement Through NEMSAS working with NPHCDA

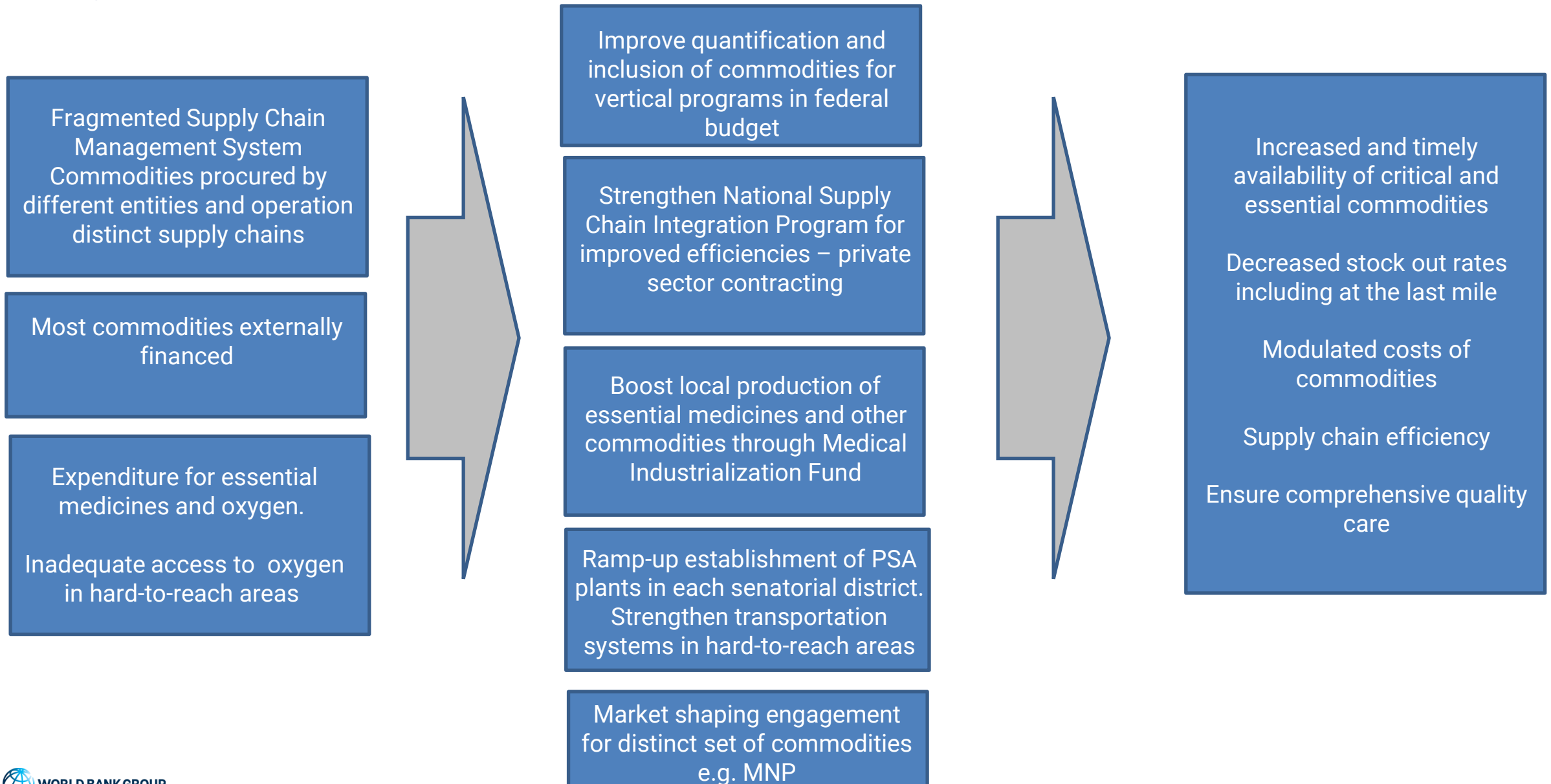
Program will deploy three service models to respond to urgent medical emergencies, all of which use 112 or mobile-cellular & call centre technology to connect local EMS operators and community members as first responders.

- 1. Local Government Area (LGA)-Wide Rural Ambulance Service Model:** Through SEMSAS, contracting a private sector operator covering a specific catchment population. Operators will deploy trained staff using BLS tricycles to deliver emergency care during patient transport to LGA hospitals.
- 2. Rural Transport for Maternity Services:** Local vehicle fleets, designated community members and commercial drivers in trained basic first aid and skilled to offer transport for maternity-related services.
- 3. Decentralized Community-based Model:** A hybrid model combining LGA-wide and maternity services outsourced to local private and commercial transport operators for maternity care based on location and catchment population.

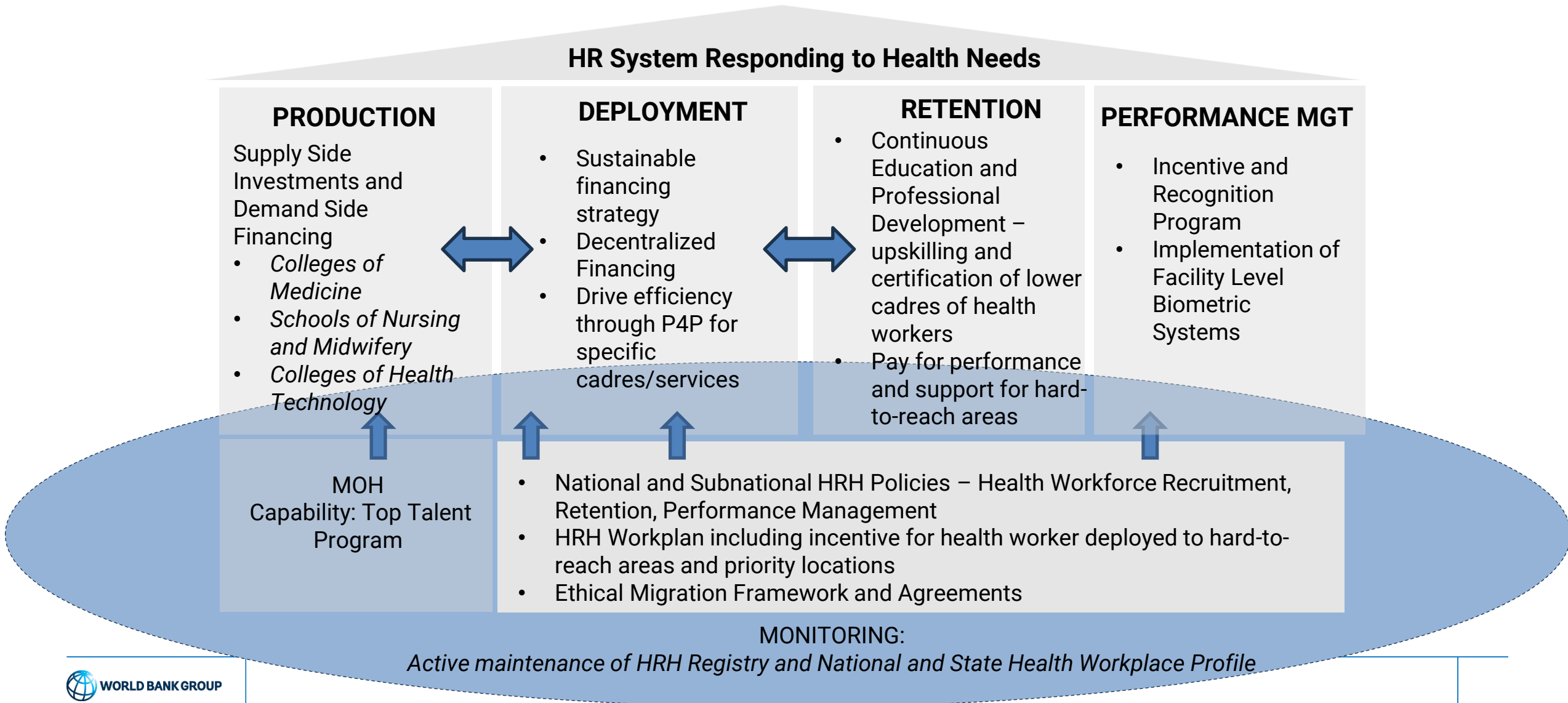


LGA= Local government Area

An integrated approach leveraging private sector engagement to ensure commodity security across all levels of care



A long-term strategic effort to boost the stock of Human Resources for Health will be employed across the HRH value chain for PHC



In the near/short term: Producing midwives for Universal Maternal Health Care

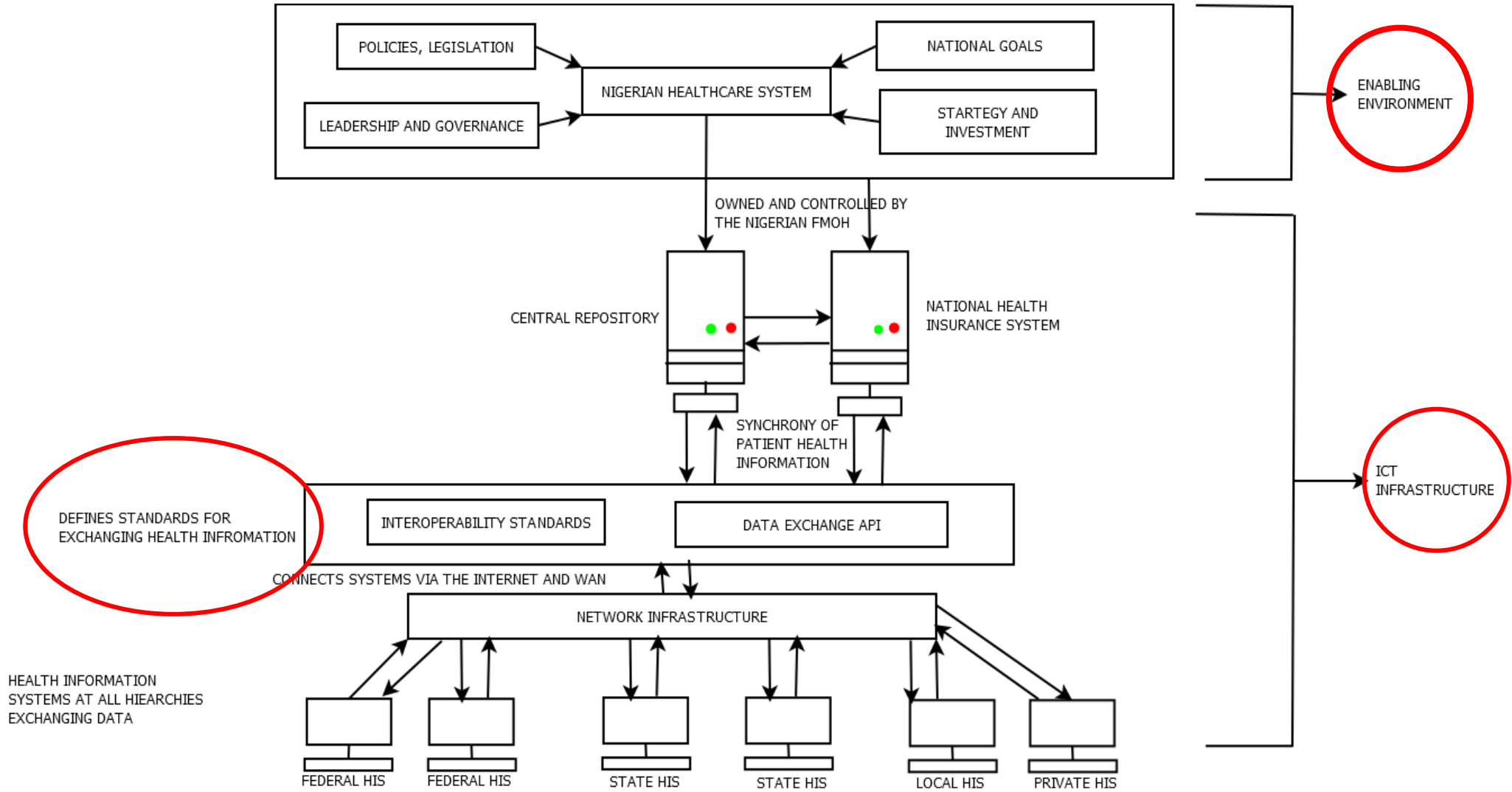
Overproduction of midwives to address immediate needs.....

MIDWIVES TRAINING FUND:

1. INFRA UPGRADE FOR PUBLIC SECTOR SCHOOLS OF NURSING
~ WITH THE AIM OF DOUBLING ADMISSIONS {ADDITIONAL HOSTELS, CLASSROOMS, TOP UP FOR TEACHING STAFF}.
2. MIDWIVES TRAINED POSTED TO CEMONC FACILITIES FOR A DEFINED PERIOD OF TIME.
3. EXPAND PRIVATE SECTOR TRAINING AS WELL, WITH SIMILAR APPROACH.

Medium/long term: Increase the production capacity of medical schools/post graduate levels

A strong Digital in Health effort can facilitate a move beyond “electronic” to real forms of Digital



04

Health Security

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

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Health Security

Governance, Financing and Accountability

- Defragmenting Sector Financing for Improved Efficiency
- Federal-State Partnership for Improved Ownership and Accountability
- Citizens Engagement and Social Accountability

Adopt a sector wide approach to ensuring adequacy of core capacities to prevent, detect and respond to public health emergencies

Early Warning Systems (Integrated Disease Surveillance and Response (IDSR):	Public Health Laboratory Network	Health Emergency Preparedness and Response:	Digital Transformation (Leveraging technology for health security):
Indicator-based surveillance • Event-based Surveillance (EBS) • Community-based surveillance (CBS) • Serological Surveillance • Genomics Surveillance • Cross-Border Surveillance • Interoperable surveillance system across One Health • Subnational strengthening	• Invest in a cohesive tiered-laboratory network of reference, zonal and subnational public health laboratories with full diagnostic network optimization and biomedical engineering support.	• Pandemic-ready Public Health Emergency Outbreak Response (“Rainy day”) Fund • National Stockpile (national & zonal) – warehouse, commodities, equipment, end-to-end information management systems • Risks Communication and Community Engagement (subnational and national) • Strengthening multi-hazard approach to preparedness and readiness for Public Health Emergencies (Multi sectoral)	(Leveraging technology for health security): SORMAS deployment (all health facilities - public and Private) Information management systems (enterprise solutions, data protection, cybersafe) Inter-operability of human, animal and environment health surveillance systems Harmonization of all digital systems

05

Governance, Financing and Accountability

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Enabling Systems for Delivery and Improved Outcomes

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Health Security

Governance, Financing and Accountability

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- Citizens Engagement and Social Accountability

Invigorate a government- and citizen-led effort to ensure social accountability and amplified citizen's voice in the delivery of health services

A socially accountable health care system for a healthy and productive population

Service Delivery Transformation to enhance patient safety, client responsiveness, client satisfaction, right to information through citizen engagement

Strategies	Establish social compact between government and citizens	Increase client power through feedback mechanisms	Patient protection and safeguarding patient experience	Enhance transparency
	➤ Increase accountability, transparency, awareness and civil engagement through ➤ Dialogue with citizens, CSOs and CBOs ➤ Creating space for civil society engagement through information sharing ➤ Engaging with media as service accelerators to amplify citizen voices ➤ Engaging citizens and CSOs in policy-making processes	➤ Leveraging community led institutions to institute a grievance redressal mechanism through the WDC structure and technology platforms ➤ <i>SQUATS</i> ➤ Enhance the functioning of Health Facility Management Committees in terms of service planning, resourcing, delivery, responsiveness and client satisfaction	➤ SERVICOM + Consumer Protection Council+ Quality Assessment body constitute <i>Quality Commission (Ombudsman)</i> to ensure patient satisfaction, optimal patience experience adherence to Patients' Bill of Rights and function as quasi-independent ombudsman	Federal, State, LGA: ➤ Public disclosure on use of resources and sector performance <i>National Health Poverty Index</i> including <i>Patients Voice Survey</i> ➤ Public disclosure of audited financial records/resource tracking Facilities: ➤ Price, package and quality score declaration and publication by health facilities

Traditional and Religious Institutions

06

Conclusion/Summary

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

07

Annex

NIGERIA HEALTH SECTOR RENEWAL INVESTMENT PROGRAM

Proposed methodology for outcome indicators and their targets

Methodology for identifying core outcomes

For each element of the mission...

- save lives
- reduce both physical and financial pain
- and produce health
- for all Nigerians

- Step 1:** Best-in-class indicators were identified based on:
- SDG¹ indicators
 - Presidential commitments for Health²
 - To fill any gaps: WHO recommended indicators and other “gold-standard” indicators
- Step 2:** Indicators were filtered by data availability and frequency of collection

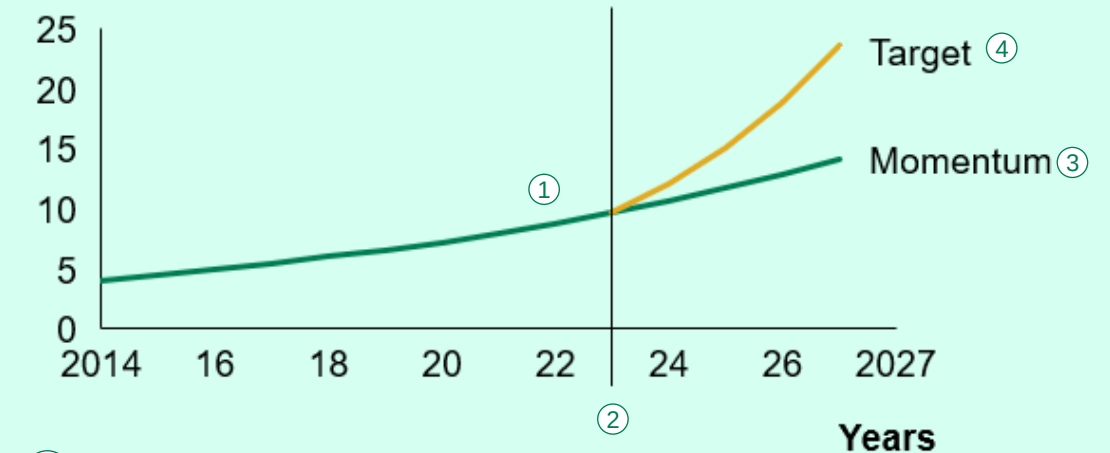
1. Sustainable Development Goals
2. Outcome indicators from Presidential commitments are included here; other indicators are included in output and input indicator list
3. Low and Middle Income Countries



Methodology for setting targets

ILLUSTRATIVE

Outcome Indicator for Nigeria



- ① 10-year historical trend
- ② Baseline performance on outcome indicator
- ③ Est. 2027 performance if historical trend continues
- ④ Est. 2027 performance if Nigeria can achieve more aspirational improvement rates seen in LMICs³ from when they were at Nigeria's starting point

Maternal mortality rate (per 100,000 live births)

Peer set of LMICs i.e., countries that were once at the same point as Nigeria today

Mortality rate, Maternal (per 100,000 live births)	Start year	End year	Start value	End value	CAGR	
Rwanda	2000	2010	1007	385.8	-9.1%	← High
Sierra Leone	2007	2017	1125	520.3	-7.4% ³	
Ethiopia	2000	2010	952.8	634.7	-4.0% ³	
Guinea-Bissau	2002	2012	1136	758.2	-4.0%	← Median
Afghanistan	2004	2014	1115	785.4	-3.4%	
Guinea	2000	2010	970.9	740.7	-2.7%	
Central African Republic	2006	2016	1116	877.4	-2.4%	← Low
Somalia	2000	2010	1097	963.2	-1.3%	
South Sudan	2008	2018	1138	1275	1.1% ²	
Lesotho	2009	2019	1096	628.9	3.5%	

1. Increase at same rate as 2009 – 2019 for Nigeria
2. Most recent data available for 2019. Numbers for 2020 to 2023 calculated based on past CAGR of -0.2%

Source: WHO, WorldBank

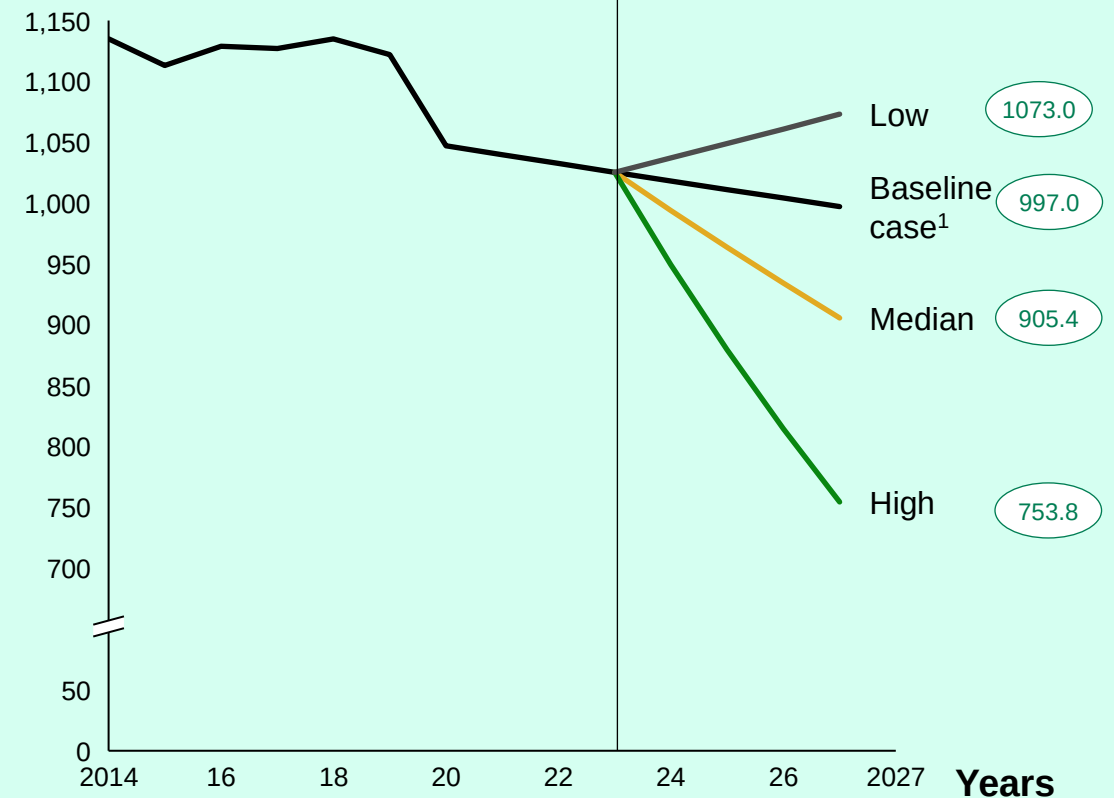
Nigeria's CAGR (2009 – 2019)
-0.2%

Current performance (2019):
1047



Target setting for maternal mortality rate

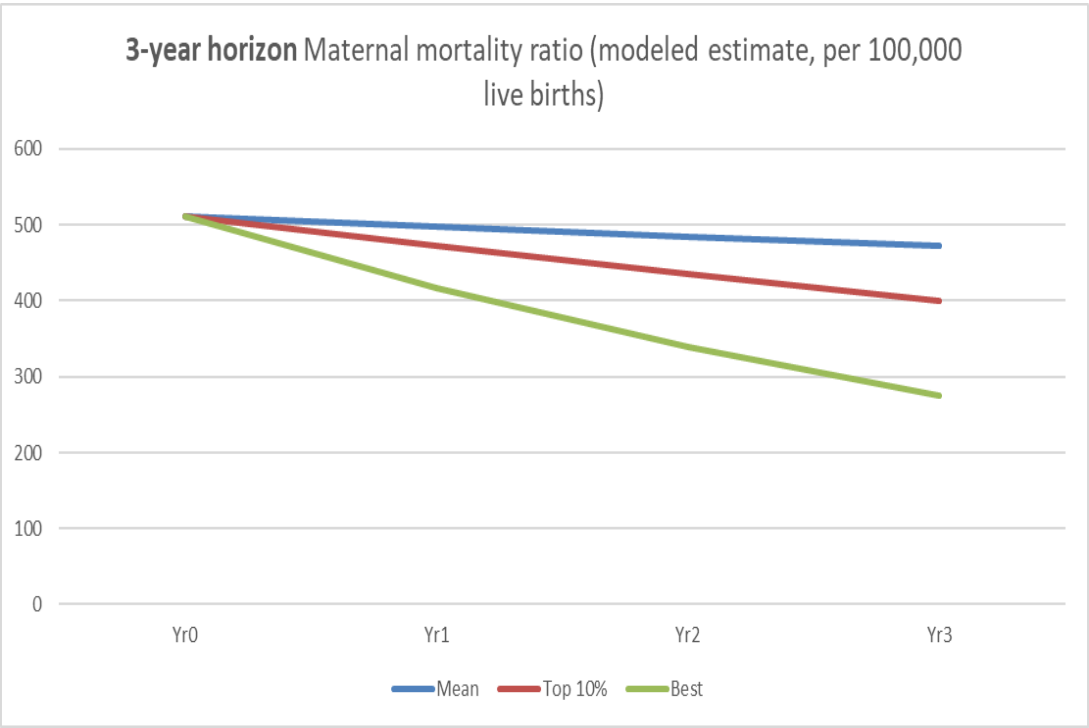
Outcome Indicator for Nigeria²



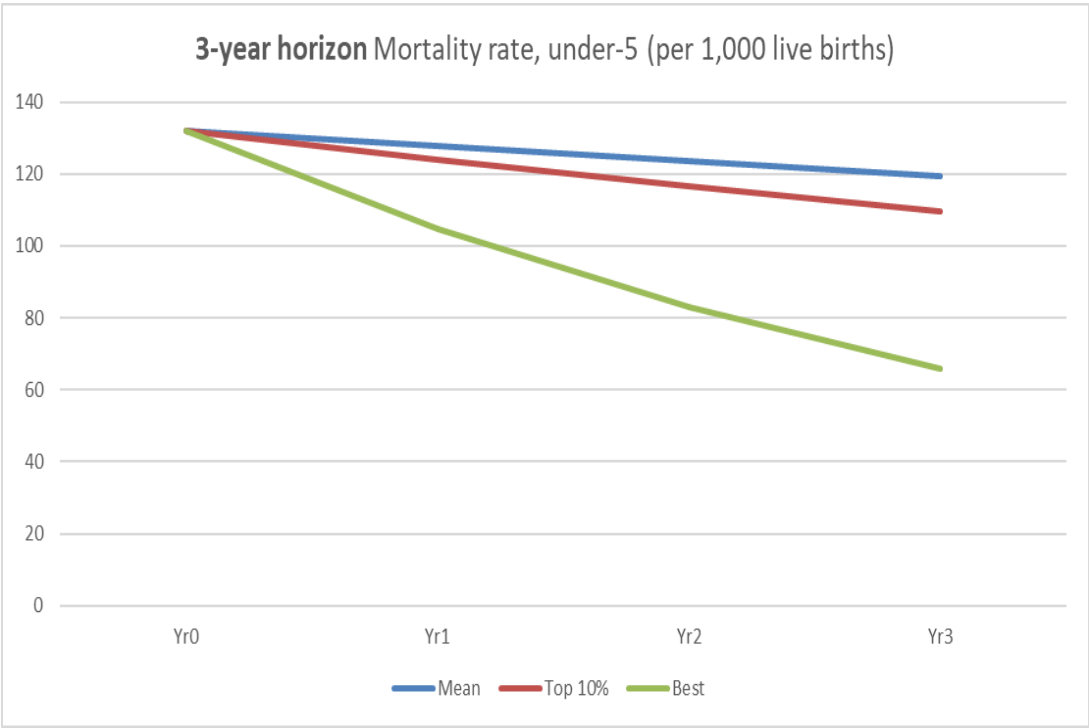
BENCHMARKING PERFORMANCE FOR IMPROVEMENT OF KEY HEALTH OUTCOMES

Average, “top 10%”, and best country performance on annual reduction of mortality over 3 years
(applied to Nigeria’s current baseline)

Maternal mortality



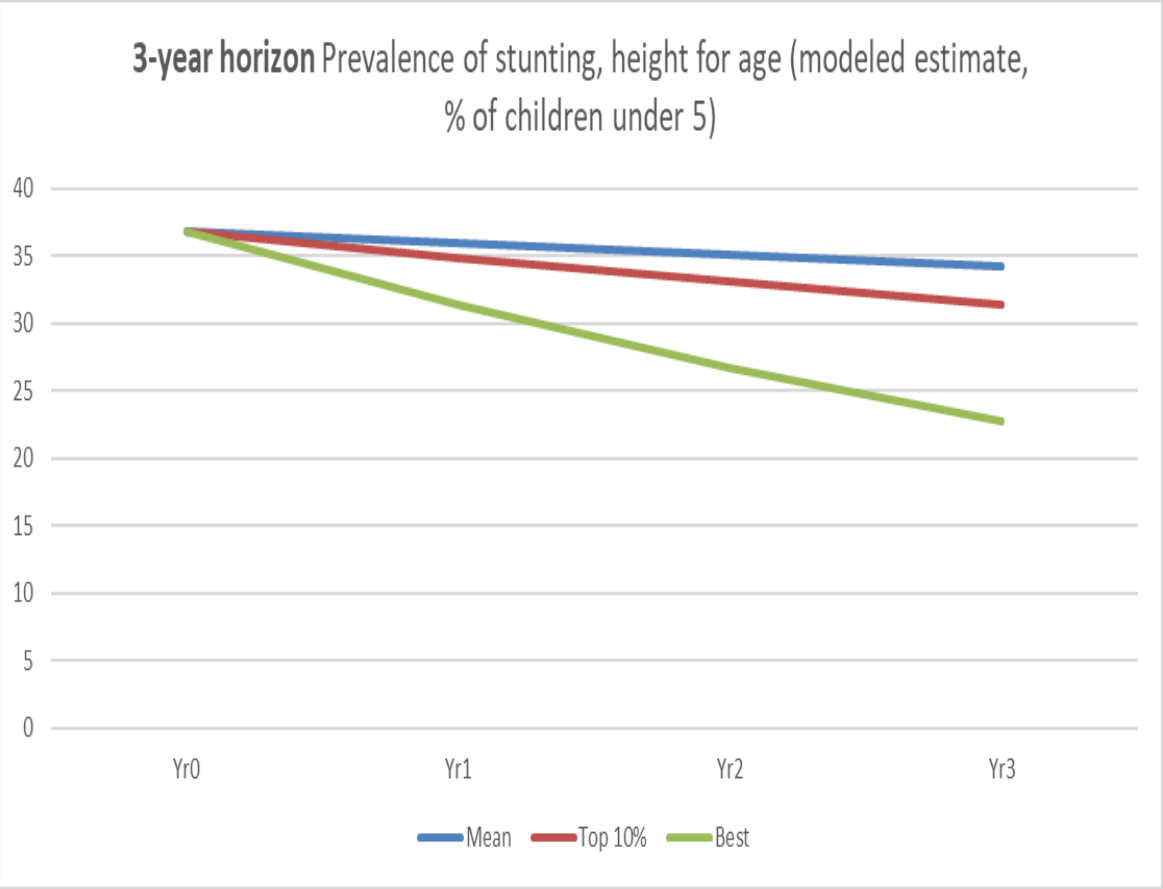
Under-five mortality



BENCHMARKING PERFORMANCE FOR IMPROVEMENT OF KEY HEALTH OUTCOMES

Average, “top 10%”, and best country performance on annual reduction of stunting and TFR over 3 years (applied to Nigeria’s current baseline)

Stunting



Total fertility rate

