This action is funded by the European Union

ANNEX

of the Commission Decision on the individual measure in favour of the Federal Republic of Nigeria to be financed from the 11th European Development Fund

Action Document for "EU Support to the Health Sector in Nigeria Phase I"

1. Title/basic act/ CRIS number	EU Support to the Health Sector in Nigeria, Phase I CRIS number: NG/FED/038-524 financed under 11th European Development Fund (EDF)			
2. Zone benefiting from the action/location	Nigeria The action shall be carried out in the following locations: Federal and States (Adamawa, Kebbi and Bauchi).			
3. Programming document	11th EDF National Indicative Programme (NIP) for the Federal Republic of Nigeria for the period 2014 – 2020			
4. Sector of concentration/ thematic area	Health, Nutrition and Resilience			
5. Amounts concerned	Total estimated cost: EUR 83 504 936 Total amount of EDF contribution: EUR 70 000 000			
6. Aid modality and implementation modalities	Project Modality: Direct Management and Indirect Management with international organisations (UNICEF and WHO)			
7 a) DAC code(s)	120 – HEALTH: (12220 – Basic health care; 12250 – Infectious disease control; 12240 – Nutrition, Social welfare services)			
b) Main Delivery Channel	Component 1 – UNICEF Components 2 and 3 – WHO			
8. Markers (from CRIS DAC form)	**General policy objective**	**Not targeted**	**Significant objective**	**Main objective**
	Participation development/good governance	☐	☒	☐
	Aid to environment	☒	☐	☐
	Gender equality (including Women In Development)	☐	☒	☐
	Trade Development	☒	☐	☐
	Reproductive, Maternal, New born and child health	☐	☐	☒
	RIO Convention markers	**Not targeted**	**Significant objective**	**Main objective**
	Biological diversity	☒	☐	☐
	Combat desertification	☒	☐	☐
	Climate change mitigation	☒	☐	☐
	Climate change adaptation	☒	☐	☐

SUMMARY

The proposal will channel EU support to the health sector in particular for maternal, new-born and child healthcare (MNCH), including nutrition and resilience, in three states of northern Nigeria (Kebbi, Adamawa and Bauchi). It will also strengthen health information management systems at national level and contribute to the complete eradication of polio in Nigeria. The proposal will be implemented in indirect management with UNICEF for component 1 and with the World Health Organisation (WHO) for components 2 and 3.

Expected results include: one functional quality Primary Health Care (PHC) facility in each ward of the three focal states, capable of providing high impact interventions in health, nutrition and resilience to surrounding communities; sustained polio eradication efforts and strengthened government capacity for data management and health expenditure tracking at national and sub-national levels.

Improving access to quality primary healthcare is a priority for the Government of Nigeria. Development indicators, such as maternal and new-born mortality and morbidity, remain extremely low. Low government expenditure on health and the division of labour between the three layers of government (federal, state and local) complicate enormously the efficiency and cost-effectiveness of the sector. The recently signed National Health Act (NHA) lays out the priorities and strategic objectives for the health sector. The proposed EU support to the health sector in Nigeria will enhance the implementation of the NHA and is coherent with the EU's Agenda for Change, Sustainable Development Goals (SDGs), Nigeria vision 20:2020 and the 11th EDF NIP (2014-2020) which identifies Health, Nutrition and Resilience as a focal sector of concentration.

1 CONTEXT

1.1 Sector/Country/Regional context/Thematic area

Nigeria's health system ranks 187th out of the 191 Member States of the World Health Organisation (WHO), reflected by:

(i) one of the highest maternal and new-born mortality and morbidity rates in the world[1];

(ii) contributing 10% to the global burden of maternal deaths and children suffering from Severe Acute Malnutrition. Stunting in northern Nigeria affects up to 62% of all children;

(iii) one of the lowest routine immunisation coverage rates in the world and until 2015, the only African country endemic for polio;

(iv) UN estimates that mortality of children under the age of 5 each year in Nigeria amounts to 960,000 deaths, second only to India.

In order to address these challenges, the government has implemented policy reforms and allocated additional resources at federal and state level to strengthen government institutions and governance and improve access to basic services. Achievements so far are limited but notable efforts include the successful containment of the spread of the 2014 Ebola outbreak in Nigeria and interrupting the Wild Polio Virus Transmission in mid-2015.

[1] An estimated 574 maternal deaths per 100,000 live births (Nigeria Demographic and Health Survey (NDHS) 2013). Infant and mortality rates for under 5s over the past 5 years are 69 and 128 deaths per 1,000 live births, respectively.

1.1.1 Public Policy Assessment and EU Policy Framework

Key policy initiatives to promote sector reform and to improve health outcomes include the "Primary Health Care Under One Roof (PHCUOR[2]) policy" which aims at integrating the fragmented health services into a one-stop shop, the "Saving One Million Lives Initiative", the "National Routine Immunisation Strategic Plan" and the "Accountability Framework for Routine Immunisation". The National Health Act (NHA) and ongoing revision of the National Health Policy will further help to provide both a legal and updated policy framework for the health sector to operate more efficiently.

Each of the 36 states and the Federal Capital Territory has a strategic health development plan which feeds into the national plan. Despite efforts for bottom-up planning, state ownership and implementation of the plans has been uneven. No state has been able to finance its plan and health budgets at state level have rarely been aligned to State Strategic Plans. There have been two annual sector reviews as well as a mid-term review of the National Health Plan. The conclusions have been mixed as health outcomes, like child mortality, have decreased while others, like maternal mortality, have stayed the same on average. The Basic Health Care Fund established by the NHA of 2014, has two main disbursement mechanisms which lend themselves to reform within the system. Health financing will aim to build the capacity of the Federal Ministry of Health and its relevant agencies; to monitor the progress in improving financial risk protection, especially for vulnerable groups in the country.

EU support to the sector will address integrated high impact interventions in health, nutrition and resilience in line with the EU Agenda for Change and national priorities.

The proposed intervention is also in line with a number of EU policies as follows:

- Enhancing maternal and child nutrition in external assistance; COM(2013)141 final of 12.03.2013;
- Action Plan on Nutrition; SWD(2014)234 final of 3.7.2014;
- Boosting food and nutrition security through EU Action: Implementing our commitments; SWD(2013)104 final of 27.3.2013 and the EU Communication on Resilience of 2012 and the subsequent Action Plan of 2013;
- Commission Communication and Council Conclusions on the "EU role in Global Health" 2010.

1.1.2 Stakeholder analysis

The primary stakeholders are the Government of Nigeria, implementing agencies such as State Primary Health Care Development Agencies/Boards, State Ministries of Health, civil society organisations and women's groups, humanitarian organisations and development partners such as WHO and UNICEF.

Input and comments from consultations with partners such as UNICEF, WHO, State and local government authorities, civil society organisations working in the health sector and private sector, which is responsible for 40-70% of health care delivery in the country have been considered during the project design.

The primary beneficiaries of this project are children under the age of five, pregnant and lactating women who are expected to have access to effective integrated primary health care services including nutrition, WASH (Water, Sanitation and Hygiene), primarily at facility level, and social protection interventions. The secondary beneficiaries of the project constitute national, state, local government area (LGA) and community level actors.

[2] PHCUOR – PHC Under One Roof. This involves States bringing together the various aspects of PHC services (such as finances, human resources, and service delivery) which have until now been managed by different local government departments and State ministries. This integrated approach enables more effective delivery of PHC services.

1.1.3 Priority areas for support/problem analysis

Within the broad framework of the National Health Plan, the priority areas identified are:

Component 1: An expansion of operations to improve maternal, new-born and child health and nutrition (MNCHN) indicators in three states in northern Nigeria

Despite improvement in some national health indices, i.e. stunting decreased from 42% to 37% (NDHS 2008, 2013), there are significant regional disparities at sub-national levels (stunting is 62% in Kebbi State). Consequently, more attention will be focused at the state level by scaling up on-going action in Kebbi and Adamawa and including a third state, Bauchi with weak social protection mechanisms and poor health and nutrition indicators.

The priority areas of the MNCHN intervention will be addressed through strengthening health system delivery and supporting community resilience with emphasis on community participation, ownership and sustainability by improving the functioning of Ward Development Committees (WDCs) and their linkage to the management of Primary Health Care (PHC) facilities. The goal is to have one functional quality PHC facility per ward linked to already existing community structures to implement integrated MNCHN services including maternal nutrition, infant and young child feeding, micronutrient deficiency control, management of severe acute and/or chronic malnutrition, ensuring availability of water and toilet facilities. The social protection component will focus on support to pregnant women to overcome financial barriers to access health services and a seasonal cash transfer in order to provide support during lean season (July to October). Birth registration mechanisms will be strengthened in all 744 wards in the three states at health facility and community level.

Component 2: Further support for integrated efforts to eradicate polio permanently.

Nigeria is at a pivotal point in its fight against polio, having interrupted wild poliovirus circulation with the last case occurring in July 2014. To maintain this, it is important that the current momentum be built upon and the immunity against poliovirus of the highest risk children continues to be strengthened. To achieve this, Nigeria has to conduct high quality supplementary immunisation activities (SIA), combined with supportive activities to reach all children with polio vaccine. Along with this, routine immunisation will be intensified through structured activities in areas identified as high risk.

Component 3: Enhance the health system by building capacity for data analysis and estimation of health expenditure patterns.

Progress towards universal health coverage for Nigeria requires adequate and efficient financing to scale up health services and financial risk protection for the most vulnerable. Mobilising adequate resources for health and ensuring efficient use of those resources has remained a challenge for Nigeria. The federal allocation to health has averaged 5% as a proportion of total federal government expenditure. The mid-term review of the National Strategic Health Development Plan noted that government budgets are not based on evidence on expenditure patterns or health needs. The health accounts which should be conducted annually are still done on an ad hoc basis and the results often are available too late to affect policy and planning. This poses a challenge to the country's stated commitment to universal healthcare.

The challenge of the unavailability of good quality data in the health sector is a longstanding one. There are gaps in data analysis capacity and in the use of data to influence policy-making, especially at sub-national levels. Following a push in the past two years, the vertical information systems being used by the disease programmes are being folded into the national (district) health information system (DHIS2). However, to date the data completeness is still at only about 60%, with many health facilities at secondary and tertiary level not reporting data through the national platform yet. In many cases, various data sources provide different values for the same indicator.

Technical expertise will be provided to institutionalise the mechanisms for monitoring and reporting on health expenditure patterns as well as explicit support to strengthen data quality frameworks for the entire health management information system and to build capacity for harmonised data analysis for planning across the entire sector. The information generated by these actions will be used to assess progress in the health sector and inform policy to improve health outcomes.

2 RISKS AND ASSUMPTIONS

Risks	Risk Level (H/M/L)	Mitigating Measures
Limited number and poorly qualified staff for health and nutrition will slow the speed and effectiveness of project implementation.	M	Build the capacity of government systems and training of key health and nutrition staff and improve effectiveness, such as task shifting/sharing, clinical mentoring, etc.
Limited oversight and coordination of MNCHN programmes and frequent turn-over of health facility staff could lead to delays in implementation.	M	Enhance collaboration and partnerships amongst stakeholders in the states and strengthen capacity of the government as an effective MNCHN Coordination Platform.
Limited capacity in financial management on the part of the Implementing Partners might mar the results of the project.	M	Conduct quarterly Integrated Supported Supportive Supervision as an accountability measure. Government agencies and partners will be helped to put in place functional financial management and auditing systems. Assurance activities and spot checks will be undertaken to minimise risk.
Low international oil prices will continue to negatively impact the government's revenues and its ability to fund its part of the proposed programmes.	M	Continued advocacy and engagement with the health and finance authorities to maintain adequate levels of funding to the health sector.
Health workers strike action due to displeasure with remuneration issues and incentives can affect implementation.	M	Advocacy with the government to strengthen the system including motivation of staff.
Insurgency and other security challenges in some states especially Adamawa which is one of the benefiting states will impede project results.	H	Implementing Partner(s) to strictly adhere to security alerts and advise. This project will continue to employ the "hit and run" strategy of reaching out to the security compromised areas of Adamawa State.
Inadequate uptake of services due to cultural belief, community social norms and limited access to MNCHN services in some instances.	M	Demand Creation is a major intervention in this project. The project will provide support for 739 health facilities in supported states to run '24/7'.
Assumptions		
1. The government will remain focused on implementing the reforms proposed in the National Health Act		
2. The States covered by this project have a State Primary Health Care Agency/Board and Government is committed (political will) to providing "Primary Health Care Under One Roof" which will enable effective co-ordination		
3. Financial resources for the civil service will be available from the Federal/States/Local Governments of Nigeria		
4. Data from the reviews and assessments will be used as recommended to improve planning		
5. Security conditions are good enough to implement polio eradication initiative activities		

3 LESSONS LEARNT, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learnt

(i) **On-going EU-MNCH programme in Adamawa and Kebbi States** and many years of experience from implementation of numerous programmes in northern Nigeria. Some of the key areas of learning and replication will include, but are not limited to, the following: (1) The cost effectiveness of strengthening one main PHC facility per ward model being practiced already in Adamawa and Kebbi resulting in improved quality of services and improved demand creation, (2) The utilisation of mobile teams for remote areas providing access and reaching more under-five children, (3) State Governments' willingness to provide counterpart funding especially when well-briefed on project objectives and outcomes, (4) Engaging the Ward Development Committees (WDC) for ownership and sustainability is a key aspect of the interventions, (5) Capacity building of low-cadre health workers is a good way to reinforce the human resources in the health sector, and (6) Project Steering Committee (PSC), such as in the ongoing EU-MNCH project which provides for participation of government, is a platform for oversight, provision of direction to programme implementation, advocacy and replication.

(ii) **Support for polio eradication** in Nigeria has become a model for implementing a robust community-based programme. The analysis that has been carried out facilitated the identification of poorly performing areas, enabling strengthening of ongoing activities as required, and the development of innovations that addressed issues identified. Some of the key areas of learning and replication will include activities as noted in the National Polio Eradication Emergency Plan (NPEEP) and support Nigeria to reach "polio free" status as well as build on previous support from the 2012-2016 project "EU Support to Immunisation Governance in Nigeria (EU-SIGN)".

(iii) **Strengthening Health systems:** The findings from the midterm review of the National Strategic Health Development Plan in 2013[3] indicated that there are gaps in resource allocation and resource use. It highlighted the high financial burden on the population as a result of healthcare and recommended the regular use of expenditure tracking mechanisms. Experience from previous expenditure tracking processes highlight the challenges in preparing annual estimates to guide planning and budgeting in a timely manner, including poor reporting practices, lack of a system for routine expenditure reporting, unavailability of expenditure data at sub-national level beyond total budget implementation, among others. The proposed measures are designed to address these gaps. The evidence for this is from WHO's global experience in expenditure tracking and reporting. Additionally, the proposed project will build on lessons learned from partners' initiatives supporting expenditure tracking efforts. The World Bank is supporting two states in improving expenditure reporting and monitoring. The DFID (Department for International Development - UK) supported "Partnership for Transforming Health Systems 2" (PATHS2) project is also supporting efforts at expenditure tracking in five states.

3.2 Complementarity, synergy and donor coordination

The project will seek synergy with the ongoing project "EU Support to Immunisation Governance in Nigeria" covering 23 states and Federal Capital Territory (FCT), the EU-MNCH project in Kebbi and Adamawa and the EU funded water supply and sanitation reform projects. Complementarity will be sought with other EU funded actions in areas such as immunisation and health systems strengthening through partners like GAVI Alliance and the Global Fund.

Synergy with the many key players supporting the Government of Nigeria to achieve health and nutrition goals in the target states will be pursued through existing coordination mechanisms

[3] Combined 2012 health sector performance and mid-term review report, Federal Ministry of Health.

operating at various levels. The National Council of Health is the main forum which brings together policy makers at federal and state levels to discuss and take decisions on key policy areas. The Health Partners Coordinating Committee (HPCC) is operational at federal level and is chaired by the Minister of Health. The Inter-Agency Coordinating Committee (ICC) is the body with strategic oversight for the immunisation programme and consequently the polio eradication initiative. The Development Partners group on Health (DPG-Health), co-chaired by the EU until December 2015, provides a platform for partners working in the health sector to contribute to the policy dialogue in a more harmonised and coherent manner.

Many donors have invested in the health information system, particularly for data collection, management and capacity building on the District Health Information System (DHIS2) at national, state and local government area (LGA) levels. Other partners have also invested in strengthening health data management in specific supported states. These have led to improved data completeness in the system. The proposed actions are not intended to duplicate these efforts in data generation but will build on and complement these investments.
Specifically on the polio eradication component, the project is aligned with the Global Polio Eradication Initiative (GPEI) strategic plans, NPEEP and routine immunisation strategic plans. The EU has been a strong and long term supporter of polio eradication in Nigeria. The current project supports the "Intensification of Nigeria's Polio Eradication Efforts" until 2016. Donor agencies also participate in the Expert Review Committee on Polio Eradication and Routine Immunisation (ERC). These groups/meetings, chaired by the National Primary Health Care and Development Agency (NPHCDA), are integral in the planning of all immunisation activities in the country and provide a regular forum for partner agencies to discuss all aspects of immunisation.

3.3 Cross-cutting issues

The focal sectors of health, nutrition and resilience will support actions that will improve the well-being of the children under five years of age, pregnant and lactating mothers. Support for increased women empowerment through health promotion and child spacing will go a long way to impact on behavioural change.

For component 2 of this project, polio eradication activities need to be sensitive to the socio-cultural norms of the area in which activities are conducted. In response to this, and the cultural demands of most communities in northern Nigeria, the programme will use the women-to-women strategy, to deploy females to conduct household immunisation. Along with this, surveillance data and national routine immunisation surveys, such as the National Immunisation Coverage Survey (NICS), will facilitate data analysis and sex disaggregation.

As part of the strengthening of health information systems, advocacy will be made for inclusion of gender disaggregation in data collection tools and appropriate analysis. Effort will be made to explore and identify the most appropriate mechanisms for including sex disaggregation in routine health facility information.

It is therefore expected that the proposed activities will contribute to the objectives of the EU Gender Action Plan (GAP) for 2016-2020.

4 DESCRIPTION OF THE ACTION

4.1 Objectives/results

The **overall objective** is to strengthen the Nigerian health system through improved primary healthcare delivery in northern Nigeria, maintaining the country's polio-free status and building capacity for improved data and financial management of the health sector.

The Specific Objectives:

Component 1:
Objective 1: To strengthen government capacity to enhance access to quality primary healthcare services in Adamawa, Kebbi and Bauchi States for poor, marginalised, rural women and under-five year old children.

Objective 2: To support the authorities in the recruitment, training of adequate and qualified health personnel and the provision of adequate supplies and equipment for health facilities and community based services in the three states.

Objective 3: To support the roll-out of the government policy of "Primary Health Care under One Roof" with a focus on health, nutrition and social protection interventions using the one PHC facility per ward model.

Component 2:
Objective 4: To increase and sustain herd immunity against poliovirus in polio high risk States.

Component 3:
Objective 5: To improve the availability and quality of health information for decision making at federal and state level.
Objective 6: To strengthen the health financing system at federal and state level.

Expected results of the project are:

Component 1:
Result 1: By 2019, 80% of women and children in the three states are reached with high impact MNCHN interventions.
Result 2: By 2019, 80% of wards have one main functional PHC facility with the capacity to provide an integrated MNCHN service in the three states '24/7'.
Result 3: By 2019, capacity for effective coordination of integrated maternal, new-born, child health and nutrition (MNCHN) service delivery and social protection mechanisms are strengthened at national, state and local government area (LGA) levels in supported states, providing a reduction of 3.9% in stunting on average.
A cross-cutting result for component 1 will be to document, disseminate and scale up lessons learnt and impact of the project to all LGAs within the three states as well in other states in the country.

Component 2:
Result 4: Achieve and maintain polio free status in Nigeria by 2017.

Component 3:
Result 5: Quality of Health Information and its use for decision making is strengthened, aiming to have fully operational health information systems by 2019.
Result 6: By 2019, improvement of local institutional capacity at state level to plan and prepare costed budgets and provide full narrative and financial reporting for the health sector.

4.2 Main activities

The main activities by result areas include the following:

Component 1

Result 1: *By 2019, 80% of women and children* in the three states are *reached with high impact MNCHN.*

1.1.1 Support the provision of community based MNCHN services through the network of community volunteers and conduct of outreaches in 774 wards for the provision of integrated PHC service delivery.

1.1.2 Institutionalise quality-of-care interventions in 774 focus health facilities including on-the-job training (OJT), clinical mentoring, task shifting, birth registrations, etc.

1.1.3 Support the provision of material to promote behavior and social change activities on key MNCHN messages to improve Key Household Practices (KHHP) including Infant and Young Child Feeding (IYCF) with specific gender considerations.

Results 2: *By 2019, 80% of wards have one main functional PHC facility with the capacity to provide an integrated MNCHN service in the three states '24/7'.*

2.1.1 Identification and mapping of 774 PHC facilities in the three states – Bauchi (323), Kebbi (225) and Adamawa (226).

2.1.2 Advocacy to the states and LGAs policy makers for the provision of minimum required number of health care providers in 774 facilities.

2.1.3 Support the states and LGAs to upgrade/renovate health facilities in 774 wards in three states including electricity, water, and sanitation facilities.

Result 3: *By 2019, capacity for effective coordination of integrated MNCHN service delivery and social protection mechanisms are strengthened at national, state and LGA levels in supported states.*

3.1.1 Strengthen policy implementation, regulation, accountability, transparency, and enhanced performance through monitoring, supportive supervision and quality control systems at community, health facility and national level to improve the effectiveness of service delivery and strengthen quality controls.

3.1.2 Support to state and LGA level planning, implementation, monitoring and evaluation in the three focus states.

3.1.3 Enhance the capacity of the states, LGAs and health facilities to plan and conduct two rounds of MNCHN campaigns every year.

Cross-cutting: to document, disseminate and scale up lessons learnt and impact of the project to all LGAs within the three states as well in other states in the country.

1. Document the success of the project and advocate for scaling up the project to all LGAs within the three states and other states though state and national health council meetings.
2. Advocate for state government to allocate budget for procurement of MNCHN supplies and commodities.
3. Advocate for state government to finance and sustain the community structure including volunteer networks to improve access to services to women and children in remote areas.

Component 2

Result 4: *Achieve and maintain polio free status in Nigeria by 2017.*

4.1 Conduct high quality supplementary immunisation activities (SIA) combined with supportive activities, such as health camps, transit vaccination, directly observed Oral Polio Virus administration, in the high risk states to ensure all children under five years receive vaccine.

4.2 In areas of insecurity, special initiatives to reach children will be undertaken, including activities in IDP (internally displaced persons) camps.

4.3 Support to polio legacy activities to help the country manage the transition to sustainable interruption of the polio virus.

Component 3

Result 5: *Quality of Health Information and its use for decision making is strengthened.*
5.1 Support the Ministry of Health to develop a harmonised data quality process comprising monthly, annual and a medium term in-depth verification of the entire system (indicator list, data tools and master facility list), and build the capacity of relevant programme managers at federal and state level.
5.2 Support for coordination of actors in health information through the relevant technical working group at national level and in the selected states.
5.3 Support the building of capacity of the Federal Ministry of Health research and statistics division and the state Monitoring and Evaluation/Health Information System (M&E/HIS) units on the analysis of health information, both from routine systems and from surveys, and the development of analysis products and policy relevant communication to inform joint sector reviews, and promote the use of health information in decision making.

Result 6*: By 2019, improvement of local institutional capacity at State level to plan and prepare costed budgets and provide full narrative and financial reporting for the health sector.*
6.1 Support to the Government for monitoring of the level of coverage of risk protection schemes at various levels of the health system as well as assessing the effect of these schemes on health service use and on the cost to households of accessing healthcare.
6.2 Support to the Government to conduct annual health accounts estimation as well as other expenditure tracking processes, like public expenditure reviews and household expenditure surveys, at regular intervals.
6.3 Analyse information from these processes alongside health outcomes data to assess efficiency of health spending and to review the extent to which health spending reflects the national health priorities and/or disease burden and review the progress in reducing the financial barriers to accessing health services.

4.3 Intervention logic

In order to significantly and sustainably improve the nutrition and health situation of children and women, as well as maintain a polio free status with strengthened health systems, a multi-pronged approach is needed. A systematic approach to the implementation of interventions in health and nutrition, complemented with water, sanitation, and social protection initiatives, is bound to be more effective and efficient than single or vertical activities.

Key Strategies to be used include:

i. Service delivery though support to the implementation of one PHC facility per ward
ii. Strengthening community resilience for greater ownership, sustainability and prevention of major disease outbreaks
iii. Outreach services to hard-to-reach communities
iv. Behaviour change and communication
v. Coordination, integrated monitoring and supportive supervision
vi. Research, evaluation, demonstration, advocacy and resource mobilisation
vii. Strengthening of governance, transparency and accountability

The proposed project will be delivered though two major approaches at two levels:

1. State (Component 1):
(a) Health facility
The main purpose is to strengthen primary healthcare in the three selected states in northern Nigeria by investing in one main PHC facility per ward approach where health, nutrition, water and sanitation, and social protection interventions would converge. The one main PHC facility per ward approach strengthens the health care system and is expected to address inequities to primary health care access within the states.

(b) Community level
The four-pronged approach will be used in the community. It will include health promotion/demand creation and community outreaches.

2. Federal (Components 2 and 3)
(a) Polio eradication
High quality SIA to reach children with polio vaccine.

(b) Health systems strengthening
Better targeting and planning can, subsequently, lead to improved service delivery resulting in increased coverage and improved health outcomes. Health expenditure tracking, if conducted regularly, will lead to improved availability of information on resource allocation to health and within the sector, to national priorities. This enables the assessment of alignment of spending to identified health priorities, and thus, efficiency of health spending.

5 IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country, referred to in Article 17 of Annex IV to the ACP-EU Partnership Agreement.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4.2 will be carried out and the corresponding contracts and agreements implemented, is **48 months**[4] from the date of entry into force of the financing agreement.

Extensions of the implementation period may be agreed by the Commission's authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to this decision constitute non-substantial amendment in the sense of Article 9(4) of the Annex to Regulation (EU) 2015/322.

5.3 Implementation modalities

The corresponding separate agreements with UNICEF and WHO will be signed by the Commission.

5.3.1 Indirect management with international organisations

This action may be implemented in indirect management with UNICEF (component 1) and WHO (components 2 and 3) in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012 applicable in accordance with Article 17 of Regulation (EU) 2015/323. This

[4] 48 months for MNCH, 12 months for polio eradication and 36 months for health systems support.

implementation entails (i) an expansion of operations to improve maternal, new-born and child health and nutrition (MNCHN) outcomes in three states in northern Nigeria through UNICEF and (ii) further support for integrated efforts to eradicate polio permanently in Nigeria and enhancing the health systems resilience by building capacity for data analysis and estimation of health expenditure patterns through WHO. This implementation is justified because:

Component 1:

Presently UNICEF is providing integrated Primary Health Care (PHC) services in 451 health facilities in 42 local government areas (LGAs) of Adamawa and Kebbi States. This support will be consolidated and scaled up to ensure that all the 451 health facilities across the 42 LGAs (1 PHC facility per ward) in Adamawa and Kebbi States are providing 24/7 services and additional health facilities in the wards of all the LGAs in Bauchi State.

Components 2 and 3:

WHO Nigeria has extensive presence in the country with six zonal offices and field offices in all 36 states plus Federal Capital Territory (FCT). Since the successful implementation of the Surge Capacity Project in mid-2012, WHO has expanded its presence to most LGAs and Wards particularly in polio priority states. At present, WHO Nigeria has over 2,600 technical staff dedicated to support immunisation activities and focused in the high risk states, working on polio eradication. They are well trained to support the implementation of supplementary immunisation activities (SIA) together with the Federal Ministry of Health and other polio eradication initiative (PEI) partners. The health systems unit has a health systems specialist and a health economist in place. WHO can also draw expertise from regional offices and headquarters as required.

Both entrusted entities would carry out the budget-implementation tasks under the activities described in section 4.2 such as: launching calls for tenders and for proposals; definition of eligibility, selection and award criteria; evaluation of tenders and proposals; award of grants and contracts; concluding and managing contracts, carrying out payments, recovering moneys due.

5.3.2 Procurement (direct management)

Subject in generic terms, if possible	Type (works, supplies, services)	Indicative number of contracts	Indicative trimester of launch of the procedure
Verification missions/audits	Services	4	2nd semester 2018, 2nd semester 2020
Mid-term, final evaluation	Services	2	2nd semester 2018, 2nd semester 2020
Communication and visibility	Services	2	2nd semester 2017

5.4 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission's authorising officer responsible may extend the geographical eligibility in accordance with Article 22(1)(b) of Annex IV to the ACP-EU Partnership Agreement on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

5.5 Indicative budget

Module	EU contribution in EUR	Third party contribution in EUR
5.3.1 Indirect management with international organisations ***Component 1(implemented by UNICEF)***		
Specific Objective 1: access to quality primary healthcare in Adamawa, Kebbi and Bauchi states	17 200 000	7 986 056
Specific Objective 2: improved functionality of health facilities in the three States	23 500 000	
Specific Objective 3: roll-out of "Primary Healthcare under one roof" policy	7 300 000	
Components 2 and 3(implemented by WHO)		
Indirect management with WHO		
Specific Objective 4: Polio eradication	15 000 000	5 000 000
Specific Objectives 5: Health Systems strengthening, data management	3 000 000	518 880
Specific Objective 6: Health Systems strengthening, Expenditure tracking	2 000 000	
5.8 and 5.9 Evaluation and Audit activities (verification)	500 000	N.A.
5.10 Communication and visibility	500 000	N.A.
Contingencies	1 000 000	N.A.
Totals	70 000 000	13 504 936

5.6 Organisational set-up and responsibilities

Activities implemented by UNICEF

Governance structure at the 3 levels: Policy, Project Management and Operational.

1. At sector Policy Review level, use will be made of existing committees that oversee the implementation of the State Strategic Health Development Plan (SSHDP2) and how these ultimately contribute to the National Strategic Health Development Plan (NSHDP2) outcomes. The National Reference Group comprises of subcommittees that oversee the implementation of the Health Plan core functions including Health Financing, Programme Alignment and Scaled up Service Delivery, Advocacy, Monitoring and Evaluation, including the conduct of the Joint Annual Reviews. UNICEF will be represented at the Reference Group and all subcommittees and will continue to provide technical support in strengthening these policy platforms. It is also expected that this project will support the strengthening of policy discussions through State Coordination Mechanisms that include the State Councils on Health and the Health Partners' Forum. This will be one of the core functions of the technical staff that will be recruited and seconded, under this project support, to the State Primary Healthcare Development Agency.

2. The EU-MNCH Project Steering Committee (PSC) will be expanded to cover additional potential states during the project transition phase and members will be, the Executive Directors of the National Primary Healthcare and Development Agency (NPHCDA and Chief Executives of State Primary Healthcare Development Agencies (SPHCDA), LGA Chairmen on a rotational basis, UNICEF) and representatives of the Federal Ministry of Health and the Ministry of

Budget and National Planning who will also serve as co-Chair. The EU Delegation will have an observer status. The PSC will oversee and validate the overall direction of the project implementation, monitor, supervise and co-ordinate the overall progress of the project activities. It will approve the annual work plans, the interim annual activity reports and the final report of the project. The PSC shall meet twice a year, with the meetings organised by the implementing agency.

3. On the operational side, the project will support the funding of a dedicated staff member position at UNICEF Country Office, who will support the implementation, coordination and reporting requirements. Technical support will be increased as two other staff recruited will be seconded to the state governments.

Activities implemented by WHO

The WHO representative in Nigeria provides overall policy and coordination leadership and is a member of the national Inter-agency Coordination Committee (ICC) for Immunisation. The Inter-agency Coordinating Committee (ICC), chaired by the Minister of Health, shall serve as the Policy Advisory Committee or governing body for overall sectoral policy direction and examine how the project can support sectoral policy reforms.

A Management Committee shall be set up to oversee and validate the overall direction and policy of the project particularly in relation to components 2 and 3 (or other responsibilities to be specified). The Management Committee shall meet four times a year. The EU Delegation will have an observer status.

5.7 Performance monitoring and reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the log frame matrix. The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

5.8 Evaluation

Having regard to the importance of the action, mid-term and final evaluations will be carried out for this action or its components via independent expert missions contracted by the Commission. They will do problem solving and lessons learned in particular with respect to implementation and the intention to launch a second phase of the action. The final evaluation will be carried out for accountability and learning purposes at various levels (including for policy revision).

The Commission shall inform the implementing partners at least 2 months in advance of the dates foreseen for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

Indicatively, one contract for mid-term evaluation services shall be concluded under a framework contract in the second semester of 2018 and a final evaluation, if considered appropriate, should be launched at the end of the operational implementation phase for an indicative budget of EUR 250 000.

5.9 Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

Indicatively, contracts for audit/verification services shall be concluded under framework contracts in 2018 and 2020. An indicative number of four contracts with an indicative total budget of EUR 250 000 will be concluded.

5.10 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU. This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.5 above.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations. A separate budget in direct management by the European commission for specific visibility activities is included and estimated at EUR 500 000.

APPENDIX - INDICATIVE LOGFRAME MATRIX[5]

	Intervention logic	Indicators	Baselines (incl. ref. year)	Targets (incl. ref. year)	Sources and means of verification	Assumptions
Overall objective: Impact	*Component 1* An expansion of operations to improve maternal, new-born and child health (MNCH) outcomes in three states in northern Nigeria	Maternal mortality ratio	574 (National)	380 (National)	NDHS, MICS	Fall in prevalence of stunting is predicted to reduce slightly higher than the rate to achieve the national target. (National Strategic Plan of Action for Nutrition, NSPAFN, 2014 – 2019)
		Under five Mortality Rate (U5MR)	NE – 160 NW-185	NE 75 NW-75	NDHS, MICS	
		Under five prevalence of stunting**	ADS – 44.5 KBS – 46.4 BAU – 43.3	ADS – 36.5 KBS – 38.4 BAU – 25.2	NDHS	
	Components 2 Further support for integrated efforts to eradicate polio permanently from the country	No indigenous poliovirus cases of Wild Polio Virus/ circulating Vaccine-Derived Polio Virus (WPV/cVDPV) in the country, from Acute Flaccid Paralysis (AFP) or environmental samples during and after the grant period	0 WPV and cVDPV	0 WPV and cVDPV	AFP data base	Planned SIAs implemented as scheduled. Security conditions are good enough to implement PEI activities
	Component 3: • -Enhance data analysis, health expenditure estimation. -Reduction in financial barriers to health care access • HIS data used for policy and planning	- % of government expenditure on health - Proportion of Nigerians covered by any risk-pooling mechanisms*	TBD TBD	15% 30%	- Expenditure reviews, - Living standard surveys, Household expenditure reviews	- Data from the reviews and assessments will be used as recommended to improve planning
		% of federal and state plans and strategies based on routine HIS data to improve coverage and quality of high impact activities	TBD	80%	Joint review processes	
Specific objectives : Outcomes	**Objective 1.** To strengthen Government capacity to enhance access to quality primary health care services in Adamawa, Kebbi and Bauchi States for poor, marginalised, rural women and under-five year old children.	% of births assisted by skilled personnel	ADS – 37 KBS – 9 BAU – 16.3	ADS – 80 KBS – 60 BAU - 90	NDHS	Commitment to deliver MNCH-services by government and project partners involved is firm. Implementing partners in the focal states are functional and LGAs have adequate capacity to improve health services performance.
		# of lives saved by Community-based Management of Acute Malnutrition (CMAM) program	ADS –NA KBS – NA BAU– NA	ADS – 5,000 KBS – 5,000 BAU– 5,000	District Health Information System (DHIS), Special Surveys	
	Objective 2. To support the authorities in the recruitment, training of adequate and qualified health personnel and the provision of adequate supplies and equipment for health facilities and community based services in the three states.	# of health facilities providing MNCHN service 24 hours	ADS – TBD KBS – 64 BAU – TBD	ADS – 226 KBS – 225 BAU – 323	DHIS, Program Reports	
	Objective 3. To support the roll-out of the Government policy of 'Primary Health Care under One Roof' with focus on health, nutrition and social protection interventions using the one PHC facility per ward model.	# of additional LGAs and states replicating one PHC facility/ward model	NA	5 states & 50 LGAs	DHIS, Program Reports	
		# of States with costed annual MNCHN operational plan	2	3	DHIS, Program Reports	

[5] Indicators aligned with the relevant programming document are marked with '*' and indicators aligned to the EU Results Framework with '**'.

	Objective 4. To increase and sustain herd immunity against poliovirus in polio high risk states	Proportion of LGAs in high risk states that have achieved >90% Lot Quality Assurance Sampling (LQAS) in three consecutive SIAs	86%	90%	NDHS, DHIS, Program Reports	Improved access in security compromised areas.
		Proportion of LGAs that have achieved 80% coverage for Inactivated Polio Vaccine (IPV)	42%	80% of LGAs	NDHS, DHIS, Program Reports	
	Objective 5. To improve availability and quality of health information for decision making	# of bulletins and health statistics briefs developed from HMIS data	0 (2015)	3 (2018) (at least one per year)	NDHS, DHIS, Program Reports	There will be political will to make recommended reforms
	Objective 6. To strengthen the health financing system at federal and state level	# of policy briefs on financing developed	0 (2015)	4 (2018)	DHIS, Program Reports	
	Result 1: By 2019, 80% of women and children in the three states are reached with high impact MNCHN interventions	Proportion of women who completed 4 Ante-natal Clinic (ANC) visits	ADS – 49.5 KBS – 26 BAU – 55	ADS – 80 KBS – 80 BAU – 80	NDHS, DHIS, Program Reports	Continued released of budgetary allocation by the States and LGAs Implementation of the National Health Act at all levels
		% children under five with diarrhoea who receive appropriate care, Oral Rehydration Salts (ORS) and Zinc.**	ADS – 27.8 BAU– 33.9 KBS – 35	ADS – 80 BAU – 80 KBS – 80	NDHS, DHIS, Program Reports	
		Proportion of pregnant women who received iron/folate supplementation**	ADS – 49.5 KBS – 13 BAU –	ADS – 80 KBS – 60 BAU – 85	MICS, DHIS, Program Reports	
		Proportion of children aged 6-59 months who received vitamin A supplementation in last 6 months**	ADS – 61.1 KBS – 15.2 BAU –	ADS – 80 KBS – 80 BAU – 80	MICS, DHIS, Program Reports	
		# of pregnant and women with children <2 years reached with appropriate IYCF messages (breastfeeding, dietary)**	ADS – TBD KBS – TBD BAUS – TBD	ADS – 200,000 KBS – 200,000 BAU – 200,000	MICS, DHIS, Program Report	
Outputs	**Result 2:** By 2019, 80% of wards have one main functional PHC facility with the capacity to provide an integrated MNCHN service in the 3 states '24/7'.	# of health workers trained on life saving skills**	ADS – 448 KBS – 446 BAU – TBD	ADS – 1628 KBS – 604 BAU – 800	DHIS, Program Reports	Continued released of budgetary allocation by the states and LGAs Implementation of the National Health Act at all levels
		# of HF that have functional cold-chain system	ADS – 142 KBS – 618 BAU – 250	ADS – 226 KBS – 700 BAU – 400	DHIS, Program Reports	
	Result 3: By 2019, capacity for effective coordination of integrated MNCHN service delivery and social protection mechanisms are strengthened at national, state and LGA levels in supported states.	# of LGAs conducting integrated quarterly Integrated Supportive Supervision (ISS) to all facilities in their catchment area	ADS – 17 KBS – 21 BAU – 20	ADS – 21 KBS – 21 BAU – 20	DHIS, Program Reports	
		% PHC facilities submitting timely and complete reports to HMIS data	ADS – 40 KBS – 44 BAU – TBD	ADS – 80 KBS – 80 BAU – 80	DHIS, Program Reports	
	Result 4: Achieve and maintain polio free status in Nigeria by 2017	Proportion of high risk LGAs that are supervised by Management support team during SIAs	TBD	80%	IPD data base	Timely prioritisation of risk LGAs done
	Result 5: Quality of Health Information and its use for decision making is strengthened.	# of planned data quality assessments conducted using internationally agreed quality criteria such as the Data Quality Assessment Framework (DQAF)	0 (2015)	3 (2018) (at least one per year)	Reports of DQA assessments	No delays or interruptions to planned timelines for activities due to political/security factors.
	Result 6.: by 2019, improvement of local institutional capacity at state level to plan and prepare costed budgets	# of health accounts estimations conducted	3 (2015)	6 (2018; cumulative)	Health accounts reports	

	Cross –Cutting: By 2019, lessons learned and impact of the project has been documented, disseminated and scaled up to all LGAs within the three states as well in other states in the country.	# of research conducted showcasing the results of the one-PHC facility per ward model	ADS – TBD KBS – TBD BAU – TBD	ADS – 2 KBS – 3 BAU – 2	District Health Information System (DHIS), Program Reports, Special Studies	Continued released of budgetary allocation by the States and LGAs Implementation of the National Health Act at all levels
		# of success stories and lessons documented concerning one-PHC facility per ward model	ADS – NA KBS – NA BAU – NA	ADS – 3 KBS – 3 BAU– 3	DHIS, Program Reports, Special Studies	

MICS – Multiple Indicator Cluster Survey

ADS – Adamawa

KBS – Kebbi

BAU – Bauchi

TBD – to be determined

NA – not available

NE – north east

NW – north west.