



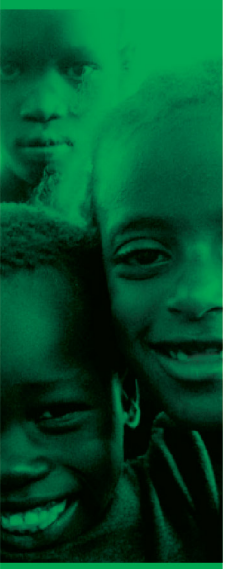

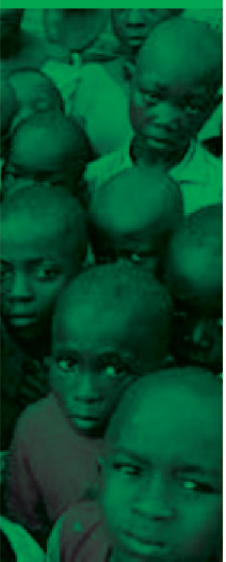


FEDERAL MINISTRY OF HEALTH

SAVING ONE MILLION LIVES PROGRAM FOR RESULTS

PROGRAM IMPLEMENTATION MANUAL (PIM)

ABUJA, NIGERIA

August, 2016

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AUGUST 2016

FOREWARD

Nigeria has made modest progress in the health sector over the last two decades, even though not commensurate with the huge investment at the three levels of government. Aggregate data now shows that some 900,000 children and mothers are dyeing per year. This slow rate of progress has serious economic and developmental consequences and therefore unacceptable. We have observed that solutions focused on improving inputs have not worked in the past but the availability of many of the needed inputs (such as health facilities, and trained health workers) suggest that governance broadly defined, is the binding constraint.

As a response to that, the Federal Ministry of Health introduced an innovative financing mechanism which we hope will help address the challenges observed. The program is the first Program for Result (PforR) in Nigeria, providing an opportunity to boldly address governance and management issues towards ensuring (i) greater focus on results; (ii) increased accountability; (iii) improved measurement; and (iv) encouragement of innovation.
This PforR will help with setting technical standards and establishing protocols as well as providing technical guidance and support to States and service providers. Furthermore, the PforR will help strengthen fiscal Federalism and encourage the Federal-State relationship to become a results-based partnership.

The Saving One Million Lives (SOML-PforR) is financed by a $500 million International Development Association credit from the World Bank to the Federal Government and then disbursed to the states as grants, based on performance improvement in maternal and new born indices. Eighty Two Percent (82%) of the total credit sum would be disbursed to states over the four year period of the program. State governments will be rewarded based on actual improvement as elucidated through the Health Facility and House hold (SMART) surveys.
The PforR indeed is an important reform which will change the way health care is delivered, not just at the PHC but the health sector in general. Analysis suggest that leading reforms in Nigeria solely affects the public sector, but the PforR will be a hybrid delivery arrangement that employs non-state actors. The program also supports the motivation of public officials through result based investments that aim to unleash their latent capacity. The program also builds strong tracking and learning systems.

With the astute leadership under President Muhammadu Buhari and the change mantra, the PforR couldn't have come at a better time when the country is experiencing huge fiscal challenge. Maximum and strict utilization of funds is therefore required, reflecting results and outcomes. I look forward to the implementation of PforR in all our tertiary health institutions and other sectors of Nigerian government in the future.

PROF. ISAAC F. ADEWOLE, FAS, FSPSP, DSc (Hons)
The Honourable Minister Of Health

THE HONOURABLE MINISTER OF HEALTH
PROF. ISAAC F. ADEWOLE, FAS, FSPSP, DSc (Hons)

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INTRODUCTION

The Save One Million Lives Program for Results (SOML PforR) is a Federal Government of Nigeria maternal and child health program, supported by the World Bank, which provides incentives based on achievement of results (health outcomes) and helps to drive institutional processes needed to achieve these results. The Program, which seeks to catalyze change in the way health business is done by focusing on results and governance, will be financed by a US$500million International Development Association (IDA) credit to the Federal Republic of Nigeria over a period of 4 years.
This Program Implementation Manual provides a description of the program and operational guidelines for effective implementation. The Manual contains guidelines and procedures relating to disbursements and fund flows, institutional arrangements, financial management as well as monitoring and evaluation, while providing clear definition of the roles and responsibilities of all stakeholders. It is based on the Program Appraisal Document, Legal Agreement and Disbursement Letter negotiated between the Federal Government of Nigeria and the World Bank. Should there arise any conflicts between the manual and these documents, the contents of the negotiated documents shall take precedence.

B. BACKGROUND

About 900,000 children and mothers die every year in Nigeria, largely from preventable causes. Over the last decade the trend in health, nutrition, and population outcomes in Nigeria has been mixed. There has been a 36% decline in the last 10 years in the under-5 mortality rate (U5MR) and a 31% decline in infant mortality rate in the same period. However, the overall outcomes are not commensurate with the huge investments that have been made in health.

The SOML Initiative was launched by the President of Nigeria in October 2012 in response to the poor health outcomes in the country, particularly for mothers and children. SOML represents a bold attempt to improve maternal and child health outcomes so that they are more in keeping with the country's level of wealth. It also intends for the health sector to contribute to the economic and social development of Nigeria instead of being a drag on growth.

The program focuses on six important aspects ("pillars") of maternal newborn and child health (MNCH) that can save lives and two 'enablers'. The pillars are: (1) Improving Maternal, Newborn and Child Health; (2) Improving routine immunization coverage and achieving polio eradication; (3) Elimination of Mother to Child Transmission of HIV; (4) Scaling up access to essential medicines and commodities; (5) Malaria control; (6) Improving child nutrition. The two enablers are (7) strengthening logistics and supply chain management and (8) promoting innovation and use of technology to improve health services.

The FGON's program document for SOML plainly states that "Continuing business as usual is not a viable option." It goes on to stress that SOML represents "a shift in focus from inputs to focusing on results and outcomes." The SOML program is also predicated on the fact that "bold innovations and changes in the approach to delivery in the sector are necessary."

The SOML program involves: (i) re-orienting the discussion of service delivery to results rather than just inputs; (ii) clearly articulating strategic priorities for the FGON and the rest of the health sector and strengthening the long term commitment to improving the delivery of these high impact interventions. It does not say that other interventions are unimportant, just that the selected intervention ("pillars") are priorities that should get the first call on resources, effort, and attention; (iii) establishing a limited set of clear and measurable indicators by which to track success; (iv) strengthening data collection so that these indicators can be measured more frequently and more robustly; (v) bolstering accountability so that managers and health workers at all levels are engaged, encouraged, and incentivized to achieve better results; and (vi) fostering innovations that increase the focus on results and include greater openness to working with the private sector.

THE SOML PROGRAM FOR RESULTS

To help catalyze the focus on results, the World Bank is supporting the FGON's SOML program through a PforR operation. The SOML PforR rewards federal and state governments based on their performance in increasingutilization of maternal and child health interventions.

Instead of focusing on inputs, the PforR is designed to disburse against measurable results. States are the greatest beneficiaries of the program, receiving up to 82% of the total credit sum as incentive for improved performance under the various disbursement linked indicators (DLIs).

Under the SOML PforR, states will be rewarded for their performance based on objective indicators using data from household and health facility surveys as well as achievement of certain process indicators related to implementation of a performance management system; and consolidation of primary health care (PHC) management and resources under one institution.

States get rewarded for improvements states in performance from their own baseline. States in each geopolitical zone are also ranked according to their performance and the best performing state, 'zonal champion' receives an additional bonus. Similarly, the best performing state in the country 'national champion' receives an additional performance bonus.

The Federal Government will also be rewarded for its performance related to conduct of household and health facility surveys and dissemination of the results; technical assistance for a performance management system that builds capacity at state level; establishment of an innovation fund; and publication of a consolidated budget execution report covering all income and expenditures for PHC.

ThisPforR will help with setting technical standards and establishing protocols as well as providing technical guidance and support to and service providers. Furthermore, the PforR will help strengthen fiscal federalism and encourage the Federal-State relationship to become a results-based partnership.

C. PROGRAM DEVELOPMENT OBJECTIVE AND INDICATORS

The PDO for this operation is 'to increase the utilization and quality of high impact reproductive, child health and nutrition interventions'.

The PDO indicators are:

i. Increase in the combined coverage of six key SOML services; (a) vaccination coverage among young children (Penta3); (b) contraceptive prevalence rate (modern methods); (c) Vitamin A supplementation among children 6 months to 5 years of age; (d) skilled birth attendance; (e) HIV counseling and testing among women attending antenatal care; and (f) use of insecticide treated nets (ITNs) by children under-5; and
ii. Improved quality of care index at health center level.

These PDO indicators will be measured by annual Standardized Monitoring and Assessment of Relief Transitions (SMART) household surveys and health facility surveys that provide state-level estimates of performance. The targets will be based on the historical progress on these indicators in Nigeria and globally and are set out in the results framework in Annex 1.

In addition, the first indicator will be tracked by income quintile to determine whether the poorest 40 percent of the population have experienced significant progress.

D. DISBURSEMENT LINKED INDICATORS (DLIS)

The PforR will provide funds to the FGON based on a set of five DLIs described below. The DLIs have been chosen, in consultation with government based on the government's SOML Program Appraisal Document (2012). The DLIs are a mix of quantitative (DLI 1) and qualitative (DLI2)measures of service utilization, as well as, process and governance measures(DLI 3, 5) focusing on strengthening country systems deemed essential to achieve the PDO.

Disbursement Linked Indicator	Means of Verification	Indicative Allocation ($US M)	% of Total
DLI 1-Increasing Utilization of High Impact Reproductive and Child Health and Nutrition Interventions DLI 1.1 States produce plans for achieving reductions in Maternal, Prenatal and Under 5 child mortality	SMART Survey Results disaggregated by state Review by FMOH & IVA	**305**	**61%**
DLI 1.2 Improvements on 6 key health indicators: a. Penta3 vaccination, b. Insecticide treated nets used by children under 5, c. Contraceptive prevalence rate, d. Skilled birth attendance, e. HIV counseling and testing during antenatal care, and f. Vitamin A coverage children 6 months to 5 years. DLI 1.3. Lagging states will strengthen their MNCH weeks as part of an impact evaluation.			
DLI 2-Increasing Quality of High Impact Reproductive and Child Health and Nutrition Interventions: States will improve the quality of care at primary health care facilities.	Health Facility Survey Results disaggregated by state Review by FMOH & IVA	**54**	**11%**
DLI 3-Improving M&E Systems and Data Utilization DLI 3.1 Improving M&E Systems A. Conduct SMART surveys in all 36+1 states; B. introduce annual health facility surveys (harmonized based on SDI and SARA methodologies) covering all 36+1 states; and C. Collect data on MMR through the 2016 census (or an acceptable alternative). DLI 3.2 Improving Data Utilization A. widely disseminate the results of SMART and harmonized health facility survey data; B. strengthen management capacity of state health and FMOH leadership. DLI 3.3 Implementing Performance Management A. Implement performance management system in all states.	Review of survey reports by Independent Verification Agent (IVA) Review by FMOH & IVA	**80**	**16%**

Disbursement Linked Indicator	Means of Verification	Indicative Allocation ($US M)	% of Total
DLI4 - Increasing Utilization and Quality of Reproductive and Child Health and Nutrition Interventions Through Private Sector Innovation: A competitive innovation fund will be established and effectively managed that supports innovations for techniques and technologies and innovations in health service delivery by private sector providers.	auditors		
DLI5 - Increasing Transparency in Management and Budgeting for PHC: States will: (i) transfer health staff to entity responsible for PHC; and (ii) produce and publish a consolidated budget execution report covering all income and expenditures for PHC. The FGON will publish a consolidated budget execution report covering all income and expenditures for PHC.	Review by FMOH and IVA	**41**	**8%**
TOTAL		**500**	**100%**

I. DLI 1-Increasing the Utilization of High Impact Reproductive and Child Health and Nutrition Interventions: This focuses on increasing the quantity of key SOML services delivered to the patients.

i. DLI 1.1 States produce plans for achieving reductions in Maternal, Perinatal and Under 5 child mortality

In order to support states and give them an opportunity to address legacy issues (such as infrequent and non-systematic supervision or poor performance during MNCH weeks) or to introduce innovations (such as performance-based financing at health facility level or pro-poor health insurance at community level) states will be provided an initial "one-off" disbursement at the beginning of the Program. Each state will receive $1.5 million. Disbursements will be made based on each state developing a plan for addressing specific weaknesses that hinder PHC service delivery with an emphasis on improving supervision and introducing innovations.

The PMU will convene a workshop with facilitators and resource persons from FMOH, NPHCDA, NHIS, World Bank and other relevant parties/agencies to address plan formulation. Modules will include plan content, appraisal criteria, budgeting, menu of innovations and available evidence on implementation. Ongoing support will be provided to states to finalize the plans by the PMU, PSU, NPHCDA or other agencies and development partners.

Following submission of these work-plans to the FMOH, the PMU will approve the plans based on explicit criteria and funds will then be released to states.

The template for state work-plans, the criteria for judging the plans as well as the proposed supervisory checklist to be usedcan be found in Annex 2.

ii. DLI 1.2 Improvements in key health indicators

Disbursements will be based on improvements by the states from their baseline performance on six key indicators: (i) immunization coverage (Pentavalent3); (ii) insecticide-treated net (ITN) use by children under 5; (iii) proportion of pregnant women who receive HIV counseling and testing as part of their antenatal care; (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage among children 6 to 59 months. The indicators selected represent the six pillars of SOML and are among the most cost-effective means for saving the lives of mothers and children.

The disbursements will be based on overall performance (improvement) on all 6 indicators to encourage health system strengthening broadly, not just a focus on individual vertical programs. The performance score will simply be the arithmetic sum of changes in the six indicators which will be calculated annually based on household surveys conducted by National Bureau of Statistics (Standardized Monitoring and Assessment of Relief and Transitions or SMART surveys) with extensive technical support from UNICEF. Baseline data exists for all 36 + 1 states for 2015. Each state will be eligible for $205,000 per percentage point gain above the minimum threshold of 6 (the average annual gain between 2008 and 2013). A state that achieves the targets set out in the results framework will receive about $3 million per year. In addition, the best improved state per geo-political zone will receive an additional $500,000, except in the Northeast and Northwest where the two best improved states will receive the additional $500,000 disbursement. A "national champion" will receive $1 million on top of the amount they receive based on their performance score. Payments to the states will not be tied to specific inputs and can be flexibly used.

Linking the amount of funding received by states to objectively verifiable improvements in results, should act as a spur to states to improve management and pay more attention to data. Friendly competition will also be engendered among the states as they strive to be zonal and national champions.

iii. DLI 1.3 - Evaluating the Impact of Results-Based Disbursements for MNCH Weeks: The Federal Government has worked with the States to implement maternal, newborn, and child health (MNCH) weeks since 2010. The MNCH weeks try to mobilize communities as a means of increasing the coverage of simple but effective, preventive interventions such as childhood immunization, Vitamin A supplementation, nutrition assessment, and de-worming. During MNCH weeks health workers from public health facilities are expected to visit more remote villages to provide these basic services and communities living closer to health facilities are expected to visit the facilities to receive the services. The MNCH Weeks are week-long events, conducted twice a year, aimed at strengthening routine services at health facilities while harnessing the excitement and energy of a campaign.

To strengthen the implementation of MNCH weeks, this DLI will provide results-based disbursement to a random selection of lagging states. In this case, the definition of lagging states is restricted to Vitamin A and immunization coverage because those are the only indicators that can be influenced by MNCH weeks. Ten out of the 20 lagging will be randomly selected to receive payments based on the increase in the proportion of children under 5 who participate in the MNCH weeks as judged by the SMART surveys. The randomly selected states would be provided $80,000 per percentage point increase from baseline or their previous best performance based on participation rates of children under 5. To test whether results-based disbursements to states are effective, lagging states will be randomly allocated to be offered results-based disbursement or not. The design of the impact evaluation is discussed further under the section on monitoring and evaluation.

MNCH weeks represent an opportunity to increase demand for preventive and promotive services and also to bring services closer to communities and can be strengthened rapidly thereby yielding "quick wins" in terms of immunization and vitamin A coverage. The impact evaluation will be important to have strong evidence of the value of results-based disbursement and also help with deciding how much of any progress made is attributable to the PforR.

II. DLI 2-Increasing the Quality of High Impact Reproductive and Child Health and Nutrition Interventions: Building on SOML's commitment to improving the quality of care, the FGON will provide performance disbursements to states based on the quality of services provided at primary health care level. This will be judged by annual health facility surveys that will build on the experience with SDI and other health facility surveys. The survey will be carried out independently by an organization identified by the Federal Ministry of Health. Quality of care will be defined according to an index that comprises:

(i) the diagnostic accuracy and adherence to guidelines by health facility staff;

(ii) availability of drugs and minimum equipment;
(iii) readiness of facilities to deliver key SOML interventions;
(iv) frequency and quality of the supervision provided to the facilities; and
(v) quality of financial management and reporting.

Baseline data for all 36+1 states will be collected in year 1 of the program. Thus, this DLI will begin disbursing in year 2 of the PforR. The disbursements to states will be based on the achievement of changes from baseline (or previous highest performance). The amount provided will be related to improvements and will be $25,000 per percentage point improvement.

This DLI will help ensure that quality of care receives sufficient consideration and attention. This aspect of the DLI will reward state level performance and act to improve management and data utilization. In addition, this focuses on process measures within health facilities (where services are actually provided) that are within the span of control of state health officials. This DLI is also one of the means by which a nationwide PforR can help address issues at the health facility level. By ensuring that the necessary inputs are available, supervision is strengthened, and by ensuring that data is properly collected, the primary health care facilities will be strengthened. Examining financial record keeping will help strengthen the financial management system in the medium term.

III. DLI 3-Improving M&E Systems and Data Utilization:

i. DLI 3.1 Data Collection

Data collection is an essential aspect of the SOML PforR. Having reliable information is a pre-requisite foundation for increased accountability and helps ensure decision-making becomes more evidence-based. Under this DLI the Government will:

(i) Slightly expand the scope of the SMART household surveys to capture data on key elements of SOML (related to MNCH Weeks, prevention of mother to child transmission, and a limited asset index to allow results to be disaggregated by income quintile) and further strengthen its quality assurance. This will mean that the SMART surveys will inter alia: (a) continue to receive technical assistance; (b) use the same sampling methodology and same questionnaires (to ensure comparability over time); and (c) continue to use tablets to conduct data collection.

(ii) As a means of tracking quality of care and better understanding performance at the level of service delivery, the Government will institutionalize annual health facility surveys. The surveys will harmonize and integrate SDI and Service Availability and Readiness Assessment (SARA) methodologies in all 36+1 states. They will provide data that is robust at state level. At a minimum the surveys will have to collect data that comprises the quality of care index under DLI 2. To ensure quality of the survey data the FGON will, inter alia: (a) sign an MOU with the organization/entity responsible for data collection; (b) ensure that high quality technical assistance is available to the data collection entity; (c) ensure consistency in the sampling methodology and questionnaires used.

(iii) Use the 2016 census to collect the most robust possible data on the maternal mortality ratio and the under-5 mortality rate at highly disaggregated levels. Should the 2016 census be significantly delayed, an acceptable alternative would be to carry out an NDHS in 2016 or 2017, earlier than currently scheduled (2018).

ii. DLI 3.2:Strengthening Performance Management and Data Utilization

SOML represents a commitment to strengthen accountability mechanisms for results and implement a performance management system across the country. This will require building the capacity of state health officials to manage for results. This aspect of DLI 3 will reward the FGON for:

(i) Widely disseminating results of the SMART and health facility survey results on the SOML PforR indicators as gathered by the improved data collection systems. This will reward the FGON for making SMART

and health facility data disaggregated by state easily available on the internet and publishing an annual summary in a large circulation national newspaper (at least two);

(ii) Supporting a system of "performance management" and building the management capacity of state and FMOH leadership. This will build on the ongoing approach to strengthen performance management which involves working with federal and state health leaders to analyze available data on PHC performance, develop action plans to address weaknesses, review action plans to see whether actions have been implemented and had intended effect. This is followed iteratively by further analysis etc. For each state where, through technical assistance provided by the Program Support Unit (as witnessed by their significant presence in the state), health managers demonstrate increasing capacity to: (a) analyze PHC performance data coming from various sources; and (b) develop high quality action plans based on the analysis of their results. The FGON would earn $100,000 per state as judged by the IVA. The FGON would earn $250,000 for each vertical program/agency (NPHCDA, NMEP, NASCP, Department of Family Health) that demonstrates increasing capacity to: (a) analyze the performance of their program based on data coming from various sources (e.g. SMART, health facility surveys; etc.; and (b) develop high quality action plans based on the analysis of their results. This would also be judged by the IVA.

iii. DLI 3.3: Implementing Performance Management in All States:
States will be rewarded for implementing a performance management system so that they can effectively track and improve the quality and quantity of SOML related services. States will receive $160,000 for meeting the following conditions: (a) state has a performance management "Lead"/Desk Officer with commensurate capacity to be accountable for the performance management process; (b) evidence of continuous analysis of the available data on PHC performance, including availability of financial resources (see DLI 5); (c) development and updating of appropriate action plans; and (d) at least quarterly, high level review meetings to discuss analysis and agree upon action plans with at least one of the following three officials present: Commissioner for Health, Permanent Secretary or Executive Director SPHCDA.

Improving data availability and quality will improve management ("you manage what you measure"). Thus, merely, collecting data will NOT be enough. In order to be useful the data needs to be widely disseminated, so as to improve accountability and increase political commitment. The data also needs to be used for management purposes by state and Federal level officials. Hence the emphasis on this DLI and the provision of technical assistance to better understand the data and formulate action plans based on their results.

IV. DLI 4-Increasing Utilization and Quality of Maternal and Child Health Interventions through Private Sector Innovation: SOML is explicit in its desire to foment bold innovations to strengthen both the quantity and quality of health services. It is also explicit in its desire to harness the energy and reach of the private sector to provide new techniques, technologies, and approaches as well as extend the coverage of services to under-served populations. Thus the FGON will contract a private sector entity (innovation fund manager) to implement an innovation fund that will, through a competitive process, support innovations by the private sector. Two types of innovations are envisaged:
(i) Developing and testing new techniques and technologies through small grants (up to $100,000 each). Examples of innovations that could be supported include: a) a smart phone application for health facility staff and outreach workers to use to improve diagnosis and management of childhood and maternal diseases using national guidelines; and b) a home-grown ready to use therapeutic food (RUTF) for malnourished children; and

(ii) Testing new approaches to improving the delivery of SOML services by non-state actors. These types of innovations would aim to expand coverage or quality of services at the population level with an emphasis on under-served rural populations, and typically would be implemented for two years. They would be supported by larger grants (up to $1 million each). All these innovations would be subjected to rigorous evaluations (including impact evaluations where practical). Proposals which will be implemented in the Northeast and the Northwest (regardless of where the proposer is from) will be prioritized by being given additional points during the selection process.

The proposals would be judged blindly by an independent panel based on explicit criteria. For the large grants the criteria would include: (i) clear description of the innovation; (ii) evidence that the proposal is actually innovative (a new approach or the application of an existing innovation to a different service/intervention); (iii) rigor and practicality of the evaluation design; (iv) reaching people in the two poorest income quintiles; (v) concentration on rural areas; (vi) credibility and track record of the proposer; (vii) efficiency (low cost per capita) and scalability of the approach; and (viii) evidence of partnership with a state government. Proposals that will be implemented in the Northeast and Northwest will receive extra points.

The FGON, and through it the innovation fund manager, will be rewarded for: (i) transparently and fairly identifying innovative proposals to fund following the criteria and processes described above; (ii) successfully managing the grants so that the innovations are actually implemented or the grants terminated; (iii) rigorously evaluating the large grants; and (iv) scaling up successful innovations and documenting the whole process. The performance of this DLI (and the innovation fund manager) will be formally reviewed annually by the Steering Committee based on a report by the Independent Verification Agent (IVA). Should there be significant challenges with this DLI the funds may be re-allocated to DLIs 1 and 2.

Through this DLI, government can find new ways of productively working with the private sector and build partnerships that help the most technically sophisticated parts of the private sector focus more on reaching the poor.

V. DLI 5 – Increasing Transparency in Management and Budgeting for PHC: Part of the problem impeding accountability for results in maternal and child health is that lines of authority are diffuse, variable, and complex. State level health officials often lack the authority to properly manage staff in public health facilities. They also often do not have control over budgets that would support the PHC management team that works at LGA level or health facilities themselves. The Government has recognized this issue and has developed a policy of "PHC under one roof." This policy, which is implicit in the National Health Act, aims to clarify lines of responsibility and authority for PHC and strengthen a weak budgeting and financial management system. Under this DLI, the FGON would provide funds to all the states as:

(i) The state level health officials responsible for PHC (the state PHC development agency [SPHCDA] or equivalent) are provided management authority over staff at health facility and LGA levels including the power to hire, fire, post, transfer and discipline such staff. The objective measure of accomplishing this will be the physical transfer of human resource files to the concerned state health entity. Each state would earn a one-time payment of $500,000 when they accomplish this.

(ii) State level health entity responsible for PHC (SPHCDA or equivalent such as a "Board") has a consolidated budget to meet the operational costs of providing PHC and can report on the execution of that budget. Each state would earn $300,000 for each year that they are able to produce consolidated budget execution report for all income and expenditures on PHC and publish it on the state government's website. The reports will describe the sources and uses of funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures. A special effort will be made to track vaccine expenditures.

FGON will also publish a Budget Execution Report for PHC: The FGON will receive $2 million for every year that it is able to produce consolidated budget execution report for all income and expenditures on PHC and publish it on the FMOH's and PforR website. The reports will describe the sources and uses of funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures.

E. MEASUREMENT AND VERIFICATION OF DLIS

To ensure veracity of results on which disbursements will be made and transparency of the process, a rigorous, multi-layered measurement and verification protocol has been designed.

Target Setting: The targets for the operation, particularly the ones related to the coverage of key services, have been set based on the experience in Nigeria over the last 5 years and also on longer term global experience. Using the NDHSs from 2008 and 2013 the average annual change, expressed in percentage points, has been calculated (see column b in Table 2). This was then compared to the median annual percentage point change for the same indicators from a large number of countries as calculated in a recent Bank study (see column a in Table 2). Based on these figures a target was set for Nigeria that takes into account the rate of change seen over the last 5 years and what can be expected based on global experience in low-income settings. The targets represent a near doubling of the rate of improvement seen from 2008 to 2013 and about 75 percent of the global median rate of change. Setting these targets is important to judge progress and have realistic expectations. The targets for the core indicators (e.g., number of children immunized, women receiving skilled birth attendance) have been calculated based on the baseline values and expected improvements in coverage multiplied by the size of the birth cohorts in Nigeria. A similar exercise was done to calculate the overall number of beneficiaries.

Table 2: Target Setting - *Percentage Point Change on Key SOML Indicators*

Indicator	Global Experience (1990-2009) Median Annual Change a (a)	Nigeria NDHS 2008-2013, Average Annual Change (b)	Proposed Annual Target in percentage points (c)	Proposed Target for 4 years of PforR
Immunization Coverage (Penta 3)	**3.0**	**0.56**	**1.5**	**6**
Vitamin A	**8.3**	**3.1**	**5**	**20**
Contraceptive Prevalence Rate	**0.7**	**0.02**	**1**	**4**
ITN use by children under 5	**3.0**	**2.22**	**3**	**12**
Skilled Birth Attendance	**1.0**	**-0.16**	**1**	**4**
Antenatal Care	**1.7**	**0.58**	**1.5**	**6**
Total (Sum)	**17.7**	**6.32**	**13**	**52**

Setting Targets in Health Nutrition and Population Projects, Arur A. et al, World Bank 2011.

Data for PDO 1 and DLI 1 will come from household surveys: DLI 1 will be measured using a population-based survey. Of the three main population-based surveys that are routinely conducted in Nigeria, the Standardized Monitoring and Assessment of Relief and Transitions (SMART) is the most practical for purposes of the PforR, and has sufficient quality control mechanisms to produce credible data that can be used for results-based disbursements. SMART has been implemented by National Bureau of Statistics (NBS), an entity independent of the FMOH which reports directly to the National Planning Commission, while technical support and quality assuranceis provided by UNICEF. The SMART tool has been revised to ensure it captures indicator estimates according to the DLI definitions as well as socioeconomic status (SES) information that will allow tracking of equity. However, if the SMART surveys do not continue a credible alternative is to implement "continuous" demographic and health surveys which have provided similarly disaggregated data in other countries.

Technical Aspects of SMART and Quality Assurance: Four rounds of SMART surveys have already been successfully conducted by NBS and the last two rounds, in 2014 and 2015, were carried out in all 36+1 states. The survey sample of nearly 26,000 households is nationally representative and providesrobust state-level estimates for key SOML indicators. The confidence intervals of these estimates are reasonably narrow and would be able to detect programmatically important changes. The results from SMART closely correlate with those from the NDHS (comparing state level immunization coverage in NDHS to SMART yields an R2 = 0.85, for skilled birth attendance the R2 = 0.825, and for CPR R2 = 0.747). The SMART survey data is collected on tablets which allows for various quality assurance checks that prevent "curb-stoning," illogical data, or incomplete data. Extensive technical support continues to be provided by UNICEF. The FGON has undertaken to continue to use the same sampling methodology, same questionnaire, and same quality assurance mechanisms so as to ensure comparability of data over time and ensure data remains robust.

PDO 2 and DLI 2 will be tracked through Health Facility Surveys: Quality of care will be measured through annual health facility surveys (HFSs) that will likely be carried out by NBS or NPopC with extensive technical support. While experience with implementing HFSs in Nigeria is not as strong as for population-based surveys, they have now been carried out in 18 states, 12 through the SDI, and another 6 from the NSHIP baseline impact evaluation study. The Government has committed to carry out a nationwide HFS that will harmonize a WHO service availability and readiness assessment (SARA) and the SDI methodology that the Bank has deployed. This harmonized HFS will be powered to provide robust state-level estimates.

Quality Assurance for HFSs: The Government has agreed to use a consistent sampling methodology, survey questionnaire, and same quality assurance mechanisms (including use of tablets for data collection) so as to ensure data is comparable over time and assure the quality of the data. Development partners will ensure that sufficient technical support is in place.

Impact Evaluation of Results-Based Disbursements: Data from the SMART surveys will be used to carry out an impact evaluation that will assess the effectiveness of the results-based disbursements for MNCH weeks. The 20 poorest performing states in terms of Vitamin A and routine immunization coverage will be randomly allocated (using a randomized block design) to be offered or not the results-based disbursements for MNCH weeks. The SMART surveys will provide information on MNCH week utilization and increases in Vitamin A and immunization coverage. With 10 states in each arm and about 770 households surveyed per state, the impact evaluation would be sufficiently powered to find a 6 percentage point difference in immunization coverage and a 4 percentage point difference in Vitamin A coverage and participation rates in MNCH weeks. While not a pure test of results-based disbursements to states (because the states would still be eligible for financing under DLI 1.1 and 1.2) this impact evaluation would provide useful evidence on the approach in an easily defined result area.

Verification Protocols

Verification for DLI 1 and 2 will be through household and health facility surveys.As described above the verification for DLIs 1 and 2, which together account for 72% of the value of the PforR, will be done on the basis of results of household and health facility surveys. These will be carried out by NBS and/or NPopC, which are independent of the health sector, and benefit from extensive technical support from development partners. The calculations of how much money states should receive (worked examples are detailed in Annex 3) will be carried out by an Independent Verification Agent (IVA) under contract to the FMOF. The IVA will be isolated from political or other pressures.

Verification of Data Collection and Management of PHC at State level will be done by the IVA. For DLI 3 the IVA will review the survey reports produced by NBS and determine whether the quality assurance mechanisms have been implemented. The IVA will also determine which states have transferred staff to the SPHCDA and have published consolidated PHC budget execution reports as per DLI 5.

Implementation of Performance Management & Private Sector Innovation will be verified by third parties. The progress on DLI 3 and 4 will be assessed by the IVA. The performance on DLI 4 will be reviewed by the Steering Committee based on the reports of the IVA and the innovation fund manager's external auditors.

Table 3: *DLI Verification Protocol Table*

#	DLI	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Protocol to evaluate achievement of the DLI and data/result verification		
				Data source/ agency	Verification Entity	Procedure
1.	**Increase of utilization of High Impact Reproductive, Child Health and Nutrition Interventions.**	1.1 States produce plans for achieving reductions in maternal and under 5 mortality 1.2 Improvements in 6 key indicators (Penta3 vaccination, ITN use, CPR, skilled birth attendance, HIV counselling during antenatal care, and Vitamin A coverage) 1.3 Lagging States strengthen their MNCH weeks	No Yes Yes	Plans approved by FMOH SMART Household Survey; National Bureau of Statistics with TA support from UNICEF. Oversight by FMOH	IVA independent Verification agency)	SMART Survey data reviewed by IVA which calculates percentage point change from baseline on the 6 indicators, subtract 6 x number of years into the program and multiply the percentage points by US$205K

#	DLI	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Protocol to evaluate achievement of the DLI and data/result verification		
				Data source/ agency	Verification Entity	Procedure
2.	**Increase of quality of High Impact Reproductive, Child Health and Nutrition Interventions**	States will improve the quality of care at primary health care facilities.	Yes	Health Facility surveys conducted by National Bureau of Statistics with TA support from BMGF. Oversight by FMOH	IVA	Health facility survey data reviewed by IVA which calculates percentage point change from previous high on index of quality of care.
3.	**Improvement of monitoring and evaluation systems and data utilization**	3.1 M&E Systems: (i) Conduct annual SMART surveys in all 36+1 states; (ii) conduct annual health facility surveys covering all 36+1 states; (iii) Collect data on MMR & U5MR using 2016 census; 3.2 Data Utilization: (i) Widely disseminate SOML results; (ii) Strengthen management capacity of state health and FMOH leadership 3.3: Implementing Performance Management (i) implement performance management system in all states	No Yes Yes	Survey reports (household, facility, etc.) coming from NBS FMOH website, newspapers; review of records; visits to states & to federal vertical programs Visits to states & review of plans etc.	IVA IVA IVA	Review survey reports to ensure they have been conducted according to quality norms. Not more than one click from main website. IVA visits states and sees whether they have capacity to implement performance anagement. Also visit federal vertical programs Visit states to assess whether they are implementing performance management system.

#	DLI	Definition/ Description of achievement	Scalability of Disbursements (Yes/No)	Protocol to evaluate achievement of the DLI and data/result verification		
				Data source/ agency	Verification Entity	Procedure
4	**Establishment and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions**	A competitive innovation fund will be established and effectively managed that supports innovations for techniques and technologies and innovations in health service delivery by private sector providers.	No	Documents and database of Innovation Fund Manager & discussions with grantees. Report of Fund Manager's external auditors.	IVA	IVA will collect data from the fund manager and this will be reviewed annually by a committee including representatives of FMOH, FMOF, World Bank.
5	**Increase of transparency in management and budgeting of primary health care:**	States will: (i) transfer health staff to entity responsible for PHC; and (ii) produce and publish a consolidated budget execution report covering all income and expenditures for PHC. The FGON will publish a consolidated budget execution report covering all income and expenditures for PHC.	Yes	Location of health worker personnel files Consolidated PHC budget execution report published online	IVA	IVA will assess whether personnel files have been transferred to SPHCDA State government websites And FMOH Website will be examined to see whether data has been published

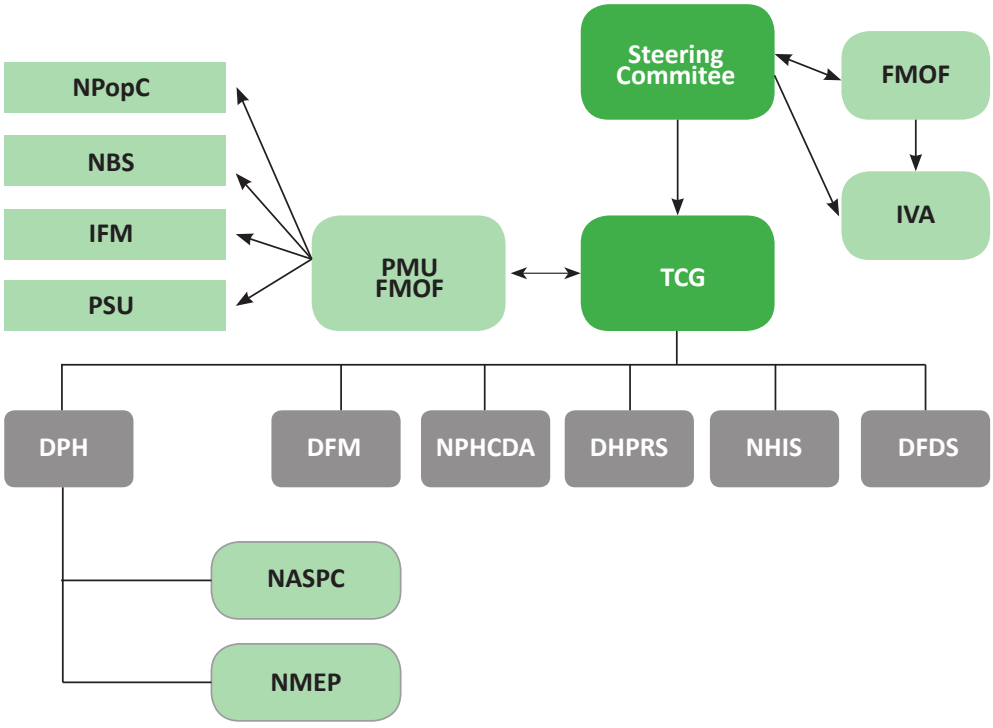
F. INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

The Program for Results will be implemented at the Federal and state levels using a hybrid delivery arrangement that employs non-state actors but also supports the motivation of public officials through results-based investments that aim to unleash the latent capacity within the public sector.
It operates mainly through existing government structures and country systems. Two major coordinating units (one at the federal and one at the state) will be responsible for program management.
Federal Level.

1. Program Steering Committee

The SOML Program will be under the supervision of a steering committee (see Figure 5), chaired by the Honorable Minister of Health and comprising members nominated by the Minister. The Steering Committee will provide oversight and be ultimately responsible for achieving the SOML PforR PDOs and the program development indicators. Members of this Committee will include heads of relevant agencies and departments involved in SOML-related interventions; State Commissioners of Health, representative of the Federal Ministry of Finance, development partners.

Figure 5: Implementation Arrangements for SOML PforR



FMOF = Federal Ministry of Finance; IVA = Independent Verification Agency; TCG = Technical Consultative Group; PMU = Program Management Unit; NBS = National Bureau of Statistics; NPopC = National Population Commission; DPH = Department of Public Health; DFH = Department of Family Health; NPHCDA = National Primary Health Care Development Agency; DHPRS = Department of Health Planning, Research, and Statistics; NMEP = National Malaria Elimination Program; NASCP = National AIDS Control Program; DFA = Department of Finance and Accounts; IFM = Innovation Fund Manager; DFDS= Department of Food and Drugs Services; NHIS= National Health Insurance Scheme; PSU = Program Support Unit

2. Federal Ministry of Finance (FMOF)

The FMOF will play a financial oversight role and will sit on the Steering Committee. The FMOF will: (i) ensure that public funds are used appropriately during implementation and that all expenditures use the FGON's integrated financial management information system (IFMIS) and follow the appropriate procurement laws and regulations; (ii) help the FMOH improve its budget execution, particularly for PHC and SOML in particular; (iii) help the health sector in creating budget execution reports (under DLI 5) and develop a medium-term expenditure framework for SOML and PHC more broadly; (iv) help ensure timely payments under the PforR are made to states and other entities supporting SOML (including PMU, PSU, IVA, Innovation Fund Manager, NBS, NPopC); and (v) ensure that the FGON is obtaining value for money.

3. Program Management Unit (PMU)

The Program Management Unit (PMU) for SOML will be in charge of the day-to-day implementation of SOML and the PforR and will work very closely with PSU(s). The PMU will be responsible for the coordination of SOML activities in the FMOH through a "Technical Consultative Group" to be chaired by the Permanent Secretary (see below). The PMU will be headed by a full time manager whose only charge will be implementation of SOML. In order to facilitate successful implementation, the PMU manager and his team as well as the approving officers will receive a performance bonus linked to timely disbursement of funds to the states (particularly under DLIs 1 and 2), timely collection and publication of data, and timely implementation of federal level actions. The bonus will be calculated as 100 percent of annual gross basic salary. The PMU manager will be supported by full time and technically competent Federal Government staff and consultants that have been competitively hired and paid market wages. The PMU will have lean and efficient staffing and its organizational structure will be reviewed by the Steering Committee. The Steering Committee will also review the performance of the PMU after 6 months and then annually. The PMU will prepare annual work-plans and budget for its operation which will be funded from the SOML Special Fund Account. In a situation which the PMU is unable to access funds easily, procure goods and services efficiently, or faces other implementation challenges, alternative secretariat arrangements (e.g. through the PSU) will be instituted.
The PMU will have specific responsibilities which include:

(i) Coordinating and facilitating FMOH activities related to SOML;
(ii) Ensuring the timely collection of high quality data and its publication (DLI 3);
(iii) Implementing and overseeing the initial disbursements to states under DLI 1;
(iv) Communicating and working with states, developing and implementing a communications plan;
(v) Serving as secretariat for the Program Steering Committee;
(vi) Facilitating the timely disbursement of funds to the States;
(vii) Knowledge management and learning;
(viii) Making sure that covenants are complied with and that the program action plan is implemented.

Some of the specific implementation tasks to be carried out by the PMU can be found in the Annex.

4. Technical Consultative Group (TCG)

The SOML Program is centered in the FMOH. The TCG to be chaired by the Permanent Secretary will comprise representatives from the Department of Family Health, the Department of Finance and Accounts, the National Primary Health Care Development Agency (NPHCDA), the Department of Health Planning, Research, and Statistics (DPRS), the Department of Public Health including the National Malaria Elimination Program (NMEP) and the National AIDS Control Program (NASCP). These parts of the FMOH are in charge of the six pillars of SOML. Representatives of the National Health Insurance Scheme and Department of Food and Drug Services will also be members of the TCG. The TCG will ensure that the vertical programs remain focused on results, survey data is regularly analyzed in detail, and that the issues identified are addressed. The PMU will serve as the secretariat for the TCG.

5. Program Support Unit (PSU)

The PSU is a contractor of the FMOH and will support the PMU. The collaboration between the FMOH and the PSU will be governed by a contract that will be signed within 1 month of effectiveness. The contract will make explicit the role of the PSU which will include:

i. Providing technical assistance around performance management to the states, particularly lagging states, to help improve their achievements (DLI 3);
ii. Helping states formulate their plans in order to access the initial disbursements under DLI 1.1;
iii. Assisting key vertical programs within the FMOH (immunization, malaria, etc.) in analyzing the data and adjusting their work accordingly; and
iv. Providing other technical assistance such as in assessing expenditure on SOML and PHC (DLI 5) and improving data analytical skills.
v. The FGON will recruit an organization to carry out the PSU functions (TORs are in Annex 4).

6. Innovation Fund Manager

The Innovation Fund Manager running the Private Sector Innovation and Learning Fund (i.e., DLI4) will have a contract with the FMOH (TORs are in Annex 4). This entity will: (i) have considerable experience running competitive innovation funds; (ii) have a history of involvement in SOML activities; and (iii) be able to play a catalytic role in bringing the private sector (including for-profit companies) into SOML activities thereby facilitating public –private partnerships. It would be an advantage if the Innovation Fund Manager brought some of its own funds to the effort so it is not solely reliant on the FGON for financing.

7. Independent Verification Agent

In order to independently verify the results achieved and calculate how much should be paid to each state, an independent verification agent (IVA) will be recruited by the FMOF (TORs are in Annex 4). The IVA will examine the results of the SMART household surveys and the health facility surveys and calculate how much should be paid to each state. It will also review the results under the other DLIs and submit its report to all members of the Program Steering Committee.
State Level

Though SOML is a Federal Program, implementation is at the state level and through health facilities where services are actually delivered to the patients. In recognition of this, states receive up to 82% of the entire program funds. It is therefore critical to clearly articulate arrangements at the state level.

Roles and Responsibilities of State Government

The state plays a huge role in the SOML PforR, including but not limited to:

1. Awareness creation for SOML PforR and earnings support of the State Government – executive and legislature.

2. Coordination/establishment of implementation structure. This will include:
i) Setting a common goal;
ii) Identifying teams and defining roles;
iii) Planning and implementation;
iv) Continuous Program advocacy/communication;
v) Appointing a State Program Manager who is technically sound with good managerial ability.

3. Preparation of plans for the use of initial investment funds and future program funds, focusing on:
i) Bottleneck analysis of PHC delivery using all available sources of data;
ii) How to improve supervision of PHC facilities;
iii) Potential innovations to introduce;
iv) Quick improvements in coverage of key SOML interventions and quality of care (to earn funds under DLIs 1.2 and 2).

4. Implementation of a performance management system in each state that includes:
i) Evidence of continuous analysis of available data on PHC performance including finances;
ii) Developing and updating of appropriate action plans;
iii) At least quarterly high level review meetings to discuss analysis and agree upon action plans with at least one of the following officials present: Commissioner, Permanent Secretary or ED/SPHCDA.

5. Tracking and improving the quantity and quality of SOML related services.

6. Constant engagement of relevant development partners and NGOs in the state involved in the implementation of the SOML PforR.

7. Establishment of State Primary Healthcare Development Agencies (SPHCDAs) as a way of consolidating the management of the PHC system:
i) Transfer PHC workers to SPHCDA – DLI 5;
ii) Start tracking PHC budget and its execution;
iii) Produce and publish a consolidated budget execution report covering all income and expenditure for PHC– DLI 5.

8. Initiation of programs aimed at addressing health system weaknesses which may include Social Health Insurance, Conditional Cash Transfer and many other intervention mechanisms to be agreed upon with the PMU before fund disbursement.

9. Engagement of private sector entities on opportunities for Public-Private Partnerships under DLI 4.

10. The different structures in the States responsible for SOML key indicators must work together – MOH, SPHCDA, HIV/AIDS & Malaria programs, SOML PForR Desk officer, MOF etc.

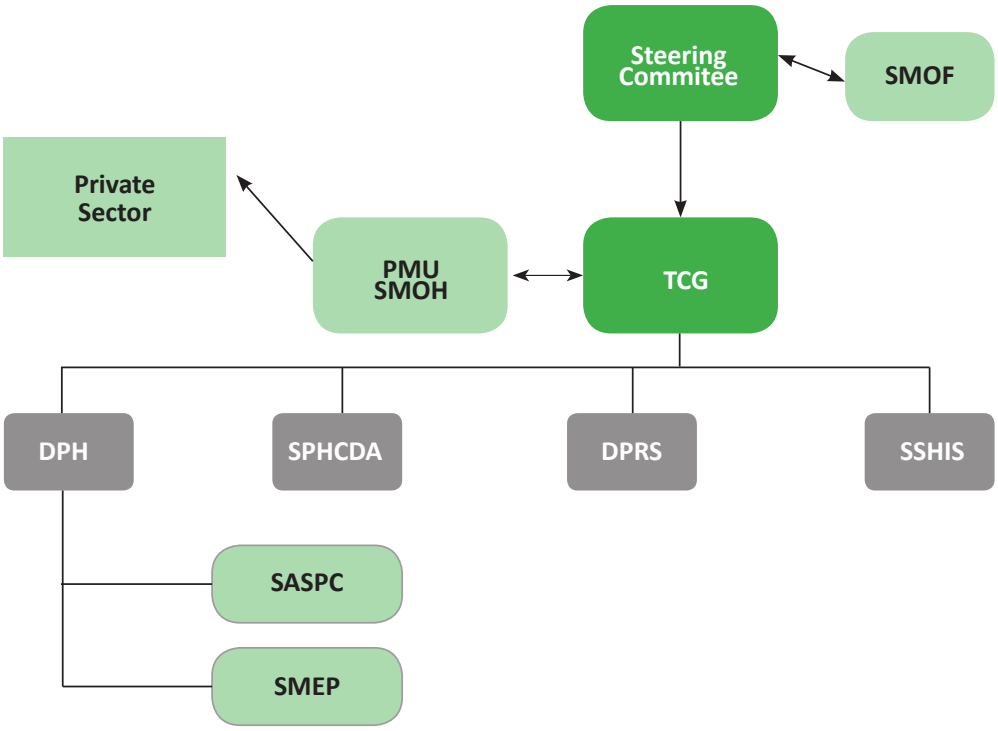
Implementation Structure

To ensure successful implementation of the program, the state will be expected to replicate a structure similar to that which obtains at the Federal level but adapted to suit the context and particular situation within the state. The Honorable Commissioner and (or) the Permanent Secretary shall have approving powers and provide oversight for the SOML PforR program activities at the state.

1. Program Steering Committee

The SOML Program will be under the supervision of a steering committee, chaired by the Honorable Commissioner of Health. The Steering Committee will provide oversight and be ultimately responsible for achieving the SOML PforR objectives and targets in the state. Members of this Committee will include heads of relevant agencies and departments involved in SOML-related interventions; Permanent Secretary of Health, representative of the State Ministry of Finance, development partners (e.g., WHO, UNICEF, UNFPA, BMGF, etc.) The Steering Committee will meet at least twice a year to review state performance.

Figure 6: Proposed Implementation Arrangements at State Level



2. Program Management Unit (PMU)

The PMU is expected to be lean and should not duplicate existing structures. It is recommended that the Unitshould consist of not more than three capable,technically competent officers with membership drawn from key departments/programs/agencies responsible for delivery of SOML interventions.The team will be responsible for day to day implementation of the program and will be headed by the Program Manager who will be the main accountability officer for the program.
The Program Managershall be a person of suitable competence, and seniority.
The PMU shall:

i) Liaise with and be in ongoing communication with the Federal PMU regarding the program;
ii) Be responsible, together with the state health management, for coordinating activities related to the program;
iii) Serve as the secretary/secretariat for all information directly related to the program;
iv) Do all that is reasonably required to ensure that the state makes progress on the DLIs
v) Ensure that the program work plan is implemented;
vi) Ensure that all stakeholders are engaged and working together to strengthen the health system and achieve program objectives;
vii) Facilitate the timely disbursement of funds to the relevant agencies and departments;
viii) Ensure that all state data relating to SOML interventions is tracked and utilized for decision making.

3. State Technical Consultative Group

This shall mirror the federal TCG and draw representation from directors of all programs directly related to the key SOML interventions. This will include but may not be limited to Director Public Health; Director Primary Health Care, Executive Secretary/Executive Chairman State Primary Health Care Development Agency/Board, State Malaria Elimination Program Coordinator, State HIV/AIDs Control Program Coordinator.

The TCG will meet quarterly and shall be responsible for ensuring that the vertical programs remain focused

on results, data (survey and administrative) is regularly analyzed in detail, and that the issues identified are addressed. The PMU will serve as the secretariat for the TCG.

G. PROGRAM FINANCIAL MANAGEMENT, GOVERNANCE AND PROCUREMENT SYSTEMS

The financial management arrangements for the program will remain anchored on the use of the country financial management systems. The existing systems of budgetary planning, budget preparation, budget execution, accounting, internal controls, funds flow, financial reporting, external audit and legislative oversight will be adopted for Program implementation.
Payments and Flow of Funds
Federal
Disbursements from the World Bank, in respect of:

• Federal government's own expenditure under the Program (including for technical verification and monitoring and evaluation activities), will be released to the Special Fund Account of the Federal Government (a sub-set of the Consolidated Revenue Fund, and that forms part of the TSA) held with the Central Bank of Nigeria.

• Funds to be directed to special program related activities like 'private sector innovation fund', these will be disbursed into a designated (segregated) account held with the CBN and paid out to beneficiaries through the FMOHbudget implementation process.

• Performance disbursements to the States based on their performance against the DLIs, withdrawals will be initiated by the FMOH and payments will be made to the Special Fund Account at the CBN. Once state earnings have been determined and verified, the Program Management Unit (PMU) will set in motion the disbursement process. As soon as the World Bank receives a withdrawal application, funds will be disbursed to a dedicated account of the Federal Government for transfer to the accounts states have in the Central Bank within 30 days.

The process flow is described below:
1. The Accountant General of the Federation, at the request of the Ministry of Finance, establishes a 'Special Fund Account' (SFA) at the CBN to receive and disburse funds under the SOML Program. The Special Fund Account will be opened with the name: 'SOML Program Account', in USD.

2. The signatories on this account will be: Panel A: (a) Director, Family Health; (b) Program Manager, SOML PforR; and Panel B: (a) Director, Finance and Account, Federal Ministry of Health (b) SOML PforR Program Accountant.One signatory from each panel would need to sign the withdrawal application from the World Bank as well as any payments out of US Dollar denominated Special Fund Account (SOML Program Account) with the CBN for such transaction to be considered valid.

3. For expenditures out of the Special Fund Account (SFA) – SOML Program Account - the following procedures will be adopted:

* In respect of operational expenditures of the Ministry of Health:

i. A single account, will be established at the CBN under a new fund (Program Operational FUND Account) akin to the TSA. This account (to be denominated in Naira – being the transaction currency of the Government budget) will be operated just like the normal budgetary expenditures are managed under the GIFMIS under the TSA. The electronic signatories will be based on the GIFMIS authorized user profiles, same as the signatories for USD Account and the Withdrawal Application.

ii. For this Naira denominated account (which will be a stand-alone form of a TSA), the process of

transferring funds from the account will be as follows:

a. The Ministry will submit cash plansthrough the GIFMIS portal.
b. The OAGF will clear the cash plans through the GIFMIS, based on available funds allocated from the SOML SFA for the purpose.
c. The Budget Department will also clear, through GIFMIS, and thus release the funds (warrant process).
d. Upon the release of the funds, the sum total value of the warrants approved for the operational expenses, based on the above process, will be formally transferred through a transfer request letter to be issued to the CBN, under the same signatories as for the withdrawal application authorizing the transfer of the Naira equivalent from the SFA of the Program to the Program Operational FUND account. The official exchange rate between the USD and Naira will be applied by the CBN to move USDs from the SFA to Naira-based Operational FUND account. This will be accounted in the GIFMIS through a journal process – crediting the Program Operational FUND account (with Naira) and debiting the SOML SFA (with the USD equivalent).
e. The Ministry will, commence the use of the funds for planned expenditures (cleared through the EFT arrangement in the GIFMIS), via the CBN, but against the Program Operational FUND account.
f. With the issuance of warrants, the control of actual expenditureswill be exercised as no expenditures in the GIFMIS would be performed beyond the amount so released under (c) above.

Note: Transfers to local NGOs, Payments to the Innovation Funds, are included as part of the Program Operational Fund expenditures in the cash plans to be submittedand subjected to GIFMIS-based warrant issue – but under a stand-alone TSA type arrangement.

* In respect of expenditures related to performance grant transfers to eligible States and Foreign/overseas denominated expenditures:

- The Program Management Unit (PMU) at the Ministry of Health will be the originator of the request for transfers. The underlying supporting documents to enable the signatories to sign-on the CBN transfer request will be the Independent Verification Agent's validation report on States' performance that was cleared by the World Bank and which formed the basis for submission of a Withdrawal Application to the World Bank.

- The signatories for the release of the grants to the respective accounts of the States /overseas denominated expenditures will be the same as for signatories on the withdrawal application to the World Bank as well as the signatories for transfer of Naira from the SFA to the Program Operational FUND account.

- The States would have established US Dollar foreign exchange accounts for the SOML grant receipts at the CBN to allow internal transfers of their entitlements from the SOML SFA to their respective State SOML Grant receipt accounts.

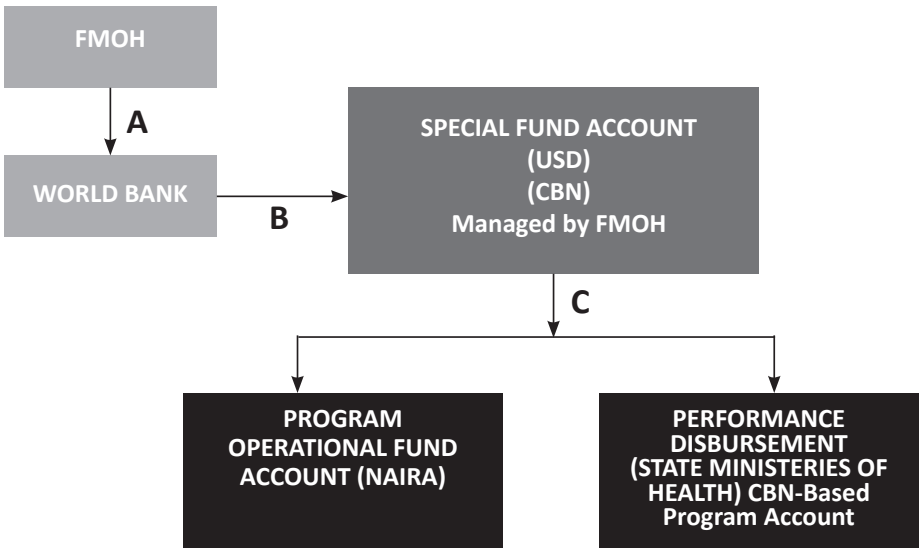
- The AGF will, upon issuance of the transfer requests, ex post, create a journal in the GIFMIS to cater to the accounting transaction against the SOML SFA (using the Government chart of accounts coding elements that will need to be introduced for the 'performance grant transfers to States').

4. The AGF would therefore need to establish new elements in the Government Chart of Accounts to capture all the transactions not only for the program operational expenditures (including transfers to local NGOs, payments to the Innovation Funds), but also the performance grant transfers to States. Of course, the SOML Program will be introduced in the Chart as a 'program' – requiring the enabling of the program element in GIFMIS.

5. The financial reporting of the IDA-related program expenditures will entail the consolidation of expenditures made for SOML Program operational activities (including NGOs/Innovation Fund transfers), and the transfers to States. As the largest proportion of expenditures under the Program will relate to

performance grant transfers to States' accounts in USD, it would be expedient to prepare the financial reports using USD as the transaction currency. The PMU at the FMOH will be responsible for preparing the Program Financial Statement.

SCHEMATIC DIAGRAM - FUNDS FLOW ARRANGEMENTS UNDER THE PROGRAM



[A]: Upon verification and approval by Steering Committee or the Honorable Minister of Health of achievement of DLIs, FMOH submits Withdrawal Application (WA) to the World Bank (WB) for disbursement.

[B]: World Bank disburses to the SOML Special Fund Account held with the CBN for subsequent payment to beneficiaries under the program.

[C]: From the Special Fund Account, transfers are made to States and to FMOH for operational expenditures. Transfers to States will be accomplished within 30 days of receipt of disbursements from the World Bank. All disbursements will be through IFMIS against the program – compensation of employees, goods and services, capital investments, transfers.
State

The process flow is described below:

1. The Accountant General of the State, at the request of the Ministry of Health, establishes a 'Special Fund Account' (SFA) at the CBN to receive and disburse funds under the SOML Program. The Special Fund Account will be opened with the name: 'State SOML Program Account', in USD as well as State SOML Program Account' in Naira.
2. The State shall determine the signatories to both its dollar and naira accounts in line with government financial regulations under the state Ministry of Health. It is recommended that the Program Manager be one of the signatories to the account
3. Withdrawal of funds shall be exclusively by electronic transfer after approval of expenditure plan by the Hon Commissioner of Health and or Permanent Secretary.
4. The GIFMIS shall be adhered to strictly.

ACCOUNTABILITY FRAMEWORK

Accounting and Financial Reporting

Accounting for and reporting on Program expenditures will be conducted as part of the expenditure management process in place at the FMOH and its agencies as well as in the Ministries of Health at State level. The process is in compliance with the guiding principles, procedures, and practices as contained in the enabling regulations, financial instructions and guidance notes provided as part of the subsidiary regulations to the organic public finance legislations across the Federation. At the Federal level, all expenditures including those for the Innovation Fund and operational expenses will need to be processed through the central IFMIS.

The financial reporting of the program expenditures will entail the consolidation of expenditures made for SOML Program operational activities (including NGOs/Innovation Fund transfers) and the transfers to States. As the largest proportion of expenditures under the Program will relate to performance grant transfers to States' accounts in USD, it would be expedient to prepare the financial reports using USD as the transaction currency. The PMU at the FMOH will be responsible for preparing the Program Financial Statement.

At state level, all program expenditures will be tracked and a summary report produced.To further incentivize states to improve financial management and transparency of financial reporting on PHC spending, DLI 5 rewards states that are able to produce a consolidated budget execution report of all expenditures including PforR resources on PHC annually. The PMU at the SMOH will be responsible for preparing the Program Financial Statement, supported by the State Accountants General or responsible agency in the state.

Program Audit

The Auditor General of the Federation will conduct the audit of the Program Financial Statements. The annual audited financial statements of the Program (entailing the NPHCDA as an entity and the Special Fund Account to be held with the Central Bank of Nigeria), representing the Bank's contribution to the overall program expenditures, will be submitted to the World Bank within twelve months of the end of each FGON fiscal year. Each audit of the Financial Statements shall cover the period of one fiscal year and will include, by way of detailed notes, the detailed sub-expenditure objects of the economic classification of expenditures of the Program, including transfers made to performing States.

Program Audit at the State

Regular auditing for compliance with financial regulations shall be conducted by the Federal PMU to ensure funds utilization in line with approved work-plans.
The State Auditors-General will also conduct audits of the financial statements of their respective States and render them to the States' Assemblies. Furthermore, to incentivize States to improve their accountability for PHC resources deployed, the Program includes a reporting requirement of consolidated budget execution for all income and expenditures on PHCas described in DLI 5.
The Auditor General of the Federation however reserves the right to audit the program financial statements in any of the states.

Utilization of Funds

The SOML PforR is not a separate program in itself. Rather, it leverages states' own efforts in delivering health services. States are thus expected to consider these funds to be additional to, rather than a substitution of their health budget and expenditures. The PforR resources are expected to be ploughed back into the health sector to achieve better performance and improved outcomes.
States enjoy flexibility in how they use the funds. However, failure to continue improving performance means that the state will NOT receive future funds.
Furthermore, it is in the interest of the state to remain financially prudent and increase health care spending as better performance earns the state more money in a virtuous cycle under the PforR.

However, to ensure that resources are not diverted from health, each state will be required to sign a Memorandum of Understanding (MOU) guaranteeing that the funds will be utilized for health, particularly, primary health care services focusing on the key SOML interventions. The MOUwill be between the states and the Federal Ministry of Health and will be signed by the State Executive Governor or a duly nominated representative.

GOVERNANCE AND PROCUREMENT SYSTEMS

SOML PforR is a FGN program, operating in line with principles of good governance and best practices in keeping with its role of providing strategic direction for the health sector in Nigeria. The programme is also intended to strengthen fiscal federalism by changing the Federal-State relationship from one where roles are sometimes duplicated and implementation is not well coordinated to one governed by a results-based partnership.

The procurement system is governed by competitive bidding, in keeping with the Public Procurement Act 2007 which enshrines transparency and accountability. It must also that ensure that SOML PforR funds are expended using the GOVERNMENT's Integrated Financial Management Information System (IFMIS) to ensure that:

i. SOML PforR funds are used to procure only those goods and services needed to increase utilization of reproductive, maternal, child health and nutrition interventions;
ii. Goods and services needed are procured with due attention to economy and efficiency;
iii. All qualified bidders are provided with an equal opportunity to compete for contracts;
iv. Encourage development of local contractors and manufacturers;
v. The procurement process is fair and transparent.

H. PROGRAM MONITORING , REPORTING AND EVALUATION

The overall monitoring and evaluation of the SOML PforR is premised on the annual SMART and Health Facility surveys.

The PMU will monitor and evaluate the progress of the program implementation and prepare Program Reports. Each Program Report shall cover the period of one Fiscal Year, and will be furnished to the World Bank not later than six (6) months after the end of the period covered by such report.

Furthermore, twenty four (24) months after the Effective Date (or such earlier or later date as agreed with the World Bank), the Program Management Unit will prepare and provide to the World Bank a mid-term report documenting progress achieved in carrying out the Program in the preceding period and setting out measures recommended to ensure the continued efficient implementation of the Program and the achievement of its objectives during the period following the mid-term review.

The FGON will also review the mid-term report with the World Bank within one month of the report submission, and thereafter take all measures required to ensure the continued efficient implementation of the Program and the achievement of its objectives, based on the conclusions and recommendations of the mid-term report and the Bank's views on the matter.

The Federal PMU shall regularly embark on structured monitoring and compliance visits to the states. A standardized reporting matrix will be used to assess states during these visits.

The State will monitor and evaluate the progress of program implementation and prepare annual Program Reports. Each Program Report shall cover the period of one Fiscal Year, and will be forwarded to the Federal PMU not later than three (3) months after the end of the period covered by such report.

I. ENVIRONMENTAL AND SOCIAL MANAGEMENT

The overall environmental impact of the Program is likely to be positive with potentially significant environmental benefits, owing to increasing accountability for results, improved coordination across the health system, as well as strengthening of the health programs. The program management unit will closely track, troubleshoot, and hold accountable Nigeria's health programs with financial rewards for quality and quantity of services rendered which in turn provides further incentives for improvement and better monitoring. The nature of the program provides opportunities to enhance the sanitation, hygiene and waste management systems and processes at the health facilities so as to further promote sound public health outcomes, while also ensuring that there are no adverse impacts to the environment.

Environmental Issues

Improper occupational practices and unsafe handling of infectious waste have beenrecognized to occur, albeit minimally, and this has the potential to expose health care workers, waste handlers, patients and the community to infection and injuries. Based on the analysis of the Nigerian regulatory system and previous activities implemented by the FMOH within the Bank supported portfolio, the program is not likely to have significant impacts on natural habitats or create environmental pollution, other than the generation of health care waste (medical waste) which is considered a localized impact.

The potential social impacts are moderate and can be addressed by the existing systems with some improvements, owing to benefits such as improved health and personal hygiene, effective information dissemination, enhanced community participation, creation of accountable arrangements for service delivery and social audits to promote good governance mechanisms. There are no land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind under the Program.

Social Issues

The key issues identified by the ESSA are: poverty and equity, and barriers to utilization of health services which include cultural barriers, cost barriers such as transportation and the price of health services. Social issues are more difficult to define than environmental issues. Without this focus the key pro-poor objectives of the program will not be achieved. The gap in access to, and utilization of, health services between the poorest and the richest deserves urgent corrective measure. Nigeria's increasing wealth is not translating into improved health for the poor. The program is expected to have significant positive social impact as it will promote improved health outcomes for the citizenry, particularly women and children, by strengthening utilization and quality of health care especially for the poorest households in Nigeria.

Grievance redress system

Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

J. FRAUD

There will be a Fraud and corruption complaints redress mechanism which will guide the program.

1. The FMOH is committed to implementing and overseeing the implementation of the Program in accordance with the objectives of the Anti-Corruption Guidelines applicable to PforR operations (ACGs) and has subscribed to the following implementation modalities:

2. The FMOH, through the IVA, will provide semi-annual and annual reports to the Bank on all credible allegations of fraud and corruption under the Program, as well as related investigations and actions taken. The Bank will also share information on any allegations or concerns of fraud and corruption with the EFCC and other anti-corruption agencies.

3. The FMOH will ensure that any person or entity debarred or suspended by the Bank is not awarded a contract under or otherwise allowed to participate in the Program during the period of such debarment or suspension.

4. Bidding documents will serve as one of the key sources of information to bidders and contractors regarding the applicability of the ACGs to the Program. Compliance will be verified and assured through the annual audit of the Program.

5. The FMOH will, under the national laws, submit for investigations under the Program, including investigations requested by the Bank, and will keep the Bank abreast of progress and findings of the investigations and ensure that the conclusion of investigations are made public.

Where there are established cases of fraud and corruption, the FMOH reserves the right to withhold further disbursements to such a state/beneficiaryand or request a refund of such misappropriated resources.

K. COORDINATION

Although SOML is a Federal Program, its impact on health outcomes transcends the Federal Government. As the overall focus is to improve service delivery up to facility level and to patients in the community, there will be need for coordinated relationships between and within Federal, States, and LGAs.
The Federal PMU shall have regular meetings with the state PMUs in order to ensure smooth implementation of the PforR.

L. PROGRAM ACTION PLAN

The Program Action Plancovers the entire spectrum of the integrated fiduciary areas requiring management, monitoring and control under the Program during the period 2015-2019. At quarterly intervals, a monitoring report on the status of implementation of the actions will need to be provided by the FMOH and discussed at each of the meetings of the Steering and Technical Committees, and strategic and technical directions and guidance provided. The PMU will be responsible for ensuring the action items in the plan are accomplished.

Table 4: Program Action Plan

Action Description	Due Date	Responsible Party	Completion Measurement**
1. Prepare standardized template for financial reporting and pilot and roll-out at facilities	Within 18 months of Effective Date	FMOH	Annual reports on facility sources and uses of funds published conspicuously at facility level.
2. Publish annual consolidated PHC expenditure report for the state based on 3 economic classifications: compensation; goods & services; investments.	Within 6 months of end of each FY	Respective State Ministry of Health	Consolidated PHC expenditure report published on state government website
3. Annual federal level budget execution report prepared at the economic (object) classification level for PHC sub-function (SOML-focused)	Within 6 months of end of each FY	FMOH	Federal budget execution report.
4. PMU in the FMOH has at least 1 financial management staff that focus on SOML management, monitoring, and reporting	Ongoing	FMOH	Staff with requisite skills are working full time in the PMU.
5. Internal audit units in FMOH assign internal auditors for ex-poste systemic and risk-based audits of the Program and report quarterly to permanent secretary, FMOH after capacity strengthening in risk-based internal audits.	Within 12 months of Effective Date	FMOH	Quarterly internal audit reports.
6. Procurement plans for SOML related activities to be prepared by FMOH and approved by minister or permanent secretary, FMOH	Within 3 months of the start of each FY	FMOH	Procurement plans with approval by appropriate authority.
7. Capacity building on procurement procedures and contract management conducted annually	Ongoing	FMOH	Attendance sheets, increased use of BPP standard templates.
8. In accordance with 2007 Procurement Act an independent procurement audit will be conducted on random sample of at least 5% of transactions under the SOML program.	Within 12 months of end of each FY	FMOH	Procurement audit report
9. Fraud and corruption complaints redress - Formal policy and procedural guidance prepared and approved as applicable to the program	Within 12 months of Effective Date	FMOH (supported by ICPC and EFCC)	Documented policy & procedures, with assigned responsibilities and oversight.

Action Description	Due Date	Responsible Party	Completion Measurement**
10. Strengthen capacity of ACTU network to deliver on mandate – assign full time staff with mandate and resources and build on the risk assessment at the level of primary health centers led by the ICPC.	Within 12 months of Effective Date	FMOH	Additional full time staff assigned to ACTU and resources budgeted in FMOH annual budgets. Preventive measures to be agreed on based on the findings of the risk assessment.
11. Undertake an expenditure tracking survey, focusing on financial and commodity flows that are critical to SOML results	Within 12 months of Effective Date	FMOH	Completed report with recommendations about recording & reporting at facility level.
12. Establish communication strategy for stakeholder engagement	Within 12 months of Effective Date	FMOH	Plan to inform stakeholders on SOML PforR and the results achieved.
13. Capacity building for FMOH staff and other health workers on health care waste management and equity issues.	Ongoing	FMOH	Attendance sheets
14. Carry out annual assessment of progress on environmental and social issues.	Within 12 months of end of each FY	FMOH	Report on progress related to health care waste management and equity issues.
15. Timely transfer of Financing proceeds to States through government processes for results achieved by the states under DLIs 1, 2, 3, and 5	Within 30 days of receipt of Financing proceeds from the Association for corresponding results	FMOF	

M. COMMUNICATIONS PLAN

The communications strategy is aimed at creating and strengthening public awareness and support for the Program through active communication of the activities, states' performance and disbursements. The strategy will be inclusive involving all key stakeholders to ensure transparency and accountability.
The stakeholders in this operation include: federal, state and local governments; civil society; communities; development partners; non-governmental organizations.

The SOML PforR shall leverage the following communication platforms and channels

- Program Website
- Print media, Audiovisual (radio, TV), Social Media
- Quarterly newsletter distributed to a mailing list of key stakeholders
- Participation at local and international meetings/conferences and delivery of presentations

N. IMPLEMENTATION SUPPORT PLAN

The World Bank will partner with the Federal Government and development partners to provide implementation support to the various agents of government at the federal and state levels in the implementation of SOML. The aims of the technical and fiduciary support are to strengthen performance management and instill the culture of results-monitoring; improve equity; enhance administrative efficiency and reduce fraud and corruption. Furthermore, implementation support will focus on timely implementation of agreed program action plan, including the conduct of SMART surveys, health facility surveys, prompt disbursement of earnings against the DLIs achievements and management of the public and private innovation funds. Lastly, implementation support will also be targeted towards strengthening institutions saddled with responsibilities for key aspects of the project such as the State Primary Health Care Development Agencies (SPHCDA), National Bureau of Statistics, the Program Management Unitand National Primary Health Care Agency (NPHCDA). The Bank implementation support team will consist of technical; fiduciary; environmental and social; and fraud and corruption specialists. The Bank will be working with other key stakeholders and partners supporting these initiatives. The task team will be primarily responsible for:

(i) Technical (Including M&E): (i) Ensuring the conduct of SMART survey and health facility survey with standard quality assurance. Providing technical support for performance management and building capacities for DLI monitoring and verification protocols; implementation of performance appraisal systems; (ii) Monitoring timely payment for DLIs achieved; and ensuring the process is fair and transparent. (iii) Providing regular oversight over the implementation of the innovation fund both in the private and public sectors. (iv) providing technical support and capacity strengthening to the various implementation agencies. (v) Lastly, engaging in a sector dialogue with government through the monitoring of the Results Framework and the DLIs

(ii) Environmental and social: Providing technical support to NPHCDA/SPHCDAs and FMOH to guide states in implementing health care waste management plan and innovative strategies to improve delivery and use of essential maternal health services by underserved populations and geopolitical zones requiring special attention especially Northwest and Northeast ones.

(iii) Fraud and corruption: Monitor the implementation of the agreed fraud and anti-corruption measures under the program and provide guidance in resolving any emerging issues;

(iv) Procurement: (i) support NPHCDA, FMOH and similar state organs in finalization of procurement manual and Standard Bidding documents; (ii) provide inputs to capacity building of NPHCDA, and MOH Procurement Units; and (iii) monitor implementation of agreed risk mitigation measures;

(v) Financial Management: Support development of action plans based on audit reports and help

capacity building of NPHCDA and FMOH finance and Internal Audit department in ensuring timely reporting and effective oversight through risk based audits.;

In particular, the following activities will purposely be used to provide implementation support for SOML: program launch and orientation workshop; semi-annual reviews and supervision missions, additional supervision activities and stakeholders' workshops; annual reviews; and mid-term review.

1. Program launch and orientation workshop: The program launch provides a unique opportunity for publicity and provision of information on the operation to a broad stakeholder group. This event will target State Governors, Ministers, parliamentarians, high level government officials from the Ministries of Finance and Health at Federal and State level; National Planning Commission and other government agencies. The launch will be immediately followed by a three-day orientation workshop for technical staff of all agencies involved in the operation at federal and state level. The orientation workshop is critical as it sets the tone for providing information on the project to key teach people and it will spell out the principles of program for results, emphasis the paradigm shift and lay out expectations.

2. Semi-Annual Supervision Missions - The Bank team will be in constant contact with Federal and State stakeholders providing timely assistance and monitoring progress on a 'virtual' basis. Formal missions will be carried out twice a year (with regular and detailed Implementation Status Report/Aide Memoir reporting). The process will include a technical review workshop at the commencement of the mission, visits to key federal agencies and some states especially good and poor performing states to engender learning. The overall objective is to monitor implementation progress and to verify that operational, management and policy responsibilities are met. It will focus on service delivery and reforms.

3. The annual reviews will be conducted jointly with Federal Government of Nigeria including FMOF, FMOH and NPHCDA under the umbrella of the Federal PSC and follow the close of the calendar/fiscal year sometime between January and March. Annual reviews would be carried out for a more comprehensive and in-depth stock-taking of progress towards achieving the project performance indicators and overall PDO during the previous year, and evaluating performance on the DLIs. Reports from the semi-annual supervision missions will feed into the annual review and the focus will be on policy dialogue. A Joint Annual Report will be produced from the proceedings and a status of the performance indicators.

4. Additional Supervision Activities and Stakeholder Participation Workshops: Field visits to health facilities, encompassing both secondary hospitals and primary health facilities, will be carried out by joint teams comprising FMOF, FMOH, NPHCDA, SPHCDA staff and World Bank representatives. Secondly at least once a year the participating states will be brought to the table to discuss the progress of the operation.

5. Overall, issues identified in the technical work and field visits will form the agenda of a high level Policy Dialogue between the Bank, FGN and States under the aegis of the Program Steering Committee. Key objectives of the Policy Dialogue will be as follows:

- To discuss key findings and recommendations proposed by the Supervision Mission;
- To discuss FGN's official comments on the above;
- To prioritize SOML Issues; and
- To agree on Proposed Actions required moving the SOML forward.

6. A Mid-Term Review will be scheduled for midway through the operation. The purpose is to evaluate overall performance of SOML against targets, appraise the DLIs and their effectiveness and identify emerging issues. As part of the exercise, dissemination of the results will be undertaken to key stakeholders inside and outside the government.

Program Development Objective: Increase the utilization and quality of high impact reproductive, child health, and nutrition interventions.											
PDO Level Results Indicators	**Core**	**DLI**	**Unit of Measure**	**Baseline**	**Target Values**				**Frequency**	**Data Source/ Methodology**	**Responsibility for Data Collection**
					Yr 1 (2016)	**Yr 2 (2017)**	**Yr 3 (2018)**	**Yr 4 (2019)**			
PDO Indicator 1: combined coverage of six key SOML services; (a) vaccination coverage among young children (Penta3); (b) contraceptive prevalence rate (modern methods); (c) Vitamin A supplementation among children 6 months to 5 years of age; (d) skilled birth attendance; (e) HIV counselling and testing among women attending antenatal care; and (f) use of insecticide treated nets (ITNs) by children under-5	No	Yes	Percent Points	237.60 Percentage points (SMART 2015) Penta3 = 49%, ITN = 39.6%, CPR=20%, skilled birth attendance = 47%, PMTCT= 40%, Vitamin A coverage = 42% (SMART 2015)	245	258	271	284	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
PDO Indicator 2: Quality of care index at health center level	No	Yes	Percent	Diagnostic Accuracy = 36.2% , Drug availability = 45.3% (SDI Survey in 12 states) Baseline for 36+1 states expected in 2015		+15% of a baseline standard deviation increase in quality index compared to baseline	+30% of a baseline standard deviation increase in quality index compared to baseline	+50% of a baseline standard deviation increase in quality index compared to baseline	Annual	Harmonized Health Facility Survey (based on SDI and SARA)	NBS and NPopC overseen by FMOH
Intermediate Results Area 1: Improve quality of care and ability to deliver key SOML Interventions											
Intermediate Results Indicator 1: Children immunized	Yes	No	Number.	3,485,000	3,638,000	3,791,000	3,944,000		Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH

Intermediate Results Indicator 2: Birth s attended by skilled health personnel	Yes	No	Number.	3,196,000	3,264,000	3,332,000	3,400,000	3,468,000	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
Intermediate Results Indicator 3: People with access to basic package of health, nutrition, or reproductive health services	Yes	No	Number.	43,928,000	47,260,000	50,592,000	53,924,000	57,256,000	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
Intermediate Results Indicator 4: Impact evaluation of Results-based disbursements for MNCH weeks –	Yes	No	Yes/No	No	Ongoing	Ongoing	Ongoing	Completed	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
Intermediate Results Area 2: Improved Management of Primary Health Care											
Intermediate Results Indicator 5: Number of states with performance management systems in place	No	No	Number	10	15	20	25	30	Annual	Review of IFM documents and assessment visits to states	IVA and FMOH (PMU)
Intermediate Results Indicator 6: States in which SPHCDA or equivalent have managerial authority over PHC staff	No	No	Cumulative Number	4	11	19	28	37	Annual	Assessment visits to states	IVA

Annex 2: DLI 1.1-State Work-plans Template, Quantitative Supervisory Checklist

Development of Initial Investment Fund Plans

Each state will receive an initial investment funding ofUSD1.5million (DLI 1.1). To access the funds, states must develop an action plan that highlights how they intend to address weaknesses in PHC delivery with a focus on strengthening supervision and introducing, if they so wish, an innovation in service delivery.

Process: Between Negotiations and Program Effectiveness, the PMU will meet with all interested states to explain the process of accessing the initial investment funding. States will be encouraged to engage with FMOH technical staff, the PSU, and consultants from UN agencies and other development partners in formulating their plans. The plans will include:
Situation analysis – a review of the status of PHC delivery in the state with a focus on SOML interventions. Objective data will be obtained from the NDHS 2008 and 2013, SMART surveys, other household surveys, and any health facility data that is available. The analysis will look at trends over time and comparisons with other states in the same geopolitical zone and will emphasize the SOML PforR indicators: vaccination coverage among young children (Penta3); contraceptive prevalence rate (modern methods); Vitamin A supplementation among children 6 to 59 months of age; skilled birth attendance; HIV counselling and testing among women attending antenatal care; use of insecticide treated nets (ITNs) by children under-5; and quality of care. An analysis of DHIS-2 data, taking into account, the percentage completeness, will also be included so as to identify LGAs or programs that are lagging.
Supervision of PHC Facilities: The plan on supervision will include:
(i) a review of the current state of supervision in the state and the challenges that it faces;

(ii) the development of quantitative supervisory checklist (QSC, an example of which will be included in the program implementation manual) that builds on the experience of PBF and that: (a) assigns numerical scores to the items included; (b) includes only items that are objectively verifiable; (c) records multiple visits on one checklist to facilitate tracking of progress over time; (d) and leaves a written record of the scores in the health facility itself. The plan will include a means for field-testing the QSC and adjusting it accordingly;

(iii) Printing of the QSC and training on its use by supervisors at state and LGA levels;

(iv) A budget for the implantation of the QSC including costs of training, transport, printing and refresher training based on supervision visits that should be done at least quarterly but hopefully more frequently;

(v) A timeline for implementation of the QSC as part of systematic supervision; and

(vi) Means for monitoring and evaluating the implementation of QSC and systematic supervision.

Introduction of Innovation: States are encouraged to use the plan to describe the introduction of an innovation in the organization or management of primary health care that will improve either the quantity or quality of PHC. The state is free to choose what kind of innovation it would like to introduce but a menu of options includes: (i) performance-based financing (PBF) building on the experience in the NSHIP states where funds are transferred to facilities based on the quantity and quality of key services provided; (ii) pro-poor health insurance mechanisms where patients have a choice of providers from both private and public sectors (“money follows the patient”) and where at least 50 percent of the public subsidy goes to the bottom two income quintiles; (iii) contracting-in managers for remote or lagging LGAs; (iv) performance-based contracts with private providers in which measurable results are specified, independent assessment of the results is undertaken, and payments are linked to the results (e.g. an NGO is paid for every additional HIV+ pregnant woman receiving PMTCT); and (v) conditional cash transfers (CCTs) for women and children accessing SOML interventions. The plans for the innovation will include:

(i) A clear description of the innovation to be introduced, including implementation arrangements and

location;

(ii) A timeline and budget;

(iii) A description of the indicators of success and a means for tracking its progress; and

(iv) Clear responsibilities and accountabilities.

Assessment of the Plans: The PMU will ensure that plans are reviewed independently by at least two staff of the FMOH using a scoring sheet. The plans will be assessed based on:
(i) Clarity of the presentation; 30%

(ii) Technical quality of the situational analysis and the innovation; 40%

(iii) Practicality of the approach to supervision and the innovation, including: the timeline; budget; integration of activities into state systems; and specific responsibility/accountability; 40%.

Saving One Million Lives Program for Results
DLI 1.1 : Plan for Improving Health Service Delivery in ___ State
TEMPLATE
(Not more than 15 pages)

A. Executive Summary – Not more than one page focused on actions to be taken.
B. Goals: To decrease under-5 mortality, maternal mortality, child malnutrition, and total fertility.
Objectives: To improve the utilization and quality of high impact maternal and child health and nutrition interventions

C. State Profile/ Background
D. Results: State Performance Over Time:

Table 1: ***Coverage of Key Indicators – State Wide Over Time***

Survey/Source	Vit. A1	DPT3/Penta3	SBA1	CPR1	ANC1	ITN1
NDHS 2008						
NDHS 2013						
SMART 2013						
SMART 2014						
DHIS-2 2014						

1Vit. A = Coverage of Vitamin A supplements in the last 6 months among children 6-59 months
DPT3/Penta3 = Coverage of DPT3/Penta3 among children 12-23 months of age, card & mother's history
SBA = Skilled birth attendance among women giving birth in the last 2-5 years.
CPR = Contraceptive prevalence rate (using modern methods) among couples.
ANC = Antenatal care at least once among women giving birth in the last 2-5 years.
ITN = Percent of children under 5 years of age who slept beneath an insecticide treated bed net the night before the survey.

Analysis of Results: What progress has the state made from 2008 to 2013? Which indicators are lagging? How do the results from different data sources compare?

E. Results: State Performance Compared to Other States and National Data

Table 2: Coverage of Key Indicators – Compared to Other States – SMART Survey 2014 (Baseline)

State	Vit. A	DPT3/Penta3	SBA	CPR	ANC	ITN
Your State						
Other State						
Other State						
Other State						
Other State						
Zonal Average						
National Average						

Analysis of Results: *How does your state compare to other states in your geo-political zone? How do you compare to the national average? What is your state's rate of progress compared to other states (Table 3)?*

State	Vit A 2008	Vit A 2013	Change	DPT3 2008	DPT3 2013	Change	SBA 2008	SBA 2013	Change	CPR 2008	CPR 2013	Change	ANC 2008	ANC 2013	Change	ITN 2008	ITN 2013	Change
Your State																		
Other State																		
Other State																		
Other State																		
Other State																		
Zonal Average																		
National Average																		

F. Results: Performance by LGA

LGA	Vit. A	DPT3/Penta3	SBA	ANC
LGA 1				
LGA 2				
LGA 3				
State Average				

Analysis of Results: *How reliable is the data? Which are the best performing LGAs? Which are the poorest performing LGAs? What can be done to improve their performance?*

G. Organization of Primary Health Care System: Does the state have an SPHCDA or equivalent? When was it established? Is it staffed? Does it control the PHC staff? Does it have the files of the PHC health workers? How do vertical programs (like EPI, Malaria Elimination, Family Health, etc.) interact with SPHCDA? To what extent has "PHC under one roof" been implemented?

H. Budget for PHC:

I. Supervision: Describe the PHC supervisory process. How frequently are supervisory visits conducted? Are checklists used? Are these qualitative or quantitative? Is there an integrated checklist for PHC or different vertical program checklists? Is a copy of the checklist retained in the facility for their use and reference?

J. System Bottleneck Analysis and Identification of Specific Interventions: Based on the review of health system performance, priority areas and gap analysis, identify specific interventions, in addition to Supervision, that this plan will address for each of the six priority service DLIs using the sample tables below.

Interventions	Bottleneck determinants	Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed operational strategies/Solution
Penta 3 vaccination	Availability essential commodities					
	Availability human resources					
	Accessibility					
	Initial Utilization					
	Timely continuous utilization					
	Effective Quality					

Tracer Interventions	Bottleneck determinants	Coverage Indicators	Baseline coverage	Bottleneck identification	Possible causes	Proposed operational strategies/ Control
ITN at Community & Family Level	Availability essential commodities	% of LLITNs + insecticide in all LGAs in relation to need				
	Accessibility	Availability of JCHEWS/ CHEWS/CORPs in relation to need				
	Initial Utilization	% households with at least one mosquito net (treated or untreated)				
	Timely continuous utilization	% children under 5 in HH using mosquito nets last night				
	Effective Quality	% pregnant women using insecticide treated net				

Interventions	Bottleneck determinants	Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed operational strategies/ Control
Contraceptive Use	Availability essential commodities	% of service delivery points without stock out of modern FP commodities in the last 6 months				
	Availability human resources	% service delivery points with at least 1 staff trained on FP services				
	Accessibility	% of villages within 5 km of a functional service delivery points providing FP services				
	Initial Utilization	% of eligible users who have ever used any FP method				
	Timely continuous utilization	% of eligible users currently using any FP method consistently for a period of 2 years.				
	Effective Quality	% of eligible users correctly using any modern FP methods				

Interventions	Bottleneck determinants	Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed operational strategies/ Control
HIV Testing and Counseling Services During ANC (e-PMTCT)	Availability essential commodities	% HC with sufficient stocks of HIV tests, nevirapine, cotrimoxazole. and ARVs				
	Availability human resources	Availability of registered nurse/midwives in relation to need				
	Accessibility	% HCs offering regular PMTCT plus services				
	Initial Utilization	% pregnant women receiving counseling, being tested and when positive receiving nevirapine.				
	Timely continuous utilization	% infants from HIV + mothers receiving cotrimoxazole prophylaxis				
	Effective Quality	% mothers and infants with AIDS receiving ARVs				

Interventions	Determinants	Baseline Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed solutions
Skilled Delivery	Accessibility	% health centers with delivery supplies, foetoscope, BP app. and artery forceps in stock				
	Availability of human resources	% of PHC with skill midwives				
	Accessibility to health centers	% families living within 10 km from a health facility offering delivery services daily				
	Initial Utilization	% deliveries assisted by a qualified health professional (midwife/nurse/ physician)				
	Timely continuous utilization	% deliveries assisted by qualified health professional (midwife/nurse/ physician) PNC and weighed at birth				
	Effective Quality	% deliveries assisted by qualified health professional (midwife/nurse/ physician) with life saving skills				

Interventions	Determinants	Baseline Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed solutions
HIV Testing and Counseling Services During ANC (e-PMTCT)	Accessibility	% of villages with no stock out of Vit A in the last 6 months				
	Availability of human resources	% of health/nutrition promoters trained on the use of Vit A at Village level				
	Accessibility to health centers	% of villages with access to at least health nutrition promoter trained on the use of Vit A supplements				
	Initial Utilization	% of caregivers that routine-ly offer Vit A at 6 months of birth				
	Timely continuous utilization					
	Effective Quality	% Percentage of children aged 6-59 months who received at least one high dose vitamin A supplement within the last 6 months				

Percentage of children aged 6-59 months who received at least one high dose vitamin A supplement within the last 6 months

K. Innovation: If the state will like to introduce an innovation, please include in this section (Available menu of innovations include: performance-based financing at health facility level or pro-poor health insurance at community level)

L. Action Plan: Develop a well thought-out implementation plan for identified interventions. This should be considered the implementation's work plan. Plan needs to be focused, evidence based and should include:

- Specific and measurable objectives
- Strategies that have a strong foundation in the evidence base
- Specific action steps with accountabilities, timelines and resources required
- Links to national and state goals, plans and strategies
- Budget
- Monitoring and Evaluation

M. Action Plan Template: For each priority area and intervention/ innovation selected please fill out the template below.

Table 5:

Priority Area	Insert the main issues selected as priorities to be addressed
Goal	Write a broad statement of what you expect to accomplish related to this priority area
Performance Measures	Demonstrate how you will know you are making progress. State specifically what you will measure to determine whether changes have occurred. Select indicators of progress for both the short term (1-2 years) and long term (3-5 years). Specify the data source you will use for those indicators
Objectives	Describe the specific measurable end-products of your intervention. Objectives should be SMART: specific, measurable, achievable, realistic, and time-bound
Intervention	Specify the intervention strategy you are using. Cite any evidence-base for the strategy.
Activity (ies)	Outline the steps you will take to achieve each objective. The activities are the "how" portion of the action plan. It is best to arrange activities chronologically by start dates.
Timeline	State the projected start and end date for each activity
Resources Required	Include all resources needed for this action step. (Examples: funding, staff time, supplies, commodities, technology, equipment, and key partners.)
Lead Person/ Accountability Officer(s)	Identify by name the key person who will initiate the activity, provide direction for the work, and monitor progress.
Expected Results	Describe the direct, tangible and measurable results of the activity as best as possible

Table 6: Summary Use of Initial Investment Funds

Action	Budgeted Amount	As % of Total	Timeframe

Please state any additional state resources that will be committed to these actions and activities.

QUANTIFIED SUPERVISORY CHECKLIST – FACILITY COPY

Objective: provide an overview of health services delivery in primary health centers and health centers in Nigeria.

Frequency: Monthly supervisory visits are recommended in each primary health facility.

By: LGA, SPHCDA, and NPHCDA supervisory staff. (Self-assessment by health facility staff is encouraged so they can improve their score).

Calculations: A calculator or calculator function on a cell phone is helpful in calculating scores. If a register is not filled in or not available at the time of the supervisory visit then the score for that item would be 0.

Table 6: Summary Use of Initial Investment Funds

Action	Budgeted Amount	As % of Total	Timeframe

Name of Supervisor:					
Affiliation:					
Name of Health Facility:					
Location of health facility:					
Type of health facility: PHC/HEALTH CENTER/Other:					
Name of In-Charge:					
SUPERVISION VISIT	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**	**VISIT 5**
DATE OF SUPERVISION (DAY/MONTH/YEAR)					
SIGNATURE/INITIALS OF IN-CHARGE					
SIGNATURE/INITIALS OF SUPERVISOR					

A. INFRASTRUCTURE	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
1. CLEANLINESS: Health Facility is clean (Score: 1 if no litter, no cobwebs, & floor is swept. Otherwise = 0)					
2. HAND WASHING: Health Facility has water to wash hands, soap and clean towel (Score: 1 if all three present. Otherwise = 0)					
3. HAND SANITIZER: Available on desk in consulting room (Yes=1/ No=0)					
4.MEDICAL WASTE MANAGEMENT: Score 1 if facility has waste disposal system (secured and covered pit or incinerator) that are in use. Otherwise =0					
5. SHARPS CONTAINER: all sharps in safety box which is readily available (Yes=1/ No=0)					
6. COMMUNICATIONS: Score 1 if facility has working mobile phone and the number is prominently displayed outside the facility Otherwise = 0					
7. LATRINE: Score 1 if facility has a clean, covered and working latrine. Otherwise = 0					
8. LIGHT: Score 1 if facility has a working source of light (if even just a working torch), Otherwise = 0					
9. WAITING AREA: Waiting room has benches or chairs for seating and is protected against sun and rain (Yes=1/ No=0)					
10. CONSULTATION ROOM: Confidentiality in the consultation room is assured (Score 1 If patient can be examined and counseled in a room with curtains or painted windows or room divider if room is shared, or doors that close; Otherwise 0)					
TOTAL INFRASTRUCTURE (out of possible 10)					
A. INFRASTRUCTURE PERCENTAGE SCORE (Total X 10)					
B. BASIC EQUIPMENT	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**	**VISIT 5**
11. Facility has a working examination table (Yes=1/No=0)					
12.Facility has a working thermometer (Yes=1/ No=0)					
13.Facility has a working stethoscope (Yes=1/ No=0)					
14.Facility has a working weight scale for children (or MUAC) (Yes=1/ No=0)					
15. Facility has a working Blood Pressure cuff (Yes=1/ No=0)					
16.Facility has latex gloves (Yes=1/ No=0)					
17. Facility has needles and syringes (Yes=1/No=0)					
18.Facility has a working vaccine carrier (Yes=1/No=0)					
19.Facility has a partogram (Yes=1/No=0)					
20.Facility has a sterile cord cutter (Yes=1/No=0)					
21. Facility has a fetoscope (Yes=1/No=0)					
22. Facility has a working delivery bed (Yes=1/No=0)					
23. Facility has rapid diagnostic tests (RDT) for malaria (Yes=1/No=0)					

24. Facility has rapid tests for HIV (Yes=1/No=0)					
TOTAL EQUIPMENT (Out of possible 14)					
B. EQUIPMENT PERCENTAGE SCORE (Total /14 x 100)					
C. HUMAN RESOURCES/HMIS/ MANAGEMENT	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
25.PRESENCE OF STAFF: Proportion of staff on roster present at the beginning of the visit (e.g. if 6 of 12 staff are present = 6/12 = 0.50)					
26.PRESENCE OF FEMALE CLINICAL STAFF: Score 1 point if at least one trained female staff is present who can carry out antenatal care and family planning counseling. Otherwise = 0					
27.DHIS2 MONTHLY REPORTS: Score 1 points if the counterfoil for the monthly report for the last completed month is available in the facility. Otherwise = 0					
28.HEALTH FACILITY REGISTER: Score 1 points if health facility register is present and up-to-date. Otherwise=0					
29.CHILD HEALTH CARD: Facility has child health card (Yes=1/ No=0)					
30.ANC Card: Facility has mothers antenatal card (Yes=1/ No=0)					
31.DRUG PRICE LIST: Legible price list for drugs clearly displayed for patients to see (Yes=1/ No=0)					
32.UP TO DATE FINANCIAL RECORDS: Cash receipts from drug sales are available, up to date & specify client's name, amount received and date (Yes to all= 1; No = 0)					
33.BANK DEPOSIT SLIPS: Deposit slips for most recently completed month available, up to date and are in concordance with billing records (Yes to all=1; No=0)					
34.EXPENDITURE RECORDS: Evidence for expenditures available specifying name of purchaser, amount spent and reason for expenditure (Yes to all=1; No=0)					
TOTAL HUMAN RESOURCES/HMIS/ MANAGEMENT (Out of possible 10)					
C. PERCENTAGE HUMAN RESOURCES/HMIS/ MANAGEMENT SCORE (Total x10)					
D. ESSENTIAL DRUGS (CHECK THEY ARE NOT EXPIRED)	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
40. Facility has ACT1 in stock at time of visit(Yes=1/No=0)					
41. Facility has ACT4 (Yes=1/No=0)					
42. Facility has SP for IPT (Yes=1/No=0)					
43. Facility has amoxicillin suspension in stock (Yes=1/No=0)					
44. Facility has ORS in stock (Yes=1/No=0)					
45. Facility has paracetamol suspension (Yes=1/No=0)					
46. Facility has injectable ampicillin in stock (Yes=1/No=0)					
47. Facility has iron sulphate now (Yes=1/No=0)					
48. Facility has ampicilin tablets (Yes=1/No=0)					

49. Facility has frolic acid tablets in stock (Yes=1/No=0)					
50. Facility has paracetamol tablets (Yes=1/No=0)					
51. Facility has magnesium sulphate in stock (Yes=1/No=0)					
52. Pharmacy is clean (Yes=1/No=0)					
53. Drugs are easy to find and on shelves (Yes=1/No=0)					
54. Pharmacy is accessible during visit (Yes=1/No=0)					
55. Bin cards: Choose 4 essential drugs at random and score 1 point each if there is a stock card available that is up to date. Maximum=4					
56. Pharmacy has inventory of drug stock from last completed month. (Yes=1/No=0)					
TOTAL ESSENTIAL DRUGS (Out of possible 20)					
D. ESSENTIAL DRUGS PERCENTAGE SCORE (Total x 5)					
E. OUT PATIENT SERVICE PROVISION	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
a. Number of patients in last completed month in register X 12					
b. Catchment area population (Use EPI data)					
57. Outpatient service use: Calculate: (a/b)X100					
E. OUTPATIENT SERVICE PROVISION SCORE:					
F. IMMUNIZATION SERVICE PROVISION	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
a. Number of children less than 1 year who received DPT1 in the last completed month in monthly report X 12					
b. Catchment area population X 0.04					
58. DPT1 coverage: Calculate: (a/b) X 100					
a. Number of children less than 1 year who received DPT3 in the last completed month in monthly report X 12					
b. Catchment area population X 0.04					
59. DPT3 coverage: Calculate: (a/b) X 100					
60. Cumulative EPI graph: Score 25 points if facility has cumulative EPI graph that is correctly filled in and up to date for the last completed month. Otherwise = 0.					
61.Register/ report agreement: Score 25 if the number of children below 12 months of age immunized with DPT1 exactly matches the number in the monthly report. Otherwise = 0.					
IMMUNIZATION TOTAL (Out of possible 250)					
F. IMMUNIZATION PERCENTAGE SCORE (Total / 25) X 10					
G. PRENATAL AND POSTNATAL CARE PROVISION	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
a. Number of mothers in facility register who received their first prenatal care visit during the last completed month X 12					
b. Catchment area population X 0.04					
62. Prenatal care coverage: Calculate: (a/b) X 100					

63. Quality of prenatal care: Choose 5 women at random from prenatal register who were registered in the last month and score 2 points each if the following are recorded: 1) age; 2) weight; 3) gestational age; 4) expected date of delivery. Maximum = 40 points					
a. Number of mothers in register with a postnatal visit within 6 weeks of delivery during the last completed month X 12					
b. Catchment area population X 0.04					
64.Postnatal care coverage: Calculate: (a/b) X 100					
65. REGISTER/REPORT AGREEMENT: Score 10 if the number of mothers registered for first prenatal visit exactly matches the number in the monthly report. Otherwise = 0.					
PRENATAL AND POSTNATAL TOTAL (Out of possible 250): Calculate 57+58+59+60					
G. PRENATAL AND POSTNATAL SCORE (Total /25 *10)					
H. SKILLED BIRTH ATTENDANCE	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
a. Number of mothers in register who gave birth at this facility during the last completed month X 12					
b. Catchment area population X 0.04					
66. Sub-total skilled birth attendance coverage: Calculate: (a/b) X 100					
H. SKILLED BIRTH PERCENTAGE SCORE					
I. FAMILY PLANNING SERVICE PROVISION	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5
a. Number of new and continuing users of modern family planning user during the last completed month in the FP register					
b. Catchment area population X 0.2					
67. CPR: calculate (a/b) X 100					
68.Quality of FP: Choose 2 women at random from family planning register from 3 months ago and score 10 points for each if they have had a follow-up visit since then. Maximum = 20 points					
69.Facility has condoms in stock (Yes=10/ No=0)					
70. Facility has oral contraceptives now (Yes=10/ No=0)					
71.Facility has injectable contraceptive now (Yes=10/ No=0)					
72.REGISTER/REPORT AGREEMENT: Score 10 points if the number of new and continuing users of family planning in the register for the last completed month exactly matches the number in the monthly report. Otherwise = 0.					
I. FAMILY PLANNING TOTAL PERCENTAGE SCORE: Calculate: (62+63+64+65+66+67)					
J. HIV CARE	VISIT 1	VISIT 2	VISIT 3	VISIT 4	VISIT 5

a. Number of pregnant women registered in the last month who were screened for HIV					
b. Total number of pregnant women registered for 1st prenatal visit.					
73. PMTCT Screen Sub-total: Calculate: (a/b) X 100.					
J. HIV PERCENTAGE SCORE: TOTAL = 68					

TOTAL SCORES:

WRITE DOWN THE SHADED TOTAL FOR EACH OF THE FOLLOWING

Service	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**	**VISIT 5**
Date					
A. Infrastructure					
B. Basic Equipment					
C. Human Resources / HMIS					
D. Essential Drugs					
E. Outpatient Services					
F. Immunization Services					
G. Prenatal and Postnatal Care					
H. Skilled Birth Attendance					
I. Family Planning					
J. HIV					
TOTAL (Out of possible 1,000)					
TOTAL SCORE (Total/10)					
FACILITY #					
Visit 1					
Visit 2					
Visit 3					
Visit 4					
Visit 5					

Annex 3: DETAILS FOR CALCULATING AND DISBURSING AGAINST DLIs WITH WORKED EXAMPLES

A. DLI 1.1 and 1.2-INCREASE OF UTILIZATION OF HIGH IMPACT REPRODUCTIVE, CHILD HEALTH AND NUTRITION INTERVENTIONS:

Result	Increased coverage of 6 high impact interventions
Level of Government	Individual States
Means of Verification	SMART Household Survey – annually
Data collection agent	National Bureau of Statistics with TA from UNICEF
Verifying Agent	Independent verification agent (IVA)
If not achieved? - Plans	Funds available to state in years 1-4 until supervision plan approved
If not achieved Years 1-4?	Funds remain available based on improvement in results
If over-achieved Year 1-4?	If above the targets in the results framework (nationally) then re-allocate funds in years 3 and 4 from other DLIs which were not achieved.

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)	**55.5**	**58.1**	**58.1**	**58.1**	**58.1**	**289**

Calculation of Amount to be Disbursed:

Year 0:

Step 1: State submits plan for strengthening supportive supervision and introducing an innovation (if they wish), including a budget, indicators of success, and clear responsibilities which is acceptable to the FMOH and in keeping with the following criteria (described in more detail in Annex 1); (i) Clarity of the presentation; 30%; (ii) Technical quality of the situational analysis and the innovation; 40% ; and (iii) Practicality of the approach to supervision and the innovation, including: the timeline; budget; integration of activities into state systems; and specific responsibility/accountability- 40%.

Step 2: Each state will receive US$1.5million after effectiveness and when their plans are approved by the FMOH.

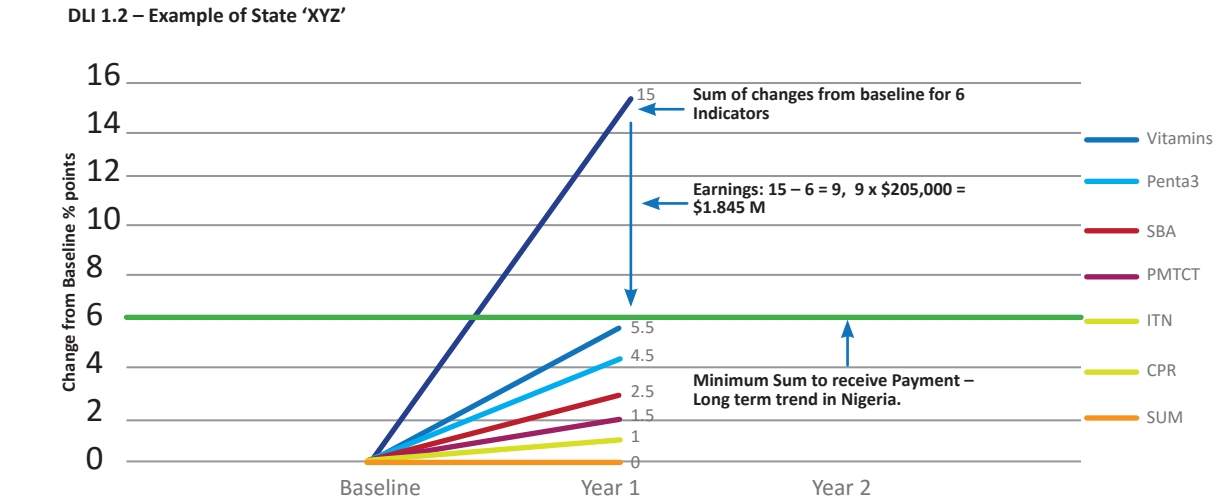
Years 1-4:

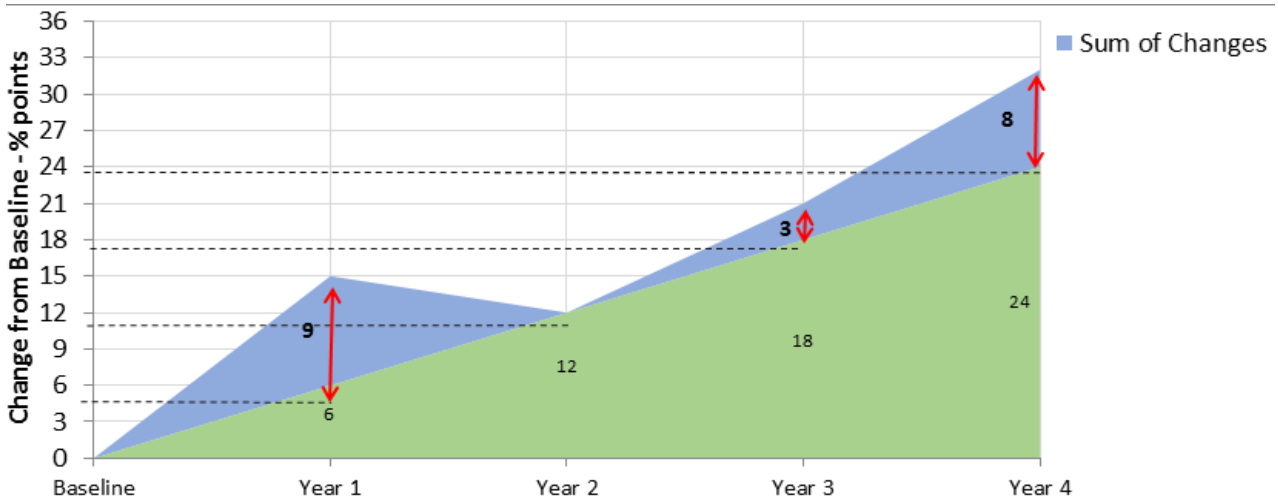
Step 1: Add up the coverage percentages from that year's SMART survey for each state on the following 6 indicators:(i) immunization coverage (Pentavalent3); (ii) insecticide-treated net (ITN) use by children under 5; (iii) proportion of pregnant women who receive HIV counselling and testing as part of their antenatal care; (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage among children 6 to 59 months.

Step 2: Subtract the baseline from latest sum. Take that number and subtract 6 percentage points (the average annual rate of change from 2008 to 2013) times the number of years the program has been effective. For example, if the sum in year 2 is 220 and the baseline is 200, the "score" would equal 220-200 = 20; 20 – (6 X 2) = 8.

Step 3: Take the "score" calculated in step 2 and multiply the number up to 1 decimal point by US$205,000. If the "score" is negative the state receives nothing. There is no upper limit on what a state can earn.

Step 4: Rank the states on their sum by geopolitical zone. Provide an additional US$500,000 to the best performing state in the zone ("zonal champion") above what they would earn based on the improvement. In the Northeast and the Northwest the top 2 states will receive US$500,000 each. No funds would be paid to "zonal champions" if their improvement was less than 6 percentage points.





Example Table 2: Adamawa goes from 40.2% DPT3 coverage in 2014 to 41.0% coverage in 2015 a change of 0.8 percentage points. On vitamin A coverage it improves 11.4 percentage points. When adding in the changes in the other 4 indicators, Adamawa saw a 23.8 percentage point improvement in its "sum" from the baseline.

From this amount (23.8), six percentage points are subtracted (6 X 1 year) giving a "score" of 17.8 and the latter amount is multiplied by US$205,000 (= US$3,649,000). Adamawa and Bauchi would receive an addition US$500,000 because they are "zonal champions," i.e. the most improved states in the zone. Thus Adamawa would earn US$4,149,000 (US$3,649,000 + US$500,000) and Bauchi would earn US$828,000 ((7.6 – (6 X 1)) x 205,000 + 500,000). Gombe would receive US$225,500 ((7.1-6) x 205,000). Borno would not receive any payment because its sum (change) is less than 6 percentage points. Taraba would receive no payment because its performance actually declined.

Table 1: Example from Northeast – percentage point change from baseline and payments

State	DPT 3 2014	DPT 3 2015	DPT 3 change	Vit A 2014	Vit A 2015	Vit A Change	Sum of Changes (all 6)	Payment Formula	Payment
	%	%	% pts.	%	%	% pts	% pts		$M
Adamawa	40.2	41	0.8	47.2	58.6	11.4	23.8	(Sum – 6) x $205K + $500K	4.149
Bauchi	38.5	39	0.5	31.1	36	4.9	7.6	(Sum – 6) x $205K + $500K +$500k	0.828
Borno	37.4	37.8	0.4	23.3	23.8	0.5	3.1	No payment	0
Gombe	35.2	35.5	0.3	26.2	27.8	1.6	7.1	(Sum – 6) x $400K	0.2255
Taraba	32.3	32.4	0.1	29.6	25.6	-4	-1.4	No payment	0
Yobe	28.4	28.5	0.1	31.4	30.5	-0.9	6.3	(Sum – 6) x $400K	0.0615

Example Table 2: In year 2 Adamawa only went up to 233.3 percentage points so its score is 233.8-200 –(6 X 2) = 21.8 so it gets US$4.469 million (21.8 x 205,000) but it does not get money for being "zonal champion" which now goes to Yobe and Borno which improved 16.9 and 18.7 percentage points respectively (compared to the 10 percentage point improvement in Adamawa). Notice that in year 2 Bauchi receives no funds because of its small improvement which is below 12 (6 X 2 years) percentage points. Gombe and Taraba also do not earn rewards in year 2 for the same reason.

State	Sum Baseline	Sum Year 1	Change Year 1	Payment Year 1 $M	Sum Year 2	Change Year 2 - baseline $M	Payment Year 2
Adamawa	200	223.8	23.8	4.149	233.8	33.8	4.469
Bauchi	180	187.6	7.6	0.828	190	10	0
Borno	140	143.1	3.1	0	160	20	2.14
Gombe	150	157.1	7.1	0.2255	154	4	0
Taraba	130	128.6	-1.4	0	129.7	-0.3	0
Yobe	140	146.3	6.3	0.0615	165	25	3.165

Step 5: The state with the highest score ("sum") nationally would be named "national champion" and would receive US$1 million above what they would earn based on their improvement.
Step 6: In the geopolitical zone of the "national champion", the second (or third in the case of the Northeast and Northwest) most improved state would receive US$500,000 above what they would earn based on their improvement but only if their "score" is positive).

B. DLI 1.3 –STRENGTHENING MNCH WEEKS AS PART OF AN IMPACT EVALUATION:

Results	Increased utilization of MNCH weeks
Level of Government	10 Randomly Selected States
Means of Verification	SMART Household Surveys
Data collection agent	NBS with support from UNICEF
Verifying Agent	IVA
If not achieved Years 0-3?	Funds remain available based on subsequent improvements in MNCH week coverage. If funds left over after IE completed, then reallocate to DLI 1 if needed.
If over-achieved Year 0-4?	Disburse to states until US$16M expended.

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement	US$2M	US$7M	US$7M			US$16M

Calculation of Amount to be Disbursed:
Year 0:

Step 1: Identify the 20 poorest performing states in terms of Vitamin A and Penta3 immunization coverage (just the sum of those 2 indicators) according to SMART survey 2014.

Step 2: Disburse US$100,000 to those 20 states after they indicate in writing their willingness to participate in the impact evaluation. They will not know which arm of the study they are in until after agreeing to participate in impact evaluation.

Years 1-2:

Step 1: For 10 randomly selected states, calculate change in MNCH week participation rates in percentage points (up to one decimal point) from SMART survey from year 1 by state.

Step 2: Multiply change by US$80,000 and disburse that amount to state.

C. DLI 2-INCREASE OF QUALITY OF HIGH IMPACT REPRODUCTIVE, CHILD HEALTH AND NUTRITION INTERVENTIONS:

Result	Improved quality of care in PHC facilities
Level of Government	Individual States
Means of Verification	Health facility survey - annually
Data collection agent	NBS or NPopC with technical support
Verifying Agent	IVA
If not achieved Years 1-4?	Funds remain available based on improvement in quality of care index
If over-achieved Year 1-4?	If above the targets in the results framework (nationally) then re-allocate funds from other DLIs which were not achieved above those needed to pay for DLI 1.

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement			US$18M	US$18M	US$18M	US$54M

Calculation of Amount to be Disbursed:

Year 2-4:

Step 1: Calculate quality of care index for each sampled health facility in a state in year 1 according to an agreed formula. For example:

Table 3: Example of Quality of Care Index in a health facility in State XX – Year 1

Criterion	Definition	Result Year 1	Weight	Score
(i) the diagnostic accuracy and adherence to guidelines by health facility staff;	Score of health worker(s) in diagnosing and managing pneumonia case (according to a vignette)	35%	3	10.5
(ii) availability of drugs and minimum equipment;	% of 25 essential drugs available in stock in the HF	45%	2	9.0
(iii) readiness of facilities to deliver key SOML interventions;	Score out of 100 on availability of SOML services in HF (is able to deliver PMTCT, immunization, skilled birth attendance, and Vitamin A)	50%	1	5.0
(iv) frequency and quality of the supervision provided to the facilities;	Score out of 100 on the quality and frequency of supervision	25%	2	5.0
(v) quality of financial management and reporting; and	Score of HF on properly recording incoming revenues and expenditures using approved template.	20%	2	4.0
			TOTAL	**33.5%**

Step 2: Take the average of the individual health facility scores across the particular state to calculate the score for the state for year 1 (baseline).

Step 3: Subtract the quality index in that year from the baseline (year 1) quality index multiply the change (to one decimal point) by US$25,000 and disburse that amount to the state.

D. DLI 3.1-IMPROVING M&E SYSTEMS FOR SOML:

Result	Annual implementation of SMART household survey and health facility survey.
Level of Government	Federal Government
Means of Verification	Review of final reports of SMART, health facility surveys, and census
Verifying Agent	IVA
If not achieved Years 1-4?	Funds will be available for re-allocation to DLI 1, can't make up for lost time, except if census is not carried out in 2016
If over-achieved Year 1-4?	Not possible.

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement	$7M	$7M	$7M	$7M	$7M	$35M

Calculation of Amount to be Disbursed:

Year 0:

Disburse US$7 million to FGON based on publication in June 2014 of SMART survey that covers all 36+1 states.

Year 1:

Step 1: Disburse US$3million to FGON if health facility survey is conducted and report produced that: (i) uses harmonized instrument that combines SDI and SARA approaches; (ii) data is collected on tablets; (iii) data collection agency has full time survey manager; and (iv) technical assistance is in place.
Step 2: Disburse US$2 million to FGON if SMART household survey is conducted and report produced if the survey uses: (i) same sampling methodology; (ii) same questionnaire; (iii) same quality assurance mechanisms including use of tablets; and (iv) technical assistance from outside data collection agency is in place.
Step 3: Disburse US$2 million to FGON if 2016 census collects data on maternal mortality. If the 2016 census is not conducted, then an acceptable alternative is for a National Demographic and Health Survey to be carried out either in 2016 or 2017.

Years 2 - 4:

Step 1: Disburse US$3.5million to FGON if health facility survey is conducted and report produced that: (i) uses harmonized instrument that combines SDI and SARA approaches; (ii) data is collected on tablets; (iii) data collection agency has full time survey manager; and (iv) technical assistance is in place.
Step 2: Disburse US$3.5 million to FGON if SMART household survey is conducted and report produced if the survey uses: (i) same sampling methodology; (ii) same questionnaire; (iii) same quality assurance mechanisms including use of tablets; and (iv) technical assistance from outside data collection agency is in place.

Result	Publication of household and health facility survey results and introduction of a performance management system.
Level of Government	Federal Government
Means of Verification	Review of final reports of SMART and health facility surveys
Verifying Agent	IVA
If not achieved Years 0-4?	Funds will be made available for re-allocation to other DLIs – cannot make up for lost time
If over-achieved Year 0-4?	Not possible

	Year 0 (or Prior Result)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
3.2 -(a) Data publication-Federal	2.0	2.0	2.0	2.0	2.0	10.0
3 .2-(b) Data utilization TA - Federal	1.0	3.0	4.0	4.2	4.6	16.8

Calculation of Amount to be Disbursed:

Year 0-4:

Step 1: Disburse US$2 million to FGON with 6 months of effectiveness and every year thereafter if the most recent SMART survey results, by state, is both: (i) published on line and readily accessible by a Google-based search; and (ii) published in a newspaper of nationwide circulation. The IVA will verify that both conditions are met.

Step 2: Disburse US$100,000 per year for each state where, through technical assistance provided by the Program Support Unit (as witnessed by their significant presence in the state), health managers demonstrate increasing capacity to: (a) analyze PHC performance data coming from various sources; and (b) develop high quality action plans based on the analysis of their results. Both aspects would be assessed by the IVA.

Step 3: DisburseUS$250,000 for each vertical program (NPHCDA, NMEP, NASCP, Department of Family Health) that demonstrates increasing capacity to: (a) analyze the performance of their program based on data coming from various sources (e.g. SMART, health facility surveys; etc.; and (b) develop high quality action plans based on the analysis of their results. This would be judged by the IVA.

F. DLI 3.3 Implementing Performance Management in all States

Result	States have put in place a performance management system that helps them improve the quantity and quality of services delivered.
Level of Government	States
Means of Verification	Visits to states and review of their analyses and plans
Verifying Agent	IVA
If not achieved Years 0-4?	Funds remain available for disbursement against this DLI until actions are achieved but will be reallocated at MTR
If over-achieved Year 0-4?	Not Possible

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)	1.6	2.4	3.2	4.8	5.9	17.9

Calculation of Amount to be Disbursed:

Year 0-4

Step 1: States received US$40,000 per year for each of the following 4 things that they have in place; (i) state has a performance management "Lead" with commensurate capacity who is clearly accountable for the performance management process; (ii) is able to provide evidence of continuous analysis of the available data on PHC performance, including availability of financial resources; (iii) has developed and updated appropriate action plans; and (iv) at least quarterly, conducts high level review meetings to discuss analysis and agree upon action plans with at least one of the three following officials present: Commissioner for Health, Permanent Secretary or Executive Director SPHCDA. Accomplishment of these four aspects of performance management will be assessed by the IVA.

G. DLI 4 – ESTABLISHMENT AND OPERATION OF THE INNOVATION FUND DESIGNED TO SUPPORT PRIVATE SECTOR INNOVATIONS AIMED AT INCREASING UTILIZATION AND QUALITY OF MATERNAL AND CHILD HEALTH INTERVENTIONS

Result	Innovations by private sector are implemented and evaluated and scaled up if successful
Level of Government	Private sector "grantees" through Innovation Fund Manager
Means of Verification	Visits to grantees and review of documents & Innovation Fund Manager's external auditor's report
Verifying Agent	Innovation Fund Review Committee (PMU, FMOF, and World Bank)
If not achieved Years 0-4?	Funds remain available for disbursement against this DLI until actions are achieved but will be reallocated if contract with Innovation Fund Manager is terminated
If over-achieved Year 0-4?	Funds could be disbursed earlier if actions are accomplished ahead of time but total amount cannot be exceeded.

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)	2	4.5	US$4.5	US$4.5	US$4.5	US$20

Calculation of Amount to be Disbursed:

Year 0:

Step 1: Disburse US$2 million to the FGON upon signing of a contact between the Innovation Fund Manager and FMOH acceptable to the Bank and in keeping with the TORs in Annex 1. The contract will need to specify: (i) how proposals will be judged (process); (ii) the explicit criteria for selection of proposals; (iii) mechanisms for tracking implementation and fiduciary controls over the use of the grants; (iv) means for evaluating the success of the large grants; (v) the maximum amount of financing per grant; and (vi) the availability to the FMOH of the results of the Innovation Fund Manager's external audit.

Year 1 - 4:

Step 1: The IVA reviews the performance of Innovation Fund Manager based on discussions with grantees, review of grant database, Innovation Fund Manager's external auditor's report, and other documents. Performance of the Innovation Fund Manager will be based on: (i) proper selection of proposals following agreed criteria and processes; (ii) effective management of grants and termination of grants that are not implementing their innovation or otherwise not complying with the grant agreement; (iii) provision of support to grantees; (iv) rigorous monitoring and evaluation of grants; (v) satisfaction of grantees as assessed by interviews with a sample; (vi) proper documentation of the process and lessons learned; and (vii) financial probity as reflected in the Innovation Fund Manager's external audit report.

Step 2: If theIVA review is positive and accepted by the Steering Committee disburse US$4.5 million to the FGON.

H. DLI 5.1 – INCREASING TRANSPARENCY IN MANAGEMENT AND BUDGETING FOR PHC AT STATE LEVEL:

Results	State entities responsible for PHC have greater management control over human and financial resources
Level of Government	Individual States
Means of Verification	Location of personnel files, published consolidated PHC budget expenditure reports
Verifying Agent	IVA
If not achieved Years 0-4?	Funds remain available for accomplishment until the end of the program
If over-achieved Year 0-4?	Not possible

	Year 0 (Prior Results)	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement (US$M)	2	6.7	8.4	10.1	13.7	US$41

Calculation of Amount to be Disbursed:

Year 0 -4:

Step 1: Determine which states have shifted the personnel files of front line health workers to appropriate state level health entity (e.g. SPHCDA). IVA will verify.

Step 2: Disburse a one-off payment of US$500,000 to those states once the files have been shifted.

Step 3: Disburse US$300,000 to a state if it is able to generate an annual consolidated PHC budget execution report and publish it on the state government's website. The reports will have to describe the sources and uses funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures.

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement (US$M)		2	2	2	2	US$8M

Step 1: Disburse US$2 million to the FGON if it is able to generate a consolidated PHC budget execution report and publish it on the FMOH's website. The reports will have to describe the sources and uses funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures.

ANNEX 4: TERMS OF REFERENCE FOR KEY CONTRACTORS:

Terms of Reference for an Independent Verification Agent.

A. Background/Context

1. The Federal Government of Nigeria is implementing the SOML Program for Results (SOML PforR), a performance based mechanism that rewards federal and state governments based on their performance in increasing utilization of maternal and child health interventions aimed at saving one million lives of women and children in Nigeria. This initiative represents a bold approach to improving health outcomes in Nigeria. The Program Development Objective is to increase the utilization and quality of high impact reproductive, child health, and nutrition interventions. To achieve this objective, several Disbursement Linked Indicators (DLIs) have been identified.

2. Under the SOML PforR, states will be rewarded for their performance based on objective indicators using data from household and health facility surveys as well as achievement of certain process indicators related to consolidation of primary health care (PHC) management and resources under one institution. To implement and support this program, the FGON would like to enter into an agreement with an independent verification Agent (IVA).

B. Scope of Work

3. The role of the IVA is to provide an independent, credible and coherent analysis of state and Federal Government performance and earnings under the SOML PforR using agreed upon data sources and earning calculations as per those specified in the program appraisal document (PAD). Specifically, the IVA will:

i. (Under DLI 1.2, assess state by state performance on the six coverage indicators (e.g. Penta3 coverage, skilled birth attendance) specified using the results of SMART surveys. Calculate the amount of money each state should earn based on the formulae in the PAD.
ii. Under DLI 1.3, assess state by state performance on MNCH weeks using the results of SMART surveys. Calculate the amount of money each state should earn based on the formulae in the PAD.
iii. Under DLI 2 assess state by state performance for the quality of care based on results of the health facility surveys and applying the agreed quality index. Calculate the amount of money each state should earn based on the formulae in the PAD.
iv. Under DLI 3, verify the number of states that have a performance management system in place according to the definition provided in the PAD;
v. Under DLI 4 assist the FMOH, FMOF in gauging the success of implementation of the innovation fund and collect data in accordance with the PAD;
vi. Verify the progress of states on transferring staff to the entity responsible for PHC in the state and in publishing budget expenditure reports for PHC in accordance with DLI 5.
vii. Develop an easy to read report, including simple graphs, pictures, and tables (more complicated ones can be in annexes) that describe the findings of its analysis and make recommendations of state and federal government earnings under each DLI. The IVA will provide a copy of its report to all members of the Program Steering Committee (PSC) within 30 days of receiving the results of the SMART and/or health facility surveys or information on the achievements of DLIs 3, 4, or 5. This may entail multiple reports as information becomes available. Together with the report, the IVA will submit all supporting documentation to the PSC and the Program Management Unit (PMU).
viii. The IVA will make a PowerPoint presentation of its verification report containing key findings to the Steering Committee including recommendations;
ix. Carry out such activities that the client reasonably requests in order to facilitate the implementation of SOML.

C. Assistance from the Client and PSC

4. The FMOF and the PSC will facilitate the provision of all available data from the SMART survey and health facility surveys as well as other relevant documents or materials, at the federal and state levels, to the IVA for smooth implementation of the assignment.

5. Should any information be deemed personal in nature (results in aggregate will not be deemed personal but any information with unique personal identifiers will be deemed personal), the IVA will not disclose such information, to any person or group without written permission of the FMOF and PSC and shall return all such information, documents and material to the FMOF and PSC within the contact period.

D. General Terms and Conditions

6. The final version of the contract will be in a form in accordance with the FGON's Procurement Act of 2007. The contract will include clauses that reflect the following conditions:
7. Parties to the Contract: The FMOF is the client and the Independent Verification Agent (IVA) is the contractor.
8. Assessment of Performance: The IVA will provide the FMOF, with annual reports of a type and content acceptable to the FMOF on its activities under the contract. It will also provide a complete copy of its external auditor's annual report. The performance of the IVA will be formally reviewed annually by a committee comprising representatives of the FMOH, FMOF, and the World Bank. The indicators of performance will include: (i) The IVA'S implementation of the scope of work, particularly its timeliness; (ii) its proper analysis of state performance and earnings following the criteria and processes described above; (iii) financial probity as reflected in the IVA's external audit reports.
9. Length of the Contract: The contract will be for three years from the date of signature of this contract. The contract may be extended based on the agreement of both parties.
10. Amendment of the Contract: The contract can be amended if both parties agree and the amendment is approved by the Program Steering Committee.
11. Dispute Resolution: Both parties will use their best efforts to amicably settle all disputes arising out of this contract or its interpretation. In the case where the disagreement persists, the parties will submit to mediation by a person acceptable to both parties. If mediation does not resolve the issue, the mediator will submit a suggested remedy to the Program Steering Committee which will decide by consensus whether to accept the remedy and enforce it on both parties.

12. Termination and Other Sanctions: The client can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; (ii) obtains agreement on a consensus basis from the Program Steering Committee and provides the Steering Committee with an acceptable alternative; and (iii) gives the IVA 3 months' notice. The client can also impose other sanctions on the IVA short of termination if it obtains agreement on a consensus basis from the Program Steering Committee. The IVA can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; and (ii) gives the client 4 months' notice.
13. Nature of the Contract – Lump Sum: This is a lump sum contract in which the IVA will receive payments on a lump sum basis every year related to the verification services it provides and subject to the conditions of payment described below.
14. Audited Accounts: The IVA will maintain a separate set of accounts for this contract and will annually submit to the FMOF the entire report of its external auditors. Unaudited statements of account will be submitted by the IVA with each annual report.
15. Payments: The maximum total amount of the contract is the equivalent of US$ [to be determined] annually. The budget and payment details are included in Annex 1. Within 15 days of contract signing the FMOF will pay to the IVA a total of US$X,000 as an advance. Subsequently, the IVA will submit an invoice to the FMOF every year with an annual report. FMOF will make a payment to the IVA of the amount stipulated in the invoice. The client has 30 days to object to payment of the remaining amount.

16. Force Majeure: For the purposes of the contract, "Force Majeure" means an event which is beyond the reasonable control of either Party and which makes a Party's performance of its obligations under the contract impossible or so impractical as to be considered impossible under the circumstances. The failure of a Party to fulfil any of its obligations under the contract will not be considered to be a breach of, or default under, this contract insofar as such inability arises from an event of Force Majeure, provided that the Party affected by such an event (a) has taken all reasonable precautions, due care and reasonable alternative measures in order to carry out the terms and conditions of this Contract, and (b) has informed the other Party as soon as possible about the occurrence of such an event. Any period within which a Party shall, pursuant to this Contract, complete any action or task, shall be extended for a period equal to the time during which such Party was unable to perform such action as a result of Force Majeure. During the period of their inability to perform the Services as a result of an event of Force Majeure, The IVA shall be entitled to continue to be paid under the terms of this Contract, as well as to be reimbursed for additional costs reasonably and necessarily incurred by them during such period for the purposes of the Services and in reactivating the Service after the end of such period.

17. Contract Management: The contract will be managed by the FMOF.

18. Authority of the client: Without limiting any of the above aspects of the contract, the client will enjoy sole discretion in: (i) visiting the states to assess their attainment of consolidation of PHC management and resources; (ii) discuss with any involved individuals or groups to assess the performance of the IVA; (iii) gain unhindered access to the IVAs verification data and analytics; and (iv) convening meetings with the management of the IVA at any mutually agreeable time to discuss and resolve issues related to the contract.

19. Authority of the IVA: Without limiting any of the above aspects of the contract, the IVA will enjoy sole discretion in: (i)the procurement of supplies, equipment, and other resources needed to meet contractual obligations. These resources will become the property of the IVA upon completion of the contract; (ii) the use of resources purchased or provided under the contract and the amount of per diem and other allowances to pay; and (iii) recruitment, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the IVA.

TERMS OF REFERENCE FOR A PRIVATE SECTOR INNOVATION FUND MANAGER

A. Background/Context

33. The Program Document (PD) of the Federal Ministry of Health (FMOH) for Saving One Million Lives (SOML) is explicit in its desire to foment bold innovations to strengthen both the quantity and quality health services. It is also explicit in its desire to harness the energy and reach of the private sector to provide new techniques, technologies, and approaches as well as extend the coverage of services to under-served populations.

34. The Federal Government of Nigeria (FGON) would like to establish and finance a private sector innovation fund to encourage the private sector to innovate and play a robust role in improving the health of Nigeria's mothers and children. Two types of innovation grants are envisaged:

i. Developing and testing new techniques and technologies through small grants (up to US$150,000 each with a minimum grant size of US$25,000). Examples of innovations that could be supported include: a) a smart phone application for health facility staff and outreach workers to use to improve diagnosis and management of childhood and maternal diseases using national guidelines; and b) a home-grown ready to use therapeutic food (RUTF) for malnourished children; and

ii. Testing new approaches to improving the delivery of SOML services by non-state actors. These types of innovations would aim to expand coverage or quality of services at the population level with an emphasis on under-served populations, and typically would be implemented for two years. They would be supported by larger grants (a minimum of US$400,000 up to US$1 million each). These innovations would be subjected to impact evaluations and a disproportionate number of these grants would be for

activities in the Northeast and the Northwest.

35. In order to implement such an innovation fund, the FGON would like to enter into an agreement with an organization to work as the Innovation Fund Manager (IFM).

B. Objectives

The IFM will support the SOML initiative in its efforts to significantly reduce the number of women and children who die every year (estimated at close to one million in 2013). The innovations that will be supported under this contract will help Nigeria make progress on the following indicators of success:

I. Vaccination coverage (Penta3) among young children;
II. Contraceptive prevalence rate (modern methods);
III. Vitamin A coverage among children 6 months to 5 years of age;
IV. Coverage of skilled birth attendance;
V. Use of insecticide-treated bed nets by children under 5;
VI. Prevention of mother to child transmission of HIV; and
VII. Improve the quality of care as measured by robust health facility surveys.

C. Scope of Work

The IFM will build on its experience to implement an innovation challenge fund to promote private sector innovations in health services related to SOML with a particular focus on improving the above-mentioned indicators. The IFM will be responsible for the following:

1. Advertising and Selection of Grantees:

38. Advertising: In seeking proposals, IFM will advertise widely in national newspapers and on the internet as well as social media.

39. Selection Criteria: The IFM will use an explicit set of criteria acceptable to the SOML Steering Committee in selecting possible grantees. In choosing proposals for the service delivery (large grants) the criteria would include: (i) clarity of the description of the innovation; (ii) evidence that the proposal is actually innovative (a new approach or the application of an existing innovation to a different service/intervention); (iii) rigor and practicality of the evaluation design; (iv) reaching people in the two poorest income quintiles; (v) concentration on rural areas; (vi) credibility and track record of the proposer; (vii) efficiency (low cost per capita) and scalability of the approach; and (viii) evidence of partnership with a state government. Twice as many large grants will be allocated for activities in the Northeast and Northwest regardless of where the proposer comes from. Some of the funds will be used to finance private sector treatment of vesico-vaginal fistulae.

40. Selection Process: The proposals received in response to advertisements will be judged blindly by an independent and diverse group of people representing the private sector, the public sector, technical experts, and civil society. All references to the name or nature of the proposer will be removed during the selection process (except for those separate people designated to carry out due diligence on the proposers). The IFM will ensure that people external to the selection panel do not exert any influence on the selection process.

2. Grant Management:

41. The IFM will carefully manage the grants based on a standard grant template acceptable to the SOML Steering Committee. Each agreement will have specific milestones against which funds will be released and include a termination clause if the proposers don't accomplish agreed milestones or do not meet the terms of the grant agreement. The IFM will maintain a computerized database of all grants in which relevant information is stored and is accessible for review. For service delivery grants, the IFM will ensure that one of their staff visit each field site at least twice a year.

Support to Grantees:

42. The IFM will provide support to the grantees, as needed, such as technical advice, access to experts in the field, help with maintaining proper financial records, help with the design of the evaluation of the proposal, etc.

3. Monitoring and Evaluation;

43. Each of the grants will have a clear set of indicators by which to judge success that are negotiated as part of the grant agreement. Particularly for the service delivery grants, the IFM will arrange for impact evaluations to be carried out. This means that the grants will have to cover defined geographical areas and include both baseline and follow on studies with a control group. The impact evaluations will be carried out by an independent group not included in the grant. The IFM will arrange, using contract funds if necessary, for the evaluation to be conducted.

4. Documentation, Disseminating Lessons, and Scaling Up Successes:

44. The IFM will be responsible for documenting the lessons learned from the innovations supported by grants. On a regular basis the IFM will organize experience sharing events where entrepreneurs can share among themselves what they've learned from their experiences. The IFM will also organize events and plans for disseminating lessons learned including which approaches appear to have been successful. The IFM will attempt to facilitate public or private sector financing for successful innovations. With the prior agreement of the Steering Committee, The IFM may also make grants to help scale up successful innovations.

D. Terms and Conditions

45. The final version of the contract will be in a form in accordance with the FGON's Procurement Act of 2007. The contract will include clauses that reflect the following conditions:

46. Parties to the Contract: The FMOH is the client and the IFM is the contractor.

47. Assessment of Performance: The IFM will provide the FMOH with quarterly reports of a type and content acceptable to the FMOH on its activities under the contract. It will also provide a complete copy of its external auditor's annual report. The performance of the IFM will be formally reviewed annually by a committee comprising representatives of the FMOH, FMF, and the World Bank. The indicators of performance will include: (i) the IFM's implementation of the scope of work; (ii) its proper selection of proposals following the criteria and processes described above; (iii) its proper management of grants and provision of support to grantees; (iv) rigorous monitoring and evaluation of grants; (v) satisfaction of grantees as assessed by interviews with a sample; and (vi) financial probity as reflected in the IFM's external audit reports.

48. Length of the Contract: The contract will be for three years from the date of signature of the contact. The contract may be extended based on the agreement of both parties.

49. Amendment of the Contract: The contract can be amended if both parties agree and the amendment is approved by the Program Steering Committee.

50. Dispute Resolution: Both parties will use their best efforts to amicably settle all disputes arising out of this Contract or its interpretation. In the case where the disagreement persists, the parties will submit to mediation by a person acceptable to both parties. If mediation does not resolve the issue, the mediator will submit a suggested remedy to the Program Steering Committee which will decide by consensus whether to accept the remedy and enforce it on both parties.

51. Termination and Other Sanctions: The client can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; (ii) obtains agreement on a consensus basis from the Program Steering Committee; and (ii) gives the IFM 4 months' notice. The client can also impose other sanctions on the IFM short of termination if it obtains agreement on a consensus basis from the Program Steering Committee. The IFM can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; and (ii) gives the client 4 months' notice.

52. Nature of the Contract – Lump Sum: This is a lump sum contract in which the IFM will receive payments on a lump sum basis every 6 months related to the number and size of the innovation grants under management and subject to the conditions of payment described below.

53. Audited Accounts: The IFM will maintain a separate set of accounts for this contract and will annually submit to the FMOH the entire report of its external auditors. Unaudited statements of account will be submitted by the IFM with each quarterly report.

54. Payments: The maximum total amount of the contract is the equivalent of US$[to be determined] The budget and payment details are included in Annex 1. Within 15 days of contract signing the FMOH will pay to the IFM a total of US$X million comprising US$X million to cover the IFM's initial costs and overhead and US$X million as an advance on initial payments to grantees. Subsequently, the IFM will submit an invoice to the FMOH every six months along with two quarterly reports. The invoice will document the amount disbursed to grantees (which will be reconciled with the US$X million advance such that the IFM has sufficient cash on hand to continue making grants). It will also include XX% of the disbursed amount for small grants and X% of the disbursed amount for large grants, as the cost to the IFM of carrying out grant management and support. The cost of evaluation will be reimbursed against actual expenditures for evaluation by third parties under contract to the IFM. FMOH will make a payment to the IFM of XX% of the amount stipulated in the invoice. The client has 30 days to object to payment of the remaining amount. If the client does not object the FMOH will pay the remaining 20% of the invoiced semi-annual payment. In the case the client does object, the FMOH will decide how much of the remaining funds should be released to The IFM.

55. Force Majeure: For the purposes of this contract, "Force Majeure" means an event which is beyond the reasonable control of either Party and which makes a Party's performance of its obligations under the contract impossible or so impractical as to be considered impossible under the circumstances. The failure of a Party to fulfill any of its obligations under the contract will not be considered to be a breach of, or default under, this contract insofar as such inability arises from an event of Force Majeure, provided that the Party affected by such an event (a) has taken all reasonable precautions, due care and reasonable alternative measures in order to carry out the terms and conditions of this Contract, and (b) has informed the other Party as soon as possible about the occurrence of such an event. Any period within which a Party shall, pursuant to this Contract, complete any action or task, shall be extended for a period equal to the time during which such Party was unable to perform such action as a result of Force Majeure. During the period of their inability to perform the Services as a result of an event of Force Majeure, the IFM shall be entitled to continue to be paid under the terms of this Contract, as well as to be reimbursed for additional costs reasonably and necessarily incurred by them during such period for the purposes of the Services and in reactivating the Service after the end of such period.

56. Contract Management: The contract will be managed by the FMOH as represented by the PMU.

57. Sub-Contracting: For the purposes of evaluating the effectiveness of the innovations, the IFM may

sub-contract with any competent organization or individual as long as the sub-contracting is done with due regard for efficiency and economy. Any sub-contract above US$X00,000 will have to receive prior approval of the FMOH and subsequently be agreed to by the Steering Committee.

58. Authority of the client: Without limiting any of the above aspects of the contract, the client will enjoy sole discretion in: (i) visiting the premises of any grantee or the location where they are working to assess their performance and compliance with the terms of their grants; (ii) discuss with any involved individuals or groups to assess the performance of the IFM; (iii) gain unhindered access to the IFM's grant management database; and (iv) convening meetings with the management of the IFM at any mutually agreeable time to discuss and resolve issues related to the contract.

59. Authority of the IFM: Without limiting any of the above aspects of the contract, the IFM will enjoy sole discretion in: (i)the procurement of supplies, equipment, and other resources needed to meet contractual obligations. These resources will become the property of the IFM upon completion of the contract; (ii) the use of resources purchased or provided under the contract and the amount of per diem and other allowances to pay; and (iii) recruitment, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the IFM.

TERMS OF REFERENCE FOR PROGRAM SUPPORT UNIT.

A. Background/Context

60. The Program Document (PD) of the Federal Ministry of Health (FMOH) for Saving One Million Lives (SOML) describes as a key aspect of the initiative a "Program Delivery Unit" (PDU) now re-branded as a Program Support Unit (PSU) whose role is to support implementation of SOML. Such a PSU is intended to: (i) ensure a continuing focus on results; (ii) assist states in analyzing data so that they can diagnose issues in service delivery and work towards resolving them; and (iii) build the capacity of federal, state and local officials to successfully implement interventions prioritized under SOML.

61. The FMOH would like to enter into an agreement with an organization, consistent with the PD of SOML, to facilitate implementation of SOML and help ensure its success in improving the health of Nigeria's mothers and children.

B. Objectives

62. The contractor will support the SOML initiative in its efforts to significantly reduce the number of women and children who die every year (estimated at close to one million in 2013). The specific indicators of success include:

(i) Vaccination coverage (penta3) among young children;
(ii) Contraceptive prevalence rate (modern methods);
(iii) Vitamin A coverage among children 6 months to 5 years of age;
(iv) Coverage of skilled birth attendance;
(v) Use of insecticide-treated bed nets by children under 5;
(vi) Prevention of mother to child transmission of HIV through testing of mothers during antenatal care; and
(vii) Improve the quality of care as measured by robust health facility surveys.

C. Scope of Work

63. The contractor will report to the Program Steering Committee and the Program Manager (and head of the Program Management Unit) designated by the Honorable Minister of Health and will have the following responsibilities:

64. Strengthening Performance Management: The contractor will provide technical assistance and support to states to develop and implement a system of performance management as well as build the management capacity of the state health leadership. This will involve working with state health leaders to analyze available data on PHC performance, develop action plans to address weaknesses, review action plans to see whether actions have been implemented and had the intended effect. Specifically, the contractor will:

i. Ensure that states appoint a "Lead" with commensurate capacity to be accountable for the performance management process;
ii.
iii. Support states and provide necessary technical expertise to analyze weaknesses in PHC service delivery, including availability of financial resources and development of appropriate action plans;
iv.
v. Work closely with and provide ongoing support, tools and capacity building to state Leads and other state health leaders to analyze weaknesses in PHC performance and develop and implement corrective measures;
vi.
vii. Ensure that its performance management officers are actively involved in, and where needed support, the organization, at least twice a year, of high level review meetings to discuss analysis and agree upon action plans. The meetings should have at least one of the three following officials present: Commissioner for Health, Permanent Secretary or Executive Director SPHCDA;
viii.
ix. If necessary, deploy full time consultant(s) to provide technical support to states that require it. The decision to deploy such will be taken in consultation with the Program Manager.

65. The contractor will be responsible for the recruitment and deployment of the full time consultants in those states where they are needed. The TORs for the full time consultant will be agreed with the Program Management Unit (PMU) and will focus on improving the performance of the state on the key SOML indicators listed above. The recruitment will be done through a transparent process that will involve: (i) public advertisement in newspapers for the positions; and (ii) explicit selection criteria based on both oral interviews and written tests which will include analysis of raw data. The Performance Management Consultant to be deployed to the states shall: (i) have a background in health, public health or related fields of study; (ii) possess strong analytical, data management and problem solving skills; (iii) have demonstrated leadership experience and ability to work effectively with multiple stakeholders; (iv) not have a 1st or 2nd degree relative who works in the FMOH, for the contractor, or in the state health or political leadership; (v) will be paid a market competitive salary commensurate with his or her salary history, likely about US$50,000. In addition the consultant will be paid a performance bonus related to the improvements seen in the state's performance on the key SOML indicators listed above.

66. Support states to formulate plans to earn initial investments. As part of the SOML PforR, states will be able to obtain initial investments based on plans to strengthen supportive supervision and, if they like, introduce innovations. The contractor will: (i) provide expertise to states to analyze data to inform the design of their plans; (ii) review draft versions of the plans and provide feedback to improve them; and (iii) review and ensure that final plans are of good quality.

67. Support to the Federal Ministry of Health on Performance Management: As part of the capacity strengthening for the FMOH staff working on programs related to SOML the contractor will (i) carry out a training needs assessment taking advantage of the literature; (ii) examine how FMOH staff are currently tracking performance; (iii) devise a training program and follow up support program acceptable to the TCG

and PMU; (iv) carry out the capacity building program as designed; and (v) assess the progress of FMOH staff's capacity compared to baseline.

68. Assist FMOH with Expenditure Analysis: As part of DLI 5, the contractor will assist the FMOH and the Federal Government in analyzing PHC expenditures, budgets, and releases and help FMOH strengthen its budget execution process.

69. Carry out such activities that the client reasonably requests in order to facilitate the implementation of SOML.

GENERAL TERMS AND CONDITIONS

60. The final version of the contract will be in a form in accordance with the FGON's Procurement Act of 2007. The contract will include clauses that reflect the following conditions:

61. Parties to the Contract: The FMOH is the client and …… (PSU) is the contractor.

62. Assessment of Performance: The contractor will provide the FMOH with quarterly reports of a type and content acceptable to the FMOH on its activities under the contract. The performance of the contractor will be formally reviewed annually by a committee comprising representatives of the FMOH, FMF, and the World Bank. The indicators of performance will include: (i) progress of those states with full time consultants on key SOML indicators; (ii) formulation and implementation of action plans by states; and (iii) financial probity as reflected in the contractor's external audit reports. The deliverables of the consultant are described under the scope of work above.

63. Length of the Contract: The contract will initially be for one year from the date of signing of the contract. The contract may be extended based on the agreement of both parties.

64. Amendment of the Contract: The contract can be amended if both parties agree and the amendment is approved by the Program Steering Committee.

63. Dispute Resolution: Both parties will use their best efforts to amicably settle all disputes arising out of this Contract or its interpretation. In the case where the disagreement persists, the parties will submit to mediation by a person acceptable to both parties. If mediation does not resolve the issue, the mediator will submit a suggested remedy to the Program Steering Committee which will decide by consensus whether to accept the remedy and enforce it on both parties.

65. Termination and Other Sanctions: The client can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; (ii) obtains agreement on a consensus basis from the Program Steering Committee; (iii) provides the Steering Committee with an acceptable alternative; and (iv) gives the contractor 3 months' notice. The client can also impose other sanctions on the contractor short of termination if it obtains agreement on a consensus basis from the Program Steering Committee. The contractor can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; and (ii) gives the client 4 month's notice.

66. Nature of the Contract – Lump Sum: This assignment will use a lump sum contract in which the contractor will receive payments on a lump sum basis every 6 months subject to the conditions of payment described below.

67. Audited Accounts: The contractor will maintain a separate set of accounts for this contract and will annually submit to the FMOH the entire report of its external auditors. Unaudited statements of account will be submitted by the contractor with each quarterly report.

68. Payments: The amount of the contract is Naira [to be determined]. The budget details are attached and reflect the agreed amount and number of equipment, consultants, operating costs, and the like. Within 15 days of contract signing and effectiveness of the PforR, the FMOH will pay to the contractor XX% of the

contact amount. Subsequently, the contractor will submit an invoice to the FMOH every six months along with two quarterly reports. The FMF will make a payment to the contractor of XX% of the stipulated amount (10.5% of the contract amount). The client has 30 days to object to payment of the remaining amount. If the client does not object the remaining XX% of the semi-annual payment will be disbursed.

69. Force Majeure: For the purposes of the contract, "Force Majeure" means an event which is beyond the reasonable control of either Party and which makes a Party's performance of its obligations under the contract impossible or so impractical as to be considered impossible under the circumstances. The failure of a Party to fulfill any of its obligations under the contract will not be considered to be a breach of, or default under, this contract insofar as such inability arises from an event of Force Majeure, provided that the Party affected by such an event (a) has taken all reasonable precautions, due care and reasonable alternative measures in order to carry out the terms and conditions of this Contract, and (b) has informed the other Party as soon as possible about the occurrence of such an event. Any period within which a Party shall, pursuant to this Contract, complete any action or task, shall be extended for a period equal to the time during which such Party was unable to perform such action as a result of Force Majeure. During the period of their inability to perform the Services as a result of an event of Force Majeure, the contractor shall be entitled to continue to be paid under the terms of this Contract, as well as to be reimbursed for additional costs reasonably and necessarily incurred by them during such period for the purposes of the Services and in reactivating the Service after the end of such period.

70. Contract Management: The contract will be managed by the FMOH as represented by the PMU.

71. Authority of the client: Without limiting any of the above aspects of the contract, the client will enjoy sole discretion in: (i) visiting states to assess the performance of the contractor in assisting state health officials; (ii) obtaining such relevant information as to allow proper monitoring and supervision of the contractor and their consultants; (iii) convening meetings with the management of the contractor at any mutually agreeable time to discuss and resolve issues related to the contract; (iv) reviewing the quarterly reports and obtaining additional information from the contractor to assess progress in implementing the contract; (v) objecting to the payment of 20% of the semi-annual payment to the contractor.

72. Authority of the contractor: Without limiting any of the above aspects of the contract, the contractor will enjoy sole discretion in: (i)the procurement of supplies, equipment, and other resources needed to meet contractual obligations. These resources will become the property of the FMOH upon completion of the contract; (ii) the use of resources purchased or provided under the contract and the amount of per diem and other allowances to pay; and (iii) recruitment, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the contractor subject to conditions stipulated above about transparency in recruitment.

ANNEX 5: IMPLEMENTATION TASKS FOR SOML PFORR

Disbursement Linked Indicator	Implementation Task	Responsibility
DLI 1- Increasing the Utilization of High Impact Reproductive and Child Health and Nutrition Interventions		
1.1: States produce plans for achieving reductions in Maternal, Perinatal and Under 5 child mortality	1. Finalize template for plans and criteria for judging	
	2. Develop and disseminate supervision checklist templates for state level use	PMU
	3. Convene a workshop with resource persons for states on the plans	PMU
	4. Coordinate TA (from NPHCDA, PSU, DPs) to support states' preparation of proposals	PMU
	5. Provide technical support to states	PMU/PSU/FMOH
	6. Review and approve plans	PMU
1.2: Improvements in key health indicators	7. Ensure funding for SMART Survey	**PMU/FMOH**
	8. Assess state by state performance on the six coverage indicators specified using the results of SMART surveys and calculate the amount of money each state should earn based on the formulae in the PAD	**IVA**
1.3: Evaluating the Impact of Results-Based Disbursements for MNCH Weeks	9. Engage lagging states so they understand how this works and encourage participation in the impact evaluation. This can be achieved as a side meeting during NCH	PMU
	10. Engage Principal Investigator and develop protocols for the evaluation	PMU/FMOH/WB
	11. Randomize states into control and test groups	PMU
	12. Assess state by state performance using the results of SMART surveys and calculate the amount of money each state should earn based on the formulae in the PAD	IVA
DLI 2- Increasing the Quality of High Impact Reproductive and Child Health and Nutrition Interventions	13. Assess state by state performance on quality of care using results of the health facility surveys and calculate the amount of money each state should earn based on the formulae in the PAD	**IVA**

Disbursement Linked Indicator	Implementation Task	Responsibility
DLI 3- Improving M&E Systems and Data Utilization		
SMART Survey	14. Expand survey scope to capture data on MNCH Weeks, prevention of mother to child transmission, and a limited asset index	**PMU/FMOH**
	15. Ensure there is a budget line for SMART in the FMOH budget and facilitate timely release of funds to implementing entities	**PMU**
	16. Ensure survey is carried out in a timely fashion	**PMU**
	17. Ensure quality assurance mechanisms are maintained at a high level	**PMU**
	18. Ensure consistent methodology of the survey	**PMU**
	19. Convene a meeting of all stakeholders involved in SMART	**PMU**
Health Facility Survey	20. Develop an integrated health facility survey that harmonizes Service Delivery Indicator (SDI) and Service Availability and Readiness Assessment (SARA) methodologies in all 36+1 states.	**PMU/FMOH/ NBS /NPopC**
	21. Ensure there is a budget line for annual health facility survey in the FMOH budget and facilitate timely release of funds to implementing entities	**PMU/PSC**
	22. Engage high quality technical assistance for the conduct of the survey	**PMU/FMOH**
	23. Identify and sign an MOU with the selected organization/entity for data collection	**PMU/PSC/FMOH**
	24. Ensure survey design provides robust state level data and collects data needed to determine the quality of care index	**PMU/FMOH**
	25. Establish the quality of care index metric	**PMU/FMOH**
	26. Ensure consistency in the sampling methodology and questionnaires used	**PMU/FMOH**

Disbursement Linked Indicator	Implementation Task	Responsibility
MMR: Census/NDHS	27. Ensure inclusion of questions related to MMR and U5MR in the enumeration instrument to be used by NPopC for 2016 census	**PMU/FMOH/NPoPC**
	28. Engage Technical assistance to work with NpopC on question inclusion	**PMU/FMOH/ NPopC**
	29. Ensure provision of necessary TA to facilitate analysis of MMR and U5MR data collected	**PMU**
	30. Alternatively, liaise with NPopC and other relevant agencies to ensure that NDHS is conducted as early as 2016	**PMU**
Data Dissemination	31. Ensure SMART and health facility data disaggregated by state is easily available on the internet and on FGON websites as well as publication of an annual summary in a large circulation national newspaper	**PMU**
	32. Organize awards/recognition ceremonies for grant winners (convened as a side session of the NCH)	**PMU**
	33. Assess federal government's performance on survey conduct and dissemination and calculate earnings based on formulae in the PAD	**IVA**
Performance Management	34. Facilitate Contract with a PSU to carry out performance management. To do this, the FMOH will: a) Draft TOR for the contract; and (b) Expeditiously complete all procurement and selection processes	**PMU/FMOH**
	35. Ensure Interim Arrangement for performance management activity with selected organization	**PMU/PSU**
	36. Provide contract oversight and adherence to TOR	**PMU**
	37. Verify the number of states that have a performance management system in place according to the definition provided in the PAD	**IVA**

Disbursement Linked Indicator	Implementation Task	Responsibility
DLI 4- Increasing Utilization and Quality of Maternal and Child Health Interventions through Private Sector Innovation	38. Facilitate Contract with a private entity to manage the Innovation Fund. To do this, the FMOH will: a) Draft TOR for the contract; and (b) Expeditiously complete all procurement and selection processes	**PMU/FMOH**
	39. Provide oversight of process and ensure timely disbursements to the Innovation Fund Manager	**PMU**
	40. Ensure impact evaluations of promising grants	**PMU**
	41. Assist the FMOH, FMOF in gauging the success of implementation of the innovation fund and collect data in accordance with the PAD	**IVA**
DLI 5– Increasing Transparency in Management and Budgeting for PHC	Ensure development and publication on FMOH website of budget execution report for PHC expenditures at the federal level	
	42. Verification of state progress on transfer of staff to SPHCDA or equivalent as well as publication of PHC budget execution report in accordance with provisions of the PAD	**IVA**
Other Program Requirements	43. Selection of Independent Verification Agency (IVA)	**FMOF**
	44. Convene annual state consultations for ongoing advocacy and program support in the 6 geopolitical zones	**PMU**
	45. Convene annual national meeting to facilitate discussions and peer learning (can be held as a side meeting to National Council of Health, NCH)	**PMU**
	46. Annual visits to about half the states to ascertain progress on program activities including but not limited to performance management, private sector innovation grants and public sector innovations where applicable. Focus should be on the lagging states	**PMU**

Disbursement Linked Indicator	Implementation Task	Responsibility
	47. Ensure implementation of activities specified in the Program Action Plan	**PMU**
	48. Provide secretariat for the Program Steering Committee and Technical Consultative Group	**PMU**
	49. Facilitate the provision of all available data from the SMART survey and health facility surveys as well as other relevant documents or materials, at the federal and state levels, to the IVA for smooth implementation of the contract	**PMU/PSC**
	50. Facilitate the provision of all available data on PHC expenditures, capacity building needs, as well as other relevant documents or materials, at the federal and state levels, to the PSU for smooth implementation of the contract	**PMU/PSC**
	51. Ensure timely disbursements to states	**PMU**
	52. Develop a detailed budget of PMU activities	**PMU**

Annex 6: Innovation Fund Manual