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MEMORANDUM OF THE HONOURABLE MINISTER OF HEALTH ON NIGERIA STATE HEALTH INVESTMENT PROJECT (NSHIP)

Purpose

The purpose of this memorandum is to provide a progress report to the National Council on Health (NCH) on the implementation of Nigeria State Health Investment Project (NSHIP) a Performance Based Financing (PBF) project in Nigeria with extension to additional five North- Eastern states of Bauchi, Borno, Gombe, Taraba and Yobe.

Background

The Nigeria State Health Investment Project (NSHIP) is a performance based financing health intervention designed to improve primary health care in the project states with a focus on maternal and child health services; strengthening participating institutions at federal, state and LGA levels; Strengthening information management; and capacity building. The project has been implemented in three states: Adamawa, Ondo and Nasarawa since 2011 as a pilot in some Local Government Areas (LGAs) and later extended to all LGAs in these states in early 2015. The Midline Impact Evaluation of the project was done in collaboration with the National Bureau of Statistics, National Population Commission and the World Bank. The preliminary analysis of the data showed marked improvement in both quantity and quality of services provided compared to non-NSHIP states. The outcome which was presented at the Mid Term Review (MTR) of the project in November 2017 revealed remarkable progress on all five Project Development Objectives (PDO) indicators—on total project beneficiaries, number of curative visits by children under-five and, number and proportion of (i) children immunized and (ii) births attended by skilled personnel. In addition, the health facilities in Project states have seen an impressive increase in quality of care, and the patients have seen a significant decrease in out-of-pocket spending.

In keeping with the Presidential mandate to re-establish health care services provision in the North East, the NSHIP building on observed positive results in the existing NSHIP states, especially in Adamawa, has been expanded to the remaining five North East states of Borno, Yobe, Taraba, Gombe and Bauchi. This expansion is made possible through an additional financing (AF) credit from the World Bank of $125 million and a Global Financing Facility grant of $20 million.

The AF is adapted to the specific conditions in the NE by: (a) reinforcing health service delivery using Performance-Based Financing (PBF); (b) promoting contracting of indigenous non-state actors to strengthen local capacity for service delivery; (c) application of special strategies including mobile clinics to provide 'hit and run' services as well as temporary structures for health service delivery, community nutritional rehabilitation and psychosocial support.

The project became effective on 27th February 2017. The pilot of the Performance-Based Financing (PBF) Project has started with success in one selected pilot LGA in Bauchi, Taraba and Gombe and 2 selected LGAs in Borno and Yobe states. The NPHCDA, as part of her technical assistance to support the project states and LGAs on implementation, has engaged the services of two Performance-Based Financing (PBF) Technical Experts and 5 Verifiers to conduct monthly quantity verification, coaching and mentoring of health facilities. The PBF verifiers and the Technical Experts have resumed work in their respective states. The details of the implementation are attached as appendix 1.

Council is invited to:

i. Note that NSHIP is a performance based financing intervention aimed at improving the quality and quantity of health services;
ii. Note the potential benefits of the project and its extension to the five additional states in the North East to rapidly restore health services in emergency situations;
iii. Note that non-state actors hold great potential for service delivery and this has been incorporated into the design of AF-NSHIP;
iv. Note the capacity of PBF to transform the health system and the need for states to explore opportunities to pilot PBF in at least one LGA;
v. Note that the AF-NSHIP became effective in February, 2017 and is being scaled up in the states;
vi. Note that the NPHCDA has developed sufficient technical capacity to support any State that desires piloting PBF;
vii. Note that the PBF approach institutionalises health worker motivation and is a likely panacea for the frequent strikes seen across the country.

Honourable Minister of Health

June, 2018

APPENDIX 1

UPDATE ON THE IMPLEMENTATION OF THE NIGERIA STATES HEALTH INVESTMENT PROJECTS: PROGRESS SO FAR

Background

On August 21, 2015, the Federal Government of Nigeria (FGN) requested donors' assistance in assessing the needs associated with peace building and crisis recovery. The Recovery and Peace Building Assessment (RPBA) of the NE region was conducted by the World Bank, EU, and UN in partnership with the Federal Government which confirmed the extensive damage to livelihoods and job opportunities especially in terms of attacks on markets and farms as well as infrastructure, particularly schools and health facilities. This meant that the provision of services, particularly in Borno and Yobe states was severely disrupted. The RPBA provides a framework for coordinated and coherent assistance to conflict-affected communities in the Northeast. It identifies the immediate and urgent need for sustaining emergency transition activities while supporting in parallel stabilization initiatives along the three strategic areas of intervention, namely: (a) peace building and social cohesion; (b) infrastructure and social services; and (c) economic recovery.

The Nigeria State Health Investment Project (NSHIP) is designed to improve primary health care in its project states with a focus on maternal and child health services; strengthening participating institutions at federal, state and LGA levels; information management; and capacity building. The project has been implemented in three states; Adamawa, Ondo and Nasarawa since 2011 as apilot which was later extended to all LGAs in these states in early 2015. In keeping with the Presidential mandate to re-establish health care services provision in the North East, the NSHIP is building on observed positive results in the existing NSHIP states, especially in Adamawa, to expand the project to the remaining five North East states of Borno, Yobe, Taraba, Gombe and Bauchi. This expansion is made possible through an additional financing credit from the World Bank of $125 million and a Global Financing Facility grant of $20 million.

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Objectives of the AF- NSHIP

The basic objectives of the project include:

- To fast track the restoration/re-establishment of health service delivery in the North East States
- To increase the delivery and use of high impact maternal and child health interventions in the North Eastern States
- To improve the quality of care at selected health facilities in the North Eastern states.

Context of the AF-NSHIP

The AF- NSHIP is a Federal Government project in collaboration with the states and the LGAs. The project is being implemented in five additional North-Eastern states; Bauchi, Borno, Gombe, Taraba and Yobe, which were selected due to the impact of insurgency seen in these areas. The insurgency has caused significant damage to the health system, particularly primary health care (PHC), resulting in a further deterioration of health indices, especially among women and children. In some parts of Yobe and Borno, the insurgency has destroyed such a large part of the health system that service provision systems in some LGAs have collapsed. This situation therefore constitutes an emergency.

Components of the AF- NSHIP

The project consists of three components: performance based contracting at service delivery point (public and private), technical assistance (TA) including contracting with non-state actors (Independent Verification Agencies

(IVAs) and Contract Management and Verification Agencies (CMVAs)) and partnerships to strengthen service delivery. The PBF component focuses on strengthening service delivery at the health facility level – with a focus on psychosocial support and mental health, and nutrition. The TA and contracting-out (to non-state actors) component supports the implementation of both PBF and the rapid emergency response. The components and the sections are described in full below:

Component 1 - Strengthening Service Delivery through Performance-based Financing

Performance subsides will be provided to health facilities based on the quarterly quantity and quality of services they provide. The project provides for health facility autonomy within the concept of independent running of the facilities, with their bank accounts and the right to use the funds accruing to the facilities within the project guidelines. The funds can be used as operational costs, for maintenance and repair, supplies and other activities, and performance bonus for health workers (up to 50% of the subsides).

PBF will be implemented in the AF States in much the same way as in the original project with some additional interventions dependent on the context. These additional interventions include:

a) Increased focus on treating and reducing malnutrition
b) Strengthened outreach services to the community
c) Psycho-social support and mental health
d) Free Paediatric and Obstetric Care

PBF Fast Track Implementation in Borno and Yobe: Consistent with the emergency nature of the project, PBF was fast-tracked in 2 LGAs each in Borno and Yobe States, all of which are host to large IDP populations. This quick rollout which commenced in January 2017 was achieved through support provided by additional TA and greater budgets. In Borno State, the selected LGAs are Maiduguri Municipal council and Jere LGA and in Yobe, the selected LGAs are Damaturu, the State capital, and Potiskum, as all contain a large number of IDPs.

Component 2 - Technical Assistance (TA)

In the original project, contract management and verficiation was handled by one organisation. The lessons learned from this resulted in i) separating the contract management and verficiation functions and ii) contracting non-state actors within the health sector to handle these functions. In this project, the Technical assistance comprises of three sub components:

A. Technical Assistance to support Phase1 of the AF: based on the experience from the initial project, NPHCDA and the Bank will procure the services of international and local consultants to provide the needed expertise to the SPHCDAs, the LGAs and HFs in order to kick start PBF implementation in the phase 1 LGAs (an extensive discussion of this is provided under the design section).

B. Contract Management and Verification Agencies (CMVAs): CMVAs will be recruited to cover a few LGAs (roughly 500,000 population and population size will determine the number of CMVAs per state) and will be charged with the following tasks: (a) managing the contracts with individual health facilities; (b) carrying out verification of health facility performance before payment (ex-ante verification); (c) coaching of health facility managers and staff on PBF and how to improve their performance: (d) managing contracts (performance frameworks) with the LGA PHC Departments and the Hospital Management Board (HMB); and (e) contract and oversee the quarterly quality verification carried out by the LGA PHC Departments and the HMB (ex-ante quality verification).

C. Independent Verification Agent (IVA): One IVA will be recruited per State to carry out independent counter verification of quality of care and to organize the quantity counter verification after payment (ex-post verification). The IVAs could be CSOs or university departments, especially faculties of public health or social sciences. There will be one IVA per participating state.

Component 3 – Partnerships to Strengthen Service Delivery

This component responds to the emergency nature of the project and the fact that many areas may not be readily accessible in some of the NE States.

A. Mobile Teams: Mobile teams will visit remote and under-served communities in LGAs recording servere damage to health infrastructure. These teams will be organized directly by CMVAs under contract and will use a PBF approach to incentivize the health workers. In security challenged areas, a "hit and run" approach will be used whereby mobile teams work in specific areas only for a few hours, ensuring that they leave before their presence is widely known.

B. **Re-establishing Health Services through CMVAs**: In LGAs where the damage is most extensive, and as such there is a lack of infrastructure and health workers, the CMVA, community and the SPHCDA will help to re-establish fully functional PHCCs using PBF principles.

C. **Strengthening LGA PHC Management**: CMVAs will provide technical support to LGA PHC departments in order to improve quality of supervision, coaching and mentoring, as a means to improve service delivery.

Design of the AF- NSHIP

The overall approach of the AF-NSHIP is to maintain the essence of the original project design, but modified based on lessons learnt to respond to the situation in the NE, as follows:

i. All LGAs will be operating using PBF;
ii. There will be no Disbursement Linked Indicators (DLIs). This is because similar DLIs for institutional strengthening have been incorporated in the Saving One Million Lives Program for Results (SOML PforR);
iii. reinforcing services under PBF by including psycho-social support and mental health, nutrition, and extensive community outreach;
iv. Modifying the approach to technical support to make it more decentralized through the use of independent CMVAs and IVAs;
v. Adding a new component that supports contracting with non-state actors to: (a) re-establish health services in LGAs where services have mostly been destroyed; (b) carry out mobile clinics; (c) strengthening management at LGA level; and
vi. Addressing demand-side constraints through selective implementation of free care for children under 5 and pregnant women.

The design will be adapted to the heterogeneous situations in the NE States. Building on the findings of the Recovery and Peace Building Assessment (RPBA), there appears to be three broad situations affecting the LGAs in the NE States: (a) LGAs where health facilities have not been damaged but are functioning optimally or sub-optimally (this is the situation in most of Bauchi, Gombe, and Taraba); (b) LGAs in which health facilities may have been damaged but remain open and have at least some staff (the situation in parts of Borno and Yobe) and (c) LGAs where many of the health facilities have been destroyed and where the primary health system is not functioning or barely functioning (the situation in other parts of Borno and Yobe).