

**ROGRAM-FOR-RESULTS INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.:PID0017891

Program Name	Saving One Million Lives
Region	Africa
Country	Federal Republic of Nigeria
Sector	Health, Nutrition and Population
Lending Instrument	Program for Results
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Borrower(s)	Federal Government of Nigeria
Implementing Agency	Federal Ministry of Health
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I. Country Context

- 1. Nigeria’s Growing Economy is the Largest in Africa but Poverty Rates Remain High:** Nigeria is the largest economy in Africa with an estimated 2013 GDP at about \$502 billion and also the most populous country in Africa with roughly 177 million people. Nigeria is a federal constitutional republic comprising 36 states and the Federal Capital Territory. It is a growing economy with oil as a dominant source of government revenues and foreign exchange receipts for the past four decades although much of the economic growth experienced in recent years has been driven by agriculture, telecommunications and services. Despite economic growth and diversification, Nigeria’s poverty rates remain high and almost one million children and women die every year, most from avoidable causes. As of 2009-2010, an estimated 46 percent of the population (with adult equivalent correction) was estimated to live below the official poverty line, close to \$1.25 a day PPP corrected.¹ Poverty is particularly concentrated in certain regions of the country, most notably in the Northeast and the Northwest. Inequality in Nigeria is high. The last official Gini coefficient was 0.45 according to the 2009/10 HNLSS, while a 2012/13 General Household Survey (GHS) found a Gini Coefficient of 0.41.
- 2. While most Nigerians live in peaceful coexistence, contentious relations among different groups have arisen in several parts of the country.** Since independence in 1960, Nigeria’s political history has been turbulent, punctuated by periods of urban riots and political confrontations. Currently, some of the most significant challenges include (a) the insurgency of a violent group popularly known as Boko Haram in the North East where

¹ More recent evidence suggests that the poverty rate in Nigeria might actually be significantly lower than this. See World Bank (2014), Nigeria Economic Report #2

service delivery is the weakest and poverty rates are the highest (since June 2013, the three northeastern states, Adamawa, Yobe and Borno, have been under a state of emergency to curb the violence and insurgency acts of Boko Haram); (b) inter-communal violence over access to economic and natural resources and political power throughout the country but especially in Plateau State; (c) kidnappings, armed robbery, oil theft and communal conflicts over oil spills especially in the South-South; and (d) ongoing efforts to reintegrate militants under an Amnesty Law in the Niger Delta.

- 3. Although macroeconomic performance has recently been strong, the continued decline in oil prices has put significant pressure on the macro-fiscal situation, and poses a major risk to development financing.** Real GDP growth in the first three quarters of 2014 averaged 6.3 percent, driven largely by the non-oil sector while inflation has remained in single digit but increased slightly to 8.0 percent in December 2014, up from 7.9 percent in November mainly due to food price increases during the festive season. However, Nigeria's dependence on oil and the sharp decline in world oil prices (40 percent since June, 2014) have put significant pressure on the macro-fiscal situation. The Government had managed to bolster its fiscal reserve fund in the Excess Crude Account (ECA) from US\$2 billion to US\$4 billion in the first half of 2014, but as of January 2015, the balance was down to US\$2.45 billion. In addition, the 2015 budget was presented to the National Assembly in December 2015 with a benchmark oil price of US\$65 per barrel. The proposed budget was already 7 percent lower in nominal terms than the approved budget for 2014. The proposed allocation to health is 5.6 percent lower than in 2014. Since oil prices have continued to decline and with the latest World Economic Outlook projecting that prices in 2015 are likely to settle at an average of US\$57 per barrel, further expenditure cuts may still be made even if additional non-oil revenue raising measures are introduced.

II. Sectoral (or multi-sectoral) and Institutional Context

- 4. About 920,000 Children and Mothers Die Each Year in Nigeria.** Over the last decade the trend in health, nutrition, and population (HNP) outcomes in Nigeria is mixed. Data from the last three Nigeria Demographic and Health Surveys (NDHSs)² demonstrates a 36% decline during this period in the under-5 mortality rate (U5MR) and a 31% decline in the infant mortality rate (see Table 1). However the country is still not on track to achieve MDG4. There has been almost no progress on reducing maternal mortality (MDG5) and fertility remains stubbornly high. Childhood malnutrition has actually worsened by some measures (low weight for age has increased by 21% and wasting has increased 64%) and improved only modestly (12%) in terms of stunting (low height for age).
- 5. Nigeria Contributes Substantially to Global Under-5 and Maternal Mortality:** Nigeria's ability to address under-5 and maternal mortality will affect global progress towards MDGs 4 and 5. Nigeria contributes 14% of all maternal deaths globally, second only to India at 17%³. Similarly, Nigeria accounts for 13% of all under-5 deaths globally, again second only to

² The use of NDHS data, collected by the National Population Commission, allows for a consistent methodology over time and facilitates cross-country comparisons. The data are also recent.

³ WHO, UNICEF, UNFPA and The World Bank, Trends in Maternal Mortality: 1990 to 2013, WHO, Geneva, 2014.
- See more at: <http://data.unicef.org/maternal-health/maternal-mortality#sthash.a1DshUTs.dpuf>

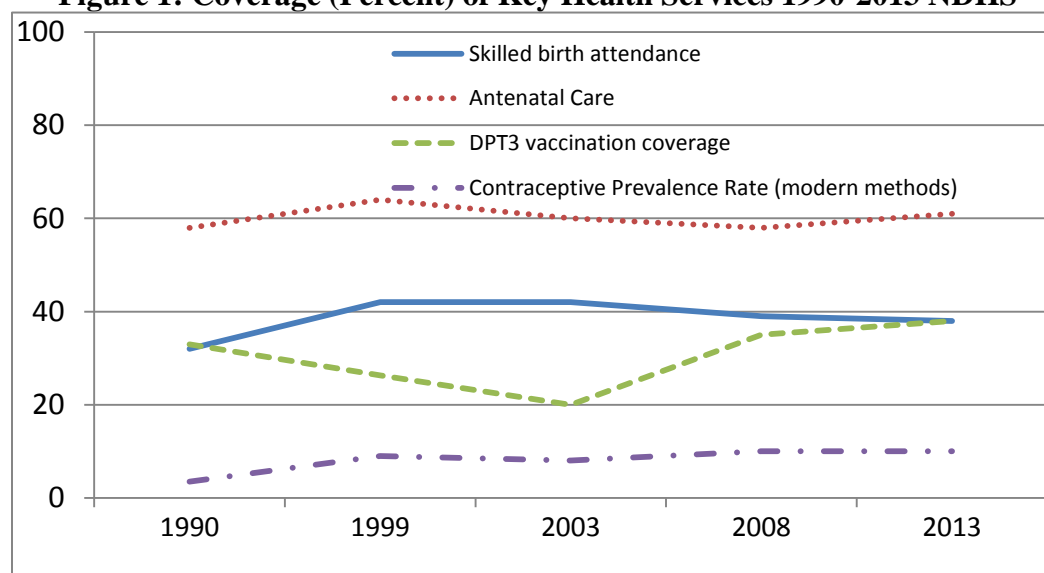
India at 21%.⁴

Table 1: HNP Outcomes in Nigeria 2003-2013 – NDHS Surveys

Outcome Indicators	Nigeria			Sub-Saharan Africa
	2003	2008	2013	2012
Under 5 Mortality Rate per 1000 births	201	157	128	97.6
Infant mortality rate per 1000 births	100	75	69	63.8
Maternal mortality ratio per 100,000 live births		545	576	510
Total Fertility Rate (Children per Woman)	5.7	5.7	5.5	5.1
Stunting, Height for Age (<-2SD) %	42	41	37	38
Low Weight for Age (<-2SD) %	24	23	29	20.8
Wasting, Weight for Height (<-2SD)	11	14	18	9.0

Source: Nigeria Demographic and Health Surveys. Sub-Saharan Africa data is from World Development Indicators and is for 2012. The data are not strictly comparable and SSA data is just illustrative.

Figure 1: Coverage (Percent) of Key Health Services 1990-2013 NDHS



- Limited Progress on Health Service Delivery:** The limited progress on HNP outcomes observed in Nigeria is consistent with the picture in service delivery (see figure 1). Over the last two decades the coverage of key health interventions has stagnated at low levels. The lack of progress on services such as family planning, antenatal care, and skilled birth attendance militates against achieving MDG5. Progress on service delivery generally has been slower than in neighboring countries.
- Quality of Care is low:** The limited coverage of important interventions is further aggravated by poor quality of care. Results from the Bank-supported Service Delivery Indicators (SDI) Survey indicate that many health workers perform poorly on standardized tests of knowledge and lack the skills to effectively treat common and important ailments in

⁴ United Nations Inter-agency Group for Child Mortality Estimation (IGME), UNICEF: Committing to Child Survival: A promise renewed-Progress report 2014, <http://data.unicef.org/child-mortality/under-five>

children or mothers. Of particular concern is that the cadre of health workers who provide primary health care in public health centers have limited knowledge of how to handle common diseases such as malaria, pneumonia, and diarrhea. SDI results indicate that Nigeria does less well than other large countries in Sub-Saharan Africa.

8. **Increasing Wealth is NOT Translating into Improved Health – Equity Issues:** The vibrant economic growth Nigeria has enjoyed over the last decade has not obviously translated into strong progress on HNP outcomes. This has been observed in other African economies with natural resource wealth and suggests that focused attention on improving health is required. The absence of a link between increasing wealth and health status in Nigeria appears partly to be a function of serious inequities. The poorest two income quintiles suffer from similarly poor HNP outcomes (see Table 2) and have nearly a one in five chance of dying before their fifth birthday. The ratio of the poorest to richest quintiles is significantly higher than the average in West Africa. As can be appreciated in the bottom part of Table 2, the differentials in access to, and utilization of, health services by income quintile are extreme.

Table 2: Health Outcomes and Outputs by Income Quintile Based on 2013 NDHS

Outcome Indicators	Q1 (Poorest)	Q2	Q3	Q4	Q5 (Richest)	Ratio of Q1 to Q5
Infant mortality rate per 1000	92	94	71	65	48	1.9
Under-five mortality rate per 1000	190	187	127	100	73	2.6
Stunting children under 5 (%)	53.8	46.1	35.1	26.3	18.0	3.0
Underweight children under 5 (%)	41.9	34.8	25.7	22.1	15.6	2.7
Output Indicators						
Fully immunized children (%)	7.0	18.5	39.7	60.0	79.5	11.4
Skilled Birth Attendance (%)	5.7	17.3	39.9	62.1	85.3	15.0
Antenatal care 1+ visits (%)	24.6	44.8	67.8	85.2	94.5	3.8

Source: NDHS 2013 and Staff Calculations.

9. **Geographical Inequity – The Northeast and Northwest lag far behind:** In addition to income inequality, there are also important geographical inequities. The U5MR is twice as high in the North West compared to the South West (185/1000 and 90/1000 respectively according to the 2013 NDHS) and service delivery is also far behind. For example, immunization coverage (DPT3/Penta3) is 14% and 21% in the Northwest and Northeast respectively compared to 70% in the South South and 80% in the Southeast (NDHS 2013).
10. **SOML is Meant to be a Bold Response to the Lack of Progress.** One of the responses by the Federal Government of Nigeria (FGON) to the challenges described above is the Saving One Million Lives (SOML) program. SOML is meant 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. Inaugurated by the President in October 2012, SOML focuses on six important aspects (“pillars”) of MCH that can change outcomes. The FGON’s program document 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*** (emphasis added).”

11. **Input-Related Issues Explain Little of the Problem:** Issues that are important in other parts of Africa do not seem to explain the slow progress of the health sector in Nigeria: (i) lack of funding: while public expenditure on health is low compared to GDP and total budget, funding alone does not appear to have much influence on service delivery. There is no correlation between state level expenditures in health and health outputs such as skilled birth attendance; (ii) lack of inputs such as drugs: while there is clearly a shortage of medicines in primary health centers, the SDI survey also found no correlation between drug availability and patient volume; (iii) lack of infrastructure: 67% of the population live within 30 minutes’ walk of a health facility, 85% live within 1 hours walk (LSMS 2010/11). This compares favorably to neighboring countries; (iv) shortage of health workers: the ratio of health worker to population is substantially higher than neighboring countries (it is twice the sub-Saharan African average) and many health facilities are actually over-staffed.
12. **Complex and Fragmented Institutional Arrangements for Delivering Public Sector Health Services:** The public service delivery system in Nigeria is characterized by overlapping and unclear institutional arrangements⁵. According to the 1999 Constitution Local Governments are supposed to provide primary health care (PHC) services. In practice, federal, state and local government all play roles in the financing and delivery of services. LGAs have been responsible for funding the operating costs of the PHC system but it is rarely a priority. The weakness of LGA financial reporting and the range of additional state and federal programs for PHC means that it has been challenging to make an accurate consolidated assessment of the resources used for PHC. Almost no financial resources are directly managed at the primary health facility level, except in some states where Drug Revolving Funds (DRFs) have been established or where user charges are collected.
13. **Federal Government Plays an Important Role in PHC:** It is estimated that the Federal Government contributes about 22% of all the funding for PHC but a much greater proportion of the non-salary expenditure. FGON resources are often supplied in kind, such as the provision of commodities, vaccines and specialized drugs for HIV and Tuberculosis. In addition, the FGON has a number of special schemes to support PHC, including activities under the National Primary Healthcare Development Agency (NPHCDA). These include: (i) the Midwife Service Scheme (MSS) which pays the salaries and support costs for the deployment of many thousands of midwives to under-served rural areas; (ii) the Subsidy Reinvestment and Empowerment Program (SURE-P) which provides support, inter-alia, for infrastructure, development of human resources, and a conditional cash transfer program; and (iii) the MDG Fund which supports the construction of additional health facilities among other things and relies partly on counterpart funds from the states.
14. **Accountability Mechanisms are Weak:** It is not surprising given the complex institutional

⁵ The Bank has carried out recent in-depth studies of the structure of primary health care in Nigeria as well as governance more broadly, including: (i) Political Economy and Institutional Assessment for Results-Based Financing for Health, 2011; (ii) Nigeria: Improving Primary Health Care Delivery: Evidence from Four States, 2009; and (iii) The Politics of Policy Reform in Nigeria Peter Lewis and Michael Watts October 2013

set up that accountability mechanisms are weak. Because funding and other resources come from diverse sources, and fund provision is unpredictable and often unrelated to budgets, managers in the PHC system are not held accountable for results. Accountability through Local Government is undermined by the fact that elected local councils are frequently suspended by State Governors. Except where functions have been consolidated under the SPHCDA there is no central point of accountability for the state PHC system as a whole. While there are functioning human resource management systems, there are generally few incentives for good staff performance and almost no sanctions for poor performance. Data on results are rarely published and are used to only a limited extent for management purposes. In addition, there is little accountability to the community despite the existence of Ward or Village Development Committees. All this translates into weak incentive structures and contributes to poor performance.

15. **Private Sector is a Major Provider of Health Services:** While the data are a bit sparse and sometimes uncertain, it is clear that the private sector is an important provider of HNP services. According to the NDHS 2013, 69% of children with fever are treated by private providers while 37% of skilled birth attendance and 55% of family planning services are provided by the private sector. Thus any attempt to improve HNP service delivery will need to address the challenge of how to constructively engage with the private sector. Until recently, the FGON has had little interaction with the private health sector and is only now starting to strengthen its links with private providers.

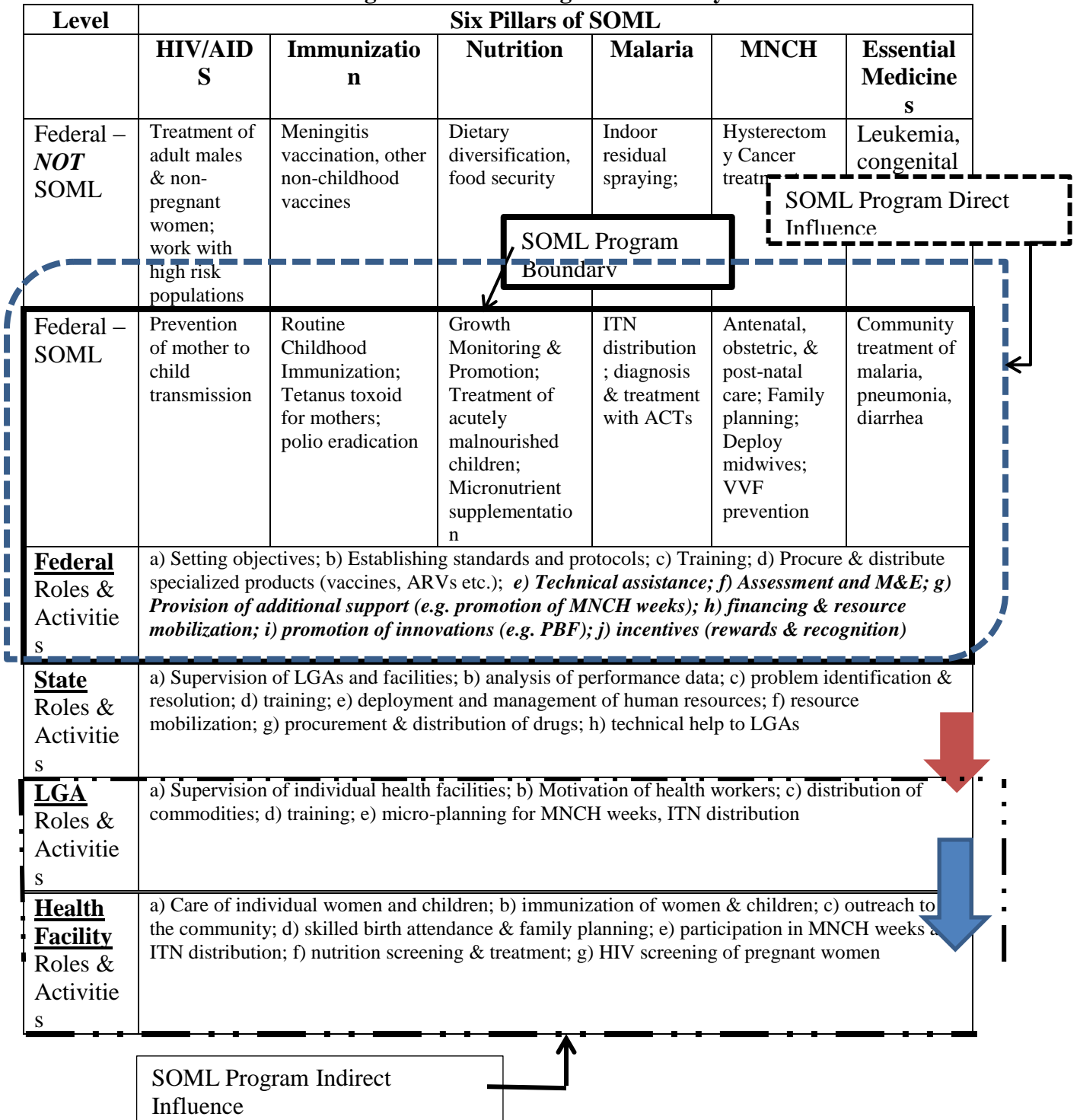
III. Program Scope

16. **The Name is the Target:** The original goal of the SOML Program was to save the lives of one million mothers and children by 2015. However, FGON has recently written to the Bank indicating its intention to extend the program for five years as part of its Second National Strategic Health Development Plan (NHSDP) 2016-20. This has been re-confirmed by the current Minister of Health. Given that close to 1 million children under 5 and women die every year in Nigeria, many of them from easily preventable causes, the name of the program continues to be a fitting commitment to save as many of those lives as possible.
17. **The SOML Program Focuses Interventions of Proven Cost-Effectiveness and Impact:** SOML builds on the President's Transformation Agenda and the First National Strategic Health Development Plan 2010 to 2015. It gives renewed priority to a package of high impact, evidence-based, cost-effective health interventions known as the six pillars: (i) maternal, newborn and child health; (ii) childhood essential medicines and increasing treatment of important childhood diseases; (iii) improving child nutrition; (iv) immunization, (v) malaria control; and (vi) the Elimination of Mother to Child Transmission (EMTCT) of HIV. The objective is to dramatically improve the coverage of these interventions that currently suffer from poor access and utilization. In addition, to its six "pillars" the SOML program also includes two "enablers": (i) promoting innovation and the use of information and communications technology; and (ii) improving the supply and distribution chain.
18. **What's new about SOML?** Given its focus on existing mother and child health initiatives, it

is reasonable to ask what is new about SOML? 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 HNP 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.

- 19. Delineation of the PforR Support – What the Federal Government can Influence:** SOML is a federal government program aimed at strengthening six “pillars” of MCH. Perhaps the best way of conceiving the program is to consider how in the Nigerian context, the FGON, particularly the FMOH, can influence the delivery of key MCH services at health facility level and in the community. Since it has no managerial control over the 36+1 states, let alone the 774 LGAs or the 37,000 publicly owned health facilities, to actually affect what happens on the ground the FGON has to rely on the levers it does have, namely strategic priority setting, data collection and analysis, technical assistance, distributing specialized commodities (typically through the states) providing rewards & recognition, setting standards, etc. (see figure 2). Using these levers, it is feasible for the FGON to influence the behaviors of states for example through: (i) collection of robust data on service delivery at community and health facility level and feeding it back to states; (ii) rewarding states for better performance; (iii) provision of technical assistance; or (iv) provision of ITNs to states for them to distribute. Thus the FGON’s SOML Program is really a federal level initiative (see the solid box in Figure 2) that influences states (the dotted line in Figure 2). Thus the boundaries of the Bank’s PforR, the funding, and accountability are all at federal level. Nonetheless, the results will be measured by state.
- 20. States Can Directly Influence Service Delivery:** While the FGON has little direct influence over health facilities and service delivery, State governments do have direct influence on providers and their authority is increasing with the advent of SPHCDAAs. States can strengthen actual service delivery in a large number of ways (see large arrows in Figure 2 and also figure 4) including: (i) strengthening health facility supervision; (ii) increasing the number of sites able to provide EMTCT; (iii) procuring more drugs; (iv) bolstering LGA management; (v) providing funds to facilities; (vi) working with the private sector etc. According to the latest available figures, the average state is currently spending about \$12 to \$15 million per year on PHC. The PforR is expected to channel around \$392 million directly to states based on their performance, an average of \$10.6 million per state over the life of the project, or about \$2.1 million per year on average. If a state were to meet the targets for the PforR they would earn about 15-20% of the states’ current expenditure through performance payments and this will be sufficient to encourage them to maximize their influence on service delivery.

Figure 2: SOML Program Boundary



Note: Focus of Bank-support PforR is shown *in bold italics*

IV. Program Development Objective(s)

21. Utilization and Quality of High Impact Maternal and Child Health Interventions: The FGON’s Program Document states that: “(T)he objective of the program initiative is to save one million lives in Nigeria, through integration of essential priority interventions into

primary health care, equitably increase access to, and utilization of quality cost-effective basic health interventions.” The PDO for this operation will thus be: Increase the utilization and quality of high impact reproductive, child health and nutrition interventions.

V. Environmental and Social Effects

22. **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. A strong program delivery 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, monitoring and higher performance. 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.
23. **Environmental Issues.** Improper occupational practices and unsafe handling of infectious waste was identified, albeit minimally, which 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 WB 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.
24. **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
25. **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.

VI. Financing

26. **Program expenditure framework for SOML:** At the Federal level, expenditures on SOML are primarily derived from activities by NPHCDA (the bulk) and to a lesser extent

from the National Malaria Elimination Program (NMEP) and the HIV/AIDS control program (NASCP). Other sources of expenditure such as SURE-P (the FGON program for reinvestment of savings as a result of eliminating the fuel subsidies in 2012, the value of which is the notional savings has declined with the large decline in market prices for oil) and the MDG Fund have not been included in the program of expenditure. Because, the last 4 years have seen rapid growth in PHC expenditures by FGON and the Government has enacted a National Health Bill, a modest increase is assumed in subsequent years (2016-2019). The actual expenditures will be easily traced through the FGON's integrated financial management information system. Overall, the Bank's contribution to SOML program financing is limited to US\$500 million equivalent which represents 48% of FGON expenditure during the life of the operation (table 3). Of course, other development partners are supporting maternal and child health related activities outside the Government's budget system.

Table 3: Estimated Program of Expenditures for SOML 2015-2019 (\$ Million)

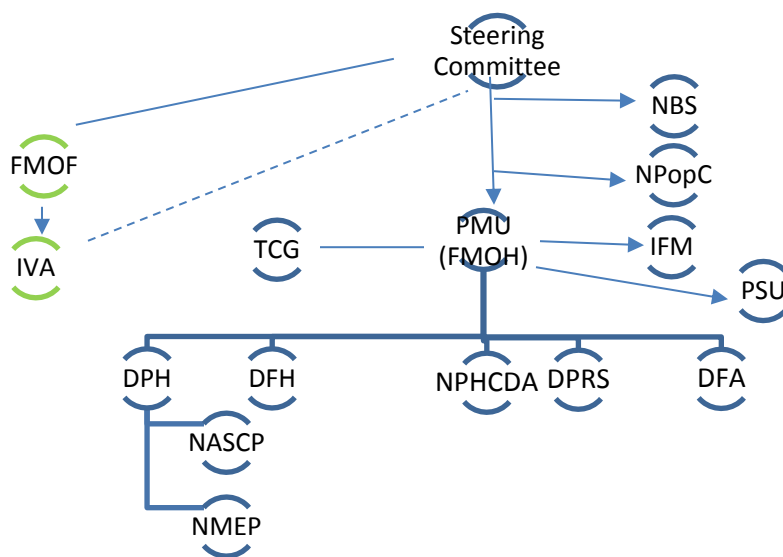
Source of Financing	Total Expenditure (\$M)	% of total
FGON Expenditure for SOML	552	52%
IDA SOML PforR	500	48%
Total	1,052	100%

Source: Federal IFMIS Report, January 2015

VII. Program Institutional and Implementation Arrangements

27. **Oversight by Steering Committee:** The SOML Program is under the supervision of a steering committee (see Figure 3), chaired by the Honorable Minister of Health and comprising representatives from the States (commissioners of health), development partners, the Federal Ministry of Finance, and various government organizations involved in the health sector. The Steering Committee is ultimately responsible for achieving the above mentioned SOML PforR indicators and that all stakeholders remain focused on objectively verified results.
28. **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 (Private sector contractors, NBS, NPopC); and (v) ensure that the FGON is obtaining value for money.

Figure 3: 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; DPRS = Department of Health Planning, Research, and Statistics; NMEP = National Malaria Elimination Program; NASCP = National AIDS Control Program; DFA = Department of Finance and Administration; IFM = Innovation Fund Manager; PSU = Program

29. Implementation of SOML and the proposed PforR - Role of the 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 a PSU. 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 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 prior actions. 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. In the case 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;

30. **Technical Consultative Group (TCG).** The SOML Program is centered in the FMOH and coordination among the different departments and agencies will be effected through a TCG to be chaired by the Permanent Secretary. The TCG will comprise representatives the Department of Family Health, Department of Finance and Administration, National Primary Health Care Development Agency (NPHCDA), the Department of Health Planning, Research, and Statistics (DPRS), the Department of Family Health including the National Malaria Elimination Program (NMEP), and the FMOH's AIDS control program (NASCP). These parts of the FMOH are in charge of the six pillars of SOML. The TCG will ensure that the focus on results is maintained, survey data is regularly analyzed in detail, and that the issues identified are addressed.

31. **Program Support Unit.** 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.

32. The FGON may recruit a firm to carry out the PSU functions (TORs are in Annex 1). However, until such a recruitment is accomplished, the FMOH will sign an interim agreement with the Program Delivery Unit (PDU). The PDU was established in early 2013 and is financed by the Bill and Melinda Gates Foundation (BMGF) as well as other development partners. It is already carrying out the kind of technical assistance described under DLI 3. It comprises locally recruited consultants and has demonstrated its commitment to SOML.

33. **Role of 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 1). 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 not solely reliant on the FGON for financing.

34. **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 1). 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.

35. **Existing and Future Development Partner Support for SOML:** The BMGF has provided multi-year funding in support of SOML directly and will continue that funding for the next few years. It has also committed to provide technical assistance in a variety of areas, such as health facility surveys and management strengthening that will be critical to the success of SOML and the PforR. The Children’s Investment Fund Foundation (CIFF) has also supported SOML directly. UNICEF has supported the SMART surveys and the Bank will sign an MOU with UNICEF regarding ongoing collaboration on SOML. Financial support for the SOML pillars has been provided by a wide variety of development partners including the United States Government, GFATM, GAVI Alliance, DFID, the EU, Government of Canada, UNFPA, and GAIN. According to the fiscal space analysis, the development partners’ contributions to the SOML will be about \$2.1 billion for the period 2015-19. Technical support for SOML has also been provided by a broad variety of partners including UNICEF, WHO, UNFPA, and UNAIDS, USAID, DFID and the EU. All the development partners have been extensively consulted on the PforR including through special meetings (such as at the concept review stage), presentations at Development Partner Group (DPG) meetings, and at the SOML/NSHIP Steering Committee Meetings.

VIII. Contact point

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