Federal Capital Territory (FCT) Health Sector Resource Mobilisation Plan (2018–2022)

FCT Health and Human Services Secretariat

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Acknowledgments

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Abbreviations

ACHA	Area Council Health Authority
AOP	Annual Operational Plan
BHCPF	Basic Health Care Provision Fund
CRF	Consolidated Revenue Fund
CSO	civil society organisation
ES PHCB	Executive Secretary, Primary Health Care Board
FAAC	Federal Allocation Account
FCT	Federal Capital Territory
FHIS	FCT Health Insurance Scheme
FMOH	Federal Ministry of Health
FSA	fiscal space analysis
GDP	gross domestic product
GGE	general government expenditure
GGHE	general government health expenditure
HCW	health care worker
HF Unit	Health Financing Unit
HFE&ITWG	Health Financing Equity & Investment Technical Working Group
HFETWG	Health Financing and Equity Technical Working Group
HHSS	Health and Human Services Secretariat
HMB	Health Management Board
HP+	Health Policy Plus
HPRS	Health Planning, Research and Statistics Department
HRH	human resources for health
IPSAS	International Public Sector Accounting Standards
NASS	National Assembly
NCH	National Council on Health
NGN	Nigerian naira

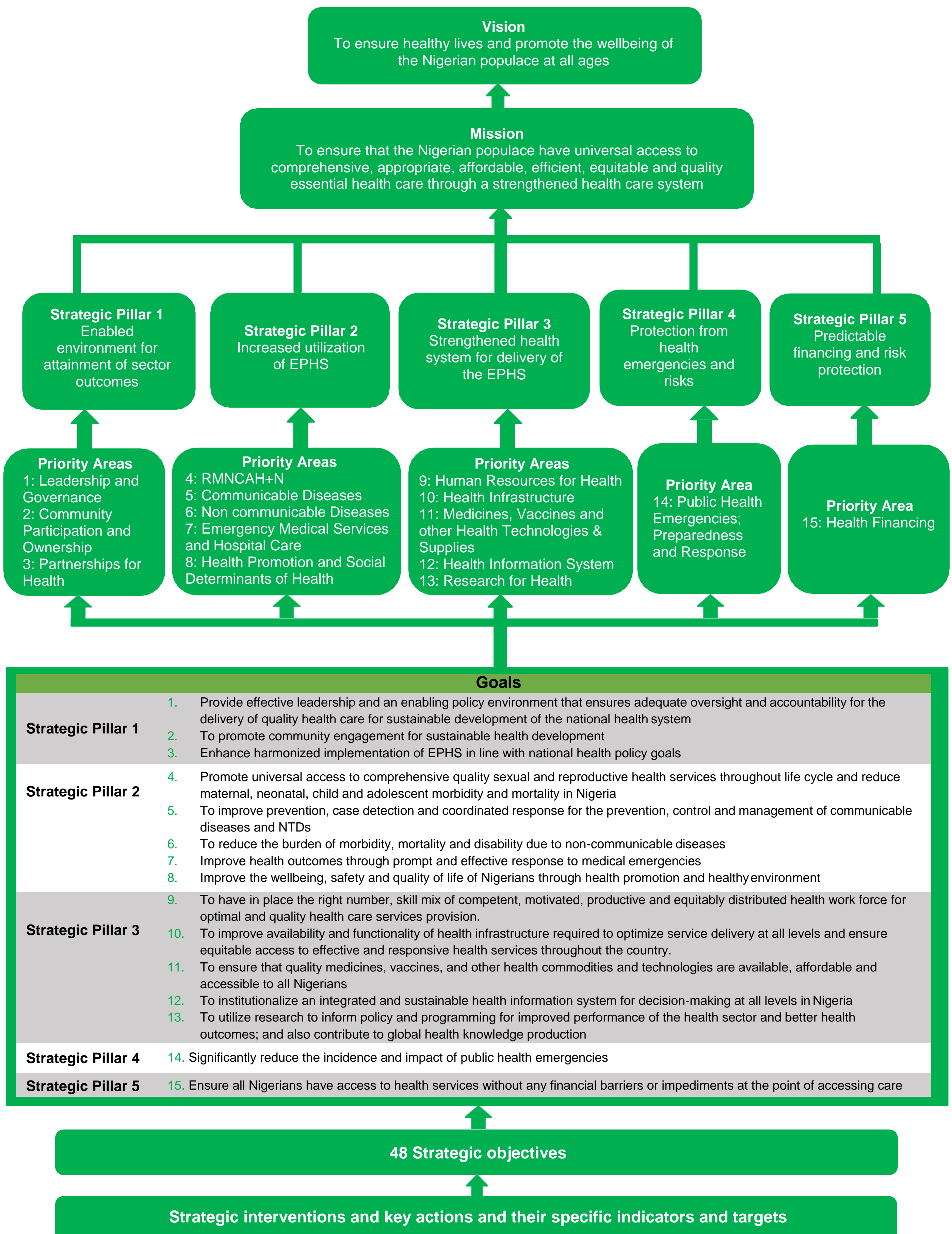
NYSC	National Youth Service Corp
ODA	official development assistance
PEL	political economy landscaping
PHC	Primary Health Care
PHCB	Primary Health Care Board
PM FHIS	Program Manager, FCT Health Insurance Scheme
RMP	Resource Mobilisation Plan
SHDP II	Strategic Health Development Plan II
SSC	state steering committee
TOR	terms of reference
TSA	treasury single account
USAID	U.S. Agency for International Development
WDC	ward development committee

1. Introduction

The Federal Capital Territory (FCT) is the seat of the federal government of Nigeria, but it faces social development challenges similar to other regions in the country. It has a land mass of 7,315 km^2 and is divided administratively into six area councils. It contains the urban capital of Nigeria, Abuja, with the surrounding area councils largely rural. Although slightly better than the national average, health outcomes are poor, especially in the rural parts of the FCT. The National Population Council estimates the FCT's population at 3.6 million as of 2016. This is projected to grow at an annual rate of 7 percent, more than double the national average. The health-seeking behaviours, health status, and socioeconomic status of migrants to the FCT reflect the characteristics of their mostly rural and underdeveloped home regions. This and the existing suboptimal health outcomes in the Territory place growing pressure on the health system and drive the need to improve the availability and quality of health services.

Organizationally, the Health and Human Services Secretariat (HHSS) of the FCT Administration is responsible for stewardship of the health sector. In addition, there are six Area Council Health Authorities (ACHAs), which oversee the health system at the local government level. In 2017, the HHSS produced its Strategic Health Development Plan II (FCT SHDP II) to be implemented 2018– 2022. The overarching goals of FCT SHDP II are to consolidate all FCT health interventions and programs in line with the National SHDP II framework and significantly improve the health of all residents. The NHSDP II encourages all states, including FCT, to mirror the five strategic pillars and 15 corresponding priority areas provided in the National Plan, while encouraging the states to develop their own strategic objectives, interventions, and activities. The FCT SHDP II strategic framework therefore adapts that of the NHSDP II, as outlined in Figure 1. The FCT SHDP II, developed by the HHSS, has 47 strategic objectives and defined 208 intervention and 747 activities over the implementation period, distributed amongst the strategic pillars and priority areas.

Figure 1. National Strategic Health Development Plan II (NHSDP II) 2018–2018 strategic framework



Source: Reprinted from the Second National Strategic Health Development Plan 2018-2022

1.1. Rationale for Mobilising Additional Resources

As outlined in Table 1, the proportion of general government health expenditure (GGHE) to general government expenditure (GGE) ranged from 7 percent to 10 percent in FCT, well below the Abuja Declaration target of 15 percent. Table 1 further illustrates that GGHE per capita reached a maximum of USD 29 in 2014, far below the USD 89 target that lower-middle income countries would be expected to be spending by 2030 to achieve the majority of Sustainable Development Goal targets related to health.[1] One of the drivers of the significant decrease in GGHE/capita in 2014–2016 is the steady decline of the Naira relative to the USD over the period; the Naira-USD exchange rate declined by almost 50 percent between 2014 and 2016.[2]

Table 1. FCT financial indicators

Indicator	2013	2014	2015	2016
General government expenditure (GGE), NGN billions*	191	176	140	132
General government health expenditure (GGHE), NGN billions**	12	14	9	12
Proportion of GGHE to GGE (%)	7%	9%	7%	10%
Population, thousands†	2,696	2,959	3,248	3,564
GGHE per capita, USD‡	28	29	13	12

* Source: CBN Statistical Bulletin
** Source: National Health Accounts (NHA) 2010–2016
† Source: National Population Commission and National Bureau of Statistics
‡ Source: Mid-year EXR on Oanda Currency Converter

Table 2 illustrates the health delivery outcomes achieved under current spending levels in FCT relative to the same outcome indicators at the national level, where income levels are assumed to be similar to FCT. FCT outperforms the national level on every indicator except the percentage of children ages 12–23 months fully covered by vaccinations.

Table 2. FCT health service delivery indicators

Indicators	FCT	National
Under-five mortality rate, deaths per 1,000 live births	71	120
% of population ages 12–23 months fully vaccinated before first birthday	16.6	23.0
Total fertility rate	4.6	5.8
Contraceptive prevalence rate as a %, any method	26.0	13.4
Unmet need for FP	24.1	27.6
Skilled attendant at delivery as a %	70.6	43.0

Source: Nigeria Multiple Indicator Cluster Survey (MICS) 2016–17

[1] Values presented in non-inflation adjusted 2014 USD. Source: Stenberg, et al. 2017. “Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries.” *Lancet Global Health* 5: e881.
Nigeria is classified as a lower-middle income country. FCT’s per-capita income is assumed to have 91 percent to 100 percent parity with national per-capita income, based on retrospective trends in fiscal space analysis.
[2] Source: Mid-year EXR on Oanda Currency Converter

The FCT HHSS costed its five-year SHDP II and estimated that a total of N185 billion will be required to fully implement the Plan. Given historical trends in the financial resourcing of the health sector, the FCT HHSS estimated a gap of N88 billion required to fund the SHDP II over the same period. Table 3 summarises the estimated annual SHDP II implementation costs and estimated funding gap with no intentional efforts to change recent financial resource growth trends.

Table 3. Estimated FCT SHDP II implementation costs and likely available financial resources

	NGN Billions					
	2018	2019	2020	2021	2022	Total
FCT SHDP II cost requirement	28.5	32.0	36.1	41.3	47.2	185.1
Recent and projected fiscal space based on recent trends	15.8	14.7	20.5	19.1	27.1	97.2
Funding gap	**-12.7**	**-17.3**	**-15.6**	**-22.2**	**-20.1**	**-87.9**

With expected annual gaps identified, the FCT HHSS conducted a fiscal space analysis (FSA) to identify potential sources and model resource projections for implementing the SHDP II and covering the funding gap. The Resource Mobilization Plan (RMP) presented in this document lays out strategies for mobilizing the resources needed to fully fund the NHSDP II.

Section 1 of this document summarises the methodology for carrying out the FSA and producing the accompanying RMP. Section 2 outlines the resource mobilisation strategies, including their rationale and intended outcomes, developed by the FCT.

2. Methods

2.1. Fiscal Space Analysis

In 2018, the FCT conducted a fiscal space analysis (FSA) to identify current and potential sources of funding to cover the costs required to fully operationalise the SHDP II. This FSA adapted the framework developed by Tandon and Cashin (2010) and examined the budgetary room available for expanding the FCT government's funding for health, while also taking into consideration efficiency gains in health sector operations and the potential for mobilizing additional Official Development Assistance and private sector resources.[3] The FSA served as a map, highlighting the potential sources of additional revenue for health that policymakers, advocates, and other health sector actors in the FCT can use to close the SHDP II resource gap described in the section above.

The methodological approach to the FSA was as follows: First, the Core FSA Working Group was established to advise the FSA analytic team from the conceptualization stage, through data and information collection, to analysis and interpretation stages.[4] A desk review of secondary documentation containing the relevant data was conducted using open-source websites. Additional information and relevant secondary materials were obtained from the FCT health sector actors. Key informant interviews were then conducted, which served to fill data gaps from the secondary document review and gauge stakeholders' perspectives on prospects for expanding the fiscal space for health in the FCT. The Core FSA Working Group then identified the characteristics influencing fiscal space for health in the FCT and situated each characteristic under the five FSA pillars. Table 4 displays each of the characteristics by FSA pillar.

Table 4. Characteristics by fiscal space analysis pillar

FSA Pillar	Characteristic
Macroeconomic Environment	National gross domestic product (GDP) growth
	Proportion of FCT to national GDP/capita
	Federal revenue
	FCT internally generated revenue
Prioritization of Health	FCT health expenditure as a proportion of FCT public expenditure
	Area council health expenditure as a proportion of area council public expenditure
Health Sector-Specific Resources	Year of implementation of Basic Health Care Provision Fund (BHCPF) earmarked for FCT
	Year of Implementation of FCT earmarks
	Number of HIS enrolees
	Earmarking of HIS enrolee premiums

[3] Tandon, A. and C. Cashin. 2010. *Assessing Public Expenditure on Health from a Fiscal Space Perspective*.
[4] The following representatives were members of the Core FSA Working Group: HHSS: SSO, Health Planning, Research and Statistics Department (HPRS); Desk Officer, Health Financing (HF) Unit, DPRS; Deputy Director, HF Unit, DPRS; Deputy Director, Plans and Programs Department; Deputy Director, Accounts Unit, DPRS; Planning Officer, HPRS; Statistical Officer, HPRS; Head, Debt Management Unit; Desk Officer, Human Resources for Health (HRH) Department; Principal Statistician, National Bureau of Statistics; FCT Department of Economic Planning; Department of Treasury Economic Planning Unit.

FSA Pillar	Characteristic
Private Sector and International Development Agency Funds	Amount of official development assistance (ODA) support
	Proportion of on-budget vs. off-budget ODA
Efficiency Gains in Health Sector Operations	Savings from redistribution and rotation of health care workers
	Savings from streamlining procurement practices

Using results from the secondary document review and key informant interviews, three scenarios were developed for each characteristic and used to forecast potential resources that could be available to fund the SHDP II. The three scenarios were matched to the overarching assumptions in Table 5.

Table 5. Scenarios for FCT's fiscal space analysis

Scenario 1	**Baseline:** The FSA characteristics will remain at the current level. National and FCT health reforms will not be implemented or will not achieve expected results, and economic growth will flatline year-on-year.
Scenario 2	**Moderate:** The FSA characteristics will marginally increase over the five-year period based on moderate economic growth and mixed implementation of the national and FCT health policies and reforms.
Scenario 3	**Optimistic:** The FSA characteristics will show substantial improvement over the five-year period driven by full recovery of the country's economy and successful implementation of all national and FCT health policies and reforms.

A detailed description of the scenarios developed for each FSA characteristic using the assumptions above is presented in Appendix 1.

The FSA results indicate that there are opportunities for expanding resources for funding health in the FCT. As indicated in Table 6, the amount of resources mobilised over the five years could range from N74 billion to N204 billion, depending on the scenarios that play out over the period.

Table 6. Estimated FCT SHDP II implementation costs and likely available financial resources

FSA Pillar*	Amount Mobilised (NGN Billions)		
	Scenario 1	Scenario 2	Scenario 3
Prioritization of health	71	112	157
Health sector-specific resources	0	13	24
Official development assistance and private sector	3	4	7
Efficiency gains in health sector operations	0	8	16
Total	**74**	**137**	**204**

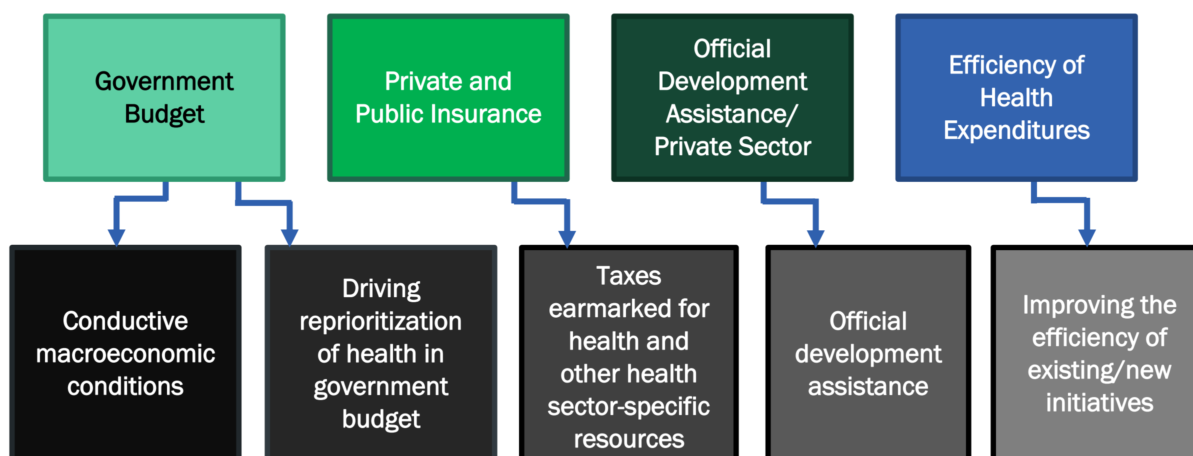
*Resource projections were developed for the macroeconomic environment pillar. These projections influence the scenario amounts displayed beside the following pillars: prioritization of health, health sector-specific resources, and official development assistance and private sector.

2.2. Resource Mobilisation Plan

Following the identification of opportunities for expanding the fiscal space for health described above, the FCT developed an RMP to outline strategies that could facilitate the realisation of selected financial scenarios identified in the FSA. To achieve this, an RMP task force, drawn from the Health Financing and Equity Technical Working Group and including representation from other departments of the FCT that were considered integral to the process of developing the RMP, was set up by the FCT HHSS. In selecting the members of the Task Force, the HHSS took into consideration familiarity with and/or knowledge of one or more FSA pillars and availability of members to assume a hands-on role in conducting background research, attending task force meetings, and developing sections of the RMP report.

The 11-member RMP task force was inaugurated in August 2018 and was split into four domain subgroups mapped to the FSA pillars, as shown in Figure 2.

Figure 2. Mapping of RMP task force domain subgroups to FSA pillars*



*Note: The macroeconomic conditions FSA pillar was not assigned to any of the domain subgroups, as it is not influenceable by the FCT HHSS and other health actors within the FCT.

A situation where all the defined FSA characteristics (in Table 5) align with one consistent scenario is unlikely; thus, the RMP task force's first task was to consider and select the most realistic scenario for each of the characteristics. To facilitate the selection of the FSA scenarios, the characteristics were grouped into macro- and micro-level characteristics. The macro-level characteristics consisted of those within the macroeconomic pillar of the FSA and were so tagged because they cannot be influenced by FCT health actors. The micro-level characteristics consisted of those related to the domain subgroups and were considered influenceable by the FCT health actors. The task force was led through the rationale behind the scenarios for the macro-level characteristics and selected the most likely scenarios based on forecasted trends of the macroeconomic dynamics in Nigeria and the FCT. The task force also considered the level of influence the FCT could exert on the micro-level characteristics and selected the most realistic scenario for each of these. The interactions of the selected scenarios for each characteristic were then modelled to determine the projected resource envelope for implementing the FCT SHDP II (discussed in Section 3).

Following the selection of scenarios for each micro-level characteristic, the task force developed a set of domain-specific strategies to actualise the scenarios and unlock the associated resources. These strategies were cross-analysed using the SMART criteria, refined, and combined to develop a cohesive RMP for implementing the FCT SHDP II.

3. RMP Projections

The RMP aims to mobilise, through the selected FSA scenarios and accompanying strategies, a total of N158 billion over the period 2018–2022, representing additional resources of N61 billion over the baseline scenario where N97 billion are mobilised and no additional efforts are made to secure additional funding. Table 7 highlights the amount of additional resources expected to be mobilised by each domain over the period.

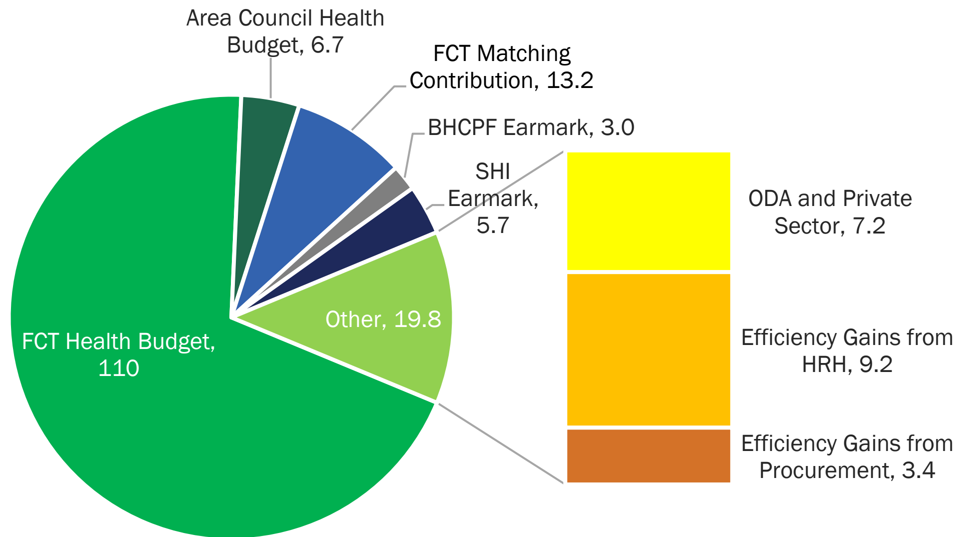
Table 7. RMP projections for implementing the SHDP II, 2018–2022

Domains/Years	2018	2019	2020	2021	2022	Total*
Government Budget	**15.0**	**18.3**	**22.4**	**27.4**	**33.6**	**116.7**
Expected funding	15.0	14.0	19.9	18.7	26.8	
Additional fiscal space generated**	-	4.4	2.5	8.8	6.8	
Health Sector-Specific Resources	**-**	**-**	**6.2**	**7.2**	**8.5**	**21.9**
Expected funding	-	-	-	-	-	
Additional fiscal space generated**	-	-	6.2	7.2	8.5	
ODA and Private Sector	**0.8**	**1.1**	**1.4**	**1.7**	**2.2**	**7.2**
Expected funding	0.8	0.7	0.6	0.5	0.4	
Additional fiscal space generated**	-	0.4	0.8	1.2	1.8	
Efficiency	**-**	**1.0**	**2.2**	**3.8**	**5.7**	**12.6**
Expected funding	-	-	-	-	-	
Additional fiscal space generated**	-	1.0	2.2	3.8	5.7	
Total*	**15.8**	**20.4**	**32.2**	**40.1**	**49.9**	**158.4**

*Values may not sum to total due to rounding
**Refers to additional fiscal space projected from the complete and successful implementation of the RMP

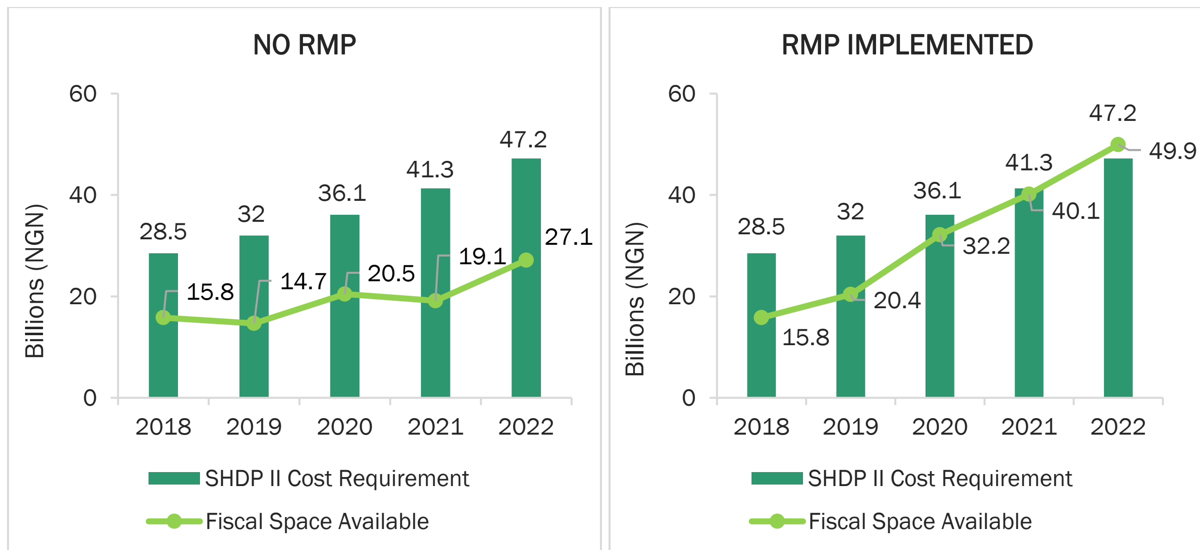
Figure 3 highlights the volume of contribution of each domain to the N158 billion expected to be mobilised through the successful implementation of the RMP. FCT and Area Council health budgets alone will account for 74 percent of the total figure, while the FCT earmarks and SHI contributions and BHCPF earmarks will contribute 8 percent, 4 percent, and 2 percent respectively, indicating that direct government funding remains the primary resource pool for health. The stacked bar in the figure represents characteristics that serve to defray the total cost requirement: efficiency gains from human resources for health (HRH) and procurement, as well as official development assistance (ODA) and private sector contributions. Together, these cost reductions amount to 13 percent of available fiscal space under RMP implementation, highlighting the importance of creating fiscal space outside of government health allocations.

Figure 3. Fiscal space for health in FCT, RMP implemented (billions NGN)



As Figure 4 indicates, a situation where fiscal space for health remains at the baseline level (as defined above) over the period 2018–2022 will result in a total SHDP funding gap of N88 billion (48 percent of the total SHDP II cost) over the same period. This funding gap will severely cripple the implementation of the SHDP II with a consequent effect on the performance and outcomes of the FCT's health system. In contrast, the full actualization of RMP results will mobilise an additional N61 billion in funds to resource the SHDP II, progressively shrinking the funding gap from 36 percent to 19 percent of projected costs in 2019 and 2020, respectively, and ultimately covering all costs in the years 2021 and 2022.

Figure 4. Impact of RMP implementation on the SHDP II funding gap



*Assumes that implementation and impact of the RMP will commence in 2019 and will not generate additional fiscal space in 2018.

4. RMP Strategies and Action Plans

As highlighted above, there are four domains of the FCT RMP, identified from the FSA as the key areas to increase the resource pool for health: government budgeting, health insurance and earmarks, official development assistance and private sector, and efficiency of health expenditures. In total, these domains set out to harness potential additional resources of N61 billion assuming full effectiveness of the RMP over 2019–2022.

Each domain further comprises strategies intended to unlock the new fiscal space identified. The FCT HHSS DPRS will be responsible for driving the implementation of the strategies. In turn, each strategy considers the health sector weaknesses or opportunities the strategy will address and the broad actions to be taken by health sector actors to implement the strategy. A detailed plan for implementing the strategies is provided in Appendix II of this document.

4.1. RMP Domains

4.1.1. Government Budgets

In FCT, health is financed through the HHSS budget and area council health budgets. Assuming full implementation of RMP strategies and resource mobilization strategies targeting larger area council health budgets, resources mobilised from these budgets could be expected to account for 70 percent of total fiscal space for health in FCT, corresponding to N22 billion more than what could be mobilised if no RMP is implemented during 2018–2022.[5] To achieve this, three strategies are recommended at different phases of the budget process:

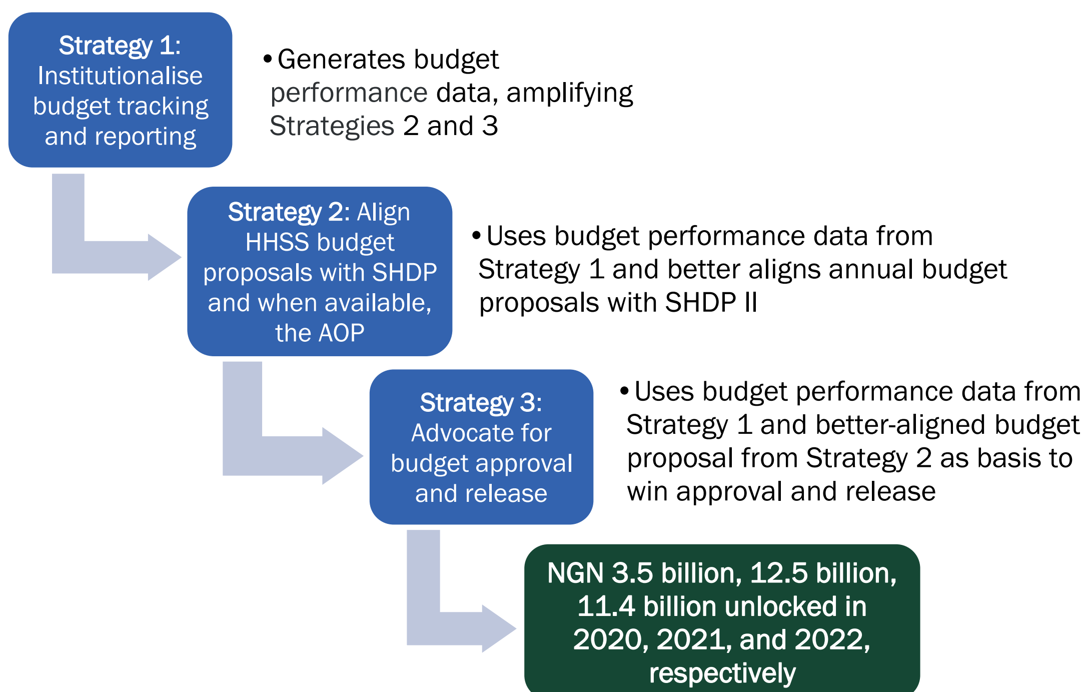
- Institutionalise health budget and expenditure tracking and reporting
- Align HHSS budget proposals with SHDP II
- Advocate for increase in health budget allocation and releases

Of the three scenarios, the RMP task force selected the moderate scenarios under the government budget domain, which assumes the progressive increase of GGHE as a percentage of general government expenditure from 10 percent to 12.5 percent by 2022.

Figure 5 depicts how the three strategies will contribute to unlocking the target fiscal space under this RMP. “Strategy 1: Institutionalise budget tracking and reporting” will amplify Strategies 2 and 3, equipping HHSS budget planners and advocates with the prior budget performance data required to develop defensible budget proposals and investment cases.

[5] Note that the RMP task force selected a moderate area council health budget scenario but has not yet developed strategies intended to expand these budgets from baseline to moderate levels. Such strategies are still under discussion.

Figure 5. Government funding strategy logic map



4.1.1.1 Institutionalise Health Budget and Expenditure Tracking and Reporting

This strategy reflects the FCT's intent to review, analyse, and report historical government budget and expenditure data of the health sector on a regular basis. The regular availability of these reports will provide critical input into and enhance the quality of prospective budgeting processes. In addition, the analysis of budget and expenditure data will highlight patterns in government prioritisation of health, which may serve as an advocacy tool for focusing attention on the inadequacy of funding for the sector. In the past, the FCT produced reports on budget performance; however, these are usually developed on an ad hoc basis, and therefore do not cover multiple years or track the activities or interventions on which resources are expended. The FCT now wishes to develop a framework to institutionalise the tracking and reporting of health budgets and expenditures.

The Health Financing (HF) Unit will lead the process of tracking and collating health expenditure across the different relevant ministries, departments, and agencies. Institutionalisation will be achieved by designing a process guide and a tool for continuous implementation of the strategy over successive years.

4.1.1.2 Align HHSS Budget Proposals with the SHDP II and the AOP, When Available

This strategy focuses on reorienting budget holders within the HHSS to enable development of expanded budget proposals that prioritise identified programs and activities in line with the FCT SHDP II.

In its annual budget proposals to the FCT economic team, the HHSS historically follows an incremental budgeting approach whereby requested amounts for each budget line item are based on prior allocation. Through this approach, the HHSS does not link budget proposals to prior or projected programmatic or financial performance. Furthermore, budget proposals

do not reflect resource needs or priorities as defined in sector strategic plans such as the SHDP II. As a result, budget reviewers cannot clearly map the through line from funding requests to performance and medium-term priorities, contributing to the low prioritization of health in FCT. This strategy aims to link the proposals developed by the HHSS to the SHDP II to ensure resources are allocated to and utilised for priority areas defined by the SHDP II. This ultimately ensures that budgets are defendable, and more likely to result in the appropriation of required resources.

To achieve this, the FCT Health Financing Unit will convene a workshop to orient the different budget holders within the FCT HHSS on the new approach to budgeting. Following the release of the budget circular and associated documents by the FCT Administration, the Health Financing Unit will work closely with budget holders to ensure budget proposals reflect priorities outlined in the SHDP II, and when available, the Annual Operational Plan (AOP), which is derived from the SHDP II. These steps will be repeated every year and linked with Strategy 1 of this domain to measure its effectiveness.

4.1.1.3 Advocate for Health Budget Allocation and Releases

It is expected that the alignment of budget proposals to the SHDP II, and when available, the AOP, will lead to more ambitious budget proposals for health in the FCT. Thus, prior to the commencement of the budget process, FCT health actors will engage in supplemental advocacy efforts to decision makers within the FCT to justify the expanded budgets proposals developed. Similarly, advocacy will be carried out to the legislators to facilitate the timely approval of the FCT budget and the appropriation of increased proportion of the total budget to health. Specific members of the National Assembly (NASS) who will be targeted are the chairmen of the committees on health and FCT, as well as the FCT representatives in the lower and upper house of the NASS, based on their influence and interest in the FCT and its health sector development.

Using the results of regularly updated political economy landscaping (PEL), which maps the priorities and level of influence of key actors in the FCT health sector, advocacy materials and messages will be tailored to identified interests and influence of its audience and will provide an investment case for the proposed health expenditure. The HHSS will leverage an advocacy team formed from the HFE&ITWG to lead the advocacy efforts. Equipped with a map of the financial flows for health, the advocacy team will define the targeted proportion of health allocations released and of health releases spent each year.

4.1.2. Earmarks and Health Insurance

The FCT Health Insurance Scheme (FHIS) has been operational for about a decade; however, it has no law setting it up, and this has hampered its ability to pool its own resources, expand its target population, and access independent sources of funding. Similarly, the FCT Primary Health Care Board (PHCB) operates without any law setting it up. The bills setting up the two agencies, currently undergoing legislative processes within the National Assembly, have each proposed earmarking 1 percent of the FCT's Consolidated Revenue Fund (CRF) to fund the health sector. If passed, the inflow of resources from these earmarks will substantially increase the available resources for health in the Territory. While the passage of the bills into law are a necessary precondition for accessing the earmarks, some further advocacy and justification may be needed to kickstart the actual allocation and release of the funds to the health sector.

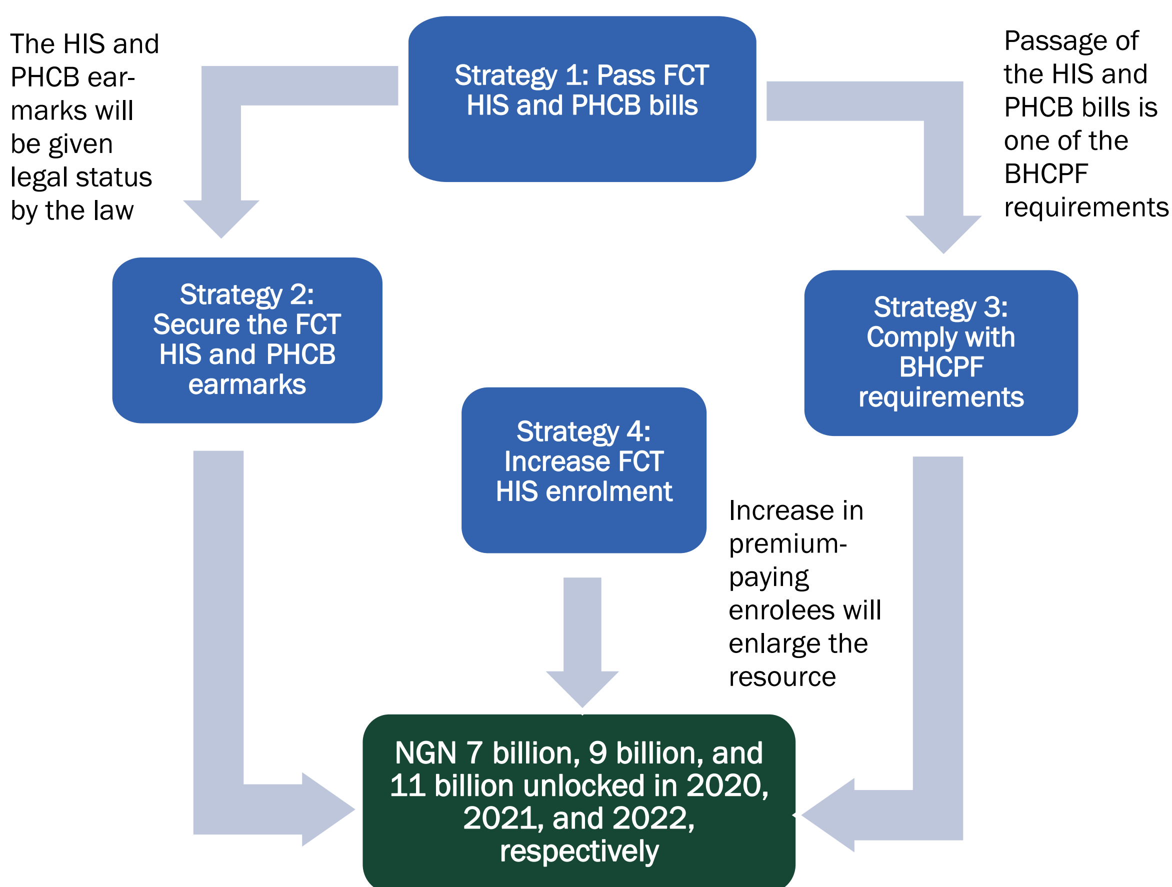
In addition, the FCT has been selected to pilot the rollout of the BHCPF through its FHIS and PHCB as mandated by the National Health Act, 2014. The BHCPF guideline, developed

by a National Steering Committee, outlines the systems and structures required to roll out the fund. The FCT has implemented some of these, but it still needs to complete some set-up activities to ensure that it is fully prepared and positioned for the BHCPF funds to flow through the FHIS and PHCB.

To unlock this new fiscal space, the following strategies are recommended through this RMP:

- Facilitate the passage of the FHIS and PHCB bills
- Secure the implementation of the FHIS and PHCB earmarks
- Comply with BHCPF requirements
- Increase the number of premium-paying enrolees in the FHIS

Figure 6. Earmarks and health insurance strategic logic map



This domain aims to ensure that the FCT can access the BHCPF and FCT earmarks in the next budget cycle, as well as take control of its FHIS pool and expand its scheme to premium-paying enrolees.

Figure 6 illustrates how the four strategies will contribute to unlocking the target fiscal space under this RMP. As depicted in the figure, the passage of the FCT and PHCB bills serves as a necessary, but not sufficient, condition for the success of Strategies 2 and 3.

4.1.2.1 Facilitate the Passage of FHIS and PHCB bills

The passage of the FHIS and PHCB bills are a necessary step to access the 1 percent FCT CRF earmarked funds proposed by each of the bills and to achieve compliance with BHCPF requirements. Both FHIS and PHCB bills have been developed and forwarded to the NASS for review and passage through the house, and some work has been done on identifying and advocating to the legislators to get the draft bills through the first reading; however, some momentum was lost as the impending elections in May 2019 drew closer. This strategy outlines preparation and advocacy efforts that will be focused on getting the bills through the second and third reading in the National Assembly by the end of the current legislative session in May 2019.

To prioritise the bills for passage through the house, the Health Financing Equity & Investment Technical Working Group (HFE&ITWG), FCT HHSS, FHIS, and FCT PHCB will conduct targeted advocacy to identified proponents and influencers within the NASS on the need for urgency. At the same time, the HHSS will sensitise relevant community stakeholders such as area council chairmen, civil society organisations (CSOs), traditional rulers, and other interest groups on the key thrusts of both bills and prepare them for a public hearing on the bills. Once passed through the NASS, the HHSS will fast-track the dissemination of relevant information required to facilitate the President's assent to the bills.

4.1.2.2 Secure the FCT HIS and PHCB Earmarked Funds

While the passage of the bills is a requirement for accessing the FCT earmarks, it does not directly translate to its implementation. The objective of this strategy is to facilitate the implementation of the additional earmarks for health (1 percent each for FCT HIS and PHCB) as contained in the two bills by the 2020 budget cycle.

The heads of both agencies (FHIS and PHCB), as well as the HHSS HF Unit, will drive this process by developing a business case to justify the need and expected results of the 2 percent FCT CRF earmarks contained in the bills over the medium term. This will inform the development of advocacy materials (fact sheet, briefs, and posters) to be used by the advocacy team, constituted from the HFE&ITWG, to identify and deliver key messages to the FCT economic team and other identified influencers of the appropriation and release of the funds. Every year, the HHSS will track and report the proportion of the CRF earmarks allocated and released, which will serve as an input into advocacy and planning for subsequent years.

4.1.2.3 Ensure Compliance with BHCPF Gateway Requirements

The National Health Act, 2014 mandates the establishment of a Basic Health Care Provision Fund to support the effective delivery of primary health care services, provision of a basic minimum package of health services, and emergency medical treatment to all Nigerians. The federal government has selected five states in Nigeria and the FCT to pilot this programme; however, rollout is contingent on the fulfilment of certain requirements outlined in the BHCPF Implementation Guide developed by the Federal Ministry of Health (FMOH). This strategy aims to ensure that FCT is positioned to roll out the BHCPF and access the first tranche of funds disbursed to pilot states to implement the programme.

One of the key requirements for accessing the BHCPF is the availability of a legal framework for the FCT HIS and PHCB. This and other key requirements have been addressed through Strategy 1 of this domain. Other requirements include setting up a strong financial management and accountability framework for the BHCPF through the setup of a state

steering committee, establishment of treasury single accounts (TSAs) for the HIS and BHCB, activating ward development committees, and developing quality improvement plans for participating PHCs.

The implementation of this strategy will be led by the FCT PHB and HIS, the key implementing agencies for the BHCPF.

4.1.2.4 Increase the Number of Premium-Paying Enrolees in the FCT Health Insurance Scheme

With this strategy, the FCT HIS seeks to double the current number of enrolees by 2022, ultimately increasing the size of its resource pool and improving cross-subsidisation. Currently, the FCT has about 100,000 enrolees in its scheme (made up of 20,000 primary enrolees and 80, 000 dependents), who are largely FCT civil servants. To increase enrolment into the scheme, the FCT HIS will expand coverage to include the staff of the six area councils (estimated at about 17,000 primary enrolees) and implement plans to enforce mandatory coverage of the organised private sector.

The FCT HIS has commenced discussions with the area council chairmen, the political heads of the area councils, to define modalities for inclusion of their staff in the scheme and plans to conclude this process by the end of 2019. Plans to enforce the coverage of the organised private sector are expected to kick into gear in 2020, following the planned assent of the FCT HIS bill in May 2019. The FCT HIS will collaborate with the FCT Inland Revenue Service, the tax collection agency of the FCT, to map out the organised private sector and facilitate enforcement.

4.1.3. Efficiency

This domain aims to ensure planned programmes and activities are implemented efficiently, leading to unlocking of resources that could potentially be diverted to other uses, and will ultimately reduce the total amount of funds required to implement the SHDP II. In developing the RMP, the FCT identified the maldistribution of health workers and the procurement and distribution of health care commodities as providing the greatest opportunities for addressing inefficiencies within the health system. Together, these two elements make up 76 percent of the cost of implementing the SHDP II. Efficiency cost savings from these could be substantial and are projected to account for 21 percent of the fiscal space gained for health over the period covered by the SHDP II, if strategies are successfully implemented. Unlike other domains, the implementation of the strategies within the efficiency domain are fully within the control of the FCT HHSS; therefore, it provides the greatest potential for effective implementation.

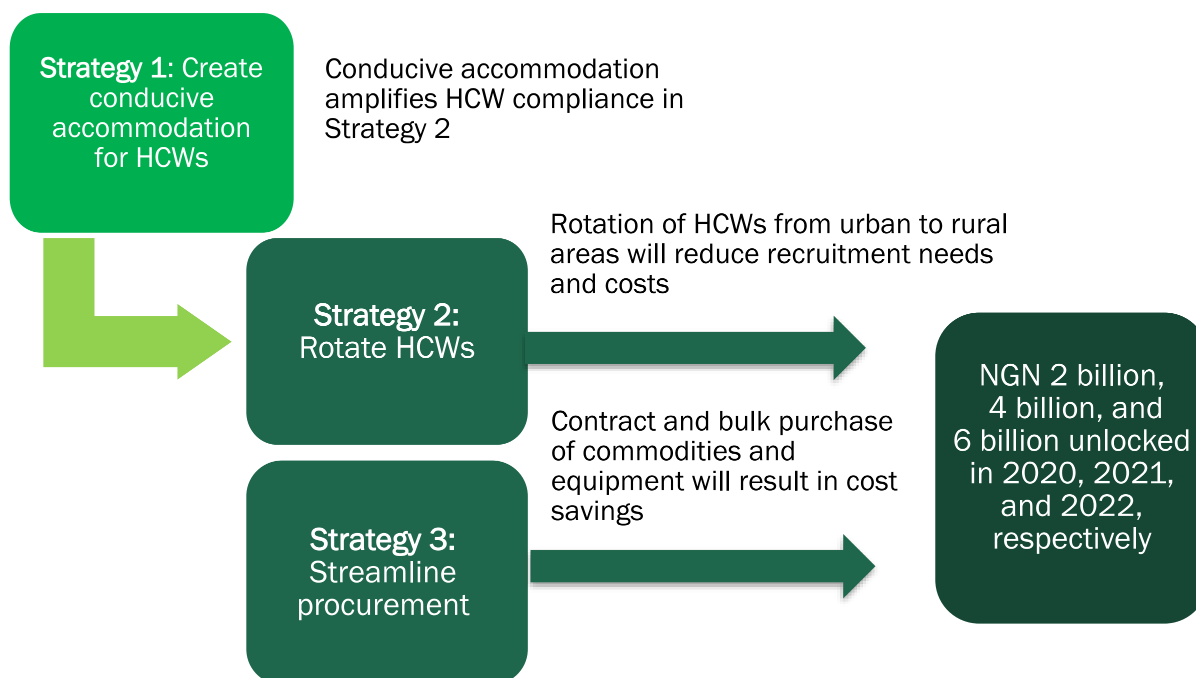
The strategies defined under this domain are to:

- Implement rotational posting of health care workers (HCWs) to rural, under-resourced facilities
- Provide conducive accommodations for HCWs in rural facilities
- Streamline procurement and/or maintenance of health commodities and equipment

The strategies under this domain are aimed at reducing the costs associated with the recruitment and wage bill of HCWs and procurement of commodities by 2.5 percent and 5 percent, respectively, year-on-year from 2019.

As outlined in Figure 7, the combination of the three strategies is expected to result in the unlocking of about N12 billion in resources over the period of implementation. While the implementation of Strategy 2 will not result in cost savings, it is expected to amplify the implementation of Strategy 1 and improve the amount of resources saved from the recruitment of additional HCWs.

Figure 7. Efficiency strategy logic map



4.1.3.1 Implement Rotational Posting of HCWs to Rural, Under-resourced Facilities

FCT has the highest number of HCWs in Nigeria, second only to Lagos state; however, the quantity and skill mix of HCWs compared to the population remains inadequate. There is also skewed distribution of health workers, with the majority within the urban areas of the FCT and a significantly lower HCW density in the rural areas. The SHDP II estimates an additional N18.7 billion over the current wage bill to retain the quantity and categories of HCWs that are essential to delivering the services modelled in the Plan. This strategy explores the possibility of reducing these costs through the implementation of policies on short-term rotation of the HCWs from areas of high density to rural areas of low density.

The strategy will leverage the National Youth Service Corp (NYSC), a mandatory service programme for all university graduates in Nigeria. Although the intent of the NYSC programme is to produce a crop of young professionals who provide skilled services across several specialties in rural areas, it has not always achieved its objectives, and youth service members are sometimes posted to work in urban cities, where there is a proliferation of highly skilled workers. In implementing this strategy, the FCT will ensure that NYSC HCWs posted to the Territory through the Health Management Board (HMB), PHCB, and area council health departments are employed in service delivery roles and deployed to areas with low HCW density from 2019 to 2022. Additionally, the federal government's youth employment programme, NPOWER, will be leveraged to source HCWs of various cadres.

In addition, the HMB, which manages the secondary health facilities in the FCT, will implement a mandatory, rotational posting of all cadres of HCWs in urban areas to rural

areas for short-term periods. To achieve this, the HMB will maintain and communicate a roster of HCWs due for posting to rural areas and implement accompanying strategies (see Strategy 2) to incentivise compliance with postings.

The National Council on Health (NCH) has approved a policy of rotation of doctors in residency training to hospitals in less urban areas. For FCT, the focus of this strategy will be to achieve full compliance with the policy and implement targeted posting of resident doctors in a manner that addresses gaps in the semi-urban or rural areas. There has been some level of implementation of this policy with the National Hospital, Gwagwalada Teaching Hospital, and secondary-level facilities, with residency programmes in the FCT posting their doctors to surrounding hospitals in semi-urban or rural areas for specific rotations. There will be a renewed focus on this to drive compliance and link the initiative with the FCT's efficiency objectives.

In keeping with the tenets of efficiency, the FCT will take into consideration the functionality and level of utilisation of health facilities in determining how the rotational postings will be implemented.

4.1.3.2 Provide Conducive Accommodations for HCWs in Rural Facilities

One of the major impediments to attracting and retaining HCWs in rural areas is concerns with availability of secure and conducive accommodation.[6] It is envisaged that this will still be a key concern for HCWs who are required to undergo rotational posting in these areas, necessitating the definition of a strategy to address the shortfalls in accommodation. This strategy will not result in any cost savings on its own, but it is expected to amplify compliance with and maximise savings from implementing Strategy 1.

The FCT HHSS has conducted a rough mapping of facilities that lack accommodation for HCWs and identified a pool of approximately 80 primary and secondary health facilities that fall into this category. A further assessment of facilities with existing accommodation will be undertaken to identify those that require refurbishment. Following this, the HHSS will further refine and prioritise targeted PHCs and secondary health facilities, which will be the focus of this strategy over the period 2019–2022. In prioritizing these facilities, the FCT HHSS will consider the availability of ongoing plans by the HMB/PHCB to build/refurbish HWC chalets/apartments, the utilisation rate of facilities, and their inclusion as a target facility in the FCT's rotational posting policy.

The upgrade and/or construction of new accommodation will require new, additional resources that have not been estimated in the SHDP II. Therefore, the agencies responsible for implementing this strategy (HMB and PHCB) will define mechanisms for how this can connect with strategies targeting resource mobilisation from private sector organisations, high network individuals with personal foundations or interest in social causes, and legislators' constituency project funds.

4.1.3.3 Streamline Procurement and Maintenance of Health Commodities and Equipment

This strategy is focused on reduction of costs associated with the purchase and distribution of health commodities to facilities. Historically, procurement of health commodities in the FCT has been fragmented, with health facilities often resorting to purchasing in small

[6] FCT Health & Human Services Secretariat (HHSS). 2018. FCT Strategic Health Sector Development Plan II (SHDP II), p. 6.

quantities from open market suppliers. The strategy will explore the prequalification and contracting of local pharmaceutical companies to manufacture and supply bulk health commodities to the FCT central medical store and health facilities as a mechanism to drive efficiency and cost savings. The FCT has commenced the process of prequalifying local manufacturing companies for certain classes of health commodities and will focus its attention on the development of framework agreements with selected pharmaceutical companies over the first six months of the RMP implementation period. As the framework agreements are implemented, the FCT HHSS will monitor, quantify, and communicate the efficiency savings with relevant policymakers, with the aim of motivating the progressive extension of these agreements to additional groups of health commodities.

In addition, the strategy will address the high costs associated with the maintenance and repair of health equipment through the execution of service and maintenance contracts with accredited equipment suppliers. This strategy was developed to shift the risk of managing the equipment to the providers and ultimately reduce the incidence of faulty equipment within the health system. This strategy will also provide some form of upfront financing for purchasing health equipment with defined mechanisms for payment over the life of the equipment.

4.1.4. Official Development Assistance and Private Sector Contributions

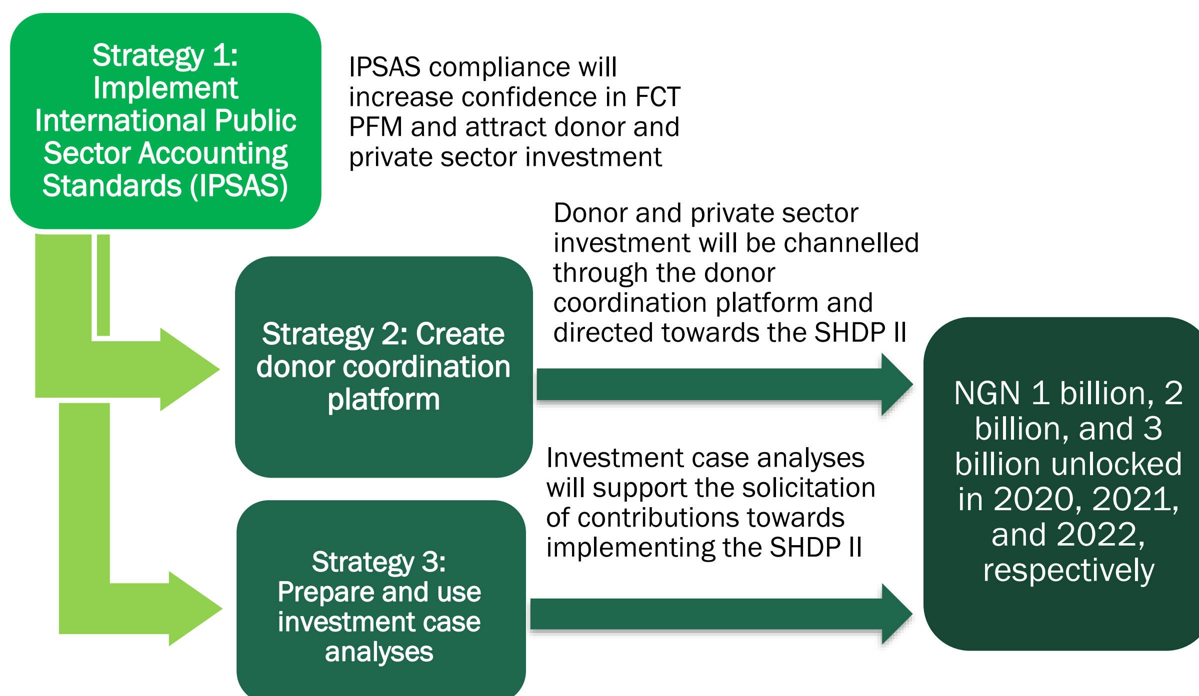
In the context of declining development assistance for health to low- and middle-income countries, the FCT's overall objective for the ODA domain is to increase the alignment of donor funding with its strategic priorities. If achieved, the savings obtained could be channelled to other interventions in the SHDP II, effectively lowering the total cost to the FCT of delivering the plan. Together, funding expected from ODA and the private sector could account for 5 percent of the fiscal space generated over the period, assuming full RMP implementation.

To unlock this new fiscal space, the following strategies are recommended:

- Implement the International Public Sector Accounting Standards (IPSAS) in the HHSS
- Establish a planning and funding coordination platform for SHDP II implementation
- Develop investment cases for health interventions targeted at donor agencies and private sector organisations and foundations

The expected outcome of implementing these strategies is to mobilise N1 billion, N2 billion, and N3 billion in 2020, 2021, and 2022, respectively, from donor and private sector sources. Figure 8 depicts how the three strategies will contribute to unlocking the target fiscal space under this RMP. In Figure 8, "Strategy 1: Implement IPSAS" will promote financial accountability in the HHSS, attracting increased donor and private sector investment through Strategies 2 and 3.

Figure 8. ODA and private sector contributions strategy logic map



4.1.4.1 Implement the International Public Sector Accounting Standards (IPSAS) in the HHSS

The IPSAS is a set of standards that guide public sector entities in recording financial transactions and preparing general-purpose financial reports. The FCT Administration is yet to adopt IPSAS across all its secretariats, departments, and agencies. The implementation of IPSAS is expected to improve the quality, reliability, and transparency of the HHSS financial reports. This will be critical to boosting donors' confidence in the HHSS financial management system as it seeks to convince donors to fund its health priorities.

The FCT HHSS will liaise with the FCT Department of Treasury (DoT) in the DoT's efforts to fast-track implementation of the IPSAS platform in the HHSS, as will be happening in other FCT secretariats, departments, and agencies. Once the platform is operational in the HHSS, the HHSS will record and report its financial transactions, train its staff on the standards, remap its process workflows, and register and measure all its assets and liabilities. The HHSS has commenced the procurement process for the relevant project management expertise to guide it through this process, with an expectation to achieve full IPSAS compliance in the preparation of financial reports by 2020.

4.1.4.2 Establish a Planning and Funding Coordination Platform for SHDP II Implementation

A high proportion of ODA in FCT is channelled off-budget and through vertical programs. There is little coordination among donors in these vertical investments, which has resulted in duplication of funding efforts. Beyond this, donors' vertical investments have tended to flow to health purposes that are not in alignment with FCT SHDP II priorities, leading to inefficient use of resources. Improved coordination among these two actors—HHSS and

donors—is expected to result in the redirection of donor and private sector funds from areas of duplication to fill SHDP II funding gaps.

To implement this strategy, a subgroup of the FCT HFE&ITWG will conduct a mapping of prospective donors who are already financing health in FCT or have demonstrated an interest in doing so. In the analysis, the entities identified will be further assessed for the likelihood of their interest in participating in a coordination platform led by the HHSS. The mapping exercise will result in a list of prospective donors who will be invited to join the platform. Following the acceptance of invitations by prospective donors, the platform will be set up with clear terms of reference outlining the responsibilities of all participants (donors and the HHSS) and how the conception, design, and implementation of integrated interventions will be carried out. The HHSS aims to achieve the operationalisation of this platform by the end of 2019.

4.1.4.3 Develop Investment Cases for Health Interventions

This strategy is primarily targeted at garnering private sector funds toward the implementation of the SHDP II. It is known that private sector organisations and individuals with high net worth fund health through corporate social responsibility arrangements and private foundations, respectively, but the HHSS has little visibility with regard to the volume or intent of these funds. Furthermore, there has been no comprehensive effort to map, engage, and coordinate with these entities. Through this strategy, the FCT HHSS will identify funding needs and gaps, which may be addressed by identifying private sector entities and developing and presenting investment cases or proposals to win funding for those needs. The investment cases may take various forms, ranging from menu lists of required equipment or infrastructure to proposals that track prospective investments to intermediate results and eventual health outcomes, depending on the identified areas of need and the interest of the private sector entities.

As with Strategy 2 above, the first steps towards implementing this strategy will be to identify relevant private sector entities and map their funding interest to HHSS needs. After developing a priority list of potential funders, the HHSS will then develop investment cases tailored to these prospective entities to demonstrate the impact of their contribution, as well as an accountability plan to highlight how investments will be tracked. Thereafter, the HHSS will communicate the investment case in a manner that resonates best with the prospective funder and will launch supplemental advocacy activities to win the desired funding. This process will be repeated whenever such a need arises under the RMP implementation period.

Annex I. Fiscal Space Analysis Scenarios

The scenarios modelled for each of the FSA pillars prior to developing the RMP are described in detail below:

Pillar I: Macroeconomic Environment. Based on five-year projections from online sources, scenarios were developed in which national gross domestic product (GDP) growth remains roughly constant (~2 percent)[7] in real terms over the period or grows to 4 percent[8] or 6 percent by 2022.[9] Depending on the effect of lower-income migrants on income/capita in FCT, FCT to national GDP/capita could range from 92 percent to 100 percent. Turning to federal revenue collection, the government's take as a proportion of national GDP could remain constant at approximately 6 percent or grow to 8 percent or 10 percent by 2022, based on CEIC estimates and prior trends. Finally, assuming FCT's tax collection efficiency improves following recent reforms, two scenarios project that internally generated revenue as a proportion of FCT GDP could remain constant at 5 percent or grow to 7 percent or 9 percent by 2022.

Pillar II: Prioritization of Health. The baseline scenario assumes that health allocations behave as a function of the Treasury's priorities and that the health sector has little ability to influence these allocations, characterised by an annually fluctuating proportion of health to total allocations over the period. More optimistic scenarios assume that FCT will approach or reach the Abuja target of 15 percent by 2022. At the area council level, the estimated range of health to total allocations is 3 percent to 5 percent, based on prior trends.

Pillar III: Health Sector-Specific Resources. Different scenarios were constructed assuming BHCPF earmark implementation in 2020, 2021, or after 2022. Another set of scenarios assumes that the Health Insurance Scheme (HIS) and Primary Health Care (PHC) bills, on which parts of FCT's matching contribution depends, are or are not both passed during the period, or one of them is passed in 2020. The other two characteristics under this pillar pertain to HIS enrolee contributions. The first assumes that HIS enrolment will remain constant at 100,000 enrolees or double/quintuple to 200,000/500,000 enrolees. The second assumes that enrolee premiums remain unavailable to the government for subsequent expenditure on health purposes, or that they become available in 2020 or 2021, made possible by the passage of the HIS bill.

Pillar IV: Efficiency Gains in Health Sector Operations. For both characteristics under this pillar, the baseline scenario assumed no efficiency gains over the period. Under the other two scenarios for each characteristic, savings in efficiency gains were assumed to climb by 2.5 or 5 percentage points annually until 2022.

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[7] IMF. 2018. "World Economic Outlook." Available at: https://www.imf.org/external/datamapper/NGDP_RPCH@WEO/OEMDC/ADVEC/WEOWORLD/NGA.
[8] Business Monitor International (BMI). 2018. *Nigeria Country Risk Report: Q4 2018.*
[9] PricewaterhouseCoopers. 2017. *Nigeria's Economic Recovery: Defining the Path for Economic Growth*.

Annex II. Detailed Implementation Plan

Domain 1: Government Budgets

Institutionalise health budget and expenditure tracking and reporting.

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Identify and map health budget, release, and expenditure data points/needs	HF Unit	Q1 2019	Q1 2019	Technical support	Data points identified
2	Identify sources within the HHSS or the FCT Administration for obtaining the data outlined in Step 1	HF Unit	Q1 2019	Q1 2019	Technical support	Data sources mapped
3	Develop Excel workbook for collating and analysing budget, release and expenditure data	HF Unit	Q1 2019	Q1 2019	Mapped data sources; technical support	Blank data collection workbook
4	Hold a meeting with stakeholders who collect, generate, and/or store the required data to discuss the data needs, how the data will be used, and mechanisms of collaboration to ensure data are available for use	HF Unit	Q1 2019	Q1 2019	Meeting venue and costs; technical support; data collection workbook	Data needs understood by stakeholders
5	Convene data gathering workshop with stakeholders, gather relevant data (over the period 2016–2018) and input into data collection workbook	HF Unit	Q2 2019	Q2 2019	Blank data collection workbook, collated data points	Populated data collection workbook
6	Review data gathered from workshop and determine gaps	HF Unit	Q2 2019	Q2 2019	Technical support	Missing/incorrect data identified
7	Follow through with stakeholders to collect data to fill identified gaps or extrapolate data based on assumptions	HF Unit	Q2 2019	Q2 2019	Technical support	Fully populated data collection workbook

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
8	Develop report and submit to FCT leadership, link with advocacy visits to FCT leadership to highlight key areas of report	HF Unit	Q2 2019	Q2 2019	Technical support	Budget, release, and expenditures tracking report
9	Develop advocacy briefs/messages from the report and link with advocacy visits on budget approval to FCT leadership	HF Unit, advocacy team	Q3 2019	Q3 2019	Technical support	Advocacy messages and materials developed
10	On a quarterly basis each year, collect budget, release, and expenditures data and enter data into Excel-based tracking workbook	HF Unit	Q3 2019	Continuous	Technical support	Populated data collection workbook (with possible data gaps/issues)
11	Review data gathered from stakeholders and identify gaps on a quarterly basis each year	HF Unit	Q3 2019	Continuous	Technical support	Missing/incorrect data identified
12	Follow through with stakeholders to collect data to fill identified gaps or extrapolate data based on assumptions on a quarterly basis each year	HF Unit	Q3 2019	Continuous	Technical support	Fully populated data collection workbook
13	Develop reports for FCT advocacy Team, in Domain 1 Strategy 3 below, to inform advocacy efforts related to increasing allocations, improving the proportion of allocations released, or improving the proportion of releases spent, on a quarterly basis each year	HF Unit	Q3 2019	Continuous	Technical support	Budget, release, and expenditures tracking report

*Repeat steps 5–9 each year.

Align HHSS budget proposals with the SHDP II and, when available, the AOP.

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Review the SHDP II (and the AOP, when available) and tease out the priority areas for the budget year 2020	HF Unit	Q2 2019	Q2 2019	Technical support	SHDP II (and AOP, when available) funding priorities for 2020 identified
2	Prior to release of budget circular, hold meetings with budget holders/owners in the FCT Administration to agree on priority areas for funding in 2020	HF Unit	Q2 2019	Q2 2019	SHDP II (and AOP, when available) funding priorities, technical support, meeting venue, refreshments, printing, and stationery	Budget holders oriented on SHDP II (and AOP, when available) priority areas
3	When budget circular is released, convene workshop with budget owners/holders and budget officials responsible for preparation to align budget proposals with SHDP II (and when available, AOP) priority areas for 2020	HF Unit	Q3 2019	Q3 2019	Budget circular instructions, SHDP II (and AOP, when available) funding priorities, technical support, meeting venue, refreshments, printing, and stationery	High-level budget envelopes for key expenditure categories identified
4	Prior to the consolidation of the HHSSS budgets, hold validation workshop to confirm alignment of budget proposal with SHDP II (and AOP, when available)	HF Unit	Q3 2019	Q3 2019	Draft budget proposals, budget circular instructions, SHDP II (and AOP, when available) funding priorities, technical support, meeting venue, feeding, printing and stationery	Budget proposals validated for alignment with SHDP II (and AOP, when available)
5	Incorporate feedback into budget proposal and submit to FCT economic team	Budget holders	Q3 2019	Q3 2019	Feedback on budget proposal	Budget proposals finalised
6	Assess shortfalls in approved budget relative to proposed budget and refine approach, as needed	HF Unit	Q1 2020	Q1 2020	Approved budget, budget proposals	Lessons learned (which feed into the next budget cycle) identified and documented

*Repeat steps 1-6 annually during 2020–2022.

Advocate for health budget allocation and releases.

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Review the political economy landscape of the FCT and identify key policymakers/influencers	HF Unit	Q1 2019	Q1 2019	Existing PEL document; technical support	Key policymakers and influencers mapped
2	Conduct a stakeholder analysis to determine the power and interest of the members of the identified policymakers/influencers	HF Unit	Q1 2019	Q1 2019	Technical support	Policymakers' and influencers' interests and power understood
3	Quantify expected results of proposed increase in public health expenditure and highlight how investment in health supports economic development	HF Unit	Q1 2019	Q1 2019	Technical support, communication, and transportation costs	Investment cases/results of increased public sector spending developed
4	Identify and nominate FCT advocacy team members from the HFETWG and other relevant organisations or groups (e.g., CSOs, legislative network on Universal Health Coverage)	HFETWG	Q2 2019	Q2 2019	Technical support, communication, and transportation costs	List of advocacy team members
5	Notify members of their nomination into the FCT advocacy team and confirm interest in participation	HFETWG	Q2 2019	Q2 2019	List of advocacy team candidates; revised PEL document	Advocacy team members confirmed
6	Hold inaugural advocacy team meeting to develop annual advocacy plan	Advocacy team	Q2 2019	Q2 2019	Advocacy team terms of reference, technical materials and logistics, meeting costs	Advocacy plan developed
7	Utilising results from Step 3, articulate and summarise key messages and evidence into effective and evidence-based advocacy materials tailored to each target audience. Print advocacy materials as required.	Advocacy team	Q3 2019	Q3 2019	Advocacy plan, technical support, printing costs	Advocacy materials developed
8	Seek appointments/opportunities to speak with the members of the FCT economic team on a one-on-one basis	Advocacy team	Q3 2019	Q3 2019	Advocacy plan, advocacy materials, communication costs	Appointments/meetings confirmed

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
9	Hold meetings with the members of the economic team to advocate for prioritization of health in the FCT's 2020 budget	Advocacy team	Q3 2019	Q3 2019	Advocacy plan, advocacy materials, transportation costs	Advocacy activities executed and target budget approved
10	Seek appointments/opportunities to speak with the legislators individually and the house committees collectively	Advocacy team	Q4 2019	Q4 2019	Advocacy plan, advocacy materials, communication costs	Appointments/meetings confirmed
11	Hold meetings with relevant legislators and house committees to advocate for approval of draft appropriation for health for 2020	Advocacy team	Q4 2019	Q4 2019	Advocacy plan, advocacy materials, transportation costs	Advocacy activities executed and target budget approved
12	Informed by budget, release, and expenditures tracking report developed in Domain 1 Strategy 1 above, hold meetings with FCT Treasury and individuals who can influence greater releases to advocate for a higher proportion of allocations released when releases are tardy or incomplete	Advocacy team	Q3 2019	Continuous	Advocacy plan; advocacy inputs including budget, release, and expenditures tracking report developed in Domain 1 Strategy 1 above; transportation costs	Advocacy activities executed and target releases issued

*Repeat steps 1–12 annually, as required.

Domain 2: Health Insurance and Earmarks

Ensure the passage of the FCT Health Insurance Scheme (HIS) and FCT Primary Health Care Board (PHCB) bills by May 2019.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Map out additional stakeholders within the NASS that are required to drive the passage of the bills	Program Manager FCT Health Insurance Scheme (FHIS), Executive Secretary (ES) Primary Health Care Board (PHCB), Health Planning, Research and Statistics Department (HPRS), HF Unit	Completed*	Completed*	N/A	List of relevant stakeholders identified
2	Hold meeting for Senate legislative aides to review the bills and prepare for second reading	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Bills ready for discussion on the Senate floor
3	Hold meeting with the Rules and Business Committee to facilitate bill review process before the second reading	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Bills ready for discussion on the Senate floor
4	Explore opportunities and relationships to continuously engage with the FCT representatives, chairmen of the committees of health, and other legislators identified in Step 1 to facilitate scheduling of a date for the second reading of the bills	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Appointments scheduled Bills go through second reading at the National Assembly
5	Hold sensitization meetings with area council chairmen, CSOs, traditional rulers, etc. to prepare for public hearing	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Community members understand and support key thrusts of bills
6	Follow up with Senate committees on health and primary health care to schedule public hearing	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Public hearing scheduled

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
7	Sensitise bill proponents (e.g., FCT executives, NHIS, World Bank, U.S. Agency for International Development (USAID), CSOs, interest groups) to attend public hearing and support passage of bills	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Attendance of stakeholders and advocates confirmed
8	Attend public hearing for bills	PM FHIS, ES PHCB, HPRS, HF Unit	Completed*	Completed*	N/A	Public hearing of bills conducted with minimal comments/suggested revisions
9	Hold retreat for the Senate committees on health and primary health care to review all submissions and comments at the public hearing	PM FHIS, ES PHCB, HPRS, HF Unit	Q1 2019	Q1 2019	Transportation costs, communication costs	Bills revised in line with issues raised at the public hearing, bills passed through third reading
10	Hold advocacy meetings with focal person in lower House for presentation of bill for concurrence	PM FHIS, ES PHCB, HPRS, HF Unit	Q1 2019	Q1 2019	Transportation costs, communication costs	Concurrence of bills at lower house obtained
11	Follow up with the honourable secretary for health and the permanent secretary, FCT to sensitise the FCT Minister for bill concurrence by the president	PM FHIS, ES PHCB, HPRS, HF Unit	Q2 2019	Q2 2019	Advocacy support	Bills assented to by the president

*These activities had already been completed as of the time when this implementation plan was being finalised.

Facilitate the implementation of the additional earmarks for health (2 percent of FCT CRF) as contained in the two bills by the 2020 budget cycle.

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Develop a business case highlighting the interventions/investments that will be made with 2 percent CRF earmarks contained in the bills and the expected results over the medium term	PM FHIS, ES PHCB, HPRS, HF Unit	Q2 2019	Q2 2019	Technical support	Business case developed
2	Develop facts sheet and advocacy briefs which summarise the key points of the business case	PM FHIS, ES PHCB, HPRS, HF Unit	Q3 2019	Q3 2019	Technical support, printing and design costs	Fact sheets/advocacy briefs developed and printed
3	Leverage the HFE&ITWG and the advocacy team previously formed to advocate to members of the FCT economic team and the National Assembly committees and members to enable the appropriation of the earmarked funds in the 2020 budget	Advocacy team	Q3 2019	Q3 2019	Fact sheet and advocacy briefs, communication costs, transportation costs	Advocacy visits conducted
4	Leverage the advocacy team formed previously to advocate to the Department of Treasury and other identified influencers for release of the funds after appropriation in the budget	Advocacy team	Q1 2020	Q1 2020	Fact sheets/ advocacy briefs	Advocacy visits conducted
5	Track and report to the FCT Administration the proportion of the CRF earmarks released each year, allocation of released funds, and results of funding	PM FHIS, ES PHCB, HF Unit	Q1 2021	Q1 2021	Technical support	Appropriation, release, and expenditure of 2 percent CRF tracked and reported

*Repeat steps 1–5 every year to secure appropriation and release of 2 percent CRF.

Ensure full compliance with the NHIS and NPHCDA gateway requirements of the BHCPF by the end of 2019.

A. Support the set-up of a state steering committee (SSC) for the BHCPF and the opening of a treasury single account (TSA) for the BHCPF.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Develop concept note for setup of SSC with extracted terms of reference (TOR) (from the manual developed by the FMOH) and other useful preliminary information for setup of SSC	HF Unit	Q1 2019	Q1 2019	BHCPF Implementation Guide, technical support	Concept note for setup of SSC developed
2	Meet with the honourable secretary for health to discuss the roles, composition, and setup strategy of the BHCPF SSC	DPRS, HF Unit	Q1 2019	Q1 2019	Concept note for setup of SSC	Secretary of Health prioritises the setup of the BHCPF nomination list for the SSC
3	Ongoing engagement with the health secretary to contact the proposed members with the TOR and propose date of inauguration	DPRS, HF Unit	Q1 2019	Q1 2019	Nomination list for SSC	Nominated members of the SSC notified SSC inauguration date set
4	Hold inauguration and orientation meeting of SSC for BHCPF and share BHCPF Manual	Honourable secretary for health	Q1 2019	Q1 2019	Meeting costs, printing costs	SSC inaugurated and oriented
5	Hold follow-on meetings to sign off on service-level agreements with the FMOH on the BHCPF, mandate implementing agencies to develop operational plans, and develop rollout plan for BHCPF	BHCPF focal person, state steering committee	Q2 2019	Q2 2019	Meeting costs, printing costs	SCC operational and implementing its roles
6	Meet with the FMOH to clarify BHCPF requirements and relevant documents required to open a TSA with the Central Bank of Nigeria	PM FHIS, ES PHCB	Q2 2019	Q2 2019	Transportation costs, communication costs	Relevant documents for opening a TSA available
7	Facilitate the development or collation of relevant documents	PM FHIS, ES PHCB	Q2 2019	Q2 2019	Transportation costs, communication costs	Relevant documents for opening a TSA available
8	Conduct advocacy visits to the FCT Minister, Director of Treasury, and other relevant decision makers to fast-track opening of TSA	PM FHIS, ES PHCB	Q2 2019	Q2 2019	Technical support	Minister buy-in, TSA opened

B. Set up and/or operationalise ward development committees (WDCs).

#	Action	Person/Team responsible	Date to Begin	Date to End	Resources Required	Expected Outputs
1	Develop tool for assessing the functionality of ward development committees in all the FCT wards	ES, PHCB	Q2 2019	Q2 2019	BHCPF Implementation Manual, technical support	WDC assessment tool developed
2	Conduct assessment of WDCs through the ACHAs to determine their existence and/or functionality	ES, PHCB ACHAs	Q2 2019	Q2 2019	WDC assessment tool, transportation costs, printing costs	WDCs assessed and their status determined
3	Supervise the ACHAs in working with communities to nominate members of WDCs in wards where they are non-existent	ES, PHCB	Q2 2019	Q3 2019	WDC assessment results, transportation costs	Non-functional WDCs activated
4	Supervise the ACHAs in the capacity development of the WDCs to carry out their stewardship and oversight roles of the PHCs	FCT SPHCB	Q2 2019	Q3 2019	Technical support, training costs, printing costs, transportation costs	Capacity of WDCs built

C. Conduct facility assessments of ward Primary Health Care facilities (PHCs).

#	Action Step	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Obtain assessment tool from the BHCPF Secretariat	ES, PHCB	Q2 2019	Q2 2019	N/A	BHCPF assessment tool obtained
2	Select ward PHCs that will participate in the BHCPF	ES, PHCB	Q2 2019	Q2 2019	N/A	Focus PHCs for BHCPF implementation selected
3	Conduct assessments in selected ward PHCs	ES, PHCB	Q2 2019	Q2 2019	Assessment tool, technical support, assessment teams, transportation costs, communication costs, refreshment costs	Assessment conducted
4	Analyse data obtained from assessment and determine quality scores for each PHC	ES, PHCB	Q2 2019	Q2 2019	Assessment results, technical support	Primary health care (PHC) quality scores computed
5	Support the ACHAs to supervise the WDCs and PHCs with the definition of quality improvement plan and scorecards	ES, PHCB	Q3 2019	Q3 2019	PHC quality scorecards, technical support	Quality improvement plans and scorecards developed

Domain 3: Efficiency

Implement rotational posting of health care workers (HCWs) to rural, under-resourced facilities.

A. Rotational Posting of Health Management Board HCWs.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Map HRH density with service utilization and prioritise secondary health facilities that will be the recipients of different cadres of HCWs	HF Unit, HRH Desk, HMB	Q1 2019	Q1 2019	Technical support	List of prioritised facilities that will benefit from rotational posting finalised
2	Conduct advocacy visits to the executive management team of the HMB to discuss the need for HCWs and obtain their commitment to implement rotational posting of HCWs to facilities in rural areas	HF Unit, HRH Desk	Q1 2019	Q1 2019	Technical support	Commitment from HMB Management obtained
3	Conduct a briefing to the honourable secretary for health on the importance of implementing rotational posting to rural areas for doctors and other HCWs	HF Unit, HRH Desk, HMB	Q1 2019	Q1 2019	N/A	Secretary of health briefed on proposed rotation of HCWs in the FCT
4	Generate a memo requesting the honourable secretary for health to approve rotational posting to rural areas for doctors and other HCWs	HF Unit, HRH Desk, HMB	Q1 2019	Q1 2019	N/A	Memo on rotational posting developed
5	Follow up on the approval and dissemination of memo	HF Unit, HRH Desk, HMB	Q1 2019	Q1 2019	N/A	Rotational posting of HCWs formalised and approved
6	Develop roster of HCWs and doctors in higher-density areas to be posted to lower-density areas for the year	HMB	Q2 2019	Q2 2019	N/A	Rotational posting roster developed
7	Follow up and monitor the implementation of memo and rotational posting of doctors and other HCWs to rural or low-density areas.	HF Unit, HRH Desk	Continuous	Continuous	Technical support, transportation costs, meeting costs	Recommendations for improving efficiency and effectiveness of rotational policy preferred

B. Leverage the NYSC and N-Power programmes to resource PHCs in rural areas.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Map HRH density with service utilisation and identify PHCS that will be prioritised for leveraging on the federal programmes	HF Unit, HRH Desk, PHCB	Q1 2019	Q1 2019	Technical support, transportation costs, communication costs, meeting costs	List of prioritised facilities that will benefit from rotational posting finalised
2	Advocate to HMB and PHCB chief executives and obtain their commitment to implement preferential posting of NYSC HCWs to rural areas	HF Unit, HRH Desk	Q1 2019	Q1 2019	Technical support, transportation costs	Commitment from HMB and PHCB management obtained
3	Advocate to the NYSC headquarters on FCT's HRH needs and formally request prioritization of FCT (in terms of number and mix) in posting of doctors and other HCWs	HF Unit, HRH Desk, PHCB, HMB	Q2 2019	Q2 2019	Technical support, transportation costs	NYSC secretariat informed of FCT's HRH need
4	Advocate to the NPHCDA NPOWER desk on FCT's HRH needs and formally request prioritisation of FCT (numbers and mix) in posting of doctors and other HCWs	HF Unit, HRH Desk, PHCB, HMB	Q2 2019	Q2 2019	Technical support, transportation costs	NPOWER informed of FCT's HRH needs
5	Monitor the posting of HCWs to the FCT (through the NYSC and N-Power programmes) and preferential posting of doctors and other HCWs by the FCT PHCB and HMB to rural or low-density areas	HF Unit, HRH Desk	Continuous	Continuous	Technical support, transportation costs, meeting costs	Recommendations for improving efficiency and effectiveness of rotational policy preferred
6	Conduct further advocacy visits, as required, to progressively increase the number of HCWs posted to the FCT and the proportion of these posted to rural/low-density areas	HF Unit, HRH Desk, PHCB, HMB	Continuous	Continuous	Technical support, transportation costs	Recommendations for improving efficiency and effectiveness of rotational policy preferred

C. Implement the National Council on Health Resolution on rotational posting of resident doctors to rural areas.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Identify secondary and tertiary hospitals with residency programmes in the FCT	HF Unit, HRH Desk	Q1 2019	Q1 2019	N/A	Potential source of resident doctors for rotational posting to rural areas identified
2	Assess the hospitals' current compliance with the National Council on Health (NCH) resolution	HF Unit, HRH Desk	Q1 2019	Q1 2019	Meeting costs	List of hospitals that are non-compliant with the policy on rural posting identified
3	Brief the honourable secretary of health on the level of compliance with the NCH resolution in the FCT	HF Unit, HRH Desk	Q1 2019	Q1 2019	N/A	Policy on rotational posting of resident doctors to rural areas reinforced
4	Draft a memo to non-complying hospitals (signed by the honourable secretary for health) compelling compliance with the NCH resolution	HF Unit, HRH Desk	Q2 2019	Q2 2019	N/A	Policy on rotational posting of resident doctors to rural areas reinforced
5	Deliver memo to relevant hospitals	HF Unit, HRH Desk	Q2 2019	Q2 2019	Transportation costs	Policy on rotational posting of resident doctors to rural areas reinforced
6	Pay follow-on visits to the executive management of the hospitals to discuss FCT's needs	HF Unit, HRH Desk	Q2 2019	Q2 2019	Technical support, transportation costs	Hospitals' management sensitised on FCT HRH needs and the impact of compliance with the rural posting policy
7	Monitor posting of resident doctors to rural hospitals	HF Unit, HRH Desk	Q3 2019	Q3 2019	Technical support, transportation costs, meeting costs	Compliance with rural posting policy continuously assessed
8	Conduct further advocacy visits, as required	HF Unit, HRH Desk	Continuous	Continuous	Technical support, transportation costs	Hospitals' management sensitised on FCT HRH needs and the impact of compliance with the rural posting policy

Provide conducive accommodation for HCWs posted to rural hospitals and PHCs.

#	Action*	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Conduct an assessment and mapping of Primary Health Centres and Secondary Health Facilities with available, conducive accommodation	HF Unit	Q1 2019	Q1 2019	Transportation costs	Rural PHCs and secondary health facilities with poor or no accommodation identified
2	Develop cost estimates for building or reconstructing accommodation at prioritised facilities	HF Unit	Q2 2019	Q2 2019	Technical support	Cost estimates developed
3	Develop proposal/investment menu highlighting accommodation needs and costs	HF Unit	Q2 2019	Q2 2019	Technical support	Proposal/investment menu developed
4	Advocate to the chief executives and management of HMB and PHCB to prioritise and include in budgets/plans provision of conducive accommodation in rural hospitals and PHCs	HFETWG, Advocacy Team	Q2 2019	Q2 2019	Proposal/investment menu	Funding needs and gaps presented
5	Advocate to the 6 Area Council chairmen to make available conducive accommodation within short distance to rural PHCs.	HFETWG, Advocacy Team, PHCB	Q2 2019	Q2 2019	Proposal/investment menu	Funding needs and gaps presented
6	Advocate to the House of Representative members for FCT and Committee Chairmen on FCT in Senate and House of Representatives to consider the provision of conducive accommodation for rural hospitals and PHCs as priority and constituency projects	HFETWG, Advocacy Team, HMB, PHCB	Q2 2019	Q2 2019	Proposal/investment menu	Funding needs and gaps presented
7	Map and conduct visits to private foundations and individuals of high net worth with interest in health systems strengthening to support provision of conducive accommodation for rural hospital and PHCs**	HFETWG core team on private sector investment	Q2 2019	Q2 2019	Proposal/investment menu	Funding needs and gaps presented

*Steps 4–7 will be repeated as often as required until objectives are met.
**This action step links with Strategy 3 of Domain 3 (ODA and private sector domain).

Streamline procurement and/or maintenance of health commodities and equipment.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Prequalify local health pharmaceutical manufacturers	Bulk procurement committee	Done	Done	N/A	Local manufacturers pre-qualified
2	Follow up with approving bodies until initial contracts are approved	Bulk procurement committee, HMB	Q1 2019	Q1 2019	N/A	Contracts approved
3	Ensure compliance with contract terms	HMB	Q2 2019	Q2 2020	N/A	Contract terms executed
4	Calculate savings from bulk procurement of selected pharmaceuticals	HF Unit, HMB	Q2 2020	Q2 2020	Technical support	Savings from bulk procurement calculated
5	Document results from the analysis in Step 4 and use to develop a concept note for a policy on bulk procurement/framework agreements for pharmaceuticals	HF Unit, HMB	Q2 2020	Q2 2020	Technical support	Draft concept note developed
6	Hold a stakeholder meeting to discuss key considerations and promote common understanding of the policy concept	HF Unit, HMB	Q3 2020	Q3 2020	Meeting costs, draft concept note	Concept note vetted and finalised
7	Send formal letter to the FCT Administration and mdinister on need to institutionalise bulk procurement/framework agreements for all pharmaceuticals	HF Unit, DPRS, HHSS	Q3 2020	Q3 2020	Final concept note, advocacy support	Drafting of bulk procurement policy approved
8	Minister endorses and approves request	Minister, FCT	Q3 2020	Q3 2020	Final concept note, advocacy support	Drafting of bulk procurement policy approved
9	Set up policy working group made up of representatives from the FCT and development partners in health	HMB	Q4 2020	Q4 2020	Final concept note, nomination lists, communication costs	Policy working group set up

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
10	Policy working group develop policy sketches	Policy working group	Q4 2020	Q4 2020	Final concept note, workshop costs, and logistics	Policy sketches developed
11	Review and consolidate draft policy	Policy working group	Q1 2021	Q1 2021	Policy sketches, meeting costs, technical support	Draft policy developed
12	Present draft policy to stakeholders	Policy working group	Q1 2021	Q1 2021	Draft policy, meeting costs, technical support	Feedback on draft policy developed
13	Update policy with modifications	Policy working group	Q1 2021	Q1 2021	Feedback on draft policy, meeting costs, technical support	Draft policy finalised
14	Circulate final draft policy to all stakeholders for concurrence	HMB	Q1 2021	Q1 2021	Updated policy, communication costs	Draft policy finalised
15	Send policy to FCT Minister for final endorsement	HMB	Q1 2021	Q1 2021	Final policy	Policy approved by the Minister
16	Disseminate policy	HMB	Q1 2021	Q1 2021	Printing costs, meeting costs	Policy disseminated

Domain 4: ODA and Private Sector Funding

Implement the International Public Sector Accounting Standards (IPSAS) in the HHSS by 2020.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Define hardware requirements for IPSAS integration in HHSS as well as software adaptation	HHSS ICT Division	Q2 2019	Q2 2019	—	—
2	Obtain required hardware for IPSAS integration	HHSS ICT Division	Q2 2019	Q2 2019	—	—
3	Liaise with the FCT Department of Treasury (DoT) in the DoT's efforts to fast-track implementation of the IPSAS platform in the HHSS, as will be happening in other FCT secretariats, departments and agencies	HHSS ICT Division, DoT	Q2 2019	Q2 2019	—	—
4	Hold training for staff of the HHSS Finance Division on IPSAS and the software	HHSS Finance Division	Q2 2019	Q2 2019	Technical materials, logistics, and meeting costs	HHSS Finance Division staff trained
5	Set up Chart of Accounts and transfer account opening balances to software	HHSS Finance Division	Q3 2019	Q3 2019	Historical accounting ledgers or books	Chart of accounts developed
6	Test-run software package on HHSS hardware	HHSS Finance Division	Q3 2019	Q3 2019	Financial transactions	Technical issues associated with software package identified
7	Troubleshoot technical issues with software package	HHSS Finance Division	Q3 2019	Q4 2019	List of technical issues	Technical issues resolved
8	Prepare IPSAS-compliant financial statements	HHSS Finance Division	Q4 2019	Q4 2019	Financial transactions	Draft financial statements
9	Certify IPSAS-compliant financial statements	External Auditor	Q1 2020	Q1 2020	Technical support - IPSAS expert	Certified financial statements
10	Publish or conduct targeted dissemination of IPSAS-compliant financial statements	DPRS, HHSS	Q2 2020	Q2 2020	Certified financial statements	Financial statements disseminated

Establish a planning and funding coordination platform for SHDP II implementation.

#	Action	Person/Team Responsible	Start Date	End Date	Resources Required	Expected Outputs
1	Identify prospective coordination platform members	HF Unit	Q3 2019	Q3 2019	—	Mapped prospective members
2	Draft coordination platform concept notes	HF Unit	Q3 2019	Q3 2019	Mapped prospective members; technical support	Draft coordination platform concept note
3	Vet draft coordination platform concept note with HHSS, other FCT health sector actors	HF Unit	Q3 2019	Q3 2019	Draft coordination platform concept note	Feedback on draft concept note
4	Incorporate feedback into concept note	HF Unit	Q3 2019	Q3 2019	Feedback on draft concept note	Finalised concept note
5	Draft coordination platform TOR	HF Unit	Q3 2019	Q3 2019	Finalised concept note Technical support	Draft coordination platform TOR
6	Hold meetings with prospective members to inform of their nomination and obtain their commitment	HF Unit HFETWG	Q4 2019	Q4 2019	Finalised concept note, communication costs, transportation costs	Finalised list of coordination platform members
7	Hold inaugural coordination platform meeting and vet draft coordination platform TOR with members	Coordination platform	Q4 2019	Q4 2019	Technical materials, logistics, meeting costs	Inaugural meeting proceedings Finalised TOR
8	Hold successive coordination platform meetings to identify SHDP II funding needs/gaps; align ODA support with identified SHDP II funding needs/gaps; monitor and evaluate effectiveness of donated funds	Coordination platform	Continuous from Q1 2020	Continuous from Q1 2020	Mapped required policies and procedures; technical support	Draft basket fund-related policies and regulations

Develop investment cases for health interventions.

#	Action*	Person/Team Responsible	Start/End Date	Resources Required	Expected Outputs
1	Set up HFETWG core team to drive increase in funding from private sector	HFETWG	—	—	HFETWG core team set up
2	Identify and map private sector foundations and organisations with corporate social responsibility interests in health	HFETWG core team	Continuous, in sequence	Technical support	Prospective private sector foundations/organisations identified
3	Narrow down list of donor agencies and private sector organizations and foundations to ones with complementary /matching objectives or interest	HFETWG core team	Continuous, in sequence	Technical support	Target private sector foundations/organisations and their interests identified
4	Identify and prioritise needs from the FCT SSHDP II that may be supported by the private sector organisations/foundations	HFETWG core team	Continuous, in sequence	Technical support	List and cost of SHDP II priorities identified
5	Determine cost of filling identified needs/gaps	HFETWG core team	Continuous, in sequence	Technical support	
6	Determine results/outcome of addressing identified needs	HFETWG core team	Continuous, in sequence	Technical support	Expected outcome from implementing SHDP II priorities quantified or articulated
7	Develop investment/proposal pack incorporating the cost benefit analysis done in Steps 6 and 7 for presentation to/engagement with potential donors or foundations	HFETWG core team	Continuous, in sequence	Technical support, printing costs	Investment pack developed
8	Arrange for meetings with donor agencies/foundations (leveraging contact persons) to discuss proposals and investment cases	HF Unit, HFETWG core team	Continuous, in sequence	Technical support, transportation costs	Funding needs and gaps presented; relationships established with target private sector foundations/ organisations

*Steps 4–8 may recur multiple times between 2019–2022 until the FCT SSHDP II is fully implemented.

Annex III. Performance Monitoring Plan

The performance monitoring plan outlined below provides a framework for measuring the progress of the RMP at various stages over the implementation period. The performance monitoring plan will also support the reporting of results of implemented activities/interventions (to the FCT HHSS leadership and HFE&ITWG) and will provide a means to continuously monitor/assess progress and generate lessons learned for improving implementation and design of strategies and approaches.

Domain 1: Government Budgets

Outcome: Mobilise N22.4, N27.4, and N33.6 in health allocations annually over 2020–2022 and maximise the proportion of health releases to health allocations.

Indicator	Data Source/Evidence	Frequency	Responsibility
% of FCT health allocations to total public allocations	Approved FCT HHSS budgets, Department of Treasury allocation reports, FCT HHSS finance reports	Annually	HF Unit, HHSS
Strategy 1: Institutionalise health budget and expenditure tracking and reporting			
Number of budget and expenditure tracking reports available	Budget and expenditure report available	Annually	HF Unit, HHSS
Strategy 2: Align HHSS budget proposals with the SHDP II, and when available, the AOP			
% of SHDP strategic objectives captured in approved HHSS budgets	SHDP II, approved FCT HHSS budget	Annually	HF Unit, HHSS
% of AOP activities captured in approved HHSS Budgets	AOP, approved FCT HHSS budget	Annually	HF Unit, HHSS
Strategy 3: Advocate for health budget allocation and releases			
Number of advocacy visits to the NASS	Meeting reports	Quarterly	HF Unit, HHSS
Number of advocacy visits to FCT economic team	Meeting reports	Quarterly	HF Unit, HHSS
% of FCT health budget to total public budget	Approved FCT budget	Annually	HF Unit, HHSS
% of FCT health budget released	Excel-based budget, release and expenditures tracking workbook from Domain 1 Strategy 1	Quarterly	HF Unit, HHSS
% of FCT total expenditure devoted to health	Accountant general's financial statement	Annually	HF Unit, HHSS

Domain 2: Earmarks and Health Insurance

Outcome: Access the BHCPF and FCT earmarks in the year 2020 budget cycle and expand premium-paying enrolees into the FCT HIS by 100%

Indicator	Data Source/Evidence	Frequency	Responsibility
Strategy 1: Facilitate the passage of the FHIS and PHCB bills			
Number of targeted advocacy visits to NASS	Meeting reports	Monthly	HF Unit, HHSS
Number of meetings/planning sessions held with the NASS committees on health	Meeting reports	Monthly	HF Unit, HHSS
Strategy 2: The FCT HIS and PHCB earmarked funds			
FCT earmarks allocated as a % of CRF	Approved HHSS budget, Federal Allocation Account allocation reports, Department of Treasury revenue reports, Department of Treasury allocation report	Quarterly	HF Unit, HHSS
FCT earmarks released as a % of CRF	FCT HHSS finance report	Quarterly	HF Unit, HHSS
Strategy 3: Ensure compliance with BHCPF gateway requirements and ensure BHCPF fund flow			
% compliance with BHCPF requirements	BHCPF roadmap, membership lists for SSCs and WDCs, meeting reports, PHC quality scorecards	Quarterly	FHIS, SPHCB
Proportion of FCT's BHCPF allocation received by FHIS and FCT PHCB	FHIS and FCT PHCB finance reports	Quarterly	FHIS, SPHCB
Strategy 4: Increase the number of premium-paying enrolees in the FCT health insurance scheme			
% increase in premium paying enrolees	FHIS database	Annually	FHIS

Domain 3: Efficiency

Outcome: Reduce the costs associated with the recruitment and wage bill of HCWs and procurement of commodities by 2.5 percent and 5 percent, respectively, year on year from 2019

Indicator	Data Source/Evidence	Frequency	Responsibility
Strategy 1: Implement rotational posting of health management board HCWs			
% of HCWs (disaggregated by cadre) employed by the HMB that undergo rotational posting to rural areas	HCW nominal roll, rosters, hospital sign-in sheets	Biannually	HMB
% of resident doctors in the FCT (tertiary and secondary facilities) that undergo rotational posting to rural areas	Resident doctors nominal roll, rosters, hospital sign-in sheets	Biannually	HF Unit
% of NYSC HCWs posted to the FCT that are posted to health facilities in rural areas	NYSC posting lists at the PHCB and HMB	Biannually	HF Unit
% of NPOWER HCWs posted to the FCT that are posted to health facilities in rural areas	NPOWER posting lists at the PHCB	Biannually	HF Unit
% savings in the HCW wage bill	HCW FTE provided in rural areas by cadre, HCW payroll by cadre	Annually	HRH Desk
Strategy 2: Provide conducive accommodations for HCWs			
% of health care facilities with no or poor accommodation (disaggregated secondary and 24-hour primary health care centres) that have been provided with conducive accommodation (as defined by an agreed checklist)	Assessment reports	Annually from 2020	HMB PHCB
Strategy 3: Streamline procurement and/or maintenance of health commodities and equipment			
% of commodities in the essential drugs list procured through bulk procurement contracts	Procurement contracts, essential drugs list	Annually	HMB
Proportion of equipment purchased with maintenance and service contracts	Procurement contracts for hospital equipment purchased within the period	Annually	HMB
% reduction in the procurement costs of health care commodities	HMB financial reports	Annually from 2020	HMB
% reduction in the maintenance and service of health care equipment	HMB financial reports	Annually from 2020	HMB

Domain 4: ODA and Private Sector Contributions

Outcome: Reduce the costs associated with the recruitment and wage bill of HCWs and procurement of commodities by 2.5 percent and 5 percent, respectively, year on year from 2019

Indicator	Data Source/Evidence	Frequency	Responsibility
Strategy 1: Implement IPSAS in the HHSS			
Availability of IPSAS complaint financial reports	IPSAS compliant financial reports available	Annually from 2021	Finance Department, HHSS
Strategy 2: Establish a funding and coordination platform			
Number of donors signed up for the donor coordination platform	Funding and coordination platform membership list	Annually	HF Unit
Number of meetings held	Meeting reports	Quarterly	HF Unit
% participation in meetings	Meeting report	Quarterly	HF Unit
Amounts received or gained as a result of the HHSS' direct efforts in mobilizing resources from the platform	Funding agreements, memoranda of understanding, evidence of receipt of assets	Annually	HF Unit
Strategy 3: Develop investment cases for health interventions			
Number of investment cases/proposals developed	Investment cases/proposals available	Quarterly	HF Unit
Number of private sectors entities engaged with investment case/proposals	Meeting reports	Quarterly	HF Unit
Amounts received or gained as a result of the HHSS' direct efforts in mobilizing resources from the private sector	Funding agreements, memoranda of understanding, evidence of receipt of assets, etc.	Annually	HF Unit