MEMORANDUM OF UNDERSTANDING

ON THE COLLABORATION FOR

STRENGTHENING THE PRIMARY HEALTH CARE SYSTEM

OF STATE X

BETWEEN:

X STATE GOVERNMENT

ALIKO DANGOTE FOUNDATION

BILL & MELINDA GATES FOUNDATION

PARTNER 4

PARTNER 5

PARTNER 6

On the..... day of .....

PREAMBLE

In January of 2016, the State X Government (herein referred to as "State X" or "State"), the Aliko Dangote Foundation (herein referred to as "ADF") and the Bill & Melinda Gates Foundation (herein referred to as "BMGF" or "Gates Foundation") entered into a three-year Memorandum of Understanding for the purpose of improving Routine Immunization (RI) in State X ("the RI MOU").

Subsequently, in September of 2016, State X, BMGF, and Partner 4 (herein referred to as "Partner 4"), entered into a four-year Memorandum of Understanding for the purpose of improving Primary Health Care (PHC) systems in State X ("the PHC MOU").

In March of 2018, a Letter of Intent (LOI) was signed between the signatories of the RI MOU and PHC MOU, along with Partner 5 (herein referred to as "Partner 5") to develop a new integrated MOU for strengthening Primary Healthcare in entirety (the "MOU"). The integrated MOU, while maintaining elements of the existing MOU agreements, will reflect a new common vision for coordination, alignment, and high-level oversight of MOU objectives, inclusive of activities, timelines and partner contributions, in support of a long-term goal to improve and save the lives of women, children, and the most marginalized communities in State X. In addition, Partner 6 (herein referred to as "Partner 6") has partnered with State X since early 2017 for an initial time-limited period focused on measurable activities supporting resilient and sustainable health systems. Partner 6 is interested in aligning its support in State X with that of the signatories of this MOU.

Partner coordination and alignment is a priority of State X following the State-led "2017-2020 State X International Development Cooperation Framework" that sets out principles by which the State will coordinate with its partners in the development and delivery of its State Development plan.

Through the signing of this MOU (operational from January 1, Year 1 to December 31, Year 5), the following Participants are committed to working together to improve governance, financing, data and performance management, supply chain management, quality service delivery, human resources, and community participation to improve and achieve optimal PHC services in State X in line with the State's overall Strategic Health Development Plan. Upon signing, this MOU supersedes and replaces the other existing RI and PHC MOUs in their entirety.

1. The State X Government, representing the people of State X in North West Nigeria, whose business address is State X Way, State X, Nigeria.
2. The Aliko Dangote Foundation, a charitable foundation incorporated as RC 7830 under Part C, Incorporated Trustees, Companies and Allied Matters Act, Chapter 20, Laws of the Federation of Nigeria, 2004, whose business address is the Union Marble House, 1 Alfred Rewane Road, Ikoyi Lagos, Nigeria.
3. The Bill & Melinda Gates Foundation, an independent, privately endowed charity whose business address is P.O. Box 23350, Seattle WA 98102, USA.
4. Partner 4, an international development agency whose country office address is at XXX, XXX, XXX, Central Business District, Abuja.

5. Partner 5, an international agency that provides humanitarian and developmental assistance in developing countries, whose country office address is XXX, XXX, Central Business District, Abuja, Nigeria.
6. Partner 6, an innovative financing institution for the purpose of attracting and managing financial resources to support national and regional programs, whose address is at XXXX, XXX, XXX, XXX, XXX.

State X, ADF, BMGF, Partner 4, Partner 5 and Partner 6 (other than for purposes of Article VI of Section 2 of this MOU and its related Appendices, which are not applicable to Partner 6) are herein referred to individually as "Participant", as "Participants" when they are referred to collectively.

SECTION I: BACKGROUND

I. State X is the third most populous State in Nigeria, with a projected population of 8,787,744 in 2018 using 3.07 growth rate as projected from the 2006 Population Census. 22% (2,109,058) of the population are women of reproductive age (15-49 years), whereas 20% (1,757,548.98) are children under five years (State X Strategic Health Development Plan; S-SHDP II 2018-2022).

II. A survey conducted in three communities in State X shows a maternal mortality rate (MMR) of 1,400/100,000 live births (S-SHDP II 2018-2022), which is significantly higher than the MMR of 1,025/100,000 live births in the North West zone, where State X is located and nearly triple the National rate at 576/100,000 live births (NDHS, 2013).

III. The 2016 National Immunization Coverage Survey & Multi-Indicator Cluster Survey showed:
   a. The neonatal mortality rate is 28/1000 live births, the infant mortality rate of State X is 66/1,000 live births, Child mortality rate is 18/1000 live births, while under-5 mortality rate is 82/1,000 live births (MICS 2016/2017).
   b. Coverage of routine childhood immunization, as measured by Pentavalent 3 coverage, is just 30%.

IV. Nutrition: The nutrition status of children under five and women of reproductive age remains generally poor requiring substantial efforts for improvement. 47% these children are stunted, and 12% are wasted with 15% prevalence of low birth weight. Only 29% of children born in State X are put to breast within the first one hour, only 20% are exclusively breastfed and 17% of those receiving complementary foods have the minimum acceptable diets. About 35% of women receive vitamin supplements post-partum and 21% consuming iron folic tablets for 90 days. (MICS 2016-17 & NDHS 2013).

V. FP/Child Spacing: State X has an mCPR goal of 46.5% by 2018, to meet their FP2020 goal. This goal will not be met as the recent PMA2020 survey (2018) reported an mCPR of 13.6%, a decrease from the 18.1% mCPR reported by PMA2020 in 2017. A 2013 survey (TNS Global, 2013) reported a large number of Community Pharmacists (CPs) and Patented Proprietary Medical Vendors (PPMVs), respectively 1,602 and 204 throughout the state, with 62% of PPMVs owners having a medical background. (PMA2020 and TNS 2013).

VI. Malaria: In State X, available data from 2015 MIS shows net ownership 91.6%, population at access of 53.0%, population net use if access of 66.6% and Malaria Prevalence of 36.7% (National Malaria Indicator Survey 2015). After Malaria, which accounts for up to 25% of deaths among under fives, diarrhea and pneumonia are the next major killers of under five children, contributing to 19% and 16% of under 5 deaths across Nigeria respectively.

VII. HIV/AIDS: In 2014, the Joint United Nations Program on HIV/AIDS (UNAIDS) estimated that the prevalence of HIV in State X was 7.7% as against the 2.2% of ANC sentinel survey of 2014. With reference to the State X AIDS indicator survey of 2017 the prevalence rate[1] among all ages is 0.6%, while Prevalence rate for adults 15 years and above is 1.1%. 34% of people living with HIV (PLHIV) ages 15 years and above report knowing their HIV status. Among PLHIV ages 15 years and above who knew their HIV status, 95% self-reported current use of antiretroviral therapy (ART), while viral suppression among HIV- positive adults ages 15 years and above in State X is 87%. State X PMTCT coverage is 61% by UNAIDS report in 2017 with outlets for PMTCT in 953 PHCs ANC sites, and we are therefore looking at elimination of mother to child transmission of HIV by 2020.

VIII. Many children in State X are not registered at birth and do not have birth certificates. According to the NDHS 2013, only 24% of children born in State X are registered at birth. At national, state and local levels, efforts to mobilize health workers to cover registration duties have limited traction especially in State X. In addition, few states are willing to provide health workers and infrastructure to facilitate birth registration. Birth registration of new born and under-five children remains persistently low in State X. To create the needed change, decentralized partnerships between National Population Commission and health care actors across the country including State X have been broadly defined and supported by the National Council on Health (NCH) since 2012. The NCH had approved that births/deaths registration activities should be conducted in partnership with all health intervention programs especially during routine immunization services - Supplemental Immunization Activities (SIAs), Immunization Plus Days (IPDs) and other similar programs. Integrating birth registration in the ongoing basic health care service programs is a cost-effective way to provide registration services without creating a parallel system. Improved integration of birth registration and health activities is set to be the important strategy that will be employed to increase the operational capacity of the birth registration system in State X.

IX. Poverty in State X remains significant at 84.9% (US$ 1.90 per person/day). High out-of-pocket expenses remains a major barrier to accessing health services for the poor, with 75% of health financing in the state supported by out-of-pocket expenditures by citizens (S-SHDP II, 2018-2022).

X. A 2016 State X PHC system diagnostic identified the following:
   a. 20% of nurses/midwives and 32% of CHEWs are absent at work (Service Delivery Indicator Survey 2013).
   b. Over 90% of State X PHC facilities receive no State or LGA funding for basic operational costs, leading facilities to rely on alternative sources of funding, including user fees (State X Health Facility Assessment 2015).
   c. The most significant barrier to accessing services cited by 31% of women in State X was “getting money for treatment” (DHS 2013).
   d. Only 6% of facilities have all 13 UN commission lifesaving commodities (State X Health Facility Assessment 2015).
   e. Just 23% of PHC patients in State X were satisfied with health services, such as hours of clinic operation and staff interactions (Service Delivery Indicator Survey 2013).

XI. The current State health budget is 16% of total government allocations. Budget release and execution against planned health interventions are poor: averaged 64% and 47% in 2016 and 2017 respectively.

[1] The country is also doing a national level HIV survey including state level burden estimations. In this regard the HIV data for State X may be further refined.

XII. State X has made significant policy reforms to improve health systems functioning:

a. As per the Primary Health Care Under One Roof policy (PHCUOR), the PHC budget, staff and program functions from the State Ministry of Local Government (SMOLG) and State Ministry of Health & Human Services (SMOH&HS) (including nutrition and family planning) have been transferred to the State Primary Health Care Development Agency (SPHCDA). The management of disease control programs (Malaria, TBL and HIV/AIDS) is yet to be transferred (S-SHDP II, 2018-2022) but the State has adopted the RACI matrix (responsible, accountable, consulted and informed) to outline roles and responsibilities for health sector agencies and authorities, development and technical partners, and other relevant stakeholders. The RACI has been adopted by the State and embedded into the State annual operational planning process.
b. State X developed and costed a Service Delivery Plan (SDP) that would ensure a viable PHC system and increase population access to the MSP, over a period of 3-4 years, to 80%. The SDP will require an investment which is 4 times the current state investment.
c. The State has consolidated the 31 Technical Working Groups (TWGs) into 13 cross-agency bodies aimed at coordinating Health sector planning and implementation.
d. The State established a Development Cooperation Framework (DCF) [State X B&P Commission, Oct 2016], which commits partners to agreed-upon operating principles.
e. The Supply Chain Transformation Project (SCTP) launched by the State X Health Supplies Management Agency in Jan 2017 has demonstrated a 70% increase in product availability and a 74% decrease in time to process supply chain orders in 28 pilot facilities (End of pilot report, March 2018).
f. The State X Bureau of Statistics is carrying out the first official health facility census in the State in 2018 and will track State performance against reaching the Sustainable Development Goals – the first State in Nigeria to take on this initiative.
g. The State X Contributory Health Management Authority was established in 2018 to launch and implement the State X Health Insurance Scheme toward removing financial barriers to accessing Healthcare for residents of State X.
h. Legislation to recognize and oversee the private sector role in health is being considered, and a regulatory agency to enforce standards and compliance in public and private sector is to be set up by law.

XIII. The State X Strategic Health Development Plan (S-SHDP II 2018-2022) has been adopted, with a vision "to be a leader in health in Nigeria, in the provision of equitable, affordable accessible and sustainable quality health care services to attain the highest health status for the people of State X."

SECTON II: AGREEMENT

The Participants have reached an agreement to cooperate as follows, acting at all times in accordance with applicable laws, regulations, each Participant's internal policies and regulations, and other standards:

Article I – Purpose and Principles

The purpose of this MOU is to support State X to achieve the strategic objectives of the S-SHDP II as well as national goals for Universal Health Coverage (UHC) and PHC, bringing together all Primary Health Care interventions under one comprehensive agreement, in order to:

- Strengthen and revitalize the Primary Health Care (PHC) system for improved quality, and affordable and sustainable delivery of health care services to all people in State X.
- Empower the State X Primary Health Care Development Agency (SPHCDA) to effectively manage the PHC system, in close coordination with relevant MDAs, such as the State Ministry of Health & Human Services (SMoH&HS), Planning & Budget Commission (P&BC), Ministry of Finance (MoF), MfLG, State Health Supplies Management Agency, State Bureau of Statistics, and State Contributory Health Management Authority, Schools of Health Technology, Schools of Nursing & Midwifery and State X National Population Commission.
- Align all PHC partners to support the State to optimize PHC services.
- Transition all responsibility for sustaining and building on the gains of the MOU to State X by 2022.

This MOU will be guided by the following principles:

- **State-led and government-owned**: State X leads the development and implementation of PHC sector activities in partnership with Development Partners and other health stakeholders, including citizens and their representatives.
- **Sustainable**: Sustainability should be a first consideration in piloting or implementing PHC interventions and service delivery models, including feasibility, affordability, and effectiveness of scale-up and future maintenance.
- **Transformative**: Bold transformation of the PHC system will require State X to pursue challenging but meaningful reform.
- **Adaptive**: PHC system strengthening is a complex and evolving effort requiring flexibility within the design and implementation of MOU activities.
- **Supportive of local capacity building**: The MOU supports the building of capacity of State X to manage, resource, and continue to improve the PHC system beyond the MOU period.
- **Leveraged**: The MOU ensures that federal, state and local government resources along with external resources are aligned and complementary.
- **Focused on the patient/client**: PHC delivery systems should be designed with women, children, and families (particularly the vulnerable and poor) in mind, to enable consistent access quality, affordable care, including the elimination of user fees.
- **Inclusive of multiple integrated interventions**: A high-performing PHC system should provide a minimum package of services to respond to multiple client needs including, but not limited to, routine immunization, nutrition, reproductive health, antenatal and postnatal care, safe deliveries, common childhood illnesses and high-burden communicable diseases.

- **Coordinated**: In addition to a primary focus at the PHC level, strong referral mechanisms to secondary and tertiary levels of the health system and linkages across other levels and sources of care, including a strong community component, are critical to improving health outcomes.
- **Agnostic of source of care**: Public, private and community-level providers all play important roles in the state's PHC system and should appropriately be engaged in the PHC delivery model.

Article II – Scope, Milestones and Targets

Based on the experience with the RI and PHC MOUs, this MOU for health seeks to support State X to strengthen the PHC system, which is defined as an essential range of promotive, preventative, curative and rehabilitative care for individuals and families in a community that begins with a person's first contact with the health system. PHC uses 3 modes for service delivery; Home, Outreach and Health Facility. PHC service delivery can occur in a public, private or faith-based setting. PHC is inclusive of critical systems elements needed to ensure quality service delivery, such as governance, financing, data and performance management, supply chain management, quality service delivery, human resources, and community participation. The UHC definition of PHC created at Alma Ata is very broad, including promotion of proper nutrition, safe water and basic sanitation, maternal and child healthcare, diagnosis and treatment of common illnesses, immunization, family planning, treatment of common injuries, and provision of essential drugs. PHC covers about 84% of population health needs, with the remainder requiring referral for advanced diagnostics and care (secondary or tertiary care) (source: Berman, P., 2000, "Organization of ambulatory health care provision in developing countries: A critical determinant of health system performance in developing countries", Bulletin of the World Health Organization, 78 (6), 791–802). Birth registration is also essential to enable proper planning for services as well as service delivery.

The MOU also aims to improve service delivery and reduce financial barriers to access for the most vulnerable populations, with the objective of increasing and sustaining effective and equitable coverage of essential health services, and accelerating reductions in maternal and child mortality.

The following sections describe the scope of the MOU according to strategic pillars, priority areas, targeted results, and milestones. The MOU strategic pillars, objectives, priority areas and targeted 4-year results (starting in Year 1) are aligned with the State X Strategic Health Development Plan (S-SHDP II). The MOU does not cover all aspects of the S-SHDP II (for example, non-communicable diseases, health promotion and social determinants of health, etc.); rather, it prioritizes key elements where Participants are able to jointly invest over a 4-year period. For each targeted result, the Participants jointly developed illustrative milestones to be achieved throughout the course of the MOU. Milestones specifying an end date of 201X have been drawn from the State's Annual Operational Plan. For those milestones without a date, they may be achieved through the 4-year timeframe. Milestones targeting PHC facilities refer to the State's prioritized 255 facilities per the 1 PHC/ward policy. A more specific M&E framework, including indicators and measurement of achievements against the milestones, shall be developed following the signing of this MOU.

Taken together, if achieved, this MOU scope will exponentially strengthen the Statewide Health System.

Strategic Pillar One: Enabling environment for attainment of sector outcomes

Priority Area 1: Leadership and Governance

Objective: To provide effective leadership and an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care; and to strengthen coordination and regulatory institutions and processes aimed at reducing barriers to access.

Targeted MOU Result 1: Relevant policies, plans, legislative and regulatory framework for the health sector established and functional

Milestones:

1. All coordination organs at State level are fully functional *[Refer to Appendix I for TWG organogram]*
2. The law for the regulation of private and public health establishment is passed by 2019
3. The Agency for regulation of private and public health establishments is established by 2020
4. A Public Private Partnership policy on strategic purchasing is established by 2019
5. Setup a monitoring committee for strategic purchasing with relevant stakeholders by 2019

Targeted MOU Result 2: Transparency and accountability in planning, budgeting and procurement process strengthened

Milestones:

1. State X's annual budget for health maintained at not less than 15% yearly
2. State X's health priorities and all funding flows included yearly in the Annual Operational Plan (AOP) and the health budget is derived therein
3. Budget and execution rate details for the health sector are published on an annual if not quarterly basis in alignment with the State's Open Government Partnership initiative

Priority Area 2: Community Participation and Ownership

Objective: To promote community engagement for sustainable health development.

Targeted MOU Result 1: To strengthen community level coordination mechanisms and capacities for health planning

Milestones:

1. 100% of Ward PHC centers are linked to Community Health Committees
2. 100% of Wards have functional Ward Development Committees *[Refer to Appendix II for TOR of the WDCs]*
3. 100% of LG Health Authorities have functional Advisory Committees
4. 100% of Wards have linkages between Community Engagement working groups and State Traditional Leaders Committee on Health *[Refer to Appendix III for TOR of State Traditional Leaders Committee on Health]*
5. 100% of children born in Ward PHC centers are registered at birth

Targeted MOU Result 2: To strengthen community engagement in the implementation, monitoring and evaluation of health programs

Milestones:

1. 100% of Ward PHC centers are implementing the outreaches and community services as per SDP
2. 100% of Ward Heads line-listing and reconciling eligible children at the PHC facilities *[Refer to Appendix IV for TOR for Ward Heads]*
3. 100% of LGAs and Wards have Community Engagement Focal Persons (CEFP) and Working Groups

Targeted MOU Result 3: Established process for tracking priorities, including processes for routine reporting at each level, as well as articulated mechanisms for addressing gaps in performance

Milestones:

1. Senior leadership establish routine and reliable methods to review improvement priorities, through use of data
2. 100% of managers receive annual transparent performance management reviews based on health system improvement priorities
3. Create standardized methods for solving complex problems (e.g. QI collaboratives, Kaizen events) and deploy at least 1 round for each priority area in 2019

Strategic Pillar Two: Increased utilization of essential package of health care services

Priority Area 1: Reproductive, Maternal, Newborn, Child, Adolescent Health

Objective: To improve overall health outcomes and nutritional status of women, neonates and children through increased ANC attendance[2], improved coverage of all antigens in the childhood immunization schedule, access to skilled birth delivery and availability of basic emergency obstetric care services; as well as reduce prevalence of stunting, wasting and under-weight in under-five children; to increase the use of child birth spacing services (CBS) services among adolescents and women of reproductive age.

Targeted MOU Result 1: To reduce maternal mortality and morbidity through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth

Milestones:

1. 100% of Skilled Birth Attendants trained on basic emergency obstetric care in Ward PHC Centers
2. 100% of Ward PHC Centers and SHFs have essential health supplies
3. 100% of identified Traditional Birth Attendants trained and supported as community mobilizers for facility-based ANC, Delivery, PNC and nutrition services
4. Recruitment of adequate number of skilled health workers and medical officers of health for the Ward PHC Centers and LGAs in compliance with SDP completed

[2] Based on the four-visit focused ANC (FANC) model being used in the State

5. 100% of nurses, midwives and SCHEWs receive audit of skills on a quarterly basis to assess basic emergency obstetric care. Data will be shared with the next level of supervision
6. To implement a statewide maternal and perinatal death surveillance and response system for all maternal and perinatal deaths

Targeted MOU Result 2: To reduce neonatal and under five mortality, and promote optimal growth, protection and development of all newborns and children under five years of age

Milestones:

1. 100% Nurses, Midwives and CHEWs trained on essential newborn care and ICCM
2. 100% of public and 70% of private health facilities providing Routine Immunization services
3. 100% of planned fixed and outreach sessions conducted
4. Develop & finalize plan for conduct of mobile sessions in hard/far to reach areas
5. Under-5 clinics set up in 100% of the Ward PHC Centers, integrated to include: Child Health Services (including treatment of pneumonia), Nutrition screening, ORS demonstration, etc.
6. 100% of nurses, midwives and CHEWs undergo skills audit on quarterly basis to assess skills in CBNC, IMCI and ICCM and birth registration processes. Data will be shared with the next level of supervision
7. State X scales up treatment of Possible Serious Bacterial Infection (PSBI) to all prioritized PHCs

Targeted MOU Result 3: To improve the nutritional status of State X residents with focus on vulnerable groups especially children under five years, adolescents, women of reproductive age and the elderly

Milestones:

1. 100% of nurses, midwives, CHEWs, LGA and facility level nutrition officers effectively trained on, coached and supportively supervised on CMAM and IYCF counselling and promotion of IYCF behaviors and practices, as well as birth registration services
2. Stabilization centers in Secondary Health Facilities in all LGAs are established, effectively supplied with commodities, and staff are trained
3. 100% of all community outreaches contain and are informed by messages on nutrition and IYCF best practices and screening for malnutrition
4. At least 50% of private sector health care providers supported to promote IYCF counselling, behaviors and practices
5. 100% of nutrition officers receive quarterly assessment of skills in CMAM and IYCF. Data will be shared with next level of supervision
6. Improve coverage of vitamin A supplementation for children under five and women of reproductive age (post-partum) by 50% from the current levels
7. Increase by 50% the proportion of women of reproductive age who consume iron folate tablets for at least 90 days

Targeted MOU Result 4: Promote demand and increase access to sexual and reproductive health services (child birth spacing and post-abortion care**)**

Milestones:

1. CBS services available in 100% of ward PHC Centers and 30 SHFs
2. All Wards have at least 2 trained and functional Community Based Distributors of CBS products
3. 25% of Ward PHC Centers offering post-delivery contraception
4. 321 PPMVs and 184 CPs enrolled in a tiered–accreditation system and supported to provide quality, CBS services
5. 100% of staff approved to offer CBS services assessed quarterly to ensure quality of counseling and delivery of services

Targeted MOU Result 5: To improve service efficiency through streamlining and integration of services at service, programmatic and organizational levels

Milestones:

1. 100% of supportive supervision visits are integrated to include service, HRH data and operational support and OJCB
2. 100% of outreach visits to the community integrated, containing a combination of RI and PHC services as well nutrition and birth registration messaging
3. All parallel supply chain systems (planning, procurement, warehousing, inventory management, distribution, data management) in the State are keyed into the State One Public Health Supply Chain System led by State X Health Supplies Management Agency

<u>Priority Area 2: HIV/AIDS, TB and Malaria</u>

Objective: To improve prevention, case detection and coordinated response for the prevention, control and management of HIV, AIDS, Tuberculosis & Malaria.

Targeted MOU Result 1: To provide equitable access to quality HIV and AIDS treatment, care, support and prevention services

Milestones:

1. 90% of people living with HIV know their status
2. 90% of all HIV positives are placed on treatment
3. 90% of people living with HIV on treatment achieve viral suppression

Targeted MOU Result 2: To ensure universal access to high quality, client-centered TB diagnosis and treatment services

Milestones:

1. Increase the number of primary health facilities providing TB services (at least TB screening and referral) and DOTS to 80% at PHC level
2. Utilization of GeneXpert optimized to at least 70% by 2020
3. 100% access to high-quality integrated services for all people co-infected with tuberculosis and HIV attained

4. 100% access to diagnosis and treatment of pauci-bacillary and multi-bacillary leprosy attained

Targeted MOU Result 3: Prevalence of malaria in children reduced by 80% by 2021

Milestones:

1. At least 80% of targeted populations utilize appropriate preventive measures by 2021
2. All persons with suspected malaria who seek care in public and private health facilities are tested with RDT or microscopy by 2021
3. At least 80% persons with confirmed malaria seen in public facilities receive prompt treatment with an effective anti-malarial drug by 2021
4. At least 80% of health facilities in all LGAs report routinely on malaria by 2021

Strategic Pillar Three: Strengthen Health System for delivery of package of essential services

Priority Area 1: Human Resources for Health

Objective: To optimize the number and enhance efficiency of the health work force in State X

Targeted MOU Result 1: To improve availability and productivity of HRH through equity in the distribution of available staff, and strengthen Monitoring and Performance Management for HRH

Milestones:

1. State HRH policies and strategic plan (including production, recruitment and retention strategies) developed and fully implemented including for frontline health care workers along with those in supportive functions such as supply chain
2. 100% of Ward PHC Centers assessed on a quarterly basis based on updated ISS guidelines. Results consolidated at the next level of supervision for senior leader review
3. 100% of LGAs with functional HRHMIS used to inform workforce planning and monitoring with annual HRH report produced and submitted to the SPHCDA
4. 100% of Ward PHC Centers have the appropriate skill mix of health care providers through operationalization of targeted recruitment and retention strategies
5. PHC staff productivity and utilization assessments conducted by end of 2019
6. PHC employee annual performance reviews established and linked to yearly staff promotions and staff rewards/incentives scheme
7. PHC staff verification and biometric capture conducted by end of 2019
8. Absenteeism reduction plan developed and institutionalized for PHC staff by end of 2019
9. 100% of Ward PHC Centers maintain attendance register, including planned and unplanned absences. Relevant data shared on time with the leadership for noting and necessary actions

Targeted MOU Result 2: Ensure the production of adequate numbers of qualified health workers

Milestones:

1. Accreditation levels of all State-owned Health Training Institutions in the state determined by end of 2019
2. 100% of State-owned Health Training institutions with full accreditation
3. Development and operationalization of a sustainable HRH production plan
4. Development and operationalization of Quality Improvement plan for HRH
5. 100% of PHC Facility Staff involved in handling health supplies trained in Supply Chain Processes and functions

Priority Area 2: Health Infrastructure

Objective: To improve PHC service provision by providing adequate infrastructure in every political ward in the state.

Targeted MOU Result 1: To improve availability and functionality of health infrastructure required to optimize service delivery at all levels

Milestones:

1. 100% of PHC Centers in 255 wards renovated as planned by the State Government
2. 100% of Corrective and Preventive Action (CAPA Plan) for the State Health Supplies Management Agency pharmagrade Warehouses completed
3. Health maintenance plan fully funded (at 100%) to ensure full functionality of focal facilities

Priority Area 3: Medicines, Vaccines, Equipment Supplies and Logistics

Objective: To strengthen availability and use of affordable, accessible and quality health supplies and technologies at all levels through an effective, efficient, end-to-end visible and well-coordinated gold standard Health Supply Chain Management System.

Targeted MOU Result 1: Strengthen the availability and use of affordable, accessible and quality medicines, vaccines, and other health commodities and technologies at all levels

Milestones:

1. Integration of all public health supply chain processes, functions and management into One Supply Chain System in the State (refer to State Health Supplies Management Agency Strategic Plan)
2. End-to-end real time supply chain visibility of health commodities and vaccines across 100% of PHC Facilities
3. 70% of State Health Supplies Management Agency staff receive certification in Supply Chain Management
4. Sustainable Health Commodities System scaled up to 100% of all PHC facilities
5. 90% availability of health supplies (including Vitamin A and iron folate supplements) in all PHC health Facilities in the state
6. Quality Management Systems for all health supplies fully operational

7. 100% of Wards with functional Cold Chain Equipment covered by comprehensive Maintenance plans

Priority Area 4: Health Management Information System

Objective: To strengthen Health Management Information Systems (HMIS) structures, as well as leverage community and survey data in the state to inform planning and adequate resource allocations.

Targeted MOU Result 1: Improve the health status of State X citizens through the provision of timely, appropriate and reliable health information services at all levels, for evidence-based decision making

Milestones:

1. At least 90% of public and 45% of private health facilities generating and transmitting routine HMIS data by 2019
2. 70% improvements in DHIS2.0 data quality through routine monthly integrated data control room and at least twice yearly integrated, harmonized DQA in 50% of PHC facilities (inclusive of the Ward PHC centres)
3. Data lab at State Bureau of Statistics fully functional
4. Establish programmatic performance management reviews utilizing the PHC scorecard and administrative and survey data to develop implementable corrective actions to address bottlenecks
5. Expand RI LQAS to PHC programming in-line with State Bureau of Statistics data revolution
6. The State conducts at least biannual reviews of health service delivery performance utilizing administrative and state representative survey data

Strategic Pillar Five: Predictable Financing and Risk Protection

Priority Area 1: Sustainable Health Financing

Objective: To strengthen planning and promote efficient management of financial resources.

Targeted MOU Result 1: To strengthen mechanism for the establishment of sustainable financing and reduce out-of-pocket expenditure for health

Milestones:

1. Sustainable Health Financing policy reviewed and updated to include new funding flows
2. Strategy for State Health Financing developed if not available
3. Organisation and management of the State Health Insurance scheme defined
4. Roles and functions of Contributory Health Scheme stakeholders defined

Targeted MOU Result 2: Increase sustainable and predictable financing for health

Milestones:

1. Increased release for operational expenditures to 255 Ward PHC Centers

2. Ensure 60% Budget Performance is achieved by 2019 with increases to 70%, 80% and 90% in years 2, 3 and 4 respectively
3. 1% of Consolidated Revenue Fund (CRF) as statutory allocation earmarked for the contributory health scheme
4. State meets minimum requirement to access 100% of Basic Health Care Provision Fund (BHCPF) accessed by the State
5. Earmarked funding for implementation of the SDP cash-backed

Targeted MOU Result 3: Enhance financial risk protection through pooled funds

Milestones:

1. Risk pooling mechanism designed and launched
2. All State civil servants and families are covered by SHIS
3. 70% of private sector employees covered by the Scheme
4. 30% of State X population covered by a risk protection mechanism (NHIS for Federal Civil servant and State X Contributory Health Scheme for all other residents)
5. Out of Pocket Expenditure (OOPE) reduced from 80% Total Health Expenditure (THE) to 70% in State X

Targeted MOU Result 4: Enhance transparency and accountability in strategic purchasing of Health Services

Milestones:

1. Provider payment mechanism for health services designed
2. State X producing Health Accounts annually
3. State X and 100% of LGAs with functional Public Financial Management Systems
4. Periodic expenditure review at all levels
5. Conduct at least one Public Expenditure Tracking Survey (PETS) to assess efficiencies in the health system

Article III – Program Period

This MOU will be effective from the date of signature through to December 31, 2022 (for all Participants other than Partner 6). This MOU, as it applies to Partner 6, will be effective through December 31, 2020 unless such period is extended by Partner 6 in writing. State X will sustain and build on the gains of the MOU from 1st January 2023 onwards.

Article IV – Governance, Leadership and Management Support for Health Systems

On an annual basis, State X will lead the development of a detailed, harmonized and costed AOP that reflects the objectives, activities and resource commitments of the State as well as each Development Partner. The AOP will specify:

- Expected outcomes with specific six-monthly execution milestones
- Metrics and benchmarks to measure performance

- State X Government's anticipated investment in PHC over the next year, including external resources expected to be leveraged to support the PHC sector
- Development Partner commitments to funding and technical assistance in support of the PHC system, including the approach, locations, and responsible implementing partner, if relevant
- Volume of projected procurement and distribution of PHC commodities, equipment and renovations by all relevant parties
- Planned trainings, with a proposed target cadre and schedule, to be supported by all relevant parties

The State will lead the development of the sector wide AOP which will be completed in time to inform the government budget in a process that facilitates the full participation of all MDAs and Development Partners so that the annual AOP reflects each Participant's priorities and planned inputs, including the following:

- The State's Health Ministries, Departments and Agencies (MDAs) and each TWG will develop costed annual work plans for the upcoming year in their programmatic area, with expected resourcing plans outlined. TWG work plans will include anticipated activities and resource commitments from each member, including implementing partners.
- The SMOH&HS, with support from the M&E TWG, will be responsible for consolidating all MDA and TWG costed work plans into a single draft State AOP and reviewing to ensure full harmonization (i.e. no overlap of roles and responsibilities, activities or resourcing plans).
- The SMOH&HS, with support from the Health Care Financing TWG, is responsible for ensuring a coherent financing plan, specifying source of state financing (e.g. planned budget appropriations, Saving One Million Lives (SOML), Basic Health Care Provision Fund (BHCPF)) as well as other support from Technical Assistance Partners. The draft AOP should clearly reflect unfunded gaps and resourcing priorities based on target state budget execution.
- Once consolidated, a dedicated and adequate period shall be provided for each Participant to review and comment on the draft AOP content. During this period, the draft AOP will be shared with all of the PHC donors and implementing partners participating in the state through the office of the DHPRS of the SMOH&HS, to provide them with an opportunity to clarify any additional external contributions to fill high priority gaps in the annual plan.
- Following the review period and finalization by the DHPRS of the SMOH&HS, with support from the M&E TWG, incorporating inputs from all Health Sector TWGs, the AOP will be reviewed and approved by the Commissioner of Health & Human Services, following which the AOP will be presented to the State Task Force on Primary Health Care for ratification then submitted to the State Executive Council. The AOP with inputs will need to be determined between the first and second quarter of each year, prior to and in time for informing the State's annual budget submission.
- Working in service of the State Health MDAs, the TWGs will lead the coordination and implementation of assigned work streams within the PHC sector. The TWGs will be led by the State technical lead and include technical support partners, civil society, and other relevant members. The proposed organization of the State TWGs is shown in Appendix I.
- Each TWG will conduct quarterly work plan reviews to update their section of the AOP, including updated activities, milestones, and budget projections. The State's relevant TWGs will meet quarterly or monthly (as defined in the Terms of Reference) to coordinate, plan, and monitor PHC sector results for their focus area.
- Technical partners will serve on those TWGs to contribute to coordination, support, and alignment of MOU work streams. Consistent with the tenets of the Development Cooperation Framework, Development Partners agree to coordinate their investments (and technical partners) through the annual work planning process with the State.

Performance against the AOP will be reviewed regularly by the Participants as the work plan for the MOU, including:

- End-of-year reviews for the MOU will be conducted with principals in December or January, during which the budgeted AOP will be approved as the MOU work plan and budget for the following year, with Q1-2 milestones agreed. Performance against Q3-4 milestones will be assessed by the principals at this time.
- Each TWG will conduct quarterly work plan reviews to update their section of the AOP, including proposing updates to the AOP/MOU six-month milestones for Q3-4 at midyear.
- Mid-year MOU review conducted with principals in June-August will result in approval of updated Q3-4 milestones and any necessary budget adjustments. Performance against Q1-2 milestones will be assessed by the principals at this time.
- The Governor of State X, Alhaji Aliko Dangote, Mr. Bill Gates, the Partner 4 Nigeria Head of Office, and Partner 5 Country Representative are expected to attend the mid-year and end-of-year meetings in person, or by video or telephone conference. Other participants include the Speaker of the State House of Assembly, His Royal Father the Emir of Zazzau, the Federal Ministry of Health, and the National Primary Health Care Development Agency (NPHCDA). A representative from Partner 6 may also participate in these reviews in person or by video or teleconference.

Article V – Roles & Responsibilities

- The State X Government shall play a coordination role in achieving and maintaining the programmatic objectives of the current MOU throughout the period of this MOU and beyond.
- Over the 4-year period, State X shall lead the management and implementation of PHC system activities to achieve the objectives, results and milestones laid out in this MOU, including:
    - Funding all operational expenses, including staffing, drugs, consumable and diagnostics, integrated supportive supervision, and monitoring and community engagement, maintenance and imprest to support health facilities in providing essential health care services (in accordance with the State's Service Deliver Plan [SDP]) in selected delivery channels: primary health centers and health clinics.
    - The State is committed to staffing 288 Ward PHC Centers at 100% and 648 PHC Clinics at 50% of the Minimum Service Package [MSP] requirement which is in line with the State's SDP.
- The State X Government will also ensure funding to match Participant contributions, including:
    - State X shall fund 70% of the total RI Fund as per the schedule in the *FUNDING APPENDIX V-a* or as otherwise agreed based on the revised needs over the MOU years, prevailing security and circumstances.
    - State X shall achieve a 5% annual increase in execution of PHC funding from state appropriated annual budgets during the MOU period, for a total 20% increase in the budget execution rate during the MOU period. Annual increases will be calculated using the average 2016 and 2017 budget execution rate as a baseline.
    - State X shall also contribute up to US$2,500,000 ($600,000 annually to support underfunded PHC activities) to support PHC activities captured in the AOP. BMGF funds will be released according to the achievement of performance-based milestones as per the schedule in the *FUNDING APPENDIX V-b* or as otherwise agreed based on the revised needs over the MOU years, prevailing security and circumstances.

- State X shall release funding to fully cover the following costs of the State X Bureau of Statistics counterpart funding for the construction of the data lab and learning center space; recurring costs for the operations of the data lab and learning center; and new staff recruitment according to needs identified over the course of the MOU.

- The Foundations will provide funding and RI technical assistance in key thematic areas:
  - The Aliko Dangote Foundation shall make a contribution of 15% of the total RI Fund as per the schedule in the *FUNDING APPENDIX V-a* or as otherwise agreed based on the revised needs over the MOU years, prevailing security and circumstances.
  - The Gates Foundation shall also make a contribution of 15% of the total RI Fund as per the schedule in the *FUNDING APPENDIX V-a* or as otherwise agreed based on the revised needs over the MOU years, prevailing security and circumstances.
  - The Foundations shall make fund release for RI support in 2019, 2020 and 2021 to SPHCDA contingent on the State Government dropping its full annual RI contribution on or before the end of the first quarter of each year.
  - Technical assistance from the Foundations shall be in the areas of RI financial management, community engagement, data management, advocacy & leadership, and targeted capacity building; and this will be carried out by sharing data and analysis, strategic insight and other views on any aspect of the implementation of the State RI Work Plan as reflected in the AOP.
- The Gates Foundation shall contribute funding and PHC technical assistance in key thematic areas:
  - The Gates Foundation shall contribute up to $2,500,000 ($600,000 Annually to support underfunded PHC activities) in matching funds into the PHC Basket Fund to support underfunded areas of PHC within the State AOP. These funds will be released according to the achievement of performance-based milestones as per the schedule in the *FUNDING APPENDIX V-b* or as otherwise agreed based on the revised needs over the MOU years, prevailing security and circumstances. In addition to performance achievements, BMGF funding is dependent upon the abovementioned pre-conditions of State contribution to the RI program and also health sector budget execution (defined as budget release and cash-backing).
  - Technical assistance from the Gates Foundation for the PHC sector will be in the areas of leadership/governance, organizational management, data/performance management, health financing, human resources for health, supply chain, service delivery, and community engagement, and establishment of State X Bureau of Statistics data lab.
- Partner 4 shall provide technical assistance in the following areas: healthcare governance, public service management, public financial management, and healthcare service delivery through existing programmes namely:
  - Partnership to Engage, Reform and Learn – Accountable, Responsive and Capable (PERL-ARC) Pillar
  - Partnership to Engage, Reform, and Learn – Engaged Citizens (PERL-ECP) Pillar
  - Maternal Newborn and Child Health Programme (MNCH2), due to finish in December 2019, with transition of MNCH2 activities outlined in the MNCH2 Transition/Sustainability Plan (signed by State Government of State X and Partner 4)
  - Support to Nigeria Malaria Programme (SUNMAP II)
  - Partner 4's new health programme "UK Support for Health in Nigeria", due to commence in 2019/20
  - Partner 4's financial contribution to other mechanisms including GAVI; Global Financing Facility; Partner 6; Global Polio Eradication Initiative; Support to UNFPA for Access to Family Planning Commodities

- Partner 5 Nigeria shall provide both financial and technical support for the PHC program in the first 3 years of the MOU and only PHC technical support in the subsequent 2 years. Partner 5 will also provide technical support for the RI program in all four years of the MOU. Partner 5 in the first year will provide a financial contribution of one million dollars ($1,000,000.00) to the basket fund to support agreed line items in the annual operational plan as per the approved Partner 5-State X Engagement Plan and within the framework of the Government of Nigeria and Partner 5 Nigeria Country Programme for 2018-2022. Partner 5 is committed to supporting State X to improve delivery of interventions for improving maternal, newborn, child, adolescent health and nutrition services to reduce maternal and child mortality and doing so in a coordinated manner to ensure programmes are delivered in synergy and are reinforcing and leveraging the gains of all stakeholders in State X.
    - Partner 5 in its support to State X to deliver on its health goals to the residents of the State, expects to provide technical assistance, financial and commodity support to the State X Government for the PHC program in the MOU. Partner 5 shall support the State in providing essential health care services – including health systems strengthening (HSS) interventions, social behavior change, provision of commodities, procurement and logistics support, monitoring and evaluation, on-the-job training (OJT), clinical mentoring, integrated supportive supervision and capacity building for health care staff, community outreach workers and volunteers on maternal, neonatal and child and adolescent health services including immunization as outlined and agreed in Federal Government of Nigeria- Partner 5 Country Program Document for 2018-2022 and as per the agreed State Engagement Plan for State X 2019-2020
    - Partner 5 will put its best efforts towards supporting fund raising towards implementing activities in the annual operational plan of the PHC program component of the MOU and continue to update the table of financial contribution as additional funds are received during the period of the MOU and the activities supported in the annual operational plan with State X.

- Partner 6 may, subject to the receipt of internal approvals, provide both financial and technical support for the PHC program until 31 December 2020, with the possibility of extending such financial and technical support for an additional 3-year period. Partner 6 support to State X would be implemented through grant agreements and would draw from Partner 6 funding allocation to Nigeria.
- ALL PARTIES will execute this MOU in good faith regardless of any change in leadership or personnel in the respective organizations for whatever reason. The principals of each Participant shall prioritize attendance at each mid and end-year review of this MOU.

Article VI – Funding, Financial Oversight & Accountability

This section refers to partners who intend to provide funding directly through state financing mechanisms. It therefore excludes the Partner 4 and Partner 6, who may support the MOU through programs they are funding in the State.

- State X and the Foundations have agreed to share the costs of implementing the MOU in State X by contributing proportions of required funds as detailed in *FUNDING APPENDIX V-a and V-b.*
- The SPHCDA shall establish a dedicated Primary Health Care (PHC) Basket Fund, into which all deposits for PHC implementation in the MOU shall be made by State X and the Foundations.

- State X will continue to deposit annual funds for RI implementation into the separate dedicated RI sub-accounts of the larger SPHCDA Operational account per the disbursement schedule and timelines agreed on by the State X Government and the Foundations as detailed in *FUNDING APPENDIX V-a.*
- State X will commit to release of funds for prioritized PHC activities (i.e. those that are typically underfunded as defined in the AOP) on time as detailed in *FUNDING APPENDIX V-a* through direct disbursement to the Primary Health Care (PHC) Basket Fund domiciled with the SPHCDA Operational account. Following a review and plan for cascading the State's PFM framework within the health sector, the approach of having a separate basket fund may evolve over time during the course of this MOU.
- The Foundations' contributions to the PHC account are contingent on full payment of RI and PHC Basket funds (respectively) by State X for an agreed period (at the beginning of the year) as per the disbursement schedule [refer to *FUNDING APPENDIX V-a and V-b]*. End-of-year PHC payments will also be contingent upon State X realizing an increase of at least 5% in budget release (including cash backing).
- In its use as the MOU work plan, the harmonized costed AOP shall:
    - Include budget lines for capital procurements (e.g. building construction and refurbishment, vehicles, generators etc.) funded by the State and/or development partners and operational expenses (e.g. PHC service delivery via integrated outreaches, essential medicines and commodities logistics, data management, social mobilization and community linkages, supportive supervision).
    - Reflect how all sources of external grant funding (direct and indirect though technical assistance partners) provided to State X, whether governed by this MOU or not, will be applied to the State's AOP execution, to allow all MOU Participants to observe no overlaps in budgeting. These direct grant sources may include but are not limited to: direct grants to State X for RI (State, BMGF, Aliko Dangote Foundation); the direct grants for PHC systems strengthening (State, BMGF and Partner 5); Saving One Million Lives, Performance for Results; and the National Basic Health Care Provision Fund.
- Contributions by the Foundations shall be prioritized for operational and underfunded activities in the work plan while the State Government shall bear capital expenses.
- Throughout the duration of the MOU, SPHCDA shall be accountable to all Participants on RI and PHC Basket funds through "no objection" requests subject to approval by the Participants for any line item on the costed workplan greater than 250,000 Naira and routine internal and annual external audit exercises.
- All procurements made under the MOU must be endorsed by the appropriate technical working group(s), MDAs and Public Procurement Authority [PPA] and acting in accordance with State X Procurement regulations.
- The SPHCDA shall address the recommendations made in the 2018 RI audit report to strengthen its financial management system by December 2018.
- Funds in the PHC account managed by the SPHCDA that are unutilized by the end of each year for whatsoever reason shall remain in the PHC account and be used to finance the PHC budget the following year.
- Retirement of funds at all levels will take place monthly, by a designated official, and duly co-signed by the stipulated co-signatories.
- The SPHCDA incorporates funding within its annual budget to cover assessed needs to meet the targets of the MOU, including critical underfunded PHC activities. Note, while SPHCDA is the

principal coordinating body of PHC, there are other relevant MDAs for PHC and as such, some of these funds be more appropriately included in other MDAs, such as SMOH&HS for health financing funds, or State Health Supplies Management Agency for supply chain activities.

- The SPHCDA will use a direct accounting and disbursement system, in accordance with State X's financing and accounting principles and regulations, in advance of receiving direct funding to ensure transparency and financial accountability at each level of disbursement and retirement.
- SPHCDA will manage deposits of direct funding through a designated bank account, from which all program expenses included in the MOU will be made.
- Payment of each tranche of funds into the dedicated bank account operated by the SPHCDA by Development Partners will be contingent on the State having paid its share as outlined in the agreed-upon disbursement schedule, unless an exception is agreed to by all Participants.
- Other Development Partners are welcome to contribute direct funding to MOU activities by identifying areas of the S-SHDP II or AOP that they may wish to support.
- The SPHCDA Finance Working Group will provide day-to-day financial oversight for all expenditures from the dedicated bank account operated by the SPHCDA and will produce a monthly report with budget amounts for key functions, allocations, and expenditure of funds.
- Financial checks will be instituted through a systematic auditing process that includes internal auditing within SPHCDA, State auditing and external or independent auditors at all levels. An annual external audit shall be conducted of the RI and PHC accounts, paid for by funding from these accounts, and the report shall be shared with all contributors to these accounts.
- Any direct funds paid to the State by Development Partners pursuant to this MOU shall be paid in accordance with State X's Treasury Single Account ("TSA") Policy (or current policy at the time of payment), and any requirements that all revenue and income of all MDAs (including disbursements of grant funds) should be paid into a TSA and banks holding MDA's funds/accounts.
- Periodic internal audits and an annual external audit will be conducted and shared with participants, and then made publicly available.

Article VII – Critical Assumptions/Conditions

- State X is committed to addressing root causes of current PHC system underperformance including taking bold reforms that challenge status quo operations, financing and management of the PHC system.
- State X will fully operationalize the Primary Health Care Under One Roof (PHCUOR) policy, in line with the National policy, inclusive of ensuring the SPHCDA has adequate capacity and authority to control PHC services, program areas, and resources (human, financial, health facilities, etc.).
- State X will ensure the SPHCDA has clear responsibility for effective coordination of PHC service delivery and that there will be no duplication of duties within other ministries, departments and agencies. Moreover, other MDAs who also are critical to other aspects of primary health care will be aligned towards a single State-led vision for primary health care.
- State X is committed to establishing and maintaining effective governance for the MOU activities and intends to appoint high-level leadership to govern its implementation.
- State X will operationalize governance for the DCF in 2019, with structures established for capturing and providing oversight to donors and implementing partners operating in the development sector in the State, including PHC.

- State X and relevant Development Partners will deposit the agreed amounts of direct funding for MOU implementation per the agreed upon grant agreements and disbursement schedules. Deposits will be made into a dedicated bank account (known as the "basket fund") operated by the SPHCDA.
- The Participants agree to establish a routine review schedule of the MOU activities, including any funding that may be provided by the Development Partners, within the first 90 days of signing the MOU. The PHC MOU review should be situated within the context of the broader health sector and State X review process and should be an appropriate cadence and at the appropriate leadership level.
- Recognizing that the flow of information among Participants is critical to the success of the PHC activities supported by the MOU, the Participants agree to, to the extent it does not conflict with any confidentiality obligations, openly and consistently share relevant data and information.
- Financial, material and human resource contributions by all State X partners supporting PHC will be assessed prior to provision of financial, material, or human resources by the MOU Development Partners to ensure coordination and optimization of existing resources and determine a pathway to ensure partner-wide collaboration.
- Partners (technical and development) will coordinate with all State X entities to streamline their planning and implementation efforts and align their results to the State's priorities as reflected in the S-SHDP-II.

Article VIII - Technical Partner Engagement

Implementing partners engaged by the Participants will contribute technical assistance based on the AOP and scope of MOU, as well as the scope of other programs the Participant is funding in the State. Terms of engagement for technical partners, if based on the AOP and scope of this MOU, will be aligned to the State Development Cooperation Framework. Alignment of technical partners to the MOU objectives and targeted results may be modified immediately or over a gradual period of time to enhance coordination. To the extent it does not conflict with the scope of a Participant's program in the State, Participants will take reasonable steps to ensure that Technical partners will conduct activities consistent with the MOU principles (MOU Article I) and operational guidelines as follows (the operating principles in the DCF, once operationalized, will supersede this clause):

- Technical partner programs shall be discussed in TWGS and incorporated in the state health AOP.
- Technical partners will support State ownership of interventions; as such, technical partners will support the State to lead and present on analyses, updates and presentations, including the increased use of State presentation formats and templates as opposed to grantee branded materials.
- Technical partners will participate in the appropriate health technical working groups led by the State to support and contribute to advancing a given MOU work stream.
- Technical partners will streamline coordination around trainings and workshops to increase efficiency and engagement between State and other health actors. Partners will seek approval from the office of the Permanent Secretary for SMOH&HS and the Chief Executives for the other MDAs to support workshops involving State health sector employees and preference will be given for workshops that align to a State-managed training plan to minimize the time participants spend away from duty stations.
- For any support of Government officials for workshops, and data collection activities, grantees will align their support to official State per diem rates/honorariums.

- Partner 5 will provide direct financial support for implementation of agreed activities within the PHC MOU annual operational plan while maintaining its obligations to the State Government as agreed in the Partner 5 – State X Engagement plans. The funding modalities will be in accordance with Partner 5's procedures based on the UN Harmonized approach to cash transfer (HACT) framework for specific and agreed line items in the annual operational plan of the PHC MOU with clear indication of activities supported by Partner 5 funds
    - In line with the UN HACT framework, State X SPHCDA shall also provide activity-based reports for funds disbursed by Partner 5.
    - The Foundations' and Partner 5's contributions to the PHC account are contingent on full payment of RI and PHC funds (respectively) by State X for an agreed period (at the beginning of the year) as per the disbursement schedule.

Article IX – Non-Exclusivity and Funding Requirements

- The Participants shall pursue the objectives of this MOU on the basis of non-exclusivity. The Participants, their affiliates, employees, or agents shall not be restricted from making any arrangement or agreements with any third party (including other government agencies, corporations, NGOs, donor, or bilateral organizations) for direct or indirect participation in support of or contribution to health and nutrition programs in State X or any other part of Nigeria. Without limiting the foregoing, the Participants may negotiate directly with any third party and not necessarily through the other.
- Funding and support referenced herein to be provided by the Development Partners must satisfy each organization's internal grant application, approval and other funding requirements, including entry into a grant agreement.

Article X – Publicity

The Participants recognize the desire of each Participant to disseminate information to the public about the fact that this MOU has been concluded and as to its contents. The Participants, however, also recognize a need to coordinate about when and how such information may be disseminated. No Participant shall use the name or logo of another Participant without the consent of that Participant. All reports, analyses & data produced as a result of this MOU will made available for public use.

Article XI – Compliance with Laws

Each Participant represents and warrants that all activities will be conducted in accordance with all laws, regulations and other legal standards, including but not limited to all applicable and anti-corruption and anti-bribery laws applicable to such Participant.

Article XII – Scope of Collaboration

- Any matter for which no provision is made in this MOU shall be determined in a manner mutually acceptable to the Participants hereto and in this regard to each Participant. Each Participant shall accept

full and primary responsibility for any and all expenses incurred by such Participant relating to this MOU. No Participant will be responsible for any expenses incurred by any other Participant unless specifically agreed to, in advance and in writing.

- Unless as may be specifically provided otherwise, the cooperation between the Participants outlined in this MOU is not to be considered or construed as a partnership or other type of legal relationship. Nothing in this MOU is intended to be construed as superseding or interfering in any way with any agreements or contracts entered into between or by the Participants, either prior to or subsequent to the activities described herein.

Article XIII – Amendment and Settlement of Disputes

- This MOU may be amended by mutual written agreement of the Participants. Any amendment shall be without prejudice to any understanding under this MOU reached prior to the effective date of such amendment.
- Any dispute over the interpretation or application of any provision herein contained shall be settled through consultations or by such other means, as the Participants shall mutually agree. The Participants shall use their best efforts to settle promptly and amicably any dispute, controversy or claim arising out of, or relating to this Agreement

Article XIV – Non-binding Legal Status of the MOU

The Participants agree and understand that, notwithstanding the above statements, this MOU is non-binding and shall not create or give rise to any legally binding obligations upon the Participants to perform any activities or provide any funding.

This MOU is executed as a non-binding arrangement in State X, Nigeria on this _____ day of _____, 201X:

IN WITNESS WHEREOF, the Participants hereto have caused this MOU to be signed in their names and made effective as of the date indicated:

_____

XXXXX XXXX **……201X**
His Excellency,
GOVERNOR OF STATE X

_____

Ms, Zouera Youssoufou **….……201X**
Managing Director and CEO,
ALIKO DANGOTE FOUNDATION

_____

Dr. XXXX XXXX **……201X**
Country Director,
BILL & MELINDA GATES FOUNDATION

_____

Ms. XXXX XXXX **……201X**
Head,
Partner 4

_____

Mr. XXXX XXXX **……201X**
Head,
Partner 6

_____

Mr. XXXX XXXX **……201X**
Representative
Partner 5

Acknowledged by:

_____

Dr. Faisal Shuaib
Executive Director
National Primary Health Care Development Agency

Witnessed by:

_____

His Royal Highness
XXXXXXXXXXXXXX

_____

Dr. XXXXX XXXXX
Country Representative
WHO

SECTION III: APPENDICES

APPENDIX I: **TWG organogram**

APPENDIX II**:** **TOR for Ward Development Committees [WDCs]**

Functions of the Ward Development Committee:

- To strengthen the link between community and services providers
- To create awareness, stimulate demand, help convince those that are hard to reach and encourage community participation
- To coordinate all components of primary health care programs in their respective villages ranging from management of the health facilities, maternal and child health care, immunization programs, family planning and the purchase and administration of drugs and other consumables

The Ward Development Committee shall:

- Meet monthly and record minutes of meetings
- Minutes of meetings be signed by the Chairman and Secretary after approval at the next meeting
- Comply with the quorum of members set for starting the meeting
- Monitor drug revolving at the Facility level
- Authorize the Treasurer to record and keep all monies
- Authorize the Treasurer to spend money only after approval by Committee
- Instruct the Treasurer to record all expenditure
- Choose where applicable, the Ward referral centre to serve as the meeting venue and Secretariat of the ward Development Committee
- Where there is a Bank Account, signatories to be the WDC Chairman and Treasurer, and if necessary, the Secretary
- Send minutes of meetings to Local Government Area Committee

APPENDIX III**: TOR for the State X Traditional Leaders Committee on Health**

- Support all health programs in the state
- Promote and strengthen demand creation activities in their emirate/chiefdom so as to increase uptake and utilization of health services
- Serve as a liaison between the SPHCDA, the Chiefdom/Emirate, and the Communities
- Develop capacity building plan and conduct the training for traditional institution in the state
- Collect and collate monthly and vital statistics and RI program data from all emirates and chiefdoms. Vital statistics data include; births and deaths etc. RI program data include; Children attending sessions, children immunized, children unimmunized, sessions held and missed, absence of health workers, disease outbreaks, etc.
- Provide monthly RI program performance and vital statistics to State X Traditional Council through the member of NTLC-PHC
- Establish and maintain a dashboard of RI program indicators for the emirate/chiefdoms
- Review RI program dashboard with NTLC-PHC member quarterly
- Present unresolved specific issues on the RI program to the state Task Force on PHC through the Committee Chairman/NTLC-PHC
- Meet quarterly to review and evaluate program progress
- Any other roles as may be assigned by the SPHCDA

APPENDIX IV**: TOR of Ward heads/Village heads/District heads**

Ward Heads

- Write down the name of all eligible children in the settlement and maintain an updated line-list
- Work with religious leaders to pass immunization messages during naming ceremonies and sermons in the community
- Work with TBAs, barbers, Imams to identify, track and mobilize eligible children back to health facility for vaccination
- Work with health facility RI service provider to plan RI sessions and refer parents to HF for vaccination
- Send out town announcers to inform the community of fixed and outreach sessions
- Attend ward performance review meetings
- Reconcile line list with health facility child register together with RI service provider at reconciliation meeting
- With support from HF, track defaulters and left outs to the HF for vaccination

- Report linked visits to the HF to the village head
- Report to the village head, all unsatisfactory behavior of health workers to caregivers or to their duties at the health facilities

Village Heads

- Supervise activities of the Mai Unguwas including their training and involvement in mobilizing children for immunization
- Work with Ward CEFP to plan and review progress on linked visits by Mai Unguwas
- Review number of linked visits by Mai Unguwas and take appropriate actions based on the data
- Provide update on progress/challenges faced during community engagement to the District Head
- Report unsatisfactory behavior of the HWs, Mai Unguwas and caregivers to the District head

District Heads

- Actively participate in LGA CEWG and monthly RI review meetings
- Provide update on progress and challenges faced during community engagement to the ECCOH
- Supervise all activities of the village heads (both training and implementation)
- Address all unsatisfactory behaviors of the village heads and HWs and flag up to the ECCOH
- Work with LGA CEFP to plan, monitor and ensure the implementation of strategy
- Ensure RI messaging during Friday prayers

APPENDIX V**: FUNDING FOR THIS PHC MOU**

It should be noted that funding for this MOU will come from Participants either through direct financial support through State government systems as well as through technical assistance grantees/partners. The section below describes direct financial support mechanism pursuant to the terms of an executed written agreement to be finalized upon signing of this MOU.

Appendix V-a: Funding distribution and disbursement schedule for R.I

Appendix V-a (i): Funding contributions by the participants

Participants		Jan – Dec Year 1	Jan – Dec Year 2	Jan – Dec Year 3	Jan – Dec Year 4	Jan –Dec Year 5
State X		70%	70%	70%	100%	100%
ADF		15%	15%	15%	0%	0%
BMGF		15%	15%	15%	0%	0%

Appendix V-a (ii): Disbursement schedule for MOU partners (Dates and Amount, in naira)

Participants	Jan – Dec Year 1	Jan – Dec Year 2	Jan – Dec Year 3	Jan – Dec Year 4	Jan –Dec Year 5
State X	199,812,763	199,812,763	199,812,763	285,446,805	285,446,805
ADF	42,817,021	42,817,021	42,817,021	-	-
BMGF	42,817,021	42,817,021	42,817,021	-	-

Appendix V-b: Funding distribution and disbursement schedule for PHC

Payment schedule for the PHC Basket Fund	Jan – Dec Year 1	Jan – Dec Year 2	Jan – Dec Year 3	Jan – Dec Year 4	Jan –Dec Year 5
State	$600,000	$600,000	$600,000	$600,000	$600,000
BMGF*	$100,000 (seed funding – to be paid by Dec Year 0)	Up to $600,000 (pending performance achievement of the 6 selected Year 1 milestones)	Up to $600,000 (pending performance achievement of the 6 selected Year 2 milestones)	Up to $600,000 (pending performance achievement of the 6 selected Year 3 milestones)	Up to $600,000 (pending performance achievement of the 6 selected Year 4 milestones)
Partner 5	$1,000,000				

*In addition to performance-based payments, BMGF allocation shall be contingent upon State contribution to the RI program as articulated in Appendix V-a (i-ii), as well as State X realizing an increase of at least 5% in budget release (inclusive of cash-backing)