UHC HIGH - LEVEL FORUM 2025

Tokyo, Japan | December 6, 2025

NATIONAL HEALTH COMPACT

Federal Republic of Nigeria

#InvestinHealth

NHS RII Nigeria Health Sector Renewal Investment Initiative

swap NIGERIA HEALTHCARE SECTOR-WIDE APPROACH

NIGERIA HEALTH SECTOR RENEWAL COMPACT TO ACCELERATE PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE (UHC)

PREAMBLE

1. **Nigeria** signed the Health Sector Renewal Compact in December 2023 to commemorate World Universal Health Coverage Day under the theme "Health for All: Time for Action". President Bola Ahmed Tinubu, GCFR, presided over the event, bringing together all 36 State Governors and development partners who pledged to improve health outcomes through a Sector-Wide Approach (SWAp) aligned with the Nigeria Health Sector Renewal Investment Initiative (NHSRII) and the Renewed Hope Health Sector Strategic Blueprint. The signing demonstrated high-level political commitment to Universal Health Coverage (UHC) and improving access to quality essential health services for all Nigerians.

2. However, since December 2023, major political, fiscal and geopolitical developments have taken place necessitating an addendum to the compact that incorporates an expanded accountability framework that includes local governments, private sector, civil society and traditional/religious institutions.

3. Local Governments serve as primary implementers of health programs at the grassroots level, ensuring accountability and responsiveness to local needs. The Private Sector contributes through financing, supply chain management, service delivery innovation, and expanded access to healthcare. Civil Society Organizations co-create policy, mobilize communities, track budgets and service quality, and use evidence-driven advocacy to hold government, private sector, and development partners accountable for equitable, high-quality healthcare. Traditional and religious leaders mobilize communities, influence social norms, and promote health service uptake as trusted gatekeepers and hold both government and communities accountable for equitable service delivery.

4. **FURTHER TO THE ABOVE, WE THE UNDERSIGNED,** representatives of the **Federal Government, State Governments, the Federal Capital Territory, and Local Governments, together with Development Partners, the Private Sector, Traditional and Religious Leaders, and Civil Society Organizations,** assembled in Abuja, Nigeria, on this 12th day of November 2025, hereby reaffirm our commitment to accelerate progress towards the achievement of Universal Health Coverage by 2030 through effective sector governance, building an efficient, equitable, and quality health system, unlocking health value chains, and improving public health security.

EFFECTIVE GOVERNANCE

5. **RECOGNIZE** that health is key to human capital accumulation; and a healthy, economically productive population, growing at a sustainable pace, supported by a health system that caters for all, is essential to Nigeria's socioeconomic development.

6. **RECOGNIZE** that the key challenges to achieving our national health objectives include constrained governance systems and structures with limited accountability, inadequate, inefficient, and inequitable health care financing, shortage, and maldistribution of human resources for health, limited availability of quality health commodities, insufficient citizens' and community engagement, and hyper fragmented, poorly coordinated external development assistance.

7. **RECOGNIZE** that the National Health Act (2014) established a National Health System comprising: **(i) the Federal Ministry of Health; (ii) the Ministry of Health in every State and the Federal Capital Territory Department responsible for Health; (iii) parastatals**

under the federal and state ministries of health; (iv) all local government health authorities; (v) ward health committees; (vi) village health committees; (vii) private health care providers; (viii) traditional health care providers; and (ix) alternative healthcare providers. The Federal Ministry of Health and Social Welfare is mandated to ensure the development of national health policy, promote adherence to training standards, monitor and evaluate health status and system performance, coordinate health services during national disasters, and facilitate health systems research for planning, evaluation, and management of health services.

8. **REAFFIRM** that consultations in 2023 with Nigeria Governors' Forum, and National Economic Council, led to the approval of the Sector-Wide approach by the 64th National Council on Health held in Ekiti State with participation of the Federal Government and all 36 States and FCT.

9. **REAFFIRM** that President Bola Ahmed Tinubu, GCFR, approved the establishment of the Sector-wide Coordinating Office-Programme Management Unit (SCO-PMU) within the Office of the Coordinating Minister of Health and Social Welfare. The SCO-PMU reports to a Steering Committee chaired by the Coordinating Minister of Health and Social Welfare, with membership including the Minister of State for Health and Social Welfare, the Permanent Secretary of the Federal Ministry of Health and Social Welfare, and representatives from the Federal Ministry of Finance, Federal Ministry of Budget and Economic Planning, and development partners.

10. **REAFFIRM** that the President approved for the SCO-PMU to serve as the secretariat and delivery unit for the NHSRII and to be headed by a national coordinator. The functions of the SCO-PMU include NHSRII programme management, monitoring and evaluation, engagement and supervision of Independent Verification Agents (IVAs) and fiduciary management, among others.

11. **RECOGNIZE** that on 13th March 2025, the **Federal Ministry of Health and Social Welfare, National Primary Health Care Development Agency (NPHCDA), all 36 States and the Federal Capital Territory, Local Government Areas (represented by the Association of Local Governments of Nigeria), Civil Society Organizations, and Development Partners** convened in Abuja for a National Stakeholders' Engagement on Accelerating Improvements in Primary Health Care in the context of Local Government Financial Autonomy. The meeting resulted in a joint communique committing all parties to collaboratively develop and implement a framework for strengthening Primary Health Care Governance, Human Resources for Health, Financing, and Service Delivery.

12. **COMMIT** all State Governments, the FCT and the Local Governments to complement the Federal Government by undertaking the following key policy actions:

    a. Increasing budget allocation and timely releases of funds for primary health care services, immunization, family planning, and public health, and make those allocations and releases public.
    b. Complement Basic Healthcare Provision Fund (BHCPF) financing with public health interventions to: (i) reduce the burden of communicable and non-communicable diseases, including malaria, tuberculosis, HIV/AIDS, and vaccine-preventable diseases; (ii) increase access to sexual and reproductive health care services; (iii) strengthen health systems; and (iv) improve health security.
    c. Refine the Vulnerable Group Fund (VGF) and optimize risk pools to strategically purchase highest impact benefit package to improve health outcomes with a focus on financial protection for critical reproductive, maternal, newborn, child, adolescent health, and nutrition services to reduce morbidity and preventable deaths.
    d. This collaboration shall be facilitated through innovative financing options such as health taxes, surcharges, and first line charge from the VAT pool.

13. **COMMIT** to strengthening the governance and accountability of Primary Health Care through the Primary Health Care Under One Roof (PHCUOR) Policy and related laws by ensuring clear role delineation across Federal, State, and Local Government levels, and institutionalizing inclusive, functional coordination structures that promote joint ownership and performance accountability. Specifically:

    a. Maintain the State Primary Health Care Board (SPHCB) as the coordinating body for PHC, with a fully functional Governing Board that includes representation from States, Local Government Areas (minimum of one LGA Chairperson from each senatorial zone), professional bodies, and Civil Society Organizations, ensuring at least 30% women's representation.
    b. Establish functional Local Government Health Authorities (LGHAs) in all LGAs, headed by qualified Medical Officers of Health, with dual reporting lines to the Executive Secretary/SPHCB (technical) and the LGA Chairperson (administrative), supported by clear terms of reference and performance oversight mechanisms.
    c. Strengthen State–LGA collaboration through quarterly PHC performance review meetings, capacity-building support for LGHA teams (including integration into national fellowship programs), and active LGA participation in State Councils on Health to enhance alignment, transparency, and joint accountability for results.
    d. Deploy targeted capacity-building programme for Local Government Councils by leveraging the Sector-Wide Approach (SWAp) Technical Assistance pool, private sector support, and Federal and State Government resources to strengthen their capacity to deliver on Primary Health Care governance, management, implementation, and accountability responsibilities.

14. **ENDORSE** the preparation and presentation of annual reports of the State of Health of Nigerians and the National Health System, as provided in the National Health Act, to the President, National Assembly, Federal Executive Council, and the National Economic Council, and the hosting of Joint Annual Reviews of core sector-wide indicators.

15. **COMMIT** to establishing a national health data ecosystem and health data governance framework in the form of a national digital health architecture and a dedicated organization to manage it that will result in "one source of truth". The Federal Government will establish the framework, States will domesticate it, Local Governments will support state-level and primary health care data collection and reporting, and the private sector and development partners will align their data systems with the national digital health architecture.

16. **COMMIT** to strengthening health data systems and performance monitoring by: (i) utilizing the National Demographic Health Survey (NDHS) and mini-DHS to evaluate midterm and end-term performance of the National Health Sector Renewal Investment Initiative (NHSRII); (ii) collating and reviewing quarterly performance reports from Ministries, Departments, and Agencies (MDAs) and State Governments using standardized core health indicators and reporting tools; (iii) fully operationalizing the National Health Management Information System (NHMIS); and (iv) utilizing data from the District Health Information System 2 (DHIS2) for routine decision-making and planning.

17. **RECOGNIZE** the implementation of the Annual People's Voices survey to crowd in citizens' voices; the use of Performance and Financial Management Officers (PFMOs); and National Health Fellows to drive local conversations about health sector priorities, performance and accountability.

18. **COMMIT** to abide by and implement the resolutions of the National Council on Health and actively participate in the Joint Annual Reviews which facilitate "one conversation" about health sector priorities and performance.

BUILDING EFFICIENT, EQUITABLE AND QUALITY HEALTH SYSTEM

19. **ACKNOWLEDGE** that "best-buy" investments in community health models serve as a critical entry point to public health services and as a first step the FG will collaborate with States and LGAs to retrain up to 120,000 frontline health workers who will be deployed to high priority areas.

20. **ACKNOWLEDGE** that the Nigeria Health Sector Renewal Investment Initiative (NHSRII) is doubling the number of fully functional Primary Healthcare Centers (PHCs) from 8,809 to 17,618 by 2027 across the 36 States and the Federal Capital Territory (FCT) through infrastructural upgrades and Decentralized Facility Financing for operational costs, enabling these facilities to deliver a high-quality essential Primary Health Care package, including routine immunization, delivery services, family planning, Antenatal Care (ANC), and Postnatal Care, and to meet Basic Emergency Obstetric and Newborn Care (BEmONC) levels one and two criteria.

21. **WELCOMES** efforts to link PHCs to Secondary Care facilities providing Comprehensive Emergency Obstetric and Newborn Care (CEmONC) with 774 CEmONC capable facilities established nationwide (1 per LGA). At least seventy of these would be upgraded by the Federal Government and the rest by the States and Local Governments.

22. **ALGON ADDITIONALLY COMMITS to:** upgrading a minimum of one Primary Health Care facility per Local Government to Tier 2 BEmONC facility standards to meet NHIA empanelment criteria.

23. **ALSO WELCOMES** the linkages of PHCs to referral Secondary Care facility providing CEmONC through progressive development of a National Emergency and Medical Ambulance System which targets the transportation of pregnant women with obstetrics and neonatal complications.

24. **RECOGNIZE** the role of State Governments in expanding access to quality essential healthcare services through private sector participation by: (i) mapping and accrediting private health facilities and integrating them into referral networks and emergency transport systems; (ii) issuing competitive tenders for private sector management of underperforming primary health centers (PHCs); (iii) contracting private Emergency Medical Services (EMS) providers and establishing dispatch centers; and (iv) co-financing health insurance premiums for the informal sector and pregnant women. Furthermore, State Governments shall collaborate with the Private Sector, Civil Society Organizations, and Development Partners to: (i) upgrade facilities to meet Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC) standards; (ii) design affordable micro-insurance products; (iii) operate ambulances and call centers; (iv) access guaranteed loans for facility upgrades; and (v) provide technical assistance, seed equipment, and gap financing.

25. **COMMIT** to expediting Nigeria Health Sector Renewal Investment Initiative (NHSRII) reform priorities by expanding private sector participation in publicly financed maternal and newborn care, primary health care, and Emergency Medical Services (EMS), with the Federal Government responsible for: (i) setting national service standards and eligibility criteria; (ii) defining contracting and payment models via National Health Insurance Authority (NHIA) and Basic Healthcare Provision Fund (BHCPF); (iii) publishing Public-Private Partnership (PPP) frameworks; (iv) issuing national EMS protocols and 3-digit emergency access; (v) approving Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAHN) benefit packages and tariffs; (vi) establishing transparent contracting frameworks with Key Performance Indicators (KPIs); (vii) guaranteeing demand through long-term contracts; and (viii) providing regulatory oversight and performance monitoring.

26. **COMMIT** to expanding and strengthening the health workforce by: (i) retraining and deploying 120,000 frontline health workers to high-priority areas, with integrated competencies in maternal and child health, infectious disease management, nutrition services etc.; (ii) establishing targets for recruitment, training, and deployment of specialized health professionals, including dieticians and nutritionists, based on the Health Resources for Health (HRH) database and national workforce strategies; (iii) strengthening pre-service and in-service training programs to ensure quality service delivery; (iv) improving working conditions, remuneration, and retention strategies for health workers at all levels; and (v) leveraging digital platforms for continuous professional development and performance monitoring.

27. **COMMIT** to achieving equitable, quality PHC service delivery by adopting and implementing updated national PHC facility standards and typologies, ensuring all PHCs have costed Annual Operational Plans and budgets aligned with LGHA and SPHCB priorities; mandating annual certification and accreditation of facilities; and developing joint State–LGA plans for infrastructure, HRH, and supply chain systems including sustainable revolving drug funds and maintenance frameworks to guarantee quality, access, and value for money.

28. **COMMIT** to strengthening quality assurance mechanisms in healthcare delivery through policies, laws, and regulations, whereby State Governments establish fully staffed health facility quality inspectorates or accreditation agencies aligned with federal standards set by FMOH, NPHCDA, and NHIA, and publish health facility quality scores and recognize facilities enrolled in accreditation programs.

29. **COMMIT** to health insurance coverage expansion and health insurance adoption by enforcing compliance with the presidential health insurance enrollment mandate and expansion of health insurance enrolment. Furthermore, States shall Strengthen State Social Health Insurance Agencies by ensuring adequate capitalization or funding while private Health Maintenance Organizations are adequately capitalized in line with directives from the National Health Insurance Authority (NHIA).

30. **WELCOMES** the National Council on Health's efforts to establish a National Data Intelligence Centre, a National Digital Health Initiative and National Digital Health Architecture to create, govern and manage a national interoperable health data ecosystem in Nigeria.

31. **RECOGNIZE** that successfully deploying the National Data Intelligence Centre or National Digital Health Initiative in collaboration with State and Local governments will foster Job Creation, fostering an enabling environment for local technology talent to build and innovate home-grown solutions on this health technology backbone. Furthermore the programmes will serve as a catalyst for innovation, encouraging local tech talent to develop cutting-edge health technology solutions.

32. **COMMIT** to leveraging digital health innovations by: (i) establishing and operating a national health information exchange with shared health records, health claims exchange, and digital health services exchange; (ii) building and operating national health registries for clients, facilities, and health workers; (iii) adopting health data standards to enable interoperability, including Fast Healthcare Interoperability Resources (FHIR) profiles and ICD-11, ICD-10 PCS, and LOINC coding terminologies; (iv) supporting integration and certification of digital health solutions; (v) establishing health data analytics platforms to provide insights to health ecosystem stakeholders; (vi) enabling health data use for research and artificial intelligence; (vii) promoting awareness of exchange use cases and benefits among all stakeholders; (viii) fostering an active health technology ecosystem for innovation in products and services; and (ix) engaging with other countries for interoperable cross-border health data sharing.

UNLOCKING HEALTH VALUE CHAINS

33. **ACKNOWLEDGE** that the high prices of health and life sciences products, inequitable access to such products, as well as financial hardships associated with high prices of these products, as well as insufficient manufacturing and production of these commodities in Nigeria continue to impede progress towards achieving universal health coverage.

34. **RECOGNIZE** the important role played by Presidential Initiative for Unlocking the Healthcare Value Chain (PVAC) to build expertise and strengthen local production of vaccines, medicines, diagnostics and other health technologies to facilitate equitable access to affordable life sciences products and building resilience of the health system supply chains.

35. **ACKNOWLEDGE** the role of the Federal Government in strengthening local pharmaceutical manufacturing and procurement through: (i) issuing a Presidential Executive Order prioritizing local manufacturing of Active Pharmaceutical Ingredients (APIs), vaccines, diagnostics, and consumables; (ii) establishing a pooled procurement platform (MediPool) for negotiating advance purchase commitments and market shaping; and (iii) providing tax holidays, reduced import duties, and preferential financing to support local manufacturers.

36. **RECOGNIZE** the Federal Government's commitment to advancing Nigeria's local pharmaceutical manufacturing aspirations by: (i) implementing the Essential Medicines List (EML) and identifying Active Pharmaceutical Ingredients (APIs) of medicines in the EML that are relevant for local production; (ii) streamlining administrative and regulatory processes to expedite required regulatory certifications; and (iii) utilizing pricing, reimbursement, and tendering mechanisms to incentivize investment in supply security.

37. **REQUEST** state governments to support life sciences manufacturing by establishing ecosystem clusters with favorable operating environments, economic incentives, and streamlined or waived state and local taxes, and partner with the Federal Government to create excise duty-free zones, Special Economic Zones (SEZ), and Active Pharmaceutical Ingredient (API) Parks equipped with common effluent treatment plants, waste disposal facilities, reliable electricity, and logistics infrastructure.

38. **COMMIT** to developing and implementing a national advanced pharmaceutical and biotechnology workforce strategy to train at least ten thousand new professionals by 2030; establish Centers of Excellence for pharmaceutical sciences, biotechnology, and regulatory science; provide tax incentives and matching grants for workforce training programs.

39. **COMMIT** to strengthening the National Agency for Food and Drug Administration and Control (NAFDAC) and related regulatory agencies by: (i) institutionalizing the digitalization of product registration and compliance tracking systems; (ii) enforcing risk-based inspections and post-market surveillance for pharmaceuticals, medical devices, and nutrition commodities; (iii) harmonizing regulatory standards with global benchmarks, including establishing quality benchmarks and regulatory requirements for locally produced nutrition supplements, fortified foods, and therapeutic nutrition products in alignment with standards;

40. **ACKNOWLEDGE** the role of the Federal Government in advancing digital health innovation through: (i) issuing national interoperability and privacy standards; (ii) fast-tracking regulatory sandboxes for telemedicine and drone logistics; (iii) enabling BHCPF/NHIA/SSHIA reimbursement for innovative digital health services and drone logistics; (iv) harmonizing national quality standards and adopting co-regulation with State health standards, accreditation agencies, and professional councils; and (v) digitizing licensing and inspection processes; and **ENCOURAGE** State Governments to: (i) procure digital triage, tele-obstetric consultation, and eReferral platforms; and (ii) designate drone corridors and hubs for healthcare delivery.

41. **RECOGNIZE** the need to establish blended finance models, credit guarantees, and sovereign-backed financing platforms; engage pension funds and development banks for long-term health sector financing and linking this financing to leverage tech-transfer partnerships with experienced multi-nationals for Nigeria based manufacturers.

42. **COMMIT** to promoting national investment in mRNA vaccine R&D plans; support the secure technology transfer agreements with global partners; expand accredited clinical trial sites nationally; streamline regulatory and ethics approval processes; fund biobanks and data systems.

IMPROVING PUBLIC HEALTH SECURITY AND CLIMATE RESILIENCE

43. **COMMIT,** to contribute to strengthening the Federal, State and Local Government capacities to prevent, detect, and respond to public health threats and events through the promotion of appropriate, safe, and effective health practices, upscaling of surveillance and adaptive early warning systems, regularization of preparedness and peacetime response actions, improved laboratory diagnosis platforms, quick and optimized outbreak response actions all backed by up-to-date legislative frameworks and health security policies.

44. **COMMIT,** to enhance preparedness and response capacity through strategic investments in public health security infrastructure, emergency stockpiles, and strategic public health security actions including periodic national and state multi-hazard risk assessments which informs the development of adept contingency plans and preparedness actions.

45. **COMMIT** to embed climate change adaptation and mitigation throughout the health system to protect population health from climate-related threats and ensure environmental sustainability through Federal and State Climate Adaptation Plans, and guidelines for climate-resilient and energy-efficient facilities and ensuring equipment purchases meet climate resilience standards.

IN CONCLUSION

46. **CALL** on all stakeholders to fully support the sector-wide approach; develop its coordinating secretariat; align behind Government's priorities supporting national ownership; strengthen and use national institutions and systems where possible; and reorient all technical and financial assistance, in a nationally coordinated manner.

SIGNED IN ABUJA, NIGERIA ON 12TH, NOVEMBER 2025 BY

SIGNED IN ABUJA, NIGERIA ON 12TH, NOVEMBER 2025 BY

PRESIDENT, HEALTHCARE FEDERATION OF NIGERIA.....

SEC. GEN., HEALTH SECTOR REFORM COALITION.....

HEALTH DEVELOPMENT PARTNER GROUP .....

HRH, SULTAN OF SOKOTO .....

HIM, OONI OF IFE.....

PRESIDENT, CHRISTIAN ASSOCIATION OF NIGERIA.....

NATIONAL PRESIDENT, ALGON .....

CHAIRMAN, NIGERIA GOVERNORS FORUM .....

MINISTER OF BUDGET AND ECONOMIC PLANNING .....

MINISTER OF FINANCE & COORDINATING MINISTER OF THE ECONOMY.....

COORDINATING MINISTER OF HEALTH AND SOCIAL WELFARE .....

HRH, EMIR OF SHONGA (NTLC).....

APPENDIX

A. NIGERIA HEALTH SECTOR RENEWAL COMPACT BASELINES AND TARGETS

Introduction

This appendix outlines the key outputs and outcomes driving the Nigeria Health Sector Renewal compact. These indicators, baseline and targets have been aggregated from exiting national plans such as the Health Strategic Sector Blueprint (HSSB) Monitoring, Evaluation, Accountability, Research and Learning (MEARL) Plan, Human Capital Opportunities for Prosperity and Equity – Primary Health Care Provision Strengthening (HOPE-PHC) programme, Human Capital Opportunities for Prosperity and Equity - Governance (HOPE-GOV) Programme and Health Security Programme (HeSP Nigeria). The indicators maintain the descriptions in the source plan and primary programme documents. National targets have been maintained while targets of programmes with narrower coverage have been increased to align with national coverage and aspirations.

NHSRII KEY PERFORMANCE INDICATORS: BASELINE AND 2030 TARGETS

The following table presents the baseline values and the corresponding 2030 targets for the eight core outcomes of the NHSRII health compact.

Indicators	Source plan/ Program	Frequency of Measurement	Source of Data/Means of Verification	Responsible Entity	Baseline	2030 Target
1. Under 5 Mortality Rate (per 1,000 live births)	SWAp core indicators	Annually	DHIS-2	F/SMoH/ NPHCDA	110	110
2. Facility stillbirth rate (disaggregated by fresh and macerated)	HSRII Core Indicators	Quarterly	DHIS-2	M&E Officer - F/SMoH/ NPHCDA	35/1000 (fresh: 49.1%; macerated: 50.9%)	20/1000 (fresh: 39.1%; macerated: 60.9%)
3. Maternal Mortality Ratio (per 100,000 live births)	SWAp Core Indicators	Annually	DHIS-2	F/SMoH/ NPHCDA	512	411
4. Pregnant women receiving ≥180 tablets of MMS during antenatal care	SWAp Core Indicators	Annually	DHIS-2	F/SMoH/ NPHCDA-Nut Dept	28	37
5. Antenatal care coverage - ANC by skilled provider (%)	Presidential Deliverables - CDCU/SWAp	Quarterly	DHIS-2/ Survey	F/SMoH	49.1%	64.1%

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6. Delivery by skilled birth attendant (%)	Presidential Deliverables - CDCU/SWAp	Quarterly	DHIS-2/ Survey	NPHCDA	46%	100%
7. Percent of Children 0-12 months fully immunized	Presidential Deliverables - CDCU	Annually	Population Surveys	PHCB	39%	50%
8. Children with zero dose (%)	Presidential Deliverables - CDCU/SWAp	Annually	DHIS-2	PCB/A	31%	20%
9. Modern Contraceptive Prevalence Rate	SWAp core indicators	Annually	Survey	F/SMoH	13.5%	20.9%
10. Percentage of population covered by pre-payment schemes/risk protection including health insurance (%)	Presidential Deliverables - CDCU/SWAp	Annually	NHIA	NHIA	7.9%	20%
11. Health Financing as % of government budget		Annually		F/SMoH	5%	7.5%
12. Regions within the country with at least one Special Economic zone designated as a bulk drug park1 with common infrastructure facilities.	Presidential Deliverables - CDCU	Annually	PVAC report	PVAC report	0	1
13. New pharmaceutical product application approved by NAFDAC within established regulatory timelines disaggregated by product category (%)	Presidential Deliverables - CDCU	Quarterly	Reports from Food & Drugs/ NAFDAC	NAFDAC	0	100
14. Regions within the country with at least one public health laboratory with functional genomic sequencing capabilities	HSSB	Quarterly	NCDC's Report	NCDC	1	6

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15. Community Health Workers recruited, deployed and retained in high burden LGAs	MAMII	Quarterly	Database/ records	N/SPHCDA	5,690	15,000
16. % of LGAs in which primary healthcare data are digitally captured at the patient level	NDHI	Quarterly	NDHI reports	NDHI	9%	80%
17. % of patients receiving healthcare benefits with NIN numbers	HSSB	Quarterly	NIN/NIMC database	NHIA	49%	95%
18. % of births registered through the eCRVS system	HSSB	Quarterly	eCRVS database	NPopC	27%	85%
19. Percentage of Birth Registered with the NPC	HSSB	Quarterly (Monthly)	M&E Data Quality Assessment (NDHS)	NPC Facilities	39%	50%
20. % of digital health information systems that exchange data through the national Health Information Exchange	NDHI	Quarterly	NDHI report	NDHI	0%	80%

SUMMARY OF AMBITION

The targets set for 2030 are transformative, requiring significant and sustained investment and effort across the entire health sector. Achieving these goals will involve dramatic reductions in mortality rates and substantial increases in access to and utilization of essential health services. The successful implementation of the health compact is critical to realizing this vision for a healthier Nigeria.

B. NIGERIA HEALTH SECTOR RENEWAL COMPACT: OVERALL RESULTS FRAMEWORK

Introduction

This document outlines the Overall Results Framework for the Nigeria Health Sector Renewal Compact. It is designed to monitor progress, ensure accountability, and drive performance toward the achievement of Nigeria's health sector goals. The framework is structured around the four strategic pillars, each with a set of key results that will be tracked and verified annually. This framework aligns with the principles of the Sector-Wide Approach (SWAp), emphasizing unified monitoring, shared accountability, and results-based management.

Overall Results Framework Summary

The following tables provide a comprehensive summary of the 18 key result indicators of the Health Compact, organized by their respective strategic pillars. Each key results indicator includes annual targets from 2025 to 2030.

PILLAR 1: EFFECTIVE GOVERNANCE

		Source plan/ Program	Frequency of Measurement	Source of Data/Means of Verification	Responsible Entity						
ID	Result Indicators					2025	2026	2027	2028	2029	2030
1.	Number of States with Strengthened state budget planning and execution for primary healthcare.	Disbursement Linked Indicators (HOPE-GOV DLI)	Annually	Online published budgets	SMB&EP	Not Due	0	7	17	27	37
2.	Strengthened accountability and transparency for Federal funding for primary health care (Binary: 1=Achieved)	Disbursement Linked Indicators (HOPE-GOV DLI)	Annually	Online published budgets and transfer receipts	BHCPF MOC	Not Due	1	1	1	1	1
3.	Number of States adopting National enterprise architecture and integrated core health functions.	Disbursement Linked Indicato	Annually		F/SMoH	Not Due	0	7	17	27	37

PILLAR 2: BUILDING EFFICIENT, EQUITABLE AND QUALITY HEALTH SYSTEM

		Source plan/ Program	Frequency of Measurement	Source of Data/Means of Verification	Responsible Entity						
ID	Result Indicators					2025	2026	2027	2028	2029	2030
4.	Cumulative Number of primary healthcare workers deployed	HSSB	Quarterly	Database/ records	N/SPHCDA	Not Due	50,000	60,000	72,000	86,000	120,000
5.	Number of Patients with obstetric and neonatal complications transported through emergency medical transport to selected facilities using the digitized EMS dispatch	Disbursement Linked Indicators (HOPE-DLI)	Quarterly	NEMSAS Electronic Dispatch Database	F/SMoH/ NPHCDA	Not Due	5,000	10,000	50,000	100,000	240,000
6.	Number of Women and neonates receiving CEmONC and neonatal services	DLIs (HOPE-DLI)/SWAp Core Indicators	Annually	NHIA portal	NHIA/NPHCDA	Not Due	20,000	50,000	150,000	250,000	350,000
7.	Number of CEmONC facilities refurbished and empanelled.	SWAp Core Indicators	Annually	NHIA empanelment records	NHIA/NPHCDA	Not Due	50	100	300	500	774

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8.	Cumulative Number of poor and vulnerable people with financial protection	Disbursement Linked Indicators (HOPE-DLI)	Annually	NHIA portal	NHIA/ NPHCDA	Not Due	2,000,000	3,500,000	5,000,000	7,500,000	10,000,000
9.	Proportion of births attended by a skilled provider (Percentage)	SWAp Core Indicators	Quarterly	DHIS-2/ Survey	NPHCDA	Not Due	50%	60%	70%	80%	90%
10.	Number of People reached with digitally enabled health services					Not Due	1,500,000	3,000,000	6,000,000	12,000,000	20,000,000
11.	Number of People who received quality essential health, nutrition and population services					Not Due	30,000,000	60,000,000	100,000,000	130,000,000	160,000,000

PILLAR 3: UNLOCKING HEALTH VALUE CHAINS

		Source plan/ Program	Frequency of Measurement	Source of Data/Means of Verification	Responsible Entity						
ID	**Result Indicators**					**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
12.	Cumulative Number of Advanced pharmaceutical and biotechnology professionals trained	HSSB	Annually	PVAC report	PVAC	0	2,000	4,000	6,000	8,000	10,000
13.	Number of New pharmaceuticals, medical devices, and nutrition commodity manufacturing plants established	HSSB	Annually	PVAC report	PVAC	Not Due	1	5	10	15	20
14.	Percentage New pharmaceutical product applications approved by NAFDAC within established timelines	Presidential Deliverables - CDCU	Quarterly	Reports from Food & Drugs/ NAFDAC	NAFDAC	Not Due	20%	40%	60%	80%	100%

PILLAR 4: IMPROVING PUBLIC HEALTH SECURITY AND CLIMATE RESILIENCE

		Source plan/ Program	Frequency of Measurement	Source of Data/Means of Verification	Responsible Entity						
ID	Result Indicators					2025	2026	2027	2028	2029	2030
15.	Number of States with a public health emergency fund with a governance framework backed by law	HeSP Nigeria	Annually		NCDC	Not Due	0	7	17	27	37
16.	Number of States where at least 50% of Secondary health facilities meet AMR/IPC standards	HeSP Nigeria	Annually	NCDC Reports	NCDC	Not Due	0	20	30	37	37
17.	Number of States demonstrating comprehensive emergency coordination capacity	HeSP Nigeria	Annually	NCDC Reports	NCDC	Not Due	0	20	30	37	37
18.	Cumulative Number of People benefitting from climate-resilient health planning and response	HeSP Nigeria	Annually	NCDC Reports	NCDC	Not Due	0	45,000,000	90,000,000	135,000,000	180,000,000

MONITORING, EVALUATION, AND REPORTING SYSTEMS

The M&E system for the Health Compact is designed to ensure robust tracking of progress, facilitate evidence-based decision-making, and promote accountability among all stakeholders. It integrates data from multiple sources and establishes a clear cadence for reporting and joint reviews.

1. Monitoring and Evaluation Plan

The M&E plan is the foundational element of the results framework, providing a comprehensive approach to data collection, analysis, and utilization. It operates through a mixed-methods approach, combining routine administrative data with periodic surveys to ensure data quality and provide a holistic view of performance.

a. Use of Administrative Data

Routine administrative data forms the backbone of continuous monitoring for the Health Compact. Key systems will be leveraged to track progress against the result indicators on a high-frequency basis. These systems include:

- **District Health Information System (DHIS2):** For service delivery indicators such as skilled birth attendance, immunization coverage, and utilization of digital health services.
- **Human Resource Information System (HRIS):** To track the deployment and distribution of the health workforce.
- **Logistics Management Information System (LMIS):** To monitor the availability of essential medicines and commodities.
- **National Health Insurance Authority (NHIA) and State Health Insurance Agency (SSHIA) Databases:** To verify enrollment numbers for financial protection schemes.

Data from these systems will be aggregated into a central dashboard, providing real-time insights to program managers at the federal and state levels. The focus will be on improving the quality and completeness of this data through regular data quality assessments (DQAs) and capacity building.

b. Use of Surveys

Periodic surveys are essential for validating administrative data and measuring outcomes and impacts that are not captured through routine systems. The M&E plan incorporates several types of surveys:

- **National Demographic and Health Surveys (NDHS) and Multiple Indicator Cluster Surveys (MICS):** These large-scale national surveys will serve as the primary source for baseline and end-line measurement of high-level impact indicators, such as mortality rates.
- **Annual Performance Assessment (APA) Surveys:** An Independent Verification Agent (IVA) will conduct annual small-scale surveys as part of the APA process. These surveys will be used to verify the results reported through administrative data, conduct spot checks, and provide an independent assessment of performance against the indicators. This is crucial for the results-based financing component of the Compact.
- **Thematic Surveys:** Targeted surveys may be commissioned to investigate specific issues, evaluate the effectiveness of particular interventions, or gather qualitative insights into barriers and enablers of progress.

2. Mid-Year Supervisory Reports

A formal mid-year review process will be conducted to assess progress and identify implementation bottlenecks. By July 31st of each year, all implementing entities at the state level will be required to prepare and submit a Mid-Year Supervisory Report to the national SWAp Secretariat. These reports will detail:

- Progress against the annual targets for each result indicator.
- Financial performance, including budget execution rates.
- Key challenges encountered and the corrective actions taken.
- An updated work plan for the second half of the year.

The reports will be reviewed by the national program management team, and feedback will be provided to the states to guide course correction and ensure that the program remains on track to achieve its annual objectives.

3. Annual National Health Program Reports

At the end of each calendar year, a comprehensive Annual National Health Program Report will be produced. This report will synthesize data from all administrative and survey sources to provide a definitive statement on the performance of the Health Compact for the year. The report will be the primary instrument of accountability and will include:

- A summary of achievements against the annual targets for all 17 result indicators.
- An analysis of performance trends across states and pillars.
- A detailed financial report, reconciling funds disbursed with results achieved.
- Case studies and lessons learned from high- and low-performing areas.

The preparation of this report will be led by the FMoH SWAp Secretariat, with input from all participating states and partners. The final report will be publicly disseminated to ensure transparency.

4. Joint Annual Reviews and State of Health Report

The Joint Annual Review (JAR) is a cornerstone of the SWAp accountability mechanism. Held each year, the JAR brings together all Health Compact stakeholders, including federal and state government representatives, development partners, civil society organizations, and the private sector. The JAR will serve several functions:

- To publicly reaffirm commitments to the Health Compact.
- To collectively review the findings of the Annual National Health Program Report and the independent verification results from the IVA.
- To engage in a high-level policy dialogue on the key strategic issues facing the health sector.
- To make collective decisions on priorities and resource allocation for the upcoming year.

5. Research and Learning Agenda

To foster a culture of continuous improvement and adaptive management, the M&E framework is intrinsically linked to a proactive Research and Learning Agenda. This agenda will be a dynamic, stakeholder-driven process to systematically generate, synthesize, and utilize evidence to inform policy and program adjustments. Key components include:

- **Annual Learning Priorities:** Each Joint Annual Review will set a small number of high-priority learning questions for the upcoming year, focusing on persistent challenges or strategic uncertainties.
- **Targeted Evaluations:** The Health Compact will commission in-depth evaluations and operational research studies to explore these learning questions. This may include process evaluations, implementation research, and cost-effectiveness analyses.
- **Knowledge Translation:** A dedicated translation strategy will ensure that findings from M&E and research are packaged into accessible formats (e.g., policy briefs, case studies, and workshops) and disseminated to relevant decision-makers.
- **Feedback Loops:** The agenda will establish formal feedback loops, ensuring that lessons learned from implementation and research are used to refine strategies, re-prioritize interventions, and inform the design of future health sector initiatives.

By embedding this learning agenda within the results framework, the Health Compact will evolve from a static performance contract into a dynamic system for driving sustainable, evidence-based improvements in Nigeria's health sector.