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Report No: PAD1741

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 88.2 MILLION

(US$125 MILLION EQUIVALENT)

AND

A GLOBAL FINANCING FACILITY (GFF) GRANT

IN THE AMOUNT OF US$20 MILLION

TO THE

FEDERAL REPUBLIC OF NIGERIA

FOR THE NIGERIA STATE HEALTH INVESTMENT PROJECT (NSHIP)

May 24, 2016

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2016)

Currency Unit	=	NGN (Nigerian Naira)
US$1	=	Naira 197
US$1	=	XDR 0.70555199

FISCAL YEAR

January 1	–	December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
ANC	Antenatal Care
CSO	Civil Society Organization
CBO	Community-Based Organization
CMVA	Contract Management and Verification Agency
DFF	Decentralized Facility Financing
DLI	Disbursement Linked Indicator
EEP	Eligible Expenditure Program
FMOH	Federal Ministry of Health
FPFMD	Federal Project Financial Management Department
GFF	Global Financing Facility
GON	Government of Nigeria
GRS	Grievance Redress System
HMIS	Health Management Information System
IDP	Internally Displaced People
ISR	Implementation Status and Results Report
IVA	Independent Verification Agent
LGA	Local Government Area
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MPS	Minimum Package of Service
NE	North East
NETSP	North East Emergency Transition and Stabilization Program
NPHCDA	National Primary Health Care Development Agency
NSHIP	Nigeria State Health Investment Project
PBF	Performance-Based Financing
PCNI	Presidential Coordination Committee on North Eastern Intervention
PDO	Project Development Objective
PHC	Primary Health Care
RPBA	Recovery and Peace Building Assessment
RBF	Result-Based Financing
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SOML PforR	Saving One Million Lives Program for Results
SPHCDA	State Primary Health Care Development Agency
TA	Technical Assistance
YLL	Years of Life Lost

Regional Vice President:	Makhtar Diop
Global Practice Vice President:	Keith Hansen
Country Director:	Rachid Benmessaoud
Practice Manager:	Trina Haque
Task Team Leader:	Ayodeji Oluwole Odutolu

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ADDITIONAL FINANCING DATA SHEET

Nigeria

Additional Financing Nigeria State Health Investment Project (P157977)

AFRICA

GHNO7

Basic Information – Parent			
Parent Project ID:	P120798	Original EA Category:	B - Partial Assessment
Current Closing Date:	30-Jun-2018		

Basic Information – Additional Financing (AF)			
Project ID:	P157977	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B - Partial Assessment
Country Director:	Rachid Benmessaoud	Expected Effectiveness Date:	10-Oct-2016
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	30-Jun- 2020
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD1741
Team Leader(s):	Ayodeji Oluwole Odutolu		

Borrower

Organization Name	Contact	Title	Telephone	Email
Federal Ministry of Finance	Haruna Mohammed	Director, IERD	2348055798172	harunam500@yahoo.com

Project Financing Data - Parent (Nigeria States Health Investment Project-P120798) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P120798	IDA-50940	Effective	12-Apr-2012	16-Apr-2013	20-Aug-2013	30-Jun-2018	30-Jun-2020
P120798	TF-13432	Effective	16-Apr-2013	16-Apr-2013	20-Aug-2013	30-Jun-2018	30-Jun-2018

Disbursements									
Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P120798	IDA-50940	Effective	USD	150.00	150.00	0.00	73.72	66.25	49.14
P120798	TF-13432	Effective	USD	21.70	21.70	0.00	9.65	12.05	44.48

Project Financing Data - Additional Financing Additional Financing Nigeria State Health Investment Project (P157977) (in USD Million)					
[ ] Loan	[X] Grant	[ ] IDA Grant			
[X] Credit	[ ] Guarantee	[ ] Other			
Total Project Cost:	145.00		Total Bank Financing:	125.00	
Financing Gap:	0.00				

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	125.00
Global Financing Facility (GFF)	20.00
Total	145.00

Policy Waivers	
Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Ayodeji Oluwole Odutolu	Team Leader (ADM Responsible)	Senior Health Specialist	Public Health	GHN07
Daniel Rikichi Kajang	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement	GGO01
Adewunmi Cosmas Ameer	Financial Management	Senior Financial Management	Financial Management	GGO25

Adekoya	Specialist	Specialist		
Adam Shayne	Counsel	Lead Counsel	Legal	LEGAM
Alexandra C. Bezeredi	Safeguards Specialist	Lead Social Development Specialist	Social Development	GSU01
Ana Besarabic Bennett	Team Member	Senior Operations Officer	Operations	GHNGE
Benjamin P. Loevinsohn	Team Member	Lead Public Health Specialist	Health	GHN07
Essienawan Ekpenyong Essien	Team Member	Team Assistant	Client Services	AFCW2
Fatimah Abubakar Mustapha	Team Member	Health Specialist	Health	GHN07
Gyorgy Bela Fritsche	Team Member	Senior Health Specialist	Health	GHN07
Johanna van Tilburg	Safeguards Advisor	Senior Social Development Specialist	Safeguards	OPSPF
Joseph Ese Akpokodje	Safeguards Specialist	Senior Environmental Specialist	Safeguards	GEN07
Luis M. Schwarz	Team Member	Senior Finance Officer	Disbursement and Expenditure Tracking	WFALA
Mayowa Oluwatosin Alade	Team Member	Consultant	Health	GHNDR
Michael Gboyega Ilesanmi	Safeguards Specialist	Social Development Specialist	Safeguards	GSU01

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Nigeria	Ondo	Ondo State		X	
Nigeria	Adamawa	Adamawa State		X	
Nigeria	Nasarawa	Nasarawa State		X	
Nigeria	Bauchi	Bauchi State	X		
Nigeria	Borno	Borno State	X		

Nigeria	Gombe	Gombe State	X		
Nigeria	Taraba	Taraba State	X		
Nigeria	Yobe	Yobe State	X		

Institutional Data

Parent (Nigeria States Health Investment Project-P120798)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[X] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	69		
Public Administration, Law, and Justice	Sub-national government administration	24		
Public Administration, Law, and Justice	Public administration-Health	7		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	30
Human development	Population and reproductive health	30
Public sector governance	Other public sector governance	10
Human development	Child health	30
Total		100

Additional Financing Additional Financing Nigeria State Health Investment Project (P157977)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[X] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	75		
Public Administration, Law, and Justice	Sub-national government administration	20		
Public Administration, Law, and Justice	Public administration- Health	5		
Total			100	

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	25
Human development	Population and reproductive health	25
Human development	Child health	25
Public sector governance	Other public sector governance	25
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Consultants will be required.

PROJECT PAPER

I. INTRODUCTION

1. This project paper seeks the approval of the Executive Directors for an additional credit of US$125 million equivalent and a Global Financing Facility (GFF) grant of US$20 million to the Federal Republic of Nigeria, and for the level 1 restructuring of the Nigeria State Health Investment Project (NSHIP) (P120798). The proposed project is being processed under OP 10.00 paragraph 12, referring to projects in situations of urgent need of assistance or capacity constraints. The proposed level 1 restructuring is requested in order to align the project development objective (PDO) to the focus of the proposed Additional Financing (AF). The proposed AF is to scale-up the parent project to the States in the North East (NE) of Nigeria (Bauchi, Borno, Gombe, Taraba and Yobe) which have been affected by the conflict. The proposed AF will be adapted to the specific conditions in the NE by the following changes:

a. Reinforcing services under Performance-Based Contracting (PBF) Component 1.A.1 in the original project while dropping the disbursement-linked indicators (DLIs) Eligible Expenditure Program (EEP) approach under component 1.B.1 in the original project;
b. Adding a new component that supports contracting with non-state actors;
c. Adding a new 'just-in-time' component to respond to changing circumstances; and
d. Modifying the approach to technical support (component 2) of the original project.

2. The original project was approved on April 12, 2012, for an amount of US$150 million and a grant of US$20 million from Health Results Innovation Trust Fund (HRITF). Subsequently, an additional US$1.7 million from HRITF was approved on March 20, 2014 for a total of US$21.7 million from HRITF. With the proposed AF, the closing date for the project will be extended by two years to June 30, 2020.

3. According to the latest Implementation Status and Results Report (ISR) (Dec. 2015), project performance is rated Satisfactory on progress towards achievement of the PDOs and for implementation progress (IP). The ISR ratings over the last 12 months have been consistently rated as Satisfactory. Also, key loan covenants, including audit and financial management reporting requirements, have been complied with. As of today, the project has disbursed in total US$73.7 million from IDA and US$9.7 million from the HRITF grant which translates to 49 percent IDA disbursement and about 45 percent HRITF disbursement in about two years of effectiveness. The project has rapidly scaled up PBF in 26 Local Government Areas (LGAs) and its equivalent (decentralized facility financing DFF) interventions in all the remaining 26 LGAs by January 2015. Results have been gratifying. Apart from improvement in service delivery, there has also been significant strengthening of the health system. The mid-term review is scheduled for March 2017. NSHIP meets the requirement for AF that a project is "well-performing."

4. On August 21, 2015, the Government of Nigeria (GON) requested donors' assistance in assessing the needs associated with peace building and crisis recovery. The Recovery and Peace Building Assessment (RPBA) of the NE region was conducted by the World Bank, EU, and UN in partnership with the Federal Government and confirmed the extensive damage to livelihoods and job opportunities especially in term of attacks on markets and farms. The RPBA provides a framework for coordinated and coherent assistance to conflict-affected communities in the Northeast. It identifies the immediate and urgent need for sustaining emergency transition activities while supporting in parallel stabilization initiatives along the

three strategic areas of intervention, namely: (a) peace building and social cohesion; (b) infrastructure and social services; and (c) economic recovery (see Annex 4).

5. According to the RPBA, about fifteen million people have been affected by the insurgency of Boko Haram in the NE of Nigeria since 2009. It is also estimated that over 20,000 lives have been lost and over 2 million people have been displaced. The displacement has created several vulnerabilities. It is estimated that only about 10 percent of Internally Displaced People (IDPs) are living in identifiable IDP camps. Most of the IDPs are living in "host" communities clustered around the State capitals of Borno and Yobe States, Maiduguri and Damaturu, respectively. For example, it is believed that 60 percent of the population of Borno State is now in Maiduguri. There has been some return of IDPs to their original communities and this may accelerate depending on the perceived security situation.

6. The overall impact of the conflict on infrastructure and social services is estimated at US$9.2 billion. Three quarters of the damages are in Borno (US$6.9 billion), followed by Yobe (US$1.2 billion) and Adamawa (US$828.9 million). The impact on the other three NE States and at the federal level are less than three percent of the direct damages and impacts. The table below provides a detailed overview.

Table 1. Estimated Damages Related to Infrastructure and Social Services (in US$ Million)

	Adamawa	Borno	Yobe	Gombe	Taraba	Bauchi	Federal	Total
Physical Sectors								
Energy	31.9	16.0	4.3	–	7.0	–	129.5	**188.7**
Environment	1.2	2.9	0.6	0.2	0.8	<0.1	–	**5.7**
ICT	–						–	**25.1**
Transport	73.8	306.1	116.9	29.0	–	–	–	**525.8**
Social Sectors								
Education	58.0	143.8	47.3	2.1	10.2	11.6	–	**273.0**
Health/Nutrition	21.1	59.0	32.9	0.4	6.5	27.8	–	**147.7**
Housing	25.8	3,179	118.3	2.9	2.8	1.2	–	**3.329.9**
Public Buildings	2.3	15.3	14.5	1.1	–	2.3	–	**35.5**
Social Protection	–	–	–	–	–	–	–	**n.a.**
Water and Sanitation	7.3	35.0	3.6	–	–	–	–	**46.0**
Productive Sectors								
Agriculture	457.9	2,377.7	868.7	4.9	12.0	7.6	–	**3,729.7**
Private Enterprises	149.8	763.6	<0.1	2.0	–	<0.1	–	**915.4**
Total	**828.9**	**6,898.5**	**1,207.2**	**42.5**	**39.2**	**50.5**	**129.5**	**9,221.5**

7. **Current Conditions are Grim**: Health conditions in the NE were grim before the insurgency started with access and utilization of health services being very low by Nigerian standards. The insurgency has caused significant damage to the health system, particularly primary health care (PHC), and prevented any substantial improvement in health conditions. In some places, particularly parts of Yobe and Borno, the insurgency has destroyed so much of the health system that services in some LGAs have collapsed. The health services for IDPs in camps are generally being provided by humanitarian organizations and the government which has established an extensive network of health facilities, much of it with external funding.

II. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Background

8. **Government Strategy**: President Buhari has established the Presidential Coordination Committee on North East Interventions (PCNI) to coordinate and provide leadership for various interventions in the NE initiated by governments, development partners, charitable organizations and civil society. The Government has also committed to significantly scaling up investments in this geopolitical zone. The key objectives of the PCNI include: (a) promotion of civic culture that is supportive of peaceful co-existence; (b) access to basic services and infrastructure; (c) increase in the production capacity and wealth creation in the zone; (d) acceleration of access to quality education; and (e) development and well-being of citizens living in the NE.

9. At the sectoral level, the Federal Ministry of Health (FMOH) is rolling out a country-wide strategy of ensuring at least one fully functional primary health center per ward. It has committed funds to rendering functional 10,000 facilities over the next two years. Fully functional means that the facility is able to provide: (a) 24 hour per day care, including skilled obstetrical services; (b) a reasonably broad package of health services, including nutrition, family planning, clinical HIV services; and (c) effective outreach services to the communities aimed at increasing the coverage of preventive and promotive interventions. This AF will leverage government investment from this initiative, especially in areas of substantial destruction.

10. **The Bank's Response and Alignment with Government Strategy:** The World Bank Group (WBG) response includes support to conducting the RPBA to assess the crisis recovery needs. The RPBA has been led by the Government and was undertaken in collaboration with the EU, WBG and UN. The RPBA was prepared in parallel and at the same time, informed the design of the North East Emergency Transition and Stabilization Program (NETSP) which initially targets the short and medium-term recovery, stabilization and peace building needs. The proposed NETSP comprises a coordinated set of six AFs across the Human Development (HD) and Agriculture Global Practices (GPs). The AFs comprise the following IDA-financed projects: (a) Community and Social Development Project (CSDP), (b) Youth Employment and Social Support Operation (YESSO), (c) State Education Program Investment Project (SEPIP), (d) Polio Eradication Support Project, (e) the Third National Fadama Development Project AF2 and (f) NSHIP.

11. **Synergies within the Proposed Northeast Emergency Transition and Stabilization Program (NETSP):** The five HD operations and the Agriculture project, FADAMA III AF, are included in the NETSP and structured as a coordinated umbrella program that includes interventions/approaches that can rapidly be scaled-up or re-engineered to benefit the vulnerable populations in the NE. The coordinated approach will ensure the greatest synergy and avoid duplication. The use of selective AFs will enable the most efficient response drawing on specific existing Federal, State, community, and non-state institutional capacities, as well as project management structures and relationships. The proposed operations will include a number of coordinated activities including: (a) psycho social support at community level (through CSDP), focused non-specialized services in health facilities and schools (through SEPIP and NSHIP) and specialized services at the hospital level (through NSHIP); (b) coordinated monitoring of use of services by the community through a common-platform telephone survey; (c) target cash transfers to increase demand for services financed through YESSO; (d) restoration of agricultural production activities through provision of starter

packages to affected farming households, including required agricultural inputs and on-farm and post-harvest productive assets to support economic opportunities of farming households; and (e) rebuilding of damaged community social and natural resources management infrastructure through CSDP.

12. **The proposed operation (AF) is fully aligned with the Country Partnership Strategy (CPS)**: The AF is fully aligned with the World Bank Group's Country Partnership Strategy FY14 - FY17 (report # 82501) discussed by the Executive Directors on April 24, 2014. It lies at the heart of the second cluster which aims to improve the "effectiveness and efficiency of social service delivery at State level for greater social inclusion." With its emphasis on encouraging innovation that achieves improved results, particularly for the poor, while making more efficient use of resources, this operation wholly supports the CPS's objective of addressing "inequities in income and opportunities" by "developing more effective mechanisms of social service delivery." By addressing the challenges of fragility, conflict, and violence, the AF will also help Nigeria deal effectively with the "shocks" associated with the insurgency in the NE. The AF is also aligned to meet three out of the seven needs identified for the health sector in the RPBA and the indicators for measuring success are included in the result framework.

13. **The NE lags far behind the rest of Nigeria:** Health conditions in the NE States are among the worst in the country and the zone lags far behind the other geopolitical zones (except the North West). For example, under 5 mortality rates (U5MR) are 54 percent higher than in the south of Nigeria and malnutrition rates are even worse. Stunting rates are 125 percent higher (see table 1) than in Southern States and have seen little improvement over the last decade. Service delivery is also substantially worse than in the South (in 2013 DPT3 immunization coverage was only 20.6 percent in the NE compared to 72 percent in the southern zones). Based on these results and as part of the government's overall strategy for development of the NE, the government has requested urgent World Bank assistance in rapidly strengthening health service delivery in these States. In response, the Bank will provide AF to the NSHIP of US$125 million to address this challenge.

Table 2. Key Health Outcomes and Outputs by Geopolitical Zone

Indicator	North-East	North-West	North Central	South-South	South-West	South-East
Under 5 Mortality Rate	160	185	100	91	90	131
Stunting (low height for age) %	42.3	54.8	29.3	18.3	22.2	16.0
Total Fertility Rate	6.3	6.7	5.3	4.3	4.6	4.7
DPT3 Vaccination coverage, %	20.6	13.9	43.9	69.8	65.5	80.7
Skilled Birth Attendance, %	19.9	12.3	46.5	55.4	82.5	82.2

Source: National Demographic Household Survey 2013.

14. **Limited progress in the last few years:** The Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey results from 2014 and 2015 (see table 3) lead to some important conclusions, including:

(i) Despite starting from coverage levels much lower than the rest of the country, the NE States have made slower than average progress;
(ii) Borno is doing surprisingly well, possibly because there are so many displaced people living around Maiduguri who now actually have physical access to health services within IDP camps and more functional health facilities in the city (the situation could deteriorate quickly if families move back to communities where health services are limited);

(iii) Yobe is the worst performing State in the NE and has seen a worsening of results in the last couple of years;
(iv) Adamawa is doing very well in terms of maternal care and family planning; and
(v) All states are doing worse on Vitamin A in 2015 compared to 2014 indicating issues with Maternal Neonatal and Child Health (MNCH) weeks and with outreach activities more broadly.

Table 3. SMART Household Survey Results - 2015 and Changes from 2014

	Vitamin A		Penta3		Measles		Skilled Birth Attendance		CPR (Modern)	
State	**2015**	**Change**	**2015**	**Change**	**2015**	**Change**	**2015**	**Change**	**2015**	**Change**
Adamawa	33.2	−27.9	45.4	−6.2	61.1	+1.0	37.8	+18.4	22.9	+14.3
Bauchi	13.6	−24.8	14.9	−5.8	23.8	−17.0	25.5	+2.2	13.1	+5.3
Borno	13.8	−14.3	32.0	+12.6	27.9	+0.8	29.3	+16.1	0.7	−0.3
Gombe	8.8	−29.8	23.9	−7.5	34.4	−16.5	46.9	+11.1	14.7	+3.7
Taraba	8.1	−38.8	26.0	−9.5	50.0	−22.7	32.7	+0.6	21.6	+12.6
Yobe	7.7	−34.1	7.8	−4.7	7.1	−19.5	9.0	−0.6	1.3	−1.1
National	41.9	−7.0	48.8	−3.4	50.6	−11.1	47.3	+4.9	20.2	+5

Note: Penta3 = Pentavalent vaccine 3rd dose. CPR=Contraceptive Prevalence Rate.
Source: National Bureau of Statistics.

15. **RPBA Findings on Health Services:** The RPBA found that about 20 percent of health facilities were damaged or destroyed in the six NE states at a replacement cost of about US$150 million. The RPBA observed that health facilities were deliberately targeted by the insurgents and besides damage to the infrastructure and equipment, drugs were stolen and health workers threatened. Figures 1 and 2 below and the maps in Annex 4 lead to the following conclusions:

(i) Yobe and Borno are most affected: There is significant variation in the proportion of health facilities damaged or destroyed, with the damage being much more extensive in Yobe and Borno than in the other States;
(ii) Many PHC facilities have been damaged but not destroyed: In Yobe and Borno many facilities have been damaged but not destroyed suggesting that in part of those States it may be possible to restore services relatively quickly, whereas other areas will require considerable effort to re-establish health services; and
(iii) PHC more affected than hospitals: With the exception of Adamawa, the damage to PHC facilities has been proportionately more extensive than to hospitals (there are obviously many more PHC facilities than hospitals). Thus the priority should be given to PHC, especially since poor people and rural communities use PHC facilities disproportionately.

Figure 1. Proportion of PHC Facilities Damaged or Destroyed by State

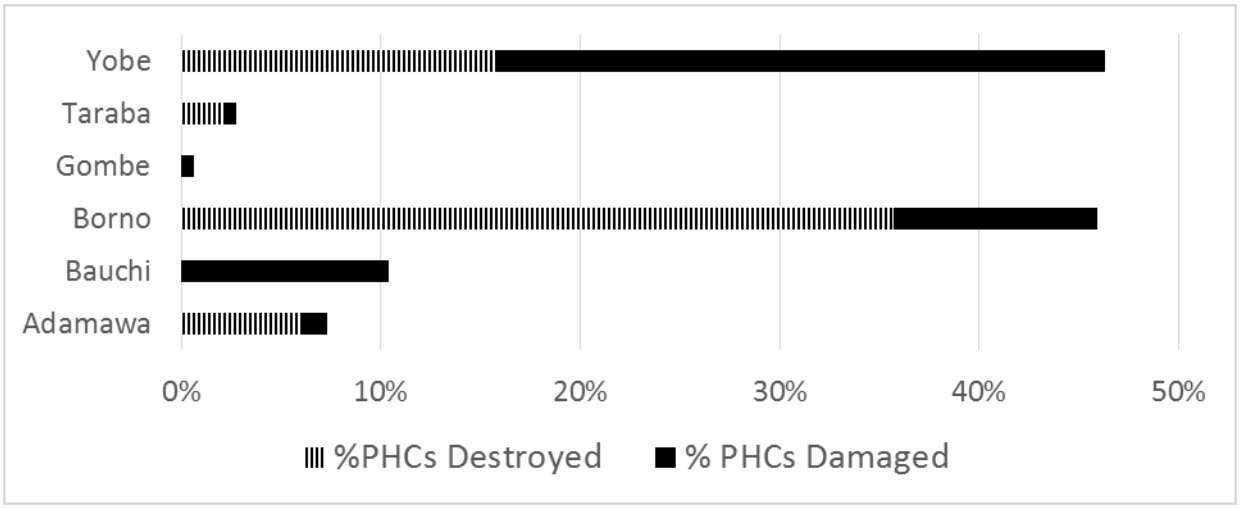
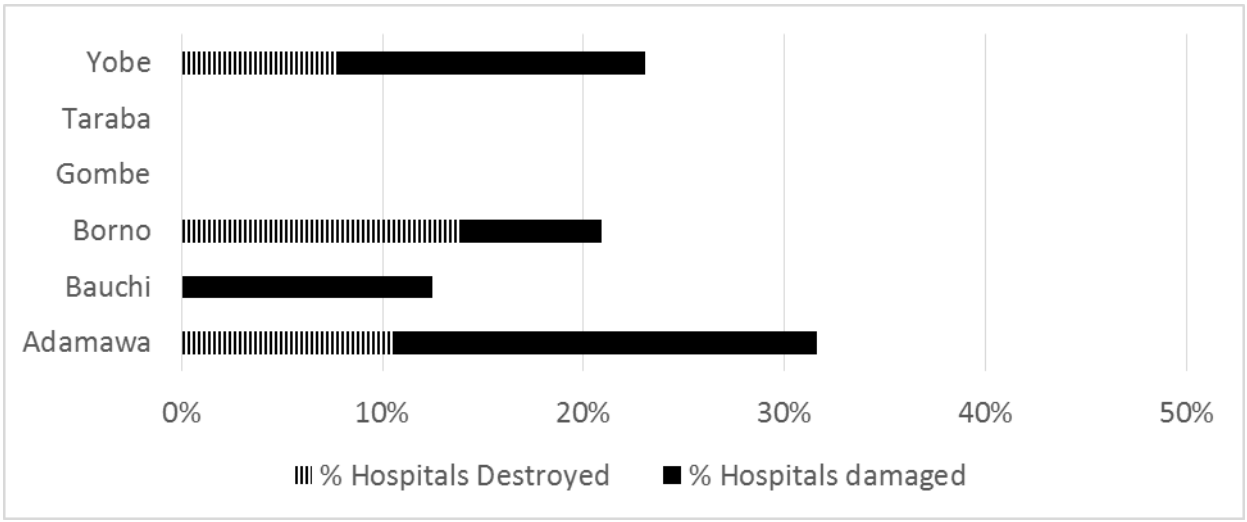


Figure 2. Proportion of Hospitals Damaged or Destroyed by State



Source: State Ministries of Health.

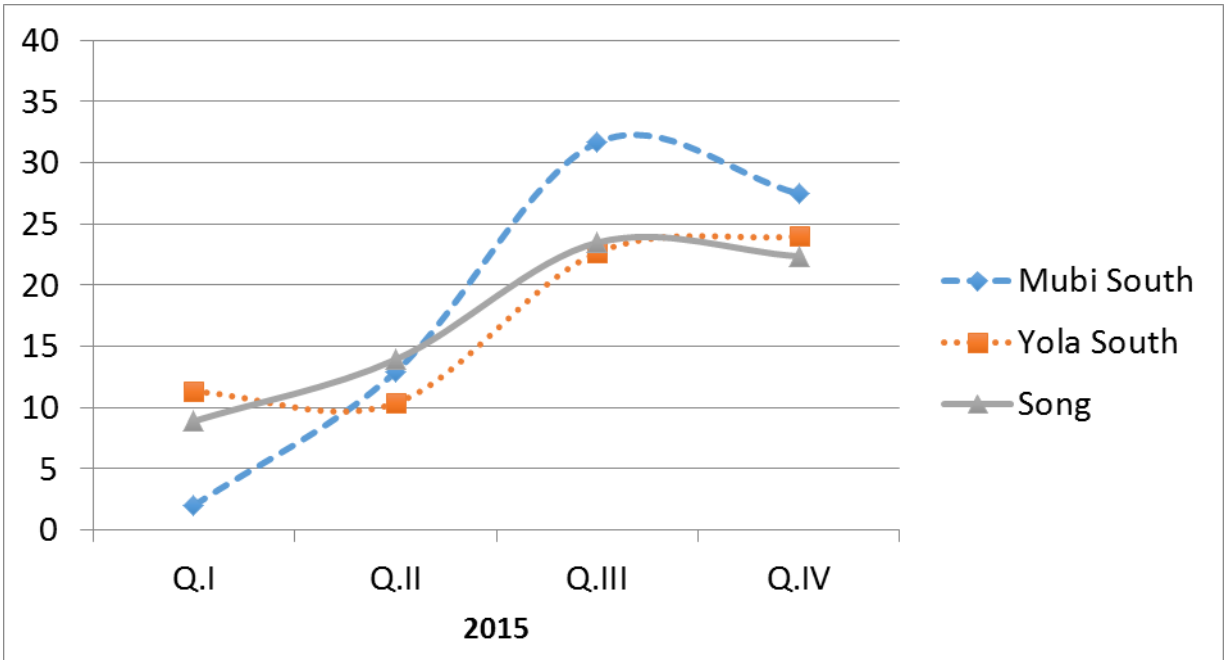
Box 1. Lessons from Adamawa: Using PBF in Conflict-Affected Areas

Boko Haram invaded and captured seven of the 21 LGAs in Adamawa State in October 2014. The insurgents were in complete control of these areas until early February 2015 when five of the occupied LGAs were secured by the Nigerian military. Basic health services were completely shut down with many health facilities damaged with equipment and drugs stolen.

In February 2015, the leadership of Adamawa State Primary Health Care Development Agency (SPHCDA) was faced with the problem of providing health care to the civilians returning to these LGAs as the military was gaining the upper hand in the five affected LGAs. Fortunately, staff in one of the affected LGAs, Mubi South, had been trained in performance based financing in September 2014 and they were in the process of developing their business plans. To address the situation in Mubi South: (i) initial investment was doubled for all affected health centers (from US$5,000 to US$10,000), in the district hospital (from US$10,000 to US$20,000); and (ii) health workers were supported to return to their duty posts. As in other PBF LGAs, decision making was decentralized, there was a high degree of community involvement, and the performance bonuses were used to improve outreach as well as infrastructure.

Since there were secure LGAs which began implementation of PBF at about the same time (Yola South and Song), it's possible to judge how well PBF performed in a conflict affected LGA, like Mubi South. As can be appreciated from Figure 3, Mubi South performed at least as well as the other LGAs and made rapid progress in attracting patients. The findings were similar for skilled birth attendance, immunization, and family planning, indicating that PBF can work well in an LGA which was just recently secured.

Figure 3. Out-Patient visits per 100 Population in a conflict affected LGA implementing PBF (Mubi South) and LGAs implementing PBF not directly affected by conflict



16. **Global Financing Facility (GFF):** The GFF is a country-driven partnership that aims to improve reproductive, maternal, neonatal, child, and adolescent health (RMNCAH). The GFF is the key financing platform of the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescents' Health (2016 - 2020). It aims to drive change with its focus on national leadership, alignment of financing behind strategic investments linked to results, encouraging innovation, including much more work with the private sector, and improvements in local health financing systems. To do this, the GFF mobilizes additional funding through the combination of grants from a dedicated multi-donor trust fund (the GFF Trust Fund), financing from IDA and IBRD, and the crowding-in of additional domestic and external resources.

17. **The proposed AF represents a sensible vehicle for delivering GFF goals**: The proposed AF represents a sensible means for achieving the objectives of the GFF, specifically: (a) it focuses on strengthening RMNCAH; (b) it does so in a part of the country where maternal and child health outcomes are lagging far behind; (c) it responds to a Government request from the highest levels to meet a pressing need; (d) it is associated with an IDA operation that uses innovative and results-based approaches; and (e) it has already benefited from extensive coordination and consultation with civil society and development partners and provides opportunities for both to be involved in implementation. In order to access the GFF trust fund resources, countries need to develop an Investment Case (IC) and a health care financing strategy and this work has already started. The Government has established technical working groups to complete both requirements and the latter will be supported by an ongoing Health Financing Systems Assessment. The aim is to develop the investment case and health financing strategy in the first year of the implementation of the AF.

B. Rationale for Additional Financing

18. **Rationale for AF – Scaling-up coverage and restructuring the original operation to adapt to NE context:** The rationale for preparing the proposed AF is to scale-up the success of PBF and to restructure the original operation to better respond to the exigencies of the NE. The use of AF is to respond to the urgent request from Government to address the conflict situation affecting the NE at a time when there are serious fiscal constraints as a result of the fall in oil price in the international markets.

19. **AF assures timely response:** Using AF reduces the project preparation time and allows the Bank to quickly respond to the request of government. Secondly, the original project is being successfully implemented in Adamawa State which is similarly affected by insurgency. The emergency response will help in the immediate and effective provision of basic health services to internally displaced person, host communities and the entire population.

III. PROPOSED CHANGES

Summary of Proposed Changes	
The Additional Financing would result in scaling up the operation to five additional States in the NE aside from Adamawa, including Borno, Yobe, Bauchi, Gombe and Taraba. As a results, the project results framework, closing date, disbursement arrangements, disbursement estimates, components and cost and implementation schedule would change.	
Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [X] No [ ]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [X] No [ ]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [X] No [ ]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results
Project's Development Objectives
Original PDO
To increase the delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities in the participating states.
Change in Project's Development Objectives
Explanation:
The change in the PDO reflects the spatial concentration of the AF on the NE and the increased focus on bringing services closer to the community. The new PDO also reflects the emergency support that will help build resilience for service delivery in conflict situation.
Proposed New PDO - Additional Financing (AF)
To increase the delivery and use of high impact maternal and child health interventions and improve quality of care available to the people in Nasarawa and Ondo and all the States in the NE.

Change in Results Framework

Explanation:

The change in the PDO reflects the spatial concentration of the AF on six states in the NE (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe) and the increased focus on bringing services closer to the community. The revised results framework includes additional indicators to capture new elements that are proposed in the AF, revised targets, and data disaggregation to track the NE States together. An additional intermediate indicator was included to track citizen engagement.

Compliance

Covenants - Additional Financing (Additional Financing Nigeria State Health Investment Project - P157977)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
IDA	Project Implementation Manual	Financing Agreement: Section II A.1 Not later than July 15, 2016, the Recipient shall revise and adopt the Project Implementation Manual in form and substance satisfactory to the Association.	15-Jul-2016	☐		New
IDA	Appointment of Independent Auditor	Financing Agreement: Section III B.4 The Recipient shall, not later than six months after the Effective Date, appoint the independent auditors referred to in Section 4.09(b) of the General Conditions, in accordance with the provisions of Section IV of this Schedule,	28-02-2017	☐		New

		with qualifications, experience and terms of reference satisfactory to the Association.				

Conditions

Source Of Fund	Name	Type
IDA	Additional Conditions of Effectiveness	Effectiveness

Description of Condition

Financing Agreement: ARTICLE IV 4.01.(a) that at least one Subsidiary Agreement, satisfactory to the Association, has been executed on behalf of the Recipient and one NE State; and

Source Of Fund	Name	Type
IDA	Additional Conditions of Effectiveness	Effectiveness

Description of Condition

Financing Agreement: ARTICLE IV 4.01.(b) that all conditions for the effectiveness of the GFF Grant Agreement, except for the effectiveness of this Credit, have been met.

Source Of Fund	Name	Type
IDA	Additional Legal Matter	Effectiveness

Description of Condition

Financing Agreement: ARTICLE IV 4.02 that the Subsidiary Agreement referred to in Section 4.01(a) of this Agreement has been duly authorized or ratified by the Recipient and the NE State and is legally binding upon the Recipient and the NE State in accordance with its terms

Source Of Fund	Name	Type
IDA	Withdrawal of the Proceeds of the Financing	Disbursement

Description of Condition

Financing Agreement: Section V B.1 No withdrawal shall be made: (b) for payments under Categories (1) and (2) made to any NE State unless and until: (i) the respective NE State has entered into a Subsidiary Agreement with the Recipient; and (ii) the Association has received an opinion satisfactory to it establishing that the Subsidiary Agreement has been duly authorized or ratified by the Recipient and the respective;

Source Of Fund	Name	Type
IDA	Withdrawal of the Proceeds of the Financing	Disbursement

Description of Condition

Financing Agreement: Section V B.1 No withdrawal shall be made: (c) for payments under Category (1) for any Grant unless the respective NE State has entered into a Grant Agreement, satisfactory to the Association, with the respective Beneficiary; and

Source Of Fund	Name	Type
IDA	Withdrawal of the Proceeds of the Financing	Disbursement

Description of Condition

Financing Agreement: Section V B.1 No withdrawal shall be made: (d) for payments under Category (3) unless the Recipient has signed at least seven (7) contracts for CMVAs and five (5) contracts for independent verification agencies to conduct the monitoring and verification in all six of the NE States.

Risk

Risk Category	Rating (H, S, M, L)
1. Political and Governance	High
2. Macroeconomic	High
3. Sector Strategies and Policies	Low
4. Technical Design of Project or Program	Low
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Substantial
8. Stakeholders	Substantial
9. Conflict	High
OVERALL	High

Finance

Loan Closing Date - Additional Financing (Additional Financing Nigeria State Health Investment Project - P157977)

Source of Funds	Proposed Additional Financing Loan Closing Date
IDA	30-Jun-2020

Loan Closing Date(s) - Parent (Nigeria States Health Investment Project - P120798)

Explanation:

With the proposed additional financing and restructuring, the closing date for the project will be extended by two years to June 30, 2020.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-50940	Effective	30-Jun-2018	30-Jun-2018	30-Jun-2020	
TF-13432	Effective	30-Jun-2018	30-Jun-2018	30-Jun-2020	30-Jun-2018

Change in Disbursement Arrangements

Explanation:

With the proposed additional financing, the disbursement estimates are revised.

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

With the proposed additional financing, the disbursement estimates are revised.

Expected Disbursements (in USD Million)(including all Sources of Financing)

Fiscal Year	2016	2017	2018	2019	2020
Total Budget	1,422,684	14,975,089	39,638,150	66,938,033	22,026,043
Cumulative	1,422,684	16,397,773	56,035,923	122,973,957	145,000,000

Allocations - Additional Financing (Additional Financing Nigeria State Health Investment Project - P157977)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	XDR		88,200,000.00	100
		Total:	88,200,000.00	

Components

Change to Components and Cost

Explanation:

20. **Overall Design Approach –** The overall design approach is to maintain part of component one and add a component three for new activities to be implemented by civil society organizations (CSOs).

(i) reinforcing services under PBF (component 1.A.1 in the original project) by including psycho-social support and mental health, nutrition; and extensive community outreach,
(ii) Not using the DFF, component 1.A.2 of the original project which was used to create a counter-factual with additional financial resources to facilitate an impact evaluation;
(iii) dropping component 1B of the original project – not using DLIs because similar DLIs for institutional strengthening have been incorporated in the Saving One Million Lives Program for Results (SOML PforR);
(iv) modifying the approach to technical support (component 2 in the original project) to make it more decentralized through the use of independent contract management and verification agencies (CMVAs) adding a new component that supports contracting with non-state actors to: (a) re-establish health services in LGAs where services have mostly been destroyed; (b) carry out mobile clinics; (c) strengthening management at LGA level; and
(v) addressing demand-side constraints through selective implementation of free care for children under 5 and pregnant women.

21. **Adaptation to the Heterogeneous Situations in the NE States:** Building on the findings of the RPBA, there appears to be three broad situations affecting the LGAs in the NE States: (a) LGAs where health facilities have not been damaged but are functioning sub-optimally and where the influx of displaced people may be causing additional challenges (this is the situation in most of Bauchi, Gombe, and Taraba); (b) LGAs in which health facilities may have been damaged but remain open and have at least some staff (the situation in parts of Borno and Yobe); and (c) LGAs where many of the health facilities have been destroyed and where the primary health system is not functioning or barely functioning (the situation in other parts of Borno and Yobe).

22. These three Scenarii will require different approaches which are described in table 4:

Table 4. Approaches in Different Types of LGAs

Scenario/ Typology	A. Minimally Affected	B. Damaged but Functioning	C. Severely Damaged or Destroyed
Facility Functionality	Sub-optimal but staffed and open, infrastructure intact	Seriously affected but still functioning	Not Functioning, staff not in place
Location	Most of Bauchi, Gombe, and Taraba	Parts of Borno and Yobe	Other parts of Borno and Yobe
Major challenges	Inflow of IDPs, poor motivation of staff	Restoring services	Insecurity and re-establishing services where facilities are few
First Phase	**May - Oct. 2016** 1) Start PBF using SOML funds then project funds in 1 LGA	**May - Oct. 2016** 1) Start PBF using SOML funds then project funds in the two most populous LGAs in Borno and Yobe	**May 2016 - Oct. 2017** 1) Mobile teams using "hit and run" approach 2) Re-establishing services through contracts with non-state

	2) Build capacity to manage PBF	where there is a large population of IDPs with substantial initial investments 2) Mobile teams to remote areas	actors (CMVAs). May involve using temporary physical structures and contractual workers
Second Phase	Starting Oct. 2016 Expansion to other LGAs based on ability of States and LGAs to implement PBF effectively and recruitment of CMVA	Starting Oct. 2016 Expansion to 6-8 LGAs per State depending on security situation, with substantial TA through CMVAs	Starting Oct. 2017 CMVAs will introduce PBF to re-established facilities and continued use of mobile teams if necessary.
Coverage	Selected LGAs, expansion based on performance	All LGAs	All LGAs that can be accessed.
Interventions in addition to "regular" PBF	1) Stronger community outreach, 2) More focus on nutrition services 3) Strengthening management at LGA level	1) Psycho-social support and mental health 2) Stronger community outreach 3) More focus on nutrition services 4) Mobile teams using PBF approach 5) Strengthening management at LGA level	1) Psycho-social support and mental health 2) Free care for children and mothers 3) Stronger community outreach 4) More focus on nutrition services 5) Mobile teams using PBF approach 6) Using non-state entities to re-establish

23. **Rapid Phased Approach**: Under Scenarii A and B, the First Phase will involve fast-track implementation of PBF which will begin even before approval of the AF and will rely on funds from the SOML PforR. The fast-track implementation in a few LGAs will provide the best type of capacity building for the SPHCDAs and LGAs as they learn about PBF by doing it as well as through more formal training. In Bauchi, Gombe, and Taraba, the extent and timing of scale-up will depend on objective performance.

24. **First Phase in Yobe and Borno** will focus on LGAs with most of the IDPs: Under Scenario B (Yobe and Borno), the fast-track implementation will be carried out in 2 LGAs each beginning in May 2016 to provide rapid local learning. Rollout will be more rapid and will be supported by additional technical assistance (TA) and greater budgets. In Borno, about 60 percent of the State population currently reside in Maiduguri Municipal council and Jere LGA. It is estimated that there are over one million IDPs in Maiduguri alone. In Yobe, the LGAs of focus will be Damaturu, the State capital and Potiskum, both are safe havens for large numbers of IDPs. This approach will allow a large number of IDPs to be covered quickly with strengthened services. Experience from Adamawa State of seconding PBF clinic staffs to work in IDP camps indicates it is possible to scale up service quickly.

25. **Re-establishing services where they have been destroyed**: Under Scenario C, the first phase will be longer and will focus on establishing health facilities in places where they have been destroyed and where few health workers are available. In this setting, it makes sense to use non-state entities to

ensure rapid re-establishment of health services using whatever arrangements are feasible (contractual workers, renting houses, temporary structures, etc.) and providing "hit and run" mobile services.

26. **Second Phase:** Under Scenario A, the extent and timing of expansion will be dependent on how well the States and LGAs implement PBF. The decision will be jointly taken by government and the association with the NPHCDA in the lead and using the criteria below. The National Primary Health Care Development Agency (NPHCDA) and the Bank will assess the performance based on objective performance criteria such as timely payment of health facilities, reliable supervision and quality verification, rapid recruitment of CMVAs, etc. Further details will be written in the PIM. Under Scenario B, substantial TA will be used to ensure successful scale-up of PBF to as many LGAs as security conditions permit. Under Scenario C, introduction of PBF will occur when the health services have been re-established, which may take a year but may be achieved more quickly. The State governments, under all scenarios, will be responsible for selecting the LGAs.

27. **Ensuring Flexibility to Respond to Changes in Context**: The AF and restructuring uses a number of approaches to increase flexibility in what is a rapidly evolving context:

a) A large amount of contingencies will be available to allow quick responses to emerging challenges;
b) Designing contracts for non-state providers that focus on results rather than processes which will allow them to adapt to the context in the LGA(s) in which they are working. This approach has been shown to work well in insecure areas (e.g., Afghanistan); and
c) Ensuring that health facility managers and the ward development committees that increase accountability, have substantial autonomy and receive funds through electronic transfer to the facility's account so that they can respond to local constraints.

Component 1: Strengthening Service Delivery (Total US$85 million: IDA US$71 million equivalent; GFF US$14 million)

28. **Adapting the original PBF design to the NE Context**: PBF will be implemented in the AF States in much the same way as in the original project but with some additional interventions that will be implemented according to the context. These additional interventions include:

a) **Increased Focus on Malnutrition:** While nutrition-related activities are already included in PBF, additional malnutrition prevention and treatment services will be included in the minimum package of activities, including the management of acute malnutrition, greater attention to micronutrients, and more regular growth monitoring and promotion especially for younger children;
b) **Strengthened Outreach to the Community:** The existing PBF tariff for household visits will be increased but will apply only to households beyond the "comfort zone" of the health facility, i.e. at least 5 kilometers away. The content of the visits will also change to increase the focus on households actually using key services. Third party verification (community client satisfaction surveys) will ascertain the effectiveness of this kind of outreach.
c) **Psycho-Social Support and Mental Health:** Training and ongoing support will be provided to health workers allowing them to recognize, support, and treat victims of gender violence, post-traumatic stress disorder, and mental illness more broadly;
d) **Larger Initial Investments:** In Scenario B, there will be a larger than usual initial investments provided when the facilities sign their PBF contracts with the SPHCDAs. This will allow for minor repairs of facilities, replacement of equipment, and recruitment of specialized staff where needed; and

e) **Free Pediatric and Obstetric Care:** On a temporary basis and in selected Scenarii B and C areas only, facilities will be provided higher than usual PBF tariffs that cover the entire cost of pediatric and maternal care so as to ensure free care to patients. The SPHCDA decides on which LGAs to focus on based on the socio-economic condition and disease burden. The criteria for eligibility will be incorporated into the PIM. Free services will be prominently advertised and the third party verification will be used to ensure patients are not charged any user fees. Sanctions will be applied to any facility caught charging pediatric or obstetric patients.

29. **PBF Fast Track Implementation in Borno and Yobe**: PBF will be fast-tracked in 2 LGAs each in Borno and Yobe States beginning in September 2016 to provide rapid local learning. Rollout will be more rapid and will be supported by additional TA and greater budgets. The Borno State government has selected Maiduguri Municipal council and Jere LGA as front-runner LGAs, partly because they are home to about 60 percent of the State population. There are estimated to be over one million IDPs in Maiduguri alone. In Yobe, the government chose Damaturu, the State capital, and Potiskum, as both contain a large number of IDPs.

Component 2: Technical Assistance (Total US$23 million: IDA US$19.5 million equivalent; GF US$3.5 million)

30. **Technical Assistance to support Phase 1 of the AF**: based on the experience from the original project, NPHCDA and the Bank will procure the services of international and local consultants to provide the needed expertise to the SPHCDAs and the LGAs in order to kick start PBF implementation in the phase 1 LGAs. The initial activities within the TA will include mapping of health facilities, training of local government PHC department staff and managers of health facilities on procedures and processes for mapping of facilities, PBF principles and tools – business plan; verification process etc. Some of this early technical support will be in place before approval of the AF to allow fast-tracked implementation of PBF to begin promptly and to ensure that rapid implementation of all aspects of the project ensues. This TA will also rely heavily on human resources available in Adamawa State and other parts of Nigeria. In addition, TA will be deployed in the first year to support the analytical work and development of the investment case, defining the approach to strengthening birth and death registrations and the health financing strategy in accordance with GFF requirements.

31. **Contract Management and Verification Agencies (CMVAs):** CMVAs will be recruited to cover a few LGAs (roughly 500,000 population) and will be charged with the following tasks: (a) managing the contracts with individual health facilities: (b) carrying out verification of health facility invoices before payment (ex-ante verification); (c) coaching of health facility managers and staff on PBF and how to improve their performance; (d) managing contracts (performance frameworks) with the LGA PHC departments and the hospital management board (HMB); and (e) oversee the quarterly quality verification carried out by the LGA PHC Department and the HMB. The recruitment of the CMVAs is expected to be carried out within six months of effectiveness by NPHCDA with State and development partners' involvement in the recruitment process. The recruitment will be competitive.

32. **Independent Verification Agent:** One Independent Verification Agent (IVA) will be recruited per State to carry out independent verification of quality of care and to organize the quantity verification after payment (ex-post verification). The latter will rely on community client satisfaction surveys (CCSS) carried out by local CSOs. It will sample from the register at four service areas (activities) to ascertain that the individuals actually obtain service at the health facility, the type of service obtained, and the level of their satisfaction. Quality verification will involve assessment of a sample of facilities on a quarterly basis to determine whether quality scores provided by the LGA PHC department and the hospital management board accurately reflect the actual patient experience. The IVAs could be CSOs or university departments,

especially faculties of public health or social sciences. Each State is required to have its own IVA.

Component 3 (NEW): Partnerships to Strengthen Service Delivery (Total $18 million: IDA US$15.5 million equivalent; GFF US$2.5 million)

33. **Mobile Teams**: Mobile teams will visit remote and under-served communities, particularly in Scenarii B and C areas to provide needed services even where health services are currently limited or non-existent. These teams will comprise contractual workers where necessary and may use a PBF approach to incentivize the health workers. They will be organized by CMVAs under contract. In security challenged areas, a "hit and run" approach will be used whereby mobile teams work in a specific area only for a few hours and then leave quickly before their presence is widely known. This "hit and run" approach was found to be effective during polio eradication efforts.

34. **Re-establishing Health Services through CMVAs**: In category C LGAs (i.e., where the health system is mostly not functioning), CMVAs will be charged with quickly re-establishing health services when the security situation is deemed acceptable. The CMVAs will be responsible for re-establishing at least one primary health center per ward and will have considerable autonomy in how they do that, including the use of rented or temporary facilities, contractual health workers, etc. CMVAs will enjoy greater flexibility to adapt to challenging situations and introduce innovative solutions to difficult problems. The contracts will be performance-based so that contractors stand to lose up to 30 percent of their payment if they do not perform well.

35. **Strengthening LGA Management**: There is a broad consensus that the management of LGA PHC departments needs to be considerably strengthened to ensure that service delivery improves quickly. In order to address this problem the SPHCDAs will develop a costed work plan acceptable to the NPHCDA and the Bank by the end of the first phase of the AF. The options for strengthening LGA management include: (a) recruiting an organization (or coordinating with development partners to recruit an organization) that will provide management training, mentoring, and feedback to the SPHCDA and follow-up for existing LGA PHC directors. The performance of the organization will be judged by the CMVAs assessment of LGA performance; (b) replacement of LGA level personnel based on the performance of the LGA as judged by verified PBF results and CMVA assessments; and (c) contracting-in managers for the LGA PHC departments that could be retirees from the public sector, secondees from the private sector, or competitively selected individuals. These contracted managers will bring higher qualifications and greater managerial skills to the LGAs. Since their remuneration will be based partly on the improvements in health facility performance, they will be incentivized to take full advantage of PBF to increase the quantity and quality of service delivery.

Explanation:

Current Component Name	**Proposed Component Name**	**Current Cost (US$M)**	**Proposed Cost (US$M)**	**Action**
Component 1: Results Based Financing using (i) PBF for outputs at health facilities and LGA PHC Departments (ii) DLI at	Component 1: Strengthening Service Delivery	122.4	207.4	Revised

State and LGA levels (iii) DFF at the health facility level to compare with PBF.				
Component 2: Technical Support that will support reforms; institutional strengthening; implementation of PBF and DLI at the State, LGA and facility levels; and monitoring and evaluation (M&E).	Component 2: Technical Assistance	34.0	57.0	Revised
Pre-Project Financing		3.0	-	-
	Component 3 (NEW): Partnerships to Strengthen Service Delivery	0.00	18.00	New
	Contingencies	10.6	29.6	Revised
	Total:	170.00	312.0	

Other Change(s)		
Implementing Agency Name	**Type**	**Action**
National Primary Health Care Development Agency	Implementing Agency	No Change

Change in Institutional Arrangements

Explanation:

n/a

IV. APPRAISAL SUMMARY

Economic and Financial Analysis

Explanation:

36. The overall development impact of the proposed AF will be the health improvement for the women, children and adolescents in the conflict affected States in the NE. To achieve this objective, the Project investments will contribute to strengthening the performance of the health system through continued scaling-up PBF that has been successfully piloted and scaled up State wide in Adamawa, Nasarawa and Ondo States on the parent project (with support of an ongoing World Bank health operation). Through the PBF mechanism, coverage and quality of MNCH services for the population will

be increased, especially in the poorest and most disadvantaged provinces of NE Nigeria where the statistics is discouraging.

37. Component 1 of the Project aims at strengthening health service delivery through PBF and component 2 at strengthening institutional capacity for improved health system performance. The rationale for public sector engagement for this Project is based on the role of the government to promote economic and social goals and their spillover effects. Investments funded through the Project are to strengthen health services delivery through PBF and institutional capacity for improving health system performance (thus increasing utilization and quality of health services for the most vulnerable), thus contributing to universal health coverage. Public sector investment is also key to provide and promote preventive health services and support equity improvements to access good quality MNCH services. Moreover, these interventions have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which justify the role of the government.

38. The economic analysis of the Project draws on empirical evidence, including results from operational data of the PBF pilot and the statewide PBF 2015 results in the 3 States in Nigeria, to demonstrate that the expected benefits outweigh the costs of the proposed interventions in terms of health, poverty and social impacts. Detailed economic and financial analysis conducted during project preparation includes: (a) a cost-effectiveness analysis of the project (what is the incremental cost effectiveness ratio?); (b) a cost-benefit analysis of the project (how much does the project cost per saved life year?) and (c) a financial analysis (how financially sustainable is the project?). The analysis estimates an incremental cost-effectiveness ratio of US$21 specifically for women beneficiaries. From this estimation, the project appears to be cost-effective and comparable to similar interventions in developing countries. The rationale for public sector engagement for this Project is based on the role of the government to promote economic and social goals and their spillover effects. Investments funded through the Project are to strengthen health services delivery through PBF and institutional capacity for improving health system performance (thus increasing utilization and quality of health services, and for the most vulnerable), then contributing to universal health coverage. Public sector investment is also key to provide and promote preventive health services and support equity improvements to access good quality RMNCAH services. Moreover, these interventions have positive externalities and important spillovers (societal returns of investing in women's and children's health for economic growth) which justify the role of the government.

39. The AF will contribute to enhance strategic purchasing in the health system and subsequently will improve allocative and technical efficiency in the health sector. Project investments will contribute also to strengthen the performance of the health system through a Scenarii mechanism and support financial access to health services, particularly for pregnant women and children. Through the combined supply (PBF) and demand-side (free health care), accessibility, coverage and quality of health services for the whole population will be increased. The set of interventions to be included in the RBF-FHC package has proven to be cost effective and evidence suggests that providing this package to mothers and children is highly cost-effective (US$82-142 per DALY averted). In comparison, the expected cost for the PBF scheme is around US$4 per capita per year.

40. Addressing maternal and reproductive health brings dividend in both the short and long terms. The packages of services included in the project is technically sound and consistent with a series of articles in The Lancet, which recommends priority, high-impact interventions to reduce child and maternal mortality rates. Worldwide, pregnancy-related conditions and sexually transmitted infections (STIs) account for one third of the global burden of disease among women of reproductive age and one-fifth among the total population. Among women of reproductive age in Sub-Saharan Africa, for example, two-thirds of the disease burden for women of reproductive age is attributable to sexual and reproductive health problems. AGI and UNFPA calculate that 250 million years of productive life are lost each year to death or

disability resulting from poor sexual and reproductive health (Cohen 2004).

41. Delaying the first birth and spacing subsequent births results in a higher likelihood of women staying in school, having more employment opportunities, and participating politically in their communities. Improved maternal health means fewer orphans and more time for and greater ability of mothers to provide appropriate childcare. One of the most cost-effective interventions is family planning (US$1.55 per new user per year) which can prevent up to one-third of all maternal deaths by delaying childbearing, spacing births, avoiding unintended pregnancies and improve adolescent health by reducing high risk pregnancy-related deaths. For every US$1 invested in family planning, the future savings are as high as US$4 in Zambia, US$7 in Bangladesh and US$8 in Indonesia. Hence, returns on investment are high especially when integrated with MCH services in this project.

Technical Analysis

Explanation:

42. **Evidence of Effectiveness:** PBF's effectiveness depends to a large degree on design and implementation.[1] Design and implementation of the NSHIP PBF approach draws from crucial lessons learned from the successful Rwanda and Burundi scaled-up PBF approaches.[2] Effectiveness from a health economics point of view relates to the level or degree of impact on health benefits. Purchasing through PBF is conditional on quality of health services. While the purchase of services increases the coverage of essential service dramatically (see box below), the focus on quality ensures that these services are of a reasonable quality, and thus effective. Hence the term 'effective coverage'.

43. **Efficiency:** Efficiency gains through PBF are at three levels. The first level is an enhanced allocative efficiency, the second level is a leveraging effect and the third level is a focus on health services that are responsible for a large part of the burden of disease in Nigeria. Enhancing allocative efficiency is achieved by investing additional money at the frontlines with a direct link to quantity and quality results obtained. This additional money, an estimated US$1.25 per capita per year, is responsible for large increases in outpatient consultations, institutional deliveries, use of modern family planning methods and immunizations.

44. The leveraging effects of PBF consist of leveraging existing resources to produce more. These resources consist of human resources, building, equipment, all vertical program support and out of pocket contributions of the population. This effect is illustrated in the box above: large increases in coverage during 2015 were obtained through leveraging existing productive potential, by investing a relatively

[1] See Chapter 17, Fritsche, György Bèla; Soeters, Robert; Meessen, Bruno. 2014. Performance-Based Financing Toolkit. World Bank Training. Washington, DC: World Bank.. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO

[2] Basinga, P., P. Gertler, et al. (2011). "Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation." The Lancet 377: 1421-1428.
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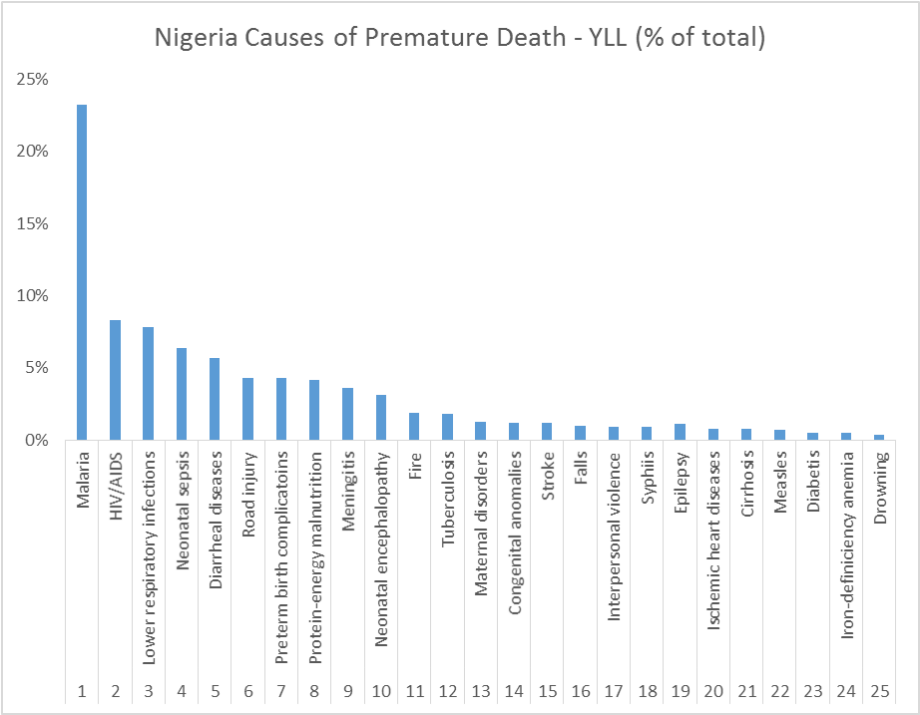
Bonfrer, I., R. Soeters, et al. (2014). "Introduction of Performance-Based Incentives in Burundi was Associated with Improvements in Care and Quality." Health Affairs 33(12): 2179-2187.
Falisse, J.-B., J. Ndayishimiye, et al. (2015). "Performance-based financing in the context of selective free health care: an evaluation of its effects on the use of PHC services in Burundi using routine data." Health Policy and Planning 30: 1251-1260.

small amount of money through PBF approaches).

45. Finally, the minimum and complementary health packages that are purchased through PBF target conditions represent over 71 percent of Years of Life Lost (YLL) in Nigeria.[3] The first ten causes contributing most to the burden of disease in Nigeria are all covered through both levels of the health care system (community/health center and General Hospital). In addition, the interventions targeted through these health packages are also some of the most cost-efficient ones known. (*See figure below).*

Figure 4. Nigeria Causes of Premature Death – YLL (% of total)



Program Implementation: The details of implementation are described in Annex 2.

46. **Geographic Coverage:** The proposed AF and restructuring would expand the original project to cover the remaining five States in the NE aside from Adamawa: Borno, Yobe, Bauchi, Taraba and Gombe. The selection of specific LGAs and facilities will be done during implementation by the State governments taking into account need and security. The proposed NSHIP AF will also target those LGAs that will be covered by other HD operations that are part of the overall emergency response package, specifically SEPIP and CSDP to ensure synergies in terms of services provided to the population and avoid any duplication of effort. Coordination of geographic coverage will be further detailed in the Operations Manual of the HD operations. Annex 3 includes three maps that visually integrate data on health facilities, conflict and IDP displacement.

47. **Advanced Actions:** In order to jump start implementation, the proposed project and restructuring involves a number of advanced actions, including: (a) fast tracked implementation of PBF will begin before effectiveness using resources the States receive under SOML; (b) deployment of TA from existing NSHIP States to the States involved in the AF; (c) recruitment of TA has already begun with agreement on terms of reference with the Government; and (d) recruitment of CMVAs to provide mobile teams and

[3] http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_nigeria.pdf

re-establish services in newly secured LGAs.

Monitoring and Evaluation:

48. **Geographic Focus on the NE:** The change reflects the increased focus on the NE and on bringing services closer to the community. The indicators by which to judge progress towards the PDO will be disaggregated by State, however to keep the results framework (and subsequent ISRs) manageable, results will be clustered by: (a) Nasarawa and Ondo; and (b) all 6 States of the NE.

49. **Using Data from Surveys:** Much of the data to judge progress on the PDO and intermediate indicators will come from surveys that are already being carried out on a regular basis or will be carried out regularly in the context of other initiatives. These surveys are not project-specific but will provide valuable and reliable information on coverage indicators as well as provide valuable feedback from communities.

50. **SMART Household Surveys:** These surveys have been carried out annually since 2012 and for 2014 and 2015 have been conducted in all 36 + 1 States of Nigeria, including Borno and Yobe. They are conducted by the Nigerian Bureau of Statistics with technical support from UNICEF. SMART surveys have a sample size of about 700 households per State and so provide reasonable estimates of progress on key indicators. The quality of SMART data appears quite reasonable as the data is collected on tablets and the results compare closely with other household surveys such as the Nigerian Demographic and Health Survey (NDHS). SMART surveys have been financed by USAID, Department for International Development (DFID), and UNICEF however, the Federal Government of Nigeria (FGON) will help finance the 2016 SMART using resources earned under the SOML PforR.

51. **Annual Health Facility Surveys:** Building on the Bank's experience with the Service Delivery Indicator (SDI) survey carried out in almost 2,500 health facilities in 12 States, the Government has committed to funding annual health facility surveys in all 36+1 States. These surveys will provide very valuable information on quality of care and provide managers with key information on performance of the PHC system. They will be financed by the FGON.

52. **Quarterly Telephone Surveys:** The AF will also take advantage of upcoming automated telephone surveys that will be used to track use of health services by community members and gauge their satisfaction with services received in public facilities. These surveys are being designed to provide reasonably precise results in the NE States and can be done at very low cost.

53. **Health Management Information System:** In addition to the household, health facility, and telephone surveys, the project will also rely on verified information coming from the routine health information system known as the DHIS-2. The DHIS-2 will be strengthened because facilities will have an incentive to improve the recording and reporting and the data will be independently verified.

54. **Updating of Baseline Data:** The PAD for the original project used data from the NDHS 2008 and the HMIS from 2010 as the source of most of the baseline data. However, since PBF was only scaled up in the original 3 States in late 2014, it makes sense to use more recently available data, i.e., the 2014 SMART survey and 2014 Health Management Information (HMIS) results. In addition, health facility survey data for the original three States is available now from the baseline of the impact evaluation for the original three States and from the Service Delivery Indicator (SDI) survey for Bauchi and Taraba. Health facility survey data for the remaining AF States should be available by October 2016.

55. **Changes in PDO Indicators:** The original PDO indicators were: (1) number and proportion of children fully immunized; (2) number and proportion of pregnant women receiving skilled assistance at delivery; (3) quality of care as measured by health facility surveys; (4) number of out-patient visits by

children under 5; and (5) number of total beneficiaries. While these indicators remain valid measures of success, they have been modified to facilitate data collection. The following changes have been made: (a) PDO #1 will be modified from tracking "fully immunized children" to pentavalent 3rd dose as the latter is captured in SMART surveys and in the HMIS; (b) PDO #3 will be modified to focus on structural quality of care measurements such as availability of drugs, skilled personnel, basic equipment, and proper waste management; (c) PDO #4 will be modified slightly to include outpatient visits for all the community not just those under-fives when it comes to absolute numbers but the telephone survey will provide data on use of health services by children; and (d) a HNP core indicator about the number of people with access to essential health services will replace the broader indicator about number of beneficiaries. The NE has been reflected in the PDO and the PDO indicators.

56. **Changes in Intermediate Indicators:** A number of changes have been made in the intermediate indicators to reflect the broader systems-strengthening approach engendered in the AF and to address citizen engagement. These changes are: (a) a new indicator on the proportion of health facilities in the project area which have functioning management committees with community representation on them; (b) number of women receiving counselling on gender-based violence or mental health services from a trained provider; (c) number of mobile clinics conducted per year in project area; (d) number of pregnant women tested for HIV during antenatal care; (e) number of children treated for severe acute or chronic malnutrition per year in project area.

Social Analysis

Explanation:

57. **Social impact**: The social impacts of the proposed NSHP AF are expected to be positive, and include extensive and improved access to health services, improved quality of health services delivery, gender-sensitive health services as well as improved public awareness of healthy lifestyles. Also, the project will strengthen equitable access to healthcare, especially for the poor and vulnerable individuals and households in NE Nigeria.

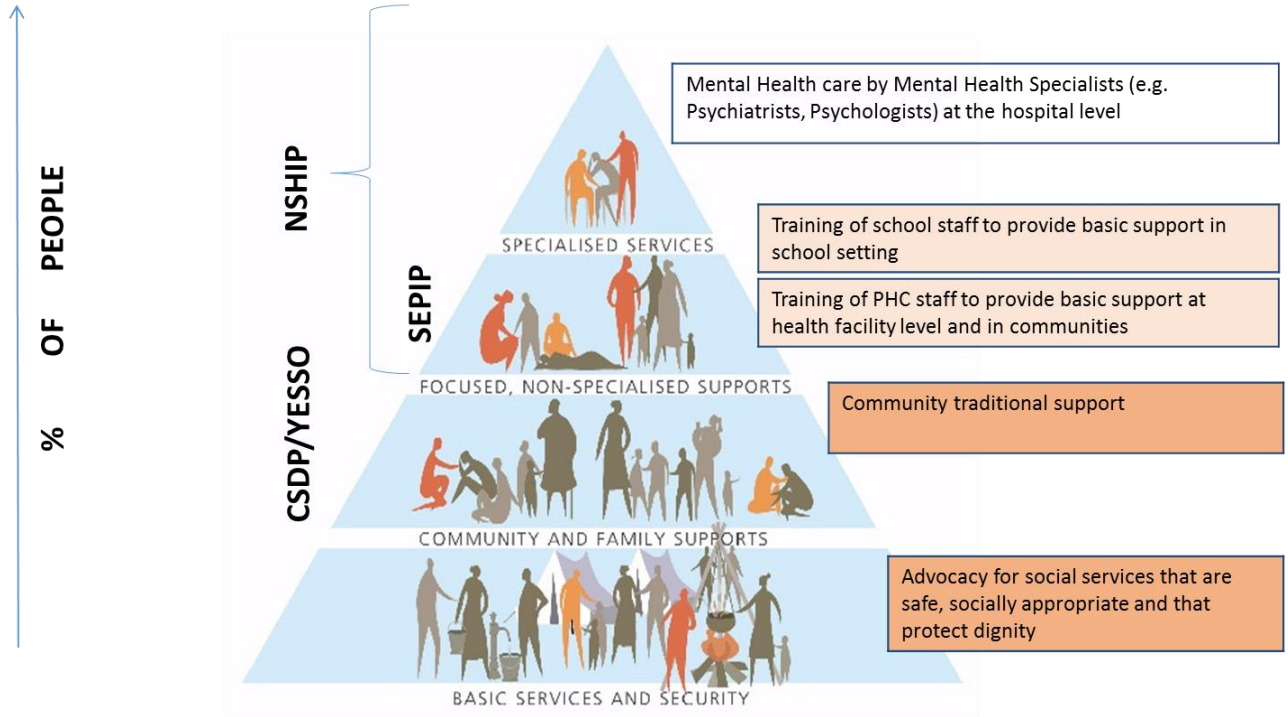
58. It is expected that the focus on improved MCH care service delivery, through access to medical facilities, medical professionals (such as skilled birth attendants), commodities, availability of emergency obstetric and sensitization and mobilization of communities would increase demand for and uptake health services.

59. **Gender**: Women (including children and infants) would be a direct beneficiary group as one of the priority areas of the NSHIP AF would focus on improving Maternal Newborn and Child Health and nutrition outcomes in Nigeria, thereby addressing some of the most common causes of preventable maternal and child mortality and morbidity in the country. Expectedly, improved child health would have a direct positive impact on school attendance rates.

60. **Psychosocial Support and Mental Health:** The HD package of AFs and restructuring will provide psychosocial support at different levels (see figure 5 below) with the two social protection and labor operations (i.e., CSDP and YESSO) focusing on community traditional support while the SEPIP and NSHIP would provide focused, non-specialized support in schools and health facilities, respectively. The NSIHP AF will provide training and support for health workers allowing them to recognize, support, and treat victims of sexual and gender-based violence, post-traumatic stress disorder, and mental illness more broadly. The NSHIP AF would also provide specialized services at the hospital level in line with the Government's strategy as outlined in the Presidential Coordinating Committee on the NE Interventions (PCNI). However, it is important that these services are confidential and sensitive to the rights, dignity and safety of patients and survivors so as to avoid discrimination, stigmatization, labeling and other

negative consequences. The project will ensure that health workers who provide these services to children and young people must be knowledgeable and trained in child safeguards and protection procedures. In addition, in order to address the gap between demand for health services and available treatment, the project will adopt a 'task-shifting' approach, whereby less specialized staff will be trained to deliver certain services. This practice is increasingly used in contexts where specialized personnel are rare, and/or service delivery areas are not easily accessible. Candidates for task shifting could include health outreach workers, youth counselors, or community leaders with moderate to low levels of formal education. The practice is seen as a way to scale up access to care and help retain capacity in complicated environments.

Figure 5. Psychosocial Support in HD Operations in NE Nigeria



61. It is imperative for health workers to work with Health Facility Committees in designing these interventions so as to ensure that the interventions are culturally sensitive and avoid harmful outcomes.

62. **Involuntary Resettlement**: Land acquisition, restriction of access to sources of livelihoods and involuntary resettlement impacts are not envisaged during implementation; hence, OP 4.12 is not triggered for this project. However, in some communities in the NE, public institutions such as hospitals and schools have been converted to formal and informal camps to accommodate persons displaced by the conflict, as such repairs to and reestablishment of such facilities may require relocating IDPs quartered in such facilities. In the event that such activities are likely to occur at implementation phase, the project implementation team will immediately notify the WBG and any sub -project would not proceed until appropriate mitigation instruments are prepared.

63. **Citizen Engagement**: Under the parent project, ward development committees have been heavily involved in implementation. Community leaders are represented on the health facility management committees that oversee the use of the funds received in the health facility's bank account through the PBF mechanism. Indeed the chair of the Ward Development Committee is one of the two signatories on

that account. Health Facility Committees will be reactivated or established in all facilities supported under the AF. The committee will be responsible for tracking, addressing and resolving complaints submitted by community members. In addition, the supervisory checklist that is used to assess quality of care in each facility has an extensive section on the functioning of the facility management committee with special attention paid to whether proper community representation is in place.

64. PBF also relies on a few client feedback mechanisms. Third parties, typically CSOs, carry out a community client satisfaction survey (CCSS) in which they go to the houses of a random sample of patients listed in health facility registers to determine whether: (a) the patients exist; (b) they received the services listed; (c) they were satisfied with the care; and (d) were paid the amounts specified in State policies. This information is provided to the State, LGA, and facility managers. During the original project an SMS feedback mechanism, MyVoice, was designed and piloted in Wamba LGA, Nasarawa State, in order to enhance accountability between users of health services, services providers and the WBG-supported NSHIP project team. The lessons learned from that experience will be reflected in the telephone survey that will be conducted every quarter.

65. Finally, it is envisaged that security constraints may limit access by the government or Bank staff ability to effectively monitor project implementation in the field. To this end, the project will work with local Non-State Actors who are present in the region and know the security situation. The NSAs will work with project components that cannot otherwise be monitored by Bank and also strengthen project monitoring when State agencies lack monitoring capacity.

Financial Management Analysis

Explanation:

66. Financial Management (FM): The responsibility for establishing and maintaining acceptable FM arrangements will continue to be handled by the existing Project Financial Management Unit (PFMU) in the participating States and the Federal Project Financial Management Division (FPFMD) at the Federal Level. State PFMUs and FPFMD will designate appropriate professionally qualified and experienced accountants and internal auditors for the project.

67. The FM arrangements for the project will remain the same to provide the requisite assurance:

i. that funds are used only for the intended purposes;
ii. that the production of project financial reports and information will be accurate, complete and timely; and
iii. project and entity assets will be properly secured and safeguarded throughout the life of the project.

68. A strengthened accountability framework will be put in place to ensure funds allocated to the Training and Operating Cost category, in particular, are used for the intended purposes with economy and efficiency. Accordingly, all training (local and international) would require prior clearance from the Bank and the project management will ensure a formal process of accountability is instituted and respected on all training expenditures. Detailed internal control framework and risk management strategy – a byproduct of the enhanced accountability framework – will be incorporated in the Financial Procedures Manual.

69. In addition, the internal audit unit will be adequately trained in risk based internal audit techniques to undertake rigorous review of processes that have been subject to abuse and the complaint failures in projects that are systemic within the Nigeria portfolio. Regular reporting by implementing entities and coordination by the NPHCDA will ensure close monitoring and implementation of actions.

70. Resulting from the above summary assessment, the FM arrangements under the AF are considered adequate, and the FM risk level remains substantial.

Procurement

Explanation:

Procurement Strategy

71. **Procurement Environment in Nigeria:** Nigeria's procurement environment is largely premised on the progress achieved in implementing a procurement reform program based on the recommendations of the 2000 Country Procurement Assessment Review (CPAR). With the enactment of a Public Procurement Act in June 2007, the enabling legal framework aimed at establishing transparent, fair, and cost-effective use of public funds has been in place. The provisions in the Act are consistent with the principles of the United Nations Commission on International Trade Law model law, and are applicable to all procurement categories (suppliers, contractors, consultants).

72. Following the enactment of the procurement act, a regulatory agency - the Bureau of Public Procurement - was established. The Government has also prepared relevant implementation tools, including Regulations, Standard Bidding Documents (SBD) and Manuals. In addition, a procurement professional cadre has been created at the federal level and in some States. A complaints and appeals mechanism has been established in accordance with the provisions of the Act to enhance transparency and accountability. The gains of the procurement reform at the federal level have extended to the 36 States of the Federation of Nigeria. Presently, 24 States have passed their respective procurement laws while other States have draft procurement bills under consideration. Three (i.e., Adamawa, Bauchi and Taraba) out of the six NE States have procurement laws.

73. Notwithstanding the above successes, there are still inherent weaknesses in the public procurement system in Nigeria. In 2012/2013, the Bank conducted a Procurement Value Chain Analysis which identified the following weaknesses at the federal level: delay in budget approval; late release of budgeted funds; lack of budget-linked procurement planning; failure of full compliance with the use of standard bidding documents; poor bid evaluation reports; delays in contract award approvals; weak procurement and performance monitoring; poor record keeping; fraud and corruption; and lack of effective enforcement of sanctions as provided for the law.

74. In 2014, the Global Alliance for Vaccines and Immunization (GAVI) audit report equally highlighted significant vulnerabilities in the procurement management and control processes in the health sector in respect of their cash support component. These include: lack of segregation of duties in the tendering and expenditure management processes; applying the 'shopping' method for higher value procurements inconsistent with the applicable rules and the methods defined in the procurement plans; splitting procurement packages to circumvent procurement thresholds; payment to suppliers who have not delivered the goods or have delivered sub-standard goods and several different suppliers sharing the same address – an apparent sign of collusion and attempt to show that there was competition; inflated costs (sometimes twice) on procurement of goods; etc.

Procurement Strategy

75. It is expected that the proposed AF will utilize procurement processes of the original project with variations to address the emergency nature of the project particularly in the procurement of the TA, recruitment of local university, NGOs and Community-Based Organizations for the verification and counter verification; outreach to the communities and mobile teams; performance contracts. Since the North-East is in a time of emergency situations where communities are vulnerable, the implementation of NSHIP will require prompt responses and actions in order to guarantee achievement of fast results. The

NPHCDA has prepared the procurement plan for the first 18 months of the AF.

76. TA for the project will be different from the original project and various approaches will be utilized based on the technical requirements and needs of the project in an emergency environment. CMVAs will provide TA on management, PBF and running of mobile clinics. They will handle contract management for the SPHCDA and verification of services provided by the health facilities. They will carry out community client satisfaction surveys. UNICEF may support the proposed nutrition program. The recruitment of the CMVAs will be carried out within six months of effectiveness by NPHCDA with State and development partner involvement in the recruitment process. Since the size of the contracts will be large, the recruitment will be competitive. NPHCDA will also be responsible for procuring the services of IVA – that will carry out quality and quantity counter verification.

77. **Procurement Arrangement and Guidelines**: Procurement under this project will largely involve goods, minor works, consultancy services and non-consulting services packages. Procurement financed under the AF will be carried out in accordance with the WBG's "Guidelines: Procurement of Goods, Works and Non-consulting services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" published in January 2011 (revised July 2014), in the case of goods, works, and non-consulting services; and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" published in January 2011 (revised July 2014) in the case of consultants' services, and the provisions stipulated in the Legal Agreement. Guidelines on Preventing and Combating Fraud and Corruption in projects Financed by IBRD Loans and IDA Credits and Grants, (the Anti-Corruption Guidelines) (October 15, 2006, revised in January 2011) apply to the project; and the provisions stipulated in the Legal Agreement. For each contract to be financed by the Credit, the different procurement methods or consultancy services selection methods, estimated costs, prior review requirements, and time frame have been agreed between the Borrower and the WBG in the procurement plan.

78. **Procurement Risk Assessment:** The fiduciary assessment carried out for NSHIP AF indicates substantial risk in procurement operations and contract management of the TA component. The procurement unit of the Bank would be providing hand-holding support to the project team to ensure smooth procurement operations and contract management.

79. **Prior Review Thresholds**: Under the TA component of the AF, the Procurement Plan, prepared by the NPHCDA, sets forth those contracts which shall be subject to the Bank's prior review. All other contracts shall be subject to Post Review by the Bank.

80. **Post Review/Integrated Fiduciary Review:** For compliance with the Bank's procurement procedures, the Bank will carry out sample post review of contracts that are below the prior review threshold. Such review (ex-post and procurement audit) of contracts below the threshold will be subject to the risk rating of the post-review contracts in the project. Procurement post-reviews will be done on annual basis depending on the number of post-review contracts.

Environmental Analysis

Explanation:

81. The AF is not envisaged to cause any potential large scale, significant and /or irreversible environmental impacts. The environmental risks and the environmental category of AF will continue to be B.

82. While the CSDP operation will provide support for provision of community social infrastructure, including health centers, the proposed NSHIP AF is not envisaged to involve any major civil works, such

as new construction or significant rehabilitation of existing buildings in the NE States. It may however, involve minor repairs such as painting, plastering, replacing doors/windows, leaking roof, and done in accordance with national and local laws and procedures. Operational Policy (OP) 4.01 on Environmental Assessment is triggered given the potential environmental concerns around the handing of Health care waste resulting from project related activities such as vaccination and routine immunization that generate healthcare waste such as expired vaccines and sharps. The FMOH has disclosed its health care waste management plan in country on April 14 and in the INFOSHOP on April 15, 2016.

Risks

Explanation:

83. **The Risks:** The overall risk is high, mainly as the focus of the AF and restructuring is on the NE States which have been heavily hit by the Boko Haram insurgency. In an environment where transition from conflict to peace remains fragile, the implementation of the AF is expected to face a number of challenges. These relate to the dynamic nature of the conflict. . Additional risks are mostly as a result of the macro-economic risks that the Government faces due to oil price declines that adversely affect its revenues. In terms of mitigation, the use of third party monitors, local NGOs and other civil society groups for supervision, monitoring and evaluation will be used.

V. GOVERNANCE AND ACCOUNTABILITY

84. The project aims at strengthening governance at three lower levels - State, LGA and community. The proposed AF will focus on three core dimensions: (i) enhancing accountability, (ii) promoting stakeholder participation, and (iii) improving transparency. The AF will enhance accountability by mitigating the risks identified during project preparation, addressing identified areas for lack of accountability and focusing on linking payments at all levels to performance. Community participation will be enhanced through greater involvement by WDCs in the management of health facilities. WDCs will also provide feedback to the health workers and support mobilization of the communities. Transparency will be improved through the quarterly LGA RBF Committee meetings, and sharing of results with major stakeholders, including NGOs. At the State level, results of the project will be displayed on the websites of participating SPHCDAs. The project will help restore public trust in government by strengthening the relationship between State and local governments with the communities.

85. To that effect, a grievance redress system ensures that individual complaints are adequately addressed as well as the systemic issues they reflect at local government level and escalated and handled at State level when needed. Given the need to restore social cohesion, the grievance redress mechanism is also designed as a conflict resolution mechanism. Details are provided in the Operations Manual. Based on the findings of the detailed FM review of the WBG portfolio with a focus on project soft expenditure and operating expenses at federal and State levels, an enhanced accountability framework will apply to provide increased assurance that funds are used for the intended purposes with economy and efficiency and attain value for money. Details are provided in the Operations Manual.

VI. COMMUNICATION

86. Communications was incorporated into original project as a tool for enhancing and showcasing results, community engagement and participation and provisions were made to mainstream communication into project implementation. A communications action plan was developed and communications specialists were recruited at the Federal and State Project Implementation Unit levels. This AF will benefit from the already existing communication arrangements which anticipate the scaling up of the implementation of the communication strategy, including a communication action plan further detailed in the Operations Manual.

VII. WORLD BANK GRIEVANCE REDRESS

87. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond.

For information on how to submit complaints to the World Bank's corporate GRS, please visit http://www.worldbank.org/GRS.
For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

ANNEX 1: REVISED RESULTS FRAMEWORK AND MONITORING

Project Development Objectives

Original Project Development Objective - Parent:

To increase the delivery and use of high impact maternal and child health interventions and improve quality of care at selected health facilities in the participating states.

Proposed Project Development Objective - Additional Financing (AF):

To increase the delivery and use of high impact maternal and child health interventions and improve quality of care available to the people of Nasarawa, Ondo and all the states in the North East.

Results

Project Development Objective Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
New	Proportion of children sick in the last month who used a government hospital or clinic (average of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe)	☐	Percentage	Value	0.00		72.00
				Date	31-Oct-2016		31-Jul-2020
				Comment	Data source: Telephone survey		Data source: Telephone Survey
New	Number of outpatient visits per year, children and adults (sum for Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe)	☐	Number	Value	409,786.00	214,501.00	500,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
New	Proportion of children sick in the last month who used a government hospital or clinic (average of Nasarawa and Ondo)	☐	Percentage	Value	0.00		85.00
				Date	31-Oct-2016		31-Jul-2020
				Comment	Data source: Telephone survey		Data source: Telephone Survey

New	Average Health Facility Score - structural Quality of Care (average of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe)	☐	Percentage	Value	24.00		72.00
				Date	31-Dec-2015		31-Jul-2020
				Comment	Data source: SDI survey for Bauchi and Taraba and IE baseline for Adamawa		Data source: Annual health facility survey
New	Average Health Facility Score - Structural Quality of Care (average Nasarawa and Ondo)	☐	Percentage	Value	45.00		72.00
				Date	31-Mar-2014		31-Jul-2020
				Comment	Data source: IE Report		Data source: IE Report
New	Proportion of births attended by skilled health personnel (average of Nasarawa and Ondo)	☐	Percentage	Value	55.65	69.00	75.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: SMART Survey	Data source: SMART Survey	Data source: SMART Survey
New	Proportion of births attended by skilled personnel (average of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe)	☐	Percentage	Value	22.20	28.30	35.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: SMART Survey	Data source: SMART Survey	Data source: SMART Survey
New	Proportion of children (12-23 months) with pentavalent 3 vaccination (average in NE states: Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe)	☐	Percentage	Value	28.50	25.00	35.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: SMART Survey	Data source: SMART Survey	Data source: SMART Survey

New	Number of children 0-12 months immunized with Pentavalent 3 vaccine per year in the 2 original states (sum of Nasarawa and Ondo)	☐	Number	Value	206,090.00	234,536.00	270,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
New	Number of children 0-12 months immunized with Pentavalent 3 vaccine per year in NE States (Sum of Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe)	☐	Number	Value	327,278.00	427,635.00	500,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
New	Proportion of children (12-23) months with Pentavalent 3 vaccination (average in 2 original states- sum of Nasarawa and Ondo States)	☐	Percentage	Value	53.35	56.85	65.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: SMART Survey	Data source: SMART Survey	Data source: SMART Survey
Revised	Births (deliveries) attended by skilled health personnel (number)	☒	Number	Value	76,960.00	130,771.00	88,503.00
				Date	31-Dec-2010	31-Dec-2014	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
Revised	Number of births (deliveries) occurring in a health facility in 2 original states (sum of Nasarawa and Ondo)	☐	Number Sub Type Breakdown	Value	27,966.00	53,757.00	62,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
Revised	Number of births (deliveries) occurring in a health facility (Sum of Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe)	☐	Number Sub Type Breakdown	Value	95,968.00	116,085.00	150,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2

Revised	Average Health Facility Quality of Care Score	☐	Percentage	Value	0.00	41.66	61.00
				Date		31-Mar-2014	31-Jul-2020
				Comment	Data source: IE	Data source: IE	Data source: IE
Revised	Number of outpatient visits per year, children and adults (sum for Nasarawa and Ondo States)	☐	Number	Value	218,016.00	118,255.00	300,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
Revised	Direct project beneficiaries	☒	Number	Value	1,113,752.00	790,283.00	1,400,000.00
				Date	31-Dec-2014	31-Dec-2015	31-Jul-2020
				Comment	Data source: DHIS 2	Data source: DHIS 2	Data source: DHIS 2
Revised	Female beneficiaries	☒	Percentage Sub Type Supplemental	Value	0.00	63.00	60.00

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
New	Proportion of health facilities in the project area with functioning management committees having community representation	☐	Percentage	Value	0.00		30.00
				Date	30-Jun-2016		31-Jul-2020
				Comment	Data source: SMART Survey		Data source: SMART Survey
New	Number of mobile clinics conducted per year in project area	☐	Number	Value	0.00		75.00
				Date	30-Jun-2016		31-Jul-2020
				Comment	Data source:		Data source:

					HMIS		HMIS
New	Number of women receiving counselling on gender-based violence or mental health services from a trained provider	☐	Number	Value	45.00		20,000.00
				Date	30-Jun-2016		31-Jul-2020
				Comment	Data source: HMIS		Data source: HMIS
New	proportion of pregnant women tested for HIV and who received test result	☐	Percentage	Value	39.50		50.00
				Date	20-Aug-2015		31-Jul-2020
				Comment	Data source: SMART Survey		Data source: SMART Survey
New	Proportions of mothers aged 15 to 19 years of age who deliver in the last two years who receive skill birth attendance.	☐	Number	Value	20		35
				Date	31-Dec-2015		31-Jul-2020
				Comment	Data source: SMART Survey		Data source: HMIS
New	Number of children treated for severe acute or chronic malnutrition per year in project area	☐	Number	Value	0.00		25,000.00
				Date	30-Jun-2016		31-Jul-2020
				Comment	Data source: PBF, HMIS		Data source: PBF, HMIS
Revised	Number of LGA with ongoing PBF pilot	☐	Number	Value	3.00	26.00	60.00
				Date	31-Dec-2011	30-Apr-2015	31-Jul-2020
				Comment	Data source: HMIS	Data source: HMIS	Data source: HMIS

ANNEX 2: IMPLEMENTATION ARRANGEMENTS FOR THE ADDITIONAL FINANCING

Institutional and Implementation Arrangements

1. The implementation arrangement will be essentially similar to that of the original project but adapted to include UN agencies and non-governmental organizations that will serve as the external validation agency to carry out the verification and counter verification of results. Some of these agencies will also work with the community based organizations to carry out regular community client satisfaction surveys, while others will be involved with outreaches to the community or be part of mobile clinics. Within the AF the federal and State structures will be retained and they will perform the same roles as in the original project.

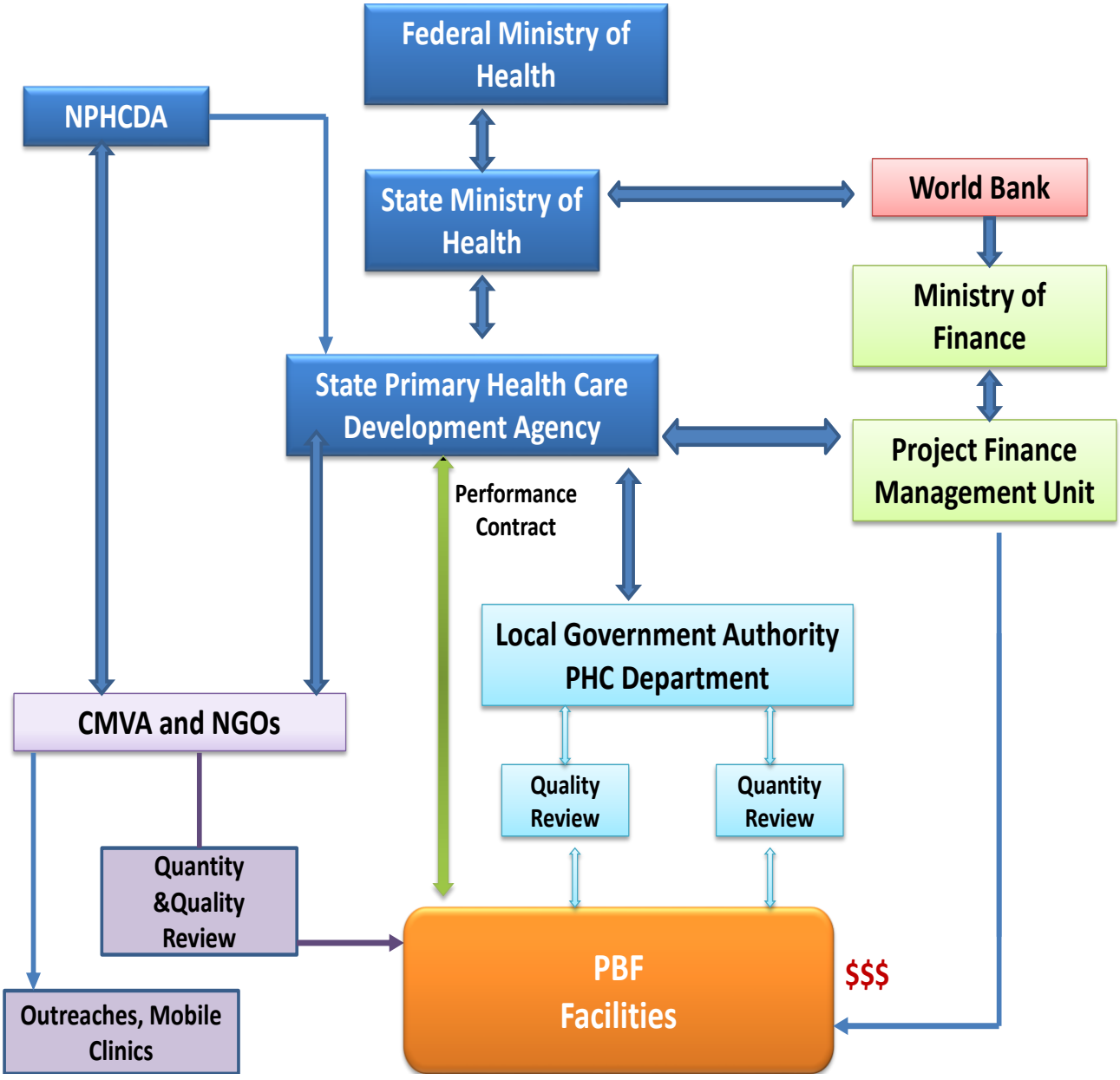
2. The ultimate sectoral authority for the project will be the Federal Minister for Health. The two lead agencies implementing the project at the federal level include: (i) the Federal Ministry of Health (FMOH); and (ii) the National Primary Health Care Development Agency (NPHCDA). The FMOH will retain its steering role. The NPHCDA has in the last four years developed its staff in the implementation of results based approaches and project management. The agency also has zonal officers that have coordinated, provided technical assistance to the States and monitored project activities in the original three States. NPHCDA is better placed now to perform this role more efficiently. The NPHCDA will contract CSOs, university departments and UN agencies to provide technical assistance to the States on project management and PBF. The CSOs will be used as CMVAs or IVAs. The amended project implementation manual will spell out the roles and responsibilities of these agencies while the terms of reference will be added as annex to this project paper.

3. Institutions involved in the implementation of the project at the State level will include (i) State Ministry of Health; (ii) State Primary Health Care Development Agency (SPHCDA); and (iii) LGA primarily through its PHC Department. Initial assessment shows all the structures exist in the newly added five States and the local government structures. The Project will leverage and strengthen these institutions to enable them to take on additional responsibilities under this AF.

4. The State Ministry of Health (SMOH), which will provide overall stewardship to the Project. SPHCDA will be the agency charged with the implementation of the Project, including planning, management and monitoring of project activities The SPHCDA will serve as purchaser of services under the PBF arrangement and also coordinate the other components of the project, hire the CSOs through a performance contract for the performance based contracting; community client satisfaction survey, outreaches and mobile health services. The SPHCDA will also contract LGA PHC department to carry out quality verification. The other coordinating platforms such as steering committees, technical working group, LGA RBF committees, ward development committee etc. will also be established in the five States. (See figure 6 below).

Institutional Arrangements: The following arrangements will be followed in each of the States.

Figure 6: Implementation Arrangement for NSHIP



Financial Management

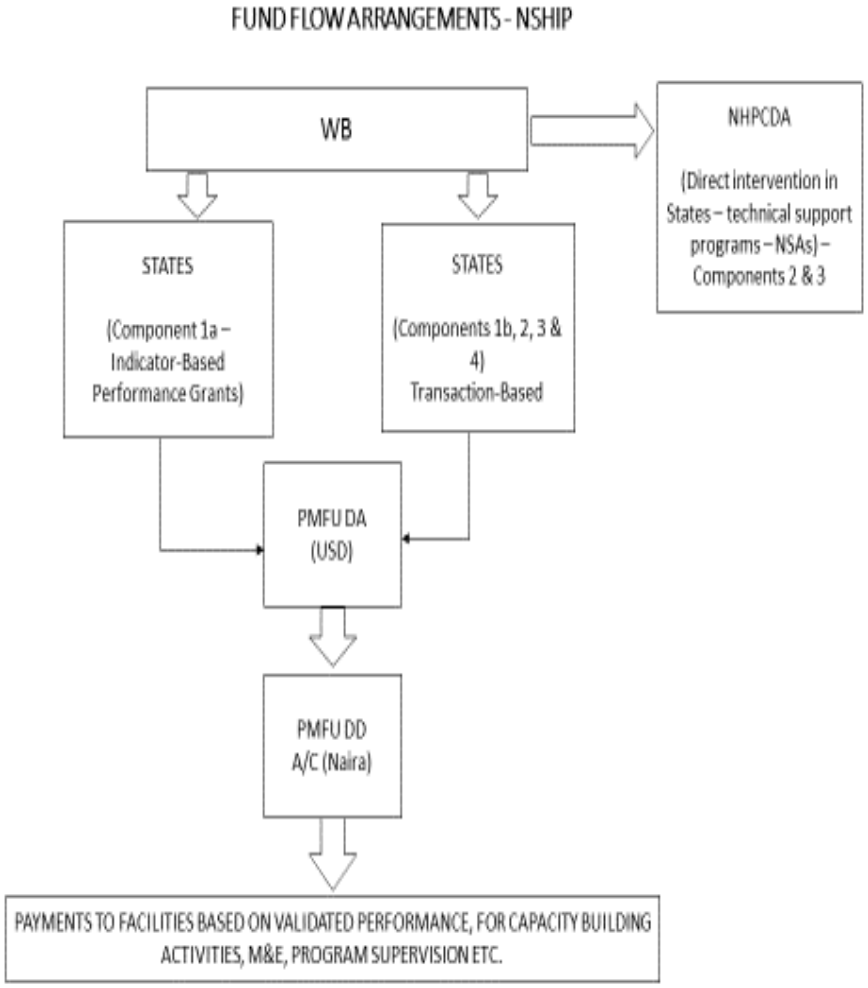
5. The Additional Financing will cover Bauchi, Borno, Gombe, Taraba, and Yobe States. The Federal Project Implementing Unit (NPHCDA), through the FPFMD at the Office of the Accountant General, will handle the financial management arrangements of the project at the federal level while the States PFMUs will handle the financial management arrangements at the State level – all consistent with the arrangements as per the original project which features Scenarii, save for the elimination of the DLI-based EEP approach. The AF will be adapted to the specific conditions in the NE by the following changes:

a) Reinforcing services under PBF Component 1.A.1 in the original project while dropping the disbursement-linked indicators (DLIs) EEP approach under component 1.B.1 in the original project;
b) Adding a new component that supports contracting with non-state actors;
c) Adding a new 'just-in-time' component to respond to changing circumstances; and
d) Modifying the approach to technical support (component 2) of the original project.

Disbursement Arrangements and Funds Flows:

6. There will be no changes in the disbursement arrangements as designed under the original project except that the DLI-based Eligible Expenditure Program (EEP) approach to disbursements will not apply for both the original project and the additional financing. This is particularly relevant since the transaction-based disbursement process, through the relevant State/Implementing Agency financial management units, shall remain in force just as is the case under the original project. The project will, under the AF, use the same designated accounts (USD DA with a Naira draw-down account) already established in the original project for each of the States and NPHCDA (the implementing entities). To reduce the inherent risks associated with the challenge of accessibility in the NE States, enhanced monitoring, through reviews of quarterly interim financial reports, will be introduced.

Figure 7: Fund Flow Arrangement for NSHIP



The additional financing will leverage on the existing disbursement categories as follows:

Disbursement Category	**Original**	**AF**	**Total**
1 Strengthening Service Delivery	122.4	85.0	207.4
2. Technical support	34.0	23.0	57.0
3.Non- state actors		18.0	18.0
4.Contingency	10.6	19.0	29.6
Total	170.0	145.0	315.0

7. ***Planning and Budgeting***: Budget preparation will follow Government procedures. Financial projections or expenditure forecasts for the relevant components would continue to be the overall responsibility of the State Ministry of Health and working closely with the PFMU to ensure among other things, that adequate arrangements are made to cover all eligible PBF facilities at the States' and LGAs' levels. The Project Accountants at the NPHCDA and States' PFMUs (in conjunction with key members of the implementing unit) will prepare the cash budget for the TA component based on the work program.

8. ***Accounting and Financial Reporting***: The AF will be accounted for using the cash basis, augmented with appropriate records and procedures to track commitments and to safeguards assets. All accounting and control procedures are documented in the Financial Procedures Manual, which will be regularly updated and shared with IDA.

9. Timely preparation of accurate financial reports for the sector will be one of the key Financial Management performance indicators to be monitored. In addition, while the Federal Project Financial Management Department (FPFMD) will prepare the Project Financial Statements (interim and annual), showing the sources of project funds and their uses in respect of the federal component of the project, the States PFMU will be responsible for preparing the same. The Project Financial Statements will take the form of quarterly Interim Unaudited Financial Reports (to be submitted to the Bank within 45 days of end of a fiscal quarter) and Annual Financial Statements which will be submitted to audit in good time to allow the audits to be completed before the submission deadline of the audit reports to the Bank. Adequate notes and disclosures consistent with acceptable international practice will be provided, at least as part of the Annual Financial Statements. The project reports and financial statements will identify the uses of funds according to the pre-defined eligible expenditure elements in respect of PBF (as is the case in respect of component 1); TA costs financed by the Bank (as is the case in respect of component 2); and Contracts with Non-State Actors (the new component 3). To strengthen flexibility, the proposed AF also includes an 'unallocated' category and use of funds from that category, with the approval of the task team, will be attributable to any of the first three components.

10. ***Internal Controls****:* Internal controls under the current project will continue to be maintained under the AF. In addition to this an enhanced accountability framework will be in place and the underlying principles will be incorporated in the PIM to ensure funds allocated to training, workshops and study tours etc., in particular, are used for the intended purposes with due attention to economy and efficiency. Accordingly, all training (local and international) would require clearance from the Bank. The requests for clearance should at a minimum include the following:

(i) demonstrated linkage between the rationales of the workshop;
(ii) be part of the Annual Work Plan to which the activity falls;
(iii) number of trainees, their function and mode of selection. This should also include the number of times during the past 18 months listed trainees had benefitted from training;
(iv) process used for selection of training providers, and if foreign training, rationale for not proposing local training;
(v) training prospectus;
(vi) detailed cost of the event-venue, how venue was or is proposed to be selected, venue rental, refreshments/lunches, per diem, transport cost (air or land travel cost per trainee).

Only on the basis of the above submissions and IDA prior clearance will expenses be committed and become eligible for financing under the project.

11. ***External Audit:*** The audited financial statements and management letter for the Federal component and each of the States components shall be submitted to the Bank within 6 months of the end of the Government fiscal year. Acceptable audited financial statements for the project would show, inter alia, sources and uses of funds according to components and sub-components, activities, and disbursement categories.

Enhanced Project Accountability Framework

12. Following from the findings of the detailed FM review that was conducted primarily on the soft expenditures of workshops, training, travel and operating expenses in the participating States and NPCU, an enhanced accountability framework is being put in place for the project (Original & AF) to provide increased assurance that funds are used for the intended purposes with economy and efficiency and attain value for money.

13. The objectives of a strengthened accountability framework include to:

- Develop and implement a robust improvement in accountability for the use of project funds that will assist in attaining expected outcomes for the various programs being financed;
- Provide guidelines on minimum requirements to be complied with regarding workshops, training, and related activities.

Specific accountability framework for training, workshops, study tours, etc

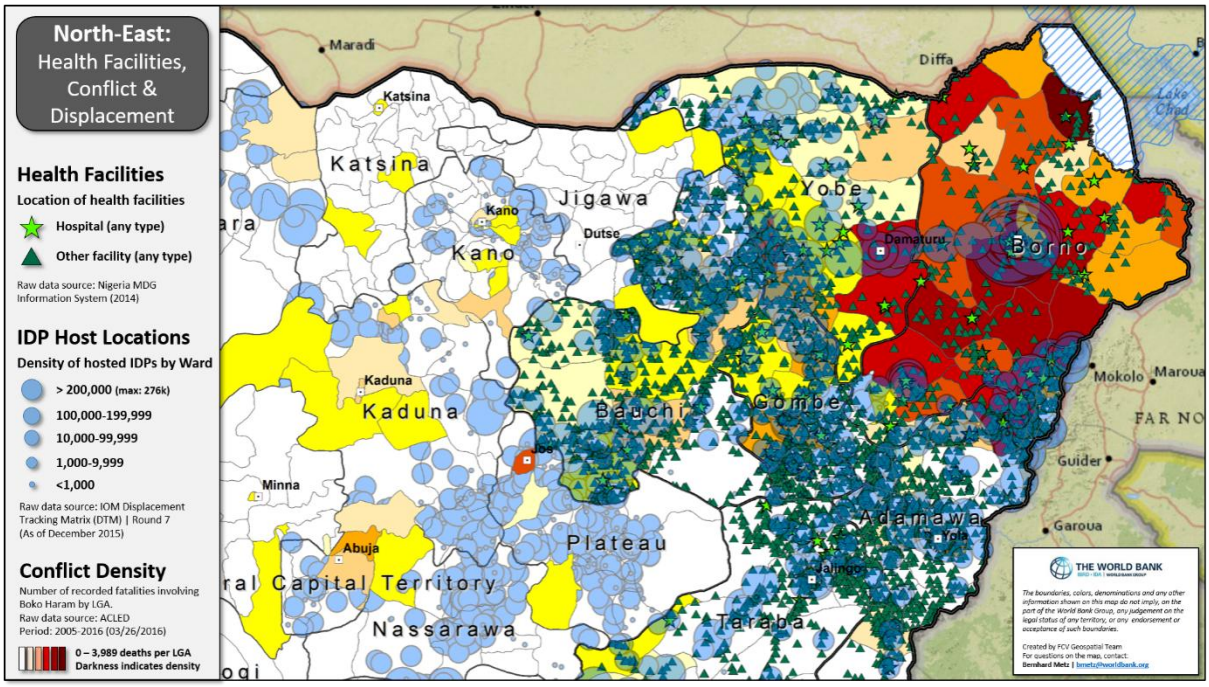
14. An enhanced accountability framework is put in place over expenditures in the areas of training, workshops, study tours, etc. as follows:

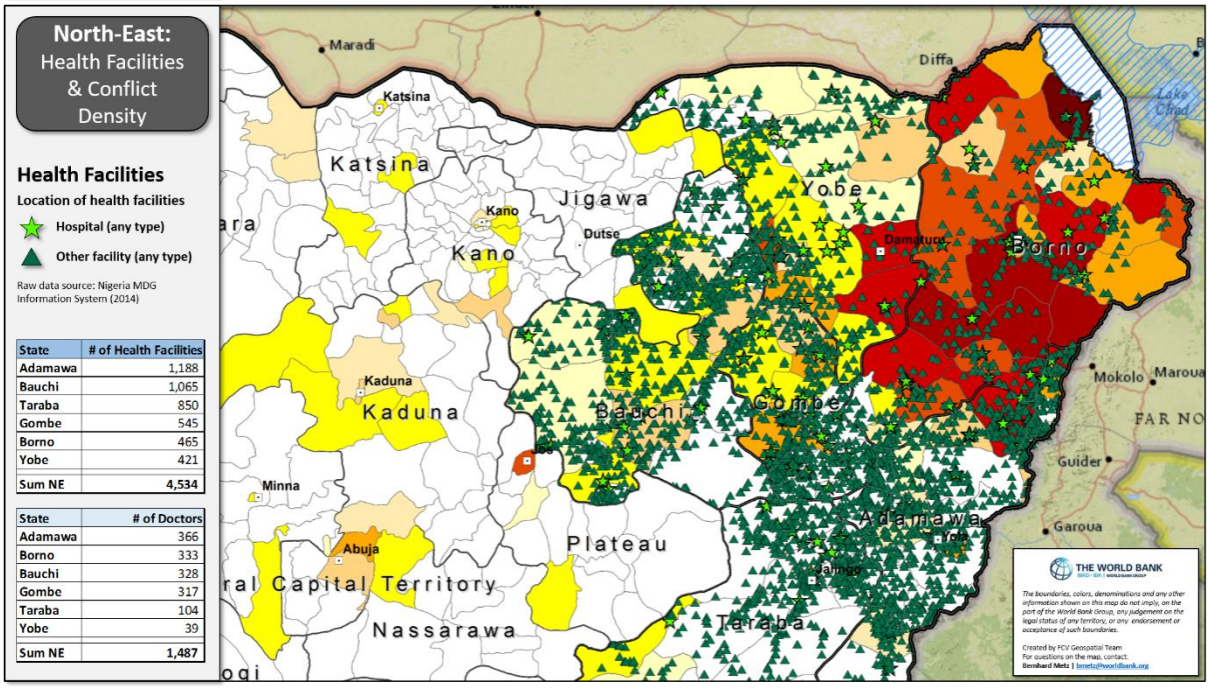
- At the beginning of each fiscal year, a separate training summary plan shall be developed and shared with the TTL for review as part of the annual work plan;
- All training, i.e. local and international, would require prior clearance from the Bank's TTL before they are undertaken. The request for clearance should, at a minimum, include the following:
  - A demonstrated linkage between the rationale for the workshop/training/etc. and the PDO shall be established;
  - Annual Work Program (AWP) to which the activity falls shall be identified;
  - The number of trainees, their function and mode of selection will be defined. This should also include the number of times during the past 18 months that listed trainees had benefitted from training;
  - Number of years before retirement from service of each of the proposed trainees;
  - The process used for selection of training providers, and if foreign training, rationale for not proposing local training, to be provided;
  - Training prospectus and reference to the beneficial outcome of the training to be provided; and
  - Provision of the detailed cost of the event: if local training/workshop/sensitization, the following additional information would need to be provided: i) venue for the event, ii) how venue was or is proposed to be selected, iii) venue rental, refreshments/lunches, per diem, transport cost (air or land travel cost per trainee);
  - No residential local training program will be allowed where the venue of the training if it is in the trainees locality; the preferred choice of locality should be the location where the majority of officials will be trained.

15. Only on the basis of these above submissions and TTLs' prior clearance will expenses be committed and become eligible for financing under the project.

- Each PIU will ensure a formal process of accountability is instituted on training expenditures which will include:
  - Submission of training report by the trainee;
  - Certificate of attendance from the training institution;
  - Relevant travel certifications such as air tickets, boarding passes for air travel, hotel bills etc.;
  - Consistent with the Government's cashless policy, air tickets shall be procured directly from the airline through electronic payment or cheque (no cash payments shall be allowed); and
  - Similar practice shall also be applied in the payment to vendors and tuition fee to training providers.
- Reduced amount of DSA will be paid where training /workshop organizers provide meals and accommodation. Cash advance granted to project staff must be retrieved by concerned staff within the timeline specified in the PIM before new advance is granted. When withdrawal of an advance is past due, an automatic payroll deduction of the unretrieved amount should be effected. To keep track of cash advances disbursed, an Advances Register shall be maintained as a control measure.
- The Project Internal Auditor shall include in their work program periodic random audits of travel advances and withdrawals thereof, as well as a review of the training /workshop conducted. A report of this review shall be provided to the PC as well as the Bank TTL.

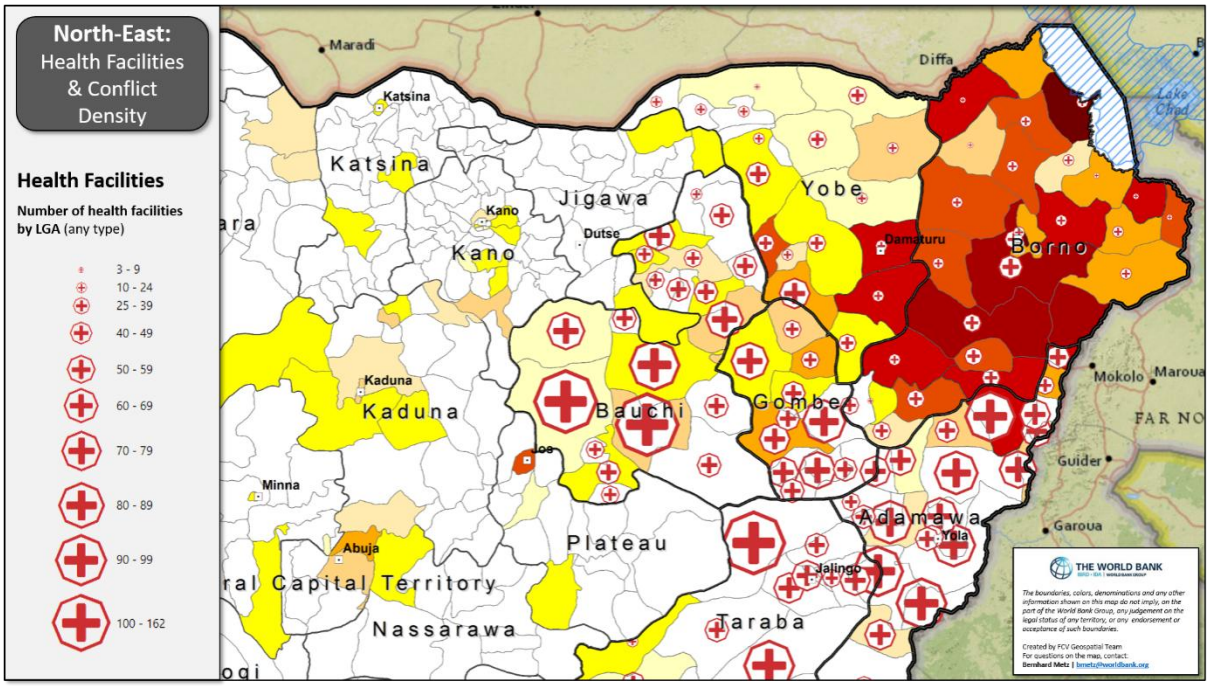
ANNEX 3: HEALTH FACILITIES, CONFLICT AND DISPLACEMENT





State	# of Health Facilities
Adamawa	1,188
Bauchi	1,065
Taraba	850
Gombe	545
Borno	465
Yobe	421
Sum NE	4,534

State	# of Doctors
Adamawa	366
Borno	333
Bauchi	328
Gombe	317
Taraba	104
Yobe	39
Sum NE	1,487


North-East:
Health Facilities
& Conflict
Density
Health Facilities
Number of health facilities
by LGA (any type)
3 - 9
10 - 24
25 - 39
40 - 49
50 - 59
60 - 69
70 - 79
80 - 89
90 - 99
100 - 162
Maradi
Katsina
Katsina
Jigawa
Kano
Kano
Dutse
Yobe
Damaturu
Borno
Diffa
Lake Chad
Kaduna
Kaduna
Bauchi
Gombe
Mokolo
Maroua
FAR NO
Guider
Minna
Abuja
Plateau
Adamawa
Yola
Garoua
Jalingo
Taraba
Nassarawa
Capital Territory
THE WORLD BANK
The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of the World Bank Group, any judgement on the legal status of any territory, or any endorsement or acceptance of such boundaries.
Created by FCV Geospatial Team
For questions on the map, contact:
Bernhard Metz | bmetz@worldbank.org

ANNEX 4: HOW PBF WORKS AND NIGERIA EXPERIENCE

1. In the example described in table 5.1 below, if a health facility fully immunizes 100 children in a quarter, they could earn US$600 (100 × US$6 per child fully vaccinated). In PHC facilities under NSHIP there are in fact 20 different specific services that are incentivized. The total amount (US$1,600 in this example) would be adjusted for the remoteness or difficulty of the facility (equity bonus), since urban or peri-urban facilities could earn a disproportionate amount. In the example below, this particular facility would earn 25 percent more if not for the difficulties it faces. The total would also be adjusted by a quality score based on a checklist administered at the facility every quarter.

2. This facility would earn 50 percent times 25 percent of its quantity payment. Funds are transferred electronically to the facility's bank account which is under the control of the Ward Development Committee representative and the facility's officer in charge. Facilities have substantial autonomy in how they use the funds. Up to 50 percent can be used to pay performance bonus for health workers and the rest can be used at the facility's discretion for operational costs, including maintenance and repair, drugs and consumables, outreach and other quality-enhancement measures.

3. At the time a PBF contract is signed with a facility, that facility receives an initial investment (not linked to performance) with which to deal with legacy issues and to fix up degraded infrastructure, obtain missing equipment, recruit skilled health workers, and so on. Under NSHIP, these initial grants were US$5,000 but with this AF it could be as high as US$10,000 for PHCs.

Table 5: Example of How PBF Works at Health Facility Level under NSHIP

Table 4

Service	Number Provided Last Quarter	Unit Price (Tariff) (US$)	Total Earned (US$)
Child fully vaccinated	100	6	600
Skilled birth attendance	50	12	600
Curative care patient visit	1,000	0.4	400
Sub-Total	–	–	1,600
Remoteness (Equity) Bonus	+25%		2,000
Quality bonus	Score (50%) x 25% of volume		200
		Total	2,200
Use of Funds			
Drugs and consumables			500
Outreach expenditures			250
Repairs and maintenance of health facility			150
Bonuses to staff in the facility			1,100
Savings			200

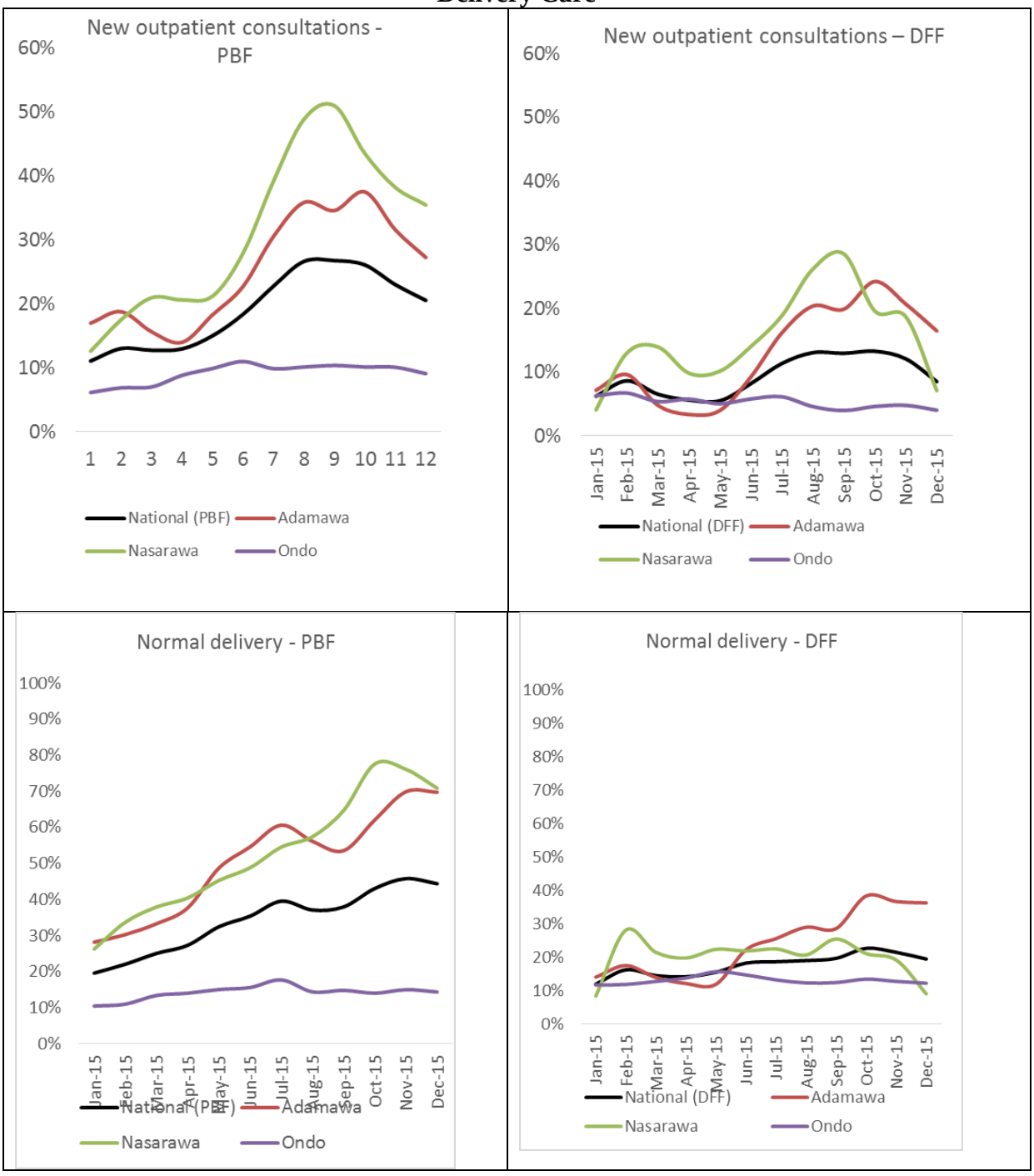
Experience with PBF in Nigeria

4. **Rationale for RBF:** A review of 20 years of Bank health sector lending in Nigeria, concluded that simply financing inputs is not enough. Even when inputs are available, performance has been modest and coverage of services has remained limited. The Government and the Bank have come to the conclusion that the best way of quickly improving services delivery is to use RBF approaches. This has led to the implementation of PBF through NSHIP and SOML PforR.

5. **PBF has achieved good results:** PBF rewards individual health facilities based on the quantity and quality of services they provide (the details of PBF are described in Annex 4). A recent household survey comparing three, "pre-pilot" LGAs that had been implementing PBF for two years with nearby control LGAs that had not implemented PBF found some compelling results. After controlling for socio-economic variables, contraceptive prevalence was twice as high, ANC, and utilization were also significantly higher in the PBF LGAs. PBF has been scaled up to 25 LGAs since the beginning of 2015 at the same time as DFF.

6. The latter simply provides cash resources to facilities and was meant as a counter-factual in the ongoing impact evaluation to control for the additional resources provided under PBF. Routinely collected data from PBF and DFF LGAs suggests the PBF has performed better and resulted in large improvements in service delivery (see graphs below). Outpatient visits have increased 150 percent and skilled birth attendance has more than doubled. The cost of PBF has been modest, about US$1.20 per capita per year, meaning that it has leveraged existing investments and is scalable.

Figure 8. Performance of PBF and DFF LGAs on Out-Patient Consultations and Skilled Delivery Care



ANNEX 5: GUIDING PRINCIPLES ON INCORPORATION OF RPBA FINDINGS IN THE PROPOSED AF

Background: The North-East Nigeria Recovery and Peace Building Assessment (RPBA)

1. **On 21 August 2015, the GON requested assistance in assessing the needs associated with peace building and crisis recovery**. Support has been provided in accordance with the 2008 Joint European Union (EU) – United Nations (UN) –WBG Declaration on crisis assessment and recovery planning. The RPBA has been prepared and implemented by the Federal Government, led by the Vice President's Office, and the Governments of the six affected States, with support from the WBG, United Nations, and European Union. A multi-stage consultation process was followed for the development of the assessment methodology, collection and validation of data and for the progressive corroboration of results, ending with consultation and validation of the RPBA findings, after which the document was fully endorsed by the different stakeholders.

2. **The RPBA informs a collective vision and strategy on peace building and recovery, and provides a framework for coordinated and coherent support to assist conflict-affected people in the North-East**. The assessment covers the six States of Borno, Yobe, Adamawa, Gombe, Taraba, and Bauchi, and provides an overarching framework for stability, peace building, and recovery. The RPBA is founded on the recognition that a durable resolution to the conflict in the North-East requires addressing the structural and underlying drivers of violent conflict. In order to assess and prioritize immediate and medium-term peace building and recovery needs, the RPBA gathered information across three components, namely: Peace Building, Stability and Social Cohesion; Infrastructure and Social Services; and Economic Recovery. The full RPBA report was made publicly available by the Nigerian government upon its launch on May 12, 2016.

RPBA Recovery Strategy and Framework

3. **The RPBA confirmed the need for recovery and peace building efforts, to be carried in tandem with the on-going scaling up of the humanitarian assistance.** Therefore, the Recovery and Peace Building Strategy (RPBS) will need to be closely coordinated with the Humanitarian Response Plan (HRP)[4] in order to build on the HRP's achievements and avoid overlaps.

4. **Careful and coordinated sequencing of the RBPA and subsequent support will be critical in view of the fluidity of the security environment, and the marked variation in security within and among the six States.** Priorities should be carefully assessed on a continuous basis, and adjusted as needed in light of the prevailing situation on the ground. In some areas, a humanitarian response combined with stabilisation will be needed, while in other areas, the context will permit more substantial movement towards recovery.

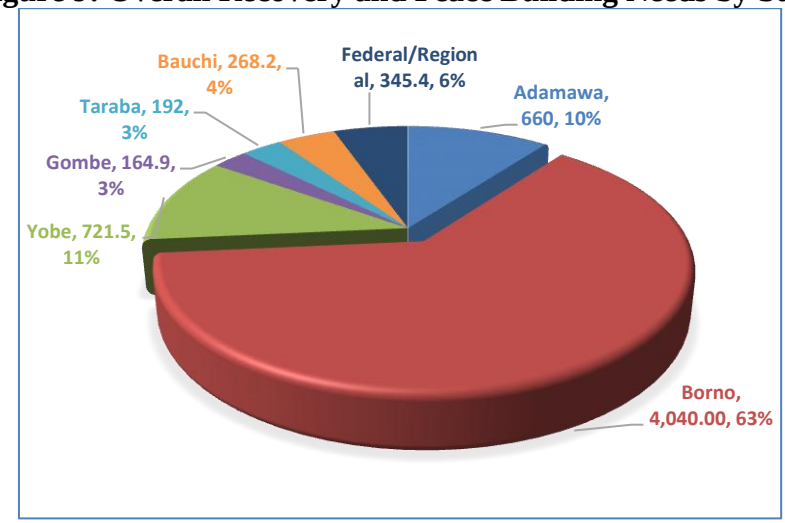
5. **An integrated and balanced approach to recovery is essential.** Peace building and social cohesion is the backbone of the assessment. Hence it is crucial to properly balance peace building, stability, and social cohesion interventions with other interventions aimed at

[4] The HRP 2016 was prepared by the UN- Nigeria, with the purpose assessing the humanitarian conditions of the Nigerian NE and providing a framework for the continuous national response and early recovery plans and interventions to these needs. For more information, please visit: https://www.humanitarianresponse.info/en/system/files/documents/files/nigeria_2016_hrp_03032016_0.pdf

reconstructing or rehabilitating social, physical, and productive assets. Peace building, stability, and social cohesion interventions will ensure the sustainability of recovery interventions on the ground and lay the foundation for human security to prevail. The assessment sets out four strategic outcomes for recovery and peace building: 1) safe, voluntary, and dignified return and resettlement of displaced populations; 2) improved human security, reconciliation, and violence prevention; 3) enhanced government accountability and citizen engagement in service delivery; and 4) and increased equity in the provision of basic services and employment opportunities.

Overview of Overall Impacts and Needs from the Crisis under the RPBA

Figure 9: Overall Recovery and Peace Building Needs by State



6. **The assessment indicates that the economic impact of the crisis is substantial, reaching nearly US$9 billion**. **Needs for recovery and peace building are disproportionately concentrated in Borno, followed by Yobe and Adamawa**. Two-thirds of the damages (US$5.9 billion) are in Borno, the most affected State; damages in Adamawa and Yobe account for US$1.6 billion and US$1.2 billion respectively. Three-quarters of the overall impacts are on agriculture (US$3.5 billion) and housing (US$3.3 billion). The conflict resulted in more than 400,000 damaged and destroyed housing units, 95 percent of which are located in Borno.

7. **The total need for recovery and peace building across the three strategic areas of interventions in both the stabilization and recovery[5] phase is US$6.7 billion** (table 6.1):

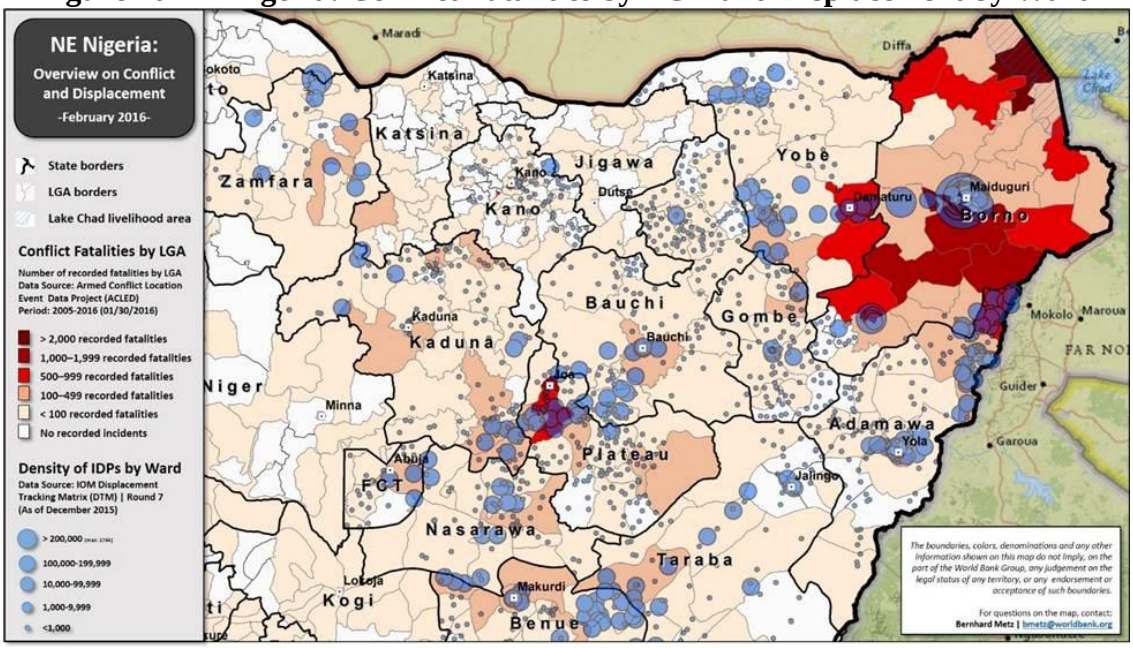
[5] Stabilization generally denotes the period during which initial recovery interventions commence and start taking effect while ongoing humanitarian operations continue. These initial recovery interventions build upon humanitarian interventions, do not duplicate them, and do not address the development deficits existing before the insurgency. Recovery denotes the period during which the initial recovery interventions start galvanizing into concrete recovery outcomes while more medium-term recovery and reconstruction activities take shape, scale up and intensify. The RPBA recognizes that these periods will overlap across the territory, with some areas being ready for recovery efforts sooner than others.

Table 6: Overall Recovery and Peace Building Needs by Component

	Adamawa	Borno	Yobe	Gombe	Taraba	Bauchi	Federal/Regional	Total
	(US$, millions)							
Peace building and social cohesion	27.5	37.8	22.5	13.6	19.4	23.9	5.7	150.5
Infrastructure and social services	594.9	3,933.3	668.3	129.1	144.9	202.9	94.7	6,040.1
Economic Recovery	37.6	68.8	30.7	22.3	27.7	41.4	245	473.5
Total	**660.0**	**4,040.0**	**721.5**	**164.9**	**192.0**	**268.2**	**345.4**	**6,664.1**

8. **Forced displacement and social cohesion are the most acute impacts of the conflict in NE Nigeria. An estimated 2 million people have been forcibly displaced by the conflict, 1.8 of which are displaced within Nigeria, making it the country with the third largest IDP population in the world.** The burden of displacement is asymmetric across regions and populations**.** Borno, at the heart of the crisis, hosts 67 percent. The majority of IDPs live in host communities with only 8.5 percent in camps and camp-like sites. The population of Maiduguri, the Borno State's capital, has more than doubled due to displaced persons. Yobe and Adamawa also share large burdens of IDPs, hosting 130,000 and 136,000 respectively, or around 6 percent in each State. Women, children, and the youth bear the brunt of forced displacement, accounting for nearly 80 percent of affected populations. Of the 1.8 million identified IDPs nationally, 53 percent are women, 57 percent are children (of which 28 percent are five or younger) (IOM, 2015).

Figure 10 NE Nigeria: Conflict Fatalities by LGA and Displacement by Ward



9. **Security remains the main factor preventing an accurate assessment of the extent of the needs of displaced population, as well as any attempts of return.** Most of Borno and parts of Yobe and Adamawa remain inaccessible due to unstable security conditions (see figure 6.2). Attempts of return by IDPs have been frustrated due to attacks by Boko Haram, forcing people to displace again. More recently, reports of unexploded ordinance have increased, preventing access to farmlands and limiting the restoration of livelihoods. Displacement has also increased vulnerability in many ways, including to Sexual- and Gender-Based Violence. There is evidence from humanitarian agencies that sexual abuse of

women and children is widespread. Girls and women who have experienced sexual violence from Boko Haram members are stigmatized by their communities, especially when they become pregnant. Men and boys also confront a range of threats, including violence, abduction, and forceful recruitment by Boko Haram and vigilante groups, and detention on suspicion of militancy sympathies.

10. **The rapid deterioration of the conflict, and vacuum of law enforcement mechanisms to contain and control conflict, resulted in widespread levels of suspicion, mistrust and stigma along ethnic, religious, political, and geographical lines.** The social fabric in the North-East was deeply damaged, eroding social relations between citizens and government, down to ethnic clans, communities and even extended families. Economic, ethnic, religious, political, and geographical divisions have hardened, affecting the way in which any recovery effort is perceived, while new divisions have emerged. The sequentially overlapping phases of humanitarian, early recovery and development assistance need to incorporate confidence and trust-building, collaboration and mutual understanding. Social impacts of efforts are central considerations in all proposed interventions in such a fragile social system.

Guiding Principles Emerging from the RPBA for Recovery and Peace Building Responses

11. The response to recovery and piece building needs in the NE will require (1) adopting holistic approaches that address the multi-dimensional impacts of the conflict; (2) retaining flexibility for future adjustment in light of post-RBPA delivery mechanisms, financial complementarity, and in-depth assessments; (3) implementation flexibility to adapt to the evolving situation around security; and (4) impact-based resource allocation along geographic, demographic and sectoral priorities.

(i). **The RPBA indicates that the recovery and peace building of the Nigerian NE calls for a holistic approach** that promotes peace, stability, and social cohesion addresses the rehabilitation of infrastructure and services, and also addresses underlying macro-economic issues to overcome the nexus of instability, conflict, and deteriorating development. Throughout this process, principles such as sustainable recovery, do-not harm approaches and building-back-better/smarter standards should be further integrated.

(ii). **Flexibility in the design of AF project components and operational and implementation modalities greatly facilitates the alignment between the post-RPBA programmatic response and the proposed AF.** The RPBA will be followed by a more detailed conflict recovery planning, prioritization and operationalization led by the Federal and State Governments and supported by the EU, UN and WB. A formal request of the GON for support during this phase has been received by partners. This post-RPBA phase will produce with a programmatic response for recovery and peace building of the NE, including duly prioritized plans for recovery at the sector levels as well as institutional arrangements for recovery for the entire recovery program in the six States as a cohesive whole. It is important that AF operations built in enough flexibility as to remain aligned with this programmatic response.

(iii). **As the situation in the NE remains fluid in terms of security and forced displacement, adaptability is key to ensure positive impacts.** Security

continues to be the number one reason preventing people from returning or resettling as large part of the NE remain unstable. The RPBA provides a series of recommendations on how to carry out interventions in this context, strongly advising that a series of steps are undertaken as to avoid that any harm is done to the affected population through operations. Risk associated with return and resettlement of displaced population have been identified as particularly high, and a series of preliminary actions have been identified as critical to ensure their safe, voluntarily and dignified return and resettlement.

(iv). **Based on RPBA findings, the following emerge as key priorities for resource allocation during stabilization and recovery:** Geographically, **i**mpacts are disproportionately concentrated in Borno, where 63 percent of total damages and hosts 67 percent of all IDPs. Within Borno, damages are heavily concentrated in areas of higher concentration of attaches including LGAs around the Sambisa forest, and LGAs closer to the border with Niger, Chad and Cameroon, and in particular those in the vicinity of the Lake Chad. LGAs with the highest concentration of IDPs include Maiduguri, Jerre, Konduga and Biu in Borno, Damaturu, Potsikum and Bade in Yobe, Michica and Yola south and north in Adamawa. Demographically**,** while the entire population in those areas has been affected by the conflict, displaced population and host communities, women (and within this group widows and abductees), unaccompanied children, youth and the elderly were identified as particularly vulnerable populations. In terms of sectoral priorities, social cohesion and peace building were identified as the most critical area for stabilization and recovery, while infrastructure and service delivery is the area in which there is highest financial need.

12. The following matrix summarizes the health priorities as identified by the RPBA:

Table 7: Summary of Health Priorities as Identified by the RPBA

Needs	Indicators for Stabilization and Recovery
Sub-component 5: Health and Nutrition	
Reconstruction or rehabilitation of PHC facilities	% of PHC facilities reconstructed/ rehabilitated
Reconstruction or rehabilitation of referral facilities (secondary hospitals)	% of secondary hospitals reconstructed/ rehabilitated
Increased availability and utilization of essential services: Deliveries attended by skilled personnel	% of deliveries attended by skilled personnel
Increased availability and utilization of essential services, particularly provided through non-permanent structures: Coverage of DPT3/Penta3	% children of 23 months or below immunized with DPT3/Penta3
Restoration of health system functions	% of facilities with CHEW trained for the essential package of service
Restoration of governance and resilience functions restored	% of LGA with operational Early Warning and Response System
Risk mitigation initiated	% of LGA with budgeted plan for awareness campaigns

ANNEX 6: WORLD BANK ENGAGEMENT FRAMEWORK IN NORTHERN NIGERIA

Context

1. **The Boko Haram insurgency has disrupted economic and social activities and has negatively affected the productive capacity, employment, and livelihoods of over fifteen million people**. The six northeast States of Borno, Yobe, Adamawa, Taraba, Bauchi and Gombe have been adversely affected by the insurgency which has severely curtailed their ability to meet the most pressing needs of IDPs, deliver basic social services and to restore essential infrastructure. The human, social and economic losses attributed to the Boko Haram insurgency are enormous, resulting in the loss of over 20,000 lives, the forced displacement of over 2 million people (nearly 80 percent are women, children and youth) by the conflict with Boko Haram, and the destruction of entire towns and villages. Furthermore, the region has witnessed a 20-30 percent decrease in crop yields and declining livestock productivity. The amount of land being used to grow food has dropped by almost 70 per cent over the past year as violence disrupted farming activities. The recently completed Northeast Nigeria RPBA[6] estimates nearly US$9.0 billion in damages across all six States. With US$5.9 billion in damages, Borno is the most affected State, followed by Adamawa (US$1.6 billion) and Yobe (US$1.2 billion). The damages to the agricultural (US$3.5 billion) and housing sectors (US$3.3 billion) are considerable and make-up three-quarters of the total losses. The economic impact of the insurgency has also transcended the geographic borders of the country, impairing cross-border trade with Niger, Chad and Cameroon.

Government's Response

2. **The critical and immediate challenge facing the GON today is ensuring the welfare of the IDPs, the host communities and the population in the conflict areas.** The immediate and effective provision of basic social services to the above target groups remains a government priority. Nigeria's Emergency Management Agency (NEMA), in coordination with State Emergency Management Agencies (SEMAs) has been monitoring IDP movements and providing a range of relief support to affected communities. According to the RPBA, food, access to clean drinking water and other emergency supplies have been provided to IDPs living in camps and many of those staying with host families in the northeast in response to Boko Haram-related violence. Emergency education for displaced children also became a priority following unprecedented attacks targeting students, teachers as well as school infrastructure. In 2014, a Safe Schools Initiative (SSI) has been setup to promote safe zones for education. In some cases, students were transferred with parental consent to other schools in States not affected by the fighting.

3. **On August 21, 2015, the GON requested donors' assistance in assessing the needs associated with peace building and crisis recovery efforts.** The joint Northeast RPBA was launched in January 2016 in support of the Government's efforts towards peace building and sustainable recovery in the northeast. The RPBA provided a framework for coordinated and coherent assistance to conflict-affected communities in the northeast. The proposed framework identified the immediate and urgent need for sustaining emergency transition activities while supporting in parallel stabilization initiatives along the three strategic areas of intervention, namely: (a) peace building and social cohesion; (b) infrastructure and social

[6] Recovery and Peace Building Assessment, *(World Bank, European Union and the United Nations, April 2016)*

services and; (c) economic recovery. The total needs across the three strategic areas of interventions are estimated to be around US$6.42 billion.

WBG's Engagement in Northern Nigeria

4. **The WBG has a critical role to play in supporting the Government in its efforts to restore stability and create economic opportunities for the most vulnerable.** Such an approach is well aligned with the WBG's twin goals of ending poverty and boosting shared prosperity. The focus of the Bank's engagement in Northern Nigeria is twofold. First, in collaboration with the authorities, the Bank has developed the Northeast Emergency Transition and Stabilization Program (NETSP) of support for the six States in the NE. In parallel, it seeks to deepen its engagement in the Northern Nigeria through the work on the formulation of a Northern Nigeria Regional Development Framework (NRDF). The Bank's support to the NE and to the North as a whole is prioritized and sequenced to complement government and development partners' interventions

Northeast Emergency Transition and Stabilization Program

5. **The Bank is fully cognizant of the importance of bridging the gap between the two phases of emergency transition and stabilization in the northeast.** A key cross-cutting objective underpinning the Bank's support relates to addressing the service delivery gaps, livelihood deficits and social cohesion issues created by the protracted crisis. The NETSP comprises a set of coordinated emergency transition and stabilization activities and targets Borno, Yobe, Adamawa, Bauchi, Gombe and Taraba. The NETSP support includes a series of AF, and a multi-sector Emergency Crisis Recovery Project (ECRP). The proposed WBG support under the NETSP (US$775 million) represents 12 percent of the total identified needs for recovery and peace building across the three strategic areas of interventions. This is expected to be further complemented by ongoing and/or planned programs funded by government and development partners in the targeted areas identified under the RPBA.

6. **The AF interventions under the NETSP focus on 4 areas: agriculture, health, education and social protection.** They are informed by the findings of the RPBA and represent a set of priority initiatives that have a tangible and quick impact. They are predominantly results-driven and aim at improving government service delivery while building on collaborative partnerships between governmental institutions and civil society. The implementation of the AF interventions relies on accumulated knowledge and existing institutional networks to assist with the rapid deployment of Bank resources.

NETSP Implementation Risks and Challenges

7. **In an environment where transition from conflict to peace remains fragile, the implementation of the NETSP is expected to face a number of challenges.** These relate to the dynamic nature of the conflict on one hand and to the evolving policy environment on the other. On the latter, both the design features and the TA to be provided under the NETSP will mitigate the anticipated policy challenges. The NETSP interventions will provide guidance to State Governments on the formulation of appropriate support schemes and subsidy systems targeting on one hand, public assets and public services (Federal and State-owned) while on the other, addressing private assets and the needs of private individuals. Such guidance will focus on the following:

(a) **Selectivity and beneficiary eligibility for government support schemes.** Social groups affected by the protracted conflict in the Northeast are quite diverse. They include among others: disabled; women and girls; elderly; youth (especially child soldiers); victims of war, IDPs living in official camps; IDPs living within host communities; refugees returning from neighboring countries; host communities; residents of areas of conflict; farmers, and so on. Hence, given the limited availability of public resources at the disposal of State Governments, guidance on the hierarchy of beneficiary groups that are eligible for immediate government assistance will be provided under the NETSP interventions.

(b) **Equity in government support schemes to private individuals and private assets.** International experience has shown that common and equitable support schemes need to be applied within beneficiary groups and across affected States (no one left behind). This is more important in situations where the NE States are implementing an array of interventions targeting various beneficiaries (IDPs, and so on) and private assets through: (i) cash transfers; (ii) financial support for repair and reconstruction of private housing; (iii) financial support for replacement of damaged private productive assets (farming tractors, and so on). Bank assistance under the NETSP will support State governments in formulating schemes that are equitable and well aligned behind past governments' track record following similar situations of natural and/or man-made disasters.

(c) **Displacement management.** The nature of population displacement resulting from the conflict is complex. Internally displaced persons in the NE include IDPs living in official camps; IDPs living within host communities; IDPs living in schools and public buildings; refugees returning from neighboring countries and resettling in official IDP camps; IDPs settling permanently in host States and IDPs returning to States and areas of origin. Bank assistance under the NETSP will support State governments in formulating consistent government policies and support schemes addressing the respective needs of each category of IDPs.

(d) **Resource mobilization strategy.** The magnitude and complexity of challenges necessitates the mobilization of considerable financial resources. As such, aligning both Federal and State budgets *(both recurrent and capital)* behind local needs while developing plans and resource mobilization strategies at international level would be required. Resources would need to cater for the basic functioning of the States, including salaries and pensions for the civil service and security sector which have a critical impact on the stabilization process. As such, Bank assistance under the NETSP will support State governments in formulating burden-sharing arrangements with the Federal Government and Development Partners.

(e) **Communication with stakeholders and beneficiaries.** The NETSP involves many nonconventional stakeholders, possibly with different priorities and interests. Coordination between these entities will become extremely difficult. This risk will be mitigated through regular information sharing processes among stakeholders, including counseling and awareness sessions for the beneficiaries to apprise them on the available support under the NETSP program.

(f) **Security and the recurrence of militancy.** The Bank foresees the difficulties in direct monitoring and supervision in the field. High security-related risks may

interfere with timely achievement of intended outcomes. Despite the external security risks, the flexibility of the NETSP design and the existing experience in quick mobilization will assist the projects in adjusting to the changing environment. Also, the government is ensuring that repatriation is announced for only those areas which have been cleared by the army and declared as safe.

(g) **Political and governance.** Due to continued insurgency in the region and lack of formal control of the government over some areas, the institution set up and the writ of the government was weakened. This led to deterioration of the informal governance structures that were being managed through the traditional authority of local leaders. The social fiber of the region has been weakened and challenged, which has been posing challenges for the government to re-establish linkages. For local people, the time tested reliance on the local elders and leaders has also grown weak. Citizen-tate relationship, improved governance and service delivery are important components of long-term development and governance reforms embedded in the NETSP.

Major Design Features of the NETSP

8. Cognizant of the implementation risks described above, the AF initiatives have incorporated a number of mitigation measures and design features that build on the findings and recommendations of the RPBA. These include:

(a) **Building on lessons learned.** The Bank's engagement under the NETSP builds on lessons learned in similar challenging circumstances. There is no *"one size fits all"* approach and a successful response needs to be flexible, creative and rapid. For example, results and service-based financing has been successfully implemented in the health sector in Adamawa with Bank support. Initial results show significant improvements in contraceptive prevalence rates, Ante Natal Care, and utilization of curative services. Experience has also shown that putting in place well-motivated and well-managed health workers with access to decentralized funding allows for large and immediate gains in service delivery during the post conflict transition phase. Furthermore, in areas where conflict is ongoing, strategies such as the use of mobile health teams to run free "health camps" that provide a broad array of medical services are being adopted.

(b) **Relying on available institutional capacities.** Given the need for a rapid and timely response, the NETSP design benefits from the available institutional capacities built under ongoing Bank financed operations. The program relies on existing institutions at both State and local government levels and work with civil society, faith-based and community-based organizations.

(c) **Factoring security concerns.** The situation in the northeast remains volatile with pockets remaining under the influence of the insurgents. To mitigate these risks, program implementation will be particularly mindful of security matters and will operate within the mechanisms established by GON and the military. Also, the Bank has extensive experience operating in fragile post-conflict areas and has demonstrated flexibility adapting to changing circumstances. The use of Third Party Monitoring Agent (TPMA) to ensure adequate fiduciary oversight and to offset the difficulties in access by Bank staff has been adopted in the design of the various project interventions.

(d) **Promoting demand-driven approaches.** Experience in restoring services in conflict-affected areas confirms that community-level empowerment and engagement are absolutely key. As such, the local participation of target community groups is an integral part of the NETSP design and implementation. This involves School-Based Management Committees (SBMC) in the education sector, Primary Health Care Development Agencies (SPHCDAs), PHC centers and non-state entities such as UN agencies and CBOs in the health sector, as well as private farmers, farming groups and farming cooperatives in the agriculture sector**.** Also, demand-based Community Driven Development (CDD) approaches have been adopted under the social protection interventions.

(e) **Integrated and balanced approach.** The NETSP design has adopted an incremental and sequenced approach focusing first on the immediate and rapid restoration and sustaining of basic social services and livelihoods followed by increasing emphasis on recovery and rehabilitation of public goods.

(f) **Targeting for maximum impact.** The NETSP supports an area-based approach that consists of a blend of statewide and LGA-specific targeting approach. Given the limited government and donor funding available, greater focus is placed on host communities and the IDPs living among them rather than on IDPs living in camps. Also, support to communities in areas of origin is envisaged so as to prepare the enabling environment for the dignified return of IDPs. The welfare impact of such an approach is justified given that several international organizations (in particular UNICEF) and CSOs are active in the IDPs camps providing education and health services. Moreover, none of the humanitarian donors agencies appear to be focusing on livelihood support either through labor-intensive public works or through cash transfers to IDPs and host communities. Some food distribution has taken place (for example, funded by FAO in health camps) but remain very limited in scale.

A State-differentiated approach for budget allocation. Considering the differing transition and stabilization needs among the six NE States, the three conflict-affected states of Borno, Yobe and Adamawa were allocated a higher share of the NETSP funds. This reflects the extent of displacement, food insecurity and destruction witnessed. However, fund allocation among states will remain flexible to cater for variation in absorptive capacity and disbursement rates.