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PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 354.7 MILLION (US$500 MILLION EQUIVALENT)

TO THE

FEDERAL REPUBLIC OF NIGERIA

FOR A

PROGRAM-FOR-RESULTS TO SUPPORT

THE SAVING ONE MILLION LIVES INITIATIVE

March 31, 2015

Health, Nutrition, and Population Global Practice (GHNDR)
Country Department (AFCW2)
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2015)

Currency Unit = Nigerian Naira (NGN)
US$1 = NGN 189.7500
US$1 = SDR 0.70932047

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ACGs	Anti-Corruption Guidelines
ACTU	Anti-Corruption and Transparency
AIS	Activity Initiation Summary
BHCPF	Basic Health Care Provision Fund
BMGF	The Bill and Melinda Gates Foundation
BPP	Bureau of Public Procurement
CAS	Country Assistance Strategy
CCT	Conditional Cash Transfer
CEMONC	Comprehensive Emergency Obstetric and Neonatal Care
CIFF	Children's Investment Fund Foundation
CIs	confidence intervals
CPAR	Country Procurement Assessment Review
CPR	Contraceptive Prevalence Rate
CPS	Country Partnership Strategy
DALY	Disability-Adjusted Life Year
DFID	Department for International Development
DHIS	District Health Information System
DHS	Demographic and Health Survey
DLIs	Disbursement-Linked Indicators
DPG	Development Partner Group
DPRS	Department of Health Planning, Research, and Statistics
DQA	Data quality assessments
DRFs	Drug Revolving Funds
ECA	Excess Crude Account
EFCC	Economic and Financial Crimes Commission
EIA	Environmental Impact assessment
EMTCT	Elimination of Mother to Child Transmission
EOC	Emergency Operations Center
ERGP	Economic Reform and Governance Project
ESMPs	Environmental and social mitigation plans
ESSA	Environmental and Social Systems Assessment
EU	European Union
EVD	Ebola Viral Disease

FFS	Fee for Service
FGON	Federal Government of Nigeria
FMOF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB, and Malaria
GHS	General Household Survey
GON	Government of Nigeria
HF	Health Facility
HFSs	Health Facility Surveys
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNLSS	Harmonized Nigeria Living Standard Survey
HNP	Health, Nutrition and Population
HPDP2	HIV/AIDS Program Development Project II
IBRD	International Bank for Reconstruction and Development
ICPC	Independent Corrupt Practices and Other Related Offences Commission
IDA	International Development Association
IFC	International Finance Corporation
IFMIS	Integrated financial management information system
IFSA	Integrated Fiduciary Systems Assessment
INT	Department of Institutional Integrity
IPF	Investment Project Financing
IQ	Intelligence Quotient
ITNs	Insecticide treated nets
IVA	Independent Verification Agent
LGA	Local Government Areas
LQAS	Lot Quality Assurance Sampling
LSMS	Living Standards Measurement Study
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG4	Millennium Development Goal 4
MDG5	Millennium Development Goal 5
ME/JSI	Measure Evaluation/John Snow International
MNCH	Maternal, neonatal, and child health
MSS	Midwife Service Scheme
NACA	National AIDS Control Agency
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS	National HIV and Reproductive Health Survey
NASCP	FMOH's AIDS control Program
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Surveys
NHSDP	National Strategic Health Development Plan
NMEP	National Malaria Elimination Program
NPHCDA	National Primary Health Care Development Agency
NPHCDA	National Primary Health Care Development Agency

NPopC	National Population Commission
NSHDP	National Strategic Health Development Plan
NSHIP	Nigerian State Health Investment Project
NSSNP	National Social Safety-Net Program
OOPs	Out-of-pocket expenditure
PBF	Performance-based financing
PDO	Project Development Objective
PDU	Program Delivery Unit
PEFA	Public Expenditure and Financial Accountability
PEIA	Political Economy and Institutional Capacity Assessment
PFM	Public financial management
PforR	Program-for-Results
PHC	Primary Health Care
PIFANs	Programmatic Integrated Fiduciary Assessments of Nigerian
PPP	Public Private Partnership
PPP	Purchasing Power Parity
PSU	Program Support Unit
QOC	Quality of care
RBF	Results-based financing
RUTF	Ready to use therapeutic food
SARA	Service Availability and Readiness Assessment
SBA	Skilled birth attendance
SBD	Standard Bidding Documents
SDI	Service Delivery Indicators
ServiCom	Service Compact With All Nigerians
SES	Socioeconomic status
SFH	Society for Family Health
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SOML	Saving One Million Lives
SPHCDA	State Primary Health Care Development Agency
SURE-P	Subsidy Reinvestment and Empowerment Program
TCG	Technical Consultative Group
U5MR	Under-five mortality rate
UBE	Universal Basic Education Program
UHC	Universal Health Coverage
UNAIDS	United Nations Program on HIV/AIDS
UNCAC	UN Convention against Corruption
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollars
VCA	Value Chain Analysis
WHO	World Health Organization
YLL	Years of Life Lost

Vice President:	Makhtar Diop
Country Director:	Marie Francoise Marie-Nelly
Senior Global Practice Director:	Timothy Grant Evans
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Task Team Leader:	Benjamin Loevinsohn

FEDERAL REPUBLIC OF NIGERIA

Saving One Million Lives Initiative Program-for-Results

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PAD DATA SHEET

Nigeria

Saving One Million Lives Initiative

PROGRAM APPRAISAL DOCUMENT

Africa Region
GHNDR - Health, Nutrition & Population – Global Practice

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Basic Information

Date:	March 31, 2015	Sectors:	Health & Public Administration – Health
Country Director:	Marie Francoise Marie – Nelly	Themes:	Child health, Health system performance, Nutrition and food security, Population and Reproductive health; and Malaria
Practice Manager/Senior Global Practice Director:	Trina S. Haque Timothy Grant Evans		
Program ID:	P146583		
Team Leader(s):	Benjamin P. Loevinsohn		

Program Implementation Period:	Start Date:	April 23,2015	End Date:	December 31, 2019

Expected Financing Effectiveness Date:	July 31, 2015
Expected Financing Closing Date:	December 31, 2019

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Program Financing Data

[ ] Loan	[ ] Grant	[ ] Other
[X] Credit		

For Loans/Credits/Others (in US$ MILLION EQUIVALENT):

Total Program Cost:	US$1,052	Total Bank Financing :	US$500
Total Cofinancing : Million		Financing Gap :	

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Financing Source	**Amount**
BORROWER/RECIPIENT	US$552 Million
IDA	US$500 Million
Total	US$1,052 Million

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Borrower:	Federal Republic of Nigeria		
Responsible Agency: Federal Ministry of Finance			
Contact:	Mr. Haruna Mohammed	Title:	Director – International Economic Relations Department
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Responsible Agency: Federal Ministry of Health			
Contact:	Dr. Ibrahim Kana	Title:	Program Manager
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Expected Disbursements (in USD Million)					
Fiscal Year	***FY16***	***FY17***	***FY18***	***FY19***	***FY20***
Annual	75	90	114	109	112
Cumulative	75	165	279	388	500

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Program Development Objective(s)			
Increase the utilization and quality of high impact reproductive, child health, and nutrition interventions.			
Compliance			
Policy			
Does the Program depart from the CAS in content or in other significant respects?		Yes [ ] NO [X]	
.			
Does the Program require any waivers of Bank policies applicable to Program-for-Results operations?		Yes [ ] NO [X]	
Have these been approved by Bank management?		Yes [ ] NO [ ]	
Is approval for any policy waiver sought from the Board?		Yes [ ] NO [X]	
Does the Program meet the Regional criteria for readiness for implementation?		Yes [X] NO [ ]	
Overall Risk Rating: Substantial			
Legal Covenants			
Name	**Recurrent**	**Due Date**	**Frequency**
Program Implementation Manual (PIM)		3 months after the Effective Date	Once
Description of Covenant Program Implementation Manual (PIM): The Recipient shall not later than three (3) months after the Effective Date, prepare a Program implementation manual in form and substance satisfactory to the Association.			
Provisions guiding the operations and procedures of the Innovation Grants developed and adopted (as part of the PIM)		12 months after Effective Date	Once
Description of Covenant The Recipient shall not later than twelve (12) months after Effective Date, cause the Innovation Fund Manager to develop and adopt, as part of the PIM, the provisions guiding the operations and procedures of the Innovation Fund (the Innovation Fund Manual), in the form and substance satisfactory to the Association.			
Recruitment of Verification		30 days after the Effective Date	Once

Agent(s)			
Description of Covenant Verification Agent(s): The Recipient shall not later than thirty (30) days after the Effective Date, through the Federal Ministry of Finance, recruit one or more organizations with experience, independence, and capacity and under the terms of reference acceptable to the Association (Independent Verification Agent[s]).			
Recruitment of the Innovation Fund Manager		9 months after Effective Date	Once
Description of Covenant Innovation Fund Manager: The Recipient shall not later than nine (9) months after the Effective Date, recruit a private firm with qualifications, experience and terms of reference acceptable to the Association ("Innovation Fund Manager").			

Conditions

Conditions of Disbursement

No withdrawal shall be made: (a) for any Disbursement Linked Result (DLR) unless and until the Recipient has furnished evidence satisfactory to the Association that said DLR has been achieved and verified, all in accordance with the Verification Protocol; or (b) for a DLR related to a DLI for a Year under Categories 1, 2, 3 and 5 unless the Recipient has furnished evidence satisfactory to the Association that an aggregate amount equivalent to the amount of Financing withdrawn in respect of the DLR under said Category for the previous Year was - as applicable - transferred to States, in a timely manner in accordance with the provisions of the Financing Agreement.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Benjamin P. Loevinsohn	Lead Public Health Specialist	Task Team Leader – Health Systems	GHNDR
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Elizabeth Radin	Health Systems - Accountability and Incentives	Oxford, United Kingdom	
Eugene Otaigbe Itua	Consultant	Abuja, Nigeria	

I. STRATEGIC CONTEXT

A. Country Context

1. **Nigeria's Growing Economy is the Largest in Africa but Poverty Rates Remain High.** Nigeria is the largest economy in Africa with an estimated 2013 GDP at about US$502 billion and also the most populous country in Africa with roughly 177 million people. Nigeria is a federal republic comprising 36 States and the Federal Capital Territory. It is a growing economy with oil as a dominant source of Government revenues and foreign exchange receipts for the past four decades although much of the economic growth experienced in recent years has been driven by agriculture, telecommunications and services. Despite economic growth and diversification, Nigeria's poverty rates remain high and almost 900 thousand children and women die every year, most from avoidable causes. As of 2009-2010, an estimated 46 percent of the population (with adult equivalent correction) was estimated to live below the official poverty line,[1] close to US$1.25 a day Purchasing Power Parity (PPP) corrected. Inequality in Nigeria is high and poverty is particularly concentrated in certain regions of the country, most notably in the North East and the North West. The last official Gini coefficient was 0.45 according to the 2009/10 H Harmonized Nigeria Living Standard Survey (NLSS), while a 2012/13 General Household Survey (GHS) found a Gini Coefficient of 0.41.

2. **While Most Nigerians Live in Peaceful Coexistence, Contentious Relations Among Different Groups Have Arisen in Several Parts Of The Country.** Since independence in 1960, Nigeria's political history has been turbulent, punctuated by periods of urban riots and political confrontations. Currently, some of the most significant challenges include (a) the insurgency of a violent group popularly known as Boko Haram in the North East where service delivery is the weakest and poverty rates are the highest (since June 2013, the three northeastern States, Adamawa, Yobe and Borno, have been under a State of emergency to curb the violence and insurgency acts of Boko Haram); (b) inter-communal violence over access to economic and natural resources and political power throughout the country but especially in Plateau State; (c) kidnappings, armed robbery, oil theft and communal conflicts over oil spills especially in the South-South geo-political zone of the country; and (d) ongoing efforts to reintegrate militants under an Amnesty Law in the Niger Delta**.**

3. **The Nigerian Government Faces a Serious Revenue Challenge**. Although macroeconomic performance remains strong, the sharp decline in oil prices has put significant pressure on the macro-fiscal situation, including development financing. Growth in 2014 is estimated to have been 6.1 percent, compared to 5.4 percent in 2013. Similarly, inflation has remained in single digits with January 2015 inflation recorded at 8.2 percent. However, world oil prices have declined by more than 45 percent since June 2014. Since oil accounts for more than 70 percent of Nigeria's fiscal revenues, the Government has had to introduce additional measures to increase non-oil revenues and control expenditures. In December 2014, the Government presented to the National Assembly a proposed budget for 2015 that was seven percent lower in nominal terms than the approved budget for 2014 and which was based on an oil benchmark price of US$65 per barrel. The proposed allocation to health was 5.6 percent lower than in 2014. However, due to the continued decline in oil prices, the Government has

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

further revised the benchmark price to US$53 per barrel. While additional revenue raising measures are being explored, further cuts to some expenditure items seem inevitable.

B. Sectoral and Institutional Context

4. **About 900,000 Children and Mothers Die Each Year in Nigeria.** Over the last decade the trend in health, nutrition, and population (HNP) outcomes in Nigeria is mixed. Data from the last three Nigeria Demographic and Health Surveys (NDHSs)[2] demonstrates a 36 percent decline during this period in the under-five mortality rate (U5MR) and a 31 percent decline in the infant mortality rate (see Table 1). However the country is still not on track to achieve MDG4. There has been almost no progress on reducing maternal mortality (MDG5) and fertility remains stubbornly high. Childhood malnutrition has actually worsened by some measures (low weight for age has increased by 21 percent and wasting has increased 64 percent) and improved only modestly (12 percent) in terms of stunting (low height for age).

5. **Nigeria Contributes Substantially to Global Under-Five and Maternal Mortality.** Nigeria's ability to address under - five and maternal mortality will affect global progress towards MDGs 4 and 5. Nigeria contributes 14 percent of all maternal deaths globally, second only to India at 17 percent.[3] Similarly, Nigeria accounts for 13 percent of all Under-five deaths globally, again second only to India at 21 percent.[4]

Table 1: HNP Outcomes in Nigeria 2003-2013

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

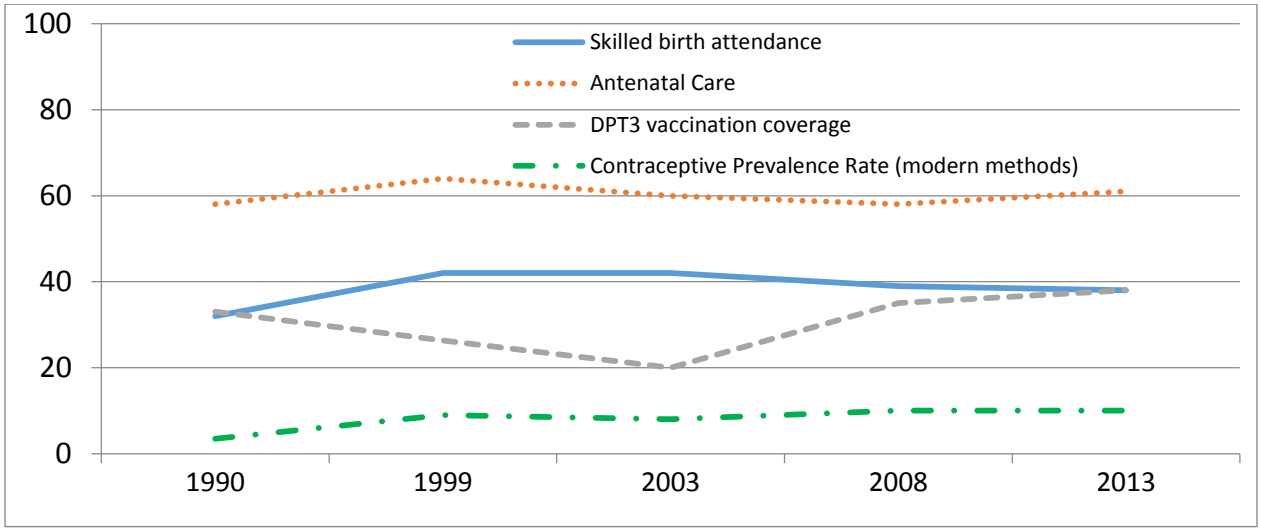
Source: Nigeria Demographic and Health Surveys (NDHS). Sub-Saharan Africa data is from World Development Indicators and is for 2012. The data are not strictly comparable and SSA data is just illustrative.

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

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

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

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



Source: NDHS.

6. **Limited Progress on Health Service Delivery.** The limited progress on HNP outcomes observed in Nigeria is consistent with the picture in service delivery (see Figure 1). Over the last two decades the coverage of key health interventions has stagnated at low levels. The lack of progress on services such as family planning, antenatal care, and skilled birth attendance militates against achieving MDG5. Progress on service delivery generally has been slower than in neighboring countries (see figure 11 in Annex 4).

7. **Quality of Care is low.** The limited coverage of important interventions is further aggravated by poor quality of care. Results from the Bank-supported Service Delivery Indicators (SDI) Survey indicate that many health workers perform poorly on standardized tests of knowledge and lack the skills to effectively treat common and important ailments in children or mothers. Of particular concern is that the cadre of health workers who provide primary health care in public health centers have limited knowledge of how to handle common diseases such as malaria, pneumonia, and diarrhea. SDI results indicate that Nigeria does less well than other large countries in Sub-Saharan Africa.

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

Table 2: Health Outcomes and Outputs by Income Quintile

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

Source: NDHS 2013 and Staff Calculations.

9. **Geographical Inequity – The North East and North West lag far behind:** In addition to income inequality, there are also important inequities among Nigeria's geo-political zones. The U5MR is twice as high in the North West compared to the South West (185/1000 and 90/1000 respectively according to the 2013 NDHS) and service delivery is also far behind. For example, immunization coverage (DPT3/Penta3) is 14 percent and 21 percent in the North West and North East respectively compared to 70 percent in the South-South and 80 percent in the Southeast (NDHS 2013).

10. **The Development Consequences of Lack of Progress in Health are Serious.** Besides the human suffering engendered by poor HNP outcomes, there are also serious economic consequences, including:

(i) It may take decades for Nigeria to capture the kind of "demographic dividend" that was so beneficial to the East Asian ("Tiger") economies[5] where it may have contributed a third of GDP growth. Also, in East Asia improvements in health outcomes (such as the infant mortality rate) preceded economic take-off;

(ii) Human capital formation is being adversely affected resulting in lost IQ (at least partly due to frequent illnesses as well as iodine and iron deficiencies) leading to an inability to fully take advantage of educational opportunities;

(iii) Preventing people from escaping poverty and driving them deeper into debt. Serious illnesses act as economic shocks that are frequently associated with asset sales and informal borrowing that have long-term adverse consequences for families; and

(iv) Efforts at improving the social safety net for poor people and increasing the demand for services will be stymied if health service delivery is not substantially improved.

11. **Saving One Million Lives is a Meant to be a Bold Response to the Lack of Progress.** One of the responses by the Federal Government of Nigeria (FGON) to the challenges described above is the Saving One Million Lives (SOML) Program. SOML is meant to improve maternal

[5] Bloom D, Finlay K, Humair S, Mason A, Olaniyan O, Soyibo (2010) Prospects for Economic Growth in Nigeria: A Demographic Perspective, Paper presented at IUSSP on Demographics and Macroeconomic Performance.

and child health outcomes so that they are more in keeping with the country's level of wealth. It also intends for the health sector to contribute to the economic and social development of Nigeria instead of being a drag on growth. Inaugurated by the President in October 2012, SOML focuses on six important aspects ("pillars") of Maternal and Child Health (MCH) that can change outcomes. The FGON's Program document plainly States that "Continuing business as usual is not a viable option." It goes on to stress that SOML represents "***a shift in focus from inputs to focusing on results and outcomes***." The SOML Program is also predicated on the fact that "***bold innovations and changes in the approach to delivery in the sector are necessary*** (emphasis added)**.**"

Box 1: Managerial and Organizational Lessons from Nigeria's Ebola Response

The Bank carried out a case study of the organizational and managerial lessons that can be gleaned from Nigeria's successful response to Ebola Viral Disease (EVD). There are a few key themes that emerge from the case study:

Taking Advantage of Existing Systems. The EVD response consciously took advantage of existing systems and resources. It drew extensively on the Polio and Lassa fever Programs as well as other disease surveillance initiatives. For example, the Emergency Operations Center (EOC) and many of the people involved in the EVD response came from the Polio Program.

Managerial Autonomy is Critical to Efficiency. Mid-level managers were given control over their operations and could take decisions quickly. This prevented bureaucratic delays. For instance, the Minister for Health, during daily briefings, provided advice but left decisions to his EOC managers.

Motivation Matters. The fear engendered by EVD allowed bureaucratic hurdles to be overcome quickly. When vehicles were needed for contact tracing, the Lagos State government provided them in under 24 hours.

Data and its Analysis Underpins Success. Data on the outbreak was reviewed twice daily and pored over to ensure its reliability. For example, tablets that had been used in the Polio eradication Program were able to detect when people carrying out contact tracing had not actually visited the houses of the contacts. This problem was quickly remedied.

12. **Input-Related Issues Explain Little of the Problem.** Issues that are important in other parts of Africa do not seem to explain the slow progress of the health sector in Nigeria: (i) lack of funding: while public expenditure on health is low compared to GDP and total budget, funding alone does not appear to have much influence on service delivery. There is no correlation between State level expenditures in health and health outputs such as skilled birth attendance (see Figure 13 in Annex 4); (ii) lack of inputs such as drugs: while there is clearly a shortage of medicines in primary health centers, the SDI survey also found no correlation between drug availability and patient volume; (iii) lack of infrastructure: 67 percent of the population live within 30 minutes' walk of a health facility, 85 percent live within 1 hours walk (LSMS 2010/11). This compares favorably to neighboring countries; (iv) shortage of health workers: the ratio of health worker to population is substantially higher than neighboring

countries (it is twice the sub-Sahara African average) and many health facilities are actually over-staffed.

13. **Complex and Fragmented Institutional Arrangements for Delivering Public Sector Health Services.** The public service delivery system in Nigeria is characterized by overlapping and unclear institutional arrangements.[6] According to the 1999 Constitution Local Governments are supposed to provide primary health care (PHC) services. In practice, Federal, State and local Government all play roles in the financing and delivery of services. Local Government Areas (LGAs) have been responsible for funding the operating costs of the PHC system but it is rarely a priority. The weakness of LGA financial reporting and the range of additional State and Federal Programs for PHC means that it has been challenging to make an accurate consolidated assessment of the resources used for PHC. Almost no financial resources are directly managed at the primary health facility level, except in some States where Drug Revolving Funds (DRFs) have been established or where user charges are collected.

14. **Federal Government Plays an Important Role in PHC.** It is estimated that the Federal Government contributes about 22 percent of all the funding for PHC but a much greater proportion of the non-salary expenditure. FGON resources are often supplied in kind, such as the provision of commodities, vaccines and specialized drugs for HIV and Tuberculosis. In addition, the FGON has a number of special schemes to support PHC, including activities under the National Primary Healthcare Development Agency (NPHCDA). These include: (i) the Midwife Service Scheme (MSS) which pays the salaries and support costs for the deployment of many thousands of midwives to under-served rural areas; (ii) the Subsidy Reinvestment and Empowerment Program (SURE-P) which provides support, inter-alia, for infrastructure, development of human resources, and a conditional cash transfer Program; and (iii) the MDG Fund which supports the construction of additional health facilities, among other things, and relies partly on counterpart funds from the States.

15. **Efforts are Underway to Simplify the System.** The FGON, through the NPHCDA, has been promoting the establishment of State Primary Healthcare Development Agencies (SPHCDAs) as a way of consolidating the management of the PHC system at the State level. Twenty-four out of 36 States have established SPHCDAs, but the extent to which PHC system staffing and finance have been consolidated under the SPHCDA varies greatly between States.

16. **Accountability Mechanisms are Weak.** Given the complex institutional setup, accountability mechanisms are weak. Because funding and other resources come from diverse sources, and fund provision is unpredictable and often unrelated to budgets, managers in the PHC system are not held accountable for results. Accountability through Local Government is undermined by the fact that elected local councils are frequently suspended by State Governors. Except where functions have been consolidated under the SPHCDA there is no central point of accountability for the State PHC system as a whole. While there are functioning human resource management systems, there are generally few incentives for good staff performance and almost no sanctions for poor performance. Data on results are rarely published and are used to only a limited extent for management purposes. In addition, there is little accountability to the

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

community despite the existence of Ward or Village Development Committees. All this translates into weak incentive structures and contributes to poor performance.

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

18. **Health Care Financing is Mostly Out-of-Pocket and Public Expenditure is Unlikely to Increase Much.** It is difficult to get reliable information on health care financing in Nigeria as efforts by the Bank (which is currently carrying out a resource tracking survey) and other partners can attest. While keeping in mind the limitations of the data, there are a few salient points (more details are in Annex 4) on which there is widespread agreement: (i) there is high out-of-pocket (OOPs) expenditure representing about two/thirds of total health expenditure. This is consistent with the wide use of the private sector, low levels of public expenditure on health, and limited use of risk pooling; (ii) public expenditure is inefficient, partly because there is little non-salary recurrent budget. What little there is does not end up at health facility level; (iii) public health expenditure, currently about 1.2 percent of GDP and about 7 percent of budget, may increase modestly as a result of economic growth and increased commitment to health (as exemplified by the recent signing of the "Health Bill"). However, the Government's heavy dependence on oil (which accounts for about 75 percent of its revenues), makes it unlikely that overall public revenues will increase substantially over the medium term. In this context increases in public expenditure on health are likely to be modest in the next few years.

19. **Recent Experience with PBF Gives Some Hints about what Might Work.** Some recent experiences in Nigeria suggest means of improving health system performance. For example, performance-based financing (PBF) was introduced in three pilot LGAs three years ago as part of the Bank-funded Nigeria State Health Investment Project (NSHIP). Under PBF, individual health facilities (both public and private) are provided cash payments (through electronic transfer to their bank accounts) based on the quantity and quality of key maternal and child health services they provide. The facilities have considerable autonomy in how they use the cash including for physical upgrading, buying drugs, and providing monetary incentives to staff (for more details on how PBF operates see Annex 4). A recent household survey comparing the three PBF LGAs with nearby control LGAs that did not implement PBF found some important results. After controlling for socio-economic variables, contraceptive prevalence, antenatal care, and utilization were significantly higher in the PBF LGAs (see Figure 14 in Annex 4). The increase in Contraceptive Prevalence Rate (CPR) of 11.5 percentage points in two years was particularly impressive given the slow progress in the last 2 decades in Nigeria as a whole (6.5 percentage points). 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 given the available fiscal space. PBF has now been scaled up to all the LGAs in three NSHIP States.

20. **Factors for Success in PBF and Lessons Learned.** The success of PBF thus far appears to be due to a number of factors, including: (i) it provides a clear signal to health staff about what

is important; (ii) it rewards staff for their efforts; (iii) it provides legitimate operating funds at health facility level, something they have rarely, if ever, had before; (iv) it gives health staff, particularly the officer in charge, substantial autonomy and this gives them the opportunity to innovate; and (v) it has substantially strengthened supervision. PBF has also faced a few challenges that are instructive, including: (i) delays in payment have a very deleterious effect on performance; (ii) the quality of management at facility level appears to be a constraint that needs to be addressed; and (iii) the system relies on independent and robust assessments of performance.

21. **Other Recent Successes Demonstrate that it is Possible to Make Substantial Progress.** Nigeria has not had a wild polio case since July 24, 2014 which is the more remarkable because it has taken place despite an active effort from Boko Haram to interfere with polio eradication activities. Independent analysis for the reasons for this success emphasize increased accountability for results and improved management. Over the last few years the country has been able to make steady progress on elimination of mother to child transmission of HIV (EMTCT), going from 13,000 HIV positive mothers receiving ART in 2006 to nearly 58,000 in 2013 (UNAIDS). The relatively rapid rollout appears to be at least partly due to the use of non-State implementing partners (IPs) who work with the public sector to improve services. Some States, such as Enugu, Kwara, Adamawa, and Bayelsa have made remarkable progress in delivering maternal and child health services over the last 5 years (see Annex 4) which is way above the country average. This suggests that committed States can achieve results in short order.

C. Relationship to the CAS/CPS and Rationale for Use of Instrument

22. **The proposed operation is fully aligned with the IBRD/IDA/IFC/MIGA Country Partnership Strategy (CPS) FY2014-2017 (discussed by the Board on April 24, 2014).** This operation is fully aligned with all three of the "strategic clusters" of the CPS. 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." The proposed operation's commitment to greater transparency, increased accountability, and improved availability of good quality data fully supports the thrust of the third cluster which seeks to improve governance and public sector management.

23. **The proposed operation may contribute to helping Nigeria capture a large demographic dividend that would in turn contribute to economic growth.** With its support for reducing under-five mortality and increasing the contraceptive prevalence rate, this operation could contribute to a fertility transition. Such a transition would be the sine qua non for Nigeria's ability to capture a substantial demographic dividend that accelerates economic growth. A possible rapid change in fertility would alter the age structure of the population in the next couple of decades leading to a change in the dependency ratio of the kind that was an essential part of the economic acceleration that benefited the East Asian economies over the last forty years. The experience in East Asia also suggests that reductions in under-five mortality and stunting precede, rather than follow, economic take-off.

24. **Bank Involvement would Add Value to SOML**: The Bank took an early and strong interest in SOML, participating energetically in the "appraisal" of SOML that the FGON requested in 2012. In addition, the Bank provided "just in time" technical assistance in response to specific Federal Ministry of Health (FMOH) requests on: (i) monitoring and evaluation mechanisms to support SOML; (ii) examining means for improving quality of care; and (iii) development of costed options for scaling up activities to address malnutrition. The Bank's value added to SOML includes:

(i) Extensive experience with results-based financing (RBF) approaches both globally and in Nigeria as part of the Nigerian State Health Investment Project (NSHIP). This has included three years of helping the country implement PBF in three LGAs in Ondo, Nasarawa, and Adamawa. Also as part of NSHIP, these three States have gained experience with disbursement-linked indicators (DLIs);

(ii) Expertise in strengthening evidence-based decision making, including monitoring and evaluation (M&E) systems: Bank support has fostered some important innovations such as lot quality assurance sampling (LQAS), health facility surveys, and impact evaluations. LQAS surveys were introduced as part of the Malaria Booster Project in 2006 and have since been used for other Programs including polio eradication. The Bank enabled the first systematic health facility survey in Nigeria (the SDI survey) that addresses all aspects of quality of care (not simply the availability of inputs and infrastructure). The Bank has also been at the forefront of impact evaluation in the health sector in Nigeria with more than 6 planned or ongoing evaluations;

(iii) Understanding and experience of working with the private sector: Helping the FGON and State Governments work effectively with the private sector will be a crucial part of SOML's success. Both the IFC and the World Bank have been working extensively with the private health sector. Under the current HIV/AIDS project (HPDP2), the Government has learned how to systematically contract with civil society organizations for delivering HIV related services. The IFC is very active in Nigeria and has done considerable work on health insurance and public-private partnerships.

25. **SOML is a good fit for a PforR.** SOML meets the criteria for using a PforR approach in that it: (i) is a clearly articulated and coherent Program aimed at achieving measurable results; (ii) it is an existing Program for which there is widespread support; (iii) the Program is technically sound and focuses on cost-effective, high impact interventions; (iv) includes a robust approach to M&E that relies on diverse sources of data including household and health facility surveys, and describes a way of using the data to increase accountability; and (v) builds on the experience with results-based approaches implemented through the NSHIP.

26. **A PforR would be the Best Option for Supporting SOML.** With its explicit interest in changing the focus from inputs to actual results, SOML is a Program that would benefit more from PforR support than from a traditional Investment Project Financing (IPF). An IPF would be extremely transaction intensive as the Program is country-wide in scope. The diagnosis implicit in SOML is that the country is not constrained by the level of inputs or the types of health interventions, but rather that it needs to make more efficient use of existing and likely future resources. Improvements in performance will require increased accountability, improved

motivation, and stronger management. The policies of the FGON needed to achieve SOML are already in place so a sectoral development policy operation would not be appropriate.

II. PROGRAM DESCRIPTION

A. Program Scope

27. **The Name is the Target.** The original goal of the SOML Program was to save the lives of one million mothers and children by 2015. However, FGON has recently written to the Bank indicating its intention to extend the Program for five years as part of its Second National Strategic Health Development Plan (NHSDP) 2016-20. This has been re-confirmed by the current Minister of Health. Given that close to 1 million children under five and women die every year in Nigeria, many of them from easily preventable causes, the name of the Program continues to be a fitting commitment to save as many of those lives as possible.

28. **The SOML Program Focuses Interventions of Proven Cost-Effectiveness and Impact.** SOML builds on the President's Transformation Agenda and the First National Strategic Health Development Plan 2010 to 2015. It gives renewed priority to a package of high impact, evidence-based, cost-effective health interventions known as the six pillars: (i) maternal, newborn and child health; (ii) childhood essential medicines and increasing treatment of important childhood diseases; (iii) improving child nutrition; (iv) immunization; (v) malaria control; and (vi) the Elimination of Mother to Child Transmission (EMTCT) of HIV. The objective is to dramatically improve the coverage of these interventions that currently suffer from poor access and utilization. In addition, to its six "pillars" the SOML Program also includes two "enablers": (i) promoting innovation and the use of information and communications technology; and (ii) improving the supply and distribution chain.

29. **What's new about SOML?** Given its focus on existing mother and child health initiatives, it is reasonable to ask what is new about SOML? The SOML Program involves: (i) re-orienting the discussion of service delivery to results rather than just inputs; (ii) clearly articulating strategic priorities for the FGON and the rest of the health sector and strengthening the long term commitment to improving the delivery of these high impact HNP interventions. It does not say that other interventions are unimportant, just that the selected intervention ("pillars") are priorities that should get the first call on resources, effort, and attention; (iii) establishing a limited set of clear and measurable indicators by which to track success; (iv) strengthening data collection so that these indicators can be measured more frequently and more robustly; (v) bolstering accountability so that managers and health workers at all levels are engaged, encouraged, and incentivized to achieve better results; and (vi) fostering innovations that increase the focus on results and include greater openness to working with the private sector.

30. **SOML is a Federal Program.** SOML is a Federal Program and was initiated by the FMOH. The FGON is the principal advocate for SOML very much in keeping with its rightful role of providing strategic direction for the health sector in Nigeria. SOML is also intended to strengthen fiscal federalism by changing the Federal-State relationship from one where roles are sometimes duplicated and implementation is not well coordinated to one governed by a results-based partnership.

31. **Delineation of the PforR Support – What the Federal Government can Influence.** As indicated above, SOML is a Federal Government Program aimed at strengthening six "pillars" of MCH. Perhaps the best way of conceiving the Program is to consider how in the Nigerian context, the FGON, particularly the FMOH, can influence the delivery of key MCH

services at health facility level and in the community. Since it has no managerial control over the 36+1 States, let alone the 774 LGAs or the 37,000 publicly owned health facilities, to actually affect what happens on the ground the FGON has to rely on the levers it does have, namely strategic priority setting, data collection and analysis, technical assistance, distributing specialized commodities (typically through the States) providing rewards & recognition, setting standards, etc. (see figure 2). Using these levers, it is feasible for the FGON to influence the behaviors of States for example through: (i) collection of robust data on service delivery at community and health facility level and feeding it back to States; (ii) rewarding States for better performance; (iii) provision of technical assistance; or (iv) provision of ITNs to States for them to distribute. Thus the FGON's SOML Program is really a Federal level initiative (see the solid box in Figure 2) that influences States (the dotted line in Figure 2). Thus the boundaries of the Bank's PforR, the funding, and accountability are all at Federal level. Nonetheless, the results will be measured by State.

32. **States Can Directly Influence Service Delivery.** While the FGON has little direct influence over health facilities and service delivery, State governments do have direct influence on providers and their authority is increasing with the advent of SPHCDAs. States can strengthen actual service delivery in a large number of ways (see large arrows in Figure 2 and also figure 4) including: (i) strengthening health facility supervision; (ii) increasing the number of sites able to provide EMTCT; (iii) procuring more drugs; (iv) bolstering LGA management; (v) providing funds to facilities; (vi) working with the private sector etc. According to the latest available figures, the average State is currently spending about US$12 to US$15 million per year on PHC. The PforR is expected to channel around $410 million directly to States based on their performance, an average of US$11.1 million per State over the life of the project, or about US$2.1 million per year on average. If a State were to meet the targets for the PforR they would earn about 15-20 percent of the States' current expenditure through performance payments and this will be sufficient to encourage them to maximize their influence on service delivery.

33. **Program Expenditure Framework for SOML.** At the Federal level, expenditures on SOML are primarily derived from activities by NPHCDA (the bulk) and to a lesser extent from the National Malaria Elimination Program (NMEP) and the HIV/AIDS control Program (NASCP). Other sources of expenditure such as SURE-P (the FGON Program for reinvestment of savings as a result of eliminating the fuel subsidies in 2012, the value of which is the notional savings has declined with the large decline in market prices for oil) and the MDG Fund have not been included in the Program of expenditure as they are expected to decline significantly over the next few years. Because, the last 4 years have seen rapid growth in PHC expenditures by FGON and the Government has enacted a National Health Bill, a modest increase is assumed in subsequent years (2016-2019). The actual expenditures will be easily traced through the FGON's integrated financial management information system. Overall, the Bank's contribution to SOML Program financing is limited to US$500 million equivalent which represents 48 percent of FGON expenditure during the life of the operation (Table 3). Of course, other development partners are supporting MCH related activities outside the Government's budget system. The size of this complimentary financing is in Annex 1.

Figure 2: SOML Program Boundary

Level	Six Pillars of SOML					
	HIV/AIDS	**Immunization**	**Nutrition**	**Malaria**	**MNCH**	**Essential Medicines**
Federal – ***NOT*** SOML	Treatment of adult males & non-pregnant women; work with high risk populations	Meningitis vaccination, other non-childhood vaccines	Dietary diversification, food security	Indoor residual spraying;	Hysterectomy Cancer treatment	Leukemia, congenital defects
Federal – SOML	Prevention of mother to child transmission	Routine Childhood Immunization; Tetanus toxoid for mothers; polio eradication	Growth Monitoring & Promotion; Treatment of acutely malnourished children; Micronutrient supplementation	ITN distribution; diagnosis & treatment with ACTs	Antenatal, obstetric, & post-natal care; Family planning; Deploy midwives; VVF prevention	Community treatment of malaria, pneumonia, diarrhea
Federal Roles & Activities	a) Setting objectives; b) Establishing standards and protocols; c) Training; d) Procure & distribute specialized products (vaccines, ARVs etc.); ***e) Technical assistance; f) Assessment and M&E; g) Provision of additional support (e.g. promotion of MNCH weeks); h) financing & resource mobilization; i) promotion of innovations (e.g. PBF); j) incentives (rewards & recognition)***					
State Roles & Activities	a) Supervision of LGAs and facilities; b) analysis of performance data; c) problem identification & resolution; d) training; e) deployment and management of human resources; f) resource mobilization; g) procurement & distribution of drugs; h) technical help to LGAs					
LGA Roles & Activities	a) Supervision of individual health facilities; b) Motivation of health workers; c) distribution of commodities; d) training; e) micro-planning for MNCH weeks, ITN distribution					
Health Facility Roles & Activities	a) Care of individual women and children; b) immunization of women & children; c) outreach to the community; d) skilled birth attendance & family planning; e) participation in MNCH weeks and ITN distribution; f) nutrition screening & treatment; g) HIV screening of pregnant women					

SOML Program Boundary

SOML Program Direct Influence

SOML Program Indirect Influence

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

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

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

Source: Federal IFMIS Report, January 2015.

B. Program Development Objective/s

34. **Utilization and Quality of High Impact Maternal and Child Health Interventions.** The FGON's Program Document States that: "The objective of the Program initiative is to save one million lives in Nigeria, through integration of essential priority interventions into primary health care, equitably increase access to, and utilization of quality cost-effective basic health interventions." The PDO for this operation will thus be: To increase the utilization and quality of high impact reproductive, child health and nutrition interventions.

C. Program Key Results and Disbursement Linked Indicators

35. The PDO indicators for this operation are listed below. The first indicator will be tracked by income quintile to determine whether the poorest 40 percent of the population have experienced significant progress. The results to be achieved will be measured annually and targets will be based on the historical progress on these indicators in Nigeria and globally:

(i) Increase in the combined coverage of six key SOML services; (a) vaccination coverage among young children (Pentavalent3); (b) contraceptive prevalence rate (modern methods); (c) Vitamin A supplementation among children 6 months to 5 years of age; (d) skilled birth attendance; (e) HIV counselling and testing among women attending antenatal care; and (f) use of insecticide treated nets (ITNs) by children under five; and

(ii) Improved quality of care index at health center level.

36. **Completing the "Half-Built Bridge" - Strengthening Governance by Paying for Results, Increasing Accountability, Improving Management, and Encouraging Innovation.** Nigeria has made limited progress in the health sector over the last two decades which means that some 900,000 children and mothers are dying per year. The slow rate of progress has serious economic and development consequences. Simple solutions focused on improving inputs have not worked in the past but the availability of many of the needed inputs (such as health facilities and trained health workers) suggests that governance, broadly defined, is the binding constraint. This has been recognized by the Government which is why the SOML initiative provides an opportunity to change the game and boldly address governance and management issues. This PforR operation supports SOML and ensures: (i) a greater focus on results; (ii) increased accountability; (iii) improved measurement; (iv) strengthened management; and (v) encouragement of innovation. Besides its direct effect on health outcomes, the operation provides an opportunity to test on a broad scale means for enhancing governance that could have consequences beyond the health sector.

37. **Results Chain – Saving One Million Lives.** The PforR aims to complete the "half-built bridge" in order to save the lives of mothers and children. This will be accomplished by strengthening management and governance at State level using a performance based approach and "management by results." The improved management capacity and governance is the key requirement for improving the "production function" and turning the existing health workers, health facilities, technical protocols, etc. into increased service utilization and improved quality of care (see the results chain graphic in Figure 3). The way in which the SOML PforR influences health facilities and service delivery is described in Figure 4.

38. **Disbursement-Linked Indicators (DLIs).** The proposed PforR will provide funds to the FGON based on a set of DLIs described below, summarized in Table 4, and described in operational detail in Annex 3 (where there are the formulae for how disbursements will be calculated with worked examples). The DLIs have been chosen, in consultation with government based on the Government' SOML Program Document (2012).

Figure 3: Results Chain for SOML PforR

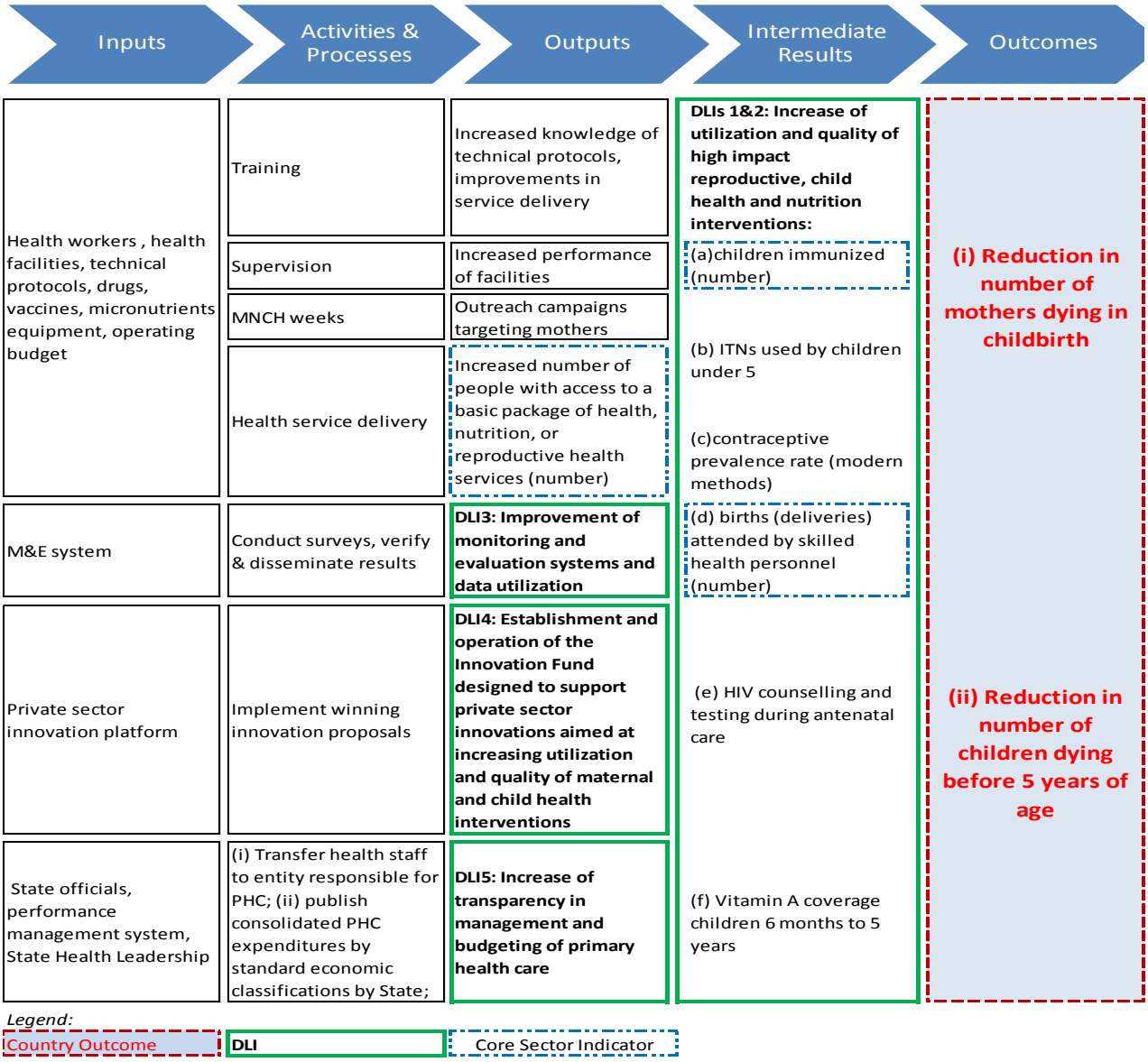
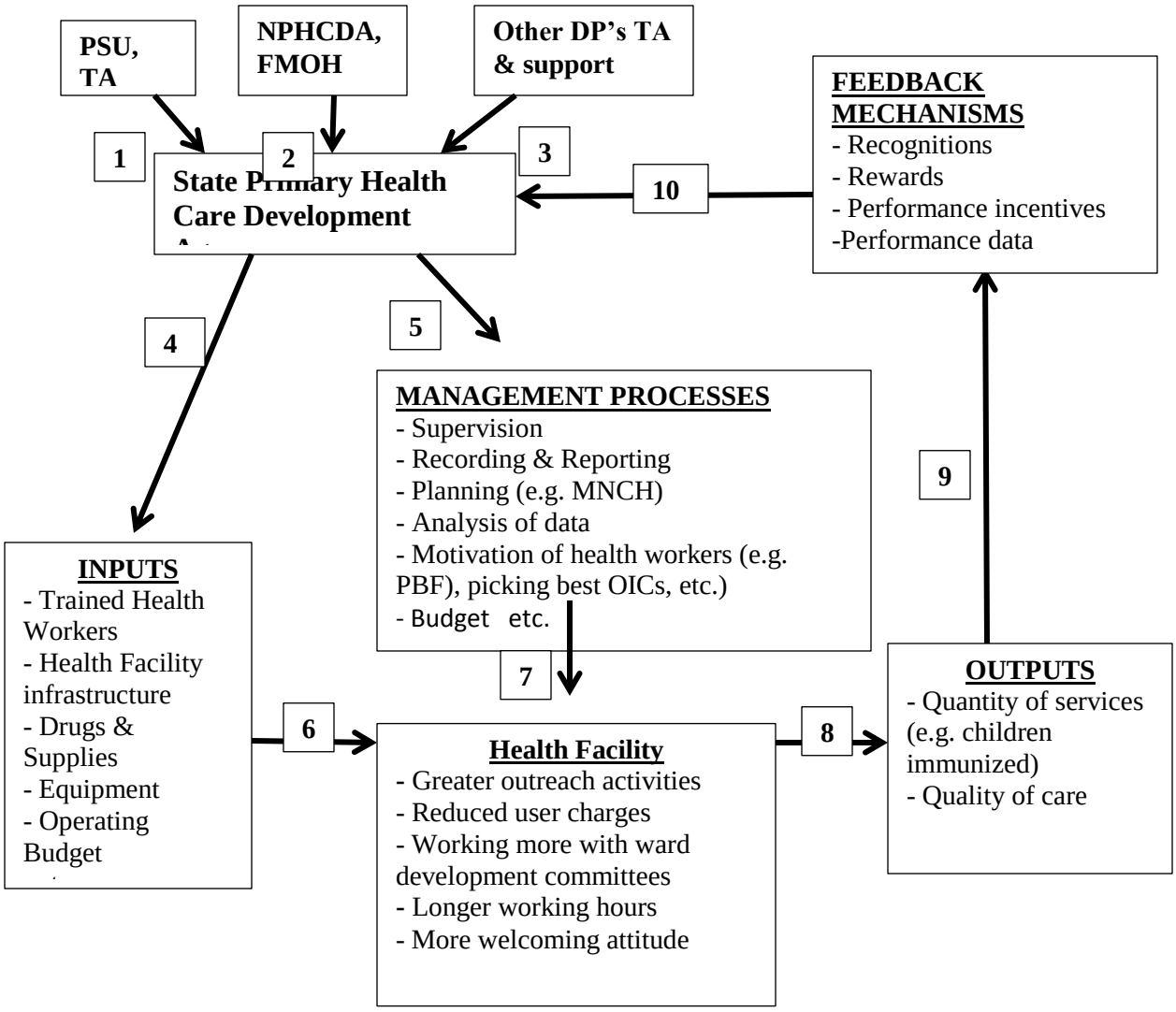


Figure 4: How SOML PforR Influences Activities at Health Facility Level



The State Primary Health Care Development Agency (SPHCDA) receives technical support, capacity building, and improved processes (for example better ways of carrying out supervision) from a variety of sources including NPHCDA, other development partners, and the PSU (arrows 1, 2, & 3). It also receives performance incentives, recognition, and data as part of other DLIs under the PforR (arrow 10). The better motivated and more capable SPHCDA does a better job of providing the inputs (arrow 4) and management processes (arrow 5) that allow it to directly and more effectively influence health facilities (arrows 6 & 7). The health facilities, benefiting from more and more effective inputs and processes, provide more and better quality services (arrow 8). There are a number of ways they do this including more outreach to communities, reduced user charges etc. The household and health facility surveys provide a means for evaluating health facility performance. The results affect the SPHCDA through the feedback mechanisms (arrow 9) that completes the feedback loop. The evidence on the primacy of management as a means of improving service delivery is discussed in Annex 4.

Table 4: DLI Summary Matrix

Disbursement Linked Indicator	Means of Verification	Indicative Allocation (US$M)	% of Total
DLI 1- Increase of utilization of High Impact Reproductive, Child Health and Nutrition Interventions DLI 1.1 States produce plans for achieving reductions in Maternal, Perinatal and Under-5 child mortality DLI 1.2 Improvements on 6 key health indicators: a) Penta3 vaccination, b) Insecticide treated nets used by children under 5, c) Contraceptive prevalence rate, d) Skilled birth attendance, e) HIV counselling and testing during antenatal care, and f) Vitamin A coverage children 6 months to 5 years. DLI 1.3. Lagging States will strengthen their MNCH weeks as part of an impact evaluation.	SMART Survey Results disaggregated by State Review by FMOH & IVA	305	61
DLI 2- Increase of quality of High Impact Reproductive, Child Health and Nutrition Interventions: States will improve the quality of care at primary health care facilities.	Health Facility Survey Results disaggregated by State Review by FMOH & IVA	54	11
DLI 3- Improvement of monitoring and evaluation systems and data utilization DLI 3.1 Improving M&E Systems a) Conduct SMART surveys in all 36+1 States; b) introduce annual health facility surveys (harmonized based on SDI and SARA methodologies) covering all 36+1 States; and c) Collect data on MMR through the 2016 census (or an acceptable alternative). DLI 3.2 Improving Data Utilization a) widely disseminate the results of SMART and harmonized health facility survey data; b) strengthen management capacity of State health and FMOH leadership. DLI 3.3 Implementing Performance Management a) Implement performance management system in all States.	Review of survey reports by Independent Verification Agent (IVA) Review by FMOH & IVA Review by FMOH & IVA	80	16

Disbursement Linked Indicator	Means of Verification	Indicative Allocation (US$M)	% of Total
DLI4 – Establishment and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions: A competitive innovation fund will be established and effectively managed that supports innovations for techniques and technologies and innovations in health service delivery by private sector providers.	Review by FMOH, IVA and external auditors	20	4
DLI5 – Increase of transparency in management and budgeting of primary health care: States will: (i) transfer health staff to entity responsible for PHC; and (ii) produce and publish a consolidated budget execution report covering all income and expenditures for PHC. The FGON will publish a consolidated budget execution report covering all income and expenditures for PHC.	Review by FMOH and IVA	41	8
TOTAL		500	100

39. **DLI 1- Increase of Utilization of High Impact Reproductive, Child Health and Nutrition Interventions.** Based on the strategic focus of SOML and the NHSDP, the operation will encourage increases in the coverage of high impact health interventions where progress has been modest.

40. **DLI 1.1 States Produce Plans for Achieving Reductions in Maternal, Perinatal and Under-Five Child Mortality.** In order to support states and give them an opportunity to address legacy issues (such as infrequent and non-systematic supervision or poor performance during MNCH weeks) or to introduce innovations (such as performance-based financing at health facility level or pro-poor health insurance at community level) states will be provided an initial "one-off" disbursement at the beginning of the PforR Operation. The 20 poorest performing states, "lagging states," as judged by the 2014 SMART survey (using the sum of the 6 indicators in PDO 1 and which form the basis for DLI 1.2) will receive $2 million. The remaining states will each receive $1 million. Disbursements will be made after effectiveness based on each state developing a plan for addressing specific weaknesses that hinder PHC service delivery with an emphasis on improving supervision and introducing innovations. The states can rely on existing technical assistance or request it from the Program Support Unit (PSU) or NPHCDA. The FMOH will have to approve the plans based on explicit criteria (see Annex 1). The disbursements do not limit the states' autonomy in how they use the funds to address their own particular issues. The approach avoids any perverse incentives or moral hazard since: (i) the data on which the initial disbursement will be based has already been collected and published; (ii) the states were unaware that they would receive these disbursements based on the performance; and (iii) subsequent results-based disbursements will be based on improvements from baseline.

41. **Theory of Change/Results Chain:** The disbursements for the production of State plans are a means of giving a boost to those states that are the poorest performing (a means of increasing equity) and give all states an opportunity to address their own performance constraints. The funds will also send a signal to states that the program is real and has actually begun.

42. **DLI 1.2 Improvements on 6 Key Health Indicators.** This part of DLI 1 will focus on improvements by the States from their baseline performance on six key indicators: (i) immunization coverage (Pentavalent3); (ii) insecticide-treated net (ITN) use by children under five; (iii) proportion of pregnant women who receive HIV counselling and testing as part of their antenatal care; (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage among children under five. The indicators selected are the key ones in the SOML scorecard and the NHSDP results matrix. They represent the six pillars of SOML and are among the most cost-effective means for saving the lives of mothers and children. The amount of the disbursements will be based on overall performance (improvement) on all 6 indicators to encourage health system strengthening broadly, not just a focus on individual vertical programs. The performance score will simply be the arithmetic sum of changes in the six indicators which will be calculated annually based on household surveys conducted by National Bureau of Statistics (Standardized Monitoring and Assessment of Relief and Transitions or SMART surveys) with extensive technical support from UNICEF. Baseline data exists for all 36 + 1 states for 2014. Each state will be eligible for $205,000 per percentage point gain above 6 (the average annual gain between 2008 and 2013). A state that achieves the targets set out in the results framework will receive about $1.4 million per year, In addition, the best performing state per geo-political zone will receive an additional $500,000, except in the North East and North West where the two best performing states will receive the additional $500,000 disbursement. A "national champion" will receive $1 million on top of the amount they receive based on their performance score. Based on the lessons from the education sector (see Annex 4), payments to the states will not be tied to specific inputs and can be flexibly used.

43. **Theory of Change/Results Chain:** State Governments will be rewarded based on actual improvements in services as experienced by beneficiaries. State performance and the amount of funding they receive will be linked to objectively verifiable results. This should act as a spur to improving management and paying more attention to data. Currently, State officials rarely know how well (or badly) their State is performing. The disbursements also send a signal of the importance of SOML indicators (a lesson learned from PBF). The payments to the best performing State per geopolitical zone should foster friendly competition among the States. The funds provided to States, although relatively small compared to overall State budgets, may be catalytic because they are available to meet recurrent costs and can be flexibly used.

44. **DLI 1.3 – Lagging States will Strengthen their MNCH Weeks as Part of an Impact Evaluation.** The Federal Government has worked with the States to implement maternal, newborn, and child health (MNCH) weeks since 2010. The MNCH weeks try to mobilize communities as a means of increasing the coverage of simple but effective, preventive interventions such as childhood immunization, Vitamin A supplementation, nutrition assessment, and de-worming. During MNCH weeks health workers from public health facilities are expected to visit more remote villages to provide these basic services and communities living closer to health facilities are expected to visit the facilities to receive the services. The MNCH Weeks are week-long events, conducted twice a year, aimed at strengthening routine services at health facilities while harnessing the excitement and energy of a campaign. They are a transitional measure to boost coverage while the PHC system is being strengthened. While the approach is attractive, the consensus is that MNCH weeks have not fulfilled their potential and that coverage (proportion of children under five who participate) is low.

45. **Theory of Change/Results Chain:** MNCH weeks represent an opportunity to increase demand for preventive and promotive services and also to bring services closer to communities, particularly those that are under-served. While strengthening a primary health care system can take time, MNCH weeks can be strengthened rapidly thereby yielding "quick wins" in terms of immunization and vitamin A coverage. This may be a real advantage especially in the North East and the North West. It is politically impractical to conduct an impact evaluation of results-based disbursements to States as a whole, however, it is possible to rigorously test their effectiveness on MNCH weeks. To strengthen the implementation of MNCH weeks, this DLI will provide results-based disbursement to a random selection of lagging States. In this case, the definition of lagging States is restricted to Vitamin A and immunization coverage because those are the only indicators that can be influenced by MNCH weeks. Ten out of the 20 lagging will be randomly selected to receive payments based on the increase in the proportion of children under five who participate in the MNCH weeks as judged by the SMART surveys. The randomly selected States will be provided US$80,000 per percentage point increase from baseline or their previous best performance based on participation rates of children under five. This impact evaluation will test the effectiveness of results-based disbursements to States and provide some evidence on whether improvements in performance can be attributed to the PforR. The design of the impact evaluation is discussed below under the section on monitoring and evaluation.

46. **DLI 2- Increase of Quality of High Impact Reproductive, Child Health and Nutrition Interventions.** Building on SOML's commitment to improving the quality of care, the FGON will provide performance disbursements to States based on the quality of services provided at primary health care level. This will be judged by annual health facility surveys that will build on the experience with SDI and other health facility surveys. The survey will be carried out independently by an organization identified by the Federal Ministry of Health. Quality of care will be defined according to an index that comprises:

a) the diagnostic accuracy and adherence to guidelines by health facility staff;
b) availability of drugs and minimum equipment;
c) readiness of facilities to deliver key SOML interventions;
d) frequency and quality of the supervision provided to the facilities; and
e) quality of financial management and reporting.

47. **Theory of Change/Results Chain:** One concern with focusing on quantity of services is that it could come at the expense of quality of care. More broadly, improving the utilization of health services may have only modest impact if the quality of care remains poor. In the past, partly due to the lack of objective information, quality of care received little attention. This DLI will help ensure that quality of care receives sufficient consideration. This DLI will reward State level performance and act to improve management and data utilization. In addition, this focuses on process measures within health facilities (where services are actually provided) that are within the span of control of State health officials. This DLI is also one of the means by which a nationwide PforR can help address issues at the health facility level. By ensuring that the necessary inputs are available, supervision is strengthened, and data is properly collected, the primary health care facilities will be strengthened. Examining financial record keeping will help strengthen the financial management system in the medium term. Baseline data is currently available for 12 States but data for all 36+1 States will be collected in year 1 of the Program. Thus, this DLI will begin disbursing in year 2 of the PforR. The disbursements to States will be based on the achievement of changes from baseline (or previous highest performance). The

amount provided will be related to improvements and will be US$25,000 per percentage point improvement.

48. **DLI 3- Improvement of Monitoring and Evaluation Systems and Data Utilization.** The Government is strongly committed to strengthening data collection which it has explicitly described as an essential aspect of SOML. It has lived up to this commitment by pushing to expand SMART from 11 to 24 States and most recently to all 36+1 states. Having reliable information is seen in the SOML program as a foundation for increased accountability and helps ensure decision-making becomes more evidence-based.

49. **DLI 3.1 Improving M&E systems.** The Government will:

a) Slightly expand the scope of the SMART household surveys to capture data on key elements of SOML (related to MNCH Weeks, prevention of mother to child transmission, and a limited asset index to allow results to be disaggregated by income quintile) and further strengthen its quality assurance. This will mean that the SMART surveys will inter alia: (i) continue to receive technical assistance; (ii) use the same sampling methodology and same questionnaires (to ensure comparability over time); and (iii) continue to use tablets for data collection.

b) As a means of tracking quality of care and better understanding performance at the level of service delivery, the Government will institutionalize annual health facility surveys. The surveys will harmonize and integrate SDI and Service Availability and Readiness Assessment (SARA) methodologies in all 36+1 States. They will provide data that is robust at State level. At a minimum the surveys will have to collect the data that comprises the quality of care index under DLI 2. To ensure quality of the survey data the FGON will, inter alia: (i) sign an MOU with the organization/entity responsible for data collection; (ii) ensure that high quality technical assistance is available to the data collection entity; and (iii) ensure consistency in the sampling methodology and questionnaires used.

c) Use the 2016 census to collect the most robust possible data on the maternal mortality ratio and the Under-five mortality rate at highly disaggregated levels. Should the 2016 census be significantly delayed, an acceptable alternative would be to carry out an NDHS in 2016 or 2017, earlier than currently scheduled (2018).

50. **Theory of Change/Results Chain:** Nigeria currently suffers from an acute shortage of reliable data about the functioning of its health system and improving data availability and quality will improve management ("you manage what you measure"). Previously, reliable data was really only available roughly every 5 years from the NDHS (and from multiple indicator cluster surveys MICS sponsored by UNICEF) which was too infrequent for management purposes. It could also be quickly dismissed as being "out of date". Progress has been made in collecting household data annually using SMART surveys and this needs to be institutionalized. Similarly, there is currently no nation-wide data on quality of care or what really goes on at health facility level. Thus, institutionalizing annual health facility surveys will allow an evidence-based discussion of how to strengthen the PHC system.

DLI 3.2 Improving Data Utilization. This aspect of DLI 3 will reward the FGON for:

a) Widely disseminating results of the SMART and health facility surveys on the SOML PforR indicators as gathered by the improved data collection systems. The FGON will be rewarded for making SMART and health facility data, disaggregated by State, easily available on the internet and publishing an annual summary in a large circulation national newspaper.
b) Strengthening management capacity of state health and FMOH leadership in data utilization. This part of DLI3 will involve working with Federal and State health leaders to analyze available data on PHC performance, develop action plans to address weaknesses, review action plans to see whether actions have been implemented and had the intended effect. This is followed iteratively by further analysis, etc. The FGON would earn US$100,000 per State that, as judged by the Independent Verification Agent (IVA) where, through technical assistance provided by the Program Support Unit, health managers demonstrate increasing capacity to: (i) analyze PHC performance data coming from various sources; and (ii) develop high quality action plans based on the analysis of their results. The FGON would earn US$250,000 for each vertical Program (NPHCDA, NMEP, NASCP, Department of Family Health) that demonstrates increasing capacity to: (i) analyze the performance of their Program based on data coming from various sources (e.g. SMART, health facility surveys; etc.; and (ii) develop high quality action plans based on the analysis of their results. This would also be judged by the IVA.

51. **Theory of Change/Results Chain:** Merely collecting data will NOT be enough. In order to be useful the data needs to be widely disseminated, so as to improve accountability and increase political commitment. The data also need to be used for management purposes by State and Federal level officials but most of them are not particularly comfortable with data analysis. They require assistance in making sense of their data and formulating actions based on their results. Regular discussions will facilitate in-depth analysis, benchmarking, peer review, and sharing of ideas.

52. **DLI 3.3 Implementing Performance Management System in All States.** SOML represents a commitment to strengthen accountability mechanisms for results and implement a performance management system across the country. There is an ongoing performance management effort in 10 States implementing such a performance management system and this will be expanded. States will receive US$160,000 for meeting the following conditions: (a) State has a performance management "Lead" with commensurate capacity to be accountable for the performance management process; (b) evidence of continuous analysis of the available data on PHC performance, including availability of financial resources (see DLI 5); (c) development and updating of appropriate action plans; and (d) at least quarterly, high level review meetings to discuss analysis and agree upon action plans with at least one of the three following officials present: Commissioner for Health, Permanent Secretary or Executive Director SPHCDA

53. **Theory of Change/Results Chain:** Capacity building of State officials in data analysis and plan formulation is important but this needs to be bolstered by a performance management system that impels officials to regularly review their progress and their plans. Thus, States will be rewarded for implementing a performance management system so that they can effectively track and improve the quality and quantity of SOML related services.

54. **DLI 4- Establishment and Operation of the Innovation Fund Designed to Support Private Sector Innovations Aimed at Increasing Utilization and Quality of Maternal and Child Health Interventions.** SOML is explicit in its desire to foment bold innovations to strengthen both the quantity and quality health services. It is also explicit in its desire to harness the energy and reach of the private sector to provide new techniques, technologies, and approaches as well as extend the coverage of services to under-served populations. Thus the FGON will contract a private sector entity (innovation fund manager) to implement an innovation fund that will, through a competitive process, support innovations by the private sector. Two types of innovations are envisaged:

(i) Developing and testing new techniques and technologies through small grants (up to US$100,000 each). Examples of innovations that could be supported include: a) a smart phone application for health facility staff and outreach workers to improve diagnosis and management of childhood and maternal diseases using national guidelines; and b) a home-grown ready to use therapeutic food (RUTF) for malnourished children; and

(ii) Testing new approaches to improving the delivery of SOML services by non-State actors. These types of innovations would aim to expand coverage or quality of services at the population level with an emphasis on under-served rural populations, and typically would be implemented for two years. They would be supported by larger grants (up to US$1 million each). All these innovations would be subjected to rigorous evaluations (including impact evaluations where practical). Proposals which will be implemented in the North East and the North West (regardless of where the proposer is from) will be prioritized by being given additional points during the selection process.

55. **Learning from the Experience of You-WiN.** You-WiN is a business plan competition financed by the Government with extensive Bank involvement (see Annex 4) and other challenge funds globally, the proposals would be judged blindly by an independent panel based on explicit criteria. For the large grants the criteria would include: (i) clear description of the innovation; (ii) evidence that the proposal is actually innovative (a new approach or the application of an existing innovation to a different service/intervention); (iii) rigor and practicality of the evaluation design; (iv) reaching people in the two poorest income quintiles; (v) concentration on rural areas; (vi) credibility and track record of the proposer; (vii) efficiency (low cost per capita) and scalability of the approach; and (viii) evidence of partnership with a State Government. Proposals that will be implemented in the North East and North West will receive extra points. The FGON, and through it the innovation fund manager, will be rewarded for: (i) transparently and fairly identifying innovative proposals to fund following the criteria and processes described above; (ii) successfully managing the grants so that the innovations are actually implemented or the grants terminated; (iii) rigorously evaluating the large grants; and (iv) scaling up successful innovations and documenting the whole process. The performance of this DLI (and the innovation fund manager) will be formally reviewed annually by the Steering Committee based on a report by the IVA. Should there be significant challenges with this DLI the funds may be re-allocated to DLIs 1 and 2.

56. **Theory of Change/Results Chain:** Clearly, Nigeria needs innovative approaches to improve service delivery and the country's vast entrepreneurial class can certainly be a source of successful ideas. The private sector plays an important role in the delivery of SOML interventions and it will be important to harness its drive, reach, and managerial capacity. So far,

the Government has found few ways of productively working with the private sector so this DLI will help build partnerships. This DLI will also help the most technically sophisticated parts of the private sector to focus more on reaching the poor.

57. **DLI 5 – Increase of Transparency in Management and Budgeting of Primary Health Care.** Part of the problem impeding accountability for results in maternal and child health is that lines of authority are diffuse, variable, and complex. As described above, State level health officials often lack the authority to properly manage staff in public health facilities. They also often do not have control over budgets that would support the PHC management team that works at LGA level or health facilities themselves. Simply put State level health officials often lack the "span of control" to manage PHC or to be held accountable for results. The Government has recognized this issue and has developed a policy of "PHC under one roof." This policy, which is implicit in the recently signed "National Health Act," aims to clarify lines of responsibility and authority for PHC and strengthen a weak budgeting and financial management system. The FGON would provide funds to all the States as:

(i) The State level health officials responsible for PHC (the State PHC development agency [SPHCDA] or equivalent) are provided management authority over staff at health facility and LGA levels including the power to hire, fire, post, transfer and discipline such staff. The objective measure of accomplishing this will be the physical transfer of human resource files to the concerned State health entity. Each State would earn a one-time payment of US$500,000 when they accomplish this.

(ii) State level health entity responsible for PHC (SPHCDA or equivalent such as a "Board") has a consolidated budget to meet the operational costs of providing PHC and can report on the execution of that budget. Each State would earn US$300,000 for each year that they are able to produce consolidated budget execution report for all income and expenditures on PHC and publish it on the State government's website. The reports will describe the sources and uses of funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures. A special effort will be made to track vaccine expenditures.

58. Some of the same issues existing at State level also afflict the FGON. Thus, the FGON will receive US$2 million for every year that it is able to produce consolidated budget execution report for all income and expenditures on PHC and publish it on the FMOH's website. The reports will describe the sources and use funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures.

59. **Theory of Change/Results Chain:** Trying to hold States accountable for improving service delivery only makes sense if State-level health managers actually control the resources, both human and financial, needed to deliver those services. Currently, the fragmented organization of PHC often precludes State health officials from effectively managing the system and this DLI will help rationalize accountability relationships. Both State and Federal level officials need to manage their financial resources more efficiently to ensure they make maximum use of their budget allocations.

60. **Addressing Equity Issues.** This operation addresses equity issues in a few different ways:

(i) **SOML Prioritizes Services for Which the Poor are Under-served:** This Program focuses on services where the coverage among the poor is particularly low and where the poor would be expected to gain disproportionate benefit. These services include immunization and skilled birth attendance where the coverage among the richest income quintile is more than ten times higher than among the poorest income quintile (see Table 2 in Annex 4);

(ii) **SOML Prioritizes Primary Health Care Facilities:** The Program will focus greater efforts on strengthening PHC facilities because that is where the most important services can be provided most efficiently and because they are used disproportionately by the poor (see Annex 4, figure 21 for the coverage of services among the richest and the poorest quintile);

(iii) **Greater Support to the North East, North West and Lagging States:** For DLIs 1, 3, and 4 there will be greater support for the Northeastern and Northwestern zones where the coverage of key SOML services is the lowest and health outcomes the worst;

(iv) **Investments to Lagging States:** At the beginning of the PforR, larger "investments" for PHC strengthening will be provided to the lagging States to allow them to address legacy issues and "prime the pump";

(v) **Ensuring Innovation Focuses on the Poor:** Innovations financed under the Program will focus on serving the poorest 40 percent of the population;

(vi) **Rewarding Improvements in Services:** Focusing on improvements in coverage of services rather than absolute levels will give lagging States an opportunity to earn more in the way of performance disbursements. Both common sense and research findings indicate that it is easier and less costly to go from 20 percent to 30 percent immunization coverage than it is to go from 80 percent to 90 percent. Thus lagging States starting at lower levels of coverage should find it easier to make improvements and be rewarded under DLI 1.2;

(vii) **Track Progress by Income Quintile:** The Program will carefully measure progress by income quintile so as to facilitate tracking of improvements in the poorest 40 percent of the population. This will allow regular review of national and zonal level results by income quintile during the annual review process.

61. **Addressing Demand-Side Issues.** There are clearly demand-side obstacles that impede utilization of SOML services. The problems are diverse and are described in more detail in the Environment and Social Safeguards Assessment (ESSA) and in Annex 6. These issues will be addressed in the following ways:

(i) Close coordination with the planned National Social Safety-Net Program (NSSNP) which will provide cash transfers to poor families conditional on them accessing preventive and promotive SOML services;

(ii) Supporting MNCH weeks through DLI 1 that increase demand for services and bring services closer to communities;

(iii) Opportunities to pilot test demand-side interventions under DLIs 1.1 and 4, such as pro-poor health insurance or maternal health specific Conditional Cash Transfers (CCTs). These could be implemented in one or two LGAs. States could expand the CCT being supported under SURE-P or test the combination transport vouchers and CCTs being piloted in 3 NSHIP-supported LGAs;

(iv) Applying lessons learned from ongoing analytical work on resource tracking that will assess the extent of user-charges at facility level and see if they decrease in response to performance-based incentives to the facilities; and

(v) Rewarding States for increasing coverage of key SOML interventions which should impel them to address demand-side issues. The experience with PBF is that supply-side incentives can induce managers to implement creative demand-side solutions.

Box 2: Impact of Conditional Cash Ttransfers on Maternal and Newborn Health

Conditional Cash Transfers (CCTs) have been identified as a means for overcoming demand-side barriers for women and families seeking maternal and neonatal health services. Most CCT Programs are broad (for example Brazil's *Bolsa Familia*, Mexico's *Opportunidades*) and aim to alleviate poverty and increase human capital through cash transfers to poor households. However, narrow CCTs that focus on increasing utilization of specific MNH services (India's Janani Suraksha Yojana, Nepal's Safe Delivery Incentive Program) are becoming more common.

A recent meta-analysis of impact evaluations found that CCTs had a positive if modest effect on antenatal visits, skilled attendance at birth, delivery at a health facility, and tetanus toxoid vaccination for mothers. There was also a significant reduction in low birth weight.

Source: A. Glassman, D Duran, M. Koblinsky. Impact of Conditional Cash Transfers on Maternal and Newborn Health. 2013. Center for Global Development Policy Paper 019.

D. Key Capacity Building and Systems Strengthening Activities

62. Nigeria's health sector is full of potential and this Program aims to support ways at unleashing that potential. As such, a traditional, input-based approach to capacity building is not desirable and, instead support will be provided to States and counterparts to the extent that they are able to shift towards an evidence-based assessment of what is working and what is not. Technical assistance will be deployed where it is needed to ensure a greater focus on results through a performance management approach. In doing so, the Program will support a shift in incentives for key actors (State health officials, consultants, development partners) towards

rewarding those that make a serious effort to shift away from "business as usual." Much of the TA will be provided by a Program support unit (PSU, see below).

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

63. **Lessons Learned in Nigeria about Implementing Reforms.** Recent analysis (see footnote 6 on page 6) of how, why and when reforms move forward in Nigeria points out a number of factors for success. This analysis suggests that leading reforms solely from the public sector is challenging. Leaders - whether of Federal reform Programs such as telecommunications, energy, or the electoral institute, or reform minded State governors - have experimented with drawing in skills from the private sector, using private sector incentives to promote delivery, while ensuring strong links to political leaders. Lessons from these reform cases suggest that this has helped delivery in the short term but that success has not always been sustained. Building on this experience, this Program will use a hybrid delivery arrangement that employs non-State actors but also supports the motivation of public officials through results-based investments that aim to unleash the latent capacity within the public sector. It will also build in strong tracking and learning systems to support the Program to adapt, as progress is unlikely to be linear.

64. **Oversight by Steering Committee.** The SOML Program will be under the supervision of a steering committee (see Figure 5), chaired by the Honorable Minister of Health and comprising members nominated by the Minister. The Steering Committee will be ultimately responsible for achieving the SOML PforR PDOs and the Program development indicators.

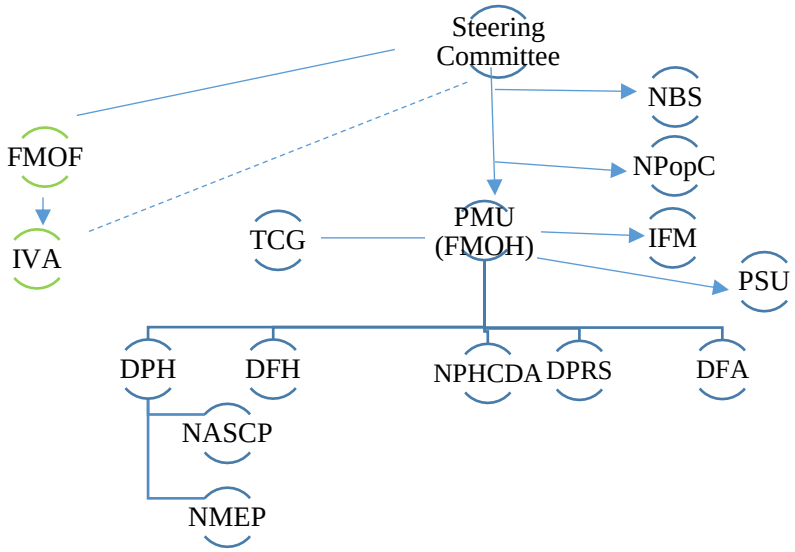
65. **Federal Ministry of Finance (FMOF).** The FMOF will play a financial oversight role and will sit on the Steering Committee. The FMOF will: (i) ensure that public funds are used appropriately during implementation and that all expenditures use the FGON's integrated financial management information system (IFMIS) and follow the appropriate procurement laws and regulations; (ii) help the FMOH improve its budget execution, particularly for PHC and SOML; (iii) help the health sector in creating budget execution reports (under DLI 5) and develop a medium-term expenditure framework for SOML and PHC more broadly; (iv) help ensure timely payments under the PforR are made to States and other entities supporting SOML (including PMU, PSU, IVA, Innovation Fund Manager, NBS, NPopC); and (v) ensure that the FGON is obtaining value for money.

66. **Implementation of SOML and the proposed PforR - Role of the PMU.** The Program Management Unit (PMU) for SOML will be in charge of the day-to-day implementation of SOML and the PforR and will work very closely with a PSU. The PMU will be responsible for the coordination of SOML activities in the FMOH through a "Technical Consultative Group" to be chaired by the Permanent Secretary (see below). The PMU will be headed by a full time manager whose only charge will be implementation of SOML. In order to facilitate successful implementation, the PMU manager and his team will receive a performance bonus linked to timely disbursement of funds to the States (particularly under DLIs 1 and 2), timely collection and publication of data, and timely implementation of Federal level actions. The PMU manager will be supported by full time and technically competent Federal Government staff and consultants that have been competitively hired and paid market wages. The PMU will have lean

and efficient staffing and its organizational structure will be reviewed by the Steering Committee. The Steering Committee will also review the performance of the PMU after 6 months and then annually. In case the PMU is unable to access funds easily, procure goods and services efficiently, or faces other implementation challenges, alternative secretariat arrangements (e.g., through the PSU) will be instituted. The PMU will have specific responsibilities which include:

(i) Coordinating and facilitating FMOH activities related to SOML;
(ii) Ensuring the timely collection of high quality data and its publication (DLI 3);
(iii) Implementing and overseeing the initial disbursements to States under DLI 1;
(iv) Communicating and working with States, developing and implementing a communications plan;
(v) Serving as secretariat for the Program Steering Committee;
(vi) Facilitating the timely disbursement of funds to the States;
(vii) Knowledge management and learning; and
(viii) Making sure that covenants are complied with and that the Program action plan is implemented.

Figure 5: Implementation Arrangements for SOML PforR



FMOF = Federal Ministry of Finance; IVA = Independent Verification Agency; TCG = Technical Consultative Group; PMU = Program Management Unit; NBS = National Bureau of Statistics; NPopC = National Population Commission; DPH = Department of Public Health; DFH = Department of Family Health; NPHCDA = National Primary Health Care Development Agency; DPRS = Department of Health Planning, Research, and Statistics; NMEP = National Malaria Elimination Program; NASCP = National AIDS Control Program; DFA = Department of Finance and Administration; IFM = Innovation Fund Manager; PSU = Program Support Unit.

67. **Technical Consultative Group (TCG).** The SOML Program is centered in the FMOH. The TCG to be chaired by the Permanent Secretary will comprise representatives of the Department of Family Health, Department of Finance and Accounts, National Primary Health Care Development Agency (NPHCDA), the Department of Health Planning, Research, and Statistics (DPRS), the Department of Public Health including the National Malaria Elimination Program (NMEP), and the FMOH's AIDS control Program (NASCP). These parts of the FMOH are in charge of the six pillars of SOML. The TCG will ensure that the vertical Programs remain focused on results, survey data is regularly analyzed in detail, and that the issues identified are addressed. The PMU will serve as the secretariat for the TCG.

68. **Program Support Unit.** The PSU is contractor of the FMOH and will support the PMU. The collaboration between the FMOH and the PSU will be governed by a contract that will be signed within 1 month of effectiveness. The contract will make explicit the role of the PSU which will include:

(i) providing technical assistance around performance management to the States, particularly lagging States, to help improve their achievements (DLI 3);
(ii) helping States formulate their plans in order to access the initial disbursements under DLI 1.1;
(iii) assisting key vertical Programs within the FMOH (immunization, malaria etc.) in analyzing the data and adjusting their work accordingly; and
(iv) providing other technical assistance such as in assessing expenditure on SOML and PHC (DLI 5) and improving data analytical skills.

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

70. **Role of Innovation Fund Manager.** The Innovation Fund Manager running the Private Sector Innovation and Learning Fund (i.e., DLI 4) will have a contract with the FMOH (TORs are in Annex 1). This Innovation Manager will: (i) have considerable experience running competitive innovation funds; (ii) have a history of involvement in SOML activities; and (iii) be able to play a catalytic role in bringing the private sector (including for-profit companies) into SOML activities thereby facilitating public –private partnerships. It would be an advantage if the Innovation Fund Manager brought some of its own funds to the effort so it is not solely reliant on the FGON for financing.

71. **Independent Verification Agent.** In order to independently verify the results achieved and calculate how much should be paid to each State, an independent verification agent (IVA) will be recruited by the FMOF (TORs are in Annex 1). The IVA will examine the results of the SMART household surveys and the health facility surveys and calculate how much should be paid to each State. It will also review the results under the other DLIs and submit its report to all members of the Program Steering Committee.

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

B. Results Monitoring and Evaluation

73. **Target Setting.** The targets for the operation, particularly the ones related to the coverage of key services, have been set based on the experience in Nigeria over the last 5 years and also on longer term global experience. Using the NDHSs from 2008 and 2013 the average annual change, expressed in percentage points, has been calculated (see column b in Table 5). This was then compared to the median annual percentage point change for the same indicators from a large number of countries as calculated in a recent Bank study (see column a in Table 5). Based on these figures a target was set for Nigeria that takes into account the rate of change seen over the last 5 years and what can be expected based on global experience in low-income settings. The targets represent a near doubling of the rate of improvement seen from 2008 to 2013 and about 75 percent of the global median rate of change. Setting these targets is not only important for being able to judge progress and have realistic expectations but also helps reduce the Bank's risk that States make too rapid progress (a happy occurrence) and use up the available funds too quickly. The targets for the core indicators (e.g., number of children immunized, women receiving skilled birth attendance) have been calculated based on the baseline values and expected improvements in coverage (in Table 5) multiplied by the size of the birth cohorts in Nigeria. A similar exercise was done to calculate the overall number of beneficiaries.

Table 5: Target Setting - Percentage Point Change on Key SOML Indicators

Indicator	Global Experience (1990-2009) Median Annual Change [a] (a)	Nigeria NDHS 2008-2013, Average Annual Change (b)	Proposed Annual Target in percentage points (c)	Proposed Target for 4 years of PforR
Immunization Coverage (Penta 3)	3.0	0.56	1.5	6
Vitamin A	8.3	3.1	5	20
Contraceptive Prevalence Rate	0.7	0.02	1	4

ITN use by children under 5	3.0	2.22	3	12
Skilled Birth Attendance	1.0	-0.16	1	4
Antenatal Care	1.7	0.58	1.5	6
Total (Sum)	**17.7**	**6.32**	**13**	**52**

[a] Setting Targets in Health Nutrition and Population Projects, Arur A. et al, World Bank 2011.

74. **Data for PDO Indicator 1 and DLI 1 will Come from Household Surveys:** DLI 1 will be measured using a population-based survey. Of the three main population-based surveys that are routinely conducted in Nigeria, the SMART is the most practical for purposes of the PforR, and has sufficient quality control mechanisms to produce credible data that can be used for results-based disbursements. SMART has been implemented by National Bureau of Statistics (NBS), an entity independent of the FMOH which reports directly to the National Planning Commission, while technical support and quality assurance is provided by UNICEF. Minor revisions in the SMART tool and analysis will allow it to produce indicator estimates according to the proposed DLI definitions as well as socioeconomic status (SES) information that will allow tracking of equity. If the SMART surveys do not continue a credible alternative is to implement "continuous" demographic and health surveys which have provided similarly disaggregated data in Senegal and Peru.

75. **Technical Aspects of SMART and Quality Assurance.** Three rounds of SMART surveys have already been successfully conducted by NBS and the last round, in 2014, was carried out in all 36+1 States. The survey sample of nearly 26,000 households is nationally representative and provides robust State-level estimates for key SOML indicators (the confidence intervals for SMART are described in Annex 4). The results from SMART closely correlate with those from the NDHS (comparing State level immunization coverage in NDHS to SMART yields an $R^2 = 0.85$, for skilled birth attendance the $R^2 = 0.825$, and for CPR $R^2 = 0.747$, see Annex 4). The implementation of other household surveys (such as the Malaria Indicator Surveys and Multiple Indicator Cluster Survey) will provide other means for checking the quality of the SMART results. The SMART survey data is collected on tablets which allows for various quality assurance checks that prevent "curb-stoning," illogical data, or incomplete data. Extensive technical support continues to be provided by UNICEF. The FGON has undertaken to continue to use the same sampling methodology, same questionnaire, and same quality assurance mechanisms so as to ensure comparability of data over time and ensure data remain robust. UNICEF has indicated its continued interest in providing technical support for SMART at least until 2017.

76. **PDO Indicator 2 and DLI 2 will be Tracked through Health Facility Surveys.** Quality of care will be measured through an annual health facility surveys (HFSs) that will likely be carried out by NBS with extensive technical support. While experience with implementing HFSs in Nigeria is not as strong as for population-based surveys, they have now been carried out in 18 States, 12 through the SDI, and another 6 from the NSHIP baseline impact evaluation study. In addition, the Government is planning to carry out a nationwide HFS that will harmonize a WHO service availability and readiness assessment (SARA) and the SDI methodology that the Bank has deployed. This harmonized HFS will be powered to provide robust State-level estimates.

77. **Quality Assurance for HFSs.** The experience with SDI and the NSHIP baseline indicate that it is certainly possible to carry out HFSs successfully but that quality assurance mechanisms

and technical assistance are important. The Government has agreed to use a consistent sampling methodology, survey questionnaire, and same quality assurance mechanisms (including use of tablets for data collection) so as to ensure data is comparable over time and assure the quality of the data. Development partners, including the BMGF, have agreed to ensure that sufficient technical support is in place. NBS does have experience carrying out a health facility because they did it for the NSHIP baseline.

78. **Financing of the Household and Health Facility Surveys.** The SMART surveys cost about US$850,000 per round and are currently being financed by UNICEF, USAID, and DFID. This funding looks to be secure in the medium term. The SDI health facility surveys were financed by the BMGF. A nationwide health facility survey that provides results representative at State level will likely cost about US$1million for the initial round but the cost could decrease for subsequent rounds. Under DLI 3 the FGON will receive US$7 million after effectiveness for prior results (scaling up SMART to all 36+1 States and publishing the results in a way that allows State by State comparisons) and this will be more than enough to cover the costs of both SMART and health facility surveys. DLI 3 also provides money to the FGON after the SMART and health facility surveys have been completed. Having the FGON allocate funds for these surveys will help ensure that they are institutionalized.

79. **Impact Evaluation of Results-Based Disbursements:** Data from the SMART surveys will be used to carry out an impact evaluation that will assess the effectiveness of the results-based disbursements for MNCH weeks. The 20 poorest performing States in terms of Vitamin A and routine immunization coverage will be randomly allocated (using a randomized block design) to be offered or not the results-based disbursements for MNCH weeks. The SMART surveys will provide information on MNCH week utilization and increases in Vitamin A and immunization coverage. With 10 States in each arm and about 770 households surveyed per State, the impact evaluation would be sufficiently powered to find a 6 percentage point difference in immunization coverage and a 4 percentage point difference in Vitamin A coverage and participation rates in MNCH weeks. While not a pure test of results-based disbursements to States (because the States would still be eligible for financing under DLI 1.1 and 1.2) this impact evaluation would provide useful evidence on the approach in an easily defined result area.

C. Disbursement Arrangements and Verification Protocols *(see also Annex 3)*

80. **Verification for DLI 1 and 2 will be through Household and Health Facility Surveys.** As described above the verification for DLIs 1 and 2, which together account for 72 percent of the value of the PforR, will be done on the basis of results of household and health facility surveys. These will likely be carried out by NBS, which is independent of the health sector, and benefits from extensive technical support from development partners. The calculations of how much money States should receive will be carried out by an independent verification agent (IVA) under contract to the FMOF. The IVA will have no vested interests and should be shielded from political or other pressures.

81. **Verification of Data Collection and Management of PHC at State Level will be Done by the IVA.** For DLI 3 the IVA will review the survey reports produced by NBS and determine whether the quality assurance mechanisms have been implemented. The IVA will also determine which States have transferred staff to the SPHCDA and have published consolidated PHC budget execution reports as per DLI 5.

82. **Implementation of Performance Management & Private Sector Innovation will be Verified by Third Parties.:** The progress on DLI 3 and 4 will be assessed by the IVA. The performance on DLI 4 will be reviewed by the Steering Committee based on the reports of the IVA and the innovation fund manager's external auditors.

83. **Disbursement Arrangements.** For payments to the States under DLIs 1, 2, and 5, the PMU Manager will submit a Results Achievement Note to the World Bank along with the supporting documentation. Once the Bank agrees with the results achieved it will write to the FMOF asking them to prepare a withdrawal application. This will allow for disbursement of funds to the Treasury Single Account. The FMOF will have 30 days in which to transfer the funds to the accounts the States have in the Central Bank. This critically important step is covenanted because in a results-based approach long delays can seriously erode any incentive effect and destroys the credibility of the system.

IV. ASSESSMENT SUMMARY

A. Technical (including Program economic evaluation)

84. **The Approach of SOML and this PforR is Justified by the Bank's Experience in Nigeria.** After more than 20 years of lending to the health sector in Nigeria, the Bank has learned a few critical lessons that would support using a PforR approach. The lessons include the following:

(i) Focusing on inputs without improving governance will not work. Reviews of the Bank projects since late 1990's clearly show that large-scale, input-based approaches rarely translated into improvements in health services. This has also been true for Government investments and those of other development partners. Failure to address key governance issues such as accountability, incentives, and management has consistently impeded progress in improving service delivery even when inputs have been available.

(ii) An intensive focus on measuring results is critical to success. A lack of attention to monitoring and evaluation in both Bank and Government investments has been a consistent and critical problem.

(iii) Influencing Governments' financing is critical to achieve large scale impact. The different levels of Government account for 26 percent of total health expenditure in Nigeria, about 6 times the total of all donor contributions. Thus it is important that Bank or donor resources exploit Government funding and leverage them to achieve population level impact. It is important to recognize that most public financing goes to salaries and there is very little left for non-salary recurrent costs.

85. **SOML Addresses the Largest Part of the Burden of Disease and the most Lives Lost.** Through its focus on improving maternal and child health, SOML addresses the most common causes of premature death in Nigeria. Its six pillars target infectious diseases, maternal and neonatal complications and nutrition deficiencies that together account for nearly 70 percent of total years of life lost (YLL). SOML targets 9 of the top 10 causes of premature loss of life in Nigeria.

86. **Institutional Assessment.** There is broad support for SOML both inside and outside Government with encouraging involvement of the private sector. A PEIA was undertaken which has pointed out the complex institutional relationships particularly at State level and below. Consolidating State-level authority for PHC in one entity ("PHC under one roof") is a necessary but not sufficient condition for success. The experience in UBEC (basic education) is likely not one worthwhile replicating. Tracking budgetary flows is challenging but some progress should be possible towards having consolidated budgets.

87. **Routine Data is Limited and Inaccurate, Monitoring and Evaluation are Under-Developed.** Weak accountability mechanisms are exacerbated by the shortage of accurate and timely data. The routine health management information system, known as the District Health Information System (DHIS) is benefiting from significant attention but reporting rates are still only about 60 percent of health facilities. The accuracy of the DHIS data needs to be improved for it to be a useful source of information. Right now it correlates poorly with the results of household surveys. The DHIS also suffers from the same weaknesses as other health information systems in its inability to capture data from the private sector, measure equity, or capture important health behaviors (such as ITN use, contraceptive prevalence, and care-seeking behavior when children are sick). Capturing such data requires good quality household surveys but up until recently these have been infrequent. Robust household surveys, such as the DHS, are carried out much less frequently than in other large low income countries. (NDHSs have been conducted less than every 5 years in Nigeria but more than every 3 years in Bangladesh).With the exception of the Bank-supported SDI Survey, there has been almost no systematic effort to capture information on the functioning of health facilities, particularly quality of care. Failure to strengthen M&E will hobble efforts to improve service delivery in Nigeria.

88. **Economic Justification.** The economic justification for a PforR is whether public investment in the Program is warranted (for more details see Annex 4). For SOML there is a strong justification for Government financing:

(i) **SOML is Designed in Part to Address Market Failures in Health in Nigeria**. Low immunization rates and limited access to services that tackle malaria represent market failures due to large externalities from communicable diseases.

(ii) **SOML is Designed to Improve the Allocative and Technical Efficiency of Public Spending on Health in Nigeria and the PforR will build on that Objective**. Compared to other investment instruments, the PforR will help Nigeria move toward more optimal allocation and achieve gains in technical efficiency through: (i) increased allocation to the "most efficient producers"; (ii) using incentives to increase technical efficiency; and (iii) increasing private delivery of publicly financed services. There has been a mismatch between the disease burden and public allocations to health. Of special concern are remaining high maternal and child mortality rates that can be addressed by proven services that are highly cost effective but which are not reaching many people

(iii) **SOML's Stated Objective is to Improve Equity in the Health Sector in Nigeria, and the PforR will Support that Objective.** As indicated in table 2, maternal and child health outcomes in Nigeria are poor on average and are especially bad for the poorest two income

quintiles. The PforR employs a number of mechanisms to improve equity (see paragraph 61).

(iv) **Addressing Insurance Market Weaknesses**. SOML has the potential to address the inefficiency and inequity of a health system that relies heavily on out-of-pocket spending due to the lack of insurance and weak public sector funding and delivery of basic services. SOML will increase the coverage of vaccines, nutritional supplements, antenatal care and delivery attendance to everyone, regardless of insurance status. This allows the uninsured majority to access basic healthcare and reduces the risk of serious morbidity and catastrophic spending while insurance markets continue to develop.

89. **SOML Provides Public *Financing* but is not Restricted to Public *Provision* of Health Services**. The private sector plays a critical role in MCH in Nigeria and in order to reach people where they seek care, SOML envisions increased engagement with the private health sector. The SOML Program document commits the Government to working with the private sector and the PforR incentivizes private sector engagement including encouraging public-private partnerships through DLI 4.

90. **Nigeria Cannot Rely on Growth Alone to Produce HNP Outcomes**. While middle and high income countries have better health outcomes on average, greater wealth does not inexorably lead to better health. In oil-driven economies in Sub Saharan Africa – including Nigeria— high under-five mortality rates persist despite relatively high GNI per capita. Even in countries where economic growth and HNP outcomes are both strong, wealth did not lead to health. In the East Asian economies improvements in health outcomes *preceded* rapid growth (see Annex 4).[7] Nigeria's experience highlights that economic growth does not inevitably lead to better health and specific concerted efforts are required. However, there is evidence that suggests improvements in health may contribute to economic growth.

91. **Attractive Cost-Effectiveness.** An initial cost effectiveness analysis suggests that the cost of a percentage increase in the quantity index can be reduced between 9.6 percent and 47.8 percent by employing the PforR approach, depending on the assumptions used.

92. **Economic Impact of the Program.** Micro evidence shows that improving health can contribute to economic growth by promoting human capital formation and increasing labor supply and productivity. In Africa and Latin America, child health interventions to improve nutrition, provide vitamin supplementation, promote breastfeeding and institutionalize deworming – all activities included in SOML—have been shown to produce economic returns as well as health benefits.

93. **Financial Sustainability:** The incremental costs of the PforR are modest, about US$0.71 per capita per year. Even with possible decreases in oil revenues the Government of Nigeria likely has the fiscal space to finance such an increase in health expenditures, especially given the recent signing of the National Health Bill (see Annex 4). Importantly, the PforR tests a way of effecting fiscal transfers that would increase the efficiency of public expenditure, even without increases in overall budget allocations. For example, the MDG Conditional Grant Scheme could employ the same results-based approach of the PforR at no additional cost. Even

[7] "Health or Wealth: Which Comes First?" Africa Health Forum: Finance and Capacity for Results. 2013.

up to ministerial level, health expenditures are perceived to suffer from a low benefit/cost ratio. The result-based approach of the proposed PforR directly links budgetary expenditure with improvements in health service delivery providing an opportunity to institutionalize this more efficient means of using scarce public resources.

B. Fiduciary

94. Consistent with the policies and procedures defined in OP/BP 9.0, the Bank task team conducted an Integrated Fiduciary Systems Assessment (IFSA) of the proposed 'Saving One Million Lives' Program. The assessment concluded that the Program's Integrated Fiduciary Systems have the capabilities to provide reasonable assurance that the financing proceeds will be used for intended purposes with the objective of supporting the achievement of the Program objectives. Nevertheless, the assessment has found that there are a number of weaknesses and risks in the overall fiduciary systems of the Program warranting the design of action plans to counter them. For the purpose of this Program, in spite of the presence of a number of other risk factors that will still need to be managed, the constituents of the key integrated fiduciary risks are the following: (i) the flow of funds to the States and down to the Facilities may be delayed or impeded by the complex and fragmented institutional arrangements, to the detriment of timely service delivery; (ii) weak internal controls and oversight across Federal and States Agencies could create a fertile ground for fraud and corruption in, budget execution, hence undermining the economy, efficiency and effectiveness of spending; (ii) weak procurement management performance at the Federal and State levels could result in stock-outs of essential drugs and vaccines or poor value-for-money; (iv) poor control of stock and distribution of pharmaceutical products could lead to leakages or losses; and (v) weaknesses in compliance with the established legal and institutional framework for combating fraud and corruption at the sector or Program level could undermine the ability of the authorities to detect and address the occurrence of fraud and corruption risk in a timely and effective manner. These risks will need to be mitigated progressively before and during the implementation of this Program as articulated in the Program Action Plan. The overall Program integrated fiduciary risk is rated '**High'** but the post-mitigation risk is rated **'Substantial'**.

95. **The Federal Government, the Anchor of the SOML, is Making Good Progress on PFM**. Analytical work carried out in the area of PFM at the Federal Government in Nigeria, including the recent PEFA, coupled with an understanding of the trajectory of reforms and accountability systems and processes point to an improving fiduciary environment, while noting a number of inherent weaknesses and the uneven implementation of PFM reforms. At present, the execution of the budget can be tracked through the IFMIS - which has been successfully implemented at the Federal level and at uneven stages of implementation in a number of States. In effect, budgeted expenditures incurred under the Program can be reported as part of the overall health sector expenditures on real time basis, and the auditing of the Program as a sub-set of the health sector audit can be equally accomplished.

96. **Earlier Assessments Conducted at the Federal And States Levels[8] Indicate Weaknesses in the Areas of Aggregate Fiscal Discipline, Allocative Efficiency and Operational Efficiency**. At the Federal level, though, the FGN performs well in terms of predictability and control in budget execution but has performed less well in a number of other areas like comprehensiveness, internal controls, transparency and oversight. Recently, and with the reforms supported under the closed ERGP, further major improvements have been realized in budget execution, implementation of a Treasury Single Account for improved cash management, and reliability and timeliness of in-year and year-end fiscal reporting.

[8] Out of 36 States, PEFA and/or PEMFAR assessments were conducted for 25 States over the past several years; thus there is a wealth of knowledge on PFM systems across the country.

97. **At the State Level, the Findings of the PEFA and Related Analytical Work Conclude there is a Wide Range of Performance Levels Across States**. There are also variations between 'de jure' and 'de facto' application of rules and procedures on accountability processes. While capacity remains an issue across States, the most critical aspect of performance links to compliance with laid down systems and procedures. The Program will support improvements in these directions and thus assure better outcomes.

98. **Following CPAR and PIFANs the Following Progress has been Realized at the Federal and State levels**. A the Federal level: (a) the legal and regulatory frameworks have been established; (b) the Bureau of Public Procurement (regulatory agency) has been established; (c) various implementation tools such as regulations, standard bidding documents and manuals have been developed and deployed; (d) professionalization of the procurement function has been achieved; and (e) complaints and appeals mechanism is in place. Areas that need improvement at the Federal level include: (a) timely approval of budget; timely release of funds; (b) preparation of procurement plans in advance of budget approval as required by the law; (c) regular procurement audit and publication of results; (d) development of procurement capacity; and (e) enforcement of sanctions as required by the law.

99. **At the State level, Procurement Law has been Enacted in 24 States.** The remaining States have draft bills at various stages of consideration; procurement regulatory agencies have been established in 18 States. The Programmatic Integrated Fiduciary Assessments of Nigerian States (PIFANS) for Lagos, Ondo, Edo, Delta, Rivers and Bayelsa also identified the procurement weaknesses at the Federal level in the States. In addition, PIFANS highlighted the: (a) need for the States to develop and deploy necessary tools, including regulations, manuals and standard bidding documents; (b) the need to professionalize the procurement function; (c) need for publication of contract award to enhance transparency and demand for accountability; and (d) need for the establishment of complaints and appeals mechanism.

100. **In 2014, the 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; 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.

101. **The Above Procurement Weaknesses, if not Mitigated, May Negatively Impact the Implementation of the Program**. The proposed mitigation measures will include preparation of budget-linked procurement plans; timely approval of budget; timely release of funds; preparation of procurement tools; improvement of procurement management information system; strengthening monitoring capacity of civil society; prosecution of individuals and contractors involved in fraud and corruption; and performance monitoring of contracts under implementation; enhancement of procurement capacity; conduct of procurement audits; and establishment of complaints and appeals mechanism. The TA component of this Program will be used to implement these mitigation measures. Staffing capacity for Program management is

anchored in the FMOH under the PMU that will be supported by a PSU. The PMU will have adequate staffing to carry out its fiduciary roles.

102. **The Program's Annual Financial Statements will be Prepared by the Finance and Accounting Unit of the FMOH**. The Bank's contribution of US$500 million will be held by the FGON in a Special Fund (under a Service Wide Vote arrangement), managed under FMOF auspices and disbursed for 'Transfers' to States as well as used for technical assistance and capacity strengthening activities under the SOML including operational expenditures of PMU, Innovation Fund Manager, and PSU. About 72 percent of the total Bank financing will be disbursed by the FMOF, upon verification by the IVA and agreed by the Steering Committee of the performance of the States against defined assessment criteria. The Chart of Accounts for SOML related expenditures from Bank's contribution will be configured to include SOML as a Program element and against which expenditures on 'compensation of employees, goods and services, capital, and transfers will be made. The sum total of these expenditures under the Program element plus those of NPHCDA will constitute the overall Program expenditures that will form the basis of the Program Audit. The audit will be conducted by the Auditor General of the Federation. FMOH capacity for accounting and financial reporting under the Program will need supplementation to, among other things, support the consolidation of expenditures across the overall Program. Although the Financial Management and Control Act 1958 provides for the annual audit reports to be ready and submitted to the legislature within 6 months of the end of the fiscal year, this provision is not normally met due to adjustment entries requiring additional time for completion and submission. To this end, while the Program will support improvements in the deadline for submission, the audited Program financial Statements (along with detailed notes on the Program expenditures) will be submitted within 12 months of the end of each FGON fiscal year.

103. **There is Ample Legal and Regulatory Framework in Place in Nigeria on Fraud and Anti-Corruption**. The principal such legislation is the 'Corrupt Practices and other related offences Act, 2000'. Nigeria has also ratified the UNCAC in 2004. Nevertheless, there are a number of implementation challenges that will need to be managed to ensure that the Program's objectives are not undermined. These challenges include (a) the strengthening of the capacity of the institutional organs (e.g. ACTU in FMOH) in addressing fraud and corrupt practices; (b) strict application of the Code of Conduct (1990) provisions; (c) institutionalizing an effective complaints handling system under the Program. Although there is little evidence that investigations into fraud and corrupt practices are systematically carried out by law enforcement agencies, the existing legal and institutional frameworks are robust enough to build on to effectively mitigate against fraud and corruption. To that effect, a number of provisions are incorporated into the Program Action Plan.

C. Environmental and Social Effects

104. **The Overall Environmental Impact of the Program is Likely to be Positive with Potentially Significant Environmental Benefits**, owing to increasing accountability for results, improved coordination across the health system, as well as strengthening of the health Programs. A strong Program management unit will closely track, troubleshoot, and hold accountable Nigeria's health Programs with financial rewards for quality and quantity of services rendered which in turn provides further incentives for improvement and better monitoring. The nature of the Program provides opportunities to enhance the sanitation, hygiene and waste management

systems and processes at the health facilities so as to further promote sound public health outcomes, while also ensuring that there are no adverse impacts to the environment.

105. **Environmental Issues**. Improper occupational practices and unsafe handling of infectious waste was identified, albeit minimally, which has the potential to expose health care workers, waste handlers, patients and the community to infection and injuries. Based on the analysis of the Nigerian regulatory system and previous activities implemented by the FMOH within the Bank supported portfolio, the Program is not likely to have significant impacts on natural habitats or create environmental pollution, other than the generation of health care waste (medical waste) which is considered a localized impact.

106. **The Potential Social Impacts are Moderate and can be Addressed by the Existing Systems with Some Improvements**, owing to benefits such as improved health and personal hygiene, effective information dissemination, enhanced community participation, creation of accountable arrangements for service delivery and social audits to promote good governance mechanisms. There are no land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind under the Program.

107. **Social Issues**. The key issues identified by the ESSA are: poverty and equity, and barriers to utilization of health services which include cultural barriers, cost barriers such as transportation and the price of health services. Social issues are more difficult to define than environmental issues. Without this focus the key pro-poor objectives of the Program will not be achieved. The gap in access to, and utilization of, health services between the poorest and the richest deserves urgent corrective measure. Nigeria's increasing wealth is not translating into improved health for the poor. The Program is expected to have significant positive social impact as it will promote improved health outcomes for the citizenry, particularly women and children by strengthening utilization and quality of health care especially for the poorest households in Nigeria.

108. **Grievance Redress System**. Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing Program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. 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 Grievance Redress Service (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 .

D. Integrated Risk Assessment Summary

Risk	Rating
Technical	Substantial
Fiduciary	High
Environmental and Social	Moderate
Disbursement Linked Indicator	Substantial
Other	
Overall Risk	Substantial

109. **Risk Rating Explanation.** The Integrated Fiduciary Systems Assessment found that the Program's Integrated Fiduciary Systems have the capabilities to provide reasonable assurance that the financing proceeds will be used for intended purposes with the objective of supporting the achievement of the Program objectives. Nevertheless, the assessment found a number of weaknesses and risks warranting actions to counter them which are reflected in DLI 5 (increasing transparency in use of human and financial resources) and the Program Action Plan. Capacity constraints at State level are mitigated by DLI 3.3 (Implementing Performance Management) and by technical assistance provided by other development partners. Fiscal constraints resulting from low oil prices may be offset by the recent signing of the National Health Act which provides increased funding and political support for primary health care. Fiscal limitations may also increase the incentive value of the results-based payments to the States. Also, the proposed operation will be a first PforR in Nigeria and not achieving results would lead to slow or limited disbursement and may undermine counterpart commitment. The overall risk for the Program is rated substantial before mitigating measures. Overall Program risk is expected to be revisited during implementation based on progress in implementing agreed mitigation measures.

110. **Program Action Plan.** The Program action plan (PAP) focuses primarily on addressing fiduciary issues related to public financial management (PFM), procurement, and fraud and corruption. PFM will benefit from a resource tracking study which will inform the development of reporting templates for health facilities. The PAP also gives considerable weight to procurement activities which have been identified as key sources of fraud and corruption. The PAP in this regard focuses on ensuring the Government at Federal and State levels actually implements its laws and regulations. The PAP aims at strengthening the anti-corruption framework at the Federal level, mainstreaming fraud and corruption redress mechanisms in the health sector throughout the country and leverages existing cooperation agreement between the Bank and Nigeria to prevent and investigate fraud and corruption.

Annex 1: Program Objectives

1. **The Program Development Objective (PDO)** of the proposed Saving One Million Lives (SOML) PforR is to increase the utilization and quality of high impact reproductive, child health, and nutrition interventions. The proposed PforR will disburse against a set of disbursement linked indicators (DLIs) which were developed through intensive consultations with key stakeholders.

2. **Consistency with the FGON's SOML Objective.** The original objective of SOML was to save one million lives by 2015. Given that an estimated one million women and children die every year in Nigeria from largely preventable causes, the original objective of the Program continues to be a fitting commitment to save as many of those lives as possible.

Program Context

3. **About 900,000 Children and Mothers Die Every Year in Nigeria.** Over the last decade the trend in health, nutrition, and population outcomes in Nigeria has been mixed. There has been a 36 percent decline in the last 10 years in the Under-five mortality rate (U5MR) and a 31 percent decline in infant mortality rate in the same period. However, in order to achieve the health MDGs, the country requires more support.

4. **SOML is the Federal Government of Nigeria's (FGON's) Response to the Lack of Progress in HNP Outcomes.** The SOML is meant to improve MCH outcomes so that they are more in keeping with the country's level of wealth. It also intends for the health sector to contribute to the economic and social development of Nigeria instead of being a drag on growth.

5. **The FGON has Indicated an Intention to Extend SOML for Five Years.** SOML was conceived in 2012 and the FGON included a budget line item for SOML starting in 2013. The FGON has indicated an intention to extend SOML for five years as part of the National Strategic Health Development Plan (NSHDP) 2016-2020. Thus the implementation period of the FGON's SOML Program is now considered to be 7 years 2014-2020.

6. **Investments that Set the Stage for Success.** There have been large and important investments in health that provide the basis for charging ahead quickly. Two-thirds of the population live within 30 minutes' walk of a health facility, 85 percent live within 1 hours walk. Thus few people lack physical access to health care. Many health workers have been trained and deployed such that the ratio of health worker to population is twice as high as the sub-Sahara African average. However, despite large investments in inputs over the past several decades, including through Bank- and other partner-supported operations, HNP outcomes have remained sub-optimal.

7. **FGON's SOML Program is a Paradigm Shift in the Approach to Delivery.** The SOML is not a new Program. The SOML approach reflects lessons learned and builds on existing policies, strategic documents[9] and frameworks. It represents a shift from focusing on

[9] National Strategic Health Development Plan 2011-2015 and 2016-2020 as well as the President's Transformation Agenda.

inputs to focusing on results and outcomes and it incorporates innovation as a key enabler of the change in approach to service delivery.

8. **FGON's SOML Program Comprises Eight Components that Contribute to the Program's Objective**. The FGON's SOML Program includes eight components - six pillars and two enablers. The pillars include (i) maternal, newborn and child health; (ii) childhood essential medicines and increasing treatment of important childhood diseases; (iii) improving child nutrition; (iv) immunization; (v) malaria control; and (vi) the Elimination of Mother to Child Transmission (EMTCT) of HIV. The two enablers include (vii) strengthening logistics and supply chain management and (viii) promoting innovation and use of technology to improve health services.

Scope of Support

9. **The Bank's PforR is Meant to Catalyze and Reinforce a Paradigm Shift to Focus on Outcomes.** The proposed PforR in the amount of US$500 equivalent million would serve as a catalyst for changing the way business is done. Instead of focusing on inputs, the PforR is designed to disburse against results. In the spirit of a PforR, the proposed operation will also focus on governance and strengthening country systems and thus some DLIs will center around processes (e.g., DLI 5) and activities (e.g., DLI 3) deemed essential to achieve the PDO.

10. **SOML is a Federal Program**. SOML is a Federal Program, envisioned by the FMOH. The FGON is the principal advocate and sponsor of SOML which is in line with its role of providing strategic direction for the health sector in Nigeria. SOML is also intended to strengthen fiscal federalism by changing the Federal-State relationship to become a results-based partnership. In addition, SOML and the proposed PforR are expected to help with setting technical standards and establishing protocols as well as providing technical guidance and supports to States and service providers.

11. **Delineation of the PforR Support – What the Federal Government Can Influence**. SOML is a Federal Government Program aimed at strengthening six "pillars" of MCH. Perhaps the best way of conceiving the Program is to consider how in the Nigerian context, the FGON, particularly the FMOH, can influence the delivery of key MCH services at health facility level and in the community. Since it has no managerial control over the 36+1 States, let alone the 774 LGAs or the 37,000 publicly owned health facilities, to actually affect what happens on the ground the FGON has to rely on the levers it does have, namely strategic priority setting, data collection and analysis, technical assistance, providing rewards & recognition, setting standards, distributing specialized commodities, etc. (see figure 1). Using these levers, it is feasible for the FGON to influence the behaviors of States for example through: (i) collection of data on service delivery and feeding it back to States; (ii) rewarding States; (iii) provision of technical assistance to States; or (iv) provision of ITNs to States for them to distribute.

12. **States Can Directly Influence Service Delivery.** While the FGON has little direct influence over health facilities and service delivery, State Governments do have influence on providers and their authority is increasing with the advent of SPHCDAs. States can strengthen actual service delivery in a large number of ways including: (i) strengthening health facility supervision; (ii) increasing the number of sites able to provide EMTCT; (iii) better organizing MNCH weeks; (iv) procuring more drugs; (v) bolstering LGA management; (vi) providing funds

to facilities; (vii) working with the private sector; (viii) increasing social mobilization; (ix) reducing user charges; (x) training health workers; (xi) facilitating outreach activities, etc. Even if it were possible to micromanage States it would be important not to be overly prescriptive in how States go about improving service delivery. Firstly, some of the challenges reflect local realities that are distinct. Secondly, telling States how to manage their health care systems can breed resentment and can inhibit innovation. Thirdly, telling States how to improve service delivery means that if things do not work out well, they have a ready excuse and other people to blame.

13. **At the Federal Level, the Program of Expenditures Assumes Decreases in FGON expenditures in 2015.** Decreases are due to the reduction of SURE-P resources (as oil prices decline the value of the subsidy is reduced and is assumed to be zero for the life of the PforR). The last 4 years have seen rapid growth in expenditures for primary health care by the FGON. While this rate of increase is unlikely to continue in the current environment, a modest increase is assumed during the PforR. This is not unreasonable given the recent signing of the "National Health Bill" that provides 0.5 percent of FGON revenues to strengthen primary health care, much of which will support SOML.

Table 6: Estimated Complimentary Financing for SOML 2015-2019 (US$ Million)

Source of Financing	**Total Expenditure (US$M)**	**% of total**
Multilaterals including IDA except PforR	1284	61
Bilateral	744	35
Foundations	79	4
Total	**2,107**	100

Sources: Staff calculations based on: "Spending to Save: Challenges and Opportunities for Financing Nigeria's Saving One Million Lives Initiative" – Results for Development Institute July 2014.

Table 7: FGON's SOML Program Supported by the PforR Operation

	The Government Program	**The Program supported by PforR**
Objectives	Save one million lives in Nigeria by 2015 (*original*) Save lives of women and children that die from preventable causes every year (*revised commitment)*	Increase the utilization and quality of high impact reproductive, child health, and nutrition interventions
Components/DLIs	**Components include 6 Pillars and 2 Enablers**: (i) improving maternal, newborn and child health; (ii) improving routine immunization coverage; (iii) elimination of mother to child transmission of HIV; (iv) scaling up access to essential medicines and commodities; (v) malaria control; (vi) improving child nutrition; (vii) strengthening logistics and supply chain management, and; (viii) promoting innovation and use of technology to improve health services.	**DLIs:** 1. Increase of utilization of High Impact Reproductive, Child Health and Nutrition Interventions 2. Increase of quality of High Impact Reproductive, Child Health and Nutrition Interventions 3. Improvement of monitoring and evaluation systems and data utilization 4. Establishment and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions 5. Increase of transparency in management and budgeting of primary health care
Activities types (sample)	- Midwife Service Scheme - Health worker training - Provision of RUTF, micronutrients, test kits, ARVs, ITNs, ACTs and RDTs - Supervision of EMTCT sites - Setting objectives - Establishing standards and protocols - Assessment and M&E - Technical assistance - Provision of additional support (e.g. promotion of MNCH weeks) - financing & resource mobilization - promotion of innovations (e.g. PBF) - rewards & recognition	- Technical assistance on performance management - Provision of additional support (e.g. promotion of MNCH weeks) - financing & resource mobilization - promotion of innovations - Data collection - Dissemination of data
Geographic scope	Whole country	Whole country
Implementation period	2014-2020	2015-2019

Terms of Reference for Key Contractors:

Terms of Reference for an Independent Verification Agent

A. Background/Context

14. The Federal Government of Nigeria is implementing the SOML Program for Results (SOML PforR), a performance based mechanism that rewards Federal and State Governments based on their performance in increasing utilization of maternal and child health interventions aimed at saving one million lives of women and children in Nigeria. This initiative represents a bold approach to improving health outcomes in Nigeria. The Program Development Objective is to increase the utilization and quality of high impact reproductive, child health, and nutrition interventions. To achieve this objective, several Disbursement Linked Indicators (DLIs) have been identified.

15. Under the SOML PforR, States will be rewarded for their performance based on objective indicators using data from household and health facility surveys as well as achievement of certain process indicators related to consolidation of primary health care (PHC) management and resources under one institution. To implement and support this Program, the FGON would like to enter into an agreement with an independent verification Agent (IVA).

B. Scope of Work

16. The role of the IVA is to provide an independent, credible and coherent analysis of State and Federal Government performance and earnings under the SOML PforR using agreed upon data sources and earning calculations as per those specified in the Program appraisal document (PAD). Specifically, the IVA will:

(i) Under DLI 1.2, assess State by State performance on the six coverage indicators (e.g. Penta3 coverage, skilled birth attendance) specified using the results of SMART surveys. Calculate the amount of money each State should earn based on the formulae in the PAD.

(ii) Under DLI 1.3, assess State by State performance on MNCH weeks using the results of SMART surveys. Calculate the amount of money each State should earn based on the formulae in the PAD.

(iii) Under DLI 2 assess State by State performance for the quality of care based on results of the health facility surveys and applying the agreed quality index. Calculate the amount of money each State should earn based on the formulae in the PAD.

(iv) Under DLI 3, verify the number of States that have a performance management system in place according to the definition provided in the PAD;

(v) Under DLI 4 assist the FMOH, FMOF in gauging the success of implementation of the innovation fund and collect data in accordance with the PAD;

(vi) Verify the progress of States on transferring staff to the entity responsible for PHC in the State and in publishing budget expenditure reports for PHC in accordance with DLI 5.

(vii) Develop an easy to read report, including simple graphs, pictures, and tables (more complicated ones can be in annexes) that describe the findings of its analysis and make recommendations of State and Federal Government earnings under each DLI. The IVA will provide a copy of its report to all members of the Program Steering Committee (PSC) within 30 days of receiving the results of the SMART and/or health facility surveys or information on the achievements of DLIs 3, 4, or 5. This may entail multiple reports as information becomes available. Together with the report, the IVA will submit all supporting documentation to the PSC and the Program Management Unit (PMU).

(viii) The IVA will make a PowerPoint presentation of its verification report containing key findings to the Steering Committee including recommendations;

(ix) Carry out such activities that the client reasonably requests in order to facilitate the implementation of SOML.

C. Assistance from the Client and PSC

17. The FMOF and the PSC will facilitate the provision of all available data from the SMART survey and health facility surveys as well as other relevant documents or materials, at the Federal and State levels, to the IVA for smooth implementation of the assignment.

18. Should any information be deemed personal in nature (results in aggregate will not be deemed personal but any information with unique personal identifiers will be deemed personal), the IVA will not disclose such information, to any person or group without written permission of the FMOF and PSC and shall return all such information, documents and material to the FMOF and PSC within the contact period.

D. General Terms and Conditions

19. The final version of the contract will be in a form in accordance with the FGON's Procurement Act of 2007. The contract will include clauses that reflect the following conditions:

20. **Parties to the Contract.** The FMOF is the client and the Independent Verification Agent (IVA) is the contractor.

21. **Assessment of Performance.** The IVA will provide the FMOF, with annual reports of a type and content acceptable to the FMOF on its activities under the contract. It will also provide a complete copy of its external auditor's annual report. The performance of the IVA will be formally reviewed annually by a committee comprising representatives of the FMOH, FMOF, and the World Bank. The indicators of performance will include: (i) The IVA'S implementation of the scope of work, particularly its timeliness; (ii) its proper analysis of State performance and earnings following the criteria and processes described above; (iii) financial probity as reflected in the IVA's external audit reports.

22. **Length of the Contract.** The contract will be for three years from the date of signature of this contract. The contract may be extended based on the agreement of both parties.

23. **Amendment of the Contract.** The contract can be amended if both parties agree and the amendment is approved by the Program Steering Committee.

24. **Dispute Resolution.** Both parties will use their best efforts to amicably settle all disputes arising out of this contract or its interpretation. In the case where the disagreement persists, the parties will submit to mediation by a person acceptable to both parties. If mediation does not resolve the issue, the mediator will submit a suggested remedy to the Program Steering Committee which will decide by consensus whether to accept the remedy and enforce it on both parties.

25. **Termination and Other Sanctions.** The client can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; (ii) obtains agreement on a consensus basis from the Program Steering Committee and provides the Steering Committee with an acceptable alternative; and (iii) gives the IVA 3 months' notice. The client can also impose other sanctions on the IVA short of termination if it obtains agreement on a consensus basis from the Program Steering Committee. The IVA can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; and (ii) gives the client 4 months' notice.

26. **Nature of the Contract – Lump Sum.** This is a lump sum contract in which the IVA will receive payments on a lump sum basis every year related to the verification services it provides and subject to the conditions of payment described below.

27. **Audited Accounts.** The IVA will maintain a separate set of accounts for this contract and will annually submit to the FMOF the entire report of its external auditors. Unaudited Statements of account will be submitted by the IVA with each annual report.

28. **Payments.** The maximum total amount of the contract is the equivalent of US$ [to be determined] annually. The budget and payment details are included in Annex 1. Within 15 days of contract signing the FMOF will pay to the IVA a total of US$X,000 as an advance. Subsequently, the IVA will submit an invoice to the FMOF every year with an annual report. FMOF will make a payment to the IVA of the amount stipulated in the invoice. The client has 30 days to object to payment of the remaining amount.

29. **Force Majeure**. For the purposes of the contract, "Force Majeure" means an event which is beyond the reasonable control of either Party and which makes a Party's performance of its obligations under the contract impossible or so impractical as to be considered impossible under the circumstances. The failure of a Party to fulfill any of its obligations under the contract will not be considered to be a breach of, or default under, this contract insofar as such inability arises from an event of Force Majeure, provided that the Party affected by such an event (a) has taken all reasonable precautions, due care and reasonable alternative measures in order to carry out the terms and conditions of this Contract, and (b) has informed the other Party as soon as possible about the occurrence of such an event. Any period within which a Party shall, pursuant to this Contract, complete any action or task, shall be extended for a period equal to the time during which such Party was unable to perform such action as a result of Force Majeure. During the period of their inability to perform the Services as a result of an event of Force Majeure, The IVA shall be entitled to continue to be paid under the terms of this Contract, as well as to be

reimbursed for additional costs reasonably and necessarily incurred by them during such period for the purposes of the Services and in reactivating the Service after the end of such period.

30. **Contract Management.** The contract will be managed by the FMOF.

31. **Authority of the client.** Without limiting any of the above aspects of the contract, the client will enjoy sole discretion in: (i) visiting the States to assess their attainment of consolidation of PHC management and resources; (ii) discuss with any involved individuals or groups to assess the performance of the IVA; (iii) gain unhindered access to the IVAs verification data and analytics; and (iv) convening meetings with the management of the IVA at any mutually agreeable time to discuss and resolve issues related to the contract.

32. **Authority of the IVA.** Without limiting any of the above aspects of the contract, the IVA will enjoy sole discretion in: (i) the procurement of supplies, equipment, and other resources needed to meet contractual obligations. These resources will become the property of the IVA upon completion of the contract; (ii) the use of resources purchased or provided under the contract and the amount of per diem and other allowances to pay; and (iii) recruitment, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the IVA.

Terms of Reference for a Private Sector Innovation Fund Manager

A. Background/Context

33. The Program Document (PD) of the Federal Ministry of Health (FMOH) for Saving One Million Lives (SOML) is explicit in its desire to foment bold innovations to strengthen both the quantity and quality health services. It is also explicit in its desire to harness the energy and reach of the private sector to provide new techniques, technologies, and approaches as well as extend the coverage of services to under-served populations.

34. The Federal Government of Nigeria (FGON) would like to establish and finance a private sector innovation fund to encourage the private sector to innovate and play a robust role in improving the health of Nigeria's mothers and children. Two types of innovation grants are envisaged:

(i) Developing and testing new techniques and technologies through small grants (up to US$150,000 each with a minimum grant size of US$25,000). Examples of innovations that could be supported include: a) a smart phone application for health facility staff and outreach workers to use to improve diagnosis and management of childhood and maternal diseases using national guidelines; and b) a home-grown ready to use therapeutic food (RUTF) for malnourished children; and

(ii) Testing new approaches to improving the delivery of SOML services by non-State actors. These types of innovations would aim to expand coverage or quality of services at the population level with an emphasis on under-served populations, and typically would be implemented for two years. They would be supported by larger grants (a minimum of US$400,000 up to US$1 million each). These innovations would be subjected to impact evaluations and a disproportionate number of these grants would be for activities in the North East and the North West.

35. In order to implement such an innovation fund, the FGON would like to enter into an agreement with an organization to work as the Innovation Fund Manager (IFM).

B. Objectives

36. The IFM will support the SOML initiative in its efforts to significantly reduce the number of women and children who die every year (estimated at close to one million in 2013). The innovations that will be supported under this contract will help Nigeria make progress on the following indicators of success:

(i) Vaccination coverage (Penta3) among young children;

(ii) Contraceptive prevalence rate (modern methods);

(iii) Vitamin A coverage among children 6 months to 5 years of age;

(iv) Coverage of skilled birth attendance;

(v) Use of insecticide-treated bed nets by children under five;

(vi) Prevention of mother to child transmission of HIV; and

(vii) Improve the quality of care as measured by robust health facility surveys.

C. Scope of Work

37. The IFM will build on its experience to implement an innovation challenge fund to promote private sector innovations in health services related to SOML with a particular focus on improving the above-mentioned indicators. The IFM will be responsible for the following:

1. Advertising and Selection of Grantees:

38. **Advertising.** In seeking proposals, IFM will advertise widely in national newspapers and on the internet as well as social media.

39. **Selection Criteria.** The IFM will use an explicit set of criteria acceptable to the SOML Steering Committee in selecting possible grantees. In choosing proposals for the service delivery (large grants) the criteria would include: (i) clarity of the description of the innovation; (ii) evidence that the proposal is actually innovative (a new approach or the application of an existing innovation to a different service/intervention); (iii) rigor and practicality of the evaluation design; (iv) reaching people in the two poorest income quintiles; (v) concentration on rural areas; (vi) credibility and track record of the proposer; (vii) efficiency (low cost per capita) and scalability of the approach; and (viii) evidence of partnership with a State government. Twice as many large grants will be allocated for activities in the North East and North West regardless of where the proposer comes from. Some of the funds will be used to finance private sector treatment of vesico-vaginal fistulae.

40. **Selection Process.** The proposals received in response to advertisements will be judged blindly by an independent and diverse group of people representing the private sector, the public sector, technical experts, and civil society. All references to the name or nature of the proposer will be removed during the selection process (except for those separate people designated to carry out due diligence on the proposers). The IFM will ensure that people external to the selection panel do not exert any influence on the selection process.

2. Grant Management

41. The IFM will carefully manage the grants based on a standard grant template acceptable to the SOML Steering Committee. Each agreement will have specific milestones against which funds will be released and include a termination clause if the proposers don't accomplish agreed milestones or do not meet the terms of the grant agreement. The IFM will maintain a computerized database of all grants in which relevant information is stored and is accessible for review. For service delivery grants, the IFM will ensure that one of their staff visit each field site at least twice a year.

3. Support to Grantees

42. The IFM will provide support to the grantees, as needed, such as technical advice, access to experts in the field, help with maintaining proper financial records, help with the design of the evaluation of the proposal, etc.

4. Monitoring and Evaluation

43. Each of the grants will have a clear set of indicators by which to judge success that are negotiated as part of the grant agreement. Particularly for the service delivery grants, the IFM will arrange for impact evaluations to be carried out. This means that the grants will have to cover defined geographical areas and include both baseline and follow on studies with a control group. The impact evaluations will be carried out by an independent group not included in the grant. The IFM will arrange, using contract funds if necessary, for the evaluation to be conducted.

5. Documentation, Disseminating Lessons, and Scaling Up Successes

44. The IFM will be responsible for documenting the lessons learned from the innovations supported by grants. On a regular basis the IFM will organize experience sharing events where entrepreneurs can share among themselves what they've learned from their experiences. The IFM will also organize events and plans for disseminating lessons learned including which approaches appear to have been successful. The IFM will attempt to facilitate public or private sector financing for successful innovations. With the prior agreement of the Steering Committee, The IFM may also make grants to help scale up successful innovations.

45.

D. Terms and Conditions

46. The final version of the contract will be in a form in accordance with the FGON's Procurement Act of 2007. The contract will include clauses that reflect the following conditions:

47. **Parties to the Contract.** The FMOH is the client and the IFM is the contractor.

48. **Assessment of Performance.** The IFM will provide the FMOH with quarterly reports of a type and content acceptable to the FMOH on its activities under the contract. It will also provide a complete copy of its external auditor's annual report. The performance of the IFM will be formally reviewed annually by a committee comprising representatives of the FMOH, FMF, and the World Bank. The indicators of performance will include: (i) the IFM's implementation of the scope of work; (ii) its proper selection of proposals following the criteria and processes described above; (iii) its proper management of grants and provision of support to grantees; (iv) rigorous monitoring and evaluation of grants; (v) satisfaction of grantees as assessed by interviews with a sample; and (vi) financial probity as reflected in the IFM's external audit reports.

49. **Length of the Contract.** The contract will be for three years from the date of signature of the contact. The contract may be extended based on the agreement of both parties.

50. **Amendment of the Contract.** The contract can be amended if both parties agree and the amendment is approved by the Program Steering Committee.

51. **Dispute Resolution.** Both parties will use their best efforts to amicably settle all disputes arising out of this Contract or its interpretation. In the case where the disagreement persists, the parties will submit to mediation by a person acceptable to both parties. If mediation does not resolve the issue, the mediator will submit a suggested remedy to the Program Steering Committee which will decide by consensus whether to accept the remedy and enforce it on both parties.

52. **Termination and Other Sanctions.** The client can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; (ii) obtains agreement on a consensus basis from the Program Steering Committee; and (ii) gives the IFM four months' notice. The client can also impose other sanctions on the IFM short of termination if it obtains agreement on a consensus basis from the Program Steering Committee. The IFM can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; and (ii) gives the client four months' notice.

53. **Nature of the Contract – Lump Sum.** This is a lump sum contract in which the IFM will receive payments on a lump sum basis every 6 months related to the number and size of the innovation grants under management and subject to the conditions of payment described below.

54. **Audited Accounts.** The IFM will maintain a separate set of accounts for this contract and will annually submit to the FMOH the entire report of its external auditors. Unaudited Statements of account will be submitted by the IFM with each quarterly report.

55. **Payments.** The maximum total amount of the contract is the equivalent of US$[to be determined]. The budget and payment details are included in Annex 1. Within 15 days of contract signing the FMOH will pay to the IFM a total of US$X million comprising US$X million to cover the IFM's initial costs and overhead and US$X million as an advance on initial payments to grantees. Subsequently, the IFM will submit an invoice to the FMOH every six months along with two quarterly reports. The invoice will document the amount disbursed to

grantees (which will be reconciled with the US$X million advance such that the IFM has sufficient cash on hand to continue making grants). It will also include XX percent of the disbursed amount for small grants and X percent of the disbursed amount for large grants, as the cost to the IFM of carrying out grant management and support. The cost of evaluation will be reimbursed against actual expenditures for evaluation by third parties under contract to the IFM. FMOH will make a payment to the IFM of XX of the amount stipulated in the invoice. The client has 30 days to object to payment of the remaining amount. If the client does not object the FMOH will pay the remaining 20 percent of the invoiced semi-annual payment. In the case the client does object, the FMOH will decide how much of the remaining funds should be released to The IFM.

56. **Force Majeure.** For the purposes of this contract, "Force Majeure" means an event which is beyond the reasonable control of either Party and which makes a Party's performance of its obligations under the contract impossible or so impractical as to be considered impossible under the circumstances. The failure of a Party to fulfill any of its obligations under the contract will not be considered to be a breach of, or default under, this contract insofar as such inability arises from an event of Force Majeure, provided that the Party affected by such an event (a) has taken all reasonable precautions, due care and reasonable alternative measures in order to carry out the terms and conditions of this Contract, and (b) has informed the other Party as soon as possible about the occurrence of such an event. Any period within which a Party shall, pursuant to this Contract, complete any action or task, shall be extended for a period equal to the time during which such Party was unable to perform such action as a result of Force Majeure. During the period of their inability to perform the Services as a result of an event of Force Majeure, the IFM shall be entitled to continue to be paid under the terms of this Contract, as well as to be reimbursed for additional costs reasonably and necessarily incurred by them during such period for the purposes of the Services and in reactivating the Service after the end of such period.

57. **Contract Management.** The contract will be managed by the FMOH as represented by the PMU.

58. **Sub-Contracting.** For the purposes of evaluating the effectiveness of the innovations, the IFM may sub-contract with any competent organization or individual as long as the sub-contracting is done with due regard for efficiency and economy. Any sub-contract above US$X00,000 will have to receive prior approval of the FMOH and subsequently be agreed to by the Steering Committee.

59. **Authority of the client.** Without limiting any of the above aspects of the contract, the client will enjoy sole discretion in: (i) visiting the premises of any grantee or the location where they are working to assess their performance and compliance with the terms of their grants; (ii) discuss with any involved individuals or groups to assess the performance of the IFM; (iii) gain unhindered access to the IFM's grant management database; and (iv) convening meetings with the management of the IFM at any mutually agreeable time to discuss and resolve issues related to the contract.

60. **Authority of the IFM.** Without limiting any of the above aspects of the contract, the IFM will enjoy sole discretion in: (i) the procurement of supplies, equipment, and other resources needed to meet contractual obligations. These resources will become the property of the IFM

upon completion of the contract; (ii) the use of resources purchased or provided under the contract and the amount of per diem and other allowances to pay; and (iii) recruitment, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the IFM.

Terms of Reference for a Program Support Unit

A. Background/Context

61. The Program Document (PD) of the Federal Ministry of Health (FMOH) for Saving One Million Lives (SOML) describes as a key aspect of the initiative a "Program Delivery Unit" (PDU) now re-branded as a Program Support Unit (PSU) whose role is to support implementation of SOML. Such a PSU is intended to: (i) ensure a continuing focus on results; (ii) assist States in analyzing data so that they can diagnose issues in service delivery and work towards resolving them; and (iii) build the capacity of Federal, State and local officials to successfully implement interventions prioritized under SOML.

62. The FMOH would like to enter into an agreement with an organization, consistent with the PD of SOML, to facilitate implementation of SOML and help ensure its success in improving the health of Nigeria's mothers and children.

B. Objectives

63. The contractor will support the SOML initiative in its efforts to significantly reduce the number of women and children who die every year (estimated at close to one million in 2013). The specific indicators of success include:

(i) Vaccination coverage (penta3) among young children;

(ii) Contraceptive prevalence rate (modern methods);

(iii) Vitamin A coverage among children 6 months to 5 years of age;

(iv) Coverage of skilled birth attendance;

(v) Use of insecticide-treated bed nets by children under five;

(vi) Prevention of mother to child transmission of HIV through testing of mothers during antenatal care; and

(vii) Improve the quality of care as measured by robust health facility surveys.

C. Scope of Work

64. The contractor will report to the Program Steering Committee and the Program Manager (and head of the Program Management Unit) designated by the Honorable Minister of Health and will have the following responsibilities:

65. **Strengthening Performance Management:** The contractor will provide technical assistance and support to States to develop and implement a system of performance management as well as build the management capacity of the State health leadership. This will involve working with State health leaders to analyze available data on PHC performance, develop action plans to address weaknesses, review action plans to see whether actions have been implemented and had the intended effect. Specifically, the contractor will:

(i) Ensure that States appoint a "Lead" with commensurate capacity to be accountable for the performance management process;

(ii) Support States and provide necessary technical expertise to analyze weaknesses in PHC service delivery, including availability of financial resources and development of appropriate action plans;

(iii) Work closely with and provide ongoing support, tools and capacity building to State Leads and other State health leaders to analyze weaknesses in PHC performance and develop and implement corrective measures;

(iv) Ensure that its performance management officers are actively involved in, and where needed support, the organization, at least twice a year, of high level review meetings to discuss analysis and agree upon action plans. The meetings should have at least one of the three following officials present: Commissioner for Health, Permanent Secretary or Executive Director SPHCDA;

(v) If necessary, deploy full time consultant(s) to provide technical support to States that require it. The decision to deploy such will be taken in consultation with the Program Manager.

66. The contractor will be responsible for the recruitment and deployment of the full time consultants in those States where they are needed. The TORs for the full time consultant will be agreed with the Program Management Unit (PMU) and will focus on improving the performance of the State on the key SOML indicators listed above. The recruitment will be done through a transparent process that will involve: (i) public advertisement in newspapers for the positions; and (ii) explicit selection criteria based on both oral interviews and written tests which will include analysis of raw data. The Performance Management Consultant to be deployed to the States shall: (i) have a background in health, public health or related fields of study; (ii) possess strong analytical, data management and problem solving skills; (iii) have demonstrated leadership experience and ability to work effectively with multiple stakeholders; (iv) not have a 1st or 2nd degree relative who works in the FMOH, for the contractor, or in the State health or political leadership; (v) will be paid a market competitive salary commensurate with his or her salary history, likely about US$50,000. In addition the consultant will be paid a performance bonus related to the improvements seen in the State's performance on the key SOML indicators listed above.

67. **Support States to Formulate Plans to Earn Initial Investments.** As part of the SOML PforR, States will be able to obtain initial investments based on plans to strengthen supportive supervision and, if they like, introduce innovations. The contractor will: (i) provide expertise to States to analyze data to inform the design of their plans; (ii) review draft versions of the plans

and provide feedback to improve them; and (iii) review and ensure that final plans are of good quality.

68. **Support to the Federal Ministry of Health on Performance Management.** As part of the capacity strengthening for the FMOH staff working on Programs related to SOML the contractor will (i) carry out a training needs assessment taking advantage of the literature; (ii) examine how FMOH staff are currently tracking performance; (iii) devise a training Program and follow up support Program acceptable to the TCG and PMU; (iv) carry out the capacity building Program as designed; and (v) assess the progress of FMOH staff's capacity compared to baseline.

69. **Assist FMOH with Expenditure Analysis:** As part of DLI 5, the contractor will assist the FMOH and the Federal Government in analyzing PHC expenditures, budgets, and releases and help FMOH strengthen its budget execution process.

70. Carry out such activities that the client reasonably requests in order to facilitate the implementation of SOML.

D. General Terms and Conditions

71. The final version of the contract will be in a form in accordance with the FGON's Procurement Act of 2007. The contract will include clauses that reflect the following conditions:

72. **Parties to the Contract:** The FMOH is the client and ……(PSU) is the contractor.

73. **Assessment of Performance:** The contractor will provide the FMOH with quarterly reports of a type and content acceptable to the FMOH on its activities under the contract. The performance of the contractor will be formally reviewed annually by a committee comprising representatives of the FMOH, FMF, and the World Bank. The indicators of performance will include: (i) progress of those States with full time consultants on key SOML indicators; (ii) formulation and implementation of action plans by States; and (iii) financial probity as reflected in the contractor's external audit reports. The deliverables of the consultant are described under the scope of work above.

74. **Length of the Contract:** The contract will initially be for one year from the date of signing of the contract. The contract may be extended based on the agreement of both parties.

75. **Amendment of the Contract:** The contract can be amended if both parties agree and the amendment is approved by the Program Steering Committee.

76. **Dispute Resolution:** Both parties will use their best efforts to amicably settle all disputes arising out of this Contract or its interpretation. In the case where the disagreement persists, the parties will submit to mediation by a person acceptable to both parties. If mediation does not resolve the issue, the mediator will submit a suggested remedy to the Program Steering Committee which will decide by consensus whether to accept the remedy and enforce it on both parties.

77. **Termination and Other Sanctions:** The client can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; (ii) obtains agreement on a consensus basis from the Program Steering Committee; (iii) provides the Steering Committee with an acceptable alternative; and (iv) gives the contractor four months' notice. The client can also impose other sanctions on the contractor short of termination if it obtains agreement on a consensus basis from the Program Steering Committee. The contractor can terminate the contract for any reason provided it: (i) has gone through the dispute resolution mechanism described above; and (ii) gives the client four months' notice.

78. **Nature of the Contract – Lump Sum:** This assignment will use a lump sum contract in which the contractor will receive payments on a lump sum basis every 6 months subject to the conditions of payment described below.

79. **Audited Accounts:** The contractor will maintain a separate set of accounts for this contract and will annually submit to the FMOH the entire report of its external auditors. Unaudited Statements of account will be submitted by the contractor with each quarterly report.

80. **Payments:** The amount of the contract is Naira [to be determined]. The budget details are attached and reflect the agreed amount and number of equipment, consultants, operating costs, and the like. Within 15 days of contract signing and effectiveness of the PforR, the FMOH will pay to the contractor XX percent of the contact amount. Subsequently, the contractor will submit an invoice to the FMOH every six months along with two quarterly reports. The FMF will make a payment to the contractor of XX percent of the stipulated amount (10.5 percent of the contract amount). The client has 30 days to object to payment of the remaining amount. If the client does not object the remaining XX percent of the semi-annual payment will be disbursed.

81. **Force Majeure:** For the purposes of the contract, "Force Majeure" means an event which is beyond the reasonable control of either Party and which makes a Party's performance of its obligations under the contract impossible or so impractical as to be considered impossible under the circumstances. The failure of a Party to fulfill any of its obligations under the contract will not be considered to be a breach of, or default under, this contract insofar as such inability arises from an event of Force Majeure, provided that the Party affected by such an event (a) has taken all reasonable precautions, due care and reasonable alternative measures in order to carry out the terms and conditions of this Contract, and (b) has informed the other Party as soon as possible about the occurrence of such an event. Any period within which a Party shall, pursuant to this Contract, complete any action or task, shall be extended for a period equal to the time during which such Party was unable to perform such action as a result of Force Majeure. During the period of their inability to perform the Services as a result of an event of Force Majeure, the contractor shall be entitled to continue to be paid under the terms of this Contract, as well as to be reimbursed for additional costs reasonably and necessarily incurred by them during such period for the purposes of the Services and in reactivating the Service after the end of such period.

82. **Contract Management:** The contract will be managed by the FMOH as represented by the PMU.

83. **Authority of the Client:** Without limiting any of the above aspects of the contract, the client will enjoy sole discretion in: (i) visiting States to assess the performance of the contractor

in assisting State health officials; (ii) obtaining such relevant information as to allow proper monitoring and supervision of the contractor and their consultants; (iii) convening meetings with the management of the contractor at any mutually agreeable time to discuss and resolve issues related to the contract; (iv) reviewing the quarterly reports and obtaining additional information from the contractor to assess progress in implementing the contract; (v) objecting to the payment of 20 percent of the semi-annual payment to the contractor.

84. **Authority of the Contractor:** Without limiting any of the above aspects of the contract, the contractor will enjoy sole discretion in: (i) the procurement of supplies, equipment, and other resources needed to meet contractual obligations. These resources will become the property of the FMOH upon completion of the contract; (ii) the use of resources purchased or provided under the contract and the amount of per diem and other allowances to pay; and (iii) recruitment, firing, posting, remuneration, and customary managerial prerogatives over staff who are receiving payments from the contractor subject to conditions stipulated above about transparency in recruitment.

Development of Initial Investment Fund Plans

85. States will receive initial investment funding (DLI 1.1). All States will receive funds with the lagging States (the poorest performing 20 States as judged by the sum of all six indicators (see PDO Indicator 1) receiving US$2 million and the remaining States, US$1 million. To access the funds, States must develop an action plan that highlights how they intend to address weaknesses in PHC delivery with a focus on strengthening supervision and introducing, if they so with, an innovation in service delivery.

86. **Process.** Between Negotiations and Program Effectiveness, the PMU will meet with all interested States to explain the process of accessing the initial investment funding. States will be encouraged to engage with FMOH technical staff, the PSU, and consultants from UN agencies and other development partners in formulating their plans. The plans will include:

87. **Situation Analysis** – a review of the status of PHC delivery in the State with a focus on SOML interventions. Objective data will be obtained from the NDHS 2008 and 2013, SMART surveys, other household surveys, and any health facility data that is available. The analysis will look at trends over time and comparisons with other States in the same geopolitical zone and will emphasize the SOML PforR indicators: vaccination coverage among young children (Penta3); contraceptive prevalence rate (modern methods); Vitamin A supplementation among children 6 months to 5 years of age; skilled birth attendance; HIV counselling and testing among women attending antenatal care; use of insecticide treated nets (ITNs) by children under five; and quality of care. An analysis of DHIS-2 data, taking into account, the percentage completeness, will also be included so as to identify LGAs or Programs that are lagging.

88. **Supervision of PHC Facilities.** The plan on supervision will include:

(i) a review of the current State of supervision in the State and the challenges that it faces;

(ii) the development of quantitative supervisory checklist (QSC, an example of which will be included in the Program implementation manual) that builds on the experience of PBF and that: (a) assigns numerical scores to the items included; (b) includes only items that

are objectively verifiable; (c) records multiple visits on one checklist to facilitate tracking of progress over time; (d) and leaves a written record of the scores in the health facility itself. The plan will include a means for field-testing the QSC and adjusting it accordingly;

(iii) Printing of the QSC and training on its use by supervisors at State and LGA levels;

(iv) A budget for the implantation of the QSC including costs of training, transport, printing and refresher training based on supervision visits that should be done at least quarterly but hopefully more frequently;

(v) A timeline for implementation of the QSC as part of systematic supervision; and

(vi) Means for monitoring and evaluating the implementation of QSC and systematic supervision.

89. **Introduction of Innovation.** States are encouraged to use the plan to describe the introduction of an innovation in the organization or management of primary health care that will improve either the quantity or quality of PHC. The State is free to choose what kind of innovation it would like to introduce but a menu of options includes: (i) performance-based financing (PBF) building on the experience in the NSHIP States where funds are transferred to facilities based on the quantity and quality of key services provided; (ii) pro-poor health insurance mechanisms where patients have a choice of providers from both private and public sectors ("money follows the patient") and where at least 50 percent of the public subsidy goes to the bottom two income quintiles; (iii) contracting-in managers for remote or lagging LGAs; (iv) performance-based contracts with private providers in which measurable results are specified, independent assessment of the results is undertaken, and payments are linked to the results (e.g. an NGO is paid for every additional HIV+ pregnant woman receiving PMTCT); and (v) conditional cash transfers (CCTs) for women and children accessing SOML interventions. The plans for the innovation will include:

(i) A clear description of the innovation to be introduced, including implementation arrangements and location;

(ii) A timeline and budget;

(iii) A description of the indicators of success and a means for tracking its progress; and

(iv) Clear responsibilities and accountabilities.

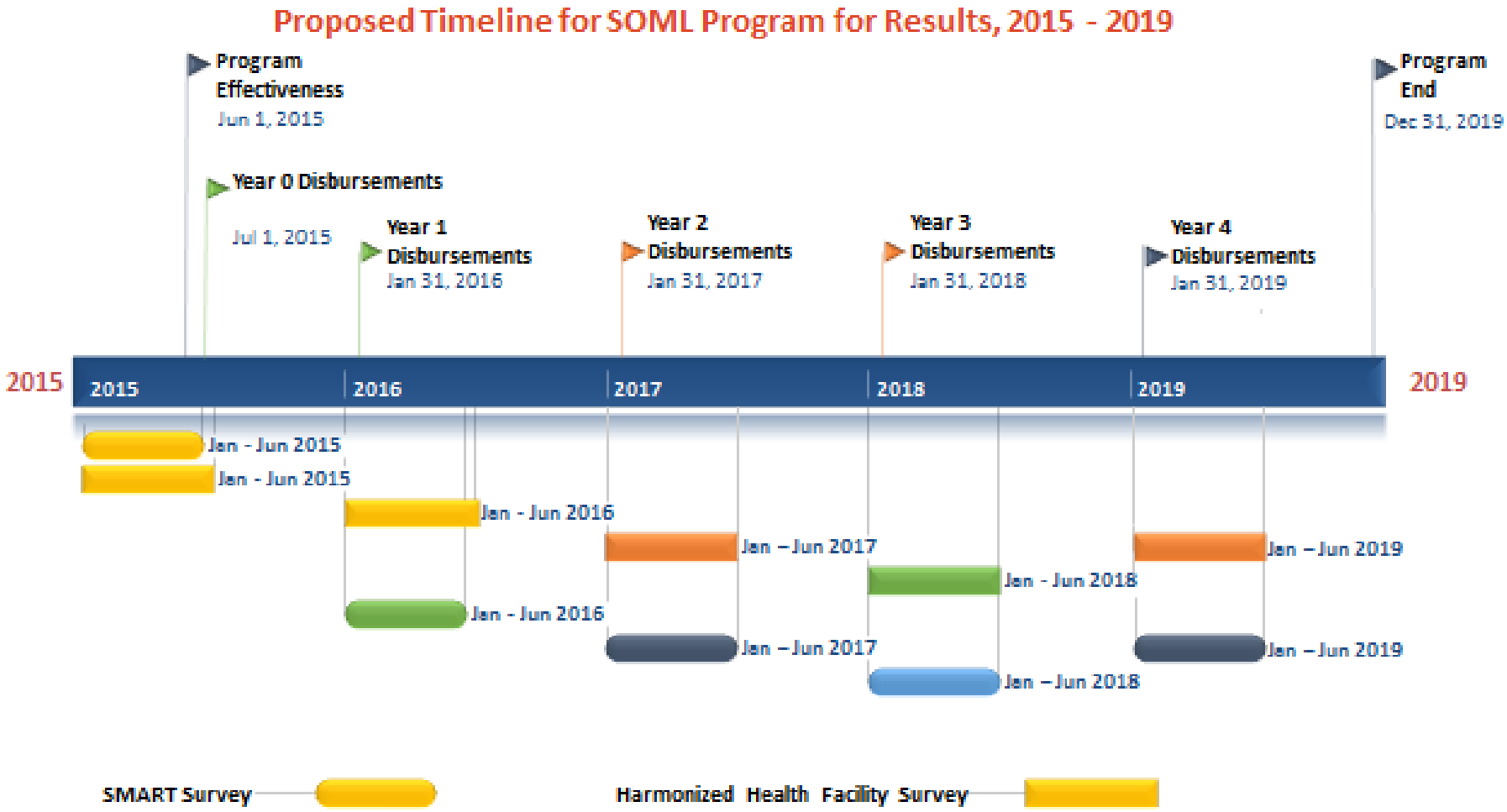
90. **Assessment of the Plans.** The PMU will ensure that plans are reviewed independently by at least two staff of the FMOH using a scoring sheet. The plans will be assessed based on:

(i) Clarity of the presentation; 30 percent

(ii) Technical quality of the situational analysis and the innovation; 40 percent

(iii) Practicality of the approach to supervision and the innovation, including: the timeline; budget; integration of activities into State systems; and specific responsibility/accountability; 40 percent.

91. **Technical Assistance for Plan Development.** The PMU will convene a workshop with facilitators and resource persons from FMOH, NPHCDA, World Bank and other relevant parties/agencies to address plan formulation. Modules may include plan appraisal criteria, budgeting, menu of innovations and available evidence on implementation. Ongoing support will be provided to States to finalize the plans by the PMU, PSU, NPHCDA or other agencies.


Proposed Timeline for SOML Program for Results, 2015 - 2019
Program Effectiveness
Jun 1, 2015
Program End
Dec 31, 2019
Year 0 Disbursements
Jul 1, 2015
Year 1 Disbursements
Jan 31, 2016
Year 2 Disbursements
Jan 31, 2017
Year 3 Disbursements
Jan 31, 2018
Year 4 Disbursements
Jan 31, 2019
2015
2015
2016
2017
2018
2019
2019
Jan - Jun 2015
Jan - Jun 2015
Jan - Jun 2016
Jan – Jun 2017
Jan - Jun 2018
Jan – Jun 2019
Jan - Jun 2016
Jan – Jun 2017
Jan – Jun 2019
Jan – Jun 2018
SMART Survey
Harmonized Health Facility Survey

Annex 2: Results Framework Matrix

Program Development Objective: Increase the utilization and quality of high impact reproductive, child health, and nutrition interventions.

Indicator	Core	DLI	Unit of Measure	Baseline	Target Values				Frequency	Data Source/Methodology	Responsibility for Data Collection
					Yr 1 (2017)	Yr 2 (2018)	Yr 3 (2019)	Yr 4 (2020)			
PDO Indicator 1: combined coverage of six key SOML services; (a) vaccination coverage among young children (Penta3); (b) contraceptive prevalence rate (modern methods); (c) Vitamin A supplementation among children 6 months to 5 years of age; (d) skilled birth attendance; (e) HIV counselling and testing among women attending antenatal care; and (f) use of insecticide treated nets (ITNs) by children under 5	No	Yes	Percent Points	232 percentage points (SMART 2014) Penta3 = 52%, ITN = 25%, CPR=15%, skilled birth attendance = 42%, ANC and blood sample taken = 49%, Vitamin A coverage = 50% (SMART 2014)	245	258	271	284	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
PDO Indicator 2: Quality of care index at health center level	No	Yes	Percent	Diagnostic Accuracy = 36.2% , Drug availability = 45.3% (SDI Survey in 12 States) Baseline for 36+1 States expected in 2015		+15% of a baseline standard deviation increase in quality index compared to baseline	+30% of a baseline standard deviation increase in quality index compared to baseline	+50% of a baseline standard deviation increase in quality index compared to baseline	Annual	Harmonized Health Facility Survey (based on SDI and SARA)	NBS and NPopC overseen by FMOH
Intermediate Results Area 1: Improve quality of care and ability to deliver key SOML Interventions											
Intermediate Results Indicator 1: Children immunized	Yes	No	Number	3,536,000	3,638,000	3,740,000	3,842,000	3,944,000	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH

Program Development Objective: Increase the utilization and quality of high impact reproductive, child health, and nutrition interventions.											
Indicator	**Core**	**DLI**	**Unit of Measure**	**Baseline**	**Target Values**				**Frequency**	**Data Source/Methodology**	**Responsibility for Data Collection**
					Yr 1 (2017)	**Yr 2 (2018)**	**Yr 3 (2019)**	**Yr 4 (2020)**			
Intermediate Results Indicator 2: Birth s attended by skilled health personnel	Yes	No	Number	2,856,000	2,924,000	2,992,000	3,060,000	3,128,000	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
Intermediate Results Indicator 3: People with access to basic package of health, nutrition, or reproductive health services	Yes	No	Number	40,324,000	43,656,000	46,988,000	50,320,000	53,652,000	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
Intermediate Results Indicator 4: Impact evaluation of Results-based disbursements for MNCH weeks –	No	Yes	Yes/No	No	Ongoing	Ongoing	Ongoing	Completed	Annual	SMART Household Survey	NBS and UNICEF overseen by FMOH
Intermediate Results Area 2: Improved Management of Primary Health Care											
Intermediate Results Indicator 5: Number of States with performance management systems in place	No	No	Number	10	15	20	25	30	Annual	Review of IFM documents and assessment visits to States	IVA and FMOH (PMU)
Intermediate Results Indicator 6: States in which SPHCDA or equivalent have managerial authority over PHC staff	No	No	Cumulative Number	4	11	19	28	37	Annual	Assessment visits to States	IVA

Annex 3: DLIs, Disbursement Arrangements and Verification Protocols
Disbursement-Linked Indicator Matrix

(Please see the notes following the DLI tables for the detailed results and formula for disbursements)

	Total Financing Allocated to DLI US$ million	***As % of Total Financing Amount***	***Indicative timeline for DLI achievement***				
			FY16	***FY17***	***FY18***	***FY19***	***FY20***
DLI 1- Increase of transparency in management and budgeting of primary health care							
DLI 1.1 States produce plans for achieving reductions in Maternal, Perinatal and Under-5 child mortality	$57.0		$57.0	$0.0	$0.0	$0.0	$0.0
DLI 1.2 Improvements on 6 key health indicators: a) Pentavelent3 vaccination, b) Insecticide treated nets used by children under 5, c) Contraceptive prevalence rate , d) Skilled birth attendance, e) HIV counselling and testing during antenatal care, and f) Vitamin A coverage children 6 months to 5 years.	$232.0		$0.0	$58.0	$58.0	$58.0	$58.0
DLI 1.3 Lagging States will	$16.0		$2.0	$7.0	$7.0	$0.0	$0.0

	Total Financing Allocated to DLI US$ million	*As % of Total Financing Amount*	*Indicative timeline for DLI achievement*				
			FY16	***FY17***	***FY18***	***FY19***	***FY20***
strengthen their MNCH weeks as part of an impact evaluation.							
Allocated amount:	$305.0	61%	$59	$65	$65	$58	$58
DLI 2- Increase of quality of High Impact Reproductive, Child Health and Nutrition Interventions: States will improve the quality of care at primary health care facilities.							
Allocated amount:	$54.0	11%	$0.0	$0.0	$18.8	$18.0	$18.0
DLI 3- Improvement of monitoring and evaluation systems and data utilization DLI 3.1 Improving M&E Systems a) Conduct SMART surveys in all 36+1 States; b) Introduce annual health facility surveys (harmonized based on SDI and SARA methodologies) covering all 36+1 States; and c) Collect data on MMR through the 2016 census or acceptable	$35.0		$7.0	$7.0	$7.0	$7.0	$7.0

	Total Financing Allocated to DLI US$ million	*As % of Total Financing Amount*	*Indicative timeline for DLI achievement*				
			FY16	***FY17***	***FY18***	***FY19***	***FY20***
alternative. DLI 3.2 Improving Data Utilization a) Widely disseminate the results of SMART and harmonized health facility survey data; and b) Strengthen management capacity of State and FMOH leadership DLI 3.3: Implementing Performance Management Implement performance management system in all States	$27.0 $18.0		$3.0 $2.0	$5.0 $2.0	$6.0 $3.0	$6.0 $5.0	$7.0 $6.0
Allocated amount:	$80.0	16%	$12.0	$14.0	$18.0	$18.0	$18.0
DLI4 -Establishment and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions: A competitive innovation fund will be established and effectively managed that supports innovations for techniques and technologies and							

	Total Financing Allocated to DLI US$ million	*As % of Total Financing Amount*	*Indicative timeline for DLI achievement*				
			FY16	***FY17***	***FY18***	***FY19***	***FY20***
innovations in health service delivery by private sector providers.							
Allocated amount:	$20.0	4%	$2.0	$4.5	$4.5	$4.5	$4.5
DLI5 - Increase of transparency in management and budgeting of primary health care: States will: (i) transfer health staff to entity responsible for PHC; and (ii) produce and publish a consolidated budget execution report covering all income and expenditures for PHC. The FGON will publish a consolidated budget execution report covering all income and expenditures for PHC.							
Allocated amount:	$41.0	8%	$2.0	$7.0	$8.0	$10.0	$14.0
Total Financing Allocated:	**$500.0**	**100%**	**$75.0**	**$91.0**	**$112.0**	**$109.0**	**$114.0**

DLI Verification Protocol Table

#	*DLI*	*Definition/ Description of achievement*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification*		
				Data source/agency	*Verification Entity*	*Procedure*
1	**Increase of utilization of High Impact Reproductive, Child Health and Nutrition Interventions**	1.1 States produce plans for achieving reductions in maternal and under-5 mortality 1.2 Improvements in 6 key indicators (Penta3 vaccination, ITN use, CPR, skilled birth attendance, HIV counselling during antenatal care, and Vitamin A coverage) 1.3 Lagging States strengthen their MNCH weeks .	No Yes Yes	Plans approved by FMOH SMART Household Survey; National Bureau of Statistics with TA support from UNICEF. Oversight by FMOH	IVA (Independent Verification agency)	SMART Survey data reviewed by IVA which calculates percentage point change from baseline on the 6 indicators, subtract 6 x number of years into the Program and multiply the percentage points by US$205K
2	**Increase of quality of High Impact Reproductive, Child Health and Nutrition Interventions**	States will improve the quality of care at primary health care facilities.	Yes	Health Facility surveys conducted by National Bureau of Statistics with TA support from BMGF. Oversight by FMOH	IVA	Health facility survey data reviewed by IVA which calculates percentage point change from previous high on index of quality of care.

#	*DLI*	*Definition/ Description of achievement*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification*		
				Data source/agency	***Verification Entity***	***Procedure***
3	**Improvement of monitoring and evaluation systems and data utilization**	3.1 M&E Systems: (a) Conduct annual SMART surveys in all 36+1 States; (b) conduct annual health facility surveys covering all 36+1 States; (c) Collect data on MMR & U5MR using 2016 census; 3.2 Data Utilization: (a) Widely disseminate SOML results; (b) Strengthen management capacity of State health and FMOH leadership 3.3: Implementing Performance Management (a) implement performance management system in all States	No Yes Yes	Survey reports (household, facility, etc.) coming from NBS FMOH website, newspapers; review of records; visits to States & to Federal vertical Programs Visits to States & review of plans etc.	IVA IVA IVA	Review survey reports to ensure they have been conducted according to quality norms. Not more than one click from main website. IVA visits States and sees whether they have capacity to implement performance management. Also visit Federal vertical Programs Visit States to assess whether they are implementing performance management system.

#	*DLI*	*Definition/ Description of achievement*	*Scalability of Disbursements (Yes/No)*	*Protocol to evaluate achievement of the DLI and data/result verification*		
				Data source/agency	***Verification Entity***	***Procedure***
4	**Establishment and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions :**	A competitive innovation fund will be established and effectively managed that supports innovations for techniques and technologies and innovations in health service delivery by private sector providers.	No	Documents and database of Innovation Fund Manager & discussions with grantees. Report of Fund Manager's external auditors	IVA	IVA will collect data from the fund manager and this will be reviewed annually by a committee including representatives of FMOH, FMOF, World Bank.
5	**Increase of transparency in management and budgeting of primary health care:**	States will: (i) transfer health staff to entity responsible for PHC; and (ii) produce and publish a consolidated budget execution report covering all income and expenditures for PHC. The FGON will publish a consolidated budget execution report covering all income and expenditures for PHC.	Yes	Location of health worker personnel files Consolidated PHC budget execution report published online	IVA	IVA will assess whether personnel files have been transferred to SPHCDA State Government websites And FMOH Website will be examined to see whether data has been published

Bank Disbursement Table

#	DLI	Bank financing allocated to the DLI ($M)	Of which Financing available for		Deadline for DLI Achievement[1]	Minimum DLI value to be achieved to trigger disbursements of Bank Financing[2]	Maximum DLI value(s) expected to be achieved for Bank disbursements purposes[3]	Determination of Financing Amount to be disbursed against achieved and verified DLI value(s)[4]
			Prior results ($M)	Advances				
1	**Increase of utilization of High Impact Reproductive, Child Health and Nutrition Interventions**	305		0	Dec. 31 2019	**6 percentage point improvement annually**	**No maximum**	**Linear – Sum of coverage of 6 indicators – baseline – (6 X number of years of implementation of PforR) X US$205,000**
2	**Increase of quality of High Impact Reproductive, Child Health and Nutrition Interventions**	54		0	Dec. 31 2019	**1 percentage point improvement in quality of care index.**		**Linear – (Quality index in % - baseline quality index) X US$25,000**
3	**Improvement of monitoring and evaluation systems and data utilization**	80	**7**	60	Dec. 31 2019	**1 State implements performance management system**	**$80 Million**	**Linear, Number of States meeting criteria for performance management system X US$250,000**
4	**Establishment**	20				**Year 0 signing**	**$20 Million**	**Acceptable**

#	*DLI*	*Bank financi*	*Of which Financing available for*		*Deadline for DLI*	*Minimum DLI value to be*	*Maximum DLI value(s)*	*Determination of Financing Amount to*
	and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions			10	Dec. 31 2019	**of contract with innovation fund manager**		**implementation of innovation fund as judged by FMOH, FMOF, WB = US$4.5 Million**
5	**Increase of transparency in management and budgeting of primary health care:**	41		10	Dec. 31 2019	**1 State or FGON**	**US$41 million**	**US$500,000 to each State one off for shifting managerial control of health workers US$300,000 per State per year if it publishes PHC consolidated disbursement report**

[1]If the DLI is to be achieved by a certain date before the Bank Financing closing date, please insert such date. Otherwise, please insert the Bank Financing closing date.
[2] If the DLI has to remain at or above a minimum level to trigger Bank disbursements (e.g. DLI baseline), please indicate such level.
[3] Please insert the DLI value(s) above which no additional Bank financing will be disbursed.
[4]Specify the formula determining the level of Bank financing to be disbursed on the basis of level of progress in achieving the DLI, once the level of DLI achievement has been verified by the Bank. Such formula may be of various types, including pass/fail, linear, or other types as may be agreed between the Bank and the borrower.

DETAILS FOR CALCULATING AND DISBURSING AGAINST DLIs

A. DLI 1.1 and 1.2- INCREASE OF UTILIZATION OF HIGH IMPACT REPRODUCTIVE, CHILD HEALTH AND NUTRITION INTERVENTIONS:

Result	Increased coverage of 6 high impact interventions
Level of Government	Individual States
Means of Verification	SMART Household Survey – annually
Data collection agent	National Bureau of Statistics with TA from UNICEF
Verifying Agent	Independent verification agent (IVA)
If not achieved? - Plans	Funds available to State in years 1-4 until supervision plan approved
If not achieved Years 1-4?	Funds remain available based on improvement in results
If over-achieved Year 1-4?	If above the targets in the results framework (nationally) then re-allocate funds in years 3 and 4 from other DLIs which were not achieved.

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)	57	58.1	58.1	58.1	58.1	289

Calculation of Amount to be Disbursed:

Year 0:

Step 1: Add up the coverage percentages from SMART 2014 for each State on the following 6 indicators: (i) immunization coverage (Pentavalent3); (ii) insecticide-treated net (ITN) use by children under five; (iii) proportion of pregnant women who receive HIV counselling and testing as part of their antenatal care – (use ANC coverage as a proxy until SMART surveys are modified to include this indicator in 2015); (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage among children 6 months to 5 years.

Step 2: Rank all the States on the sum of the six indicators.

Step 3: The poorest 20 performing States will receive US$2 million after effectiveness and when their plans are approved by the FMOH. The remaining States receive US$1 million upon the same conditions.

Step 4: State submits plan for strengthening supportive supervision and introducing an innovation (if they wish), including a budget, indicators of success, and clear responsibilities which is acceptable to the FMOH and in keeping with the following criteria (described in more detail in Annex 1); (i) Clarity of the presentation; 30 percent; (ii) Technical quality of the situational analysis and the innovation; 40 percent ; and (iii) Practicality of the approach to supervision and the innovation, including: the timeline; budget; integration of activities into State systems; and specific responsibility/accountability- 40 percent.

Years 1-4:

Step 1: Add up the coverage percentages from that year's SMART survey for each State on the following 6 indicators: (i) immunization coverage (Pentavalent3); (ii) insecticide-treated net (ITN) use by children under five; (iii) proportion of pregnant women who receive HIV counselling and testing as part of their antenatal care; (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage among children 6 months to 5 years.

Step 2: Subtract the baseline from latest sum. (See Table 1 for an example). Take that number and subtract 6 percentage points (the average annual rate of change from 2008 to 2013) times the number of years the Program has been effective. For example, if the sum in year 2 is 220 and the baseline is 200, the "score" would equal 220-200 = 20; 20 – (6 X 2) = 8.

Step 3: Take the "score" calculated in step 2 and multiply the number up to 1 decimal point by US$205,000. If the "score" is negative the State receives nothing. There is no upper limit on what a State can earn.

Step 4: Rank the States on their sum by geopolitical zone. Provide an additional US$500,000 to the best performing State in the zone ("zonal champion") above what they would earn based on the improvement. In the North East and the North West the top 2 States will receive US$500,000 each. No funds would be paid to "zonal champions" if their improvement was less than 6 percentage points.

Example Table 1: Adamawa goes from 40.2 percent DPT3 coverage in 2014 to 41.0 percent coverage in 2015 a change of 0.8 percentage points. On vitamin A coverage it improves 11.4 percentage points. When adding in the changes in the other 4 indicators, Adamawa saw a 23.8 percentage point improvement in its "sum" from the baseline. From this amount (23.8), six percentage points are subtracted (6 X 1 year) giving a "score" of 17.8 and the latter amount is multiplied by US$205,000 (= US$3,649,000). Adamawa and Bauchi would receive an addition US$500,000 because they are "zonal champions," i.e. the most improved States in the zone. Thus Adamawa would earn US$4,149,000 (US$3,649,000 + US$500,000) and Bauchi would earn US$828,000 ((7.6 – (6 X 1)) x 205,000 + 500,000). Gombe would receive US$225,500 ((7.1-6) x 205,000). Borno would not receive any payment because its sum (change) is less than 6 percentage points. Taraba would receive no payment because its performance actually declined.

Table 8: Example from North East – Percentage Point Change from Baseline and Payments

State	DPT3 2014	DPT3 2015	DPT3 change	Vit A 2014	Vit A 2015	Vit A change	Sum of Changes (all 6)	Payment Formula	Payment
	%	%	% pts.	%	%	% pts	% pts		$M
Adamawa	40.2	41	0.8	47.2	58.6	11.4	**23.8**	(Sum – 6) x $205K + $500K	4.149
Bauchi	38.5	39	0.5	31.1	36	4.9	**7.6**	(Sum – 6) x $205K + $500K + $500K	0.828
Borno	37.4	37.8	0.4	23.3	23.8	0.5	**3.1**	No payment	0
Gombe	35.2	35.5	0.3	26.2	27.8	1.6	**7.1**	(Sum – 6) x $400K	0.2255
Taraba	32.3	32.4	0.1	29.6	25.6	-4	**-1.4**	No payment	0
Yobe	28.4	28.5	0.1	31.4	30.5	-0.9	**6.3**	(Sum – 6) x $400K	0.0615

Example Table 2: In year 2 Adamawa only went up to 233.3 percentage points so its score is 233.8-200 – (6 X 2) = 21.8 so it gets US$4.469 million (21.8 x 205,000) but it does not get money for being "zonal champion" which now goes to Yobe and Borno which improved 16.9 and 18.7 percentage points respectively (compared to the 10 percentage point improvement in Adamawa). Notice that in year 2 Bauchi receives no funds because of its small improvement which is below 12 (6 X 2 years) percentage points. Gombe and Taraba also do not earn rewards in year 2 for the same reason.

Table 9: Example of DLI 1 Over Two Years of the Program

State	Sum Baseline	Sum Year 1	Change Year 1	Payment Year 1 $M	Sum Year 2	Change Year 2 - baseline	Payment Year 2 $M
Adamawa	200	223.8	23.8	4.149	233.8	33.8	4.469
Bauchi	180	187.6	7.6	0.828	190	10	0
Borno	140	143.1	3.1	0	160	20	2.14
Gombe	150	157.1	7.1	0.2255	154	4	0
Taraba	130	128.6	-1.4	0	129.7	-0.3	0
Yobe	140	146.3	6.3	0.0615	165	25	3.165

Step 5: The State with the highest score ("sum") nationally would be named "national champion" and would receive US$1 million above what they would earn based on their improvement.

Step 6: In the geopolitical zone of the "national champion", the second (or third in the case of the North East and North West) most improved State would receive US$500,000 above what they would earn based on their improvement but only if their "score" is positive).

B. DLI 1.3 –STRENGTHENING MNCH WEEKS AS PART OF AN IMPACT EVALUATION:

Results	Increased utilization of MNCH weeks
Level of Government	10 Randomly Selected States
Means of Verification	SMART Household Surveys
Data collection agent	NBS with support from UNICEF
Verifying Agent	IVA
If not achieved Years 0-3?	Funds remain available based on subsequent improvements in MNCH week coverage. If funds left over after IE completed, then reallocate to DLI 1 if needed.
If over-achieved Year 0-4?	Disburse to States until US$16M expended.

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)	2	7	7			16

Calculation of Amount to be Disbursed:

Year 0:

Step 1: Identify the 20 poorest performing States in terms of Vitamin A and Penta3 immunization coverage (just the sum of those 2 indicators) according to SMART survey 2014.

Step 2: Disburse US$100,000 to those 20 States after they indicate in writing their willingness to participate in the impact evaluation. They will not know which arm of the study they are in until after agreeing to participate in impact evaluation.

Years 1-2:

Step 1: For 10 randomly selected States, calculate change in MNCH week participation rates in percentage points (up to one decimal point) from SMART survey from year 1 by State.

Step 2: Multiply change by US$80,000 and disburse that amount to State.

C. DLI 2- INCREASE OF QUALITY OF HIGH IMPACT REPRODUCTIVE, CHILD HEALTH AND NUTRITION INTERVENTIONS:

Result	Improved quality of care in PHC facilities
Level of Government	Individual States
Means of Verification	Health facility survey - annually
Data collection agent	NBS or NPopC with technical support
Verifying Agent	IVA
If not achieved Years 1-4?	Funds remain available based on improvement in quality of care index
If over-achieved Year 1-4?	If above the targets in the results framework (nationally) then re-allocate funds from other DLIs which were not achieved above those needed to pay for DLI 1.

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)			18	18	18	54

Calculation of Amount to be Disbursed:

Year 2-4:

Step 1: Calculate quality of care index for each sampled health facility in a State in year 1 according to an agreed formula. For example:

Table 10: Example of Quality of Care Index in a Health Facility in State XX – Year 1

Criterion	Definition	Result Year 1	Weight	Score
(i) the diagnostic accuracy and adherence to guidelines by health facility staff;	Score of health worker(s) in diagnosing and managing pneumonia case (according to a vignette)	35%	3	10.5
(ii) availability of drugs and minimum equipment;	% of 25 essential drugs available in stock in the HF	45%	2	9.0
(iii) readiness of facilities to deliver key SOML interventions;	Score out of 100 on availability of SOML services in HF (is able to deliver PMTCT, immunization, skilled birth attendance, and Vitamin A)	50%	1	5.0
(iv) frequency and quality of the supervision provided to the facilities;	Score out of 100 on the quality and frequency of supervision	25%	2	5.0
(v) quality of financial management and reporting; and	Score of HF on properly recording incoming revenues and expenditures using approved template.	20%	2	4.0
			TOTAL	33.5%

Step 2: Take the average of the individual health facility scores across the particular State to calculate the score for the State for year 1 (baseline).

Step 3: Subtract the quality index in that year from the baseline (year 1) quality index multiply the change (to one decimal point) by US$25,000 and disburse that amount to the State.

D. DLI 3.1- IMPROVING M&E SYSTEMS FOR SOML:

Result	Annual implementation of SMART household survey and health facility survey.
Level of Government	Federal Government
Means of Verification	Review of final reports of SMART, health facility surveys, and census
Verifying Agent	IVA
If not achieved Years 1-4?	Funds will be available for re-allocation to DLI 1, can't make up for lost time, except if census is not carried out in 2016
If over-achieved Year 1-4?	Not possible.

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement (US$M)	7	7	7	7	7	35

Calculation of Amount to be Disbursed:

Year 0:

Disburse US$7 million to FGON based on publication in June 2014 of SMART survey that covers all 36+1 States.

Year 1:

Step 1: Disburse US$3million to FGON if health facility survey is conducted and report produced that: (i) uses harmonized instrument that combines SDI and SARA approaches; (ii) data is collected on tablets; (iii) data collection agency has full time survey manager; and (iv) technical assistance is in place.

Step 2: Disburse US$2 million to FGON if SMART household survey is conducted and report produced if the survey uses: (i) same sampling methodology; (ii) same questionnaire; (iii) same quality assurance mechanisms including use of tablets; and (iv) technical assistance from outside data collection agency is in place.

Step 3: Disburse US$2 million to FGON if 2016 census collects data on maternal mortality. If the 2016 census is not conducted, then an acceptable alternative is for a National Demographic and Health Survey to be carried out either in 2016 or 2017.

Years 2 - 4:

Step 1: Disburse US$3.5million to FGON if health facility survey is conducted and report produced that: (i) uses harmonized instrument that combines SDI and SARA approaches; (ii) data is collected on tablets; (iii) data collection agency has full time survey manager; and (iv) technical assistance is in place.

Step 2: Disburse US$3.5 million to FGON if SMART household survey is conducted and report produced if the survey uses: (i) same sampling methodology; (ii) same questionnaire; (iii) same quality assurance mechanisms including use of tablets; and (iv) technical assistance from outside data collection agency is in place.

E. DLI 3.2 – STRENGTHENING DATA UTILIZATION:

Result	Publication of household and health facility survey results and introduction of a performance management system.
Level of Government	Federal Government
Means of Verification	Review of final reports of SMART and health facility surveys
Verifying Agent	IVA
If not achieved Years 0-4?	Funds will be made available for re-allocation to other DLIs – cannot make up for lost time
If over-achieved Year 0-4?	Not possible

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year4**	**Total**

3.2 -(a) Data publication-Federal	US$2.0	US$2.0	US$2.0	US$2.0	US$2.0	US$10.0
3.2-(b) Data utilization TA - Federal	US$1.0	US$3.0	US$4.0	US$4.2	US$4.6	US$16.8

Calculation of Amount to be Disbursed:

Year 0-4:

Step 1: Disburse US$2 million to FGON with 6 months of effectiveness and every year thereafter if the most recent SMART survey results, by State, is both: (i) published on line and readily accessible by a Google-based search; and (ii) published in a newspaper of nationwide circulation. The IVA will verify that both conditions are met.

Step 2: Disburse US$100,000 per year for each State where, through technical assistance provided by the Program Support Unit (as witnessed by their significant presence in the State), health managers demonstrate increasing capacity to: (a) analyze PHC performance data coming from various sources; and (b) develop high quality action plans based on the analysis of their results. Both aspects would be assessed by the IVA.

Step 3: Disburse US$250,000 for each vertical Program (NPHCDA, NMEP, NASCP, Department of Family Health) that demonstrates increasing capacity to: (a) analyze the performance of their Program based on data coming from various sources (e.g. SMART, health facility surveys; etc.; and (b) develop high quality action plans based on the analysis of their results. This would be judged by the IVA.

F. DLI 3.3 Implementing Performance Management in all States

Result	States have put in place a performance management system that helps them improve the quantity and quality of services delivered.
Level of Government	States
Means of Verification	Visits to States and review of their analyses and plans
Verifying Agent	IVA
If not achieved Years 0-4?	Funds remain available for disbursement against this DLI until actions are achieved but will be reallocated at MTR
If over-achieved Year 0-4?	Not Possible

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement (US$M)	1.6	2.4	3.2	4.8	5.9	17.9

Calculation of Amount to be Disbursed:

Year 0-4

Step 1: States received US$40,000 per year for each of the following 4 things that they have in place; (i) State has a performance management "Lead" with commensurate capacity who is clearly accountable for the performance management process; (ii) is able to provide evidence of continuous analysis of the available data on PHC performance, including availability of financial resources; (iii) has developed and updated appropriate action plans; and (iv) at least quarterly, conducts high level review meetings to discuss analysis and agree upon action plans with at least one of the three following officials present: Commissioner for Health, Permanent Secretary or Executive Director SPHCDA. Accomplishment of these four aspects of performance management will be assessed by the IVA.

G. DLI 4 – ESTABLISHMENT AND OPERATION OF THE INNOVATION FUND DESIGNED TO SUPPORT PRIVATE SECTOR INNOVATIONS AIMED AT INCREASING UTILIZATION AND QUALITY OF MATERNAL AND CHILD HEALTH INTERVENTIONS

Result	Innovations by private sector are implemented and evaluated and scaled up if successful
Level of Government	Private sector "grantees" through Innovation Fund Manager
Means of Verification	Visits to grantees and review of documents & Innovation Fund Manager's external auditor's report
Verifying Agent	Innovation Fund Review Committee (PMU, FMOF, and World Bank)
If not achieved Years 0-4?	Funds remain available for disbursement against this DLI until actions are achieved but will be reallocated if contract with Innovation Fund Manager is terminated
If over-achieved Year 0-4?	Funds could be disbursed earlier if actions are accomplished ahead of time but total amount cannot be exceeded.

	Year 0	Year 1	Year 2	Year 3	Year 4	Total
Estimated Disbursement (US$M)	2	4.5	4.5	4.5	4.5	20

Calculation of Amount to be Disbursed:

Year 0:

Step 1: Disburse US$2 million to the FGON upon signing of a contact between the Innovation Fund Manager and FMOH acceptable to the Bank and in keeping with the TORs in Annex 1. The contract will need to specify: (i) how proposals will be judged (process); (ii) the explicit criteria for selection of proposals; (iii) mechanisms for tracking implementation and fiduciary controls over the use of the grants; (iv) means for evaluating the success of the large grants; (v) the maximum amount of financing per grant; and (vi) the availability to the FMOH of the results of the Innovation Fund Manager's external audit.

Year 1 - 4:

Step 1: The IVA reviews the performance of Innovation Fund Manager based on discussions with grantees, review of grant database, Innovation Fund Manager's external auditor's report, and other documents. Performance of the Innovation Fund Manager will be based on: (i) proper selection of proposals following agreed criteria and processes; (ii) effective management of grants and termination of grants that are not implementing their innovation or otherwise not complying with the grant agreement; (iii) provision of support to grantees; (iv) rigorous monitoring and evaluation of grants; (v) satisfaction of grantees as assessed by interviews with a sample; (vi) proper documentation of the process and lessons learned; and (vii) financial probity as reflected in the Innovation Fund Manager's external audit report.

Step 2: If the IVA review is positive and accepted by the Steering Committee disburse US$4.5 million to the FGON.

H. DLI 5.1 – INCREASING TRANSPARENCY IN MANAGEMENT AND BUDGETING FOR PHC AT STATE LEVEL:

Results	State entities responsible for PHC have greater management control over human and financial resources
Level of Government	Individual States
Means of Verification	Location of personnel files, published consolidated PHC budget expenditure reports
Verifying Agent	IVA
If not achieved Years 0-4?	Funds remain available for accomplishment until the end of the Program
If over-achieved Year 0-4?	Not possible

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)	2	6.7	8.4	10.1	13.7	41

Calculation of Amount to be Disbursed:

Year 0 -4:

Step 1: Determine which States have shifted the personnel files of front line health workers to appropriate State level health entity (e.g. SPHCDA). IVA will verify.

Step 2: Disburse a one-off payment of US$500,000 to those States once the files have been shifted.

Step 3: Disburse US$300,000 to a State if it is able to generate an annual consolidated PHC budget execution report and publish it on the State Government's website. The reports will have to describe the sources and uses funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures.

I. DLI 5.2 – INCREASING TRANSPARENCY IN MANAGEMENT AND BUDGETING FOR PHC AT FEDERAL LEVEL:

Result	Production and publication of budget expenditure report on PHC
Level of Government	FGON
Means of Verification	Published consolidated PHC budget expenditure reports available on FMOH website
Verifying Agent	IVA
If not achieved Years 0-4?	Funds remain available for accomplishment until the end of the Program
If over-achieved Year 0-4?	Not possible

	Year 0	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Total**
Estimated Disbursement (US$M)		2	2	2	2	8

Step 1: Disburse US$2 million to the FGON if it is able to generate a consolidated PHC budget execution report and publish it on the FMOH's website. The reports will have to describe the sources and uses funds according to the following three classification levels: (a) compensation of employees – salaries, allowances; (b) Goods and services – drugs and medical commodities, operational expenses; and (c) investments – capital expenditures.

Annex 4: (Summary) Technical Assessment

1. **This Technical Assessment is broken down into the following sections**: (i) Strategic Relevance of SOML: (ii) Technical Soundness of the Program; (iii) Institutional Arrangements; (iv) Monitoring and Evaluation; (v) the Economic Evaluation; (vi) Assessment of Specific DLIs. The expenditure framework is discussed in Annex 1.

2. **Overview of Strategic Relevance.** SOML addresses the major health issues facing Nigeria where progress over the last two decades has been slow. Nigeria's ability to address the health MDGs is of global importance because it contributes disproportionately to global under-five and maternal mortality. SOML's relevance for Nigeria lies in the fact that it addresses almost 70 percent of the entire burden of disease. There is a strong rationale for Government intervention in those areas covered by SOML and this is discussed in detail in the economic evaluation section. The latter section also addresses the economic impact of SOML which would be expected to be large and positive.

3. **Overview of Technical Soundness.** SOML emphasizes a series of maternal and child health and nutrition interventions that are highly cost effective (see Economic Evaluation). These interventions also turn out to have very strong evidence of effectiveness based on multiple randomized trials. SOML takes as its point of departure the limited progress that Nigeria has made on delivering these services to broad swaths of the population and rightly emphasizes the importance of both increasing coverage and improving the quality of care. The latter has not garnered much attention previously but is clearly a serious issue. The technical soundness of the SOML approach, which emphasizes a focus on results, strengthening accountability, and encouraging innovation, can be discerned from those recent initiatives in Nigeria which have achieved good results.

4. **Overview of Institutional Arrangements.** There is broad support for SOML both inside and outside Government. A PEIA was undertaken which has pointed out the complex institutional relationships particularly at State level and below. Consolidating State-level authority for PHC in one entity ("PHC under one roof") is a necessary but not sufficient condition for success. The experience in UBEC (basic education) is likely not one worthwhile replicating. Tracking budgetary flows is challenging but some progress should be possible towards having consolidated budgets.

5. **Overview of Monitoring and Evaluation.** Up until recently the health system in Nigeria suffered from a dearth of reliable and timely information. This was particularly true when it came to data that was sufficiently disaggregated to provide management information at State level. Thus, SOML's focus on improving data availability and quality is entirely appropriate. The recent progress on expanding SMART surveys and introducing health facility surveys reflects the Government's willingness to improve the M&E systems for SOML. While the routine health information system has been getting considerable attention it faces some challenges that make it inappropriate to use for evaluating progress on DLIs 1and 3. Collecting robust and useful information on DLIs 1 and 3 will require the use of annual SMART surveys and annual health facility surveys with appropriate care given to quality assurance.

6. **Overview of Economic Evaluation.** Health care financing in Nigeria is mostly out-of-pocket and only a modest increase in public expenditures in health is expected over the next few years. There is a strong rationale for public investment in SOML arising from: (i) the public goods nature of many of the interventions prioritized under SOML: (ii) the allocative and technical efficiency of the SOML interventions, including their cost-effectiveness; (iii) the equity enhancing nature of SOML; and (iv) the insurance market failures that SOML will help address. The economic impact of SOML is expected to be substantial and will arise from the direct micro effects of improved maternal and child health which will enhance human capital formation. It will also be aided by hastening the demographic dividend Nigeria could enjoy if it goes through a rapid fertility transition. The financial sustainability of SOML, if it is successful, is not a serious concern because its incremental cost is only US$0.71 per capita per year. The Government could easily use some of its existing budget allocations in a more results-based way.

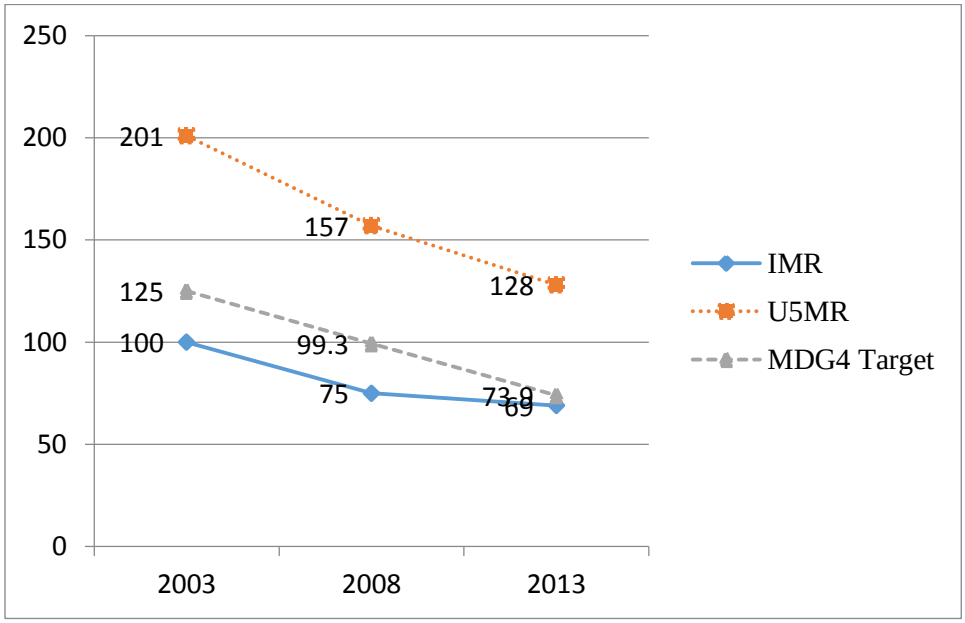
7. **Experience with Results-Based Incentives to sub-National Governments and Innovation Funds.** DLIs 1 and 2 involve financial incentives to States based on their performance. The experience in Nigeria and globally is that such incentives can be successful if a few conditions are met; (i) the criteria for releasing the disbursements are clear and objective; (ii) they are within the span of control of the Government; (iii) achievements are measured fairly and transparently; (iv) sub-national Governments can use the funds flexibly and have sufficient autonomy. The proposed disbursements under the PforR meet these criteria. Similarly the experience with learning and innovation funds emphasizes the importance of: (i) clear selection criteria; (ii) transparent and fair selection process; (iii) proper grant management; and (iv) designing evaluation and learning right from the start. The innovation and learning funds proposed under DLI 4 takes these lessons into account.

I. Strategic Relevance of SOML

8. **Improvement in U5MR and IMR.** Over the last decade the trend in health, nutrition, and population (HNP) outcomes in Nigeria is mixed. Data from the last three Nigeria Demographic and Health Surveys (NDHSs)[10] demonstrates a 36 percent decline during this period in the under-five mortality rate (U5MR) and a 31 percent decline in the infant mortality rate (see Figure 1). While the country is still not on track to achieve MDG4, these improvements are considerable. Given the slow progress on service delivery (see below) it is an interesting question why Nigeria has made progress on U5MR and IMR. It is possible that the decrease is due to increased access to anti-malarial drugs and antibiotics that has come about due to the expansion of the private sector even into remote rural areas. Increases in ITN coverage may also play an important role.

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

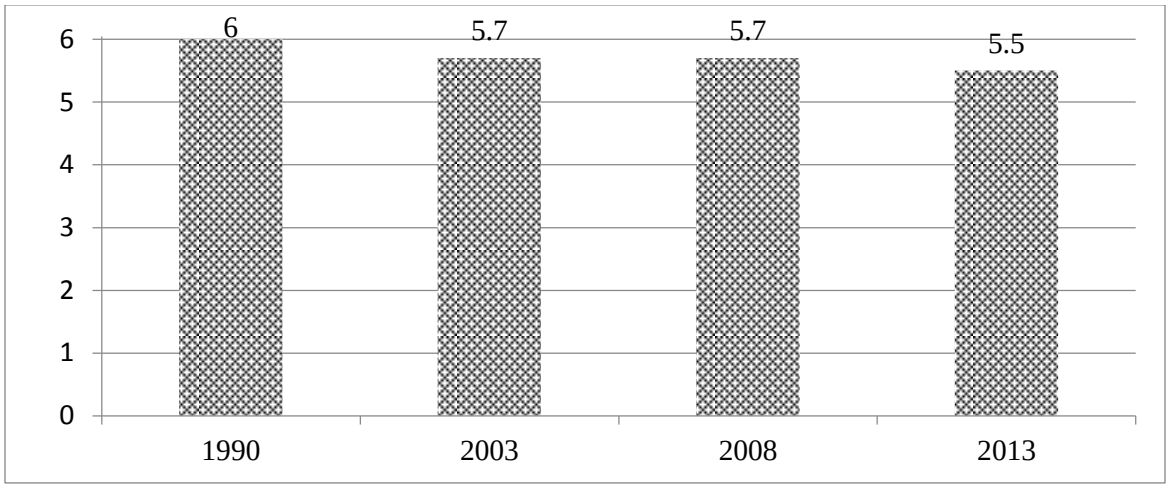
Figure 6: Trends in U5MR and IMR (per 1000 live births)



Source: NDHS.

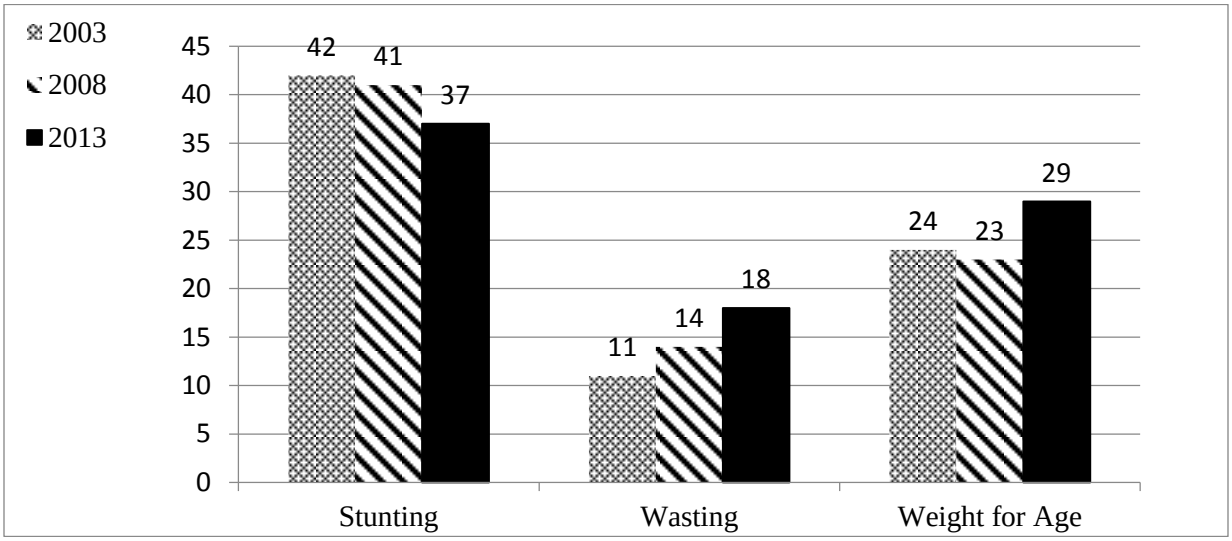
9. **There Has Been Little Improvement in Other Health Outcomes.** There has been almost no progress on reducing maternal mortality (MDG5) which has plateaued at about 550 per 100,000 live births according to the NDHS. Fertility remains stubbornly high and has changed less than 10 percent in the last 25 years (see figure 7). Childhood malnutrition, during the last decade (see figure 8), has actually worsened by some measures (low weight for age has increased by 21 percent and wasting has increased 64 percent) and improved only modestly (12 percent) in terms of stunting (low height for age).

Figure 7: Total Fertility Rate 1990 to 2013



Source: NDHS.

Figure 8: Nutritional Status of Children Under Five (%) 2003-2013



Source: NDHS.

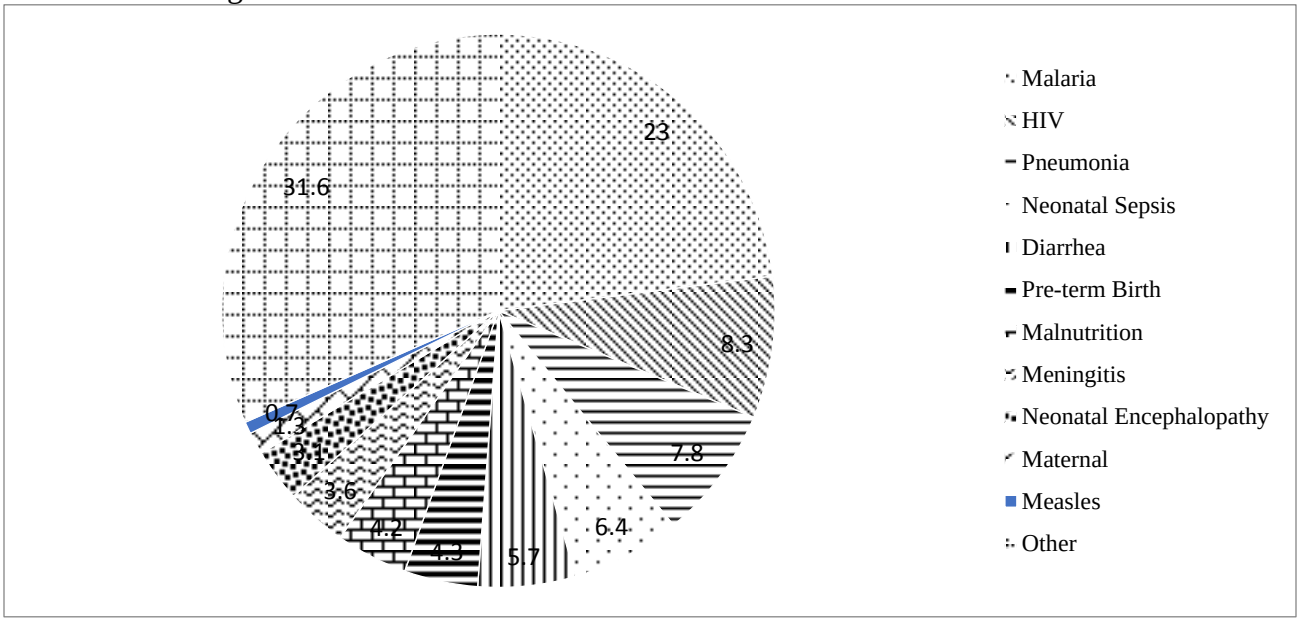
10. **Nigeria Contributes Substantially to Global Under-Five and Maternal Mortality.** Nigeria's ability to address under-five and maternal mortality will affect global progress towards MDGs 4 and 5. Nigeria contributes 14 percent of all maternal deaths globally, second only to India at 17 percent.[11] Similarly, Nigeria accounts for 13 percent of all under-five deaths globally, again second only to India at 21 percent.[12]

11. **SOML Addresses the Largest Part of the Burden of Disease and the most Lives Lost.** The burden of disease (BOD) in Nigeria remains primarily due to infectious diseases although there is some evidence that the country is slowly going through an epidemiological transition. Through its focus on improving maternal and child health, SOML addresses the most common causes of premature death in Nigeria. Its six pillars target infectious diseases, maternal and neonatal complications and nutrition deficiencies that together account for nearly 70 percent of total years of life lost (YLL) according to a recent study. This may overstate the case a little as the children only represent a portion of the BOD due to HIV. Nonetheless, SOML targets 9 of the top 10 causes of premature loss of life in Nigeria (see Figure 9).

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

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

Figure 9: Burden of Disease – Years of Life Lost as % of the Total



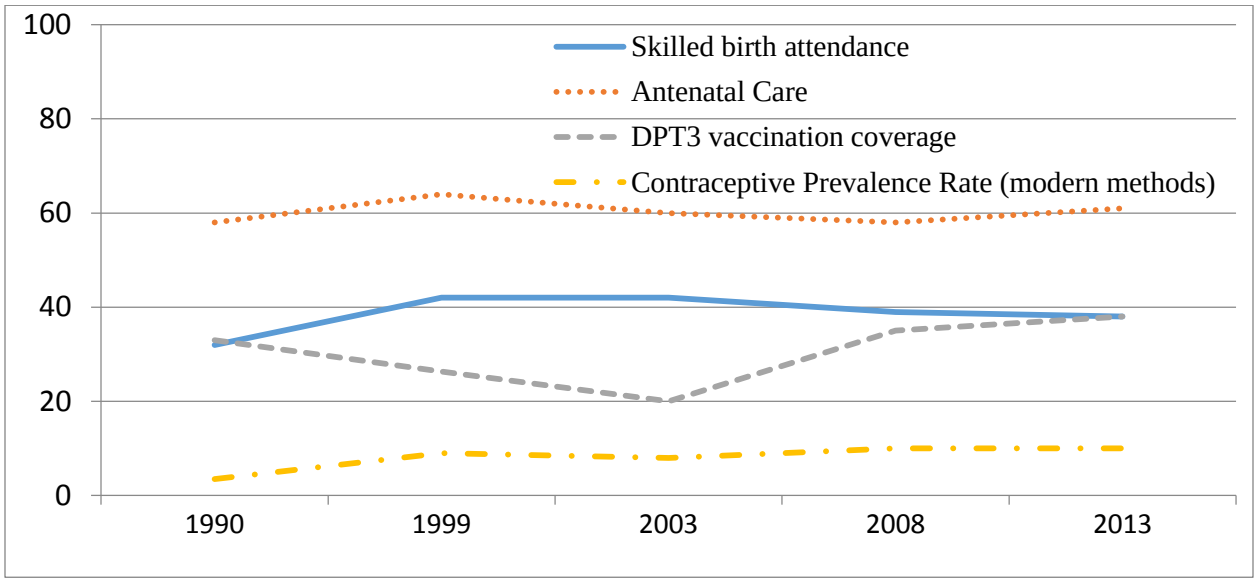
*Sourc*e: Institute for Health Metrics and Evaluation – Global Burden of Disease Study – 2010.

II. Technical Soundness of SOML

12. **Limited Progress on Health Service Delivery.** The limited progress on HNP outcomes observed in Nigeria is consistent with the picture in service delivery (see Figure 10). Over the last two decades the coverage of key health interventions has stagnated at low levels. The lack of progress on services such as family planning, antenatal care, and skilled birth attendance militates against achieving MDG5 and makes it hard to argue that Nigeria has made much progress on reducing MMR.

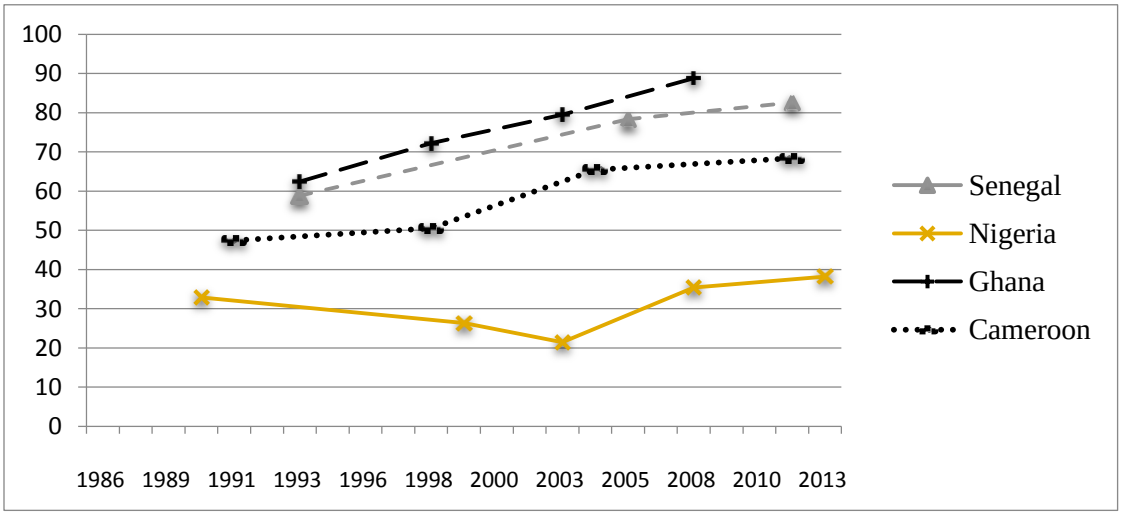
13. **Nigeria is Doing Less Well than its Neighbors.** Progress on service delivery in Nigeria generally has been slower than in some of its larger neighboring countries. For example, in looking at immunization coverage as estimated by Demographic and Health Surveys it appears that Nigeria has significantly poorer results than countries like Senegal, Ghana, and Cameroon. It has also made slower progress over the last 25 years even though it started at a lower base (see figure 11).

Figure 10: Coverage (%) of Key Health Services 1990-2013



Source: NDHS.

Figure 11: Trends in Immunization (DPT3) Coverage (%) in Selected West African Countries



Source: Demographic and Health Surveys.

14. **Quality of Care is Low.** The limited coverage of important interventions is further aggravated by poor quality of care. Results from the Bank-supported Service Delivery Indicators (SDI) Survey indicate that many health workers perform poorly on standardized tests of knowledge and lack the skills to effectively treat common and important ailments in children or mothers (see Figure 12). Of particular concern is that the cadre of health workers who provide primary health care in public health centers have limited knowledge of how to handle common diseases such as malaria, pneumonia, and diarrhea. SDI results indicate that Nigeria does a little

better than Senegal but less well than other large countries in Sub-Saharan Africa in terms of the knowledge and skills of its health workers (see Table 11).

Figure 12: Knowledge and Skills of Health Workers – SDI Survey 2013

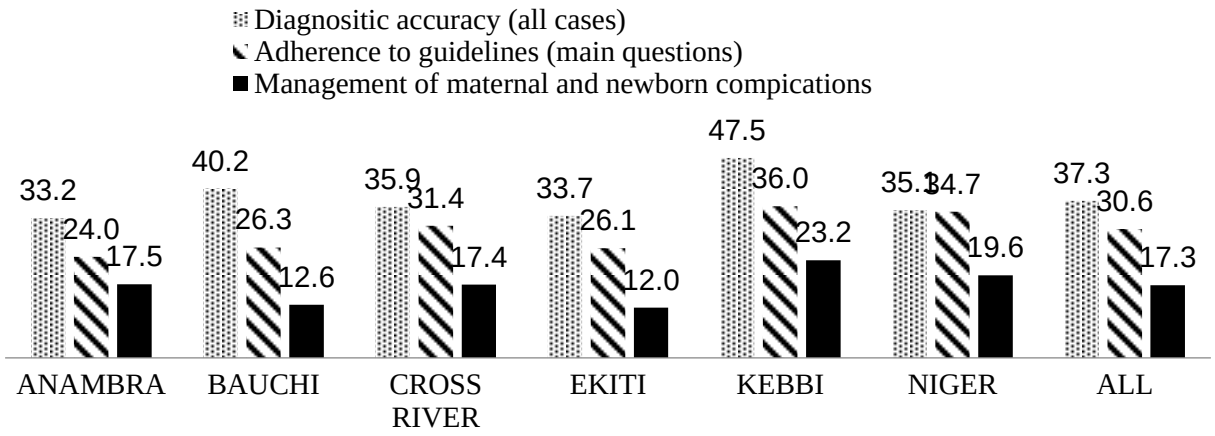


Table 11: Knowledge & Skills of Health Workers Compared to Other Countries in Africa

	Kenya	**Nigeria**	**Senegal**	**Tanzania**	**Uganda**
Diagnostic accuracy	**74%**	**36%**	**34%**	**57%**	**58%**
Adherence to clinical guidelines	**43%**	**31%**	**22%**	**35%**	**35%**
Correct manage maternal and neonatal complications	**44%**	**17%**	**--**	**--**	**20%**

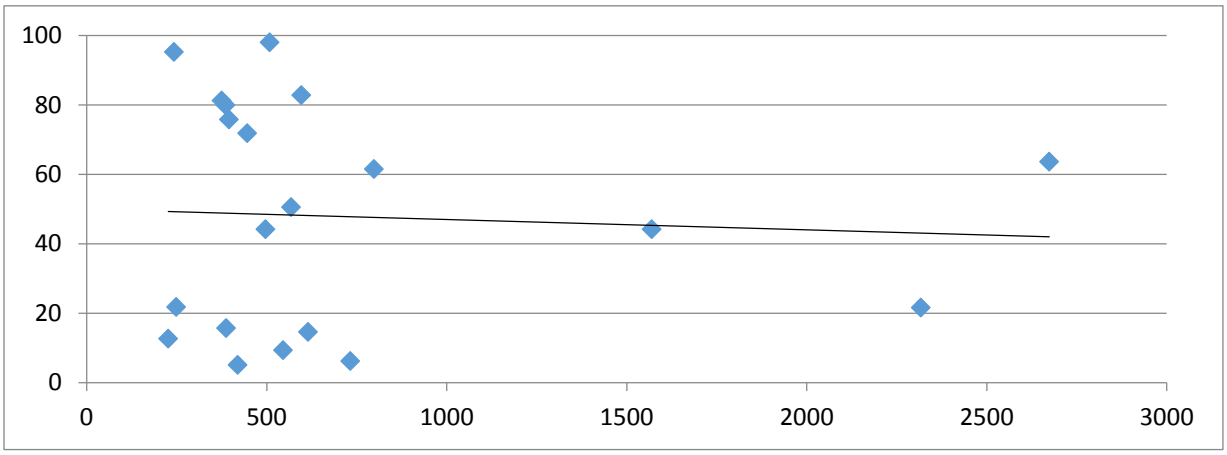
Source: Service Delivery Indicators (SDI) Survey 2013.

15. **What Things Have Seemed To Work And Why.** While the rate of progress of PHC services in Nigeria has been slow, the situation is by no means bleak. Some recent experiences in Nigeria suggest means of improving health system performance. It is also important to understand what does NOT explain the slow progress.

16. **Input-Related Problems Explain Little of the Problem.** Issues that are important in other parts of Africa do not seem to explain the slow progress of the health sector in Nigeria: (i) lack of funding: while public expenditure on health is low compared to GDP and total budget, funding alone does not appear to have much influence on service delivery. There is no correlation between State level expenditures in health and health outputs such as skilled birth attendance (see figure 13); (ii) lack of inputs such as drugs: while there is clearly a shortage of medicines in primary health centers, the SDI survey also found no correlation between drug availability and patient volume; (iii) lack of infrastructure: 67 percent of the population live within 30 minutes' walk of a health facility, 85 percent live within 1 hours walk (LSMS 2010/11). This compares favorably to neighboring countries; (iv) shortage of health workers: the ratio of health worker to population is substantially higher than neighboring countries (it is twice the sub-Sahara African average) and many health facilities are actually over-staffed.

17. **Recent Experience with PBF Gives Some Hints about what Might Work.** Performance-based financing (PBF) was introduced in three pilot LGAs three years ago as part of the Bank-funded Nigeria State Health Investment Project (NSHIP). Under PBF, individual health facilities (both public and private) are provided cash payments (through electronic transfer to their bank accounts) based on the quantity and quality of key maternal and child health services they provide. The facilities have considerable autonomy in how they use the cash including for physical upgrading, buying drugs, and providing monetary incentives to staff.

Figure 13: Real per Capita Health Expenditure (Naira) and Skilled Birth Attendance (%)



Source: World Bank Analysis from State PEMFAR/PER/PEFA Reports and NDHS 2008.

18. **Example of How PBF Works.** In the example described in table 12, if a health facility fully immunizes 50 children in a quarter, they could earn US$100 (100 x US$2 per child fully vaccinated). In PHC facilities under NSHIP there are in fact 20 specific services that are incentivized. The total amount 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 because of the difficulties it faces. The total would also be adjusted by a quality score based on a checklist administered at the facility every quarter. This facility would earn 50 percent times 25 percent of its quantity payment. Facilities can use the funds for: (i) health facility operational costs (about 50 percent), including maintenance and repair, drugs and consumables, outreach and other quality-enhancement measures; and (ii) performance bonus for health workers (up to a maximum of 50 percent) according to defined criteria.

Table 12: Example of How PBF Works at Health Facility Level Under NSHIP

Service	**Number Provided Last Quarter**	**Unit Price**	**Total Earned**
Child fully vaccinated	50	US$2	US$100
Skilled birth attendance	60	US$10	US$600
Curative care patient visit	1,800	US$0.5	US$900
Sub-Total			US$1,600
Remoteness (Equity) Bonus	+25%		US$2,000
Quality bonus	Score (50%) x 25% of volume		US$200
		Total	US$2,200
Use of Funds			
Drugs and consumables			US$500
Outreach expenditures			US$250
Repairs & maintenance of health facility			US$150
Bonuses to staff in the facility			US$1,100
Savings			US$200

19. **Initial Evaluation of PBF.** A recent household survey comparing the three PBF LGAs with nearby control LGAs that did not implement PBF found some important results. After controlling for socio-economic variables, contraceptive prevalence, antenatal care, and utilization were significantly higher in the PBF LGAs (see Figure 14). Routinely collected data also suggests large improvements in service delivery in PBF facilities (see Figure 15). 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 given the available fiscal space. PBF has now been scaled up to 27 LGAs.

Figure 14: Household Survey Results Comparing PBF Pre-Pilot LGAs with Control LGAs

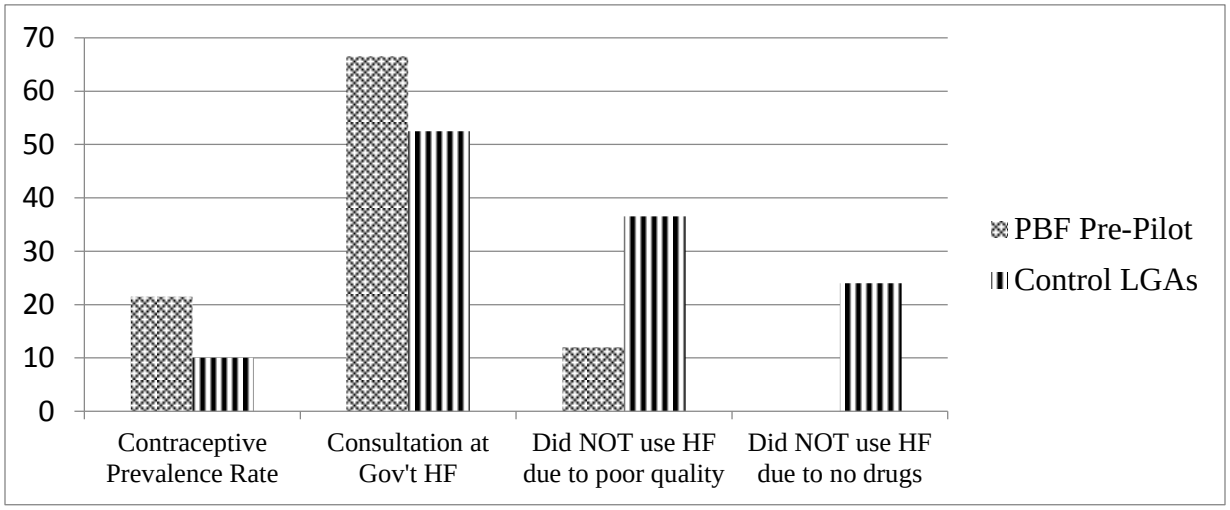
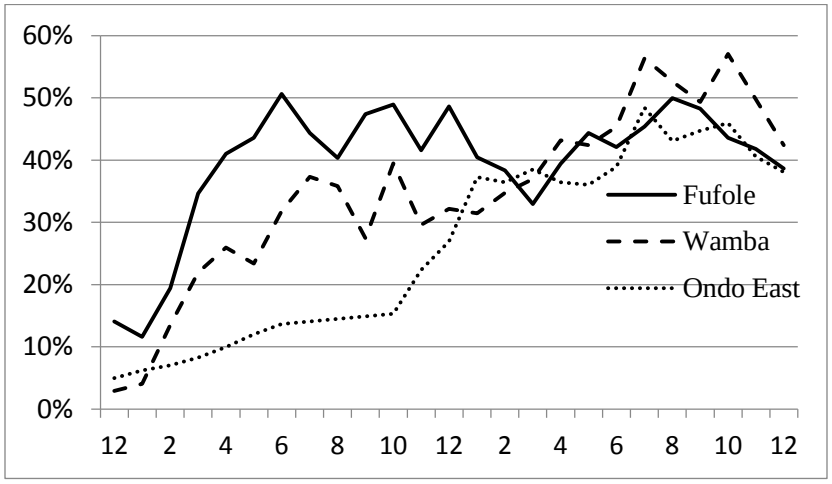


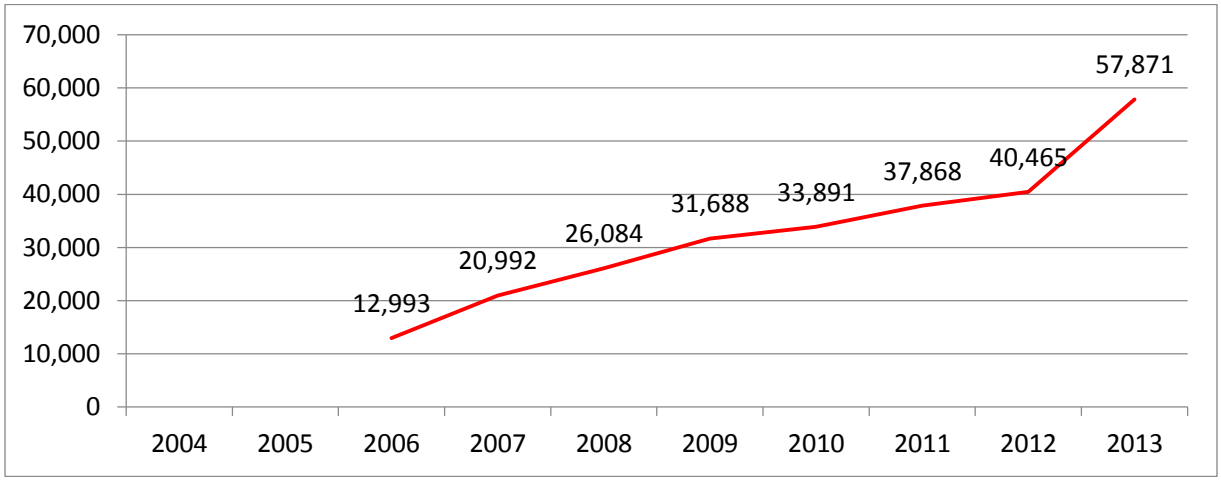
Figure 15: Coverage of Institutional Delivery in PBF Pilot LGAs since Dec. 2011



20. **Factors for Success and Lessons Learned.** The success of PBF thus far appears to be due to a number of factors, including: (i) it provides a clear signal to health staff about what is important; (ii) it rewards staff for their efforts; (iii) it provides legitimate operating funds at health facility level, something they have rarely, if ever, had before; (iv) it gives health staff, particularly the officer in charge, substantial autonomy and this gives them the opportunity to innovate; and (v) it has substantially strengthened supervision. PBF has also faced a few challenges that are instructive, including: (i) delays in payment have a very deleterious effect on performance; (ii) the quality of management at facility level appears to be a constraint that needs to be addressed; and (iii) the system is dependent on robust assessment of performance that is independent.

21. **EMTCT has Made Significant Progress.** Another seeming success Nigeria has enjoyed is in HIV where prevalence and the estimated number of new infections has been declining. Of note has been the increase in the number of HIV positive mothers who have been benefiting from anti-retroviral therapy to prevent mother to child transmission (see figure 16). The improvements have been faster than in other areas of mother and child health and may be due to: (i) the use of non-governmental "implementing partners" by PEPFAR, the Global Fund and support of NGOs under the Bank-financed HIV project; (ii) the fact that implementing partners have worked with public sector facilities to improve performance; and (iii) that State AIDS control agencies (SACAs) appear to have been strengthened.

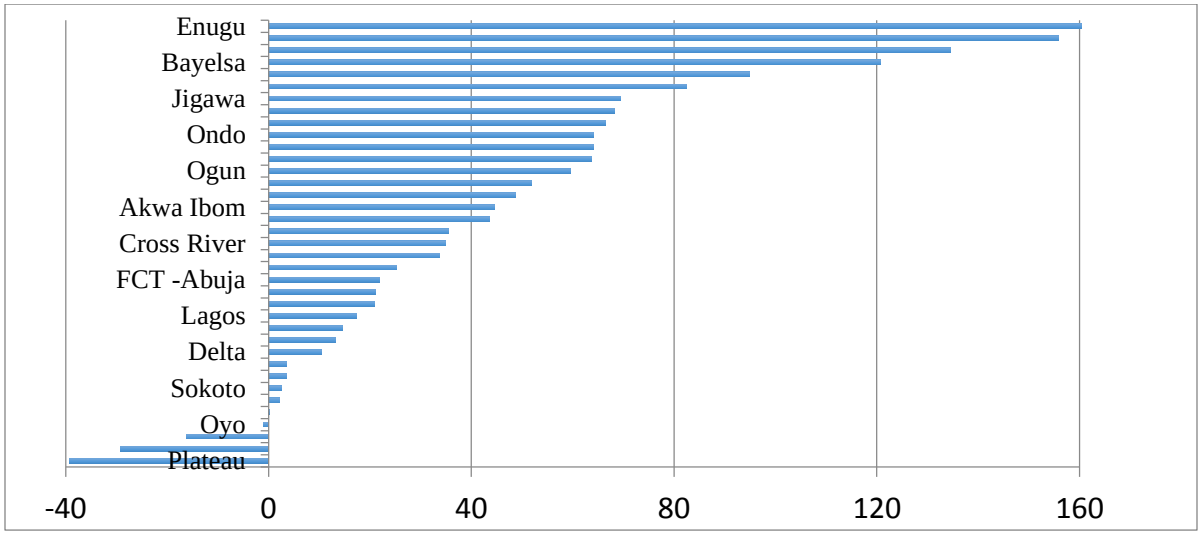
Figure 16: Number of HIV + Women Receiving ART for EMTCT



Source: UNAIDS 2014.

22. **Some States have Performed Very Well.** There are wide variations in the performance of States over the last few years. An analysis of changes in 8 different MCH services from 2008 to 2013, based on the NDHS indicates that there is a very large variation in the extent to which performance has improved (see figure 17). Importantly, baseline level of performance does NOT appear to be a predictor of success. Also the most improved States come from all over the country and are NOT concentrated in any particular geopolitical zone. For example, Enugu has not suffered from security challenges but two other high performing States, Adamawa and Bayelsa, have been affected by conflict. An ongoing analysis is examining predictors of success but the wide variation in performance itself suggests that State governments can influence key PHC service delivery even in the current context.

Figure 17: Change in 8 Maternal and Child Health Indicators by State, 2008 - 2013



Source: NDHS.

III. Summary of Political Economy and Institutional Assessment

23. **There is Widespread Support for SOML.** SOML was inaugurated by the President in October 2012. There appears to be widespread support for SOML, and PHC more broadly, throughout the country. The FGON has increased its health budget substantially in the last four years and there has been a recent effort through the "Health Bill" to ring fence funds for PHC. The NHSDP also supports much of the SOML approach explicitly.

24. **Complex and Fragmented Institutional Arrangements for Delivering Public Sector Health Services.** The public service delivery system in Nigeria is characterized by overlapping and unclear institutional arrangements. [13] Although Local Governments are supposed to provide primary health care (PHC) service, Federal, State and local Government all play roles in the financing and delivery of services. PHC staff are employed by LGAs who have also been responsible for funding the operating costs of the PHC system. The weakness of LGA financial reporting and the range of additional State and Federal Programs for PHC means that it has been in general impossible to make an accurate consolidated assessment of the resources used for PHC. At the same time, because most of the spending on PHC is directed through either the Federal or local Government, State Ministries of Health have had little capacity to manage the PHC system, affect overall spending, or manage the deployment of resources across the State. Almost no financial resources are directly managed at the primary health facility level, except in some States where Drug Revolving Funds (DRFs) have been established or where user charges are collected.

25. **Federal Government Plays an Important Role in PHC.** It is estimated that the Federal Government contributes about 22 percent of all the funding for PHC. These resources are often supplied in kind, such as the provision of commodities, vaccines and specialized drugs for HIV and Tuberculosis, and technical support to the States and LGAs. In addition, the FGON has a number of special schemes to support PHC, including activities under the National Primary Healthcare Development Agency (NPHCDA) such as (i) the Midwife Service Scheme (MSS) which pays the salaries and support costs for the deployment of many thousands of midwives to under-served rural areas; (ii) the Subsidy Reinvestment and Empowerment Program (SURE-P) which provides support, inter-alia, for infrastructure, development of human resources, and a conditional cash transfer Program; and (iii) the MDG Fund which supports the construction of additional health facilities among other things and relies partly on counterpart funds from the States.

26. **Efforts are Underway to Simplify the System.** The FGON, through the NPHCDA, has been promoting the establishment of State Primary Healthcare Development Agencies (SPHCDAs) as a way of consolidating the management of the PHC system at the State level. Twenty-four out of 36 States have established SPHCDAs, but the extent to which PHC system staffing and finance have been consolidated under the SPHCDA varies greatly between States.

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

27. **Accountability Mechanisms are Weak.** It is not surprising given the complex institutional set up that accountability mechanisms are weak. Because funding and other resources come from diverse sources, and fund provision is unpredictable and often unrelated to budgets, managers in the PHC system are not held accountable for results. Except where functions have been consolidated under the SPHCDA there is no central point of accountability for the State PHC system as a whole.

28. **Incentive and accountability reforms in NSHIP States.** Compared to 2011 study, review of experience in the NSHIP States, found that both the process of transferring management of the PHC system to the SPHCDAs and the PBF pilot had contributed to at least a potential strengthening in the accountability relationships through the system. PBF has created an accountability link from the PHC facility to facility users, strengthened the relationship with the community (through the ward committee) which may have some accountability benefits, as well as encouraging stronger supervision from LG PHC Departments.

29. **Strengthening SPHCDAs may be a Necessary but not Sufficient Condition for Success.** It appears plausible that transfer and consolidation of PHC services under SPHCDA is likely to be a necessary, but not sufficient, condition for achieving significant system improvement. The suggestions that emerge include:

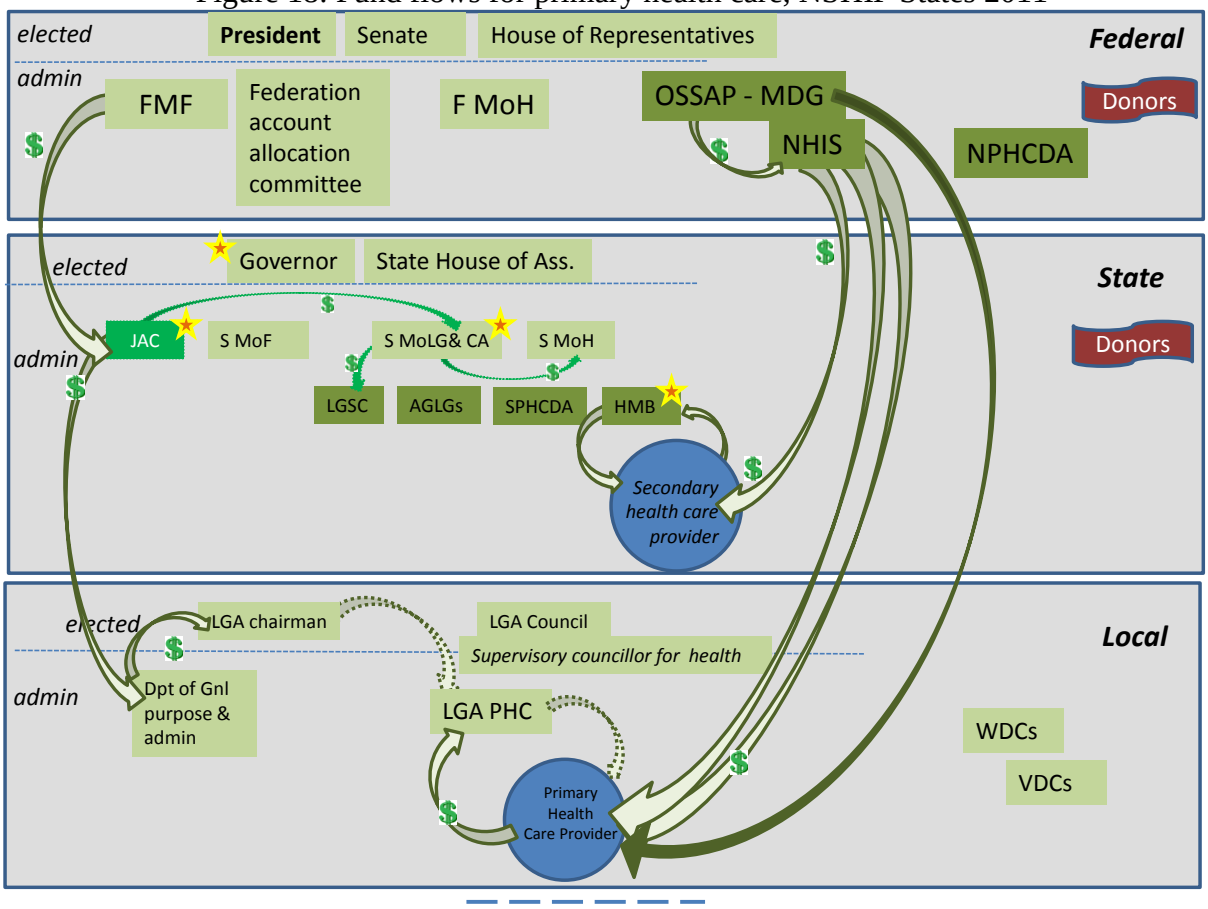
(i) Potential actions to be supported through DLIs should focus on ensuring the effective functioning of key management systems, and could potentially include: (i) the completion of the transfer of management and budgeting of PHC services to the SPHCDA; (ii) the implementation of agreed supervision plans; (iii) the collection and use of monitoring information; and (iv) the execution of agreed budgets, focusing in particular on the provision of non-staff operational funding.

(ii) Selection of performance rewards (monetary and non-monetary) and pilot accountability mechanisms at different levels of the health system: Additional individual monetary rewards beyond a nominal level should be restricted to staff at the facility level under PBF arrangements. Non-financial incentives in terms of recognition, and the provision of resources to improve service provision, should be the principal rewards at higher levels of the system.

(iii) Approaches to design of the Innovation Fund: Important to draw a distinction between the use of a prize fund approach in order to encourage genuinely new and innovative ideas, and the provision of support to funding the roll out of established approaches (such as PBF or the completion of the transfer of functions to SPHCDAs). There is likely to be a case for supporting both types of measure but different forms of support would be required to do this.

30. **Finance for PHC – Flow of Funds and Bottlenecks From the 2011 Study.** The 2011 study identified the flow of funds for PHC in the three States, as summarized in Figure 18.

Figure 18: Fund flows for primary health care, NSHIP States 2011



Source: OPM (2011).

31. **Factors Affecting Funds Flow to Facilities.** The key bottlenecks in the flow of funds to PHC facilities were: (i) the release of funds by the FAAC to State and LG Joint Accounts, made in accordance with a fixed formula but dependent on receipts from oil sales; (ii) the release of funds by the JAC to LGAs, nominally controlled by the SMoLG, but in practice subject to direct influence from the Governor; (iii) decisions on the allocation between sectors of funds received by LGAs, made by the F&GPC but subject to direct influence from the LG Chair. Because there was no earmarking of financial transfers between levels of Government, funding for PHC ultimately depended on decisions about priorities made at LG level in response to extremely uncertain releases of funds to LGAs. The decision process at LG level was extremely opaque and lacked any systematic reporting, let alone being subject to effective accountability against budgets. Since delays in salary payment were likely to have an immediate political cost, salaries were prioritized and the burden of fluctuations in resources fell on operational and capital spending. Where there were DRFs these provided some level of resources under facility control and subject to some community accountability. Capitation payments under the NHIS-MDG Program potentially provided resources under facility control in Ondo, but in practice expenditure decisions were still made at State level through the SIC.

32. **Changes in Health Financing.** Although the process of transfer of financing and functions to SPHCDAs is ongoing with the result that a process of consolidation of PHC

financing is taking place, considerable challenges were encountered in obtaining financial data to provide any clear picture of funding trends for PHC. The problems of overall fiscal management resulting from revenue uncertainty are reflected in the fact that revenue performance varied from 128 percent of budget in 2011 to 54 percentage in 2013 in Nasarawa, and from 67 percentage of budget in 2011 to 90 percent in 2012. Only 65 percent of the budget was executed in Nasarawa in 2012, and 52 percent in 2013. Information on expenditure out-turns in Ondo was only available for two years (2010 and 2012) since 2009, where budget execution increased from 52 percent to 108 percent (although total expenditure increased), because of a sharp reduction in budgeted spending. Overall, there does not yet appear to have been progress in moving towards more realistic budgeting. However, the consolidation of all PHC spending in SPHCDAs provides some hope both that information on PHC expenditure will be more transparent and better managed to focus on priorities. In comparison to the financial flows in 2011 described earlier, the changes that are taking place in the NSHIP States are the following:

(i) The role of the SMoLG and of LGAs in decision-making on PHC spending is ending, except to the extent that an LGA may decide to put additional resources into the sector beyond the core spending managed through the SPHCDA.

(ii) Since the SPHCDA budget comes under that of the SmoH, there should now be a single consolidated State health sector budget, with management of PHC expenditure consolidated under the control of the SPHCDA. This process should greatly increase transparency, accountability and remove the lowest level bottleneck to financial flows. In addition to the changes resulting from the consolidation of PHC functions under the SPHCDA, in facilities where PBF has been implemented, an additional direct flow of funds under the control of the facility has been established.

33**. Comparison with UBEC.** A comparison may be made of the consolidation of PHC spending under the SPHCDA with the establishment of the State Universal Basic Education Boards (SUBEB) in the education sector.[1] In the education sector, the Universal Basic Education Commission (UBEC) manages the Intervention Fund, a source of Federal Government funding for basic education. Grants from this Fund are distributed annually to all States that are able match UBEC funding for the infrastructure component (on a 50-50 basis) via the SUBEB. The majority of basic education funding is transferred to the service delivery points (e.g., schools) via SUBEBs, who are responsible for managing both salary and non-salary education spending. Salaries are deducted from LGA allocations each month and these funds are transferred to SUBEBs for onward transfer to personnel, including teachers. The State Ministries of Education (SMoE).

34. **Funds for Basic Education Flow from Three Distinct Channels**: (i) direct Federal funding from the UBEC to the SUBEBs, (ii) State resources, including matching funds for the UBEC infrastructure component, and (iii) LGA budgets. UBEC funding is transferred directly to the SUBEB, which utilizes the funds without any involvement of the SMoE. Matching funds from the State to the SUBEBs (and allocations for other implementing agencies) are provided for under the SMoE capital budget. The UBEC Program has significantly expanded the role and responsibilities of the Federal Government in the funding of basic education and is a potential

[1] This discussion is based on OPM (2014).

source of tension between State Governments and UBEC. The matching fund system, the way it is structured, does provide an incentive for State Governments to increase spending on basic education, but in recent years the number of States qualifying for matching funding appears to be falling.

35. **Some States Find the Federal Government's Conditions Overly Stringent as They Substantially Reduce State Autonomy and Flexibility in Strategic Planning for the Education Sector**. In addition, States are also concerned that the parallel management system is inefficient. Importantly, UBEC funds are not tied to improved results or improved measurement of educational outcomes. It is widely believed that additional funds are reaching the States and schools, but there are differing views as to UBEC's success. UBEC was established in 2004 but, despite 10 years of experience and the expenditure of billions of dollars, no systematic Program evaluation has been carried out.

IV. Summary of M&E Assessment

36. **Household Surveys.** There are three major sources of household survey data in Nigeria that are broad in coverage and focus beyond single diseases or interventions, NDHS, SMART, and MICS.

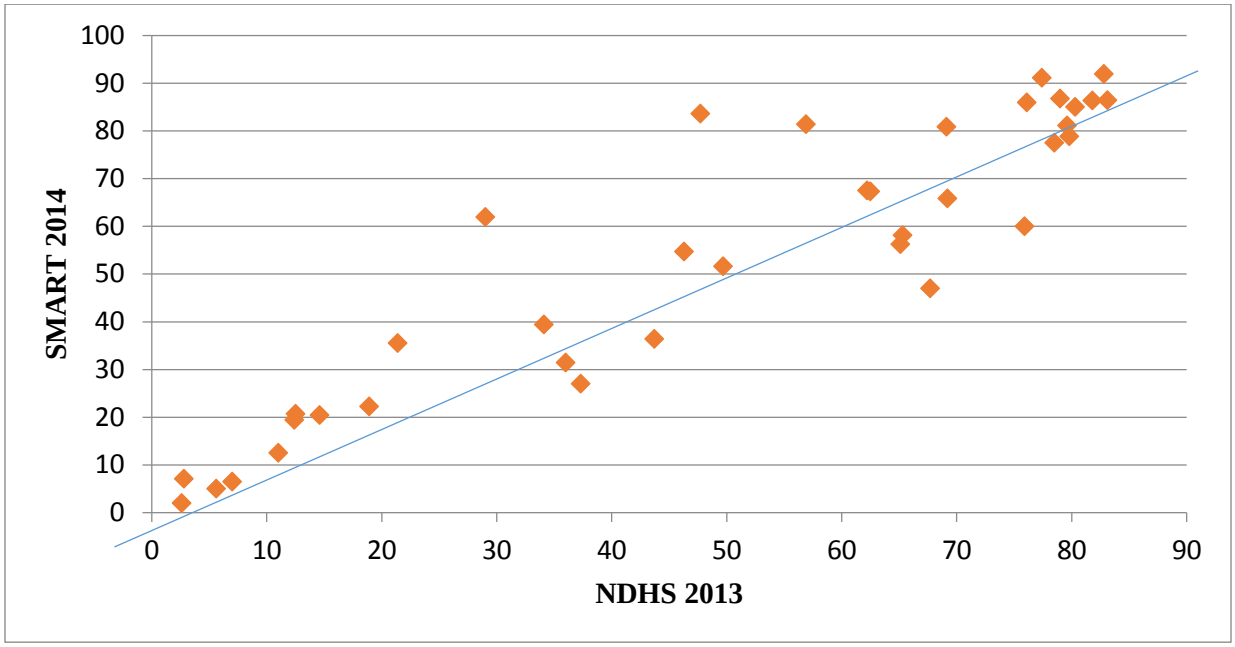
37. **Nigeria Demographic Health Survey (NDHS).** The NDHS collects demographic, health service utilization, and basic health status information, and is implemented by the National Population Commission (NpopC) with technical support from ICF Macro. The NDHS is conducted using a well standardized methodology and rigorous sampling and has been carried out on average a little less than every 5 years. Previous surveys were conducted in 1990, 1999, 2003, 2008 and most recently 2013. NDHS obtains the majority of its support from USAID.

38. **Standardized Monitoring and Assessment of Relief and Transitions (SMART) Survey.** The SMART survey was developed as an annual household survey to provide State-level information on nutritional status and related information for children and women. It has expanded to meet the data needs of other Programs, primarily the SOML, to include information for basic reproductive and child health indicators. It was initially implemented in 11 States (2012), but in 2014 it covered all States (36+ FCT). SMART is implemented by the National Bureau of Statistics (NBS) with technical support and funding from UNICEF. It provides State-level estimates for key indicators and information for scorecards used by the States to monitor their SOML progress.

39. **Quality Assurance for SMART.** The results from SMART closely correlate with those from the NDHS. For example, comparing State level immunization coverage in NDHS to SMART yields a highly significant correlation coefficient with an $R^2 = 0.85$ (see figure 19). Data is collected on tablets which allows for various quality assurance checks. Extensive technical support continues to be provided by UNICEF. The FGON has undertaken to continue to use the same sampling methodology, same questionnaire, and same quality assurance mechanisms so as to ensure comparability of data over time and ensure data remain robust. UNICEF has indicated its continued interest in providing technical support for SMART at least until 2017.

40. **Multiple Indicator Cluster Survey (MICS).** The MICS survey covers multiple aspects of health and health practices focusing on women and children. It is implemented by the National Bureau of Statistics (NBS), with technical support from UNICEF. Primary external partners are UNICEF, UNFPA, and Department for International Development (DFID). The MICS was conducted most recently in 2011 and provides zonal and urban-rural level estimates for key indicators.

Figure 19: Correlation of Penta3 Coverage (%) at State Level in NDHS v. SMART



Source: SMART 2014 and NDHS 2013 – Staff calculations.

41. **There are a few Other Relevant Surveys that Could Help Triangulate Results.** These include: (i) NSHIP baseline and follow-on surveys conducted by NpopC with technical support from a private company: (ii) National HIV and Reproductive Health Survey (NARHS) most recently conducted in 2012 by the FMOH in collaboration with the National AIDS Control Agency (NACA), Society for Family Health (SFH) and NpopC which collects information on key HIV/AIDS and RH indicators; and (iii) disease-specific surveys such as the Malaria Indicator Survey.

42. **The Routine Health Management Information System (HMIS) is Rreceiving Considerable Attention.** The FMOH introduced a new HMIS system, called the District Health Information System version 2 (DHIS-2): in 2010 to ensure standardized and harmonized reporting across the country. The DHIS2 is a computer-based platform for the routine (monthly) collection of HMIS data from facilities in each State. Facilities use standardized data collection forms and submit a standardized report, either electronically or on paper, on a monthly basis. The DHIS2 website is open access (dhis2nigeria@org.ng) with a dashboard that shows reporting rates in real time and is managed by the FMOH through the Health Planning Research & Statistics Division.

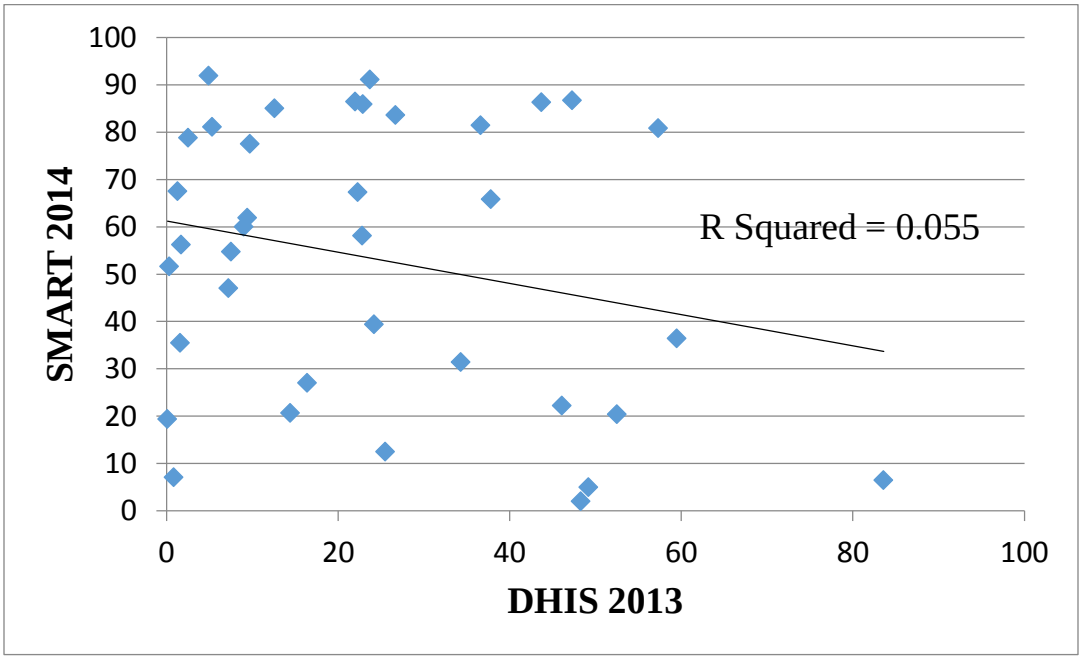
43. **DHIS-2 Faces Some Challenges**. Some identified weaknesses which make the DHIS impracticable for calculating the DLIs include the following:

(i) Differing levels of completeness for Government facilities. Routine HMIS information is currently submitted from approximately 61 percent of primary health care facilities—with reporting rates ranging from 96 percent to 0 percent across States. The accuracy of the denominators for reporting rates (number of public and private facilities) vary greatly by State—particularly for private facilities with only 38 percent of private facilities currently submitting reports. Although information is received from only primary health care facilities at present, by the end of 2014 secondary and tertiary facilities are expected to be reporting.

(ii) Lack of routinely applied internal checks for data consistency and routine systems for data quality assessments (DQA) to validate reported data against source data. Data validation assessments are being developed at the national level but are not presently being implemented.

(iii) Existence of significant differences in estimated coverage based on DHIS reports and population-based surveys, even for immunization services that are almost completely provided through the public sector. For example a comparison of SMART results and the appropriate DHIS2 data shows an insignificant and negative correlation with an R^2 =.055 (See Figure 20).

Figure 20: Correlation of Pentavelent3 Coverage (%) - SMART 2014 v. DHIS-2 2013



Source: SMART 2014 and NDHIS-2, staff calculations.

44. **There are Few Sources of Routine Information on Quality of Care.** Some routine practices being promoted by the FMOH to support and monitor quality of care include health facility registration; Quality of care (QOC) checklists used at secondary level facilities and primary level referral centers focusing on the service environment (e.g., triage/records/ organization); and Integrated Supportive Supervision tools for assessment of quality of care at secondary level facilities (first level referral facilities). However, the only systematic supervisory checklist available for PHC facilities is the one used for PBF.

45. **Until Recently there were Almost no Health Facility Surveys in Nigeria.** Until now health facility surveys have not been carried out on a large scale with the exception of the Bank-sponsored SDI survey. Plans are underway for the conduct of the first national level SARA survey.

46. **Service Delivery Indicator (SDI) Survey.** The SDI is a standard survey conducted through the World Bank to provide comparable data across countries. In Nigeria SDI was carried out by a private sector firm. The focus of SDI is on service readiness (equipment and supplies at the facility), finance and budget at the facility level human resources at the health facility (HF), and service provider knowledge based on responses to vignettes. The SDI was conducted in 12 States Nigeria in 2014. Findings were consistent across States with results from the first six States showing that an average of 36 percent providers accurately diagnosed conditions and 32 percent adhered to clinical guidelines when interviewed using a vignette. Only 17 percent adequately demonstrated knowledge for management of maternal/newborn complications. About 45 percent of facilities had essential drugs available and about 18 percent equipment and infrastructure required for basic services. There was more diversity in results between States for the availability of items assessed using the facility audit.

47. **Service Availability and Readiness Assessment (SARA).** The SARA is a standard health facility survey for primary health care and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). The standard tools are adapted to each country. A Nigeria SARA is in the final planning phase with main donors GAVI and Global Fund. It will be implemented early 2015 by the NBS with technical support for all aspects of the survey by Measure Evaluation/John Snow International (ME/JSI) and will cover both private and public facilities in all States.

48. **NSHIP Baseline Facility Survey.** As part of the baseline for the NSHIP impact evaluation a health facility survey was conducted in 6 States by NBS with technical assistance from the University of South Carolina. NBS experienced delays in completing the survey.

49. **Recommendations for SOML PforR.** At this time DHIS 2 is still evolving and will not be able to provide credible data on DLIs. Also, some of the proposed DLIs will require population based information while others need facility level data. Therefore, the proposed approach includes a combination of SMART population based survey for population based indicators and health facility surveys for quality of care indicators. The latter should be based on a harmonized SDI-SARA methodology that is being developed at global level.

50. **Confidence Intervals.** Using the sample sizes from the SMART and the published design effects form NDHS 2013 (to take into account the effect of cluster sampling) it is possible to calculate the expected confidence intervals (CIs) for SMART surveys at the State level for immunization coverage (DPT3), contraceptive prevalence rate (CPR), and skilled birth attendance (SBA). The CIs at zonal or national level would be substantially narrower but even at State level they are reasonably narrow and would be able to detect Programmatically important changes (see Table 13).

Table 13: Expected Confidence Intervals in Percentage Points of Selected Indicators from SMART Surveys for State Level Estimates

Indicator	**Baseline Coverage (%)**	**95% CI ±**	**90% CI ±**	**80% CI ±**
All States				
CPR	10	2.74	2.13	1.40
DPT3	38	7.20	5.61	3.68
SBA	38	7.83	6.11	4.00
North West Zone				
CPR	3.6	2.20	1.71	1.12
DPT3	13.9	5.23	4.08	2.67
SBA	12.9	5.44	4.24	2.78

V. Summary of Economic Evaluation

51. **Health Care Financing is Mostly Out-of-Pocket and Public Expenditure is Unlikely to Increase Much.** It is difficult to get reliable information on health care financing in Nigeria as efforts by the Bank, WHO, Children's Investment Fund Foundation (CIFF), and DFID can attest. The Bank is in the process of carrying out a resource tracking study and this is proving challenging, as have previous public expenditure reviews. While keeping in mind the limitations of the data, there are a few salient points on which there is widespread agreement:

(i) There is high out-of-pocket (OOPs) expenditure representing about two/thirds of total health expenditure. This is consistent with the wide use of the private sector as described above, low levels of public expenditure on health, and the very limited use of risk pooling;

(ii) Public expenditure on health is low by any standard and represents less than 2 percent of GDP. With the recent re-basing of the GDP, public expenditure on health may be as low as 1 or 1.2 percent of GDP;

(iii) Public expenditure is inefficient, partly because there is little non-salary recurrent budget. What little there is does NOT end up at health facility level;

(iv) As described above, public expenditure is NOT correlated with actual results in Nigeria and there is little reliable information for making decisions about how to better use resources;

(v) Public expenditure is not equitable with more than half of public funds going to hospital care where the benefit incidence is pro-rich and fewer public funds going to primary health care which is significantly more pro-poor; and

(vi) Public health expenditure may increase as a result of economic growth and increased commitment to health (as exemplified by the recent passage of the "Health Bill"). However, the Government's heavy dependence on oil (which accounts for about 75 percent of its revenues), makes it unlikely that overall public revenues will increase substantially over the medium term. In this context increases in public expenditure on health are likely to be modest in the next few years, on the order of US$1-US$2 per capita per year.

52. **Public Financing and Enhanced Fiscal Federalism.** The Bank has recently carried out a review of fiscal federalism in Nigeria. [14] Nigerian federalism exhibits important positive features that are associated with successful federations elsewhere such as the substantial autonomy enjoyed by State Governments, hard budget constraints, and allocation of revenues among States according to an objective formula that is consistently applied over time with little intrusion of political concerns. However, Nigeria could take better advantage of these positive features of its federalism to enhance the delivery of health and other services. Global experience suggests that conditional transfers to subnational Governments can be effective in achieving national priorities so long as the transfers are based on clear criteria and objectives, the conditions focus on outcomes and the application of standards rather than inputs and processes, and that subnational Governments manage the transferred resources themselves. Nigeria's experience with conditional transfers is limited but appears to confirm global lessons. The Universal Basic Education Program (UBE) is generally seen not to be working well because of excessive Federal Government incursion into the management of resources at State level. By contrast the experience with the MDG conditional grants Program appears to have been more successful because there was less Federal involvement in the management of transferred resources. This PforR can build on this experience and help the FGON provide conditional disbursements to States based on objective criteria, measured independently, and where management of transferred resources resides with State Governments. The disbursements to State Governments envisioned under DLI's 1, and 3 will provide an opportunity for testing such a results-based approach.

53. **Recent Signing of the National Health Bill.** The President of Nigeria in December 2014 signed into law the National Health Bill. The Bill is expected to give significant impetus to efforts to reduce maternal and infant health indices in the country. One of the major provisions of the Bill is the increased availability of funding for primary healthcare services through the *Basic Health Care Provision Fund* (BHCPF). The law stipulates that not less than one percent of the consolidated revenue of the Federal Government will be used to finance the BHCPF which in 2013 would have amounted to a little more than US$500 million. The increasing fiscal space for health in Nigeria is both a reflection of Nigeria's economic growth and recognition of GON to improve health outcomes. However there is a possibility that the increased revenues through the BHCPF annual grant could crowd out normal budgetary allocations to the health sector – it is unclear how this will play out but critical to note that budgetary allocation releases to the health

[14] Nigeria Economic Report No.1, May 2013.

sector in Nigeria are inconsistent and at best only partially implemented. It may as well turn out that rather than be an additionally it could fill the role of unreleased budget allocations.

54. **NHIS will Receive 50 percent of the Funds and Already Employs a Results-Based Payment Mechanism.** The National Health Insurance Scheme (NHIS) is the Government body responsible for implementing the Social Health insurance scheme, which began implementation in 2005. As Stated in the bill it will be responsible for the provision of basic minimum package of health services to citizens and the NHIS hopes to procure MCH services through its network of public and private providers. The benefit package as envisaged by the NHIS closely aligns with the indicators in the SOML package. The modus operandi of the NHIS is a performance based financing mechanism, which pays for outputs. Providers in the NHIS are paid through capitation and Fee for Service (FFS) payments. The capitated payments ensures providers maintain the enrollees under them are healthy and hence will require less treatments whilst the FFS are consumed when needed after clearance from a third party intermediary. The actual mechanism for managing the funds to be received by the NHIS remains unclear but it is likely that it will continue to utilize the funds as described. This is a mechanism, which further reinforces the proposed operation in two ways: it is aligned with the cost effective health interventions and guarantees the sustainability of an approach that pays for results.

55. **NPHCDA will Manage 45 Percent of the Funds but the Mechanism is Less Clear.** The NPHCDA will manage 45 percent of the funds from the BHCPF. The bill States that the agency will disburse money to the States on the attainment of certain criteria (mostly commitment to counterpart funding). Even though the bill does not explicitly State the basic minimum package of health as it did for the NHIS it assumes that PHC boards will focus on basic minimum package as well. There are specified amounts in the bill set aside for drugs and supplies, health facility construction, and health worker training. This may limit the opportunity to make it results based but the Bank has been asked by the FMOH for assistance in ensuring the most efficient use of the funds. The projects financed under this part of the bill will be cleared by the NPHCDA and the NPHCDA also has the power to withhold further disbursements to State and local Governments for improper use of the funds.

56. **Economic Justification.** The economic justification for a PforR is whether public investment in the Program is warranted. For SOML there is a strong justification for Government financing based on (i) addressing market failures; (ii) improving the allocative and technical efficiency of public spending: (iii) improving equity; and

a. Addressing Market Failures

57. **SOML is Designed in Part to Address Market Failures in Health in Nigeria**. Low immunization rates and low use of insecticide treated nets (ITNs) and other services that address malaria represent market failures due to large externalities from controlling communicable diseases. High immunization coverage and increasing ITN use provide “herd immunity” even to those children who are not vaccinated or don’t sleep under ITNs. Increasing behaviors that promote good health (such as family planning) also exhibit features of public goods. The design of the PforR operation, through for example its selection of DLIs, further strengthens the

incentive systems to address public good features and large social externalities in the health sector.

b. Allocative and Technical Efficiency

58. **The PforR will Help Nigeria Use its Health Resources More Efficiently.** Compared to other investment instruments, the PforR will help Nigeria move toward more optimal allocation and achieve gains in technical efficiency in the following ways:

(i) **Increased Allocations to the "Most Efficient Producers"**: The PforR will help increase allocative efficiency by providing more funds to the best performing States (as measured by their rate of improvement). DLI 1 will act as a quasi-market mechanism to reward the most efficient producers of health services in terms of both quantity and quality. The more efficient the State the more resources they are allocated. This differs from a more traditional input financing model under which results achieved do not determine allocations to the various actors;

(ii) **Incentive Effect will Increase Technical Efficiency.** The PforR provides incentives to States and State officials to get better results from the resources they are already spending. The better results they achieve (i.e., the better their technical efficiency) the more benefits they will receive (including both financial incentives and non-financial rewards such as recognition, training, and "bragging rights"). This compares to previous investment approaches that did not focus on incentives to enhance efficiency.

(iii) **Increasing Public Financing of Private Sector Delivery.** Through DLI 4, the PforR will provide the State Governments the opportunity to work with the private sector much more than they have in the past. Contracting with private providers (both for-profit and non-profit) to deliver publicly financed services— will be a more efficient use of public resources than having the public sector deliver those services itself.

59. **SOML is Designed to Improve the Allocative and Technical Efficiency of Public Spending on Health in Nigeria and the PforR will Build on that Objective**. There has been a mismatch between the disease burden and public budget allocations to health. Of special concern are remaining high maternal and child mortality rates. SOML prioritizes services that are highly cost effective[15, 16, 17] (see table 14) in terms of the estimated cost per disability-adjusted life year (DALY) saved. SOML interventions represent very efficient investments compared to other possible expenditures such as the treatment of childhood leukemia or congenital defects. Sadly many of the highly cost-effective SOML interventions are <u>not</u> reaching

[15] Laxminarayan R, Chow J, Shahid-Salles SA (2006) Intervention cost-effectiveness: overview of main messages. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB et al (eds) Disease Control Priorities in Developing Countries, vol 2. World Bank/Oxford University Press, Washington, DC.

[16] Ruth Levine, Ana Langer, Nancy Birdsall, Gaverick Matheny, Merrick Wright, and Angela Bayer (2006) Contraception. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB et al (eds) Disease Control Priorities in Developing Countries, vol 2. World Bank/Oxford University Press, Washington, DC

[17] Imdad A et al. Vitamin A supplementation for preventing morbidity and mortality in children from 6 months to 5 years of age. Cochrane Database of Systematic Reviews, 2010, (12):CD008524.

large proportions of the population, especially the poor. SOML and the support it will receive through the PforR operation is expected to increase the attention paid to currently under-funded and under used services thereby increasing the allocative efficiency.

Table 14: Cost Effectiveness of Selected Interventions – US$/DALY

Condition	Intervention [A]	Cost Effectiveness (US$/DALY)
Malaria	**Insecticide Treated Nets (ITNs)**	11
Unwanted Pregnancy	**Family Planning Programs**	117
Tuberculosis, diphtheria-pertussis-tetanus, polio, measles	**Additional coverage of traditional Expanded Program on Immunization**	7
Tuberculosis	Directly Observed Treatment	301
HIV/AIDS	Voluntary Counseling and Testing	47
Stroke (Ischemic)	Aspirin	149
Maternal Mortality	**Increased overall quality of care and coverage**	86
Malaria	**Intermittent preventive treatment with Sulfadoxine –Pyrimethamine**	19
Integrated Management of Childhood Illnesses	**Integrated Management of Childhood Illnesses**	39
Ischemic Heart Disease	Coronary Artery Bypass Graft	36793
HIV/AIDS	**EMTCT**	192
HIV/AIDS	Antiretroviral therapy	922
Measles	**Second opportunity measles vaccination**	4
Breast Cancer	Radiation therapy	23,300

[A] Interventions in **bold** are those prioritized by SOML.
Source: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB et al (eds) Disease Control Priorities in Developing Countries, vol 2. World Bank/Oxford University Press, Washington, DC 2006.

60. **Results-Based Approaches will be More Efficient than Input-Based Strategies.** The experience of the Bank, for example through the Second Health Systems Development Project (HSDP II), is that providing input financing does not obviously yield increased service delivery. By contrast, the funding under NSHIP does indicate that results-based approaches will produce more and better quality health services. For the reasons noted above SOML's results-based approach is expected to improve resource allocation and achieve greater technical efficiency gains compared to an input-based strategy.

c. Improving Equity

61. **SOML's Stated Objective is to Improve Equity in the Health Sector in Nigeria, and the PforR will Support that Objective.** As indicated in table 5 below maternal and child health

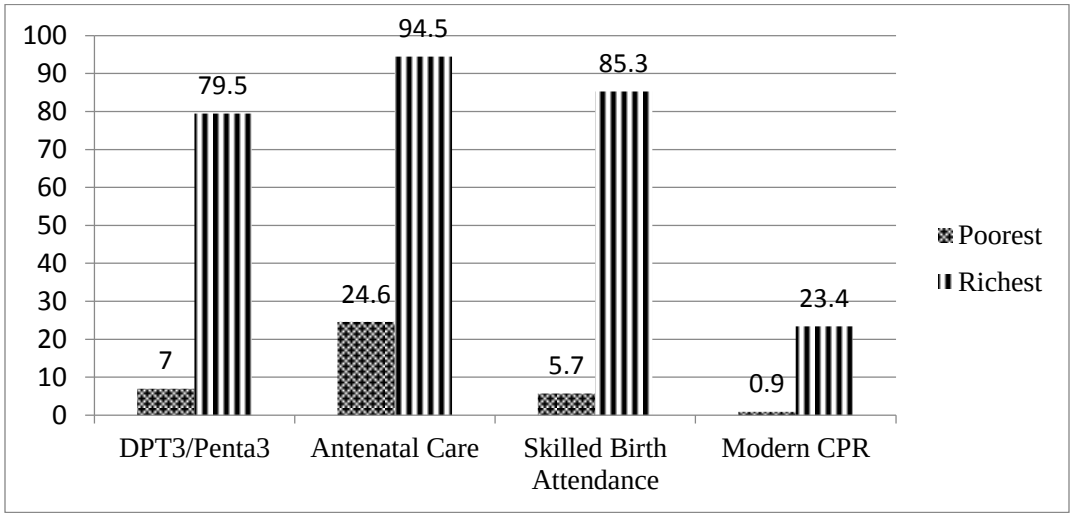
outcomes in Nigeria are poor on average and are especially bad for the poorest two income quintiles. The poorest two income quintiles suffer from similarly poor HNP outcomes and have nearly a one in five chance of dying before their fifth birthday. The ratio of the poorest to richest quintiles varies is significantly higher than the average in West Africa. Children from the poorest quintile are 3 times more likely to be stunted than children from the wealthiest quintile. Access to care is even more unequal with the wealthiest quintile 11 times more likely to be fully immunized or to have a skilled birth attendant than the poorest quintile. As can be appreciated in the bottom part of Table 5, the differentials in access to, and utilization of, health services by income quintile are extreme (see Figure 21).

Table 15: Health Outcomes and Outputs by Income Quintile

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

Source: NDHS 2013 and Staff Calculations.

Figure 21: Coverage of Services Among the Richest and Poorest Income Quintiles



Source: NDHS 2013.

62. **SOML Emphasizes Equity in Practical Ways.** SOML's commitment to improving equity is evident from; (i) its focus on essential intervention where coverage among the poor is very low; (ii) its focus on the North East and North West regions of the country (see table 6 and Figure 17); and (iii) its desire to strengthen primary health care facilities where the benefit incidence is significantly pro-poor (See Figure 18).

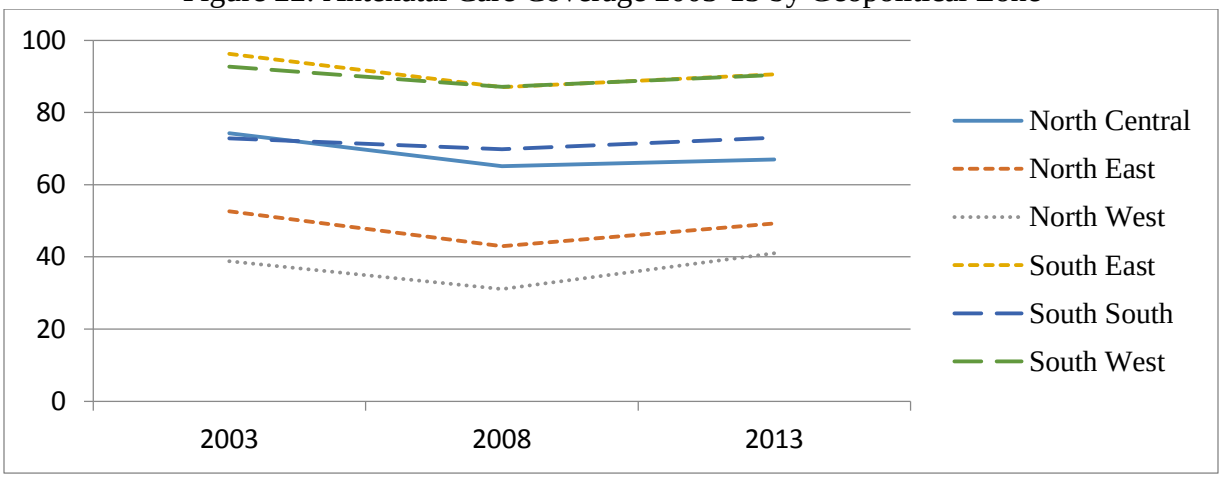
63. **Geographical Inequity – The North East and North West Lag far Behind.** In addition to income inequality, there are also important geographical inequities. The U5MR is twice as high in the North West compared to the South West (185/1000 and 90/1000 respectively) and service delivery is also far behind. For example, immunization coverage (DPT3/Penta3) is 14 percent and 21 percent in the North West and North East respectively compared to 70 percent in the South and 80 percent in the Southeast (see Table 6). It does not appear that the geo-political zones have different rates of progress which is surprising because it should be easier for the North East and the North West to improve given their low baselines (see Figure 22).

Table 16: 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: NDHS 2013.

Figure 22: Antenatal Care Coverage 2003-13 by Geopolitical Zone



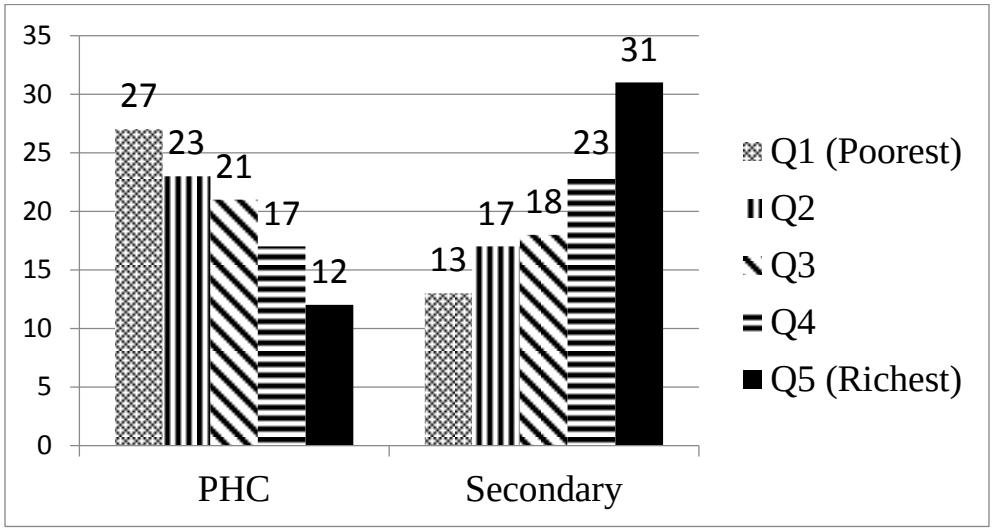
Source: NDHS.

a. Addressing Insurance Market Failures

64. **SOML has the Potential to Address the Inefficiency and Inequity of a Health System that Relies Heavily on out-of-pocket Spending due to the Lack of Insurance and Weak Public Sector Funding and Delivery of Basic Services.** The nascent National Health Insurance Scheme (NHIS) currently covers only 3-4 percent of the population, mostly Federal Government employees. The vast majority of people have no access to risk pooling, leaving them vulnerable to catastrophic spending and potentially unable to pay for health expenses. SOML will increase the coverage of vaccines, nutritional supplements, antenatal care and delivery attendance to everyone, regardless of insurance status. This allows the uninsured majority to access basic

healthcare and reduces the risk of serious morbidity and catastrophic spending while insurance markets continue to develop. In this way SOML contributes to Universal Health Coverage (UHC).

Figure 23: Utilization of PHC and Secondary Health Facilities by Income Quintile

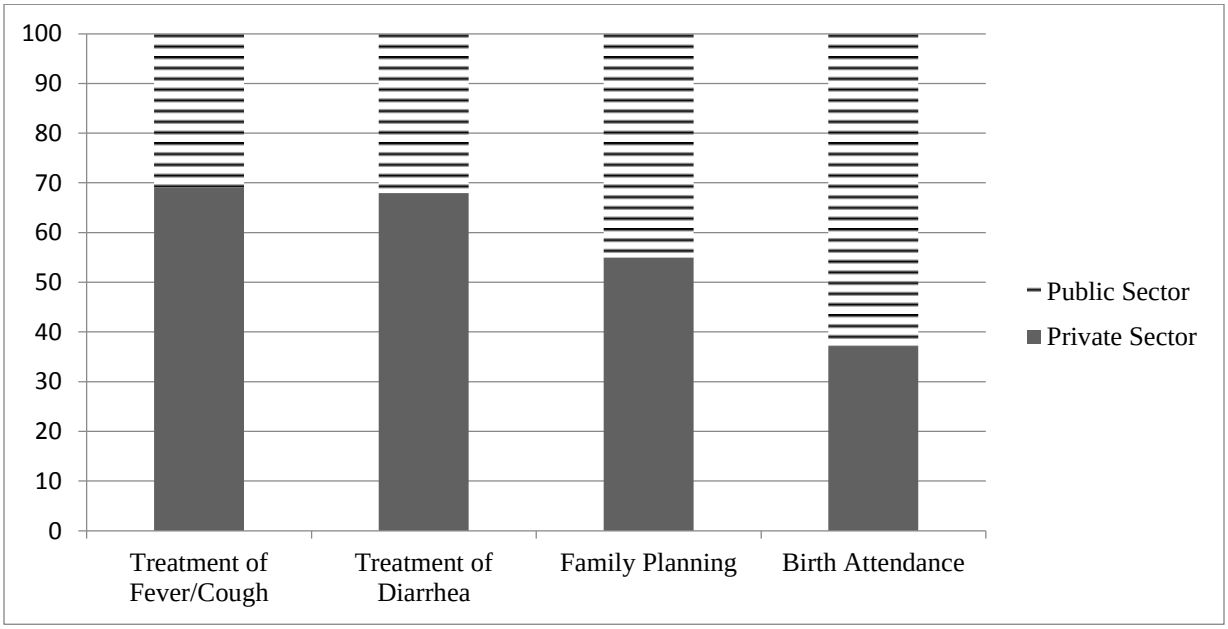


Source: Service Delivery Indicators (SDI) Survey 2013.

65. **SOML Provides Public *Financing* but is Not Restricted to Public *Provision* of Health Services**. In order to reach people where they seek care, SOML envisions increased engagement with the private health sector. The SOML Program document commits to finding ways of Government engaging with the private sector in meaningful ways. It explicitly encourages Public-Private Partnerships.

66. **Private Sector is a Major Provider of Health Services.** While the data are a bit sparse and sometimes uncertain, it is clear that the private sector is an important provider of HNP services. According to the NDHS 2013, 69 percent of children with fever are treated by private providers while 37 percent of skilled birth attendance and 55 percent of family planning services are provided by the private sector (see figure 24). It is NOT the case that the private sector only serves the richer income quintiles. Analysis of the 2013 NDHS indicates that among people with fever, 72 percent of the poorest income quintile get their care in the private sector. This is actually a little higher than the richest income quintile where 69 percent of patients source their care in the private sector. Patent and proprietary medicine vendors (PPMVs) provide care to 65 percent of poor children with fever who access the private sector. Thus any attempt to improve HNP service delivery will need to address the challenge of how to constructively engage with the private sector. Until recently, the FGON has had little interaction with the private health sector and is only now starting to strengthen its links with private providers. The PforR's innovation fund (DLI 4) further incentivizes private sector engagement including many kinds of public-private partnerships.

Figure 24: Sources of Care by Sector



Source: NDHS 2013.

67. **Efficiency Estimates.** In the past, Nigeria has suffered relatively low efficiency in improving coverage of basic services. Based on estimations from the PDU, annual total Government expenditure on PHC ranges between US$849 and US$1,642 million. Comparing this against the improvement in coverage of these services shown by Nigerian DHS 2008 and 2013, it appears that for each percentage point increase in the index (consisting of six key indicators in DLI 1), average cost is between US$134.9 and US$260.7 million.

68. **With the Implementation of SOML PforR, Incentives will be Introduced for State to be more Results Focused and More Efficient**. This shift which will help catalyze the impact and efficiency of Government spending on primary care. It is expected that more results will be achieved under PforR, and even taking account of additional fund for incentives, the cost per percentage point increase in the index will still decrease. Table 17 shows that the cost of a percentage point increase in the index can be reduced between 9.6 percent and 47.8 percent, depending on the scenario used. Four scenarios were examined based on (i) the proportion of all public health expenditure dedicated to PHC is 29 percent or 15 percent; and (ii) the increase in the index is 13 percentage points per year (the target for the operation) or is 8 percentage points per year (2 percentage points higher than the current rate of improvement). The proportion of the Government health budget spent on PHC was estimated by the PDU using a careful examination of budget line items in a sample of States. The 15 percent estimate is a very conservative figure used as a lower bound. Seeing as salaries account for most public expenditures on health and there are more Government health workers involved in PHC it is unlikely that PHC expenditure could be lower than this. As part of DLI 5, each State will be incentivized to report on its expenditure on PHC. Thus, better estimates of Government spending on PHC will be available during the Program, allowing for an updated analysis of efficiency.

Table 17: Cost Effectiveness PforR Under Various Scenarios

	Proportion of government spending on PHC	Expected percentage point improvement in index under PforR	Reduction of unit cost per percentage point increase in index (percent)
Scenario 1	29%	13%	47.8%
Scenario 2	15%	13%	44.4%
Scenario 3	29%	8%	15.2%
Scenario 4	15%	8%	9.6%

70. **Economic Impact of SOML.** The economic impact of SOML is likely to be very large and may derive from creating the conditions for economic take-off particularly improved human capital formation through greater returns to education and speeding up the demographic dividend.

71. **Nigeria Cannot Rely on Growth Alone to Produce HNP Outcomes**. While middle and high income countries have better health outcomes on average, greater wealth does not inexorably lead to better health. In oil-driven economies in Sub Saharan Africa – including Nigeria as well as Gabon, Angola and Equatorial Guinea— high under-five mortality rates persist despite relatively high GNI per capita. Even in countries where economic growth and HNP outcomes are both strong, wealth did not lead to health. In the East Asian economies improvements in health outcomes *preceded* rapid growth (see Figure 25). [18] Nigeria's experience highlights that economic growth does not inevitably lead to better health and specific concerted efforts are required. However, there is evidence that suggests improvements in health may contribute to economic growth.

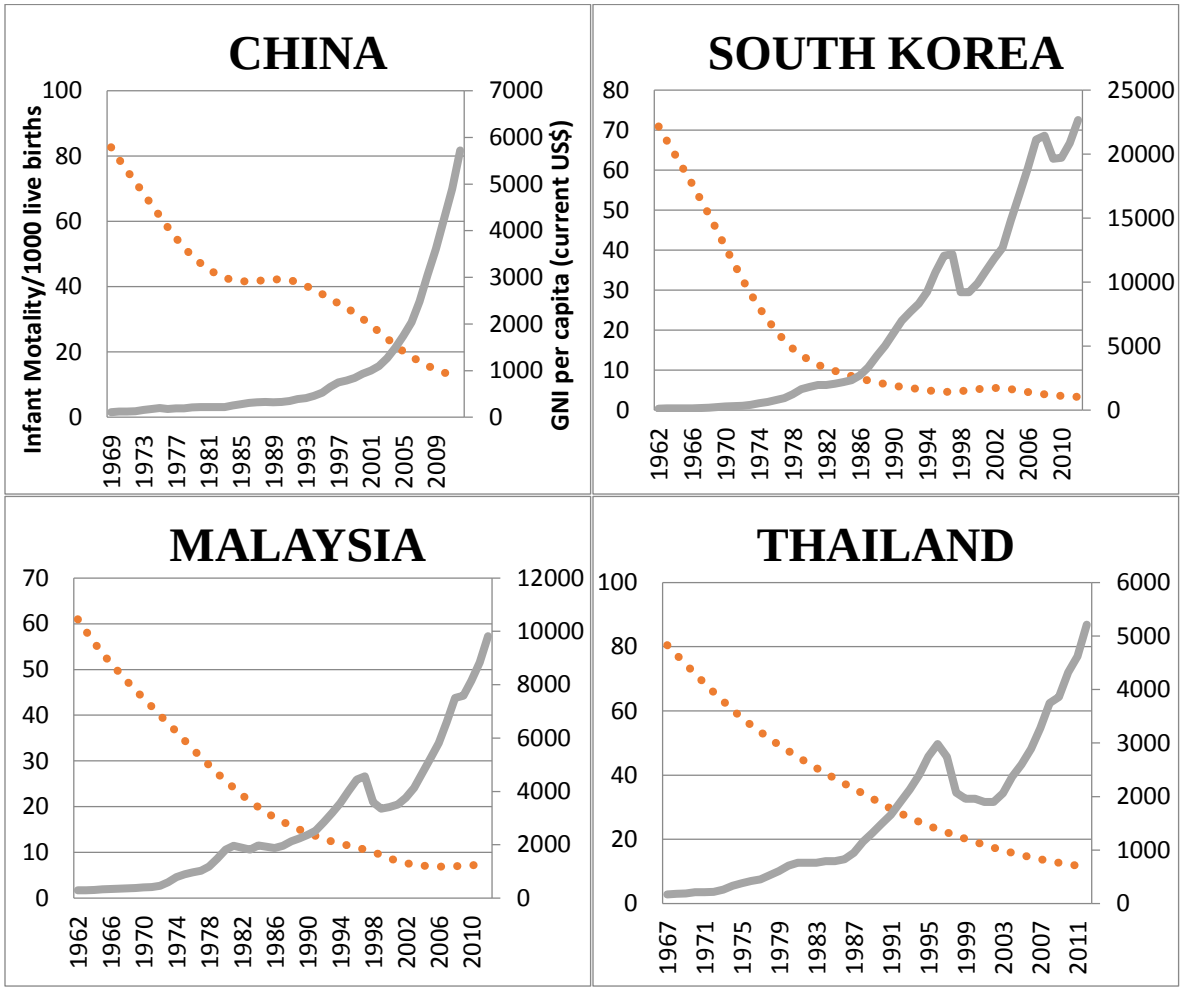
72. **Economic Impact of the Human Capital Improvements.** Micro-economic evidence shows that improving health can contribute to economic growth by promoting human capital formation and increasing labor supply and productivity. In Africa and Latin America, child health interventions to improve nutrition, provide vitamin supplementation, promote breastfeeding and institutionalize deworming – all activities included in SOML—have been shown to produce economic returns as well as health benefits. In addition:

(i) Micronutrient deficiencies alone in Nigeria add up to an estimated loss of over US$1.5 billion in GDP every year.
(ii) In Kenya, deworming was found to be a cost effective approach to improving human capital formation, increasing school attendance by a year for only US$ 3.50 per student. Adults who received deworming as children have been found to work an additional 5 hours per week and to earn 20 percent more on average. They are also more likely to be employed in the formal sector.
(iii) In Guatemala, boys who benefited from an early childhood nutrition intervention had 46 percent higher earnings 30 years later. [19]

[18] "Health or Wealth: Which Comes First?" Africa Health Forum: Finance and Capacity for Results. 2013.
[19] Ibid.

(iv) A randomized impact evaluation in Nigeria showed that the offer of a workplace based malaria testing and treatment Program increases worker earnings by approximately 10 percent.[20]

Figure 25: Health before Wealth - Infant Mortality Rates & GNI per capita in East Asia



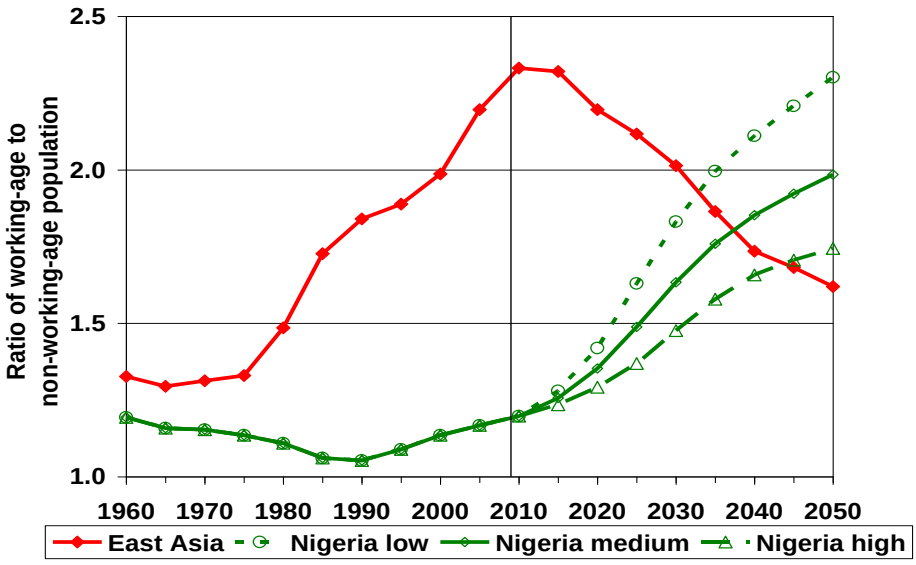
73. **SOML Supports a Fertility Transition which may allow Nigeria to Accelerate Growth by Capturing a *Demographic Dividend*.** Nigeria has an opportunity to obtain the kind of demographic dividend that has played an important role in the growth of East Asian and other economies. A demographic dividend is achieved when the ratio of economically productive adults to (mostly younger) dependents rapidly increases. When Nigeria will capture its economic dividend crucially depends on how quickly fertility declines (see figure 26). Capturing a demographic dividend requires (i) a fertility transition to a substantially lower level than Nigeria has so far achieved; (ii) an improvement in human capital formation and (iii) the creation of

[20] Health information, treatment, and worker productivity: Experimental evidence from malaria testing and treatment among Nigerian sugarcane cutters, Dillon et al, 2014.

roughly 2 to 2.5 million new jobs per year. SOML aims to accelerate the fertility transition by increasing the contraceptive prevalence rate and reducing child mortality through prevention and treatment of common childhood illnesses. Improving child health and nutrition also promotes human capital formation. Creating jobs as well will require good governance, solid macroeconomic management, a carefully designed trade policy, efficient infrastructure, and well-functioning markets. The Bank is working with the Government of Nigeria to develop infrastructure, increase trade and ultimately create jobs.

Figure 26: Dependency Ratio Over Time in East Asia and Nigeria

(with Different Population Projections)



74. **If Nigeria can Achieve a Fertility Transition and Improve Institutions Critical to the Economy, a Substantial Acceleration in Growth is Within Grasp.** Specifically, if Nigeria achieves the medium fertility scenario posited by the World Population Prospects, increases life expectancy to the world average, and improves institutions (such as rule of law and bureaucratic efficiency) in keeping with similar countries, it is estimated that, by 2030 (i) its per capita GDP would be 31 percent higher; (ii) an additional 32 million people would be lifted out of poverty; and (iii) its economy would be 50 percent larger as compared with a status quo scenario with no demographic dividend.[21] By promoting a fertility transition and contributing to human capital formation through better health and nutrition, SOML creates an opportunity for Nigeria to reap the economic benefits of a surge in productivity relative to the age structure of the population. On the contrary, if the status quo of a sluggish fertility transition and uneven improvements in child health persists, Nigeria will not be able to capture a demographic dividend.

21 Bloom D, Finlay J, Humair S et al. 2010 Prospects for Economic Growth in Nigeria: A Demographic Perspective. Paper presented at the IUSSP Seminar on Demographics and Macroeconomic Performance held at Novotel, Gare de Lyon, Paris, France 4-5 June 2010.

75. **Financial Sustainability.** The incremental costs of the PforR are modest, about US$0.71 per capita per year. Even with possible decreases in oil revenues the Government of Nigeria likely has the fiscal space to finance such an increase in health expenditures. Importantly, the PforR tests a way of effecting fiscal transfers that would increase the efficiency of public expenditure, even without increases in overall budget allocations. For example, the MDG Conditional Grant Scheme could employ the same results-based approach of the PforR at no additional cost. Even up to ministerial level, health expenditures are perceived to suffer from a low benefit/cost ratio. The result-based approach of the proposed PforR directly links budgetary expenditure with improvements in health service delivery providing an opportunity to institutionalize this more efficient means of using scarce public resources.

VI: Assessment of Specific DLIs

76. This assessment looks at the global and Nigerian experience with approaches that are relevant to the design of the DLIs 1 and 4. It looks at: (i) the evidence on improved management capacity on health services; and (ii) the effectiveness of results-based grants to sub-national Governments; and (iii) innovation and learning funds in the private and public sectors.

a. The Effects of Good Management on Delivery of Health Services

77. DLI 1 relies on improved management at State level to influence what happens in health facilities so the latter become more effective and efficient. Below in roughly ascending order of methodological rigor is the evidence supporting the effect of better State/district management on service delivery:

(i) **Anecdotal Evidence in Nigeria.** It is a cliché to say that "management matters" but the experience in Nigeria with PBF indicates that this is true. When the officers in charge (OICs) of poorly-performing are changed and new OICs are assigned, performance often changes, sometimes quite dramatically. Similarly, many observers feel that the surprisingly good performance of PBF in Adamawa (very rapid progress despite a difficult security situation) is due to the talented management of the SPHCDA Executive Director supported by high quality consultants.

(ii) **Variation in State Performance in Nigeria.** As described above (see figure 12) there is very wide variation in the performance of Nigerian States in terms of their change in coverage levels from 2008 to 2013. There are 5 or 6 States that have made remarkable progress, much higher than the national average while there are other States where performance deteriorated substantially. There is no simple explanation for the wide variation and it does make sense that it reflects State level management.

(iii) **Correlation Studies in Coronary Care Units.** A recent study[22] in 579 American coronary care units demonstrated that management practices that focused on standardizing care, tracking of key performance indicators, setting targets, and incentivizing employees had a very large effect on decreasing 30 day mortality rates from

[22] KJ McConnell et al; Management Practices and the Quality of Care in Cardiac Units, JAMA 2013 March 18.

acute heart attacks. These kind of management practices are similar to the ones envisioned under the PforR.

(iv) **Effect of Systematic Supervision.** A recent Cochrane Collaboration meta-analysis[23] of studies in low income settings suggests that supervision can have an influence on provider behavior and the care that they provide. More work is needed and the rigor of the studies needs to be improved.

(v) **Contracting-In Managers.** There is a long tradition of getting private sector managers to manage publicly owned assets. In the health sector this has been done on a large scale in Pakistan where it covers districts with a population of more than 100 million people. The results have been encouraging and represent large efficiency gains because the incremental costs have been essentially none. Given that contracting in managers does not change the health workers or basic arrangements, the experience in Pakistan and elsewhere indicates that improved management can make a hug difference.

(vi) **Contracting Out Service Delivery.** A quasi-experimental study in Cambodia demonstrated a very large improvement in service delivery (a 1 baseline standard deviation) when NGOs were contracted to deliver health services. Interestingly the NGOs had to rely on existing health workers which gave rise to the first recorded use of performance-based financing (PBF). Other studies from other settings confirm these results and strongly suggest that it is the improved management that contracted organizations bring that determines their success.

b. DLI 1: Experience with Results-Based Grants to Sub-National Government

78. **Lessons from the Universal Basic Education Commission (UBEC) Intervention Fund** are discussed under the institutional arrangements section above.

79. **Global Experience.** Performance based grant systems are intended to be integrated into national systems of intergovernmental fiscal transfers as a strategy for the delivery of public goods and services. Through incentives, sub-national Governments are influenced to improve performance (especially the cost, efficiency, quality and effectiveness of service provision), comply with central Government policy imperatives and improve service delivery. Although there is a dearth of RCTs, evidence from case studies and evaluations shows that performance-based transfers are effective in improving service delivery and local Government performance. Overall, performance-based incentive schemes in the health sectors of several low and middle income countries, including Costa Rica, Nicaragua and Indonesia, have had positive impacts on performance with resulting efficiency and accountability gains, quality and equitable service delivery. Results from Argentina's 'Plan Nacer' and Brazil are discussed in more detail below but they confirm the conclusion that where national financial transfers to States and municipalities are linked to verifiable results, there can be an improvement in health outcome indicators and achievements of agreed service delivery targets.

[23] X Bosch-Capblanche et al: Managerial supervision to improve primary health care in low and middle-income countries. Cochrane Collaboration 2011.

80. **Gates Immunization Leadership Challenge.** Recognizing the critical role of political commitment at the State level in the fight to eliminate polio and improve routine immunization (RI), the Bill and Melinda Gates Foundation (BMGF), launched the Immunization Leadership Challenge in September 2011. The objective was to use incentive based advocacy to stimulate direct oversight and leadership by State Governors.

81. **The Challenge Identified Seven Winning States**. One best performing State from each geopolitical zone and one State with overall most improved performance based on a set of pre-defined indicators. In addition to recognition from Bill Gates at an awards ceremony, each winning State was awarded a grant of US$500,000 to be used for a priority health intervention which could potentially be increased to US$1,000,000 if the State provided counterpart funds of US$250,000.

82. **The Challenge Appears to have Galvanized the Governors to Pay Closer Sttention to RI and Polio Eradication**. Although it is a little difficult to ascribe specific successes to it. It is unclear whether it has improved RI. However, Nigeria has now gone more than 4 months without a case of wild polio. For many State officials, the monetary incentive though appreciated, was less of a motivation than meeting Mr. Gates. Furthermore, the 'bragging rights' that come with being able to outperform their peers appears to have been a good motivator.

83. **Millennium Development Goals Conditional Grant Scheme (MDGs CGS).** In 2005, Nigeria successfully negotiated a US$18 billion debt relief package from the Paris Club of creditors, giving rise to annual debt savings of roughly US$1 billion. The Conditional Grants Scheme (CGS) channels these debt relief gains (DRGs) to States and local Government areas (LGAs) in a bid to address Nigeria's most pressing developmental needs and catalyze the achievement of the MDGs. States and LGAs apply competitively for grants from the CGS, which is dedicated to supporting sectoral initiatives, to help attain the MDGs.

84. **Under the Scheme, States and LGAs are Required to Provide Matching Counterpart Funds for Supported Projects in Priority Sectors and Areas**. Access to grants is conditioned on several criteria including a needs assessment, community participation, public expenditure reforms and modernization of State budget processes. Though there has been no formal evaluation of the Scheme, an assessment of a sample of State projects funded by the CGS between 2007 and 2009 shows that the CGS has largely met its objectives with high completion rates of 98 percent in 2007, and 88 percent in 2008. The Scheme's success has been attributed to wide stakeholder engagement, competitive access to funds, flexibility to State priorities and accountability for funds. Furthermore, by requiring States to have public sector reforms underway, particularly in managing public expenditure and developing human capacity, as part of the criteria for applications, the grant can be used to successfully leverage reform in the public sector.

86. **Brazil's Family Health Program (PSF):** Created in 1994, the Family Health Program is a primary care Program which seeks to provide a full range of quality health care to families in their homes, at clinics and in hospitals. Based on this approach, the family health team includes doctors, nurses, dentists and community health agents. In 1998, due to the slow uptake of the Program by municipalities, the PSF performance based financing

scheme was implemented to provide incentives, as cash grants, to municipalities to establish the Program and expand to the poorest Brazilians. A flat one-time transfer is provided by the Federal Government for establishing each new PSF team and variable transfers are given to incentivize continuous coverage extension.

88. **Recent Reforms have Focused on Improving Coverage, Effectiveness, Quality and Efficiency of PSF**. In particular in large cities with financing from the Federal Government varying according to compliance with performance indicators. There has been an increase in the number of family health teams across the country and analysis of achievements in health service indicators, such as maternal and child health (prenatal coverage) and reduction in hospital admissions for ARI and diarrhea show improvements commensurate to the level of PSF coverage in participating municipalities.

89. **Argentina's Plan NACER.** Plan Nacer, the provincial social insurance Program that targets uninsured pregnant women and children under six years of age, was launched in 2004 in nine provinces in Argentina with a nationwide roll-out in 2007. The objective of Plan Nacer is to provide an established MCH package of services using a capitation-based grant transfer between different levels of Government. Of the funds transferred to the Provincial Government, 60 percent are 'monthly base transfers' determined by the number of eligible beneficiaries enrolled in Plan Nacer. The remaining 40 percent of the payment is released based on the achievement of Stated targets for ten output and outcome health indicators (tracers) calculated quarterly. The Provincial government subsequently reimburses the providers- public and private- on a fee-for-service basis. Quarterly audits are carried out in each province by independent auditors who verify enrollment eligibility of beneficiaries and achievement of tracer targets. By 2009, the Program had reached 80percent of the target population in five States with significant increases in immunization rates as well as proportion of women seeking prenatal care and receiving four prenatal visits.

c. DLI 4 – Experience with Innovation and Learning Funds

92. **Experience with YouWiN!** Currently in its fourth cycle, Youth Enterprise with Innovation in Nigeria (YouWiN!) is a FGON initiative, with development partner support, with the objective of creating jobs and encouraging innovation and youth entrepreneurship. It is implemented through annual business plan competitions providing grants of between 1million and 10 million Naira (US$6000 and US$60,000) to about 1,200 to 1,500 awardees to establish new businesses or expand existing ones.

93. **The Results Emerging from YouWiN! Appear Positive**. People close to the Program feel that some of the factors that were helpful to YouWin! include a focus on merit, independent adjudication of proposals by business experts, placing a premium on innovation, feasibility as well as a demonstrable track record of entrepreneurial capabilities. Additionally, a systematic mechanism for grant disbursement in tranches triggered by external validation of attainment of pre-determined milestones; and capacity building through training "boot camps" and mentorship Programs for awardees have resulted in successful Program implementation.

94. **Global Experience with Challenge Funds:** Innovation and Learning Funds have been used by a number of development agencies and recent reviews[24] of experience have highlighted the importance of the following:

(i) Defining a clear and explicit rationale with a very clear and operational definition of innovation.

(ii) Establishing transparent and predetermined criteria for awarding grants.

(iii) Defining the maximum and minimum grant sizes and funding period.

(iv) Defining the cost-sharing expectations and how the grant may be used.

(v) Identifying any additional support that may be provided such as technical assistance.

(vi) Including fund management costs which have typically represented 20-50percent of the total budget.

(vii) Deciding on whether there should be some performance-based or additional incentive element to the grant (e.g., some additional reward for success).

(viii) A strong emphasis on monitoring and oversight to ensure grants are not misused.

(ix) A strong emphasis on lesson learning, evaluation and impact assessment, recognizing that success should be judged against actual and potential scope for broader uptake, not just on the success or failure of individual projects.

(x) Weaknesses in past experience with Innovation Funds to promote innovation have included a failure to ensure that funded projects are innovative, potentially replicable, and genuinely additional, as well as paying insufficient attention to evaluating impact.

[24] Sources: (i) Brain, A., N. Gulrajani and J. Mitchell, Meeting the challenge: How can enterprise challenge funds be made to work better? EPS PEAKS, April; (ii) SIDA Challenge Funds – Guidelines, Swedish International Development Agency.

Annex 5: Fiduciary Systems Assessment

A. Introduction

1. The Integrated Fiduciary Systems Assessment (IFSA) has been carried out, as part of the preparation of the SOML PforR, consistent with OP/BP 9.0 and in accordance with the Guidance Notes provided by OPCS for this instrument. The objective of the Assessment was to examine whether Program systems provide reasonable assurance that the financing proceeds will be used for their intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. The financial management systems were assessed to gauge the extent to which the planning, budgeting, accounting, controls, funds flow, financial reporting and auditing systems and practices provide a reasonable assurance on the appropriate use of Program funds and safeguarding of its assets. Equally, the Program procurement systems have also been assessed to establish the extent to which the planning, bidding, evaluation, contract award and contract administration arrangements and practices provide a reasonable assurance in support of achievement of the Program results. In addition, the assessment considered how Program governance systems manage the risks of fraud and corruption and how such risks will be mitigated.

2. The Bank's governance practice staff conducted the IFSA through a methodical review of systems and practices at the Federal level as well as a number of diagnostic work earlier carried out at the levels of the States. The analysis took cognizance of the diagnostics on service delivery and resource tracking in the health sector, PEFA/PEMFAR work carried out in 25 out of 36 States and on the Federal Government, and PIFANS carried in six States. In addition, work has been carried out on the political economy and institutional assessment of results-based health financing by Oxford Policy Management. The team reviewed the lessons learned in implementation of the four health projects under implementation, in particular the results based health project. The results of the assessment, including 'work-through' analysis and discussions held with the fiduciary stakeholders in Government, conclude that while there are remaining challenges which will be managed through methodical implementation of the Program Action Plan, the risks can be managed and that the SOML is a perfect candidate for financing under the Bank's PforR instrument.

A. Program Design and Expenditure Framework

3. The design of the Program benefits from the already established policy framework and governing principles of the FMOH for SOML. The Program will support improvements in the focus areas of the health sector, linking delivery performance to health outcomes in Nigeria. The Program itself is fully aligned to the Nation's transformation agenda and the National Strategic Health Development Plan (NSHDP 2010-2015) and its successor Program.

4. As a Federal sponsored Program, the SOML expenditures of the FMOH, corresponding to the budget of the Ministry for the core PHC sub-function (NPHCDA) as well as targeted expenditures from the funds provided by the Bank as leveraged resources that will be used to provide 'transfers' to performing States and other PHC delivery entities as well as finance technical assistance needs in the form of meeting expenditures for PMU, Innovation Fund

Manager, and PSU, will be the basis of analysis and presentation as part of the financial reports of the FMOH at the end of each fiscal year and presented in the annual financial Statements of the Program. The fact that the FGON, and by extension, the NPHCDA and the FMOH uses a Government integrated financial management information system to execute its budget using a GFS-compliant chart of accounts and budget classification, the mapping of Program expenditures from the function and sub-functions classifications of Government (using COFOG[25]) together with the economic classifications of expenditures will facilitate the production of financial information for the core of SOML's six pillars supported under the Program. It is encouraging to note that all budget execution processes (in respect of the consolidated fund) at the Federal level for FMOH and its agencies responsible for delivering on the Program activities, are conducted through the Federal GIFMIS. All expenditures undergo a process of cash planning, budget releases, and direct payments through the Treasury Single Account (TSA) held centrally at the CBN. Except for a few MDAs that have yet to fully transition to the TSA (27.7percent), this is widely the case in as much as the Federal Government has yet to migrate to using the 'procure to pay' module of GIFMIS as a way of managing and controlling the expenditure commitment process. The status of budget execution (appropriation, budget releases, actual payments, payments in transit, total expenditures against appropriations and budget releases, and unexpended balance of appropriations), even for agencies under the FMOH, is known 'real time' – a factor that supports timely and efficient expenditure management.

5. Although SOML is a Federal Program, its impact on health outcomes transcends the Federal Government. All 36 States and FCT of the Federation benefit from the initiative and all indeed do make provisions for expending on public health interventions. The Federal SOML initiative therefore leverages States' own efforts in delivery health services. As the overall focus of the SOML is to improve service delivery up to facility level, which involves the States and LGAs, there will be coordinated relationships between Federal, States, and LGAs**.** For the purpose of this Program however, the scope of the expenditure Program is limited to the Federal SOML Program that this Bank operation supports. Comprehensive, detailed data on overall health spending (including the values of pharmaceuticals and other medical goods purchased) are not yet available and this Program will help fill that gap.

6. It may be reiterated that with fiscal federalism at play in Nigeria, States and local Governments enjoy significant fiscal autonomy. As health service delivery is on the concurrent list, primary and secondary cares are responsibilities of the Local and State governments respectively. Therefore, given the central role of the primary health care system in the frontline service provision, engagement with the States is a critical element for the practical implementation of Programs to achieve Program objectives.

7. The expenditure framework for the Program is described in Annex 1. The overall contribution of the Bank to the financing of the Federal Program is US$500 million over 5 years, including a prior result year. On the estimated annual allocation of the Program expenditures over the five years, the Table below provides an overview, showing the expenditures consistent with the defined Program boundary. It may be noted that in reality, a number of entities have, in one form or the other, related expenditures that contribute to the SOML overall expenditures.

[25] Classification of Functions of Government.

Such entities or agencies include NACA, NOMO in Sokoto, National Aids Programs complementarily supported by donors including the Bank. These have been excluded from the specific targeted Program focus of the SOML for reasons of establishing a discrete boundary.

Indicative Annualized Expenditure Program

CoA Code	*Chart of Accounts (CoA) Description*	*Fiscal Year/Budget (in USD)*					*Total*
		Year 0	*Yae 1*	*year 2*	*Year 3*	*Year 4*	
21	Compensation of Employees (personnel cost)	7,927,000	7,927,000	7,927,000	8,125,000	8,328,000	40,234,000
22	Goods and Services (Other Recurrent Costs)	2,785,000	2,785,000	2,785,000	2,855,000	2,926,000	14,136,000
23	Investments (Capital Expenditure)	97,251,000	97,251,000	99,683,000	102,175,000	104,729,000	501,089,000
TBD	IDA SOML Program	75,000,000	90,000,000	114,000,000	109,000,000	112,000,000	500,000,000
Total Program Expenditure Boundary		**107,963,982**	**107,963,982**	**110,395,268**	**113,155,150**	**115,984,029**	**1,055,459,000**

B. Program Financial Management Systems

8. As a sub-sector wide and national–wide based Program that the Bank will be supporting, using a PforR financing instrument, the financial management arrangements for the Program will remain anchored on the use of the country financial management systems. The existing systems of budgetary planning, budget preparation, budget execution, accounting, internal controls, funds flow, financial reporting, external audit and legislative oversight will continue to be adopted for Program implementation.

B1. Institutional and Legal Framework - Financial Management Arrangements

9. The key institution for public financial management in the Federal and States Governments is the Federal or States Ministries of Finance and its agencies, but there are other players. The other players include the National Planning Commission (NPC), the Revenue Mobilization, Allocation and Fiscal Commission (RMAFC), the National Assembly (NASS), the Central Bank of Nigeria (CBN[26]), the Economic Management Team (EMT), the National Economic Council (NEC), and the Office of the Auditor General for the Federation (OAuGF).

10. At the sector level, the Program financial management at the Federal level will be managed under the auspices of the FMOH within the Directorate of Finance and Administration, in association with the National Primary Health Care Development Agency (NPHCDA). At the States level, the financial management will be managed under the financial management directorates within the respective Ministries of Health in association with SPHCDAs where they are established. In all cases, the Accountants-General of the Federation and the States as well as the Budget Directorates play a significant part in the overall management and control of public finances.

11. In Nigeria, the enabling institutional and legal framework for financial management are contained in the (1) Constitution (Sections 80-89) – accounts, audit, and investigations; (2) Finance (Control & Management), Act 1958 – the organic finance management law; (3) Fiscal Responsibility Act, (FRA) 2007, aiming to instil discipline into fiscal planning and management;

[26] See the Central Bank of Nigeria Act of 2007.

(4) Federal Public Procurement Act, (PPA) 2007, and PPAs at States levels that mirror the Federal PPA - regulating public procurement for Federal and States' government funds; and (5) Freedom of Information Act (FoI), 2011 - aiming to improve the transparency and public accountability by providing for public access to non-sensitive official data. *Along with the subsidiary legislations, regulations, and operation and financial directives, it is concluded that the legal framework is in place and acceptable to the Bank.*

B2. Planning and Budgeting

12. The budgeting of the Program expenditure (for purposes of Program boundaries) will constitute part of the Government budgeting process and the funds for the Program will be appropriated from both recurrent and capital sides of the Federal budget. Existing budgetary planning and budget preparation system entails the determination of the budget years' service delivery framework through sector plans and preparing financial estimates therefore, based on the budget ceilings provided by the Ministries of Finance. While, in general, the draft MDA budgets are delivered from MDAs to the Budget Directorate (at Federal) or Ministries (in States) well before the commencement of the fiscal year, the Federal budget (not the States) approval by the legislature has been marred by delays, year on year. Invariably, also, the planned budgets submitted by MDAs are reduced at aggregation/collation stage at the Federal Ministry of Finance and Budget and Planning Ministries in the States. *In effect, approved budgets remain at variance with the regular submissions from MDAs, thus impairing the ability of the MDAs to comprehensively deliver on their Programs.* The risk for this phenomenon to the SOML Program, though, is limited as funding gaps are filled from extra-budgetary funds or in-kind supply of commodities provided by donor partners. However, there is the attendant risk that with the use of extra-budgetary funds and resources from other sources (GAVI, Global Fund, etc.), unless coordination and accountability processes are properly streamlined, there could be issues of 'double dipping', but the use of the performance-based approach for the IDA funds suggest that this would not likely be an issue, since one source would pay for inputs and the other would pay for using those inputs effectively.

13. The SOML Program commenced in 2013. The budgets for the Program expenditures constitute part of the overall Ministry of Health budget. From a review of the budget execution at the key PHC entity (NPHCDA) of the FMOH for the SOML related sub-functions, there is ample evidence of under-utilization/execution of the appropriated funds due largely to the low releases of the budget by the FMOF. For the fiscal year 2014, out of a total appropriation to the NPHCDA of 19.43 billion Naira, only 8.66 billion Naira was released through warrants and only 7.24 billion Naira (37.3 percent) was actually spent. As SOML also benefits from financing from non-Government budget sources (development partners and other NGOs), it would be noted that the Bank's contribution to the Program's financing (about 47.5[27]) will be included as part of the overall national health budget in as much as the funds will be held in a Special Fund Account at the CBN. In effect, the Bank's contribution to the SOML Program will be part of the FGON annual budgets.

14. The SOML Program acknowledges that, despite this reasonable performance within the Federal Government, there is a broader issue with the transparency of budgeting arrangements

[27] Based on the defined Program boundaries.

for primary health care at State, LGA and facility levels. The institutional fragmentation of the sector has led to a situation where no single entity has an overview of the budget allocated to and spent on primary health care for that purpose. This is an issue that this operation tackles directly by incentivizing States to develop comprehensive budget execution reports for primary health care under DLI 5.

B3. Payments and Flow of Funds

15. In general, the Federal government transacts its budgetary spending through a system of a Treasury Single Account (TSA) held with the Central Bank of Nigeria. At present, about 72.3 percent of budgetary resources are processed through the Government integrated financial management information system (IFMIS), and all FMOH agencies conduct their budgeted expenditure payment processing using the system. The Permanent Secretary of the FMOH is the accounting officer for health expenditures in as much as some health agencies (NPHCDA for example) have relative autonomy for their respective expenditure commitments. All Federal Medical Centers and Federal Teaching University Hospitals rendering health delivery services in the States are on budget and the flow of funds to them from the Ministry's budget are managed through a systems-based TSA. The funds flow is initiated through the relevant health agency preparing a cash plan based on the appropriated budget and submitting the plan to the Accountant General of the federation; when validated and approved by the Accountant General of the Federation (all through the IFMIS), the Budget Directorate provides a budget release to confirm the cash backing for the relevant agency to enter into commitments. The process assures the availability of cash to finance commitments through the TSA as and when obligations arise. The current practice enables the agencies to make expenditures direct through the TSA, electronically. This is a significant improvement from the erstwhile status quo when cash was being indiscriminately moved from the Consolidated Revenue Fund (CRF) held with the Central Bank of Nigeria to nominated commercial bank accounts of agencies, thus undermining the good principles of an effective and efficient cash management system. In general, the system of funds flow within the Federal Government, using Government systems, works appropriately as commitment expenditures are liquidated in a timely and efficient manner, through a Treasury Single Account, as soon as they translate into obligations.

16. However, an issue that may affect the results of this Program is that the funds need to flow not just within the Federal Government, but also to States, LGAs and facilities. In respect of the States, the control in funds flow is exercised through the Ministries of Finance, and by extension, the Offices of the States Accountants-General, after the budget release to Agencies is made through the Budget Office. They do not maintain a Treasury Single Account system. However, they maintain a cash management system based on a strictly cash budgeting arrangement, and their CRFs are held across a number of selected commercial banks within their respected States and the daily status of cash balances in individual accounts is monitored. Expenditures undergo a process of validation at the MDA level as well as at the States' Accountant General Offices, and pre-payment audits are undertaken on every expenditure transaction before payment is authorized. Apart from a few States that operate a mixture of electronic cash transfers and check system (under a cashless economy policy), most of the States execute their payments by check or even cash. The latter constitutes areas of risk of fraud and corruption. As regards funds flow at the facility level, evidence indicates that, facilities receive

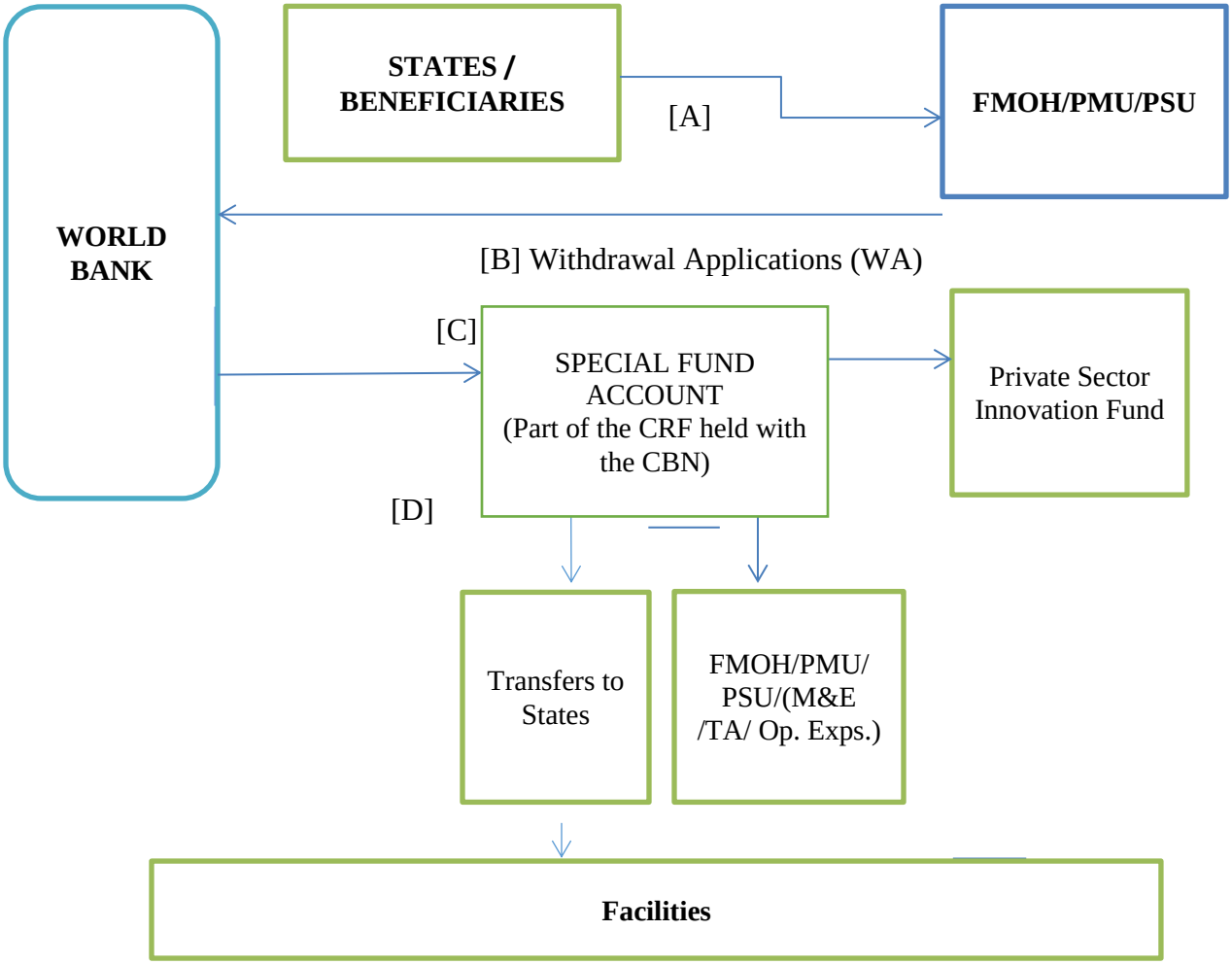
variable but mostly limited financial resources from the Federal, State or LGAs (largely through the drugs revolving fund, NHIS capitation payments and user fees). Resources are transferred to them largely in kind or as part of the centralized payroll system – from midwives' schemes, P-Sure and MDG funds.

17. The lack of non-salary recurrent expenditures flowing to the facilities can impede the operational effectiveness of facilities. There is also sporadic evidence that salaries of health professionals have occasionally been affected by arrears, which can impact staff morale, motivation and performance. However, the extent of the issue is unknown at this stage, in view of the lack of available data on budget execution for primary health care, particularly at the facilities' level. This operation thus supports the regular production of consolidated budget execution reports, broken down by economic classification, in order to help the authorities identify spending levels and trends on compensation of employees, goods and services and capital investments for primary health care (DLI 5). This financial reporting information will be regularly reviewed jointly with results achieved in each State as part of the Program performance monitoring (DLI 2).

18. Disbursements from the World Bank, in respect of:

- *Federal Government's own expenditure reimbursements under the Program (including for technical verification and monitoring and evaluation activities),* will be released to the Special Fund Account of the Federal Government (a sub-set of the Consolidated Revenue Fund) held with the Central Bank of Nigeria.
- the Consolidated Revenue Fund or such other Sector Fund account (a sub-consolidated fund account) held with the Central Bank of Nigeria and that forms part of the TSA.
- *Funds to be directed to special Program related activities like 'private sector innovation fund for 'private sector participation in Program implementation',* these will be disbursed into a designated (segregated) account held with the CBN and paid out to beneficiaries through the FMOH budget implementation process.
- *Performance disbursements to the States* based on their performance against the set criteria, withdrawals will be initiated by the FMOH and direct payments made to the Consolidated Fund Account of the respective qualifying States.

SCHEMATIC DIAGRAM - FUNDS FLOW ARRANGEMENTS UNDER THE PROGRAM



[A]: States and other beneficiaries submit evidence of performance against criteria to FMOH/PMU/IVA for verification.

[B]: Upon verification and assessment against criteria, FMOH submits WA to WB for disbursement.

[C]: World Bank disburses to the FMOF's Special Fund Account held with the CBN for subsequent payment to beneficiaries under the Program.

[D]: From the Special Fund Account, FMOF transfers to qualifying States and makes payments through Sector Wide Votes to FMOH, PMU, PSU, Innovation Fund Manager, and other NGOs. Transfers to States will be accomplished within 30 days of receipt of disbursements from the World Bank. All disbursements will be through IFMIS against the Program – compensation of employees, goods and services, capital investments, transfers. The States either directly or

through their SPHCDAs or Local Governments, as the case may be, will be responsible for providing the required resources to their facilities.

B4. Accounting and Financial Reporting

19. The Federation has adopted the IPSAS cash basis of accounting and financial reporting as of fiscal year 2014 although a majority of States is still lagging behind in implementation. In addition, the Federation has adopted the new chart of account and budget classification system that is GFS 2001 compliant (although implementation remains uneven across States, with the Federal Government and only four other States having commenced implementation). In effect, Nigeria is moving progressively towards complying with international standards on accounting and financial reporting as well as on use of a classification methodology (for budgeting, budget execution, accounting, and reporting) that conforms to international best practice. Implementation challenges remain, but these are being monitored and managed under the auspices of the Federal Account Allocation Committee (FAAC).

20. With an IFMIS in place at the Federal and a number of States Governments, in-year and year-end accounting and reporting of expenditures is generally timely (real time), and budget execution Statements can be conveniently generated from the system to guide budget implementation decision making. Annual financial Statements are finalized within 3-5 months of the end of the fiscal year and submitted to audit, but this can be improved as soon as a few systems glitches and processing arrangements are attended to across the Federation.

21. For those States that have yet to transition to an IFMIS, a mixture of manual and IT-based processing of transactions in place. Notwithstanding the inherent weaknesses in using non-ICT based systems in the accounting of multiplicity of transactions – ranging from errors in postings and the absence of audit trails - the system of accounting and financial reporting at the States is generally performed at acceptable levels.

22. The focus of the Program for purposes of Program expenditure reporting, as already highlighted, will be on the SOML, initiated and coordinated at the Federal level under the auspices of the FMOH. Since each MDA, by law, prepares its own financial Statements for audit, the FMOH, NPHCDA, and the States' MOH do prepare their own financial Statements and render them for audit. The Program expenditures will constitute part of these Statements although the expenditures are not traditionally segregated as the MDAs have yet to transition to a form of Program-based budgeting and reporting. Nevertheless, as part of the actions to support the Program implementation, the core Program expenditures across implementation agencies, will be analyzed through mapping across functions and sub-functions to show what the actual expenditures of the Program were at each annual reporting period. Such analysis shall be included as a note in the entity financial Statements of the FMOH.

23. Already, accounting for and reporting on Program expenditures are conducted as part of the expenditure management process in place at the FMOH and its agencies (principally, the NPHCDA – a key agency constituting the expenditure Program boundary defined for this operation) as well as in the Ministries of Health at States level. The process is in compliance with the guiding principles, procedures, and practices as contained in the enabling regulations,

financial instructions and guidance notes provided as part of the subsidiary regulations to the organic public finance legislations across the Federation. All expenditures including those for the Challenge/Innovation Fund will need to be processed through the central IFMIS that has since been rolled-out to MDAs including FMOH and its agencies, including NPHCDA.

24. While the expenditure of States and health facilities do not form part of the expenditure Program of this Federal Program, one of the objectives of the Program is to improve the financial management of facilities through DLIs and Program Action Plan through transparency of financial reporting on PHC spending by States themselves.

B5. Internal Controls and Internal Audit

25. The internal control over expenditures is one of the key areas of risk for the Program. Evidence from other Programs indicates that internal controls over procurement processes, as well as operational expenses (travel, per diem and workshops) represent particular risk areas. As per the Program of expenditures, most of the spending will leverage government expenditures directed to finance the procurement of vaccines (largely handled by UNICEF) and pharmaceuticals, as well as the payment of health sector staff, which means that operational expenses will not be a central concern in this Program. It will be very important however to ensure that internal controls over the handling of commodities are strengthened through the Program. Resource tracking has been an important feature of and body of knowledge in understanding the implementation process of health Programs. This is a relevant diagnostic that has been exposing the bottlenecks to health service delivery activities across States to the facilities' level and has made recommendations on how to further improve the service delivery through elimination of 'stock-outs' of medicines, bottlenecks in elements of the supply-chain management, reductions in response time to crisis, etc. DLI 1 will measure stock-outs of essential drugs and vaccines and incentivize their reduction over time. In addition, the action plan under the Program entails the annual conduct of this exercise and ensuring the reports have impact through full discussion and actions at the level of the Program Steering Committee. In addition, the next section provides a detailed discussion of procurement risks and their mitigation.

26. The internal audit process, largely focused on pre-payment audits, entails the reviewing of expenditures for genuineness, accuracy of values and delivery elements, authority, and appropriateness, among others. It is, though, skewed on compliance and stewardship, while lacking in oversight as a support function to management. Although leakages remain in the expenditure management system due to minimal risk-based internal audit and control processes, and lack of focus on systemic issues. However, a key challenge would be how to divorce the internal audit function from involvement in the expenditure processing cycle and accord independence to the role the internal auditors play. This is an institutional issue cutting across the Federation but the FMOH, through the SOML Program, will address the shortcoming, on pilot basis, by ensuring that internal audit function operates independent of the expenditure processing cycle, as the current arrangement entails, while the internal control function, carried out also by the assigned staff from the Accountants General's department, can remain.

B6. Oversight – Program Audit

27. The Auditor General of the Federation as well as the States' Auditors-General conduct the independent audits of public finances in their respective jurisdictions.

28. In respect of the Federal Government, external audit (according to the PEFA 2013) covers at least 50 percent of total expenditures of central Government, including the health sector. The submission of the audit report (as well as the financial Statements upon receipt of the draft accounts from the Accountant General of the Federation) to the legislature has been achieved within four months of the end of the period covered. The quality of audit has begun to be improved, especially with the implementation of key reforms supported under the Bank-financed ERGP, and there is a progressive transition to INTOSAI standards of auditing. However, audit follow up has continued to remain weak.

29. The annual audited financial Statements of the Program (entailing the NPHCDA as an entity and the Special Fund Account to be held with the Central Bank of Nigeria), representing the Bank's contribution to the overall Program expenditures, will be submitted to the Bank within twelve months of the end of each FGON fiscal year. For the purpose of this Program, these will constitute the focus boundaries of the annual financial Statements and will include, by way of detailed notes, the detailed sub-expenditure objects of the economic classification of expenditures of the Program, including transfers made to performing States. The Auditor General of the Federation will conduct the audit of the Program Financial Statements.

30. The States Auditors-General also conduct the audits of the financial Statements of their respective States and render them to the States' Assemblies. PEFA reports of States indicate that, in general, the audit reports are submitted to the legislature within 12 and 15 months of end of each fiscal year although a few States do render these accounts within 6 months of fiscal year end. The quality of these audits remained, though, uneven across States. As part of the audit for this Program, the audit reports of the States will not be required due to the definition adopted on Program boundaries. Nevertheless, to incentivize States to improve their accountability for PHC resources deployed, the Program includes a reporting requirement as part of DLI 5.

B7. Disbursements from the World Bank

31. The IDA credit proceeds will be disbursed to the Federal Government's Special Fund Account which serves as a sub-account of the Federal Consolidated Revenue Fund (CRF) or such other Health Sector Fund account (that forms part of the CRF) held with the Central Bank of Nigeria, triggered by the achievement of the DLI related results for the Program. Upon achieving a DLI related result, a withdrawal application will be submitted to the Bank, using the Bank's standard disbursement forms through the e-disbursement functionality in the Bank's Client Connection system. The withdrawal application would be accompanied by certified and cleared evidence from the task team that the related results were achieved. As also highlighted under the 'payments and funds flow' section, the disbursements to performing States will be made directly from the Special Fund Account managed by the FMOF to the designated account of the respective States, managed by the States and held in the CBN, for further transfer to the

States CRF. The withdrawal applications will be submitted under joint signature of the FMOF and FMOH.

32. Prior results emanating from meeting DLIs for a prior period (in this case for year 2014/2015) would form part of the Program operations. All disbursements for prior results will be made directly to the Special Fund Account under the CRF of the Federal Government in the name of SOML. In addition, the Program disbursement arrangements will allow disbursement of 'advances' to a tune of about 25 percent of DLI values for a succeeding year with a view to facilitate acceleration and drive to achieving the results for one or several DLIs designed for achievement in a future year. Any advances provided shall be recovered when the related DLIs remain unmet at a subsequent disbursement period.

33. A summary indicative quantification of DLI disbursement is annex 3. The principle for disbursements against DLIs that has been adopted for the Program implementation is as follows: For any DLI not met at the evaluation date in any single year, the price allocated to that DLI would remain undisbursed (or recovered from the next cycle of disbursements if a prior advance was made) until the DLI is met at a future date during the life of the Program.

B8. Program Financial Management Risk

34. As highlighted earlier, the SOML is a Government-owned Program in support of focusing on health service delivery results with a view to achieving objectives. Critical to achieving these, the financial resources must be adequate to enable the effective and efficient delivery of the services both at volume and quality levels. In spite of the existence of a robust financial management information system at the Federal level to track spending for SOML related delivery activities, the Government budgeting is not carried out according to Programs to enable the identification, from the budgetary planning stage, the direct attributes of SOML spending. Equally, since the SOML extends beyond the Federal jurisdiction to the States, there is, overall, no clear and segmental budgeting of expenditures for direct attribution of spending to SOML related activities except for a few entities like the NPHCDA, NACA. The activities germane to the Program are cross-cutting in terms of their implementation across organization units within the health sector. Therefore, in the spirit of infusing increased transparency and accountability in the implementation of the Program from the perspectives of financial management results and outcomes, the implementation of the Program action plan will include the remapping of the annual health budget to enable ascribing expenditures of certain related organization and delivery units to the Program. Such an analysis will be carried out as part of the annual financial reporting and included in the annual financial reporting of the health sector (essentially the FMOH) by way of detailed notes to the accounts. At the level of the States, and as a DLI to cater to the risk of in-transparent financial information on PHC spending, the SPHCDAs will be required to prepare and publish quarterly consolidated budget execution reports on all PHC activities across the entire State within six weeks of end of quarter.

35. Another critical activity that would need to feature in the action plan is the reinforcement of internal controls through the introduction of a methodical internal audit function within the health sector (essentially the FMOH and NPHCDA). Currently, the role of internal audits at both the Federal and States levels is limited to conducting 'pre-payment audits' – just like how a

control function operates in incurring expenditures. This functioning mandate comes from the local laws and does imply that internal auditors who should be independent, consistent with the International Institute of Internal Auditors' standards, are directly involved the expenditure processing cycle. This undermines the independence and integrity of internal auditors. As part of the action plan, the Accountant General of the Federation would lead the States in assigning separate internal auditors to do ex-post audits that will focus on systemic issues and risk and thus mitigate the effects of possible collusion between the pre-payment audit teams and those with spending authority under the Program. Reports of the ex-post internal auditors should be submitted to the Permanent Secretaries of the Ministries of Health, the Accountant General, the Auditor General, and shared with the Bank on quarterly basis.

36. Again, as part of regular in-year fiscal reporting, the Office of the Accountant General of the Federation, in association with the FMOH's PMU, will provide to the Bank quarterly budget execution reports at the economic (object) classification level for each of the sub-functions of the health sector within 30 days of the end of each fiscal quarter for overall Program monitoring purposes. The sub-functions of health that contribute most directly to the pursuit of SOML objectives will be the key focus of monitoring.

37. The draft financial Statements of the Program will need to be prepared within three months of the end of the fiscal year and submitted to the Auditor General of the Federation. The financial Statements, as highlighted above, would need to provide detailed notes on the Program in terms of actual expenditures derived from the mapping of Program expenditures from the implementing units' budget execution reports (NPHCDA and the IDA supported component of the SOML Program). Equally, in addition to meeting the DLIs, one of the criteria to be established is for ensuring that the overall Federal Program expenditures (actual) at Program closure is more than or equal to the Program withdrawals (disbursements) from IDA. Any shortfalls will need to be recovered from/refunded by the Federal Government. This will ensure that the results achieved have a relationship with financial resources deployed.

38. Finally, the external audit of the Program expenditures, as part of the audit of the entity financial Statements of the FMOH, will be critical to providing the requisite assurance that the Program resources were appropriately used with the requisite economy, efficiency and effectiveness towards achieving the Program goals. To this end, and with a view to managing the risks to Program outcomes in a timely manner, the Auditor General of the Federation will carry out: (a) the financial audit of the SOML as defined by the Program boundary and (b) deliver the audit report to the legislature as well as submit to the Bank within 12 months of end of the fiscal year.

39. Overall, notwithstanding the established deficiencies in the financial management at the sector level (drilled down from the conclusions of the PEFAs/PEMFARs), there is reasonable assurance that the established systems will be adequate especially when the mitigating factors as highlighted in the Program action plan are adopted and implemented.

C. Program Procurement Systems

C1. Assessment of Procurement Framework

40. 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 UNCITRAL model law, and are applicable to all procurement categories (suppliers, contractors, consultants).

41. Following the enactment of the procurement act, a regulatory agency - the Bureau of Public Procurement (BPP) - 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.

42. 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 (VCA) 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.

43. At the States' level, procurement law has been enacted in 24 States while the remaining States have draft bills at various stages of consideration; procurement regulatory agencies have been established in 18 States. The Programmatic Integrated Fiduciary Assessments of Nigerian States (PIFANS) for Lagos, Ondo, Edo, Delta, Rivers and Bayelsa also identified the procurement weaknesses at the Federal level in the States. In addition, PIFANS highlighted the: (a) need for the States to develop and deploy necessary tools, including regulations, manuals and standard bidding documents; (b) the need to professionalize the procurement function; (c) need for publication of contract award to enhance transparency and demand for accountability; and (d) need for the establishment of complaints and appeals mechanism.

44. In 2014, the 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; 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.

Overview of Procurement Performance in the Federal Ministry of Health:

45. *Scope of the Review:* This assessment covers the enabling legal framework, the organizational aspects, procurement processes, record keeping and document management system, staffing capacity, quality and procurement planning, development of the procurement documents, bids/proposals submission, evaluation of the proposals and contract award, and application and appropriateness of the laws, rules and regulations applicable to FMOH in the implementation of the SOML PforR operation.

46. *Institutional Arrangements:* Pharmaceuticals and medical goods procurement are domesticated in different places within the FGN ministries, departments and agencies. For instance, the FMOH along with UNFPA procure family planning commodities for the whole country. FMOH with NPHCDA through UNICEF centrally procure the vaccines and consumables for administration of the vaccines. Many MDA are involved in the procurement of maternal, newborn and child health commodities. These include the FGN through the FMOH, SURE-P MCH, NPHCDA, Ministry of Women Affairs and Social Development and Development Partners through various bilateral and multilateral donations. State Governments, too, procure pharmaceutical and medical goods in accordance with their State needs. In respect of family planning commodities alone, the FMOH and partners spent about US$49 million last year.

47. The national health policy allows each MDA to procure pharmaceuticals and medical goods but there is no coordination mechanism among the above institutions to ensure that there is no duplication of roles in product selection, forecasting, procurement, inventory management, distribution and ensuring rational use of drugs. There is therefore the need to establish a coordination mechanism to address this weakness.

48. *Procurement Management:* There are a number of problems associated with procurement management at the FMOH. These include: (i) lack of understanding of supplier market which has led to adoption of inappropriate procurement methods; (ii) use of wrong prequalification and post-qualification criteria; (iii) inappropriate packaging and delivery schedules; (iv) potential increase in chances of collusion and other improper practices, particularly where the number of prequalified local manufacturers is very limited; (v) high bid costs in comparison with estimates/budgets, thus reducing the chances of achieving best value for money in the procurement of critical health sector goods, (vi) limited capacity of suppliers of some critical items such as Long Lasting Insecticide Treated Nets, Rapid Test Kits, etc., and (vii) poor data or non-availability of data for procurement forecasting.

49. The procedures for the bidding process are generally being complied with as provided by the law. However, there are two key areas of weaknesses: the approval of award recommendations, and the documentation and record keeping. For instance, approval of award

recommendation for RBF contract valued US$8,946,530 under NSHIP was delayed for four months, in spite of the fact that the Bank's No Objection had been given. In addition, the Team was informed that there were management and political interference in the procurement process.

50. *Funding:* Although budgetary allocations are made annually, budget releases fall short of contract commitments. Consequently, in many occasions goods that have been received are not fully paid due to insufficient funds. This has created serious lack of confidence of suppliers on the FMOH. The Assessment Team was informed that in some of those cases that the goods have not been fully paid, management does not distribute the drugs which sometimes lead to expiration and wastage of the drugs. The Assessment Team could not understand why the unpaid drugs are not distributed since these are unlikely to be returned to the suppliers.

51. *Logistics:* The main problem with availability of pharmaceuticals and medical goods is logistics. Starting from receipt of goods at the ports, the Assessment Team was informed that there are serious delays with customs clearance of commodities. These delays are caused by lack of funds for customs clearance, issuance of duty waiver and NAFDAC inspection. The next bottleneck is storage. There is inadequate warehouse capacity, particularly for drugs which are stored in Central Medical Store, Oshodi. Other logistics issues are: (i) distribution to the last mile remains ad hoc arrangement and not planned along with procurement; (ii) lack of capacity to ensure good recording keeping both at the warehouses (Federal and States) as well as at facility level on actual consumption data, pilferage therefore cannot be totally ruled out; and (iii) States not funding distribution to the last mile (Health Facilities) even when the Federal has distributed to the State stores from the Federal central warehouse. There are internal control mechanisms to guide against expiration of drugs through the use of "First expire first out" while in the central stores and the use of reputable security outfits to monitor the central stores. Also, care is exercised in off-loading and stocking into the stores; appropriate temperatures are maintained for optima storage, including cold chain in the case of vaccines

52. *Stock Control:* The poll system is used to ensure control and optimal supply of commodities. In order to ensure that commodities do not go beyond the reorder level, the reorder policy for commodities at the central store is 16 months, 9 months at State level, 6 months at the LGA and 4 months at the health facility level. Reorder of family planning commodities is guided by Review and Resupply meeting which is held four times in a year. However there is provision for emergency supply if this is necessary and justifiable

53. *Staffing:* The FMOH Procurement Unit is headed by a Director and supported by 13 BPP-certified procurement staff. The Assessment Team was informed by the Head of the Unit that there was not enough capacity to undertake all the procurement work. In order for the current staff to perform optimally, they need much more training, which will be address through the TA component of the Program.

54. *Record Keeping:* For each contract, there is a specific file for procurement and contract management that ensure an audit trail and lend themselves to easy auditing. Each file individually describes the entire history of the procurement process - from invitation for bids up to the contract award. The Procurement Unit implements a manual filing system and all procurement files are kept in metallic locked cabinets in the offices of the procurement staff.

The procurement information can be located and this is protected from unauthorized access. More sensitive documents such as the financial proposals and original bids that are being evaluated, etc. are kept in a secured safe, accessible only to the procurement staff. This practice fulfills the legal requirements of the Public Procurement Act.

55. *Procurement processes:* Major high value procurements of pharmaceutical and medical goods will be carried out through UNICEF and UNFPA. A Memorandum of Understanding will be signed with the two UN Agencies by FGON for these purchases. With regards to other procurements, the national systems will be used. Invariably, however, a significant amount of procurement for health products (immunization, drugs etc.) are acquired from extra-budgetary resources provided by donor partners through direct procurements from UNICEF and related agencies.

D. Assessment of Fraud & Corruption Risks and Mitigation

56. Consistent with OP/BP 9.0, and as part of the Integrated Fiduciary Systems Assessment (IFSA), an assessment was carried out on the existing institutional and oversight systems and practices in Nigeria pertaining to 'Governance and Anticorruption' (GAC) and their applicability to the proposed SOML Program. The assessment examined the proposed design and implementation of the Program using the Governance framework principles of transparency, accountability and participation and whether the existing institutions and processes were able to meet requirements of the "*Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing (February 1, 2012)*. As part of the assessment, the institutions participating in the implementation of the Program and their inter-linkages were examined to draw conclusions on the impact of their governance structure and practices on the objectives of the Program, and how they may well interfere with the effective and efficient service delivery activities foreseen under the Program across different layers of Government in Nigeria. Specifically, the assessment examined the extent to which fraud and corruption can surface during implementation and how these can be mitigated under viable action plans and other mitigating factors. It appears that the Program is exposed to three main risks of fraud and corruption: 1) fraudulent or corrupt procurement transactions; 2) diversion of funds; and; 3) extortion by medical staff from patients in need of medical attention. A recent audit report by the Global Vaccine Alliance (GAVI) of its funding to NPHCDA highlights "*significant weaknesses in the accounting processes"* and internal controls on the use of funds as well as pervasive violation of procurement procedures resulting to questions on whether value for money was indeed obtained. In response, the FMOH and NPHCDA have agreed to strengthen their fiduciary systems. A recent survey also highlights that up to two-fifths of patients' claim that they have had to pay a bribe to medical staff to get needed medical attention. [28]

57. The assessment methodology applied benefitted from dialogue carried out with responsible stakeholder institutions and agencies including the ICPC, EFCC, and the sector-specific anti-corruption units that are all central to the determination of policy, regulatory and/or operational 'fraud and anti-corruption' aspects in Government (namely the Anti-Corruption and Transparency Unit of the Federal Ministry of Health). Specific reference to the laws and

[28] Action Aid, Report of Research into the Relationship between Poverty and Corruption in Nigeria., November 2014, unpublished).

regulations governing fraud and corruption was made to identify the adequacy of these enabling legislations to, at least in principle, serve as instruments of deterrents against governance malpractices. This assessment resulted in the identification of measures and actions in the Program Action Plan that could together support the mitigation framework for improved outcomes during Program implementation.

58. For lack of an objective indicator of corruption, one usually refers to perception of corruption. In this regard, Nigeria fares poorly despite recent progress. Under Transparency International Corruption Perception Index, Nigeria was deemed the most corrupt country in 1997 and ranked 144th in 2013 along with Cameroon and Ukraine among 177 countries, after having reached its best ranking in 2008 (121st out of 180 countries). Although such indicator reflects a general perception of pervasive and unremitting corruption in the country, it does not say much about the effectiveness of the country's anti-corruption institutions and systems. Unfortunately, anti-corruption agencies (including the ICPC and EFCC) do not report publicly on their activity, and statistics on investigations and prosecutions are not available, so that we miss objective data to make such an assessment.

59. According to a recent peer review of the implementation of the UN Convention against Corruption (UNCAC) in Nigeria, that its legal and institutional anti-corruption framework is robust enough[29] while in demand of strengthening on several critical dimensions such as data collection, criminal immunities, protection of witnesses, the independence of anti-corruption agencies from the executive.

60. **The anti-corruption legal framework in Nigeria.** The anti-corruption legal framework rests essentially on the criminal justice system and more specifically on the Corrupt Practices and other related offences Act, 2000, the Economic and Financial Crimes Commission (Establishment) Act, 2004, as well as on the UNCAC, ratified in 2004. Additional pieces of legislation address conflict of interest, promote transparency (asset disclosure and freedom of information) and strengthen the governance of extractive industries (Nigeria Extractive Industries Transparency Initiative Act). Legal provisions relevant to the health sector defined in Corrupt Practices Act as criminally punishable corrupt practices include:

> "*Any public officer who uses his office or position to gratify or confer any corrupt or unfair advantage upon himself or any relation or associate of the public officer or any other public officer shall be guilty of an offence and shall on conviction be liable to imprisonment for five (5) years without option of fine."* This provision extends to sheer solicitation by a public officer of any undue advantage for providing assistance of using one's influence, as well as to an attempted (but not actual) corrupt practices as well as to corrupt practices on behalf of third parties.

61. The Nigerian criminal law also sanctions "*any person who, being employed in the public service, takes, or accepts from any person, for the performance of his duty as such officer, any reward beyond his proper pay and emoluments, or any promise of such reward*". The law punishes both active and passive corruption, i.e. both public officials and the private parties to the transaction – with the definition of public officers under the Corrupt Practices Act extending

[29] UNODC, UNCAC Implementation Review Group, June 11, 2014.

to all elected and non-elected officials, at Federal, State and local levels, in public administrations or State-owned enterprises.

62. With regard to public procurement, the Corrupt Practices Act specifies that:

"*Any public servant who, without lawful authority or reasonable excuse, solicits or accepts any advantage as an inducement to or reward for or otherwise on account of his giving assistance or using influence in, having assistance or used influence in the promotion, execution, or procuring of*

(i) *Any contract with a public body for the performance of any work, the providing of any service, the doing of anything or the supplying of any article, material or substance; or*

(ii) *any sub-contract to perform any work, provide any article, materials or substance required to be performed provided, done or supplied under any contract with a public body; or*

(iii) *The payment of the price, consideration or other moneys stipulated or otherwise provided for in any such contract or sub- contract as aforesaid;* shall be guilty of an offence."[30]

63. The Corrupt Practices Act also sanctions conflict of interests of public officers in charge of financial transactions: "*Any person who, being employed in the public service, knowingly acquires or holds, directly or indirectly, otherwise than as a member of a registered joint stock company consisting of more than twenty (20) persons, a private interest in any contract, agreement or investment emanating from or connected with the department or office in which he is employed or which is made on account of the public service, is guilty of an offence, and shall on conviction be liable to imprisonment for seven (7) years.*"

64. Public officers are also criminally liable for not reporting any unduly offered, promised or granted gratification. Private individuals who have been solicited to pay a bribe to a public officer are also criminally liable for not reporting it to the ICPC or the police.

65. **Asset Disclosure.** all public officers are legally mandated to declare to the Code of Conduct Bureau their assets and liabilities on assumption and term of office, and every four years for permanent employees. Failure of declaration of assets may entail removal from office, disqualification from holding any public office and forfeiture to the State of any property acquired through abuse of office or dishonestly.

66. **The Anti-Corruption Institutional Framework.** The Nigerian anti-corruption institutional framework comprises multiple agencies at the Federal level, loosely coordinated by the President's office (within the Inter-agency task team on anti-corruption[31]). But the weakest

[30] Under the Corrupt Practices Act, also qualify as criminal offences 1) the award or signing of contracts without budget provision, approval and cash backing and 2) the transfer and payment of any sum allocated to a particular project or service to another one.

[31] The IATT comprises of representatives of the Office of the Attorney General of the Federation and Ministry of Justice, the Ministry of Foreign Affairs, the Federal Ministry of Finance, the Economic and Financial Crimes

level rests at the departmental level, with the line ministries' Anti-Corruption and Transparency Units (ACTU) which are the most relevant for the purpose of assessment under the Program. The anti-corruption nodal agency in Nigeria is the Independent Corrupt Practices and Other Related Offences Commission (ICPC) but in practice its jurisdiction overlaps with that of the Economic and Financial Crimes Commission (EFCC).

67. **The Independent Corrupt Practices Commission (ICPC).** Established in 2000 by the corrupt Practices Act, the ICPC has both a repressive and preventive role. It has a membership of 12 seasoned professionals (two from each of the six geopolitical regions of Nigeria) and a chairman (who has to be a magistrate) - all nominated by the President and confirmed by the Senate. Legal provisions ensure the independence and probity of the Commission. For the past three years, the ICPC has refocused on the prevention of corruption in three areas of service delivery: health, education and water supply. In the health sector, it is presently working with the National Primary Health Care Development Agency (NPHCA) on a corruption risk assessment at the level of primary health centers. Its recommendations will be applicable to the implementation of this Program. Allegations of corruption can be conveyed to it by email or by phone and are also conveyed to it indirectly through websites such as BribeNigeria or Egunje (which publishes statistics on the geographical and sectoral distribution of gathered allegations) run by NGOs. Unfortunately, it has not disclosed its activity report since 2009 but it is reputed to reach only few convictions.

68. **The Economic and Financial Crimes Commission (EFCC).** The EFCC (created in 2004) is the nodal agency for anti-money laundering, financing terrorism and other economic and financial crimes. In practice, it also investigates petty corruption. Its role is complementary to that of ICPC and it may be concurrently mobilized for the purpose of this Program. The MoU signed between INT and the EFCC should facilitate the exchange of information for the purpose of investigation.

69. Other agencies also contributing to anti-corruption include: The Public Complaints Commission (established in 1975); **Code of Conduct Bureau (**created in 1990) essentially ensuring compliance by public officers of their legal obligations in the performance of their functions, including asset disclosure.

70. **Anti-Corruption and Transparency Units (ACTU) within Federal Ministries.** ACTUs are the nodal anti-corruption agency at the departmental level. Their creation has been decided by the Head of Services on recommendation from the ICPC. They are responsible for the prevention of corruption and preliminary investigations. They are partly independent from the chief executive officer of department (Permanent Secretary): their chairman is appointed by the Head of Services and cleared by the ICPC; they report on their investigations to the ICPC (with copy for information to the Permanent Secretary). But their budget is still allocated by the

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Commission, the Nigerian Financial Intelligence Unit, the Independent Corrupt Practices and Other Related Offences Commission, the Code of Conduct Bureau, the Public Complaints Commission, the Nigerian Extractive Industry Transparency Initiative, the Technical Unit on Governance and Anti-Corruption Reforms, the Nigerian Police Force, the Federal Inland Revenue Service, the Office of the Auditor General, the Corporate Affairs Commission, the Central Bank of Nigeria, the National Drug Law Enforcement Agency, the Bureau of Public Service Reforms, the Budget Office of the Federation.

ministerial department they belong to, thus impairing their financial independence. The ICPC is reviewing the budget issue of ACTUs while arguing that they should not be conducting full scale investigations by themselves but only collecting intelligence to be conveyed to the ICPC, sole agency in charge of criminal investigations. The role of ACTUs is to serve as the main link between Ministries and Government Agencies on the one hand and the Commission on the other. For the repression of corruption, ACTUs "*receive oral and/or written reports of conspiracy to commit/attempt to commit an offence of corruption and submit both their initial report and their comments to the Secretary of the Commission with copies to the Permanent Secretary/Chief Executive within thirty (30) working days*". At the Federal Ministry of Health, allegations of corruption are mostly conveyed to the ACTU through "*suggestion boxes*" dispatched in the Ministry buildings. This hardly qualifies as a complaints handling system mechanism. As regards prevention, ACTUs "*examine the practices, systems and procedures in the Ministries, Agencies, etc., and where in the opinion of the Unit, such practices, systems or procedures aid or facilitate fraud or corruption, they submit a detailed report with recommendations to the Secretary of the Commission for appropriate action with copies to the Permanent Secretary/Chief Executive.*" Their role extends to training and sensitization of department staff and counterparts (e.g. visitors) on corruption. For the purpose of the Bank Program supporting the SOML, the main structural limitation of the ACTU of the Federal Ministry of Health is that it does not have jurisdiction beyond Federal hospitals, i.e. on primary health care. By their own admission, anti-corruption units in Federal hospital are anyway ineffective for lack of independence from the hospital management.

71. **Anti-Corruption Institutional Framework at the State Level.** The Corrupt Practices Act applies to any State level or local level Government employee and grants the ICPC jurisdiction over all of them. So does the ECPC (Establishment) Act. For the purpose of this Program, an important initiative of the ICPC is its engagement with the National Primary Health Care Development Agency (NPHCDA) to assess and address corruption risks at the level of primary health facilities. Another significant development would be the replication at the States level of **ServiCom** (an acronym for service compact) rolled out at the Federal level since 2004 and which aims at improving service delivery to customers by: monitoring and ensuring performance against a set of service standards, and overseeing adequate handling of citizens' complaints. Under the purview of its director for Reforms Coordination & Service Improvement, the Federal Ministry of Health conducts regular inspections of Federal hospitals to monitor their compliance with ServiCom service standards, including by capturing patients feedback. Despite important limitations (including the lack of a proper management system of health care performance standards), ServiCom can help mitigate the risk of corruption (including through the mandatory displaying in Federal hospitals of medical fees) and handle patients complaints against medical staff corrupt practices (e.g. through the grievance redress mechanism introduced in each Federal hospital). The National Health Council is considering the replication of this initiative at the State level (i.e., across primary health centers). Such a decision would serve well the purpose of the Bank Program to strengthen anti-corruption mechanisms and more generally improve the effectiveness and quality of health services.

72. **Operationalization of the Anti-Corruption Systems in the Bank Program.** Based on this findings of this assessment, it seems that to best mitigate the risks of fraud and corruption under the Program, (1) the legal and institutional country frameworks need be fully

operationalized within the scope of the SOML Program; and (2) the anti-corruption framework along the whole chain of health service delivery, i.e. down to primary health centers, would need to be strengthened. In this regard, (1) the Anti-Corruption and Transparency Unit of the Federal Ministry of Health would need to be operationalized to fully exercise its preventive and repressive mandates; (2) that effective fraud and corruption complaints handling systems need to be further developed, institutionalized and mainstreamed down to the level of the frontline service providers (namely primary health centers) following a defined protocol (ensuring easy access, tracking of treatment of complaints, and reporting on final outcome) to be detailed in the Program action plan; and (3) the existing agreement between INT and the EPCC to be implemented to ensure adequate exchange of information for investigation purpose.

73. Specific requirements for operationalizing effective fraud and anti-corruption functions at each of the defined layers in the health delivery function would be as follows:

- *At the ACTU of the Federal Ministry of Health*: Adequacy in staffing and associated funding - duly empowered as per ICPC guidelines, compliant with instructions from the Head of Services Office (Circular No. OHCSF/MSO/192/94 of 02/10/01) both on its preventive and repressive responsibilities. Its annual report of activities and annual action plan to be submitted to the ICPC would also need to be shared with the Bank to help identify areas for further improvements. In addition, it is noted that the ACTU is also conducting a corruption risk assessment at the level of Federal health facilities (funded by UNDP) which should help it figure how to address risks identified and strengthen the anti-corruption system within the Ministry.

- *At the primary health centers*: The ICPC is conducting a corruption risk assessment with the NPHCDA. Implementation of the recommendations will be incorporated as an action item in the Program action plan.

- *Strengthening, mainstreaming and institutionalizing grievance redress*, either 1) as a stand along fraud and corruption complaints handling system (to be designed and operated under the responsibility of the ACTU of the Federal Ministry of Health) or 2) as part of the proposed deployment of ServiCom (performance monitoring of the quality of service provided by frontline service providers) at the States level offers a unique opportunity to roll out an effective grievance redress mechanism in primary health centers. It would also strengthen the SOML M&E framework and ensure the required capture of citizens' feedback across Bank funded projects. To that effect, the National Health Council, which is considering such development, and the PMU which oversees the implementation of SOML Program at the Federal Ministry of Health, would need to be engaged to mainstream the deployment.

- *Consultation, exchange of information and cooperation between INT and EFCC* as per their MoU to facilitate investigation and help strengthen preventive and risk mitigating measures for the implementation of SOML. This will be formalized in the anti-corruption provisions of the legal documents.

74. Client Commitment: The FMOH is committed to implementing and overseeing the implementation of the Program in accordance with the objectives of the Anti-Corruption Guidelines applicable to PforR operations (ACGs) and has subscribed to the following implementation modalities:

- The FMOH, through the IVA, will provide semi-annual and annual reports to the Bank on all credible allegations of fraud and corruption under the Program, as well as related investigations and actions taken. The Bank will also share information on any allegations or concerns of fraud and corruption with the EFCC and other anti-corruption agencies.

- The FMOH will ensure that any person or entity debarred or suspended by the Bank is not awarded a contract under or otherwise allowed to participate in the Program during the period of such debarment or suspension.

- Bidding documents will serve as one of the key sources of information to bidders and contractors regarding the applicability of the ACGs to the Program. Compliance will be verified and assured through the annual audit of the Program.

- The FMOH will, under the national laws, submit for investigations under the Program, including investigations requested by the Bank, and will keep the Bank abreast of progress and findings of the investigations and ensure that the conclusion of investigations are made public.

E. Program Integrated Fiduciary Risk Assessment

75. The integrated assessment concludes that the SOML Program Integrated Fiduciary Systems have the capabilities to provide reasonable assurance that the financing proceeds under the Program will be used, generally, for intended purposes. The assessment noted the existence of significant gaps and weaknesses in these systems which will need to be addressed in the Program Action plan as part of Program implementation. Key lessons learned in the implementation of the GAVI Program as well as the 'Global Fund to Fight Aids, Tuberculosis and Malaria' – pertaining to the identified major fiduciary issues - have been considered and factored in the design of the Action Plan. There are opportunities to be harnessed, based on prevailing legal framework on anti-corruption that the Program can take advantage of. The existing gaps, though, do have a high potential of elevating the overall risks of the Program to **'**high', thus impacting the expected results against the Program objectives. Based on the findings of the assessment, a Program Action Plan has been developed, and whose implementation would support the mitigation of the risks to a residual level of 'substantial'. Monitoring the implementation of the Action Plan and refining the operational modalities as and when required would be critical to managing the risks during Program life.

F. Program Action Plan

76. The Program Action Plan (see Annex 8) covers the entire spectrum of the integrated fiduciary areas requiring management, monitoring and control under the Program during the period 2015-2019. At quarterly intervals, a monitoring report on the status of implementation of

the actions will need to be provided by the FMOH and discussed at each of the meetings of the Steering and Technical Committees, and strategic and technical directions and guidance provided.

G. Implementation Support

77. The Nigeria Country office has a team of fiduciary staff – Procurement, Financial Management, and Governance – that will, as part of the Program task team, monitor the implementation of the Program's fiduciary aspects, and in particular, the status of implementation of the 'action plan'. This will be carried out not only half-yearly during implementation missions but quarterly, at least for the first year of Program implementation. The team will provide hands-on support to the FMOH teams dealing with procurement, financial management, and to the ACTU at FMOH as well as to other organs (like ServiCom) supporting the mitigation of fraud and corruption at facility levels.

78. In carrying out its implementation support, the Bank team will review the Program's financial reports and their conformance with applicable standards and, at the same time, serve as a first layer reviewer of the planned disbursements against DLIs met at each verification cycle. As regards independent procurement and technical audits, the fiduciary team will review upon their availability and provide the requisite professional and technical guidance in support of actions needed to drive the Program towards achieving its objectives.

Annex 6: Summary Environmental and Social Systems Assessment

A. ESSA Scope and Methodology

1. An Environmental and Social Systems Assessment (ESSA) was undertaken by the Bank team for the Program as per the requirement of the Bank's Operational Policy/Bank Procedure (OP/BP) 9.00. The assessments were carried out through a comprehensive review of relevant Government policies, legislations, institutional roles, Program procedures and an analysis of the extent these are consistent with Bank's OP/ BP 9.00. Further, actions to address gaps to enhance risk mitigation were identified and detailed. The methodology of the ESSA included analysis of information/data on SOML Programs, field reviews, and consultations with all key stakeholders. The Environmental and Social Systems Assessment (ESSA) has been disclosed on March 11, 2015 on the Federal Ministry of Health's website as well as in Infoshop on March 18, 2015.

B. Environmental System

2. The risk screening suggests that the overall environmental impact of the Program is likely to be positive with potentially significant environmental benefits, owing to increasing accountability for results, improved coordination across the health system, as well as strengthening of the health Programs. A strong Program delivery unit will closely track, troubleshoot, and hold accountable Nigeria's health Programs with financial rewards for quality and quantity of services rendered which in turn provides further incentives for improvement, monitoring and higher performance The nature of the Program provides opportunities to enhance the sanitation, hygiene and infection control and waste management systems and processes at the health facilities so as to further promote sound public health outcomes, while also ensuring that there are no adverse impacts to the environment. However, improper occupational practices and unsafe handling of infectious waste was identified, albeit minimally, which has the potential to expose health care workers, waste handlers, patients and the community to infection and injuries.

3. Based on the analysis of the Nigerian regulatory system and previous activities implemented by the FMOH within the WB supported portfolio, the Program is not likely to have significant impacts on natural habitats or create environmental pollution, other than the generation of health care waste (medical waste) which is considered a localized impact

C. Key Findings on the Environmental System

The key findings of the ESSA on the environmental system are:

4. The Legal and Regulatory framework governing the environmental and the health sector is strong in terms of the provisions enlisted for safeguarding the environment. Thus the Program implementing agencies, especially the FMOH operate within a well-defined regulatory system for safeguarding environmental resources and ecologically significant areas from degradation. The system includes protection of environmental resources, excluding activities that are likely to

have significant adverse impacts on eco-sensitive areas, coastal areas and wetlands or degrade the environmental extensively.

5. Generally, Nigeria is considered to have a fairly complete set of environmental regulations and legal instruments even for the SOML Program, however consistent implementation remain a challenge, principally due to weak enforcement; inadequate manpower, etc. Strengthening of capacity of the Federal Ministry of Environment EA Department to supporting the Program will boost the compliance status of the Program.

D. Key Program Actions - Environment

Identified Actions

6. In order to address the identified environmental impacts, risks and gaps the following key actions have been identified:

(i) Exclusion of high risk activities from the Program through early screening, and;
(ii) Strengthening the existing system for environmental management: The Program Action Plan includes an annual assessment of environmental interventions under the Program.

E. Capacity building of sector institutions on Environmental Management

7. The key elements are the Human resources: The human resources to be positioned in the key sector institutions starting from the first year of the Program are:

(i) Key positions to ensure implementation of strengthened environmental rules and procedures for the Program;
(ii) Environment Management Function at the PMU level.

E. Social System

8. The ESSA reveals that the social impact of the Program is likely to be positive- owing to benefits such as improved health and personal hygiene, effective information dissemination, enhanced community participation, creation of accountable arrangements for service delivery and social audits to promote good governance mechanisms. The Program is expected to have significant positive social impact as it will promote improved health outcomes for the citizenry, particularly women and children by strengthening utilization and quality of health care especially for the poorest households in Nigeria. The SOML has a strong focus on poverty and equity which is a key issue in relation to maternal and child health. However, maternal and child health outcomes in Nigeria are poor on average and are especially bad for the poorest two income quintiles. Nevertheless, the PforR shall employ a number of mechanisms to strengthen equity such as Prioritizing Services for Which the Poor are Under-served, prioritizing Primary Health Care Facilities, Greater Support to the North East, North West and Lagging States, Investment Grants to Lagging States, Ensuring Innovation Focuses on the Poor, Rewarding Improvements in Services and Tracking Progress by Income Quintile.

9. Analysis of the Nigerian regulatory system shows that the social management systems in Nigeria are not as well developed as those for Environmental management except in the context of land acquisition and involuntary resettlement, which are not applicable to this Program. However, this lack of targeted social management provides an opportunity for the Federal, State and local Governments and the World Bank via the PforR to establish objectives, systems and management that address the social aspects of health services delivery with the integration and management of social issues within this Program. For effective delivery, FMOH departments, such as the Department of Family Health, which is within the Ministry of Health, could as well as Government agencies, such as the NPHCDA, have specific responsibilities for developing and executing an action plan to address issues of varied demand, social inclusion and equitable access to health services. The PSU could provide technical support.

F. Key Findings on Social Aspects

10. The key findings of the ESSA on social aspects are:

a) Although there are no formal systems or required processes such as an EIA for the social elements of health, Nigeria has formulated, in 1988, a national health policy targeted at achieving quality health care for all Nigerians. As a result of emerging issues and the need to focus on realities and trends, a review of the policy became necessary. The new policy, referred to as the Revised National Health Policy and launched in September 2004, outlined the goals, structure, strategy, and policy direction of the health care delivery system in Nigeria (Federal Ministry of Health, 2004). Roles and responsibilities of different tiers of Government, including nongovernmental organizations, were clearly defined. The policy's overall long-term goal is to provide adequate access to primary, secondary, and tertiary health care services for the entire Nigerian population through a functional referral system [Nigeria Demographic Survey 2013].
b) Although, gender dynamics and women's empowerment are not directly part of the SOML remit, it does have implications for achieving the objectives of increasing uptake of Government health services among poor and disempowered women.

G. Key Program Actions - Social

Key Social Issues identified are:

- Poverty and Equity
- Barriers to Utilization of PHC services

11. Poverty and Equity and Barriers to Utilization of PHC services are directly addressed through the Program design. For example, the PDO Indicator 1 and DLI 1 both focus on increasing utilization of high impact maternal and child health services. Progress towards achieving targets against the PDO Indicator 1 and DLI 1 will be monitored as part of the results framework. Further specific actions needed to enhance the Program's current work and address current gaps related to poverty and equity, and utilization barriers could include:

- Technical support to develop and monitor a stakeholder/community engagement strategy

- Agree on multi-stakeholder consultation framework: a) timeline, b) participating States, c) input to community outreach and MNCH weeks, d) type of stakeholders to be targeted

12. The ESSA highlights opportunities available to Government to strengthen existing environmental and social management systems applied to the Programs supported by the PforR. World Bank Implementation Support (IS) will periodically monitor that no changes have taken place that would reduce the effectiveness of the overall systems as assessed in the ESSA. In addition, World Bank IS will monitor the implementation of the environmental and social assessment outlined in the PAP.

H. Conclusion

13. Overall, the ESSA shows that the Environmental and Social systems are adequate for the Program implementation, with implementation of actions to address the gaps and to enhance performance during implementation with environmental and social risks ranging from low to moderate. Environmental and social inputs to the Program Action plan are included in Annex 8.

Annex 7: Integrated Risk Assessment
Nigeria: Saving One Million Lives

Stage: Approval

<table>
<tr><td colspan="5">1. PROGRAM RISKS</td></tr>
<tr><td>1.1 Technical Risk</td><td colspan="2">Rating:</td><td colspan="2">Substantial</td></tr>
<tr><td>Description :
• Gaming the system by providing inaccurate or falsified outcome data so that certain States receive grants despite limited or no progress on key SOML indicators.

• Shortage of Technical Capacity particularly at State level could interfere with State’s ability to take full advantage of the performance based grants and opportunities for innovation.</td><td colspan="4">Risk Management :
• Verifying the achievement of DLI’s in this Program is done through diverse data sources (including SMART household surveys and health facility surveys building on SDI) which are independent from the implementers. The bodies which are responsible for collecting, aggregating and reporting this data are autonomous and have little vested interest in the outcomes. The DHIS, which is improving but still under the purview of State officials, will not be used in deciding on disbursements to States. Other available surveys such as Nigerian Demographic and Health Survey (NDHS), Multiple Indicator Cluster Survey (MICS) and LSMS will provide useful data by which to triangulate results. Analysis during preparation suggested mechanisms for further strengthening quality assurance under SMART surveys and will be the subject of ongoing discussion during implementation.
• An existing PSU is already providing technical assistance to States and it is envisaged that this service will be further expanded to support States where TA is most needed. The Bank will explore with the FMOH staffing options to ensure continued support for the Program. Other development partners are also providing extensive technical assistance, particularly in the lagging States. The private sector will have opportunities (as part of the operation as well as under the innovation fund established by PHN) to support States as part of the innovation grants. Recognition and reward of individuals at State level is also expected to increase the take-up of available technical assistance.</td></tr>
<tr><td></td><td colspan="4"></td></tr>
<tr><td></td><td>Resp: FMOH and PMU</td><td>Stage: Implementation</td><td>Due Date : Continuous</td><td>Status: Ongoing</td></tr>
</table>

2.2 Fiduciary Risk	**Rating:**	**High**		
Description: While significant progress has been made at the Federal level in terms of strengthening PFM and procurement, there is still substantial work to be done. The Integrated Fiduciary Systems Assessment (IFSA) found that the Program's Integrated Fiduciary Systems have the capabilities to provide reasonable assurance that the financing proceeds will be used for intended purposes with the objective of supporting the achievement of the Program objectives. Nevertheless, the assessment has found that there are a number of weaknesses and risks in the overall fiduciary systems of the Program warranting the design of action plans to counter them. Key risks include: (i) funds may not be used for intended purposes; (ii) the flow of funds may be delayed; (iii) weak internal controls and oversight across Federal and State Agencies; (iv) weak procurement management performance at the Federal and State levels; (v) poor control of stock and distribution of pharmaceuticals; (vi) weakness in compliance with the established legal and institutional framework for combatting fraud and corruption.	**Risk Management:** Fiduciary risks will need to be mitigated progressively before and during the implementation of this Program as articulated in the Program Action Plan. In addition, a disbursement linked indicator (DLI 5) is proposed to incentivize increasing transparency in management and budgeting for PHC at State Level.			
	Resp: FMOH &Bank Task Team	**Stage:** Implementation	**Due Date :**Continuous	**Status:** Program Action Plan has been agreed
2.3 Environmental and Social Risk	**Rating:**	**Moderate**		
Description : • Potential environmental and social	**Risk Management :** A simplified facility-specific waste management plan and an ESMP will be prepared. Having facility specific plans will help the operators to manage the			

impacts are rather small in scope, site specific, not cumulative and relatively easy to remediate. The identified environmental risks are typical of the nature of the SOML pillars. They are manageable, and can be mitigated through strengthening implementation of existing legal/regulatory provisions and Program procedures, sound technical design and operational practice, supported by enhanced capacity. Healthcare waste poses greatest risk amongst the identified risks and experience has proven that when such wastes are properly managed, generally pose no greater risks than that of properly treated municipal or industrial wastes. In addition, the Program might induce and/or lead to the renovation of existing buildings and ancillary infrastructure (such as waste management structures) to accommodate the anticipated increases in utilization. Wastes resulting from such rehabilitation works and injuries to workers are areas of concern that would require management and mitigation to acceptable levels. • The overall social impact of the Program is likely to be positive owing to the potentials to enhance hygiene status of the health facilities, information	identified risk through a step-by-step identification of environmental impacts, the planning of mitigation or preventive measures, and the implementation and monitoring of such measures through Environmental Checklist and screening, Supervisory Checklist monitoring and Health facility survey and independent performance measurement, preparation and review of ToRs, preparation and review of action plans and audits. All these will ensure roles and accountabilities in safeguard compliance. Training Programs will target capacity issues related to the implementation of the environmental and social management plan.			
	Resp: FMOH and Bank Task Team	**Stage:** Implementation	**Due Date :** Continuous	**Status:** Program Action Plan has been agreed

dissemination, and creation of accountable arrangements for service delivery and social audits that promote good governance mechanisms. No land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind under the Program.				
2.4 Disbursement linked indicator risks	**Rating:**	**Substantial**		
Description : **Not achieving results** would lead to slow or limited disbursement and may undermine counterpart commitment.	**Risk Management :** The DLI risk will be managed by carefully defining DLIs, following extensive consultations with key stakeholders and setting realistic targets whose achievement depends *inter alia* on actions directly within the control and influence of Federal and State Governments. Identifying DLI's and setting targets for this Program draws on both Nigerian and global experience with RBF in order to select appropriate, useful, achievable metrics and goals. DLIs are also diversified such that underperformance in one area will not jeopardize all disbursements across the Program. Furthermore, for the State, key indicators are combined into a weighted index such that i) achievements reflect overall health system *improvement* and ii) States with weak improvement in one area can still compete if performance in other areas is strong.			
	RespBank &FMOH	**Stage:** Implementation	**Due Date :** Continuous	**Status:** Under implementation
2.5 Other Risks (Optional)	**Rating:**			
Description :	**Risk Management :**			
	Resp:	**Stage:**	**Due Date :**	**Status:**
3. OVERALL RISK RATING				
		Substantial		

Legend: L – Low M – Moderate S – Substantial H – High

Annex 8: Program Action Plan

Action Description	Due Date	Responsible Party	Completion Measurement**
1. Prepare standardized template for financial reporting and pilot and roll-out at facilities.	Within 18 months of Effective Date	FMOH	Annual reports on facility sources and uses of funds published conspicuously at facility level.
2. Publish annual consolidated PHC expenditure report for the State based on 3 economic classifications: compensation; goods & services; investments.	Within 6 months of end of each FY	Respective State Ministry of Health	Consolidated PHC expenditure report published on State Government website
3. Annual Federal level budget execution report prepared at the economic (object) classification level for PHC sub-function (SOML-focused).	Within 6 months of end of each FY	FMOH	Federal budget execution report.
4. PMU in the FMOH has at least 1 financial management staff that focus on SOML management, monitoring, and reporting.	Ongoing	FMOH	Staff with requisite skills are working full time in the PMU.
5. Internal audit units in FMOH assign internal auditors for ex-poste systemic and risk-based audits of the Program and report quarterly to permanent secretary, FMOH after capacity strengthening in risk-based internal audits.	Within 12 months of Effective Date	FMOH	Quarterly internal audit reports.
6. Procurement plans for SOML related activities to be prepared by FMOH and approved by minister or permanent secretary, FMOH.	Within 3 months of the start of each FY	FMOH	Procurement plans with approval by appropriate authority.
7. Capacity building on procurement procedures and contract management conducted annually.	Ongoing	FMOH	Attendance sheets, increased use of BPP standard templates.
8. In accordance with 2007 Procurement Act an independent procurement audit will be conducted on random sample of at least 5% of transactions under the SOML Program.	Within 12 months of end of each FY	FMOH	Procurement audit report

Action Description	Due Date	Responsible Party	Completion Measurement**
9. Fraud and corruption complaints redress - Formal policy and procedural guidance prepared and approved as applicable to the Program.	Within 12 months of Effective Date	FMOH (supported by ICPC and EFCC)	Documented policy & procedures, with assigned responsibilities and oversight.
10. Strengthen capacity of ACTU network to deliver on mandate – assign full time staff with mandate and resources and build on the risk assessment at the level of primary health centers led by the ICPC.	Within 12 months of Effective Date	FMOH	Additional full time staff assigned to ACTU and resources budgeted in FMOH annual budgets. Preventive measures to be agreed on based on the findings of the risk assessment.
11. Undertake an expenditure tracking survey, focusing on financial and commodity flows that are critical to SOML results.	Within 12 months of Effective Date	FMOH	Completed report with recommendations about recording & reporting at facility level.
12. Establish communication strategy for stakeholder engagement.	Within 12 months of Effective Date	FMOH	Plan to inform stakeholders on SOML PforR and the results achieved.
13. Capacity building for FMOH staff and other health workers on health care waste management and equity issues.	Ongoing	FMOH	Attendance sheets
14. Carry out annual assessment of progress on environmental and social issues.	Within 12 months of end of each FY	FMOH	Report on progress related to health care waste management and equity issues.
15. Timely transfer of Financing proceeds to States through Government processes for results achieved by the States under DLIs 1, 2, 3, and 5.	Within 30 days of receipt of Financing proceeds from the Association for corresponding results	FMOF	

Annex 9: Implementation Support Plan

1. **The Bank will partner with the Federal Government and development partners to provide implementation support to the various agents of Government at the Federal and State level in the implementation of SOML**. The aims of the technical and fiduciary support are to strengthen performance management and instill the culture of results-monitoring; improve equity; enhance administrative efficiency and reduce fraud and corruption. Furthermore, implementation support will focus on timely implementation of agreed Program action plan, including the conduct of SMART surveys, health facility surveys, prompt disbursement of earnings against the DLIs achievements and management of the public and private innovation funds. Lastly implementation support will also be targeted towards strengthening institutions saddled with responsibilities for key aspects of the project such as the State Primary Health Care Development Agencies (SPHCDA), National Bureau of Statistics, the Program Management Unit, Program Delivery Unit, National Primary Health Care Agency (NPHCDA) and Private Sector Health Alliance. The Bank implementation support team will consist of technical; fiduciary; environmental and social; and fraud and corruption specialists. The Bank will be working with other key stakeholders and partners supporting these initiatives. The task team will be primarily responsible for:

(i) Technical (Including M&E): (i) Ensuring the conduct of SMART survey and health facility survey with standard quality assurance. Providing technical support for performance management and building capacities for DLI monitoring and verification protocols; implementation of performance appraisal systems; (ii) Monitoring timely payment for DLIs achieved; and ensuring the process is fair and transparent. (iii) Providing regular oversight over the implementation of the innovation fund both in the private and public sectors. (iv) Providing technical support and capacity strengthening to the various implementation agencies. (v) Lastly, engaging in a sector dialogue with Government through the monitoring of the Results Framework and the DLIs

(ii) Environmental and social: Providing technical support to NPHCDA/SPHCDAs and FMOH to guide States in implementing health care waste management plan and innovative strategies to improve delivery and use of essential maternal health services by underserved populations and geopolitical zones requiring special attention especially North West and North East ones.

(iii) Fraud and corruption: Monitor the implementation of the agreed fraud and anti-corruption measures under the Program and provide guidance in resolving any emerging issues;

(iv) Procurement: (i) support NPHCDA, FMOH and similar State organs in finalization of procurement manual and Standard Bidding documents; (ii) provide inputs to capacity building of NPHCDA, and MOH Procurement Units; and (iii) monitor implementation of agreed risk mitigation measures;

(v) Financial Management: Support development of action plans based on audit reports and help capacity building of NPHCDA and FMOH finance and Internal Audit department in ensuring timely reporting and effective oversight through risk based audits.;

2. **Most of the implementation support team members work from the Abuja therefore there will be occasional face to face interactions with the officials of Government in the PMU, PSU, NPHCDA and the larger FMOH.** Otherwise some of the support activities will be done 'virtually'. In particular the following activities will purposely be used to provide implementation support for SOML: Program launch and orientation workshop; semi-annual reviews and supervision missions, additional supervision activities and stakeholders' workshops; annual reviews; and mid-term review.

3. **Program launch and orientation workshop:** The Program launch provides a unique opportunity for publicity and provision of information on the operation to a broad stakeholder group. This event will target State Governors, Ministers, parliamentarians, high level Government officials from the Ministries of Finance and Health at Federal and State level; National Planning Commission and other Government agencies. The launch will be immediately followed by a three day orientation workshop for technical staff of all agencies involved in the operation at Federal and State level. The orientation workshop is critical as it sets the tone for providing information on the project to key teach people and it will spell out the principles of Program for results, emphasis the paradigm shift and lay out expectations.

4. **Semi-Annual Supervision Missions -** The Bank team will be in constant contact with Federal and State stakeholders providing timely assistance and monitoring progress on a 'virtual' basis. Formal missions will be carried out twice a year (with regular and detailed Implementation Status Report/Aide Memoir reporting). The process will include a technical review workshop at the commencement of the mission, visits to key Federal agencies and some States especially good and poor performing States to engender learning. The overall objective is to monitor implementation progress and to verify that operational, management and policy responsibilities are met. It will focus on service delivery and reforms.

5. **The annual reviews will be conducted jointly with Federal Government of Nigeria including FMOF, FMOH and NPHCDA under the umbrella of the Federal PSC** and follow the close of the calendar/fiscal year sometime between January and March. Annual reviews would be carried out for a more comprehensive and in-depth stock-taking of progress towards achieving the project performance indicators and overall PDO during the previous year, and evaluating performance on the DLIs. Reports from the semi-annual supervision missions will feed into the annual review and the focus will be on policy dialogue. A Joint Annual Report will be produced from the proceedings and a status of the performance indicators.

6. **Additional Supervision Activities and Stakeholder Participation Workshops:** Field visits to hospitals and other health facilities, encompassing both secondary hospitals and primary health facilities, will be carried out by joint teams comprising FMOF, FMOH, NPHCDA, SPHCDA staff and World Bank representatives. Secondly at least once a year the participating States will be brought to the table to discuss the progress of the operation.

7. **Overall, issues identified in the technical work and field visits will form the agenda of a high level Policy Dialogue** between the Bank, FGN and States under the aegis of the Project Steering Committee. Key objectives of the Policy Dialogue will be as follows:

- To discuss key findings and recommendations proposed by the Supervision Mission;
- To discuss FGN's official comments on the above;
- To prioritize SOML Issues; and
- To agree on Proposed Actions required moving the SOML forward.

8. **A Mid-Term Review** will be scheduled for midway through the operation. The purpose is to evaluate overall performance of SOML against targets, appraise the DLIs and their effectiveness and identify emerging issues. As part of the exercise, dissemination of the results will be undertaken to key stakeholders inside and outside the Government.

Main focus of Implementation Support

Time	***Focus***	***Skills Needed***	***Resource Estimate***	***Partner Role***
First twelve months	Design and implementation of SMART surveys and household survey including quality assurance Development of State Performance Scorecards and consensus building	*Monitoring and Evaluation* *Data management* *Technical*	*500*	*Support from to Gates Foundation to PSU for State Scorecards* *Support from UNICEF SMART Surveys*
12-48 months	Timely implementation of action plan and surveys Prompt disbursement against DLI achievements Monitoring of procurement, financial management and environmental and social and fraud and corruption action plans	*Fiduciary* *Social and Environmental* *Technical* *Hands on M&E -PSU*	*400 each year*	*Support from Gates, UNICEF and academic institutions*
Other				

Task Team Skills Mix Requirements for Implementation Support

Skills Needed	***Number of Staff Weeks***	***Number of Trips***	***Comments***
Task Team Leader	*36*		*Country Based*
Technical Consultant	*20*		*Country based*
M&E Consultant	*8*	*3*	*Consultant familiar with household and health facility surveys*
Financial management	*3*		*Country based/region*

Procurement	*3*		*Country based/region*
Environment	*3*		*Country based/region*
Social	*3*		*Country based/region*
Fraud and corruption	*3*		*Country based/region*
Results based Financing	*4*		*Country based/region*

Role of Partners in Program implementation (template)

Name	***Institution/Country***	***Role***
BMGF	*USA*	*Support for Scorecard approach and health facility survey*
USAID – IFC MACRO	*USA*	*DHS*
UNICEF	*Nigeria*	*SMART survey*