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CONCEPT STAGE

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Concept Review Decision	

I. Introduction and Context

Country Context

1. **While some progress has been registered towards the MDGs, slow poverty reduction is reflected in Nigeria's challenges to meet some MDGs by 2015, particularly MDGs 1C, 4 and 5.** 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)[1] demonstrates a 36% decline during this period in the under-5 mortality rate (U5MR) and a 31% decline in the infant mortality rate. However, the country is still not on track to achieve Millennium Development Goal 4 (MDG4). There has been almost no progress on reducing fertility. Childhood malnutrition has actually worsened by some measures (low weight for age has increased by 21% and wasting has increased 64%) and improved only modestly (12%) in terms of stunting (low height for age).

2. **Limited Progress on Health Service Delivery in the Last Decade:** The limited progress on Health, Nutrition and Population (HNP) outcomes over the last decade is consistent with the picture in service delivery. Vaccination coverage and use of insecticide treated nets (ITNs) have improved but remain unacceptably low. More worrying, coverage of family planning and antenatal care have stagnated at low levels, while other services such as skilled birth attendance, have declined. The lack of progress in the latter militates against achieving the Millennium Development Goal 5 (MDG5). Compounding the issue of limited coverage, the quality of services is also poor. Preliminary 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.

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

3. **Increasing Wealth is NOT Translating into Improved Health:** The vibrant economic growth Nigeria has enjoyed over the last decade has not translated into strong progress on Health, Nutrition and Population (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, both economic and geographic. The poorest two quintiles suffer from similarly poor Health, Nutrition and Population (HNP) outcomes with greater than a one in five chance of dying before their fifth birthday. The ratio of the poorest to richest quintiles varies from 2 to 3.5, significantly higher than the West African average. Differentials in access to health services by income quintile are extreme.

4. **Geographical Inequity – The Northeast and Northwest lag far behind:** In addition to income inequality, there are also important geographical inequities. The U5MR is 2.5 times higher in the North East compared to the South West (222/1000 and 89/1000 respectively according to the 2008 NDHS) and service delivery is also far behind. For example, immunization coverage (DPT3/Penta3) is 14% and 21% in the Northwest and Northeast respectively compared to 70% in the South - South and 80% in the Southeast (NDHS 2013).

5. **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) Nigeria will likely capture little of the kind of "demographic dividend" that was so beneficial to the East Asian ("Tiger") economies[2] where it may have contributed a third of GDP growth;
(ii) Human capital formation is being adversely affected resulting in lost IQ and an inability to take full advantage of educational opportunities;
(iii) Preventing people from escaping poverty and driving them deeper into debt. Serious illnesses have often occasioned 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.

6. **SOML 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. Saving One Million Lives (SOML) is meant to improve HNP 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. The FGON's program document stresses that SOML represents "***a shift in focus from inputs to focusing on results and outcomes***." The premise for SOML is that "***bold innovations and changes in the approach to delivery in the sector are necessary*** (emphasis added)**.**"

Sectoral & Institutional Context

[2] 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

7. **Lack of Progress in Nigeria is NOT Explained by:** (i) ***lack of funding:*** while public expenditure on health is relatively low compared to GDP and total budget, funding alone appears to have minimal influence on service delivery. There is no correlation between state level expenditures in health and health outputs such as skilled birth attendance; (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) l***ack of infrastructure:*** 67% of the population live within 30 minutes' walk of a health facility, 85% 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 in neighboring countries and many health facilities are actually over-staffed.

8. **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.[3] According to the constitution, the delivery of primary health care (PHC) services is under the purview of local governments, although local government areas (LGA's) often spend little on health services. In practice many of the staff working in the LGAs are paid by the State governments which also provide resources for many of the inputs. The FGON, in theory, has responsibility for tertiary health services and providing strategic direction for the HNP sector. However, it is estimated that FGON contributes about half of all the funding for PHC, largely through in-kind commodities and technical assistance. In addition, the FGON has a number of special schemes to support PHC. These include: (i) the Midwife Service Scheme (MSS) which pays the salaries and support costs for the deployment of 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.

9. **Accountability mechanisms are weak.** Because responsibility is vague and funding comes from diverse sources, managers at all levels are rarely held accountable for results. Since all public sector managers and health workers are paid a salary, there are few incentives for good performance and almost no sanctions for poor performance. Actual results are rarely discussed in detail and there is very little data is publicly disclosed. There is little interaction with the community despite the existence of Ward or Village Development Committees. This translates into weak incentive structures and extensive health worker absenteeism (30% on the day of the last SDI survey).

10. **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. Robust household surveys, such as the DHS, are carried out much less frequently than in other large low income countries. The routine health management information system, known as the District Health Information System (DHIS) is benefiting from significant attention but still has shortcomings including: (i) reporting rates below 50%

[3] 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

(ii) unreliable accuracy and (iii) as with any public facility-based information system, an inability to capture data from the private sector, measure equity, or capture important health behaviors (such as ITN use, contraceptive prevalence, and care-seeking for sick children). The Bank-supported SDI Survey has been the first widespread effort to capture information on the functioning of health facilities, particularly quality of care, not limited to a particular vertical intervention. Failure to strengthen M&E will hobble efforts to improve service delivery in Nigeria.

11. **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. About 60% of children with fever are treated by private providers (National Health Accounts 2008), while 43% of skilled birth attendance and 75% of family planning services are provided by the private sector (DHS 2008). 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 strengthening links with private providers.

12. **Health Care Financing is Mostly out of Pocket and Public Expenditure is Likely to Increase Slowly:** 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 survey 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 and represents less than 2% of GDP. With the re-basing of the GDP, public expenditure on health may be as low as 1 or 1.2% of GDP; (iii) public expenditure is inefficient, partly because there is little non-salary recurrent budget; (iv) as described above, public expenditure is NOT correlated with actual results in Nigeria; (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 (for example the passage of the "Health Bill" by the Senate). However, the Government's heavy dependence on oil (which accounts for about 75% of its revenues), makes it unlikely that overall public revenues will increase 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 $1-$2 per capita per year.

13. **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 two and a half years ago. Under PBF, individual health facilities (both public and private) are provided cash rewards 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. The results with PBF have been gratifying with large improvements seen on most indicators including those, like institutional delivery, which usually change only slowly. The approach is now being scaled up. The cost of PBF has been modest, about $1 per capita per year, meaning that

it has leveraged existing investments. The success of PBF up until now suggests that approaches that address incentive issues, have clear goals, carefully measure progress towards goals, hold people accountable for results, and involve bold innovations may be required.

14. **Other Innovations that Hold People Accountable for Measurable Results have also Worked:** A few other recent innovations also appear to have been successful in improving performance. The Bill and Melinda Gates Foundation (BMGF) put in place a "Polio Challenge" that created competition among states based on success in routine immunization and polio eradication. The general view is that for a relatively small prize ($500,000) the challenge fostered very useful competition that had a discernable impact on polio eradication activities. The Government itself used funds from SURE-P to introduce a conditional cash transfer (CCT) for mothers who access antenatal care, skilled birth assistance, and post-natal care. There is an ongoing impact evaluation of this CCT but the initial experience appears quite positive. There has also been positive results from a voluntary health insurance scheme in Kwara State where public subsidies provide patients with choice of provider and appear to have significantly improved the quality of care.

15. **The SOML Program Focuses on Cost-Effective and Proven Interventions:** SOML builds on the President's Transformation Agenda and the National Strategic Health Development Plan (NHSDP) 2010 to 2015. It gives renewed priority to a package of high impact, evidence-based, cost-effective health interventions: (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; 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 includes two "enablers": (i) promoting innovation and the use of information and communications technology; and (ii) improving the supply and distribution chain.

16. **What's new about SOML?** Given its focus on existing government programs, it is reasonable to ask what is new about SOML. The program involves: (i) re-orienting the discussion of service delivery to results rather than 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 "pillars" are priorities for resources and attention; (iii) establishing a limited set of clear and measurable indicators by which to track success encapsulated in a carefully considered SOML "scorecard"; (iv) strengthening data collection so that these indicators can be measured more frequently and more robustly, allowing the scorecard to be populated with reasonably accurate information; (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.

Relationship to CAS/CPS

17. **The proposed operation is fully aligned with the Country Partnership Strategy FY2014-FY2017:** 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 also aligns nicely with the third strategic cluster which seeks to improve governance and public sector management. 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.

18. **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 precede, rather than follow, economic take-off.

Rationale for Bank Engagement and Choice of Financing Instrument

19. **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 would include:

(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 two years of helping the country implement performance-based financing (PBF) in three LGAs in Ondo, Nasarawa, and Adamawa;

(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.

20. **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 PforR approaches (such as DLIs) implemented through the NSHIP.

21. **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 Development Objective(s)

22. The PDO for this operation would thus be: Equitably increase utilization of quality, cost-effective reproductive and child health interventions.

A. Key Program Results

23. The PDO indicators for this operation are listed below. The first three indicators will be tracked by income quintile to determine whether the poorest 40% 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 vaccination coverage (fully immunized) among young children;

(ii) Increase the contraceptive prevalence rate (modern methods);

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

(iv) Increase the coverage of skilled birth attendance; and

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

III. Program Description

24. **Strengthening Governance by Paying for Results, Encouraging Innovation, and Increasing Accountability:** Nigeria has made little progress in the health sector over the last decade with serious economic and development consequences. Simple solutions focused on improving inputs have not worked in the past. This has been recognized by the Government which is why the SOML initiative provides an opportunity to change the game and boldly address governance issues. These issues have plagued the HNP sector and other sectors as

well. This PforR operation supports SOML and ensures a focus on results, increases accountability, improves measurement, and encourages 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 health.

25. T**he Bank's Support for SOML will be located at the Federal Level:** 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. The program will also help strengthen other stewardship functions of the federal government such as: (i) collecting, analyzing, disseminating data and helping states use the information; (ii) setting technical standards, establishing protocols; and (iii) providing technical guidance to States and service providers. Initial discussions with the Government have indicated that disbursement to the FGON is their preferred option with subsequent provision of performance-based grants to the States. The Bank will ensure that the grants are based on objective indicators of performance.

26. **Delineation of the PforR Support – Federal Ministry of Health:** As indicated above, SOML is a federal government program. It aims to strengthen six existing intervention areas, called "pillars" that comprise: (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 prevention of mother to child transmission of HIV. The proposed PforR will support that portion of the Federal Government's expenditure on SOML that is accounted for by the Federal Ministry of Health (FMOH). The reason for focusing on FMOH expenditures is that it would support the type of conditional grants to subnational governments that can help strengthen performance. The FMOH is also the primary advocate for SOML. In addition, FMOH expenditures are the most predictable and will continue during the entire life of the proposed operation. The MDG Fund also supports SOML but its funding is designed to finish by the end of 2015. SURE-P also provides financing for SOML but the length and extent of its financing is uncertain.

27. **Estimates of Annual Expenditures on Inputs for SOML**: Obtaining estimates of current FMOH expenditure on SOML is complicated by the nature of funding and difficulties in allocating common resources among different vertical programs, some of which are not included in SOML. It is fortuitous that there has recently been an independent analysis of Federal Government expenditures on SOML, likely financing requirements, and financing gaps within SOML.[4] This analysis substantially understates total expenditures on SOML as it focused on inputs purchased by FMOH and did not consider salary and other costs. It estimates that FMOH spent about $123 million of its own funds in 2013 on inputs for SOML, of which more than half represented contributions for immunization, both routine immunization and polio eradication. The immunization investments comprised payments to UNICEF to procure $27.1 million worth of oral polio vaccine and $36.9 million "counterpart" contributions to GAVI for new vaccines.

[4] Spending to Save: Challenges and opportunities for financing Nigeria's Saving One Million Lives initiative, Draft May 2014

28. **Program Expenditure Framework for SOML:** The Program document developed by the FMOH in 2012 highlights six pillars and their estimated requirements until 2015. More recent analysis (see Footnote 4) extends the analysis until 2017. IDA support for the Program focusses on the subset of expenditures by the FMOH in support of SOML and will extend from 2015 to 2019 (the FGON is considering the extension of SOML beyond 2015). Overall, the IDA's contribution to program financing is limited to US$305 million equivalent which likely represents about 30 per cent of FMOH expenditure during the life of the operation. It's important to realize that the financing gaps in the table below represent estimates that likely under-estimate financing in the outer years.

SOML Program of Expenditure - Estimates

No.	***Program Area***	***Estimated Requiremenst 2014-2017(US$m)*** [a]	***Range of Likely Financing Gaps as % of requirements***	***Estimated Government Expenditure (US$m)2014-17*** [a]
1	Improve Malaria Control	1,581	62-93%	36
2.	Improving Maternal, New Born and Child Health	637	30-65%	341
3.	Elimination of Mother-Child Transmission of HIV	378	61-98%	16
4.	Essential medicines and commodities	278	35%	31
5.	Improving routine immunization coverage and achieving polio eradication	628	55-62%	218
6.	Improving childhood nutrition	589	29-47%	40
	Total	4,091		682

[a] Estimates for Essential Medicines and Immunization (No. 4 and 5) are only for 2014-15
Source: See Footnote 4

29. **Disbursement-Linked Indicators (DLIs):** The proposed PforR will provide funds to the FGON based on a set of 6 DLIs summarized in the table below:

Indicative DLI Matrix

Disbursement Linked Indicator	Means of Verification	Indicative Allocation ($M)	% of Total
1. Performance-based grants to States - Quantity. Best performing States per geopolitical zone receive grants from Federal Government based on improvements on 6 key indicators (Penta3 vaccination, ITN use, :CPR, skilled birth attendance, PMTCT, and Vitamin A coverage)	SMART Surveys & independent verification for PMTCT	$125M	42%
2. Performance based grants to States - Quality Best performing states per geopolitical zone receive grants from Federal Government based on quality of care index	Health Facility Surveys	$40M	13%
3. Encourage results-focused innovations: Establishment of a competitive process that would fund results-based innovations in health service delivery that are directly linked to improving health outputs or outcomes for beneficiaries.	Third party verification	$60M	20%
4. Improving Data Collection and Accuracy: Expanding SMART surveys to all 36+1 states, introducing annual health facility surveys, deploying DHIS verification mechanism, strengthening demographic surveillance tp provide annual estimates of key outcome measures.	Review of data collection instruments by FMOH & Bank task team	$35M	12%
5. Strengthening Accountability Mechanisms: Widely disseminate SOML results, regularly analyze state level results to facilitate benchmarking; and discuss progress on key indicators at national annual review.	Review by FMOH & Bank task team	$15M	5%
6. Enhanced MNCH Weeks: Enhanced MNCH weeks implemented twice a year with increased coverage	SMART surveys	25M	8%
TOTAL		**$300M**	**100%**

30. **Performance-based Grants to States - Quantity:** Based on the strategic focus of SOML and the NHSDP, the operation will encourage increases in the coverage of high impact interventions where progress has been modest. The FGON will provide performance grants to states based on improvements on six key indicators: (i) immunization coverage (Pentavalent3); (ii) insecticide-treated net (ITN) use by children under 5; (iii) proportion of HIV positive mothers who receive ARV to prevent mother-to-child transmission (PMTCT); (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage. 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.

31. The best performing state (i.e. the one with the largest improvements from their previous highest coverage) within each geopolitical zone would receive a performance grant, except for the Northeast and the Northwest where the 2 top performing states will receive a performance grant. The grant will be based on overall performance on all 6 indicators to encourage health system strengthening broadly, not just a focus on individual vertical programs. Performance on these 6 indicators will be judged annually based on household surveys conducted by National Bureau of Statistics (SMART surveys), except in the case of PMTCT where an independent verification mechanism will be developed.

32. **Performance-based Grants to States – Quality:** Building on SOML's commitment to improving the quality of care, the FGON will provide performance grants to states based on the quality of service provision at primary health care level. This will be judged by annual health facility surveys that will build on the experience with SDI. Quality of care will be defined broadly to include, diagnostic accuracy, adherence to guidelines, ability to manage maternal and newborn complications as well as availability of drugs and minimum equipment. As with the grants for improved coverage, the quality grants will be provided to the best performing state within each geopolitical zone except for the Northeast and the Northwest where the 2 top performing states will receive a performance grant.

33. **Encouraging Results-Focused Innovations – Partnerships with the Private Sector:** SOML is explicit in its desire to foment bold innovations to strengthen both the quantity and quality health services. Thus the FGON will develop an innovation fund that, through a competitive process, would finance results-based innovations in health service delivery. The nature of the process will encourage public-private partnerships. Any entity, whether private of public, may put forward proposals for an innovation where payments are directly linked to improving health outputs or outcomes for beneficiaries at a reasonable cost. Proposals would have to demonstrate buy-in from the concerned State but also have significant private sector involvement. The proposals would be judged according to a set of agreed criteria such as: clear description of the innovation, results focus, clarity and rigor of results measurement, proportion of funds that would go to private sector providers, buy-in from the state, equity, credibility of the proposer, efficiency (low cost per capita), and scalability of the approach. These criteria will be judged by an independent panel. The ten best proposals (highest scoring and meeting a minimum score) including at least one per geopolitical zone and two from the Northeast and Northwest, would receive funding for their innovations over 3 years. Disbursements would be based on achieving agreed milestones in implementation of the innovation such as actual performance payments made to providers. A second round of request for proposals would use the same approach in the second year of the operation.

34. **Menu of Options:** Without limiting the scope for innovation excessively, it is expected that proposals would choose from a menu of options that would include: (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) 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); (iii) 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% of the public subsidy goes to the bottom two income quintiles; (iv) conditional cash transfers (CCTs) for women and children accessing SOML interventions; (v) a voucher scheme, say for skilled birth attendance in the private or public sector; and (vi) contracting-in managers for remote or poorly performing LGAs.

35. **Strengthening Data Collection:** The Government is strongly committed to strengthening data collection which it has explicitly described as an essential aspect of SOML. For example, it pushed development partners to expand SMART from 11 to 24 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.

The Government will expand the existing SMART surveys to all 36+1 states, slightly expand its scope to capture data on key elements of the SOML scorecard, and further strengthen its quality assurance. As a means of tracking quality of care and better understanding performance at the level of service delivery, the Government will institutionalize health facility surveys so they are carried out annually. These health facility surveys will build on the experience with the SDI and other surveys and provide data that is robust at state level. As the District Health Information System (DHIS) is being rolled out, a robust and independent system for verification of the DHIS will be developed that involves actual visits to a sample of health facilities in each state. Given its size and diversity, Nigeria will benefit from bolstering its demographic surveillance system so that it can get near-real time information on key outcomes such as under 5 mortality rate, maternal mortality ratio, and total fertility rate. A strengthened demographic surveillance system would provide important information on how many lives are being saved.

36. **Strengthening Mechanisms for Accountability:** SOML represents a commitment to strengthen accountability mechanisms for results, thus the operation will support: (i) the widespread publication and dissemination of results on the key SOML indicators as gathered by the improved data collection system; (ii) regular (at least semi-annual) reviews of results from the SMART and health facility surveys and the DHIS with individual states (likely by zone) that facilitates benchmarking and sharing of ideas; and (iii) an annual review at national level of progress by state.

37. **Enhanced MNCH Weeks:** The Federal Government has worked with the States to implement maternal, neonatal, and child health (MNCH) weeks which try to mobilize communities to come to health facilities as a means of increasing the coverage of simple interventions such as immunization, Vitamin A supplementation, and de-worming. While the approach is attractive the consensus is that MNCH weeks have not fulfilled their potential. To strengthen their implementation the FGON will work with the States to: (i) carry out a detailed review and analysis of MNCH weeks in coordination with diverse stakeholders; (ii) make the content of the MNCH-weeks more standardized and based on considerations of cost-effectiveness; (iii) use the SMART surveys to judge their success; (iv) increase State funding (actual expenditures) for the MNCH weeks; and (v) substantially increase the coverage of the MNCH weeks.

38. **Addressing Equity Issues:** This operation addresses equity issues in a few different ways: (i) it 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 ten times higher than among the poorest income quintile; (ii) careful measurement of progress by income quintile so as to facilitate tracking of improvements in the poorest 40% of the population; (iii) providing additional performance grants to the Northeastern and Northwestern geopolitical zones where the coverage of key SOML services is the lowest and health outcomes the worst; (iv) working with the Government and development partners to ensure greater amounts of technical assistance in the Northeast and Northwest to take advantage of the opportunities provided by this operation; and (v) focusing on improvements in coverage of services rather than absolute levels. This gives poorly performing states more opportunity to gain performance grants because they are starting at lower levels of coverage and making improvements should be proportionately easier.

39. **Implementation Arrangements:** The SOML Program is under the supervision of a steering committee, chaired by the Honorable Minister of Health. It is the same steering committee which provides oversight for the NSHIP. The SOML Program is centered in the FMOH and the current program manager is from Department of Family Health. Coordination at Federal level is carried out by the SOML PforR Core Team which comprises representatives from various parts of the FMOH including Department of Family Health, National Primary Health Care Development Agency (NPHCDA), Department of Planning and Statistics, and the SOML Program Delivery Unit (PDU). The PDU was established in early 2013 and is supported by the FMOH and the Bill and Melinda Gates Foundation. Its responsibilities including providing technical advice to the FGON and supporting states in all aspects of the implementation of SOML. It will play a key role in monitoring progress on SOML indicators.

IV. Initial Environmental and Social Screening

40. To address Environmental and Social issues as they relate to SOML, under the proposed PforR operation in a manner consistent with Operational Policy/Bank Procedure (OP/BP) 9.00, *Program for Results Financing*, it will be necessary to prepare an Environmental and Social Systems Assessment (ESSA).

41.The SOML is not expected to involve any civil works including rehabilitation of buildings. Potential adverse environmental and social impacts are expected to be minor, site specific, non-cumulative and relatively easy to mitigate. Accordingly, in terms of Environmental Assessment, the program would be categorized as B. The program triggers World Bank safeguards Policy OP 4.01 on Environmental Assessment as program related activities would generate health care wastes.

42. An initial environmental risk screening conducted suggests that the overall environmental impact of the Program is likely to be positive 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. As a performance driven activity, the program provides financial rewards for quality and quantity of services rendered which in turn provides further incentives for improvement, monitoring and higher performance.

43. **Issues**: Currently, systems for the management of hospital waste are poorly developed at all levels. This is due to low capacity/general lack of understanding of environmental health issues by the facility operators, minor rearrangement/renovation of the existing stores for the health care commodities storage and no consistent waste disposal practices such as segregation of hospital waste, burial pits are not built according to accepted standards, and waste is burned in the open in some cases. A study on waste management practices conducted during the preparation of the Nigeria: HIV/AIDS Medical Waste Management Plan (2008) found the following problems with current medical waste management practices at health facilities in Nigeria: (i) lack of waste generation data; (ii) inadequate waste treatment and disposal equipment; (iii) inadequate knowledge of waste management practices among health workers and community members; and (iv) lack of code of conduct and technical guidelines for proper waste management, resulting in poor practices at health facilities and dumpsites

44. The study identified a need for (i) strict enforcement of existing provisions; (ii) capacity building of health care workers at all levels; (iii) creation of greater awareness in communities of the need for and importance of proper management of medical wastes; and (iv) the establishment of a better environmental management system.

45. **The risks**: occupational and public health safety and environmental pollution. Improper and unsafe health care waste management (HCWM) practices put at risk healthcare workers, patients, and communities at large who are exposed to nosocomial infections both within Health Facilities (HFs) and the surrounding communities.

46. Although a well-defined Environmental Assessment legal system (EIA Act, Cap EI2LFN2004) for safeguarding the environmental aspect of the program exists as well as guidelines and policy/plan on health care waste management such as draft national policy and Healthcare Waste Management Plan For the Nigeria State Health Programmatic Investment Credit (2011), the operators, especially at facility levels do not seem to be aware of these hence inadequate waste management and thus poor implementation or utilization of the instruments. Initial information gathered during the implementation of PBF in three LGAs suggests that this approach can make appreciable improvements in HCWM at very modest cost. Independent confirmation of data obtained from the quantitative supervisory checklist (QSC) will be available soon and provide important insights on HCWM at health facility level.

47. The potential risks are considered to be small in scope, site specific, and easy to avoid, prevent, and manage as well as remediate to acceptable levels. Experience has proven that when healthcare wastes are properly managed, generally they pose no greater risks than that of properly treated municipal or industrial wastes. Thus the risks are manageable and can be mitigated through development and implementation of simplified facility-specific waste management plan and ESMP, preparation and review of Term of references, preparation and review of the site-facility ESMPs, the implementation of sound operational practice supported by enhanced capacity and monitoring of mitigation measures through Environmental Checklist and screening, Supervisory Checklist, Annual Health facility survey and independent performance measurement, and audit. While all these will ensure roles and accountabilities in safeguard compliance, the training programs will target capacity strengthening to ensure and assure adequate implementation and monitoring of the environmental and social management issues/plans.

48. **Government actions to date**: Nigeria has demonstrated its commitment to mitigating adverse social and environmental impacts in the implementation of a range of World Bank projects. There are adequate legal and institutional frameworks in the country to ensure compliance with World Bank safeguards policies. In 2007, the government established the National Medical Waste Management Policy. The policy stipulates that waste generated by both public and private medical institutions in Nigeria must be safely handled and disposed of by these institutions, and provides guidelines and a rollout plan for medical waste management activities at medical institutions.

49. **Lessons from PBF:** PBF has been implemented in 3 LGAs for more than two years and it appears to have had a salubrious effect on HCWM and other aspects of environmental hygiene. Under PBF health facilities are paid partly on the basis of quality of care as determined by a standardized quantitative checklist implemented by supervisors from the LGA. Supervision is carried out at least quarterly and make up roughly 25% of the bonuses

earned by the health facilities. One of the main domains, included in the checklist is environmental hygiene (which accounts for 10% of the total score). The checklist provides scores on the extent to which health care wastes are properly segregated according to national norms, protective gear is available for staff, safety boxes and needle cutters are available and used, the grounds are properly maintained and have no medical waste, and a proper heath care waste pit is in place according to national guidelines. The scores on environmental hygiene in the three LGAs have increased substantially over the last two years. The average score on hygiene at the beginning of the pilot was 17% and this has increased to 64%. The experience with PBF suggests that making HCWM part of a systematic supervision mechanism and incentivizing facilities to improve their quality of care can have noticeable impact on compliance with environmental guidelines.

50. **Program Intervention*:*** The SOML program provides opportunity to put into practice the relevant waste management guidelines at the facility level through the expansion of PBF and related approaches. Through the annual health facility surveys there will be independent verification of results. This will be supported by close supervision by the Bank for compliance.

51. Social: The social impact of the Program is likely to be positive owing to the potential to enhance hygiene status of the health facilities, information dissemination, creation of more accountable arrangements for service delivery, and social audits that promote good governance. No land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind under the Program. If such activities are likely to occur within the program, they should be excluded from this PforR support or, alternatively, if included be subjected to investment lending policies.

V. Tentative financing

Source:	($m.)
Borrower/Recipient	$680 Million
IBRD	
IDA	$300 Million
Others (specify) Health Results Innovation Trust Fund (HRITF)	$5 Million
Total	$305 Million

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