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Report No: PADHP00116

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROGRAM APPRAISAL DOCUMENT

ON A
PROPOSED CREDIT
IN THE AMOUNT OF US$500.00 MILLION

AND ON A
PROPOSED GRANT
IN THE AMOUNT OF US$70.01 MILLION
FROM THE GLOBAL FINANCING FACILITY FOR WOMEN, CHILDREN AND ADOLESCENTS
MULTI-DONOR TRUST FUND

TO THE
FEDERAL REPUBLIC OF NIGERIA

FOR A

PRIMARY HEALTHCARE PROVISION STRENGTHENING (HOPE-PHC) PROGRAM

September 5, 2024

Health, Nutrition and Population Global Practice
Western and Central Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2024)

Currency Unit = Nigerian Naira (NGN)

NGN 1660 = US$1

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ABBREVIATIONS AND ACRONYMS

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
ANRIN	Accelerating Nutrition Results in Nigeria
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
BHCPF SOC	Basic Health Care Provision Fund State Oversight Committee
BHCPP	Basic Health care Provision Program
CBN	Central Bank of Nigeria
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker
CIFF	Children's Investment Fund Foundation
CHEW	Community Health Extension Worker
CMHSW	Coordinating Minister of Health and Social Welfare
CPF	Country Partnership Framework
CRI	Corporate Results Indicator
CRVS	Civil Registration and Vital Statistics
DCP-3	Disease Control Priorities Project
DPG-Health	Development Partners Group for Health
DFF	Decentralized Facility Financing
DHIS-2	District Health Information System 2
DIME	Development Impact
DLI	Disbursement Linked Indicator
DLR	Disbursement Linked Result
DMA	Drug Management Agency
EC	Eligibility Criteria
EDGE	Excellence in Design for Greater Efficiency
EFCC	Economic and Financial Crimes Commission
EMS	Emergency Medical Services
EPR	Emergency Preparedness and Response
E&S	Environmental and Social
ESCP	Environmental and Social Commitment Plan
ESSA	Environmental and Social Systems Assessment
FASTR	Frequent Assessments and Systems Tools for Resilience
FCDO	Foreign, Commonwealth and Development Office
FCT	Federal Capital Territory
FPFMD	Federal Project Financial Management Department
FGN	Federal Government of Nigeria
FHW	Frontline Health Worker
FM	Financial Management
FMBEP	Federal Ministry of Budget and Economic Planning
FMOH&SW	Federal Ministry of Health and Social Welfare
FSA	Fiduciary System Assessment
GDP	Gross Domestic Product
GFF	Global Financing Facility
GHG	Greenhouse Gas
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCI	Human Capital Index
HIV	Human Immunodeficiency Virus
HMB	Hospitals Management Board

HMSH	Honorable Minister of State for Health
HNP	Health, Nutrition and Population
HOPE	Human Capital Opportunities for Prosperity and Equality
HOPE-BED	Human Capital Opportunities for Prosperity and Equality—Education
HOPE-GOV	Human Capital Opportunities for Prosperity and Equality—Governance
HOPE-PHC	Human Capital Opportunities for Prosperity and Equality—Primary Healthcare Provision Strengthening Program
HRH	Human Resources for Health
ICPC	Independent Corrupt Practices Commission
IFR	Interim Financial Report
IFSA	Integrated Fiduciary Systems Assessment
IPF	Investment Project Financing
IVA	Independent Verification Agency
LARC	Long-Acting Reversible Contraceptive
LGA	Local Government Area
M&E	Monitoring and Evaluation
MAMII	Maternal Mortality Reduction Innovations Initiative
MDAs	Ministries, Departments and Agencies
MDTF	Multi-donor Trust Fund
MICS	Multiple Indicator Cluster Survey
MMS	Multiple Micronutrient Supplements
MOC	Ministerial Oversight Committee
NCD	Non-Communicable Disease
NCDC	Nigeria Center for Disease Control and Prevention
NDC	Nationally Determined Contribution
NDHS	National Demographic and Health Survey
ND-GAIN	Notre Dame Global Adaptation Index
NEMSAS	National Emergency Services and Ambulance Scheme
NHIA	National Health Insurance Authority
NHSRII	Nigeria Health Sector Renewal Investment Initiative
NPCU	National Program Coordinating Unit
NPHCDA	National Primary Health Care Development Agency
NSC	National Steering Committee
OAGF	Office of the Accountant General of the Federation
OAuGF	Office of the Auditor General for the Federation
PAD	Program Appraisal Document
PAP	Program Action Plan
PDO	Program Development Objective
PEF	Program Expenditure Framework
PFM	Public Financial Management
PforR	Program-for-Results
PHC	Primary Health Care Center
POM	Program Operations Manual
PPR	Pandemic Preparedness and Response
PPSD	Project Procurement Strategy for Development
PSH	Permanent Secretary for Health
RMNCAH-N	Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition
SCO	SWAp Coordinating Office
SDG	Sustainable Development Goal
SMoH	State Ministry of Health
SOML	Saving One Million Lives
SOP	Standard Operating Procedure
SORT	Systematic Operations Risk Tool

SPHCDA	State Primary Health Care Development Agency
SSC	SWAp Steering Committee
SSHIA	State Social Health Insurance Agency
SWAp	Sector-wide Approach
TA	Technical Assistance
TWG	Technical Working Group
UHC	Universal Health Coverage
UNCITRAL	United Nations Commission on International Trade Law
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VGF	Vulnerable Group Fund
VSL	Value of Statistical Life
VVF	Vesico-Vaginal Fistula
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
Nigeria	Nigeria: Primary Healthcare Provision Strengthening Program		
Operation ID	Financing Instrument	Does this operation have an IPF component?	Environmental and Social Risk Classification (IPF Component)
P504693	Program-for-Results Financing (PforR)	Yes	Low

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[✓] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[✓] Conflict
[ ] Alternative Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster
[ ] Hands-on Expanded Implementation Support (HEIS)	

Expected Approval Date	Expected Closing Date
26-Sep-2024	30-Jun-2029
Bank/IFC Collaboration	
No	

Proposed Program Development Objective(s)

The Program Development Objective is to improve utilization of quality essential health care services and health system resilience in the Federal Republic of Nigeria.

Organizations

Borrower:	FEDERAL REPUBLIC OF NIGERIA
Implementing Agency:	FEDERAL MINISTRY OF HEALTH
Contact:	DAJU KACHOLLOM
Title:	MRS
Telephone No:	08033119400
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COST & FINANCING (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)?	No
Is this project Private Capital Enabling (PCE)?	No

SUMMARY

Government program Cost	**3,665.29**
Total Operation Cost	**570.01**
Total Program Cost	525.00
IPF Component	45.01
Total Financing	**570.01**
Financing Gap	**0.00**

Financing (US$, Millions)

World Bank Group Financing	
International Development Association (IDA)	500.00
IDA Credit	500.00
Non-World Bank Group Financing	
Trust Funds	70.01
Global Financing Facility	70.01

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	500.00	0.00	0.00	0.00	500.00
Total	**500.00**	**0.00**	**0.00**	**0.00**	**500.00**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2025	2026	2027	2028	2029
Annual	60.42	138.76	135.09	135.75	100.00
Cumulative	60.42	199.18	334.27	470.01	570.01

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Education; Governance

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	High
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate

5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Substantial
9. Overall	High

POLICY COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Area OP 7.60	No

ENVIRONMENTAL AND SOCIAL

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
ESS 1: Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10: Stakeholder Engagement and Information Disclosure	Relevant
ESS 2: Labor and Working Conditions	Relevant
ESS 3: Resource Efficiency and Pollution Prevention and Management	Not Currently Relevant
ESS 4: Community Health and Safety	Not Currently Relevant
ESS 5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant

ESS 6: Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
ESS 8: Cultural Heritage	Not Currently Relevant
ESS 9: Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

LEGAL

Legal Covenants

Sections and Description
Financing Agreement, Schedule 2, Section I.A, paragraph 1.1.1(a): The Recipient shall, not later than three (3) months after the Effective Date, establish and thereafter maintain throughout the implementation of the Operation, a joint inter-ministerial steering committee at the federal level (the "National Steering Committee" or "NSC") responsible for providing high-level guidance, advice, and strategic oversight on the HOPE series of operations with functions, composition and resources satisfactory to the Association, as further detailed in the Operations Manual.
Financing Agreement, Schedule 2, Section I.A, paragraph 1.1.3 (a):The Recipient shall, not later than three (3) months after the Effective Date, establish and thereafter maintain throughout the implementation of the Operation, a coordination unit for the Operation (the "National Program Coordination Unit" or "NPCU") within the SWAp Coordination Office, with functions, composition, and resources satisfactory to the Association.
Financing Agreement, Schedule 2, Section I.D, paragraph 2 (a): The Recipient shall: (i) not later than ninety (90) days after the Effective Date, engage an independent verification agency or independent verification agencies ("Independent Verification Agent(s)" or "IVA(s)"), as the case may be, under terms of reference(s) satisfactory to the Association.
Per ESCP, the Recipient will hire one environmental specialist and one social specialist no later than one month after the effective date and maintain the position throughout project implementation.
Per ESCP, a Labor Management Procedures shall be prepared, disclosed, consulted, and adopted no later than three months after the effective Date and implemented throughout the Project lifecycle.
Per ESCP, the Recipient will establish the grievance mechanism no later than three (3) months after the effective date and thereafter maintain and operate the mechanism throughout project implementation.
Per ESCP, an E&S Screening Checklist shall be developed no later than three months after the effective date and implemented by the SPIUs during project implementation to screen activities for E&S impacts.

Conditions

Type	Citation	Description	Financing Source
Effectiveness	Article V, Section 5.01(a)	The GFF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right	IBRD/IDA, Trust Funds

		of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled;	
Effectiveness	Article V, Section 5.01(b)	The Recipient has established the NPCU and appointed or hired the NPCU staff, other than the environmental and social specialist, in accordance with the provisions of paragraph 3(b) of Section I.A of Schedule 2 to the Financing Agreement; and	IBRD/IDA, Trust Funds
Effectiveness	Article V, Section 5.01(c)	The Recipient has adopted the Operations Manual in accordance with the provisions of Section I.C of Schedule 2 to the Financing Agreement.	IBRD/IDA, Trust Funds

I. STRATEGIC CONTEXT

A. Country Context

1. **Nigeria, Africa's most populous country and home to the second-largest population living below US$2.15 per day, possesses substantial untapped economic potential yet is one of the least developed nations globally.** Nigeria is among the largest economies in Africa, with a gross domestic product (GDP) of approximately US$363 billion in 2023, but over 40 percent of its population live in poverty. Economic growth over the past decade has not maintained pace with population growth: real income per capita in 2023 was US$2,455, lower than US$2,490 recorded in 2010. Nigeria's key development constraints include the high dependence on oil, insufficient economic diversification and inclusive growth, and a poor scorecard on good governance and service delivery including investments in human capital. As a diverse federation of 36 autonomous states and 220 million people, federal-state coordination is a challenge. Pathways for development include improving economic governance and generating more trust in State institutions, boosting government investments in human capital, expanding social assistance programs to sustain the move away from fuel subsidies, and improving opportunities for the young and entrepreneurial to diversify the economy and invest in inclusive economic growth.

2. **Elections in 2023 brought in a new President and administration committed to improving macroeconomic stability and addressing fiscal and debt vulnerabilities due to low revenues and a dependence on global oil prices.** Macroeconomic stability steadily deteriorated over the past decade leading to an increasing difference between official and parallel market exchange rates, a shortage of foreign exchange, and high inflation. Confronted with a fragile economic reality, the new administration that took office in May 2023 made two critical macro-fiscal reforms: the increase in the price of gasoline or premium motor spirit which was subsidized at a fiscal cost of 2.2 percent of GDP in 2022, and the liberalization of the exchange rate. These policies are expected to help boost revenues from 6.7 percent of GDP in 2022 to 8.6 percent of GDP in 2024. Nonetheless, the fiscal deficit is projected to remain above 3 percent of GDP for 2024-2027. This fiscal outlook limits scope for essential public investments and services and highlights the urgent need to mobilize domestic revenues to shore-up fiscal sustainability and provide funding for government investments in inclusive and sustainable development.

3. **The economic and fiscal outlook continues to be vulnerable to shocks and oil-dependence and to the challenges associated with improving governance of the State.** In recent years, the economy has been hit by the COVID-19 pandemic, a fall in global oil prices, increasing insecurity, and weak domestic oil production. The post-COVID recovery was short-lived with real GDP growth dropping from 3.6 percent in 2021 to 3.1 percent in 2022-2023, due to low oil production, flood-related low agricultural output, and the disruptive currency demonetization policy instituted in Q1-2023. The fiscal space is limited by the need to service debts (101.5 percent of revenues in 2022) and vulnerable to fully realizing the fiscal transfers from the oil and gas sector, thus restricting public investments. Long-standing perceptions of corruption and other governance challenges such as weak institutions and limited transparency and accountability also dampen business sector confidence.

4. **Climate change threatens development gains in Nigeria, with a disproportionate impact on the poor.** Nigeria is highly vulnerable to climate shocks, including extreme heat, floods, and drought, all of which are predicted to become more frequent and severe with climate change. The country has low adaptive capacity to address climate change, ranking 154 out of 185 countries on the Notre Dame Global Adaptation Index (ND-GAIN) of climate vulnerability and readiness.[1] Climate change already has negative impacts on the country's economic growth, with an estimated GDP loss of between 6 percent and 30 percent by 2050, worth an estimated US$100–460 billion, due to climate change.[2]

[1] Notre Dame Global Adaptation Initiative (NDGAIN), Readiness Index, 2021: https://gain.nd.edu/our-work/country-index/rankings/
[2] Department for International Development. 2009. Impact of Climate Change on Nigeria's Economy.

B. Sectoral and Institutional Context

5. **Nigeria's youthful population represents a vast reservoir of human capital waiting to be tapped, but the country's low score on the Human Capital Index (HCI 2020) undermines this potential.** Nigeria's HCI of 0.36 implies that a child born in Nigeria today is expected to achieve only 36 percent of his/her potential productivity by age 18 if she had attained a complete education and optimal health. This falls below the Sub-Saharan African average of 40 percent, as well as regional comparators such as South Africa (43 percent), Ghana (45 percent), and Kenya (55 percent). If Nigerian children were to reach their full educational and health potential, the country's per-capita GDP could be 2.8 times higher.

6. **Nigeria ranks among the bottom five or ten countries globally on most key health indicators.** Life expectancy, at 54 years, is the third lowest in the world. Under-five mortality is the second highest globally, at 114 per 1,000 live births, while maternal mortality is third highest in the world, at over 1,000 per 100,000 live births.[5] These numbers translate to over 800,000 deaths among children under five and about 80,000 maternal deaths each year. Nigeria therefore accounts for one out of six child deaths globally, and one out of four maternal deaths.[6] The prevalence of stunting among children under five is 37 percent, one of the 10 highest rates in the world, with long-term implications for human development. The same is true of the total fertility rate, which at 5.3 births per woman is down only slightly from its 1990 level of 6.0. Nigeria is in the early stages of the epidemiological transition, with non-communicable diseases (NCDs) accounting for 24 percent of total deaths and posing a growing burden.[5]

7. **Nationwide health indicators mask profound economic disparities**. A child in the poorest wealth quintile is over three times more likely to die under the age of five than a child in the richest wealth quintile. At the same time, nearly every Nigerian state—including the richest—lags far behind the global average for under-five mortality at their income level (measured by state gross national income per capita). If Nigeria's *second-richest* socioeconomic quintile was a country (with a population over 40 million), its under-five mortality rate would rank among the 10 highest globally and far behind the target set out in the Sustainable Development Goals (SDGs).

8. **Nigeria's health system is characterized by huge geographical disparities**. The states in the Northern geopolitical zones have a worse performance than those in the Southern geopolitical zones on maternal mortality and other health outcomes.[3] For example, a woman living in the North-East is 10 times more likely to die during childbirth than a woman living in the South-West. The disparities in these regions influence their levels and determinants of maternal mortality. For instance, some northern states like Kano in 2008 had a maternal mortality ratio of 1600 deaths per 100,000 livebirths,[4] while 1049 deaths per 100,000 livebirths were reported in Zamfara state.[5] The North South differentials are characterized by socio cultural factors, women in the North are less likely to give birth at health facilities,[6] and many in some northern states, live far from health centers which are plagued by severe shortages of health workers compared to the South of Nigeria.[7]

9. **Shortcomings in access to essential health services and quality of care are major drivers of poor health outcomes.** Skilled birth attendance has increased only marginally, from 39 percent in 2008 to 43 percent in 2018.[8] Childhood immunization coverage remains a significant challenge, with diphtheria, pertussis, and tetanus Pentavalent vaccine (DPT-3/Penta-3) coverage estimated at 57 percent. As of 2020, Nigeria had the largest number of zero-dose children in the

[3] Wall LL. Dead mothers and injured wives: the social context of maternal morbidity and mortality among the Hausa of northern Nigeria. Stud Fam Plan. 1998;29:341–59.
[4] Galadanci H, Idris S, Sadauki H, Yakasai I. Programs and policies for reducing maternal mortality in Kano state Nigeria: a review. Afr J Reprod Health. 2010;14:31–6.
[5] Doctor HV, Olatunji A, Findley SE, Afenyadu GY, Abdulwahab A, Jumare A. Maternal mortality in northern Nigeria: findings of a health and demographic surveillance system in Zamfara state, Nigeria. Trop Dr. 2012;42:140–3.
[6] Ononokpono DN, Odimegwu CO. Determinants of maternal health care utilization in Nigeria: a multilevel approach. Pan Afr Med J. African Field Epidemiology Network. 2014;17:2.
[7] McDermott R, Cowden J. Polygyny and violence against women. Emory Law J. 2015;64(6):1767-814. http://law.emory.edu/elj/content/volume-64/issue-6/articles-and-essays/polygyny-violence-against-women.html.
[8] Nigeria Demographic and Health Survey, 2018

world,[9] with the estimated number of zero- or missed-dose children increasing to 3.1 million from 3.0 million the previous year. The quality of healthcare services in Nigeria remains suboptimal and compares poorly with peers. For example, the availability of essential equipment within health centers in Nigeria is 33 percent, compared to 89 percent in Tanzania and 84 percent in Kenya.[10] Clinical competence is similarly weak: only 43 percent of clinical conditions in Nigeria are accurately diagnosed, compared to 69 percent in Tanzania and 67 percent in Kenya.[11] A national assessment of maternal deaths and near misses at hospitals reported that over 90 percent of mothers arrived in critical condition, but still the median time between diagnosis and critical intervention was 60 minutes;[12] in 21.9 percent of cases, it was over four hours. Shortages in human resources for health (HRH) and health infrastructure, along with a chronically weak supply chain and poor referral systems, intensify these service delivery challenges.[13]

10. **Several barriers impede access to good quality healthcare services for persons with disabilities.** These individuals often require specialized and general health services, but they may not receive them due to systemic and attitudinal barriers. The attitudes of health professionals have a detrimental effect on the mental health and psychosocial well-being of disabled patients, rendering them more susceptible to abuse, injuries, and diseases. It is common for healthcare providers to administer medication to patients with disabilities without obtaining their consent, contravening the ethical principles governing their conduct. Moreover, patients are often perceived as exaggerating their symptoms due to healthcare providers' insufficient knowledge on effectively managing patients with disabilities. Consequently, individuals with disabilities may experience mistreatment from caregivers, whether consciously or unconsciously, directly, or indirectly.[14]

11. **Government health spending as a share of GDP ranks the lowest in the world, at 0.5 percent.** This translates to about US$14 per capita, of which less than 20 percent (US$2.62 per capita) is allocated to primary care. Low levels of health financing severely limit the country's ambition to achieve universal health coverage (UHC). For example, this allocation is a fraction of global estimates of the cost of providing an essential health service package in countries at Nigeria's income level, with two recent estimates falling between US$70 and US$80 per capita. It is also far less than the estimated cost of a basic primary care package in Nigeria (about US$14 per capita). A major constraint on health spending is the overall low level of government revenue, at about 7 percent of GDP, exacerbated by the low prioritization of health within the budget, at 4 percent. The low priority placed on public health spending is particularly evident at the state level, due in part to low rates of budget execution. As a result of low government health spending, household out-of-pocket expenditures account for almost 75 percent of total health spending in Nigeria, the fourth-highest share in the world.[15]

12. **Nigeria's poor health outcomes and weak health financing environment are linked to its complex federal arrangements.** Nigeria's constitution provides for a vertical revenue-sharing formula across federal, state, and local governments and centrally controlled special funds. This has resulted in federal fiscal dominance and financially weak states. Furthermore, the constitutional allocation of roles and responsibilities in healthcare is unclear across all levels of government, with all levels playing a role in delivery of essential primary healthcare services. Consequently, there are accountability challenges, especially at the lower levels. Also, in the face of limited fiscal space, subnational entities in Nigeria face difficult policy choices, such as prioritizing the expansion of priority basic services and population coverage. The government has used conditional fiscal transfers through the Basic Healthcare Provision Fund (BHCPF) in the health sector to transfer resources and influence policy since 2017 with mixed results.

[9] World Health Organization (WHO) and United Nations Children's Fund (UNICEF) estimate of National Immunization Coverage (WUENIC).
[10] World Bank. 2016 Nigeria Service Delivery Indicators Survey.6.
[11] *Ibid.*
[12] https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.13450
[13] *ibid*
[14] Ayub, A. O., and A. J. Rasaki. 2021. "Barriers in Accessing Healthcare Services by Patients with Disabilities in Nigerian Hospitals." *Gusau International Journal of Management and Social Sciences* 4 (1): 280–296.
[15] https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG

13. **External development assistance accounts for about 10 percent of Nigeria's total health spending but represents less than the sum of its contributions due to significant fragmentation.** There are many multilateral, bilateral, and philanthropic development partners in the health sector in Nigeria, with a complex array of inputs (for example, financing technical assistance (TA) and commodities), geographical distribution (focus states and federal government), sectoral priorities, and institutional arrangements (for example, monitoring and evaluation (M&E) frameworks, public financial management (PFM) practices, and authorizing structures). This fragmented approach places a transactional and prioritization burden on government authorities and undermines long-term sustainability.

14. **Climate change further threatens Nigeria's health system and jeopardizes health outcomes and is already impacting health in the country**.[16] Climate change s exacerbating transmission of water and vector borne diseases in the country. Transmission of malaria, the leading cause of under-five mortality in Nigeria,[17] is linked to rising temperatures and changes in precipitation due to climate change.[18] Drought has affected food production, with 31.5 million people estimated to be severely food insecure in 2023.[19] Food insecurity due to climate change is contributing to burgeoning rates of stunting and wasting in children under-five, at 37 percent[20] and 7 percent,[21] respectively. Climate change, particularly increased flooding, also debilitated the country's health system. For example, severe floods in 2022 destroyed 30 medical facilities in the hardest-hit state of Jigawa alone.[22] It is estimated that, by 2050, the health impacts of climate change in Nigeria will total US$399 billion in economic costs.[23]

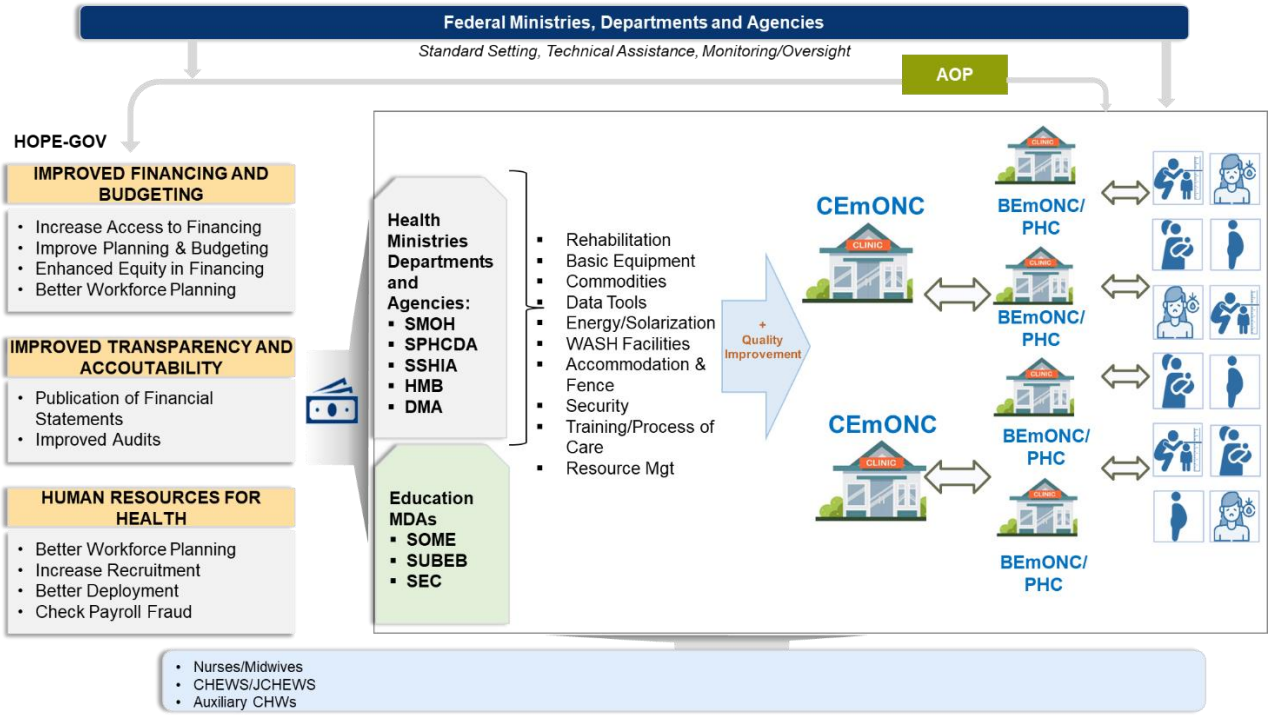
15. **Nigeria's key UHC initiative in recent years was the BHCPF, a specific-purpose intergovernmental fiscal transfer for health established by the National Health Act of 2014.** The BHCPF is an earmarked fund for health to be financed with no less than 1 percent of the Government's Consolidated Revenue Fund.[24] In 2018, BHCPF implementation commenced through a grant from the Global Financing Facility (GFF). The original design was only partly pursued and, while implementation has since restarted, there are constraints to its effective implementation. *First,* the quantum of resources from the BHCPF translates to less than US$0.25 per capita in most years, an insufficient amount to make a major impact. *Second*, there are governance challenges with respect to implementation and accountability mechanisms for funds at the national and subnational levels. *Third,* effective utilization of funds at the state level is hampered by weak coordination and limited capacity to plan and implement the Basic Healthcare Provision Program (BHCPP). Under new leadership, the BHCPF will be redesigned as part of the broader Nigeria Health Sector Renewal Investment Initiative (NHSRII) and will be a key financing vehicle for the broader BHCPP. As part of the health sector reform, the first sector-wide approach (SWAp) in the health sector in Nigeria will be adopted to channel public and development partners resources, improve coordination, and reduce inefficiencies.

16. **The strategic partnership between the World Bank and the government is set to play a pivotal role in the implementation of these health sector reforms.** Given the scale of the challenge and the limited resources available, transforming Nigeria's health system will require embracing a *"business unusual"* approach. Strengthening primary healthcare is not only about enhancing service delivery, but also about instituting significant changes in the governance of

[16] Adebanke L. Adebayo. 2022. "Mitigating Climate Change Effects on Maternal and Prenatal Health in Nigeria." In *The Nature, Causes, Effects and Mitigation of Climate Change on the Environment*, edited by Stuart A. Harris. IntechOpen; Godpower C. Michael, and Musa Dankyau. 2022. "Climate Change and Primary Health Care in Sahelian Kano, Nigeria." *Afr J Prim Health Care Fam Med* 14 (1):3745; Oluwatimilehin, Isaac Ayo et al. 2022. "Assessment of the Impact of Climate Change on the Occurrences of Malaria, Pneumonia, Meningitis, and Cholera in Lokoja City, Nigeria." *Regional Sustainability* 3 (4): 309–18.
[17] O.O. Ayoola, et al. 2005. "A five-year review of childhood mortality at the UCH, Ibadan." *West Afr. J. Med*. 24(2): 175–79.
[18] Badaru, Yahaya Usman, et al. 2014. "Rainfall Variations as the Determinant of Malaria in the Federal Capital Territory Abuja, Nigeria." *J. Environ Earth Sci*. 4 (20): 149–59; Oluwatimilehin, Isaac Ayo, et al. 2022. "Assessment of the Impact of Climate Change on the Occurrences of Malaria, Pneumonia, Meningitis, and Cholera in Lokoja City, Nigeria." *Regional Sustainability* 3 (4): 309–18.
[19] Cadre Harmonise for Identification of Risk Areas and Vulnerable Population in the Sahel and West Africa March 2024: Nigeria.
[20] UNICEF. The Challenge: Malnutrition is a direct or underlying cause of 45 percent of all deaths of under-five children.
[21] USAID. 2021. Nigeria Nutrition Profile.
[22] Abdulrakib Abdulrahim et al. A catastrophic flood in Nigeria, its impact on health facilities and exacerbations of infectious diseases. PAMJ - One Health. 2022;9(21). 10.11604/pamj-oh.2022.9.21.38023.
[23] World Bank. 2024. Climate and Health Economic Valuation (CHEV) tool: Nigeria. This figure is drawn on the SSP3 scenario.
[24] National Health Act, 2014.

the health sector. Recognizing this dual need, the government has requested the World Bank to finance a series of interdependent operations this operation-Human Capital Opportunities for Prosperity and Equality—Primary Healthcare Provision Strengthening Program (HOPE-PHC Program, **P504693**), along with the crosscutting HOPE-Governance (HOPE-GOV; P181476) and HOPE Basic Education (HOPE-BED; P507001). The HOPE-GOV operation, with a focus on governance, aims to contribute to: (a) increasing the availability and effectiveness of financing for basic education and primary healthcare; (b) enhancing transparency and accountability for basic education and primary healthcare; and (c) improving recruitment, deployment and performance management of basic education teachers and primary healthcare workers by federal, state, and local government. This is a critical step toward ensuring the sustainability of all health programs. HOPE-PHC Program, focusing on primary healthcare service delivery, is designed to contribute to the reorganization of primary healthcare and the prioritization of cost-effective interventions. This will be instrumental in improving access to good-quality, essential health services, thereby laying a solid foundation for a more robust and resilient health system in Nigeria. HOPE-BED will support reforms in the basic education sector. The interdependencies between HOPE-GOV and HOPE-PHC are shown in Figure 1 below.

Figure 1. Relationship between HOPE-GOV, HOPE-PHC and HOPE-BED



C. Relationship to the CPF and Rationale for Use of Instrument

17. **The Nigeria Human Capital Opportunities for Prosperity and Equity—Primary Healthcare Provision Strengthening (HOPE-PHC) Program is aligned with the core objectives of the World Bank's Nigeria Country Partnership Framework (CPF) FY21-25 (Report No. 153873-NG) and Performance and Learning Review (Report No. 185161-NG)**[25] First, it aligns with *Core Objective 3: Improve Primary Healthcare*, which is focused on enhancing the quality and coverage of public health services and sustainable financing for health through the BHCPF. Second, it aligns with *Core Objective 1: Increase Domestic Revenues, Improve Quality of Public Expenditures and Enhance Debt Management,* which seeks to strengthen federal–state coordination and accountability within Nigeria's fiscal federalism framework. In coordination with the Nigeria HOPE-GOV operation, the HOPE-PHC Program will also contribute to *Core Objective 1, Complementary Priority 2:*

[25] https://documents1.worldbank.org/curated/en/526171611619063445/pdf/Nigeria-Country-Partnership-Framework-for-the-Period-FY21-FY25.pdf

Enhance the Effectiveness, Transparency and Accountability of Public Institutions and Systems for Service Delivery. Third, the HOPE-PHC Program, with its predominant focus on women and young children through the delivery of reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services, deepens the CPF's drive to reduce gender gaps and inequities.

18. **The CPF states that Nigeria's vast development agenda calls for, among other steps, investment in human capital and harnessing the demographic dividend.** Of particular importance is maximizing women's potential contributions, especially with respect to the health, education, and life chances of adolescent girls and women in the north, where gender gaps are wider than elsewhere in the country. This is due to more restrictive social norms; issues around fragility, conflict, and violence; and weaker overall economic development. Both the Nigeria Systematic Country Diagnostic[26] and the CPF call for concerted action on gender gaps to close the north-south divide in human capital outcomes; reduce fragility, conflict, and violence; accelerate per-capita income growth; and improve Nigeria's overall development trajectory.

19. **The HOPE-PHC Program will contribute to the World Bank's regional and global agenda.** With the world's second highest number of deaths among children under five and the sixth-largest population in the world, Nigeria will play a major role in contributing to key goals, such as the reduction of under-five mortality (as captured in the new World Bank corporate scorecard) and the new commitment to support countries in delivering good-quality essential health services to 1.5 billion people by 2030. The HOPE-PHC Program is also aligned with the objectives of the Africa Human Capital Plan: Powering Africa's Potential Through its People, to which it will contribute by scaling up financing for health, tackling critical human capital challenges, leveraging technology and innovation, and strengthening partnerships. The HOPE-PHC Program will address interdependent climate and health challenges by proactively integrating climate resilience into health systems planning and infrastructure. The HOPE-PHC Program is aligned with the goals of the Paris Agreement (Section IV and Climate Technical Note).

20. **The rationale for World Bank support of the HOPE-PHC Program is based on the centrality of human capital to Nigeria's future employment opportunities, productivity, economic development, and poverty reduction.** The HOPE-PHC Program is an important complement to previous and ongoing interventions through the World Bank's Health, Nutrition and Population (HNP) portfolio in Nigeria, including operations that have utilized the HOPE-PHC Program for Results (PforR) mechanism. The Saving One Million Lives (SOML) PforR Program (US$500 million, P146583), which closed in October 2019, supported efforts to increase the utilization and quality of high-impact reproductive, child health, and nutrition interventions. The ongoing Accelerating Nutrition Results in Nigeria (ANRIN) Project (US$225 million, P162069) supports an increase in the utilization of good-quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls, and children under five, building knowledge on primary healthcare systems and multisectoral linkages. Through its interventions, specifically under its Component 2: expanding the implementation of the redesigned BHCPF by leveraging Decentralized Facility Financing (DFF), the Immunization Plus and Malaria Progress by Accelerating Coverage and Transforming Services - IMPACT (P167156) Project has been laying the critical foundation for HOPE-PHC. After approval of its currently proposed restructuring, the IMPACT Project will further support HOPE-PHC by reprogramming additional resources to further expand the implementation of the BHCPF.

21. **The outcomes from previous HNP interventions have been mixed, with coverage of some health interventions stagnating at low levels but impressive results in critical areas, such as polio eradication.** A lesson learned from the SOML PforR is that policies formulated for adoption by states require collaboration across all levels of government. Other lessons suggest that, given Nigeria's fiscal structure, innovative reforms that hold lower levels of government accountable should be linked to fiscal transfers. The HOPE-PHC Program builds on a determined high-level leadership and political

[26] https://documents1.worldbank.org/curated/en/891271581349536392/pdf/Nigeria-on-the-Move-A-Journey-to-Inclusive-Growth-Moving-Toward-a-Middle-Class-Society.pdf

commitment to health reforms across the political class, aligning its timeline with the political cycle (2024–2028) to capture this opportunity.

22. **The HOPE-PHC Program provides a platform for a SWAp, leveraging significant additional resources to support a critical agenda.** Following the compact signed by all orders of government in Nigeria and development partners, the SWAp was established by the FMOH&SW in 2023. Most partners have started aligning their resources with the priorities outlined in the SWAp compact and are members of the thematic technical working groups set up to actualize the approach. Several partners have started processing agreements to align their financing with the SWAp, with three of such entities already completing the process. The World Bank has a clear comparative advantage to serve as the anchor organization for the first-ever SWAp in Nigeria, as it brings a long history of supporting this approach in health and other social sectors across the globe. In addition, the World Bank has provided significant resources to Nigeria's health sector reforms over the last decade, through which significant lessons have been learned on sector governance, health systems performance, and health financing, among others. A SWAp will provide the leverage to deepen federal–state dialogue for additional domestic resource mobilization and better accountability for results. Providing joint platforms for planning, delivery, monitoring, and accountability will drive efficiency, transparency, and accountability for health spending and key inputs and processes. By aligning development partner financing with the government's own resources, the HOPE-PHC Program will foster convergence around a common set of results in building a resilient and sustainable primary healthcare system.

23. **The PforR instrument is considered appropriate for the HOPE-PHC Program.** There is explicit interest in shifting the focus from inputs to results, with a stronger focus on accountability for results, given the complex institutional federal system. In addition, there is a need to incentivize government ownership and accelerate the implementation of critical reforms and policies in the health sector, all of which support the NHSRII's goal of serving as an anchor for a SWAp. Furthermore, the PforR design recognizes the need to make more efficient use of limited resources in a context where improvements in performance will require leveraging state and local government autonomy, boosting accountability, and aligning development assistance for health. A standalone Investment Project Financing (IPF) operation would be extremely transaction-intensive, given the national scope. However, a complementary smaller IPF component will allow the National Program Coordinating Unit (NPCU) to carry out targeted TA and procurement of critical consultancies to address states' capacity needs, targeted support to lagging states and ensuring government capacity is in place to assure that inputs are well-designed, and that sufficient quality assurance is provided, including on the verification of the results. As such, the HOPE-PHC Program adopts a hybrid PforR and IPF approach.

24. **A new political constellation and lessons from past reform experiences have been incorporated into Program design to inject fresh hope into Nigeria's health sector outlook.** First, there is an unprecedented level of stakeholder alignment around health reform, as evidenced by the federal compact signed in December 2023 by all states and by Federal Government of Nigeria (FGN). Second, there is greater focus on addressing upstream governance issues that significantly constrain sectoral prospects, especially in the realm of PFM and human resources at the state level, which are the focus of the HOPE-GOV operation. Third, the SWAp modality, which is new to Nigeria, will serve to de-fragment the external assistance architecture and overcome inefficiencies that have plagued the sector in the past. In addition to these macro-level shifts, the HOPE-PHC Program includes several important service delivery innovations that were not part of previous reform efforts. These include the purchasing of Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services, digital health platforms, expansion of community health service delivery, commodity security, and a focus on the complementarities of supply and demand-side efforts and different levels of care.

25. **The HOPE-PHC Program is consistent with Nigeria's updated (2021) Nationally Determined Contributions (NDCs),[27] the Nigeria Energy Transition Plan,[28] Nigeria's Long-Term Vision for Low-Carbon Development 2050,[29] and the National**

[27] UNFCCC (United Nations Framework Convention on Climate Change). 2021.Updated Nationally Determined Contribution (NDC) for Nigeria
[28] Nigeria Energy Transition Plan, 2021.
[29] 2050 Long Term Vision for Nigeria, November 2021.

Adaptation Strategy and Plan of Action.[30] Nigeria has committed to a national target of reducing greenhouse gas (GHG) emissions by 20 percent by 2030 compared to the business-as-usual scenario.[31] HOPE-PHC will finance energy efficient health facility refurbishment and solar power purchases consistent with this. The HOPE-PHC Program supports Nigeria's policies to manage climate risks, as identified by the National Council on Climate Change and the Federal Ministry of Health and Social Welfare (FMOH&SW), to mainstream climate actions nationally to achieve GHG emissions reduction targets and promoting community resilience to reduce vulnerability to climate change through both the improvement of health services, which are highlighted as critical to climate change adaptation, and climate actions incorporated throughout the operation including financing climate change emergency preparedness planning and the development of a National Health Adaptation Plan (HNAP).[32] The HOPE-PHC Program supports Nigeria's commitment to climate adaptation in the health sector, as articulated in the National Strategic Health Development Plan II,[33] including developing the capacity to respond to climate health emergencies and climate-sensitive diseases, including NCDs; building resilience in vulnerable communities; and developing climate-resilient health systems.[34]

II. PROGRAM DESCRIPTION

A. Government Program

26. **The proposed PforR Program is grounded in the NHSRII, an ambitious and transformative initiative launched in December 2023 with a view to improving Nigeria's health outcomes and economic potential by drastically reducing maternal and under-five mortality rates.** The BHCPP, driven by the BHCPF, established by the National Health Act of 2014 is an integral pillar of the NHSRII. By investing in service readiness, frontline health workers (FHWs), and evidence-based interventions, the BHCPP aims to unlock Nigeria's human capital potential. In addition, to exploit the economic potential embedded in the healthcare value chain, the Presidential Initiative for Unlocking Healthcare Value Chain (Nigeria Healthcare Industrialization Program), will be delivered through a dedicated pool of funds and private sector partnerships to fast-track Nigeria's ambitions in tertiary healthcare and local manufacturing. Overall, the NHSRII presents a call to action for the international development community and all levels of government to build a robust coalition to help Nigeria save lives, boost its human capital, build a platform for medical industrialization, and improve the efficiency and impact of its public and development financing. The HOPE-PHC Program is also consistent with the National Strategic Health Development Plan II (2018–2022), Medium-Term National Development Plan 2021–2025, and Agenda 2050.

27. **The BHCPP's essential benefit package prioritizes cost-effective services, focusing on reproductive health, maternal care and nutrition, childhood illnesses, and NCD screening.** A discrete package of promotive, preventive, and simple curative interventions will be delivered at the community level, complementing facility-based primary healthcare services. The estimated cost of achieving full coverage of 57 primary care services under the BHCPP is US$14 per capita annually, more than currently available government resources. Achieving this goal will therefore require careful consideration of the pace of the planned scale-up and of service priorities. To consolidate investments, the BHCPP proposes to: (a) expand Primary Health Centers (PHCs) from one per ward to a population-responsive distribution of two per ward, on average, with a total of over 17,000[35] nationwide; and (b) support the implementation of Basic and BEmONC and CEmONC, including one CEmONC per Local Government Area (LGA), for a total of 774, and an equitable distribution of Tier 2[36] BEmONC facilities linked to each of the CEmONC facilities. The BHCPP leverages the opportunity to strengthen emergency

[30] Nigeria National Adaptation Strategy and Plan of Action, 2011.
[31] Updated NDC Nigeria.
[32] The National Council for Climate Change. 2021. "Leading Nigeria's Climate Change Response."
[33] file:///C:/Users/wb292592/Downloads/National%20Strategic%20Health%20Development%20Plan%20II_2018-2022_1661872868.pdf
[34] National Strategic Health Development Plan II
[35] BEmONC facilities constitute 30 to 40 percent of PHCs.
[36] This indicates facilities that meet adaptive service readiness criteria by Nigerian Minimum Standards for Primary Healthcare including servicing a population of 10-20,000 Nigerians having been equipped amongst other things with good infrastructure, at least two delivery rooms, an in-patient ward, maternity ward, laboratory, and pharmacy and 4 nurses/midwives, 4 Community Health Extension Workers and 6 Junior Community Health Extension Workers.

medical response in rural areas by addressing transportation barriers. In addition, the BHCPP includes plans for workforce strengthening, including investments in training curricula, to address personnel gaps and improve competency and skills. The BHCPP will leverage digital health to create an integrated ecosystem and supports the development of a digital backbone, ensuring interoperability and data exchange.

28. **The BHCPP will be managed through a SWAp that pools government financing with available funding from all stakeholders to address fragmentation, increase alignment, and improve efficiency in health systems financing and service delivery.** The vision aims to align the government at all levels and its partners incrementally around a "one plan, one budget, one M&E" framework, driving a single, nationally led conversation and actions aimed at achieving Nigeria's health sector aspirations, notably on reducing maternal and newborn mortality. The adoption of a SWAp demonstrates a concerted effort to bolster institutional capacity in the health sector, including in the National Primary Health Care Development Agency (NPHCDA), the National Health Insurance Authority (NHIA), and their respective state counterparts. The BHCPP acknowledges the accountability challenges that span multiple levels—federal to state, state to LGA, and state to provider—and are actively being addressed to ensure a robust and responsive health system under the SWAp framework.

29. **PforR Program financing will total US$570.01 million comprising of concessional financing from the International Development Association (IDA) plus grant financing from other development partners.** The GFF multi-donor trust fund for Women, Children, and Adolescents is a country-led multistakeholder partnership housed at the World Bank that supports investments to scale up coverage of essential health services at the community and primary care levels, enhance service quality and resilience, and support health system redesign and innovation. The GFF grant of US$50.00 million will be allocated to disbursement-linked indicators (DLIs) supporting primary healthcare service delivery capacity; improvements in health policy, financing, and PFM; and increased utilization of primary healthcare services. In addition, the GFF will also provide two grants from the Joint Financing Window in the amounts of US$10.67 million from the Children's Investment Fund Foundation (CFF) and US$9.35 million from the United Kingdom Foreign Commonwealth and Development Office (UK-FCDO).

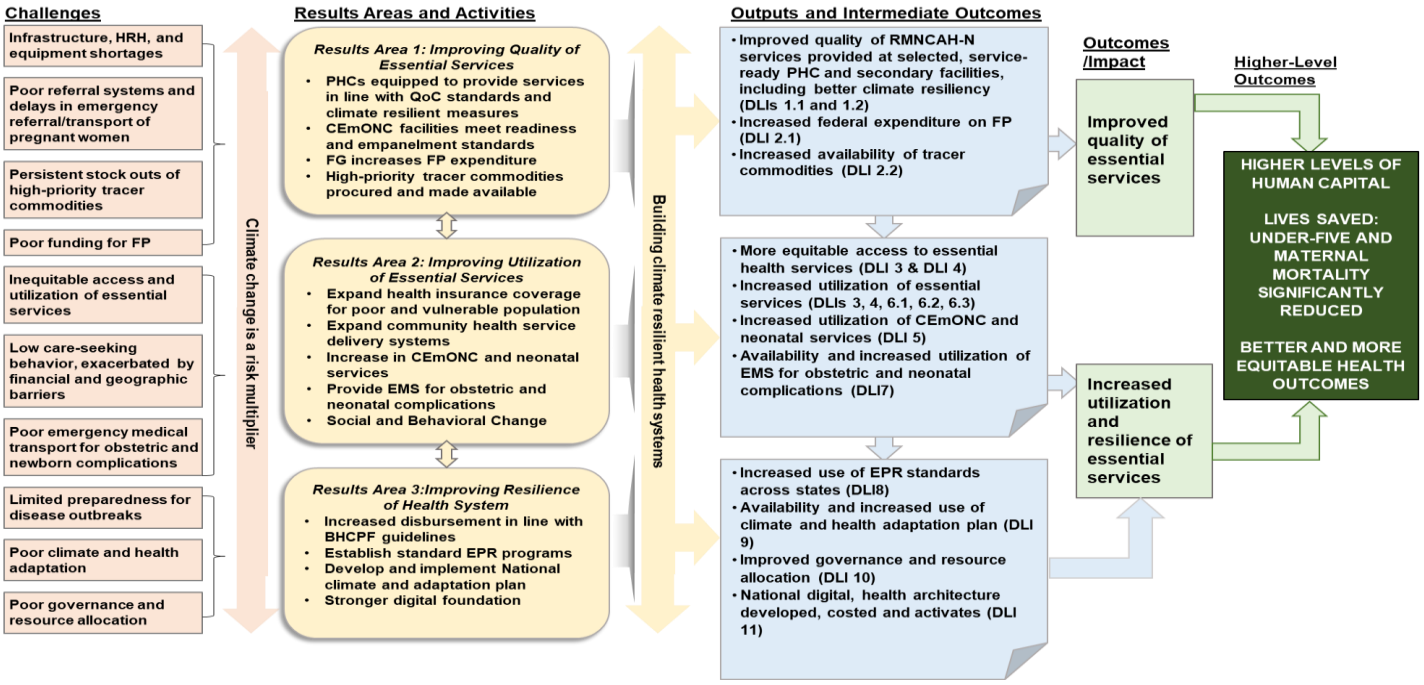
B. Theory of Change

30. **The HOPE-PHC Program will support the government's program through its focus on strengthening the primary healthcare system to deliver good-quality essential health services and improve resilience.** The HOPE-PHC Program will focus especially on improving the quality and utilization of core RMNCAH-N services needed to substantially reduce maternal and under-five mortality in Nigeria, building on the government's primary healthcare reform agenda to address a series of interrelated challenges: (a) on the supply side, poor quality of care with particular attention to weaknesses in facility readiness, commodity availability, and supply chain management; (b) on the demand side, limited demand for and utilization of essential services with considerable inequities, due in part to weaknesses in the community-based health workforce; and (c) the twenty-first century threats of climate change and health emergencies as key risk multipliers.

31. **The HOPE-PHC Program is built around three key results areas:** (1) improving quality of services; (2) improving utilization of essential services; and (3) improving the resilience of the health system. Figure 2 outlines a theory of change that connects these challenges with the HOPE-PHC Program's results areas and activities, outputs, intermediate outcomes, and impact. The DLIs represent key reform areas undertaken by both the federal and state governments to drive progress toward program impact. Arrows highlight the intended synergistic impact of the HOPE-PHC Program design, with key focus areas encompassing interventions to strengthen the supply side, including quality improvements; measures to improve and strengthen demand for and utilization of essential services at the community, primary, and secondary levels; and steps to strengthen resilience. The expected outcome is increased coverage of good-quality essential health services, with the ultimate impact of substantially reducing mortality rates. Key assumptions underlying

the theory of change include sustained political commitment, broader government and economic stability, and continued development partner support for the SWAp modality.

Figure 2. Theory of Change



C. PforR Program Scope

32. **HOPE-PHC supports key activities of all sub-components of the BHCPP spanning community-based health services, primary healthcare delivery, vulnerable group/special intervention financing for select secondary services and medical and public health emergency preparedness and response (EPR) systems, operationalizing a service delivery model that mirrors the "hub-and-spoke" structure of Nigeria's healthcare system**. All results incentivized by the PforR are part of the BHCPP. Table 1 below demonstrates the alignment between HOPE-PHC and the BHCPP. Table 2 clarifies the financing for the HOPE-PHC Program. The HOPE-PHC Program will include: (a) primary healthcare service readiness, availability, and quality in the NPHCDA and its counterpart State Primary Health Care Development Agencies (SHPDAs) to enable receipt of DFF from the BHCPF; (b) strategic purchasing for maternal and child health, administered by the NHIA and the State Social Health Insurance Agencies (SSHIAs) through general hospitals managed by the State Ministries of Health; (c) health security functions delivered by the Nigeria Center for Disease Control and Prevention (NCDC); (d) a National Emergency Services and Ambulance Scheme (NEMSAS); (e) digital-in-health to strengthen information systems and HRH; (f) medical industrialization; and (g) citizen engagement.

Table 1. Scope of Government Program and PforR Program

	Government's Basic Healthcare Provision Program	PforR Program	Reasons for Non-Alignment
Objective	Improve population health outcomes through strengthened primary healthcare systems.	Improve utilization of quality essential healthcare services and health system resilience.	Improve health outcomes over the longer term, building on

			strengthened primary healthcare systems.
Duration	2024–2028	2024–2028	Aligned. HOPE-PHC will support the initial phase of implementation of government program.
Geographic coverage	National	States that express interest and meet HOPE-GOV and HOPE-PHC eligibility criteria (EC).	Aligned
Results areas	Provide financing, enhance access to essential health services, improve quality of care, strengthen governance, enable a high-performing health workforce, and strengthen institutions, partnerships, and community engagement.	Results Area 1: Improving Quality of Services Results Area 2: Improving Utilization of Essential Services Results Area 3: Improving Resilience of the Health System	This is aligned with the focus of the Basic Healthcare Provision Program and the PforR's focus on health systems strengthening, service readiness and improved service delivery.
Overall Program Financing	**US$3.67 billion**	**US$525.00 million**	
Investment Project Financing		**US$45.01 million**	
		US$570.01 million	

Table 2. Program Financing

Source	Program Amount (US$ millions)	IPF amount	% of IPF Total
IDA Credit	460.51	39.47	87.67%
GFF	46.05	3.95	8.77%
GFF Nigeria Joint Financing (CIFF)	9.83	0.84	1.87%
GFF Nigeria Joint Financing (FCDO)	8.60	0.74	1.63%
Total Program Financing	**525.0**	**45.01**	**100**

Results Area 1: Improving Quality of Services
(US$177.5 million, of which IDA US$155.7 million and Grant US$21.8 million)

33. **This results area aims to improve service delivery by expanding the availability of PHC and CEmONC facilities that meet minimum criteria to deliver essential primary healthcare services and secondary obstetric and infant care.** The HOPE-PHC Program interventions under this results area allow for a progressive increase in the number of well-staffed, well-equipped, and climate-resilience BEmONC and CEmONC facilities in underserved and rural areas.

34. **The CEmONC facilities will be empaneled by the NHIA, effectively accrediting them for reimbursement of eligible services provided to the target population.** This will help to ensure the availability of lifesaving commodities in required amounts, including family planning supplies, which are essential to reduce neonatal and maternal mortality, as they decrease the number of high-risk births, increase birth spacing, and delay first births. In addition, effective RMNCAH-N services require the availability of other commodities, such as oxytocics, antimalarials, rapid diagnostics, nutrition commodities, and vaccines. The HOPE-PHC Program will ensure that domestic resources are guaranteed in the budget to allow for uninterrupted access to lifesaving commodities and will support facilities to address stockouts by measuring the availability of tracer commodities across the priority RMNCAH-N disease areas.

Results Area 2: Improving Utilization of Essential Services
(US$272.5 million, of which IDA US$239.0 million and Grant US$33.5 million)

35. This results area will support the NHIA to facilitate the enrollment of beneficiary populations by SSHIAs. The government made health insurance mandatory in 2022 through the revision of the NHIA Act, but full implementation will require significant public financing to ensure financial risk protection for targeted beneficiaries. Enrollment in the NHIA gateway of the BHCPF has been hampered by an inability to identify the beneficiary population and by the lack of appropriate technology to facilitate seamless enrollment. SSHIAs will be incentivized to adopt enhanced identification and enrollment protocols and report enrollment figures to the NHIA portal. The IPF component, described in detail in Annex 7, will provide TA to enhance the operationalization of SSHIAs.

36. Global experience has highlighted the strategic role of community health workers (CHWs) in delivering health services, especially in contexts where mistrust exists between service users and the formal health system. This results area leverages CHWs to provide critical frontline services, such as: (a) providing micronutrient powders or small-quantity lipid-based supplements to prevent malnutrition; (b) monitoring growth and screening for acutely malnourished children; (c) identifying and following up with pregnant women and referring them to receive multiple micronutrient supplements (MMS); and (d) treating childhood illnesses, such as diarrhea, rapid breathing, and fever through the use of Integrated Community Case Management. The CHWs are also able to link beneficiaries to available emergency medical services (EMS) in the community, allowing for quick referrals to secondary/CEmONC facilities. The HOPE-PHC Program leverages the HOPE-GOV operation to address gaps in financing, policy, and legal frameworks for CHWs.

37. This results area will support critical interventions to address maternal and neonatal mortality by ensuring free hospital admissions for emergency obstetric and neonatal care for pregnant women and newborns. In Nigeria, large socioeconomic inequalities exist in RMNCAH-N services. The 2018 National Demographic and Health Survey (NDHS) showed that only 12 percent of deliveries in the poorest wealth quintile had skilled birth attendants, compared to 87 percent in the wealthiest quintile. Moreover, fewer than 3 percent of pregnant women utilize CEmONC services for delivery. There is a critical need to provide public financing for catastrophic but cost-effective maternal, newborn, and child health interventions by ensuring the reimbursement of services utilized by the beneficiary population.

38. To support improvements in health outcomes, this results area aims to improve the quality and utilization of maternal and child health services at the PHC level. It will focus on the priority interventions listed in the benefit package agreed by the NPHCDA and NHIA in the planned revision of the BHCPF guidelines, including family planning, antenatal care (ANC), safe delivery, postnatal care, nutrition services, treatment of pneumonia and diarrhea, and malaria treatment for children under five.

39. Increasing the utilization of EMS among pregnant women and newborns is crucial, as delays in accessing appropriate healthcare in the case of pregnancy complications and poorly managed deliveries have been linked to high maternal mortality. This results area aims to enhance the utilization of quick and prompt EMS, referral, and transport of complicated deliveries in community/BEmONC facilities requiring CEmONC care and advanced neonatal resuscitation for newborns. It will also facilitate the scale-up of a digitally enabled ambulatory health service to improve sustainability and dispatch times for ambulatory health services more generally.

Results Area 3: Improving Resilience of the Health System
(US$75.0 million, of which IDA US$65.8 million and Grant US$9.2 million)

40. This results area will seek to increase the equitable allocation and disbursement of the BHCPF. Given the notable disparities in utilization of health services between urban and rural areas, with rural residents of the North-West and North-East geopolitical zones facing the highest risk of under-five and maternal mortality, prioritizing the deployment of

scarce resources to such areas can secure rapid improvements in health outcomes. A responsive BHCPF guideline that incorporates this targeted approach will increase access to essential healthcare services and improve the chances of survival for vulnerable populations. Revision of the BHCPF is a prior result under the HOPE-PHC Program.

41. Enhancing the health system's resilience against shocks such as disease outbreaks, climate emergencies, and other humanitarian crises is a critical part of safeguarding access to and delivery of essential health services. This results area will further improve the containment of emergencies and shocks to the health system by ensuring that states are better prepared to mitigate health system vulnerabilities through the development and implementation of multiyear EPR plans. In addition, it will support the development and implementation of a costed national climate and health adaptation plan to be adopted by subnational entities and incentivize implementation of the plan at both the national and state levels.

42. Finally, this results area will support the development of an integrated, interoperable health data ecosystem to support evidence-based improvements in value (efficiency, quality, access, and health outcomes) for patients and providers. Learning from other countries and customizing solutions to fit the Nigerian context, this results area aims to lay a strong digital foundation by strengthening national standards, regulations, rules, and business processes for creating and maintaining a national health data space through a distributed enterprise architecture approach, and to facilitate the adoption and effective functioning of the health data ecosystem at the state level by integrating individual private, public, and program-specific health information systems.

E. Program Development Objective (PDO) and PDO Level Results Indicators

43. The Program Development Objective (PDO) is "to improve utilization of quality essential healthcare services and health system resilience in the Federal Republic of Nigeria." Four PDO-level indicators align with the PDO's emphasis on quality and utilization of primary and priority secondary healthcare services and resilience of health systems (Table 4).

Table 3. PDO Indicators

	Elements of PDO	
PDO Indicator	*Improving utilization of quality essential services*	*Improving resilience of the health system*
Women and children who receive tracer essential health services in the community increased (number)	✓	
PHC facilities achieving service readiness assessment criteria (percentage)		✓
National climate and health adaptation plan developed, costed, validated, and implemented (number)		✓
Proportion of births attended by a skilled provider (percentage)	✓	

F. Disbursement-Linked Indicators and Verification Protocols

44. **The HOPE-PHC Program will incentivize the achievement of DLIs in each of the three results areas.** DLIs are chosen based on key principles: (a) incentivizing a mix of DLIs across the results chain; (b) placing a heavier weighting on service outputs and direct drivers of health outcomes; (c) reducing the complexity of results measured;(d) limiting the number of DLIs; (e) linking to data sources and standardized measurement approaches; (f) ensuring the scalability of DLIs, where relevant; and (g) adopting continuous rather than periodic verification cycles. The DLIs include a combination of outcomes, intermediate results, and outputs (Annex 1). Allocations against the DLIs will allow for regular disbursement flow throughout the HOPE-PHC Program period. Annex 1 provides more detail on each of the DLIs, including whether they are timebound and scalable, and corresponding verification protocols.

45. **HOPE-PHC Program will disburse based on the achievement of eleven DLIs identified and pre-agreed with the FMOH&SW and its agencies, states, and health partners.** For each DLI, yearly targets (disbursement-linked results, or DLRs) are defined, against which a "price" will be paid. Each DLI price represents a combination of strategic importance, ambition, and feasibility of achieving the DLRs, but not the cost of achieving them. Prior results will be non-scalable. From Year 1, most results will be scalable, and any time the results are met fully or partially, disbursement will be made in proportion to the achievement of the DLR. A summary of DLIs proposed under the HOPE-PHC is captured in Table 4 below.

Table 4. Summary Table of DLIs Across Results Areas

DLI		DLI IDA Amount (US$)	DLI Grant Amount (US$)	Recipient DLI Unit	Scalable	Time-Bound
Results Area 1: Improving Quality of Services						
DLI 1: Improved service readiness	**DLR 1.1:** Improved primary healthcare facility readiness, quality, and climate resilience in Participating States (percentage)	53.95	7.55	States	Yes	Yes
	DLR 1.2: Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (number)	50.88	7.12	States	Yes	Yes
DLI 2: Increased availability of essential commodities	**DLR 2.1:** Federal expenditure on quality family planning commodities increased (percentage)	21.93	3.07	Federal	Yes	Yes
	DLR 2.2: Frontline availability of tracer products improved in Participating States (percentage)	28.95	4.05	States	Yes	Yes
Results Area 2: Improving Utilization of Essential Services						
DLI 3: Increased enrollment of poor and vulnerable populations	**DLR 3.1:** Financial protection for poor and vulnerable populations increased in Participating States (number)	35.09	4.91	States	Yes	Yes
DLI 4: Enhanced community delivery of health services	**DLR 4.1:** Women and children who receive tracer essential health services in the community increased in Participating States (number)	43.68	6.14	States	Yes	No
DLI 5: Increased utilization of priority secondary care services	**DLR 5.1: Secondary Facility Quality of Care for CEmONCs (Prior Result)**	2.19	0.31	Federal	No	Yes
	DLR 5.2: Women and neonates receiving CEmONC and neonatal services and/or vesico-vaginal fistula surgeries (number)	61.40	8.60	Federal	Yes	No
DLI 6: Increased Primary Healthcare utilization of	**DLR 6.1:** Deliveries with skilled birth attendant present increased in Participating States (percentage)	30.70	4.30	States	Yes	No
	DLR 6.2: Introduction of MMS for pregnant women during antenatal	17.54	2.46	States	Yes	No

priority services	care in Participating States (percentage)					
	DLR 6.3: Increase in Penta 3 coverage in Participating States (percentage)	30.70	4.30	States	Yes	No
DLI 7: Increased utilization of emergency medical services	**DLR 7.1**: Patients with obstetric and neonatal complications transported through emergency medical transport to selected facilities using the digitized EMS dispatch system (number) in Participating States (number)	17.54	2.46	States	Yes	No
	Results Area #3: Improving Resilience of the Health System					
DLI 8: Improved allocation and disbursement of BHCPF funds	**DLR 8.1: Governance for improved resource allocation and performance (Prior Result)**	2.19	0.31	Federal	No	Yes
	DLR 8.2: Participating States receiving funds in compliance with allocation formula in revised guidelines (number)	8.77	1.23	States	No	Yes
DLI 9: Enhanced pandemic preparedness and response (PPR) through deployment	**DLR 9.1-9.4:** System and standards for state EPR programs are established (number)	13.16	1.84	States	Yes	Yes
DLI 10: Improved climate resilience	**DLR 10.1-10.4:** Climate and health adaptation plan developed, costed, and validated (number)	26.32	3.68	States	Yes	Yes
DLI 11: Stronger digital foundation	**DLR 11.1: National enterprise archtecture developed, costed, and adopted (Prior Result)**	2.19	0.31	Federal	No	Yes
	DLI 11.2: Participating States adopting national enterprise architecture and integrating core health functions (number)	13.16	1.84	States	No	Yes
TOTAL		**460.53**	**64.47**			

Eligibility Criteria (EC) for States

46. **The annual EC for States are intended to strengthen interdependencies between pursuit of governance actions under HOPE-GOV, such as enhanced preparation and transparency of the basic elements of the budget cycle and sectoral planning through the Annual Operational Plans**. Participation in HOPE-PHC will be contingent upon States' participation in HOPE-GOV demonstrated in the achievement of annual EC. HOPE-GOV EC build on EC initially introduced by the States Fiscal Transparency, Accountability and Sustainability (SFTAS PforR; P162009) and already being practiced in all 36 states and the Federal Capital Territory (FCT). HOPE-GOV EC include annual preparation and publication of the budget prepared in accordance with the Chart of Accounts and approved by the State Assembly; annual preparation and publication of audited financial statements in accordance with IPSAS; and annual publication of quarterly budget

implementation reports on primary healthcare within 30 days of the end of the quarter. For HOPE-PHC, additional criteria will include the preparation of sectoral Annual Operational Plans that translates the BHCPP into short-term operational plans; maintenance of BHCPF State Oversight Committees and implementation of Funds Release Policies which strengthen re-investment of DLI proceeds in the health sector.

Table 5. States' Eligibility Criteria (EC) for HOPE-PHC

	Year 1 – 2025	Year 2 – 2026	Year 3 - 2027	Year 4 - 2028
EC-GOV	Participation in and achievement of Annual EC for HOPE-GOV	Participation in and achievement of Annual EC for HOPE-GOV	Participation in and achievement of Annual EC for HOPE-GOV	Participation in and achievement of Annual EC for HOPE-GOV
EC-1	State Annual Operational Plan that aligns with the goals of the sector wide approach as articulated in the signed health compact is approved by the SWAp Coordinating Office (SCO).	State Annual Operational Plan that aligns with the goals of the sector wide approach as articulated in the signed health compact is approved by the SCO.	State Annual Operational Plan that aligns with the goals of the sector wide approach as articulated in the signed health compact is approved by the SCO.	State Annual Operational Plan that aligns with the goals of the sector wide approach as articulated in the signed health compact is approved by the SCO.
EC-2	State revises the terms of reference and composition of the BHCPF State Oversight Committee.	State maintains composition and functioning of the State Oversight Committee in accordance with the revised terms of reference.	State maintains composition and functioning of the State Oversight Committee in accordance with the revised terms of reference.	State maintains composition and functioning of the State Oversight Committee in accordance with the revised terms of reference.
EC-3	State adopts and signs Funds Release Policy for management of PforR earnings.			

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

47. The table below outlines the institutional and implementation arrangements for HOPE-PHC, including linkages to HOPE-GOV through joint governance arrangements:

Table 6. HOPE-PHC Institutional and Implementation Arrangements

RESPONSIBLE ENTITY	COMPOSITION	ROLES AND RESPONSIBILITIES	ACCOUNTABILITIES
HOPE INTER-MINISTERIAL NATIONAL STEERING COMMITTEE (NSC) "Joint inter-ministerial steering committee at the federal level (the "National Steering Committee" or "NSC")"	• Co-Chaired by Coordinating Minister of Health and Social Welfare (CMHSW)/Minister of Budget and Economic Planning/Minister of Education. • Also, include as members the minister responsible for finance, and any other relevant ministries and subnational entities, as further detailed in the POM.	• Responsible for providing high-level guidance, advice, and strategic oversight on the HOPE interdependent series of operations, with functions, as further detailed in the POM. • Guardian of rules for the HOPE SOPs. • Adoption of government wide Human Capital Development (HCD) policies. • Setting and achieving of HCD reforms agenda.	• Realization of HOPE interdependent series of operations contribution to the HCD vision of the Government of Nigeria.
SWAp STEERING COMMITTEE "Steering committee at the federal level (the "SWAp Steering Committee" or "SSC") responsible for providing strategic sectoral oversight with functions, composition and resources detailed in the Program Operations Manual (POM)".	SSC shall be chaired by the minister responsible for health and social welfare and includes as members the Minister of State for Health, the representative of the Minister of Finance, the Permanent Secretary for Health (PSH), relevant heads of agencies of the FMOH&SW, selected members of the Development Partners Group for Health (DPG-Health), and other members nominated by the CMHSW, as further detailed in the POM.	• Approving policy and strategic direction for the NHSRII. • Defines the health sector priorities, convenes relevant entities, provides steer and direction to all SWAp bodies on strategies recommended by them. • Approve POM including Standard Operating Procedures (SOPs). • Administrative approval of IPF proposals under the project. • The SSC will be ultimately responsible for achieving the HOPE-PHC PforR PDOs through the achievement of DLI results.	• The investments and other projects/programs are aligned to national priorities and state's demands as articulated in the NHSRII.
NPCU/SCO "Coordination unit for the operation (the "National Program Coordination Unit" or "NPCU") within the SWAp Coordination Office, with functions, composition, and resources detailed in the POM.	• The NPCU shall be headed by a national coordinator. • Include specialists in program management, procurement, financial management (FM), environmental and social matters, communications and such other specialist as may be specified in the POM, all with qualifications, experience, and ethics, and subject to the terms of reference acceptable to the Bank, as further defined in the POM.	• Day-to-day operations and overall coordination of the project. • Planning, budgeting, and reporting. • Serving as the secretariat of the SSC. • Monitoring and coordinating the implementation of the Program in line with guidance from the SSC. • Implementing the Project with responsibilities including but not limited to FM, procurement, environmental and social, M&E, and communications, as further defined in the POM.	• Attaining the PDO-level and intermediate-level indicators
STATE BHCPF OVERSIGHT COMMITTEE. "Based on a revised terms of reference and composition of the BHCPF state oversight committee (the "State Oversight Committee" or "BHCPF SOC") to accommodate membership	• Chaired by Commissioner of Health responsible for the State health system. • Membership includes technical experts from relevant state departments. • Includes state-based DPG-Health members. • Meets at least quarterly	• Coordination between state government and NPCU. • Technical approval for State Annual Operational Plans. • The BHCPF SOCs shall be responsible for providing technical oversight and implementation monitoring to ensure that critical actions are on	• Ensuring that the investments conform to national standards. • M&E of Program indicators

RESPONSIBLE ENTITY	COMPOSITION	ROLES AND RESPONSIBILITIES	ACCOUNTABILITIES
from the State Ministry of Finance; Budget and National Planning; office of the state accountant General and any other entity.		track towards the achieving of the DLIs in participating states as applicable, all as further specified in the POM. • Day-to-day operations and overall coordination of the project. • Planning, budgeting, and reporting.	

B. Results Monitoring and Evaluation

48. **The HOPE-PHC Program's M&E framework will rely on multiple data sources, with an emphasis on supporting and strengthening existing information systems.** Program monitoring will take place across the federal, state, health facility, and community levels and will be anchored by the SCO's M&E Technical Working Group (TWG). At the federal level, the NPCU working with FMOH&SW Department of Health, Planning, Research, and Statistics and the NPCU will be responsible for developing and publishing the annual State of Health Report, which will include a state performance index to support both equitable and needs-based allocation of the BHCPF and broader data-driven decision making. At the state level, M&E will draw on administrative data from the District Health Information System 2 (DHIS-2) and other national surveys to assess service coverage and utilization. NDHS data (and likely mini-DHS) will be used to assess skilled birth attendance; and the Multiple Indicator Cluster Survey (MICS) and mini-MICS for immunization coverage, with the possibility of a mid-term "mini-DHS" in 2026. Where available, surveys will be leveraged to triangulate results. Quality assessment and supportive supervision checklists, health facility surveys, and essential medicine assessments will also be used for progress monitoring and DLI achievement verification. Sample-based approaches will be used for facility readiness, commodity stock, and other relevant data collection, particularly where there is risk of gaming. The performance monitoring system will capture data on shocks (climate-related or others) that may affect service delivery. A detailed overview of the HOPE-PHC Program's results framework and DLIs are found in Annex 1, including detailed descriptions of verification protocols.

49. Lessons from previous PforRs in the sector suggest relying on more routine systems with data quality assurance and verification adjustments to assess performance and make payments against results. Innovative methods to estimate service contact coverage will therefore be explored, including service coverage estimations for high-volume services using rigorous data quality assessment processes to derive quality-adjusted DHIS-2 estimates (following validated approaches from the Countdown to 2030 collaboration and the GFF's Frequent Assessments and Systems Tools for Resilience (FASTR) initiative).

50. **The HOPE-GOV NPCU will competitively recruit a third-party Independent Verification Agency (IVA), on terms of reference acceptable to the World Bank.** The IVA will verify the achievement of DLRs in accordance with the approved verification protocol and work closely with the National Bureau of Statistics, M&E experts at the Federal Ministry of Budget and Economic Planning (FMBEP) NPCU and FMOH&SW NPCU/SCO. Full details of the protocol will be included in the POM. The IVA will be tasked to verify the achievement of the DLI targets based on data reported by the implementing agencies and other information sources identified in the protocol. The IVA procurement will be an eligible expenditure under the HOPE-PHC; however, the procurement process will be done under the HOPE-GOV within sixty days of the Program's effectiveness.

C. Disbursement Arrangements

51. **Disbursements will be made based on the achievement of results under each DLI.** The government will partly pre-finance expenditures for the HOPE-PHC Program, using its own budget resources through the identified budget lines of

the Program Expenditure Framework (PEF). The implementing entities will prepare technical reports to document the achievement of DLIs, to be verified by the designated IVA. Upon verification, the NPCU/SCO will communicate the achievement of DLIs and corresponding DLI values to the World Bank, along with supporting documents. For payments to states, the NPCU/SCO will submit a Results Achievement Note to the World Bank, along with supporting documentation. Once the World Bank agrees with the results achieved, it will provide a written request to the NPCU to prepare a withdrawal application. Upon notification of acceptance of the verification report by the World Bank, the NPCU will submit the withdrawal application to the World Bank, using its Client Connection System's e-disbursement functionality. The proceeds of the IDA credit and trust fund grants under the HOPE-PHC Program will be disbursed to the government's Special Fund Account, a subaccount of the Treasury Single Account held with the Central Bank of Nigeria (CBN) and managed by the FMOH&SW NPCU. Disbursement to participating states will be made directly from the Special Fund Account to a segregated HOPE-PHC Program account to be opened in each state, which will be a sub-account of the consolidated revenue fund account of the respective states and from which disbursements will be made to the implementing agencies according to the Funds Release Policy adopted by participating states.

52. **There will be an advance equivalent up to 30 percent of the total value of DLI 1.1, 1.2 and 5.2, totaling US$55 million.** The advance is necessary for the implementation of activities to achieve DLIs in the initial years, benefitting activities with longer lead times (such as capital investments). When the DLIs are achieved, the advance amount will be deducted (recovered) from the amount due to be disbursed and will be available again on a rolling basis, as requested by the government.

53. **Prior results (DLIs 5.1, 8.1, and 11.1) are expected to be achieved before the HOPE-PHC Program's legal agreements are signed.** Combined with the achievement of prior results, estimated at US$7.5 million, the total disbursement upon effectiveness is expected to be US$62.5 million (not more than 30 percent of IDA financing), within the PforR's allowed threshold.

D. Capacity Building

54. **Capacity building support will be critical to achieving the transformational results envisaged under the NHSRII.** Through its IPF component, the HOPE-PHC Program will support sector-wide efforts for: coordinated deployment of needs-based and demand-driven TA and diagnostic support. The coordinated TA mechanism will be financed by development partners and managed by the SCO. Furthermore, in recognition of pronounced geographical spatial disparities and inequalities associated with poor health outcomes, the program will provide additional TA under the IPF component to states with the worst health outcomes in Nigeria.

55. **An IPF component (US$45.01 million) will largely finance TA designed to enhance states' performance.** The design, procurement, and deployment of a federated digital-in-health enterprise architecture including TA on enhanced digital capacity, including[37] consultancies on defining regulatory frameworks, enterprise architecture design, and acquisition; TA for strengthening the strategic purchasing and regulatory functions of NHIA including institutional building blocks for provider empanelment, tariffs, claims management, medical audit, provider payment, beneficiary feedback and engagement of third-party administrators, and support for standards adoption by SSHIAs; effective peer learning support through the Nigeria Governor's Forum and Association of Local Governments of Nigeria for intensive engagement with leaders at the subnational level to maintain strong political support and commitment. The IPF component will also enhance service delivery capacity in high-burden and climate-vulnerable states who may face institutional, financial and/or delivery capacity constraints through innovations deployed in partnership with public or private sector actors under the umbrella of Maternal Mortality Reduction Innovations Initiative (MaMII). The IPF component will also contribute to the Joint Health Development TA coordination platform. See Annex 7 for IPF component details.

[37] Due attention will be paid to avoiding the fragmentation of IT-enabled platforms and encourage consolidation while developing digital innovations.

56. **Retroactive Financing.** The IPF component will include retroactive financing as follows: (a) regarding the credit, up to an aggregate amount not to exceed US$877,170 may be made for payments made prior to but not more than twelve (12) months before the Signature Date of the Financing Agreement for Eligible Expenditures specified in the Financing Agreement; and (b) with respect to the GFF grant, up to an aggregate amount not to exceed US$122,830 may be made for payments made prior to but not more than twelve (12) months before the Signature Date of the GFF Grant Agreement for Eligible Expenditures specified in the GFF Grant Agreement.

57. **The World Bank will provide additional TA to develop and implement an operational impact and learning agenda linked to the PDOs and government learning priorities**. This process will be led by the Development Impact (DIME) Group at the World Bank, in collaboration with partners. DIME will support the government in using "trial-and-adopt" impact evaluations to increase effectiveness and cost-effectiveness, working to: (a) embed existing knowledge in the design of programs/interventions; (b) test alternative intervention designs and delivery modalities to identify what works best in practice and iteratively optimize design; and (c) credibly document outcomes and impacts so that effective solutions can be adopted and scaled. The focus and scope of trial-and-adopt activities will be defined jointly with the government as part of detailed implementation planning. This approach is consistent with the World Bank's Knowledge Compact.

58. **The Nigeria DPG-Health has been actively and extensively involved in operationalization of the SWAp and co-creation of the NHSRII.** Partners are aligned with the government's reform imperatives, including its laser focus on strengthening health systems and primary healthcare. Most development partners are already aligning their resources with the requirements of the NHSRII and working through the established TWGs, with membership from the FMOH&SW and its ministries, departments, and agencies (MDAs); subnational entities; and development partners. This effort seeks to ensure that TA resources are deployed in a transparent manner to enable lagging states to access needed support.

ASSESSMENT SUMMARY

A. Technical (including program economic evaluation)

59. **The HOPE-PHC Program is designed to target strategic health outcomes that are crucial for advancing overall development outcomes in Nigeria.** Primary healthcare system strengthening, as supported by the HOPE-PHC Program, is one of the most cost-effective approaches to improving human capital outcomes through the health sector and generates significant economic benefits.[38] Specifically, improvements in maternal and child survival are crucial if Nigeria is to improve its HCI. Nigeria's efforts to reduce child mortality and improve maternal health contribute to SDG 3, which aims to ensure healthy lives and promote well-being for all.

60. **The HOPE-PHC Program will enhance the capacity of primary healthcare facilities in Nigeria to deliver high-quality health services in line with global recommendations**. The investment in facility readiness encompasses efforts to improve infrastructure, train staff, and secure necessary medical supplies and equipment, all of which are critical for delivering quality of care. Furthermore, the HOPE-PHC Program will increase the availability of funding at the frontline to respond to specific needs and challenges. Focusing on quality in healthcare delivery is of paramount importance, as highlighted by the Lancet Commission on High-Quality Health Systems, which emphasizes that access to care alone is insufficient; the quality of care is equally crucial for achieving positive health outcomes, including ensuring the availability of and sustainable financing for high-quality drugs and commodities at facilities. Dependence on development partners for critical commodities, such as contraceptives, risks supply chain disruptions due to the unpredictability of funding. Increases in domestic resources for key drugs and commodities over time through the recurrent budget will align with the

[38] WHO. 2018. "Building the economic case for primary health care: a scoping review." https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf

aims of the SWAp. Moreover, strengthening supply chain management will not only support the provision of a basic package of services, but also have spillover effects to help build a climate- and emergency-resilient health systems.

61. **The HOPE-PHC Program's basic package of interventions is designed to be delivered primarily at the primary healthcare level, ensuring that foundational healthcare is accessible to all**. To ensure the most effective allocation of resources given the limited resource envelope, the HOPE-PHC Program will be guided by global and national evidence, including Disease Control Priorities. The package will focus predominantly on RMNCAH-N, aligning with the national commitment to reduce maternal and child mortality. The full scope of services extends beyond primary healthcare facilities, incorporating crucial community-level interventions on health promotion, disease prevention, and simple curative measures. In scenarios where access to health facilities is severely limited, the services provided at the community level may be expanded beyond the core package to include essential curative care to improve health outcomes across all segments of the population.

62. **In settings where health services are underutilized, it is crucial to actively foster demand for these services.** This is particularly important for essential health services, such as family planning and ANC, which are often underutilized despite their significance in improving health outcomes. Demand generation activities are most effective when implemented at the community level, leveraging existing community-based service delivery mechanisms that are already trusted by the local population. The HOPE-PHC Program will support investments to enhance the effectiveness of current community-based service delivery platforms. To achieve this, the HOPE-PHC Program will adopt a "hub-and-spoke" model designed to strengthen links between PHC facilities and community health actors, such as Community Health Officers, Community Health Extension Workers (CHEWs), and auxiliary CHWs.[39] The HOPE-PHC Program also places a high priority on the professional development of community health actors, offering training opportunities to enhance their skills and ensure that the quality of services provided at the community level meets the high standards necessary for improving health outcomes. Through these strategic interventions, the HOPE-PHC Program aims to build a more resilient and responsive health system at the grassroots level.

63. **Ensuring that every Nigerian pregnant woman and newborn has access to lifesaving care at the CEmONC level is necessary to reduce maternal and newborn mortality.** The HOPE-PHC Program will focus on refurbishing, accrediting, and empaneling at least one public or private CEmONC facility per LGA and will support improvements in the structural and process quality of Tier 2 PHC facilities, in line with the revised emergency obstetric and neonatal care guidelines of the World Health Organization (WHO), to ensure the availability of BEmONC services that can refer women and babies to CEmONC, as needed.

64. **Strengthening PHC systems is not only vital for immediate health outcomes, but also a means to create positive spillovers for the broader resilience agenda.** Strong primary healthcare systems form the backbone of effective PPR, ensuring that communities are better equipped to handle public health emergencies. Resilient primary healthcare systems are more adept at adapting to and addressing the emerging health needs brought about by climate change, thereby safeguarding the well-being of populations against a spectrum of environmental challenges.

65. **The HOPE-PHC Program has a strong economic rationale.** Many services provided in the primary care setting have public good or externality dimensions, including infectious disease treatment and maternal and child health services. Moreover, primary care interventions such as family planning, ANC, immunization, and nutrition services are generally more cost-effective (with a greater health impact per Naira spent) than secondary and tertiary care. Because of the high value attached to better health (both intrinsically and as an investment in human capital), the benefit–cost ratio of effective government health spending is favorable. Simulations suggest that a ratio of over 20:1 is possible. In addition, the focus on governance and accountability, especially in the interdependent HOPE-GOV operation, can help mitigate potential "government failure" issues that may beset healthcare delivery, helping to ensure greater impact. While BHCPP

[39] CHEWs/CHOs are formally trained health workers.

investments have recurrent budget implications for federal and state governments, Nigeria is among the world's lowest health spenders, such that increased (and more effective) spending is to be welcomed and can be managed. Given the very low baseline (government spending on primary care is about 0.1 percent of GDP), even significant proportional increases would not pose a risk to overall public finances. Moreover, increased PHC spending can be partly achieved by reallocations away from less effective secondary and tertiary care. Finally, public primary care facilities and community health service delivery platforms operate close to the population and thus represent the most pro-poor segment of the government's delivery network. These issues are discussed further in Annex 2.

Paris Alignment

66. The HOPE-PHC Program is consistent with the Paris Agreement on climate change. The HOPE-PHC Program's service delivery activities are anticipated to be vulnerable to storm surges, increasing temperatures, and floods, and measures to build resilience to these shocks are embedded throughout activities to achieve the DLIs. On adaptation, through national climate structures, execution of World Bank-financed HOPE-PHC Program, and climate-change-focused health structures, including the FMOH&SW's Office of Climate Change and Environmental Health and the Climate Change and Health TWG, the Government has demonstrated capacity to execute resilience measures to achieve the HOPE-PHC Program's results. Climate EPR plans, including planning capacity, will be developed to respond to climate emergencies, as part of DLI 9, which will help guide climate EPR for the HOPE-PHC Program's activities. Health service delivery interventions under Results Areas 1 and 2 will use climate-sensitive planning and data, for example from the climate and health vulnerability assessment, along with CHW visits and outreach visits to ensure continuity of services during climate shocks and targeted response to the most vulnerable communities during these periods. The CHW digitization platform, financed through DLIs 4 and 11 and IPF subcomponent 2, will include climate EPR training, job aides, and a communication platform to facilitate the use of CHWs for service continuity. PHC and CEmONC facility rehabilitation in DLI 1 will incorporate climate resilience measures, going beyond standard practice to reduce exposure to flooding, high heat, and storm surges. DLI 7 on increased utilization of EMS will include resilience measures, such as climate-sensitive planning, specific climate shock operating procedures in the standard operating procedures (SOPs) for emergency transportation and ensuring that real-time weather information is available to dispatchers to ensure service continuity. Therefore, the risks from climate hazards have been reduced to an acceptable level, and the project is aligned with the adaptation and resilience goals of the Paris Agreement. On mitigation, most of the HOPE-PHC Program's activities are universally aligned with the Paris Agreement on Climate Change. Building rehabilitation activities will incorporate energy efficiency measures, to ensure at least a 20 percent improvement in energy efficiency in comparison to current practice including EDGE level 1 certification for CEmONC facilities.

B. Fiduciary

67. **An Integrated Fiduciary Systems Assessment (IFSA) was conducted by the World Bank, reviewing PFM, procurement, anticorruption, and relevant laws, policies, systems, practices, and procedures at the participating MDAs.** In addition to the FMOH&SW, the IFSA assessed the NPHCDA, NHIA, and a sample of state-level counterparts. The IFSA is deemed to be adequate, carried out in line with the World Bank's PforR Policy and Directive. The assessment concluded that the fiduciary systems in place for procurement, financial management (FM), governance, and anticorruption provide reasonable assurance that financing proceeds would be used for the intended purposes, subject to implementation of the Program Action Plan (PAP) with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability, and will support achievement of the PDO. A detailed assessment is described in Annex 3.

68. **The overall fiduciary risk (FM, procurement, and governance) is rated Substantial.** Key contributing factors include: (a) use of HOPE-PHC Program funds for purposes other than those intended, which will be mitigated by adequate verification of results by the IVA; (b) delayed appropriated releases to implementing agencies, which will be mitigated by introducing service standards in the release of HOPE-PHC Program funds as part of the PAP and ensuring that the terms

of reference for external auditors and IVAs include a review of the timeliness of funds released to the agencies; (c) implementing agencies' limited knowledge of and lack of experience with PforR operations, which will be mitigated through training and capacity building to be financed, as needed, under the IPF component; (d) ambiguity on the HOPE-PHC Program's operational procedures, which will be mitigated by preparing the HOPE-PHC POM detailing procedures for procurement, FM, anticorruption, and environmental and social (E&S) safeguards processes; (e) low procurement capacity, leading to inefficient and non-transparent procurement, which will be mitigated by preparing and implementing a comprehensive Procurement Capacity Development Plan for the implementing agencies based on a needs assessment and deployment of an experienced Procurement Officer for the PforR in each implementing agency; (f) weak controls and inadequate compliance with Public Procurement Acts and Regulations, which will be addressed through a program procurement performance and value for money audit to be carried out by an independent third party using terms of reference agreed with the World Bank; and (g) multiple procurement processes throughout the year for recurring items, leading to higher costs, delays, and stockouts, which will be addressed by using a Framework Agreement for procuring recurring items. A fiduciary risk summary is included in Annex 3.

69. **The implementing agencies have a robust budget and accounts classification system that will enable reporting on HOPE-PHC Program expenditures.** The audit of the HOPE-PHC Program will be conducted by the Office of the Auditor General for the Federation (OAuGF) and the State Auditors General for federal and state agencies, respectively. After receiving their audit reports, the NPCU will compile program expenditure data for the federal and state participating MDAs, extracted from the audited financial statements. The data will be certified by the OAuGF, with an opinion expressed based on an agreed-upon procedure. The implementing agencies will strengthen their capacity to undertake risk-based internal audits, and the FMOH&SW and other implementing agencies will prepare and implement an internal audit plan.

70. **The Nigeria Public Procurement Act 2007 and associated procurement regulations and systems are adequate for the achievement of PDOs.** Federal and state-level procurement laws are based on the United Nations Commission on International Trade Law (UNCITRAL) model, with minor differences to cater for peculiarities at the state level. The World Bank's Procurement Regulations will govern procurement under the IPF component. The NPCU has prepared a Procurement Plan for the IPF component for the first 18 months with inputs from participating states. The Procurement Plan describes each contract to be financed under the IPF, the selection methods, estimated costs, prior review requirements, and time frame in accordance with the procurement arrangements in the Program Procurement Strategy for Development (PPSD) acceptable to the World Bank. The Procurement Plan will be updated at least annually, or as required, to reflect the actual project implementation needs. All procurement transactions will be executed on the World Bank online tool, the Systematic Tracking of Exchanges in Procurement (STEP). The Procurement Plan will be updated at least annually, or as required, to reflect the actual project implementation needs.

71. **The World Bank Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results-Financing will apply to the HOPE-PHC Program, and grievance redress mechanisms (GRM) will be implemented across all implementing agencies.** The NPCU in the FMOH&SW will consolidate the cases of fraud and corruption received from all implementing agencies, including procurement agencies across the states, and provide a semi-annual report to the World Bank. The report will indicate the status and outcome of any investigations and measures taken, if any; if no allegations or actions are reported during a period, this will be indicated. Conversely, if the World Bank uncovers evidence of corruption, it will, in line with its policies, refer the case to the Independent Corrupt Practices Commission or other relevant agency through the FMOH&SW and the independent integrity vice presidency of the World Bank. If the World Bank initiates an administrative review of potential fraud and corruption related to the HOPE-PHC Program, the Government will need to ensure full cooperation from all relevant parties, including FMBEP, FMOH&SW, NHIA, NPHCDA, SMoH, SSHIAs, and SPHCDAs. The Economic and Financial Crimes Commission (EFCC), Independent Corrupt Practices Commission, and Nigeria Police will handle investigations of fraud and corruption. Under the HOPE-PHC Program, the World Bank will appraise at the earliest opportunity all allegations and complaints of fraud and corruption related to HOPE-PHC Program.

C. Environmental and Social

72. **The World Bank has undertaken and consulted on an Environmental and Social Systems Assessment (ESSA).** The ESSA concludes that policy, institutional, and legal provisions are adequate to ensure that the HOPE-PHC Program's social and environmental risks are minimized and its effects positive. While gaps exist, the World Bank has agreed with the Government on specific actions to strengthen E&S management systems and mitigate potential risks as specified in the PAP (Annex 5).

73. **Overall E&S risks have been assessed as Moderate.** In line with the six core principles outlined in the World Bank's PforR Policy, the relevant E&S risks directly associated with HOPE-PHC Program interventions that may impact the achievement of its intended objectives are as follows: (a) refurbishment and rehabilitation of facilities could result in negative environmental impacts, such as the generation of solid waste, noise, and air pollution; (b) discrimination could exist in the recruitment of healthcare workers, such as skilled birth attendants; (c) generation of e-waste could increase due to the digitization of the health system; (d) there could be an increase in the generation of healthcare waste due to increased spending on the provision of facilities, an expansion in the number and improved quality of healthcare facilities, and increased expenditure for provision of health products; (e) there could be discrimination against vulnerable groups, ethnic bias, and sexual abuse or harassment of women in the provision of health insurance under the NHIA gateway in the revised BHCPF guideline and in the provision of essential health services by CHWs; (f) negative environmental impacts may be associated with renewable energy, such as solar systems, especially electronic waste, old batteries and panels, and possible clearing of land/vegetation to install solar panels; and (g) rehabilitation work could affect workers' health and safety. The PAP outlines comprehensive measures to manage these E&S risks (Annexes 4 and 5).

74. **The E&S risks of the IPF TA component are rated Low, given its minimal scope.** The Environmental and Social Commitment Plan (ESCP), which has been prepared and publicly disclosed in-country on August 21st, 2024, and August 30th, 2024, on the Bank website[40] includes activities to improve labor management procedures and continuous stakeholder engagement throughout implementation, including grievance mechanisms for direct and indirect workers, including IVAs. To further promote understanding of social accountability and build trust in government systems, the HOPE-PHC Program will ensure that a GRM is in place, which will be incorporated into the Stakeholder Engagement Plan SEP), which has been prepared and publicly disclosed (in-country on August 21st, 2024, and August 30th, 2024, on the Bank website.[41] The IPF TA component includes the deployment of a communications strategy and people's voice survey and will leverage civil society to help improve social accountability in the health sector. Nigeria's education, health, and governance sectors are governed by public service rules that address issues with labor and working conditions. However, because private entities such as the IVA and M&E consultants are not covered by public service rules, the FMOH&SW will prepare a labor management procedure to address the risks associated with such entities. The procedure will include information on occupational health and safety; the Code of Conduct for preventing sexual exploitation, abuse, and sexual harassment; and grievance mechanisms. An Environmental and Social Screening Checklist will be developed to identify other potential E&S activities.

75. **Communities and individuals who believe that they are adversely affected as a result of HOPE-PHC Program interventions, as defined by the applicable policy and procedures, may submit complaints to the existing program Grievance Redress Mechanism (GRM) or the World Bank's Grievance Redress Service (GRS).** The GRS ensures that complaints received are reviewed promptly to address pertinent concerns. Communities and individuals affected by the HOPE-PHC Program and IPF may submit their complaint to the World Bank's independent Accountability Mechanism. This Mechanism houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted at

[40] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099083124055516550/p5046931d1f9490e1adea10b19d9dc50db
[41] https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099082024122057708/p5046931e41e3d0d1a15f1570797c9bc69

any time after concerns have been brought directly to the World Bank's attention and World Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's GRS, visit https://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank's AM, visit https://accountability.worldbank.org.

D. Gender

76. **Nigeria has a gender gap of 63.9 percent and is among the 10 percent of countries with the highest levels of gender discrimination.** The gender gap remains a significant challenge across various dimensions, including economic participation, educational attainment, health and survival, and political empowerment. Nigeria ranks 130th out of 146 countries on the World Economic Forum's Gender Gap Index for 2023. This ranking reflects the combined scores across four subindexes—economic participation and opportunity, educational attainment, health and survival, and political empowerment—highlighting the persistent and multifaceted nature of gender inequality in the country. Nigeria ranks relatively better (54th) on economic participation and opportunity, but women still face considerable disparities in earnings and job opportunities. Men earn significantly more than women for similar roles. Although women's labor force participation has improved, they often occupy lower-paying jobs and fewer high-ranking positions, which affects their wealth accumulation and financial independence.[42] Nigeria ranks poorly on women's educational attainment (137th). Despite improvements in girls' primary school enrollment, significant gaps remain at the secondary and tertiary levels. Cultural and socioeconomic factors contribute to girls' lower educational attainment, limiting their opportunities for better-paying jobs and career advancement.[43] Political empowerment is where Nigeria faces the most significant challenges (142nd). Women's representation in political and legislative roles is minimal, with cultural and structural barriers impeding their participation. Efforts to address this issue have seen limited success, and substantial reforms are necessary to achieve meaningful progress in this area.[44]

77. **Nigeria lags other Sub-Saharan African countries. such as Rwanda, Namibia, and South Africa, which have made more significant strides in closing gender gaps.**[45] Nigeria's progress has been slow and uneven, requiring targeted policies and initiatives to address the underlying causes of gender inequality. Addressing this requires comprehensive policies focused on education, economic participation, healthcare access, and political representation.

78. **The HOPE-PHC Program's DLIs sufficiently outline practical measures to reduce gender gaps and improve sexual and reproductive health.** These include: (i) the number of women with deliveries attended by skilled health personnel; (ii) the proportion of births attended by a skilled provider; (iii) the number of women and children who receive tracer essential health services by CHWs; and (iv) disaggregation of all indicators by sex. These indicators are part of the results chain.

V. RISKS

79. **Based on the Systematic Risk Rating Tool, the overall residual risk of the HOPE-PHC Program is considered High.**

Political and Governance Risks (High)

The HOPE-PHC Program is based on the incentive framework provided to the state governors and, without their buy-in, implementation could be affected. A significant change in health policy is anticipated following the recent Supreme Court (SC) judgement on LGA financial autonomy. As primary healthcare is on the concurrent legislative list, federal, state, and

[42] World Economic Forum. Global Gender Gap Report 2023. https://www.weforum.org/publications/global-gender-gap-report-2023/in-full/benchmarking-gender-gaps-2023/; Global Gender Gap Report. https://youngafricanpolicyresearch.org/global-gender-gap-report-2023-progress-challenges-and-the-road-to-parity/
[43] Khadijat Kareem. How is Nigeria's Gender Gap Report Card? Improving but Still Poor. https://www.dataphyte.com/latest-reports/gender/how-is-nigerias-gender-gap-report-card-improving-but-still-poor/
[44] World Economic Forum. Global Gender Gap Report 2023. https://www.weforum.org/publications/global-gender-gap-report-2023/in-full/benchmarking-gender-gaps-2023/
[45] Global Gender Gap Report. https://youngafricanpolicyresearch.org/global-gender-gap-report-2023-progress-challenges-and-the-road-to-parity/

local governments all have roles to play in ensuring its full functionality. Delivery of key services such as: immunization; safe ANC and delivery; and early surveillance for health security, could be at risk particularly if there is lack of adequate oversight and weak governance at LGA level. At this time, it is too early to tell if decentralization as envisaged will be strengthened through effective grassroots governance due to the influence of state governors and state legislatures. LGA autonomy will promote transparency and accountability but could also lead to a lack of trust between state governors and LGA executives, leading to reduced political commitment, changes in policy stance, or delayed implementation. While the impact of the judgement is difficult to fully mitigate, it will be lowered through continuous engagement with key stakeholders, such as the Nigeria Governor's Forum and Association of Local Government of Nigeria, being proven and effective platforms for policy dialogue with states and LGAs, respectively.

Macroeconomic Risks (High)

Nigeria has recently taken important policy reforms to address restore macroeconomic stability. The CBN has unified exchange rates to allow the rate to reflect market conditions and tightened monetary policy to reign in inflation. The government also started to move towards market-based pricing of PMS to address the large fiscal cost of subsidized pricing. Despite these policy improvements the macroeconomy remains fragile. Failure to maintain a tight monetary policy until a clear dis-inflationary path is observed and any return to deficit monetization could cause inflation to worsen and feed an inflation-depreciation spiral. Financing pressures could intensify if there was a renewed decline in oil production, delays in ramping up non-oil revenues, and or a significant and inefficient increase in spending. Despite being resilient, economic growth remains modest and not enough too significantly boost per capita income in the long run. With limited local manufacturing for pharmaceutical supplies and consumables, the health sector depends heavily on imports. As a result, severe volatility in the exchange rate and shortage of US dollar availability could affect HOPE-PHC Program implementation and could have a serious impact on finances and timelines. The government has recently rolled out a social protection program that may mitigate the adverse impact of reforms on the poor and most vulnerable. The industrialization of the medical value chain, which advances pooled procurement and local manufacturing capabilities, is part of the government's efforts to mitigate this risk.

Sector Strategies and Policies (Moderate)

Although overall risks related to sector strategies and policies are moderate given high political commitment to the reform program, the substantial outflow of HRH may hinder smooth implementation. Mitigation measures include preparing and adopting state-level HRH strategy and recruitment plans under HOPE-GOV to allow states to adequately plan and finance the recruitment and deployment of much-needed staff. Sector strategies and policies to leverage the potential of the private health sector face a Substantial risk. Nigeria is a mixed health system with the private sector providing significant opportunities for scaling up of service coverage, however, the private sector is heterogenous, complex, and context specific all with varying degrees of quality and high out of pocket costs for vulnerable populations. This risk is mitigated by ensuring poor and vulnerable women and children access services without encountering financial costs; dissemination of empanelment and accreditation guidelines for private health providers ensures that the quality of MNCH care delivered aligns with national standards. Greater outreach to private facilities and providers is warranted as is the inclusion of stakeholders from the private sector in developing national policies, standards, and strategies; and strengthening case referrals between the public and private sectors.

The sector strategies and policies to leverage the potential of the private health sector face a Substantial risk. Nigeria is a mixed health system with the private sector providing significant opportunities for scaling up of service coverage, however, the private sector is heterogenous, complex, and context specific all with varying degrees of quality and high out of pocket costs for vulnerable populations. This risk is mitigated by ensuring poor and vulnerable women and children access services without encountering financial costs; Dissemination of empanelment and accreditation guidelines for private health providers ensures that the quality of MNCH care delivered aligns with national standards. Greater outreach to private facilities and providers is warranted as is the inclusion of stakeholders from the private sector in developing national policies, standards, and strategies; and strengthening case referrals between the public and private sectors.

Institutional Capacity for Implementation and Sustainability (Substantial)

The HOPE-PHC Program supports an ambitious, expansive, and complex reform agenda, and the SWAp is a fundamentally new approach to aligning the government's plan with those of other stakeholders. In addition, Nigeria's federal context presents unique challenges with respect to the allocation of roles and responsibilities in the health sector. The implementation capacity of the FMOH&SW and subnational entities will need to be scaled up to achieve expected implementation progress and secure the sustained buy-in of development partners on the approach. Mitigation measures include engaging with the Nigeria Governors' Forum and the Association of Local Government of Nigeria, building on existing implementation platforms such as the BHCPF, aligning the HOPE-PHC with the SWAp, and operationalizing a coordinated learning platform in collaboration with other development partners to equitably deploy TA to subnational entities.

There are also risks associated with Independent Verification. Lessons learnt on the use of IVAs in Nigeria are well-known. This risk is mitigated by building on lessons such as the careful selection of data sources, independence of the IVA, development of IVA terms of reference, procurement process, careful selection, and contract management. The risk is mitigated by the following actions: identifying the National Bureau of Statistics (NBS) to work intricately with the IVA under the oversight of the Ministry of Budget and Economic Planning; supporting the advanced procurement of an external firm by the NPCU to carry out the role of the IVA for the Program with the aim of having it in place within sixty days of effectiveness and well ahead of the first annual performance assessment; the scope and details of the IVA reports will need to be satisfactory to the World Bank; and the verification protocol will be updated regularly throughout the Program duration to be responsive to changes identified during implementation.

The sequencing and coordination of the HOPE interdependent series of operations also poses substantial risks. A key innovation in the HOPE programs is how they leverage each other and generate synergies to reinforce much needed reforms necessary for accelerating human capital development in Nigeria. There is a risk that the operations are not adequately sequenced in a manner which allows the necessary upstream reforms to be in place in good time to allow for the downstream actions that will lead to improvements in service delivery e.g. upstream PFM reforms allowing for downstream contracting of private providers.

Fiduciary Risks (High)

The PEF will involve both national and state-level budget lines, introducing additional complexities and implementation bottlenecks. The procurement profile of the HOPE-PHC Program, the federal nature of the health system, and the varied capacities of participating states all contribute to substantial fiduciary risks. Other fiduciary risks include: (i) the use of financing proceeds for unintended purposes; (ii) fraud and corruption; (iii) political interference in the deployment of FM staff; (iv) the capacity of NPCU staff to produce acceptable financial reports in a timely manner; and (v) use of the fund for expenditures that may not meet fiduciary requirements. Mitigation measures have been built into the HOPE-PHC Program on reporting, fund flows, and audit mechanisms, as reflected in the PAP (Annex 5). The HOPE-PHC Program and IPF component will include improved additional fiduciary assurance measures, including clarity on beneficiaries and increased use of digital-in-health interventions.

ANNEX 1. RESULTS FRAMEWORK MATRIX

Program Development Objective(s)

The Program Development Objective is to improve utilization of quality essential health care services and health system resilience in the Federal Republic of Nigeria.

PDO Indicators by Outcomes

Baseline	Period 1	Period 2	Period 3	Closing Period
Resilience				
Percentage of PHC facilities achieving service readiness assessment criteria (Percentage) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	25	50	75	100
National climate and health adaptation plan developed, costed, validated, and implemented (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	5	20	30	37
Utilization of Quality Essential Services				
Proportion of births attended by a skilled provider (Percentage) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
43	46	50	52	54
Women and children who receive tracer essential health services in the community increased (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	5,000,000	10,000,000	15,000,000	20,000,000

Intermediate Indicators by Results Areas

Baseline	Period 1	Period 2	Period 3	Closing Period
Improving utilization of quality essential services				

Financial protection for poor and vulnerable populations increased (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
1,800.000	2,520,000	3,528,000	4,939,200	6,914,880
Increase in Penta 3 coverage (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
53	55	57	59	61
Introduction of MMS supplementation for pregnant women during ANC visits (Percentage) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
25	28	31	34	37
Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (VVF surgeries ≤ 30% of the total share of reimbursed services) (Number) DLI				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	50,000	150,000	250,000	350,000
People reached with digitally enabled health services (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,000,000	3,000,000	6,000,000	10,000,000
➢People reached with digitally enabled health services - Female (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	500,000	1,500,000	3,000,000	5,000,000
People who have received quality essential health, nutrition and population (HNP) services (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	10,000,000	20,000,000	30,000,000	40,000,000
➢People who have received quality essential health, nutrition and population (HNP) services - Adolescent (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,000,000	2,000,000	3,000,000	4,000,000
➢People who have received quality essential health, nutrition and population (HNP) services - Female (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	5,000,000	10,000,000	15,000,000	20,000,000
➢People who have received quality essential health, nutrition and population (HNP) services - Youth (Number)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,000,000	2,000,000	3,000,000	4,000,000
Increase in patient experience score (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
47.70	50	55	65	75
Received complaints resolved within defined timelines using established feedback channels (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	80	80	80	80

Improving resilience of the health system				
People benefiting from climate resilient infrastructure (Number of people) [CRI]				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	2,000,000	7,000,000	1,400,0000	20,000,000
➢People benefiting from climate resilient infrastructure - Female (Number of people) [CRI]				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	1,200,000	4,000,000	8,000,000	12,000,000
➢People benefiting from climate resilient infrastructure - Youth (Number of people) [CRI]				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	600,000	2,100,000	4,200,000	6,000,000
Federal expenditure on quality family planning commodities increased (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	6	12	21	30
Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (Number) [DLI]				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	100	300	500	774
Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number) [DLI]				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	10,000	50,000	100,000	240,000
Front-line availability of tracer products improved (Percentage) [DLI]				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	25	50	75	100
Tier 2 BEmONC facilities achieving minimum quality of care score (Percentage)				
Dec/2024	Dec/2025	Dec/2026	Dec/2027	Dec/2028
0	50	60	70	80

Disbursement Linked Indicators (DLI)

Period	Period Definition
Prior Results	Prior Result
Period 1	CY2025
Period 2	CY2026

Period 3	CY2027
Period 4	CY2028

Baseline	Prior Results	Period 1	Period 2	Period 3	Period 4
1:Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number)					
0		10,000	50,000	100,000	240,000
0.00	0.00	500,000.00	2,500,000.00	5,000,000.00	12,000,000.00
DLI allocation		20,000,000.00	As a % of Total DLI Allocation		3.81%
2:Introduction of MMS supplementation for pregnant women during ANC visits (Percentage)					
25	28	31	31	0	37
0.00	0.00	0.00	10,000,000.00	0.00	10,000,000.00
DLI allocation		20,000,000.00	As a % of Total DLI Allocation		3.81%
3:Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (VVF surgeries ≤ 30% of the total share of reimbursed services) (Number)					
0	CEMoNC Strategy	50,000	150,000	250,000	350,000
0.00	2,500,000.00	4,375,000.00	13,125,000.00	21,875,000.00	30,625,000.00
DLI allocation		72,500,000.00	As a % of Total DLI Allocation		13.81%
4:Increase in Penta 3 coverage (Number)					
53		0	57	0	61
0.00	0.00	0.00	17,500,000.00	0.00	17,500,000.00
DLI allocation		35,000,000.00	As a % of Total DLI Allocation		6.67%
5:Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (Number)					
0		100	300	500	774
0.00	0.00	3,464,000.00	10,396,000.00	17,320,000.00	26,820,000.00
DLI allocation		58,000,000.00	As a % of Total DLI Allocation		11.05%
6:Front-line availability of tracer products improved (Percentage)					
0		25	50	75	100
0.00	0.00	3,300,000.00	6,600,000.00	9,900,000.00	13,200,000.00
DLI allocation		33,000,000.00	As a % of Total DLI Allocation		6.29%
7:National climate and health adaptation plan developed, costed, validated, and implemented (Number)					
0		National Plan Developed	37	37	37
0.00	0.00	1,000,000.00	5,700,000.00	7,750,000.00	15,550,000.00

DLI allocation		30,000,000.00	As a % of Total DLI Allocation		5.71%
8:Financial protection for poor and vulnerable populations increased (Number)					
1,800.000		2,520,000	3,528,000	4,939,200	6,914,880
0.00	0.00	5,630,631.00	7,882,883.00	11,036,036.00	15,450,450.00
DLI allocation		40,000,000.00	As a % of Total DLI Allocation		7.62%
9:Percentage of PHC facilities achieving service readiness assessment criteria (Percentage)					
0		25	50	75	100
0.00	0.00	6,150,000.00	12,300,000.00	18,450,000.00	24,600,000.00
DLI allocation		61,500,000.00	As a % of Total DLI Allocation		11.71%
10:Federal expenditure on quality family planning commodities increased (Percentage)					
0		6	12	21	30
0.00	0.00	5,000,000.00	5,000,000.00	7,500,000.00	7,500,000.00
DLI allocation		25,000,000.00	As a % of Total DLI Allocation		4.76%
11:States receiving funds in compliance with allocation formula in revised guidelines (Number)					
0	Guidelines Developed	37	37	37	37
0.00	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00	2,500,000.00
DLI allocation		12,500,000.00	As a % of Total DLI Allocation		2.38%
12:System and standards for state EPR programs are established. (Number)					
0		National Standards Developed	37	37	37
0.00	0.00	1,000,000.00	2,750,000.00	3,750,000.00	7,500,000.00
DLI allocation		15,000,000.00	As a % of Total DLI Allocation		2.86%
13:States adopting National enterprise architecture and integrate core health functions (Number)					
0	National Health Enterprise Architecture	37	37	37	37
0.00	2,500,000.00	3,750,000.00	3,750,000.00	3,750,000.00	3,750,000.00
DLI allocation		17,500,000.00	As a % of Total DLI Allocation		3.33%
14:Proportion of births attended by a skilled provider (Percentage)					
43			50		54
0.00	0.00	0.00	17,500,000.00	0.00	17,500,000.00
DLI allocation		35,000,000.00	As a % of Total DLI Allocation		6.67%
15:Women and children who receive tracer essential health services in the community increased (Number)					
0		5,000,000	10,000,000	15,000,000	20,000,000

0.00	0.00	5,000,000.00	10,000,000.00	15,000,000.00	20,000,000.00
DLI allocation		50,000,000.00	As a % of Total DLI Allocation		9.52%

Disbursement Linked Indicators Verification Protocol

	Results Area 1: Improving Quality of Services	Scalability
DLI 1	**Improved service readiness.**	
DLI 1.1	**Improved primary healthcare facility readiness, quality, and climate resilience in Participating States (Percentage)**	
Definition	Percentage of BHCPF-supported Tier 2 (BEmONC PHC) facilities that maintain a score of 75 percent on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience	**Yes**
Description	To be accredited to receive DFF by NPHCDA, Tier 2 PHC facilities -- i.e., those that offer PHC services plus BEmONC services -- will need to meet a score of 75 percent on the health facility readiness assessment that will be developed by NPHCDA before project effectiveness. The assessment tool will have components around structural quality (water source, toilets, blueprint for bed numbers and layout, commodities, medicines, equipment, health information system and human resources); Accredited facilities will have to be assessed biannually for re-accreditation. Refurbishment to be financed through the DLI will include financing for (i) solar power; (ii) minor rehabilitation of facilities; (iii) climate resilient measures for all health facilities in climate vulnerable areas and facilities that are identified as at risk of climate shocks; (iv) Water, Sanitation and Hygiene (WASH) improvements at facilities; and (v) energy efficiency measures at high power use facilities. The assessment tool will include content on each of these areas.	
Data Source	NPHCDA Reports (linked to DHIS-2)	
Verification Entity	Independent Verification Agent	
Procedure	The IVA will visit 25 percent of all accredited BEmONC facilities in the first year and inspect the premises for compliance against the NPHCDA checklist. Facilities must meet the 75 percent score to remain accredited. In subsequent years, the IVA will visit 5 percent or more of previously accredited BEmONC facilities in each state and 25 percent of newly accredited BEmONC facilities to inspect for compliance to the checklist. Furthermore, facilities that fell below the 75 percent mark on verification will have 90 days to take remedial action and request a re-verification. A disbursement of US$12,300 per facility meeting the BHCPF tier 2 standard per ward would be received.	
DLI 1.2	**Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (Number)**	
Definition	Number of EDGE level 1 certified CEmONC facilities that are empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures.	**Yes**

Description	CEmONC facilities will be refurbished by the SCO and inspected and empaneled by NHIA according to the accreditation guidelines developed under the related Prior Result. Refurbishment will include key structural elements of quality (water source, toilets, mother-newborn intensive care units, surgical theatres, bed numbers, visibly posted schedule of free services, equipment, commodities and medicines, human resources, health information system) reaching EDGE level 1 certification and implementing climate resilience measures. Empanelment will be renewed on an annual basis.	
Data Source	NHIA empanelment records (linked to DHIS-2)	
Verification Entity	Independent Verification Agent	
Procedure	The IVA will go to 25 percent of all CEmONC facilities reported by NHIA to have been empaneled in the first year and use the checklist of criteria developed as a prior result to ensure that the requirements for structural readiness, and climate resilience have been met, and EDGE level 1 certification has been achieved. In subsequent years, the IVA will go to 25 percent additional facilities reported by NHIA to have been empaneled and check for compliance against the checklist; AND visit or verify by phone a random sample of 10 percent or more of all previously empaneled facilities in each state to ensure that they are still in compliance with previously empaneled facilities. A selection of empanelment criteria will be checked. Facilities must meet 100 percent of the assessed criteria to be verified as newly empaneled and to be verified as continuingly complaint if previously empaneled. US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5 percent reward to SSHIAs of participating states and 2.5 percent reward to NHIA.	
DLI 2	**Increased availability of essential commodities.**	
DLI 2.1	**Federal expenditure on quality family planning commodities increased (Percentage)**	
Definition	Annual increases in domestic spending on contraceptive commodities to reach 15 percent of forecasted total need by the end of the Program	**Yes**
Description	The Government of Nigeria will match donor and IDA contributions of US$25 million over the life of the Program with US$12.5 million of domestic spending on contraceptive commodities from a baseline of US$0.	
Data Source	Budget Implementation Reports (BIR) from Accountant General	
Verification Entity	Independent Verification Agent	
Procedure	The designated IVA will review expenditure data of the state and national level budget execution reports annually to verify achievement of domestic spending on contraceptive commodities. If expenditures fall below the targeted amount for any year, the DLI disbursement will be prorated against spending level after a minimum increase of 20 percent of target increase is met. Irrespective of target achievements each year, the target for the subsequent year remains fixed. For example, if an increase of US$1 million is the target, a minimum of US$200,000 in domestic spending must be in evidence to scale disbursement proportional to actual achievement.	

	The amount received per percentage point increase in federal expenditure varies annually increasing annually from US$0.4 million per percentage point annual increase in year 1 to US$0.28 million per percentage point annual increase and US$0.32 million per percentage point annual increase.	
DLI 2.2	**Frontline availability of tracer products improved in Participating States (Percentage)**	
Definition	Percentage of BHCPF-supported Tier 2 (BEmONC PHCs) facilities that have a minimum of five of six commodities available.	**Yes**
Description	A tracer basket of commodities and medicines will be assessed for availability of a minimum stock position at Tier 2 facilities and reported by the SPHCDAs. The tracer commodities include oxytocin, MMS, Artemisinin-based Combination Therapy (ACTs), Human Immunodeficiency Virus (HIV) rapid test kits, Pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC). A minimum stock position by commodity or threshold and the essential medicines score will be defined in the HOPE-PHC Program POM.	
Data Source	Annual Health Facility Readiness Assessment and DHIS-2	
Verification Entity	Independent Verification Agent	
Procedure	States are expected to achieve different percentage point increase annually on the proportion of the 2,000 BHCPF-supported Tier 2 (BEmONC PHCs) facilities NHSRII-service ready facilities that have a minimum of five of six commodities above the defined minimum stock position. US$5,600 per BHCPF supported facilities per ward. Several data sources will be used to verify reported achievement of this indicator. The IVA will first review procurement and delivery data by state for the tracer commodities. The IVA will note stock positions at federal and state central medical stores, as well as reported stocks at facility level. The facility level stock positions will be triangulated with the respective services delivered reported in the annual facility readiness survey and DHIS2 to ensure coherence. The IVA may opt to do spot checks of facilities that do not report rational stock positions; and will visit 5 percent of Tier 1 PHC facilities that have reported adequate stock per state. Facility visits that result in discordant verification from reported data will be labeled as High Risk. All High-Risk facilities will have repeat visits within 6 months of first visit; this will not be part of the 5 percent pool. Facilities that meet the requirement for minimum threshold will qualify as successfully verified and will be labeled as Low Risk. Low Risk facilities will be randomly selected in the 5 percent pool the following year.	
	Results Area 2: Improving Utilization of Essential Services	
DLI 3	**Increased enrollment of poor and vulnerable populations.**	
DLI 3.1	Financial protection for poor and vulnerable populations increased (Number) in Participating States	
Definition	This DLI will reflect progress in the number of poor and vulnerable persons covered by health insurance under the NHIA gateway in the revised Basic Healthcare Provision Fund guideline.	**Yes**
Description	This is the number of eligible population (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs.	

Data Source	NHIA portal	
Verification Entity	Independent Verification Agent	
Procedure	1. The achievement report provided by the NHIA should provide a breakdown of the total number of enrollees per state in each period. This data would be from the NHIA portal. The IVA should cross-check these figures against the SSHIA portal, in consultation with the NPCU. 2. The IVA will also apply a stratified random sampling method to verify at least one percent of all enrollees listed in each report, via field visits/telephonic surveys – to ensure the figure reported in the NHIA portal for the selected SSHIAs and selected period corresponds to what is seen from the NHIA records (and the IVA should cross-check the various records with unique identification number ~ NIN to ensure accurate reporting). 3. The strata will be: (i) state; and (ii) whether in urban or rural. 4. Each 1 percentage point discordance above 5 percent as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 7 percent discordance will result in (7-5) = 2 percent deduction of the total eligible disbursement) 5. US$8 per eligible health insurance enrollment to be shared by allocating 97.5 percent reward to SSHIAs of participating states and 2.5 percent reward to NHIA. 6. The maximum earning for this DLI per State will be US$1.08 million and overall maximum of US$40 million.	
DLI 4	**Enhanced community delivery of health services.**	
DLI 4.1	**Women and children who receive tracer essential health services in the community increased in Participating States (Numbe**r)	
Definition	This DLI will disburse when the tracer essential health services are delivered by health workers in the community.	**Yes**
Description	The DLI will incentivize the number of household visits made by CHWs to deliver key services including provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification/follow up of pregnant women and referral to receive MMS, treatment of any childhood illness (Integrated Community Case Management – for diarrhea, fast breathing, fever) as measured by (i) Number of Children with Growth Monitoring Cards/(ii) Children (6-59 months) who received micronutrient powders and (ii) Number of pregnant women attending ANC revisited by a community health workers/Pregnant women identified for ANC (new).	
Data Source	CHMIS or independent MIS data feed to DHIS-2	
Verification Entity	Independent Verification Agent	
Procedure	1. The baseline is established using the Community Health Management Information System (CHMIS)-2 or MIS for the CHW program. 2. The annual aggregate number of pregnant women who were visited by a community health worker at home and total number of children who have a growth monitoring card (or MCH handbook).	

	3. FASTR will confirm the validity of CHMIS. Each 1 percentage point discordance above 10 percent as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 15 percent discordance will result in (15-10) =5 percent deduction of the total eligible disbursement) 4. Validation through small-scale survey done using household visits and telephone verification methods based on primary records. Wards/LGAs with anomalous data trends will automatically be included in the household verification sample. 5. Anomalies could include out of age range beneficiaries, out of ward beneficiaries, 6. US$1 per CHW-client contact in the communities verified from the CHMIS or other nationally agreed MIS. 7. Earnings will be allocated at 97.5 percent reward to SPHCDAs of participating states and 2.5 percent reward to NPHCDA.	
DLI 5	**Increased utilization of priority secondary care services.**	
DLI 5.1	***Secondary Facility Quality of Care for CEmONCs (Prior Result)***	
Definition	This DLI will disburse against the design and approval of a CEmONC empanelment and reimbursement strategy.	**No**
Description	NHIA will develop operational documents that detail (1) definition of empanelment criteria for CEmONC facilities by the NHIA, (2) baseline assessment of secondary facilities in participating states, the package list of CEmONC services eligible for reimbursement, (2) the tariff schedule corresponding to each eligible package, (3) SOPs for claim submission, review and payment, (4) identification of key entities and development of MOUs involved (NHIA, TPAs, etc.), and (5) the key performance indicators for claims management.	
Data Source	NHIA	
Verification Entity	Independent Verification Agent	
Procedure	This is a Yes/No prior result. NHIA will share the relevant document(s) for review. Disbursement will depend on validation against confirmation that the document includes the above elements. One-time payment of US$2.5 million following the achievement of the DLI to be shared by allocating 97.5 percent reward to SSHIAs of participating states and 2.5 percent reward to NHIA.	
DLI 5.2	**Women and neonates receiving CEmONC and neonatal services and/or vesico-vaginal fistula surgeries (Number)**	
Definition	This DLI will disburse against the number of women and neonates availing CEmONC services from NHIA-empaneled public or private health facilities.	**Yes**
Description	NHIA is developing a benefit package of eligible CEmONC services for reimbursement. This will include both obstetric and neonatal care packages, plus VVF surgeries. The DLI is a count of these reimbursed services (paid claims, not submitted claims). To ensure a relatively equitable share of service coverage, no individual state can account for more than 1.25 times its share of the annual births (that is, any reimbursement above 1.25 times that	

	state annual births forecast will not be eligible to count towards DLI disbursement). Estimates will be based on the 2006 population census data.	
Data Source	NHIA portal	
Verification Entity	IVA	
Procedure	1. NHIA will share anonymized individual claim data that includes (1) date of patient admission; (2) empaneled facility where admitted; (3) CEmONC/VVF service package provided; (4) date of payment. The IVA will confirm that the facility is on the empaneled list, the service provided is on the eligible list, and that the date of payment occurred during the relevant period. 2. The IVA apply a stratified random sampling method to verify at least one percent of all claims listed in each report, via field visits/telephonic surveys – to ensure the figure reported in the NHIA portal and selected period corresponds to what is seen from the NHIA records (and the IVA should cross-check the various records with unique identification number ~ NIN to ensure accurate reporting). 3. Each 1 percentage point discordance above 5 percent as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 7 percent discordance will result in (7-5) = 2 percent deduction of the total eligible disbursement). 4. US$87.5 per woman or neonate is reimbursed to the NHIA for CEMONC services in an accredited CEmONC facility of which, at least 50 percent of the target met on a year-on year basis should be for CEmONC services (deliveries and neonates); not more than 30 percent to be VVF surgeries; the balance being under five child admissions.	
DLI 6	**Increased primary healthcare utilization of priority services**	
DLI 6.1	**Deliveries with skilled birth attendant present increased in Participating States (Percentage)**	
Definition	This DLI will disburse against the increase in the proportion of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)	**Yes**
Description	Proportion of pregnant women whose births were attended by a skilled provider	
Data Source	NDHS/mini-DHS	
Verification Entity	Independent Verification Agent	
Procedure	1. The baseline is established using the NDHS 2023. 2. Annual performance will be measured in 2025 and 2027 by two mini-DHS surveys conducted by the Government of Nigeria 3. US$118,243 will be paid out per percentage point annual increase per State, over and above the previous year's results. 4. Earnings will be allocated at 97.5 percent reward to SPHCDAs of participating states and 2.5 percent reward to NPHCDA.	

DLI 6.2	**Introduction of MMS for pregnant women during antenatal care visits (Percentage) in Participating States Introduction of MMS for pregnant women during antenatal care visits in Participating States (Percentage)**	
Definition	Percentage of women receiving MMS during antenatal visits	**Yes**
Description	This maternal nutrition service is the distribution of at least 180 MMS (MMS) (one bottle) for pregnant women aged 15-49 years at least once during any ANC service or contact with health worker at community level.	
Data Source	NDHS/mini-DHS	
Verification Entity	Independent Verification Agent	
Procedure	1. The baseline is established using the NDHS 2023. 2. Annual performance will be measured in 2025 and 2027 by two mini-DHS surveys conducted by the Government of Nigeria 3. US$45,045 will be paid out per percentage point annual increase per State, over and above the previous year's results. 4. Earnings will be allocated at 97.5 percent reward to SPHCDAs of participating states and 2.5 percent reward to NPHCDA.	
DLI 6.3	**Increase in Penta 3 coverage in Participating States (Percentage)**	
Definition	Percentage of children immunized with Penta-3 vaccination	**Yes**
Description	This is the proportion of children aged 12-23 months who received DPT-HepB-Hib vaccination (3 doses)	
Data Source	DHIS-2	
Verification Entity	Independent Verification Agent	
Procedure	1. The baseline is established using the NDHS 2023. 2. Annual performance will be measured in 2025 and 2027 by two mini-DHS surveys conducted by the Government of Nigeria 3. US$118,243 will be paid out per percentage point annual increase per State, over and above the previous year's results. 4. Earnings will be allocated at 97.5 percent reward to SPHCDAs of participating states and 2.5 percent reward to NPHCDA.	
DLI 7	**Increased utilization of EMS**	
DLI 7.1	**Patients with obstetric and neonatal complications transported through emergency medical transport to selected facilities using the digitized EMS dispatch system in Participating States (Number)**	
Definition	This DLI will disburse when patients with obstetric and neonatal complications are transported to Tier 2 (PHC BEmONC) facility or empaneled CEmONC facilities using the digitized EMS dispatch system	**Yes**
Description	This DLI will incentivize the scale-up of digital dispatch platform on the national emergency transport gateway of the BHCPF encompassing both use of community transport and the formal transport system. The DLI will target	

	pregnant women and children and track the number of these targets from Community to BEmONC/CEmONC centers.	
Data Source	NEMSAS Electronic Dispatch Database	
Verification Entity	Independent Verification Agent	
Procedure	The IVA will verify from NEMSAS digital platform database the number of pregnant women and children that were transported on the digital platform. 2. There is a year-on-year increase in the target set for the number of pregnant women and children expected to be transported on the digital platform. 2. The IVA will conduct call backs and visit states to confirm a randomized sample of 1 percent of digital EMS dispatch records provided by NEMSAS for reimbursement to confirm the dispatch entries. 3. The IVA will recommend for disbursement upon satisfactory verification of presented record from NEMSAS. 3. US$50 per obstetric and neonatal patient transported to be shared by allocating 97.5 percent reward to SEMSAS of participating states and 2.5 percent reward to NEMSAS	
	Results Area 3: Improving Resilience of the Health System	
DLI 8	**Improved allocation and disbursement of BHCPF funds**	
DLI 8.1	***Governance for improved resource allocation and performance (Prior Result)***	
Definition	This prior result will disburse against revised and approved BHCPF 2.0 guidelines reflecting equity and climate resilience	**No**
Description	This prior result will reimburse the government upon revision and approval of BHCPF guidelines by the BHCPF-MOC. The revised guidelines will identify the allocation formula whereby BHCPF funds are disbursed to states. The formula will give due consideration to state variation in (1) RMNCAH-N burden, (2) poverty headcount and (3) climate vulnerability, among other relevant factors as determined by BHCPF MOC.	
Data Source	BHCPF MOC	
Verification Entity	IVA	
Procedure	This is a Yes/No prior result. BHCPF MOC will share the relevant document(s) for review. Disbursement will depend on validation against confirmation that the document includes the above 3 elements. One-time payment of US$2.5 million following the achievement of the DLI to be shared by allocating 20 percent reward to BHCPF MOC, 20 percent to NPHCDA, 20 percent to NHIS, 20 percent to NEMSAS, and 20 percent to NCDC	
DLI 8.2	**Participating States receiving funds in compliance with allocation formula in revised guidelines (Number)**	**No**
Definition	This DLI will disburse against the adherence to the allocation formula contained in the revised BHCPF guidelines reflecting RMNCAH+N burden, poverty headcount and climate vulnerability	

Description	This DLI will disburse based on a review of BHCPF MOC documents that will determine/confirm the adherence to the allocation formula contained in the revised BHCPF guidelines prevailing at the time of verification.	
Data Source	BHCPF MOC	
Verification Entity	Independent Verification Agent	
Procedure	The IVA will review the minutes of quarterly MOC meetings to confirm adherence to the revised, prevailing guidelines with respect to state-wise allocations. Yearly payment of US$2.5 million following the achievement of the DLI to be shared by allocating 20 percent reward to BHCPF MOC, 20 percent to NPHCDA, 20 percent to NHIS, 20 percent to NEMSAS, and 20 percent to NCDC	
DLI 9	**Enhanced PPR through deployment**	
DLI 9.1-9.4	**System and standards for state EPR programs are established (Number)**	
Definition	This DLI will disburse when states develop and implement a multi-year EPR plan encompassing disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies.	**Yes**
Description	The DLI will incentivize the strengthening of subnational EPR by encouraging states to develop peacetime plans to improve emergency response and health security. The plans will address use of seasonal, multi-hazard risk calendars to support responsive risk response, risk profiling, responsibility chains for shock response, shock response simulations, commodity stockpiling and quantification of pharmaceuticals to respond to shocks, preparations for health service delivery during shocks. The NCDC will play a role in providing TA to states in developing a multi-year EPR plan which meets specified standards as determined by the NCDC following risk profiling and multi-hazard assessment of states including disease outbreaks, climate shocks, natural disasters, and other emergency emergencies. Following these plans' development, the NCDC will also provide technical support and guidance to states for the implementation of the state specific EPR plans.	
Data Source	NCDC subnational assessments	
Verification Entity	Independent Verification Agent	
Procedure	1. The IVA will verify from the NCDC states that they have prepared and validated an EPR plan that meets the predetermined standards set by the NCDC for the development of subnational EPR plans and include disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies. 2. The IVA will recommend for disbursement when states prepare and validate their multi-year EPR plans with the NCDC. 3. The NCDC will monitor states on the implementation of validated multi-year EPR plans and provide to the IVA; states that have reached 50 percent and 100 percent implementation of the validated multi-year EPR plan. 4. The IVA will visit a randomized sample of states (not less than 25 percent) to confirm the NCDC report the status of implementation of the multi-year state EPR plans.	

	5. Each 1 percentage point discordance above 5 percent as detected by the IVA will be deducted from the total maximum eligible disbursement. (e.g., 7 percent discordance will result in (7-5) =2 percent deduction of the total eligible disbursement) 6. The IVA will recommend for disbursement upon satisfactory confirmation that states meet the implementation milestones for 50 percent and 100 percent respectively. 7. One-time payment of maximum of US$1.0 million to NCDC on achievement of DLI in year 1. 8. Subsequently, an incremental annual amount allocated is per 36+1 state per costed EPR Plan developed. a) From Year 2, the amount of US$74,324 for each state that delivers a plan in adherence with the national standard. b) For Year 3, the amounts of US$101,351 will be disbursed to each State that achieves 50 percent implementation of the plan. c) For Year 4, US$202,703 will be disbursed to each State that achieves 80 percent implementation of the plan.	
DLI 10	**Improved Climate Resilience**	
DLI 10.1-10.4	**National climate and health adaptation plan developed, costed, and validated (Number)**	
Definition	This DLI will disburse with the development of the National climate and health adaptation plan which will include costs followed by implementation	**Yes**
Description	This DLI will disburse with the development of the National Climate and Health Adaptation Plan including its costing in the first year, followed by development of implementation plans in the second year, and implementation in the third and fourth years.	
Data Source	The country, led by the FMOH&SW, has developed a National Climate and Health Adaptation Plan, outlining timebound actions throughout the health system that are aimed at addressing climate change and health vulnerabilities identified in the National Climate and Health Vulnerability Assessment. The plan has been costed, linked to available resources, and validated. Implementation plans have been developed at the state and national levels, and implementation has commenced. Implementation plans are developed by states and the national level in the second year and the plans are implemented in the third and fourth year.	
Verification Entity	Independent Verification Agent	
Procedure	**Year 1:** A.) NCCC verifies National Climate and Health Adaptation plan for (i) completeness of plan; (ii) costing; (iii) linking plan to available resources; and (iv) inclusion of a template and guidelines for national and state implementation plans; and B.) verifies TWG meeting minutes for validation of the plan through a participatory process. Year 1 will be paid based on the completeness of all elements defined here. Any incomplete elements will not result in payment. The amount of US$1 million will be disbursed for the national plan. One-time payment of US$1.0 million following the achievement of the DLI to be shared by allocating 33 percent reward to BHCPF FMOH, 33 percent to NPHCDA, and 33 percent to NCDC. **Year 2:** NCCC verifies State and National level implementation plans for consistency, completeness, and adherence to the template and guidelines as developed in the NCHAP. Each state will be paid on a fully	

	developed plan. A partially complete plan will not result in payment. Each state will be paid based on their own plan, not contingent on the progress of other states. The amount of US$154,054 will be disbursed to each State that develops their plan in adherence to national standard. **Years 3 and 4:** IVA verifies State and federal documents to confirm implementation of plans and spot checks implementation through in-person or phone verification (i.e., confirming trainings conducted; renovations done, etc.). States and the Federal Level will be paid once they have achieved at least 50 percent of activities in year 3 and at least 80 percent of activities in year four. Subsequent years, an amount will be paid per 36+1 state per state climate and health adaptation developed; 97.5 percent Reward to states; 2.5 percent Reward to be shared by FMOH, NPHCDA and NCDC. In year 3he amount of US$209,459 will be disbursed to each State that achieves 50 percent implementation of its plan, and in Year 4, US$420,270 for each State that achieves 80 percent implementation of its plan.	
DLI 11	**Stronger Digital Foundation**	
DLI 11.1	**National enterprise architecture developed, costed, and adopted (Prior Result)**	
Definition	This DLI will support the development of an integrated, interoperable health data ecosystem to support evidence-based improvements in value (efficiency, quality, access, and health outcomes) for patients and providers. The Program shall support the FMOH&SW and its agencies to lay the foundations for an interoperable platform to systematically exchange data to enhance systems functions.	**No**
Description	This subcomponent will finance the architecture, costing and adoption of three digital interventions.(1)Development and adoption of a digital health services platform for frontline CHW to strengthen the frontline CHW system (2)Development of the digital infrastructure for the emergency transportation platform (3) A federated digital-in-health enterprise architecture platform which will enable the switch from a paper-based to digital platform and support digital interoperability between health information systems to reduce data hyper- fragmentation and duplication.	
Data Source	Committee on Digital in Health Initiative	
Verification Entity	Independent Verification Agent	
Procedure	Year 1 Define a national set of standards, regulations, rules, and business processes for creating and maintaining a national health data space through a distributed enterprise architecture approach. Year 2 -Definition of regulatory frameworks, enterprise architecture design, and acquisition. Year 3 and 4. A federated digital-in-health enterprise architecture platform which will enable the switch from a paper-based to digital platform and support digital interoperability between health information systems to reduce data hyper- fragmentation and duplication. One-time payment of US$2.5 million following the achievement of the DLI to the MOH in year 1.	
DLI 11.2	**Participating States adopting national enterprise architecture and integrating core health functions (Number)**	
Definition	This DLI will facilitate the adoption and effective functioning of the health data ecosystem at the state level by integrating individual private, public, and program-specific health information systems.	**Yes**

Description	States will prioritize 4 core health functions from the list of functions (electronic health records, emergency response management (SORMAS), ambulatory services dispatch and management system, supportive supervision, QOC management, HRH/HRIS, CHW Service management, claims management, health insurance enrollment management, essential drugs and stock logistics management, and DHIS-2) and have these functions interoperable and feed into the national health data ecosystem at the federal level integrating individual private, public, and program-specific health information systems.	
Data Source	SMoH, SPHCDA and SSHIA and all public and private hospitals at the state	
Verification Entity	Independent Verification Agent	
Procedure	1. To follow the implementation plan laid out by the committee on digital in health initiative 2. The IVA will verify before disbursement to states that they are fully plugged in on the digital in health initiatives across the SMOH, SPHCDA, SSHIA, and the public hospitals in the state. 3. Payment of US$101,351 per state following the achievement of the DLI reward is to be shared 97.5 percent to the state and 2.5 percent to the MOH	

ANNEX 2. TECHNICAL ASSESSMENT

1. **Improving health outcomes is crucial for bolstering Nigeria's human capital—a determinant of economic prosperity and inclusive economic growth.** Healthy and well-nourished children achieve greater cognitive development and better educational outcomes, which are essential for their future productivity and success. Healthier populations are more productive, which can stimulate faster economic growth and foster more equitable development. Moreover, investments in health are pivotal for poverty alleviation, a matter of great urgency for Nigeria, which harbors 13 percent of the global poor and has the second-largest number of individuals living in extreme poverty. Such investments can break the cycle of poverty by closing the gap in learning outcomes and enhancing the opportunities of poor communities to effectively contribute to the economy.

2. **Accelerating progress toward UHC in Nigeria will require deliberate and transformative action**. In recent decades, Nigeria has seen the development of various strategies that aim to expand healthcare access, such as the National Strategic Health Development Plan 2018–2022, the National Health Act 2014, the SOML 2015, and the NHIA 2022 to introduce mandatory insurance coverage. Further, the Vulnerable Group Fund (VGF) was established to provide additional funding to cover poor and vulnerable Nigerians. The implementation of these strategies has been inadequate, however, due primarily to low government investment and a fragmented health system that struggles with coordination and efficient resource allocation. Given the scale of the challenge and the limited resources available, transforming Nigeria's health system will require embracing a "business unusual" approach. This means fostering innovations in healthcare delivery and financing and ensuring robust coordination among all health sector players. Only through such concerted efforts can Nigeria make significant strides toward UHC for all its citizens.

3. **There is a palpable window of opportunity for Nigeria to embark on a transformative journey toward UHC**. This opportunity is underscored by the emergence of new leadership that brings a clear and focused vision for health sector reform. There is a growing consensus among stakeholders that revitalizing the health system hinges on injecting dynamism into primary healthcare—the cornerstone of effective and equitable health service delivery. This revitalization is seen as the most impactful approach to strengthen the health system from its foundation. Furthermore, there is robust support from the development partner community, which is ready to back these reforms with resources, expertise, and advocacy. This confluence of favorable conditions creates an unprecedented chance to implement meaningful changes that can significantly improve health outcomes for Nigeria's population.

4. **The government is striving to accelerate progress toward UHC through an ambitious strategy known as the NHSRII**. This strategy encompasses two key components: the BHCPP and the Nigeria Industrialization Fund. The BHCPP represents an expansion of the BHCPF to also cover services delivered at the community level. The BHCPF already provides DFF to over 8,000 primary healthcare facilities and includes the VGF to subsidize care for vulnerable populations, targeted secondary care services facilitated by the NHIA, and a Medical and Public Health Emergency Fund. The Nigeria Industrialization Fund focuses on tertiary and quaternary care, in addition to a medical industrialization plan that aims to encourage the production of medical commodities in the local market. Integral to the BHCPP are the health security agenda and community engagement activities, which are crucial for generating demand for health services.

5. **The strategic partnership between the government and the World Bank is set to play a pivotal role in the implementation of these health sector reforms**. Strengthening primary healthcare is not only about enhancing service delivery, but also about instituting significant changes in the governance of the health sector. Recognizing this dual need, the government has requested the World Bank to prepare interdependent operations. The first operation, with a focus on governance (HOPE-GOV), aims to contribute to the improvement of resource allocation, encompassing both financial and human resources. This is a critical step toward ensuring the sustainability of all health programs. The second operation, focusing on service delivery (the HOPE-PHC Program), is designed to contribute to the reorganization of primary

healthcare and the prioritization of cost-effective interventions. This will be instrumental in improving access to good-quality, essential health services, thereby laying a solid foundation for a more robust and resilient health system in Nigeria.

6. **The FMOH&SW in Nigeria has laid the foundation for collaboration by establishing a SWAp.** The aspiration to unify all relevant stakeholders in the health sector under a shared framework has been crystallized with the signing of the compact by both state and federal actors. The HOPE-PHC Program is poised to become a central platform for coordinated support to the government's health sector reform agenda. Through its various TWGs, the SWAp will be instrumental in setting key sectoral priorities. These priorities will be financed through a strategic blend of pooled resources, including both domestic and external sources, which will be funneled through the HOPE-PHC Program, and parallel financing provided by selected development partners. This approach ensures that the collective efforts of the government and its partners are harmonized and aligned, thereby maximizing the impact of the resources invested in Nigeria's health system transformation.

7. **The HOPE-PHC Program's relevance is thus derived from its high potential to achieve transformational impact.** The HOPE-PHC Program offers a significant opportunity to enhance the quality of health service delivery in Nigeria, a move that is essential for the betterment of the country's (and global) health outcomes. Moreover, the HOPE-PHC Program's relevance is echoed by the widespread endorsement from the wider health community, as evidenced by the signing of the compact, signaling a collective vision to revitalize Nigeria's healthcare system.

8. **The HOPE-PHC Program is informed by lessons from previous World Bank operations and analytical work:**

   a. **The Nigeria State Health Investment Project (NSHIP) made notable strides in enhancing the use of good-quality health services across various states.**[46] This success can be attributed to several key strategies. First, health facilities received direct funding into their accounts, which they could use with considerable discretion. The involvement of local ward development committees in managing these facilities also played an important role. Accessibility and use of health services were further improved by subsidizing vital RMNCAH-N services and waiving fees for at-risk populations. Quality enhancements[47] were due primarily to swift upgrades in structural quality, consistent supportive oversight with a detailed quality checklist, and training for healthcare workers in maternal and newborn care, drug management, and hygiene practices. Moreover, the verification of data and the implementation of stronger governance and accountability measures were instrumental in delivering concrete outcomes amidst challenging political and emergency situations.

   b. **The SOML Program represented Nigeria's inaugural PforR, heralding the potential for profound transformation.** It emphasized the use of government systems, the mobilization of increased domestic health funding, and the pursuit of systemic reforms. The HOPE-PHC Program also introduced performance incentives to drive these outcomes. The execution of a realistic M&E plan is crucial, however. The frequency of survey data collection fell short of the annual target, hampering the project's overall success.

   c. **Programmatic support and TA are vital to bolster the effectiveness of incentives and outcome measurement in a federal system like Nigeria's.** A combined approach of PforR and IPF TA can bridge critical implementation gaps and mitigate risks, encompassing areas such as program support, M&E execution, IVA performance, and the advancement of health system strengthening through private sector engagement and innovation. The phased implementation strategy, as evidenced by the SOML Program, is another crucial lesson, demonstrating its importance in managing large-scale programs.

[46] Project data shows that the proportion of skilled births deliveries increased from a baseline of 20 percent to 47.2 percent, the proportion of sick children who attended government health facilities increased from 27 percent to 69.1 percent and Penta 3 coverage increased from 27 percent to 68.6 percent by June 30, 2020 (SMART survey). In addition, the project had a significant positive impact on immunization coverage and net usage by under-five children, improving curative care for under-five children and antenatal care utilization.

[47] Based on the health facility Quality of Care survey, the NE states improved quality of care from a baseline of 38.8 percent in 2016 to 59.4 percent by June 30, 2020. This was higher than the national average of 51.7 percent in 2019.

d. **The Huwe project (BHCPF; P163969) has illustrated that, with meticulous planning, federal funds can be directed to shape the expenditure of social programs at the subnational level.** The operationalization of the BHCPF has enabled the federal government to prioritize and secure additional public financing, creating a system that holds subnational entities accountable for the judicious use of public and other funds, with the goal of enhancing the standard and quality of healthcare services. This reform presented a significant opportunity to fortify FM, ensure accountability for performance, and promote value-for-money within the health system. In addition, the Huwe project took advantage of other FM reforms by the government, such as the Treasury Single Account used by government institutions, to streamline the flow of funds from the central government to frontline health facilities. The blending of government and World Bank project resources, with the same fiduciary protections as foreign grants and loans, has improved transparency and accountability in financing and ensured coordination among development partners. This blending has also set the stage for the SWAp that the government is currently implementing, with several development partners having signed an agreement to implement a single national financing program under the NHSRII.

e. **Nigeria's RMNCAH-N Investment Case, spanning from 2017 to 2030, was formulated in line with the RMNCAH-N strategy through a collaborative process.** It received the endorsement of Nigeria's health sector leadership, under the guidance of the health minister, in March 2018. This initiative was bolstered by a US$50 million grant to aid in its execution. The government, in partnership with the GFF and other stakeholders, facilitated the prioritization of Investment Case interventions, employing transformative, geographical, and programmatic methods within three World Bank projects: NSHIP, Huwe, and ANRIN. The midterm review delved into the FMOH&SW's strategy formulation process and examined the interplay between the National Health Sector Development Plan and specific plans like the RMNCAH-N strategy. Six years into its implementation, there have been encouraging signs of improvement in health indicators, although a definitive assessment awaits the release of the 2023 Demographic and Health Survey report.

9. **Lessons learned from the midterm review emphasize the significance of ongoing advocacy, particularly through changes in leadership, and the necessity of comprehensive monitoring and mapping of outcomes to ensure adherence to strategy implementation.** The development of policies and strategic plans alone did not ensure their faithful execution or the attainment of intended results; rigorous M&E across health sector strategies are essential. The activation of DFF in the BHCPF was transformative in the three project states, serving as an advocacy mechanism that demonstrated the alignment of external resources with national initiatives, essential for fostering synergistic efforts toward positive outcomes. Other lessons include the identified lack of coordination among MDAs at the federal level, underscoring the need for interagency collaboration for effective implementation and mutual accountability. In addition, there is no clear evidence of how the government, at both national and subnational levels, prioritized and preferentially implemented essential RMNCAH-N interventions beyond donor-driven projects.

10. **Primary healthcare is widely recognized as the most appropriate and efficient[48] means of delivering health services to reduce maternal and child mortality rates.** Evidence from various studies[49] highlights that primary healthcare promotes equity by ensuring that healthcare services are accessible to all segments of the population, particularly underserved and rural communities. This equitable distribution of health services is crucial in reaching vulnerable groups and providing them with the care needed to improve health outcomes. In addition, primary healthcare is often lauded for its cost-effectiveness. By focusing on prevention, early detection, and treatment of common conditions, primary healthcare helps to reduce the need for more expensive specialized care, thereby saving costs for both the healthcare system and patients.

11. **The HOPE-PHC Program will bolster the capabilities of primary healthcare facilities in Nigeria, ensuring that they provide top-tier health services.** This commitment to enhancing facility readiness includes upgrades to infrastructure,

[48] https://www.afro.who.int/countries/nigeria/news/who-harp-efficient-investment-primary-healthcare-backbone-resilient-health-system
[49] Starfield, B. (2009) Primary Care and Equity in Health: The Importance to Effectiveness and Equity of Responsiveness to Peoples' Needs; Hanson, K. et al. (2022) The Lancet Global Health Commission on financing primary health care: putting people at the center. The Lancet Global Health Commissions.

professional development for staff, and the procurement of essential medical supplies and equipment. Additionally, the HOPE-PHC Program will boost the accessibility of funds at the grassroots level, allowing for tailored responses to unique local needs and obstacles. The pursuit of quality in healthcare is of utmost importance, as underscored by the Lancet Commission on High-Quality Health Systems. The Commission asserts that having access to healthcare is not enough; the caliber of the care provided is equally vital to secure favorable health outcomes. Strengthening primary healthcare systems not only is vital for immediate health outcomes, but also offers positive spillovers for the broader resilience agenda.

12. **The HOPE-PHC Program will provide universal access to a basic package of health services**. This basic package of interventions is designed to be delivered primarily at the primary healthcare level, ensuring that a foundational level of healthcare is accessible to all. As part of the BHCPP, the basic package of health services extends beyond the primary healthcare level, incorporating crucial interventions at the community level, which center mostly around health promotion, disease prevention, and simple curative measures. In addition, targeted secondary-level interventions are earmarked specifically for maternal and newborn health, recognizing the specialized care required in these areas at higher levels of care.

13. **In areas where essential health services are not fully utilized, it is vital to focus on both enhancing the availability of these services and actively encouraging their use.** To effectively stimulate demand, initiatives should be rooted in the community, utilizing established community service delivery systems that have the community's confidence.

14. **In addressing Nigeria's health challenges, it is crucial to recognize that poor outcomes are not confined to the most impoverished segments of society.** For instance, even when considering the second-richest quintile of the Nigerian population in isolation, it would stand among the ten nations in the world with the highest rates of under-five mortality. This stark reality underscores the necessity for the HOPE-PHC Program to adopt a universal approach in its interventions. Universality, in this context, means committing to the provision of a simple package of good-quality essential health services that is accessible to all Nigerians. As additional resources become available, the scope of these services can be broadened based on their cost-effectiveness, but the foundational principle remains that good-quality essential health services must be accessible to all.

Results Areas

15. **The HOPE-PHC Program is poised to be at the heart of the SWAp, an approach that has demonstrated success in various settings and brings forth significant benefits**. By adopting a SWAp, there is a concerted effort to bolster institutional capacity in the health sector, including the capacity of the NPHCDA and the NHIA, along with their respective state counterparts. Concurrently, the initiative acknowledges the existing accountability challenges that span multiple levels—federal to state, state to LGA, and state to provider. These challenges are recognized and actively being addressed to ensure a robust and responsive health system under the SWAp framework.

16. **The HOPE-PHC Program is set to significantly strengthen all health financing functions.** On the mobilization side, it aims to raise substantial resources, including contributions from the HOPE-PHC Program, HOPE-GOV, and through the reprogramming of resources under the IMPACT initiative. The establishment of the SWAp is a pivotal step toward pooling funds, moving toward the harmonization of domestic and external funding, which includes the strategic pooling of investments. On the strategic purchasing side, the HOPE-PHC Program's alignment of funding with key sectoral priorities promises to improve the efficiency of health spending, ensuring that financial resources are used effectively to support the health sector's most critical needs. Furthermore, the HOPE-PHC Program will play a crucial role in scaling up DFF, a strategy whose effectiveness has been affirmed by an impact evaluation in Nigeria. In addition, HOPE-GOV is committed to tackling PFM challenges that pose significant bottlenecks in ensuring the flow of funds to the frontlines.

17. **Through investments in the governance of the health system, the HOPE-PHC Program will enhance the service delivery environment by emphasizing critical enablers such as digital health.** By providing foundational support for a high-performing digital health ecosystem, the HOPE-PHC Program will aid in the establishment of national health data standards and the reinforcement of the regulatory landscape. These steps are crucial for encouraging the adoption of digital health tools by the private sector. Moreover, the introduction of unique patient identifiers will be instrumental in promoting the interoperability of digital health tools, ensuring a more connected and efficient healthcare system. In addition to these technological advancements, the HOPE-PHC Program will focus (under Results Area 3) on strengthening community platforms to foster community engagement, thereby ensuring a holistic approach to service delivery enhancement.

Results Area 1: Improving Quality of Services

18. **The HOPE-PHC Program is set to facilitate the operationalization of a service delivery model that mirrors the "hub and spoke" structure.** This model will underpin the BHCPP's support for investments aimed at fortifying community-based service delivery, enhancing the capacity of primary healthcare facilities to dispense an essential package of health services, and ensuring the availability of good-quality BEmONC and CEmONC services across every LGA. Achievement of these goals will be pursued through a suite of investments, which include broadening universal primary healthcare by way of equity-focused DFF, reimbursements for CEmONC, an Incentive-based Quality of Care Program that prioritizes the process and content of care, and an overhauled community-based health services system strengthened by robust FHWs. Climate change resilience and energy efficiency measures will be embedded in health facility upgrades.

19. **Access to family planning is a critical component of reproductive health services, playing a significant role in reducing fertility rates by minimizing the incidence of unwanted pregnancies.** This, in turn, can lead to more sustainable population growth and better allocation of household resources. Ensuring that adolescents have access to family planning commodities is particularly crucial, as early childbearing can have detrimental effects on maternal and child health outcomes. Early pregnancies can increase the risks of maternal mortality and morbidity and can adversely affect the child's health and future socioeconomic potential. Addressing this challenge will necessitate substantial efforts to generate demand for family planning services, especially considering that only 36 percent of married women aged 15-49 have expressed a desire to access these services, more than half of whom face an unmet need for family planning.[50]

Results Area 2: Improving Utilization of Services

20. **The demand for health services in Nigeria remains notably low, which can be attributed in part to the subpar quality of care offered by public health facilities**. Merely enhancing the quality of these services is not sufficient to guarantee an uptick in their utilization. It is crucial, therefore, to pair quality improvements with initiatives that aim to stimulate demand. To address this, the HOPE-PHC Program is committed to financing investments designed to bolster community-based service delivery, recognizing that a multifaceted approach is essential for expanding access to and coverage of health services across the nation. To further create demand for health services, strategies such as conducting home visits, encouraging care-seeking at primary healthcare centers, and mobilizing communities for outreach programs and health campaigns will be implemented. These will be informed by stakeholder consultations and a patient voice/perception survey. In parallel, primary healthcare facilities will be strengthened to manage increases in demand for services. In addition, social behavior change communication will be employed to enhance interpersonal communication, community outreach, and counseling, particularly on maternal and child health, ANC attendance, improved dietary practices, vaccination for children under five, NCD counseling, and birth spacing.

[50] National Population Commission (2018) *Demographic Health Survey 2018.*

21. **The HOPE-PHC Program is set to play a salient role in the implementation of the Nigeria NHIS, which is operated by the NHIA.** The HOPE-PHC Program will address one of the main challenges faced by the NHIA, the low rate of enrollment. It will leverage revised BHCPF guidelines to support states' health insurance agencies to boost enrollment rates among poor and vulnerable populations. All mothers supported through the CEmONC intervention will also be automatically enrolled. This effort will be supported through the national scale-up of the newly developed digital Civil Registration and Vital Statistics (CRVS) system (VITAL REG), and the HOPE-PHC Program will facilitate the automatic enrollment of every newborn registered in VITAL REG and pregnant women with a NIN into the NHIA system. This strategic approach is anticipated to significantly boost enrollment, with the goal of adding more beneficiaries to the NHIA by the end of the project, thereby expanding access to healthcare services and enhancing overall health outcomes in the country.

22. **Community-based service delivery has proven to be an effective model in various countries, bringing healthcare closer to the people, especially in underserved and climate-vulnerable areas.** This approach is designed to complement facility-based services, with a phased and targeted strategy to enhance demand creation, as well as promotive, preventive, and simple curative services at the community level. Key to this model is the retraining of all existing FHWs such as midwives, CHEWs, and auxiliary CHWs. In addition, the recruitment of additional FHWs, including CHEWs and auxiliary CHWs, is essential to bolster the workforce. The regularization and upskilling of FHWs, particularly auxiliary CHW agents, is crucial, ensuring that they serve as a complement to, and not a substitute for, other FHWs. This involves rationalizing, standardizing, and certifying competencies, as well as improving remuneration and supervision and expanding their scope of work to effectively complement other facility based CHWs. Furthermore, absorbing unemployed CHWs and partnering with the private sector through contracting out and other collaborative models can significantly enhance the reach and quality of community-based health services.

23. **A functional "hub and spoke" model will require substantial investments to improve Nigeria's low supply-side readiness to deliver essential quality health services**. In Nigeria, various studies[51] have highlighted a concerning trend: health facilities, particularly in rural areas, score significantly low in their readiness to provide good-quality services. This encompasses a range of issues, including inadequate infrastructure, a lack of medical equipment and critical commodities, and a shortage of trained medical personnel. These deficits are more pronounced in rural settings, exacerbating the urban–rural divide in healthcare quality. Studies have also revealed the low readiness of health facilities in Nigeria to deliver BEmONC services,[52] which are essential in preventing maternal and neonatal mortality. The HOPE-PHC Program will play a significant role in supporting the implementation of the NHSRII by placing a critical emphasis on improving primary healthcare readiness, including for the provision of BEmONC, and meticulously tracking advancements using quality scorecards. In addition, the integration of solar energy systems in health facilities is a key component of the climate agenda. The HOPE-PHC Program is committed to supporting investments that will increase health facilities' access to solar energy, thereby contributing to the resilience of healthcare services while simultaneously addressing environmental concerns.

24. **The HOPE-PHC Program will contribute to the prioritization of essential RMNCAH-N services through the "hub and spoke" model**. This support is key to hastening progress toward Nigeria's key development goals and the main objectives of the NHSRII, which focuses on the reduction of maternal and child mortality. By enhancing the availability and quality of RMNCAH-N services, the HOPE-PHC Program is expected to play a significant role in advancing the health outcomes of mothers and children in Nigeria, thereby contributing to the success of the NHSRII's ambitious health targets. The prioritized benefit package has been thoughtfully designed to integrate considerations of the impact of climate change on the health system and health outcomes, including factors such as the effects of extreme heat, the heightened risks of

[51] WHO (2016) National Health Facility Survey; Oyekale, A.S. (2017) Assessment of primary health care facilities' service readiness in Nigeria; Oluwale, E.O. et al. (2022) Maternal and child health service readiness among primary health care facilities in Ekiti, Nigeria; Ekenna, A. et al (2020) How ready is the system to deliver primary healthcare? Results of a primary health facility assessment in Enugu State, Nigeria.
[52] Ibadin, S.H. (2020) Facility readiness for basic emergency obstetric and neonatal care at PHC centers in Nigeria.

malnutrition, and the potential for increased prevalence of malaria and other vector borne as well as waterborne diseases. The essential package will include, among other services:

a. **Basic immunization.** Universal immunization coverage is a cornerstone of public health, vital for preventing the spread of infectious diseases. High population coverage is essential for immunization efforts to be effective, as it ensures herd immunity and protects those who are unable to be vaccinated. Immunization stands out as one of the most cost-effective health interventions, offering significant returns on investment through reduced healthcare costs and the prevention of disease outbreaks. On the other hand, zero-dose coverage, where individuals have not received any vaccinations, signaled deep-seated deprivation, and reflected an inequitable health system. As of 2020, Nigeria had the largest number of zero-dose children in the world,[53] as estimates of the number of zero- or missed-dose children increased to 3.1 million (from 3.0 million in 2019). Prioritizing the availability of vaccines and achieving high vaccination coverage rates is fundamental for any health system. The HOPE-PHC Program's commitment to supporting Nigeria in this endeavor is crucial, as it strives to ensure that every individual, especially the most vulnerable, has access to life-saving vaccines.

b. **Maternal nutrition, antenatal care, and deliveries**. With a staggering 37 percent of children under the age of five experiencing stunting, Nigeria faces a significant challenge in improving the nutritional status of the youngest segments of its population. Strengthening the health system is imperative, linked with multisectoral interventions to prevent more children from becoming stunted. The HOPE-PHC Program is set to bolster community platforms to enhance maternal nutrition services at the primary healthcare level and to ensure nutrition counselling at the community level. Special focus will be given to the nutritional and birth outcomes of pregnant women, recognizing their vulnerability and the impact of a mother's nutritional status on her newborn's nutrition outcomes, as well as the critical impact of nutrition on early development.

c. **CEmONC services.** Improving maternal mortality rates is contingent upon a robust secondary healthcare level that is fully equipped and prepared to provide quality CEmONC services. In the face of stringent financial limitations, the BHCPP is unable to extend its coverage to a broad spectrum of secondary-level services. However, for Nigeria to realize its ambitious objectives of drastically diminishing maternal and child mortality rates, it is imperative to guarantee that pregnant women have effective access to CEmONC services. While investments under Results Area 2 are poised to mitigate some of the geographic and financial hurdles, it is the support provided by Results Area 1 that will be pivotal in ensuring that at least one facility in every LGA, reaching a total of 774, is primed to deliver good-quality CEmONC services.

25. **Another critical element of the health system is the provision of transportation for referrals and emergency care, which is vital for timely access to medical services**. The HOPE-PHC Program recognizes this need and will support the New Rural EMS Program Arrangement, which introduces three innovative service models to address urgent medical emergencies. Utilizing 112 or mobile-cellular technology and call center capabilities, the program connects local EMS operators with community members who serve as first responders. Private sector operators will be equipped with Basic Life Support tricycles, staffed by trained professionals, to provide emergency care *en route* to LGA hospitals. In addition, designated community members and commercial drivers will receive training in basic first aid and be skilled to offer specialized transport for maternity-related services, ensuring that pregnant women have access to the care they need during critical times.

Results Area 3: Improving Resilience of Health System

26. **DLI 8 supports the implementation of and adherence to an enhanced allocation formula for BHCPF resources, to be stipulated in revised guidelines.** A revised allocation formula will consider, inter alia, state-by-state variations in the disease burden (especially maternal and under-five mortality), poverty headcount, and climate vulnerability. The impact

[53] WHO / UNICEF *Estimate of National Immunization Coverage (WUENIC)*

of BHCPF can be improved by taking these factors into account in resource allocation decisions. Adherence to the revised guidelines will also ensure transparency and integrity in Program implementation.

27. **EPR is a critical pillar of the NHSRII, given the health security challenges faced by Nigeria and the world beyond.** The country developed a National Action Plan for Health Security, which was partially funded and partially implemented. The Joint External Evaluation, which aimed to assess the core capacities of International Health Regulations (IHR) 2005, revealed low scores in its first assessment (39 percent), with marginal improvements in the second round (54 percent). Given the low level of preparedness at the subnational level, the BHCPP will, alongside other national health protection efforts under the NHSRII, incentivize subnational governments to strengthen state-level systems to adequately prevent, detect, and respond to public health threats of disease outbreaks, including both epidemic and pandemic risks, climate shocks, natural disasters, and other humanitarian emergencies. These incentives will sharpen subnational focus on planning, systems capacity development, and financing of emergency preparedness efforts.

28. **Proactive measures to adapt to the impact of climate change on health and health system outcomes, embedded throughout the health system, are needed to minimize the health effects of climate change.** To facilitate a national approach to climate change adaptation, integrated into the health system, the HOPE-PHC Program will finance the development of a costed national climate and health adaptation plan. To initiate and support implementation of the plan, the HOPE-PHC Program will finance: (a) a financing strategy and monitoring framework for the plan; (b) development of state- and national-level implementation plans; and (c) implementation of the national- and state-level implementation plans. Implementation will be coordinated closely with FCDO, which will provide TA for the development of the plans in conjunction with the World Bank.

29. **The HOPE-PHC Program is set to bolster investments aimed at enhancing Nigeria's health management information system**. The PforR component presents an additional avenue to scale the use of digital-in-health initiatives in Nigeria's health sector. Furthermore, the governance of data, as well as its collection, analysis, and application, will receive a significant boost from the support directed toward the digital health agenda, ensuring a more robust and data-driven approach to health system management.

Economic Justification

30. **The HOPE-PHC Program has a strong economic rationale.** Many services provided in the primary care setting have public good or externality dimensions, including infectious disease treatment and maternal and child health services. Moreover, primary care interventions such as family planning, ANC, immunization, and nutrition services are generally more cost-effective (with a greater health impact per naira spent) than secondary and tertiary care. Because of the high value attached to better health (both intrinsically and as an investment in human capital), the benefit–cost ratio of effective government health spending is favorable. Simulations suggest that a ratio of over 20:1 is possible. In addition, the focus on governance and accountability, especially in the interdependent HOPE-GOV operation, can help mitigate potential "government failure" issues that may beset healthcare delivery, helping to ensure greater impact. While BHCPP investments have recurrent budget implications for federal and state governments, Nigeria is among the world's lowest health spenders, such that increased (and more effective) spending is to be welcomed and can be managed. Given the very low baseline (government spending on primary care is about 0.1 percent of GDP), even significant proportional increases would not pose a risk to overall public finances. Moreover, increased PHC spending can be partly achieved by reallocations away from less effective secondary and tertiary care. Finally, public primary care facilities and community health service delivery platforms operate close to the population and thus represent the most pro-poor segment of the government's delivery network.

31. **Nigeria is facing a challenging macro-fiscal outlook, but the incremental recurrent costs implied by the HOPE-PHC Program are sustainable.** First, it is noteworthy in this context that government health spending in Nigeria is currently the

lowest in the world as a share of GDP, implying that increased spending is to be welcomed. This is due in part to low prioritization of health within both the federal and state budgets. At the federal level, BHCPF funding is derived from the 1 percent earmark from the Consolidated Revenue Fund, which is expected to grow in part due to revenue generation reforms supported under a new World Bank project. At the state level, there is scope to boost primary healthcare spending in part through reallocations, for example from secondary care to primary care or from "extra" primary healthcare facilities to those supported under BHCPF (which account for about 17,000 out of the 30,000 nationally). Ultimately, Nigeria's health system performance will require additional government resources.

32. **The priority services to be supported under the HOPE-PHC Program are closely aligned with principles of cost-effectiveness to ensure value for money.** By incorporating insights from the third phase of the Disease Control Priorities Project (DCP-3), the HOPE-PHC Program is committed to making the most judicious use of available funds. DCP-3 provides a comprehensive review of the most effective interventions in health, offering guidance on how to achieve the best health outcome per naira spent. By aligning the benefits package with DCP-3 recommendations, the HOPE-PHC Program aims to optimize the health impact of its investment, focusing on interventions that deliver the greatest benefits to the population at the lowest possible cost. This approach is crucial in a context where resources are limited, and health needs are significant.

33. **The HOPE-PHC Program's focus on improving the quality of care is an important aspect of ensuring efficiency.** As highlighted in the Lancet Global Health Commission on High-quality Health Systems in the SDG Era, poor quality of care is a major barrier to reducing mortality—of equal or greater importance than access barriers in many settings. Quality of care is thus expected to become an even larger driver of population health as utilization of health systems increases. Strengthening the quality of the primary care system in Nigeria will help the government make better use of scarce resources. In addition, the SWAp model offers efficiency gains by reducing transaction costs and duplicated efforts that have been common in a fragmented approach.

34. **Prioritizing primary healthcare and community services is a cornerstone of the HOPE-PHC Program's strategy to enhance health outcomes for Nigeria's poor and vulnerable populations**. There are several pro-poor features in the program's design. First, the focus on primary care and community service delivery models ensures that care is offered as close as possible to the population, favoring those without the resources to travel long distances. Second, and related, the benefit package covers RMNCAH-N services that are more prevalent among lower socioeconomic groups, as per evidence from the Nigeria DHS 2018. Third, the revision of BHCPF guidelines will incorporate equity considerations in its allocation formula, including decisions around where to locate additional facilities during the expansion from 8,800 to 17,600 facilities. Fourth, expanded coverage of CEmONC services through a reimbursement model will help protect the poor and vulnerable from the catastrophic costs of emergency obstetric care in a hospital setting. Fifth, the climate focus of the HOPE-PHC Program promises to disproportionately help poorer, climate-vulnerable communities.

35. **An illustrative cost-benefit analysis was undertaken assuming that coverage rates for critical RMNCAH-N services would rise by 20 percentage points over 2025–2028.** This progressive scale-up was assumed to be achieved through annual increments of 5 percentage points versus intervention-specific baselines for Nigeria incorporated in the Lives Saved Tool (https://www.livessavedtool.org/). This reflects a commitment to substantial improvements in the delivery and uptake of essential RMNCAH-N interventions over the specified period.

36. **This rate of service coverage expansion is projected to avert an estimated 825,000 deaths**. This figure includes 783,000 children under the age of five and 42,000 pregnant women. The anticipated reduction in mortality among children under five is attributed to a wide range of interventions, including safe deliveries, neonatal care, nutrition supplementation, and better case management of malaria, pneumonia, and diarrhea. For pregnant women, the combination of expanded periconceptual services and CEmONC availability are the main drivers.

37. **The high value of mortality reduction at this scale implies a highly favorable benefit-to-cost ratio.** Mortality reduction can be valued using either a human capital approach (wherein foregone income is the key metric) or a "value of statistical life" (VSL) concept, which aims to capture the intrinsic value of better health and longevity. At Nigeria's income level, estimates of VSL fall between US$75,000 and US$350,000, depending on the methodology.[54] Even at the lower end of this range, the implied benefit-to-cost ratio of averting over 800,000 deaths with a program cost of US$3.8 billion is over 16:1. This does not include the value of morbidity reduction. The human capital approach, which equates the value of life to income earned, would be less than this but still offers high returns.

Program Expenditure Framework

38. **Program Expenditure Framework (PEF).** The IDA contribution to the HOPE-PHC PforR (2025-2028) will be US$570 million, for an expenditure framework estimated at US$3.6 billion for the HOPE-PHC government program (IDA accounts for 15.6 percent).

Table 2.1: Financing Framework (US$, millions)

Financing Source	2025	2026	2027	2028	Total
Borrower/Recipient	610	742	850	894	3,084
IDA	60.04	138.70	135	235.70	525.00
Total program financing	670.04	880.7	985	1129.7	3,665.44

Notes: 1. IDA funding equally divided into 4 years, but year-year allocation may vary. Total program financing includes government's own funding as well as IDA funding for both PforR and IPF components. Figures for 2025 were estimated assuming a 21 percent increase from the approved budget of 2024, subsequent year-on-year increases are assumed to be 20 percent, 16 percent and 14 percent respectively. 2. An estimated US$100m projected to be disbursed against 2028 expenditures will be disbursed in 2029 as reflected in the datasheet.

39. **Critical aspects of the government program, the BHCPP, are described in the National Health Act 2014 and the NHIA Act of 2022** and include: (a) primary healthcare service readiness, service availability, and quality in the National and State Primary Healthcare Development Agencies; (b) strategic purchasing for maternal and child health, administered by the National and State Health Insurance Agencies through general hospitals managed by the State Ministries of Health; (c) health security functions delivered by the Nigeria Centre for Disease Control; (d) a NEMSAS; (e) Digital-in-Health for information systems strengthening and HRH by the Department of Health, Planning, Research, and Statistics of the FMOH&SW and State Ministries of Health; (f) medical industrialization; and (g) citizen engagement.

40. **The government will support the expenditure framework through annual budgets aligned with key pillars of the government program.** These expenditures will cover several entities of the government including Federal and State Ministries of Health, Federal and State Primary Healthcare Development Agencies, National and State Health Insurance Agencies, State Drug Management Agencies, State Hospitals Management Boards (HMB) spanning 36 + 1 states and the National Annual Operational Plans of the government. The expenditure categories and economic codes to be considered include: (a) the BHCPF for fiscal transfers to 36 + 1 states by the FMOH&SW; (b) general services and utilities; (c) consulting services; (d) acquisition of fixed assets including medicines, basic equipment and other commodities; (e) acquisition of non-tangible assets; (f) provision and repair of general fixed assets; (g) training; and (h) preservation of the environment. These expenditures are directed towards the following activities: (a) strategic purchasing through the NHIA; (b) investment in primary healthcare rehabilitation; (c) essential commodities; (d) emergency and ambulance services; and (e) data and information systems. The HOPE-PHC Program boundaries will exclude high-value equipment procurement, extensive civil works and construction, and land acquisition. A portion of salaried recurrent line items will be covered under HOPE-GOV. Non-salary recurrent line items including the cost of administration, supervision, and minor inputs will not be prioritized for funding within this HOPE-PHC Program.

[54] Robinson, L., J. Hammitt and L. O'Keeffe (2018). Valuing Mortality Reductions in Global Benefit-Cost Analysis. https://sites.sph.harvard.edu/bcaguidelines/

41. **The Program Expenditure Framework (PEF) is assessed as fiscally sustainable.** The government's medium-term trajectory is sound. The overall cost of the PforR Program over the next four years is US$3.67 billion, out of which US$500.00 million in IDA financing; US$50.00 million from GFF and US$70.01 million expected from other Development Partners. The PEF aligns with the results areas. Table 2.2 provides details of the overall Program financing.

Table 2.2: PEF Summary (HOPE-PHC)

Budget Code	Yearly Projections of program expenditures (US$[55])					
	2024	2025	2026	2027	2028	Total
(A) FGN MDAs						
(A_1) BHCPF						
Personnel Cost						
210101 Salaries & Wages	92,725,825	112,198,248	134,637,898	156,179,962	178,045,156	673,787,089
Total - BHCPF	**92,725,825**	**112,198,248**	**134,637,898**	**156,179,962**	**178,045,156**	**673,787,089**
(A_2) FMoH						
Other Recurrent Costs						
220201 Travel & Transport- General	47,669	57,679	69,215	80,290	91,530	346,384
220202 Utilities- General	16,741	20,257	24,308	28,197	32,145	121,648
220203 Materials & Supplies- General	26,228	31,736	38,083	44,176	50,361	190,584
220204 Maintenance Services- General	19,944	24,132	28,959	33,592	38,295	144,922
220206 Other Services- General	27,609	33,407	40,088	46,502	53,013	200,619
220208 Fuel & Lubricants- General	42,724	51,696	62,035	71,961	82,035	310,452
220209 Financial Charges- General	6,245	7,556	9,068	10,519	11,991	45,379
220210 Miscellaneous	86,924	105,178	126,214	146,408	166,905	631,628
Capital Expenditures						
230101 Purchase of Fixed Assets- General	22,018,348	26,642,201	31,790,641	37,085,944	42,277,976	159,995,110
230201 Construction/Provision of Fixed Assets-General	5,310	6,425	7,710	8,944	10,196	38,585
230301 Rehabilitation/Repairs of Fixed Assets-General	1,475	1,785	2,142	2,484	2,832	10,718
230401 Preservation of the Environment-General	-	-	-	-	-	-
230501 Acquisition of Non-Tangible Assets	46,899,618	56,748,538	68,098,245	78,993,965	90,053,120	340,793,485
Total - FMoH	**69,198,835**	**83,730,590**	**100,476,708**	**116,552,982**	**132,870,399**	**500,837,898**
(A_3) NHIS						
Capital Expenditures						
230101 Purchase of Fixed Assets- General	-	-	-	-	-	-
230201 Construction/Provision of Fixed Assets-General	-	-	-	-	-	-
230301 Rehabilitation/Repairs of Fixed Assets-General	-	-	-	-	-	-
230401 Preservation of the Environment-General	-	-	-	-	-	-
230501 Acquisition of Non-Tangible Assets	422,339	511,030	613,236	711,354	810,944	3,068,903
Total - NHIS	**422,339**	**511,030**	**613,236**	**711,354**	**810,944**	**3,068,903**
(A_4) NPHCDA						
Other Recurrent Costs						
220201 Travel & Transport- General	16,522	19,992	23,990	27,828	31,724	120,056
220202 Utilities- General	21,976	26,591	31,909	37,015	42,197	159,687
220203 Materials & Supplies- General	19,230	23,268	27,922	32,389	36,924	139,734
220204 Maintenance Services- General	8,038	9,762	11,671	13,539	15,434	58,408
220206 Other Services- General	66,336	80,267	96,320	111,731	127,373	482,027
220208 Fuel & Lubricants- General	23,776	28,769	34,523	40,046	45,653	172,767
220209 Financial Charges- General	-	-	-	-	-	-
220210 Miscellaneous	34,929	42,264	50,717	58,832	67,068	253,810

[55] Exchange rate as of 30th April 2024; US$1 – NGN1,356.01.

Budget Code	Yearly Projections of program expenditures (US$[55])					
	2024	2025	2026	2027	2028	Total
Capital Expenditures						
230101 Purchase of Fixed Assets- General	27,622,411	33,423,117	40,107,741	46,524,979	53,038,476	200,716,725
230201 Construction/Provision of Fixed Assets-General	1,174,479	1,421,120	1,705,344	1,978,198	2,255,146	8,534,287
230301 Rehabilitation/Repairs of Fixed Assets-General	16,167,064	19,562,147	23,474,577	27,230,509	31,042,781	117,477,078
230401 Preservation of the Environment-General	-	-	-	-	-	-
230501 Acquisition of Non-Tangible Assets	1,751,415	2,119,212	2,543,055	2,949,943	3,362,935	12,726,560
Total – NPHCDA	**46,906,176**	**56,756,473**	**68,107,768**	**79,005,010**	**3,729,309**	**340,841,139**

Budget Code	Yearly Projections of program expenditures (US$)					
	2024	2025	2026	2027	2028	Total
B) 36 States, excluding FGN[56]						
Other Recurrent Costs						
220201 Travel & Transport- General	1,707,965	2,066,638	2,479,965	2,876,760	3,279,506	12,410,833
220202 Utilities- General	429,354	519,518	623,422	723,170	824,413	3,199,877
220203 Materials & Supplies- General	5,573,248	6,743,630	8,092,356	9,387,133	10,701,332	40,497,699
220204 Maintenance Services- General	2,477,827	2,961,871	3,554,245	4,122,924	4,700,133	17,787,000
220206 Other Services- General	5,212,855	6,307,555	7,569,065	8,780,116	10,009,332	37,878,923
220208 Fuel & Lubricants- General	876,997	1,061,166	1.273,400	1,477,144	1,683,944	6,372,650
220209 Financial Charges- General	791,112	957,246	1,148,695	1,332,486	1,519,034	5,748,572
220210 Miscellaneous	11,934,713	14,441,003	17,329,203	20,101,876	22,916,138	86,722,933
220400 Grants and Contribution General	1,971,498	2,835,513	2,862,615	3,320,634	3,785,522	14,325,781
220700 Transfers-Payments	806,334	975,664	1,170,797	1,358,124	1,548,262	5,859,182
Capital Expenditures						
230101 Purchase of Fixed Assets- General	84,698,039	102,484,627	122,981,553	142,658,601	162,630,805	615,453,625
230201 Construction/Provision of Fixed Assets-General	93,869,969	113,582,662	136,299,195	158,107,066	180,242,055	682,100,948
230301 Rehabilitation/Repairs of Fixed Assets-General	33,803,894	40,902,712	49,083,254	56,936,575	64,907,695	245,634,130
230401 Preservation of the Environment-General	224,795	272,002	326,402	378,627	431,634	1,633,460
230501 Acquisition of Non-Tangible Assets	51,086,533	61,814,705	74,177,646	86,046,069	98.092,519	371,217,472
Total – 36 States	**295,435,133**	**357,476,511**	**428,971,813**	**497,607,303**	**567,272,326**	**2,146,763,086**

Source: 2024 Appropriation published by the BoF (FGN MDAs), and the websites of each of the 36 states, and WB staff calculations.

FGN + 36 States	Yearly Projections of program expenditures (US$)					
	2024	2025	2026	2027	2028	Total
Total – PEF	504,706,308	610,672,852	742,807,423	850,056,611	882,728,134	3,665,298,115

- ***Note 1:*** *BHCPF: 100 percent of 2024 Budget. Budgeted by the FGN under personnel cost, salaries & wages.*
- ***Note 2:*** *FMoH: 40 percent of 2024 Budget, excluding Personnel Costs. The same applies to the States, MoH.*
- ***Note 3:*** *NHIS: 50 percent of 2024 Budget, excluding Personnel Costs. The same applies to the States, SHIS.*
- ***Note 4:*** *NPHCDA: 100 percent of 2024 Budget, excluding Personnel Costs. The same applies to the States, SPHCDB.*
- ***Note 5:*** *States HMB: 20 percent of 2024 Budget, excluding Personnel Costs.*
  Note 6: *States DMA: 60 percent of 2024 Budget, excluding Personnel Costs.*

[56] Figures only relate to States Ministries of Health, States Health Insurance Agencies, States Primary Health Care Development Board, and States Hospital Management Board.

ANNEX 3. SUMMARY FIDUCIARY SYSTEMS ASSESSMENT

1. **An FSA was carried out to review the systems, practices, and procedures at the participating MDAs.** These include the FMOH&SW, NPHCDA, and NHIA, including state-level counterparts across a sample of four representative states: Enugu, Nasarawa, Ondo, and Oyo. Capacity and performance with respect to procurement, FM, and anticorruption systems are adequate to provide reasonable assurance that financing proceeds will be used for the intended purposes of the HOPE-PHC Program.

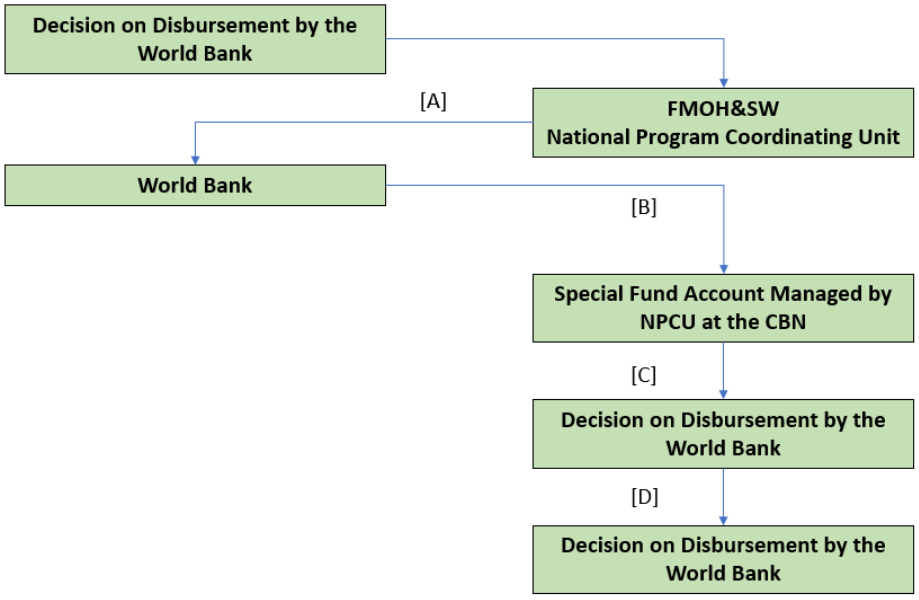
2. **A summary of key fiduciary risk and mitigation measures identified by the assessment are listed in the PAP (Annex 5).** This includes both FM and procurement.

3. **Program Budget and Audits. The implementing agencies have a robust budget and accounts classification system that will enable reporting of Program expenditures. The HOPE-PHC Program audit will be conducted by the OAuGF and the State Auditors General for federal and state agencies, respectively.** The PCU will, after receiving the audit reports from the OAuGF and SOAuGs, compile the data on Program expenditures for the federal and state participating MDAs extracted from the audited financial statements. The data will be certified by the OAuGF with an opinion expressed based on agreed upon procedure. **The implementing agencies will strengthen their capacity to undertake risk-based internal audit.** The FMOH&SW and other implementing agencies will prepare and implement an internal audit plan under the HOPE-PHC Program.

4. **In respect of Procurement, the HOPE-PHC Program will use the government's public procurement management mechanism which is considered adequate and saw reform with the enactment of the Public Procurement Act 2007 and related states legislation which guide the procurement of goods, works, and services.** Both the Federal and states procurement laws are based on the UNCITRAL model with minor differences to cater for peculiar domestications at the State level. The World Bank Procurement Regulations will govern procurement under the IPF component of the HOPE-PHC Program. The Nigeria Public Procurement Act 2007 and associated procurement regulations and systems meet the requirements of the PforR policies and procedures - and are adequate for the achievement of the HOPE-PHC Program objectives. The government has created a procurement cadre in the public service. The MDAs use the Public Procurement Act and apply procurement approaches and procedures that are based on the Procurement Regulations developed by the Bureau of Public Procurement.

5. **The World Bank 'Guidelines on Preventing and Combating Fraud and Corruption in PforR-Financing'** will apply to the HOPE-PHC Program and Grievance Redress Mechanisms will be implemented across all the implementing agencies. The HOPE-PHC Program governance and anti-corruption arrangements will rely on the country's national level governance and anti-corruption arrangements with additional Program-specific reporting and agreed protocol.

Figure 3.1 Disbursement Arrangements



[A] Submits withdrawal application to the World Bank

[B] World Bank disburses to the NPCU Special Fund Account held with the CBN for subsequent payment to beneficiary states

[C] From the special fund account, the NPCU transfers to qualifying states. Transfer to states will be accomplished within 14 days of receipt of disbursement from the World bank.

[D] From the consolidated revenue fund account, states disburse to sector sub-accounts.

ANNEX 4. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

1. **The ESSA examines the extent to which the existing E&S management systems of Nigeria's federal and state governments operate within an adequate legal and regulatory framework to guide E&S impact assessments, mitigation, management, and monitoring at the HOPE-PHC Program level.** It assesses their consistency with the six "core principles" of the PforR Policy and recommends actions to address the gaps and to enhance performance during Program implementation. This ESSA incorporates recognized elements of good practice in E&S assessment and management, defines measures to strengthen the system, and recommends measures that will be integrated into the overall HOPE-PHC Program. The ESSA is undertaken to ensure consistency with six core principles and key planning elements of the PforR ESSA.[57]

2. **The World Bank prepared the ESSA through a combination of detailed reviews of existing program materials and available technical literature.** This literature includes policies, regulations, guidelines and examples of due diligence and design documents, interviews and extensive consultations with government staff, nongovernmental organizations, regulatory agencies, private sector organizations, and sector experts associated with the health sector in Nigeria.

3. **In line with the six core principles, the relevant risks associated with the HOPE-PHC Program, and within the proposed Results Areas that cover E&S issues, include:**

(a) The refurbishment and rehabilitation of facilities to achieve a 75 percent score on the health facility readiness assessment could result in negative E&S impacts, such as the generation of solid waste, noise, and air pollution.
(b) Discrimination could exist in the recruitment of healthcare workers, such as skilled birth attendants, to meet the readiness assessment criteria.
(c) Generation of e-waste may increase due to the digitization of the health system for digital health enterprises in health architecture.
(d) There could be a potential increase in the generation of healthcare waste due to increased spending on the provision of facilities, an expansion in the number and improved quality of healthcare facilities, and increased expenditure for provision of health products.
(e) There could be potential discrimination against vulnerable groups, ethnic bias, and sexual abuse or harassment of women in the provision of health insurance under the NHIA gateway in the revised BHCPF guideline, and in the provision of essential health services by CHWs.
(f) The rehabilitation of facilities with climate resilience and energy efficiency features under the National Climate and Health Implementation Plan could lead to negative E&S impacts associated with rehabilitation, such as the generation of solid waste, noise, and air pollution. In addition, there are negative environmental impacts associated with renewable energy, such as solar systems, especially electronic waste, old batteries and panels, and possible clearing of land/vegetation to install solar panels.
(g) Rehabilitation work can also impact workers' health and safety.

4. **The overall E&S risks have been assessed as moderate.** Although the HOPE-PHC Program does not involve construction works, and Program activities are not likely to require significant changes to the government's overall environmental systems, the HOPE-PHC Program was generally assessed as moderate because there are some rehabilitation works on facilities to strengthen the health system.

5. **The ESSA process includes stakeholder consultations and disclosure of the ESSA Report, in accordance with the World Bank Policy and Directive for Program for-Results Financing and Access to Information Policy.** At present, the ESSA consultation process is embedded in the HOPE-PHC Program consultation process.

[57] https://ead.gov.ng/public-disclosure-of-the-escp-sep-essa-for-hope-p-for-r-by-federal-ministry-of-health/

6. **Some analysis was carried out to determine the range of E&S risks and benefits that are associated with the HOPE-Health Program based on each of the DLIs.** The HOPE-PHC Program will generate some E&S risks and benefits.

7. **The HOPE-PHC Program will generate some E&S benefits and risks.** The environmental risks will result from the rehabilitation and refurbishment of infrastructure, digital health enterprise in health architecture, and traffic risks due to increased patient emergency transport. On the other hand, the environmental benefits are minimal and limited to facilitating climate resilience measures for primary healthcare centers and BEmONC facilities and the climate benefits from the implementation of the National Climate and Health Adaptation Plan.

8. **The HOPE-PHC Program will deliver some direct and indirect environmental benefits.** Direct environmental benefits will accrue from achieving DLI 1.1, which focuses on the percentage of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75 percent on the health facility readiness assessment and includes measures of structural and process quality, solar power, and climate resilience, and DLI 1.2, which aims for an increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency. The installation of solar power and efforts to strengthen energy efficiency and climate resilience in health facilities will help reduce emissions and facilitate the achievement of Nigeria's 2060 zero emission target.

9. **Activities to achieve DLI 9, which strengthens EPR at the subnational level, will also yield environmental benefits.** Achieving this DLI will improve Nigeria's ability to handle climate shocks, natural disasters, and other humanitarian emergencies and generate some climate co-benefits. In addition, the development and implementation of a national climate and health adaptation strategy in DLI 10, which will help address climate change and vulnerabilities, will generate some climate co-benefits.

10. **The HOPE-PHC Program includes some activities that are expected to have an environmental impact.** Rehabilitation and refurbishment activities would be conducted to achieve a score of 75 percent on the health facility readiness assessment in DLI 1.1 and to ensure that CEmONC facilities demonstrate service readiness, climate resilience, energy efficiency in DLI 1.2. Implementation could involve the rehabilitation of facilities—for example, WASH facilities—that may be exposed to natural disasters, such as floods. Environmental risks associated with rehabilitation, such as solid waste, noise, and air pollution, as well as occupational health and safety risks, would negatively impact the environment.

11. **Generation of waste from electrical and electronic equipment, often referred to as e-waste, is expected.** This is due to the increased use of information and communications technology to facilitate digital health transformation in DLI 11.1 and states' adoption of digital health infrastructure to achieve DLI 11.2.

12. **The emergency medical transport system in DLI 7 will increase the number of vehicles transporting patients during emergencies and the number of patients transported to primary or secondary healthcare facilities.** This will result in increased consumption of fossil fuels, which will lead to increased CO_2 emissions and air pollution from transportation. Moreover, the digitized system that will be employed in emergency transportation could, in the long run, result in e-waste.

13. **The HOPE-PHC Program will result in many social benefits from achieving the DLIs.** These benefits include enhanced health outcomes, reduced infant and maternal mortality rates, increased life expectancy, enhanced economic development, and poverty reduction, given that more people will be healthy enough to work and contribute to economic development.

14. **The refurbishment and staffing of primary healthcare facilities to meet readiness in the assessment tool and application of the tool (DLI 1.1) and the refurbishment and empaneling of CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency (DLI 1.2) will facilitate the availability of water sources, toilets, mother–newborn intensive care units, surgical theatres, and equipment.** This will help to enhance health outcomes,

reduce infant and maternal mortality rates, and increase life expectancy. Improving the quality of healthcare services in Nigeria's healthcare facilities will help to ensure equity in access to healthcare, which will facilitate the realization of some health-related SDGs.

15. **Moreover, the rehabilitation of health facilities will lead to increased employment for locals who may be engaged in menial jobs.** The rehabilitation may lead to an influx of workers into communities, enhancing the local economy. Health workers will also be recruited for primary healthcare facilities, thus creating employment opportunities for unemployed health workers, and enhancing their income and well-being.

16. **In addition, activities under DLI 2 will facilitate the provision of contraceptives, tracer commodities, and medicines to women and children.** Tracer commodities include oxytocin, MMS, ACTs, HIV rapid test kits, Pentavalent vaccine, and a minimum of three modern contraceptive methods, including at least one LARC. Provision of these commodities will reduce the incidence of malaria, especially during pregnancy; reduce mother-to-child transmission of HIV; enhance the health of mothers and children; reduce infant and maternal mortality rates; and enhance life expectancy.

17. **Increased insurance coverage through linkages with the NHIA gateway (DLI 3) will increase child enrollment in the NHIA.** Increased insurance coverage will help ensure access to health services, especially among the poor, as it will protect them from increased healthcare costs. This will help to ensure improved health outcomes and quality of life.[58] In addition, the provision of tracer health services (DLI4) through CHWs, including micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification of and follow-up with pregnant women and referral to receive MMS, and treatment of childhood illnesses, among others, will enhance the health of women and children, reduce infant and maternal mortality rates, and enhance life expectancy.

18. **Skilled birth attendance during delivery in primary healthcare centers (DLI 6.1) will help to ensure that women can deliver babies in the presence of skilled professionals, thus reducing infant and maternal mortality rates.** Moreover, because children under five and pregnant and lactating women are particularly vulnerable to micronutrient deficiencies, providing MMS for pregnant women in DLI 6.2 will help prevent micronutrient deficiency in pregnant mothers and their babies and increase the changes of delivering healthy babies with high immunity against diseases that threaten the lives of infants. Provision of MMS will also help to ensure the normal functioning and growth of babies and the health of their mothers. In addition, the provision of Penta-3 vaccination in DLI 6.3 will help to ensure that children aged 12 to 23 months are maximally protected against diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B and Haemophilus influenzae type b (Hib), thereby substantially reducing infant mortality rates.

19. **Digitizing the health system in DLI 11 (digital-in-health enterprise in health architecture) offers many benefits to primary healthcare and general healthcare.** For example, it would help policymakers make informed decisions about resource allocation and thus reduce healthcare costs and free up resources for other important healthcare services. It would also help doctors and nurses prioritize individual treatment plans and thus enhance better health outcomes. A study in Ethiopia found that implementing a 20-month data-informed digital platform for health management resulted in strengthened health management through better use of data and appraisal practices, enhanced stakeholder engagement, and systemized problem analysis to follow up on action points.[59]

20. **The HOPE-PHC Program is associated with some social risks.** The refurbishment and rehabilitation of medical facilities under DLI 1 could potentially affect the health and safety of workers involved in the rehabilitation works. The workers may

[58] Institute of Medicine (US) Committee on the Consequences of Uninsurance. Coverage Matters: Insurance and Health Care. Washington (DC): National Academies Press (US); 2001. 1, Why Health Insurance Matters. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223643/
[59] Avan BI, Dubale M, Taye G, Marchant T, Persson LÅ, Schellenberg J. Data-driven decision-making for district health management: a cluster-randomised study in 24 districts of Ethiopia. BMJ Glob Health. 2024 Feb 29;9(2):e014140. doi: 10.1136/bmjgh-2023-014140. PMID: 38423549; PMCID: PMC10910485.

be exposed to pollution caused by dust and noise at the work site. There could also be an influx of workers into the communities where rehabilitation work will occur, and there could be cases of sexual abuse, drug abuse, and other social problems.

21. **There is the potential for discrimination against women and other vulnerable groups, ethnic considerations, and sexual abuse or harassment of women.** This discrimination could occur in the provision of tracer essential health services by CHWs (DLI 4), provision of health insurance under the NHIA gateway (DLI 3), provision of CEmONC, neonatal and under-five services and/or VVF surgeries (DLI 5.2), distribution of MMS supplementation for pregnant women during ANC visits (DLI 6.2), and provision of emergency medical transportation for patients with obstetric and neonatal complications (DLI7). In addition, although social conflict as envisaged by the ESSA—especially regarding armed conflict—is not applicable, discrimination along the lines of ethnicity and religion in medical staff recruitment under DLI 1, provision of tracer essential health services and provision of emergency transportation for patients with neonatal complications, and distribution of MMS supplementation for pregnant women can result in complaints, grievances, social unrest, and demonstrations among communities that feel left out or cheated.

22. **Following the identification of E&S risks, the E&S management system in place to manage the identified risks was assessed.** The assessment was conducted using the following criteria: the strengths of the system, or where it functions effectively and efficiently and is consistent with the World Bank Policy and Directive for PforR Financing; inconsistencies and gaps between the principles espoused in the World Bank Policy and Directive for PforR Financing and capacity constraints; and actions to strengthen the existing system. Information from this analysis, including the identification of gaps and opportunities/actions, was used to inform the recommendations and PAP as detailed in Annex 5.

ANNEX 5. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Develop and publish on Ministry website, Program Operations Manual (POM)	Other	NA	NPCU/SCO	Other	At effectiveness.	Finalized Program Operations Manual developed in agreement with the World Bank and published.
Develop Code of Conduct, Traffic Management and Occupational Health and Safety Plans for managing traffic related risks from increased emergency patients transport.	Environmental and Social Systems	NA	NPCU/NEMSAS	Other	Within one year of effectiveness	Finalized Code of Conduct and Occupational Health and Safety Plans reports.
Develop referral pathways and communication on GBV prevention and management to be integrated into retraining curricula for front line workers.	Environmental and Social Systems	NA	NPCU/FMOWA	Other	Within one year of effectiveness	Referral pathways developed and integration of GBV prevention and management in curricula.
Undertake environmental screening of designs for the rehabilitation of facilities to ensure that the rehabilitation activities filter out substantial or high-risk civil works and proposed actions	Environmental and Social Systems	NA	Federal Ministry of Health and NPCO/SCO	Other	Prior to commencement of rehabilitation works	Environmental screening checklist satisfactory to the World Bank developed for use before rehabilitation works

Develop e-waste and health care waste management strategies for managing e-waste and healthcare waste result from the program.	Environmental and Social Systems	NA	NPCU	Other	Within one year of effectiveness	Health care e-waste management plan developed and disseminated to health care facilities.
Deployment of key financial management, procurement and safeguards personnel, with TOR acceptable to the Association	Fiduciary Systems	NA	NPCU	Other	At effectiveness	Terms of Reference, Curriculum Vitae and Appointment Letter for each designated officer
Prepare and implement a comprehensive Procurement Capacity Development Plan for the Implementing Agencies based on a need assessment.	Fiduciary Systems	NA	NPCU	Other	Within 90 days of effectiveness	Capacity development plan developed
Conduct clinics to strengthen procurement institutions and systems through capacity building.	Fiduciary Systems	NA	NPCU	Other	Throughout Program implementation	Annual training reports
Ensure that individuals or firms debarred or suspended by the Bank are not awarded a contract by verifying the same prior to award under the Program.	Fiduciary Systems	NA	NPCU	Other	Throughout Program implementation	Annual reports *TOR for audit firms will include the requirement to assess on random basis whether any contract has been awarded to a suspended or*

						debarred firm and no parties debarred or suspended by the Bank shall benefit from the program funds.
Development and adoption of standardized framework agreements for procurement of recurring items.	Fiduciary Systems	NA	NPCU	Other	Within six months from effectiveness.	Standard Framework Agreement and procurement package templates
Carry out program procurement performance and value for money audit by an Independent Agency/Consultant (Third Party) using the terms of reference agreed by the World Bank.	Fiduciary Systems	NA	NPCU	Other	Once at mid-term review (MTR) and once at program closure.	Value for Money audit report
Establish service standards with implementing agencies to ensure timely for the release of Program funds.	Fiduciary Systems	NA	NPCU	Other	At effectiveness	Fund Release Policy
Engagement of IVA with technical and audit skill to review the achievement of DLIs and release of funds to the implementing agencies by the Government in conjunction with HOPE-GOV PCU	Fiduciary Systems	NA	PCU	Other	2 months after Program effectiveness.	Engagement of IVA by implementing agencies.

Submit report on fraud and corruption allegations. Where there are no such allegations or complaints, a statement to that effect shall be included in the submission.	Fiduciary Systems	NA	NPCU /implementing agencies	Other	Bi-annually after effectiveness	Bi-annual report
Strengthening of ICPC's Anti-Corruption and Transparency Unit (ACTU) at FMOH and strengthening reporting linkages to the Economic and Financial Crimes Commission (EFCC).	Fiduciary Systems	NA	NPCU	Other	Throughout Program implementation	Semi-annual summary reports
Submit PEF based Program financial and IPF interim financial reports.	Fiduciary Systems	NA	NPCU	Other	Throughout Program implementation	Annual report and updated expenditure framework
Focused training to fiduciary staff in implementing agencies to strengthen financial management and reporting.	Fiduciary Systems	NA	NPCU /implementing agencies	Other	Within 90 days of effectiveness	FM Training Report package that includes agenda, training manual
Capacity training on risk based internal audit for internal auditors.	Fiduciary Systems	NA	NPCU /implementing agencies	Other	Within 18 months of effectiveness	Annual report
Government shall strengthen Maternal and Perinatal Deaths Surveillance and Response (MPDSR) system	Technical	NA	NPCU/DFH-FMOH	Other	Throughout Program implementation	Annual PDSR Assessment / Report

ANNEX 6. IMPLEMENTATION SUPPORT PLAN

1. **The Implementation Support Plan is designed based on the residual risks identified in the SORT assessment, in addition to other technical, fiduciary, environmental, and social gaps noted by the World Bank team.** Implementation support will cover all facets of the HOPE-PHC Program (Table 6.1), and World Bank team roles and inputs are proposed in Table 6.2. Advisory and TA activities that are critical for the achievement of DLIs, identified in the PAP (Annex 5), will be implemented with the support of the World Bank team.

2. **The World Bank will partner with the NSC and development partners under the SWAp TWGs to provide implementation support to national and subnational entities in the implementation of the HOPE-PHC Program.** The SCO has recently established seven TWGs to coordinate development partner TA under the SWAp. The TWGs are responsible for acting on sector-wide priorities (for example, the M&E TWG is tasked with creating sector-wide indicators and collecting inputs from relevant sub-groups, such as NHIA, NPHCDA, and Family Health). All SWAp TWGs report their findings to the NSC, chaired by the CMHSW, and have specific mechanisms through the SCO to hold them accountable, as described in Section III(A) – Program Implementation. The technical and fiduciary support provided through enhanced development partner coordination aims to facilitate coordination, monitor progress and outcomes, help identify and resolve roadblocks, strengthen performance management, improve equity, and enhance overall administrative efficiency. Table 6.3 lists the development partners that are currently providing financial and technical support for the NHSRII.

3. **To ensure successful Program/Project implementation, the World Bank team will be comprised of members with different skills and required experience.** Table 6.2 outlines the expected staff, staff time, and travel needed to ensure sufficient resources to implement planned program actions and schedules.

Table 6.1: Focus of Implementation Support

Time	Focus	Skills Needed from Task Team	Resource Estimate (US$)	Partner role
First 12 months	• Project readiness and preparation in advance of project effectiveness • Procurement preparation pre-award • Capacity building • Design and implementation of surveys, including quality assurance. • Development of the State of Health Report • Design and implementation of public health fellows' program. • Advice to results teams on development of workplans and implementation start; determination of whether advisory support is needed to achieve the DLIs.	• M&E • Data management • Technical	1,500,000	

Time	Focus	Skills Needed from Task Team	Resource Estimate (US$)	Partner role
12–48 months	• Review of progress in tender process and construction • Timely implementation of action plan and surveys • Prompt disbursement against DLI achievements. • Monitoring of procurement, FM, E&S, and fraud and anticorruption action plans • M&E, E&S, and FM • Capacity building • In-depth midterm review	• Technical • Fiduciary • Social and environmental	1,500,000	

Table 6.2: Task Team Skills Mix Requirements for Implementation Support

Skills Needed	Number of Staff Weeks	Number of Trips per Year	Comments
Task Team Leaders (TTLs)	88		TTL and co-TTL based in Abuja
M&E specialists	24–30	3–4	One based in Abuja/HQ
Procurement specialists	10–15	nan	Based in Abuja
FM specialist	6	n.a.	Based in Abuja
Environmental/social specialists	5–6	n.a.	Based in Abuja
Operational support	5–10	2	One based in Abuja/HQ
Specialized technical experts	5–10	3	
Administrative support	5-10	n.a.	Based in Abuja

Table 6.3: Role of Partners in Program Implementation

NAME	ROLE
Bill and Melinda Gates Foundation (**BMGF)**	TA
CIFF	Cofinancing /TA
GLOBAL AFFAIRS CANADA	TA
FCDO	Cofinancing/TA
GAVI	TA
GLOBAL FUND	TA
GIZ	TA
UNICEF/UNFPA/WHO	TA
US Center for Disease Control (CDC)	TA
USAID	NDHS/State of Health Report/TA
Japan International Cooperation Agency (JICA)	TA for EPR

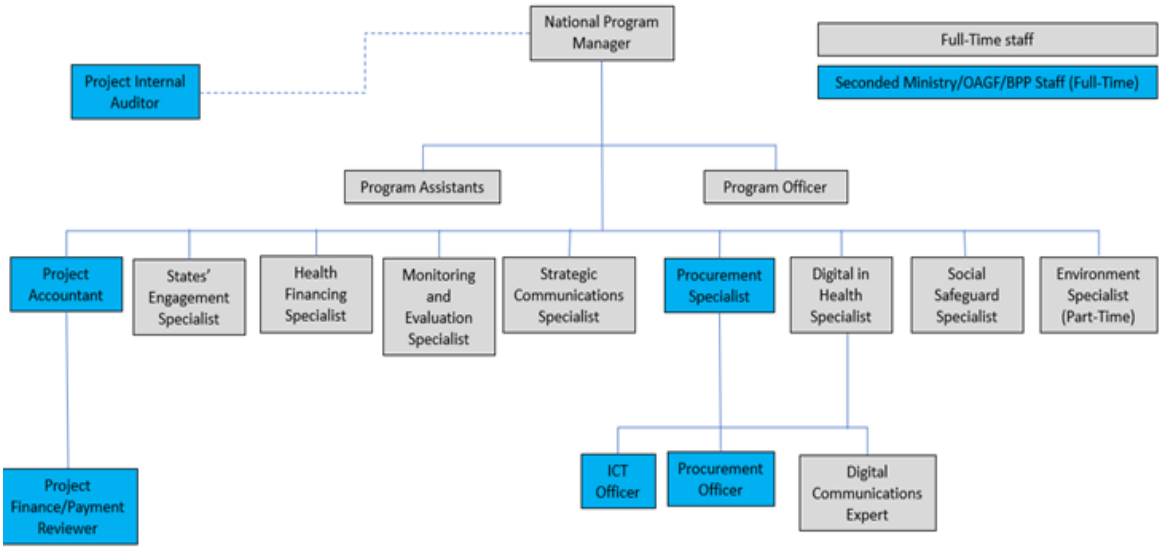
ANNEX 7. INVESTMENT PROJECT FINANCING COMPONENT

1. **Implementation arrangements for the HOPE-PHC Program will be fully streamlined into existing government structures at the federal and state government levels.** The government launched the NHSRII in December 2023, supported by a SWAp. A compact outlining the roles and responsibilities of key stakeholders in the SWAp framework was signed by the federal and state governments and most development partners in Nigeria, and its implementation is supported by a SCO in the office of the CMHSW. To ensure alignment of the SCO's activities with the objectives of the HOPE-PHC Program, the SCO will also serve as the NPCU for the HOPE-PHC Program. Oversight of state-level implementation will be through the BHCPF SOCs. This implementation arrangement reflects the recommendations and outcomes of various consultations and assessments carried out as part of Program preparation.

2. **The main features of the institutional, implementation, and coordination arrangements for the HOPE-PHC Program include:** (a) alignment with the SWAp; (b) establishment of an NSC, which comprises development partners and civil society; and (c) expansion of the functions of the BHCPF SOCs. Within this framework, the HOPE-PHC Program leverages key implementation models, processes, and tools from the existing organizational structure of the FMOH&SW and subnational entities to ensure the sustainability of investments and improve service delivery.

3. **The HOPE-PHC Program's governance structure comprises NSC and the NPCU/SCO.** First, the HOPE-PHC NSC will be chaired by the Honorable CMHSW and will comprise Honorable Minister of State for Health (HMSH), PSH, relevant heads of agencies of the FMOH&SW, selected members of the DPG-Health, and other members nominated by the CMHSW. The key responsibility of the NSC is to provide oversight and policy guidance to the SWAp Program in pursuit of the achievement of the HOPE-PHC PforR PDOs and Program development indicators. The terms of reference for setting up the NSC will be prepared by the NPCU/SCO and will be cleared by the World Bank. These TORs are expected to adequately reflect that the NSC provides important strategic oversight for the overall SWAp Program and for the IPF project, and it will define the future direction and sustainability of the HOPE-PHC Program. This will include broader investments mobilized under the SWAp, including deployment of additional CEmONC facilities, implementation of the public health fellows' program, and expansion of midwifery and nursing training capabilities. The NSC will be expected to have periodic interface with the broader HOPE Program at the national level to further strengthen engagement with the FMBNP and Federal Ministry of Education. The NPCU/SCO will function as the core task team, reporting to the CMHSW and serving as the secretariat for the Steering Committees. This hierarchical structure draws on experience with other successful PforR operations implemented in Nigeria and facilitates efficient communication, oversight, and resolution of implementation challenges at various levels.

Figure 7.1. HOPE-PHC NPCU Organigram



4. **Federal-level project management, coordination, and implementation arrangements.** The NPCU/SCO, headed by a National Program Manager recruited from either the public or private sector and reporting to the CMHSW/PSH, will meet weekly to steer day-to-day Program activities. The head of the SCO will double as the National Program Manager based in the Office of the coordinating minister and will serve as a secretariat for the NSC and as the World Bank's counterpart. The head of the NPCU/SCO will work under the overall supervision and guidance of the CMHSW, HMSH, and PSH. The NPCU/SCO will manage and coordinate implementation of the HOPE-PHC Program. While the actual implementation of the HOPE-PHC Program will be the responsibility of states, relevant entities such as NHIA, NPHCDA, NEMSAS, NCDC, BHCPF MOC will provide general oversight, technical support, supervision, M&E, and resource management, as required for states' engagement. The NPCU/SCO for the HOPE-PHC Program will oversee day-to-day implementation and will be responsible for coordinating HOPE-PHC Program activities in the FMOH&SW. The NPCU will have specific responsibilities, including: (a) coordinating and facilitating FMOH&SW activities related to the HOPE-PHC Program; (b) ensuring the timely collection of high-quality data and publication of the State of Health Report; (c) implementing and overseeing disbursements to states and participating entities under the various DLIs; (d) communicating and working with the states, including developing and implementing a communications plan; (e) serving as the NSC secretariat; (vi) facilitating the timely disbursement of funds to the states; (f) coordinating knowledge management and learning; (g) serving as a focal point for FMOH&SW activities within the broader HOPE Program; and (h) making sure that covenants are complied with and that the PAP is implemented. The head of the NPCU/SCO will be supported by a full-time, technically competent staff, either seconded from the FMOH&SW or competitively recruited from the private sector. The NPCU will be supported by a procurement specialist, an E&S specialist, and a communications specialist, in addition to the FM staff deployed to the PCU by the Accountant General. The ToRs for the staff to be deployed to the unit will be reviewed and agreed with the World Bank. The NPCU/SCO will have lean and efficient staffing, and its organizational structure will be reviewed by the NSC. The NSC will also review the performance of the SCO/NPCU after six months and then annually. The POM will include a clear delineation of the roles and responsibilities of relevant entities**.**

5. **BHCPF SOC.** The BHCPF SOCs will provide oversight and policy guidance for the HOPE-PHC Program at the state level. Each BHCPF SOC is chaired by the Commissioner of Health, and the current membership of the BHCPF SOC will be expanded

to include the Commissioner (or equivalent) responsible for planning and budget in the state. The ToRs for this expanded BHCPF SOC will be prepared in consultation with the Nigeria Governors' Forum and will be cleared by the World Bank. The BHCPF SOCs will provide important strategic oversight for the HOPE-PHC Program at the state level and will serve as the secretariat for state-level BHCPF implementation and the HOPE-PHC Program. The rationale for aligning the BHCPF and the HOPE-PHC Program is to help ensure the sustainability of the HOPE-PHC Program and allow for the holistic inclusion of all resources deployed at the state level to be considered as part of broader SWAp implementation. The BHCPF SOCs will be expected to meet on a quarterly basis and will periodically interface with the various State Executive Councils to further strengthen program engagement at the state level. The BHCPF SOCs will approve Annual Operational Plans required to support states in implementing activities and interventions required to access disbursements under the various DLIs and will assist key stakeholders in analyzing data and adjusting workplans to allow the achievement of DLIs.

6. **State-level project implementation and coordination arrangements.** The BHCPF SOCs are established in all 36 states and the FCT and will perform functions like that of NSC, at the state level. The NPCU/SCO will provide guidance to the state-level implementation bodies to ensure the speedy implementation of activities, with the aim of fostering and building strong state-level institutions under the BHCPF. The secretaries of the BHCPF SOCs will, in addition to this role, serve as the focal points for the HOPE-PHC Program in the 36 states and the FCT. There are no Project/Program Implementation Units at the state level, as there are no IPF procurement or FM functions. This approach focuses subnational entities on achieving results and not on process. This way, the states can organize themselves in ways that is most effective in their context.

7. **The IPF component of the HOPE-PHC (US$45.01 million equivalent) will provide targeted financing in key areas.** The IPF component for TA has two components: (1) Strengthening Systems and Capacities; and (2) Strengthening Program Coordination and Verification of Results. The IPF will be delivered by selected national-level institutions that are critical for supporting state governments to achieve program results, as well as to strengthen state government capacities in a sustainable manner. The first component will be the largest, focusing on establishing platforms for service delivery and supporting all participating state governments to strengthen their systems and capacities to enable them to achieve the HOPE-PHC Program results (the DLRs). The second component will focus on program management, IVA functions, and the learning agenda. Activities under the IPF include the establishment of a MaMII initiative; the design, procurement, and deployment of a federated digital-in-health enterprise architecture; joint TA coordination platform; operationalization of the public health fellows' program; hiring of an IVA; and critical TA and capacity building activities.

8. **The first IPF component will provide support to strengthen systems and build capacities.**

(a) Operationalization of the Maternal Mortality Reduction Innovation Initiative (MaMII). MAMII innovation initiative "investments" focus primarily on strengthening primary healthcare in high-burden, lagging, and climate-vulnerable states, allowing them to address legacy issues and "prime the pump." These types of service delivery innovations would aim to expand the coverage or quality of services at the population level, with an emphasis on underserved rural populations. The MAMII initiative will be designed to support public and private sector innovations aimed at increasing the utilization and quality of maternal and child health Interventions. The establishment and operation of the MAMII initiative will support not only private sector innovations aimed at increasing utilization and quality of maternal and child health interventions, but also partnerships with the public sector to test new approaches or scale up services to improve the delivery of RMNCAH-N services. The initiative will support interventions critical to ending preventable maternal, newborn, and infant deaths, including midwifery, emergency obstetric and newborn care, maternal and perinatal death surveillance and response, obstetric fistula and other obstetric morbidities, and digital capabilities and technologies. The MAMII initiative will be managed through a competitive process, to be established by the NPCU. The process will be cleared by the World Bank before its operationalization. Given the link between climate change and maternal, neonatal, and child health conditions

in Nigeria, the initiative will prioritize proposals focused specifically on climate-vulnerable areas with measures to address the additional burden of disease from climate change.

(b) Design, procurement, and deployment of a federated digital-in-health enterprise architecture. The NHSRII reforms include plans to bring about a digital transformation in the health sector by digitizing most information systems, including the electronic human resource management information system, the electronic national health insurance system, and the electronic health records systems. The TA will support enhanced digital capacity, including TA[60] and consultancies for the definition of regulatory frameworks and acquisition of hardware and software. The HOPE-PHC Program will support the FMOH&SW and its agencies to achieve an interoperable platform to systematically exchange data. In addition, the National Digital Transformation Office shall be supported to undertake feasibility study and to establish requirements for an enterprise data-sharing protocol, and a system for interoperability and data governance will be financed. Furthermore, any professional and consulting charges required to finance the design, building, and implementation of the data-sharing architecture will be financed by the HOPE-PHC Program, including consultancies to support platforms to undertake: (a) improved management of medicine stocks and supply chains; (b) introduction of advanced digital learning tools to upskill CHWs; (c) digital platforms for the management of emergency transportation for pregnant women and vulnerable patients; (d) expansion of the existing information technology (IT) application for Application Programme Interface; (e) strengthening of the health sector digitalization strategy; and (f) an increase birth registration using e-CRVS systems, with National Identification Number issued, and children enrolled in national health insurance.

(c) Platform for coordinated TA to support implementation. Supported activities will include the deployment of needs-based and demand-driven TA, as well as TA for climate activities.

(d) Strengthening strategic purchasing and regulatory functions of NHIA. The IPF will be used to provide TA on establishing a stronger strategic purchasing platform for the NHIA. Many key institutional building blocks and operational documents are in need of updating or development at the NHIA, including: (a) provider empanelment guidelines; (b) a tariff schedule based on a costing exercise; (c) a claims management manual; (d) a medical audit manual; (e) a fraud control manual; (f) a grievance redress manual; (g) a functional call center for beneficiary feedback; (h) beneficiary communication guidelines; and (i) contract templates for providers and third-party administrators. These building blocks are best developed at the NHIA as "public goods" for operationalization by SSHIAs, rather than each SSHIA attempting to develop its own approach, which would result in inefficiency and fragmentation.

(e)Platform to support implementation of Public Health Fellows' Program. The NHSRII reforms includes the establishment of the National Health Fellows' Program,[61] with young Nigerian fellows engaged across all 774 LGAs. The fellows will serve as fiduciary and performance management agents, strengthening health facilities' capacity for effective planning and resource management and equipped with appropriate tools to track the performance of BHCPF-supported health facilities across the nation.

9. **The second IPF component will support program management, measurement, results, and the learning agenda.**

(f) Hiring of an IVA for Independent Verification of Program Results. The IPF will be used to procure the consultancy services of an IVA responsible for the implementation of the verification protocol and reporting to the NPCU/SCO on the HOPE-PHC Program results. The IVA will be engaged by the FMBEP. The role of the IVA is to provide an independent, credible, and coherent analysis of state and federal government performance and earnings under the HOPE-PHC Program using agreed-upon data sources and earnings calculations as specified in this PAD.

(g) Program Monitoring and Evaluation and Learning, including Data Quality Assessments and publication of the annual State of Health Reports and Performance Ranking. The NPCU/SCO will put in place a robust program M&E system to select

[60] Due attention will be paid to avoiding the fragmentation of IT-enabled platforms and encourage consolidation while developing digital innovations.
[61] https://statehouse.gov.ng/news/president-tinubu-approves-establishment-of-national-health-fellows-programme/

the right tools to monitor program activities and ensure comprehensive data collection on all results and DLIs and DLRs, including through internal checks and balances to ensure continuous availability of credible data sources for verification. An M&E Specialist in the NPCU/SCO will assist the HOPE-PHC Program Manager to implement and coordinate these activities. The IPF component will cover the costs of consultancy services to implement the annual State of Health Report. Furthermore, the HOPE-PHC Program incorporates a strong emphasis on the learning agenda to support the HOPE-PHC Program in adapting and enable peer learning and knowledge dissemination. The NPCU, through the IPF, will implement a program of peer learning and knowledge dissemination to support the PforR. Thus, the knowledge and learning agenda provides support for state peer learning forums and periodic exchanges among state health commissioners, with a view to tapping into the tacit knowledge that exists within state governments and facilitating peer learning among states. In addition, the learning agenda will support South-South learning through exchange visits to countries with long experience with the SWAp, such as Bangladesh, and countries with experience using intergovernmental fiscal transfers as part of fiscal federalism.

(h) Support SCO as the PCU for program communications, stakeholder engagement, and SWAp coordination. The NNPCU/SCO will receive support in providing effective coordination of stakeholders across the three tiers of government, as well as stakeholder management and aid coordination in the context of the SWAp. The PCU will collect and analyze relevant data, coordinate with national and state entities to make sure that results are on track, solve problems early and rigorously and, when necessary, escalate issues for corrective action to achieve the program's aspirations, reporting regularly to the CMHSW/NSC. The NPCU/SCO will work to coordinate the strategic communications activities to be implemented by relevant agencies, including the NHIA, NPHCDA, NCDC, and NEMSAS. The HOPE-PHC Program will implement activities with all stakeholders to enable regular dialogue and information sharing throughout its lifecycle. The communication strategy aims to reinforce the accountability framework underpinning the HOPE-PHC Program. The HOPE-PHC Program's stakeholder engagement and program communication will support activities such as a people's voice survey, advocacy for the State of Health Report, and communicating and working with states on the HOPE-PHC Program communications plan. The results of the people's voice survey[62] will be used to directly inform the following: improvements in the delivery of services under the program; performance in the health system more broadly; and to develop and implement a communications strategy to bolster service delivery morale, strengthen public awareness of the health system, and support the advocacy campaign for the State of Health Report. Specialists will be hired within the NPCU/SCO, in addition to seconded FMOH&SW staff, on specific areas of program management.

Procurement Arrangements

10. **Procurement under the IPF component of the operation will be carried out in accordance with the World Bank procedures, as follows:** Procurement for goods, non-consulting and consulting services for the project will be carried out in accordance with the procedures specified in the 'Procurement Regulations for IPF Borrowers" (Procurement Regulations) dated September 2023 and the Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants of July 1, 2016, as well as the provisions stipulated in the Financing Agreement.

11. **Procurement will be carried out by the NPCU/SCO at the FMOH&SW**: The categories of procurement consist mainly of procurement of goods, non-consulting services and consulting services. Procurement of works is not envisaged under the IPF component. The consulting services will include the engagement of consulting services to deploy the federated digital in health architecture, selection of IVA firm by the FMBEP for the HOPE-PHC Program. The IVA procurement will be an eligible expenditure under the HOPE-PHC; however, the procurement process will be done under the HOPE-GOV. High performing consultants will be hired to strengthen the NPCU/SCO/SCO as needed. In addition, for specific technical aspects of the TA to help states achieve specific DLRs, the NPCU/SCO may engage consultants or firms.

[62] Kruk ME, Gage AD, Arsenault C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Health 2018; 6: e1196–252.

12. **The NPCU has prepared a Program Procurement Strategy for Development (PPSD) acceptable to the World Bank.** The Procurement Plan will be updated annually and as necessary and in agreement with the World Bank to reflect the project's actual implementation needs and improvements in institutional capacity. Advance procurement of key TA activities will be critical.

Operating Costs

13. **Operating costs for the NPCU/SCO, and the implementing agencies for the capacity building** will include the following: staff's travel expenditures and other travel-related allowances with prior clearance from the World Bank; equipment rental and maintenance; vehicle operation, maintenance, and repair; office rental and maintenance; supply of office consumables; utilities and communication expenses; and bank charges. The operating costs financed by the project will be procured using the government administrative procedures that are acceptable to the World Bank. The operating expenses will be subject to a statement of expenditure (SOE) review by the World Bank.

14. **Operating costs for the NPCU/SCO and the implementing agencies for the capacity building will be based on annual work plan and budget and will include the following**: staff travel expenditures and other travel-related allowances with prior clearance from the World Bank; equipment rental and maintenance; vehicle operation, maintenance, and repair; office rental and maintenance; supply of office consumables; utilities and communication expenses; and bank charges. The operating costs financed by the Project will be procured using the government administrative procedures that are acceptable to the World Bank. The operating expenses will be subject to a statement of SOE review by the World Bank. Operating costs exclude the salaries of government civil servants.

Training, Capacity Building, and Workshops

15. **The NPCU/SCO and other implementing agencies (through the NPCU/SCO) will submit their annual training plans, including capacity building activities for the states and training for their own staff, to the World Bank for clearance**. The plans will include, but not be limited to, the names of the officers to be trained, training institutions and/or facilitators, contents, justification for the training, and estimated cost.

16. **The IPF component will include training targeted at improving the capacity of the NPCU/SCO on E&S compliance.** This training will be delivered by the hired E&S officers/consultants.

Financial Management

17. **Implementation of the IPF component will be managed by the NPCU/SCO in the FMOH&SW.** The Federal Project Financial Management Department (FPFMD), established in the Office of the Accountant General of the Federation (OAGF), will be responsible for managing the financial affairs of the project, along with the NPCU/SCO. The FPFMD has been assessed and found to be acceptable for the implementation of World Bank-assisted projects. ***A Project Accountant and a Project Internal Auditor will be assigned to the NPCU/SCO by the FPFMD, and they will be subject to clearance by the World Bank.*** Given the NPCU/SCO's larger role regarding FM on the PforR component, an FM consultant may be hired, if needed. The consultant will be funded from the TA and will be hired under terms of reference acceptable to the World Bank.

18. **Budgeting.** Budget preparation will follow the Federal Government's procedures, as appropriate. The NPCU/SCO will prepare the annual project budget based on the TA work plan. The annual work plan and budget will be submitted by the

NPCU/SCO to the World Bank for approval at least two months prior to the start of the fiscal year. There are adequate procedures in place for planning and budgeting.

19. **Accounting and Financial Reporting.** The TA funds will be accounted for by the NPCU/SCO using its computerized accounting system. The annual financial statements for the IPF component will be prepared in accordance with the relevant IPSAS. The biannual Interim Unaudited Financial Reports (IFRs) and annual project financial statements will be generated from the accounting system. Quarterly IFRs will be prepared and submitted to the World Bank by the NPCU/SCO within 45 days of the end of each calendar quarter.

20. **Internal Controls, including Internal Audit.** The internal control mechanism is considered adequate and acceptable for the purpose of this project. Staffing is adequate, and there is proper segregation of functions. A ***Project Internal Auditor will be assigned to the NPCU/SCO by FPFMD***. The internal auditor will carry out project internal audits on a quarterly basis and prepare corresponding reports. The project internal audit should focus specifically on controls over soft expenditures under the TA (including travel, workshops, and study tours). The quarterly internal audit reports will be shared with the World Bank within 45 days from the end of the quarter.

21. **External Audit. The** NPCU/SCO will prepare annual project financial statements and will be responsible for having them audited by the OAGF. The audit reports will be due within six months of the end of the fiscal year. The cost of such audits will be funded under the project.

22. **FM Supervision.** FM supervision and implementation support will follow a risk-based approach. Supervision will be carried out at least twice a year, and onsite review will be carried out at least once a year covering all aspects, including transaction review of TA expenditures. The review will include staffing, IFRs, and annual audit reports, along with management letters, internal audit reports, internal controls, and follow-up on any previously identified issues. Training and capacity building will be provided by the World Bank on a periodic basis, as needed.

23. **Funds Flow and Disbursements.** The World Bank will disburse advances into an US$ Designated Account to be opened at the CBN and managed by the NPCU/SCO/FPFMD. A Naira drawdown account will also be set up, into which transfers can be made from the US$ Designated Account based on need and from which payments will be made for eligible expenditures. A flexible advance ceiling will be applicable for the Designated Account and will be determined based on a six-month forecast of expenditures. The quarterly IFR, apart from reporting expenditures of the relevant quarter, will provide a forecast for the subsequent six months.

24. **Disbursement.** After initial advance to the Designated Account, replenishment will be made against withdrawal applications supported by Statements of Expenditures. Authorized account signatories for the NPCU will consist of panels (A and B), as in Table 7.1 One signatory from each panel will jointly sign the project financial documents/instruments.

Table 7.1: Authorized Account Signatories for the Federal and State Project FM

	Panel A	Panel B
Main	National Program Manager	Project Accountant
Alternate	PS FMOH&SW	Director FPFMD (Federal)

Environment and Social

25. **The NPCU/SCO will assign a focal person prior to effectiveness to ensure E&S compliance.** A full-time environmental consultant and a social consultant will be hired by the NPCU/SCO within three months of effectiveness to provide technical support to the NPCU/SCO on ensuring E&S compliance of the IPF component. The consultants/officers will help the NPCU/SCO to prepare a half-yearly monitoring report. Both the E&S officer/consultant will be maintained throughout the operation's implementation period. Both consultants will provide regular training to the NPCU/SCO staff, project/program-related state-level staff, and participating private sectors players on the requirements of the proposed ESSA for the PforR and Environmental and Social Framework for the IPF to effectively manage E&S risks. The requirement of the IPF component has been clarified in the ESCP.