



1. Project Data

Project ID P162069	Project Name Nigeria Accelerating Nutrition Results Project
Country Nigeria	Practice Area(Lead) Health, Nutrition & Population

L/C/TF Number(s) IDA-62690,WBTF-A7516	Closing Date (Original) 31-Dec-2023	Total Project Cost (USD) 138,209,005.13
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Bank Approval Date 27-Jun-2018	Closing Date (Actual) 31-Dec-2024
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	IBRD/IDA (USD)	Grants (USD)
Original Commitment	225,000,000.00	7,000,000.00
Revised Commitment	130,908,540.49	7,000,000.00
Actual	131,220,184.34	6,988,820.79

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2. Project Objectives and Components

a. Objectives

Per the original Financing and Grant Agreements, the PDO was “to increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under **two** years of age in select areas of the Recipient’s territory”. Per the PAD, the PDO was to “increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under **five** years of age in select areas of the Recipient’s territory”. As in fact the project’s interventions targeted children under five, the PAD’s version of the PDO statement was correct. The discrepancy was attributed in the ICR to



a typographical error in the original Financing and Grant Agreements; both legal documents were amended to match the PAD as of October 2024, under the Project's third restructuring (ICR, p. 14).

Neither the ICR nor this Review parsed the PDO. Rather it was assessed as a single objective where to increase the utilization of nutrition services for pregnant and lactating women, adolescent girls, and children under age five was the main intention of the project.

Other than correcting the error on target population, the PDO statement was not revised during implementation. However, the first restructuring conducted in February 2022 included a reduction in project scope including downward revisions of targets for the majority of PDO indicators. As such, a split rating is applied.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

No

c. Will a split evaluation be undertaken?

Yes

d. Components

ANRiN used performance-based contracts with non-state actors (NSAs) to improve community-based delivery of a package of cost-effective nutrition interventions in 12 high-burden states, with a particular focus on adolescent girls and their children. Concurrently, it used DLIs to incentivize Nigeria's federal and state governments to better address malnutrition through improved stewardship. With respect to the PDO, the choice to use NSAs was driven by the fact that Nigeria does not have a central nutrition programming platform to guide scaleup and as such NSAs – which are a key part of Nigeria's mixed health system (ICR, p. 14) and which have been repeatedly demonstrated as effective in achieving broadened coverage and increased equity of impact (PAD, p. 38) - were a sound choice for extending reach and increasing accountability. In addition to improved service quality and coverage, the project's expected key outcomes comprised improved knowledge of adolescent, maternal, infant and young child nutrition (AMIYCN) behaviors among pregnant women and mothers of children under five, and improved capacity at Federal and State levels to plan, manage, and evaluate large-scale nutrition programs. These outcomes were anticipated to result from outputs on increased delivery of nutrition services, increased exposure to messages on AMIYCN practices, and strengthened institutional knowledge, management, and learning for nutrition results, the latter supported by improved collection and use of nutrition information for knowledge generation, monitoring and evaluation of nutrition-specific interventions, and improved multisectoral coordination.

Original components

The original design included two components for an estimated total cost of US\$232 million, of which US\$225 million was to be IDA and US\$7 million was to be Trust Fund (TF) financing from the Global Financing Facility for Women, Children and Adolescents (GFF). Cost estimates at appraisal are provided for each original component description, actual costs are provided under the Revised Components section. As neither the PAD nor the ICR stipulated explicit subcomponents in their project descriptions, they are not



formally delineated as such below. However, this Review does periodically refer to subcomponents, as there are instances where it was expedient to do so.

Component 1: Basic Package of Nutrition Services (Appraisal: Total estimated US\$185.75, of which IDA US\$180.15 million, GFF grant financing US\$5.6 million)

The objective of this component was to scale up a basic package of nutrition services (BPS) in Abia, Akwa Ibom, Gombe, Kaduna, Kano, Katsina, Kogi, Kwara, Nasarawa, Niger, Oyo, and Plateau. These 12 states, which at appraisal accounted for over 41 percent of stunted children in Nigeria, were selected based on assessment of state government willingness to borrow IDA funds for nutrition, availability of state costed strategic plans for nutrition, and commitment of state financial resources to these plans (PAD, p. 21). All but three (Abia, Oyo and Akwa Ibom) were located in Northern Zones, where chronic malnutrition rates are most severe. Specific BPS interventions were as follows:

- Behavior change communication (BCC) to improve infant and young child feeding behaviors (IYCF), namely early and exclusive breast feeding (0-6 months) and appropriate complementary feeding (6-23 months).
- Provision of micronutrient powders to children 6-23 months to improve the quality of food provided for complementary feeding.
- Iron/folic acid supplementation for pregnant women, with a focus not only on provision per se, but also counselling to improve compliance.
- Intermittent presumptive treatment for malaria (IPT) for pregnant women.
- Zinc and oral rehydration salt (ORS) therapy for treatment of diarrhea in children 6-59 months.
- Vitamin A supplementation twice a year for children 6-59 months.
- Deworming twice a year for children 12-59 months.
(PAD, p. 19)

At appraisal, although each of these services were included in the National Nutrition Strategic Plan, they were at very low rates of coverage for the states in question and the project's proposed solution was to increase coverage using NSAs (PAD, pp. 20-21). As such, Component 1 included two DLIs designed to initiate and manage results-based contractual agreements between NSAs and state governments, and a third complementary DLI designed to improve coordination of development partners (DPs) involved in state-level nutrition activities:

- DLI 4: "Service delivery through non-state actors (NSAs) for improved nutrition outcomes" held states accountable for entering into and managing performance-based contracts with NSAs for community-based service delivery.
- DLI 5: "Service delivery through primary health centers for improved nutrition and health outcomes" incentivized delivery of the BPS during Antenatal Care (ANC) visits in Primary Health Care Centers (PHCs).
- DLI 6: "Coordination of Development Partners (DPs) at State level" reduced fragmentation by providing an incentive to states to sign MoUs with development partners setting terms for financial support and subsequent mapping of nutrition interventions.

The PAD noted that the introduction of performance-based contracts would require strengthening state governments' management capacity, and stated that, in addition to DLI 4, technical assistance (TA) and training to this end would be provided to both the Federal Project Management Unit and State level PIUs.



The PAD further stated that the World Bank would hire two consultants per state to provide TA to the contract management units of the PIUs (PAD, pp. 21-22).

States and NSAs were expected to ensure safe delivery points for women to access services, and to emphasize outreach to adolescent mothers (PAD, p. 34). In line with this directive, NSAs were anticipated to pilot innovative delivery models, requirements for which were embedded in the performance-based contracts with NSAs. One state-NSA pair (to be selected during implementation), was also expected to pilot an intervention on birth spacing which specifically targeted adolescent girls who were breastfeeding. Finally, this Component allocated up to 15 percent of funds for treatment of severe acute malnutrition, where applicable (PAD, p. 19).

Component 2: Stewardship and Project Management (Appraisal: Total estimated US\$46.25, of which IDA US\$44.85 million, GFF US\$ 1.4 million)

The principal objective of this component was to strengthen institutional capacity at federal and state levels across five nutrition governance functions, as follows:

- **A National Strategy for Social and Behavior Change Communication (SBCC)**, comprising a mass media campaign - radio and television spots, edutainment series - spearheaded by the Federal Ministry of Health (FMOH), underpinned by messaging disseminated through religious leaders. Content for both initiatives was anticipated to support behaviors linked to services provided under Component 1 (e.g. improved IYCF), as well as women's decision-making autonomy. With respect to the latter, the PAD clarified that a performance-based contract with the Nigerian Inter Faith Action Agency (deployed across 7 states in 2011 for the Malaria Control Booster Project with good results) would be instrumental in leveraging the clout of religious and traditional leaders to shift the needle on social norms (PAD, p. 20 & p. 34). DLI 1 - "Communication for Social and Behavior Change" - was established with the FMOH to finance these activities.
- **Multi-sectoral coordination for accountability**, based on a process involving (*inter-alia*) agriculture, education, health, and social protection, and anchored by the annual publication of a "State of Malnutrition" report. This Report was anticipated to evaluate the performance of each relevant sector on annual nutrition action plans, based on incremental increases in budget allocations to nutrition sensitive interventions assessed using pre-agreed score-card targets (PAD, p. 22 & p. 89). DLI 2 - "Multisectoral coordination and accountability for nutrition results" - was assigned to the Federal Ministry of Budget and National Planning (FMBNP) in support of this process, with disbursements initially linked specifically to publication of the Annual Report (and later to nutrition sensitive budget tagging, see Revised Components, below). Notably, while not mentioned in the ICR or main text of the PAD, the latter's DLI Annex sheds some light on how this process was expected to unfold, with initial disbursements in the sequence linked to two essential pre-requisites: i) ratification of a Multisectoral Coordination and Accountability Plan for Nutrition by FMBNP, and ii) subsequent signing of an MOU between FMBNP and designated Sector Ministries (PAD, pp. 88-89). Additionally, it is important to note that the strategy of casting the FMBNP in an oversight and coordination role was complemented by placing the Office of the Vice President at the helm of the National Council on Nutrition, thus creating a high level "institutional home" for reducing malnutrition (ICR, p. 30).
- **A Knowledge and Learning Platform** that could be leveraged at state, federal and international levels established within the Nutrition Unit of the FMOH. This platform was expected to capacitate the Nutrition Unit's stewardship role in evidence gathering and knowledge transfer, and to be supported by a consortium of knowledge management partners – recruited primarily from Nigerian academia - contracted by the unit to provide TA on implementation research at federal level as well



as to state PMUs and NSAs, with an emphasis on local capacity building in IR skills. DLI 3 – “Evidence of new knowledge for nutrition and adolescent health” – was assigned to the FMOH in support of the platform, with disbursements linked to an annual Results Conference held to share lessons from ANRiN and other nutrition initiatives (PAD, p. 23).

- **A Research Program** comprising a series of studies on strengthening operational capacity for nutrition service delivery, to be overseen by the FMOH (presumably the Nutrition Unit but not stipulated as such), with technical assistance from the afore-mentioned knowledge management consortium. Planned studies cited in the PAD included (inter alia) a review of human resource requirements to scale up nutritional service delivery nationwide, assessment of the potential of frontline [health] workers to contribute to nutrition service delivery, assessment of local production of complementary foods, and a scoping study to develop a national nutrition surveillance system. There were no DLIs associated with this subcomponent.
- **A National Nutrition Information System**, hosted by the FMOH Nutrition Unit and capable of providing timely and accurate data for planning, monitoring and reporting on service delivery and outcomes. To this end, the PAD cited co-financing of annual National Nutrition and Health Surveys (NNHS) using Standardized Monitoring and Assessment of Relief and Transition Methods (SMART) methodology (PAD, p. 23). Notably, the rollout of these annual NNHS were expected to provide a source of data to measure ANRiN’s own impact, with multiple indicators in the Results Framework (RF) citing NNHS/ SMART survey data as a means of verification (see “M&E Implementation”, below). There were no DLIs associated with this subcomponent

Component 2 was also anticipated to finance project management costs at federal and state levels, including financing for household surveys conducted by the project’s Independent Verification Agent (IVA).

Revised components

Over the course of implementation, ANRIN’s scope was reduced, with cumulative cancellations equaling approximately 35 percent of the original envelope at closing (see “Program Cost”, below). In terms of activities (as opposed to cancelled financing) the lion’s share of downsizing occurred in Component 2, indicative of the project’s recognition of the need to roll back the level of ambition regarding governance strengthening. However, the spirit of both components remained unchanged, with several new subcomponents introduced in an effort to ensure progress in stewardship and institutional capacity. Key changes are described below, with additional details provided under the restructuring synopsis (see “Dates” section).

- *Component 1 (Actual: US\$83.9 million)*: Delivery of the BPNS was downsized, resulting in the removal of 3.9 million women and children from projected project beneficiaries (Restructuring Report, No. RES47759, p. 8), cancellation of \$US 51.8 million allocated to NSA contracts, and reduction of relevant targets and adjustment of disbursement requirements for DLIs 4,5 and 6. A subcomponent designed to provide Integrated Management of Acute Malnutrition (IMAM) was introduced under the third restructuring, and subsequently canceled (see Dates, below).
- *Component 2 (Actual: US\$54.3 million)*: Key changes under this component comprised i) a downsizing of the SBCC mass media campaign, with the edutainment series dropped; ii) narrowing of the Knowledge and Learning Platform’s scope, with the revised focus on preliminary preparation of a costed strategy and capacity building, iii) downsizing of the Research Program such that the agenda was rescoped from 5 to 1 research pieces, and iv) downsizing of the National Nutrition Information System with support retained only for Roadmap development, formative assessment, and capacity building (Restructuring Report, No. RES47759, pp. 8-9). DLIs were duly adjusted or



canceled, with specific changes well-documented in individual restructuring papers. Of these, perhaps the most major was a shift between DLI2 and DLI 3, with the latter linking in years 4 and 5 to the “State of Malnutrition” Annual Report which had initially been associated with DLI 2. DLI 2, in turn, was revised to link to nutrition investment budget tagging across relevant sectors (as opposed to the annual Results Conference with which it had initially been associated), in line with a new subcomponent on state fiscal commitments introduced under the first restructuring. Principle non-downsizing changes under Component 2 comprised extending implementation of the multisectoral coordination and accountability pilot (in Gombe) by one year, and the addition of new subcomponents supporting i) strengthened state engagement on sustainable financing strategy development, and ii) capacity transfer to public primary healthcare workers (designed to align with PHC reforms introduced by the new administration elected in February 2023).

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Program Cost, Financing and Borrower Contribution

ANRiN was financed primarily via IDA credit disbursed through investment project financing (IPF), complemented by Trust Fund (TF) financing from the Global Financing Facility for Women, Children and Adolescents (GFF). As above, at appraisal, disbursements were projected to total US\$225 million under IDA and US\$7 million under GFF, for an estimated total cost of US\$232 million. However, the first restructuring cancelled US\$51.80 million of the IDA allotment and an additional US\$30 million (also IDA) was cancelled at closure (fourth restructuring), with both attributable to delays in decision-making, procurement, and related implementation bottlenecks.

By closing, the restructured amount was 99 percent disbursed, with the actual financing under IDA equal to US\$131.2 million and the actual amount spent via GFF equal to US\$6.9 million, for a grand total of US\$138.2 million. There was no Government contribution.

Dates

ANRiN was approved on June 27, 2018 and declared effective on May 20, 2019. The Mid-Term Review (MTR) occurred on May 30, 2021. Closing was extended once, from December 31, 2023 to December 31, 2024, in an effort to recoup losses in intervention effectiveness incurred by implementation delays. The project was restructured four times, as follows:

- The first restructuring, in February 2022 cancelled, as above: i) US\$51.8 million allocated to NSA contracts, resulting in a downsizing of BPNS delivered under Component 1, ii) US\$2.30 million allocated to Component 2’s Knowledge Management and Learning Platform resulting in a downsizing which retained only the preparation of a costed strategy for such a platform and associated capacity development activities, and iii) US\$2.05 million allocated to Component 2’s National Nutrition Information and Surveillance Systems for Health Activities, resulting in a downsizing with support retained only for Roadmap development, formative assessment, and capacity building (Restructuring Report, No. RES47759, pp. 8-9). Additionally, 10 PDO indicators were changed from percentage-based to number-based units (ICR, p. 23) to align with data captured through the ANRiN App (which proved instrumental for data collection during implementation, see “Monitoring and Evaluation” below). In response to overly ambitious assumptions made at appraisal regarding institutional capacity for multisectoral coordination, this restructuring also repurposed US\$1.8 million under Component 2 for a new subcomponent supporting strengthened state engagement, including TA and analytical support on nutrition



investment budget tagging, in part to address the fact that a routine resource tracking system had yet to be institutionalized within Public Financial Management systems, impairing tracking of DLI 2 on multisectoral coordination and accountability for nutrition results (Restructuring Report, No. RES47759, p.7). As above, this DLI was revised in line with the addition of this subcomponent to explicitly track budget tagging, as opposed to the “State of Malnutrition” Annual Report which it had originally been linked to. This restructuring also revised DLI 1 on SBCC by revising the annual targets from explicit percentages to “percentage point increase over the achievement of the previous year” (Restructuring Report, Report No. RES47759, pp. 98 & 101). Both the ICR and the restructuring paper rationalized the revision as incentivizing achievement above “pegged” or “capped” targets (Restructuring Report, No. RES47759, p. 7 & ICR, p. 18). Finally, in line with these changes, the ICR reported that 9 Disbursement Linked Results (DLRs) – presumably associated with the cancelled activities - were dropped, and 12 were revised (ICR, p. 18).

- The second restructuring, in December 2023, **extended** the project closing date by one year and upwardly revised end-targets accordingly. Two extension-related DLRs were also added to DLIs 3 (Evidence of new knowledge for nutrition and adolescent health results) and 5 (Service delivery through primary health centers for improved nutrition and health outcomes), respectively, as both of these had shown good results and were considered critical to strengthening long-term institutional capacity for inclusion of nutrition in basic PHC packages (ICR, p. 18). Changes also included i) formal closeout of Akwa Ibom State, which had not participated in the Project since 2021, ii) introduction of a new capacity building subcomponent under Component 2, targeting frontline health workers, and iii) modification of names of most implementing agencies, in line with changes in nomenclature made by the new administration. Additionally, all adolescent-disaggregated baselines and targets were recalibrated based on the 2021/22 Multiple Indicator Cluster Survey (MICS) which found i) that the median national adolescent birth rate had declined significantly from 120 in 2017 to 75 in 2021 and ii) that the median for ANRiN states in 2021 was 72.5. As such, intermediate and end targets were adjusted to reflect this progress. Finally, with respect to financing, this restructuring i) modified the IDA-GFF disbursement ratio (which had been sub-optimal due to implementation delays) from 96.5 percent IDA: 3 percent GFF to 50 percent: 50 percent, pending full disbursement of the GFF grant and ii) reallocated funds from Component 1 to Component 2. This latter adjustment was made possible largely through the combined savings generated by Akwa Ibom State’s exit (with less than 10 percent of their allotment disbursed), late onboarding of Katsina State, (with 20 percent of their allocation projected to be utilized), and SDR gains from exchange rate fluctuations (Restructuring Report, No. RES58687, p. 7).
- The third restructuring, in October 2024, focused primarily on responding to Nigeria’s looming food and nutrition security crisis by leveraging ANRiN’s IDA resources to fast-track mitigation. The main change was the introduction of a new Component 1 subcomponent for IMAM in Food Crisis States. Per the Restructuring Report, activities would be managed by the Federal Government and would consist of the procurement and distribution of essential nutrition commodities for the prevention and treatment of Acute Malnutrition for children under five in thirteen crisis-affected States, as well as TA and supervision costs for service delivery. Financing was proposed via reallocation of US\$30 million from exchange rate savings and unprogrammed resources under Component 2 (possibly from the new subcomponent created under the second restructuring, not discussed in project documents). A PDO indicator “number of children under five years of age treated for Severe Acute Malnutrition” was proposed to track the new sub-component, with data for reporting to be sourced from the District Health Information System 2 (DHIS-2), which the Restructuring Paper reported as extant in all states (Restructuring Report, No. RES00180, p. 4). Additional changes under this restructuring



aimed to correct changes to DLIs which had not yet been corrected in the Operations Portal, despite having been flagged for deletion or revision, as well as the above-mentioned correction to the PDO Statement in the Finance and Grant Agreements (Restructuring Report, No. RES00180, pp. 4-5, ICR, p. 18).

- The fourth restructuring, in December 2024, cancelled the US\$30 million re-allocated under the third restructuring to IMAM, as delays in state selection persisted too long for procurement be initiated, given pending closure of the Project. As a result, both the relevant activities and the associated PDO indicator were dropped, and the cancelled funds were reallocated to the project's successor, ANRiN 2.0.

3. Relevance of Objectives

Rationale

Relevance to country context

At appraisal, PDO relevance to country context was high. Chronic malnutrition rates in Nigeria had not improved markedly since 2008, attributable primarily to a *rising* stunting burden in northern states - exceeding 50 percent in some areas – which skewed the national average. In these high burden regions, key proximate drivers of undernutrition, namely low diet quality, poor access to antenatal, nutrition and other health services, and inadequate knowledge and care practices, were pervasive and exacerbated by poverty, significant gender gaps in education, and high fertility rates (7.26 in the Northwest and 6.35 in the Northeast, compared to under 4.5 in Southern Zones). Adolescent pregnancies, which are associated with low female autonomy and increased risk of poor health outcomes for mother and child were common (particularly in the North) and comprised an additional driver of low service uptake and pervasive malnutrition (PAD, pp.10-14).

Contextual relevance remained high over the course of implementation, as a series of shocks increased malnutrition and concomitant need to improve access to and utilization of nutrition services. Key among these were i) a series of widespread and recurrent flooding events which disrupted agricultural production and increased incidence of water-borne disease, ii) persistent political unrest and instability concentrated mainly in Northern Zones, which eroded food security and access to services, iii) macroeconomic reforms which contributed to food price inflation, reduced household purchasing power, and increased negative coping practices, and iv) the COVID-19 pandemic, which disrupted health services as well as commodity and food supply chains (ICR, p. 20).

Relevance to government strategy

At appraisal, financing for nutrition in Nigeria was insufficient and provided primarily by donors. Although there was a budget line for nutrition activities within the FMOH, the allocation was modest and focused on small-scale capacity building activities. Some states were investing their own resources, but financing was scant and reactively focused on treating severe acute malnutrition. The National Nutrition Program, while extant, relied on facility-based routine services and biannual Maternal, Newborn and Child Health Week (MNCHW) campaigns, neither of which were adequate platforms to deliver last-mile services in disadvantaged, rural communities.



Given these public sector shortfalls, ANRiN reasonably aimed to harness Nigeria's considerable private sector resources to address the country's - primarily Northern Zones' - urgent malnutrition needs. Concurrently, and equally reasonably, it also sought to engage at federal and state level on systems strengthening to improve government stewardship, despite the obvious risks presented by weak institutional capacity and low political commitment. This tension was acknowledged explicitly in the PAD, which described the project as a balancing act between workstreams addressing the immediate need to reduce malnutrition, and workstreams comprising the "first slice" of a presumed extended engagement with the GoN on improved nutrition governance and accountability, anticipated to run for 15 or 20 years (PAD, p. 16 & p. 28). The fact that governance strengthening was not explicit in the PDO was presumably a result of this calculus, designed to pitch the development objective at a level commensurate to country capacity.

Per this framing, ANRiN was deliberately designed to contribute directly to the Nigerian National Policy on Food and Nutrition, most concretely by supporting specific actions in health sector programming as outlined in the National Strategic Plan of Action on Nutrition, which included a portfolio of costed, nutrition-specific interventions with measurable targets to be achieved at scale between 2014 and 2019. It also supported

implementation of the 2014 National Health Act which legislated increased public investment in primary health care, including a specification that all Nigerians were entitled to a BPNS (PAD, p. 16), and contributed to the (ratification and fledgling implementation of) the National Multi-Sectoral Plan of Action for Nutrition 2021–2025 (ICR, p. 20). Additionally, the project contributed to the GoN's Economic Recovery and Growth Plan (2017-2020), which committed to investment in health and education to spur inclusive human capital development for economic growth (PAD, p. 16).

Alignment with World Bank Strategy

At appraisal, ANRiN's PDO and PDO indicators were aligned with the second Strategic Cluster - "Improving the quality and efficiency of social service delivery at the state level to promote social inclusion" - of the World Bank's 2014 - 2017 Country Partnership Strategy (CPS) for Nigeria (Report No. 82501-NG, pp. 28-30). The first Cluster- which is referred to in the PAD as "Promoting diversified growth and job creation by reforming the power sector, enhancing agricultural productivity, and increasing access to finance" (PAD, p. 17) - was predicated on a strong human capital base, for which good nutrition outcomes are requisite. (Note that the CPS itself refers to this engagement area as "Federally Led Structural Reforms for Growth and Jobs" (Report No. 82501-NG. p. 24).)

PDO relevance remained high through closing, as improved delivery and uptake of nutrition services is germane to all four of the current pillars of the 2021-2025 CPF (Strengthening the Foundations of the Public Sector", "Investing in Human Capital", "Promoting Jobs and Economic Transformation", and "Enhancing Resilience": Report No. 153873-NG, pp. 28-30).

The project was also aligned with the World Bank Group's twin goals of eliminating poverty and promoting shared prosperity, and with the World Bank Group 2024 plan to expand the delivery of quality health services to 1.5 billion people by 2030.

Regarding previous sector experience, ANRiN drew on a range of lessons learned from Bank-funded projects in Nigeria and globally. Key among these were insights on i) the management of performance-based contracts for NSAs (e.g. limit the number of performance based results in contracts, engage extensively with stakeholders during contract development, build capacity within government on effective contract management), ii) the need to tailor SBCC campaigns to local contexts and to engage key



influencers, iii) the importance of making costed strategic plans for nutrition a prerequisite for project participation, iv) the need for special measures when targeting adolescent girls (e.g. provision of “safe spaces” for counseling), and v) the need to foster a government-owned central nutrition programming platform using a non-line ministry with convening clout, such as the FMBNP (PAD, p. 27).

Appropriateness of Financing Instrument

The PAD noted that various World Bank financing instruments were considered and an IPF was determined to be the most appropriate, given that there was no sufficiently well-defined nutrition program in Nigeria which a Program for Results (PforR) operation could finance. As such, the Project Team aimed to “start small”, using DLIs where possible, bolstered by input-based financing to rapidly improve aspects of the National Nutrition Program, namely its information system and research capacity. The PAD noted that, as performance-based contracts for nutrition services were a new approach in Nigeria, NSAs would be hired via standard service contracts, following World Bank procurement rules (PAD, pp. 26-28).

With respect to DLIs, the aim of those associated with Component 1 was to incentivize the public health sector to manage PBCs with NSAs effectively and to build nutrition implementation capacity at state and sub-state levels. The aim of those under Component 2 was to strengthen governance capacity for nutrition service delivery at federal and state levels. Given this orientation, all 6 DLIs remained highly relevant to the PDO throughout the period of implementation. Changes to content and targets were appropriate and indicative of timely course correction, with the repurposing of DLIs 2 and 3 to “zero in” on two well recognized requisites for multisectoral coordination - budget tagging and associated reporting on sector-specific performance - of particular note.

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under five years of age in select areas of the Recipient's territory
(Under the original outcome targets)

Rationale

While no diagram was included in the PAD, the TOC's causal links at appraisal were sound, with appropriate and attributable connections between inputs, outputs, and outcomes. The project assumed low utilization of nutrition services was proximately underpinned by a weak focus on community-based approaches, inadequate PHC coverage in remote areas, and insufficient targeting of pregnant and lactating women, and distally underpinned by inadequate nutrition stewardship and management at federal and state level. It was further assumed that i) proximate causes of underutilization could be addressed using NSAs to deliver a BPNS at community level, complemented by improved integration of maternal nutrition services in routine



antenatal care offered at PHCs, with key messages reinforced via a large-scale SBCC campaign, and ii) distal causes could be addressed via a program of governance strengthening activities, namely enhanced data systems for decision making and accountability.

To unpack the “cost effective” and “quality” characteristics of the project’s interventions, the ICR noted that the BPS package of services was internationally recognized as highly cost-effective (see “Efficiency” section). Regarding quality, many of the key interventions supported by the project required sustained compliance over time and multiple service contacts to achieve their intended impact (e.g. three doses of Sulfadoxine-Pyrimethamine for malaria prevention, receiving 90 iron-folic acid tablets typically across three ANC contacts, or collecting micronutrient powders over repeated visits). As the PDO indicators measured only completed interventions, not partial uptake, these aspects of service quality were well-captured (ICR, p. 22).

Intermediate outcomes

Neither targets nor baselines for intermediate results indicators (IRIs) were revised during restructuring. As such they are reported only once, immediately below and not in the “Revised Objective” section.

All IRIs on BCC were met or exceeded:

- The proportion of direct caretakers of children 6-23 months with acceptable knowledge related to appropriate IYCF practices reached 74 percent at completion, exceeding the target of 50 percent (baseline 16.5 percent in ICR and 15.3 in PAD)
- The proportion of people aged 15 and older who could correctly identify key SBCC messages on nutrition and antenatal health was 88.4 percent at completion exceeding the target of 60 percent (baseline 0)
- The proportion of males aged 15 and older who could correctly identify key SBCC messages on nutrition and antenatal health was 89.8 percent at completion, exceeding the target of 50 percent (baseline 0)
- The proportion of females aged 15 and older who could correctly identify key SBCC messages on nutrition and antenatal health was 87.2 percent at completion, relative to the target of 75 percent (baseline 0)
- These results are indicative of effective awareness raising at community level (via BCC delivered through the BPS under Component 1), and national level (delivered via the SBCC strategy under Component 2). Of particular note is the proportion of males who were able to identify key messages by closing. This indicator exceeded its target by 179 percent and implies progress in shifting social norms.

The two IRIs which assessed progress in the use of NSAs both fell slightly short:

- The number of signed NGO contracts for service delivery properly managed as per agreed timeline was 23 at completion, relative to the target of 25 (baseline 0)
- The number of states with complaint redressal mechanisms which responded to at least 85% of the complaints was reported as 11 at completion, relative to the target of 12 (baseline 0). However, the ICR also noted that “10 states have activated Grievance Redress Committees. Sixty-six complaints were received in 8 states, 68% of which have been resolved” (ICR, p. 42). No further information was provided to clarify the discrepancy.



Given the considerable delays faced by the project regarding NSA contracting and logistics, these results – which imply that very close to the anticipated number of performance-based contracts were executed in full – can be interpreted as positive. This conclusion is supported by results for the corporate IRI – “number of women and children who received basic nutrition services” – indicating that 13,344,813 beneficiaries had received services at completion, relative to the target of 8,700,000 (target not reported in ICR, see PAD, p. 44) and especially noteworthy given the reduction in beneficiary pool after the first restructuring.

Additionally, while not addressed in the ICR, the numbers on NSA contracting may be distorted by the facts that i) Akwa Ibom’s de facto participation in the project ended in 2021, and ii) the performance-based contracts target does not appear to have been adjusted accordingly.

There were two IRIs included in the RF on governance strengthening:

- The cumulative number of Annual Results Conferences held was recorded as 3 at completion in the ICR’s RF Annex (p. 43), relative to the target of 4 (baseline 0). However this was identified as an error during the Project Team interview, which stated that all 4 Conferences had been held.
- The number of states with nutrition intervention mapping systems developed and updated at least annually was 11 at completion, relative to the target of 12 (baseline 0)

Similar to the IRIs on NSA contracting, these results imply considerable progress; they may also be slightly distorted due to a lack of target revision. As above, the Annual Results Conferences were deprioritized in years 4 and 5 in favor of activities to support budget tagging. However, per the Project Team, all four were implemented. Given the exit of Akwa Ibom from the project, the number of states with nutrition mapping systems at closing could not have equaled more than 11.

PDO-level Outcomes

(Targets with an asterix* were converted from percentages to numbers by the ICR, based on demographic estimation of the relevant population in 2024)

- The proportion of infants 0-6 months who were exclusively breastfed was 28.8 percent at completion, representing 7 percent of the original target of 50 percent (original baseline 24 percent)
- The number of children 6-24 months who received micronutrient powders as part of complementary feeding was 1,362,586 at completion, slightly exceeding the original target of 1,333,497* by 102 percent (original baseline 0)
- The number of children 6-24 months of adolescent girls who receive micronutrient powders as part of complementary feeding was 71,041 at completion, achieving 22 percent of the original target of 322,805* original baseline 0)
- The number of children 6-59 months who received zinc and ORS as treatment for diarrhea was 4,152,464 at completion, exceeding the original target of 3,667,392* by 113 percent (original baseline 6 percent, not converted to absolute numbers).
- The number of children 6-24 months of adolescent girls who receive zinc and ORS as treatment for diarrhea was 122,613 at completion, achieving 39 percent of the original target of 313,582* (original baseline 6 percent; not converted)
- The number of children 12-59 months dewormed twice a year was 5,838,768 at closing, exceeding the original target of 3,109,426* by 188 percent (original baseline 27 percent, not converted)
- The number of children 6-24 months of adolescent girls dewormed twice a year was 177,045, achieving 58 percent of the original target of 304,359* (original baseline 27 percent, not converted)



- The number of pregnant women who received a minimum of 90 iron-folic acid tablets was 907,694, exceeding the original target of 532,749* by 170 percent (original baseline 20.5 percent, not converted)
- The number of pregnant women (15-19 years) who received a minimum of 90 iron-folic acid tablets was 108,847, exceeding the original target of 47,604* by 229 percent (original baseline 13.2, not converted)
- The number of pregnant women who received intermittent presumptive treatment for malaria (at least 3 doses) was 663,954, achieving 97 percent of the original target of 685,743* (original baseline 14.9 percent, not converted)
- The number of pregnant women (15-19 years) who receive intermittent presumptive treatment for malaria (at least 3 doses) was 81,097, exceeding the original target of 44,585* by 182 percent (original baseline 14.9, not converted)

When assessing final outcomes against original targets (transformed from percentage to numbers), 7 of the 11 PDO indicators were met or surpassed, indicative of overall Modest progress with approximately 64 percent of the original PDO targets achieved. Indicators which showed weaker results, namely those for breastfeeding and for interventions targeting the children of adolescent girls, improved after restructuring - albeit not to the extent that targets were met - and are discussed below.

Rating

Modest

OBJECTIVE 1 REVISION 1

Revised Objective

Increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under five years of age in select areas of the Recipient's territory.
(Under revised outcome targets)

Revised Rationale

The ICR provided a detailed ToC that reflected changes made during restructuring. Although the basic assumptions regarding the proximate drivers of low service uptake remained the same as at appraisal, the assumptions regarding inadequate nutrition stewardship and management at federal and state level were refined to clarify that the lack of transparency on nutrition financing posed a key constraint. As such, the ICR's ToC included new governance and finance links in the "stewardship" results chain, representing the added activities on nutrition responsive budget tagging and expenditure tracking. However, other than revising DLI 2 as described above, the results framework did not add any additional indicators or make any major changes to track these new aspects of the project. (This constitutes a shortfall in design which is discussed further below). As such, the assessment below differs from the original only with respect to the changes that were made to PDO baselines and targets. Additionally, as above, IRIS are not discussed as they were not revised.

PDO-level Outcomes

All but three PDO indicators markedly exceeded their targets, as follows:



- The number of children 6-24 months who received micronutrient powders as part of complementary feeding was 1,362,586 at completion, exceeding the revised target of 955,090 by 143 percent (unrevised baseline 0)
- The number of children 6-59 months who received zinc and ORS as treatment for diarrhea was 4,152,464 at completion, exceeding the revised target of 2,332,335 by 178 percent (baseline revised to 0)
- The number of children 12-59 months dewormed twice a year was 5,838,768 at closing, exceeding the original target of 2,040,463 by 286 percent (baseline revised to 0)
- The number of pregnant women who received a minimum of 90 iron-folic acid tablets was 907,694, exceeding the revised target of 493,814 by 184 percent (revised baseline 0)
- The number of pregnant women (15-19 years) who received a minimum of 90 iron-folic acid tablets was 108,847, exceeding the revised target of 44,443 by 245 percent (revised baseline 0)
- The number of pregnant women who received intermittent presumptive treatment for malaria (at least 3 doses) was 663,954, achieving 134 percent of the revised target of 493,814 (revised baseline 0)
- The number of pregnant women (15-19 years) who receive intermittent presumptive treatment for malaria (at least 3 doses) was 81,097, exceeding the revised target of 44,443 by 182 percent (revised baseline 0)

The magnitude of overachievement for these indicators likely reflects an increasingly strong implementation performance over the course of the project, combined with conservative target-setting that began in ANRiN's initial stages, which as above was characterized by slow movement on and understanding of the NSA delivery model, presumably including scale of delivery. Although *momentum* unequivocally increased after restructuring, it appears that there was a lag in *understanding* regarding the capacity for NSAs to deliver, resulting in chronic underestimation of the population served by performance-based contracts which persisted even in later years after implementation accelerated. To this point, the ICR noted that - after adjustment for independent verification of results - average coverage reported by NSAs from 2021 through 2024 using the ANRiN app ranged from 107 to 197 percent (ICR, p. 23). Given the delays in data collection associated with the app (see "Monitoring and Evaluation"), the project team was unaware of this disconnect until it was too late to course correct (Project Team Interview).

Although the four PDOIs which did not meet their targets were those which had also shown weak progress prior to restructuring, extent of achievement increased considerably during this second phase, as follows:

- The proportion of infants 0-6 months who were exclusively breastfed was 28.8 percent at completion, equaling **15** percent of the revised target of 38 percent (revised baseline 27 percent; compared to **7** percent of the original target of 50 percent)
- The number of children 6-59 months of adolescent girls who receive zinc and ORS as treatment for diarrhea was 122,613 at completion, achieving **58** percent of the revised target of 209,910 (revised baseline 0 percent; compared to **39** percent of the original target)
- The number of children 6-24 months of adolescent girls who received micronutrient powders as part of complementary feeding was 71,041 at completion, achieving **83** percent of the revised target of 85,958 (unrevised baseline 0; compared to **22** percent of the original target)
- The number of children 12-59 months of adolescent girls dewormed twice a year was 177,045, achieving **96** percent of the revised target of 183,642 (baseline revised to 0; compared to **58** percent of the original target)



With respect to breastfeeding, progress clearly occurred, albeit not to target levels, presumably attributable in large part to increased awareness and improved practices achieved through the project's community-based interventions and efforts on behavior change, as corroborated by IRIs on positive SBCC results and contract-based service delivery. The story appears similar with respect to outcomes on interventions targeting the children of adolescent girls. Progress was clearly made, particularly with respect to deworming and use of micronutrient powders, albeit not to target levels. The ICR cites discrepancies in demographic estimates of the population of adolescent mothers and related birth rates, which may have led to an overestimation in targeting.

With respect to overall achievement, the ICR included robust complementary evidence to triangulate findings and strengthen plausibility of attribution, including results from population-level surveys and a difference-in-difference analysis. Regarding the former, the Multiple Indicator Cluster Survey (MICS) 2021, Demographic Health Survey (NDHS) 2023/24, and the National Nutrition and Health Survey (NNHS) 2018 all showed that, between 2018 and 2023 in ANRiN states, i) children's zinc and ORS treatment nearly tripled, jumping from 11.1 percent to 28.7 percent, and ii) the rate of IPT among pregnant woman nearly doubled, gaining 13 percent to reach 27.5 percent in 2023. These findings were further validated by counterfactual modeling of eight nutrition indicators using district health information data from ANRiN and non-ANRiN states. Seven out of eight metrics - including treatment of diarrhea with ORS, use of micronutrient powders, and IPT and iron/folic acid supplementation for pregnant women - showed greater progress in ANRiN states, with an average advantage of 19.6 percentage points (ICR, pp. 24-25). Finally, the ICR cited the very plausible role played by the project in mitigating the effects of the food security crisis, which, as above, affected the entire country during the second half of the project. In line with this event, national prevalence of stunting actually increased from 36.8 percent in 2018 to 39.5 percent in 2023/2024. Although several ANRiN states (Katsina, Kogi, Kwara, Nasarawa, Niger, and Plateau) recorded setbacks in stunting reduction during this same period, others (Abia, Gombe, Kaduna, Kano, and Oyo) recorded significant *progress*, including three states achieving declines between 5 and 11 percentage points. Per the ICR, it is highly likely that in the absence of the project, states which made progress would have mirrored the national regression, and states which suffered setbacks would have experienced sharper declines (ICR, p. 25).

Finally, although there were no PDOIs that measured stewardship, it is important to note that the Federal Ministry of Finance, Budget, and Economic Planning reported increased transparency in nutrition financing at Federal and State levels, attributed to the budget tagging mechanism introduced under ANRiN (and supported by the nutrition intervention mapping systems tracked as an IRI). Specifically, the Ministry reported a 300 percent increase in budget earmarked for nutrition-related expenditure in 2024. As such, the ICR reported that "budget tagging for nutrition is now institutionalized at the federal level in the ANRiN states, championed by the FMBEP and Budget Office, and will be extended to other states of the federation as part of ANRiN 2.0" (ICR, p. 29).

Given these results, achievement of the revised objective is rated Substantial. The majority of PDOIs exceeded their targets by multiple orders of magnitude. This was probably attributable to under targeting as well as effectiveness, but regardless clearly indicative of achievements in nutrition service utilization, supported by IRI results on behavior change and service delivery as well as corroboration by multiple external data sources. Although the PDOs on breastfeeding and children of adolescent girls fell shy of their targets, progress was documented across all four indicators over the course of the project. Further, it may be that errors in estimation of the adolescent population inflated the shortfall. The positive results on budget tagging, while framed as ancillary to the RF, are an important finding regarding the project's contribution to governance strengthening.



Revised Rating
Substantial

OVERALL EFFICACY

Rationale

Findings indicate that the objective (to increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under five years of age in select areas of the Recipient's territory) was partly achieved. Overall efficacy is therefore rated modest under the original outcome targets.

Overall Efficacy Rating
Modest

Primary Reason
Low achievement

OVERALL EFFICACY REVISION 1

Overall Efficacy Revision 1 Rationale

Under the revised outcome indicators and targets, efficacy is rated Substantial, given clear progress across the entire RF regarding service utilization, as well as “evidence on governance strengthening and stewardship. Regarding the latter, it is important to highlight that ANRiN was instrumental in shifting Nigeria’s nutrition doctrine from reactive treatment of acute malnutrition to proactive prevention of chronic malnutrition. Key achievements included integration of nutrition into PHCs systems, rollout of budget tagging for improved transparency, expanded use of community health workers, strengthened M&E through the ANRiN App (which the ICR characterized as interoperable with the national Health Management Information System, see “M&E Utilization”, ICR p. 30), and increased capacity for behavior change programming and multisectoral convergence at state and federal levels.

Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

Ex-Ante Assessment of Economic Efficiency

The PAD provided a thorough write-up on links between improved nutrition outcomes and economic growth, with both global and Nigeria-specific evidence referenced. It also cited global and regional evidence for the cost-efficacy of interventions aimed at improving child nutrition and adolescent health. Additionally, a detailed economic analysis was conducted to estimate the internal rate of return and economic benefits that could result from the proposed project. The analysis showed that the original project investment of US\$232 million would



prevent over 83,100 deaths in children, mothers, and adolescent girls, and about 389,000 cases of anemia among pregnant women. Additionally, some 92,000 children were projected to grow up free from stunting. These results were used to calculate projected economic benefits with a net present value of US\$7 billion, an internal rate of return of 19 percent, and an impressive 32:1 benefit-cost ratio (BCR). However, no information was provided regarding modeling assumptions.

The PAD also cited evidence for projected high allocative and technical efficiency. Regarding the latter, the cost for one death averted was estimated to be about US\$2,789 under ANRiN, relative to the global and regional benchmarks of US\$18,000 and US\$17,000, per the World Bank's Global Investment Framework for Nutrition. With respect to the former, the PAD noted that World Bank analyses (Shekar et al. 2014) demonstrate that focusing on the most cost-effective interventions combined with correct geographic targeting reduced cost per DALY averted by up to 20 percent (compared to scaling up all interventions nationwide). ANRiN used precisely this approach in its geographical targeting of Components 1 and 2 of the project, with Component 1 focused on high burden states and Component 2 aiming to strengthen stewardship nationwide (PAD, pp. 35-36).

Ex-Post Assessment of Economic Efficiency

The ICR conducted an ex-post cost analysis using the actual project cost of US\$138.2 million, divided by the number of pregnant and lactating women and children reached (13,730,797). This was found to equal roughly US\$10 per person for the duration of the project; approximately US\$2.8 per person per year (divided by 3.5 years of effective implementation). This cost estimate included the system-strengthening activities in addition to performance-based contracts, high-impact nutrition intervention delivery, community mobilization, and BCC. The ICR also revised the cost-benefit analysis using actual project costs, and found a notably lower return on investment of 1:8.46, attributed not only to the reduced envelope, but also to application of an annual discount rate of 4 percent in the ICR analysis, to account for the fact that the majority of benefits which accrue to improved nutrition outcomes are only fully realized in the long term. While the logic of this statement is sound, its validity with respect to the difference between the two ratios is difficult to assess, as the discount rate used in the PAD was not disclosed.

Implementation Efficiency

The ICR cited several issues which reduced ANRIN's implementation efficiency:

- States were hesitant to deploy NSAs, and as such selections were not made until the third year of implementation. This was attributed in the ICR to changes in government staff following the 2023 elections, with low commitment on the part of incoming personnel who had not been involved in the considerable efforts during preparations to introduce and create ownership for the new approach. That said, NSA-based service delivery accelerated markedly during the 4th and 5th year of the project, attributed in the ICR to sustained state engagement and hands on support, including that provided by the consultants hired to provide TA to the contract management units of state PIUs.
- Recruitment of the IVA was postponed by 30 months, resulting in serious delays with DLI verification including incentivizing management and stewardship and fund release for the performance-based contracts with NSAs
- Staffing the PMU per requirements was only achieved after the first restructuring, and with significant attrition thereafter. This led to delays in procurement, financial management, and recruitment of the verification agent. The GFF, World Bank project team's engagement, and increased responsibility taken by state PIUs over the course of implementation offset a portion of these losses.
- The NNHS/SMART surveys were cancelled due to data quality concerns, weakening validation of the RF which became wholly reliant on data provided through the ANRiN app



- Both COVID-19 and the 2023-24 food security crisis reduced the availability of food at household level and affected implementation; however, the food crisis (which led to a quadrupling of the food insecure population) may have an even greater impact. For target populations in Northern Zone states, these challenges were exacerbated by conflict and political unrest. The ICR stated that these challenges were partially mitigated by following proper procedures to prioritize service delivery within safety windows, rapid deployment, timed entry, and short duration service in areas of active insecurity (ICR, pp. 36-37).

Regarding disbursements, although the project cancelled 35 percent in financing, it did so in a timely manner and closed having disbursed 99 percent of the revised envelope. Exchange rate fluctuations resulted in unanticipated gains which were also disbursed, and, as above, the US\$30 million cancelled close to closing was re-allocated to ANRiN 2.0, ensuring continuation of service delivery strengthening in targeted areas and cultivation of improved institutional capacity nationwide.

ANRiN demonstrated high allocative efficiency as it prioritized evidence-based interventions for the right target population. The project experienced serious setbacks during its first two years, related to state trepidation regarding the NSA approach and political turnover, very slow recruitment of an IVA, a low capacity PMU, data collection delays and cancellations, COVID -19, and the 2023-24 food security crisis. Losses during this period were partially recouped as implementation accelerated following restructuring in February 2022, attributable to timely course correction including streamlined financing and intensified technical assistance, as well as leveraging of the ANRiN app for data collection and verification. The project closed having disbursed essentially all of the revised envelope, although questions remain regarding the cost-benefit ratio of interventions. When these circumstances are weighed against each other and against the project’s overall complexity and geographic spread, net efficiency can be rated Substantial.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Under the original outcome indicators and targets, Relevance was High, Efficacy was Modest, and Efficiency was Substantial, resulting in an Outcome rating of Moderately Unsatisfactory (3).



Under the revised outcome indicators and targets, Relevance was High, Efficacy was Substantial, and Efficiency was Substantial, resulting in an Outcome rating of Satisfactory (5).

According to IEG/OPCS harmonized guidelines, the overall outcome rating is determined by weighting the two outcome ratings by the percentage of Bank funds that were disbursed under each set of outcome indicators and targets:

- Original outcome indicators and targets: US\$42 million, or 30.4 percent of total disbursements (US\$138.2 million)
- Revised outcome indicators and targets: US\$96.2 million, or 69.6 percent of total disbursements (US\$138.2 million)

Weighting the outcome ratings, application of the split rating guidelines produces a Moderately Satisfactory overall Outcome rating, as follows:

$$0.304 * 3 = 0.912$$

$$0.696 * 5 = 3.48$$

$$0.912 + 3.48 = 4.392, \text{ which rounds to } 4 = \text{Moderately Satisfactory}$$

a. **Outcome Rating**

Moderately Satisfactory

7. Risk to Development Outcome

The ICR characterized the risk to development outcome as Low, based on the assumption that the project was the first of four five-year phases and the foundation for an anticipated two-decade long engagement on the nutrition agenda between 2018 and 2040. Per the ICR, this four-phased approach includes increasing multi-sectoral coordination and investments while maintaining a sharp focus on nutrition-specific interventions, generating new knowledge and evidence on an ongoing basis, and incrementally shifting toward domestic financing and public-sector service delivery. What is not addressed in the ICR is the degree to which political turnover and volatility might threaten this engagement, especially during the current “interim” phase which i) requires a shift from NSAs to public sector service delivery (the Project Team clarified that the NSA model will not be deployed under ANRiN 2.0), and ii) remains characterized by relatively low - albeit improving- political commitment in terms of budget allocation. There was no mention in the ICR regarding GoN contributions to the project envelope for ANRiN 2.0.

An additional risk is maintenance of positive attitudes and commitment on the part of community health workers (CHWs). Per the Project Team, approximately 10,000 CHWs were engaged through NSAs under ANRiN, some NSAs worked with existing public-sector CHWs using stipend top-ups, and CHWs were responsible for substantially higher service volumes than facility-based providers, underscoring their centrality to delivery and sustainability. Moreover, ANRiN 2.0 is anticipated to rely exclusively on CHWs for last-mile service delivery (Project Team Interview). To this point, the ICR cited a 2023 “CHW Redesign” program under the MoH that formally integrates community health workers into the public sector service delivery model. Specifically, the program provides improved pay and structured training for two tiers of frontline staff: auxiliary and junior community health extension workers. No further details were provided in



the ICR but the Project Team was able to clarify that ANRiN directly informed this redesign, including for training curricula and service delivery models. As of the interview, 14 states had activated the redesigned CHW program, hopefully contributing to the sustainability of this essential workforce's contribution to service delivery.

Finally, there is the perennial risk posed by the impact of climate change and other exogenous shocks on food security. The relative weight of this risk and associated poor nutrition, health, and child development outcomes cannot be overstated, as each time a crisis occurs, projects are forced to course correct away from proactive prevention in favor of short-term "band aids". The latter save lives, but do nothing to build the governance and stewardship functions which are requisites for preventing such emergencies from occurring in the first place

8. Assessment of Bank Performance

a. Quality-at-Entry

As above, ANRiN's design was informed by insights on i) the management of performance-based contracts for NSAs, ii) the need to tailor SBCC campaigns to local contexts and to engage key influencers, iii) the importance of making costed strategic plans for nutrition a prerequisite for project participation, iv) the need for special measures when targeting adolescent girls, and v) the need to foster a government-owned central nutrition programming platform using a non-line ministry with convening clout, such as the FMBNP (PAD, p. 27).

Regarding institutional arrangements, the FMOH was designated as anchor ministry at federal level, with the Department of Family Health expected to provide technical guidance to states on SBCC, research, and nutrition surveillance, and the National Primary Health Care Development Agency expected to support State Primary Health Care Development Agencies on delivery of a nutrition sensitive antenatal package in their respective facilities. Concurrently, the MBNP was the designated lead on multisectoral coordination, including line ministries and social protection units hosted under the Office of the Vice President. State level arrangements were also briefly described, albeit with less detail than ideal regarding actors and fostering of linkages at state and sub-state level. State MoHs were designated as providing technical oversight and hosting PIUs and contracting NSAs, and State Primary Health Care Development Agencies were expected to oversee delivery of nutrition sensitive antenatal care services. A full-time Project Coordinator deputized to each state PIU was expected to lead implementation, drawing expertise "as required" from both the state MoH and Primary Health Care Development Agency on: (i) nutrition and infant and young child feeding; (ii) community mobilization and engagement; (iii) communications; (iv) procurement; (v) accountant/finance; (vi) contract management; (vii) internal auditing; and (viii) monitoring and evaluation (PAD, p. 99). Although the PAD acknowledged the "inherent risks and issues of multiple implementation levels" of this ambitious agenda, the concession was not strongly reflected in the text on federal and state implementation pathways. Of particular note was a lack of information in support of the statement that "one of the core functions of the state MoHs is to ensure strong contract management, such that state level DLIs are achieved in a timely manner and any bottlenecks that compromise their achievement are swiftly dealt with, in escalating the issue to the right level (PAD, p. 30). Other than a short section summarizing anticipated GFF and associated TF assistance for implementation, there was not much



information provided in the PAD to demonstrate how state health agencies were equipped to deal with the various risks inherent to the project's complex approach.

That said, the project's overall risk rating was "Substantial" at appraisal, attributed in the PAD to Nigeria's overall macroeconomic context and subsequent implications for budgetary provision, the likelihood of political transitions expected after the 2019 elections, and introduction of the novel results-based approach using performance-based contracts with NSAs for service delivery. To mitigate the latter, in addition to DLI4 to incentivize state performance on contracting, the PAD cited i) procurement clinics on performance-based contracts to be organized with grant financing ahead of project effectiveness to build capacity of the PMU and PIUs and ii) formation of "elite contract management units" at federal and state levels for on-going training and backstopping to facilitate state management (PAD, p. 33).

Despite these measures, state reluctance to sign contracts with NSAs, combined with bureaucratic bottlenecks and a low functioning, understaffed PMU at federal level, delayed effectiveness by approximately one year, including via retarding recruitment of an IVA, obstructing procurement, and compromising financial management processes (see "Fiduciary Compliance").

Stakeholder risk was also rated "Substantial" due to the project's convergence aspects and its aspirations to reach adolescent girls. With respect to convergence, the PAD cited the national DLIs for multi-sectoral planning and accountability as well as TA through the GFF, associated trust funds, and extant Bank activities in education, social protection, agriculture, water and sanitation, and social development. With respect to reach, the PAD anticipated that the project's SBCC strategy – which as above leveraged messaging disseminated through religious leaders – would be sufficient to positively impact pregnant girls. It appears that this assumption generally held, as although none of the targets for interventions for children of adolescent girls were met, the numbers may have been distorted by inaccurate population estimates, and moreover, progress was clearly made overall.

As above, the overall strategic approach of the project was relevant to the country context and government strategy. Also as above, the project's technical basis was sound as it used empirical evidence on cost-effective interventions and lessons learned from previous projects in Nigeria and globally. The ToC was in line with the PDO, however there was weak alignment between the ToC and the RF, as the latter was not fully representative of all impact pathways (discussed in "M&E Design", below).

In sum, ANRiN's strategic relevance was high, its technical design was cogent, and its social development aspirations were valid. However, there were RF shortcomings, and given the project's demanding implementation arrangements, it appears that risks associated with project readiness were underestimated. To this point, there was a lack of elaboration in the PAD describing how state health agencies were equipped to deal with the various risks inherent to the project's complex approach. As such, quality-at-entry is rated Moderately Satisfactory, indicating moderate shortcomings in project design and the proactive identification and resolution of threats.

Quality-at-Entry Rating
Moderately Satisfactory



b. Quality of supervision

Following the election and subsequent delays in NSA contracting, the Government and World Bank team used the MTR to recalibrate the RF, restructure underperforming components, cancel funds, and streamline delivery mechanisms by focusing on building capacity at state level. These efforts led to a dramatic acceleration in implementation, with disbursements rising from under 30 percent to over 90 percent in the final 2 years of the project. Per the ICR, the project team played a critical, hands-on role in this turnaround by re-engaging state officials, rebuilding momentum despite weak PMU capacity, and navigating significant data limitations attributable i) to failed implementation of the NHHS/SMART surveys and ii) challenges related to use of the ANRiN App, field testing for which had been made impossible due to COVID. Implementation support was described as “consistent, responsive, and highly appreciated by both the PMU and PIUs” by the ICR, corroborated by Stakeholder Comments in Annex 4 (most notably Gombe state). The fact that four restructurings were undertaken during the project further reflects the team's proactive stance in adapting to evolving operational and contextual realities including shifts in government leadership, pandemic-related disruptions, and changing sector priorities.

With respect to candor and quality of performance reporting, thirteen Implementation Status and Results Reports were submitted on time over the project period, ensuring regular tracking of RF indicators and permitting additional insight into the supervision process, including evidence for downgrading of the risk rating for Institutional Capacity from High to Substantial and upgrading of the Overall Implementation and Progress Toward PDO Ratings from Moderately Satisfactory to Satisfactory.

Regarding sustainability, as above, ANRiN was implemented under the assumption that it would be the first in a series of five year operations designed to strengthen capacity and accountability for improved nutrition outcomes, underpinned by a shift from reactive treatment to proactive prevention and multisectoral coordination. As such, the mechanism for adequate transition arrangements was built into the project's design and implementation, including alignment with extant sector policies (i.e. Nigerian National Policy on Food and Nutrition, National Strategic Plan of Action on Nutrition), and use of incentives to improve the performance of line ministries, states, and federal agencies.

Overall, World Bank supervision faced significant challenges, including political turnover and the impact of the COVID-19 pandemic, both of which were beyond its control. Despite these challenges, the team maintained focus on development impact through targeted restructuring, proactive decisions on cancellation and re-allocation of funding, sustained state engagement, and hands-on support, enabling strong service coverage results within a shortened implementation period.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization



a. M&E Design

The project's ToC and impact pathways were clearly described and sound, and its objectives well specified. However, the RF did not fully reflect all aspects of the ToC, as it lacked IRIs along the pathway from service delivery to outcomes—particularly for assessing quality, counselling effectiveness, and user satisfaction (ICR, p. 33). Additionally, the selection of IRIs could have been more balanced, and less heavily focused on BCC outputs under Component 1. Component 2—despite its complexity and multiple subcomponents—had only two associated IRIs, with none linked to the knowledge platform, research activities, or multisectoral pilot. Although it is possible that these omissions were due to the fledgling nature of the activities related to stewardship (see “Relevance to government strategy”), there still should have been a sharper focus on process indicators to track country and state progress on governance strengthening.

Original indicators were specific, measurable, achievable, relevant, and timebound, and expected to be supported by three planned verification methods: the ANRiN App, household surveys by the IVA, and the national NNHS/SMART surveys.

With respect to the extent to which M&E arrangements were institutionally embedded, the PAD noted that the annual NNHS/SMART would assure incorporation within wider national data systems. The PAD further noted that should the NNHS not be conducted due to unforeseen reasons in a particular year, results would be validated using MICS or DHS, both of which had been used to provide baseline data for the PDOIs (PAD, p. 31). This is in fact precisely what happened; however, validation did not occur prior to closing, an eventuality not considered at appraisal

b. M&E Implementation

As above, under the first restructuring, all PDOIs - except for exclusive breastfeeding - were converted from percentages to absolute numbers with zero baselines, attributable to the unavailability of percentage-based verification data which the NNHS/SMART surveys had been expected to provide. These surveys were never conducted due to external delays and GoN data quality concerns. Consequently, the ANRiN App became the primary verification tool. While this adaptation enabled continued measurement during implementation, it limited the project's ability to assess impact relative to the original baselines and targets, thus reducing capacity to provide comprehensive assessment of progress in coverage within participating States.

Additional changes to the RF included recalibration of DLI 1 on SBC under the second restructuring to include scalable, open-ended DLR targets (to incentivize ongoing government performance beyond the original “capped” benchmarks), revision of all adolescent-disaggregated baselines and targets under the second restructuring, based on findings from MICS 2021 (which found that the median national adolescent birth rate had declined significantly), and the revision or deletion of multiple additional DLRs under the second and third restructurings, all in line with the project's changes and indicative of diligent correction of the M&E design.

With respect to the ANRiN App itself, early deployment delays and connectivity glitches were attributed primarily to COVI-19 travel restrictions, which prevented both field testing and hands-on support, especially for CHWs who faced a steep learning curve due to habitual reliance on paper-based registers (Project Team Interview). Despite these initial challenges, the app had stabilized by late 2023 and



permitted real-time service tracking and dashboard reporting through closing. ISR Reports, which consistently included RF data, show clear progress across most indicators beginning in 2022 (ICR, p. 33).

No details were reported in the ICR regarding IVA attention to M&E effectiveness. However, the Project Team clarified recruitment was led by the Ministry of Finance, ensuring independence from project implementers, that all IVA teams included statisticians and M&E specialists as minimum requirements, and that IVA verification significantly improved data quality and credibility.

c. M&E Utilization

Despite its limitations, there were several examples provided in the ICR regarding the extent to which data collected by the ANRiN App was distributed, given that it was tied to DLR verification and disbursements: First, National and State Primary Health Care Development Agencies institutionalized monthly data validation and review meetings for delivery of nutrition-sensitive ANC at PHCs, and held quarterly supportive supervision meetings to review health facility performance and strengthen service delivery and reporting capacities on the ANRiN deliverables. Second, the FMBNP conducted routine virtual and in-person performance reviews of the sectors engaged in the multisectoral coordination and accountability for nutrition results (DLI 2). Third, the Annual Results Conferences featured results from the ANRiN App and multisector pilot dashboards.

Regarding the extent to which M&E processes are likely to be sustained, the ICR reported that data from the ANRiN App has been successfully integrated into Nigeria's National Health Management Information System (NHMIS). This statement was corroborated by the Project Team, which added that integration was enabled through an application programming interface linking client-level app data with aggregate NHMIS reporting. This integration was a successful feat unto itself, requiring substantial investment and support from the Bank to develop the interface and ensure government readiness of the NHMIS community module (Project Team Interview).

Summary

With respect to design, the ToC was sound, but the RF was not fully representative of all impact pathways and should have included more diverse IRIs, namely for better assessment of service delivery outputs and progress in governance strengthening under Component 2. With respect to implementation, diligence in course correction was undermined by an initial delay in deployment of the ANRiN App, cancelation of the NNHS/SMART surveys, and the subsequent major change to the RF's units of measurement introduced under the first restructuring. This change, while necessary given data limitations, complicated assessment of improvements in coverage, thereby reducing robustness of outcome measurement during implementation. The sum of these significant shortfalls was partially offset by i) the project team's efforts to generate ex-post evidence of impact, and ii) the overall success of the ANRiN App, both for data generation and analysis during implementation, and institutional integration thereafter, in keeping with an overall rating of Modest.



M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

Operational Policy (OP) 4.01 on Environmental Assessment was triggered by ANRiN, which was classified as Environmental Category B in view of potential environmental concerns around the handling of health care waste resulting from project related activities (PID/ISDS Appraisal Stage).. Per the ICR, a Health Care Waste Management Plan (HCWMP) was duly prepared, with all PMU and PIU safeguard focal persons trained on HCWM. Additionally HCW equipment including personal protective equipment, bins and weighing scales were procured and periodic reports on implementation of the HCWMP were submitted. The project recorded one fatality, one accident and a fire incident (involving some of its NSAs). Each case was treated according to the World Bank Environment and Social Incident Response Toolkit guidelines and closed satisfactorily (ICR, p. 34).

Extensive consultations were conducted with project stakeholders during preparation, implementation and at project closure. No cases of sexual abuse, exploitation or harassment were recorded. By closing, all participating states had functional Grievance Redress Mechanisms (GRM) in place, enabling community members and stakeholders to report concerns through accessible channels. A total of 8,562 grievances were received and resolved, the lion's share related to commodity shortages. Monthly meetings with GRM and Ward Development Committees helped ensure transparency and accountability (ICR, p. 35). The Project's ES Risk Rating remained low across all 13 ISRs.

The Overall Safeguards Rating was reported by the ICR as Satisfactory.

b. Fiduciary Compliance

Financial management (FM) was rated Moderately Satisfactory for most of the project's implementation period, due to submission of unaudited interim financial reports that were on time but of variable quality. Most specifically the ICR noted that the weak capacity of FM staff to adequately implement internal control arrangements resulted in several instances of unretired advances and inadequate documentation. Hands-on support provided during FM implementation support missions (dates not provided) resulted in improvement and a reduction in issues was flagged. That said, bank reconciliation issues (mainly in Niger and Kogi State PIUs) persisted through closing, attributed in the ICR to staffing gaps.

All PIUs and the PMU submitted the FY23 audited annual financial statements promptly and auditors expressed unqualified opinions. The backlog of audit reports for the Akwa Ibom State PIU was cleared after the State's closeout, and the auditor expressed an unqualified opinion. No information was provided in the ICR regarding whether any audit recommendations were made or addressed (ICR, p. 35)

The Project's Fiduciary Risk Rating remained low across all 13 ISRs.



During project implementation, a total of 35 Goods, 61 Consultancy Services and 5 Non-Consultancy Services were procured across the States PIUs and Federal PMU/PIUs at a total of approximately US\$90 Million. All contracts were completed and adequately documented in STEP. The major procurement activity was of the BPNS across participating States using performance-based contracts. This activity comprised over 90 percent of ANRiN’s procurement costs. Although there was provision to use Advance Procurement / Retroactive Financing to facilitate engagement of the IVA, the agent was engaged after signing of the Credit Agreement. Major procurement risks identified during the assessment were weak capacity of Project staff on (i) World Bank Procurement procedures and (ii) Health Sector procurement. The identified mitigation measures, which included (i) engagement of an experienced Procurement Consultant, (ii) training and (iii) backstopping by Bank staff, were used heavily to enhance capacity and to navigate bureaucracy and system glitches. Per the ICR, these measures, plus intensive Quality Assurance by Bank staff, led to a satisfactory procurement performance (ICR, p. 35).

c. Unintended impacts (Positive or Negative)

None

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Moderately Satisfactory	There is no disagreement, as the ICR (para 59) also rates outcome as Moderately Satisfactory.
Bank Performance	Satisfactory	Moderately Satisfactory	Quality at entry rated “Moderately Satisfactory” due to moderate shortcomings in readiness and M&E
Quality of M&E	Modest	Modest	
Quality of ICR	---	Substantial	

12. Lessons

Selected Lessons from the ICR are re-stated below:

- **In decentralized contexts, prioritizing sub-national capacity may streamline implementation and improve accountability.** ANRiN’s design empowered States to lead on procurement, mass media rollout, and workforce training, thus reinforcing ownership and



(eventually) fast-tracking implementation. This approach also fostered clear lines of accountability at decentralized level, a nutrition priority in all countries and imperative in larger ones. Under ANRiN 2.0, further institutionalization within State Ministries of Budget and Planning and State Nutrition Committees—with oversight from Executive Governors—positions States to continue to drive results.

- **Digital tools can potentially add value in resource constrained, data-scarce contexts, however field-testing and acclimation for front-line staff are imperative.** COVID-19 restrictions prevented field-testing of the ANRiN app, resulting in initial connectivity limitations and delays in CHW uptake which might otherwise have been avoided. However, once usage stabilized in late 2023, the app performed well and served dual functions by collecting data on service delivery for DLI verification (outputs) *and* bridging a critical M&E gap given the cancellation of the NNHS/SMART surveys (outcomes). The utility of the latter is noteworthy, given frequent challenges to evaluating nutrition results in data-scarce environments.
- **In conservative contexts, faith-based leaders can extend reach and impact of BCC campaigns.** Initiation and maintenance of good nutrition practices is based on sustained behavior change. However, moving the needle on social norms is frequently an uphill battle as it requires buy-in not only from beneficiaries but from entire communities. The project's work with imams and other religious leaders on promoting specific actions for improved nutrition knowledge and practices was likely essential to fostering precisely this engagement. The ICR estimated that over 6 million people - including 400,000 adolescent girls - were reached through culturally sensitive nutrition-linked sermons and faith-based messaging, indicative of a scope of influence which was likely far wider than secular messaging alone. The fact that the proportion of males who were able to identify key messages at closing was 179 percent of the target is testament to this effect.
- **In less conservative contexts, consider multiple targeting strategies for adolescent girls.** Although the project appropriately targeted married, pregnant adolescent girls, non-married adolescents were excluded due to socio-cultural sensitivities in the majority of implementing states. This reflects a missed opportunity in programming, as there were a few select areas targeted in the project (not specified in the ICR but likely Abia, Akwa Ibom, and Oyo in the less conservative South) where socio-cultural sensitivities surrounding adolescent girls are less pronounced. In these states, nuanced interventions targeting non-pregnant, non-married adolescents might have been well-tolerated.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR's narrative supported the ratings and made a strong case for a well-intentioned project that was eventually impactful despite serious implementation and M&E challenges and moderate design flaws. It



followed the guidelines, was internally consistent, results oriented, and did a good job describing the project's principal aspects and key technical considerations. Overall quality of evidence was substantial. In addition to the RF, the Report cited findings which permitted estimation of the counterfactual using difference-in-difference analysis, as well as multiple population level surveys (MICs, NDHS, and NNHS), strengthening the case for attribution in terms of improved utilization. Quality of analysis, especially with respect to the mismatch between the ToC's causal pathways and results chains captured in the RF, was clear and helped alert the ICR Reviewer to discrepancies. There were a few minor shortfalls in terms of clarity of writing and reporting (e.g. practically no details provided on the birth spacing pilot for adolescent girls, questions regarding the cost-benefit analysis discount rate and assumptions), and also with respect to Lessons Learned, which while illustrative of operational realities were in some cases only weakly linked to the narrative and ratings. That said, on balance and considering the exceptional complexity of this project, the ICR's shortcomings were far outweighed by its positive aspects.

a. Quality of ICR Rating
Substantial