Report Number : ICRR0023058

1. Project Data

Project ID P146583	**Program Name** NG-Saving One Million Lives
Country Nigeria	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Program Cost (USD)
IDA-56000	31-Dec-2019	387,579,069.24
Bank Approval Date	**Closing Date (Actual)**	
23-Apr-2015	31-Jan-2021	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	500,000,000.00	0.00
Revised Commitment	379,777,658.15	0.00
Actual	387,579,069.24	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Program Context and Development Objectives

a. Objectives

The Objective of the Program was to increase the utilization and quality of high impact reproductive, child health, and nutrition interventions (Financing Agreement, May 22, 2015, p. 5).

The Program formed part of the Federal Government of Nigeria's program titled “Saving One Million Lives Initiative” (SOML) that aimed at strengthening the pillars of maternal and child health in the country.

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

No

c. Will a split evaluation be undertaken?

No

d. Components

The Program would consist of the following activities (Program Description, Financing Agreement, p. 5):

I. Carrying out, by States, of programs of **activities designed to increase utilization** of High Impact Reproductive, Child Health and Nutrition Interventions, including: (a) preparation of plans to achieve reductions in maternal, perinatal and under-5 child mortality; (b) carrying out of High Impact Reproductive, Child Health and Nutrition Interventions; and (c) strengthening of Maternal, New-Born and Child Health (MNCH) Weeks **(Appraisal: US$305 million; Actual: US$309 million).**

II. Carrying out, by States, of a program of **activities designed to increase the quality** of High Impact Reproductive, Child Health and Nutrition Interventions **(Appraisal: US$54 million; Actual: US$16 million).**

III. Carrying out of a program of **activities designed to improve monitoring and evaluation systems and data utilization**, including: (a) conducting SMART Surveys (see definition below); (b) conducting Health Facility Surveys; (c) collecting data on maternal mortality rate from available sources; (d) disseminating widely the results of SMART Surveys and Health Facility Surveys; and (e) implementing performance management systems in all States and building and strengthening management capacity of leadership of the Federal Ministry of Health (FMOH) and ministries responsible for health at the state level **(Appraisal: US$80 million; Actual: US$42 million).**

Definition of SMART Survey (Standardized Monitoring and Assessment of Relief and Transitions): The survey is a standardized, simplified, cross-sectional field survey method designed to aid the collection of quality, up-to-date, and timely data necessary for decision-making. It was originally used for assessment of the magnitude and severity of a humanitarian crisis and acute emergencies. This survey method balances simplicity for rapid assessment and technical soundness.

IV. **Establishment and operation of the Innovation Fund designed to support private sector innovations aimed at increasing utilization and quality of maternal and child health interventions,** including: (a) development and testing of new techniques and technologies; and (b) development and testing of innovations designed to expand coverage and quality in health service delivery by private sector providers **(Appraisal: US$20 million; Actual: US$0 million).**

V. Carrying out of a program of **activities designed to increase transparency in management and budgeting of primary health care (PHC),** including such activities as: (a) transferring of health staff at health facility and Local Government Authority (LGA) levels to the State Primary Health Care Development Agency (SPHCDA); (b) publication, by state ministries of health, of consolidated budget execution reports covering all sources and uses of funds for primary health care at the state level; and (c) publication, by FMOH, of consolidated budget execution reports covering all sources and uses of funds for primary health care at the federal level **(Appraisal: US$41 million; Actual: US$19 million).**

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

Program scope, boundaries, cost and financing: The Program was designed to support the federal government's overall expenditure framework for its SOML program during the life of the operation. SOML was also part of the Second National Strategic Health Development Plan 2016-20. The total planned expenditure for SOML was estimated at US$1,052 million, to be financed by a government contribution of about US$552 million and a World Bank contribution of about US$500 million. The PforR Program was designed to encompass mostly federal roles and activities. Some state roles and activities at the apex level were financed by the Program (supervision of LGAs and facilities, technical help to LGAs, analysis of performance, problem identification, training, deployment and management of human resources, procurement and distribution of drugs), but overall LGA levels and below were not included within the Program financial boundaries, although the ICR (p. 10) noted that overall state activities would be directly or indirectly "influenced" by the Program. In addition, other development partners were supporting maternal and child health (MCH) activities outside the government's budget.

The World Bank's contribution was provided through an IDA Credit of US$500 million that represented about 48 percent of total federal expenditure on SOML during the operation's time frame of five years. The Program had a partial cancellation of US$120.4 million on January 28, 2021, prior to the closing date of January 31, 2021, because it was unlikely to achieve more results by the closing date (see below under the fourth restructuring). The actual cost of the Program was US$387.6 million.

Dates: The Program was approved on April 23, 2015, and became effective on May 29, 2015. It had a slow start during the first two years. A Mid-Term Review was carried out on January 31, 2019. The Program closed on January 31, 2021, about one year beyond the originally anticipated closing date of December 31, 2019.

Restructurings: The Program underwent four level-2 restructurings:

The First Restructuring (May 20, 2016): The federal government requested the restructuring to use the recent 2015 SMART survey results that covered all the states as a more robust baseline for service utilization, rather than the 2014 survey that covered only a few states. It also rewarded all states with US$1.5 million to increase utilization, instead of US$2 million for the 20 weakest performing States and US$1 million for the remaining 16 states.

The Second Restructuring (December 18, 2019) extended the Program closing date by nine months, from December 31, 2019 to September 30, 2020, to allow the completion of two surveys (National Health Facility Survey and 2019 SMART survey) to measure progress toward the PDO and disbursement against Disbursement Linked Indicators (DLIs) achievement.

The Third Restructuring (September 29, 2020): There were quality concerns with the 2019 SMART survey, and therefore the Program was reluctant to use its results for disbursing against DLI 1.2 (improving key health indicators). The restructuring extended the closing date of the Program from September 30, 2020 to January 31, 2021, to allow time to verify the survey or to seek credible data alternatives to disburse against DLI 1.2.

The Fourth Restructuring (January 28, 2021) partially modified DLI 1.2 (see DLI 1 Revision 2 below) and partially cancelled undisbursed funds across DLIs 2,3,4 and 5 in the amount of US$120.4 million per government and Task Team's assessment that the Program would not be able to achieve more results to trigger disbursements before the Program closing date. In this context, the restructuring allowed the Program to use alternative and credible data sources, such as the Lot Quality Assurance Sampling for vaccination coverage of pentavalent vaccine, and the 2019 post-harvest General Household Survey (GHS) for the utilization of insecticide-treated nets for malaria prevention and control (see section 4 for more details).

3. Relevance

a. Relevance of Objectives

Rationale

At appraisal, the Program was responsive to the country's health challenges and intended to support SOML that was meant by the government to be a bold response to the slow progress in MCH outcomes. Over the preceding two decades, coverage of key health interventions had stagnated at low levels, the quality of care was poor, and important inequities remained among Nigeria's geo-political zones (PAD, pp. 3-4). Based on 2013 data of Nigeria's Demographic and Health Survey, the maternal mortality ratio was at 576 maternal deaths per 100,000 live births; the total fertility rate at 5.5; child stunting (height for age) at 37; infant mortality rate at 69 per 1,000 live births; and under-5 mortality at 128 per 1,000 live births.

In terms of relevance of the PforR instrument, the PAD (p. 9) argued that the PforR instrument was a good fit because SOML was a well articulated and technically sound program that aimed at achieving measurable results in priority areas; it was an existing program with widespread support; and there was an explicit interest in changing the focus from inputs to actual results. Improvements in performance would be expected to be associated with increased accountability, motivation, and stronger management. Also, government policies that can facilitate the achievement of SOML goals were already in place, and therefore a sector development policy operation would not have been a suitable option.

At Program closing, the objectives remained closely relevant to the goal of improving primary health care under the second pillar of the Country Partnership Framework (CPF) for the Federal Republic of Nigeria for the period FY21-FY25, dated November 16, 2020. This second pillar on "Investing in Human Capital and Harnessing Nigeria's Demographic Dividend" had several objectives: increase access to and quality of basic education, improve primary health care, increase access to basic water and sanitation services, increase the coverage and effectiveness of social assistance programs, and empower women and girls by increasing their human capital and economic opportunities, along with a complementary priority to promote youth employment and skills.

Under CPF Objective 3 to improve primary health care, the CPF stated that, with a large portfolio in this area, support would focus on consolidating the main financing platforms to provide programmatic support to help reduce under-five mortality, improve the quality and coverage of public health services, and promote

sustainable financing for basic health services. The CPF also used a Program-specific indicator (Pentavalent 3 vaccination) as a CPF indicator.

Rating
High

b. Relevance of DLIs

DLI 1

DLI
Increase of Utilization of High Impact Reproductive, Child Health and Nutrition Interventions

Rationale
The DLI was in line with the strategic focus of SOML and the National Strategic Health Development Plan. The DLI would encourage increases in the coverage of key health interventions. DLI 1 had three elements:

DLI 1.1 -- States Produce Plans for Achieving Reductions in Maternal, Perinatal and Under-Five Child Mortality: DLI 1.1 would motivate the states by providing them with an opportunity to address legacy issues of poor planning and infrequent supervision. States would be provided with initial “one-off” disbursements at the beginning of the PforR Operation, based on each state developing a plan for addressing its own performance constraints that hinder PHC service delivery with an emphasis on improving supervision and introducing innovations. The 20 most lagging states as judged by the 2014 SMART survey would receive US$2 million, and the remaining states would receive US$1 million each. The arrangement avoided perverse incentives or moral hazard since: (i) data on which the initial disbursement would be based had already been collected and published; (ii) states were unaware that they would receive these disbursements based on performance; and (iii) subsequent results-based disbursements would be based on improvements from the baseline.

DLI 1.2 -- Improvements on 6 Key Health Indicators: The indicators used were key ones in SOML scoring and were known to be among the most cost-effective means for saving the lives of mothers and children: (i) immunization coverage, Pentavalent 3; (ii) insecticide-treated nets utilization by children under five; (iii) proportion of pregnant women who receive HIV counselling and testing as part of their antenatal care; (iv) proportion of mothers benefiting from skilled birth attendance; (v) contraceptive prevalence rate using modern methods; and (vi) Vitamin A coverage among children under five. Funds provided to States, although relatively small compared to overall state budgets, may be catalytic because they could be flexibly used, including to meet recurrent costs.

But DLI 1.2 did not assign appropriate unit prices. Since the DLI depended on a combined coverage of services, this meant that even if the entire allocated amount for DLI 1.2 was spent, the final target may not have been achieved across all states. There were no consequences for low or declining performance. This has subsequently contributed to discrepancies between relatively high levels of disbursement for DLI 1.2 compared to actual target achievements (ICR, p. 19).

DLI 1.3 -- Lagging States will Strengthen their MNCH Weeks as Part of an Impact Evaluation: MNCH Weeks can mobilize communities, notably remote ones, as a means of increasing coverage of preventive interventions such as childhood immunization, Vitamin A supplementation, nutrition assessment, and de-worming. MNCH Weeks are transitional measures that can boost coverage while the PHC system is being strengthened. While the approach appears attractive, past experience since 2010 had shown that MNCH Weeks did not fulfill their potential, and that the participation of children under five remained low.

Rating
Modest

DLI 1 REVISION 1

Revised DLI
DLI 1.2: Increase in quantity of high impact Reproductive, Child Health and Nutritional interventions as measured by improvements on key health indicators as indicated by SMART or other quality-assured household surveys with data from SMART Survey 2015 providing the baseline

Revised Rationale
The revision provided more robust baseline data on service utilization, as the 2015 SMART survey covered all the states with more recent data in contrast with the initial baseline that was based on the 2014 SMART survey that covered only a few states. Also, the rewards of DLI 1.1 were revised to provide all states with US$1.5 million as an incentive to increase utilization, instead of US$2 million for the 20 weakest performing States and only US$1 million for the remaining and better performing 16 states.

Revised Rating
Substantial

DLI 1 REVISION 2

Revised DLI
DLI 1.2: % improvements in average national performance of the Key Health Indicator relating to the use of insecticide-treated nets by children under 5

Revised Rationale
The alternative source of reliable data for service utilization (the 2019 post-harvest GHS that was selected in lieu of the 2019 SMART survey) dealt with national level performance for insecticide-treated nets. Hence, the Program changed the DLI from state level performance for this indicator to average national performance. The trade-off was justifiable because the average national performance under the household survey was more reliable than the 2019 SMART survey measurements for this indicator, and an overall improvement pattern was common across the states.

Revised Rating
Substantial

DLI 2

DLI
Increase of Quality of High Impact Reproductive, Child Health and Nutrition Interventions

Rationale
DLI 2 would help to ensure that the quality of care receives sufficient consideration. It would reward state level performance and contribute to improving management and data utilization. Quality of care would be defined by an index that comprised a combination of indicators that are discussed in section 4. However, the index was based on general process indicators that reflect quality aspects in overall service delivery.

Rating
Substantial

DLI 3

DLI
Improvement of Monitoring and Evaluation Systems and Data Utilization

Rationale
Having reliable information was considered by SOML as a foundation for increased accountability and would help decision-making to become more evidence based. The DLI had three elements:

DLI 3.1-- Improving M&E systems: This would largely consist of motivating the expansion of SMART surveys and institutionalizing annual health facility surveys. The DLI would support conducting SMART surveys in all states; introducing annual health facility surveys in all states; and collecting data on the Maternal Mortality Rate.

DLI 3.2 -- Improving Data Utilization by widely disseminating survey results.

DLI 3.3 -- Implementing Performance Management System in All States: This part of the DLI would help in bolstering performance management systems in the states with a focus on capacity and accountability, evidence of continuous analysis, and regular reviews of action plans.

Rating
High

DLI 4

DLI

Establishment and Operation of the Innovation Fund Designed to Support Private Sector Innovations Aimed at Increasing Utilization and Quality of Maternal and Child Health Interventions

Rationale

A competitive innovation fund was planned to support innovations for techniques, technologies, and innovations in health service delivery by private sector providers. The relevance of engaging the private sector and harnessing its potential is self-evident in theory, but, in the specific context of the country Program and its objectives, the DLI was difficult to implement and operationalize, and the recruitment of a firm according to the implementation plan was not consistent with government guidelines (ICR, p. 19 and p. 60). The Task Team also clarified on August 17, 2022, that the Federal Ministry of Health was reluctant to proceed with this activity given the large amount of funds that would be managed by the private sector on behalf of the government and in view of limited health sector experience in such an undertaking. The DLI was not implemented.

Rating

Modest

DLI 5

DLI

Increase of Transparency in Management and Budgeting of Primary Health Care

Rationale

This DLI was relevant because holding states accountable for improving service delivery would make sense only if relevant managers had actual control of human and financial resources that are required for service delivery. States would: (i) transfer health staff to SPHCDA, an autonomous entity responsible for PHC that would be provided with management authority over staff at health facility and LGA levels, including the power to hire, fire, post, transfer, and discipline such staff; and (ii) produce and publish a consolidated budget execution report covering all income and expenditures for PHC. The federal government would publish a consolidated budget execution report covering all income and expenditures for PHC.

Rating

High

OVERALL RELEVANCE RATING

Rationale

Overall relevance encompasses a full alignment between Program objectives and the CPF at Program closing, and a substantial alignment between DLIs and Program objectives, where shortcomings were observed in the design of some DLIs. The aggregation of both elements is consistent with a substantial rating for overall relevance.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
Increase the utilization of high impact reproductive, child health, and nutrition interventions

Rationale
The theory of change held that better management of human resources, training, supervision, provision of equipment, drugs, vaccines, medical supplies, and operating budgets, along with technical assistance, outreach, and community engagement would contribute to increasing the number of people with access to a basic package of health, nutrition, and reproductive health services, including immunization and attended deliveries. In turn, these developments would plausibly contribute to an increase in utilization of high impact reproductive, child health and nutrition interventions.

The theory of change for utilization was intertwined with that of increasing quality under Objective 2 below, as both aspects were mutually reinforcing. For example, high service quality would motivate people to seek health care.

The number of people who received essential health, nutrition, and population services increased from a baseline of 9.9 million in 2015 to 11.7 million people by the end of 2019, exceeding the target of 10.7 million people. Out of this total, the number of females increased from a baseline of 6.7 million to 7.7 million, exceeding the target of 7.4 million.

The number of women and children who received basic nutrition services increased from a baseline of 2.9 million in 2015 to 3.2 million by the end of 2019, short of the target of 3.4 million women and children.

The number of Pentavalent 3 immunized children increased from a baseline of 3.3 million in 2015 to 4.6 million by the end of 2019, exceeding the target of 3.5 million immunized children.

The number of deliveries attended by skilled health personnel increased from 3.7 million in 2015 to 3.9 million by the end of 2019, exceeding the target of 3.8 million attended deliveries.

As an outcome reflecting increased utilization, the ICR reported that the combined coverage of six key SOML services (Pentavalent 3 vaccination coverage among young children; modern methods contraceptive

prevalence rate; Vitamin A supplementation among children 6 months to 5 years of age; skilled birth attendance; HIV counselling and testing among women attending antenatal care; and use of insecticide-treated nets by children under five) increased from a baseline of 236.6 percent in 2016 to 271.1 percent in 2019, short of the target of 284 percent in combined coverage. Aspects pertaining to the reliability of these results are explained below.

In view of quality concerns related to the 2019 SMART survey, the project used the robust 2018 SMART survey in addition to two other reliable data sources (Lot Quality Assurance Sampling for vaccinations and the 2019 post-harvest General Household Survey (GHS) for the use of insecticide-treated nets (ICR, pp.55-59). The restructuring of January 2021 formalized the use of reliable alternative data sources for Program assessment (ICR, p. 22).

Rating
Substantial

OBJECTIVE 2
Objective
Increase the quality of high impact reproductive, child health, and nutrition interventions

Rationale
The theory of change held that, in addition to the interventions included in the theory of change for increasing utilization under Objective 1, the application of quality scores in service delivery, improving M&E systems and data utilization, increasing transparency in management and budgeting, and establishing an innovation fund for the private sector would plausibly contribute to increased quality of high impact reproductive, child health, and nutrition interventions

The number of states with performance management systems in place increased from a baseline of 10 states in 2015 to 37 states in 2020, exceeding the target of 30 states with performance management systems.

The number of states in which SPHCDA had managerial authority over PHC staff increased from a baseline of four states in 2015 to 31 states in 2020, short of the target of 37 states.

In terms of outcomes, the Program used a Quality-of-Care assessment at the health center level that was based on a composite index of several general domains. Data was measured through National Health Facility Surveys. The Quality-of-Care Index increased from a baseline of 33.9 percent in 2016 to 51.7 percent in 2019, exceeding the target of 37.1 percent. This indicator combined the following domains: (a) clinical competence of health workers and adherence to guidelines; (b) availability of drugs and minimum equipment; (c) readiness to deliver SOML activities, including outreach; (d) frequency and quality of supervision; (e) quality of financial management and quality of data reporting; and (f) health care waste management (ICR, p. 23 and p. 40).

The first National Health Facility Survey (NHFS) was used in 2016 to determine the baseline. It was followed by the above results that were based on the second NHFS survey that was carried out by the National

Bureau of Statistics in 2019. No subsequent rounds were undertaken. The impact evaluation of results-based disbursements for MNCH Weeks was not performed.

Rating
Substantial

OVERALL EFFICACY

Rationale
The two objectives to increase the utilization and quality of high impact reproductive, child health, and nutrition interventions were almost fully achieved. The aggregation of achievements under both objectives is consistent with a substantial rating for overall efficacy. Nevertheless, DLI shortcomings affected project performance. Alternative sources of data lacked state specificity. Also, low interaction and complementarity between the public and private sector, a major provider of health services, remains an important issue that has a bearing on Program objectives.

During ICR interviews (p. 24), stakeholders reported favorably on the change generated by the Program, namely on the results-oriented shift in the sector and the heightened interest of state officials in using data for making evidence-based decisions toward strengthening and improving MCH services.

Rating
Substantial

5. Outcome

Overall relevance is rated substantial, encompassing a full alignment between Program objectives and the Country Partnership Framework at Program closing, and substantial alignment between DLIs and Program objectives. Efficacy is rated substantial, as Program objectives were almost fully achieved, but with shortcomings in Program performance, largely related to DLI design issues, and with shortcomings in state-specific evidence on achievements. These findings are consistent with a moderately satisfactory rating for overall outcome.

Outcome Rating
Moderately Satisfactory

6. Risk to Development Outcome

The risk that development outcomes may not be maintained is largely related to fiscal aspects (ICR, p. 35). Although there was a strong demand for continuing SOML, there may not be a direct successor in the near term largely due to economic constraints and demands on public finances that were exacerbated by the COVID-19 pandemic. Nevertheless, SOML continues to be favorably considered as a catalytic fund that increased attention to results and facilitated health system strengthening. Importantly, the Program was perceived as a mainstream government initiative rather than as a parallel health program.

Other programs such as the Basic Health Care Provision Fund and Accelerating Nutrition Results in Nigeria could contribute to sustaining some of the Program outcomes. Also, the ICR (p. 35) reported that there was an early discussion on a proposed Human Capital PforR for Nigeria.

7. Assessment of Bank Performance

a. Quality-at-Entry

According to the ICR (p. 33), the Program was the first Program-for-Results operation in the health sector in Nigeria, and both the government and World Bank Team went through a learning process during preparation and implementation. Preparation benefited from lessons of reform programs in other sectors, including reliance on independent assessments, drawing skills from the private sector, taking advantage of existing systems, and the importance of motivation. The design benefited from a robust technical assessment, clear objectives, added focus on cost-effective interventions, and sufficient available information on barriers to access and service utilization (Task Team clarifications, August 17, 2022). Institutional arrangements (PAD, pp. 28-30) included an Oversight Steering Committee chaired by the Minister of Health, oversight by the Federal Ministry of Finance, a Project Management Unit (PMU) in charge of day-to-day implementation, and an Independent Verification Agency (IVA). In addition, FMOH was to contract with an organization to act as a Program Support Unit (PSU) to support the PMU at the federal and state levels through the provision of technical assistance in various areas, largely in performance management, data analytical skills, and helping states in formulating their action plans. Also, a Fund Manager was to be contracted by FMOH to administer the Private Sector Innovation and Learning Fund.

Quality at Entry had moderate shortcomings. The Fiduciary Systems Assessment did not benefit from the early involvement of fiduciary specialists, and a detailed definition of the Program Expenditure Framework was deferred to the implementation phase. Some risks were not adequately identified and mitigated, such as for the capacity to conduct high-quality population-based and facility-based surveys on an annual basis, engaging a PSU to provide technical assistance to the states, mixed commitment to the innovation fund, and clarity of the terms of reference and quality assurance functions of the IVA. Some DLI unit pricing was not sufficiently accurate to align incentives, disbursements, and target achievements. The above issues subsequently affected initial implementation and reduced the frequency of planned surveys. In the larger context, and since PforR was a novel financing instrument in the health sector, a

closer scrutiny of capacities, readiness, and risks would have been expected during the preparation process.

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
There was concerted effort to advance implementation while addressing preparation shortcomings (ICR, p. 35). The Bank Task Team was pro-active in addressing Program threats, and facilitated four restructurings, including for overcoming M&E weaknesses. The Team facilitated a strong outreach effort to involve the states in terms of their understanding of the PforR, results that needed to be achieved, and provision of necessary technical assistance to achieve the same. The Team extended efforts to overcome government delays in recruiting a PSU for technical assistance, and to find alternative sources of credible data to address quality weaknesses in some surveys. The Team was able to provide effective implementation support in a complex sector, with government changes, disruptions caused by the COVID-19 pandemic, and in a challenging context of increasing fragility and violence. This included the Boko Haram insurgency in the North-East and communal conflicts over oil spills in the South-West.

However, in terms of procurement support, the ICR (p. 33) reported that the quality of World Bank's procurement implementation support was not effective due to limited participation of the procurement team in implementation support missions, and weak monitoring of procurement-related Program Action Plan (PAP) actions with respect to annual procurement planning and performance. Also, the Task Team did not initiate a detailed definition of the Program Expenditure Framework in a timely manner.

Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

8. M&E Design, Implementation, & Utilization

a. M&E Design
The objectives were clearly stated and generally reflected by the indicators. The design of the M&E system was technically appropriate for the Program, although it was ambitious and carried implementation risks related to insufficient capacity, as M&E design was based on conducting yearly surveys involving a combination of SMART surveys for population-based indicators and health facility surveys for quality-of-care indicators.

b. M&E Implementation

In terms of the planned yearly surveys, only two rounds of the NHFS and three rounds of the SMART National Nutrition and Health Survey were conducted. The first NHFS round was carried out in 2016 by a private firm to establish the baseline, and the second NHFS assessment round was undertaken by the National Bureau of Statistics in 2019. The ICR reported that there was not much time left to conduct another survey.

SMART household surveys were implemented by the National Bureau of Statistics with technical support from UNICEF. These surveys were meant to be nimble. The process took 18 months to start. Only three SMART surveys were carried out during the Program period. There was an expectation that surveys would be institutionalized, but they were funded by development partners. Concerns about data quality issues were raised at the 2019 SMART survey, triggering a technical review that identified several issues, including in documentation, methodology, analysis, and date-related errors. In consultation with the government and development partners, the World Bank decided not to use the results for assessing achievements and facilitating disbursements. Instead, the fourth Program restructuring allowed the use of credible alternative data sources, including GHS for the utilization of insecticide-treated nets and the Lot Quality Assurance Sampling for measuring Program progress in Pentavalent 3 vaccination coverage.

M&E implementation issues were also encountered at the level of IVA, a public health consultancy firm for verification that had prior working experience with the government. There was an expectation that IVA would provide quality assurance for the entire process of SMART surveys under SOML, but such a task was not well specified in the terms of reference (TORs) and was not adequately budgeted. The quality assurance task was not carried out by IVA for the 2018 SMART survey or for the 2019 SMART survey. IVA was reluctant to take on this function that was perceived to be outside its TORs and beyond its technical capacity. Other IVA issues were related to lack of clarity on the timelines of the verification process.

c. M&E Utilization

M&E findings were used for Program monitoring and adjustments. Dissemination of survey results was mixed: the 2015 and 2018 National Nutrition and Health Surveys were disseminated to a wide range of audiences, while the 2019 survey was not disseminated because of data quality issues. Likewise, the 2016 NHFS was disseminated, while the 2019 survey was not. The ICR (p. 31) reported that M&E utilization was stymied to a certain extent by the issues encountered during implementation, but that M&E contributed to the move toward a results-based approach.

In view of overall M&E shortcomings, M&E quality is rated modest. In this context, the use of alternative sources of credible data and evidence, beyond the Program's M&E system, contributed to validate the efficacy of the Program, as discussed in section 4.

M&E Quality Rating

Modest

9. Other Issues

a. Safeguards

According to both PAD (p. 40) and ICR (p. 32), the Environmental and Social Safeguards Assessment (ESSA) found that the overall environmental impact of the Program was likely to be positive, owing to expectations of increased accountability, improved coordination across the health system, and strengthened health programs. The PAD noted that the Program would provide opportunities to enhance sanitation, hygiene, infection control, and waste management at health facilities while ensuring that there were no adverse impacts to the environment. The related Legal and Regulatory framework in Nigeria was found to be strong in terms of provisions for safeguarding the environment. Therefore, the focus of actions for environmental management was on increasing capacities at the PMU and sectoral institutions to implement regulations and early risk screening. Regular assessments were planned and carried out at the state level. There was compliance, and no major risks were encountered. However, the ICR reported that more could have been done to strengthen the environmental management system in terms of capacity, and noted that, at the federal level, there was no team to follow up on ESSA.

Key social issues were related to poverty and equity as well as access barriers to quality maternal, newborn and child health services. Although elements of Program design were focused on reaching the poor, the ICR reported that a greater focus on community engagement to help increase demand for services could have been envisaged. The ICR (p. 32) noted that the multi-stakeholder engagement approach to drive community outreach and MCH Weeks was weak, thus contributing to low awareness about available services at various health facilities. The PMU did not have officers dealing with social aspects. The PAD (p. 41) discussed the availability of the Grievance Redress System, but the ICR did not offer information on related experience.

b. Fiduciary Compliance

The ICR (p. 33) reported that financial management arrangements were satisfactory. However, two sets of issues were encountered:

The first was related to the late involvement of fiduciary staff from both sides (Bank and government counterparts). Initially, it was incorrectly assumed that using the government's systems under PforR implied that the fiduciary oversight was limited to the review of financial reports. The ICR suggested that an earlier involvement and closer participation could have led to better performance in conducting procurement audits per the PAP and better performance under DLI 5 (management and budgeting).

The second set of issues was related to the granular definition of the Program Expenditure Framework and which expenditures were subject to audit. As noted in section 7a, a detailed definition of the Program Expenditure Framework was deferred to the implementation stage. The World Bank Team and government counterparts worked collaboratively to prepare a detailed listing of Program expenditures. A substantial bundle of expenditures related to SOML was incurred by the National Primary Health Care Development Agency that was an autonomous body with financial governance independent of FMOH. The World Bank and FMOH agreed that related expenditures would be subject to audit, and past financial statements were

restated. The final audit for the Program, covering the period January 1, 2020 to May 31, 2021, was received by the World Bank on December 3, 2021. The auditors issued an unqualified opinion

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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10. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	
Bank Performance	Moderately Satisfactory	Moderately Satisfactory	
Quality of M&E	Modest	Modest	
Quality of ICR	---	High	

11. Lessons

The ICR (pp. 36-38) identified several lessons and recommendations, including the following lessons partially re-stated by IEG Review:

A meticulous delineation of Program boundaries can incentivize states to achieve more results. As SOML was a federal program, SOML PforR largely focused on federal-level expenditures. But a substantial part of the accountability for financing and delivery of primary health care services also resided at the state level. A more focused Program boundary with the inclusion of some key expenditures for the delivery of primary care services in the states could incentivize states to achieve more results and accountability.

In a large federal setting, technical assistance in support of the Program facilitates PforR implementation progress and complements the role of incentives and financing. The SOML PforR envisaged strong Program support in terms of technical assistance, but during early implementation, progress was disrupted by changes in leadership and withdrawal of technical support. Notable progress was observed only after putting in place a new program support entity that provided technical assistance and advocacy to the states. It would be reasonable to assume

that a more binding arrangement for the provision of technical assistance during the preparation phase itself would have contributed to more energetic implementation at the outset.

A realistic assessment of delivery readiness during preparation is key to addressing early implementation issues. Under the SOML Program, readiness was variable, with overestimated capacity in some areas. Advancing readiness in a realistic manner during preparation would have contributed to reducing delays in establishing institutional arrangements for Program implementation, such as for the intensive M&E surveys, Independent Verification Agency scope of functions, and facilitating the provision of technical assistance to the states.

Also, The Borrower's ICR (p. 70) identified the following lesson:

PforR can increase financial transparency at all levels. The Program had a robust system of financial flows where funds were domiciled in the Central Bank of Nigeria and administered by Remita platform, remitting end-to-end payments to beneficiaries with clear tracking of transactions. The release of funds was independent of officers of the Federal and State Ministries of Health who approved Program activities.

12. Assessment Recommended?

No

13. Comments on Quality of ICR

The ICR provided a thorough overview of the Program experience. Its narrative was very candid, accurate, aligned to development objectives, and supported the outcome rating and available evidence The analysis and evidence were aligned to the messages outlined in the ICR. The latter aptly identified shortcomings in DLIs design, implementation readiness, and M&E, where its discussion on the use of alternative sources of data was thorough. The ICR offered specific lessons derived from Program experience. It followed guidelines and was internally consistent, although it was lengthy and had occasional but relatively minor lapses in clarity.

a. Quality of ICR Rating

High