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Report No: PAD2762

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 156.5 MILLION
(US$225 MILLION EQUIVALENT)

AND A PROPOSED GRANT

IN THE AMOUNT OF US$7 MILLION
FROM THE GLOBAL FINANCING FACILITY

TO THE

FEDERAL REPUBLIC OF NIGERIA

FOR AN

ACCELERATING NUTRITION RESULTS IN NIGERIA PROJECT
May 23, 2018

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2018)

Currency Unit =	Special Drawing Rights (SDR)
SDR 0.69538128 =	US$1.00
US$ 1.44 =	SDR 1

FISCAL YEAR
January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

ADM	Accountability and Decision Making
ANC	Ante Natal Care
ANH	Adolescent Nutrition and Health
ANRiN	Accelerating Nutrition Results in Nigeria
BMGF	Bill & Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
BP	Bank Policy
CBN	Central Bank of Nigeria
CHOICE	Choosing Interventions that are Cost Effective
CIFF	Children's Investment Fund Foundation
CPF	Country Partnership Framework
CPS	Country Partnership Strategy
DA	Designated Account
DALY	Disability-Adjusted Life Year
DFH	Department of Family Health
DFID	Department of International Development
DHS	Demographic and Health Survey
DLI	Disbursement-Linked Indicator
EEP	Eligible Expenditure Program
ERGP	Economic Recovery and Growth Plan
FM	Financial Management
MBNP	Ministry of Budget and National Planning
FMOF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
FPFMD	Federal Project Financial Management Department
FPM	Financial Procedures Manual
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GIFMIS	Government Integrated Financial Management Information System
GoN	Government of Nigeria
GRC	Grievance Redressal Committee
GRS	Grievance Redressal Service
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IFC	International Finance Corporation
IFR	Interim Financial Management Report
ISA	International Standards on Auditing
ISR	Implementation Status and Results Report

IVA	Independent Verification Agency
IYCF	Infant and Young Child Feeding
KML	Knowledge Management and Learning
MDTF	Multi-Donor Trust Fund
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MoU	Memorandum of Understanding
NASSCO	National Social Safety Nets Coordination Office
NASSP	National Social Safety Nets Project
NBS	National Bureau of Statistics
NCTO	National Cash Transfer Office
NEC	National Executive Council
NGO	Non-Government Organization
NIFAA	Nigerian Inter Faith Action Association
NNHS	National Nutrition and Health Survey
NPHCDA	National Primary Health Care Development Agency
NSHIP	Nigeria State Health Investment Project
OAGF	Office of the Accountant General of the Federation
OAGS	Office of Accountant-General in each State
OP	Operations Policy
ORS	Oral Rehydration Solution
PA	Project Accountant
PANRiN	Partnership for Accelerating Nutrition Results in Nigeria
PDO	Project Development Objective
PFMU	Project Financial Management Unit
PHCs	Primary Health Care Centers
PIM	Project Implementation Manual
PRIMA	Portfolio and Risk Management
RMNCAH	Reproductive, Maternal, Neonatal Child and Adolescent Health
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SAM	Severe Acute Malnutrition
SBCC	Social and Behavior Change Communication
SCD	Systematic Country Diagnostic
SDG	Sustainable Development Goal
SMART	Standardized Monitoring and Assessment of Relief and Transition Methods
SMOF	State Ministry of Finance
SMOH	State Ministry of Health
SOE	Statement of Expenditures
SOML	Saving One Million Lives
SoN	Standards of Nigeria
SORT	Systematic Operations Risk-Rating Tool
SPFMU	State Project Finance Management Unit

SPHCDA	State Primary Health Care Development Agency
SP	Sulphadoxine/pyrimethamine
TFR	Total Fertility Rate
TOR	Terms of Reference
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WISE	Women's Initiative for Socio-Economic Engagement

BASIC INFORMATION

Country(ies)	Project Name	
Nigeria	Accelerating Nutrition Results in Nigeria	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P162069	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[✓] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
14-Jun-2018	31-Dec-2023

Bank/IFC Collaboration

No

Proposed Development Objective(s)

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.

Components

Component Name	Cost (US$, millions)
Basic Package of Nutrition Services	180.15

Stewardship and Project Management	44.85

Organizations

Borrower:	Federal Ministry of Finance
Implementing Agency:	Federal Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	232.00
Total Financing	232.00
of which IBRD/IDA	225.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	225.00
IDA Credit	225.00

Non-World Bank Group Financing

Trust Funds	7.00
Global Financing Facility	7.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Total Amount
National PBA	225.00	0.00	225.00
Total	**225.00**	**0.00**	**225.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2018	2019	2020	2021	2022	2023	2024

Annual	0.00	11.25	33.75	33.75	56.25	56.25	33.75
Cumulative	0.00	11.25	45.00	78.75	135.00	191.25	225.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Gender, Governance

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	High
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	High
6. Fiduciary	Substantial
7. Environment and Social	Low

8. Stakeholders	Substantial
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

To facilitate the carrying out of Part 1 of the Project, the Recipient, through FMOF, shall make a portion of the proceeds of the Financing available to each Participating State under a Subsidiary Agreement entered into between the Recipient and the Participating State, under terms and conditions acceptable to the Association.

Recurrent

Sections and Description

The Recipient shall and shall cause the Participating States to:

(a) implement the Project in accordance with the institutional, safeguards, financial management and procurement arrangements set out in this Schedule 2 to this Agreement;

(b) throughout the period of implementation of the Project as necessary, carry out assessment to determine whether the DLIs/DLRs have been met as detailed in the PIM; and

(c) furnish an assessment report together with all necessary supporting documents to the Association for its review.

Recurrent

Sections and Description

The Recipient shall through the FMOH cause the Participating States to carry out the Project activities in their respective states in accordance with the Health Care Waste Management Plan.

Recurrent

Conditions

Type	Description
Effectiveness	The Recipient must furnish an opinion acceptable to IDA, showing on behalf of the Recipient that the FA has been duly authorized or ratified by, and executed and delivered on behalf of the Recipient and is legally binding upon the Recipient in accordance with its terms.
Effectiveness	The GFF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled.
Effectiveness	At least one (1) Subsidiary Agreement, acceptable to the Association, has been executed on behalf of the Recipient and one Participating State; and the World Bank has received a legal opinion certifying that said Subsidiary Agreement has been duly authorized or ratified by the Recipient and the Participating State and is legally binding upon each such party in accordance with its term.
Effectiveness	The Recipient has, through the FMOH, adopted the Project Implementation Manual, in form and substance satisfactory to the Association.

Type	Description
Disbursement	No withdrawal shall be made under Category (2), unless and until the Recipient has furnished evidence satisfactory to the Association that: (i) payments for Eligible Expenditures Program have been made in accordance, and in compliance with the procedures set forth in the Recipient's applicable laws and regulations and the PIM; and (ii) the DLIs/DLRs set forth in Schedule 4 for which payment is requested have been met and verified in accordance with the PIM.

NIGERIA
ACCELERATING NUTRITION RESULTS IN NIGERIA

TABLE OF CONTENTS

I. STRATEGIC CONTEXT 9
A. Country Context 9
B. Sectoral and Institutional Context 10
B. Higher Level Objectives to which the Project Contributes 16
II. PROJECT DEVELOPMENT OBJECTIVES 17
A. PDO 17
B. Project Beneficiaries 17
C. PDO-Level Results Indicators 18
III. PROJECT DESCRIPTION 18
A. Project Components 18
B. Project Cost and Financing 25
C. Lessons Learned and Reflected in the Project Design 26
IV. IMPLEMENTATION 28
A. Institutional and Implementation Arrangements 28
B. Results Monitoring and Evaluation 30
C. Sustainability 32
V. KEY RISKS 33
A. Overall Risk Rating and Explanation of Key Risks 33
VI. APPRAISAL SUMMARY 35
A. Economic and Financial (if applicable) Analysis 35
B. Technical 38
C. Financial Management 38
D. Procurement 39
E. Social (including Safeguards) 40
F. Environment (including Safeguards) 41
H. World Bank Grievance Redress 41
VII. RESULTS FRAMEWORK AND MONITORING 43

ANNEX 1: DISBURSEMENT LINKED INDICATORS, MILESTONES AND CUMULATED ALLOCATED AMOUNTS 87

ANNEX 2: NUTRITION INTERVENTIONS FINANCED BY THE PROJECT 96

ANNEX 3: IMPLEMENTATION ARRANGEMENTS 97

NATIONAL NUTRITION PROGRAM IN NIGERIA 113

I. STRATEGIC CONTEXT

A. Country Context

1. **The 2015 elections marked, for the first time in Nigeria's history, a peaceful democratic transfer of power between two political parties, but the new administration faced a fast-deteriorating macroeconomic environment.** The Gross Domestic Product (GDP) growth fell from 6.3 percent in 2014 to 2.7 percent in 2015, and to negative 1.6 percent in 2016, bringing Nigeria's first full-year of recession in 25 years. In 2016, global oil prices reached a 13-year low and oil production was severely constrained by vandalism and militant attacks in the Niger Delta. While the oil sector represents only 8.3 percent of total GDP, it provides the majority of foreign exchange (FX) earnings and three-quarters of government revenues. The decline in FX earnings from oil exports, compounded by Central Bank of Nigeria's (CBN) introduction of several FX allocation/utilization rules that restricted access to FX at the official market rate, had significant negative spillover effects on non-oil sectors dependent on FX to import inputs and raw materials.

2. **Fiscal revenues at all levels of Government were severely hit by the decline in oil revenues.** Total government revenues, which were already low at 10.3 percent of GDP in 2014, declined to 5.9 percent of GDP in 2016. The decline in government revenues would have been less if oil revenues were converted at a higher rate than the official NGN 305 per US dollar. Although recurrent spending was rationalized and capital budgets were under-executed, the consolidated government fiscal deficit widened from 1.2 percent in 2014 to 3.9 percent of GDP in 2016. While the total public debt-to-GDP ratio remained low (17.3 percent of GDP at the end of 2016), interest payments-to-revenue ratio[1] for the Federal Government increased to 61 percent in 2016.

Table 1: Selected economic indicators, 2014-2018

	2014	2015	2016	2017 e	2018 f
Real GDP growth, at constant market prices (percent)	6.3	2.7	-1.6	0.8	2.1
Private consumption (percent)	0.6	1.5	-5.7	-0.8	0.6
Government consumption (percent)	-7.0	-11.9	-15.1	1.9	19.5
Gross fixed capital investment (percent)	13.4	-1.3	-5.0	0.9	1.2
Exports, goods, and services (percent)	24.1	0.1	11.5	1.0	6.0
Imports, goods, and services (percent)	6.0	-25.7	-10.4	-11.6	14.8
Real GDP growth, at constant factor prices (percent)	6.2	2.8	-1.6	0.8	2.1
Agriculture (percent)	4.3	3.7	4.1	3.4	3.5
Industry (including oil) (percent)	6.8	-2.2	-8.9	2.2	3.8
Services (percent)	6.8	4.8	-0.8	-0.9	0.8
Inflation (Consumer Price Index) (percent)	8.1	9.0	15.7	16.5	14.5
Fiscal balance (consolidated government, percent of GDP)	-1.2	-3.2	-3.9	-4.4	-4.0

[1] Total Revenue differs from Federal Government of Nigeria's computations due to World Bank excluding irregular items considered revenue by FGN but financing by the World Bank. The Federal Government's estimate of debt service (including amortization) to revenue ratio is estimated at 47 percent by FGN for 2016.

Government Revenue	10.3	7.5	5.9	6.2	7.3
Government Expenditure	11.5	10.7	9.8	10.7	11.3
Debt (consolidated government, percent of GDP)	12.5	14.2	17.3	19.1	20.4
Poverty rate (US$1.9/day purchasing power parity terms)	46.8	46.8	48.4	49.2	49.3
Poverty rate (US$3.1/day purchasing power parity terms)	72.9	72.9	73.9	74.6	74.7

Source: National Bureau of Statistics and World Bank staff projections.

3. **The Nigerian economy emerged from recession with GDP growth of 0.8 percent in 2017.** The recovery was driven by higher oil prices and production. Agriculture and non-oil industry grew by 3.4 percent and 0.6 percent, respectively. However, services, which account for over half of GDP, continued to contract (-0.9 percent). Unemployment increased in 2017 to 18.8 percent of the labor force, with a further 21.2 percent underemployed in Q3. Inflation remained sticky at just below 16 percent, despite monetary tightening from the Central Bank. The parallel exchange rate premium vis-à-vis the official exchange rate remains stable at just under 20 percent. Total government revenues performed below expectations as oil revenues remained below pre-crisis levels and non-oil revenues largely stagnated in the absence of significant tax reforms, leading to a larger than planned general government fiscal deficit of 4.4 percent.

4. **The recovery is expected to be slow, largely oil driven, and thus susceptible to oil production disruptions and oil price shocks**. Real GDP growth is estimated to reach just over 2 percent in the World Bank's baseline growth scenario. Oil production is expected to remain above 2 million barrels per day in the medium term, but below the Government's projections. Output growth in the agricultural sector is expected to remain positive but below its potential due to ongoing conflicts. Non-oil industry and services are expected to grow only slowly due to subdued consumer and investment demand. Fiscal sector outcomes will be subject to considerable uncertainty and the need for fiscal adjustment at all levels of Government remains.

5. **The Government launched the National Economic Recovery and Growth Plan (ERGP) for the period 2017-2020 in March 2017.** The ERGP sets out to restore macroeconomic stability in the short-term and to undertake structural reforms, infrastructure investments and social sector programs to diversify the economy and set it on a path of sustained inclusive growth over the medium- to long-term. The priority areas of action under the ERGP are: stabilizing the macroeconomic environment; achieving agriculture and food security; ensuring energy sufficiency in power and petroleum products; improving transportation infrastructure; and driving industrialization through focus on small- and medium-scale enterprises. The ERGP has the ambitious target of 7 percent real GDP growth by 2020, initially driven by the oil sector and then increasingly by strong non-oil sector growth. To increase growth above the baseline of 2 percent will require effective implementation of the structural reforms in the ERGP and a strengthened macroeconomic framework.

B. Sectoral and Institutional Context

6. **Nigeria has very high rates of malnutrition that are unevenly spread across the country. Stunting, a measure of chronic malnutrition, and micronutrient deficiencies generate the highest burden.** Stunting rates have not changed considerably since 2008, indicating a long-term nutritional problem in the country. Two out of every five (44 percent) children under five years of age suffer from chronic malnutrition. This translates into 14.5 million Nigerian children at risk of either dying or not developing to their full potential.

Micronutrient deficiencies– mainly in vitamin A, iodine, iron, folic acid and zinc – are a serious problem and despite their high cost-effectiveness, coverage rates of micronutrient supplementation and fortification remain generally low. It is estimated that 30 percent of Nigerian children and 20 percent of pregnant women are vitamin A deficient, while 76 percent of children and 67 percent pregnant women are anemic. The national rate of acute malnutrition has decreased over the last few years from a high of 18 percent in 2013 to 3 percent in 2017.

7. **The "nutrition map" of Nigeria is highly uneven**. Nine of the North East and North West States have rates of child stunting that exceed 50 percent, whereas some other States in the South have rates of child stunting as low as 17 percent. The gap in stunting between the North and South is widening due to several reasons. Increasing disparities in socio-political stability (armed insurgency in the North East; militant attacks on oil and gas infrastructure in the Niger Delta, and conflict between farmers and pastoralists in the Sahel region) has resulted in stagnating poverty rates in the North East and North West zones, which reflects the growing gap in socio-economic indicators and economic opportunities between the northern and southern geo-political zones. The number of poor people residing in the North East and North West zones increased from 29 million to 37 million between 2004 and 2013. Significant gender gaps in education levels of parents and child schooling (attendance rates and completion) between the northern and southern states, especially lower levels of women's education have further exacerbated the issue. Curtailed female agency and decision making in the household coupled with high fertility rates of 7.26 and 6.35 in the North West and North East regions as compared to less than 4.5 in the Southern zones of the country has contributed to poor maternal, infant and young child feeding and caring practices and therefore, the inter-generational cycle of stunting. Stunting in the North West has been consistently *increasing* between 2008 and 2015 whereas the states of the South West and South East have recorded consistent decreases in stunting.

8. **Most of the largely irreversible damage from chronic malnutrition in Nigeria, as in other countries, happens during the "first 1000 days," which is the period from conception to the child's second birthday.** From 6 months of age until two years of age is when most children fall behind. This significant deterioration in nutrition status can be reduced by focusing on a set of well proven interventions, notably appropriate infant and young child feeding (e.g., breastfeeding, complementary feeding), healthy sanitation behaviors (e.g., handwashing before preparing meals and feeding children), prevention and, when necessary, appropriate treatment of diarrhea, and ensuring adequate intake of essential vitamins and minerals through food fortification and supplementation. These are inexpensive and cost-effective interventions that can be scaled-up relatively rapidly, thus not only boosting children's chances of survival, but enabling them to fully develop their cognitive functions and prepare them to be active learners and contributors to economic growth. Most of the damage caused by malnutrition (see section on "consequences" below) is largely irreversible later in life and, conversely, once the benefits from early nutrition are captured by young children, they carry these benefits with them the rest of their lives.

9. **Children from the poorest quintiles are much more likely to be stunted, but poverty per se is not the only driver of malnutrition.** Half of the children in the bottom two quintiles (poorest 40 percent of households) are stunted (54 percent in lowest quintile and 46 percent in second lowest quintile). However, it is important to note that stunting rates are high even in the highest income quintile (26 percent in the second highest quintile and 18 percent in the highest quintile).[2]

[2] Demographic Health Survey, 2013.

10. **There are no significant differences in Nigeria in stunting rates between girls and boys.** However, there is significant gender inequality in other spheres that affects women's and children's health and nutritional status. At 152th place out of 188 countries, Nigeria ranks near the bottom of the UNDP's 2016 Gender Equality Index. Nigeria has 2 percent of the world's population but 10 percent of global maternal deaths. Gender disparities in education are significant and are particularly concentrated in the rural North, where 34 percent of primary school-age rural girls are out of school compared with 25 percent of boys. Women's lower status in the household is a strong determinant of their nutritional status and that of all children in that household. Adolescents and women who are significantly younger than their husbands, those with lower levels of education, and those with less access to, and control over, resources are particularly disempowered. Increasing women's agency, defined as "the ability to make choices and to transform them into desired actions and outcomes," combined with knowledge of good practices and the resources to implement them, is thus a key pathway to improved nutrition.

11. **Out-of-school rates are higher among girls in rural areas and among the poorest in society.** At the national level, the out-of-school rate increased from 24 percent in 2010 to 30 percent in 2013 and remained highest in 2013 among girls (32 percent versus 28 percent among boys), in rural areas (41 percent versus 11 percent in urban areas), and among the poorest (72 percent for the poorest quintile versus 3 percent for the wealthiest). Though there are out-of-school children throughout Nigeria, broadly speaking, most out-of-school children in the North never attended school, while in the South most dropped out of school. In addition to low and inequitable access, the quality of basic education, measured in terms of student learning outcomes, is low in Nigeria. According to international standards, children who have completed grade 3 are expected to be fully literate. Yet, in Nigeria only 66 percent of public school students can read at least one of three words and 78 percent can add single digits after completing grade 4.[3] The GoN also recognizes that women's empowerment is critical to achieving inclusive growth and addressing malnutrition. A separate project, Nigeria for Women Project (P161364) is currently being developed for World Bank financing. The Project aims to empower women and would be nutrition-sensitive.

12. **Chronic malnutrition in Nigeria is the result of three main categories of factors**: (i) inadequate access to nutrition and health services, including family planning services; (ii) inappropriate caring practices and poor environment for young children and for women during pregnancy; and (iii) insufficient and poor quality food. Access to health services remains low and inequitable. For example, only 30 percent of children with diarrhea were taken to a health facility or provider and 21 percent of children received no treatment at all.[4] The high fertility rate and high rate of adolescent pregnancies also contribute to chronic malnutrition. The total fertility rate in Nigeria is 5.5 births per woman. Twenty-three percent of women age 15-19 have already begun childbearing and about one-third (32 percent) of women age 20-49 have given birth by age 18.

13. **Improving child nutrition, especially is the first 1000 days, and improving adolescent health is critical for addressing the World Bank twin goals of reducing poverty and boosting shared prosperity.** At the individual level, chronic malnutrition in children is estimated to reduce potential lifetime earnings by at least 10 percent.[5] Other studies have shown that a 1 percent loss in height results in a 2 to 2.4 percent loss

[3] NEDS, 2015
[4] Demographic Health Survey, 2013.
[5] World Bank, 2006

in productivity.[6] The economic costs of undernutrition have the greatest effect on the most vulnerable in the developing world. A recent analysis estimates these losses at 4 to 11 percent of GDP in Africa and Asia each year[7]—equivalent to about US$149 billion annually. Most of those losses are due to cognitive deficits. As developing countries move from manual labor-based economies to ones based on skilled labor requiring high mental capacity, the negative impacts of child malnutrition and stunting on incomes, inequality and economic growth will likely increase further. Malnutrition, particularly in young children, leads to increased mortality: undernutrition is an underlying cause for approximately half of under-five mortality and one-fifth of maternal mortality in Nigeria. It is estimated that Nigeria loses over US$1.5 billion in GDP annually to vitamin and mineral deficiencies alone. At the same time, nutrition interventions are consistently identified as among the most cost-effective development actions.

14. **More than four in ten girls marry before the age of 18 in Nigeria**. Twenty-eight percent of women ages 18-22 have their first child before the age of 18. In some countries, early childbirth may take place outside of marriage. In Nigeria, however, early childbirth is in most cases a direct consequence of child marriage. Early marriage is closely associated with early school drop-out, early sexual activity, high lifetime fertility, and low contraceptive use. Adolescent girls in poor rural households are often restricted in their mobility, socially isolated, have access to fewer income-generating opportunities and are less likely to make the transition to secondary school than their male counterparts. Poor parents often see marriage as a way to keep their daughters safe. Modern contraceptives are rarely used by married adolescents. The use of family planning is low amongst married women in general in Nigeria (10.8 percent). It is particularly low amongst married adolescents (1.8 percent)[8] and the mean ideal family size remains high. In addition to low overall contraceptive use, the Nigerian family planning market is oriented to short-term and less effective methods, in which male condoms currently make up 40.2 percent of the mix.

15. **Adolescents in Nigeria must be reached with nutrition and health interventions to break the inter-generational transmission of stunting from mother to child.** Adolescent girls, when pregnant, require extra nutrients for their still-growing bodies, as well as for their growing fetuses. The competition for nutrients between the adolescent mother and her child puts the mother at risk for undernutrition, leading to higher risk of maternal mortality, morbidity and adult anemia, while also placing the offspring at a higher risk for mortality (neonatal, infant and under five years), morbidity (onset and severity or illness) and low birth weight, stunting and other forms of malnutrition, including low micronutrient stores, as compared to adult pregnancies. Stunted children have a greater risk of poor cognitive development and children of adolescent mothers are further disadvantaged in terms of cognitive development, leading to poorer learning outcomes than other children and higher poverty rates in adulthood. Adolescent mothers are also at higher risk of obstetric fistula and obstructed labor (since their bodies have not developed enough yet to go through childbearing) and related maternal morbidity or death. Nutrition-specific interventions need to be targeted at adolescents in a way that addresses the specific constraints they face when accessing services. There is a growing body of evidence that shows that stunting can be reduced by eliminating teenage pregnancy and increasing birth intervals. Interventions should not only reach the adolescent girls but also involve their influencers (e.g., mothers and grandmothers, boys, family members, religious and traditional leaders).

[6] Horton and Steckel, 2013; Caulfield et al. 2004; Strauss and Thomas 1998
[7] Horton and Steckel 2013
[8] Multiple Indicator Cluster Surveys, Household survey, MICS (2016/17)

16. **Nigerian children are not being exclusively breastfed or given appropriate complementary foods at the right ages.** WHO recommends that children should receive nothing but breast milk during the first six months of life. Currently, only 24 percent of children under six months in Nigeria are being exclusively breastfed. Starting at six months, children should receive a diversified and nutrient-rich diet, and be actively fed several times a day. However, only 40 percent of children are receiving foods from four or more food groups daily and 42 percent are receiving the minimum number of meals. In most cases, these poor feeding practices are not primarily caused by food insecurity because the quantities of food required by young children are small. It is rather a question of inadequate knowledge and beliefs about how children should be fed.

17. **Nigeria has considerable food security challenges; however, these are less of a determinant of poor nutritional outcomes than the lack of access to diverse and micronutrient-rich foods.** Available data showed that total average expenditure on food by households between 2009 and 2010 was about 65 percent.[9] The food distribution system in Nigeria remains largely inefficient due to factors such as crop seasonality, inadequate storage technology and facilities, inadequate transport and distribution systems, as well as market information. These factors create considerable spatial and seasonal variation in food production and availability and are responsible for considerable variations in food prices across the country. However, given that half of the households even in the poorest quintiles have been able to raise children who are not stunted and that children require only small quantities of food, it is unlikely that access to sufficient quantities of food is a main driver of malnutrition in Nigeria. A key food security challenge for many Nigerians is to ensure that they have adequate vitamins and minerals in their diets, including ensuring that the diets of children 6-24 months are diverse and micronutrient-rich.

18. **The Government of Nigeria has identified investing in people as a strategic priority in its Economic Recovery Growth Plan (ERGP, 2017-2020).** The plan envisages investment in health and education, as a core pathway for human capital development and an essential catalyst in the revised growth story of Nigeria. GON looks to achieving its growth potential by sharply targeting the poorest and the most vulnerable members of the society with programs and opportunities for inclusive and sustained growth. This was affirmed during the meeting of the National Economic Council (NEC) of Nigeria,[10] by its Chair, the Vice President of Nigeria and several political and thought leaders from the federal and state levels. Leading this agenda, the Government is reaching out for evidence and experience available with key stakeholders including donor partners, private sector and civil society organizations to inform its strategies and programs for development of human capital.

19. **The Federal Government approved and launched a multi-sectoral National Policy on Food and Nutrition in Nigeria in September 2016.** This policy provides the framework for addressing Nigeria's malnutrition challenges from the individual, household, community and up to the national level. It recognizes that a range of sectors needs to play their specific roles to resolve this complex development challenge, and specifically covers health, agriculture and rural development, women's affairs and social development, education, as well as National Social Safety Nets Coordination Office (NASSCO) and National Cash Transfer Office (NCTO) under the office of the Vice President of Nigeria for social protection. However, it remains to be implemented at scale in a coordinated manner.

[9] National Bureau of Statistics, 2012
[10] National Executive Council Meeting, March 22, 2018

20. **The health sector has taken the lead in developing its sector-specific plan to address malnutrition.** The "National Strategic Plan of Action on Nutrition" sets out costed, nutrition-specific interventions with measurable targets to be achieved at scale between 2014 and-2019. The National Health Act provides increased funding and political support for primary health care and was signed into law by the President of Nigeria in December 2014. The Act specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS), which includes basic nutrition services. Nigeria has strong guidelines and regulations to enable the provision of necessary micronutrients. All the guidelines and regulations to enable the provision of key interventions such as micronutrient supplements (Vitamin A, iron, and zinc) and food fortification to be scaled-up exist in Nigeria, either under the leadership of the Federal Ministry of Health (FMOH) or of the Standards Organization of Nigeria within the Ministry of Trade and Investment. To date, financing has not been sufficient to implement the guidelines and regulations.

21. **The Ministry of Agriculture has also developed its sector-specific plan to address malnutrition. This will constitute that sector's contribution to implementing the multi-sectoral National Food and Nutrition Policy.** The GoN in its new strategy called Green Alternative has prioritized nutrition-sensitive agriculture for investment. The World Bank agriculture sector operations are focusing on nutrition-sensitive interventions.

22. **Nigeria is in the process of developing a national safety net program which aims to be nutrition-sensitive.** In the short term, this new program offers the potential to target the poorest with information on nutrition-related behavior change along with cash transfers. It also may eventually be used as a means for sectors such as health and agriculture to target and tailor their interventions to the poorest. This targeting is important given that the rates of stunting are considerably higher in the poorest quintiles.

23. **The education sector also has an important role to play in addressing malnutrition.** One of the determinants of child malnutrition is the education level of the child's mother. Initiatives to increase the education levels of adolescent girls have a clear impact on the nutritional status of the children they may have in their adult years. Schools can also serve as platforms to increase community knowledge about malnutrition, through extra-curricular activities that position teachers and children as agents of change (e.g., hand washing campaigns) and through the curriculum. Nigeria for the past year has been implementing a World Bank-financed program for results operation that focuses on basic education. This will be a good platform to introduce more nutrition-sensitivity into Nigeria's primary school system.

24. **Nigeria has a large, vibrant private health sector which provides access to some services that otherwise would not be available**. The private sector plays an important role in the financing and delivery of basic primary health services especially for reproductive, maternal, neonatal, child and adolescent health (RMNCAH) and nutrition services. Private sector capabilities, expertise, resources, reach and innovation can be leveraged to accelerate improvement in nutrition outcomes in Nigeria. Involvement of the private sector can be leveraged, inter alia, through performance-based contracts.

25. **Current financing for nutrition in Nigeria is provided primarily by donors and programmed outside of the budget.** The Federal Government has a budget line for nutrition within the FMOH but it is poorly financed and focused mainly on relatively small-scale capacity building activities. Some State governments have started investing their own resources but this financing remains far from sufficient and is used mainly to address severe acute malnutrition. In recent years, an increasing number of donors have prioritized

nutrition, notably the African Development Bank, the Bill & Melinda Gates Foundation, the Children's Investment Fund Foundation, the Dangote Foundation, the European Union, the United Kingdom/Department of International Development, the United States Agency for International Development (USAID) and the World Bank. With some exceptions, most of the financing to date has focused on addressing the most visible "tip of the iceberg" emergency nutrition through the treatment of severe acute malnutrition. Some World Bank-financed projects, especially in agriculture, health and social protection, have increased their nutrition sensitivity in recent years; these operations largely focus on the prevention of chronic malnutrition. A mapping of financial resources for nutrition was carried out as part of project preparation to avoid overlaps and assist in setting performance targets. The findings indicate donor investments of over US$260 million for addressing malnutrition in Nigeria between 2018-2022, of which approximately US$46.7 million is invested in nutrition specific interventions and US$6 million in nutrition sensitive interventions in the twelve states identified for implementation of ANRiN. Overall, the available financing is far from reaching the levels needed to generate a significant reduction in stunting and thus there exists a financing gap that will be partially covered by this project.

B. Higher Level Objectives to which the Project Contributes

26. **The higher-level goal to which this project will contribute is to reduce chronic malnutrition (stunting and micronutrient deficiencies) to reduce maternal and child mortality rates and, over time, increase school completion and performance and improve labor force productivity.** In doing so, the project will contribute to the GON's focused Economic Recovery and Growth Plan (2017-2020), which commits to inclusive human capital development to spur economic growth. Evidence from other countries shows that the rate of reduction of chronic malnutrition can be accelerated by scaling up the interventions proposed in this project. This is a long-term (i.e., 15-20 year) process that requires sustained commitment. The current project is thus a "first slice" of this long-term engagement. Annex 4 provides additional details on a possible phasing of the long-term engagement.

27. **The project will contribute to the advancement of three of the Sustainable Development Goals (SDGs) in Nigeria.** It will contribute to SDG 1 (End poverty) by enabling adults to be more productive in the short term (increased iron intake) and by enabling children's brains to develop more fully, leading to more productive lives and lower risk of poverty later in life. The project will also contribute to SDG 2 (Ending hunger, achieving food security and improve nutrition) through its focus on improving the quality of the diet (increased micronutrient intake) and through overall reductions in child stunting. The project will also contribute to SDG 3 (Ensure healthy lives and promote well-being at all ages) because well-nourished children and women are less likely to be sick and face a lower risk of mortality, and adolescent girls will benefit from reduced fertility at a young age.

28. **The project has been designed to contribute directly to Nigeria's National Policy on Food and Nutrition in Nigeria by scaling up some of the key interventions outlined in the policy.** The project will contribute specifically to the health sector aspects of the Policy, as outlined in the National Strategic Plan of Action on Nutrition, which sets out costed, nutrition-specific interventions with measurable targets to be achieved at scale between 2014 and 2019. The project also supports the implementation of the 2014 National Health Act which provides increased funding and political support for primary health care. The act specifies that all Nigerians shall be entitled to a BMPHS, which includes basic nutrition services.

29. **The project supports the first two pillars of the Country Partnership Strategy (CPS) that guide the World Bank-financed portfolio in Nigeria, notably: (a) promoting diversified growth and job creation by reforming the power sector, enhancing agricultural productivity, and increasing access to finance; and (b) improving the quality and efficiency of social service delivery at the state level to promote social inclusion.** Good nutrition in the first 1000 days of life is essential for children to develop the learning ability that will enable them to perform well in school and thus acquire the skills needed to be productive participants in the economy in their adult years. A strong human capital base is essential for diversified growth – including to increase agricultural productivity – and an inclusive jobs strategy. The project will also contribute to the second pillar by improving the quality and efficiency of the delivery of nutrition services in health facilities as well as at the community level, through innovative results-based financing approaches. The project is designed to address social inclusion by targeting the poorest households, particularly women and the most vulnerable, with services that will increase their capacity, thus enabling them to work their way out of the poverty trap.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

30. The proposed Project Development Objective (PDO) is 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. Nutrition services related to infant and young child feeding behavior change (breastfeeding and complementary feeding) and the related provision of micronutrient powders will target children under two years.

B. Project Beneficiaries

31. **The project will improve the lives of direct beneficiaries in select States by increasing access to a package of nutrition interventions that will be provided to pregnant and lactating women and children less than five years of age, with a focus on the "first 1000 days" period from conception to the child's second birthday.** Specific measures will be taken to ensure that adolescent girls and their children have access to these interventions. In one of the twelve States additional focus will be given to providing services to increase birth spacing to adolescent girls.

32. **Indirect project beneficiaries will include individuals who influence women, adolescent girls and children to utilize the nutrition services financed by the project and who influence nutrition-related behaviors in households and communities.** These indirect beneficiaries include husbands/fathers/sexual partners, mothers and grandmothers, as well as religious and traditional leaders. Public servants in the FMOH, National Primary Health Care Development Agency (NPHCDA), Federal Ministry of Finance (FMOF), Ministry of Budget and National Planning (MBNP) and relevant ministries, departments and agencies at the state level, who are responsible for policy and service delivery at all levels of the health system in Nigeria will also benefit through capacity development aspects of the project. Staff from non-state actors who will implement the performance-based contracts will also benefit through increased experience in implementing programs at scale.

C. PDO-Level Results Indicators

33. **Progress against the PDO would be measured by the following indicators (see Annex 1):**
    - Infants 0-6 months exclusively breastfed (proportion)
    - Children 6-24 months who receive micronutrient powders as part of complementary feeding
        - Of which, children of adolescent girls
    - Children 6-59 months who receive zinc and Oral Rehydration Solution (ORS) as treatment for diarrhea (proportion)
        - Of which, children of adolescent girls
    - Children 12-59 months dewormed twice a year
        - Of which, children of adolescent girls
    - Pregnant women who consume a minimum of 90 iron-folic acid tablets (proportion)
        - Of which, adolescent girls
    - Pregnant women who receive intermittent presumptive treatment for malaria [at least three doses] (proportion)
        - Of which, adolescent girls

III. PROJECT DESCRIPTION

A. Project Components

34. **The project is designed to achieve a balance between the urgent need to protect Nigerian children from the devastating and lifelong effects of stunting through the scale-up of cost-effective interventions, and the importance of strengthening systems in Nigeria to plan, finance, deliver and monitor such interventions.** The project is thus designed to harness all available capacity to deliver interventions, including in the not-for-profit and for-profit non-state actors while ensuring that the government is in a leadership position and that its capacity in key areas such as information systems, research, and behavior change communication is strengthened. The project is primarily focused on actions within states, which are aligned with a set of key actions at the federal level to enable delivery at the state level and enhance sustainability.

35. **Component 1 comprises the largest part of the project; it focuses on delivering a set of core nutrition interventions within selected States, mainly through performance-based contracts with non-state actors working in communities and through disbursement linked indicators (DLIs) that will incentivize results to be achieved through government delivery channels.** Component 2, in addition to financing the project management functions, also focuses on critical stewardship functions at the national level which will be aligned and will facilitate delivery within States and will put in place key building blocks of a national nutrition system.

Component 1: Basic Package of Nutrition Services (IDA US$180.15 million, GFF US$5.6 million)

36. **The objective of this component is to scale up a basic package of nutrition-related interventions in the following 12 States: Abia, Akwa Ibom, Gombe, Kaduna, Kano, Katsina, Kogi,**

Kwara, Nasarawa, Niger, Oyo, and Plateau. These States, which account for over 6.7 million (41 percent) of the 14.5 million stunted children in Nigeria, were selected through a transparent process based on the burden of stunting in each of the six geo-political zones of Nigeria and other factors such as state willingness to borrow IDA funds for nutrition, availability of state costed strategic plans for nutrition and commitment of state financial resources to these plans.

37. **All 12 targeted States will scale up the following package of services, with a focus on reaching adolescent girls and their children:**

a. Behavior change communications to improve infant and young child feeding behaviors, namely, early and exclusive breast feeding (0-6 months) and appropriate complementary feeding (6-23 months).
b. Provision of micronutrient powders to children 6-23 months to improve the quality of the food provided for complementary feeding.
c. Iron/folic acid supplementation for pregnant women, with a focus not only on provision to women but also counselling to improve compliance.
d. Intermittent presumptive treatment for malaria to pregnant women.
e. Zinc and ORS for treatment of diarrhea in children 6-59 months.
f. Vitamin A supplementation twice a year for children 6-59 months.
g. Deworming twice a year for children 12-59 months.

38. **All 12 targeted states will also each commission at least two innovative nutrition service delivery pilots to expand the body of knowledge on interventions and on new implementation modalities.** These pilots will be embedded into the performance-based contracts and will focus on the critical first 1000-days period from conception to the child's first two years, they will be designed to be cost-effective and scalable and they will be closely monitored and robustly evaluated.

39. **A sub-set of the participating states may allocate up to 15 percent of their state's project envelope to finance the delivery of services to treat severe acute malnutrition (SAM) in children 6-59 months**. These resources for treatment of severe acute malnutrition will serve exclusively as government's contribution to financing for existing programs for treatment of SAM. The government's contribution from this project will not exceed 20 percent of the SAM project value for the period during which the financing is to be provided.

40. **The same 12 states will specifically target adolescent girls to provide nutrition services before, during and after pregnancy, both to the adolescent girls and to their children.** Particular attention will be given to the additional nutritional requirements of adolescent girls who are lactating. In one of the 12 states, focus will be given to birth spacing among adolescent girls through performance-based contracts with non-state actors. A review of global and Nigerian evidence on programs to improve adolescent health has been carried out during the project and will guide the design and delivery of this pilot. The selection of the non-state actor to deliver these services will be contingent on the strength of evidence for approaches proposed along with the operational feasibility in the Nigerian/state context. Experience gained in this large-scale pilot will be shared with other states as the project is implemented and it is anticipated that future phases of the project would scale up these interventions to other states.

41. **The project will be implemented through a combination of DLI- and performance-based contracts.** The DLIs will incentivize government delivery channels to focus on the following results areas: (i) improved coordination of development partners who are active in the states; (ii) sharper focus on nutrition during ante-natal visits in facilities (specifically provision and counselling on iron folic acid tablets during pregnancy, counselling on early and exclusive breastfeeding and provision of presumptive intermittent treatment for malaria), and (iii) strong management of the performance-based contracts as per agreed standards.

42. **There is interest for and experience to deliver public goods through performance-based contracts with non-state actors in Nigeria.** The IDA-financed Nigeria Malaria Control Booster Project in 2011 contracted the Nigerian Inter-Faith Action Association through a performance based contract to support social mobilization activities in seven states for prevention and early treatment of malaria, with encouraging independently verified results. Similarly, USAID has recruited NGOs for service delivery in the health sector, demand creation and for monitoring and evaluation in several states. A consultation to assess the interest of non-state actors to deliver nutrition services through the project, demonstrated strong interest with over 39 international and local firms participating.

43. **Each of the 12 targeted States will divide its territory in two to three discrete areas, each of which will be assigned through a performance-based contract, to a non-state actor who will be selected through a competitive process to deliver the following services**:

a. Behavior change communications to improve infant and young child feeding behaviors, namely, early and exclusive breast feeding (0-6 months) and appropriate complementary feeding (6-23 months).
b. Provision of micronutrient powders to children 6-23 months to improve the quality of the food provided for complementary feeding.
c. Iron/folic acid supplementation for pregnant women, with a focus not only on provision to women but also counselling to improve compliance.
d. Intermittent presumptive treatment for malaria to pregnant women.
e. Zinc and ORS for treatment of diarrhea in children 6-59 months.
f. Vitamin A supplementation and deworming to children 6-59 months and 12-59 months twice per year respectively.
g. One nutrition service delivery innovation pilot per non-state actor.

44. These services were selected based on a determinants analysis and on national and international evidence of the most cost-effective nutrition services that should be scaled up on a priority basis. They were prioritized as part of the costing assessment carried out by the World Bank in 2014 at the request of the government. They are all included in the national nutrition strategic plan and are all currently at very low rates of coverage (see results framework baseline figures and Annex 2). The non-state actors will be incentivized to attain coverage rates established for each of the states over and above current baselines. A range of cost-effective approaches could be used to achieve these results (e.g., community-based growth monitoring and promotion, positive deviance, strengthening the capacity of health outreach workers). Given the discrete geographic areas assigned to for each contract, coordination in a given area between two non-state actors is not anticipated. However, the non-state actors may collaborate/coordinate amongst themselves in the procurement and supply of commodities for improved cost efficiencies with economies of scale.

45. To enhance sustainability and facilitate behavior change, a strong focus will be given in the performance-based contracts to community ownership and empowerment, and community-based service delivery.

46. **In one of the 12 States, two additional performance-based contracts with non-state actors will introduce specific interventions to counsel adolescent girls on health and nutrition; and provide quality services to married adolescents to enable birth spacing.** This pilot seeks to improve the nutritional status of the adolescent girl and her future children and will build on existing experience in Nigeria where such services have been delivered by non-State actors. The project will enable the government to test at large scale the contracting of non-State actors to deliver these services. Through a contract with a specialized non-state actor, religious and traditional leaders will be engaged in creating an enabling environment for the interventions among target communities. Rigorous implementation research methods will be employed to assess the performance of these pilots to inform possible scale up to other states.

47. **Performance-based contracts will be signed with these non-state actors; these contracts will be managed on the basis of the pre-agreed results targets and following Government of Nigeria guidelines.** Various modalities were considered and performance-based contracts were selected because: i) many of the services are best delivered at community level and there exists considerable experience amongst non-State actors in Nigeria to deliver such services; ii) various previous attempts to work solely through capacity building of community health extension workers (CHEWS) in Nigeria have not worked; iii) there is compelling evidence from Nigeria (malaria) and other countries (Afghanistan, Senegal) that performance-based contracts can deliver results in an equitable manner. Various consultations with non-State actors during project preparation indicate that there is considerable interest from international and national firms to bid for these contracts. The performance-based contracts will be procured and managed following the World Bank's Procurement Regulations. Consortia will be allowed to bid, to ensure that the full skills set will be available for effective delivery. While the non-state actors will be empowered to select the approach(es) they judge appropriate to achieve the agreed results, it is anticipated that the bulk of the activities will be community-based. Non-state actors will have full autonomy and responsibility for procuring the commodities required to achieve the agreed results. The commodities will need to meet agreed Government of Nigeria quality standards and the IVA will verify their quality. Approximately 70 percent of the contract would be paid on a lump sum basis (based on population covered) and the remaining portion based on coverage rates verified on a sample basis by Independent Verification Agencies (IVA) recruited and managed by the Federal Ministry of Finance and financed by the proceeds from the Credit. The results of the IVA will be validated with the annual household National Nutrition and Health Surveys (NNHS) undertaken with Standardized Monitoring and Assessment of Relief and Transition Methods (SMART) methodology.

48. **The introduction of performance-based contracting will require strengthening state government capacity to effectively manage these contracts.** The performance-based contracts themselves will be simple in design to allow for clear management and objective evaluation. With support from the PANRiN (Partnership for Accelerating Nutrition Results in Nigeria) multi-donor trust fund (MDTF), technical assistance and training will be provided to the Project Management Unit (PMU) at the Federal level and the Project Implementation Units (PIU) at the project state levels, as well as the selected non-state actors on how to manage performance based contracts. In addition to using a DLI to

incentivize the states to follow performance standards for managing the contracts, "elite" contract management units at the state level will be formed and their staff will be provided regular training and other forms of capacity development to manage and administer the contracts effectively. In addition, the World Bank will hire two consultants per state who will provide technical assistance to the states, including to strengthen the capacity of the contract management units. The financing for the two state consultants and the capacity building of the state contract management units will be provided by the Global Financing Facility (GFF).

Component 2: Stewardship and Project Management (IDA US$44.85 million, GFF US$ 1.4 million)

49. The objective of this component is to strengthen key stewardship functions at the federal and state levels for the sustained delivery of nutrition services. The component will also finance the project management costs at federal and state levels, including activities related to project monitoring and verification of results. People in every state of Nigeria will benefit from the results of this component. The component will focus on the following five areas: (i) national aspect of communication for social and behavior change for nutrition, including a performance-based contracts with a non-state actor specialized in engaging with religious leaders; (ii) multi-sectoral coordination and accountability for nutrition and adolescent health results; (iii) knowledge platform; (iv) research program; and (v) national nutrition information system for improved planning, monitoring and reporting of service delivery and outcomes.

a. *Social and behavior change communication (SBCC).* As part of a national behavior change strategy that will be developed for the project, a DLI will be established with the FMOH for airing a national mass media campaign that will focus on key messages related to behaviors around the key services provided through the project, that will also be reinforced and deepened at community level and in health facilities through activities in Component 1. This campaign will be entirely focused on the key results to be achieved by state and non-state actors in Component 1. The mass media will be complemented by messages that will be disseminated through religious leaders. Building on previous successful experience with malaria prevention and control, a performance-based contract will be issued to a specialized non-state actor to engage with religious leaders at all levels in the 12 project focus States for behavior change communication around key nutrition and adolescent health services. The success of the SBCC will be measured through retention of knowledge of these key behaviors amongst key stakeholders and will be measured on a sample basis by the IVA and validated by the annual NNHS using SMART methodology.

b. *Multi-sectoral coordination for accountability.* The project will incentivize, through a DLI assigned to the Ministry of Budget and National Planning (MBNP), the creation of a process for multi-sectoral coordination and planning for accountability to achieve nutrition results across key sectors such as: agriculture and rural development, health, NASSCO and NCTO under the office of the Vice President of Nigeria for social protection, education, women's affairs and social development, science and technology, economy and industry. The DLI will specifically incentivize the production of an annual "State of Malnutrition in Nigeria" report which will be based on performance of the afore-mentioned sectors on annual action plans and their evaluation against targets in score-cards pre-agreed for each sector. The advocacy strategy for

the project will ensure that these reports are used in multiple ways to increase accountability for nutrition results in Nigeria. Additionally, increases in financial commitments to nutrition-sensitive programs by these sector ministries will be incentivized by the project through DLIs.

c. *Knowledge platform.* The proposed project will invest in the systematic development of a knowledge management and learning platform that can be effectively leveraged at the state, federal and international levels and will be institutionalized as a core capacity of the FMOH. As such, a knowledge management and learning (KML) unit will be established within the Nutrition Unit of the FMOH to capacitate their stewardship role in evidence gathering and knowledge management and transfer. The FMOH will be incentivized through a DLI to capture and share the lessons emerging from the project, as well as from other nutrition initiatives in Nigeria and abroad, in an annual results conference that will be held in Nigeria. A consortium of KML partners, including national academic institutions, will be contracted by the Nutrition Unit primarily to provide technical assistance in implementation research (IR) in general, and in nutrition research specifically. It is envisioned that this consortium will work closely with the KML unit to guide KML agenda setting and help to convene the annual workshop, among other tasks. They will also provide technical assistance to the state PMUs and non-state actors to carry out nimble, real-time IR on questions relevant to the delivery of interventions through the project, with an emphasis on local capacity building in IR skills.

d. *Research.* The project will also provide up to US$2.5 million to support a program of discrete nutrition system strengthening studies, which will be overseen by the FMOH and receive technical assistance by the afore-mentioned KML consortium. Again, the focus will be on generating high quality evidence while building capacity in Nigerian academic institutions to do so. The following studies have been identified for financing in the first year of the project: (i) a series of studies to prepare for the introduction of double-fortified salt; (ii) a review of the human resources needed to deliver nutritional services nationally (iii) an assessment of the potential of frontline workers to contribute to nutrition service delivery; (iv) an assessment of local production of complementary foods; (v) a scoping study to develop a national nutrition surveillance system; and (vi) an evaluation of the adolescent pilot. Subsequent studies (with accompanying Terms of Reference (TORs), up to the established maximum agreed value, would be approved by the Project Steering Committee. This sub-component will be managed as input-based (investment project financing).

e. Nutrition information system. The project will support the strengthening of the nutrition information system in Nigeria. This national level set of activities will be managed by the Federal Ministry of Health Nutrition Unit and will include: (i) strengthening the accuracy, timeliness and completeness of reporting nutrition indicators in the HMIS; (ii) financing for periodic independent verification of project results; (iii) co-financing of annual SMART surveys; (iv) financing for a national nutrition survey, including on micronutrient deficiencies; and (v) financing of additional surveys as required.

Addressing Binding Constraints

50. The project, and a multi-donor trust fund that will accompany it, are designed to address the most critical binding constraints that have limited Nigeria's progress so far in addressing its chronic malnutrition challenge. As Table 2 illustrates, there exist both supply and demand side constraints.

Table 2. Binding Constraints for Good Nutrition Addressed by the Project

Constraints	Project Actions
• **Supply**	
Low political awareness and commitment	DLIs incentivizing multi-sectoral accountability mechanism and increased allocations for nutrition sensitive interventions by six sectors advocacy strategy (MDTF)
Low health system worker motivation/ weak focus of delivery systems on nutrition	Performance-based contracts and guidance on use of incentives to foster team effort for achievement of results
Weak capacity of health service delivery systems	Immediate training of existing workers, development of tools, contracting out community based services to firms/NGOs, study on strengthening tertiary education programs
Weak community outreach in health	Performance contracts to provide community-based services
Insufficient nutrition commodities	Special procurement provisions for (initial) import of certain commodities
Insufficient financing for nutrition	Advocacy to increase domestic financing (MDTF), project financing, harmonization of donor financing (MDTF)
Insufficient and irregular data for decision-making and accountability	Development of national surveillance system, strengthening of data systems, and co-financing of annual NNHS using SMART methodology.
Insufficient public information on good nutritional practices and products	Mass media campaigns, strong focus on information in facility and community-based components e.g. through performance based contracts with a specialized non-state actor for inter-personal counseling through religious leaders.
Food insecurity (quantity and quality)	Being addressed by agriculture projects, as well as the Multi-Donor Trust Fund collaborating with the World Bank financed National Social Safety Nets Project (NASSP) on conditional cash transfers for IYCF related behaviors. ANRiN addresses quality through food fortification and micronutrient powders for children
• **Demand**	
Cultural norms, including gender norms, that hinder good nutrition behaviors	Partnering with community leaders (e.g., religious leaders, teachers, etc.) and other influencers for behavior change
Limited physical access to services	Bringing key services to the community through community-based programs
Poor economic access to products and services	Reducing financial barriers through free community based services and reduced cost facility-based services, free supply of key commodities. NASSP financed conditional cash transfer program promoting Infant and Young Child Feeding (IYCF) behaviors will also help.
Low knowledge and awareness	Mass media campaigns, linked to community and facility-based behavior change activities
Adolescent fertility	Addressed through the community-based behavior change services
Poor sanitation	Addressed through the community-based services

B. Project Cost and Financing

51. **The total cost of the project is US$232 million, financed by the World Bank for US$225 million through Investment Project Financing (IPF) and a grant of US$7 million from the Global Financing Facility (GFF) in Support of Every Woman, Every Child.** Table 2 describes the financing support. The various World Bank financing instruments were considered and an IPF was determined to be the most appropriate. While the medium-term objective would be to engage on the malnutrition challenge in Nigeria through a Program for Results (PforR) operation, preliminary analyses by the team concluded that there is no sufficiently well-defined nutrition program in Nigeria which a PforR could finance. This IPF is thus designed to start using DLIs where possible while using input based financing in areas such as studies to support the government to fill the gaps in their current national nutrition program. The eligible expenditures for the DLIs will be the salary and allowances bill for officials from the Ministry of Health/health workers providing health services through public health facilities in the 12 project states. The performance-based contracts for nutrition services being a relatively new approach in Nigeria, it was determined that these will be better managed as standard service contracts, following World Bank procurement rules.

52. **The financing from the GFF[11] will be used mainly to strengthen government capacity and incentives to manage performance-based contracts and for specific measures, including additional data requirements, to target adolescent girls and their children.** The GFF investment case for Nigeria identifies this project as Phase 4 of its scale-up plan. Both areas supported by the GFF are transformational because they will sharpen the focus on adolescent girls, a target age group that is often unreached unless special measures are taken to reach them and for performance-based contracting as an innovative service delivery modality that promises to increase the availability of nutrition services. The Grant will specifically co-finance all non-DLI parts of the project.

[11] The Global Financing Facility (GFF) is a broad partnership that supports countries to get on a trajectory to achieve the SDGs by strengthening dialogue among key stakeholders under the leadership of governments and supporting the identification of a clear set of priority results that all partners commit their resources to achieving; getting more results from existing resources and increasing the total volume of financing from domestic government resources, financing from IDA and IBRD, aligned external financing and private sector resources; and strengthening systems to track progress, learn, and course-correct. This approach is guided by two key principles: country ownership and equity. The GFF is driven at country level by a "country platform": a forum or committee that brings together under government leadership the broad set of partners involved in improving the health outcomes of women, children, and adolescents, including different parts of the government, civil society, the private sector, and development partners. A multi-donor trust fund – the GFF Trust Fund – has been established at the World Bank Group to be a catalyst for this process.

Table 3. Project Financing (US$ million)

Project Components	Project cost	IBRD or IDA Financing	Trust Funds	Counterpart Funding
1. Basic Package of Nutrition Services	185.75	180.15	5.60	0.00
2. Stewardship and Project Management	46.25	44.85	1.40	0.00
Total Costs				
Total Project Costs	232.00			
Front End Fees	NIL			
Total Financing Required	232.00			

C. Lessons Learned and Reflected in the Project Design

53. **The project design reflects lessons from ongoing operations, international good practice, and thematic evaluations.** It draws on lessons learned from similar World Bank-funded projects in Nigeria and globally. The following lessons have been considered:

a. **Selectivity.** Some nutrition projects have suffered from overload by including too many types of interventions and particularly from attempting to work with too many sectors within the same project. This project focuses on a limited package of evidence-based interventions implemented largely through the health sector, while providing incentives for multi-sectoral coordination through a process led by the MBNP. Other World Bank-financed projects will take the lead in supporting the achievement of nutrition results in other sectors, working under the coordination structures of the Investing in Early Years Initiative.

b. **Evidence-based programming.** Interventions with the strongest evidence of impact on chronic malnutrition (stunting and micronutrient deficiencies) have been selected. This is a risk-based approach that focuses resources on interventions that have the most likelihood of succeeding and reduces the risk of not achieving project outcomes.

c. **Equity.** While the coverage of the seven-high impact, low cost, services to be financed by the project is low amongst the masses, data also shows that health and nutrition indicators are *worsening* for the poorest households and that specific groups (e.g., adolescents) do not have equitable access to health and nutrition services. By specifically targeting rural areas of the high malnutrition burden states of Nigeria, this project builds on these lessons by introducing specific geographical (rural) and age group targeting in the performance-based contracts and the DLIs, as well as disaggregating project results tracking by age groups when feasible.

d. **Performance-based contracts.** The experience with contracting non-state actors has led to significant results in countries such as Afghanistan, Bangladesh and Senegal. In Nigeria, the Nigerian Inter Faith Action Association (NIFAA) Network achieved significant results on malaria prevention through a performance-based contract. The lessons from these experiences were adapted to the specific nutrition challenges in Nigeria through the design of the performance-based contracts. A number of lessons on how to manage performance based contracts have been included in this project, notably the need for more than one contract per State to enable the transition out of non-performing contracts should the need arise, the need to limit the number of performance-based indicators in the contracts, the need to engage extensively with stakeholders during the contract development process and to cultivate champions and the need to build capacity within government on effective contract management.

e. **Behavior change communication.** The evidence emerging in recent years from initiatives such as Alive and Thrive (initially in Bangladesh, Ethiopia and Vietnam but now also present in Nigeria) has shown that behavior change communication needs to be data-driven, messages need to be rigorously prioritized and tested with targets groups and that gender and other cultural dimensions need to be factored in. A full behavior change communication strategy – which builds on the evidence from other large-scale behavior change initiatives – will be developed during project implementation to guide the investments in this key aspect of the project. One of the key lessons that has been integrated is to ensure that religious leaders are engaged to create an enabling social environment for the expected behavior changes.

f. **Adolescent girls.** The experience from Nigeria and other countries demonstrates that special measures need to be taken to target adolescents and to provide them a "safe space" where they can receive counseling and information on a set of life skills, including family planning. Otherwise, they are often not able to cross the social and financial barriers that limit their access to services. The experience from programs that have successfully targeted adolescent girls in Nigeria and elsewhere has been integrated into the design of this project.

g. **Gender.** Gender relations vary across Nigeria according to region, religion, rural vs urban location, polygamous and monogamous practices, and other factors. Conducting formative gender analysis in a project's different intervention sites has been key to identifying local gender and inter-generational relations and how they influence nutrition and other practices. Successful behavior change interventions designed on this basis have generally adopted an ecological approach that recognizes the importance of key 'influencers' (husbands, peers, grandmothers, religious leaders, health workers, among others) while seeking to strengthen women's agency within this network of relationships. Conducting local gender analysis, adopting an ecological approach, and seeking to increase adolescent girls' and women's agency have therefore been integrated into the project design.

h. **Sustainability of financing.** Financing for nutrition in Nigeria has historically been low. Other countries which have sustained nutrition results over the period required to reduce stunting have had increases in domestic financing for nutrition. The project addressed this issue early in the design by requiring that, to be selected to participate in the project, States would need to develop a costed strategic plan for nutrition and allocate at least NGN 250 million over the life of the project to its implementation. The MDTF will also support the development and

implementation of an advocacy strategy that will focus largely on domestic resource mobilization for nutrition.

i. **Balancing urgency with systems strengthening.** The nutrition data in Nigeria point to a crisis, with more than 14.5 million children suffering the consequences of brain impairment due to stunting. The project is thus designed to harness all available resources, including from non-state actors, to address this urgent need. However, at the same time, the project will also act on a select few areas of systems strengthening, such as information systems, to enhance the likelihood of sustained impact beyond the life of the project.

j. **Stakeholder alignment.** Nigeria does not currently have a central nutrition programming platform on which key partners can align to scale up interventions. In the spirit of the GFF, it is envisaged that the stakeholder consultations during project design, the project communication strategy, and the technical assistance matrix will all contribute to aligning key stakeholders to the project as a joint programing platform. Other countries have shown that once such a platform is created efficiencies are created and sustainability is enhanced.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

54. **Steering Committee.** The Steering Committee that is facilitating intergovernmental coordination, collaboration, communication, knowledge sharing and monitoring of Saving One Million Lives (SOML) and the Nigeria State Health Investment Project (NSHIP, P120798) will also oversee ANRiN. The Steering Committee in its current form is chaired by the Honorable Minister of Health (or Permanent Secretary), with representation from Federal Ministries of Health, Finance (i.e., the International Economic Relations Department), Budget and National Planning, NPHCDA, State Ministries of Health (SMOH) and State Primary Healthcare Development Agencies (SPHCDAs), as well as Civil Society Organizations. The Steering Committee will benefit from and inform the agenda of the Food and Nutrition Committee, co-chaired by the Federal Ministries of Health and Agriculture.

55. **Multi-sectoral coordination.** The Ministry of Budget and National Planning (MBNP) will lead multi-sectoral coordination on the National Policy on Food and Nutrition in Nigeria (2016) and its monitoring with Ministries such as health, agriculture and rural development, women's affairs and social development, education, NASSCO and NCTO under the office of the Vice President of Nigeria for social protection, trade, economy and industry and science and technology. Specifically, the National Nutrition Council of the MBNP will consultatively develop scorecards and annual targets for achievement towards the national policy for each participating Ministry, monitor progress and disseminate State of Nutrition Reports on an annual basis.

56. **Financial oversight.** The FMOF will provide overall financial oversight to the project ensuring streamlined and timely fund flow. It will contract an IVA to verify progress towards ANRiN DLI targets for indicators tracked through annual NNHS using the SMART methodology. It will also recruit additional IVAs, as required, to verify achievement of DLI targets for indicators through household surveys or methods prescribed in the verification protocols. Based on the qualification and

quantification of DLI indicators achieved as confirmed by the periodic IVA reports, disbursements of IDA Credit allocated to each indicator will be triggered.

57. **Overall project management.** The project itself will be anchored within the FMOH. The Department of Family Health (DFH) and the NPHCDA of the FMOH will provide technical guidance to project states for implementation of the project. The DFH will work with the states to ensure that states have the standards, tools and technical capacity to meet their nutrition targets. It will take the lead in finalization of the social and behavior change strategy developed with technical assistance of the MDTF, in collaboration with the Advocacy and Communications Department of the NPHCDA for the project and facilitate its deployment at federal level and in project states. It will also be incentivized to finalize the design of and deploy the proposed national nutrition surveillance system and to manage a knowledge management and learning as well as a research program. In parallel, the nutrition division of the NPHCDA will be responsible for provision of tools and guidelines and implementation support to service delivery in state health facilities by the State Primary Health Care Development Agencies. It will work with the SMOHs to ensure technical quality of the nutrition focused activities delivered in the primary health care facilities.

58. **Project management unit.** The Project Management Unit housed in the FMOH will oversee overall coordination of the project. The PMU will be responsible for the coordination of day-to-day administration, monitoring and reporting on project activities and serve as the liaison with FMOH and the NPHCDA, the MBNP, as well as State Ministries of Health (SMOH) and SPHCDAs responsible for project implementation at the state level. A senior officer will be identified by the Honorable Minister of Health to serve as the full-time Project Coordinator for ANRiN. He/she will be supported by technical experts in the fields of (i) nutrition and infant and young child feeding; (ii) adolescent nutrition and health; (iii) communication; (iv) procurement; (v) contract management; (vi) community mobilization and engagement; (vii) accountant/finance; (viii) internal auditor; and (ix) monitoring and evaluation. These experts could be either seconded from the FMOH and/or NPHCDA, where available or recruited as consultants, where such skills are lacking in both the federal ministry and the Agency. The responsibilities of the PMU will include:

a. Overseeing the implementation of all Project components;
b. Coordinating and facilitating FMOH/NPHCDA activities related to the project;
c. Implementing and overseeing the disbursements to participating states;
d. Communicating and working with states, developing and implementing a communications and outreach plan;
e. Facilitating the timely disbursement of funds to the states;
f. Knowledge management and peer learning; and
g. Ensuring that covenants are complied with and that the project is implemented according to the project implementation manual (PIM).

It was agreed that in the period until project effectiveness, the PMU of SOML will provide offices and accommodate the administrative secretariat for the ANRiN PMU. This will enable ANRiN to be in full-readiness of implementation upon effectiveness.

59. **State level arrangements.** At the state level, the Commissioner of Health will chair the Technical Consultative Group and be accountable for project outcomes. It was agreed that at the state

level, the SMOH will provide technical oversight to project implementation, and house the project implementation unit. The SMOH will also contract and manage the non-state performance based contracts for delivering the basic package of nutrition services and focused package of adolescent health interventions and be held accountable for achievement of relevant disbursement linked indicators. The SPHCDA, will oversee delivery of a subset of basic package of nutrition services, namely IFA supplementation of and IPT for pregnant women; and counseling on IYCF for pregnant beneficiaries during ANCs through the state health facilities and be held accountable for achievement of the relevant disbursement linked indicators at the state level. A full-time Project Coordinator deputed to the Project Implementation Unit (housed in SMOH) will lead project implementation, drawing from the SMOH as well as the SPHCDA, as required, expertise in the areas of (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 auditor; and (viii) monitoring and evaluation. Additionally, in the state that will be piloting the adolescent health services an officer for adolescent health and nutrition will be deputed. The role of the PIU will be to provide administrative support to the project, drawing upon technical guidance from SMOH and facilitating project implementation through the SPHCDA.

60. **The responsibility for establishing and maintaining acceptable financial management (FM) arrangements for the project will be handled by the existing Project Financial Management Units (PFMUs) in the 12 states and the Federal Project Financial Management Department (FPFMD) at the federal level.** The Federal Treasury Circular of March 2010 established the FPFMD in the Office of the Accountant General of the Federation (OAGF) to handle the FM responsibilities for funds provided to ministries, departments and agencies by donor partners. At the state level, the PFMUs have been established under the Office of Accountant-General in each state (OAGS).

61. **Performance-based contracts.** The state PIUs will issue performance based contracts for a basic package of nutrition services and, in one state, a focused package of adolescent health services. One of the core functions of the SMOH 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.

62. **Partnership for Accelerating Nutrition Results in Nigeria Trust Fund**. The World Bank will create a multi-donor trust fund which will provide additional resources to enable the World Bank to commission technical assistance to strengthen project implementation. The trust fund will also support targeted communications to continue to raise the importance of nutrition as a development issue in the country. It is currently envisaged that the resources from the trust fund would be made available primarily for World Bank-executed activities but could also eventually be used to pool donor resources for recipient-executed activities, i.e., scaling up project interventions, should such financing become available. In that case, the resources would be added to the project using the World Bank procedures for additional financing.

B. Results Monitoring and Evaluation

63. **Data are a critical element of the results-based implementation modalities that will be used to deliver this project.** The project design has a strong focus on data generation and management

systems. The primary focus will be on the data that will determine the extent to which the DLIs and performance-based contract results have been achieved. However, implementation research will also be undertaken to monitor the quality of implementation and help explain any deviations (positive or negative) from anticipated results.

64. **The PMU at the federal level and the PIUs at state levels will be responsible for overall monitoring of project results and reporting to the World Bank.** The PMU and PIUs will include monitoring and evaluation specialists as part of their core team. The Nutrition Units at the federal and state levels will play an advisory role to the PMU/PIUs on technical issues as required and will facilitate in the monitoring process, as needed, through performance-based MoUs. Monitoring of project indicators will rely on the data and information provided by the non-state actors who will implement the performance-based contracts as well as by federal and state officials who will implement activities to achieve DLIs. An IVA will be contracted by the FMOF with the proceeds of the Credit to verify the information reported by state and non-state actors, a function they will perform by collecting household and facility data and conducting in-depth verification on samples of administrative data. The project will use the annual NNHS using SMART methodology to validate project results verified by the IVA, thus also embedding the project data into the wider national data systems. Should NNHS be not conducted due to unforeseen reasons in a particular year, the results for the particular year will be validated using data from either DHS or Multiple Indicator Cluster Surveys (MICS), based on the source of the baseline data.

65. The mechanisms established for verification of project results will be informed by experiences and lessons from other results based operations financed by the World Bank in Nigeria. Efforts will be made to mitigate risks arising from mis-reporting or incorrect collation of data (M&E officers of the PMU/PIU will be tasked with continuous review of quality, completeness and timeliness of data recording and reporting) at each level of reporting and higher level of data aggregation. Any willful misreporting of performance will invite remedial measures and sanctions amounting to cancellation of Credit allocated to the particular result from the overall Credit allocated to the project state.

66. **Subject to the availability of finances from the MDTF, the World Bank will commission an independent impact evaluation for the project with a nested evaluation of the adolescent health interventions.** All innovations deployed by non-state actors will also be evaluated**.**

67. **Beyond monitoring the project-specific results, the project also has a focus on strengthening national capacity to monitor and evaluate for learning and innovation.** The project has a specific focus on designing, deploying and strengthening the national nutrition information system to enable the data-related processes to continue beyond the life of the project. The DLI related to multi-sectoral coordination for accountability will rely on data systems within each of the key sectoral ministries that contribute to nutrition. The knowledge management and learning program, including the annual results conference, and the innovative pilots for nutrition financed by the project will enable the generation of new data and lessons to enable the scaling up process. Additionally, the project will explore opportunities of partnering with federal and state level government research agencies as well as universities on implementation research related to its interventions.

C. Sustainability

68. **The sustainability of the results of this project will be enhanced through five interrelated pathways: (i) targeting the first 1000 days window; (ii) affordability; (iii) political will and domestic resource mobilization; (iv) partner alignment; and (v) capacity development.**

a. ***First 1000 days.*** At the individual level, the cognitive capacity that will be developed in young children from conception to their second birthday, a point when most brain development has occurred, will be sustained throughout their lifetime. Impaired cognitive function resulting from chronic malnutrition during the first 1000 days is largely irreversible.

b. ***Affordability.*** The low cost, high impact interventions financed by this project have been carefully selected so they can eventually be absorbed within Nigeria's fiscal space constraints.

c. ***Political will and domestic resource mobilization.*** The project states were selected on fulfillment of criteria comprising (i) high malnutrition burden and hence, an urgent need for action; (ii) willingness to borrow IDA resources; (iii) establishment of a kick-off fund for nutrition annually financed by state resources; (iv) costed strategic plans for nutrition ratified by the State Executive Council or Governors; and (v) establishment of a Project Implementation Unit with Project Coordinator and other supportive officials deputed to drive project implementation. All 12 states have met each of the five criteria demonstrating their long-term commitment to nutrition and the project.

   Additionally, a strong emphasis has been given from the start to ensuring that an ever-widening group of champions is cultivated to understand and act on the issue of malnutrition and specifically advocate for increased domestic resource mobilization for this development priority. This advocacy will continue during project implementation and will increasingly use the results data generated from the project to widen the group of advocates and deepen their engagement.

d. ***Partner alignment.*** The project intends to serve as a large-scale implementation platform to which other partners could progressively align. This alignment will reduce inefficiencies and will enhance sustainability.

e. ***Capacity development.*** Unlike most other development partner support for nutrition in Nigeria, the project will work through government systems, thus building national systems capacity for large-scale program delivery. Specific project activities focus on strengthening national capacity for stewardship.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

69. **The overall risk rating of the proposed project is Substantial.** The risks related to the current macroeconomic environment are rated high given that the project builds on government systems that depend on public revenues. Any further deterioration of the macroeconomic environment (e.g., inflation, and further devaluation of the Nigerian naira) may not only affect the GoN's ability to provide services but also further decrease the ability of poor people to access health services (demand side) and thus affect the project. Additionally, the risks associated with institutional capacity for implementation and sustainability of project interventions is also proposed as high in view of the limited experience of the federal and state governments to competitively procure and contract out to non-state actors nutrition services to be deployed on a large scale and management of such contracts on the basis of results achieved.

70. **Political and Governance, fiduciary, technical design of project, and stakeholder risks are considered Substantial.** The risks associated with political and governance are rated substantial because of the likely political transitions expected with the elections of 2019. Decision making in the government could face severe delays or recalibration with changes in leadership at the federal and state levels. Fiduciary risks are generally substantial in Nigeria and this project is in line with the rest of the portfolio in terms of fiduciary risk. The project focuses on a limited set of well proven interventions, virtually all of which are currently implemented in Nigeria hence the risks associated with the efficacy of interventions is low. The results based approach being pursued by the project through a mix of DLIs to incentivize the stewardship role of the federal and state governments to address malnutrition and performance based contracts with non-state actors for service delivery of key nutrition and focused adolescent health interventions is risker than traditional input financed operations. While capacity for implementation is well proven for DLIs and for performance-based financing in health facilities due to the two existing World Bank financed operations, the performance-based contracting with non-state actors would be new to the health sector in Nigeria and thus presents an increased risk. The capacities of the government and the non-state actors to deliver on this mandate effectively and efficiently in the Nigerian context needs investment and strengthening. To mitigate these risks, a clinic on performance based contracting will be organized with grant financing and ahead of project effectiveness to build capacity of PMU and PIUs in effective management of these contracts. Additionally, elite contract management units will be set up at the federal and state levels and their capacities built through on-going training programs hand-holding to mitigate the risk of poor contract management. Finally, effective contract management at the state level is being incentivized through a DLI. Stakeholder risk is substantial because of the multi-sectoral nature of some aspects of the project and aspired scale of reach for some beneficiaries (e.g., adolescent girls). Multi-sectoral planning and accountability for nutrition results is being incentivized through national level DLIs. Just-in-time and high quality technical assistance through the trust funds supporting ANRiN will be leveraged to facilitate this multi-sectoral action. Finally, the trust funds will also support a strong federal and state level advocacy program with the various stakeholders for concerted action. The World Bank's Investing in Early Years program, will also be leveraged, to catalyze multi-sectoral action for nutrition through the existing World Bank portfolio in Nigeria, especially in the areas of education, social protection,

agriculture, water and sanitation, and social development. The SBCC strategy that will be deployed through the project will support reaching the hard-to-access beneficiaries, such as adolescent girls.

71. **Sector strategies and policies are considered a Moderate risk.** All sector strategies and policies are in place but this remains a moderate risk due to the weakness at times in the capacity to implement them. High quality, donor harmonized technical assistance, including state-based technical and operational consultants financed by the World Bank executed trust funds, will be made available at the federal and state levels to support implementation of the project to mitigate this risk.

72. **Finally, environmental and social risks are considered Low.** The project is not expected to have any significant negative environmental impact and it is anticipated to have considerable positive social impact by targeting some of Nigeria's most vulnerable people -- such as adolescent girls and the women and children from the poorest households -- with interventions that will increase their long-term resilience and opportunities to thrive. The project has also been screened for climate and disaster risks, which are assessed to have negligible potential impact on either target beneficiaries and project activities during the project tenure or immediately thereafter because of extreme temperatures. In the next 80 years, this impact could lead to moderate potential risk, which may impact service delivery, health seeking behavior and disease status of project beneficiaries, with increased heat strokes, incidence of diarrhea, inability to service hard to reach populations through outreach services on very hot days and inability of beneficiaries to access care due to high temperatures.

73. The project will target pregnant and lactating women, particularly adolescent mothers, through its interventions for improved knowledge and practices for maternal, infant and young child nutrition as well as promote uptake of the basic package of nutrition services in the community and through the primary health care centers. Given the power imbalances within families and in the community, these key project beneficiaries are disempowered to participate in decision making related to their children and their own health and nutrition. Women and adolescent girls lack the negotiating power to decide whether to access nutrition and health services when they need, to spend resources on their children's and their own health and nutrition or make informed/uncoerced decisions concerning pregnancy and birth speaking and may be at risk of experiencing gender based violence (GBV). The SBCC strategy of the project will leverage the performance based contract with the Nigerian Inter Faith Action Agency to promote through religious and traditional leaders (i) women's agency and empowerment for decision making regarding maternal, infant and young child nutrition related choices and practices; (ii) access to basic package of nutrition services through counseling especially for vulnerable, disempowered women, especially adolescent mothers; and (iii) address gender imbalances in the community by engaging with the enabling environment in which rural women operate and sensitize them on GBV and health seeking. Additionally, the mass media campaign deployed by the project will promote women's role in decision making around MIYCN and adoption of appropriate behaviors. Separately, the performance based contracts with non-state actors will be designed to ensure safe delivery points for the basic package of nutrition services for women in the community and emphasize outreach to vulnerable groups, especially adolescent mothers with IYCF counseling support and for promoting access to the package of nutrition services.

74. The project will also systematically identify any risks that its interventions may pose for GBV towards the project beneficiaries by September 30, 2018. Based on the findings of the GBV risk

assessment, the SBCC strategy and its interventions as well as the outreach through the non-state actors will be nuanced to mitigate the risks. GBV services available in the communities of interventions will be identified/mapped and non-state actors trained to refer women, girls and children survivors to these. These actions will be designed taking into account the specific gender dynamics in the communities and how the project will interact, contribute or may aggravate the contextual GBV prevalent in them.

VI. APPRAISAL SUMMARY

A. Economic and Financial (if applicable) Analysis

75. **Although an intrinsic development objective in its own right, good nutrition is also instrumental in stimulating economic growth.** Malnutrition in early childhood results in decreased cognitive ability, poor educational outcomes, lost earnings and losses to national economic productivity. Malnutrition, particularly in young children, leads to increased mortality: undernutrition is an underlying cause of approximately half of under-five mortality and one-fifth of maternal mortality in Nigeria. Its most damaging effects occur during pregnancy and in the first two years of a child's life, and the impact of this early damage is largely irreversible. The recent Lancet series on early childhood development estimates that, every year, Nigeria loses about 3 percent of its Gross Domestic Project (GDP) because of not addressing the developmental needs of children in the first 1000-days window.[12] This is about as much as the country's annual government expenditure on health (3.9 percent).

76. **Improving adolescent health brings about a threefold benefit.**[13] First, in the short term, it reduces health expenditure and improves school performance. In the medium term, those improvements lead to increased adult productivity and faster economic growth. Finally, improved adolescent health has inter-generational effects. Children of teenage mothers are 20 percent more likely to be stunted than children of mothers who are 20 years old or older.[14] Healthier mothers, who have their first birth later in life and longer time periods between births, have healthier babies and the effects of improved adolescent health spill over into the next generation. Finally, addressing reproductive health of adolescents is essential to ensure that developing countries can reap the demographic dividend.

77. **Interventions aimed at improving child nutrition and adolescent health have been identified as some of the most cost-effective development actions.** According to the global investment framework for reproductive, maternal, neonatal and child health (RMNCH), one dollar invested in the essential package of maternal and child health and nutrition interventions is estimated to yield about nine dollars in economic benefits. This cost-benefit ratio is even higher for evidence-based high impact nutrition interventions that target stunting and micronutrient deficiencies – the interventions that will be financed by this project. The recently published global investment framework for nutrition demonstrates that one dollar invested in interventions targeting stunting would bring about US$10.5 in

[12] Richter et al., 2016
[13] WHO 2016
[14] Danaei et al., 2016

economic benefits; one dollar invested in anemia prevention – US$12, and one dollar invested in improving exclusive breastfeeding – as much as US$35.

78. **These global estimates are confirmed by recent country-specific analyses conducted by the World Bank for the GoN.** The analyses show that scaling up the package of high-impact nutrition interventions in Nigeria would generate about US$2.6 billion annually in economic benefits.[15] Based on the international benchmarks such as the WHO Commission's on Macroeconomics and Health Choosing Interventions that are Cost Effective (CHOICE) criteria, this package of interventions is also very cost-effective. The cost of one disability-adjusted life year (DALY) averted is US$102 – significantly below Nigeria's GDP per capita – the WHO CHOICE cost-effectiveness threshold. Interventions that would be financed under the proposed operation: maternal and child micronutrient supplementation and community nutrition and hygiene promotion programs, are even more cost-effective with cost per DALY averted reaching as low as US$12. The World Bank analyses also demonstrate that focusing on the most cost-effective interventions combined with correct geographic targeting, the cost per DALY averted could be reduced by as much as 20 percent as compared to scaling up all interventions nation-wide. This increased allocative efficiency explains the proposed geographical targeting of components 1 and 2 of the project, the former concentrated in 12 high malnutrition burden states of Nigeria and the latter influencing outcomes for the whole of Nigeria by strengthening the stewardship role of the governments to implement large-scale nutrition programs. No comprehensive assessment of the economic impact of improvements in adolescent health have been conducted. However, it is estimated that just reducing fertility rates in Nigeria by addressing the reproductive health of adolescents could increase economic output by 5.6 percent in the medium term (over 30 years) and by as much as 11.9 percent in the longer term (over 50 years).[16]

79. **By focusing on cost-effective preventive interventions targeting malnutrition, the proposed project will contribute to lowering public and out of pocket health expenditure resulting from excess maternal and child morbidity in the short term.** More importantly, in the long term, the proposed investment will result in increased economic productivity and contribute to GDP growth. 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 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 would grow up free from stunting. The reductions in stunting, anemia, and mortality would generate economic benefits with a net present value of US$7.00 billion and an internal rate of return of 19 percent. The investment would have an attractive 32.2 benefit-cost ratio, indicating that each dollar invested has the potential of generating about US$32 in economic benefits. The analysis also suggests the investment has high technical efficiency. The cost for one death averted was estimated to be about US$2,789, which compares very well with global and regional benchmarks. The recent Global Investment Framework for Nutrition shows that the average cost of preventing one child death is about US$18,000. The average cost for Sub-Saharan Africa is about US$17,000 per death prevented.

[15] Shekar et al., 2014
[16] Ashraf et al. 2013

80. **Rationale for public sector provision/financing**. In general terms, public investment in health and nutrition focusing on women, adolescents, infants, and young children can be rationalized based on their merit good nature (a good whose availability should not be dependent on the ability to pay). In addition, public financing, regulation, and even provision is justifiable due to widely recognized market failures in health and nutrition resulting from information asymmetries, presence of supplier-driven demand, complex and opaque production functions, and other market imperfections. Because of this, in Nigeria, like in most countries in the region, basic health and nutrition services, including those whose provision will be supported by the proposed project, are already provided primarily through the public sector. Public financing and provision are necessary to improve the efficiency and equity of service delivery. However, it is also important to distinguish within "provision" between the purchasing function and the service delivery function. This project will introduce this clear distinction through the facility based performance based financing and through the performance based contracts for community services. In both cases, the public sector will be the purchaser using public funds but service delivery in the community will be done by the private sector and through public health facilities by the public sector.

81. **Value added of World Bank's support.** The proposed project builds on several years of technical engagement by the World Bank on nutrition. This engagement includes a review of community based approaches for nutrition and the preparation of the "Costed Plan for Scaling up Nutrition", published in September 2014, a seminal document for the preparation of the health sector plan for nutrition which this project will support. Given its media visibility and political salience, much of the focus on nutrition in Nigeria until recently has been on the emergency response to the severe acute malnutrition crisis in the North East of the country that is partly caused by the Boko Haram insurgency. The World Bank has been a leading voice in pointing out that the costs to the economy of chronic malnutrition (i.e., stunting and micronutrient deficiencies) far outweigh the costs of severe acute malnutrition and that investments needs to be scaled up to address chronic malnutrition. By working with Nigeria leaders, the World Bank has contributed to developing a sense of urgency recently around addressing chronic malnutrition and a coalition of key Nigerian stakeholders is ready for action.

82. The World Bank's value added through this project, in addition to providing significant financing at a time of fiscal stress, lies in its ability to support the government in facilitating the dialogue required to align the relevant stakeholders around a package of highly cost-effective interventions and facilitate the implementation of the multi-sectoral nutrition strategy. The World Bank will bring to this project its global expertise in supporting the implementation of nutrition programs at scale using financial incentive mechanisms such as DLIs and performance based contracting. The World Bank will also add value in the strengthening of human resource capacity and data systems to enable Nigeria to sustain its nutrition programs. Finally, as a global convener, the World Bank is also creating a multi-donor trust fund for Nigeria that will provide technical assistance to the project and the World Bank is positioning Nigeria vis-à-vis private investors through the Power of Nutrition, to "crowd-in" private investment to address Nigeria's malnutrition challenge.

B. Technical

83. **The program design was informed by several studies conducted in Nigeria over the last several years, including a review of community-based approaches for nutrition and a costing and prioritization study.** The project preparation included a gender and nutrition in Nigeria analysis, a review of determinants of malnutrition, a landscape analysis of infant and young child nutrition in Nigeria, an institutional capacity assessment, a review of the global and Nigerian evidence for the proposed nutrition interventions, and a review of evidence and Nigerian experience specifically relating to adolescent health and nutrition.

84. **The interventions selected for scale up are fully aligned with global evidence on the cost-effectiveness of nutrition interventions that should be scaled up on a priority basis in countries with high burden of stunting.** The project addresses the main determinants of stunting that relate to the health sector and will enable other sectors which are addressing other determinants of stunting to be well coordinated. Interventions are sharply focused on the first 1000-day window of opportunity when most of the largely irreversible damage from malnutrition occurs. They put a strong emphasis on a combination of focused behavior change communication along with the provision of a few key commodities in line with packages of services that have led to accelerated reductions in stunting in countries like Nigeria. The geographic targeting of the highest burden States in each geo-political zone is an effective way to enhance allocative efficiency.

85. **The use of non-state actors to deliver health and nutrition interventions has been demonstrated in countries such as Afghanistan, Bangladesh and Senegal to be effective ways to reach a broader base of beneficiaries and achieve more equitable impact.** This is particularly important in Nigeria given that health and nutrition outcomes have been worsening for women and children from households in the poorest income quintiles and for specific age groups such as adolescents. Nigeria has had experience contracting non-State actors to deliver health services in the context of two World Bank-financed projects, one on malaria control and prevention and one to fight HIV/AIDS. The lessons learned through these projects (e.g., on size of contracts, verification mechanisms, etc.) have been incorporated into the design of this project.

C. Financial Management

86. The responsibility for establishing and maintaining acceptable FM arrangements will be handled by the existing PFMU in the participating states and the FPFMD at the federal level. The PFMUs and FPFMD are multi-donor and multi-project FM platforms, established in all states and at federal level respectively through the joint efforts of the World Bank and the government. These common FM platforms feature robust systems and controls. The PFMUs and FPFMD are presently involved in the implementation of a number of World Bank-assisted projects. The World Bank's recent review showed that these units have been performing satisfactorily. A project accountant, a project internal auditor and other supporting accounting technicians will be designated for the project from the pool of professional accounts in the Office of the State Accountant General and Office of the Accountant General of the Federation that will make for appropriate segregation of duties. To strengthen the financial management system in the PFMUs and FPFMD, implementation of some action plans is required. Further to the recommended action plans being implemented as per the agreed time frame,

the financial management arrangements will meet the minimum FM requirement in accordance with OP/BP 10.00. Considering the risk mitigation measures, the financial management risk for this financing is assessed as **Substantial**. Annex 3 provides additional information on financial management.

D. Procurement

87. The FMOH and the participating states will carry out procurement for the proposed project in accordance with the World Bank's "Procurement Regulations for IPF Borrowers" (Procurement Regulations) dated July 2016 (revised November 2017) under the "New Procurement Framework (NPF), the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated October 15, 2006 and revised in January 2011 and as of July 1, 2016, and other provisions stipulated in the Financing Agreements. Procurement shall be carried out by the FMOH and the various states implementing units. The World Bank's Systematic Tracking and Exchanges in Procurement (STEP) system will be used to prepare, clear and update procurement plans and conduct all procurement transactions for the project.

88. All procuring entities as well as bidders, and service providers, i.e. suppliers, contractors and consultants shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraph 3.32 and Annex IV of the Procurement Regulations.

89. As part of the preparation of the project, the FMOH (with technical assistance from the World Bank) has prepared a Project Procurement Strategy for Development (PPSD), which describes how procurement activities will support project operations for the achievement of project development objectives and deliver value for money. The procurement strategies are linked to the project implementation strategy at the federal and the state levels ensuring proper sequencing of the activities. The PPSD clarifies institutional arrangements for procurement; roles and responsibilities; thresholds, procurement methods, and prior review, and the requirements for carrying out procurement. It also includes a detailed assessment and description of the FMOH and the various state government capacity for carrying out procurement and managing contract implementation, within an acceptable governance structure and accountability framework. Other issues that are considered include the behaviors, trends and capabilities of the market (i.e. market analysis) to respond to the ANRiN procurement plan.

90. The FMOH procurement cycle management has been rapidly assessed and is found to be moderately satisfactory. Procurement plans are usually prepared, so also bidding documents, evaluation reports, etc. The Federal Government of Nigeria, has already established the Bureau for Public Procurement (BPP) charged with the responsibility of ensuring that procurement activities in the Federal ministries, departments and agencies are implemented in accordance with the 2007 Public Procurement Act and in line with international standards. The interim assessment of the FMOH about the procurement arrangements for ANRiN confirms that current procurement capacity in the FMOH, and the participating states provides significant prospects and assurances that the procurement function will be carried out successfully. However, the procurement risk rating at inception of ANRiN is Substantial, but could be reduced to Moderate or Low on finalization of the PPSD and after the implementation procurement risk mitigations set out in the project.

91. The project design provides a window to enable the Borrower to carry out Advance Contracting and Retroactive Financing in accordance with Section V (5.1 and 5.2) of the World Bank Procurement Regulations for IPF Borrowers. The retroactive financing will be allowed up to 20 percent of the credit covering the expenditures incurred by the project, not more than 12 months before the expected date of the signing of the Legal Agreements for the World Bank Credit. A detailed procurement description and institutional arrangements can be found in the PIM.

E. Social (including Safeguards)

92. The project aims to address nutritional and health challenges and constraint experienced by women of reproductive age, adolescent girls and children in selected identified states through utilization of quality, cost effective nutritional services. OP 4:12 is not triggered as activities under the project will not lead to land acquisition or restriction of access to resources or livelihood. Thus, the project will maintain a pro-poor approach focused on increasing access to the project financed services by the poorest and most vulnerable in targeted states; with an indirect benefit to husbands, sexual partners, mothers and other relevant stakeholders in policy and service delivery in the health sector.

93. Lack of information and low participation in decisions related to health services have been identified as some of the challenges or constraints that communities and beneficiaries face in accessing health care service delivery. To mitigate these constraints and ensure full coverage of the targeted most poor and vulnerable, the project will develop a robust behavioral change communication strategy that will be responsive to community's needs, promote participation and influence nutrition-related behavioral change in households and communities.

94. **Gender.** This project will have a direct positive impact on the nutritional status and general well-being of women and adolescent girls as they are among the direct project beneficiaries. In particular, women of reproductive age will have increased access to nutritional services and participate in behavior change interventions targeting some of the underlying inequalities that lead to poor nutritional status of their children and themselves. Given that adolescent girls and adolescent mothers are at particularly risk of malnutrition, project targets have been established to monitor project impacts on this vulnerable group. All behavior change interventions will be carefully designed to respect cultural norms to avoid potential conflicts within the household or community, while simultaneously seeking to address underlying dynamics of gender inequality that lead to malnutrition (such as restrictions on women's access to health services due to cultural constraints, women's lack of control of food purchasing decisions, etc.). To this end, behavior change interventions will include the participation of men and boys as well as that of community and religious leaders.

95. **Citizen engagement and beneficiary feedback/grievance mechanism.** Citizen engagement gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of any intervention, and also helps beneficiaries hold service providers accountable for results. It is understood that communities with a participatory stake in the delivery of health care services are more likely to use and support them and take greater care of their own health needs than those who do not participate. For this reason, the ANRiN project will promote and develop a citizen engagement plan designed to make communities more aware of the project activities, more

involved in health care services, better able to communicate with service providers and, in turn, feel more responsible for the successful implementation of the project.

96. Furthermore, the project will also develop a project based feedback and grievance redress mechanism to receive, address and resolve complaint resulting from project related activities. Non-state actors will be mandated to establish functional grievance redressal mechanisms, the responsiveness of which will be annually independently assessed.

F. Environment (including Safeguards)

97. ANRiN has been classified as a Category B project, as the activities that will be financed under this project will not involve any major civil works, but any works are expected to be minor, site specific and relatively easy to mitigate. OP 4.01 on Environmental Assessment is triggered given the potential environmental concerns around the handling of health care waste resulting from project related activities in Component 1. The FMOH disclosed its Health Care Waste Management Plan (HCWMP) in the country on April 14, 2016 and in the World Bank INFOSHOP on April 15, 2016.

98. The Health Care Waste Management Plan developed and disclosed for the National State Health Investment Project (NHSIP) being implemented in Nigeria is also appropriate for ANRiN and has been modified and updated to reflect the geographical scope of the project, and thus complies with World Bank's policies in the participating states. The Health Care Waste Management Plan was publicly disclosed on the World Bank's external website on March 29, 2018 and in-country on April 4, 2018.

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

100. Finally, no climate impacts are foreseen under this project.

H. World Bank Grievance Redress

101. **Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel that determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and World Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service

(GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

Project Development Objective(s)

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.

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets				End Target
					1	2	3	4	
Increased utilization of quality, cost-effective nutrition services									
Infants 0-6 months exclusively breastfed			Percentage	24.00	29.00	34.00	40.00	45.00	50.00
Children 6-24 months who receive micronutrient powders as part of complementary feeding			Percentage	0.00	7.00	14.00	21.00	28.00	35.00
Children 6-24 months of adolescent girls who receive micronutrient powders as part of complementary feeding			Percentage	0.00	7.00	14.00	21.00	28.00	35.00
Children 6-59 months who receive zinc and ORS as treatment for diarrhea			Percentage	6.00	13.00	20.00	26.00	33.00	40.00
Children 6-59 months of adolescent girls (aged 15-19 years) who receive zinc and ORS and treatment for diarrhea			Percentage	6.00	13.00	20.00	26.00	33.00	40.00
Children 12-59 months dewormed twice a year			Percentage	27.00	34.00	40.00	47.00	54.00	60.00
Children 12-59 months of adolescent mothers (15-19 years of age) dewormed twice a year			Percentage	27.00	34.00	40.00	47.00	54.00	60.00
Pregnant women who consumed a minimum of 90 iron-			Percentage	20.50	24.50	29.00	33.00	37.00	40.00

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets				End Target
					1	2	3	4	
folic acid tablets									
Pregnant women (15-19 years) who consume a minimum of 90 iron-folic acid tablets			Percentage	13.20	18.50	24.00	30.00	35.00	40.00
Pregnant women who receive intermittent presumptive treatment for malaria (at least 3 doses)			Percentage	14.90	20.00	25.00	30.00	35.00	40.00
Pregnant women (15-19 years) who receive intermittent presumptive treatment for malaria [at least 3 doses]			Percentage	14.90	20.00	25.00	30.00	35.00	40.00

Intermediate Results Indicators by Components	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets				End Target
					1	2	3	4	
Basic Package of Nutrition Services									
People who have received essential health, nutrition, and population (HNP) services		Yes	Number	0.00	1,919,905.00	3,839,810.00	5,759,715.00	7,679,620.00	8,700,000.00
Number of women and children who have received basic nutrition services		Yes	Number	0.00	1,919,905.00	3,839,810.00	5,759,715.00	7,679,620.00	8,700,000.00
Direct caretakers of children 6-23 months with acceptable knowledge related to appropriate infant and young child feeding practices			Percentage	15.30	22.00	29.00	36.00	45.00	50.00
People, age 15 and older, who can correctly identify key			Percentage	0.00	10.00	25.00	35.00	45.00	60.00

SBCC messages on nutrition and ANH									
Males aged 15 and older, who can correctly identify key SBCC messages on nutrition and ANH			Percentage	0.00	10.00	15.00	20.00	40.00	50.00
Females age 15 and older, who can correctly identify key SBCC messages on nutrition and ANH			Percentage	0.00	10.00	25.00	40.00	50.00	75.00
Signed NGO contracts for service delivery properly managed as per agreed timeline			Number	0.00	8.00	12.00	20.00	25.00	25.00
States with complaint redressal mechanism which responds to at least 85% of the complaints			Number	0.00	0.00	12.00	12.00	12.00	12.00
Stewardship and Project Management									
Annual Results conferences held			Number	0.00	0.00	1.00	2.00	3.00	4.00
States with nutrition intervention mapping system developed and updated at least annually			Number	0.00	0.00	2.00	12.00	12.00	12.00

RESULT_FRAME_TBL_UL

Indicators to be mapped	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets					End Target
					1	2	3	4	5	
Intermediate Outcome Indicators										
Signed NGO contracts for service delivery properly managed as per agreed timeline			Number	0.00	8.00	12.00	20.00	25.00	25.00	25.00
States with complaint redressal mechanism which responds to at least 85% of the complaints			Number	0.00	0.00	12.00	12.00	12.00	12.00	12.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Infants 0-6 months exclusively breastfed
Definition/Description	This data represents information from the 12 project states of ANRiN only. Numerator: Number of infants 0-6 months receiving only breastmilk; Denominator: Total number of infants 0-6 months of age amongst live births in the last two years
Frequency	Annual
Data Source	The Baseline data is from MICS (2016-17). This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes Behavior Change Communication (BCC) to improve infant and young child feeding (IYCF) behaviors; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from IYCF counseling provided by non-state actors providing BPNS; and (iii) annual household surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator will be of the Federal Ministry of Health.
Indicator Name	Children 6-24 months who receive micronutrient powders as part of complementary feeding
Definition/Description	The data represents information from 12 ANRiN states.

	Numerator: Number of children 6-24 months who received micronutrient powders in complementary feeding on the day previous to the survey/Denominator: Total number of children 6-24 months of age
Frequency	Annually
Data Source	The data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes provision of micronutrient powders for children 6-23 months to improve the quality of food provided for their complementary feeding; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from micronutrient powders provided by non-state actors providing BPNS; and (iii) annual household SMART surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	Federal Ministry of Health
Indicator Name	Children 6-24 months of adolescent girls who receive micronutrient powders as part of complementary feeding
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Number of children 6-24 months of adolescent mothers (age 15-19 years) who received micronutrient powders in complementary feeding on the day previous to the survey/Denominator: Total number of children 6-24 months of age of adolescent mothers (age 15-19 years).
Frequency	Annual
Data Source	The data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes provision of micronutrient powders for children 6-23 months to improve the quality of food

	provided for their complementary feeding; and (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from micronutrient powders provided by non-state actors providing BPNS.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The Federal Ministry of Health
Indicator Name	Children 6-59 months who receive zinc and ORS as treatment for diarrhea
Definition/Description	This data represents information from the 12 project states of ANRiN only. Numerator: Number of children 6-59 months with diarrhea in the last two weeks who received Zinc and ORS as treatment; Denominator: Total number of children 6-59 months with diarrhea in the last two weeks
Frequency	Annual
Data Source	The Baseline data is from NNHS, 2015. This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes Zinc and ORS for treatment of diarrhea in children 6-59 months; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from Zinc and ORS for treatment of diarrhea in children 6-59 months; and (iii) annual household surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology

Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	Children 6-59 months of adolescent girls (aged 15-19 years) who receive zinc and ORS and treatment for diarrhea
Definition/Description	This data represents information from the 12 project states of ANRiN only. Numerator: Number of children 6-59 months of adolescent mothers (age 15-19 years) with diarrhea in the last two weeks who received Zinc and ORS as treatment; Denominator: Total number of children 6-59 months of adolescent mothers (age 15-19 years) with diarrhea in the last two weeks
Frequency	Annual
Data Source	The Baseline data is from NNHS, 2015. This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes Zinc and ORS for treatment of diarrhea in children 6-59 months; and (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from Zinc and ORS for treatment of diarrhea in children 6-59 months.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	Children 12-59 months dewormed twice a year
Definition/Description	This data represents information from the 12 project states of ANRiN only. Numerator: Children 12-59 months dewormed twice a year/Denominator: Total number of children 12-59 months
Frequency	Annual
Data Source	The Baseline data is from NNHS, 2015.

	This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes provision of deworming twice a year for children 12-59 months; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from twice a year deworming of children 12-59 months; and (iii) annual household surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The Federal Ministry of Health
Indicator Name	Children 12-59 months of adolescent mothers (15-19 years of age) dewormed twice a year
Definition/Description	This data represents information from the 12 project states of ANRiN only. Numerator: Children 12-59 months of adolescent mothers (age 15-19 years) dewormed twice a year/Denominator: Total number of children 12-59 months of adolescent mothers (age 15-19 years)
Frequency	Annual
Data Source	The Baseline data is from NNHS, 2015. This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes provision of deworming twice a year for children 12-59 months; and (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from twice a year deworming of children 12-59 months.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and

	(iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The Federal Ministry of Health
Indicator Name	Pregnant women who consumed a minimum of 90 iron-folic acid tablets
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Number of pregnant women who consumed a minimum of 90 iron-folic acid tablets during last pregnancy; Denominator: Total number of pregnant women with a birth in last two years
Frequency	Annual
Data Source	The Baseline data is from DHS, 2013. This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes IFA supplementation to pregnant women with a focus on counseling to improve compliance with consumption; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households with pregnant women benefitting from IFA supplementation and counseling for compliance provided by non-state actors providing BPNS; and (iii) annual household SMART surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank. The total number of pregnant women with a birth in the last two years will also be captured through the annual household SMART survey.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	Pregnant women (15-19 years) who consume a minimum of 90 iron-folic acid tablets

Definition/Description	The data represents information from 12 ANRiN states. Numerator: Number of pregnant adolescent girls (age 15-19 years) who consumed a minimum of 90 iron-folic acid tablets during last pregnancy; Denominator: Total number of pregnant adolescent girls (age 15-19 years) with a birth in last two years
Frequency	Annual
Data Source	The Baseline is from DHS, 2013. This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes IFA supplementation to pregnant women with a focus on counseling to improve compliance with consumption; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households with pregnant women benefitting from IFA supplementation and counseling for compliance provided by non-state actors providing BPNS; and (iii) annual household SMART surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	Pregnant women who receive intermittent presumptive treatment for malaria (at least 3 doses)
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Number of women age 15-49 years who received at least three doses of SP/Fansidar, at least one of which was received during an ANC visit, to prevent malaria during their last pregnancy that led to a live birth in the last two years; Denominator: Total number of women age 15-49 years with a live birth in

	the last two years
Frequency	Annual
Data Source	The Baseline data is from MICS 2016-17 This data will be captured from (i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes IPT for malaria for pregnant women; (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from IPT for malaria for pregnant women provided by non-state actors providing BPNS; and (iii) annual household SMART surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	Pregnant women (15-19 years) who receive intermittent presumptive treatment for malaria [at least 3 doses]
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Number of women age 15-19 years who received at least three doses of SP/Fansidar, at least one of which was received during an ANC visit, to prevent malaria during their last pregnancy that led to a live birth in the last two years; Denominator: Total number of women age 15-19 years with a live birth in the last two years
Frequency	Annual
Data Source	The Baseline data is from MICS 2016-17 This data will be captured from

	(i) MIS maintained by the non-state actors providing basic package of nutrition services (BPNS), which includes IPT for malaria for pregnant women; and (ii) periodic household surveys conducted by the Independent Verification Agency (IVA) in a sample of households benefitting from IPT for malaria for pregnant women provided by non-state actors providing BPNS.
Methodology for Data Collection	(i) Data will be collected in reporting formats developed for tracking performance of non-state actors (ii) The Independent Verification Agency (IVA) will conduct periodic surveys in a sample of households benefitting from services provided by non-state actors ; and (iii) Annual NNHS using smart methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health

Monitoring & Evaluation Plan: Intermediate Results Indicators	
Indicator Name	People who have received essential health, nutrition, and population (HNP) services
Definition/Description	
Frequency	Annual
Data Source	The data represents information from 12 ANRiN states. Beneficiaries: 0-5 months (breastfeeding): 1,002,281 6-59 months (deworming/comp feeding Records maintained by contracted non-state actors and PHCs providing basic package of nutrition services and focused package of adolescent health services
Methodology for Data Collection	Records maintained by contracted non-state actors and PHCs providing basic package of nutrition services and focused package of adolescent health services
Responsibility for Data Collection	The responsibility of reporting on this indicator lies with Federal Ministry of Health and State Ministries of Health

Indicator Name	Number of women and children who have received basic nutrition services
Definition/Description	
Frequency	Annual
Data Source	The data represents information from 12 ANRiN states. Records maintained by contracted non-state actors and PHCs providing basic package of nutrition services and focused package of adolescent health services
Methodology for Data Collection	Records maintained by contracted non-state actors and PHCs providing basic package of nutrition services and focused package of adolescent health services
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health and State Ministries of Health
Indicator Name	Direct caretakers of children 6-23 months with acceptable knowledge related to appropriate infant and young child feeding practices
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Number of direct caretakers (mothers) of children 6-23 months with knowledge of at least three infant and young child feeding practices from a list of four; Denominator: Total number of direct caretakers (mothers) of children 6-23 months of age. The four IYCF practices are: 1. Introduce semi-solid/solid foods to infants at the age of 6 months 2. Breastfeeding should be continued till 2 years of age 3. Foods from at least four food groups must be fed to the child. These are (i) grains, roots and tubers; (ii) deep yellow and orange fruits and vegetables rich in Vitamin A; (iii) legumes and nuts rich in protein; (iv) meat, fish and animal protein; (v) milk, cheese, yogurt; (vi) eggs; and (vii) other fruits and vegetables including green leafy vegetables. Recall of any four food groups is acceptable. 4. Frequency of meals: breastfed children 6 to 8 months must be fed 2-3 meals in a day with 1-2 snacks and breastfed children 9-23 months must be 3-4 meals in a day with 1-2 snacks; while non-breastfed children 6-23 months must be fed 4-5 meals a day with other milk and milk products at least twice a

	day.
Frequency	Annual
Data Source	The Baseline data is from MICS 2016-17. This data will be captured from annual household SMART surveys that will be jointly conducted by the National Bureau of Statistics, Government of Nigeria; National Population Commission, Government of Nigeria; and Development Partners, including the World Bank.
Methodology for Data Collection	Annual NNHS using SMART methodology
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	People, age 15 and older, who can correctly identify key SBCC messages on nutrition and ANH
Definition/Description	The data represents information from 12 ANRiN states. Numerator: People, age 15 and older, who can correctly identify at least three key SBCC messages on nutrition and ANH from the given list of messages; Denominator: People, age 15 and older, who are interviewed with the list of SBCC messages on nutrition and ANH.
Frequency	Annual
Data Source	KAP survey undertaken
Methodology for Data Collection	Sample Household Survey
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	Males aged 15 and older, who can correctly identify key SBCC messages on nutrition and ANH
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Males, age 15 and older, who can correctly identify at least three key SBCC messages on nutrition and ANH from the given list of messages; Denominator: Males, age 15 and older, who are interviewed with the list of SBCC messages on nutrition and ANH.
Frequency	Annual
Data Source	KAP survey

Methodology for Data Collection	Sample Household Survey
Responsibility for Data Collection	The responsibility to report on this indicator is with Federal Ministry of Health
Indicator Name	Females age 15 and older, who can correctly identify key SBCC messages on nutrition and ANH
Definition/Description	The data represents information from 12 ANRiN states. Numerator: Females, age 15 and older, who can correctly identify at least three key SBCC messages on nutrition and ANH from the given list of messages; Denominator: Females, age 15 and older, who are interviewed with the list of SBCC messages on nutrition and ANH.
Frequency	Annual
Data Source	KAP survey
Methodology for Data Collection	Sample Household Survey
Responsibility for Data Collection	The responsibility of reporting on this indicator lies with Federal Minister of Health
Indicator Name	Signed NGO contracts for service delivery properly managed as per agreed timeline
Definition/Description	The data represents information from 12 ANRiN states. Cumulative number of contracts signed with non-state actors for provision of basic package of nutrition services and focused package of adolescent health services by State Ministries of Health where payments are made within 45 days of raising of invoice by non-state actor after independent verification agency confirms achievement of results
Frequency	Annual
Data Source	Date of raising of invoice and date of release of payment against invoice by SMOH
Methodology for Data Collection	Payment details from the SPFMUs
Responsibility for Data Collection	The responsibility of reporting on this indicator lies with Federal Ministry of Health and State Ministries of Health
Indicator Name	States with complaint redressal mechanism which responds to at least 85% of the complaints
Definition/Description	The data represents information from 12 ANRiN states.

	Number of states with a complaints redressal system that has responded to 85% of complaints raised annually
Frequency	Annual
Data Source	Records maintained by SMOH of each project state
Methodology for Data Collection	FMOH will collated state reports on complaint redressal system maintained by the participating states in the formats agreed with the World Bank
Responsibility for Data Collection	The responsibility of reporting on this indicator lies with Federal Ministry of Health and State Ministries of Health
Indicator Name	Annual Results conferences held
Definition/Description	Cumulative number of annual results conferences held sharing latest national and international experience on nutrition and adolescent health held
Frequency	Annual
Data Source	Annual Nutrition and Adolescent Health Results Reports disseminated in conference
Methodology for Data Collection	FMOH will provide the Annual Nutrition and Adolescent Health Results Reports to the World Bank
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health
Indicator Name	States with nutrition intervention mapping system developed and updated at least annually
Definition/Description	Cumulative number of states with nutrition intervention mapping system developed and updated at least annually with data
Frequency	Annual
Data Source	Annual state reports generated from the nutrition intervention mapping system with updated data
Methodology for Data Collection	FMOH will review and confirm the availability of updated data on the nutrition intervention mapping system developed and deployed for each of the participating states annually
Responsibility for Data Collection	The responsibility of reporting on this indicator is of Federal Ministry of Health and State Ministries of Health

Disbursement Linked Indicators Matrix				
DLI 1	Approval by FMOH of (i) mass media content; and (ii) deployment plan in 2019			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	250,000.00	0.11
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019	Yes		250,000.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 2	FMOH contracting with religious leaders on SBCC on nutrition and adolescent health			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	250,000.00	0.11
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	

ending December 31, 2019	Yes		250,000.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 3	FMOH contracting media entities for deployment of mass media content as per approved plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	500,000.00	0.22
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020	Yes		500,000.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 4	At least 55% of caretakers of children 6-23 months of age with acceptable knowledge of IYCF			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Percentage	125,000.00	0.05
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	24.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	55.00		125,000.00	US$ 4,032 per percentage point increase over baseline (of 24
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 5	At least 25% of approved deployment plan of 2019 broadcasted in 2021			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Percentage	375,000.00	0.16
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	

ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	25.00		375,000.00	US$ 15,000 per percentage point increase over baseline (of 0
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 6	At least 65% of caretakers of children 6-23 months of age with acceptable knowledge of IYCF			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Percentage	125,000.00	0.05
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	55.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	65.00		125,000.00	US$ 12,500 per percentage point increase over baseline (of 0
ending December 31, 2023			0.00	

DLI 7	At least 50% of approved deployment plan of 2019 broadcasted in 2022			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Percentage	375,000.00	0.16
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	25.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	50.00		375,000.00	US$ 15,000 per percentage point increase over baseline (of 2
ending December 31, 2023			0.00	

DLI 8	At least 75% of caretakers of children 6-23 months of age with acceptable knowledge of IYCF			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Percentage	125,000.00	0.05
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	65.00			
ending December 31, 2018			0.00	

ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	75.00		125,000.00	US$ 12,500 per percentage point increase over baseline (of 6
DLI 9	At least 75% of approved deployment plan of 2019 broadcasted in 2023			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Percentage	375,000.00	0.16
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	50.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	75.00		375,000.00	US$ 15,000 per percentage point increase over baseline (of 5

DLI 10	Multi-sectoral coordination and accountability plan for nutrition, results dashboard, ratified			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Yes/No	250,000.00	0.11
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018	Yes		250,000.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 11	MOU signed between FMOBNP and the Sector Ministries to implement the ratified multi-sectoral coo			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Number	1,500,000.00	0.65
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018	5.00		1,500,000.00	US$ 250,000 to FMONBP and US$ 250,000 to each Sector Ministr

ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 12	Annual National Nutrition report produced and disseminated under results for 2019			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,500,000.00	0.65
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019	Yes		1,500,000.00	US$ 250,000 to FMOBNP and US$ 250,000 to each of the Sector
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 13	Annual National Nutrition report produced and disseminated with results for 2020			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,500,000.00	0.65
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020	Yes		1,500,000.00	US$ 250,000 to FMONBP and US$ 250,000 to each Sector Ministr
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 14	Annual National Nutrition report produced and disseminated with results for 2021			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,500,000.00	0.65
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	

ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	Yes		1,500,000.00	US$ 250,000 to FMOBNP and US$ 250,000 to each of the Sector
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 15	At least 50% increase in public budget utilized on nutrition sensitive interventions over 2020			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	500,000.00	0.22
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	1.00		500,000.00	US$ 250,000 per any sector ministry other than the FMOH, wit
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 16	Annual National Nutrition report produced and disseminated with results for 2022			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,500,000.00	0.65
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	Yes		1,500,000.00	US$ 250,000 to FMOBNP and US$ 250,000 to each of the Sector
ending December 31, 2023			0.00	

DLI 17	At least 50% increase in public budget utilized on nutrition-sensitive interventions over 2021			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	750,000.00	0.32
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	1.00			
ending December 31, 2018			0.00	

ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	3.00		750,000.00	US$ 250,000 per any sector ministry other than the FMOH, wit
ending December 31, 2023			0.00	
DLI 18	Annual National Nutrition report produced and disseminated with results for 2023			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,500,000.00	0.65
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	Yes		1,500,000.00	US$ 250,000 to FMOBNP and US$ 250,000 to each of the Sector

DLI 19	At least 50% increase in public budget utilized on nutrition-sensitive interventions over 2022			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	750,000.00	0.32
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	1.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	3.00		750,000.00	US$ 250,000 per any sector ministry other than the FMOH, wit

DLI 20	Annual results conference sharing national and international experience held in 2019			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Number	200,000.00	0.09
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	

ending December 31, 2019	1.00		200,000.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 21	Annual results conference sharing national and international experience held in 2020			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Number	200,000.00	0.09
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	1.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020	2.00		200,000.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 22	Annual results conference sharing national and international experience held in 2021			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Number	200,000.00	0.09
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	2.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	3.00		200,000.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 23	Annual results conference sharing national and international experience held in 2022			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Number	200,000.00	0.09
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	3.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	

ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	4.00		200,000.00	
ending December 31, 2023			0.00	
DLI 24	Annual results conference sharing national and international experience held in 2023			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Number	200,000.00	0.09
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	4.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	5.00		200,000.00	
DLI 25	Participating States sign PBC with at least two prequalified NDAs to fully cover states			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**

Output	Yes	Number	2,450,000.00	1.06
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018	12.00		2,450,000.00	US$ 200,000 to each SMOH that signed PBC with at least two n
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	

DLI 26	Participating States releasing payment to NSA based on performance within 45 days for results of 2019			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,250,000.00	0.54
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	
ending December 31, 2019	12.00		1,250,000.00	US$ 100,000 to each SMOH that released payment to non-state
ending December 31, 2020			0.00	

ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 27	Participating States releasing payment to NSA based on performance within 45 days for results of 2020			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,250,000.00	0.54
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020	12.00		1,250,000.00	US$ 100,000 to each SMOH that released payment to non-state
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 28	Participating States releasing payment to NSA based on performance within 45 days for results of 2021			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,250,000.00	0.54

Timetable	Value		Allocated Amount (USD)	Formula
Baseline	0.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	12.00		1,250,000.00	US$ 100,000 to each SMOH that released payment to non-state
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 29	Participating States releasing payment to NSA based on performance within 45 days for results of 2022			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,250,000.00	0.54
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	

ending December 31, 2022	12.00		1,250,000.00	US$ 100,000 to each SMOH that released payment to non-state
ending December 31, 2023			0.00	
DLI 30	Participating States releasing payment to NSAs based on performance within 45 days for results of 2023			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Number	1,250,000.00	0.54
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	12.00		1,250,000.00	US$ 100,000 to each SMOH that released payment to non-state
DLI 31	Work plan for nutrition sensitive antenatal visit developed by SPHCDAs and submitted to IDA			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	650,000.00	0.28
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	No		
ending December 31, 2018	Yes	650,000.00	US$ 50,000 for NPHCDA and US$ 50,000 for each SPHCDA that pr
ending December 31, 2019		0.00	
ending December 31, 2020		0.00	
ending December 31, 2021		0.00	
ending December 31, 2022		0.00	
ending December 31, 2023		0.00	

DLI 32	Package of nutrition-related services in PHCs during the ante-natal visit delivered as per work plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,800,000.00	0.78
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019	Yes		1,800,000.00	US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$ 180,000)
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	

ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 33	Package of nutrition-related services in PHCs during the ante-natal visit delivered as per work plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,800,000.00	0.78
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020	Yes		1,800,000.00	US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$ 180,000)
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 34	Package of nutrition-related services in PHCs during the ante-natal visit delivered as per work plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,800,000.00	0.78
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	Yes		1,800,000.00	US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$ 180,000)
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 35	Package of nutrition-related services in PHCs during the ante-natal visit delivered as per work plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,800,000.00	0.78
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	Yes		1,800,000.00	US$ 15,000 for NPHCDA per SPHCDA

				(i.e. maximum US$ 180,000)
ending December 31, 2023			0.00	
DLI 36	Package of nutrition-related services in PHCs during the ante-natal visit delivered as per work plan			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	1,800,000.00	0.78
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	Yes		1,800,000.00	US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$ 180,000)
DLI 37	MoU signed in 2018 by FMOH with at least three major DPs in project states			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	Yes	Yes/No	600,000.00	0.26
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019	Yes		600,000.00	US$ 50,000 per SMOH that signed MOUs with major development
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 38	Mapping report produced and validated in public meeting with DPs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Yes/No	600,000.00	0.26
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019	Yes		600,000.00	US$ 50,000 per SMOH which produced a map of interventions su
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	

ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 39	Mapping report produced and validated in public meeting with DPs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Yes/No	600,000.00	0.26
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020	Yes		600,000.00	US$ 50,000 per SMOH which produced a map of interventions su
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 40	Mapping report produced and validated in public meeting with DPs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Yes/No	600,000.00	0.26
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021	Yes		600,000.00	US$ 50,000 per SMOH which produced a map of interventions su
ending December 31, 2022			0.00	
ending December 31, 2023			0.00	
DLI 41	Mapping report produced and validated in public meeting with DPs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Yes/No	600,000.00	0.26
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022	Yes		600,000.00	US$ 50,000 per SMOH which

				produced a map of interventions su
ending December 31, 2023			0.00	
DLI 42	Mapping report produced and validated in public meeting with DPs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Yes/No	600,000.00	0.26
Timetable	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
ending December 31, 2018			0.00	
ending December 31, 2019			0.00	
ending December 31, 2020			0.00	
ending December 31, 2021			0.00	
ending December 31, 2022			0.00	
ending December 31, 2023	Yes		600,000.00	US$ 50,000 per SMOH which produced a map of interventions su

ANNEX 1: DISBURSEMENT LINKED INDICATORS, MILESTONES AND CUMULATED ALLOCATED AMOUNTS

COUNTRY : Nigeria
Accelerating Nutrition Results in Nigeria

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
DLI 1: Communication for Social and Behavior Change			1.1 Approval by FMOH of (i) mass media content comprising at least 5 TV spots; 5 Radio spots; and 5 episodes of Soap Opera, and (ii) deployment plan for mass media in 2019 1.2 FMOH contracting with religious leaders on social and behavior change on nutrition and adolescent nutrition and health (ANH), on TOR approved by the Association, in 2019 (1.1) **NATIONAL DLI:**	1.3 FMOH contracting media entities for deployment of mass media content as per approved deployment plan in 2020 (1.3) **NATIONAL DLI:**	1.4 At least 55% of caretakers of children 6-23 months of age with acceptable knowledge related to IYCF practices in 2021 1.5 At least 25% of approved deployment plan of 2019 broadcasted in 2021 (1.4) **NATIONAL DLI:**	1.6 At least 65% of caretakers of children 6-23 months of age with acceptable knowledge related to IYCF practices in 2022 1.7 At least 50% of approved deployment plan of 2019 broadcasted in 2022 (1.6) **NATIONAL DLI:**	1.8 At least 75% of caretakers of children 6-23 months of age with acceptable knowledge related to IYCF practices in 2023 1.9 At least 75% of approved deployment plan of 2019 broadcasted in 2023 (1.8) **NATIONAL DLI:**

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
			FMOH/PMU **Baseline:** No **Target:** Yes **Value:** (US$ 250,000) (1.2) **NATIONAL DLI: FMOH/PMU** **Baseline:** No **Target:** Yes **Value:** (US$ 250,000)	**FMOH/PMU** **Baseline:** No **Target:** Yes **Value:** (US$ 500,000)	**FMOH/PMU** **Baseline:** 24% **Target:** 55% **Value:** (US$ 4,032 per percentage point increase over baseline (of 24%) up to 55% (in 2021); Maximum: US$ 125,000) (1.5) **NATIONAL DLI: FMOH/PMU** **Baseline:** 0% of deployment plan **Target:** 25% of deployment plan **Value:** (US$ 15,000 per percentage point increase over baseline (of 0%) up to 25% (in 2021); Maximum: US$ 375,000)	**FMOH/PMU** **Baseline:** 55% **Target:** 65% **Value:** (US$ 12,500 per percentage point increase over baseline (of 55%) up to 65% (in 2021); Maximum: US$ 125,000) (1.7) **NATIONAL DLI: FMOH/PMU** **Baseline:** 25% of deployment plan **Target:** 50% of deployment plan **Value:** (US$ 15,000 per percentage point increase over baseline (of 25%) up to 50% (in 2022); Maximum: US$ 375,000)	**FMOH/PMU** **Baseline:** 65% **Target:** 75% **Value:** (US$ 12,500 per percentage point increase over baseline (of 65%) up to 75% (in 2023); Maximum: US$ 125,000) (1.9) **NATIONAL DLI: FMOH/PMU** **Baseline:** 50% of deployment plan **Target:** 75% of deployment plan **Value:** (US$ 15,000 per percentage point increase over baseline (of 50%) up to 75% (in 2023); Maximum: US$ 375,000)
DLI 1 value	**US$ 2,500,000**		**US$ 500,000**	**US$ 500,000**	**US$ 500,000**	**US$ 500,000**	**US$ 500,000**
DLI 2: Multi-sectoral coordination and accountability for nutrition		2.1 Multi-sectoral coordination and accountability plan for	2.3 Annual National Nutrition report following TORs approved by the Association,	2.4 Annual National Nutrition report following TORs approved by the Association,	2.5 Annual National Nutrition report following TORs approved by the Association,	2.7 Annual National Nutrition report following TORs approved by the Association,	2.9 Annual National Nutrition report following TORs approved by the Association,

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
results		nutrition, with results dashboard, ratified by MBNP in 2018 2.2 MOU signed between MBNP and the Sector Ministries to implement the ratified multi-sectoral coordination and accountability plan (2.1) **NATIOAL DLI: MBNP** **Baseline:** No **Target:** Yes	produced, with input from the participating Sector Ministries, and disseminated in 2019 and the planned results under DLR 2.1 for 2019 are met (2.3) **JOINT DLI: MBNP and Ministries** **Baseline:** NO **Target:** YES	produced, with input from the participating Sector Ministries, and disseminated in 2020 and the planned results under DLR 2.1 for 2020 are met (2.4) **JOINT DLI: MBNP and Ministries** **Baseline:** NO **Target:** YES	produced, with input from the participating Sector Ministries, and disseminated in 2021 and the planned results under DLR 2.1 for 2021 are met 2.6 At least 50% increase in amount of public budget utilized on nutrition sensitive interventions over the previous year (2020) in one sector other than health in 2021. (2.5) **JOINT DLI: MBNP and Ministries** **Baseline:** NO **Target:** YES	produced, with input from the participating Sector Ministries, and disseminated in 2022 and the planned results under DLR 2.1 for 2022 are met 2.8 At least 50% increase in amount of public budget utilized on nutrition-sensitive interventions over the previous year (2021) in three sectors other than health in 2022. (2.7) **JOINT DLI: MBNP and Ministries** **Baseline:** NO	produced, with input from the participating Sector Ministries, and disseminated in 2023 and the planned results under DLR 2.1 for 2023 are met 2.10 At least 50% increase in amount of public budget utilized on nutrition-sensitive interventions over the previous year (2022) in three sectors other than health in 2023. (2.9) **JOINT DLI: MBNP and Ministries** **Baseline:** NO

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
		Value: (US$ 0.25 million) (2.2) **JOINT DLI: MBNP AND KEY FEDERAL MINISTRIES** **Baseline:** 0 MOUs **Target:** 5 MOUs **Value:** (US$ 250,000 to MNBP and US$ 250,000 to each Sector Ministry (up to a maximum of five) that signs MOU in 2018; Maximum: US$ 1,500,000)	**Value:** (US$ 250,000 to MBNP and US$ 250,000 to each of the Sector Ministries, up to a maximum of five, having achieved at least 60% of planned results according to DLR 2.1 in 2019; Maximum: US$ 1,500,000)	**Value:** (US$ 250,000 to MNBP and US$ 250,000 to each Sector Ministries, up to a maximum of five, having achieved at least 70% of planned results according to DLR 2.1 in 2020; Maximum: US$ 1,500,000)	**Value:** (US$ 250,000 to MBNP and US$ 250,000 to each of the Sector Ministries, up to a maximum of five, having achieved at least 80% of planned results according to DLR 2.1 in 2021; Maximum: US$ 1,500,000) (2.6) **FEDERAL MINISTRIES** **Baseline:** 0 sector **Target:** 1 sector other than health **Value:** (US$ 250,000 per any sector ministry other than the FMOH, with a maximum of two, increasing amount of public budget utilized on nutrition sensitive interventions by at least 50% over 2020, in 2021; Maximum: US$ 500,000)	**Target:** YES **Value:** (US$ 250,000 to MBNP and US$ 250,000 to each of the Sector Ministries, up to a maximum of five, having achieved at least 80% of planned results according to DLR 2.1 in 2022; Maximum: US$ 1,500,000) (2.8) **FEDERAL MINISTRIES** **Baseline:** 1 sector **Target:** 3 sectors other than health **Value:** (US$ 250,000 per any sector ministry other than the FMOH, with a maximum of three, increasing amount of public budget utilized on nutrition sensitive interventions by at least 50% over 2021, in 2022; Maximum: US$ 750,000)	**Target:** YES **Value:** (US$ 250,000 to MBNP and US$ 250,000 to each of the Sector Ministries, up to a maximum of five, having achieved at least 80% of planned results according to DLR 2.1 in 2023; Maximum: US$ 1,500,000) (2.10) **FEDERAL MINISTRIES** **Baseline:** 1 sector **Target:** 3 sectors other than health **Value:** (US$ 250,000 per any sector ministry other than the FMOH, with a maximum of three, increasing amount of public budget utilized on nutrition sensitive interventions by at least 50% over 2022, in 2023;

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
							Maximum: US$ 750,000)
DLI 2 value	**US$ 11,250,000**	**US$ 1,750,000**	**US$ 1,500,000**	**US$ 1,500,000**	**US$ 2,000,000**	**US$ 2,250,000**	**US$ 2,250,000**
DLI 3: Evidence of new knowledge for nutrition and adolescent health results			3.1 Annual results conference sharing latest national and international experience in nutrition and adolescent health held in 2019 (3.1) **JOINT NATIONAL DLI: FMOH/NPHCDA** **Baseline:** 0 **Target:** 1 **Value:** US$ 100,000 each to FMOH and NPHCDA	3.2 Annual results conference sharing latest national and international experience in nutrition and adolescent health held in 2020 (3.2) **JOINT NATIONAL DLI: FMOH/NPHCDA** **Baseline:** 1 **Target:** 2 **Value:** US$ 100,000 each to FMOH and NPHCDA	3.3 Annual results conference sharing latest national and international experience in nutrition and adolescent health held in 2021 (3.3) **JOINT NATIONAL DLI: FMOH/NPHCDA** **Baseline:** 2 **Target:** 3 **Value:** US$ 100,000 each to FMOH and NPHCDA	3.4 Annual results conference sharing latest national and international experience in nutrition and adolescent health held in 2022 (3.4) **JOINT NATIONAL DLI: FMOH/NPHCDA** **Baseline:** 3 **Target:** 4 **Value:** US$ 100,000 each to FMOH and NPHCDA	3.5 Annual results conference sharing latest national and international experience in nutrition and adolescent health held in 2023 (3.5) **JOINT NATIONAL DLI: FMOH/NPHCDA** **Baseline:** 4 **Target:** 5 **Value:** US$ 100,000 each to FMOH and NPHCDA
DLI 3 value	**US$ 1,000,000**		**US$ 200,000**	**US$ 200,000**	**US$ 200,000**	**US$ 200,000**	**US$ 200,000**
DLI 4: Service delivery through non-state actors for improved nutrition		4.1 Participating States sign performance-based contracts (PBC) with at	4.2 Participating States releasing payment to non-state actors based on performance	4.3 Participating States releasing payment to non-state actors based on performance	4.4 Participating States releasing payment to non-state actors based on	4.5 Participating States releasing payment to non-state actors based on	4.6 Participating States releasing payment to non-state actors based on

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
outcomes		least two prequalified non-state actors to deliver on TORs approved by the Association ensuring full geographic coverage of such states in 2018	within 45 days from invoicing after IVA confirms achievement of results for 2019	within 45 days from invoicing after IVA confirms achievement of results for 2020	performance within 45 days from invoicing after IVA confirms achievement of results for 2021	performance within 45 days from invoicing after IVA confirms achievement of results for 2022	performance within 45 days from invoicing after IVA confirms achievement of results for 2023
		(4.1) **State level DLI: SMOH** **Baseline:** 0 **Target:** 12 **Value:** (US$ 200,000 to each SMOH that signed PBC with at least two non-state actors for service delivery in entire state + US$ 50,000 to one of the 12 SMOHs for signing two PBCs for ANH service with two non-state actors in 2018; Maximum: US$	(4.2) **State level DLI: SMOH** **Baseline:** 0 **Target:** 12 **Value:** (US$ 100,000 to each SMOH that released payment to non-state actor within 45 days of invoicing for services verified by IVA as delivered in entire state in calendar year 2019 + US$ 50,000 to one of the 12 SMOH for released payment to non-state actor within 45 days of invoicing for ANH	(4.3) **State level DLI: SMOH** **Baseline:** 0 **Target:** 12 **Value:** (US$ 100,000 to each SMOH that released payment to non-state actor within 45 days of invoicing for services verified by IVA as delivered in entire state in calendar year 2020 + US$ 50,000 to one of the 12 SMOH for released payment to non-state actor within 45 days of invoicing	(4.4) **State level DLI: SMOH** **Baseline:** 0 **Target:** 12 **Value:** (US$ 100,000 to each SMOH that released payment to non-state actor within 45 days of invoicing for services verified by IVA as delivered in entire state in calendar year 2021 + US$ 50,000 to one of the 12 SMOH for released payment to non-state actor within 45 days of	(4.5) **State level DLI: SMOH** **Baseline:** 0 **Target:** 12 **Value:** (US$ 100,000 to each SMOH that released payment to non-state actor within 45 days of invoicing for services verified by IVA as delivered in entire state in calendar year 2022 + US$ 50,000 to one of the 12 SMOH for released payment to non-state actor	(4.6) **State level DLI: SMOH** **Baseline:** 0 **Target:** 12 **Value:** (US$ 100,000 to each SMOH that released payment to non-state actor within 45 days of invoicing for services verified by IVA as delivered in entire state in calendar year 2023 + US$ 50,000 to one of the 12 SMOH for released payment to non-state actor

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
		2,450,000)	services verified by IVA as delivered in the state in the calendar year 2019; Maximum: US$ 1,250,000)	for ANH services verified by IVA as delivered in the state in calendar year 2020 Maximum: US$ 1,250,000)	invoicing for ANH services verified by IVA as delivered in the state in calendar year 2021; Maximum: US$ 1,250,000)	within 45 days of invoicing for ANH services verified by IVA as delivered in the state in calendar year 2022; Maximum: US$ 1,250,000)	within 45 days of invoicing for ANH services verified by IVA as delivered in the state in calendar year 2023; Maximum: US$ 1,250,000)
DLI 4 value	**US$ 8,700,000**	**US$ 2,450,000**	**US$ 1,250,000**	**US$ 1,250,000**	**US$ 1,250,000**	**US$ 1,250,000**	**US$ 1,250,000**
DLI 5: Service delivery through primary health centers for improved nutrition and health outcomes		5.1 Work plan for nutrition sensitive antenatal visit developed by SPHCDAs and submitted to the Association through NPHCDA in 2018. (5.1) **Joint DLI: NPHCDA/SPHCDA** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 for NPHCDA and US$ 50,000 for each SPHCDA that	5.2 Package of nutrition-related services in PHCs during the ante-natal visit delivered in Participating States as per terms and targets defined in work plan in DLI 5.1 (5.2) **Joint DLI: NPHCDA/SPHCDA** **Baseline:** No **Target:** Yes **Value:** (US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$ 180,000) + maximum US$ 135,000 per	5.3 Package of nutrition-related services in PHCs during the ante-natal visit delivered in Participating States as per terms and targets defined in work plan in DLI 5.1 (5.3) **Joint DLI: NHCDA/SPHCDA** **Baseline:** No **Target:** Yes **Value:** (US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$ 180,000) + maximum US$ 135,000 per	5.4 Package of nutrition-related services in PHCs during the ante-natal visit delivered in Participating States as per terms and targets defined in work plan in DLI 5.1 (5.4) **Joint DLI: NPHCDA/SPHCDA** **Baseline:** No **Target:** Yes **Value:** (US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$	5.5 Package of nutrition-related services in PHCs during the ante-natal visit delivered in Participating States as per terms and targets defined in work plan in DLI 5.1 (5.5) **Joint DLI: NPHCDA/SPHCDA** **Baseline:** No **Target:** Yes **Value:** (US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$	5.6 Package of nutrition-related services in PHCs during the ante-natal visit delivered in Participating States as per terms and targets defined in work plan in DLI 5.1 (5.6) **Joint DLI: NPHCDA/SPHCDA** **Baseline:** No **Target:** Yes **Value:** (US$ 15,000 for NPHCDA per SPHCDA (i.e. maximum US$

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
		prepared a work plan for nutrition sensitive ANC and distributed it to the Association through NPHCDA in 2018 Total: US$ 650,000)	SPHCDA where 100% of planned results for 2019 according to work plan in DLR 5.1 is achieved in 2019 (US$ 1,350 per percentage of achieved results); Maximum: US$ 1,800,000)	SPHCDA where 100% of planned results for 2020 according to work plan in DLR 5.1 is achieved in 2020 (US$ 1,350 per percentage of achieved results); Maximum: US$ 1,800,000)	180,000) + maximum US$ 135,000 per SPHCDA where 100% of planned results for 2021 according to work plan in DLR 5.1 is achieved in 2021 (US$ 1,350 per percentage of achieved results); Maximum: US$ 1,800,000)	180,000) + maximum US$ 135,000 per SPHCDA where 100% of planned results for 2022 according to work plan in DLR 5.1 is achieved in 2022 (US$ 1,350 per percentage of achieved results); Maximum: US$ 1,800,000)	180,000) + maximum US$ 135,000 per SPHCDA where 100% of planned results for 2023 according to work plan in DLR 5.1 is achieved in 2023 (US$ 1,350 per percentage of achieved results); Maximum: US$ 1,800,000)
DLI 5 value	**US$ 9,650,000**	**US$ 650,000**	**US$ 1,800,000**	**US$ 1,800,000**	**US$ 1,800,000**	**US$ 1,800,000**	**US$ 1,800,000**
DLI 6: Coordination of Development Partners at State level		6.1 MoU signed in 2018 by FMOH with at least three major development partners providing financial support for nutrition related activities in Participating States to set out the terms of	6.2 Mapping report of interventions supported/implemented by development partners in the relevant state produced and validated in a public meeting with the development partners	6.3 Mapping report of interventions supported/implemented by development partners in the relevant state produced and validated in a public meeting with the development partners	6.4 Mapping report of interventions supported/implemented by development partners in the relevant state produced and validated in a public meeting with the development partners	6.5 Mapping report of interventions supported/implemented by development partners in the relevant state produced and validated and validated in a public meeting with the development partners	6.6 Mapping report of interventions supported/implemented by development partners in the relevant state produced and validated in a public meeting with the development partners

DLI	Amount of Credit Allocated to DLI ($ million)	Year 0.5 (ending December 31, 2018)	Year 1.0 (ending December 31, 2019)	Year 2.0 (ending December 31, 2020)	Year 3.0 (ending December 31, 2021)	Year 4.0 (ending December 31, 2022)	Year 5.0 (ending December 31, 2023)
		coordination (6.1) **State level DLI: SMOH** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 per SMOH that signed MOUs with major development partners in 2018; Total: US$ 600,000)	(6.2) **State level DLI: SMOH** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 per SMOH which produced a map of interventions supported/implemented by development partners in the state and validated it in 2019; Maximum: US$ 600,000)	(6.3) **State level DLI: SMOH** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 per SMOH which produced a map of interventions supported/implemented by development partners in the state and validated it in 2020; Maximum: US$ 600,000)	(6.4) **State level DLI: SMOH** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 per SMOH which produced a map of interventions supported/implemented by development partners in the state and validated it in 2021; Maximum: US$ 600,000)	(6.5) **State level DLI: SMOH** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 per SMOH which produced a map of interventions supported/implemented by development partners in the state and validated it in 2022; Maximum: US$ 600,000)	(6.6) **State level DLI: SMOH** **Baseline:** No **Target:** Yes **Value:** (US$ 50,000 per SMOH which produced a map of interventions supported/implemented by development partners in the state and validated it in 2023; Maximum: US$ 600,000)
DLI 6 value	**US$ 3,600,000**	**US$ 600,000**	**US$ 600,000**	**US$ 600,000**	**US$ 600,000**	**US$ 600,000**	**US$ 600,000**
Total DLI value	**US$ 36,700,000**	**US$ 5,450,000**	**US$ 5,850,000**	**US$ 5,850,000**	**US$ 6,350,000**	**US$ 6,600,000**	**US$ 6,600,000**

ANNEX 2: NUTRITION INTERVENTIONS FINANCED BY THE PROJECT

Intervention	Description	Target Population	Current Coverage
Community nutrition programs for growth promotion	Behavior change communication focusing on optimal breastfeeding and complementary feeding practices, proper hand-washing, sanitation and good nutrition practices Delivery: Community-based	Children 0-23 months, women of reproductive age	Negligible
Vitamin A supplementation	Single capsule provided every 6 months Delivery: Child Health Weeks/Outreach	Children 6-59 months of age	42 percent (SMART 2015)
Therapeutic zinc supplementation with oral rehydration solution (ORS)	As part of diarrhea management with ORS Delivery: Facilities and community-based	Children 6-59 months of age	6 percent (SMART 2015)
Multiple micronutrient powders	For in-home fortification of complementary foods Delivery: Community-based	Children 6-23 months of age	Negligible
Deworming	One treatment every 6 months Delivery: Child Health Weeks/Outreach	Children 12-59 months of age	27 percent (SMART 2015)
Iron-folic acid supplementation	Supplement taken daily during pregnancy Delivery: Facilities	Pregnant women	28.5 percent (MICS 2011)
Fortification of staple foods	Fortification of staple foods (wheat flour, oil, sugar) with essential vitamins and minerals Delivery: Private sector, plus regulation at national level	General population	Negligible
Intermittent presumptive treatment for malaria during pregnancy	Intermittent preventive treatment of malaria in pregnancy is a full therapeutic course of antimalarial medicine given to pregnant women at routine antenatal care visits, regardless of whether the recipient is infected with malaria.	Pregnant women	
Community-based management of severe acute malnutrition	Includes the identification of severe acute malnutrition, community or clinic-based treatment (depending on the presence of complications), and therapeutic feeding using ready-to-use therapeutic food Delivery: community-based identification and treatment, some facility-based	Children found to be severely wasted (WHZ <-3) among children 6-59 months of age	16 percent (UNICEF, 2016)

ANNEX 3: IMPLEMENTATION ARRANGEMENTS

A. Overall Project Management

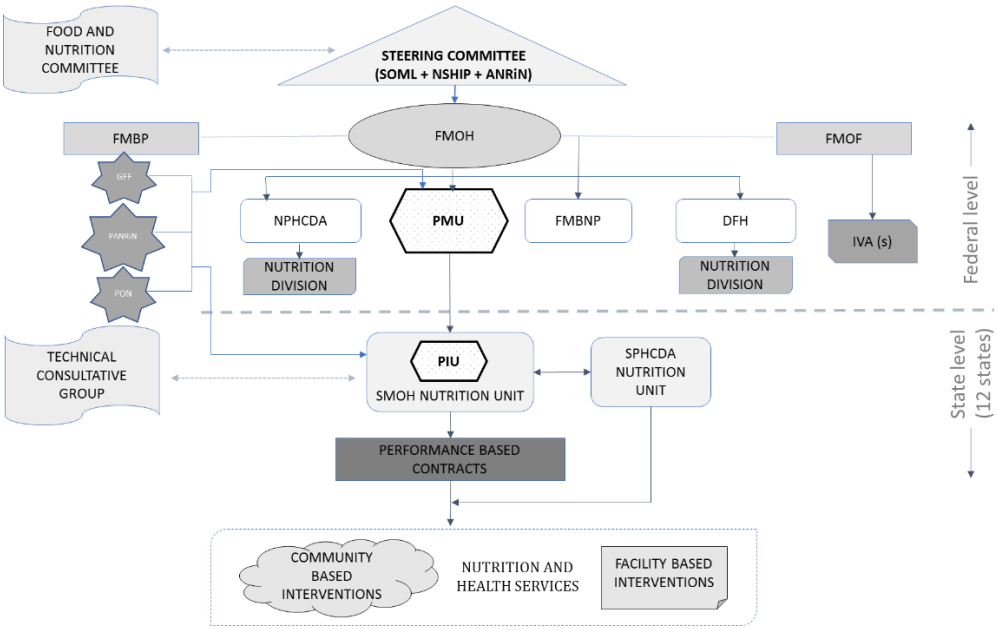
1. The Steering Committee facilitating intergovernmental coordination, collaboration, communication, knowledge sharing and monitoring of the SOML and the NSHIP will also similarly support ANRiN.

2. The project will be anchored within the FMOH. The Department of Family Health (DFH) and the NPHCDA of the FMOH will provide technical guidance to project states for implementation of the project. The MBNP will lead multi-sectoral coordination on the National Policy on Food and Nutrition in Nigeria (2016) and its monitoring with key ministries such as health, agriculture and rural development, education, women's affairs and social development, and NASSCO and NCTO under the office of the Vice President of Nigeria for social protection.

3. The DFH will work with the states to ensure that states have the standards, tools and technical capacity to meet their nutrition targets. It will take the lead in finalization of the social and behavior change strategy developed with technical assistance of the MDTF, in collaboration with the Advocacy and Communications Department of the NPHCDA for the project and facilitate its deployment at the federal level and in project states. It will also be incentivized to finalize the design of and deploy the proposed national nutrition surveillance system and to manage a research program.

4. The nutrition division of the NPHCDA will be responsible for provision of technical support to the State Primary Health Care Development Agencies for service delivery of a nutrition sensitive antenatal package in its primary health care facilities.

5. The organizational structure of the project is shown below (Figure 3.1).



Project Management Unit

6. The Project Management Unit housed in the FMOH will oversee overall coordination of the project. The PMU will be responsible for the coordination of day-to-day administration, monitoring and reporting on project activities and serve as the liaison with the FMOH, the NPHCDA, MBNP as well as the SMOHs and SPHCDAs responsible for project implementation at the state level.

7. A senior officer will be identified by the Honorable Minister of Health to serve as the full-time Project Coordinator for ANRiN. He/she will be supported by technical experts in the fields of (i) nutrition and infant and young child feeding; (ii) adolescent nutrition and health; (iii) communication; (iv) procurement; (v) contract management; (vi) community mobilization and engagement; (vii) accountant/finance; (viii) internal auditor; and (ix) monitoring and evaluation. These experts could be either seconded from FMOH and/or NPHCDA, where available or recruited as consultants, where such skills are lacking in both the Federal Ministry and the Agency. The responsibilities of the PMU will include:

a. Overseeing the implementation of all Project components;
b. Coordinating and facilitating the FMOH/NPHCDA activities related to the project;
c. Implementing and overseeing the initial disbursements to participating states;
d. Communicating and working with states, developing and implementing a communications and outreach plan;
e. Facilitating the timely disbursement of funds to the states;
f. Knowledge management and peer learning; and
g. Ensuring that covenants are complied with and that the Project is implemented according to the PIM.

8. It was agreed that in the period until project effectiveness, the PMU of SOML will provide offices and accommodate the administrative Secretariat for the ANRiN PMU. This will enable ANRiN to be in full-readiness of implementation upon effectiveness.

State Level Arrangements

9. At the state level, the Commissioner of Health will chair the Technical Consultative Group and be accountable for Project outcomes. It was agreed that at the state level, the SMOH will provide technical oversight to project implementation, and house the Project Implementation Unit. The SMOH will also contract and manage the non-state performance based contracts for delivering the basic package of nutrition services in all states and focused package of adolescent health interventions in one pilot state and be held accountable for achievement of relevant DLI milestones.

10. The SPHCDA, will oversee delivery of nutrition sensitive antenatal care comprising IFA supplementation and IPTp for pregnant women, and counselling on IYCF for pregnant beneficiaries in its Primary Health Care facilities and be held accountable for achievement of the relevant DLI milestones at the state level.

11. A full-time Project Coordinator deputed to the Project Implementation Unit (housed in SMOH) will lead project implementation, drawing from the SMOH as well as the SPHCDA, as required, expertise

in the areas of: (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 auditor; and (viii) monitoring and evaluation. Additionally, in the state that will be piloting the adolescent health services an officer for adolescent health and nutrition will be deputed. The role of the PIU will be to provide administrative support to the project, drawing upon technical guidance from SMOH and facilitating project implementation through the SPHCDA.

Implementation Support from the World Bank with Financing from Trust Funds

12. Technical assistance and implementation support to the project will be coordinated and provided by the World Bank with financing from three trust funds, the Partnership for Nutrition Results in Nigeria (PANRiN); the GFF and the Power of Nutrition (PON). In addition, a technical assistance platform will be created through GFF to facilitate the coordination of the technical assistance provided by other development partners.

13. The GFF financing will enable the World Bank to place two consultants in each of the project states supporting the PIU with technical and operational expertise to fast track project implementation, with a particular focus on building government capacity to manage the performance contracts effectively. The GFF will also support evaluation of the adolescent health pilot in the project.

14. The PON will support project implementation at both the PMU at the Federal level and the PIUs at the State levels with quality improvement interventions; the need based technical assistance for design and evaluation of innovations within the project; and the knowledge management and learning agenda under the project.

15. The PANRiN MDTF will focus on financing ongoing just in time technical assistance to the project at the federal and state levels by way of formative research in support of the SBCC and the development and testing of consequent mass media content; development and deployment of an advocacy strategy for the nutrition in Nigeria; annual SMART surveys; technical assistance for developing nutrition information systems; ongoing implementation support and review visits; and impact evaluation of the project independent verification of project results. Additionally, the PANRiN will be leveraged to prepare for the design and scope of the next phase of IDA support by undertaking relevant scoping and review studies.

B. Financial Management, Disbursements and Procurement

16. *Financial Management.* A financial management (FM) assessment of the implementing entities in line with the Financial Management Manual (March 1, 2010) and the AFTFM Financial Management Assessment and Risk Rating Principles (October 2010) was done in April 2018. The objective of this assessment was to determine whether the implementing entities have acceptable financial management arrangements in place that satisfy the World Bank's OP/BP 10.00, which will ensure: (i) that all transactions and balances relating to the project are correctly and completely recorded; (ii) the preparation of regular, timely, and reliable financial statements; (iii) safeguarding of the entity's assets; and (iv) existence of auditing arrangements acceptable to the World Bank.

17. The overall FM risk for the Project is assessed as Substantial at preparation phase. This is mainly because of the inherent risks and issues of multiple implementation levels, not because of the control risks associated with the basic elements of the project FM arrangement. However, these inherent risks are well mitigated by the use of the PFMU and FPFMD, which feature robust controls (internal and external). The PFMUs at the state levels, where payments to multiple beneficiaries will take place have obtained adequate experience in managing financial flows to multiple levels from other projects in the portfolio and they will be given additional training. With the mitigation measures, the residual FM risk is Substantial. The mitigation measures include use of computerized accounting systems, professionally qualified and experienced FM staff, and independent and effective internal audit that will adopt risk based internal audit methodology involving risk mapping, etc. The Financial Procedures Manual (FPM) will detail adequate internal controls which will include an enhanced accountability framework over soft expenditures (travels, study tours, workshops, etc.) which shall be implemented in the project. Regular reporting arrangements and supervision plan will also ensure that the implementation of the Project is closely monitored and that appropriate remedial actions are taken expeditiously. The FM risks will be reviewed during project implementation and updated as appropriate.

18. The PFMUs and FPFMD are established in all states and federal level respectively through the joint efforts of the World Bank and government. These units are presently involved in the implementation of a number of World Bank-assisted projects. The financial accountable architecture in the FPFMD and PFMUs feature among other things the following: (i) all the key elements of FM, including: budgeting, funds flow, accounting, internal control, reporting and audit; (ii) computerized system and robust FM procedures manual; (iii) qualified staff that are well-trained in relevant World Bank procedures and requirements, including procurement; (iv) robust segregation of functions/duties; (v) a strong control environment, which is required to mitigate fiduciary risks; (vi) highly independent and well-trained internal auditors; and (vii) full alignment with the government own FM system but with some important enhancements and controls.

19. The World Bank's recent reviews showed that the PFMUs and FPFMD are performing satisfactorily. The key issues noted within the PFMUs and FPFMD are that of unretired advances and inadequate documentation for incurred eligible expenditures. To mitigate the risks of unretired travel advances and provision of inappropriate documentation to acquit the travel advances, and unjustifiable claims for travel not undertaken, the project will implement an enhanced accountability framework which is aimed at arresting such eventuality. The details of the enhanced accountability framework will be elaborated in the FPM.

20. *Planning and Budgeting.* The project accountants (PAs) with guidance from the Director, Financial FPFMD at the federal level, and Heads of SPFMUs will take the lead in preparing Federal Project Coordinating Units' budgets and State's Project implementing Unit's budgets respectively. The budgets would be prepared on an annual basis for the fiscal year based on the approved work program, and in consultation with key members of the coordinating/implementing units. Detailed procedures for planning and budgeting are documented in the FPM.

21. Project financing would represent only a fraction of the overall financing for the State Health Plan included in the pooled Eligible Expenditure Program (EEP) for the implementation period. The financial management dimensions (budget/treasury management, reporting and monitoring) would be the overall responsibility of the State Ministry of Finance. The State Ministry of Finance would work

closely with the SMOH to prepare disbursement requests which will be sent to the SPFMU for processing.

22. *Accounting.* The FPFMD and the SPFMUs will maintain adequate and appropriate books of accounts. The books of accounts to be maintained for ANRiN will be set up and shall include: the cash book, ledgers, journal vouchers, fixed asset register, advances register, and contracts register. The books of accounts will be maintained on a computerized system. The accounting software in use in FPFMD and the SPFMUs or the Government Integrated Financial Management Information System (GIFMIS) where in existence, will be utilized. A list of accounts codes (Chart of Accounts) for the project will be drawn up. This shall match with the classification of expenditures and sources and application of funds indicated in the Financing Agreement. The Chart of Accounts should be developed in a way that allows project costs to be directly related to specific work activities and outputs of the project.

23. The books of accounts to be used for the project will be opened and a Chart of Accounts will be completed in accordance with the standard provision in Financing Agreement of maintaining books of accounts for the project.

24. *Internal controls.* Adequate internal controls are in place at the FPFMD and SPFMUs but will be strengthened further and will be applied to the project. The control features include robust FM procedures manual, relevantly qualified staff who are trained in relevant World Bank procedures and requirements, including procurement; robust segregation of functions/duties and highly independent and well-trained internal auditors. The FM staff are appointed by the Accountant General of the Federation and State Accountants General.

25. *Internal audit.* The FPFMD and SPFMUs have Internal Audit Units headed by a professionally qualified auditor who reports to the project coordinators. The work programs of the internal auditors would include periodic review of ANRiN activities. The internal audit arrangements at FPFMD and SPFMUs are considered adequate. The internal auditors will carry out the traditional internal or compliance audit and the non-financial or operational internal audit but without adopting the pre-payment audit system. Payroll audit will be conducted in each fiscal year by the Internal Audit Unit in the FPFMD and each SPFMU.

26. *Funds flow arrangements.* Project funding will consist mainly of IDA Credit and GFF grant. The project accounts will be opened with the Central Bank of Nigeria (CBN) and the federal level and commercial banks acceptable to IDA, at the state level.

27. Signatories to the bank account are in two panels:

a. Panel A – PC (Main Signatory)
   Supervising Director in MDA (Alternate)

b. Panel B – Director, FPFMD or Head SPFMU (Main Signatory)
   Project Accountant (Alternate)

28. All authorization to disburse payments is signed by two signatories in combinations elaborated in the Manual of Authority.

29. The funds flow arrangements are summarized and detailed in the table below.

- Two Designated Accounts (DAs) will be established for the FPMU and each SPIU, each for a Category.
- IDA will make an initial advance disbursement from the proceeds of the Credit by depositing into the Recipients-operated DAs denominated in US dollars, held in the CBN at the federal level, and commercial banks acceptable to IDA in the states.
- Actual expenditure will be reimbursed through submission of withdrawal applications and documented Statement of Expenditures (SOEs).
- For Category 1, transfers from the DAs (for payment of transactions in local currency) will be deposited in the Project Draw-Down Account in the same bank where the DA is domiciled, to pay all local currency project transactions denominated in Nigerian naira.
- For Category 2, payment will be made from the DAs (for reimbursement of EEPs in US dollars) to the government consolidated fund bank account.

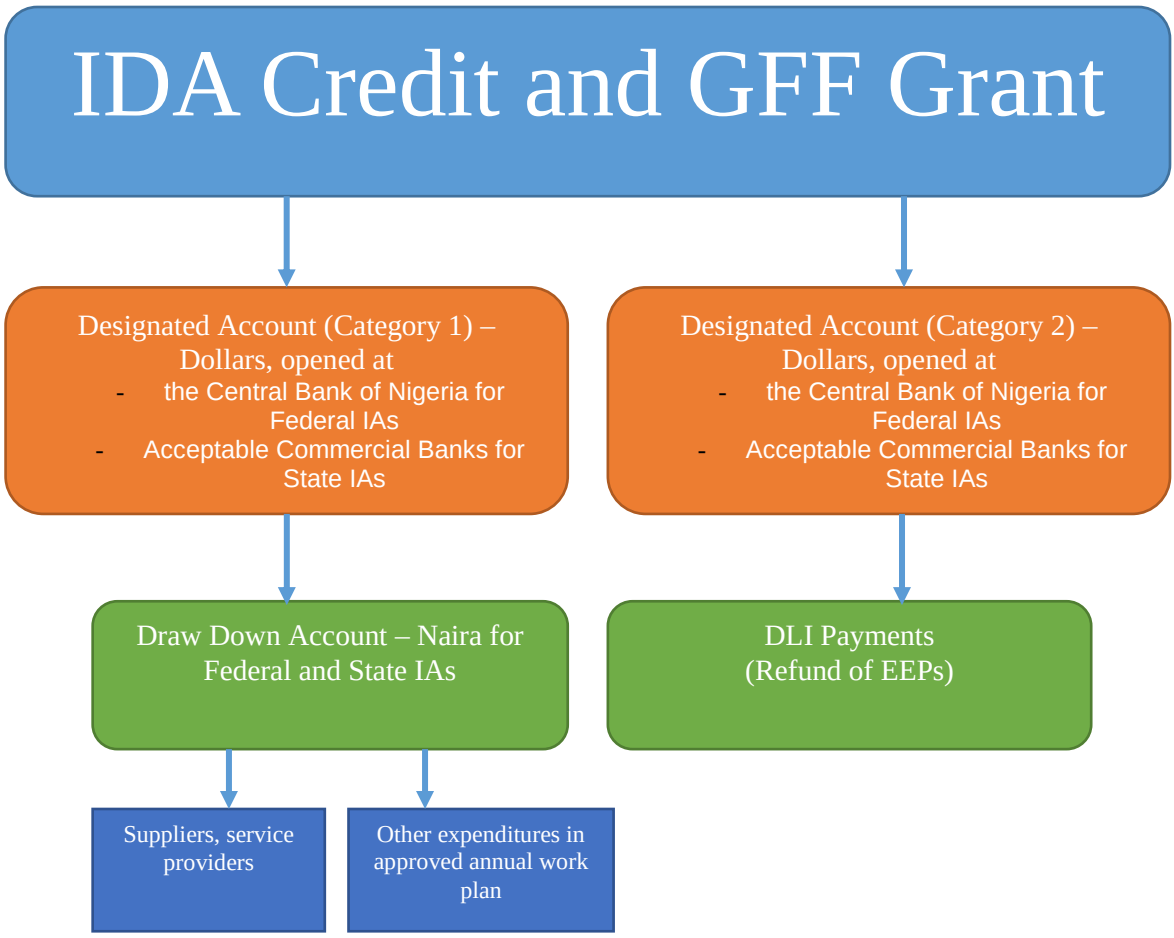


Table 4: Fund Flow Arrangements

Description	Category 1 (Goods, Consulting Services, Non-Consulting Services, Training and Operating Cost)	Category 2 (Reimbursement of Eligible Expenditure Program) Disbursement Linked Indicators
		DLIs - Federal and State Payments
Recipient	Federal; State	Federal; State
Paid into	FPMU, SPIUs' Designated Account	Ministry of Finance
Basis of payment	Specific statements of expenditures against contracts in the approved Procurement Plans and activities in the approved Work Plan.	Reimbursement of EEPs upon achievement of DLIs in the DLI Matrix, with set amounts per DLI
Vetting	World Bank	F(S)MOH/N(S)PHCDA/Independent Third Parties; final payment approval by the World Bank
Frequency	As needed.	Annual – End of twelve (12) months period.
Amount	Federal US$ xx m States US$ xx m	Up to US$ 0.31 annual per state. Federal: 1. Up-to US$ 1.75 m Year 0 2. US$ 2.1 m for years 1 and 2 each 3. US$ 2.6 m for year 3 and 4. US$ 2.85 m for years 4 and 5
Use of Funds	Consultant fees, operating costs, goods, minor works and non-consulting services, training/workshops.	Discretionary funding deposited in Consolidated Fund

Table 5: DLIs Pricing Table

	Year ending Dec 2018 (US$ million)	Year ending Dec 2019 (US$ million)	Year ending Dec 2020 (US$ million)	Year ending Dec 2021 (US$ million)	Year ending Dec 2022 (US$ million)	Year ending Dec 2023 (US$ million)	Total (US$ million)
Federal EEP	1.75	2.2	2.2	2.7	2.95	2.95	14.75
Total State EEP (for 12 states)	3.7	3.65	3.65	3.65	3.65	3.65	21.95
EEP per state	0.31	0.30	0.30	0.30	0.30	0.30	1.83
Total EEP	5.45	5.85	5.85	6.36	6.6	6.6	36.7

Eligible Expenditures

30. The DLI component reimburses a portion of the Federal/State government health EEP expenditures. Part of this disbursement goes to states in recompense for completing DLIs. The Project will work with the federal/state government to ensure that the State Financial Management Information Systems (FMIS) systems adequately captures the budgeted EEPs and actual expenditures in a credible and timely manner. The EEPs should also contribute to meeting ANRiN DLI and advancing Credit objectives. The EEP will comprise state health worker salaries. It is possible that over the course of Credit implementation some additional state EEPs could be added including program budgets (if budgeting reforms are implemented) and possibly maintenance, utilities, training, etc. However, at this juncture they do not meet all of the essential EEP criteria which include the following:

i. Expenditures must be by the state, not direct federal expenditure or earmarked funding from other organizations.
ii. EEP must be budgeted annually and approved with budget codes (separate sub-accounts) that allow expenditures to be tracked and recorded at the states;
iii. Tracking and recording of EEP expenditures must be timely (within three months of the close of a period), credible and capable of being audited with an adequate paper trail.
iv. EEP must be important budget items both in terms of size of resources and relevance to ANRiN objectives. Smaller but important line items may be included if they satisfy all of the criteria.
v. EEP must satisfy World Bank fiduciary (FM, procurement and safeguards) requirements.

31. Federal/State health worker salaries is the most logical EEP and the one that is budgeted, tracked and reported from a credible system and without delay. The value of these budget lines is also sufficient to cover DLI payments to the federal/state governments.

Table 6: Budget Codes for EEPs

Object Code Classification	***Expenditure Element Description of Object Classification***
Federal	
21001001/21010101	Ministry of Health - Salary
Abia State	
21001001/21010101	Ministry of Health - Salary
Akwa-Ibom State	
21001001/21010101	Ministry of Health - Personnel Cost
Gombe State	
21001001/21010101	Ministry of Health – Basic Salary
21001001/21010201	Primary Health Care Dev. Agency – Basic Salary
Kaduna State	
21001001/21010101	Ministry of Health – Basic Salary
21001001/21010104	Ministry of Health – Basic Wages
Kano State	
21001001/21010101	Ministry of Health - Salary
Katsina State	

4271201	Ministry of Health - Personnel Cost
4271201	Health Management Board - Personnel Cost
Kogi State	
21001001/21010101	Ministry of Health - Salary
Kwara State	
21001001/21010101	Ministry of Health - Salary
Nasarawa State	
21001001/21010101	Ministry of Health - Salary
Niger State	
21001001-21010101-70131-2101	Ministry of Health - Personnel Cost
Oyo State	
052100100100-21010101	Ministry of Health - Salary
052110200100-21010101	Oyo State Hospitals' Management Board - Salary
Plateau State	
423000	Ministry of Health - Personnel Cost
437004	Hospital Management Board – Personnel Cost

32. *Disbursement:* The project will use the transaction-based disbursement procedures at effectiveness. Proceeds of the Credit will be used for eligible expenditures as defined in the Financing Agreement. Details of the disbursement arrangement are provided in the Disbursement Letter.

Disbursement Categories

33. The table below sets out the expenditure components and percentages to be financed out of the credit proceeds.

Table 7: Allocation of credit proceeds to be financed for eligible expenditures in each category

Components	Amount of the Credit Allocated (expressed in USD	Percentage of Expenditures to be Financed (inclusive of Taxes)
1. Basic Package of Nutrition Services	180,150,000	100%
2. Stewardship and Project Management	44,850,000	100%
TOTAL AMOUNT	225,000,000	

34. *Financial Reporting.* Interim Financial Reports (IFRs) will be prepared by ANRiN on a semester basis. The project will submit the IFRs to IDA not later than 45 days after the end of each calendar semester. The formats of IFRs will be agreed within 30 days of Negotiations.

35. *Risk mitigation measures related to governance and anti-corruption*. Measures to mitigate FM governance and anti-corruption related risks in the project include: having in place Grievances and Appeal mechanism. A Grievance Resolution Committee shall be constituted.

36. *External Audit.* Each state government will prepare project financial statements for the designated accounts (EEPs and technical assistance) and have them audited by auditors acceptable to the World Bank and submitted to the World Bank within six months from the end of each financial year. In addition, the State Auditors-General will carry out Special Audits of health sector expenditures to check on allocation of funds from DLI and their utilization in the sector. These reports will be expected to be part of the State Auditors-General report that will be submitted to their State Parliament within nine months from the end of each financial year. The Auditors-General will send a copy to the World Bank for review and as input to the World Bank implementation support team.

37. The annual financial statements for the FPCU will be audited by the Auditor-General of the Federation, on the basis of Terms of Reference acceptable to IDA. The auditor will express an opinion on the Annual Financial Statements in compliance with International Standards on Auditing (ISA).

38. In addition to the audit report; the external auditors will prepare a Management Letter (ML). Copy of the audited financial statements along with the ML will be submitted to IDA not later than six months after the end of each financial year.

Financial Management Action Plan

39. Actions to be taken for the project to further strengthen its financial management system are listed in table below.

Table 8: FM Action Plan

No.	Action	Date due by	Responsible
1	Agreement of format of Interim Financial Report (IFR), Annual Financial Statement and External Auditors Terms of Reference	Within 30 days of negotiations	FPMU/FPFMD and SPIU/PFMU with support and guidance of IDA task team
2	Train designated PFMU and FPFMD staff in World Bank FM procedures and Disbursement Guidelines.	Before effectiveness	FPCU/FPFMD and SPIU/PFMU
3	Appoint external auditor	Within 90 days after effectiveness	FPCU/FPFMD and SPIU/PFMU
4	Update computerized accounting systems at FPMU and all participating SPIUs	270 days after effectiveness	FPCU/FPFMD and SPIU/PFMU
5	Designate PA, PIA and support accounting technicians to FPMU and SPIU	Within 60 days after negotiations	FPCU/FPFMD and SPIU/PFMU
6	Agreement on Memorandum of financial services and service standards between FPFMD & FPMU and PFMU & SPIU	Within 60 days after negotiations	FPCU/FPFMD and SPIU/PFMU

40. *Financial Management Implementation Support Plan.* FM supervision will be consistent with a risk-based approach, and will involve collaboration with the World Bank's project team, WFALA and procurement. The supervision intensity is based initially on the assessed FM risk rating and subsequently on the updated FM risk rating during implementation. Given the High residual risk rating, on-site

supervision will be carried out at least twice a year. On-site review will cover all aspects of FM, including internal control systems, the overall fiduciary control environment, and tracing transactions from the bidding process to disbursements as well as SOE review. Additional supervision activities will include desk review of semester IFRs, quarterly internal audit reports, audited Annual Financial Statements and management letters as well as timely follow up of issues that arise, and updating the FM rating in the Implementation Status and Results Report (ISR) and the Portfolio and Risk Management (PRIMA) system. Additional target reviews may be conducted depending on emerging risks. The World Bank's project team will support in monitoring the timely implementation of the action plan.

Conclusion

41. The financial management assessment conclusion is that subject to the mitigation measures and the action plan being implemented as per agreed time frame, the project has met the minimum FM requirement in accordance with OP/BP 10.00. Further, this objective will be sustained by ensuring that strong and robust financial management arrangements are maintained for the project throughout its duration. Detailed financial management reviews will also be carried out regularly, either within the regular proposed supervision plan or a more frequent schedule if needed, to ensure that expenditures incurred by the project remain eligible.

C. Procurement

42. To respond to its malnutrition challenge, the Government of Nigeria is currently preparing a US$232 million ANRiN project to be financed by the World Bank leveraging results and performance based approaches of project implementation. The development objective of the project is to expand the quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under five years in select states of Nigeria. In doing so, it is anticipated that the project will contribute positively to reducing stunting and micronutrient malnutrition, and therefore, maternal and child mortality rates, over time increasing school completion and performance and improved labor force productivity.

43. The bulk of the project resources will focus on increasing provision and utilization of key nutrition interventions through performance based approaches in Nigeria. Therefore, the *Accelerating Nutrition Results in Nigeria* (ANRiN) project is expected to lead to positive social impacts and benefits as it will help to continue the efforts of the Government of Nigeria as well as sustain coverage and prevent a deterioration of nutrition services in the country by scaling up basic package of nutrition interventions in the following 12 States: Abia, Akwa Ibom, Gombe, Kaduna, Kano, Katsina, Kogi, Kwara, Nasarawa, Niger, Oyo, and Plateau.

44. While the anticipated results of ANRiN would primarily be in the domain of the health sector, the project would also strengthen other system building blocks such as: improving the multi-sectoral coordination and increasing accountability for nutrition results across key sectors; developing a national nutrition surveillance system; and strengthening domestic human resource capacity to design and manage large-scale nutrition-focused programs—interventions that are national in scope.

45. The project is designed to deliver a set of core nutrition interventions within the selected States, mainly through performance based contracts with non-state actors working in communities and through

Disbursement Linked Indicators (DLIs) that will incentivize results to be achieved through government delivery channels. The procurement arrangements and implementation under project will therefore harness all available capacity to deliver interventions, including those of not-for-profit and for-profit non-state actors while ensuring that the government is in a leadership position.

46. The major procurement activities under the ANRiN project will include: Performance based contracts (PBCs) to deliver a package of (i) basic nutrition and health services and/or (ii) adolescent nutrition and health services in the communities of twelve states representing the six geopolitical zones of Nigeria. The expression of interest for the PBCs will be targeted at organizations and or firms which have demonstrated ability for financial management of projects of a value of at least US$ 5 million in the last three to five years. Other key procurement activities will include-Behavior change communications, project management services at federal and state levels, including activities related to, research, monitoring and verification of results etc. In addition, the consulting services under the project are likely to include both consultancy and non-consultancy services which will be provided during project implementation. Further, there will be trainings and workshops to strengthen capacities of project staff and other health staff in the project.

Procurement Implementation Arrangements: at the Federal/States

47. To facilitate project implementation at the federal and at the state level, Project Management Unit will be established within the FMoH and in the Project Implementation Units in the State Ministries of Health and will be in charge of the overall coordination of the project. At the state level, the role of the PIUs will be to provide administrative support to the project, drawing upon technical guidance from SMOH and facilitating project implementation through the State Primary Healthcare Development Agency.

48. *Federal Ministry of Health (FMoH).* The FMOH procurement cycle management has been rapidly assessed and is found to be moderately satisfactory. Procurement plans are usually prepared, so also bidding documents, evaluation reports etc. The Federal Government of Nigeria, has already established the Bureau for Public Procurement (BPP) charged with the responsibility of ensuring that procurement activities in the Federal MDAs are implemented in accordance with the 2007 Public Procurement Act and in line with international standards. The interim assessment of the FMoH in reference to the procurement arrangements for the ANRiN project confirms that current procurement capacity in the FMOH, and the participating states provides significant prospects and assurances that the procurement function will be carried out successfully. However, the procurement risk rating at inception of ANRiN is *Substantial,* but could be reduced to Moderate after the implementation of the procurement risk mitigations set out in the project.

49. *Filing and record keeping***.** The ANRiN Procurement Procedures Manual will set out the detailed procedures for maintaining and providing readily available access to project procurement records, in compliance with the Credit Agreement. The implementing agencies will assign one person responsible for maintaining the records. The logbook of the contracts with unique numbering system shall be maintained.

50. The signed contracts as in the logbook shall be reflected in the commitment control system of the Borrower's accounting system or books of accounts as commitments whose payments should be

updated with reference made to the payment voucher. This will put in place a complete record system whereby the contracts and related payments can be corroborated.

51. *Procurement risk rating.* The project procurement risk at the time of preparation of the PPSD and prior to application of mitigation measures is "Substantial". The risk may be reduced to a residual rating of "Moderate" upon consideration of successful implementation of the mitigation measures. The risks and mitigation measures are provided at the end of this annex.

52. *Procurement strategy***.** The procurement strategy is linked to the project implementation strategy ensuring proper sequencing of the activities. It considers the procurement capacity for carrying procurement and managing contract implementation, and governance aspects on the one hand and adequacy, behavior and capabilities of the market to respond to the ANRiN procurement activities on the other hand.

53. *Procurement Plan***.** The Borrowers and their Implementing Agencies have prepared a detailed 18-month procurement plan. This plan was agreed on by the Government and the World Bank at the credit negotiation. The Procurement Plan will be updated in agreement with the World Bank Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

54. *Use of UN agencies*. UN agencies may be hired by the Governments on sole-source basis for contracts for which they offer their unique roles and qualifications and specialization. Standard forms of agreement for UN agencies as acceptable to the World Bank will be adopted. For those UN agencies, if such forms have not been agreed with the World Bank, the World Bank team will provide acceptable sample forms for use by the PIUs. For the UN agencies hired by the Government, certain quick-disbursing arrangements may be agreed upon to finance a positive list of imported or locally produced goods that are required for the project, further subject to the World Bank's prior agreement on the conditions for the release of the financial tranches and the required documentation and certifications, such a s customs and tax certificates or invoices.

55. *Training, workshops, study tours, and conferences***.** Training activities would comprise workshops and training, based on individual needs, as well as group requirements, on-the-job training, and hiring consultants for developing training materials and conducting training. To ensure fiduciary prudence and transparency, annual training plans will be developed for training and workshop activities (other than consulting services) that would identify the general framework of training activities for the year, including: (i) the type of training or workshop; (ii) the personnel to be trained; (iii) the institutions which would conduct the training and reason for selection of this particular institution; (iv) the justification for the training, how it would lead to effective performance and implementation of the project and or sector; (v) the duration of the proposed training; and (vi) the cost estimate of the training. These along with collated trainee feedback reports for each workshop/training will be shared with the World Bank during the six-monthly missions for review.

56. *Operational costs.* Operational costs financed by the project would be incremental expenses, including office supplies, vehicles operation and maintenance cost, maintenance of equipment, communication costs, rental expenses, utilities expenses, consumables, transport and accommodation,

per diem, supervision costs, and salaries of locally contracted support staff. Such services' needs will be procured using standard Government of Nigeria procurement procedures acceptable to the World Bank.

57. *Retroactive financing*. This will be applicable, in accordance with sections 5.1 and 5.2 of the Procurement Regulations for IPF Borrowers will be allowed up to 20 percent of the Credit, covering the expenditures incurred by the country prior to the signing of the Credit Agreement under the activities agreed with the World Bank.

58. *Procurement manual***.** Procurement arrangements, roles and responsibilities, methods and requirements for carrying out procurement have been elaborated in detail in the Procurement Manual which is a section of the Project Implementation Manual (PIM). The PIM was prepared by the Borrowers and agreed with the World Bank.

59. *Procurement methods***.** The methods as indicated in the below table and within the thresholds indicated in the below tables can be used. The thresholds for the World Bank's prior review requirements are also provided in the table below:

Table 9: Thresholds*, Procurement Methods, and Prior Review

No.	Expenditure Category	Contract Value Threshold* [eq. USD]	Procurement Method	Contracts Subject to Prior Review /[eq. US$]
1	Works if any	C ≥ 5,000,000	ICB / LIB	All
		200,000 ≤ C < 5,000,000	NCB	None
		C < 200,000	Shopping	None
		All Values	Direct Contracting	All Contracts ≥ 100,000
2	Goods and non-consulting services	C ≥ 500,000 C ≥ 1,000,000	ICB / LIB	All contracts ≥ 1,000,000
		100,000 ≤ C < 500,000	NCB	None
		C<100,000 C<500,000 for procurement of vehicles	Shopping	None
		All Values	Direct Contracting	All Contracts ≥ 100,000
3	Consulting Services	C ≥ 300,000 (firms) **	QCBS, QBS LCS, FBS,	All contracts
		C < 300,000 (firms)	As above and CQS	Contracts for procurement and legal services. TOR and Shortlists for the remaining contracts.
		All values	IC	All contracts ≥ 200,000. TOR and Shortlists for the remaining. Contracts. The entire process for the contracts for procurement and legal services regardless of the value.

No.	Expenditure Category	Contract Value Threshold* [eq. USD]	Procurement Method	Contracts Subject to Prior Review /[eq. US$]
		All values	SSS	All contracts ≥ 100,000
4	Training, Workshops, Study Tours	All Values	Based on approved Annual Work Plan & Budgets (AWPB)	All

*These thresholds are for the purposes of the initial procurement plan for the first 18 months. The thresholds will be revised periodically based on re-assessment of risks. All contracts not subject to prior review will be post-reviewed.

60. **The World Bank's procurement implementation support and supervision.** Project execution is the Borrower's responsibility. Striving to cultivate strong and frank partnerships with staff of the Borrowers the World Bank will provide the Borrowers with procurement implementation support which shall include advice and assistance taking into consideration project features and the risk profile, and as reasonably required. Such support would be available to the project due to experience capacity constraints in the health sector. In addition, procurement support shall be provided during the World Bank's supervision missions held at least once a year.

61. Although each PIU will ensure that procurement is based on the specific needs of their project, there may be common items, especially major equipment and specialized or important services that would be procured by various states. To secure the best competition, avoid inconsistencies, for such commonly procured items and/or services, it is advisable to form a working group or a committee of technical experts drawn one each from the participating states who would review and agree in advance on specifications of such major items before bidding. This will also insure optimization of the outcome of such procurement towards achieving the best value for money given that the same providers of goods and services are likely to bid in respective states.

Table 10: Procurement Risk Assessment and Mitigation Action Plan

Procurement Risk	Mitigation measure	Responsibility and Deadline	Risk level Initial/residual
FMOH/SMOHs			Substantial/Moderate
Federal Ministry of Health/States MOH,			
Weak capacity of procurement staff on the World Bank Procurement procedures. The FMOH/SMOHs procurement units will need to build more capacity in order to be able to absorb the additional responsibility brought in by ANRiN implementation.	▪ Appointment designated Procurement Officers at FMOH/ SMOHs ▪ Recruitment of procurement Consultants experienced in World Bank procurement to build the procurement capacity for ANRiN operations in the first six months of implementation of the project. ▪ The capacity of procurement unit of the ANRiN PIUs will be enhanced through training and hand-holding mechanism by the World Bank, and all major procurement in the first year of implementation may be prior-reviewed.	FMOH /States/WB Immediately or Within three months from signing the Financing Agreement	

Weak capacity of the procurement staff in the Health sector on Procurement of Health sector Goods and Commodities/ Procurement of services of NGOs/Grants Process	▪ The FMOH/SMOHs could contract UN Agencies. ▪ Special capacity building will be provided by the World Bank on procurement of health sector goods and commodities; procuring services of NGOs and Grant Process.	FMOH /States/WB Immediately or Within three months from signing the Financing Agreement	

ANNEX 4: POTENTIAL PHASING OF WORLD BANK SUPPORT TO A NATIONAL NUTRITION PROGRAM IN NIGERIA

As this PAD explains, the proposed project is a first phase of a longer-term vision of support to build a national nutrition program in Nigeria. Experience from countries which started at Nigeria's current high level of child stunting and succeeded in reducing stunting significantly indicates that at least a 20-year engagement will be required to address stunting sustainably in Nigeria. However, the type of support required from one phase to the other will evolve, with a gradual but important shift from donor financing to domestic resources – both public and private – for assurance of the long-term sustainability. The focus on prevention will also lead to the reduction of the total burden of stunting, such that the total financing requirements will gradually decrease in the later phases of the national nutrition program.

Phase 1: Building the Foundations with Accelerating Nutrition Results in Nigeria Project (2018-2023)

- Building the mechanism and accountability for multi-sectoral coordination, while incentivizing financing increases for nutrition-sensitive investments in key sectors.
- Defining, testing and rolling out of a national information system for nutrition.
- Creating and scaling up a national knowledge management and learning platform to inform, in real time, the development and roll-out of the national nutrition program.
- Sharp focus on scaling up nutrition-specific interventions especially in the rural areas through a combination of community based activities using performance-based contracts with non-state actors for delivery of a basic package of nutrition services and DLIs with primary health care facilities for more focus on nutrition during the ante-natal visit, in an initial 12 States.
- The roll out of a national behavior change campaign through mass media and faith based leaders to create a supporting environment for the behavior change interventions in households, communities and primary health care facilities.
- Initial studies to prepare next phases of roll-out of national nutrition program (e.g. human resources for nutrition, food fortification, national production of nutrition commodities, etc.)
- Advocacy program to build national commitment to addressing malnutrition as a core national development issue, to support the mobilization of domestic resources.
- Initiating a mechanism of citizen engagement on nutrition services with active engagement of non-state actors initially.

Phase 2: Solidifying gains from Phase 1, expanding to other states, widening the scope of national activities (2024-2029)

- Continued support to the mechanism to enhance accountability for multi-sectoral coordination, while further increasing financing and intervention coverage for nutrition-sensitive investments in initially prioritized sectors.
- Increasing use of the national social registry to target the poorest and most vulnerable beneficiaries with all interventions. Scale-up of conditional cash transfer program targeting the poorest households.
- National roll-out of the national information system for nutrition.

- Support for PPPs and other approaches to incentivize the private sector to produce nutrition commodities nationally.
- Continued support for the national knowledge management and learning platform to inform, in real time, the development and roll-out of the national nutrition program.
- Continued focus on scaling up nutrition-specific interventions especially in the rural areas through a combination of community based activities using performance-based contracts with non-state actors for a nuanced package of nutrition services and DLIs with primary health care facilities for more focus on nutrition during the ante-natal visit. The financing for the initial 12 states would lead to even higher coverage rates as government, households (richer households to pay for at least part of the costs) and other partners increase their own financing in these states; World Bank financing in the 12 states structured to phase out in these 12 states in the second phase. Expansion of the World Bank financing to the other 24 states.
- Continued roll-out of a national behavior change campaign through mass media and faith based leaders to create a supporting environment for the behavior change interventions in communities and facilities. This second phase would focus on a new set of behaviors.
- Scale up of regulatory systems and PPPs to scale up fortification of salt and foods commonly eaten in Nigeria.
- Roll out of a national program with tertiary education institutions to develop the skills required in-country to manage large scale nutrition programs.
- Advocacy program to build national commitment to addressing malnutrition as a core national development issue, to support the mobilization of domestic resources.
- Strengthening the existing community based and expanding the citizen engagement platform to the network of public health care facilities.

Phase 3: Full scale up country-wide while government assumes greatest share of financing in initial 12 States (2030-2035)

- Continued support to the mechanism to enhance accountability for multi-sectoral coordination, while further increasing financing and intervention coverage for nutrition-sensitive investments in expanded list of sectors.
- National information system for nutrition sustained by government financing with technical assistance as required from partners.
- Increasing use of the national social registry to target the poorest and most vulnerable beneficiaries with all interventions. Further roll-out of conditional cash transfer programs to target the poorest households.
- National knowledge platform to inform, in real time, the development and roll-out of the national nutrition program, financed by the government with technical assistance from development partners as required.
- Continued support for PPPs and other approaches to incentivize the private sector to produce nutrition commodities nationally.
- Continued focus on scaling up nutrition-specific interventions especially in the rural areas through a combination of community based activities using performance-based contracts with non-state actors with a customized state-specific package of services and DLIs with primary

health care facilities for more focus on nutrition during the ante-natal visit. The World Bank is no longer financing the initial 12 states and this phase of financing structured to phase out of the 24 states.

- Continued roll-out of a national behavior change campaign through mass media and faith based leaders to create a supporting environment for the behavior change interventions in communities and facilities. This third phase would focus on a new set of behaviors.
- Regulatory systems and PPPs to scale up fortification of salt and foods commonly eaten in Nigeria fully financed by the government with technical assistance from development partners as necessary.
- Continued support for the national program with tertiary education institutions to develop the skills required in-country to manage large scale nutrition programs. This phase of support would be designed to phase out the World Bank financing.
- Advocacy program to build national commitment to addressing malnutrition as a core national development issue, to support the mobilization of domestic resources.
- Strengthening the citizen engagement platform for nutrition services delivered through both public sector and through non-state actors.

Phase 4: Phasing out of World Bank support, while focusing on remaining pockets of malnutrition across the country (2035-2040)

- Main focus of this phase will be in targeting behavior change and other interventions to the pockets of households who still have stunted children. Expanded use of the national social registry to target the poorest and most vulnerable beneficiaries with all interventions.
- The supply side interventions are being delivered and largely financed by the government or through public-private partnerships, with some technical assistance as required provided by development partners.
- Greater focus on targeted demand side interventions (e.g. conditional cash transfers) as the main way to address the pockets of malnutrition that would reside in specific groups (e.g. due to poverty, social exclusion, geographic isolation).
- Advocacy program to build national commitment to addressing malnutrition as a core national development issue, to support the mobilization of domestic resources.