AFRICAN DEVELOPMENT BANK

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28 November 2019
Prepared by: RDNG/AHHD
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Probable Date of Board Presentation
12 December 2019

FOR CONSIDERATION

MEMORANDUM

TO : THE BOARD OF DIRECTORS

FROM : Vincent O. NMEHIELLE
Secretary General

SUBJECT : NIGERIA – INCLUSIVE HEALTH INFRASTRUCTURE AND SYSTEMS STRENGTHENING PROJECT IN ANAMBRA AND ONDO STATES*

ADB LOAN OF USD 68.3 MILLION

Please find attached the Appraisal Report relating to the above-mentioned project.

The Technical Annexes will be distributed separately.

The Outcome of Negotiations and the draft Resolutions will be submitted to you as an addendum.

Attch. :

Cc.: The President

*** Questions on this document should be referred to:**

Mr. E. FAAL	**Regional Director**	**RDNG**	**Extension 7754**
Ms. H. DOROBA	**Sector Director**	**AHHD**	**Extension 4551**
Mr. B. OMILOLA	**Sector Manager**	**AHHD.2**	**Extension 4553**
Mr. L. LAWSON ZANKLI	**Country Operations Manager**	**RDNG**	**Extension 7751**
Mr. G. OSUBOR	**Task Manager**	**RDNG**	**Extension 7753**

SCCD :E.D.

AFRICAN DEVELOPMENT BANK

PROJECT: INCLUSIVE HEALTH INFRASTRUCTURE AND SYSTEMS STRENGTHENING PROJECT IN ANAMBRA AND ONDO STATES

COUNTRY: NIGERIA

PROJECT APPRAISAL REPORT

October 2019

Project Team	Task Manager	Greg OSUBOR, Principal Social Development Officer	RDNG
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		Evaristus KUATSINU, Infrastructure Consultant	RDNG
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AFRICAN DEVELOPMENT BANK

NIGERIA

INCLUSIVE HEALTH INFRASTRUCTURE AND SYSTEMS STRENGTHENING PROJECT IN ANAMBRA AND ONDO STATES

PROJECT APPRAISAL REPORT

RDNG/AHHD

November 2019

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CURRENCY EQUIVALENTS

(As of September 2019)

1 UA	=	USD 1.37
1 UA	=	Naira 419.84
1 USD	=	Naira 306.83

FISCAL YEAR

January 1 – December 31

WEIGHTS AND MEASURES

1 metric tonne	=	2,204 pounds (lb)
1 kilogramme (kg)	=	2.200 lb
1 metre (m)	=	3.28 feet (ft)
1 millimetre (mm)	=	0.03937 inch (”)
1 kilometre (km)	=	0.62 mile
1 hectare (ha)	=	2.471 acres

ACRONYMS AND ABBREVIATIONS

ACTs	Artemisinin-based Combination Therapies
AfDB	African Development Bank
ADF	African Development Fund
AHHD	Human and Social Development Department
BPM	Bank Procurement Policy and Methodology
BPP	Bureau of Public Procurement
BPS	Borrower Procurement System(s)
CBN	Central Bank of Nigeria
CHEW	Community Health Extension Worker
COGH	Ghana Country Office
CSP	Country Strategy Paper
DALY	Disability Adjusted Life Year
DfID	Department for International Development, UK
DLIs	Disbursement-Linked Indicators
DQAs	Data Quality Assessments
EA	Executing Agency
ERGP	Economic Recovery and Growth Plan
EU	European Union
FGN	Federal Government of Nigeria
FM	Financial Management
FME	Federal Ministry of Environment
FMF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GPN	General Procurement Notice
IDP	Internally Displaced Persons
IERD	International Economic Relations Department
IFMIS	Integrated Financial Management Information System(s)
IPSAS	International Public Sector Accounting Standard(s)
IPT	Intermittent Preventive Treatment
IQFPR(s)	Interim Quarterly Financial Progress Report(s)
IYCFP	Infant and Young Child Feeding Practices
LLINs	Long Lasting Insecticidal Nets
M&E	Monitoring and Evaluation
MBNP	Ministry of Budget and National Planning
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MIS	Management Information System
MNCH	Maternal, Newborn and Child Health Programme
MSME	Medium, Small and Micro Enterprises
MTEF	Medium Term Expenditure Framework
NGN	Nigeria Naira
NGO	Non-Governmental Organization
NMEP	National Malaria Elimination Programme
NSA	Non-State Actor
OCB	Open Competitive Bidding
PAR	Project Appraisal Report
PCN	Project Concept Note
PCR	Project Completion Report
PCU	Project Coordination Unit
NPHCDA	National Primary Health Care Development Agency
PIU	Project Implementation Unit
PPA	Public Procurement Act 2007

PRCA	Procurement Risk and Capacity Assessment
PMI	Presidential Malaria Initiative
RBM	Roll Back Malaria
RDNG	Regional Department, Nigeria
RDTs	Rapid Diagnostic Tests
RMC	Regional Member Country
SAM	Severe Acute Malnutrition
SBCC	Social and Behavior Change Communication
SMEP	State Malaria Elimination Programme
SMOH(s)	State Ministry/Ministries of Health
SOP	Standard of Practice
SP	Sulfadoxine-Pyrimethamine
SSD	Standard Solicitation Document
TA	Technical Assistance
UA	Unit of Account
WB	World Bank

PROJECT INFORMATION

Nigeria – Inclusive Health Infrastructure and Systems Strengthening Project in Anambra and Ondo States

CLIENT INFORMATION	
Borrower	**Executing Agency**
Federal Republic of Nigeria	Federal and States (Anambra and Ondo) Ministries of Health

FINANCING PLAN	
Financier	**Amount (USD M)**
AFRICAN DEVELOPMENT BANK (AfDB)	
ADB Loan	68.30
Total ADB Financing	**68.30**
WORLD BANK (WB)	
Loan	223.5
Total WB Financing	**223.5**
ISLAMIC DEVELOPMENT BANK (IsDB)	
Loan	100.0
Total IsDB Financing	**100.0**
COUNTERPART FUNDING	
Government [1]	17.06
Total Counterpart Funding	**17.06**
TOTAL PROGRAMME COST	**408.86**

[1] NOTE: This counterpart amount is for the 2 ADB supported states only. It is exclusive of in-kind and government funding of staff (service providers) remunerations/salaries of over USD 30 million.

AFRICAN DEVELOPMENT BANK KEY FINANCING INFORMATION

Institution	African Development Bank (AfDB)
Currency	United States Dollars (USD)
Loan Type	Fully Flexible Loan
Maturity	Up to 25 years inclusive of Grace Period
Grace Period	Up to 8 years
Interest Rate	Base Rate + Funding Cost Margin + Lending Margin + Maturity Premium This Interest Rate will be floored to zero
Base Rate	Floating Base Rate (6 month LIBOR reset each 1st February and 1st August) A free option to fix the Base Rate is available
Lending Margin	80 basis points (0.8%) per annum
Maturity Premium	Function of Average Maturity
Front-end fees	0.25% of the total amount of the Loan shall be due on entry into force of the Loan, and payable at the earliest of, (i) up to 60 days from the Date of entry into force of the Loan, or (ii) at the time of first disbursement
Commitment fees	0.25% per annum of the undisbursed amount. Commitment fees start accruing 60 days after signature of the loan agreement and are payable on Payment Dates
Option to convert the Base Rate	In addition to the free option to fix the floating Base Rate, the Borrower may reconvert the fixed rate to floating or refix it on part or full disbursed amount Transaction fees are payable
Option to cap or collar the Base Rate	The Borrower may cap or set both cap and floor on the Base Rate to be applied on part or full disbursed amount. Transaction fees are payable
Option to convert loan currency	The Borrower may convert the loan currency for both undisbursed and/or disbursed amounts in full or part to another approved lending currency of the Bank Transaction fees are payable

TIMEFRAME – MAIN MILESTONES (expected)	
Concept note approval	September 2018
Initial Appraisal	November 2018
Project Reappraisal	June 2019
Board Presentation	December 2019
Effectiveness	March 2020
First Disbursement	April 2020
Last disbursement	June 2025
Project Completion	December 2024

PROJECT SUMMARY

Project overview	**Project name**: Inclusive Health Infrastructure and Systems Strengthening Project in Anambra and Ondo States. **Project objectives**: The main objective of the proposed intervention is to support improved access to quality primary healthcare services and a reduction in under-5 morbidity and mortality in both Anambra and Ondo States. **Expected outputs:** a. Health facilities rehabilitated, equipped and accessed; b. Health providers trained and basic service provided c. Households and communities engaged through management and preventive campaigns. **Implementation timeframe**: March 2020 to March 2025 (60 months). **Project total cost:** The Project is part of a USD 408.86 million National Malaria Elimination Programme in 13 states to be co-financed by the African Development Bank, World Bank (WB) and the Islamic Development Bank (IsDB). The Bank is providing an ADB loan of USD 68.30 million for the federal and 2 states (Anambra and Ondo) while the World Bank and IsDB are investing USD 223.5.million (for 6 states) and USD 100 million (for 5 states) respectively. The government's contribution is both in cash (USD 17.06 million) and in-kind amounting to about USD 30 million (facilities, service providers salaries, etc.). **Project beneficiaries:** The direct project beneficiaries are children under 5 years of age, pregnant women, healthcare workers and the general population due to improved healthcare infrastructure and services. Indirect beneficiaries will include women, youth, and artisans.
Project outcome	The project aims at improving access and quality of health services with particular focus on supporting the development of health infrastructure and targeted interventions for malaria elimination and improved nutrition in the two states with the expected outcome of; a. Improved basic health Infrastructure in intervention states; b. Improved services delivery with resultant reduction in malaria and malnutrition prevalence among children under 5 years in project states; c. Improved knowledge and practices of malaria and malnutrition prevention measures, and its management among target population.
Needs assessment	Primary health care infrastructure and services are far from adequate in Nigeria. Most public health centres lack basic infrastructure, equipment and drugs and about 80% of health facilities are reportedly at different levels of dysfunctionality, including issues with water and electricity.[2] Under-5 mortality rate is 132 per 1000 live births with malaria accounting for as much as 30% (excluding neo-natal mortality). Worldwide, Nigeria accounts for 25% of global malaria cases, and 19% of deaths, making it the highest burdened country globally, which calls for urgent and concerted efforts at addressing the challenge. It is noteworthy that 50% of death cases affecting the under-5 are associated with malnutrition therefore making it a major health and development issue in the country. Malnutrition, particularly in young children, leads to increased mortality and undernutrition is responsible for approximately half of under-five mortality and one-fifth of maternal mortality in Nigeria. The prevalence of exclusive breastfeeding in infants up to 6 months is low (23.7% at national level). Half of women of reproductive age suffer from anemia. These high rates of morbidity and mortality reflect the poor basic health delivery, which consequently affects the productivity of the individuals, communities and the nation at large. This contributes to the poverty levels and often sets off a chain of events that continually hinder the growth and development of Nigeria's human capital for enhanced labour productivity and economic growth. The project will support ongoing efforts by Government to address these challenges.
Bank's added value	The Bank enjoys comparative advantage in the social sector in the country particularly in health infrastructure, service delivery and capacity development. It has supported over 7 health projects amounting to UA 87,884,620.35 (USD 119,813,981.77) since 1993 when it commenced the health services and infrastructure rehabilitation project in 7 states. The proposed Project draws significantly from many years of Bank experience in the sector, and will build on its immediate past support to the country through the Health Systems

[2] National Health Policy 2016.

	Development Project, which centred on maternal and child health improvements by increasing access to services in these 2 states that were not part of the initial project. The infrastructural rehabilitation of health facilities, staff quarters and capacity upgrade for providers will not only ensure their availability at service points but also enhancement effective services delivery. The project will also strengthen transparency and governance through support to public procurement bureaus in both states by funding studies for public procurement reform strategy and implementation roadmap.
Knowledge management	The project will contribute to institutional and individual capacity development and knowledge generation, management, and effective healthcare services planning. The Bank will capture and disseminate knowledge and experience from this project through regular sharing of the findings from project review missions as well as household and facility-based surveys conducted to monitor malaria and nutrition status in the intervention areas. Project Completion Report (PCR) lessons learned and experience gained will be made available to inform similar future Bank operations.

RESULTS-BASED LOGICAL FRAMEWORK

Country and Programme Name: Nigeria: Inclusive Health Infrastructure and Systems Strengthening Project in Anambra and Ondo States

Purpose of the Programme: Contribute to Improved Access to Quality Primary Healthcare Services in participating states

	RESULTS CHAIN	PERFORMANCE INDICATORS			MEANS OF VERIFICATION	RISKS/MITIGATION MEASURES
		Indicator (including CSI)	Baseline 2018	Target 2023		
IMPACT	Reduced mortality and morbidity in children (Anambra & Ondo States)	Under-5 Mortality Rate (no. of deaths per 1000 live births)	**Ondo:** 67 **Anambra:** 53	**Ondo:** 55 **Anambra:** 40	• NDHS, MICS, NHMIS and other survey reports * NBS, NDHS and other survey reports	**1. Risk:** 2020 and 2021 Governorship election preparations and outcome in Ondo and Anambra states respectively may cause delays and or changes in government policy direction **Mitigation:** Effective dialogue as well as securing strong political will and commitment of all the 3 arms of government.
		Stunting prevalence in children under 5 years	**Ondo:**[3] 22.4% **Anambra:** 14.3%	**Ondo:** 20% **Anambra:** 10%		
OUTCOMES	**Outcome 1:** Improved basic health services delivery in intervention states	(i) Malaria test positivity among children under 5 with fever	**Ondo:** 41.5%[4] **Anambra:** 21.1%	**Ondo:** 20% **Anambra:** 10%	• NDHS, MICS, NHMIS and other survey Reports • NHFS	**2. Risk:** Treatment disruptions in public sector due to stock-outs of health products and medicines **Mitigation:** a. Programme will involve state and other non-state relevant stakeholders to ensure timely and accurate quantification of health product needs. b. The programme will use reputable logistics providers with valid goods-in-transit insurance to ensure secure, on-time delivery of products. **3. Risk:** Inadequate capacity of executing agency could affect implementation effectiveness and efficiency. **Mitigation:** The Project integrates capacity building interventions particularly in procurement, contract and financial management for the Project Implementation Unit (PIU) and, where necessary, experts will be hired to reinforce capacities gap of the PIU.
		(ii) Anemia prevalence in children under 5 years	**Ondo:** 72%[5] **Anambra:** 49% **National:** 68%	**Ondo:** 40% **Anambra:** 25% **National:** 40%		
		(iii) Percentage of children under 5 with fever receiving rapid diagnostic test (RDT) and artemisinin combination therapy (ACT) at appropriate timing	**Ondo:** 3.9% **Anambra:** 12.8%	**Ondo:** 40% **Anambra**: 50%		
		(iv) Percentage of children 12-59 months dewormed twice a year	**Ondo:** 21.3% **Anambra:** 31%	80% for both states		
		(v) % of pregnant women receiving appropriate (3) doses of IPT	**Ondo:** 19.1% **Anambra:** 14.8%	**Ondo:** 40% **Anambra:** 40%		
		(vi) % of women attending anti-natal clinics (ANCs)	**Ondo:** 76.1% **Anambra:** 82%	**Ondo:** 91% **Anambra:** 95%		
	Outcome 2: Improved knowledge, and practices of the communities in malaria management and malnutrition prevention	(i) % of children under 5 years that slept inside LLINs the previous night	**Ondo:** 56.2% **Anambra:** 51.2%	**Ondo:** 80% **Anambra:** 80%	• NDHS, MICS, NHMIS and other survey Reports NHFS	
		(ii) %of pregnant women sleeping under LLINs	**Ondo:** 11% **Anambra:** 10%	**Ondo:** 60% **Anambra:** 60%		
		(iii) % of households reporting sleeping under LLINs	**Ondo:** 46.6% **Anambra:** 47%	**Ondo:** 80% **Anambra:** 80%		

[3] Data from MICS 2016-2017 report
[4] Data from DHIS 2018
[5] National Malaria Indicator Survey Report 2015

		(iv) Exclusive breastfeeding rate in children 0-6 months	**Ondo:** 23.5% **Anambra:** 24.6%	**Ondo:** 50% **Anambra:** 50%		**4.Risk:** Persistence of detrimental/harmful cultural practices could limit service delivery and health outcomes **Mitigation:** Project includes education and advocacy campaigns at both facility and community levels aimed at sensitizing against detrimental cultural beliefs and practices.
		(v) % of live births delivered in a health facility	**Ondo:** 56.2% **Anambra:** 84.6%	**Ondo**: 80% **Anambra:** 95%		
		(vi) % of women aged 15 or older, who can correctly identify key social and behavioral communication change (SBCC) messages on nutrition and malaria prevention	**Ondo:** 27% **Anambra:**30%	**Ondo:** 60% **Anambra:** 60%		
	Outcome 3: Employment opportunities generated	No. of jobs created (disaggregated by gender and age) through project intervention	**Ondo:** 0 **Anambra:** 0	**Ondo:** 1000 **Anambra:** 1000 (80% & 40% for youth & women respectively)		
OUTPUTS	**COMPONENT 1: EXPANDING ACCESS TO QUALITY HEALTH CARE SERVICES DELIVERY**					**5.Risk:** Poor quality and availability of Monitoring and Evaluation (M&E) data at subnational level **Mitigation:** i) The national PIU will deploy M&E staff to SMOHs to provide hands-on technical assistance (TA) and capacity strengthening. ii) Ensure regular DQAs conducted: PIU and malaria partners conduct biannual DQAs to States; State Malaria Elimination Programmes (SMEPs) conduct regular DQAs to Local Government Areas and health facilities. iii) National PIU will work with states to ensure availability of SOPs and data collection tools at HFs
	Output 1.1: Health Facilities rehabilitated and equipped	No. of Health Facilities Rehabilitated (including water and energy supply facilities)	**Ondo:** 0 **Anambra:** 0	**Ondo:** 30 **Anambra:** 40	• PIU Survey Reports	
		No. of Health Facilities Equipped	**Ondo:** 0 **Anambra:** 0	**Ondo:** 30 **Anambra:** 40		
	Output 1.2: Health Providers trained and basic services provided	No. of beneficiaries of LLINs	**Ondo:** 0 **Anambra:0**	**Ondo:** > 2 m **Anambra:** > 2 m	• Project Survey Reports	
		% of pregnant women received SP	**Ondo:** 0 **Anambra:** 0	**Ondo:** 70% **Anambra:** 70%		
		Selected drugs and health materials (ACTs, RDTs, Microscopes) in place routinely	**Ondo:** No **Anambra:** No	**Ondo:** Yes **Anambra:** Yes		
		No. of pregnant women who received iron Folic Acid supplementation	**Ondo:** 0 **Anambra:** 0	**Ondo:** 95,282 **Anambra:** 113,528		
		No. of children 6-59 months admitted for SAM treatment (disaggregated by gender)	**Ondo: 0** **Anambra:** 0	**Ondo:** 5,000 **Anambra:** 5,000		
		No. of health workers trained on malaria prevention and management	**Ondo: 0** **Anambra:** 0	**Ondo:** 265 **Anambra:** 305		
		No. of health workers trained on nutrition counselling including IYCF and Baby Friendly Hospital Initiative	**Ondo: 0** **Anambra:** 0	**Ondo:** 150 **Anambra:** 230		
		No. of persons trained for SBCC, commodities distribution and surveys	**Ondo: 0** **Anambra:** 0	**Ondo:** 1200 **Anambra:** 1200		
	COMPONENT II: COMMUNITY ENGAGEMENT, LEARNING AND SYSTEM STRENGTHENING					
	Output 2.1: Household and community	No. of gender sensitive campaigns (education and advocacy) carried out on malaria and malnutrition prevention and management.	**Ondo:** 0 **Anambra:** 0	**Ondo:** 25 **Anambra:**25		

	engaged through management and preventive campaigns	% of women of child bearing age that benefit from dietary counselling during their lactation and pregnancy	**Ondo:** 0% **Anambra:** 0%	**Ondo:** 80% **Anambra:** 80%		
		No. of specific survey/indicators reports produced	0	5		
	Output 2.2: TAs to support national and state PIUs recruited to strengthen health system	No. of TAs recruited	0	3		
	Output 2.3: Procurement reform studies conducted	Reports/documents on the Reform – Procurement roadmap, no. of staff trained,	**Ondo:** 0 **Anambra:** 0	**Ondo**: 1 set **Anambra:** 1 set		
	Output 2.4: School health clubs established/strengthened	No. of School health clubs Established/Strengthened	**Ondo:** 0 **Anambra:** 0	**Ondo:** 30 **Anambra:** 30		
		No. of Quiz competitions conducted	**Ondo:** 0 **Anambra:** 0	**Ondo:** 5 **Anambra:** 5		
		No. of community engagements (outreaches, campaigns etc.) conducted by school clubs	**Ondo:** 0 **Anambra:** 0	**Ondo:** 10 **Anambra:** 10		
	COMPONENT III: PROJECT MANAGEMENT AND CAPACITY DEVELOPMENT					
	Output 3.1: PIU Staff trained	No. of PIU & ministry of health staff trained (disaggregated by gender)	**Ondo:** 0 **Anambra:** 0	**Ondo:** 30 (30% female) **Anambra:** 30 (30% female)		
	Output 3.2: Project progress and audit reports duly submitted	No. of quarterly progress reports submitted	**Ondo:** 0 **Anambra:** 0	**Ondo:** 20 **Anambra:** 20		
		No. of audit reports submitted	**Ondo:** 0 **Anambra:** 0	**Ondo:** 5 **Anambra:** 5		
	Output 3.3: PIM & accounting software developed/modified	PIM & accounting software in place and in use	**Ondo:** Nil **Anambra:** Nil	**Ondo:** Yes **Anambra:** Yes		
KEY	**COMPONENTS**				**INPUTS**	

	Key activities ***Component I: Expanding Access to Quality Health Services Delivery*** • Rehabilitation and equipping of health facilities • Provision of water supply to health facilities • Provision of solar lights in and around health facilities • Delivery of cost-effective malaria prevention and treatment services • Delivery of cost-effective nutrition services ***Component II: Community Engagement, Learning And System Strengthening*** • Interpersonal behaviour change communication to improve behaviour and knowledge in rural communities to malnutrition and malaria prevention and management; • Establishment/strengthening of 60 health clubs in schools and organization of quiz competitions and seminars; • Training of persons (youths, women, community members) for SBCC, commodities distribution and surveys • Public Procurement reform in the two states. ***Component III: Project Management And Capacity Development*** • Capacity development for national and state PIUs; • Development of Project Implementation Manual (PIM) • Financial/accounting software developed/modified to accommodate the project. • Rehabilitation of project office	INPUTS: ADB Loan of USD 68.30 Million

TABLE 1: PROJECT TIME FRAME

Years	2019	2020				2021				2022				2023				2024				2025		Action by
Activities	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	
Project Processing and Management																								
Loan approval																								AfDB
Signing of Loan Agreement																								AfDB, FGN & States
Publication of GPN																								AfDB, FGN & States
Project Effectiveness and Launching																								AfDB
Project Implementation and Delivery																								
Project Activities Implementation																								FGN & States
Submission of Audit Reports																								FGN & States
Mid-term Review																								AfDB FGN & States
Project Completion Report																								AfDB FGN & States

REPORT AND RECOMMENDATION OF THE MANAGEMENT OF THE ADB GROUP TO THE BOARD OF DIRECTORS ON A PROPOSED ADB LOAN OF USD 68.30 MILLION TO THE FEDERAL REPUBLIC OF NIGERIA FOR THE INCLUSIVE HEALTH INFRASTRUCTURE AND SYSTEMS STRENGTHENING PROJECT IN ANAMBRA AND ONDO STATES

Management submits the following report and recommendation for a proposed loan for USD 68.30 million from the African Development Bank (ADB), to the Federal Republic of Nigeria (FRN) to finance the Inclusive Health Infrastructure and Systems Strengthening Project in Anambra and Ondo States.

I. STRATEGIC THRUST AND RATIONALE

1.1. Programme Linkages with Country Strategy and Objectives

1.1.1 ***The Federal Government of Nigeria's medium-term development and economic policy thrust is articulated in its Economic Recovery and Growth Plan (ERGP) (2017-2020). The ERGP has three broad strategic objectives that will help achieve the vision of inclusive growth,*** namely: i) restoring growth, ii) investing in the people, and iii) building a globally competitive economy. The proposed project is in direct linkage with the ERGP's second objective (ii) which has "improved human capital" as one of its three cardinal goals.[6] Under this, the Government intends to invest in health and education as a means of building a strong workforce to fill the skills gap in the economy, and meet the international targets set under the UN's Sustainable Development Goals (SDGs). The ERGP aims to improve the accessibility, affordability and quality of healthcare and expand coverage of the National Health Insurance Scheme across the entire country. The proposed project will build on the achievements of the Health Systems Development Project (HSDP) implemented in 12 states with Bank support between 2003 and 2010. The two States however have not benefited from previous Bank financing for health.

1.1.2 ***The Bank's Country Strategy Paper (CSP) for Nigeria (2013-2017 extended to 2019) is hinged on two strategic pillars***: (i) supporting the development of a sound policy environment and social inclusion and; (ii) investing in critical infrastructure to promote the development of the real sector of the economy. The first pillar with which this proposed project has direct linkage to is in alignment with the Bank's High-5 – "improve the quality of life of the people of Africa" of which nutrition and general wellbeing, including the health of the people, are priority.

1.2 Rationale for Bank's Involvement

1.2.1 The proposed ***project rightly fits into the Bank's "improve the quality of life of the people of Africa" High 5 as well as the gender strategy and the Bank's Multi-Sectoral Nutrition Action Plan.*** It is also very much in line with the current Bank's CSP for Nigeria. The Bank equally has comparative advantage and experience in this sector (infrastructure and services delivery improvement) having undertaken previous successful similar projects (e.g. Health IV) in the country. Most public health centres lack basic infrastructure, equipment and drugs and about 80% of health facilities are reportedly at different levels of dysfunctionality, including issues with water and electricity[7]. Only a quarter of health facilities have more than 25% of minimum equipment package[8].

[6] Federal Government of Nigeria Economic Recovery and Growth Plan 2017-2020; produced by the Ministry of Budget and National Planning, February 2017, pages 27-28.
[7] National Health Policy 2016
[8] WHO 2017, Primary Health Care System (PRIMASYS): Case study for Nigeria.

1.2.2 ***Nigeria as a result of its weak health system is faced with many health challenges. With a population nearing 200 million, it is ranked 157 of 189 countries in the human development index with a life expectancy of 53.9 years[9]. The under-5 mortality rate is 132 per 1000 live births[10] up from 128 in 2013 with malaria accounting for as much as 30% (excluding neo-natal mortality)[11].*** Current infant and neonatal mortality rates are equally unacceptable, 67 and 38 respectively. Apart from malaria, other major causes of death for the age group include diarrhea and pneumonia – see Figure 1: Causes of Under-5 Deaths.

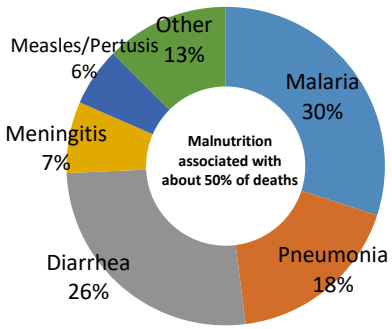


Figure 1: Causes of Under-5 Deaths

Malaria is endemic in Nigeria with all year transmission and 97% of the population at risk. Plasmodium falciparum is the predominant parasite specie, mainly transmitted by Anopheles gambiae S.S., An. funestus and An. arabiensis. Malaria parasite prevalence is high, with an average parasite prevalence of 42% among children under five years of age with zonal variations[12].

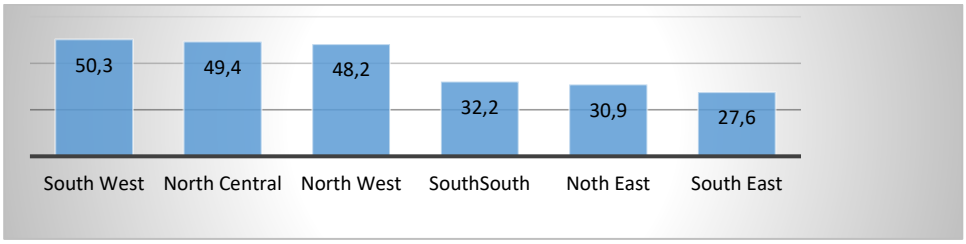


Figure 2: Malaria Parasite Prevalence

Management efforts by government and partners across the country have been on use of Long-lasting insecticide treated bed nets (LLINs), Seasonal Malaria Chemoprophylaxis (SMC), Social and behavior change and Artemisinin Containing Treatments (ACT), Rapid Diagnostic Tests (RDTs) and intermittent presumptive treatment for pregnant women (IPTp) for prevention and treatment of cases respectively. These have been substantially successful in reducing the burden, which is however still unacceptably high.

Worldwide, Nigeria accounts for 25% of the global malaria cases, and 19% of the deaths, making it the highest burdened country globally,[13] which calls for urgent and concerted efforts at addressing the challenge. These high rates of morbidity and mortality result in decreased productivity of the individuals, communities and the nation at large. This contributes to the poverty levels and often sets off a chain of events that continually hinders the growth and development of the people. Malaria test positivity among children under 5 with fever for Ondo and Anambra States are 41.5% and 21.1% respectively. Accurate diagnosis of malaria by health providers in Nigeria has been challenging. A study on malaria and anemia diagnosis revealed that 36.1% of doctors could provide accurate diagnosis while 16.5%, 9.4% and 10.7% was recorded for nurses, CHEWs and other workers respectively[14]. This calls for skills improvement for all the categories of service providers.

[9] UNDP 2018 Human Development Indices & Indicators Briefing Note, Nigeria
[10] Nigeria NDHS 2018 Report
[11] NPC 2016: A verbal/social autopsy study to improve estimates of the causes and determinants of neonatal and child mortality in Nigeria
[12] National Malaria Strategic Plan 2014-2020, Federal Ministry of Health, Nigeria
[13] WHO World Malaria Report 2018.
[14] FMOH Nigeria: National health Facility Survey 2016

1.2.3 ***The burden of malnutrition in Nigeria is equally very high, with a national prevalence of stunting (chronic malnutrition) of 43.6% and a national prevalence of wasting (acute malnutrition) of 10.8%.***[15] These percentages are above the WHO threshold for public health concern and the stunting prevalence is above the global average 23%. These figures indicate that over 40% of the age group's population in Nigeria is stunted which is about twice the case of Thailand, three times that of Tunisia and about one and a half of the figures for South Africa (27.4%) and Ethiopia (32.9%).[16] It is noteworthy that 50% of death cases affecting the under-5 are associated with malnutrition[17] therefore making it a major health and development issue in the country. The prevalence of exclusive breastfeeding in infants up to 6 months is low (23.7% at national level). Half of women of reproductive age suffer from anaemia.[18]

In Anambra and Ondo States, the percentage of low birth weight stands high at respectively 17.3% and 16.9%. This highlights the importance of ensuring adequate antenatal care, including iron folic acid supplementation and intermittent preventive treatment for malaria. The prevalence of stunting in Anambra State is lower than the national average and stands at 14.3%, and the prevalence of wasting stands at 8%, of which 1.8% represent severe acute malnutrition (SAM). The prevalence of stunting in Ondo State stands at 22.4%, while the prevalence of wasting stands at 5.9%, of which 1.8% represent SAM. Currently, there are no services for the treatment of SAM in both States, although there is a plan to establish three facilities for the treatment of SAM in Anambra State. The prevalence of exclusive breastfeeding in infants up to 6 months is near to the national average for both states (24.6% for Anambra and 23.5% for Ondo), while the target is a minimum of 50%.

Studies have shown that exposure to Plasmodium has a significant impact on the nutritional status of children; previous exposure to Plasmodium infection was found to be a predictor for the manifestation of malnutrition in children aged under 5 years.[19] Therefore, it is recommended that malnutrition control interventions should be consolidated with malaria prevention strategies, particularly in high malaria transmission areas. A recent study also showed that children who were severely wasted and had uneducated caretakers had higher odds of malarial attack.[20] Treatment for severely wasted children and integrated social and behavior change communication on malaria and nutrition are important in the prevention and control of both. Trials of intermittent presumptive treatment of malaria in pregnancy in malaria-endemic regions to estimate their effect on birth outcomes have shown significant reductions in low birth weight and increases in mean birth weight of infants,[21] which in turn have significant effects on stunting.

1.2.4 ***The high malaria and malnutrition burden in Nigeria limits the country's economic and social developmental.*** The dangers in not addressing the challenge include risk of increases in malaria morbidity and mortality with the attendant economic losses, threat of a weakened work force with decreased productivity with consequences on development, and loss of confidence in public health programmes. Private expenditure on treatment of malaria constitutes a high economic burden to households and to the health system. In a household survey, over half of the households (57.6%) had an episode of malaria within one month to the date of the interview. The average household expenditure per case was 12.57US$ and 23.20US$ for out-patients (OPD) and in-patients (IPD) respectively. Indirect consumer costs of treatment were higher than direct consumer medical costs.

[15] Nigeria Multi Indicator Cluster Survey (MICS) report 2016-2017.
[16] UNICEF, WHO, World Bank: Joint child malnutrition estimates (JME). Aggregation is based on UNICEF, WHO and the World Bank harmonized dataset (adjusted, comparable data) and methodology.
[17] AfDB Sector Brief: Health and Nutrition, 2019
[18] Global Nutrition Report. Country Profile Nigeria, 2017.
[19] Terefe Gone et al. The association between malaria and malnutrition among children aged under 5 years in Shashogo District, Southern Ethiopia: A case-control study. *Infectious Diseases of Poverty* (2017) 6:9.
[20] Bilal Shikur et al. Association between malaria and malnutrition among children aged under 5 years in Adami Tulu District, south-central Ethiopia: a case-control study. *BMC Public Health* (2016) 16:174.
[21] Garner and Gülmezoglu 2006; Radeva-Petrova et al. 2014. Investment Framework for Nutrition, World Bank, 2016.

From a health system perspective, the recurrent provider costs per case was 30.42 US$ and 48.02 US$ for OPD and IPD while non recurrent provider costs were 133.07US$ and 1857.15US$ for OPD and IPD[22]. When malaria morbidity increases by 1% and the other explanatory variables held constant, growth in annual real GDP decreases by 0.038% per annum[23]. It is estimated that Nigeria loses over USD 1.5 billion in GDP annually due to effects of vitamin and mineral deficiencies alone. The effect of malnutrition and the high malaria disease burden on the national economy, and household and individual finances is enormous and the lower-income households are most affected thereby worsening the poverty situation for the group. In Nigeria, out-of-pocket expenditure on health is over 70% and health insurance coverage less than 10%.[24] Enhancing basic health care delivery services will therefore improve on the quality of life as well as the finances of the people. The project implementation will augment government's efforts towards meeting the SDGs.

1.3. Donor Coordination

1.3.1 ***There is a fairly well developed and active Development Partners Working Group on Health at the federal level in the country***, having the United Nations Development Fund (UNFPA) and Canada Development Agency as co-chairs. Key members include the African Development Bank (AfDB), the World Bank, the European Union (EU), UK's Department for International Development (DfID), the Global Fund, Japan, USAID, the UN system (WHO, UNDP, UNFPA, UNICEF), and a few international and local Non-Governmental Organizations (NGOs). The group meets on a bimonthly basis at the national level to share ideas and work experiences. The group has been in strong effective partnership with federal health authorities providing very useful support to government, for example in the development of national health plans, tackling emergencies (Ebola disease incidence, Lassa fever, polio, etc.) and development of health policies and laws.

Table 2: Donor Support to Health Sector in Nigeria

	Players – Public Annual Expenditure (average) 2017 – 2021					
	Government	**Donors**	AfDB 1.5%	DfID 22%		
USD	**11.42 billion**	**2.79 billion**	WB 29%	GF 10.2%		
% Tot	**80.4%**	**19.6%**	USAID 35%	PMI 2.3%		
		Level of Donor Coordination				
	Existence of Thematic Working Groups (this sector/subsector)			**[Y]**		
	Existence of SWAPS or Integrated Sector Approaches			**[Y]**		
	ADB Involvement in Donor Coordination			**[M]**		

Key: ***M:*** *Member but not leader.* ***Y:*** *Yes*

II. PROJECT DESCRIPTION

2.1 Project Objectives and Components

2.1.1 ***The overall goal of the proposed project is to contribute to improvement in the quality of life for the people in the intervention States of Anambra and Ondo.*** The project development objective is to improve access to quality primary healthcare services with the aim to contribute to the reduction in under-5 morbidity and mortality in both Anambra and Ondo States.

2.1.2 ***The specific objectives, in line with the National Health Policy, and the National Strategic Health Development Plan II, are*** to: (i) improve Health Infrastructure in the intervention states, and (ii) improve access to and quality of services rendered at primary health care facilities.

[22] Obinna Onwujekwe, Nkoli Uguru,Enyi Etiaba ,Ifeanyi Chikezie,Benjamin Uzochukwu,Alex Adjagba
The Economic Burden of Malaria on Households and the Health System in Enugu State Southeast Nigeria Published: November 4, 2013https://doi.org/10.1371/journal.pone.0078362

[23] Economic Burden of Malaria in six Countries of Africa, European Journal of Business and Management, ISSN 2222-1905 (Paper) ISSN 2222-2839 (Online), Vol 3, No.6, 2011

[24] B.S. Aregbeshola, Out-of-pocket payments in Nigeria. *The Lancet* (June 2016) Vol 387. Issue 10037: P2506.

2.1.3 *Project Components: The project is to be executed under three reinforcing components with key expected outcomes as follows:*

a. Improved basic health infrastructures in intervention states;
b. Improved services delivery with resultant reduction in malaria and malnutrition prevalence among children under 5 years in project states;
c. Improved knowledge and practices of malaria and malnutrition prevention measures, and its management among target population.

Table 3: Detailed Project Description

Component I: Expanding Access to Quality Healthcare Services Delivery USD 64.26 million	***Sub-component 1.1: Improving Access to Health Facilities:*** Under this subcomponent, the project will rehabilitate and equip some existing public health facilities in both states. This will include; • 40 and 30 Primary Health Care facilities including staff quarters for Anambra and Ondo states respectively to serve as reference points in support of other smaller facilities • The two central medical stores in both states rehabilitated for proper storage of medical goods, drugs and materials. • One school of health technology laboratory per state • One maternal & child specialist facility per state to serve as referral facilities • Provision of portable water mainly through boreholes in the facilities • Solar system to power water supply systems mainly based on ground water/boreholes, cold chains and lighting points in and around the facilities. The rehabilitation/upgrade works will contribute to increased access to services; staff retention and availability at duty posts and ensure better storage of drugs, medical materials and commodities.
	Sub-Component 1.2: Strengthening Quality Services Delivery. Under this sub-component, the project will support the scaling up of quality malaria and nutrition interventions in the project states with a focus on children under 5years and women.. These shall be under taken through performance-based contracts signed between State PIUs of Ministries of Health and competitively procured Non-State Actors (NSAs). Activities to be undertaken by these NSAs include; • Malaria and malnutrition case management improvement in the facilities through capacity building for public and private as well as community based healthcare service providers; • Training of facility-based health care providers and logistics officers on drugs and commodities logistics management. • Development/training on use of SOPs Additionally, robust management of these performance-based contracts and the achievement of agreed quantitative and qualitative targets for service delivery by the NSAs and the public health centres, will trigger disbursements to appropriate implementing agencies at the state level through a disbursement-linked indicator (DLI) mechanism. These will focus on some agreed-upon outputs/outcome and process indicators including: • Increased utilization of LLINs by children under-5 years, and pregnant women; • Increased LLIN ownership and use by households; • Improved knowledge on malaria and malnutrition prevention measures among households; • Deworming twice per year; • Sharper focus on nutrition during antenatal visits in facilities (specifically, provision of and counselling on iron folic acid tablets during pregnancy, and counselling on early and exclusive breastfeeding).
	Sub-Component 1.3: Provision of health commodities/materials and drugs; • Provision of relevant commodities and drugs including LLINs, ACTs, RDTs, SPs, deworming medications, folic acid, F-75 and F-100 therapeutic milk for children with SAM and complications etc.; • Distribution of procured items to healthcare facilities and communities/ households as required
Component II: Community Engagement, Learning and System Strengthening USD 14.13 million	***Sub-component 2.1: Enhancing Demand and Utilization of Malaria and Nutrition Healthcare Services (Social Behavioural Change Communication)*** • The Project shall strive to improve community uptake of malaria and malnutrition prevention and curative services and knowledge through the services of the recruited NSAs at state level. This shall be through mass/social media, inter-personal & group interactions/communication, traditional and religious leaders, etc. • The project will also fund the training and retraining of health workers in inter-personal communication to encourage care-seeking behaviour. • Mobilization and training of community health influencers, promoters and volunteers as agents for behavioural change with special focus on nutrition and gender;

	• Community enlightenment on climate change effect on the project; • Establishment/ strengthening of school health clubs with organization of seminars, quiz competitions and campaigns.
	Sub-component 2.2: Strengthening Monitoring, Evaluation and Reporting. • Support the government (NPHCDA etc.) in the conduct of routine household and health-facility-based surveys to produce results for the project progress monitoring and status report on malaria and malnutrition key indicators in the intervention states. • Use of Verification Agents to support data generation for project progress (output/outcome) monitoring. • Support the State Health Management Information System (HMIS)
	Sub-component 2.3: System Strengthening: This shall include; • Support to Public procurement reform through a study for the strategy and implementation roadmap development. Also, a scheme of service and competency framework for procurement cadre in both states shall be developed. • Provision of technical support to state key operations staff across the 2 states of project intervention • Institutional capacity building for the ministries of health in both states.
Component III: Project Management and Capacity Development USD 6.97 million	The Project shall undertake the following under this component: • Rehabilitation and equipping of the office space • Project supervision, reporting, gender and consultants' services for the 2 states • Project audit services for two states and FMOH • Project coordination/supervision and reporting activities by FMOH • Capacity development/retraining of PIU staff • Performance-based contract/incentives/bonuses to PIU to foster accountability and efficient achievement of results. • Two pick-up vehicles and • Project office maintenance and supplies

2.1.4 Planned World Bank (WB) & Islamic Development Bank (IsDB) Support: The WB through an estimated USD 223.5 million will specifically fund project activities in 6 of the 13 states currently not been supported by a development partner with focus on malaria. Part of its funding will also support certain activities (listed below) in all the 13 states including AfDB's Anambra and Ondo states (under component II);

- Operations research in support of learning agenda.
- Capacity development for relevant federal and state health officials in support of system strengthening in areas AfDB will not be covering e.g. immunization and conduct of surveys. Work plans are to be shared to prevent duplication.
- Technical assistance to government agencies in the conduct of routine household and health-facility-based surveys.

The IsDB board in September 2019 approved the total sum of USD 100 million in support of the programme in 5 of the 13 states. The planned activities essentially focus on malaria elimination in these states.

2.2 Technical Solution Retained and Other Alternatives Explored

2.2.1 This project's design was informed by extensive consultative engagement with key stakeholders including senior ministry officials (health, education, women affairs, finance & budget, bureau of procurement), health care providers (public & private), community leaders and development partners during the preparation stages of the project as well as lessons learned from ongoing and closed Bank-funded projects. As such, it reflects the need for: more effective and efficient service delivery; complementarity with related interventions of partners and government, and ensuring the sustainability of gains made through the interventions.

2.2.2 The project shall be engaging non-state actors (NSAs) in the delivery of the malaria and nutrition services through performance-based contracts as against the usual practice of using government workers entirely. This promises to reduce losses and increase reach as well as improve private sector involvement and interaction with government in the overall delivery of health services particularly at the rural levels. The NSAs will work closely with state counterparts for knowledge and skills transfer.

Table 4: Programme Alternatives Considered and Reasons for Rejection

Alternative	Brief Description	Reason for Rejection
Use of government structures/staff for the distribution of major project commodities to beneficiaries instead of non-state actors	Distribution, intake and use of the project commodities like the LLINs at the community level is vital for achievement of the project's objectives. This therefore means that the products must reach the beneficiaries and the necessary advocacy and support provided for them to do the right things. Under the project, non-state actors will be competitively recruited with performance-based contracts to implement these functions. These NSAs will work very closely with the government counterparts to ensure transfer of knowledge and skills for sustainability.	Previous efforts with use of government structures/staff witnessed significant product losses and wastages. Accountability is difficult to secure using government staff particularly, as the system is weak.
Input-based financing, particularly for service providers	The project will use innovative approaches that pay for results rather than simply inputs. NSAs recruited under the project will be paid only after meeting some set performance targets.	The goal of the project is to meet set targets and not just carrying out activities. Some previous projects in the country did not meet set goals yet the money was spent.
Procurement of the LLINs directly by the two AfDB-supported implementing states instead of through the National Malaria Elimination Programme (NMEP)	The project has planned that the procurement of LLINs in the 13 states (AfDB-supported states inclusive) will be carried out jointly by the states with strong technical and administrative support from the NMEP rather than individually by the states.	• Loss of economics-of-scale benefit if the different states are to go separately making their individual purchases. • Import waivers are much more difficult through the states compared with NMEP and so landing costs are likely to be higher if making the purchases through the states. • Quality and time efficiency is less assured and may be compromised, particularly as the states have not been involved in international procurement of such volumes of LLINs which NMEP has been doing over the years with support from development partners.

2.3 Project Type

2.3.1 The project is part of the Federal Government's overall National Malaria Elimination Programme (NMEP) and Nutrition Services Management in the country and is anchored on both the malaria and nutrition programme strategic plans for 2014-2020 and 2014-2019 respectively. The NMEP is supported by the Global Fund, PMI and some other partners in all but 13 of the 36 states of the country and the Federal Capital Territory (FCT). Based on this gap (unsupported states), the Federal Government requested the African Development Bank, World Bank and the Islamic Development Bank to provide parallel co-financing for the 13 states (2, 6 and 5 states respectively). The support aims at complementing the efforts of government in addressing the challenges of health infrastructure, malaria and malnutrition.

2.3.2 The IsDB Board in September approved the project for implementation while that of the World Bank is scheduled for board approval in November 2019).

2.4 Project Cost and Financing Arrangements

2.4.1 The estimated overall programme financing by partners for the 13 states is about USD 408.86 million out of which the AfDB, the World Bank and the Islamic Development Bank will, in parallel, finance USD 68.30 million, USD 223.5 million and USD 100 million, respectively. Government contribution for the WB and IsDB financed states is manly in-kind but for the ADB states, the

Government shall contribute USD 17.06 million (about 25% of the Bank's input) apart from the in-kind contributions (office space for PIUs, staff, facilities and equipment for service delivery etc.) amounting to about USD 30 million. This level of financial participation is also, in part, explained by Nigeria's gradual emergence from a deep recession that exacerbated its fiscal debt profile. Details of the Project cost by component and expenditure category are also presented in Technical Annex B2.2.

Table 5 (a): Programme (13 States) Costs by Sources of Financing (USD million) – From All Sources

Sources of Financing	**Amount (USD Million)**	**% Total**
ADB Loan	68.30	16.71
World Bank	223.50	54.66
Islamic Development Bank	100.00	24.46
Government Counterpart*	17.06	4.17
Total Programme Cost	**408.86**	**100.00**

***Note:** The stated counterpart is for AfDB project only and is exclusive of in-kind and government funding of staff (service providers) remunerations/salaries of over USD 30 million.

Table 5 (b): Project (Fed & 2 States – Anambra & Ondo) Financing by Source (in USD m)

Source of Financing	**FC**	**LC**	**Total Cost**	**% of Total**
ADB Loan	47.28	21.02	68.30	**80.0**
Government Counterpart	7.16	9.90	17.06	**20.0**
Total project cost	**54.44**	**30.92**	**85.36**	**100.0**

Table 5 (c): Project (Fed, Anambra & Ondo States) Cost Estimates by Component (in USD m)

Components	**FC**	**LC**	**Total Costs**	**% of Total**
1. Expanding Access to Quality Healthcare Services Delivery:	45.72	14.40	60.12	70.4
2. Community Engagement, Learning & System Strengthening	5.41	8.05	13.46	15.8
3. Project Management & Capacity Development	0.05	6.59	6.64	7.8
Total Base Cost	51.18	29.04	80.22	94.0
Contingency	3.26	1.88	5.14	6.0
Total project cost	**54.44**	**30.92**	**85.36**	**100.0**

Table 5 (d): Total Project cost by category of expenditure in USD million

Categories of expenditure	**FC**	**LC**	**Total Cost**	**% of Total**
Works	14.20	9.76	23.96	28.1
Goods	20.38	3.35	23.73	27.8
Services	16.60	15.43	32.03	37.5
Misc.	-	0.50	0.50	0.6
Total base cost	51.18	29.04	80.22	94.0
Contingency	3.26	1.88	5.14	6.0
Total PROJECT COSTS	**54.44**	**30.92**	**85.36**	**100.0**

Table 5 (e): Finance Allocations to Anambra and Ondo States, Federal (USD Million)

SOURCE	**ANAMBRA**	**ONDO**	**SUBTOTAL**	**FEDERAL**	**TOTAL**
ADB Loan	36.19	30.73	66.92	1.38	68.30
Govt. Counterpart	8.63	8.22	16.85	0.21	17.06
TOTAL	**44.82**	**38.95**	**83.77**	**1.59**	**85.36**

Table 5 (f): Project cost by category of expenditure in USD million (ADB Funds Only)

Categories of expenditure	FC	LC	Total	% of Total
Works	14.46	9.64	24.10	35.3%
Goods	19.92	3.26	23.18	33.9%
Services	12.90	8.12	21.02	30.8%
Total Project Costs	**47.28**	**21.02**	**68.30**	**100.0%**

Table 5 (g): Expenditure schedule in USD million

Components	Year					
	2020	2021	2022	2023	2024	Total
1. Expanding Access to Quality Healthcare Services Delivery:	12.77	24.00	16.23	5.54	5.72	64.26
2. Community Engagement, Learning & System Strengthening	3.46	2.67	2.66	2.67	2.67	14.13
3. Project Management & Capacity Development	2.01	1.27	1.25	1.25	1.19	6.97
Total project cost	**18.24**	**27.94**	**20.14**	**9.46**	**9.58**	**85.36**

Table 5 (h): Expenditure schedule in USD million (ADB Funds)

Components	Year					Total
	2020	2021	2022	2023	2024	
1. Expanding Access to Quality Healthcare Services Delivery	11.88	22.33	15.10	5.16	5.32	59.79
2. Community Engagement, Learning & System Strengthening	1.19	0.45	0.45	0.45	0.45	2.99
3. Project Management & Capacity Development	1.41	1.06	1.03	1.03	0.99	5.52
Total project cost	**14.48**	**23.84**	**16.58**	**6.63**	**6.76**	**68.30**

2.5 Project Target Beneficiaries, Area and Population

2.5.1 The project will cover two states, one in the South East (Anambra) and the other in the South West (Ondo), both with a population of over 8 million people (about 4.5% of national population). Criteria used in selecting the states include absence of development partners support (to health infrastructure and primary health care), indication of interest from the state, and current and future Bank investments in the states. It will specifically target children under 5 years of age, and pregnant women (15-49 years) as the direct beneficiaries, with special focus on the rural population in the concerned states. Expected major outcomes include reduced malaria and malnutrition prevalence among children under 5-years and improved knowledge and practices on malaria and malnutrition prevention measures and management in intervention states. Direct and indirect beneficiaries include;

- 113,528 and 95,282 nos. pregnant women in Anambra and Ondo States respectively will benefit from iron folic acid tablets.
- 408,698 and 343,020 nos. children 6-59 months in Anambra and Ondo States respectively will benefit from the deworming exercise in the course of the project implementation.
- 5,000 and 1,500 nos. children 6-59 months from Anambra and Ondo States respectively suffering from severe acute malnutrition will benefit from Ready-To-Use Therapeutic Foods to be provided.

- 60 schools with over 9,000 students from Anambra and Ondo States will benefit from the health clubs establishment/strengthening activities.
- Over 5 million persons will benefit from LLINs during campaigns

2.6 Participatory Process for Project Identification, Design and Implementation

2.6.1 The conceptualization and design of the project was shaped by guidance on government priorities as spelt out in the health strategic plan and builds synergies with interventions by other development partners. Guidance was obtained from the, National Malaria Elimination Programme (NMEP) and Nutrition units of the Federal Ministry of Health (FMOH), Nigeria malaria consortium, State Ministries of Health (SMOHs) in both Ondo and Anambra as well as development partners including World Bank, UNICEF, WHO and international and local NGOs. Community leaders and groups as ultimate beneficiaries were equally consulted to get their perspectives on the design and implementation strategy. The major issues raised during the consultations included the need for more effective commodities (particularly nets) distribution/logistics mechanism; the need for enhanced community ownership and sustainability by better engagement of leaders and women groups in beneficiary communities; the need to enhance quality of implementation; the need to strengthen monitoring and need to strengthen women's participation in the project. The Project design therefore considered these and also the need to build synergies and complementarity with donor partners.

2.7 Bank Group Experience and Lessons Reflected in Project Design

2.7.1 ***The design of the current project benefited from lessons learned from implementation of ongoing and previous health and other sector projects in the country by both the Bank and other Development Partners.*** A summary of these lessons include:

- ***Capacity Strengthening***: A major cause of projects failure and funds wastages is weak capacity for implementation, coordination, effective supervision and monitoring and evaluation. This project will support through technical assistance and training exposures improvement of the capacity of the government to carry out these activities. The NSAs will transfer knowledge to government staff.
- ***Effectiveness and Implementation Delays***. This Project will strive to eliminate key causes of effectiveness and implementation delays like overly cumbersome conditions (precedent to effectiveness and first disbursement), slippage in obtaining subsidiary loan agreements signature, PIU set-up/take-off, etc. These can be through streamlining conditions, having constructive engagement and dialogue with government and other concerned key stakeholders before and after Board approval.
- ***Sustainability of Project Gains:*** Some projects in the past were not sustainable due to ownership issues as well as budgetary challenges. Project will promote partnerships with end-users, community based organizations and more effectively engage the beneficiary communities and major stakeholders including development partners, community health workers and governments (state and local) at all stages of the project cycle for sustainability through long term government budgetary allocations. The project has specifically integrated component II interventions on community engagement and learning to increase knowledge and instil preventive health practices in communities. This will go a long way to improve health care delivery with the aim to curb the incidence of malaria and nutrition challenges. The targeting of children as change agents through school clubs is to ensure inter-generational dialogue on good health behaviours.
- ***Strengthening of gender inclusion/mainstreaming***: Many projects lack the capacity to effectively mainstream gender partly due to inadequate knowledge and skills. This Project will not only support capacity development in this regard but also strive to give voice to women through the community engagements.

2.7.2 ***As at end September 2019, the ongoing Bank's portfolio in Nigeria comprised a total commitment of US$ 4.25 billion***[25] on 54 operations, of which 47 were national and 7 were regional. 24 are in the public sector, with a total commitment of US$ 1.58 billion (37 percent), The portfolio includes 32 non-sovereign operations, with a total commitment of US$ 2.67 billion (63 percent), of which the most significant share is allocated to the financial sector**.** Of the total net amount approved, some US$2.82 billion (representing 70 percent of the amount approved) has been disbursed to date. The portfolio is largely dominated by the financial sector (45 percent) supported through equity investments (e.g., in Development Bank of Nigeria), Lines of credit, and trade finance packages. Other significant sectors include the Industrial sector (11 percent), Water Supply and Sanitation (10 percent), Agriculture (10 percent), Transport (10), Social and Human Capital Development (7 percent), Power (5 percent), and Governance & Multi-Sector (1 percent). Details of the ongoing projects are provided in appendix II.

2.7.3 ***Overall, Nigeria's portfolio performance has significantly improved in recent years and is assessed as satisfactory with a score of 3 (on a scale of 1-4)***. The average age of public sector operations is 4.2 years, with a cumulative disbursement ratio of 32 percent. There are no Projects at Risk (PAR) in the portfolio. Moreover, the percentage of projects flagged for implementation issues dropped from 50 percent in September 2017 to 24 percent in September 2019. All projects approved by the Bank in 2018 (US$567.7 m) have been signed and approved by the Federal Executive Council (FEC) in about six months, a remarkable feat when compared with previous years. Key outstanding implementation challenges include start-up delays primarily due to lengthy processes of securing Legal Opinion from Attorney General's Office, non-payment of counterpart funding and weak monitoring and evaluation capacity. These are being addressed through continued dialogue with the authorities and stronger support to the project implementation teams, including through fiduciary clinics.

2.8 Project's Performance Indicators and Results Measurement

2.8.1 The project's results based logframe has identified set of indicators at both output and outcome levels (see pages viii – xi). The indicators will be the basis for the monitoring and evaluation of the project performance during project implementation and at completion. Data for the measurement will be from routine administrative sources, NDHS, UNICEF MICS reports and independent surveys to be carried out annually by a competitively recruited agent under the project. The surveys will fill in the missing data gap and so ensure adequacy of information for progress measurement.

2.8.2 The project will support M&E units of the health ministries in both states to ensure routine reporting, dissemination and presentation to policy makers for decision-making. There shall be quarterly reviews and reporting by the project team for management and Bank action in line with project goals and objectives.

III. PROJECT FEASIBILITY

3.1 Economic and Financial Performance

3.1.1 It has been established that malaria could be responsible for significant GDP loss following man-hour loses on the part of the affected or relatives of the affected. The government also spends a lot in caring for the affected and subsidizing medications required in tackling the disease. It has been estimated that for Nigeria, when malaria morbidity increases by 1%, growth in annual real GDP

[25] 1 UA = 1.38825 US$

decreases by 0.038% per annum.[26] It is estimated that Nigeria loses over USD 1.5 billion in GDP annually to vitamin and mineral deficiencies alone arising from malnutrition. This project will contribute to the reduction of these losses and lead to improved productivity. In a report, it was stated that using 1000 ACTs for children 0-4 years with fever helps to avert as much as 68 Disability Adjusted Life Years (DALYs) i.e. 68 years of life lost to illness or death. Use of LLINs and RDTs reduces further the likelihood of getting malaria and wastages/losses resulting from wrong treatment[27].

3.1.2 ***The Cost-Effectiveness Analysis (CEA) and the Incremented Cost-Effectiveness Ratio (ICER) show that the proposed Project is very cost-effective.*** Shephard et al. (2015), and WHO (2011[28], 2015[29]) provide guidance to interpret ICERs as summarized in the technical annex. According to our parameters and calibration, the ICER for the proposed project varies between 56 and 62 USD. Comparing these values with a GDP per capita of 1968.2 USD, suggest that the ICERs is lower and thus the proposed Project can be deemed as very cost-effective both at the level of each state and for the two states put together.

Box 1: The methodology for the Cost-Effectiveness Analysis

The methodology model follows Shephard et al. (2015). It implies weighting benefits (expressed in terms of effectiveness) and costs (expressed in monetary units). Costs include all those related to the interventions included in all the components of the project. Gains are expressed in terms of lives enhanced because of the supported interventions. To determine these gains, the expected number of lives to be enhanced by the project is compared to a status-quo scenario. The output of the cost-effectiveness analysis is an incremental cost-effectiveness ratio (ICER), which reflects the change in cost divided by the change in the amount of lives enhanced because of the implementation of the project, compared to the GDP per capita. The choice of the GDP per capita as threshold was promoted by the Commission on Macroeconomics and Health in the World Health Organisation and adopted in the world health report of 2002 and by WHO-CHOICE. It refers to the population willingness and capacity to pay. In using a cost–effectiveness threshold that is based on a country's per capita GDP, analysts tacitly assume that the country is willing to pay up to that threshold for the health benefit.

Sources; The world health report 2002 - Reducing Risks, Promoting Healthy Life;
Donald Shephard, Zeng W. and Nguyen H.T.H (2015) - cost Effectiveness analysis of results Based financing Programmes

3.2 Environmental and Social Impacts

3.2.1 ***Environment:*** In accordance with the Bank's Integrated Safeguards System (ISS) and its operational Safeguards, the project was assigned a Category 2 classification, after site visit to all the Project Public Health Centres in Anambra and Ondo States respectively. The health facilities to be rehabilitated/renovated in the respective states are each in existing fenced areas, thus to a large extent the environmental and social risks can be identified on specific site basis. Sites inspection visits indicated that the potential impacts of the health centres construction and renovation activities vary from minor to moderate, location-specific, short term in duration, and reversible. These impacts include risk of increased road traffic accidents, increased risk of harm and injuries to workers, generation and management of clinical and construction wastes among others. It is noteworthy that there are no Project Affected Persons (PAPs) and consequently no Abbreviated Resettlement Action Plan (ARAP). The Environmental and Social Impact Assessment (ESIA), and the resultant Environmental and Social Management Plan (ESMP) of the project can thus be a light one. There is

[26] European Journal of Business and Management, ISSN 2222-1905 (Paper) ISSN 2222-2839 (Online), 3.6 (2011), www.iiste.org.
[27] PSI Malaria Health Impact Brief, 2009
[28] World Health Organization (2011) Commission on Macroeconomics in Health. Geneva: World Health Organization
[29] World Health Organization (2015) Cost-effectiveness Thresholds

the need however to carry out consultation and sensitization of the persons in concerned communities and areas particularly in Akinjagunla area of Ondo State where a few persons expressed concerned of the possible consequences of the civil works on their petty trading.

3.2.2 ***Climate Change and Green Growth:*** This project has been categorised as a Category 3 operation according to the Bank's Climate Safeguard System (CSS). In this regard therefore, the project may be exposed to future climate risks such as flooding in facility locations and beneficiaries, especially in gully-prone areas of Anambra state. Therefore, the project will ensure that the health facilities are built away from actively eroding sites, climate resilient sanitation facilities provided to manage breeding sites for mosquitoes that could increase incidences of malaria. Solar systems will be used for rehabilitating and upgrading project facilities and their operation, use and maintenance will be sustained through capacity building and training of PIU and facility staff. The school clubs as well as the SBCC activities will be used as means of sensitization, advocacy and knowing building on climate change and green growth for the communities.

3.2.3 ***Gender: The project focus is mainly on the health improvement of women and children and as such, it is expected to bring about a positive impact on gender. It promises to significantly contribute to gender equality and general wellbeing of women and children and is assigned Category II under the Bank's Gender Marker System.*** The project will strive to give women more voice in health related issues through the planned advocacy and sensitization of key community political and religious leaders. It will also improve women's access to healthcare as well as educating women particularly those with young children on preparation of nutrition-rich agro-processed foods for children in project areas. The improved health status of thousands under the project arising from the various interventions will alleviate the burden of care-giving that is most suffered by women and girls who will now have more time to engage in their economic activities. Women will benefit from the jobs expected from the project.

3.2.4 ***Social:*** The project will have a significant positive impact on livelihoods following reduced illnesses, freeing of monies that would have otherwise been used in treatment of malaria and malnutrition related illnesses. There will be increased productivity resulting in more money and time available for household economic uses. The project will open over 1000 job opportunities particularly for women and youths as social mobilization agents, household surveys and commodities distribution agents. Artisans including masons, carpenters, plumbers, painters and constructions workers in general shall be engaged in the course of the rehabilitation works. Contracts with the civil works, service delivery and other contractors expected to undertake some jobs in the project will have clauses that encourage youth and women employment. One million households will benefit from social and behavior communication change campaign outreaches addressing malaria and malnutrition prevention and management issues. The community based enlightenment and behavioral change campaigns will impact positively on incidence of HIV as well as other communicable disease in the project states.

3.2.5 ***Involuntary resettlement:*** There is no displacement envisaged under the project and so resettlement does not arise.

IV. IMPLEMENTATION

4.1 Implementation Arrangements

The project shall be implemented at both federal and state levels but most of the practical activities will take place at the states level.

4.1.1 Federal Level

The Federal Republic of Nigeria (FRN) is the borrower and will on-lend part of the funds to the two states (Anambra and Ondo) for the project implementation. ***The Federal Ministry of Health (FMOH) will be the Implementing Agency to coordinate the roll-out and overall execution of the operation through the National Malaria Elimination Programme (NMEP) office of the ministry.*** This was setup by government with support from partners over 20 years ago with the mandate for malaria initiatives coordination and management in the country. NMEP is currently coordinating federal and development partner-financed projects/programmes, and has relevant project management, monitoring, procurement, and fiduciary systems in place. With regards to procurement, weaknesses were observed in the capacity to implement the project as detailed in the annex – B. 5.8.2 which explains the need for Technical Assistance (TA).

The National Malaria Elimination Programme will designate the following key staff: Project Focal Officer, Procurement Officer, Project Accountant (designated from the Accountant General's Office), and Nutrition Focal Point (from the national Nutrition Unit) which shall comprise the Federal Project Implementation Unit (FPIU) to coordinate and provide technical support and oversight to the two states, Ondo and Anambra: In addition to the focal team which reports to the NMEP Coordinator, a procurement TA will be recruited to strengthen the capacity of NMEP and carry out regular procurement post reviews for the two states. The Bank (AfDB) shall provide funds to NMEP for coordination, supervision, monitoring and evaluation activities under the project.

4.1.2 State Level

The State Ministries of Health will be the Executing Agencies for State Components. There shall be a Project Steering Committing (PSC) and a project implementation unit (PIU) for each state.

The Project Steering Committees in each of the states (chaired by the Health Commissioner) shall consist of representatives from the Ministries of Health, Agriculture, Women Affairs, Finance, Budget and Economic Planning. Financier representatives (AfDB and WB) and the FMF may participate as observers. The committee that will be responsible for project oversight shall meet twice yearly and on an ad hoc basis to approve workplans/budgets and review project progress.

The state PIU shall be responsible for the day-to-day project management and shall include a manager, accountant (from PFMU), procurement officer, training officer, M&E officer and financial compliance officer. Recruitment for civil works contractors and of non-state actors (NSAs) under component 1 activities shall be carried out by the PIU. The NMEP of the FMOH shall provide technical support as necessary and, jointly with the states, prequalify NSAs and major suppliers (health and nutrition products) as a means of providing a pool of quality-assured contractors from which the states may proceed with their procurement. One NSA (firm) will be required to take on activities in an entire state. The NSA activities include distribution and use of procured goods and commodities in providing services at facility and community levels. In addition to this, verification third party agents shall also be recruited for M&E activities that will be used to measure project progress and determine/verify activities of the NSAs regarding the provision of malaria and nutrition services at both facility and community levels. Details on the functions of the PIU and the different actors under the project are defined in Technical Annex B.

4.1.3 *Procurement arrangements*

4.1.3.1 Procurement management. Procurement of goods (including non-consultancy services), works and the acquisition of consulting services, financed by the Bank for the project, will be carried out in accordance with the "Procurement Policy and Methodology for Bank Group Funded Operations" (i.e. Bank Procurement Policy and Methodology – BPM), dated October 2015 and

following the provisions stated in the Financing Agreement to be entered into in respect of the Project. The BPM refers to Bank standard PMPs, including usage of the relevant Bank Standard Solicitation Documents (SDDs).

4.1.3.2 Procurement risk and capacity assessment (PRCA*)*. Assessment of procurement risks were undertaken for the project at the levels of the Federal Government, Anambra and Ondo States, the country's Health sector, and the project. In addition, an assessment of procurement capacities of the Implementing agencies: NMEP, Anambra and Ondo States Malaria Elimination Programmes. The appropriate risks mitigation measures have been included in the procurement PRCA action plan proposed in Annex B5.

4.1.4 Financial Management and Disbursement Arrangements

4.1.4.1 Financial Management. The Financial Management (FM) (that includes budgeting, accounting, internal controls, treasury management, financial reporting and external audit) arrangements for the project at the Federal and State levels for Anambra and Ondo meet the Bank requirements and are adequate for overall project implementation.
At Federal level, project financial management will be under the responsibility of the Finance and Administration (F&A) Department within the NMEP Office of the FMOH.

At State level where the majority of the activities under the project will be implemented, the Anambra and Ondo State Governments Ministries of Health will be the executing agencies with the project implemented by the respective PIUs.

The respective agencies, one at the Federal and two at State level (for Anambra and Ondo) whose responsibility shall cut across management of their specific project activities will be staffed with a qualified project accountant and financial compliance officer (among other staff) and will be responsible for the project financial management. Each of the PIUs shall have robust accounting software that will be established and used for project accounting and capable of generating the required financial reports for the project. The personnel shall maintain accurate accounting records and will be deployed from their respective staff within the Project Financial Management Units (PFMU) in the Office of the Accountant General (OAG) at both Federal and State levels. The assignment of the project accountants by the respective OAG with the requisite experience to be part of the PIU will form part of the conditions precedent to first disbursement. The respective PFMUs at the Federal and the State levels have the requisite experience and currently handle the accounting for a number of ongoing donor funded (primarily World Bank) projects. Training in Bank requirements regarding FM will also be given as part of project launching and during its implementation as a capacity building initiative taking into account lessons learned from previous and ongoing projects.

4.1.4.2 The FM capacity assessment of the NMEP office at Federal level and the respective State Ministries of Health (Anambra and Ondo) conducted as part of appraisal concluded that there is adequate capacity to carry out the effective financial management of the proposed project.

There will also be an experienced financial compliance officer as part of the project teams which will be a further measure towards enhancing project internal control. Use will therefore be made of the existing project financial management arrangements that are also in line with the acceptable country fiduciary risk levels, thereby permitting the Bank to adopt an approach on the use of country systems including for budgeting, accounting, internal control and Treasury Management. The overall FM risk for the project is assessed as "Substantial" primarily due to the nature of the project that is being implemented across a wide spread of areas in the two States necessitating the need for proper coordination and some of the inherent weaknesses in internal controls based on Bank experience in the ongoing projects. The satisfactory implementation of agreed FM actions is expected to strengthen

the existing systems aimed at ensuring the proper financial management of the project. The detailed FM *assessment is in Technical Annex B4.*

4.1.4.3 Financial Reporting

In accordance with the Bank's financial reporting and audit requirements, each project implementing agency at the Federal and at State levels shall prepare separate project Interim Quarterly Financial Progress reports (IQFPR) showing the different sources of financing (Bank and Counterpart) and expenditures by category/ component to monitor project implementation.

The reports that will also be submitted to the Bank not later than forty-five (45) days after the end of each calendar quarter. A set of separate project financial statements shall be prepared at the end of each year at State level and also at Federal level which shall be audited by Office of the Auditor General or recruited independent audit firms (contained on the Bank pre-approved list of private audit firms maintained for Nigeria) that will be procured competitively with the involvement of the respective Offices of the Auditors General. The respective auditor's report and management letter together with the audited project financial statements will be submitted to the Bank not later than 6 months after the end of each fiscal year. The external audits will be carried out in accordance with a Bank approved audit terms of reference with the costs of audit financed under the Loan resources. The detailed audit arrangements are in Annex B6.

4.1.4.4 Disbursement Arrangements

At Federal level, the project would make use of primarily the Direct Payment method of disbursement for payments on contracts; while a project specific USD Special Account together with the related local currency (Naira) will be opened at the Central Bank of Nigeria (CBN) to facilitate all other project related payments in local currency. At State level, each State PIU (one per State) will open a USD denominated Special Account which shall have local Naira denominated draw down account in a commercial bank acceptable to the Bank. The Special Account for each State shall be used to make payments in respect of the operating and recurring expenses. The Reimbursement and Reimbursement Guarantee methods also remain available for use with all disbursements to be done in accordance with Bank rules and procedures as laid out in the Disbursement Handbook as applicable. The Bank will issue a Disbursement Letter of which the content will be discussed and agreed with the Borrower during negotiations.

4.2 *Monitoring and Evaluation*

4.2.1 ***The project is scheduled for implementation over a 60 month period.*** This schedule is reasonable, given the scope of activities to be implemented and routine activity, output and outcome monitoring that will be undertaken. Baseline indicators are available but will be augmented with data reports that will be generated from surveys planned before the end of 2019 under the project by a third party agent (firm) to be competitively recruited. Progress data that will assist in tracking achievement of targets will be collected twice a year from the annual national health facility survey (NHFS) reports as well as the project funded household and facility surveys conducted between the (NHFS). NDHS, MICS, NBS and other national and subnational data sources will also be utilized in monitoring progress. Everything will be tracked through the agencies' existing monitoring systems. The PIUs will be responsible for the routine project supervision.

4.2.2 The PIUs at state and federal levels will ensure that quarterly and annual activity reports are prepared and submitted to the Bank as required. The Bank through the Nigeria Country Office will carry out a rigorous monitoring and supervision mission jointly with the Federal Ministry of Finance (FMF) and FMOH at least twice a year, to the extent possible with other development partners in Nigeria particularly the World Bank and Islamic Development Bank. Coordination meetings will be

routinely held with WB to monitor progress and ensure smooth implementation. A PCR will be undertaken to evaluate progress against outputs and outcomes and draw lessons for possible follow-up operation. Table 6 below presents the Project implementation and monitoring schedule.

Table 6: Key Milestones

Task / Milestone	Responsible Party	Time Frame
Project Board Approval	AfDB	November 2019
Loan Signature	AfDB/Government	January 2020
Loan Effectiveness	AfDB/Government	March 2020
Project Launching	AfDB/Government	April 2020
Project Implementation Period	Government	2020 to 2024
Annual Audit Report	Government	June 2021, 2022, 2023, 2024 and 2025
Supervision Mission	AfDB/Government	December/June 2020, 2021, 2022, 2023 and 2024
Mid-term Review	AfDB/Government	June 2022
Project Completion	AfDB/Government	December 20124
Project Completion Report	AfDB/Government	June 2025

4.3 Governance

4.3.1 ***The project has no potential issues or risks linked to governance.*** As a means of reducing the possibilities of fraud and corruption during project implementation, NSAs whose actions will be supervised by government staff will implement key activities and the expected outcomes or deliverables determined by a third party. A financial compliance officer that shall be reviewing and approving disbursements shall be part of the PIU.

4.4 Sustainability

4.4.1 Ownership: The project design is in tandem with the government's medium/long term plans and policies including the Economic Recovery and Growth Plan (ERGP), National Health Policy as described in clause 1.1.1 of the PAR. In addition, the project work plans from the two states will be be subsets of the states' health plans for the different years. Ownership is also expected to be strengthened by the community involvement/participation at all stages of implementation including supervisions, reviews etc. The social and behavioural communication change (SBCC) activities will not only increase community knowledge and practices on preventive health but also improve health seeking behaviour and appetite to prioritize and participate in issues concerning their health.

4.4.2 Institutional Capacity Strengthening*:* The project shall build institutional as well as individual relevant government functionaries/service providers' capacities at both federal and state levels to ensure continuity and ability to initiate similar activities after project completion. Funding for these and also for studies in support of sustainability measures during and after implementation have been provided. Specific areas of capacity enhancement shall include; advocacy for increased and sustained government funding, health budgeting, building synergies and complementarities, coordination of partners support and activities to eliminate wastages and fiduciary system. Under the project, there are plans also to support the health management information system which will provide for data availability for advocacy, planning and management purposes.

4.4.4: Availability and Affordability of Products: A major challenge to the drugs and commodities manufacturers in Nigeria is the production high cost and lack of WHO prequalification. This results in high cost of products and poor patronage. The project plans to provide technical support to the association of manufacturers with regards to identifying and instituting measures that will assist their members in obtaining the WHO prequalification which will open their markets to other countries and bodies leading to increased productivity. This will reduce prices (a result of economics of scale) and make the commodities more affordable.

4.4.5 Financial Sustainability: The project is expected to be sustained after the Bank support in view of the following:

i. ***Dedicated Health Funds***: The Federal Government in 2014 approved a health law that stipulates a statutory transfer of 1% of the national consolidated revenue for primary health care services in the country through the Basic Health Care Provision Fund (BHCPF). Implementation just began with the release of 25% of the USD 180 million in the 2018 budget. The two project States (Ondo and Anambra) are working towards meeting the criteria set for accessing the funds and are likely to begin draw down from the fund in the next one years.

ii. ***Contributory Health Scheme:*** Both States are at different stages of health insurance scheme development. The governments under the scheme are expected to invest huge sums of funds annually to ensure free services for under-5 and the vulnerable in the society. The project is proving TA to establish a functional system in place.

iii. ***Drug Revolving Fund (DRF) Scheme:*** The DRF scheme under implementation in the states will be strengthened and sustained to ensure continues availability of drugs and commodities. Wastages in the system will be reduced through the improved governance envisaged under the project.

4.5 Risk Management

Table 7: Risk Management

S/N	Key Risk	Probability/ Impact	Mitigation Measures
1	2020 and 2021 Election outcomes in both States may cause delays and or changes in government policy direction	Low	• Effective dialogue as well as securing strong political will and commitment of all aims of government in both States as well as at federal.
2	Poor quality and availability of M&E data at subnational level	Medium	• The NMEP will deploy TA to SMOHs to provide capacity strengthening. • NMEP works with DPRS to activate community component and secondary health facility component on DHIS. • Project to ensure availability of SOPs and data collection tools at HFs.
3	Treatment disruptions in public sector due to stock-outs or loss of health products	Low	• NMEP will support States and other relevant stakeholders to ensure timely and accurate quantification of health product needs. • NMEP will use reputable logistics providers with valid goods-in-transit insurance to ensure secure, on-time delivery of products.
4	Inadequate capacity of executing agency could affect implementation effectiveness and efficiency	Low	• The Programme integrates Capacity building interventions particularly in procurement and financial management for the project management unit (PMU) and where necessary, experts will be hired to reinforce gap capacities of the PMU.
5	Discordance in implementation of WB and ADB components	Low	• Frequent coordination meetings between the 2 agencies.

4.6 Knowledge Building

4.6.1 ***Knowledge data will be generated through the planned regular household and facility-based surveys as well as the operations research to be carried out by the third party agent to be recruited under the project.*** Additionally, the Project includes skills upgrade and capacity improvement of healthcare providers at both public and private facilities by the NSAs responsible for quality service delivery, training of locals on community mobilization, and advocacy by the SBCC

firm. Technical assistance will be provided at the federal and state levels, particularly for the PIUs aimed at building institutional and individual capacities as well as ensuring the smooth implementation of the project.

4.6.2 ***The Bank will capture and disseminate knowledge through sharing the findings of supervision mission/progress reports, and the Project Completion Report.*** Lessons learned and experience gained will be available to inform future policy operations.

4.6.3 ***Capacity building.*** The Project shall also be supporting institutional strengthening in data management for improved evidence-based policy, strategy and intervention development.

V. LEGAL INSTRUMENT AND AUTHORITY

5.1. Legal Instrument

The financing instrument to be used for the project will be an ADB loan. The Bank and the Federal Republic of Nigeria ("Borrower") shall sign a loan agreement for the amount of USD 68.30m.

5.2. Conditions Associated with the Bank's Intervention

5.2.1 Condition precedent to entry into force of the loan agreement

The loan agreement shall enter into force subject to fulfilment by the Borrower of the provisions of section 12.01 of the General Conditions Applicable to the African Development Bank Loan Agreements and Guarantee Agreements (Sovereign Entities).

5.2.2 *Conditions precedent to first disbursement for the loan*

The obligations of the Bank to make the first disbursement of the ADB loan shall be conditional upon the entry into force of the loan agreement and fulfilment by the Borrower of the following conditions: Submission of evidence of:

- having signed: (a) an on-lending/subsidiary agreement between the Borrower and each of the two (2) states where the Borrower transfers the entire proceeds of the ADB loan on terms and conditions acceptable to the Bank; and
- the establishment of a Project Implementation Unit (PIU) at the federal and in each of the participating states and designation of members with qualifications acceptable to the Bank.

5.2.3 ***Other conditions:*** No later than end of the second quarter of 2020, submission of evidence of:

- the preparation of a Project Implementation Manual (PIM) by the Federal Executing Agency to include all project activities, acceptable to the Bank; The implementation of all agreed Financial Management actions (Annex B4);
- the execution and delivery of co-financing Agreements on terms and conditions acceptable to the Bank or the submission of evidence that the Borrower has secured financing from alternative sources to cover the financing gap resulting from failure to obtain the Co-financing;
- the Establishment of a Project Steering Committee and designation of its members with composition and qualifications acceptable to the Bank; and
- the recruitment of a Procurement Officer to strengthen the capacity of NMEP.

5.2.4. Environmental and Social Safeguards. The Borrower shall, and shall cause the Executing Agency, Implementing Agency and their respective contractors and agents to:

(a) carry out the Project in accordance with the Environmental and Social Management Plan (ESMP), the Bank's Safeguards Policies and the applicable national legislation in a manner and in substance satisfactory to the Bank;

(b) prepare and submit to the Bank, as part of the Project Report, semi-annual reports on the implementation of the ESMP including any implementation failures and related remedies thereof;

(c) refrain from taking any action which would prevent or interfere with the implementation of the ESMP including any amendment, suspension, waiver, and/or voidance of any provision thereof, whether in whole or in part, without the prior written concurrence of the Bank; and

(d) cooperate fully with the Bank in the event that the implementation of the Project or a change in the Project scope results in hitherto unforeseen displacement of persons, and shall not commence implementation of any works on the affected area under the Project, unless all Project affected persons (PAPs) in such area(s) have been compensated and/or resettled in accordance with a RAP, to be prepared.

5.3. Compliance with Bank Policies

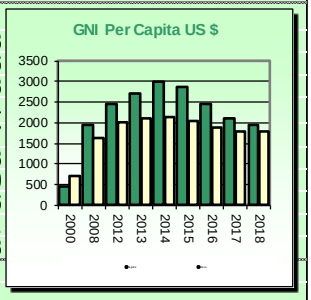
This project complies with all applicable Bank policies, including the 2008 Policy on Expenditure Eligible for Bank Group Financing, where a justification for reduced counterpart funding (Appendix V) has been provided accordingly; and the Bank's on-lending policy.

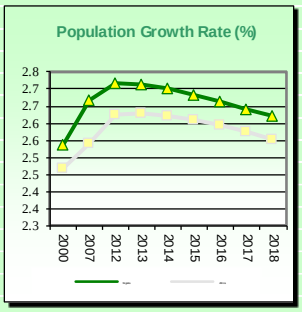
VI. RECOMMENDATION

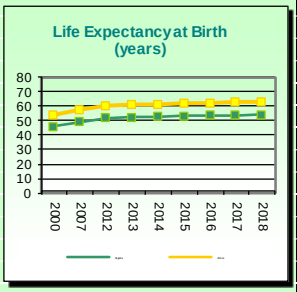
Management recommends that the Board of Directors of the ADB approve the proposal for an ADB loan of USD 68.30 million to the Federal Republic of Nigeria for the purposes and subject to the terms and conditions stipulated in this report.

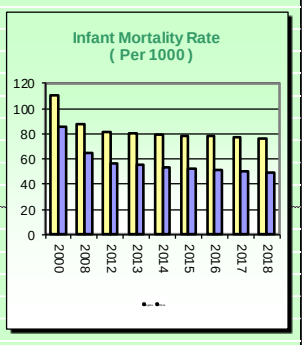
Appendix I: Nigeria's Comparative Socio-Economic Indicators (October 2019)

	Year	Nigeria	West Africa	Africa	Develo-ping Countries
Basic Indicators					
Area ('000 Km²)	2018	911	5,115	30,067	94,808
Total Population (millions)	2018	195.9	376.8	1,274.2	6,306.6
Urban Population (% of Total)	2018	50.3	46.4	42.9	49.8
Population Density (per Km²)	2018	215.1	74.9	43.4	68.4
GNI per Capita (US $)	2018	1 960	1 551	1 783	4 837
Labor Force Participation *- Total (%)	2018	55.2	60.1	63.5	61.8
Labor Force Participation **- Female (%)	2018	50.6	54.6	54.6	47.0
Sex Ratio (per 100 female)	2018	102.7	101.3	99.8	100.6
Human Develop. Index (Rank among 189 countries)	2017	157	...	...	...
Popul. Living Below $ 1.90 a Day (% of Population)	2007-17	53.5	41.6	31.2	11.8
Demographic Indicators					
Population Growth Rate - Total (%)	2018	2.6	2.7	2.5	1.3
Population Growth Rate - Urban (%)	2018	4.3	4.1	3.6	2.4
Population < 15 years (%)	2018	43.9	43.6	40.8	27.7
Population 15-24 years (%)	2018	19.1	19.5	19.3	16.5
Population >= 65 years (%)	2018	2.7	2.8	3.4	7.0
Dependency Ratio (%)	2018	87.3	86.5	79.2	54.6
Female Population 15-49 years (% of total population)	2018	22.9	23.3	24.1	25.4
Life Expectancy at Birth - Total (years)	2018	54.3	57.7	63.2	70.6
Life Expectancy at Birth - Female (years)	2018	55.2	58.7	65.0	72.7
Crude Birth Rate (per 1,000)	2018	37.9	37.2	33.5	20.3
Crude Death Rate (per 1,000)	2018	11.9	10.2	8.1	7.4
Infant Mortality Rate (per 1,000)	2018	75.7	64.1	48.7	31.3
Child Mortality Rate (per 1,000)	2018	119.9	99.6	70.2	42.0
Total Fertility Rate (per woman)	2018	5.4	5.2	4.4	2.6
Maternal Mortality Rate (per 100,000)	2017	917.0	704.7	432.3	230.0
Women Using Contraception (%)	2018	18.5	21.2	38.5	61.6
Health & Nutrition Indicators					
Physicians (per 100,000 people)	2010-16	38.3	25.7	33.6	119.9
Nurses and midwives (per 100,000 people)	2010-16	145.2	106.6	123.3	233.9
Births attended by Trained Health Personnel (%)	2010-17	40.3	50.5	61.7	78.5
Peop. Using at least basic drinking water services (% of Pop.)	2017	71.4	69.8	66.3	87.7
Peop. Using at least basic sanitation services (% of Population)	2017	39.2	32.5	40.3	68.5
Percent. of Adults (aged 15-49) Living with HIV/AIDS	2018	1.5	1.5	3.4	...
Incidence of Tuberculosis (per 100,000)	2016	219.0	146.2	221.7	157.0
Child Immunization Against Tuberculosis (%)	2018	53.0	70.4	81.4	85.0
Child Immunization Against Measles (%)	2018	65.0	71.0	76.1	85.2
Underweight Children (% of children under 5 years)	2010-16	31.5	19.8	17.5	15.0
Prevalence of stunding	2010-16	43.6	36.3	34.0	24.6
Prevalence of undernourishment (% of pop.)	2017	13.4	13.9	18.5	12.3
Current health expenditure (% of GDP)	2016	3.6	4.1	5.3	5.4
Education Indicators					
Gross Enrolment Ratio (%)					
Primary School - Total	2010-18	84.7	89.4	100.1	104.1
Primary School - Female	2010-18	82.2	87.1	98.0	104.4
Secondary School - Total	2010-18	42.0	45.0	52.8	71.9
Secondary School - Female	2010-18	39.8	42.2	50.6	71.4
Primary School Female Teaching Staff (% of Total)	2010-18	48.2	40.2	48.6	62.9
Adult literacy Rate - Total (%)	2010-18	62.0	56.0	66.9	84.0
Adult literacy Rate - Male (%)	2010-18	39.1	53.6	70.8	88.2
Adult literacy Rate - Female (%)	2010-18	52.7	46.8	60.0	79.8
Gouvernment expenditure on Education (% of GDP)	2010-17	...	4.1	4.3	...
Environmental Indicators					
Land Use (Arable Land as % of Total Land Area)	2016	37.3	10.8	8.7	11.4
Agricultural Land (as % of land area)	2016	77.7	43.9	41.8	38.3
Forest (As % of Land Area)	2016	7.2	9.2	23.1	31.9
Per Capita CO2 Emissions (metric tons)	2014	0.5	0.4	1.2	3.5









Sources : AfDB Statistics Department Databases; World Bank: World Development Indicators; UNAIDS; UNSD; WHO, UNICEF, UNDP; Country Reports. *last update : Octobor 2019*

*Note : n.a. : Not Applicable ; ... : Data Not Available. * Labor force participation rate, total (% of total population ages 15+)*

*** Labor force participation rate, female (% of female population ages 15+)*

Appendix II: Table of Bank's Portfolio in Nigeria

RDNG ONGOING PUBLIC SECTOR OPERATIONS | OCT-31-2019

Sector	Project Title	Amount (UA M)	Loan Number	Funding Source	Approval Date	Entry into force	Completion Date	Age	Cum. Disb. Rate (%)	Amount Disbursed	Type of Operations	Type	Instrument
Agriculture Sector													
	SAY NO TO FAMINE FOR NIGERIA	11.9	2100150040593	ADF	12/14/2018	7/24/2019	8/1/2028	0.9	0.0%	0.0	SO	Invest.	Loan
	PLATEAU STATE POTATO VALUE CHAIN SUPPORT PROJECT (PS-PVCP)	8.0	2100150037297	ADF	3/30/2017	11/6/2017	12/31/2023	2.6	13.4%	1.1	SO	Invest.	Loan
	MIC-GRANT SUPPORT TO BANK OF AGRICULTURE (BOA) LIMITED	0.7	5500155010351	MICTAF	5/5/2016	7/1/2016	9/28/2020	3.5	86.5%	0.6	SO	Invest.	Grant
	AGRICULTURAL TRANSFORMATION AGENDA SUPPORT PROGRAM - PHASE I	98.8	2100150029994	ADF	10/30/2013	12/13/2014	6/30/2025	6.0	21.2%	21.0	SO	Invest.	Loan
	AGRICULTURAL TRANSFORMATION AGENDA SUPPORT PROGRAM - PHASE I	0.3	2100155025974	ADF	10/30/2013	2/20/2015	6/30/2025	6.0	41.0%	0.1	SO	Invest.	Loan
		119.6						**3.6**	**25.7%**	**22.8**			
Environment Sector													
	NIGERIA-PROGRAMME FOR INTEGRATED AGRIC DEVT. AND ADAPTATION	6.0	2100150040844	ADF	11/7/2018		12/31/2025	1.0	0.0%	0.0	SO	Invest.	Loan
	NIGERIA-PROGRAMME FOR INTEGRATED AGRIC DEVT. AND ADAPTATION	2.3	5110155000451	EU PAGODA	11/7/2018	5/20/2019	12/31/2025	1.0	0.0%	0.0	SO	TA	Grant
		8.3						**1.0**	**0.0%**	**0.0**			
Financial Sector Development Sector													
	DEVELOPMENT BANK OF NIGERIA (DBN)	32.6	2100150032693	ADF	12/15/2014	11/3/2017	12/31/2022	4.9	100.0%	32.6	SO	Invest.	Loan
		32.6						**4.9**	**100.0%**	**32.6**			
Governance & Multi-Sector Sector													
	INSTITUTIONAL SUPPORT PROJECT FOR ECONOMIC MANAGEMENT AND DE	10.0	2100150040544	ADF	12/3/2018	6/19/2019	6/30/2022	0.9	0.0%	0.0	SO	Policy	Loan
	NIGERIA - AFRICAN TRADE INSURANCE (ATI) COUNTRY MEMBERSHIP P	8.8	2100150040595	ADF	12/14/2018	10/8/2019	12/31/2026	0.9	100.0%	8.8	SO	Invest.	Loan
	NIGERIA - AFRICAN TRADE INSURANCE (ATI) COUNTRY MEMBERSHIP P	1.4	2100150040596	ADF	12/14/2018	10/8/2019	12/31/2026	0.9	100.0%	1.4	SO	Invest.	Loan
		20.2						**0.9**	**50.5%**	**10.2**			
Power & Energy Sector													
	PARTIAL RISK GUARANTEE PROGRAM IN SUPPORT OF THE POWER SECTOR	120.0	ML-0024	ADB	12/18/2013	8/28/2018	1/1/2028	5.9	0.0%	0.0	SO	PRG	Loan
	SEFA GRANT-JIGAWA IPP PROCUREMENT TECHNICAL ASSISTANCE GRANT	1.1	ML-0024	SEFA	12/6/2017	8/28/2018	1/1/2028	1.9	0.0%	0.0	SO	Invest.	Grant
	NIGERIA ELECTRIFICATION PROJECT	108.9	2000200003401	ADB	11/29/2018	7/29/2019	1/1/2028	0.9	0.0%	0.0	SO	Invest.	Loan
	NIGERIA ELECTRIFICATION PROJECT	36.3	5050200000551	AGTF	11/29/2018	7/29/2019	1/1/2028	0.9	0.0%	0.0	SO	Invest.	Loan
		266.3						**2.4**	**0.0%**	**0.0**			
Social and Human Capital Development Sector													
	ECOWAS - NELSON MANDELA INSTITUTE - AFRICAN INSTITUTIONS OF	6.7	2100155032824	ADF	7/15/2016	9/30/2016	12/1/2020	3.3	69.8%	4.7	SO	Invest.	Loan
	ADDITIONAL LOAN TO IBSDLIEP FOR THE COMPLETION OF FSTC LASSA	4.0	2100150040594	ADF	12/14/2018	7/8/2019	12/31/2026	0.9	0.0%	0.0	SO	Invest.	Loan
	INCLUSIVE BASIC SERVICE DELIVERY AND LIVELIHOOD EMPOWERMENT	108.9	2000200000701	ADB	12/14/2016	12/21/2017	11/19/2026	2.9	1.4%	1.6	SO	Invest.	Loan
	INCLUSIVE BASIC SERVICE DELIVERY AND LIVELIHOOD EMPOWERMENT	71.8	2100150036593	ADF	12/14/2016	11/3/2017	11/19/2026	2.9	3.0%	2.2	SO	Invest.	Loan
	INCLUSIVE BASIC SERVICE DELIVERY AND LIVELIHOOD EMPOWERMENT	4.0	5800155001751	RWSSI	12/14/2016	11/3/2017	11/19/2026	2.9	2.7%	0.1	SO	Invest.	Grant
	SUB-NATIONAL DEBT MANAGEMENT CAPACITY BUILDING PROJECT (SUBD	0.8	5500155011551	MICTAF	1/24/2017	5/22/2017	12/31/2022	2.8	5.3%	0.0	SO	Invest.	Grant

	196.2						**2.6**	**4.4%**	**8.5**			
Transport Sector												
TRANSPORT FACILITATION PROGRAMME FOR THE BAMENDA-MAMFEABAKAL	30.6	6550655000401	ACFA	3/31/2009	3/31/2009	12/31/2019	10.6	0.0%	0.0	SO	Invest.	Loan
TRANSPORT FACILITATION PROGRAMME FOR THE BAMENDA-MAMFEABAKAL	188.6	2100150019643	ADF	11/25/2008	11/4/2009	12/31/2019	10.9	75.7%	142.8	SO	Invest.	Loan
TRANSPORT FACILITATION PROGRAMME FOR THE BAMENDA-MAMFEABAKAL	16.2	2100155015166	ADF	11/25/2008	5/13/2009	12/31/2019	10.9	44.7%	7.2	SO	Invest.	Loan
ABIDJAN-LAGOS CORRIDOR HIGHWAY DEVELOPMENT PROJECT STUDY-NIG	1.0	2100150036600	ADF	9/21/2016	1/28/2019	12/31/2024	3.1	100.0%	1.0	SO	Invest.	Loan
STUDY FOR CROSS RIVER STATE RURAL ACCESS AND MOBILITY PROJEC	0.9	2100150039993	ADF	9/3/2018	8/9/2019	12/31/2022	1.2	0.0%	0.0	SO	Invest.	Loan
EBONYI STATE RING ROAD PROJECT	29.0	2000200003851	ADB	4/24/2019		6/30/2025	0.5	0.0%	0.0	SO	Invest.	Loan
EBONYI STATE RING ROAD PROJECT	21.8	5050200000751	AGTF	4/24/2019		6/30/2025	0.5	0.0%	0.0	SO	Invest.	Loan
ABUJA BUS RAPID TRANSIT (BRT) PROJECT STUDY	0.7	5560155000601	CTF	2/5/2013	1/29/2016	12/31/2021	6.7	69.7%	0.5	SO	TA	Grant
MICTAF- ABIA STATE INTEGRATED INFRASTRUCTURE DEVELOPMENT PRO	1.2	5500155013301	MICTAF	2/7/2019	5/15/2019	12/31/2025	0.7	0.2%	0.0	SO	TA	Grant
	289.9						**5.0**	**52.3%**	**151.5**			
Water Supply and Sanitation Sector												
RURAL WATER SUPLY AND SANITATION SUB-PROGRAMMES FOR YOBE AND	51.0	2100150015645	ADF	10/10/2007	12/5/2008	2/1/2020	12.1	80.2%	40.9	SO	Invest.	Loan
URBAN WATER & SANITATION IMPROVEMENT PROJECT IN OYO AND TARA	50.0	2100150025696	ADF	9/2/2009	10/30/2012	12/31/2025	10.2	91.7%	45.9	SO	Invest.	Loan
ZARIA WATER AND SANITATION EXPANSION PROJECT	63.9	2100150026597	ADF	2/8/2012	10/24/2013	12/31/2020	7.7	88.4%	56.5	SO	Invest.	Loan
URBAN WATER REFORM & PORT HARCOURT WSSP	145.2	2000130011585	ADB	3/26/2014	11/12/2015	4/30/2021	5.6	1.8%	2.7	SO	Invest.	Loan
URBAN WATER REFORM & PORT HARCOURT WSSP	3.3	2100150031043	ADF	3/26/2014	9/28/2015	4/30/2021	5.6	5.6%	0.2	SO	Invest.	Loan
	313.5						**8.2**	**46.6%**	**146.1**			

RDNG ONGOING PRIVATE SECTOR OPERATIONS | OCT-31-2019

Sector	Project Title	Amount (UA M)	Loan Number	Funding Source	Approval Date	Entry into force	Completion Date	Planned final Disb. date	Age	Cum. Disb. Rate (%)	Type of Operations	Type	Instrument
Agriculture Sector													
	OLAM AFRICA INVESTMENT PROGRAM II	78.1	2000120004569	ADB	1/11/2017		12/31/2025		2.8	0.0%	NSO	Invest.	Loan
	OLAM AFRICA INVESTMENT PROGRAM	2.1	5060140000052	EPSA	9/28/2016		8/1/2023	8/1/2023	3.1	0.0%	NSO	Invest.	Loan
	OLAM AFRICA INVESTMENT PROGRAM	35.0	2000130015880	ADB	6/26/2013	12/15/2016	8/1/2023	12/15/2018	6.3	100.0%	NSO	Invest.	Loan
	FLOUR MILLS OF NIGERIA PLC	54.5	2000130019880	ADB	9/19/2018		12/31/2027		1.1	0.0%	NSO	Invest.	Loan
	FUND FOR AGRICULTURAL FINANCE IN NIGERIA (FAFIN)	6.7	2000100002	ADB	10/19/2016	6/12/2017	12/15/2025	12/15/2025	3.0	45.8%	NSO	Equity	Loan
		176.2							**3.3**	**23.6%**			
Financial Sector Development Sector													
	VEROD CAPITAL GROWTH FUND	10.3	2000100003	ADB	12/14/2018	6/12/2017	12/15/2025	12/15/2025	0.9	20.6%	NSO	Equity	Loan
	AFRICA FINANCE CORPORATION	21.7	000-000	ADB	12/15/2018	10/18/2012	1/20/2022	4/18/2015	0.9	0.0%	NSO	Invest.	Loan
	AFRICA FINANCE CORPORATION	145.6	2000130008630	ADB	2/15/2012	10/18/2012	1/20/2022	4/18/2015	7.7	100.0%	NSO	Invest.	Loan
	INFRASTRUCTURE CREDIT GUARANTEE COMPANY LIMITED (INFRACREDIT	7.3	2000130020381	ADB	4/5/2019		12/31/2027		0.6	0.0%	NSO	Invest.	Loan
	INFRASTRUCTURE CREDIT GUARANTEE COMPANY LIMITED (INFRACREDIT	3.6	2000140001251	ADB	4/5/2019		12/31/2027		0.6	0.0%	NSO	Invest.	Loan
	WEMA BANK LINE OF CREDIT 2015	10.9	2000130017380	ADB	3/9/2016	8/1/2017	1/10/2028	8/1/2027	3.6	100.0%	NSO	Invest.	Loan
	STERLING BANK - IMPROVING THE QUALITY OF LIFE OF THE PEOPLE	36.3	2000130019680	ADB	9/25/2018		12/31/2027		1.1	0.0%	NSO	Invest.	Loan
	ABN MICROFINANCE BANK Equity 2008	5.0	2000100001	ADB	10/19/2008	6/12/2017	12/15/2025	12/15/2025	11.0	34.5%	NSO	Equity	Loan
	FIDELITY BANK PLC	54.5	2000130010730	ADB	7/17/2013	3/24/2014	11/1/2020	3/24/2016	6.3	100.0%	NSO	Invest.	Loan
	LINE OF CREDIT - UNITED BANK FOR AFRICA PLC	108.9	2000130015931	ADB	6/8/2016	11/30/2016	12/31/2025	11/30/2017	3.4	100.0%	NSO	Invest.	Loan
	DOMESTIC-ORIENTED SME FINANCING PROGRAM	72.6	2000130009884	ADB	5/26/2011	7/15/2014	3/16/2021	12/31/2017	8.4	100.0%	NSO	Invest.	Loan
	EXPORT-ORIENTED SME FINANCING PROGRAM	36.3	2000130009885	ADB	5/26/2011	1/29/2013	3/18/2024	1/29/2015	8.4	100.0%	NSO	Invest.	Loan
	DEVELOPMENT BANK OF NIGERIA (DBN)	290.5	2000130013130	ADB	12/15/2014	8/21/2017	12/31/2022	7/30/2020	4.9	100.0%	NSO	Invest.	Loan
	ZENITH BANK LOC II	72.6	2000120001070	ADB	12/13/2006	5/18/2007	12/31/2013	8/1/2013	12.9	100.0%	NSO	Invest.	Loan
	LINE OF CREDIT II TO GUARANTY TRUST BANK	65.4	2000130007031	ADB	6/23/2010	12/14/2011	1/31/2019	4/6/2012	9.4	100.0%	NSO	Invest.	Loan
	STANBIC IBTC BANK PLC	0.9	2000130011531	ADB	3/26/2014	6/9/2015	1/15/2028	6/9/2017	5.6	100.0%	NSO	Invest.	Loan
	STANBIC IBTC BANK PLC	0.9	5560130000501	CTF	5/27/2014	6/9/2015	1/15/2028	6/9/2017	5.4	100.0%	NSO	Invest.	Grant
	ZENITH BANK PLC - LOC III	90.8	2000130011530	ADB	3/26/2014	6/26/2014	1/15/2025	6/26/2015	5.6	100.0%	NSO	Invest.	Loan
	ACCESS BANK NIGERIA LOC II	72.6	2000130012130	ADB	5/15/2014	10/1/2014	8/1/2024	8/1/2016	5.5	100.0%	NSO	Invest.	Loan
	ACCESS BANK NIGERIA LOC II	5.1	5060140000255	ACFA-FAPA	10/11/2017		8/1/2024	8/1/2024	2.1	0.0%	NSO	Invest.	Loan
	NAIRA LINE OF CREDIT TO FRB SUBSIDIARY, RAND MERCHANT BANK N	31.0	2000130011783	ADB	12/12/2012	7/17/2014	5/21/2022	7/11/2017	6.9	100.0%	NSO	Invest.	Loan
	USD 300 MILLION TRADE FINANCE PACKAGE FIRST BANK OF NIGERIA	145.2	2000130015733	ADB	6/27/2016	12/7/2016	11/17/2019	12/7/2018	3.3	100.0%	NSO	Invest.	Loan
	FSDH MERCHANT BANK TRADE FINANCE LINE OF CREDIT	36.3	2000130015734	ADB	6/27/2016	12/2/2016	6/2/2020	12/2/2017	3.3	100.0%	NSO	Invest.	Loan
	FSDH MERCHANT BANK TRADE FINANCE LINE OF CREDIT	13.5	5060140000254	ACFA-FAPA	10/11/2017		6/2/2020	6/2/2020	2.1	0.0%	NSO	Invest.	Loan
	FIDELITY BANK	36.3	2000130019881	ADB	10/10/2018	5/7/2019	1/11/2025	5/7/2020	1.1	80.0%	NSO	Invest.	Loan
	LAPO MICROFINANCE LIMITED	5.7	2000130014181	ADB	10/1/2014	11/17/2015	1/10/2020	6/30/2017	5.1	100.0%	NSO	Invest.	Loan
		1,379.8							**4.8**	**92.6%**			
Industry Sector													
	INDORAMA ELEME FERTILIZER II	58.1	2000120005019	ADB	5/16/2018	6/12/2018	12/19/2027	3/12/2022	1.5	34.5%	NSO	Invest.	Loan
	INDORAMA FERTILIZER	72.6	2000120003769	ADB	1/30/2013	2/18/2013	11/19/2023	8/15/2016	6.8	100.0%	NSO	Invest.	Loan
	DANGOTE INDUSTRIES LIMITED	217.9	2000130015232	ADB	6/13/2014	12/22/2016	3/5/2021	12/22/2019	5.4	100.0%	NSO	Invest.	Loan
		348.6							**4.5**	**89.1%**			
IT & Communication Sector													
	HELIOS SHARED TELECOMS INFRASTRUCTURE PROJECT	21.9	2000130004580	ADB	9/2/2009	12/14/2009	3/31/2017	12/31/2011	10.2	100.0%	NSO	Invest.	Loan
		21.9							**10.2**	**57.1%**			

Social and Human Capital Development Sector												
INSTUTIONAL SUPPORT AFE BABALOLA UNIVERSITY MIC	0.7	5500155013001	MICTAF	5/30/2017	10/22/2018	3/31/2023	3/31/2023	2.4	5.6%	NSO	Invest.	Grant
AFE BABALOLA UNIVERSITY NIGERIA	14.5	2000130016430	ADB	10/19/2016	6/12/2017	12/15/2025	12/15/2025	3.0	100.0%	NSO	Invest.	Loan
AFE BABALOLA UNIVERSITY NIGERIA	15.1	2000130017037	ADB	10/19/2016		12/15/2025	12/15/2025	3.0	0.0%	NSO	Invest.	Loan
	30.4							**2.8**	**48.0%**			
Transport Sector												
LEKKI TOLL ROAD PROJECT	36.0	2000120001769	ADB	6/18/2008	9/18/2008	12/31/2023	9/18/2010	11.4	100.0%	NSO	Invest.	Loan
	36.0							**11.4**	**100.0%**			

Appendix III: Similar Projects Financed by the Bank and other Development Partners in Nigeria

S/N	Development Partners	Project/Amount	Sector/Subsector	Coverage
1	GLOBAL FUND	Malaria Elimination USD 283m (2018-2021)	Malaria	13 states: Kano, Kaduna, Katsina, Adamawa, Jigawa, Niger, Taraba, Kwara, Osun, Delta, Gombe, Yobe and Ogun
2	PMI	USD 65m (2018-2021)	Malaria	11 states: Bauchi, Sokoto, Kebbi, Zamfara, Oyo, Benue, Nassarawa, Plateau, Ebonyi, Akwa Ibom and Cross River
3	DfID	SUNMAP 2 GBP 50,000,000 (2018-2024)	Malaria	6 states of which 5 are co-funded by Global Fund (including Kano, Yobe, Kaduna, Jigawa and Katsina States)
4	DfID	MNCH2 – GBP 139.2 million programme over 5 years finishing in December 2019	Maternal, Newborn and Child Health Programme (MNCH)	
5	DfID	Women for Health (W4H) – GBP 34.9 million programme over 8 years, finishing in October 2020	MNCH	
6	DfID	Access to Family Planning Commodities – GBP 24 million programme over 8 years, finishing in June 2019	MNCH	
7	DfID	Nigeria Flagship Health Project – GBP 235 million over eight years 2019-2027	MNCH and Family Planning	
8	Canada	Bauchi Opportunities for Responsive Newborn and Maternal Health (BORN) (CAD 12.2 million, March 2016 to March 2020), Plan International Canada	MNCH	Bauchi State
9	Canada	"Enhancing Sexual and Reproductive Health for Women of Reproductive Age in Kaduna, Kano and Katsina States" – A CAD 19.75 million	Sexual and Reproductive Health	Kaduna, Kano and Katsina States
10	World Bank	SOML (Saving One Million Lives) USD 130m	MNCH	
11	World Bank (in process, not yet approved)	IMPACT USD 200 million (2020 – 2024)	Malaria	6 states: Abia, Borno, Ekiti, Imo, Lagos and Rivers
12	Islamic Development Bank (in process, not yet approved)	USD 100 million (2019-2024)	Malaria	5 states: Edo, Enugu, Bayelsa, FCT and Kogi

Appendix IV: Map of Nigeria showing Beneficiary States

Appendix V: Justification for Bank Financing of Project Costs Higher than the Proportion Stipulated by the Principle of Cost Sharing with the Regional Member Countries (RMCs)

The Government's counterpart contribution of USD 17.03 million accounts for about 20.0% of the total cost of the "Support to Health Systems Strengthening for Malaria Elimination and Nutrition Improvement in Anambra and Ondo States". This falls significantly short of the required minimum 50% of total project costs. The justification is based on four key parameters: (i) the strong commitment of the Federal Government in the implementation of the Economic Recovery and Growth Plan, 2017-2020, (ii) the Government's budgetary allocation to malaria prevention, (iii) the finance situation of the federal and state governments, and (iv) the precarious domestic debt situation of the two intervention states (Anambra and Ondo).

1. COMMITMENT BY THE FEDERAL GOV OF NIGERIA TO IMPLEMENT THE ECONOMIC RECOVERY AND GROWTH PLAN – ERGP (2017-2020)

Nigeria has just emerged from economic recession which started in 2016 and lasted for five consecutive quarters. This recession, which was attributable to volatility in oil prices and disruptions in production, imposed huge costs on social and human development indicators which have severely affected poverty and vulnerability across multiple households in Nigeria. The national government responded with its Economic Recovery and Growth Plan, which was launched in March 2017 and clearly emphasized health and education as strategies for investing in the Nigerian people.

The Federal Government has implemented the ERGP with strong commitment and utilized new innovative approaches including Focus Labs. These Labs adopted the "Big, Fast, Results" methodology to determine "high impact" priority investment projects as well as strategies to reduce any associated delivery bottlenecks. As part of the measures to ensure macro-economic stability, the Federal Government is pursuing fiscal consolidation through inter alia, cost cutting measures such as rationalization of overheads and recurrent expenditures and sub-national fiscal coordination. An Efficiency Unit at the Federal Ministry of Finance was also set up to help re-prioritize public spending and cut costs on recurrent expenditure, thus ensuring value for money.
In addition, selected public enterprises/ assets are planned to be privatized to optimize their operational efficiency and reduce the fiscal burden on the government. Measures on fiscal stimulus include on-going initiatives to increase revenue via privatization of public enterprises/assets as well as tax review initiatives aimed at expanding the tax to GDP ratio.

2. BUDGETARY ALLOCATIONS FOR THE HEALTH SECTOR HAVE BEEN CONSISTENT BUT SIGNIFICANT GAPS EXIST EACH YEAR FOR MALARIA ELIMINATION AND CONTROL

For several years, the Federal Government's total allocation to the health sector has remained relatively stable. Even though the average annual health allocation out of the total budget allocation is still lagging behind the Universal Health Care requirement of minimum allocation (which is 15% of National Budget to the health sector), the allocative efficiency for most of the years look quite good.

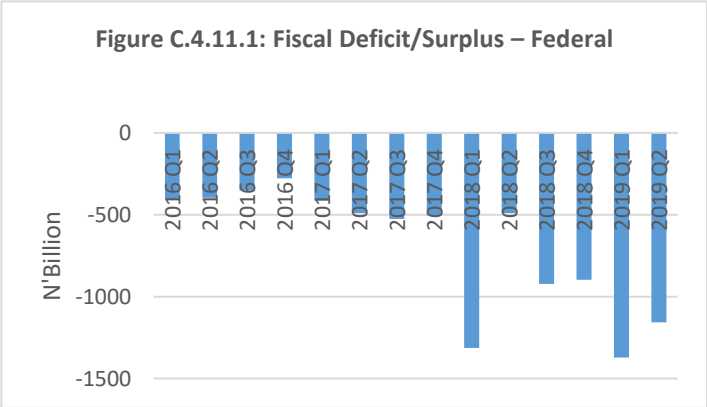
Nigeria Investments in Malaria Control (2014-2017)

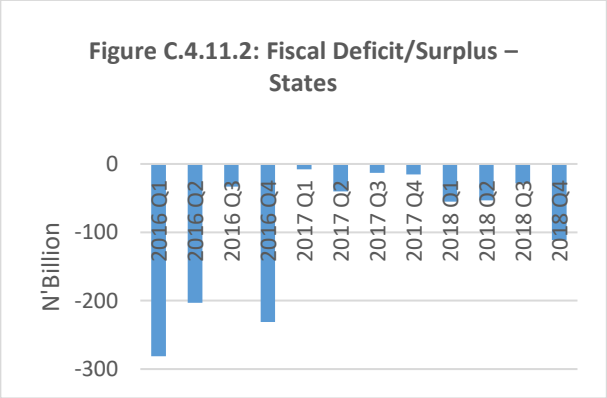
Year	Total Allocation to Health (USD)	Percent-age Allocation (%)	NMSP Projected Budget for Malaria (USD)	Allocation to Malaria by Government of Nigeria and Partners (USD)	Gap by Year (USD)
2014	1,648,245,845	0.18	604,914,891	324,196,153	280,718,738
2015	1,650,921,627	0.17	685,975,197	478,793,048	207,182,149
2016	1,649,885,596	0.27	828,663,941	186,997,348	641,666,593
2017	1,947,942,059	0.05	1,042,473.949.45	171,135,763	871,338,186.5

There are, however, gaps in the allocation to malaria by the government and its partners. In 2014 and 2015, the allocations for malaria prevention and eradication were high, and more than half the projected budget by the National Malaria Strategic Plan – NMSP (2014-2020). To these efforts, the Federal Government in 2014 approved a health law that stipulates a statutory transfer of 1% of the national consolidated revenue for primary health care services in the country through the Basic Health Care Provision Fund (BHCPF). However, the actual implementation was effected in 2018 with the release of 25% of the USD 180 million that is expected to continue in coming years. This is to help address among others the significant drop of the 2016 and 2017 allocation by the FGN to NMSP , a period that coincided with the recent economic recession era when government revenues reduced drastically following slips in oil prices and production.

3. FINANCE SITUATION OF THE FEDERAL AND STATE GOVERNMENTS

The financial situations of the Federal and State Governments remain precarious. Since oil revenues dominate the total revenues accruing to all levels of government in Nigeria, slippages as those in 2016 and 2017 have huge impacts on spending in social services and infrastructure. Given the low levels of internally generated revenues for both the Federal and State Governments, the level of deficit expenditure has been huge, especially for the Federal Government. In 2016 and 2017, the deficit was nearly as large as the total revenues. The level of fiscal deficit has risen again since 2018 for the federal government and even for the States because of the declining oil revenues amidst growing expenditures. The Federal and State Governments have recorded the weakest revenue mobilization efforts in the world but there are recent efforts to reverse the trend at both tiers of government.





At the Federal level, such measures as; the 'Voluntary Assets and Income Declaration Scheme (VAIDS), the 'Enhanced Taxpayer Education Programme', the 'Tax Automation Scheme', the Taxpayer Identification Number' amongst others. In Anambra and Ondo States, the governments have also introduced new measures and tax policy reforms including the 'Autonomy of the State Internal Revenue Service', the 'Presumptive Tax Initiative, New coding system for PAYE, Point of Sale (POS) terminals at tax office, 'State Wide electronic taxpayer enumeration surveys' amongst others. These new strategies and reforms have yielded modest gains. At the Federal level, internally generated revenue rose from 3.3 trillion Naira in 2016 to 5.3 trillion Naira in 2018, an increase of more than 60 percent. Similar gains have also been achieved at the State levels. In Anambra State, the internally generated revenue moved from 14.7 billion Naira in 2015 to 19.3 billion Naira in 2018 (31 percent increase) while in Ondo State, the Internally generated revenue also moved from 10.1 billion Naira in 2015 to 24.6 billion Naira in 2018 (more than 143 percent increase). Despite these efforts to improve revenue performance, Nigeria's revenue-GDP ratio of 6% remains one of the lowest in Africa. Very recently, , the Government has further strengthened the institutions and administration of taxation in

Nigeria by ensuring enforcement and compliance in tax payments which is encouraging even though the fiscal deficits remain huge.

Both the Federal and State Governments have resorted to borrowing to finance their deficits. As at end March 2019, total public debt (external and domestic) for Federal and State governments was USD 81.274 billion or 24.974 trillion Naira, equivalent to 18.0% of national GDP. Of these, the domestic debt for all the states was USD 12.94, while the domestic debt for the Federal Government was USD 55.6 billion. Even though at current levels, Nigeria's Debt/GDP ratio remains tolerable when compared to other countries, there are key efforts by the government to minimize new borrowings as well as aggressively pursue domestic revenue mobilization. The 2020 budget estimates have proposed an increase in VAT rate which will help raise sufficient revenues especially for the State governments.

4. PRECARIOUS DOMESTIC DEBT SITUATION OF ANAMBRA AND ONDO STATES

While the total domestic debts for all states are huge, there are marked differences between them. In Ondo State, the size of domestic debt has increased significantly in recent times especially since 2016 . Surprisingly, the domestic debt stock in Anambra State also increased as from 2018. These domestic debt levels have constrained states' ability to increase expenditures on basic social services, especially for health and education, but recent internal revenue generation efforts will be key to addressing the expenditure challenges in future.