AFRICAN DEVELOPMENT FUND

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APPRAISAL REPORT

HEALTH SYSTEMS DEVELOPMENT PROJECT (HEALTH IV)

THE FEDERAL REPUBLIC OF NIGERIA

NB: This document contains errata or corrigenda (see Annexes)

SOCIAL DEVELOPMENT DEPARTMENT
OCSD

MAY 2002

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This report is based on the findings of a Joint ADB/World Bank mission that visited Nigeria from 26 January to 17 February 2002. The ADB mission comprised Pap J. Williams, Principal Health Specialist and Team Leader (OCSD.1), Ms. M. Kilo, Principal Operations Officer, NICO and a Consultant Architect. Inquiries should be addressed to Mr. R. Cressman, Division Manager, OCSD.1, ext. 4112 or Ms. Z. El Bakri, Ag.Director, OCSD, ext. 4101.

AFRICAN DEVELOPMENT BANK
01 BP 1387, ABIDJAN 01
Tel: (225) 20 20 44 44
Fax: (225) 20 21 77 53
Telex: 23717

PROJECT INFORMATION SHEET

Date: February 2002

The information given hereunder is intended to provide some guidance to prospective suppliers, contractors, consultants and all persons interested in the procurement of goods and services for projects approved by the Boards of Directors of the Bank Group. More detailed information and guidance should be obtained from the Executing Agency of the Borrower.

1.	COUNTRY	:	The Federal Republic of Nigeria
2.	NAME OF PROJECT	:	Health Systems Development (Health IV)
3.	LOCATION	:	Country-wide
4.	BORROWER	:	The Federal Republic of Nigeria
5.	EXECUTING AGENCY	:	State Ministries of Health and the Federal Ministry of Health

6. PROJECT DESCRIPTION:

The project will support three main components:

i) Capacity Strengthening of 35 State Ministries of Health

ii) Support to Primary Health Care in 30 states

iii) Capacity Strengthening of the Federal Ministry of Health

7.	TOTAL COST	:	UA	163.92 mill.
i)	Foreign Exchange	:	UA	42.23 mill.
ii)	Local Costs	:	UA	121.70 mill.

8. BANK GROUP FINANCING:

ADF	:	UA	34.74 mill.

9. OTHER SOURCES OF FINANCE:

THE WORLD BANK	:	UA	100.97 mill.
GOVERNMENT	:	UA	28.22 mill.

10.	DATE OF APPROVAL	:	To be determined
11.	ESTIMATED STARTING DATE AND DURATION	:	January 2003, 5 years

12. PROCUREMENT:

National Competitive Bidding (NCB)
Works; goods.

National Shopping (NS)
Drugs and supplies for primary health care activities; equipment for project management; operating costs and local training costs.

Short-Listing
Consultancy services; technical assistance; auditors.

13. CONSULTANCY SERVICES REQUIRED

Consultancy services will be required for overall monitoring and supervision of the project; financial management of disbursements; supervision of rehabilitation works for PHC facilities; studies; training activities; and, auditing.

CURRENCY AND MEASURES

(May 2002)

National Currency - Naira (NGN)
1 UA = 143.920 NGN; 1 UA = USD 1.24204
1 USD = 135 NGN

FISCAL YEAR

January 1 – December 31

WEIGHTS AND MEASURES

Metric System

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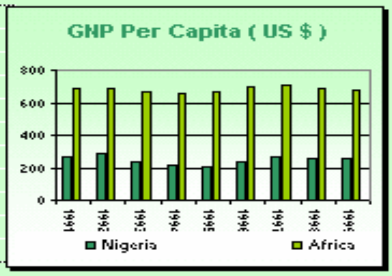
LIST OF ABBREVIATIONS

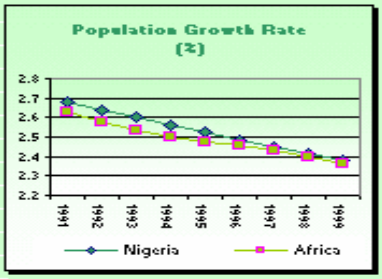
AfDB (ADB)	African Development Bank
ADF	African Development Fund
CBO	Community-Based Organization
CHW	Community Health Worker
CPRP	Community-Based Poverty Reduction Project
DALY	Daily Adjusted Life Years
DFID	Department for International Development (U.K.)
DOTS	Directly Observed Treatment Short Course
EPI	Expanded Programme of Immunization
FCT	Federal Capital Territory
F.E.	Foreign Exchange
FGN	Federal Government of Nigeria
FMOF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
FP	Family Planning
GNP	Gross National Product
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMB	Health Management Board
HNP	Health, Nutrition and Population
HSF	Health Systems Fund
HSR	Health Sector Reform
IEC	Information, Education and Communications
IMCI	Integrated Management of Childhood Illnesses
L.C.	Local Costs
LGA	Local Government Authority
MCH	Maternal and Child Health
MOU	Memorandum of Understanding
MTPA	Medium Term Plan of Action
NCB	National Competitive Bidding
NGO	Non Government Organisation
NHMIS	National Health Management Information System
NPCU	National Project Coordinating Unit
NPSC	National Project Steering Committee
NS	National Shopping
PHC	Primary Health Care
PIP	Project Implementation Plan
PIU	Project Implementation Unit
RH	Reproductive Health
SHC	Secondary Health Care
HSDP-II	Health Systems Development Project II
SMOH	State Ministry of Health
STD	Sexually Transmitted Diseases
SWOP	Sector-Wide Operation
UA	Unit of Account
USD	United States Dollar(s)

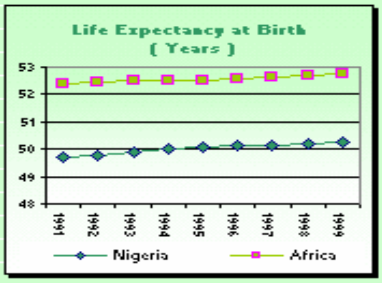
NIGERIA

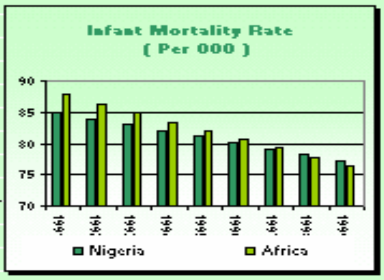
COMPARATIVE SOCIO-ECONOMIC INDICATORS

	Year	Nigeria	Africa	Developing Countries	Developed Countries
Basic Indicators					
Area ('000 Km²)		924	30,061	80,976	54,658
Total Population (millions)	1999	108.9	765.6	4,793.2	1,185.2
Urban Population (% of Total)	1999	41.9	37.1	39.4	75.8
Population Density (per Km²)	1999	117.9	25.5	59.2	21.7
GNP per Capita (US $)	1999	260	684	1,250	25,890
Labor Force Participation - Total (%)	1999	40.7	43.3	...	...
Labor Force Participation - Female (%)	1999	29.3	35.0	...	...
Gender -Related Development Index Value	1998	0.4	0.483	0.634	0.916
Human Develop. Index (Rank among 174 countries)	1998	151	n.a.	n.a.	n.a.
Popul. Living Below $ 1 a Day (% of Population)	1997	70.2	45.0	32.2	...
Demographic Indicators					
Population Growth Rate - Total (%)	1999	2.4	2.4	1.6	0.3
Population Growth Rate - Urban (%)	1999	4.9	4.5	2.8	0.6
Population < 15 years (%)	1999	43.4	42.7	32.8	18.5
Population >= 65 years (%)	1999	3.0	3.2	5.0	14.0
Dependency Ratio (%)	1999	100.2	86.1	61.0	48.6
Sex Ratio (per 100 female)	1999	98.4	99.4	103.3	94.8
Female Population 15-49 years (millions)	1999	24.8	181.1	151.8	297.2
Life Expectancy at Birth - Total (years)	1999	50.2	52.7	64.3	75.5
Life Expectancy at Birth - Female (years)	1999	51.6	53.5	66.0	79.2
Crude Birth Rate (per 1,000)	1999	37.8	36.3	23.4	10.9
Crude Death Rate (per 1,000)	1999	14.5	13.7	8.4	10.3
Infant Mortality Rate (per 1,000)	1999	77.2	76.4	57.6	8.9
Child Mortality Rate (per 1,000)	1999	129.0	116.6	79.8	10.2
Maternal Mortality Rate (per 100,000)	1990-96	1,000	698	491	13
Total Fertility Rate (per woman)	1999	4.8	4.8	2.8	1.6
Women Using Contraception (%)	1990-99	6.0	...	56.0	70.0
Health & Nutrition Indicators					
Physicians (per 100,000 people)	1992-97	19	35	78	287
Nurses (per 100,000 people)	1992-97	66	107	98	782
Births attended by Trained Health Personnel (%)	1992-98	15	38	58	99
Access to Safe Water (% of Population)	1992-98	49	58	72	100
Access to Health Services (% of Population)	1992-98	51	64	80	100
Access to Sanitation (% of Population)	1990-97	41	58	44	100
Percent. of Adults (aged 15-49) Living with HIV/AIDS	1997	4.1	5.7	...	...
Incidence of Tuberculosis (per 100,000)	1997	14	201	157	24
Child Immunization Against Tuberculosis (%)	1997	53	72	82	93
Child Immunization Against Measles (%)	1997	69	64	79	90
Underweight Children (% of children under 5 years)	1990-97	36	26	31	...
Daily Calorie Supply	1998	2,882	2,439	2,663	3,380
Public Expenditure on Health (as % of GDP)	1993-98	0.3	2.0	1.8	6.3
Education Indicators					
Gross Enrolment Ratio (%)					
Primary School - Total	1996	82.0	80.0	100.7	102.3
Primary School - Female	1996	74.0	73.4	94.5	101.9
Secondary School - Total	1996	34.0	29.3	50.9	99.5
Secondary School - Female	1996	31.1	25.7	45.8	100.8
Primary School Female Teaching Staff (% of Total)	1990-97	46.4	40.9	51.0	82.0
Adult Illiteracy Rate - Total (%)	1999	37.6	38.8	27.2	1.3
Adult Illiteracy Rate - Male (%)	1999	28.8	30.7	19.5	0.9
Adult Illiteracy Rate - Female (%)	1999	46.0	48.2	35.0	1.7
Percentage of GDP Spent on Education	1990-97	0.7	3.5	3.9	5.9
Environmental Indicators					
Land Use (Arable Land as % of Total Land Area)	1998	31.0	5.9	9.9	11.6
Annual Rate of Deforestation (%)	1990-95	0.9	0.7	0.4	-0.2
Annual Rate of Reforestation (%)	1981-90	3.0	4.0	...	...
Per Capita CO2 Emissions (metric tons)	1996	0.1	1.1	2.1	12.5









Source : Compiled by the Statistics Division from ADB databases; UNAIDS; World Bank Live Database and United Nations Population Division.

Notes: n.a. Not Applicable ; ... Data Not Available.

NIGERIA HEALTH SYSTEMS DEVELOPMENT PROJECT MPDE

Narrative Summary	Verifiable Indicators	Means of Verification	Important Assumptions and risks
Sector Goal The overriding goal of this project is to assist the Nigerian Health authorities in their efforts to redress the serious deterioration in the delivery of basic health care services following decades of neglect, and build institutional capacities paving the way for a more sustained development of the Nigerian health care system.	By 2007: - maternal, infant and under-five mortality rates reduced by 10%; - inequalities in health status and in access to health care services improved by 20%; - utilisation of primary health care facilities increased by 30%; - user satisfaction increased; - health personnel motivation and satisfaction increased; - per capita public spending on health increased by 4%; - public spending on primary health care services increased by 10%; - spending targeted to the poor increased by 20%.	Demographic and Health Surveys (baseline is DHS 1999) Studies on inequalities in health Social and beneficiary assessments Special Surveys Public health sector expenditure reviews Benefit incidence analysis	Improved health status and reduced inequalities in health outcomes lead to reduction in poverty Political support for policy and institutional reforms at federal and state level Stable macroeconomic and fiscal conditions No major political crisis or civil unrest
Project Objectives 1. Strengthened capacities for health system management at the state level. 2. Improved delivery of primary health care services. 3. Strengthened capacities for health system management at the federal level.	By 2007: - all states with approved 3-year rolling and annual plans; - all states having developed state health accounts; - all states with certified/audited financial statements. - utilisation of PHC facilities increased by 25%; - proportion of children under one year and under two years fully immunised increased by 20%; - proportion of births attended by skilled health personnel (doctor, nurse, midwife) increased by 30%; - TB detection rate increased by 20%. - Improved situation in the five areas of reform: i) provision of the basic package of services; ii) legal and institutional framework; iii) role of the private sector; iv) financial and fiscal management; and, v) human resources.	Financial management assessments and project supervision reports FMOH/SMOH annual reports FMOH/SMOH/NPI reports on immunisation coverage Demographic and Health Survey; special surveys; FMOH/SMOH annual reports Conclusion of the annual sector performance reviews	Strong and continued political support to health sector reforms and to improved governance Reduced economic and social barriers to access primary health care Public/private partnerships for the delivery of PHC developed Adequate supply of vaccines and cold chain equipment Improved health staff technical skills Sustained high-level political support for policy and institutional reforms
Outputs Component 1: 1.1 Improved managerial capacities at the state level. 1.2 Improved technical skills of the health staff. 1.3 Strengthened health management information system. 1.4 Improved access to information and exchange of information.	- At least 90% of activities carried out as planned; - proportion of practising midwives trained in life-saving skills increased by 60%; - proportion of health staff at PHC facilities trained in IMCI increased by 50%; - proportion of health staff (both at PHC and SHC) trained in DOTS for TB increased by 70%. - proportion of states and LGAs having implemented the minimum HMIS package increased to 80%. - proportion of states having at least 3 communication node sites fully equipped and functional. increased to 95% - the planned number of studies carried out and completed.	SMOH annual reports Project supervision reports Special surveys	States have access to appropriate information and technical support SMOH and Project Managers focus their efforts on a limited number of activities Expertise involved in implementation is competent Appropriate training programs can be identified regionally and/or overseas

1.5 Research and studies developed. Component 2: 2.1 Improved delivery of primary health care services in participating states. 2.2 Improved quality of training at nursing schools in participating states. Component 3: 3.1 The Federal Ministry of Health assisted in the implementation of its health sector reform agenda.	- all selected PHC facilities rehabilitated and equipped with adequate medical equipment and essential drugs; - all selected PHC facilities with adequate functioning cold chain equipment; - proportion of PHC facilities offering essential obstretic care increased by 30%; - proportion of PHC facilities offering access to essential laboratory examinations increased by 30%; - proportion of practising midwives trained in life-saving skills increased by 50%; - proportion of health staff in PHC facilities trained in IMCI increased by 50%; - number of TB patients under directly-observed treatment increased by 30%. - all selected nursing schools rehabilitated and equipped with adequate pedagogical materials and connected to the Internet.	SMOH annual reports Project supervision reports Special surveys FMOH annual reports Project supervision reports	No substantial delays in the procurement of goods and services Expertise involved in implementation is competent Qualified staff can be hired.
Activities Component 1: - capacity strengthening of SMOH; - staff training; - strengthening of HMIS; - provide access to IT; - conduct research and studies Component 2: - facility upgrading - support to essential drugs program; - support to PHC activities Component 3: - strengthening NHMIS; - develop health policies and systems; - prepare national health accounts; - carry out studies and research; - annual performance reviews; - support to project management and coordination	*Inputs* ADF/GOV Input Resources in UA million F.E. L.C. TOT A. Goods 9.45 6.30 15.75 B. Works 2.76 11.02 13.78 C. Services 0.60 2.42 3.02 D. Op. Costs - 1.97 1.97 E. Miscellaneous 1.18 4.72 5.90 TOTAL 13.99 26.43 40.42 Sources of Financing: F.E. L.C. TOT ADF 13.99 19.56 33.55 GOV - 6.87 6.87 TOT 13.99 26.43 40.42	- Government accounts - Bank Group disbursement ledgers and vouchers -Audit reports - Progress reports -Portfolio review reports - Borrower's Project Completion Report; - Bank's PCR - Back-to-office reports - Project file	- Activities implemented on schedule -Counterpart funds readily made available

EXECUTIVE SUMMARY

Project Background

The Project is the result of dialogue with beneficiary states and consultations carried out between the African Development Bank, the World Bank, the Federal Ministry of Health and key partners in the sector. It has its origins in experiences learned from the implementation of ADF-financed projects such as the Bauchi/Gome Health Project, the Kwara/Kogi/Niger Health Project and the Multi-State Health Project, as well as the World Bank assisted Health Systems Fund Project. It will be implemented within the Medium Term Plan of Action for Health Sector Reform (2000 – 2003) framework, and it takes into account lessons learned from previous Bank Group experience in the sector**.** The overriding focus of the project will be on activities that will provide tangible results quickly, so that the population begin reaping the democracy dividends while creating the conditions for a more sustainable development of the health sector in Nigeria.

Purpose of the Loan

The ADF Loan of UA 34.74 million, covering 21.2 % of the total project cost, will be used to finance 36.6 % of foreign exchange (UA 15.46 million) and 15.8 % of the local costs (UA 19.28 million).

Sector Goal and Project Objectives

The sector goal of the health sector is the attainment of a good standard of health by all Nigerians in order to promote a healthy and productive life. The objective of the project is to: i) strengthen capacities for health systems management at the federal and state levels; and ii) improve the delivery of primary health care services.

Brief Description of the Project Outputs

In order to achieve its objectives, the project will focus on the following three components:

1) Capacity Strengthening of State Ministries of Health

Activities under this component will strengthen the capacity of State Ministries of Health in the areas of planning, financial management, monitoring and evaluation. Support will be provided to improve the technical skills of trainers and key health care providers. The sub-components are: i) support to managerial processes and skills; ii) support for technical skill development; iii) support for the HMIS; iv) access to information and communication technology; and v) research and studies. The total amount to be provided to each state under this component will be US $ 1.5 million. The World Bank will finance the entire cost of this component.

2) Support to Primary Health Care

Through this component the project will support activities aiming at improving the delivery of primary health care services. Emphasis will be placed on strengthening immunization services as well as safe motherhood interventions and communicable disease control. The project will finance activities for each state, based on the State's perceived priorities and the objectives and goals that it wants to achieve. Activities will be taken from the Project Implementation

Plans prepared by the States, with priority given to those improvements that can be clearly perceived by the population and that will result in measurable improvements, particularly for the poor. A total of 30 states are included in this component of which the ADF will finance 12 and the World Bank 18. Each state will receive up to USD 3.5 million (in addition to the USD 1.5 million received from the first component financed by the World Bank).

3) Capacity Strengthening of the Federal Ministry of Health

The project will provide support to the Federal Ministry of Health to: i) build capacity and strengthen key public health functions and processes and ii) coordinate, monitor and evaluate the implementation of the project. Activities to be financed under the project include 3 sub-components: (a) Support to the formulation of health policy and strategies and health reform process, (b) Support to the strengthening of the Health Management Information System and Health Sector performance assessment, (c) Project co-ordination, monitoring and evaluation. This component will be financed entirely by the World Bank.

Project Costs

The total project cost is estimated at UA 163.92 million out of which UA 42.23 million (25.8 %) will be foreign costs and UA 121.70 million (74.2 %) will be local costs.

Sources of Finance

The project will be financed by the ADF, the World Bank and the Government of Nigeria. ADF funds (UA 34.74 mill. loan) will be utilised to finance parts of Component 2 in 12 States, two from each geo-political zone. The ADF contribution, representing 21.2 % of the total project costs, will be utilised to cover 36.6 % of foreign costs and 15.8 % of local costs.

The World Bank's contribution of UA 100.97 million, representing 62.6 % of total project costs, will cover the remaining 63.4 % of foreign costs, and 61.0 % of the local costs, and will be utilised to finance Component 1 and 3, and parts of 2.

The Government of Nigeria's contribution of UA 28.22 million, representing 17.2 % of the total project costs, will be utilised to cover parts of civil works, goods and operating costs.

Project Implementation

The project will be implemented over a period of 5 years starting from 01/01/2003.

Conclusions and Recommendations

It is recommended that an ADF Loan not exceeding UA 34.74 million be granted to the Federal Republic of Nigeria for the purpose of implementing the project as described in this report, subject to conditions specified in the loan agreement.

1. ORIGIN AND BACKGROUND OF THE PROJECT

1.1 With a population of about 120 million in 2000, Nigeria is the most populous and one of the largest countries in Africa. By 2025, its population is expected to reach close to 200 million. It is widely recognised that the country has a tremendous potential to become an economic giant in Africa because of its impressive human capital, rich natural resources, and undeveloped economic capacity. Nevertheless, decades of military regimes, financial mismanagement, and the downside of the oil boom have triggered a crisis situation in the social sectors, which has plummeted Nigeria to being ranked among the 13 poorest countries in the world in terms of the UNDP Human Development Index (2001).

1.2 Since the return to democracy, the Government has articulated a Health Systems Development Programme (HSDP) to provide a framework for health sector investment. The goal is to raise the health status of all Nigerians by improving the performance of the health care delivery system at all levels. It addresses many of the issues enumerated above and aims to confirm the new civil administration's commitment to improving health care for all Nigerians. The Government initiated a broadly based consultative process bringing together key stakeholders from across Nigeria as well as major partners in the health sector. The results of these consultations are reflected in the Medium Term Plan of Action (MTPA) whose objectives will come on stream over a ten-year time horizon. In the first phase, it will build up capacities, sequence investments according to capacity, and build on lessons learned. The Government has invited major partners in the sector to assist in broadening and deepening this consultation process, with a view to developing a shared vision of a future direction for the health sector.

1.3 In response and State Ministries of Health, a joint World Bank/ADF Preparation mission went to Nigeria to initiate dialogue with the Federal and State Governments, and to prepare a health project for possible Bank financing in selected States of the Federal Republic of Nigeria. A key focus of these discussions has been the revitalisation of Nigeria's health development effort. To facilitate the preparation of the project, a joint Government/Donors Workshop, attended by representatives from the Federal and State Governments and Development Partners was convened from 10 –16 February 2001 to review the States' Health Systems Investment Plans (38 documents in all) carried out by all the States under the leadership of the Federal Ministry of Health, with the support of the World Bank. Sector dialogue between Government and other development partners during the workshop provided an opportunity to solicit development partners' technical inputs into the preparation of the proposed project to be jointly financed by the World Bank (IDA) and the ADF.

1.4 During the workshop, the investment plans were further elaborated to include annual work plans, which summarise the strategies and critical activities that States will undertake to revitalise the basic health services in Nigeria. They embrace the concept of community empowerment by enabling States and Local Governments to address their own basic health care priorities as defined by them.

1.5 The proposed project will be the fourth Bank Group operation in the sector. It will enhance the Bank's previous assistance to the sector, namely, the Bauchi/Gombe Health Project, the Kwara/Kogi/Niger Health Project and the Multi-State Health Services Rehabilitation Project, approved in 1990 and 1992 respectively. It is part of a concerted effort by the World Bank and the ADF to provide assistance to Government of Nigeria's efforts in poverty reduction and the attainment of the Millennium Development Goals such as reduction of child mortality, improvements of maternal health and combating HIV/AIDS, malaria and other endemic diseases following decades of dramatic decline in the quality of services during the past decades of military rule. Data from both the ADF and the World Bank indicate that Nigeria will meet non of the

Millennium Development Goals by the set target dates. It provides another opportunity to actualize the MOU signed between the World Bank and the African Development Bank emphasizing strategic partnership between both institutions.

2. THE HEALTH SECTOR

2.1 Health Status In Nigeria

2.1.1 Nigeria's health sector is characterised by poor quality and inefficiencies in the provision of public sector health services resulting in poor health outcomes, lack of appropriate targeting strategies for reaching poor and under-served populations; large disparities in health status between the poor and non poor, inadequate quality of government health services, which stems from, inter alia, lack of drugs, limited human resources and managerial capabilities; lack of an enabling environment to allow private sector providers to build partnerships with the public sector; low levels of public funding combined with shortcomings in the way resources are allocated, spent and managed; and poor delineation of roles and responsibilities within the three tiers of government with regard to the provision and financing of health care. During the past two decades of military regimes health outcomes have generally stagnated or deteriorated. Basic health indicators are poor. The resurgence in malaria combined with the HIV/AIDS/TB co-epidemic now runs the risk of further deterioration in health outcomes.

2.1.2 Life expectancy at birth is 54 years while the infant mortality rate is 77 per 1000 live births. In the next five years, about 25 million children will be born in Nigeria, and in the same period about 5 million children will die before they reach the age of five, representing about 10% of global childhood deaths. High infant and child mortality and morbidity rates; poor nutritional status and high fertility rates are the indicators of the adverse effects of poor sanitation, low incomes and other determinants of the pervasive poverty in Nigeria.

2.1.3 The major causes of mortality and morbidity in children under five are diarrhea, respiratory infections, malnutrition, vaccine-preventable diseases, and malaria. Children under five appear to be particularly hard hit by malaria, with 75 percent of malaria deaths occurring in this age group. Child mortality and malnutrition, which are good proxies for social welfare, are consistent with the increasing trend in poverty. Nigerians are having difficulties feeding their children and ensuring their survival.

2.1.4 Less than 30 % of children under five years of age are fully immunized against vaccine preventable diseases (VPD). Thus, pertussis (whooping cough), cerebrospinal meningitis, neonatal tetanus and measles, account for over 90 percent of morbidity and 80 percent of mortality in children.. Diarrhoeal diseases are the second and third main causes of infant and under-five mortality respectively. A 1999 Multiple Indicator Cluster Survey (MICS) reported that 15.3 percent of children under five had experienced diarrhoea in the two weeks preceding the survey and less than 50 percent of these children visited a health facility.

2.1.5 Maternal mortality, one of the main indicators of the state of reproductive health, is unacceptably high (704 per 100,000 live births). Approximately 10% of all maternal deaths in the world take place in Nigeria. This implies that with about 2.4 million live births annually, some 170 000 Nigerian women die as result of complications associated with pregnancy or childbirth. The excessively high maternal mortality levels are a reflection of the inadequate access to obstetric care, poorly functioning referral systems, socio-cultural barriers to health care, and general systemic problems concerning the health care delivery system.

2.1.6 Nigeria appears to have experienced a moderate decline in fertility, but continues to lag considerably behind most African countries. Although, recent data indicates that the Total Fertility Rate (TFR) and population growth rate dropped from 6.9 to 5.3 and 3.2 to 2.6 percent respectively. Patterns of fertility suggest large urban rural and intra regional differentials, with the Northeast and Northwest regions recording the highest fertility rates. The number of births are higher among rural women and those with fewer years of schooling .It is probable that most of the decline is attributable to a shift towards a late pattern of childbearing rather than to improvements in access to family planning services. The recent Demographic Household Survey (DHS) found that the Contraceptive Prevalence Rate was only 15 percent (all methods) and less than one-quarter of currently married non-users intended to use family planning in the future. Approximately, 42% of women compared to 77% of males are aware of family planning methods. More aggressive family planning efforts among women could help reduce the high maternal mortality rate. About 35% of Nigerian women marry before age fifteen with adverse consequences for their education, maternal health and economic status.

2.1.7 As in other developing countries communicable diseases in Nigeria affect the poor disproportionately setting in place a downward spiral of illness and poverty. Worldwide, 80 percent of the rich-poor gap in both mortality and Daily Adjusted Life Years (DALY) loss is due to the disproportionate burden of communicable diseases on the poor. In Nigeria, there are growing concerns that the rapidly rising HIV/AIDS and TB co-epidemic, the resurgence in malaria, and continuing morbidity and mortality losses due to childhood communicable diseases (e.g. measles, diarrhea, respiratory infections) will further erode the gains in national health development. Although Nigeria has a lower HIV/AIDS prevalence rate than the Eastern and Southern African countries, the magnitude of the potential impact because of the large population base and the rising prevalence rate calls for urgent action. The prevalence rate of HIV/AIDS has increased from 1.8% in 1991 to 5% in 1999. Projections indicate that by 2005, the number of HIV/AIDS infected adults will be about four million and will reach five million by 2010. Nigeria is at the exponential state of the HIV/AIDS epidemic where further explosive spread of the virus is certain unless effective control effort is put in place with great speed. It is projected that an epidemic would dramatically reverse the gains of various child survival activities as vertical transmission and the number of HIV/AIDS orphans significantly increase. Public knowledge about the disease is very low.

2.1.8 With a prevalence rate of over 20%, malaria is endemic in Nigeria. It accounts for approximately half of all outpatient visits, 20% of all hospital admissions, and 35% of deaths in children less than 5 years of age. Acknowledging the serious threat that malaria poses to the health and economic development of Nigeria, the Government convened the African Summit on Roll Back Malaria in Abuja on April 25, 2000. The summit, which was attended by 25 heads of state and high-level delegates from all other countries with endemic malaria in sub-Saharan Africa, resulted in the Abuja Declaration. The declaration committed countries in the region to meet three specific targets which include provision of prompt access to correct, affordable and appropriate treatment with 24 hours of the onset of symptoms by at least 60% of those suffering from malaria; at least 60% of those at risk of malaria, particularly pregnant women and children less than 5 years of age, benefit from the most suitable combination of personal and community protection measures, such as insecticide-treated nets (ITNs) and other interventions which are accessible and affordable to prevent infection and suffering; and at least 60% of pregnant women who are at risk of malaria, especially those in their first pregnancy, have access to chemo prophylaxis or intermittent presumptive treatment. Eleven out of forty country partnerships in Africa are now implementing the plans that have been jointly elaborated. These plans, developed around a national consensus by all Roll Back Malaria stakeholders, reflect an agreement on how best to scale up the national and local response to malaria.

2.1.9 The health sector in Nigeria is going through a reform process aimed at restoring the capacity of the public health services to deliver quality health care to all Nigerians. To this end, the Bank is collaborating with Government and the World Bank and other partners to foster a debate on new ways of doing business in Nigeria's health sector, with a particular focus on moving towards programmatic support, promoting public/partnerships, and broadening health financing options. The project will provide resources to strengthen the capacity of the States and LGAs (Local Government Authorities) in order to enable them to undertake their mandate in the provision of quality primary health care.

2.2 Organization of Health Services

2.2.1 The organizational structure of the Nigerian health care system suffers from lack of specificity and ambiguities in the definition of roles and responsibilities of the three tiers of the system, the Federal, State and Local Government levels. Even when roles are clearly assigned, there are instances where some tiers of Government take on responsibilities that are clearly not within their mandate. There are also concerns for the pace and scope of decentralization of responsibilities and resources in light of low and undependable capacity. The associated problems of ownership and accountability abound.

2.2.2 The Federal Ministry of Health (FMOH) provides policy guidance and technical assistance to the 36 States and the Capital Territory (Abuja), co-ordinates State efforts towards the goals set by the national health policy, and is establishing a management information system designed to improve both national and state-level planning. The FMOH also monitors and evaluates the implementation of the national health policy. Additionally, FMOH has direct operational responsibility for training medical doctors; operating teaching, psychiatric and orthopaedic hospitals; monitoring and controlling contagious and communicable diseases; and ensuring adequate availability of vaccines and essential drugs. Formal linkage between FMOH and the State Ministries of Health (SMOHs) occurs through the National Council of Health, chaired by the Federal Minister of Health and composed of all State Commissioners of Health. This Council meets on a quarterly basis to discuss national health concerns.

2.2.3 At the state level, responsibility for health programs is shared by the State Ministry of Health (SMOH), the Hospital Management Board (HMB), and the Local Government Authorities (LGAs). The SMOH is headed by the State Commissioner of health, who is responsible to the State Executive Council and is assisted by the Director General in the SMOH. Its responsibilities include: planning and co-ordinating the state health systems; operating and maintaining secondary and non-specialized tertiary hospitals and some primary health facilities; implementing public health programs; training nurses, mid-wives and auxiliary staff; and assisting the LGAs with the management and operation of some primary health facilities. Each State has at least one health training institution. However, deteriorated infrastructure, lack of teaching equipment, poorly trained staff, and low morale seriously undermine the quality of training and trainees.

2.2.4 The HMB administers the State's hospitals and, in some cases, health centers and urban clinics; its main responsibility is personnel administration and the financing and management of logistical support systems, including drugs, supplies, equipment and maintenance. The HMB is headed by a chairman, who in some states, reports to the State Commissioner of Health and in others to an independent board. The SMOH establishes the policy under which the HMB functions, while maintaining overall responsibility for the state health program.

2.2.5 Each of the 774 LGAs in Nigeria is responsible for operating the health facilities within the area, including the provision of basic outpatient, community health, hygiene and sanitation services. The SMOH coordinates these activities and provides technical support. Health service delivery in each LGA is the responsibility of the Health and Social Welfare Counselor. However, many LGAs lack the capacity to effectively carry out their mandate.

2.3 The National Health Policy

2.3.1 In 1987, the Government adopted a primary health care approach as the principal health sector development strategy. The underpinning principles of the choice of primary health care as the foundation of the National Health System include: the need to ensure equity, promote rational use of resources, assure technical quality and reliability as well as support for preventive measures. Nigeria's National Health Policy affirms the centrality of health to social and economic development.

2.3.2 The overall goal of the policy is the attainment of enhanced standards of health by all Nigerians in order to promote a healthy and productive life. The guiding principles of the policy among others include emphasis on Primary Health Care (PHC) and the introduction of the Basic Health Services Scheme, mainstreaming of gender issues in planning and implementation, and a special focus on health systems development. The policy also builds on the National Poverty Alleviation Programme (2000-2005), which recognises the close links between health and economic growth for sustainable development.

2.3.3 The Medium Term Plan of Action calls for the implementation of cost-effective health development interventions in an integrated manner to address the priority health problems. It emphasises the control of communicable diseases (malaria control, STD/HIV/AIDS, TB), reproductive health (essential antenatal and obstetric care, and family planning), and the Integrated Management of Childhood Illness (IMCI). Other public health interventions include immunization, environmental health, health education, protection and promotion, epidemic and disaster prevention, preparedness and response, improved nutrition, and the strengthening of basic health services.

2.3.4 The policy seeks to empower local communities by emphasizing greater decentralization of decision-making through the devolution of greater autonomy to the State, local Governments and communities. Administrative, legislative, political, executive, and financial responsibilities are gradually being devolved. This will, in turn, enable the empowerment of communities, which have been historically marginalized including women and youth.

2.3.5 Given the enormous challenges facing the health sector, the Government has articulated a Medium Term Plan of Action to operationalise the Health Policy and to provide a framework for health sector investment. Based on this sector goal, the Medium Term Plan of Action addresses many of the issues enumerated in the African Development Bank's Vision Statement and Health Policy as well as the Millennium Development Goals. It aims to confirm the new civil administration's commitment to improving health care for all Nigerians in a sustainable and efficient manner. The current Government initiated a broadly based consultative process bringing together key stakeholders from across Nigeria. The results of the Nigerian consultations form the basis for the objectives of the Medium Term Plan of Action.

2.4 Health Care Financing

2.4.1 At the State level, financial resources for public health services are mostly derived from State government budgetary allocations. Nominal revenue is generated from user charges at health facilities, sanitary inspection and licensing fees. Revenue generated from user charges provides additional resource for the procurement of drugs, medical supplies and maintenance. The current health care delivery in Nigeria is plagued with persistently low funding at all levels. Nigeria spends less than US$ 4 per person per year on health care-well below the recommended levels of US$ 12 in developing countries. The private sector provides more than 60% of the health care. The per capita expenditure on health at federal level has been less than US$ 4 from 1990 to 1998. It experienced a sharp decline between 1994 to1996 following the steep decline in oil revenue during the same period. This decline on health spending was further accentuated as a result of the introduction of Structural Adjustment Programmes (SAP). Indeed, at its lowest point in 1996, federal health expenditure was 77 percent less in real terms than it had been at the height of the oil boom in 1980.

Table 2.1
Trends in Federal Government Health Expenditure (in USD)
1990 –2001

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*
Recurrent	170.8	186.8	290.5	309.4	177.4	163	121.6	162	170.2	179.4	183.2	187.1
Capital	110	46.4	51	32.1	63.5	63.5	63.5	90.4	265.1	289.3	291.4	294.2
Total	280.8	233.2	341.5	341.5	240.9	226	185.1	253	435.3	459.1	462.5	467.4
Per capita expenditure	3.3	2.6	3.7	3.6	2.5	2.3	1.8	2.4	3.7	3.7	3.7	3.8

Source: Compiled from Central Bank of Nigeria Annual Reports & Statistical Bulletins.
* Provisional

2.4.2 In per capita terms, the decline in health expenditure was even more precipitous in 1996. This dramatic decline in funding is one of the major causes of the crisis in the health system. There was some recovery in 1998 but even as late as 1999 health expenditure was 32 percent lower than it had been in the 1980s. The dramatic decline in the exchange rate of the Naira led to large cutbacks in imports of equipment, drugs and other materials. There was an especially large decline in capital expenditure from its high level in the oil boom years (1970s), although this was reversed in the late 1990s.At the State level, financial resources for public health services are mostly derived from State Government budgetary allocations. Nominal revenue is generated from user charges at health facilities, sanitary inspection and licensing fees. The project will assist in improving health care financing by providing resources for the procurement of basic equipment, seed stock of essential drugs and other medical supplies, as well as improved financial governance through training in financial planning and management.

2.4.3 In contrast to the poor financing of the public health services, Nigeria benefits from vibrant private health care providers, which have grown rapidly during the past two decades. However, there is need to create an enabling environment for private sector providers and to build effective public/private partnership. In this regard, the Government is committed to acquiring a better understanding of the private health care providers; identify options for collaboration, and to establish appropriate regulatory mechanisms and enforcement capabilities in order to ensure minimum standards of care among this heterogeneous group of health care providers.

2.4.4 The priority for the government at this stage is to restore operational capacity in the public sector and to improve its knowledge of service delivery in the private sector. Hence, it was agreed that the main focus of the operation would be to assist the public sector to enhance quality, efficiency, and equity of public investment while building consensus and capacity for greater partnership with the private sector and community groups in the future.

2.5 Interventions of Donor Agencies

2.5.1 The Government of Nigeria receives assistance for the health sector from bilateral, multilateral agencies, and non-Governmental organizations (NGOs). All the major donors operating in the health sector have committed finance, on a parallel basis, to assist in the expansion and strengthening of the PHC services with a special focus on mothers and children. These organizations are supporting projects covering priority areas such as HIV/AIDS, reproductive health and family planning, health systems development and capacity building. The table below provides an indicative summary of selected ongoing donor support to the sector.

TABLE 2.2
Selected Development Partners, Estimated Level of Support in Health Sector and Programme Focus

Agency	Esti. level of support in US$ millions			Programme Focus				
	Federal	*State*	*LGA*	*BHS*	*EPI*	*Civil works*	*Rep.Health/FP*	*HIV/AIDS/STD*
World Bank	8.0	42.0	70.0	x				X
UNFPA	3.0	8.0	9.0	x			x	X
JICA	3.0	10.0			x			
WHO	6.0	39.0	60.0	x	x		x	X
UNICEF	3.0	36.0	70.0	x	x		x	X
USAID		40.0	80.0		x		x	X
Ireland Aid		60.0	45.0	x	x	x	x	X
DFID (UK)	5.0	20.0		x	x	x	x	X
Canada	3.0							

Source: Adapted from the World Bank Project Appraisal Document 2002.

2.5.2 Under the leadership of the FMOH, the Government has articulated a medium Term Plan of Action to provide a framework for health sector investment. Accordingly, the Government has initiated a broadly based consultative process bringing together key stakeholders in Nigeria's health sector. A number of donors namely, the World Bank, DfID, and Irish Aid, have directed all or part of their 2000/01 – 2002/3 support to the sector through budgetary support at cost centers. Other partners such as WHO, UNFPA, the African Development Bank, UNICEF, GTZ, USAID, JICA, and EU are supporting ongoing projects, exploring budgetary support or preparing new projects covering areas such as HIV/ AIDS, reproductive health, capacity building, HMIS, human resources development, and essential drugs management. Channels of donor interventions include recurrent budget support and project funding through the SMOHs, Local Government Authorities, NGOs and CBOs.

3. THE SUB-SECTOR

3.1 Neglect and under-funding has caused a severe decline in quality and capacity of the public health system, creating a disconnect between the public and the private parts of the health system. In the public sector, for years health workers have not been given incentives to provide quality care, which has led to the practice of informal user fees, on top of formal fees. Another problem is the functional divide between PHC and secondary health care with weak management at all levels.

3.2 The PHC service is beset with the following challenges: lack of equitable and affordable health care at the community level; a serious decline in the provision of a quality primary health

care with a concomitantly low level of coverage of basic health services such as immunization; lack of reliable supply of essential drugs and poor management and; inadequate referral system between under-funded, poorly equipped local government health and state-run secondary facilities with inadequately trained health staff.

3.3 Large inequalities in access to primary health care prevail. It is estimated that less than 30% of the population in Nigeria has access to primary health services. The poor health status in Nigeria is due in part to the lack of geographical access to quality primary health care by the most vulnerable groups such as women, children and the poor. Patterns of maternal and infant mortality by mother's level of early childbearing, short birth intervals and high parity emphasise the importance of expanding access to MCH/FP services.

3.4 An analysis of health service utilisation portrays a consistent picture of gender inequality acting as a constraint to increased access to basic health services and poverty reduction. Only 9 percent of the poorest women have access to a trained health worker at delivery and over 87 percent continue to deliver at home, which implies that when complications are encountered many of these women are not within easy reach of medical care. Immunization coverage rates also highlight large disparities between the poor and non-poor, with less than 14 percent of the children from the poorest families fully immunised, in comparison to about 58 percent in the richest households. Coverage gaps are reflected in large disparities in health and nutrition outcomes, with the largest differentials in under five mortality and nutritional status.

3.5 Shortage of appropriately trained health personnel is a major constraint affecting the provision of quality primary health care in Nigeria. The lack of trained health personnel at the state and local Government levels has resulted in most primary health care facilities being managed by untrained health workers. Health workers lack the skills to effectively control endemic diseases. HIV/AIDS, and diseases of poverty such as tuberculosis, malaria, measles, diarrhea, and acute respiratory infections persistently account for over 60 percent of the disease burden particularly among the poor. Communities continue to rely on traditional medicine because of few qualified staff in the primary health care centres. In Nigeria, over 70 percent of the deliveries in the LGAs take place in the home and are often attended to by untrained Traditional Birth Attendants. Thus, when complications arise, many of these women and their children die. Therefore the operational support to primary health care activities under the project include concerted efforts by all partners to break the cycle of poverty, illness and communicable diseases through training of health staff and TBAs in life saving techniques, IMCI, and case management of endemic diseases.

3.6 Since the adoption of PHC as the most appropriate strategy of delivering basic health services in 1987, the training of health staff in PHC remains high on the Government's list of priorities for the health sector. However, the number of trained health staff as well as the quality of their training steadily declined along with Government expenditures in the health sector. The health training institutions are plagued by old and dilapidated infrastructure, lack of furniture and learning materials, underpaid and unmotivated teaching staff, and outdated curricula. Deteriorated infrastructure and equipment, lack of drugs, and low health staff morale have led to a dramatic reduction in the provision and utilization of health services. There is a strong need to improve public health training facilities in order to enable them to effectively undertake their role in the training of health workers in primary health care.

3.7 The focus of the proposed project is on increasing the coverage of quality primary health care to previously under-served LGAs in twelve Nigerian States. The project will therefore finance only public sector goods and services. Project funds will be used to improve the coverage of quality primary health care through improved community access to basic health services in targeted states. It will not finance the construction of new health facilities. Sub-project menus reflect the combined priority areas of each state government within the framework of the Medium Term Plan of Action.

3.8 Detailed activities under each sub-project menus were extensively discussed with the FMOH, the ADF, World Bank, DfID and other major partners in the health sector. In this regard, support to primary health care activities and the strengthening of health training institutions were identified as major priority areas of intervention for improved access to quality primary health care. The scope of the proposed project will respond to these three substantive areas.

3.9 The government is committed to improving the health status of all Nigerians, enhancing the involvement of all development partners, communities and the private sector in national health development. In this regard, States have prepared draft health development plans that seek to develop and sustain close working relationship between the communities, NGOs and the private sector in national health development. These considerations are some of the reasons for the proposed ADF support to the health sector.

4. THE PROJECT

4.1 Project Concept and Rationale

4.1.1 The overall project concept emerged from a series of discussions with the SMOHs, the FMOH and development partners about the urgent need to quickly restore a minimum level of the country's basic health service delivery, and from discussions between the Bank and the World Bank on closer collaboration between the two institutions in increasing the coverage of quality primary health care in Nigeria. To this end, the Government of Nigeria identified a Medium Term Plan of Action for Health Sector Reform (2000-2005) along the lines of a sector investment programme. The Plan of Action has been designed as an overall umbrella programme. It identifies a set of priority projects aimed directly at improving the health status of the population.

4.1.2 Its concept is guided by the Bank Groups CSP for Nigeria (1999-2001) and supports the government’s program for accelerated economic growth and poverty reduction. It is based on the idea that effective poverty reduction is more likely to occur if people are empowered to make their own decisions and define their own priorities with respect to their poverty reduction needs idea that the restoration of a comprehensive quality basic health service delivery in Nigeria is more likely to occur if the States and LGAs are empowered to make their own decisions and define their own priorities with respect to their health development needs. The bottom up participatory approach has been demonstrated to be the most effective strategy available to revitalise primary health care, improve governance and increase gender sensitivity because beneficiaries are leaders in their own health development in Nigeria. The project seeks to view women, children, the poor and the under-served as the major clients. It is designed as a response to felt health development needs of communities. The Medium Term Plan of Action for Health Sector Reform will not only provide technical backstopping when needed but will also act as a catalyst for proactive community participation in national health development.

4.1.3 Past ADF financed health projects in Nigeria have experienced chronic delays in project implementation. These delays were to a large extent due to the Borrower’s non-compliance with the loan covenant (i.e. non-compliance with procurement rules and regulations of the Bank; delayed or non-submission of audit and progress reports) and or non-compliance with the loan conditions. It is anticipated that the ADF institutional support to the FMOF will assist in enhancing compliance with the loan covenant.

4.1.4 In an environment of multiple needs and limited capacities, such as Nigeria, there is a need to keep the design simple. To this end, the proposed operation would include only three components and focus on a limited span of activities.

4.1.5 Experiences with the previous health project demonstrate the importance of strong supervision teams, particularly in light of the variable institutional capacities and limited knowledge with Bank procedures and guidelines. The new operation builds and expands on this experience and will finance the activities of consultant firms , who would be responsible for close support and monitoring of problems in each state.

4.1.6 Communications to Nigeria is very difficult relative to other countries. Most of the PIUs do not have telex or an e-mail facility. In this regard, Component I under the project will support the installation of these systems in PIU offices. In addition, the Country Office will be strengthened to assist in addressing the communication issue.

4.1.7 The financing of supply driven, traditional investments have yielded limited results, particularly when beneficiaries have not been adequately consulted. According to the government's recent report on selected externally financed health projects, improvements in health infrastructure did not lead to increased use of health services. These findings were broadly consistent with results from a beneficiary assessment carried out as part of the joint World Bank/ADF project preparation, where the majority of beneficiaries interviewed said that they continue to rely on traditional medicine rather than attend the newly renovated facilities. Reasons cited included: lack of drugs and equipment, few qualified staff, and perceptions of poor quality of care. This highlights the importance of introducing mechanisms of accountability, rewards for good performance and penalties for abuse. In the context of this project, the goal would be to improve accountability through use of, inter alia, annual work programs based on results, regular expenditure and performance reviews and supervision.

4.1.8 The country's tradition of military rule and its three tiers of government make it particularly challenging to ensure broad based consultation and participation. Additional work is required to build community level ownership of health facilities. To this end, the project would support activities to encourage community involvement and to assess client satisfaction, so that beneficiary preferences are better reflected in the future. The project will encourage the participation of the civil society and private sector in the sector performance reviews and health meetings.

4.1.9 To redress the inadequate and irregular availability of counterpart funding during the previous project, the current design envisions deductions at source.

4.2 Project Area and Beneficiaries

Project Area

4.2.1 The overall project (Components I, II & II) area will cover the 36 States and the Federal Capital Territory. It was agreed between the ADB, the Federal Government of Nigeria and the World Bank that the ADF support in Component II will cover the following 12 States from all the geo-political areas: Bauchi, Yobe, Katsina, Kaduna, Benue, Niger, Imo, Abia, Oyo, Lagos, Akwa Ibom and Edo States. States were chosen based on a set of selection criteria as agreed with the FMOH, the States and development partners. These included assessments of state's financial and procurement capacity; geographic representation; current level of indebtedness with the Federal Government, and the estimated size of the population. Thirty States qualified for inclusion under these criteria.

Beneficiaries

4.2.2 The project would benefit primarily poor Nigerians, who are the main users of public health services. The nationwide focus implies that the project will have a potentially important impact in terms of reaching large number of beneficiaries. About three quarters of the population (approximately 90 million people) will benefit from the over all project. The total beneficiaries from the ADF intervention in 12 States is estimated at 30 million of which children under one year constitute 4% (1.2 million), under five, 20% (6 million) and women of child bearing age, 22% (28.6 million). The poor, women, children, and vulnerable groups constitute at least 65% of the population. They are the main users of the public health services and therefore the major beneficiaries of this project. Enhancements in the availability and quality of basic health services would be in large part targeted to children and women. They will benefit from improved health services in respect of improved MCH and reproductive health services. Sub project beneficiaries will include primary health care givers who will acquire life saving skills for improved reproductive health care and effective case management of endemic diseases. In the long run, improved health status of the target population will result in better quality of life, which will in turn contribute to the nation's economic development through higher productivity of the labour force. Finally, activities under this project will help build the health sector reform agenda and prepare the groundwork for a more sustained development of the health sector.

4.3 Strategic Context

4.3.1 The Government of Nigeria places the highest priority on demonstrating that there is a "democracy dividend" whereby civilian Government, with popular participation and democratization, can begin to reverse the decades of economic and social decline that has afflicted Nigeria. Visible and effective actions that improve health status will deliver a political dividend and demonstrate that a democratic system can be responsive to the needs of local communities. Without strong, vibrant State and Local Government Authorities actively participating in health development, primary health care programmes will not succeed. Nigerians must, therefore, work together at the State and local Government levels to improve the health status of their communities through increased coverage of sustainable quality primary health care for their poor, under-served and vulnerable population. Although Nigeria needs to urgently address its poverty situation, it is still very far behind in the preparations of its PRSP. However, the Health Project IV will offer a carefully crafted vehicle for implementing the Government's strategy of bottom-up support to primary health care development through local empowerment in light of this strategic context. Improvements in health development will occur within a reforming macro-economic framework leading to a more effective enabling environment for increasing access to quality primary health care.

4.3.2 The project will contribute to the Bank Group's Vision and Health Policy's overarching goal of poverty reduction and improvements in health status. In the medium-term, the operation will contribute to the goals of the Bank's Country Strategy for Nigeria (1999-2001) by improving governance, promoting poverty reduction and community based development. The project will assist the Nigerian Government to put in place the conditions for improved governance in the management of public funds in the health sector through development of expenditure programs, mechanisms of accountability, and performance standards. The main focus of the operation is to assist states in rebuilding minimum capacity in the delivery of public services catering primarily to the poor.

4.3.3 The project demonstrates closer partnership between the ADB and the World Bank in providing development assistance at client country level. To this end, it is an attempt to operationalise the Memorandum of Understanding signed by the ADB and the World Bank by

strengthening and deepening the co-operation and partnership at the country level based primarily on client country preference, and comparative advantages and division of labour between them.

4.3.4 In addition, the project will complement a number of African and international initiatives designed to improve resource mobilization for the health sector such as: the UN Global Funds for Malaria, Tuberculosis and HIV/AIDS (GFATM). These initiatives and additional resources that will be available under the proposed project will support the Medium Term Plan of Action for health development in Nigeria and contribute towards achieving three of the Millennium Development Goals, namely, i) reduction of child mortality; ii) improved maternal health and iii) combatting HIV/AIDS, malaria and other diseases.

4.4 Project Objective

The sector goal of the health sector is the attainment of a good standard of health by all Nigerians in order to promote a healthy and productive life. The objective of the project is to improve the delivery of primary health care by restoring a minimum level of quality in the provision of public sector health services targeted to the poor.

4.5 Project Description

4.5.1 A number of the key issues affecting service delivery are beyond the scope of this project and will require progress in public sector management, fiscal decentralization, and civil service reform. Selectivity is therefore essential particularly in light of the relatively modest available resources. This project can only begin to address the government's hefty agenda and to lay the groundwork for further support. Thus, the overriding focus of the project will be on activities that will provide tangible results quickly so that the population may begin reaping the democracy dividends while creating the conditions for a more sustainable development of the health sector in Nigeria. In order to achieve its objectives the project will focus on the following three components:

Component I: Capacity Strengthening of State Ministries of Health

4.5.2 All thirty six States will be eligible to participate in this component which will be completely financed by the World Bank. The objective of this component is to provide support to all states to strengthen the capacity of SHOHs in the areas of planning, financial management, monitoring and evaluation. Support under this component will concentrate on the following areas:

Capacity strengthening of State Ministries of Health. Support will be provided to improve budget management processes and develop state health accounts. Through regular staff training and workshops, SMOHs officials will receive financial and technical support to organise annual performance reviews to discuss results, lessons learned and share good practices with stakeholders and beneficiaries.

Human Resources Development. This sub-component will support the provision of staff training with a particular emphasis on maternal and child health, reproductive health, obstetric care, and communicable disease control.

Health Management Information System. Support will be provided to strengthen the HMIS in order to improve access to basic information for decision making.

Access to Information Technology and Communications. At least 3 communication node sites with access to the internet will be provided for each state, to be strategically located at the SMOH/PIU and one nurse training facility.

Research and Studies. Studies and technical audits of the health system will be supported under this sub heading.

Component II: Support to Primary Health Care

4.5.3 Through this component parallel ADF/WB funding will support activities to improve the delivery of primary health care services. The main focus would be on restoring a minimal level of quality in the provision of public sector health services targeted to the poor. Emphasis will be placed on strengthening immunisation services, safe motherhood interventions and communicable diseases control. The project will finance activities in each state based on beneficiaries' expressed priorities. Activities have been selected and developed from the Project Implementation Plans prepared by the States and discussed and agreed with Government and development partners. Particular attention will focus on cost-effective strategies that will result in measurable improvements in health status particularly for the poor. Thirty states will benefit under this component of which the ADF will finance 12 and the World Bank 18. Each state will receive up to USD 3.5 million, plus contingencies, (in addition, and in parallel to USD 1.5 million under Component I from the World Bank loan). To maintain a balance between the elements under the project, a maximum budget allocation for each category of expenditure was jointly agreed by Government, the World Bank and ADF as follows: 40% for goods, 35% for works, 15% for services, and 5% for operating costs and miscellaneous expenditures respectively. Activities under this component are carried out within the following five sub-components:

4.5.4 Improved Access to Primary Health Services: Between 35% and 45 % of the allocation per state is expected to be spent on this sub-component. Funding will be provided for activities under the categories of works, goods and services. On average, 10-15 primary health care facilities in each state will be rehabilitated (and provided with potable water). Participating states are undertaking an inventory of existing facilities in order to identify priority rehabilitation needs. The project will finance the professional services of local architects, engineers and quantity surveyors to produce architectural and engineering designs for the required civil works, development of tender documents with bills of quantities, tendering and selection of contractors, as well as supervision of the required civil works through regular visits, and documentation of progress of works on the sites. The rehabilitated facilities will be supplied with adequate medical equipment and furniture. Technical and management support to the primary health care facilities under the project will be provided to put in place a system for greater autonomy in the management and maintenance of local health facilities through training and technical assistance. In this regard, existing village health committees will be trained in basic management skills for greater involvement in the management and oversight of these facilities. The provision of outreach HIV/AIDS and Malaria control IEC activities is envisaged within the IMCI and MCH/FP interventions under this component.

4.5.5 Support to PHC Activities: About 25% of the allocation per state is expected to be spent on this sub-component. Resources for activities under this sub-component will be provided under the categories of goods, services and miscellaneous expenditures. Support will be provided for the expanded use of cost-effective strategies of basic health care delivery such as the Integrated Management of Childhood Illnesses (IMCI), Safe Motherhood, and Communicable Disease Control technical training packages provided by WHO at the primary health and community levels. This will be accomplished through procurement of basic equipment and materials and contracting of specialised agencies (WHO and other UN Agencies) with expertise in introduction of specialised technical packages in basic health care. Health staff will be trained to improve case management skills and techniques in expanded programme of immunisation. Community outreach activities in IEC for health promotion and protection will be supported. The proposed activities to be supported under this component will be based on the internationally approved strategies of Integrated Management of Childhood Illnesses (IMCI) and MCH/FP interventions. To address the excessively high rate of maternal mortality in Nigeria, support will be provided to increase access to MCH/FP

services, training of TBAs and improved midwifery management of complications from unsafe abortions as well as the strengthening of state health training institutions.

4.5.6 Support to Health Training Facilities: About 25% of the allocation per state is expected to be spent on this sub-component. Funding will be provided for activities under the categories of works, services and goods. At least one health training institution will be rehabilitated in each state. Funds will be provided to update curricula and upgrade the managerial and clinical skills through the training of trainers including skills in the management of HIV/AIDS and other communicable diseases. Equipment, furniture and learning materials for the rehabilitated facilities will be provided. Collaboration between State and Local Government Authorities in the project states and communities will ensure that buildings, furniture and learning materials are well maintained.

4.5.7 Essential Drugs Management: About 5% of the allocation per state will be used for this sub-component. The expenditures will be under the categories of services and goods. Logistical support will be provided to ensure an initial supply of essential drugs at the primary level. To this end, the project will expand access to affordable essential drugs at the local level by providing support to state authorities to put in place a cost efficient distribution system, and/or providing seed stocks to PHC health facilities. The project will also assist a select number of secondary level facilities to strengthen their internal drug procurement, management and distribution systems through the training of staff in drugs supply management. Support will also be provided for States to carry out analytic work to identify cost effective and sustainable local solutions ensuring a steady supply of essential drugs.

4.5.8 Project Management: About 5% of the allocation per state will be used for this sub-component. Funding will be provided under the categories of goods and operating costs. Each Project Management Unit (PMU) in the 12 states will receive computers, printers, software, photocopiers, office furniture and one vehicle each. Operating costs for project management will include office expenses, communications and travelling costs for the PMUs' supervision staff. The World Bank will finance similar arrangements in the 18 states they are supporting under this component. At the central level, the ADF and the World Bank will finance the following services: i) technical assistance to strengthen the Procurement Unit in the World Bank's office in Abuja; ii) consultancy services for overall day-to-day project supervision and monitoring; iii) financial management consultants for the development of a Financial Procedures Manual to be adopted by all implementing agencies of the project; and, iv) annual auditing.

Component III: Capacity Strengthening for the Federal Ministry of Health

4.5.9 This component, to be exclusively financed by the World Bank, will provide assistance to the Federal Ministry of Health to build capacity and to strengthen its normative functions (e.g. coordination, monitoring and evaluation), within the framework of the Government's health sector reform agenda. Specifically, assistance will be provided to the FMOH to: (i) coordinate and guide the design and implementation of the National Health Management Information System (NHMIS) in order to improve access to basic information for decision making; (ii) strengthen health policies and systems development, with a particular focus on the health sector reform program, including the national health insurance scheme; (iii) coordinate the preparation of national health accounts in order to get a comprehensive view of levels and sources of health spending; (iv) carry out institutional and management audit studies and reviews, including joint assessments of health systems performance; (v) organize annual performance reviews, in order to provide feedback to the National Council on Health on progress in designing reform measures and to generate a consensus on the reform agenda; and, (vi) support project management and co-ordination.

4.6 Environmental Impact

4.6.1 The proposed project is classified as Category III. Project activities will include rehabilitation of PHC Centers and the provision of related services over a large geographical area. The project does not raise any significant environmental issues to the extent that it emphasizes rehabilitation of facilities. While most of these activities will have either no adverse or a beneficial environmental impact, the rehabilitation of PHC facilities could affect the immediate environment. Therefore, the proposed project will ensure that activities with potentially adverse environmental impact are clearly identified and mitigating measures built into relevant project activities. In addition, adherence to WHO guidelines on waste management would be emphasized in the operational manual and staff training.

4.6.2 To minimise negative environmental impact, the following specific measures will be taken: i) collaborate with State environmental agencies to sensitise communities in conservation and other positive environmental practices as may be relevant; ii) include in the Operations Manual guidelines and a checklist of environmentally-related actions that must be completed before project activities may commence.

4.6.3 At the national level, it is expected that the State Ministries of Health will work with the Ministry of Environment, other relevant Government institutions and NGOs to better link issues such as health institution waste management, desertification, soil erosion and bio-diversity to primary health care IEC campaigns. The objective will be to place environmental concerns in the mainstream of PHC activities by increasing popular understanding of the relationship between health and environmental degradation.

4.7 Project Costs

4.7.1 The total project cost is estimated at UA 163.92 million (USD 203.6 million) out of which the ADF and the World Bank will, in parallel, finance UA 34.74 million and UA 100.97 million, respectively. The Government will contribute UA 28.22 million, which represents 17.2 % of total project cost. A summary of the total cost of the project, net of taxes and customs duties for all sources of financing by component is presented in Table 4.1(a) below.

4.7.2 For the purpose of costing, all items have been priced in USD and converted into UA at the exchange rate applicable in the Bank for the month of February 2002. Physical contingency has been calculated based on 5 % of base cost for all categories of expenditure, and price contingencies based on a yearly average of 3.5 % price escalation, compounded until mid-point of each activity, on an overall basis, since almost 80% of local costs (national procurement) are financed from external resources.

Table 4.1 (a)
Summary of Total Project Costs by Component (All Sources)

	- - - - -USD million - - - - -			- - - - - - UA million - - - - - -			%
COMPONENTS	**F.E.**	**L.C.**	**Total**	**F.E.**	**L.C.**	**Total**	**Tot**
I. Capacity Strengthening (States)	13.86	51.75	65.61	11.16	41.67	52.83	32.2
II. Support to PHC	36.36	91.95	128.30	29.27	74.03	103.30	63.0
III. Capacity Strength. (FMOH)	2.23	7.45	9.68	1.80	6.00	7.79	4.8
Total Cost	**52.45**	**151.15**	**203.60**	**42.23**	**121.70**	**163.92**	100.0
Percentage of Total	25.8	74.2	100.0	25.8	74.2	100.0	

Note: All figures are rounded automatically from spreadsheet calculations and may not always "add up" exactly in these tables

4.7.3 Table 4.1(b) below shows the costs of the ADF-financed part of Component II by sub-components. The ADF will fund costs for 12 states under Component II: Support to Primary Health Care.

Table 4.1 (b)
Summary of ADF Project Costs – Component II

Component II	**- - - - -USD million - - - - -**			**- - - - - - UA million - - - - - -**			**%**
Support to Primary Health Care	**F.E.**	**L.C.**	**Total**	**F.E.**	**L.C.**	**Total**	**Tot**
2.1 Improved Access to PHC	7.26	12.39	19.65	5.84	9.98	15.82	37.8
2.2 Support to PHC Activities	3.63	6.20	9.82	2.92	4.99	7.91	18.9
2.3 Support to Health Training	3.63	6.20	9.82	2.92	4.99	7.91	18.9
2.4 Essential Drugs Management	0.99	1.69	2.68	0.80	1.36	2.16	5.2
2.5 Project Management	0.99	1.69	2.68	0.80	1.36	2.16	5.2
Total Base Cost	**16.49**	**28.16**	**44.65**	**13.28**	**22.67**	**35.95**	85.9
Physical Contingency	0.82	1.41	2.23	0.66	1.13	1.80	4.3
Price Contingency	1.88	3.21	5.10	1.52	2.59	4.10	9.8
Total Cost	**19.20**	**32.78**	**51.98**	**15.46**	**26.39**	**41.85**	100.0
Percentage of Total	36.9	63.1	100.0	36.9	63.1	100.0	

4.7.4 Table 4.2 below shows the cost by category of expenditure of the ADF-financed part of the project.

Table 4.2
Summary of ADF Project Costs by Category of Expenditure

	- - - - - USD million - - - - -			**- - - - UA million - - - -**			**%**
CATEGORY OF EXPENDITURE	**F.E.**	**L.C.**	**Total**	**F.E.**	**L.C.**	**Total**	**Tot.**
(A) Goods	10.08	6.72	16.80	8.12	5.41	13.53	32.3
(B) Works	2.94	11.76	14.70	2.37	9.47	11.84	28.3
(C) Services	3.05	5.90	8.95	2.46	4.75	7.21	17.2
(D) Operating Costs	-	2.10	2.10	-	1.69	1.69	4.0
(E) Miscellaneous	0.42	1.68	2.10	0.34	1.35	1.69	4.0
Total Base Cost	**16.49**	**28.16**	**44.65**	**13.28**	**22.67**	**35.95**	85.9
Physical Contingency	0.82	1.41	2.23	0.66	1.13	1.80	4.3
Price Contingency	1.88	3.21	5.10	1.52	2.59	4.10	9.8
Total Cost	**19.20**	**32.78**	**51.98**	**15.46**	**26.39**	**41.85**	100.0
Percentage of Total	36.9	63.1	100.0	36.9	63.1	100.0	

4.8 Sources of Financing and Expenditure Schedules

4.8.1 The project will be financed by the World Bank (62.1 %), The ADF (20.6 %) and the Government (17.2 %) as shown in table 4.3 (a) below. The entering into an agreement between the Government and the World Bank for parallel financing of the project will be a loan condition.

Table 4.3 (a)
Sources of Finance (all sources)
(UA millions)

SOURCE	**F.E.**	**%**	**L.C.**	**%**	**TOT**	**%**
ADF	15.46	36.6	19.28	15.8	34.74	21.2
WORLD BANK	26.77	63.4	74.20	61.0	100.97	61.6
GOVERNMENT	0.00	0.0	28.22	23.2	28.22	17.2
TOTAL	**42.23**	100.0	**121.70**	100.0	**163.92**	100.0
Percentage	25.8		74.2		100.0	

4.8.2 The financing plan for the of the ADF-financed part of the project is shown in table 4.3 (b) below.

Table 4.3 (b)
Sources of Finance (ADF)
(UA millions)

SOURCE	F.E.	%	L.C.	%	TOT	%
ADF	15.46	100.0	19.28	73.0	34.74	83.0
GOVERNMENT	0.00	0.0	7.11	27.0	7.11	17.0
TOTAL	**15.46**	100.0	**26.39**	100.0	**41.85**	100.0
Percentage	36.9		63.1		100.0	

4.8.3 The ADF's financing of part of the local costs, covers goods, works, services, operating costs and miscellaneous costs. The financing of part of the local costs is justified on the following grounds:

i) the nature of the project, which focuses on health development activities that require inputs that are largely available locally;
ii) domestic resource mobilisation is far from adequate and consequently the Government has continued to rely on external sources to finance part of the development budget;
iii) the level of aggregate domestic savings in Nigeria is low (below 10 %) and therefore the country's capacity to finance a project of this size entirely from domestic resources is limited.

4.8.4 Table 4.4 below shows the expenditure schedule by category of expenditure and source of financing for the part of Component II to be co-financed by the ADF and the Government.

Table 4.4
Expenditure Schedule by Category of Expenditure and Source of Financing
(UA millions)

A D F:	2003	2004	2005	2006	2007	TOTAL	% Total
(A) Goods	2.52	3.78	5.04	1.26	0.00	12.60	36.3
(B) Works	1.65	3.31	4.96	1.10	0.00	11.02	31.7
(C) Services	1.68	2.52	2.52	0.84	0.84	8.39	24.2
(D) Operating Costs	0.15	0.15	0.15	0.15	0.15	0.76	2.2
(E) Miscellaneous	0.39	0.39	0.39	0.39	0.39	1.97	5.7
TOTAL	**6.40**	**10.15**	**13.06**	**3.75**	**1.38**	**34.74**	100.0
Percentage per Year	18.4	29.2	37.6	10.8	4.0	100.0	
GOVERNMENT:	**2003**	**2004**	**2005**	**2006**	**2007**	**TOTAL**	**% Total**
(A) Goods	0.63	0.94	1.26	0.31	0.00	3.15	44.3
(B) Works	0.41	0.83	1.24	0.28	0.00	2.76	38.7
(D) Operating Costs	0.24	0.24	0.24	0.24	0.24	1.21	17.0
TOTAL	**1.29**	**2.01**	**2.74**	**0.83**	**0.24**	**7.11**	100.0
Percentage per Year	18.1	28.3	38.5	11.7	3.4	100.0	
T O T A L E X P:	**2003**	**2004**	**2005**	**2006**	**2007**	**TOTAL**	**% Total**
(A) Goods	3.15	4.72	6.30	1.57	0.00	15.75	37.6
(B) Works	2.07	4.13	6.20	1.38	0.00	13.78	32.9
(C) Services	1.68	2.52	2.52	0.84	0.84	8.39	20.0
(D) Operating Costs	0.39	0.39	0.39	0.39	0.39	1.97	4.7
(E) Miscellaneous	0.39	0.39	0.39	0.39	0.39	1.97	4.7
TOTAL	**7.68**	**12.16**	**15.80**	**4.58**	**1.63**	**41.85**	100.0
Percentage per Year	18.4	29.1	37.8	10.9	3.9	100.0	

5. PROJECT IMPLEMENTATION ARRANGEMENTS

5.1 Executing Agency

5.1.1 At the federal level, the Directorate General of Planning in the Federal Ministry of Health will have the overall national responsibility for the project, operating through the National Project Coordinating Unit (NPCU). The NPCU will specifically monitor the implementation of the third component and provide policy guidance to states, as needed, to implement their respective work programs under components one and two. It will consolidate annual work programs, reports and accounts and submit to ADF and the World Bank consolidated Audited Project Financial Statements within six months after year end.

5.1.2 At the state level, the Executing Agencies for all ADF-funded activities (component two), are the 12 State Ministries of Health (SMOHs) through their Project Management Units (PMUs), that have already been established in these states (Bauchi, Yobe, Katsina, Kaduna, Benue, Niger, Imo, Abia, Oyo, Lagos, Akwa Ibom and Edo). They have the mandate to manage the implementation of project activities in their respective states under the auspices of the State Health Commissioners (SHCs) in co-operation with the Project Coordinating Committees (PCCs) at the state level, and the National Project Steering Committee (NPSC) at the federal level.

5.1.3 The PMU in each State will be responsible for the day-to day management of the project including procurement of works, goods and services, financial management, monitoring and evaluation and the preparation and submission of all required reports, based on the policies and procedures set forth in a joint ADB/World Bank Operations Manual and the ADF Project Implementation Document (PID). The States and Local Governments will decide what types of goods and services they need most and how their project can be sustained. The size of the PMUs may vary according to State conditions. The PMUs will comprise, at a minimum, a Project Manager, who will be a Health Planner/Administrator or an equivalently experienced health services administrator by profession, an Accountant, an Internal Auditor, a Procurement Specialist, a Senior Secretary, a Secretarial Assistant and drivers. This will be a loan condition. Administratively, the Project Manager will report to the Permanent Secretary of the SMOH. He will work closely with all other relevant SMOH units at the headquarters level as well as at the level of Local Government Authorities (LGAs).

5.1.4 The PMUs will prepare annual work programs in close consultation with their respective LGAs, the Directorate of Planning and Statistics and the PCC in their respective State Ministry of Health. The work program and related budget will be reviewed by the State Health Council, responsible for state budget approval and be forwarded through the NPCU to ADF and IDA for approval.

5.1.5 A Project Accounting Section, headed by a professionally qualified accountant and supported by appropriately qualified staff will be established in each PMU. All accounts personnel will be given training, as appropriate, in bank procedures, computer applications, and other relevant skills. The Project Accounting Section will be responsible for the day-to-day management of the proceeds of the loan and for consolidating project budgets and reports, and forwarding them to the ADF through the a World Bank/ADF procurement unit in Abuja. Specifically, it will be responsible for preparing and consolidating budgets, monthly reports, quarterly financial monitoring reports, annual financial statements, and progress reports. Each PMU will maintain the following accounts: i) a current account in Naira to which counterpart funds will be deposited, and ii) a special account to which the proceeds of the loan will be credited. The PMUs will be responsible for preparing and submitting consolidated applications for disbursement requests. Appropriate procedures and controls, which will be documented in a Financial Procedures Manual (FPM), will be instituted to

ensure disbursement and flow of funds is carried out in an efficient and effective manner. Detailed banking arrangements, including controls over bank transactions, will be documented in the FPM.

World Bank/ADF Arrangements

5.1.6 For the World Bank financed parts of the project, all procurement requests will be reviewed and approved by the Procurement Unit in the World Bank's country office in Abuja. The ADB will authorise the head of this unit to approve procurements under the ADF-financed part of the project in line with ADF procurement Rules and Regulations. In view of the expected high number of procurement requests from the states and limited knowledge of the Bank's financial procedures and guidelines, there will be need to improve financial governance in order to facilitate efficient procurement and disbursement processing throughout project implementation. In this regard, the ADF will strengthen the Procurement Unit in the World Bank's country office in Abuja through the provision of two technical assistants conversant with the ADF Procurement Rules and Regulations. To facilitate efficient procurement processing, all procurement activities by the states and the NPCU in respect of ADF financing will be examined for approval by a team of two ADF procurement specialists based in the World Bank's country office in Abuja. Approval of procurements will be required before any disbursements are made from either special accounts or direct payment by the Banks. However, post review of procurements will be made for expenditures under not exceeding USD 20,000 under the categories of operating costs and miscellaneous.

5.1.7 With respect to financial arrangements and funds flow, each state will sign an 'on lending agreement' with the FMOF. This agreement will define the financial roles and responsibilities of both parties in the implementation of the project. This will be a loan condition. The Banks will jointly hire a Financial Management Consultant to develop a Financial Procedures which will form a section of the Operations Manual. The Financial Procedures will be adopted by all implementing agencies of the project. It will include, inter alia, institutional arrangements; chart of accounts; basis of accounting adopted; planning and budgeting, including cash-flow management; procurement procedures for goods, works and services; disbursements; banking activities; staff, wages and salaries; fixed assets register; financial reporting, auditing; legal covenants; and records management.

5.2 Institutional Arrangements

5.2.1 At the federal level, a National Project Steering Committee (NPSC) will be established to enhance management, provide overall policy direction, and monitor progress for the entire project. The NPSC will consist of representatives of the Federal Ministry of Health (FMOH), the Federal Ministry of Finance (FMOF), NPCU, Department of States and Local Government Authorities (LGAs); representatives of states; World Bank; ADF; and other development partners. The National Project Coordinating Unit (NPCU) shall provide secretarial support for the steering committee. The specific functions of the NPSC are to: (a) examine annual action plans of all project teams; (b) undertake periodic review of all project activities and review all monitoring and evaluation reports; (c) review problems emanating from credit disbursement and Government counterpart funds and flow of funds mechanisms; (d) provide strategic direction to project management; (e) contribute to resolving implementation constraints and propose remedial actions; and, (f) provide briefs for Government for the annual portfolio review meetings and make recommendations to Government on matters pertaining to the project.

5.2.2 At the state level, Project Coordinating Committees (PCCs), which will include the State Commissioner of Health as Chairperson; the Permanent Secretary; the Chief Health Adviser; Representatives of the Ministries of Finance and Local Government; Representatives of Civil Society; Local Government Authority Representatives; and the Project Manager will be

established. This will be a loan condition. The PCCs will have two Technical Sub-Committees, one for training and the other for PHC. The Sub-Committees will assure follow-up of work plans, provide technical guidance and reinforce project implementation. Their functions will include: overseeing project implementation; providing strategic directions for project management; and convening quarterly meetings with LGAs, NGOs and other stakeholders.

5.2.3 The State Health Commissioners (SHCs) will have overall responsibility for ensuring that annual work plans are consistent with state health plans. State governors will ensure that health services and project facilities are adequately funded. In particular they will ensure that SMOHs budgetary allocations are increased annually to cover the additional recurrent costs created by the project. SMOHs will be responsible for project management through their Project Management Units (PMUs). LGAs will be responsible for delivering basic health services in the rehabilitated PHC facilities supported under the project.

5.2.4 To ensure maximum transparency and to provide the SMOHs with clear guidelines on the policies, rules and procedures to be followed, a standard Project Operations Manual is being finalized and will be used by each State and the FMOH. The manual will be based on internationally recognised best practices and are being developed with the technical support of World Bank staff with respect to content and procedures used successfully in similar projects elsewhere. The manual will contain sections outlining legal status; institutional arrangements; target groups; the size, management systems; relations with LGAs, procurement and financial management procedures; personnel recruitment procedures; conflict of interest issues; monitoring and evaluation procedures and requirements; reporting procedures, etc.

5.2.5 ADB and the World Bank must approve the content of the Operations Manual. The status and structure of the approved Operations Manual shall not be changed without the prior written approval of both Banks. This will be a loan condition.

5.3 Supervision and Implementation Schedules

5.3.1 Project supervision of the 30 states participating both in components 1 and II will be especially demanding and time-consuming. In addition to the necessary controls of implementation, procurement and financial management, there is a need to provide the project teams with implementation support. To monitor implementation and provide assistance to the States, joint supervision missions, including the ADB/World Bank team and representatives of the NPCU will be effected twice a year. All the 6 zones and all the 30 States will be covered at least once a year. The ADB's Nigeria Country Office will also provide assistance to the day to day supervision of the project.

5.3.2 The Banks and the Borrower will also undertake a mid-term project review to assess performance of project management units at the federal and state levels, performance of intermediaries, cost-effectiveness, quality and probity of financial, procurement and accounting practices and implementation issues. This evaluation will recommend any necessary modifications to the operations manual or institutional arrangements and will be conducted in close co-ordination with all stakeholders.

5.3.3 To ensure adequate quality in supervision and implementation support provided, the services of an internationally reputable consultancy firm will be contracted under TORs acceptable to both ADF and the World Bank to carry out day to day monitoring and supervision for this project. The consultants will be responsible for monitoring and maintaining the performance indicators for the project, visit states regularly to identify problems and issues, bring these issues to

the attention of the NPCU, the Banks and the NPSC and prepare (and participate in) the joint supervision missions.

5.3.4 The Government of Nigeria is strongly committed to the implementation of this project. State representatives have worked intensively to prepare, revise and refine their project proposals since early 2000. The creation of a "forum" of States with a mandate to speed up the taking off of this project is also a clear indication that state Governments are keen to borrow money for these investments and illustrates that health is perceived to be an important element in the State Government's programs.

5.3.5 The World Bank has made available a PPF on the IDA loan to the Multilateral Division of the Ministry of Finance for substantial work to be accomplished before the project becomes effective. The Ministry of Finance is using the PPF to finalize the Operations Manual and other administrative tasks, consolidating the States' project proposals, ensuring procurement procedures for transparency and competition, etc. It is expected that all monitoring and evaluation, financial management and procurement systems will be in place by the time the project is launched (January/February 2003).

5.3.6 It is envisaged that the loan will be approved in June 2002. Fulfilment of loan conditions and procurement will start thereafter. The project will be implemented during a period of 5 years from effectiveness of the loan, assumed to be in the last quarter of 2002. The detailed implementation schedule is presented in Annex V. The key implementation target dates are summarised in Table 5.1.

Table 5.1 - Implementation Schedule

ITEM	ACTIVITY	TARGET DATE	ACTION BY
A.	ADMINISTRATION		
A.1	Board presentation	06 – 2002	ADF
A.2	Loan signature	09 – 2002	ADF/FMOF
A.3	Effectiveness	11 – 2002	FMOF/FMOH
A.4	Launching Mission	01 – 2003	ADF
A.5	Mid-term review	06 – 2005	ADF/PARTNERS
A.6	Project Completion Report	12 – 2007	ADF/ARI
B.	WORKS		
B.1	Bidding documents approved (initial contracts)	06 – 2003	ADF
B.2	Bids invited and received	09 – 2003	PIU/SMOH
B.3	Bids evaluated	10 – 2003	PIU/SMOH
B.4	Bid evaluation report approved	11 – 2004	ADF
B.5	Contracts awarded	01 – 2004	PIU/SMOH
B.6	Construction completed (all contracts)	12 – 2005	PIU/SMOH
B.7	Defects Liability Periods Completed (all contracts)	12 – 2006	PIU/SMOH
C.	PROCUREMENT OF GOODS		
C.1	Equipment for Project Management supplied	03 – 2003	PIU/SMOH
C.2	Equipment/furniture for project facilities supplied	12 – 2005	PIU/SMOH
C.3	Drugs and supplies procured	annually	PIU/SMOH
D.	TRAINING ACTIVITIES		
D.1	Approval of training programmes	06 – 2003	ADF
D.2	Training programmes completed	06 – 2007	SMOH
E.	CONSULTANCY SERVICES		
E.1	Shortlists approved	03 – 2003	SMOH/ADF
E.2	Bids invited and received	05 – 2003	PIU/SMOH
E.3	Bids evaluated	06 – 2003	PIU/SMOH
E.4	Bid evaluation reports approved	07 – 2003	SMOH/ADF
E.5	Consultants appointed	08 – 2003	PIU/SMOH
E.6	Auditors approved and appointed	09 – 2003	FMOH

5.4 Procurement Arrangements

5.4.1 Procurement of goods, works and services financed by the ADF will be in accordance with the Bank's Rules of Procedure for Procurement of Goods and Works or, as appropriate, Rules of Procedure for the Use of Consultants, using the relevant Bank Standard Bidding Documents. The procurement arrangements are summarised in Table 5.2 below.

5.4.2 All procurements using ADF funds at the state level will be initiated by the SMOH/PMU based on annual work plans approved by the ADF. The National Project Coordinating Unit (NPCU) will initiate procurements at the federal level under IDA and ADF funding. . Procurement documents requiring approval are listed in paragraph 5.4.10 below. To facilitate efficient procurement processing for both Banks, all procurement and disbursement activities by the states and the NPCU will be examined for technical accuracy and completeness by two ADF procurement specialists based in the World Bank's country office in Abuja. To strengthen the capacity of the procurement specialist team, the ADF will provide financial support to meet the costs of two technical assistants conversant with the ADF's procurement rules and procedures. The two technical assistants will review procurement and disbursement requests from the PIUs in order to ensure conformity with ADF procurement rules and regulations and request for any needed modifications before these requests are forwarded to the Bank for approval. Approval of procurements will be required before any disbursements are made from either special accounts or direct payment by the Bank.

Table 5.2
Procurement Arrangements
(UA millions)

CATEGORIES OF EXPENDITURE	NCB	OTHER	SHORTLIST	TOTAL	NON-BANK FUNDED
Goods*:*					
Equipment and Supplies for 12 States	10.50 [8.40]	5.25 [4.20]		**15.75 [12.60]**	3.15
Works:					
Rehabilitation of PHC facilities in 12 States	13.78 [11.02]			**13.78 [11.02]**	2.76
Services:					
Training Services for 12 States			2.95 [2.95]	2.95 [2.95]	
Consultancy Services for 12 States			2.95 [2.95]	2.95 [2.95]	
T/A for Procurement Unit in Abuja			0.47 [0.47]	0.47 [0.47]	
Overall Supervision Consultants			1.41 [1.41]	1.41 [1.41]	
Financial Management Consultants			0.47 [0.47]	0.47 [0.47]	
Annual Project Auditing			0.14 [0.14]	0.14 [0.14]	
Sub Total Services			**8.39 [8.39]**	**8.39 [8.39]**	
Operating Costs:					
Project implementation costs – 12 States		1.97 [0.76]		**1.97 [0.76]**	1.21
Miscellaneous:					
Local training activities – 12 States		1.97 [1.97]		**1.97 [1.97]**	
TOTAL	**24.28 [19.42]**	**9.19 [6.93]**	**8.39 [8.39]**	**41.85 [34.74]**	**7.11**

Note: The amounts in brackets are financed by the ADF. Other include National Shopping of equipment and supplies for the 12 states (estimated at 1/3 of the total); and Government procedures for operating costs for project management at state level; and miscellaneous expenses.

5.4.3 Goods: Estimated at UA 15.75 million in aggregate, the goods to be financed by the ADF under Component II in 12 states include: (i) basic medical equipment, furniture and essential drugs for primary health care centres; (ii) training equipment and furniture for nurse training facilities; (iii) computers, printers, software, photocopiers, and office furniture for use by the PIUs; and iv) a limited number of vehicles and motorbikes for PHC activities. The amount per state is estimated at UA 1.31 million. Because of the diversity of the procurement, each contract will be small. In addition, the various states will be following separate implementation schedules, making it unfeasible to group procurements in order to attract international bidders. Given that the goods are of such value and quantities that their supply can not possibly interest suppliers outside the Borrower's country, the mode of procurement will be NCB; and National Shopping where off-the-shelf goods or standard specification commodities are readily available. A sufficient number of national suppliers exists to ensure competitive bidding.

5.4.4 Works: Estimated at UA 13.78 million in aggregate, the civil works to be financed by the ADF under Component II in 12 states comprise rehabilitation of primary health care centres and nurse training facilities. The amount per state is estimated at UA 1.15 million. On average, 10-15 facilities may be rehabilitated in each of the 12 states, spread over large geographical areas, which makes it impractical to group several projects into larger bid packages. The services of local contractors will, therefore, be procured through National Competitive Bidding (NCB) given that the character, location and size of the construction works to be undertaken are such that they are unlikely to attract bids from outside the Borrower's country.

5.4.5 Services: Estimated at UA 5.9 million in total (UA 0.49 per state) the services required at state level include specialised training, consultancy services and technical assistance. The services of WHO for specialised technical training (estimated at UA 2.95 million in aggregate for all 12 states) to improve quality health service will be procured through single source selection procedure because WHO is uniquely and exceptionally qualified to provide the required technical training under the project. The consultancy services and technical assistance required at state level (estimated at UA 0.25 million per state) include: i) professional services from local architects, engineers and quantity surveyors to produce specifications for rehabilitation works, development of tender documents with bills of quantities, tendering and selection of contractors, as well as supervision of the required works through regular visits, and documentation of progress of works on the sites; and, ii) technical assistance from reputable firms and institutions in areas of outreach IEC and information technology. All these services will be procured on the basis of shortlists (SL) with selection procedure based on technical quality with price consideration. At the central level, the ADF and the World Bank will finance the following services (the amounts in brackets indicate the ADF's contribution): i) technical assistance for the Procurement Unit based in Abuja (UA 0.47 million); ii) consultancy services for overall project supervision (UA 1.41 million); iii) Financial Management Consultants (UA 0.47 million; and, iv) annual auditing (UA 0.14 million). All these services will be procured on the basis of shortlists (SL). Selection of such consultants and the form of contract will be designed for ease of funding.

5.4.6 Operating Costs: Estimated at UA 1.97 million in aggregate, or UA 0.16 million per state, operating costs for project management at state level include office expenses, communications and travelling costs for the PMUs. Government procedures acceptable to the Bank will apply to this category of expenditure.

5.4.7 Miscellaneous: Estimated at UA 1.97 million in aggregate, or UA 0.16 million per state, this category includes costs for venues and facilities for local and regional workshops and seminars on institutional strengthening and capacity building for key health staff at the SMOHs and the PHC centres. Government procedures acceptable to the Bank will apply to this category of expenditure.

National Procedures and Regulations

5.4.8 Nigeria's national procurement laws and regulations have been reviewed and determined to be acceptable.

General Procurement Notice

5.4.9 The text of a General Procurement Notice (GPN) has been agreed during negotiations. The Boards of Directors will publish the notice in the UN Development Business (UNDB), upon the approval of the loan and the grant.

Review Procedures

5.4.10 The following documents are subject to review and approval by the Fund before promulgation:

- Specific Procurement Notices;
- Shortlists and Requests for Proposals (RFP) for consultancy services and training institutions;
- Shortlists and Requests for Proposals (RFP) for project accounts auditors;

- Lists, Designs, Specifications, Tender Documents, with Draft Contract Agreements for Civil Works, Furniture and Equipment;
- Tender Evaluation Reports, or Reports on Evaluation of Consultants' Proposals, including Recommendations for Contract Award;
- Draft Procurement Contracts, if these have been amended from the drafts included in the tender documents, and draft contracts for consultancy services and training.

5.5 Disbursement Arrangements

5.5.1 The ADF will use two disbursement methods: i) special account, and ii) direct payment. The special account method will be used for all expenditures by the states in respect of procurement of goods, works, services, operating costs and miscellaneous expenses. As described in paragraph 5.4.1 above, all procurement activities by the states will be examined for approval by the head of the joint World Bank/ ADF team of procurement specialists in the World Bank's country office in Abuja before funds are released from the special accounts. The direct payment method will apply to consultancy services for: i) overall project supervision; ii) financial management; iii) technical assistance for the team of procurement specialists in the World Bank office; and, iv) external auditing. Procurement of these services will be initiated by the National Project Coordinating Unit and are subject to the same review and approval procedures as described above. All procurement deemed to fall short of ADF's rules during post review will be paid for from counterpart funds.

5.5.2 With respect to financial arrangements and funds flow, ADF will disburse the loan through 12 Special Accounts (SAs), one for each of the states receiving funding from ADF. Each SMOH/PMU will maintain one Special Account in convertible currency (US Dollars) to which the initial deposit and replenishments from ADF will be lodged and one current account in Naira to which Counterpart Funds will be deposited. The World Bank will use a similar arrangement for the states receiving funding from IDA. The opening of these accounts, and the deposit in advance of counterpart funds for one year, will be a loan condition.

5.5.3 To ensure adherence to agreed financial regulations, the special accounts will monitored to ensure compliance with the FPM by the ADF and World Bank financial supervision missions. Funds from the special accounts will only be released when disbursement and procurement requests have been cleared by the two ADF Technical Assistants Procurement Specialists.

5.6 Monitoring and Evaluation

5.6.1 The PMUs shall, within thirty (30) days following the end of each quarter, submit to the ADF quarterly project progress reports (QPPR), in accordance with the established format, covering all aspects of project implementation. QPPRs will be expected to cover progress measured against indicators in the project matrix. In the final year of implementation, the PMUs will also collate and submit a project completion report in accordance with the format recommended by the Fund. Additional reports and clarifications will be submitted to the Fund as and when required. The project will also benefit from the joint ADB/World Bank and Government supervision missions to be undertaken biannually. Monitoring and evaluation of quantifiable indicators will assist in measuring project impact.

5.6.2 Furthermore, the Federal Ministry of Health shall establish annual meetings in which State Ministries of Health, NGOs and other stakeholders, including Development Partners will be expected to participate in reviewing the project implementation.

5.6.3 In addition semi-annual audits and periodic supervision missions from the ADB and the World Bank will provide additional regular monitoring and feedback to stakeholders and donors. External evaluators will review the project at mid-term and at the project's completion.

5.7 Accounting and Auditing

5.7.1 The Project Accounting Section in each PMU will maintain accounts in accordance with international accounting standards. They will ensure that accounting and financial management systems, acceptable to ADF, will include internal controls and procedures, and a set of records (general ledger, balance sheet, income statement, and loan tracking system and portfolio management reports). In order to ensure efficient monitoring of project expenditure, the FMUs in each state will maintain separate project accounts, which should correspond to the project budget. Detailed accounts concerning expenditure financed by the Fund and the Government should facilitate the identification of expenditure by project component, category of expenditure and source of finance. The accounts should clearly document disbursed amounts from the Fund and the Government by category of expenditure and the status of any special account. The accounts and ledgers will be kept separately from other projects under implementation.

5.7.2 Reputable and qualified external auditors will be appointed by the FMOH on terms of reference (TORs) acceptable to both ADF and the World Bank. This will be a loan condition. The auditors will audit the project accounts and financial statements in accordance with International Standards on Auditing (ISAs). The External Auditors will prepare and submit to ADF and IDA Audited Project Financial Statements (Consolidated) within six months after year end as well as audit reports which will include opinion paragraphs on the Audited Project Financial Statements (Consolidated); the accuracy and propriety of expenditures made under the SOE procedures; and the extent to which these can be relied upon as a basis for loan disbursements. Regarding each Special Account, the auditors will also be expected to form an opinion on the degree of compliance with ADF and IDA procedures and the balance at the year-end for each individual special account

5.8 Aid Coordination

5.8.1 Under the Health Sector Development Programme (HSDP), all donor input are coordinated to increase efficiency in resource application, achieve equity in distribution of resources and access to quality health care for all Nigerians. It provides a broad framework for this coordination for the period 2000/1 – 2005/6. The Programme indicates Government's priorities in the health sector as well as strategies to achieve the stated goals and objectives for the priority interventions.

5.8.2 The Bank team will improve and sustain the close collaboration with the World Bank established during the joint preparation and appraisal missions as well as other thematic meetings through out the entire project cycle. In this regard the ADB'S Nigeria Country Office will maintain close liaison with the World Bank Country Office in Abuja as well as other partners in Nigeria on all activities related to the project. The Federal Ministry of Health coordinates donor meetings which include representatives from all the UN Agencies, ADB, World Bank, and bilateral donors such as DfID, USAID, DANIDA. The NGOs and private sector's inputs should prove invaluable in extending the PHC network.

6. PROJECT SUSTAINABILITY AND RISKS

6.1 Recurrent Costs

6.1.1 The project is an integral part of Nigeria's Medium Term Plan of Action for Health Sector Reform (2000 – 2003) in which all the major partners are taking part. All the interventions proposed within the Plan were endorsed by the Government and the collaborating partners with the aim that the recurrent cost implications should be minimum. To avoid generating additional recurrent costs, the project will not finance the construction of new structures or new primary health facilities, but it will improve the effectiveness of existing facilities. The rehabilitated, re-equipped primary health facilities with appropriate seed stock of drugs and medical consumables managed by well trained health workers will result in at least 30-50% increase coverage of primary health care services when the facilities become fully functional by the year 2009.

6.1.2 The increase in recurrent budgets of the health sector from the federal and state government over the past years and the application of the existing user fees in the health facilities under the project will provide communities with additional resources for locally based maintenance as well as other associated recurrent cost of service delivery.

6.1.3 On completion, after 2008, the fiscal cost of incremental state and local budgets to cover maintenance, supplies and other new operating expenses under the ADF financed component will require a total Government cash flow of 0.09 percent of the aggregate health budget (across all levels of Government) during the first project year falling to 0.04 percent over the life of the project. Although the recurrent costs of the project, both during implementation and after completion, are quite reasonable for a sector wide project, it requires a clear commitment to funding on the part of the federal and local financing authorities. With a modest assumption of a 2.5 percent real growth rate of the Government budgets and stable allocations among Government levels, functions and line items, the Government's share of the incremental cost of the ADF financed project will be less than 0.3% of total projected health budgets (total of federal, state and local levels).

6.2 Project Sustainability

6.2.1 The sustainability of the project will be determined by three key elements: (i) degree of ownership of key stakeholders, (ii) implementation capacity, and (iii) timely availability of adequate financial resources, including counterpart funds. While Nigeria does not have a long standing tradition of participation and consultation, a concerted effort has been made to build into the project design appropriate interventions such as involvement of beneficiaries on local health committees, autonomy in management of health facilities, consultation workshops, patient satisfaction surveys, all of which will strengthen local ownership.

6.2.2 In addition, capacity-building interventions have been incorporated in the design. Consequently, project funds are targeted for strengthening institutional capabilities at both the state and federal levels. Institutional sustainability will be enhanced through training and the establishment of staffing norms and enabling the availability of trained state and local Government health personnel to continue delivery of quality primary health after termination of external inputs. It will also ensure technical sustainability by building sufficient safeguards against dependency through the promotion of active transfer of skills at all levels.

6.2.3 The financial impact of the project, both during implementation and after completion, is reasonable for a sector wide project but requires a clear commitment to funding on the part of the federal and local financing authorities. It is estimated that the total Government cash flow required to implement this project is 4% of the aggregate health budget (across all levels of Government) during the first project year falling to 1 percent over the life of the project. The problem with availability of counterpart funds will be addressed through deductions at source. Finally, other features of the project such as preparing expenditure analyses, and improving accountability and transparency in budget management processes will ultimately enhance the sustainability of health sector investments.

6.3 Project Risks and Mitigating Measures

6.3.1 Weak capacity at the FMOH and SMOHs: This could compromise the effective planning and management of public health services which may translate into low utilisation particularly by the poor as they are more likely to use the publicly financed health care services. To control this risk, institutional strengthening and capacity building will be included for the FMOH, PIU and SMOHs staff through training in procurement, financial management and disbursement; the promotion and strengthening of the support network of state PIUs; and the provision of continuous

support and monitoring by the internationally reputable Supervision Consultants to provide rapid response to emerging problems.

6.3.2 Security: Security in Nigeria is gradually improving. However, changing economic conditions and political instability may affect the security situation of each target area. Thus, the levels of crime and civil strife will be seriously assessed by the appropriate UN Agency before project activities are initiated.

6.3.3 Probity in financial matters: Nigeria is emerging from a period where corruption was pervasive and tolerated at the highest levels. Current leaders are trying to root out corruption at all levels and this has been a major concern of Nigerian civil society and a prominent issue in the nation's media. The project will provide safeguards that include financial reporting requirements outlined in the Operations Manual, regular and thorough financial audits, and transparency in recruitment, sub-project selection, review meetings etc. Before hiring staff, candidates' backgrounds and resumes will be checked thoroughly and findings used as part of the candidate review process. As part of the loan agreement setting up the project, a clause will be included stipulating that the Government of Nigeria and/or State Governments as appropriate will prosecute anyone found guilty of corrupt practices.

6.3.4 The size and scale of the project: The size and scale of the project covering a large number of states, might make it difficult to supervise. To minimize this risk, internationally reputable Supervision Consultants will be recruited to assist in monitoring and supervision. In addition, beneficiary groups and other stakeholders will be represented on all oversight bodies. They will also have a key role in identifying and implementing project activities at the LGA level. The design of the project will facilitate oversight by the Federal and State authorities via financial and technical audits of the project.

7. PROJECT BENEFITS

7.1 Economic Benefits

7.1.1 Expenditure under the proposed project will be concentrated in states selected across each of the six geo-political zones of Nigeria. Many of these funds will be used to procure goods, works and services locally from small businesses, NGOs and other non-profit associations. This will result in some increase in income-generation opportunities for local people. The capacity building element of the project may also have a multiplier effect since skills imparted at the local level may diffuse to colleagues, friends and communities.

7.1.2 Many of the sub-projects will have broad economic benefits. For example, improved access to quality primary health care and clean water will reduce the number of healthy days of life lost due to illness, thus increasing opportunities for improved economic output and productivity.

7.2 Social Benefits

7.2.1 In Nigeria, the quality and coverage of public health services are poor. Consequently, the health status of the poor and the disadvantaged groups, particularly women and children is worse because they depend entirely on public health services. The better-off can afford to seek quality services of private health care providers. Therefore, the social impact of this project is expected to be positive for the majority of poor Nigerians.

7.2.2 Access to quality health care is one of the barriers to women's health care particularly in rural communities. Health facilities in the rural areas are often in dilapidated, run down conditions, ill equipped and poorly staffed. Consequently, residents in rural communities often bypass these facilities in search of better health care in more urban and distant communities. Therefore, the number of PHC centers to be rehabilitated, re-equipped, furnished and staffed by appropriately

trained health personnel under this project will reduce the travelling time and associated costs of searching for health care among rural dwellers (who are often the poorest), thus making it possible for them to have more time for other productive activities. With improved access and utilization of these improved health services, the establishment of effective referral systems, the risks of infant and maternal mortality as well as other emergencies will be significantly reduced.

7.2.3 The successful implementation of sub-project activities will enhance the quality and coverage of primary health care to hitherto under-served population in the LGAs by providing quality reproductive health and immunization services against vaccine preventable diseases and outreach services for HIV/AIDS and malaria control. These will save thousands of lives, increase productivity and improve human welfare. The enormous gender differential in the burden of disease as measured by deaths and disability-adjusted life years (DALYs) will be significantly narrowed. Malaria and HIV/AIDS messages can reach millions of people repeatedly on radio, in newspapers, on posters, in schools and clinics and wherever people gather. If, for example, five million people improve their knowledge of malaria and HIV/AIDS prevention and only 10% act consistently on that knowledge and alter their behaviour, one million Nigerians could reduce their risk and at least 100,000 lives could be saved. Malaria remains a major killer in Nigeria and incapacitates millions of people annually. National campaigns to use mosquito nets impregnated with insecticide and remove stagnant water around households has been proven effective in reducing the incidence of malaria, raising productivity and saving lives.

7.2.4 The health status of mothers and children will improve due to improved MCH/FP services and household income, which will otherwise be spent in search of medical care for the sick, may be used to provide additional spending on food resulting in improved nutritional status. The multiplier effects will grow over time as healthy children and educated future generations become better able to contribute effectively to the economic development of Nigeria. HIV/AIDS and malaria prevention are especially critical for children since the child mortality rate for malaria is higher for children than adults and AIDS orphans face enormous difficulties. Project basic education and nutrition initiatives within the IMCI programme will also disproportionately benefit children. The training of staff in reproductive health, including TBAs, and providing them with life-saving skills to attend to women of childbearing age will improve the quality of maternal services and consequently the health of women and infants.

7.2.5 The project will provide an opportunity to institutionalise and translate Nigeria's international commitments at Cairo, Copenhagen, Beijing, and Istanbul Conferences, and in the Convention for the Elimination of All Forms of Discrimination against women by enabling women to be adequately represented and have a say in the planning, implementation and reviews of project activities at the LGAs, State and Federal levels, thus decreasing gender barriers that limit women's participation in national health development and narrowing the power gap between the sexes.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

8.1.1 The gravity of the Nigeria's poor health status is reflected in the fact that poverty has spread to all socio-economic groups. Chronic malnutrition (stunting) afflicts nearly half of the poorest children and roughly a third of the children from the higher income households. The proportion of the poorest children who are severely underweight (combination of chronic and acute malnutrition) is also larger, highlighting the vulnerability of poor households during periods of economic hardships.

8.1.2 The Government of Nigeria is strongly committed to the implementation of this project. State representatives have worked intensively to prepare, revise and refine their project proposals since early 2001. The creation of a "forum" of States with a mandate to speed up the taking off of this project is also a clear indication that the state Governments are keen to borrow money for these investments and illustrates that health is perceived to be an important element in the State Government's programs.

8.1.3 The proposed health project is feasible, desirable, addresses critical gender issues and fits within the overall framework of the Health Development Programme, the Nigerian Medium Term Plan of Action for Health Sector Reform and the Bank Group's Vision and Social Policies, as well as its Country Strategy for Nigeria.

8.1.4 The project will also assist in the actualization of the raised expectations of Nigerians for a "democracy dividend" stemming from the election of a democratic Government in May 1999. This is a window of opportunity for the Bank's timely response to these imperatives. The current Government must deliver tangible benefits to its citizens urgently. The joint financing option with the World Bank will facilitate concerted interventions by both institutions based on experiences with sector wide approaches in member countries such as Ethiopia, Ghana, Tanzania and Mozambique.

8.2 Recommendations and Conditions for Loan Approval

It is recommended that an ADF loan not exceeding UA 34.74 million be granted to the Federal Republic of Nigeria for the purpose of implementing the project as described in this report. The loan will be subject to the following conditions:

Conditions Precedent to Entry into Force

The entry into force of the present Loan, under the terms of Section 5.01 of the General Conditions, is also subject to the fulfilment of the following specific conditions.

Conditions Precedent to First Disbursement

The obligations of the Fund to make the first disbursement of the loan shall be conditional upon entry into force of the Agreement and the fulfillment by the Borrower of the following conditions:

The Borrower shall have:

i) provided evidence that the Project Management Units already established within the State Ministries of Health in Bauchi, Yobe, Katsina, Kaduna, Benue, Niger, Imo, Abia, Oyo, Lagos, Akwa Ibom and Edo States comprise, at a minimum, a Project Manager, who will be a Health Planner/Administrator or an equivalently experienced health services administrator by profession, a Procurement Specialist, an Accountant/Budget Officer and an Internal Auditor whose qualifications and experience shall be acceptable to the ADF and the World Bank. (paragraph 5.1.3);

ii) obtained the approval of the Board of Directors of the World Bank for the parallel-financing of this Project (paragraph 4.8.1);

iii) provided evidence of deposit of counterpart funds for one year in a current account for each SMOH in a bank acceptable to the ADF and the World Bank (paragraph 5.5.2);

iv) submitted evidence that a special account for each SMOH, into which proceeds of the loan shall be deposited, has been opened in financial institutions approved by the ADF and the World Bank (paragraph 5.5.2);

v) entered into legally binding agreements with each Participating State that: (i) grant authority to and allow the Participating States to severally apply for and obtain directly from the Fund the proceeds of the Loan, and in furtherance of such legally binding agreements, the Borrower shall have issued to the Fund authority to disburse the proceeds of the Loan directly to the Participating States (paragraph 5.5.2);

vi) provided proof of the establishment of the Project Co-ordinating Committees in each State (paragraph 5.2.2).

The Borrower shall undertake:

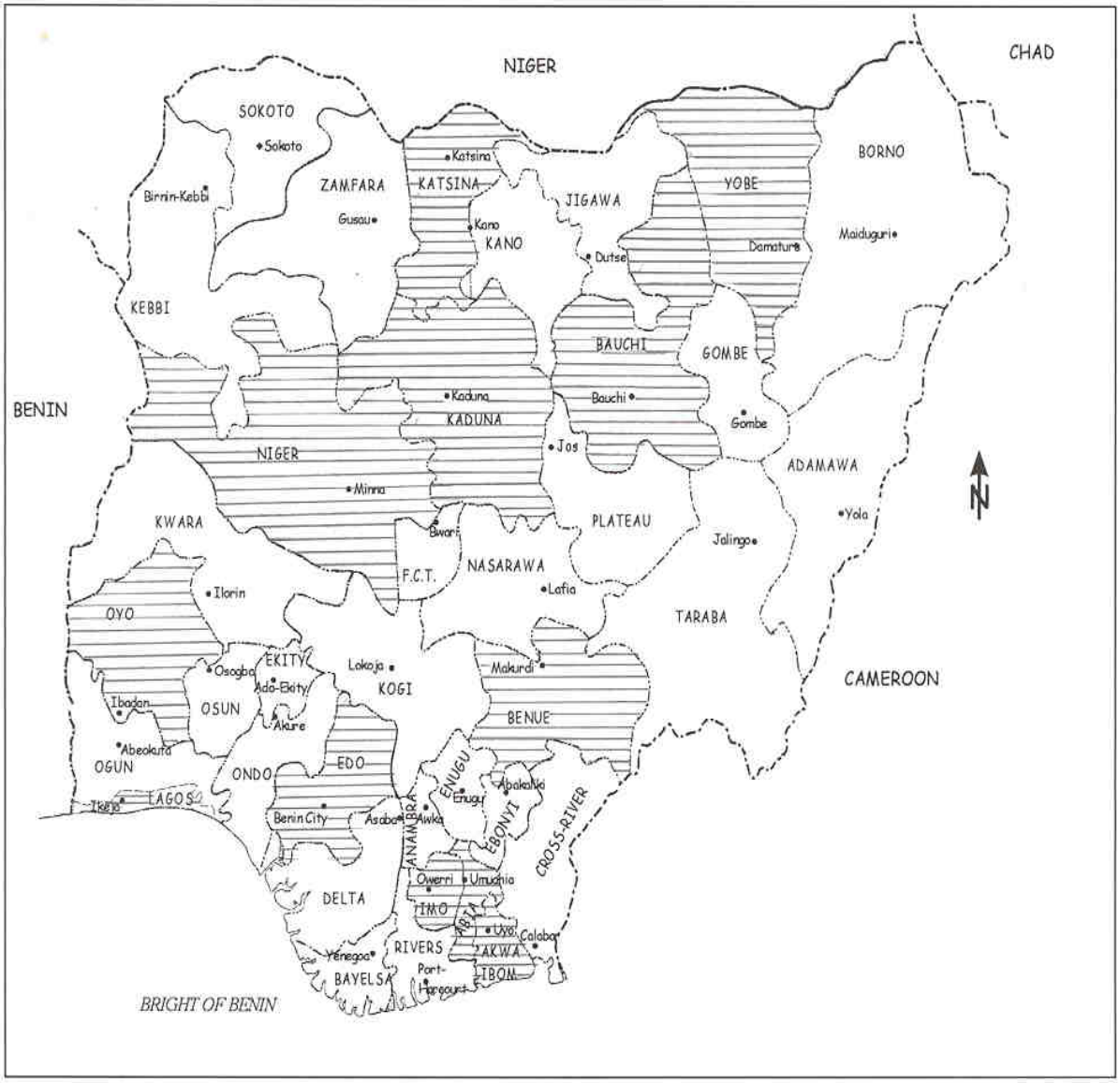
(i) not to change or alter the status, or structure of the Operations Manual except with the prior written approval of the Fund (paragraph 5.2.6);

ii) appointed external auditors acceptable to the Fund within six months of loan effectiveness (paragraph 5.7.2).

ANNEX 1

MAP OF NIGERIA WITH ADF-FINANCED PROJECT AREAS INDICATED

(This map is intended exclusively for the use of the readers of the report to which it is attached. The names used and borders shown do not imply on the part of the Bank and its members any judgement concerning the legal status of a territory nor any approval or acceptance of these borders)



ANNEX II

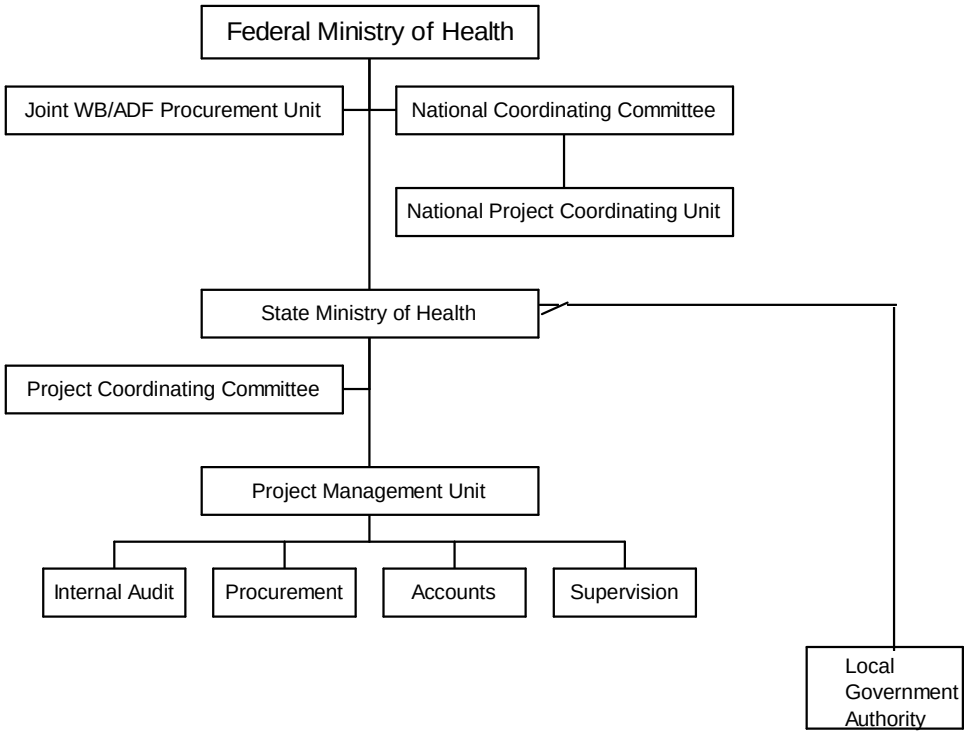
FEDERAL REPUBLIC OF NIGERIA
HEALTH SERVICES REHABILITATION PROJECT
BANK GROUP OPERATIONS IN NIGERIA

SECTOR/PROJECT	Date Approved	Loan Amount (UA Million)	Amount Disb. (UA Million)	% Disbursed
AGRICULTURE				
1. Forestry Development	28/10/86	(ADB) 69.55	36.36	52.3
2. Savannah Sugar Rehabilitation	23/09/91	(ADB) 45.80 (ADF) 6.45	44.68 6.19	97.6 96.1
3. Bacita Sugar Expansion	27/11/90	(ADB) 67.48	60.28	89.3
PUBLIC UTILITIES				
1. Anambra/Ebonyi/Enugu States Infrastructures	21/04/89	(ADB) 81.70	58.42	71.5
2. Ibadan Water Supply II	(ADB) 02/05/91 (ADF) 02/05/91	(ADB) 74.14 (ADF) 3.21	67.16 3.08	86.6 96.1
3. Plateau State Water Supply	(ADB) 02/05/91 (ADF) 02/05/91	(ADB) 90.17 (ADF) 3.83	88.33 2.81	98.0 73.5
4. Muilti-state Water Supply	(ADB) 02/10/92 (ADF) 02/10/92	(ADB) 119.17 (ADF) 14.92	12.00 5.67	34.9 38.0
5. Ibadan Emergency Water Rehabilitation	23/12/86	(ADB) 26.0	15.83	60.9
SOCIAL SECTOR				
1. Kwara/Kogi/Niger States Health	18/12/90	(ADF) 13.08	8.71	66.6
2. Multi-states Health Kaduna/ Kebbi/Sokoto/Ondo/Ogun	02/10/92	(ADF) 55.26	28.02	50.7
MULTI-SECTOR				
1. Community-based Poverty Reduction	02/11/2000	(ADF) 20.0	0	0

FEDERAL REPUBLIC OF NIGERIA ANNEX III

NIGERIA HEALTH SYSTEMS DEVELOPMENT PROJECT (HEALTH IV)

ORGANIGRAMME



ANNEX IV

FEDERAL REPUBLIC OF NIGERIA
HEALTH SYSTEMS DEVELOPMENT PROJECT
SUMMARY OF COST ESTIMATES

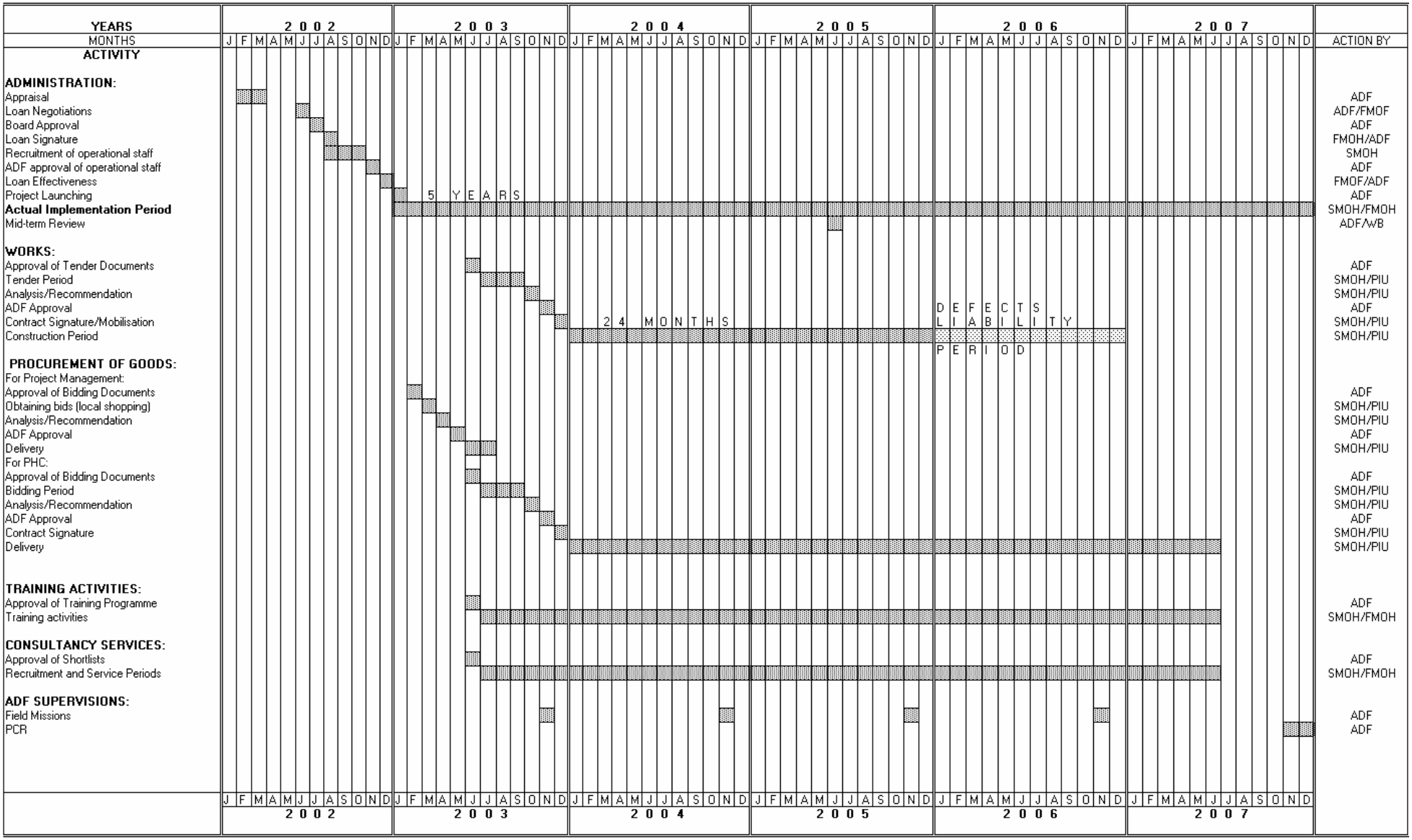
Summary of Cost Estimates										
(in US Dollars - USD)										
CATEGORIES OF EXPENDITURE										
A. Goods	**Unit**	**Nos**	**Unit cost**	**Base cost**	**Phy cont**	**Sub-Total**	**Price cont**	**Total**	**% of F.E.**	**% of Total**
12 States @ 1,400,000 each for procurement of goods	Lot	12	1,400,000	16,800,000	840,000	17,640,000	1,917,783	19,557,783		37.63%
Total: Goods				**16,800,000**	**840,000**	**17,640,000**	**1,917,783**	**19,557,783**	**60%**	37.63%
B. Works	**Unit**	**Nos**	**Unit cost**	**Base cost**	**Phy cont**	**Sub-Total**	**Price cont**	**Total**	**% of F.E.**	**% of Total**
12 States @ 1,225,000 each for rehabilitation of PHC facilities	Lot	12	1,225,000	14,700,000	735,000	15,435,000	1,678,060	17,113,060		32.92%
Total: Works				**14,700,000**	**735,000**	**15,435,000**	**1,678,060**	**17,113,060**	**20%**	32.92%
C. Services	**Unit**	**Nos**	**Unit cost**	**Base cost**	**Phy cont**	**Sub-Total**	**Price cont**	**Total**	**% of F.E.**	**% of Total**
12 States @ 262,500 each for training services	Lot	12	262,500	3,150,000	157,500	3,307,500	359,584	3,667,084	20%	7.05%
12 States @ 262,500 each for consultancy services and T/A	Lot	12	262,500	3,150,000	157,500	3,307,500	359,584	3,667,084	20%	7.05%
T/A for Procurement Unit in Abuja	Lot	5	100,000	500,000	25,000	525,000	57,077	582,077	100%	23.81%
Supervision Consultants	Lot	5	300,000	1,500,000	75,000	1,575,000	171,231	1,746,231	60%	71.43%
Financial Management Consultants	Lot	5	100,000	500,000	25,000	525,000	57,077	582,077	60%	23.81%
Annual Auditing	Lot	5	30,000	150,000	7,500	157,500	17,123	174,623	60%	7.14%
Total: Services				**8,950,000**	**447,500**	**9,397,500**	**1,021,676**	**10,419,176**	**27.0%**	20.04%
D. Operating Costs	**Unit**	**Nos**	**Unit cost**	**Base cost**	**Phy cont**	**Sub-Total**	**Price cont**	**Total**	**% of F.E.**	**% of Total**
12 States @ 175,000 each for project management	Lot	12	175,000	2,100,000	105,000	2,205,000	239,723	2,444,723		100.00%
Total: Operating Costs				**2,100,000**	**105,000**	**2,205,000**	**239,723**	**2,444,723**	**0.0%**	4.70%
E. Miscellaneous	**Unit**	**Nos**	**Unit cost**	**Base cost**	**Phy cont**	**Sub-Total**	**Price cont**	**Total**	**% of F.E.**	**% of Total**
12 States @ 175,000 each for local training activities and workshops	Lot	12	175,000	2,100,000	105,000	2,205,000	239,723	2,444,723		4.70%
Total: Miscellaneous				**2,100,000**	**105,000**	**2,205,000**	**239,723**	**2,444,723**	**20%**	4.70%
SUMMARY COSTS BY CATEGORY				**Base cost**	**Phy cont**	**Sub-Total**	**Price cont**	**Total**	**% of F.E.**	**% of Total**
A. Goods				16,800,000	840,000	17,640,000	1,917,783	19,557,783	**60.0%**	37.63%
B. Works				14,700,000	735,000	15,435,000	1,678,060	17,113,060	**20.0%**	32.92%
C. Services				8,950,000	447,500	9,397,500	1,021,676	10,419,176	**27.0%**	20.04%
D. Operating Costs				2,100,000	105,000	2,205,000	239,723	2,444,723	**0.0%**	4.70%
E. Miscellaneous				2,100,000	105,000	2,205,000	239,723	2,444,723	**20.0%**	4.70%
TOTAL				**44,650,000**	**2,232,500**	**46,882,500**	**5,096,966**	**51,979,466**	**35.5%**	**100.00%**
In UA				**35,948,923**	**1,797,446**	**37,746,369**	**4,103,705**	**41,850,074**		

ANNEX V

FEDERAL REPUBLIC OF NIGERIA

HEALTH SYSTEMS DEVELOPMENT PROJECT

IMPLEMENTATION SCHEDULE



ANNEX VI

FEDERAL REPUBLIC OF NIGERIA

HEALTH SYSTEMS DEVELOPMENT PROJECT
PROVISIONAL LIST OF GOODS AND SERVICES

		- - - - USD (mill.)- - - - -			- - - - - UA (mill.) - - - - -				
	Category	**F.E.**	**L.C.**	**TOT**	**F.E.**	**L.C.**	**TOT**	**ADF**	**GOV**
1.	**Goods:**								
1.1	Procurement of equipment and supplies for 12 States	10.080	6.720	16.800	8.116	5.410	13.526	**10.821**	**2.705**
2.	**Works:**								
2.1	Rehabilitation of PHC facilities in 12 States	2.940	11.760	14.700	2.367	9.468	11.835	**9.468**	**2.367**
3.	**Services:**								
3.1	Consultancy Services and Training Services for 12 States	1.260	5.040	6.300	1.014	4.058	5.072	**5.072**	
3.2	T/A for Procurement Unit in WB Office, Abuja	0.500	0.000	0.500	0.403	0.000	0.403	**0.403**	
3.3	Supervision Consultants (3 firms)	0.900	0.600	1.500	0.725	0.483	1.208	**1.208**	
3.4	Project Financial Management Unit (PMFU)	0.300	0.200	0.500	0.242	0.161	0.403	**0.403**	
3.5	Annual Auditing	0.090	0.060	0.150	0.072	0.048	0.121	**0.121**	
4.	**Operating Costs:**								
4.1	Project implementation costs for 12 States (SMOH/PIUs)	0.000	2.100	2.100	0.000	1.691	1.691	**0.652**	**1.039**
5.	**Miscellaneous:**								
5.1	Local training seminars and workshops for 12 states	0.420	1.680	2.100	0.338	1.353	1.691	**1.691**	
	Base Cost	16.490	28.160	44.650	13.277	22.672	35.949	**29.838**	**6.111**
	Physical Contingencies	0.825	1.408	2.233	0.664	1.134	1.797	**1.492**	**0.306**
	Price Contingencies	1.882	3.215	5.097	1.516	2.588	4.104	**3.406**	**0.698**
	Total Cost	19.197	32.783	51.979	15.456	26.394	41.850	**34.736**	**7.115**

Annexe

CONFIDENTIAL

AFRICAN DEVELOPMENT FUND

ADF/BD/WP/2002/50/Corr.1
04 July 2002
Prepared by: OCSD
Original: English

Probable Date of Board Presentation
TO BE DETERMINED

FOR CONSIDERATION

MEMORANDUM

TO : **THE BOARD OF DIRECTORS**

FROM : **Philibert AFRIKA**
Secretary General

SUBJECT : **NIGERIA : PROPOSAL FOR AN ADF LOAN OF UA 34,740,000 TO FINANCE THE HEALTH SYSTEMS DEVELOPMENT PROJECT (HEALTH IV) – CORRIGENDUM ***

Please find attached a **corrigendum** relating to the above-mentioned Appraisal Report.

Attach:

cc: The President

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

Mrs. Z. EL BAKRI	**Director**	**OCSD**	**Extension 4101**
Mr. R. CRESSMAN	**Division Chief**	**OCSD.1**	**Extension 4112**
Mr. P.J. WILLIAMS	**Principal Health specialist**	**OCSD.1**	**Extension 4772**

SCCD : G.G.

NIGERIA
HEALTH SYSTEMS DEVELOPMENT PROJECT

CORRIGENDUM

1. The institutional arrangements for procurement foreseen in paragraph 5.1.6 in the Appraisal Report were based on the idea of a shared location with the World Bank and the delegation of approval for certain procurement decisions to the Head of the World Bank Procurement Unit in Abuja. This has been replaced by a new arrangement wherein the two Procurement Experts to be recruited under the project will be located in the ADB Nigeria Country Office (NGCO) to assist and advise the NPCU and State PMUs on all procurement and disbursement related matters. This arrangement has been preferred in view of ensuring a greater role for NGCO in project implementation.

2. The two Experts will assist the NPCU and the State SMOHs in the finalization of annual work-plans; annual procurement plans and examine all procurement and disbursement documents to ensure conformity with Bank rules and procedures. This arrangement was agreed by the Federal Government of Nigeria and the World Bank during the successfully completed negotiations of the Loan Agreement in Abuja.

3. Paragraph 5.1.6 to be deleted and paragraph 5.1.7 now becomes 5.1.6

4. Paragraph 5.4.11 introduced to read

   Post Procurement Review

   To facilitate efficient procurement processing, all procurement activities by the States and the NPCU in respect of ADF financing will be examined by the team of two ADF Procurement Experts based in the Nigeria Country Office (NGCO). Approval of procurement activities will be required before any disbursement is made from either the special accounts or direct payment by the Bank. Post review of procurements will be made for expenditure under the categories of Operating Costs and Miscellaneous items not exceeding US$ 50 000 for the following reasons: i) this arrangement will harmonize thresholds of post procurement reviews of the World Bank and ADF so as not to discriminate against any group of beneficiary States under the project; and ii) it is in line with arrangements of previous joint World Bank/ADF operations in Nigeria.