



1. Project Data

Project ID

P163969

Project Name

Huwe

Country

Nigeria

Practice Area(Lead)

Health, Nutrition & Population

L/C/TF Number(s)

TF-A7938

Closing Date (Original)

30-Jun-2021

Total Project Cost (USD)

6,235,405.56

Bank Approval Date

13-Aug-2018

Closing Date (Actual)

30-Jun-2021

IBRD/IDA (USD)
Grants (USD)

Original Commitment

20,000,000.00

20,000,000.00

Revised Commitment

20,000,000.00

20,000,000.00

Actual

11,500,000.00

6,235,405.56

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2. Project Objectives and Components

a. Objectives

The Grant Agreement (GA), p. 5, and Project Appraisal Document (PAD), p. 1, stated the project objective: “to establish the accreditation, verification and payment mechanisms for the operationalization of the Basic Health Care Provision Fund (BHCPF) in the Participating States.” The wording was identical in the GA and PAD.

There were no changes to the objective or to any of the indicators or targets during the project.



b. Were the project objectives/key associated outcome targets revised during implementation?
No

c. Will a split evaluation be undertaken?
No

d. **Components**

The project contained two components:

Component 1: Strengthening Primary Health Care (PHC) services through the Basic Health Care Provision Fund (Appraisal: US\$17 million; Actual: \$5.29 million)

Nigeria's National Health Act (NHA), passed in 2014, had established the legal framework for a Basic Minimum Package of Health Services for all Nigerians, to be financed through the BHCPF, which would channel federal funding to accredited public and private providers. The HUWE project would provide support to set up accreditation, verification and payment systems (Component 2) and would enable the Fund to be operationalized in three states (Abia, Niger and Osun) as a proof-of-concept, piloting the flow of funds from the BHCPF to service providers through the National Health Insurance Scheme (NHIS) and the National Primary Health Care Development Agency (NPHCDA) (Component 1). The participating states were to be selected through a competitive process developed by the Federal Ministry of Health (FMOH) that included: (a) a formal application to pilot BHCPF in the state, (b) demonstration of vested financial investments through the upfront payment of NGN 100 million as "counterpart funding" to be used for supporting BHCPF operations, (c) agreement to use private providers in the delivery of services, and (d) diverse socio-geographic characteristics. The selected states provided a cash transfer and signed a Memorandum of Understanding with the FMOH outlining their rights and responsibilities for participating in the project during project preparation.

Subcomponent 1a: Strengthening service delivery using fee-for-service payments through the NHIS (Appraisal: US\$8.9 million; Actual: \$1.578 million)

Before the project, the NHIS covered mainly government employees. The new system would expand this coverage and use public funds to subsidize high-impact basic health care services for the poorest and most vulnerable Nigerians. Beneficiaries would be selected, verified, and enrolled. They would be able to choose which accredited private or public provider to use, and money would follow the patient.

Public and private facilities would have to meet accreditation criteria in order to become empaneled with the BHCPF. They would then sign a service contract with the State Social Health Insurance Agency (SSHIA) and would be paid at preapproved tariffs for services provided to enrolled beneficiaries. Accredited providers would receive monthly payments based on the number of service bundles provided.

Private sector providers would not be restricted in how they could use the funds received but would be encouraged to use the funding for continuous quality improvement to retain accreditation. Public PHC facilities would be required to use the funds exactly as outlined in the BHCPF Operational Manual (OM), to



strengthen PHC service delivery. There would be rigorous ex-post verification of public facilities' use of funds.

This approach was designed to encourage competition between public and private facilities, improve quality and staff productivity, and provide beneficiaries with a choice of where to access care. However, in the pilot project, only one PHC facility would be selected per ward; competition and choice would come once additional providers were accredited.

Subcomponent 1b: Strengthening service delivery through decentralized facility financing under the NPHCDA (Appraisal: US\$8.1 million; Actual: US\$3.711 million)

Through the NPHCDA, accredited public PHC facilities would receive quarterly grants to complement their operating budgets, in line with an improvement plan that would be monitored closely. Each ward in the pilot would be required to nominate at least one public PHC facility (with a maximum of three) for a baseline assessment by the NPHCDA. A checklist would be used to assess the availability and quality of infrastructure, equipment, services, drugs, and supply chain capabilities; financial management capabilities; health management information systems capabilities; governance structures; staff competencies; and general details of the facility (i.e., catchment area population, opening hours, utilization of services, etc.). The baseline assessment would be used to select a focal PHC facility for the ward. Accredited facilities would receive quarterly payments through the NPHCDA. PHC facilities could use the funds to make upgrades needed for accreditation with the NHIS, which was planned to be more stringent.

The NPHCDA targeted the poor using a geographic approach. Public PHC facilities were the first point of care for the poor, and the scheme aimed to prioritize at least one PHC facility per ward in urban and rural areas. Although the OM states that "all Nigerians shall be eligible for the Basic Minimum Package of Health Services (BMPHS)," in the initial five years of implementation, priority would be given to the rural poor because of the way the allocation formula was set up. Beneficiaries in both funding mechanisms would be given a card that entitled them to access free care for key reproductive, maternal, newborn, and child health and nutrition (RMNCH+N) conditions at accredited facilities.

Component 2. Health systems management strengthening to support BHCPF implementation
(Appraisal: US\$3 million; Actual: US\$882,137)

This component would build and strengthen the institutions and systems needed to implement the BHCPF at the national level (subcomponent 2a) and state level (subcomponent 2b).

Subcomponent 2a: Strengthening the BHCPF national institutions and systems (Appraisal: US\$1.5M; Actual: US\$254,761)

The BHCPF Secretariat was to serve as the Project Coordinating Unit and oversee all BHCPF operations. A National Steering Committee Secretariat (or "BHCPF Secretariat") was to undertake the daily responsibilities of managing the BHCPF, including monitoring and coordinating the activities of the NPHCDA and NHIS through which most of the funds flowed to providers. The project would finance: (a) the operational costs of the Secretariat, including office expenditures; (b) hiring of consultants; (c) technical assistance and capacity building to monitor and coordinate the activities of implementing entities at federal and state levels; (d) establishment of a transparent facility accreditation system to improve quality of care; (e) development and piloting of a verifiable payment and information and communication technology (ICT)



system for the BHCPF; (f) design of a citizen grievance redress mechanism to allow citizens to provide feedback of negative experiences; (g) hiring of external auditors for the project; and (h) staffing of project implementing units within the NPHCDA and NHIS. Accountants would be seconded from the Office of the Accountant General of the Federation (Federal Project Financial Management Division) to monitor the project's fiduciary arrangements.

Subcomponent 2b: Strengthening the performance of state-level implementing agencies
(Appraisal: US\$1.5 million; Actual: US\$627,376)

This subcomponent was to provide operational support and performance frameworks for the state-level agencies responsible for implementing the NHIS and NPHCDA systems. The project would provide the operating costs to enable the SPHCDA (State Primary Health Care Development Agencies) and SSHIAs to implement their functions under the BHCPF. These would include: (a) supervising and mentoring public and private health facilities to meet quality standards; (b) making timely payments to providers; (c) ensuring timely and accurate ex ante verification of quality and quantity of services by providers; and (d) training and orientation of providers on the NPHCDA.

State-level verification would ensure that states and local government authorities would identify one PHC per ward that met all criteria and would complete mandatory capacity building exercises. These agencies would accredit public and private facilities to deliver services of acceptable quality, verify and process claims, and strengthen the supervision and mentoring of public facilities. The project would provide some of the operating costs for the SPHCDA and SSHIAs to implement these functions under the BHCPF, with ad hoc staff support. Their functions would include: a) supervising and mentoring public and private health facilities to meet quality standards; b) ensuring timely and accurate ex-ante and ex-post verification of the quality and quantity of services by providers; and c) the training and orientation of providers on the NPHCDA and NHIS systems.

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

Total project costs were estimated at appraisal at US\$20 million, fully financed by a grant through the Global Financing Facility for Women and Children. No formal contribution was expected from the Borrower. A total of US\$11.5 million was advanced to the Designated Account, but the project disbursed only US\$6,172,069.31, leaving US\$5,327,930.69 to be refunded to the World Bank. The Ministry of Health processed the refunds through the Central Bank ahead of the December 31, 2021 deadline, but procedural errors prevented the transaction from being completed. Reimbursement was more complicated than usual because the funds sat in the Government of Nigeria account rather than in a dedicated project special account. The refund was finally completed on June 30, 2022.

There were several reasons that the project spent much less than expected. Soon after the project became effective, the Ministry of Health made changes to the OM. These changes triggered a suspension in disbursements that was resolved after 8 months. The uncertainty caused by the OM changes, and lower reimbursement rates than those in effect under the NHIS, deterred private providers from seeking to be accredited. These factors, and the disruptions caused by COVID-19, resulted in a considerably lower volume of services reimbursed under the project than expected, and only partial use of the project funds.



Dates: The project was approved on August 13, 2018, signed on October 25, 2018, and became effective on January 17, 2019, within the 90-day deadline specified in the GA (p. 2). The project closed on June 30, 2021, earlier than originally expected. The PAD stated the expected closing date as December 31, 2021, but the GA specified the closing date as June 30, 2022. The project team later explained that it was expected that the accreditation, verification, and payment mechanisms would be set up within the first year of project implementation, and that during the remainder of the project period the system would operate and be monitored and evaluated. A later closing date would also enable sustained supervisory support and application of the usual project fiduciary and other safeguards, and continuity until an expected follow-on project was prepared and appraised. The ICR incorrectly listed the original closing date as June 30, 2021. The project was not restructured.

3. Relevance of Objectives

Rationale

The project was an important step towards implementing Nigeria's ambitious plans to improve primary health care, as explained in the ICR (pp. 5-6). There were serious issues to address. At appraisal, health outcomes in Nigeria were amongst the lowest globally, with large inequalities across income groups and between rural and urban areas. Low spending on health and inefficient use of funds were key contributing factors: government health spending of US\$11 per capita was among the lowest in the world, and most went to secondary and tertiary care facilities, leaving PHC facilities dysfunctional or nonfunctional, even though over 70 percent of the country's disease burden could have been prevented or treated at PHC or community levels. Institutional arrangements for delivering health care were complex and fragmented. Salary payments to providers were often delayed by two or three months. Only a third of publicly owned PHC facilities received any operational funding, leaving them with few basic amenities, equipment, and drugs. Three fourths of PHC facilities reported charging user fees for drugs, delivery services, and antenatal care, all services that were intended to be free. The private sector provided 60 percent of PHC services but was poorly coordinated with the public sector. The NHIS, set up in 2005, covered only 4.2 percent of the population (mainly civil servants), and remained voluntary, with no mechanism to cover the poor.

After a decade of planning and advocacy, the NHA had been passed in 2014. It provided the legal framework for financing a basic package of the most cost-effective services for all Nigerians. This would require a transformation of the PHC system, including changes in the control of funds and accountability across multiple levels of the governance and political system. The federal government launched a three-pronged plan to implement the NHA, of which the project was a central part. The plan included: (a) an OM that spelled out how the BHCPF would be operationalized, with financial accountability and transparency at its core; (b) efforts to gain international backing for the HUWE pilot project to serve as a proof-of-concept and develop the systems needed for nationwide roll-out; and (c) building a coalition among senior government leaders, civil society, the general public, and donors to support the implementation of the BHCPF. The design of the project set out the details of a health reform that persuaded the government in 2018 to finally release the financing of one percent of the Consolidated Revenue Fund approved in the Health Act of 2014 (first through a temporary mechanism, and later through the Statutory Fund) for the BHCPF. The Ministry of Finance (MOF) had been holding off releasing the funds for health because a similar two percent earmarked for education had failed to improve education. MOF was persuaded by the extensive policy dialogue, advocacy from a broad set of stakeholders, the fact that the project would begin to implement the reform while ensuring transparency, and that the additional funds would go to frontline



services and highly cost-effective essential care, giving priority to the poor. This additional one percent was important because it would provide resources over and above those budgeted for the health sector through the "regular" budget process and set up a predictable resource stream to finance operating budgets of PHC facilities (conditional on meeting specific criteria). Fund transfers through this mechanism would have two important features: they would be paid before the regular budget allocation process, which would safeguard them from budget cuts and reallocations across ministries, departments, and agencies; and once transferred, they could be retained, rather than having to be returned to the Treasury if unspent during the fiscal year. This would enable funds to be held in reserve in case claims were higher than the earmark in any year, and these funds could cover services that were reported after the year in which they were delivered.

The project was therefore a crucial step in beginning to implement an important national policy aimed at improving health outcomes, especially among the poorest, improving the efficiency and effectiveness of the health sector, and reducing the barriers to health care and the impoverishing costs of out-of-pocket spending on health care. The government planned to build on what was learned through the HUWE project to then roll out the provision of the basic package to the rest of Nigeria.

The project's objective aligned with the government's policy to expand access to and the quality of primary health care services. The NHA of 2014 codified Nigeria's commitment to improving financing of and access to essential healthcare services, as an important step towards Universal Health Coverage. These goals were reiterated in the National Health Strategic Development Plan 2018-2022 (NHSDP II), which described the BHCPF as the platform for achieving Nigeria's Universal Health Coverage aspirations.

The project was reflected in Nigeria's macroeconomic policies. The project contributed to the second main pillar of the government's Economic Recovery and Growth Plan (ERGP), which included the aim of investing in people through human capital development. The BHCPF also featured prominently in the successor to the ERGP, the Nigeria National Development Plan (2021-2025), which was approved by the Federal Executive Council in December 2021. The BHCPF is included in the government's fiscal sustainability plan approved as the Medium-Term Expenditure Framework (MTEF) (2022-2024). The inclusion of the BHCPF as a statutory transfer in the MTEF is both a fiscal commitment and an accountability device to secure payment for primary health care.

The project aligned fully with the Bank's partnership strategy with Nigeria. The key expected outcome of the project was included in the World Bank's past (FY14–FY17) and current (FY21–FY25) Country Partnership Frameworks (CPF). The current CPF includes improvement of PHC as its third core objective, under the "Investing in Human Capital" pillar. The project's plan to prioritize a package of cost-effective services, with a focus on services for women and children and a mechanism that would target the poor, aligned with the equity and inclusion agenda of the World Bank core goals of reducing poverty and increasing shared prosperity. By targeting public facilities, the project would be inherently pro-poor, because public PHCs are the main source of care for the poor.

Rating

High

4. Achievement of Objectives (Efficacy)



OBJECTIVE 1

Objective

Establish the accreditation, verification and payment mechanisms for the operationalization of the Basic Health Care Provision Fund (BHCPF) in the Participating States

Rationale

The theory of change was that project support for activities to establish the accreditation, verification and payment mechanisms at the national level and in three states would enable the BHCPF to be operationalized and piloted. At the national level, the project would support: the establishment of a small BHCPF Secretariat and financing for its operating costs; design of a poverty-weighted formula for allocating resources to states; and guidelines for states to transfer funds to accredited facilities. Program accounts would be set up through which program funds would flow in a transparent way, consistent with World Bank fiduciary processes. The project would support the participating states to identify one facility in each ward at which baseline assessments would be done, and infrastructure and staff upgraded if necessary. The facilities would be accredited if they met agreed quality and service readiness criteria, including opening a bank account and establishing a Health Facility Management Committee (HFMC) with community representation. Accreditation would enable them to receive additional operational funds through the project, to be spent within program guidelines, to deliver a defined set of essential health services. Facilities would also develop annual quality improvement plans. HFMCs would be trained in management skills, including book-keeping, prioritizing health care needs, workforce motivation, and quality improvement. States would be supported to review facility plans, provide supportive supervision, audit the facility expense statements and accounts, and carry out annual assessments of quality at all participating facilities. States also would be supported to define mechanisms for identifying (a limited number) of poor beneficiaries, who would receive the designated services free. Each SSHIA would be supported to sign contractual agreements with accredited PHC facilities to provide reimbursable defined essential health services to the enrolled beneficiaries. States would be supported to develop mechanisms and procedures for verifying facility claims for reimbursement, including contacting a sample of beneficiaries to verify that services were delivered as reported, and to seek feedback on service quality.

The expected result of establishing the BHCPF was that accredited facilities would provide high-impact PHC and RMNCH+N services that would be free to the poor. Accredited private and public providers would receive timely performance-based payments through the NHIS. The additional financing and improved readiness to deliver services was expected to improve quality, accountability, and transparency in the use of health funding. The expected impact was that the project would enable the program to be rolled out nationally, and that the increased availability and timeliness of financing to providers, especially public PHC facilities, and the availability of subsidized insurance coverage and free essential services would increase utilization of these services, reduce out-of-pocket expenditures, and, in the medium- and longer-term, contribute to improved health outcomes.

Outputs



Institutional Development

The states were required to make an upfront payment of N100 million (US\$330,000) as "counterpart funding" used to set up the governance structure; pay for training at the facility and community level on the new BHCPF operations; finance facility upgrades; and hire new staff. Project funds were used by states to set up State Steering Committees, develop the legal framework for SPHCDA and SSHIA, and build capacity of staff.

SSHIA were set up in all three states. SPHCDA had already been established before the project began.

Management committees with community representation were set up at all the public health facilities in the project area. The ICR explained (p. 31) that a committee member co-signed all PHC plans, budgets, and payments, and that they helped to institutionalize a culture of community participation in the planning and monitoring of the BHCPF, which was expected to help ensure that the decentralized BHCPF program would be adapted to local circumstances.

PHC facilities were enabled to set up bank accounts for the first time and received regular quarterly operating funds.

The project design further increased PHC facilities' accountability to the community by making citizens and providers aware of their entitlements through community sensitization, and by advertising the services beneficiaries were entitled to receive on signs outside the facilities and requiring participating facilities to enable their clients to access a grievance redress mechanism.

Accreditation

A checklist was compiled of the criteria that facilities had to meet to become "accredited" and eligible for funding. Baseline and follow-up assessments were designed and conducted to monitor adherence to these criteria during supervision visits and regular reporting.

At least one PHC facility in each ward was accredited, except for two wards in Niger state where there were severe security challenges in border communities. In total, the NPHCDA accredited 898 public facilities, and 645 of them were also accredited by the NHIS. Initially, the NHIS had planned to set more stringent criteria, but during the project it was decided to use the same criteria to avoid duplication and inefficiency.

Scorecards were developed through which to hold facilities accountable for quality of care.

Identification and verification of beneficiaries

A process was adopted to enroll and verify poor and vulnerable beneficiaries eligible for the care funded through the NHIS. The revised OM called for using the National Social Register to identify beneficiaries, but since states were not fully familiar with the register, they sometimes adopted different identification and revalidation strategies to confirm poverty status using their own data, while giving priority to women of reproductive age and children.

Registered beneficiaries were required to have a National Identification Number (NIN). When the National Identity Management Commission responsible for issuing NINs was found to lack the operational funding and



equipment needed to register project beneficiaries, the project adapted the process to allow SSHIAs to issue their own NINs for the poor and vulnerable.

Verification of facilities' use of funds

Facility staff were supported to develop explicit quarterly work plans (in collaboration with the management committees) to guide the use of funds, and to report on the use of funds. The workplans were approved by the SPHCDA before funding was released. The OM specified that almost all funds were to be used for service delivery. A system to verify that funds were used as intended was set up.

The project improved internal audit and controls for ensuring proper management of resources and detecting and quickly correcting improper use. All public facilities in the project submitted statements of expenses, payments vouchers, and receipts quarterly to SPHCDA. These were collated and audited as part of internal fiduciary safeguards at the state and national implementation levels. The audit verified that these documents showed no more than ten percent deviation from the claims submitted by facilities to the NHIS.

Training in claims verification was completed in December 2019.

Other outputs

The project channeled funds through the Central Bank of Nigeria's (CBN) account (using the Treasury Single Accounts), co-mingling project funds with government funds and funds from the Gates Foundation – the first ever World Bank project to do so. This is important, because it uses a tool for consolidating and managing the government's cash resources that allows traceability of expenditures and fund flows. All funds, including the government funds comingled in the same CBN account, were subject to the same fiduciary standards as a World Bank-financed project.

The project established effective audit systems. First, there was a requirement to undertake external audits by the Office of the Auditor General of the Federation annually. Secondly, the project mandated that an internal auditor provide additional assurances that all fiduciary controls were in place before implementation and disbursement of funds.

The project provided technical assistance to help enable states to use funding provided through other World Bank projects to introduce medium-term expenditure frameworks (MTEFs), which introduced predictability into state budget processes.

Intermediate Results

Ninety percent of health facilities enrolled in the decentralized facility financing payment system received supervision in the final quarter of the project, surpassing the target of 75 percent. Several levels of supportive supervision were put in place, including at the ward, Local Government Area (LGA), state, and national levels, to monitor and hold facilities accountable for conducting activities in line with their work plans.

Management committees with community representation were functioning at 100 percent of the PHC facilities in the project area, exceeding the target of 75 percent.



Outcomes

Accreditation

Accredited facilities were reassessed for quality each year. The indicator for the average health facility quality-of-care score was greatly surpassed. Average scores improved from the baseline of 28 (out of 100) to over 71, well above the target of 43. The target was exceeded in all three states (62 in Niger, 75 in Osun, and 78 in Abia).

Verification

All of the health facilities financed through the fee-for-service mechanism were independently verified to have submitted valid claims (verified as less than a 10 percent discordance from claims), surpassing the target of 90 percent.

74,930 beneficiaries received services financed through the fee-for-service mechanism, not reaching the target of 600,000 beneficiaries.

Payment

The number of public PHC facilities receiving operational expenses via the decentralized facility financing mechanism reached 898, surpassing the target of 800 facilities. In addition, 19 other states also accredited PHCs and began disbursing funds under the same mechanism. This mechanism provides facilities with up-front funding to enable them to deliver services covered by the benefit package, without having to resort to out-of-pocket payments from individuals. It also gives providers autonomy to use resources as needed as long as this is in line with the OM guidelines for eligible expenditures.

The number of accredited facilities receiving payments for services financed through the fee-for-service mechanism was 646, failing to meet the target of 1,000. The disaggregation by public and private showed that the target of 750 public facilities was substantially achieved at 645, but that no private facilities were included, compared to a target of 250.

The ICR (p. 27) listed four main reasons that no private providers were empaneled. When it was decided that the BHCPF should aim to have one accredited health facility per ward, priority was given to public PHCs, and there were limited resources to also accredit a private facility. Second, when the NHIS began paying providers on a per capita basis, a cap was set at 150 beneficiaries per ward. Third, private providers were already receiving N750 per enrollee per year from SSHIAs for existing health insurance enrollees, whereas the BHCPF offered N500 per enrollee for poor beneficiaries enrolled under the project, undermining the incentive for private providers to participate. Fourth, in some parts of the participating states, particularly in remote and rural settlements, there were no private facilities. The project team later explained that the changes that the FMOH made in the OM and subsequent suspension of disbursement left the terms of potential contracts with private providers uncertain and were also an important disincentive (conversation with TTL on 8/26/22).

The target of 950 project facilities receiving on-time payments was substantially achieved, at 898. The shortfall was entirely the result of no private facilities being enrolled in the new mechanisms. The sub-targets



for both kinds of payment to public facilities were surpassed: 795 public fee-for-service facilities received payments on time, compared to the target of 500; and all 898 enrolled public PHC facilities received on-time operational expenses through the decentralized facility financing mechanism, compared to the target of 45.

An important aspect of the project's design was that it would change the criteria for allocating funding from the national to state level from being based on the level of inputs (hospital beds, health personnel, etc.), which tend to be higher in wealthier states, to being based on poverty rates in the region. The federal government adopted this allocation model not only for project funding, but also for government co-mingled funding allocated to the other states. This is intended to help reduce inequality in health care funding.

Impact

The number of outpatient visits per year in the three participating states of Abia, Niger, and Osun increased from a baseline of 294,915 to 1,181,776 in the final year of the project, surpassing the target of one million.

The percentage of children aged 12-23 months who received their Pentavalent 3 vaccination (taking the average in the three states of Abia, Niger, and Osun) increased from 57 percent at baseline to 68.7 percent, exceeding the target of 67 percent.

The number of people who received essential health, nutrition, and population services in participating states reached 945,420, surpassing the target of 850,00. The target number of 650,000 for females was also surpassed, at 756,336. The sub-target of 200,000 for the number of children immunized was also exceeded, at 302,534.

The percentage of births attended by skilled health personnel in the three states increased from 70 percent to 79.5 percent, surpassing the 75 percent target. However, the number of deliveries attended by a skilled attendant of 60,506 did not meet the target of 100,000.

By December 2021, six months after the end of the project, 6,409 facilities had been authorized to receive funds, one in each of 70 percent of the wards in Nigeria, and 5,829 of them had begun to receive funds specifically for service delivery, a significant improvement over the baseline where only a third of publicly owned PHC facilities received any form of operational funding.

The BHCPF program health insurance coverage for the poor had enrolled almost a million people by December 2021, expanding access to services and providing financial protection. The package of essential services included treatment for malaria, which Yamey et. al. (2016) (ICR, p. 62) estimated as having an average cost-benefit ratio of 1:5. The ICR noted that malaria alone accounted for about half of all out-of-pocket spending on health care in Nigeria, and, with 76 percent of all health spending being out-of-pocket in 2018, this could lead to substantial reduction in financial burden on households.

Rating
Substantial



OVERALL EFFICACY

Rationale

The accreditation, verification, and payment mechanisms were fully established for both funding mechanisms supported under the project and were operationalized in public facilities, but not in private facilities. The fact that the program had been scaled up well beyond the initial three pilot states included in the project helps demonstrate that the project went beyond the “proof of concept” goal and enabled the program to begin being rolled out nation-wide.

The ICR (p. 32) noted that the processes and procedures set up under the project were adopted for the national operationalization of the BHCPF. By the time the ICR was written, all 36+1 Nigerian states had started to operationalize the BHCPF through the NPHCDA and NHIS in selected public facilities. Although the project did not engage private sector facilities as planned, the systems and structures were developed to be able to do so.

Many of the results measured by the project indicators were highly project-specific, and thus clearly attributable to the project. The ICR noted that there was “a global coalition to support the implementation of the BHCPF, including the World Bank, the Bill and Melinda Gates Foundation, the Director General of the World Health Organization, Gavi, the Global Fund, and other donor organizations” that contributed to the project results. A prerequisite for the project to become effective was that the OM be completed; this was done with support from the Gates Foundation. However, it can reasonably be assumed that under the counterfactual of what the situation might have been without the project, the ambitious reform program might well not have begun to be implemented. The World Bank played a significant role in advocating for the health reform and helping give strategic direction. The NHA had languished unimplemented for four years because of the failure of the similar two percent budget earmark for education to achieve the expected results. The federal government needed reassurance that the funds for health, if released, would be used well. It is quite likely that the release of the one percent of funds and the significant health reforms in the BMPHS would not have happened without advocacy from the Bank and other stakeholders (including civil society organizations and non-government organizations) and the project, especially the dialogue during project design and preparation, and the health financing analysis that informed the project design. The project team later described the project as “a very small project punching way way above its weight” in impact (discussion with TTL on 8/27/22). Without the project and the fund allocation principles it adopted, it is quite likely that even if the funds had been released, they would have been allocated similarly to other government funding for health – mostly for tertiary care, rather than most of it going to front-line care as ensured by the project.

The project results framework included indicators for increased utilization of essential services. This was an expected impact of removing financial barriers for the poorest citizens, and improving the ability of PHC facilities to deliver essential services and improving the quality of service delivery. The ICR reported substantial increases in service utilization in the pilot states and noted that the increases in services delivered were achieved despite only one PHC facility per ward being accredited, and without the expected contribution of private providers (since the project was unable to accredit any private providers). This increase may have been the result of the project, but the ICR did not present data to support this assumption (such as data showing significantly greater increase in service utilization in facilities that participated in the project compared to facilities that did not), so the service delivery increases cannot be attributed to the project with confidence. Furthermore, although these increases are measured in the results framework and clearly the purpose of the health reform, they were not captured in the PDO as an explicitly stated project objective.



Overall Efficacy Rating

Substantial

5. Efficiency

Ex-ante analysis of efficiency

The PAD (p. 40) provided a qualitative discussion of the reasons the project was expected to be an efficient investment. It noted that the project design was built on the implementation experience of related programs in Nigeria and on extensive analytical and technical work conducted during project design. The design of the BHCPF largely relied on the demonstrated effectiveness of performance-based financing (PBF) in Nigeria through the ongoing federal government implementation of the National States Health Investment Project (US\$315 million, 2012-2020) in several Nigerian states, as well as demonstrated efficiency gains using PBF in Rwanda and Burundi.

The PAD's analysis described three sources of expected efficiency gains of the BHCPF. The first was enhanced allocative efficiency through increased resource allocations to primary care services, especially to the maternal, neonatal, and child health conditions that accounted for 67 percent of the burden of disease in Nigeria and were the leading causes of premature death. The second was an expected increase in technical efficiency expected to come from new increased availability of operational expenses through the decentralized facility financing system that would allow public PHC facilities to stock up on essential commodities and supplies and provide them the enabling environment to do the right things the right way. Furthermore, the accreditation, subsequent enrollment of accredited providers, and service-based mode of payment under the fee-for-service system would create incentives to providers to deliver quality care, since reimbursement would be based on services delivered. Thirdly, a leveraging effect was expected, in which the BHCPF would leverage the existing infrastructure and human resources and mobilize the capacity of private sector providers to deliver high-quality primary care. Public PHC facilities would be incentivized to use their operational expenses to increase the coverage and quality of their services to receive fee-for-service accreditation.

The investments in institutional coordination were expected to improve overall coordination of the health sector and further increase resource efficiency. Finally, because the project would set up mechanisms and processes that would later be used at scale for a nationwide deployment of the BHCPF, the relatively small project investment would generate large gains.

Ex-post analysis of efficiency.

The ICR (pp. 31-33) explained why it judged the project to have achieved high allocative and technical efficiency, and modest implementation efficiency. It did not attempt any quantitative estimate of project returns or efficiency, but it is difficult to see how this could have been done.

The project design was highly efficient (what the ICR called “allocative efficiency”) in funding activities that are cost-effective, and/or have high returns. It focused on financing an explicit package of highly cost-effective interventions to prevent or treat conditions that account for roughly 72 percent of the disease burden in Nigeria, beginning to redress the extreme mismatch between the disease burden and public financing allocations to



health in Nigeria. Annex 4 in the ICR cited typical cost-benefit ratios for some of these interventions ranging from \$3 to \$48 for every \$1 of spending (Yamey et.al., 2016).

The project's modest investment of \$6.2 million leveraged N87.99 billion (~US\$218 million) in domestic funding between the start of the project and December 2021, over and above what was allocated through the regular budget process. In addition to the federal funding through the Service Wide Votes and Statutory Transfers, participating states provided counterpart financing for facility upgrades, hiring of staff, and other investments to improve the functioning of the selected facilities. The project team later stated that they thought it unlikely that the additional national-level funding would have been released without the project and the concerted advocacy by a wide range of stakeholders that helped persuade the MOF that the funds were likely to be spent well (conversation with TTL on 8/26/22), and the additional funds from the states were a condition of their participation in the project.

The project accreditation of PHC facilities and provision of quarterly funding that facilities could use within guidelines to cover basic operating costs improved their ability to deliver the package of basic essential health services in poor, underserved rural communities. This was enhanced by the project investment in quality improvement at PHC facilities through accreditation and improved management and supervision. The project design included an innovative comingling of project funds and government funds and made all funds subject to mechanisms for transparency, accountability, and World Bank fiduciary procedures, which is likely to have enhanced efficiency in the use of those comingled funds.

The TTL noted that the project was able to learn from the failures of the Education Fund that is administered by the Universal Basic Education Commission with a staff of 2,000, and set up a lean administrative structure with a staff of only ten people (conversation with TTL on 8/26/22), an additional element of project design efficiency not noted in the ICR.

Some delays could have been better anticipated by the project; notably, the system for targeting the poor and issuing NINs proved problematic and slowed progress in implementing the NHIS. This, and an understanding of private sector incentives and payment levels, could have used more investigation and discussion during project preparation and appraisal.

The ICR rated **implementation efficiency as modest** because of substantial implementation delays. These included delays in claims verification training and in developing the ICT platform that was intended to be part of the verification mechanism. The ICR noted that many delays were outside the control of the project: the review and changes to the OM and subsequent negotiations over the dissolution and re-constitution of the BHCPF Secretariat and changes in the fiduciary mechanisms; bureaucratic delays in opening facility bank accounts and transferring funds from the federal to state level; and delays because of the low capacity of SSHIAs. The COVID-19 pandemic led to lower volumes of service delivery and inhibited and delayed training and in-person supervision.

The ICR (p. 34) noted that despite the challenges and implementation delays, the project achieved most of its targets, at less cost than expected, and commented that "in this respect, the project was highly efficient in its implementation."

Project implementation was completed within the original project time frame, at about one third of the appraised cost, with most planned activities completed. The main activities not completed were: the ICT platform was not developed; no private providers were accredited; fewer poor beneficiaries were identified and verified than intended; and an evaluation to compare the participating states with "control" states was not done. Most of the



expected institutional and systems/mechanisms development was accomplished (Component 2) at the national and state levels at about half of the appraised cost. Component 1 funding was for PHC facility operating costs and to reimburse providers for service provision; the lower spending than appraised reflects the failure to operationalize the program in the private sector, implementation delays, lower than planned beneficiary identification, and reduced use of health services due to COVID-19.

An important aspect of implementation efficiency is whether activities were done at least cost. No standards or norms are provided by which to judge this, but a total expenditure of \$0.9 million seems modest for setting up and supporting systems and institutions at the national level and in three states and providing training (Component 2). The decision during implementation to use a single accreditation system for both project funding mechanisms rather than using separate standards, criteria, and processes, as originally designed, saved resources and effort (ICR, p. 23). That, and the decision to use the existing government grievance redress mechanism instead of setting up a new mechanism specifically for the health system, also enhanced implementation efficiency. The high cost-effectiveness of the \$5.3 million disbursed (Component 2) on reimbursing selected essential services, and of providing additional operating budgets to accredited PHCs, has already been noted.

The ICR rated the technical efficiency of the project as high because of the measures introduced to improve the efficiency of health expenditures in the country. Although these refer to sectoral efficiency rather than project efficiency per se, it is reasonable to include them in a discussion of efficiency, since they are the intended gains of the health reform for which the project established key implementation processes. Accountability mechanisms were introduced at the facility, ward, and state levels. Quality and functionality of participating PHC facilities was improved. The project piloted a low-cost model of care that channeled most of the funds to the front lines to deliver a package of essential, cost-effective services addressing the easily treatable and preventable conditions that account for a large part of Nigeria's burden of disease. The requirement that all implementing entities maintain financial records of transactions and the audit arrangements should contribute to improved governance, accountability, and transparency, and help ensure that funds are used only for the intended purposes.

The project catalyzed other gains in health system efficiency by beginning a shift in funding allocations away from tertiary care and vertical program towards PHC, and using country systems rather than donor- and program-specific systems. The new ability introduced by the BHCPF to comeingle funds while providing strong fiduciary controls enables better alignment of donor financing with Nigeria's priority health care needs. The major financiers of immunization services in Nigeria, Gavi and the Global Polio Eradication Initiative, explicitly incorporated the BHCPF in their planning.

The overall efficiency rating weighs the substantial design efficiency and the mixed record of implementation efficiency. IEG Guidelines define a modest rating as one that is below the expectations for the sector, and that a project rated as having substantial efficiency must meet the expectations for the sector. Using this metric, on balance, the project efficiency is rated substantial. Despite some clear implementation shortfalls, the project succeeded in achieving most aspects of its PDO well within the appraised cost, and succeeding in setting up the key mechanisms of an important and difficult health reform, and testing them with considerable success in all three pilot states, despite considerable political and technical challenges.

Efficiency Rating

Substantial



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

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

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

6. Outcome

Relevance of objectives is rated High because the project addressed important development challenges, and aligned with country conditions and with current Bank and Government strategies. The achievement of project objectives is rated substantial because the accreditation, verification, and payment mechanisms were set up, and the health reform operationalized in the public sector (although not the private sector). Efficiency is rated Substantial after weighing the efficient, cost-effective, and successful aspects of the project against the delays and difficulties during implementation. Taken together, these ratings reflect only minor shortcomings in the project's preparation, implementation, and achievement, producing an overall Outcome rating of Satisfactory.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

The PDO, as narrowly defined, could be said to have no risk, since the accreditation, verification, and payment mechanisms were in fact established, and the BHCPF was operationalized in the participating states in the public sector (but not the private sector). However, a broader view considers the risks to the mechanisms and BHCPF continuing to operate successfully as designed.

BHCPF financing is secured by being a statutory inter-governmental fiscal transfer from national to subnational entities, and is included in critical government documents, notably the MTEF 2022 – 2024 and the National Development Plan. A new National Health Insurance Law has been signed by the President which makes the BHCPF the key financing arrangement for the poor and vulnerable through the mandatory insurance program.

There are several sources of risk. As a percentage of the government's Consolidated Revenue Fund, the actual amount of financing for the BHCPF declines if total revenues fall, and these revenues have been less than anticipated because of COVID-19 and other global economic shocks. A second key risk is possible future changes to the OM that might weaken the transparent, accountable tracking of funding flows, or weaken the incentives or support for sustained quality improvements. A third key risk is that weak capacity of



institutions could compromise program implementation and performance. In most wards, except for those included in the Nigeria States Health Investment Project, this is the first time that facilities are receiving funds, and there is still low capacity to manage. SSHIAs also require ongoing support to implement social health insurance. There is overall weak capacity for budgeting and planning at the subnational level.

The risk of not sustaining the gains made under the BHCPF is mitigated through ongoing support from the World Bank, the federal government, and other donors. A future World Bank project is expected to provide continued support to national roll out of the BHCPF by further strengthening investments in PHC. The challenges faced in identifying and enrolling poor people in the program are likely to be eased by the establishment of a National Social Registry that is being supported by a World Bank-financed US\$800 million credit for the National Social Safety Net Program Scale-Up (NASSP-SU). It is important to be able to identify the poorest beneficiaries because BHCPF resources are limited, and the federal government has decided to move to a capitation payment mechanism that can cover only a limited number of beneficiaries.

The failure to attract private providers to participate requires attention in the future if the program is to fully realize its potential. Since the project closed, some contracts with private providers have been signed to provide specific services (notably Caesarean sections) that are beyond the capacity of participating PHC facilities (conversation with TTL on 8/26/22).

8. Assessment of Bank Performance

a. Quality-at-Entry

The project addressed important development and health sector challenges in seeking to reorient the allocation of health financing towards cost-effective, essential services addressing the bulk of the burden of disease, improve the quality of PHC and transparency and efficiency in the use of scarce health care resources, and reduce the financial barriers and burdens of out-of-pocket health care spending. It drew on extensive analytic work and experience in Nigeria and globally on output-based financing and health reform. It was fully consistent with the Bank's country assistance strategy. The design benefitted from health financing analysis (Nigeria Health Financing Program: P162108) that also reviewed relevant good practices. The World Bank preparation team included a good skill mix, with expertise in public finance, governance, health financing, and social protection. The OM incorporated good practices from the Nigeria States Health Investment Project and learned from its unsuccessful aspects and from experience in the education sector. The project enabled the federal government to begin to implement its stalled ambitious health reform plans.

The project objective was pragmatic and well-focused, appropriate PDO-level indicators were included in the results framework, and activities were well chosen to achieve the project objective. The project was appropriately selective in its geographic scope, and detailed implementation arrangements were clearly described. The risks were identified and described in detail in the PAD (pp. 35-37), and reasonable measures were identified and planned to mitigate them, including arrangements for flexible and extensive levels of technical assistance.

The team coordinated well with other development partners during project design and throughout implementation. The World Bank helped leverage international partners to commit to the implementation of the BHCPF. The Bill and Melinda Gates foundation released US\$2 million for BHCPF operational



support and purchase of essential health services, and the United Kingdom Foreign, Commonwealth & Development Office pledged about £70M for purchasing essential health services.

The main respects in which project design could have been improved were in the arrangements for identifying beneficiaries; selection of intermediate results indicators to measure progress in project activities rather than impacts (see Section 9a); assessment of incentives and disincentives for private providers to participate; underestimating how long ICT systems take to design and implement; and not arranging for the planned impact evaluation to begin very early in project implementation. In relative terms, these are minor shortcomings in Quality at Entry.

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

The ICR (p. 44) reported that key informants from the state and national implementing entities of the BHCPF considered the quality of the Bank team's technical support and supervision to be outstanding. The task team had a real challenge in resisting changes that a new Minister of Health wanted to make in the OM and working to ensure that the design of the health reform was not compromised. They maintained an ongoing policy dialogue and convened many meetings to increase the visibility of the project and overall BHCPF reform. The Abuja-based team provided direct continuous supervisory support to the national implementing entities. Regular missions were carried out by a state-level health financing specialist to the three states included in the project, in person until COVID constrained these to virtual missions. The team also supported non-project states when the government of Nigeria began scaling the program nationwide, soon after implementation began. They helped the BHCPF Secretariat to train all heads of agencies in all states and explain the rationale for the design of the BHCPF, using Health Financing Program ASA support. Two workshops were held over five days each in Abuja, sharing lessons from the pilot states. The team also held a "Lessons Learned" workshop with government officials to reflect on the lessons and discuss opportunities and potential challenges facing the agencies with the nationwide roll-out.

There were no changes in the TTL during project preparation and implementation. Missions included highly qualified World Bank experts to advise on fiduciary management (financial management (FM) and procurement), environmental safeguards, and social protection/targeting of beneficiaries. The ICR noted that Implementation Status and Results Reports (ISRs) were timely, and aides-memoire or back-to-office reports for each mission provided a clear picture of project progress. Quarterly reviews and Integrated Supportive Supervision at the LGA and state levels helped monitor project progress and enabled timely corrective action.

The ICR identified two minor shortcomings in the quality of supervision. The final ISR reported data for all states, instead of only the three project states. It attributed the long delay in the repayment of undisbursed project funds to inadequate communication about transition arrangements at the end of the project (ICR, p. 44). No mid-term review was held because of the disruption to project implementation when disbursement was halted in response to the dissolution of the BHCPF Secretariat and changes made to the OM that were not agreed to by the World Bank.



The quality of World Bank supervision is rated as Satisfactory because of the reported high quality of support offered to the government during implementation, strong supervision, and innovation employed throughout the project. Due to the significant amount of work and the strategic relevance of the project to the client, the World Bank continues to lead the development support to the Government of Nigeria on the implementation of the BHCPF.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The positive features of M&E design were that the PDO was specific, well-focused, and consistent with the design of the project; the theory of change was sound; and a manageable number of clearly defined indicators was chosen to track project activities and results, and these met the "SMART" criteria. The results framework included baseline and target values for all indicators, data sources, and frequency and clearly specified responsibility for data collection. The indicators used a mix of existing sources of data and new mechanisms to monitor the quality of PHC services and flow of funds. The M&E system put mechanisms in place for using data for course-correction and scale-up. The design included third-party monitoring and verification of data by an external auditor. The project planned an impact evaluation in which the three pilot states would be compared with three matched control states, to assess the effectiveness and efficiency of the BHCPF. This evaluation was expected to use existing household and health facility surveys as well as data that would be collected specifically for the evaluation and was planned to be contracted to an independent firm. The PAD did not comment on how this impact evaluation would be funded.

The ICR (p. 40) identified several shortcomings in M&E design. More process-level indicators such as "number of facilities accredited" or "number of facilities that have opened bank accounts" could have helped to monitor whether the pilot was on track. The theory of change could have more clearly shown the pathways through which the project was expected to change the health system, especially for people unfamiliar with health reform details, and the expected long-term outcomes, including increased public financing for health and more efficient use of financing. Three other shortcomings can be added to the list. No arrangements seem to have been included to ensure timely collection of baseline data for the impact evaluation. Although the PDO had the virtue of being specific and consistent with the project design, it was relatively limited in scope. Finally, some of the indicators included as measuring intermediate results measured impact, much further along the results chain.



b. M&E Implementation

The ICR listed many strengths in M&E implementation. Most of the data needed for project monitoring were collected, collated, and analyzed by the respective national and state implementing agencies, and by LGA authorities, both in real time and during integrated supportive supervision visits. The project had intended to track health outcomes using the 2019 SMART survey, but results of SMART were rejected by the World Bank when operational gaps were identified. Instead, the project team used multiple data sources for health indicators through the Federal Ministry of Health Multi-Source Data Analytics and Triangulation Platform, which includes data from surveys and routine monthly data from the Nigeria Health Management Information System. The project strengthened supervision across state, LGA, and facility levels, and the supervisory function included clearly defined M&E roles. For example, all facilities underwent a baseline survey before accreditation, and this was repeated over time.

The main M&E shortcoming identified in the ICR was delayed implementation, which affected the establishment and timely use of M&E systems; for example, the National District Health Information System created a module to track all the indicators used in the BHCPF, but the indicators were incorporated later than planned. The ICR also noted that the final ISR included data from states other than the three project states, whereas the results framework and PAD and Grant Agreement referred only to the three states of Abia State, Niger State and Osun State. The impact evaluation was not done, although the project team later explained that the early start to the country-wide roll-out would have made it impossible to find matched states as controls as intended in the IE design (conversation with TTL on 8/26/22).

c. M&E Utilization

The ICR (p. 41) noted substantial use of M&E data during project implementation. The World Bank and government teams regularly monitored the results framework and used the information to communicate progress to decision makers and inform implementation. The BHCPF-Ministerial Oversight Committee (MOC), NHIS, NPHCDA, State Implementing Entities, and HFMCs used data to monitor performance and identify areas for additional operational support. Quarterly reports provided real time data to monitor the level and quality of service delivery at facilities, sometimes catalyzing additional operational support. At the national level, NPHCDA and NHIS presented collated reports quarterly to the MOC; similarly, state level agencies reported quarterly. On the NHIS gateway, monthly client utilization records were used to validate the capitation payments and monitor signs of over-utilization risk and actuarial validation. The ICR also said that these data were used by the World Bank to assess progress and make decisions or design corrective actions, but it did not offer specific examples.

Data on progress of the three project states (and other states once the roll-out began) were presented regularly to the Nigerian Legislature, the State Executive Council, and development partners and donor groups as part of advocacy for improved resource mobilization for BHCPF implementation.

M&E Quality Rating

Substantial

10. Other Issues



a. Safeguards

The project was classified as a Category B project, with low social and environmental risk, as project activities were considered likely to have minimal or no adverse social impacts. Operational Policy (OP) 4.01 on Environmental Assessment was triggered by the potential environmental concerns around the handling of health care waste resulting from project-related activities such as immunizations. The Environmental and Social Management Framework was disclosed on March 26, 2018, and the FMOH updated and disclosed its health care waste management plan in-country in March 2018 and on the World Bank website in May 2018. Implementation Status Reports (ISRs) consistently rated safeguards compliance in the satisfactory range.

The PAD included plans for a grievance redress mechanism (GRM), which the ICR (p. 41) described in some detail as functioning well, with grievances and complaints channeled through GRM committees at facilities and state implementing entities, those related to beneficiary identification and targeting adequately addressed on the NHIS gateway, and continuous case management throughout the project implementation allowing verification and addressing of appealing households' cases. It concluded that "the project had a good record of GRM utilization and response." However, the TTL noted that although many facilities signed on to the existing federal government GRM "Servicom," they did not post the hotline numbers or other information about how to submit a complaint (conversation with TTL on 8/26/22).

b. Fiduciary Compliance

The financial management arrangements of the project were assessed as Moderately Satisfactory at closing and fiduciary risks rated as moderate. In the first year of project implementation, the BHCPF Secretariat was dissolved, which meant there were no officers from the Office of the Accountant General to document expenditures in Client Connection. Once the BHCPF Secretariat was reconstituted, all backlogged and new expenses were uploaded. Financial management compliance continued to improve steadily until the project became fully compliant.

Procurement under the BHCPF followed the World Bank and National Procurement Procedures. Contracts administrations were reliable, timely, and transparent. At the facility level, procurements were according to business plans, and HFMCs met weekly to review contract administration. State implementing entities' oversight of procurement at PHC facilities improved reliability and transparency. There were some problems with procurement performance during project implementation, including delays in preparing and processing procurement and glitches (like a failure to enter documentation in the Systematic Tracking of Exchange in Procurement system), that were resolved by the end of the project.

c. Unintended impacts (Positive or Negative)

None reported.



d. Other

11. Ratings

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

12. Lessons

These lessons are drawn from the ICR, pp. 46-48, and restated by IEG.

1. Health sector reforms often disrupt the status quo and so have supporters and opponents; the political economy of reform is challenging and needs careful and sustained attention.

The BHCPF changed the way resources flow from the national to subnational level and how they are distributed to states and agencies, and introduced new levels of transparency and accountability. It strengthened incentives for performance and value-for-money at multiple levels, especially at PHC facilities. Many of the changes created political challenges, which caused delays in getting the Operational Manual approved, and then efforts to make changes. Turnover in political positions can change priorities, and sustained advocacy by stakeholders who support the reforms may be needed. The broader and more visible the coalition of support, the more likely it is that the reform will be protected. Health reform projects need to include careful analysis of the politics of the reforms, understand where opposition might come from, and be aware of political cycles and the possible impact on project implementation. The HUWE project showed the value of including safeguards in the grant agreement against policy changes that could undermine the intent or principles of the reform, and the importance of sustained, strong engagement by civil society and health advocates at every stage of the reform.

2. Health reforms have many aspects -- financing, governance, management, organization, payment/incentives for providers, and behavioral responses by providers and users (in addition to the political aspects commented on above) -- and they all need to be considered, as changes in one or more aspects can have important implication for other aspects.

The operationalization of the BHCPF supported mobilization of additional public financing from the federal government in a way that holds subnational levels accountable for using funds and establishes incentives for better quality, more targeted care. The Statutory Transfer ensured predictability and allowed a shift towards strategic purchasing and output-based payment. The increased financing needed to result in increased and improved delivery of services, which required changes in the way service priorities were set, planned, managed, and supervised; new incentives



to providers in the way services were delivered; and incentives to beneficiaries to make greater use of available essential services.

3. Beneficiary identification and targeting mechanisms need careful planning.

The project faced delays because of the lack of a common beneficiary identification program and inadequate guidance to states. World Bank-financed operations in health may need to work closely with colleagues in social protection to strengthen identification and targeting systems to better identify the intended target beneficiaries, especially if resource or other constraints require stringent selectivity. If the expectation is that a national poverty registry or other existing targeting mechanism or safety net program records will be used, a detailed appraisal or pilot is likely to be useful to check whether the records/data are adequate and up-to-date enough, and if not, to make plans for alternative mechanisms for beneficiary identification and selection.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was clear, well written, and very thorough (although long). It provided a comprehensive account of the project's context and design, the logic and importance of the health reform, project implementation, and results. The theory of change was well developed and especially helpful for readers unfamiliar with health reform. It mostly followed guidelines (exceptions noted below). The lessons and recommendations were thoughtfully selected.

Annex 1 Table B is supposed to list key outputs by component. Instead, it merely listed the indicators. This is a common shortcoming in ICRs. The Annex 3 project funding summary table was incomplete; instead of showing the actual amounts disbursed for each line, the table repeated the appraised amounts. There was no discussion of the reliability of the data on project results, or the extent to which results were likely to be attributable to the project.

a. Quality of ICR Rating

Substantial

