



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 08-May-2018 | Report No: PIDISDSA24172



BASIC INFORMATION

A. Basic Project Data

Country Nigeria	Project ID P163969	Project Name BASIC HEALTHCARE PROVISION FUND PROJECT (HUWE PROJECT)	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 19-Jan-2018	Estimated Board Date 28-May-2018	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Federal Ministry of Finance	Implementing Agency Federal Ministry of Health	

Proposed Development Objective(s)

The project development objective (PDO) is to strengthen health system management for the operationalization of the Basic Health Care Provision Fund in selected states.

Components

Strengthening PHC services through BHCPF
Health systems management strengthening to support BHCPF implementation

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	20.00
Total Financing	20.00
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	20.00
Global Financing Facility	20.00



Environmental Assessment Category

B-Partial Assessment

Decision



Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Despite robust economic growth in the last decade, government revenues are limited.** The Nigerian economy experienced relatively healthy economic growth rates over the past decade. However, a global decline in oil prices helped cause a recession between 2015 and the first quarter of 2017. The recent recovery in the economy has been driven by recovering oil production and modest growth in non-oil industry and agriculture. Even during the period of growth however, government tax collection amounted to less than 6% of GDP, among the lowest rates in the world. This partly explains why investments in the social sectors, including health, remained modest.

Sectoral and Institutional Context

2. **Crisis in health outcomes in Nigeria:** Nigeria did not come close to achieving MDG4 (reduction in under 5 mortality), Improvements seen in under-five mortality in previous years have slowed considerably, and remains unacceptably high at 120 per 1000 live births in 2016 while infant mortality rate is at 70 per 1,000 live births¹. (See Table 1). There has been no discernable progress made on the maternal mortality ratio which remains high at 576 per 100,000 live births or childhood stunting (low height for age). The country is not on track to meet SDG3.

TABLE 1: HNP OUTCOMES IN NIGERIA 2003-2016

Outcome Indicators	Nigeria				SSA
	2003	2008	2013	2016	2016
Under 5 mortality rate per 1000 births	201	157	128	120	78
Infant mortality rate per 1000 births	100	75	69	70	53
Maternal mortality ratio per 100,000 live births		545	576	576	547
Total Fertility Rate (children per woman)	5.7	5.7	5.5	5.8	4.9
Stunting, Height for age (<-2SD) %	42	41	37	44	34
Low weight for age (<-2SD) %	24	23	29	32	19
Wasting, Weight for height (<-2SD)	11	14	18	11	8

Source: Nigeria Demographic and Health Surveys 2003-2013 and MICS 2016-17. Sub-Saharan Africa (SSA) data is from World Development Indicators and is for 2015-2016. The data are not strictly comparable and SSA data is just illustrative.

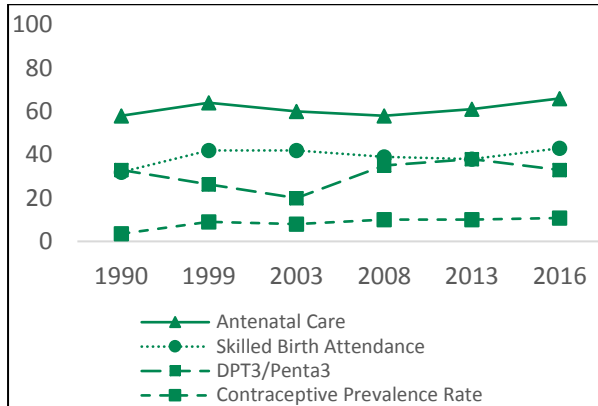
3. **No progress in service delivery; immunization coverage has worsened:** There has been no progress in services such as family planning, antenatal care, and skilled birth attendance, and these services are at levels lower than that of poorer neighboring countries. Immunization coverage has recently worsened—only 33% of the children have received three doses of pentavalent vaccine (Penta3) as of 2016 (Figure 1) down from 38% in 2013. There has been no

¹ National Bureau of Statistics (NBS), & United Nations Children’s Fund (UNICEF). (2017). *Multiple Indicator Cluster Survey, 2016-17. Survey Finding Report*. Abuja, Nigeria: National Bureau of Statistics and United Nations Children’s Fund.



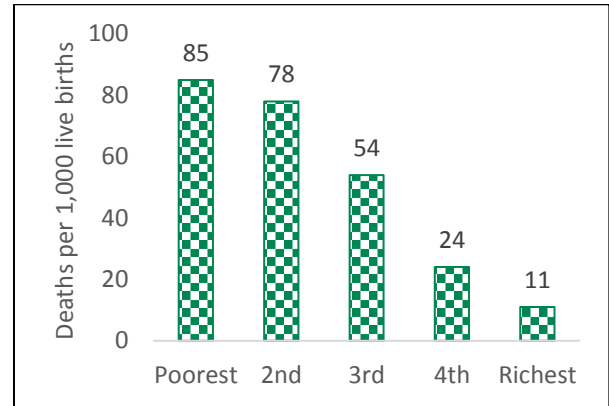
progress in modern contraceptive prevalence rate (mCPR) in the last fifteen years, with mCPR at 13%, below the SSA average of 24%².

FIGURE 1 TRENDS IN HEALTH SERVICE DELIVERY IN NIGERIA 1990-2016



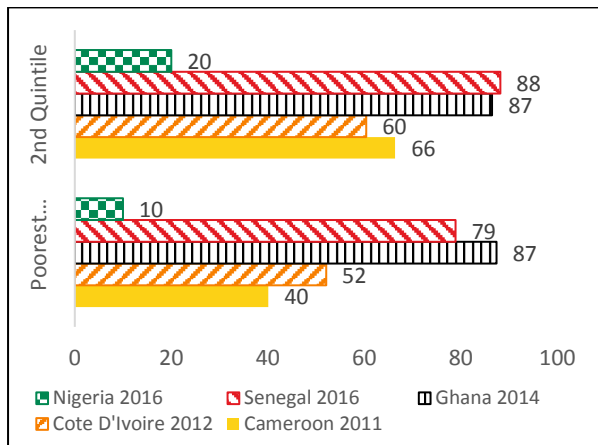
Sources: NDHS 1990, 1999, 2003, 2008, 2013 & MICS 2016-17

FIGURE 2 CHILD MORTALITY RATE BY WEALTH QUINTILES IN NIGERIA 2016-17



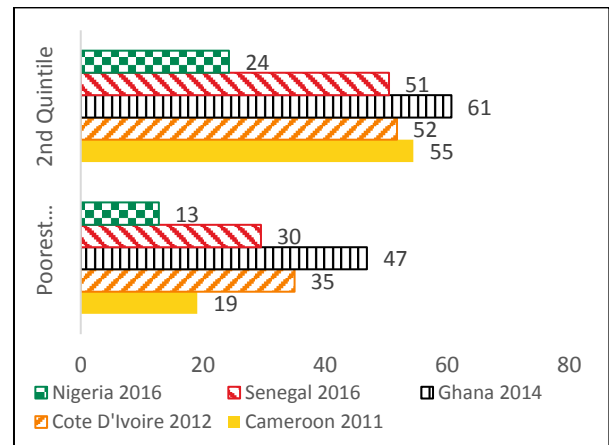
Note: The aggregate child mortality (probability of dying between first and fifth birthday) for Nigeria is 54 deaths per 1000 live births. Source: MICS 2016-17

FIGURE 3 PENTA3 VACCINATION COVERAGE (%) FOR TWO POOREST QUINTILES IN WEST AFRICA



Source: Latest Demographic and Health Survey & MICS 2016 for Nigeria

FIGURE 4 SKILLED BIRTH ATTENDANCE IN THE TWO POOREST INCOME QUINTILES



Source: Latest Demographic and Health Survey & MICS 2016 for Nigeria

² FP 2020, Mid-Term Review, 2016



4. **Grave inequities in health:** Nigeria is the worst place in West Africa to be a poor mother or a poor child. Poor Nigerian children are almost 8 times more likely to die after infancy as compared to children from rich households (see Figure 2). Vaccination coverage among the poorest children in Nigeria is four to nine times lower than neighboring countries like Ghana, Senegal, and Cote D’Ivoire (Figure 3). Similarly, skilled birth attendance in the two poorest quintiles in Nigeria is considerably lower as compared to its neighboring countries with lower GDP per capita (Figure 4).

5. **Government investment in health in Nigeria is one of the lowest in the world.** Investments in the health sector have been consistently low over the last two decades compared to countries of similar economic status³. Despite having a lower GDP per capita than Nigeria, Ghana and Kenya spend considerably more on publicly funded healthcare (Table 2). In 2014, total government health expenditure in Nigeria was 2.2% of total government expenditure, Evidence from the National Health Accounts suggests that on average, most states spend less than 5% of their total expenditure on health.

TABLE 2: HEALTH FINANCING INDICATORS IN AFRICA ⁴

	Nigeria	Ghana	Kenya	Africa
Public expenditure on health as a share of GDP (%)	1	2	4	3
Public expenditure on health as a share of Total Health Expenditure (THE) (%)	25	60	61	51
Out of pocket expenditure as a share of THE (%)	72	27	26	32

6. **High out-of-pocket expenditures for health are further impoverishing Nigerians.** Nigerians face catastrophic healthcare payments due to high out-of-pocket expenditures. Government investments make up only 25% of total health financing, because of which health spending in Nigeria is dominated by out-of-pocket (OOP) expenditures. OOP expenditures account for 72% of the total health expenditures in Nigeria which is much higher than the regional average. As a result, 25% of Nigerians face catastrophic health expenditures defined as exceeding 10% of their total consumption or income. By comparison, Africa had a 1.4% rate of impoverishment⁵ due to catastrophic health expenditures in 2010.

7. **Misallocation of government spending on health—Neglected Primary Care:** Healthcare utilization in Nigeria is the highest at primary level, but government spending is highest at secondary and tertiary levels. Poorest households in Nigeria are more likely to use Primary Health Care Centers (PHCCs) rather than secondary facilities—27 percent of patients in PHCCs are from the poorest quintile whereas 31 percent of the patients in secondary hospitals are from the richest quintile. However, government spending on health is focused on secondary and tertiary hospitals—78 percent of all government spending on health is on secondary and tertiary health facilities.

³ World Bank. (2017). *World Development Indicators 2017*. Washington, D.C.: World Bank.

⁴ World Health Organization. (2016). Public financing for health in Africa: from Abuja to the SDGs.

⁵ As measured by the \$1.90-a-day poverty line



8. **Primary health facilities lack operational funds which affects their readiness.** Only a third of public facilities in Nigeria receive any form of cash grant to meet their operational costs⁶, and public primary care is currently characterized by frequent drug and vaccine stock outs, lack of equipment, and almost no maintenance of physical facilities. Part of the problem is that state and local governments (LGAs) rarely prioritize the financing of PHC. In addition, almost no⁷ financial resources are directly managed at the facility level.

9. **Weak accountability mechanisms constrain the delivery of primary healthcare services:** The complex institutional set up of the health system is compounded by a number of issues that contribute to the weak accountability and poor performance of the PHC system: (i) health workers are simply paid salaries which provide no incentive to increase the quantity or quality of care; (ii) salaries are on average more than 3 months in arrears and are often not paid in full which makes it harder for managers to instill discipline; (iii) supervision is infrequent and is not systematic; and (iv) data on results are rarely published and are infrequently used for management purposes.

10. **The private sector has been ignored, despite it being a major provider of primary care.** The private health sector constitutes about 38% of the health facilities in the country and provides about 60% of the health care services⁸. 53 % of children with fever are treated by private providers while 35 % of skilled birth attendance and 55 % of family planning services are provided by the private sector⁹. Despite being an important source of primary healthcare, the government rarely interacts with it and there is little constructive engagement.

11. **Nigeria can do better because it has done better:** Nigeria can rapidly improve PHC performance by learning from the experience of performance-based financing (PBF) and Decentralized facility financing (DFF) approaches (See Box 1) being implemented under the Nigeria State Health Investment Project (NSHIP).

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective (PDO) is to strengthen health system management for the operationalization of the Basic Health Care Provision Fund in selected states.

Key Results

Progress towards the key project results and attainment of the PDO will be measured through the following indicators:

⁶ National Health Facility Survey 2016

⁷ except in some states where Drug Revolving Funds (DRFs) have been established or where user charges are collected

⁸ Oyibocho, E. O., Irinoye, O., Sagua, E. O., Ogunjide-Essien, O. T., Edeki, J. E., & Okome, O. L. (2014). Sustainable Healthcare System in Nigeria: Vision, Strategies and Challenges. *Journal of Economics and Finance*, 5(2), 28–39.

⁹ MICs 2016/17; NDHS 2013



- (i) Number of accredited facilities receiving payments for services financed through the Fee-for-Service (FFS) mechanism, disaggregated by public and private
- (ii) Number of public primary health centers receiving operational expenses via Decentralized Facility Financing (DFF) mechanism
- (iii) Percentage of health facilities financed through the FFS mechanism whose claims are found to be valid (less than 10% discordant from their claims) as independently verified
- (iv) Average health facility quality-of-care score
- (v) The number of beneficiaries receiving services financed through the FFS mechanism

D. Project Description

12. The Project will finance the early implementation of the BHCPF in 3 states of the Federation. Based on the lessons learned it is envisaged that the Federal Government will provide most of the financing for the nationwide scale-up of the BHCPF. The project will finance two components: Component 1: payments for service delivery through the FFS mechanism (NHIS gateway) and DFF mechanism (NPHCDA Gateway); and Component 2: health systems management strengthening to support BHCPF implementation. The project is like setting up a plumbing system and putting in water to see if the pipes are patent, don't leak, and the water arrives at the end-user.

E. Implementation

Institutional and Implementation Arrangements

13. Implementation arrangements for the Project will be fully streamlined into the existing government structures at the federal, state and local government levels. Additional technical assistance and coordination support will be provided through the project to strengthen implementation. The arrangements involve: (i) The National Steering Committee (NSC) of the BHCPF for overall coordination of project funds; (ii) The Secretariat of the National Steering Committee (Secretariat); (iii) coordination and implementation offices at the state level (SPHCDA, SSHIAs and SPFMU); and (iv) implementation at the level of private and public PHC facilities. Across all these, significant coordination with line ministries and civil society will be included.

14. **The National Steering Committee of the BHCPF:** Project oversight will be provided is provided by the NSC with representation from federal, state and local government institutions and members of civil society. The NSC is responsible for overall monitoring of project implementation by the project teams and various contracting agents.

15. **The Secretariat of the National Steering Committee Will Oversee BHCPF Implementation:** The Secretariat is a body set up in line with the approved BHCPF guidelines. The Secretariat will serve as the PMU and oversee the day to day running of the BHCPF and coordinate the activities of the two gateways involved in the proposed Project. It reports to the NSC. Its role can be broadly divided into five areas: (i) execution of contract with participating states through a global agreement (ii) oversight of the verification and audit process; (iii) oversight and guidance on the implementation of BHCPF management guidelines, development of protocols, manuals, and service delivery guidelines and their revision based upon implementation experience; (iv) management of the information technology (IT) base for the project; and



(v) oversight of operations research and impact evaluation. Carrying out these functions will require formulation of annual work plans, budgets, training plans, procurement plans, M&E, grievance mechanisms, technical support to States, and stakeholder engagement, etc.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project will be implemented in three states of the federation namely Niger, Osun and Abia states with central coordination from the Federal government . The following observations are made: The Project is not envisaged to cause any potential large scale, significant and /or irreversible impacts. There is no potential indirect or long-term impacts due to anticipated future activities in the project area. There are no major civil works envisaged on the project, such as new constructions or significant rehabilitation of existing buildings in the three participating States. However, minor rehabilitation repairs such as painting, plastering, replacing doors/windows, leaking roofs in public primary healthcare facilities will occur in existing buildings and health facilities. No land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind are planned under the Project.

G. Environmental and Social Safeguards Specialists on the Team

Joseph Ese Akpokodje, Environmental Safeguards Specialist
Michael Gboyega Ilesanmi, Social Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The services being funded by the Project, for eg. vaccination, skilled birth attendance, curative services for under-five, etc. are potentially significant sources of waste generation, especially through expired vaccines and medications due to poor stock management and cold chain. However, in the context of Nigeria this is of modest environmental concern since the volume of waste from wasted vaccine vials, medications and diagnostics is small and because sterilized vaccines,



and packaged medications do not present a public health or environmental risk.

The project is not envisaged to involve any major civil works, such as new constructions or significant rehabilitation of existing buildings in the three participating States. However, minor rehabilitation repairs such as painting, plastering, replacing doors/windows, leaking roofs, will occur in existing buildings and health facilities. The exact locations and numbers of health facilities are not yet known and therefore the ESMF prepared details processes and procedures to be followed to ensure that the potential adverse impacts. The ESMF is aligned to the approved National Healthcare Waste Management Plan and Guidelines for Nigeria.

An Environmental and Social Management Framework (ESMF), and a Health Care Waste Management (HCWM) Plan have been prepared and publicly disclosed by the Borrower.

Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	No physical activities and no impact on Natural habitats.
Forests OP/BP 4.36	No	No physical activities and no impacts on forests
Pest Management OP 4.09	No	The project will not utilize pesticides
Physical Cultural Resources OP/BP 4.11	No	This project will not be implemented in areas of physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the Project location
Involuntary Resettlement OP/BP 4.12	No	The Project does not involve nor will it finance land acquisition.
Safety of Dams OP/BP 4.37	No	This project will not support dam activities.
Projects on International Waterways OP/BP 7.50	No	This project will not support activities in international waterways
Projects in Disputed Areas OP/BP 7.60	No	This project will not be implemented in a disputed area.



KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The Project is not envisaged to cause any potential large scale, significant and /or irreversible impacts.

The environmental risks and the environmental category of this project is B due to medical waste disposal. Overall environmental impact of the Project is likely to be positive as the health facilities that will be enrolled in the Project will benefit from the and a Health Care Waste Management (HCWM) Plan developed under this Project.

The services being funded by the Project, for eg. vaccination, skilled birth attendance, curative services for under-five, etc. are potentially significant sources of waste generation, especially through expired vaccines and medications due to poor stock management and cold chain. However, in the context of Nigeria this is of modest environmental concern since the volume of waste from wasted vaccine vials, medications and diagnostics is small and because sterilized vaccines, and packaged medications do not present a public health or environmental risk.

The project is not envisaged to involve any major civil works, such as new constructions or significant rehabilitation of existing buildings in the three participating States. However, minor rehabilitation repairs such as painting, plastering, replacing doors/windows, leaking roofs, will occur in existing buildings and health facilities. The exact locations and numbers of health facilities are not yet known and therefore the ESMF prepared details processes and procedures to be followed to ensure that the potential adverse impacts. The ESMF is aligned to the approved National Healthcare Waste Management Plan and Guidelines for Nigeria.

An Environmental and Social Management Framework (ESMF), and a Health Care Waste Management (HCWM) Plan have been prepared and publicly disclosed by the Borrower.

The overall social impacts of the Project are likely to be positive due to projected (i) increased utilization of services targeted towards rural areas, and (ii) financial protection offered under the FFS gateway to beneficiaries. No land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind are envisaged under the Project.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

There is no potential indirect or long-term impacts due to anticipated future activities in the project area.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

Not applicable.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

NATIONAL: Nigeria has demonstrated its commitment to mitigating adverse social and environmental impacts in the



implementation of a range of World Bank projects. There are adequate legal and institutional frameworks in the country to ensure compliance with World Bank safeguards policies. On September 4, 2013, the Nigerian Federal Executive Council (FEC) approved a new National Strategic Healthcare Waste Management policy, including National Strategic Healthcare Waste Management Plan and Guideline for the country. The fact that Ministers of Environment and Health jointly presented the memo seeking Council's approval for the adoption of the National Healthcare Waste Management policy, underscores the high level of the commitment of the Government toward improving the situation of the sector.

INSTITUTIONAL ARRANGEMENTS TO MANAGE ENVIRONMENTAL AND SOCIAL SAFEGUARDS: The draft operational manual of the BHCPF project has being updated to reflect the consultations organized by the safeguards team from the bank and this is true commitment to put safeguard measures front and center of project implementation. The project will hire at least one full time environmental and social specialist with relevant skill set to manage issues around environmental and social issues on the project. The specialist will support the PIU during the whole life cycle of the project. Periodic reports will be prepared to provide relevant information on the safeguards implementation status.

CONSULTATIONS: The GoN/FMoH consulted stakeholders during the pre appraisal phase of project preparation with participating states, on 18th of January 2018. About 40 stakeholders from federal and state governments, donor organizations and NGOs such as the target states' Ministries of Health, State Social Health Insurance Agencies (SSHIA), WHO, Gates Foundation, Results for Development (R4D), Health Reform Foundation of Nigeria (HERFON), Society for Family Health, Nigeria (SFHNigeria), etc. were engaged in the consultations. The stakeholders agreed that the project will ensure that participants voice on the project is heard with an annual consultation plan which supports the implementation and disclosure strategy.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

Key stakeholders include: (i) poor and vulnerable groups across the country, and vulnerable groups such as women and children who face a disproportionate risk of mortality and morbidity due to preventable causes; (ii) state and local governments; (iii) the government at the federal level and its implementing partners namely the National Primary Healthcare Development Agency (NPHCDA) and National Health Insurance Scheme (NHIS); and (iv) the development partner community.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank 15-Mar-2018	Date of submission for disclosure 23-Mar-2018	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
--	--	--

"In country" Disclosure



Nigeria

26-Mar-2018

Comments

The Environmental and Social Management Framework (ESMF), and a Health Care Waste Management (HCWM) Plan were disclosed in Two National newspapers viz Daily Trust and The Punch newspapers and Radio advertisements as per directive of the FMOE.

These were also publicly displayed in the three states:

Abia State Ministry of Environment, Umuahia, Abia State

Abia State Ministry of Health, Umuahia, Abia State

Niger State Ministry of Environment, Minna, Niger State.

Niger State Ministry of Health, Minna, Niger State

Osun State Ministry of Environment, Osogbo, Niger State.

Osun State Ministry of Health, Osogbo, Niger State

Federal Ministry of Environment, Osogbo, Osun State.

Federal Ministry of Environment, Umuahia, Abia State.

Federal Ministry of Environment, Minna, Niger State

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

No

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes



All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

CONTACT POINT

World Bank

Olumide Olaolu Okunola
Senior Health Specialist

Borrower/Client/Recipient

Federal Ministry of Finance
Aliyu Ahmed
Director IERD
ahmed4.aliyu@gmail.com

Implementing Agencies

Federal Ministry of Health
Osarenoma Uwaifo
Permanent Secretary
clemuwaifo@yahoo.com



FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Olumide Olaolu Okunola
----------------------	------------------------

Approved By

Safeguards Advisor:		
Practice Manager/Manager:	Trina S. Haque	10-May-2018
Country Director:	Indira Konjhodzic	17-May-2018