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Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 26-Apr-2018 | Report No: PIDISDSC22342

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BASIC INFORMATION

A. Basic Project Data

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

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	Concept Review Decision

B-Partial Assessment	Track I-The review did authorize the preparation to continue

Have the Safeguards oversight and clearance functions been transferred to the Practice Manager? (Will not be disclosed)
Yes

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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 pushed the country into 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. Government tax collection amounted to less than 6% of GDP, among the lowest rates in the world. Even during the period of growth, the social sectors including health did not enjoy increased financing and the period of recession had serious consequences for much needed investments. Ultimately the current poor state of health has been driven primarily by the steadily declining public investments in health.

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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 births[1]. (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

	Nigeria				SSA
Outcome Indicators	**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

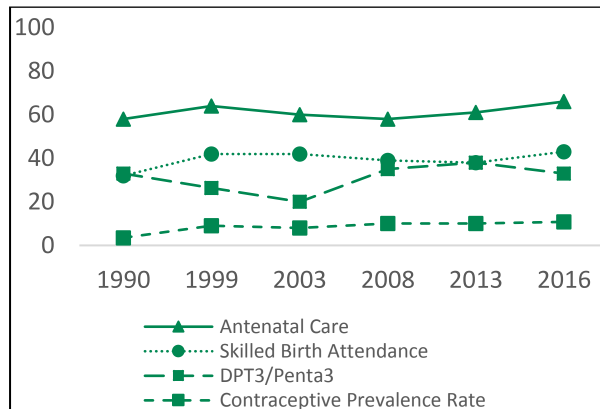
Source: Nigeria Demographic and Health Surveys 2003-2013 and MICS 2016-17. Sub-Saharan Africa (SSA) data is from World Development Indicators and is for 2015-2016. The data are not strictly comparable and SSA data is just illustrative.

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

[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.

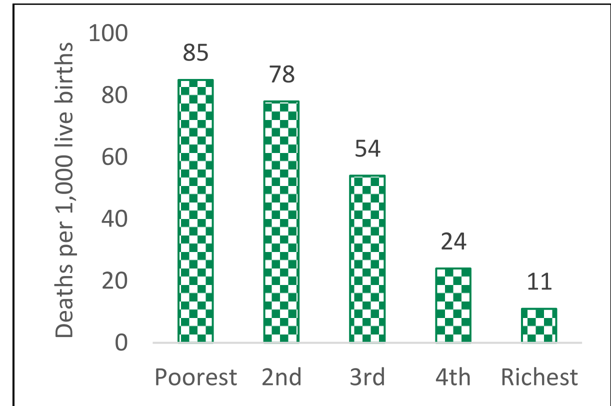
coverage has recently worsened—only 33% of the children have received three doses of pentavalent vaccine (Penta3) as of 2016 (Figure 1) down from 38% in 2013. There has been no progress in modern contraceptive prevalence rate (mCPR) in the last fifteen years, with mCPR at 13%, below the SSA average of 24%[2].

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



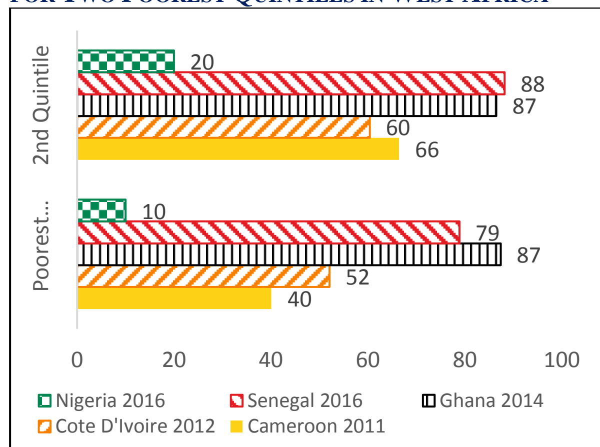
Sources: NDHS 1990, 1999, 2003, 2008, 2013 & MICS 2016-17

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



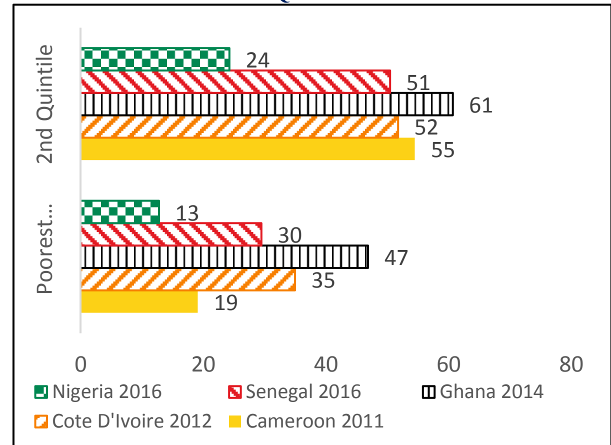
Note: The aggregate child mortality (probability of dying between first and fifth birthday) for Nigeria is 54 deaths per 1000 live births. Source: MICs 2016-17

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

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[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'Iviore (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 status[3]. 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

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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 impoverishment[5] 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.

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 costs[6], and public primary care is currently characterized by <u>frequent drug and vaccine stock outs, lack of equipment, and almost no maintenance of physical facilities</u>. Part of the problem is that state and local governments (LGAs) rarely prioritize the financing of PHC. In addition, almost no[7] financial resources are directly managed at the facility level.

[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
[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

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 services[8]. 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 sector[9]. 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).

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Relationship to CPF

12. **The proposed operation is fully aligned to the CPS**: The Project is fully aligned with the World Bank Group's Country Partnership Strategy (FY14-FY17) and brings in lessons from the 2016 PLR. In particular, the proposed operation lies at the heart of the second CPS pillar which aims to improve the "*effectiveness and efficiency of social service delivery at State level for greater social inclusion*". Its emphasis on (i) supporting efforts that increases service delivery for the poorest households in the rural areas particularly women, children & adolescents; (ii) the building of an effective system to support the delivery of BMPHS; and (iii) the development of appropriate institutions, policies and guidelines and practices for addressing service delivery to the last mile in Nigeria are objectives critical to the success of the CPS. The use of government processes through the strengthening of the public financial management in the health sector supports the third pillar of the CPS. Additionally, the Project will directly contribute to the two pillars of the World Bank's global strategy of reducing absolute poverty and promoting shared prosperity. The project is considered as part of the ***innovation phase*** of a planned **Multi Phase Approach** for the health sector in Nigeria. A follow-on ***Expansion and Consolidation phases*** will allow for substantial scale up of lessons learnt in this first phase.

C. 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.

Key Results (From PCN)

[8] Oyibocha, E. O., Irinoye, O., Sagua, E. O., Ogungide–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

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

(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. Concept Description

13. 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.

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SAFEGUARDS

A. 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. 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 is no construction to be financed under the project.
*Vaccination is potentially a significant source of waste generation, especially through expired vaccines 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 is small and because they are sterilized vaccines.
*Overall environmental impact of the Project is likely to be positive with potentially significant environmental benefits with medical waste disposal as the main risk.
*The overall social impacts of the Project are likely to be positive with main issue being utilization of services.
*No land requirements or restriction of access to sources of livelihoods or involuntary resettlement of any kind under the Project.

B. Borrower's Institutional Capacity for Safeguard Policies

Generally, Nigeria is considered to have a fairly complete set of regulations and legal instruments however consistent

implementation of monitoring and enforcement measures remain a challenge. 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. The Health Care Waste management plan was updated and disclosed in-country and in the infoshop on March 26, 2018 as part of project preparation and is aligned with the approved National Healthcare Waste Management Plan and Guidelines for Nigeria. An ESMF was also prepared and disclosed in-country and the infoshop on March 26th. The project will hire at least one full time environmental and one full time social specialist with relevant skill set to manage issues around environmental and social issues on the project. The specialists 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.

C. Environmental and Social Safeguards Specialists on the Team

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

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D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Vaccination is potentially a significant source of waste generation, especially through expired vaccines 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 is small and because they are sterilized vaccines. which do not present a public health or environmental risk.
Performance Standards for Private Sector Activities OP/BP 4.03		
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; the civil works are at existing hospitals/clinic sites.
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.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

May 04, 2018

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The Health Care Waste management plan was updated and disclosed in-country and in the infoshop on March 26, 2018. An Environmental and Social Management Framework (ESMF) was also prepared and disclosed in-country and in the World Bank Infoshop on March 26, 2018. The ESMF was prepared to provide a guide for community participation allowing beneficiaries to understand their rights, eligibility and assurance for free service provision as envisioned under BHCPF.

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APPROVAL

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