FEDERAL REPUBLIC OF NIGERIA
WORLD BANK

PROGRAM-FOR-RESULTS FINANCING

NIGERIA HUMAN CAPITAL OPPORTUNITES FOR PROSPERITY AND EQUALITY HEALTH

PROGRAM-FOR-RESULTS (HOPE-HEALTH-PFORR)

ENVIRONMENT AND SOCIAL SYSTEMS ASSESSMENT (ESSA)

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Prepared by the World Bank

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LIST OF ACRONYMS	
BEMONC	Basic Emergency Maternal, Obstetrics, Newborn Care
BHPF	Basic Healthcare Provision Fund
BVN	Biometric Verification Number
CCT	Conditional Cash Transfer
CoC	Code of Conduct
CRF	Consolidated Revenue Fund
CRF	Consolidated Revenue Fund
CRVS	Civil Registration and Vital Statistics System
DLI	Disbursement-Linked Indicators
E&S	Environment and Social
EMS	Emergency Medical Services
ENB	Environment, Natural Resources and Blue Economy
ESSA	Environmental and Social Systems Assessment
FMEnv	Federal Ministry of Environment
FMFBNP	Federal Ministry of Finance Budget and National Planning
FMoH	Federal Ministry of Health
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GoN	Government of Nigeria
GRM	Grievance Redress Mechanism
HCI	Human Capital Index
HOPE	Human Capital Opportunities for Prosperity and Equality
ICT	Information Communications Technology
IMR	Infant Mortality Rate
IPF	Investment Project Financing
IPV	Intimate Partner Voilence
ISR	Implementation Status and Results Report
LGA	Local Government Area
MDA	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
NCD	Non-Communicable Diseases
NEC	National Economic Council
NGF	Nigeria Governor's Forum
NGO	Non-Governmental Organization
NIN	National Identification Number
PAP	Program Action Plan
PCU	Program Coordinating Unit
PDO	Program Development Objective
PFM	Public Financial Management
PforR	Program-For-Results
PHC	Primary Health Care
RA	Result Area
SABER	State Action and Business Enabling Reforms
SFTAS	State Fiscal Transparency Accountability and Sustainability
SMEnv	State Ministry of Environment
SMoF	State Ministry of Finance
SMoH	State Ministry of Health
SMoH	State Ministry of Health

SMoLG	State Ministry of Local Government
TA	Technical Assistance
U5MR	Under-five Mortality Rate
UNH	Universal Health Coverage

EXECUTIVE SUMMARY

1. To facilitate health efforts in Nigeria, the World Bank is proposing to support the Government of Nigeria (GoN) with a Program for Results (PforR) instrument referred to as Nigeria Human Capital Opportunities for Prosperity and Equality- Health Program-For-Results (HOPE-Health-PforR) (hereafter, the Program). The total program cost is US$500 million.

2. The proposed HOPE-Health provides a Sector-Wide Approach (SWAp) platform, leveraging significant additional resources to support a critical agenda. By aligning donor financing with the government's resources, the proposed operation will foster convergence around a common set of results that are reflective of Nigeria's disease burden. A SWAp will also provide the leverage to deepen federal-state dialogue towards additional domestic resource mobilization and better accountability for results. Providing mutual and joint platforms for planning, delivery, monitoring, and accountability will drive efficiency, transparency, and accountability for health spending and key health systems inputs and processes. It would be a hybrid Program for Results (PforR), consisting of two parts: the Program and a technical assistance (TA) component, which uses the Investment Project Financing (IPF) approach.

3. The Program Development Objective (PDO) is to improve access to and utilization of quality essential healthcare services in Federal Republic of Nigeria. Four PDO-level indicators align with the PDO emphasis on access, utilization, and quality of primary and priority secondary health care services.

a. Number of women and children who receive tracer essential health services by community health workers.
b. Number of PHC facilities achieving service readiness assessment criteria.
c. Proportion of deliveries with skilled provider.
d. Number of empaneled EDGE level 1 CEmONC facilities certified.

4. The PforR will support the Government program's action plan, reorganized into three result areas and eleven disbursement-linked indicators (DLIs) and disbursement -inked results (DLRs) as shown in Table ES1.

Table ES1: Result Areas and DLIs

DLI		DLI Amount	Recipient DLI Unit	Scalable	Time-Bound
		US$			
RA1: IMPROVING QUALITY OF SERVICES ***(US$203.5 million overall, of which IDA -US$155.5 million and Grant - US$48.0 million)***					
DLI 1: Improved service readiness.	**DLI 1.1:** Improved primary health care facility readiness, quality, and climate resilience (Percentage)	61.5	States	Yes	Yes
	DLI 1.2: Increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (Number)	58.0	States	Yes	Yes
DLI 2: Increased availability of essential commodities.	**DLI 2.1:** Federal expenditure on quality family planning commodities increased (Percentage)	50.0	Federal	Yes *(up to annual cap)*	Yes

	DLI 2.2: Front-line availability of tracer**[1] products improved (Percentage)	34.0	States	Yes	Yes
RA2: IMPROVING UTILIZATION OF ESSENTIAL SERVICES ***(US$332.5 million overall, of which IDA - US$254.5 million and Grant - US$79.0 million)***					
DLI 3: Increased enrollment of poor and vulnerable populations.	**DLI 3:** Financial protection for poor and vulnerable populations increased (Number)	40.0	States	Yes	Yes
DLI 4: Enhanced community delivery of health services.	**DLI 4:** Women and children who receive tracer essential health services in the community increased (Number)	50.0	States	Yes	No
DLI 5: Increased utilization of priority secondary care services.	**DLI 5.1: Secondary Facility Quality of Care for CEmONCs (Prior Result)**	2.5	Federal	No	Yes
	DLI 5.2: Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (Number)	70.0	Federal	Yes	No
DLI 6: Increased PHC utilization of priority services.	**DLI 6.1:** Deliveries with skilled birth attendant present increased (Number)	50.0	States	Yes	No
	DLI 6.2: Introduction of MMS supplementation for pregnant women during ANC visits (Number)	40.0	States	Yes	No
	DLI 6.3: Increase in Penta 3 coverage (Number)	40.0	States	Yes	No
DLI 7: Increased utilization of EMS.	**DLI 7**: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number)	40.0	States	Yes	No
RA #3: IMPROVING RESILIENCE OF THE HEALTH SYSTEM ***(US$75.0 million overall, of which IDA - US$57.0 million and Grant - US$18.0 million)***					
DLI 8: Improved allocation and disbursement of BHCPF funds	**DLI 8.1: Governance for improved resource allocation and performance (Prior Result)**	2.5	Federal	No	Yes
	DLI 8.2: States receiving funds in compliance with allocation formula in revised guidelines (number)	10.0	States	No	Yes
DLI 9: Enhanced pandemic preparedness and response (PPR)through deployment	**DLI 9:** System and standards for state EPR programs are established. (Numbers)	15.0	States	Yes	Yes
DLI 10: Improved Climate Resilience	**DLI 10:** National climate and health adaptation plan developed, costed, validated, and implemented	30.0	States	Yes	Yes

[1] Tracer commodities include oxytocic, multiple micronutrient supplements (MMS), artemisinin-based combination therapy (ACTs), HIV rapid test kits, pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC).

DLI 11: Stronger Digital Foundation	**DLI 11.1: National enterprise architecture developed, costed, and adopted (Prior Result)**	2.5	Federal	No	Yes
	DLI 11.2: States adopting National enterprise architecture and integrate core health functions	15.0	States	No	Yes
TOTAL		**611.0**			

5. he Program will exclude activities that do not meet the World Bank's Policy on eligibility for PforR financing (September 2020). The borrower shall ensure that the Program excludes any activity which, in the opinion of the World Bank, is likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and humans and/or requires significant civil works, land acquisition, displacement and or resettlement of affected people. Given that the HOPE-PforR Program is an institutional reform program, it will not support investments with high environmental and social risks and impacts, such as construction and infrastructure development. It will not accommodate involuntary displacements and resettlements. Thus, any Program activity that entails land acquisition, negative impact on natural habitat and cultural resources, public and workers' health and safety will not be funded under the PforR.

6. The Environmental and Social Systems Assessment (ESSA) examines the extent to which the Federal and State Government's existing environmental and social management systems operate within an adequate legal and regulatory framework to guide environmental and social impact assessments, mitigation, management and monitoring at the PforR Program level. It assesses their consistency with the six 'core principles' of the Program for Results Policy and recommends actions to address the gaps and to enhance performance during Program implementation. This ESSA incorporates recognized elements of good practice in environmental and social assessment and management and thereafter defines measures to strengthen the system and recommends measures that will be integrated into the overall Program. The ESSA is undertaken to ensure consistency with six core principles and key planning elements of PforR ESSA.

7. The World Bank team prepared the ESSA through a combination of detailed reviews of existing program materials and available technical literature, including policies, regulations, guidelines and examples of due diligence and design documents, interviews and extensive consultations with government staff, non-governmental organizations, regulatory agencies, private sector organizations and sector experts associated with public revenue generation. Based on the analysis conducted, the findings, conclusions and opinions expressed in the ESSA are those of the Bank.

8. In line with the six core principles, the relevant risks associated with the HOPE-Health (HOPE-PHC) Program and within the proposed Result Areas (RAs) under the PforR cover environmental and social issues and include:

i. Refurbishment and rehabilitation of facilities to meet the 75% score on the health facility readiness assessment could result in negative environmental impacts associated with rehabilitation, such as the generation of solid waste, noise, and air pollution.
ii. There could also be discrimination in the recruitment of health care workers, for example, skilled birth attendants, to meet the readiness assessment criteria.
iii. Increased e-waste generation due to the digitization of the health system for digital health enterprises in health architecture.

iv. Potential increase in generation of healthcare wastes due to increased spending on provision of facilities, expansion in the number and improved quality of health care and increased expenditure for provision of health products.
v. Potential discrimination of vulnerable groups, ethnic bias and sexual abuse or harassment of women in the provision of health insurance under the NHIA gateway in the revised Basic Health Care Provision Fund guideline and in the provision of essential health services by community health workers.
vi. Rehabilitation of facilities with climate resilience and energy efficiency features under the National Climate and Health Implementation plan could lead to negative environmental and social impacts associated with rehabilitation, such as the generation of solid waste, noise and air pollution. Also, there are negative environmental impacts associated with renewable energy, such as solar systems, especially electronic waste, old batteries and panels, and possible clearing of land/vegetation to install solar panels.
vii. Rehabilitation work can also impact workers' health and safety.

9. The overall environmental and social risks have been assessed and deemed to be **Moderate.** Although the Program does not involve construction works and program activities are not likely to require significant changes to the borrower's overall environmental systems, the program was generally assessed as moderate because there could be slight rehabilitation works of facilities to strengthen the health system, waste from electrical and electronic equipment (WEEE) (e-waste) associated with stronger digital foundation (DLI11), implementation of the national health adaptation plan developed under DLI 10 and social risks associated with MMS supplementation for pregnant women in DLI6, emergency medical transport for patients with obstetric and neonatal complications in DLI 7 and activities to be carried out under Improved allocation and disbursement of BHCPF funds (DLI8).

10. The ESSA process includes stakeholder consultations and disclosure of the ESSA Report, in accordance with the World Bank Policy and Directive for Program for Results Financing and Access to Information Policy. Currently, the ESSA consultation process is embedded in the Program consultation process. Consultations were held prior to the development of the ESSA and after the production of the draft ESSA.

11. Some analysis was carried out to determine the range of environmental and social risks and benefits associated with the PforR program based on each DLIs. The PforR component of HOPE -Health will generate some E&S risks and benefits.

12. The PforR component of HOPE-Health will generate some E&S benefits and risks. The environmental risks will result from the rehabilitation and refurbishment of infrastructure, digital health enterprise in health architecture, and traffic risks due to an increase in patient emergency transport. On the other hand, the environmental benefits are minimal and limited to facilitating climate resiliency measures for PHC and BEmONC facilities and the climate benefits from the implementation of the national climate and health adaptation plan.

13. The PforR program will deliver some direct and indirect environmental benefits. Direct environmental benefits will accrue from achieving DLI 1.1, which is the Percentage of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience and DLI 1.2 which is increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency. The installation of solar power and ensuring energy efficiency

and climate resilience measures for health facilities will help reduce emissions and facilitate the achievement of Nigeria's 2060 zero emission target.

14. Activities to achieve DLI 9, which strengthens emergency preparedness and response at the subnational level, will also yield environmental benefits. Achieving this DLI will improve handling climate shocks, natural disasters and other humanitarian emergencies and generate some climate Co-Benefits. In addition, the development and implementation of a national climate and health adaptation strategy in DLI 10, which will help address climate change and vulnerabilities, will generate some climate co-benefits.

15. The HOPE-Health PforR has some activities that are expected to impact the environment. Rehabilitation and refurbishment activities would be conducted to meet a score of 75% on the health facility readiness assessment in DLI 1.1 and to ensure that Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities demonstrate service readiness, climate resilience, energy efficiency (DLI 1.2). Also, rehabilitation work would be carried out during the implementation of the national climate and health adaptation plan in DLI 10. The implementation could involve the rehabilitation of facilities, such as WASH facilities, that may be exposed to natural disasters such as floods. Thus, environmental risks associated with rehabilitation, such as solid waste, noise, air pollution, and occupational health and safety (OHS) risks, would negatively impact the environment.

16. Generation of waste from electrical and electronic equipment (WEEE), often referred to as e-waste, is expected, given the increased use of ICT to facilitate digital health transformation in DLI 11.1 and the adoption of digital health infrastructure by states to achieve DLI 11.2.

17. Also, the implementation of the emergency preparedness (EPR) program in DLI 9 and the emergency medical transport system in DLI 7 will lead to more vehicles for transporting patients in emergency and an increased number of patients transported to PHC or secondary health facilities. This will result in increased consumption of fossil fuels, and which will lead to increased CO_2 emissions and air pollution from transportation. The digitized system that will be employed in emergency transportation could, in the long run, result in e-waste.

18. The HOPE-Health PforR will result in many social benefits from achieving the DLIs. These benefits include enhanced health outcomes, reduced infant and maternal mortality rates, increased life expectancy, enhanced economic development, and poverty reduction, given that people will be healthy to work and contribute to economic development.

19. For example, the refurbishment and staffing of PHC facilities to meet readiness in the assessment tool and application of the tool (DLI 1.1) and the refurbishment and empaneling of CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency in DLI 1.2 will facilitate the availability of water source, toilets, mother-newborn intensive care units, surgical theatres, and equipment. This will help ensure enhanced health outcomes, reduced infant and maternal mortality rates, and increased life expectancy. Improving quality healthcare services in Nigeria’s healthcare facilities is recommended to ensure equity regarding access to healthcare, which will facilitate the realization of some health-related sustainable development goals (SDGs).

20. Also, the rehabilitation of health facilities, will also lead to increased employment for the locals who may be engaged in menial jobs. Besides, the rehabilitation may lead to an influx of workers into the communities, thus enhancing the local economy. Besides the rehabilitation, health workers will also be

recruited for PHC facilities, thus creating employment opportunities for unemployed health workers and thus enhancing their income and well-being.

21. In addition, activities under DLI2 will facilitate the provision of contraceptives, tracer commodities and medicines to women and children. Tracer commodities include oxytocics, multiple micronutrient supplements (MMS), artemisinin-based combination therapy (ACTs), HIV rapid test kits, pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC). Provision of these commodities will reduce the incidence of malaria, especially during pregnancy, reduce mother-to-child transmission of HIV, enhance the health of mothers and children, reduce infant and maternal mortality rates, and enhance their life expectancy.

22. Increased insurance coverage through linkages with the NHIA gateway (DLI 3), which will facilitate increased child enrolment in the NHIA and increased insurance coverage, will help ensure access to health, especially for the poor, as it will protect them from increased healthcare costs and ensure improved health outcomes and quality of life[2]. Also, the provision of tracer health services (DLI4) through community health workers including the provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification/follow-up of pregnant women and referral to receive multiple micronutrient supplements, treatment of any childhood illness, among others, will enhance the health of women and children, reduce infant and maternal mortality rates and enhance their life expectancy.

23. Having skilled birth attendants during delivery in PHC centres (DLI 6.1) will help ensure that pregnant women being delivered babies are attended to by skilled professionals, thus reducing the incidence of infant and maternal mortality rates. Also, under-five children, pregnant and lactating women, are particularly vulnerable to micronutrient deficiencies. However, the provision of multiple micronutrient supplementation for pregnant women in DLI 6.2 will help prevent micronutrient deficiency in pregnant mothers and their babies and ensure that they are delivered of healthy babies with high immunity against diseases that threaten the lives of infants. It equally helps to ensure the normal functioning and growth of babies and the health of their mothers. In addition, the provision of penta-3 vaccination in DLI 6.3 will help ensure that children 12-23 months are maximally protected against Diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B and Haemophilus influenzae type b (Hib) and thus substantially reduce infant mortality rates.

24. Digitizing the health system in DLI 11 (digital in health enterprise in health architecture) offers many benefits to primary health care and general health care. For example, it would help policymakers make informed decisions about resource allocation and thus reduce healthcare costs. This will free up resources for other important healthcare services. It equally helps doctors and nurses to prioritize individual treatment plans and thus enhance better health outcomes. A study in Ethiopia found that implementing a 20-month data-informed platform for the management of health resulted in strengthened health management through better data use and appraisal practices, enhanced stakeholder engagement and systemized problem analysis to follow up on action points[3].

[2] Institute of Medicine (US) Committee on the Consequences of Uninsurance. Coverage Matters: Insurance and Health Care. Washington (DC): National Academies Press (US); 2001. 1, Why Health Insurance Matters. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223643/

[3] Avan BI, Dubale M, Taye G, Marchant T, Persson LÅ, Schellenberg J. Data-driven decision-making for district health management: a cluster-randomised study in 24 districts of Ethiopia. BMJ Glob Health. 2024 Feb 29;9(2):e014140. doi: 10.1136/bmjgh-2023-014140. PMID: 38423549; PMCID: PMC10910485.

25. The HOPE-Health PforR is also associated with some social risks. The refurbishment and rehabilitation of medical facilities under DLI 1 could potentially impact workers' health and safety for workers involved in rehabilitation works that may be associated with this DLI. The workers may be exposed to pollution caused by dust and noise at the work site. There could also be an influx of workers to the communities where rehabilitation work will occur. This may affect the communities as there could be cases of sexual abuse and other vices, for example, drug abuse. Activities in DLI10, which may involve rehabilitation, will also impact workers' health and safety as workers will be exposed to air pollution, noise, and other environmental impacts associated with rehabilitation work.

26. There could be potential discrimination of women and other vulnerable groups, ethnic considerations and sexual abuse or harassment of women in the provision of tracer essential health services by community health workers (DLI 4), provision of health insurance under the NHIA gateway (DLI3), provision of CEmONC, neonatal and under-5 services and/or VVF surgeries (DLI 5.2), distribution of MMS supplementation for pregnant women during ANC visits (DLI 6.2), provision of emergency medical transportation for patients with obstetric and neonatal complications (DLI7), ,. In addition, although social conflict as envisaged by ESSA, especially regarding armed conflict, is not applicable, discrimination along the lines of ethnicity and religion in medical staff recruitment under DLI1, provision of tracer essential health services and provision of emergency transportation for patients with neonatal complications, and distribution of MMS supplementation for pregnant women can result in complaints, grievances, social unrest and demonstrations among communities that feel left out or cheated. .

27. Following the identification of environmental and social risks, the E&S management system in place to manage the identified risks was assessed. The assessment was done using the following criteria: strengths of the system, or where it functions effectively and efficiently and is consistent with Bank Policy and Directive for Program-for-Results Financing; inconsistencies and gaps between the principles espoused in Bank Policy and Directive for Program-for-Results Financing and capacity constraints; actions to strengthen the existing system. Information from this analysis, identification of gaps and opportunities/actions, was used to inform the recommendations and Program Action Plan (PAP).

28. Given the environmental impact of this project, some recommendations are made as follows:

a) Undertake environmental screening of designs for the rehabilitation of facilities to ensure that the rehabilitation activities under some DLIs especially DLI 1 filter out substantial or high-risk civil works and proposed actions.

b) Strengthening the E&S capacity under the project is needed. To facilitate this, E&S specialists should be recruited for the Program.

c) E-waste and healthcare waste management strategies should also be developed to facilitate their management. The requirements for e-waste and healthcare waste control should be included in the bidding document under HOPE-Health PforR.

d) There is a need to develop an environmental management strategy or manual and OHS guidelines for primary health care centers.

Given the identified social issues and weaknesses in the federal system, the following recommendations are made:

a) Ensure that the provision of MMS for women, provision of tracer essential health services, and provision of emergency transportation to patients with obstetric and neonatal complications are carried out transparently to avoid bias and avoid ethnic or religious considerations.
b) Carry out Program outreach campaigns and citizen engagement activities to adequately target rural, marginalized, and vulnerable populations, especially in the provision of MMS for women, tracer essential health services, and emergency transportation to patients with obstetric and neonatal complications.
c) Strengthen the grievance mechanism in the health sector to ensure that complaints from different stakeholders are well addressed.
d) Strengthen provisions on gender-based violence (GBV) prevention and response, including clear protocols for identifying, reporting, and addressing instances of GBV within the program.
e) Ensure beneficiaries who may experience various forms of GBV because of cash transfer intervention will access services from community- based /NGO GBV service providers and the PHCs.
f) Specific communication on GBV prevention should be rolled-out as part of the outreach activities for the Program.

29. Following the recommendations, the breakdown of actions to be included in the Program Action Plan (PAP) with indicative timeline, responsibility for implementation and indicators for measuring the completion of such actions are detailed in the Table ES2 below.

Table ES2: Program Action Plan (PAP)

s/n	Action Description	Due Date	Responsible Party	Completion Measurement
1	Engage an Environmental Officer that will support the Program in developing e-waste and health care waste management strategies. for managing e-waste and healthcare waste result from the program	Within one year of effectiveness.	Federal Ministry of Health and NPCO/SCO	Environmental officer engaged with responsibilities provided in the Program Operational Manual (POM) E-waste and healthcare waste management strategy document.
2	Develop Code of Conduct, Traffic Management and Occupational Health and Safety Plans for managing traffic related risks from increased emergency patients transport.	Within one year of effectiveness	Federal Ministry of Health and and NPCO/SCO	Finalized Code of Conduct and Occupational Health and Safety Plans reports.
3	Engage a Social/GBV Officer to support the Program in i. Developing referral pathways and communication on GBV prevention and management. This will be integrated into retraining curricula for front line workers. ii. Strengthening the grievance management mechanism for the Health Sector to ensure timely follow ups on tracking and escalation. iii. Carrying out Program outreach campaigns and citizen engagement activities to adequately target rural, marginalized, and vulnerable populations	Within one year of effectiveness	NPCU/FMOWA	• Social Officer engaged with responsibilities provided in the POM. • Referral pathways developed and integration of GBV prevention and management in curricula. • Detailed grievance mechanism procedures is publicized on the websites of the Federal, State and other relevant health agencies; (ii) the availability of the GM to beneficiaries and (iii) annual reports on GM implementation • Outreach program guide and record of outreach actvities.
4	Undertake environmental screening of designs for the rehabilitation of facilities to ensure that the rehabilitation activities filter out substantial or high-risk civil works and proposed actions	Prior to commencement of rehabilitation works	Federal Ministry of Health and NPCO/SCO	Environmental screening checklist satisfactory to the World Bank developed for use before rehabilitation works

SECTION I: PROGRAM DESCRIPTION AND SCOPE

1.1 Introduction

30. 1,000 live births. Maternal Nigeria's health outcome is among the lowest in the world. The country is among the bottom five globally in terms of maternal mortality rate (MMR), infant mortality rate (IMR), under-five mortality rate (U5MR) and life expectancy. Life expectancy of 54 years is the lowest in the world. Under-five mortality is the second highest globally at 114 per mortality is third highest in the world at over 1,000 per 100,000 live births. These numbers translate into over 800,000 deaths annually among children under five, and about 80,000 maternal deaths. Nigeria therefore accounts for 1 out of 6 child deaths globally, and 1 out of 4 maternal deaths. The prevalence of stunting among children under five is 37% – with long-term implications for human development – and ranks among the top 10 in the world. The same is true of the total fertility rate (5.3 births per woman), which has only fallen slightly from its 1990 level of 6.0. While Nigeria is at the early stages of the epidemiological transition, with non-communicable diseases (NCDs) accounting for only 24% of total deaths, the NCD burden poses a new and growing challenge.

31. Profound disparities exist across the country's health indicators, with wide variation by geography, income, and rural/urban areas. For example, a woman living in the Northeast is 10 times more likely to die during childbirth compared to a woman living in the Southwest. A child in the poorest wealth quintile is over three times more likely to die under the age of five than a child in the richest wealth quintile. At the same time, Nigeria's lagging performance vis-à-vis global patterns is not limited to only certain regions or income levels. Nearly every Nigerian state – including the richest – is far behind the global average for under-five mortality at their income level (state GNI per capita). If Nigeria's *second richest* socioeconomic quintile was a country (population > 40 million), its under-five mortality rate would still rank among the ten highest globally.

32. To address these challenges, the Federal government established the Basic Health Care Provision Fund (BHCPF). But it has been operating sub-optimally, and many gaps remain.

1.2 Program Description

33. To facilitate health efforts in Nigeria, the World Bank is proposing to support the Government of Nigeria (GoN) with a Program for Results (PforR) instrument referred to as Nigeria Human Capital Opportunities for Prosperity and Equality- Health Program-For-Results (HOPE-Health-PforR) (hereafter, the Program). The total program cost is US$500 million.

34. The proposed HOPE-Health provides a platform for a Sector-Wide Approach (SWAp), thereby leveraging significant additional resources to support a critical agenda. By aligning donor financing with the government's own resources, the proposed operation will foster convergence around a common set of results that are reflective of Nigeria's disease burden. A SWAp will also provide the leverage to deepen federal-state dialogue towards additional domestic resource mobilization and better accountability for results. Providing mutual and joint platforms for planning, delivery, monitoring and accountability will drive efficiency, transparency, and accountability for health spending and key health systems inputs and processes. It would be a hybrid Program for Results (PforR), consisting of two parts: the Program and a technical assistance (TA) component, which uses the Investment Project Financing (IPF) approach.

The Program Development Objective (PDO) is to improve quality and utilization of essential health care services and health system resilience in Nigeria. Four PDO-level indicators align with the PDO emphasis on utilization, and quality of essential health care services.

- Number of women and children who receive tracer essential health services by community health workers.
- Number of PHC facilities achieving service readiness assessment criteria.
- Proportion of deliveries with skilled birth attendants present.
- Number of empaneled EDGE level 1 CEmONC facilities certified.

35. The DLI matrix is presented in Table 1.1.

Table 1.1: DLI Matrix

Key Result Area 1	**IMPROVING QUALITY OF SERVICES *(US$203.5 million overall – US$152.6 million IDA, US$50.9 million Grant)***			
DLI 1	**Improved Service Readiness**			
Total Allocated (US$)	**119.50**			
DLI 1.1	**Improved primary health care facility readiness, quality, and climate resilience**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Percentage	**61.50**	9.30
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline	0			
Prior Result	-			
Result to be achieved in Yr 1	25% of 2,000 of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience		**6.15**	US$12,300 per facility meeting the BHCPF tier 2 standard per ward up to a total of US$7.5million to be shared by allocating 90% reward to SPHCDAs of States with representative tier 2 PHCs and 10% reward to NPHCDA
Result to be achieved in Yr 2	50% of 2,000 BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience		**12.30**	US$12,300 per facility meeting the BHCPF tier 2 standard per ward up to a total of US$12.00 million to be shared by allocating 90% reward to SPHCDAs of states with representative Tier 2 PHCs and 10% reward to NPHCDA
Result to be achieved in Yr 3	75% of 2,000 of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience		**18.45**	US$12,300 per facility meeting the BHCPF tier 2 standard per ward up to a total of US$18.00million to be shared by allocating 90% reward to SPHCDAs of states with representative Tier 2 PHCs and 10% reward to NPHCDA
Result to be achieved in Yr 4	100% of 2,000 of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience		**24.60**	US$12,300 per facility meeting the BHCPF tier 2 standard per ward up to a total of US$24.00 million to be shared by allocating 90% reward to SPHCDAs of states with representative Tier 2 PHCs and 10% reward to NPHCDA
DLI 1.2	**Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**58.00**	8.77
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline	0			

Prior Result	-			
Result to be achieved in Yr 1	100 EDGE level 1 certified CEmONC facilities empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures.		**3.46**	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 2	300 EDGE level 1 certified CEmONC facilities empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures.		**10.39**	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standard to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 3	500 EDGE level 1 certified CEmONC facilities empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures.		**17.32**	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 4	774 EDGE level 1 certified CEmONC facilities empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures.		**26.82**	US$34,647.55 per facility per LGA meeting the NHIA CEmONC standards to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
DLI 2	**Increased availability of essential commodities.**			
Total Allocated (US$)	84.00			
DLI 2.1	**Federal level expenditure on quality family planning commodities increased**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes *(up to annual cap)*	Percentage	**50.00**	7.56
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result	-			
Result to be achieved in Yr 1	12 percentage points increase over the 2024 baseline		**10**	US$0.8m per percent point annual increase federal level expenditure on quality FP commodities on the 2024 baseline to a maximum of $10m
Result to be achieved in Yr 2	18 percentage points increase over the 2024 baseline		**10**	US$0.56m per percent point annual increase federal level expenditure on quality FP commodities on the 2024 baseline to a maximum of $10m
Result to be achieved in Yr 3	24 percentage points increase over the 2024 baseline		**15**	US$0.63m per percent point annual increase federal level expenditure on quality FP commodities on the 2024 baseline to a maximum of $15m
Result to be achieved in Yr 4	30 percentage points increase over the 2024 baseline		**15**	US$0.5m per percent point annual increase federal level expenditure on quality FP commodities on the 2024 baseline to a maximum of $15m
DLI 2.2	**Front-line availability of tracer** products improved**			

Type of DLI	Scalability	Unit of Measure	Total Allocated (US$)	As % of Total financing Amount
Outcome	Yes	Percentage	**34.00**	5.14
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result	-			
Result to be achieved in Yr 1	Up to a maximum of 10pp increase in the number of Tier 2 (PHC + BEmONC) NHSRII-service ready facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position.		**8.50**	US$22,972.97 per percentage point increase per state to be shared by allocating 97.5% reward to SPHCDAs (48.75%)/SDMAs (48.75%) of participating states and 2.5% reward to the FMOH
Result to be achieved in Yr 2	Up to a maximum of 20pp increase in the number of Tier 2 (PHC + BEmONC) NHSRII-service ready facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position.		**8.50**	US$11,486.49 per percentage point increase per state to be shared by allocating 97.5% reward to SPHCDAs (48.75%)/SDMAs (48.75%) of participating states and 2.5% reward to the FMOH
Result to be achieved in Yr 3	Up to a maximum of 30pp increase in the number of Tier 2 (PHC + BEmONC) NHSRII-service ready facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position.		**8.50**	US$7,657.66 per percentage point increase per state to be shared by allocating 97.5% reward to SPHCDAs (48.75%)/SDMAs (48.75%) of participating states and 2.5% reward to the FMOH
Result to be achieved in Yr 4	Up to a maximum of 40pp increase in the number of Tier 2 (PHC + BEmONC) NHSRII-service ready facilities over the 2024 baseline that have a minimum of five of six commodities above the defined minimum stock position.		**8.50**	US$5,743. 24 per percentage point increase per state to be shared by allocating 97.5% reward to SPHCDAs (48.75%)/SDMAs (48.75%) of participating states and 2.5% reward to the FMOH
Key Result Area 2	**IMPROVING UTILIZATION OF ESSENTIAL SERVICES (US$332.5 million overall - US$249.4 million IDA, US$83.1 million Grant)**			
DLI 3	**Increased enrollment of poor and vulnerable populations.**			
Total Allocated (US$)	40.00			
DLI 3	**Financial protection for poor and vulnerable populations increased**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**40.00**	6.05
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline	1,800,000			
Prior Result	-			
Result to be achieved in Yr 1	20 percent increase from the previous year in the number of eligible population (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs.		**10.00**	US$13,513.52 per percentage point increase in eligible health insurance enrollment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 2	20 percent increase from the previous year in the number of eligible population (poor and vulnerable)		**10.00**	US$13,513.52 per percentage point increase in eligible health insurance enrollment per state to be shared by

	enrolled in the NHIA gateway of the BHCPF by the SSHIAs.			allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 3	20 percent increase from the previous year in the number of eligible population (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs.		**10.00**	US$13,513.52 per percentage point increase in eligible health insurance enrollment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 4	20 percent increase from the previous year in the number of eligible population (poor and vulnerable) enrolled in the NHIA gateway of the BHCPF by the SSHIAs.		**10.00**	US$13,513.52 per percentage point increase in eligible health insurance enrollment per state to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
DLI 4	**Enhanced community delivery of health services.**			
Total Allocated (US$)	50.00			
DLI 4	**Women and children who receive tracer essential health services in the community increased**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**50.00**	7.56
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result	-			
Result to be achieved in Yr 1	5 percent increase from the previous year in the number of tracer essential health services delivered by health workers in the community.		**5.00**	US$27,027.52 per percentage point increase per state in essential health services provided by CHW in the communities on the DHIS-2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 2	10 percent increase from the previous year in the number of tracer essential health services delivered by health workers in the community.		**10.00**	US$27,027.52 per percentage point increase per state in essential health services provided by CHW in the communities on the DHIS-2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 3	15 percent increase from the previous year in the number of tracer essential health services delivered by health workers in the community.		**15.00**	US$27,027.52 per percentage point increase per state in essential health services provided by CHW in the communities on the DHIS-2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 4	20 percent increase from the previous year in the number of tracer essential health services delivered by health workers in the community.		**20.00**	US$27,027.52 per percentage point increase per state in essential health services provided by CHW in the communities on the DHIS-2 platform to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
DLI 5	**Increased utilization of priority secondary care services.**			

Total Allocated (US$)	72.50			
DLI 5.1	**Secondary Facility Quality of Care for CEmONCs**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Prior Result	No	Guideline/Report	**2.50**	0.38
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result	The design and approval of a CEmONC empanelment and reimbursement strategy by the NHIA for SSHIAs		**2.50**	One-time payment of US$2.5m following the achievement of the DLI to be shared by allocating 97.5% reward to SSHIAs of participating states and 2.5% reward to NHIA
Result to be achieved in Yr 1				
Result to be achieved in Yr 2				
Result to be achieved in Yr 3				
Result to be achieved in Yr 4				
DLI 5.2	**Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (Number)**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**70.00**	10.59
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result				
Result to be achieved in Yr 1	25,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		**4.37**	US$ 175 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 4.37m for CEMONC services in an accredited CEmONc facility
Result to be achieved in Yr 2	75,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		**13.12**	US$ 175 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 13.12m for CEMONC services in an accredited CEmONc facility
Result to be achieved in Yr 3	125,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		**21.87**	US$ 175 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 21.87m for CEMONC services in an accredited CEmONc facility
Result to be achieved in Yr 4	175,000 women and neonates receiving CEmONC and neonatal services and/or VVF surgeries		**30.45**	US$ 175 per woman or neonate is reimbursed to the NHIA to a maximum of US$ 30.45m for CEMONC services in an accredited CEmONc facility
DLI 6	**Increased PHC utilization of priority services.**			
Total Allocated (US$)	130.00			

DLI 6.1	Deliveries with skilled birth attendant present increased			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**50.00**	7.56
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result				
Result to be achieved in Yr 1	2.5 percentage points increase over the 2024 baseline on the of number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)		**12.50**	US$135,135 per percent point annual increase per state for the number of deliveries with SBA presents on the previous year result to a maximum of $12.5m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 2	2.5 percentage points increase over the 2025 result on the of number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)		**12.50**	US$135,135 per percent point annual increase per state for the number of deliveries with SBA presents on the previous year result to a maximum of $12.5m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 3	2.5 percentage points increase over the 2026 result on the of number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)		**12.50**	US$135,135 per percent point annual increase per state for the number of deliveries with SBA presents on the previous year result to a maximum of $12.5m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 4	2.5 percentage points increase over the 2027 result on the of number of deliveries with skilled birth attendant present (i.e., Skilled Birth Attendance -SBA)		**12.50**	US$135,135 per percent point annual increase per state for the number of deliveries with SBA presents on the previous year result to a maximum of $12.5m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
DLI 6.2	**Introduction of MMS supplementation for pregnant women during ANC visits**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**40.00**	6.05
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result				
Result to be achieved in Yr 1	2,000,000 pregnant women using MMS supplementation for not less than 180 days		**7.28**	US$3.64 per women receiving supplementation dosage of at least 180 tablets to a maximum of US$ 7.28m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA

Result to be achieved in Yr 2	2,500,000 pregnant women using MMS supplementation for not less than 180 days		**9.10**	US$3.64 per women receiving supplementation dosage of at least 180 tablets to a maximum of US$ 9.10m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 3	3,000,000 pregnant women using MMS supplementation for not less than 180 days		**10.92**	US$3.64 per women receiving supplementation dosage of at least 180 tablets to a maximum of US$ 10.92m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
Result to be achieved in Yr 4	3,500,000 pregnant women using MMS supplementation for not less than 180 days		**12.74**	US$3.64 per women receiving supplementation dosage of at least 180 tablets to a maximum of US$ 12.74m to be shared by allocating 97.5% reward to SPHCDAs of participating states and 2.5% reward to NPHCDA
DLI 6.3	**Increase in Penta 3 coverage**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**40.00**	6.05
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline	5,500,000 penta 3 doses pa			
Prior Result				
Result to be achieved in Yr 1	6,000,000 penta 3 doses delivered		**4**	US$8 per penta 3 immunization delivered to be shared by allocating 90% reward to SPHCDAs of participating states and 10% reward to NPHCDA
Result to be achieved in Yr 2	6,500,000 penta 3 doses delivered		**8**	US$8 per penta 3 immunization delivered to be shared by allocating 90% reward to SPHCDAs of participating states and 10% reward to NPHCDA
Result to be achieved in Yr 3	7,000,000 penta 3 doses delivered		**12**	US$8 per penta 3 immunization delivered to be shared by allocating 90% reward to SPHCDAs of participating states and 10% reward to NPHCDA
Result to be achieved in Yr 4	7,500,000 penta 3 doses delivered		**16**	US$8 per penta 3 immunization delivered to be shared by allocating 90% reward to SPHCDAs of participating states and 10% reward to NPHCDA
DLI 7	**Increased utilization of EMS**			
Total Allocated (US$)	40.00			
DLI 7	**Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**40.00**	6.05

Period	Value		Allocated Amount (US$)	Formula
Baseline				
Prior Result				
Result to be achieved in Yr 1	10,000 patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system		**1.00**	US$100 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Result to be achieved in Yr 2	50,000 patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system		**5.00**	US$100 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Result to be achieved in Yr 3	100,000 patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system		**10.00**	US$100 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Result to be achieved in Yr 4	240,000 patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system		**24.00**	US$100 per obstetric and neonatal patient transported to be shared by allocating 97.5% reward to SEMSAS of participating states and 2.5% reward to NEMSAS
Key Result Area 3	**IMPROVING RESILIENCE OF THE HEALTH SYSTEM (US$75 million overall - US$56.3 million IDA, US$8.7 million Grant)**			
DLI 8	**Improved allocation and disbursement of BHCPF funds**			
Total Allocated (US$)	12.50			
DLI 8.1	**Governance for improved resource allocation and performance (Prior Result)**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Prior Result	No	Guideline/Report	**2.50**	0.38
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result	The design and approval of a revised and approved BHCPF 2.0 guidelines reflecting equity and climate resilience		**2.50**	One-time payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to BHCPF MOC, 20% to NPHCDA, 20% to NHIS, 20% to NEMSAS, and 20% to NCDC
Result to be achieved in Yr 1				
Result to be achieved in Yr 2				
Result to be achieved in Yr 3				
Result to be achieved in Yr 4				

DLI 8.2	States receiving funds in compliance with allocation formula in revised guidelines			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	No	Number	**10.00**	1.51
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result				
Result to be achieved in Yr 1	Adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines		**2.50**	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to BHCPF MOC, 20% to NPHCDA, 20% to NHIS, 20% to NEMSAS, and 20% to NCDC
Result to be achieved in Yr 2	Adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines		**2.50**	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to BHCPF MOC, 20% to NPHCDA, 20% to NHIS, 20% to NEMSAS, and 20% to NCDC
Result to be achieved in Yr 3	Adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines		**2.50**	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to BHCPF MOC, 20% to NPHCDA, 20% to NHIS, 20% to NEMSAS, and 20% to NCDC
Result to be achieved in Yr 4	Adherence to the allocation formula contained in the revised BHCPF guidelines that meets the equity and climate resilience guidelines		**2.50**	Yearly payment of US$2.5m following the achievement of the DLI to be shared by allocating 20% reward to BHCPF MOC, 20% to NPHCDA, 20% to NHIS, 20% to NEMSAS, and 20% to NCDC
DLI 9	**Enhanced PPR through deployment**			
Total Allocated (US$)	15.00			
DLI 9	**System and standards for state EPR programs established and implemented**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**15.00**	2.27
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline	0			
Prior Result	-			
Result to be achieved in Yr 1	NCDC establish and disseminate templates for all 36+1 states EPR program plans based on public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		**1.00**	One-time payment of maximum of $1.0m to NCDC on achievement of DLI

Result to be achieved in Yr 2	All 36+1 states have developed and costed state EPR program plans addressing key public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		**2.75**	US$74,323 per 36+1 state per costed EPR Plan developed; 97.5% Reward to states; 2.5% Reward to NCDC
Result to be achieved in Yr 3	All 36+1 states have implemented up to 50% of their state EPR program plans addressing key public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		**3.75**	$101,351 at 50% implementation per state; 97.5% Reward to states; 2.5% Reward to NCDC
Result to be achieved in Yr 4	All 36+1 states have implemented up to 80% of their state EPR program plans addressing key public health risks and vulnerabilities including climate resilience and other humanitarian emergencies		**7.50**	$202,703 at 80% implementation; 97.5% Reward to states; 2.5% Reward to NCDC
DLI 10	**Improved Climate Resilience**			
Total Allocated (US$)	30.00			
DLI 10	**Climate and health adaptation plan developed, costed, validated, and implemented**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**30.00**	4.54
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline				
Prior Result				
Result to be achieved in Yr 1	Development of the National climate and health adaptation plan which will include the cost followed by implementation		**1.00**	One-time payment of US$1.0m following the achievement of the DLI to be shared by allocating 33% reward to BHCPF FMOH, 33% to NPHCDA, and 33% to NCDC
Result to be achieved in Yr 2	All 36+1 states have developed and costed state climate and health adaptation plans addressing key climate and health risks and vulnerabilities		**5.70**	US$153,985 per 36+1 state per state climate and health adaptation developed; 97.5% Reward to states; 2.5% Reward to NCDC
Result to be achieved in Yr 3	All 36+1 states have implemented up to 50% of their state climate and health adaptation plans addressing key climate and health risks and vulnerabilities		**7.75**	$209,419 at 50% implementation per state; 97.5% Reward to states; 2.5% Reward to NCDC
Result to be achieved in Yr 4	All 36+1 states have implemented up to 80% of their state climate and health adaptation plans addressing key climate and health risks and vulnerabilities		**15.55**	$420,379 at 80% implementation; 97.5% Reward to states; 2.5% Reward to NCDC
DLI 11	**Stronger Digital Foundation**			
DLI 11.1	**National enterprise architecture developed, costed, and adopted**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	No	Compliance	**2.50**	0.38

Period	Value		Allocated Amount (US$)	Formula
Baseline				
Prior Result	The design and approval of a national enterprise architecture for digital health		**2.50**	One-time payment of US$2.5m following the achievement of the DLI to the MOH
Result to be achieved in Yr 1				
Result to be achieved in Yr 2				
Result to be achieved in Yr 3				
Result to be achieved in Yr 4				
DLI 11.2	**States adopting national enterprise architecture and integrating core health functions**			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated (US$)**	**As % of Total financing Amount**
Outcome	Yes	Number	**15.00**	2.27
Period	**Value**		**Allocated Amount (US$)**	**Formula**
Baseline	0			
Prior Result				
Result to be achieved in Yr 1	All 36+1 States adopt and integrate into the national enterprise architecture for digital in health framework and integrate at least 1 of 4 bundle of functions on the list of core health functions		**3.75**	Payment of US$101,351 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the MOH
Result to be achieved in Yr 2	All 36+1 States adopt and integrate into the national enterprise architecture for digital in health framework and integrate at least 2 of 4 bundles of functions on the list of core health functions		**3.75**	Payment of US$101,351 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the MOH
Result to be achieved in Yr 3	All 36+1 States adopt and integrate into the national enterprise architecture for digital in health framework and integrate at least 3 of 4 bundles of functions on the list of core health functions		**3.75**	Payment of US$101,351 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the MOH
Result to be achieved in Yr 4	All 36+1 States adopt and integrate into the national enterprise architecture for digital in health framework and integrate at least 4 of 4 bundles of functions on the list of core health functions		**3.75**	Payment of US$101,351 per state following the achievement of the DLI reward is to be shared 97.5% to the state and 2.5% to the MOH

1.3 Program Implementation and Institutional Arrangements

36. Implementation arrangements for the HOPE-PHC will be fully streamlined into the existing government structures at the federal and state government levels. The GoN launched the Nigeria Health Sector Renewal Investment Initiative (NHSRII) in December 2023, thus the implementation arrangements for the Program are based on the NHSRII implementation platform. The implementation of the NHSRII is supported by a Sector-Wide Approach (SWAp), a compact outlining the roles and responsibilities of key stakeholders in the SWAp framework was signed by the federal and state governments and most development partners in Nigeria. The FMOH has subsequently created a SWAp Coordinating Office (SCO) to function as a Performance/Project Management and Delivery Unit in the FMOH. To ensure the alignment of the activities of the SCO with the objectives of the HOPE-PHC, the SCO will also serve as the NPCU for the HOPE PHC. Oversight for implementation at the state level will be through the BHCPF SOCs. Within this framework, institutional, implementation, and coordination arrangements for the HOPE PHC include (a) alignment with the broader SWAp reforms; (b) establishment of the National Steering Committee (NSC); (c) expansion of the functions of the BHCPF State Oversight Committees.

37. The HOPE PHC Program governance structure comprises two key committees and the NPCU/SCO. First**,** the HOPE PHC Program will be under the supervision of the NHSRII National Steering Committee chaired by the Honorable Coordinating Minister of Health & Social Welfare. It will comprise, HMSH, PSH, relevant heads of agencies of the FMOH, selected members of the DPG-Health, and other members nominated by the coordinating minister. The key responsibility of the NSC is to provide oversight and policy guidance to the SWAp program and will be responsible for achieving the HOPE PHC PforR PDOs and the Program development indicators. ***Second,*** the NSC will establish a **technical committee** chaired by the PSH and meeting monthly for technical oversight and monitoring progress towards achieving the DLIs. The technical committee will be coordinated by the secretariat of the NSC and will include pooled funding development partners (not more than three), and other relevant stakeholders including civil society. The membership of this sub-committee will not exceed a maximum of 10 members. ***Third,*** the NPCU/SCO will function as the core task team reporting to the CMHSW and serving as the secretariat for the Steering and Technical Committees. This hierarchical structure draws upon the experience in other successful PforR operations implemented in Nigeria, and facilitates efficient communication, oversight, and resolution of implementation challenges at various levels.

38. Federal-level project management, coordination, and implementation arrangements**.** The NPCU/SCO, headed by a Program Manager recruited either from the public or private sector and reporting to the CMHSW/PSH, will meet weekly to steer day-to-day program activities. The NPCU/SCO will manage and coordinate implementation of the HOPE PHC. While the actual implementation of the program will be the responsibility of states; relevant entities such as NHIA, NPHCDA, NEMSAS, NCDC, BHCPF MOC will provide general oversight, technical support, supervision, M&E, resource management, as required for states engagement. The Program Implementation Manual (PIM) will include a clear delineation of the roles and responsibilities of relevant entities.

39. State-level project implementation and coordination arrangements. The BHCPF SOCs are established in all 36 states and the FCT. The BHCPF SOCs in each of the 36 states and the FCT will serve similar functions to that of NHSRII NSC at the state level. NPCU/SCO will provide guidance to the state-level implementation bodies to ensure speedy implementation of activities. This is building onto and fostering a continuation of the strong state-level institutions under the BHCPF. Thus, the BHCPF SOC will approve AOPs required to support states in implementing activities & interventions required to access

disbursements under the various DLIs and assist key stakeholders in analyzing data and adjusting plans to allow DLIs to be achieved.

1.4 Program Boundaries and Activities

40. The government program, "*p*", encapsulates the Nigeria Health Sector Renewal Investment Initiative 2023-27 roadmap. Critical aspects of the project, particularly the Basic Healthcare Provision Program are described in the National Health Act 2014 and the enacted NHIA Act 2022. The program ("p") will include: (i) primary healthcare service readiness, service availability and quality by *National and State Primary Healthcare Development Agencies*; (ii) strategic purchasing for maternal and child health administered by *National and State Health Insurance Agencies* through general hospitals managed by the *State Ministries of Health;* (iii) Health Security functions delivered by the *Nigeria Centre for Disease Control;* (iv) *National Emergency Services and Ambulance Scheme (NEMSAS);* (v) Digital in Health for Information Systems Strengthening and *Human Resources for Health* by the *Department of Health, Planning, Research and Statistics of the Federal Ministry of Health and State Ministries of Health;* (vi) cash transfers*;* (vii) medical industrialization; and (viii) citizens engagement program*.* The Basic Healthcare Provision Program of the NHSRII is estimated at US$2.8 billion annually.

41. The proposed Program ''P" of support by the World Bank will incentivize a subset of expenditures across all pillars of the government program "p". Program boundaries will include the following discrete expenditure categories: BHCPF for fiscal transfers to 36 + 1 states, by the Federal Ministry of Health, strategic purchasing through the NHIA, capital investment in primary healthcare rehabilitation, essential commodities, health worker salaries, emergency and ambulance services, data and information systems and conditional cash transfer programs. The expenditure categories will be financed under *State Ministries of Health*, *State Primary Healthcare Development Agencies* and *State Health Insurance Agencies*. The Bank's contribution to the Government's expenditure program will be US$850 million, with intent of other development partners to provide co- and parallel financing. The Bank's financing represents 7.5% of BHCPP program costs.

42. The program boundary is summarized in Table 1.2.

Table 1.2: Program Boundaries

	Government's Basic Health care Provision Program	PforR Program	Reasons for Non-Alignment
Objective	Improve population health outcomes through strengthened Primary Health care Systems	Improve quality and utilization of essential health services and health systems resilience in Nigeria	The longer-term goal is to improve population health outcomes. In the medium term, primary health care systems strengthening provide a credible pathway for achievement of those outcomes
Duration	*2024-2028*	*2024-2028*	Aligned
Geographic coverage	National	*States that express interest and meet HOPE-GOV and HOPE-PHC eligibility criteria*	Aligned

Results areas	Providing financing, enhancing access to essential health services, quality of care, governance, enabling high-performing health workforce, strengthening institutions, partnerships, and community engagement	Results Area 1: **Improving Quality of Services** Results Area 2: **Improving Utilization of Essential Services** Results Area 3: **Improving Resilience of the Health System**	Aligned
Overall Financing	**US$3.2. billion**	**US$656.65 million**	

The PforR will support the Government program's action plan, reorganized into three result areas and nine disbursement-linked indicators (DLIs) with the following activities:

The disbursement-linked indicators for each of the result areas are as follows:

Result Area 1: *Improving Quality of Services:* This result area has two (four sub DLIs) DLIs as follows:
46. DLI 1*:* Improved service readiness: This DLI aims to improve service delivery by expanding the availability of primary healthcare and CEmONC facilities that meet the minimum service criteria to deliver essential primary healthcare services and secondary obstetric and infant care. This DLI allows for a progressive increase in the number of PHCs and CEmONC facilities in underserved and rural areas with the necessary human resources for health and infrastructure, enabling more women to give birth safely in well-equipped health facilities.
(a). DLI 1.1: Improved primary health care facility readiness, quality, and climate resilience (Percentage)- Percentage of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience. To be accredited to receive Direct Facility Financing (DFF) by NPHCDA, Tier 2 PHC facilities -- i.e., those that offer PHC services plus BEmONC services -- will need to meet a score of 75% on the health facility readiness assessment that will be developed by NPHCDA before project effectiveness. The DLI will finance refurbishment and staffing of PHC facilities to meet readiness in the assessment tool and application of the tool. This assessment tool will have components around structural quality (water source, toilets, blueprint for bed numbers and layout, commodities, medicines, equipment, health information system and human resources); process quality (adherence to clinical protocols, infection prevention and control, and record keeping/data reporting). Accredited facilities will have to be assessed biannually for re-accreditation. Refurbishment to be financed through the DLI will include financing for (i) solar power; (ii) minor rehabilitation of facilities; (iii) climate resilient measures for all health facilities in climate vulnerable areas and facilities that are identified as at risk of climate shocks; (iv) WASH improvements at facilities; and (v) energy efficiency measures at high power use facilities. The assessment tool will include content on each of these areas.

(b) DLI 1.2: Increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (Number)**-** Number of EDGE level 1 certified CEmONC facilities that are empaneled according to the NHIA guidelines and maintain the empanelment requirements and have implemented climate resilience measures. Under DLI 1.2, CEmONC facilities will be refurbished by the SWAP Coordinating office and inspected and empaneled by NHIA according to the accreditation guidelines developed under the related Prior Result. Refurbishment will include key structural elements of quality

(water source, toilets, mother-newborn intensive care units, surgical theatres, bed numbers, visibly posted schedule of free services, equipment, commodities and medicines, human resources, health information system) reaching EDGE level 1 certification and implementing climate resilience measures. Empanelment will be renewed on an annual basis.

DLI 2: Increased availability of essential commodities- This DLI will increase the availability of lifesaving commodities including family planning supplies. Family planning efforts are essential to reducing neonatal and maternal mortality, as they decrease the number of high-risk births, increases birth spacing, and delays the mother's age at first birth. This DLI will ensure that domestic resources are guaranteed in the budget to ensure uninterrupted access to lifesaving commodities. In addition, this DLI will support facilities address the issue of stock outs.

(a) DLI2.1: Federal expenditure on quality family planning commodities increased (Percentage)- defined as annual increases in domestic spending on contraceptive commodities to reach 30% of forecasted total need by the end of the program. Under this DLI, the Government of Nigeria will match donor and IDA contributions of $50 million over the life of the program with $25 million of spending on contraceptive commodities from a baseline of $0. This would result in the GoN spending 30% of total contraceptive requirements from domestic non-IDA resources by the final year of the program.

(b) DLI2.2: Front-line availability of tracer products improved (Percentage)- defined as the number of Tier 2 (PHC + BEmONC) NHSRII-service ready facilities that have a minimum of five of six commodities available. Under this DLI, a tracer basket of commodities and medicines will be assessed for availability of a minimum stock position at Tier 2 facilities and reported by the SPHCDAs. The tracer commodities include oxytocics, multiple micronutrient supplements (MMS), artemisinin-based combination therapy (ACTs), HIV rapid test kits, pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC). A minimum stock position by commodity or threshold and the essential medicines score will be defined in the HOPE-PHC PIM.

Result Area 2: *Improving Utilization of Essential Services:* This result area has five (eight sub DLIs) DLIs as follows:

43. **DLI 3: Increased enrollment of poor and vulnerable populations-** This DLI will support the NHIA in facilitating the enrolment of beneficiary populations by SSHIAs. The GON in 2022 made health insurance mandatory through the revision of the NHIA act, however its implementation will require significant public financing to prioritize financial risk protection beneficiary population. Enrolment in the NHIA gateway of the BHCPF is marred by an inability to identify beneficiary populations and the lack of appropriate technology to seamlessly allow for enrolment. This DLI will incentivize the adoption of an enhanced identification and enrolment protocol by the SSHIAs, who in turn report the enrolment figures to the NHIA portal.

a) **DLI 3.1: Financial protection for poor and vulnerable populations increased (Number)-** This DLI will reflect progress in the number of poor and vulnerable persons covered by health insurance under the NHIA gateway in the revised Basic Health Care Provision Fund guideline. This is the number of eligible population (poor and vulnerable) that have been enrolled into to the NHIA gateway of the BHCPF by the SSHIAs.

44. **DLI4: Enhanced community delivery of health services-**

a) **DLI4.**1: **Women and children who receive tracer essential health services in the community increased (Number).** This DLI will disburse when the tracer essential health services are delivered by

health workers in the community. The DLI will incentivize the number of household visits made by community health workers to deliver key services, including the provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification/follow-up of pregnant women and referral to receive multiple micronutrient supplement, treatment of any childhood illness (Integrated Community Case Management -iCCM - diarrhea, fast breathing, fever) as measured by (i) Number of Children with Growth Monitoring Cards/(ii) Children (6-59 months) who received MNP and (ii) Number of pregnant women attending ANC revisited by a community health workers/Pregnant women identified for ANC (new).

45. **DLI 5: Increased utilization of priority secondary care services-**

a) **DLI5.1: Secondary Facility Quality of Care for CEmONC (Prior Result)-** This DLI will disburse against the design and approval of a CEmONC empanelment and reimbursement strategy. Under this DLI, NHIA will develop operational documents that detail the package list of CEmONC, VVF and under-5 admission services eligible for reimbursement, the tariff schedule corresponding to each eligible package, standard operating procedures for claim submission, review and payment, identification of key entities and development of MOUs involved (NHIA, TPAs, etc.); the key performance indicators for claims management and definition of empanelment criteria for CEmONC facilities by the NHIA.

b) **DLI 5.2: Women and neonates receiving CEmONC, neonatal and under-5 services and/or VVF surgeries (Number)-** This DLI will disburse against the number of women, neonates and under-5 children availing CEmONC, VVF and under-5 admission services from NHIA-empaneled public or private health facilities. Under this DLI, NHIA is developing a benefit package of eligible CEmONC services for reimbursement. This will include both obstetric and neonatal care packages, plus VVF surgeries, plus selected under-5 admissions (e.g., severe malaria, severe acute malnutrition with complications, severe diarrhea, or severe acute respiratory infections, etc.) The DLI is a count of these reimbursed services (paid claims, not submitted claims). At least 50 percent of reimbursed services should be for CEmONC deliveries, or correspondingly, no more than 50 percent should be for neo-natal, VVF or under-5 cases. To ensure a relatively equitable share of service coverage, no individual state can account for more than 1.25 times its share of the annual births (that is, any reimbursement above 1.25 times that state annual births forecast will not be eligible to count towards DLI disbursement). Estimates will be based on the 2006 population census data.

46. **DLI 6: Increased PHC utilization of priority services-**

a) DLI 6.1: **Deliveries with skilled birth attendants present increased (Number)-** This DLI will disburse against the increase in the number of deliveries with skilled birth attendants present (i.e., Skilled Birth Attendance -SBA). Under this DLI, Pregnant women whose births were attended by a skilled provider will be captured.

b) DLI 6.2: **Introduction of MMS supplementation for pregnant women during ANC visits (Number)-** This will capture the number of women receiving MMS during antenatal visits. Maternal nutrition service is the distribution of at least 180 multiple micronutrient supplements (MMS) (one bottle) for pregnant women aged 15-49 years at least once during any antenatal care (ANC) service or contact with health worker at the community level.

c) DLI 6.3: **Increase in Penta 3 coverage (Number)-** This DLI captures the number of children immunized with penta-3 vaccination. This is the number of children aged 12-23 months who received DPT-HepB-Hib vaccination (3 doses).

47. DLI7: **Increased utilization of EMS-**

48. DLI7.1: **Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to Selected facilities using the digitized EMS dispatch system (Number)-** This DLI will disburse when patients with obstetric and neonatal complications are transported to Tier 2 (PHC BEmONC) facility or empaneled CEmONC facilities using the digitized EMS dispatch system. This DLI will incentivize the scale-up of the digital dispatch platform on the national emergency transport gateway of the BHCPF, encompassing both the use of community transport and the formal transport system. The DLI will target pregnant women and children and track the number of these targets from Community to BEmONC/CEmONC centers.

Result Area 3: *Improving Resilience of the Health System:* This result area has four (six sub DLIs) DLIs as follows:

49. DLI 8: **Improved allocation and disbursement of BHCPF funds-** This DLI aims to increase the equitable allocation and disbursement of the Basic Healthcare Provision Funds. In Nigeria, region of residence and urban/rural disparities are significantly associated with the use of health services. For example, the use of health facility for child delivery varied across geopolitical zones, with a lower proportion of women from Northwest and Northeast delivering in a health facility. Women who lived in communities with a high proportion of educated women and a high proportion of women from different ethnic groups were more likely to deliver in a health facility compared with women who resided in disadvantaged communities. To help mitigate these issues, the BHCPF guidelines will be revised.

a) DLI 8.1: **Governance for improved resource allocation and performance (Prior Result)-** This prior result will be disbursed against revised and approved BHCPF 2.0 guidelines reflecting equity and climate resilience. This prior result will reimburse GoN upon revision and approval of BHCPF guidelines by the Ministerial Oversight Committee (MOC). The revised guidelines will identify the allocation formula whereby BHCPF funds are disbursed to states. The formula will give due consideration to state variation in (1) RMNCAH+N burden, (2) poverty headcount and (3) climate vulnerability, among other relevant factors as determined by MOC.

b) DLI 8.2: **States receiving funds in compliance with allocation formula in revised guidelines (number)-** This DLI will disburse against the adherence to the allocation formula contained in the revised BHCPF guidelines reflecting RMNCAH+N burden, poverty headcount and climate vulnerability. This DLI will disburse based upon a review of MOC documents that will determine/confirm the adherence to the allocation formula contained in the revised BHCPF guidelines prevailing at the time of verification.

50. DLI 9: **Enhanced PPR through deployment-** This DLI aims to improve pandemic preparedness and response as part of the overall strategy towards enhancing the health system's resilience against shocks. Disease outbreaks, climate emergencies, and any other humanitarian crisis are examples of shocks to the health system which are inevitable and have been linked to the disruption of essential health services and reversal of progress made during peace times. The development and implementation of subnational (states) multi-year emergency preparedness and response plans will help heighten preparedness and response to these shocks, reducing to the barest minimum the disruption of essential health services. The DLI will improve the containment of emergencies and shocks to the health system by ensuring States are better prepared to mitigate vulnerabilities in the health system safeguarding access and the delivery of essential health services.

51. DLI9.1: **System and standards for state EPR programs are established. (Numbers)-** This DLI will disburse when states develop and implement a multi-year EPR plan encompassing disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies. The DLI will incentivize the strengthening of subnational emergency preparedness and response by encouraging states to develop peacetime plans to improve emergency response and health security. The plans will address use of seasonal, multi-hazard risk calendars to support responsive risk response, risk profiling, responsibility

chains for shock response, shock response simulations, commodity stockpiling and quantification of pharmaceuticals to respond to shocks, preparations for health service delivery during shocks. The NCDC will play a role in providing technical assistance to states in developing a multi-year EPR plan which meets specified standards as determined by the NCDC following risk profiling and multi-hazard assessment of states including disease outbreaks, climate shocks, natural disasters, and other emergency emergencies. Following the development of these plans, the NCDC will also provide technical support and guidance to states for the implementation of the state specific EPR plans.

52. **DLI 10: Improved Climate Resilience-**

a) **DLI 10:** National climate and health adaptation plan developed, costed, validated, and implemented- This DLI will disburse with the development of the National climate and health adaptation plan which will include costs followed by implementation.

53. DLI 11: **Stronger Digital Foundation-** This DLI aims to support the development of an integrated and interoperable health data ecosystem so that these data can be used to improve value (efficiency, quality, access, and health outcomes) for patients, providers, health financing, and health system resilience. The health data ecosystem will facilitate one health record per patient for the life of that patient being created and used through a health information exchange, standardized terminology standards, master registries of facilities, providers, and patients, exchange rules, data governance agreements, and regulatory processes to validate health information systems that are approved to operate in the health information exchange. Learning from the efforts of other countries and customizing solutions to fit the Nigerian context, this DLI will (a) strengthen a national set of standards, regulations, rules, and business processes for creating and maintaining a national health data space through a distributed enterprise architecture approach, and (b) facilitate the adoption and effective functioning of the health data ecosystem at State level by integrating individual private, public, and program-specific health information systems to adopt and use them.

a) DLI11.1: Digital in health enterprise in health architecture designed and adopted- This prior result will disburse against the design and adoption of Digital in health enterprise in health architecture. This prior result will reimburse GoN upon design and adoption of Digital in health enterprise in health architecture. The design will ensure that DiH attributes of (i)leadership and partnership, interoperability standards, and data governance; (ii) Focus on technology and data efforts that will address the most rapidly growing disease burden; and (iii) prioritization for equity; among other relevant factors as determined by NDTO are reflected in the design of the standards.

b) DLI 11.2: **States adopting National enterprise architecture and integrate core health functions-** The DLI will disburse against the adoption of the DiH architecture by states and the integration of at least two of the following core health systems function namely: digital platform for training CHWs; purchasing platform for NHIA; EMR; and other to be identified by the NDTO.

1.5 Excluded Activities

54. The Program will exclude activities that do not meet the World Bank's Policy on eligibility for PforR financing (September 2020). The borrower shall ensure that the Program excludes any activity which, in the opinion of the World Bank, are likely to have significant adverse impacts that are sensitive, diverse or unprecedented on the environment and/or requires significant land acquisition, displacement and or resettlement of affected people.

55. Given that the HOPE-Health-PforR Program is an institutional reform program, it will not support investments with high environmental and social risks, such as construction and infrastructure development. It will not accommodate involuntary displacements and resettlements. Thus, any Program

activity that entails land acquisition, negative impact on natural habitat and cultural resources, and public and worker's health and safety will not be funded under the PforR without adequate environmental and social management. For example, the program will support the procurement of any IT equipment but with a requirement for a plan on handling e-waste and renewable energy equipment put in place in the bidding document and monitored and reported regularly.

1.6 Scope of the Environmental and Social Management System Assessment (ESSA)

56. The ESSA for the program examines the extent to which the Federal and State Government's existing environmental and social management systems: operates within, an adequate legal and regulatory framework to guide environmental and social impact assessments, mitigation, management and monitoring at the PforR Program level; It evaluates how the system incorporates recognized elements of good practice in environmental and social assessment and management, via due diligence including: (i) early screening of potential impacts; (ii) the consideration of strategic, technical, and site alternatives (including the "no action" alternative); (iii) explicit assessment of potential induced, cumulative, and transboundary impacts; (iv) the identification of measures to mitigate adverse environmental or social risks and impacts that cannot be otherwise avoided or minimized; (v) clear articulation of institutional responsibilities and resources to support implementation of plans; and (vi) responsiveness and accountability through stakeholder consultation, timely dissemination of the PforR Program information, and responsive grievance redress mechanisms; among others. Based on these findings, the ESSA thereafter defines measures to strengthen the system and recommends measures that will be integrated into the overall Program.

57. This ESSA has been prepared for the HOPE Program to ensure consistency with the "core principles" outlined in the World Bank's policy for the PforR instrument to effectively manage the Program's risks and impacts while promoting sustainable development. These six core principles are:

a) **Environment: To promote environmental and social sustainability in the Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program's environmental and social impacts.**

b) **Natural Habitats and Cultural Resources:** To avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.

c) **Public and Worker Safety**: To protect public and worker safety against the potential risks associated with: (a) construction and/or operations of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

d) **Land Acquisition:** To manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards.

e) **Vulnerable Groups:** To give due consideration to the cultural appropriateness of and equitable access to Program benefits, giving special attention to the rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.

f) **Social Conflict:** To avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial dispute.

58. In line with the six core principles above, the relevant risks associated with the HOPE-Health Program and within the proposed Result Areas (RAs) under the PforR covers environmental and social issues and include:

i. Refurbishment and rehabilitation of facilities to meet the 75% score on the health facility readiness assessment could result in negative environmental impacts associated with rehabilitation such as the generation of solid waste, noise, and air pollution.
ii. There could also be discrimination in the recruitment of health care workers, such as, skilled birth attendants, to meet the readiness assessment criteria.
iii. Increased e-waste generation due to the digitization of the health system for digital health enterprises in health architecture.
iv. Potential increase in generation of healthcare wastes due to increased spending on provision of facilities, expansion in the number and improved quality of health care and increased expenditure for provision of health products.
v. Potential discrimination of vulnerable groups, ethnic bias and sexual abuse or harassment of women in the provision of health insurance under the NHIA gateway in the revised Basic Health Care Provision Fund guideline and in the provision of essential health services by community health workers.
vi. Rehabilitation of facilities with climate resilience and energy efficiency features under the National Climate and Health Implementation plan could lead to negative environmental and social impacts associated with rehabilitation, such as the generation of solid waste, noise and air pollution. Also, there are negative environmental impacts associated with renewable energy, such as solar systems, especially electronic waste, old batteries and panels, and possible clearing of land/vegetation to install solar panels.
vii. Rehabilitation work can also impact workers' health and safety.

59. The details of the applicability of Core Environmental and Social Principles (CP) to HOPE-Health PforR Result Area and Disbursement Linked Indicators (DLIs) are presented in Annex 1. A summary of DLI applicability by Core Principle is presented in the table below:

Table 1.3: Summary of DLIs Applicability by Core Principle

DLI #	DLI Description	DLI Description	Applicability by Core Principle	
			Environment	Social
1	Improved service readiness	DLI 1.1: Improved primary health care facility readiness, quality, and climate resilience (Percentage)	CP1	C3, C5, C6
		DLI 1.2: Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency (Number)	CPI	C3, C5
2	Increased availability of essential commodities.	DLI 2.1: Federal expenditure on quality family planning commodities increased. (Percentage).	CP1	
		DLI 2.2: Front-line availability of tracer** products improved (Percentage)	CP1	
3	Increased enrollment of poor and vulnerable populations.	DLI 3: Financial protection for poor and vulnerable populations increased (Number)		C5, C6
4	Enhanced community delivery of health services.	DLI 4: Women and children who receive tracer essential health services in the community increased. (Number)		C5, C6

5	Increased utilization of priority secondary care services.	DLI 5.2: Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries (Number)		C5, C6
6	Increased PHC utilization of priority services	DLI 6.1: Deliveries with skilled birth attendant present increased (Number)		C5
		DLI 6.2: Introduction of MMS supplementation for pregnant women during ANC visits. (Number)		C5, C6
7	Increased utilization of EMS	DLI 7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system (Number)	C1	C5, C6
8	Improved allocation and disbursement of BHCPF funds	DLI 8.1: Governance for improved resource allocation and performance (Prior Result)	C1	C3
		DLI 8.2: States receiving funds in compliance with allocation formula in revised guidelines (Number)	C1	C3
9	Enhanced PPR through deployment	DLI 9: System and standards for state EPR programs established and implemented. (Numbers)	C1	C5
10	Improved Climate Resilience	DLI 10: Climate and health adaptation plan developed, costed, validated, and implemented	C1	C3, C5
11	Stronger Digital Foundation	DLI 11.1: National enterprise architecture developed, costed, and adopted (Prior Result)	C1	
		DLI 11.2: States adopting National enterprise architecture and integrate core health functions	C1	

1.7 Objectives of this ESSA

60. The specific objectives of this ESSA are to:

a) Identify the potential environmental and social impacts/risks applicable to the Program's interventions.

b) Review all relevant Nigerian policy and the legal framework of the Government of Nigeria (GoN) and relevant State Governments related to the management of environmental and social impacts of the Program's interventions.

c) Review the environmental and social due diligence management procedures and institutional responsibilities that the GoN is using for the HOPE-Health program.

d) Assess capacity within domestic revenue generation institutions and Environmental and Social management within the public sector operating systems of the GoN put in place for environmental and social impact management within the Program system.

e) Assess the Program's system performance concerning the core principles of the Program-for-Results (PforR) instrument, as well as identify gaps in the Program's performance.

f) Recommended actions to fill gaps identified that will be embedded into the Program Action Plan (PAP) to strengthen the Program's performance with respect to the core principles on Environment and Social of the PforR instrument to ensure sustainable implementation via good due diligence.

61. The overall environmental and social risks have been assessed and deemed to be **Moderate.** Although the Program does not involve construction works and program activities are not likely to require significant changes to the borrower's overall environmental systems, the program was generally assessed as moderate because there would be rehabilitation and refurbishment of facilities to strengthen the health system, implementation of the national climate and health adaptation plan developed under DLI 10, traffic risks due to emergency transport services under DLI 7 and social risks associated with financial protection for the poor and vulnerable in DLI 3.

1.8 Approach of ESSA

62. The World Bank team prepared the ESSA through a combination of detailed reviews of existing program materials and available technical literature, including policies, regulations, guidelines and examples of due diligence and design documents, interviews and extensive consultations with government staff, non-governmental organizations, regulatory agencies, private sector organizations and sector experts associated with the health sector in Nigeria.

63. An environmental and social risk screening of proposed activities was undertaken at the concept stage. The purpose of the screening was to:

- Confirm that there are no activities which meet the defined exclusion criteria included in the PforR in line with the Bank Guideline for the ESSA; and
- Establish the initial scope of the ESSA. This includes identification of relevant systems under the PforR and relevant stakeholders for engagement and consultations.

64. The ESSA process was informed by the Bank Guidance on PforR Environmental and Social System Assessment (September 2020). The guidance sets out core principles (See Section I.5) and planning elements used to ensure that PforR operations are designed and implemented in a manner that maximizes potential environmental and social benefits while avoiding, minimizing, or mitigating environmental and social harm.

65. Following the initial screening, the system review was conducted using a two-step approach:

- Identification of relevant systems that are pertinent to the ESSA was addressed in Section IV which presents an overview of relevant government environmental and social management systems; and
    - **Assessment of CLIENT'S environmental and social management systems for consistency with the applicable Core Principles, including capacity and enforcement of certain environmental and social measures, was addressed in Section V, while environmental and social recommendations were addressed in Section VI**

SECTION II: STAKEHOLDER CONSULTATION

66. This section summarizes the stakeholder consultation activities undertaken for the ESSA. The ESSA process includes extensive stakeholder consultations and disclosure of the ESSA Report, in accordance with the World Bank Policy and Directive for Program for-Results Financing and Access to Information Policy. Currently, the ESSA consultation process is embedded in the Program consultation process. Feedback from stakeholders have been instrumental in designing and revising the Program Action Plan, indicators, and program operations manuals and appraisal documents via providing data and details on the existing situation, management status and government priorities regarding primary health care and basic education.

67. Initial consultations with the government and a large group of stakeholders over a period led to the formulation of the HOPE PforR. The outcomes of those consultations are embedded in this program and have influenced its design. Consultations were held prior to the development of the ESSA and after the draft ESSA was developed. Prior to ESSA development, consultations were held with State government stakeholders on the 22nd and 24th of April 2024 for states in Northern Nigeria and Southern Nigeria, respectively.

68. The stakeholders consulted include the Directors from the State Ministry of Budget and Economic Planning, State Ministry of Education, SUBEB, State Ministry of Health, State Primary Health Care Development Boards, and State Health Insurance Agencies. Three states from Northern Nigeria, namely Kwara, Borno and Nasarawa on the 22nd of April and Taraba on the 24th of April. On the other hand, five states from Southern Nigeria, namely Anambra, Enugu, Osun, Rivers and Ogun participated in the discussion. The attendance list is presented in Annex 5.

69. During the discussion, the stakeholders received detailed information about the purpose of the consultation and the HOPE program, including the project development objectives, the result areas, and the DLIs. The World Bank team also inquired from the stakeholders about the capacity of the states to handle E&S issues. Several questions based on the result areas were raised by the World Bank team, to which representatives from the states responded. The questions centered on the capacity of the states to handle E&S issues in procurement, availability of legislations and regulations and procedures for handling ESIA, ESMP, e-waste management, solid waste management, hospital waste management, grievance redress mechanism, gender-based violence and sexual harassment, OHS procedures, social inclusion, among others. Some of the discussion questions and responses by the states regarding the result areas are presented in Tables 2.1 and 2.2. The details are in Annex 3 and 4.

Table 2.1: Questions and Responses Regarding Result Areas 1 and 2

Question	**How do you handle safeguard issues (environmental and Social) in your procurement?**
State	Response
Osun	We have a robust procurement law that incorporates provisions for tender bidding, ensuring environmental and social issues are addressed. We conduct all procurement activities within the boundaries of this law; they do not operate outside of it. They strictly adhere to the details outlined in the procurement process.
Rivers	The River State Bureau of Public Procurement (BoPP) oversees all procurement activities, particularly those related to construction and civil works. The BoPP must oversee all such projects. Additionally, they handle environmental impact assessments with dedicated consultants for this purpose. Within the ministry, there are separate units for project management and procurement. Collaboration between the ministry and the BoPP ensures effective oversight and coordination of procurement processes.
Anambra	Anambra's Bureau of Public Procurement (BoPP) handle all procurement issues. The Environmental and Social (E&S) officers ensure that all procurement activities incorporate E&S concerns. The BoPP centrally manages procurement processes across the state.
Enugu	Established both the BoPP and the due process unit. This agency and the unit ensure that procurements adhere to the laws and regulations.
Taraba	Taraba has a BoPP and a law that governs procurement issues.
Ogun	
Kwara	E&S is an important part of procurement. Procurement considers issues related to location, the project, and the socio-cultural needs of individual community members. We consider the cost implications, procurement of materials, and other fundamental aspects of procurement policy. The state has a public procurement agency that deals with procurement issues.

Borno	
Nasarawa	We have a robust Nasarawa State Bureau of Public Procurement. Procurement is initiated in the state. The efficiency unit in the Ministry of Finance vets' procurement and safeguards issues before procurement. In the absence of the safeguard's office, the procurement will be discarded, and the attention of the officer will be called upon.
Question	**Do you have experience preparing Environmental and Social Management Plans (ESMP) and Environmental and Social Impact Assessment (ESIA)? If yes, describe how it was carried out in one of the ministry's projects.**
State	Response
Osun	Yes, the World Bank implements programs and interventions in the state and collaborates with consultants to develop the necessary instruments. Oversee all agencies that handle intervention in the ministry of budget and planning but need the project manual.
Rivers	Yes, they have a project unit attached to the Ministry of Health. The project unit engages consultants who work alongside with architects, engineers, and surveyor to assist with preparations. Regarding the P4R initiative, they focus solely on innovation and do not undertake any construction projects
Anambra	They work with the WB during program inception, and the plans are developed. They got a consultant who liaised with an on-ground E&S officer to develop an E&S impact assessment for a project.
Enugu	Has robust social protection bodies developed by an assembly of concerned stakeholders for the state that passed through concerned areas for social issues and has a legal framework. The system incorporates gender-specific safeguards to protect vulnerable groups. Environment issues are within the purview of the Ministry of Environment.
Taraba	Ministry of Environment
Ogun	We developed social issues plan in collaboration with the Women Advocate Research Documentation Center and other government agencies, including the Ogun State Primary Healthcare Board. The desk officer, who was part of the training, is involved. Other collaboration plans with NGOs may exist. Though the respondent was not well-versed in the environmental plan, I'll contact the Ministry of Environment for details.

Table 2.2: Questions and Responses Regarding Result Area 3

Question	**How do you handle complaints and grievances? Do you have a framework, procedure, legislation, or regulation for redressing grievances? Do the Ministry and Agencies have a grievance redress mechanism?**
State	Response
Osun	In schools, we have a disciplinary committee headed by a senior teacher who listens to the complaints of the students. There are also suggestion boxes where grievances are dropped. The committee decides on the grievances.
Rivers	There are administrative protocols that addresses different types of grievances in the schools and workplace to ensure fair hearing and justice is served
Anambra	Has GRM framework in MDA which is a bottom-top approach
Enugu	Depending on the aggrieved person, for a learner, it starts from class management and escalated to the school management and further to the system management. For teachers, it goes to the management of the institution and scaled up to the management of the system until it is resolved
Taraba	
Ogun	Teacher can register their complaint through school head to zonal level and district and addressed
Kwara	Yes, GRM is functional in all 193 wards of the states, and there is a suggestion box in all wards. The social safeguard officer may resolve some complaints, and if cascaded, individuals from the ministry or community may handle them.

Borno	Yes, they have established GRM in the school communities. There are suggestion boxes, and there are telephone lines that can be called. There are GRCs in all communities. The secretary receives the complaint and calls for the GRC to sit down and resolve it with the aggrieved party. There is a framework in place.
Nasarawa	Yes, GRM is in SPHCDA and the state health insurance agency. The latter handles complaints about services provided by the agency. There are numbers available to all, and they address them. Quality control swings into action if it is escalated. QC also handles it if it is above the Local Government level at SPHCDA. A framework was adopted from the NSHIP project in their operation around services at the facility level. Each agency has a GRM, and most start from the lower level all the way up. For the health insurance scheme, each beneficiary has access to a phone number on their health card, which they can call to lodge their complaints.
Question	**Can marginalized people or those who feel they were not appropriately treated have a procedure to report their grievance? Do you have a mechanism to address the issues to the satisfaction of the complainants? Please give an example of how you handled this in the past.**
State	Response
Osun	Suggestion box is provided at the entrance for complains about those who complaints of marginalization. HIV patient was marginalized as no nurse wanted to attend but reported to the management and was treated
Rivers	Complaints can be addressed formally and informally but the complainant needs to lay the complaint
Anambra	
Enugu	Every class has a form master. If not addressed, it is scaled up to the principals, UBEC until resolved to the satisfaction of the complaint
Taraba	
Ogun	
Kwara	A team constitutes the GRC, with the ward chairman as head. Provision of micronutrient powder to children under 5, where some were excluded, was a result of fatigue from the community volunteers. GRM box and a GRM or line to be called
Borno	There is a suggestion box in the school committees where the GRC sits to deliberate on issues. E.g., renovation in one of the schools, and some classes do not have ramps, and the component lead was informed, who informed the SBMC, and the feedback on including ramps was communicated to the aggrieved person within a week.
Nasarawa	There is a client satisfaction survey conducted quarterly in delayed services to gather information from marginalized people to address issues relating to them. This is a result of limited human resources.

The findings and report of ESSA were presented to the stakeholders on June 21, 2024. Representatives from the Federal Ministry of Health (FMoH), National Primary Health Care Development Agency (NPHCDA), National Health Insurance Authority (NHIA), World Bank (WB), Executive Secretaries of State Primary Health Care Boards (SPHCB), Executive Secretaries of State Health Insurance Agencies (SHIA), and Partners attended the meeting.

70. During the meeting, the World Bank team presented a paper on the purpose of the consultation, the ESSA objectives, and the methodology. They equally provided a summary of the potential environmental and social risks and benefits of the HOPE-PforR, an overview of the relevant government environmental and social management systems, a summary of the systems assessment, and the program action plan (PAP), which includes the activity description, due date for activity implementation, description, and completion measurement. The comments/ questions by the attendees and the response from the World Bank team are in Table 2.3 below.

Table 2.3: Questions and comments by attendees and repose from the World Bank Team

S/N	Questions/Comments	Responses
1	A physical interaction will be more suitable to allow for in-depth discussions, immediate feedback, and better understanding of the project.	This is part of a series of consultations for project preparation. For the technical aspects, there will be physical meetings with the implementing entities to discuss the DLIs. This meeting is just the beginning of the process.
2	The DLIs on social risk of the influx of workers should be reviewed not just to capture gender-based violence but also child trafficking and labor. DLIs on GBV intervention should also address access to health for women and its benefit.	This shall be included in the Environmental and Social Safeguard documents and guidelines as well as incorporated within the DLIs.
3	The context of the E&Ss should be more focused rather than being too wide. At federal level we want to control all, we should set standard and monitor, we should incentivize results to achieve our objectives.	The program is designed as P4R at the state level. There should be collaboration at all levels to ensure there are no negative environmental and social impacts that would affect the communities, beneficiaries, and project. This session covers only the ESSA aspect. Subsequent sessions will focus on the technical aspect of the project
4	Gender related violence: The Context should be evidence based before it can be made a national document.	The bank team admitted that this would be considered
5	Sectors that would handle the Project should be properly informed for a seamless implementation of the program	Subsequent meetings will be held to discuss detailed project DLIs
6	Broaden the scope of the project to accommodate other key areas	The bank team admitted that this would be considered
7	The Ministry of Local Government should be key stakeholders in the program.	This will be considered in states with the presence of the Ministry of Local Government
8	Drug abuse should be incorporated in the component	This will be incorporated
9	Are there Measures of tracking process for the action plan	This process is detailed in the Program Action Plan (PAP).
10	Any measures to protect the health workers from violence.	The team shall develop measures to ensure health worker safety. States will also leverage on other risk management programs available in their respective states to manage issues and concerns.

SECTION III: DESCRIPTION OF EXPECTED PROGRAM ENVIRONMENTAL AND SOCIAL IMPACTS

3.1 Overview of Program Risks and Benefits

71. Low levels of investment in primary health care are the bane of health outcomes in Nigeria. Public sector spending on health (seven percent of the national budget, 0.8 percent of GDP, $15 per capita) is among the lowest in the world. Besides, Nigeria suffers from a shortage of qualified professionals,

including health workers, compared to LMICs. These are also highly unequal across regions/states. The World Bank is supporting the government of Nigeria through a hybrid program to increase the financing available for primary health care and enhance spending in basic primary health care through the HOPE Program.

72. The PforR component of HOPE-Health will generate some E&S benefits and risks. The environmental risks will result from rehabilitation and refurbishment of infrastructure, digital health enterprise in health architecture (digitization of the health system to ensure integrated and interoperable health data ecosystem), traffic risks due to increase in emergency transport of patients with obstetric and neonatal complications. On the other hand, the environmental benefits are minimal and limited to facilitating climate resiliency measures for PHC and BEmONC facilities and the climate benefits from the implementation of the national climate and health adaptation plan. The detailed range of key environmental and social risks and benefits associated with specific DLI in HOPE PforR is presented in Annex 2.

3.2 Expected Environmental Benefits

73. The PforR program will deliver minimal direct and indirect environmental benefits. Direct environmental benefits will accrue from achieving DLI 1.1, which is Percentage of BHCPF-supported Tier 2 (PHC+BEmONC) facilities that maintain a score of 75% on the health facility readiness assessment that includes measures of structural and process quality, solar power, and climate resilience and DLI 1.2 which is increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, and energy efficiency. Installing solar power and ensuring energy efficiency and climate resilience measures for health facilities will help reduce emissions and facilitate the achievement of Nigeria's 2060 zero emission target.

74. Activities to achieve DLI 9, which strengthens emergency preparedness and response at the subnational level, will also yield environmental benefits. Achieving this DLI will improve the handling of climate shocks, natural disasters and other humanitarian emergencies and generate some climate Co-Benefits.

75. In addition, the development and implementation of a national climate and health adaptation strategy in DLI 10 which will help address climate change and vulnerabilities will also generate some climate Co-Benefits. Activities under the plan could involve the use of facilitates and equipment that reduce emissions, especially renewable energy, thus, facilitating the achievement of the country's net-zero target.

3.3 Expected Environmental Risks and Impacts

76. The HOPE-Health PforR has some activities that are expected to impact the environment. Rehabilitation and refurbishment activities would be conducted to meet a score of 75% on the health facility readiness assessment in DLI 1.1 and to ensure that Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities demonstrate service readiness, climate resilience, energy efficiency (DLI 1.2). Also, rehabilitation work would be carried out due to improved fund allocation and disbursement under DLI8 and during the implementation of the national climate and health adaptation plan in DLI 10. The implementation could involve the rehabilitation of facilities, for example, WASH facilities that may exposed to natural disasters such as floods. Thus, environmental risks associated with rehabilitation, such as solid waste, noise, and air pollution, as well as occupational health and safety (OHS) risks, would negatively impact the environment.

77. Generation of waste from electrical and electronic equipment (WEEE), often referred to as E-waste, is expected, given the increased use of ICT to facilitate digital in health transformation in DLI 11.1 and adoption of digital in health infrastructure by states to achieve DLI 11.2 Also, e-waste could also be generated through the provision of health insurance under DLI6 activities.

78. In addition, some activities in the National Climate and Health Adaptation Plan (DLI 10|) may negatively impact the environment. For example, if the plan involves e-procurement, there could be e-waste generation. Also, if it involves the use of renewable energy, such as solar power, there could be negative environmental impacts associated with solar power, such as e-waste because of the disposal of used batteries, solar panels, and inverters as well as possible clearing of vegetation to install solar panels.

79. Also, the implementation of the emergency preparedness (EPR) program in DLI 9 and the emergency medical transport system in DLI 7 will lead to more vehicles for transporting patients in emergency and an increased number of patients transported to PHC or secondary health facilities. This will result in increased consumption of fossil fuels, and which will lead to increased CO_2 emissions and air pollution from transportation. The digitized system that will be employed in emergency transportation could, in the long run, result in e-waste.

3.4 Expected Social Benefits

80. The HOPE-Health PforR will result in many social benefits from achieving the DLIs. These benefits include enhanced health outcomes, reduced infant and maternal mortality rates, increased life expectancy, enhanced economic development, and poverty reduction, given that people will be healthy to work and contribute to economic development.

81. The refurbishment and staffing of PHC facilities to meet readiness in the assessment tool and application of the tool (DLI 1.1) and the refurbishment and empaneling of CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency in DLI 1.2 will facilitate the availability of water source, toilets, mother-newborn intensive care units, surgical theatres, and equipment. This will help ensure enhanced health outcomes, reduced infant and maternal mortality rates, and increased life expectancy. Improving quality healthcare services in Nigeria's healthcare facilities is recommended to ensure equity regarding access to healthcare, which will facilitate the realization of some health-related sustainable development goals (SDGs)[4].

82. Also, the rehabilitation of health facilities, will also lead to increased employment for the locals who may be engaged in menial jobs. Besides, the rehabilitation may lead to an influx of workers into the communities, thus enhancing the local economy. Besides the rehabilitation, health workers will also be recruited for PHC facilities, thus creating employment opportunities for unemployed health workers, and thus enhancing their income and well-being.

83. In addition, activities under DLI2 will facilitate the provision of contraceptives, tracer commodities and medicines to women and children. Tracer commodities include oxytocics, multiple micronutrient supplements (MMS), artemisinin-based combination therapy (ACTs), HIV rapid test kits, pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC). Provision of these commodities will reduce the incidence of malaria

[4] Oyekale, A.S. Assessment of primary health care facilities' service readiness in Nigeria. *BMC Health Serv Res* **17**, 172 (2017). https://doi.org/10.1186/s12913-017-2112-8

especially during pregnancy, reduce mother to child transmission of HIV, enhance the health of mothers and children, reduce infant and maternal mortality rates, and enhance their life expectancy.

84. Increased insurance coverage through linkages with the NHIA gateway (DLI 3), which will facilitate increased child enrolment in the NHIA and increased insurance coverage, will help ensure access to health, especially for the poor, as it will protect them from increased healthcare costs and ensure improved health outcomes and quality of life[5]. Also, the provision of tracer health services (DLI4) through community health workers including the provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification/follow-up of pregnant women and referral to receive multiple micronutrient supplements, treatment of any childhood illness, among others, will enhance the health of women and children, reduce infant and maternal mortality rates and enhance their life expectancy.

85. In addition, the design and approval of a CEmONC empanelment and reimbursement strategy and the provision of CEmONC, neonatal and under-5 services and/or VVF surgeries for women and under five children will equally enhance their quality of life, reduce infant and maternal mortality rates and enhance their life expectancy.

86. Having skilled birth attendants during delivery in PHC centres (DLI 6.1) will help ensure that pregnant women being delivered babies are attended to by skilled professionals, thus reducing the incidence of infant and maternal mortality rates. Also, under-five children and pregnant and lactating women are particularly vulnerable to micronutrient deficiencies. However, the provision of multiple micronutrient supplementation for pregnant women in DLI 6.2 will help prevent micronutrient deficiency in pregnant mothers and their babies and ensure that they are delivered of healthy babies with high immunity against diseases that threaten the lives of infants. It equally helps to ensure normal functioning and growth of babies and health of their mothers. In addition, the provision of penta-3 vaccination in DLI 6.3 will help ensure that children 12-23 months are maximally protected against Diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B and Haemophilus influenzae type b (Hib) and thus substantially reduce infant mortality rates.

87. Providing emergency transportation for patients with obstetric and neonatal complications in DLI 7 will help ensure that they receive timely medical services and thus prevent mortality. Also, improved resource allocation in DLI8 will help ensure that the required health facilities are provided in PHC, thus ensuring efficient health service delivery. This will in turn ensure reduced maternal and infant mortality rates, and increased life expectancy.

88. Furthermore, enhancing emergency preparedness and response in DLI9 will help in better management of disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies. Adequate emergency preparedness facilitates faster response times by healthcare workers, more efficient care, and better outcomes.

89. In addition, social benefits will accrue from the development and implementation of national climate and health adaptation plan in DLI 10. The plan will facilitate the provision of equipment and infrastructure, such as solar power, and the handling of diseases that result from climate disasters such

[5] Institute of Medicine (US) Committee on the Consequences of Uninsurance. Coverage Matters: Insurance and Health Care. Washington (DC): National Academies Press (US); 2001. 1, Why Health Insurance Matters. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223643/

as flooding. This will thus enhance the provision of needed medical services and thus enhance positive health outcomes.

90. Digitizing the health system in DLI 11 (digital in health enterprise in health architecture) offers many benefits to primary and general health care. For example, it would help policymakers make informed decisions about resource allocation and thus reduce healthcare costs. This will free up resources for other important healthcare services. It equally helps doctors and nurses to prioritize individual treatment plans and thus enhance better health outcomes. A study in Ethiopia found that implementing a 20-month data-informed platform for the management of health resulted in strengthened health management through better data use and appraisal practices, enhanced stakeholder engagement and systemized problem analysis to follow up on action points[6].

3.5 Social Risks and Impact

91. The HOPE-Health PforR is also associated with some social risks. The refurbishment and rehabilitation of medical facilities under DLI 1 and DLI8 (due to improved fund allocation) could potentially impact workers' health and safety for workers involved in rehabilitation works that may be associated with this DLI. The workers may be exposed to pollution caused by dust and noise at the work site. There could also be an influx of workers to the communities where rehabilitation work will occur. This may affect the communities as there could be cases of sexual abuse and other vices, for example, drug abuse. Activities in DLI10, which may involve rehabilitation, will also impact workers' health and safety as workers will be exposed to air pollution, noise, and other environmental impacts associated with rehabilitation work.

92. There could be potential discrimination of women and other vulnerable groups, ethnic considerations and sexual abuse or harassment of women in the provision of tracer essential health services by community health workers (DLI 4), provision of health insurance under the NHIA gateway (DLI3), provision of CEmONC, neonatal and under-5 services and/or VVF surgeries (DLI 5.2), distribution of MMS supplementation for pregnant women during ANC visits (DLI 6.2), provision of emergency medical transportation for patients with obstetric and neonatal complications (DLI7), ,. They could also be exposed to dangers of child theft and trafficking. In addition, although social conflict as envisaged by ESSA, especially regarding armed conflict, is not applicable, discrimination along the lines of ethnicity and religion in medical staff recruitment under DLI1, provision of tracer essential health services and provision of emergency transportation for patients with neonatal complications, and distribution of MMS supplementation for pregnant women can result in complaints, grievances, social unrest and demonstrations among communities that feel left out or cheated.

SECTION IV: OVERVIEW OF RELEVANT BORROWERS ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

The government of Nigeria (GON) has several policies, instruments and laws which support environmental and social management and environmental and social impact assessment processes. There are a few sectoral policies which provide directives to integrate environmental and social considerations in the decision-making process to avoid or minimize impacts associated with program

[6] Avan BI, Dubale M, Taye G, Marchant T, Persson LÅ, Schellenberg J. Data-driven decision-making for district health management: a cluster-randomised study in 24 districts of Ethiopia. BMJ Glob Health. 2024 Feb 29;9(2):e014140. doi: 10.1136/bmjgh-2023-014140. PMID: 38423549; PMCID: PMC10910485.

implementation. This section summarizes the policy, regulatory, institutional, and legal frameworks for environmental management Nigeria.

4.2 The Constitution of the Federal Republic of Nigeria (1999)

The basis of environmental policy in Nigeria is contained in the 1999 Nigerian Constitution of the Federal Republic of Nigeria. Pursuant to section 20 of the Constitution, the State is empowered to protect and improve the environment and safeguard the water, air and land, forest, and wildlife of Nigeria. In a similar way, social policy in Nigeria also originates from the 1999 Nigerian Constitution of the Federal Republic of Nigeria. Section 17 encourages the state to pursue equality of rights, equal pay for equal work, obligations, opportunities, and human dignity for all citizens. In addition, the state shall avoid social exclusion and discrimination of any form including gender, protection of children and vulnerable from any exploitation and moral and material neglect. The state will also promote equal access to facilities including health services.

4.2 Policies Relevant to the HOPE-Health Program

The national policies relevant to the HOPE-Health PforR is presented in Table 4.1.

Table 4.1: Nigerian Policies Relevant to the HOPE-Health Program

Policy	Objectives
National Policy on the Environment (Revised 2016)	**Overall, Policy Goal** To define a new holistic framework for guidance, management, and protection of the environment as well as the conservation of natural resources for sustainable development' of the country. **Objectives** ▪ Ensuring and securing the quality of Nigeria's environment to support good health and well-being. ▪ Promoting efficient and sustainable use of Nigeria's natural resources and the restoration and maintenance of the biological diversity of ecosystems. ▪ Promoting understanding of essential linkages between the environment, social and economic developmental issues. ▪ Encouraging individual and community participation in environmental improvement initiatives. ▪ Raising public awareness and engendering a national culture of environmental preservation; and ▪ Building partnership among all stakeholders, including government at all levels, international institutions and governments, non-governmental agencies, and communities on environmental matters.
National Policy on Health, 2016	**Vision, Mission, and Policy Goal** The vision is universal health coverage (UHC) for all Nigerians. The mission is to provide stakeholders in health with a comprehensive framework for harnessing all resources for health improvement towards the achievement of UHC as encapsulated in the National Health Act 2014, in tandem with the SDGs. The overall policy goal is to strengthen Nigeria's health system, particularly the primary health care sub-system, to deliver effective, efficient, equitable, accessible, affordable, acceptable, and comprehensive health care service to all Nigerians. **Policy Thrust:** It has ten policy thrusts derived from the National Strategic Health Development Plan (NSHDP) and WHO health system block. The policy thrusts are governance, health system delivery, health financing, medicines, human resources for health, vaccines, commodities and health technologies, health information system, health infrastructure,

	health research and development, community ownership/participation and partnerships for health.
National Gender Policy (2006)	**Overall, Policy Goal** The goal of the gender policy is to "build a just society devoid of discrimination, harness the dull potentials of all social groups regardless of sex or circumstance, promote the enjoyment of fundamental human rights and protect the health, social , economic and political well-being of all citizens in order to achieve equitable rapid economic growth, evolve an evidence based planning and governance system where human, social, financial and technological resources are efficiently deployed for sustainable development". One of the principles of the gender policy is a general recognition that gender issues are central and critical to the achievement of national development goals and objectives and by extension water, sanitation, and hygiene programs. **Objectives** ▫ Establish the framework for gender responsiveness in all public and private spheres and strengthen capacities of all stakeholders to deliver their component mandate of the gender policy and National Strategic Framework ▫ Develop and apply gender mainstreaming approaches, tools and instruments that are compatible with the macro- policy framework of the country at any given time towards national development. ▫ Adopt gender mainstreaming as a core value and practice in social transformation, organisational cultures and in the general polity in Nigeria. ▫ Incorporate the principles of CEDAW and other global and regional frameworks that support gender equality and women empowerment in the country's laws, legislative processes, judicial and administrative systems. ▫ Achieve minimum threshold of representation for women to promote equal opportunity in all areas of political social and economic life of the country for women as well as for men. ▫ Undertake women and men- specific projects as a means of developing the capabilities of both women and men, to enable them take advantage of economic and political opportunities towards the achievement of gender equality and women's empowerment. ▫ Educate and sensitize all stakeholders on the centrality of gender equality and women's empowerment to the attainment of overall national development.

4.3 Relevant Nigerian National Laws

The national laws relevant to the HOPE PforR is presented in Table 4.2.

Table 4.2: Nigerian Laws that are Relevant to the HOPE-Health Program

S/N	Law	Description/Summary of Objectives
Environmental Acts		
1	EIA Act - CAP. E12 L.F.N. 2004	▪ The main aim of the Act is to ensure environmentally sound and sustainable development projects. ▪ To carry out an EIA on all projects likely to have significant impact on the environment. ▪ Encourage information exchange and consultation between all stakeholders when proposed activities are likely to have significant impact on the environment.
2	National Environmental Standards and Regulations,	▪ Enforce compliance with national (and international) laws, legislations, guidelines, policies and standards on environmental matters; ▪ Coordinate and liaise with, stakeholders, within and outside Nigeria on matters of environmental standards, regulations and enforcement;

	Enforcement Agency Act, (NESREA) 2007	▪ Ensure that environmental projects funded by donor organizations and external support agencies adhere to regulations in environmental safety and protection; ▪ Enforce environmental control measures through registration, licensing and permitting Systems other than in the oil and gas sector; and ▪ Conduct environmental audit and establish data bank on regulatory and enforcement mechanisms of environmental standards other than in the oil and gas sector. Some relevant sections include *Section 7:* Authority to ensure compliance with all of Nigeria's environmental laws and treaty obligations; and ▪ *Section 8 (1) K and Section 27:* Authority to make and review regulations on air and water quality, discharge of effluents and other harmful substances as well as control of other forms of environmental pollution. ▪ The Agency has powers to: ▪ prohibit processes and use of equipment or technology that undermine environmental quality; ▪ conduct field follow-up of compliance with set standards and take procedures prescribed by law against any violator; ▪ subject to the provision of the Constitution of the Federal Republic of Nigeria, 1999, and in collaboration with relevant judicial authorities establish mobile courts to expeditiously dispense cases of violation of environmental regulation.
Social Acts		
5	Trade Union Amended Act 2005	▪ Makes provisions with respect to the formation, registration and organization of trade unions, and the Federation of Trade Unions ▪ It states, "notwithstanding anything to the contrary in this Act, membership of a trade union by employees shall be voluntary and no employee shall be forced to join any trade union or be victimized for refusing to join or remain a member". The amended Act, to ensure the funding of trade unions, empowers employers to make deduction from the wages of every worker who is a member of any of the trade unions for the purpose of paying contributions to the trade union so registered;
6	Employees Compensation Act (2010)	▪ This Act repeals the Workmen Act of 1980. ▪ The objectives of the Act include Provide for an open and fair system of guaranteed and adequate compensation for all employees or their dependents for any death, injury, disease or disability arising out of or in the course of employment; ▪ provide rehabilitation to employees with work-related disabilities as provided in this Act; ▪ establish and maintain a solvent compensation fund managed in the interest of employees and employers; ▪ provide for fair and adequate assessments for employers; ▪ provide an appeal procedure that is simple, fair, and accessible, with minimal delays; and ▪ combine efforts and resources of relevant stakeholders for the prevention of workplace disabilities, including the enforcement of occupational safety and health standards.
7	Trade Dispute Act CAP. T8 LFN 2004	▪ The Act makes provisions for the settlement of trade disputes and other matters ancillary thereto. The Act established the National Industrial Court. The Act provides for procedure of settling dispute before it is reported; apprehension of trade dispute by the Minister; reporting of dispute if not amicably settled; appointment of conciliator, etc. Regarding the procedure before dispute is reported, the Act provides that parties to the dispute shall first attempt to settle it by an agreed means for settlement of the dispute apart from the Act. It is only when this procedure fails or does not exist that the parties report within seven days and come together to settle the dispute under a conciliator. Notwithstanding this

		provision, the Minister can apprehend the dispute and decide on the cause of action for the settlement of the dispute.
8	Labor Act CAP L1 LFN 2004	▪ Act provides for the protection of wages, contracts of employment and terms and conditions of employment as well as recruiting guidelines. It provides for special classes of worker and miscellaneous special provisions. The Act in the different parts made a lot of provisions to ensure that the interest of the worker is protected. For example, under protection of wages the Act made provisions to ensure that the worker's dignity regarding wages is maintained. For example, the Act provides in part 1No 2 that no employer shall impose in any contract for the employment of any worker any terms as to the place at which, or the manner in which, or the person with whom any wages paid to the worker are to be expended; and every contract between an employer and a worker containing any such terms shall be illegal, null and void
9	Child Right Act 2003	▪ Incorporate into its laws all the rights guaranteed in the United Nations' Convention on the Rights of the Child. The U.N. convention, adopted in 1989, states that: "The child shall be protected against all forms of neglect, cruelty, and exploitation. He shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental, or moral development." The Act must be ratified by each state to become law in its territory.
10	Violence Against Persons (Prohibition) VAPP Act 2015	▫ The Act was passed into law in a bid to eliminate violence in private and public life; prohibit all forms of violence, including physical, sexual, psychological, domestic, harmful traditional practices; discrimination against persons and to provide maximum protection and effective remedies for victims and punishment of offenders. ▫ The content of the Act is rich in its provisions as it covers most of the prevalent forms of violence in Nigeria today ranging from physical violence; psychological violence; sexual violence; harmful traditional practices; and socio-economic violence. ▫ The National Agency for the Prohibition of Trafficking in Persons (NAPTIP) is named as the service provider. ▫ Under the VAPP Act, the following offences are punishable offences.; ○ rape, ○ spousal battery, ○ forceful ejection from home, ○ forced financial dependence or economic abuse, ○ harmful widowhood practices, ○ female circumcision or genital mutilation, ○ abandonment of children, ○ harmful traditional practices, ○ harmful substance attacks such as acid baths, ○ political violence, ○ forced isolation and separation from family and friends, ○ depriving persons of their liberty, ○ incest, ▫ indecent exposure and violence by state actors (especially government security forces).
Health Acts		
11	Nigeria National Health Act 2014	▪ The Act provides the framework for the regulation, development and management of the national health systems and set standards for the regulation of the health system and sets standards for rendering health services in the country. The Act covers both the public and private providers of health services.

		▪ It provides that the national health system includes the federal ministry of health, states ministry of health, FCT departments responsible for health services, parastatals under the ministries of health in federal and state, all local government areas health authorities, ward health committees, village health committees, private health care providers, traditional health care providers and alternative health care providers. The Act established the national health council and provided for the duties of the ministries of health headed by the Minister at the federal level and commissioners at the state level. It also established the national tertiary health institutions and committees among others.

4.4 Relevant Nigerian National Environmental Regulations

The national environmental regulations relevant to the HOPE PforR is presented in Table 4.3

Table 4.3: Nigerian Regulations that are Relevant to the HOPE-Health Program

S/N	Regulation	Objectives
1.	Harmful Waste (Special Criminal Provisions) Act Cap H1I, 2004v	The Act prohibits, without lawful authority, the carrying, dumping, or depositing of harmful waste in the air, land or waters of Nigeria.
2.	National Environmental (Permitting and Licensing System) Regulations, 2009. S. I. No. 29.	The provisions of this Regulation enable consistent application of environmental laws, regulations, and standards in all sectors of the economy and geographical regions.
3.	National Environmental (Sanitation and Wastes Control) Regulations, 2009. S.I. No. 28	To provide the legal framework for the adoption of sustainable and environment friendly practices in environmental sanitation and waste management to minimize pollution.
4.	The National Environmental (Electrical Electronic Sector) Regulations SI No 23 of 2011	This regulation prevents and minimizes pollution from all ancillary activities of the Electrical/Electronic Equipment (EEE/UEEE) in the country based on the 5Rs (reduce, repair, re-use, recycle and recover) principle.

4.5 Nigeria's Institutional Framework

4.5.1 Federal Ministries Relevant to HOPE-Health Program

The Federal Ministries whose functions and responsibilities are relevant to the HOPE PforR is presented in Table 4.4.

Table 4.4: Relevant Ministries and Agencies and Their Functions at the Federal Level

S/N	Ministry	Relevant Functions and Responsibilities
1	Federal Ministry of Finance, Budget, and National Planning	Iin collaboration with the World Bank controls disbursement of funds. Program funds will be channeled through the Federal Ministry of Finance.
2	Federal Ministry of Environment (FMEnv)	The focal ministry of environmental issues in Nigeria. They will lead in implementing environmental actions at the federal level as recommended in the PAP. They are also responsible for oversight and disclosure regarding EIA at the federal level.
3	The Federal Ministry of Labor and Employment	▪ Development and promotion of productive employment policies and programs for employment generation and actualization of national employment policies of the Federal Government. ▪ Skills Development, upgrading, certification, placement and empowerment of artisans, tradesmen, and applicants in various areas of national needs ▪ Provision of Social Security Coverage, Welfare and Employee's Compensation to the nation's workforce ▪ Provision of Labor Protection Services, supervision, enforcement, Education, Promotion of Social Justice, Ratification, Implementation and Review of National Labor Laws and Policies including collective bargained agreements. ▪ Trade Unions Education and Training

		▪ International Labor Diplomacy ▪ Promotion of Occupational Safety and Health under the Occupational Safety and Health Department ▪ Enforcement of the Labor Laws under the Inspectorate Department (INSP)
4	Federal Ministry of Women Affairs, Community and Social Development	▪ The focal ministry of social issues in Nigeria. They will lead in implementing and monitoring environmental and social actions at the federal level as recommended in the PAP
6	Federal Ministry of Health and Social Welfare	▪ The ministry is responsible for the formulation and implementation of health policies in Nigeria. It has different departments that are specialized in the different aspects of health care. The ministry is the secretariat to the National Council on Health. It will be primarily responsible for the implementation of HOPE-Health.

4.5.2 State Ministries Relevant to HOPE-Health Program

The State Ministries whose functions and responsibilities are relevant to the HOPE PforR is presented in Table 4.5.

Table 4.5: Relevant Ministries and Agencies and Their Functions at the State Level

S/N	Ministry	Relevant Functions and Responsibilities
1	State Ministry of Finance, Budget, and Economic Planning	▪ In collaboration with the World Bank controls disbursement of funds. Program funds will be channeled through the State Ministry of Finance.
2	State Ministry of Environment (SMEnv)	The focal ministry of environmental issues at the state level. All the states have a ministry responsible for environmental issues. They will lead in implementing environmental actions at the state level as recommended in the PAP. They are also responsible for oversight and disclosure regarding EIA at the state level. Some states have environmental protection and waste management agencies responsible for waste management and other environmental protection activities in the states.
3	State Ministry of Women Affairs, Community and Social Development	▪ The focal ministry of social issues in states. They will lead in implementing and monitoring d social actions at the state level as recommended in the PAP
4	State Ministry of Health	▪ The state ministries of health, like the federal counterpart is responsible for the development/ formulation and implementation of health policies at the state level.

SECTION V: ASSESSMENT OF THE CLIENT'S ENVIRONMENTAL AND SOCIAL MANAGEMENT SYSTEMS

This section describes the E&S management systems in place to manage all identified E&S risks associated with the program interventions detailed in Section III, especially adverse impacts and risks. It describes the main elements of applicable client's systems and provides an analysis of the acceptability of these systems, considering the level of risk and the extent to which Borrower systems and practices are aligned with the World Bank's 6 core principles on E&S on Performance-for-Results financing. That is, the analysis will show the extent to which the applicable systems are consistent with the core principles and key planning elements expressed in the PforR Guidance Document. It also provides a review of aspects where gaps exist between the two systems. The assessment was done using the following criteria:

- An analysis of the strengths of the existing environmental and social due diligence system, or where it functions effectively and efficiently and is consistent with Bank Policy and Directive for Program-for-Results Financing.

- Identification of inconsistencies and gaps between the principles espoused in Bank Policy and Directive for Program-for-Results Financing and capacity constraints and gaps in existing capacity; and
- Based on the above findings, recommendations to fill gaps and proposed mitigation measures and actions to strengthen the existing system to ensure environmental and social soundness and long-term sustainability in line with the design and implementation and operation of program interventions across the project areas.

93. Section 5.1 presents a summary of the assessments of Federal Government systems in accordance with the core principles. Information from this analysis and the resulting identification of gaps and opportunities/actions informed the program's recommendations regarding managing E&S aspects and the preparation of the Program Action Plan (PAP).

5.1: Summary of Systems Assessment

Core Principle 1: General Principle of Environmental and Social Management

Table 5.1: Assessment Core Principle 1: General Principle of Environmental and Social Management

Bank Policy for Program-for-Results Financing: Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program's

***Bank Directive for Program-for-Results Financing**:* Program procedures will:

- Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the program level.
- Incorporate recognized elements of environmental and social assessment good practice, including:
- early screening of potential effects;
- consideration of strategic, technical, and site alternatives (including the "no action" alternative);
- explicit assessment of potential induced, cumulative, and trans-boundary impacts;
- identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized.
- clear articulation of institutional responsibilities and resources to support implementation of plans; and
- Responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and responsive grievance redress measures.

Applicability: YES / NO

The E&S team has conducted a screening of initial risks of the PforR. Environmental and social risks are posed due to Improved primary health care facility readiness, quality, and climate resilience (DLI1.1), Increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (DLI1.2), Federal expenditure on quality family planning commodities increased (DLI2.1), Increased utilization of EMS (DLI7), Improved allocation and disbursement of BHCPF funds (DLI8) System and standards for state EPR programs are established (DLI9), National climate and health adaptation plan developed, costed, validated, and implemented (DLI10) and Stronger Digital Foundation (DLI11). .

Applicable RA/DLIs	Systems Assessment	Gaps	Suggestions to Fill Gaps/Proposed Mitigation Measures
DLI 1.1, DLI1.2, DLI2.1, DLI7, DLI8, DLI9, DLI10 and DLI11	**FEDERAL LEVEL** ▫ At the Federal level, National Policies, Acts, Regulations for environmental management as well as institutional system's identifying environment procedures, roles and legislation to be followed in the country (See Chapter 4) are well defined and are consistent with Core Principle 1 of the Bank Policy and Directives on PforR Operation. ▫ The national EIA system (EIA Act No. 86 of 1992) provides a comprehensive legal and regulatory framework for environmental and social impact	**FEDERAL LEVEL** ▫ The EIA Act only focuses on the environmental standards. The World Bank standards on social issues is not addressed by the EIA particularly requirements on stakeholder engagement, labor, resettlement and land acquisition or ecosystem services. ▫ At the national level there is no direct/ single ministry that is responsible for the totality of the social sustainability components, that is required by the World Bank Standards. What we have are isolated ministries performing isolated roles related to social concerns. See Chapter 4.	▫Support should be provided at specific project levels and a technical assistance component be used to fill capacity gaps and strengthen E&S risk management systems. ▫There is also a need to strengthen the E&S capacity at the agencies responsible for the program implementation at the federal level namely NHIA,. NPHCDA ▫There is a need to strengthen the E&S management capacities of the Federal Government in terms of management of

	assessment that is broadly consistent with the Core Principle 1 of the Bank Policy and Directive. ▫ Environmental Assessment (EA) Department of the Federal Ministry of Environment is responsible for ensuring that the environmental risks are assessed, and adequate measures are taken to mitigate and or manage potential project impacts in line with the Federal Republic of Nigerian EIA Act of 1992. ▫ E-waste regulation compels all manufacturers and importers of electrical equipment, e-waste collection centres, and recycling facilities to register with the E-waste Producer Responsibility Organization Nigeria (EPRON) ▫ NESREA is also empowered to enforce non-compliance with environmental laws and regulations. STATE LEVEL ○ Most States in the federation have their own state environment Ministry or agency. ○ Most of the sample states have robust framework regarding environmental assessment and management, for example, Delta State has a environmental sanitation law, ecology law and waste management law. Lagos State has environmental protection law, etc. ○ States also have strong coordination with Federal Ministry of Environment and NESREA.	▫ There is no requirement for consulting with local communities or vulnerable people in EIA process. ▫ The capacity of the ministry and responsible agency to monitor and enforce environmental assessments is weak. ▫ STATE LEVEL ▫ There are weak infrastructural and human resources capacities in delivering a robust ESIA process at the State level ▫ The State environment ministries have weak capacities and mirror gaps in the federal environmental regulation and laws ▫ The corresponding ministries to E&S thematic areas at the state level do not interface well with the Ministry of Education and Health.	e-waste, and provision of adequate skilled human resources. ▫ Need for e-waste management procedure for the program to ensure that e-waste disposal is well covered. ▫ There is a need to strengthen the E&S management capacities of the states involved in terms of OHS, and provision of adequate skilled human resources to tackle E&S issues especially at the States/SPHCDA

Core Principle 2: Natural Habitats and Physical Cultural Resources

Table 5.2: Assessment Core Principle 2: Natural Habitats and Physical Cultural Resources

Bank Policy for Program-for-Results Financing: Environmental and social management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program.
Bank Directive for Program-for-Results Financing*:* As relevant, the program to be supported: ▪ Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas. ▪ Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities. ▪ Takes into account potential adverse effects on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects
Applicability: YES / **NO** It is not expected that the Program will have any impact on natural habitats and physical cultural resources since it will not involve any new construction but possible rehabilitation of existing facilities.

Core Principle 3: Public and Worker Safety

Table 5.3: Assessment Core Principle 3: Public and Worker Safety

Bank Policy for Program-for-Results Financing: Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
***Bank Directive for Program-for-Results Financing**:* ▪ Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed. ▪ Promotes use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated through program construction or operations; and promotes use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with international guidelines and conventions. ▪ Includes measures to avoid, minimize, or mitigate community, individual, and worker risks when program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.			
Applicability: YES / **NO** It is expected that the Program will have impact on pubic and worker safety since it will involve rehabilitation of health infrastructure through improved primary health care facility readiness, quality, and climate resilience (DLI1.12), Increase in refurbished and empaneled CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (DLI1.2), Improved allocation and disbursement of BHCPF funds (DLI8) , and activities under the National climate and health adaptation plan (DLI10),			
Applicable DLIs	**Systems Assessment**	**Gaps**	**Suggestions to Fill Gaps/Proposed Mitigation Measures**
DLI 1.1, DLI1.2, DLI8, and DLI10.	**FEDERAL LEVEL** ▫ The legal/regulatory system of the country includes provisions for protecting worker, community, and public safety. Some of these include, Labour Act of 2004, the Trade Union Amended Act of 2005, and the Employees Compensation Act of 2010. See Table III.5 ▫ NESREA has regulations to protect the public from hazardous chemicals, pesticides, and agrochemicals (National Environmental (Hazardous Chemicals and Pesticides) Regulations, S.I. No 65, 2014). ▫ The country also has some legal statutes	**FEDERAL LEVEL** ▫The national EIA system does not comprehensively encompass aspects of public and worker safety. ▫There is limited awareness by the public, especially farmers, on public health and safety issues, particularly in relation to exposure to hazardous materials, fertilizers and pesticide handling and safety precautions. ▫Lack of awareness of relevant authorities' staff to appreciate the need to ensure occupational health and safety. The FMH and FME have little	▫ The Federal Ministry of Environment should work towards improving the EIA system to incorporate important aspects lacking in the system, for example, issues relating to public and workers' safety and broader ESHS. Meanwhile, they should ensure that EIA reports submitted for review cover social issues especially relating to public and worker safety. ▫ States and Federal Ministry of Environment, States and Federal Ministry of Labour and States and Federal Ministry of Health should collaborate and build the capacity of

	and provisions to protect workers. Some of these include, Labour Act of 2004, the Trade Union Amended Act of 2005, and the Employees Compensation Act of 2010. ▫ The federal government has the Ministry of Labor, and their responsibilities include the protection of the rights of workers. ▫ The Federal Child's Right Act (CRA) (2003) codifies the rights of children in Nigeria. It has penalties on the use of child labour ▫ The Nigerian Labor Law requires compliance with all national and international labor laws on occupational health and safety. The law requires routine inspection of workplaces, accident investigation, preparation of safety and health regulations, code of practice, guidelines and standards for various operations, processes, and hazards. **STATE LEVEL** ▫ Most state governments also have Ministries of Labor and these ministries also work to protect the rights of workers at the state level. ▫ Some of the states have standalone laws and regulations to protect the rights of children and workers, e.g. Plateau State Child's Right Law 2005 was gazette in the state in 2017. ▫	experience in OHS in a project environment. ▫The enforcement of national labor laws is weak. ▫The national EA Department of the FMEnv and NESREA have not comprehensively incorporated OHS management into civil works. **STATE LEVEL** ▫Some States lack OHS guidelines and procedures to be adopted by contractors, firms (especially MSEs), employers of labour and workers in most of the States ▫Lack of awareness of relevant authorities' staff to appreciate the need to ensure occupational health and safety. ▫There is limited awareness and lack of interest by the public, on public health and safety issues, ▫Inadequate awareness of relevant authorities' staff to appreciate the need to ensure OHS.	the leaders in the different institutions in the sector for them to become knowledgeable on issues relating to occupational health and hazard and how to deal prevent and deal with it. ▫ State governments should ensure that government and employers of labour in the state enroll or cover their workers under the Workers Compensation Insurance. ▫ Provide on-site training to workers and laborers that will be involved in rehabilitation and upgrading work so that they will be familiar with OHS issues at their workplace. ▫ Provide training supply chain laborers/employers. ▫ State governments should ensure that contractors, and other employers of labour especially those involving rehabilitation, health work, sanitation and waste management provide personal protective equipment for their workers. ▫ Ensure that all workers engaged under medical waste collection are provided with a relevant personal protective and safety equipment. ▫ Put in place a Grievance redress mechanism to handle workers conflicts. ▫ .

Core Principle 4: Land Acquisition

Table 5.4: Assessment Core Principle 4: Land Acquisition

Bank Policy for Program-for-Results Financing*: Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.*
Bank Directive for Program-for-Results Financing*:* As relevant, the program to be supported: ▪ Avoids or minimizes land acquisition and related adverse impacts; ▪ Identifies and addresses economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy; ▪ Provides compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access; ▪ Provides supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment); and ▪ Restores or replaces public infrastructure and community services that may be adversely affected.
Applicability: YES / **NO** The Program does not involve any form of land acquisition; thus, this core principle is not applicable. .

Core Principle 5: Social Considerations - Indigenous Peoples and Vulnerable Groups

Table 5.5: Assessment Core Principle 5: Social Considerations - Indigenous Peoples and Vulnerable Groups

Bank Policy for Program-for-Results Financing: Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of Indigenous Peoples and to the needs or concerns of vulnerable groups.
Bank Directive for Program-for-Results Financing: • Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program. • Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples. • Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.
Applicability: YES / NO It is expected that vulnerable people may be impacted through discrimination and biased implementation of activities aimed at improving primary health care facility readiness, quality, and climate resilience (DLI1.1), biased implementation of refurbishment and empaneling CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency (DLI1.2), biased implementation of financial protection for poor and vulnerable populations (DLI3), discrimination in the implementation of tracer essential health services for women and children in DLI4, discrimination in the provision of CEmONC and neonatal services and/or VVF surgeries to women and children, discrimination in the provision of emergency medical transport to patients with obstetric and neonatal complications (DLI7), and biased implementation of the national climate and health adaptation plan (DLI10). The applicability in terms of specific DLIs is /indicated below.

Applicable DLIs	**Systems Assessment**	**Gaps**	**Suggestions to Fill Gaps/Proposed Mitigation Measures**
DLI1.1, DLI1.2, DLI2, DLI3, DLI4, DLI7, and DLI10.	**FEDERAL LEVEL** ▫ Chapter IV of the Nigerian Constitution contains a variety of fundamental rights set out in Sections 33 - 44. of particular relevance is Section 42, which prohibits discrimination on the grounds of ethnic origin, sex (gender), religion, or linguistic affiliation. ▫ There is a Federal Ministry of Women Affairs and Social Development that deals with all gender related issues especially as it concerns the vulnerable especially women youths and People living with Disabilities (PWDs). They have a unit that deals with GBV and discrimination.	**FEDERAL LEVEL** ▫ There is a serious lack of trust in government and government ministries and agencies responsible for effective communication and engaging with the people, for example, the National Orientation Agency, Federal Ministry of Information and Culture and the Federal Ministries of Women Affairs and Social Development lack the requisite capacity and trust to build social contract. ▫ There is lack of information and weak knowledge of the public especially vulnerable groups regarding the issues relating to the economy, the need for effective tax system and payment of tax and the benefits of petroleum subsidy removal. ▫ There is weak of capacity in Ministries of Women	▫ Deliberate efforts to strengthen multi-agency coordination e.g. between the National Orientation Agency, Federal Ministry of Information and Culture and the Federal Ministries of Women Affairs and Social Development to facilitate effective communication of government policies to the citizens, build trust in government and to strengthen the social contract, such as actions to tackle corruption and improve the delivery of services. Although these agencies are not directly involved in the implementation of HOPE-Health. ▫ There is also a need to strengthen the capacities of the technical staff of these agencies to enhance communication of government programs and build trust with the

	▫ The Federal Ministry of Information and Culture has some institutions and agencies under it, for example, Radio Nigeria, Nigeria Television Authority and the National Orientation Agency that are responsible for communicating government programs and building trust with citizens. **STATE LEVEL** ▫ Also, most state governments have Ministry of Women Affairs/Gender Affairs and Social Development. These ministries help to address the issues of GBV and discriminations of vulnerable people. Specifically, the Law in Ekiti State provides welfare package (cash/in-kind) to the elderly. ▫ Many States have robust legal framework for Gender considerations, youths' affairs and social exclusions and discrimination. ▫ Many states have laws and frameworks in dealing with violence and discrimination while some states, in addition, some have response teams to deal with GBV for example Kaduna State GBV Response Team. ▫ Few States have adopted the Violence against persons Law, e.g Kaduna State (adopted in 2018) and Ekiti State (adopted in 2019)	Affairs and Social Development to tackle the issues of GBV and other issues relating to gender and youths. ▫ There is no coordinated strategy for implementing a broad social inclusion agenda across public services in Nigeria. **STATE LEVEL** ▫ Many States are yet to adopt the Violence Against Persons (Prohibition) Law. ▫ Many states do not have adequate framework and institutional arrangement for combating GBV or prosecuting and punishing those involved in GBV thus offenders often do not get punished. ▫ Many of the states do not have policy to ensure inclusion of minority/ ethnic groups at local level or the extreme poor in programs. ▫ Also, many of the States do not have gender policy or guidelines for dealing with vulnerable people and PWDs to ensure that they are not treated with contempt and partiality. ▫	citizens. ▫ States without Gender Policy should set in motion the process of developing their gender policy which will contain guidelines and processes of preventing discrimination against vulnerable groups and PWDs. ▫ States without a gender-based violence response team should quickly set up Domestic and Gender-based (Sexual) Violence Response Team (DSVRT) to for quick response to issues of GBV in the states. ▫ Sates should carryout regular enlightenment programs for the public and capacity building programs for staff of gender/women ministries. ▫ The Program implementing agencies should ensure that there is not discrimination ion recruitment of teachers and health work and put in place an effective GRM to ensure that peoples' complaints especially regarding recruitment are addressed effectively. ▫

Core Principle 6: Social Conflict

Table 5.6: Assessment Core Principle 6: Social Conflict

Bank Policy for Program-for-Results Financing: Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes. • ***Bank Directive for Program-for-Results Financing****:* Considers conflict risks, including distributional equity and cultural sensitivities. **Applicability: YES** / No Armed conflicts are not expected during the implementation of the Program, however, there could be disagreements, complaints, demonstrations and grievances may arise during the Program implementation due to discrimination or biased in recruitment of medical staff in DLI 1.1, provision of health insurance (DLI3), provision of tracer essential health services (DLI4), provision of MMS supplementation for women (DLI6.2), provision of emergency transportation for patients with obstetric and neonatal complications (DLI7)			
Applicable DLIs	**Systems Assessment**	**Gaps**	**Suggestions to Fill Gaps/Proposed Mitigation Measures**
DLI 1.1, DLI3, DLI4, DLI6.2 and DLI7. :	**FEDERAL LEVEL** ▫ The constitution of the Federal Republic of Nigeria 1999 (as amended) provides in Section 17 (3) (g) that "the State shall direct its policy towards ensuring that provision is made for public assistance in deserving cases, or other conditions of need. ▫ Federal throughout the country with well-trained police and security forces who maintain the rule of law and also provides security against bandits and other forms of violent crimes and attacks. ▫ The military also provides security against armed insurgency and terrorism. ▫ There is also a justice system with courts where people can seek redress. ▫ The federal government also has the public complaints commission where people can make complaints regarding administrative injustices. ▫ **STATE LEVEL** ▫ State presence is strong throughout the country with well-trained police and security forces who maintain the rule of law and also provides security against bandits and during	**FEDERAL LEVEL** ▫ Lack of a Grievance Redress Mechanism (GRM) for the poor and vulnerable. Although Nigeria has a justice system with courts where people can seek justice, poor and vulnerable people do not have the capacity to seek justice in courts. ▫ The available GRM are weak and ad-hoc and not properly institutionalized. This is a need to ensure that people's grievances are properly redressed even when there is need to seek further redress if the individual is not satisfied with the outcome of existing arrangements. ▫ **STATE LEVEL** ▫ Most of the states do not have a GRM where poor and vulnerable can make complaints and get redress. ▫ Although some states have ways of settling grievances, these arrangements are ad-hoc and needs to be properly institutionalized.	▫ Strengthened stakeholder engagement and grievance redress mechanisms and increased transparency to provide information and communication avenues for complaints and their resolutions. ▫ Build social contract with the people to facilitate success of proposed reforms. ▫ States without a framework to provide free legal services/legal aid and advice to the citizens should work towards providing that. ▫ States without an agency responsible for grievance redress and peaceful resolution of disputes should make effort to provide one. ▫ States should strengthen their GRM to facilitate resolution of conflicts. ▫

	clashes between farmers and herders. There is also a justice system with courts where people can seek redress. ▫ Some state government also have different institutional arrangements, e.g. Multidoor Courthouse Law and Public defender Law in Delta State. ▫	▫ Available GRM frameworks are not formalized and not well recognized. ▫ ▫ Most of the states do not have GRM mechanisms where poor and vulnerable can make complaints and get redress.	

SECTION VI: PROGRAM ACTION PLAN (PAP) AND RECOMMENDATIONS

This section recommends measures that will be taken to strengthen system performance in line with the gaps and risks identified in section iv of the system assessment section to ensure that the Program interventions are aligned with the Core Principles 1, 3, 5 and 6 of Bank Policy for Program-for-Results financing as stated below:

- **Core Principle 1: General Principle of Environmental and Social Management:**

- Core Principle 3: Public and Worker Safety
- Core Principle 5: Social Considerations - Indigenous Peoples and Vulnerable Groups:
- Core Principle 6: Social Conflict

These actions may be further refined and adjusted during the consultation process and the implementation of the Program.

6.1 Environmental Summary and Recommendations

Although Nigeria has a well-defined environmental system that is close to the core principle on environmental assessment, some gaps remain. For example, the monitoring of EIA implementation is weak as there is no tracking system to monitor environmental and social risks and performance. At the State and local levels, there is a weak capacity to deliver a robust environmental assessment process. OHS framework is also weak, especially in primary health care centres. There is equally weak monitoring and evaluation of environmental and social systems at the state level, in addition to weak enforcement.

Given the environmental impact of this project, some recommendations are made as follows:

- Undertake environmental screening of designs for the rehabilitation of facilities to ensure that the rehabilitation activities under some DLIs especially DLI 1 filter out substantial or high-risk civil works and proposed actions.
- Strengthening the E&S capacity under the project is needed. To facilitate this, E&S specialists should be recruited for the Program.
- E-waste and healthcare waste management strategies should also be developed to facilitate their management. The requirements for e-waste and healthcare waste control should be included in the bidding document under HOPE-Health PforR.
- There is a need to develop an environmental management strategy or manual, traffic management plan and OHS guidelines for primary health care centres.

6.2 Social Summary and Recommendations

Given the identified social issues and weaknesses in the federal system, the following recommendations are made:

- Ensure that the provision of MMS supplementation for women, provision of tracer essential health services, and provision of emergency transportation to patients with obstetric and neonatal complications are carried out transparently to avoid bias and avoid ethnic or religious considerations.

- Carry out Program outreach campaigns and citizen engagement activities to adequately target rural, marginalized, and vulnerable populations, especially in the provision of MMS for women, tracer essential health services, and emergency transportation to patients with obstetric and neonatal complications.
- Establish a robust grievance redress mechanism specific to the Program to ensure that complaints from different stakeholders are well addressed.
- Strengthen provisions in the Code of Conduct (CoC) on gender-based violence (GBV) prevention and response, including clear protocols for identifying, reporting, and addressing instances of GBV within the program.
- Ensure beneficiaries who may experience various forms of GBV because of cash transfer intervention will access services from community- based /NGO GBV service providers and the PHCs.
- Specific communication on GBV prevention should be rolled-out as part of the outreach activities for the Program.

94. Following the recommendations, the breakdown of actions to be included in the Program Action Plan (PAP) with indicative timeline, responsibility for implementation and indicators for measuring the completion of such actions are detailed in the Table ES2. below.

SECTION VII. SUPPORTING ANNEXES AND REFERENCE DOCUMENTS

Annex 1: Applicability of Core Environmental and Social Principles (CP) to the HOPE Program Result Area and Disbursement Linked Indicators (DLIs)

DLI	CP1 Environment	CP2 Natural Habitats	CP3 Public & Worker Safety	CP4 Land Acquisition	CP5 Vulnerable groups	CP6 Social Conflict
RA 1: Improving quality of services.						
DLI 1.1: Improved primary health care facility readiness, quality, and climate resilience	Applicable, as there are rehabilitation works supported by the DLI.	Not Applicable as new construction is not supported by the DLI	Applicable as there are rehabilitation works supported by the DLI	Not Applicable	This is applicable as.	applicable as there could be complaints, grievances and social unrest due to biased recruitment of medical staff to achieve health care facility and quality readiness.
DLI 1.2: Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency	Applicable, as there are rehabilitation works supported by the DLI.	Not Applicable as new construction is not supported by the DLI	Applicable as there are rehabilitation works supported by the DLI	Not Applicable	This is applicable as.	applicable as there could be complaints, grievances and social unrest due to biased recruitment of medical staff to achieve health care facility and quality readiness.
DLI 2.1.: Federal expenditure on quality family planning commodities increased	This is applicable as there is a possibility of waste because of increased procurement of health commodities.	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Not Applicable	Not Applicable
DLI 2.2: Front-line availability of tracer** products improved	This is applicable as there is a possibility of waste because of	Not Applicable as there are no physical works	Not Applicable as there are no physical works	Not Applicable as there are no physical works	Not Applicable	Not Applicable

DLI	CP1 Environment	CP2 Natural Habitats	CP3 Public & Worker Safety	CP4 Land Acquisition	CP5 Vulnerable groups	CP6 Social Conflict
	increased procurement of health commodities.	supported by the DLI	supported by the DLI	supported by the DLI		
RA2: Improving Utilization of Essential Services						
DLI 3: Financial protection for poor and vulnerable populations increased	Not Appliable as there is no rehabilitation works and activities that may impact the environment due to the implementation of the DLI.	Not applicable as there are no physical works that may affect	Applicable as there are rehabilitation works supported by the DLI	Not Applicable	This is applicable as there could be discrimination against the vulnerable in health insurance provision.	This is applicable as there couild be complaints and and social disturbances in communities due to lopsided provision of health insurance.
DLI 4: Women and children who receive tracer essential health services in the community increased	Not Applicable, as there are no rehabilitation works supported by the DLI.	Not Applicable as new construction is not supported by the DLI	Applicable as there are rehabilitation works supported by the DLI	Not Applicable	This is applicable as there could be discrimination against the vulnerable in provision of tracer essential health services	This is applicable as there couild be complaints and and social disturbances in communities due to lopsided provision of tracer essential health services.
DLI 5: Increased utilization of priority secondary care services – DLI 5.2: Women and neonates receiving CEmONC and neonatal services and/or VVF surgeries	Not Applicable, as there are no rehabilitation works supported by the DLI.	Not Applicable as new construction is not supported by the DLI	Applicable as there are rehabilitation works supported by the DLI	Not Applicable	This is applicable as there could be discrimination against the vulnerable in provision of secondary care services	This is applicable as there could be complaints and social disturbances in communities due to lopsided provision of secondary care services
DLI6: Increased PHC utilization of priority services	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works	Not Applicable as there are no physical works	Not Applicable as there are no physical works	This is applicable as there could be discrimination	Not Applicable

DLI	CP1 Environment	CP2 Natural Habitats	CP3 Public & Worker Safety	CP4 Land Acquisition	CP5 Vulnerable groups	CP6 Social Conflict
DLI 6.1: Deliveries with skilled birth attendant present increased DLI 6.2: Introduction of MMS supplementation for pregnant women during ANC visits		supported by the DLI	supported by the DLI	supported by the DLI	against the vulnerable in provision of skilled birth attendants and MMS services	
DLI 7: Increased utilization of EMS DLI 7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system.	Applicable as there may be increased emissions due to increased use of vehicles and petrol (fossil fuels) in operating the vehicles for emergency medical services.	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Applicable as there could be discrimination and bias in delivery of emergency medical transport services.	
RA 3: Improving Resilience of the Health System						
DL8: Improved allocation and disbursement of BHCPF funds DLI 8.1: Governance for improved resource allocation and performance DLI 8.2: States receiving funds in compliance with allocation formula in revised guidelines	Applicable, as there are rehabilitation works supported by the DLI.	Not Applicable as new construction is not supported by the DLI	Applicable as there are rehabilitation works supported by the DLI	Not Applicable as there are no physical works supported by the DLI		

DLI	CP1 Environment	CP2 Natural Habitats	CP3 Public & Worker Safety	CP4 Land Acquisition	CP5 Vulnerable groups	CP6 Social Conflict
DLI9: Enhanced PPR through deployment- System and standards for state EPR programs established and implemented.	Applicable as activities for emergency preparedness and response could result in some environmental risk, for example, wastes.	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Not applicable	Applicable as there could be discrimination against the vulnerable in EPR.	No applicable
DLI10: Improved Climate Resilience – DLI 10: Climate and health adaptation plan developed, costed, validated, and implemented	Applicable as there could be rehabilitation works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Applicable as there are no rehabilitation works supported by the DLI and thus may affect workers health and safety.	Not Applicable as there are no physical works supported by the DLI	Applicable as there could be discrimination and bias in the delivery of essential health services to communities and individuals especially during climate induced disaster, such as, flooding.	Not Applicable
DLI11: Stronger Digital Foundation DLI 11.1: National enterprise architecture developed, costed and adopted. DLI 11.2: States adopting National enterprise architecture and integrate core health functions	Applicable as activities under this DLI will result in E-waste	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Not Applicable as there are no physical works supported by the DLI	Not Applicable	Not Applicable

Annex 2: Key Environmental & Social Risks and Benefits Associated with Program Activities

DLIs	Environmental Benefits	Environmental Risks	Social Benefits	Social Risks
Results Area 1: Improving Quality of Service				
1. Improved service readiness - DLI 1.1: Improved primary health care facility readiness, quality, and climate resilience DLI 1.2: Increased empanelment and refurbishment of CEmONC facilities that demonstrate service readiness and climate resilience and energy efficiency	Installing solar power and ensuring energy efficiency and climate resilience measures for health facilities will help reduce emissions and facilitate the achievement of Nigeria's 2060 zero emission target.	Rehabilitation activities could be conducted under this `DLI. Thus, environmental risks associated with rehabilitation, such as solid waste, noise and air pollution, as well as occupational health and safety (OHS) risks, would negatively impact the environment.	The refurbishment and staffing of PHC facilities to meet readiness in the assessment tool and application of the tool and the refurbishment and empanelling of CEmONC facilities that demonstrate service readiness, climate resilience, energy efficiency in DLI 1.2 will facilitate the availability of water source, toilets, mother-newborn intensive care units, surgical theatres and equipment. This will help ensure enhanced health outcomes, reduced infant and maternal mortality rates, and increased life expectancy. Improving quality healthcare services in Nigeria's healthcare facilities is recommended to ensure equity regarding access to healthcare, which will facilitate the realization of some health-related sustainable development goals (SDGs). . Rehabilitation will also lead to increased employment for the locals who may be engaged in menial jobs. Besides, the rehabilitation	Achieving the DLI could potentially impact workers' health and safety especially workers involved in rehabilitation works that may be associated with this DLI. Influx of workers to the communities where rehabilitation work will occur. could lead to cases of sexual abuse and other vices, for example, drug abuse.

			may lead to an influx of workers into the communities, thus enhancing the local economy.	
2. Increased availability of essential commodities- DLI 2.1: Federal expenditure on quality family planning commodities increased. DLI 2.2: Front-line availability of tracer** products improved	This is negligible	Achieving this DLI may result in increased generation of solid waste.	Activities under DLI2 will facilitate the provision of contraceptives, tracer commodities and medicines to women and children. Tracer commodities include oxytocics, multiple micronutrient supplements (MMS), artemisinin-based combination therapy (ACTs), HIV rapid test kits, pentavalent vaccine, and a minimum of three modern contraceptive methods including at least one long-acting reversible contraceptive (LARC). Provision of these commodities will reduce the incidence of malaria especially during pregnancy, reduce mother to child transmission of HIV, enhance the health of mothers and children, reduce infant and maternal mortality rates and enhance their life expectancy.	Negligible.
Results Area 2: Improving Utilization of Essential Services				
3. Increased enrollment of poor and vulnerable populations -	Negligible	Negligible	Increased insurance coverage through linkages with the NHIA gateway (DLI 3), which will facilitate increased child enrolment in the NHIA and increased insurance	Negligible

DLI 3: Financial protection for poor and vulnerable populations increased.			coverage, will help ensure access to health, especially for the poor, as it will protect them from increased healthcare costs and ensure improved health outcomes and quality of	
4. Enhanced community delivery of health services – DLI 4: Women and children who receive tracer essential health services in the community increased.	Negligible	Negligible	The provision of tracer health services (DLI4) through community health workers including the provision of micronutrient powders or small-quantity lipid-based supplements for prevention of malnutrition, growth monitoring and screening for acutely malnourished children, identification/follow up of pregnant women and referral to receive multiple micronutrient supplement, treatment of any childhood illness, among others, will enhance the health of women and children, reduce infant and maternal mortality rates and enhance their life expectancy,	There could be potential discrimination of women and other vulnerable groups, ethnic bias and sexual abuse or harassment of women in the provision of tracer essential health services by community health workers
5. Increased utilization of priority secondary care services. DLI5.1:Secondary Facility Quality of Care for CEmONC DLI 5.2: Women and neonates receiving	Negligible	Negligible	The design and approval of a CEmONC empanelment and reimbursement strategy and the provision of CEmONC, neonatal and under-5 services and/or VVF surgeries for women and under five children will equally enhance the quality of life, reduce infant and maternal mortality	There could be potential discrimination of women and other vulnerable groups, ethnic bias and sexual abuse or harassment of women in the provision of neonatal and under-5 services and/or VVF surgeries

CEmONC and neonatal services and/or VVF surgeries (Number)			rates and enhance their life expectancy	
6. Increased PHC utilization of priority services – DLI 6.1: Deliveries with skilled birth attendant present increased DLI 6.2: Introduction of MMS supplementation for pregnant women during ANC visits. DLI6.3: Increase in Penta 3 coverage	Negligible	Negligible	Having skilled birth attendants during delivery in PHC centers (DLI 6.1) will help ensure that pregnant women being delivered of babies are attended to by skilled professionals thus reducing the incidence of infant and maternal mortality rates. The provision of multiple micronutrient supplementation for pregnant women in DLI 6.2 will help prevent micronutrient deficiency in pregnant mothers and their babies and ensure that they are delivered healthy babies with high immunity against diseases that threaten the lives of infants. It equally helps to ensure the normal functioning and growth of babies and the health of their mothers. The provision of penta-3 vaccination in DLI 6.3 will help ensure that children 12-23 months are maximally protected against Diphtheria, tetanus, pertussis (whooping	There could be potential discrimination of women and other vulnerable groups, ethnic bias and sexual abuse or harassment of women in the distribution of MMS supplementation for pregnant women during ANC visits

			cough), polio, hepatitis B and Haemophilus influenzae type b (Hib) and thus substantially reduce infant mortality rates.	
7. Increased utilization of EMS- DLI 7: Number of patients with obstetric and neonatal complications transported through Emergency Medical Transport to selected facilities using the digitized EMS dispatch system	Negligible	Emergency medical transport system in DLI 7 will lead to more vehicles for transporting patients in emergency and an increased number of patients transported to PHC or secondary health facilities. This will result in increased consumption of fossil fuels, and which will lead to increased CO_2 emissions and air pollution from transportation. The digitized system that will be employed in the emergency transportation could in the long run result in e-waste.	Providing emergency transportation for patients with obstetric and neonatal complications in DLI 7 will help ensure that they receive timely medical services and thus prevent mortality	There could be potential discrimination of women and other vulnerable groups, ethnic bias and sexual abuse or harassment of women in the provision of emergency medical transportation for patients with obstetric and neonatal complications
Result Area 3: Improving Resilience of the Health System				
DLI 8: Improved allocation and disbursement of BHCPF funds. DLI 8.1: Governance for improved resource allocation and performance (Prior Result) DLI 8.2: States receiving funds in compliance with	The funds could be invested in solar power and energy efficiency in health services delivery thus facilitating emission reduction.	Also, rehabilitation work would be carried out due to improved fund allocation and disbursement under DLI8 resulting in environmental risks associated with rehabilitation, such as solid waste, noise, and air pollution, as well as occupational health and safety (OHS) risks.	Improved resource allocation in DLI8 will help ensure that the required health facilities are provided in PHC and thus ensure efficient health service delivery. This will, in turn, ensure reduced maternal and infant mortality rates, and increased life expectancy.	Negligible

allocation formula in revised guidelines				
DLI 9: Enhanced PPR through deployment – DLI 9: System and standards for state EPR programs established and implemented	Achieving this DLI will improve the handling of climate shocks, natural disasters and other humanitarian emergencies and generate some climate co-benefits.	The implementation of the emergency preparedness (EPR) program in DLI 9 could generate emissions through transportation etc.	Enhancing emergency preparedness and response in DLI9 will help in better management of disease outbreaks, climate shocks, natural disasters, and other humanitarian emergencies. Adequate emergency preparedness facilitates faster response times by healthcare workers, more efficient care, and better outcomes	Negligible
10. Improved Climate Resilience DLI 10: Climate and health adaptation plan developed, costed, validated, and implemented	Activities under the plan could involve the use of facilitates and equipment that reduce emissions, especially renewable energy, thus, facilitating the achievement of the country's net-zero target.	Rehabilitation activities could be conducted under the PforR due to need-based allocation formular. Thus, environmental risks associated with rehabilitation, such as solid waste, noise and air pollution, will impact the environment. Also, there could be generation of e-waste due to use of ICT and use of other e-facilities.	The development and implementation of the plan will help guarantee enhanced health outcomes, reduced infant and maternal mortality rates, increased life expectancy,	Negligible
11. Stronger Digital Foundation DLI 11.1: National enterprise architecture developed, costed and adopted	Digitization of the health system will reduce documentation with paper and thus save the environment as less tress will be cut for paper production.	Achieving this DLI may result in increased generation of e-waste.	Data-backed medical system will help policymakers make informed decisions about resource allocation and thus reduce healthcare costs. Benefits include enhanced health outcomes, reduced infant and maternal mortality	Negligible

DLI 11.2: States adopting National enterprise architecture and integrate core health functions			rates, increased life expectancy.	

Annex 3: Discussion Questions and Responses from Representatives of States in Southern Nigeria
Questions and Responses Regarding Result Areas 1 and 2

Question	**How do you handle safeguard issues (environmental and Social) in your procurement?**
State	Response
Osun	We have a robust procurement law that incorporates provisions for tender bidding, ensuring environmental and social issues are addressed. We conduct all procurement activities within the boundaries of this law; they do not operate outside of it. They strictly adhere to the details outlined in the procurement process.
Rivers	The River State Bureau of Public Procurement (BoPP) oversees all procurement activities, particularly those related to construction and civil works. The BoPP must oversee all such projects. Additionally, they handle environmental impact assessments with dedicated consultants for this purpose. Within the ministry, there are separate units for project management and procurement. Collaboration between the ministry and the BoPP ensures effective oversight and coordination of procurement processes.
Anambra	Anambra's Bureau of Public Procurement (BoPP) handle all procurement issues. The Environmental and Social (E&S) officers ensure that all procurement activities incorporate E&S concerns. The BoPP centrally manages procurement processes across the state.
Enugu	Established both the BoPP and the due process unit. This agency and the unit ensure that procurements adhere to the laws and regulations.
Taraba	Taraba has a BoPP and a law that governs procurement issues.
Ogun	

Question	**Are there units or departments in the ministries responsible for environmental and social issues?**
State	Response
Osun	We have the ministry of environment and environmental officers deployed to Ministries Department and Agency (MDAs). For the social issues, we have the ministry of women and children affairs responsible for social issues. There is no specific department. The state has key in various P4R programs, which require them to perform various E&S studies. When they have a project like that, what we do is to check around to ensure compliance with the program standard. A particular department responsible for a program create an interdepartmental or intergovernmental ministerial committee to ensure E&S issues are taken care of before the project is sited in a particular location, e.g., the provision of drinkable water to a certain community that is done under CSDP. They have a way of mitigating handling E&S issues before starting the project. The results and experience gathered under the ongoing P4R program in the state can be domesticated in the HOPE program.
Rivers	The E&S public health department houses environmental officers. There are project units that deal with construction work. When projects involve environmental issues, they conduct impact assessments. They work in collaboration with the Ministry of Environment. In the Ministry of Women Affairs, there is a desk officer in charge of sexual harassment and NGO issues.
Anambra	E&S issues are handled centrally by the Ministry of Environment and Women Affairs, and for specific programs, E&S officers are seconded to different projects to support.
Enugu	The Ministry of Environment responsible for environmental issues. The emergency management unit deals with shock issues. Ministry of Gender deals with aspect of social issues.
Taraba	There is a Ministry of Environment and a Taraba State Environmental Protection Agency. On the social side, there is also the ministry of social justice, orientation, and state emergencies.
Ogun	Ministries collaborate with the Ministry of Environment and emergency management response agencies. On social issues, the Ministry of Women Affairs and the Ministry of Justice are responsible.

Question	**Do you have experience preparing Environmental and Social Management Plans (ESMP) and Environmental and Social Impact Assessment (ESIA)? If yes, describe how it was carried out in one of the ministry's projects.**
State	Response

Osun	Yes, the World Bank implements programs and interventions in the state and collaborates with consultants to develop the necessary instruments. Oversee all agencies that handle intervention in the ministry of budget and planning but need the project manual.
Rivers	Yes, they have a project unit attached to the Ministry of Health. The project unit engages consultants who work alongside with architects, engineers and surveyor to assist with preparations. Regarding the P4R initiative, they focus solely on innovation and do not undertake any construction projects
Anambra	They work with the WB during program inception, and the plans are developed. They got a consultant who liaised with an on-ground E&S officer to develop an E&S impact assessment for a project.
Enugu	Has robust social protection bodies developed by an assembly of concerned stakeholders for the state that passed through concerned areas for social issues and has a legal framework. The system incorporates gender-specific safeguards to protect vulnerable groups. Environment issues are within the purview of the Ministry of Environment.
Taraba	Ministry of Environment
Ogun	We developed social issues plan in collaboration with the Women Advocate Research Documentation Center and other government agencies, including the Ogun State Primary Healthcare Board. The desk officer, who was part of the training, is involved. Other collaboration plans with NGOs may exist. Though the respondent was not well-versed in the environmental plan, I'll contact the Ministry of Environment for details.

Question	**Do you have an environmental and social specialist in the agencies UBEC, NPHCDA, and NHIA (including for state counterparts)?**
State	Response
Osun	Yes, the Ministry of Environment is responsible for deploying officers to different ministries as needed. They will provide confirmation for UBEC and NHIA.
Rivers	Yes, they have handled E&S issues under primary health care at the health centers and community level. This includes inspecting waste disposal and potable water in the community, ensuring ventilation and sanitation, and verifying that individuals have the necessary approval to carry food. Developed a gender-based violence program in four of their facilities, where survivors receive free care. Recently, I collaborated with a UN consultant on a sensitization on gender integration in primary health agencies.
Anambra	UBEC, SPHCDA, Health insurance agency have in house E&S specialist in the agency
Enugu	There is no specific office for E&S in their ministries, but the specialists are in the Ministry of Environment, Gender, and Socio. The state is synergistic, with the relevant ministry providing support.
Taraba	The specialists are domiciled at the Ministry of Environment and TSEPA. There is a specialist in UBEC, and for primary health care, it is not certain.
Ogun	A specialist from the Ogun State Waste Management Agency is collaborating with them in the ministry.

Question	**Do you have waste management procedures under your programs (especially for managing hospital waste and school waste)?**
State	Response
Osun	Yes, there is hospital waste; for the school, waste is well managed in the state that prohibits people from throwing waste anyhow. Have designated reserved areas for depositing waste while seeking global, evaluate government facilities segmentation at the generation of the waste.
Rivers	Has a robust medical waste management system. Waste is collected at a central point. The state health insurance scheme has a medical waste department that takes care of the waste. The Ministry of Environment deals with school waste.
Anambra	Has a robust waste management law with procedures for disposing different types of waste
Enugu	Enugu state waste management agency responsible for collection and disposal of all kinds of waste. Hospitals, communities are sensitized on the disposal of waste at a central point for final disposal by EGSWAMA
Taraba	Has Ministry of waste management and resource innovation responsible for waste management and has a waste management procedure used in health facilities for waste disposal

Ogun	The state has accredited PSP for collection and disposal for schools and health facilities. Health care waste is segregated at the point collection in different bags

Question	**How do you handle the disposal of electronic waste and hazardous waste material?**
State	Response
Osun	Hazardous waste is grouped into infectious, highly infectious, and sharps and is disposed of in three ways. 1. burn and bury; 2. incinerate; 3. link with a local government waste management agency to incinerate at the final disposal site. Sharps are placed in the sharp box to be disposed of by the local government. The state has a contract with an organization (a private company) that is responsible for medical waste collection and disposal. Electronic waste is managed by a waste management agency.
Rivers	In the health system, the state has a proper waste management system under the director of medical services. There are colour coded waste containers for segregating and incinerating sharps and hazardous medical wastes. The Ministry of Environment take care of other waste.
Anambra	Waste management agencies under the Ministry of Environment have detailed procedures for managing waste.
Enugu	Enugu State Waste Management authority takes care of the disposal after collection. There has been sensitization on segregation of biodegradable and non-biodegradable waste
Taraba	The Ministry of Waste Management and Resource Innovation take care of waste materials in health facilities by burning them in incinerators, and some are collected by individuals for recycling.
Ogun	Hazardous and electronic waste is handled by the Ministry of Environment and electronic waste is handled by OG Waste Management Agency

Question	**What is the process for social inclusion in the education and health sector? How are stakeholders and communities represented and consulted before development takes place?**
State	Response
Osun	In Osun State, a bottom-up approach is used in the budget process, reflecting a comprehensive development plan created by citizens across all 16 sectors. The state implements a gender equity and social inclusion policy to address the needs of all individuals. Parent-Teacher Associations (PTAs) facilitate community involvement by collaborating with religious, community, and traditional leaders to address school absenteeism, with at least one healthcare facility within a 15-minute drive from every home. Additionally, citizen engagement occurs annually to gather input before finalizing the fiscal year's budget.
Rivers	The PHCs have a ward development committee that aims to include community members. The PHCs utilize social behavioral change committees to guarantee inclusivity, while GBV groups expedite decision-making processes. Has desk officers in different ministries on GBVs with the inclusion of CBOs in all programs.
Anambra	Has the 4th arm of government, the closest to the people. Has community demand embedded into the state budget. Free education and free maternal care are strategies to create more inclusivity in the education and health sectors
Enugu	Has an inclusive education policy. To ensure implementation, the government has decided to build one smart-green school to ensure qualitative basic education is served to all groups, irrespective of social strata. For the health sector, the health provision is for levels that reach all and sundry.
Taraba	There is free education at the basic education level. There are state-owned institutions that have reduced by 50% at the tertiary level. Certain categories of diseases are treated freely in government hospitals. 1–5 children receive treatment free for some services. SBMC runs the schools and is part of the systems to get their input into the management of schools. Some CDDs come up with their project, collate it at the local government level, and forward it to the state for inclusion in the yearly budget.
Ogun	Periodic engagement with traditional owners, community development associations, and media to ensure social inclusion. There are ongoing health insurance plans. For education. The minimum budget and planning coordinate other agencies for effective management. A town hall meeting with the people at the grassroots for suggestions and needs of each division is held at

	the meeting. The governor chairs the meeting with excos members and thereafter discusses financial implications and passes a bill for financing and implementation.

Question	**To what extent are school premises kept clean, safe and green?**
State	Response
Osun	90% safe, secured, clean and well managed
Rivers	Very clean schools with responsibility of Ministry of education and regulatory agencies who inspects regularly
Anambra	Our schools are very safe and clean
Enugu	Has rolled out integrated smart green school translated into 60 units of green schools
Taraba	
Ogun	

Question	**Are there dedicated budget for environmental sanitation and hygiene in schools?**
State	Response
Osun	Yes, has budget provision passed by the House of Assembly
Rivers	Not sure
Anambra	Yes
Enugu	Yes
Taraba	
Ogun	

Question	**Do schools have enough supply of clean and potable water?**
State	Response
Osun	Yes larger percentage of the schools have but not all of them
Rivers	Yes most schools have clean and portable drinking water
Anambra	Yes most schools have clean and portable drinking water
Enugu	The current govt is targeting providing clean water in all schools for the green schools
Taraba	
Ogun	Appropriation is done in respect of education facilities in the state

Question	**How are accidents, incidents, injuries handled in schools?**
State	Response
Osun	There is first aid box to take care of injuries in nearly all schools, then refer for injuries beyond first aid to primary health care. The state has a state emergency medical agency called an ambulance system
Rivers	Not sure but there should be a protocol for that
Anambra	Has sick bays and first aid units and cases are escalated to PHCs where required
Enugu	Schools are encouraged to have a medical system (first aid system) where emergency cases are handled and referred to PHCs for further management
Taraba	
Ogun	Schools have sick bays and nurses and referral to PHCs when need be

Question	**What is the system of handling occupational health and safety (OHS) during civil works in the health and education sectors?**
State	Response
Osun	Has a mobile ambulance to take victims for medical care. Licensed consultants handle the civil work. There is an entrance and exit place to ensure people can be evacuated in terms of emergency.
Rivers	Has health and safety protocols that entail how safety measures are carried out and licensed safety officers at construction sites.
Anambra	No system is in place yet.
Enugu	Measures start from prevention as construction sites are screened off and learners prevented from getting to hazardous areas
Taraba	

Ogun	

Question	**Are minors allowed to work at construction sites for schools and hospitals?**
State	Response
Osun	No
Rivers	No
Anambra	
Enugu	Has a child rights act, which prohibits the engagement of minors
Taraba	
Ogun	No

Question	**What system exist in preventing environmental degradation in the health and education sector (at construction and operational stages)?**
State	Response
Osun	Proper waste disposal to avoid environmental pollution
Rivers	Has E&S laws that protects the environment and people of the state which are abide by to guide environmental degradation and waste management and prevention of use of certain chemical in construction sites
Anambra	
Enugu	All construction sites are cordoned off to prevent fallout from the construction and debris cleared after the construction and disposed off
Taraba	
Ogun	

Question	**What source(s) of energy are used in schools and health facilities?**
State	Response
Osun	3 sources of energy used in Osun state 1. National grid-electricity, 2. Generators and 3. some use solar energy. Some don't have and source of energy. Looking for partnership to install solar energy in schools
Rivers	3 sources of energy used in the state 1. National grid-electricity, 2. Generators and 3. some use solar energy. Some don't have and source of energy. Looking for partnership to install solar energy in schools
Anambra	In Anambra State, EEDC, Gen, and Solar, exist in different facilities.
Enugu	Electricity in major. There is challenges in provision of secure powers, alternate is generators. Looking for partnership to install solar energy in schools
Taraba	
Ogun	Most schools are connected to national grid, alternate is generator and solar powered electricity

Questions and Responses Regarding Result Area 3

Question	**How do you handle complaints and grievances? Do you have a framework, procedure, legislation, or regulation for redressing grievances? Do the Ministry and Agencies have a grievance redress mechanism?**
State	Response
Osun	Has a disciplinary committee headed by a senior teacher who listens to the complaints of the students. There are also suggestion boxes where grievances are dropped. The committee decides on the grievances.
Rivers	Has administrative protocols that addresses different types of grievances in the schools and workplace for fear hearing and justice is served
Anambra	Has GRM framework in MDA which is a bottom-top approach
Enugu	Depending on the aggrieved person, for a learner, it starts from class management and escalated to the school management and further to the system management. For teachers, it goes to the management of the institution and scaled up to the management of the system until it is resolved
Taraba	

Ogun	Teacher can register their complaint through school head to zonal level and district and addressed

Question	**Can marginalized people or those who feel they were not appropriately treated have a procedure to report their grievance? Do you have a mechanism to address the issues to the satisfaction of the complainants? Please give an example of how you handled this in the past.**
State	Response
Osun	Suggestion box is provided at the entrance for complains about those who complaints of marginalization. HIV patient was marginalized as no nurse wanted to attend but reported to the management and was treated
Rivers	Complaints can be addressed formally and informally but the complainant needs to lay the complaint
Anambra	
Enugu	Every class has a form master. If not addressed, it is scaled up to the principals, UBEC until resolved to the satisfaction of the complaint
Taraba	
Ogun	

Question	**Do you have a gender policy? Have you experienced sexual harassment or exploitation in your ministry/agency? How do you handle issues relating to sexual harassment, sexual violence, and exploitation?**
State	Response
Osun	Has a robust Gender equity and social inclusion policy. It is being investigated for review in line with the current reality now. Welcome partnership for the review of the policy. Not experienced SEA/SH in their ministry but the ministry of women affairs has measures in place
Rivers	Has a gender policy in place. The policy needs to be reviewed and more robust. A gender integration and sensitization workshop have bene carried out and a stakeholder engagement where key stakeholders from different gender/women groups on their perception in the gender narrative
Anambra	
Enugu	Has ministry of gender who partners with NGOs engaged in the protection of right of women and other vulnerable groups.
Taraba	
Ogun	Has a gender policy in place. Mainly handled by min of women affairs. In the school system, a committees investigate and takes necessary judgement

Question	**Has there been any complaint about discrimination due to religion or gender in your programs?**
State	Response
Osun	No
Rivers	Yes, complaints on non-inclusion, programs are mainly concentrated on women and children
Anambra	
Enugu	No complaints on religion but on gender, there may be but unreported and fewer
Taraba	
Ogun	No

Question	**If there was, how did you handle it?**
State	Response
Osun	Nil
Rivers	Nil
Anambra	Nil
Enugu	Nil
Taraba	Nil
Ogun	Nil

Question	Do you have a policy or regulation regarding gender discrimination or discrimination due to religion or tribe?
State	Response
Osun	Has VAP law that focuses on discrimination being implemented by the ministry of women affairs
Rivers	Has a policy on all kinds of discrimination, but a need to review the policy which are currently obsolete
Anambra	
Enugu	Has min of gender and have social protection policy which requires partnership to review the policy to accommodate emerging issues.
Taraba	
Ogun	

Question	Are Health and Safety Officers recruited and posted to Primary Health Care Centers?
State	Response
Osun	Not yet
Rivers	No, but make use of health workers to act in that capacity who are trained
Anambra	
Enugu	Not sure
Taraba	
Ogun	

Question	Are these officers trained on Health Care Waste Management?
State	Response
Osun	Yes, most of the officers have capacity to manage health waste
Rivers	Yes have health workers trained on waste management who also undergo refresher training
Anambra	
Enugu	Not sure
Taraba	
Ogun	Not sure

Question	Do teachers receive training on environmental health and safety?
State	Response
Osun	Yes, they do
Rivers	Not sure
Anambra	
Enugu	Yes
Taraba	
Ogun	Yes, a department organizes a regular training on environmental health and safety. Collaborates with min of health for E&H training in regard to sanitation and immunization

Question	Do syllabuses contain topics on environmental health, safety, or sustainability
State	Response
Osun	Yes, it does
Rivers	Yes, the syllabus contains HS
Anambra	
Enugu	Yes, the school syllabus contains EHS
Taraba	
Ogun	Yes, it does, graded into scheme of works across all level in primary and secondary

Annex 4: Discussion Questions and Responses from Representatives of States in Northern Nigeria Questions and Responses Regarding Result Areas 1 and 2

Question	**How do you handle safeguard issues (environmental and Social) in your procurement?**
State	Response
Kwara	E&S is an important part of procurement. Procurement considers issues related to location, the project, and the socio-cultural needs of individual community members. We consider the cost implications, procurement of materials, and other fundamental aspects of procurement policy. The state has a public procurement agency that deals with procurement issues.
Borno	
Nasarawa	We have a robust Nasarawa State Bureau of Public Procurement. Procurement is initiated in the state. The efficiency unit in the Ministry of Finance vets' procurement and safeguards issues before procurement. In the absence of the safeguard's office, the procurement will be discarded, and the attention of the officer will be called upon.

Question	**Are there units or departments in the ministries responsible for environmental and social issues?**
State	Response
Kwara	Yes, the Ministry of Environment and the Ministry of Social Development. These two ministries collaborate with the Kwara State procurement agency to identify the procurement issues of a specific unit, or MDA. Any MDA that wants to do procurement must do it in line with public procurement agencies, including the Ministry of Justice and the Ministry of Finance.
Borno	The Safeguard Unit under the Social Mobilization Unit has a desk officer in the Borno State Universal Basic Education Board (SUBEB), Ministry of Environment, and Ministry of Women Affairs and Social Development.
Nasarawa	The Ministry of Environment, the Ministry of Women Affairs, the Ministry of Humanities, and the and the Ministry of Health also have an environmental unit.

Question	**Do you have experience preparing Environmental and Social Management Plans (ESMP) and Environmental and Social Impact Assessment (ESIA)? If yes, describe how it was carried out in one of the ministry's projects.**
State	Response
Kwara	The Ministry of Environment and the Ministry of Social Development coordinate environmental issues in the state. Several projects under the Ministry of Health involve personnel in some of the safeguard's issues.
Borno	The Ministry of Environment also has the Borno State Environmental Protection Agency, which handles environmental and social issues. We will leverage what has been done on the AGILE project.
Nasarawa	The Ministry of Environment has an agency under the ministry, which is the Environmental Protection Board, and the Ministry of Environment is saddled with this responsibility. NARUWASA, under water resources, handles the provision of water for communities and local communities. Ministry of Humanitarian Services.

Question	**Do you have an environmental and social specialist in the agencies UBEC, NPHCDA, and NHIA (including for state counterparts)?**
State	Response
Kwara	Yes, they have an E&S seconded from the Ministry of Environment to the Kwara State Primary Care Development Agency (SPHCDA).
Borno	None from UBEC; a safeguard team is however available in the Ministry of Education, including GRM, GBV, and E&S specialists.
Nasarawa	There is no designated officer in the SPHCDA. There is an impact project, and there are designated E&S officers under the project domiciled in the agency.

Question	Do you have waste management procedures under your programs (especially for managing hospital waste and school waste)?

State	Response
Kwara	Health workers are trained on medical waste and its associated protocols. Incineration at the Ilorin Teaching Hospital is what they leverage now, as the other two are not currently in use.
Borno	Have Safeguard team members well trained under WB projects and have school waste management in place, which they will leverage.
Nasarawa	A healthcare waste management system in the state came on board under the Nigerian state health investment project. Health care waste is segregated into their bin, and hazardous waste is disposed of in the FMC in Keffi, the state specialist hospital in Lagos, and the infectious disease specialist hospital. A focal person at SPHCDA is responsible for managing health care waste.

Question	**How do you handle the disposal of electronic waste and hazardous waste material?**
State	Response
Kwara	The general waste is well-managed, just like any other.
Borno	Training was held on how to handle hazardous waste. Electronic waste is kept in the store before final disposal.
Nasarawa	There is a unit in the Ministry of Environment, but he cannot be specific. There is a unit in the Department of Public Health for e-waste and a desk officer assigned to e-waste and management in the Department of Health.

Question	**What is the process for social inclusion in the education and health sector? How are stakeholders and communities represented and consulted before development takes place?**
State	Response
Kwara	In education, we carry out our survey to identify the stakeholders. Every program target different stakeholder, including religious, political, and community leaders. Done through a mass campaign on social media, print and electronic media, and house-to-house advocacy to win the target group and have an overall inclusion. Health and functional ward development committees are critical stakeholders consulted when critical activities are consulted. Have a function. GRM to get feedback and respond.
Borno	The school-based management committee comprises different stakeholders from the school and community and mobilizes the communities for implementation. Comes up with plans and implements them. SBMC involves ward heads and district heads who have influence in the community. Classes are also built to accommodate special needs.
Nasarawa	Health, GRM well-structured in the agencies at SPHCDA and the health agency. Chairman GM is involved in all programs at the agency.

Questions and Responses Regarding Result Area 3

Question	**How do you handle complaints and grievances? Do you have a framework, procedure, legislation, or regulation for redressing grievances? Do the Ministry and Agencies have a grievance redress mechanism?**
State	Response
Kwara	Yes, GRM is functional in all 193 wards of the states, and there is a suggestion box in all wards. The social safeguard officer may resolve some complaints, and if cascaded, individuals from the ministry or community may handle them.
Borno	Yes, they have established GRM in the school communities. There are suggestion boxes, and there are telephone lines that can be called. There are GRCs in all communities. The secretary receives the complaint and calls for the GRC to sit down and resolve it with the aggrieved party. There is a framework in place.
Nasarawa	Yes, GRM is in SPHCDA and the state health insurance agency. The latter handles complaints about services provided by the agency. There are numbers available to all, and they address them. Quality control swings into action if it is escalated. QC also handles it if it is above the Local Government level at SPHCDA. A framework was adopted from the NSHIP project in their operation around services at the facility level. Each agency has a GRM, and most start from the lower level all the way up. For the health insurance scheme, each beneficiary has access to a phone number on their health card, which they can call to lodge their complaints.

Question	Can marginalized people or those who feel they were not appropriately treated have a procedure to report their grievance? Do you have a mechanism to address the issues to the satisfaction of the complainants? Please give an example of how you handled this in the past.
State	Response
Kwara	A team constitutes the GRC, with the ward chairman as head. Provision of micronutrient powder to children under 5, where some were excluded, was a result of fatigue from the community volunteers. GRM box and a GRM or line to be called
Borno	There is a suggestion box in the school committees where the GRC sits to deliberate on issues. E.g., renovation in one of the schools, and some classes do not have ramps, and the component lead was informed, who informed the SBMC, and the feedback on including ramps was communicated to the aggrieved person within a week.
Nasarawa	There is a client satisfaction survey conducted quarterly in delayed services to gather information from marginalized people to address issues relating to them. This is a result of limited human resources.

Question	Do you have a gender policy? Have you experienced sexual harassment or exploitation in your ministry/agency? How do you handle issues relating to sexual harassment, sexual violence, and exploitation?
State	Response
Kwara	SEA/SH plan developed by the Kwara State Ministry of Health 50% of honorable commissioners are female. Rape and sexual harassment have been addressed in communities. SH and an assault referral center have been established where survivors can be referred, and there is a line for survivors to call. Ministry of Women Affairs handles the SEA/SH case. If measures to arrest perpetrators are taken and the survivors are taken to the Ministry of Social Development for custody, then the case is being handled.
Borno	In the process of the state gender policy. No experience in the ministry or agency. Service providers on the ground in case of an occurrence. In cases of incidents, there is a manual for referral.
Nasarawa	The state has, through the public sector, a gender desk officer and is currently undergoing the domestication of gender policy in the state, with only the validation in collaboration with the Minister of Women Affairs, who solely handles gender mainstreaming in the state. The health sector provides treatment for victims. Arrest and prosecution of perpetrators are handled by the Ministry of Women Affairs. Frequently, presentations on prevention are being made to health care workers, and the law calls for outright dismissal from service. No segregation in employment or property is given to females as well as males.

Question	Has there been any complaint about discrimination due to religion or gender in your programs?
State	Response
Kwara	No complaints on such ever received to the best of his knowledge
Borno	Not existent in Borno State, there are many faith-based organization
Nasarawa	Has a system of zero tolerance to discrimination as the service provided is to the people of the state

Question	If there was, how did you handle it?
State	Response
Kwara	Nil
Borno	Nil
Nasarawa	Nil

Question	Do you have a policy or regulation regarding gender discrimination or discrimination due to religion or tribe?
State	Response
Kwara	Yes, a Violence Against Persons provisions act (VAP law)

Borno	They operate based on their constitution, which does not discriminate. If there is a policy for discrimination, then the problem is there, but they do not have the problem. People refusing medical treatment based on religious instruction is the vase they have.
Nasarawa	The validation of the gender policy is the only thing left to domesticate. All the regulations are captured in the policy document. The effect of noncompliance with the regulation applies to the person.

Annex 5: List of Participants at Consultation with States

Name	MDA	Designation	State
Julienne Darlington-Nwoke	Rivers State Ministry of Health	Head Health Planning, Ag. Director of Health Services, Standards and Quality Control, Rivers State Contributory Health Protection Program.	River
Chinwe Atata	Ministry of Health	Director of Planning, Research an d Statistics	Rivers
Precious Jack		Head of Planning, Policy & Budget	River
Ogochukwu Orji	Ministry of Budget and Eco nomic Planning	SSA to the Governor on Budget a nd Economic Planning	Anambra
Ogochukwu Orji	Ministry of Budget and Eco nomic Planning	SSA to the Governor on Budget a nd Economic Planning	Anambra
Christopher Edenwatu	Ministry of Education	Director Planning Research and St atistics	Enugu
Chris Edenwatu	Ministry of Education	Director Planning Research and St atistics	Enugu
Christopher Edenwatu	Ministry of Education	Director Planning Research and St atistics	Enugu
Dr. Isiaka Adekunle	Ministry of Health	Permanent Secretary	
Mr Patrick Ochi	Ministry of Education	Permanent Secretary	Enugu
Mrs Francisca Nwokolo	Ministry of Education	Director Schools	Enugu
Mrs ozougwu Nnene	Ministry of Education	Director Lib/ICT	Enugu
Mr kingsley Eneh	Ministry of Education	Director Finance and Acct	Enugu
Mr Sylvanus Ogbodo	Ministry of Education	Director Admin and Supply	Enugu
Mrs Easther Nwoga	Ministry of Education	Director Education Services	Enugu
Bar. ikwueze	Ministry of Education		Enugu
Mr Chris Edenwatu	Ministry of Education	Director Planning Research and Statistics	Enugu
Mr Samuel Udeh		Head of EMIS	Enugu
Otunuga Akinyemi Olajide	Ministry of Budget and Pla nning	Director. Planning	Ogun
Akinwande Kayode Segun	Ministry of Environment	Dir. PRS	Ogun
Hon Mayowa Adejoorin		Commissioner For Environment a nd Sanitation	Osun
Danjuma Saigudu		Director of Budget	Taraba
Chiamaka Nnake			
Oluwakemi			
SAMUEL UDEH			
Dr Obinna Muoh			
DPC			
Kofoworola Olajide			
Dr. Isiaka Adekunle			
Ochi Patrick			
Dr Elijah Ayowole Ogunsola			
Prof Shehu Raheem Adaramaja	Executive Chairman	Kwara State Universal Basic Education Board, Ilorin	Kwara
Alh. Alimi K.Surajudeen	Director Planning		Kwara
Mr. Peter Wale Awoniyi	Director Planning Research and Statistics	Ministry of Health	Kwara

Olanrewaju Bake Rebecca	Peremanent Secretary	Ministry of Education and Human Capital Development. Ilorin	Kwara
Adewuyi V. F.,	Director, Curriculum Assesment	Ministry of Education and Human Capital Development. Ilorin	Kwara
AdeAboyeji O.O	Director QAB	Ministry of Education and Human Capital Development. Ilorin	Kwara
Dr Abubakar Hassan	Special Adviser Health, Governor	Governors Office	Borno
Aisha Musa Sheikh	Permanent Secretary	Ministry of Education	Borno
Engr. Ibrahim Baba			Borno
Hassana Pindar	Team Member Safeguards, Agile		Borno
Kabiru Mohammed	Team Member Safeguards, Agile		Borno
Prof Baba Mallam Gana	Commissioner for Health and Human Services	Ministry of Health and Human Services	Borno
Dr. Ibrahim Adamu Alhassan	DPH		Nasarawa
Baba Gana Goni Ali	Director PRS	SUBEB	Nasarawa
Cindy Ijeoma Ikeaka,	Senior Social Development Specialist	World Bank	
Ikechukwu John Nweje	Senior Public Sector Specialist	World Bank	
Ugonwa Unaogu	Public Sector Specialist	World Bank	
Nnaemeka Chukwuone	Consultant	World Bank	
Olufunmilola Temitayo Ayoola	Social Developm,ent Specialist	World Bank	
Halima Femi Pat-Natson	Consultant	World Bank	

Annex 6: List of Participants at the Presentation of the ESSA Findings

• Ayoola Olufunmilola, Social Development Specialist World Bank
• Cindy Ikeaka, Senior Social Development Specialist World Bank
• Elijah Siakpere, Senior Social Development Specialist World Bank
• Dr Nnnaemeka Chukwuone, Senior Social Development Consultant, World Bank
• Dr. Ashiru Adamu Abubakar, State Engagement Lead, SWAP Coordinating Office
• Dr. Ngozi Nwosu,Director, Primary Health Care Systems Development, NPHCDA Itoro Ata, STA to ED/CEO NPHCDA Charles Doherty, General Manager, Ekiti State Health insurance Scheme
• Dr. Emmanuela Zamba, PS CEO, of SHIA
• Dr. Asmau Benzies Leo, Executive Director, Centre for Nonviolence and Gender Advocacy i n Nigeria- CENGAiN, Gender, Inclusion and Social Safeguard Expert
• Dr Abiodun Oyeneyin , Director-General , Ondo State Contributory Health Commission
• Ashifa Agede, Program Coordinator at Centre for Health Systems Support and Initiatives fo r Development (CHESIDS)
• Dr. Jafa Mohammed, ES, SHIA
• Dr Amina Abdul-One Muhammed, the National Project manager IMPACT project
• Dr Vetty Agala,Ag. Executive Secretary,Rivers State Contributory Health Protection Progra mme (RIVCHPP)
• Pharm. Mohammed A.Mohammed, Deputy Director/Head,Health Financing Division. PHC -System Development Dept. NPHCDA.
• Jamila Hammanga, Social Safeguard Officer, NPHCDA
• Dr Simeon Onyemaechi, Managing Director Anambra State Health Insurance Agency
• Dr. Edidiong Etete Senior Manager, from NHIA Headquarters Abuja.
• Dr. Oritseweyimi Ogbe, Director Special Duties, NPHCDA
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