



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

Concept Stage | Date Prepared/Updated: 11-Jun-2018 | Report No: PIDISDSC24738



BASIC INFORMATION

A. Basic Project Data

Country Nigeria	Project ID P167156	Parent Project ID (if any)	Project Name Nigeria Cutting U5MR in Half in a Decade MPA (P167156)
Region AFRICA	Estimated Appraisal Date Dec 17, 2018	Estimated Board Date Mar 21, 2019	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Federal Ministry of Finance	Implementing Agency Federal Ministry of Health	

Proposed Development Objective(s)

The PDO of this Multi-Phased Approach (MPA) is to cut under five mortality rate in half in a decade.

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	1,000.00
Total Financing	1,000.00
of which IBRD/IDA	1,000.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	1,000.00
IDA Credit	1,000.00

Environmental Assessment Category

B - Partial Assessment

Concept Review Decision

Track II-The review did authorize the preparation to continue



Other Decision (as needed)

B. Introduction and Context

Country Context

Nigeria has just emerged from a year of economic recession but recovery is weak. Nigeria's GDP shrank by 1.5 percent in 2016 for the first time in two decades and recovered with a slight growth estimated at 0.8% in 2017. However, the recovery is driven by higher oil prices and production, while non-oil industry and services continued to contract. The budget deficit was estimated at 4.8% in 2017, up from 4.7% in 2016, and total spending as a percentage of GDP declined from 13% in 2014 to 10.3% in 2017¹. The recovery is expected to be slow, strongly linked to a sustained increase in its oil production, and thus susceptible to oil production disruptions and oil price shocks.

Nigeria still faces significant economic challenges. As oil continues to dominate Nigeria's growth pattern, the instability of oil prices imposes welfare costs which can have implications on social and economic progress. This was evident in the last recession as unemployment has reached up to 18.8 percent in 2017. Inflation has increased from 8.7 in 2015 to as high as 18.6 in December 2016. Food inflation reached its highest level in eight years (20%). This has adversely affected the conditions of poverty and vulnerability among Nigerian households.

Nigerian governments raise little revenue as a share of GDP in 2016. The federal and state governments recorded the weakest revenue mobilization effort in the world (IMF,2017) at under 5% of GDP. This resulted in a doubling of the debt service to revenue ratio from 33% in 2015 to 66% in 2016, and significantly hampered the government's ability to invest in social sector. Revenue projections are not expected to recover soon and might see a slow increase to 7% by 2022 (IMF,2017).

Economic growth is weakly associated with poverty reduction. Nigeria's poverty level has been persistent and the effect of economic growth on poverty rates has been modest. The growth elasticity on poverty rates in Nigeria is estimated to be -0.6 -compared to -1.2 in sub-Saharan Africa (SSA) and -2.2 in lower-middle-income countries (LMIC) as a whole - which means that poverty rates have fallen by only a fraction of the amount that Nigeria's economy has grown. Such disparity between the growth of the GDP and stagnant poverty rates is indicative of the unequal distribution of Nigeria's wealth and demonstrates that growth alone will not eliminate poverty.

Being poor in Nigeria is worse than being poor in other west African countries. Poor women and children in Nigeria lack access to basic social services. 10.5 million children are out-of-school- the world's highest number. Sixty percent of those children live in rural areas. Poor children in Nigeria are twice as likely to be stunted as poor children in Ghana and Cameroon. Similarly, women in lowest two income quintiles in Nigeria are half as likely to be delivered by skilled health personnel compared Cote D'Ivoire, Senegal, Ghana, and Cameroon.

Nigeria is not well positioned to capture much of a demographic dividend. Nigeria's total fertility rate (TFR) of 5.8

¹ African Economic Outlook (2018)



children per woman in 2016 has changed little since 1990 when it was 6.0. Among the poor and the uneducated the TFR appears to be increasing. Persistently high fertility rates have created a worker to dependent ratio of 1.1, less than half of the ratio in East Asian economies. Without a swift reduction in fertility, Nigeria will not benefit from the kind of demographic dividend that was so helpful to the “tiger” economies of East Asia. Capturing a demographic dividend will require supportive macro-economic policies that helps create many more jobs. However, a rapid fertility transition is the sine qua non of a demographic dividend.

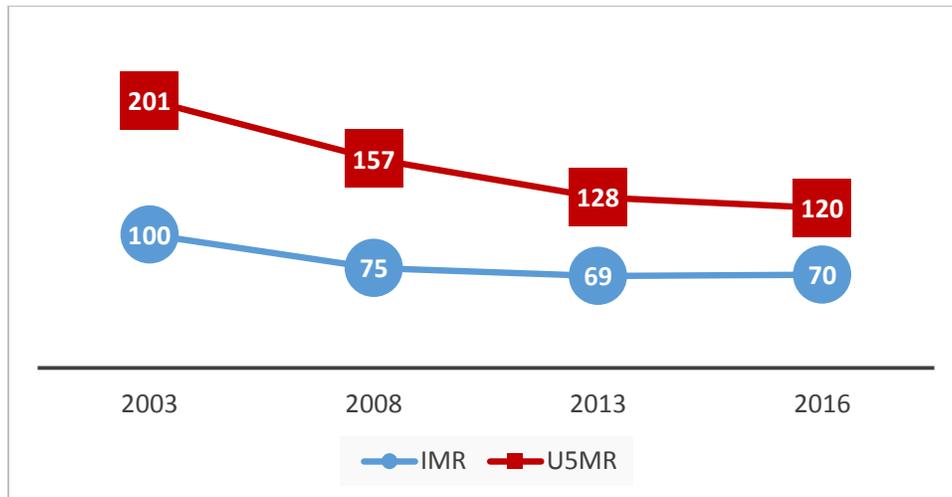
Sectoral and Institutional Context

Summary: The under-five mortality rate (U5MR) in Nigeria is high, especially by comparison to other lower-middle income countries. It is also highly inequitable. Being a poor child in Nigeria means that you face the highest risk of dying before your fifth birthday in all West Africa. Reducing U5MR is not just about improving welfare, it is also a crucial contributor to economic growth without which Nigeria’s development will be stunted. Almost 75% of U5MR in Nigeria, excluding neonatal mortality, is due to 3 diseases: malaria, pneumonia, and diarrhea. The technologies available to control these diseases, including some new vaccines, are highly cost effective and based on rigorous impact evaluations. Controlling these diseases requires both preventive and curative services, the coverage of which are variable. Immunization coverage is the lowest in West Africa, especially for poor children. However, good progress has been made on malaria prevention and some states have significantly strengthened the primary health care (PHC) system through performance-based financing (PBF) and decentralized facility financing (DFF). The results achieved by PBF and DFF are in stark contrast with the generally poor performance of the rest of the PHC system. Despite some of the successes, Nigerian governments invest very little in health and are thus unable to take full advantage of the available techniques and technologies that will improve health outcomes. A robust response to these challenges is the Basic Health Care Provision Fund (BHCPF) envisaged in the National Health Act of 2014. The BHCPF promises significant additional domestic resources for PHC and employs results-based approaches to accomplish much better results.

Under 5 Mortality in Nigeria is High and Rates of Decline are Slowing: The under-five mortality rate (U5MR) in Nigeria is stagnating at high levels (see figure 1) although progress was made from 2003 to 2013. There are a number of explanations posited for the decline in the 2000’s, including: (i) increased access to antibiotics and anti-malarials in rural areas as the private sector expanded; (ii) successes in malaria control (see page 7); and (iii) some progress on controlling measles. Despite the progress, Nigeria’s U5MR is very high by any standard but is particularly high for a lower-middle income country (see figure 2).

Nigeria is Pretty Much the Worst Place to be a Poor Child in West Africa: Not only is Nigeria’s U5MR high, it is also very inequitable. Among children in the poorest income quintile, Nigeria’s U5MR is the highest in West Africa (see figure 3), more than twice the rate of Ghana or Senegal. This turns out to be true for nutritional status as well. Within Nigeria, the poorest quintile has a U5MR that is 2.6 times higher than the richest quintile. Both in relative and absolute terms, poor children in Nigeria are faring very badly.

Figure 1: Under-5 and Infant Mortality Rates Nigeria 2003-201



Sources: Nigerian Demographic and Health Surveys – NPopC and MICS 2016-17 NBS

Reducing U5MR will have important economic benefits: Besides simple welfare effects, slashing U5MR will have important socio-economic benefits for Nigeria:

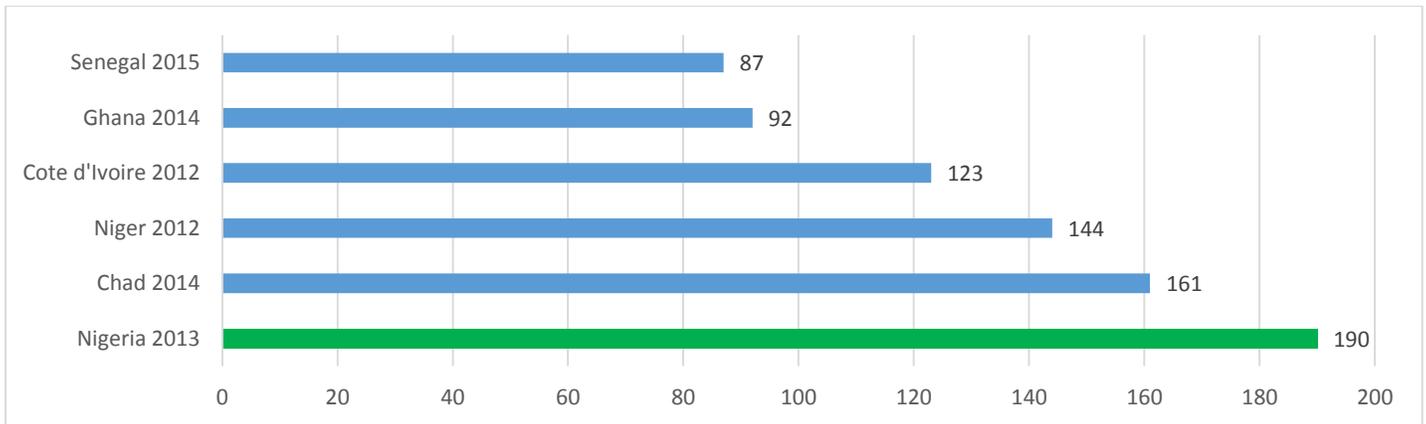
- i) **Cognitive Development:** Improved child health has an important influence on the cognitive development. Children who are frequently sick experience significant psycho-motor development delays.
- ii) **Nutritional Effects:** Children who are frequently sick are also at high nutritional risk. Frequent illness and malnutrition combine in a vicious cycle. Children who are sick have increased metabolic needs and are also less able to consume and absorb nutrients, while children who are malnourished are have compromised immunity which renders them more prone to becoming sick.

Figure 2: Under-Five Mortality Rates and National Income - 2016



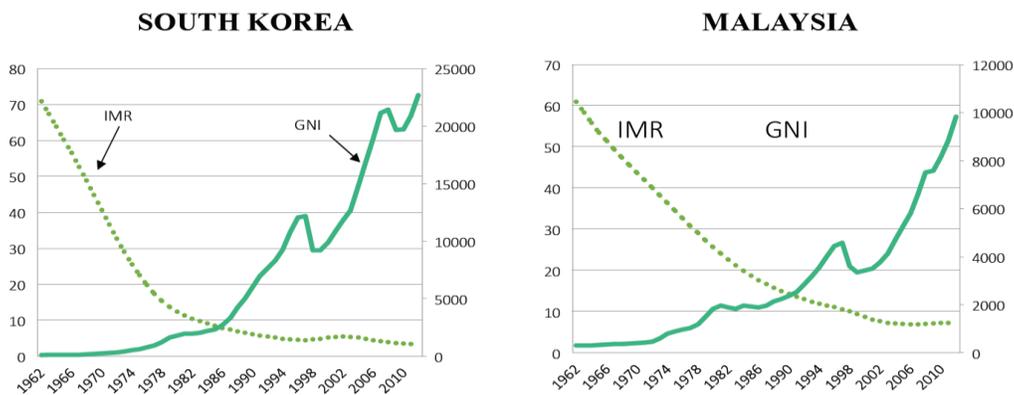
Source: World Development Indicators 2017 (Data for 2016)

Figure 3: U5MR Among the Poorest Income Quintile – Latest Demographic & Health Survey



- iii) **Fertility reduction:** There has never been a significant reduction in fertility that wasn't preceded by a steep reduction in U5MR. Families the world over will continue to have high fertility if they fear that many of their children will die in childhood. Since reducing U5MR is critical to fertility reduction, it also an essential aspect of obtaining a demographic dividend.
- iv) **Economic Growth:** A paper by Dean Jamieson, Larry Summers and others² has argued that reductions in mortality account for about 11% of recent economic growth in low and middle-income countries based on national income accounts. Using a more encompassing measure of growth based on "full income," they argue that 24% of the growth observed between 2000 and 2011 in full income was due to mortality reduction.
- v) **Reductions in Child Mortality have preceded economic take-off:** Whether they are causal or not, improvements in child mortality preceded the economic take-off observed in East Asian "tiger" economies (see figure 4). Waiting for economic growth to improve child health has not worked in Africa and is out of keeping with the experience in East Asia.

Figure 4: Trends in the Infant Mortality Rate (IMR) and Gross National Income (GNI) in South Korea and Malaysia 1962-2010



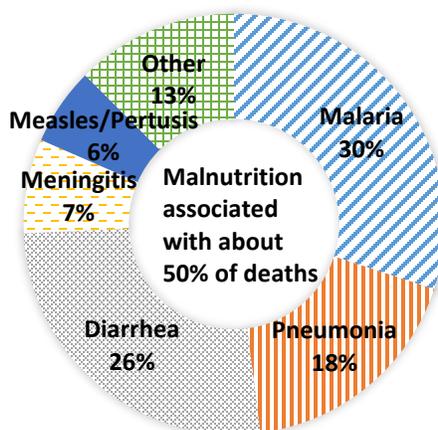
Most Under 5 Mortality is due to Malaria, Diarrhea, and Pneumonia: Just three diseases account for 74% of U5MR in

² Jamieson DT, Summers LH, et al: Global health 2035: a world converging within a generation. *Lancet*: 2013, 382: 1898-955



Nigeria (excluding neo-natal mortality, i.e. deaths within the first month of life). According to a verbal autopsy and social autopsy study³ involving more than 2,000 under-5 deaths, conducted in 2014 (see figure 5), malaria accounts for 30% of under-5 deaths while diarrhea and pneumonia account for another 26% and 18% respectively (another 13% of deaths are caused by the vaccine-preventable diseases measles, pertussis, and meningitis).

Figure 5: Causes of Under 5 Mortality (excluding neonatal mortality)



These diseases are susceptible to very cost-effective and evidence-based technologies: One reason for optimism is that the main killers of children in Nigeria can be prevented or treated using low cost, highly efficacious, and easy-to-implement interventions (see table 1). The evidence supporting these interventions is rock solid, coming from multiple randomized trials in diverse settings. Among the newer (to Nigeria) interventions are Rota-virus and pneumococcal vaccines, which are powerful ways of reducing the impact of diarrhea and pneumonia, respectively. These vaccines could represent a real breakthrough if they are provided to poor children.

Table 1: Available Technologies for Controlling the main causes of Under 5 Mortality in Nigeria

Disease	Prevention	Treatment
Malaria	- Long-lasting insecticide treated bed nets (LLINs) - Seasonal Malaria Chemoprophylaxis (SMC), - Social and behavior change communications (SBCC)	- Artemisinin Containing Treatments (ACT) - Rapid Diagnostic Tests (RDTs) - intermittent presumptive treatment for pregnant women (IPTp)
Pneumonia	- New vaccine against pneumococcal disease	- Antibiotics (ampicillin)
Diarrhea	- New vaccine against rota-virus - Hand washing, sanitation, clean water supplies	- Oral rehydration solution with Zinc

Delivering these live-saving interventions will require stronger vertical programs and health systems: Vertical programs

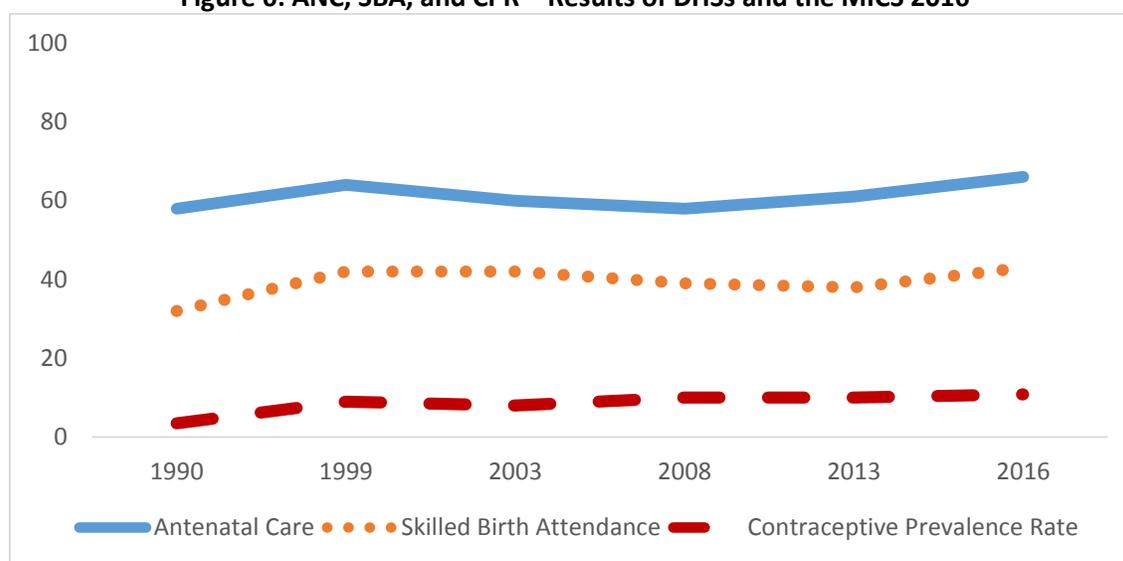
³ A Verbal/Social Autopsy Study to Improve Estimates of the Causes and Determinants of Neonatal and Child Mortality in Nigeria – 2016 Johns Hopkins University.



are those parts of a government that focus on a particular disease or series of intervention, e.g., malaria control or immunization. In addition, making progress on reducing U5MR will require strengthening the health system, i.e., the infrastructure, logistics, organization, and people needed to vaccinate children, treat sick children, and safely deliver babies. By analogy to the internet, a vertical program is like web content and the internet service provider is like a health system. Neither are much good without the other.

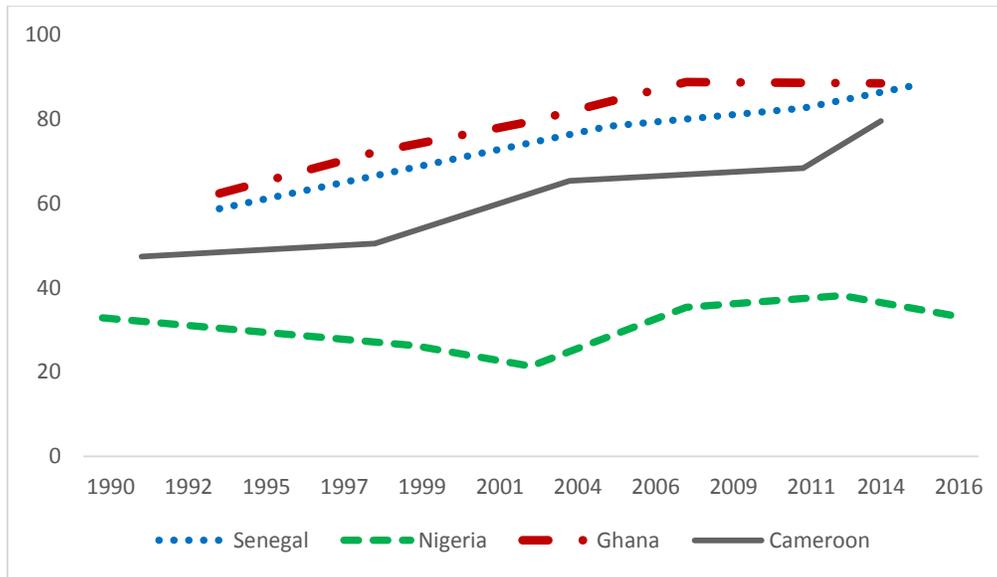
The coverage and utilization of these live-saving interventions is variable: Nigeria has made real progress in reducing the burden of malaria and is on the cusp of eradicating polio. In some states, results-based financing approaches, or extensive political commitment, have significantly strengthened PHC. However, overall there has been little improvement over the last 25 years in the coverage of key services (see figure 6) such as antenatal care (ANC), skilled birth attendance (SBA), and the contraceptive prevalence rate (CPR) and these services remain mired at low levels.

Figure 6: ANC, SBA, and CPR – Results of DHSs and the MICS 2016



Immunization coverage is low and inequitable: Vaccination coverage rates from household surveys have changed little in Nigeria over the last 25 years (see Figure 7). This is in sharp contrast to other countries in West Africa which have made more rapid progress even though they started from higher levels. Despite the availability of almost all the required inputs (such as vaccines, cold chain equipment, needles, syringes, etc.) the absolute level of vaccination coverage remains very low in Nigeria. It is also highly inequitable. In 2016 a multiple indicator cluster survey (MICS) found that Penta3 coverage among Nigerian children in the poorest income quintile was only 10%, up from 7% in the 2013 demographic and health survey (DHS). This compares to 27% in Chad, 52% in Niger, and 87% in Ghana. About 90% of immunizations in Nigeria are provided by public sector facilities, so the low coverage rates reflect challenges in public sector delivery of basic services.

Figure 7: DPT3/Penta3 Coverage (%) from DHS and MICS Surveys 1990-2016

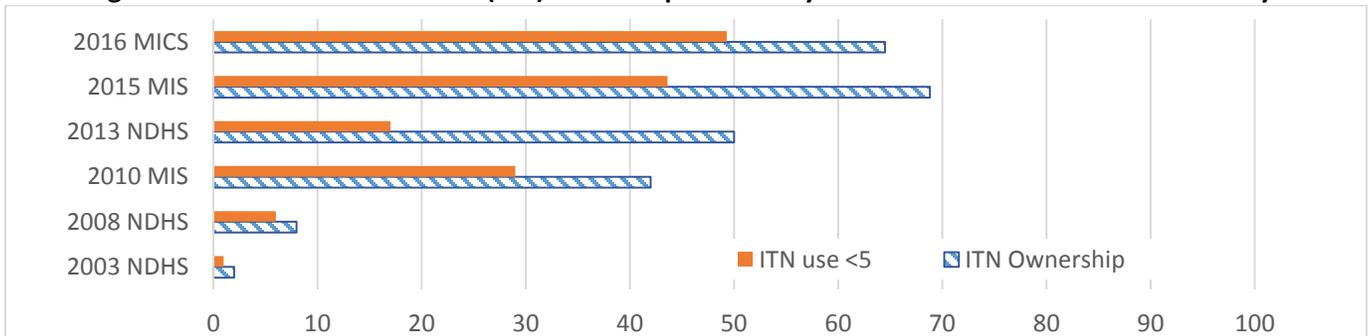


Sources: Demographic and Health Surveys (DHSs) and Multiple Indicator Cluster Surveys (MICS), the latter just for Cameroon 2014 and Nigeria 2016.

Physical access to services is not the problem: The typical reasons for low coverage that are seen in other parts of SSA do not explain the challenges in Nigeria. 85% of the population live within a one-hour travel of a health facility and 67% live within a 30-minute walk of a facility. Similarly, the health worker to population ratio is twice the SSA average. Thus, neither a shortage of infrastructure nor human resources can explain the low coverage of services. Better explanations are weak management, poorly incentivized health workers, and limited accountability mechanisms as well as user fees (even in the public sector) which act as financial barriers to care.

Nigeria has made considerable progress in controlling malaria but has more to do: From 2008 to 2016, substantial progress was recorded in malaria control throughout the country. For instance, DHS and MICS surveys indicate that the utilization of LLINs by children under five increased from 6% to 49% over the eight years (see figure 8). Not only were the gains rapid, they were also equitable. Among the children in the poorest income quintile LLIN use was 59% compared to 27% among the richest income quintile (household ownership of LLINs also decreases monotonically with income). Consequently, health outcomes have also improved – malaria prevalence declined from 42% to 27% nationally between the two Malaria Indicator Surveys conducted in 2010 and 2015. While the progress on malaria is gratifying and demonstrates what can be accomplished, Nigeria still has more work to do. The 49% utilization rate for LLINs achieved in Nigeria is well below the sub-Saharan Africa average and much lower than the rates achieved in DRC (56%), Mali (71%) and Burkina Faso (75%).

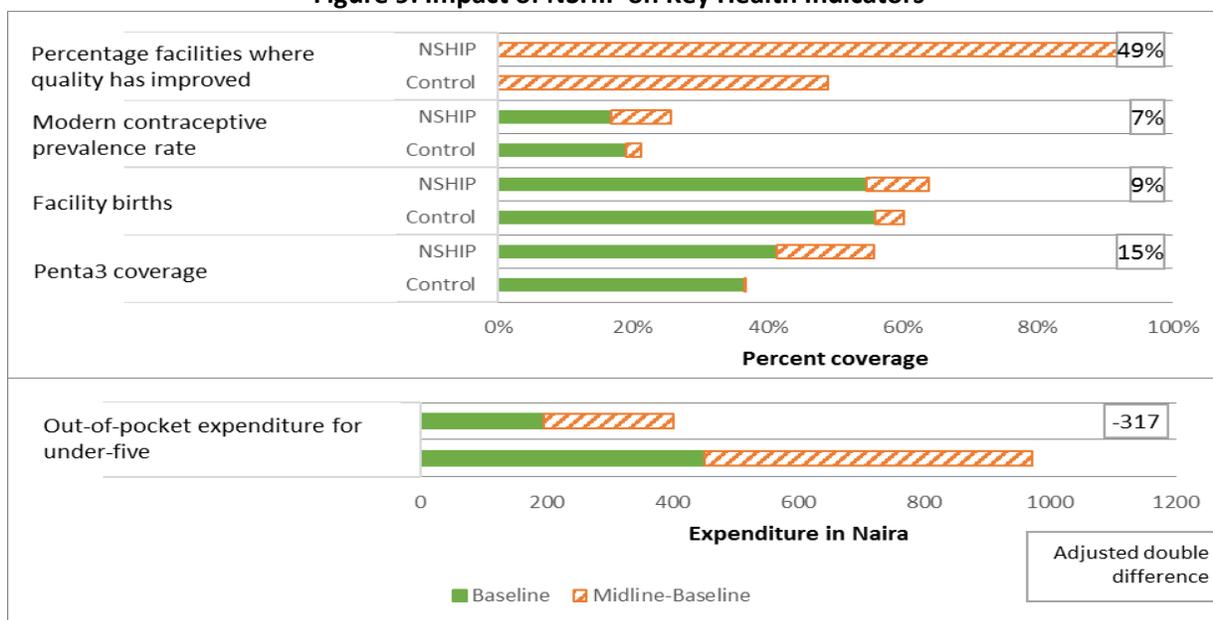
Figure 8: Insecticide Treated Net (ITN) ownership and use by Children under 5 – Household Surveys





Performance-based financing (PBF) and decentralized facility financing (DFF) have strengthened PHC. As part of the Bank-supported Nigeria State Health Investment Project (NSHIP), PHC facilities in 3 states introduced PBF and DFF in 2014. PBF provides payments directly to public sector health facilities based on the quantity and quality of specific services they provide. Funds are transferred electronically to an account controlled by the health facility office-in-charge and a representative of the ward development committee. These funds can be used by the facility to buy drugs and supplies, maintain and repair the facility, and up to half the funds can be used to pay performance-based bonuses to the staff. Under DFF lumpsum payments are also transferred to the facilities but payments are not linked to performance. A randomized impact evaluation over the course of more than 30 months of implementation demonstrated positive results on the quantity of services (particularly improvements in immunization coverage and institutional deliveries) as well as in the quality of care. NSHIP increased Penta3 immunization coverage by 15 percentage points, facility births by 9 percentage points and modern contraceptive prevalence rate by 7 percentage points (see figure 9). Furthermore, NSHIP improved quality of care in 49% of facilities, and reduced out-of-pocket expenditures for under-five care by 317 Naira.

Figure 9: Impact of NSHIP on Key Health Indicators



Data source: NSHIP Baseline and Midline surveys, 2014-2017

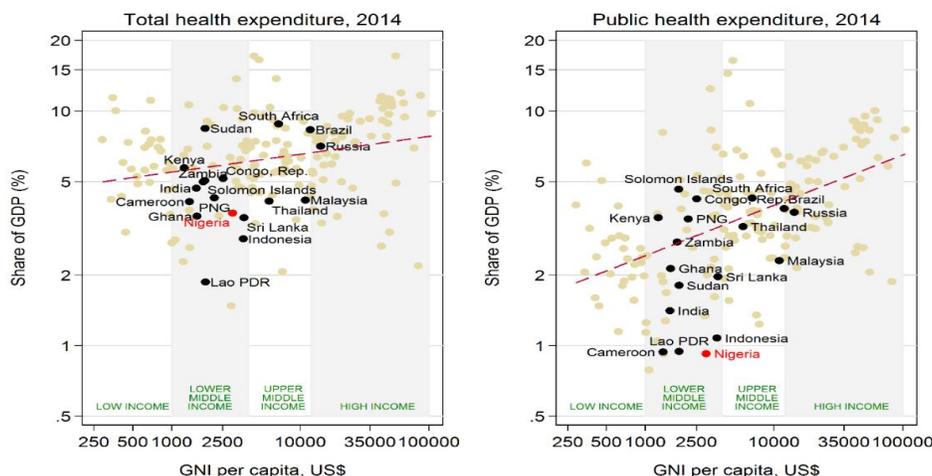
The Governments of Nigeria spends less on health than nearly every country in the world. To accelerate progress to universal health coverage (UHC) the government will need to significantly invest more in health. In 2016, government health spending was 0.6% as a share of GDP or just \$US11 per capita, among the lowest in the world (see figure 10). The consequences of this low level of public spending include: (i) there are limited resources available to pay for basic preventive and promotive health services that could have outsized impact; and (ii) there are high levels of out-of-pocket payments at the point of delivery which reduce the use of services and act as a barrier to care, especially for the poor.

A Potentially Transformative Response by the Government: In response to the crisis in the health sector, the Government of Nigeria has enacted a potentially transformative National Health Act (NHAct), operationalized through the Basic Health Care Provision Fund (BHCPF). The BHCPF, if implemented as envisioned in the Act, will mobilize Naira 50 billion (\$150 million) in new money per year for PHC. In addition, to more funding for PHC, the BHCPF builds on some of the successes Nigeria has achieved under NSHIP which involve results-based and decentralized approaches. Thus, the BHCPF represents “more money and smarter money.”



Bold Innovations in Service Delivery: The BHCPF will use Fee-for-Service payments to providers (akin to PBF under NSHIP) to spur, initially, the delivery of a small number of high-impact maternal and child health interventions with a focus on rural areas. Funds will be paid to accredited private and public health facilities after the services have been provided, while keeping services free to beneficiaries, thus reducing barriers to accessing care.

Figure 10: Total Health Expenditure and Public Health Expenditure by per capita GNI - 2014



Source: World Development Indicators; WHO Global Health Expenditures Database
Note: Both y- and x-axes logged

Long-term Importance of the BHCPF: The BHCPF engenders approaches that could alter the long-term trajectory of the Nigerian health system, because: (i) the government will use its own resources to purchase services not inputs; (ii) the government will buy services from both public and private providers using a level playing field; (iii) it establishes a system of accreditation to improve quality of care; (iv) it will finance a rigorous system of verification that helps ensure value for money; (v) creates robust payment systems via electronic transfer to providers, that reduces the chance of corruption; and (vi) demonstrates long-term government commitment to using public funds to subsidize the cost of services for the poor.

Relationship to CPF

The proposed MPA and Malaria operation are fully aligned with the Country Partnership Strategy FY2014-2017. The proposed operation is fully aligned with all three of the “strategic clusters” of the CPS. It lies at the heart of the second cluster which aims to improve the “effectiveness and efficiency of social service delivery at State level for greater social inclusion.” With its emphasis on encouraging innovation that achieves improved results, particularly for the poor, while making more efficient use of resources, this MPA wholly supports the CPS’s objective of addressing “inequities in income and opportunities” by “developing more effective mechanisms of social service delivery.” The proposed operation’s commitment to greater transparency, increased accountability, and improved availability of good quality data fully supports the thrust of the third cluster which seeks to improve governance and public-sector management.

C. Proposed Development Objective(s)

The PDO of this Multi-Phased Approach (MPA) is to cut under five mortality rate in half in a decade.



Key Results (From PCN)

The first operation of the MPA will be a malaria control operation entitled IMPACT (Innovative approaches to Malaria Prevention and Control/Treatment). Ultimately, the project will contribute towards significantly decreasing U5MR, reducing the burden of malaria particularly among the poor and vulnerable populations, mitigating the public health and economic risks posed by malaria and thereby promoting economic growth and development.

- i) Percentage of children under 5 sleeping under an anti-malaria bed net the night prior to the survey.
- ii) Percentage of children under 5 with fever in the last two weeks who received a rapid diagnostic test (RDT) and artemisinin combination therapy (ACT).
- iii) Percentage of women pregnant in the last two years who received three or more doses of IPT during antenatal care.
- iv) Within Sahelian project states, the proportion of children who received SMC during the rainy season.
- v) Change in knowledge of parents on the prevention and management of malaria.
- vi) Number of Beneficiaries

D. Concept Description

The proposed first operation under this MPA, IMPACT, builds on the success of the Bank-supported Malaria Booster Project and will fill gaps in the coverage of malaria services by working with states not covered by other development partners. IMPACT will introduce a series of innovations including:

- i) Use of mathematical optimization to determine the most efficient use of scarce resources in the Nigerian context. The study conducted by the Burnett Institute revealed that the optimal combination of interventions would be: (a) distribution of Long Lasting Insecticide Net (LLINs); (b) prompt treatment of malaria using ACTs; (c) Seasonal Malaria Chemoprophylaxis (SMC) in Sahelian states; (d) intermittent presumptive treatment of pregnant women (IPTp); and (e) Social and Behavior Change Communication (SBCC);
- ii) Contracting with non-state actors (NSAs) using a results-based approach to support the delivery of this optimized package of services in the selected states. The global experience thus far has shown that NSAs perform better than governments on reaching rural communities, carrying out SBCC, and organizing logistics;
- iii) Working closely with private sector health care providers to improve the quality of malaria treatment. Recent household surveys in Nigeria show that between 60 and 69% of fever cases are treated in the private sector. Ignoring private providers and only focusing on the public sector will not achieve the desired results.

Component 1: Expanding and Strengthening Preventive and Curative Services Through NSAs (\$170 million): The project will finance contracts with NSAs to: (i) provide LLINs to households and ensure nets are hung and used; (ii) strengthen the management of children and adults with malaria in both the public and rural private sectors; (iii) distribute Sulfadoxine-Pyrimethamine (SP) to pregnant women during Antenatal Care through both the public and rural private providers; (iv) provision of SMC to children under 5 in selected Sahelian states; (v) interpersonal behavior change communication to improve behavior and knowledge in rural communities; (vi) commodity procurement and supply chain management. NSAs will be recruited using a performance-based approach where a proportion of their payment will be directly linked to results of household level and facility-level surveys.



The project will also support the centralized procurement of selected commodities, such as LLINs, where economies of scale and prior experience ensure it makes sense.

Component 2: Health System Strengthening and Capacity Building (\$30 million): The project will support the health system and strengthen capacity at federal and state levels in the following ways:

- i) Strengthening monitoring and evaluation through: (a) establishment of a sample registration system (SRS) in conjunction with the appropriate federal government agency; (b) conducting special studies to help assess the performance of the NSAs; and (c) carrying out qualitative assessments and operational research to improve program performance;
- ii) Provision of performance-based technical support to the state malaria elimination programs (SMEPs) and the national malaria elimination program (NMEP) to help manage contracts, assess performance, improve management and supervision, and make strategic decisions on malaria control. The technical support will also include: (a) training of key state officials in performance and contract management; (b) use of performance frameworks for key state and national level staff to incentivize critical actions; and (c) organizing annual or semi-annual results conferences that bring together all states to learn from their implementation experience; and
- iii) Recruitment of a firm/organization to implement SBCC activities at national and state levels including through mass media and the use of mosques and churches.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The MPA will be implemented throughout Nigeria.

B. Borrower's Institutional Capacity for Safeguard Policies

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

C. Environmental and Social Safeguards Specialists on the Team

Joseph Ese Akpokodje, Environmental Safeguards Specialist
Elijah Abiodun Siakpere, Social Safeguards Specialist

D. Policies that might apply



Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	<p>The services being funded by the Project (e.g., vaccination, skilled birth attendance, curative services for under-five, etc.) are potentially significant sources of waste generation, especially through expired vaccines and medications due to poor stock management and cold chain. However, in the context of Nigeria this is of modest environmental concern since the volume of waste from wasted vaccine vials, medications and diagnostics is small and because sterilized vaccines, and packaged medications do not present a public health or environmental risk.</p> <p>The MPA is not envisaged to involve any major civil works, such as new constructions or significant rehabilitation of existing buildings. However, minor rehabilitation repairs such as painting, plastering, replacing doors/windows, leaking roofs, may occur in existing buildings and health facilities. The exact locations and numbers of health facilities are not yet known and therefore the ESMF will be prepared to elaborate the processes and procedures to be followed to ensure that the potential adverse impacts are mitigated. In addition, a Health Care Waste Management Plan (HCWMP), aligned with the National Health Care Waste Management Plan and other existing health projects in Nigeria will be prepared due to the potential medical waste generated through expired vaccines and medications resulting from poor stock management and cold chain. The ESMF and HCWMP will be disclosed in country and infoshop before project appraisal.</p>
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples.
Involuntary Resettlement OP/BP 4.12	TBD	Project activities are expected to have positive social impact as the program will ultimately contribute towards significantly decreasing Under Five Mortality Rate (U5MR) as well as reducing the burden of malaria



particularly among the poor and vulnerable populations. To this end from a social safeguards point of view, the project is low risk and it is not expected to involve land acquisition that might lead to involuntary resettlement or restriction of access to assets, resources or livelihoods.

Safety of Dams OP/BP 4.37 No

Projects on International Waterways
OP/BP 7.50 No

Projects in Disputed Areas OP/BP 7.60 No

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Dec 17, 2018

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

An ESMF and a HCWMP will be prepared and disclosed before the end of appraisal, expected by mid-December 2018.

CONTACT POINT

World Bank

Benjamin P. Loevinsohn
Lead Public Health Specialist

Borrower/Client/Recipient

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

Implementing Agencies

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



FOR MORE INFORMATION CONTACT

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

APPROVAL

Task Team Leader(s):	Benjamin P. Loevinsohn
----------------------	------------------------

Approved By

Safeguards Advisor:	Maman-Sani Issa	30-Jun-2018
Practice Manager/Manager:	Trina S. Haque	30-Jun-2018
Country Director:	Indira Konjhodzic	30-Aug-2018