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

Appraisal Stage | Date Prepared/Updated: 29-Jan-2018 | Report No: PIDISDSA24128

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Nigeria	P162069	Accelerating Nutrition Results in Nigeria	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	16-Apr-2018	27-June-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Federal Ministry of Finance	Federal Ministry of Health	

Proposed Development Objective(s)

To expand utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under two years in select areas of the Recipient's territory.

Components

Basic Package of Nutrition Services
Stewardship and Project Management

Financing (in USD Million)

Financing Source	Amount
Global Financing Facility	7.00
International Development Association (IDA)	225.00
Total Project Cost	**232.00**

Environmental Assessment Category

B - Partial Assessment

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

Yes

Decision

The review authorized the preparation to continue subject to disclosure of safeguards documents.

Other Decision (as needed)

B. Introduction and Context

Country Context: Nigeria has very high rates of malnutrition that are unevenly spread across the country. Stunting, a measure of chronic malnutrition, and micronutrient deficiencies, generates the highest burden. Stunting rates since 2008 have not improved, indicating a long-term nutritional problem in the country. Over 43.6 percent of children under five years of age suffer from chronic malnutrition, which translates to 14.5 million Nigerian children who will either die or not develop to their full potential. Chronic micronutrient malnutrition – mainly deficiencies in vitamin A, iodine, iron, folic acid and zinc – is a serious problem and, despite their high cost-effectiveness, coverage rates of micronutrient supplementation and fortification remain generally low. It is estimated that 30 percent of Nigerian children and 20 percent of pregnant women are vitamin A deficient, while 76 percent of children and 67 percent pregnant women are anemic. Encouragingly, the national rate of acute malnutrition has decreased over the last few years from a high of 18 percent in 2013 to 2.9 percent in 2016-17.

The "nutrition map" of Nigeria is highly uneven with nine of the North East and North West States having rates of child stunting that exceed 50 percent, while some States in the South have rates of child stunting as low as 17 percent. The gap in stunting between the North and South is widening. Stunting in the North West has been consistently *increasing* between 2008 and 2015 whereas it is consistently decreasing in the South West and South East states have recorded consistent decreases in stunting.

Half of the children from the poorest two quintiles stunted, though poverty per se is not the only driver of malnutrition—stunting rates are high even in the highest income quintile. Adolescents in Nigeria must be reached with nutrition and health interventions to break the inter-generational transmission of stunting from mother to child. Adolescent girls, when pregnant, require extra nutrients for their still-growing body, as well as for their growing fetus. The competition for nutrients between the adolescent mother and her child puts the mother at risk for undernutrition, leading to higher risk of maternal mortality and adult anemia, while also placing the offspring at a higher risk for poorer birth outcomes, including low micronutrient stores, low birth weight and stunting, as compared to adult pregnancies. Children of adolescent mothers are also often at greater risk of poor nutritional care and feeding practices. Inadequate knowledge and beliefs amongst households contributes to poor feeding practices leading to poor nutrition outcomes in the children of Nigeria. Only 23.7 percent of Nigerian children are exclusively breastfed till six months of age in line with WHO recommended standards and only 40 percent of children are receiving foods from four or more food groups daily and the recommended minimum number of meals starting at six months of age.

Malnutrition, particularly in young children, leads to increased mortality: undernutrition is responsible for approximately half of under-five mortality and one-fifth of maternal mortality in Nigeria. It is estimated that Nigeria loses over US$1.5 billion in GDP annually to vitamin and mineral deficiencies alone.

Sectoral and Institutional Context: Government of Nigeria has identified investing in people as a strategic priority in its Economic Recovery Growth Plan (ERGP, 2017-2020). The plan envisages investment in health and education, as a core pathway for human capital development and an essential catalyst in the revised growth story of Nigeria. GON looks to achieving its growth potential by sharply targeting the poorest and the most vulnerable members of the society

with programs and opportunities for inclusive and sustained growth. This was affirmed during the meeting of the National Economic Council (NEC) of Nigeria[1], by its Chair, the Vice President of Nigeria and several political and thought leaders from the federal and state levels. Leading this agenda, the Government is reaching out for evidence and experience available with key stakeholders including the donor partners, private sector and civil society organizations to inform its strategies and programs for development of human capital.

Nutrition interventions are consistently identified as among the most cost-effective development actions. The Federal Government approved and launched a multi-sectoral National Policy on Food and Nutrition in Nigeria in September 2016. This Policy provides the framework for addressing Nigeria's malnutrition challenge from the individual, household, community and up to the national level. It recognizes that a range of sectors need to play their specific roles to resolve this complex development challenge, and specifically covers health, agriculture, science and technology, education, trade, economy and industry as well as social protection.

The health sector has taken the lead in developing its sector-specific plan to address malnutrition. The "National Strategic Plan of Action on Nutrition" sets out costed, nutrition-specific interventions with measurable targets to be achieved at scale between 2014 and 2019. The National Health Act provides increased funding and political support for primary health care and was signed into law by The President of Nigeria in December 2014. The Act specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS), which include basic nutrition services.

Nigeria has strong guidelines and regulations to enable the provision of necessary micronutrients. All the guidelines and regulations to enable the provision of key interventions such as micronutrient supplements (Vitamin A, iron, zinc) and food fortification to be scaled-up exist in Nigeria, either under the leadership of the Federal Ministry of Health (FMOH) or of the Standards Organization of Nigeria (SON) within the Ministry of Trade and Investment.

The public health infrastructure of Government of Nigeria, comprising the Ministry of Health with its National Primary Health Care Development Agency and Department of Health Services at the federal level and their counterpart agencies at the state levels are organized to implement and manage structured nutrition specific interventions of the National Strategic Plan of Action for Nutrition.

Concurrently, the Ministry of Agriculture has also developed its sector-specific plan to address malnutrition. A nutrition sensitive national safety nets program is also being developed for the country, which provides an opportunity to better targets populations at highest risk of malnutrition. There is opportunity to introduce nutrition-sensitivity in the recently approved program for results operation focusing on basic education, given that one of the determinants of child malnutrition is the education level of a child's mother, her knowledge of nutrition, which influences her practices and behaviors at the household level.

The presence of a vibrant private health sector in the provision of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) and nutrition services provides a unique opportunity to leverage their capacities, expertise, resources, reach and innovation through performance based contracts for targeted outreach to address the malnutrition challenge of Nigeria.

C. Proposed Development Objective(s)

[1] National Executive Council Meeting, March 22, 2018

Development Objective(s) (From PAD)

To increase utilization of quality, cost-effective nutrition services for pregnant and lactating women, adolescent girls and children under two years in select areas of the Recipient's territory.

Key Results: The PDO indicators for the project are:

- Infants 0-6 months exclusively breastfed (proportion)
  - Of which, infants of adolescent girls
- Children 6-24 months who receive micronutrient powders as part of complementary feeding
  - Of which, children of adolescent girls
- Children 6-59 months who receive zinc and Oral Rehydration Solution (ORS) as treatment for diarrhea (proportion)
  - Of which, children of adolescent girls
- Children 6-59 months dewormed twice a year
  - Of which, children of adolescent girls
- Pregnant women who consume a minimum of 90 iron-folic acid tablets (proportion)
  - Of which, adolescent girls
- Pregnant women who receive intermittent presumptive treatment for malaria [at least 2 doses] (proportion)
  - Of which, adolescent girls

D. Project Description

Project Beneficiaries: The direct beneficiaries of the project will include pregnant and lactating women, also specifically adolescent girls and their children less than 5 years of age in the twelve identified project states of Nigeria, with increased access to a package of nutrition interventions focused on the "first 1000 days" period from conception to the child's second birthday. In 1-2 States, additional focus will be given to providing adolescent girls services to delay age of first birth and to increase birth spacing. Special measures will be taken to target women and children from the poorest households through community-based approaches.

Indirect project beneficiaries will include individuals who influence women, adolescent girls and children to utilize the nutrition services financed by the project and who influence nutrition-related behaviors in households and communities. These indirect beneficiaries include husbands/fathers/sexual partners, mothers and grandmothers, as well as religious and traditional leaders. Public servants who are responsible for policy and service delivery at all levels of the health and food regulatory system in Nigeria will also benefit through capacity development aspects of the project. Staff from non-state actors who will implement the performance-based contracts will also benefit through increased experience in implementing programs at scale.

Component 1: Basic Package of Nutrition Services: The component will support scaling up of a basic package of nutrition interventions in the identified project states with a focus on reaching households from the poorest two quintiles as well as adolescent girls and their children. These interventions will include:

a. Behavior change communications to improve infant and young child feeding behaviors, namely, early and exclusive breast feeding (0-6 months) and appropriate complementary feeding (6-23 months).
b. Provision of a course of micronutrient powders to children 6-23 months to improve the quality of the food provided for complementary feeding.

c. Iron/folic acid supplementation for pregnant women, with a focus not only on provision to women but also counselling to improve compliance.
d. Intermittent presumptive treatment for malaria to pregnant women.
e. Zinc and ORS for treatment of diarrhea in children 6-59 months.
f. Vitamin A supplementation twice a year for children 6-59 months.
g. Deworming twice a year for children 6-59 months.

States will also commission pilots to test new cost-effective, scalable, implementation modalities for interventions targeting the first 1000 days from conception to the child's first two years. States will allocate up to 15 percent of their project envelope to co-finance up to 20 percent of existing program for treatment of severe acute malnutrition. Additionally, the component will finance interventions specifically targeted at adolescent girls before, during and after pregnancy with the objective of reducing proportion of early pregnancies and spacing between consecutive births. Children of adolescent mothers will be targeted with the relevant interventions included in the basic package of nutrition services.

In keeping with the results-based approach of the project, the above services will be delivered through at least two performance based contracts signed with State Ministries of Health with competitively procured non-state actors and performance based contracts signed between State Primary Health Care Development Agencies and Primary Health Centers in the states. Additionally, robust management of these performance based contracts and the achievement of agreed quantitative and qualitative targets for service delivery by non-state actors and the public health centers, will trigger disbursements to appropriate implementing agencies at the federal and state levels through a disbursement linked indicator (DLIs) mechanism. The DLIs will focus on the following results areas:

(i) improved coordination of development partners who are active in the States;
(ii) increased coverage of Vitamin A supplementation and deworming twice per year;
(iii) sharper focus on nutrition during ante-natal visits in facilities (specifically provision and counselling on iron folic acid tablets during pregnancy and counselling on early and exclusive breastfeeding); and
(iv) strong management of the performance-based contracts as per agreed standards.

Component 2: Stewardship and Project Management: This component will strengthen key stewardship functions at the federal level for the sustained delivery of nutrition services thereby positively impacting program delivery across entire Nigeria. The component will also finance the project management costs at federal and state levels, including activities related to project monitoring and verification of results. The component will focus on the following five areas:

(i) Communication for social and behavior change for nutrition, including a performance-based contracts with Nigerian Inter Faith Action Association (NIFAA): A national behavior change communication strategy will be developed and deployed through the Federal Ministry of Health. The strategy will emphasize a mass media campaign focusing on key messages that will also be reinforced and deepened at community level and in health facilities through activities in Component 1. This campaign will be entirely focused on the key results to be achieved by state and non-state actors in Component 1. The mass media will be complemented by messages that will be disseminated through religious leaders, through a performance based contract issued to NIFAA for leveraging conducive behavior change.
(ii) Multi-sectoral coordination and accountability for nutrition and adolescent health results: The Federal Ministry of Budget and National Planning (FMBNP), will be incentivized to lead multi-sectoral coordination, planning and accountability for nutrition results across the key sectors of agriculture, health, social protection, education, water and gender. Specifically, DLI indicators will incentivize the production of an annual "State of Malnutrition

in Nigeria" report which will be based on progress towards pre-agreed work plans as recorded in sector-specific score cards. The advocacy strategy for the project will ensure that these reports are used in multiple ways to increase accountability for nutrition results in Nigeria.

(iii) Knowledge platform: ANRiN will present a unique knowledge platform for organic generation, curation and dissemination of implementation experience of key nutrition services deployed through both non-state actors and the public health system leveraging results based approaches. The Federal Ministry of Health will be incentivized through DLIs to capture lessons that will emerge from the project and facilitate sharing of these lessons and experiences between project states, amongst project states as well as bring international best practices to bear upon implementation strategies. Additionally, cross-learning between experiences of non-state actors engaged in delivery of basic package of nutrition services in twelve project states and focused package of adolescent health services in one pilot state will also be facilitated. This knowledge platform will also facilitate sharing of experiences from other nutrition initiatives in Nigeria and abroad, through annual results conference held in Nigeria.

(iv) Research program: Through an input based mechanism, the project will finance a modest program of operational research in support of strengthening Nigeria's national nutrition program. The project will look to work with local research institutions including universities to strengthen domestic capacities for operational research to facilitate development. A menu of research topics will be identified in consultation with FMOH for pursuing through this sub-component; and

(v) National nutrition information system for improved planning, monitoring and reporting of service delivery and outcomes: With an aim to support the strengthening of the nutrition information system in Nigeria, the project will incentivize the Nutrition Unit in the FMOH for (a) development of a surveillance system in project implementation States to track nutrition and adolescent health outcomes; (b) financing for annual SMART surveys; (c) financing for a national nutrition survey, including on micronutrient deficiencies; and (d) financing of additional surveys as required.

E. Implementation

Institutional and Implementation Arrangements:

Steering Committee: The Steering Committee that is facilitating intergovernmental coordination, collaboration, communication, knowledge sharing and monitoring of Saving One Million Lives (SOML) and the Nigeria State Health Investment Project (NSHIP) will also oversee ANRiN. The Steering Committee in its current form is chaired by the Honorable Minister of Health (or Permanent Secretary), with representation from Federal Ministries of Health, Finance (i.e., the International Economic Relations Department), Budget and National Planning, National Primary Healthcare Development Agency (NPHCDA), State Ministries of Health (SMOH) and State Primary Healthcare Development Agencies (SPHCDAs), as well as Civil Society Organizations (CSOs). The Steering Committee will benefit from and inform the agenda of the Food and Nutrition Committee, co-chaired by the Federal Ministries of Health and Agriculture.

Multi-sectoral Coordination: The Ministry of Budget and National Planning (MBNP) will lead multi-sectoral coordination on the National Policy on Food and Nutrition in Nigeria (2016) and its monitoring with Ministries of health, agriculture, science and technology, education, trade, economy and industry and social protection. Specifically, the National Nutrition Council of the MBNP will consultatively develop scorecards and annual targets for achievement towards the national policy for each Ministry, monitor progress and disseminate State of Nutrition Reports on an annual basis.

Financial Oversight: The Federal Ministry of Finance (FMOF) will provide overall financial oversight to the project ensuring streamlined and timely fund flow. It will contract an Independent Verification Agent (IVA) to verify progress towards ANRiN DLI targets for indicators also tracked through annual National Nutrition and Health household surveys using the SMART methodology from Year 3 of project implementation. It will also recruit additional IVAs, as required, to verify achievement of DLI targets for indicators through additional household surveys or methods prescribed in the verification protocols. Based on the qualification and quantification of DLI indicators achieved, disbursements of IDA Credit allocated to each indicator will be triggered. It is anticipated that the Bank would hire the IVA in the initial 1-2 years of project implementation with financing from the PANRIN MDTF.

Overall Project Management: The project itself will be anchored within the FMOH. The Department of Family Health (DFH) will host the Project Management Unit (PMU) and the NPHCDA will provide technical guidance to project States for implementation of the project. The DFH will work with the states to ensure that states have the standards, tools and technical capacity to meet their nutrition targets. It will take the lead in developing the social and behavior change strategy in collaboration with the Advocacy and Communications Department of the NPHCDA for the project and facilitate its deployment at federal level and in project states. It will also be incentivized to develop a national nutrition surveillance system and to manage a research program. In parallel, the nutrition division of the NPHCDA will be responsible for implementation support to service delivery in State Health Facilities by the State Primary Health Care Development Agencies. It will work with the SPHCDAs to ensure the technical quality of nutrition-focused activities in states and the smooth implementation of performance-based contracts at community and facility levels.

Project Management Unit: The Project Management Unit housed in the FMOH will be in charge of overall coordination of the project. The PMU will be responsible for the coordination of day-to-day administration, monitoring and reporting on project activities and serve as the liaison with FMOH and the NPHCDA as well as State Ministries of Health (SMOH) and SPHCDAs responsible for project implementation at the state level. A Senior Officer will be identified by the Honorable Minister of Health to serve as the full-time Project Coordinator for ANRiN. He/she will be supported by technical experts in the fields of (i) nutrition; (ii) adolescent health; (iii) communication; (iv) procurement; (v) contract management; (vi) community mobilization and engagement; (vii) accountant/finance; (viii) internal auditor; (ix) monitoring and evaluation. These experts could be either seconded from FMOH and/or NPHCDA, where available or recruited as consultants, where such skills are lacking in both the Federal Ministry and the Agency. The responsibilities of the PMU will include:

a. Overseeing the implementation of all Project components;
b. Coordinating and facilitating FMOH/NPHCDA activities related to the project;
c. Implementing and overseeing the initial disbursements to participating States;
d. Communicating and working with States, developing and implementing a communications and outreach plan;
e. Facilitating the timely disbursement of funds to the States;
f. Knowledge management and peer learning; and
g. Ensuring that covenants are complied with and that the Project is implemented according to the Project Implementation Manual (PIM).

State Level Arrangements: At the state level, the Commissioner of Health will chair the Technical Consultative Group and be accountable for Project outcomes. It was agreed that at the state level, the SMOH will provide technical oversight to project implementation, and house the Project Implementation Unit. The SMOH will also contract and manage the non-state performance based contracts for delivering the basic package of nutrition services and focused package of adolescent health interventions and be held accountable for achievement of relevant disbursement linked indicators. The SPHCDA, will be in charge of delivery of the basic package of nutrition services and focused package of

adolescent health interventions through the state health facilities and be held accountable for achievement of the relevant disbursement linked indicators at the state level. A full-time Project Coordinator deputed to the Project Implementation Unit (housed in SMOH) will lead project implementation, drawing from the SMOH as well as the SPHCDA, as required, expertise in the areas of (i) nutrition; (ii) community mobilization and engagement; (iii) communications; (iv) procurement; (v) accountant/finance; (vi) contract management; (vii) internal auditor; and (viii) monitoring and evaluation. Additionally, in the state that will pilot adolescent health interventions, an adolescent health officer will also be nominated to the PIU. The role of the PIU will be to provide administrative support to the project, drawing upon technical guidance from SMOH and facilitating project implementation through the SPHCDA. It was confirmed that in Akwa Ibom, the SPHCDA is not established entity. The state will revert to the Bank with advice on the preferred implementation arrangements for the project clarifying the agencies that have been identified to provide technical oversight and to lead project implementation in the state.

Performance-based Contracts: The identified project implementing agencies will issue performance based contracts for a basic package of nutrition services and, in 1 State, a focused package of adolescent health services. One of the core functions of the SMOH is to ensure strong contract management, such that state level DLIs are achieved in a timely manner and any bottlenecks that compromise their achievement are swiftly dealt with, in escalating the issue to the right level. Each State will also have resources which they will manage directly to provide nutrition services; the level of resources available to each State will be directly related to its level of achievement of DLIs.

Partnership for Accelerating Nutrition Results in Nigeria Trust Fund*:* The World Bank has created a multi-donor trust fund which will provide additional resources to enable the World Bank to commission technical assistance to strengthen project implementation. The trust fund will also support targeted communications to continue to raise the importance in the country of nutrition as a development issue. It is currently envisaged that the resources from the trust fund would be made available primarily for Bank-executed activities but if could also eventually be used to pool donor resources for Recipient-executed activities, i.e., scaling up project interventions, should such financing become available. In that case, the resources would be added to the project using the World Bank procedures for additional financing.

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

The project will be located in 12 targeted States to be selected during preparation. It will focus on increasing the utilization of nutrition services. It will not finance and physical works.

G. Environmental and Social Safeguards Specialists on the Team

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

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Operational Policy (OP) 4.01 on Environmental Assessment is triggered in the project and classified as Environmental Category B resulting from the potential environmental concerns around the handling of health care waste resulting from project related activities in Component 1. Activities that will be financed under this project will not involve any major civil works, and impacts are expected to be minor, site specific and relatively easy to mitigate. There is an effective provision in the National Health Care Waste Management Plan and the implementing agencies – FMOH and NPHCDA have an existing health care waste management plan which will be adapted for this project.
Natural Habitats OP/BP 4.04	No	This policy is not triggered because the project will not be implemented in natural habitats.
Forests OP/BP 4.36	No	This policy is not triggered because the project will not involve activities that would have an impact on forests.
Pest Management OP 4.09	No	This policy is not triggered because the project will not involve pest management activities.
Physical Cultural Resources OP/BP 4.11	No	This policy is not triggered because the project will not be implemented in areas with physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	The policy is not triggered as there are no Indigenous Peoples in the project area.
Involuntary Resettlement OP/BP 4.12	No	This policy is not triggered since the project activities will not lead to land acquisition or restrictions of access to resources or livelihoods.
Safety of Dams OP/BP 4.37	No	This policy is not triggered because the project activities do not related to dams.
Projects on International Waterways OP/BP 7.50	No	This policy is not triggered because the project will not be implemented on international waterways.
Projects in Disputed Areas OP/BP 7.60	No	This policy is not triggered because the project will not be implemented in disputed areas.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

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

The project been classified as a Category B project, as the activities that will be financed under this project will not involve any major civil works, but impact are expected to be minor, site specific and relatively easy to mitigate. Operational Policy (OP) 4.01 on Environmental Assessment is triggered given the potential environmental concerns around the handling of Health care waste resulting from project related activities

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

There are no potential indirect or long-term environmental and social impacts due to anticipated future activities envisaged in the project area.

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

None

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

The Health Care Waste Management Plan developed and disclosed for the National State Health Investment Project (NHSIP) being implemented in Nigeria is also appropriate for ANRiN and is modified and updated to reflect the geographical scope of the project, thus complying with Bank policies in the participating states. The updated Health Care Waste Management Plan (HCWMP) is reviewed and provided clearance to by the Bank team and disclosed in-country by the FMOH on April 4, 2018 and the World Bank's external website on March 29, 2018.

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

Key stakeholders include: (i) vulnerable people -- such as adolescent girls and the women and children from the poorest households; (ii) states, including the State Ministries of Health (SMOH) , State Primary Healthcare Development Agencies (SPHCDAs) and local governments; (iii) the government at the federal level, including the Federal Ministry of Health, National Primary Healthcare Development Agency (NPHCDA); (iv) the development partner community,and (v) civil society organizations.

Public consultation will be an on-going activity taking place throughout the entire project process. Public participation and consultation would take place through meetings, requests for written proposals/comments, filling in of questionnaires, explanations of project to the locals, making public documents available at the state and local levels.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
28-Mar-2018	**29-Mar-2018**	

"In country" Disclosure

Nigeria

04-April-2018

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

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

No

The World Bank Policy on Disclosure of Information

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

Yes

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

Yes

All Safeguard Policies

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

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

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

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

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