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Report No: PAD2606

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED THIRD ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 104,400,000 MILLION
(US$150 MILLION EQUIVALENT)

TO THE

FEDERAL REPUBLIC OF NIGERIA

FOR THE

NIGERIA POLIO ERADICATION SUPPORT PROJECT

May 23, 2018

Health, Nutrition and Population Global Practice
Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2018)

Currency Unit = Nigerian Naira (NGN)

NGN 314.75 = US$1.00

US$1.44 = SDR 1

FISCAL YEAR
January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AFP	Acute Flaccid Paralysis
BHCPF	Basic Health Care Provision Fund
CBN	Central Bank of Nigeria
CDC	Centre for Disease Control and Prevention
DA	Designated Account
DALYs	Disability-Adjusted Life Years
DP	Development Partner
DPT	Diphtheria, Pertussis, Tetanus
ED	Executive Director
EOC	Emergency Operation Center
ERGP	Economic Recovery and Growth Plan
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
EU	European Union
EVM	Effective Vaccine Management
FGN	Federal Government of Nigeria
FM	Financial Management
FX	Foreign Exchange
FMOH	Federal Ministry of Health
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GPEI	Global Polio Eradication Initiative
GRS	Grievance Redress Service
HCWM	Health Care Waste Management
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IFR	Interim Financial Report
IPD	Immunization Plus Days
IPV	Inactivated Polio Vaccine
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau
LGA	Local Government Areas
LMIC	Low and Middle-Income Country
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey

MPA	Multiple Phase Approach
NBS	National Bureau of Statistics
NDHS	National Demographic and Health Survey
NERICC	National Emergency Routine Immunization Coordination Centre
NPHCDA	National Primary Health Care Development Agency
NSCS	National Strategic Cold Store
NSHIP	Nigerian State Health Investment Project
OPRC	Operations Procurement Review Committee
OPV	Oral Polio Vaccine
PDO	Project Development Objective
PforR	Program-for-Results
PHC	Primary Health Care
RI	Routine Immunization
RIFP	Routine Immunization Focal Person
SDR	Special Drawing Rights
SDD	Solar Direct Driven
SEA	Sexual Exploitation and Abuse
SERICC	State Emergency Routine Immunization Coordination Centre
SIA	Supplementary Immunization Activity
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SOML	Saving One Million Lives
SPHCDA	State Primary Health Care Development Agency
UN	United Nations
UNICEF	United Nations Children’s Fund
WHO	World Health Organization
WPV	Wild Polio Virus

BASIC INFORMATION – PARENT (Polio Eradication Support Project - P130865)

Country	Product Line	Team Leader(s)		
Nigeria	IBRD/IDA	Ayodeji Oluwole Odutolu		
Project ID	**Financing Instrument**	**Resp CC**	**Req CC**	**Practice Area (Lead)**
P130865	Investment Project Financing	GHN07 (9322)	AFCW2 (6548)	Health, Nutrition & Population

Implementing Agency: National Primary Health Care Development Agency

Is this a regionally tagged project?
No

Bank/IFC Collaboration
No

Approval Date	Closing Date	Original Environmental Assessment Category	Current EA Category
12-Jul-2012	31-Dec-2018	Not Required (C)	Partial Assessment (B)

[ ] Situations of Urgent Need or Capacity Constraints	[ ] Financial Intermediaries (FI)
[ ] Series of Projects (SOP)	[ ] Project-Based Guarantees

Development Objective(s)

To assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80% coverage with oral poliovaccine immunization in every state in the Recipient's territory, and sustain national routine immunization coverage.

Ratings (from Parent ISR)

	Implementation					Latest ISR
	08-Jun-2015	22-Dec-2015	27-Jun-2016	27-Dec-2016	28-Jun-2017	20-Dec-2017
Progress towards achievement of PDO	S	HS	HS	S	S	S
Overall Implementation Progress (IP)	S	HS	HS	HS	S	S
Overall Safeguards Rating						
Overall Risk	S	M	H	H	H	M

BASIC INFORMATION – ADDITIONAL FINANCING (Nigeria Polio Eradication Support Project Additional Financing - P165247)

Project ID	Project Name	Additional Financing Type	Urgent Need or Capacity Constraints
P165247	Nigeria Polio Eradication Support Project Additional Financing	Restructuring, Scale Up	No
Financing instrument	**Product line**	**Approval Date**	
Investment Project Financing	IBRD/IDA	14-Jun-2018	
Projected Date of Full Disbursement	**Bank/IFC Collaboration**		
30-Apr-2021	No		

Is this a regionally tagged project?	
No	
[ ] Situations of Urgent Need or Capacity Constraints	[ ] Financial Intermediaries (FI)
[ ] Series of Projects (SOP)	[ ] Project-Based Guarantees
[ ] Disbursement-linked Indicators (DLIs)	[ ] Contingent Emergency Response Component

	(CERC)
[ ] Alternative Procurement Arrangements (APA)	

Disbursement Summary (from Parent ISR)

Source of Funds	Net Commitments	Total Disbursed	Remaining Balance	Disbursed
IBRD				%
IDA	419.94	409.01	3.62	99 %
Grants				%

PROJECT FINANCING DATA – ADDITIONAL FINANCING (Nigeria Polio Eradication Support Project Additional Financing - P165247)

FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	150.00
Total Financing	150.00
of which IBRD/IDA	150.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	150.00
IDA Credit	150.00

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any other Policy waiver(s)?

[ ] Yes [✓] No

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

No

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

No

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

No

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
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Extended Team

Name	Title	Organization	Location

NIGERIA

NIGERIA POLIO ERADICATION SUPPORT PROJECT ADDITIONAL FINANCING

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I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Background

1. This project paper seeks the approval of the Board of Executive Directors to provide an additional credit of US$150 million equivalent to the Federal Republic of Nigeria, and a level 2 restructuring for the Polio Eradication Support Project (P130865). The proposed level 2 restructuring is requested to align the project development objective (PDO) with the added focus of the proposed Additional Financing (AF), specifically to improve routine immunization (RI) coverage, and it has been approved by Management consistent with World Bank policy on Investment Project Financing, paragraph 23. The focus on improving RI coverage is particularly relevant in the lagging states. Lagging states are 12 out of the 18 states with Penta3 coverage of less than 50 percent according to the 2016 Multiple Indicator Cluster Survey (MICS) result. The Federal Government of Nigeria (FGN) made a request on July 31, 2017 to the World Bank for the proposed AF and level 2 restructuring. The FGN made this request because it had already made large investments in polio eradication that have resulted in no new cases of polio in the last 21 months and would want to maintain the progress until eradication is achieved. The Government also proposed an additional component to address low routine immunization coverage in 12 lagging states in the country and requested an extension of the closing date to December 31, 2020.

2. Much of the resources provided under the proposed AF will support vaccine procurement, as has been the case for the parent project and previous AFs. The proposed AF will provide critically needed funds to (a) avoid any disruption in polio eradication activities; and (b) sustain coverage and prevent deterioration in Routine Immunization (RI). This AF will also support the scale-up of immunization activities which includes (a) strengthening the management of the immunization program at the national and subnational levels and (b) supporting the cold chain and logistics system. The management strengthening innovation will be implemented on a trial basis and if successful, can be scaled up in a subsequent and larger immunization project that the FGN has already requested.

3. The proposed AF builds upon substantial past investments. The World Bank has already provided US$610.4 million to support the Polio Eradication Program in Nigeria over the last 13 years. After the Oral Polio Vaccine (OPV) funds from the parent Polio Eradication Support Project (US$95 million equivalent) were exhausted in November 2014, Japan International Cooperation Agency (JICA) took over the OPV financing with a US$67 million credit. Subsequently, two other AF credits were approved - the first AF of US$200 million was approved by the Board on April 10, 2015, with a closing date of July 31, 2017, and the second AF of US$125 million was approved by the Board on June 7, 2016, with an original closing date of December 31, 2018. The original credit and the first AF have been fully disbursed, while the second AF has a remaining balance of US$0.01 million and with this third AF, the proposed closing date for both credits will be extended to December 31, 2020. In the last six years, the World Bank has financed polio eradication and routine immunization with a total of US$415 million in IDA credits. The investments have paid off handsomely, with the country now on the cusp of eradication of polio, but there is considerably more work to be done on RI.

4. Strong political will and partnerships are in place. There is strong political will for polio eradication in Nigeria. This is evident by the establishment of the Presidential Task Force for Polio Eradication that consists of governors from the 12 polio high-risk states. To demonstrate the Government's commitment, it released NGN 9.7 billion during the resurgence of the poliovirus in 2016 in response to the polio outbreak. Responding to the low coverage of routine immunization in the country, the Federal Ministry of Health (FMOH) through the National Primary Health Care Development Agency (NPHCDA) declared a state of emergency in RI in June 2017. This is a public health concern given the huge number of unimmunized children in the country. Consequent to this declaration, the Emergency Routine Immunization Coordination Centers were inaugurated at the national and subnational levels -National Routine Immunization Coordination Centre (NERICC) and State Routine Immunization Coordination Centers (SERICCs) in the 18 poorly performing states with the objective of revamping the routine immunization performance in the country. These coordinating centers have been tasked with the planning and coordination of the country's immunization program to improve national immunization coverage to at least 85 percent and unimmunized children are reached through innovative strategies. The proposed AF will support these Emergency Routine Immunization Coordinating Centers by strengthening the management of these centers through performance-based frameworks.

5. In terms of partnerships, Nigeria has been able to gather a host of partners (World Health Organization [WHO], United Nations Children's Fund [UNICEF], Bill and Melinda Gates Foundation, Kreditanstalt für Wiederaufbau [KfW], JICA, Center for Disease Control and Prevention [CDC] in Atlanta, and so on) to support its polio eradication efforts. Development Partners (DPs) have aligned with the Government's agenda to improve RI and strengthen Primary Health Care (PHC) and are also supporting the transition from the Global Alliance for Vaccine and Immunization (Gavi).

6. In line with the Government's request, the proposed changes under this AF include the following:

(a) Change in the PDO from 'to assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with oral polio vaccine immunization in every state in the Recipient's territory, and sustain national routine immunization coverage' to 'to assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with oral polio vaccine immunization in every state in the Recipient's territory, and *improve* national routine immunization coverage';
(b) Introduction of a third component –Routine Immunization System Strengthening that entails an innovative management approach at the national and subnational levels in 12 states, strengthening of the cold chain system (expansion of the cold store in Lagos and renovation of the Kano cold store), and strengthening of supply and logistics for vaccines;
(c) Extension of the closing date of the project from December 31, 2018 to December 31, 2020;
(d) Changes in the Result Framework – to incorporate indicators for monitoring and evaluation (M&E) of improvements in RI as well as correcting the end target for the number of children immunized, from 6,561,446 to 60,561,446, replacing three doses of diphtheria, pertussis, and tetanus (DPT3) with Pentavalent coverage, and deleting the duplicate indicator on the number of beneficiaries;
(e) Consolidation of Sub-components 1(a) and 1(b) under Component 1 into a single component renamed Polio Eradication Support; and

(f) Changes to the implementation and institutional arrangements as a result of the inclusion of the new Component 3 on Routine Immunization System Strengthening which will be implemented by the NPHCDA;
(g) Changes to procurement arrangements since Component 3 on Routine Immunization System Strengthening will be directly implemented by the NPHCDA while funds for Components 1 and 2 will be channeled through UNICEF and WHO;
(h) Changes to safeguards policies[1] triggered by including OP/BP4.11 on Physical Cultural Resources since activities related to the renovation/expansion of the two hubs in Lagos and Kano may impact cultural physical resources.

(a) Strategic Context

i. Country Context

7. Extreme poverty fell moderately from 54 percent to an estimated 49 percent during 2009-2017. About 94 million persons live below the purchasing power parity (PPP)-corrected US$1.90 poverty line. These estimates are based on the Government's official household survey, the Nigeria Living Standards Survey 2009/10. The World Bank projects that poverty will remain stagnant in 2018 and be on a gradual upward trend for the remainder of the decade. Nigeria's poverty rate is high compared to the average of low- and middle-income countries (LMICs) of 16 percent in 2013. Poverty is less responsive to economic growth in Nigeria—unlike in many other countries and in Sub-Saharan Africa. The poor progress in poverty reduction is due to multiple factors including (a) the high population growth rate, (b) weak employment creation, and (c) growing income inequality.

8. The 2015 elections marked, for the first time in Nigeria's history, a peaceful democratic transfer of power between two political parties, but the new administration faced a fast-deteriorating macroeconomic environment. Gross domestic product (GDP) growth fell from 6.3 percent in 2014 to 2.7 percent in 2015, and to −1.6 percent in 2016, bringing Nigeria's first full year of recession in 25 years. In 2016, global oil prices reached a 13-year low and oil production was severely constrained by vandalism and militant attacks in the Niger Delta. While the oil sector represents only 8.3 percent of the total GDP, it provides the majority of foreign exchange (FX) earnings and three-quarters of government revenues. The decline in FX earnings from oil exports, compounded by the introduction of several FX allocation/utilization rules that restricted access to FX at the official market rate by the Central Bank of Nigeria (CBN), had significant negative spillover effects on non-oil sectors dependent on FX for the import of inputs and raw materials.

9. Nigeria's GDP returned to growth in Q2 of 2017 and reached 1.4 percent (year on year) in Q3 of the same year. This has been driven by the recovery of oil production as well as a more stable oil price. The non-oil industry also returned to growth in Q2 but contracted by 0.8 percent (year on year) in Q3. Inflation remained sticky at just below 16 percent despite monetary tightening from the CBN. The parallel exchange rate premium as against the official exchange rate remains stable at just under 20 percent. With

[1] *Note*: The EA category for this AF remained the same as the previous two AFs. The EA category was originally 'Not Required (C)' and was then changed to 'Partial Assessment (B)' with the first AF and continues to be 'Partial Assessment (B)'.

higher oil prices and production and economic growth, fiscal revenues are expected to increase slightly, although they will remain below pre-crisis levels. However, there is a high degree of fragility and risk to economic recovery.

10. In March 2017, the FGN launched the national Economic Recovery and Growth Plan (ERGP) for 2017–2020. The ERGP sets out a plan to restore macroeconomic stability in the short term, as well as structural reforms, infrastructure investments, and social sector programs to diversify the economy and places it on a path of sustained inclusive growth over the medium to the long term. It sets an ambitious target of 7 percent real GDP growth by 2020.

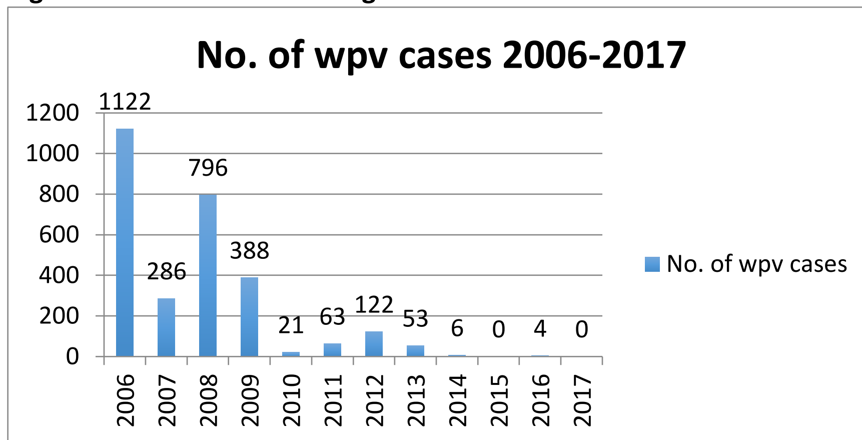
ii. Sectoral Context

11. Nigeria has recorded some progress in polio eradication. This success can be attributed in part to the establishment of the Polio Emergency Operations Centre (EOC). The Polio EOC has strengthened the management of polio in Nigeria through its reliance on routinely collected data (both programmatic and surveillance). The Polio EOC has huge capacity and extensive knowledge about effective responses in the country's context for polio eradication. Programmatically, Nigeria is well-equipped, monitoring the epidemic and developing innovative approaches to complete eradication of polio, despite the challenge of insecurity in polio high-risk states. To avoid cross-border transmission of polio, there is strong coordination with the Lake Chad countries. This involves conducting Immunization Plus Days (IPDs) in conjunction with the Lake Chad countries. This synergy of efforts has prevented the transmission of the poliovirus across borders.

12. In security-compromised areas and LGAs with low coverage, different innovative approaches are deployed to reach children. These include (a) involvement of religious and traditional leaders; (b) the use of performance approaches to incentivize and motivate vaccinators and immunization officers; (c) strategies such as 'hit and run'; firewalling; transient health camps along borders, markets, and motor parks; and house-to-house vaccination; and (d) the use of military personnel and the Joint Task Force to serve as security escorts and vaccinators in inaccessible LGAs. These approaches have resulted in no recorded case of Wild Poliovirus (WPV) in the last 21 months.

13. Progress on polio eradication requires stronger RI. Nigeria needs to maintain its current efforts if it wants to eradicate polio. Nigeria needs to redouble its efforts to improve RI coverage both as a means of helping eradicate polio and ensuring that children receive the powerful vaccines that are now available. Achieving polio eradication and significantly increasing routine immunization coverage requires continuing support from all stakeholders. After more than two years of WPV transmission interruption, four new cases were reported in Borno State in August 2016 – a security-compromised area whose population has been inaccessible because of the Boko Haram insurgency. Since then, for the past 21 months, there has not been a single case of WPV in Nigeria and the country stands on the cusp of eradication (Figure1 below).

Figure 1: Trends in WPV in Nigeria – 2006-2017



Source: National Polio EOC

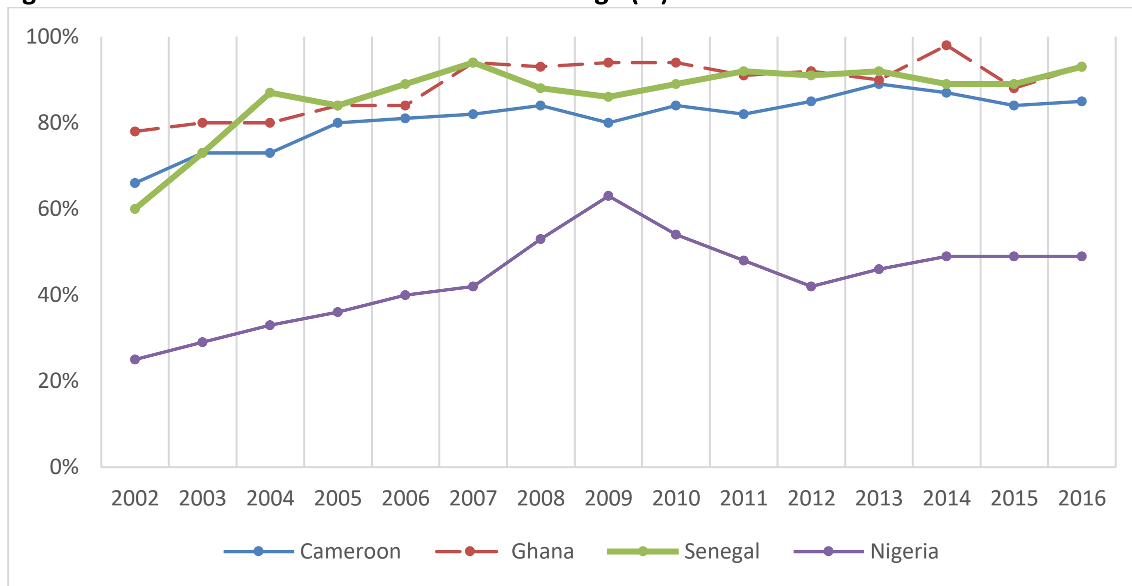
14. Limited Progress on RI. The latest Multiple Indicator Cluster Survey (MICS) 2016 shows poor coverage for routine immunization with 33 percent coverage for the third dose of Pentavalent vaccine (Penta3). This represents a decline of 5 percentage points from the 2013 National Health and Demographic Survey (NDHS) and is almost the same as it was in 1990. One of the greatest threats to polio eradication is poor RI coverage. Hence, there is a pressing need to boldly address the low routine immunization coverage found particularly in the very low coverage states. More than a quarter of states have less than 20 percent Penta3 coverage rates signifying the urgency of the challenge. The observed drop in routine immunization coverage is due to the deteriorating primary health care services, lack of management skills, and lack of accountability for under-performance at subnational levels. This proposed AF will test innovative management approaches and build on lessons learned from polio eradication efforts, as well as from the Nigeria State Health Investment Project (NSHIP) (P120798) and the Saving One Million Lives (SOML) (P146583) operation, that could dramatically increase RI coverage rates.

15. Lessons learned from other IDA supported operations in Nigeria over the past decade center around a greater focus on results, innovations, partnerships and stakeholder engagement. Specifically, results monitoring of key health indicators, such as RI coverage, is based on household and health facility surveys instead of operational data from health facilities alone. The use of performance and accountability frameworks for management at national and sub-national levels has also proven effective in engendering better outcomes. Innovations enabled Nigeria to increase access to and quality of service delivery to vulnerable and marginalized populations. For example, in the North East, the Government has introduced several strategies, such as the use of mobile clinics; shorter 'hit and run' immunization campaigns; border approaches (for example, the Lake Chad Polio Eradication Initiative, led by WHO and managed by a Technical Advisory Group with representatives from all the countries sharing borders with Nigeria in the region) which includes cross border immunization, joint IPDs and regular sharing of information; and third-party monitoring using local non-governmental organizations and communities. Lastly, building strong partnerships with the Government at all levels, DPs, and other stakeholders has enhanced coordination and effectiveness of implementation support.

16. The proposed AF will help inform future engagement on child health through the planned Multiphase Programmatic Approach (MPA).

17. Much of the resources provided under the proposed AF will support vaccine procurement, as has been the case for the parent project and previous AFs. While this is input financing, it is justified for a few reasons: (a) as described below the vaccine financing challenge is large at least partly due to the ambition to widely introduce new and potent vaccines such as rotavirus and pneumococcal vaccines; (b) when Nigeria experienced interruptions of stock-outs in the past, vaccination coverage suffered significantly (Figure 2); and (c) while routine coverage is low compared to other LMICs, it could get worse if vaccines are unavailable.

Figure 2: WHO-UNICEF Estimates of DPT3 Coverage (%) for Select West African Countries



Source: http://apps.who.int/immunization_monitoring/globalsummary (October 2017)
Note: These estimates are based on reported data, routinely collected information, and household survey results.

18. Vaccine financing. Nigeria is now out of recession and the 2018 Appropriation Bill allocated US$33 million for vaccine procurement. However, the high cost of new vaccines, which are co-financed between Gavi and the FGN, makes it difficult for the Government to meet the cost of vaccines such as rotavirus, meningitis A, measles and human papilloma virus (HPV) vaccines.

19. The impending transition from Gavi and Global Polio Eradication Initiative (GPEI). While, depending on the June 2018 meeting of the Gavi Board, the Gavi transition may be extended till 2023, GPEI is already reducing its support to Nigeria. The immunization program is dependent on both these programs for the financing of vaccines and immunization and with the transition of these programs, the Government will face a financing gap.

20. Management strengthening. The 2016 MICS demonstrates wide variation in the RI coverage rates between states. Sokoto achieved 3 percent Penta3 coverage, compared to 76 percent in Anambra and 75

percent in Edo. The wide variation between states is, at least partly, a function of the quality of management. RI managers at state level have not been held accountable for results and used optimistic and inaccurate data from the routine health information system to avoid accountability for poor coverage. New leadership of the NPHCDA is trying to increase the use of household surveys instead of routine data and wants to increase the accountability of state and LGA-level RI managers. These managers, in the past, have mostly been selected based on seniority and have not been held accountable for RI program performance. Newly recruited managers will be evaluated quarterly using performance frameworks by members of NERICC (comprised of NPHCDA and donors). Any manager found to be underperforming will be sanctioned by the Executive Directors (EDs) of the SPHCDA or the ED of NPHCDA.

21. Vaccine supply chain systems are an important component of a country's immunization program in terms of vaccine availability, coverage and program costs. Nigeria operates a five tier vaccine supply chain system. Vaccines are shipped from the manufacturer to the National Strategic Cold Store (NSCS) in Abuja. From the NSCS, vaccines are delivered directly (push) to the six zonal cold stores and from the zonal stores, to the states stores quarterly, using third-party logistics. Vaccines are delivered from the LGA cold stores to the health facilities either through a push or pull (collected by the facilities when needed) system. There are challenges in the cold chain supply and logistics, especially storage at the national hubs and inadequate storage capacity at the three national hubs in Lagos, Abuja, and Kano - only 50 percent of required vaccine storage space is available at the NSCS and 60 percent more storage space is required for planned new vaccines (rotavirus, human papilloma virus and second dose measles vaccine) to be introduced in country over the next 2-3 years based on Gavi's approval. The Lagos cold store has inadequate cold rooms to accommodate the large volume of vaccines received from the NSCS and there is no dry store for vaccine devices (Lagos serves as the national storage for all devices due to proximity to the sea port). With the lack of storage capacity, there are frequent shipments of vaccines to the country and distribution to subnational stores, resulting in high cost of logistics. The challenges associated with the lack of cold storage capacity in the country will gain in intensity as a large volume of new vaccines is introduced in 2018.

22. To alleviate the inadequate storage capacity, the 2017 Effective Vaccine Management Assessment recommended the installation of cold houses in Abuja, Kano and Lagos to make a three-hub system. To address the lack of cold chain equipment at subnational levels, the European Union (EU) and Gavi are supporting the Government to procure solar direct drive refrigerators.

23. Under the proposed AF, the World Bank will support the strengthening of the cold chain and supply logistics for immunization by renovating and expanding the insufficient cold and dry storage capacity in Lagos and renovating cold chain storage capacity in Kano State. By supporting the cold chain and logistics system, every Nigerian child will have access to vaccines of assured quality, delivered at the right time through efficient logistics, proper vaccine management, and a functioning cold chain. This will also help reduce vaccine wastage resulting from poor cold chain supply and logistics.

24. Strong partnerships are in in place. The activities under the proposed AF build on a very strong network of DPs that are supporting Nigeria in its efforts to eradicate polio. Most of the funds under the proposed AF will be channeled through the WHO and UNICEF through United Nations (UN) contracts for polio operations support and procurement of vaccines under components 1 and 2. These financing arrangements have proven to be very successful. In addition, to WHO and UNICEF, many other partners

have supported RI in Nigeria, including Gavi, CDC Atlanta, Bill and Melinda Gate Foundation, U.S. Agency for International Development, JICA, KfW, and the EU.

(b) Parent and Previous Additional Financings

25. The original PDO of the project was 'to assist the Government of Nigeria, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with OPV immunization in every state in the country'. The PDO was modified under the first AF to incorporate changes to the components under the AFs. Thus, the modified PDO was 'to assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with oral polio vaccine immunization in every state in the Recipient's territory, and sustain national routine immunization coverage'. The parent project had one component, that is, the supply of OPV to NSCSs in Abuja. As part of the subsequent AFs, the components were revised to include (a) Supply of OPV to national strategic cold stores; and Polio Eradication Operations Support; and (b) Routine Immunization support.

26. Satisfactory implementation. According to the recent Lot Quality Assurance Sampling (LQAS) surveys, every state has surpassed the 80 percent benchmark for the coverage of OPV3. More impressive is that 98 percent of high-risk LGAs have met that standard despite persistent insecurity. Given the progress on improving coverage and the 21 months since the last confirmed case of WPV, the project is rated Satisfactory for both PDO and implementation progress ratings. The fiduciary ratings are satisfactory. Legal covenants were compiled with and there were no outstanding audits, fiduciary, environmental, or social issues.

27. Key challenges to the project. One of the major setbacks to polio eradication in Nigeria is the insurgency in the northeastern part of the country. This has led to inaccessibility to some LGAs causing reduced vaccination of children in these areas and reduced surveillance activities. The observed drop in routine immunization coverage as shown in Penta3 coverage from 38 percent in 2013 DHS to 33 percent in 2016 (MICS) is likely due to the deteriorating PHC services, lack of management skills, and lack of accountability for under performance at subnational levels.

28. The parent project and the AFs have no fiduciary nor audit issues from inception till date. UNICEF procures the vaccines under components 1 and 2, and there have been signed agreements between the GON and UNICEF for this purpose. The environment safeguards category for the original project was C and was upgraded to B for AF1 and AF2 because of the concerns about health care waste management (HCWM) with the introduction of the RI component.

(b) Higher Level Objectives to which the Project Contributes

29. The proposed operation is aligned with the Country Partnership Strategy[2] FY 2014–2017, as well as its adjustment under the 2016 Performance and Learning Review[3]. In particular, the proposed AF is aligned with the second cluster, which aims to improve the 'effectiveness and efficiency of social services at state level for greater social inclusion'. Immunization is a public good, but evidence has shown that the upper wealth quintiles in Nigeria have better access to immunization services. This operation will help

[2] Report No. 82501-NG
[3] Report No. 104646

bridge the gap and ensure that this public good is available to all. In this sense, the proposed AF also contributes to the twin goal of eliminating extreme poverty and boosting shared prosperity. The AF also aligns with the FGN's ERGP and the PHC Revitalization Plan.

B. Rationale For Additional Financing

30. Over the past 13 years, the World Bank has been providing financial support through IDA credits for the procurement of OPV. These credits have ensured a constant supply of OPV to all states in the country resulting in increased herd immunity against WPV. This is evident from the absence of recorded cases in the last 21 months. To assist the FGN in finishing the last mile in polio eradication, the proposed AF will continue to provide financial support to the Government's efforts. At this critical juncture in polio eradication, any lack of funding could erase the hard-earned successes that required a huge national effort and very large investments.

31. Investment in polio eradication is a global public good because of the epidemic potential of polio and its devastating impact both on children and adults. Polio remains a lethal and crippling disease that is entirely preventable. Eradicating polio in Nigeria contributes to the Global Polio Eradication Program and makes the world a safer place for all children. Nigeria has officially interrupted the transmission of the poliovirus, and by July 2019, if there are no new cases, Nigeria will be certified polio-free - a significant milestone toward global polio eradication.

32. Improving routine immunization coverage is critical. RI is a critical part of polio eradication, especially in the challenging security environments. RI is also in itself critical to improving child health and will become an even more potent weapon against childhood mortality with the advent of new vaccines. Immunization is also an important element of universal health coverage, which Nigeria is striving to achieve through the National Health Act. In addition, immunization is one of the best buys in public health, with recent studies citing a 16-fold return on investment.

33. Stock-outs of routine vaccines in previous years have been associated with declining coverage. With the current drop in immunization coverage, any stock-outs of vaccines could further worsen the situation as was observed in 2012 when stock-outs of routine vaccines were associated with sharp declines in immunization coverage. This would have a deleterious effect on child health and could result in epidemics of vaccine-preventable diseases.

34. The majority of efforts will take place in the northeastern high-risk states. The last eight polio endemic states were mostly in the North East. Due to their security risk, the North East states pose the highest risk to polio eradication. They will also receive the major benefits in the form of improved access to PHC services through the extensive field-level staff placed in these states and activities supported by NSHIP.

35. The proposed AF will enhance positive developments taking place in the health sector. For example, service delivery of immunization is expected to become more financially sustainable in the medium term for a few reasons. First, the Basic Health Care Provision Fund (BHCPF) within the National Health Act, of 2014, will soon be piloted through a separate project currently under preparation and financed by the Global Financing Facility (GFF). The BHCPF is expected to fundamentally change provision

of PHC by mandating provision of a minimum package of basic PHC services with joint financing from the federal and state governments. When fully functional, the federal contribution will be a direct statutory transfer that represents significant additional funding for PHC. This financing mechanism will also ensure availability of operating costs at the health facilities for essential activities such as outreach, supervision, and maintenance of equipment. Second, the FGN has allocated US$33 million in its 2018 Federal Budget for procurement of vaccines and about US$10 million for immunization-related activities. The FGN is expected to continue increasing its budgetary allocation annually. Other DPs, such as Bill and Melinda Gates Foundation, are interested in incentivizing the Government based on performance of such incremental budgetary allocations, in sync with the Gavi transition. Finally, if the current trend continues, polio eradication can be fully achieved by 2019, and activities and expenditures will decrease and be phased out in the medium term.

II. DESCRIPTION OF ADDITIONAL FINANCING

36. The revised PDO is 'to assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with oral polio vaccine immunization in every state in the Recipient's territory, and improve national routine immunization coverage'. The PDO has been revised to reflect the project's objective to improve routine immunization in the country. Improvements in routine immunization coverage are expected to be achieved through the expansion of the cold store in Lagos and renovation of the Kano cold store, strengthening supply chain and logistics systems, and strengthening management at national and subnational levels.

37. The proposed AF will continue to finance the existing two components: Component 1(a) Procurement of Oral Polio Vaccines to national strategic cold stores, and Component 1(b) Polio Eradication Operations Support as well as, Component 2 Routine Immunization Support. As part of the proposed AF, Subcomponents 1(a) and 1(b) will be combined and renamed as Component 1 - Polio Eradication Support (US$65 million). This component will support the procurement of OPV and operations for polio eradication efforts. Component 2 on Routine Immunization Support will support the procurement of vaccines for routine immunization (US$69 million). A new, third component will be added, Component 3 on Routine Immunization System Strengthening (US$16 million). The new component aims at strengthening the routine immunization system by improving the cold chain, supply and logistics, and management capacity at all levels. Component 3 aims to increase effectiveness and efficiency of the supply and logistic system through timely and effective vaccine delivery at lesser cost, and by introducing performance frameworks for State Emergency Routine Immunization Coordination Centers (SERICCs). This component will be used for (i) strengthening management at state and LGA levels to address the weak management capacity of the RI program in 12 lagging states (Adamawa, Bayelsa, Gombe, Jigawa, Katsina, Kebbi, Kogi, Nasarawa, Niger, Plateau, Taraba and Zamfara), (ii) expansion of the cold store in Lagos and renovation of the Kano cold store, and (iii) strengthening the supply and logistics system for all vaccines from the national to the subnational levels to ensure availability of vaccines.

38. The proposed changes under this AF include (a) revision of the PDO; (b) extension of the project closing date from December 31, 2018 to December 31, 2020; (c) adding one new component, Component 3 Routine Immunization System Strengthening to improve immunization coverage by strengthening the cold chain, strengthening of supply and logistics for vaccines, and improving management at the national

and subnational levels in twelve states; (d) changes in the Result Framework – to incorporate indicators for M&E of improved RI coverage as well as correcting the end target for the number of children immunized from 6,561,446 to 60,561,446, replacing DTP3 with Pentavalent coverage, and deleting the duplicate indicator on the number of beneficiaries; (e) consolidation of sub-components (a) and (b) under Component 1 into a single component renamed as Polio Eradication Support; and (f) changes to the implementation and institutional arrangements since the new Component 3 on Routine Immunization System Strengthening will be implemented by the NPHCDA; (g) changes to procurement arrangements since Component 3 on Routine Immunization System Strengthening will be directly implemented by the NPHCDA while funds for Components 1 and 2 will be channeled through UNICEF and WHO; (h) changes to safeguards policies[4] triggered by including OP/BP4.11 on Physical Cultural Resources since activities related to the renovation/expansion of the two hubs in Lagos and Kano may impact cultural physical resources.

Components
Change to Components and Cost
Explanation:
The proposed AF and level 2 restructuring will fund the procurement of OPV and the implementation of national- and state-level polio immunization campaigns and support the procurement of vaccines for RI. Subcomponents under Component 1 will be consolidated into a single component which will be renamed as 'Polio Eradication Support'. The proposed AF has the following three components: **Component 1: Polio Eradication Support (financing up-to-date is US$245 million, and proposed financing is SDR 45.24 million or US$65 million equivalent)** – Consolidates the two sub-components into a single and renamed Component 1. This component will support the procurement of OPV and the operational requirements of polio eradication activities, just like in the previous two AFs. i. Within this component, UNICEF will procure OPV (US$50 million). The total estimated costs for OPV is US$40.7 million for 2018 and US$32.6 million for 2019. The IDA credit will cover the major part of the funding gap for 2018 and 2019 while the Government will cover the rest from its own budget. ii. Polio Eradication Operations Support (US$15 million) will include payment for any of the following activities where a funding gap is identified and the funds will be managed by either UNICEF (US$5million) or WHO (US$10 million) as required. o Vaccination personnel allowances during IPDs (WHO)

[4] *Note*: The EA category for this AF remained the same as the previous two AFs. The EA category was originally 'Not Required (C)' and was then changed to 'Partial Assessment (B)' with the first AF and continues to be 'Partial Assessment (B)'.

- IPD training and planning (WHO)
- Supervision and M&E (WHO)
- Transport and logistics (UNICEF)
- Supplementary Immunization Activities (SIAs) social mobilization (UNICEF)
- Engagement of traditional leaders (UNICEF)
- Payment mechanisms and others (WHO)
- Intensified SIAs and transport for supervision (WHO)
- Contingency counterpart funding for mop-ups (WHO)

M&E will be carried out through the existing mechanisms where the WHO surveillance system provides weekly information on polio cases, their typology, and distribution. Data from this system will feed into the Results Framework. The project's results indicator – for example – 'immunization coverage of OPV in each high risk state' with a target of 80 percent in each state measures the quality of the OPV campaigns while the 'percentage of teams with viable vaccine according to the Vaccine Vial Monitor' will measure the quality of the cold chain. These findings are externally validated through the LQAS.

Component 2: Routine Immunization Support (up-to-date financing is US$175 million, and proposed financing is SDR 48.02 million or US$69 million equivalent) – No Change

This component will finance the procurement of traditional RI vaccines (US$30 million); special vaccines for outbreaks and travelers (US$2 million); and devices (US$1 million). In the 2018 budget of the NPHCDA, the government has also made a provision of US$29 million for RI vaccines and devices. Procurement of RI vaccines and some devices is managed by UNICEF; the FGN will finance some of the devices and RI operations including the measles and yellow fever campaigns. M&E for this component will be carried out through the annual household survey (Standardized Monitoring and Assessment of Relief and Transition [SMART] survey) that will be conducted by the National Bureau of Statistics (NBS) in collaboration with stakeholders while UNICEF will provide technical assistance.

Component 3: Routine Immunization System Strengthening (proposed financing is SDR 11.14 million or US$16 million equivalent) – New component

This component will include support in expanding two cold chain hubs, strengthening supply chain and logistics systems, and strengthening management at national and subnational levels:

(a) Expansion and renovation of two cold chain hubs (in Lagos and Kano). The proposed AF will finance the expansion of the cold store in Lagos and renovation of the Kano cold store (US$8 million). The Lagos

hub will be enabled to receive vaccine supply directly through the Lagos airport to relieve the Abuja hub and reduce the cost and frequency of freights to Abuja. The NPHCDA will handle the construction and renovation work. The NPHCDA will ensure that the procurement procedures for procurement of contractors and monitoring of the project are in line with the World Bank's procurement processes. The recruitment of a construction firm and the bill of quantity and drawings for the expansion and renovation will be sent to the World Bank for a formal no objection.

(b) Supply chain and logistics systems strengthening. The proposed AF will finance the logistics strengthening (US$3.5 million) including supply chain systems strengthening which will support the optimization of the vaccine and devices supply chain and strengthening of cold chain management systems at national and subnational levels to ensure uninterrupted availability of potent vaccines. The support will mainly focus on: distribution from the NSCS to state stores and LGAs; warehouse management activities; effective vaccine management (EVM) capacity building; strengthening of temperature monitoring control systems; data management software licenses and server services; implementation of 2017 EVM improvement plan; deployment of cold chain equipment procured through the Gavi Cold Chain Equipment Optimization Platform (CCEOP) support to equip wards; and implementation of the PHC Revitalization Supply Chain Strategy. This subcomponent will be implemented by the NPHCDA.

(c) Strengthening management at national and subnational levels (US$4.5 million). To address the widely perceived weaknesses in management of RI programs at national and subnational levels, the AF will pilot a management strengthening approach and support the following activities in 12 lagging states (Adamawa, Bayelsa, Gombe, Jigawa, Katsina, Kebbi, Kogi, Nasarawa, Niger, Plateau, Taraba and Zamfara):

i. Conducting of LQAS surveys that provide robust estimates of immunization coverage at the state level and can provide a pass/fail assessment at LGA level;

ii. Competitive recruitment of state program managers and deputy program managers (from public sector candidates) through a selection process that includes diverse stakeholders. The selection procedures will also include objective testing of the candidate's analytical skills and knowledge of immunization program implementation;

iii. Payment of performance-based bonuses to these state-level managers that are calculated from quantitative improvements in vaccination coverage as observed in quarterly LQAS surveys;

iv. Competitive recruitment from the private sector of individual consultants to support the state level programs. Part of the consultant's pay (about 30 percent) will be linked to the performance of the state they are working in as judged by quarterly LQAS surveys. This ensures that the incentives of the consultants and the state level managers are fully aligned. Selection of these consultants will also be done by selection committees comprising members from diverse stakeholders; and

v. Competitive recruitment, in each of the state's LGAs, of two routine immunization focal persons (RIFPs). These RIFPs will be identified from public sector candidates, where they are available, and meet minimum standards. The successful candidates will be paid a performance bonus based on vaccination coverage as observed in quarterly LQAS surveys.

Current Component Name	Current Cost Parent, AF1 and AF2 (US$, millions equivalent)	Proposed Component Name	Proposed Cost under AF3 (US$, millions equivalent)	Total (US$, millions equivalent)
1. (a) Supply of oral polio vaccine to national strategic cold stores	145.00	1. Polio Eradication Support	65.00	310.00
1. (b) Polio Eradication Operations Support	100.00			
2. Routine Immunization Support	175.00	2. Routine Immunization Support	69.00	244.00
	-	3. Routine Immunization System Strengthening	16.00	16.00
Total	420.00		150.00	570.00

39. There will be no changes to institutional and implementation arrangements for Components 1 and 2. NPHCDA will directly implement Component 3. NPHCDA's capacity will be strengthened to enable it to carry out supply and logistics management of vaccines, coordination and management of the immunization program in lagging states through its state-level arms, that is, State Primary Health Care Development Agencies (SPHCDAs) and/or State Ministries of Health, and the expansion of the cold store in Lagos and renovation of the Kano cold store. The NPHCDA will house a small Project Implementation Unit (PIU) consisting of a project coordinator, fiduciary specialists, environment safeguards specialist, social safeguards specialist, and a civil engineer for design and implementation support of public works. The PIU will work with the zonal coordinators in Lagos and Kano and the procured firms in the renovation and rehabilitation of the cold stores. The PIUs and responsible units with the NPHCDA will work with the SPHCDA and the SERICC. The SERICC will be responsible for planning, implementation, and monitoring of RI activities at the state and local government level. The PIU will procure services of public health experts who will work within the SERICC to strengthen the capacity of the 12 lagging states in managing the RI program. They will also be responsible for building the capacity of the 12 lagging states and LGA officials. The consultants will be on performance contracts. Lastly, WHO will carry out quarterly LQASs and provide the results for management.

III. KEY RISKS

40. Although most risks associated with the proposed AF and level 2 restructuring are similar to those under the parent project, the key differences are high institutional capacity for implementation and sustainability risk and substantial fiduciary risk given the changes in implementation arrangements for Component 3. The overall risk for the project is high mainly because of high political and governance, macroeconomic, and institutional capacity for implementation and sustainability risks:

(a) Political and governance risks. By mid-2018, political campaigns will heighten toward the 2019 election and these campaigns may have negative effects on project implementation. Decision making in the government could face severe delays or recalibration with changes in leadership at federal and state levels. There are major governance issues and to mitigate governance risks, the project channels 86 percent of IDA financing through UN partners. Continuing insecurity in the North East and the Niger Delta are of political concern. Although the FGN has degraded the capabilities of Boko Haram, there are still flare-ups of suicide bombing and the threats from Niger Delta Avengers, including blowing up of pipelines.

(b) Macroeconomic risks. Although fiscal revenues are expected to increase slightly with higher oil prices and production and economic growth, they will remain below pre-crisis levels. There is also a high degree of fragility and risk to economic recovery. Thus, fiscal constraints continue to hamper the government's ability to finance development activities.

(c) Institutional capacity for implementation and suitability risks. Project funds will continue to be channeled through WHO and UNICEF for the first two components as was the case with previous AFs while Component 3 will be implemented directly by NPHCDA, and thus the high risk rating in this category reflects this change in implementation arrangements. These risks will be mitigated by strengthening the capacity of NPHCDA and of the states. The PIU will procure services of public health experts to work within SERICC to strengthen the capacity of states to manage the RI program. They will also be responsible for building the capacity of state and LGA officials. WHO will carry out quarterly LQASs and provide the results for management's attention and action.

(d) Fiduciary risks. With the introduction of Component 3 in the proposed AF, the fiduciary risks were rated as substantial. To mitigate fiduciary risks, the FM and procurement assessment of the NPHCDA was carried out during appraisal and found that the agency would provide adequate assurance that the World Bank's fiduciary requirements would be met. The assessment also provides a guide for areas that need capacity strengthening (for example, the development of financial and procurement manuals to ensure that World Bank's fiduciary guidelines are used).

Risk Categories	Rating (H, S, M or L)
1. Political and governance	High
2. Macroeconomic	High
3. Sector strategies and policies	Low

4. Technical design of project or program	Moderate
5. Institutional capacity for implementation and sustainability	High
6. Fiduciary	Substantial
7. Environmental and social	Moderate
8. Stakeholders	Moderate
9. Other	
Overall Risk	High

41. Safeguards. The proposed AF is not envisaged to cause significant environmental risks and continues to be classified as Environmental Category B, although the project will in this case, finance civil work activities including the construction and expansion of the cold store in the Lagos hub and renovations of the Kano hub. The Environmental and Social Management Framework (ESMF) has been prepared and disclosed in-country in Nigeria and in the World Bank's InfoShop on March 26, 2018.

IV. APPRAISAL SUMMARY

A. Economic and Financial Analysis

42. There is a strong economic rationale for the FGN to invest in polio eradication and RI:

(a) The control of communicable diseases, such as those prevented by vaccination, has large positive externalities beyond the individual benefits that warrants public financing.

(b) Polio eradication is a global public good because of its epidemic potential; and eradicating polio in Nigeria is part of a global effort that would rid the world of this disease.

(c) Children of poor families are more likely to be exposed to vaccine preventable diseases and are less likely to be immunized. Thus, there is a strong equity argument for public financing of vaccination.

(d) Families may under-value immunization because of a lack of information on the benefits of vaccination or the risks posed by the vaccine-preventable diseases. In this way, immunization is a 'merit' good that deserves Government financing. The economic rationale for this AF is clear.

(e) The World Bank has been providing financial support through IDA credits for the past 13 years and thus ensured constant supply of OPV to all states resulting in increased herd immunity against Wild Polio Virus.

43. Eradicating polio will reduce costs and save lives. For polio eradication, an economic analysis estimated that the incremental net benefits of the GPEI between 1988 and 2035, assuming that polio was eradicated in 2015, would have been US$40 billion (Tebbens et al, 2010). Sensitivity analysis suggested that the net benefits remain positive over a wide range of assumptions, and that including additional

externalities such as mortality reduction with Vitamin A supplements together with OPVs increases the net benefit to US$59–US$130 billion. Given that the difference in the incremental net benefits between the 2012 and 2015 eradication scenarios is about US$2 billion, any delays in eradication will only marginally reduce the estimated net benefits. WHO declared that Nigeria is no longer polio-endemic in 2015. Barring the four new cases seen in Boko Haram seized territories in Borno State in 2016, Nigeria was on track to be declared polio-free in July 2017. Meanwhile it has been polio free for the past 21 months.

44. The costs of the vaccine requirements for RI have been worked out carefully by a third party (McKinsey) and reviewed and approved by all the stakeholders. If Nigeria continues to achieve the coverage targets defined in its newest strategy, routine immunization would result in 3.3 million lives saved over the period 2018-2025[5].This is a particularly important time to avoid financing gaps that would nullify all the gains made in polio and would exacerbate the emergency in routine immunization. Given that Gavi – which in 2016 financed two-thirds of the vaccine budget in the country - and GPEI, are both set to transition support in the near term, increasing investment in immunization is critical.

B. Technical

45. Evidence of effectiveness. The quality of evidence supporting the effectiveness of RI and polio eradication is exceptionally high. Most of the vaccines, especially the new vaccines, have been subjected to multiple randomized trials in diverse settings and proven both their efficacy and effectiveness under field conditions. Vaccine efficacy rates (incidence rate among unvaccinated individuals minus incidence among immunized individuals over the incidence among the vaccinated) for most of the vaccines are above 80 percent. In addition, numerous studies have indicated that ‘herd immunity’ (that is, the proportion of individuals that need to be vaccinated to prevent transmission to unimmunized individuals) can be obtained at about 80 percent coverage.

46. Efficiency. Studies show that immunization is one of the best buys in public health, with recent studies citing a 16-fold return on investment over a 10-year period.[6] The country has declared an emergency around routine immunization; Nigeria has the highest number of unimmunized children in the world and one quarter of all the unimmunized children globally.[7] If successful, polio eradication would have an infinite cost-effectiveness ratio because the benefits would accrue far into the future while future costs would be zero. Cost-effectiveness of immunization interventions (including tuberculosis, DPT, polio, and measles) is US$7 per disability-adjusted life year (DALY) saved and for second opportunity measles vaccination is US$4 per DALY saved.

47. Program implementation. The implementation of polio eradication activities has improved over the last few years as judged by increasing OPV coverage rates. This has occurred in every high-risk state and in almost every high risk LGA. The results of polio (AFP) surveillance confirm the effectiveness of the

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[5] Nigeria cMYP 2017 - 2020

[6]The vaccines considered in the study were *Haemophilus influenzae* type b, Hepatitis B, Human Papillomavirus, Japanese encephalitis, Measles, *Neisseria meningitidis* serogroup A, rotavirus, rubella, *Streptococcus Pneumoniae*,and yellow fever.

[7] WHO, 2017. Immunization Coverage Factsheet [online]
Available at: *http://www.who.int/mediacentre/factsheets/fs378/en/* Accessed September 2017

polio program. The proposed AF will test a mechanism for strengthening RI at the state and local levels. It builds on successes observed under NSHIP where 'performance frameworks' were used to incentivize good performance at state and local levels. In the medium term, the building blocks for improving vaccination coverage rates are in place. Other World Bank-supported initiatives as well as other DP support are also providing help to the RI program.

48. M&E. The progress on RI will be judged using SMART surveys that are conducted by the NBS in collaboration with stakeholders and technical assistance from UNICEF. SMART surveys provide reasonable state-level estimates of immunization coverage and are carried out by an independent entity without a vested interest in the results. Other sources of information, such as the annual estimates from WHO and UNICEF will provide supplemental data. For polio activities, the independent quarterly LQAS surveys that provide pass/fail data at the LGA level but provide robust state-level estimates will be used to judge OPV coverage. Ultimate success will be judged by AFP surveillance, which so far has proven to be of high quality. Poorly performing progress on RI will also be monitored using quarterly LQAS surveys.

C. Financial Management

49. The financial management (FM) arrangements for Components 1 and 2 will remain the same as under the original project—Polio Eradication Support Project (P130865). The funds for procurement of OPV will be disbursed directly by the World Bank to UNICEF, while funds for polio eradication logistics and technical support will be disbursed to WHO or UNICEF depending on which part of the polio eradication operations has a funding gap. Component 2 (Routine Immunization Support) will be disbursed directly by the World Bank to UNICEF.

50. For Component 3 (Routine Immunization System Strengthening), the funds will be disbursed directly to the NPHCDA. The World Bank will disburse the funds for Component 3 into a Designated Account (DA) opened at the CBN. The DA will be managed by the PIU/NPHCDA; a project accountant and internal auditor will be designated for this component. A Naira drawdown account will be established by the NPHCDA, from which Naira payments will be made for eligible expenditures and to service providers. Disbursements under Component 3 will be made primarily as advances on the basis of unaudited interim financial reports (IFRs) prepared by the PIU/NPHCDA and submitted to the World Bank quarterly. The ceiling will be based on six months of forecasted expenditures, and replenished quarterly for the same period. The PIU will, amongst other things, be responsible for ensuring compliance with the FM requirements of the Government and the World Bank, including the submission of half-yearly unaudited IFRs to the World Bank within 45 days from the end of the relevant semester. The PIU will also be responsible for ensuring that the project audit report/audited financial statements are submitted to the Bank within six months from the end of the Government fiscal year. The internal auditor in the PIU will be responsible for the internal audit of the project. Consistent with the World Bank Policy and Directives, the adequacy and appropriateness of the project FM arrangements will be reviewed using a risk-based approach for the on-site review, and routine desk review of periodic reports will be undertaken.

51. The assessment of the FM arrangements confirms that the arrangements in the NPHCDA would provide adequate assurance that the World Bank's fiduciary requirements would be met, especially that funds will be used for the purpose intended with due regard to economy and efficiency. The FM risk is Substantial.

D. Procurement

52. The Borrower will carry out procurement for the proposed AF in accordance with the World Bank's 'Procurement Regulations for IPF Borrowers' (Procurement Regulations) dated July 2016 under the 'New Procurement Framework', and the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006 and revised in January 2011, and other provisions stipulated in the Financing Agreements. The procurement management arrangements are the same as in the current project for the first two components on Polio Eradication Support and Routine Immunization Support. UNICEF will be responsible for procurement of vaccines for polio as well as RI and devices that are estimated to cost US$119 million. UNICEF and WHO will provide technical assistance for polio operations (US$15 million). Under Component 3, the NPHCDA will procure the services of a competent cold chain construction firm and support logistics management. Funds for the Routine Immunization System Strengthening will also be channeled through the NPHCDA. The estimated total cost for this component is US$16 million.

53. Under the proposed AF, UNICEF will undertake the procurement and supply of RI vaccines under components 1 and 2 through its international procurement division, based in Copenhagen, as agreed under the previous project. The Operations Procurement Review Committee (OPRC) will give the regional procurement advisor authority to provide IDA no-objection to the draft contract between the FGN and UNICEF for the duration of the project. Under the contract, UNICEF will purchase the vaccines from the most advantageous source, while considering its other obligations to respond to the global needs for polio and RI vaccines and its own institutional requirements. The development of the draft contracts to UNICEF for the procurement of the vaccines for the OPRC review is already ongoing. Because procurement will be managed by UNICEF, and its procurement systems are acceptable under the World Bank-UN Financial Management Framework Agreement, no formal assessment of UNICEF and WHO systems will be conducted.

54. For polio operations, the World Bank will finance the payment for operating costs through the contracts to be signed with both UNICEF and WHO under component 1. The expenditures under these contracts will not be subject to the World Bank's procurement procedures but the requirements for documentation, verification, internal and external audits, ceiling amounts, and so on will be agreed with the World Bank before disbursing of such expenditures. UNICEF and WHO will sign contracts including technical agreements with the FGN (NPHCDA) for handling of operations costs and related logistics costs following the model template used for the Ebola Emergency Response Project.

55. Nigeria would have run out of vaccines by the first quarter of 2018 but stock-outs were prevented by UNICEF taking advantage of retroactive financing. The proposed AF therefore proposes to apply retroactive financing not to exceed SDR 20,880,000. The project design provides a window to enable the Borrower to carry out advance contracting and retroactive financing in accordance with Section V (5.1 and 5.2) of the World Bank Procurement Regulations for IPF Borrowers. Retroactive financing will be allowed for up to 20 percent of the credit for payments made within twelve months prior to the Signature Date for Eligible Expenditures. Pre-financing may be available from DPs through the Vaccine Independence Initiative or World Bank-supported retroactive financing.

56. NPHCDA will be responsible for directly implementing Component 3 with an estimated total cost of US$16 million. The assessment of the procurement arrangements for the polio AF confirms that current procurement capacity in the NPHCDA, and the partnership with UN agencies will provide adequate assurances that the procurement function will be carried out successfully. The procurement risk is Moderate.

E. Social (including Safeguards)

57. The project is expected to have positive social impacts and benefits as it will support polio eradication efforts of the GoN as well as help sustain coverage and prevent a deterioration of Routine Immunization (RI). The project will not finance any activities necessitating land acquisition and resulting in (a) the involuntary resettlement of people and/or loss of (or access to) assets, means of livelihoods, or resources or (b) the involuntary restriction of access to legally designated parks and protected areas, resulting in adverse impacts on the livelihoods of the displaced persons.

58. Poverty and vulnerable groups focus. The proposed AF has a strong poverty focus because poor families, particularly poor children, are the primary beneficiaries. Poor people living in unhygienic conditions are at the greatest risk of having polio. Besides, children in poor families tend to have the lowest immunization coverage.

59. Ability to reach insecure areas. LQAS survey data and AFP surveillance indicate that the polio program’s ability to reach conflict-affected areas is impressive. The program has established a special set of interventions for security-compromised areas, including monthly security risk assessments, expansion of ‘hit and run’ and ‘catch-up’ campaigns based on the changing security status, enhanced RI services with attractive ‘pluses’ (for example, malaria diagnosis, multivitamin supplementation, and biscuits for children) through health camps, and strengthening of permanent health teams from within the community. The risks are high but the program has been able to mitigate the risks. Going forward, although the insurgency has been weakened, the program will continue to use these approaches and respond with more strategies as the need arises.

60. Gender and equity issues. There is no evidence suggesting preferential vaccination of male children. In addition, the focus on introducing HPV vaccine and emphasizing tetanus toxoid demonstrates that RI will have a disproportionate impact among women.

61. Citizen engagement. Community participation and ownership is key to the overall success of the project. The proposed AF continues to build awareness and political support of LGA Chairmen in collaboration with the Association of Local Governments of Nigeria by requiring their participation in the supervision of SIA and RI. NPHCDA, WHO, and UNICEF will ensure active participation of traditional and religious leaders in task forces at all levels and traditional/religious leaders head rapid response teams to deal with immunization non-compliance in all high risk/ vulnerable LGAs. They are called to help vaccinators and social mobilization teams to convince households to accept OPV and thereby assist with addressing immunization non-compliance in all high risk and vulnerable LGAs. The government also strengthened the engagement of faith-based and community-based organizations in mobilizing communities. National advocacy teams visit State Governors and other top government officials of the high-risk states to ensure complete political support. All these approaches to citizen engagement will be

strengthened in the conflict affected areas of the NE where it has been proved to be effective in the past. The AF will harness the media and use information, education and communication (IEC) materials and other communication approaches to counter risks such as misinformation and rumors.

62. Gender-Based Violence (GBV). GBV, like in other jurisdictions, remains a challenge in Nigeria. The ESMF includes measures aimed at protecting children from the social risks of labor influx, including GBV/Sexual Exploitation and Abuse (SEA). This includes a Code of Conduct for contractor employees and contract workers, acknowledging a zero-tolerance policy towards child labor and child sexual exploitation. In addition, there will be sanctions in the contracts for non-compliance (for example, termination). Finally, the proposed AF will include training of workforce about refraining from unacceptable conduct as well as informing workers about national laws. As the Environmental and Social Management Plans are developed for the project, they may include additional specific measures, where required. This would include incorporation of a GBV/SEA sensitive protocol in the project GRM and appropriate requirements in the bid documents for the proposed civil work activities envisaged as part of the planned expansion of the cold store in the Lagos hub and renovations of the Kano hub.

F. Environment (including Safeguards)

63. OP 4.01 on Environmental Assessment is triggered in the proposed AF and the Environmental Category continues to be Category B as was the case with the previous two AFs because of potential environmental concerns around the handing of health care waste resulting from project related activities such as RI that generate healthcare waste. In addition, the project also includes the proposed civil work activities, that is, the expansion of the cold store in the Lagos national hub and renovations of the Kano hub. OP 4.11 on Physical Cultural Resources is triggered because part of the renovation/expansion of the two hubs in Lagos and Kano may impact cultural physical resources. To mitigate these risks, specific procedures (such as chance finds procedures) will be prepared, if required. There are also potential environmental concerns around the handing of health care waste resulting from project related activities such as Routine Immunization that generate healthcare waste such as expired vaccines and sharps.

64. Currently, improper and unsafe HCWM practices place at risk healthcare workers, patients, and communities at large who are exposed both within health facilities and the surrounding communities. The potential risks are small in scope, site specific, and easy to avoid, prevent, manage, and remediate to acceptable levels. Experience has proven that when health care waste is properly managed, generally it poses no greater risks than that of properly treated municipal or industrial waste. Thus, the risks are manageable and can be mitigated through development and implementation of the approved National Healthcare Waste Management Plan (NHWMP). To date, implementation of the NHWMP has been satisfactory. Safeguards procedures are monitored during the IPD campaigns and HCWM protocols are followed by the health facilities.

65. Nigeria has demonstrated its commitment to mitigating adverse social and environmental impacts in the implementation of a range of World Bank projects such as the HIV/AIDS project, NSHIP and Polio Eradication Support project. 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 approved a new National Strategic Healthcare Waste Management Policy, including the National Strategic Healthcare Waste Management Plan and Guideline for the country.

66. The fact that the Ministers of Environment and Health jointly presented the memo seeking Council's approval for the adoption of the NHWMP, underscores the high level of the commitment of the Government toward improving the situation of the sector. The policy stipulates that waste generated by both public and private medical institutions in Nigeria must be safely handled and disposed of by these institutions, and provides guidelines and a strategic plan for medical waste management activities at medical institutions.

67. The project will (a) apply the necessary safeguard requirements at primary care facility level; (b) draw upon the HCWMP to provide guidance on processes for the implementing agencies (federal, states, local government authorities, and healthcare facilities) and to ensure the protection of health care workers, waste handlers, and the community from the harmful impacts of hazardous health care waste and to maximize project compliance with international and national environmental regulations and best practices. Following the clearance of the final document by the FGN, the plan has been disclosed both in country on April 14, 2016 and at the Bank InfoShop on April 15, 2016. A Health Care Waste Management Plan was updated for the proposed AF and disclosed in-country in Nigeria and in the World Bank's InfoShop on March 26, 2018.

68. Sub- projects in the new Component 3 will involve construction and rehabilitation works. An ESMF was prepared and disclosed in-country and in the World Bank Infoshop on March 26, 2018. The ESMF represents a framework for screening, monitoring, and mitigating potential impacts, to improve decision making and to ensure that the structures, either new constructions or rehabilitations being considered under the proposed AF are environmentally and socially sound, sustainable and take into consideration mitigation measures for possible adverse or negative effect on stakeholders during project implementation. Furthermore, site specific Environmental and Social Management Plans (ESMPs) should be prepared and disclosed as soon as site specific activities are identified in both Lagos hub for the expansion of the cold store and in the Kano hub for the renovation of the cold store.

V. WORLD BANK GRIEVANCE REDRESS

69. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*.

VI. SUMMARY TABLE OF CHANGES

	Changed	Not Changed
Change in Project's Development Objectives	✓	
Change in Results Framework	✓	
Change in Components and Cost	✓	
Change in Loan Closing Date(s)	✓	
Change in Disbursements Arrangements	✓	
Change in Safeguard Policies Triggered	✓	
Change of EA category	✓	
Change in Procurement	✓	
Change in Implementing Agency		✓
Cancellations Proposed		✓
Reallocation between Disbursement Categories		✓
Change in Legal Covenants		✓
Change in APA Reliance		✓
Other Change(s)		✓

VII. DETAILED CHANGE(S)

PROJECT DEVELOPMENT OBJECTIVE

Current PDO

To assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80% coverage with oral poliovaccine immunization in every state in the Recipient's territory, and sustain national routine immunization coverage.

Proposed New PDO

To assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with oral polio vaccine immunization in every state in the Recipient's territory, and improve national

routine immunization coverage.

RESULTS FRAMEWORK

Project Development Objective Indicators

Children immunized (number)
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	50,479,402.00	60,561,446.00	Revised
Date	09-Jul-2012	30-Oct-2015	31-Dec-2020	

Children immunized - under 12 months against Pentavalent 3 (number)
Unit of Measure: Number
Indicator Type: Custom Breakdown

	Baseline	Actual (Current)	End Target	Action
Value	0.00	30,304,952.00	30,465,493.00	Revised
Date	09-Jul-2012	30-Oct-2015	31-Dec-2020	

Pentavalent 3 coverage among children under 12 months in 12 lagging states
Unit of Measure: Percentage
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	23.25	23.25	33.00	New
Date	18-Dec-2017	18-Dec-2017	31-Dec-2020	

Number of LGAs with Pentavalent 3 coverage among children under 12 months <25% in the 12 lagging states
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	71.00	71.00	24.00	New
Date	18-Dec-2017	18-Dec-2017	31-Dec-2020	

Number of LGAs with Pentavalent 3 coverage among children under 12 months <50% in the 12 lagging states
Unit of Measure: Number

Indicator Type: Custom Supplement

	Baseline	Actual (Current)	End Target	Action
Value	123.00	123.00	41.00	New

Direct project beneficiaries
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	0.00	5,479,402.00	6,561,446.00	Marked for Deletion
Date	09-Jul-2012	30-Oct-2015	31-Dec-2018	

Female beneficiaries
Unit of Measure: Percentage
Indicator Type: Custom Supplement

	Baseline	Actual (Current)	End Target	Action
Value	0.00	50.00	50.00	Marked for Deletion

Intermediate Indicators

Number of LQAS conducted in 12 lagging states
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	1.00	1.00	5.00	New
Date	31-Jan-2018	31-Jan-2018	31-Dec-2020	

Number of shipments of vaccines and consumables shipped to Lagos and Kano
Unit of Measure: Number
Indicator Type: Custom

	Baseline	Actual (Current)	End Target	Action
Value	1.00	1.00	40.00	New

Date	31-Jan-2018	31-Jan-2018	31-Dec-2020

COMPONENTS

Current Component Name	Current Cost (US$, millions)	Action	Proposed Component Name	Proposed Cost (US$, millions)
Supply of oral polio vaccine to national strategic cold stores	145.00	Marked for Deletion		0.00
Polio Eradication Operations Support	100.00	Revised	Polio Eradication Support	65.00
Routine Immunization Support	175.00	No Change	Routine Immunization Support	69.00
	0.00	New	Routine Immunization System Strengthening	16.00
TOTAL	**420.00**			**150.00**

LOAN CLOSING DATE(S)

Ln/Cr/Tf	Status	Original Closing	Current Closing(s)	Proposed Closing	Proposed Deadline for Withdrawal Applications
IDA-51330	Closed	31-Jul-2015	31-Jul-2015		
IDA-56180	Closed	31-Jul-2017	31-Jul-2017		
IDA-58530	Effective	31-Dec-2018	31-Dec-2018	31-Dec-2020	30-Apr-2021

DISBURSEMENT ARRANGEMENTS

Change in Disbursement Arrangements
Yes

Expected Disbursements (in US$, millions)

Fiscal Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
Annual	4.95	12.09	18.38	21.88	24.30	20.34	19.37	15.76	12.92
Cumulative	4.95	17.05	35.43	57.31	81.61	101.95	121.32	137.08	150.00

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Latest ISR Rating	Current Rating
Political and Governance	Moderate	High
Macroeconomic	Substantial	High
Sector Strategies and Policies	Low	Low
Technical Design of Project or Program	Low	Moderate
Institutional Capacity for Implementation and Sustainability	Low	High
Fiduciary	Low	Substantial
Environment and Social	Low	Moderate
Stakeholders	Low	Moderate
Other		
Overall	Moderate	High

COMPLIANCE

Change in Safeguard Policies Triggered

Yes

Safeguard Policies Triggered	Current	Proposed
Environmental Assessment OP/BP 4.01	No	Yes
Performance Standards for Private Sector Activities OP/BP 4.03	No	No
Natural Habitats OP/BP 4.04	No	No
Forests OP/BP 4.36	No	No
Pest Management OP 4.09	No	No
Physical Cultural Resources OP/BP 4.11	No	Yes
Indigenous Peoples OP/BP 4.10	No	No

Involuntary Resettlement OP/BP 4.12	No	No
Safety of Dams OP/BP 4.37	No	No
Projects on International Waterways OP/BP 7.50	No	No
Projects in Disputed Areas OP/BP 7.60	No	No

Environmental Assessment (EA) Category

Change of EA Category	Original EA Category
Yes	Not Required (C)
Current EA Category	**Proposed EA Category**
Partial Assessment (B)	Partial Assessment (B)

LEGAL COVENANTS – Nigeria Polio Eradication Support Project Additional Financing (P165247)

Sections and Description
No information available

Conditions

Type	Description
Disbursement	No withdrawal shall be made for payments made prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed SDR 20,880,000 may be made for payments made within twelve months prior to the Signature Date for Eligible Expenditures under Categories (1), (2), and (3).
Disbursement	No withdrawal shall be made: (a) for payments made prior to the date of the Financing Agreement; (b) under Category (1), until the WHO Agreement has been duly entered into between the Recipient and WHO for the purpose of implementing the WHO Parts of the Project, under terms and conditions acceptable to the Association; and (c) under Category (2), until the UNICEF Agreement has been duly entered into between the Recipient and UNICEF for the purpose of implementing the UNICEF Parts of the Project, under terms and conditions acceptable to the Association.

VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Nigeria
Nigeria Polio Eradication Support Project Additional Financing

Project Development Objectives

To assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80 percent coverage with oral polio vaccine immunization in every state in the Recipient's territory, and improve national routine immunization coverage.

Project Development Objective Indicators

Action	Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source / Methodology	Responsibility for Data Collection
No Change	**Name:** Immunization coverage of OPV in the country		Percentage	91.80	80.00	Every Immunization round	EIM	UNICEF, NPHCDA
Description:								
No Change	**Name:** Immunization coverage of OPV in each high risk state		Percentage	89.00	80.00	Every 6 months from	Cluster sample survey according to WHO approved methodology The last report of	WHO/EOC/NAPH AD

						LQAS	performance audit in 8 high risk states was carried out between September 5 and October 29 2015 in Bauchi, Jigawa, Kano, Kaduna, Katsina, Kebbi, Sokoto and Zamfara States. The average OPV coverage 95	

Description: Coverage 95%

Revised	**Name:** Children immunized (number)		Number	0.00	60,561,446.00	Annually	DHIS2	NPHCDA
Revised	Children immunized - under 12 months against Pentavalent 3 (number)		Number	0.00	30,465,493.00	Annually	DHIS2	NPHCDA

Description: This indicator measures the cumulative number of children receiving vaccines purchased through a Bank-financed project, as well as the cumulative number of children immunized with vaccines purchased with other resources (i.e. GAVI or government funds) that are delivered through a Bank-supported program. It captures the number of children immunized and not the number of vaccinations.

No Change	**Name:** Pentavalent 3 coverage rate		Percentage	52.00	52.00	Annually	SMART Survey/MICS	UNICEF/NBS/NPHCDA
Description: Percentage of children under 1 year who had the third dose of pentavalent vaccine.								
New	**Name:** Pentavalent 3 coverage among children under 12 months in 12 lagging states		Percentage	23.25	33.00	Annually	SMART Survey	NPHCDA
Description: Lagging states: these are states with Penta3 coverage of <50% according to the 2016 MICS/NICS result. The project will be focusing on 12 of these 18 states. The remaining 6 states (states with MOU with BMGF and Dangote Foundation) will be founded by funds from Gates Foundation. Percentage of children under 1 year who had the third dose of pentavalent vaccine.								
New	**Name:** Number of LGAs with Pentavalent 3 coverage among children under 12 months <25% in the 12 lagging states		Number	71.00	24.00	Quarterly	LQAS	NPHCDA
New	Number of LGAs with Pentavalent 3 coverage among children under 12 months <50% in the 12 lagging states		Number	123.00	41.00	Quarterly	LQAS	NPHCDA

Description: Number of LGAs in the 12 lagging states with Penta3 coverage less than 25%.

Intermediate Results Indicators

Action	Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source / Methodology	Responsibility for Data Collection
No Change	**Name:** Percentage of teams with viable vaccine according to the Vaccine Vial Monitor		Percentage	97.00	98.00	WHO	WHO	Annual
Description:								
No Change	**Name:** Percentage of campaigns where vaccines are available on time		Percentage	100.00	100.00	UNICEF, NPHCDA	WHO/UNICEF campaign reports	Every round
Description:								
No Change	**Name:** Percentage of health facilities in the project area with functioning management committees having community representation		Percentage	0.00	30.00	Annually	SMART Survey	UNICEF/NBS
Description:								
New	**Name:** Number of LQAS conducted in 12		Number	1.00	5.00	Quarterly	LQAS	NPHCDA

	lagging states							
Description:								
New	**Name:** Number of shipments of vaccines and consumables shipped to Lagos and Kano		Number	1.00	40.00	Annually	NPHCDA	NPHCDA
Description:								

Target Values

Project Development Objective Indicators

Action	Indicator Name	Baseline	End Target
No Change	Immunization coverage of OPV in the country	91.80	80.00
No Change	Immunization coverage of OPV in each high risk state	89.00	80.00
Revised	Children immunized (number)	0.00	60,561,446.00
Revised	Children immunized - under 12 months against Pentavalent 3 (number)	0.00	30,465,493.00
No Change	Pentavalent 3 coverage rate	52.00	52.00
New	Pentavalent 3 coverage among children under 12 months in 12 lagging states	23.25	33.00
New	Number of LGAs with Pentavalent 3 coverage among children under 12 months <25% in the 12 lagging states	71.00	24.00
New	Number of LGAs with Pentavalent 3 coverage among children under 12 months <50% in the 12 lagging states	123.00	41.00

Intermediate Results Indicators

Action	Indicator Name	Baseline	End Target
No Change	Percentage of teams with viable vaccine according to the Vaccine Vial Monitor	97.00	98.00
No Change	Percentage of campaigns where vaccines are available on time	100.00	100.00

No Change	Percentage of health facilities in the project area with functioning management committees having community representation	0.00	30.00
New	Number of LQAS conducted in 12 lagging states	1.00	5.00
New	Number of shipments of vaccines and consumables shipped to Lagos and Kano	1.00	40.00