I. Project Context

Country Context

Nigeria fares poorly on key health indicators. Comparing the data from 2003 and 2008 Demographic and Health Surveys it is evident that Nigeria has made limited progress in delivering critical health services and that they are unlikely to meet the health related targets for the Millennium Development Goals (MDG) especially for MDG4 (for which the target value is an under 5 mortality rate of 67).

There are large income related inequalities in health outcomes: There are severe income related inequalities in health outcomes and in health care utilization - the poor have far worse health outcomes than the rich.

There are also regional differences in achievements of key health indicators. While the southern states fare better than the national average the northern states fall substantially behind on a number of indicators. Likewise for polio eradication, the eight northern states remain with endemic polio while the rest of the country has been polio free for almost ten years.

II. Sectoral and Institutional Context

Nigeria has been struggling to eradicate Polio for many years. While the country had more than 1100 cases of polio in 2006, very intensive efforts resulted in a substantial reduction in the number of cases between September 2009 and 2010. Suboptimal program implementation and security issues during the national election year 2011, however, resulted in an increase in the number of cases totaling 62 cases in eight endemic states by the end of 2011. In addition, 33 cases due to vaccine derived poliovirus were reported. Transmission of all three types was restricted to the northern states, particularly Borno, Zamfara, Sokoto, Yobe, Kaduna, Bauchi, Jigawa, Katsina, Kano, Kebbi, Niger, Plateau.

Nigeria is one of the three remaining countries with endemic polio transmission. The Independent Monitoring Board for the Global Polio Eradication Program note in their September 2011 report state that: “Seven countries have persistent polio transmission. Four countries have endemic transmission – Afghanistan, India, Nigeria and Pakistan. Of these India is making great progress and appears on track to stop polio transmission in 2011. Nigeria made strong progress in 2010, but has slipped backwards in 2011. Most cases in Africa (apart from Angola and D. R. Congo) can be traced back to Nigeria.

While most Southern states have been polio free for almost ten years, polio cases remain in the Northern states. During the March 2012 ERC meeting, an analysis of the 62 cases found in 2011 showed that 95% of all cases were found in eight key states and 80% of all cases are in five states – Kano, Jigawa, Borno, Zamfara, Sokoto. 67% of the cases were found in known high risk LGAs and all cases in other areas were genetically related to the cases in these high risk LGAs. 90% of all cases were found in children under 5 years of age; out of these children 32% had received no dose of OPV (against the national average of only 2% of children missed in 2011). The average polio case can therefore be described as a young child who has received zero doses or is under-immunized, and is from a high risk LGA in a high risk state.

Nigeria's polio eradication effort includes (i) routine immunization and (ii) campaign immunization. In single disease eradication efforts such as this, campaigns are the most effective way to reach vulnerable populations in the short term, while health systems are being strengthened to respond adequately in the longer term. Routine immunization covers children under the age of five at health facilities and through outreach services. The targeted diseases include tuberculosis, measles, diphtheria, tetanus, hepatitis B, yellow fever and polio. The routine immunization is mainly funded by the government with some support provided by GAVI for cold chain equipment and improvement. Campaign immunization supplements the routine polio immunization through: 1) National Immunization Plus Days (NIPDs); 2) Sub-national Immunization Plus Days (SIPDs); 3) Local Immunization Days (LiDs); 4) Mop-up activities; and 5) Maternal, Neonatal and Child Health weeks. Short Interval Additional Doses are used in locations where any of the above activities do not adequately cover.

The supporting activities include (i) OPV supply chain management; (ii) community mobilization, communication and advocacy activities; and (iii) monitoring and evaluation. For the immunization campaigns, OPV is procured and delivered by UNICEF to the country several weeks in advance and placed in the NPHCDA cold stores in Abuja from where they are distributed directly to the campaign sites with a buffer stock managed by the
Community mobilization focuses on reaching children in high-risk states and hard to reach areas through increasing human resources and eliminating barriers that lead to noncompliance. Volunteer community mobilizers cover a large number of settlements in Kano, Kebbi, and Sokoto in an attempt to identify, characterize, and facilitate the vaccination of chronically missed children. Mass communication efforts include using celebrities and the private sector to convey messages effectively. The Federal Governors Forum, a very strong political body in Nigeria, has recently endorsed their commitment to polio eradication through their participation in the ‘Nigeria Immunization Challenge’ fund which jointly with BMGF provides a bonus of $US 500,000 to states which can document adequate immunization coverage.

Program progress is monitored through enhanced independent monitoring (EIM) and Lot Quality Assurance Sampling (LQAS). In EIM, independent monitoring staff cover the immunization campaigns, and calculate the Polio immunization coverage as “the number of children vaccinated/catchment population”. In contrast, LQAS tracks immunization coverage by thoroughly investigating children in randomly selected lots. EIM claims on average 36% more OPV coverage than the LQAS. The government and WHO therefore plan to scale up the LQAS, while improving the quality of the EIM.

Cases of acute flaccid paralysis (AFP) are identified by the local Disease Surveillance and Notification Officer and confirmed by WHO staff. Stool samples are sent to one of the two laboratories in the country for analysis within 2-3 days of notification. Laboratory staff identifies the poliovirus and maps the virus to determine the origin. WHO employs LGA facilitators who support the state government on AFP surveillance. Community Health Extension Workers at both primary health care facilities and hospitals are the “focal persons” who coordinate AFP surveillance activities.

Due to the upsurge in Polio cases during 2011 a Presidential Task Force on Polio Eradication was officially inaugurated 1st March 2012. This task force has the overall objective of providing leadership support to Nigeria’s efforts to accelerate interruption of poliovirus transmission by the end of 2012. The Task Force is chaired by the Minister of State for Health and has membership drawn from the National Assembly (Chairman Senate Committee on Health, Chairman House Committee on Health), the Nigeria Governors Forum, the National Primary Health Care Development Agency, the Federal Ministry of Health, Polio high risk and polio-free states, Northern Traditional Leaders Committee on Primary Health Care, Nigeria Inter-Faith Group and GPEI Partners.

The FGN has furthermore prepared an Emergency Plan for Polio Eradication. The main features of this emergency plan are: (i) Direct engagement of The President through a Presidential Task Force; (ii) establishing a National Accountability Framework; (iii) preparation of a detailed plan for improving team performance. This plan includes clarification of levels of responsibility of all stakeholders at all levels, restructuring and revising work load and remunerations and introducing improved supervision. In addition, a large number of additional staff is being placed in the High Risk Areas, and Intensified Ward Communication Strategy and Village Community Mobilizers are being placed in high risk wards. A Short Interval Additional Dose of OPV will also be introduced in selected locations where security or other issues limit access during regular campaign days. New technologies such as the use of geographic information system/global positioning system (GIS/GPS) to locate all villages and hamlets is rapidly being expanded and short message service (SMS) and toll free lines for reporting and communication are being added. The plan also includes new micro-planning guidelines which will use the GIS technology. A new training package is being developed for these new technologies as well as for training in interpersonal communication. Finally a tool to investigate reasons for children being missed is already in use and is regularly being improved.

While there is strong commitment at the federal level this is not always translated into action on the ground. The NPHDA has therefore started deploying most of their professional staff to the field during the preparation for and implementation of the national and sub-national immunization rounds in the high risk states.

A number of institutions are working closely with the FGN to intensify the efforts to eradicate polio (e.g., WHO, UNICEF, Bill and Melinda Gates Foundation [BMGF], Centers for Disease Control, USA [CDC]); the FGN also continues to closely follow the regular advise provided from the Expert Review Committee (ERC) with regards to the type of vaccine to use, frequency of immunization rounds, research to be conducted and strategies to be followed to achieve program objectives.

In order for all of the efforts described above to succeed Oral Polio Vaccine (OPV) must be available, on time and of good quality. For the OPV financed by the World Bank, UNICEF undertakes the procurement, supply and delivery to end user. This system is well tested and there have been no cases where immunization was interrupted due to non-availability of OPV.

The proposed Bank financing will provide for 100% of the oral polio vaccine and 45% of the overall polio eradication cost in Nigeria over the next two years. Other potential financiers of vaccine requirement over and above what is financed through this credit are BMGF, Rotary International, CDC, United States Agency for International Development, Department for International Development (UK), Kreditanstalt for Wiederaufbau (KfW), the government of Japan, UNICEF and WHO.
VI. Implementation

The project will provide funding for the procurement and supply of Oral Polio Vaccine for the Nigeria polio eradication efforts. This is a repeater project of the Partnership for Polio Eradication Project (P080295), which is scheduled to close on April 30, 2012. The original project PDO was to assist the Government of Nigeria to achieve its goal of interrupting the transmission of the wild polio virus, and to sustain these efforts throughout the implementation of the Project through effective oral polio vaccine coverage of the target population. The original credit, in the amount of SDR 20.9 million (US$ 28.70 million equivalent) was approved on April 29, 2003, and was supplemented with three additional credits of (i) SDR 33.4 million (US$ 51.7 million) approved on May 10, 2005; (ii) SDR 31.8 million (US$50 million) approved on September 8, 2008; and (iii) SDR 39 million (US$ 60 million equivalent) approved on March 17, 2011. The previous credits have been fully disbursed, the target of 80% for OPV coverage has been reached, the overall implementation progress is rated as satisfactory, legal covenants have been complied with, and there is no outstanding audit, fiduciary, environmental or social issue.

Compared to the original project, which included additional donor- and counterpart-financed polio eradication activities, this project is limited to the IDA financed part of the Polio Eradication Program. In line with this, the project development objective has been modified to address only the OPV coverage. The project complies with the requirements for a repeater project i.e. (i) it is consistent with current CAS objectives; (ii) the previous project has demonstrated tangible results and was rated as satisfactory for the past 12 months; (iii) there are no unresolved fiduciary, environmental or safeguard issues; and (iv) there is demonstrated client support for Bank participation in this final effort to eradicate polio.

While the epidemiology of polio is not easily understood and it therefore is not possible to predict how long it will take to eradicate polio from Nigeria, it is now evident that full eradication has taken longer than originally anticipated. The developments in Nigeria over the last five years, the recent intensified efforts by the country and its partners, as well as the recent success of eradication efforts in India indicate that there is an opportunity that the last case may be recorded within the next one or two years. A repeater project is therefore justified to ensure that there is secured financing of OPV for this – possibly – final effort to eradicate polio from Nigeria.

VII. Safeguard Policies (including public consultation)

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