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Report No: PAD1890

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED SECOND ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 88.2 MILLION

(US$125 MILLION EQUIVALENT)

TO THE

FEDERAL REPUBLIC OF NIGERIA

FOR THE

POLIO ERADICATION SUPPORT PROJECT

May 24, 2016

Health, Nutrition and Population Global Practice
Africa Region

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CURRENCY EQUIVALENTS
(Exchange Rate Effective April 30, 2016)

Currency Unit	=	NGN (Nigerian Naira)
US$1	=	Naira 197
US$1	=	SDR 0.70555199

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AFP	Acute Flaccid Paralysis
DALYs	Disability Adjusted Life Years
DP	Development Partner
DPT	Diphtheria, Pertussis, Tetanus
EOC	Emergency Operation Center
FGN	Federal Government of Nigeria
FM	Financial Management
GRS	Grievance Redress Service
HCWM	Health Care Waste Management
HPV	Human Papillomavirus
IDP	Internally Displaced Persons
IPV	Inactivated Polio Vaccine
LGA	Local Government Areas
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
NE	North East
NETSP	Northeast Emergency Transition and Stabilization Program
NPHCDA	National Primary Health Care Development Agency
NSHIP	Nigerian State Health Investment Project
OP	Operational Policy
OPRC	Operations Procurement Review Committee
OPV	Oral Polio Vaccine
PBF	Performance-Based Financing
PCV	Pneumococcal Conjugate Vaccine
PDO	Project Development Objective
PforR	Program for Results
PHC	Primary Health Care
Polio EOC	Polio Emergency Operations Center
RPBA	Recovery and Peace Building Assessment
RI	Routine Immunization
SIA	Supplementary Immunization Activity
SDR	Special Drawing Rights
SMART	Standardized Monitoring and Assessment of Relief and Transition
SOML	Saving One Million Lives

UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization
WPV	Wild Polio Virus

THE FEDERAL REPUBLIC OF NIGERIA
SECOND ADDITIONAL FINANCING – NIGERIA POLIO ERADICATION PROJECT (P158557)

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Country Director:	Rachid Benmessaoud
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Task Team Leaders:	Ayodeji Oluwole Odutolu; Ana Besarabic Bennett

ADDITIONAL FINANCING DATA SHEET

The Federal Republic of Nigeria

Additional Financing - Polio Eradication Support Project (P158557)

AFRICA

GHN07

Basic Information – Parent			
Parent Project ID:	P130865	Original EA Category:	C - Not Required
Current Closing Date:	31-Jul-2017		

Basic Information – Additional Financing (AF)			
Project ID:	P158557	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B - Partial Assessment
Country Director:	Rachid Benmessaoud	Expected Effectiveness Date:	01-Aug-2016
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Dec-2018
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD1890
Team Leader(s):	Ayodeji Oluwole Odutolu, Ana Besarabic Bennett		

Borrower				
Organization Name	Contact	Title	Telephone	Email
Federal Ministry of Finance	Haruna Mohammed	Director, IERD	2348055798172	harunam500@yahoo.com

Project Financing Data - Parent (NG-Polio Eradication Support (FY13)-P130865) (in USD Million)							
Key Dates							
Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P130865	IDA-51330	Closed	12-Jul-2012	16-Apr-2013	05-Jun-2013	31-Jul-2015	31-Jul-2015
P130865	IDA-56180	Effective	10-Apr-2015	22-May-2015	29-May-2015	31-Jul-2017	31-Jul-2017
Disbursements							

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undis bursed	% Disbursed
P130865	IDA-51330	Closed	XDR	61.30	61.26	0.04	61.26	0.00	100.00
P130865	IDA-56180	Effective	XDR	142.20	142.20	0.00	127.55	14.65	89.70

Project Financing Data - Additional Financing Additional Financing NG-Polio Eradication Support Project (P158557)(in USD Million)

[ ]	Loan	[ ]	Grant	[ ]	IDA Grant
[X]	Credit	[ ]	Guarantee	[ ]	Other

Total Project Cost:	125.00	Total Bank Financing:	125.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	125.00
Total	125.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Ayodeji Oluwole Odutolu	Team Leader (ADM Responsible)	Senior Health Specialist	Health	GHN07
Ana Besarabic Bennett	Team Leader	Senior Operations Officer	Operations	GHNGE
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	Responsible)			
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Adam Shayne	Team Member	Lead Counsel	Legal	LEGAM
Benjamin P. Loevinsohn	Team Member	Lead Public Health Specialist	Public Health	GHN07
Essienawan Ekpenyong Essien	Team Member	Team Assistant	Administration and Client Support	AFCW2
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Mayowa Oluwatosin Alade	Team Member	Consultant		GHNDR
Michael Gboyega Ilesanmi	Team Member	Social Development Specialist	Social Development	GSU01

Extended Team

Name	**Title**	**Location**
Birte Holm Sørensen	Consultant, Service Delivery, DLI approach	Copenhagen

Locations

Country	**First Administrative Division**	**Location**	**Planned**	**Actual**	**Comments**
Nigeria	Sokoto	Sokoto State		X	
Nigeria	Rivers	Rivers State		X	
Nigeria	Plateau	Plateau State		X	
Nigeria	Oyo	Oyo State		X	
Nigeria	Ondo	Ondo State		X	
Nigeria	Ogun	Ogun State		X	
Nigeria	Niger	Niger State		X	
Nigeria	Lagos	Lagos State		X	
Nigeria	Kwara	Kwara State		X	
Nigeria	Katsina	Katsina State		X	
Nigeria	Kano	Kano State		X	

Nigeria	Kaduna	Kaduna State		X	
Nigeria	Imo	Imo State		X	
Nigeria	Cross River	Cross River State		X	
Nigeria	Borno	Borno State		X	
Nigeria	Benue	Benue State		X	
Nigeria	Bauchi	Bauchi State		X	
Nigeria	Anambra	Anambra State		X	
Nigeria	Akwa Ibom	Akwa Ibom State		X	
Nigeria	Abia	Abia State		X	
Nigeria	Delta	Delta State		X	
Nigeria	Adamawa	Adamawa State		X	
Nigeria	Edo	Edo		X	
Nigeria	Enugu	Enugu State		X	
Nigeria	Jigawa	Jigawa State		X	
Nigeria	Bayelsa	Bayelsa State		X	
Nigeria	Ebonyi	Ebonyi State		X	
Nigeria	Ekiti	Ekiti State		X	
Nigeria	Gombe	Gombe State		X	
Nigeria	Nasarawa	Nasarawa State		X	
Nigeria	Zamfara	Zamfara State		X	
Nigeria	Kebbi	Kebbi State		X	
Nigeria	Kogi	Kogi State		X	
Nigeria	Osun	Osun State		X	
Nigeria	Taraba	Taraba State		X	
Nigeria	Yobe	Yobe State		X	
Nigeria	FCT	Federal Capital Territory		X	

Institutional Data
Parent (NG-Polio Eradication Support (FY13)-P130865)
Practice Area (Lead)
Health, Nutrition & Population
Contributing Practice Areas
–
Cross Cutting Topics

[ ] Climate Change
[X] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Child health	90
Social dev/gender/inclusion	Social Inclusion	10
Total		100

Additional Financing Additional Financing NG-Polio Eradication Support Project (P158557)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

–

Cross Cutting Topics

[ ] Climate Change
[X] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)				
Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	90		
Health and other social services	Other social services	10		
Total		100		

☒I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)		
Major theme	Theme	%
Human development	Child health	90
Social dev/gender/inclusion	Social Inclusion	10
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)
Consultants Required? Consultants will be required

I. Introduction

1. **This project paper seeks the approval of the Executive Directors to provide an additional credit of US$125 million equivalent to the Federal Republic of Nigeria for the Polio Eradication Support Project (P130865).** The original project was approved on July 12, 2012, for an amount of US$95 million, with a closing date of July 31, 2015. The proposed project is being processed under OP 10.00 paragraph 12, referring to projects in situations of urgent need of assistance or capacity constraints. With the first Additional Financing (AF), the closing date was extended to July 31, 2017. The original credit is fully disbursed. The first AF of US$200 million was approved by the Board on April 10, 2015 and became effective on May 29, 2015. With this second AF, the proposed closing date will be December 31, 2018.

2. **Urgent request to avoid financing gap.** The Federal Government of Nigeria (FGN) has made a request on April 21, 2016 to the Bank for the proposed AF which will provide critically needed funds to: (a) avoid any disruption in polio eradication activities; and (b) prevent a deterioration in Routine Immunization (RI). The FGN made this request because it has already made large investments in Polio Eradication and can ill afford not to complete polio eradication. Likewise, large investments have been made in RI, but the FGN may not be in a position to sustain this investment as the country is facing a critical shortfall in revenues due to declining oil prices. This AF will fill an immediate financing gap for 2016 and part of 2017. The FGN's immunization program is financially sustainable in the medium term due to: (a) the establishment of the Basic Health Care Provision Fund as a result of the Health Act signed in 2014, which will make one percent of the country annual revenue available for Primary Health Care (PHC)[1]; (b) up until last year, the FGN has been increasing year by year its investments in immunization demonstrating national commitment to the program; and (c) if polio eradication is fully achieved by mid-2017, activities and expenditures will decrease and be phased out in the medium term.

3. **Strong partnerships are in place.** The activities under the AF build on a very strong network of Development Partners (DPs) that have helped Nigeria achieve interruption of polio transmission. All of the funds under the proposed AF will be channeled through the World Health Organization (WHO) and United Nations Children's Emergency Fund (UNICEF) which have a large and well-functioning presence on the ground including field level workers with access to communities in the North Eastern States. These are the financing arrangements that the FGN itself uses and which have proven to be successful during the original project.

4. **Finishing the job on polio eradication and sustaining RI.** Oral Polio Vaccine (OPV) financing will be required at a minimum through 2017. The Bank has provided US$485.4 million to support the polio eradication program in Nigeria over the last 12 years. Now that Nigeria is getting close to be certified as polio free, it is essential to ensure that an acute financing gap does not derail hard earned gains. After the OPV funds from the current Polio Eradication Support project (US$95 million) were exhausted in November 2014, Japan International Cooperation Agency (JICA) took over the OPV financing with a US$67 million credit. The first AF of

[1] While the fund was agreed upon in 2014, the administrative arrangements including fund application criteria and procedures are still being drafted.

US$200 million was approved by the Board in 2015 for polio eradication and vaccines for RIs. Ninety percent of this has now been disbursed.

5. **The interruption of RI due to vaccine shortages would have a devastating effect on maternal, neonatal and child health as vaccine-preventable diseases contribute significantly to the overall burden of disease in Nigeria.** This could also adversely affect polio eradication, as inactivated polio vaccine (IPV) is provided during RI sessions, particularly important in security-compromised areas.

6. **Given that much of the polio operations and the procurement of RI vaccines will be carried out in the first half of 2016, funds are needed before the expected date of project effectiveness.** It is proposed to use retroactive financing for 20 percent of the AF credit up to US$25 million.

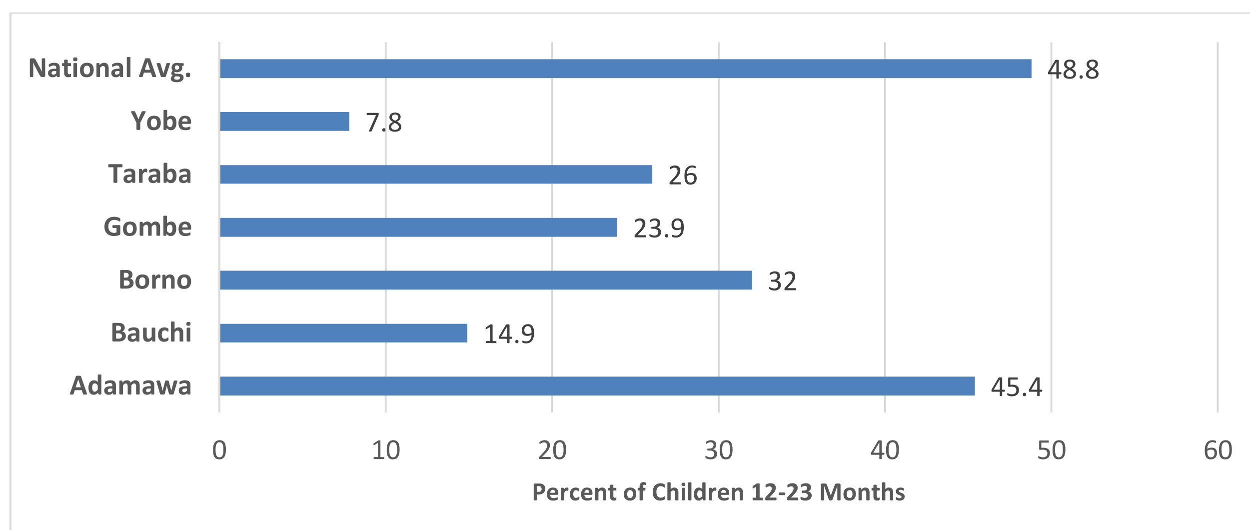
II. Background and Rationale for Additional Financing

A. Background

7. **The six states in the North East (NE) are particularly vulnerable.** Over the past eight years, the NE has been struggling with the threat of violent extremism. The NE has been at the epicenter of the Boko Haram insurgency which has led to a rapid increase of internally displaced persons (IDPs), estimated at over 2.0 million people, as well as the displacement of 170,000 Nigerians as refugees in neighboring countries. The insurgency affected about fifteen million people. The proposed AF is part of Northeast Emergency Transition and Stabilization Program (NETSP) (see annex 3) of support for the six states which also includes: (a) Community and Social Development Project (CSDP), (b) Youth Employment and Social Support Operation (YESSO), (c) State Education Program Investment Project (SEPIP), (d) the Third National Fadama Development Project AF2 and (e) Nigeria State Health Investment Project. The Recovery and Peace Building Assessment (RPBA) (see annex 4) shows that more than 40 percent of the health facilities in Borno and Yobe were either damaged or destroyed thus limiting the access of children to immunization in general and polio vaccination in particular. The last few cases of polio infection were found in eight (8) endemic states including Borno, Yobe and Bauchi states. Further deterioration of the current situation could lead to poor surveillance, reduced immunization coverage and resurgence of polio infection. Similarly, shortages of RI vaccines would lead to poor coverage and escalation of vaccine preventable diseases in these security compromised states.

8. **Immunization coverage in the NE lags far behind the national average.** Results from the 2015 Standardized Monitoring and Assessment of Relief and Transition (SMART) household survey (conducted from July to September 2015) indicate that the NE performs poorly compared to the rest of the country (see figure 1). With the exception of Adamawa, all the states in the NE lag far behind the national average. Despite starting from a lower base, the states in the NE have also made slower progress (in percentage point terms) than the rest of the country.

Figure 1. Pentavalent 3 Immunization Coverage (%)—SMART Household Survey 2015



9. **Findings and recommendations from the RPBA on health services.** The RPBA found that about 20 percent of the health facilities were damaged or destroyed in the six NE states at a replacement cost of about US$150 million. The RPBA observed that health facilities were deliberately targeted by the insurgents and besides damage to the infrastructure, equipment and drugs were stolen and health workers threatened. The report shows that:

(a) Yobe and Borno states are most affected. There is a significant variation in the proportion of health facilities damaged or destroyed, with the damage being much more extensive in Yobe and Borno than in the other states;

(b) Many PHC facilities have been damaged but not destroyed. In Yobe and Borno many facilities have been damaged but not destroyed suggesting that in part of those states it may be possible to restore services relatively quickly, whereas other areas will require considerable effort to re-establish health services; and

(c) PHC facilities are more affected than hospitals. With the exception of Adamawa, the damage to PHC facilities has been proportionately more extensive than to hospitals (there are obviously many more PHC facilities than hospitals). Thus the priority should be given to PHC, especially since poor people and rural communities use PHC facilities disproportionately.

10. The RPBA recommended that the recovery strategy for the sector should be of two complementary approaches, ensuring access to essential health and nutrition services for target groups and restoring critical health system functions. RI has been badly affected already—SMART survey of 2015 shows that states are regressing in their immunization coverage. Non-availability of RI vaccines coupled with insurgency would worsen the situation. Also RI is a widely appreciated service.

Polio Eradication

11. **Nigeria has made huge progress on Polio Eradication. The last polio case was confirmed on July 24, 2014.** Since then, OPV coverage has remained highly effective with 97 percent of Local Government Areas (LGAs) surveyed in high risk states reaching more than or equal to 80 percent coverage as documented through the Lot Quality Assurance Sampling (LQAS) and confirmed by the 2015 independent performance audit.[2] The multi donors supported Polio Emergency Operations Center (Polio EOC) continues to perform well and exceeds the global standards for quality and timeliness.[3] The Polio Partners meeting in November 2015 concluded that a number of initiatives introduced since 2012 had contributed to making and keeping Nigeria polio free. These include (a) setting up a Presidential Task Force which also includes all 36 Governors in support of polio eradication; (b) large increases in field level staff in 2012; (c) strong accountability systems with the use of monitoring against standard operating procedures; (d) timely use of data to identify and target vulnerable populations; (e) introduction and scale-up of Directly Observed Polio Vaccination; (f) introduction of IPV into RI and IPV administration in mass campaigns in LGAs in 5 high risk states; and (g) regular meetings with poor performing LGAs focusing on the 38 very high risk and vulnerable LGAs and providing extra capacity to these areas. New approaches to increase communities' acceptance have also been continued. These include scale-up of health camps that provide other essential health services while immunizing children with OPV, use of polio survivor groups for immunization and communication, engagement with religious leaders, use of community clowns and local theaters for communication, and distribution of "pluses" (e.g., whistles, balloons) to attract children.

12. **A main obstacle to eradicating polio in Nigeria has been the inaccessibility of communities in the Northern States.** In security compromised areas, a number of special measures have therefore been introduced. They are: (a) 'hit and run' interventions where vaccinators will use any opportunity to go to difficult areas with the military and leave as soon as all children have been reached; (b)'fire-walling' that is, ensuring immunity in areas surrounding inaccessible villages; (c) using local people as vaccinators who can operate without drawing attention; (d) including IPV in RI activities; (e) having transit bus-stop and market vaccination teams; and (f) ensuring that all internally displaced people residing in camps are covered. The focus now is for Nigeria to sustain the gains and maintain momentum to remain without new polio cases and obtain polio free status by mid-2017. In addition, the positive experiences from the use of special measures to eradicate polio will now be transferred to provision of much needed basic health services in these same areas through the AF to National State Health Investment Project (NSHIP).

13. **Disease surveillance, even in insecure areas, remains robust.** The surveillance system on which case detection is based continues to perform well, even in insecure areas. The system depends on local key informants and LGA-level surveillance officers who are all locally hired. They identify cases of acute flaccid paralysis (AFP) and obtain stool specimens in a timely fashion. Since there are other causes of AFP besides polio, it is possible to judge whether the system is performing well by looking at: (a) whether it is finding enough non-polio AFP cases;

[2] Performance Audit in 8 High Risk States. November 2015.

[3] The experience of and support from the Polio EOC led to the rapid containment of Ebola in Nigeria in July 2014.

and (b) obtaining stool samples expeditiously. In addition to AFP surveillance, environmental sampling is carried out looking for Wild Polio Virus (WPV) in water and sewage. Environmental sampling has not found circulating WPV during the past year. Combining the results of AFP surveillance and environmental sampling makes it very likely that the progress toward polio eradication is real.

14. **Polio legacy planning.** Over the years, Nigeria engaged and trained a large number of people in polio surveillance, project management, monitoring and evaluation and data management. Similarly, a lot of infrastructure were established. As part of the polio end game plan, Nigeria, working with DPs, has set up a committee to assess the polio infrastructure, human resources and equipment and develop a plan on how to deploy the resources to support other parts of the health system in general and the RI in particular as polio eradication is achieved. The plan is being finalized. As part of the plan, the Minister of Health has designated the polio EOC as the project coordinating unit for the proposed Regional Disease Surveillance Systems Enhancement Project with a view to sustain the Centre and take advantage of its competences in disease surveillance, project management and data management.

Routine Immunization

15. **Maintaining RI is important to complete polio eradication and improve child and maternal health.** There is a broad consensus that RI is important for interrupting the transmission of wild polio and thereby in completing polio eradication. It is also clear that RI is a critical aspect of improving child and maternal health. While Nigeria has made very slow progress on improving immunization coverage, it would be very unfortunate for coverage to actually deteriorate during a time of macro-economic challenges. There have been no stock-outs of vaccines since 2013 but other components of the RI program especially the staff (paid by the LGAs) are poorly and irregularly funded. The current government has proposed to re-vitalize primary health care services including RI and a transition plan for utilizing the assets from the Polio Eradication Program (knowledge, human and material) to this end is currently being prepared. While it may not be possible to significantly improve immunization services during the short term, it is important to prevent hard earned gains from being eroded due to acute vaccine stock-out as has happened in the past (see figure 2 below).

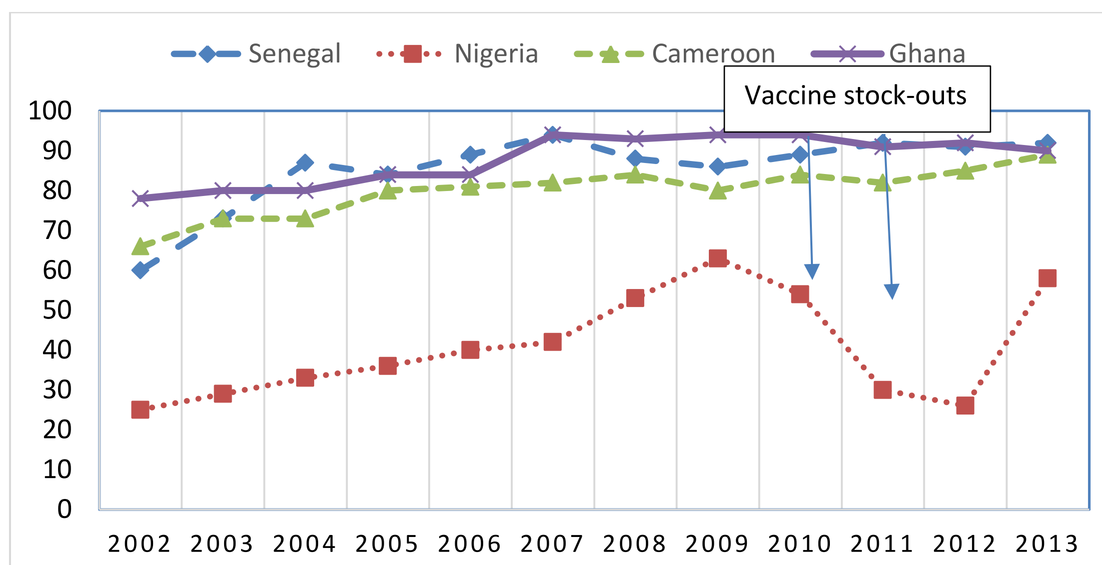
16. **The recent and impressive success of polio eradication efforts, especially in the northern states, indicates that focused attention, careful collection and analysis of data, application of appropriate technologies, and frequent review, can make a significant difference in program achievement.**[4] A Polio Legacy Transition plan (currently being drafted jointly by FGN and DPs) proposes that these lessons are transferred and used for strengthening the general primary health care system including the RI program. Initial experience with expanding the role of Village Communicators and Mobilizers in the high risk northern states starting in May 2015 has been very successful. The number of women referred every month for Ante Natal Care increased from 12,300 to 60,000; the number of children who received birth registration increased from 532,000 to more than one million from 2014 to 2015; and the percentage of defaulters referred for RI services increased from 78 percent in May 2015 to 85

[4] Overview found at: http://www.polioeradication.org/mediaroom/newsstories/Journal-of-Infectious-Diseases-publishes-supplement-on-polio-eradication-in-Nigeria/tabid/526/news/1355/Default.aspx

percent in February 2016. Likewise, the Ministry's administrative data showed an increase in coverage of Penta 3 vaccine from 68 percent in 2015 to 97 percent in 2016. This should be seen in the context of a national average for Penta 3 coverage of 48.8 percent found in the national household survey.

Figure 2. WHO-UNICEF Estimates of DPT3 Coverage (%)

for Select West African Countries



Source: [*http://apps.who.int/immunization_monitoring/globalsummary (May 2014)*](http://apps.who.int/immunization_monitoring/globalsummary)
Note: DPT3 = 3 doses of diphtheria, pertussis, and tetanus.
These estimates are based on reported data, routinely collected information, and household survey results.

17. **Other initiatives to improve RI.** Other Bank-supported initiatives are also helping to improve RI and increase coverage rates. As a part of the NSHIP as well as the AF proposed for the project, 20 percent of the funds allocated to performance-based financing are used to reward vaccination. The Saving One Million Lives (SOML) Program-for-Results (PforR) rewards states for improving their vaccination coverage rates as documented by household surveys. WHO, UNICEF, the GAVI Alliance, as well as other DPs such as United States Agency for International Development (USAID), Department for International Development, the European Union, Dangote Foundation and the Bill and Melinda Gates Foundation are also investing considerable effort and money in improving RI services.

18. **Nigeria has successfully introduced new vaccines.** Using funds from DPs and its own budget, Nigeria has recently (from June 2012 to December 2013) introduced "pentavalent" vaccine throughout the country. Pentavalent vaccine combines the "old" antigens (diphtheria, pertussis and tetanus) with Hepatitis B and Haemophilus Influenza B. The latter is an important cause of pneumonia and meningitis in children. As part of its RI strategy, FGN has begun the introduction of pneumococcal conjugate vaccine (the major cause of fatal pneumonia in children) and inactivated polio vaccine and plans are in place to introduce other new vaccines especially rota-virus (a major cause of serious diarrhea in children), and human papilloma vaccine (the major cause of cervical cancer). The FGN has estimated that introducing these new vaccines will avert 487,000 deaths over the next six years.

Polio and Routine Immunization Financing

19. **Financing for Polio Eradication 2016 and 2017.** According to the latest Financial Resource Requirements[5] approved by the Interagency Coordinating Committee, the financing gap for 2016 is US$18.3 million including tentative funding from FGN and International Development Association (IDA) (this proposed AF). For 2017, the total requirement is US$234 million and for 2018, it is US$201 million. Estimates which exclude tentative donors and expected FGN contribution of US$80 million indicate that for 2016, 2017 and 2018, there will be a financing gap, specifically for OPV, of approximately US$6.5 million, US$34 million and US$29 million respectively. For operational costs, the funding gap, exclusive of tentative financing for 2016, 2017 and 2018, is estimated to be US$20 million, US$61 million and US$51 million respectively. Pre-financing may be available from DPs through the Vaccine Independence Initiative or Bank-supported retroactive financing.

20. **Financing for RI.** Given its per capita income, GAVI expects the government of Nigeria to pay a rapidly increasing share of the RI costs up to 2021 after which time the country should be fully self-financing. Due to the shortage of FGN funds, Nigeria only has secured financing for vaccines for RI up to end 2016 (including the first AF). In addition, the cost of vaccine supplies and logistics for immunization will increase significantly from US$67 million in 2013 to US$259 million in 2018 with the introduction of a number of new vaccines (IPV in 2015; Pneumococcal Conjugate Vaccine in 2015/2016; Meningitis A vaccine in 2017; Rota virus vaccine in 2018 and Human Papillomavirus (HPV) in 2019).

21. **FGN spends considerable sums on vaccines and immunization.** Over the past five years, the FGN has spent an annual average of US$150 million annually of its own budget appropriation, presidential pledge, and additional appropriation for traditional and new RI vaccine. Such funds have been financing procurement and operational activities for RI mainly through WHO and UNICEF. The United Nations agencies have developed effective mechanisms for payments while maintaining strong fiduciary controls. All vaccine procurement is done through UNICEF. Experience with these arrangements for the IDA credits in the past have been positive with performance reports provided regularly and on time.

Parent Project

22. **Fully satisfactory implementation.** The Project Development Objective (PDO) for the parent project, Polio Eradication Support Project (P130865) is "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." According to LQAS, every state has surpassed the 80 percent benchmark. More impressive is that 96 percent of high risk LGAs have met that standard despite persistent insecurity. Given the progress on improving coverage and the 20 months since the last confirmed case of wild polio has been detected, the project is rated highly satisfactory for both PDO and Implementation Progress ratings. The fiduciary ratings are satisfactory. Of the first AF of US$200 million, 90 percent has been disbursed by March 2016.

[5] April 4, 2016.

B. Rationale

23. **There is a strong rationale for the AF:**

(a) **Global public good.** 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 polio virus, and by July 2017, if there are no new cases, Nigeria will be certified polio free - a significant milestone toward the global polio eradication.

(b) **An acute financing gap could derail progress on polio eradication.** At this critical juncture in polio eradication, an acute financing gap resulting from declining oil revenues could erase hard-earned successes and millions of dollars spent.

(c) **Maintaining RI 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.

(d) **Stock outs of routine vaccines are associated with declining coverage.** Previous stock outs of routine vaccines have been 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.

(e) **The majority of the efforts will take place in the northern high risk states.** The last eight (8) polio endemic states were mostly in the NE. Due to their security risk, the NE states pose the highest risk to both polio eradication and to the RI Program. They will also receive the major benefits in the form of improved access to primary health care services through the extensive field level staff placed in the states and the proposed AF for the NSHIP.

24. **The proposed operation is aligned with the Country Partnership Strategy FY 2014–2017.** Particularly within 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 is primarily available to those who can pay for it. This operation will contribute to bridging the gap and make this public good available to all. In this sense, the proposed AF is also contributing to the twin goal of eliminating extreme poverty and boosting shared prosperity.

III. Proposed Changes

Summary of Proposed Changes	
The proposed AF would help finance the costs associated with polio eradication in all the states in Nigeria and the procurement of vaccines for RI for children under 5 years and women of reproductive age.	
Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
Change in Results Framework	Yes [ ] No [X]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results
Project's Development Objectives
Original 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 sustain national routine immunization coverage.
Current PDO No change.

Compliance

Covenants - Additional Financing (NG-Polio Eradication Support - Additional Financing - P158557)						
Source of Funds	**Finance Agreement Reference**	**Description of Covenants**	**Date Due**	**Recurrent**	**Frequency**	**Action**
IDA	Schedule 2(II)B2b	The Recipient shall, in accordance with the terms of the UNICEF Agreement and WHO Agreement: require UNICEF and WHO to prepare and furnish to the Recipient as soon as available, but in any case not later than sixty (60) days after the end of each calendar semester, "utilization" reports prepared in accordance with the provision of the UNICEF Agreement and WHO Agreement, respectively.		X	Semi-Annually	New

Conditions

Source Of Fund	Name	Type
IDA	Additional Condition of Effectiveness	Effectiveness

Description of Condition

The Additional Condition of Effectiveness is the following: The UNICEF Agreement and WHO Agreement have been executed and delivered, under terms and conditions satisfactory to the Association, in accordance with Section I.A.2 of Schedule 2 to this Agreement, between the Recipient and UNICEF and between the Recipient and WHO, respectively, and all conditions precedent to their effectiveness (other than the effectiveness of this Agreement) have been fulfilled (Article IV4.01).

Source Of Fund	Name	Type
IDA	Withdrawal Conditions; Withdrawal Period	Disbursement

Description of Condition

Notwithstanding the provisions of Part A of Section IV of the Financing Agreement, no withdrawal shall be made for payments made prior to the date of this Agreement, except that withdrawals up to an aggregate amount not to exceed SDR 17,700,000 may be made for payments made prior to this date but on or after March 1, 2016, for Eligible Expenditures.

Risk

Risk Category	Rating (H, S, M, L)
1. Political and Governance	High
2. Macroeconomic	High
3. Sector Strategies and Policies	Low
4. Technical Design of Project or Program	Low
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Low
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Conflict	High
OVERALL	High

Finance

Loan Closing Date - Additional Financing (NG-Polio Eradication Support - Additional Financing - P158557)

Source of Funds	Proposed Additional Financing Loan Closing Date
IDA	December 31, 2018

Loan Closing Date(s) - Parent (NG-Polio Eradication Support (FY13) – (P130865)

Explanation:

It is proposed to change the closing date of the project to December 31, 2018 (a one-year extension) due to this AF.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-51330	Closed	31-Jul-2015	31-Jul-2015		13-Jan-2016
IDA-56180	Effective	31-Jul-2017	31-Jul-2017	31-Dec-2018	31-Jul-2017

Change in Disbursement Estimates (including all sources of Financing)

Explanation:
With the proposed additional financing, the disbursement estimates have changed.

Expected Disbursements (in USD Million)(including all Sources of Financing)

Fiscal Year	2017	2018	2019
Total Budget	38,000,000	62,000,000	25,000,000
Cumulative	38,000,000	100,000,000	125,000,000

Allocations - Additional Financing (FGN-Polio Eradication Support - Additional Financing - P154660)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement % (Type Total)
			Proposed	Proposed
IDA	XDR		88,200,000.00	100
		Total:	88,200,000.00	

Components
Change to Components and Cost

Explanation:

The AF will help fund the procurement of OPV and the implementation of national and state level polio immunization campaigns and support the procurement of vaccines for RI. Given that most of the OPV procurement, the polio eradication activities and RI vaccine procurement need to take place in the first half of 2016 (the lead time required to procure and deliver vaccines is at least two months), the AF proposes to apply retroactive financing of 20 percent (US$25 million). The project has the following three components:

Component 1: Support to Polio Eradication (financing up-to-date is US$185 million, and proposed financing is US$60 million)

This component will support the procurement of OPV and the operational requirements of polio eradication activities.

- Subcomponent 1a. Within this subcomponent, UNICEF will procure OPV (US$50 million). The total estimated costs for OPV is US$34 million for 2016 and a similar amount for 2017. For 2018 this will reduce to US$29 million. While some funding is likely to be provided by the FGN, the IDA credit will cover the major part of the funding gap for 2016, 2017 and 2018.

- Subcomponent 1b: Polio Eradication Operations Support (US$10 million). This will include payment for any of the following activities where a funding gap is identified and the funds will be managed by either UNICEF or WHO as required.
    - Vaccination personnel allowances during IPDs (managed by WHO)
    - Immunization Plus Days (IPD) Training and planning (WHO)
    - Supervision, monitoring and evaluation (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)

Monitoring and evaluation (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 outcome measures e.g., "immunization coverage of OPV is at least 80 percent in each endemic state" the quality of the OPV campaigns while the monitoring of the cases of AFP measures the quality of surveillance. Furthermore, the monitoring of the Vaccine Vial Monitoring will measure the quality of the cold chain. These findings are externally validated through the LQAS.

Component 2: Procurement of Routine Immunization Vaccines (financing up-to-date is US$110 million, and proposed financing is US$65 million)

Procurement of RI vaccines is managed by UNICEF. The cost of vaccine and devices for 2017 is estimated at US$211 million. With GAVI funding expected to provide US$135 million, it leaves a funding gap of US$76 million for 2017. M&E for this component will be carried out through annual household survey (SMART survey) that will be conducted by the National Bureau of Statistics in collaboration with stakeholders while UNICEF will provide technical assistance.

Current Component Name	Proposed Component Name	Current Cost (US$M)	Proposed Cost (US$M)	Action
Supply of oral polio vaccine to national strategic cold stores		95.00	145.00	
Polio Eradication Operations Support		90.00	100.00	
Routine Immunization Support		110.00	175.00	
	Total:	295.00	420.00	

IV. Appraisal Summary

Economic and Financial Analysis

Explanation:

There is a strong economic rationale for 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; eradicating polio in Nigeria is part of global effort that would rid the world of this disease; (c) the 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; and (d) families may under-value immunization because of a lack of information on the benefits of vaccination or the risks posed by vaccine-preventable diseases. In this way, immunization is a "merit" good that deserves Government financing.

The economic rationale for this particular AF includes: (a) the country has not had an indigenous case of Polio since July 2014. This is a particularly important time to avoid financing gaps that would nullify all the gains made so far; and (b) disrupting nationwide RI activities due to lack of vaccines will adversely affect the health of 32 million children under-five country wide and negatively impact

polio eradication efforts.

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. For polio eradication, an economic analysis estimated that the incremental net benefits of the Global Polio Eradication Initiative between 1988 and 2035, assuming that polio will be eradicated in 2015, are US$40 billion (Tebbens et al, 2010). Sensitivity analysis suggested that the net benefits remains 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.

Technical Analysis

Explanation:

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 their 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" (i.e., the proportion of individuals that need to be vaccinated to prevent transmission to un-immunized individuals) can be obtained at about 80 percent coverage.

Efficiency: Numerous studies from different settings and using different assumptions have consistently found RI to be among the most cost-effective interventions in public health. 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. In particular, cost effectiveness of immunization interventions (including tuberculosis, diphtheria-pertussis – tetanus, polio and measles) is US$7/Disability Adjusted Life Years (DALYs) and for second opportunity measles vaccination is US$4/DALYs.

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 LGAs. The results of polio (AFP) surveillance confirm the effectiveness of the polio program. It is unlikely that the funding for RI will similarly improve the performance of the RI program except a strong management team like the polio EOC is established (perhaps as part of polio legacy. In the medium term the building blocks for improving vaccination coverage rates are in place. Other Bank-supported initiatives as well as other DP support are also providing help to the RI program.

Monitoring and Evaluation: The progress on RI will be judged using annual household surveys (SMART) that are conducted by the National Bureau of Statistics 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 LQAS surveys that provide pass/fail data at 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.

Social Analysis

Explanation:

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

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 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 (e.g., malaria diagnosis, multi-vitamin supplementation, 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.

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 disproportionate impact among women. There are issues of equity, both by geo-political zone and by income quintile. Efforts at addressing these inequities are incorporated in NSHIP and the Saving One Million Lives (SOML) program for results (PforR).

Citizen engagement. There is strong community involvement. The proposed AF continues to build awareness and political support of LGA Chairmen in collaboration with Association of Local Governments of Nigeria by requiring their participation in the supervision of SIA and RI. Further, to consolidate traditional and religious leaders' engagement—the NPHCDA, WHO and UNICEF 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 non-compliance in all high risk/ vulnerable LGAs. They are called to help vaccinators and social mobilization teams to convince non-compliant households to accept OPV and thereby assist with addressing 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's engagement will be strengthened in the conflicted affected areas of the NE where it has been proved to be effective in the past.

Financial Management Analysis

Explanation:

The financial management (FM) arrangements under this AF will remain the same as under the original project—Partnership for Polio Eradication Project (P130865). The funds for Component 1a (Procurement of OPV) will be disbursed directly by the WB to UNICEF, while funds for Component 1b (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 (Procurement of Vaccines for Routine Immunization) will be disbursed directly by the World Bank to UNICEF. The assessment of the FM arrangements for the AF confirms that the arrangements would provide adequate assurance that the Bank's fiduciary requirements would be met, especially that funds will be used for the purpose intended with due regard to economy and efficiency. FM risk is low. Please refer to Annex 2 for more details.

Procurement

Explanation:

For this AF, the procurement management arrangements are the same as in the first AF for the Polio Eradication Support Project (P130865). Under this AF, UNICEF will be responsible for procurement of Vaccines for Polio as well as RI which is estimated to cost US$115 million. UNICEF and WHO will provide Technical Assistance for Polio Operations (US$10 million).

Under this AF, UNICEF will undertake the procurement and supply of RI vaccines through its international procurement division, based in Copenhagen, as agreed under the previous Project. 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 buy 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 on-going. Since procurement will be managed by UNICEF, and its procurement systems are acceptable under the Bank-UN Financial Management Framework Agreement, no formal assessment of UNICEF and WHO systems will be conducted.

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

Retroactive financing in accordance with the Procurement Guidelines will be allowed up to 20 percent of the Credit prior to the signing of the Financing Agreement. The effective date of the retroactive financing was agreed as March 1, 2016. Pre-financing may be available from DPs through the Vaccine

Independence Initiative or Bank-supported retroactive financing.
Environmental Analysis
Explanation: The Proposed AF is not envisaged to involve any civil works including construction and rehabilitation of existing buildings. Operational Policy (OP) 4.01 on Environmental Assessment is triggered given the potential environmental concerns around the handing of Health care waste resulting from project related activities such as Vaccination and Routine Immunization that generate healthcare waste such as expired vaccines and sharps. **The risks.** Improper and unsafe health care waste management (HCWM) practices put at risk healthcare workers, patients, and communities at large who are exposed both within Health Facilities (HFs) and the surrounding communities. The potential risks are considered to be small in scope, site specific, and easy to avoid, prevent, and manage as well as remediate to acceptable levels. Experience has proven that when healthcare wastes are properly managed, generally they pose no greater risks than that of properly treated municipal or industrial wastes. 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 health care waste management protocols are followed by the health facilities. **Government actions to date.** Nigeria has demonstrated its commitment to mitigating adverse social and environmental impacts in the implementation of a range of WB projects such as the HIV/AIDS, the NSHIP and Polio Eradication Support. There are adequate legal and institutional frameworks in the country to ensure compliance with WB safeguards policies. On September 4, 2013, the Nigerian Federal Executive Council approved a new National Strategic Healthcare Waste Management policy, including National Strategic Healthcare Waste Management Plan and Guideline for the country. The fact that the Ministers of Environment and Health jointly presented the memo seeking Council's approval for the adoption of the National Healthcare Waste Management policy, underscores the high level of the commitment of the Government toward improving the situation of the sector. 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. **Project interventions.** The project will (a) apply the necessary safeguard requirements at primary care facility level; (b) draw upon the National Healthcare Waste Management (HCWM) Plan to provide guidance on processes for the implementing agencies (Federal, States, Local Government Authorities, and Healthcare Facilities Managements) and to ensure the protection of healthcare workers, wastes handlers, and the community from the harmful impacts of hazardous healthcare wastes and to maximize project compliance with international and national environmental regulations and best practices. Following the clearance of the final document by FGN, the plan has been disclosed

both in country on April 14, 2016 and at the Bank InfoShop on April 15, 2016.
Risks:
Explanation: The overall risk is high, mainly as the focus of the AF is on the North East states which have been heavily hit by the Boko Haram insurgency. In an environment where transition from conflict to peace remains fragile, the implementation of the AF is expected to face a number of challenges. These relate to the dynamic nature of the conflict as well as government policies related to the emergency transition and stabilization phases. There are increasing security challenges in the North East part of the country which pose implementation risk for the Government and supervision risk for the World Bank team. Macroeconomic risk is also rated high due to declining oil revenues and an acute financing gap that could derail progress on polio eradication. In terms of mitigation, the use of third party monitors, local NGOs and other civil society groups for supervision, monitoring and evaluation will be used.

V. Communication

25. Communications was incorporated into the Nigerian Polio program as a tool for enhancing and showcasing results, community engagement and participation and provisions were made to mainstream communication into project implementation. A communications action plan was developed by the Polio EOC. This AF will benefit from the already existing communication arrangements.

VI. World Bank Grievance Redress

26. 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 GRS, please visit http://www.worldbank.org/GRS.
For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Revised Results Framework and Monitoring

Project Development Objectives	
Original Project Development Objective - Parent:	
The development objective of the proposed Project is to assist, as part of a global polio eradication effort, the Government of Nigeria to achieve and sustain at least 80% coverage with OPV immunization in every state in the country	
Current Project Development Objective - Parent:	
To assist the Recipient, as part of a global polio eradication effort, to achieve and sustain at least 80% coverage with oral polio vaccine immunization in every state in the Recipient's territory, and sustain national routine immunization coverage.	
Proposed Project Development Objective - Additional Financing (AF):	
No change.	
Results	
Core sector indicators are considered: Yes	Results reporting level: Project Level

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Immunization coverage of OPV in the country	☐	Percentage	Value	91.80	95.60	80.00
			Date	31-Dec-2012	31-Jan-2016	31-Dec-2018
			Comment	Data source: LQAS 2012	Data source: 2015 Performance Audit	Data source: 2018 Performance Audit
Immunization coverage of OPV in each high risk state	☐	Percentage	Value	89.00	95.60	80.00
			Date	31-Dec-2012	31-Jan-2016	31-Dec-2018
			Comment	Data source: LQAS 2012	Data source: 2015 Performance Audit	Data source: 2018 Performance Audit

Indicator	Core	Unit of Measure		Baseline	Actual (Current)	End Target
Children immunized (number)	☒	Number	Value	0.00	5,479,402.00	6,561,446.00
			Date	09-Jul-2012	30-Oct-2015	31-Dec-2018
			Comment			
Children immunized - under 12 months against DTP3 (number)	☒	Number	Value	0.00	3,304,952.00	3,465,493.00
		Sub Type	Date	09-Jul-2012	31-Dec-2015	31-Dec-2018
		Breakdown	Comment		Data source: DHIS 2	Data source: DHIS 2
Direct project beneficiaries	☒	Number	Value	0.00	5,479,402.00	6,561,446.00
			Date	09-Jul-2012	30-Oct-2015	31-Dec-2018
			Comment		Data source: DHIS 2	Data source: DHIS 2
Female beneficiaries	☒	Percentage Sub Type Supplemental	Value	0.00	50	50
Pentavalent 3 coverage rate	☐	Percentage	Value	52.00	48.80	52.00
			Date	05-May-2014	15-Sep-2015	31-Dec-2018
			Comment	Data source: SMART Survey	Data source: SMART Survey	Data source: SMART Survey
Percentage of teams with viable vaccine according to the Vaccine Vial Monitor	☐	Percentage	Value	97.00	98.00	98.00
			Date	15-Apr-2012	30-Oct-2015	31-Dec-2018
			Comment	Data Source: WHO Campaign Reports	Data Source: WHO Campaign Reports	Data Source: WHO Campaign Reports

				(frequency: every round)	(frequency: every round)	(frequency: every round)
Percentage of campaigns where vaccines are available on time	☐	Percentage	Value	100.00	100.00	100.00
			Date	09-Jul-2012	30-Oct-2015	31-Dec-2018
			Comment	Data Source: WHO and UNICEF Campaign Reports (frequency: every round)	Data Source: WHO and UNICEF Campaign Reports (frequency: every round)	Data Source: WHO and UNICEF Campaign Reports (frequency: every round)
Percentage of health facilities in the project area with functioning management committees having community representation	☐	Percentage	Value	0	0	30
			Date	23-May-2016	23-May-2015	31-Dec-2018
			Comment		Data source: SMART Survey	Data source: SMART Survey

Annex 2: Implementation Arrangements

Financial Management

1. The FM arrangements under this AF will remain the same as under the original project Partnership for Polio Eradication Project (P130865). The funds for Component 1a (Polio Eradication Logistics and Technical Support - WHO) will be disbursed directly by the World Bank to WHO while funds for Component 1b (Polio Eradication logistics and technical Support - UNICEF) and Component 2 (Routine Immunization Support), will be disbursed directly by the World Bank to UNICEF, (Copenhagen, Denmark) based on contracts signed between the government and these UN agencies. The assessment of the FM arrangements for the AF confirms that the arrangements would provide adequate assurance that the Bank's fiduciary requirements would be met, especially that funds will be used for the purpose intended with due regard to economy and efficiency.

2. These FM operating procedures are consistent with the procedures agreed and documented in the Project Paper for the first AF and summarized below:

(a) An agreement will be signed between the FGN and UNICEF on a single source contract basis for the purchase of Vaccines for RI.

(b) An agreement will be signed between the FGN and WHO on providing support for the distribution of vaccines from the point of entry in the country to various states of the federation and subsequently to the LGAs and health facilities.

(c) The Agreements will be cleared with the World Bank, and the signing of the Agreements with UNICEF and WHO will be a condition of effectiveness of the AF.

(d) The Vaccines for Routine Immunization (VRI) will be procured and operational expenses under Component 1b would be incurred in accordance with UNICEF's rules, regulations and procedures.

(e) The operational expenses under Component 1a would be incurred in accordance with WHO's rules, regulations and procedures.

(f) The credit proceeds will be disbursed by the Bank directly to UNICEF for the purchase of the required VRI on the basis of Withdrawal Applications, along with forecast expenses for six (6) months replenishable quarterly, upon receipt of a Utilization Certificate from UNICEF/WHO.

(g) UNICEF and WHO will maintain a separate ledger accounts in theirs books through which all receipts and expenditures, for the purposes of providing these services contemplated by the Agreement, will be recorded.

(h) The credit proceeds will be disbursed by the Bank directly to UNICEF and WHO as "advance" for operational expenses on the basis of instructions from the Government of Nigeria.

(i) UNICEF will report every semester to the FGN (with a copy to the Bank) on the use of funds received showing inter alia, the fund balance at the beginning and end of the reporting period. The Fund Utilization Report will include, at a minimum:

(i) sales and purchase orders placed by UNICEF during the reporting period;

(ii) actual quantities of VRI delivered during the reporting period; and

(iii) expenditures from the Procurement Account during the reporting period.

(j) WHO will report every six months to the FGN (with a copy to the Bank) on the receipt and use of funds received indicating, inter alia, allocation of expenditures made and committed balance at the beginning and end of the reporting period.

3. As the IDA credit will not be directly disbursed to the FGN, all FM responsibilities under the AF are vested in UNICEF and WHO. The reports submitted under (i) and (j) above will allow the project to meet the Bank's financial reporting requirements, given that UNICEF and WHO financial regulations and procedures are accepted under the Bank-United Nations Financial Management Framework Agreement. Both UNICEF and WHO have subscribed to the UN Framework Agreement. This AF, as in the case of the original project (P130865), will also not request financial audits. The team has received an audit exemption for this project from the Bank Financial Management Sector Board, with the understanding that the IDA reserves the right in the Financing Agreement to request for such audit should any issue come to its attention.

4. Since the funds will be managed by UNICEF and WHO, and their FM systems and financial regulations are acceptable under the Bank-United Nations Financial Management Framework Agreement, no formal assessment of UNICEF and WHO systems were conducted. Rather, the assessment was limited to the existing arrangements that ensure that the procured vaccines are delivered to the Government and that the accompanying invoices and delivery notes are consistent with the financial utilization reports submitted by UNICEF. The assessment therefore was limited to the review of the records presented by UNICEF to the Government, including the delivery notes covering the vaccines and traced to the distributed quantities by government and also the financial utilization reports submitted by both UNICEF and WHO to the Government.

5. **Estimated project financing costs.** Table 1 below shows the project financing costs for the original project, AF-1 and the proposed AF:

Table 1 Estimated Project Financing Costs

Component	parent project and the first AFl (US$ millions)	Proposed second AF (US$ millions)	Total (US$ millions)
Supply of OPV to national strategic cold stores *(Current)*	95.0	50.0	145.0
2. Polio Eradication Operations Support *(New)*	90.0	10.0	100.0
3. Routine Immunization Support *(New)*	110.0	65.0	175.0
Total	**295.0**	**125.0**	**420.0**

6. **Disbursement by category.** The table below sets out the expenditure categories and percentages to be financed out of the AF proceeds.

Table 2. Disbursement Categories

Category	Amount of the Credit Allocated (expressed in XDR '000	Amount of the Credit Allocated (expressed in US$ Millions)	% of Expenditures to be Financed
1. Goods, Training, Consultant Services	88.2	125.0	100
Total Amount	**88.2**	**125.0**	

7. The Bank assessment found these systems to be functioning well and no exceptions were noted, which gives the assurance that the funds will be used for the purposes of the project. These arrangements therefore meet the Bank's minimum FM requirements.

Annex 3: World Bank Engagement Framework in Northern Nigeria

I. Context

1. **The Boko Haram insurgency has disrupted economic and social activities and has negatively affected the productive capacity, employment, and livelihoods of over fifteen million people.** The six northeast states of Borno, Yobe, Adamawa, Taraba, Bauchi and Gombe have been adversely affected by the insurgency which has severely curtailed their ability to meet the most pressing needs of internally displaced persons (IDPs) to deliver basic social services and to restore essential infrastructure. The human, social and economic losses attributed to the Boko Haram insurgency are enormous, resulting in the loss of over 20,000 lives, the displacement of over 2.0 million people (nearly 80 percent are women, children and youth) forcibly displaced by the conflict with Boko Haram, and the destruction of entire towns and villages. Furthermore, the region has witnessed a 20 to 30 percent decrease in crop yields and declining livestock productivity. The amount of land being used to grow food has dropped by almost 70 percent over the past year as violence disrupted farming activities. The recently completed Northeast Nigeria RPBA[6] estimates nearly US$9.0 billion in damages across all six states. With US$5.9 billion in damages, Borno is the most affected state, followed by Adamawa (US$1.6 billion) and Yobe (US$1.2 billion). The damages to the agricultural (US$3.5 billion) and housing sectors (US$3.3 billion) are considerable and make-up three-quarters of the total losses. The economic impact of the insurgency has also transcended the geographic borders of the country, impairing cross-border trade with Niger, Chad and Cameroon.

II. Government's Response

2. **The critical and immediate challenge facing the government of Nigeria today is ensuring the welfare of the IDPs, the host communities and the population in the conflict areas.** The immediate and effective provision of basic social services to the above target groups remains a government priority. Nigeria's Emergency Management Agency, in coordination with State Emergency Management Agencies has been monitoring IDP movements and providing a range of relief support to affected communities. According to the RPBA, food, access to clean drinking water and other emergency supplies have been provided to IDPs living in camps and many of those staying with host families in the northeast in response to Boko Haram-related violence. Emergency education for displaced children also became a priority following unprecedented attacks targeting students, teachers as well as school infrastructure. In 2014, a Safe Schools Initiative has been setup to promote safe zones for education. In some cases, students were transferred with parental consent to other schools in states not affected by the fighting.

3. **On August 21, 2015, the Government of Nigeria requested donors' assistance in assessing the needs associated with peace building and crisis recovery efforts.** The joint Northeast RPBA was launched in January 2016 in support of the Government's efforts toward peace building and sustainable recovery in the northeast. The RPBA provided a framework for coordinated and coherent assistance to conflict-affected communities in the northeast. The proposed framework identified the immediate and urgent need for sustaining emergency

[6] Recovery and Peace Building Assessment, *(World Bank, European Union and the United Nations, April 2016)*

transition activities while supporting in parallel stabilization initiatives along the three strategic areas of intervention, namely: (a) peace building and social cohesion; (b) infrastructure and social services; and (c) economic recovery. The total needs across the three strategic areas of interventions are estimated to be around US$6.42 billion.

III. World Bank's Engagement in Northern Nigeria

4. **The WB has a critical role to play in supporting the Government in its efforts to restore stability and create economic opportunities for the most vulnerable.** Such an approach is well aligned with the WB Group's twin goals of ending poverty and boosting shared prosperity. The focus of the Bank's engagement in Northern Nigeria is twofold. First, in collaboration with the authorities, the Bank has developed the Northeast Emergency Transition and Stabilization Program (NETSP) of support for the six states in the NE. In parallel, it seeks to deepen its engagement in the Northern Nigeria through the work on the formulation of a Northern Nigeria Regional Development Framework. The Bank's support to the NE and to the North as a whole is prioritized and sequenced to complement government and DPs' interventions.

Northeast Emergency Transition and Stabilization Program

5. **The Bank is fully cognizant of the importance of bridging the gap between the two phases of emergency transition and stabilization in the northeast.** A key cross-cutting objective underpinning the Bank's support relates to addressing the service delivery gaps, livelihood deficits and social cohesion issues created by the protracted crisis. The NETSP comprises a set of coordinated emergency transition and stabilization activities and targets Borno, Yobe, Adamawa, Bauchi, Gombe and Taraba. The NETSP support includes a series of AF, and a multi-sector Emergency Crisis Recovery Project. The proposed WB support under the NETSP (US$775 million) represents 12 percent of the total identified needs for recovery and peace building across the three strategic areas of interventions. This is expected to be further complemented by ongoing and/or planned programs funded by government and DPs in the targeted areas identified under the RPBA.

6. **The AF interventions under the NETSP focus on 4 areas: agriculture, health, education and social protection.** They are informed by the findings of the RPBA and represent a set of priority initiatives that have a tangible and quick impact. They are predominantly results-driven and aim at improving the government service delivery while building on collaborative partnerships between governmental institutions and civil society. The implementation of the AF interventions relies on accumulated knowledge and existing institutional networks to assist with the rapid deployment of Bank resources.

IV. NETSP Implementation Risks and Challenges

7. **In an environment where transition from conflict to peace remains fragile, the implementation of the NETSP is expected to face a number of challenges.** These relate to the dynamic nature of the conflict on one hand and to the evolving policy environment on the other. On the latter, both the design features and the technical assistance to be provided under the NETSP will mitigate the anticipated policy challenges. The NETSP interventions will provide

guidance to State Governments on the formulation of appropriate support schemes and subsidy systems targeting on one hand, public assets and public services (Federal and State-owned) while on the other, addressing private assets and the needs of private individuals. Such guidance will focus on the following:

(a) *Selectivity and beneficiary eligibility for government support schemes.* Social groups affected by the protracted conflict in the Northeast are quite diverse. They include among others: disabled; women and girls; elderly; youth (especially child soldiers); victims of war, IDPs living in official camps; IDPs living within host communities; refugees returning from neighboring countries; host communities; residents of areas of conflict; farmers, etc. Hence, given the limited availability of public resources at the disposal of State Governments, guidance on the hierarchy of beneficiary groups that are eligible for immediate government assistance will be provided under the NETSP interventions.

(b) *Equity in government support schemes to private individuals and private assets.* International experience has shown that common and equitable support schemes need to be applied within beneficiary groups and across affected States (no one left behind). This is more important in situations where the Northeast States are implementing an array of interventions targeting various beneficiaries (IDPs, etc.) and private assets through: (i) cash transfers; (ii) financial support for repair and reconstruction of private housing; and (iii) financial support for replacement of damaged private productive assets (farming tractors, etc.). The Bank's assistance under the NETSP will support State governments in formulating schemes that are equitable and well aligned behind past governments' track record following similar situations of natural and/or man-made disasters.

(c) *Displacement management.* The nature of population displacement resulting from the conflict is complex. Internally displaced persons in the Northeast include IDPs living in official camps; IDPs living within host communities; IDPs living in schools and public buildings; refugees returning from neighboring countries and resettling in official IDP camps; IDPs settling permanently in host States and IDPs returning to States and areas of origin. Bank assistance under the NETSP will support State governments in formulating consistent government policies and support schemes addressing the respective needs of each category of IDPs.

(d) *Resource mobilization strategy.* The magnitude and complexity of challenges necessitates the mobilization of considerable financial resources. As such, aligning both Federal and State budgets *(both recurrent and capital)* behind local needs while developing plans and resource mobilization strategies at international level would be required. Resources would need to cater for the basic functioning of the States, including salaries and pensions for the civil service and security sector which have a critical impact on the stabilization process. As such, Bank assistance under the NETSP will support State governments in formulating burden-sharing arrangements with the Federal Government and DPs.

(e) *Communication with stakeholders and beneficiaries.* The NETSP involves many nonconventional stakeholders, possibly with different priorities and interests. Coordination between these entities will become extremely difficult. This risk will be mitigated through regular information sharing processes among stakeholders, including counseling and awareness sessions for the beneficiaries to apprise them on the available support under the NETSP program.

(f) *Security and the recurrence of militancy.* The Bank foresees the difficulties in direct monitoring and supervision in the field. High security-related risks may interfere with timely achievement of intended outcomes. Despite the external security risks, the flexibility of the NETSP design and the existing experience in quick mobilization will assist the projects in adjusting to the changing environment. Also, the government is ensuring that repatriation is announced for only those areas which have been cleared by the army and declared as safe.

(g) *Political and governance.* Due to continued insurgency in the region and lack of formal control of the government over some areas, the institution set up and the writ of the government was weakened. This led to deterioration of the informal governance structures that were being managed through the traditional authority of local leaders. The social fiber of the region has been weakened and challenged, which has been posing challenges for the government to re-establish linkages. For local people, the time tested reliance on the local elders and leaders has also grown weak. Citizen-state relationship, improved governance and service delivery are important components of long term development and governance reforms embedded in the NETSP.

V. Major Design Features of the NETSP

8. Cognizant of the implementation risks described above, the AF initiatives have incorporated a number of mitigation measures and design features that build on the findings and recommendations of the RPBA. These include:

(a) *Building on lessons learned.* The Bank's engagement under the NETSP builds on lessons learned in similar challenging circumstances. There is no *"one size fits all"* approach and a successful response needs to be flexible, creative and rapid. For example, results and service-based financing has been successfully implemented in the health sector in Adamawa with Bank support. Initial results show significant improvements in contraceptive prevalence rates, antenatal care, and utilization of curative services. Experience has also shown that establishing well-motivated and well-managed health workers with access to decentralized funding allows for large and immediate gains in service delivery during the post conflict transition phase. Furthermore, in areas where conflict is ongoing, strategies such as the use of mobile health teams to run free "health camps" that provide a broad array of medical services are being adopted.

(b) *Relying on available institutional capacities.* Given the need for a rapid and timely response, the NETSP design benefits from the available institutional capacities built

under ongoing Bank financed operations. The program relies on existing institutions at both state and local government levels and work with civil society, faith-based and community-based organizations.

(c) *Factoring security concerns.* The situation in the northeast remains volatile with pockets remaining under the influence of the insurgents. To mitigate these risks, program implementation will be particularly mindful of security matters and will operate within the mechanisms established by Government of Nigeria and the military. Also, the Bank has extensive experience operating in fragile post-conflict areas and has demonstrated flexibility adapting to changing circumstances. The use of Third Party Monitoring Agent to ensure adequate fiduciary oversight and to offset the difficulties in access by Bank staff has been adopted in the design of the various project interventions.

(d) *Promoting demand-driven approaches.* Experience in restoring services in conflict-affected areas confirms that community-level empowerment and engagement are absolutely key. As such, the local participation of target community groups is an integral part of the NETSP design and implementation. This involves School-Based Management Committees in the education sector, Primary Health Care Development Agencies, Primary Health Care (PHC) centers and non-state entities such as UN agencies and Community-Based Organizations in the health sector, as well as private farmers, farming groups and farming cooperatives in the agriculture sector**.** Also, demand-based Community Driven Development approaches have been adopted under the social protection interventions.

(e) *Integrated and balanced approach.* The NETSP design has adopted an incremental and sequenced approach focusing first on the immediate and rapid restoration and sustaining of basic social services and livelihoods followed by increasing emphasis on recovery and rehabilitation of public goods.

(f) *Targeting for maximum impact.* The NETSP supports an area-based approach that consists of a blend of statewide and LGA-specific targeting approach. Given the limited government and donor funding available, greater focus is placed on host communities and the IDPs living among them rather than on IDPs living in camps. Also, support to communities in areas of origin is envisaged so as to prepare the enabling environment for the dignified return of IDPs. The welfare impact of such an approach is justified given that several international organizations (in particular UNICEF) and civil society organizations are active in the IDPs camps providing education and health services. Moreover, none of the humanitarian donors agencies appear to be focusing on livelihood support either through labor-intensive public works or through cash transfers to IDPs and host communities. Some food distribution has taken place (e.g. funded by Food and Agriculture Organization in health camps) but remain very limited in scale.

(g) *A state-differentiated approach for budget allocation.* Considering the differing transition and stabilization needs among the six northeast states, the three conflict-affected states of Borno, Yobe and Adamawa were allocated a higher share of the

NETSP funds. This reflects the extent of displacement, food insecurity and destruction witnessed. However, fund allocation among states will remain flexible to cater for variation in absorptive capacity and disbursement rates.

Annex 4: Guiding Principles on the Incorporation of RPBA Findings in the Proposed AF

Background: The North-East Nigeria Recovery and Peace Building Assessment (RPBA)

1. **On 21 August 2015, the Government of Nigeria requested assistance in assessing the needs associated with peace building and crisis recovery.** Support has been provided in accordance with the 2008 Joint European Union (EU) – United Nations (UN) – World Bank (WB) Declaration on crisis assessment and recovery planning. The RPBA has been prepared and implemented by the Federal Government, led by the Vice President's Office, and the Governments of the six affected states, with support from the World Bank, United Nations, and European Union. A multi-stage consultation process was followed for the development of the assessment methodology, collection and validation of data and for the progressive corroboration of results, ending with consultation and validation of the RPBA findings, after which the document was fully endorsed by the different stakeholders.

2. **The RPBA informs a collective vision and strategy on peace building and recovery, and provides a framework for coordinated and coherent support to assist conflict-affected people in the North-East.** The assessment covers the six states of Borno, Yobe, Adamawa, Gombe, Taraba, and Bauchi, and provides an overarching framework for stability, peace building, and recovery. The RPBA is founded on the recognition that a durable resolution to the conflict in the North-East requires addressing the structural and underlying drivers of violent conflict. To assess and prioritize immediate and medium-term peace building and recovery needs, the RPBA gathered information across three components, namely: Peace Building, Stability and Social Cohesion; Infrastructure and Social Services; and Economic Recovery. The full RPBA report was made publicly available by the Nigerian government upon its launch on May 12, 2016.

RPBA Recovery Strategy and Framework

3. **The RPBA confirmed the need for recovery and peace building efforts, to be carried in tandem with the on-going scaling up of the humanitarian assistance.** Therefore, the Recovery and Peace Building Strategy (RPBS) will need to be closely coordinated with the Humanitarian Response Plan (HRP)[7] to build on the HRP's achievements and avoid overlaps.

4. **Careful and coordinated sequencing of the RBPA and subsequent support will be critical in view of the fluidity of the security environment, and the marked variation in security within and among the six states.** Priorities should be carefully assessed on a continuous basis, and adjusted as needed in light of the prevailing situation on the ground. In some areas, a humanitarian response combined with stabilisation will be needed, while in other areas, the context will permit more substantial movement toward recovery.

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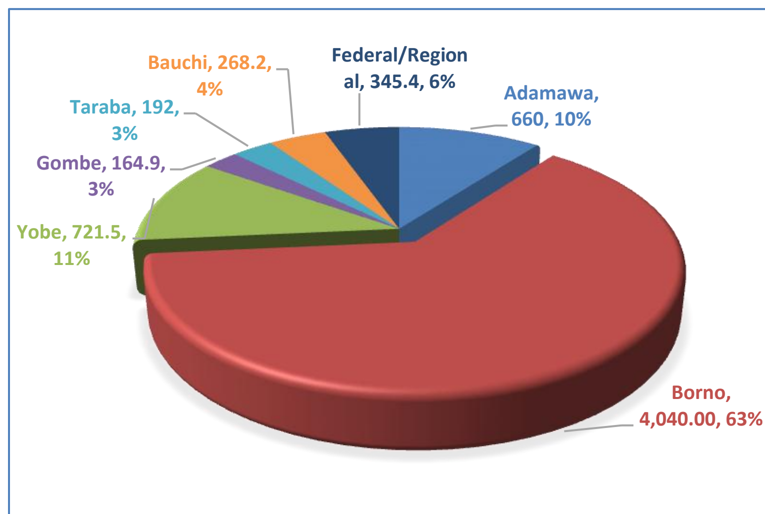
[7] The HRP 2016 was prepared by the UN-Nigeria, with the purpose assessing the humanitarian conditions of the Nigerian NE and providing a framework for the continuous national response and early recovery plans and interventions to these needs. For more information, please visit: https://www.humanitarianresponse.info/en/system/files/documents/files/nigeria_2016_hrp_03032016_0.pdf

5. **An integrated and balanced approach to recovery is essential.** Peace building and social cohesion is the backbone of the assessment. Hence it is crucial to properly balance peace building, stability, and social cohesion interventions with other interventions aimed at reconstructing or rehabilitating social, physical, and productive assets. Peace building, stability, and social cohesion interventions will ensure the sustainability of recovery interventions on the ground and lay the foundation for human security to prevail. The assessment sets out four strategic outcomes for recovery and peace building: (a) Safe, voluntary, and dignified return and resettlement of displaced populations; (b) Improved human security, reconciliation, and violence prevention; (c) Enhanced government accountability and citizen engagement in service delivery; and (d) and Increased equity in the provision of basic services and employment opportunities.

Overview of Overall Impacts and Needs from the Crisis under the RPBA

Figure 3. Overall Recovery and Peace Building Needs by State



6. **The assessment indicates that the economic impact of the crisis is substantial, reaching nearly US$9 billion. Needs for recovery and peace building are disproportionately concentrated in Borno, followed by Yobe and Adamawa.** Two-thirds of the damages (US$5.9 billion) are in Borno, the most affected state; damages in Adamawa and Yobe account for US$1.6 billion and US$ 1.2 billion respectively. Three-quarters of the overall impacts are on agriculture (US$3.5 billion) and housing (US$3.3 billion). The conflict resulted in more than 400,000 damaged and destroyed housing units, 95 percent of which are located in Borno.

7. The total need for recovery and peace building across the three strategic areas of interventions in both the stabilization and recovery[8] phase is US$6.7 billion (table 3).

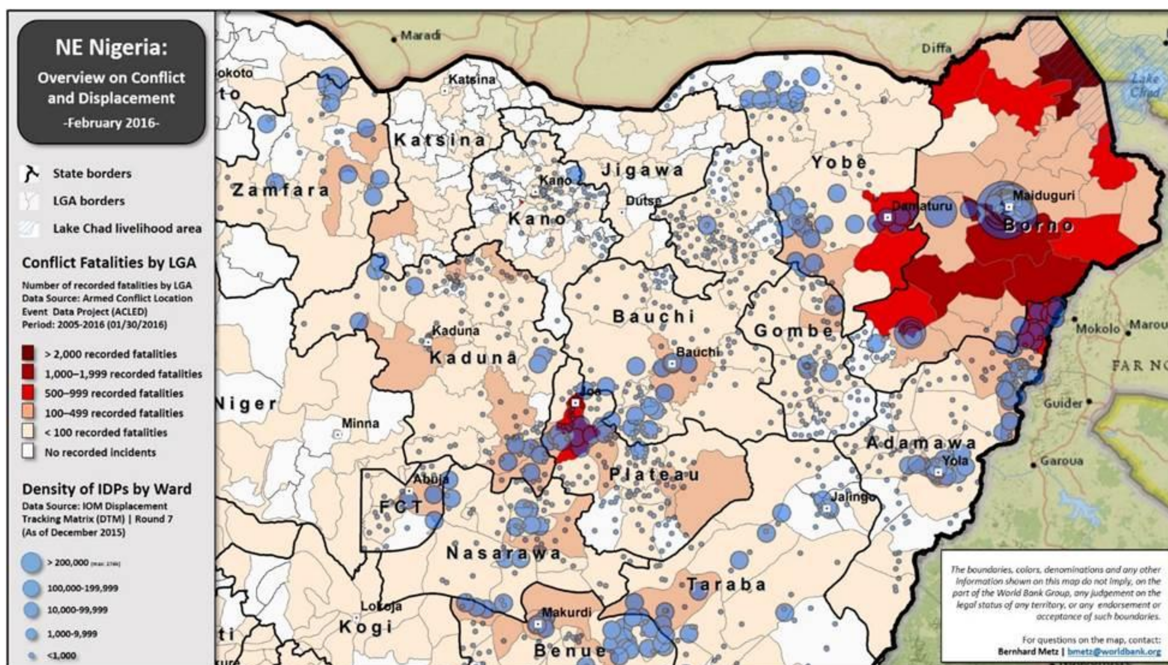
[8] Stabilization generally denotes the period during which initial recovery interventions commence and start taking effect while ongoing humanitarian operations continue. These initial recovery interventions build upon humanitarian interventions, do not duplicate them, and do not address the development deficits existing before the insurgency. Recovery denotes the period during which the initial recovery interventions start galvanizing into concrete recovery outcomes while more medium-term recovery and reconstruction activities take shape, scale up and intensify. The RPBA recognizes that these periods will overlap across the territory, with some areas being ready for recovery efforts sooner than others.

Table 3. Overall Recovery and Peace Building Needs by Component

	Adamawa	Borno	Yobe	Gombe	Taraba	Bauchi	Federal/Regional	Total
	(US$, millions)							
Peace building and social cohesion	27.5	37.8	22.5	13.6	19.4	23.9	5.7	150.5
Infrastructure and social services	594.9	3,933.3	668.3	129.1	144.9	202.9	94.7	6,040.1
Economic Recovery	37.6	68.8	30.7	22.3	27.7	41.4	245	473.5
Total	**660.0**	**4,040.0**	**721.5**	**164.9**	**192.0**	**268.2**	**345.4**	**6,664.1**

8. **Forced displacement and social cohesion are the most acute impacts of the conflict in NE Nigeria. An estimated 2 million people have been forcibly displaced by the conflict, 1.8 of which are displaced within Nigeria, making it the country with the third largest IDP population in the world.** The burden of displacement is asymmetric across regions and populations**.** Borno, at the heart of the crisis, hosts 67 percent. The majority of IDPs live in host communities with only 8.5 percent in camps and camp-like sites. The population of Maiduguri, the Borno State's capital, has more than doubled due to displaced persons. Yobe and Adamawa also share large burdens of IDPs, hosting 130,000 and 136,000 respectively, or around 6 percent in each state. Women, children, and the youth bear the brunt of forced displacement, accounting for nearly 80 percent of affected populations. Of the 1.8 million identified IDPs nationally, 53 percent are women, 57 percent are children (of which 28 percent are five or younger) (International Organization for Migration 2015).

Figure 4. North-East Nigeria: Conflict Fatalities by LGA and Displacement by Ward



9. **Security remains the main factor preventing an accurate assessment of the extent of needs of displaced population, as well as any attempts of return.** Most of Borno and parts of Yobe and Adamawa remain inaccessible due to unstable security conditions (see figure 4).

Attempts of return by IDPs have been frustrated due to attacks by Boko Haram, forcing people to displace again. More recently, reports of unexploded ordinances have increased, preventing access to farmlands and limiting the restoration of livelihoods. Displacement has also increased vulnerability in many ways, including to Sexual and Gender Based Violence. There is evidence from humanitarian agencies that sexual abuse of women and children is widespread. Girls and women who have experienced sexual violence from Boko Haram members are stigmatized by their communities, especially when they become pregnant. Men and boys also confront a range of threats, including violence, abduction, and forceful recruitment by Boko Haram and vigilant groups, and detention on suspicion of militancy sympathies.

10. **The rapid deterioration of the conflict, and vacuum of law enforcement mechanisms to contain and control conflict, resulted in widespread levels of suspicion, mistrust and stigma along ethnic, religious, political, and geographical lines.** The social fabric in the North-East was deeply damaged, eroding social relations between citizens and government, down to ethnic clans, communities and even extended families. Economic, ethnic, religious, political, and geographical divisions have hardened, affecting the way in which any recovery effort is perceived, while new divisions have emerged. The sequentially overlapping phases of humanitarian, early recovery and development assistance need to incorporate confidence and trust-building, collaboration and mutual understanding. Social impacts of efforts are central considerations in all proposed interventions in such a fragile social system.

Guiding Principles Emerging from the RPBA for Recovery and Peace Building Responses

11. The response to recovery and piece building needs in the NE will require (a) adopting holistic approaches that address the multi-dimensional impacts of the conflict; (b) retaining flexibility for future adjustment in light of post-RBPA delivery mechanisms, financial complementarity, and in-depth assessments; (c) implementation flexibility to adapt to the evolving situation around security; and (d) impact-based resource allocation along geographic, demographic and sectoral priorities.

(a) **The RPBA indicates that the recovery and peace building of the Nigerian NE calls for a holistic approach** that promotes peace, stability, and social cohesion addresses the rehabilitation of infrastructure and services, and also addresses underlying macro-economic issues to overcome the nexus of instability, conflict, and deteriorating development. Throughout this process, principles such as sustainable recovery, do-not harm approaches and building-back-better/smarter standards should be further integrated.

(b) **Flexibility in the design of AF project components and operational and implementation modalities greatly facilitates the alignment between the post-RPBA programmatic response and the proposed AF.** The RPBA will be followed by a more detailed conflict recovery planning, prioritization and operationalization led by the Federal and State Governments and supported by the EU, UN and WB. A formal request of the Government of Nigeria for support during this phase has been received by partners. This post-RPBA phase will produce with a programmatic response for recovery and peace building of the NE, including duly prioritized plans for recovery at the sector levels as well as institutional

arrangements for recovery for the entire recovery program in the six states as a cohesive whole. It is important that AF operations built in enough flexibility as to remain aligned with this programmatic response.

(c) **As the situation in the NE remains fluid with regard to security and forced displacement, adaptability is key to ensure positive impacts.** Security continues to be the number one reason preventing people from returning or resettling as large part of the NE remain unstable. The RPBA provides a series of recommendations on how to carry out interventions in this context, strongly advising that a series of steps are undertaken as to avoid that any harm is done to the affected population through operations. Risk associated with return and resettlement of displaced population have been identified as particularly high, and a series of preliminary actions have been identified as critical to ensure their safe, voluntarily and dignified return and resettlement.

(d) **Based on RPBA findings, the following emerge as key priorities for resource allocation during stabilization and recovery.** Geographically, **i**mpacts are disproportionately concentrated in Borno, where 63 percent of total damages and hosts 67 percent of all IDPs. Within Borno, damages are heavily concentrated in areas of higher concentration of attaches including LGAs around the Sambisa forest, and LGAs closer to the border with Niger, Chad and Cameroon, and in particular those in the vicinity of the Lake Chad. LGAs with the highest concentration of IDPs include Maiduguri, Jerre, Konduga and Biu in Borno, Damaturu, Potsikum and Bade in Yobe, Michica and Yola south and north in Adamawa. Demographically**,** while the entire population in those areas has been affected by the conflict, displaced population and host communities, women (and within this group widows and abductees), unaccompanied children, youth and the elderly were identified as particularly vulnerable populations. With regard to sectoral priorities, social cohesion and peace building were identified as the most critical area for stabilization and recovery, while infrastructure and service delivery is the area in which there is highest financial need.

12. The following matrix summarizes the health priorities as identified by the RPBA:

Table 4. Summary of Health Priorities as Identified by the RPBA

Needs	Indicators for Stabilization and Recovery
Subcomponent 5: Health and Nutrition	
Reconstruction or rehabilitation of PHC facilities	% of PHC facilities reconstructed/ rehabilitated
Reconstruction or rehabilitation of referral facilities (secondary hospitals)	% of secondary hospitals reconstructed/ rehabilitated
Increased availability and utilization of essential services: Deliveries attended by skilled personnel	% of deliveries attended by skilled personnel
Increased availability and utilization of essential services, particularly provided through non-permanent structures: Coverage of DPT3/Penta3	% children of 23 months or below immunized with DPT3/Penta3
Restoration of health system functions	% of facilities with CHEW trained for the essential package of service
Restoration of governance and resilience functions restored	% of LGA with operational Early Warning and Response System
Risk mitigation initiated	% of LGA with budgeted plan for awareness campaigns