1. Introduction

Child survival interventions – in health, nutrition, WASH and HIV prevention and treatment – are key to reducing the extremely high rates of maternal, infant and child mortality in Nigeria. All of these interventions come under Pillar 2 of the UNDAF, equitable access to quality basic services. Integrating them in one programme component will allow space for greater geographic and programmatic convergence of activities over the span of the country programme, especially in the context of the Government's plan to revitalize the primary health care (PHC) system, which will provide renewed impetus to improving child survival. By increasing convergence between these sectors, the programme aims to maximize its impact on child survival by addressing the interrelated underlying causes of child mortality (disease, lack of antenatal care, malnutrition of children and their mothers, poor hygiene practices, etc.) using the PHC centres and community structures such as schools and WASH Committees as entry points, and integrating specific measures for emergency preparedness, response and recovery into each programme. The programme strategies were developed in close consultation with other UN agencies and government counterparts as part of the UNDAF preparation process, in which UNICEF played a leading role, and UNICEF is in fact the lead agency for nutrition and WASH. Because of Nigeria's federal government structure, counterparts exist at the national and state levels. The Federal Ministry of Health plays a key role in all four sectors. In addition, the main partners in health and nutrition are the National Primary Health Care Development Agency (NPHCDA), state Primary Health Care Development Boards and state Ministries of Health. The Ministry of Health implements the major part of the nutrition programme and the Ministry of Budget and Planning is responsible for coordinating the food and nutrition policy and response. For WASH, the main partners are the Ministry of Water Resources, Ministry of Environment and Ministry of Education. For HIV and AIDS, the partners are the National Agency for the Control of AIDS, National AIDS and STD Control Program, and NPHCDA.

In parallel with the development of its programme components, UNICEF has supported and participated in national consultations for the following policy frameworks and strategies, all of which inform the proposed UNICEF programmes: National Strategic Health Development Plan; Revised Integrated Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategic Plan; the Every New Born Action Plan; national comprehensive multi-year plan for immunization; national measles strategic plan; National policy on Food and Nutrition in Nigeria, launched in 2016; Ministry of Health Nutrition Action Plan, 2014-2018 (launched in 2015); the National ODF Road Map; the Partnership for Expanded Water Supply, Sanitation and Hygiene (PEWASH) and the National Water Resources Bill; and the National AIDS Strategic Framework 2017-2022 (under development),

2. Prioritized issues and areas

2.1 Health

Nigeria's rates of maternal, infant and under-five mortality and morbidity are among the highest in the world, with poorer health indicators in the northern states. The MMR is estimated at 576 per 100,000 live births (NDHS, 2013), accounting for some 10 per cent of the global burden of maternal deaths. According to the 2013 NDHS, the IMR and U5MR were 69 and 128 per 1,000 live births, respectively, although 2015 data using the inter-agency model found the U5MR to be 109.1 Within the country, U5MR ranges

http://www.childmortality.org/index.php?r=site/graph#ID=NGA_Nigeria
from 185 per 1,000 live births in north-west Nigeria to 160 in the north-east and 100 for north-central, compared to rates for south-east, south and south-west of 131, 91, and 90 respectively. About 960,000 children under the age of five die each year in Nigeria, second only to India. Some 262,000 of these deaths are estimated to occur in the newborn period, which is the second highest national total globally and about 9 per cent of the total global burden of neonatal mortality. Its high mortality rate and large population size combine to give Nigeria the second largest number of under-five deaths in the world.

The situation analysis found disparities in neonatal, infant and mortality according to wealth quintiles, the education level of mothers and rural/urban residence, with the lowest wealth quintiles, children of less educated mothers and people living in poverty in rural areas experiencing higher rates of mortality. Although progress has been noted over the years in reduction of under-five, infant and neonatal mortality Nigeria did not met the MDG target despite its level of investment. Over a 15-year period, U5MR declined by 31 per cent and IMR by 26 per cent, but neonatal mortality declined by only 20 per cent over the same period, hence the need to scale up high-impact interventions targeting the neonatal period. The rate of mortality reduction for all the three age groups from 2008 to 2013 was not as significant as during the preceding period. This is more notable for newborns, where a mere 3 percentage point decline was recorded.

While a notable downward trend has been observed in the North (East, Central and West) despite known challenges and in South-South, mortality still remains the highest in the North East and North West. Although a good decline was observed from 2003 to 2008 in the South West, performance plateaued in the following period. Of major concern is the South East, where mortality rates increased from 2003 to 2008, followed by a slow decline. The poorest segments of the population continue to bear a higher burden of mortality in all age groups. There are percentage point differences as high as 44 between the poorest and the richest. This disparity is much higher in the under-five population (117 percentage points) than in infants (44) and newborns (15). The higher the mother’s educational attainment, the lower the rate of childhood mortality. This correlation seems to be stronger in children under five (118 percentage point difference between mothers with no education and those with more than secondary education) than infants (39 percentage points) and newborn (17 percentage points).

Coverage has plateaued since 1999 for key life-saving services such as antenatal care, skilled birth attendance, Institutional delivery and contraceptive prevalence while performance sharply declined in childhood immunization before commencing an upward mobility from 2003. All these cost-effective interventions are yet to reach a coverage level that needs to be sustained to significantly contribute to mortality reduction. Full immunization and coverage has not progressed impressively over the years as the rates still stand below 20% according to the latest NDHS. Measles coverage mirrors the same trends, falling below 50 per cent.

There is a notable discrepancy between rural and urban setting across services, whether ANC or immunization as well as a positive correlation between income and immunization coverage. Suboptimal service coverage and disparities in service uptake are very notable in most aspects of newborn care. In general, 34 per cent of pregnant women in Nigeria receive no ANC services, with rates by state ranging from 80 per cent in Sokoto to 0.9 per cent in Imo. Major variations also exist by educational levels (69 per cent for those with no education vs. 1.1 per cent in women who received more than secondary education); income (3.1 per cent in the highest wealth bracket vs. 69.4 per cent in the lowest); and location (11 per cent in urban and 47 per cent in rural areas).

In Nigeria, 63 per cent of deliveries take place at home, with rates ranging between 7.5 per cent in Imo and 94.2 per cent in Sokoto and Zamfara. Nine states (Bauchi, Borno, Jigawa, Kano, Katsina, Kebbi, Sokoto, Yobe and Zamfara) have home delivery rates surpassing 80 per cent. Over 86 per cent of pregnant women deliver at home in all the northwestern states, except Kaduna. Disparities still exist
across residency status (77 per cent in rural vs. 37 per cent in urban areas); income (93 per cent in the lowest wealth bracket vs. 19 per cent in the highest) and educational attainment (88 per cent of women with no education vs. 7 per cent of those with more than secondary education).

Overall, 85 per cent of newborns in Nigeria receive no post-natal check-up, with rates ranging from over 98 per cent in Kebbi and Sokoto to 37.5 per cent in Lagos. Seventeen states record rates in excess of 80 per cent, and in all the north-western states, except Kaduna, the rate is over 93 per cent. Major differences persist depending on the women’s residency status (rural: 91 per cent/urban: 72 per cent); income (96 per cent in the lowest wealth bracket vs. 62.4 per cent in the highest) and educational attainment (94 per cent of women with no education vs. 57 per cent of those with more than secondary education).

Immunization coverage rates have not improved over the country programme period and rates for full EPI coverage still stand below 20 per cent nationally, according to the latest NDHS (2013). measles coverage mirrors the same trends, falling below 50 per cent. Bottlenecks specific to immunization include: poor community sensitization on available routine services with prioritization of immunization campaigns rather than on health system strengthening and provision of commodities for routine services; frequent and prolonged public sector health worker strikes in some states; prolonged periods of non-payment of salaries; inadequate funding and fund disbursement delays; insecurity in the north-eastern states affecting the most marginalized communities; inadequate integration of routine immunization services with broader PHC services; poor community linkage, trust and community engagement, which slows the Reach Every Ward immunization approach; weak demand at community level due to low awareness of benefits of immunization; poor quality of immunization data at LGA and health facility levels; and poor maintenance of cold chain equipment.

Teenage pregnancy is also a major health concern because of its association with higher morbidity and mortality for both the mother and the child. Overall, 23 per cent of women age 15-19 years have begun childbearing (17 per cent have had a child and 5 per cent are pregnant with their first child). A larger proportion of teenagers in rural areas than in urban areas have begun childbearing (32 per cent versus 10 per cent). Teenagers with no education represent about half of those who have begun childbearing, while only 2 per cent of teenagers with more than a secondary education have begun childbearing. Teenagers in the lowest wealth quintile are more than twice as likely to have started childbearing as those in the middle wealth quintile (43 per cent and 21 per cent, respectively) and almost 10 times as likely as those in the highest quintile. With the exception of mothers in the 40-49 age group, infant and perinatal mortality are higher for mothers under age 20 than for older mothers. (NDHS 2013). Teenage pregnancy has its clear gender component as related to adolescent girls. Gender inequality factors pertaining to health, such as girl child marriage, are to be addressed through a convergence approach.

The PHC system has not functioned well for decades. One important factor is that this proven cost-effective approach was not captured in the National Health Policy and thus did not receive the needed institutional backing to have it prioritized. To accelerate progress towards the MDGs, because Nigeria’s trends revealed slow progress towards the MDG targets, an MNCH week strategy was adopted in 2009 to provide an integrated package of impact interventions using a campaign mode. In 2016, following six years of implementing this approach, an independent evaluation found that the ‘MNCH week’ approach had limitations as there was no practical mechanism for funding the strategy at different levels, making it difficult to attain its objectives and hence unsustainable.

A stakeholder bottleneck analysis undertaken as part of the situation analysis identified a series of bottlenecks in PHC delivery, some of which are the lack of necessary commodities and equipment and of skilled and motivated human resources; problems of access in remote areas, including lack of delivery points and a referral system; the cost and perceived poor quality of services; lack of awareness of the availability of services; and inadequate community mobilization. In response, the Government has
launched the 'One PHC per Ward' strategy, which aims to revitalize primary health care through the establishment or rehabilitation of up to 10,000 PHC centres one in each administrative ward. Getting buy-in and commitment of state governors is critical as funding for state activities is solely at the discretion of the governors. Improved allocations and managed efficiencies will significantly reduce gaps.

UNICEF Nigeria has been a key actor in repositioning PHC revitalization through high-level advocacy and technical assistance to the Federal Ministry of Health, the National Assembly and the NPHCDA. The country office has expertise and experience in integrated (health, nutrition and HIV) service delivery at the decentralized level in development and humanitarian emergency situations. With political will and commitment, results can be achieved. Nigeria has demonstrated its ability to achieve its objectives through funding of its routine immunization vaccines, swiftly responded to Ebola and made tremendous progress in polio eradication. Spreading UNICEF’s support thin across several states for the sake of presence is a strategy that needs to be revisited in light of limited resources.

Nigeria continues to be affected by major security concerns such as the Boko Haram insurgency in the north-east, militancy in the south and inter-community clashes in the north central region. This insecurity is compounded by seasonal outbreaks of vaccine-preventable and water-borne diseases with a potential to spread rapidly owing to low herd immunity and non-functional basic health care services. While the Ministry of Health pursues its collaboration with armed forces and civilian joint task forces to secure access for service delivery in the north-east, UNICEF will continue to advocate on rights and protection in humanitarian settings; promote and support peacebuilding initiatives; and use diverse and innovative tactical approaches that have proven effective in polio eradication efforts in delivering services in security-compromised areas.

After two years of no polio cases in Nigeria, late in 2016 four cases were confirmed in Borno state, putting Nigeria back on the list of endemic countries and elevating polio even higher on the national agenda. The most recent case in Borno has a close genetic match with a case in Borno in 2011, indicating it has been transmitting somewhere (either in Nigeria or neighbouring countries) undetected since outbreak. UNICEF and partners responded with a major immunization campaign in the Lake Chad Basin area to vaccinate over 41 million children against polio to contain the outbreak. Nearly 39,000 health workers were deployed across Nigeria and neighbouring Chad, Niger, Cameroon and the Central African Republic to deliver oral polio vaccine in areas at high-risk for the virus during five rounds of coordinated vaccination campaigns across the five countries.

Delivery of an integrated package of services proved to be an effective strategy in addressing rejections and non-compliance to polio immunization and in increasing coverage of crucial unmet needs for basic services using health camps and the hard-to-reach strategies. The extensive polio communication network through the Voluntary Community Mobilizer (VCM) platform helped to build trust in communities for interventions beyond polio immunization, creating a link with routine immunization and other health service delivery. Overall high awareness and acceptance of polio vaccination in most areas of Nigeria. However, trust and confidence in the programme, as measured by Harvard Polling Data (HPD) fell in almost all states between 2014 and 2015, emphasizing the fragility of caregiver confidence and the importance of maintaining strategies in high-risk areas.

Inaccessible children in Borno State (approx. 600,000- 800,000) pose the greatest threat to stopping polio in Nigeria. The programme must continue to focus on gaining access and building trust with affected populations including internally displaced persons (IDPs) who have fled these areas. There are significant differences between perceptions of the polio programme in Borno as compared to the rest of the country.

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with lower intent to vaccinate and people more likely to hear and believe destructive rumors. Rates of refusal and child absence even in accessible areas of Borno and Yobe are the highest in country, but there is also a need to monitor closely refusals in Sokoto, Kano and Kaduna.

In 2016, the VCM network vaccinated nearly 2 million children during naming ceremonies and tracked more than 500,000 newborns, of which 94 per cent were vaccinated with OPV, proving to be a channel of trust. The VCM network contributed to higher supplemental and routine immunization coverage in areas where the network was established. Populations demonstrate a high perception of the polio threat despite very localized transmission, however there are significant knowledge gaps linked to symptoms and overall there is diminishing intent to vaccinate children with polio vaccine every time it is offered. Political commitment is increasingly hard to maintain. Release of funds/oversight, particularly at LGA level, is waning and needs to be rapidly boosted to maintain quality. Traditional leaders remain active and committed, partnering with agencies to facilitate access to children in security-compromised and other high-risk areas. The media environment remains supportive with opportunities to refocus some long-running partnerships to Borno and neighbouring north-eastern states.

**Remaining challenges for polio elimination: inaccessible areas**

Accessing children for vaccination is a challenge in security-compromised and hard-to-reach LGAs and settlements in north-east Nigeria. In Borno State, many children eligible for polio vaccination live in settlements that are inaccessible due to ongoing insecurity. Children in these areas lack access to health and immunization information and services and therefore face an increased risk of contracting and transmitting wild polio virus. To date, all four cases of wild polio virus detected in Borno in 2016 came from or were directly linked to populations from inaccessible areas. Reaching the estimated 600,000 to 800,000 children still living in inaccessible areas of Borno is the single greatest threat to the success of polio eradication in Nigeria and Africa. As more populations become accessible to the programme, it is vital that the programme be ready with communication strategies, tools and approaches to rapidly sensitize and build trust with these communities to facilitate immediate, repeated vaccination.

**2.1 Nutrition**

Malnutrition is a direct cause or underlying factor in 54 per cent of all under 5 deaths in Nigeria. Yet nutrition is not only critical for the survival of young children, but also for their optimal physical and cognitive development. The effects of chronic malnutrition in the first years of life are largely irreversible, resulting in the major loss of human capital. African countries lose an estimated 11 per cent of GDP annually to malnutrition, highlighting that the effects go well beyond the individual, impacting communities and national development.

Recent analysis for Nigeria shows a marginal decline in child malnutrition between 1990 and 2015, for all three core indicators: stunting, underweight and global acute malnutrition. Nigeria was close to meeting MDG target 1 (C) – to halve the proportion of people who suffer from hunger between 1990 and 2015 – with the prevalence of underweight falling from 35.1 to 17.6 per cent during this time. Nevertheless, despite progress over the past 25 years, malnutrition remains a major issue within Nigeria. Globally
Nigeria has the second highest burden of stunted children, behind only India. The national prevalence of stunting remains at 33 per cent (NNHS 2015). This equates to 11 million Nigeria children under age five years who are not reaching their full physical and cognitive potential. Furthermore, an estimated 2.5 million children suffer from severe acute malnutrition and are in need of immediate life-saving treatment; about half a million of them will likely die if not treated. Micronutrient deficiencies in women of reproductive age and young children are also pervasive – particularly vitamin A, zinc, iron, folic acid and iodine deficiencies – which contribute significantly to the high levels of maternal and child morbidity and mortality. Iron deficiency accounts for 20 per cent of the estimated 536,000 maternal deaths in Nigeria (NSSPAN, 2014-2019); in economic terms, Nigeria loses over $1.5 billion in GDP every year to micronutrient deficiency alone.

Children are at greatest risk of malnutrition during their first 1,000 days, a period spanning from conception to a child’s second birthday. Day 1 of the 1,000 plays a significant role for the development of the fetus and the future nutritional status of the child. In Nigeria 7 per cent of women of childbearing age are suffering from acute malnutrition with almost 4 per cent being severely malnourished (NNHS 2015). The prevalence of acute malnutrition among adolescent women (15-19 years) is more than 4 time that of older women (20-49 years) at 20% and 5% respectively. Other maternal factors contribute significantly to child malnutrition. In Nigeria, 18 per cent of women are married before age 15 and 40 per cent were married before age 18. In several of the northern states where malnutrition is common, more than 40 per cent of the girls are married by the age 15. About 19 per cent of Nigerian women age 15–19 have begun childbearing. About one in three women (31 per cent) aged 15-19 in North West have had a live birth. At this age, the body is not fully grown and the pregnant girl is at a high risk of complication and the child of being born with low birth weight. Given the importance of maternal nutrition – both pre-conception and during pregnancy – and the current estimated high levels of malnutrition seen in women, it is not surprising that around 10 per cent of neonates in Nigeria are born malnourished.

Large disparities in both the prevalence and the burden of malnutrition exist between the 37 states. States in the north-east and north-west geopolitical zones have higher burdens of both chronic and acute malnutrition among children under five and women of reproductive age compared to South East, South South and South West. The prevalence of stunting in children ranges from 63 per cent in Jigawa (north-west) to 9 per cent in Anambra (south-east). Of the 2.5 million children estimated to have SAM, 89 per cent reside in just 12 northern states. It is important to also recognize that even in states where the prevalence of nutrition indices is better than the national average, the burden of malnutrition can be very high due to the large population sizes. The National Food and Nutrition Policy approved by the Federal Government (2016) is aligned with the SDG and WHA targets. Overall, currently the Annual Average Rate of Reduction (AARR) in stunting rate for Nigeria is at 3.1% and with this trend Nigeria will reduce the prevalence to 23.2%. However, to achieve the WHA target by 2025 the AARR needs to be increased from the current 3.1% to 5.5% through, a significant scale up the implementation of nutrition interventions (both sensitive and direct) in the country is required.

Complementary feeding is also a major concern in Nigeria. Only 37 per cent of children aged 6-23 months consume the minimum dietary diversity, a figure which falls to 16 per cent in those aged 6-11 months. The minimum acceptable diet is a composite indicator that combines both meal frequency and dietary diversity to give an overall score of a child’s dietary intake. Nationally only 10 per cent of children 6-23 months receive a minimum acceptable diet. This figure is only 5.8 per cent for children aged 6-8 months (NDHS 2013). The NDHS 2013 showed that the most vulnerable groups not receiving this minimum acceptable diet are children of mothers from Ogun (0 per cent) and Zamfara (1 per cent), from the lowest wealth quintile (6 per cent) and those of mothers with no education (7 per cent).

There are a number of proximal and distal determinants of malnutrition. Direct causes such as food security and feeding and caring practices are also influences by the underlying factors including resource availability and the political, social and economic context. The availability of, and access to a diverse,
nutrient-rich diet is a distant reality for many Nigerians. Access to quality health services also remains a major issue. These factors are not mutually exclusive, as malnutrition and infectious disease share an intricate relationship. Malnourished children are at greater risk of contracting infectious diseases, and in turn those with infectious diseases are at greater risk of malnutrition. Without access to both good nutrition and quality health services children will continue to be at greater risk of death and illness.

Knowledge, cultural beliefs and attitudes around child feeding practices are significant factors in the etiology of malnutrition. Nationally, exclusive breastfeeding is practiced by fewer than 20 per cent of mothers and the median duration of breastfeeding for babies under six months of age is 1.8 months. Infants with the shortest duration of exclusive breastfeeding are those with mothers from the lowest wealth quintile (median duration 0.4 months), from the north-west (0.4 months), north-central and north-east zones (0.5 months), and those with no education (0.4 months) (NDHS 2013). Nationally, 59 per cent of neonates receive pre-lacteal feeds, the most common consumed feeds being plain water and water with herbs. This practice is most common in Sokoto, Yobe and Bauchi State, with rates of 91, 89 and 88 per cent, while in Ekiti State only 15 per cent of neonates are exposed to this practice.

Malnutrition cannot be viewed outside of the wider social context; it is both a consequence and a cause of poverty. The poorest and most vulnerable are disproportionately affected and bear the majority of malnutrition’s negative consequences. A women living in a low socioeconomic status household is at greater risk of poorer nutritional status, and as a result her children also have greater risk of being malnourished, which can impact their physical and cognitive development. This creates a vicious cycle that is embedded in poverty. The prevalence of stunting among the poorest Nigerian children is 54 per cent, three times higher than among the wealthiest quintile (18 per cent) (NDHS 2013). However, even in the wealthiest quintile, nearly one in five children are stunted, and almost 50 per cent of the poorest mothers do not have a stunted child, which suggests that while economic status has a major role to play in malnutrition, there are other important factors to also consider.

Other key determinates include poor WASH, early marriage and early age of pregnancy, which can result in low birth weight and short birth spacing. Sociocultural factors are also very important, including maternal educational and access to adequate water and sanitation facilities.

The situation analysis identified four major behaviours that contribute to the high levels of malnutrition, especially in the north: (1) drinking water and other fluids during the first six months instead of exclusive breastfeeding; (2) meals, especially for young children, with inadequate nutrients, often heavily starch based; (3) not enough meals and/or snacks, inadequate quantity of food intake especially by the youngest children; and (4) inadequate use of clean water and sanitation and inadequate washing hands before preparing foods and feeding/eating.

The current political, economic and cultural context in Nigeria presents a number of risks for nutrition. The humanitarian crisis in the north-east continuous to require the mobilization of significant resources to deliver lifesaving interventions. Communities in many areas have been unable to farm for significant periods, and the large scale need for food and nutrition assistance will remain for the foreseeable future. Throughout Nigeria, climate change also represents a significant risk. Rains are becoming less predictable and droughts more frequent. This has implications for crop yields which in turn influences the availability and costs of food items. Climate change, availability of resources and internal conflict can all results in the mass movement of people, as recently witnessed in the north-east emergency. The mass movement of people poses a number of issues for nutrition as it can place strain on resources—food, availability of health services, adequacy of water and sanitation infrastructure—and thus it is important to provide adequate support in communities under strain, and mitigate against the risks where mass migration occurs.
UNICEF led the introduction and successful implementation of treatment for severe acute malnutrition in children 6-59 months into PHC. This included development of national treatment guidelines for outpatient and inpatient which were adopted by 12 states, resulting in 1.1 million children being treated (as of December 2016), which translates to 210,000 lives saved. In addition, the programme was able to leverage government resources from three states (Bauchi, Gombe and Kaduna) for procurement of therapeutic supplies, and other states contributed to logistics costs for distribution of therapeutic supplies as well as routine drugs for the treatment of underlying causes.

UNICEF has also championed the development of key strategies to promote, protect and support recommended infant and young child feeding practices. In 2016, UNICEF supported the federal Ministry of Health and partners to develop a National Strategy for Infant and Young Child Feeding in Nigeria. The overall goal of the 2016 National Strategy on Infant and Young Child Feeding in Nigeria is to ensure the optimal growth, protection and development of the Nigerian child from birth to the first five years of life. However, limited resources and commitment for IYCF intervention has resulted into very low (20%) coverage of the intervention.

Deficiencies of essential micronutrients (such as vitamin A, iron, folate, zinc and iodine) continue to be widespread with significant adverse effects on child survival, growth and development, as well as on women’s health and well-being. Coverage for Vitamin A supplementation remains low in Nigeria at 41% (NNHS 2015). Though there is limited data on current status of micronutrient deficiency in Nigeria, the NSPAN reported about 63% of women are anaemic; 30% and 20% of children under five years with Vitamin A and iodine deficiencies respectively. The coverage and utilization of zinc, Iron/folate and deworming are also low. The NNHS 2015 results showed very poor quality of complementary foods – dietary diversity, minimum meal frequency and minimum acceptable diet. A FACT survey conducted in 2016 also showed low availability of fortified foods at household level. This further puts Nigerian children at a higher risk of micronutrients deficiencies. Preventing and treating micronutrient deficiency is recognized by the Government of Nigeria because of the significant role it plays in child survival. As such, seven out of the ten prioritized interventions of the National Strategic Plan of Action for Nutrition for Nigeria relates to micronutrient deficiency control. Currently, provision of Vitamin A, Iron/Folate and Zinc supplies are donor driven, and largely through UNICEF. This makes the commodities limited in only few states and local government areas where donor interventions are being implemented. Apart from Vitamin A supplementation that has a visible history as an ongoing intervention; there is limited government capacity at the state and LGA levels to implement other micronutrient interventions – notably, Micronutrient powder (MNP), zinc/Lo-ORS and iron folate supplementation. In 2015, UNICEF introduce MNP in Nigeria as a pilot and as at 2016 only 130,000 children out of an eligible 11 million children received MNP. Even though some Northern Nigeria States started committing some limited resources in health, micronutrient supplies are the least considered in such decisions, thus further limiting the availability of such commodities. Only 21% of the poorest and 34% of those in rural areas received Vitamin A supplementation, raising inequity as an issue in Vitamin A supplementation delivery. There is currently no iron/anaemia intervention targeting adolescents/first mothers as a group despite the average age of first pregnancy being 17 years. The current health system in Nigeria is not robust enough to deliver micronutrients; the main channel for delivering iron and other micronutrients is through the biannual Maternal, Newborn and Child Health Week (MNCHW). The Federal Ministry of Health in 2016 started to revitalize primary health care centers across the country in phased approach. Until the PHCs are strengthened there is constraint to increase coverage of micronutrient delivery through the routine health system.

As routine health service delivery and uptake in Nigeria remain weak the Government initiated the Maternal New-born and Child Health Week (MNCHW) programme in 2010. Since the inception of MNCHW in 2010, interventions delivered through this platform has increased to provide health and nutrition interventions including Tetanus Toxoid vaccine, Penta and Oral Polio vaccines to children to
pregnant women and birth registered HIV counselling. Since its inception cumulatively, 246 million dosages of vitamin A supplementation 83 million dosages of deworming and 32 million iron-folic acid supplements have been given through MNCH week.

The performance of MNCH week seems to have stagnated in recent years. There is concern that the most vulnerable children with the largest capacity benefit are amongst the 53% of children not being reached. Analysis from Demographic and Health Surveys (DHS) 2008 and 2013 showed that there is a lot of disparities in vitamin A supplementation coverage in the North-West region – the region with the highest prevalence of poverty – was only 26%, compared with 65% in the South-South region, where the prevalence of household poverty is 65 percentage points lower. While Nigeria has experienced some success in increasing Vitamin A coverage, between 2008 and 2013 the equity gains have been regressive, resulting in greater inequity with children from the vulnerable poorest families not experiencing the gains of wealthier families. Since 2013 limited attention has been given to addressing inequities in the reach of the program and therefore it is expected that as of 2016 the situation is still similar. UNICEF has supported the government developing a costing tool for advocacy for equity-based financing leveraging government resources and facilitate budgeting and costing for MNCH weeks across the country.

A number of key lessons have been learned during the current country programme. The need for a multisectoral approach to nutrition including integration of nutrition interventions into the PHC system and multisectoral coordination beyond the health sector such as WASH stood out as key areas for improvement. While the renewed government commitment to the PHC system provides an opportunity for strengthening nutrition-specific interventions within the health system, the approval of the Food and Nutrition Policy by the Federal Government laid a foundation for strengthening an enabling policy environment for a multisectoral coherence of policies for nutrition-sensitive interventions in the country.

As discussed above, malnutrition and infectious disease are closely linked, and to have the maximum impact on a child’s health and development it is imperative to address both simultaneously. Now that there is a proven package of high-impact interventions and proven approaches for scaling them up, it is imperative to mobilize the resources required to take these interventions to greater scale. The availability of data for evidence-based planning and programming has been greatly enhanced in recent years. To further ensure the collection and utilization of data, it will be important to integrate core nutrition data into the HMIS and ensure that this data is owned by the relevant stakeholders at all levels. Clear lines of accountability are key to the successful coordination of programming planning and implementation. The importance of strengthening government capacities to lead the nutrition response has also been clearly shown, including raising the profile of nutrition in Nigeria beyond the nutrition community.

While UNICEF is still considered a trusted partner by donors for service delivery, this must be balanced with having greater focus on upstream policy activities to strengthen the enabling environment for overall nutrition interventions and programming. Though there is no trend analysis on obesity in children, there has been growing concern in childhood obesity and its implication in adulthood by the Government, especially with the growing urbanization of Nigeria. As a consequent, the two main policy documents for nutrition: the National Policy on Food and Nutrition, and the Health Sector Strategic Plan of Action for Nutrition made policy and strategic intent to address obesity and aligned with the WHA target.

UNICEF’s comparative advantage continues to be its experience, expertise and leadership as the main development partner supporting the Government in its nutrition response. As a significant voice for nutrition in Nigeria, UNICEF uses its unique relationship with Government keep nutrition on the political agenda and work for greater government ownership and accountability for the programme.

2.3 WASH

Between 1990 and 2015, 82 million people gained access to water and another 16 million to improved sanitation, but progress in access to water and sanitation has not kept pace with the burgeoning
population. As a result, as of 2015, 57 million Nigerians were without access to improved water sources and another 130 million people without access to improved sanitation.

There are huge gaps in access to improved water sources and improved sanitation with wide disparities between urban and rural areas and across the wealth quintiles (NDHS 2013). People in rural areas are about 1.5 times less likely to have access to safe water and improved sanitation than those in urban areas. The disparities are higher in relation to wealth quintiles, with the poorest 36 (MICS 2011) times more likely to defecate in the open than their richest counterparts.

Twenty-nine per cent \(^3\) of Nigerians use improved sanitation, above the sub-Saharan average of 30 per cent but significantly lower than the global average of 68 per cent. Open defecation practices are common across the country, with an estimated 25 per cent of Nigerians having to do this on a daily basis. The rate of open defecation is three times higher in rural areas and the disparity between urban and rural areas has not changed much in over four years. Other important disparities are between area of residence and between rich and poor.

Nigeria ranks among the top three countries globally for having large numbers of people without access to safe water, improved sanitation and practicing open defecation. Between 1995 and 2010, Nigeria’s progress has been even lower than the regional average for sub-Saharan Africa in both water and sanitation.\(^4\) Among countries with similar populations and GDP per capita, Nigeria fares poorly on the sanitation front. Poor access to WASH is directly linked to incidences of diarrhoea and this is clearly reflected in Nigeria's high child mortality rates.

Nigeria is subject to climate-related emergencies. The unprecedented floods in 2012 affected over 2.1 million people across the country and exposed weaknesses in the country's response capacity. This led to the establishment of a National Emergency WASH sector Working Group with UNICEF as co-lead. There was a resurgence of cholera in 2014 and 2015, resulting in nearly 42,000 cases and 943 deaths and continued in 2016.

The conflict in the north-east led to a significant number of IDPs in the country (over 3.6 million in need of WASH assistance)\(^5\) in 2017. UNICEF is working closely with the national and subnational emergency WASH working groups to support emergency response and cholera prevention activities. Thirty-seven per cent of IDPs in camps have WASH facilities that are below standards. Only 23 and 9 per cent of IDPs in host communities have access to water and sanitation respectively, and 75 per cent of the WASH infrastructure has been destroyed in affected LGAs.

Progress in the water and sanitation sector is undermined by a number of factors hinging on the political and economic context, institutional arrangements, capacity deficiencies and ecological/behavioural factors. Key issues hampering the WASH sector can be categorized into six broad areas that cuts across policies/plans; institutional capacities and arrangements at national/sub-national level; lack of reliable data; low investments in the sector; poor operation & maintenance regime and lack of mechanisms to harness domestic resources/private funding.

The WASH Bottleneck Analysis conducted in late 2014 for the national rural water and sanitation subsector identified the following as the major barriers hindering access to water and sanitation in rural areas: inadequate legal and policy frameworks; inadequacy of budgets and expenditures; a poor equity

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\(^3\) 2016, WHO-UNICEF JMP report – A snapshot of Drinking Water and Sanitation in the sub-Saharan Africa region


focus in legal, policy and budget frameworks; weak investment planning; and low private sector involvement.

The focus during the MDG period was the provision of infrastructure without making adequate provisions for operation and maintenance, resulting in a large number of facilities in a state of disrepair. A 2014 survey revealed that only 37 per cent of solar powered motorized boreholes were functioning at any time. The situation may not have improved significantly since then and represents huge losses for the water sector. Ensuring the functionality of existing water sources will be critical to achieving SDG 6.1. Other weak areas are the lack of adequate community engagement coupled with an underdeveloped supply chain for fast moving consumables and spare parts. Water quality monitoring and surveillance have been neglected due to lack of investment in the area. Water safety planning was introduced under the UNICEF programme of cooperation and there is good potential for scale-up in the coming years.

Poor data management accounts largely for the low funding to the sector. A systematic data gathering and reporting mechanism is still evolving, with some states having moved forward in implementing a WASH Information Management System (WASHIMS) in 107 LGAs. Lack of sector capacity for planning, design, implementation, monitoring and reporting is also a major gap. Poor sector funding vis-à-vis the needs coupled with weak financial management systems mean that even the low resources allocated to the sector is not put into optimal use. Another largely untapped area is with regard to poor tariff/ cost-recovery mechanisms and harnessing of domestic financing for the sector including from the private sector.

Citizen participation in planning and budget formulation has been lacking in the sector due to poor awareness on the part of citizens and duty bearers of their human rights to water and sanitation, and a lack of active CSOs pressing for inclusion of water and sanitation in policy and constitutional reforms. Mechanisms for promoting citizen voice and accountability are grossly lacking in the sector.

Although the 2000 National Water Supply and Sanitation Policy is already overdue for a review, it remains the policy document around which the Government plans its programmes and partnerships. The strategies adopted in the sector are drawn largely from the National Policy. The policy upholds a demand-responsive approach in service delivery and funding of water and sanitation programmes in the rural areas is based on cost-sharing between the communities, local and state governments and the Federal Government. The policy recommends appropriate tariffs for urban water supply services as an economic good while considering its social nature and the need for pro-poor initiatives.

The Community Led Total Sanitation (CLTS) approach is helping accelerate access to sanitation in the country. The number of reported Open Defecation Free (ODF) communities has expanded from just about 15 in 2008 to over 16,000.

The organization of the Presidential Summit on Water in February 2013 and the participation of the Ministers of Finance and of Water Resources at the Sanitation and Water for All High-Level Meetings in 2012 and 2014 is a testimony to increased commitment to the WASH sector. The recent launch (in November 2016) of the Partnership for Expanded WASH (PEWASH) program by the Vice President further consolidates this high level commitment. PEWASH aims at achieving 100 per cent access to basic water and basic sanitation in rural areas by 2030. In the same month, the National Roadmap for elimination of open defecation in Nigeria by 2025 was launched by the Minister of Water Resources. The draft National Water Resource Bill has been approved.

UNICEF has a strong comparative advantage in the WASH sector, and co-chairs the WASH Sector Development Partner’s Group with the African Development Bank. Its strong credibility with federal and state governments and donors positions UNICEF to be an influencer in WASH for children, based on its extensive footprint in the country (over 35,000 communities in 120 LGAs in 22 states), which allows opportunities to engage with communities to address other child survival issues.
2.4 HIV/AIDS

Nigeria has the world’s second highest HIV burden; 3 per cent of the adult population is HIV positive and an estimated 3.4 million Nigerians are living with HIV. The epidemic is heterogeneous in nature with 70 per cent of all HIV infections occurring in 12 states, which have HIV prevalence rates ranging between 3 and 13 per cent. About 10 per cent of all new infections are due to mother-to-child transmission. An estimated 300,000 children are currently living with HIV, of whom more than 90 per cent were infected through mother-to-child transmission. Prevention of mother-to-child transmission (PMTCT) programmes have evolved from a few pilot sites in 2002 to a scaled-up programme with 6,533 sites by 2014, including tertiary, secondary and primary health facilities as well as outreach services to rural communities. As a result, the number of pregnant women tested and who know their results has increased from 300,100 in 2006 to 2,747,093 in 2015. The number of pregnant women living with HIV receiving PMTCT services also continues to increase, with an estimated 53,677 women receiving such interventions in 2015. Despite this progress, population level coverage remains low and much still needs to be done to achieve elimination of mother-to-child transmission of HIV in Nigeria by 2020.

The number of children living with HIV who are receiving treatment remains sub-optimal with coverage of anti-retroviral therapy for eligible children currently estimated at 20 per cent. This low coverage is attributable to ongoing mother-to-child transmission due to low uptake of PMTCT services, and a weak programme for the early diagnosis of HIV in infancy. Paediatric HIV services are available at tertiary and secondary level health facilities with very limited services in selected primary health centres. This limits access to life-saving services particularly to women and children in the rural areas.

HIV incidence is relatively high among young people aged 15 to 24 years old, especially among young women. As of 2014, there were approximately 382,000 children below the age of 15 years living with HIV in Nigeria with an estimated 47,366 new infections and 28,664 HIV/AIDS-related deaths. An estimated 160,000 adolescents aged 10-19 years are living with HIV. In 2013, there were an estimated 17,000 new infections and 11,000 AIDS related-deaths among adolescents. Reported drivers of the epidemic in adolescents and young people include multiple and concurrent sexual partnerships, intergenerational sex, sexual coercion, low risk perception and transactional sex. Gender inequalities, gender-based violence, poverty, unemployment/underemployment, stigma and discrimination further increase the vulnerability of adolescents and young people. Substance abuse may also increase HIV acquisition either directly such as through sharing of contaminated needles, or indirectly due to sexual risk taking resulting from drug associated to loss of inhibition.

In the national programmatic response to HIV and AIDS, there are a number of interventions specifically designed and developed for the HIV prevention, care and treatment in children and adolescents. However, population-level coverage of these services remains low. Currently, only 42,000 of an estimated 250,000 eligible children are receiving ART, translating to 18 per cent treatment coverage. Similarly, only 21.8 per cent of adolescents and young people have comprehensive HIV knowledge and HIV testing rates are still low at 12.7 per cent. A key focus of the HIV program is therefore to expand coverage and uptake of services for the prevention, care and treatment of HIV in children and adolescents.

The following bottlenecks have been identified based on reports from the National AIDS and STD Control Program (NASCP) and the National Agency for the Control of AIDS (NACA), state-level bottleneck analysis and consultations with key partners and stakeholders:

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6 All data in are from ANC SENTINEL SURVEY (FMoH 2014) and UNAIDS 2014 HIV and AIDS estimates (July 2015), as cited in Situation Analysis.
• Inadequate government funding of the HIV response;
• Weak coordination systems at federal and state level;
• Inadequate decentralization and integration of services;
• Poor estimates of the HIV burden (particularly at subnational level);
• Weak structures for commodity procurement and management;
• Social norms that constitute barriers for demand and utilization of services by adolescents and young people;
• Inadequate platforms and models for delivery of adolescent-friendly services;
• Inadequate capacity and platforms and models for adolescent participation;
• The need for a better response to HIV in emergencies (continuity of services, prevention and psychosocial care and support; entry point for adolescent engagement and life-skills)

The main lessons learned are that advocacy for domestic financing of the response, including engagement of the private sector and the use of innovative financing approaches, remains a key issue to ensuring long-term sustainability of the response, and that galvanizing leadership at all levels is an important strategy for achieving sustainable results. System and capacity strengthening across the continuum from the community to the facility and policy levels are critical. Integration of HIV services within other key sectors remain crucial to successful delivery of interventions. A key opportunity is the government initiative to revitalize PHC through the One PHC per Ward initiative. Finally, the use of state-level data has the potential to better focus the response to high-burden regions and achieve greater impact.

As one of the UNAIDS cosponsors, UNICEF has a specific comparative advantage in evidence-informed advocacy; convening and partnership building to achieve results for children; technical leadership in PMTCT, paediatric HIV and adolescent HIV programming, and innovations and knowledge generation to strengthen the response for children. Other development partners (United States PEPFAR, EU) provide support for programme implementation and technical assistance.

3. Theory of change

3.1 Health

The proposed outcome for health is that children, adolescents and women have equitable access to and use improved, quality, high-impact maternal, newborn and child health interventions and adopt healthy life practices.

The focus of the UNICEF programme will be on supporting the Government, at federal and state levels, to:

• Implement the ‘One PHC Centre per ward’ approach in 10,000 priority wards as a strategy for achieving universal health coverage.
• Continue the focus on polio eradication within a context of polio end game strategy;
• Strengthen routine immunization, including vaccine security nationwide and contribute to other accelerated disease control strategies, including measles elimination.

The programme will have six outputs, one on strengthening the enabling environment, four on strengthening national capacities for specific health interventions and one on emergency preparedness, response and recovery.

In order to inform prioritization and geographic focus and maximize efficiency with available resources, the country office will conduct an in-depth, child rights-focused statistical analysis with the aim of
assessing, documenting and further understanding inequities across Nigeria using selected child health/rights indicators. This would enable a sound aggregation of performance across multiple indicators and ranking for identification of identify areas with multiple deprivations and vulnerability in children and women.

Output 1. Strengthened political commitment, accountability and national capacity to legislate, plan and budget for scaling up of health interventions

UNICEF has been instrumental in putting PHC revitalization high on the national agenda as a priority intervention for achieving universal health coverage in Nigeria. This involved influencing the inclusion of PHC in the National Health Policy, developing the concept and rationale, costing the approach, advocating with Parliaments, Ministry of Health and NPHCDA, supporting public hearings on funding and engaging with state governors and health authorities in implementing the ‘Primary Health Care under One Roof’ (PHCUOR) approach. Another priority will be the dissemination and implementation at state level of the Nigeria National Every Newborn Action Plan.

Going forward, evidence-based policy dialogue and advocacy will continue, centred on supporting the roll out of the ‘One PHC per ward’ as an overarching approach. The PHCUOR bill will be signed into law and gazetted in 16 states, the National Health Act will be implemented and key MNCH policies will be adopted and implemented at the state and LGA levels. The country office will also continue to foster partnerships and coordinated efforts not only in the emergency response to epidemics and in disaster-prone areas, but also to address the weak institutional capacity for emergency preparedness and response and disaster risk reduction.

UNICEF will advocate with Government for increased funding and provide technical and capacity-building support for planning, budgeting and budget tracking/accountability. In particular, UNICEF will support the Government in finding ways to sustaining immunization financing given the expected transition from GAVI support. Specifically, UNICEF will work with CSO and other key partners to advocate for increased budgetary allocation for vaccine procurement and support local vaccine production that will hope to reduce costs for the government and sustain immunization financing.

UNICEF will provide technical and capacity-building support to improve the quality of data collection and reporting at the operational level, from facility to state to federal level, and to use improved data for planning and budgeting purposes.

Support for strengthening accountability for results will involve mapping and tracking of disparities and growing citizen engagement through the use of U-report.

Output 2. Increased national capacity to provide access to essential high-impact maternal and newborn health interventions.

Output 3. Increased national capacity to provide access to essential high-impact child health interventions.

These two outputs centre on the revitalization of PHC for quality integrated material, newborn and child service delivery, including in emergency situations, through implementation of the Government’s ‘One PHC centre per ward’ strategy. UNICEF will support direct implementation in eight states (Kebbi, Adamawa and Bauchi with funding from the EU and Ondo, Rivers, Enugu, Katsina and Kaduna with funding from other sources).
The vision for change is that there will be a functional PHC centre in each of the approximately 10,000 administrative wards in Nigeria, with the capacity to deliver 24/7 the Ward Minimum Health Care Package consisting of the following health interventions:

- Control of Communicable Diseases (Malaria, STI/HIV/AIDS, TB);
- Child survival; Maternal and Newborn Care;
- Nutrition;
- Non Communicable Disease Prevention; and
- Health Education and Community Mobilization.

The conditions for this change are implementation of the scorecard for PHC Under One Roof (PHCUOR), an accountability and advocacy tool to assess nine programmatic and managerial dimensions of the approach; continued release of budgetary allocation by the states and LGAs; implementation of the National Health Act at all levels; firm commitments by the Government and project partners to deliver MNCH services; functioning implementing partners in the focal states; adequate LGA capacities to improve the performance of health services; and a strengthened Health Information Management System.

To achieve these ends, the main bottlenecks affecting maternal, newborn and child health at all levels have to be addressed:

- Poor health seeking behaviour, harmful traditional practices misconceptions, about MNCH care and commodities, use of traditional birth attendants rather than trained midwives in health facilities for deliveries;
- The need for improved coordination among the three tiers of government (Federal, state and LGA) and for convergence around integrated PHC service delivery;
- Availability of necessary commodities and equipment;
- Availability of skilled and motivated human resources;
- Difficulties in outreach to remote settlements and the need for a strengthened referral system;
- Removal of financial and geographic barriers to access;
- To improve the quality of services, adherence to SOPs and job aids related to MNCH, and effective monitoring systems.
- Promotion of and use of innovation.

UNICEF will contribute through the following strategies:

**Integration and cross-sectoral linkages.** Given the lack of progress in newborn mortality reduction, the country office will continue to support the Government in scaling up the high-impact facility-and community-based interventions outlined in the Nigeria Every Newborn Action Plan, and strengthen institutional capacities within the context of PHC revitalization. This will be anchored in the recently-revised strategic plans for reproductive, maternal, newborn, child and adolescent health.

With support from UNICEF, Nigeria revised the integrated maternal, newborn and child health strategic plan to include adolescents and nutrition. This aimed to do away with the silo approach and implement an overarching plan along the continuum of care. Being multisectoral by design, the EU-supported project provides a platform for integrating implantation between different functional sections of the country office in convergence areas. The country office will strive to improve coordination and integration during implementation of phase 2 of this multisectoral initiative to support PHC revitalization, based on lessons learned to date. Efforts will be pursued to ensure the delivery of an integrated package of services in emergency settings, linking interventions with proven disaster risk reduction approaches.
Capacity building. The roll-out of PHCUOR has been slow in most states. In collaboration with other partners, UNICEF will support the NPHCDA and states in fast-tracking implementation of the approach through the following interventions:

- Sensitization/capacity-building of state-level stakeholders, including regular briefings of the Governors Forum on implementation progress;
- Development/implementation of an advocacy plan, including advocacy to First Ladies and Governors' wives to champion PHC revitalization;
- Technical support states to develop/implement acceleration plans for PHCUOR;
- Technical support for the annual PHCUOR Score Card assessment.
- Capacity-building and technical support to states in implementing the reproductive, maternal, newborn, child and adolescent health and nutrition plan, including the target priority areas of the Every Newborn Action Plan.

System strengthening and institutional capacity development. Continued support is needed to build capacities for PHC revitalization in the 10,000 high-burden wards. The country office will not only support the roll-out of the nine domains of the PHCUOR, but also assist selected states in the rehabilitation of PHC facilities, training of staff in integrated MNCH service delivery and leverage resources to ensure availability of basic commodities.

Communication for development/behavioural change. In Nigeria, the determinants of health seeking behaviours differ from state to state and indeed from region to region (north and south). Studies (Akeju, et al., 2016; Musoke, Petra.Boynton, Ceri.Butler, & Musoke, 2014) show that determinants of health-seeking behaviours in Nigeria and other African countries include trust, religious beliefs, cultural beliefs, the cost of services, distance to health facilities, level of education and health facility inadequacies, e.g., stock-out of drugs and absenteeism of health personnel. In order to improve health-seeking behaviours, strategic behavioural communication strategies in Nigeria focus on the following aspects:

- Social mobilization: Because of the influence of culture and religion, social mobilization strategies focus on mobilizing communities through traditional and religious institutions through the existing strategies. Social mobilization also focuses on mobilizing specific groups within communities such as pregnant women, youth, religious groups such as FOMWAN, Christian Association of Nigeria and traditional leaders. They act as gatekeepers to the community and are able to reach targeted groups with specific messages.
- Advocacy targets policymakers and those in position to make change, including politicians, religious and traditional leaders, professional groups and media. Through dialogues such advocacy activities are able to provide an avenue for change and also to address issues such as the availability of health services.
- Communication refers to means by which target communities and populations are reached. In different areas, several communication methods are employed. Radio is the key to transmitting messages to remote and urban areas. Jingles, music and drama are broadcast in different languages. Other methods include the use of visual images in different setting. Using technology such as Bluetooth has proven successful for information sharing and as an effective means of communication. Community and compound dialogues have proven to be effective in resolving issues related to health-seeking behaviours.

Strategic partnerships. Consultations have started with the new Executive Director of NPHCDA and partners on ways of harmonizing efforts around PHC revitalization. A division of labor for the support needed by the Government for reproductive, maternal, newborn, child and adolescent health is being
agreed in line with the mandates of the main partners. Arrangements will be further defined during the upcoming consultations with NPHCDA.

Partners include the Bill and Melinda Gates Foundation, Government of Canada, EU, GAVI, UNFPA, WHO and international and local NGOs, particularly in the areas of immunization, including polio eradication, and innovative equity-focused MNCH service delivery.

**External risks and mitigation strategies.** State governments not following through with PHC revitalization represents the most important risk to the national effort. The country office, in collaboration with field offices, will intensify advocacy efforts with state executives and other relevant stakeholders. Prolonged health workers strike actions stemming from unpaid wages have also been observed in many states since the beginning of the economic downturn. This has a potential to negatively affect service delivery. Mitigation efforts include advocating with state leadership for regular payment of salaries, especially using the epidemiological justifications, and providing adequate motivation and incentivizing health workers.

**Output 4. Increased national capacity to provide access to essential immunization**

**Output 5. Strengthened national capacity for the implementation of the Polio End Game Strategy and accelerated disease control.**

Immunization is part of PHC revitalization, but in addition to the factors mentioned above some additional conditions apply, especially for polio eradication and ensuring sustained financing for vaccine security. The vision of change is that polio transmission is interrupted in Nigeria and the country achieves sustained financing for routine immunization.

The conditions for achieving this vision are the continued commitment of the Government of Nigeria and the Global Polio Eradication Initiative (GPEI) /GAVI partners to supporting polio eradication and routine immunization. This requires continuous advocacy efforts by UNICEF using epidemiology and evidence of the improved quality of campaigns.

A major risk is a potential significant reduction of government or donor funding for polio eradication and routine immunization in a context of prolonged economic recession in Nigeria. UNICEF will explore sources of local funding including the private sector and philanthropic foundations, work towards optimizing the efficient utilization of available resources, finalize and implement the financial sustainability plan for immunization, and undertake sustained advocacy for resource mobilization.

Strengthening immunization is part of the revitalization of PHC. UNICEF will continue its support to addressing inequities in immunization through the following institutional support:

- Planning and roll out of integrated and comprehensive communication for sustained demand creation;
- formulation and implementation of the comprehensive multi-year immunization plans;
- high-level advocacy to leverage domestic resources;
- optimization of the cold chain systems;
- capacity building at state and LGA levels; and
- procurement services for vaccines and consumables.

Any potential organized massive resistance to polio eradication efforts and immunization in general will be addressed through KAP surveys to better understand community concerns and attitudes; mapping of resistance groups and engaging them thorough their leaders, using multi-channel social mobilization approaches to reach the community with clear messages; proactively and regularly engaging with the
media, journalists, professional societies, women and youth associations, Ward Development committee (WDC), etc. to provide them with clear and up-to-date information; using school initiatives to enlist pupils as change agents in support to immunization; devising tailored strategies and providing customized service delivery to resistant groups; and identifying national champions/ambassadors for polio eradication and routine immunization.

**Contributions of other development partners.** There is a well-defined partnership around polio eradication and immunization with a clear division of labour. GAVI, the Bill and Melinda Gates Foundation and the Government will continue to provide funding for vaccines and operational costs. WHO will lead in outbreak response and UNICEF will continue to spearhead support in communication and procurement. The two agencies shall pursue their technical support in other technical areas of comparative advantage (Planning and implementation of routine immunization and SIAs). Considering the fact that GAVI support to Nigeria will be discontinued in 2021, UNICEF and other immunization partners will assist the government in transition planning and advocate accordingly for the Government to self-finance its vaccine and immunization needs.

**Output 6. Increased country capacity and institutional resilience in delivery of services to prevent mortality and morbidity among girls, boys and women in humanitarian situations and high-burden local government areas (LGAs).**

Revitalization of PHC, including routine immunization and polio eradication activities, are continuing in areas in the north-east affected by conflict. Given the weak capacity of the northern states coupled with poorly functioning PHC systems, emergency service delivery is the main strategy adopted in the humanitarian context. As areas become increasingly accessible, UNICEF will build on its ongoing work to provide integrated PHC services through health facilities in IDP camps and PHC clinics in host communities in Borno, Adamawa and Yobe.

A major risk is the worsening of the security situation through escalation of the Boko Haram insurgency in the north-east, community clashes in north-central and militancy in the south: This would severely limit access to security-compromised areas to carry out social mobilization and immunization activities as well as overall primary health care service delivery. UNICEF will collaborate with the Ministry of Defense and support the civilian Joint Task force to ensure access to vulnerable populations with immunization services. Immunization partners will employ diverse effective approaches to provide vaccination services in security compromised areas such as the “hit and run” approach and periodic intensification of routine immunization.

Major outbreaks such as Ebola have the potential to cripple the health system. An effective response would require a massive mobilization of financial, managerial and human resources, leaving no space for polio eradication interventions. In collaboration with WHO, whose mandate is disease surveillance, UNICEF will support communication activities for family health practices, including hygiene and sanitation.

### 3.2 Nutrition

The proposed outcome for nutrition is that children, adolescent mothers and women, particularly in vulnerable and deprived areas, have increased access to quality services and information, and adopt appropriate nutritional practices to prevent and treat malnutrition.

The programme will support the Government to implement the National Policy on Food and Nutrition, which is aligned with SDG 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture). The strategic approach will be to support the strengthening of health and community systems and the full integration of nutrition in all aspects of the PHC system including
policies, strategies and guidelines; coordination; budgeting; human resource development; supply procurement and management; organization and provision of health facility and community-based services; and monitoring and evaluation of the programmes. There will be specific focus on aligning nutrition intervention with prevention and control of pneumonia and diarrhoea, immunization, deworming and distribution of insecticide-treated bednets.

Nutrition programming in Nigeria is dependent on donor funding. With the growing potential for domestic resources to fund nutrition interventions, UNICEF and UN partners will increasingly focus on strengthening policies, government systems and accountability measures to ensure increasing and adequate financial commitments for nutrition. Recognizing the geographical differences in the scale of malnutrition, UNICEF will continue to support service delivery in emergency and non-emergency states in the northern part of the country while increasing the scale and intensity of upstream advocacy activities in all states, and at the Federal level in the southern part of the country will focus fully on upstream work. UNICEF expects a gradual shift from service delivery in the north such that by 2022, 85 per cent of its nutrition support to the Government will be on upstream work. UNICEF will take a lead role in advocacy for coherence and coordinated efforts by development partners so as to create synergy and maximize results.

Two major underlying assumptions of the nutrition programme are increasing political commitment to nutrition at the federal, state and LGA levels, and increased funding commitments from a range of sources (Government, UN, private entities). UNICEF recognizes these as two important areas to be addressed in tandem. Output 1 of the programme specifically focuses on the enabling environment in which various partners, including the Government, choose to invest in nutrition. In the absence of increased funding, UNICEF will continue to focus available resources on the most vulnerable children and mothers, while advocating for the rights of all Nigerian children to access quality nutrition services.

The nutrition programme will have 4 outputs; one on strengthening the enabling environment, three on specific nutrition interventions including on emergency preparedness, response, disaster risk reduction and recovery.

**Output 1. Improved early childhood nutrition services for children under two years to prevent stunting and other forms of malnutrition in Nigeria. …**

Early childhood nutrition is one of the key nutrition approaches contributing to prevention of child mortality, morbidity and malnutrition. Nigeria is in a process of intensifying its efforts to ensure Maternal, Infant and Young Child Nutrition (MIYCN) practices are protected, promoted and supported. The MIYCN policy has been developed and approved since 2011 as well as training and counselling manuals for community IYCF including their translation into local languages. The Health Component of National Strategic Plan of Action for Nutrition 2014-2019 in Nigeria highlights infant and child feeding (IYCF) – the right to nutrition during a child’s first 1000 days (from conception until a child turns two) as one of the key intervention area. In that line, recently, the MIYCN strategic documents and plans including the social and behavior change communication for MIYCN were developed and available and ready for implementation.

To support implementation, some conditions apply, including focusing on a life-cycle holistic approach for nutrition interventions for adolescence, maternal and children under 2 years. More attention will be given to adolescent girls, pregnant and lactating women, under 6 months, 6-23 months children and beyond. The Social and behavior change communication strategic plan for MIYCN will be a priority for implementation and enforcement of national regulation for marketing of breastmilk substitutes. It will be essential to scale up implementation for increased coverage and service delivery in order to reach impact (positive change in MIYCN indicators).
The vision for change is that, adolescent, maternal, infant and young child nutrition, awareness around enforcement of national regulation for marketing of breastmilk substitutes, social and behavior change communication strategic plan for MIYCN are given priority for implementation to reach families, communities, meso and macro levels surrounding and influencing the behavior change of the caregivers in scaling up the programme for improved coverage and adopted MIYCN good practices in Nigeria.

The conditions for achieving this vision include the Federal Ministry of Health to ensure adoption of policy/legislation /strategic plans for early childhood nutrition, funding contribution from FMOH, SMOH, NPHCDA/SPHCDA, NAFDAC and others to M-IYCN along with other nutrition components, and continued financial/technical support and capacity/ (institutional and individual) building from development partners for scale up MIYCN programme implementation nationwide including in emergency settings. In addition, to improve quality of complementary food a detailed analysis of communities needs to be conducted to identify groups and their levels of access to food. The linkages and synergies will also need to be established with the food systems, social protection and private sector is required to ensure the children and women lowest quintile and poor purchasing households have access to livelihood and financial schemes. There is also a need to identify and lobby with private sector to facilitate availability of affordable and low cost fortified complementary foods.

This requires continuous partnership between UNICEF with key Donors including DFID, EU, USAID, and collaboration with Government (FMOH, NPHCDA/SPHCD, NAFDAC, SMOH) and different development partners (WHO, Alive and Thrive, SPRING, SCI, ACF, WINNN consortium, etc.) It will also be required to conduct strong and extensive advocacy for awareness creation and leveraging resources with the use champions and Ambassadors for MIYCN such as first ladies, Traditional and Religious forum chaired by Sultan, national youth council, Nutrition Society for Nigeria, Child Health Advocacy Initiative, C-SUN, etc. for programme expansion to increase coverage. Involvement of traditional rules, husbands, mother in law, grandmothers, etc. as a key way to influence social and behavior change of individuals, households, communities and other levels for improved IYCF practices. Mass campaigns using jingles, videos, and entertainment movies on IYCF promotion for behavior change is a key highlight to reach the majority with appropriate promotion and educational messages.

A major risk is limited capacity and funding for scale up implementation remain a key challenge affecting programme coverage. Misconceptions, myths, cultural belief and social norms, low knowledge among caregivers and key influential people in the community remain also a challenge due to resistance to positive change in favor of optimal IYCF practices. ) In addition, conflict of interest by key stakeholders-medical community and Infant formula Manufacturer (IFM) and their distributors affects promotion of breastfeeding

UNICEF will undertake the following actions for the vision of change:

**Partnership and collaboration:** Engage with Donors, development partners in IYCF is key to ensure complementarity as scaling up the programme through integration with CMAM, MNP and sensitive interventions such as income generating activities, WASH etc) for improved results, collaboration with different sections will be also encourage (C4D, Education, WASH, Child protection, Maternal Health)

Strategic interventions to reach the majority for improved quality and improved practices: the developed IYCF strategic plans will be implemented at all levels which will include: adoption of the developed strategies (MIYCN, Code for marketing of BMS, etc.) and domestication of the Strategies and plans at state level, costing of the plans and fund mobilization for scale up implementation to contribute to increase coverage.

**Social and behavior change for IYCF practices:** Promotion of IYCF and counselling using different channels such individual and group counselling as well as mass media through jingles, musics, videos,
entertainment movies, (Nollywood) will be a key priority, town hall meetings, community dialogues will contribute to the behavior change and practices for IYCF, collaboration with C4D and medias will be continued and strengthened

**Coordination strengthening:** the operationalized of IYCF Task Force at Federal and state level, will be conducted and will ensure a regular mapping for IYCF interventions is done, regularly updated and shared. All stakeholders at all levels to attend to share progress and lesson learned and way forward in regard to improvement of programming.

**Capacity development:** integrated trainings of HW and CV will be supported and will be linked with implementation for proper use of gained skills. Motivation of the trained HW and CV will be a priority in order to avoid turnover and ensure improved quality of services. The use if IYCF Innovations such teaching video, talking books for HW, CV and caregivers will improve their day to day knowledge and skills in IYCF counselling. Training and counselling materials as well as cooking equipment and other materials will be provided.

**Supportive supervision, M&E as well as evidence generation and documentation:** Supportive supervision, mentoring and coaching will be regularly conducted and supported to ensure progress and quality results. In addition, researches will be encouraged for evidence generation in MIYCN, Real time reporting and analytical reports/documentation will be IYCF focus.

**Output 2. Increased access and update of nutritional services by adolescents and school-age children for the prevention of anaemia and other forms of malnutrition in Nigeria.**

The conditions for change are:

- National guidelines for control of micronutrients deficiency revised.
- A bundle of micronutrient package delivered at the Ministry of Health PHC per ward centers.
- Frontline health workers have skills to deliver MNP, Iron and Iodine.
- Federal and State level Government begins to procure micronutrient commodities.
- Duty bearers (mothers, fathers, community leaders) accept micronutrient supplementation and home fortification products for children.
- Adolescent girls and first mothers in Northern Nigeria allowed to participate in anaemia reduction intervention activities, including Antenatal activities.
- Nigeria SON and NAFDAC committed to regulating and enforcing fortification laws in Nigeria.
- Private sector, especially in the food industry, willing to produce fortified foods.
- Guideline on school-age children nutrition developed.

Main bottlenecks for the conditions include:

- Micronutrients not part of Federal and state Ministries of Health essential medicines/commodities lists.
- Lack of data on the current micronutrient situation in Nigeria.
- Low access and acceptability of fortified foods in communities.
- Poor quality programme data for Iron and Deworming exercises/campaigns.
- Inaccessibility of the “hard-to-reach” communities where the most vulnerable groups in greater needs of micronutrient supplementation reside.
- Health workers lack of knowledge and skills in micronutrient programmes, especially iron reduction intentions, deworming and home fortification.
- Lack of routine health service delivery to provide channel for routine delivery of micronutrients especially for ANCs.
- Restriction of adolescent girls/mothers in communities to access services.
- Non-enforcement and compliance of the Nigeria fortification standards
- Nutrition in school-age children is relatively new area in UNICEF.

**UNICEF will contribute through:**

- Support to the government to update micronutrients data and to integrate into the health surveillance system at the Federal and state level.
- Conduct equity analysis of access and utilization of micronutrients in Nigeria.
- Provide technical support and advocacy to integrate a minimum package of micronutrients in the government PHC model launched in 2016. Support will be provided to NPHCDA and FMOH to ensure a bundle of micronutrient deficiency control are fully integrated in PHCs including the supplies of micronutrients as essential medicine/commodity lists.
- Provide guidance and technical support for policies, programmes, advocacy and knowledge generation for the prevention of anemia and other forms of malnutrition among adolescents and school-age children, and provide technical support for programme scale up in selected states.
- Work with the NPHCDA and FMOH (including states MOH) to ensure a bundle of micronutrient deficiency control are fully integrated in PHCs including the supplies of micronutrients as essential medicine/commodity lists.
- Strengthen micronutrients guidelines and advocate for enforcement of fortification standards/laws.
- Provide support to strengthen micronutrients task force and other micronutrients coordination mechanisms at the federal and state levels.
- Engage stakeholders, including CSOs, private sector and communities to create demand for micronutrients and access by adolescents and children.
- Provide technical guidance and support for policies, programmes, advocacy and knowledge generation to improve food systems at scale (including through largescale food fortification and salt iodization) to respond to the nutritional needs of children, adolescents and women, and provide technical support for programme scale up in selected states.

**Output 3. Increased access and utilization of quality services for the treatment of severe wasting and other forms of malnutrition including in emergency situations among children under five years in Nigeria.**

**The conditions for change are:**

- Government authorities at federal and state levels demonstrate sufficient political will and commitment reduce acute malnutrition by financing the management of severe acute malnutrition and placing it at the top of the political agenda;
- Government prioritizes treatment in the annual budget (Federal and state), with specific budget line and procure supplies for the management of severe acute malnutrition;
- Government is willing to ensure the management of acute malnutrition is streamline into the health sector flagship program of revitalization of Primary Health Care (PHC), have clear roles and responsibilities and put-in place clear accountability mechanisms to ensuring availability of supplies;
- All LGAs in focus states adopt and use the health Management Information System and DHIS for regular progress updates and decision-making, to enable equity-based targeting of
- Communities have a platform to engage with duty bearers to voice their concerns and foster greater accountability from service providers.
Creating these conditions will require:

- The national guideline is rolled out in the focus states, which have yet to be selected, led by the government
- Incorporate management of acute malnutrition into training medical, health allied and training institutions
- A plan to reduce acute malnutrition developed, endorsed and implemented under the leadership of the government
- Scale-up of management of severe acute malnutrition into all Primary health care in all focused states
- Staff at all levels have capacity to provide treatment for severe acute malnutrition;
- Communities are sensitized and aware of their rights to access of severe acute malnutrition
- SAM information and database is incorporated into HMIS and DHIS2 at Federal, State and LGA level
- Integration within the nutrition sector and between WASH and other relevant sectors

The UNICEF contribution will comprise: (1) policy advocacy and technical support, by engaging with key stakeholders at federal level to develop clear accountability framework, strategies and guidelines; and supports states/LGAs in the adaptation and roll-out of these policies/strategies and guidelines; (2) sector coordination: as the lead agency for Nutrition until 2018, UNICEF will use the opportunity to influence donors on key issues affecting children and the scale-up of successful pilots/approaches; (3) leveraging resources through evidence-based advocacy for increased investment in the nutrition sector through match funding for procurement of supplies (4) system strengthening, including capacity development of staff down to LGA level to plan, budget implement, manage and monitor interventions, equipment and logistics support (IT, vehicles); (5) technical support to strengthen knowledge management and scaling-up of the monitoring and evaluation framework through sharing of information, development of tools and guidelines, documentation of best practices and evidence generation; (6) media engagement to sensitize citizens and decision makers on severe acute malnutrition issues and foster accountability of duty bearers.

Using the strategies outlined above, emergency and humanitarian nutrition assistance will continue in the north-east of the country and other areas where there are critical nutrition situations. UNICEF will also focus on increasing the ability of Government and partners to proactively identify risk factors for the nutritional status of the population, such as poor harvest yields or worsening purchasing power, and to plan and implement measures to mitigate against these. UNICEF will work to strengthen coordination mechanisms, including the development of contingency plans to respond to, prevent and treat malnutrition in emergency and humanitarian situations. CMAM, IYCF and micronutrient deficiency control interventions will be scaled up as needed.

Output 4. Improved knowledge management and partnerships for sustainable reduction in malnutrition.

The conditions needed to effect this change are:

- Information management has to be strengthened through generation and use of timely and quality data for planning and programming;
- The national nutrition plan has to be updated, disseminated, adapted at the state level;
- Improved coordination of nutrition activities and actors at federal, state and LGA levels;
- The Government funds the national nutrition response as per national policies, priorities and strategies consistent with international commitments;
- Improved policies to strengthen human resource capacities to deliver nutrition services (pre-service and in-services curriculum) at all levels;
• Increased awareness among the general population and policymakers on the consequences and impact of malnutrition and the rationale for investing in prevention and treatment of malnutrition;

Creating these conditions will require:

• Improved quality of data collection, analysis and reporting at operational level, from facility through the LGA to state and ultimately to federal levels;
• Updating of the plan requires an inclusive process to draft, analyse, review and finalize the evidence-based strategy document;
• Evidence-based advocacy and media engagement to make the case for increased funding for nutrition and increase awareness among the population and policymakers;
• A more diversified resource base is needed to ensure sustainability of interventions. UNICEF funding is the major only source of funding for nutrition in the federal budget for 2017.

The UNICEF contribution for the next five years will include: (1) technical support for evidence-based planning, programming, development, revision and updating of policies; (2) capacity-building of LGA staff to improve the collection, collation and analysis of data, including training and supervision of staff, a feedback loop to the facility level and submission of data to the state and federal levels; (3) capacity-building at the Federal and state levels on data management, so that staff are able to analyse and interpret data both for planning purposes and advocacy to policymakers; (4) strengthening advocacy for development and updating of policies, plans and evidence-based budgeting; (5) acting as convener and technical lead to strengthen and coordinate partnerships, including in emergencies; (6) coordinate innovation, knowledge management and capacity-building for improved data quality for nutrition services; (6) coordinating and leveraging resources from global initiatives and partners such as SUN, Power of Nutrition, World Bank, Bill and Melinda Gates Foundation, the Dangote Foundation (Nigerian) and international NGOs. It is envisioned that nutrition partners including but not limited to: Save the Children, Action Against Hunger, IFRC and the International Rescue Committee will support implementation at the LGA and facility levels; and strengthen the community component of nutrition through advocacy and sensitization at LGA and community levels and capacity-building at facility and community levels.

**Partners**

There is a wide range of bilateral, multilateral, foundation and NGO partners and actors in the nutrition sector. Major donors include the African Development Bank, DFID, EU (including ECHO), World Bank, USAID (FFP, OFDA), the Governments of Japan and Germany, the Children's Investment Fund Foundation and the Dangote Foundation. United Nations partners include WHO, FAO, IFAD, UNFPA and WFP, the latter which will complement UNICEF work with nutrition-sensitive interventions geared towards the sustainable reduction of chronic malnutrition. Funds are also provided by the CERF and Multi-Partner Trust Fund. NGO partners include Action Against Hunger, ALIMA, COOPI, IFRC, IMC, IRC, MSF (France, Holland, Spain, Swiss), Save the Children International, PUI, Caritas

**3.3 WASH**

The outcome for WASH is that Nigerians, especially women and girls and those in vulnerable situations in rural and urban settings, have equitable and sustainable access to and use safe and affordable water supply, sanitation and hygiene practices in communities and institutions and live in an open defecation-free environment.

The programme will support the Government in implementing the Partnership for Expanded Water Supply, Sanitation and Hygiene (PEWASH), which is a national collaboration for improving access to
water supply and sanitation through a structured multisector partnership. PEWASH aims at eliminating open defecation by 2025 and providing access to basic water supply and basic sanitation (including hand washing facilities with soap) to all rural inhabitants by 2030. PEWASH was finalized by the Ministry of Water Resources with support of the WASH Development Partners Forum (comprising the World Bank, EU, UK Aid, USAID, JICA, and Water Aid with UNICEF serving as chair and AfDB as the co-chair) and subsequently launched by the Vice President of Nigeria.

The programme has five outputs, one on the enabling environment, three focusing on issues of supply, quality and demand for specific subsectors – namely water, sanitation & hygiene and WASH in Institutions, and one for emergency preparedness, response and recovery.

**Output 1 (Enabling Environment). Strengthened political commitment, accountability and capacities at national/subnational level to legislate, formulate evidence-based plans, budget, coordinate, monitor and mobilize resources for scaling-up of equitable water supply, sanitation and hygiene interventions.**

The conditions for effecting these changes are:

- Government authorities at federal and state levels demonstrate sufficient political will and commitment to the WASH sector by firmly placing at the top of the political agenda;
- Government prioritizes WASH in the annual budget (Federal and state), with specific budget line for sanitation and hygiene;
- Government is willing to undertake sectoral reform including review/update of WASH policies (in line with the revised national WASH policy), have clear roles and responsibilities and put-in place clear accountability mechanisms;
- All LGAs in focus states adopt and use the WASH Information Management System (WASHIMS) for regular progress updates and decision-making, to enable equity-based targeting of WASH interventions;
- Communities have a platform to engage with duty bearers to voice their concerns and foster greater accountability from service providers.

Creating these conditions will require:

- The PEWASH Strategy is rolled out in the focus states, which have yet to be selected, led by the Ministry of Water Resources;
- The Road Map for Ending Open Defecation is implemented in the focus states, led by Ministry.
- Institutional arrangements are in place, with wash departments at LGA level;
- The WASH-MIS is scaled up across all LGAs in the focus states;
- Staff at all levels have capacity to implement the policies and manage investments;
- Communities are sensitized and aware of their rights to clean water and sanitation.

The UNICEF contribution will comprise: (1) policy advocacy and technical support, by engaging with key stakeholders at federal level to develop clear policy framework, strategies and guidelines; and supports states/LGAs in the adaptation and roll-out of these policies/strategies and guidelines; (2) sector coordination: as the lead agency for WASH until 2018, UNICEF will use the opportunity to influence donors on key issues affecting children and the scale-up of successful pilots/approaches; (3) leveraging resources through evidence-based advocacy for increased investment in the WASH sector, cost-sharing in donor programmes and through the roll-out of PEWASH program; (4) system strengthening, including capacity development of staff down to LGA level to plan, budget implement, manage and monitor interventions, equipment and logistics support (IT, vehicles); (5) technical support to strengthen knowledge management and scaling-up of the monitoring and evaluation framework (WASH-MIS) through sharing of information, development of tools and guidelines, documentation of best practices and
evidence generation; (6) partnerships and engagement with civil society and the private sector to invest in
the sector and build on their marketing capacities to promote affordable WASH services; and (7) media
engagement to sensitize citizens and decision makers on WASH issues and foster accountability of duty
bearers.

Output 2 (Water Supply): National and subnational governments and relevant stakeholders have
increased capacities to deliver equitable and sustainable access to safe and affordable drinking
water, progressively attaining safely managed levels of water service

The conditions for effecting these changes are:

- Adequate resources are available to LGAs for investments in water facilities, including operations
  and maintenance and replacement of infrastructure;
- Water points are equitably distributed, functional and maintained;
- Communities are empowered to manage their WASH facilities through WASH Committees
  (WASHCOMS) and voice their concerns (e.g. through Federation of WASHCOMs);
- Village-level Operations and Maintenance (VLOM) is institutionalized at state and LGA level
  comprising a functioning supply chain network (spare parts dealers, etc.) with trained local area
  mechanics at LGA level.
- People are willing to change and adopt community water safety plan, household water treatment
  and storage and water conservation measures.

Creating these conditions will require:

- A dedicated Rural Water Supply and Sanitation Agency at the state level and WASH department
  at LGA level equipped with qualified staff with capacity to plan, implement, manage and monitor
  resources invested in the water sector;
- Budget and plans developed, funded and implemented at LGA level;
- WASHCOMS are established, trained and engaged in WASH activities (e.g. management of
  WASH facilities, development of water safety plans, etc.);
- Capacity-building systems in place (to build capacity of LGA staff, local mechanics, hygiene
  promoters, community caretakers, etc.);
- Supplies, spare parts are available in the local markets and are affordable;
- Promotional activities raise awareness on key household practices including HWTS, water
  conservation, etc.

The UNICEF contribution will comprise: (1) service delivery: based on available resources, rehabilitate
and install water points in focus LGAs; (2) capacity-building of state Rural Water Supply and Sanitation
Agency (RUWASSA), LGA staff, communities, CSO/NGO staff; (3) Community engagement and
empowerment through setting-up of WASHCOMs, Federation of WASHCOMs; (4) Institutionalizing
VLOM with private sector engagement; (4) climate change adaptation: by prioritizing vulnerable areas,
water conservation, resilience, appropriate technologies; (5) strengthening water quality through water
safety plans, monitoring and surveillance; (6) fostering sustainability: SMS based real-time tracking of
water point functionality to address breakdowns in quick time (within 48 hours); community and private
sector managed service delivery.

Output 3. Sanitation and hygiene: National and subnational governments and relevant stakeholders
have increased capacities to eliminate open defecation and achieve adequate and equitable access to
sanitation and hygiene services, progressively attaining safely managed levels of sanitation.

The conditions for effecting these changes are:
Adequate resources are available to LGAs for investments in sanitation and hygiene promotion, monitoring and evidence based planning;
- Trained CLTS facilitators and village-level hygiene promoters are available in the LGAs;
- Communities are mobilized and empowered to become ODF through CLTS process.
- Social norms change so open defecation is considered unacceptable.
- Private sector exists and responds to increased demand for improved sanitation through appropriate supply side interventions.
- Latrine options are available to suit the needs and aspirations of all market segments in rural communities
- Financial institutions have developed financing products that respond to the financing needs of the households for construction/upgradation of their latrines.
- Households construct and use latrines, and wash their hands at critical times.

Creating these conditions will require:
- Budgets and plans for sanitation and hygiene promotion and follow-up activities are developed and implemented at LGA level.
- There is a large enough resource pool of trained CLTS facilitators to support LGAs level facilitators capacity building needs for quality CLTS triggering.
- LGA staff remain motivated and have the capacity to implement CLTS and hygiene promotion activities.
- Capacity-building systems in place (training programmes target LGA staff and community facilitators, CSOs/NGOs, WASHCOMS are established and trained).
- Communities develop and monitor implementation of their ODF plans, and households are aware of proper sanitation and handwashing practices.
- Microfinance Institutions (MFIs) are willing and have appropriate financing products, to offer affordable sanitation financing to households and sanitation businesses.
- Appropriate latrine designs are available which are climate change adaptive and responds to the needs of communities in high water table and flood prone areas.
- Sanitary and hygiene supplies are available and are affordable.

The UNICEF contribution will comprise: (1) service delivery: based on available resources, support state RUWASSA and LGAs to provide sanitation facilities in public places on public-private partnership basis; (2) capacity-building of state RUWASSA, LGA staff, CSO/NGO staff and community consultants in CLTS, social mobilization, community engagement, hygiene promotion and WASHCOM formation, as well as capacity-building of private enterprises/MFIs/community saving groups, etc.; (3) behaviour change communication; development of communication strategy, IEC materials, promotional activities including media campaign; (4) mobilize private sector (entrepreneurs, MFIs and other providers) to shape markets, develop/offer sanitation products and services, and affordable financing; (5) community engagement and empowerment through setting-up of WASHCOMs, WASHCOM Saving Groups; and (6) sustainability: quality assurance mechanisms through third-party ODF certification and validation in place; smartphone based real-time tracking of constructed toilets; enabling private sector to not only supply to the increased demand for improved sanitation but also create demand for improved sanitation.

Output 4. WASH in Institutions: National and subnational governments and relevant stakeholders have strengthened capacities to provide gender-sensitive and disabled-friendly, sustainable access to water supply, sanitation and hygiene services in institutions, especially schools and primary health centres.

The conditions for effecting these changes are:
All the relevant Ministries (Water Resources, Health, Education, Works) at national and state level work together and prioritize investments in WASH in Institutions including provision for operations and maintenance, and replacement of infrastructure;

WASH facilities in Institutions are constructed as per the national guidelines along with the establishment of a proper regime for operations and maintenance regime;

WASH facilities are equitably distributed, gender and disable-friendly, functional and well maintained;

Relevant structures at institutional (e.g. school-based management committee) and community level (e.g. WASHCOM), are engaged in the planning, siting and upkeep of WASH facilities in Institutions.

People including children accessing institutions are aware of proper hygiene practices.

Creating these conditions will require:

Greater collaboration and engagement between the relevant Ministries (Water Resources, Health, Education, Works) at national and state level;

Costed plans (capital and operational) for WASH facilities in schools and primary health centres available;

Resources for provision of WASH facilities in Institutions and their maintenance are available at national/state/LGA levels;

Staff within the Ministries have capacity to plan, implement, manage and monitor resources invested in WASH facilities in Institutions;

Resources to procure soap, cleaning materials, etc. and maintain WASH facilities in Institutions are available;

Promotional activities within institutions raise awareness on key household practices including proper handwashing and sanitation practices.

The UNICEF contribution will comprise: (1) interministerial collaboration through establishment and operationalization of WASH in Education and WASH in Primary Health Care working groups at national/state levels; (2) based on available resources, rehabilitate and provide WASH facilities in schools and primary health centres in focus LGAs; (2) capacity-building of staff from the related MDAs on planning, implementation, monitoring and on national guidelines/strategies and best practices; (3) establish linkages between the various community (e.g. WASHCOMs) and institutional structures (e.g. school-based management committee); (4) establish environmental health clubs within schools to promote proper hygiene practices, awareness of water conservation, climate change, maintenance of WASH facilities, etc.; and (5) foster sustainability through SMS-based real-time tracking of water point functionality to address breakdowns in quick time (within 48 hours), engaging school children in monitoring and reporting of WASH services within schools and linking status of WASH facilities in institutions to WASHIMS.

Output 5 (WASH in Humanitarian Settings): Strengthened capacity of national and subnational institutions and relevant stakeholders to foster increased community resilience to disasters, and to deliver gender sensitive basic WASH services in humanitarian situations.

Conditions for change

All the relevant Ministries (Water Resources, Emergency Management Agency, Environment, Health, etc.) at national and state level work together on Disaster Risk Reduction (DRR), building community resilience, and have a coordinated and timely response to humanitarian situations.

National/ State level DRR and emergency preparedness plans are in place and budget allocated.

WASH Services in humanitarian settings are provided as per National/ SPHERE standards.
- People in humanitarian situations are aware of proper hygiene and sanitation practices.

**Pathways to change**
- Active WASH in Emergency Working Groups at national and sub-national level
- Resources for implementing WASH facilities in humanitarian situations are available
- Staff within the relevant Ministries (Water Resources, Emergency Management Agency, Environment, etc.) have capacity to plan, implement, manage and monitor resources invested in DRR/WASH services
- High-risk/disaster prone areas are mapped and activities aimed at promoting community resilience and disaster preparedness are in place
- WASH facilities are provided as per standards (National/SPHERE) and functional
- Promotional activities raise awareness on key household practices including proper handwashing and sanitation practices.

**UNICEF contribution to the change effort**
- WASH in Emergency (WiE) Sector Coordination – support to establish and strengthen WiE working groups at national and state level
- Promote Community resilience, DRR/Early Recovery
- Institutional strengthening support: for setting up an updated Information Management system including mapping of hot spot/high risk areas, partner presence, ongoing activities and gaps;
- Capacity Building: of government staff, NGOs/CSOs on planning, implementation, monitoring; DRR, WASH standards in humanitarian situations, hygiene promotion, etc.
- Service Delivery: based on available resources, rehabilitate and provide WASH facilities in affected locations in collaboration with WiE sector actors
- Sanitation and Hygiene Promotion in humanitarian situations

**Key partners:**

**3.4 HIV and AIDS**
Impact: Children and adolescents, especially the most vulnerable survive and thrive with no new HIV infections and AIDS related deaths.

The proposed outcome for HIV and AIDS is that children, adolescents and women, particularly in high HIV burden areas, have increased access to quality services to prevent and treat HIV.

The programme will support the Government in implementing the national plan to fast track the HIV response for children and adolescents to achieve the ‘90 90 90’ targets by 2020 and to end AIDS by 2030 in Nigeria.

The programme has five outputs, one for the enabling environment, three focusing on supply, demand and quality issues and one on emergency preparedness, response and recovery.
Output 1. Federal, state and LGA capacities are strengthened to lead, plan, finance, coordinate and monitor HIV programmes for women, children and adolescents.

The condition needed to effect this change are:

- Federal and state governments adopt, disseminate and implement current technical guidelines;
- Technical working groups effectively convene partners at federal and state levels and serve as platforms for coordinating and monitoring the HIV response and disseminating technical guidance;
- Federal and state governments have and utilize up-to-date, quality data from a robust HMIS that incorporates all relevant HIV indicators from multisectoral platforms;
- Federal and state governments allocate and utilize sufficient budgetary resources for HIV programming.

Creating these conditions will require that:

- Federal and state governments have human, financial and managerial resources at all levels to disseminate and implement the guidelines;
- Technical working groups receive adequate resources from government to facilitate timely follow through on recommendations and ensure sustainability;
- Monitoring and evaluation staff are adequately trained in data management and supervision to ensure timely reporting of quality data;
- Programme data are utilized more efficiently at all levels from facilities to policymakers to inform programming.

The UNICEF contribution will comprise: (1) advocacy with federal and state governments to allocate resources for HIV programme implementation and for implementing guidelines; (2) capacity-building of technical working groups by training and mentoring to empower them to take ownership of the process, remain abreast of new developments, share information through position papers for government, and leverage technical and financial resources by fostering effective partnerships; (3) ongoing technical support and training on software and data entry, training for supervisors in data analysis, support for synthesizing data in user-friendly formats (fact sheets, report cards, etc.).

Output 2. Health systems are strengthened at national, state and LGA levels to provide integrated quality, cost-effective, innovative and sustainable services for prevention and treatment of HIV in children and adolescents.

The condition needed to effect this change are that:

- Federal and state governments provided adequate funding for HIV programming for women, children and adolescents;
- Federal and state governments implement policies and guidelines on integrated HIV prevention and treatment services;
- Improved coordination and planning for integrated HIV services across sectors.

Creating these conditions will require:

- Service providers have the capacity to deliver integrated services;
- Effective commodity management systems;
- Infrastructural upgrades, particularly at primary level, to ensure more equitable access to services.
The UNICEF contribution will comprise: (1) advocacy for increased funding for procurement of commodities for the delivery of the integrated package, resource mobilization for infrastructural upgrade and a stronger referral/linkage system; (2) policy dialogue on sustainable human resources development; (3) institutional capacity-building and for systematic planning and implementation of suitable models; and (4) technical support for the development of guidelines, tools and relevant standard operating procedures for integrated programming, improved provider-client relationship, adolescent friendly service delivery and commodity management.

Output 3. Community support systems are strengthened to promote timely uptake of an integrated package of HIV services by pregnant women, their infants, partners and families, and by adolescents.

The condition needed to effect this change are:

- Federal and state governments commit human and financial resources for community systems;
- Policies and guidelines outlining the role of community systems for the delivery of integrated HIV and maternal and neonatal health services are adopted and implemented.

Creating these conditions will require:

- Community structures are in place to promote uptake of integrated HIV and MNCH services for pregnant women, children and adolescents;
- Community facility linkages are strengthened to facilitate utilization of HIV/MNCH services
- Communities have the capacity and tools to create demand for services.

The UNICEF contribution will comprise: (1) establishment of partnerships with communities and civil society organizations to empower families with the information necessary for them to adopt positive behaviours and increase demand for HIV services; (2) technical assistance for the development of communication materials to raise awareness on HIV and MNCH interventions for women, children and adolescents.

Output. Evidence generation is strengthened for greater convergence of strategic planning and integrated programming for HIV and maternal, newborn, child and adolescent health.

The conditions required to effect this change are:

- Federal and state governments allocate adequate resources for monitoring and evaluation of integrated HIV/MNCH and adolescent programmes;
- Federal and state governments utilize emerging programmatic evidence on cost-effective approaches to integrated programming.

Creating these conditions will require:

- Relevant directorates/departments develop joint plans for HIV and maternal, newborn, child and adolescent health programming;
- Monitoring and evaluation tools are adapted to include indicators for integration;
- Programmatic data are utilized more efficiently at all levels, from facilities to policymakers to inform programming.
The UNICEF contribution will comprise: (1) advocacy to increase resource allocation for evaluation of HIV/MNCH integration surveillance and surveys; (2) ongoing technical support for results-based planning; and (3) building capacities for evidence generation on the impact of integrated programming.

**Output 5. Systems are strengthened and responding to the needs of adolescents during emergencies and promote resilience and DRR/early recovery in selected states.**

The condition needed to effect this change are:

- Community systems are promoting, providing and monitoring provision of adolescent-friendly services;
  - Multisectoral programmes have a coordinated and timely response to the needs of adolescents and build their resilience during emergencies;
  - National and state-level DRR and emergency preparedness plans that address the needs of adolescents are in place and budgets allocated.
  - Multisectoral data systems produce evidence to inform further refinement of adolescent programmes;
  - Federal and state governments sustain and utilize sufficient multisectoral budgetary resources for adolescent programming at scale.

Creating these conditions will require:

- Community leaders and gatekeepers put structures and an enabling environment in place to promote empowerment and participation of adolescents;
  - Adolescent-focused staff in all sectors have skills for fostering and promoting innovative models of adolescent service provision in emergencies at scale;
  - Multisectoral operational strategies, data systems and tools available for adolescent programming and data collection;
  - Federal and state governments have human and financial resources in all relevant sectors and at all levels for a coordinated implementation of adolescent-focused programmes.

The UNICEF contribution will comprise: (1) raising community awareness and engaging community leaders/gatekeepers on the benefit of empowering adolescents as key actors in development processes, especially during emergencies; (2) strengthen sectoral capacities on programming for and with adolescents, especially during emergencies; (3) technical support to sectors to develop adolescent-focused interventions and data collection systems; (4) promotion of resilience and DRR/early Recovery among adolescence in emergency settings; and (5) advocacy with federal and state governments for budgetary allocation to implement multisectoral adolescent-friendly/-focused interventions.

**4. Results structure and framework**

Reference attached Annex.

**5. Aligning results, strategies and required resources (see annex)**

**6. Monitoring achievement of outputs and UNICEF’s contribution to outcomes**

Monitoring of the outputs will be done by the respective sections and by the cross-sectoral monitoring team, which will conduct complementary independent monitoring and rapid assessment. Each section will be accountable for conducting the monitoring of its activities, the analysis of the removal of the bottlenecks and progress toward immediate results. The sections will be responsible for conducting
programme monitoring visits and assurance activities as per the HACT framework. This will allow the sections to be fully accountable for the resources provided to them and ensure that implementation is done according to their workplans and in light of the intended results. Each section will also develop a monitoring plan that will be consistent with the programme monitoring visits (as per HACT), but will focus on immediate results and coverage, i.e., by visiting the beneficiaries of interventions (CMAM, PHC centre, community group such as WASHCOMs, IYCF support groups, etc.). The criteria for identifying the sample of the monitoring visit will include the hard to reach, level of efforts and convergence.

The sections will focus on supporting and strengthening the capacities of national and subnational monitoring systems.

The health section will support the Federal Ministry of Health, NPHCDA and SPHCDAs in strengthening the monitoring system supporting the One PHC per Ward approach through Primary HealthCare under One Roof (PHCUOR) Score Card assessment exercises across the nine established domains. In collaboration with field offices, the health section will provide assistance to priority states in integrating PHCUOR score card performance monitoring in the established review processes and institutionalize such exercises. In order to avoid parallel systems, immunization and MNCH data sources will be drawn from existing data collection processes agreed to by stakeholders and outlined in the M&E frameworks for the comprehensive immunization multi-year plan and integrated maternal, newborn, child and adolescent health and nutrition plan, which are aligned with the National Health Strategic Development Plan. In a bid to improve quality and credibility of the HMIS, the programme will also support national efforts in the expansion of DHIS2 and implementation of data quality improvement plans. In humanitarian settings such as in the North-East, efforts will be made to establish a functioning real-time monitoring system with the aim of informing timely delivery of life-saving interventions.

The nutrition section will continue working with Nigeria Bureau of Statistics and federal Ministry of Health to conduct yearly Nigeria Nutrition and Health Surveys (NNHS) to provide updated and quality data for planning and programming. In emergency settings, the section will continue to support the sector in implementation of surveillance surveys, which have been crucial in informing the situation and need for response. Regular meetings of nutrition stakeholders will address issues of coordination and reviews of progress, including programme performance, stock levels and technical issues and provide feedback to facilities to improve performance and quality of data and reporting. The programme will continue to improve the quality of data and reporting through on-the-job training of M&E officers at federal and state levels on nutrition data management, interpret and provide real-time feedback to LGAs and facilities.

The UNICEF supported WASH-IMS is already the sector monitoring platform for Nigeria and currently is operational in 117 LGAs. UNICEF is now supporting the establishment of the learning and monitoring hub aimed at generating evidence, sharing and promoting lessons and best practices for learning, replication and scaling up. To foster sustainability of WASH interventions, UNICEF has put in place SMS-based real-time tracking system that tracks the functionality of water points and ensures that facility breakdown is responded to within 48 hours. There is a plan to extend this to sanitation in institutions as well as in the emergency context. Smartphones are now being used for baseline surveys and have lowered survey costs by 10 per cent. This will be extended to cover mid-line and end-line surveys and specific assessments. Smartphones are increasingly being deployed in real-time monitoring of field facilitators’ performance (capturing implementation of activities and roll out of processes as they happen) and in the overall management and documentation of results in the project LGAs. This is being set up to monitor and improve the quality of the roll-out of large-scale, community-level activities such as formation and training of WASHCOMs, CLTS implementation and water safety planning.

The HIV programme reports annually on globally agreed targets to track the HIV response (the Global Annual Programme Report (GAPR)). UNICEF HIV sections will focus on supporting and strengthening the capacities of national and subnational monitoring systems to report quality data on the nationally
agreed indicators for EMTCT, paediatric and adolescent treatment and adolescent prevention. Routine monitoring of the HIV results will be done using data collected via existing government systems such as the DHIS2 platform and HIV antenatal surveillance systems; and validated biannually. Additionally, UNICEF focus states will be supported to conduct L3 monitoring at LGA level to identify and address programmatic barriers and bottlenecks. Impact-level HIV monitoring will be done through population surveys such as DHS and specialized surveys such as AIDS indicator surveys conducted at state level.

Supply assistance. Supplies are a significant component of UNICEF’s commitment to achievement of expected programme results in Nigeria. It is therefore important that the supplies provided are monitored systematically to identify any risks and corrective measures taken to ensure quality and timely delivery, and they reach end users.

Upon receipt of supplies by the end users, UNICEF programme and supply staff will regularly conduct monitoring of the supplies, as part of their monitoring plans to check whether the objectives for which the supplies were provided are being fulfilled. The report provided by the section to the chief, deputy representative and/or senior management will allow for corrective actions to be taken.

At the beginning of the year, budget owners in collaboration with the supply section will develop a Supply End User Monitoring Plan for high-value items (offshore purchase orders valued at $100,000 and above) and all local orders above $50,000. This will allow the sections to be fully aware of the status of commodities available under their programmes and ensure that they reach the targeted populations.

Complementary independent monitoring. At the beginning of the year, a monitoring plan will be prepared in coordination with the chiefs of field offices. The cross-sectoral monitoring team will complement the monitoring done by the sections by focusing on Level 3 monitoring, and removal of barriers, achievement of milestones as well as progress towards the achievement of the outputs. The team will visit the affected population and targeted intervention area and will sample several unit of analysis. Focus will be on the quality of services and compliance with national standards.

For WASH, the selection of communities/water points to visit will be determined using the sampling technique of probability proportional to size. The selection of households/dwellings for sanitation assessment at the community level will use combination of sampling methods. In schools where WASH is implemented, the functionality of Environmental Health Clubs should be accessed in addition to water points and sanitation facilities assessment. At the LGA office (WASH unit), documents related to the UNICEF WASH programme including but not limited to workplans, WASHIMS, baseline study, ODF-wide policy, field visit schedule and reports and guidelines, will be reviewed.

For monitoring the health programme, the team will use Lot Quality Assurance Sampling. Specific attention will be given to the selection of PHCs and communities/clusters in assessing the functionality of One PHC per ward, cold-chain equipment and health service coverage. At the facility level, all facilities in the communities are to be sampled using the developed checklist with specific monitoring of cold-chain/stores, supply and distribution data. At the LGA level, workplans, the cold stores, supply monitoring, data documentation and training should be monitored in real time.

The nutrition section will monitor the facilities implementing UNICEF-supported nutrition interventions (CMAM, IYCF, micronutrients deficiency prevention and control). UNICEF staff and nutrition consultants will conduct routine monitoring of performance indicators on a quarterly basis in all UNICEF-supported primary health centres implementing nutrition services using a predesigned supervision checklist. The monitoring will take place within the state-level structures for nutrition coordination, the State Food and Nutrition Coordination Committees. The programme will intensify use of smartphones for real-time monitoring of programme and RapidPro for real-time reports, especially for supplies, to ensure no stock outs and facilitate continuum of care.
The key elements of the HIV programme include HIV counselling and testing and ANC/PMTCT (through demand creation by the VCMs). A sample size of key intervention area will be drawn and adapted according to the number of LGAs. If it is less than or equal to five LGAs, then all should be monitored and if it is more than, a sample size of 50 per cent of the total should be selected and monitored. At the facility level, all related documents should be reviewed including communication for development activities in programme communities.

Proposed studies and evaluations:

**Health**

- Evaluation of the EU-UNICEF MNCH project (2020), to understanding the performance on the grant on service coverage and system strengthening;
- Mid-term and end-term evaluation of the GAC-supported hard-to-reach project (2018-2020), to gain insight on the performance on the grant on service coverage in hard-to-reach communities and system strengthening to inform design of the outreach component of the PHC revitalization
- Economic evaluations new vaccines (2019) to understand the cost-effectiveness of new vaccine to inform future plans for immunization financing sustainability.
- Mid-term (2018) and final (2021) evaluation of the comprehensive Multi-year Plan (cMYP) to assess implementation status of the CMYP and understand factors of success and shortcoming in achievement HSS pillars and immunization performance.
- National Immunization coverage survey (2021) to assess effective coverage of immunization nationwide in comparison to administrative coverages.
- KAPB studies (2019) to gain understanding on the effects of MoV and home-based records on immunization performance at community level.

**Nutrition**

- Developing simplified outcome measures for mortality and disability attributable to childhood acute malnutrition – secondary data analysis;
- Long term outcome of CMAM programme – Prospective cohort study;
- A comparison study; Rapid-Pro (SMS reporting system) vs paper data collection system;
- Documenting lessons learned on effect of nutrition advocacy, experience from Nigeria
- Study to test different delivery mechanisms for micronutrient powder (MNP) to improve programme coverage ;
- National Nutrition and Health Survey;
- Nutrition and food security surveillance – North East Nigeria;
- Evaluation of the integrated nutrition package in the one PHC model;
- Evaluation of MNP programme in emergency states;
- Evaluation of routine vitamin A delivery and expanded outreach strategy;

**WASH**

- Research to understand the level of exposure of newborns at birth to unsafe water, poor sanitation, hygiene and poor waste management in Nigerian health facilities (2018-2019);
- Research to understand the risks associated with accessing WASH facilities for women and girls in Nigeria, particularly in emergency situations (2018);
- Case study on understanding the role of environmental health clubs as a channel to promote hygiene education in primary schools (2018);
- Study to understand WASH in peri-urban settings with focus on public/private partnerships (2020);
- WASH programme impact evaluation - randomized controlled trial (2021-2022);
- Evaluation of the impact of school WASH on absenteeism - cluster randomized trial (2019-2020);

**HIV**
The HIV programme component will be evaluated at the midterm of the programme cycle to assess effectiveness and to identify lessons learned to inform the rest of the cycle.