POLICY BRIEF

EVIDENCE-BASED PROGRAMMING AND ADVOCACY

Lessons learned from the end-cycle evaluation of the Federal Government of Nigeria–UNICEF Health and HIV/AIDS Country Programme, 2018–2022

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The first independent evaluation of the Health and HIV/AIDS component of the Country Programme of Cooperation between the Federal Government of Nigeria and the United Nations Children's Fund (UNICEF) 2018–2022 (referred to in this brief as the Country Programme 2018–2022) was a systematic and rigorous assessment of the relevance, effectiveness, efficiency, impact and sustainability of the component. The evidence generated showed significant effects in child health outcomes in 18 intervention states, with a strong equity dimension. Services to strengthen maternal, newborn, child and adolescent health (MNCAH) interventions had a significant impact on reducing neonatal and infant mortality. States that consistently increased budgetary allocation to their health sectors; that increased their annual budget implementation rate by 25 per cent and that had drug revolving fund systems (10 of the 11 states had such systems) contributed to the positive programme impact on childhood mortality and/or reduction in childhood diarrhoea prevalence. A key lesson learned is that using a systematic multisectoral approach, coupled with strategic partnerships and targeted social mobilization, and including consistent and meaningful community engagement, led to notable successes in reducing child health issues and improving postnatal care.

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BACKGROUND

This policy brief presents key evidence of results achieved, lessons learned and priority recommendations for future programming from the first independent evaluation of the Health and HIV/AIDS component of the Country Programme 2018–2022. The evaluation covered the period 2018–2022 for accountability and learning and included a 2010–2022 retrospective trend and causal analysis of outcomes and impact in 18 focus states. The evaluation aimed to generate sound evidence on the quality and value of UNICEF's and its partners' investments in the health sector within the framework of the Country Programme 2018–2022. The lessons learned from the evaluation and strategic and actionable recommendations will be useful to the government, UNICEF and key partners to reshape approaches, adopt responsive measures that can be used to improve the UNICEF business model and accelerate progress towards the health–HIV/AIDS-related Sustainable Development Goals in the current programme cycle (2023–2027). This first independent evaluation thereby serves as a critical milestone for the health–HIV/AIDS programme in Nigeria.

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PROGRAMME OVERVIEW

The Health and HIV/AIDS component of the Country Programme 2018–2022 aimed to reduce maternal, infant and child mortality, undernutrition and poor child development in Nigeria by ensuring equitable access to quality basic services for children, adolescents and women.

Aligned with the United Nations Development Assistance Framework pillar for equitable access to quality basic services and the Sustainable Development Goals, the programme sought to demonstrate the impact of investing in institutional and community-based systems for children's survival and development.

It pursued universal coverage through replicable models in selected states and provided rapid life-saving humanitarian assistance, focusing on high-impact areas where UNICEF could effectively support the government.

The health component of the programme aimed to ensure equitable access to quality maternal, neonatal and child health interventions and increase access to HIV prevention and treatment services in high-burden states. Strategies included supporting the 'one primary health-care centre per ward' initiative for universal health coverage, polio eradication, routine immunization and strengthening women's decision-making capacities regarding children's health. UNICEF provided technical support for primary health-care revitalization and capacity-building for state stakeholders, and promoted health-seeking behaviours through communication strategies. Efforts also focused on maintaining immunization systems and transitioning to government self-financing for vaccines post-2021.

For the HIV/AIDS component, the programme supported the national plan to eliminate mother-to-child HIV transmission, enhance paediatric HIV treatment and prevent adolescent HIV, aiming for the '90-90-90'[1] targets by 2020 and ending AIDS by 2030. It combined programmatic responses with policy support, focusing on high-need areas and facilitating evidence-based approaches and South–South exchanges. Community support systems were strengthened to empower families, improve service demand and improve linkages

1 The 90-90-90 targets were established by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in an effort to end the AIDS epidemic by 2030. The targets, which were to be achieved by 2020, were: (i) 90 per cent of all people living with HIV to know their HIV status, (ii) 90 per cent of all people with diagnosed HIV infection to receive sustained antiretroviral therapy and (iii) 90 per cent of all people receiving antiretroviral therapy to have viral suppression (UNAIDS, '90-90-90: Treatment for all' <https://www.unaids.org/en/resources/909090>).

between communities and facilities for HIV care. Innovative approaches targeted at-risk adolescents for high-impact prevention services were promoted, and evidence was generated on integrated programming for HIV and maternal and child health.

The programme spanned five years and had an initial budget of US$772 million. The bulk of UNICEF's financial investment in Nigeria's health sector (44 per cent or US$181,736,925) was used to strengthen the capacity to deliver routine immunization and sustain the country's polio certification status.

EVALUATION METHODOLOGY

The evaluation used a mixed methods approach, combining qualitative and quantitative data from various sources. The methodology adopted a theory-based approach and involved a quasi-experimental design that was developed to simulate a 'before and after' approach and a with/without comparison, using data from Multiple Indicator Cluster Surveys. A cross-sectional exploratory study measured changes at the endline, involving focus group discussions, semi-structured interviews and health facility assessments. Propensity score matching was used to generate credible comparison sites. The difference-in-differences method was employed to compare trends over time between intervention and comparison groups. Qualitative data provided context and explanations for quantitative findings, ensuring a comprehensive analysis of the programme's impact.

The methodology aimed to ensure meaningful participation by stakeholders, including children, adolescents and women, to effectively inform future interventions and policy decisions.

Data were collected through a comprehensive desk review of secondary data and documentation, including federal and state plans, programme documents, monitoring and financial reports and national surveys. Additionally, 68 key informant interviews and 29 focus group discussions with various stakeholders and beneficiaries provided qualitative insights. Field data on supply chain management were gathered through observations and interviews with key personnel at different levels of government.

KEY FINDINGS

Impact on child-health outcomes

Though nationwide targets were not met across the 36 states in Nigeria, a comparative assessment of the intervention and non-intervention states displayed positive effects of the intervention. Overall, child health indicators related to diarrhoea, fever and acute


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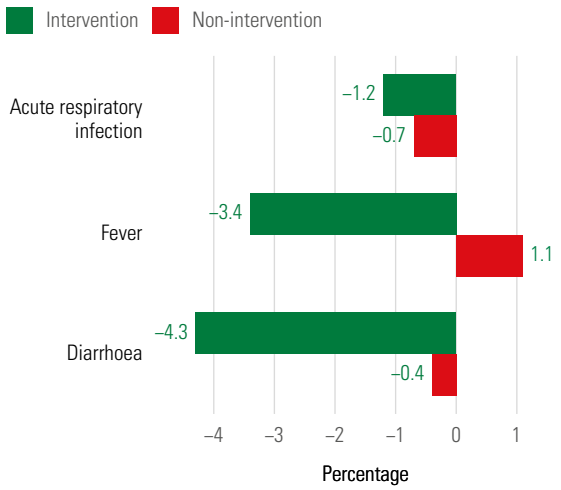
Figure 1: Percentage change in the prevalence of selected child-health outcomes post-intervention, 2011–2021



respiratory infections showed a trend of more reductions during 2011–2021 in the 18 intervention states compared with the non-intervention states, but variations existed between geopolitical zones and states. Figure 1 shows the percentage change in the prevalence of selected child-health outcomes post-intervention.

The intervention showed a significant effect in reducing the odds of diarrhoea in the intervention group. In both the unadjusted and adjusted models, the odds ratio was 0.76, indicating a lower likelihood of diarrhoea in the intervention states compared to the non-intervention states. The households in the poorest quintiles in the intervention states were the most advantaged, displaying the equity focus of the programme. The programme also showed a significant effect in reducing the prevalence of fever in the intervention states. In both the unadjusted and adjusted models, the odds ratio was below 1 (0.81 and 0.83, respectively), indicating a lower likelihood of fever in the intervention states. However, the intervention did not show a significant effect on the odds of acute respiratory infections in both the unadjusted and adjusted models.

Impact on childhood mortality

The MNCAH-service-strengthening interventions had a significant impact on reducing neonatal mortality. In the unadjusted model, the odds ratio was 0.68 ($p = 0.007$), suggesting that the odds of neonatal mortality are 32 per cent lower in the intervention group than in the non-intervention group. After adjusting for confounders, the adjusted model showed an odds ratio of 0.65 ($p = 0.002$), indicating a similar reduction in neonatal mortality. For infant mortality, the unadjusted model suggests a potential reduction associated with the intervention, although it was not statistically significant (odds ratio 0.83, $p = 0.109$). However, when accounting for confounders in the adjusted model, the MNCAH interventions demonstrated a significant reduction in infant mortality, with an odds ratio of 0.80 ($p = 0.035$). In contrast, there was no significant treatment effect observed on under-five mortality in both the unadjusted and adjusted models.

The best achievement in neonatal mortality reduction was seen in the intervention group in the South-West geopolitical zone, which showed a 52 per cent reduction in neonatal mortality compared to no reduction in the non-intervention group in the same region.

Overall, Lagos, Oyo, Yobe and Zamfara were the best performing states, showing positive effects of the programme interventions in all the childhood mortality indices and in diarrhoea prevalence. Benue, Kano, Kebbi and Nasarawa states showed decreases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in all three childhood mortality indicators but not in diarrhoea prevalence.

States that had consistently increased budgetary allocations to their health sectors (Anambra, Benue, Kano, Kebbi, Lagos and Yobe) and those that increased their annual budget implementation rate by 25 per cent (Borno, Kano, Yobe, Kebbi, Kaduna and Oyo) contributed to the positive impact of the programme on childhood mortality and/or the reduction in childhood diarrhoea prevalence. This displayed the importance of states' financial commitments to their health sectors.

Of the 18 intervention states, 11 had drug revolving fund systems. Ten of these 11 states contributed to the programme's impact and/or the reduction of childhood diarrhoea prevalence. Specifically, 8 of these 10 states (Adamawa, Cross River, Gombe, Kano, Lagos, Nasarawa, Yobe and Zamfara) contributed to the programme's impact on childhood mortality. Figure 2 displays the impact of the intervention on childhood mortality.

In terms of maternal health outcomes, the interventions significantly increased the odds of postnatal care for both children and mothers in the adjusted model, suggesting a positive effect of postnatal care utilization. Changes in prevalence of some maternal health indicators post-intervention are shown in Figure 3.

However, in the assessment of impact, the interventions did not display significant effects on the '4+ antenatal visits' and 'skilled birth attendance' indicators. Nevertheless, overall, more pronounced positive trends in PMTCT care utilization among HIV-positive pregnant women were displayed in the intervention group than in the non-intervention group.

The 'one primary health-care centre per ward' initiative was fundamental in pursuing universal health coverage. By the end of the programme, over 400 new primary health-care centres were established across various wards, significantly increasing access to basic health services. These centres served millions of people, reducing the average distance to the nearest health facility from over 10 kilometres to less than 5 kilometres for many rural communities.

UNICEF provided significant technical support for the revitalization of primary health-care services. This included capacity-building initiatives for state stakeholders to enhance their ability to deliver quality health services.

More than 10,000 health-care workers were trained, improving the quality of health-care services. This included training in essential maternal and child health-care practices and emergency obstetric and newborn care. Additionally, over 500 health facilities were upgraded with better infrastructure and equipment, directly benefiting millions of patients. Technical support also included developing and implementing health policies and protocols that standardized care across facilities.

Figure 2: Percentage change in childhood mortality indices post-intervention, 2011–2021

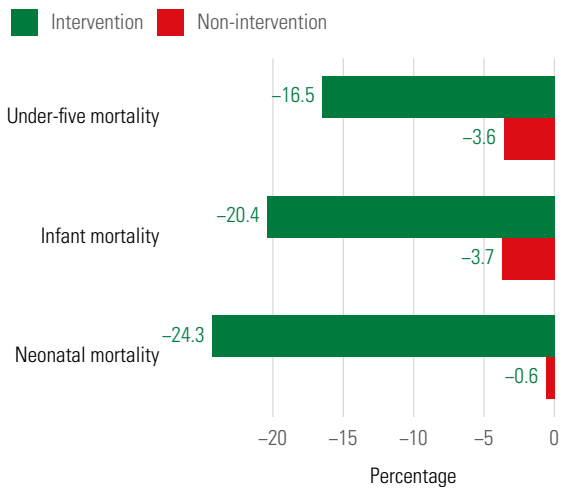
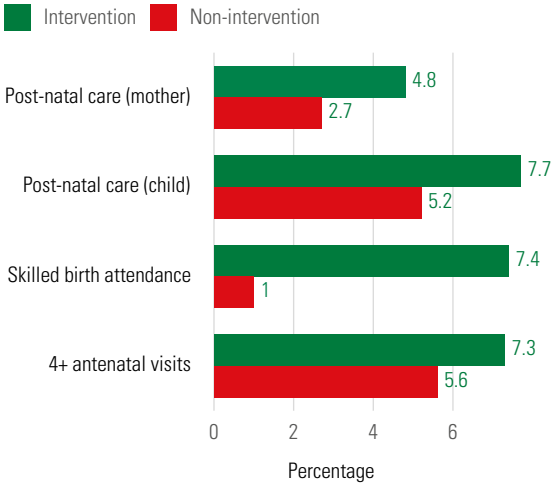


Figure 3: Changes in prevalence of selected maternal health indicators post-intervention, 2011–2021



Challenges and quality of care

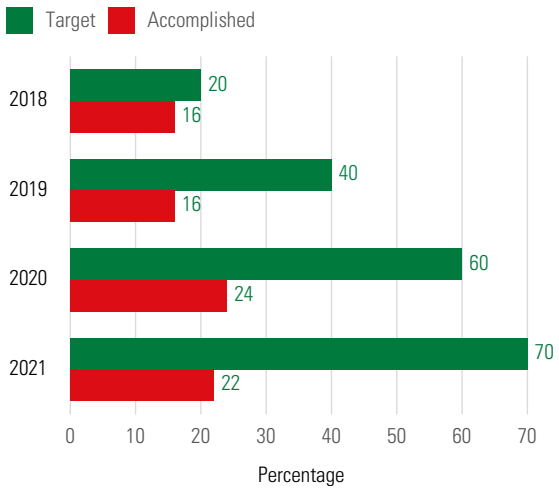
The Health and HIV/AIDS component of the Country Programme 2018–2022 was implemented within the context of a severe humanitarian crisis in the north-east and a precarious security situation in the north-west, further complicated by the global COVID-19 pandemic and the devastating cholera outbreak in 2021.

The nationwide performance evaluation of some impact and upstream interventions in the 36 states of the federation showed that the programme impact and outcome targets were not achieved by 2021 and the trajectory of improvements showed that, due to the aforementioned disruptions, they were unlikely to be achieved by 2022.

The programme displayed flexibility during the COVID-19 lockdowns and restrictions, adopting different virtual innovations for advocacy and to facilitate trainings and orientation sessions. There was integration of resources and activities, with several thematic areas across units in health facilities taken into consideration to improve efficiency. For instance, GeneXpert machines were used for tuberculosis, HIV and COVID-19 tests. To address issues of loss to follow-up before and after treatment, the programme tried to ensure that clients had access to commodities through digital methods of tracking supply and demand, especially for HIV patients. Key vendors in communities were also identified to support the procurement of commodities to allow easier access for clients. The programme also used the pandemic as an opportunity to strengthen the immunization system, including cold chain storage capacity and oxygen supply systems.

The cholera epidemic caused twice as many deaths in one year in the country as the COVID-19 pandemic did in two years. The overall case fatality rate of 3.2 per cent was a pointer to limitations in case management, health-care access or both.

Figure 4: Percentage change in the prevalence of selected child-health outcomes post-intervention, 2018–2021



Overall, the quality of health-care services delivered was suboptimal due to poor budgetary allocation by the government. Security and governance issues and an unstable economy were major factors that hindered change the most between 2018 and 2022. Data quality issues (especially in District Health Information Service 2) hindered effective tracking of change in the programme. Human resource challenges, such as health workforce shortages (exacerbated by post-COVID mass emigration of health workers); poor health infrastructure; and shortage of health commodities and drugs were all key challenges.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The Nigerian government's expenditure on health was inadequate throughout the 2018–2022 programme period, with average health provision barely exceeding 3 per cent. Public health expenditure as a proportion of gross domestic product was low at 0.65 per cent, less than the 4–5 per cent of gross domestic product suggested for realizing universal health coverage. In 2022, the percentage of government health expenditure as a share of gross government expenditure was 4.3 per cent (increasing to 5.75 per cent in 2023), far below the 15 per cent target set in the Abuja Declaration in 2001.

Furthermore, poor budget utilization was common and the release of allocated funds was often hampered. It is also important to note that budgetary allocation did not automatically translate into actual spending. The percentage of states that increased their annual budget implementation rate by 25 per cent was less than the target throughout the programme years (see Figure 4, p. 6).


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GOOD PRACTICES AND POLICY IMPLICATIONS

- Intensive social behaviour change activities effectively create demand and **stimulate utilization of MNCAH and prevention of mother-to-child transmission (PMTCT) services. Engaging multiple actors at different levels** enhances knowledge and awareness of interventions like immunization, antenatal and postnatal care and HIV issues. Community ownership through religious and traditional structures and health-related mobilization structures like ward development committees is crucial for success. Community engagement with peer support structures like mentor mothers improves PMTCT and paediatric HIV service uptake.
- Strengthening **integration between the MNCAH, immunization, HIV and nutrition sectors** accelerates achievements even if resources are limited. Integrated health, nutrition and child protection campaigns lead to better outcomes for children. **Combining routine antenatal care and PMTCT services** improves outcomes for mothers and babies. The integrated primary health-care model supports state priorities and reduces system fragmentation.
- **Concentrating resources on one issue** for significant impact quickly is effective. The programme's success in immunization coverage demonstrates this. Investments in integrating delivery methods, social mobilization and expanding the vaccine cold chain increased coverage significantly.
- **High-level engagements are crucial** for support and achieving results. Strategic partnerships with the Presidency and federal ministries promote accountability and policy advocacy for children's agendas. UNICEF leveraged national dialogue on PMTCT and engaged with the Vice-President's Office and the Ministry of Budget and National Planning to influence child-sensitive indicators and targeted social protection services for children.


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RECOMMENDATIONS

The government and UNICEF should prioritize addressing the fiscal gap, which has stalled progress and challenges the sustainability of the programme. The evaluation has provided evidence that states that showed more financial commitments towards health contributed to programme impact. **Several strategies can be used to address the financial gap:**

- **Intensify advocacy efforts to increase the government annual budget for the health sector to at least 10 per cent**, closer to the 15 per cent target of the 2001 Abuja Declaration, to meet the country's health services requirements. Kaduna and Sokoto states were able to achieve 15 per cent between 2020 and 2022. In addition to budget commitments, actual release of counterpart funding for the Basic Health-Care Provision Fund and other donor-supported funding is crucial to achieving programme targets.
- **Intensify advocacy for the actualization and implementation of the Sector-Wide Approach in Health (SWAp–Health) and the Nigeria Health Sector Renewal Investment Initiative.** These present opportunities as critical pathways towards feasible joint, long-term, domestically financed national and state health systems and universal health coverage. UNICEF can support the process in several ways:
  - Create awareness and propose possible solutions to relevant stakeholders on ways to address contextual issues that challenge SWAp. For instance, Nigeria's highly decentralized health-care system and the country's weak public financial management system are key elements to consider.
  - Build government capacity for the implementation of SWAp–Health and support the rethinking of the current implementation model, which involves multiple memoranda of understanding with state governments.
  - Support the speedy development of an implementation framework that includes expenditure, monitoring, evaluation and accountability frameworks. This will maintain the momentum already achieved among donors and other stakeholders. Clarity on the code of conduct, available assets and resources at state level and financial transparency relating to allocation, disbursement and actual use of funds will encourage financial commitments to the pool and actualization of the SWAp model.
  - Continue direct engagement with states to advocate for increased fiscal space and allocation of funds for health.
- **Strengthen public–private sector collaboration** to bridge the funding gap worsened by the decline of donor funding.
- **Introduce a climate-oriented (health-related) vision and explore other emerging areas (such as mental health)** to enable UNICEF to have a competitive advantage and added value, especially with regard to attracting available donor funding.

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