United Nations Population Fund (UNFPA) Nigeria 8th Country Programme (2018 – 2022)

Final Evaluation Report

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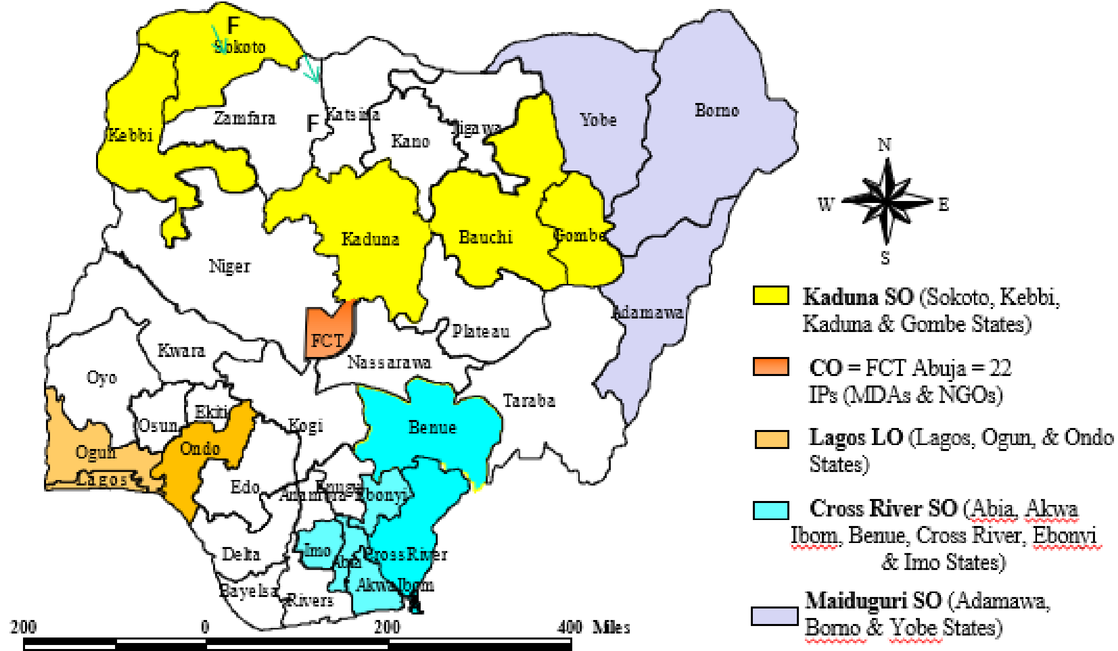
Volume 1: Main Report

Map of Nigeria with UNFPA Focal States



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Abbreviations and Acronyms

ABU	Ahmadu Bello University
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
AYP	Adolescents and Youth Programmes
BAY States	Borno, Adamawa, Yobe States
BMGF	Bill & Melinda Gates Foundation
CA	Communications Analyst
CBO	Community-based Organisation
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CIP	Costed Implementation Plan
CO	Country Office
COAR	Country Office Annual Report
CLMS	Contraceptive Logistics Management System
COVID-19	Coronavirus Disease 2019
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CR	Country Representative
CRVS	Civil Registration and Vital Statistics
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DaO	Delivering as One (by all UN partners)
DD	Demographic Dividend
DFID	Department for International Development
DHS	Demographic and Health Survey
DMPA-SC	Depomedroxy Medroxyprogesterone acetate –Subcutaneous
DoL	Division of Labour (of UN co-sponsors of UNAIDS)
EM	Evaluation Manager
EQ	Evaluation Question
EQA	Evaluation Quality Assessment
ERG	Evaluation Reference Group
EU	European Union
ET	Evaluation Team
FBO	Faith Based Organisations
FCT	Federal Capital Territory
FGI	Focus Group Interview
FGM	Female Genital Mutilation
FLHE	Family Life Health Education
FMA	Frisky Mobile Application
FMWA	Federal Ministry of Women's Affairs
FMoH	Federal Ministry of Health
FMoYSD	Federal Ministry of Youth and Sport Development
FP	Family Planning
GBV	Gender-Based Violence
GBViE	Gender-based Violence in Emergencies
GCCC	Government Cash Counterpart Contribution
GDP	Gross Domestic Product
GEWE	Gender Equality and Women's Empowerment
GIS	Geographical Information System

GNI	Gross National Income
GoN	Government of Nigeria
GPI	Gender Parity Index
GRID3	Geo-Referenced Infrastructure and Demographic Data for Development
HBV	Hepatitis B Virus
HCT	Humanitarian Country Team
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPTRP	Health Policy Training and Research Programme
HRP	Humanitarian Response Plan
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
IDP	Internally Displaced Person
ILO	International Labour Organization
IMF	International Monetary Fund
IMPACT	Information Mobilized for Performance Analysis and Continuous Transformation
IMR	Infant Mortality Rate
IP	Implementing Partner
KOICA	Korean international Cooperative Agency
KII	Key Informant Interview
LARCs	Long-Acting Reversible Contraceptives
LMIS	Logistic Management information System
mCPR	Modern Contraceptive Prevalence Rate
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MEA	Monitoring and Evaluation Advisor (regional)
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MoU	Memorandum of Understanding
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MPDSR	Maternal and Perinatal Death Surveillance and ResponseMSMMen who have Sex with Men
MTP	Medium Term Plan
MTR	Mid Term Review
MVA	Manual Vacuum Aspiration
NACA	National Agency for the Control of AIDS
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organisation
NPHCDA	Nigeria Primary Health Care Development Agency
NMC	Nursing and Midwifery Council
NNTC	Nigeria National Technical Committee
NPC	National Population Commission
NV20:2020	Nigeria Vision 20:2020
NV20:2030	Nigeria Vision 20:2030
NWOW	New Way of Working
ODA	Official Development Assistance
OECD	Organization for Economic and Cultural Development
PMTCT	Prevention of Mother to Child HIV Transmission
PD	Population Dynamics
PoA	Programme of Action (of ICPD)
PLW	Pregnant and lactating women
PPE	Personal Protective Equipment
PRB	Population Reference Bureau
RBM	Results-based Management
RC	Resident Coordinator

RCO	Resident Coordinator's Office
RHR	Reproductive Health and Rights
RMNCAH+N	Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
RRF	Results and Resources Framework
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedure(s)
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
UN Women	United Nations Entity for Equality and the Empowerment of Women
UNAIDS	United Nations Joint Programme on AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
UNJT	UN Joint Team on HIV and AIDS
UNSDPF	UN Sustainable Development Partnership Framework
USD	United State Dollars
VAPP Act	Violence Against Persons (Prohibition) Act
WB	World Bank
WCARO	Western and Central Africa Regional Office (of UNFPA)
WHO	World Health Organization
YC	Youth Cohorts
YFC	Youth Friendly Centre

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Table of Key Facts on Socio-Economic, Demographic and Health Indicators

Indicators	Values	Source
Land Area		
Geographical location	West Africa	
Land area in square kilometers (km^2)	923,768 (km^{2})	NV20:2020[1]
Population		
Population size census	140,431,790	2006 NPC[2]
Projected population size in 2021	211,493,324	2020 NPC
Rate of population growth per annum	3.2%	2006 NPC
Percentage of Nigeria urban population	49.5%	2015[3]
Male	26.7%	
Female	22.8%	
Women of reproductive age (15-49) as a percentage of the total population of women projected for 2016	50.6%	2016, NPC[4]
Women of reproductive age (15-49) as a percentage of the total population of women projected for 2021	47.7%	2021, NPC
Mortality		
Neonatal mortality rate	39/1,000	2018 NDHS[5]
Post-neonatal mortality rate	132/1,000	2018 NDHS
Infant mortality rate	67/1,000	2018 NDHS
Life expectancy at birth	54 years	2018 WB [6]
Maternal mortality ratio (per 100,000 live births)	512	2018 NDHS
Fertility and Early Marriage		
Total Fertility Rate	5.3 children	2018 NDHS
Adolescent Fertility Rate	118/1000	2018 NDHS
Percentage of adolescent girls aged 15-19 who are in first marriage	43%	2018 NDHS
Contraception		
Modern contraceptive prevalence rate among currently married womenaged 15-49	12%	2018 NDHS
Unmet FP needs for among currently married women aged 15-49	19%	2018 NDHS
Maternal and Newborn Health		
Proportion of ANC by skilled healthcare provider	67%	2018 NDHS
Proportion of births assisted by skilled provider overall	43%	2018 NDHS
Percentage receiving antenatal care from a skilled provider by geo-political zone		
Northcentral	66.2%	
Northeast	58.5%	
Northwest	53.9%	
Southeast	89.2%	
South-South	77.1%	2018 NDHS
Southwest	88.2%	
Prevalence of GBV and Female Genital Mutilation (FGM) among women aged 15-49		
Percentage of women who have experienced spousal violence, whether physical, sexual, or emotional	36%	2018 NDHS
Prevalence of FGM among women age 15-49	20%	2018 NDHS
HIV and Sexual Behaviour		
Prevalence of HIV among population aged 15-49	1.4%	2018 NAIIS[7]
HIV prevalence among women aged 15-49	1.9%	2018 NAIIS
Prevalence of HIV 15-19 years	3.5%	2018 NAIIS
Economy		

[1] Nifty 50 Value 20 Index (2020) www.icicipruamc.com
[2] National Population Commission (2006) Population and Housing Census
[3] World Bank collection of development indicators (2016)
[4] National Population Commission (2016) - Statistical report on women and men in Nigeria
[5] National Population Commission (2018) Demographic and Health Survey www.dhsprogram.com
[6] World Bank (2018) www.worldbank.org
[7] Nigeria HIV/AIDS Indicator and Impact Survey (2019) www.naiis.ng

GDP 2018	$577.34 million	NBS, 2019[8]
GDP per capita 2018	$2,229	NBS, 2019
Growth rate 2018	2.2%	NBS, 2019
Inflation rate 2018	16.5%	NBS, 2019

Progress in Nigeria against the Sustainable Development Goals

Sustainable Development Goals (SDGs) Status	Indicator and source	Status
Goal 1. End poverty in all its forms everywhere	Proportion of population below the international poverty line.	62.6[9]
	Proportion of men, women and children of all ages living in poverty in allits dimensions according to national definitions	42.2
	Proportion of population covered by social protection floors, distinguishing children, unemployment persons, older persons, persons with disabilities, pregnant women, new-born, work-injury victims, and the poor and the vulnerable.	5.56
Goal 2. End hunger, achieve food security and improved nutrition, and promote sustainable agriculture	Proportion of children under 5 years who are underweight	n/a
	Proportion of under 5 years severely underweight	72
Goal 3. Ensure healthy lives and promote well-being for all at all ages	Maternal mortality ratio (per 100,000 live births)	176
	Births attended by skilled health personnel	43.3
	Antenatal care coverage	61%
	Infant mortality rate (per 1,000 live births)	67
	Under 5 years mortality rate (per 1,000 live births)	132
	HIV prevalence among general population	1.4%
	HIV prevalence among 20-24 years old	4.2%
	Proportion of adult population infected with HIV accessing ARVs	1.4%
	Proportion of pregnant women who slept under ITN	7.5%
	TB incidence rate (per 100,000)	2.8
	Contraceptive prevalence rate among currently married women aged 15-49	12%
	Unmet need for family planning	19%
Goal 4. Ensure inclusive and equitable quality education and promote life-long learning opportunities for all	Primary school net enrolment rate (NER)	63.8%
	Proportion of pupils completing primary school	73.3%
	Primary to secondary transition rate	57.7%
	Secondary school NER	46.9%
	Ratio of girls to boys in primary school (NBS)	2.27
	Annual growth rate of real GDP per capita (%)	2.20
Goal 5. Achieve gender equality and empower all women and girls	Does Nigeria have legal frameworks in place to promote, enforce andmonitor equality and non-discrimination based on sex?	Yes
	Proportion of women aged 15-49 years who were married or in a unionbefore age 15years	15.7
	Proportion of women aged 20-49 years married or in union before age 18	43.4
	Annual growth rate of real GDP (%) – (2019)	1.22[10]

[8] National Bureau of Statistics (2019) www.nigerianstat.gov.ng

[9] Nigeria Integration of the SDGs into National Development Planning - A Second Voluntary National Review Integration – (2020) - OSSAP-SDGs

[10] National Bureau of Statistics – (2019). - https://nigerianstat.gov.ng

Goal 8. Promote inclusive and sustainable economic growth, employment, and decent work for all	Unemployment rate	23.1

Structure of the Nigeria Country Programme Evaluation (CPE) Report

The CPE fully complies with the stipulations of the UNFPA Handbook 2019 on conducting country programme evaluations. The preliminary pages include: the title; consultant team; map of Nigeria showing the states that UNFPA supports by the geo-political zones, and from which the field visits were drawn; acknowledgments; the table of contents; abbreviations and acronyms; list of table and figures; the key facts table plus an overview of relevant Sustainable Development Goals (SDGs) achievements in Nigeria; and the executive summary.

The main report has six chapters. Chapter 1 introduces the 8th Country Programme Evaluation (CPE) purpose and objectives, the scope of the evaluation, and the methodology and process. Chapter 2 summarizes the country context, with main development challenges and national strategies in the areas of concern to UNFPA, and the extent and role of external assistance. Chapter 3 indicates the UN and UNFPA responses and programme strategies, the UNFPA strategic response and the response through the 8th country programme, compares the previous 7th programme cycle and the current 8th programme cycles' thematic areas, outcomes, and outputs, and presents the country programme financial structure. Chapter 4 presents the findings at strategic level and thematic programme levels; while addressing relevance and responsiveness, effectiveness and coverage, efficiency, sustainability, and coordination and cohesion, with a particular focus on the humanitarian situation. Chapter 5 presents the conclusions drawn from the findings, and Chapter 6 presents the linked recommendations. The report has nine annexes: the terms of reference; list of institutions and persons met; documents consulted; list of Atlas projects; evaluation matrix; the main tools; theory of change; country programme achievements table; and the implementing partners and budget and implementation rate across the years of the CP.

Executive Summary

1. Purpose and Objectives of the Evaluation of Nigeria 8CPE and Intended Audience

The UNFPA Nigeria Country Office (CO) commissioned the 8th Country Programme Evaluation (8CPE) in line with the 2019 UNFPAEvaluation Policy[11] in order to: demonstrate to all stakeholders[12] the accountability of the 8CP 2018 – 2022 in achieving results and regarding invested resources; support evidence-based decision-making; and to contribute key lessons learned regarding accelerating theimplementation of the ICPD 1994 Programme of Action. It provides an independent assessment of the 8CPE and informs and broadens the evidence base for the design of the next programme cycle, 9th CP (2023-2027). The objectives are to assess: the relevance, effectiveness, efficiency, sustainability, and coordination of UNFPA support and progress towards the results framework; the humanitarian coverage of UNFPA programming and the link between immediate and long-term development objectives; and UNFPA contributions to the UN Country Team and Humanitarian Country Team. Also, to draw key conclusions and provide clear, forward- looking, actionable recommendations for the next programme cycle.

The intended audience is the Nigeria UNFPA CO and sub-offices, all partners, and stakeholders, the UNFPA West and Central Africa Regional Office (WCARO) and headquarters, and the UNFPA Executive Board. The final report and the evaluation quality assessment will also be available on the UNFPA website to reach a wider audience.

2. Country Programme (CP) Outline

The 8th CP has four thematic areas, sexual and reproductive health (SRH) services, adolescents, and youth (AY), gender equality and women's empowerment (GEWE), and population dynamics (PD), and addresses the cross-cutting issues of human rights, gender mainstreaming and disability. The focus of all thematic areas is on building capacity, including for policy development, finance, services,human capital, knowledge management and information, using all five modes of engagement: advocacy and policy dialogue; capacity development; knowledge management; partnership and coordination, as well as service delivery Addressing humanitarian situations is amajor focus throughout.

The SRH services thematic area is addressed by three outputs, to strengthen policy, services, and human resources for SRH respectively.This includes family planning and maternal and neonatal health and addressing obstetric fistula and the needs of adolescents and youth.In the adolescents and youth thematic area, the single output focuses on multi-sectoral youth-related policies to address their wider reproductive health, development, and well-being. In GEWE, the single output addresses multi-sectoral capacity regarding gender-based violence (GB), including data, health services, psychosocial support, and coordination. Under PD, the focus is on population projections and addressing socio-demographic trends in policies and programmes, including advocacy. The results chain logic and logic across thematic areas is not entirely clear, with apparent areas of overlap between the thematic areas.

3. Methodology

The CPE had the five phases of preparation, design, field, reporting, and facilitation of use and dissemination. In the ***preparatory phase***the evaluation manager set up the evaluation reference group (ERG), jointly with the ERG developed terms of reference, and recruited one international, two national consultants and a young emerging evaluator. The consultants ***designed the evaluation*** and drafted a designreport for approval by the ERG, undertook the ***field*** phase of primary and secondary data capture and analysis, and ***reported and presented*** their findings, conclusions and recommendations to the CO, and incorporated feedback for further review by the CO and ERG, and further feedback from the stakeholder meeting and after evaluation quality assurance (EQA). In the ***facilitation of use and dissemination phase,*** the consultants undertook the final incorporation of comments, and the CO implemented the full communication plan to share thereport, the management response and, finally, publication of the report on the UNFPA website.

The UNFPA Handbook 2019[13] and UN ethical standards, including UNFPA COVID-19 guidelines, guided the evaluation process throughout, and also, the structuring of the design and final reports. The evaluation purpose, objectives, overall process, and methods (including the evaluation matrix, overarching questions, evaluation criteria and main tools), a brief country situation overview and overview of the present and previous UNFPA country programming are described in the design report. The CO assisted with stakeholder selection, which followed the Handbook requirements, and the overarching theory of change was reviewed during field work. The evaluation had a participatory approach, and the extensive document review was supplemented by largely virtual semi-structured interviews with wide ranging stakeholders. Field visits were undertaken in nine states for some key informant interviews, focus group

[11] ToR for UNFPA CPE 2021

[12] UNFPA WCARO and Headquarters, the Government of Nigeria, civil society implementing partners and programme beneficiaries

[13] Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, 2019

interviews with primary and secondary beneficiaries, and site visits (health and regarding GBV). Confidentiality was assured throughout. Both qualitative and quantitative data were captured, and the evaluation involved analysis and triangulation of data from both the primaryand secondary sources. The full list of documents and stakeholders reached are annexed. The conclusions and recommendations are basedon robust assessment of the findings and, where the consultants were not sufficiently confident or there was ambiguity in the findings, this is acknowledged. The CPE achieved its purpose and the main objectives.

4. Main Conclusions

The 8CP is **fully relevant** and adapted to international frameworks of the SDGs and ICPD programmes of action, as well as to other international commitments and the New Way of Working, to UNFPA global strategic direction and objectives, the UN Strategic Development Partnership Framework for Nigeria and to Nigeria Vision 20:2020, although the theory of change needs elaborating furtherto reflect this fully. It is also well aligned to national priorities and the needs of diverse populations, including the more vulnerable and marginalised, particularly young women. However, despite Nigeria having the second highest number of people living with HIV, and UNFPA holding the mandate for prevention of sexual transmission of HIV, the focus on HIV appears insufficient. UNFPA has shown **strong responsiveness** to changing needs and priorities in Nigeria, particularly in relation to humanitarian settings and with regards COVID-19, as well as in relation to specific issues such as high teen pregnancies and reaching high numbers of girls and women duringsporadic displacements with dignity kits.

The 8CP **effectively achieved most planned activities across all thematic areas**, reaching or exceeding the output targets in many cases, although financial limitations impeded the achievement of some results and many initial targets had to be revised down. Revisionsto planned activities were also made in relation to COVID-19. All modes of engagement were deployed, although the balance of modesof engagement in different states may need review to strengthen strategic results. The results logic between thematic areas also merits a rethink to become more streamlined. Interventions included contribution to developing laws and policies across the thematic areas to achieve a more enabling environment, capacity development of rights bearers to strengthen services, direct service support, community engagement and awareness creation, and empowerment of stakeholders including the more marginalized. The availability of populationdata for development was enhanced, although without the planned census. Human rights, gender and disability inclusion were all addressed and seen to be strengthened during the 8CP. Coverage remains insufficient to meet all needs, however, particularly in humanitarian settings because of the huge and increasing scale of need.

UNFPA has shown **improving efficiency** during the 8th CP. The agency has made generally good use of human, financial and administrative resources, but with sub-optimal budget utilisation for various reasons including, in the past two years, COVID-19 restrictions. There is insufficient movement away from direct project funding towards emphasizing government financing in order to achieve more strategic, sustainable results. High adherence to standard protocols and systems is evident, and M&E has improved duringthe CP in the use of GPS and SIS, although M&E in the field inevitably declined during COVID-19. Delays in filling key staff posts hasreduced efficiencies at times and increased the stress on remaining staff. Staff presence on the ground makes programming more efficient,
e.g., for capacity building and monitoring. UNFPA staff from all the offices gave mostly positive feedback in an anonymous online internal review.

Various aspects of UNFPA programming should **contribute to sustainable results**. UNFPA programming focuses on strengthening government at national and state level to improve SRH, gender equality and women's empowerment, and for improved generation and use of population data. The results show increased national ownership, increased capacity and budgetary allocations of government, positive legal and policy development, improved services for SRH and regarding gender issues, and greater generation and use of population data. In addition, capacity has been built to varying extents in implementing partners (IPs) and rights holders. However, manygaps and issues remain, including high staff turnover especially in government IPs.

Regarding **coordination**, the UNFPA contribution to the UN Country Team and Humanitarian Country Team coordination mechanismsis extensive and greatly appreciated, including for the UN delivering as one and, in the UN, Joint Team on HIV and AIDS. Also, **connectedness and cohesiveness** are evident in several joint interventions with other UN agencies across sexual and reproductive healthand addressing GBV, including involvement in multi-country programming. UNFPA **interventions in humanitarian settings** are extensive across all thematic areas but cannot systematically reach all geographic areas with affected populations because the scale of need is so high. Capacity is being built in local and national actors to address the humanitarian crisis, and also, the longer-term goals towards peace

and development, but with challenges in recruiting, training and retaining sufficient personnel in the humanitarian settings.

At a **strategic level**, UNFPA programming for the demographic dividend, family planning, gender, and strengthening population data are all essential, as continued high population growth will jeopardise achievement of all sustainable development goals. However, it appears that UNFPA may be spreading itself too thin to achieve optimal, sustainable results, with 54 implementing partners across 16 states and the Federal Capital Territory. This poses a heavy administrative and oversight burden, and the capacity building for IPs may be too broad and of insufficient depth, with inadequate quality assurance and follow up. Spreading so thin reduces the scope for significantoutcome results. UNFPA has not moved sufficiently from project funding to a financing modality to support quality government programming. Given the severe inequalities, high poverty levels and diverse nature of Nigeria as a country, it is appropriate that UNFPA has utilized all modes of engagement, although it is essential in the way forward to strategise for catalytic results through a shift from funding multiple projects to government financing to provide quality programming. Despite its high relevance, the results and resourcesframework of the 8th CP lacks sufficient logic across thematic areas and the theory of change has significant gaps.

UNFPA responded extensively to humanitarian needs, including in the context of COVID-19. UNFPA established a humanitarian sub- office with fixed term posts. Inevitably, however, programme coverage could not address the full scale of the problems, which includedemerging and escalating crises and, elsewhere, state transitioning to peace and development. The response included renovation of healthfacilities, supply of commodities and equipment, staff training and assisting access to services, as well as the gender response noted below. However, the exodus of health workers from humanitarian situations is one major ongoing challenge among many.

With regards to **sexual and reproductive health (SRH)** services, despite extensive support from UNFPA and partners, provider capacityfor SRH remains insufficient to provide the coverage of quality services needed for family planning, maternal and neonatal health, to address obstetric fistula, and to meet the needs of young women. Funding issues contributed to the challenges, particularly around contraceptive commodities and medicines for maternal health, and high staff turnover in the health services reduces the long-term benefits of both pre- and in-service training. UNFPA contributed to strengthening contraceptive procurement and distribution, but both supply and uptake remain inadequate to meet immediate and long-term needs. With regards HIV prevention in priority populations of sex workers, men who have sex with men and other key populations, or in young women, UNFPA has not sufficiently addressed HIV prevention although Nigeria has high numbers of people living with HIV, and UNFPA was active at policy and coordination levels.

Resource allocation to **adolescents and youth**, particularly to adolescent girls and young women, was insufficient for extensive capacitydevelopment as required to harness the demographic dividend, although the 8th CP did contribute to strengthened policies, strategies, andprogrammes in relevant sectors to address their SRH, development and well-being. Access to and uptake of SRH services increased, including opportunities to build knowledge and skills, but the focus of providers emphasized abstinence as opposed to comprehensive sexuality education, with conservative traditional and religious values proving an impediment. Engagement of young people in the humanitarian setting was particularly effective, although far larger numbers remain to be reached. Young people with disabilities were not systematically reached in programming, but during the 8th CP the focus on people with disabilities was strengthened.

Gender Equality and Women's Empowerment (GEWE) has been addressed through successful policy support as well as holistic approaches in joint programmes and projects to prevent and respond to gender-based violence (GBV), and to end harmful traditional practices such as female genital mutilation (FGM) and child marriage. This focus is entirely appropriate given the extent of GBV, particularly in humanitarian settings, with capacity building of rights bearers, a one-stop centre, and safe spaces for survivors in the response to the Call to Action. Numbers reached have greatly exceeded targets and beneficiaries are highly appreciative. However, the thematic focus inappropriately incorporates related aspects that belong in other thematic areas. Certain gaps are also apparent, such as achieving justice for survivors and addressing longer-term safety in the context of intimate partner violence (IPV). Synergies between different projects may not be optimal, and contributions to sustained outcomes are not always clear.

In **population dynamics**, UNFPA contributed through financial and technical support to considerable progress in the production, dissemination, and use of socio-economic data to monitor achievements of the Sustainable Development Goals and to guide multi-sectoral policies and plans at national and state levels. Examples include a Multiple Indicator Cluster Survey (MICS), Nigeria Demographic Health Survey (DHS), Commodity Security Survey and Demographic Dividend programming. Weak capacity of the implementing partners, including for coordination at the national level, remains a challenge, however, despite efforts to build capacity, and there is farto go for optimal capturing and use of population data across multi-sectoral policies and planning. UNFPA supported programming for the demographic dividend, a

demographic and health survey and preparatory actions for the census that is overdue but, despite its great importance, political and other concerns meant that it did not take place.

5. Main Recommendations

At the **strategic level**, UNFPA should give priority to multi-sectoral advocacy at the highest national and state levels to catalyse government investment to achieve the demographic dividend and demographic transition, including an investment case for the three UNFPA transformative results, and to build capacity among youth and for staff for quality health services. There is need to explore strategic partnerships and innovative funding modalities to leverage the finance needed for quality government programming. To achievemore effective results UNFPA should consider narrowing the range of supported states and intensify programming within them, with fewer implementing partners, and consider whether to capacitate one strong IP to oversee others in that state. All modes of engagement remain relevant, but UNFPA should evaluate the balance of modes of engagement to ensure optimal strategic weight across thematic areas and geographically. The humanitarian response should be incorporated as a core programme with dedicated funding and a long- term focus. Further capacity needs to be built with strategic partnerships to address SRH, GBV and to capacitate adolescents and youth in humanitarian settings, widening the geographical scope of interventions as humanitarian situations emerge, change, and develop. Howto strengthen the theory of change with respect to content, logic and specificity is elaborated in the first chapter.

In **SRH**, UNFPA should intensify efforts to leverage funding to build contraceptive supply chain stewardship nationally and sub- nationally, including for condoms with a total market approach. UNFPA should also help explore the potential for Nigeria to manufacturekey medicines for maternal health and family planning commodities and expand further the support for last mile distribution in line withintensified efforts at demand creation. UNFPA needs to strategize to optimize SRH service capacity through strengthening all areas of SRH, including for obstetric fistula linked with family planning, rethinking the balance of training and ongoing support modalities (physical and virtual) for pre- and in-service training, with advocacy to government for greatly increased financial investments and commitments for health. The agency also needs to work with the government on staff attraction and retention schemes. UNFPA needs tofulfill its accountability for HIV prevention according to the UNAIDS Division of Labour, with a greatly strengthened focus on priority populations, both advocacy for an enabling environment, and support to implement relevant pillars of prevention to reach them.

In relation to **adolescents and youth,** UNFPA should increase funding allocations and undertake continuous capacity building as well as advocating for greatly increased investment in young people across all sectors. UNFPA should advocate for and support state governments to domesticate and implement policy on comprehensive sexuality education and undertake evidence-informed advocacy atall levels with multi-sectoral actors, including community engagement to raise understanding of its importance for the health and development of all young people. Young people with disabilities should be systematically included.

The focus on **gender equality and women's empowerment, GEWE**, should be narrowed to strengthened advocacy for gender transformation, technical and financial support regarding gender-based violence, female genital mutilation, child marriage, girls and women's socio-economic and political empowerment, and the engagement of boys and men in communities. The other thematic areas need to strengthen their gender lens (in SRH services, data, and young people). A priority is high-level advocacy for the domestication of the Violence Against Persons (Prohibition) Act in the remaining states and support for its effective implementation. This needs to include advocacy for effective and ethical approaches to achieve justice for survivors and in relation to perpetrators. Greater synergies between the gender programmes and projects with more intense programming in a smaller number of states could achieve stronger, sustainable results and showcase achievements for other states, including lessons learned around GBV in humanitarian settings.

In **population dynamics**, UNFPA should continue to address capacity building in the government IPs at national and state level and support coordination, strengthen the relationship with the National Bureau of Statistics with a direct memorandum of understanding, andintensify support for packaging and distribution of data to meet diverse user needs. To emphasize the centrality of realizing the demographic dividend for all development goals, UNFPA should undertake high-level advocacy at national and state levels, including for demographic dividend programming, legislation to mandate a regular census and for resource mobilization. The agency should continue to provide technical support for the collection of data disaggregated by sex, age, disability, and other variables, and for data packaging, dissemination and use in all sectors.

1 Introduction

1.1 Purpose and Objectives of the Country Programme Evaluation

In line with the 2019 UNFPA Evaluation Policy, UNFPA Nigeria Country Office commissioned the 8th Country Programme Evaluation(8th CPE) 2018-2022 in order to: [14]

- Demonstrate accountability to stakeholders on the achievement of development results and on invested resources;
- Support evidence-based decision-making; and
- Contribute key lessons learned to the existing knowledge base on how to accelerate the implementation of the Programme ofAction of the 1994 ICPD.

The **specific purpose** of the 8th CPE as cited in the Terms of Reference (ToR) are to:

- Provide the UNFPA CO in Nigeria, national stakeholders, the UNFPA Western and Central Africa Regional Office (WCARO), UNFPA Headquarters, the Government of Nigeria, implementing partners in non-governmental organisations (NGOs) and civil society organisations (CSOs), and beneficiaries of UNFPA programmes with an independent assessment of the Nigeria 8th CP, and
- Inform and broaden the evidence base for the design of the next programme cycle (9th CP (2023-2027).

The CPE has the **objectives** to:

- Provide an independent assessment of the relevance, effectiveness, efficiency, sustainability, and coordination of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of the country programme.
- Provide an assessment of the geographic and demographic coverage of UNFPA humanitarian action and the ability of UNFPAto connect immediate, life-saving support with long-term development objectives.
- Provide an assessment of the role played by the UNFPA Nigeria country office in the coordination mechanisms of the UNCT and HCT (Humanitarian Country Team) with a view to enhancing the United Nations collective contribution to national development results and long-term recovery
- Draw key conclusions from past and current cooperation and provide a set of clear, forward-looking, and actionable recommendations for the next programme cycle.

1.2 Scope of the Evaluation

Beginning in October 2021 and ending in January 2022, the evaluation covered UNFPA Nigeria programmes and projects during the period from January 2018 to September 2021. It addressed the 8th CP thematic areas of sexual and reproductive health, adolescents and youth, gender equality and women's empowerment, and population dynamics. In addition, it addressed the cross-cutting issues of human rights, disability, internal displacement and migration, and transversal functions, such as coordination, office typology, management, monitoring and evaluation, innovation, resource mobilization and use, and strategic partnerships, with a 'deep dive' to analyze the response of UNFPA to the humanitarian crises of the insurgency and of the COVID-19 pandemic.

Geographically, the 8th CP evaluation covered all six geo-political zones addressed by the UNFPA programme: North Central, Northeast, North-West, South-East, South-South, and South-West, with a purposive selection from the 18 states of the federation and the Federal Capital Territory (FCT), where UNFPA has implemented interventions. As well as geographically specific programming for maternal health, adolescents, and youth and/or in relation to gender, gender-based violence (GBV) and harmful traditional practices in states within the six geo-political zones, including in humanitarian situations, UNFPA addresses family planning and population dynamics nationwide. Field visits were made to Borno, Sokoto, Oyo, Lagos, Kaduna, the FCT, Ebonyi, Cross River and Uyo to undertakeFGIs with primary and secondary beneficiaries, and for site visits. Annex 2 provides the full list of institutions and stakeholders consultedfor the evaluation.

[14] ToR for UNFPA Nigeria CPE 2021

1.3 Methodology and Process

1.3.1. Evaluation Criteria

UNFPA Handbook[15] on CPEs and in the ToR (Annex 1) stipulate standard evaluation criteria, and the evaluation followed these, whichare also indicated in the United Nations Evaluation Group (UNEG) and the Organization for Economic Cooperation and Development (OECD).[16] In addition, the evaluation followed the UNFPA global guidance on undertaking evaluations during the COVID-19 pandemic,and within the UN coordination framework of Nigeria, taking the national context into account. The core focal areas of the evaluation[17]are indicated in the table below from the ToR with, in addition, attention to the cross-cutting issues of a right-based approach, disabilityand gender mainstreaming, and to synergies between the thematic areas and UNFPA added value. The evaluation involved two levels ofanalysis, strategic and programmatic, and assessed the responsiveness of programming to emerging needs, in particular to the humanitarian crisis and the COVID-19 pandemic.

Table 1.1: Core criteria for the UNFPA Nigeria 8th CP evaluation[18]

Relevance	The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (in particular, those of vulnerable groups), and were aligned throughout the programme period with government priorities and withstrategies of UNFPA.
Effectiveness	The extent to which country programme outputs have been achieved and the extent to which these outputs have contributed tothe achievement of the country programme outcomes.
Efficiency	The extent to which country programme outputs and outcomes have been achieved with the appropriate amount of resources(funds, expertise, time, administrative costs, etc.).
Sustainability	The continuation of benefits from a UNFPA-financed intervention after its termination, linked, in particular, to their continuedresilience to risks.
Coordination	The extent to which UNFPA has been an active member of and contributor to existing coordination mechanisms of the UNCT. This also includes UNFPA membership of and contributions to humanitarian coordination mechanisms of the HCT: i) Internallydisplaced persons due to insurgency in Northeast Nigeria (BAY[19] States) and ii) response to the COVID-19 pandemic.
Coverage	How far humanitarian action reached major population groups facing life-threatening suffering.
Connectedness	The extent to which activities of a short-term support to IDPs in the BAY States are carried out in a context that takes longer-term and interconnection to the humanitarian-peace-development nexus into account. This also includes the extent to which the 8th CP (2018-2022) was responsive in mitigating the COVID-19 pandemic.

UNFPA strategic positioning is reflected in the agency's responsiveness to changing needs, its coordination roles and connectedness, and in the relation of the 8th CP to the Sustainable Development Goals (SDGs), the International Conference on Population and Development(ICPD) programmes of action, other international, regional and national commitments and policies, the United Nations Assistance Development Framework (UNDAF) outcomes for Nigeria and the UN partnership for delivering as one (DaO) as articulated in the UN Strategic Development Partnership Framework (UNSDPF).

1.3.2. Analysis of Theory of Change

The overarching theory of change (ToC), (Annex 7), was reviewed and felt to require strengthening with respect to overall content, degree of specificity and logic. The ToC is, in effect, in line with international, UNFPA and national commitments, but it does not specifically mention the UNFPA Strategic Plan 2018-2021. In some respects, it is insufficiently specific, for instance indicating that theUNFPA thematic areas of sexual and reproductive health (SRH) and adolescents and youth (AY) address 10 of the SDGs, and the othertwo thematic areas also address 10 SDGs, so that all areas of the SDGs are covered. Greater specificity regarding would be more useful.On the other hand, the specificity of some aspects of the ToC means that there are major omissions, for instance regarding modes of engagement and in the problem statements or risk factors. A significant gap is the lack of potential enabling factors that could assist the achievement of results, including synergies with government, the UN, and other partners. Chapter 4 goes further into the results chain logic of each thematic area.

[15] UNFPA Evaluation Handbook 2019: How to Design and Conduct a Country Programme Evaluation

[16] OECD/DAC evaluation criteria https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf.

[17] OECD/DAC evaluation criteria https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf.

[18] ToR for Nigeria CPE p26

[19] Borno, Adamawa and Yobe

The ToC only indicates three of the five modes of engagement, policy influencing, integrated service delivery and capacity building. These respond to the stated problems of weak capacity for policy development and implementation, weak capacity to deliver integrated family planning, maternal health and HIV services, and inadequate and unskilled human resources for health. Also, the ToC does not indicate in which institutions there is weak capacity – government, civil society, and/or the private sector. The problem statements shouldalso include at least: the enormous challenges of the humanitarian emergencies, with massive population displacement and violence; andthe severe gender inequality and GBV in the highly patriarchal culture; the extreme socio-economic inequality in the country; and, especially, the rapid population growth that is challenging health and well-being and contributing to poverty, violence and other fundamental concerns and, more than anything, putting at risk achievement of all the SDGs. The ToC should also note the limited use ofpopulation data for multi-sectoral policy and planning. Another gap is that only two of the outcome results of the UN Sustainable Development Partnership Framework (UNSDPF) are mentioned, whereas UNFPA contributes to all three. The UNDAF results to whichUNFPA contributes do not feature, although these are more specific and directly relevant for UNFPA programming (as indicated in the Results and Resources Framework).

In light of the above, it is proposed that:

- The ToC for the next CP retains as a chapeau the SDGs and AU 2063, replaces Nigeria's Vision 2020 with Vison 2030, and adds the global UNFPA Strategic Plan Bull's Eye: *Achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the International Conference on Population and Development agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights andgender equality.* Beneath or above this, the ToC could include the three global UNFPA transformative goals of ending a) preventable maternal mortality, b) the unmet need for family planning, and c) gender-based violence and all harmful practices;
- The new UNDAF results are added to which UNFPA will contribute;
- The problem statements are widened on the lines suggested above and are more specific to indicate where the institutional gapslie.
- Enablers are also added that can highlight potential opportunities for the strategic engagement of UNFPA, for instance with respect to strategic partnerships, increasing government financial contributions, more supportive policies, etc;
- The modes of engagement are widened to include all five: (a) Advocacy and policy dialogue; (b) capacity development; (c) knowledge management; (d) partnership and coordination and; (e) service delivery, and these could be placed horizontally beneath all the thematic areas;
- The underlying principles on which UNFPA operates[20] should be indicated also as cross-cutting for all the thematic areas and could form the basis of the ToC.

1.3.3. Evaluation Questions

The evaluation team developed the following overarching evaluation questions (EQs) to address the evaluation criteria above, based onthe draft questions in the ToR and guidance from the UNFPA Handbook. Probing around each question ensured a granular understanding of how the UNFPA 8th CP has functioned, highlighting the strengths and limitations.

Relevance and responsiveness

1.1 To what extent is the country programme adapted to: Priorities articulated in international frameworks and agreements, in particularthe ICPD Programme of Action and the SDGs, and the New Way of Working and the Grand Bargain; the strategic direction and objectives of UNFPA; and national development strategies and policies and the needs of diverse populations, including the needs of vulnerable andmarginalized groups (e.g., young people and women with disabilities)?

1.2 To what extent has the country office been able to respond to changes in national needs and priorities, including those of vulnerableor marginalized groups, or to shifts caused by crisis or major political changes, including innovations in relation to the COVID-19 epidemic?

Effectiveness and coverage

2.1 How far have the interventions supported by UNFPA delivered outputs and contributed to the achievement of the CP outcomes in each of its thematic areas, including reach to the most vulnerable?

[20] As expressed in the new global UNFPA Strategic Plan, and relating to human rights, leaving no-one behind, gender responsiveness, reducing risks and vulnerabilitiesand building resilience, a nexus approach to humanitarian and development actions, and relating to accountability, transparency, and efficiency

2.2 How far has UNFPA successfully integrated human rights, gender perspectives and disability inclusion in the design, implementationand monitoring of the country programme in all thematic areas?

Efficiency
3. To what extent has UNFPA made good use of its human, financial and administrative resources, and used a set of appropriate policies,procedures, and tools to pursue and to measure the achievement of the outputs and intended outcomes defined in the country programme?

Sustainability
4. How far across all thematic areas has UNFPA been able to promote national ownership in national policies, planning and programming, with increased budgetary allocations and strengthened capacity of government and civil society implementing partners, and supported rights-holders with mechanisms to ensure the durability of effects?

Coordination, connectedness, and coherence
5.1 To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms of the UNCT and the HCT?

5.2 How far is the 8th CP coherent with and engaged in joint interventions of the UN agencies and Government in relation to each thematicarea, including through the New Way of Working, NWOW?

5.3 To what extent have UNFPA Nigeria humanitarian interventions to address the insurgency and IDP situation in the BAY States i) systematically reached all geographic areas with affected populations (women, adolescents, and youth); ii) contributed to developing thecapacity of local and national actors to better prepare for, respond to and recover from humanitarian crisis, with longer-term developmentgoals taken into account?

1.3.4. Data Collection Methods and Data Analysis

In accordance with Handbook guidance,[21] the United Nations Evaluation Group (UNEG) Code of Conduct, Ethical Guidelines and Norms and Standards informed the whole evaluation process, including that the evaluation was participatory, objective, and impartial and ensured informant confidentiality and privacy. Stakeholders, particularly in focus group interviews (FGIs), were informed that they were free not to respond to any question they found uncomfortable. They were assured that there were no right or wrong answers, and that it was UNFPA, not they themselves, that was being evaluated, with the purpose of helping to guide UNFPA in the way forward.
Primary data collection involved key informant, mainly virtual, semi-structured interviews with stakeholders at different levels on the relevant aspects of the core evaluation questions, and the qualitative information from these interviews and FGIs with beneficiaries contributed to the assessment of programme relevance, effectiveness, efficiencies, sustainability, coordination, and challenges, assessed by thematic content analysis. The process of stakeholder selection is outlined below. Key informant interviews were supplemented by short, emailed questionnaires as needed when connectivity interrupted communications, or it had not been possible to schedule an onlineinterview with a key stakeholder and no alternate was available. Site visits contributed to the understanding of the context for activities,
e.g., within maternal health care or services regarding gender-based violence (GBV), and the facilities available in youth-friendly settingsand, where appropriate, utilized the site checklist (see Annex 5) to promote comparability of assessment. Secondary data collection involved extensive document review from a wide range of sources, guided by the evaluation manager among others (see Annex 3).

The participatory process facilitated wide stakeholder engagement, and triangulation and weighting of data from different primary and secondary sources ensured that findings were robust. Analysis included contribution analysis, to assess how far the documented inputs and activities sufficed and were relevant to the outputs and likely to have contributed meaningfully to the intended outcomes (as in analysis of the theory of change). Trend analysis explored changes in results over time as measured in the quantitative CP indicators andcontributed to conclusions regarding the appropriateness of indicators, both outputs and targets. Qualitative changes over time were alsoreported in key informant and focus group interviews. Challenges to monitoring were also explored, including in the context of the COVID-19 pandemic. Follow up was undertaken to the extent possible in the event of conflicting findings, but where a strong conclusioncould not be reached, this is indicated.

21 UNFPA Evaluation Handbook 2019: How to Design and Conduct a Country Programme Evaluation

The evaluation matrix (Annex 5) formed the framework for conducting the evaluation, with the overarching questions, assumptions to be tested, indicators, data sources and methods for data capture. The matrix links the main evaluation criteria and the evaluation questionsand had minor modifications during the evaluation.

1.3.5. Selection of the Sample of Stakeholders

The comprehensive UNFPA guidelines on stakeholder selection guided purposive stakeholder selection,[22] based on discussion between the evaluation team and the evaluation manager and technical thematic leads. Sampling included both larger and smaller IPs, programmesand projects, and a wide range of stakeholders. Sampling included civil society and government implementing partners, UN partners, donors, UNFPA staff, government policy makers and programmers at national and state levels, face-to-face focus group interviews withprimary and secondary beneficiaries, and selected site visits within the states noted above. Direct and indirect UNFPA partners were included (stakeholders who play a key role in one of the thematic areas, even if they do not work directly with UNFPA). The list of stakeholders contacted is provided in Annex 2, as well as site observations. The geographical coverage of field visits is indicated in Section 1.2, but the evaluation addressed online all sub-offices of UNFPA and key players in all the states with UNFPA projects, and with respect to national programming.

Table 1.2: Stakeholders Interviewed

Type of Stakeholder	Number	Type of Stakeholder	Number
UNFPA CO and sub-offices	30	GoN, national and state levels	56
UN partners	12	Civil society implementing partners	6
Donors	5	Beneficiary FGIs, primary and secondary	32
Total number of stakeholders from all categories (excluding beneficiaries): 141. Beneficiary groups ranged between 4 and 20participants, and there were 27 site visits.			

Field visits were undertaken with regards the thematic areas of sexual and reproductive health services, including for adolescents and youth, and in relation to programming around GBV (FGIs undertaken on behalf of the lead consultant by the young emerging evaluatorwho also undertook some FGIs for SRH and youth). All population dynamics interviews were conducted virtually from Abuja. Virtual interviews with regards coordination and strategic positioning of UNFPA included members of the UN Country Team (UNCT), the Humanitarian Country Team (HCT), the UNAIDS Joint Team on HIV and AIDS (UNJT), and the main donors. The Nigeria map at thestart of the CPE highlights areas of UNFPA programming. The selected states for field work in the six geo-political zones were as follows:Northeast: Bauchi and Adamawa; Northwest: Sokoto and Kaduna; North Central: Nasarawa, Kwara, and Federal Capital Territory; Southwest: Oyo and Ogun; Southeast: Ebonyi and Imo; South-South: Akwa Ibom and Edo.

1.3.6. Limitations Encountered

During the design phase, challenges arose in the late orientation for the evaluation team to the country office and provision of thematic presentations, and in stakeholder sampling and field work logistics, which meant that field work was delayed. Another challenge has been that the evaluation was taking place late in the year when many stakeholders, including the UNFPA CO and sub-offices, were stretched with heavy workloads, limiting their availability.

The evaluation was also being undertaken in the context of the COVID-19 epidemic, requiring the lead consultant to operate from her home outside the country, and most key informant interviews had to take place virtually. Most communications between the consultant team and all communications with the lead consultant had to be virtual, hampering the extent and frequency of joint discussions compared with all being present in the CO. Connectivity issues seriously hampered many virtual interviews, leading to delays and the need to supplement many with brief additional questions sent by email, to which responses were limited. Also, security issues limited the optionsfor field visits in humanitarian areas and elsewhere where conflict was escalating.

[22] UNFPA Evaluation Handbook 2019: How to Design and Conduct a Country Programme Evaluation

Nonetheless, the evaluation proceeded well overall, with the CO, sub-offices, and consultants flexible to accommodate the required changes. The CO availed office facilities for the national consultants, set up zoom links and some virtual interviews, and addressed all travel logistics. Despite some unavoidable gaps in the initially planned interviews, most intended stakeholder interviews and FGIs did take place (as listed in Annex 2), and occasionally a substitute interviewee was reached when the first selected stakeholder wasnot available. Recruiting a young emerging evaluator who could undertake FGIs on behalf of the lead consultant, troubleshoot regardinglogistics and communications and contribute in other ways to the evaluation, was an invaluable innovation of the evaluation manager.

1.4 Evaluation Process, Responsibilities and Next Steps

The five phases of the evaluation are: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase, with quality assurance measures integrated throughout. The table below highlights the phases, actions required in each phase, and the responsible actors, including the next steps after the finalization of the evaluation report.

Table 1.3: Main phases and activities of the overall evaluation process

Phase	Actions	Lead[23]
1 Preparation	ToR development and approval; forming of Evaluation Reference Group (ERG); prequalification and hiring of evaluation team; collection of relevant documents; mapping of stakeholders; development of draft communication plan; preparation of theory of change (ToC) if not in place	EM
2 Design	Document review; purposive stakeholder sampling; assessment of limitations and risks, and identificationof mitigation measures; review of results matrix and ToC; finalisation of evaluation questions and development of evaluation matrix and tools; development of data collection and analysis strategy and field work plan/agenda; drafting of design report and annexes, presentation, and revisions for approval	ET
3 Field	Virtual and face-to-face interviews with key informants (KIs) and FGIs with beneficiaries; supplementary emailed questionnaires if required; continued extensive document review; cleaning and initial collating, triangulation, and analysis of data; follow up on gaps; brief to CO	ET
4 Reporting	Further analysis and drafting of CPE report for presentation to and review by CO; incorporation ofcomments, submission of revised report and presentation to CO and ERG; incorporation of comments Completion of Evaluation Quality Assessment (EQA) Grid for ET response and revisions	ET EM, MEA
5 Use and dissemination	ET presentation to stakeholders for comment and finalisation; final EQA; CO units prepare managementresponse; implementation of communication plan	EM, CA

The evaluation reference group (ERG) and UNFPA Country Office are responsible for quality assurance of the design report and the final evaluation report prior to submission to wider stakeholders and to UNFPA headquarters. The final evaluation report is entered intothe UNFPA website and reformatted for publication in hard copy.

[23] EM is evaluation manager, ET is evaluation team, MEA is Regional Monitoring and Evaluation Advisor, and CA is Communications Analyst. In the absence of an MEAin WCARO, another staff member is seconded.

2 Country Context

2.1 Development Challenges and National Strategies

2.1.1. General Country Context

Nigeria, on the West coast of Africa, borders with Niger to the north, Benin to the west, Cameroon to the east, and a short border with Chad to the northeast, sharing maritime borders with Equatorial Guinea and Ghana and São Tomé and Príncipe. Nigeria has a large landmass of 923,768 square kilometers,[24] and an estimated population of over 181.1 million people in 2015, around half (49.5 percent in 2015) being urban.[25] The World Bank also estimates that 22.8 percent of the urban population in 2015 was female. Nigeria has the seventh highest population globally, with 2.64 percent of the total world population, and a mean population density of 226 per square kilometers.

Since independence in 1960, Nigeria has been a federal, presidential, representative democratic republic, with government exercising executive power, and legislative power vested in the federal government and two chambers, the House of Representatives, and the Senate.The judiciary forms a separate branch. Government has three tiers, federal, state, and local government authorities (LGAs). The climateis tropical, with variable dry and rainy seasons depending on location, with the far north having low rainfall. Diverse agriculture is the main source of family income, including farming, fishing, and forestry. Agriculture is the largest occupation and contributes about 25 percent of gross domestic product (GDP).[26] The country is classed as middle income, with a mixed economy including mining, manufacturing, energy production and construction, as well as increasing financial, service, communications, and technology sectors.

Around 300 ethnic groups are present in Nigeria, speaking over 520 languages or dialects, making Nigeria the most diverse nation in Africa.[27] The official language is English. The most populous groups are the mainly Islamic Hausa population at 25 percent (including Fulani), then mainly Christian and Islamic Yoruba at 21 percent, and the mostly Christian Igbo at 18 percent. Other ethnic groups includethe Ijaw (10 percent), and multiple smaller groups. Overall, the population is estimated to be 54 percent Muslim, 46 percent Christian (11 percent Catholic and 35 percent other Christian), with 0.6 percent of the population having traditional or other beliefs.

The Human Development Index (HDI) for Nigeria in 2019 was 0.539 (not taking into account inequality),[28] with an inequality adjustedHDI of 0.348. Nigeria ranked 161st out of 199 countries in the HDI. Nigeria has high disparity in terms of access to social services and income distribution, linked partly to types of employment and parental education as well as to geography – average incomes are lower in the north compared with the south, and in rural as opposed to urban areas. An estimated 46 percent of the population experienced multidimensional poverty in 2019, and about 40.1 percent of the populace surviving on less than 1.9 USD per day. [29] Annual real gross domestic product (GDP) growth rate, which averaged 7 percent from 2000 to 2014, fell to 2.7 percent in 2015 and to -1.6 percent in 2016, with growth rebounding to 0.8 percent in 2017, 1.9 percent in 2018, and then plateauing at 2 percent in 2019.[30] In 2020, the economy shrank by 1.8 percent, driven partly by the COVID-19 epidemic, with marked capital outflows, intensified risk aversion, lower foreign remittances and lower oil prices, and GDP in 2020 of under USD 2,149.00.[31] The economy is not creating enough jobs to absorb the burgeoning youth population, which takes up nearly 60 percent of the 221.4 million people in Nigeria.[32]

Nigeria faces many development challenges for social development for its young and rapidly increasing population, including poor healthcare services, high maternal and infant mortality, and high illiteracy rates. Economically, the country faces inadequate funding, with limited infrastructure and power supply, inflation, unemployment, corruption, monetary policies, over-reliance on oil, and insufficient human capital development at all levels, exacerbated by a brain drain. Problems have been greatly exacerbated by the insurgency and conflict in the north, the COVID-19 epidemic, and the collapse of oil prices.[33]

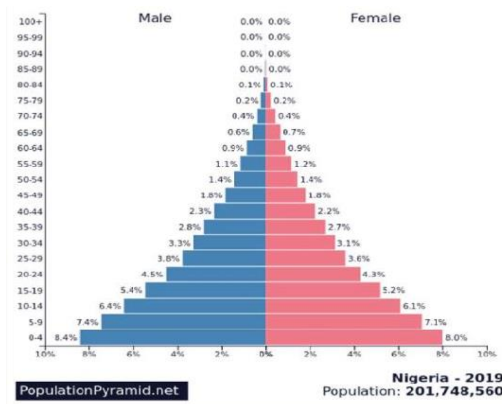
[24] Nigeria Vision 20: 2020.
[25] World Bank (2016) World Bank Collection of Development Indicators.
[26] Future Learn (2021) https://www.futurelearn.com/info/blog/biggest-employment-industries-in-nigeria
[27] The Culture Trip https://theculturetrip.com/africa/nigeria/articles/a-guide-to-the-indigenous-people-of-nigeria/
[28] UNDP Human Development Report 2020: Nigeria http://hdr.undp.org
[29] National Bureau of Statistics (2019) Poverty and Inequality in Nigeria
[30] Ibid.
[31] UNDP (2020) http://hdr.undp.org/en/countries/profiles/NGA
[31] National Population Commission (2011), (2006) https://nationalpopulation.gov.ng
[32] Ibid.

To address its development challenges, Nigeria Vision 2030 prioritizes progress towards the Sustainable Development Goals as follows:SDG1 on poverty; SDG3 for health and well-being; SDG4 for education; SDG5 for gender equality and the empowerment of women; SDG8 for an inclusive economy; SDG16 for an enabling environment of peace and security; and SDG17 for effective partnerships.[34] TheNigeria Economic Update: Resilience through Reforms 2021 aims to reduce inflation and to protect poor households.[35] Nigeria is realigning the National Statistical System (NSS) to measure the SDG indicators, and has developed a home-grown analytic framework to assess policy making to address the SDGs in an integrated manner (the Integrated Sustainable Development Goals, iSDG Model). The2020 Voluntary National Review report includes an ongoing evaluation of progress regarding SDGs 3 and 4 (health and education), and the government is committed to strengthen evidence-based planning and accountability mechanisms at State level.[36] The National Development Plan 2021-2030, succeeding the Economic Recovery and Growth Plan 2017-2020, is key to this.

2.1.2. Challenges and National Strategies for Population and Development

Nigeria faces multiple challenges in relation to population and development, including high population growth with a young age structure, extensive poverty, significant humanitarian concerns leading to widespread population displacement, and severe limitations to both dataavailability and the use of available data in national and regional development policies, plans and strategies. The last national census tookplace in 2006. The population size, rapid population growth rate, and youthfulness make it challenging for the Government of Nigeria to provide adequate social services (health and education), with limited human and financial resources. Life expectancy at birth, which roseonly marginally from 45.1 years in 1985 to 45.84 years in 1994, rose to 55 years in 2019.[37] Maternal mortality remains high, however, with a maternal mortality ratio of 512 per 100,000 live births (see the following section), and the infant mortality rate is 67 per 1000.[38] The total fertility rate (TFR) rose between 2013 and 2016 (from 5.5 births per woman to 5.8),[39] and then declined slightly to an estimated 5.3 children per woman in 2018,[40] although desired family size varies geographically. An estimated 45.7 percent of the population are under 15, with 31.7 percent aged 10 to 24. The population pyramid below provides the age and sex structure of the Nigerian population.

Figure 2.1: Population Pyramid of Nigeria



Annual population growth is estimated at 3.2 per cent with, as noted earlier, the country's population projected in 2011 to reach over 221.4 million in 2020,[41] making Nigeria Africa's most populous country. The youth unemployment rate in Nigeria has been rising since 1999 at an estimated 9.6 percent to almost 14.2 percent per annum in 2020.[42]

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[33] https://sustainabledevelopment.un.org/memberstates/nigeria

[34] World Bank (2021) https://www.worldbank.org/en/country/nigeria/publication/nigeria-economic-update-resilience-through-reforms 15 June 2021 update

[35] Ibid.

[36] World Bank (2020) https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZW

[37] NDC (2018) NDHS

[38] HPTRP (2018); Harnessing the demographic dividend for the sustainable development of Nigeria

[39] NDC (2018) NDHS

[40] National Population Commission (2011)

Yet the youthful population provides an opportunity for Nigeria to harness the demographic dividend if there are effective policies with the requisite investments in health, education and employment creation, good governance, and leadership. Currently, job creation lags considerably behind the rate of population growth.

The demographic dividend is the economic growth potential when the share of the working-age population (15 to 64) is larger than the non-working-age share of the population (14 and younger, and 65 and older) and the potential of the burgeoning population of young adults can be effectively harnessed. To achieve the demographic dividend, policy makers need to prioritize strategies that contribute to reducing both fertility and mortality, to achieve the full demographic transition from high birth and death rates to low birth and death rates. In Nigeria, while mortality rates have been falling and life expectancy at birth increasing, fertility remains high, as noted above. Continued high population growth mitigates against achieving the demographic dividend, so it is vital to address population growth to achieve the sustainable development goals as enshrined in NV20:2030. Ever-increasing population numbers make it increasingly challenging for policy makers to strengthen the economy sufficiently and meet development goals by: expanding jobs in sectors in whichthe country enjoys a global competitive advantage or strong domestic demand; improving access to finance for these sectors; building appropriate infrastructure; cutting unnecessary regulation, and ensuring that the labour force has the necessary skills.[43] Failure to educate,value and gainfully employ the nation's young also creates a large, disaffected sector of the population at risk of becoming a destabilizingforce as they see no future for themselves (demographic doom). Young people are the future of any country and must be a high priority for multi-sectoral investment and support in their own right, in particular educating, empowering girls and helping them to join the formaleconomy. This is also key to curbing fertility and population growth to enable socio-economic growth and development to benefit all.

Government policies over the past two decades have paid insufficient focus on slowing population growth (document review), hamperingthe potential for rapid economic growth despite the rich natural and human resources of the country. Sustained development will requireeffective population policies based on sound data that are effectively incorporated across multiple sectoral policies and planning for development. Major challenges in data collection contribute to the low level of use of population data, including insufficient capacity togenerate quality data, inadequate logistics, wastage of resources, insufficient finance and limited quality assurance, so that potential usersmay not be sure of the accuracy of data that they access.[44] Beyond this, data may not be packaged in ways accessible to diverse users across sectors, and they may lack the capacity to utilize data effectively in their policies and plans. Further, they may not clearly understand the centrality of reducing fertility and curbing population growth to achieve sustainable and equitable development.

Despite the limitations, various efforts have been made towards sustainable development, notably the Nigeria Vision 20:2020 (2010- 2020), which aimed to bring Nigeria into the top 20 world economies, the 2004 National Policy on Population for Sustainable Development (NPP) 2004-2015, the National Economic Empowerment and Development Strategy 2004, the Nigeria Economic Recoveryand Growth Plan (2017-2020) and the National Youth Policy 2014-2018 and revised National Youth Policy 2019-2023. The National Policy on Education 2016 aimed to strengthen human capital among young people towards realizing the demographic dividend. The Government of Nigeria needs urgently to strengthen development planning and implementation to realize the Sustainable Development Goals and the aspirations of the Vision 2030: to end all poverty, secure the planet and ensure peace and prosperity for all by 2030.

2.1.3. Challenges and National Strategies for Sexual and Reproductive Health

Nigeria faces challenges regarding high fertility leading to rapid population growth, as addressed earlier, with insufficient contraceptiveuse, continued high maternal mortality, obstetric fistula, and a significant HIV burden. SRHR in young people is addressed in the following section and is of great concern given the multiple challenges facing adolescent girls, in particular. The high total fertility rate of 5.3 per woman is associated with a low modern contraceptive prevalence rate (mCPR) of 12 percent among currently married women,one of the lowest in Africa. Use of any modern contraceptive was 12 percent in 2018,[45] far below the revised national mCPR goal of 27percent by 2024. Married women most commonly use injectables and implants (at 3 percent each), while male condoms are the most commonly used contraceptive among sexually active unmarried women, at 19 percent.[46] Total demand for family planning (FP) has

[41] International Labour Organisation (ILO) 2020

[42] Olaniyan et al. (2012)- Programming the Demographic Dividend for Achieving the UNFPA Mandate

[43] Ibid.

[44] FMOH (2018) Second National Strategic Health Development Plan 2018-2022

[45] FMOH (2018) National Demographic Health

increased from 12 percent in 1990 to 36 percent in 2018. Unmet need for FP decreased from 22 percent in 1990 to 16 percent in 2013 and rose again to 19 percent in 2018 (7 percent for limiting conception and 12 percent for child spacing). Among women aged 15-49, 35.7 percent accessed modern contraceptives, with 35 percent of married women reporting that they intend to use FP in the future.

Progress over the years to reduce the maternal mortality rate (MMR) has been sluggish. MMR has declined from 576 deaths /100,000 live births in 2013 to 512 in 2018.[47] In 2017, Nigeria bore 14 percent of the global maternal mortality burden and Nigeria plus five othercountries contributed more than 50 percent of all global maternal deaths.[48] Under 5 mortality has decreased since 2008, from 157 per 1,000 live births to 132 per 1,000 in 2018. Similarly, there has been a slight decline in infant mortality from 75 to 67 per 1,000 over thattime frame. However, there has been no noticeable improvement in neonatal death during the same period (40 per 1,000 live births in 2008 and 39 in 2018). These poor indices make attainment of the SDGs by 2030 unlikely. Although the percentage of deliveries taking place at health facilities has increased over time from 35 percent in 2008 and 36 percent in 2013 to 39 percent in 2018, this rate of progress and coverage is insufficient to impact substantially on the MMR. Similarly, births assisted by skilled birth attendants have increased overthe past decade from 39 percent in 2008 to 43 percent in 2018 but remain markedly low. The proportion of women receiving any antenatal care from skilled birth attendants has increased from 57 percent in 2008 to 67 percent in 2018, while women who have had at least four ANC visits supervised by skilled birth attendants for their most recent pregnancy rose from 51 percent in 2013 to 57 percent in 2018. Regionally, this varied from 53.9 percent in the northwest to 89.2 percent in the southeast, with skilled attendance at birth generally lower, and likewise varying geographically for a national average of 43 percent.

Obstetric fistula (OF) is a major public health concern, with Nigeria contributing 15 percent of the global burden of OF. There are an estimated 150,000 prevalent cases and an annual incidence of 12,000 cases. It is closely related to the inadequacy of skilled antenatal care and, especially, to delays in women with obstructed labour being able to access the skilled professional care that they need.

In 2018, HIV prevalence among adults aged 15-64 years was 1.4 percent, 1.0 percent in men and 1.8 percent in women,[49] with the higherrate in women rooted in gender inequalities among other factors.[50] HIV prevalence is similar in urban and rural areas (1.3 and 1.5 percent respectively).[51] Twenty-four percent of pregnant women with HIV worldwide who are not on ARVs are Nigerian, and HIV prevalence among children aged 0-14 years is 0.1 (0.1 percent for males and 0.2 for females).[52] One in every seven babies born globally with HIV isNigerian. Other sexually transmitted infections (STIs) are also challenging. In 2018, HBV[53] prevalence in adults aged 15-64 was 8.1 percent, (10.3 percent in men, 5.8 percent in women), prevalence of HCV was 1.1 percent, (1.3 percent in men, 1.0 percent in women), and 16.1 percent of women tested positive for syphilis in ANC clinics.[54]

Nigeria's health sector response has been guided by Vision 20:2020 and the medium-term Economic Recovery and Growth Plan (ERGP),with the Nigerian Constitution and the National Health Act (NH Act) guaranteeing the right to health for all Nigerians.[55] The 2016 National Health Policy provides an implementation framework for the NHAct and the SDG Goal 3 on health and well-being for universalhealth coverage, including for SRH. Many further policy and strategy initiatives have been developed, such as domestication of the Primary Health Care under One Roof policy, the Basic Health Care Provision Fund for Universal Health Coverage, a commitment to RMNCAH+N,[56] the National Long-Acting Reversible Contraceptive Strategy, the Reproductive Health Commodity Security Strategy, the Maternal, Newborn, and Child Health Strategy, and the National Strategic Health Development Plan with a revised family planning blueprint in 2020.[57] To increase FP demand, the government introduced the National Family Planning Communication Plan (NFPCP), and resuscitated the National Health Promotion Forum, launching the new FP logo 'The Green Dot' to serve as site identifiers for

[46] Ibid

[47] Estimates by WHO, UNICEF, UNFPA, World Bank Group and the UN Population Division (2019): Trends in Maternal Mortality: 2000 to 2017 (2019)

[48] FMOH (2018) Nigeria HIV/AIDS indicator and Impact a survey 2018 Technical report

[49] Global information and education on HIV and AIDS (2018): HIV and AIDS in Nigeria. https://www.avert.org

[50] FMOH (2018) Nigeria HIV/AIDS indicator and Impact a survey 2018 Technical report

[51] UNAID [2021] Prevention of Mother to Child Transmission www.unaids,org sept 2021

[52] FMOH (2018) Nigeria HIV/AIDS indicator and Impact a survey 2018 Technical report

[53] FMOH (2018) National Demographic Health

[54] FMOH (2018) Second National Strategic Health Development Plan 2018-2022

[55] FMOH [2016] National health policy 2016

[56] FMOH [2020] Revised Family planning Blueprint [2020]

affordable, safe, and reliable FP services, as well as the development of the National Health Promotion Policy in 2019. Efforts have also been made to strengthen MNCH services (the Midwife Service Scheme) and community-based volunteers (the Community Health Influencers, Promoters and Services programme of 2018 as part of wider task shifting efforts. Policy is in place for free contraceptives and life-saving maternal/RH commodities, creation of budget lines and increased funding for key SRH-related activities and strengthenedcollaboration with the private health sector in health care delivery, among other interventions.

2.1.4. Challenges and National Strategies for Adolescents and Youth[58]

The major challenges affecting adolescents and young women are poverty, child marriage, early childbearing, female genital mutilation(FGM), and gender-based violence in the context of a highly patriarchal society (elaborated below). Both sexes are affected by poverty,limited schooling, unemployment, and poor health and education infrastructure. The insurgency areas greatly exacerbate risks for youngwomen of abduction, rape, forced childbearing and forced marriage, for young men of violence and forced recruitment by the insurgents.

An estimated 43 percent of women are married by age 18 and 8 percent of women aged 15-19 are married before age 15,[59] with povertydriving parents and caregivers to marry off their daughters early. Nigerians constitute 40 percent of girls in child marriages within Westand Central Africa.[60] Child marriage and early pregnancy contribute greatly to school dropout, limiting girls' life options and contributing to high population growth. Early and repeated childbearing incur risk of maternal morbidity and mortality, and pregnant teens may seekunsafe abortion when they have an unintended pregnancy. In 2017, 29 per 1000 women had an abortion, many being unsafe.[61] Among teenage girls aged 15 to 19, over 14 percent have already had children, while over 4 percent are carrying their first baby.[62] Rural rates ofteen pregnancy are higher at 27 percent compared with urban rates at 8 percent. Nonetheless, between 1990 and 2018, the percentage of adolescent girls who had already had a baby or been carrying a pregnancy has declined from 28 percent to 19 percent.

About 19 percent of young women have sexual debut before age 15, and 57 percent before age 18, with a mean of 17.2 years in womenaged 25 to 49. For men aged 30 to 59 years, the mean age of sexual debut was at 21.7 years. The prevalence of pre-marital sex among youth is high, with 73.4 percent of girls and 81.3 percent of boys sexually active before marriage.[63] With regards contraceptive use in adolescent girls 15-19, 96.4 percent of those who are married (in union) report using no contraception, and only 2.3 percent use a modernmethod. Of those not in union, 82.4 percent do not report using contraception, and 14.6 percent report using a modern method of whichover 80 percent is condom use. Fully 57 percent of young unmarried and 15 percent of young married women report unmet need for family planning.[64] The use of long-acting reversible contraceptives (LARCs) is low in both groups, but particularly so in those not in union. Other methods include withdrawal, lactational amenorrhea, emergency contraception and periodic abstinence. Fewer than 40 percent of young women compared with 80 percent of young men report that they make their own decisions about their healthcare.

Around 31 percent of Nigerian girls and young women have experienced physical violence before age 15.[65] Female genital mutilation (FGM) is another concern, with a 20 percent prevalence of FGM among women aged 15-49 and 19 percent in girls aged 0-14 nationally,far higher in some states (notably Osun, Ekiti, Oyo, Imo and Ebonyi). Despite a lower national prevalence than some other countries practicing FGM, Nigeria has the third highest absolute number of girls and women mutilated, owing to its large population. The Child Rights Act of 2003, supported by UNFPA and UNICEF for domestication in increasing numbers of states, is a legal tool to strengthen children's rights in general, but it is the more recent VAPP Act that specifically addresses FGM (see the gender section below).

The prevalence rate for HIV in 2018 was 3.5 percent for adolescents aged 15 to 19, and 4.2 percent among young adults aged 20 to 24.[66]Only one in three boys and one in four girls had comprehensive knowledge of HIV and AIDS, and gender disparity in HIV infection is highest in adolescents and young people aged 10-24.[67] The 2017 MICS found that fewer than 25 percent of young people had ever testedand knew their HIV result. Sexualty education is mainly guided by the National Family Life and HIV Education (FLHE) Curriculum for

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[58] UN definitions of age cohorts are adolescents aged 10-19; young people aged 10-24; youth aged 15-24

[59] 2018 NDHS

[60] UNICEF (2018) Child Marriage in West and Central Africa: At a Glance

[61] PMA2020 Abortion Survey Results

[62] NDC (2018) NDHS

[63] Ibid.

[64] NPS (2018) NDHS

[65] Ibid.

[66] NAIIS 2018

[67] Ibid.

Junior Secondary School in Nigeria, 2003. The extent of implementation of family life and HIV education in secondary schools across 35 states in 2015 ranged from 13.5 percent in Adamawa to 100 percent in Anambra, Jigawa, Kebbi, Sokoto and Lagos.[68] Also, Nigeria has severe school drop-out rates, an estimated one-third of children dropping out of primary school, 27.2 percent of children aged between6 to 11 years not going to school, and 25.8 percent of children 12 to 17 years with no school access, and girls less attendance than boys.[69]

The 1995 National Policy on Adolescent Health designated wide-ranging interventions in key areas affecting young people such as sexual behaviour, reproductive health, nutrition, accidents, drug use, career and employment, parental responsibilities and social adjustments, and education.[70] The policy was updated in the National Policy on the Health and Development of Adolescents and Young People in Nigeria (2006), the National Adolescent Health and Development Policy (2021- 2025), the National Adolescent and Young People's Health and Development Implementation Plan (2021-2025), the National Adolescent and Young People's Health and Development Monitoring and Evaluation Framework (2021-2025), and the Strategic Health Development Plan II 2018-2022.[71] The RMNCAH+N agenda for 2017-2030 also includes adolescent health. The Child's Rights Act 2003 has now been domesticated in 24 of the 36 states.[72] Other developments include the Action Plan for Advancing Young People's Health and Development in Nigeria 2010-2012, the NationalGuidelines for the Promotion and Integration of Adolescent and Youth Friendly Services into Primary Health Care Facilities in Nigeria (2013), and the National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services of 2018. Furtherreview of national policy on adolescent health and development was carried out in 2019,[73] and efforts are ongoing to build capacity for effective adolescent health programming, including for SRH. The overarching policy for adolescent FP is partly enabling, with no age restrictions in access or marriage restrictions. However, it is unclear that adolescents have free or subsidized access to all FP methods including LARCs, family life education tends to emphasize abstinence only messaging, youth friendly services do not guarantee confidentiality and provider support, and laws do not explicitly prohibit the need for spousal or parental consent.[74] Also, unsafe abortionsare reported to be high, with many pregnancies being unintended and safe abortion only legal if performed to save a woman's life.[75]

In 2019, the Federal Ministry of Youth and Sports Development launched a youth development policy which, if fully implemented, couldgo far towards harnessing the demographic dividend for sustainable development. The policy prioritizes five cross-sectoral developmentpillars: the sustainable economic engagement of youth; young people's physical, social, mental, and spiritual well-being; active and equitable youth participation and inclusivity; quality education and skills development; and creating adequate opportunities for productive employment and successful entrepreneurship. It is thus a rights-based approach to improved opportunities and self-actualisation for all.

2.1.5. Challenges and National Strategies on Gender Equality and Women's Empowerment

Nigeria has a highly patriarchal society, with severe gender inequality and inequity regarding political representation, access to and control over land, credit facilities, technologies, education, and health. The Gender Development Index (GDI) was 0.881, placing Nigeriain the lowest category (Group 5) for deviation from gender parity (over 10 percent).[76] With respect to the Human Development Index (HDI), the value for women was 0.504 and for men 0.572; life expectancy at birth was 55.6 for women and 53.8 for men; expected yearsof school for girls was 9.4 compared with 10.6 for boys, and mean years of schooling for girls was 5.7 compared with 7.7 for boys.[77] Themost recent Global Gender Gap Report[78] placed Nigeria 139th of 156 countries. Harmful and discriminatory gender, socio-cultural and religious norms impede women from making informed SRH decisions or accessing contraceptives.[79] Other factors, limiting FP access

[68] Bola I. Udegbe1, Funke Fayehun2, Uche C. Isiugo-Abanihe*2, Williams Nwagwu3, Ifeoma IsiugoAbanihe4 and Ezebunwa Nwokocha (2015), Evaluation of the Implementation of Family Life and HIV Education Programme in Nigeria, African Journal of Reproductive Health, June; 19 (2): 79

[69] UNICEF Nigeria Education Factsheet 2019

[70] Federal Ministry of Health (2006) National Policy on the Health & Development of Adolescents & Young People in Nigeria

[71] National Strategic Health Development Plan II 2018-2022

[72] National Human Rights Commission https://www.nigeriarights.gov.ng/focus-areas/child-rights.html#:~:text=Child's%20Right%20Act%20(2003)%20is,CRA%20as%20a%20state%20law.&text=At%20the%20National%20Human%20Rights,in%20all%20of%20its %20forms accessed Nov 2021

[73] 2019 Nigeria Annual Health Sector Report

[74] PRB Youth Family Planning Policy Scorecard, April 2021 Update

[75] Guttmacher Institute (2015) Fact Sheet: Abortion in Nigeria. https://www.guttmacher.org/fact-sheet/abortion-nigeria

[76] UNDP (2021) Human Development Reports; Gender Development Index. http://hdr.undp.org/en/content/gender-development-index-gdi

[77] UNDP (2021) Human Development Report. http://hdr.undp.org/

[78] World Economic Forum (2021). Global Gender Gap Report, March 2021. https://www.weforum.org/reports/global-gender-gap-report-2021

[79] ToR for Nigeria CPE

and jeopardizing maternal and neonatal health, include inadequate health infrastructure and human resources, weak supply chain management and, particularly in the north-east of the country, severe insecurity.[80] Female genital mutilation (FGM) is also common in Nigeria, with 20 percent of Nigeria women aged 15-49 years circumcised in 2018, a decrease from 25 percent reported in 2013.[81] Gender-based violence is also widespread, with 36 percent of women reporting experience of intimate partner sexual, physical, or psychologicalabuse.[82] In humanitarian situations GBV is of extreme concern, particularly for young women (as noted earlier).

The Federal Ministry of Women Affairs and Social Development spearheaded the National Gender Policy 2006 to mainstream gender across sectors, change perceptions, principles, and attitudes to gender inequality throughout government and all population groups, to empower women economically and to reduce gender-based violence.[83] It is currently under review. A National Strategic Gender Framework was developed to implement the policy, set targets, and establish guidelines for monitoring and evaluation. Significant gainsare reported,[84] such as in girls' school attendance, literacy rates and women's labour force participation, but there is still far to go, particularly regarding high level political engagement (as above). The FMoH National Gender in Health Policy adds an important lens on gender in the health sector. With respect to gender-based violence, the National Nigerian Assembly passed the Violence against Persons (Prohibition) Act 2015, which provides comprehensive legislation against FGM, forceful ejection from home, harmful widowhood practices, and stronger penalties against rape and domestic violence. Violence is widely defined to include physical, sexual,emotional, verbal, and other forms of violence and refers to male and female violence. The law initially only applied to the FCT, Abuja, but other states are gradually domesticating the law. By late 2021, 10 states had yet to domesticate the law, while the other 24 had fully passed and assented to the law or were in the process of doing so.[85] The COVID-19 pandemic has worsened GBV both in terms of puttingvulnerable women and children at heightened risk, and also, making it harder to provide face-to-face support services

2.1.6. Progress towards SDGs and ICPD

The Sustainable Development Goals (SDGs) of most relevance to UNFPA are Goal 3 on health and well-being, and Goal 5 on gender equality and female empowerment. The core beneficiaries of UNFPA are women, especially young and reproductive women, young people including those out of school, and the more marginalized and vulnerable, including people with disabilities or facing humanitariansituations. The table highlights country achievements, and the Key Facts Table elucidates country progress towards wider SDG targets.

Table 2.1: Country Progress in Nigeria on SDGs 3 and 5 Relevant to UNFPA Mandate

SDG Goal 3: Ensure healthy lives and promote well-being for all at all ages	
Targets and indicators	**Country achievement**
3.1.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births 3.1.2 Proportion of births attended by skilled personnel	72[86]
3.3 By 2030 end the epidemic of AIDS 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations	176[87]
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning,information and education, and the integration of reproductive health into national strategies and programmes 3.7.1 Proportion of women of reproductive age (aged 15-49 years) with family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	81% [88]

[80] UNFPA CPD 2018-2022
[81] FMOH (2018) National Demographic Health
[82] NDC (2018) NDHS
[83] Federal Ministry of Women Affairs and Social Development (n/d) National Gender Policy: Situation Analysis [84] Okoro I, (2016) National Bureau of Statistics (n/d) Gender Mainstreaming in Nigeria: The Cross Cutting Issues [85] VAPP Tracker https://www.partnersnigeria.org/vapp-tracker/
[86] NIGERIA Integration of the SDGs into National Development Planning - A Second Voluntary National Review Integration 2020
[87] Ibid.
[88] National Primary Health Care Development Agency-2018

	190/1000[89]
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care servicesand access to safe, effective, quality, and affordable essential medicines and vaccines for all 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)	
SDG Goal 5: Achieve gender equality and empower all women and girls	
5.1 End all forms of discrimination against all women and girls everywhere 5.1.1 Legal frameworks in place to promote, enforce and monitor equality and non-discrimination, on the basis of sex.	Signed CEDAW, VAPP, CRA[90]
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including traffickingand sexual and other types of exploitation 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, orpsychological violence by a current or former intimate partner in previous 12 months, by form of violence and by age 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than anintimate partner in the previous 12 months, by age and place of occurrence	20.4[91] 23.2[92]
5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation 5.3.1 Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18 5.3.2 Proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting, by age	11.8[93] 16.6[94] 20% (FGM)

Globally, UNFPA contributes to the ICPD agenda and the SDGs through addressing the three transformative goals of ending preventablematernal deaths, ending the unmet need for family planning, and ending sexual and gender-based violence (SGBV) and harmful practices.The table notes progress towards the SDGs and ICPD PoA, highlighting many outstanding challenges. With respect to SDG 3, in Nigeria72 percent of births were attended by skilled practitioners. The next DHS will provide information on progress during the 8th CP.

2.2 The Role of External Assistance

The net official development assistance (ODA) to Nigeria was low between 1960 and 2003, ranging between USD 32 and 344 million, and close to USD 600 million in 2004. ODA spiked sharply in 2005 and 2006, at USD 6.4 billion and USD 11.4 billion respectively, declining to under USD 2 billion in 2007. Since then, there has been an uneven increase in net ODA to USD 3.5 billion in 2019, the latestyear for which data are available.[95] This was equivalent to 3.1 percent of imports of goods, services, and primary income in that year, with the highest percentage between 2011 to 2019 occurring in 2017 at 5.4 percent. As a percentage of Gross National Income, GNI, ODA peaked at 4.6 percent in 2006 and was 0.8 percent in 2019. In terms of USD per capita, ODA amounted to USD80.00 in 2006 andUSD17.5 in 2019, and with respect to gross capital formation, the peak in 2006 was 17.4 percent and 3.0 percent in 2019. Further information on the focus of ODA has proven a challenge to source, either by the CO or the consultants through online search, for instancethrough UNDP or the World Bank sites, and seeking information from key informants. This includes challenges in identifying the mainfocus of ODA support, particularly to assess how far it contributed to health, gender equality or youth, as opposed to other areas of development assistance, and therefore how far it benefitted the populations that UNFPA prioritizes. Nonetheless, the overall picture is clear, that ODA to Nigeria is substantially lower than the spike 15 years ago, despite being considerably higher than in prior years.

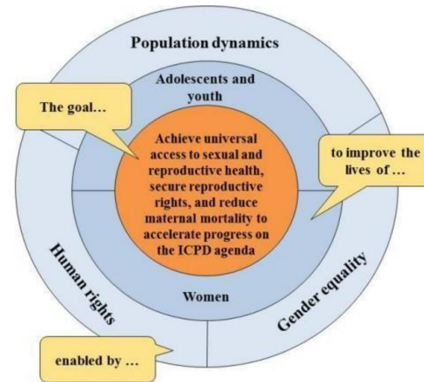
[89] Ibid.
[90] Child's Rights Act
[91] NIGERIA Integration of the SDGs into National Development Planning - A Second Voluntary National Review Integration 2020
[92] Ibid.
[93] Ibid.
[94] Ibid.
[95] World Bank https://data.worldbank.org

3 UNFPA Strategic Response and Programme

3.1 UNFPA Strategic Response

The global UNFPA Strategic Plan of 2018-2021 provides the strategic direction of the Nigeria 8th CP, exemplified by the bull's eye placing women and young people[96] as key beneficiaries. The strategic direction addresses three transformative results by 2030, to end preventable maternal mortality, unmet need for family planning, and gender-based violence and harmful practices.[97]

Figure 3.1: The UNFPA Bull's Eye



The box below highlights the four overarching outcomes of the Strategic Plan that guided the development of the 8th CP to address the International Conference on Population and Development (ICPD) Programme of Action as well as the SDGs. The outcomes particularlyaddress SDG 3 on health and well-being and SDG 5 on gender equality and the empowerment of women and girls (GEWE). In addition,they contribute to SDG 10 to reduce income inequality, Goal 16 on peaceful and inclusive societies for sustainable development, and Goal 17 on strengthened partnerships. In line with the goals and principles of the SDGs is the underlying principle of reaching the mostvulnerable first and leaving no-one behind. Also, the UNAIDS Division of Labour (DoL) on HIV and AIDS guides the UNFPA strategicresponse regarding HIV prevention.

UNFPA Strategic Plan (2018-2021) Outcomes

Outcome 1. Every woman, adolescent, and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductivehealth services and exercised reproductive rights, free of coercion, discrimination, and violence.
Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health andreproductive rights, in all contexts.
Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitariansettings.
Outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.

The previous UNFPA Strategic Plan 2014-2017 also addressed sexual and reproductive health and rights, adolescents and youth, especially young adolescent girls, GEWE, and evidence-based analysis of population dynamics, and the 2018-2021 built further on this,as does the upcoming Strategic Plan 2022-2025 towards achieving the 2030 SDGs.

As well as aligning with the global UNFPA Strategic Plan, the SDGs, ICPD PoA and UNAIDS DoL, the 8th CP aligns with the United Nations Development Assistance Framework (UNDAF) for Nigeria. The UNDAF, based on a UN common country assessment (CCA),provides the programming framework for a collective response by the UN in the country, and the outputs and outcomes of all UN agenciescontribute to the overarching outcomes of the UNDAF. In turn, these contribute to the priorities expressed in Nigeria Vision 20:2020. The Results and Resources Framework of the UNFPA CPD (3.2.1) indicates the flow and linkages between the Nigeria priorities, the UNDAF, and the outcomes and outputs of UNFPA.

[96] The UN definition of young people is the age cohort 10-24, including adolescents (10-19) and youth (15-24)
[97] UNFPA Transformative Results: https://www.unfpa.org

3.2 UNFPA Response through the Country Programme

3.2.1. The Country Programme

The table below provides the Results and Resources Framework from the UNFPA 8th Country Programme Document, highlighting theoutcomes and outputs, thematic areas, indicators, baselines and targets, key partners, and indicative resources.

Table 3.1: Nigeria UNFPA 8th Country Programme 2018-2022 Results and Resources Framework[98]

National priority: Guaranteeing the well-being and productivity of the people of Nigeria (Vision 20:2020). **UNDAF outcome:** By 2022, Nigerians, with focus on most disadvantaged have access and use quality health, nutrition, and HIVservices **Indicator**: Percentage of births attended by skilled health personnel *Baseline:* 38.1%*;* *Target:* 42%				
UNFPA SP outcome	**Country programmeoutputs**	**Output indicators, baselines, andtargets**	**Partner contributions**	**Indicative resources**
Outcome 1: Sexual and reproductive health Outcome indicator(s): Maternal mortality ratio *Baseline*: 576; *Target*: 520 Contraceptive prevalence rate *Baseline*: 12.1%; *Target*: 20%	Output 1: Enhanced capacities to develop and implement policies, including financial protection mechanisms, that prioritize access to SRH information and services by those women, adolescents, and youth left furthest behind, including in humanitarian settings	Number of states in which capacities to develop and implement policies that prioritize access of women, adolescents,and youth most left behind to SRH information and services have been enhanced. *Baseline*: 0; *Target*: 10	Ministries of: Health; Budget and Planning, Youth, Bureau of statistics and civil society organizations, United Nations organizations	$9.0 million ($4.0 million from regular resources and $5.0 million from other resources)
	Output 2: Strengthened capacities in delivering quality integrated family planning, comprehensive maternal health and STIs and HIV information and services, in particular for adolescents and youth and in humanitarian settings	Percentage of facilities with no stock-out of modern contraceptives in the past three months *Baseline*: 77%; *Target*: 80% Number of new users of family planning services *Baseline*: 8,600,000; *Target*: 13,600,000	Ministries of: Health; Budget and Planning, Bureau of statistics and civil society organizations; National Emergency Management Agency, United Nations organizations	$21.0 million ($6.0 million from regular resources and $15 million from other resources)
	Output 3: Strengthened capacities for improvinghuman resources for health management and skills, especially for midwives, to deliver quality and integrated SRH services, including in humanitarian settings	Number of midwife training institutions using updated curricula (universal rights of childbearing women, and the prevention and management of violence against women) *Baseline*: 0; *Target*: 50 Number of schools supported to train midwifery service providers, especially on Minimum Initial Service Packages *Baseline*: 0; *Target*: 50 Antenatal care coverage (at least four visits)Baseline: 51; Target: 60	Ministries of Health and Education, National Midwifery Councilof Nigeria, civil society organizations, United Nations organizations	$7.0 million ($2.0 million from regular resources and $5 million from other resources)

[98] Because the RRF is a published document, the consultants cannot make any amendments to it despite requests to do so.

National priority: Fostering sustainable social and economic development (Vision 20:2020). **UNDAF outcome:** By 2022, Nigerians, with a focus on the most disadvantaged children and young/adults, access and complete quality educationwhich provides relevant skills and knowledge for lifelong learning. **Indicator**: Youth literacy rate, population aged 15-24 years. *Baseline:* 65%*; Target:* 71%				
Outcome 2: Adolescents andyouth Outcome indicator(s): Adolescent birthrate *Baseline*: 122 per 1,000 women aged 15-19 years; *Target*: 100 per 1,000 women aged 15-19 years	Output 1: Strengthened capacities across relevant sectors to prioritize adolescents and youth in policies and address the broader determinants of their reproductive health, development, and well-being	Output indicators: Number of supported states that reflect adolescent and youth health, development and well-being in multi-sectoral policies *Baseline*: 2; *Target*: 12 Number of national and state plans thatintegrate approaches to harnessing the demographic dividend *Baseline*: 1; *Target*: 10 Number of adolescents and youngpeople reached with SRH services including family planning and HIV education *Baseline:* 1,000*; Target:* 10,000 Number of condoms distributed *Baseline:* 62,560,952*; Target:* 312,000,000	Ministries of Health, Budget and Planning, Youth and Sports, & Women's Affairs; Bureau of Statistics, National Population Commission, and civil society organizations	$15.0 million ($5.0millionfrom regularresources and $10 million fromother resources)

National priority: Fostering sustainable social and economic development (Vision 20:2020). **UNDAF outcome:** By 2022, the National and State Social Protection Policies are implemented and adequately financed at federaland state levels as well as protection systems and services are strengthened to more effectively prevent and respond to violence, abuse, exploitation (including trafficking) and harmful social norms **Indicator**: Proportion of ever-partnered women who have been subjected to physical violence *Baseline*: 30%; *Target*: 15%				
Outcome 3: Gender equalityand women's empowerment Outcome indicator (s): Proportion ofever-partnered women who have been subjected to physical violence *Baseline:*	Output 1: Increased multisectoral capacity to prevent and address gender-based violence, with a focus on advocacy, data, health and health systems, psychosocial support, and coordination, within a continuum approach	Number of state level information management systems in place to collect, analyse and disseminate data on gender-based violence *Baseline: 3; Target: 6* Number of adolescent girls participating in mentoring or vocational skills programmes and safespace sessions *Baseline: 0; Target: 600*	Ministries of Health, Youth and Sports, Women's Affairs; Bureau of Statistics, and civil society organizations	$7.5 million ($2.5million from regular resources and $5 million from otherresources)

30%; *Target: 15%*				
National priority: Fostering sustainable social and economic development (Vision 20:2020). **UNDAF outcome:** By 2022, Nigeria's population dynamics becomes a strong basis for national development and resourcemanagement through better use of demographic intelligence. UNFPA is the outcome lead within the UNCT for this UNDAF				
Outcome. **Indicator**: Census conducted in line with international standards *Baseline:* 0*; Target:* 1				
Outcome 4: Population dynamics Outcome indicator(s): Census conducted inline with international standards *Baselin*: 0; *Target*: 1	Output 1: Increased capacity to generate population projections andidentify sociodemographic trends and address themwithin policies, programmes and advocacy	Number of supported states generating quarterly rapid appraisals of populations affected by humanitarian crises, including estimated numbers of reproductive age women, young people, pregnant women, and persons over 65 years of age *Baseline*: 1; *Target*: 4 Number of supported states with institutional capacity to analyse and use disaggregated data on a) adolescentsand youth and b) GBV *Baseline*: 5;*Target*: 10 Number of states supported to produce disaggregated data to monitor SDG indicators *Baseline*: 0; *Target*: 10	Ministries of Health, Budget and National Planning, Youth and Sports; Women's Affairs, Bureau of Statistics, National Population Commission, andcivil society organizations	$15.0 million($5.0 million from regular resources and $10.0 million from other resources)

The following table highlights the changes in the Nigeria 8th CP from the previous country programme.

Table 3.2: Nigeria 7th CP and 8th CP Programme Component Areas and Outputs

7th Country Programme 2013-2017		8th Country Programme 2018-2022	
Strategic Outcome Area	**Outputs**	**Strategic Outcome Area**	**Outputs**
RHCS and FP Services (Outcome 1 Output 2)	Increased national capacity to strengthen enabling environments, increase demand for and supply of modern contraceptives and improve quality family planning services that are free of coercion, discrimination, and Violence	**Sexual and Repro-ductive Health Services**	Output 1: Enhanced capacities to develop and implement policies, including financial protection mechanisms, that prioritize access to SRH information and services by those women, adolescents, and youth left furthest behind, including in humanitarian settings
Comprehensive Maternal Health Services (Outcome 1 Output 3)	Increased national capacity to deliver comprehensive maternal health services		Output 2: Strengthened capacities in delivering quality integrated family planning, comprehensive maternal health and STIs and HIV information and services, in particular for adolescents and youth and in humanitarian settings
SRH in Humanitarian Settings Outcome 1 Output 5)	Increased national capacity to provide sexual and reproductive health services in humanitarian settings		Output 3: Strengthened capacities for improving human resources for health management and skills, especially for midwives, to deliver quality and integrated SRH services, including in humanitarian settings
Comprehensive ASRH Programme (Outcome 2 Output 8)	Increased capacity of partners to design and implement comprehensive programmes to reach marginalized adolescent girls includingthose at risk of child marriage	**Adolescents andYouth**	Output 1: Strengthened capacities across relevant sectorsto prioritize adolescents and youth in policies and address the broader determinants of their reproductive health, development, and well-being
	No separate thematic area on GEWE	**Gender equality and women's empower-ment**	Output 1: Increased multisectoral capacity to prevent andaddress gender-based violence, with a focus on advocacy, data, health and health systems, psychosocialsupport, and coordination, within a continuum approach
Data for Development (Outcome 4 Output 12)	Strengthened national capacity for productionand dissemination of quality disaggregated data on population & development issues that allows for mapping of demographic disparities and socio-economic inequalities, and for programming in humanitarian settings	**Population Dynamics**	Output 1: Increased capacity to generate populationprojections and identify socio-demographic trends and address them within policies, programmes and advocacy.

The 8th CP builds clearly on the 7th CP, with the most significant development being a strengthened focus on gender as a thematic area in its own right. The outcome on data for development has been narrowed down to population dynamics, but with a similar focus on capacity building and emphasis on the use of data. Also, within SRH, a focus on HIV and other sexually transmitted infections (STIs) has been introduced, an important addition. Both RRFs address SRH in humanitarian settings and, meeting the SRH needs of the more vulnerable, particularly adolescents and young people. Building capacity for improved service provision, data analysis and use is the priority in both RRFs, with less clear focus on generating demand and the uptake of services. Regarding geographic coverage, UNFPA established a fourth sub-national office during the 8th CP to address the humanitarian crisis in the north-east of the country in relation toBoko Haram, the terrorist organisation operating in Borno State from (as well as in Chad, Niger, and northern Cameroon).

3.2.2. The Country Programme Financial Structure

The Nigeria 8th Country Programme Document of 3 July 2017 proposed assistance of USD 26 million from regular resources, and USD50 million from co-financing modalities and other resources for the five-year programme, as indicated below.

Table 3.3: Proposed Indicative Assistance in Millions of US$

Strategic plan outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	12.0	25.0	37.0
Outcome 2	Adolescents and youth	5.0	10.0	15.0
Outcome 3	GEWE	2.5	5.0	7.5
Outcome 4	Population dynamics	5.0	10.0	15.0
Programme coordination and assistance		1.5	-	1.5
TOTAL		**26.0**	**50.0**	**76.0**

This shows little change from the indicative resources for the previous CP of USD 29.2 million in regular resources, and USD 45.8 million in other resources, for a total of USD 75 million. However, actual budget and expenditures indicate successful leveraging of additional resources from 23 international donors and 10 government sources (eight states, the Federal Capital Territory, and the Federal Ministry of Health), amounting to a total budget of USD 101,103,23.59 from 2018 to 2021. Utilization rates were 72 percent in 2018, 79percent in 2019, and 75 percent in 2020. The most significant reasons for under-utilisation (CO informants) were given as late receipt offunding by implementing partners (IPs) for a number of reasons (see 4.3 on efficiency) or sometimes IP incapacity to implement programmes at scale. Late disbursement was reported as most significant at the start of 2018 and 2019 when UNFPA could not disburse funds in the first quarter owing to the general elections. In 2020 and 2021, many activities had to be canceled or reduced because of the COVID-19 pandemic and, where possible, activities were undertaken virtually at greatly decreased cost.

Figure 3.2 shows the relative funding by thematic area, and Figure 3.3 shows the evolution over time of funding by thematic areas. Figure 3.4 provides budget vs expenditures across thematic areas, and the two graphs in Figure 3.5 provide information on budget and expenditure in relation to funding sources. Clearly, sexual and reproductive health is substantially the largest funding area, followed by GEWE, with the adolescents and youth (AY) thematic area being the least funded. This reflects that most activities relating to AY were incorporated in funding for SRH or GEWE in line with emphasis on integration, as indicated in the RRF. In Figure 3.4, the reference to maternal health in fact incorporates the full SRH budget and expenditures. Within SRH, the highest area of budget and spending was on maternal health, including antenatalcare and obstetric fistula, and the lowest was on female genital mutilation followed by family planning. Section 4.2.2 elaborates further.

Figure 3.2: Funding by Thematic Area, 2018-2021 (USD)

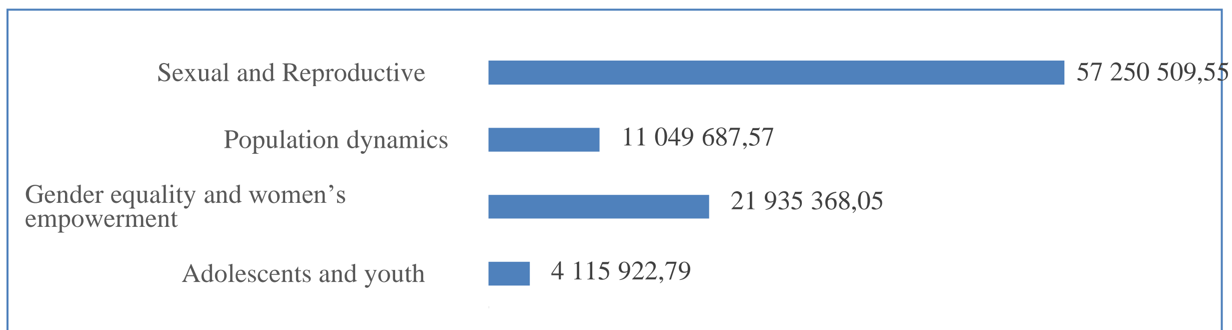


Figure 3.3: Evolution Over Time of Funding by Thematic Areas (USD)

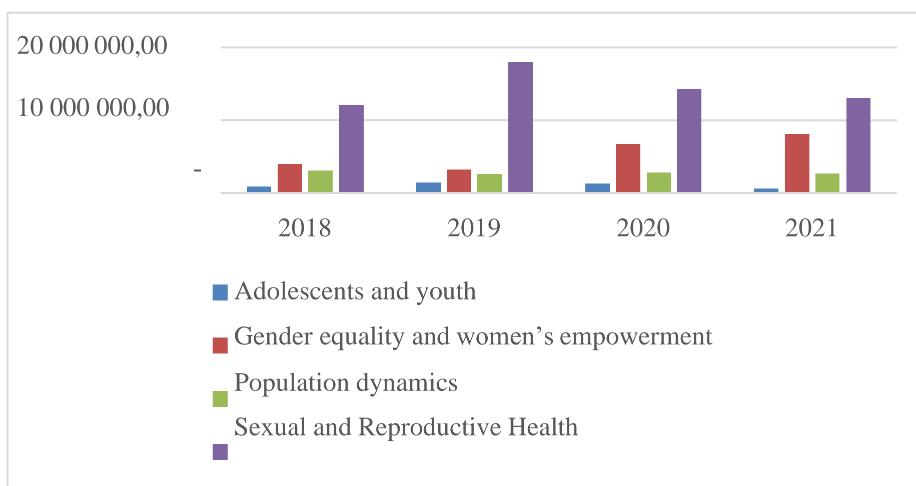


Figure 3.4: Total Budget vs Expenditure by Thematic Area, 2018-2021 (USD)

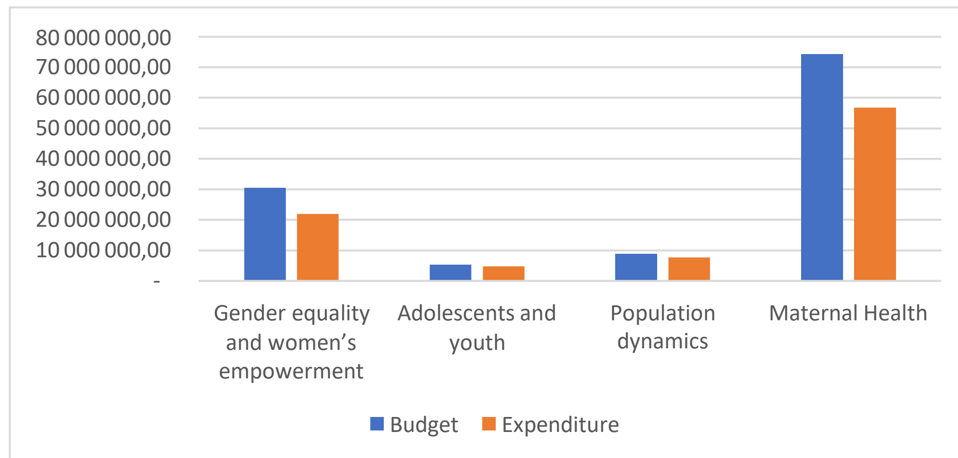
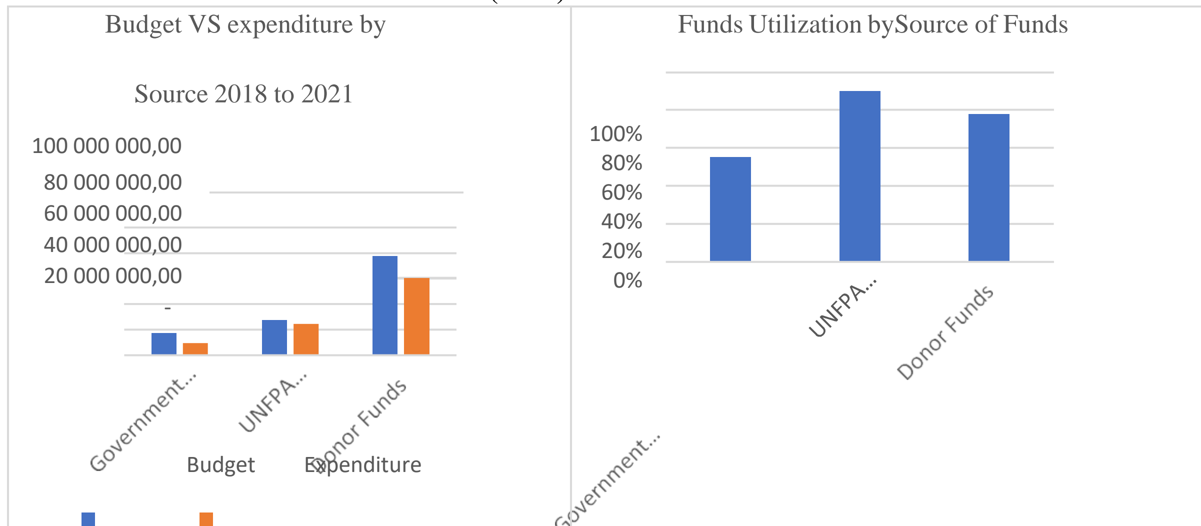


Figure 3.5: Budget vs Expenditure and Relative Fund Utilisation by Source of Funds (USD)



Donor funds comprised by far the largest source of finance, but the highest budget utilization rate (at close to 90 percent)was of UNFPA core funding. All financial data have been provided by the CO.

4 Findings

4.1 Relevance and Responsiveness

Summary: The 8th CP is fully adapted to international frameworks of the SDGs and ICPD programmes of action, as well as to other international commitments, UNFPA global strategic direction and objectives, the UN Strategic Development Partnership Framework for Nigeria and to Nigeria Vision 20:2020. It is also fully aligned to national priorities and the needs of diverse populations including the more vulnerable and marginalised, particularly young women. However, despite Nigeria having the second highest number of people living with HIV, the focus on HIV appears to be insufficient. UNFPA has shown strong responsiveness to changing needs and priorities in Nigeria, particularly in humanitarian settings and with regards COVID-19, as well as in relation to specific issues such as high teen pregnancies and reaching high numbers of girls and women during sporadicdisplacements with dignity kits.

4.1.1. To what extent is the country programme adapted to: Priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, and the New Way of Workingand the GrandBargain; the strategic direction and objectives of UNFPA; and national development strategies and policies and the needs of diverse populations, including the needs of vulnerable and marginalized groups (e.g., young people and women with disabilities)?

4.1.1.1. Overview

The 8th Country Programme of UNFPA (8th CP) is fully aligned to the 2030 agenda for Sustainable Development Goals (SDGs), the International Conference on Population and Development (ICPD) programmes of action, and with complementary international, regional,and national commitments. With regards to the ICPD, the programme addresses: sexual and reproductive health and rights (SRHR) as part of the commitment to universal health care within the SDGs and to stop preventable maternal morbidity and mortality; gender equality and women's empowerment (GEWE), particularly in ending gender-based violence and harmful practices such as female genitalmutilation (FGM) and child marriage; reaching adolescents and youth (particularly SRHR in adolescent girls) as a key population to engage and empower; and population dynamics. UNFPA advocates for and supports legal and policy change, capacity development, service provision, building knowledge and awareness, and transforming conservative community norms in all areas of its mandate, and also, in line with ICPD, has a particular focus on SRHR and gender in humanitarian situations. The 8th CP is relevant to the ICPD regarding improved national population data systems and on reporting systems for gender-based violence, GBV (see section 4.1.5), as critical to facilitate evidence-informed programming. While particularly relating to SDG 3 on health and well-being, and to SDG 5 on gender equality and female empowerment, the 8th CP is also aligned with multiple other SDGs directly or indirectly. These include, for example, efforts to reduce poverty by empowering girls, and also, addressing child marriage that keeps girls from school (SDGs 1 and 8),helping teen mothers return to school and supporting comprehensive sexuality education (SDG 4), reducing inequalities (SDG 10), and building partnerships based on accessible data to inform programming (SDG17).[99]

One area of international commitment in which the UNFPA 8th CP could be more fully aligned is with respect to the global UNAIDS Division of Labour (DoL) on HIV and AIDS,[100] with Nigeria being one of the 28 Global Prevention Coalition countries that is co- convened by UNAIDS and UNFPA (as the lead on prevention of sexual transmission of HIV). Addressing HIV is part of the wider ICPDprogramme of action on SRH, as stressed in the Nairobi commitment,[101] although UNFPA only incorporated in its revised Results and Resource Framework the commitments to zero unmet need for family planning and zero maternal deaths, two of the existing three globalUNFPA transformative goals (document review). In the DoL, UNFPA is co-convenor for HIV prevention in young people, in achievingminimum 30 percent community service delivery by 2020, and for HIV prevention in priority populations of sex workers, gay men and other men who have sex with men, transgender populations and migrants, including young members of these priority populations. Although UNFPA is contributing to these areas (document review and KI interviews), KIs within the CO and among implementing partners (IPs) and beneficiary FGIs, confirmed that the agency's role needs to be strengthened. Although HIV prevalence in Nigeria is

[99] https://www.unfpa.org/resources/unfpa-sustainable-development-goals-0 for further elaboration

[100] UNAIDS (2018) Division of Labour https://www.unaids.org/en/resources/documents/2019/UNAIDS-Division-of-Labour

[101] Nairobi Summit on ICPD25 (2019) https://www.nairobisummiticpd.org/content/icpd25-commitments

far lower than that in most of East and Southern Africa, the total number of people living with HIV is high (see Chapter 2) and HIV prevention (and care and treatment) must remain high on the national SRH and gender agendas.

The programme is closely aligned with the global UNFPA strategic positioning as stated in the UNFPA Strategic Plan 2018-2021. This addresses ICPD and places women, especially young women and reproductive women, young people including those out of school, andthe more marginalized and vulnerable, including people with disabilities and people affected by humanitarian situations, at the heart of programming to address the transformative goals of ending preventable maternal deaths, ending the unmet need for family planning, andending harmful traditional practices (such as early marriage, female genital mutilation, and gender based violence). The 'bull's eye,' carried forward from the previous UNFPA Strategic Plan 2014-2017, illustrates the targeting of the UNFPA global strategy to which theNigeria programme adheres (see Chapter 3). Chapter 2 also elaborates the outcomes of the Strategic Plan.

As well as aligning with the global UNFPA Strategic Plan, the SDGs, ICPD PoA and, to some extent, the UNAIDS DoL, the 8th CP aligns with the United Nations Development Assistance Framework (UNDAF) for Nigeria. The UNDAF, based on a UN common country assessment (CCA), provides the programming framework for a collective response by the UN in the country, and the outputs and outcomes of all UN agencies contribute to the overarching outcomes of the UNDAF. In turn, these contribute to the priorities expressedin Nigeria Vision 20:2020. The Results and Resources Framework of the UNFPA CPD indicates the flow and linkages between the Nigeria priorities, the UNDAF, and UNFPA outcomes and outputs, highlighted under each thematic area in EQ 4.2.

The New Way of Working (NWOW)[102] commits the UN and partners to develop multi-year funding commitments to achieve common goals. In Nigeria, this is evidenced by the collaboration within the UN to the CCA as above, the UNDAF and the UN Sustainable Development Partnership Framework (UNSDPF) of 2018. The latter provides agreed commitments for multi-year national planning, andwith clearly articulated complementary responsibilities within various joint programmes that have multi-year funding. These are elaborated in EQ4.5 on coordination, cooperation, and cohesiveness. With respect to the Grand Bargain, first articulated in 2016,[103] UNFPA is an active participant in the multi-sectoral humanitarian response in Nigeria, leading on gender-based violence (GBV) and onSRH services and capacity building, primarily in the camps for displaced persons, but also with host populations and contributing to thetransition to peace and development in Adamawa State. UNFPA is reported to be highly active in the Humanitarian Country Team (HTC),too. The roles of UNFPA in the humanitarian states and the HCT are elaborated in EQ4.2 and EQ4.5.

Nigeria Vision 20:2020 is focused primarily on economic transformation and growth to reduce poverty and hunger. The vision statementis: 'By 2020, Nigeria will have a large, strong, diversified, sustainable and competitive economy that effectively harnesses the talents and energies of its people and responsibly exploits its natural endowments to guarantee a high standard of living and quality of life to itscitizens.' Towards achieving greater equity and justice, Nigeria Vision 20:2020 promotes respect for all people irrespective of race, class,gender, or disability, thus the UNFPA focus on GEWE and on the inclusion of people with disabilities as a cross-cutting focus are well aligned. The national priorities to which the UNDAF and UNFPA relate include: access to and use of quality health including HIV services; focus on the disadvantaged regarding education, knowledge and skills; the prevention and response to violence, abuse and exploitation, and to harmful social norms; and strengthening the understanding of and response to population dynamics to foster sustainable social and economic development.[104] Prior to the 8th CP UNFPA undertook formative assessment[105] to inform the design of interventions and ensure programme alignment to prevailing needs with an appropriate gender balance in programming.

One critical barrier to achieving the Vision is high population growth, although how to address this is not clearly elaborated in NV20:2020or NV20:2030. Because they recognize the need to address population dynamics, both visions provide an entry point for UNFPA programming. NV20:2030 builds on the previous vision and stresses ending poverty, securing the planet, and building peace and prosperity. The support of UNFPA at national and state levels to capture disaggregated geo-spatial population (demographic and health)data with multiple variables of inequality (such as overall numbers, sex, age, density, location, income, and other variables) is highly relevant. Also relevant is UNPA support to state plans to address trends and changes in population growth (fertility, mortality, and migration) including marriages, urbanization, demographic structures, and societal changes. This includes documenting the proportions of dependent, young,

[102] https://www.agendaforhumanity.org/sites/default/files/20170228%20NWoW%2013%20high%20res.pdf
[103] https://interagencystandingcommittee.org/grand-bargain
[104] NV20:2020 and Nigeria UNDAF
[105] UNFPA (2016) Nigeria Country Analysis: A human-rights based, equity focused, gender sensitive and sexual and reproductive rights focused analysis of women andyoung people in Nigeria

incapacitated, and older persons versus the economically active population, so that realization of the demographic dividend is apparent and better understood to influence multi-sectoral policy, planning and programming (as ICPD PoA advocates).

Achieving the demographic dividend requires capacitated, healthy young women and men entering the productive workforce, and the UNFPA mandate to end unmet needs for family planning, to end GBV and to achieve women's empowerment are important contributions. Slowing population growth can only be achieved by the transformation of cultural preferences for large family size and the acceptance of child marriage and reducing the high rates of teen pregnancy. These, in turn, are facilitated by keeping girls in school, capacitating young women and men for productive labour, and achieving greater gender equity as well as ensuring access to a wide range of moderncontraception. Given the high value Nigerian societies place on entrepreneurship (KI interviews), aligning family planning, ending child marriage, and increasing gender equality and women's empowerment with improved family income and security, may be an approach that resonates widely.

4.1.1.2 Sexual and Reproductive Health Services

The SRH mandate of UNFPA correlates strongly with the Nigeria international and regional commitments such as the Common AfricanPosition (CAP) on the Post 2015 Agenda (African Union 2014), which seeks to achieve universal and equitable access to quality health care on the continent, prioritizing improvement in maternal, neonatal and child health (MNCH), and enhanced access to sexual and reproductive health and family planning. The CAP itself aligns with the ICPD and links with SDGs. It has a special focus on vulnerablegroups, including youth, the unemployed, children, the elderly, and people with disabilities, which fall within the mandate of UNFPA inaddressing the most vulnerable. The 8th CP aligns also with the related national commitments of the National Strategic Health Development Plan II of 2018, specifically Strategic Pillar 2 Priority Area 4, to promote universal access to comprehensive quality sexual and reproductive health services throughout the life cycle, and to reduce maternal, neonatal, child and adolescent morbidity and mortality.

UNFPA has also responded to emergency issues such as supporting the Calabar and Abeokuta midwifery schools to repair structural damage from a storm, and to meet accreditation requirements. The innovative programme of establishing young mums' clinics and helpingthe girls to return to education addresses recognized challenges and gaps in existing provisions and high rates of teen pregnancy. UNFPA support for midwifery is in line with global best practices, recognizing the critical role of midwives in preventing maternal mortality, strengthening facility-based delivery, and addressing capacity building. Strengthening data on maternal mortality through the Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines has been shown to contribute to reductions in maternal deaths, with services strengthened in Calabar, Lagos, Gombe, Kaduna and Ogun states (KI interviews and document review). Likewise,the UNFPA focus on repairing obstetric fistula and rehabilitating patients is also in line with priorities in the National Strategic Health Development Plan II, and received the support, for example, of the first ladies of the states of Sokoto and Kaduna to champion the response, including with the private sector. Chapter 2 highlights legislation and policies to which UNFPA SRH support aligns within theoverarching health plan.

Most important of all, UNFPA has continued to fund and procure commodities, strengthen services, develop provider capacity, continueadvocacy, and support community engagement for family planning as a cornerstone of the 8th CP. UNFPA recognizes the critical importance of addressing the demographic transition in Nigeria to meet the sustainable development goals across all sectors, as addressedabove. Demand has increased, although there is still extensive unmet need for FP, and intensified efforts are needed to slow population growth nationwide. Reducing the high teenage pregnancy rate is a key factor, and this has been a particular focus of the 8th CP.

4.1.1.3. Adolescents and Youth

As well as aligning with the ICPD, SDGs and UNFPA Strategic Plan (2018-2021) regarding the focus on young people, the UNFPA 8thCP is fully in line with federal government policy on youth development articulated in the National Youth Policy of 2009[106] and updates,notably the National Youth Policy 2015-2020.[107] The update assists coordination and complementarity between the various sectors that relate to youth. The policy aims to protect the fundamental human rights, health, social, economic, and political well-being of young people so that they can participate in the overall development process and have an improved quality of life. The subtitle of the revised policy is: 'We are generation 2020. We don't want a handout, we want a hand up!' so the emphasis of UNFPA engagement with and empowering youth and strengthening their knowledge through supporting comprehensive sexuality education (CSE), is highly relevant.

[106] Second National Youth Policy Document of the Federal Republic of Nigeria (2009)

[107] National Youth Development Agency (2015) The National Youth Policy https://www.google.com/search?client=firefox-b-d&q=Youth+policy+in+Nigeria

Specific areas of UNFPA engagement around adolescents and youth are elaborated throughout the following sections of Chapter 4 as, inaddition to the demographic focus on this cohort, adolescents and youth are addressed within the SRH and gender thematic areas relatingparticularly to the SRH needs of adolescent girls. EQ 5 addresses the roles of UNFPA in inter-agency coordination and collaboration around young people. UNFPA has supported states to strengthen capacities to prioritize adolescent and youth policies, health, and development, including policy dialogue, convening IPs, and establishing platforms to harness the demographic dividend, with advocacyfor policies that support quality education with gender parity, and for policies on adolescent and youth health across all sectors.

4.1.1.4. Gender Equality and Women's Empowerment

In the highly patriarchal society of Nigeria, scoring in the worst category in the Gender Development Index (see Chapter 2), addressing gender equality and women's empowerment (GEWE) is particularly relevant, including to stop female genital mutilation (FGM) and child marriage. The limited scope for adolescent girls and women to make informed decisions regarding sex, FGM, marriage, childbearing and other aspects of their sexual and reproductive health and rights, let alone wider engagement in the economy and in development, contributes directly to high population growth, maternal morbidity and mortality, and gender-based violence (GBV). ThatUNFPA works to transform conservative socio-cultural and religious norms that impede the access of women and sexually active girls to contraceptives and exposes girls, as well as supporting service provision and capacity development among providers, is therefore critically important and relevant. In humanitarian settings, UNFPA also responded actively to the global Call to Action[108] to mitigate andaddress GBV.

In the previous CP, UNFPA advocated for and supported the passing of the Violence Against Persons (Prohibition) Act 2015, VAPP, atfederal level, and the agency has supported its domestication at state levels during the 8th CP. UNFPA is particularly active in addressingboth the prevention of GBV and supporting holistic responses for survivors, as well as addressing harms such as FGM. The extent of GBV in the humanitarian regions is of extreme concern, particularly for young women, and the humanitarian settings are, appropriately,a major and expanding focus for UNFPA programming.

With regards to women and young people with disabilities, typically among the most vulnerable and marginalized, UNFPA has also expanded its relevance by appointing the gender specialist to lead on promoting their inclusion and supporting positive policy and programme development to address their needs (see EQ4.2.2).

4.1.1.5. Population Dynamics

UNFPA engaged with government in developing the National Development Plan 2021-2025 and the new National Policy on Population2021. The agency also supported Nigeria on improved national population data systems to map and address inequalities, advance achievement of the SDGs and ICPD, and inform interventions in times of humanitarian crisis,[109] all activities that related closely to the national aim of achieving evidence-informed sustainable development planning (NV20:2020 and NV20:2030). UNFPA promoted advocacy and policy dialogue for population and development including harnessing the demographic dividend at national and state levels to enhance investments in the ICPD Programme of Action unfinished business.[110] In particular, there is growing recognition in Nigeria of the need to have timely, accurate and comprehensive data on which to develop policy and to commission services relating to domestic, sexual and gender-based violence, and this has been an important area of UNFPA engagement.

The UNFPA 8th CP is highly relevant in supporting the National Bureau of Statistics (NBS) to generate population statistics and in conducting the Multiple Indicator Cluster Survey (MICS) and Nigeria Demographic and Health Survey (NDHS) respectively to bridge gaps in data for policy formulation and for decision-making at national and state levels. UNFPA also supports the Federal Ministry of Health in generating health data on the National Health Management Information system (NHMIS) and in conducting the annual SuppliesSurvey to bridge gaps in health facility data for policy formulation and for decision-making at national and state levels. UNFPA has funded the selected states[111] in strengthening GBV incidence administrative data documentation with necessary tools for reporting cases, database development, capacity building and routine analysis to inform future programme strategies and implementation (KI interviews

[108] The Call to Action on Protection from Gender-Based Violence in Emergencies is a global initiative dating from 2013 to ensure that all humanitarian responses include, from the start, protection against GBV and safe and comprehensive services for survivors

[109] UNFPA Strategic Plan 2018-2021, Outcome 4, Output 14

[110] UNFPA Nigeria COAR 2019

[111] Lagos, Abia, Ebonyi and Cross River (COAR and document review)

and document review). Also, UNFPA assisted capacity building on the Geographic Information System (GIS) and STATA, and on civilregistration (Civil Registration and Vital Statistics, CRVS) at state level, addressing a major gap in birth, death, and marriage registration.

4.1.2. To what extent has the country office been able to respond to changes in national needs and priorities, includingthose of vulnerable or marginalized groups, or to shifts caused by crisis or major political changes, including innovations in relation to the COVID-19 epidemic?

The main changes in national needs and priorities during the 8th CP have been in the nature and extent of the humanitarian crisis in the north-east, increasing conflict in other regions and, in 2020, the emergence of the COVID-19 pandemic. UNFPA has responded to thesechanges in multiple ways, including by strengthening its organisational structure and staffing better to address them, particularly the growing humanitarian crisis and the need for a long-term nexus approach (KI interviews and document review). In particular, the new sub-office in Maiduguri was strengthened to support challenges regarding sexual and reproductive health, increasing gender-based violence, and data needs in the escalating humanitarian situation. Lessons had already been learned (document review and KI interviews) that programming supported by UNFPA is more effective and efficient when the agency has a presence in a given state or region. The humanitarian response addresses protracted and critical challenges and also responds to the changing insecurity situation as exemplifiedthrough short-term support in the north-west as well as in Cross River. Other sections of Chapter 4 elaborate the responses further.

When the COVID-19 pandemic emerged in 2020, UNFPA followed international and national guidelines on staff working from home and cutting back on direct service provision such as face-to-face training. The agency implemented various measures to ameliorate the impact of reduced travel and face-to-face interactions, such as strengthening their own and the capacity of implementing partners to communicate virtually, e.g., through the provision of tablets and other electronic devices to IPs and other stakeholders. UNFPA helped ensure continuous provision of RMNACH services to address COVID-19 induced service delivery. UNFPA also provided extensive personal protective equipment (PPE), consumables and other supplies, and trained health providers, as well as widely circulating and promoting safety guidelines on COVID-19.[112] The agency utilized technology such as solar-powered radios, a GBV virtual referral network, a COVID-19 youth ambassadors' social media campaign on COVID-19, HIV, GBV and SRHR, the Text4life app and the Tech4Youth regional platform, amongst others, to provide SRHR information sharing on essential RMNCAH information, and services.Both mainstream and social media platforms were engaged to reach a wide audience (KI feedback, COARs). Nonetheless, inevitably some programme implementation slowed down during COVID-19 (document review and KI interviews), despite recognition that the risk for GBV including IPV would increase, and field monitoring visits and face-to-face meetings had to stop (see EQ4.3). EQ4.2 elaborates further on the extensive policy, service, procurement, and capacity development that UNFPA supported around COVID-19. To understand the situation better, UNFPA undertook a cross-sectional study of the effects of COVID-19 on primary SRH services, finding that, although services declined somewhat, there was surprising resilience, suggesting that the supportive efforts of the agency had contributed effectively.[113] With regards UN staff and diplomat safety, also, UNFPA was widely extolled nationally and even internationally[114] for leading the refurbishment and organisation of a health facility for COVID-19 treatment (see EQ4.5).

4.2 Effectiveness and coverage

Summary: The 8th CP successfully achieved most planned activities across all thematic areas, reaching or exceeding the targets in many cases although financial limitations impeded the achievement of some results and many initial targets had to berevised down. Revisions to planned activities were made in relation to COVID-19. All modes of engagement were deployed, although the balance may need review to strengthen strategic results. The results logic between thematic areas also merits a rethink to become more streamlined. Interventions included contribution to developing laws and policies across the thematic areas to achieve a more enabling environment, capacity development of rights bearers to strengthen services, direct service support, community engagement and awareness creation, and empowerment of stakeholders including the more marginalized.The availability of population data for development was enhanced, although without the planned census. Human rights, genderand disability inclusion were all addressed and seen to be strengthened during the 8th CP. Coverage remains insufficient, however, particularly in humanitarian settings because of the huge and increasing scale of need.

[112] E.g., through contributing to the 13-country Risk Communication and Community Engagement strategy and through international UNFPA policy guidelines onCOVID-19, including various updates.

[113] Adelekan et al. Effect of COVID-19 pandemic on provision of sexual and reproductive health services in primary health facilities in Nigeria: a cross-sectional study. Reproductive Health (2021) 18:166. https://doi.org/10.1186/s12978-021-01217-5

[114] Including a reported visit by the Deputy Secretary General of the UN

4.2.1. How far have the interventions supported by UNFPA delivered outputs and contributed to the achievement ofthe CP outcomes in each of its thematic areas, including reach to the most vulnerable?

4.2.1.1. Overview

The focus of the 8th CP is reflected in the results and resources framework (RRF) within the four thematic outcome areas relating to sexual and reproductive health (SRH) services, adolescents, and youth (AY), gender equality and women's empowerment (GEWE), andpopulation dynamics (PD). The RFF indicates the use of all five modes of engagement across the thematic areas: advocacy and policy dialogue, capacity development, knowledge management, partnership and coordination, and service delivery. Such wide engagement remains appropriate for Nigeria because of severe inequalities, despite it being classed as a lower-middle income country.[115] However, the overall balance of interventions merits review, and the logic between the thematic areas and the outputs and activities within each isinconsistent, with responsibilities not fully aligned within the designated teams. This leads to potentially overlapping areas of responsibility, risk of duplication of effort or omission, and potential confusion regarding reporting. For example, the gender and youth team presented six interventions on gender[116] but are only responsible for three (the joint programme on abandonment of female genitalmutilation, FGM, the Spotlight Initiative, and the Canada-funded programming to address GBV and harmful traditional practices), whilethe SRH team addressed the Norway-funded programme on empowering girls and women and the UBRAF[117] HIV programme on HIV prevention in adolescents, and the PD team the GBV Emergency Course at the American University in Nigeria. The RRF indicates sevenintervention areas under GEWE addressed in section 4.2.1.4. The placing of indicators in the RRF also indicates some overlap and inconsistency with, for example, the SRH thematic area addressing family planning commodity procurement, and both the SRH and theAY thematic area including an indicator for condom distribution (see Annex 8). Where gaps appear in the tables provided here this reflects the absence of data, marked N/A, or that programming was not undertaken, the most common reason given being a lack of statefunding to support the intervention. Where this is confirmed as the reason, the target has been stated as '0'.

Strengthening policies, services, and information to address SRH for adolescents falls within the SRH thematic area, but increased priorityon very young adolescents for comprehensive sexuality education (CSE), and also, for sexual and reproductive health are given as outcomes for AY. The GEWE outcome area includes adolescents and youth also, including girls' empowerment and reproductive rights,with a focus on advocacy, data, health, and health systems (as well as other areas). The PD outcome area focuses on strengthening national policies, as does the AY outcome area. Within AY a stated intervention is advocacy for policies and programmes to address child marriage, although addressing harmful traditional practices appears under the gender thematic area where it has been operationalized. The focus on data appears to overlap between all thematic areas. A more rational configuration might be to narrow the gender focus to include women and girls' empowerment, male engagement, CSE, GBV, FGM and child marriage, and to integrate adolescent and youthSRH service strengthening and demand creation fully within SRH. Another option would be to maintain AY as its own thematic area addressing adolescent and gender friendly health services (such as the young mums' clinics), CSE and other mechanisms for demand generation. It is proposed that the interventions for data generation and support for data use by government at national and sub-national level across multiple sectors, fall within the PD programme, which should strongly integrate age, sex, and disability disaggregation. Support for policy development should align with the thematic areas to which it applies.

It was not possible for the evaluators to understand the full rationale for the current arrangement of the framework, although a key informant suggested one factor was that the gender lead took responsibility for AY in the absence of an AY technical lead. In the next CP the results chain logic both within and, particularly, across thematic areas should be restructured to ensure clarity of responsibilities,to strengthen synergies, and to avoid potential overlap or possible omission of complementary actions. Each thematic section below addresses in more detail the internal logic of the thematic results chains, looking at the outcome focus, the outputs, and the activities/interventions to address them. The review of the theory of change in Chapter 1 also elaborates on the overall logic of the country programme design. The matrices below include additional indicators from those contained in the RRF, which were considered too narrow.

Funding available during the 8th CP from the states, while showing some increases, was far lower than anticipated, hence the greatly reduced annual targets from the initial ones cited. The measure of achievement is given against the revised targets, not the originals andare, in many cases substantially, lower.

[115] The UN Industrial Development Organisation made this classification of Nigeria in 2016 at the G20 Summit, and the modes of intervention are usually narrower in LMICs because of increased government capacity to provide quality services.

[116] Powerpoint presentation for the CPE consultants, November 2021

[117] Unified Budget, Results and Accountability Framework of UNAIDS

4.2.1.2. Sexual and Reproductive Health Services

Table 4.1: Nigeria 8th CP Results Framework for Sexual and Reproductive Health Services, 2018 to Sept 2021

UNDAF Outcome: By 2022, Nigerians, with focus on the most disadvantaged, have access and use quality health, nutrition,and HIV services							
Indicator	**CPD Baseline**	**CPD Targets**	**Achieved**				**Progress against targets**
			2018	**2019**	**2020**	**Sept 2021**	
Percentage of births attended by skilledhealth personnel	38.1%	42%	N/A	N/A	N/A	N/A	
UNFPA Strategic Plan Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for qualityof care and equity in access.							
Maternal mortality ratio	576	520	N/A	N/A	N/A	N/A	
Contraceptive prevalence rate	12.1%	20%	N/A	N/A	N/A	N/A	
Output 1: Enhanced capacities to develop and implement policies, including financial protection mechanisms, that prioritize access to SRH information and services by those women, adolescents, and youth left furthest behind, including in humanitariansettings							
Number of states in which capacities to develop and implement policies that prioritize access of women, adolescents,and youth most left behind to SRH information and services have beenenhanced.	0	10	6 11	2 3	3 3	0 0	11* **Exceede dtarget** 17
Output 2: Strengthened capacities in delivering quality integrated family planning, comprehensive maternal health and STIsand HIV information and services, in particular, for adolescents and youth and in humanitarian settings							
Percentage of facilities with no stock-out of modern contraceptives in the past three months	77%	80%	77 70.2	77 62	82 80	N/A	82 **Exceeded target by 2020** 80
Number of new users of family planningservices	8,600, 000	13,600, 000	1,000, 000 2,752, 854	1,000, 000 2,956, 293	1,000,000 3,866, 563	1,000, 000 N/A	4,000,000 **Exceede dtarget** 9,575,710
Number of States meeting coverage of emergency obstetric and newborn care, as per the international recommended minimum standards	0	17	17 24	1 1	2 2	N/A	20 **Exceede dtarget** 27
Number of women and girls living with obstetric fistula receiving treatment with the support of UNFPA	3638 (2017)	10,000	600 728	500 650	395 1962	1530	3025 **Achieved** 3340
Output 3: Strengthened capacities for improving human resources for health management and skills, especially for midwives, to deliver quality and integrated SRH services, including in humanitarian settings							

Number of midwife training institutions using updated curricula (universal rights of childbearing women, and the prevention and management of violence against women)	0	50	1 10	0 0	0 0	0 0	1 **Exceeded** 10
Number of schools supported to train midwifery service providers, especially on Minimum Initial Service Packages	25	50	1 10	10 1	1 3	0 0	12 **Achieved** 14
Antenatal care coverage (at least fourvisits)	51%	60%	57%	N/A	N/A	N/A	**On track in2018**

*In all columns, the first figure given is the target for that year and the second figure is the total achieved in that year.

The thematic area on sexual and reproductive health (SRH) services addresses three inter-related outputs to strengthen capacity with respect to policy, services, and human resources. While all are relevant, the internal logic for the results chain needs to be strengthened. For example, the outputs are, in effect, outcomes of strengthened institutional capacity, albeit logically coherent and mutually supportive.The outcome measure on maternal mortality is an impact measure, while what is given as the UNDAF[118] outcome measure, percentage of births attended by skilled personnel, is in fact an output measure. Thus, the structure of the results chain needs to be reconsidered in the next CP and in the development of the next UNDAF. Also, while the indicators are all relevant, they could be more strategic in goingfurther than just measuring numbers, for instance including some measure of achievement of quality to ensure that the interventions have made a meaningful difference. The table here includes two additional measures from what is included in the Results and Resources Framework (RRF), the third and fourth measures under Output 2, which have been included from the overall matrix of achievements provided by the evaluation manager. The full RRF includes the interventions to address the outputs, including some with overlap in the other thematic areas (as addressed above). With regards to the 15 interventions to address the three outputs, it was challenging for the evaluators to address each independently as they appeared to overlap. In the next CP it is recommended to streamline the interventions to a greater extent so that it is clearer what each activity involves. During the evaluation, no unforeseen consequences were observed in relation to the SRH programme.

Output 1.1: **Enhanced capacities to develop and implement policies, including financial protection mechanisms, that prioritize access to SRH information and services, in particular in, adolescents and youth and in humanitarian settings.**

This output was addressed by four related interventions: policy mapping across all levels of government; policy development and reviews; high-level advocacy, including the use of champions to stimulate policy implementation; and policy advice regarding human rights-basedand culturally sensitive, age-appropriate SRH policies and protocols. Two further linked interventions were included in 2020: policy guidelines and reviews on COVID-19, and high-level advocacy for the implementation of COVID-19 guidelines and protocols.

The first four interventions can be summed up as assessing what policies were in place in the areas of the UNFPA mandate on SRH, andadvocating for, advising on and supporting policy development where there were gaps, an appropriate and valuable approach. A range of activities were undertaken in each of these areas, including in humanitarian situations. Of particular importance for SRH at national level were UNFPA technical and financial support to government for **policy development** including for the development of the NationalFamily Planning Blueprint (2020-2024), and the National Guidelines for State-Funded Procurement of Family Planning Commodities, Nigeria National Standards and Minimum Service Package for Adolescent and Youth Friendly Health Services (2019).

[118] UN Development Assistance Framework, for which indicators are jointly agreed

As well as national level support, UNFPA also strengthened capacity in 17 states (against a target of 10 states) to develop or implementpolicies in SRH services and/or information prioritizing women, adolescents and youth left behind. This included, for example, the utilization of the demographic and household data base in the humanitarian crisis in Calabar State in order to guide the Minimal Initial Service Package (MISP) requirements and wider SRH response (KI informants) – an essential contribution to ensure appropriate programming to meet emerging needs. Other areas of policy and programme support are addressed under further outputs of SRH.

UNFPA also undertook **culturally sensitive and rights-based high-level advocacy** to draw attention to key areas of its mandate and tomobilize resources (FGIs, KI interviews and COARs). One achievement early in the CP (COAR 2018) was advocacy in Kaduna State, where the governor created a 50 million-naira ($140,000) budget line to address obstetric fistula (OF) and pledged to rehabilitate the Vesico Vaginal Fistula (VVF) Rehabilitation Unit at Hajiya Gambo Sawaba General Hospital in Zaria. Given that Nigeria has high ratesof OF, with many girls and women untreated (see below), this was an important development. UNFPA also successfully advocated for the incorporation of comprehensive sexuality education (CSE) into the educational curriculum in Lagos (COAR 2018), although familylife health education (FLHE) is generally taught in Nigeria with a focus on abstinence (see other thematic areas). UNFPA has supportedthe capacitating and engagement of champions to take forward areas of its mandate, including the first ladies of Bauchi, Kaduna and Sokoto states, as well as traditional and religious leaders, for example to oppose child marriage and female genital mutilation (FGM) (FGIs, COARs and KI interviews). UNFPA also, in conjunction with UNESCO, engaged with high-level stakeholders including traditional rulers, adolescents and young people, and the ministries of education, womens' affairs, youth and health, to secure Government of Nigeria commitment towards achieving an educated, healthy and thriving cohort of adolescents and young people as part of the WestAfrican and Central African Regional effort towards realizing the demographic dividend.

During the COVID-19 pandemic, UNFPA-led advocacy strengthened the priority given to SRH issues, as well as developing COVID- 19 guidelines and protocols (KI interviews, document review). UNFPA worked through civil society organisations to create awareness in the community about COVID-19 and on preventive measures, as well as providing hand washing stands at strategic places in the community, providing dignity kits to adolescent girls in need, rape kits and other supplies among multiple other responses (for instance, see 4.1 on responsiveness and the gender section of this chapter).

Output 1.2: Strengthened capacities in delivering quality integrated family planning, comprehensive maternal health and STIs and HIV information and services, in particular for adolescents and youth and in humanitarian settings

Six interventions were cited in the RRF to address this output, strengthening: supply chain management for FP and HIV prevention; capacity for maternal and SRH service delivery in humanitarian settings; evidence-based approaches to increase demand for maternal health care, including emergency obstetric and newborn care (EmONC) services; national and state level coordination mechanisms; renovation of facility infrastructure, especially in settings of humanitarian recovery; and the generation and dissemination of quality datafor evidence-based programming. In response to the COVID-19 pandemic, additional interventions in the RRF included: procurement and supply of COVID-19 commodities; strengthening capacity for maternal and SRH services and also their utilization in the context ofCOVID-19. A further addition to the RRF was supported to implement the Nairobi Summit Commitment regarding unmet need for familyplanning, which is in effect addressed already within UNFPA commitments and therefore effectively covered in various sections.

Supporting **supply chain management** for FP and HIV prevention is a critical part of the UNFPA mandate as the lead procurement agency for contraceptive commodities. UNFPA supported the Federal Ministry of Health (FMoH) to distribute contraceptives to the statestores in all 36 states and the Federal Capital Territory (COAR 2020), and for last mile distribution scale up in 17 states. The support mainly involved adapting the IMPACT model[119] of John Snow International, a people-centered approach holistically to strengthen the supply chain. Considerable progress has been achieved with last mile distribution and the momentum needs to be sustained. Capacity was built also to utilize an upgraded e-management information system, the NHLMIS,[120] leading to greatly strengthened reporting on FPservices, stock availability, last mile distribution and related aspects of commodity stewardship (KIs and document review). Nonetheless, challenges in reporting remain as noted, for instance, in Borno and Cross River. Further capacity development is needed including for oversight of the responsible staff in the various states. UNFPA-supported government interventions, however, exceeded the target of 80 percent of facilities having no stockouts of modern FP

[119] Information Mobilized for Performance Analysis and Continuous Transformation

[120] Nigeria Health Logistics Management Information System

methods in the previous three months (achieved 82 percent in 2020), an admittedlylow level of increase against the baseline of 77 percent.

Site visits in the states of Borno, Cross River, Lagos, and Ogun found that increased demand had been a factor in stockouts, again requiringstronger forecasting and supply chain security. Interestingly, resistance to family planning was not found to be pronounced owing to successful demand creation activities as well as the harsh economic realities, with unmet demand for FP services in several sites, even inthe conservative settings of Sokoto and Borno states (FGIs and KI interviews). In the next CP, a strong focus will still be needed on demand creation to address the unmet need in close conjunction with strengthened supply chains to the last mile.

During the 8th CP, over 13.3 million new users were documented, reflecting both increased population size and likely influence of effective demand creation activities particularly in hard-to-reach areas, and with incentives to health providers and free services (KI interviews). During the 8th CP many more health facilities were capacitated to provide FP, increasing access and uptake including in more remote areas and, in hospital settings in Lagos and Ogun states, UNFPA helped establish an FP training centre. This was linked with other services such as screening for cervical cancer and manual vacuum aspiration for post-abortion care. FMoH key informants and FGI participants greatly appreciated this development and proposed that the centres be expanded further. The COARs indicate multiple milestone and output achievements in terms of numbers of health staff trained on FP and other areas, as indicated in Annex 8, which provides information on the extent of achievement in relation to all indicators.

Despite the achievements in increased FP demand, the overall improvement in the modern contraceptive prevalence rate (mCPR) is slow.Recent data are not available, but NDHS data in 2013 and 2018 show that mCPR increased only from 10 to 12 percent, and fertility rateshave only slightly decreased. Clearly there is a need to bridge the current demand-supply gap through improved mobilization of funds, implementation of the state guidelines for FP commodities, support for local manufacturing, and continued support for last mile distribution. A more aggressive approach to improve service uptake is required through intensive integrated demand creation activities including leveraging on existing structures, as well as strengthening integrated service delivery outreach to achieve wider coverage.

To strengthen the **HIV response** and programming, UNFPA supported different policies and plans through financial and technical assistance as indicated in Output 1, and in strengthening supply chain management, which included male and female condoms and lubricant. Condoms are especially important as the only contraceptive method that also provides protection against HIV and several othersexually transmitted infections (STIs). UNFPA supported the development of the revised National Prevention Plan (2018 – 2021), National Condom Strategy Operational Plan (2021-2025), the National Condom and Lubricants Quantification Plan (2021-2025), HIV Programming in Adolescents, Young People in Nigeria: An Investment Case (2021-2025), the Guide for the Implementation of Community-Based HIV Programmes Focused on Adolescents and Young People in Nigeria (2020), and the National Consolidated HIVPrevention and Treatment Guidelines for Key Populations. Also, under development with UNFPA and other agency support, are a National HIV Prevention Plan, the National Strategy on HIV for Adolescents and Young people and a Minimum Package of Prevention,among others. In addition, UNFPA assisted the updating of the National HIV Prevention Road Map and scorecard in 2020 and supportedthe National AIDS Control Agency (NACA) to organize the National HIV Prevention Technical Working Group quarterly meetings, which had become non-functional during the COVID-19 pandemic (COARs). UNFPA also supported curriculum development for the Patient Education and Empowerment Plan and the PLHIC HIV Stigma Index Survey. However, condom procurement and distribution fell far below the planned and required levels, primarily due to funding shortages (only 30 percent of the required budget was mobilizedaccording to KI reports), with anticipated international funding for condoms not materializing when the UK pulled out. Condoms were provided to adolescents, sex workers, displaced people in the camps and other marginalized people through civil society organisations, but there was little focus on key populations such as men who have sex with men (MSM) despite the data indicating their higher rate ofHIV. Widespread homophobia makes this a particularly challenging population to reach effectively but addressing the HIV and other needs of key populations, particularly MSM, is essential to curb the epidemic (see also EQ4.1).

Despite intensive UNFPA resource mobilization efforts for FP, (UNFPA contributes about 60 percent of the country basket funds for FPcommodities), a huge funding gap of an estimated USD 10-12 million per annum remains in FP commodity procurement due to government not meeting financial commitments (KI interviews). It is essential that government increasingly finances the bulk of FP commodities. Stock outs were also reported because of the inability of manufacturers to meet demand for some contraceptives (desk review and KI interviews). It is imperative for UNFPA to intensify resource mobilization efforts and also to advocate strongly for and support local production of FP commodities, including condoms, particularly with the funding cuts by the UK for FP commodity

procurement (which had been about 36 percent of funding).[121] This would require mapping and engagement of key stakeholders for private-public partnerships, technical guidelines, and capacity development of local manufacturers to meet WHO prequalification criteriaand to ensure that products meet global standards of quality, safety, and efficacy. Local production of some essential for medicines for maternal health, such as iron and folic acid tablets, should also be supported. Although initial outlays would be substantial, UNFPA couldleverage on the recent Central Bank of Nigeria funding intervention for vaccine and pharmaceutical products and engage with initiativessuch as the Africa Business Coalition on Health and the African Development Bank. UNFPA engaged with development sector organisations such as SHOP Plus, Planned Parenthood Foundation Nigeria, the DK Tyang organisation [for social marketing of condoms], and Marie Stopes International) in relation to contraceptive commodities, and supported the development of FP guidelines and stakeholder meetings to institutionalise task shifting policy in the private sector (KI interviews) to support government. UNFPA mappedprivate sector stakeholders in Cross River, and engagement with them in that and other states led to some resource mobilization from private sector organisations, such as 9mobile and Larfage, a cement manufacturer, to renovate selected health facilities. In Kaduna State,a polo club, Fifth Chukker, has a memorandum of understanding with UNFPA to work towards ending obstetric fistula in the state of Kaduna. Private sector partnerships will continue to strengthen in the next CP (KI feedback).

At state level, UNFPA provided support for the successful development, validation and dissemination of FP costed implementation plans(CIPs) in three of the planned 17 states. This limitation was partly attributed (KI interviews and document review) to the inability of stateimplementing partners (IPs) to meet their commitments, with only the states of Kaduna and Lagos indicating readiness to provide somefunding to meet their FP commodity procurement needs. However, this being a core area of the UNFPA mandate, the agency needs to advocate and scale up support for strengthened supply chain management in the next CP. Support for the development of national guidelines for state-funded contraceptive procurement is an important step in this direction, although the guidelines have yet to be fully implemented (KI interviews). More broadly, UNFPA also supported development of the National Health Supply Chain Strategic plan (2020-2025), a patient-oriented supply chain master plan to achieve high levels of efficiency and effectiveness in the delivery of medicines and other health products (COAR 2020). This needs widespread adoption and domestication by all states.

With regards to **emergency obstetric and newborn care** (EmONC), UNFPA supported a greater number of states than planned (27 against a target of 17) to meet basic standards in line with the international recommended minimum standards, a key intervention to reduce maternal and perinatal mortality and morbidity. Capacitating providers is addressed further under Output 1.3, and Annex 8 provides details of numbers of women reached. UNFPA leveraged considerable funding to address maternal health, including for antenatal care, EmONC and obstetric fistula. The total budget was over USD 34 million, of which over USD 28 million had been expended by September 2021 (UNFPA financial reporting). This was substantially higher than the reported USD 8.38 million leveragedfor FP/reproductive health commodity security, of which slightly over USD 7 million had been expended by September 2021. Nonetheless, significant gaps remain in women having the recommended full number of antenatal visits and facility births with skilled attendants, and further capacity building with stronger government investment is essential.

UNFPA is the lead agency supporting services to address **obstetric fistula** (OF), including support to develop the National Fistula Strategic Framework and a communication plan for interventions. UNFPA also supported the FMoH to develop a national protocol for social reintegration/rehabilitation of women before and after OF repair, available online,[122] and UNFPA supports the national TechnicalWorking Group addressing OF. UNFPA strengthened service provision by supporting the construction and equipping of two new OF centres as well as providing support to existing centres to improve service delivery capacity, including one in Calabar under the SpotlightInitiative (document review). Spotlight also raised awareness and demand. Importantly, the services are provided free of charge, inclusive of feeding and other ancillary needs of patients, and the overall service is greatly appreciated (FGIs and KI interviews).

However, limitations were also noted, for example in Cross River and, to a lesser extent, in Borno, where the facilities are inadequate foroptimal practice (site visits and KI feedback). The planned upgrade of the centre by the Spotlight Initiative is timely. Also, despite providing OF treatment for 5,237 clients during the 8th CP, this was little over half of the planned target of 10,000 because of funding

[121] The Guidelines on State Funded Procurement for FP Commodities was launched on March 9th, 2022, alongside the Launch of FP 2030 Commitments and other strategic documents.

[122] FMoH (2021) National Protocol for Rehabilitation and Social Reintegration of Women Pre and Post Obstetric Fistula Repairs

limitations and insufficient skilled providers in several states (including surgeons, nurses, midwives, and anesthetists), leading to lengthening waiting lists (document review, KI interviews). An estimated 5,000 new cases arise each year, and the waiting list is estimated at between 100,000 and 150,000 (KI feedback and document review) so that, at present, need and demand for OF repair far outweigh supply. Strengthened efforts to prevent OF through early referral in obstructed labour are essential, drawing attention again to the need for antenatal care services meeting international standards, and for greatly increased EmONC. Also, it is essential that family planning services are routinely provided when addressing obstetric fistula, yet this is not routine practice (KI feedback).

The rehabilitation of women successfully treated for OF has been greatly appreciated, nonetheless, including livelihood skills training, although the number of women supported (404) was a small fraction of the planned 1,000 during the CP, again limited by funding shortages (KI interviews), and barely scratching the surface of what is needed. Demand for OF treatment, and wider maternal care, increased partly owing to an extensive awareness campaign through traditional and social media, reaching millions of people. This included media events that involved radio and television talk shows, broadcasts of fistula messages in jingles and the print and electronicmedia (document review, KI interviews), and also the capacitating of champions (as noted elsewhere). However, the priority for OF treatment needs to be advocacy to leverage funds and support for memoranda of understanding with FMoH and both federal and state health institutions greatly to expand service availability with increased training and deployment of staff.

As the lead agency for SRH in the humanitarian response, UNFPA has strengthened **capacity for maternal and SRH service deliveryin humanitarian settings, including infrastructure renovation in the recovery phase, and has undertaken demand generation activities.** UNFPA support also included provision of tricycle ambulances to strengthen the referral system across the community to primary health care facilities and beyond and developed mobile outreach services to provide integrated clinic and community health carein the camps for internally displaced people (IDPs) and host communities. Site visits, for instance in Sokoto, also confirmed UNFPA support to upgrade facility infrastructure, including maternity waiting homes. UNFPA has supported a number of IDP camps thro ugh building and rehabilitation of health facilities as well as supplying equipment, drugs and consumables, including drugs (KI interviews, site visits, document review). Annex 8 provides details of the level of achievement against targets.

Although security remains an issue in parts of Borno State, with the occurrence of sporadic attacks, the government is closing IDP camps,placing many people in imminent danger. UNFPA needs to be flexible to address immediate issues that arise and also to institute strategies to assist states to transition to longer-term peace and development. Damaged health facilities need repair, and ward committees and otherstructures in the local government areas (LGAs) need strengthening. High level advocacy is also needed to ensure that health facilities inIDP camps close to communities are accessible, as they are presently closed (KI interviews and document review). Support for human resources for health should be prioritized and the frontline initiative should be sustained and strengthened. The GBV response should also widen to include men, with specific consideration also for female-led households where GBV risks are often higher (KI interviews).

To strengthen national and state level coordination mechanisms, UNFPA supported national technical working group (TWG) meetings on family planning and wider reproductive health, as well as the bimonthly review meetings at state level (document review and KI interviews). UNFPA supported the FMoH Reproductive Health Commodity Supply/Family Planning Coordinating Unit to conduct the National e-HLMIS situation room aim of strengthening reporting on FP, contributing to an increased national reporting ratefrom 75 percent at inception (November/December 2018) to 81 percent (July to August 2019) according to the 2020 COAR. UNFPA also provides support for the Maternal and Perinatal Death Surveillance and Response (MPDSR) steering committees at state and facilitylevels (see below), although not for the TWGs at national and state level for obstetric fistula (KI feedback). Maintaining these coordination activities is critical for UNFPA to monitor implementation status and provide timely support as necessary, and in the next CP it would be valuable for UNFPA to extend this support into OF TWGs as well, at national and state levels. One objective would be to help mobilise resources from other partners.

To generate and disseminate **quality data for evidence-based programming**, UNFPA regularly conducted the UNFPA Supplies Survey, which provides critical information on Reproductive Health Commodity Security (RHCS), and also, the printing, dissemination and promotion of the use of findings to refine country programme implementation. By 2019, UNFPA had also supported five of 17 plannedstates to implement the MPDSR through helping to set up state steering committees and subcommittees as well as the establishment of facility-based committees. The support includes capacity building, provision of MDPSR forms and bi-annual support for review meetingsand for review meetings in facilities. Despite the potential for these reviews to strengthen programming, KI interviews and documentation

indicated that these developments have had limited results because of low political will, limited funding, poor motivation, lack of capacityand the attrition of trained staff. A state bill on maternal death notification was only achieved in one state (Cross River) out of the planned10 states. Yet achieving far wider collection and dissemination of data on maternal morbidity and mortality has been shown to increase political commitment to midwifery training and deployment and must be strengthened.

Other areas of UNFPA support to improve data were for the National Supply Chain Integration Project in the development of its quarterlyIntegrated National Stock Status Report, and technical and financial support for the development of the NHLMIS.[123] UNFPA supportedthe FMoH Reproductive Health Commodity Supply/Family Planning Coordinating Unit to conduct the National e-HLMIS situation roomaim of improving the reporting rates for family planning, contributing to an increased national reporting rate from 75 percent at inception(November to December, 2018) to 81 percent (July to August, 2019), according to the COAR 2020.

Both Outputs 1 and 2 stress **improving access to and uptake of FP/SRH among adolescents,** and extensive efforts were made towardsthis, although none of the interventions under SRH of the RRF mention reaching AY. UNFPA utilized multiple channels to raise knowledge and SRH service demand and service provisions for AY. Efforts included, for instance, using social media platforms, developing radio programmes, establishing young mum clinics, developing safe spaces for adolescent girls (see the projects addressed under the gender section), supporting youth friendly centers, advocating for and supporting second chance education for young mothersto return to school, empowering youth hub ambassadors, developing outreach services, and distributing a popular booklet for adolescentson adolescent sexual and reproductive health, ASRH (document review, field visits and KI interviews). In addition to providing extensivecore funding to UNFPA for GBV, Norway also funded SRH activities to empower adolescent girls and young women in the states of Akwa Ibom and Gombe, complementing the funding for other states by Canada, the EU and other donors, and expanding the scale of coverage of quality SRH services and information for both adult women and adolescents (document review). Addressing provider bias in relation to adolescent sexuality was also part of the focus, and there is need greatly to expand adolescent friendly SRH service provision. One implementing partner (IP) Education as Vaccine provides ASRH services through a web based interactive platform that links with health facilities to facilitate access to FP for adolescents who are reluctant to visit health facilities (KI informants). Overall, the number of AY reached by 2021 with SRH services greatly exceeded the planned target (197,320 by September 2021).

FGIs with adolescents and KI interviews noted positive experiences with regards to improvement in knowledge of SRH, expressed attitude and behaviour change, in personal relationships, communication skills, decision making and personal hygiene. Despite the sensitivities surrounding adolescent sexuality in Nigeria, one community mobiliser commented: *If action is not taken, they* (pregnant teenagers) *will land in the hands of quacks and the life of these teenagers will be in danger.* Limitations in the youth-friendly facilities were also noted, however, such as insufficient space for activities such as peer group meetings, which sometimes lack any privacy, and lack of facilities for other activities that might attract young people to attend (site visits and KI interviews). Also, there was limited engagement of parents and guardians, which is needed to support teen access to FP and other SRH services, and there was insufficient engagement of men and boys (KI interviews). A few youth centres have also been established, such as 11 in Benue State within one localgovernment area, to encourage SRH uptake (site visit and KI interviews). There is a need to consolidate and greatly expand youth- and gender-friendliness in SRH services, as current coverage is limited, and further sensitization and training of health providers is greatly needed. For instance, initially provider bias was apparent in the young mum clinics. Whether independent youth centres are an appropriate way forward to address ASRH needs to be carefully evaluated prior to scale up, given that in many countries UNFPA has moved away from this approach towards integrated ASRH in existing facilities as a more sustainable way forward.

Output 1.3: Strengthened capacities for improving human resources for health management and skills, especially for midwives,to deliver quality and integrated SRH services, including in humanitarian settings

This output was addressed through five broad interventions inclusive of the COVID-19-related interventions. These were to: support theuse of evidence-based, gender sensitive policies, strategies and plans to engage health workers (male and female); support the development of health workforce attraction and retention schemes, in collaboration with professional associations and regulatory bodies;provide assistance for the review and update of national training curricula and methodologies (including gender sensitive methods), for community health officers, community health extension

[123] Nigeria Health Logistics Management Information System

workers and midwives preservice training; strengthen partnerships andcoordination for mobilizing sustainable health workforce resources; and provide assistance to pre-service health training institutions to meet accreditation standards as stipulated by their respective regulation bodies.

Evidence for the use of **evidence-based, gender sensitive policies, strategies and plans to engage health workers** (male and female) was not available during the review. However, through support from Women for Health (WFH), the Nigeria Women and Nursing Councildeveloped the NMC Strategy 2020-2025 which outlines a key evidence-based gender-sensitive strategy to engage health workers, and UNFPA is well placed to support the implementation process to achieve the targets.

With regards to health **workforce attraction and retention**, the revised RRF indicates that this was not systematically undertaken. However, document review and key informants noted that UNFPA promoted dialogue and advocacy at national level for enhanced investments in the midwifery workforce, and that, in Kaduna State, health staff recruitment improved, including a strategy to bring on board retired midwives. Observed shortages and high reported staff turnover show the need for strategies to support and retain staff.

The planned support to **review and update training curricula and methodologies in** Pre-service midwife training institutions was onlypartly achieved, with 10 of the planned 50 institutions in humanitarian settings being supported with integration of the Minimum Initial Service Package (MISP) for reproductive health in humanitarian settings. The programme had to be curtailed because of lack of fundingwithin the states (KI feedback), although it is important to fast track its implementation.

Support to train various health workers was provided on the MISP, BEmONC, LARCs, GBV, CMR,[124] and for ASRH, exceeding most targets (see Annex 8). There are, however, concerns about the quality of training, and whether it includes sufficient skills building; also,the combined focus of some training was questioned (KI interviews). For example, one facilitator of a five-day training programme addressing LARCs, and the clinical management of rape commented: *Combining two major trainings such as LARC and CMR is inappropriate as it makes it difficult for us to deliver the content adequately for participants to acquire necessary skills and competency*.With respect to family planning, only 960 of the planned 5,000 health providers were equipped with adequate capacity to administer DMPA-SC,[125] UNFPA should consider adopting a hybrid virtual-physical approach for capacity building of health workers on contraceptive technology and LARCs to reach more providers. UNFPA also supported implementing partners to reach new users of FP through community outreach to women and girls in underserved areas through piloting self-injection of DMPA-SC. This helped greatlyto increase the number of new users of DMPA-SC (Annex 8) and should be widely brought to scale. In relation to the **elimination of mother-to-child HIV transmission**, EMTCT, UNFPA supported the FMoH to train nurses and midwives using the Mandatory Continuing Professional Development modules developed earlier with UNFPA support and including afocus on addressing young mothers and youth-friendly approaches (document review and KI interviews). Additionally, UNFPA conveneda national stakeholders' meeting with the FMoH, the Nigeria AIDS Control Authority and others on EMTCT, which identified serious programming gaps including lack of capacity, inadequate linkages to antiretrovirals (ARVs), prevalence of user fees, and poor data quality among others (KI interviews). Addressing these limitations should be a key consideration going forward.

UNFPA provided support for the Continued Professional Development Programme, leading to a wide range of further training activities.For example, this included training lead facilitator assistants and zonal facilitators, and training 25,249 health workers in Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) by 2020, over twice the initial target of 10,000, with nutrition added.

To **enhance the capacity of pre-service health training institutions** to meet accreditation standards, UNFPA supported selected schools to serve as centers of excellence through provision of an e-library, ICT equipment and skill demonstration. Although this intervention was achieved in only four schools of the 10 planned, it showed valuable results in the selected schools gaining accreditation in line withthe Nursing and Midwife Council revised standards and has increased their carrying capacity (KI interviews). Tutors valued the support,which has enhanced both learning and research activities. As one tutor commented: *It allows us to demonstrate and mentor our students(with) different maneuvers especially for delivery, to allow the students to gain skills and confidence, and it becomes easy when they*

[124] Minimum Initial Service Package, Basic Emergency Obstetric and Neonatal Care, Long-acting reversible contraceptives, Case Management of Rape

[125] Subcutaneous (SC) depot medroxyprogesterone acetate (DMPA): DMPA-SC

transit to the clinical sites. The e library capability was particularly useful during the COVID-19 restrictions. In the words of one schooldirector: *We are able to hold virtual lectures with our students who log on through their android phones*.

The support of UNFPA overall for SRH has been extensive and varied, ranging from strengthening the enabling environment through tocapacity development and direct service support on the ground. Nonetheless, funding limitations have significantly impacted on the scaleof most of the initially planned interventions. Further resource mobilization will be essential for the next CP, particularly around the critical area of strengthening family planning provisions and uptake – as a human right in itself, and also, to reduce total fertility rates, which is vital to realizing all sustainable development goals. Successful advocacy for greater government investment is essential.

4.2.1.3. Adolescents and Youth

Table 4.2: Nigeria 8th CP Results Framework for Adolescents and Youth, 2018 to Sept 2021

UNDAF Outcome: By 2022, Nigerians, with a focus on the most disadvantaged children and young/adults, access andcomplete quality education which provides relevant skills and knowledge for lifelong learning.							
Indicator	**CPD Baseline**	**CPD Targets**	**Achieved**				**Progress against targets**
			2018	**2019**	**2020**	**Sept 2021**	
Youth literacy rate, populationaged 15-24 years	65%	71%	75.03%	N/A	N/A	N/A	**Target achieved**
UNFPA Strategic Plan Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national developmentpolicies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.							
Adolescent birth rate	122 per 1,000 women 15-19 years	100 per 1,000 women aged 15-19years	118/1,000	N/A	N/A	N/A	**Target achieved**
Output 1: Strengthened capacities across relevant sectors to prioritize adolescents and youth in policies and address the broaderdeterminants of their reproductive health, development, and well-being							
Number of supported states that reflect adolescent and youth health, development, and well-being in multi-sectoral policies	2	10	2 11	6 2	N/A	N/A	8* **Target achieved** 13
Number of national and state plans that integrate approaches to harnessing the demographic dividend	1	10	2 3	2 1	1 5	N/A	**5 On track** 9
Number of adolescents and young people reached with SRH services including family planning and HIVeducation	1,000	10,000	20,000 134,118	20,000 13,876	20,650 23,742	13,950 25,584	74,600 **Exceeded target** 197,320
Number of condoms distributed[126]	62,560,952	312,000,000	11,250,000 36,668,702	172,000 51,157	38,000 460,100	49,500 142,349	11,509,500 **Off track**** 37,322,208

[126] This indicator was included in the RRF for AY although its greatest relevance is for the SRH thematic area

Number of young people reachedwith ASRH information	0	10,000, 000	37,500 227,588	23,430,00 0 34,213,42 6	15,042,06 0 24,731,69 9	1,204,95 2 13,865,11 1	39,714,512 **Exceeded target** 73,037,82 4
Number of national and state officers with knowledge and skillsto develop Demographic Dividendprofile	16	1016	15 45	250 59	250 40	250 198	750 **Off track**** 442
Number of adolescents with increased knowledge and skill on Demographic Dividend	0	1000	150 9,800	300 1,000	300 1,800	250 0	1000 **Greatly exceeded** 12,600

** These are off track in relation to the original planned targets as opposed to the greatly reduced annual targets, which they have achieved or exceeded.

The table presents achievements against targets by year up to September 2021, reflecting the Results and Resources Framework and additional output indicators from annual reporting. As indicated, most targets have been reached or exceeded, with the exception of progress on the demographic dividend and with regards condom distribution (elaborated in EQ4.2.1 on SRH). Annex 8 provides the fullreported achievements of targets and milestones. The gaps in the table reflect gaps in the data available at national level and in the UNFPAreports, which in some instances, means that further activities were not undertaken generally because of funding limitations.

Overall, the results chain logic for the adolescents and youth thematic area, AY, has limitations. The overarching UNDAF outcome areais on access to quality education, 'complete quality education' for life-long learning in children and young adults, measured by the youthliteracy rate. The global UNFPA outcome focus on comprehensive sexuality education (CSE) does contribute to this but addressing SRHis somewhat different. The output might fit better within the UNDAF outcome for health and well-being. The output given for the 8th CPis, in fact, an outcome measure of strengthened institutional capacity, and the indicators could be more strategic by including quality measures rather than simply numbers reached. For example, measuring the numbers reached with ASRH information gives no indicationof the intensity of provision, the quality of information, a gender breakdown, or information on whether this was in- or out-of-school. Tomeasure the effectiveness of the combined approaches, a useful outcome measure would be to incorporate a globally accepted indicatorof SRH knowledge in young women and men or, better, measures of safer sexual behaviour. See also the overview to EQ4.2 on the overlap between the thematic areas and the need for clearer alignment, and also, the focus on the theory of change in Chapter 1.

The AY thematic area addressed one output, 'Strengthened capacities across relevant sectors to prioritize adolescents and youth in policiesand to address the broader determinants of their reproductive health, development and well-being,' to be implemented through five intervention areas employing all modes of engagement. These inter-related interventions are to: create an enabling policy environment to ensure universal access to quality SRH services, including culturally appropriate sexuality education; support policy dialogue and advocacy on issues of young people in national development strategies and plans; convene partners and establish platforms in the effortto harness the demographic dividend; advocate for policies and programmes that address child marriage; and advocate for policies that address the social and economic determinants of adolescent and youth health across all sectors. No unintended consequences were observed in relation to programming around AY within any of the thematic areas.

The first intervention focused on creating an **enabling policy environment** to ensure universal access to quality SRH services, includingculturally appropriate sexuality education. The policy environment for SRH services, including for young people, is addressed under theSRH thematic area. Regarding AY development, UNFPA provided funding and technical assistance to support the federal government to finalise the review of the National Youth Policy (NYP 2019-2023) in 2018. As a result, the revised NYP is now in line with the aimsof the demographic dividend to empower youth as active participants in the economy. It is in line with the National Economic Recoveryand Growth Plan for sustainable development and youth inclusiveness (document review). The National Youth Policy was launched in Akure in May 2019. Since then, UNFPA has supported the printing and dissemination of thousands of hard copies and a pocket-size version, as well as an online version.[127] UNFPA also supported the FMoYSD to convene a

sensitization and advocacy workshop on the implementation and monitoring of the NYP and Action Plan for about 90 state youth development officers and sports officers from around 20 states, and the Mapping, Registration and Establishment of Youth Organisations online register/database.

UNFPA supported Kaduna state to domesticate the NYP, while Lagos state was supported in the development of the Lagos State YouthPolicy Strategic Implementation Plan. In Ondo State, technical support was provided for the development of the State Action Plan for Adolescents and Young People. Also, UNFPA has supported the FMoYSD in the development and production of the National Action Plan on Youth, Peace, and Security (2021-2024). Various activities relevant to the youth policy, such as safe spaces in several states, arebeing widely implemented. These and related interventions are addressed primarily in the GEWE thematic area.

Regarding sexuality education, although the global UNFPA outcome refers to comprehensive sexuality education (CSE), this was not found to be a strong focus within the 8CP (KI interviews, FGIs and document review). However, some components of CSE are addressedin activities such as the safe spaces, which have been implemented more extensively in the north in school settings such as in Sokoto State, and within camps for internally displaced populations (IDPs) in the humanitarian areas (notably BAY States), and UNFPA provides condoms. Other than the safe spaces, less was apparent in terms of reaching out-of-school young people in general. In the Young MumsClinic in Lagos, CSE was addressed to a greater extent, but the quality of information shared in schools and with peer educators in general appears to be more related to abstinence than to practical information and skills building on sexuality and sexual relationships, contraception including condom negotiation and use of long-acting reversible contraception (LARCs), prevention of HIV and other sexually transmitted infections, and related issues (KI interviews, FGIs and document review). This is of considerable concern given theimperative to achieve the demographic transition in Nigeria in order to meet all sustainable development goals, and in the light of high rates of teen pregnancies. The approach is in line with conservative cultural values in the communities, service providers in health and education, and in government, however, and it is a challenge to find the optimal balance between providing accurate information to guidesafe sexual activity and not alienating the parents, care providers, communities, local and wider leaderships to the extent that they opposeCSE altogether. Despite limitations regarding CSE, the participation of adolescent girls in mentoring and vocational skills training, the safe spaces in Kaduna, Gombe, and Sokoto states and boot camps has been greatly valued as addressed in 4.2.1.3.

The second intervention is on **policy dialogue and advocacy** on issues of young people in relation to national development strategies and plans**.** UNFPA is chair of the UN Inter-agency Technical Working Group on Youth, a platform to promote youth-responsive programming in both the development and humanitarian context. The aim is to ensure a harmonized approach to coordination, implementation, and reporting of the UN Youth Strategy – Youth 2030 in Nigeria. UNFPA provided funding and technical assistance tosupport federal ministries, departments, and agencies (MDAs) regarding youth policies, for example the finalisation of the Minimum Package of Services and Standards for Youth Friendly Services in 2018. UNFPA provided support for the First National Conference onAdolescent Health and Development in Nigeria in 2019 and the 1st African Regional and 2nd National Conference on Adolescent Health and Youth Development in 2021. The main conference objectives are to highlight adolescent and youth concerns and to find sustainablesolutions. Other thematic areas also address policy, dialogue, and advocacy, often relevant to young people as well as to adults.

The third intervention was to convene partners and establish platforms to **harness the demographic dividend**. Desk review found that nine states had plans that integrated approaches to harnessing the demographic dividend (DD), exceeding the target of five states. UNFPAalso supported the Health Policy Training and Research Programme in collaboration with the Department of Economics of the Universityof Ibadan, Nigeria, to address DD programming with a multisectoral focus. This involved as key stakeholders the staff in the Ministry ofEconomic Planning (statisticians and planning officers) to take the DD into the planning and budgeting structure of the nation and states.Beneficiaries of the programme included MDAs, the staff of which were capacitated regarding the DD programming, although further training will still be required (KI interviews and document review). UNFPA also supported the review of a Sustainable Development Goals train-the-trainer manual for the National Youth Service Corps (NYSC) members so that it includes the demographic dividend messages. The extent to which the various initiatives have led to significant and sustainable results will need to be assessed. The fourth intervention, **advocacy for policies and programmes that address child marriage**, was addressed as part of the Spotlight Initiative, Canadian-supported interventions for

[127] https://youthandsports.ng/wpcontent/uploads/2021/12/Nigeria-National-Youth-Policy-2019-2023.pdf

adolescent girls, the UNFPA-UNICEF joint programme on ending harmful practices, and in the Norwegian-funded project. It is addressed under mainly under the GEWE thematic area. Notably, the adolescent girls' participation in mentoring or vocational skills programmes and safe spaces in Kaduna, Gombe, and Sokoto States contributes to delay in marriages (KI interviews, FGIs, document review).

The fifth intervention is on advocacy for **policies addressing the social and economic determinants** of adolescent and youth health across all sectors, which complements and overlaps with the second intervention, and also, with the need to harness the demographic dividend, the third intervention. UNFPA provided funding and technical assistance for dialogue and advocacy to domesticate youth policies through several activities. Four states have implemented activities in line with the National Adolescent and Young People HIV Strategy – FCT, Kaduna, Lagos, and Benue (KI feedback). UNFPA leveraged finances to train 22 peer educators in social media advocacyas young ambassadors and advocates to launch campaigns for wide dissemination of messages on the prevention of COVID-19 and HIVand to strengthen SRH in Kaduna, Cross River, and Lagos states (document review). These ambassadors held physical sensitization and awareness campaigns in communities reaching traditional and religious leaders, adults, and young people in these states. In 2020, a virtuallive dance drama event anchored by young persons was held to commemorate International Youth Day. The activity addressed elementsof love, rape and SRHR preventive measures including condom use, to stress the need for young people to be equipped with the right information on their sexual and reproductive health and access to youth friendly SRH services.

Some of the challenges faced in implementing adolescent and youth policies in the states were seen to relate to differing priorities and mandates between different sectors. For example, partners working with in-school youth report facing delay or refusal by some higher institutions to grant access for their students (KI interviews). Inadequate resources at government and UN level for addressing the hugescale of challenges facing adolescents and youth, particularly girls, is also a serious ongoing concern (see Chapter 2).

4.2.1.4. Gender Equality and Women's Empowerment

Table 4.3: Nigeria 8th CP Results Framework for GEWE, 2018 to Sept 2021

Indicator	CPD Baseline	CPD Targets	Achieved				Progress against targets
			2018	2019	2020	Sep 2021	
UNDAF Outcome: By 2022, the National and State Social Protection Policies are implemented and adequately financed at federal and state levels as well as protection systems and services are strengthened to more effectively prevent and respond to violence, abuse, exploitation (including trafficking) and harmful social norms.							
Proportion of ever-partnered women who have beensubjected to physical violence	30% (2016)	15%	31%				
UNFPA Strategic Plan Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for themost vulnerable and marginalized women, adolescents, and youth							
Same as above	30%	15%	31%				
Output 1: Increased multi-sectoral capacity to prevent and address gender-based violence, with a focus on advocacy, data, health and healthsystems, psychosocial support, and coordination, within a continuum approach							
Number of state level information management systems in place to collect, analyse and disseminate data on gender-based violence	3	6	3 3	3 3	6 6		12* **Achieved** 12
Number of adolescent girls participating in mentoring or vocational skills programmes and safe space sessions	0	50,000	10000 3400	10000 39200	10000 4044	10000 43216	40,000 **Exceeded** 89,873
Number of communities supported by UNFPA that declarethe abandonment of FGM	801 (2017)	1000	30 78	49 21	40 71	45 45	164 **Exceeded** 215
Number of women and/or girls reached with SRH/GBVservices in humanitarian settings (through reproductive health kits, rape kits, etc)	605,028	1605028	200000 451274	244,250 534,571	463,679 102,386	605542 1,101,668	1,513,471 **Exceeded** 2,189,899

*In all columns, the first figure given is the target for that year and the second figure is the total achieved in that year. The final totals given for targetshave been revised in some cases from the initial target set for the programme.

The gender component addresses the UNFPA strategic outcome on gender equality and women's empowerment (GEWE) through one overarching output: 'increased multisectoral capacity to prevent and address gender-based violence, with a focus on advocacy, data, health and health systems, psychosocial support and coordination within a continuum approach.' The table shows target achievements up to September 2021 and the alignment of the UNDAF outcome. This output has been addressed in several ways, through different programmes and projects in various states, and with a national approach to family planning (see the thematic area of sexual and reproductive health services) and data (see thematic areas on adolescents and youth and population dynamics). Addressing GBV in humanitarian settings has also been key and highly relevant. There were no unforeseen consequences in relation to the GEWE programme.

The table indicates that the numbers reached were far higher than initially planned, including states with information management systems on gender-based violence (GBV), adolescent girls in safe spaces and/or skills programmes, and the numbers of women and girls reachedin humanitarian settings. The number of communities rejecting female genital mutilation (FGM) was also slightly higher than anticipatedby September 2021. However, data are not available on the incidence of GBV, the baseline for which was higher in 2018 than in 2016, perhaps linked with the escalating humanitarian situation and increased violence and population displacement. GBV, particularly intimatepartner violence (IPV), is also likely to have increased more recently because of COVID-19 restrictions.[128] Although the indicators show huge achievements in terms of numbers reached, they could be more strategic. The RRF only indicates the top two indicators cited here,and it would be useful in the next CP to include the wider range shown here at the output level, and to elaborate them into lower-level outcome indicators. For example, instead of measuring the number of state management information systems, the RRF could measure the number with well-functioning systems producing data used to address GBV. This would in effect measure how many systems are inplace, whether they are effectively collecting data, and whether the data are being utilized in strategies to reduce GBV – a much more informative result to assess if the approach is working. The milestones, which are well documented in the UNFPA CO quarterly and annual reports (see Annex 8), provide many options for selecting and developing more strategic measures. It is also proposed that the overall gender focus be more streamlined, with health and health systems included in the SRH thematic area, with a gender focus, and data within population dynamics, so that gender is more effectively

mainstreamed throughout the CP. The thematic area on AY should be fully age and gender disaggregated throughout, and document disability integration. As noted earlier, perhaps the AY and gender thematic areas could be amalgamated unless separate areas of responsibility are clarified, or AY could be partly incorporated in SRH services and partly within gender.

The RRF indicates seven interventions to address the output on GBV, which were mainly operationalized by the gender team through three complementary projects: the multi-country European-UN Spotlight Initiative to end GBV and other harmful traditional practices; the UNFPA-UNICEF Joint Programme on Accelerating the Abandonment of FGM; and the Canadian-supported Adolescent Girls Initiative in Sokoto, Oyo and Bauchi, and assistance on addressing gaps in GBV and harmful traditional practices. Three further gender-related projects in the 8th CP were an integrated approach to empowering adolescent girls and young women through SRHR access, funded by Norway and reported to be addressed by the SRH team (see the SRH section above); an UBRAF-funded HIV prevention programme with adolescents and youth, also under the SRH team; and a training course on GBV in emergencies (GBViE) through the American University in Nigeria, addressed within the international humanitarian Call to Action on GBV, with particular support from Norway. Altogether, the gender team supported 11 states through the main projects, with the multi-country Risk Communication and Community Engagement project (RCCE) adopted as an addition in 2020 in states that already had existing projects for GBV and/or FGM.

The seven interventions under the GEWE thematic area were: national, sub-national and community engagements with community leaders, security forces, civil society organisations and media to end GBV; community dialogues on the elimination of harmful traditional practices; advocacy for the promotion of human rights, gender equality and empowerment of women and girls; and three inter-related interventions addressing GBV in humanitarian settings. These are: partnerships to develop gender-responsive integrated programmes forwomen and girls; psychosocial counseling for traumatized populations, especially women and girls; and support for evidence-based datagathering through a GBV management information system. EQ4.5 provides further review of GEWE in relation to coordination and connectedness, including in humanitarian settings, and various aspects of data in relation to gender are incorporated under the populationdata thematic area.

The first and second interventions are interrelated and mutually reinforcing, although they were not completely synchronized or implemented in all the same states. They were addressed through several projects and with multiple funders, including Canada, Norway,the European Union (EU) and others. To **end GBV through engagement with community leaders, security forces, civil society organisations and the media and community dialogues** the EU-UN Spotlight Initiative was implemented in six states, Adamawa, Sokoto, Cross River, Ebonyi, Lagos, and the FCT, thus including both humanitarian and development settings. The Spotlight Initiative is a major multi-country, multi-year-funded response to GBV, harmful practices and related SRHR issues, which is implemented throughgovernment and civil society partners. UNFPA, UNICEF, UNDP and UN Women provide technical assistance for the six programme pillars, coordination of which is addressed in EQ 4.5. It is a strong example of the New Way of Working UN partnership.

The Spotlight Initiative is a highly active, synergistic partnership programme in the states where it is implemented including, for example,the development of one-stop shops for GBV and safe spaces in development and humanitarian settings, multiple community surveillancecentres as watchdogs to support the prevention and reporting of GBV, and various activities related to SRH. For instance, Spotlight addresses obstetric fistula, as documented in EQ4.2.1.2. FGIs with survivors of GBV in safe spaces in the states of Sokoto and Borno found a mix of how participants had heard of the safe spaces, including through media, police referral and community human rights informants, suggesting that the multi-pronged approaches all contributed to uptake. Nonetheless, under-reporting of GBV was seen as aserious ongoing concern (FGIs with secondary beneficiaries, KI interviews and document review).

An independent mid-term review of the Spotlight Initiative[129] in Nigeria found significant increased access to GBV services with a survivor-centred approach, addressing clinical, legal, and psychosocial support; strengthened linkages and referrals; shelters forsurvivors; safe spaces in the community and in the school setting; capacity development among survivors including livelihood training;a return to education for girls taken out of school; and the development of national guidelines on essential services that was integrated inhealth worker training. The review found that the contributions to GBV prevention and regarding laws and policies (the domestication of the VAPP Law and the review and development of other GBV and FGM protocols) were considered potentially transformative.

[128] Multiple international reports including statements by UNFPA ED, and KI interviews

Canada supported the three-year project Adolescent Girl Initiative in Sokoto and Bauchi states, with multiple government and NGO IPs.It also addressed GBV, FGM, early marriage and obstetric fistula (KI informants), and supported girls to stay in school in multiple settings. It established the safe spaces approach that has been adapted under Spotlight, and also, implemented in the Norwegian-funded project against GBV and FGM and supporting young women for wider SRH in Gombe and Akwa Ibom states (KI informants, documentreview). The safe spaces approach builds girls' confidence and capacity, with the central focus on assisting girls to stay in school throughacademic and other support, as a strategy to delay marriage, and to reduce vulnerability to GBV and harmful practices. Multi-media engagement has been a major focus, particularly in the Canada project, as well as the use of social media. However, political, and other challenges delayed the intended initiation of the project in March 2018 and took time to resolve (KI feedback), and then implementationwas further impeded by the COVID-19 pandemic in 2020 and 2021. The Canada project has been extended (KI interviews) to September2022 and will require evaluation of the outcomes of the various strategies, including how far the extensive media campaigns may have contributed to knowledge and behaviour change.

National landscape analysis on GBV, harmful traditional practices and obstetric fistula (OF)[130] was undertaken in Sokoto, Oyo, and Bauchi with Canadian funding, and in further humanitarian settings through Norwegian and other funding sources (KI interviews, document review) for a total of 12 states and the FCT.[131] Although preliminary work was undertaken early in the CP, various factors delayed implementation and the field work took place in 2021. The draft report provides extensive baseline data on the areas of focus, highlightskey drivers and perpetrators, progress made, the roles of the states, and the capacity of duty bearers. It is too late to influence the Canadianproject, which had been the original intention, but the findings should guide UNFPA programming in the next CP.

Safe spaces were developed in schools and in the IDP camps and other settings to provide girls with technical skills as well as to addresssexuality education (see the previous section). Despite the positive feedback from FGIs with girls in safe spaces in Sokoto, Oyo and Borno, the emphasis on abstinence before marriage rather than equipping girls with accurate and comprehensive sexuality education is of concern. FGIs found that sexual matters are discussed in the safe space and the girls are quite knowledgeable about sex, pregnancy, HIV and other STIs, knowing what these infections are and how they can be transmitted, as well as benefitting from dignity kits, information on personal hygiene and health, and discussion of gender and GBV. They have basic knowledge about how to protect themselves from STIs and pregnancy, but the overarching focus is on abstinence (KI interviews, FGIs, document review). *The right timeto have sex is when a girl is married*; *Sex should not be our focus as teenagers in order not to lead to unwanted pregnancy*; *We learnt that we should abstain from sex, we were not taught about when to have sex*. Given high teen pregnancy rates this is clearly inappropriatedespite the cultural sensitivities. Safe spaces in the humanitarian settings are addressed further below.

The multi-country UNFPA-UNICEF Joint Programme on FGM[132] was implemented in Osun, Ekiti, Oyo, Imo and Ebonyi, where FGM rates were higher, and overlapped with Spotlight in one state (Ebonyi) and with the Canada project in Oyo State. It has an intervention package of advocacy for legislative and policy change, capacity development of health workers to manage and treat survivors of FGM, data and research, changing social norms and addressing the medicalization of FGM (feedback from the gender team, document review).Operating since 2014 in Nigeria, all the supported states have documented significant declines in FGM prevalence in girls aged 15-19 between the 2013 and 2018 National Demographic and Health Surveys, the greatest reductions being in Oyo and Osun, and the least in Imo State. Thus, it appears to have been a well-focused and successful approach that needs to continue – in three of the states FGM prevalence was still over 50 percent in girls aged 15-19 in 2018. Community dialogues to eliminate FGM were one part of the Joint Programme package and were also part of the Spotlight and Canadian interventions addressing GBV and wider harms. Otherinterventions to address FGM under the Canadian project and Spotlight (KI interviews) included a combination of engaging men and boys, capacitating traditional and political leaders as champions, advocacy, policy development, adolescent girls' asset building in campsthrough safe spaces, and capacity building for prevention and services (medical, legal, and social). The table above indicates that the targets for numbers to reach in safe spaces through the various projects were greatly exceeded, and also, the numbers of women and adolescent girls reached with SRH and GBV support services in humanitarian settings as part of the UNFPA response to the Call-to-Action. The UNFPA-UNICEF programme did not utilize the safe spaces approach but developed annual adolescent girls' boot camps tohelp empower them as change agents (addressed under AY).

[129] HERA (n/d) Spotlight Initiative: Nigeria Programme MTA

[130] Aina OI, Ejembi C, Fawole O (2022) Landscape Analysis of Gender-Based Violence, Harmful Traditional Practices and Obstetric Fistula in Nigeria, Technical Report. Draft report for UNFPA, 15 Jan 2022

KI interviews found that the Federal Ministry of Women's Affairs (FMWA) is highly appreciative of the roles of UNFPA, including forits contributions to Spotlight and the other gender programmes, describing the agency in relation to gender as *reliable, dynamic, receptive,and able to respond to change* and *one of the best UN partners*. Technical support from UNFPA was particularly appreciated in relationto FGM and GBV, as well as for the advocacy for policy development in several states (notably Oyo, Sokoto and Adamara).

The third intervention, **advocacy to promote human rights and GEWE** was implemented in the states of Osun, Ekiti, Oyo, Lagos, Imo,Ebonyi, Adamawa, Cross River, Sokoto, Bauchi and in the FCT, in other words across the states with GEWE programming in order to generate support for the interventions and to complement them. This was supported by Canadian funding and through the Spotlight Initiative in both humanitarian and development states. The domestication of the Violence Against Persons (Prohibition) Act, VAPP, inmost states was a major achievement to which UNFPA contributed, and extensive efforts are underway to assure its effective implementation. An unintended result, however, in at least one state (Kaduna, according to KI interviews) was that excessively punitivemeasures have been legislated, including castration of convicted rapists. Apart from the human rights violation, this may deter reportingof rape and hence backfire in terms of seeking justice for survivors.

FGIs were conducted with mainly male community members and leaders in Sokoto, Ebonyi and Oyo states, some of whom have had earlier training by the state ministries of health and women's affairs and have become champions for abandonment of FGM and early marriage. These included, for instance, some state first ladies and various religious leaders. The FGIs found positive results regarding expressed attitude change: *We advocate that harmful practices be stopped, we changed from traditional practices to modern*; *Personally,my mindset changed towards my wife, I help her with chores when she is pregnant, I help her bath the baby and also see her off to the hospital*. Feedback indicated that all messaging around gender and SRH, particularly regarding young people, must be sensitively tailoredaccording to local cultural values, religion, and traditions (KI interviews with wide-ranging IPs, and FGIs), which vary quite widely despite having in common, strongly patriarchal foundations. Regarding data, one of the areas of UNFPA co-leadership, national systems to capture data on GBV were strengthened in collaboration with the FMWA, although further strengthening is needed. The first GBV data situation room and dashboard in Nigeria was launched inNovember 2020, described by the Minister of FMWA as *an innovation data management and visualization platform which is expected to use technology to enable government, decision-makers and programme managers view and analyze gender-based violence data with ease*.[133] As noted above, the landscape analysis will also provide valuable data on GBV, harmful traditional practices and OF.

UNFPA CO and sub-offices undertook various actions to ameliorate GBV during the COVID-19 pandemic, recognizing the risks of increased violence, especially intimate partner violence (IPV) and of limited access to SRH and GBV services. UNFPA supported the Risk Communication and Community Engagement Strategy in five states (Sokoto, Oyo, Bauchi, Adamawa and the FCT) as addressed in EQ4.1. In relation to gender, this included providing dignity kits among other support through the UN Basket Fund RCCE for COVID-19.[134] UNFPA also strengthened toll free lines and reporting apps, establishing a virtual GBV response centre in Lagos, and training partners to use IT platforms to reach beneficiaries. When schools were closed, UNFPA used radio and other means to continue educationon GBV and SRH (KI interviews, document review). As part of the response, UNFPA also partnered with the Value Female Network, a youth-led NGO to use the Girls' Survival Model to protect girls from FGM and other forms of GBV.[135] This aimed to reach 1.2 million people in communities in Osun State over a three-month period with local media such as radio and television to raise awareness about the harmful effects of FGM, and to protect 1000 girls from the practice. It also aimed directly to support 850 vulnerable adolescent girlswith girls' 'survival kits' of sanitary pads, face masks, and other protective materials, with some kits including condoms. The full results and achievements need to be evaluated. Peer educators also played a key role in the COVID-19 awareness campaign in 2020 in the dissemination of prevention messages to young people living with disabilities (KI informants).

A recent development has been the training of peer educators for either three or four days, including adolescent girls and adults (collegeundergraduates and graduates) undertaken in 2021 in Sokoto, Oyo and Ebonyi states. The aim is to build information around SRH, GBV,harmful practices and gender issues, as well as to build basic vocational skills. FGIs with participants found positive feedback, particularly with regards skills training (e.g., to make soap), but it is too soon to assess how effective this approach may be in terms of numbers of peers reached, whether communications will be sufficiently intensive and effective to influence peer knowledge and change behaviour. It is also yet unclear how long peer educators will remain in the programme despite positive early feedback on personal benefits: *I havebecome more confident*; *I have*

[131] The study states are Northeast: Bauchi and Adamawa; Northwest: Sokoto and Kaduna States; North Central: Nasarawa, Kwara, and FCT; South West: Oyo and Ogun; Southeast: Ebonyi and Imo States; and South-South: Akwa Ibom and Edo states.

[132] Initiated in 15 countries in 2008, and widened to include Nigeria and Yemen in 2014

learnt how to work in a group; (as a result of becoming a peer educator) *I appreciated the need to learn a skill*; and benefits to their peers such as: *we want to enlighten more people so that the young girls out there will not be sexually harassed*;*so that those who don't go to school can be enlightened*. In the FGIs, funding appeared inadequate to provide promised stipends for the college group, or information materials and other items that the peer educators would have valued. It will be essential to implement andmonitor the sound application of lessons learned from peer education programmes for adolescent SRH and GBV in other developing countries (south-to-south learning) to increase the chances of programme success.

UNFPA implemented several **interventions relating to gender in the humanitarian settings** of the Bay states. These included developing partnerships for gender-responsive integrated programming for women and girls, psychosocial counseling around GBV, andevidence-based data gathering through a GBV management system, as part of the Call-to-Action response. Also, in humanitarian settingsand more widely through the Spotlight Initiative, UNPFA supported GBV coordination and referral mechanisms to meet regulatory standards. As noted earlier, UNFPA coordination roles are addressed in EQ4.5. The role of UNFPA in humanitarian settings was said tohave strengthened considerably over the 8th CP, one additional example being support to Borno State for maternal health, including fistularepair, and around GBV and other actions implemented by the state government with Korea International Cooperation Agency financialsupport (KI interviews, document review). This project, which is coming to an end, will be evaluated in 2022.

The development of safe spaces for survivors of GBV in IDP camps and selected locations in the Bay States (and in development settings)was highly appreciated (FGIs with participants), addressing several interrelated needs. Participants meet social and community workersfor counseling and other support, or for referral to other services, access information on GBV and SRH through sensitization activities, meet others with whom they can share experiences, and have opportunities to develop skills. For example, some survivors of GBV in thehumanitarian setting have been brought into a factory to make components of dignity kits, learning skills around business management as well as practical sewing skills (KI interviews and FGIs), which may potentially help transform conservative attitudes more widely about female engagement in economic activities. This approach to vocational skills training could be replicated elsewhere and go beyondjust traditional 'female' entrepreneurial skills. Positive feedback from FGIs in the safe spaces in the IDP camp (and in Lagos and Sokoto)related to information on GBV, the dignity kits provided, medical and legal support and referral, and in building social and economic assets in terms of confidence, knowledge, creativity and vocational skills and support for economic activities. Comments were made suchas: *Our skills have helped us earn a living a lot, it has helped us to be more independent, we feel safer now*; *Before coming to the centrewe were suffering in silence… but in the safe space we can offload the things that are bothering us*; *All the problems we came here withwe have been able to get relief and healing.*

Security forces were engaged in capacity building and sensitization and in the coordination mechanisms in the NE states as part of the Call to Action[136] to address social protection for vulnerable children, women, and girls. The Call-to-Action also engaged stakeholders beyond the armed forces under the Spotlight Initiative and joint FGM programming through sensitization workshops and capacity building initiatives. Addressing security forces is particularly relevant and important given their critical roles in humanitarian settings amid escalating GBV.

Despite many achievements in both humanitarian and development settings, certain challenges were apparent (KI interviews, FGIs, document review), worsened by long delays in staff recruitment for gender for the Maiduguri Sub-Office, and for an international GBVspecialist in Abuja (despite the availability of Swiss funding). The attempt to achieve justice for survivors of GBV was challenging, partly because of the slowness of the judicial processes in Nigeria (KI informant feedback), and there was insufficient development of shelters for survivors of GBV who needed to escape a violent household. Long-term options for survivors to escape IPV are limited by multiple factors (KI interviews and FGIs), not least their economic dependence on perpetrators and unsupportive community attitudes.

FGIs with secondary beneficiaries found that, although training for psychosocial counseling helped providers to listen to participants more and to be more sensitive to their needs, the level of training was inadequate for the depth of skill and understanding needed to support traumatized GBV survivors. "*We need more training to build our capacities on mental health. We also need in-depth training onpsychosocial support*' (FGI participant in Sokoto). It was also reported (KI interviews and FGIs) that, apart from in Borno and Sokoto states, there was little or no on-the-job mentorship or supportive supervision, in other words a lack of quality assurance of the improvements in practice resulting from training. People with disabilities were reportedly not extensively included or documented, although this is improving (see section 4.2.2).

[133] Government of Nigeria and EU-UN Spotlight Initiative Jointly Launch the National Gender-Based Violence Data Situation Room and Dashboard in Nigeria November 17, 2020, Press release

[134] https://nigeria.unfpa.org/en/events/handover-ceremony-dignity-kits-and-items-under-un-basket-fund-project-risk-communication-and

[135] Value Female Network (2020) Budget Justification Fund Code ZZ129

Also, the overall number of survivors reached, while consistently exceeding targets, is a fraction of the total number of women and girls in need. Boys and men affected by GBV also need attention. Currently a reported 5 percent of the UNFPA budget for GBV was reported (KI interview) to be allocated to addressing their needs, with hesitancy around addressing male on male GBV. The fieldwork focus of the CPE was not able explore this issue further, beyond the male engagement activities reported above.

Other needs expressed in the FGIs with service providers around GBV in Sokoto, Maiduguri, Lagos and Oyo (that is in humanitarian anddevelopment settings) included: further training for the rights bearers in law enforcement; vehicles; upgraded and more spacious facilities;more appropriate and better information materials; strengthened community sensitization and engagement, also with all opinion leadersand potential change agents; and increased staff able to address clients with special needs. Another expressed need was for better psychosocial support for providers themselves, as the work can be highly stressful. While addressing many of these needs is beyond themandate of UNFPA, intensive advocacy with government at all levels, and engagement of the private sector and with international and national development partners and with community stakeholders is needed, with a rigorous assessment of the gaps in support and what could make a strategic difference. The recently developed guidance on coordination and areas of responsibility on GBV should also guideUNFPA in the next CP.[137] Despite reaching far higher numbers of survivors than the original targets, the reality is that the majority of those in need are not being reached, whether in humanitarian or development settings, and without extensive multi-sectoral engagement and transformative community sensitization to address gender inequalities and inequities, including around GBV and harmful traditional practices, there will not be sustainable improvements on the scale needed.

It also appears (KI and FGI feedback) that where FGM projects are implemented some components of GBV may have been less well addressed, and UNFPA needs to scale up their implementation in those states for more substantive results. For example, Ebonyi State has a GBV centre that needs upgrading and support with commodities, as well as capacitating staff capacity. Oyo State needs sensitizationof communities on GBV.

Despite the recognized limitations, the gender component of the 8th CP has made significant contributions to addressing GBV and harmfulpractices, with a highly active and respected team, and it is hoped that the next demographic and health survey (due in 2022) will demonstrate strengthened indicators.

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[136] The Call-to-Action on Protection from Gender-Based Violence in Emergencies is a global initiative dating from 2013 to ensure that all humanitarian responses include, from the start, protection against GBV and safe and comprehensive services for survivors

[137] Global Prevention Cluster Gender-Based Violence Area of Responsibility UNFPA Strategy 2021-2025. https://gbvaor.net/

4.2.1.5. Population Dynamics

Table 4.4: Nigeria 8th CP Results Framework for Population Dynamics, 2018 to Sept 2021

Indicator	**CPD Baseline**	**CPD Targets**	**Achieved 2018**	**2019**	**2020**	**Sept 2021**	**Progress against targets**
UNDAF Outcome: By 2022, Nigeria's population dynamics becomes a strong basis for national development and resource management through better use of demographic intelligence.							
Census conducted in line with international standards	0	1	N/A	N/A	N/A	N/A	**Progress on preparation for census**
UNFPA Strategic Plan Outcome 4: Strengthened national policies and international development agendas through integration of evidence- based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality							
Output 1: Strengthened capacities across relevant sectors to prioritize adolescents and youth in policies and address the broader determinants of their reproductive health, development, and well-being							
Number of supported states generating quarterly rapid appraisals of populations affected by humanitarian crises, including estimated numbers of WRA, young people, pregnant women, and persons over 65 years of age.	1	10	2 2	1 1	1 1	N/A	4* **Target achieved** 4
Number of supported states with institutional capacity to analyse and use disaggregated data on a) adolescents and youth and b) GBV	5	10	2 2	2 2	6 6	N/A	**10** **Target achieved** 10
Number of states supported to produce disaggregated data to monitor SDG indicators	0	10	2 3	2 2	1 1	N/A	**5** **On track** 6
Number of state-level information- management systems in place to collect, analyse and disseminate data on GBV incidence	3	10	4 3	N/A	N/A	N/A	4 **Target not achieved** 3
Number of State Officers with improved knowledge and skills to use relevant statistical packages (R-Statistics, STATA, CAPI, QGIS etc.) for data management	0	100	0 0	30 70	- N/A	15 15	45 **On track** 85
Number of State officers (M&E, NBS) with improved capacity to analyse and use disaggregated data on VAWG/GBV	0	100	N/A	N/A	60 25	N/A -	60 **Target not achieved** 25

*In all columns, the first figure gives the target for that year and the second figure is the achievement in that year. Thus, the totals for the targets and those of the achievements are compared for this assessment

The UNDAF outcome that UNFPA leads has indicator only relates to the national census, which appears to be unduly narrow and was not achieved, although preparatory activities took place (addressed below). Most targets of the population dynamics (PD) thematic area were achieved, as shownin the table, with UNFPA undertaking a wide range of activities to strengthen the generation, analysis, reporting, dissemination, and useof population data across sectors to influence development policies and plans. To some extent this focus is also addressed within the thematic area of adolescents and youth, particularly with reference to realising the demographic dividend, and the second indicator hererelates to both the AY thematic area and gender. All indicators are highly relevant to the output, which is, in fact, as noted in all results frameworks, an outcome measure of institutional strengthening. It would be more strategic to indicate not just states capacitated to collectand use population data, but those demonstrating the multi-sectoral dissemination of data and its use within diverse sectoral planning and programming for development within the state. However, apart from the inappropriately narrow UNDAF outcome indicator, the resultschain logic within PD appears relatively robust. One of the challenges observed is the weak policy environment for data including GRID3and demographic dividend programming (KIs, Document review).

The thematic area was addressed through one output, 'increased capacity to generate population projections and identify sociodemographictrends and address them within policies, programmes and advocacy.' This was to be implemented through six intervention areas: the generation, dissemination and use of disaggregated data at the national and sub-national levels to monitor the SDG; use of demographic data to assess the economic impact of population dynamics; mapping, generation and analysis of SRH and GBV indicators at the nationaland sub-national levels; conduct of the national census and sociodemographic surveys; collection and analysis of disaggregated data in humanitarian settings; and institution of a national demographic observatory to track progress towards harnessing the demographic dividend. The main modes of engagement were advocacy and policy dialogue, capacity development, knowledge management, and partnerships. One unplanned intervention, the GRID3 project, was also implemented. The Geo-Referenced Infrastructure and Demographic Data for Development programme is part of a bigger global initiative, which aims to improve access to data for decision making in all participating countries. GRID3 works with countries to generate, validate, and use geospatial data on population. Unforeseenconsequences arising from UNFPA programming were not apparent.

The first intervention area is the generation, dissemination, and use of disaggregated data at the national and sub-national levels to monitorthe Sustainable Development Goals (SDGs), and the second is use of demographic data to assess the economic impact of population dynamics, which is closely related. At national level, UNFPA supports the National Bureau of Statistic (NBS) and the National Population Commission (NPC) by providing financial and technical assistance in generating social and economic data for the government to monitorthe SDGs. For example, UNFPA provided funding and technical assistance to the NBS to carry out a Multiple Indicator Cluster Survey (MICS) to generate the required data. Published reports by the two agencies show extensive data disaggregation by sex and age, thoughnot disability. Low capacity of staff at state level is a challenge to how effectively data are utilized in state planning and programming, and their impact at community level. Recognising the need, UNFPA supported NBS staff skills training through different empowermentprogrammes, including training on computer software such as STATA, which has helped strengthen data analysis. Training needs to include raising understanding of the importance of data disaggregation by age, sex and disability, and cover the process from survey design through to survey instruments, with UNFPA providing some oversight. However, the high turnover of staff is a challenge, as trained staff have moved on to seek better opportunities. One other valued area of support for the NBS has been UNFPA funding an independent monitor to enhance the quality of data generated (KI interviews, document review).

The National Population Commission has the statutory duty and powers to collect, analyze and disseminate demographic data, including the population and housing census, and the Nigeria Demographic and Health Surveys (NDHS). It is also mandated to undertake demographic sample surveys, to compile, collate and publish migration and civil registration statistics as well as to monitor the country'spopulation policy. In the 8th CP, UNFPA has provided financial and technical assistance to the NPC to carry out these statutory functions. However, the coordinating role of the Federal Ministry of Finance, Budget, and National Planning (FMFBNP) is observed by the NBS as a challenge, slowing down the implementation of programmes (KI interviews, document review). In the next CP, UNFPA should seek toestablish a direct memorandum of understanding with NBS in order to facilitate improved programme implementation (KI interviews, document review).

UNFPA has supported eight states to produce disaggregated data to monitor SDG indicators during the 8th CP. UNFPA has been supportingNPC on population policy development. The population policy has a very strong and well-designed framework which we have 3 levels: the national counsel level on population, the population advisory, and the population technical working group. In support for data management and utilization, UNFPA provided support for data management and utilization at national and state levels to increase capacity to generate population projections and identify sociodemographic trends and address them within policies, programmes and advocacy. Thiswas conducted through assistance for the dissemination of the 2018 NDHS results nationally at national and in the 36 states and the FCT.At the end of the exercises, the 2018 NDHS data were available to the Ministries, Departments, Agencies and Agencies (MDAs) at the national and state levels for planning and decision making on issues of women and girls. UNFPA scaled up its engagements for the roll ofthe demographic dividend programming with different stakeholders through the first private sector conference on demographic dividend, segmentation of consultations with religious leaders, and state-level engagements on harnessing demographic dividend, starting with Muslim Religious Leaders. The UNFPA has also been supporting NPC to convene the Population technical working group meeting, as well as the Ministry of Budget and National Planning to convene Quarterly National Task Force on South-South Cooperation Meetings, periodically. The population technical working group works on the preparation of the upcoming census in Nigeria. (KIIs and desk review) while Task Force on SSC garners inter-ministerial innovations towards National Development Plan.

The third intervention area is mapping, generation, and analysis of SRH and GBV indicators at national and sub-national levels, whichis also highly relevant to measuring progress on the SDGs, with extensive efforts to develop the IP staff skills (KI interviews and documentreview). For example, in Kaduna Sub-Office, a capacity assessment of organisations working on gender-based violence, and adolescent sexual and reproductive health was conducted for different stakeholders, mapping the range of civil society organisations, including community-based organisations (CBOs) and faith-based organisations (FBOs). The aim of the mapping was to support the states in forminga consultative forum where relevant stakeholders can share best practices and provide assistance to the state in programme design, implementation, monitoring and evaluation, including data for use in interventions with women and young people across the state. However, it was unclear to the evaluators whether this mapping had been done nationally. One of the main challenges is insufficient federal and state government cash counterpart contribution (GCCC) to sustain the capacity building programme, as funding is intended to be jointbetween resources leveraged by UNFPA and the federal/state governments. Where the federal/state government is lacking, programme sustainability is unlikely when UNFPA funding ends.

The fourth intervention area is the conduct of the national census and socio-demographic surveys. Although a census did not take place, partly because of political sensitivities and lack of political will (KI interviews), UNFPA has supported the National Population Commission on different census-related activities, including staff capacity building, to prepare for a census later. Preparatory activities included demarcation of the enumeration areas, as well as support for multiple other activities. The last census was conducted by the NPCin 2006, but the 10-yearly serial intervention did not take place in 2016 in the absence of a legislative act that would have ensured it. In view of the great importance of population and housing census data for national and state level planning, UNFPA should intensify high level advocacy with the National Assembly to influence political will for the regular implementation of the project and intensify advocacy at federal and state levels regarding the value of having a census. In addition, and more urgently, UNFPA should advocate for the regularconduct of Nigeria demographic and health surveys (NDHS) within the states to provide critical data for development. Other approaches to increasing the population database that UNFPA has supported are updating the capacity of NPC on GIS and on Civil Registration and Vital Statistics (CRVS), which is an important contribution to strengthening civil rights.

The fifth intervention area is collection and analysis of disaggregated data in humanitarian settings. Document review indicated that UNFPA supported all the states on collection and analysis of disaggregated data, not just for humanitarian settings. UNFPA provided funding and financial assistance to support data management and utilization at national and state levels to increase capacity to generate population projections and identify socio demographic socio-demographic trends and to address them within policies, programmes and advocacy. This was conducted through assistance for the dissemination of the 2018 NDHS results at national and in the 36 states and the Federal Capital Territory (FCT). After this, the 2018 NDHS data were available to all ministries, departments, and agencies (MDAs) at the national and state levels for planning and decision making on issues of women and girls. UNFPA also provided assistance for FMoH and its partners to conduct the 2019 UNFPA Supplies Survey which was assessed by key informants and in document review (COARs) as verysuccessful. However, as noted earlier, the low capacity of staff at the state level to collect and analyse disaggregated data remains a challenge that UNFPA will need to address further in the next CP.

The sixth and final intervention in the RRF is the institution of a national demographic observatory to track progress towards harnessingthe demographic dividend (DD). A national demographic observatory is a network of stakeholders responsible for producing, analyzing,and disseminating data on a meaningful set of indicators that reflect collectively prioritized issues on sustainable development in the country. Data and information resources produced by the network are to be used to support decision-making and the formulation of evidence-informed policies. The DD refers to the growth in an economy that is the result of a change in the age structure of a country's population. It is realized when the proportion of working people in the total population is high, meaning that more people have the potential to be productive and contribute to growth of the economy than are dependent on others. With a young population age structure,as in Nigeria, of particular importance is the capacitating of young women and men to become economically productive, which also requires investment in appropriate job creation (discussed further in Chapter 2). UNFPA has provided financial and technical support tothe states to domesticate policies on DD, and some states have implemented the policies. Several activities were implemented with UNFPA technical and financial support at national, zonal, and state levels to stimulate wider DD intelligence programming to acceleratethe process of harnessing the demographic dividend in the country. These include, at national level, development of the National Roadmap for Harnessing the Demographic Dividend; estimation of 2016 National Demographic Dividend Profile and computation of baseline National Demographic Dividend Monitoring Index, each including capacity development workshops for government bureaucrats.

At zonal level, sensitization workshops were held regarding harnessing the DD in North Central, Southeast and Southwest Nigeria for the State Ministries/Commissions of Planning and Budget. Six states were also supported to develop their roadmaps for harnessing the DD (Lagos, Kaduna, Ogun, Ondo, Sokoto and FCT), with DD profiles estimated for Kaduna and Lagos. UNFPA provided support to finalise,publish and disseminate the Nigeria Demographic Dividend Report regarding DD profiling at the national and sub-national levels. One thousand copies of the Demographic Dividend Profile Report, 250 copies of the Demographic Dividend Monitoring Index, 500 copies of the Snapshot of Demographic Dividend, and 500 copies each of six policy briefs on the DD were printed and disseminated. Challenges remain of low capacity for data and demographic dividend programming and low appreciation of population data for development, and further capacity building on DD in all the participating states is still needed (KI interviews and COARs).

4.2.2. Integration of human rights, gender perspectives and disability inclusion in the design, implementation, and monitoring of the country programme in all thematic areas

Human rights are mainstreamed within UNFPA programming across thematic areas, although there was little evidence of the use of rightslanguage such as citing duty bearers, rights holders, and gatekeepers. Nonetheless, the principle behind human rights planning is clearly there in the design, implementation, and monitoring of the programme in that states have been selected for programming where health indicators are poor, there has been a strong response to humanitarian situations, and the entire programme is geared to improving policies,service provision and access, and to transforming harmful cultural norms and practices and ending gender-based violence. It might sharpen the focus of programming to utilise rights language more explicitly, although this was not explicitly probed.

Gender is addressed as a specific thematic area, with the focus on prevention of gender-based violence and support for survivors throughmultiple channels – supporting policy and legal change, capacity, and service development, influencing community attitudes and norms,knowledge management and empowering girls and young women as highlighted in section 4.1.4 above. Although to some extent all thematic areas address gender-related issues (for instance obstetric fistula and supporting safe motherhood, including for adolescent mothers, are key areas of SRH service provision, the PD section includes mapping of GBV) there could be stronger mainstreaming of gender throughout the programme as addressed earlier. A promising consideration, however, is that within the SRH thematic area, the results and resources framework specifically include support to update national training curricula with gender sensitive methods.

With regards disability, UNFPA has appointed the thematic lead person on gender as focal point on disability to ensure greater awarenessof and response to the needs of people with disabilities across SRH, gender and among adolescents and young people. Of particular noteis that UNFPA Nigeria hosted an eight-country West and Central Africa workshop in 2019 to raise the awareness and commitment of governments, parastatals, UNFPA, and CSOs to UNFPA commitments on addressing people with disabilities,[138] and to the UN Convention of the Rights of People Living with Disabilities (CRPD), in relation to the SDGs and to the ICPD Agenda 2030, and other

[138] UNFPA: We Decide: Including and Empowering People with Disabilities https://www.unfpa.org/we-decide-including-and-empowering-persons-disabilities promotes up-to-date data, global dialogue and advocacy, guidance on standards of intervention, disability inclusion in SRH and around GBV, and building partnerships with organisations of people with disabilities and other social movements

key frameworks. The workshop also trained participants on the UNFPA guidelines on addressing young people with disabilities[139] to help them contextualise the guidelines within their own country situations.

Since the workshop, in Nigeria a UN Interagency Group on Disability Inclusion has been established, headed by UNESCO, to address the rights and gender considerations of people with disabilities.[140] A score card is being developed to assess disability inclusion across all UN programming to elucidate how far programming is responsive to the needs of people with diverse disabilities. An overarching aim of the workshop was for all the countries to develop a national disability plan. In Nigeria, components on sensitisation and awarenessand economic empowerment were acted on with funding support from core and other funds, within the Spotlight Initiative and RCCE[141](KI interviews and document review). Various initiatives have been undertaken in relation to people with disabilities, one example (KI interviews and document review) being that the Benue State Ministry of Health and Ministry of Youth and Sports, working closely with UNFPA, established a youth boot camp for adolescents living with disabilities, training 30 adolescents (20 females and 10 males) to build their confidence and life skills capacities.

UNFPA Nigeria is paying closer attention to disability-inclusive programming, is actively involving people with disabilities in events, and has disseminated the guidelines on disability inclusion to all the sub-offices and to partners (KI feedback). Nonetheless, challenges remain. For instance, according to KI feedback, centres selected for events and also the UNFPA offices themselves are not entirely disability friendly (e.g., re access and spatial logistics). UNFPA itself should set a positive example by employing a representative quotaof people with disabilities, a global demand by organisations involved in disability integration. In the field work for the CPE, it was not possible specifically to ensure the inclusion of beneficiaries with disabilities in the FGIs. There is evidence, however, that state and federal governments are more committed to disability inclusion. In January 2021 President Muhammadu Buhari signed into law the Discrimination against Persons with Disabilities (Prohibition) Act 2018, after reportedly years of advocacy by disability rights groups and activists (KI interviews). Also, the FMoH developed a national policy on SRH for people with disabilities in 2018.[142] KIs in health and UNFPA report that people with disabilities are more apparent in functions and events. A full national action plan would be advantageous and could be a valuable result from a national disability conference planned with UNFPA support for 2022. In humanitariansettings there is a need for stronger inclusion and focus on people with disabilities, which was reported (KI interview and document review) to be in the process of being planned across agencies as an indicator to measure.

The global guidelines on addressing SRH and GBV in women and young people with disabilities[143] are reported to be increasingly incorporated in UNFPA programming, particularly around sensitization, awareness, and economic empowerment aspects, although they have not yet been contextualized for Nigeria. The evaluators were not able systematically to review the extent to which all IPs are integrating people with disabilities and disability awareness into their programming, but this was reported (KI interviews and documentreview) to be increasing, for instance in the Spotlight Initiative and in activities supported by Canadian funding. The COVID-19 awareness outreach to schools included information provided in braille (KI feedback). The focus on disability inclusion should be expanded further in the next CP as an explicit focus on people left behind, aligning with the new global UNFPA strategy on disability inclusion and empowerment published in December 2021.[144] Further, the fundamental principle of the population dynamics thematic area is to disaggregate population data by age, sex and other variables of inequality that impinge on the realization of human rights, of which disability is clearly one.

4.3 Efficiency

Summary: UNFPA has made good use of human, financial and administrative resources, but with sub-optimal budget utilisation for various reasons including, in the past two years, COVID-19 restrictions. High adherence to standard protocols and systems is evident, and M&E has improved during the CP with strong adherence to protocols and use of GPS and SIS, although M&E in the field inevitably declined during COVID-19. Delays in filling key staff posts has reduced efficiencies at times and increased stress on

[139] UNFPA (2018) Women and Young Persons with Disabilities. https://www.unfpa.org/publications/women-and-young-persons-disabilities

[140] People with disabilities include anyone who has an impairment that impedes normal tasks of daily living and may reduce their participation in any area of life (work, recreation, relationships etc). Impairments include developmental, mental impairment and illness, physical/motor and sensory impairments from any cause,including those with social implications such as albinism and obstetric fistula.

[141] The Risk Communication and Community Engagement Strategy around COVID-19, an international initiative in 13 countries in Africa that was domesticated in Nigeria

[142] National Policy on Sexual and Reproductive Health and Rights of Persons with Disabilities with emphasis on Women and Girls, 2018

[143] UNFPA (2018) Women and Young Persons with Disabilities. https://www.unfpa.org/publications/women-and-young-persons-disabilities

[144] UNFPA (2021) We Matter. We Decide. We Belong: UNFPA Disability Inclusion Strategy 2022-2025

remaining staff in the CO and sub-offices. For optimal catalytic results, UNFPA needs to shift from direct funding to advocating forgovernment financing to mount quality programmes.
UNFPA staff from all the offices gave mostly positive feedback in an anonymous online internal review.

4.3.1 To what extent has UNFPA made good use of its human, financial and administrative resources, and used a setof appropriate policies, procedures, and tools to pursue and to measure the achievement of the outputs and intendedoutcomes defined in the country programme?

4.3.1.1 Human and administrative resources

Overall, UNFPA appears to have made good use of its human, financial and administrative resources, although improvements could be made in certain respects. Prior to the incoming monitoring and evaluation specialist in 2019, a gap in this key post was reported to havecontributed to significant gaps in documentation by both IPs and UNFPA staff, but the situation appears to have greatly improved (KI interviews). Country Office Annual Reports (COARs) and quarterly reports indicate that the implementation rate of activities was high,with milestone targets often exceeded across thematic areas, although KI interviews found that at the end of the year there were sometimes reporting delays by implementing partners (IPs) and late planning, leading to late disbursements and hence postponed programme implementation. In 2020 and 2021, annual planning was undertaken earlier to address this, in November, and this was reported for manyreasons to be an improvement in 2020 for most IPs, though not all. On balance, earlier planning was reported (KI interviews in UNFPAand with IPs, document review) to improve the calibre of work plans, to avoid overlap with end of year financial closure activities and, despite the challenges it posed for some IPs juggling planning and existing implementation commitments, the UNFPA recommendationwas that it should continue.

There were also IP reports that quarterly funding was often late, even delaying implementation into the third month, and that it appearedthat bureaucratic delays in UNFPA were at least in part to blame. However, late reporting by many IPs was also a widespread issue (KI feedback), even though they all know the fixed deadline for submitting financial and progress reports. Poor quality of draft reports also leads to delays in approval and hence delayed funding for the next quarter.

Regarding activities implemented by UNFPA itself, to improve efficiencies and reduce delays, the level at which sub-offices can authorise expenditures without awaiting CO approval has been raised (KI feedback), and sub-offices have a programme budget (e.g., for training workshops) as well as a budget for operations. A new procurement SOP was reported (KI feedback) to have been launched in 2021, which was reported to be due for assessment, and it is hoped that it will reduce delays within the sub-offices.

Another delaying factor cited (KI interviews in IPs and UNFPA) was inefficiencies in coordinating ministries[145] and bodies, some of which have no memorandum of understanding (MoU) with UNFPA (e.g., the National Bureau of Statistics, NBS). UNFPA communicatesthrough the coordinating ministry to the IPs, which promotes government ownership but increases bureaucracy and can consequently delay programme implementation. It was not possible for the evaluators to weigh how far the issues lay within UNFPA or with IPs, including ministries, but clearly undue delays caused concern. The quality of reporting by IPs also varied, as addressed below. IPs may lack a qualified M&E officer, particularly in state and local governments, and often face high staff turnover.

Coordination and communications between the offices appears well organised through weekly senior management meetings, where jointdecisions are made, and each office provides an update on issues affecting their region. Some concern was expressed (KI interviews) as to how consistently feedback was shared within each office, however, which could be remedied by having a consistent distribution list for the weekly reports. Also, the reports need to be made much more analytic rather than merely recounting activities, and efforts are reported to be underway with a new template to promote this. One example of poor coordination and communication was that two sub- offices appear to be working independently on an online tool for MPDSR,[146] perhaps also indicative of the need for greater sharing, andthe CO is now exploring how to harmonise the two approaches (KI feedback).

One issue that came up repeatedly during the evaluation (KI interviews in UNFPA and IPs) was the cost of having senior posts left unfilled for too long – for instance for the country representative, CR, and GBV coordinator (one year plus), the monitoring and evaluation

[145] The Federal Ministry of Budget and National Planning (FMBNP) coordinates at the federal level and is a UNFPA IP, and the Ministry of Economic Planningcoordinates at state level. The NBS is under the FMBPN, so UNFPA engages with the NBS through the ministry.
[146] Maternal and Perinatal Death Surveillance Registration, in Lagos Liaison Office and Calabar sub-office

post as above (one year), and the gender violence P4 post in Maiduguri Sub-Office (over six months) among others. Stakeholders reported that time lags in recruitment led to decline in the level, efficiency, and effectiveness of programming and, in the case of the CR post, leadership for strategic direction was reduced. When a new post holder comes on board, there might be little effective hand over or induction, requiring the new recruit to effectively learn by doing, and sometimes imposing an unduly high work burden on them (KI interviews). Reasons for the recruitment delays were variously given as bureaucracy and staff shortages in headquarters, lack of push from WCARO (lacking a human resources manager), and inefficiencies or other blocks within the CO. It was not possible for the evaluators to weigh the various factors, which no doubt varied across different posts at different times. However, it became clear that better preparation for the departure of staff and more rapid recruitment, with effective hand over and induction, would enhance office efficiencies, budget expenditures and programme achievement, and reduce stress on the staff required to cover vacant posts in addition to their existing work (KI interviews).

During the 8th CP the office structure expanded, particularly in the humanitarian sub-office in Maiduguri, which moved to fixed term posts from the original Surge modality. This was an appropriate response to the escalating humanitarian situation and the need for long-term nexus preparation, that is, for a connected, coordinated approach. Nigeria, with a huge population and severe issues in relation to all areas of the UNFPA mandate, benefits from substantial UNFPA staffing, including the valuable decentralisation into different states.A finding of the evaluation (multiple KI interviews) was that programme implementation is stronger where UNFPA has a significant presence. However, given the likelihood that UN funding globally will continue to contract, the staffing complement of over 100 is unlikely to be sustainable indefinitely. This will require that UNFPA is as strategic as possible in terms of where to prioritize policy andprogramme support to achieve the best synergies and multiplier effects, how (and where) to advocate for strengthened government funding and policy and programme implementation, which partnerships are the most strategic to strengthen and, most challenging of all,which areas of work to cut back. The current number of IPs, 54, requires heavy administrative support and oversight and is higher than the 44 documented in the mid-term review of the previous CP,[147] although the review noted the need to reduce numbers. The exhortationto 'do more with less' essentially requires streamlining to avoid an unsustainable burden on reduced numbers of staff, while retaining theposts that are most critical and ensuring rapid recruitment when these falls vacant.

Also to promote efficiencies and the achievement of results in the next country programme: the current balance of modes of engagementneeds review for the optimum balance in different states; decisions need to be made on how best and where to intensify complementaryprogrammes; consideration needs to be given to which IPs have been the most effective and should therefore have continued support; and mechanisms should be considered to reduce the administrative and oversight burden of UNFPA while sustaining technical support. One possibility could be capacitating a strong IP to oversee others within the state, perhaps as a pilot.

Finally, consideration needs to be given to the view expressed by many KIs that UNFPA may be spreading itself too thin by supportingprojects and programmes in 16 states plus the Federal Capital Territory, and that the agency should substantially reduce the number of supported states. It is essential that UNFPA continues to strengthen the national programming for family planning and regarding data, and strategies for resource mobilization will remain critical (addressed further below). But which states to support beyond national programming, and which to drop, will require careful decisions based on a range of considerations. For example, where are the state governments most active and providing finance, leading to a greater likelihood of sustainable results, which could be influential in motivating other states? Linked with this, where are there stronger government and civil society IPs who can build on and take forward areas of the UNFPA mandate most effectively? Conversely, where are the population data the poorest, and hence the population is in greatest need of maximum support? Where are the most pressing humanitarian emergencies that need growing support, including for thetransition to peace and development? These and other factors need to be fully debated in the planning process for the coming CP and it goes beyond the role of the evaluators to stipulate an optimal selection. The main focus needs to be on how to achieve the best synergiesbetween different complementary programmes, and where there is the potential to achieve the most strategic, catalytic results.

To assess internal views of staff on UNFPA as a supportive workplace, an anonymous internal staff survey (see Annex 5) with a 57 percent response rate across all offices found mixed views on all criteria assessed, raising some concerns about the use of service contractsvs fixed term posts, and quality of supervision in some cases (although review showed that the lines of reporting and supervision in the UNFPA organogram appear appropriate). The only criterion consistently rated good to very good was in-team communications, while communication between teams was mostly rated quite good, and that between sub-offices somewhat lower despite there being several

[147] UNFPA (n/d) Draft Mid Term Review of the UNFPA 7th Country Programme (2014-2017)

mechanisms reportedly in place for inter-office communications.[148] A majority reported that their workload was about right, though a significant minority said it was too heavy, particularly those who felt that COVID-19 had increased their stress a little or a lot. Only fivestaff across all offices expressed low job satisfaction, four being programme staff, and this tended to be linked with not feeling valued and with negative assessments across multiple criteria. The most negative and the most positive individual comments related to the Maiduguri office: *There is no teamwork and love in the Maiduguri office*; and *I love the office because I am valued, and I am provided with the necessary support to carry out my job*. Overall, despite a few positive to very positive assessments of efficiencies in this office in the humanitarian setting, the more personal criteria also included more low scores than did other offices, suggesting that an internal review might be useful to assess the reasons and to provide some support. The evaluators were not able to probe these issues further.

4.3.1.2 Financial resources

As noted in the previous chapter, budget utilisation was not optimal during the 8th CP. Once the COVID-19 epidemic emerged, this wasperhaps inevitable, as travel and face-to-face meetings, including for training, were greatly restricted. Prior to this, the main reasons for the underspend within the different thematic areas were attributed (UNFPA and IP feedback) to late receipt of funding tranches; devaluation of the Naira against the USD; resources being received near year end; some delays or cancellation of activities (e.g., becauseof COVID-19); and full implementation of the Treasury Single Account by government, blocking the release of money to the accounts of government IPs, which delayed implementation. In response, UNFPA tried to use the direct payment modality. Other issues that emerged included health worker strikes, and the reportedly low capacity of some IP managers to ensure effective programmeimplementation. The internal staff survey found mixed views about the efficiency of internal financial systems, but only four respondents(15.5 percent) rated it poor, with the remainder rating them fairly to very efficient. Likewise, only three respondents rated office efficiencies overall as poor. Several IPs across the thematic areas noted frustration when some initially planned activities, approved by UNFPA, could not be implemented because of insufficient funds, and also, that payment of IP vendors by UNFPA appeared bureaucraticand was sometimes slow. Despite budget underutilization, across all thematic areas further funding for IPs was needed.

The harmonized approach to cash transfers (HACT) framework, a common operational framework for UN agencies' transfer of cash to government and non-governmental implementing partners, was reported to be generally working well, with periodic micro assessmentsto assess the strength of IP control frameworks.

All programme staff are reported to have responsibility for resource mobilisation (KI interviews) under the sub-office heads and thematicleads, with sub-office heads also liaising with the focal points of state and national government IPs for the Government Cash Counterpart Contribution (GCCC). In addition, the Deputy Representative heads a resource mobilisation committee[149] to coordinate and quality assureall proposals for clearance by the CR. Some UNFPA KIs proposed that this committee play a greater role, reducing the workload on technical staff. The evaluators could not form a view on this except to recognise that optimising technical support will require reducing other workloads, particularly if the total staff numbers decline. UNFPA engaged with the private sector for resource mobilization, e.g., inregarding young people and in population dynamics, and succeeded in mobilizing resources for the Nigeria Humanitarian Fund (COARs).

For the most catalytic results, however, UNFPA needs to shift the focus much further to financing as opposed to direct funding of projects. This requires UNFPA to broaden its partnership network, including with the private sector, academia, foundations, non-traditional donorsand with strategic ministries such as for the environment (KI and document review), as well as exploring cost sharing with partners (as in the GCCC approach). It will be essential to advocate for greatly increased government investments for quality programme delivery rather than supporting multiple small IPs and projects, (and in line with advocating for government to meet the commitment of the AbujaDeclaration of 15 percent funding for health). Strong collaboration with other UN partners is also needed, using pooled finance mechanisms to a greater extent, with the UN system developing a common fund mobilization strategy such as the One UN Covid-19 Basket Fund or the National Basket Fund for Commodity Procurement. An investment case around the three transformative results (ending preventable maternal deaths, unmet need for family planning and GBV and other harms) would assist government to understandthe level of financial investment required and help motivate higher level funding.

[148] Weekly Senior Management Team meetings, programme meetings, weekly reporting from sub-offices and units, monthly staff meetings and email sharing ofdocuments (KI feedback).

[149] According to KI feedback, this includes the Assistant Representative, International Operations Manager, all thematic leads and the M&E Specialist, and would include the Maternal Health Adviser were this post filled.

4.3.1.3 Monitoring and Evaluation (M&E)

In general, the planning, monitoring, reporting and evaluation systems in UNFPA appear to be on track and consistent with standard operations policy. Only four respondents to the staff survey rated M&E as poor. The global Strategic Information System (SIS) is beingutilised, which links the global strategic plan to country level outcomes, outputs, and indicators, and includes tracking of progress throughdetailed milestones in each thematic area. Review of quarterly and annual reports showed extensive reporting against multiple milestones,both by UNFPA staff and by IPs (COARs, IP and UNFPA quarterly reports). Use of the GPS and e-FACE was also reported to be goodby both UNFPA and IPs, except for connectivity issues. Importantly, each sub-office has an M&E officer who coordinates with the leadM&E officer in the CO to quality assure annual work plans after planning meetings and SIS reporting. However, it was noted (KI feedback) that M&E officers need to provide greater support to thematic leads on reporting than is happening at present. The competence for M&E within different IPs and in UNFPA (apart from M&E staff) was reported to vary, with high turnover of IP staff meaning that training in RBM had to be repeated every year during annual planning meetings. Document review and KI interviewsmade it clear that while the activity and output milestones are well measured, there is insufficient measurement of contribution to outcomes, as addressed above within the thematic areas (EQ.4.2). An RBM training workshop has been proposed as part of preparing the next CP, and a GPS training workshop was also reported to include an RBM component. Another possible issue (KI reports) is that service contracts for UNFPA staff have contributed to higher staff turnover in the past, and the reported move already being implementedto increase fixed term posts, with better benefits and security, should aid both efficiency and staff morale.

M&E was also reported (KI interviews) to worsen considerably with the COVID-19 epidemic, as there could not be joint UN financial spot checks, face-to-face M&E and technical support by focal points for the sub-offices or for IPs. Virtual engagement was undertaken across the states supported by the CO and sub-offices, but this was limited by challenges in connectivity, particularly with IPs as well asUN staff working from home, and is in any case less effective than site visits. Over time, however, the situation is reported to be improving for both implementing and monitoring activities. The table below presents the timing of activities reported to be consistently undertakenapart from the COVID-19 limitations, and document review showed consistent attainment of the required UNFPA reports.

Table 4.5: Outline of Reporting and Quality Assurance Activities of UNFPA Nigeria[150]

Type of Report/Activity	Frequency
Planning	
CPD and RRFCO	Every 4 or 5 years depending on CP cycle
Work Plans by IPs, Country Office, and Sub-Offices	Annually, with Mid-Year Review
CP Planning Matrix for M&E	Annually, with Mid-Year Review
Work Plans with IPs including for Joint Programmes	Annually, with Mid-Year Review
HACT assurance planning tool (work plan figures from GPS)	Bi-Annually
Results Planning (integrating CP outputs and organizational effectiveness and efficiency (OEE), as part of SIS myResults	Quarterly
UNSDPF: UN HCT, UNCT, UNJT HIV	Quarterly
Compact of commitment for development results	Every 4 or 5 years depending on CP cycle
SIS myResults planning	Annually, with Mid-Year Review
UNFPA-UNICEF Joint Programme of FGM	Annually, with Mid-Year Review
Monitoring	
CP Planning Matrix for M&E	Annually, with Mid-Year Review
Programme review of CP	Annually, with Mid-Year Review
SIS myREsult monitoring	Quarterly
IP work plan monitoring	Quarterly
Work Plan Progress Report (IPs) narrative	Quarterly
FACE form (IP) financial report, eFACE (online)	Quarterly
Spot checks with IPs	Bi-Annually by Joint UN Team of programme and finance staff
HACT assurance includes Spot checks and annual HACT audits	Bi-Annually by Joint UN Team of programme and finance staff
IP financial audits	Annually
HQ management audit of CO	Annually
Financial management dashboard	Monthly
UNSDPF: UN HCT, UNCT, UNJT HIV	Quarterly
Compact of commitment for development results	Annually
SIS monitoring	Quarterly
UNFPA-UNICEF Joint Programme of FGM	Quarterly

External Evaluation[151]	
CPE to assess accountability in present CP and orient to next	Every other Country Programme
CP Mid-Term Evaluation	Every other Country Programme
CP Projects Evaluation	End of CP Project
CP Projects Mid-Term Evaluation	Mid-way into the CP Project
Reporting	
Country Office Annual Report (COAR)	Annually
Work Plan Progress Reports	Quarterly with Annual Progress Report
Donor report: Dashboard according to donor requirements uploaded	Annually with end of project report
UNFPA/UNSDPF reports/SIS, DaO, UNHCT, UNCT, UNJT HIV	Quarterly
UNFPA-UNICEF Joint Programme on FGM	Quarterly

150 Report provided by M&E Specialist in the CO

4.4 Sustainability

Summary: UNFPA programming focuses on strengthening government at national and state level to improve SRH, genderequality and women's empowerment, and for improved generation and use of population data. The results show increasednational ownership, increased capacity and budgetary allocations of government, positive legal and policy development, improved services for SRH and regarding gender issues, and greater generation and use of disaggregated population data. In addition, capacity has been built to varying extents in implementing partners and rights holders, but many gaps remain.

4.4.1 How far across all thematic areas has UNFPA been able to promote national ownership in national policies, planning and programming, with increased budgetary allocations and strengthened capacity of government and civilsociety implementing partners, and supported rights-holders with mechanisms to ensure the durability of effects?

The 8th CP has potentially achieved sustainable results through capacity development in both government and civil society implementingpartners, advocacy for changes in laws and policies, building services for sexual and reproductive health, empowering adolescents, and youth, and in changing harmful norms and cultural practices such as female genital mutilation (FGM), and regarding gender-based violence (GBV). Strengthening the collection and use of data for development has also been a core focus, including with regards the demographic transition, with some gains in government ownership and the use of data for development at national and state levels, although extensive advocacy, technical and financial support for a much-needed census was not successful in securing the intended result.

State funding has grown (e.g., through the Government Cash Counterpart Contribution, GCCC) in various states, with increased allocationof resources and capacity development, for example, for family planning, for maternal health[152] and to address GBV (KI interviews anddocument review). It is anticipated that, even if UNFPA withdraws support, some states, such as Kaduna, will continue with these commitments. Where programmes are implemented through civil society organisations (CSOs), there is a requirement that they go through state governments, so that all programming supported by UNFPA, whether directly through government partners or through CSOs, involves state government bodies (KI feedback). This systematically contributes to national ownership (KI interviews, document review).

For instance, with regards family planning commodities, provisions were reported to be driven mainly by the federal level untilthe development of state procurement guidelines. This has led to many states now including commodity procurement in their budget lines, which is particularly important for sustainability given the funding cuts by the UK Government. Nonetheless, as indicated in EQ4.2,financial resources for FP remain woefully inadequate and for some states, like Akwa Ibom and Gombe, generating revenue is a challenge.

151 A mid-term review of the 7CP was undertaken, with no end evaluation and no mid-term review of the 8th CP. This is within the stipulated guidelines.

152 For instance, financial support for a midwifery school, and training practitioners in EmONC and to address obstetric fistul

In addressing obstetric fistula, there has also been a reported increase in state support for ongoing services, which is likely to continue (KI feedback) but, with demand increasing faster than service supply, the backlog of untreated cases is escalating. Family planning, although essential, has yet to be systematically integrated into OF programming. Regarding wider support for maternal health, capacity development of providers and refurbishment of various facilities should also contribute to some sustainable results in improved services.

Some states are not financially supporting UNFPA-linked programming and not all have a memorandum of understanding with the agency (KI feedback). Donor-driven bilateral programmes that do not address the priorities of a given state are far less likely to lead to government ownership and financial support. This was raised as a concern (KI interviews) with respect to the safe spaces programmingin schools, for example, which have been attempted before but without being sustained when projects closed. The reasons could includelack of government capacity to continue them, lack of funding, or lack or prioritization (KI feedback). UNFPA respondents raised this concern in relation to the Canadian- and Norwegian- supported projects and indicated that efforts were underway with partners to build government capacity to promote sustainability after the projects close.

Several sustained results are evident with regards legal and policy development, extensively regarding SRH (as addressed in EQ4.1 and4.2), and in the review and enactment of the youth policy. With regards to gender, UNFPA strongly advocated for and supported the passing of the Violence Against Persons (Prohibition) Act at federal level in 2015, and since then its domestication in the individual states. By the end of 2021, it has been domesticated in all but six states nationwide, a critical, sustainable result to protect women and children not only against violence, but also against other harms such as FGM. An increasing number of communities are publicly rejecting FGM after UNFPA-supported engagement with traditional and religious leaders and communities, and there are examples of legal prosecution of FGM practitioners in the states where the VAPP has been enacted (KI feedback from the states). However, there are also reports that, even in communities that have publicly declared abandonment of FGM and where it is illegal (sometimes in additional statelegislation on FGM as well as the domesticated VAPP), FGM continues to be practised in secret (KI feedback). Legally banning FGM and prosecuting offenders are necessary but not sufficient to ensure its prevention, which requires fundamentally changing the traditionalvalues that endorse it. This, of course, takes long-term, consistent investment in communities and with traditional leaders, and engagement with young women and men as agents of change.
With regards disability, as noted in EQ4.2.2, UNFPA is increasing commitments to the SRH and gender needs of people with disabilities, including young people and women, with government also increasingly addressing disability in legislation and policies. These efforts should lead gradually to greater disability inclusion over time although, with multiple other development challenges, there is far to go.

To achieve greater sustainability of results in humanitarian situations, UNFPA has converted most international and short-term Surge recruitment posts to fixed term and service contracts and ensures staff training on critical UNFPA humanitarian commitments (CO feedback). The 8th CP has seen a strengthened response to the Call to Action on GBV, in renovating health facilities and SRH staff training, all of which contribute to the potential for sustained benefits. In particular, the strong focus on adolescents and youth, includingthe safe spaces for girls, has the potential to equip them with enhanced life skills and knowledge that will benefit them long term.

Extensive training has taken place across the thematic areas to strengthen the capacity of providers and implementing partners, as highlighted in EQ4.2. However, sustainability of results depends, for instance, on the sufficient deployment of trained staff and their retention in post and support to implement new skills; training quality; and supportive supervision and quality assurance. Various gaps and limitations were reported in the different thematic areas and, as reported elsewhere, not all the targets for training were reached. Throughout government IPs, it was reported that staff turnover tended to be high, jeopardizing long-term gains from the training that didtake place. Building capacity in government and civil society IPs remains a major ongoing need, not just for programme implementation,but also to build and retain capacity for results-based monitoring and reporting. Nonetheless, some potentially lasting gains can be identified. With respect to gender, for example, capacity has been built in a holistic way to address GBV, including with the rights bearersof health staff, legal practitioners and the police, and social workers to address psychosocial impacts of GBV. Also, community leaders have been addressed to change attitudes towards GBV, although the extent to which GBV has declined is unknown.

Essentially, while it is challenging to measure how far the efforts of UNFPA have led to long-term sustainable benefits for the population,including for those in greatest need, the added value in terms of what would have taken place in the absence of UNFPA is undoubted, as was widely confirmed (KI interviews, FGIs, site visits and document review). The key underlying challenges remain the huge size of thepopulation in need, escalating humanitarian situations, and the multiple challenges facing the government, civil society, and all partners to deliver on development goals in the face of rapidly growing population numbers and limited international support.

4.5 Coordination, Connectedness and Coherence

Summary: The UNFPA contribution to the UNCT and HCT coordination mechanisms is extensive and greatly appreciated. Also,joint interventions with other UN agencies are evident across sexual and reproductive health and addressing GBV, including involvement in multi-country programming, showing high connectedness and coherence in programming. UNFPA interventions in humanitarian settings are extensive across all thematic areas but cannot systematically reach all geographic areas with affectedpopulations because the scale of needs is so high. Capacity is being built in local and national actors to address the humanitarian crisis, and also, the longer-term goals towards peace and development, but with challenges in recruiting, training and retaining sufficient personnel in the humanitarian settings.

4.5.1 To what extent has UNFPA contributed to the functioning and consolidation of the coordination mechanisms ofthe UNCT and the HCT?

UNCT partners universally lauded UNFPA within the UNCT and its subcommittees as proactive, reliable, and constructive. The currentUNFPA CR was especially credited with raising the profile of UNFPA, and for advocacy to intensify focus on family planning, despite the sensitivity of the issue, and on empowering women and addressing GBV. Within the UNCT, UNFPA facilitated the establishment of,and chairs, the UN Inter-agency Group on Youth, established to promote youth responsive programming in both the development and humanitarian context, and to ensure a harmonized approach to coordination, implementation, and reporting of the UN Youth Strategy – Youth 2030 in Nigeria. UNFPA also co-chairs with UN Women the Gender Theme Group. The agency participates in the Programme Management Team, the Security Management Team, the UNCT Core Group, and the M&E/Data Group (key informants) and is active in the UN PSEA[153] Network. UNFPA chairs the UNCT Operations Management Team and was reported by UNCT members to be efficient and effective in this multifaceted role. UNFPA *punches above its weight* and is seen as one of the strongest of the 24 UN agenciespresent in Nigeria, including in its reach into 16 other states beyond the Federal Capital Territory (UN partner interviews). The capacity of UNFPA to consult and coordinate with other UN and development partners was rated highly across the thematic areas (KI interviews).

UNFPA was also highly valued (UN KI interviews) in the UN Joint Team on HIV and AIDS at national and state levels although, as addressed in EQ4.1 and 4.2, its HIV prevention roles in the UNAIDS Division of Labour need to be strengthened. UNFPA has been active in the TWG on HIV Prevention, and engaged with the National AIDS Control Authority, NACA, UNAIDS, UNICEF and others about the need for greatly strengthened comprehensive sexuality education and for prevention of mother-to-child HIV transmission but,to a much lesser extent, with regards reaching key populations. This is an area of great sensitivity in Nigeria that needs addressing.

UNFPA is also reported as highly active within the Humanitarian Country Team, HCT, led in the UN by the Office for the Coordinationof Humanitarian Affairs, OCHA, through the Country Resident and Humanitarian Coordinator. For instance, UNFPA is active on the HCT Sub-Committee on Engagement with Borno State Government (KI interviews), as well as being highly active with regards sexual and reproductive health, young people, gender-based violence (in the Call to Action) and supporting data management (see question 5.3below). UNFPA has succeeded in having GBV made a standing agenda item within the Protection Cluster. In 2020, for the first time, UNFPA leveraged substantial funding for Nigeria under the global People in Need (PIN) funding for humanitarian situations, considereda major achievement (KI interviews). UNFPA contributes to all three results areas of the UN Strategic Development Partnership Fund (UNSDPF),[154] and the 8th CP Results and Resources Framework aligns with UNDAF outcome areas. Globally, the Inter-Agency StandingCommittee[155] designates UNFPA to lead UN agency coordination of GBV responses, which should guide future action on GBV in the next CP, and in the 8th CP in Nigeria preventing and addressing GBV has been the major programme focus of GEWE.

[153] Prevention of Sexual Exploitation and Abuse

[154] These are: 1) Governance, human rights, peace, and security; 2) Equitable quality basic services; 3) Sustainable and inclusive growth and development

[155] Global Prevention Cluster Gender-Based Violence Area of Responsibility UNFPA Strategy 2021-2025. https://gbvaor.net/

With regards COVID-19, UN partners particularly noted the agency's lead role in programming guidelines and the conversion of a healthfacility for UN staff and families affected by COVID-19, later extended to diplomatic partners. This contributed to there being no deathsamong staff despite multiple infections and *put Nigeria UN on the map* according to one representative. The UN reserve funding channeled through UNDP (KI interviews) funded the initiative. UNFPA co-chairs with the International Organisation on Migration (IOM) the COVID Committee within the UNCT. Further UNFPA actions regarding COVID-19 are addressed in previous questions.

4.5.2 How far is the CP coherent with and engaged in joint interventions of the UN agencies and Government in relation to each thematic area, including through the NWOW?

Across all thematic areas, UNFPA is coherent with and engaged in several joint programmes, including participation in multi-country ones. With regards to strengthening the UN delivering as one (DaO), different agencies are taking the lead in six different states, with UNFPA taking the lead in Cross River State with flagship programming on an SDG integrated village and a focus on digitalization for schools and health facilities (KI interviews and document review). This is a multi-country project with South Africa and Ghana, fundedby Samsung with technical support from UNFPA, UNESCO and UNICEF, and aims to develop capacity for telemedicine. The digital infrastructure has already been provided but, according to KI feedback, the project cannot yet be implemented because of non-release offunds and inadequate human capacity. It is anticipated that the partners will revive the project in 2022. Another recent development in SRHR is that the World Health Organization (WHO) is leading an initiative with its partners, including UNFPA, to address abortion, a highly sensitive issue in Nigeria. A stakeholder meeting on a comprehensive abortion system was held in December 2021, but only UNFPA of all the agencies attended (KI feedback). UNFPA should join WHO and other partners in a comprehensive consultative processto address the barriers to safe abortion as part of an approach to prevent maternal morbidity and mortality through unsafe practices.

In gender, one key example of joint programming is the multi-country Spotlight Initiative operating since 2018 in six states in Nigeria (see EQ4.2.1.4). Through the Technical Coordination Specialist, UNFPA plays an important coordination role between the agencies leading each of the six pillars of the project: UNFPA (as lead on services and co-lead on prevention with UNICEF and with UNDP on data), UNDP (leading on laws and policies and institutions), and UN Women (leading on CSOs and women's movement), with UNESCO providing support across pillars. The overarching lead is the Resident Coordinator. Strong progress was cited in the Spotlight Initiative towards the UN delivering as one. As a major multi-year-funded partnership between the European Union (EU) and the UN towards a common goal, this is also a strong example of global commitment to the new way of working (NWOW). Lines of communication and complementarity between the pillars of the Spotlight Initiative were reported (KI interviews) to be effective and improving, although it was commented that UNFPA functions through putting government in the 'driver's seat', while its partner UNICEF does not.This reportedly led to temporary splitting of local government areas in which each agency operated but is being resolved with more clearly defined responsibilities - UNICEF to a greater extent on child protection, and UNFPA on community mobilisation, GBV and SRH. EQ4.2.1.4 addresses the Spotlight Initiative further. Within the gender thematic area, another major joint and multi-country programme is the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting, which is also addressed within EQ4.1.2.4.This programme, that predates the 8th CP, has demonstrated significant results in reducing the practice of FGM in the six states in whichit operates, and is again a strong example of long-term inter-agency cooperation, cohesion, and synergy within the NWOW framework.

4.5.3 To what extent have UNFPA Nigeria humanitarian interventions to address the insurgency and IDP situation in the BAY States systematically reached all geographic areas with affected populations (women, adolescents, and youth), and contributed to developing the capacity of local and national actors to better prepare for, respond to and recover from humanitarian crisis, with longer-term development goals taken into account?

UNFPA has prioritized addressing SRH, GBV, young people and data in humanitarian situations through multiple interventions, and through strengthening the capacity of the Maiduguri Sub-Office with fixed term posts as opposed to relying heavily on the Surge modalityof recruitment. The Surge modality allows for rapid short-term international recruitment to address extreme emergencies, but has limitedrelevance for long-term responses, as required in Nigeria, as states move from crisis to peace and development. In the Bay States, the Surge modality initially supported SRH and GBViE[156] programming with NORCAP[157] standby roster support (KI interviews). A limitation, however, was a long delay in recruiting a fixed term GBV sub-cluster coordinator after the Surge staff member left in 2020.

[156] Gender-Based Violence in Emergencies
[157] The Norwegian Refugee Council

The CPE found that UNFPA is highly valued as the lead on SRH and GBV in emergency (GBViE) situations (KI interviews and FGIs), for instance through the safe spaces for girls in the camps, provision of personal protective equipment regarding COVID-19, activities addressing adolescent boys and young men, the one-stop shop for GBV in Maiduguri, and other initiatives addressed in EQ4.1 and EQ4.2. UNFPA addresses SRH through the free Minimum Initial Service Package for SRH, a critical response, and has incorporated this into nursing and midwifery pre-service training in 10 schools in the north-east in the four states of Borno, Adamawa, Yobe and Gombe. Theseefforts exceeded the targets for programming (see EQ4.2). UNFPA support has been instrumental in building local provider capacity forMISP in humanitarian settings. The outcome of the training on MISP was also followed up to monitor how effectively it was being implemented (document review). Staff turnover in humanitarian settings is high, however, and UNFPA has continued to support the recruitment and training of frontline workers in basic emergency obstetric and neonatal care, contraceptive commodities, and adolescent-friendly SRH and GBV in the attempt to ensure continued service delivery over time. UNFPA also supports clinic services in the camps and host communities, including repairing damaged infrastructure and procuring drugs and equipment. The strengthened hospital referralfrom the camps through tricycle ambulances is also providing valued support, enabling people in need to access medical services.

In addition to direct service provision and training, UNFPA also supports monitoring and the data system, including an integrated humanitarian database[158] and the GBV information management system, GBVIMS (document review). This is an important contributionto guide the responses and ensure that they adapt to changing situations and needs as new humanitarian emergencies arise and as they evolve towards peace and development. Linked with this, UNFPA also facilitates and contributes to state and field level coordination inSRH and GBV, including through the Call to Action on GBV in Emergencies. These are all contributions to an appropriate, sustained response. Over 100 local government staff in different line ministries have been trained in GBViE over the previous two years, reportedlyresulting in improved service delivery, advocacy, and resource mobilisation (KI interviews and document review), and further training isboth urgently needed and continuing. Training is organised through partnerships with academic institutions at both state and federal level,although with COVID-19 restrictions, much of the training has had to be undertaken virtually. UNFPA has specific staff in post to buildGBViE capacity. An ongoing challenge is the high turnover of staff in humanitarian settings, as noted above, with great need for strategiesto promote recruitment and retention of staff regarding both GBV and SRH (as well as in other areas of the humanitarian response).

The escalating scale of the humanitarian crisis[159] makes it impossible to provide the level of coverage needed, however, despite the concerted efforts of the government with multiple international, national, and local partners through an annually updated humanitarian response plan (HRP). According to the 2019 HRP, an estimated 26 million people were affected in Borno, Yobe, and Adamawa, of whomover 7 million required humanitarian assistance (3.3 million girls, 1.9 million boys, 1.6 million women and 1.3 million men). Fifty-six percent of internally displaced persons (IDPs) were aged under 18. The humanitarian situation (and response) has been primarily in the north-east, but conflicts, abductions, banditry, and population displacement are also occurring in the north-west (Sokoto State), Kaduna in the central region and elsewhere, for reasons such as competition for land and resources, and flooding. The HRP is reported not yet to address these areas, but the UN, including UNFPA, are reported (KI interviews) to be engaging in joint meetings with government and NGO partners to address these emerging situations. They are also engaged in the long-term transitional processes in Adamawa State, such as training development officers on UNFPA mandate concerns to assist in emerging humanitarian settings and their transition.

KI interviews reported serious funding constraints, with one estimating that only 10-20 percent of full humanitarian funding needs are currently being met (even with the valued PIN finance noted earlier). Major difficulties also arise in accessing people in need, particularlyin the BAY States, because of security issues, and health service disruptions, reported to be worst in Borno with the Boko Haram insurgency (document review, KI interviews). COVID-19 has added to the difficulties in reaching people with services and information.During the CPE, reports were also made in KI interviews of many people being removed from camps despite a lack of services and security, with unclear consequences for their health and well-being. The consultants were not able to assess the gravity of this situation.

Multiple key informants, including beneficiaries, commended UNFPA for addressing humanitarian support, ensuring that SRH and GBV,and young people (potential change agents, not just beneficiaries), are not marginalized in the context of food insecurity and unmet basicneeds. Yet much more is needed from all stakeholders in the context of escalating needs.

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[158] OCHA Nigeria (2019) https://www.humanitarianresponse.info/en/operations/nigeria/3ws
[159] OCHA Nigeria (2021) https://www.humanitarianresponse.info/en/document/nigeria-2021-humanitarian-response-plan
[160] The 10 priorities (KI) are: responding to COVID-19; starting an inclusive and sustainable economic recovery; making peace with nature; tackling poverty and inequality; reversing the assault on human rights; achieving gender equality; healing geopolitical rifts; reversing the erosion of the nuclear disarmament and non-proliferation regime; seizing the opportunities of digital technologies while protecting against their growing dangers; and launching a reset for the 21st century.

The contributions to data management were also seen as critical to ensure that population dynamics and intervention outcomes are documented and visible to inform policy and programmes. More broadly, UNFPA needs to consider how best to fit into the global mega trends of irregular migration, partly driven by conflict, and the 10 UN global priorities.[160] Of these, the UNFPA focus in Nigeria on addressing COVID-19 and gender inequality isparticularly strong, including innovative use of digital technologies. Responding to IDP needs for SRH and protection against GBV, withyoung people in sharp focus, provides insights into strategies to expand in development contexts also.

5 Conclusions

5.1 Strategic Level

Conclusion 1.1: Achieving the demographic dividend and the final stage of the demographic transition are key to Nigeria achievingits development goals and, although the UNFPA mandate is central, the current engagement of UNFPA is insufficiently catalytic toachieve high-level outcomes.

Origin: Evaluation questions 1, 2,4; **Evaluation criteria:** Relevance and responsiveness, effectiveness, sustainability

Conclusion 1.2: UNFPA efficiency and effectiveness to achieve catalytic, sustainable results is reduced by spreading too thin with insufficient focus on strategic partnerships, a high administrative burden, sub-optimal balance of modes of engagement per state, andsometimes slow recruitment of senior posts.

Origin: Evaluation questions 2,3; **Evaluation criteria:** Effectiveness, efficiency, sustainability

Conclusion 1.3: During the 8th CP UNFPA has strengthened the SRH and GBV responses in humanitarian settings, including the effective engagement of young people, but the nature and scale of humanitarian emergencies and areas moving into the peace and development phase continue to grow.

Origin: Evaluation questions 1,2,3,4,5; **Evaluation criteria:** Relevance and responsiveness, effectiveness, efficiency, sustainability, coordination, and connectedness

Conclusion 1.4: The overarching theory of change is insufficiently robust, and the Results and Resources Framework is notsufficiently logical across thematic areas or within them.

Origin: Evaluation questions 2, 3; **Evaluation criteria:** Effectiveness and efficiency

Conclusion 1.5: IP capacity development may be too wide and of insufficient depth optimally to improve services in sexual and reproductive health, regarding gender-based violence, for comprehensive sexuality education (CSE), and for results-based management.

Origin: Evaluation questions 2,3,4; **Evaluation criteria:** Effectiveness, efficiency, sustainability

5.2 Sexual and Reproductive Health Services

Conclusion 2.1: Although UNFPA has greatly contributed to strengthening contraceptive procurement and distribution, both supplyand uptake remain inadequate to meet immediate and long-term needs.

Origin: Evaluation questions 1,2,4; **Evaluation criteria:** Relevance and responsiveness, effectiveness, sustainability.

Conclusion 2.2: The efforts of UNFPA to strengthen the capacity of the health workforce have been notable, but many gaps still remain with respect to preventive health care, achieving a high standard of care at scale, and obstetric fistula services linked with FP,in particular, are falling short.

Origin: Evaluation questions 1,2,4; **Evaluation criteria:** Relevance and responsiveness, effectiveness, sustainability

Conclusion 2.3: Despite Nigeria being a Global Prevention Coalition country, UNFPA has not sufficiently addressed HIVprevention in priority populations of sex workers and men who have sex with men and other key populations, or in young women.

Origin: Evaluation questions 1, 2; **Evaluation criteria:** Relevance and responsiveness, effectiveness

5.3 Adolescents and Youth

Conclusion 3.1: The 8th CP strengthened policies, strategies, and programmes in relevant sectors to prioritize adolescents and youth to address the broader determinants of their sexual and reproductive health, development, and well-being, but resource allocation and implementing partner capacity remain limited.

Origin: Evaluation questions 1, 2, 4; **Evaluation criteria**: relevance and responsiveness, effectiveness, sustainability

Conclusion 3.2: UNFPA support to states has contributed to adolescent SRH service access and uptake, including opportunities to buildknowledge and skills to build demand, but it remains inappropriately focused on abstinence.

Origin: Evaluation questions 1, 2, 4; Evaluation criteria: relevance and responsiveness, effectiveness, and sustainability

5.4 Gender Equality and Women's Empowerment

Conclusion 4.1: The GEWE focus on gender-based violence and harmful practices is entirely appropriate given the extent of GBV,particularly in humanitarian settings, but the thematic focus in the RRF omits some key factors in addressing GBV while inappropriately incorporating related aspects that belong in other thematic areas.

Origin: Evaluation questions 1,2,3; **Evaluation criteria:** Relevance and responsiveness, effectiveness, efficiency

Conclusion 4.2: UNFPA has successfully advocated for the domestication of the Violence Against Persons (Prohibition) Act in different states, but there is far to go to ensure its effective implementation regarding GBV and harmful cultural practices and, currently, project synergies are not optimal.

Origin: Evaluation questions 1,2,4; **Evaluation criteria:** Relevance and responsiveness, effectiveness, sustainability

5.5 Population Dynamics

Conclusion 5.1: Despite progress in the production, dissemination, and use of socio-economic data to monitor achievements of the Sustainable Development Goals and to guide multi-sectoral policies and plans at national and state levels, weak capacity of the implementing partners, including for coordination at the national level, and inadequate government commitment, remain challenging.

Origin: Evaluation questions 1, 2; Evaluation criteria: relevance and responsiveness, effectiveness

Conclusion 5.2: UNFPA supported programming for the demographic dividend, a demographic and health survey and preparatoryactions for the census that is overdue but, despite its great importance, political and other concerns meant that it did not take place.

Origin: Evaluation questions 1,2,4; Evaluation criteria: relevance, effectiveness, and sustainability

6 Recommendations

6.1 Strategic Level

Recommendation 1.1: UNFPA should give priority to multi-sectoral advocacy at the highest national and state levels to catalyse government investment to achieve the demographic dividend and demographic transition, including an investment case for the threeUNFPA transformative results; and explore strategic partnerships and innovative funding modalities to leverage the finance neededfor quality government programming.

Priority: High; **Target level:** Country office, HQ; **Based on conclusion: 1.1**
Operational implications:
There are no operational implications arising from this recommendation beyond ensuring sufficient capacity for high-level advocacy andstrategic thinking across the thematic areas in all UNFPA offices, including rapid recruitment of high-level posts. This recommendationshould be implemented in the short term and throughout the next CP.

Recommendation 1.2: UNFPA should increase efficiency and programme effectiveness for strategic results by carefully selecting fewer, supportive states that contribute financing, and on cementing strategic partnerships, employing complementary modes of engagement to intensify programming, and showcase results with strong implementing partners selected through a systematic plan;ensure rapid recruitment for senior posts, and also consider capacitating one strong IP to oversee others in one state as a pilot initiative.

Priority: High; **Target level:** Country office, HQ; **Based on conclusion: 1.2**
Operational implications: Narrowing the geographic spread of programming would require fewer monitoring and operational staff because the oversight and administrative burden would be reduced, except for increased effort in the short term to capacitate a strong IPin one or two states. This would potentially allow for stronger recruitment and/or retention of experienced staff for high-level technical support and advocacy for resource mobilization, with attention to which sub-offices may need capacity development. This recommendation should be addressed in the short and medium term.

Recommendation 1.3: UNFPA should incorporate the humanitarian response in Nigeria as a core programme with dedicated funding and a long-term nexus/coordinated focus, developing further its capacity and strategic partnerships to address SRHR, GBV and to capacitate young people in humanitarian settings, and widening the geographical scope of interventions as humanitarian situations emerge, change, and develop.

Priority: High; **Target level:** Country office, WCARO, HQ; **Based on conclusion:1.3**
Operational implications: Despite the overall need to reduce staffing, the complement of technical and other capacitated staff requiredin the field specifically to address humanitarian situations is likely to grow as humanitarian emergencies escalate and as some regions move towards peace and development. It is essential that key posts are rapidly filled and that long vacancies are avoided. This recommendation should be addressed in the short and long term.

Recommendation 1.4: Strengthen both the theory of change and the logic across and within the thematic areas in the Results and Resource Framework, so that each thematic team addresses all associated interventions with appropriate interactions and complementarity with the other teams.

Priority: High; **Target level:** Country office, HQ; **Based on conclusion:1.4**
Operational implications: This recommendation has no specific operational implications beyond the potential need for some realignmentof staff posts and lines of supervision, and further guidance on RBM while revising the theory of change and developing the next CP RRF.This recommendation should be addressed in the immediate term.

Recommendation 1.5: To strengthen sustainable results, UNFPA should review training curricula for SRH, CSE, in gender, around disability inclusion and in PD where needed, supporting refresher courses, and ensuring mentoring and supportive supervision after training with quality assurance regarding strengthened practice.

Priority: Medium; **Target level:** Country office; **Based on conclusion:1.5**
Operational implications: No operational implications arise from this recommendation in terms of increased workload on

existing staff, particularly if the number of supported states is reduced. This recommendation should be addressed in the medium and long term.

6.2 Sexual and Reproductive Health Services

Recommendation 2.1: UNFPA should intensify efforts to leverage funding to build contraceptive supply chain stewardship nationally and sub-nationally, including for condoms with a total market approach, explore the potential for Nigeria to manufacturecommodities, and support last mile distribution in line with intensified efforts at demand creation.

Priority: High; **Target level:** Country office; **Based on conclusion: 2.1**
Operational implications: The main operational implication is to ensure capacity for high-level advocacy for resource mobilization atnational level and within all sub-offices. This recommendation should be addressed in the short and long term.

Recommendation 2.2: UNFPA needs to strategize to optimize preventive health care and SRH service capacity through strengthening *all* areas, in particular those lagging furthest behind such as services for obstetric fistula with integrated FP services,rethinking the balance of training and ongoing support modalities (physical and virtual) for pre- and in-service training, and workwith government on staff attraction and retention schemes to expand the provider

Priority: High; **Target level:** Country office; **Based on conclusion: 2.2**
Operational implications: No major operational implications arise from this recommendation beyond ensuring strong technological capacity for efficient online training programmes, adequate funding for extensive training and institutional support, and to aid supportivesupervision and mentoring within the implementing partners. This recommendation should be addressed in the short and long term.

Recommendation 2.3: UNFPA must fulfill its accountability within the UN for HIV prevention according to the UNAIDS Divisionof Labour, with greatly strengthened focus on all priority populations, advocacy for an enabling environment, and to implement therelevant pillars of prevention to reach them.

Priority: High; **Target level:** Country office, HQ; **Based on conclusion: 2.3**
Operational implications: Within the revised UNFPA structure in Nigeria, HIV prevention needs a dedicated lead person as well as ensuring the capacity of all programme staff in SRH, gender and adolescents and youth and in the humanitarian settings to integrate HIV prevention within their programme focus. This recommendation should be addressed in the short term.

6.3 Adolescents and Youth

Recommendation 3.1: UNFPA should leverage increased funding allocations for adolescents and youth and undertake continuous capacity development through strategic partnerships, as well as advocating for greatly increased government investment in young peopleacross all sectors, including attention to those with disabilities.

Priority: High; **Target level:** Country office; **Based on conclusion: 3.1**
Operational implications: There are no operational implications arising from this recommendation beyond those indicated under the strategic level, and the capacity in all sub-offices to leverage financing. This recommendation should be addressed in the short term andthroughout the next CP.

Recommendation 3.2: UNFPA should advocate for and support state governments to domesticate policy on comprehensive sexuality education, strengthen provider training and, together with other UN partners, undertake evidence-informed advocacy at all levels with multi-sectoral actors to raise understanding of its importance for the health and development of all young people, strongly advocating forincreased federal and state government funding

Priority: High; **Target level:** Country office; **Based on conclusion: 3.2**
Operational implications: No particular operational implications arise from this recommendation. This recommendation should beaddressed in the short and medium term.

6.4 Gender Equality and Women's Empowerment

Recommendation 4.1: Narrow the gender thematic area to greatly strengthened advocacy for gender transformation, technical and financial support regarding gender-based violence, female genital mutilation, child marriage, girls' and women's socio-economic andpolitical empowerment, and the engagement of boys and men and communities, while the thematic areas of population dynamics, SRHservices and AY strongly incorporate a gender lens throughout.

Priority: High; **Target level:** Country office; **Based on conclusion: 4.1**
Operational implications: The main operational implications relate to the need for adequate staffing, particularly in the humanitarian settings, to address gender and GBV holistically, including to strengthen the focus on justice, longer-term support for survivors, and working to transform patriarchal attitudes. The division of labour between thematic teams should be accurately reflected in the RRF so that the activities within each results chain correspond fully with the thematic area, and that all staff are capacitated to mainstream genderappropriately throughout. This recommendation should be addressed in the immediate term, during development of the next CP.

Recommendation 4.2: Together with UN partners, strongly advocate for and support VAPP implementation in all states, advocate foreffective and ethical responses to violations to achieve justice, and strengthen synergies within states to achieve more strategic, sustainable results including lessons from humanitarian settings.

Priority: High; **Target level:** Country office, HQ; **Based on conclusion: 4.2**
Operational implications: No operational implications arise from this recommendation beyond the need to ensure adequate staffing to address gender in all offices and that all staff are capacitated in gender responsive approaches and are capacitated with advocacy skills forengagement at different levels of government and communities. This recommendation should be addressed in the short and medium term.

6.5 Population Dynamics

Recommendation 5.1: UNFPA should continue to address capacity building in the government implementing partners at national and state level, strongly advocate with government and intensify support for the state level collection, use, packaging, and distribution of datato meet diverse user needs, support coordination, and strengthen the relationship with the National Bureau of Statistics with a direct memorandum of understanding.

Priority: High; **Target level:** Country office; **Based on conclusion: 5.1**
Operational implications: No particular operational implications arise from this recommendation. This recommendation should beaddressed in the short term and throughout the next CP.

Recommendation 5.2: To emphasize the centrality of realizing the demographic dividend for all development goals, UNFPA should undertake high-level advocacy at national and state levels, including for demographic dividend programming, for legislation to mandate a regular census, and for resource mobilization, as well as providing technical support for collection of data disaggregated by sex, age, disability, and other variables, and for data packaging, dissemination and use in all sectors.

Priority: High; **Target level:** Country office; **Based on conclusion: 5.2**
Operational implications: This recommendation has no operational implications for UNFPA beyond ensuring continued capacity in theCO and sub-offices to undertake high-level advocacy for funding and undertaking the census on a regular basis, and to provide the necessary technical capacity support. This should be addressed in the short, medium, and long term.