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ANNEX 3

To the Commission Implementing Decision on the financing of the Annual Action Plan in favour of the Federal Republic of Nigeria for 2023 – Part 2

Action Document for Strengthening Access to Reproductive and Adolescent Health (SARAH) in Nigeria

ANNUAL PLAN
This document constitutes the annual work programme within the meaning of Article 110(2) of the Financial Regulation, within the meaning of Article 23 of the NDICI-Global Europe Regulation.

1 SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Strengthening Access to Reproductive and Adolescent Health (SARAH) in Nigeria OPSYS number: ACT-61551 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)/ Overseas Association Decision/European Instrument for International Nuclear Safety Cooperation Regulation
2. Team Europe Initiative	No
3. Zone benefiting from the action	Nigeria
4. Programming document	Nigeria Multiannual Indicative Programme (MIP) of the NDICI 2021-2027
5. Link with relevant MIP(s) objectives / expected results	The Action is contributing to MIP Priority Area 3: Human Development Specific Objective 2 "**Supporting Family Planning and Reproductive Health**" to enable young people fulfil their potential fostering a demographic dividend, prosperous societies and stronger enabling institutions at Federal and selected States level. Expected results: Lives of women, men and families are improved through universal access to sexual and reproductive health.
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	**Priority area 3**: Human Development; **Sector:** Reproductive Health (DAC Code 130)
7. Sustainable Development Goals (SDGs)	Main SDG: 3 (Good Health and wellbeing) Other significant SDGs (up to 9) and where appropriate, targets: 1 (end poverty), 2 (end hunger), 4 (quality education), 5 (Gender equality), 6 (clean water and sanitation), 8 (decent work and economic growth), 10 (reduced inequalities) and 17 (partnership in sustainable Finance and Technology)
8 a) DAC code(s)	DAC code 1 – 13010 – population policy and administrative management 5% DAC code 2 – 13020 – Reproductive health care 45%

	DAC code 3 – 13030 – Family planning 20% DAC code 4 – 13040 – STD control including HIV/AIDS 5% DAC code 5 – 11231 – Basic life skills for youth 10% DAC code 6 – 12220 – Basic health care 10% DAC code 7 – 12240 – Basic nutrition 2.5% DAC code 8 – 14030 – Basic drinking water supply and basic sanitation 2.5%			
8 b) Main Delivery Channel	*United Nations (UN) Agencies 41000 - (UNICEF and or UNFPA/WHO)* *Other international organisation*			
9. Targets	☐ Migration ☐ Climate ☒ Social inclusion and Human Development ☒ Gender ☐ Biodiversity ☐ Education ☐ Human Rights, Democracy and Governance			
10. Markers **(from DAC form)**	**General policy objective** @	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	☐	☒	☐
	Aid to environment @	☒	☐	☐
	Gender equality and women's and girl's empowerment	☐	☒	☐
	Reproductive, maternal, new-born and child health	☐	☐	☒
	Disaster Risk Reduction @	☒	☐	☐
	Inclusion of persons with Disabilities @	☐	☒	☐
	Nutrition @	☐	☒	☐
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity @	☒	☐	☐
	Combat desertification @	☒	☐	☐
	Climate change mitigation @	☒	☐	☐
	Climate change adaptation @	☒	☐	☐
11. Internal markers and Tags	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation @	☐	☒	☐
	digital connectivity digital governance digital entrepreneurship digital skills/literacy digital services	YES ☐ ☒ ☐ ☒	NO ☐ ☐ ☐ ☐	

		☒	☐	
	Connectivity @	☐	☐	☐
	digital connectivity energy transport health education and research	YES ☐ ☐ ☒ ☐	NO ☐ ☐ ☐ ☐	
	Migration @	☒	☐	☐
	Reduction of Inequalities @	☐	☒	☐
	Covid-19	☐	☐	☐
BUDGET INFORMATION				
12. Amounts concerned	Budget line(s) (article, item): BGUE-B2023-14.020120-C1-INTPA Total estimated cost: EUR 45 000 000 Total amount of EU budget contribution EUR 45 000 000			
MANAGEMENT AND IMPLEMENTATION				
13. Type of financing	**Direct management** through: - Procurement **Indirect management** with UN Agencies led by UNICEF with UNFPA and others to be selected in accordance with the criteria set out in section 4.4.2 and another international organisation			

1.2 Summary of the Action

The proposed Action aims to strengthen Access to Reproductive and Adolescent Health (SARAH) [1] by addressing three key areas: i) Enabling **policy and institutions:** support formulation, revision and operationalisation of relevant strategy and Sexual and Reproductive Health and Rights (SRHR) policy instruments to harness the demographic dividend, ii) **Access and utilisation:** promote access to, and use of, quality health information, counselling and integrated reproductive health services with nutrition. This will target adolescents and youths in rural and undeserved communities including those caught in conflict/humanitarian settings at National and subnational levels and iii) **Data for decision:** improve the collection and utilisation of data at Primary Health Care (PHC) level towards achieving Universal Health Coverage for the underserved and leaving no one behind. Understanding better the quality of the supply-side through improved data structures will help effectively target demand-side campaigns. Promoting demand to health facilities with limited capacity is likely to discourage the use of health services. The action shall therefore be complemented in 2024 by an ***EFSD+ commercial guarantees for SMES*** that will aim to boost investments in the health sector. Sexual and reproductive health facilities will be targeted, such as laboratories and other health facilities, especially for start-up investments (high capital expenditure (CAPEX) costs of contact and infrastructure) and in the rural areas. It leverages on the lessons learned from interventions targeted at Maternal, Newborn, Adolescent and child health in northern Nigeria using a Primary Health Care (PHC approach). For instance, teenage pregnancies and neonatal causes are major drivers of maternal and under five mortalities which can be addressed at the basic health care level by use of multisector convergent approaches and platforms that facilitates delivery of integrated and comprehensive service along a continuum of care for women and children including use of Mobile-based solutions as

[1] Adolescents are those from 10 to 19 years while young persons between 10 and 24 years.

a low-cost option for promoting health-seeking behaviours. Additionally, improved government capacity to coordinate partners drives programme efficiency and accelerates achievement of results.

Nigeria's demographic dividend has unguaranteed potential, with a high dependency ratio, a fast-growing population, and slow reduction in child mortality. Effective reproductive, maternal, and child health services including family planning, contraception and female education and empowerment are paramount to accelerate demographic transition and yield a demographic dividend. Birth spacing in particular has been identified as a way to manage sustained high fertility rates and reduce the high maternal and child mortality rates but Nigeria still struggles to make modern contraceptives readily available especially in Northern Nigeria.

This action aligns with the objectives of the EU-Federal Republic of Nigeria Multi-Annual Indicative Programme (MIP) 2021-2027, in particular its third priority sector area focusing on Human Development. It aims to continue supporting investment in Youth, Family Planning and Reproductive Health as a pathway to helping Nigeria achieve a favourable demographic transition. Investing in SRHR is critical for human development and fundamental for achievement of the SDGs. The proper management of Nigeria's growing population which the UN predicts to be one of the largest populations in the world by 2050 faces major SRHR challenges.

The intervention is proposed for a period of five years, from 2023 to 2028, and will build on the achievements of a previous EU funded programme under the 11th EDF, by responding to the Reproductive, Maternal, Newborn Child and Adolescent Health with Nutrition (RMNCAH+N) challenges identified by the relevant Nigerian development and sector policies.

The Action targets SDG 3, underpinned by at least 4 sub-targets (3.1 – maternal mortality, 3.2 – neonatal and child mortality, 3.7 - sexual and reproductive health care, and 3.8 – Universal health coverage). It also targets SDG 1 (no poverty), SDG 2 (no hunger), SDG 4 (quality education), SDG 5.3 (Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation), SDG 5.6 (gender equality and universal access to SRHR) and SDG 6 (clean water and sanitation) and SDG 10 (reduced inequalities), and 17 (partnership in sustainable Finance and Technology). Likewise, the action will contribute to the realisation of the EU Gender Action Plan 2021-2025 GAP III, in particular to its thematic area of engagement "Promoting sexual and reproductive health and rights".

The Action's specific objectives are complementary to the regional Team Europe initiative programming's integrated and comprehensive support package that will tackle gender norms and barriers to accessing SRHR commodities; including manufacturing and access to health products and technologies in West Africa. The action also complements the Government of Nigeria agenda on Primary Health Care and the health sector reform. Finally, the Action supports the data accountability objective and incorporates learning through impact evaluation research activities to explore specific interventions, innovations and/or implementation modalities which will inform future investments by the EU, Federal and State governments, and other development partners in the area of health. It will ensure improved cost-effectiveness of specific health interventions, innovations and/or implementation modalities through rigorous evaluations.

2 RATIONALE

2.1 Context

Nigeria has a young population (63% of the population is under the age of 25) [2] confronted with numerous political, socio-economic, environmental, and security challenges; exacerbated by COVID-19 and the deepening of insecurity crises. Human development indicators have slumped, recession is looming and as many as 4 out of 10 Nigerians live below the poverty line (World Bank) [3]. Nigeria ranks 123rd among 146 countries on the 2022 World Economic Forum's Global Gender Gap Index (GGGI)[4] and has a 97th rank in health and survival compared with the 104th rank from 2021. Nigeria also has one of the highest maternal mortality rates in the region, as well as neonatal and under five mortality[5].

[2] Federal Republic of Nigeria Multi-Annual Indicative Programme 2021-2027, paragraph 5, page 2

[3] Strategic Steering Committee (SSC) Annotated SSC Fiche **September 2023**, paragraph 1.1. Political outlook.

[4] Global Gender Gap Report 2022 | World Economic Forum (weforum.org)

[5] Women who were involved in household decision making were more likely to have children who survived to their fifth birthday (NDHS 2018).

In response to these structural and exogenous challenges, the Government of Nigeria set out to build a more resilient nation through Nigeria's National Development Plan 2021-2025, supported by the revised National Population Policy (2022-2030), with a particular focus on human capital development and girls' education

However, implementing this vision and unlocking Nigeria's demographic potential requires an enabling environment with good strategies, policies, plans, budgets/sustained financial provisions, fiscal governance, discipline, citizens engagement and appropriate technology that work for Nigerians, especially women, young people and the people living in poverty**.** Indeed, Nigeria's demographic dividend has unguaranteed potential, with a high dependency ratio, a fast-growing population, and slow reduction in child mortality. Effective, quality reproductive, maternal, and child health services including family planning, and female education and empowerment are the foundations likely to accelerate demographic transition and yield a demographic dividend.

The country is a signatory of several international conventions and treaties that establish its commitments to the human rights of men and women and to gender equality. These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1985, the Optional Protocol in 2004, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)[6]; the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples' Rights. In recent years, progress has been recorded in the adoption of domestic legislation that has an impact on gender equality such as the Violence Against Persons Prohibition Act, 2015 (VAPP Act) and the Child Rights Act, 2003 (CRA) across the States of the country. These pieces of legislation prohibit gender-based violence, including FGM[7] (VAPP Act) and child marriage (Child Rights Act) which disproportionately affect girls[8].

This Action will contribute to the health pillar of the Global Gateway. The intervention will address adolescent health, stimulate growth and jobs, facilitate trade, engage with the private sector, and help reinforce scientific ties with Nigeria. Its specific objectives are complementary to the regional Team Europe initiative programming of an integrated and comprehensive support package that will tackle barriers to SRHR commodities including manufacturing and access to health products and technologies in West Africa and is also aligned with the government of Nigeria Primary Health Care transformation agenda and its approach to the Minimum Service Package. It will help implement the Nigeria Family Planning Blueprint 2020-2024, National Population Policy 2022, National Health Policy 2014, National Policy on Sexual and Reproductive Health Rights for Persons with Disabilities (2018 Act) and National Strategic Health Development Plan 2 or its successor and the National Policy on Elimination of Female Genital Mutilation in Nigeria (2021-2025).

The Action addresses SDGs 3 (Health and wellbeing), 4 (quality education/relevant skills for decent work), 5 (Gender equality), 8 (decent work and economic growth), 9 (industry and innovation), 10 (reduced inequalities), 16 (good governance) and SDG 17 (Partnership for the Goals), in order to leave no one behind. It thus functions as an enabler for sector specific flagship programmes such as *Achieving the Demographic Dividend, Digital and Green Transition* and cross-cutting programmes such as Digitalisation[9] and Gender. It contributes to creating a conducive environment for unlocking access to finance under the *Mobilisation of private finance for sustainable and inclusive growth* actions. The Action also helps to ensure that public expenditures are well managed to promote effective service delivery and contribute to effective implementation of sectoral development programmes (health, digitalisation, gender).

2.2 Problem Analysis

The Action will seek to address the three problems identified below:

I. **Policy issues:** Efforts to improve sexual and reproductive health are constrained by lack of coherence between policies and programme implementation, resulting in poor programme performance and lack of accountability mechanisms or allocation of funds for implementation**.** This has often been linked to poor co- creation process in the policy process. Policies have also been designed with assumptions policy implementers have the necessary critical

[6] EU Gender country profile Nigeria available at GCP Nigeria | Capacity4dev (europa.eu)
[7] Female Genital Mutilation (FGM)
[8] Ibid
[9] An opportunity here is to leverage existing partnerships and social media research of impact evaluation organisations such as DIME, which include working with the entertainment industry, marketing firms, and the World Bank's behavioural science unit in designing and testing campaigns to promote the demand for health services, promote social cohesion, and reshape gender attitudes in Nigeria and other countries in the region.

soft skills and emotional intelligence to deliver on the expected policy outcomes, and this has led to limited successes**.** Translation of policies and guidelines developed at the Federal level into actionable strategies for implementation at the state level has been a challenge to deliver evidence-based quality services. Nigeria is still amongst the top ten countries in the world with the highest burden of maternal mortality, contributing approximately 14% to the global maternal death burden with a maternal mortality rate of 512 deaths per 100,000 live births [10]. Most of the maternal deaths can be averted using evidence-based interventions such as focused antenatal care (ANC), skilled birth delivery and timely access to emergency obstetric care. Also, high fertility rate remains a huge challenge: 33% of the population is made up of young persons between the ages of 10 and 24 years, with the resultant high dependency ratio. The population growth rate can be attributed mainly to the combination of high total fertility rate (TFR) of 5.3 and a low contraceptive prevalence rate of 12% (NDHS 2018). Only 22% of married women and 5.6% of married adolescent girls have access to contraception, while 36% of unmarried women and 30% of adolescents do not have access to any contraceptive method. Differences per state also exist with girls in Northern Nigeria facing additional barriers inhibiting their access to quality education, including early child and forced marriage, unintended/adolescent pregnancy, child labour, school-related gender-based violence, increasing security related challenges and now, COVID-19 pandemic

II. **Access issues:** Health sector in Nigeria is characterised by inadequate access to, and suboptimal utilisation of, quality sexual and reproductive health care information and services. This trend disproportionately affects girls, women and youth**.** Despite significant investments, the poor health outcomes of women, children, adolescents, and young girls in Nigeria have multiple factors including a persistently fragile health system, significant inequities in access (including age of consent to services for adolescents 11-15 years) and utilization of quality health services, as well as negative socio-cultural gender norms and beliefs. Several reasons are responsible for this:

a) **Poor access to quality multisector and convergent PHC services.** Financial access remains the major barrier to accessing PHC services with a high out-of-pocket expenditure, accounting for 70% of total expenditures. Additionally, there is no designated physical space for the adolescent female or male to have free consultation in the health facilities nor are there alternative non formal centres for adolescents[11].

a) **Underfunding:** The fiscal space for PHC is characterised by severe underfunding, overdependence on public sector and donor funding, and allocative and technical inefficiencies. There is little exploration of private sector funding and other innovative funding sources due to inadequate understanding of the returns on health investment into the economy.

b) **Human resource gaps:** There are huge inadequacies in the quantity, quality, mix and distribution of human resources for health at the primary health care level. Low motivation of health workers is also an issue.

c) **Inadequate community engagement and participation:** While noting that community participation is a foundational principle of PHC, the functioning of the Ward Development and Village Development Committee remains suboptimal. The slow and inconsistent implementation of the community health strategy (CHIPS[12]) is a major limiting factor to bridging the equity gap and achieve UHC.

d) **Inadequate attention accorded to addressing social determinants of health:** Without investment in addressing social determinants of health like poverty, water and sanitation, food and nutrition, gender norms, and education; health vulnerabilities affecting women and particularly adolescent girls cannot be reduced, nor outcomes improved.

e) **Inequality:** Deep-rooted inequalities and asymmetries in age, gender and social norms are often at the root of the neglect of the health of vulnerable groups. Moreover, effective prevention of gender-based violence necessitates interventions from multiple sectors beyond health.

f) **Harmful social and gender norms, and socio-cultural beliefs:** Women, children adolescents girls, and young women predominately bear the brunt of vulnerability exacerbated by social-cultural beliefs and gender norms resulting in early child and forced marriages and unintended pregnancies, limited decision making at the household, reduced access to education, harmful practices and violence against women, including sexual and gender-based violence (SGBV).

[10] NDHS (Nigeria Demographic and Health Survey) 2018

[11] A low percentage of facilities currently meet the standards outlined in the National guidelines on promoting access of young people to Adolescent and Youth Friendly PHC services in Nigeria.

[12] Community Health Influencers Promoters and Services (CHIPS) being rolled out by the NPHCDA

g) **Supply is not enough when demand for health services is suppressed:** An important barrier to the utilization of health services is the lack of, or low demand for such services, where adverse social norms often supress their uptake.

III. **Data issues**: Finally, the digital transition and shift towards evidence-based decision-making exposed the weak health information systems for tracking progress and created new human resource and technology needs at national and sub-national as well as institutional and facility levels**.** Adaptive learning underpinned by system thinking and driven by horizontal and vertical coordination and implementation mechanisms have been sparsely seen in the SRHR space. While progress has been made in institutionalizing the RMNCAH+N[13] scorecards and other initiatives at federal and state level, with 36 states now developing quarterly analysis and using them to plan and manage health programmes, the systematic utilisation of evidence for decision making and resource allocation is still poor. Gaps in the quality of routine data, disconnect between researchers and decision-makers, poor funding of research, and the lack of appreciation of the need for empirical evidence for health planning, implementation and evaluation were identified as factors frustrating the optimal performance of the health care system. Sustaining, good fiscal governance and inclusive access to finance require accountability and dialogue based on credible and transparent data/evidence, which is not readily available. Putting this in place requires coordination that brings oversight institutions and other agencies together, including data interoperability and supporting the collection and harmonization of data using non-health sector community instruments.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action:

- **National (Federal) authorities**, specifically public administration in the key ministries involved in cooperation with the EU. On the basis of the MIP priority areas, various ministries and national institutions should be involved in both design phase and implementation of intervention. These include, in particular: **Ministry of Health**, **National Primary Health Care Development Agency** (NPHCDA) with mandate for PHC implementation oversight, **National Health Insurance Authority (NHIA)**, and others with oversight on social determinants of health, including FMWASD (Federal Ministry of Women Affairs and Social Development), FMYSD (Federal Ministry of Youths and Sports Development), Ministry of Education, NIPRD (National Institute for Pharmaceutical Research and Development), **National Population Commission (NPopC)** with responsibility for coordinating the implementation of the National Population Policy and the Demographic Dividend agenda, **Ministry of Finance**, Budget and National Planning (for planning, budgeting/finance relevant to foster multisector leadership and coordination on the demographic dividend agenda in Nigeria) as well as the Nigeria Governors Forum (for high level oversight and accountability at the level of Executive Governors). Also important are the Nigeria Centre for Disease Control (NCDC) for disease control, NACA (National Agency for the Control of AIDS), **NAFDAC, National Agency for Food and Drug Administration** (drug, SRHR commodity quality assurance and regulation), **National Assembly** that have legislation, appropriation, accountability, and oversight function on health. At the same time, the intervention will involve entities supporting persons with disabilities, such as the National Commission for Persons with disabilities (NCPD).
- **State (and local) authorities** stakeholders are particularly crucial as the Action aims to also strengthen system capacity at four levels – State, LGA (Local Government Area), PHC/service provider and community and improve knowledge and accountability for health and nutrition results. Such stakeholders include **State Ministries of Health, Women**, **Youth, Budget and Planning,** State Primary Health Care Development Agencies/Boards, State Health Insurance Agencies (responsible for coverage of the population on essential health services towards financial risk protection), State House of Assembly (for legislation, appropriation, accountability, and oversight function on health as well as LGA (Local Government Area) **Primary health Care Coordinators,** who are the health managers at the local government level. Key ministries such as the Local Government Service Commission can be engaged to leverage on their coordination of these institutions for sustainability. Governmental and private institutions and organisations who provide social and health services for clients with disabilities are also important partners.
- **Media and Civil Society actors**. CSOs (including those working on disabilities and with gender transformative approaches to combat harmful practices and change social norms) and local NGOs with health

[13] RMNCAH+N Scorecard is an integrated, action-oriented management and accountability tool that supports the Ministry of Health Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Investment Framework, Health Sector Strategic Plan, and the Government's commitment to Universal Health Care.

focus play a key role in enhancing right to health, participation and accountability from the Government, monitoring of budget implementation, use of policy negotiation instruments, propaganda and investment which are capable of initiating positive changes in the health system and gender norms. Cross partnerships with Civil society actors who offer linkages to education and empowerment programmes for beneficiaries of SRHR services, especially vulnerable women and girls is key for sustained action. The Action will operate in close cooperation with women's right associations such as *Girl Child Concerns* and *Adaoha Foundation for Women* and other network of organisations that work to tackle gender and child-based violence in Nigeria.

- **Others.** Other critical stakeholders include EU Youth Sounding Board which comprise youths, young professionals that reach and positively influence adolescent boys and girls, women of reproductive age group (15-49 years), Young men and women in the communities as leaders of change, health staff and academia such as schools of nursing/midwifery and colleges of medical/health sciences/public health that educate and prepare future generations to drive evidence policy-making and Traditional leaders/Institutions who serve as community gate keepers and crucial for grassroots' mobilisation, and demand creation and community participation in positive health seeking behaviour or lifestyle changes.
- **Right holders**: These will include Women of reproductive age (15-49 years), Young People (10-24 years), healthcare workers, teachers (Direct beneficiaries) households, community members, religious and traditional leaders, local authorities. (Indirect beneficiaries).

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The overall objective of this action is - women, men and families enjoy universal access to sexual and reproductive health and the benefits of a harnessed demographic dividend in Nigeria.

The Specific(s) Objective(s) of this action are:

1. **SO1**. To enhance inclusion of SRHR/RMNCAH+N[14] information and services in national (health) policies, strategies, plans and budgets
2. **SO2**. To increase availability, utilisation and sustainable financing of integrated quality SRHR/ RMNCAH+N[15] services at State, LGA and community levels, with special focus on women and girls
3. **SO3**. To improve use of health information/data including SRHR and nutrition practices of women, adolescents and children[16] for decision making and accountability

The Outputs to be delivered by this action are:

Contributing to Outcome 1 (SO1 – Stronger policy initiation and implementation)

1. Strengthened capacities of relevant Ministries, Agencies and Departments and Local Government structures to lead, coordinate and provide technical oversight to LGA's, PHC and communities for the delivery of integrated PHC services (including SRHR and nutrition services)
2. Strengthened capacities for multisector programming, partnership and coordination of integrated PHC programmes including SRHR including private sector engagements.

Contributing to Outcome 2 (SO2 – Better Access to SRHR/ RMNCAH+N)

1. Strengthened government capacity to coordinate and provide technical oversight on SRHR/RMNCAH+N
2. Improved availability and accessibility of gender responsive, comprehensive and integrated quality SRHR/ RMNCAH+N services

C**ontributing to Outcome 3 (SO3**– Improved data governance)

[14] SRHR/ RMNCAH+N = Sexual Reproductive Health and Rights / Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition

[15] Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N)

[16] Children, including those with disabilities

1. Strengthened capacities for evidence based digital health governance, policy development, planning, implementation and monitoring at Federal, State, LGA
2. Improved capacities of National Digital Health and information systems processes, Platforms and Architecture for PHC and SRHR/RMNCAH+N data capture, storage and analysis setup based on adopted national standards

3.2 Indicative Activities

Activities relating to Output 1– Improved capacity for inclusive sound SRHR/RMNCAH+N policy planning and delivery

- Development of effective and sustainable mechanisms for improving the coverage and promote equitable access to essential SRHR integrated in RMNCAH+N information and services with particular focus on inclusion of women and adolescent girls from groups living in vulnerable situations (including persons with disabilities);
- Development and implementation of policies and strategies for continuation of quality essential SRHR/RMNCAH+N services during pandemics and other emergency situations
- Technical Assistance support to capacity development of Health policy makers and implementers on critical thinking, leadership and management
- Support of the implementation of the revised National Population Policy (NPP) and the DD Roadmap at national and state levels;

Activities relating to Output 2 – Improved access to quality comprehensive and gender responsive SRHR/ RMNCAH+N information and services

- Technical support and training of medical staff, exchange of expertise, including via digital technologies;
- Development of activities for a comprehensive RMNCAH+N during the first 1000 days of the child addressing mother and child malnutrition and SRHR+N counselling;
- Technical and logistic support, including via digital technologies, to medicines supply chain, laboratories and monitoring of health centres;
- TA (Technical Assistance) support for expansion of Health Insurance towards financial risk protection and universal health coverage
- Awareness raising campaigns, public events; provision of information for family planning and birth spacing, including implementation of male engagement strategies, prevention of FGM.
- Provide technical support to State Governments to screen and train community members, especially women, to become CHIPs to provide basic RMNCAH+N, including referral mechanism.

Activities relating to Output 3– Improved knowledge, use and monitoring of reliable health data/information

- Mapping of health structures' capacity contract, plus reference to supply of water and electricity, WASH
- Training to improve capacity for quality Data collection, data analysis for M&E (Monitoring and Evaluation) and utilisation at all levels of health care focusing on SRHR/ RMNCAH+N.
- Leverage existing platforms such as Health Data Consultative Committee (HDCC) and Health Data Governance Council (HDGC), and inter and intra organisational management and technical platforms for presentation, analysis and decision making using SRHR data.
- Set up knowledge exchange and learning platforms to write, edit, and disseminate knowledge management tools, norms and protocols; align evidence/data and knowledge management.

3.3 Mainstreaming

Environmental Protection & Climate Change

Outcomes of the SEA screening
The Strategic Environmental Assessment (SEA) screening concluded that no further action was required.

Outcomes of the EIA (Environmental Impact Assessment) screening
The EIA (Environment Impact Assessment) screening classified the action as Category C (no need for further assessment).

Outcome of the CRA (Climate Risk Assessment) screening (relevant for projects and/or specific interventions within a project)
The Climate Risk Assessment (CRA) screening concluded that this action is no or low risk (no need for further assessment). However, there are opportunities for training and data collection materials to be digitized as well as include educational information on sustainable management of natural resources and the impacts of climate change and how to contribute to its mitigation. Building the competencies, skills and knowledge needed to get new job opportunities, in particular **green** jobs, establishing preference in materials that raise awareness on climate change, environment, natural resource (including land) degradation and **climate-sensitive infrastructure** and strengthening resilience will be explored embracing the Green Deal and Nigeria's NDC[17] and relevant policies as well as contributing to the objectives of GGW[18] initiatives.

Better family planning can help development, but also ensure better access to education and healthcare which in turn can put less pressure on natural resources and our ecosystem and ensure that measures are in place to manage it more sustainably.

Environmental issues will be taken into account and sustainable measures will be promoted. In particular, sustainable health care waste management in hospitals and health centres, through the construction of hospital incinerators and the definition of sustainable procedures for the elimination of organic and inorganic residues, will be addressed. Where required, the improvement of sanitary infrastructures (water, sanitation, electricity) in health facilities will be based on the use of renewable energy (**solar energy**) and good environmental practices. Moreover, training for proper maintenance practices of renewable energy systems will be ensured.

Gender equality and empowerment of women and girls
As per the OECD[19] Gender DAC[20] codes identified in section 1.1, this action is labelled as G1. This implies that the objectives, products and activities of this action are directly oriented towards the reduction of gender inequalities (reduction of maternal mortality) and to favour the empowerment of women and the right to sexual and reproductive health with a life cycle approach to prevent harmful practices against adolescent girls. The basis of the actions to be developed will focus on eliminating financial barriers in access to care, rethinking direct payment for health services, promoting the active involvement of women in decision-making related to their health and well-being; and improving women's health as a resource to generate considerable socio-economic benefits and accelerate efforts towards universal health coverage and a favourable demographic transition.

Gender equality and women empowerment issues will be taken into account in the design and implementation phases through the involvement of women associations, such as "*Girl Child Concerns*" (women's CSO for Empowerment, Gender Equality and Political Participation) and organisations like *DIME* (focus on use of media for gender quality, female empowerment and behavioural change communication). Moreover, this action is fully aligned with the new EU Action Plan on Gender Equality and Women's Empowerment in External Action 2021-2025 (GAP III[21]), notably its objective of promoting sexual and reproductive health and rights. Policy makers will be invited to strive for demystifying traditional practices by communicating and engaging with local and community structures in a joint, strategic objective to eliminate gender-based discrimination and to promote the positive social attitudes necessary for girls and women's empowerment.

Human Rights
The intervention logic of the action is based on the assumption that accessible SRHR (including maternal health) care is a critical component of Universal Health Coverage and that access to and respect for sexual and reproductive health and rights is related to multiple human rights, including the right to health. Through this Action the EU intends to build a credible political and policy dialogue on human rights and gender equality on the basis of its very concrete actions on maternal and child health.

[17] Nigeria's Determined Contribution (NDC) to the Paris Agreement

[18] Great Green Wall (GGW) initiative unites the Sahel-Sahara region in a campaign to fight land degradation and desertification

[19] The Organisation for Economic Cooperation and Development

[20] Development Assistance Committee (DAC)

[21] Gender Action Plan (GAP) III

Some of the main issues and risks related to safeguarding of human rights in the context of the development of this programme may be related to persistence of violence against women and girls, and a general absence of sexual and reproductive health rights for young people. These violations generally translate into greater vulnerability to risks associated with sexual and reproductive health. This implies that the Action will promote activities to ensure protection of girls and women and providing access to reproductive, maternal, new-born and infant health care. All relevant ministries, not just health, and religious and traditional leaders will be consulted and involved to support progress on women's health issues.

Disability

As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D1. This implies that persons with disabilities, often facing stigma, discrimination and difficulty in accessing public service, particularly regarding their access to sexual and reproductive health and rights, specifically because of their disability, will be facilitated in accessing RMNCAH (including SRHR and Nutrition) services[22]. Within this framework all the activities of this programme contribute to the respect, protection and fulfilment of the rights and inclusion of people with disabilities, ensuring and promoting their empowerment and accessibility to health care, sexual and reproductive health and rights, and influencing the development and strengthening of policies to support the participation of these persons with disabilities and/or their representatives in society. The establishment of universal health coverage in the country should ultimately allow equitable access by people with disabilities to the services they need: while supporting the creation of a national health insurance scheme for essential health care (under output 3), the EU will advocate for the inclusion of the costs of basic disability contract and devices (wheelchairs, prostheses, etc.) in the essential package covered by the national scheme. This would be a strong, concrete measure in favour of people living with disabilities. Women with disabilities face obstacles such as limited access to services, narrow selections of contraceptive methods, insensitivity of the health service providers, lack of information on reproductive health issues which can be an obstacle to receiving the treatments, adequate reproductive health services and support in family planning. Women with disabilities and chronic health problems need accurate information, easily accessible health services and supportive and competent health service providers. The barriers that prevent or limit their ability to become clients of these services should be removed. Additional obstacles can be poverty, non-accessible transportation dependence on others for personal care, communication difficulties and stereotyped perceptions. This programme will advocate the development of accessible health services for persons with disabilities by providing relevant information both to services providers, authorities and persons with disabilities themselves.

Reduction of inequalities

Nigeria faces major challenges in terms of levels and inequalities in SRHR outcomes and access to services. These inequalities related to poverty highlight the persistence of social inequities in the country. Furthermore, addressing gender inequalities is central to improving the sexual and reproductive health outcomes and more broadly the wellbeing of women including those living with HIV. There is a need for pro-equity interventions, with stronger efforts in targeted areas with larger socioeconomic vulnerabilities as highlighted in the recently released multidimensional poverty index survey results 2022[23]. The Action will address the social and structural context of inequality through interventions to reach the poor with SRHR services as well as ensure disability inclusive SRHR services.

Democracy

This programme has been designed respecting international benchmarks and indicators in order to maximise the potential benefits of the activities developed. Through a democratic, collaborative and shared dynamics, best practices in public health and in the governance of the health system will be promoted and stimulated.

Conflict sensitivity, peace and resilience

The action will take forward the recommendations from the Conflict Analysis Screening (CAS) for Nigeria undertaken in 2021. It would strengthen the capacity of relevant health or health related MDAs at National and Sub-national levels to be more resilient towards their limited financial and technical resource capacities and assist them in improving their workflow processes, management procedures and performance for them to adequately monitor their strategies and policies. The present Action aims to counteract negative trends and ensure access to

[22] DCD/DAC/STAT (2020). The OECD-DAC policy marker on the inclusion and empowerment of persons with Disabilities - Handbook for data reporters and users. OCDE.

[23] https://nigerianstat.gov.ng/elibrary/read/1241254

quality services for all, thus contributing to prevent and reduce social conflicts. Furthermore, noting that Nigeria's next generation elections comes up in 2023, conflict prevention will be integrated using political dialogue and appropriate measures to avoid violence before, during and after the elections. Actions implemented under the programme will be conflict-sensitive, in line with the "do-no-harm principle" and to particularly prevent politically motivated tensions and violence.

Disaster Risk Reduction

Nigeria faces specific challenges that need special attention and support in order to ensure adequate, sustainable and timely means of development. Within the Sendai Framework for Disaster Risk Reduction 2015-2030, building resilience, reducing risks and potential loss and damage is achieved by supporting and investing in the reduction of maternal and child mortality; availability and access to early warning systems related to maternal and child health; sharing of experiences, lessons learned, good practices and capacity building and training of national, regional and local human resources; improving management and governance of the health system with involvement of the government and relevant national authorities[24]. Disaster Risk Reduction requires knowledge for informed decision making and coordinated action. Risk management aims at protecting people, their health, cultural and environmental assets, promoting and protecting all human rights, including the right to development.

Other considerations if relevant

The COVID-19 pandemic exposed weaknesses in Nigeria health system resilience, inequality in access to quality care and neglect for adolescent health needs especially during the lockdown where level of education showed up as both an expression of inequalities and a driver of equality. Unequal access to education affects people's ability to obtain decent jobs with fair compensation. The country was particularly at high risk for transmission on account of inadequate number of trained health workers, minimal local capabilities to implement Infection Prevention and Control (IPC) components and limited legislation around IPC protocols. However, Nigeria also learned valuable lessons on the need for effective partnerships, multi-lateralism, support of the private sector and need for local home-grown solutions for sustainable quality health care delivery including local manufacturing of medicines and medical technologies. The importance of proper risk communication and community engagement activities in order to have greater adherence and minimise logistical difficulties (staff fatigue, etc.) was crucial. Implementation of SRHR policies, strategies and plans, focusing on expanding service coverage, quality of care, population coverage and improved financial protection requires a multi-annual approach. This is a EUR 45M annual action with EUR 45M to be committed in 2023.

3.4 Risks and Lessons Learnt

Category	**Risks**	**Likelihood (High/ Medium/ Low)**	**Impact (High/ Medium/ Low)**	**Mitigating measures**
External environment	The political situation and the recurrent insecurity crises. Risk of worsening insecurity in any of the Northern States selected is a concern	**L**	**M**	EU cooperation with Nigeria depends on a stable political, socio-economic and security context. It should be noted, however, that the international community remains engaged in a political dialogue with the authorities and that the situation is being closely monitored through close collaboration with government, other partners and local Civil Society Organisations (CSOs).

[24] UN (2015). Sendai Framework for Disaster Risk Reduction 2015-2030. UN General Assembly.

Planning, processes and systems	Institutional instability, resulting in high turnover of administrative staff, especially managers, in the line ministries	**H**	**M**	Establishment of an EU-government interface structure and a common consultation framework including other Technical and Financial Partners, with a view to increase donor coordination and facilitate regular and coherent dialogue with national officials occupying strategic positions within the ministries.
People and the organisation	Low degree of ownership and participation of the national authorities (technicians) in the implementation of interventions	**M**	**M**	Establishment through policy dialogue of an EU-government interface structure will help to continuously verify and foster ownership by the authorities, particularly in the formulation and implementation of EU interventions.
Environment and climate change	Increase of environmental hazards, shocks and stresses	**M**	**M**	Establishment of increased dialogue of the EU with national and international stakeholders to strengthen readiness, responsiveness and provision of essential services
Legality and regularity aspects	The institutions involve in project implementation have capacity limitations and often encounter difficulty with coordination of project activities and entities	**L**	**L**	TA to be provided at Federal and State levels to support implementation and capacity building support to ensure sustainability of impacts
Sustainability of interventions	The outcomes may not be sustained beyond the project	**M**	**M**	A participatory co creation will underscore every intervention, looking at current and future realities and tying it to sustainable processes. Sustainability plans that include technical, financial, social domains will be developed at the beginning of each intervention and implemented and monitored through the intervention life cycle. Pilot to scale approach will be used for adaptive learning to ensure sustainability.
Lessons Learnt[25]**:** 1. The use of multisector convergent approaches and platforms facilitates delivery of integrated and comprehensive service along a continuum of care for women and children.				

[25] Lessons from successful implementation of a previous EU funded project to improve MNCH-N outcomes in 3 State in Northern Nigeria

2. Disaggregation by sex, age and other indicators is essential to identify and target specific needs, but not all data needs to be disaggregated.

3. Teenage pregnancies and neonatal causes are major drivers of maternal and under five mortalities.

4. Improved government capacity to coordinate partners drives programme efficiency and accelerates achievement of results.

5. Use of the RMNCAH Score Cards during performance reviews improved PHC service quality, coverage and accountability for results.

6. Mobile-based solutions can be a low-cost option for promoting health-seeking behaviours.

7. Water, sanitation and hygiene improvement in PHC's drives improved health facility deliveries and improved quality of RMNCHN services.

8. Community based Health Workers are central to increase coverage and uptake of lifesaving interventions and bridge the equity gaps as demonstrated by Volunteer Community Mobilizers being integrated into the CHIPS (Community Health Influencers Promoters and Services) programme of government.

9. Motivating health workers through evidence-based incentives highlights the importance of facility-level decision-making in improving quality standards and the role of monetary and non-monetary incentives in retaining frontline health workers.

10. The engagement of communities, including influencers, is essential to spread and build confidence in messaging, and to facilitate the adoption of new positive care practices.

11. Social protection systems and programmes like the conditional cash transfers improves PHC utilisation however it had far reaching impact on targeted households/families and communities.

12. A child not registered at birth is invisible – non-existent in the eyes of the government or the law. Without proof of identity, children are often excluded from education, health care and other vital services.

These lessons learnt also point out the importance of ensuring regular monitoring of interventions and continuously sharing this information with the national authorities and community leaders.

3.5 The Intervention Logic

If relevant Ministries, Departments and Agencies are enabled to better include and implement relevant SRHR policies that especially target and empower women and girls, **and** SRHR services are integrated in universal health coverage through a primary health care approach **and** accountability processes and measures supported to adequately capture and report utilisation data (while government commitment to universal health coverage through a PHC approach is sustained);

then there will be better inclusion and execution of SRHR/RMNCAH+N in national policies, plans and budgets **with** increased availability and demand for quality SRHR services **and** enhanced use of health data for further SRHR advocacy, resource mobilisation and mutual accountability resulting in overall benefit for families and larger society (provided government remains commitment to sustained favourable demographic transition);

because *when girls and women are empowered and productively engaged, and live in supportive and safe communities, and systems and institutions provide high-quality, gender-equitable and responsive SRHR/RMNCAH+N care and services, and policies, laws, budgets and processes are supportive, and systems and institutions are coordinated, accountable and utilising evidence for decision making, then the result will be that women and girls will exercise their rights empowered by non-discriminated access to SRHR/RMNCAH+N services and participate as equal members of society.* ***This will increase proportion of population (families) achieving universal health coverage and a lead to a favourable demographic transition and population management in Nigeria.***

3.6 Logical Framework Matrix

This indicative logframe constitutes the basis for the monitoring, reporting and evaluation of the intervention.

On the basis of this logframe matrix, a more detailed logframe (or several) may be developed at contracting stage. In case baselines and targets are not available for the action, they should be informed for each indicator at signature of the contract(s) linked to this AD, or in the first progress report at the latest. New columns may be added to set intermediary targets (milestones) for the Output and Outcome indicators whenever it is relevant.

At inception, the first progress report should include the complete logframe (e.g. including baselines/targets).

Progress reports should provide an updated logframe with current values for each indicator.

The final report should enclose the logframe with baseline and final values for each indicator.

The indicative logical framework matrix may evolve during the lifetime of the action depending on the different implementation modalities of this action.

The activities, the expected Outputs and related indicators, targets and baselines included in the logframe matrix may be updated during the implementation of the action, no amendment being required to the Financing Decision.

Results	Results chain (@): Main expected results (maximum 10)	Indicators (@): (at least one indicator per expected result)	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To ensure women, men and families enjoy universal access to sexual and reproductive health and the benefits of a harnessed demographic dividend in Nigeria.	1 Maternal Mortality Ratio 2 Adolescent Fertility rate 3 Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods*	1 MMR 576/100 live births 2018; 2 AFR 106 births/1000 Adolescent females 2018 3 TBD in the inception phase	1 MMR 100 by 2027 2. AFR 50 by 2027 3 TBD in the inception phase	1 NDHS 2. MICS 2 NDHS	*Not applicable*
Outcome 1	1 **I**nclusion of SRHR/RMNCAH+N information and services in national (health) policies, strategies and plans and budgets enhanced - *Implementation of the Road Map on Harnessing the Demographic Dividend (HDD) supported*	1.1 No. of activities implemented in line with the Road Map on HDD at National, State and local government level* 1.2 Percentage of health expenditure dedicated to RMNCAH+N 1.3 No. of States with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education 1.4 Extent to which SRHR-sensitive policies, strategies and programmes are introduced by partner government on: a) ending harmful practices e.g. child marriage and female genital mutilation; b) adolescent SRHR; c) comprehensive sexuality education; d) family planning; e) control of sexually transmitted infections including HIV and AIDS; f) cancer screening (GAPIII)	1.1 TBD in the inception phase 1.2 TBD in the inception phase 1.3 TBD in the inception phase 1.4 TBD in the inception phase	1.1 TBD in the inception phase with partners 1.2 TBD in the inception phase with partners 1.3 TBD in the inception phase with partners 1.4 TBD in the inception phase with partners	1.1 Progress reports for the EU-funded intervention 1.2 National and State Health Account 1.3 Health sector annual reports 1.4 Joint Annual Review Report of the NSHDP	Government is committed to sustained favourable demographic transition

Outcome 2	2 Availability, utilisation and sustainable financing of integrated quality RMNCAH+N services at State and LGA and community levels increased - *State government's capacity to lead, oversee, implement, monitor, strengthen and expand adolescent health and family planning services is strengthened*	2.1 No of health centres and schools that deliver family planning education and commodities reducing fertility rate in selected States* 2.2 No. of persons covered on health insurance, disaggregated by sex 2.3. No. of health facilities that provide telemedicine and or quality laboratory services 2.4 Number of women of reproductive age using modern contraception methods with EU support (GERF 2.34) (GAPIII)	2.1 TBD in the inception phase 2.2 TBD in the inception phase for target States 2.3 TBD in the inception phase 2.4 TBD in the inception phase	2.1 Actual targets (facilities) disaggregated by Health Centres and Schools TBD in the inception phase with partners 2.2 TBD in the inception phase with partners 2.3 TBD in the inception phase with partners 2.4 TBD in the inception phase with partners	2.1 Progress reports for the EU-funded intervention 2.2 National and State Health Account 2.3 Health Insurance Management Information Systems 2.4 National Digital Health Atlas	Government commitment to Universal Health Coverage is sustained
Outcome 3	3 Use of health information/data including SRHR/RMNCAH and nutrition practices by women, adolescents and children (including those with disabilities) increased - *A comprehensive health management information system is in place and linked to the digital social registry*	3.1 Extent to which the health and education management information system is comprehensive 3.2 Percentage of Annual Government Expenditure on Health 3.3 Level of performance score of the National Health Information System based on the Global SCORE tool 3.4 Status of use of the health and education management information system for political decision making and in budgetary processes	3.1 Not present 2022 3.2 TBD 3.3 Not available 2022 3.4 Not present 2022	3.1 A functional information system, linked to the State social registry that reflects all health facilities by LGA, no. of workers per facility and beneficiaries to inform decision	3.1 Implementation M&E, Ministry reports, third party monitoring 3.2 National and State Health Account 3.3 Annual National SCORE report 3.4 National and State Health Account and similar registries at sub-national level	

				making by 2025 3.2 -3.4 TBD in the inception phase		
Output 1 **relating to Outcome 1**	1.1 Capacities of relevant Ministries, Agencies and Departments and Local Government structures to lead, coordinate and provide technical oversight to LGA's, PHC and communities Strengthened	1.1.1 No. of LGA management and technical committees supported by the EU-funded intervention 1.1.2 No. of LGHA annual operational plans developed with support of the EU-funded intervention aligned to the state health development plan	1.1.1 Zero (0) 1.1.2 Zero (0)	1.1.1 TBD in the inception phase 1.1.2 TBD in the inception phase	1.1.1 Progress reports for the EU-funded intervention, and data base of beneficiaries 1.1.2 National and State Health Account studies	Political stability and security assured in selected focal states
Output 2 **relating to Outcome 1**	1.2 Capacities of LGA programme managers to plan, implement, monitor and scale-up efficient multisector PHC programmes with a focus on SRHR/ RMNCAH+N Strengthened	1.2.1 No. of health staff trained by the EU-funded intervenient with increased knowledge and/or skill in delivery of quality health, including nutrition and SRHR (disaggregated by sex) 1.2.2 No. of health staff provided with national guidelines and protocols relevant to their work on SRHR with the support of the EU	1.2.1 Zero (0) 1.2.2 Zero (0)	1.2.1 1000 1.2.2 TBD in the inception phase	1.2.1 Pre- and post-training test reports 1.2.2 Database of beneficiaries/participants,	
Output 1 **relating to Outcome 2**	2.1 Government capacity to coordinate and provide technical oversight on SRHR/RMNCAH+N strengthened	2.1.1 No. of Functional platforms for coordinating adolescent health/SRHR//RMNCAH+N at Federal and State level that are revitalised or established with EU support	Zero (0)	TBD in the inception phase	Implementation M&E	
Output 2 **relating to Outcome 2**	2.2 Availability and accessibility of gender responsive, comprehensive and integrated quality SRHR/ RMNCAH+N services improved	2.2.1 No. of Skilled Birth Attendance supported through the EU intervention	Zero (0)	All targets TBD with implementing partners and government in	2.2.1NDHS	

		2.2.2 No. of LGHAs with approved and released budget for all planned PHC programmes 2.2.3 No. of health facilities with at least one service provider trained to care for and refer GBV survivors 2.2.4 No. of service providers trained by the EU-funded intervention with increased knowledge and/or skills in caring for and referring GBV survivors 2.2.5 No. of facilities provided with stocks of emergency contraceptives with support of the EU-funded intervention	Zero (0) Zero (0) Zero (0) Zero (0)	the inception phase	2.2.2 National and State Health Account studies 2.2.3. Progress reports for the EU-funded 2.2.4 Pre- and post-training test reports	
Output 1 **relating to Outcome 3**	3.1. Capacities for evidence based digital health governance, policy development, planning, implementation and monitoring at Federal, State, LGA strengthened	3.1.1 Number of Annual M&E operational plans developed and implemented at the Federal and States with support of the EU-funded intervention 3.1.2 No. of health facilities implementing ICD-11 with EU support 3.1.3 Extent to which there is Quarterly use of RMNCAH+N scorecards for decision-making (no. of LGAs reporting based on the scorecards) with the EU support	5 Zero (0) Zero (0)	15 200 TBD at inception phase	3.1.1. Annual M&E Review Reports 3.1.2 Annual Health Sector report 3.1.3 Vital Statistics Report	
Output 2 **relating to Outcome 3**	3.2. Capacities of National Digital Health and information systems processes, Platforms and Architecture for PHC and SRHR/RMNCAH+N data capture, storage and analysis setup based on adopted national standards improved	3.2.1 Up to Date registry of digital health interventions guiding planning and investments 3.2.2 Extent to which EU-funded intervention contributed to development of an integrated digital	0 0	1 1	Digital Health Atlas Health Sector Annual reports	

		health platform based on national standard 3.2.3 Interoperability framework operationalized (no of reports provided using the framework) 3.2.4 No. of PHCs with proper recording, documentation and archiving.	No baseline TBD at inception No baselines TBD at inception	Targets per year TBD with implementing partners Targets per year TBD with implementing partners		

4 IMPLEMENTATION ARRANGEMENTS

4.1 Financing Agreement

In order to implement this action, it is envisaged to conclude a financing agreement with the partner country

4.2 Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is **60** months from the date of entry into force of the financing agreement.

Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

4.3 Implementation of the Budget Support Component – N/A

4.4 Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[26].

4.4.1 Direct Management (Procurement)

Contracts will be established for studies and analysis, etc. contributing to:

- Outcome 1 - Improved general leadership, governance and regulatory capacities of relevant Government ministries, Agencies and Departments (MDAs) including on gender issues, and in particular the following activity: Support the strengthening of research and vital statistics institutions targeting women's health and nutrition, support collection of disaggregated data. This will be done by researchers with extensive experience in quantitative and qualitative research, in order to allow evidence-informed policymaking.
- Contract to support Technical Working Groups, Coordination platforms and assessments or monitoring. This will be transversal and will contribute to the implementation of all the activities. Through this contract, a pool of experts can support both the implementing partners and the EU Delegation on specific technical issues, as well as the relevant MDAs on specific issues.
- If procurement under direct management as mentioned above fail, this aspect may be included in the indirect management with the entrusted UN agencies already identified and integrated as part of their activities.

4.4.2 Indirect Management with an entrusted entity

A part of this action may be implemented in indirect management with a lead UN agency such as UNICEF with UNFPA and others. This implementation entails policy support and improving access to comprehensive SRHR/RMNCAH+N services under Specific Objectives 1, 2 and parts of 3. UNICEF has been selected having been identified as the most reliable implementing partner to support a significant increase in administrative, programming and execution capacity.

The envisaged entity has been selected using the following criteria:

- Its experience in supporting and strengthening Health governance (leadership, legal framework, policies, etc.) of the health sector, the National Health Information System;
- Its role in coordinating partners, especially in fighting COVID-19.

[26] www.sanctionsmap.eu. Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

Close collaboration with other UN agency(cies) such as WHO, will ensure complementarity with related initiatives in the health sector, included those that will be promoted under the health component of the new regional programme focusing on health security along the One Health approach, sexual and reproductive health and rights, medicines regulation and availability, and the role of public health institutions.

If negotiations with the entrusted entity(ies) mentioned above fail, this initiative may be implemented in indirect management with similar structures, e.g. UN agencies or cooperation bodies that are positively pillar assessed. The implementation by these alternative entrusted entities would be justified by active engagement in the health sector with specific expertise in Sexual and Reproductive Health and Rights. The alternative entrusted entity(ies) would carry out the tasks initially entrusted to UNICEF and or UNFPA.

Exception to the non-retroactivity of costs
The Commission authorises that the costs incurred may be recognised as eligible as of 1/01/2023, a date prior to the adoption of this Decision because it is crucial that the development of this intervention is informed by a rigorous review of an evaluation of the previous programme for MNCH-N under the 11th EDF to establish some key indicator baselines, a political economy analysis of Nigeria, a security assessment, and a realistic successor plan with the previous implementing partner (UNICEF). Hence the need for preparatory work to begin much earlier than actual start of the intervention.

4.5. Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.6. Indicative Budget

Indicative Budget components	**EU contribution (amount in EUR)**
Implementation modalities – cf. section 4.4	44 000 000
Objective 1 composed of support to strengthen capacity for inclusion of SRHR/RMNCAH+N information and services in national (health) policies, strategies, plans and budgets	**11 000 000**
Indirect management with lead UN agency e.g. UNICEF cf. section 4.4.2	10 000 000
Procurement (direct management) – cf. section 4.4.1	1 000 000
Objective 2 composed of support to increase availability, utilisation and sustainable financing of integrated quality comprehensive SRHR/RMNCAH+N services at State, LGA and community levels	**22 000 000**
Indirect management with lead UN agency e.g. UNICEF cf. section 4.4.2	20 000 000
Procurement (direct management) – cf. section 4.4.1	2 000 000
Objective 3 composed of Support to increase knowledge and adoption of positive use of health information/data including SRHR and nutrition practices by women, adolescents and children	**11 000 000**

Indirect management with lead UN agency e.g. UNICEF cf. section 4.4.2	10 000 000
Procurement (direct management) – cf. section 4.4.1	1 000 000
Procurement – total envelope under section 4.4.1	4 000 000
Evaluation – cf. section 5.2 **Audit** – cf. section 5.3	**500 000**
Contingencies	**500 000**
Totals	**45 000 000**

4.7 Organisational Set-up and Responsibilities

A Steering Committee will be organised at least twice a year in order to review progress, analyse the results of the programme's implementation and to evaluate the need for adjustments. The steering committee will be formed by the EU Delegation, UNICEF, relevant MDAs[27] and another international UN agency (permanent members), and by observers –- who may contribute to discuss key operational issues and share information. Periodic internal monitoring and coordination meetings will be held by the partners responsible for implementing the programme with the support of technical assistance. Contract may be procured separately to support the EU Delegation and may act as the secretariat of the Steering Committee. In addition to the participation of the programme implementing agencies, participation in the Steering Committee meetings will be open to other partners active in the health sector in Nigeria.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission will participate in the governance structures set up for governing the implementation of the action.

4.8 Pre-conditions – N/A

5 PERFORMANCE MEASUREMENT

5.1 Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the logframe matrix.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

Monitoring and evaluation will assess gender equality results, an impact on rights of groups living in the m*ost* vulnerable situations and the implementation of the rights based approach working principles (applying all human rights for all; meaningful and inclusive participation and access to decision-making; non-discrimination and equality; accountability and rule of law for all; and transparency and access to information supported by disaggregated data). Monitoring and evaluation will be based on indicators that are disaggregated by sex, age, disability and area (*urban/rural)* when applicable. Indicators of changes in situation with health services for persons with disabilities will include those on inclusive information, removed barriers, inclusive services, trained personnel of health services, aids and others supports.

[27] Water, Sanitation and Hygiene (WASH)

Human rights and gender equality competence is ensured in the monitoring and evaluation teams.

Roles and responsibilities for data collection, analysis and monitoring:

The EU Delegation, national authorities and the implementing partners of the action will be jointly responsible for monitoring and reporting on indicators of the logframe matrix, including the collection of baselines and regular data collection, which can be supported by specific monitoring and evaluation missions. Data collection and reporting is under the responsibility of the implementing partners. Specific studies supporting data collection may also be funded under the regular budget of the action (budget lines grants or procurement). Active and meaningful participation of stakeholders in the Health sector, including their identification, will be sought, via regular exchanges with national authorities and civil society including to monitor aspects addressing inequalities.

5.2 Evaluation

Having regard to the nature of the action, a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission. It will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the fact that it will be necessary to verify, in particular, whether the Action has been able to strengthen the capacities of national authorities and civil society actors in a sustainable way.

The Commission shall inform the implementing partner at least 2 months in advance of the dates envisaged for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities. The evaluation reports shall be shared with the partner country and other key stakeholders following the best practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

The evaluation will assess to what extent the action is taking into account the human rights-based approach as well as how it contributes to gender equality and women's empowerment. Expertise on human rights and gender equality will be ensured in the evaluation teams including through the use of a Distributional Impact Assessment tool (DIA).

Evaluation services may be contracted under a framework contract.

5.3 Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle has adopted a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.

In line with the 2022 "Communicating and Raising EU Visibility: Guidance for External Actions", it will remain a contractual obligation for all entities implementing EU-funded external actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. This obligation will continue to apply equally, regardless of whether the actions concerned are implemented by the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, action documents for specific sector programmes are in principle no longer required to include a provision for communication and visibility actions promoting the programmes concerned. These resources will instead be consolidated in Cooperation Facilities established by support measure action documents,

allowing Delegations to plan and execute multiannual strategic communication and public diplomacy actions with sufficient critical mass to be effective on a national scale.

Appendix 1 REPORTING IN OPSYS

A Primary Intervention (project/programme) is a coherent set of activities and results structured in a logical framework aiming at delivering development change or progress. Identifying the level of the primary intervention will allow for:

Articulating Actions or Contracts according to an expected chain of results and therefore allowing them to ensure efficient monitoring and reporting of performance;

Differentiating these Actions or Contracts from those that do not produce direct reportable development results, defined as support entities (i.e. audits, evaluations);

Having a complete and exhaustive mapping of all results-bearing Actions and Contracts.

Primary Interventions are identified during the design of each action by the responsible service (Delegation or Headquarters operational Unit).

The level of the Primary Intervention chosen can be modified (directly in OPSYS) and the modification does not constitute an amendment of the action document.

The intervention level for the present Action identifies as (tick one of the 4 following options);

Action level		
☒	Single action	Present action: all contracts in the present action