Delivering on Nigerian Commitments for Women's, Children's and Adolescents' Health

Report on Mapping and Assessment of Commitments on Women's, Children's and Adolescents' Health

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ABBREVIATIONS AND ACRONYMS

ADF	Aliko Dangote Foundation
AHWB	Adolescent Health and Well Being
ANC	Ante-Natal care
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation
CAAP	Collaborative Advocacy Action Plan
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CHIPS	Community Health Influencers, Promoters and Services
COPASAH	Community of Practitioners on Accountability and Social Action in Health
CRA	Child Right Act
CRF	Consolidated Revenue Fund
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
ECOWAS	Economic Community of West African States
ENAP	Every Newborn Action Plan
EPMM	Ending Preventable Maternal Mortality
RMNCAEH+N	Reproductive Maternal, Newborn, Child, Adolescent, Elders Health and Nutrition
FMOH	Federal Ministry of Health
FP	Family Planning
Gavi	the Vaccine Alliance
GBV	Gender-Based Violent
GFF	Global Financing Facility
GHI	Gem Hub Initiative
GoN	Government of Nigeria
HERFON	Health Reform Foundation of Nigeria
HIV	Human Immunodeficiency Virus
HSRC	Health Sector Reform Coalition
HTPs	Harmful Traditional Practices
ICPD	International Conference on Population and Development
mCPR	Modern Contraceptive Prevalent Rate
MDA	Ministries, Departments and Agencies
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoU	Memorandum of Understanding
MSPCP	Multi-Stakeholder Partnerships and Coordination Platform
NAPTIP	National Agency for Prohibition of Trafficking in Persons
NDHS	Nigerian Demographic Health Survey
NEMCHIC	National Emergency Maternal and Child Health Intervention Center
NERICC	National Emergency Routine Immunization Coordinating Center
NGP	National Gender Policy
NHAct	National Health Act
NHIA	National Health Insurance Authority
NHP	National Health Policy
NNHS	National Nutrition and Health Survey
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NPP	National Policy on Population and Sustainable Development
PHC	Primary Health Care
PMNCH	Partnership for Maternal, Newborn and Child Health
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals

SOGON	Society for Obstetricians and Gynecologist of Nigeria
SPHCDA	State Primary Health Care Development Agency
SRHR	Sexual Reproductive Health Research
STI	Sexually Transmitted Diseases
TWG	Technical Working Group
U5C	Under-Five Children
U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USD	United States Dollar
V4M	Value for Money
VGC	Vulnerable Group Fund
VAPPA	Violence Against Persons Prohibition Act
VNDC	Vaccine Network for Disease Control
WCAH	Women Children and Adolescents' Health

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1. EXECUTIVE SUMMARY

Nigeria has over the years joined other countries and stakeholders to make commitments towards improving the health and well-being of women, children, adolescents and young people. Most of the commitments made by the Government of Nigeria (GoN) were crafted to align with global best practices and aim to deliver concrete and ambitious actions for the aforementioned population groups. Such commitments which are later highlighted in this document are designed to address the context-specific needs of mothers, children, adolescents, and young people.

These commitments were made at different global or regional or national platforms or fora. For example, the International Conference on Population and Development (ICPD25) Nairobi Summit in 2019 and Maputo Plan of Action 2016-2030 were platforms where commitments were made at the level of the African region. Others such as the General Assembly of the United Nations (SDGs) and Family Planning (FP) 2030 are global initiatives. These global and regional commitments created leverage for commitments documented in the various national policies and strategic plans such as the National Health Policy (NHP), National Gender Policy (NGP) and National Youth Policy (NYP) among others. The target years for each commitment differ to allow for innovative plans to support and complement the implementation efforts of government-led commitments and priorities. The highest target set for any of the commitments is year 2030 which coincides with the Sustainable Development Goals (SDG) targets.

Globally, Nigeria aligns with the SDG 2030, the third of which is to *"ensure healthy lives and promote wellbeing for all at all ages".* Also, the Global Strategy for Women's, Children's and Adolescents' Health contains sets of agendas for advancing RMNCAEH + N with the vision that: "*By 2030, a world in which every woman, child and adolescent in every setting realize their rights to physical and mental health and well-being, have social and economic opportunities, and can participate fully in shaping prosperous and sustainable societies".*

The Nigerian government made both financial and non-financial commitments. Relevant at the national level is Section 11 of the National Health Act (NHAct) 2014 which has mandated that one percent of the country's Consolidated Revenue Fund (CRF) be assigned to provide Basic Minimum Package of Health Services. The National Health Policy (NHP) 2016 also provide clear guidance for the implementation of the health Act. Other financial commitments at the national level is that of the FP 2030 which pledged to allocate at least one percent of the annual National and State health budget to Family Planning (FP) - aimed at mobilizing domestic resources, and/or catalytic donor financing. Also, some commitments have been made in the area of policy development towards improving the reproductive and sexual health of vulnerable groups especially mothers, and adolescents e.g. the National Policy on Population for Sustainable Development (NPP**)**. In terms of providing relevant and adequate services, the GoN committed to strengthening and expanding programs to meet the needs of these vulnerable groups while promising improved access to quality services. Almost all of the government's commitments are guided by these three thematic areas – financial, policy, and improving service delivery. Although a range of institutions oversee laws and policies intended to achieve each commitment, federal and state funding is

chronically inadequate to meaningfully address most of these issues. The commitments extracted from the reviewed relevant Nigerian policy documents and plans also fundamentally consider the availability of finances to achieve set targets.

In Nigeria, both government and partners are aligned in the need to improve investment in Reproductive Maternal, Newborn, Child, Adolescent, and Elder's Health and Nutrition (RMNCAEH+N). Key strategic documents that guide Nigeria's health sector and the implementation of the abovementioned commitments include the NHAct 2014, National Health Policy (NPC) 2016 and the National Strategic Health Development Plan II (NSHDP) developed in 2017. Furthermore, there is a newly revised National RMNCEAH+N Strategy (yet to be published) and another document focusing on Quality of Care (QoC) on RMNCEAH+N among others. The NHAct 2014 defines the relationship between various tiers of government and provides a framework for standards and regulation of health services. The NHP identifies priority goals of reducing "maternal, neonatal, child and adolescent morbidity and mortality in Nigeria, and promote universal access to comprehensive sexual and reproductive health services for adolescents and adults throughout their life cycle. The NSHDP II breaks down the policy more to be better understood and implementable.

The purpose of this scoping and assessment exercise was to map commitments made by the GoN related to women's, children's, and adolescents' health (WCAH) issues namely in the areas of Maternal, Newborn, and Child Health (MNCH), Sexual and Reproductive Health Rights (SRHR), and Adolescent Health and Well-being (AHWB), as well as to analyze the quality and implementation status of the commitments themselves. Overall, from the scoping analysis of the commitments, a total of 148 commitments have been documented in this report under the three thematic areas. Under the MNCH, a total of 59 commitments were analyzed most targeting improving high quality services for mothers, newborn and child with focus to reduce mortality rate, improve immunization coverage and nutritional status. Other commitments in this domain include targeting MNCH intervention embedded into UHC and strengthening health system to improve the lives of mothers and children. Findings show that the highest investment was made by the GoN in terms of financial, policy, and quality of service on issues relating to MNCH including emergency obstetric and newborn care, immunization and nutrition.

For instance, as part of MNCH commitment, the GoN committed to increasing its co-financing obligation on immunization and vaccine procurement with other development partner (such as Gavi and UNICEF) to 60% by 2024. Between 2019 to 2023, this financial commitment was only fully released in 2022. An assessment report shared with stakeholder in November 2023 showed that the 69 billion naira budgeted for vaccine procurement had not been released for same year.

For the second classification – SRHR, a total of 61 commitments were analyzed in this report. Some of the commitments focused on access and choice of effective contraception methods starting from financial pledges made at global and national level. For example, the GoN pledged in 2018 to increase from 3 million USD to 4 million USD annually the allocation for procurement of modern contraceptives. Implementation of this commitments has been generally poor just as in the previous years. Between 2012 and 2016, the Federal government fulfilled only 11% of its FP2020 pledge to provide 3 million USD annually for the procurement of FP commodities.[1] Nigerian government has not also been consistent with releasing pledged fund for FP since 2018. However, as a result of advocacy efforts by stakeholders, a new

[1] Jurczynska K. Evidence and Advocacy: Unlocking Resources for Family Planning in Nigeria: Palladium, HP+; 2017

budget line targeting procurement of FP commodities was recently approved in the FMoH 2024 appropriated budget.

While there are no specific commitments towards providing legal abortion services under the SRHR, the GoN subscribed to ending unintended pregnancy and unsafe abortion in the Maputo Plan of Action. Reducing sexual and Gender Based Violence (GBV) and harmful practices against women and girls is another aspect of SRHR that Nigerian government committed to. In terms of policy and laws, the passage of some legislation at federal and state levels suggests some progress in addressing GBV of various kinds especially physical and sexual violence. The Violence Against Persons Prohibition Act (VAPPA), 2015 has been enacted by the federal government, so also the Child Right Act (CRA) 2003 which guarantees the rights of every child in Nigeria. As at 2022 November, 32 States have adopted the CRA, while 34 have so far domesticated the VAPPA, to help in reducing cases of GBV in Nigeria.[2] However, there is still rise in reported cases of GBV in Nigeria as implementation is generally inadequate across the country. A key gap in the VAPPA is that it lacks preventative measures that would help address the root causes of violence against women. A key gap in the CRA is its lack of alignment with the Nigerian Constitution regarding minors and marriage; for example, the Constitution states that a child is an adult after marriage, regardless of age, but the CRA puts the age of marriage at 18 years.

The third thematic area focuses on AHWB. Adolescents are aged 10-19 years and are usually grouped into young (10-14 years) and older adolescents (15-19 years). Commitments made by the GoN were reviewed for quality and implementation towards availability of national policy and programs for adolescent well-being and national standards for delivery of AHWB information and services. There are specific gaps in some of the commitments made un AHWB. Some of the commitments do not have a defined timeline for achievement. Also, while commitments were specific for adolescents, most are not adequate for younger adolescents and no specific strategies and plans to execute some of the commitments. This area has the least attention from the government at the national and subnational in terms of policy, financing and services provided.

Generally, findings of this report shows that the implementation of most commitments made by the Nigerian government are hampered firstly, by poor budget allocations and weak performance in terms of releases of budget allocations. Secondly, reliance on donor funding and services within the health sector space has consistently slowed down implementation towards achieving set targets. Most health interventions in Nigeria are donor-driven, which is very risky for the country as funding from donor agencies continue to dwindle due to donor fatigue. Thirdly, there is poor political will to adapt and adopt some of the key commitments at the subnational levels including States and Local Government Areas (LGA), where implementation of health polices and guidelines is carried out. Relevant policies and implementation guidelines have been provided at the federal level; however, some States have not adequately domesticated the documents. Since there are variations in socioeconomic status, belief system and geographical locations etc, policies and guidelines need to be localized and adopted at subnational levels. There is therefore an urgent need for the GoN to take more seriously the implementation and quality of service of all the commitments made as there seem to be good progress in policy formation.

This scoping and assessment exercise was coordinated by Africa Health Budget Network (AHBN) with support from the Partnership for Maternal, Newborn, and Child Health (PMNCH), the world's largest

[2] https://www.partnersnigeria.org/childs-rights-law-tracker/

alliance for the global strategy for women, children, and adolescents, made up of both state actors and non-state actors. PMNCH has over the years helped to amplify various commitments made by countries across the world. The non-state actors especially the Civil Society Organizations (CSOs) have been playing a supportive role by setting up advocacy campaigns and generating attention for more government investment to the commitments. For example, recently, due to advocacy efforts of some stakeholders in Nigeria, 'elders' are also being considered and included among vulnerable groups. With knowledge of these commitments, CSOs have continued to consolidate their efforts by working with PMNCH partners to analyze the current strengths and gaps of the various documented commitments made by the federal Government of Nigeria (GoN).

The results of the scoping exercise will be captured within the PMNCH digital 'Commitment Compendium' for easier access to partners and the public. Overall, the results of the scoping and assessment exercise will harness partners' efforts more effectively and deepening accountability of governments for WCAH commitments made in the context of national, regional and global pledging platforms, through the development of a Collaborative Advocacy Action Plan (CAAP).

2. BACKGROUND

Nigeria is the most populous country in Africa, and this large population with over 250 ethnic groups has remarkable diversity. Although accurate census data is lacking, the country has a high population growth rate at 2.4%, which is sustained by high fertility at about 5.2 children per woman according to NDHS 2018. Notable is the population of young people which is highest in the world with a median age of 18.1 years. About 70 percent of the population are under 30 years, and 42 percent is under the age of 15 years.[3] Percentage of female population in Nigeria was reported at 49.46 percent in 2022, according to the World Bank collection of development indicators. The youths, women and girls/adolescents form majority of the vulnerable population.

Nigeria made modest progress on key RMNCAEH-N outcomes in the last decade although the achievement is not strong enough for the country to meet the SDG 3 target. One of the key challenges is inequality in access to services due to variations in socioeconomic status and geographical locations. The National Demographic Health Survey (NDHS) of 2018 showed a marginal reduction in Maternal Mortality Ratio (MMR) from 576 in 2013 to 512 deaths per 100,000 live births. Similar improvement was also reported in the Infant Mortality and Under-5 Year Mortality Rate (U5MR). There were also small-scale improvements reported for the Total Fertility Rate (TFR), contraceptive uptake, Skilled Birth Attendant (SBA) coverage, Penta 3 coverage and measles immunization coverage. However, the neonatal mortality rate remained persistently high at 39 deaths per 1,000 livebirths (NDHS 2018) higher than the 2013 result (37). According to NDHS 2018, 37% of Nigerian children aged 6-59 months are stunted, 7% are wasted, 22% are underweight.

More recent data, according to the Multiple Indicator Cluster Survey & National Immunization Coverage Survey (MICS/NICS) 2021/22, Nigeria's neonatal mortality rate is 34 per 1,000 live births and U5MR is 102 per 1,000 live births. There has been progress also in the national immunization coverage, Penta 3 coverage is nationally at 57 percent lower than the African region average of 72 percent, despite this improvement, Nigeria has the highest number of zero dose children in Africa. About 60.4 percent of

[3] https://theconversation.com/nigerias-growing-population-can-be-an-advantage-with-better-data-and-a-policy-focus-on-young-people-209530

women made at least four antenatal care visits (ANC) to care providers. With inflation and a poor economy, the nutrition of several households is also being greatly affected and this reflects more negatively on children.

Considering the SRHR and AHWB approaches, while the fertility rate is known to be relatively high and a very youthful population bulge in Nigeria[4], the national birth rate for adolescent girls between the age 15-19 years is high at 75 births per 1,000 women. According to MICS 2021, this rate is 25 times higher for women with no education and eight times higher for women from poor households of the country. For example, Nigeria is currently not on target to meet SDG 3.7.2 indicator under target 3.7: *By 2030, ensure universal access to sexual and reproductive health-care services including Family Planning (FP), information and education, and the integration of reproductive health into national strategies and programs*. The current scenario and resulting challenges which a country like Nigeria is facing, will be effectively addressed if FP is strengthened and prioritized as a national development agenda, with strong leadership commitment and funding at all levels. There is therefore need to take sexual and reproductive health more seriously especially among adolescent girls and young women of 15-24 year in which about 8.4 percent of them reportedly had sex before age 15 years in Nigeria (MICS 2021/22).

Health is on the concurrent legislative list in the country's constitution, meaning that both federal and State governments can legislate on health issues. Laws are mostly implemented at the subnational levels (States and LGAs), thus domestication at the subnational level is a necessary precondition for a law to be implemented, and is often a critical gap in the legal framework. National-level offices oversee State agencies; these stakeholders guide policy direction and capacity development activities. Various agencies and departments have also been created under relevant Ministries to drive policy implementation across the country. For example, the National Primary Health Care Development Agency (NPHCDA) and National Health Insurance Authority (NHIA), both under the Federal Ministry of Health (FMoH) were established to drive policy implementation around MNCH and some parts of SRHR while working towards Universal Health Coverage (UHC). Thus, implementing the NHAct, NHP, BHCPF guideline and NHIA Act is critical to achieve expected results. The Ministry of Women Affairs implements the National Gender Policy (NGP) 2007. The National Agency for the Prohibition of Trafficking In Persons (NAPTIP) has been active at the national level in the area of Gender Based Violence (GBV) and in the implementation of some relevant policies and Acts such as the CRA and VAPPA.

The Government of Nigeria has therefore made commitments towards Women's, Children's and Adolescent's Health (WCAH) issues in relation to national, regional and global pledging platforms to accelerate progress. In order to harness partners efforts more effectively and deepening accountability of governments, PMNCH and partners will focus on prioritizing advocacy and accountability actions for existing WCAH-related commitments. They will also focus on identifying gaps and advocating for bold, ambitious, and new commitments, where these are needed (such as in the domain of AHWB). PMNCH has now established the Collaborative Advocacy Action Plan (CAAP) initiative to implement the revised approach to commitments and accountability. Under this initiative, PMNCH developed guidelines for commitment mobilization and accountability on WCAH. This guide classified the various commitments into three namely Maternal, Newborn and Child Health (MNCH), Sexual and Reproductive Health Research (SRHR) and Adolescent Health and Well-Being (AHWB).

[4] Aaron O'Neill (2023), Statista - Fertility Rate in Nigeria from 2011-2021; https://www.statista.com/statistics/382212/fertility-rate-in-nigeria/

In most settings, including in Nigeria, maternal, perinatal and child health data and indicators are the most sensitive reflectors of the general health status, wellbeing, and the health system performance of a population. Decades of mortality reduction for women and children are now under threat of reversal due to the toxic combination of COVID-19, conflict and climate change. Women, children and adolescents bear a disproportionate burden in crises effected contexts. This grim context necessitates that partners collaboratively support governments to implement national WCAH commitments.

The scope of this assignment is mainly to assess what the federal government of Nigeria has committed to over years in the area of maternal, child and adolescent health and wellbeing and overall reproductive and sexual health and rights. The main purpose of this assignment is to gather and extract information on the implementation of existing national WCAH commitments made by the Nigerian government. This will be submitted and captured within digital 'Commitment Compendium' and made easily accessible to all partners for their knowledge and follow-up action. This scoping and assessment report will be used to inform the collaborative advocacy efforts of partners in the country. This compilation of commitments through the scoping is also intended to give visibility to partners about the areas in which the government has promised action and a starting point for partner-led advocacy actions for accountability. The revised PMNCH guideline developed by partners for commitment mobilization and accountability on WCAH is to precipitate progress towards achievement of national WCAH goals and objectives.

African Health Budget Network (AHBN) is an indigenous organization that has been engaging with the government and other stakeholders for years. Its main purpose is to advance and embed improvements in health budget allocation, spending, transparency, participation, and accountability aimed at increasing greater investment in health and wellbeing. AHBH hosts the global secretariat of the Community of Practitioners on Accountability and Social Action in Health (COPASAH), a global south bottom-up accountability peer learning network. Also, member of the FP2030 CSOs' Accountability Advisory Group and member of PMNCH since 2014 and currently sits on its Board of Champions and a member of its Partners in-country Engagement committee.

As a member of the RMNCAEH+N Multi-Stakeholder Partnerships and Coordination Platform (MSPCP), AHBN influences finances on RMNCAH+N with experience in supporting CSOs in Nigeria and other African countries such as Sierra Leone, Liberia, Ethiopia etc. The organization also support members to take forward advocacy and monitoring of financial commitments made within existing accountability platforms at national and regional levels. With the experience in assessment of this kind, AHBN equally participated in several official government events where some commitments were announced and launched such as;

1. Nigeria Government Commitment Statement for Adolescent Well-Being in SDG Priorities (Local Launch of the Global Forum for Adolescents).
2. Nigeria FP2030 commitment launched.
3. Nigeria RMNCAEH+N Strategy Finalization Meeting from 16th to 20th October 2023.
4. Desk Review of existing commitments. (Websites)

For all the documents reviewed, the Nigerian federal government through the relevant Ministries, Departments and Agencies (MDAs) is responsible for ensuring that necessary actions are taken on these commitments. However, the States and LGAs has a strong role to play in ensuring implementation of the commitments across Nigeria.

3. METHODOLOGY

There was desk review of relevant documents where Nigerian government made commitments and set targets on issues related to RMNCEAH-N. Some of these include policies documents, strategic plans, declarations and other globally or regionally recognized commitments. Classification of the government's commitment was carried out according to the PMNCH guideline for country's commitments mapping and assessment as shown in the table below:

MNCH	SRHR	AHWB
High-quality MNCH services for mothers, newborns and children • ANC • Postnatal care • Prevention of still birth • Breastfeeding and child nutrition • Immunization services • Emergency obstetric care • etc	**Access and choice to effective contraception methods (family planning).** ● FP ● Comprehensive sexual health education (CSE) **Inclusion of essential packages of SRHR interventions within UHC and PHC schemes,** ● Coverage of all essential SRH interventions ● Out-of-pocket expenditure for SRH	**National policy and programs for adolescent well-being (10-19 years)** ● Provision of quality education and training opportunities ● Health education ● Nutrition ● Pregnant adolescent support ● Financial protection for adolescent health
MNCH interventions embedded in UHC schemes, including MNCH financing • UHC scheme • Country health expenditure per capita on MNCH financed from domestic sources	**Access to safe and legal abortion services.**	**National standards for delivery of AHWB information and services to adolescents,** Health services for adolescents – user fee exemptions for health services (contraceptives, immunizations)
Country health expenditure per capita on MNCH financed from domestic sources • Data & accountability • Health workforce & Training • Health information systems • Health system financing • Leadership and governance • etc	**Prevention and treatment/referrals for Sexual and Gender-Based Violence** ● Legal mechanisms for addressing GBV ● Training and support for health workers on GBV ● Violence against women and girls including intimate partner violence	**Legal systems to protect the rights of adolescents (both female and male)** ● Legal provisions against child marriage ● Interventions to eliminate female genital mutilation ● protection from violence (including physical, sexual, GBV, electronic violence
Intersectoral approaches for MNCH across the life-course, ● Nutrition ● Education ● Shelter ● WASH facilities and services ● Social protection ● Child Protection ● etc	**Prevention, detection and management of reproductive cancers, especially cervical cancer.** ● Cervical cancer screening programs ● HPV vaccine programs	**AHWB is embedded in national policies and plans with dedicated financing for AHWB programs**

AHBN used its existing relationship and partnership with key government MDAs, and development partners to obtain the documents where commitments were extracted. These commitments were then listed and categorized into three – Global, Regional and National as shown in Annex 1.

In Annex 2, quality of commitment in terms of Policy and Technical Considerations and progress made on implementing the commitments were scored using defined color grades.

Interviews were also done to seek specific clarifications as needed. Some of the stakeholders contacted to provide feedback which enriched the scoping process are as follows:

- The Coordination Unit, Department of Family Health, Federal Ministry of Health.
- Global Financing Facility (GFF) Liaison Officer, World Bank, Nigeria
- National Population Commission (NPC)
- NGOs at the CAAP Inception Meeting convened by AHBN (Education as a Vaccine, Vaccine Network for Disease Control, Gem Hub Initiative, Health Reform Foundation of Nigeria, Health Sector Reform Coalition, Association of Women in Trade and Agriculture etc.)

The methodology used in scoring the status of commitment was prescribed in the PMNCH's Guide for Country's Commitment Mapping and Assessment. As part of the assessment process in the guide, the commitments were analyzed based on two major classes – (a) Quality and (b) Implementation status. In other words, are the commitments of adequate quality to significantly improve WCAH? What is the current implementation status of each commitment made by the GoN?

The quality of the commitments was assessed from the policy and technical point of view. Policy consideration is the extent to which a commitment is strategic, equitable, relevant and inclusive while technical consideration measures the extent to which a commitment is specific, measurable, time-bound and represents good value for money (V4M).

The other consideration was used to assess the extent to which the commitments were implemented. This is in terms of if the commitment has been made operational, if implementation is linked to an institutionalized accountability process and if progress is being documented.
The scoring categories of the quality assessment was 'Very Good', 'Good', 'Average' and 'Poor' with different color grades.

- 'Very Good' *means that commitment meets all quality requirements of strategy, equitable, attainable, relevant and inclusiveness. It also means that it is technically sound in terms of being specific, time bound and with value for money (V4M)*
- 'Good' *means that means that commitment meets part of the quality requirements of strategy, equitable, attainable, relevant and inclusiveness. It also means that it is technically sound in terms of being specific, time bound and with value for money (V4M)*
- 'Average' *means that means that commitment meets about half of the quality requirements of strategy, equitable, attainable, relevant and inclusiveness. It also means that it is technically sound in terms of being specific, time bound and with value for money (V4M)*
- 'Poor' *means that means that commitment meets a minimal part of quality requirements of strategy, equitable, attainable, relevant and inclusiveness. It also means that it is technically sound in terms of being specific, time bound and with value for money (V4M)*

For the implementation status, the categories used were 'On-track', 'Moderate', Insufficient Progress and 'No Progress'. While similar color grade was used for the four categories, the commitments with no color means 'No Data Available'

- 'On-track' *means that the commitment has been made operational, linked to a formal/institutionalized accountability process and progress well documented*
- 'Moderate Progress' *means that the extent in that the commitment has been made operational, linked to a formal/institutionalized accountability process and progress well documented is average*
- 'Insufficient Progress' *means that the extent in which the commitment has been made operational, linked to a formal/institutionalized accountability process and progress well documented is quite low*
- 'No Progress' *means that there is no tangible or appreciable progress in the extent that the commitment has been made operational, linked to a formal/institutionalized accountability process and progress well documented*

Categories of scoring imply that the implementation progress is in line with major milestones indicated in PMNCH Guide.

4. FINDINGS

Commitment of the FGoN in relation to PMNCH Platform

The PMNCH platform provides guidance for easy tracking of government's commitments through the classification into MNCH, SRHR and AHWB. The GoN has always endeavor to align herself with global best practice by subscribing to relevant commitment that is believed to bring better outcomes to the health and wellbeing of women, children and adolescent. Under the three areas of focus, a total of 148 commitments were reviewed and documented in this report. The GoN made series of commitments (59) targeting provision of high-quality MNCH service packages of care include emergency obstetric and newborn care, and the prevention of stillbirths, antenatal care and postnatal care, including nutrition and immunization etc. A total of 61 commitments were assessed for SRHR focusing also on the different area of interest such as FP, GBV, sexual and health education cancer screening and management, out-of-pocket expenditure for SRH etc. Specific for adolescent health and well-being was 28 commitment recorded, the assessment of the national policies and programs in the public sector, offering information and services and dedicated financing on health, education including Comprehensive Sexuality Education (CSE), nutrition, financial protection, and vocational training.

Some of the commitments are similar with different targets timeframe, however, the farthest year was 2030 aligning with the SDGs. Just as Nigeria did not meet most of the Millenium Development Goals, it is unlikely that most of the commitments are met based on the current implementation status.

Assessment of quality of key commitments

Generally, the federal government of Nigeria has learnt, over the years to collaborate with stakeholders especially development partners in the development of relevant policies, strategic plans and legislations. Therefore, designing good quality policy documents has been possible since various stakeholders are involved. In terms of policy considerations, the federal government performed very good in making available quality policies and strategic plans which could lead to the expected outcomes especially under MNCH and SRHR. Some of the state governments have also adopted the NHAct and the domesticated

the health policy. Action plans are also being developed routinely with the involvement of development partners to guide conduct of planned activities.

The FMoH has also been responded to advocacy efforts and global call to invest in SRHR especially access and choice to effective contraception methods (family planning). In terms of policy and guideline, the FMoH has incorporated FP into most health documents including the recently revised RMNCEAH+N strategy and as one of the services to be provides through the national and state insurance scheme. In addition, the GoN has aligned with global and regional commitment in the SDGs, the Generation Equality Forum and Maputo Plan of Action to mention a few on prevention and treatment/referrals for sexual and GBV. The federal government has developed the Child Right Act and the Violence Against Persons Prohibition Act (VAPPA) 2015 and most states have domesticated the Act. Implementation of this Acts at the national level is ongoing especially through NAPTIP, however could not be determined at subnational level.

However, despite improved qualities of policies, implementation is not sometimes backed by the Nigerian's constitution. There are areas which quality of policy are inadequate in the area of aligning with the beliefs and tradition of the people. For example, consultations with stakeholders are needed for specific areas around SRHR (gender-based violence, birth control and abortion) and adolescent rights and wellbeing.

Assessment of implementation of key commitments

In Nigeria, some of the strategies designed to implement planned activities of commitments made by the government are active only at the national level. However, implementation is carried out mainly at the subnational levels. Health of women, children and adolescents are not on the exclusive list of the federal GoN. The state government and LGA has much to do in ensuring implementation guidelines are well designed to work in their localized environment. Implementation approach at subnational has to consider various factors such as culture, religious beliefs, terrain, population density and political structure. Failure to properly domesticate available national policies and guidelines is one of the banes of Nigerian system.

Inadequate funding has also been noted to be one of the main factors affecting implementation. The FMoH and its state counterpart have huge support from development partners for MNCH and some aspect of SRHR both in cash and in-kind. The support or contributions by some partners are made in a way to compel the government to pay counterpart fund before such partners' fund could be used. The immunization basket fund in some Northern states or the vaccine co-financing fund between Gavi and the FMoH are good examples. The federal also ensures counterpart fund contribution by the state government with BHCPF implementation. Although there remains huge funding gap despite this effort from partners. Overall, MNCH interventions still gets the greatest attention and highest domestic financing when compared to SRHR and AHWB.

Moreover, the government has done relatively well in the inclusion of essential packages of SRHR interventions in health. While good progress has been recorded in the quality and technical consideration of available policies and plans. implementation is mostly affected by inadequate of fund and weak political will. The FMoH has mostly failed in its commitment to released pledged counterpart fund of four million USD per annum for procurement of FP commodities. Most state governments are also not interested in allocating fund for FP especially since they get national commodity supply mostly funded by development

partners such as UNFPA. Although, these commodities are mostly inadequate, a bigger problem is that adolescents and women seeking for FP services have to spend out-of-pocket for medical consumables which should have been made available by the states.

Below are the documents from where commitments made by the federal government of Nigeria were retrieved and analyzed as shown in the tables - Annexes 1 and 2.

a. FMOH Family Planning (FP) 2030 Commitment

The FP 2030 is a global initiative committed to using FP to advance global health, support gender equality and develop thriving countries. It is the successor of FP2020 which ran from 2012-2020 in which target set by Nigeria could not be met. The Nigerian government envisioned that *by the end of 2030, everyone, including adolescents, young people, population affected by crisis and other vulnerable populations, can make informed choices, have equitable and affordable access to quality family planning, and participate as equals in society's development.* Nigeria made a total of eight commitments each with clear set strategies and planned activities to achieve the commitments.

The FP 2030 commitments were made with specific objectives and well-defined strategies to better integrate FP in the development space, increase FP access and choice, reduce stock-out rate of FP commodities and mobilize more resources for FP. Furthermore, commitments were made towards emergency response of modern FP services. With the rapidly growing population, advocacy to the national and sub-national governments has increased in recent time to prioritize FP as it affects the socio-economic development of the country. The use of modern contraceptive is still low as FP services are usually not accessible or acceptable by majority of households especially those in the rural areas.

Aside plan to strengthen integration of FP into Nigeria's socio-economic development frameworks, one of the key commitments made by the GoN in the FP2030 is to improve financing for FP by allocating a minimum one percent annually of the national and state health budgets. If this commitment on financing is well implemented, others such as strengthening national FP supply chain with a view to reducing stock out rates below 20% will easily be achieved.
Generally, at national and subnational levels, key activities, especially procurement of FP commodities, is very donor-driven, which is very risky for the country as funding from donor agencies continue to dwindle due to donor fatigue. For instance, between 2012 and 2016, the federal government fulfilled only 11% of its FP2020 pledge to provide 3 million USD annually for the procurement of family planning commodities. GoN committed $4 million annually to family planning at the London Summit 2017. This is $1 million beyond the initial $ 3 million commitment before this period. The only known release of this $ 4 million commitment was made in 2023 with BMGF fund released to the government as a grant to support BHCPF. According to a 2022 report, Nigeria needs to domestically invest 35 million USD every year to address FP gaps but only 50,000 USD was allocated for FP in the national budget in 2022[5]. This issue has been linked to poor political will and inadequate awareness of policy makers on FP. Recently in the FMoH appropriated budget for 2024, a specific budget line for counterpart contribution for FP commodities was created. Although the one percent of health budget envelop promised was not allocated, this is considered by health advocates a huge stride towards achieving FP2030 commitments. However,

[5] https://www.voanews.com/a/funding-gaps-patriarchy-hinder-family-planning-in-nigeria/6854345.html

this win needs to be domesticated at the subnational levels. (states and LGAs) to increase FP access and choice from 12% mCPR 27% by 2024.

Furthermore, the FMoH in collaboration with development partners have developed the National Guideline for the Integration of Family Planning into Comprehensive Primary Healthcare and National Health Insurance in Nigeria in February 2024. Although this is yet to be published, this guideline attends to several of the strategies in the FP 2030 commitment document, and if adopted will support implementation at the subnational levels. Integrating FP and PHC will help increase mCPR and provide policy-driven and enabling environment for uptake especially in rural and poor communities across Nigeria.

The GoN needs to take the commitments in the FP2030 document seriously to reduce the high fertility rate and even the high MMR which characterizes the country's national surveys. In fact, the lifetime risk of a Nigerian woman dying during pregnancy, childbirth, postpartum or post-abortion is 1 in 22, in contrast to the lifetime risk in developed countries (1 in 4900)[6]. FP contributes to reducing the number of births that expose women to mortality risk and helps to prevent sexually transmitted diseases, mis-timed/unplanned pregnancies, high-risk pregnancies and unsafe abortion (especially among adolescents and unmarried)[7]

Other policies which align with the commitments of the government in FP include the national private health sector engagement strategic plan for family planning services (2020); Nigeria Postpartum Family Planning strategic and implementation plan 2020 – 2023; Nigeria Family Planning Blueprint (Scale Up Plan), 2014 (Updated for 2020-2024) among others. Nigeria with diverse cultures and complexities needs to strategize her methodologies in implementing these polices. When relevant policies and guidelines are developed at the national level, the need to domesticate them before implementing at the subnational is critical. In some states, implementation becomes cumbersome as it does not consider certain factors – culture, religious beliefs, terrain etc. of the people before being rolled out. Since the community-based distribution of family planning began in Nigeria, it has been adopted as part of the national policy for improving access to family planning.

The Nigerian government recognizes that increasing access to family planning services is crucial to improving maternal and child health, reducing poverty, and promoting economic growth. This has made Nigeria through the department of health promotion, FMoH

Available policies and plans define what is meant to be achieved in terms of FP services and other SRH rights. These strategies align with the best practice recommended by the WHO and the SDG 3 and 5.

b. National Policy on Population for Sustainable Development (NPP) – Revised (2021)

After the first National Policy on Population for Development (NPP) in 1988 which sought to integrate population dynamics into national development, revision was necessary in 2004 and another in 2021 because of some emerging national, regional and global trends and development. Some of the trends include the MDGs and later SDGs, Nigeria economic Recovery and Growth Plan 2017-20 and increased level of migration and crisis. The goal of the NPP 2021 is to improve the quality of life and standard of living of the people by promoting RMNCEAH+N and achieve a moderate population growth rate through voluntary fertility regulation and empowerment of women and youths. The timeline for the 21 main targets in the NPP is year 2030, however, only about 15 of the commitments are related to the PMNCH

[6] www.joghr.org/article/12733-reducing-maternal-mortality-in-nigeria-addressing-
[7] www.healthpolicyplus.com/archive/ns/pubs/hpi/Documents/

classifications of commitments. The NPP states the roles and responsibilities of every relevant MDA, private sector, religious /traditional leaders, legislatures and the CSOs among others

Nigeria is still faced with the major challenge of maintaining an up-to-date and accurate population database after the last census conducted in 2006. Population dynamics is also critical as Nigeria has one of the world's highest fertility rates and population growth. The implication of this is that it puts constraints on the government to fulfill the overall goal of the NPP. The target set in this policy aligns with what the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) promotes.

Specifically, the revised NPP addresses the inter-relationship of population, the environment and the socio-economic factors. It also addresses reproductive health and rights, FP and fertility management including ageing and nutrition. The federal government is to provide one PHC per Ward and implement PHCUOR policy to achieve UHC by 2030. The NPP has nine principles one of which is that Government shall recognize the needs of young people and make appropriate provision for their growth and development and meaningful participation in national development including provision of enabling environment.

Among other commitments, the NPP focuses on reducing mortality rate of neonates, under-fives and mothers with an overall aim of achieving UHC of 75% by 2030. Judging from other countries with higher UHC, it is difficult to achieve progress without a strong and reliable health insurance scheme which covers majority of the population. Nigeria, with only about three percent (3%) insurance coverage, in 2023 enacted the NHIA Act making health insurance compulsory for all Nigerian citizens and with provision for Vulnerable Group Fund (VGF) targeted to provide basic minimum package of health for women, children and adolescents. However, implementation of the Act has not begun. These commitments also align with the National Health Policy (2016). National Reproductive Health Policy (2017) and the National Strategic Health Development Plan (NSHDP) II (2018 – 2025). All the above documents emphasized government's plan and strategies to towards achieving better outcomes in WCAH.
One key commitment that could unlock the best result for other commitment in the NPP is the *increase antenatal care (ANC 4 visits) rate from 57% to 72% by 2025 and 87% of every pregnant woman per community by 2030*. Although WHO has reviewed the preferred number of ANC visit to eight to improve quality of care, reduce the risk of stillbirths and pregnancy complications and give women a positive pregnancy experience[8] In Nigeria, there is gradual increase in health seeking behavior by pregnant women to receive ANC at least four times and save the lives of both mother and child. However, the progress is generally slow especially among non-educated pregnant women in rural communities. Also, there is no are enough functional PHC facilities due to poorly-equipped health facilities with constant commodity stockout for ANC to encourage utilization. Government's effort to encourage visits is inadequate as mostly, partners support most of the community sensitization and behavior change initiatives. There is poor accountability on government's investment and low allocation of fund to health promotion. The government has tried to improve sensitization by partnering with development partners to conduct community sensitization/ education through the CHEW / CHIPS and provide needed supportive supervision in the PHC. However, this has only been implemented in very small geographical areas. The challenge with Human Resource for Health (HRH) is also low especially in rural areas as most health workers are hardly motivated to work. There is also issue of insecurity in some areas causing outright facility close down and thereby affecting provision of ANC. With high poverty level, many women are

[8] https://www.who.int/news/item/07-11-2016-new-guidelines-on-antenatal-care-for-a-positive-pregnancy-experience

unable to afford transport, scan, drugs (if not made provide free). there should be enforcement or policy emphasize more on compulsory sensitization by relevant MDAs including NOA.

The FMoH commenced the implementation of BHCPF in 2019 to improve the functionalities of some PHCs across the country. At least one facility per Ward has been receiving direct financing from this fund to ensure better implementation. One of the main challenges is that the subnational level especially the LGA is responsible for the Human Resource for Health (HRH) as some facilities lack Skilled Birth Attendant (SBAs) to attend to clients. Available functional PHCs with trained health workers usually situated in urban or sub-urbs have higher ANC visits that increase the likelihood of timely detection of danger signs in pregnancy. With at least four contacts with a skilled health worker, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus. So far in Nigeria, this commitment is adequate with good quality in terms of policy and technical considerations. The likelihood of a women having health facility delivery by a Skilled Birth Attendant (SBA) is higher if she has at least four ANC visits. Thus, this is likely to reduce MMR and negative health effects on children. ANC has been embedded into all MNCH documents in Nigeria and routine data is available for this variable on the DHIS 2. The FMOH is about to roll out a new initiative where some PHCs will receive funding directly from the NPHCDA without passing through the state. This is to improve accountability process within the PHC system. Furthermore, a woman's 'contact' with her antenatal care provider should be more than a simple 'visit' but rather the provision of care and support throughout pregnancy. It has been reported that many of the care providers are not adequately skilled or trained when they are available. In several PHC across the country, there are no working tools or equipment for some of the trained frontline health workers. These challenges occur more in rural areas where supervision do not occur regularly.

Also, provision of HIV testing and medications to prevent mother-to-child transmission of HIV and prevention of malaria in both mother and fetus in Nigeria where the disease is endemic is critical and there will be reduction in the risk of low birth weight.

c. National Youth Policy (2019 -2023)

The National Youth Policy was developed to improve the general wellbeing and health of young people. Fostering the health development of youth through appropriate health systems and supportive social sector actions and health-related behaviors is critical for youths. The leading health challenges among youths in Nigeria are in the domain of SRH, nutrition, mental health and violence. SRH include HIV and other Sexually Transmitted Infections (STIs), teenage motherhood and unsafe abortion etc. Thus, the NYP is geared towards the attainment of physical, social, mental, and spiritual well-being. This is to enable young people live meaningful and fulfilling lives, and contribute appropriately to the achievement of a healthier and more productive society.

The National Youth Policy represents a declaration and commitment to the priorities, directions and practical supports that a country intends to provide for the development of its young men and women. The age bracket of 'youths' in the context of this policy is 15-29 years. For statistical purposes, youth is defined by the United Nations as the age range 15 to 24 years, but this age bracket is largely considered as too narrow for countries in Africa, given their political, economic and socio-cultural circumstances. In Nigeria, the transition to independent adulthood life, in terms of achieving the economic and social stability that comes with steady employment, may extend into the late twenties and sometimes beyond. Specific policy objectives related to health include:

- Improve the quality of youth-related health care services
- Improve the coverage of health care services for youth
- Promote appropriate health behavior, including sports and leisure-time activities

Although the quality of the commitments is good, there is no realistic specific time-frame stated for the implementation of the commitments in this policy. The target set for year 2024 for the commitments cannot be met based on the current socio-economic situation of the country Also, There is no specific consideration given to young adolescents (10 – 14 years) in the NYP. Sensitization and adequate knowledge are needed at this stage in issues around sexuality education, menstrual hygiene, prevention from STIs and pregnancy etc.

Although the commitments in the NYP focus most on adolescents and youths, there is little or no specific implementation plan for this age group especially at the subnational level. Interventions for commitments such as "*At least 75% of pregnant adolescents and young people have skilled attendants at birth by 2024"* or those relating to adolescent girls attending ANC and postnatal care are lumped with other age groups. In Nigeria, despite available policies, implementation is not enforced to specifically support adolescents' sexual and reproductive health especially in preventing early pregnancy and unsafe abortion. There is no special facilities or section providing specific health services or counseling for pregnant adolescents. According to MICs 2022: 53.1% of pregnant women <20 years had home delivery, mostly attended to by untrained Traditional Birth Attendants (TBAs) and mostly from poorest of the population.

There are other specific commitments around HIV/AIDS such as "Increase the proportion of adolescents and young people (15-24 years) who have comprehensive knowledge of HIV transmission to at least 80% by 2024" and *At least 75% of students in upper primary & secondary school students (private & public sector) are provided with school-based family life & HIV/AIDS education by 2024.*Knowledge on HIV is still shallow in rural areas. Only one in four has comprehensive knowledge on HIV as at 2021/22. (MICS). In fact, the school curriculums do not expose adolescents in most schools to adequate information on HIV and other STIs till date. Generally, adolescents take part in risky sexual behavior including unprotected sex because of lack of knowledge about STIs. Except in secondary schools where some knowledge on HIV is passed, government's effort to improve the knowledge of out-of-school adolescents and youths who form the majority is low.

There are several other policies at the national level focusing on adolescent sexual health and wellbeing. This includes the National Gender Policy (2021) developed by The Federal Ministry of Women Affairs, National Guidelines for Integration of Adolescent and Youth-Friendly Health Services into Primary Health Care in Nigeria – 2013; National Policy on the Health and Development of Adolescents & Young People In Nigeria (2021-2025), and the implantation plan. They are all adequate in quality to improve the sexual health and wellbeing of youths and adolescents, based on the criteria laid down in the PMNCH Guide for Country Commitment Mapping and Assessment. The NYP increases Nigeria's financial commitments develop programs and service delivery actions that will improve adolescent wellbeing. In line with the SDG priorities. However, most of these policy documents do not consider much the diversity of the youths and the complexity of Nigerian situation in terms of tradition and religious beliefs.

d. Every Newborn Action Plan (ENAP)

Developed in 2016 and revised in 2022, the ENAP is a global framework with documented eight commitments that outlines specific mortality reduction and coverage targets, milestones to progress and recommendations to address newborn mortality, including stillbirths. Nigeria has adopted and is

implementing the WHO standards for effective newborn care, including prevention of stillbirths and s sick newborn care at all levels of the health system and has a learning system to achieve quality of care.

One of the key commitments of the ENAP and EPMM is to develop RMNCAEH-N coordination strategy which incorporates a roadmap for both initiatives. This has been achieved at the national level as a revised version of the strategy is currently undergoing final review by experts in the health system. This revised strategy is adequate in quality and highlights plan to implement government's commitments made in ending health crises in newborn and U5C. Relevant for both framework for mother and child is the National Maternal, Perinatal and Child death surveillance and response (MPCDR) 2022 revised. There is also the National Child Health Policy which was developed in 2006 and revised in 2022 and several other policies and plans. These are all adequate in quality in terms of policy and technical considerations.
Even with all these policies and plans, Nigeria accounts for a quarter of all neonatal and child deaths in Sub-Sahara African and is now the country with the highest number of under-five deaths in the world. Furthermore, the neonatal mortality rate only slightly declined, from 48 per 1000 live births in 2003 to 39 per 1000 live births in 2018. Nigeria's under-five mortality rate declined over the 15 years from 201 per 1000 live births to 132 per 1000 live births. The slow progress to reduce maternal mortality ratio and under-five mortality rates were attributed to poor political commitments at both National and subnational levels to fully fund approved annual health budgets which translated to poor disbursements of resources expected to be utilized to improve women, children and adolescent health.

e. Ending Preventable Maternal Mortality (EPMM)

This is a similar framework to the ENAP. This framework focuses on women and health issues that affect them (antenatal, peri-natal and post-natal). A total of seven commitment were documented from the EPMM. Nigeria is to ensure timely procurement, equitable distribution and access, appropriate use and maintenance of medical commodities and products (equipment, technologies and diagnostics) to facilitate the delivery of high-quality, affordable maternal care, to reduce preventable maternal mortality. The ENAP and EPMM have strategic objectives, coverage targets and milestones that are complementary.

For example, a key commitment of the GoN in the EPMM framework is to reduce maternal mortality ratio by 75 percent from 576 per 100,000 live births in 2013 to 144 per 100,000 live births by 2028. This commitment is adequate in quality in terms of relevance, being strategic and attainable. However, there is need for better accountability process in the operationalization of the commitments relating EPMM. There are existing national polices that support these commitments - National Reproductive Health Policy (2017), National Guidelines for Maternal and Perinatal Deaths Surveillance and Response in Nigeria (2017). Nigeria also has the Accelerated Reduction of Maternal and New-born Mortality in Nigeria, Roadmap for Action 2019 - 2021 which clearly define road map in achieving key commitments which concerns women and children.
National guideline on Self-care for Sexual Reproductive and Maternal health (2020) also exists in Nigeria to improve the reproductive and sexual health of women. In the area of nutrition, several policies and plans have also been developed with focus on enhancing the nutritional status of women and children. Some of such policies is the National Policy on Maternal, Infant and Young Child Nutrition 2022 and the National Strategic Plan of Action for Nutrition, 2021-2025.

f. Nigerian RMNCAEH-N Strategy (2023-2028)

The RMNCAEH+N strategy has a total of 12 commitments reviewed with the goal to reduce maternal, neonatal, child, adolescent and elderly morbidity and mortality in Nigeria, and promote universal access

to comprehensive sexual and reproductive health services for adolescents and adults throughout their life cycle and comprehensive nutritional services especially for under-fives.

The Strategy emphasizes the fact that gender and inequality issues are important elements in Nigeria's socio-economic development discourse and majorly on the health of the people especially the female folks. This is coupled with the low level of literacy among females, especially in Northern Nigeria which has contributed to the poor statistics on women, children and adolescents in Nigeria. Gender norms are linked to several reproductive, maternal, child and adolescent health problems, manifesting as childhood marriages, early pregnancy and childbirth, delay in seeking maternal health care services etc. This Strategy has a five-year timeframe with related guideline developed on how Quality of Care (QoC) will influence service delivery of WCAH. However, during COVID, the RMNCAEH+N COVID-19 Response Continuity Plan 2020-2022 was officially launched by the Minister of health in 2021. The Nigerian government committed about N12.1 billion on this plan over a 3-year period. However, this fund was not fully released.

One of the key commitments of the RMNCAEH+N strategy is to develop the National Maternal Newborn Health (MNH) Quality of Care (QoC) standards and protocols in line with the WHO MNH standards of care. In February 2017, Nigeria joined eight other African Countries to establish a global network to improve the Quality of Care (QoC) for mothers and newborns. Nigeria's participation is based on high-level political commitment and readiness for intensified coordinated actions. Nigeria has recently revised the National RMNCAEH+N Quality of Care Strategy which outlines the commitments of government and relevant stakeholders to the provision of quality-of-care services for not only women and newborns but also adolescents and elders. In the year 2020, the Nigerian government adopted the RMNCAEH+N Multi-Stakeholder Partnerships and Coordination Platform (MSPCP) to enhance the achievement of the Universal Health Coverage and the Sustainable Millennium Goals (SDGs) – Targets 3 and 5 by the year 2030. Thus, most commitments made towards WCAH have similar timelines to the SDGs 2030.

With focus of quality of care, the national basic minimum package of health services has been developed to aligned QoC standards which guides the implementation of the Basic Health Care Provision Fund (BHCPF). GoN has made available the BHCPF to provide basic minimum package Nigerians towards achieving UHC. This catalytic fund (1% of the consolidated revenue fund) is statutorily made available by the government in accordance to the NHAct 2014. Recently, as the guideline for the BHCPF is being reviewed, more emphasis is being laid on quality of services provided in the area of immunization, antenatal care (ANC), postnatal care (PNC), nutrition services, among others. However, best practices have not being systematically documented and assessments of QoC at the PHC level and MPCDSR at tertiary are not regularly disseminated when conducted. QoC indicators for adolescent and nutrition have been adopted but not included in the National Health Management Information System (NHMIS) register which houses the indicator of interest tracked for WCAH. Data quality is also not regularly monitored while data use for action is still suboptimal within the health space.

If the implementation of this QoC strategy is emphasized, health outcomes among women, children and adolescents will greatly improve. Improvement will be in the area ANC 4 and even 8 visits, proportion of pregnant women delivered by skilled attendants, immunization uptake, adolescent sexual wellbeing among others.

g. Sustainable Development Goals (SDG 2030):

The 2030 agenda for Sustainable Development, which produced the 17 Sustainable Development Goals (SDGs), was adopted by all United Nations Member States including Nigeria in 2015. In 2020, Nigeria joined other 46 countries to conduct a voluntary national review on seven of the SDGs including SDG 3 (Health and Well Being) and SDG 5 (Gender Equality).

Nigeria committed to SDG 5 to promote eliminate all forms of violence against women and girls, with specific target to eliminate forced marriages and genital mutilation (target 5.3) and promote universal access to reproductive health and rights (target 5.6). To achieve the various targets under goals 3 and 5, several commitments have been highlighted in various strategic documents and plans in Nigeria. Implementing this commitment involves multi-sectoral collaboration including partnership with non-state actors. There are still a lot of gaps in achieving gender equality since this issue is rooted in socio-cultural beliefs of the people.

One of the key commitments which Nigeria subscribed to is to end all forms of discrimination against all women and girls everywhere by 2023. There are existing policies which ensures that health rights of women and girls are guaranteed throughout her lifetime, equal to that of men. In fact, women are more affected by many of the same health conditions as men, but women experience them differently due to both genetics and the social construction of gender. The WHO stated that morbidity and mortality in women and girls not only result from ineffective health systems, but are also a consequence of deep-seated gender inequalities that hinder many women from active participation in decisions that influence aspects of their health and general welfare.

Nigeria in 2017 reported that there were challenges as cases of physical, psychological and sexual abuse against women still persisted: about 33.5 per cent of women and girls 15 years and older still confronted cases of violence and emotional abuse; it was 34.9 per cent in the baseline report. Also 24.8 per cent of girls and women aged 15 to 49 were reported to have undergone genital mutilation or cutting. By the VNR 2020, Nigeria only reported slight improvement on two indicators – GBV and child & early forced marriage (CEFM) before 15 years. However, result of CEFM before age 18 was worse.[9]

h. International Conference on Population and Development (ICPD25)

The summit in 2019 brought together governments, civil society, academia, the private sector, faith-based organizations, international financial institutions, grass roots organizations and other partners, interested in the pursuit of sexual and reproductive health and rights. Nigeria was also represented in Nairobi, Kenya and joined to make voluntary commitments with timeline of 2030 just as the SDGs.

By 2030, part of Nigeria's targeted commitments is to improve the lives of women and girls and thereby reducing maternal death to the lowest, end gender-based violence and improve childhood development among others. All these aligns with relevant SGD goals 2023.

Using the BHCPF to revive and strengthen the health sector, especially the Primary Health Care (PHC) system is one of the commitments of the GoN at the ICPD conference. Nigeria immediately commence implementation of the BHCPF in 2019 by releasing one percent of the consolidate revenue fund (CRF) as the national health law requires. In recent time, one of the steps the government has taken through the FMoH is to set out a strategic vision for the health sector 2023-2026. The current administration plans to

[9] Odinakachukwu et al. Nigeria's Implementation of he Sustainable Development Goals, 2024. https://doi.org/10.32388/R5I131

operationalize the BHCPF under four basic pillars to improve financing and work with other stakeholders including NGOs for effective governance, quality health care, health security and unlocking value chains. The new initiative of the government referred to as the Nigerian Health Sector Renewal Investment Program in which the BHCPF will be managed through a sector wide program via pooling of all available fund is being implemented, the number of PHCs to be funded through the BHCPF would double in the next three years and more frontline health workers will be trained.

In fact, the commitment made at the International Conference on Population and Development in 2019 committed to education & enlightenment program to reach 20,000 young girls & boys over 36 months on life skills, personal hygiene & gender-based violence in Nigeria. There is no evidence that these number of adolescents and youths were reached with sexual education with government's effort.

i. GFF RMNCAH + N Investment Case 2017 – 2030)

Supported by the Global Financing Facility (GFF) was launched at Third International Financing for Development Conference in 2015 in Ethiopia by a partnership comprising governments, CSOs, UN agencies, Gavi etc. With each country secretariat hosted by World Bank office, about 67 high-burdened, low middle-income countries were to benefit from this financing platform, thus each country had to develop a document (investment case) with key commitments made. The investment case for Nigeria, with 18 commitments was developed by the RMNCAH+N sub-group of the NSHDP II Technical Working Group (TWG) to operationalize the GFF and accelerate results for women, children and adolescents in Nigeria. This investment case highlights several immediate actions to reach these commitments. It sets out the federal GoN's commitments, priorities, and strategies in RMNCAH+N over the next five years. The goals of the federal GoN are to reduce; (i) under-5 and infant mortality rates; (ii) the maternal mortality ratio; (iii) stunting rates; and (iv) the total fertility rate. Apart from the RMNCAEH+N multi-stakeholder platform that have been meeting over the last three years, the current administration at the FMoH has rolled out a new initiative (with seven different TWGs) called the Sector-Wide Approach (SWAp) under the BHCPF. One of the TWG is the RMNCEAH+N TWG. The modality of their operation to the existing multi-stakeholder group is still not yet known.

The Reproductive, Maternal, Newborn, Child, Adolescent and Elders Health plus Nutrition (RMNCAEH+N) is not another vertical Programme, but a strategy to integrate an existing range of interventions, improve the use of resources and greatly expand health care coverage. If the initiative is well planned and implemented as conceived by the Federal Ministry of Health and its partners, Nigeria stands a better chance of achieving commendable progress for the attainments of the Sustainable Development Goals (SDGs) by 2030.

The implementation of the Basic Health Care Provision Fund (BHCPF) is a proof of government's commitments in this area. As some of the commitments in the Investment Case is targeted at reducing MMR, U5MR and neonatal mortality rate. As BHCPF operates through four gateways, two of which are most important in achieving strategic result– National Primary Health Care Development Agency (NPHCDA) and the National Health Insurance Authority (NHIA), the two gateways implement through the subnational level to improve WCAH and thereby serving the most vulnerable especially in the rural areas. The NPHCDA has many ongoing programs on RMNCAEH-N that provides support to the State Primary Health Care Agencies (SPHCDA), LGA Health Authorities and the health facilities. These programs are financed from the government's budget and donor support. They include National Emergency Routine Immunization Coordination Centre (NERICC), National Emergency Maternal and

Child Health Intervention Centre (NEMCHIC), Community Health Influencers, Promoters and Services (CHIPS) and Technical Support Program. The agency also serves as coordinating units for donor projects. The NHIA gateway of BHCPF has been able to develop its protocol and other implementation documents which dictate how enrollees in the system benefit.

However, one of the key commitments of the investment case is to *Increase Skilled Birth Attendance (SBAs) by 50% from 38% to 57% by 2030*. To achieve excellent result in the RMNCAEH+N program, the human resource for health (HRH) aspect must improve, thus the target set for year 2030. This quality of the commitment is good as Nigeria has a clearly documented guideline for health workforce especially for the lowest level of health service delivery - PHC. The HRH and especially inadequate SBAs is one of the main causes contributing to high MMR, U5MR, NMR etc. While there are strong and good policies, technical considerations are limited in terms of V4M and accountability process especially in the rural areas mostly responsible for the poor statistic. Most health documents on HRH does not adequately address several underlining factors, antecedents and complexity of the country before setting the targets. There is poor implementation of HRH guidelines especially for the frontline skilled birth attendants. In actual fact, untrained Traditional Birth Attendants (TBAs) are responsible for majority of deliveries, thus the high MMR. Only 18 percent of births in the North West are attended by a skilled provider, compared with 85 percent each in the South East and South West. The proportion of deliveries with skilled assistance ranges from 3 percent in Kebbi State to 98% in Imo State (NDHS 2018).

Subnational financial investment is poor in many States of the federation despite stakeholders' involvement. MICS 2021 reported that only 49% of women had facility delivery, 50.7% delivered by any SBA (doctor, nurse/ midwife and other trained personnel. Aside issues from demand side fueled by ignorance, misconceptions, poverty etc. availability of SBA 24hrs PHC service is poor in most parts of the Nigeria. Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health professionals educated, trained and regulated to national and international standards. It is worth to note that some of the SBA across Nigeria also lack up-to-date trainings and relevant equipment that could support their work.

j. Maputo Plan of Action 2016-2030

The Maputo Protocol was adopted over 20 years ago by Nigeria. It is a regional treaty for advancing gender equality and SRHR. About 49 countries in Africa signed this treaty including Nigeria. This revised Maputo Plan of Action 2016 - 2030 is for the operationalization of the African Union Commission's Continental Policy Framework for Sexual and Reproductive Health and Right. This action plan has 17 commitments which was subscribed to by the GoN. With Nigeria presence, it seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa. It is a long-term plan for the period up to 2030, built on nine action areas: political commitment, leadership and governance etc. While recognizing the need for an emphasis on SRH, this revised Plan recognizes that this must be built into and on an effective health system with sufficient infrastructural, financial and human resources and that SRH interventions will be impeded until the crisis in these is resolved.

One of the key commitments of the Maputo plan targets children, adolescents and youth, especially girls both in and out of school with age-appropriate and culturally sensitive comprehensive sexuality

education. Nigeria, despite adequate policies has weak implementation status on dealing with sexual and reproductive issues specific to adolescent.

One of the setbacks in most policies and plans developed to address adolescent wellbeing is that these key policy documents generalize adolescents, without explicit focus on younger adolescents. For example, the GFF investment Case, and the health policy focus mainly on older adolescents 15-19 years. Younger adolescents are not explicitly mentioned in most documents. Thus, this is of great concern as there are several issues around SRHR and AHWB such as menstrual hygiene etc. which younger adolescents also need to benefit. There is no adequate information on adolescents at the national level as they are generally not prioritized. Also, interventions related to this age group are not specific.

For children, the Nigerian government committed in the Maputo Plan to expand access to high-impact health interventions such as immunization etc. Critical MNCH services such as immunization and nutrition services including exclusive breastfeeding have been adopted by Nigeria. All these interventions are adequately documented in the NSHDP2 to provide high-impact and quality healthcare. It can be said that Nigeria has very good and quality policies, plans, and laws that support immunization

Nigeria operates the immunization schedule of the Expanded Program on Immunization (EPI) for infants which prescribes five visits to receive one dose of Bacille Calmette Guerin (BCG), four doses of oral polio vaccine, three doses of diphtheria, pertussis, and tetanus vaccine, and one dose of measles vaccine.
The uptake of basic vaccines is steadily improving in Nigeria. The progress can be said to be moderate among elites and insufficient among rural dwellers. For example, 57% of eligible children took Penta 3 according to MICS 2021. Some of the commonly reported health system barriers in Nigeria's immunization program is funding constraints, human resource factors such as health worker shortages, training deficiencies, and poor attitude of health workers and vaccination teams.
Government's effort at the national level is inadequate as commitments made towards immunization funding especially vaccine procurement is never met at the national. Subnational investment is also generally inadequate.

k. *United Nation's Secretary-General's call for national and global commitments to deliver the 'Rescue Plan for People and Planet' at the SDG Summit 2023 and in response to the 1.8 Billion Young People for Change Campaign*

To ensure that young people (10-24) reach their full potential, PMNCH is coordinating a campaign called the 1.8 Billion young people for Change, reflecting the population of young people worldwide. PMNCH, therefore, organized a global alliance to advocate for the health and well-being of Women, Children, and Adolescents (WCA), hosted by the World Health Organization (WHO). A platform for world leaders and country governments to commit to WCA. On the 5th of October 2023, during the national event toward the Global Forum for Adolescents, the Honorable Minister of Health and Social Welfare on behalf of the Nigeria Government, committed to the health and well-being of young people. Primarily, the commitment is to improve adolescents' well-being and accelerate the achievement of related SDG priorities for adolescents and young people as a smart investment in the future of our societies.

Implementation of commitments relating to young people range from poor to insufficient as the GoN do not specifically target this age group. Few interventions of the governments that reach the adolescents only target in-school adolescent, however, majority of this age group are out-of-school. Given the very

young population make-up of Nigeria it would be good to advocate that that adolescents are explicitly considered across health, health related policies, and their rights protected and promoted as such.

In June 2021, the government through the office of the Office of the Special Adviser to the President on SDG (OSSAP-SDG) launched Nigeria SDG implementation plan 2020-2030 with support of UNDP. The OSSAP-SDG is mandated to provide strategic direction, planning and coordination for all the SDGs in Nigeria including how health, nutrition and climate change affect could be improved for children and adolescents. With state representatives in attendance at the launching, there was clear emphasis on SDGs 3 and 5.

l. The Generation Equality Forum (2021)

This forum took place in 2021 to kickstart a five-year journey to accelerate ambitious actions and implementation on global gender equality. Convened by the UN Women ad co-hosted by the governments of France and Mexico, the forum generated about 40 billion USD in financial commitments as well as multiple policy and program commitments. Together with several other global leaders and stakeholders including CSOs and youth-led organizations and trade unions, Nigerian government joined to adopt these commitments. The outcome of the five-year action plan is to be transformative to achieve irreversible progress towards gender equality. At this events, different coalitions were formed in which Nigerians were part of.

Nigeria has some strong policies around gender issues. First was the National Gender Policy (NGP) 2007 which presents an analysis of the national context and priorities for national gender mainstreaming and gender sensitivity and responsiveness in national policymaking. The State Ministry of Women Affairs (SMWA) is responsible for implementing the policy. The policy has 16 priority areas, including GBV, reproductive health, and HIV/AIDS. The second is the VAPPA 2015 which is the most encompassing legislation addressing violence against persons in Nigeria. The law's relevant sections include criminal provisions for harmful traditional practices (HTPs), rape, physical injury, spousal battery and intimidation, and domestic violence Some states that domesticate the VAPPA choose to set up structures for its implementation, including sexual and gender-based violence response teams. In 2003, the Child Right Act (CRA) was passed at the federal level, indirectly outlawing child marriage. As soon as the law was passed, it faced opposition from the Supreme Council for Sharia in Nigeria. However, progress has been made in the last 10 years with only three states (Adamawa, Bauchi and Gombe) are yet to domesticate the Act These states largely rely on rationales related to the preservation of culture and religion.

There is serious issues with the implementation of these laws at the state level in Nigeria.

5. CONCLUSION

The Nigerian government has made several commitments on various national and international events and platforms to improve the lives of women, children and adolescents. The government signed and ratified these commitments as it was officially agreed that they were all for the growth and development of the country. Subscription to the regional and global commitments is evident through the formulation of relevant national policies and localized implementation plans and guidelines. Even at the subnational levels, some of the commitments have been adapted or adopted. A total of 148 commitments from different

documents were highlighted in this report. Most of the commitments were also made in collaboration with other non-state actors including civil society, private sector and academias etc. Generally, Nigeria's commitments are guided by good policies and strategic plans that are relevant, attainable and equitable in terms of quality, as most times, needs of vulnerable groups are usually addressed. In terms of technical consideration, the quality of the policies and plans is specific and time-bound. There are more quality policies to commitments made in the area of Maternal, Newborn and Child Health (MNCH) than other areas.

Generally, implementation of most of the commitments is inadequate to achieve set target. Commitments made under MNCH had the highest level of attention in terms of policy, financial investment and service delivery when compared to the SRHR and AHWB. The Nigerian government and development partners are mostly focused to reduce death rates among women and children. Recently, some areas of sexual and reproductive health have begun to gain government's attention also especially family planning, gender-based violence, cervical screening and Human Papillomavirus (HPV) vaccination for women of child bearing age. There are good policies and laws developed to guide implementation in SRHR such as the Violence Against Prohibition In Persons Act and Child Right Act which has been adopted by most states.

The most neglected area is the adolescent health and wellbeing. Although some adolescents also benefit from some of the ongoing interventions in MNCH and SRHR, most of the specific commitments made to improve the health and wellbeing of this group are not properly implemented or institutionalized. In fact, this is worse for out-of-school adolescents in rural communities, who do not benefit from any national policies and programs for adolescents involving nutrition, health education, and legal provision against marriage etc. Specific interventions on user-free exemption for health services, WASH and several other have not been rolled out for the adolescents. For some commitments under SRHR and AWHB, implementation process does not have clear roadmap and roles. Some MDAs such as Ministry of Women Affairs and Ministry of Sport and Youth do not allocate government resources to specific interventions to bring positive result to made commitments. Also, in areas where there is ongoing implementation such as GBV and school feeding for children and young adolescents etc, implementation is not linked to institutionalized accountability process. The health and wellbeing of adolescents have not been specifically prioritized in the implementation process without adequate accountability measure. Most interventions specific to adolescents' wellbeing are conducted by NGOs and private sectors including religious groups

For the Nigerian government to record appreciable success concerning the commitments made in the area of Women Child and Adolescent Health (WCAH), implementation process need to be strategic. There is need to better advocate for to policy makers at the state level especially the Governors to prioritize WCAH. Continuous engagement with key stakeholders is crucial as planned interventions must align with the country's need to improve WCAH. The Federal Ministry of Health must facilitate an effective partnership with non-state actors who have interest in supporting WCAH and enhance multi-sectoral interactions with other MDAs.

6. RECOMMENDATIONS

- There have been improvements and in many cases policies and frameworks exist to achieve success on most of the commitments made, but they are not enforced, and some of the targets/progress are not adequate to accelerate progress and reach the set national targets/SDG goals. The following recommendations are therefore proposed as partners develop the collaborative advocacy action plan (CAAP):

- CSOs and other advocates need to capacity and funding to conduct proper advocacy at the subnational levels for states and LGAs to domesticate most of the available policies, laws and guidelines that will improve WCAH in Nigeria. This is important to enhance the knowledge of policy makers for them to make better informed decisions and understand needs for improved WCAH.

- Government at all levels need to operationalize more consistency in allocation and release of fund for critical activities that will lead to success in improving WCAH. Dependency on donor funding which is dwindling should be discouraged first by fulfilling pledges made on counterpart funding of vaccine procurement and FP etc. Domestic Resource Mobilization (DRM) is critical to meeting set targets on WCAH.

- Some of the policies and plans do not have concrete milestones of achievements For example, most commitments made on ENAP and EPMM: (a) 80% early routine postnatal care (within 2 days), (b) 90% coverage of four or more antenatal care contacts lack specific timelines of achievement. It is critical to measure progress more often than wait till the due date of the commitment to report progress. At least, progress should be measured every two years.

- There is also need for the advocates to follow up during the Nigerian constitution amendment process on relevant areas of the document that need changes. For example, the constitution says that a child is an adult once she is married while the Child Right Act stipulates age of marriage to be at least 18 years.

- There is need for government of Nigeria to prioritize implementation of planned activities related to the health and wellbeing of adolescents. Government is not paying adequate attention to several of the commitments made on AHWB for example, separate and clean toilets, appropriate menstrual hygiene management facilities and counseling units for adolescents are lacking in most of the public schools across Nigeria.

6. REFERENCES

ANNEX 1: National Commitments Identified

	Commitment / Policy	Pledging Platform	Category (National / Regional / Global)
MNCH			
	High-quality MNCH services for mothers, newborns and children		
1.	Reduce MMR from the current 512 to 256 per 100,000 livebirths by 2025 and zero maternal death by 2030	National Policy on Population	National
2.	Multiple Indicator Cluster Survey/ National Immunization Coverage Survey Report, 2021	Federal Ministry of Health/UNICEF	National
3.	Reduction of MMR from 576 per 100,000 live births to 288 per 100,000 live births (made in 2021 again)	GFF investment case RMNCAH+N(2017-30	Global
4.	Reduce neonatal mortality rate from 39per 1000 livebirths in 2020 to 19 in 2025 and 9per 1000 livebirths by 2030	National Policy on Population	National
5.	Reduce Neonatal MR from 37/1000 live births (2013) to 18/1000 live births (2021)	GFF Investment Case RMNCAH+N(2017-30	Global
6.	Reduce infant mortality rate from current 67 to 45 per 1000 live births in 2025 and 35 per 1000 live births by 2030	National Policy on Population	National
7.	Reduce infant mortality rate from 75/1000 to 38/1000 live births	GFF investment case RMNCAH+N(2017-30	Global
8.	Reduce child mortality rates from 64 to 42 deaths per 1000 live births in 2025 and 25 deaths per 1000 live births by 2030	National Policy on Population Development	National
9.	Reduce U5MR from 132 to 88 per 1000 live births by 2025 and 40 per 1000 live births by 2030	National Policy on Population	National
10	Reduce U5MR from 128 per 1000 live births to 64 per 1000 live births	GFF investment case RMNCAH+N(2017-30	Global
11	Reduce neonatal mortality rate to at least 15 per 1000 livebirths by 2030	ENAP	Global
12	By 2030 to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births	SDG	Global
13	Reach MMR of 270 per 100,000 livebirths by 2030	EPMM	Global
14	Reduce maternal mortality ratio by 75 percent from 576 per 100,000 live births in 2013 to 144 per 100,000 live births by 2028	RMNCAEH-N Strategy	National
15	By 2030, reduce the global maternal mortality ratio to less than 70 per 100, 000 live births	SDG	Global
16	Reduce Neonatal MR by 50% to 18 per 1,000 LB and U5MR to 64 per 1,000 LB by 2030	GFF Investment Case - RMNCAH+N	National
17	Increase growth monitoring for children under 5 from 16% (2013)	GFF investment Case RMNCAH+N(2017-30	Global
18	Increase Antenatal care coverage (8 visits) by 50% from baseline of 61% (2013)	GFF Investment Case RMNCAH+N(2017-30	Global
19	Increase ANC (4 visits) rate from 57% to 72% by 2025 and 87% of every pregnant woman per community by 2030	National Policy on Population	National
20	Increase immunization coverage for U5C from 31% in 2020 to 56% in 2025 and 80% by 2030	National Policy on Population	National
21	90% coverage of four or more antenatal care contacts	EPMM	Global
22	Achieve at least 80 percent of pregnant women attending at least 8 ANC visits throughout the course of a particular pregnancy by 2028	RMNCAEH-N Strategy	National

23	Sustained Midwives Service Scheme with recruitment of additional 1,586 midwives annually to achieve increase in Skilled Birth Attendance from 38% to 70% by 2030;	ICPD@25	Regional
24	Increase number of women who deliver in a facility from 37% (2013)	GFF Investment Case RMNCAH+N(2017-30	Global
25	Increase the proportion of pregnant women delivered by skilled attendants by 50 percent from 38 percent in 2013 to 57 percent by 2028.	RMNCAEH-N Strategy	National
26	Births attended to by skilled birth attendants to reach 95% by 2030	ENAP	Global
27	Increase Skilled Birth Attendance by 50% from 38% to 57% by 2030	GFF Investment Case - RMNCAH+N(2017-30	
28	Achieve at least 80 percent of women attending postnatal care services within 48hrs of delivery by 2028.	RMNCAEH-N Strategy	National
29	Increase postnatal care coverage by 50% from 42% to 63% by 2030	GFF Investment Case - RMNCAH+N(2017-30	National
30	80% early routine postnatal care (within 2 days	ENAP	Global
31	Expand access to high-impact health interventions such as immunization; skilled attendance at birth	Maputo Plan of Action 2030	Regional
32	Increase percentage of children exclusively breastfed, 1st 6months of life to 60% by 2030	GFF Investment Case - RMNCAH+N (2017-30	Global
33	Increase immunization coverage from 25% (12-23 months)	GFF investment Case RMNCAH+N(2017-30	Global
34	fully implement the Strategic Roadmap to Accelerate Reduction of Maternal and Neo-natal Mortality	ICPD@25	Regional
35	Reduce childhood wasting (U5) from 18% to less than 10% by 2030	GFF Investment Case RMNCAH+N(2017-30	Global
36	Reduce childhood stunting (U5) from 37% to less than 20% by 2030	GFF Investment Case RMNCAH+N(2017-30	Global
	MNCH interventions embedded in UHC schemes		
1.	Apportion 10% of the N55.1 billion "Basic Health Care Provision Fund" (BHCPF) for maternal and child health care package - including free maternal care for all mothers in rural areas, 4 ANC visits, delivery (including C/S), two Post-Natal Care visits;	ICPD@25	Regional
2.	Sustain the National Task Shifting and Task Sharing Policy;	ICPD@25	Regional
3.	Continued Conditional Cash Transfers for maternal and Child Health for rural and humanitarian populations.	ICPD@25	Regional
4.	Achieve UHC of 38% by 2025 and 75% by 2030	National Policy on Population	National
5.	Facilitate equitable access to quality child and neonatal services	ENAP	Global
6.	Facilitate equitable access to quality maternal and perinatal services	EPMM	Global
7.	Integrate SSNB, pediatric and adolescent standard into the current MNH QoC strategy	EPMM	Global
8.	Reducing unplanned pregnancies and maternal death through the promotion of health literacy for informed decisions and access to quality health services is a viable reason to invest in sexual and reproductive health as only 1 in 6 women in Nigeria use any form of contraception and on a yearly basis 1.25 million Nigerian women have an abortion based on data from the WHO	ICPD+25	Regional
9.	Integrate maternal, newborn, child and adolescent health into other health services	Maputo Plan of Action 2030	Regional
10	Using part of the BHCPF to revive and strengthen the health sector, especially the Primary Health Care (PHC) system.	ICPD+25	Regional
	Health systems strengthening including MNCH data and accountability		
1.	Strengthen the National & Sub National multi-stakeholder Accountability Mechanisms including CSOs (FP Motion tracker and scorecards) & media structures	FP 2030	Global
2.	Develop RMNCAEH-N coordination strategy which incorporates a roadmap for ENAP	ENAP	Global
3.	Strengthen the national FP supply chain with a view to reducing stock out rates below 20%,	FP 2030	Global

4.	Improve recruitment, development and training motivation and retention of the health workforce	Maputo Plan of Action 2030	Regional
5.	Increase domestic resources for health by ensuring financial deepening and inclusion	Maputo Plan of Action 2030	Regional
6.	Implement of strengthen MCDSR systems that monitor, evaluates and responds to all contributing factors to poor maternal outcomes, including those related to services delivery, access and sociocultural/gender inequality barriers	Maputo Plan of Action 2030	Regional
7.	More than half of population within 2 hours of emergency obstetric care	EPMM	Global
8.	Generating quality, timely, disaggregated, geo-referenced data through census (within the 2020 Round of Censuses) and surveys	ICPD@25	Regional
9.	Implement a Revised National Policy on Population for Sustainable Development that aligns with the ICPD "Unfinished Business & the 2030 Agenda" and a Roadmap on demographic dividend	ICPD@25	Regional
10	include using part of the BHCPF to revive and strengthen the health sector, especially the Primary Health Care (PHC) system	ICPD@25	Regional
11	National implementation plan for inpatient units and sub-national inpatient unit (Level 2 plus CPAP)	ENAP	Global
12	80% of districts with at least one Level 2 inpatient unit plus CPAP	ENAP	Global
13	80% of districts with at least half of population within 2 hours of emergency obstetric care	EPMM	Global
14	Encourage and support member states to invest in medical infrastructure, and local manufacturing of health equipment, medicines and consumables	Maputo Plan of Action 2030	
	Inter-sectoral approaches for MNCH across the life-course		
1			
2			
	SRHR		
	Access and choice to effective contraception methods		
1.	Achieve a reduction in the total fertility rate from the current 5.3% to 4.7% by 2025 and to 4.0% by 2030	National Policy on Population	National
2.	Achieve reduction in the national annual population growth rate from current 2.6% to 2.5% in 2025 and 2% by 2030	National Policy on Population	National
3.	Reduce unmet need for family planning from the current 19 percent to 10 percent in 2025 and to zero by 2030	National Policy on Population	National
4.	Increased annual allocation from $3 to $4 million annually from 2018 for procurement of modern contraceptive	ICPD@25	Regional
5.	provide free family planning information, counseling and services to all women in public health facilities;	ICPD@25	Regional
6.	Implement revised national Blueprint Scale-up Plan for family planning for improved funding for family planning commodities and consumables	ICPD@25	Regional
7.	implement age appropriate SRH information, counseling and services for adolescents and youths.	ICPD@25	Regional
8.	Increase FP access and choice from 12% mCPR to at least 27% through scaling up evidence-based, high impact practices by 2024 that meet individual and family needs and rights-based services through total market approach by 2030.	FP 2030	Global
9.	Strengthen the national family planning supply chain with a view to reducing stock out rates below 20%, increasing end-to-end data visibility and enhancing nationwide capacity for last mile assurance of family planning programme supplies by 2030	FP2030	Global
10	Improve financing for FP by allocating a minimum 1% annually of the National and State Health budgets equivalent to N4.7 billion and N6.9 Billion respectively and leveraging both existing and additional innovative domestic financing mechanisms to increase financing for FP by 2030.	FP 2030	Global
11	Strengthen the National and Sub National multi-stakeholder Accountability Mechanisms including CSOs (FP Motion tracker and scorecards) and the media structures to include key indicators for measuring and monitoring individual rights and needs by December 2023 through facility health and ward health development committees, SLAMs, RMNCAEH+N, NRHTWG,	FP 20303	Global

12	Reduce social and gender norms hindering women and girls agency and autonomy, and access, including those of men, young people, people living with disability and key vulnerable populations, to rights-based family planning information and services by 2030	FP2030	Global
13	Reinforce the use of data to inform evidence-based policy actions and program strategies at all levels through improved accountability in data generation and empowerment of data producers and users by 2030.	FP2030	Global
14	To Increase modern contraceptive prevalence rate (mCPR) from 11% (2013) to 43% (2021)	GFF Investment Case RMNCAH+N(2017-30	Global
15	Increase modern contraceptive prevalent rate (mCPR) to 27 percent by 2020 and thereafter achieve at least 2 percentage points per year till 2030- achieve mCPR of 37% by 2025 and thereafter achieve 47% by 2030	National Policy on Population	National
16	Increase demand of family planning by 50% by the year 2028	RMNCAEH-N Strategy	National
17	Percentage of women with unmet need for contraception reduce by 50% by 2028	RMNCAEH-N Strategy	National
18	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 programs.	SDG	Global
19	Increase proportion of family planning demand met with modern contraception by 50% by the year 2028	RMNCAEH-N Strategy	National
20	65% of women making own informed empowered decisions	EPMM	Global
21	80% of districts with more than half of women making own informed empowered decisions	EPMM	Global
	Access to safe and legal abortion services		
1.	Implement national policies, strategies and action plans to end unintended pregnancies and unsafe abortion	Maputo Plan of Action 2030	Regional
2.			
	Prevention and treatment/referrals for Sexual and Gender-Based Violence		
1.	Reduce GBV and harmful practices against women and girls from 46% in 2020 to 20% in 2025 and zero by 2030	National Policy on Population	National
2.	Develop and implement legal and policy frameworks that prevent child marriages	Maputo Plan of Action 2030	Regional
3.	Develop legal frameworks, strategies and programs that deal with GBV	Maputo Plan of Action 2030	Regional
4.	Protect the rights of women, youth, and adolescents and address sexual and GBV	Maputo Plan of Action 2030	Regional
5.	Reduce the proportion of women aged 20-24 years who were married or in a union before age 18 from 50% to 25% by 2024	National Youth Policy 2019-2023	National
6.	Eliminate female genital mutilation by 2024	National Youth Policy	National
7.	At least two-thirds of the States in Nigeria and the Federal Capital Territory adopt and implement the Violence Against Persons Prohibition law by 2024	National Youth Policy	National
8.	By 2030, end all forms of discrimination against all women and girls everywhere	SDG	Global
9.	By 2030, end violence and exploitation of women and girls	SDG	Global
10	By 2030, eliminate harmful practices such as child early and forced marriage and female mutilation	SDG	Global
11	Eradicate female genital mutilation/cutting and other harmful traditional practices	Maputo Plan of Action 2030	Regional
12	Institute effective behavior change communication and information sharing mechanisms to promote SRH services including initiatives to reduce gender inequality	Maputo Plan of Action 2030	Regional
13	Act on Violence Against Persons Prohibition Act (VAPP) at all levels	ICPD@25	Regional
14	Implement National Strategic Plan to end Child Marriage	ICPD@25	Regional

15	Commit to uphold the rights of persons with disability and other vulnerable groups in public and private spaces including ease of physical and service access in all public facilities	The Generation Equality Forum	Global
16	Commit to investing in GBV prevention and response by December 2022 and to institutionalize an accountability framework for tracking expenditure.	The Generation Equality Forum	Global
17	Commit to ratify and implement the ILO Convention 190 on eliminating Gender-Based Violence and Harassment in the world of work in 2026 in close partnership with agencies and the private sector	The Generation Equality Forum	Global
18	Commit to provide technical support to the Presidential Inter-Ministerial Committee on GBV	The Generation Equality Forum	Global
19	Building on the results of the Joint EU-UN Spotlight Initiative implemented in partnership with the Government of Nigeria, we commit to scale up investment on GBV research and capacity building to improve evidence-based programming by 2026	The Generation Equality Forum	Global
20	Commit to establishing at least one GBV/Family Court in each region by 2026	The Generation Equality Forum	Global
21	Commit to investing on the establishment of a minimum of 1 modern, one-stop centre in all the 36 states and FCT by December 2023 with annual budgetary allocation to ensure the running of one-step centres	The Generation Equality Forum	Global
22	Commit to ensuring GBV prevention and response in conflict and crises	The Generation Equality Forum	Global
23	Commit to support Safe School policy and related gender-based violence response and prevention	The Generation Equality Forum	Global
24	Commit to establishing a multi-sectoral Gender Equality and Women Empowerment Framework committee to ensure accountability, coordination and monitoring of the implementation of commitments to the Action Coalitions on GBV	The Generation Equality Forum	Global
25	Commit to gender responsive fiscal budget with at least 2% recurring allocation for gender-based violence response.	The Generation Equality Forum	Global
26	Commit investment to the establishment of gender desks in all state police commands, and all state ministries of justice by December 2023	The Generation Equality Forum	Global
27	Commit to effective coordination, supervision and monitoring of GBV cases in Nigeria	The Generation Equality Forum	Global
28	Commit to the nationwide domestication and implementation of the Violence Against Persons Prohibition Act (VAPP, 2015) and Child Rights Act (CTA, 2003) by advocating for the remaining 14 and 10 states yet to domesticate the Acts to pass it into law	The Generation Equality Forum	Global
29	Commit to supporting all 36+1 state governments to develop a costed action plan for the effective implementation of the Violence Against Persons Prohibition (VAPP, 2015) Act by June 2023	The Generation Equality Forum	Global
30	Commit to reviewing the electoral act to ensure meaningful participation of women in politics including clearly defined frameworks for preventing election induced GBV.	The Generation Equality Forum	Global
	Prevention, detection and management of reproductive cancers, especially cervical cancer		
1.	Increase the proportion of women 30 to 49 years old who are screened for cervical cancer from about 3.5 percent in 2007 to at least 80 percent by 2028.	RMNCAEH-N Strategy	National
2.	Increase the proportion of men who screen for prostate cancer by 25% of the baseline by 2028	RMNCAEH-N Strategy	National
3.	Achieve 100% treatment coverage for all women in reproductive age with pre-cancerous lesions of the cervix by 2028	RMNCAEH-N Strategy	National
4.	Increase the proportion of the population 9 to 15 years who are immunized for HPV from 2% in 2015 to 50% by 2028	RMNCAEH-N Strategy	National
5.	Improve access to and uptake of quality SRH services for youth and adolescents including HPV vaccination	Maputo Plan of Action-2030	Regional
	Inclusion of essential packages of SRHR interventions within UHC and PHC schemes		

1.	To strengthen integration of family planning into Nigeria's socio-economic development frameworks and plans as a key facilitator of Human Capital Development and Universal Health Coverage to achieve Demographic Dividend by 2030**.**	FP 2030	Global
2.	Establish sustainable systems at national, state and LGA levels to respond to the SRH Needs of all citizens in humanitarian / fragile contexts, health emergencies and natural disasters	FP 2030	Global
3.	By 2030, ensure universal access to SRH-care services, including for FP, information and education, and the integration of reproductive health into national strategies and programs.	SDG	Global
4.	Reduce HIV prevalence from 1,4% to less than one by 2023 and less than 0.5% by 2030	National Policy on Population	National
5.	Increase HIV testing among pregnant women	GFF Investment Case - RMNCAH+N (2017-30	National
6.	Redoubling of efforts to eliminate mother-to-child transmission of HIV	Maputo Plan of Action 2030	Regional
7.	Remove legal regulatory and policy barriers limiting access to SRH commodities, programs and services	Maputo Plan of Action 2030	
	AHWB		
	Policy: National policy and programs for adolescent well-being (10-19 years) offering information and services in the public sector		
1.	At least 80% of early adolescent girls (10-14 years) and 67% of early adolescent boys (age 10-14 years) have adequate knowledge regarding menstruation and menstrual hygiene management by 2024	National Youth Policy 2019-2023	National
2.	At least 75% of schools have separate and clean toilets for females and males in adequate number and with appropriate menstrual hygiene management (MHM) facilities in the female toilets	National Youth Policy 2019-2023	National
3.	Target children, adolescents and youth, both in and out of school with age-appropriate and culturally sensitive comprehensive sexuality education	Maputo Plan of Action 2030	Regional
4.	Provision of budget line, appropriation, approval and timely release of funds for Adolescents Well-being interventions at the national level	Global forum for adolescents 2023	Global
5.	Optimizing the strengths and prospects of Nigeria's youthful population through investments in their health and development which are necessary preconditions to realize demographic dividends and sustainable Development Goals	Global forum for adolescents 2023	Global
6.	FGN is committed to all efforts directed at the realization of adolescents' and young people's potentials in national building and becoming healthy adolescents now, healthy adults in the future and flourishing healthy future generations	Global forum for adolescents 2023	Global
7.	Institute effective behavior change communication and information sharing mechanisms to promote SRH services including initiatives to reduce gender inequality	Maputo Plan of Action 2030	Regional
8.	Ensure that all girls and boys complete free equitable and good-quality primary and secondary education	Maputo Plan of Action 2030	Regional
	National standards for delivery of AHWB information and services to adolescents, including on user fee exemption		
1.	At least 75% of students in upper primary & secondary school students (private & public sector) are provided with school-based family life & HIV/AIDS education by 2024	National Youth Policy 2019-2023	National
2.	Increase the proportion of adolescents and young people (15-24 years) who have comprehensive knowledge of HIV transmission to at least 80% by 2024	National Youth Policy 2019-2023	National
3.	By 2024, increase the proportion of adolescents (15-19 years) who used a condom at the last intercourse with a non-marital partner from 36% in 2018 to 70% for females, and from 57% to 80% for males	National Youth Policy 2019-2023	National
4.	Increase contraceptive prevalence rate (modern method) for adolescents and young people from 2% in 2008 to 15% by 2028	RMNCAEH-N Strategy	National

AHWB is embedded in national policies and plans with dedicated financing for AHWB programs			
1.	Increase the integration of adolescents and young people into development efforts and effectively address their SRH	National Policy on Population	National
2.	All the 36 states of Nigeria and the Federal Capital Territory adopt and domesticate the Child Act Rights by 2024	National Youth Policy 2019-2023	National
3.	By 2024, at least 90% of adolescents and young people (15-24 years) with symptoms suggestive of STIs seek treatment from formal health services	National Youth Policy 2019-2023	National
4.	Reduce adolescent childbearing rate from 19% in 2017 to 12% by 2024	National Youth Policy	National
5.	By 2024, reduce the prevalence of overnutrition (overweight and obesity) among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018	National Youth Policy 2019-2023	National
6.	By 2024, reduce the maternal mortality ratio among adolescent girls by at least 40% compared to 2018	National Youth Policy 2019-2023	National
7.	By 2024, reduce the prevalence of acute undernutrition malnutrition among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018 {from 25% in 2018 to 13% in 2024}	National Youth Policy 2019-2023	National
8.	Reduce the proportion of non-pregnant adolescent girls (age 15-19 years) with anaemia from 61% in 2018 to 30% in 2024.	National Youth Policy 2019-2023	National
9.	Increase the proportion of young men and women aged 15–24 with basic knowledge about SRHR to 90% by the year 2028	RMNCAEH-N Strategy	National
10.	Reduce maternal mortality ratio among adolescent girls by 75% of the 2018 rate by 2028	RMNCAEH-N Strategy	National
11.	Reduce adolescent maternal mortality by 50% by 2030	GFF Investment Case - RMNCAH+N	National
12.	Reduce the proportion of young people with nutritional problems in 2018 by 75% by 2028	RMNCAEH-N Strategy	National
13.	At least 80% percent of pregnant young people (age 10-24 years) attend at least 8 ANC visits throughout the course of every pregnancy by 2024	National Youth Policy 2019-2023	National
14.	At least 75% of pregnant adolescents and young people have skilled attendants at birth by 2024	National Youth Policy 2019-2023	National
15.	At least 80% percent of adolescents and young mothers receive postnatal care services within 48 hours of delivery by 2024	National Youth Policy 2019-2023	National

ANNEX 2: Summary Assessment of Key Commitments

	Commitment /Policy	Quality of Commitment	Implementation progress
MNCH			
High-quality MNCH services for mothers, newborns and children			
1	Increase ANC (4 visits) rate from 57% to 72% by 2025 and 87% of every pregnant woman per community by 2030 \ (NPP)	Nigeria has adequate policy to achieve this commitment. NHAct 2014, NH Policy, NSHDP-2, BHCPF guideline, RMNCAH+N strategy etc. Although the commitment as stated in the EPMM has no specific timeline, the revised EPMM (2022) targets year 2030. is guided by very good policies All these strategic documents emphasize on the importance of pregnant women having at least 4 visits as recommended by WHO.. The quality of this commitment is supported by the fact that ANC 4 visits is a key reflector to measure progress in health of Nigerians.	ANC 4 visits was 51% in NDHS 2013, 57% in 2018 and in the MICS 2021, it was 60.4% average and always lower in rural areas (49% for MICS 2021). Progress has been moderate, but needs to improve to meet the 87% target by 2030. ANC is one of the basic minimum health packages provided by the government. However, problem with poorly-staffed, poorly-equipped and distance to PHC has led to lower visits or outright avoidance especially in rural communities contributing to high MMR (512/100,000 livebirth & neonatal MR of 38/1,000lb – NDHS 2018)). Religious and cultural undertone also slowed down progress over years. In recent time, under the current administration, one of the new initiatives of the FMoH – Nigeria Health Sector Renewal Initiative (NHSRII) . Service Wide Approach (SWAp) under BHCPF identifies ANC coverage as one of the ways health progresses will be measured. FMoH has planned to double the number of BHCPF -supported facilities to two per Ward across the country to provide better ANC services and others..
2	90% coverage of four or more antenatal care contacts (EPMM)		
3	Increase Antenatal care coverage (8 visits) by 50% from baseline of 61% in 2013 (GFF)	This commitment is not adequately entrenched into the Nigeria health system which is guided by the NHP, NSHDP-2, BHCPF guideline, RMNCAH+N strategy etc. The national progress on antenatal care services is mostly measured by ANC 4 visits. The progress of this commitment is insufficient in quality. It is not realistic nor attainable considering the effectiveness and efficiency of effort of the GoN in achieving result. Although the number of recommended visits has been increased to eight to ensure more contacts and early detection of pregnancy's danger signs, most Nigerian documents including the NPP recognizes ANC 4 visits as a benchmark for success.	While this was not captured in the national survey 2013, the NDHS 2018 reported ANC 8 visits as 2%, but rose to 23.2%. according to MICS 2021. The progress in implementation is very insufficient to meet the target of 80% by 2028. ANC 8 visits was abysmally low in Nigeria and hardly emphasized by frontline health workers. In fact, the MICS report was questioned by stakeholders. The progress with this commitment is worse especially among low educated and poor women. WHO recommended eight or more contacts for ANC can reduce perinatal deaths by up to 8 per 1000 births when compared to 4 visits. This commitment is achievable only if implementation strategies changes with the involvement of sub-national commitments. Some efforts of the government in social mobilization through Community Health Workers (CHEW/CHIPS) has not yielded much result due to poor accountability system and low coverage.
4	Achieve at least 80 percent of pregnant women attending at least 8 ANC visits throughout the course of a particular pregnancy by 2028. (R-Strategy)		
5	Increase the proportion of pregnant women delivered by skilled birth attendants (SBA) by 50 percent from 38 percent in 2013 to 57 percent by 2028. (R-Strategy)	This commitment is supported by good enough policies and national plans which focus on needed number and quality of frontline HWs. In fact, the National PHC guideline for HRH details number of staff that should run each PHC facility where most birth deliveries should occur. The progress on this commitment is considered good based on the fact that skills in attending to pregnant women is critical in all relevant policies. However, while most health policy documents prioritize availability of trained SBAs, they do not adequately emphasize on the accountability process that will ensure effectiveness and efficiency of the HWs. especially Reward & Sanction motivating of the SBA and better accountability system.	The proportion of birth attended to by skilled HW has steadily increased from 39% in 2008 to 43% in 2018 (NDHS). The later reported that 68% of births in urban areas are assisted by a skilled provider, as compared with 28% in rural areas. The MICS 2021 also reported 50.7% national average for pregnant women delivered by SBA, while 49% had facility delivery. There is insufficient progress as the latest generally on this commitment. HRH has been a major challenge especially at the subnational level which is in charge of PHC facilities. Although there are several Schools of Nursing and Midwifery, the personnel are not willing to work in rural communities mostly due to lack of social amenities. Even if they agree to work, they do not offer 24 hours services as recommended.

6	Increase Skilled Birth Attendance by 50% from 38% to 57% by 2030 (GFF)	.	Another key gap in implementation is poor monitoring & accountability process, poor remunerations of HWs and poor supportive supervision etc. Another gap is failure to integrate the Traditional Birth Attendance (TBA) system into the health system. Untrained TBAs are responsible for majority of deliveries in the country. Majority of the TBAs could be trained to work closely with SBAs. As part of the effort, the FMoH is working towards doubling the number of PHC benefiting from BHCPF from 8,809 to 17,618 PHCs by 2027 in 36 States and the FCT. While additional frontline health workers will be hired, the current government initiative to strengthen people-centered health system is to begin by retraining of up to 120,000 as collaborative effort between Federal, State Governments & key partners.
7	Births attended to by skilled birth attendants to reach 95% by 2030 (ENAP)		
8	Sustained Midwives Service Scheme with recruitment of additional 1,586 midwives annually to achieve increase in Skilled Birth Attendance from 38% to 70% by 2030		
9	Increase postnatal care (PNC) coverage by 50% from 42% to 63% by 2030 (GFF)	Nigeria has integrated PNC into its health policy guides and strategic plans postnatal care services. All MNCH documents have a clear guide as recommended by WHO on the inclusion of postnatal care (PNC) These commitments made of various platforms are good quality in terms of policy consideration however from technical consideration, there may be a need to adapt to the complex situation of the country. There may be need to revise relevant policies and guidelines to be more inclusive with reflect V4M by involving Traditional Birth Attendants (TBAs) who are mainly patronized by pregnant women, especially in rural communities. With adequate training, the government can collaborate with TBAs, train them and propose certain guideline for better improvement in the technical considerations.	The proportion WCBA with a live birth in the 2 years preceding NDHS 2018 received a PNC within 48 hours after delivery has increased from 30% in 2008 to 42% in 2018. According to MICS 2011, it was 61.4%. Postnatal health checks for newborn on the other hand is 62.4 (MICS 2021). The fact that over 50% of women give birth outside the health facility automatically influences the number of mothers receiving PNC. Higher ANC visits increase hospital birth and in turn, PNC services uptake. According to MICS 2021, 81.7% of women who had ANC 8 visits and 66.6% of those who had 4 visits delivered in health facility. Considering the commitment made on PNC in the RMNCEAH+N Strategy of 80% by 2024, it will take strategic implementation process to improve PNC uptake in the rural areas and among uneducated women who contribute to this slow and insufficient progress Some women are eager to go home immediately after delivery without extra check first as beds and necessary hospital equipment ae mostly unavailable in PHC while some avoid it due to poverty and inadequate skilled workforce. Recent data of the NSIPSS Accountability Framework (Nov 2023) shows that only 20% of the 8000 PHC facilities in Nigeria are functional. Moreover, unlike ANC which is highly subsidized or free in some areas, PNC involves more spending at the facility. Government is also not ensuring adequate emphasis on PNC unlike ANC.
10	Achieve at least 80 percent of women attending postnatal care services within 48hrs of delivery by 2028. (R-Strategy)		
11	Achieve 80% early routine postnatal care (within 2 days) (ENAP)		
12	Increase immunization coverage for U5C from 31% in 2020 to 56% in 2025 and 80% by 2030 (NPP)	Nigeria has adequate policies to achieve these commitments made on immunization. The NH Policy and NSHDP2 strategically prioritizes immunization services. In fact, the RMNCAH+N strategy emphasizes on immunization to improve MNCH and these documents are routinely revised to consider emerging issues. There is also legislation on vaccine to ensure quality and potency of vaccines in the country according to the Nigerian Vaccine Policy 2021. On immunization, the quality of relevant commitments is very good as adequate policies to guide implementation technically. Specific strategies have been designed to meet specific needs of neonates, infants, U5C, and adults. Also, there is very good progress with routine updates of policies and plans on immunization.	NDHS 2018 reported 50% DPT coverage while coverage of DPT3 is at 57% according to MICS 2021. In, fact, 31% of children aged 12-23 months received all basic vaccinations, while 21% had received all age-appropriate vaccinations. The 57% coverage is lower than the African average of 72% and the SDG target of 90% in a few years. Many children are still missed or of zero doses (2.2 million children according t UNICEF 2023). Nigeria is has made moderate progress when we look at the fund invested in immunization. However, Nigeria needs to do more to achieve the 80% target set for 2030. Both at the national and subnational, the government allocates funds for RI and campaigns. However, there are gaps in implementation as mostly affected by poor releases of budgeted funds. There is vaccine stock-out, lack of funding for outreaches, sensitization & mobile facilities, unavailability of HWs, and issues with client's perception which community mobilization could resolve. The federal
13	Increase immunization coverage from 25% (12-23 months) (GFF)		
14	Expand access to high-impact health interventions such as immunization Maputo Plan)		

			GoN, despite her commitment to huge fund for vaccine procurement failed several times to release the fund yearly. The federal & state MoH works with development partners using different strategies such as immunization campaigns, outreach and setting out RI days to improve coverage. In fact, immunization is one of the services provided in health that has consistent government funding, though inadequate. Nigeria has also aligned with the Immunization Agenda 2030 (IA2030). In implementing high-impact immunization, leveraging on the success recorded in polio eradication, several concepts are used such as Reaching Every Ward (REW) and Reaching Every Community (REC) among others. Children are reached not only with OPV but also with RI vaccines. There is a recent Strategic Blueprints & Priorities for NPHCDA with clear plan to improve immunization coverage. The FMoH ensures better coordination with donors and partners in the country. Based on recent report from the NSIPSS, number of partners that adequately coordinate their activities with NPHCDA/NSIPSS / Total number of mapped partners supporting RI has improved. file:///C:/Users/USER/Downloads/20240212_NPHCDA%20Strategic%20Priorities%20and%20Initiatives_v1.pdf
15	Increase percentage of children exclusively breastfed, first 6months of life to 60% by 2030 (GFF)	Nigeria aligns with WHO and UNICEF recommendations with the target of at least 60% of mothers to exclusively breastfeed their children for the first 6 months of life There exist adequate policies such as the Nations Policy on Infant and Young Child Feeding (IYCF) in Nigeria which has been revised twice. The IYCF policy and guideline both key into the national health policy and strategic plan which emphasize on EBF. This commitment is adequate based on the available policies and also in terms of technical consideration.	According to the NDHS 2018, about 29% of children are exclusively breastfed in their first 6 month of life in Nigeria. However, this increased to 34% in the MICS 2021. In almost all health facilities including the PHC centers, exclusive breastfeeding is a popular concept embedded in health education and promotion. Despite the baby-friendly hospital initiative that was introduced in 1991 by UNICEF, Nigeria reports sub-optimal practice of EBF among nursing mothers. Several factors are responsible for this insufficient progress, one of them is women getting involved in certain jobs which makes it difficult to breastfeed exclusively for six months. For example, Kayode et al. reported EBF among female doctors in Nigeria to be 11.1% (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10481784/) The nutrition status of mothers also affects their ability to EBF. Poor nutrition in mothers is highest among uneducated mothers and those on low wealth quantile. 58% of mothers age 15-49 were anaemic while 2% of women aged 15-49 are thin (BMI below 18.5, while 28% are overweight or obese in 2018 NDHS. Although, the Nigeria government has continued to strengthen workplace policy on EBF and extended maternity leave to at least three months. However, policy or government system are not adequately implemented to protect the jobs of nursing mothers especially in the private sector. Thus, progress is insufficient despite that EBF has been institutionalized into our health system. Implementation is also poor in the area of awareness creation of women who do not attend ANC or have facility delivery.
16	Reduce childhood wasting (U5) from 18% to less than 10% by 2030 (GFF)	The Nigerian health system prioritizes childhood nutrition and growth monitoring in all its health policies and guidelines. These commitments are very good in terms of the available policies and plan to achieve them. The IYCF policy and other relevant nutrition plans are relevant and attainable if the government is dedicated to achieve them	NDHS 2018 report showed that only 11% of children aged 6-23 months were fed a minimum acceptable diet in the 24 hours before the survey. 68% of children aged 6-59 months are anaemic. The NNHS 2018 reported that 32% of children are stunted and 32.9% are underweight. Also, 18 per cent of children suffer from wasting, half of them severely (NDHS 2018. These poor statistics fall within the WHO serious levels, although the situation is worse in Northern Nigeria There are specific action plans developed to implement nutrition interventions. Although implementation to achieve these commitments is greatly supported by development partners, there are a lot of gaps especially in rural
17	Reduce childhood stunting (U5) from 37% to less than 20% by 2030 (GFF)		
18	Increase growth monitoring for children under 5 from 16% in 2013 (GFF)		

			communities. N*igeria* still has one of the highest burden of *stunted children* in the world as government's contributions to improving nutrition in U5C are inadequate and in some cases not available at all. Although the GoN approved 16.5 billion naira in 2021 and 32.8 billion naira in 2022 as counterpart fund for the Accelerating Nutrition Results In Nigeria (Anrin) program, not all the fund was released. Poor release of fund as continuously affected the progress of nutrition interventions in Nigeria especially with the high population of uneducated, poor and unaware people. The progress of these commitments is insufficient despite that routine survey and documentation of activities.
	Reduce neonatal mortality rate from 39% per 1000 livebirths in 2020 to 19 in 2025 and 9% per 1000 livebirths by 2030 (2)	Nigeria has adequate policy to achieve this. From the NHAct 2014 to the NH Policy, NSHDP-2, BHCPF guideline, RMNCAH+N strategy etc. the quality of policy is very good. There is also good progress with routine updates of policies and plans which are technically adequate. The NHAct for example ensures that 1% of Nigeria's CRF goes mainly to mainly PHC and especially the most vulnerable in the society. This 1% is released as BHCPF distributed to the subnational to support health of the poorest. There is also the NHIA Act 2023 which makes provision for 'vulnerable group fund' (VGF) in which women and children mostly affected by lack of fund will benefit as enrollees in the system. All these laws are targeted towards reducing MMR, and mortality among neonates and U5C. These listed commitments are very good in terms of policy developed to achieve them and the technical achievement the GoN has ensured are documented,	Nigeria's U5MR declined over the 15 years from 201 per 1000 live births to 132 per 1000 live births (NDHS 2018) and to 102 live births in 2021 MICS. neonatal mortality rate only slightly declined, from 48 per 1000 live births in 2003 to 39 per 1000 live births in 2018 (NDHS, then to 34 live births in 2021 (MICS). While both policy and financial commitments are made, there is no reflection on this on service delivery leading to persistent high mortality rates. With Nigeria's MMR, U5MR, and others, progress has been limited considering the SDG global U5MR target of 25 per 1000 live births. Despite a clear road map, resource allocation, and support from stakeholders there is a low V4M and optimal accountability process. Most State governments are not committed to implementing the listed commitments from various platforms. In fact, in some States, the little financial investments made are based on conditional releases into a pooled fund. For example, Tripartite agreement between the government, Aliko Dangote Foundation, and BMGF (and in some states UNICEF). The MoU signed by the parties forces the government to allocate and release funds. Recent government initiatives such as the Although the GoN is committed to conducting routine national survey – NDHS and MICS/NICs every five years, the poor performances have informed decisions to only make more commitment, however, there is issue with executing the commitments. GoN help reduce mortality in children and women by investing in immunization services, ANC, FP, and health education etc. Part of the government fund and pooled fund from other sources have recently been earmarked as vulnerable group fund (VGF) in the NHIA Act with focus on financial protection for critical reproductive, maternal, newborn, child, adolescent health, and nutrition services to reduce morbidity and preventable deaths. Implementation of this is yet to begin. Also, despite national buy-in into the MPDSR guidelines, there is poor data on death and reviews not consistent to help reduce root causes of death and prevent reoccurrence. Optimal implementation of strategies to make these commitments achievable is lacking, thus there is insufficient or slow progress.at the current rates.
21	Reduce neonatal mortality rate to at least 15 per 1000 livebirths by 2030		
22	By 2030 to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births		
23	Reduce Neonatal MR by 50% to 18 per 1,000 LB and U5MR to 64 per 1,000 LB by 2030		
24	Reduce MMR to 256 per 100,000 livebirths by 2025 and zero maternal death by 2030 (2)		
25	Reach MMR of 270 per 100,000 livebirths by 2030		
26	Reduction of MMR by 50% to 288 per 100,000 LB by 2030		
27	Reduce Neonatal MR by 50% to 18 per 1,000 LB and U5MR to 64 per 1,000 LB by 2030		
28	Reduce maternal mortality ratio by 75 percent from 576 per 100,000 live births in 2013 to 144 per 100,000 live births by 2028		
29	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births		
30	Reduce U5MR to 88% per 1000 livebirths by 2025 and 40% per 1000 livebirths by 2030 (NPP)		
	fully implement the Strategic Roadmap to Accelerate Reduction of Maternal and Neo-natal Mortality (ICPD25)		
	MNCH interventions embedded in UHC schemes		
1	Sustain the National Task Shifting and Task Sharing Policy (ICPD25)		

2	Achieve UHC of 38% by 2025 and 75% by 2030 (NPP)	The NHIA Act 2023, NHAct, 2014 (BHCPF), and other plans, policies and guidelines were designed to create a clear roadmap to reduce mortality in mothers and newborn. All these documents exist with quality content.in terms of technical and policy considerations to achieve UHC. In line with the SDG 3, target 3.8 There is good progress in the quality as most policy documents to achieve these commitments are mostly updated although updated are sometimes delayed. The quality of these commitments is not also realistic based on the trend and antecedent.	As at year 2024, only about 7% of the Nigerian population are covered by the various health insurance system at the national, states and private. This low subscription to the insurance is due to and poor-quality services of the government insurance scheme and poor awareness, The insurance is being coordinated by the NHIA which operates under an Act enacted in 2022, and guideline developed in 2023. Achieving UHC cannot be achieved without implementing the NHIA Act. The government is aware of the need to invest in PHC as the backbone of a resilient health system. However, while there are existing policies and guidelines to achieve UHC, ooperationalization of these health-related Strategic Plans is poor. BHCPF is a crucial element of UHC especially implementation of the health insurance component. Implementation of the BHCPF currently covers only about 20% of the total PHC facilities in Nigeria. Although there is a lot of awareness around achieving UHC, progress is slow due to several man-made factors. There is a problem with financial protection as a majority of Nigerians still pay out-of-pocket Implementation of the building blocks of UHC designed by the WHO is poor. This building block explains which inputs are needed to lead to outputs and outcomes before the impact of UCH can be seen. For example, despite subscribing to Abuja declaration of 15% national annual budget allocation to health, the highest percent allocation has been slightly above 5%. Also, the FMOH has also proven to have poor absorptive capacity as fund utilization is poor leading to poor implementation and threat to achieving UHC. The GoN has initiated 'Vulnerable Group Fund' in the NHIA Act 2023 to improve UCH. Low policy implementation due to low awareness and poor evidence generation for decision making has been identified as challenges hampering UHC and achieving the ultimate SDG 3 goal of health and well-being for all https://bmjopen.bmj.com/content/13/3/e064710
	Apportion 10% of the N55.1 billion "Basic Health Care Provision Fund" (BHCPF) for maternal and child health care package - including free maternal care for all mothers in rural areas, 4 ANC visits, delivery (including C/S), two Post-Natal Care visits. (ICPD25)	This is not documented by the BHCPF guideline. However, a huge percentage of the fund is sent to PHC facilities to support maternal and child health indirectly as facility infrastructure, workforce and others are supported monthly.	Implementation of this is ongoing. Although the 10% earmarking is not documented, most of the fund affects the TFR in Nigeria health and wellbeing of mothers and children.
3	Achieve a reduction in the total fertility rate (TFR) from the current 5.3% to 4.7% by 2025 and 4.0 by 2030 (NPP)	There is plan to achieve this through FP. However, this has cultural & religious undertone that are not well addressed in some of the available policies. The quality of the this on fertility, even in NPP is inadequate in terms of technical consideration. Progress of the commitment in terms of policy consideration is good, the quality of policy content has also improved over time despite the cultural and religious undertone.	There has been steady decrease in the TFR from 6.0 in 1990 to the current 5.3 in the NDHS 2018. It also reported 8% of the birth were mistimed, and 3% unwanted in 2018, this is higher depending on the region. Also reported wanted birth of 4.8 as against in 2018 as against wanted birth of 5.8 in 1990. Until recently, government has not practically thought out the best way to implement commitment of reducing fertility rate in Nigeria. In fact, there has been poor investment by the national and subnational government in FP services – a major intervention that has been used by many societies to control their population. However, there is likely to be some level of improvement with a renewed commitment of the FP2023 and the plan to allocate at least 1% of the health budget to FP at the national level. This however needs to be replicated at subnational. The health budgets of many States and the FCT in the country often lumps FP intervention with reproductive health, and this increases the likelihood that FP services will be overlooked in the budgetary allocations. High level of illiteracy and poverty which is dominant in Nigerian society are underlining factors causing this high rate. Poor women who never attended any formal education

			(mostly from North) have highest number of children. Reducing the number of births that expose women to mortality risk is critical. Reduced poverty and high level of illiteracy especially for women will inform better decision to control TFR. Progress made over two decades in reducing TFR in Nigeria is slow and insufficient.
4	Facilitate equitable access to quality child and neonatal services (ENAP)	The GoN has moved ahead to develop the National Strategy for RMNCHEAH+N Quality of Care (QoC) in 2024. While this may not be perfectly adequate, the document highlights the strategic objectives and quality improvement processes that will be carried out to implement RMNCHEAH+N services in Nigeria. It shares vision on QoC cutting across continuum of care and is guided by the principle of country leadership, equity, human rights and accountability. Nigeria policies and plans all align with the Global Strategy for Women, Newborn, Children and Adolescents Health; Universal Health Coverage; Global agenda of Ending Preventable Maternal Mortality (EPMM); and Every Newborn Action Plan. All of these aim at improving QoC which is one of the most critical steps towards the achievement of the health-related SDGs.	Nigeria has joined other progressive countries to lay emphasis on quality of care over years. Gaps in QoC are a greater contributor to poor health outcomes than care coverage. The RMNCAEH+N) Multi-Stakeholder Partnerships and Coordination Platform (MSPCP) was adopted in 2020. The objectives of the coordination platform are to provide leadership and strategic direction for the delivery of quality RMNCAEH+N services. With focus on equitable access, in 2017, Nigeria became a member of the Global Quality, Equity and Dignity (QED) Network. The network employs various evidence-based strategies to enhance the quality of care and experience of care for improving maternal and newborn health One of the major issues with quality of maternal and newborn services is that there is no adequate emphasis on checks which come with supportive supervision and quality data gathering for evidence generation. Above all, implementation of the laid down accountability process is usually poor Without partners, quality of care (QoC) would be worse. Numbers of HRH and functional PHC very low . For sustainability, the country is leveraging on BHCPF for PHC facilities and at the secondary level of healthcare, some States have allocated and released funds for QoC implementation. There has been emphasis on QoC in several health documents, however, progress on implementation is insufficient. especially at subnational levels.
5	Facilitate equitable access to quality maternal and perinatal services (EPMM)		
6	Integrate SSNB, pediatric and adolescent standard into the current MNH QoC strategy		With the inclusion of adolescent, elderly health including nutrition in the Nigeria Strategy, it is key that a wholistic RMNCAEH+N QoC strategy has been developed.
9	Integrate maternal, newborn, child and adolescent health into other health services	Concerns with WCAH have been integrated into all available health services including national and subnational insurance schemes, immunization etc. For example, the NHIA Act 2023 prioritizes women, children and youths and set aside a vulnerable group fund to provide basic health care services. With the updated RMNCAEH+N Strategy, this commitment can be marked as good in terms of policy and quality considerations.	Implementation of this commitment is ongoing successfully; Moderate progress is recorded in the legislating special fund for vulnerable groups to receive basis minimum health package. There is also special attention of the government in the area of investing in drugs and vaccines procurement. In fact, there was a commitment, yet to be fulfilled promising investment in vaccine production in Nigeria to reduce vaccine-preventable diseases (VPD) especially among children. In the area of nutrition, there is special focus in the implementation of service delivery to women, children, but less attention is placed on the adolescents. Even for sexual health, the government is not adequately implementing for young people most of the planned-out activities outlined in the various commitments. However, implementation status is relatively insufficient in progress
10	Using part of the BHCPF to revive and strengthen the health sector, especially the Primary Health Care (PHC) system	With the ongoing revision of the BHCPF guideline to 2.0 version, the health system will be better strengthened. The PHCUOR Policy also puts into consideration technical strategies of achieving this commitment	The BHCPF has been funded and implemented since 2019. Although there have been challenges, health facilities benefiting from this fund are better monitored. Currently has about 8,500 regularly funded PHCs with a plan to increase to about 17,000 in the next three years The government through the FMoH has set out a strategic vision for the health sector 2023-2026. Under four basic pillars, the ministry plans to improve financing and work with other stakeholders including NGOs for effective governance, quality health care, health security and unlocking value chains.

			The new initiative of the government referred to as the Nigerian Health Sector Renewal Investment Program in which the BHCPF will be managed through a sector wide program via pooling is all available fund. With this initiative, facility-based services will be complemented by a phased and targeted approach to boosting demand creation, promotive, preventive and simple curative services at the frontlines. Also, a tier of Community Based Health Services will be improved on to significantly boost coverage and deepen promotive, preventive and simple curative measures as a complement to the Basic Package of Health Services delivered at facility level Moderate progress is recorded for this commitment owning to the fact that the current administration has commenced better strategies to implement
Health systems strengthening including MNCH data and accountability			
1	Strengthen the National and Sub National multi-stakeholder Accountability Mechanisms including CSOs (FP Motion tracker and scorecards) and the media structures	Establishment of the RMNCAEH+N Multi-Stakeholder. Partnerships and Coordination Platform (MSPCP). This group is made up key individuals with technical know-how who contributed to the development and revision of the RMNCAEH+N Strategy.	The RMNCAEH+N) Multi-Stakeholder Partnerships and Coordination Platform (MSPCP) was adopted in Nigeria in 2020 as an accountability platform to track, ensure proper implementation and report all RMNCAEH+N interventions. This is focused to enhance the achievement of the UHC and the SGDs – Targets 3 and 5 by 2030. The objectives of the coordination platform are to provide leadership and strategic direction for the delivery of quality RMNCAEH+N services including FP. The MSPCP is made up of state mainly from the FMoH, donors, CSOs and stakeholders from private sector. They meet regularly to discuss RMNCAEH+N implementation processes and results. Recently, the Hon. Minister of Health has also created a RMNCAEH+N Technical Working Group Meeting (TWG) under the Sector-Wide Approach (SWAp) initiative of the BHCPF. While implementation may be moderate at the national level, there is still no replication of this at the subnational levels when issues on RMNCAEH+N abound. Thus, this is insufficient progress score for implementation status on this commitment.
2	Develop RMNCAEH-N coordination strategy which incorporates a roadmap for ENAP (4)	The Nigerian RMNCAEH+N Strategy document developed and currently being revised, thus quality considered very good with key emphasis on ENAP	Moderate progress established as it awaits development of its implementation guideline. If the strategy is technically implemented, there will be better result. Accountability processes of various part of the country was not adequately considered in the previous strategy, thus the recorded moderate achievement for achieving improved health outcomes for newborns and children under five.
3	Strengthen the national FP supply chain with a view to reducing stock out rates below 20%	All the recent MNCH documents including the FP2030 Commitment document incorporates plans to reduced stock out rate of FP commodities. Policy consideration is good, so also the technical one ensuring that	There is an existing counterpart fund for FP between the GoN and relevant partners such as the UNFPA etc. This basket fund for FP is inadequate as there is consistent default on the part of the GoN, thus improved domestic fund mobilization is needed at the national and subnational. Aside allocating percentage of BHCPF to FP, FMoH also budgeted for FP commodity in 2022 to the tune of two billion naira. However, the fear is that the allocation may not be released as observed for previous years. Sub-national investment on FP commodity is quite low and not available in many states. Supply chain strengthening requires financial investment by the government as donor fatigue lingers in Nigeria. Progress has been recently recorded, however insufficient as a new line item for procurement of FP commodities is approved in the national health budget 2024.

4	Improve recruitment, development and training motivation and retention of the health workforce	The policies available are inadequate and very weak to motivate and retain health workforce. Currently remunerations are inadequate and health workforce are immigrating in droves to other countries, yet there is no plan or policy paper to still inadequacies of trained HWs.	A report in 2016 says that Nigeria has 20 nurses, midwives, and doctors for every 10,000 people, less than the minimum recommended by the WHO to provide adequate access to care. This is far worse especially at the secondary and tertiary levels as the level of immigration has increased in the last few years. Therefore, implementation of any policies concerning health workforce is poor In Nigeria, experts have reported that historically, '*brain drain*', in the form of migration of health workers to high-income settings, has been a major setback in the country. The health workforce density is estimated at 1.95 per 1000 population. Brain-drain involves the migration of skilled workers out of their countries to more developed countries in search of a better standard of living in terms of better remuneration, better working conditions. Nigeria is reported to be the highest workforce exporting country in Africa. A national statistical report published in August 2022 by the UK government revealed that 13,609 healthcare workers have left Nigeria for the UK between 2021 to 2022 The implementation of this is poor and off track. https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0205-4 https://www.gov.uk/government/statistics/immigration-statistics-year-ending-march-2021/why-do-people-come-to-the-uk-for-family-reasons
5	Increase domestic resources for health by ensuring financial deepening and inclusion	In Nigeria, health financing through domestic resource mobilization (DRM) has been incorporated into almost all health documents. In the NHAct 2014, there are clear statutory allocation to certain area of health. This was further emphasized in the NHP 2016. This specific commitment is very good as there is plan by the government to ensure financial mobilization domestically both at the national and states since health is on concurrent list.	Despite subscribing to Abuja declaration of 15% national annual budget allocation to health, highest percentage allocation has been 5.5% for 2024. Though there is increase in absolute amount, only 19.7% of the health budget is allocated to PHC falling short of the 35% target. *(Data from NSIPSS Accountability Framework result)* Domestic resource mobilization (DRM) is the process through which countries raise and spend their own funds to provide for their people. Also, the health sector over some years lacks good absorptive capacity. There are bureaucratic challenges and systematic issues which are responsible for non-release of allocated health budgets. This poor expenditure performance has ensured poor domestic funding of the system. Both at the nation and subnational, most of the spendings are done by donor organizations. With focus on vaccines and immunization, the NSIPSS Accountability Framework was developed in 2018 and has been instrumental for the tracking of indicators in key areas including timeliness and allocations to health financing by the FGoN. It also looks at financial management, vaccine accountability, immunization coverages and data quality. The performance indicators are critical for Gavi's decision regarding its continued investment in the implementation of NSIPSS. For 2023, the total co-financing and traditional vaccine procurement obligation for FGoN was $151million (69.5 billion naira) which has not been released and the June 2023 timeline (for a C rating) is past due. Also, a total of 10.9 billion naira from 2022 is still pending release. Although the country's co-financing obligation for 2023 was met using World Bank Impact funds. Implementation if this commitment is insufficient, although there has been consistent increase in allocation to health in Nigeria.
6	Implement of strengthen MCDSR systems that monitor, evaluate and respond to all contributing factors to poor maternal	Relevant for mother and child's death audit is the National Maternal, Perinatal and Child death surveillance and response (MPCDR) 2022 revised.	Maternal and child death review as a strategy has been recommended by the WHO 2004. In Nigeria, relevant stakeholders are aware of a system of review of maternal and

	outcomes, including those related to services delivery, access and sociocultural/gender inequality barriers		child death at the national level, however, the adaptation of this concept into the health structure at subnational level has been poorly managed in some states. This is one of the key strategies designed to reduce preventable maternal, perinatal and child deaths by reviewing possible causes of death and taking actions to prevent reoccurrence. The MPCDSR has guidelines and tools which have been reviewed over years and with an electronic platform for reporting. However, proper use of the toolkits and implementation of the guideline cannot be affirmed especially at the state and LGA level. Almost all states in Nigeria have established a MPCDSR team after full institutionalization of the concept at the National level with a functional MPCDSR Steering Committee. This is also
7	More than half of population within 2 hours of emergency obstetric care	This commitment is well integrated into the Nigerian health system at all levels. There are clear roles for obstetric emergency issues from the lowest facility (PHC) to the highest. The referral channel is also well established in the medical care curriculum. For this commitment however, there is no clear timeline. This commitment is good in terms of policy and technical considerations	Obstetrical emergencies are life threatening conditions that occur in pregnancy during labor and after delivery. It is common that approximately 15% of all pregnant women develop serious complication from conception to delivery. The implementation of this commitment has been a major challenge as majority of the government PHC do not operate for 24 hours as planned. Also, there is challenge with frontline health workers in terms of adequate skills and availability. This is more pronounced in the rural areas. The necessary equipment needed for emergency obstetric care are also lacking in most cases, even in some secondary health facilities. There is insufficient progress in the implementation of this especially with the lack of such adequate emergency obstetric care services.
Inter-sectoral approaches for MNCH across the life-course			
SRHR			
Access and choice to effective contraception methods			
1	Increase FP access and choice from 12% mCPR to at least 27% through scaling up evidence-based, high impact practices by 2024 (1)	These commitments are strategic, attainable and relevant. E.g. these FP commitments are embedded into the Nigeria Family Planning Blueprint (Scale Up Plan), 2014 (Updated for 2020-2024), Nigeria postpartum FP strategic and implementation plan (2020), The national private health sector engagement strategic plan for family planning services (2020) etc. The commitments define in real term what is meant to be achieved. The commitments are generally good.	According to MICS 2021, 18.2% (slightly higher than the last two previous national surveys) used any modern FP method among married women in Nigeria. However, it is evident that key implementing partners contribute majorly to this progress. Except for more government investment and sincerity of purpose at subnational, this commitment will not be achievable by 2024 or in 2030. Challenge in most parts of the country includes resistance to increased FP services for different reasons, including religion and gender inequality, with only 11% of women in kano state reporting feeling empowered enough to make decisions on their own bodies Implementation at the sub-national is characterized by FP commodity stock-out. Demand is also affected by myths & misconceptions etc. Implementation performance is thus subject to release of allocated fund. State government's commitment & implementation at the sub-national is also poor, but crucial. Even with the recent budgetary commitment to FP at national level, we record insufficient progress for these commitments. Judging from antecedents the GoN has consistently defaulted in releasing approved or pledged fund for FP. https://articles.nigeriahealthwatch.com/fundfpnaija-domestic-funding-for-family-planning-needs-urgent-prioritisation/
2	Increase modern contraceptive prevalent rate (mCPR) to 37% by 2025 and thereafter achieve 47% by 2030 (2)		
3	Percentage of modern methods users (all women) disaggregated by age marital status increase by at least 50% by 2028 (1)		
4	Increase demand of family planning by 50% by the year 2028		
	Reducing unplanned pregnancies and maternal death through the promotion of health literacy for informed decisions and access to quality health services is a viable reason to invest in sexual and reproductive health as only 1 in 6 women in Nigeria use any form of contraception and on a yearly basis 1.25 million Nigerian women have an abortion based on data from the WHO		

5	Improve financing for FP by allocating a minimum 1% annually of the National and State Health budgets equivalent to N4.7 billion and N6.9 Billion respectively (1)	The FP2030 Nigeria Commitment Form is a policy document which defines government's direction and road map to achieving better outcomes in FP implementation. it's a good consideration. However, no realistic timeframe or efficient way of getting the fund defined. Adding to the score point is the development of the National Guideline for the Integration of FP into Comprehensive Primary Healthcare and National Health Insurance in Nigeria. This was recently developed in 2024 and will be validated soon at the national level with the hope of it been domesticated at subnational. The national and state health insurance guidelines has also incorporated FP into the list of benefits. However, implementation is yet to begin in most states. Quality of the FP2030 where 1% of health budget to be allocated for FP is promised can be said very good.	Between 2012 and 2016, the Federal government fulfilled only 11% of its FP2020 pledge to provide US$3 million annually for the procurement of family planning commodities. https://doi.org/10.1186/s12905-023-02396 There exist specific budget lines for procurement of quality FP commodities in the national budget. Nigeria's progress in achieving the targets of FP has been slow and inconsistent, owing to poor government funding of family planning service. Specifically, counterpart contribution will contribute to improved access & quality of FP commodities. The two billion naira budgeted for FP in 2024 by FMoH though inadequate, is an improvement in domestic fund at national level compared to last 4 years. Although 1% of health budget for FP not achieved, challenges with releases & utilization of fund poses some threat. However, there is no known institutionalized accountability process to achieving this commitment.
6	Reduce unmet needs of FP from 19% in 2020 to 10% in 2025 and to zero by 2030 (2)	The Guideline for the Integration of FP into Comprehensive Primary Healthcare and National Health Insurance in Nigeria focuses more on reducing unmet needs. The document highlights various methods clients can choose from. Policy considerations is good especially since a lot about FP has been incorporated into several health documents. However, there is need to be more specific with the different reasons why modern contraceptives are not being used by some women and proffer specific solutions in the various government documents The commitments targeting reducing unmet needs for FP are good in terms of quality.	Unmet needs for FP in MICS 2021 was 23.9% for married and 50% for unmarried women. This shows insufficient progress over the years While many partners are supporting, achieving this target, achievement mainly depends on subnational govt investment which is currently lacking in most states. So far, there has been very poor investment into FP by the state governments. The current level of progress in implementation status, though insufficient is mainly driven by development partners.
7	Percentage of women with unmet need for contraception reduce by 50% by 2028		
8	Increase proportion of family planning demand met with modern contraception by 50% by the year 2028		
9	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 programs.	This target 3,7 of the SDG 3 has been adopted by Nigeria right from inception. With the development of RMNCEAH+N strategy and QoC, Nigeria has quality plan to implement and achieve access to SRH services by all citizens. This is a good commitment with strong policy and technical considerations as SRHR is now at the forefront of being entrenched into national strategies. The quality of this commitment is good.	WHO states that in order for SRHR to become a reality, it is necessary to provide comprehensive and people-centered services that address the different elements of SRHR. These services need to be supported by a quality health systems, and meaningful community engagement. With collaborative effort of partners, implementation of elements such as FP, awareness and sensitization and community engagement are ongoing, but government investment in this is relatively low. The implementation of this commitment has been insufficient over the years. With the current rate of implementation, Nigeria cannot achieve this target.
Access to safe and legal abortion services			
1	Implement national policies, strategies and action plans to end unintended pregnancies and unsafe abortion	This commitment has been entrenched into various policies and plans on FP and is adequate enough to succeed. In terms of technical consideration, it good enough. However, this commitment is not adequate in terms of setting timelines. The quality of this commitment is good.	Available evidence indicates that only 2.1 percent and 1.2 percent of married (or in union) adolescents in Nigeria are using any method and modern method of contraceptives respectively. This has contributed to the estimated 1.2 million induced abortions done annually of which 60 percent were unsafe. Unintended pregnancies are most common among adolescents and young women, thus the need to better implement this commitment to ensure that lives are safe. There are still several quark doctors and nurses who are engaged in unsafe medical practices and contributing to the high mortality rate of WCBA. While action plans exist to support existing policies developed to reduce unwanted pregnancy and safe abortions, implementation is insufficient.
2			

Prevention and treatment/referrals for Sexual and Gender-Based Violence			
1	Reduce social & gender norms hindering women and girls' agency and autonomy, and access, to rights-based FP information & services by 2030 (1)	National Youth Policy, WCA event, SDG Summit 2023 etc. All reaffirmed commitment to social and gender norm which Nigeria has keyed into. WHO and SDG has provided good guidelines for social and gender norm. However, the quality of this commitment is average in terms of policy and technical consideration seems to be unattainable, not measurable and lack inclusiveness as there is no buy-in of all stakeholders - MDAs that should be involved in enforcing implementation and even beneficiaries./ Legislation for discriminations against women and girl child has no progress in most states The quality of this commitment is average.	In June 2021, the government through the office of the Office of the Special Adviser to the President on SDG (OSSAP-SDG) launched Nigeria SDG implementation plan 2020-2030 with support of UNDP. With state representatives in attendance, there was clear emphasis on SDG 5 The MoH, MWA, Min of Youth & Sport are limited in their investment & implementation. So far, there is no know special save centers for adolescent girls or women. For example, in the case of unintended pregnancy, rape they are subjected to the harshness and stigmatization of the society. However, in terms of violence and exploitations, there exists NAPTIP, a government agency Insufficient progress has been made on this commitment as government's efforts are inadequate to achieve the 2030 target at the rate of current implementation..
2	By 2030, end all forms of discrimination against all women and girls everywhere		
3	By 2030, end violence and exploitation of women and girls		
4	Develop legal frameworks, strategies and programs that deal with GBV	Apart from the Nigerian constitution, there is National Gender Policy 2007 and other two major legislations on these commitments in Nigeria to GBV - Violence Against Persons Prohibition Act (VAPPA) and the Child's Rights Act (CRA). The VAPPA is the most encompassing legislation in Nigeria addressing violence against persons, whereas the CRA is the first law to restrict the age of marriage to 18 years. The Constitution needs to be amended for VAPPA and CRA to function optimal, thus, the quality of the policy is average	Although Nigerian government has a budget line item for GBV, there is hardly any impact felt in implementation as there is very low awareness. About 63 million naira was budgeted by the Ministry of Women Affairs for survivors of GBV & harmful traditional practices. in 2024. However, this is grossly inadequate even if the fund is released. Moreover, beyond rehabilitation of victims, there should be focus on prevention of GBV also Intervention of such should be multi sectoral involving all relevant MDAs, there is also poor accountability within the system and poor documentation, thus evidence-based decisions are difficult to make. As a member state of the United Nations (UN), Nigeria has ratified a number of international laws aimed at eliminating GBV and abuses against children. These include the Maputo protocol, African Charter on Human and People's Rights and the Convention on the Rights of the Child. Despite the passage of new legislation in Nigeria at federal and state levels to address gender-based violence (GBV), many forms such as sexual violence, intimate partner's violence (IPV) of GBV are increasing At the national level, a key challenge to implementing the VAPPA and CRA is the need to implement after domesticating them at each state. Some states. Mostly states have domesticated the two laws. A key gap in the VAPPA is that it lacks preventative measures that would help address the root causes of violence against women. While a key gap in the CRA is its lack of alignment with the Nigerian Constitution regarding minors and marriage; for example, the Constitution states that a child is an adult after marriage, regardless of age, but the CRA puts the age of marriage at 18 years file:///C:/Users/USER/Downloads/MCGL_GBV-Nigeria_LRA_Final.pdf https://lasdinstitute.org/resource/an-analysis-of-laws-and-policies-to-combat-gbv-in-nigeria/
5	Protect the rights of women, youth, and adolescents and address sexual and GBV		
6	Reduce GBV and harmful practices against women and girls from 46% in 2020 to 20% in 2025 and zero by 2030 (2)		Implementation is generally poor. This indicator is not tracked according to the SDG recommendation – "*Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and /or sexual violence by a current or former partner in the last 12 months"*
7	Eliminate female genital mutilation (FGM) by 2024	Nigeria being a signatory to international human rights treaties and conventions that prohibit and made commitment to elimination of FGM. An expression of this commitment is the signing into law of the Violence Against Persons (Prohibition) Act 2015. There also exists national policies adopted toward the elimination of this practice in Nigeria. The most recent	This is reflected with the rise of FGM in younger girls (NDHS 2018). By 2010, Nigeria had the highest absolute number of cases of FGM in the world. By 2022, with an estimated 19.9 million survivors, Nigeria accounts for the third highest number of women and girls who have undergone FGM worldwide. (UNICEF). While the national prevalence of FGM among women in Nigeria aged 15-49 dropped from 25 per cent in 2013 to 20 per cent in 2018, prevalence among girls aged 0-
9	Eradicate female genital mutilation/cutting and other harmful traditional practices		

		National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria 2013 – 2017 with an extension to the end of 2019. These law and policies are good in quality The look at the culture of the people and suggested financing by the government. The policies align with the best global practice however, this commitment is not realistic. The quality of this commitment is good.	14 increased from 16.9 per cent to 19.2 per cent in the same period, according to NDHS figures FGM is defined by the WHO as all procedures which involve partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons. It is a violation of person's right to health and physical integrity. There are punitive actions to be melted on offenders, but the implementation of this policy is poor. There is no recorded progress in the implementation of this commitment.
10	At least two-thirds of the States in Nigeria and the Federal Capital Territory adopt and implement the Violence Against Persons Prohibition (VAPP) law by 2024 (4)	In almost all the states, just like the Child Right Act, VAPP law has been assented to by the State governments. The Act is in line with best practices around the world and aligns with the recommendations in the SDGs	https://www.premiumtimesng.com/news/top-news/563672-gender-based-violence-34-states-domesticate-nigerias-vapp-act-official.html?tztc=1 By the year 2022. 34 of the total 36 states and FCT have domesticated the VAPP Act 2015 to curb incessant cases of violence across states. Despite the passage of the law, women and children are mostly affected by different types of physical and sexual violence and abuse. Most of these violences stemmed from the fact that there is no awareness on the rights of women, children and adolescents. Also, there is no adequate justice system or safe centers created by the government in most states. At the national level, we have an active agency of the government called National Agency of the Prohibition of Trafficking In Person (NAPTIP). Although there are state offices also, they are not adequately funded to attend to all complaints. This is moderate progress in legislating the Act. However, actual implementation of the law at the state level is ultimately insufficient
11	Reduce the proportion of women aged 20-24 years who were married or in a union before age 18 from 50% to 25% by 2024 (NYP)	Quality of this commitment is average. Revised policy (NYP 2019-23) is comprehensive However, there is no realistic timeframe, no consideration of V4M economy & sustainability which may be influenced by myths and traditional beliefs. The policy does not also highlight how this will be achieved.	The government has not developed a guideline to implement relevant policies that would achieve this commitment. Adequate resources not specifically allocated to achieve this commitment and stakeholders at community especially women-groups are not aware or empowered. Poor implementation is observed with no appreciable progress There is no known institutionalized accountability process that any recorded progress (if any) can hinge on. Documentation of progress if available may not be reliable.
12	Institute effective behavior change communication and information sharing mechanisms to promote SRH services including initiatives to reduce gender inequality	Government is only averagely concerned about effective behavior change communication (BCC) among the masses. While BCC is entrenched in some of the policies and plans that promotes SRH, the concepts of BCC to use per geographical area are not adequately explained in the policies. The quality of this commitment is average.	The GoN through the FMoH, Ministries of Information and National Orientation Agency is not doing enough to continuously educate and inform the masses on SRH services. In fact, gender equality is not generally implemented, even though it was subscribed to by Nigerian government. In most parts of the country, there is still inequality especially in the rights given to women in terms of their sexual and reproductive health. The implementation of this commitment is inadequate.
Prevention, detection and management of reproductive cancers, especially cervical cancer			
1	Increase the proportion of women 30 to 49 years old who are screened for cervical cancer from about 3.5 percent in 2007 to at least 80 percent by 2028.	Quality of policy and technicalities are good as it falls in line with recommendations of WHO update on HPV vaccination schedule. The Nigerian health system has also adopted the WHO recommendation on using the HPV to prevent cervical cancer. The quality of this commitment is good.	In 2020, Globally, **C**ervical cancer was responsible for 604,000 new cases with 342,000 deaths, with about 12,000 cases occurring in Nigeria and over 8,000 women dying from the disease. Cervical cancer ranks as the 2nd most frequent cancer among women in Nigeria and the 2nd most frequent cancer death among women between 15 and 44 years of age. Should be a routine service for WCBA presenting at health facilities. Poor investment by the govt The government collaborates with partners (WHO, Gavi and others to secure over 6 million doses of Human Papilloma Virus HPV in 2023. Much of the interventions going on in the country are mainly supported by partners although there was low coverage before the most recent campaign in late 2023. In 2022, WHO reported global decline in HPV
2	Increase the proportion of the population 9 to 15 years who are immunized for HPV from 2% in 2015 to 50% by 2028		
3	Achieve 100% treatment coverage for all women in reproductive age with pre-cancerous lesions of the cervix by 2028		

			vaccination coverage. Between 2019 and 2021, coverage of the first dose of HPV vaccination fell from 25% to 15%. This means 3.5 million more girls missed out on HPV vaccination in 2021 compared to 2019. In October 2023, the FMoH and Social Welfare, through its NPHCDA introduced a single dose vaccine against Human Papilloma Virus HPV into its RI system. The initiative aims to vaccinate 16.6 million girls aged 9 to 14 by the end of 2025. Supported by WHO, Gavi and UNICEF, it rolled out a mass HPV vaccination campaign in 16 states. From October 2023 till January 2024, with the claim that about 4.7 million girls aged 9 to 14, have received the HPV vaccines in the 16 phase 1 states. Also, In line with the Global strategy, WHO with funding from the Susan Thompson Buffet Foundation, provides catalytic support to five states (Anambra, Ondo, Kebbi, Niger and Ekiti) to reach 5,000 per states In addition, Government has concluded plans to start a new cancer center in each of the 6 geopolitical zones in Nigeria. While this is yet to be implemented, the second batch of the HPV campaign is ongoing in about 12 states from May 2024. The implementation of this commitments can be said to be insufficient based on the current status and system of operation. https://www.afro.who.int/countries/nigeria/news/safeguarding-future-women-and-girls-nigeria-against-cervical-cancer
4	Improve access to and uptake of quality SRH services for youth and adolescents including HPV vaccination	Revised the RI policy to include HPV for adolescent girls. The SRH part of the RMNCAEH strategy has also been revised to better involve adolescents and young people,	There are no clear guidelines on how uptake of quality SRH including HPV vaccine will be implemented for adolescents especially those out of school. The group of youths and adolescents form the majority especially in the Northern region of the country. Although the government has now included HPV into RI and recently vaccinated millions of adolescent girls mostly in secondary schools with HPV. This was carried out in the last quarter on year 2023 in partnership with Gavi and WHO among other key partners
5	Increase the proportion of men who screen for prostate cancer by 25% of the baseline by 2028	The Nigerian health plans and policy only made a brief recommendation for prostate cancer. However, there is no plan for support even for the elderly as there is no financial commitment. The quality of this commitment if generally poor owning to the fact that this is not of national priority. Only recently did the RMNCEAH+N include the Elders. The quality of this commitment is poor.	The International Agency for Research on Cancer (IARC) reported that in Nigeria, prostate cancer constituted 29.1% of all male cancers in 2018. A study also reported for Benign Prostatic Hyperplasic (BPH) that one in four men 51-60 years has symptoms suggestive of BPH, with a reported prevalence of 24.9%.in rural settings in South-West Nigeria Prostatic hyperplasia increases urethral resistance resulting in compensatory changes in bladder function and can lead to prostate cancer Prostate cancer screening is not a common practice in Nigeria in spite of prostate cancer being the most commonly diagnosed cancer in Nigerian men. Awareness about prostate cancer is also poor. Majority of our patients therefore usually present in the hospital with the disease in the advanced stage. The including of the elders into the RMNCEAH+N has not led to any specific intervention for this group especially in the area of the health and cancer management. The commitment is vague as the baseline is not even known. A lot needs to be done in the area of awareness creation as studies shows poor level of awareness especially among uneducated men across the country The implementation of this commitment is poor and not on track https://pubmed.ncbi.nlm.nih.gov/30116888/

			https://www.sciencedirect.com/science/article/pii/S2211035724003257
Inclusion of essential packages of SRHR interventions within UHC and PHC schemes			
1	Strengthen integration of FP into Nigeria's socio- economic development frameworks and plans (1)	Availability of policies that are strategic, attainable and relevant e.g. National Reproductive Health Policy (2017), NSHDP (2018-22) etc. Most of these plans are specific, measurable & time-bound. Quality of achievement is good. Most recent policy & strategic documents on WCAH & SRH have updated FP plans. The quality of this commitment is good.	FP now appears on national budget line in 2024 unlike the previous year when it is embedded with other interventions like malaria, MNCH etc.. However, only 2 billion naira budgeted for FP in 2024 instead of the proposed 1% of health budget. Nigeria missed FP 2020 target partly due to poor govt funding, she may also not achieve FP2030. The State counterparts are making this difficult for the implementation of this integration to be better achieved. There is moderate progress https://www.premiumtimesng.com/news/headlines/653524-2024-budget-again-nigerian-govt-fails-to-prioritise-family-planning.html
2	Establish sustainable systems at national, state and LGA levels to respond to the SRH Needs of all citizens in humanitarian / fragile contexts, health emergencies and natural disasters	Good progress as health policies and plans are being revised to accommodate sexual and reproductive health services. Most RMNCEAH+N documents and related policies have technical qualities needed to drive implementation. The Guideline for the Integration of FP into Comprehensive Primary Healthcare and National Health Insurance in Nigeria. The quality of this commitment is good.	Sexual and reproductive health (SRH) refers to physical and emotional wellbeing and include the ability to be free from unwanted pregnancy, unsafe abortion, STIs including HIV, and all forms of sexual violence and coercion. In Nigeria, the government is paying more attention to the implementation of FP, pregnancy care, voluntary counselling and testing (VCT). Although, issues affecting SRH education in school curriculum, safe abortion and STIs screening and management have been incorporated in available policies, implementation is quite low and insufficient. Health systems that achieve UHC and the health-related SDGs rely heavily on a solid foundation of PHC. The majority of SRH services, such as antenatal and post-natal care, contraception and abortion care, can be provided through PHC. This is currently ongoing as under the BHCPF, government invest N 300,000 quarterly to about 8,000 PHC of the total 28,947 government-owned PHC (1 per Ward). There is plan double this number with support of BHCPF. There are other areas of SRH that is Nigeria is not performing so well – legalizing and access to safe abortion services, GBV, HPV vaccine program and reducing out-of-pocket payment for some related services. Being a wide area of health, Nigeria needs to come to terms to better implement these interventions. The progress of the commitments is also insufficient like several other SRHR commitments.
3	By 2030, ensure universal access to SRH-care services, including for FP, information and education, and the integration of reproductive health into national strategies and programs.		
4	Reduce HIV prevalence from 1,4% to less than one by 2023 and less than 0.5% by 2030	Nigeria has available policies to support the eradication of HIV. These policies and plans are majorly driven by international funding especially from the US government through the President's Emergency Plan for AIDS Relief (PEPFAR). However, the GoN makes available some counterpart funding and enabling envirionments. Existing financial and implementation policies are not quality enough to sustain the prevalence of the disease The quality of this commitment is good.	Since its first case in 1985, Nigeria has joined other countries to fight and reduce the prevalence of HIV/AIDS. The first HIV/AIDS sentinel survey was conducted in 1991 with a prevalence of 1.8% which since then increased to 3.8% in 1993, 4.5% in 1996, 5.4% in 1999, and peaked at 5.8% in 2001. Post 2001, decline trend was observed in 2003 (5.0%), 2005 (4.4%), 2008 (4.6%), 2010 (4.1%), 2013 (3.4%) The national prevalence of HIV in Nigeria is 1.4% *(from the 2018 NAIIS and UNAIDS estimation)*. It is estimated to have increased to 2.1% in 2023 among adults 15-49 years. This increase has resulted in the current score of insufficient progress on this commitment Although Nigeria has the second largest HIV-positive population in the world, the country relies mostly on external donors for its HIV control. International donors account for over 81% of Nigeria's HIV spending, which is unsustainable and creates funding gaps. According to a research study published on The Lancet, challenges to HIV financing include inadequate budgetary allocation, mostly caused by government perception of the HIV program as the responsibility of donors; delays in fund releases; inefficient use of the HIV funds; poor tracking of funds and commodity

			use; inadequate country ownership; and poor accountability structures. There implementation status for this commitment is insufficient. https://www.unaids.org/sites/default/files/country/documents/NGA_2020_countryreport.pdf https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00154-1/fulltext
5	Increase HIV testing among pregnant women	The national prevention of mother-to-child transmission of HIV (PMTCT) program in Nigeria started in 2002. Since then, Nigeria has aligned all health documents at the national including the NHP and NSHDP 2 to reduce the prevalence of PMTCT. The issue with PMTCT is well documented with good quality in all health documents in Nigeria. The quality of this commitment is very good.	. Nigeria accounts for 24% of pregnant women living with HIV worldwide who are not on antiretroviral therapy and is the largest contributor among the seven countries that account for half of all new HIV infections among children globally. One in every seven babies born with HIV in the world is a Nigerian baby. Because of this, there is an urgent need to scale up sustainable programs for the elimination of vertical transmission of HIV in the country, and the government has committed to end vertical transmission by the end of 2022. In 2021, the FMoH delivered 1.7 million of the 4 million HIV test kits ordered as a step towards ensuring that all pregnant women are screened. The procurement of the HIV test kits is a powerful demonstration of political leadership and country ownership by the Government of Nigeria for an AIDS-free generation. Some of the challenges we identified included: difficulty in identifying HIV-infected pregnant women because of low uptake of antenatal care; interrupted supplies of medical commodities; knowledge gaps among healthcare workers; and lack of a national unique identifying system to enhance data quality. Although there is progress in this commitment over the years, this is quite insufficient as majority of pregnant women still have delivery outside health facility. Several of those who have in facilities do not also have necessary health equipment or skill to prevent mother to children transmission https://academic.oup.com/inthealth/article/11/4/240/5480911
6	Redoubling of efforts to eliminate mother-to-child transmission of HIV		
AHWB			
Policy: National policy and programs for adolescent well-being (10-19 years) offering information and services in the public sector			
1	At least 80% of early adolescent girls (10-14 years) and 67% of early adolescent boys (age 10-14 years) have adequate knowledge regarding menstruation and menstrual hygiene management by 2024	The National Youth Policy and NPP expresses interest in adolescents' menstrual knowledge and hygiene. There is quality in the development of these policies as they consider all relevant factors especially for in-school adolescents. However, the NYP proposes community engagement to also improve the knowledge of out-of-school adolescents. The quality of this commitment is good.	The government has included menstruation hygiene for adolescents in Junior Secondary School under Civic (social) studies. Although, the curriculum is not deep, it prepares a girl child for this period until she gets better knowledge in senior school under Biology. Unfortunately, there are several adolescents' boys and girls who are not opportune to be in school, they contribute to the high percentage of adolescents who lack knowledge. Menstruation knowledge remains highly essential for young adolescents. Inadequate awareness and understanding of menstruation have far-reaching consequences on the overall wellbeing and health outcomes. Adolescent girls (10-19) make up a large percentage of high school students in Nigeria. In a study published on the National Library of Medicine in November 2023, most of the respondents in Nigeria were not adequately prepared for the onset of their first menstrual period. Knowledge and attitude levels were low regarding periods for adolescents. In another study before the COVID-19, government has not been forth coming in ensuring MHM facilities especially WASH including toilets with locks, wash hand basin and soap. The implementation of this commitment is insufficient. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10745060/
2	At least 75% of schools have separate and clean toilets for females and males in adequate number and with appropriate menstrual hygiene management (MHM) facilities in the female toilets		

3	Target children, adolescents and youth, both in and out of school with age-appropriate and culturally sensitive comprehensive sexuality education		There is currently no known comprehensive sexuality education being implemented by the government for out-of-school children and adolescents. In fact, most of the curriculums being used in government schools are shallow. Most adolescents gain knowledge mostly from peer-to-peer.
4	Increase the proportion of young men and women aged 15–24 with basic knowledge about SRHR to 90% by the year 2028		
5	To improve adolescents' well-being and accelerate the achievement of related SDG priorities for adolescents and young people as a smart investment in the future of our societies, economies, and the planet.	The policies made for the following commitments in Nigeria is good. Aligning with the SDG, the NPP and the NYP strategically highlighted priority activities to be carried out to improve wellbeing of every adolescent in Nigeria. The quality of this commitment is good.	As mentioned, the implementation status of these commitments is poor. There is little attention paid to adolescents both in school and out of school. Majority of the government schools do not have sick bay or clinic. They also lack portable water, toilets and counseling rooms where psycho-social issues may be handled. Government's educational curriculum lacks necessary practical equipment and facilities including laboratories, sport facilities and others which could promote optimal learning for adolescents. There is huge gap in the learning culture and curriculum between private and public schools. Thus, progress is grossly insufficient.
6	To prioritize adolescents' well-being and related SDG priorities in our national development plans and strategies		
7	Ensure that all girls and boys complete free equitable and good-quality primary and secondary education		
National standards for delivery of AHWB information and services to adolescents, including on user fee exemption			
1	At least 75% of students in upper primary & secondary school students (private & public sector) are provided with school-based family life & HIV/AIDS education by 2024	Average score observed. While the commitment exists, there are no very clear and comprehensive means it can reach target holistically. The quality of this commitment is average.	New curriculum in civic study, science etc. has family life and HIV incorporated, however, not deep enough for basic knowledge. This is insufficient progress
2	Increase the proportion of adolescents and young people (15-24 years) who have comprehensive knowledge of HIV transmission to at least 80% by 2024	Average score mainly from the work IPs are doing in collaboration with some MDAs. The quality of this commitment is average.	Knowledge on HIV still shallow in rural areas. Only 1 in 4 has comprehensive knowledge on HIV as at 2021/22. (MICS) https://www.unicef.org/nigeria/media/1641/file/Nigeria-equity-profile-his.pdf.pdf
3	By 2024, increase the proportion of adolescents (15-19 years) who used a condom at the last intercourse with a non-marital partner from 36% in 2018 to 70% for females, and from 57% to 80% for males	While relevant policy exists, it is inadequate. Policy may need to prevent young people from not taking condom use serious. May need to criminalize indiscriminate sex that increases STI and unwanted pregnancies and abortion which could lead to death. There is very little investment by the government (Ministries of women affairs, and Youth and Sport, which gives this commitment an average score. The quality of this commitment is average.	MICS 2021/22: 49.0% females and 57.3% male adolescents (15-19 years) used condom at the last intercourse with a non-marital partner. Also, 27.1% of female & 14.5 male adolescent (15-19 years ever had sex. 49.3% female & 44.1% male had more than 1 sexual partner in the last 12 months. Condoms are the most effective method to prevent sexually transmitted infections (STIs) and HIV for sexually active youth. In a study in Plateau state, Inconsistent condom use was more likely among adolescents; with lower education and with low awareness of SRH issues. It has been generally observed that the government is doing very little on this commitment There is insufficient progress in implementation.
4	Increase contraceptive prevalence rate (modern method) for adolescents and young people from 2% in 2008 to 15% by 2028	The national policies and plans such as RMNCAEH+N strategy, the NPP and NYP clearly makes available quality with this commitment. Specifically, these policies emphasize on the strategies to ensure that adolescents' use of modern contraceptive is supported by the government. However, implementation progress is insufficient. The quality of this commitment is good.	Available evidence from the NDHS indicates that only 2.1 percent of married (or in union) adolescents in Nigeria are using any method and while only 1.2 percent use modern method of contraceptives. Between 2013 and 2018, NDHS result shows increased knowledge and use of contraceptives currently married and sexually active unmarried women aged 15-19 year. None of the adolescents adopted Long-acting methods (LAM), Intrauterine device (IUD), and female sterilization contraceptive methods. GoN has not implemented an inclusive and youth-friendly, client-centered contraceptive services and information centers for adolescents notwithstanding their marital status. Until this is done, the sight progress would be attributed mainly to partners working at subnational levels. There is insufficient progress in implementation.
Legal systems to protect the rights of adolescents (both female and male) with a specific focus on minimum age of consent			

AHWB is embedded in national policies and plans with dedicated financing for AHWB programs			
1	Increase the integration of adolescents and young people into development efforts and effectively address their SRH (2)	Several policy documents are good enough – NPP, RMNCAEH+N Strategy etc. Technically, average progress is made as more of AHWB is being integrated into strategic documents as revisions are made The quality of this commitment is good.	Implementation especially in schools and youth centers is poor. If any, government is hardly involved, thus sustainability problem. No documented and sustainable evidences on large scale funded by the govt in schools, religious centers, youth centers, communities etc.
2	All the 36 states of Nigeria and the FCT adopt and domesticate the Child Act Rights by 2024	The Act is available except in Adamawa, Bauchi & Gombe. This commitment is very good in terms of quality consideration. The Problem is with proper implementation https://www.partnersnigeria.org/childs-rights-law-tracker/	The passage across all states is on track. While it has been recently passed in some states, it was passed 10-20 years ago in many. However, no evidence its operational in many states as evidences of child neglects are observable. No documented tracking of issues affecting children except in health
3	By 2024, at least 90% of adolescents and young people (15-24 years) with symptoms suggestive of STIs seek treatment from formal health services	Most policies and plans to reduce the prevalence of HIV/AIDS in Nigeria also focus on reducing other STIs among young people. The quality of this commitment is good.	Although there are no adequate statistics on the prevalence of STIs among adolescents in Nigeria, it is estimated that they account for between 15 and 30 percent of all reported cases of infections and often times, due to the exorbitant cost of procuring treatment, many of those infected do not seek health care from professionals. There is a level of awareness among educated and city-dwellers than adolescents in rural areas. Many of them do not even know the signs and symptoms of STIs. Except for HIV/AIDS, there is little or no attention paid by the government in this area. In a study carries out by Mmari et al, to determine STI treatment-seeking behaviour among adolescents. A greater proportion of males than of females had sought treatment for their STIs (64% vs. 48%). Among those who had sought treatment, 60% of females had gone to formal sources, most commonly a government clinic; 54% of males had sought care from informal sources, most commonly a traditional healer. The implementation of this commitment is insufficient https://pubmed.ncbi.nlm.nih.gov/20663743/
4	Reduce adolescent childbearing rate from 19% in 2017 to 12% by 2024	The commitment is adequate as there are policies specific to adolescent reproductive health. This includes the RMNCAEH+ N strategy, the NPP and others with clear road map to reduce child bearing rate among young people. The quality of this commitment is good.	Adolescent is by some measure the healthiest period in the life-course, yet, it can also mark the first manifestations of issues which can have life-long effects and wellbeing such as unsafe sexual behaviour and early child bearing. It is critical to achieve this in Nigeria, where the adolescent birth rate is 107.3 per 1000 women between the ages of 15-19 (NDHS 2018) However in the 2021 MICS, this dropped to 75 births per 1000 women in Nigeria. The implementation of this commitment is insufficient
5	By 2024, reduce the prevalence of over nutrition (overweight and obesity) among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018	The policies and strategic documents are average to meet the nutritional demands of adolescents. This are no emphasis on specific nutritional needs for adolescents in most of the health documents available. The quality of this commitment is average.	Adolescents age 10-19 years make up about 24% of the total population of Nigeria. Health interventions including nutritional are shown to have long-lasting effect on adolescents. Nutritional issues are rampant among adolescents as they have heightened risks to unfavorable nutritional behaviors leading to malnutrition including aneamia. Adolescent females require approximately 2200 calories/day, whereas male adolescents require 2500-3000 calories/day. Nutritional deficiencies and poor eating habits established during adolescence can have long-term consequences, including delayed sexual maturation, loss of final adult height, osteoporosis, hyperlipidemia, and obesity. https://pubmed.ncbi.nlm.nih.gov/10030685/ In another study by Olatona et al, 2023 among adolescents in Lagos, Dietary habits were poor and dietary diversity was low. The prevalence of overweight and obesity was 13.4% and 7.0%. Eating dinner, dieting to control weight and daily consumption of foods outside the home were associated with overweight and obesity. https://pubmed.ncbi.nlm.nih.gov/37763409/
6	By 2024, reduce the prevalence of acute undernutrition malnutrition among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018 {from 25% in 2018 to 13% in 2024}		
7	Reduce the proportion of young people with nutritional problems in 2018 by 75% by 2028		
8	Reduce the proportion of non-pregnant adolescent girls (age 15-19 years) with anaemia from 61% in 2018 to 30% in 2024.		

9	By 2024, reduce the maternal mortality ratio among adolescent girls by at least 40% compared to 2018	The is adequate plan and good enough policies to meet these objectives. Although most of these policies are not specific for adolescents, but generally for women of child bearing age (15-49 years). The quality of this commitment is good.	The adequate knowledge needed by adolescents to prevent unwanted pregnancies and related consequences are usually not provided by the government. Although, partners invest in these commitments, there are no specific intervention directed towards adolescents to reduce death rates relate to pregnancy. Specific implementation strategies for adolescents are not generally implemented across the country. Except for partner's efforts, government does not invest to protect young girls from dying as a result of pregnancy related issues. The implementation of this commitment is insufficient
10	Reduce adolescent maternal mortality by 50% by 2030		
11	Reduce maternal mortality ratio among adolescent girls by 75% of the 2018 rate by 2028		
12	Education & enlightenment program to reach 20,000 young girls & boys over 36 months on life skills, personal hygiene & gender-based violence.	Available policies and plans define in real terms what is meant to be achieved in terms of personal hygiene and other SRH rights for adolescents. These strategies align with the best practices recommended by the WHO and the SDGs 3 and 5. However, policies are not adequately adapted at the subnational levels to reflect the economy, effectiveness, efficiency, equity, and sustainability at the state and LGA levels. The quality of this commitment is average.	Nigeria with diverse cultures and complexities needs to strategize its methodologies in implementing these policies. When relevant policies and guidelines are developed at the national level, the need to domesticate them before implementing them at the subnational is critical. In some states, implementation becomes cumbersome as it does not consider certain factors – culture, religious beliefs, terrain, etc. of the people before being rolled out. There is insufficient progress on this commitment mainly due to non-alignment by the state government.
13	At least 80% percent of pregnant young people (age 10-24 years) attend at least 8 ANC visits throughout the course of every pregnancy by 2024 (3)	Specific laws and policies such as the NHAct and NYP that could influence this commitment exist. The quality of this commitment in terms of policy and technical consideration is average as there is not any specific strategy developed to achieve this. Although this is measured in NDHS, it's not usually used to measure general health progress. ANC 8 visit can however give a clue of the health-seeking nature of young pregnant women who may need better attention from a skilled HW due to inexperience and lifestyle needing counseling. The quality of this commitment is average.	Only 13.1% of young < 20 years in MICS 2021 had at least 8 ANC visits. Though the age categorization is not the same, % of 20-34 years with 8 visits was a low as 24.3% Although the NYP highlighted various strategies with focus on young people such as establishing national accreditation system and certification for training programs in adolescent- & youth-friendly health (AYFHS), and integrating adolescent- and youth-friendly health into PHC, MDAs responsible for this are not implementing as there is not special attention paid to young pregnant women. Insufficient progress was observed with this commitment. There are no specific health facilities & HRH delivering ANC readily accessible for this age group No realistic timeframe to achieve as this target is unattainable in 2024. no consideration of V4M economy & sustainability. This target is unrealistic in Nigerian society where pregnancy by young people (who may be unmarried) is stigmatized, thus she hides the pregnancy for the best part of 1st & sometimes 2nd trimester. The implementation of this commitment has no progress.
14	At least 75% of pregnant adolescents and young people have skilled birth attendants (SBA) by 2024 (3)	There is no adolescent-specific SBA in health facilities. Policies do not deeply address how adolescents will deal with stigmatization and societal rejection which discourages them from opening up when pregnant. Although there was mention of adolescent and youth-friendly platforms to be established, how, where, and when they will be established to support young people were not mentioned in the policy The quality of this commitment in terms of policy and technical consideration is average. The quality of this commitment is average.	MICs 2012: 34.8% of pregnant women <20 years had delivery assisted by a skilled attendant. Others were attended to by untrained TBAs and mostly depending on educational level & from poorest of the population. Many pregnant adolescents are locked up in baby factories in some parts of Nigeria to sell their unwanted newborn. No special facilities for health or counseling for adolescents for them do act right after pregnancy. The NYP highlights as a strategy to ensure that the NHIS covers the adolescent- and youth-friendly minimum package of service. This has not been achieved. Without health insurance, pregnant adolescents may not be able to afford out-of-pocket payment as sometimes, they are abandoned and stigmatized by families and friends. The implementation of this commitment has no progress 2021 MICS full report .pdf (unicef.org) https://www.jstor.org/stable/26638164
15	At least 80% percent of adolescents and young mothers receive postnatal care services within 48 hours of delivery by 2024	This commitment is adequately good in terms of quality of the policy. Also, technically, there are well laid down strategies to achieve it This has also been adopted in other national	Specifically for adolescents. 88.5% of pregnant women <20 years has no postnatal care (PNC) visits and only 2.4% received PNC 2 days following birth. In many clans,

		documents such as the RMNCAEH+N strategy (revised). There is a clear mention and focus on young mothers. The quality of this commitment is good.	adolescents may intentionally avoid health facility to prevent shame faced by having unwanted pregnancy. While this is recommended and committed to in the NYP with guidelines on how to achieve this, there is no known health facility or section in health facility to provide postnatal care specifically for adolescents. The implementation of this commitment has no progress https://www.unicef.org/nigeria/media/6316/file/2021%20MTR%20Nylife%20report%20.pdf

\Definition of Keys (QUALITY):

Poor	
Average	
Good	
Very Good	

Definition of Keys (IMPLEMETATION STATUS)

No Progress	
Insufficient progress	
Moderate Progress	
On-track	