



JOINT SDG FUND



# Independent Evaluation of the United Nations Joint Programme to accelerate SDGs in Nigeria 2020-2022:

*Institutionalising social protection for accelerated SDG implementation in Nigeria*

## Final Analytical Report



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## FOREWORD

On behalf of the Federal Ministry of Budget and National Planning and the UN System in Nigeria, we are pleased to deliver this final analytical report of the independent evaluation of the UN-Government Joint Programme to Accelerate SDGs in Nigeria 2020-2022. It has been jointly funded by the UN SDG Project from its headquarters in New York and by the Federal Government of Nigeria.

Nigeria is committed to achieving the 2030 Agenda and to leaving no one behind on the path to universal peace and prosperity.

This Nigeria-based Joint Programme for institutionalizing social protection for accelerated SDG implementation, as part of the Joint SDG Fund, was implemented from January 2020 to June 2022. There were four participating UN organizations: i) United Nations Children's Fund (UNICEF); ii) the World Food Programme (WFP); iii) the International Labour Organization (ILO); and iv) the United Nations Development Programme (UNDP). Together, they enhanced the social protection of Nigerian citizens through the implementation of various intervention approaches which integrated institutional strengthening strategies with policy- and capacity-strengthening, as well as more direct activities to finance social protection through a pilot in Sokoto State in North-West Nigeria.

To ascertain the extent which the joint programme achieved its aims, an independent evaluation was commissioned by the UN System in Nigeria, coordinated by UNICEF. The independent evaluation assessed the relevance, effectiveness, efficiency, coherence, impact, sustainability, and the performance of the Joint Programme in achieving the expected results. The evaluation also examined what worked well for whom, what did not work, why, and what can be done better in future. Our expectations are that the results and learnings will be scalable and replicable across other states.

In the selection of the evaluation firm, due process and protocol were strictly followed. Ultimately, Samuel Hall, an international firm with a wealth of experience in conducting evaluations for international organizations, was commissioned for this project. A wide range of relevant individuals were consulted in order to procure insights and primary data for the evaluation, from beneficiaries to high-level stakeholders.

The findings and recommendations are clearly defined in the body of the report. But, it is important to mention that the relevance of the Joint Programme is not in doubt as the need for a social protection system is evident throughout the country. The Joint Programme impacted the lives of ordinary Nigerians through cash transfers, and it also built capacity and provided the policy and legal framework to implement social protection programmes in Nigeria. However, the duration of the implementation was short at just 2 years, compared to the long-term nature of implementation for social protection programmes. This needs to be factored into the development of further programmes at the UN in Nigeria.

We commend the UN agencies and government partners for their professionalism in the coordination, implementation, and evaluation of the Joint Programme without which the project would not have been a success.

We implore all relevant stakeholders including the government to make use of the findings and recommendations from the evaluation and to consider them during the course of future programming.

<b>Prince Clem Ikanade Agba</b> Minister of State for Budget and National Planning	<b>Matthias Schmale</b> UN Resident Coordinator in Nigeria
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Samuel Hall is very grateful for the leadership and facilitation of the Honourable Minister of Finance, Budget and National Planning (FBNP), Minister Zainab Shamsuna Ahmed and Honourable Minister of Humanitarian Affairs, Disaster Management and Social Development (FMHADMSD), Sadiya Umar Farouq. The leadership coordination role of the Acting National Coordinator of the National Social Safety- Nets Coordinating Office (NASSCO), Mr Kabir Abdullahi is also recognized.

Samuel Hall recognises the key leading role played by Participating United Nations Organisations (PUNO) within the funding provided by the UN Secretary-General's Office in 2020-2022 to this UN Joint SDGs Project through respective Head of Agencies Mr Peter Hawkins former UNICEF Country Representative, UNICEF being the lead agency coordinating this UN joint SDG project with the Resident Coordinator's office jointly with Mr Paul Howe former Country Representative of the World Food Programme (WFP), Mr Dennis Zulu Country Representative of International Labour Organization (ILO), and Mr Mohamed Yahya Country Representative of the United Nations Development Programme (UNDP) who have successfully driven this joint project at the federal level and state levels.

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Samuel Hall engaged key stakeholders throughout this evaluation, including government institutions, the United Nations, Academia, and the National Bureau of Statistics.

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*All photos were taken by the Mindset team as part of the community observations.*

## ACRONYMS AND ABBREVIATIONS

CO	Community Observation
CWG	Cash Working Group
FCDO	Foreign, Commonwealth and Development Office
FGD	Focus Group Discussion
HoH	Head of the Household
ILO	International Labour Organization
IP	Implementing Partners
JP	Joint Programme
KII	Key Informant Interview
LGA	Local Government Area
LNOB	Leave No One Behind
MFBNP	Ministry of Finance, Budget and National Planning
MDAs	Ministries, Departments and Agencies
MHDSD	Ministry of Humanitarian Affairs, Disaster Management, and Social Development
MLE	Ministry of Labour and Employment
MoE	Ministry of Education
MoH	Ministry of Health
MoWCA	Ministry of Women and Children Affairs
NASCCO	National Social Safety-Net Coordinating Office
NCTO	National Cash Transfer Office
NECA	Nigeria Employers Consultative Association
NHIS	National Health Insurance Scheme
NLC	National Labour Congress
NSPP	National Social Protection Policy
OECD DAC	Organisation for Economic Cooperation and Development's Development Assistance
OSSAP-SDG	Office of the Senior Special Assistant to the President on Sustainable Development Goals
PHC	Primary Healthcare Centre
PUNO	Participant United Nations Agencies
SCI	Save the Children International
SDGs	Sustainable Development Goals
SOCHEMA	Sokoto State Contributory Health Management Agency
SOCU	State Operations Coordination Unit
SOP	Standard Operating Procedures
SP	Social Protection
TUC	Trade Union Congress
TWG	Technical Working Group
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WFP	World Food Programme



# EXECUTIVE SUMMARY

## METHODOLOGY & OBJECTIVES

From January 2020, four UN agencies - United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the International Labour Organization (ILO), and the United Nations Development Programme (UNDP) - implemented the two-year “Institutionalising Social Protection for Accelerated Sustainable Development Goals (SDG) Implementation in Nigeria” Joint Programme (JP). This two-year \$2 million JP aimed to enhance social protection at the federal and state levels in Nigeria (SDG 1.3.) and thereby support the achievement of SDG targets 1.3, 2.2, 2.8, 4.1 and 10.4. The JP used a combined intervention approach outlined below:

- The operational component provided health insurance coverage for a year for 6,000 recipients from vulnerable groups in four LGAs in Sokoto State, namely Bodinga, Wamakko, Tambuwal and Wurno. Among those recipients, 658 Pregnant and Lactating Women (PLW) and caregivers of children under two were eligible to receive cash transfers in Bodinga, Wamakko and Wurno.
- The institutional component supported Nigeria’s national social protection legal framework through the development of a social protection bill and building the capacity of government ministries, departments and institutions working on social protection at federal and state levels.

UNICEF has commissioned Samuel Hall on behalf of the four participating UN Agencies to

- conduct an external and gender-responsive endline evaluation of the UN Joint SDG Programme (JP) at the Federal level and in Sokoto State using the OECD criteria; and
- identify good practices and lessons learned for any future implementation.

The evaluation of the JP is based on primary and secondary data gathered. The primary data collection approaches served to obtain diverse perspectives from individuals implicated at various levels by the programme - from recipients to high-level stakeholders. Those included 20 key informant interviews, 10 focus groups discussions with recipients and 3 community observations in Tambuwal, Bodinga and Wurno, and a quantitative phone and in-person survey with a total of 261 recipients and 471 non-recipients (control group).

The UN Joint SDGs Project aimed to support a social contract between the government and the people through “*sustainable, equitable and quality social protection benefits and services*” ensured by the development and implementation of National and State Social Protection key guiding documents (2021-2025 National Development Plan, Economic Sustainability Plan, and National Social Protection Policies). Moreover, while the operationalization of Soc. Prot. was focused on the Sokoto State, the result of this piloting is expected to be scalable and replicable across other states in Nigeria. To that effect, the Theory of Change model (in Annexe) for the UN Joint SDGs Project emphasises the development of a “*blueprint for successful implementation and expansion of the cash transfer and universal health insurance*” to all state governments in Nigeria, using the learnings of the programme’s implementation in Sokoto State.

It is important to note that all the conclusions of the UN Joint SDGs Programme are based on the two-year experimental dimension of the programme. As such, a two-year pilot may not be sufficient in meeting all the timely objectives that require at least seven or eight years. All the UN and Government partners interviewed also alluded to the short Implementation period. Therefore, time must be given, while learning from the successes and challenges of the pilot programme.

## KEY FINDINGS & LESSONS LEARNT: 5 KEY MESSAGES

An analysis according to the OECD-DAC evaluation criteria is developed in this study, particularly in sections 4 (Findings) and 5 (Conclusions). However, the evaluation team has adopted an innovative approach of presentation of strategic findings and lessons learnt generated by this evaluation by considering the two ways: i) the presentation of key five strategic messages and the ii) the presentation of key findings by each evaluation criteria to ensure compliance to the global standard of evaluation of UNEG.

### KEY FINDINGS BY 5 STRATEGIC MESSAGES

#### 1. The UN SDGs Project alleviated recipients' financial burdens and encouraged them to seek professional healthcare.

Beneficiaries emphasised the positive impact generated by the Cash Transfer and Health Insurance on their wellbeing. Several women's testimonies indicate that they felt empowered to take their sick infant and child(ren) to the health centre or hospital without waiting on or consulting with their husband, who manages household finances. At the same time, husbands said they spent less out of pocket expenditures for health care, and they no longer had to prioritise food over healthcare.

Government and UN agencies have applied the evidence-based planning using data from the capacity need assessment undertaken by the Federal Ministry of Budget and National Planning<sup>1</sup> and data from Health Need Assessment undertaken by UNICEF using an independent consultant and the Nigeria Demographic and Health Survey 2018 which revealed the challenging issues of nutritional food and access to health care for pregnant women and children. However, the unavailability of more up to date baseline data for Household livelihood expenditures, health insurance and cash transfers component in Sokoto State, created limitations for adequate measurement of the impact of cash transfer delivered to beneficiaries in Sokoto State. The evaluation team applied the quasi-experiment design approach in comparing findings between the treatment group (beneficiaries) and the control group (non-beneficiaries) during the end line evaluation. This approach limits definitive conclusions from being drawn.

While there is no doubt that the JP had positive impacts on its recipients in terms of access to professional health care services and meeting immediate needs. However, It Is recommended that for Soc. Proc. programming in the future, base line assessment must be done.

#### 2. The cash transfers contributed to meeting immediate needs.

While the cash transfers allocated to pregnant and lactating women (PLW) were meant to cover transportation costs (5,200 Naira)<sup>2</sup>; the cash transfers thereby provided beneficiaries with extra financial resources that they could spend or save as they wished. The perceived main strength of the cash transfers by the recipients is that facilitated access to basic social services, such as meeting immediate food needs; improved health seeking behaviours by mothers and care givers. Few women reported that they succeeded to save money and start small businesses that will reduce the financial barriers that prevent poor family from accessing basic social services.

In line with this, the most commonly chosen weakness of the SDGs Project was that the aid was too short-term. Moreover, when the SDGs Project ended, there was no mechanism in place to ensure that these beneficiaries, who are among the poorest populations of Northwest Nigeria, would still benefit from healthcare insurance or cash transfers.

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<sup>1</sup> Report on the on status of the Social Protection Policy and Program In Sokoto state: Result of the Analysis of Base Line Data collected In Sokoto state by the Ministry of Finance, Budget and National Planning.

<sup>2</sup> WFP to provide explanations



3. High levels of redistribution among health insurance recipients suggest that a more universal targeting approach is more suitable for the context.

The health insurance interventions aimed to facilitate access to health care and reduce out of pocket expenditure on health. The perceived Impact of the health insurance Interventions is that it increased demand of primary health care services including antenatal and post-natal.

Despite sensitization and awareness, some beneficiaries share their own health insurance card among other members of extended family members and neighbours with respect to the African cultural value of love and solidarity of sharing resources. A deeper understanding of the socio-cultural modalities of redistribution of assistance at the community and family level would undoubtedly help to refine the modalities of transfer better. More universal and inclusive forms of targeting vulnerable categories of the population might be more impactful and efficient in terms of costs than a narrow poverty-targeted programme for a population with high poverty levels and a chronic food insecurity crisis. The newly amended Health Insurance Act 2022 has expanded the coverage to ensure large scale access of poor families to health primary health care In Nigeria through the establishment of the Vulnerable Group Fund (VGF).



4. The SDGs Project fostered collaboration and coordination among social protection of key Government stakeholders to build the foundation of a nationally owned system.

The overall outcome of the UN Joint SDGs Project's is to ensure that the social protection system has improved at national level with a reinforced legal framework and a financial mechanism integrated in national budget and planning efforts. UN agencies have provided adequate support to government for the review and the endorsement of the revised national social protection policy that was approved on 14th December 2022 by the Federal Executive Council and the policy was domesticated and approved by Sokoto State Executive Council on 16 December 2022.

The UN joint SDGs Project supported in strengthening government institutions to create an environment where relevant MDAs are empowered to take the Social Protection (Soc. Prot.) policy forward through the establishment of relevant Social Protection coordination platforms. All the UN agencies involved have noted the positive externalities in coordination, mainly through establishment of the Social Protection Technical Working Group at the national level. At the state level, the Sokoto State Cash Working Group (CWG) was established as a sub-set of the Sokoto State Social Protection Technical Working Group. Each Participating UN Agency (PUNO) and the national body delivered as one to achieve a common objective that would not have been possible had these institutions been operating separately.

The UN joint SDGs Project created an environment that helped improve capacity and coordination among state agencies (MBNP, MLE, and MHSDS) and with UN agencies. This is clearly a new and solid foundation that the UN Joint SDGs project can now build to enhance social protection at the federal and respective state levels in Nigeria. *Following the pilot implementation of the JP in Sokoto State, and notably the state consultations, led to over 20 states<sup>3</sup> adopting the Social Protection policy and similar coordination mechanisms.*

5. A blended phased approach is more suitable for institutional social protection programmes.

The relevance of the UN Joint SDG Project is evident considering the high poverty rate in Nigeria with over 89million persons living below the poverty line (40%) and the recently published 2022

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<sup>3</sup> ILO to provide information on the list of 20 states

Multidimensional Poverty Index (MPI) report which reveals that over 113 million (63%) people are multidimensionally poor. Sokoto state especially has 91% who are multidimensionally poor.

The two-year duration of the UN Joint SDGs Project was short. Moreso, the challenging Covid-19 pandemic context (with restrictions around implementation such as field travel) limited implementation of the project activities. Although, the project succeeded in combining both institutional and operational (blended) approach to Implementation at both national and sub-national levels. It is advised that in certain instances, a phased approach is adopted, where the operational dimension of a pilot builds on the institutional dividends such as to change mindsets, develop skills and secure an ecosystemic approach for targeting and accountability. On the government side It is advised that strengthening regular updates of social registers and effective consolidation of various social registers will reduce duplication and overlap of social protection related interventions to beneficiaries.

Furthermore, despite the successful capacity-building efforts, some concerns remain around stakeholders understanding of what Soc. Prot. entails and how to consolidate partnerships that ensures coordinated delivery of Social Protection programmes in Nigeria.

While the UN Joint SDG Project was conceptualised as a pilot in building social protection systems, cost-intensive direct interventions, the evaluation found that there is an absence of a strategy to continue the programme, which risks sustainable impact on beneficiaries and the continuity by the state government. Given the funds spent on identifying recipients and setting up processes for the distribution of health insurance coverage and cash transfers, it needs a mechanism for continued funding and implementation beyond the pilot of the health insurance scheme, cash transfers and capacity strengthening of government stakeholders.

## KEY FINDINGS BY EVALUATION CRITERIA

This concluding section summarises the report’s findings by OECD-DAC evaluation criteria. In particular, it aims to respond to the following two main broader expectations in line with the overall purpose of the evaluation:

1. Analyse whether the UN’s Joint SDGs Programme in Nigeria met its high-level objectives;
2. Analyse the extent to which the UN Joint SDGs Project strengthened the capacity of government and the ecosystem for the scale-up and **sustainability** of social protection system in Nigeria.

The evaluation team adopted the following rating criteria to make judgement on the merit or shortfall of the UN Joint SDGs project.

*Table 1: Colour code for OECD DAC Evaluation*

Category of Merit's Rating	Description	Colour
<b>High</b>	High level of satisfaction – more than 80% of achievement and a reassuring outlook for the future (80% - 100)	
<b>Positive</b>	Average level of satisfaction – more than 50% of achievement and a reassuring outlook for the future	
<b>Insufficient</b>	Not satisfactory – less than 50% of achievement and concerning outlook for the future	
<b>Not achieved</b>	Expectations Not Met (Shortfall)	



**Relevance** (*Was the 2020-2022 UN Joint SDG Project doing the right things?*)

**UN Joint SDGs Project is Highly Relevant**

The evaluation team has concluded that the UN Joint SDGs Project is highly relevant to the need of the poor and vulnerable population of Nigeria. This is based on the evidence of multidimensional poverty and negative effects of Covid-19, considering the fact that Sokoto State is one of the states in the Northwest with the highest levels of poverty, insecurity and an economy dependent on agriculture in primarily rural communities. Most people living in the state are in such dire conditions that immediate assistance is needed.

The design of the UN Joint SDG project is based on key evidence generated from relevant national and local surveys, assessments, and studies: i) Nigeria Demographic and Health Survey 2018, ii) National Nutrition and Health Survey 2018, iii) Sokoto State Government Led Capacity Needs Assessment and iv) UNICEF Health Needs Sokoto State Level Assessment. In addition, this UN Joint SDG is well aligned with the National and State Development Plans and National Social Protection Policy as well as the National Health Act 2014.

**However**, due to funding limitation the Universal Social Protection coverage approach was not adopted for the UN Joint SDGs Project. As such, categorical targeting of population associated with multidimensional poverty (elderly, children, pregnant women, persons living with disability) were given priority in the selection of the UN Joint SDG beneficiaries.

From qualitative focus group discussion with beneficiaries at community level in Sokoto State, the evaluation's findings reveal that there are some errors of exclusion and inclusion of relevant beneficiaries. The lack of consolidated and harmonised registry of the poor and vulnerable affected the adequate targeting of beneficiaries. The implementing agency Sokoto State Operations Coordinating Unit (SOCU) faced challenges of outdated obsolete data from multiple sources of registry (MoWCA, SOZECOM, State Level SDGs Office and SOCU) and conflict of Interest within the MDAs at the state level.

**Coherence** (*Was the 2020-2022 UN Joint SDG Project well aligned with global framework and national priorities?*)

**UN Joint SDGs Project is Positively Coherent with Global, National and Sub National Priorities**

The assessment of the coherence of the UN Joint SDGs Project Is based on the following questions commissioned based on the Terms of Reference:

- i. To what extent is the programme addressing gender and equity? Are the rights of people with disabilities consistently integrated into all aspects of programming and implementation?
- ii. What are the comparative strengths of the joint programme in comparison to other social protection programmes?
- iii. What are the comparative strengths of the coordination and convening roles of the joint programme, and to what extent did the joint programme contribute to enhancing UNCT coherence?

Based on the evidence of desk review of available documents, key Informant Interviews and Focus Group Discussions (FGDs), the evaluation team concludes that the UN Joint SDGs project is positively coherent with global and national priorities and takes into consideration issues of gender equality, equity, and rights of persons with disability.

It also aligns with existing Soc. Prot. programmes at the federal and state level this Includes the national cash transfer programmes, the basic healthcare provision fund programme on health insurance, Zakat and Endowment Commission's cash and food assistance programme, Ministry of Social Welfare cash transfer for persons with disability, Ministry of Women and Children Affairs cash



transfers to selected vulnerable population (widows, orphans, and SGBV survivors), State Cash Transfer Office (SCTU) cash transfer programme to vulnerable populations.

UN Joint SDG project promotes gender equality and rights of persons with disability, through focus on intervention of pregnant women and lactating mothers, formulation of a rights-based Soc. Prot. bill, the provision of input into the national health insurance act 2022 that makes health insurance mandatory for all Nigerians. promotion of right based approach on Soc. Prot.

**However**, findings from the review of relevant documents and field data collection, revealed that the implementation of UN Joint SDGs Programme did not pay special attention to persons with disability. The absence of information from the registry related to the category of beneficiaries (persons with disability) has affected the appropriate targeting of beneficiaries of the Soc Prot. programme (health insurance and cash transfer) in Sokoto State.

There were also allegations of fraud in the distribution and selection of beneficiaries which can seriously damage the relationship between citizens and the state. Furthermore, to build a social contract, the population needs to be aware of who is behind the benefits they are receiving. Some respondents credited local authorities, health centers or individual health workers for the assistance they received without being aware that the programme is grounded in national and federal policies.

**Strengthening the coordination, awareness, communication, and outreach dimensions to highlight the social contract dimension of social protection**, the UN Joint SDGs Programme has strengthened coordination amongst partners through knowledge sharing, active participation, and Involvement in the Soc. Prot. Development Partners Group, institutionalisation of quarterly meeting between partners and relevant implementing MDAs, joint approach to communication. this has enhanced government's common understanding of Soc. Prot. landscape and the national coordination systems. the UN Joint SDGs programme leveraged on existing programmes Implemented by other partners (Save the Children, Action Against Hunger, Plan International, and European Union etc).



**Effectiveness** (Has the 2020-2022 UN Joint SDG Project achieved expected results?)

**UN Joint SDGs Project is Highly Effective in achieving expected results**

The independent evaluation of the effectiveness of the SDGs project Is guided by the evaluation’s questions within the TOR:

- i. To what extent has the joint programme contributed to accelerating the SDGs at the national and state levels, as well as contributed to UNSDPF Outcome 6?
- ii. What have been the major factors influencing the achievement or non-achievement of the programme objectives in providing integrated services? Did any innovations or unintended (negative or positive) consequences arise as a result of the implementation of the joint programme?

Based on strong evidence, the evaluation team has concluded that the SDGs Project has successfully achieved expected results as committed within the Results Framework regarding the two Outcomes and Outputs. The evaluation team review of relevant documents, key Informant Interviews, focus group discussions reveal that a holistic social protection bill was drafted and submitted to the relevant government Institutions for onward submission to the national assembly. The bill, once approved will make social protection a right for all, a Soc. Prot. policy was approved by the federal executive council. during the same period, the budget allocation for Soc. Prot. Increased by over 100% from 2020 to 2022.

The UN Joint SDGs programme provided capacity and Institutional strengthening that led to an increase in health Insurance coverage from 3% to over 5% of 200 million citizens of Nigeria (10 million beneficiaries).

Regarding the Soc. Prot. activities at the state level, over 600 pregnant and lactating women, and caregivers of under-fives benefited from the mixed (unconditional and conditional) cash transfer with over NGN 5,200 received monthly for a period of six months. The Health Insurance beneficiaries totalling 6,000 comprised of 70% female and 30% male were registered in primary health facilities across four Local Government Areas. Beneficiaries were able to access free healthcare services whenever they visited their designated centres.

**Efficiency** (*Has the 2020-2022 UN Joint SDG Project achieved adequate economy?>*)

**UN Joint SDGs Project is Positive in Value For Money**

Three specific evaluation questions were considered for the assessment of Value For Money of SDGs Project as below:

- i. Have the integrated social protection services been implemented in an effective and efficient way, both in terms of human and financial resources, compared to other alternatives?
- ii. Are activities low in cost and affordable (yet, of adequate quality) to improve the situation of vulnerable households)?
- iii. Is the current organisational set-up, collaboration and contribution of concerned ministries and others working.

Regarding the promotion of a culture of value for money to optimize interventions and interagency synergies to achieve results, the Evaluation Team has found that the Joint UN SDGs Project has positively achieved adequate Value for Money: The Unit Cost of intervention is about 68.9 USD (30,314 Naira) for the delivery of multiple times access to free health services and medication that benefited to 6,000 women and children as implemented by UNICEF Field Office in Sokoto. The unit cost is around 112.65 US Dollars (49,566 Naira) for 658 pregnant/ lactating women and children under two years old who benefited of digital cash disbursement as delivered by WFP in Sokoto State.

Despite the limitations identified such as knowledge gap, the project's human and financial resources were utilized in an efficient manner through effective coordination of development partners and government to deliver on the project outputs. The catalytic impact of the approved national soc. prot. policy will ensure the extension of the coverage to previously excluded population.

**However**, there remains a need for improved interagency collaboration in terms of pooling of resources or costs between agencies or actors. Also, the focus remains results-oriented (= delivering the expected numbers vs. planned) without sufficiently considering the real (and evolving) needs of a population exposed to multidimensional and chronic crises). In this regard, it is essential that the Joint UN SDGs Project strengthened its capacity to understand, compare and analyze the real value of its operational contribution to the population. Simple avenues can be identified: 1) favoring longitudinal analyses, to capture improvements in VFM over time; 2) systematizing comparative analyses with

similar contexts/programs; 3) disaggregated cost analyses, to better understand how and where the JP spends most of its money; and finally, 4) a focus on the broader context to understand how the SDGs Project.

**Impact** (*Was the 2020-2022 UN Joint SDG Project has achieved expected impact on lives adequate economy?)*

UN Joint SDGs has **Positive Impact**

**Following evaluation questions served as reference for the assessment of Impact of SDGs Project:**

- i. To what extent has the Social Assistance (Cash Transfer) provided to vulnerable populations in the pilot state of Sokoto generated positive effects in income and social transformations to households and communities vis-à-vis SDG1 (ending poverty) and SDG10 (reducing inequality)?
- ii. What lessons can be documented, or challenges observed from the implementation of the model in reaching the vulnerable population and providing services?
- iii. What are the negative externalities of the Joint UN SDGs Project, with a focus on ethical (fraud) and societal (tensions) issues?

The evaluation team has performed the measurement of the impact of the social protection interventions implemented in Sokoto state using the method of quasi experimental design which compares findings of treatment group (beneficiaries) with findings of non-beneficiaries. Evidence of statistical quantitative data and qualitative opinions revealed that the SDGs project has made difference in the healthy lives and livelihoods of beneficiaries (6.000 pregnant and lactating women and children) who received assistance for health insurance and cash transfer in comparison to non-beneficiaries.

**Regarding Health Insurance**, the joint UN SDGs Project has alleviated beneficiaries' financial burden and encouraged recipients to seek healthcare: beneficiaries were able to access professional healthcare when needed, women recipients were more likely to have received services from qualified health personnel, specifically for maternal and child health. The health insurance coverage encouraged beneficiaries to seek and receive care from health professionals instead of self-medicating or relying on pharmacists' diagnoses. The quantitative data confirms that 59% of surveyed beneficiaries were assisted by a qualified health personnel for any health problem in the past year compared to 47% of surveyed non-beneficiaries.

**Concerning Cash Transfer** which benefited 620 women, the Evaluation Team concludes that there is positive impact on health-expenditure indicators and the effects and usage of the cash transfers related to SDG1 (ending poverty) and SDG10 (reducing inequality).

The health insurance coverage encouraged beneficiaries to seek and receive care from health professionals instead of self-medicating or relying on pharmacists' diagnoses. The quantitative data confirms that 59% of surveyed beneficiaries were assisted by a qualified health personnel for any health problem in the past year compared to 47% of surveyed non-beneficiaries. A participant in Bodinga, for instance, stated that: "people usually stay home when they are sick and do not consult a doctor; they often believe that they have malaria and will ask pharmacists for medicine without receiving an actual diagnosis".<sup>4</sup>

When zooming in on health expenditures that are relevant to the SDGs Project activities namely preventive health services and maternal and child health expenditures the differences are more solidified. The difference in spending patterns on maternal and child health expenditures are even more accentuated than preventive health which points to the programme impact as it paid special attention to that domain.

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<sup>4</sup> FGD8, Women, Bodinga, Bodinga

Many of the beneficiaries have expressed that the health insurance coverage specifically has had a significant positive impact on their lives as opposed to having received cash transfers in isolation or immunisation to specific diseases from other programmes in the past. Lastly, there was a clear gender focus as the target beneficiaries were pregnant and lactating women, whom as a result were able to get the medical attention they needed without the financial or psychological burden on the household.

**Sustainability** (*Has the 2020-2022 UN Joint SDG Project achieved adequate economy?*)

**UN Joint SDGs Project is Un-successful in Sustainability**

The specific evaluation questions are as follow:

- i. To what extent has the strategy adopted by the joint programme contributed to the sustainability of results, especially in terms of the SDG Leave No One Behind (LNOB) and the social protection system?
- ii. To what extent has the joint programme supported the long-term buy-in, leadership and ownership by the government and other relevant stakeholders? How likely is it that the results will be sustained beyond the joint programme through the action of the government and other stakeholders and/or UNCTs?
- iii. What are the lessons learned about the provision of integrated social protection services?
- iv. In what ways should the current joint programme approach be revised or modified to improve the sustainability of the programme services?

The evaluation team has concluded that the Joint UN SDGs Project has shortfall to ensure the sustainability of gains.

**Learning from crises and uncertainty:** The COVID-19 pandemic led to significant delays of about one year in the Joint UN SDGs Project's implementation, which had to be extended following a missed launch date in March 2020, when the pandemic spread across the world. Until late 2020, the Joint UN SDGs Project did not have a coordinator who could serve as an intermediary between implementing partners and ensure that the programme was moving forward. Activities that were required to be carried out in person, such as baseline data collection in Sokoto, had to be postponed. According to Joint UN SDGs Project stakeholders, however, the pandemic acted as a catalysing event toward the strengthening and streamlining of SP in Nigeria. The government provided cash transfers and food throughout the country and may have been more inclined to take the SP bill forward.

In terms of access to healthcare during the various peaks of the pandemic, discussion participants believe that COVID-19 did not prevent them from receiving medical care, both under the SDGs Project and in general. A participant in Dogon Daji<sup>5</sup>, for instance, said that the hospital helped people cope with COVID-19 early on by raising awareness on protective methods - face masks, hand washing, etc. and on symptoms of the disease.

In the current context, where uncertainty and multidimensional crises have become the norm, it is therefore important for a larger-scale or longer-term social protection program to incorporate the uncertainty and risk dimension. In today's context, where uncertainty and multidimensional crises have become the norm, it is therefore important for a larger-scale or longer-term social protection program to incorporate the dimension of uncertainty and risk-both in preparation, with an ability to quickly adjust or modify design and implementation, and in learning, with a willingness to learn from each crisis.

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<sup>5</sup> FGD005

**Promoting sustainability and ensuring follow-up (including a proper exit strategy).** Social protection is by its defined long-term and predictable as compared to the short-term cycles of humanitarian aid.<sup>6</sup> This means it needs long-term funding, objectives, and programming. While the JP was conceptualised as a pilot in Sokoto State, building a social protection system with policies and direct interventions is cost-intensive and not having a strategy to continue the programme risks that the funds spent have no sustainable impact. Given the funds spent on the identification of beneficiaries and setting up processes for the distribution of health insurance coverage and cash transfers, it needs a plan for continued funding and implementation beyond the pilot. Furthermore, as a NASSCO representative put it, Nigeria suffers from several success stories tied to pilot projects; but replicating and scaling up those projects to go beyond the pilot stage has proven to be a challenge.

As argued in the findings 5.1 and 5.2, there was no strategy in place to ensure that these beneficiaries, who are among the poorest populations of Northwest Nigeria, would still benefit from healthcare coverage after the Joint UN SDGs Project ended. Beyond the monitoring of the initiative, the sustainability dimension also implies - from the very beginning of the initiative and at the very heart of its theory of change - planning for: 1) the exit strategy for the JP's partners; 2) the gradual ramping up of government partners (technical and financial).

## RECOMMENDATIONS

**Recommendation #1: Promoting a necessary debate towards more equitable social protection mechanisms, which involves rethinking vulnerability and targeting.** Before favouring a pro-poor approach that targets the most vulnerable segments of the population, it is important to consider the purpose of a social protection system (social contract, universal protection) in contexts of almost widespread socio-economic destitution and chronic multidimensional crises.

**Recommendation #2: Starting with an informed, realistic, flexible, and contextualised Theory of Change.** Any expansion or follow-up of the JP will require a much more pragmatic, realistic and contextualized ToC to translate the abstract goals of the SDGs and the multi-country ambition of the JP into effective and sustainable action and interventions.

**Recommendation #3: Promoting a real MEAL approach for better adjustment or revision of the pilot.** Significant learning dividends from the pandemic crisis, associated with the current political, security, and economic instability, may be lost – without any future positive strategic or operational impact – if an appropriate MEAL approach, beyond the basic OECD or baseline approach, is not systematized.

**Recommendation #4: Putting gender analysis at the heart of both the strategy and the social protection system.** The JP has promoted a proactive approach to gender equality through specific programs and dedicated indicators. It is necessary to go further by not simply conceiving women as 'the most vulnerable populations' and therefore natural beneficiaries, but by understanding that they are the actors of change in rural areas, particularly in terms of community decisions, allocation of household resources, diversification of income through migration decisions (husbands, sons), etc.

**Recommendation #5: Understanding redistribution phenomena.** Redistribution and solidarity must not only be analyzed but encouraged, according to the intra-community (so-called 'traditional') mechanisms, by a targeted advocacy and outreach campaign. This can help multiply the benefits of the social contract in terms of resilience and cohesion: from the state to citizens through social protection, from citizens to citizens through redistribution.

**Recommendation #6: Promoting a culture of value for money to optimize intervention and interagency synergies.** It is imperative that the JP strengthen its capacity to analyze the real value of its strategic and operational contribution. Simple avenues are worth mentioning again: 1) favoring

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<sup>6</sup> Directorate-General for International Cooperation and Development, 'Supporting Social Protection Systems', Concept Paper, Tools and Methods Series (European Commission, September 2015).

longitudinal analyses, to capture improvements in VFM over time; 2) systematising comparative analyses with similar contexts/programs; 3) disaggregating cost analyses; and finally, 4) focusing on the broader context to understand how the JP contributes to improving people's lives and well-being.

**Recommendation #7: Shedding light in a transparent manner on every allegation of fraud (real or perceived).** Targeting beneficiaries for social protection interventions should be transparent and easily understood. It is important to be aware of, analyze, respond to and eliminate any perception of fraud or unfairness from the population.

**Recommendation #8: Making social protection a national cause by strengthening the awareness, communication and outreach dimensions.** A proper reflection must be conducted so that the communities do not perceive the initiative as another humanitarian assistance program, with no '*social and societal solidarity agenda*'<sup>7</sup>; similarly, the strong link between institutional efforts and the implementation of concrete interventions should be further emphasized in Nigerian opinion and among all stakeholders. The development of a Nigerian social protection system must be perceived as a *national* cause.

**Recommendation #9: Promoting sustainability and ensuring follow-up (including a proper exit strategy).** Ensuring the sustainability of the social protection system (inaugurated through institutional efforts) and the Sokoto pilot project also implies - from the outset of the initiative and at the very heart of its theory of change - planning for: 1) the exit strategy of the Joint UN SDGs Project partners; and 2) the gradual ramping up of the government partners (technical and financial).

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<sup>7</sup> KII with UNICEF, July 2022.



# 1 BACKGROUND



Photo 1 Community cooperative health centre in Dogon Daji, in Tambuwal

# 1 BACKGROUND

## 1.1 Introduction

From January 2020, four UN agencies - United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the International Labour Organization (ILO), and the United Nations Development Programme (UNDP) - implemented the two-year “Institutionalising Social Protection for Accelerated Sustainable Development Goals (SDG) Implementation in Nigeria” Joint Programme (JP). This two-year \$2 million JP aimed to enhance social protection at the federal and state levels in Nigeria through diverse targeted intervention strategies. The joint programme supported accelerating the implementation of the SDGs in Nigeria by focusing on specific SDGs (1, 2, 3, 4, 5, 10, and 16) and seven indicators (1.3, 2.2, 3.8, 4.1, 5.1, 10.4, 16.9 & 17.1). Each of the SDGs is intricately linked and interdependent.

The JP used a combined intervention approach that integrated institutional strengthening strategies, founded upon policy and capacity-strengthening, and more direct activities to finance social protection through a pilot in Sokoto State, north-western Nigeria.

UNICEF has commissioned Samuel Hall on behalf of the four participating UN Agencies to conduct an external and gender-responsive endline evaluation of the UN Joint SDG Programme (JP) at the Federal level and in Sokoto State, while deriving good practices and lessons learned for any future implementation. Through this assessment, the research team evaluated the JP, and the present evaluation report, presents best practices as well as lessons learned to better inform any future scale-up and implementation.

The United Nations Child Fund (UNICEF) defines social protection as “*the set of public and private policies and programmes aimed at preventing, reducing, and eliminating economic and social vulnerabilities to poverty and deprivation. Social justice aids in the advancement of equality, fairness, and justice in society, allowing children and adults to reach their full potential.*” UNICEF’s approach is grounded in three key principles; 1) Progressive realisation of universal coverage, 2) National systems and leadership, and 3) Inclusive social protection.<sup>8</sup>

### 1.1.1 Evaluation objectives

The overall goal of this evaluation was to conduct an independent assessment of the JP outcomes, interventions, and strategies and its contribution to the Nigerian Social Protection Programme, using the OECD/DAC evaluation criteria.<sup>9</sup> The key objectives were to:

1. Assess the relevance, effectiveness, efficiency, coherence, impact, and sustainability (OECD-DAC criteria) of the JP with a focus on how it responded to the needs of the most vulnerable households, including people living with disabilities;
2. Assess the performance of the JP in achieving expected results (outcomes and outputs) as committed within the Results Framework and Theory of Change;
3. Determine the programme’s effective and/or intended or unintended benefit (impact) and higher-level effects of social protection interventions implemented in pilot Sokoto State on marginalised populations regarding household income generation and social coverage.

In addition, the evaluation examined the strengths and weaknesses for activity replication and the United Nations’ (UN) accountability towards the government and relevant partners on the following aspects: what worked well for who, what did not work, why, and what can be better done in the future. While the operationalization of social protection was focused on the State of Sokoto, the initial

<sup>8</sup> UNICEF, ‘UNICEF’s Approach to Social Protection’, January 2016, <https://www.unicef.org/easterncaribbean/media/851/file/Social-Inclusion-Summaries-%20UNICEF>.

<sup>9</sup> OECD, ‘Better Criteria for Better Evaluation. Revised Evaluations Criteria Definitions and Principles for Use. OECD/DAC Network on Development Evaluation.’, 2019, <https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf>.

assumption is that the results and learning of this piloting should be scalable and replicable across other states.

### 1.1.2 Evaluation scope

The final evaluation report, therefore, presents evidence-based findings to determine the reasons for the occurrence of certain results, to draw lessons, and to derive good practices and pointers to inform the replication and scale-up of integrated social protection programmes across Nigeria.

It covered the implementation of the JP from January 2020 until the end of June 2022 and paid particular attention to the policy framework and outcomes in relation to gender, including Gender Equality and the Empowerment of Women (GEEW), and people living with disabilities, as well as issues tied to institutional capacity development and sustainability.

The primary data collection approaches, combined with the literature review, served to obtain diverse perspectives from individuals implicated at various levels by the programme - from beneficiaries to high-level stakeholders. While surveys provided a large set of beneficiary perceptions and experiences, critical to assessing the impact of their participation in the programme, qualitative data collection methods provided more in-depth feedback, essential to analyse statistics. In addition, the literature review and interviews with high-level stakeholders provided a deeper insight into the programmes' policy and capacity-building components. They helped contextualise beneficiaries' perceptions surrounding the successes and shortcomings of the provided health insurance and cash transfers. The primary data collection was conducted in person in Wurno, Bodinga, and Tambuwal and remotely in all programme intervention areas and at the national level.

The evaluation is intended for use by a wide variety of stakeholders and for different purposes, including the promotion of accountability, documentation and learning, as summarised below (Table 1).

Table 2 Evaluation users and intended uses

Evaluation users	Intended uses of findings and recommendations
United Nations Resident Coordinator Office	<ul style="list-style-type: none"> <li>• Ensure accountability towards the UN Secretary-General Coordination of SDGs Funds.</li> <li>• Coordinate UN agencies' future policy advocacy.</li> <li>• Leverage partnerships and evidence-informed decision-making of UN joint programming.</li> </ul>
UN Funds, Programs and Specialized Agencies in Nigeria	<ul style="list-style-type: none"> <li>• Review and refine intervention strategies.</li> <li>• Inform expansions of the JP in other states, articulate the cash transfer and universal health insurance scheme for greater impact on social protection access and improved health, education and nutrition, especially among vulnerable groups.</li> <li>• Develop a communications strategy for greater engagement of national actors in social protection.</li> </ul>
Departments and Agencies (MDAs) working on Social Protection programmes	<ul style="list-style-type: none"> <li>• Inform national social protection policy for the expansion and replication of integrated social protection programmes throughout the country.</li> </ul>

CSOs and NGOs	<ul style="list-style-type: none"> <li>Familiarise them with successful approaches and build on the lessons learned during the evaluation to strengthen advocacy and intervention approaches.</li> </ul>
Development Partners, Donors, Private Actors & Individuals	<ul style="list-style-type: none"> <li>Encourage additional humanitarian and development support to Nigeria by increasing the visibility of UN support to the country.</li> </ul>

## 1.2 Programme Background

### 1.2.1 Programme rationale

It was anticipated that the JP would contribute to strengthening the access to social protection in Nigeria (SDG 1.3.) and thereby support the achievement of SDG targets 1.3, 2.2, 2.8, 4.1 and 10.4.<sup>10</sup> It is noteworthy to mention that there was a strong emphasis on institutional strengthening in the programme and the aim was to have the government take the lead in project implementation. While the operationalisation of SP was focused on the Sokoto State, the results of this pilot programme should be scalable and replicable across other states. To that effect, the Theory of Change model (in Annexe C) for the JP emphasises the development of a “*blueprint for successful implementation and expansion of the cash transfer and universal health insurance*” to all state governments in Nigeria, using the learnings of the programme’s implementation in Sokoto.

The Joint UN SDGs Project aimed to support a social contract, the legitimacy of the state rule over its constituents, through the “*sustainable, equitable and quality social protection benefits and services*” ensured by the development and implementation of National and State Social Protection Policies. Based on the targeted recipients there was a specific focus was on the most vulnerable groups (women, girls, children, youth, people living with HIV/AIDS, tuberculosis and leprosy, and people living with disability, older people, migrants, etc.) who have relatively limited access to social protection services compared to the general population. The institutional commitment for the JP was aimed to be further enhanced through strengthening the capacity of state institutions to effectively deliver social intervention programmes and state consultations in all the geopolitical zones and the set-up of SDG accelerators through the:

1. The communal engagement of women and adolescent girls in social behavioural change communication activities, which will strengthen the efforts made in the reduction of infant and child mortality due to malnutrition (SDG 2.2).
2. The expansion of existing cash transfer programs promoting girls’ education, which will help increase the proportion of children at the end of primary education achieving at least a minimum proficiency level in reading and mathematics (SDG 4.1).
3. The improved participation of women and adolescent girls in the decision-making process, through their inclusion in the establishment of communal project management committees, which will help create conditions that advance rather than undermine gender equality and women’s empowerment (SDG 5).

<sup>10</sup> SDG 1 / 1.3 (no poverty): Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable. SDG 2 / 2.2 (no hunger): By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. SDG 3 / 3.8 (good health and well-being): Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. SDG 10 / 10.4 (inequalities): Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality



## Institutional Component

From a legislative and institutional perspective, the JP assisted the Federal Government of Nigeria in aligning its legislative framework with the policy reform agenda toward universal social protection for all by strengthening Nigeria's national social protection legal framework through the development of a social protection bill for consideration by the National Assembly.

At the same time, the programme developed the capacity and role of government ministries, departments and institutions working on social protection (both social insurance and social assistance pillars) in Nigeria to implement social protection programmes, with a particular focus on cash transfers and improving access to health and health situation of vulnerable groups such as women, children, girls, youth and persons with disabilities' health, education and nutrition.

## Operational Component

The programme targeted 6,000 recipients from vulnerable groups in Sokoto state who received health insurance coverage for a year. Within this group, the JP allocated cash transfers for transportation costs and other ancillary needs to cover 658 Pregnant and Lactating Women (PLW)<sup>11</sup> visits as well as vaccinations and immunisations at the designated eight Primary Healthcare Centres (PHCs) within the three LGAs of Bodinga, Wamakko and Wurno in Sokoto state. While the health insurance programme was implemented in four LGAs in Sokoto State, namely Bodinga, Wamakko, Tambuwal and Wurno.

When enrolled under the health insurance coverage jointly provided by UNICEF and SOCHEMA, beneficiaries receive a card displaying their name, which they can present at the closest affiliated health centre to receive medical care free of charge. These beneficiaries were selected according to the following criteria:

- Elderly
- Pregnant or lactating
- Caregivers of children under five
- Persons living with a disability
- Teenage girls

Among those recipients, 658 - under the "PLW and "caregivers of children under two" (U2s) categories - were eligible to receive cash transfers. To obtain these transfers, these PLW and U2s beneficiaries were expected to access health services at the PHCs where they are registered. At the end of the month, the PHCs shares attendance lists with SOCHEMA, a member of the CWG, who then sent the names to WFP. CWG processed the cash transfers for eligible beneficiaries through a handholding process with WFP. Recipients were thus expected to go to the PHCs for the required health services such as antenatal care (ANC), skilled delivery, and postnatal care, vaccination/immunization to be eligible to receive cash transfers. With this approach, the JP attempted to use cash transfer as an incentive to change behavioural patterns and encourage communities to seek professional healthcare services more frequently.

### 1.2.2 Results Framework

The Results Framework (RF), which can be found in the Annexe C, was adjusted from its initial version by participating UN agencies (PUNOs) following the JP's close-out in August 2022 to account for delays and modifications tied to the COVID-19 pandemic. The main transformative results for this impact evaluation were re-introduced by the Joint SDG Fund Secretariat in June 2021 and are based on the Joint Programme (JP) document detailing the JP's desired impact and objectives. The RF contributes to the JP's performance evaluation with regard to its impact and effectiveness. The main transformative results identified by implementing agencies are as follows:

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<sup>11</sup> Daily oral iron and folic acid supplementation with 30 mg to 60 mg of elemental iron and 400 µg (0.4 mg) of folic acid is recommended for pregnant women to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth. In Nigeria, IFA or MMS is dispensed to pregnant women every month.

- Implement a legally and financially strengthened social protection system (SDG 1.3). The JP is expected to have a draft SP bill which includes financial provisions on social protection expenditure of the Government, presented to the National Assembly. This reinforcement of the country’s institutional framework will accelerate progress in the field of social protection.
- Develop a digital cash transfer programme to alleviate out-of-pocket expenditure in contributory health insurance under a State-financed health insurance scheme for the poorest and most vulnerable (SDG 3.8). 6,000 poorest and most vulnerable groups have been identified to be enrolled in a selected state’s health insurance scheme, among which 2,100 pregnant women and caregivers of children under 2 years will be provided with transportation stipends through innovative digital cash transfer mechanisms and standard operating procedures. A basis for this cash transfer program will be laid down in the selected state. In particular, the state cash transfer institutions will be provided with a foundation to adopt a shock-responsive social protection approach through cash transfer mechanisms.
- Establish and build the capacity of 6 state SDGs offices, to serve as an innovation hub for other states' SDGs offices. The six pilot states will provide a platform to share feasible and innovative solutions that will use social protection to overcome bottlenecks and expand financing in order to accelerate SDG achievement. The JP will ensure that the achievement of social protection-related SDGs can be accelerated and learning and sharing across states can be improved.

The table below details and explains JP’s deliverables under each output listed in the results framework. These elements are critical to understanding what the evaluation team considered in its assessment of the JP’s achievements.

*Table 3 List of outputs and corresponding deliverables*

Outputs	Details
<p>Output 1.1: Strengthened national social protection legal framework with the development of a social protection bill, aimed at realising the rights to social protection for consideration by the National Assembly</p> <p><i>Output 1.1a. % of key stakeholders with increased capacity/knowledge on social protection system development (gender disaggregated)</i></p> <p><i>Output 1.1b. Existence of social protection bill is technically validated by stakeholders</i></p>	<p>Main deliverables (2021)</p> <ul style="list-style-type: none"> <li>• Trainings covering policy drafting, financing and legal frameworks for SP, engaging federal MDAs</li> <li>• Outreach to state actors, CSOs, groups representing persons with disabilities, workers, and employers</li> <li>• Draft revised NSPP</li> <li>• Draft National Social Protection Harmonization Bill</li> </ul> <p>The JP completed a legal mapping report, which preceded the attorney general’s appointment of legal experts to draft a harmonized SP bill. ILO delivered training to build the legal team’s understanding of SP, the ILO Social Security Convention 102, and Social Protection Floors Recommendation 202. The legal team subsequently held three technical sessions over a period of 30 days to (1) discuss and validate findings and (2) present recommendations for the drafting of the revised National SP bill. The process involved consultations with legal advisers from MFBNP, MLE and MHDS to ensure that the harmonized bill is in line with the existing legal framework and to secure the buy-in of relevant political stakeholders. The National SP Policy includes a shock-responsive approach to SP and a costed work plan, and captures inputs from the private sector, CSOs, groups representing persons with disabilities, workers, and employers. At the end of the year, the JP supported the MFBNP</p>



Outputs	Details
	<p>in convening a high-level stakeholder forum to introduce the revised NSPP and the draft bill to secure its pre-approval.</p> <p>The JP supported the development of Sokoto State Social Protection Policy (awaiting governor sign-off), including a costed action plan (Multisectoral M&amp;E framework and costing of the policy). The policy and MEAL framework will act as a blueprint for a sound SP programme. The final version of the Sokoto State Social Protection Policy was introduced to the Sokoto State Executive Council for its approval.</p> <p>PUNO further recruited two consultants to work closely with the MFBNP in drafting an implementation plan and M&amp;E framework, to strengthen the revised NSPP.</p>
<p>Output 1.2: Increased and institutionalised social protection financing with reinforced institutional framework through identification and creation of fiscal space and setting-up of innovative financing for social protection</p> <p><i>Output 1.2a. Fiscal space determined for Social Protection</i></p> <p><i>Output 1.2b. National Priorities in SP costed</i></p> <p><i>Output 1.2c. New strategy designed and signed by the Government.</i></p>	<p>Main deliverables (2021-2022)</p> <ul style="list-style-type: none"> <li>• Fiscal space assessment</li> <li>• SP costing, prioritisation, and fiscal space report</li> </ul> <p>2021   The JP completed a fiscal space study reviewing the government’s revenue and budgetary allocation to SP, including regional and global comparisons. The study served to shape the SP policy’s financial component and was used to advocate with the government to create a budget line dedicated to SP. The JP further encouraged the government to establish an SP trust fund.</p> <p>2022   The JP produced a report on the costing, prioritisation, and fiscal space, for SP, using the Regulatory Accounting Principles to evaluate the cost of 19 SP policies. The report also identified innovative ways to fund SP by 2026 through increasing tax and contributory revenues.<sup>12</sup> The JP further built the MFBNP’s capacity to use the RAP model and develop SP cost scenarios.</p>
<p>Output 1.3: SDGs Innovation and Accelerator States identified and established with proven innovative solutions and financing towards achieving Social Protection</p> <p><i>Output 1.3a. Number of quick wins identified for immediate implementation at the sub-national level</i></p>	<p>Main deliverables (2020-2022)</p> <ul style="list-style-type: none"> <li>• Six zonal consultations</li> <li>• 21 quick wins</li> <li>• Nine accelerated financing methods for the SDGs.</li> </ul> <p>2020 – 2021   The JP organised six zonal consultations, one in each of the country’s geopolitical zones. The consultations identified nine financing solutions towards SP,<sup>13</sup> and 21 potential quick wins<sup>14</sup> for states to take forward and implement. Through these consultations, the JP carried out trainings for the establishment of SDG Innovation Hubs and advocated with private sector stakeholders, including the Private Sector Advisory</p>

<sup>12</sup> The double-digit inflation will however pose significant challenges for SP budgeting.

<sup>13</sup> Some of those innovative solutions include allocating 1% of internally-generated revenue towards SP and using endowment funds for healthcare service delivery through public-private initiatives.

<sup>14</sup> Possible quick wins included: the use of a single state registry for all SP activities; the review of existing SP policies every three years to ensure that they respond to emerging issues and to address challenges identified during the M&E process; the establishment and training of state Technical Working Groups (TWG) on SP and also state Cash Working Groups (CWG) with members from relevant MDAs.

Outputs	Details
<p><i>Output 1.3b. Number of accelerated financing methods for the SDGs acceleration identified, recommended, and utilised</i></p>	<p>Group (PSAG), to support the creation of these hubs. Network service provider MTN and Amina J Mohammed Skills Acquisition Centre pledged to support the Gombe hub, while solar tech company ASG promised to train 1,300 youth on solar energy infrastructure and repairs and to provide solar energy to the Nasarawa hub.</p> <p>2022   The JP supported the SDG hubs with IT equipment (laptops) and carried out capacity-building activities. The JP further built the capacity of government stakeholders to strengthen the capacity of institutions in charge of SP.</p>
<p>Output 2.1: The existing cash transfer scheme is expanded, and the basis for universal cash to pregnant women and new-born children in Sokoto is laid down.</p>	<p>Main deliverables (2020-2022)</p> <ul style="list-style-type: none"> <li>• Establishment of the Sokoto state SP Cash Working Group (CWG) capacitated through training workshops and hand-holding process of its members to transfer cash to PLW and caregivers of U2 children.</li> <li>• Transformed paper-based cash transfers in the state to digital cash transfers, using CBT enabled MIS .</li> <li>• Set up a Complaints Feedback Mechanism (CFM) structure</li> <li>• Trainings on digital CBT processes to the Sokoto state CWG covering</li> </ul> <p>2021   The JP carried out a Capacity Needs Assessment (CNA), which resulted in the establishment of the Sokoto state SP Cash Working Group (CWG), whose members received trainings to implement and transform the paper-based cash transfer to digital cash transfers. The impact of the trainings was measured through a self-assessment leading to the calculation of a capacity index (baseline score: 1.2; endline score: 2.1). CWG members developed a Transfer Mechanism Selection (TMS) document, identifying the most effective and feasible cash transfer approaches in Sokoto which was endorsed and approved by the State’s Technical Working Group members. The JP further reviewed the CWG’s Terms of Reference and supported the CWG in developing Standard Operating Procedures (SOPs) to adopt a shock-responsive approach. The CWG’s key roles were implementing the enrolment of the beneficiaries through capturing of required information, distribution of payment instruments, preparing the payment list that meet conditionality criteria for the cash transfer programme, monitoring and, CFM (complaint and feedback management) . The CWG did not operate the digital payment platform as the tool to carry out cash transfers was not available in the state.</p> <p>2022   Following a financial landscape analysis, the JP linked up the CWG with a financial service provider to subsequently implement Sokoto’s first digital cash transfer project, targeting PLW and children under two years old. The project relied on CBT enabled Management Information Systems (MIS) and consisted of six rounds of monthly transfers. As part of the cash transfer</p>

Outputs	Details
	<p>project, the JP supported the CWG to establish a complaint and feedback mechanism.</p>
<p>Output 2.2. Universal Health Coverage at the state level accelerated using the Basic Health Care Provision Fund &amp; community-based insurance mechanisms</p>	<p>Main deliverables (2020-2022):</p> <ul style="list-style-type: none"> <li>• Developed 15 training manuals for SOCHEMA</li> <li>• Supported actuarial valuation of the National Health Insurance Authority</li> <li>• Raised awareness on World Universal Health Coverage Day</li> <li>• Held eight training sessions with NHIS</li> <li>• Provided healthcare coverage to 6,000 beneficiaries</li> <li>• Conducted a study on health needs of pregnant women and children in Sokoto state.</li> </ul> <p>2021   The JP assessed SOCHEMA’s ability to implement health insurance activities and developed 15 training manuals intended for SOCHEMA’s staff and approved by NHIS, this led to the operationalization of the scheme. In December, the JP and Sokoto state government commemorated World Universal Health Coverage Day to raise awareness of the importance of healthcare. At the federal level, the JP held eight training sessions with NHIS, focusing on actuarial valuation, data collection, and data quality requirements, and delivered a study on NHIS. These steps paved the way for Nigeria’s president to turn the National Health Insurance Authority bill into a law that makes health insurance mandatory and will lead to the establishment of the Vulnerable Group Fund.</p> <p>2021-2022   With SOCHEMA, Sokoto State’s Zakat and Endowment Commission (SOZECOM), and the Ministry of Women and Children Affairs, the JC identified 6,000 beneficiaries to whom they distributed ID cards in 2021 and who received health insurance coverage for a year.</p>

### 1.2.3 Leading Agencies and Implementing Partners

The JP relied on a number of stakeholders to deliver and support its activities: leading United Nations agencies (ILO, UNICEF, UNDP, and WFP), federal authorities and entities, and institutional branches of the Sokoto state. A detailed list of all stakeholders engaged, and roles and responsibilities can be found in Annexe.

The visual below presents how the different actors were involved in the key results:

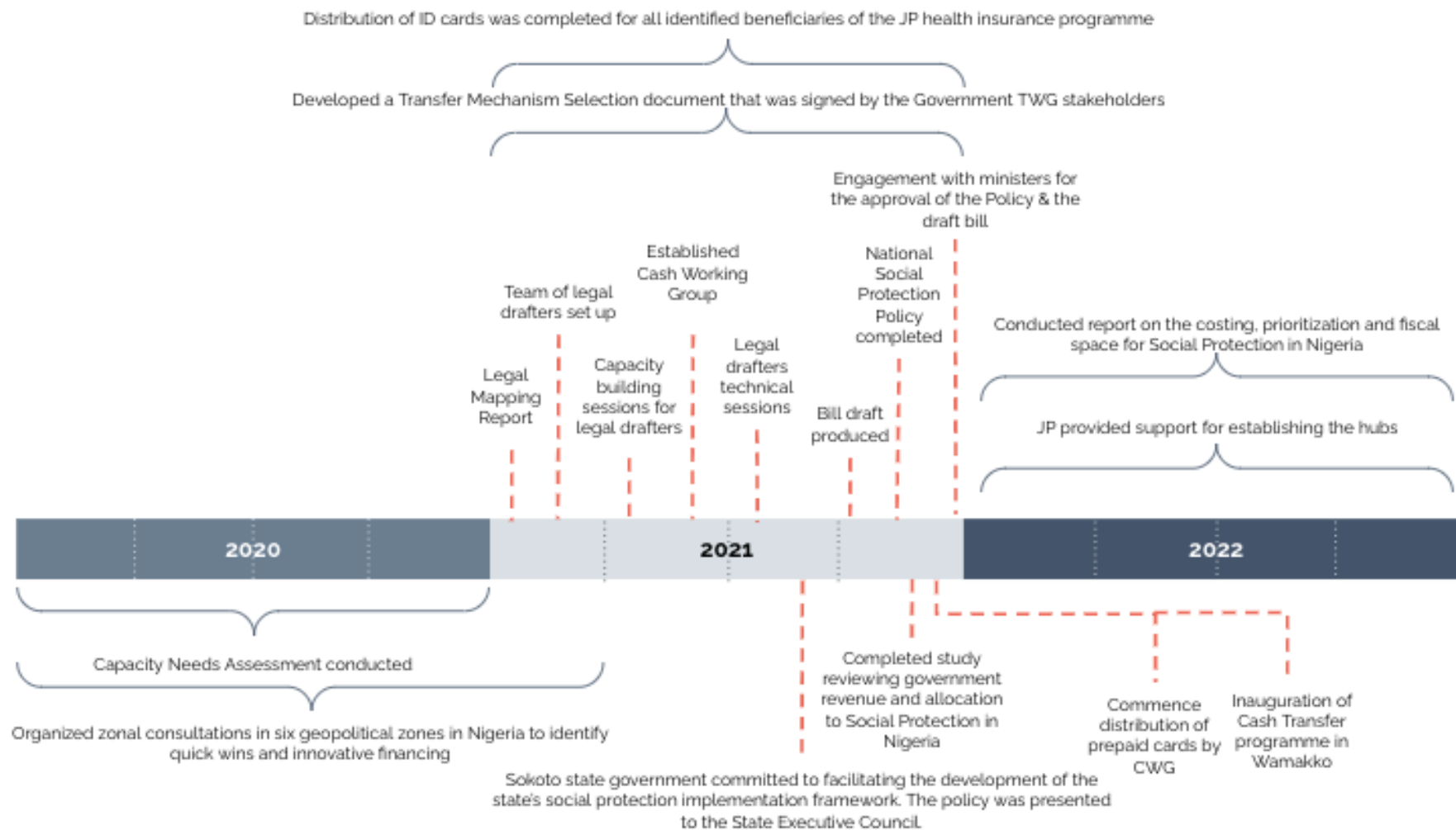
Figure 1 Stakeholder per result (over two pages)

Leading Agencies	Implementing Partners	Expected Results
ILO   UNDP   UNICEF	Budget Office   MFBNP   MLE   National Assembly	Establishment of a coherent and financially viable SP system at the federal level, grounded in a legal framework and integrated in national budget and planning efforts <b>(1)</b>
ILO   UNDP   UNICEF	MFBNP   MLE   National Assembly   Social partners   Civil Society	Strengthened national SP legal framework with the development of a SP bill, aimed at enforcing the right to SP, for consideration by the National Assembly <b>(1.1)</b>
ILO   UNICEF	MHDS   MFBNP	Increased and institutionalized SP financing, with reinforced institutional framework through the identification and creation of a fiscal space and the setting up of innovative financing mechanisms for SP <b>(1.2)</b>
UNDP   UNICEF	All Ministries in charge of planning (state and federal levels)   OSSAP-SDGs   State SDG offices	SDG Innovation and Accelerator states identified and established, with proven innovative solutions and financing towards achieving SP <b>(1.3)</b>
Leading Agencies	Implementing Partners	Expected Results
ILO   UNICEF   WFP	Sokoto state Min of Budget and Economic Planning, Sokoto state Social protection TWG, Sokoto state CWG .	The NSPP is operationalised in Sokoto, ensuring social development with a reduction in poverty and improvement in nutrition, education, health, and birth registration for women and children <b>(2)</b>

### 1.3 Programme Timeline

The \$2 million JP was initially set to finish in January 2022 but was extended until June 2022. The timeline below presents the various milestones of the JP.

Figure 2 Programme timeline



## 2. METHODOLOGY



*Photo 2 Primary Health care centre in Bodinga town, Bodinga*



## 2 METHODOLOGY

This section presents the methodology used for the final evaluation of the Joint SDG Programme on Institutionalising Social Protection in Nigeria, conducted by Samuel Hall between July through September 2022. The following sections summarise the evaluation design, research methods, sampling, analysis and challenges faced and mitigated.

### 2.1 Evaluation Design

The final evaluation used a mixed-methods design to allow for cross-validation and triangulation across data sources. Primary and secondary data were analysed to answer the following evaluation questions (EQ)<sup>15</sup> along the OECD/DAC criteria:

1. Relevance: How relevant are the integrated social protection services to priorities and policies at the national and state levels?
2. Coherence: How coherent has the programme been with international commitments, including gender equality, equity for children, and the human rights-based approach?
3. Effectiveness: How effective has the programme been in achieving its set objectives and its results, including any unintended and differential results?
4. Efficiency: How efficiently has the joint programme been managed, given the human and financial resources available? What have been the costs, including both funds and in-kind support, as well as UNCT efficiency (reducing transaction costs)?
5. Sustainability: How has the joint programme been conducive to sustainable results in terms of social protection and buy-in from key stakeholders?
6. Impact: What has been the impact of cash transfers in Sokoto state?

While embedded in the OECD/DAC framework, a number of research lenses were adopted to frame the development of research tools, data analysis and articulation of research results. Those lenses are not used in addition to the EQs but overlap and continue to address the OECD/DAC criteria. The table below outlines these key lenses.

Table 4 Research Framework - a set of critical lenses for the evaluation

Programme	Inclusion	Ecosystems	Strategic	Resilience
Design, delivery, outcomes, learning	Gender, disability, nationality/background, etc.	Considering relevant factors from the micro-macro level.	SDGs, triple nexus, regional priorities, best practices	Impacts of COVID, sustainability of programming

The inclusion lens considers gender, disability, and other factors of marginalisation. On the other hand, the ecosystems approach considers barriers and enablers at community, local, national, and other levels relevant to the programme. The strategic lens focuses on the programme's coherence and relevance, which are part of the OECD DAC framework, and considers its alignment with humanitarian priorities, UNICEF's mandate, and international best practices. Finally, the resilience lens looks at how the programme may have contributed to resilience and how resilient the programme and its beneficiaries are to shocks – particularly considering the impacts of COVID-19 and other socio-economic factors more broadly.

<sup>15</sup> The full list of evaluation questions and sub-questions is available in the Annex.

## 2.2 Research Methods

Data collection incorporated a mix of primary qualitative and quantitative data, as well as secondary data. The tools were developed to directly address the EQs further summarised in the Evaluation Matrix in the Annex.

1. Key informant interviews (KIIs): Phone and in-person interviews with key stakeholders were conducted to understand the interrelations between relevant actors better and assess how their coordination or competition can be leveraged for the development of social protection and the potential for replication and scale-up of integrated social protection programs across Nigeria. KIIs were conducted with JP partners and key stakeholders within the intervention areas in Sokoto, Enugu, Nasarawa, Delta, Lagos, Gombe, and Abuja.
2. Focus group discussions (FGDs): The FGDs covered recipients that benefitted from the health insurance coverage and some that received the cash transfers in addition to the health insurance. These discussions allowed for meaningful participation of the recipients. FGDs were accompanied by three Community Observations (COs) to gather feedback and insight from communities with beneficiaries of the health insurance coverage programme in Sokoto State.
3. Survey: Quantitative data from the survey served exclusively to gather measurements tied to OECD DAC criteria and aspects of inclusion in the health insurance coverage programme in Sokoto State. The survey was initially planned to be administered solely via phone. Still, due to unforeseen obstacles in achieving the targets outlined in the challenges and limitations sections, an in-person survey was conducted in addition to the phone survey.
4. Secondary research: Samuel Hall integrated two secondary research elements, namely a literature review and analysis of programme material, including activity and progress reports, for evaluation criteria that could not be assessed through primary data collection.

For this evaluation, Samuel Hall partnered with Mindset, an international social research organisation with a Nigeria office, to undertake quantitative and qualitative data collection, namely the FGDs, COs, and phone survey. Samuel Hall thoroughly trained Mindset's field teams on their respective data collection methods. Samuel Hall's locally based field network coordinator supervised the qualitative data collection team deployed within Sokoto State and conducted in-person KIIs.

## 2.3 Sampling

### 2.3.1 Location Selection

Research locations for FGDs and surveys were selected based on a list of PHCs and discussions with UNICEF during the inception phase. Given the scope of the evaluation, the research team was unable to cover all target areas and it was decided to cover areas covered by solely the health insurance and some areas covered by the additional cash transfers,

Primary Healthcare Centres (PHCs) were essential for the health insurance and cash assistance programme. The programme targeted 6,000 beneficiaries from vulnerable groups who were enrolled for one year of health insurance coverage. Within this group, the JP allocated cash transfers for transportation costs and some top-up for additional household use to cover 658 pregnant women and children basically to cover ante and postnatal visits/immunisation at Primary Healthcare Centres (PHCs). The beneficiary groups for the cash transfers were chosen because of poor Indicators of the state on maternal and health Indicators for women and children.

The research team conducted in-person fieldwork in three local governorates areas (LGAs) in Sokoto, namely Bodinga, Wurno and Tambuwal. The specific communities in those LGAs were chosen by

prioritising areas with a high number of beneficiaries. Ultimately, FGDs and in-person surveys were administered in the following communities.

1. Achida, Wurno
2. Bodinga, Bodinga
3. Dogon Daji, Tambuwal

The phone survey and KIIs were administered in all targeted LGAs and communities.

### 2.3.2 Qualitative Sampling

The research team used a targeted, purposive sampling approach rather than a random approach to select the participants of the FGDs and KIIs. The beneficiary lists were used to initially identify FGD participants, after which SOCHEMA supported the mobilisation based on the criteria. The key informant interviews were conducted from a comprehensive list of key stakeholders provided by UNICEF and partners. The qualitative sampling allowed the research team to capture a diverse set of beneficiaries and highly relevant stakeholders. While planned targets for FGDs and COs were met in all locations, the target number of KIIs was not completed due to the limited available time and reasons outlined in the challenges and limitations section.

Table 5 Qualitative sampling

Tool	Target		Actual	
KIIs	20		15	
FGDs	10	4 with female recipients	10	2 in Bodinga, Bodinga (cash and health) 1 in Achida, Wurno (cash and health) 1 in Dogon Daji, Tambuwal (only health)
		6 mixed (male/female), with recipients of the health insurance coverage, in the two communities that have the highest number of beneficiaries who provided a phone number. (2 per community)		2 in Bodinga, Bodinga (cash and health) 2 in Achida, Wurno (cash and health) 2 in Dogon Daji, Tambuwal (only health)
COs	3	1 per community (Bodinga, Wurno and Wamakko)	3	1 in Bodinga, Bodinga (cash and health) 1 in Achida, Wurno (cash and health) 1 in Dogon Daji, Tambuwal (only health)

### 2.3.3 Quantitative Sampling

The sampling was randomised, but due to limitations in the beneficiary lists provided by SOCHEMA and SOCU, which will further be elaborated on in the challenges and limitations section, the initial

target of the phone survey with 800 household surveys (600 with beneficiaries as the treatment group and 200 with non-beneficiaries as the control group) could not be reached.

- The treatment group was based on the beneficiary lists provided by SOCHEMA and SOCU. It was initially planned to use criteria clusters (under 5-year-olds’ caregivers, adolescents, elderly, and pregnant beneficiaries), each with an ideal data collection target based on a proportionally representative sample. However, the limited number of successful survey attempts made cluster sampling impossible which is further discussed in section 2.5.
- The control group helped capture what health outcomes would have been for the broader population of Sokoto State had the JP not been implemented. Differences observed between the control and treatment groups may be attributable to the JP. There was no baseline evaluation, which would have provided a list of non-beneficiaries performed at the onset of the JP’s implementation. Initially, Samuel Hall planned to ask selected beneficiaries, at the end of the survey, if they could provide the phone numbers of 1-2 persons living in their community and who they knew did not benefit from the programme. As the majority of the phone numbers provided in the beneficiary lists turned out to be registered to non-beneficiaries, using the snowball technique to reach the control group was not necessary.

Due to limitations in the beneficiary lists provided by SOCHEMA and SOCU, which will be further elaborated on in the challenges and limitations section, the initial targets of the phone survey could not be reached. Therefore, the research team changed their approach and conducted an additional in-person survey with the support of SOCHEMA at Primary Healthcare Centres (PHCs) in Wurno, Bodinga, and Tumbawal.

*Table 6 Quantitative sampling*

Participants	Planned	Total actual	Phone survey	In-person survey
Beneficiaries	600	261	123	138
Non-beneficiaries	200	471	358	113
Total	800	732	481	251

Within the sample, 138 of 251 (55%) face-to-face respondents reported being beneficiaries of the Joint SDG programme. 123 of 481 (26%) of phone respondents reported the same. 97% of face-to-face respondents were women and 82% of phone respondents were male.

Figure 3 Face-to-face respondents beneficiary profile

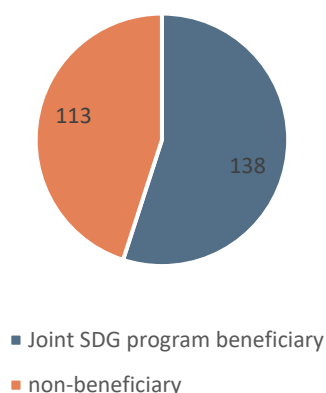
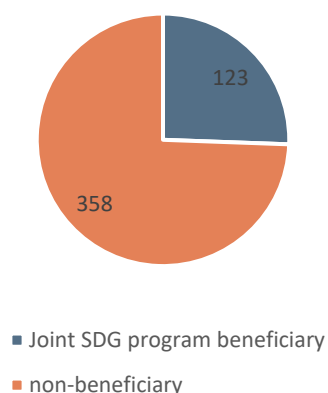


Figure 4 Phone respondents beneficiary profile



Of all survey respondents, 66% of face-to-face respondents and 54% of phone respondents reported receiving health insurance while 62% of face-to-face respondents and 68% of phone respondents reported receiving direct cash transfers.

## 2.4 Analysis

After the data collection phase was completed, the SH team conducted the analysis of the primary and secondary data collected, namely qualitative and quantitative data analysis and financial analysis. Qualitative analysis was performed utilising an inductive qualitative analysis approach to draw findings from collected data drawing on the research questions, guided by the Evaluation Matrix. For the quantitative data analysis, the statistical teams went through each variable in the data set collected in order to identify any anomalies. Then, analysts proceeded to calculate simple frequencies of all the variables of interest and disaggregated analyses of all key indicators by the community. Furthermore, Samuel Hall provides a brief financial analysis of the JP, focused on the effectiveness of the programme with regards to the budget that was allocated and to the programme's modus operandi – as one UN fund as opposed to agencies implementing in a siloed approach - through reviewing relevant documentation provided by the PUNOs.

## 2.5 Challenges and Limitations

The JP is a large and complex programme operating in a similarly complex environment – as a result, capturing the nuance needed to adequately assess and understand the programme's impact was naturally challenging. As such, the research team, after consultation with UNICEF, focused primarily on research questions that required primary data collection, particularly with direct beneficiaries, to ensure the most efficient use of time and resources.

**Lack of theory of change and baseline data limited the impact analysis:** The absence of a theory of change and comprehensive baseline and monitoring activities throughout the programme implementation limited the ability of the evaluation team to conduct an impact analysis. The baseline study conducted by a government partner was insufficient and the context analysis for each component does not provide data on health expenditures or behaviour regarding the use and access to professional health care services among the targeted population in Sokoto State. Moreover, while a MEL plan was developed, it was not followed through the end and therefore provides limited data for the present final evaluation.

To mitigate this shortcoming, the evaluation team collected data from non-beneficiaries. The test and control sampling focused explicitly on assessing the impact question more rigorously. However, it is essential to note that the sample sizes do not allow granularity at all levels and are, therefore,

indicative. The quantitative data is not representative of the beneficiaries for the reasons outlined below. The qualitative component highlights trends, lived experiences and individual perceptions and is, by its nature, not representative.

The main challenge in collecting primary data with direct beneficiaries and a control group was based on the information contained in the beneficiary lists from SOCU. While the cash transfers recipients are also part of the health insurance coverage, a comprehensive list of all beneficiaries and whether they are part of both was not provided. It should be noted that JP programme did not implement but strengthened government's capacity in implementing the health insurance and cash transfers and therefore the recipient lists were created and drafted by the government.

The lists of beneficiaries provided included a total of 6,633 recipients of the health insurance coverage, but only 1342 individuals were listed with a phone number. The list of the 658 cash transfer recipients did not include any phone numbers. From the total sample of phone numbers, the team was able to snowball 100 additional contacts from the primary sample making the total 1,442. Out of those, only 507 surveys could be completed, mainly because the phone number did not belong to the recipient, or the phone numbers were disconnected. Of the 507 surveys, only 162, which accounts for 32%, were recipients, and the majority were non-recipients. Many recipients on the lists claimed they did not receive assistance, had a different name than the one indicated on the list or were unaware of who the intended beneficiary was.

Different reasons could explain the low success rate of the phone surveys. It might be related to the low rates of phone connectivity and ownership among these areas in Nigeria and particularly among the target groups. However, it might also point to a limited depth of monitoring exercises throughout the implementation of health insurance which was managed by SOCHEMA and cash transfers which were managed by the CWG, it is noteworthy to mention that these two projects are different.

**Lack of financial documents for the efficiency analysis:** The financial analysis requested in the Inception Report could not be completed in a satisfactory manner due to the lack of relevant information in the documents received by the research team. The financial data provided by the agencies was analysed in chapter 4.3 but due to the nature of the documents received, the team was unable to conduct a comprehensive analysis according to the efficiency criterion.

Furthermore, the evaluation team faced various **implementation challenges, resulting from the following factors:**

- Delays during the inception phase and in receiving the beneficiary lists resulted in the postponement of the data collection activities and, therefore, subsequent time limitations in the analysis and drafting phases.
- The limited information of phone numbers provided in the beneficiary lists made the initially planned phone survey targets and random sampling of participants impossible, and the newly adopted in-person survey and additional attempts in the phone survey led to a prolonged data collection phase.
- After contacting and following up with the potential KII respondents from the provided list, only 15 were eventually successfully interviewed either individually or in a group. The challenges concerning reaching the stakeholders on the list provided included unresponsiveness, invalid email addresses, and refusal to participate.

*These challenges presented above were addressed and mitigated as much as possible during the research study and in constant consultation with UNICEF and key partners.*



### 3. CONTEXT ANALYSIS



Photo 3 Observation room at PHC in Bodinga town, Bodinga

### 3 CONTEXT ANALYSIS

The following sections summarise the JP programmes' context at the national level, the pilot state Sokoto and presents household profiles based on the survey conducted. The information presented is mainly based on a secondary desk review, programme documents, the household survey with beneficiaries and non-beneficiaries, and community observations conducted by Samuel Hall in the towns of Bodinga in Bodinga LGA, Achida in Wurno LGA, and Dogon Daji in Tambuwal LGA of Sokoto State.

#### 3.1 Nigeria

Nigeria has an estimated population of 216.7 million<sup>16</sup>, who have been faced with a volatile insecurity situation for decades, particularly in the Northeast and North-West, and huge socioeconomic disparities. It is a multi-ethnic and culturally diverse country with stark geographic differences in terms of economic growth and well-being.<sup>17</sup> Residents in the lowest wealth quintiles are concentrated in the North-East and North-West, while those in the highest wealth quintiles are concentrated in the South-South and South-West.<sup>18</sup>

In the past decade, the Nigerian economy experienced challenges of various kinds, aside from the economic consequences of the COVID-19 pandemic, including various violent conflicts across the country, zero economic growth rates, poor management of economic and financial affairs, as well as high unemployment rates, especially among the youth. According to the World Bank, the gross domestic product (GDP) went from US\$3,100 in 2014 to US\$2,085 per capita in 2021<sup>19</sup>. Evidently, large proportions of the Nigerian population are both monetarily and multidimensionally poor<sup>20</sup>, and in 2020 an estimated 39.1% of Nigerians lived below the international poverty line.<sup>21</sup>

In this environment, the nexus of recent and protracted political, security, socioeconomic and financial crises, compounded by the COVID-19 pandemic, has affected most sectors of society, resulting in significant budget cuts in key areas such as education and health care.<sup>22</sup> These cuts occurred in a context with already high infant mortality rates at 67 deaths per 1,000 births. According to the 2018 National Demographic Health Survey (DHS), only 2.6% of women and 3.4% of men have subscribed to any health insurance scheme.<sup>23</sup> In terms of education, the enrolment rate in primary education is 92.8% for girls and 94.5% for boys.

This context has compelled the government to adopt concentrated social protection measures to address the country's challenges in order to alleviate the scourge of precariousness and promote the general well-being of all Nigerians. The Nigerian Social Protection Policy (NSPP) launched in 2019 was a milestone in the country's social policy and is an umbrella policy framework that encompasses social agenda principles aimed at alleviating poverty and ensuring a dignified existence for all citizens. The policy defines social protection as: *"A mix of policies and programmes designed for individuals and households throughout the life cycle to prevent and reduce poverty and socio-economic shocks by promoting and enhancing livelihoods and a life of dignity."*<sup>24</sup>

While the NSPP is very ambitious, the rollout is still nascent, with only a small percentage of the vulnerable population being covered currently, and there is a lack of a clear policy direction at the national and federal levels. Social protection programmes vary amongst federal states as state governments are encouraged to contextualise SP interventions. At the same time, Nigeria's budget for social spending has been inadequate to finance a social protection system. International development actors such as UN agencies and the World Bank have funded various SP programmes in the country and supported the state in capacity building and policymaking.

The development of the National Social Registry (NSR) was essential for the roll-out of the NSPP; it is *"a repository of information about potential beneficiaries for multiple social assistance programs that share a common population of interest, but not necessarily the same eligibility approach"*.<sup>25</sup> The initiative led by the National Social Safety-Net Coordinating Office (NASSCO) and the World Bank was designed and developed concomitantly to, but independently from, the JP. To build the registry, NASSCO used Community-Based Targeting, which relies on community members to identify households they deem poor and vulnerable within their area of residence. UNICEF representatives emphasised the role played by the JP in

<sup>16</sup> UNFPA, 'World Population Dashboard -Nigeria', United Nations Population Fund, 2022, <https://www.unfpa.org/data/world-population/NG>.

<sup>17</sup> World Bank Group, 'Poverty & Equity Brief - Nigeria', October 2021.

<sup>18</sup> National Population Commission, 'Nigeria Demographic and Health Survey', October 2019.

<sup>19</sup> World Bank (The), GDP per capita (current US\$), data for 2021.

<sup>20</sup> 46.4% of Nigerians are multidimensionally poor, according to 2018 estimates. See: Oxford Poverty and Development Initiative United Nations Development Programme, 'Global Multidimensional Poverty Index 2020, 2020.

<sup>21</sup> National Bureau of Statistics (NBS), 'Nigeria - Living Standards Survey (2018-2019)', July 2020.

<sup>22</sup> Mershak Shem Yenle, 'THE EFFECTS OF ECONOMIC RECESSION ON EDUCATION IN NIGERIA', *PEOPLE: International Journal of Social Sciences* 3, no. 3 (15 December 2017): 502–9; Abba Kale, Babaji Maigari, and Habu Haruna, 'Economic Recession in Nigeria: Implications for Nursing Education and Practice', *IOSR Journal of Nursing and Health Science* 06, no. 02 (May 2017): 54–62; Bamgboye M. Afolabi, 'Predictable Impact of Current Economic Recession on the Spread and Severity of Diseases in African Countries: Focus on Nigeria', *Journal of Prevention and Infection Control* 03, no. 01 (2017).

<sup>23</sup> National Population Commission, 'Nigeria Demographic and Health Survey'.

<sup>24</sup> Federal Republic of Nigeria and Federal Ministry of Finance, Budget, and National Planning, 'Revised Draft National Social Protection Policy', June 2021.

<sup>25</sup> Community & Social Development Authority (COSDA) of the Government of Nigeria, 'Learn More about the NSR', 2022.

operationalising the NSR by using data mined from the registry to identify Sokoto beneficiaries in partnership with State Operations Coordination Unit (SOCU) and enhancing collaboration with NSSP at the federal level.

### 3.2 Sokoto State

The Federal State of Sokoto in the country's North-West was selected as a pilot area for the SP operationalisation component of the JP programme. Disparities in terms of access to social services and socioeconomic status are high in Nigeria, based not only on types of occupations and educational level of parents but also geographically, primarily between North and South and urban and rural areas. Sokoto is one of the states in the North with high levels of poverty, insecurity and an economy dependent on agriculture in primarily rural communities.

Gender disparities, political representation, access to and control over property, credit facilities, technologies, education and health, are ubiquitous in Sokoto State. 52% of residents are in the lowest wealth quintile, with health, nutrition and education indicators particularly low, making it one of the country's most economically disadvantaged regions. Over 80% of the population is engaged in agriculture. Unemployment and inflation rates are higher than the national average in Nigeria, and women and youth are particularly disadvantaged in the economy. Just 5% of women have completed secondary education or more - the lowest rate in the country.<sup>26</sup> The state experiences insecurity with incidents of banditry attacks leading to deteriorating living conditions and human displacement. Many people living in the state are in such dire conditions that immediate assistance is needed to avoid a major humanitarian crisis.

The JP health insurance programme commenced in four LGAs, namely Bodinga, Wamakko, Tambuwal and Wurno, and cash transfers were provided in Bodinga, Wamakko, and Wurno LGAs. Before rolling out the operational component of the programme, the JP partners conducted a mapping of ministries, departments and agencies engaged in cash transfers in the state to form the CWG, then conducted a capacity needs assessment (CAN) to identify capacity gaps requiring strengthening for sustainability, and conducted an assessment to assess the "Transfer Modality Selection for delivery of cash assistance in Sokoto State", which compared different modalities for the cash transfers and identified the capacities and capabilities of implementing institutions to deliver the cash transfers and potential risks and mitigation measures. The assessment also provided a rationale for selecting the LGAs for the cash transfer programme, which included a discussion on the multiple types of vulnerabilities experienced by families which need immediate and coordinated efforts to mitigate.

Despite relatively low bank account and mobile phone ownership rates in Sokoto, particularly among women, the assessment established that either bank account or mobile money are feasible options for implementing cash transfer in all project areas. For example, no banks are available in Achida, Wurno. However, this challenge was mitigated by the JP programme as the cash transfer mechanism included a detailed plan of utilising POS stations instead of formal banks.

In terms of the capacity of institutions to implement SP interventions, the government of Sokoto State has shown the political will and financial commitment to institutionalise the SP policy. It is important to note that prior to JP there was no platform where social protection implementing ministries, departments and agencies could meet to plan and share ideas. It was through the JP that the SP TWG was established, and the State Commissioner of Budget and Economic Planning was formally inaugurated. Effective collaboration concerning SP programmes among agencies in the state was facilitated by the JP, most notably with the establishment of the Social Protection TWG (SP – TWG). The JP developed a TOR for a TWG, got approval from the government and supported the establishment of the TWG while giving support to the monthly meetings.

### 3.3 Community observations in Bodinga, Wurno and Tambuwal

The selected LGAs in Sokoto have similar poverty levels and education characteristics. Still, the level of insecurity and access to healthcare services vary slightly, as observed in the community observations conducted by Samuel Hall, which allowed the evaluation team to zoom into three towns:

- Bodinga town's geographic location is an advantage for its economy. Due to its closeness to the state capital and an express road linking it to other LGA and states, the town has experienced consistent development. The town is the Headquarter of Bodinga LGA and is culturally homogeneous. Respondents interviewed argued that the city is relatively safe, but insecurity is still vast in a few villages in the LGA.
- Achida in Wurno is highly affected by increasing rates of crime and insecurity. One informant argued these crimes result from increasing competition for resources. It is a relatively culturally diverse population, but ethnic conflicts are rare. Food scarcity is a significant problem, particularly among widows, orphans and the elderly, and, therefore, a health worker complained that these are not included in the health insurance coverage. The economy depends on agriculture, similar to the rest of Sokoto State and has favourable land for this activity.
- Farming is reportedly the primary occupation for people in Dogon Daji town of Tambuwal LGA, and businesses are secondary, with only a few shops in the city. There is little cultural diversity among the population of roughly 90,000 in the district. The town has a thick forest where criminal activities such as kidnapping and robberies are frequently happening. Some respondents argued the security situation is improving due to government and community mobilisation efforts.

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<sup>26</sup> National Population Commission, 'Nigeria Demographic and Health Survey'.

Across communities, the state of health facilities and people’s ability to cover medical costs are significant hindrances in accessing adequate health care, particularly for pregnant women and people with a disability. Residents interviewed by Samuel Hall in the town of Dogon Daji in Tambuwal LGA gave the most positive responses when asked about the state of their Primary Healthcare Centre (PHC), as it was recently built and provides disabled-accessible services to the community and has designated spaces for pregnant women. However, observations in the towns of Bodinga and Achida revealed that health facilities are in a very poor state and not inclusive of the needs of people with disabilities and pregnant women. One health professional in Bodinga mentioned the high prevalence of self-medication and how health facilities need more functional dispensaries and funding to provide accessible and free medicine. While insufficient staff in PHCs was reported in all locations, a majority of respondents spoke highly of the health care workers’ commitment to helping the communities.

Regarding the state of education in Sokoto, the main barrier for children to continue school after the primary or secondary level is that parents cannot afford their education. Boys often follow their parents’ pathway and work on the family farms, and girls get married young when they leave school. While it was argued that most girls do not pursue education further than the secondary level, various people interviewed confirmed that the culture in this regard is changing, and an increasing number of girls are continuing their education.

### 3.4 Household Profiles: Beneficiaries vs Non-Beneficiaries

The following section provides a brief comparison of key socioeconomic and health indicators for beneficiaries and non-beneficiaries of the JP programme to better contextualise the findings presented in the subsequent chapter. Section 2.5 highlights the limitations of the sampling.

#### 3.4.1 Household characteristics

Beneficiary respondents tend to live in slightly larger households. The average household size of non-beneficiaries who were surveyed via phone was 18, compared to 19 of the programme beneficiaries. Among the face-to-face interviewees, the average size of non-beneficiary households was 14, in comparison to 16 for beneficiaries.

Most respondents reported to have small children, both within the face-to-face and phone samples. 74% of non-beneficiaries and 64% of the programme beneficiaries interviewed via phone reported to have children under 2 years old. The share of such households was slightly lesser among the face-to-face respondents, among whom 46% of non-beneficiaries and 54% of beneficiaries had children of such age. Similar tendencies were observed when respondents were asked about having children who were under 5 years old in 2020/2021.

Table 6 below shows that while differences between non-beneficiaries and beneficiaries were not significant when asked about healthcare conditions during birth of children under 2 years old, they were significant when asked about assistance of qualified health personnel for any health issues in children under 5 years old.

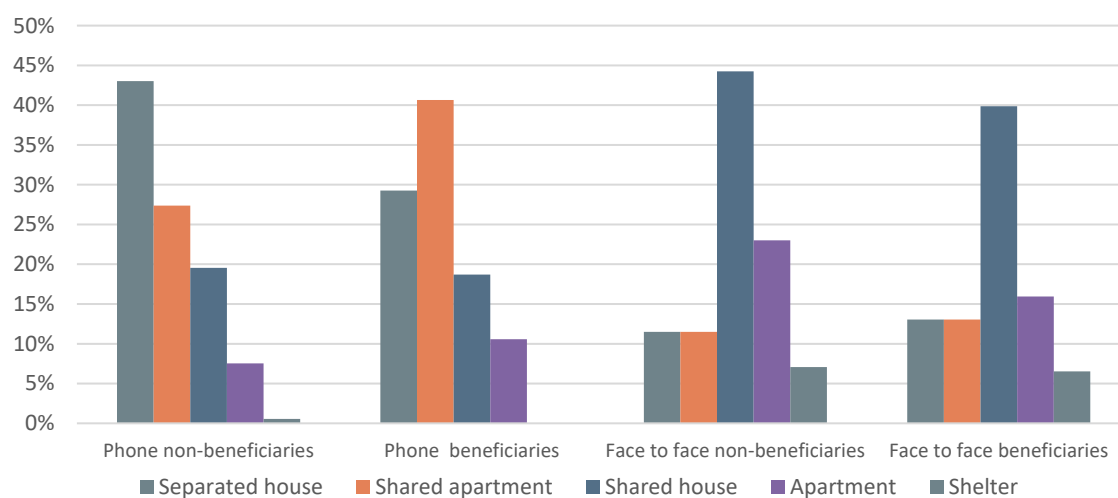
Table 7 Health assistance received

Respondents / Answers	Phone respondents		Face-to-face respondents	
	Non-beneficiaries	Beneficiaries	Non-beneficiaries	Beneficiaries
Children under 2 years old	74%	64%	46%	54%
% of whom were born in a health facility or clinic	41%	44%	52%	51%
Children who were under 5 years old in 2020/2021	72%	73%	45%	60%
% of whom have been assisted by qualified health personnel for any health problem in the past	73%	90%	67%	87%

When asked about specific household characteristics, respondents in both samples most often reported pregnant women among household members (22% among the face-to-face interviewees and 44% among the phone interviewees), followed by reports of chronically ill persons (7% among the face-to-face interviewees and 20% among the phone interviewees). Additionally, 3% of face-to-face respondents and 11% of phone interviewees told that they live with physically disabled household members.

When asked about the type of home they live in, phone interviewees most frequently reported separated houses and shared apartments, whereas the largest share of face-to-face interviewees lived in shared houses. There are no substantial differences in the home types reported by beneficiaries vs. non-beneficiaries.

Figure 5 Type of home respondents live in



Within both samples and among both beneficiaries and non-beneficiaries, around 3 in 10 respondents reported unprotected dug well as their main source of drinking water. Other most frequently reported main sources of drinking water were protected dug wells, tube wells or boreholes, and public piped water.

Table 8 Drinking water access

Respondents / Answers	Phone respondents		Face-to-face respondents	
	Non-beneficiaries	Beneficiaries	Non-beneficiaries	Beneficiaries
Dug well – unprotected well	30%	28%	29%	38%
Tube well or borehole	29%	27%	29%	22%
Dug well – protected well	26%	25%	12%	21%
Piped water (public tap/standpipe)	11%	8%	21%	16%

### 3.4.2 Income and household expenditures

The top 3 main sources of income identified by respondents within both face-to-face and phone samples were agriculture, trade (retail) and livestock. In addition, 17 respondents interviewed via phone identified their job in civil service as the main source of income, followed by 9 who reported



their teaching job as the main income generating activity. Differences between beneficiaries and non-beneficiaries in both samples were not statistically significant.

Figure 6 Main sources of income, phone interviewees

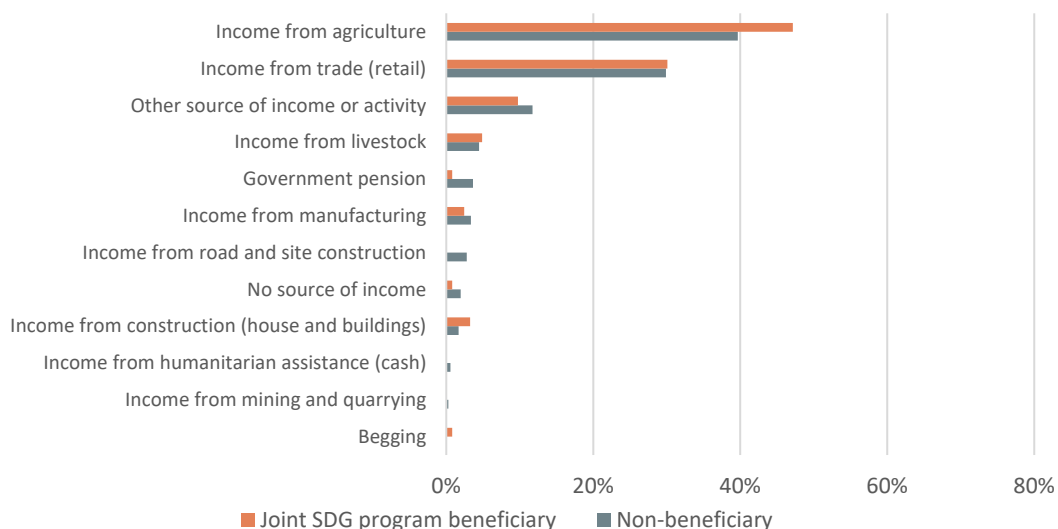
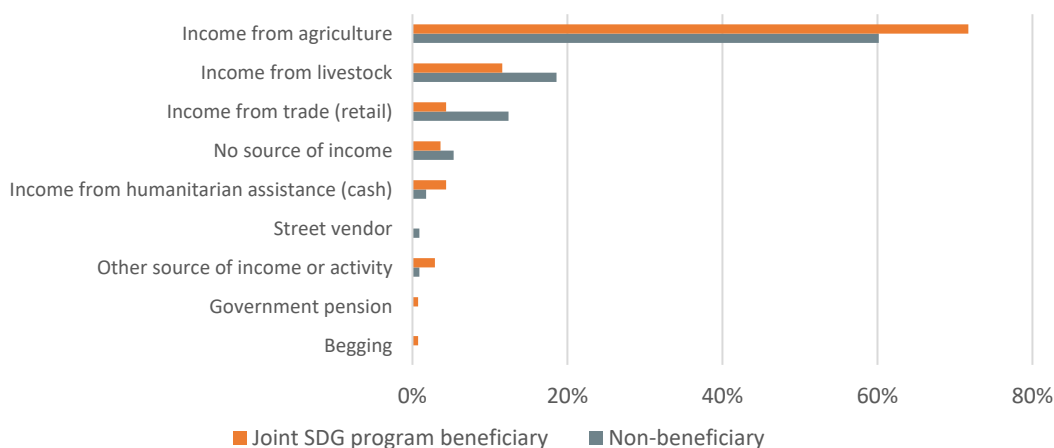


Figure 7 Main sources of income, face-to-face interviewees



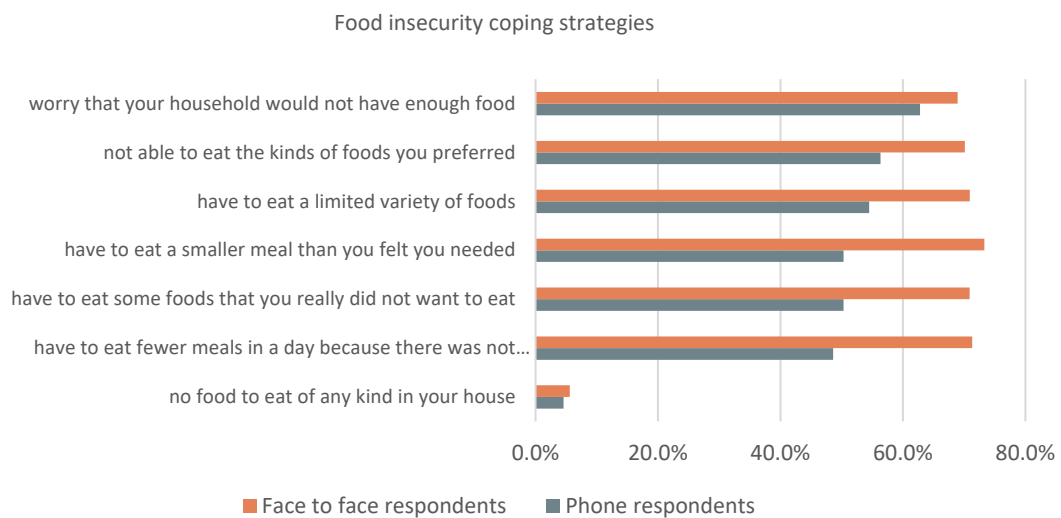
When asked about spending on basic items and services, most phone respondents (53%) reported that between 70% and 100% of household expenditures is spent on food.<sup>27</sup> Meanwhile, only 8% of face-to-face non-beneficiary respondents and 17% of face-to-face beneficiaries spent this much on food.

<sup>27</sup> Beneficiary and non-beneficiary differences were not statistically significant.



When asked about food insecurity coping strategies and concerns, phone interviewees most often reported that they worried their household would not have enough food (63% of respondents). Among the face-to-face interviewees, most frequently employed strategy was having a smaller meal than needed (73% of respondents). Differences in strategies employed were largely insignificant within both samples when beneficiaries and non-beneficiaries are compared.

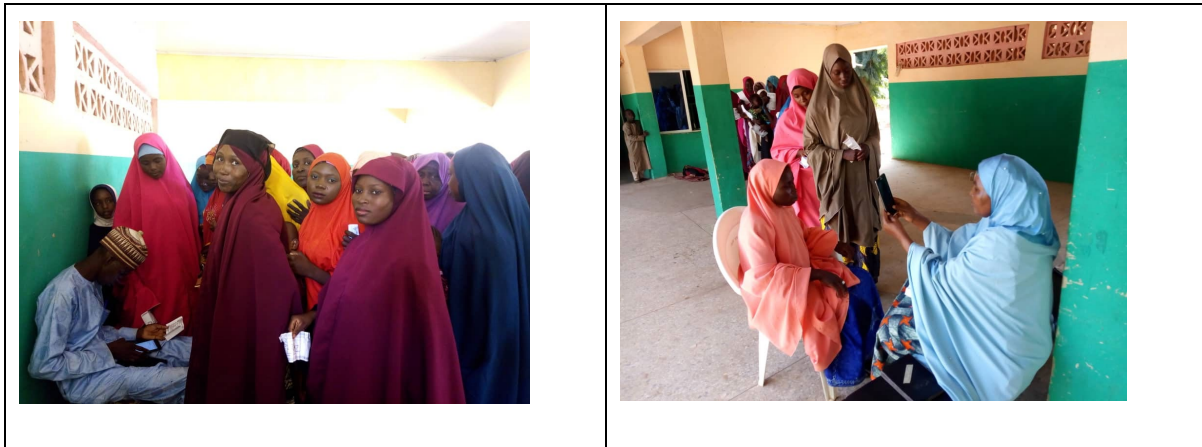
Figure 8 Food insecurity coping strategies



### 3.4.3 Household expenditures on health

Meanwhile, most respondents in both samples spent up to 10% of their expenditure on health. When asked about how much of it is spent on maternal and child health specifically, joint JP beneficiaries reported lower maternal and child health costs among both phone and face-to-face interviewees when compared to non-beneficiaries in each of the groups. Among phone respondents, most beneficiaries (40%) reported spending less than a quarter, in comparison to only 22% of non-beneficiaries respectively. Similarly, among face-to-face interviewees it was 21% for non-beneficiaries and 33% for beneficiaries.

Beneficiary respondents who were interviewed via phone also reported lower expenditure on preventive health services when compared to their non-beneficiary counterparts: 40% of phone non-beneficiaries spent less than a quarter, in comparison to 55% of phone beneficiaries. The difference between the two groups was however not significant within the face-to-face sample.





## 4 EVALUATION FINDINGS



Photo 4 Market in Dogon Daji, Tambuwal

## 4 EVALUATION FINDINGS

The evaluation findings presented in the following sections are based on a range of primary and secondary data collected and analysed. The findings are discussed in line with the OECD-DAC Evaluation Criteria and the corresponding evaluation questions and sub-questions outlined in the methodology. The evaluation team defined 3 categories of assessment of the SDGs project's merit or inadequacy in relation to the six evaluation criteria, keeping in mind the status of the project and nuancing the level of requirement in a pandemic and post-pandemic context. Finally, it must be recognized that the evaluation grid imposed by UNICEF for this evaluation (OECD-DAC) does not work in the program's favor, insofar as it involves evaluating the dimensions of sustainability and impact according to a timetable that is too short and does not allow for a full assessment of a program that was developed in a very short period of time and in situations of emergency and endemic crisis, which would undoubtedly call for a different evaluation approach. These dimensions, which appear to be the weakest, will be more accurately evaluated in a few years, if the program is renewed.

*Table 9: Colour code for OECD DAC Evaluation*

Category of Merit's Rating	Description	Colour
<b>High</b>	All expectations of OECD/DAC Criteria are fully achieved by the project given a realistic operational and strategic calendar	Dark Green
<b>Positive</b>	Average level of satisfaction – more than 50% of achievement and a reassuring outlook for the future	Light Green
<b>Insufficient</b>	Not satisfactory – less than 50% of achievement and concerning outlook for the future	Yellow
<b>Not achieved</b>	Expectations Not Met (Shortfall)	Red

*Figure 9: Overview of the evaluation (according to OECD DAC criteria)*





## 4.1 Relevance

**UN Joint SDGs Project  
is Highly Relevant**

*To assess the relevance of the Joint UN SDGs Project, the evaluation team looked at whether the project did “the right thing” in terms of how its interventions responded to the needs of most vulnerable households, including people with disabilities.*

### Synthesis

The question of the relevance of the JP is not in doubt, as the need for a social protection system is clear throughout the country, according to respondents. In this regard, the institutional component of the JP helped identify gaps and strengthened existing systems based on a needs assessment and a feasibility study carried out prior to the programme implementation. As for the pilot intervention in Sokoto, the basic humanitarian needs (food security, health, education) are so great that the development of a safety net can only help local populations to be more resilient in the face of the consequences of climate change, the various conflicts and insecurity that plague Sokoto State, and the lack of a sufficiently stable political and socioeconomic framework. Generally, respondents reflected positively upon the messaging, transparency, implementation, and beneficiary selection within the Joint SDG programme.

The evaluation team has concluded that the UN Joint SDGs Project is highly relevant to the need of the poor and vulnerable population of Nigeria. This is based on the evidence of multidimensional poverty and negative effects of Covid-19, because Sokoto State is one of the states in the Northwest with the highest levels of poverty, insecurity, and an economy dependent on agriculture in primarily rural communities. Most people living in the state are in such dire conditions that immediate assistance is needed. The design of the UN Joint SDG project is based on key evidence generated from relevant national and local surveys, assessments, and studies: i) Nigeria Demographic and Health Survey 2018, ii) National Nutrition and Health Survey 2018, iii) Sokoto State Government Led Capacity Needs Assessment and iv) UNICEF Health Needs Sokoto State Level Assessment. In addition, this UN Joint SDG is well aligned with the National and State Development Plans and National Social Protection Policy as well as the National Health Act 2014. However, due to funding limitation the Universal Social Protection coverage approach was not adopted for the UN Joint SDGs Project. As such, categorical targeting of population associated with multidimensional poverty (elderly, children, pregnant women, persons living with disability) were given priority in the selection of the UN Joint SDG beneficiaries.

Evaluation Questions	Rating
1.1. Are the activities and outputs of the joint programme consistent with the national social protection strategy and the attainment of its objectives?	Yellow
1.2. Have contextual factors (specific to each of the programme sites) been considered in the design and implementation, and adaptation of integrated social protection services?	Yellow
1.3. To what extent are the integrated social protection services relevant to the most vulnerable households? Have services been fully adapted to meet the needs of different groups, in particular women, girls, and people living with disabilities?	Green
<b>RELEVANCE (given the limited time and pandemic context)</b>	Green

**4.1.1. National Social Protection Policy (NSPP):** JP stakeholders supported MFBNP in the development of a harmonized bill and the revision of a federal NSPP taking into consideration emerging issues such as COVID-19, and worked with Sokoto institutions to draft a state-level SP policy<sup>28</sup>. Nigeria’s first national SP policy framework was endorsed in 2017, and the revised version obtained under the JP’s mandate delineated the roles and responsibilities of SP implementers.<sup>29</sup> Beyond drafting the SP policy,

<sup>28</sup> Federal Republic of Nigeria and Federal Ministry of Finance, Budget, and National Planning, ‘Revised Draft National Social Protection Policy’.

<sup>29</sup> KII9, World Bank.

the federal government approved the National Health Insurance Act in May 2022. According to the ILO representative, ILO further expects that the Nigerian government will soon ratify its Convention 102 on Social Security as a result of the advocacy and capacity-building work performed under the JP.

While the JP supported Nigeria's strengthened investment towards SP and despite having a prior SP policy, the policy had expired in 2020 and there was no implementation plan nor was the policy costed. The JP supported the revised policy to include an implementation plan, and M&E framework and costed the policy as well. As the NASSCO representative pointed out, SP is a concept that is recent, not necessarily well understood by all political bodies, and remains fragmented; the federal government and state authorities did not share a common vision and strategy, and there is yet to be an expenditure tracking mechanism in place. A focal point for ILO further noted that the SP policy drafting process highlighted coordination issues between governmental agencies. To address this, the JP supported the Technical Working Group (TWG) in implementing a legal and harmonisation committee composed of legal advisers from key ministries to support the drafting of the social protection bill. The bill identifies SP as a human right and focuses on increasing and improving coordination between state institutions, which have implemented various SP programmes but failed to "speak to each other."<sup>30</sup> If the policy is taken forward, state institutions will establish a national SP Council, which will act as a key link between implementing ministries.

**4.1.2. Contextual factors.** Prior to implementing pilot activities in Sokoto, JP stakeholders (UNICEF and WFP) carried out a needs assessment and a feasibility study, which were critical to identifying an area where the opportunities and challenges tied to SP were well understood. As the OSSAP-SDG representative put it, "*a blanket approach will not work in Nigeria due to the country's diversity and differences within states.*"<sup>31</sup> The MoE delegate noted that various aspects were considered in the JP's design phase, ranging from security to access to healthcare. A representative for the UN Resident Coordinator's Office, however, pointed out that assumptions surrounding Nigeria's institutional capacity with regards to SP were not verified prior to implementation. According to this informant, these inaccurate assumptions affected the rollout of the pilot component in Sokoto, with beneficiary identification being more challenging and time-consuming than anticipated.

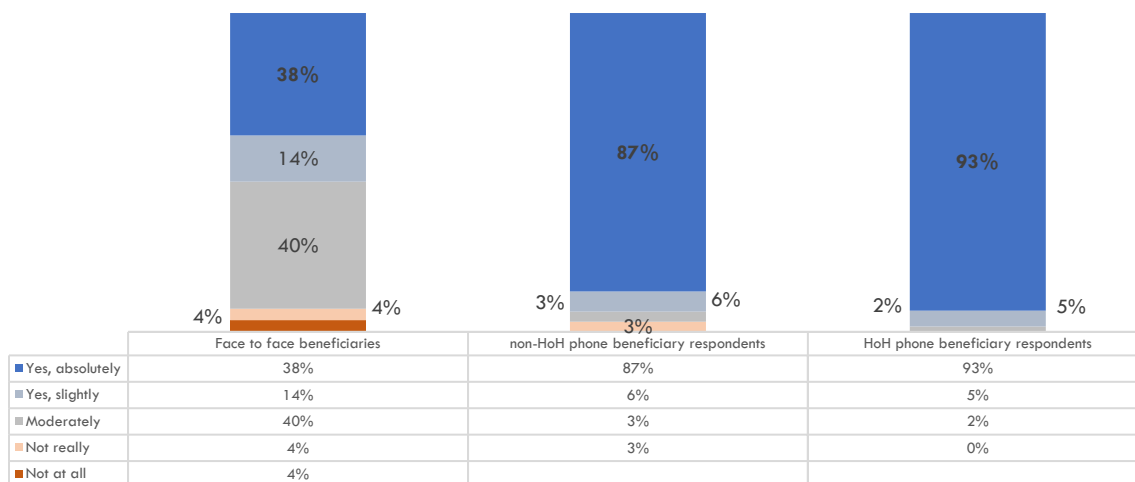
**4.1.3. Integrated SP services' relevance to the most vulnerable households.** Most survey respondents agreed that the programme assistance was adapted to the local context of the community, however face-to-face respondents were much less likely to report that they absolutely agree with this statement (39%) as compared to phone respondents (90%), potentially reflecting gender bias. 93% of face-to-face respondents agreed that assistance matched the context at least moderately. Phone respondents were also more inclined to report that the programme matched the needs of women. 87% of phone respondents reported that this was absolutely the case compared to 44% of face-to-face respondents. As a majority of those interviewed face-to-face are women, this likely suggests that male phone respondents overestimated the effectiveness of the programme in meeting the needs of women. Generally, both face-to-face and phone respondents reflected positively upon the messaging, transparency, implementation and beneficiary selection within the Joint SDG programme. 16% of face-to-face beneficiary respondents reported having any challenges compared to 24% of phone head of the household (HoH) respondents and 22% of non-HoH phone respondents.

*Figure 10 Programme assistance's relevance to local context: Do you feel the type of programme assistance is adapted to the local context of the community?*

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<sup>30</sup> KII4, ILO.

<sup>31</sup> KII12, OSSAP-SDG.



Despite seeking to explicitly target people with disabilities, the interview with the SoME (Sokoto Ministry of Education) representative suggests that this group was not purposely reached out to during the implementation phase, and the JP did not seem to have taken into account their specific needs. This was apparent in the distribution modalities the programme opted for, which beneficiaries themselves identified as inadequate. In Achida, several participants<sup>32</sup> indeed raised that the waiting line at the distribution site did not allow for people with disabilities to be in a separate queue and obtain assistance faster. Similarly, those people with disabilities may be unable to go to health centres to receive care.

*“When we go for registration and meet them in the field, we involve everybody. But to target those with disabilities, no. The health program is for women and girls, but it is also not restricted to them. If you find someone with a disability, fine, but specific arrangements for them are not made.” KII14, Sokoto State Government, Ministry of Education*

*“I have been handicapped since I was born, but nobody has ever given me a penny. But now, because of the existence of this health centre, my family and I have been benefiting from it.” FGD3, Mixed, Bodinga*

While the aims of the programme seemed to be clear to the majority of respondents, they might not have been aware that people with disabilities were explicitly targeted (97% of face-to-face respondents and 80% of phone respondents reported that either they thought or were absolutely sure this was the case). The clarity regarding the project may be a result of the high uptake and attendance of awareness sessions for the program as 76% of face-to-face beneficiaries responded that someone from their community likely attended an awareness raising session compared to 68% of beneficiaries reached by phone.

Discussion participants had diverging opinions about which intermediaries should have been used to identify beneficiaries and pointed out that corruption is widespread in their communities. In both Achida and Bodinga, participants felt that the JP stakeholders should have used traditional rulers to make the beneficiary identification and distribution processes more efficient. According to information received from WFP, the CWG consulted traditional and religious leaders to validate the recipient lists before payments were distributed. However, a participant in Bodinga further noted that politicians who are tasked with coordinating beneficiary identification only select those who are affiliated with their party – *“if you don’t do their politics, they wouldn’t include you in this support.”*<sup>33</sup> Another participant in Achida said that there was an announcement that the heads of districts would be handing out 30 health insurance slips to *“their people”*.<sup>34</sup>

<sup>32</sup> FGD1, Women, Wurno, Achida

<sup>33</sup> FGD3, Mixed, Bodinga, Bodinga

<sup>34</sup> FGD2, Mixed, Wurno, Achida

*“We should also involve our traditional leaders; they were supposed to be giving the support because last time we were given the slip, if you could remember, they didn’t get women’s names right. They were all mixed up. You could hardly figure out which woman was given a slip with her name on it; you see, there have been many problems. And also, when the ATM card was distributed, you see my name is XX, but I was given YY’s slip and her ATM card. I collected the 5,000 cash with it. The other 20,000 that was supposed to be given to us was not given. In general, the women who received this money were not more than 10; they were in the process of giving when they stopped. They said they will fix some things, but until now, they have not [done so].” FGD3, Mixed, Bodinga, Bodinga*

This was not the case in Dogon Daji,<sup>35</sup> where participants recommended not using traditional community leaders, who they perceived as unfair and corrupt. A participant recalled an activity to tackle malaria, through which traditional rulers received mosquito nets and distributed them only to community members they were close to. Another participant further said that traditional rulers do not believe in medicine, which implies that these leaders may be biased in the way they communicate about the project.

**4.1.4. Awareness and perception of targeting criteria and registration process:** The selection criteria also seemed to remain vague for beneficiaries in Bodinga and Achida. Several discussion participants appeared unaware of the selection criteria; this suggests that communication surrounding the assistance and which community members could apply may have been insufficient. On that note, a participant in Bodinga said that the onset of the selection and distribution activities was confusing and poorly organised. In Achida<sup>36</sup>, participants further said they did not know when to go collect the cash transfers; one of them said, *“if you heard [that someone] collected theirs, you go to the [collection point] with yours.”* In Dogon Daji, while a participant recalled that there had been numerous announcements of the upcoming health insurance activities in nearby towns and villages, several participants from the same discussion mentioned that door-to-door visits, as well as communication through hospital staff, would have facilitated the identification and registration of beneficiaries. In a discussion in Dogon Daji where no cash transfers were distributed, several participants, who were pregnant or breastfeeding and therefore eligible in the other targeted LGAs, were aware of the programme’s cash transfer component in the other three LGAs. One of these participants<sup>37</sup> noted, *“we were not given [the cash transfer] even though we heard that neighbouring towns received it.”*

*“At the time they came for our names, there were the elderly who didn’t know about the program at the beginning. There was so much misinformation when distributing the cards that led to some mistakes in the distribution of cards with so many errors in naming and classification of patients.” FGD8, Women, Bodinga, Bodinga*

The SOCHEMA representative further said that there was limited awareness or interest surrounding the health insurance coverage in communities selected for the piloting. In comparison, the distribution of cards for cash transfers sparked more requests to register, either because the word spread that certain households were now receiving health insurance coverage or due to cash being a preferred type of assistance. Word-of-mouth, however, seems to have played a key role in incentivising eligible households to apply, according to testimonies from various participants who said they informed neighbours or family members. In Dogon Daji, for instance, a participant recalled informing a neighbour, who was unaware of the project, about the ongoing registration process.

*“I would like to add that there is an old woman who is our neighbour...she always thanks us because when this program started, and we registered, I went and told her to register as well because she was left with orphan children when their father died; she is now their caretaker. Among the children, there were some that were very sick. But now they are enjoying and benefitting from the program and are very happy. [...] She told me before the program, she used to beg for medical and financial support*

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<sup>35</sup> FGD5, Mixed, Tambuwal, Dogon Daji

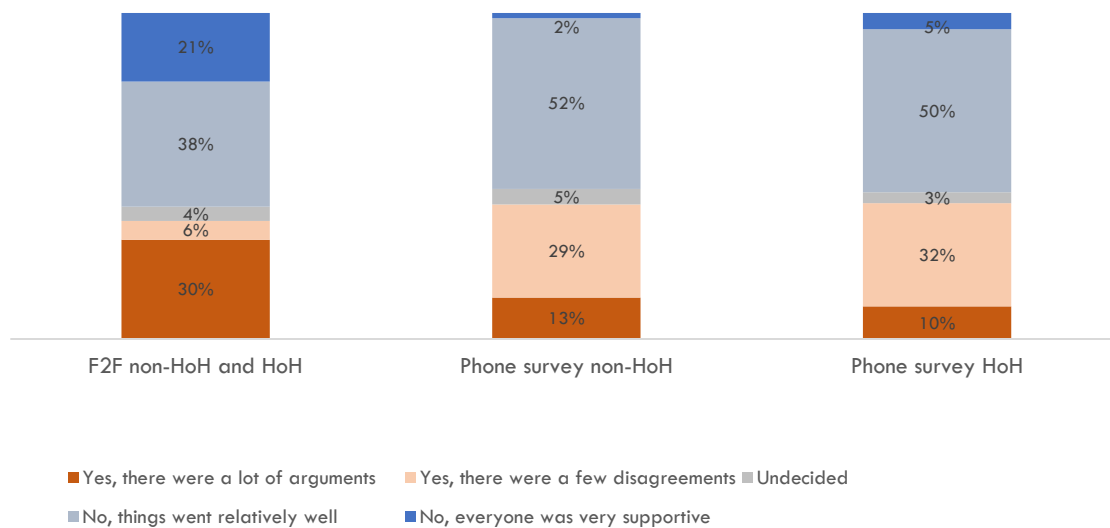
<sup>36</sup> FGD1, Women, Wurno, Achida

<sup>37</sup> FGD5, Mixed, Tambuwal, Dogon Daji

*from the rich houses and the politicians. But now they can easily use the slip to seek medical care in the hospital.” FGD5, Mixed, Tambuwal, Dogon Daji.*

While a majority of survey respondents reported that they understood the targeting framework (88% face-to-face respondents and 72% phone respondents), believed that targeting was fair and transparent (86% of face-to-face respondents and 80% of phone respondents) and that needy households were selected in an unbiased manner (63% of face-to-face respondents and 85% of phone respondents), this did not necessarily result in diminished tensions at the community level.

Figure 11 Challenges or problems with receiving programme assistance



36% of face-to-face respondents and 42% of phone respondents reported that at least a few disagreements had arisen as a result of the programme, with 30% of face-to-face respondents reporting that there had been many disagreements. However, these arguments seemed to be confined to inter-community dynamics. Few respondents who received cash transfers reported that any conflict had arisen with the household itself (89% of face-to-face and 87% of phone respondents reported that conflicts either never or rarely arose within the household).

## 4.2 Coherence

**UN Joint SDGs Project is Positively Coherent with Global, National and Sub National Priorities**

*To evaluate the coherence of the SDGs Project, the evaluation team asked more broadly, “how well does the intervention fit?” and assessed how the various components of the programme yielded positive changes and if the JP fits in well with similar or comparable SP interventions.*

### **Synthesis**

In terms of coherence, the Joint UN SDGs Project program has certainly succeeded in initiating or strengthening collaborations with the various government agencies (at the national and local levels). Similarly, all the UN agencies involved have noted the positive externalities in terms of coordination, particularly through the establishment of the Cash Working Group. Each implementing UN agency and national body was able to bring a different skillset to the table to achieve a common objective that would not have been possible had these institutions been operating separately. In terms of the joint programme’s uniqueness in comparison to other programmes, it was able to address hard-pressing needs which have not been tackled before.

Based on the evidence of desk review of available documents, key Informant Interviews and Focus Group Discussions (FGDs), the evaluation team concludes that the UN Joint SDGs project is positively



coherent with global and national priorities and takes into consideration issues of gender equality, equity, and rights of persons with disability.

It also aligns with existing Soc. Prot. programmes at the federal and state level this includes the national cash transfer programmes, the basic healthcare provision fund programme on health insurance, Zakat and Endowment Commission's cash and food assistance programme, Ministry of Social Welfare cash transfer for persons with disability, Ministry of Women and Children Affairs cash transfers to selected vulnerable population (widows, orphans, and SGBV survivors), State Cash Transfer Office (SCTU) cash transfer programme to vulnerable populations.

UN Joint SDG project promotes gender equality and rights of persons with disability, through focus on intervention of pregnant women and lactating mothers, formulation of a rights-based Soc. Prot. bill, the provision of input into the national health insurance act 2022 that makes health insurance mandatory for all Nigerians. promotion of right based approach on Social Protection.

Evaluation Questions	Rating
2.1. To what extent is the programme addressing gender and equity? Are the rights of people with disabilities consistently integrated into all aspects of programming and implementation?	Green
2.2. What are the comparative strengths of the joint programme in comparison to other social protection programmes?	Yellow
2.3. What are the comparative strengths of the coordination and convening roles of the joint programme, and to what extent did the joint programme contribute to enhancing UNCT coherence?	Green
<b>COHERENCE (given the limited time and pandemic context)</b>	Green

**4.2.1. Gender and equity focus:** While the JP sought to involve the Women Affairs Ministry in its implementation phase, a representative of the latter said the Ministry was seldom involved in the roll-out of the Sokoto pilot, despite being a member of the TWG. The Women Affairs Ministry was tasked with handling protection-related cases identified in the health facilities and provided a list of beneficiaries to its coordination branch in Sokoto. The JP has also sought to address the needs of gender-based violence survivors through its SOCHEMA partner – the SOCHEMA representative recalled that the Gender-Based Violence Unit informed survivors about the JP and occasionally encouraged them to participate in SP discussions in Sokoto. The SOCHEMA representative further pointed out that SOCHEMA carried out gender-sensitive training with enumerators in charge of identifying beneficiaries. WFP provided PSEA and Protection trainings to all CFM Desk Officers, CWG members and SOCHEMA call centre contact personnel. Similarly, and as discussed above, the JP sought to include persons with a disability among its beneficiaries, but they were not directly targeted, and their special needs were not considered in the design of activities. In a discussion in Bodinga, health insurance and cash transfer beneficiaries said that the programme responded to two critical needs, health and a lack of financial resources; this, in their opinion, singles out the programme compared to other initiatives they previously benefited from.

*“It’s all in the health programmes as a pregnant woman when sick you can go to the hospital. In the instance of receiving cash (...) let’s say they gave you money to buy medication. There are other things you may end up buying that you may not need due to self-medication and limited knowledge in the medical field. But if you go to the doctor and he prescribes it and then proceeds to give medication to you for free, you are sure of getting the right treatment and saving something. Don’t forget we are under someone’s care. It is either the father or the husband. Let’s say a wife is sick, and she has a family member with her, and the husband must feed them first. With this programme, now he can*

*concentrate on providing other aspects of life like feeding and clothing as the medication is taken care of.” FGD8, Women, Bodinga.*

However, the absence of a true gender-adaptive approach is very regrettable, as the programme seemed to lend itself to this. A reflection on the possible benefits of the program in Sokoto, a real strategy around the role and social representation of women within the household and the community could have increased the understanding of the social protection programme. Nonetheless, community mobilisers were trained on SP and were sent to educate the community on SP concepts, health insurance and cash transfers with the aim of inducing social and behavioural change. Moreover, gender and child social protection systems strengthening training was conducted for the TWG members.

Given the central role of women in social cohesion as well as in the socio-economic resilience of communities, for example, thinking about JP in terms of an authentic gender adaptive analysis could have increased the programme's readability and impact. Similarly, it must be emphasised that the understanding of gender by key actors remains limited and static: there is often an emphasis on women's vulnerability and GBV, rather than really reflecting on issues of masculinity, patriarchal frameworks inherited from colonisation or local traditions, or women-led social initiatives at community levels. However, this is not to say that the programme implementers were not aware of the aforementioned issues but rather constrained by the social norms of Sokoto which would have rejected such considerations.

**4.2.2. Strengths of the JP compared to other SP programming:** Interestingly, many discussion participants believe that health insurance coverage is a more adequate type of assistance than solely cash transfers. While this could partly be due to the fact that most participants were able to reflect on the type of assistance they received, i.e., health insurance coverage, it could also very well be tied to the JP's ability to respond to concrete needs and to alleviate beneficiaries' mental workload with regards to healthcare.

All in all, beneficiaries appear to have been unable to compare the JP's assistance with other assistance programmes implemented in Sokoto; many of them reported that this was the first time they received such assistance but emphasised that its regularity was a considerable advantage. In terms of other aid received, the quantitative data showed that 27% of Joint SDG Programme beneficiaries reported having received aid outside of this program compared to 7% of non-joint SDG program beneficiaries. The most commonly reported aid received from other organisations are direct cash transfers, medical assistance and financial support. As a participant in Bodinga put it, *“both me and my family have received medicines countless times from the hospital.”*<sup>38</sup>

One of the participants in Dogon Daji<sup>39</sup> further explained that the JP's assistance was timely due to the fact that things are very hard now. In July 2022, in the aftermath of the JP and shortly before data collection, Nigeria witnessed its highest inflation rate since 2005 (19.6%),<sup>40</sup> with immediate consequences: *“The only medical intervention we benefited from in the past was immunisation for some diseases like measles, polio, etc. It was hardly unlikely to receive free prescription drugs in the hospital in the past. They would only prescribe it for you to buy outside of the hospital.”* FGD5, Mixed, Tambuwal, Dogon Daji

It was, however, unclear for most discussion participants who were behind the JP; this could be related to the low literacy levels, but it implies that it should have been more strongly emphasised during the beneficiary identification and assistance distribution processes. Several participants in Dogon Daji<sup>41</sup> believed that the government had provided health insurance coverage and cash transfers, while some participants in Achida identified a doctor – “OC Saadu” – as the source of assistance. In Achida,<sup>42</sup> a

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<sup>38</sup> FGD3, Mixed, Bodinga

<sup>39</sup> FGD6, Mixed, Tambuwal, Dogon Daji

<sup>40</sup> Adeoye Aanu, 'Nigerian Inflation Hits 17-Year High', Financial Times, 16092022.

<sup>41</sup> FGD6, Mixed, Tambuwal, Dogon Daji.

<sup>42</sup> FGD4, Mixed, Wurno, Achida.

participant believed that the hospital was behind the provision of her healthcare coverage – *“I received 5,000 naira, four times, and my daughter and I also benefited from health coverage. We can go to the hospital and receive free medical care. That is the only benefit that I got. The money I received [it] from the hospital.”*

**4.2.3. Strengths of the JP’s coordination and convening roles/contribution to enhancing UNCT coherence:** Throughout interviews, JP stakeholders emphasised the critical role played by the United Nations Country Team (UNCT), which capitalised on implementing agencies and stakeholders’ unique skill sets. The ILO representative, for instance, felt that UNCT provided a platform to *“come together and deliver on a common objective,”*<sup>43</sup> while the SCI delegate noted that *“the program played a unifying [role]... the Development Partners Group was strengthened, and membership broadened”*.<sup>44</sup> The NASSCO delegate further said that *“there is [a] huge complementarity in bringing different skillsets towards [the] implementation of the program”*, which was apparent in the way NASSCO worked with UN bodies to expand the registry to Sokoto state through the Zakat list.<sup>45</sup>

These statements echo the testimony shared by the representative from the UN Resident Coordinator’s Office, who believes that, despite challenges, coordination between the various implementing agencies worked well and that the Sokoto pilot yielded encouraging results, in part due to the complementary roles and expertise of leading agencies - policy development for ILO; children, women, and nutrition for UNICEF; SP and cash transfers for WFP; institutional capacity building and innovation hubs creation for UNDP. This informant further emphasised that the JP could not have achieved these results if implementing agencies had been working separately - *“the JP changed the way the government perceives SP and encourages states, even the poorest ones, to look for ways to generate revenue.”*<sup>46</sup>



<sup>43</sup> KII4, ILO.

<sup>44</sup> KII7, SCI.

<sup>45</sup> KII8, NASSCO.

<sup>46</sup> KII10, UN Resident Coordinator Office.

### 4.3 Effectiveness

UN Joint SDGs Project is **Highly Effective** in achieving expected results

To understand the effectiveness of the JP, the evaluation team sought to identify “how well the JP’s design met its objectives,” assessing factors of inclusivity and contributions towards accelerating SDGs.

#### Synthesis

Despite the absence of a baseline which made it difficult to capture the effectiveness of the health insurance coverage on the JP recipients, great strides have been made on the institutional side: Most notably the drafting of a revised National Social Protection Policy and the National Harmonized Social Protection Bill as well as advocacy efforts to ensure the buy-in of the relevant actors. Moreover, the fiscal space study conducted was used to create momentum on the policy front as it was used to advocate for a separate social protection budget line.

Based on strong evidence, the evaluation team has concluded that the SDGs Project has successfully achieved expected results as committed within the Results Framework regarding the two Outcomes and Outputs. The evaluation team review of relevant documents, key Informant Interviews, focus group discussions reveal that a holistic social protection bill was drafted and submitted to the relevant government Institutions for onward submission to the national assembly. The bill once approved will make social protection a right for all, a Soc. Prot. policy was approved by the federal executive council. During the same period, the budget allocation for Soc. Prot. increased by over 100% from 2020 to 2022.

The UN Joint SDGs programme provided capacity and Institutional strengthening that led to an increase in health insurance coverage from 3% to over 5% of 200 million citizens of Nigeria (10 million beneficiaries).

Regarding the Soc. Prot. activities at the state level, over 600 pregnant and lactating women, and caregivers of under-fives benefited from the mixed (unconditional and conditional) cash transfer with over NGN 5,200 received monthly for a period of six months. The Health Insurance beneficiaries totalling 6,000 comprised of 70% female and 30% male were registered in primary health facilities across four Local Government Areas. Beneficiaries were able to access free healthcare services whenever they visited their designated centres.

Evaluation Questions	Rating
3.1. To what extent has the joint programme contributed to accelerating the SDGs at the national and state levels, as well as contributed to UNSDPF Outcome 6?	Highly Effective
3.2. What have been the major factors influencing the achievement or non-achievement of the programme objectives in providing integrated services? Did any innovations or unintended (negative or positive) consequences arise as a result of the implementation of the joint programme?	Highly Effective
<b>EFFECTIVENESS (given the limited time and pandemic context)</b>	<b>Highly Effective</b>

#### 4.3.1. Performance Evaluation of SDGs Project Effectiveness vis-a-vis the Results Framework

The assessment of the results achieved against the target and baseline of the outcome and output indicators, as presented in Table 9 below, reveals that the SDG project was overall successful in meeting expectations. Given the operational timeframe (2.5 years), what is considered a "result" is often actually an "output" (more than an "outcome") and the analysis of effectiveness is therefore based on results in mostly quantitative terms. This is not surprising in itself and only time will tell if these outputs have actually contributed to community and household social protection outcomes, using the indicators considered at two levels: 1) institutional capacity building and implementation of the strategies developed; 2) positive impact in the target areas of Sokoto (pilot) in terms of health,

education, nutrition, etc. In this regard, it should be noted that the final report of the SDG project submitted by UN RCO to the SDG Secretariat at headquarters, as well as the FGDs and KIIs with stakeholders, are the reference sources for the evaluation of program effectiveness. It naturally has some limitations, as the data was not collected for each indicator by an appropriate independent third party (baseline and final).

**Outcome 1:** By 2022, the social protection system has been improved at the federal level with a strengthened legal framework and financial mechanism integrated into the national budget and planning efforts. Significant gains have been made in establishing the legal framework for social protection in Nigeria: a revised Social Protection Bill has been approved to create an enabling environment for the realization of social protection rights in Nigeria.

**Outcome 2:** By 2021, the National Social Protection Policy (NSPP) is now implemented in Sokoto State, ensuring gender responsive social development with reduced poverty and improved nutrition, education and health of women and children. It is evident that the SDGs project has successfully operationalized social protection cash transfer and health insurance for beneficiaries at the community level in Sokoto State. A total number of 620 women (vs. 2,000 expected) received a numerical cash transfer allocation of about N20,000 and about 6,000 pregnant women and girls were provided with free access to health services under the health insurance program. In addition, under the Basic Health Fund program funded by the government and the World Bank, about 59,615 women were enrolled in the health insurance program in Sokoto State.

**Outcome 2a:** The logical framework targets a specific percentage of girls and boys with access to education (disaggregated by gender) under outcome indicator 2a. If we consider that access to education is defined by very specific modalities<sup>47</sup>, it is essential to better specify - in a context where the quality of education, dropouts and illiteracy are the norm - what the JP considers as “access” in a very deprived environment: is it an opportunity for access (possibility)? is attendance measured? is progress observed? how is monitoring concretely carried out in order to feed the log frame and the indicators? To do that, there is a need to shift from a purely quantitative approach to a more contextual one (focusing on quality and complexity) – for both the indicator and results.

Table 10: Assessment of Achievement of Expected Results of the SDGs Project In Nigeria

Expected Results	Indicators	Baseline	Expected Results 2021	Results Achieved in 2022 (Final Result)	Analytical Assessment
Outcome 1: By 2022, the Social Protection System has improved at Federal level with a reinforced legal framework and a financial mechanism integrated in national budget and planning efforts	Outcome Indicator 1a: Existence of a holistic social protection bill/law	No	Yes	Yes	Achieved
	Outcome Indicator 1b: Share of public spending on social protection	1%	3%	3%	Achieved
Output 1.1: Strengthened national social protection legal framework with the development of a social protection bill, aimed at realizing the rights to social protection for consideration by the National Assembly	Output Indicator 1.1a: % of key stakeholders with increased capacity/ knowledge on social protection system development (gender disaggregated)	TBD	90%	80%	Achieved with significant caveats: 1) efforts to be made in terms of gender parity; 2) qualitative interviews contradict 2022 data.
	Output Indicator 1.1b: Existence of social	No	Yes	Yes	Achieved

<sup>47</sup> According to UNESCO, access to education includes: ‘on-schedule enrolment and progression at an appropriate age, regular attendance, learning consistent with national achievement norms, a learning environment that is safe enough to allow learning to take place, and opportunities to learn that are equitably distributed’ (Lewin, Keith M. 2015. *Educational access, equity, and development: planning to make rights realities*. Fundamentals of Educational Planning 98. Paris: UNESCO-IIEP).



	protection bill technically validated by stakeholders				
Output 1.2 - Increased and institutionalized social protection financing with reinforced institutional framework through identification and creation of fiscal space and setting-up of innovative financing for social protection	Output Indicator 1.2a. Fiscal space determined for Social Protection	No	Yes	Yes	Difficult to actually achieve ("fragile promise" according to a governmental KII).
	Output Indicator 1.2b. National Priorities in SP costed	No	Yes	Yes	Achieved
	Output Indicator 1.2c. New strategy designed and signed by Government	No	NA	NA	Missing
Output 1.3 - SDGs Innovation and Accelerator States identified and established with proven innovative solutions and financing towards achieving Social Protection	Output Indicator 1.3a. Number of quick wins identified for immediate implementation at the sub-national level	No	10	21	Achieved (with significant differences in the definition and understanding of 'quick wins', though). Output 1.3a should be revised.
	Output Indicator 1.3b. Number of accelerated financing methods for the SDGs acceleration identified, recommended, and utilized.	0	8	10	Achieved with limited evidence communicated to the research team.
Outcome 2: By 2021, The National Social Protection Policy (NSPP) is operationalized at Sokoto State ensuring gender-sensitive social development with a reduction in poverty and improvement in nutrition, education, and health for women and children	Outcome Indicator 2.a. % of girls/boys with access to education (disaggregated by gender)	Boys 68% Girls 54%	Boys 70% Girls 60%	Boys 70% Girls 60%	Achieved according to data, but the quality of education, attendance, and drop-out rates must be assessed. Also, observations contradict these data.
	Outcome Indicator 2.b. % of poor with access to health care (disaggregated by gender)	Male 27.7%; Female 72.2% (Out of 31,362 enrolled beneficiaries)	50,000 enrolled beneficiaries with access to state health care  Male 40%; Female 60%	59,615 enrolled beneficiaries	Achieved.
	Outcome Indicator 2.c. % of poor/vulnerable girls covered by cash transfer program (disaggregated by gender)	0	2,000 pregnant and lactating women.	620 Females  100%	The objective could not be achieved, for reasons that have been documented and explained – marginally due to the JP.
Output 2.1. Universal Health Coverage at state level accelerated using the Basic Health Care Provision Fund & community-based insurance mechanisms	Output Indicator 2.1.a.: % of girls and women covered by health insurance (disaggregated by gender)	Male 27.7%; Female 72.2% (Out of 31,362 enrolled beneficiaries)	5,000 Male = 35% Female = 65%	6,000 Male = 30.1 Female = 69.9%	Achieved with a positive trend in the last few months of implementation

#### 4.3.2. Assessment of Beneficiaries Opinion/Satisfaction - Contribution towards accelerating SDGs, UNSDPF Outcome 6.

*UNSDPF Outcome 6: By 2022, the National and State Social Protection Policies are implemented and adequately financed with protection systems and services strengthened to effectively prevent and respond to violence, abuse, exploitation (including trafficking) and harmful social norms, with a focus on the most disadvantaged.*

Stakeholders overall believed that the JP's focus on capacity building of government institutions played a key role in creating an environment where those institutions are empowered to take the SP policy forward. The JP, primarily through the TWG that was created by the UNICEF informed WFP of



the creation of a <sup>48</sup> Cash Working Group (CWG). In turn the WFP organised a series of trainings for the CWG members to develop payment strategies and monitoring tools for cash transfers.<sup>49</sup> The CWG subsequently engaged in other projects, including a cash transfer programme to encourage school enrolment with UNICEF<sup>50</sup> and trained Ministries, Departments, and Agencies (MDAs) on how to locate beneficiaries and effectively transfer cash.

According to the UN Resident Coordinator's Office representative, the JP also sought to change the paradigm around SP - across the country, SP was considered a federal responsibility, and the JP attempted to engage states into adopting SP policies. This echoes words from the SOCHEMA representative, who recalled that ILO carried out a needs capacity assessment to identify the agency's needs, delivered training on SP and health insurance, and WFP updated SOCHEMA's management information system. Similarly, the OSSAP-SDG delegate mentioned that UNICEF and UNDP strengthened SDG learning centres with their resources, which they made available to researchers and students, and that UNICEF delivered the ad-hoc capacity building on SP and children's rights in Enugu.

There were different views on the JP's effectiveness for building government capacity. The JP through UNICEF aimed to build the capacity of government partners on SP programme designing and implementation. Beyond the policy, implementations and MEAL activities, the JP has supported the development of the Sokoto State Social Protection Costed Implementation Plan to ensure the inclusion of SP cost estimates into annual fiscal year. An SCI representative, however, said that the JP should have put a stronger emphasis on capacity building, assigning roles and responsibilities to government institutions from the onset to promote continuity by ensuring that the government had the ability to source resources beyond the project. While ILO is working with the government to identify an innovative way to generate revenue for SP, the JP relied on asking the government to contribute additional financial resources to SP.

*"Unfortunately, most people in the government don't have the knowledge to effectively and innovatively generate revenue, so [we need to be] pointing out ways [that] may help and contribute to better resource generation, which in turn enhances allocation for social protection."* KII7, SCI

It must be noted that increased budget allocation to social protection both at the federal and state level has been achieved and the JP's fiscal space assessment identified innovative funding mechanism for social protection. The JP sought to identify innovative financing for SP through state-wide consultations and private sector engagement in six states. The outcomes of these consultations were disseminated widely and will be used for future policies.

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<sup>48</sup> KII10, UN Resident Coordinator Office.

<sup>49</sup> KII14, Sokoto State Government, Ministry of Education.

<sup>50</sup> KII14, Sokoto State Government, Ministry of Education.

## 4.4 Efficiency

**UN Joint SDGs Project is Positive in Value For Money**

*To address the SDGs Project's efficiency, the evaluation team looked at the economy (financial, human and timing) of the project if it is was adequately used to achieve expected results.*

### Synthesis

It is worth mentioning, that important efforts have been made in terms of coordination among the relevant entities of the SDGs Project, such as the memorandum of understanding signed to ensure that interventions implemented under the basic care delivery fund will include beneficiaries of the national registry. In addition, the establishment of the TWG will ensure that efforts continue after the completion of the SDGs Project. Nonetheless, concerns have been raised about tensions between the different NSP entities that could limit these coordination efforts.

Regarding Value For Money, the Unit Cost of intervention is about 68.9 USD (30,314 Naira) for the delivery of multiple times access to free health services and medication that benefited to 6,000 women and children as implemented by UNICEF Field Office in Sokoto. The unit cost is 112.65 US Dollars (49,566 Naira) for 658 pregnant/ lactating women and children under two years old who benefited of digital cash disbursement as delivered by WFP in Sokoto State.

The project's human and financial resources were utilized in an efficient manner through effective coordination of development partners and government to deliver on the project outputs. The catalytic impact of the approved national soc. protection policy will ensure the extension of the coverage to previously excluded population.

The Evaluation Team has concluded that the Joint UN SDGs Project ensure adequate Value For Money.

Evaluation Questions	Rating
4.1. Have the integrated social protection services been implemented in an effective and efficient way, both in terms of human and financial resources, compared to other alternatives?	Yellow
4.2. Are activities low in cost and affordable (yet, of adequate quality) to improve the situation of vulnerable households)?	Yellow
4.3. Is the current organisational set-up, collaboration and contribution of concerned ministries and others working effectively to help ensure accountability? What more can be done?	Red
<b>EFFICIENCY (given the limited time and pandemic context)</b>	Yellow

### 4.4.1. Assessment of the organisational set-up, collaboration and contribution of concerned ministries and others towards ensuring accountability.

The JP fostered encouraging steps towards increased coordination. According to the ILO representative, the organisation worked with NHIS, NASSCO, and WHO, to sign an MoU with SOCU and ensure that all health insurance interventions implemented under the basic care provision fund will identify beneficiaries through the national registry. Similarly, the JP established the TWG to take over the role of its implementing agencies following its closure in June 2022. However, key informants interviewed during this evaluation raised concerns tied to state institutions' ability to coordinate to take the SP policy forward and develop a legal framework around its implementation; key informants also discussed underlying issues. One of them<sup>51</sup> noted that there are political disagreements and tensions between NASSCO and NCTO that translate into limited information sharing, as well as a lack of coordination and communication between SP entities and the government. This informant noted that a key government stakeholder working on SP in Sokoto was not aware of the JP. Another

<sup>51</sup> KII 5, NCTO.

informant,<sup>52</sup> representing one of the implementing agencies, raised concerns about the government’s ability to deliver on SP due to critical capacity gaps. While the JP, and some of its leading stakeholders, are working with the Nigerian government to streamline and integrate SP, the government remains ill-equipped to implement SP.

Once again, the lack of a phased approach between the implementation of institutional support (ILO, UNDP) and the pilot in Sokoto (WFP, UNICEF) did not allow for a real multiplier effect or even the gradual, progressive, and structured implementation of a social protection system pilot in Sokoto. This is reflected in the many inconsistencies, targeting errors and risks of abuse and misappropriation highlighted in this sub-section.

#### 4.4.2. Financial Analysis.

The tables below provide a breakdown of expenses over the period 2020-2021, based on documents shared by UNICEF, WFP, ILO and UNDP with Samuel Hall. As previously indicated in section 2.5, there is no comprehensive financial analysis that can be performed due to the lack of relevant and related financial documentation.

As shown in the table 8 below all the UN agencies have utilised almost their entire allocated funds except for ILO who utilized around 88% of their allocated funds, which brought the total utilisation rate of the JP to 96%. In terms of shares of the allocated funds distribution amongst the UN agencies: out of the 1.951 million USD UNICEF had the highest share (36%) followed by ILO (26%) then followed by UNDP (21%) and lastly WFP had the lowest share (18%).

*Table 11 Status of SDGs Project Funds*

Category	UNDP	UNICEF	WFP	ILO	Total
Allocated USD	400,000	700,935	350,000	500,000	1,950,935
Utilized USD	397,590	695,062	350,000	439,626	1,882,278
Balance non-utilized USD	2,410	5,873	0	60,374	68,657
% Utilized	99%	99%	100%	88%	96%

The main limitation regarding the analysis of the amount spent according to expenditure category is that the ILO's expenditures are not included due to being categorised by project outputs unlike the rest of the agencies. Therefore, the analysis is restricted to the amount spent by UNNDP, UNICEF and WFP. It is noteworthy to highlight that the spending category that had the highest share from total spending for the three agencies was cash disbursements (around 43%), followed by services (32%), total travel expenditures had the third highest share but a by large difference (8% of total expenditures). The rest of the expenditure categories were between 3 to 5% of total expenditures.

When taking a closer look at the highest total expenditure spending category (cash disbursement) we find that UNICEF makes up 67% of the spending category while WFP makes up for the rest, UNDP has not had cash disbursement spending. As for services spending, UNDP and UNICEF have almost contributed equally to that category (48% and 52% respectively) while WFP has not had services spending. Lastly, in terms of total travels spending UNDP has expensed the most (64% of the category's total) followed by UNICEF (21%) and lastly WFP (15%).

<sup>52</sup> KII3, WFP.

Table 12 Total amount spent by UN Agency and by category of expenditures

Type	UNDP	UNICEF	WFP	ILO	Total
Salary	10,954.4	1,869.0	40,000.0	Data missing	52,823.4
<b>Cash Disbursement</b>		413,380.0	204,487.8	Data missing	617,867.8
Services	221,893.1	239,130.8	0.0	Data missing	461,023.9
Supplies	0.0	16,676.5	56,390.4	Data missing	73,066.9
Travels	71,495.0	24,004.9	16,603.0	Data missing	112,102.9
Direct Charge Head Cost	67,323.4	0.8	11,157.3	Data missing	78,481.5
Programme support costs	25,924.5		21,361.5	Data missing	47,286.0
<b>Total</b>	<b>397,590.38</b>	<b>695,062.00</b>	<b>350,000.00</b>	Data missing	<b>1,442,652.38</b>

#### 4.4.3. Value for Money – Cost Effectiveness Analysis

Despite the challenging constraint to obtain adequate financial data related to the operationalization of the Social Protection to beneficiaries in the Sokoto's State, the Evaluation Team has tried to perform cost effectiveness analysis of the SDGs Project using two approaches: i) the estimation of Unit Cost of Service delivery of Health Insurance to women and children Digital Cash Transfer to pregnant women and children; and ii) the cost analysis by the 3 categories of Outcomes (example of ILO's interventions) using specific financial data per outcomes provided by ILO.

##### a) Cost effectiveness analysis of delivery of Health Insurance and Digital Cash Transfer

According to UN counterparts, *'there is a positive Value For Money for Cash Transfer assistance within the UN Joint SDGs Project: the Unit Cost of intervention is about 68.9 USD (30,314 Naira) for the delivery of multiple times access to free health services and medication that benefited to 6,000 women and children as implemented by UNICEF Field Office in Sokoto. The unit cost is about 112.65 US Dollars (49,566 Naira) for 658 pregnant/ lactating women and children under two years old who benefited of digital cash disbursement as delivered by WFP in Sokoto State. SDGs Project sounds partially cost effective, in the view of Value For Money due to limited result achieved for Digital Cash Transfer: only 32.4% of expected target of beneficiaries are reached.'*<sup>53</sup>

While these results confirm the achievement of the first objective and the shortcomings of the second, it should be noted that the focus remains: 1) outputs and results-oriented (= reaching the expected

<sup>53</sup> This section and analysis of the VFM was shared by UN counterparts between the draft and final iterations of the present document. Calculations are their responsibility.

number of beneficiaries) without sufficiently considering the real (and evolving) needs of a population exposed to chronic crises); 2) limited in terms of VFM analysis, as there is no comparative evidence to draw conclusions (e.g., other similar implementation contexts for UNICEF or WFP, other programs in Sokoto implemented by other humanitarian actors).

This important caveat naturally leads to some simple recommendations for strengthening future JP VFM calculations: 1) favouring longitudinal analyses, to capture improvements in VFM over time; 2) systematising comparative analyses with similar contexts/programs; 3) disaggregated cost analyses, to better understand how and where the JP spends most of its money; and finally, 4) a focus on the broader context to understand how the JP contributes to improving people's lives and well-being. This last point suggests a shift from a strictly quantitative understanding of VFM to a more dynamic and qualitative approach, which would help capture the actual *value* and *effectiveness* of the programme for the populations in need: to what extent does the JP contribute to improving their lives in a given context?

Table 13: Analyses of JP's results in terms of achievement and unit cost

Expected Result	Planned Number of Beneficiaries	Beneficiaries Reached (Result achieved)	% Achieved (coverage)	Total Expenditures in USD	Estimated Average Unit Cost
Provision of healthcare coverage to 6,000 beneficiaries	6,000 beneficiaries	6,000 women and children	100 %	413,380 US Dollar	68.9 USD (30,314 Naira)
Digital cash transfer provided to pregnant/lactating women and children under two years old	2,030	658 women	32.4 %	74,124 US Dollar	112.65 USD (49,566 Naira)

## b) Cost effectiveness analysis of SDGs Project Results by Outcomes

In terms of financial analysis by outcome, this was only feasible for ILO spending as ILO is the only agency that had expenditure categorisation according to the project outcomes as show in table 10 below. Moreover, given that ILO did not engage in outcome 3, there are no expenditures to show for that outcome in the table. The larger bulk of ILO spending went to {outcome 1: Implement a legally and financially strengthened social protection system (SDG 1.3)} which constituted around 63% while {outcome 2: Develop a cash transfer programme to alleviate out-of-pocket expenditure in contributory health insurance under a State-financed health insurance scheme for the poorest and most vulnerable (SDG 3.8)} made up around 37% of ILO's total funding per outcomes. Lastly, it is noteworthy to mention that ILO has no spending on outcome 2 during this year.

Table 14 ILO funds utilisation/distribution per outcomes

Outcome	Previous year	Current year	Total	% Share of fundings per outcome
Outcome 1: Implement a legally and financially strengthened social protection system (SDG 1.3). The JP is expected to have a draft SP bill which includes financial provisions on social protection expenditure of the Government, presented to the National Assembly.	112,873	51,808	164,681	63.42%
Outcome 2: Develop a cash transfer programme to alleviate out-of-pocket expenditure in contributory health insurance under a State-financed health insurance scheme for the poorest and most vulnerable (SDG 3.8): 6,000 poorest and most vulnerable groups have been identified to be enrolled in a selected state's health insurance scheme, among which 2,100 pregnant women and caregivers of children under 2 years will be provided with transportation stipends through innovative digital cash transfer mechanisms and standard operating procedures	94,991	0	94,991	36.58%
Outcome 3: Establish and build the capacity of 6 state SDGs offices, to serve as an innovation hub for other states' SDGs offices. The six pilot states will provide a platform to share feasible and innovative solutions that will use social protection to overcome bottlenecks and expand financing in order to accelerate SDGs achievement.	Data missing	Data missing	Data missing	Data missing
<b>Grand Total</b>	<b>207,864</b>	<b>51,808</b>	<b>259,672</b>	<b>100.00%</b>



## 4.5 Sustainability

### UN Joint SDGs Project is Un-successful in Sustainability

*To evaluate the SDGs Project sustainability, the evaluation team sought to assess whether the “benefits will last and if the intervention can be replicated” through evaluating government institutions’ capacity to take forward the gains leveraged by the Joint UN SDGs Project, as well as through identifying good practices and lessons learned.*

#### Synthesis

The evaluation team has concluded that the Joint UN SDGs Project has shortfall to ensure the sustainability of gains. There was no strategy in place to ensure that these beneficiaries, who are among the poorest populations of Northwest Nigeria, would still benefit from healthcare coverage after the Joint UN SDGs Project ended. Beyond the monitoring of the initiative, the sustainability dimension also implies - from the very beginning of the initiative and at the very heart of its theory of change - planning for: 1) the exit strategy for the JP’s partners; 2) the gradual ramping up of government partners (technical and financial).

The joint SDGs Project helped improve capacity and coordination among state agencies (MBNP, MLE, and MHDSD) and with UN organizations/associations. However, the JP started from a very low base and may have misjudged the extent of the effort required to make social protection issues understood by the various stakeholders. From this point of view, continuity, and takeover on the part of governmental authorities is not guaranteed. For agencies such as ILO or UNDP, the lack of understanding, capacity, training and resources of governmental and institutional partners can jeopardize the interventions implemented over the past two years. Moreover, the difficulties of implementation in Sokoto and the fact that the specificity of social protection (as opposed to a cash-based assistance program) was only marginally understood, seem to condemn the intervention. However, when it comes to social protection, this lack of follow-up, takeover or sustainability sends a particularly ambiguous message: social protection is also, if not above all, a social contract between the government, the communities, and the people. Beyond the necessary improvements to be made to the design and implementation of the program, beyond the questions of scale up or replicability, this calls for a reflection on the modalities of follow-up of the assistance already provided since the beginning of the intervention in Sokoto.

Evaluation Questions	Rating
5.1. To what extent has the strategy adopted by the joint programme contributed to the sustainability of results, especially in terms of the SDG Leave No One Behind (LNOB) and the social protection system?	Yellow
5.2. To what extent has the joint programme supported the long-term buy-in, leadership and ownership by the government and other relevant stakeholders? How likely is it that the results will be sustained beyond the joint programme through the action of the government and other stakeholders and/or UNCTs?	Red
5.3. What are the lessons learned about the provision of integrated social protection services?	Red
5.4. In what ways should the current joint programme approach be revised or modified to improve the sustainability of the programme services?	Red
<b>SUSTAINABILITY (given the limited time and pandemic context)</b>	Yellow

**5.1. The JP fostered coordination among state agencies and with organisations/associations:** Interviews with JP implementing agencies highlighted that the JP brought together several ministries, including the MBNP, MLE, and MHDSD. Following the implementation of the JP, and notably the state consultations, other states appear to have expressed interest in adopting an SP policy - this is the case

in Kaduna<sup>54</sup> and Zamfara.<sup>55</sup> Another encouraging step towards the strengthening of SP includes the signature of Memorandums of Understanding (MoUs) between SOCHEMA and three associations in Sokoto State - the All Farmers Association of Nigeria (AFAN), the Traders Association of Nigeria, and the Amalgamated Association of Motorcycle Riders - to secure their participation in the state health insurance coverage, through the provision of 12,000 naira per person.<sup>56</sup> AFAN representatives notably said that the association secured a loan of one billion naira for their 1.5 million members, who agreed to a one-year deduction to pay for health insurance. The success of their enrolment process, however, remains to be seen. Other stakeholders mentioned the role played by the TWG in harmonising SP programming carried out by Sokoto MDAs. According to one of them,<sup>57</sup> the TWG encouraged entities responsible for SP implementation to coordinate for the first time, notably due to UNICEF developing an SP policy that encourages state ministries to abide by it.

**5.2. Continuity, takeover from governmental authorities is not guaranteed:** Despite coordination efforts led by governmental authorities, some concerns remain around these authorities' understanding of what SP entails<sup>58</sup> and how to deliver it - according to the ILO representative, certain institutional personnel believe that SP is about handing out cash, as opposed to providing health insurance. This misunderstanding negatively affects operational coordination between institutions tasked with implementing the SP policy. Several stakeholders also pointed out that it remains challenging to ensure continuity when there is a change of administration, which is scheduled for February 2023. Notably, the WB representative explained that an SP programme driven by the federal government needs to receive buy-in from the states, which are semi-autonomous; in practice, this means that the federal government should go beyond the management of the national registry and provide services, but does not yet seem committed to doing so, despite an overall awareness that SP is a "vector of poverty reduction." In addition, some key informants<sup>59</sup> called for the government to identify funding sources for SP, as opposed to simply advocating for and promising to dedicate more budget.

"We should not detract from the real responsibility of the government to be at the forefront of financing social protection more broadly. While philanthropy is fine, it might not be sustainable and at scale enough. What we need from the private sector is collaboration to innovate solutions geared towards the vulnerable we are trying to serve." KII11, FCDO

Similarly, the SCI representative noted that most of the governors who committed to an SP reform in their state, including the governor of Sokoto, are about to achieve their political mandates: "We are engaging a programme in four states, and three of the governors are not coming back. We cannot assume that there is going to be continuity in the implementation of [the] SP intervention after the change of administration. [...] Part of what we are doing is to engage with political players, parties, candidates, even with the electorate, to say that there is a need for mainstream SP in our political discourse so that whoever emerges already understands the need for these programs." Similarly, an MoE representative in Sokoto State said that, while the MBEP set aside 225 million naira for SP in 2021 - an outcome sought by the JP - the release of the funds has yet to happen, and JP are continuing their advocacy work on that matter.

**5.3. Lessons learnt/revisions to programme approach:** Stakeholders emphasised the critical need for continuous capacity building throughout state agencies as well as for the involvement of more permanent structures, such as civil society organisations (CSOs), which can act as reliable relays when administrations change and political mandates end.<sup>60</sup> As a NASSCO representative put it, Nigeria suffers from a number of success stories tied to pilot projects, but replicating and scaling up those projects to go beyond the pilot stage has proven to be a challenge.

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<sup>54</sup> KII4, ILO.

<sup>55</sup> KII10, UN Resident Coordinator Office.

<sup>56</sup> KII5, SOCHEMA.

<sup>57</sup> KII13, Sokoto State Ministry of Budget and Economic Planning.

<sup>58</sup> KII4, ILO, KII6, Ministry of Humanitarian Affairs, Disaster Management and Social Development.

<sup>59</sup> KII11, FCDO, KII4, ILO.

<sup>60</sup> KII7, SCI, KII8, NASSCO.

*“If there is another phase of the program, there is a need to build structures for sustainability at the very onset. To me, those structures involve CSOs alongside government; how can they be part of the design and implementation of the program so that when partners are gone, the CSOs are still in place.”* KII7, SCI

*“We are trying to ensure there is legislation backing SP programmes on the ground. With [a] lack of legislation, once there is a change in government, there is a risk of abandonment. Institutionalising the SP programs requires legislation backing the operations. Once that is put in place, if this can be achieved before the expiration of the current administration, it will be difficult to undo it..”* KII6, MHDSD

Furthermore, one of the main weaknesses of the SP approach set up by the JP is that its beneficiaries cannot afford to pay for health insurance through a contributory mechanism.<sup>61</sup> When the JP ended, there was no mechanism in place to ensure that these beneficiaries, who are among the poorest populations of Northwest Nigeria, would still benefit from healthcare coverage. It has to be noted that the JP was designed as a pilot and it previously mentioned government capacity building regarding SP policies and funding were conducted to contribute to the sustainability of this pilot SDG SP programme. While there are also other already present solutions – relying on wealthier community members to pay for health insurance through the Zakat commission or using the government’s basic healthcare provision fund – these are yet to be explored. This is particularly concerning for households whose main source of income comes from the informal economy. The latest WB report indicates that, in 2018, 20% of the Nigerian population was covered by social protection and labour programs;<sup>62</sup> an ILO representative specified that most of those are workers who belong to the formal economy since their contributions are legally framed. However, most of Nigeria’s workers belong to the informal sector; while the National Health Insurance Scheme (NHIS) created a program dedicated to those workers, funding is limited, and those who cannot afford to contribute are excluded from this scheme.

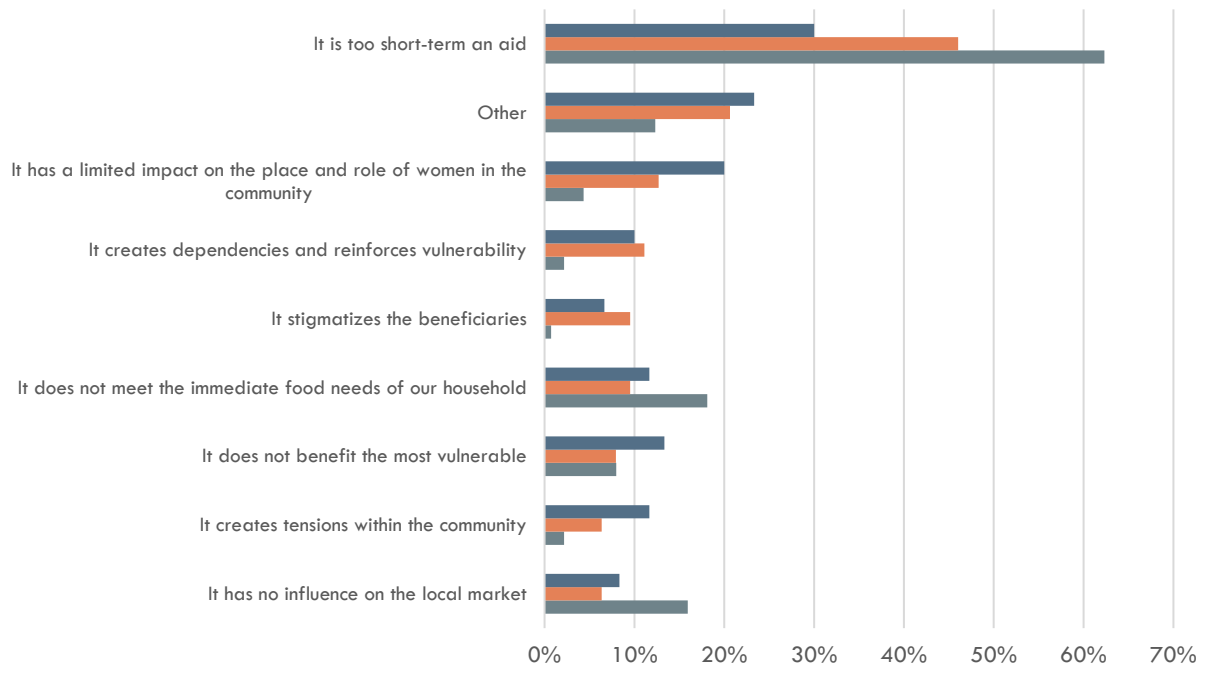
**5.4. Perceived main strength by the beneficiaries was meeting immediate needs rather than sustainable investments.** In line with this, by far the most commonly chosen weakness of the Joint SDG program was that the aid was too short term and survey respondents attributed the main strength of the programme to cover basic needs. For those who selected ‘other’, many reported that there were no significant weaknesses that could be attributed to the program.

*Figure 12 Main weaknesses of the Joint SDG Programme*

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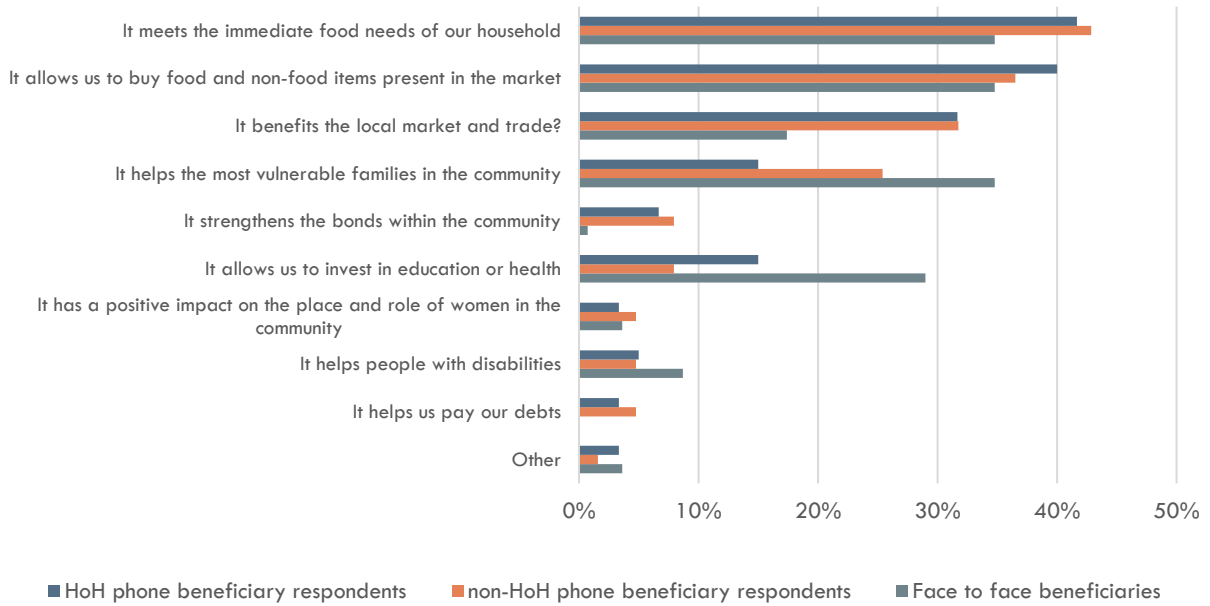
<sup>61</sup> KII4, ILO.

<sup>62</sup> Source: ASPIRE: The Atlas of Social Protection - Indicators of Resilience and Equity, The World Bank. Data are based on national representative household surveys. ([datatopics.worldbank.org/aspire](http://datatopics.worldbank.org/aspire))



Reported strengths of the Joint SDG program do not , but generally the most highly reported strengths were related to positive food security and livelihood outcomes. However, face-to-face respondents also reported that the program was beneficial in helping the most vulnerable families in the community (35% of face-to-face respondents) and that it allowed them to invest in health or education (29% of face-to-face respondents).

Figure 13 Main strengths of the Joint SDG Programme



## 4.6 Impact

### UN Joint SDGs has Positive Impact

*Lastly, to evaluate the JP's impact, the evaluation team sought to understand "what difference does the Joint UN SDGs Project make?" - by looking at the intended and unintended consequences of the programme and measuring their impact on beneficiaries and their household.*

#### Synthesis

In order to provide answers to the evaluation's question related to impact, beyond simple short-term outputs, we need to measure the contribution of the SDGs Project: i) to the institutional and collaborative capacity of Nigerian counterparts on social protection issues; ii) to the well-being of communities and households. The evaluation questions are consistent with this, with a greater emphasis on the contribution to the people of Sokoto.

There is little doubt that the JP has improved collaborative and coordinating relationships among UN agencies; similarly, while Nigerian stakeholders had little knowledge of social protection issues, the programme has helped to initiate and consolidate dialogues with UN agencies and other social protection actors. This is clearly a new and solid foundation on which agencies such as ILO and UNDP in particular – but also UNICEF and WFP - can now build. It has to be noted that the impact of policy and capacity-building activities is challenging to assess as those efforts are often not seen immediately but rather in the long-term policy and operational work of the relevant actors. However, the lack of baseline data for the health insurance and cash transfers component, prevents definitive conclusions from being drawn. While there is no doubt that the JP had positive impacts on its recipients in terms of access to professional health care services and to some degree children's and nutrition, the evaluation team was unable to compare the situation of recipients before the programme implementation to after which is needed for a more comprehensive impact analysis.

The evaluation team has performed the measurement of the impact of the social protection interventions implemented in Sokoto state using the method of quasi experimental design which compares findings of treatment group (beneficiaries) with findings of non-beneficiaries. Evidence of statistical quantitative data and qualitative opinions revealed that the SDGs project has made difference in the healthy lives and livelihoods of beneficiaries (6,000 pregnant and lactating women and children) who received assistance for health insurance and cash transfer in comparison to non-beneficiaries.

Many of the beneficiaries have expressed that the health insurance coverage specifically has had a significant positive impact on their lives as opposed to having received cash transfers in isolation or immunisation to specific diseases from other programmes in the past. Lastly, there was a clear gender focus as the target beneficiaries were pregnant and lactating women, whom as a result were able to get the medical attention they needed without the financial or psychological burden on the household.

#### Evaluation Questions

- 6.1. To what extent has the Social Assistance (Cash Transfer) provided to vulnerable populations in the pilot state of Sokoto generated positive effects in income and social transformations to households and communities vis-à-vis SDG1 (ending poverty) and SDG10 (reducing inequality)?
- 6.2. What lessons can be documented or challenges observed from the implementation of the model in reaching the vulnerable population and providing services?
- 6.3. What are the negative externalities of the JP programme, with a focus on ethical (fraud) and societal (tensions) issues?

#### 4.6.1. JP alleviated beneficiaries' financial burden and encouraged recipients to seek healthcare.

Across the board, beneficiaries who took part in discussions and surveys emphasised the positive impact generated by the JP on themselves and their household. The JP notably contributed to alleviating the financial burden that families typically face when one of their members is ill. This is



evident in the qualitative data which shows that beneficiaries were able to access professional healthcare when needed, in particular women, and the quantitative findings confirm that recipients were more likely to have received services from qualified health personnel, specifically for maternal and child health. The analysis below further presents the positive impact on health-expenditure indicators and the effects and usage of the cash transfers related to SDG1 (ending poverty) and SDG10 (reducing inequality).

*“The first person to have benefited [the] most is the father because he is the provider, then the mother who is the caretaker of the children, then the children who usually suffer from the illness. (...) In this rainy season, we usually spend days at home without going to our businesses and farms. Two or three children may fall sick at the same time, and a father being at home will be cashless. But with this programme, we can take our sick children to the hospital to receive free medical care. Hence, every member of the family benefited.” FGD4, Mixed, Wuruno, Achida*

*“The benefit of this programme cannot be overemphasised. As the saying goes, ‘health is wealth’ - everyone needs to be healthy in order to carry on with his/her life, so this health coverage is very, very important. And we are very grateful for it.” FGD4, Mixed, Wuruno, Achida*

**Effects on health expenditures and general health:** The health insurance coverage encouraged beneficiaries to seek and receive care from health professionals instead of self-medicating or relying on pharmacists’ diagnoses. The quantitative data confirms that 59% of surveyed beneficiaries were assisted by a qualified health personnel for any health problem in the past year compared to 47% of surveyed non-beneficiaries.

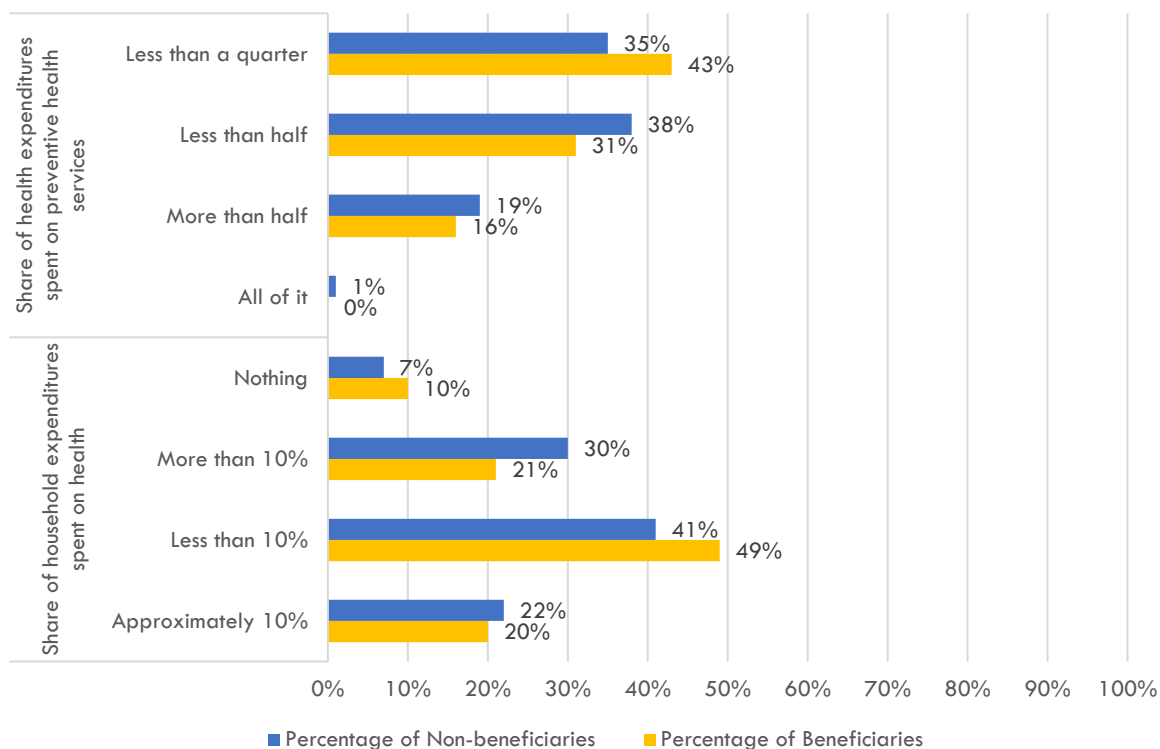
A participant in Bodinga, for instance, stated that people usually stay home when they are sick and do not consult a doctor; they often believe that they have malaria and will ask pharmacists for medicine without receiving an actual diagnosis.<sup>63</sup>

Similarly, the quantitative data confirms the positive effects on health expenditures and access to professional health care as well as preventive health services as seen in Figure 13 below. While the differences in health expenditures are minimal as shown in figure 13, programme beneficiaries reported spending relatively less on health care compared to non- beneficiaries. When zooming in on health expenditures that are relevant to the JP activities namely preventive health services and maternal and child health expenditures the differences are more solidified. The difference in spending patterns on maternal and child health expenditures are even more accentuated than preventive health which points to the programme impact as it paid special attention to that domain.

*Figure 14 Household health expenditure*

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<sup>63</sup> FGD8, Women, Bodinga, Bodinga



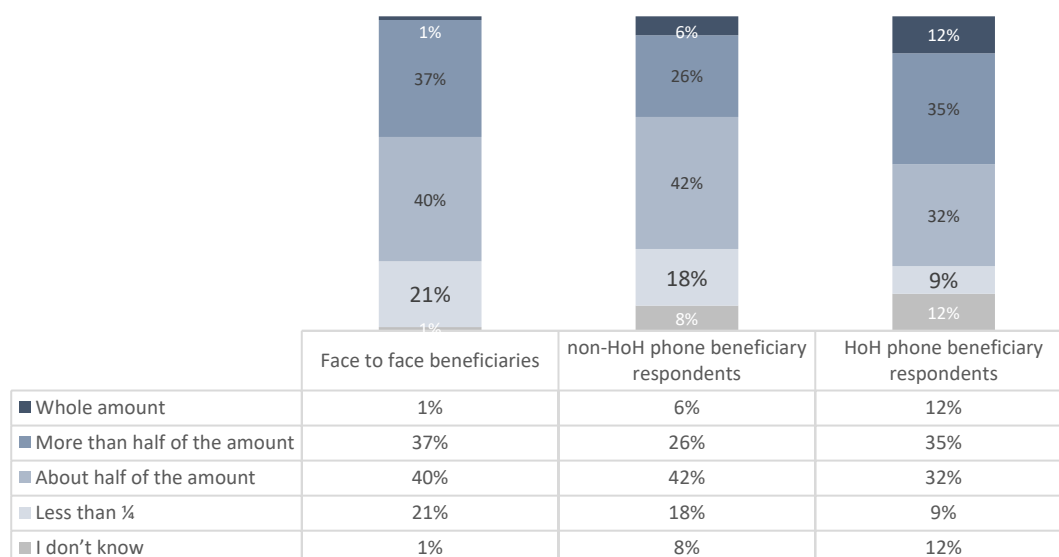
**Impact and usage of cash transfers:** With regards to cash transfer beneficiaries, the JP provided a lump sum of 5,200 Nigeria naira per month (NGN 5,000 for transport and NGN 200 to cover POS withdrawal charges) after verifying PHC attendance lists. In general, survey respondents reported receiving their last assistance in 2022 (88% of face-to-face respondents and 70% of telephone respondents). However, the month in which assistance was received was more varied. Face-to-face respondents receiving aid in 2022 were most likely to have last received it in July (35%) followed by June (25%) and February (27%) and phone to phone respondents in August (29%) followed by June (17%) and July (15%). On average, face-to-face respondents reported receiving 28,140 Nigerian naira in the last distribution and phone respondents 29,011 Nigerian naira. While 25% of face-to-face respondents and 8% of phone respondents reported not knowing how many times assistance had been received, those who did know had received aid on an average of 2.1 and 1.6 occasions for face-to-face and phone respondents respectively.

While these lump sums were meant to cover transportation costs, those appear to be considerably lower – a reality known and understood by JP stakeholders; the cash transfers thereby provided beneficiaries with extra financial resources that they could spend or save as they wished. To contextualise this amount and what it means, a participant in Achida<sup>64</sup> said that people in this area typically pay around 100 naira for a round trip to the nearest PHC using a tricycle (keke napep).

The quantitative data confirms that a high proportion of cash transfers was spent on food. 78% of face-to-face respondents and 76% of phone respondents reported spending at least half of the cash transfer on food. When not buying food, by far the most common use of cash transfers was to start a business (76% face-to-face respondents and 52% of phone respondents), followed by hospital and medical fees (22% of face-to-face respondents and 24% of phone respondents). Typically, women make the decision on how money should be spent, 87% of face-to-face respondents, of which 97% are women, report deciding on household expenditure themselves. Alternatively, 67% of phone respondents, of which 82% are men, reported that their spouse directed cash transfer funds.

<sup>64</sup> FGD1, Women, Wurno, Achida

Figure 15 Proportion of the cash transfer used to buy food



A representative of the Sokoto State Ministry of Education also noted that cash transfers provided beneficiaries with an appreciable - albeit temporary - additional source of income; following issues with the release of the first transfer, they opted to release the second and third cash transfers together, which gave some beneficiaries the opportunity to invest into a small business, such as livestock, poultry, or petty trade. Respondents, however, remained vague on the purpose and sustainability of these investments.

*“Yes, they benefited from it because women have businesses of their own now. Some are even breeding animals with the support they got.” FGD2, Mixed, Wurno, Achida*

*“I am really happy with the support because they gave us free medication at the hospital. I wasn't the only one that got the card, as my son was given one too. We were given 5,000 at first and later got 20,000. To be frank, I didn't have any money when I was given the support, so I invested it in my sewing business and continued my business. I am also very thankful.” FGD8, Women, Bodinga, Bodinga*

Most face-to-face respondents reported that they did not share the benefits (69%). On the other hand, 60% of non-HoH cash recipients reached by phone reported that they shared with either people in need or family members and 71% of HoH cash recipients reached by phone reported the same. On average, face-to-face respondents who shared their cash transfers distributed 4,542 Nigerian naira to neighbours and people in need, and phone respondents 4,882 Nigerian naira.

#### 4.6.2. Lessons learned in reaching the vulnerable population and providing services: Positive effects on prenatal, maternal and child health care but little impact on nutrition and education indicators

Prior to receiving health insurance coverage, beneficiaries reported experiencing juggling feelings akin to a mental workload that negatively impacted them. Several men said that they felt less financial pressure because they no longer had to prioritise food over healthcare, while women's testimonies suggest that they felt empowered to make the decision to take their sick child(ren) to the health centre or hospital without waiting on or consulting with their husband who manages household finances. Notably, a male participant in Achida said, *“With [...] this program, when a child is sick at my house, they don't even bother to call me, my mother or wives will just use the slip to take the child to receive free medical care.”*<sup>65</sup> Several participants felt that, beyond children, women were the ones who benefited the most from the health insurance coverage, as they no longer had to ask for permission and/or money from their spouses to take sick children to the hospital.

<sup>65</sup> FGD4, Mixed, Wurno, Achida

*“We women benefited from it the most because whenever we are sick, you can just give your husband a call that you want to go to the hospital to see a doctor without hesitation. Then in the instance of the kids, because two usually fall sick, the moment they are sick, you can just take them to the hospital for treatment without the husband giving you money, as all you need to do is inform him before proceeding to the hospital. We only inform him of the medications given to us.” FGD8, Women, Bodinga, Bodinga*

**Impact on pregnant/lactating women:** Across discussions, participants who were pregnant or knew a woman who was pregnant during the programme’s timeframe shared stories about how the health insurance coverage allowed them or these women to receive sometimes life-saving care that they could not have afforded otherwise. To provide further context surrounding maternal issues, the SOCHEMA representative said that a caesarean section would cost around 70,000 naira in a public hospital and can go up to 200,000 naira in private structures.

*“There’s a woman I know that always goes to the hospital due to her pregnancy. There was a time her husband wasn’t at home, and she felt sick after going to the hospital. She discovered that the baby was bridged. The doctor checked her and didn’t collect a dime from her. You see, if not for this SOCHEMA and SOCU, she wouldn’t have been able to see a doctor, [to receive] treatment or [to know] what’s wrong with the baby. It might [have led] to a major problem. There’s another [woman] who spent two days admitted at the hospital because of her pregnancy also and was treated for free. The baby had already died in her stomach, and she was going to be operated on to remove it. If not for this hospital, she might have lost her life because her husband doesn’t have the money to take her to the hospital, and nobody would know what’s wrong with her or the baby.” FGD8, Women, Bodinga, Bodinga*

*“What I like the most is when I was pregnant, I went to the hospital and confirmed my pregnancy, I started from the first month, and I always go there because I know I will be taken care of when I have a problem, or I’m feeling sick, I just go to the hospital and complain, and I will be given drugs or advises on what to do and what not to do, up to the time [I delivered], and I delivered safely [...]. My baby was immunized there, and any sickness I see, I take my baby to them.” FGD8, Women, Bodinga, Bodinga*

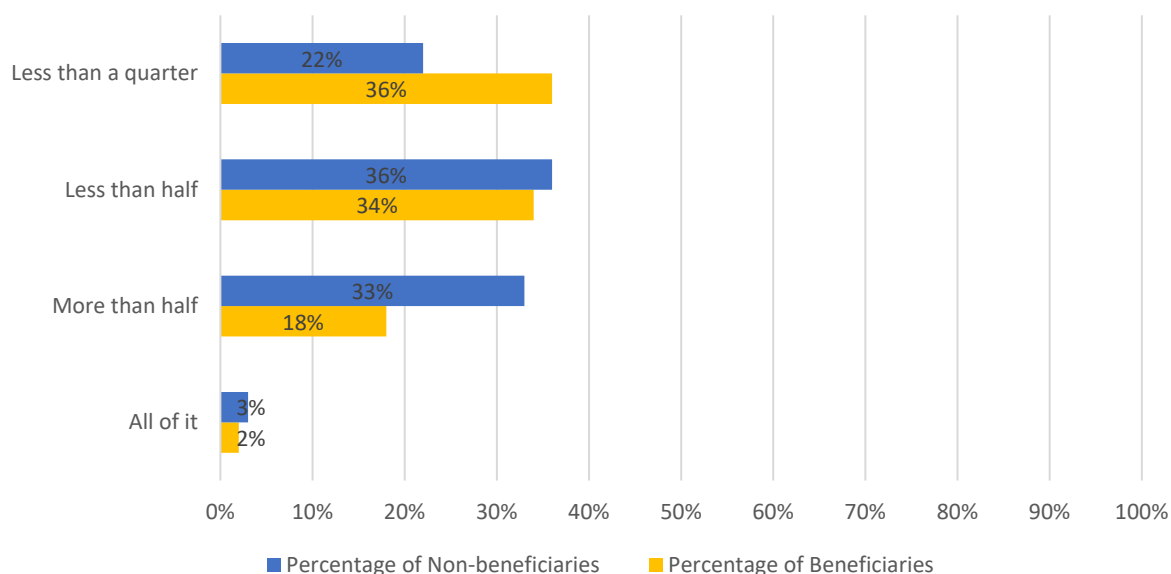
This was confirmed by a SOCHEMA representative, who stated that the health insurance coverage has made men more inclined to let their wives go to the hospital when they go into labour and to let children under two receive vaccines. On that note, a woman in Bodinga said that she had not received any prenatal care for her previous pregnancies and only went registered at the hospital ahead of the birth; with her last pregnancy, however, the health insurance coverage enabled her to receive prenatal care and to give birth within the structure of the hospital.<sup>66</sup>

While the quantitative data does not show a significant impact on having children born in a health facility or a clinic, it shows positive results on the recipient’s reduced of health expenditures spent on maternal and child health specifically. The percentage of beneficiaries who reported having had their children (under 2 years of age) born in a health facility is similar the percentage of non-beneficiaries (28% vs 29%). When looking figure 15 below, it clearly shows how the JP health insurance coverage contributed to recipient households spending less on maternal and child health.

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<sup>66</sup> FGD8, Women, Bodinga, Bodinga

Figure 16 Share of health expenditures spent on maternal and child health



**Impact on education and nutrition:** While JP stakeholders assumed that beneficiaries would allocate part of that cash towards their child(ren)’s education and improved nutrition, the evidence gathered thus far does not indicate that it happened in most cases as discussed previously on how cash was spent; there also does not appear to have been an intention survey carried out at the onset of the project to anticipate how beneficiaries would spend cash transfers. The differences of quantitative indicators related to education and nutrition between beneficiaries and non-beneficiaries were overall not significant which is not surprising given the high level of poverty in the targeted areas. All in all, only a handful of discussion participants said that they used the cash in the framework of their children’s education; a female beneficiary in Bodinga, for instance, said, *“sincerely, the little donation I got, I used it for my children’s school matters.”*<sup>67</sup>

*“Our Father died, leaving behind younger siblings. In the past, for example, I used to generate 15,000 naira per month, and the health issues of my siblings cost 5000-7000 naira per month. [...] I used to always buy medications for them, but now with this programme, I can save that money and use it for my school or other needs. In the past, I used to divide my attention and money between school and my siblings at home.”* FGD6, Mixed, Tambuwal, Dogon Daji

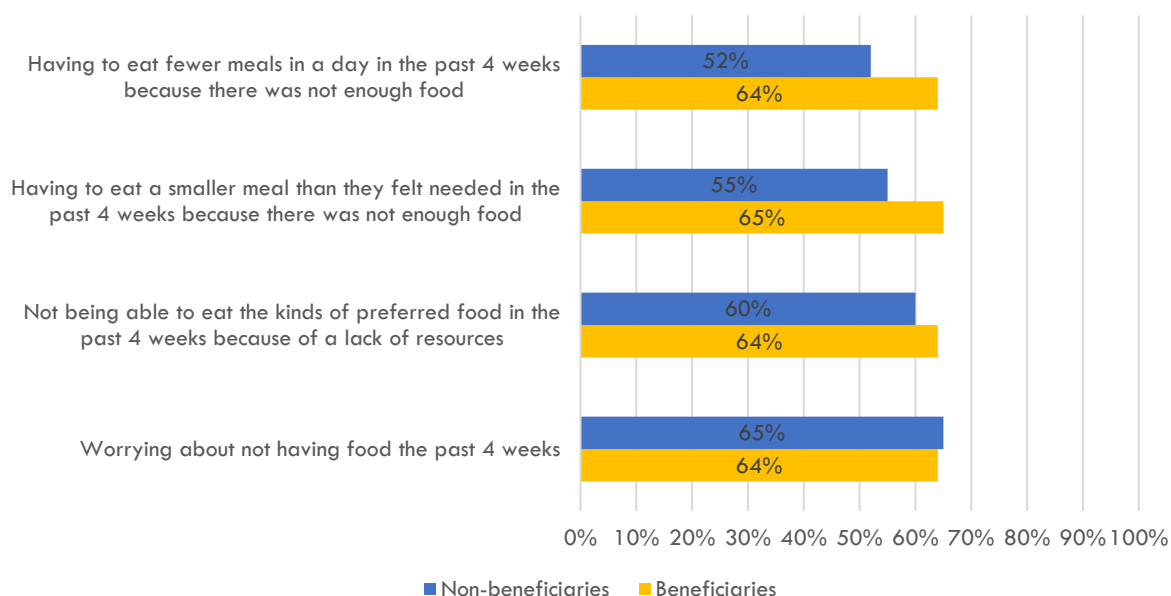
The survey results do not indicate a significant impact as the percentage of beneficiaries who reported having school-aged children in their household not attending school: 92% of beneficiaries compared to 90% of non-beneficiaries.

The programme seems to have had no effect in terms of nutritious well-being (as shown by figure 16 below) which could be explained by the high poverty levels prevalent in the target areas. This is indicated by the fact that there was a higher percentage of beneficiaries than non-beneficiaries who reported having fewer/less meals because there was not enough food. That was also the case for those reporting on not being able to eat the kinds of preferred food in the past 4 weeks because of a lack of resources. Moreover, even though the percentage of beneficiaries reporting that they had to worry about food in the past 4 weeks was lower than the percentage of non-beneficiaries who reported the same, the difference was minimal. Lastly, the reported percentages between the beneficiaries and non-beneficiaries on the number of meals eaten per day is inconclusive.

<sup>67</sup> FGD3, Mixed, Bodinga, Bodinga



Figure 17 Impact on nutrition indicators



### 4.6.3. Negative externalities of the JP programme

While much can be learned from the pilot, primarily from design and implementation errors which will be discussed in chapter 7, this subsection focuses on only a few aspects, related to social cohesion, and fraud claims. Other lessons learned are presented throughout the evaluation.

*Tensions with non-beneficiaries:* In some cases, the health insurance coverage and cash transfer allocation fostered some resentment on the part of those who did not receive either. Some discussion participants noted that some people in their community believed that the assistance would only be given to the family members of those distributing it and subsequently did not seek to register. A participant in Dogon Daji said that this resentment led some non-beneficiaries to claim that the medication received by beneficiaries under their health insurance coverage is of lesser quality and will negatively affect beneficiaries in the future. While this participant said that she did not believe this to be true, such claims could have harmed the JP. In another discussion in Bodinga, a participant said that many did not register because they felt it was “a waste of time and [...] a scam, that [those doing the registration] will just collect your information and leave.”<sup>68</sup>

*“There are people that were convinced that we were chosen based on bias. We told them that was not true. There was an announcement about the program before they started, and people were told to come out and register, and we even went to our neighbours and told them about the program and how to register. But, the majority of them did not follow us to register. Now seeing that we got the slip while they did not, and also seeing us enjoying the free medical treatment, they are jealous and saying all sorts of things, such that there was bias in the selection of beneficiaries, that we are related to the program coordinators/organisers that was why we were selected.” FGD5, Mixed, Tambuwal, Dogon Daji.*

<sup>68</sup> FGD8, Women, Bodinga, Bodinga

**Alleged cases of fraud:** Across areas where discussions took place, there appears to have been serious mishaps in assistance distribution modalities. Testimonies from beneficiaries raise concerns about cases of fraud. These cases include the following issues:

Table 15 Testimonies of alleged fraud

Theme	Example(s) from FGDs
<p>1. Multiple cases of wrongly labelled health insurance cards led to non-beneficiaries receiving them</p>	<p>In Bodinga,<sup>69</sup> a participant said that she witnessed someone taking another person’s card, while two other participants recalled receiving three cards bearing their personal information.</p>
<p>2. Beneficiaries lent their health insurance cards to family members and seemed unaware that they were not allowed to do so</p>	<p>In Achida,<sup>70</sup> a discussion participant mentioned that it is not uncommon to have someone in the neighbourhood picking up medicine for children who are not from her family. In Dogon Daji,<sup>71</sup> a participant said: <i>“there are a lot of people [to whom] I lend [my] and my son’s card, to go and collect medication from the hospital, and they really appreciate it,”</i> while another participant said, <i>“even if you don’t receive the medication, you can go to other people that are beneficiaries who might have the medication you require, they will most happily help because they are getting free medication from the government.”</i> Similar statements were made during a discussion in Bodinga,<sup>72</sup> where participants said they lent their cards to their siblings so that they could receive healthcare free of charge, with one of them explaining: <i>“we benefit from the program because of the free medication given to us because you can also give someone the card who in turn can go the hospital with another person’s card to collect the medication because when my sister is sick, I usually give her my card to get free medication as if it’s without the card we will have to give her money for going to the hospital.”</i> <i>“There was a time my sister was sick, and she went to a different hospital to see a doctor, but she later came back because there was no medication at the hospital, so I gave her my card, and she went to the other [hospital], and she got what she wanted.”<sup>73</sup></i></p>
<p>3. Beneficiaries stopped receiving cash assistance without being informed of why.</p>	<p>In Bodinga,<sup>74</sup> a participant said that he was given a slip with which he received 5,000 naira and was informed, as JP stakeholders were distributing 20,000 naira, that there was an issue and they would revert back to beneficiaries who had not received the second batch of the cash transfer; when fieldwork was carried out, that beneficiary had not yet received the missing 20,000.<sup>75</sup></p>

<sup>69</sup> FGD8, Women, Bodinga, Bodinga

<sup>70</sup> FGD4, Mixed, Wurno, Achida

<sup>71</sup> FGD6, Mixed, Tambuwal, Dogon Daji

<sup>72</sup> FGD8, Women, Bodinga, Bodinga

<sup>73</sup> FGD8, Women, Bodinga, Bodinga

<sup>74</sup> FGD8, Women, Bodinga, Bodinga

<sup>75</sup> Beyond the interruption of cash transfers, this case raises another problematic question: this beneficiary is elderly and received cash assistance when he did not meet the selection criteria for this part of the JP.

## 5. LESSONS LEARNED



*Photo 5 Market street in Bodinga town, Bodinga*

## 5 LESSONS LEARNED

*These few reflections on the program are intended to provide lessons that go beyond this one assessment. The main aspects of knowledge or understanding gained - positive or negative - are summarized here in 8 key lessons.*

### Assessment

**Starting with an informed, realistic, flexible, and contextualised Theory of Change at the national and Sokoto levels.** The function of a theory of change is to place implementation choices (strategic and programmatic) within a given context and time frame. There are several reasons why the JP in Nigeria could not be supported by a robust theory of change.

- First, the global nature of the experiment - in several countries - did not always allow for contextualizing standards and expectations to institutional realities (awareness, level of inter-agency coordination, familiarity with the issues, capacity) and operational realities (targeting, needs assessments, implementation, MEAL). **A first lesson of the program** is therefore certainly not to consider multi-country strategies or frameworks as sufficient theories of change at the scale of a country (Diffa) or a region (Sokoto). It is essential to rethink the objectives, strategy, operational framework, timeline and feasibility locally to define a real theory of change - that is, a framework that allows for implementation, adjustments, partnerships and operational learning throughout the 2-3 year duration of the intervention.
- Second, and related to the previous and next points, the timeframe for implementation was very (too) short, in a pandemic context, and in a context of universal and chronic poverty. It is understood that the multi-country nature of the JP pilot did not allow for this long-term approach. However, this short-termism is also incompatible with obtaining truly significant results, because mentalities (government, communities) and operational modalities (UN, NGOs, IPs) have not had the time necessary to evolve. **The second lesson** is that to allow the development of effective and impactful social protection programs, only a long-term approach should prevail (over a decade or more).
- Finally, it is also necessary to take the measure of the change required of the various actors (government, UN agencies and NGOs) in terms of social protection, in a context of extreme precariousness (Sokoto) and structural weakness (institutional, governmental), where all the actors consulted were clearly more skilled and used to responding to emergency situations than to implementing social protection programs. **A third lesson** relates, once again, to contextual knowledge, but this time from the point of view of the actors: humanitarian actors are not necessarily in a position to develop a strategy, implement and monitor programs that go beyond emergency logic. This applies to all stakeholders and undoubtedly points to a lack of upstream analysis (JP): to obtain better results, an approach over several years would have been necessary, in order to allow for a shift from emergency approaches to resilience and social protection logics.

### Design

**Focusing on step-by-step and phased approaches rather than parallel and hasty approaches.** A key lesson learned from the evaluation is to adjust timetables to national and local contexts so as not to end up with an output-driven, emergency programme logic. As mentioned earlier, many actors remained in a humanitarian output logic, without learning or understanding the theoretical and programmatic specificities of social protection. However, after two to two-and-a-half years, there are

certainly achievements. For instance, despite challenges, coordination between the various implementing agencies worked well and the Sokoto pilot yielded encouraging results, in part due to the complementary roles and expertise of leading agencies – policy development for ILO; children, women, and nutrition for UNICEF; SP and cash transfers for WFP; institutional capacity building and innovation hubs creation for UNDP. Stakeholders overall believed that the JP’s focus on capacity building of government institutions played a key role in where institutions such as the CWG or TWG are empowered to take the SP policy forward. The JP creating an environment also helped improve capacity and coordination among state agencies (MBNP, MLE, and MHDS) and with UN organizations/associations. Despite these positive results, **a fourth lesson** is that only a phased approach, where the implementation dimension (= Sokoto) builds on the institutional dividends (= central government and State level, as well as between international agencies), can create real impact - through ecosystemic and coordinated action between the key actors of the intervention. Implementing the programmatic aspect at the same time as the foundation-institutional work is indeed premature because it does not take advantage of the benefits of working with actors to change mindsets, develop skills, and consolidate partnerships.

**Considering the gender perspective as central in strategic and operational terms.** The program has taken into account the gender dimension in the implementation of its activities. However, by limiting this approach to a conception of gender as: 1) a cross-cutting issue; 2) a criterion of vulnerability, it seems that the program has cut itself off from a truly transformative dimension, which could have helped improve its outcomes. This is a missed opportunity insofar as a detailed understanding of gender dynamics and social constructions at work within communities and families can help optimize programmatic outcomes. In particular, in terms of the use and redistribution of assistance, notable differences are noted between men and women. **A fifth lesson** of this evaluation is therefore related to gender dynamics: to increase the acceptability, impact and positive externalities (= redistribution) of a social protection program, the gender issue must be placed at the heart of the strategy. This requires minimal semi-ethnographic analyses of the contexts in which gender identities are constructed in often different communities, where the roles and functions of men and women are different.

## Implementation

**Expanding beyond health insurance and limited financial inclusion.** The JP’s assistance gave beneficiaries an incentive to seek healthcare when they are ill by providing them with health insurance and thereby tackling a prominent issue that affects access to healthcare, but there are other critical factors that cannot be mitigated by the provision of health insurance. While a SOCHEMA representative emphasised that financial issues are the main challenge constraining the population’s access to health centres - *“most [people] will just say that the challenge is access or cost of services; they are worried they cannot pay for these services [and] will tell you when [they] get to the hospital that everything is about money”* - discussion participants frequently listed the absence of adequately equipped health facilities near their area of residence, poorly maintained roads, and the lack of doctors, including female practitioners to tend to women, as critical issues<sup>76</sup>. A World Bank representative confirmed these issues and highlighted that clinics remain ill-equipped to cater to the needs of disabled persons. From this perspective, **a sixth lesson** is to better understand the needs and types of vulnerabilities specific to the communities benefiting directly (assistance) or indirectly (redistribution) from the intervention. Is coordination and collaboration with other interventions in the fields of resilience or development possible and conceivable? Under what conditions? A mapping

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<sup>76</sup> This is particularly challenging for pregnant women who get into labour at night; many participants in Bodinga and Achida reported that there are no doctors working night shifts and that pregnant patients need to go to other towns. In Bodinga, participants said that the rainy season further damages roads, and they have to opt for alternative and longer routes to reach health centres. Participants also noted the lack of medical staff, with one of them pointing out that doctors are only available between 10 AM and 3 PM; at the nearest hospital, only nurses are available at night. Another critical issue is the lack of medicine. Several participants said that they were not given medicine on at least one occasion because the health centre had run out of stock.



of the assistance (protection) actors and an understanding of the real needs are therefore essential. This will allow the program to generate a multiplier effect, in terms of impact and sustainability, by coupling cash assistance with other actions currently envisaged in the field of health, hygiene, livelihoods, irrigation, food diversification, animal vaccination, fertilizers, etc.

**Understanding redistribution phenomena.** Testimonies from beneficiaries and survey data showed that the health insurance coverage was not only used for the health concerns of the beneficiaries but also for extend family members and neighbours. This is not a surprising finding given the high levels of poverty in the targeted areas. The phenomenon confirms that informal social safety nets beyond Zakat are common among the communities and therefore, the provision of health insurance coverage and cash transfers might have had a wider positive impact on the communities beyond the direct beneficiaries. These informal redistributions and sharing arrangements are an indirect positive externality of JP and social protection intervention. In this regard, **a seventh lesson learned** is that a deeper understanding of the socio-cultural modalities of redistribution of cash (or even in-kind) assistance at the community and family level would undoubtedly help to better refine the modalities of transfer and deployment of a true safety net for a population in a chronic food insecurity crisis. More research is needed to understand the sharing patterns of the beneficiaries and how the programme has impacted the beneficiary communities.

### Ethics and accountability

**Minimizing the risk of fraud (perceived or real) by promoting transparency and accountability.** It should be noted that targeting problems (see 4.1.3), allegations of fraud, and cases of social tension have been mentioned by the communities. Regardless of the reality of these accusations, which are outside the scope of this study, it is important to keep in mind that this perception of the programme is often shared within the communities. For example, in some cases, the health insurance coverage and cash transfer allocation fostered some resentment on the part of those who did not receive either. An **eighth key lesson** is that, on programs of this magnitude, implemented in relative urgency, it is essential to identify a framework of accountability and transparency to avoid rumours and suspicions of fraud.



# 6. FINAL CONCLUSIONS



Photo 6 Primary school in Dogon Daji, in Tambuwal

## 6 FINAL REFLECTIVE CONCLUSIONS-DISCUSSIONS

The JP aimed to support a social contract through the “*sustainable, equitable and quality social protection benefits and services*” ensured by the development and implementation of National and State Social Protection Policies. Moreover, while the operationalization of SP was focused on the State of Sokoto, the results of this piloting should be scalable and replicable across other states. To that effect, the Theory of Change model (in Annexe) for the JP emphasises the development of a “*blueprint for successful implementation and expansion of the cash transfer and universal health insurance*” to all state governments in Nigeria, using the learnings of the programme’s implementation in Sokoto.

This concluding section summarises the report’s findings and links them to wider discussions in the social protection field. In particular, it aims to respond to the following objectives in line with the overall purpose of the evaluation:

3. Analyse whether the UN’s Joint SDGs Social Protection Programme in Nigeria met its high-level objectives;
4. Analyse the extent to which the JP laid a foundation for the future sustainability of social protection in Nigeria.

An important caveat to all of these conclusions is of course the experimental dimension of the program, which was emphasized during a presentation of the preliminary findings: a two or two-and-a-half year pilot cannot be blamed for not meeting objectives that require seven or eight years. All the UN partners consulted reiterated this point forcefully at each interview. Therefore, time must be given to time, while learning from the successes and shortcomings of the pilot.

### Relevance

**Rethinking vulnerability and targeting.** Sokoto is one of the states in the North with the highest levels of poverty, insecurity and an economy dependent on agriculture in primarily rural communities. Most people living in the state are in such dire conditions that immediate assistance is needed to avoid a major humanitarian crisis. In this context, defining targeting criteria to identify beneficiaries can be a double-edged sword. On the one hand, it is likely that the categories identified as vulnerable are particularly in need of assistance; on the other hand, targeting entails a risk of confining the identity of people who are identified as ‘women’, ‘youth’, ‘people with disabilities’, etc. In a context of chronic poverty, defining pro-poor criteria of vulnerability to include or exclude from access to social protection remains highly questionable. This debate is of course broader than the Nigerian context alone, but it is crucial to defining the success and effective impact of a social protection program in an environment of chronic poverty and vulnerability.

**Challenging Criteriology.** More universal and inclusive forms of targeting vulnerable categories of the population and promoting equity might be more impactful and efficient in terms of costs than narrow poverty-targeted programmes. Words and concepts such as poor and vulnerable have different meanings for subgroups within communities, NGOs, governments, and donors. ‘The poor’ or ‘the vulnerable’ is not a fixed group but rather fluid, particularly in contexts like Sokoto State. Therefore, “...distinguishing the target groups for distinct policy interventions is hard, because the poorest, transitory poor and vulnerable non-poor are fluid and fuzzy rather than static and crisp sets.”<sup>77</sup> Generally, poverty targeting generates errors of exclusion and inclusion, and static surveys or assessments to identify “the poor” do not allow to account for the dynamic and pervasive nature of vulnerability. This debate has not taken place and should take place before scaling up or replicating the program in another context. This should be one of the issues of the JP - not in a polemical way but in a constructive way, through a pilot and a conceptual discussion that includes all stakeholders.

<sup>77</sup> Armando Barrientos and Jocelyn DeJong, ‘Reducing Child Poverty with Cash Transfers: A Sure Thing?’, *Development Policy Review* 24, no. 5 (September 2006): 537–52.

## Coherence

**Continuing the effort of operational coherence between UN agencies and other parties.** While the UN agencies interviewed emphasize the improvement in relations with the government (towards more information and coordination) as well as between partners (UN and NGOs), it must also be emphasized that these efforts are still limited after two and a half years, as capacities appear limited (at the government and Sokoto levels), and institutional habits are still marked by a form of inertia and a focus on the emergency to the detriment of collaboration with a view to increasing positive effects on the ground. From this point of view, social protection is undoubtedly the theme that can strengthen the coordination and collaboration of all the actors, and the first years of implementation are moving in this direction, albeit in a fragile manner.

**Strengthening the awareness, communication and outreach dimensions to highlight the social contract dimension of social protection.** While the JP aimed at supporting a social contract through “sustainable, equitable and quality social protection benefits and services” grounded in National and State Social Protection Policies, some stakeholders (findings 5.1/5.2) argued that the JP lacked a handing over strategy to the government and considerations to ensure the sustainability of the health care insurance coverage. There were also allegations of fraud in the distribution and selection of beneficiaries which can seriously damage the relationship between citizens and the state. Furthermore, to build a social contract, the population needs to be aware of who is behind the benefits they are receiving. Some respondents credited local authorities, health centres or individual health workers for the assistance they received without being aware that the programme is grounded in national and federal policies.

## Effectiveness

**Promoting a necessary debate between stakeholders, towards more equitable social protection mechanisms.** To clarify the question, does the choice of vulnerability criteria, which leads to identity-based targeting ('lactating women', 'people with disabilities', etc.) and to a distinction between a quintile of very poor and other quintiles of 'less poor' (with exclusion errors often higher than 50-60%), not go against the universalist purpose of social protection systems? How can we talk about a social contract in this case? The provision of universal health care could be more efficient because identification and distribution costs would be reduced and potential social conflicts due to targeting would be avoided. Of course, this would require a more specific approach to identifying all beneficiaries (census of the population) and to securing more long-term funding. However, the return on social, societal, political and economic investment could be significant and the JP cannot simply invoke the limits of its funding to continue to favour a pro-poor targeting approach by imposing the questionable label of social protection.

## Efficiency

**Promoting a culture of value for money to optimize intervention and interagency synergies.** The efficiency analysis section reveals a lack of knowledge of the value for money per intervention and a clear absence of inter-agency collaboration, which is not only detrimental to the accountability of the program but also to its optimization and to generating possible multiplier effects (through the pooling of resources or costs between agencies or actors). As it stands, the focus remains results-oriented (= delivering the expected numbers vs. planned) without sufficiently considering the real (and evolving) needs of a population exposed to multidimensional and chronic crises). In this regard, it is essential that the JP strengthen its capacity to understand, compare and analyze the real value of its operational contribution to the population. Simple avenues can be identified: 1) favoring longitudinal analyses, to capture improvements in VFM over time; 2) systematizing comparative analyses with similar contexts/programs; 3) disaggregated cost analyses, to better understand how and where the JP



spends most of its money; and finally, 4) a focus on the broader context to understand how the JP contributes to improving people's lives and well-being.

## Sustainability

**Learning from crises and uncertainty:** The COVID-19 pandemic led to significant delays in the JP's implementation, which had to be extended following a missed launch date in March 2020, when the pandemic spread across the world. Until late 2020, the JP did not have a coordinator who could serve as an intermediary between implementing partners and ensure that the programme was moving forward. Activities that were required to be carried out in person, such as baseline data collection in Sokoto, had to be postponed. According to JP stakeholders, however, the pandemic acted as a catalysing event toward the strengthening and streamlining of SP in Nigeria. The government provided cash transfers and food throughout the country and may have been more inclined to take the SP bill forward.

In terms of access to healthcare during the various peaks of the pandemic, discussion participants believe that COVID-19 did not prevent them from receiving medical care, both under the JP and in general. A participant in Dogon Daji<sup>78</sup>, for instance, said that the hospital helped people cope with COVID-19 early on by raising awareness on protective methods - face masks, hand washing, etc. - and on symptoms of the disease. In the current context, where uncertainty and multidimensional crises have become the norm, it is therefore important for a larger-scale or longer-term social protection program to incorporate the uncertainty and risk dimension. In today's context, where uncertainty and multidimensional crises have become the norm, it is therefore important for a larger-scale or longer-term social protection program to incorporate the dimension of uncertainty and risk-both in preparation, with an ability to quickly adjust or modify design and implementation, and in learning, with a willingness to learn from each crisis.

**Promoting sustainability and ensuring follow-up (including a proper exit strategy).** Social protection is by its defined long-term and predictable as compared to the short-term cycles of humanitarian aid.<sup>79</sup> This means it needs long-term funding, objectives, and programming. While the JP was conceptualised as a pilot in Sokoto State, building a social protection system with policies and direct interventions is cost-intensive and not having a strategy to continue the programme risks that the funds spent have no sustainable impact. Given the funds spent on the identification of beneficiaries and setting up processes for the distribution of health insurance coverage and cash transfers, it needs a plan for continued funding and implementation beyond the pilot. Furthermore, as a NASSCO representative put it, Nigeria suffers from a number of success stories tied to pilot projects, but replicating and scaling up those projects to go beyond the pilot stage has proven to be a challenge. As argued in the findings 5.1 and 5.2, there was no strategy in place to ensure that these beneficiaries, who are among the poorest populations of Northwest Nigeria, would still benefit from healthcare coverage after the JP ended. Beyond the monitoring of the initiative, the sustainability dimension also implies - from the very beginning of the initiative and at the very heart of its theory of change - planning for: 1) the exit strategy for the JP's partners; 2) the gradual ramping up of government partners (technical and financial).

## Impact

**Building on the initial promising outputs to generate longer-term impact.** During the feedback exchanges of this evaluation with the UN agencies, some actors felt negatively criticized by the research. From their point of view - a legitimate one - they have done their best and have often succeeded in achieving their objectives in a particularly unfavourable environment and under huge

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<sup>78</sup> FGD005

<sup>79</sup> Directorate-General for International Cooperation and Development, 'Supporting Social Protection Systems', Concept Paper, Tools and Methods Series (European Commission, September 2015).

time pressure. We do not dispute these views, which are based on verifiable achievements and outputs. The question of impact, however, is not limited to outputs or to what can be attributed to this or that actor. It is more a question of contribution and effective, long-term change in people's lives. This is even more the case when it comes to social protection. In other words, the question of impact is not only dependent on the intrinsic quality of a program or its ability to achieve the objectives of a logframe – as our analysis of effectiveness shows. We must always think in context (Nigeria, Sokoto) and over time. From this point of view, as UNICEF, WFP and the FAO in particular pointed out in their interviews, the JP has been able to put foundations in place. Institutionally, with a dialogue now established between UN agencies and the government on the issue of social protection; programmatically, because the Sokoto pilot - despite numerous limitations and a very volatile security, pandemic, climatic and societal context - has been able to relieve certain categories of the population and can allow for learning and better working together in the future. To properly assess impact, it is therefore necessary to revisit the findings of this study in a few years (on outputs and outcomes), to better take into account variations and contextual factors, and to continue the JP effort by building on these few successes.

**Shedding light in a transparent manner on every allegation of fraud (real or perceived).** Allegations of fraud, nepotism, or unfairness (real or perceived) in the targeting mechanisms can undermine people's trust in the state and implementing agencies. This is true of any programme, but it is even more true of a social protection program, which is supposed to constitute a common base and a universal social contract. Experiences of social protection initiatives suggest that interventions can potentially have negative impacts on social cohesion by generating conflicts between beneficiaries and non-beneficiaries.<sup>80</sup> Targeting beneficiaries for social protection interventions should be transparent and easily understood.

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<sup>80</sup> Stephen Devereux et al., 'The Targeting Effectiveness of Social Transfers', *Journal of Development Effectiveness* 9, no. 2 (3 April 2017): 162–211.

## 7. RECOMMENDATIONS



*Photo 7 School Library in Bodinga town, Bodinga)*



7 RECOMMENDATIONS	Short-term recommendation	Medium-term recommendation	Long-term recommendation
Key conceptual recommendations: theory of change, contextualized logical framework and MEAL approach.			
#1: Promoting a necessary debate towards more equitable social protection mechanisms.	All UN Agencies involved + government and other stakeholders		
#2: Starting with an informed, realistic, flexible, and contextualised Theory of Change.	All UN Agencies involved		
#3: Promoting a real MEAL approach for better adjustment or revision of the pilot.	All UN Agencies involved, implementing partners, and governmental counterparts		
Key programmatic recommendations: a gender transformative approach paired with contextual knowledge and accountability			
#4: Putting gender analysis at the heart of both the strategy and the social protection system.	All UN Agencies involved + government		
#5; Understanding redistribution phenomena.		UNICEF, WFP	
#6: Promoting a culture of value for money to optimize intervention and interagency synergies.	All UN Agencies involved, implementing partners, and governmental counterparts		
#7: Shedding light in a transparent manner on every allegation of fraud (real or perceived).		All UN agencies	
Towards a realistic roadmap: building an inclusive social contract and ensuring sustainability			
#8: Making social protection a national cause through awareness, advocacy and communications		All UN Agencies involved + government and other stakeholders	
#9: Promoting sustainability and ensuring follow-up (including a proper exit strategy).			All UN Agencies involved + government

Table 16: Synoptic table of recommendations

Note that long-term recommendations may require very short-term actions whose benefits are only visible in the long term: e.g. an exit strategy should be planned from the start.

All of the recommendations listed above are based on the findings and conclusions of this study. They are addressed to partner agencies in Nigeria as well as to other contexts, which may benefit from the preliminary lessons of the JP experience in Nigeria and Sokoto in particular. The objective is therefore twofold: at the national level, these recommendations can help to better guide an extension, or even an expansion, of a joint social protection program; beyond the Nigerian case, these recommendations can be useful for replicating, contextualizing and improving the intervention conducted in Nigeria.

### 7.1 Key conceptual recommendations: theory of change, contextualized logical framework and MEAL approach.

**Recommendation #1: Promoting a necessary debate towards more equitable social protection mechanisms, which involves rethinking vulnerability and targeting.**

Before favouring a pro-poor approach that targets the most vulnerable segments of the population, it is important to consider the purpose of a social protection system (social contract, universal protection) in contexts of almost widespread socio-economic destitution and chronic multidimensional crises. This requires a real debate between agencies as well as with the government - because of the political message sent to the populations - as well as a thorough reflection on the issues of 'vulnerability criteria' or 'targeting'.

**Recommendation #2: Starting with an informed, realistic, flexible, and contextualised Theory of Change.**

A social protection program in a context as volatile as Nigeria-or the Sokoto region-requires a very clear and detailed Theory of Change, in order to anticipate changes and not be subject to short-term or unprepared for crises. Any expansion or follow-up of the JP will require a pragmatic, realistic and contextualized ToC to translate the abstract goals of the SDGs and the multi-country ambition of the JP into effective and sustainable action and interventions.

**Recommendation #3: Promoting a real MEAL approach for better adjustment or revision of the pilot.**

The JP has not developed an ambition in terms of MEAL, which is counterproductive if the goal of the intervention in Sokoto is indeed to be a pilot. Much of the potential learning from the pilot as well as institutional efforts with the government may thus be lost with turnover in each agency or institution. Similarly, significant learning dividends from the pandemic crisis, associated with the current political, security, and economic instability, may be lost-in strategic and operational terms-if an appropriate MEAL approach, beyond the basic OECD or baseline approach, is not systematized.

### 7.2 Key programmatic recommendations: a gender transformative approach paired with contextual knowledge and accountability

**Recommendation #4: Putting gender analysis at the heart of both the strategy and the social protection system.**

The JP has promoted a proactive approach to gender equality through specific programs and dedicated indicators. It is necessary to go further by not simply conceiving women as 'the most vulnerable populations' and therefore natural beneficiaries, but by understanding that they are the actors of change in rural areas, particularly in terms of community decisions, allocation of household resources, diversification of income through migration decisions (husbands, sons), etc. They must therefore be at the heart of the program in a way that is not only 'passive' (= vulnerable) but 'active' (= transforming agents). This implies a better knowledge of the socio-cultural contexts as well as specific empowerment interventions for women and the promotion of equality.

#### Recommendation #5: Understanding redistribution phenomena.

A better understanding of the redistributive phenomenon, which is very present in Sokoto, can contribute to a better reduction of poverty and vulnerability factors, by promoting the percolation of assistance, by reducing targeting errors and by contributing to a better social cohesion. Redistribution and solidarity must not only be analyzed but encouraged, according to the intra-community (so-called 'traditional') mechanisms, by a targeted advocacy and outreach campaign. This can help multiply the benefits of the social contract in terms of resilience and cohesion: from the state to citizens through social protection, from citizens to citizens through redistribution.

#### Recommendation #6: Promoting a culture of value for money to optimize intervention and interagency synergies.

As mentioned in the findings and conclusions of the present document, the absence of real value for money analysis is highly problematic – especially if the objective of the past two to three years were a possible replication, duplication, scaling up of the intervention. So, it is imperative that the JP strengthen its capacity to analyze the real value of its strategic and operational contribution. Simple avenues are worth mentioning again: 1) favoring longitudinal analyses, to capture improvements in VFM over time; 2) systematizing comparative analyses with similar contexts/programs; 3) disaggregating cost analyses; and finally, 4) focusing on the broader context to understand how the JP contributes to improving people's lives and well-being.

#### Recommendation #7: Shedding light in a transparent manner on every allegation of fraud (real or perceived).

Targeting beneficiaries for social protection interventions should be transparent and easily understood. Whether community-based or institutional targeting, there is no targeting method that fits every context, mechanisms have to be contextualised, and local capacities need to be built to support the process of identification and ensure safeguarding. In these respects, beyond the debates on the choices in the approach (pro-poor targeting, vulnerability criteria, universal coverage), it is important to be aware of, analyze, respond to and eliminate any perception of fraud or unfairness from the population.

### 7.3 Towards a realistic roadmap: building an inclusive social contract and ensuring sustainability

#### Recommendation #8: Making social protection a national cause by strengthening the awareness, communication and outreach dimensions

The near absence of any mention of the JP in the media or in the Nigerian media, as well as the lack of any real ambition to communicate with the government (nationally and state level) so that it takes ownership of the pilot and the development of a social protection system, are not detrimental at this stage. On the other hand, a real reflection must be conducted so that the communities do not perceive the initiative as another humanitarian assistance program, with no '*social and societal solidarity agenda*'<sup>81</sup>; similarly, the strong link between institutional efforts and the implementation of concrete interventions should be further emphasized in Nigerian opinion and among all stakeholders.

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<sup>81</sup> KII with UNICEF, July 2022.

**Recommendation #9: Promoting sustainability and ensuring follow-up (including a proper exit strategy).**

By its very nature, a social protection system should be defined by its universality (beyond targeted beneficiaries) and sustainability (beyond one-time assistance). In this regard, ensuring the sustainability of the social protection system (inaugurated through institutional efforts) and the Sokoto pilot project also implies - from the outset of the initiative and at the very heart of its theory of change - planning for: 1) the exit strategy of the JP partners; and 2) the gradual ramping up of the government partners (technical and financial). This recommendation is theoretically valid for any development intervention, but it is even more relevant in the case of social protection given the closer involvement of government and the highly political/politicized dimension of social protection in volatile contexts like Nigeria. Any replication or scaling up should consider this last recommendation as a priority and a key factor for success and sustainability.

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## 9. ANNEXES

## 9 ANNEXES

The following annexes are provided under a separate cover in conjunction with this report. Please refer to the supplemental document titled “Independent Evaluation of the UN’s Joint SDGs Social Protection Programme in Nigeria - ANNEXES”.

### ANNEX A. DETAILED METHODOLOGY

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## ABOUT SAMUEL HALL

Samuel Hall is a social enterprise that conducts research in countries affected by issues of migration and displacement. Our mandate is to produce research that delivers a contribution to knowledge with an impact on policies, programmes and people. With a rigorous approach and the inclusion of academic experts, field practitioners, and a vast network of national researchers, we access complex settings and gather accurate data.

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