Attachment 1 to USAID Community Health NOFO

PART A: Country Context

With an estimated population of 227.8 million as of April 2024 (projections based on 2006 census), Nigeria has the largest population in Africa. Despite being one of the largest and fastest growing economies in Africa, Nigeria is home to the largest number of people living in extreme poverty in the world – about 85 million, or roughly 40 percent of the population (2023 State of World Population Report). Nigeria is divided into six geopolitical zones namely: North-West (NW), North-East (NE), North-Central (NC), South-West (SW), South-East (SE) and South-South (SS), each zone comprising states with similar ethnic groups and common political history. Nigeria practices a decentralized political system, mirrored in the health sector, made up of a three-tiered government structure. The structure is made up of a central federal government, 36 federating states and 774 local governments. Nigeria's federated structure gives significant autonomy to the 36 states and the Federal Capital Territory, Abuja.

Nigeria is perpetually grappling with conflict tensions rooted in ethnic and regional rivalry, criminality, and competition for scarce resources. There are terrorist insurgencies in the NE, kidnapping and armed robbery rings in the NW, NC and southern regions, militant groups and criminal gangs in the SS, and conflict between farmers and pastoralists over access to land in the NC region. Drivers of conflict differ by geographic region and violence is often exacerbated by high levels of poverty, economic inequalities, and hardship. Conflict affects marginalized groups (women, children, religious minorities, and persons with disabilities (PWDs) differently. Arguably, women and girls are most impacted, as indicated in the distribution of internally displaced persons, particularly in the Northeast (Internal Displacement Monitoring Center 2019), and more marginalized from political and conflict mitigation processes, as well as the weight of deepened levels of Gender Based Violence (GBV).

A.1 Health Context

Nigeria accounts for 2.4 percent of the world's population but contributes 10 percent of the global maternal deaths[1]. The Nigeria healthcare system is constantly challenged with inadequate infrastructure, limited number of trained health care providers, and worsened by high burden of communicable and non-communicable disease with significant disparity across the regions. The NW and NE regions have the worst health indices (NDHS 2023-24). Access to health services is limited especially in rural areas with inequitable distribution of health facilities and health care providers.

National indicators are masked by regional variations and disparities by wealth quintile, education levels, age, urban/rural residence. National indicators are masked by regional variations and disparities by wealth quintile, education levels, age, urban/rural residence. For example, the Northwest (NW) and Northeast (NE) regions have the worst health indices (National demographic Health survey {NDHS} 2023-24), access to health services is limited in rural areas, only forty one percent of women with no education received antenatal care (ANC) services from a skilled provider, as compared with 95 percent of women with more than a secondary education. Similarly, uptake of skilled assistance during delivery also varies with only 22 percent of births in the NW region attended by a skilled provider, compared with 87 percent in the Southeast (SE). These variations by geographical regions and socio-economic status are also applicable to child health, malaria and nutrition indicators. For example, the 2023-24 NDHS found that advice or treatment was sought for 60 percent of children under age 5 who had symptoms of fever; women with no education (54%) were less likely than those with secondary education (68%) to seek care just as women in the lowest quintile (50%) were less likely than those in the highest quintile (73%)

[1] https://www.unicef.org/nigeria/situation-women-and-children-nigeria

to seek care. Nutrition indicators have also worsened from the 2018 NDHS, with poorer outcomes for women with no education or in the lowest wealth quintiles. For example, stunted children are more likely to be in households where mothers have no education (55%) or in the lowest wealth quintiles (56%) compared to mothers with secondary education (29%) and in the highest wealth quintile (15%). Power dynamics within households, especially in relation to decision making and economic means, also largely influence the time and place for seeking health care.

Family Planning and Reproductive Health: Over the last ten years, Nigeria has focused on expanding the FP method mix[2], task shifting/sharing[3] to increase the pool of health workers cadres who are able to provide long-acting methods and the deployment of a national family planning communication plan to increase exposure to evidence-based FP messages. In 2023-24, the NDHS found 15 percent of currently married women used any[4] method of contraceptives. Between 2018 and 2023, total demand for family planning among currently married women increased from 36 percent to 41 percent and unmet need stood at 36 percent and 21 percent among sexually active unmarried women and currently married women respectively. Variations in the desired family size, total fertility rate (TFR), and contraceptive prevalence rate (CPR) exist among geopolitical regions and different socioeconomic levels. For example, TFR is highest in the NE (6.1 children per woman) and lowest in the SS (3.3 children per woman). Similarly, demand for family planning is lowest in the NW (31 percent) and highest in the SW (63 percent).

Variation across and between regions and groups is driven by a range of factors including variable service access and quality, low exposure[5] to FP messages, and sociocultural attitudes affecting desired family size and FP demand. A USAID funded behavioral sentinel survey (BSS) in October 2022 among over 3,000 women with a child under 2 years old living within SBC intervention wards in Kebbi, Sokoto, and Zamfara states found that emotional factors (such as injunctive & descriptive norms), and social factors (such as spousal communication, support) were predictive of FP use among couples, buttressing the need for continued investments in evidence-based SBC interventions. As part of efforts to expand access to FP products and services, Nigeria has implemented several innovative approaches including community-based distribution of contraceptives, mobile clinics and outreaches. This Activity will enhance these efforts and contribute to achieving objective two of Nigeria's FP2030 commitment to increase FP access and choice through a total market approach, including community-level delivery using CHIPS or other volunteers.

Maternal Health: The proportion of women with four or more ANC visits reduced from 57 percent to 52 percent between 2018 and 2023-24. Between 2013 and 2018, the proportion of women with an ANC visit in the first trimester of pregnancy increased from 16 percent to 18 percent and a 10- percentage point reduction in the proportion of mothers with no antenatal care. The proportion of women receiving ANC from a skilled provider stood at 63 percent, decreasing by 4 percentage points between 2018 and 2023-24. These numbers are masked by disparities along rural/urban, geopolitical, and social status. For example, only 41 percent of women with no education received ANC services from a skilled provider, as compared with 95 percent of women with more than a secondary education. Additionally, due to women's late registration for ANC and other factors, the gap between ANC-1 and ANC-4 uptake remains high.

[2] includes the introduction and scale up of hormonal IUDs, and a focus on FP self-care with the introduction and scale up of DMPA-SC
[3] Task shifting/task sharing policy for essential health care services in Nigeria as well as the standard of practice (SOP) (Federal Government of Nigeria 2018)
[4] includes modern and traditional FP methods.
[5] 65 percent and 56 percent of women and men respectively report no exposure to FP messages through any of the four media sources (radio, television, newspaper/magazine, and mobile phone) in the months preceding the NDHS 2018 survey.

Uptake of ANC services and facility-based delivery is influenced by a mix of internal, social, and structural factors. The 2022 BSS found internal enabling factors to include knowledge (specifically, women who knew at least one ANC benefit; knew to go to ANC at least four times; and knew to initiate ANC in the first trimester were 3.2, 2.1 and 1.2 times more likely to attend ANC 4+ times than those who didn't); self-efficacy (women with confidence in own ability to get to a facility were 2.5 times as likely to attend ANC 4+ times); beliefs and attitudes (women who believed ANC was effective or perceived childbirth services to be of quality were significantly more likely to attend ANC 4+ times) and social factors such as spousal support (women whose spouses supported their decision to attend ANC were 1.2 times more likely to attend ANC 4+ times). Documented barriers to ANC services included widespread misperceptions including that ANC is a curative and not preventive service; restrictive social and gender norms such as those that restrict women's movements and social interactions or require spousal consent before leaving home; and structural wealth gaps e.g. women in lower wealth quintiles were 7 times less likely to attend ANC 4+ times than those in the top wealth quintiles – the single most important barrier to ANC uptake. These findings strengthen the case for continued investments in evidence-based SBC interventions and increasing access to services through community channels.

Maternal mortality ratio (MMR) remains high at 512/100,000 live births (2018 NDHS), accounting for over 10 percent of global maternal deaths. Many of these deaths occur outside of the health facility as nearly 6 in 10 births (57 percent) happen at home (NDHS 2023-24). Skilled assistance during delivery, a key factor in reducing maternal and neonatal mortality remains low with less than half (46 percent) of deliveries assisted by a skilled provider. As with many health outcomes, there is considerable variation by age group, geo-political zone, and mothers' educational status. For example, the 2023-24 NDHS reported that births to mothers less than age 20 were more likely to be at home (67 percent) compared with older mothers (56 percent) as were births to mothers with no education (82 percent) compared to mothers with more than a secondary education (10 percent). Also, only 26 percent of births in the NW region are attended by a skilled provider, compared with 88 percent in the SE.

The 2022 BSS found positive shifts in behavioral drivers of facility-based deliveries. For example, the most cited reason for not delivering in a health facility – lack of a perceived need or "not necessary to go" -- declined in importance in all three states by between 16 and 31 percentage points. On the average, 6 in 10 women agreed that a health facility is the best place to deliver a baby and 5 in 10 reported intentions to deliver their next child at a health facility. Additionally, as with ANC, the study found husbands greatly influenced decision-making about facility delivery. These suggest amenability of enabling factors for uptake of facility-based deliveries to SBC interventions to modulate perceptions, and decision-making processes regarding birth planning. Despite approximately half of maternal deaths occurring within the first 24 hours after delivery, postnatal care (PNC) for mothers within two days of delivery remains low at 42 percent. The 2018 NDHS found that low awareness of the benefits of PNC in helping women recover from childbirth was a barrier to uptake, highlighting the need to integrate tailored SBC interventions to promote uptake of PNC services at community level.

Newborn Health: In Nigeria, 7 million babies are born annually[6] and 250,000 die within the first month of life[7]. The country also has a high number of stillbirths, recording 171,428 in 2019[8]. Over half of these

[6] UNICEF, Situation of Women and Children in Nigeria. Source: <https://www.unicef.org/nigeria/situation-women-and-children-nigeria

[7] UNICEF, 'Every Child Alive,' 11 July 2018. Source: https://www.unicef.org/nigeria/stories/every-child-alive-nigeria

[8] United Nations Inter-Agency Group for Child Mortality Estimation, 2019. Source: https://data.unicef.org/about-us/

stillbirths occur in labor and childbirth and are mostly preventable[9]. Neonatal deaths are significant contributors (30 percent) to under five mortality (2018 NDHS). High rates of home deliveries with unskilled providers are a key driver of newborn deaths. The 2022 BSS reinforces this as it found newborn practices, including but not limited to skin-to-skin contact and cord care, improved among women who delivered in a health facility across all three states compared to those who birthed at home. Limited knowledge among women and families about newborn danger signs and poor health seeking behavior are other drivers of newborn deaths strengthening the need for continued SBC investments and community-based health services.

Child Health: Infant and Under-5 mortality rates are at 63 and 110 deaths per 1,000 live births respectively with only 39 percent of children aged 12-23 months receiving all basic vaccinations (NDHS 2023-24). The NDHS also reported that while care seeking for the largest contributors to child deaths improved (advice or treatment was sought for 60 percent of children under age 5 who had symptoms of ARI and diarrhea), prompt care (on the same or next day) remained low (only 29 percent and 50 percent of these children sought care promptly). The BSS found positive shifts in uptake of any vaccination, improved trust in health care worker and systems delivering RI, but reported persistent mistrust in vaccine efficacy/benefits, gaps in shared norms regarding vaccination and spousal opposition, signaling need for continued, targeted SBC interventions, including those that promote community and male engagement.

Nutrition: Malnutrition remains a serious public health and development concern in Nigeria, severely affecting the most vulnerable populations, especially children, adolescents, and women. NDHS 2023-24 found that among children under 5, about 40 percent are stunted; 8 percent suffer from wasting (low weight for height); and an estimated 27 percent are underweight. As with other indices, these numbers vary by geopolitical zones (with higher prevalence of wasting in the south south), rural-urban and socioeconomic quintiles. The 2022 BSS which sampled women exposed to USAID funded SBC programs reported positive shifts in cognitive (awareness of breastfeeding and its benefits) and social factors (spousal support) influencing the practice of exclusive breastfeeding while documenting persistent normative barriers (such as widespread practice of giving non-breastmilk liquids to a child in the first three days after birth). Similarly, the consumption of minimum dietary diverse meals by children under two improved by at least 20 percentage points among women exposed to community level interpersonal interventions, progress remains challenged by cognitive, normative, and structural factors.

Malaria: The 2021 Nigeria MIS reported a fever prevalence of 22 percent in children two weeks before the survey, down from 42 percent in 2010. The prevalence of malaria parasitemia in rural populations is 2.5 times that in urban populations (27 percent vs. 11 percent), and, when compared to the highest socioeconomic group, the prevalence among children in the lowest socioeconomic group is six times higher (31 percent vs. 5 percent). Access to, and use of insecticide treated nets (ITNs) is a priority prevention intervention and behavior. Nigeria's use:access ratio dropped from 0.7 (DHS 2018) to 0.6 (MIS 2021) with wide variations from 0.3-0.8 across states, necessitating continued investments in tailored SBC interventions to address behavioral factors.

The 2021 MIS reported a 31- percentage point difference between children for whom care was sought (62.8 percent) and sought promptly[10] (31.7 percent). Among children for whom advice or treatment was

[9] World Health Organization (WHO), Reaching every newborn national 2020 milestones: country progress, plans and moving forward, WHO, Geneva, 2017, p. 17

[10] Prompt care-seeking (within 48 hours of onset of symptoms) for febrile children is an evidence-based accelerator behavior.

sought, 45 percent and 31 percent sought from the public and private health sectors respectively. Evidence suggests a mix of internal and social factors facilitate or create barriers to prompt care-seeking, many of which may be amenable to SBC interventions. Additionally, providers tested 24.3 percent of children with fever, for whom formal care was sought (from 14 percent in DHS 2018), suggesting continued room for behavioral interventions to improve health worker adherence to diagnostic and treatment guidelines.

Despite improvements in the uptake of IPTp3+ from 17 percent (DHS 2018) to 31 percent (MIS 2021), missed opportunities for increasing IPTp coverage remain justifying the need for community-level SBC activities to address behavioral barriers to early and consistent ANC uptake, improve pregnancy-related ideations, and increase IPTp uptake. Finally, evidence supports that the introduction of malaria vaccines, deployed alongside the continued uptake of other previously existing tools e.g. ITN, IPTp, SMC, increases intervention efficacy.

Tuberculosis: According to the World Health Organization (WHO), Nigeria has the highest TB burden in Africa, ranks sixth globally and is a high burden country for TB-HIV Co-Infection and Multidrug Resistant TB (MDR-TB). While the estimated incidence rate has remained the same (219/100,000 population) over the past ten years, the total estimated incidence has increased from 357,000 in 2010 to 479,000 in 2022. Of the 479,000 estimated incident TB cases in 2022, about 71,000 (15 percent) were children, 27,000 (6 percent) were persons living with HIV (PLHIV), 12,000 (3.2 percent) had DR-TB and 125,000 (27 percent) people died from TB[11]. Following the United Nations high level meeting (UNHLM) in September 2023, Nigeria committed to the new targets including reaching 90 percent of people with TB prevention and care services, using a WHO-recommended rapid test as the first method of diagnosing TB; providing social benefit packages such as health insurance to all people with TB; licensing at least one new TB vaccine; and closing funding gaps for TB implementation and research by 2027[12]. At the end of 2022, TB treatment coverage rate was 59 percent, notifying 282,184 new and relapse TB cases, a significant stride from 24 percent in 2018[13]. The goal of the Mission TB Strategy is to help Nigeria make significant strides to accomplish the UN HLM targets and meet the WHO goals of ending the global TB epidemic by 2035 with a focus on strengthening case finding and treatment within the subpopulations with the largest gaps in treatment coverage - children and men of reproductive age.

Zoonotic diseases: In 2023 alone, Nigeria was faced with many re-emerging zoonotic, food-borne, and environmental-borne disease outbreaks such as Lassa fever, rabies, cholera, highly pathogenic avian influenza (HPAI), mpox, diphtheria, anthrax, bovine TB and yellow fever. This is despite the One Health strategy's list of top five ranked priority zoonotic diseases (PZDs) of rabies, avian influenza, Ebola Virus Disease (EVD), swine influenza and Anthrax. Since 2021, USAID/Nigeria has supported risk communication systems strengthening, public facing risk communication and community engagement (RCCE) interventions targeting high risk populations for zoonotic diseases, contributing to improving Nigeria's Joint External Evaluation (JEE) Scores across key RCCE indicators.

Social and Gender Norms: Gender roles, norms, and inequalities influence multiple health outcomes (e.g., risk for HIV, use/non-use of contraception, use of ANC and delivery services). As noted above, utilization of health care is affected by education levels, economic factors, and cultural beliefs and practices. Other determinants include knowledge about benefits and availability of health facilities and

[11] Nigeria Profile, WHO Global TB Report 2023

[12] WHO 2023. World leaders commit to new targets to end TB. United Nations high level meeting (UNHLM) in September 2023. https://www.who.int/news/item/22-09-2023-world-leaders-commit-to-new-targets-to-end-tb

[13] FMOH NTBLCP 2022 Annual Report

services, perceived risk and susceptibility to an illness, gender and power dynamics, perceived quality of services including those related to negative provider attitudes and behaviors, and the health care system itself. For example, delay in seeking care (phase I delay) is a recognized contributor to adverse pregnancy outcomes in Nigeria. Factors such as cost of services, social status, health beliefs and personal characteristics of the users have been found to largely influence decision to seek timely obstetric care for pregnant women[14].

The likelihood of seeking advice or treatment increases with a caregiver's level of education and wealth. Studies have continued to document that health-related knowledge does not translate to behavior change or increased utilization of services. For example, the main factors for giving pre-lacteals to babies are social norms, buttressing the need for SBC interventions that identify, deploy interventions to shift, and measure changes to social and gender norms.

Power dynamics within households, especially in relation to decision making and economic means, also largely influence the time and place for seeking health care. For example, only 34 percent of currently married women participate in three household decisions (regarding their own health care, household purchases, and visits to their family or relatives), while 37 percent are not involved in any of these decisions (NDHS 2018). Women's participation in household decision making can be used to examine the relationship between women's empowerment and selected health outcomes. For example, the more decisions in which women participate, the higher their contraceptive use (27 percent of women participating in all three decisions use a contraceptive method, as compared with 8 percent who do not). Additionally, several and widespread social norms enable gender-based violence (GBV), which in turn impacts on health seeking behavior and outcomes. For example, among ever married women, 36 percent report that they have ever experienced physical, sexual, or emotional violence. Of these, more than half of women (55 percent) have never sought help to stop the violence. Among those who do not seek help, their own families are the most common source of help. Finally, men tend to engage in less health-seeking behavior compared to their female counterparts because the primary health care system is perceived to cater to maternal and child health priorities—ANC, delivery, and routine immunization. Despite these touch points in accessing care, there are a lot of missed opportunities to provide integrated RH services to men, women, adolescents, and children.

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4943510/

PART B: Priority Development Challenges

While weak health systems (inadequate infrastructure, limited number of trained health care providers) explain partly the gaps in the supply side, unhealthy behaviors and practices, diverse sociocultural and religious factors explain gaps on the demand side accounting for the poor health indices in Nigeria. Furthermore, uptake of optimal preventive and health-seeking behaviors are low. There are varying levels of understanding of, when, how and where to obtain health services (health literacy). Service provider behavior can influence (positively or negatively) health seeking practices. People are treated as passive recipients of health and nutrition services. In addition, certain prevailing gender and social norms are barriers for healthy practices and behaviors. The limited levels of health literacy, health system literacy and healthcare seeking behaviors results in poor health outcomes, particularly for FP/RH, MNCH, TB, malaria, nutrition; sanitation and hygiene; and zoonotic diseases risk.

Therefore, this Activity will address a number of priority challenges to achieve the proposed results and contribute to broader population-level changes in health outcomes in targeted states. These challenges were derived from stakeholder consultations at national and subnational levels and lessons learnt from recent USAID/Nigeria investments and include:

- Continued misinformation and disinformation about health, health services and health products (e.g. vaccines)
- Limited end user/patient/client/community member engagement to drive evidence-based SBC campaigns
- Cultural factors and poor attitudes of health care providers towards pregnant women and their significant others or caregivers.
- Lack of adequate infrastructure, commodities and other supplies to support delivery of quality care
- *Limited use of the full range of evidence-informed SBC approaches; specifically, an overreliance on communication-based approaches.* To advance the field, the SBC community must continue to prioritize approaches that allow for improved efficiency or behavioral impact in a variety of settings and contexts. In Nigeria, many local organizations continue to rely on communication-based approaches, sparingly adopting newer, proven, or promising approaches such as behavioral economics, human-centered design (HCD) or information and communication technology, often at a limited scale. This Activity will need to support the SBC community to proactively seek out and test emerging and proven approaches from fields such as advertising, artificial intelligence (AI)/machine learning, psychology, neurosciences and establish mechanisms that support ongoing innovation.
- *Inadequate application of norms and gender-transformative programming to address deep-rooted inequalities.* Contextually (see Annex A), inequitable social and gender norms and power dynamics continue to restrict the participation and limit the agency of, particularly women, girls, and other marginalized groups in health decision making, access and uptake of lifesaving behaviors, services, and products. This Activity will advance the integration of evidence and learning on programming that seeks to transform social inequitable gender relations, power dynamics and shift norms that influence health behaviors throughout the program cycle. The goal will be to create an enabling environment for positive and sustained SBC and improved uptake of health services and products at the community level.
- *Uneven capacity and opportunity among local actors to drive and sustain programming* – market research has shown that there are many local organizations in Nigeria that have developed and are implementing their own health programs that USAID can support. For example, the report of a 2023 desk review to document capabilities of local organizations identified 308 local organizations, with 87 and 99 local organizations reporting some expertise and experience with

implementing SBC and health service delivery, including at community level respectively. Additionally, preliminary analysis of the Mission-issued Localization in Health Request for Information, which received 225 responses from Nigerian local organizations, suggests varying levels of expertise and sufficient geographic spread in SBC and community health service delivery programming in Nigeria. Previous USAID investments in SBC capacity strengthening have been directed primarily at the public sector (government ministries, departments, and agencies). An evaluation of these investments found incremental gains in capacity at individual (improved skills for planning, facilitating and monitoring SBC activities, for developing health messages, community mobilization), organizational (improved skills for SBC partner coordination) and systems level (increased state adoption and domestication of operational and orientation guidelines for ward level committee engagement in health).

- *Insufficient integration of SBC into health systems to optimize health system performance and effect change of system actors* - Provider behavior change (PBC) interventions remain an important and underused tool for improving health service quality, client satisfaction, and provider job satisfaction. The success of PBC interventions is often dependent on wider health system factors, such as organizational norms, supportive systems, and supervision, often driven by other health system actors. While continued attention is needed to maintain a focus on provider behavior, attitudes and norms, this Activity will deploy a health systems lens, expanding beneficiary lens to include health systems actors at managerial and governance levels, especially at the local government level.
- *Inadequate and inconsistent measurement of behavioral outcomes and impact have hindered the assessment of program effectiveness and use of local data for evidence-based decision making* – USAID/Nigeria has led ground-breaking SBC research investing in three rounds of cross-sectional behavioral sentinel studies, which collected extensive data on intermediate (or ideational) factors influencing thirteen RMNCH-NM behaviors among beneficiary households across three states in North West Nigeria. Data and findings from these studies, highlighted in the context section above, remains necessary for design and adaptive management purposes as well as improved understanding of whether and how SBC programming is effecting change in desired health outcomes. Consistent measurement, with the right rigor and frequency, will ensure catalytic investments in high-quality, effective SBC programming. Monitoring and evaluation approaches also need to be strengthened to better deal with complexity and to measure and monitor complex factors such as normative change.
- *Gaps in country-led, coordinated SBC responses to mitigate recurring health shocks* - on an annual basis, *e*merging and recurring health outbreaks and epidemics continue to pose disruptions to health services, product availability, systems, and outcomes. Effective responses, including for RCCE, to mitigate spread and impact often require interdisciplinary, coordinated multi-sectoral and gender-integrated approaches, yet the organization of Nigerian health systems remain fragmented, and capacity remains suboptimal, especially at sub-national levels. Also, despite the clear and important role of RCCE in preparedness and response to health shocks, RCCE is often underfunded, undervalued, reactive (rather than proactive), and/or not data informed. Finally, the rapidly evolving nature of outbreaks often require adaptive programming approaches; the nuanced data needed to enable these approaches is often not intentionally generated, and competencies for adaptive management are weak.
- *Untapped opportunities to understand and thoughtfully incorporate new technologies and media into SBC and Community Health programming* – Harnessing the potential of digital platforms, mobile apps, and social media for improved programming both to expand access to services at community level or to expand reach and coverage of SBC interventions as well as monitoring (e.g., surveillance, data collection and management, and information exchange) remain largely

unexplored or untapped to its full potential. There is the need to build on and integrate such efforts into national systems to achieve sustainability. Development and uptake of new technologies is also fast paced, driven mostly by Nigeria's tech savvy youth population, requiring public health practitioners to build media and digital literacy skills to keep up. While considering and exploring approaches to close the digital divide (e.g. male/female or urban/rural disparities), this Activity will pursue thoughtful innovations to incorporate new technology in ways that expand access, reach and coverage of community health and SBC interventions.

- *Limited scale, coverage, and absence of a consistent approach to community-based health intervention programs* – Community-based programs, often utilizing volunteer community workers to expand the availability and accessibility of primary health care services, information and products are not new to Nigeria. Recognizing the role of community-based approaches to achieving UHC, Nigeria launched its national community health influencers, promoters, and services (CHIPS) program in 2018 to harmonize existing community-based programs into one category of community-based health workers, served by one training curriculum and one M&E framework. Nigeria operates a decentralized health care system, with states having autonomy in the decision to adopt/adapt and scale implementation of national programs such as CHIPS. Adoption of this promising program has remained suboptimal across states, have been mainly donor-funding dependent, with variations in approach (e.g. some states deployed CHIPs for single health areas/service e.g. malaria case management) and scale (e.g. CHIPs are deployed in a few local government areas). The NPHCDA is currently leading an ongoing evaluation of the success, challenges, and lessons from the CHIPs program with the intention to refine and redesign. The redesigned CHW program will greatly shape this Activity's design and implementation of community-health strategies and approaches.

PART C: Activity Alignment with USAID and Government of Nigeria Priorities

Alignment with USAID Global and Mission Priorities

This Activity will align with and advance the development priorities of USAID and the U.S. Government. USAID's work advances U.S. national security and economic prosperity, demonstrates American generosity, and promotes a path to recipient self-reliance and resilience, including in Nigeria. This Activity will advance the goals of key USAID health policies and initiatives, and global efforts detailed below.

Reproductive Empowerment and Family Planning

USAID's family planning and reproductive health (FP/RH) programming supports partner countries to realize a world where ongoing improvements to sexual and reproductive health (SRH) contribute to longer, healthier, and more prosperous lives for all. To reach this transformational destination, USAID Nigeria supports three rights-based pathways, articulated by USAID Pathways to Progress, that collectively operate at societal, systems, and individual levels. These pathways include:

1) SBC interventions to a) enable individuals, couples and communities to have accurate information, skills, and ability to decide, voice, and act on their reproductive intentions and achieve the highest attainable levels of SRH across their lifetime and b) strengthen local communities, organizations, institutions, and governments to create and foster social norms and policies that support individuals to make and act on their own SRH decisions, free from violence, coercion, and discrimination;
2) Service readiness and health systems strengthening support to increase quality and access to people-centered sexual and reproductive healthcare; and
3) Contraceptive commodity security through data-informed forecasting, quantification, procurement and distribution of SRH/FP commodities, including to the last mile.

This activity will advance the SBC pathway, including support to cross-cutting best practices such as youth engagement and integration in programming and gender-transformative programming (i.e., programming that addresses the root causes of gender inequalities and transforms gender relations to promote equality and achieve FP/RH objectives. Given Nigeria's demography and youth bulge, youth-centered programming is particularly important to enable adolescents to delay childbearing and to contribute to improved economic, social, and health outcomes for adolescent girls and boys and their communities. Meaningful, participatory engagement and programming will include a focus on underrepresented groups, indigenous groups, and racial and ethnic minorities. Finally, this activity will continue to support the FP2030 partnership and hub including the government, donors and multilateral agencies, civil society organizations, and private sector entities working together to advance family planning in Nigeria.

Maternal, Child Health and Nutrition

In the last 30 years, USAID has contributed to progress in improving maternal and child survival, across the world and in Nigeria but gaps remain (see section in Nigeria context). In March 2023, Administrator Power released the Agency's Preventing Child and Maternal Deaths (PCMD) Framework, which provides the overarching direction of USAID's MCH program. Through this framework, USAID will work to reduce preventable child and maternal mortality in 25 countries, including Nigeria, to 12 percent or lower of total deaths by 2030. USAID/Nigeria's MCH support is guided by, and aligns with the six strategic approaches including: anchoring our response in primary health care systems to optimize health outcomes; reaching the hardest to reach mothers and children; identifying and tailoring solutions through locally-led development; investing in the health workforce as the foundation of health systems; catalyzing country commitment; and generating and using data and evidence in decision making. The

Maternal and Child Health and Nutrition (MCHN) Technical Roadmap further focuses on the pillars of coverage, quality, and equity and articulates a measurable results framework. The Roadmap guides USAID Nigeria on priority actions to support the achievement of 2030 Sustainable Development Goals (SDGs) for mothers, newborns, and children. The Roadmap acknowledges the centrality of behaviors and norms to support healthy individuals and communities. This activity will contribute to the achievement of priority areas for MCHN SBC investments including efforts to improve quality of care including respectful care, provider behavior change, and demand for MCH services.

USAID's Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM) are global action plans supported by a multi-partner group to strengthen synergy and coordination of actions at the global and country level to accelerate reductions in maternal and newborn mortality and to prevent stillbirth. The International Maternal Newborn Health Conference (IMNHC) in Cape Town in May 2023 heralded the launch of the first Joint ENAP-EPMM Progress report which highlighted coverage targets and milestones (renewable every two years) and stimulated the development of 28 ENAP-EPMM country acceleration plans, including for Nigeria, that identified priority actions to achieve the targets. Child Survival Action (CSA) works alongside EPMM and the ENAP to address mortality across the lifecourse. Nutrition interventions directly contribute to ENAP-EPMM-CSA goals. This activity will contribute to efforts to strengthen community platforms for the delivery of high impact interventions essential for maternal, newborn and child survival, and to reduce fragmentation/optimize available resources.

In 2021, the U.S Congress passed the Global Malnutrition Prevention and Treatment Act, which directs USAID to prevent and treat malnutrition globally. USAID's Implementation Plan serves as a roadmap for USAID's investments in the prevention and treatment of malnutrition for the period from October 2022 to October 2029. A number of health-related nutrition behaviors which are vital to improve nutrition outcomes are highlighted in this plan. USAID/Nigeria's Multi Sectoral nutrition strategy and Action Plan (2022–2026) addresses the prevention of all forms of undernutrition, with emphasis on those that target the "1,000 day window of opportunity" from pregnancy through a child's second birthday – a period in which good nutrition is critical for optimal physical and cognitive development. Expanding access though community health services as well as SBC for improved nutrition behaviors[15] is a key aspect of this strategy. This activity will build on recent mission investments in SBC for nutrition that have focused on improving the quality of SBC design, implementation, and measurement. Applying innovative techniques that have proven successful in other sectors to nutrition in the health sector to accelerate progress in preventing malnutrition is a priority area for this activity.

Malaria

The past two decades have seen extraordinary progress in malaria control efforts globally. The World Health Organization's (WHO) 2022 World Malaria Report estimates that more than 10.6 million malaria deaths and 1.7 billion malaria cases were averted worldwide between 2000 and 2020. During that same time period, many countries, including Nigeria, have made notable progress towards subnational or national malaria elimination. For example, fever prevalence reduced from 42 percent to 22 percent among children between 2010 and 2021. Despite these achievements, progress has been uneven and has fallen short of global and national goals and targets. *The U.S. President's Malaria Initiative 2021-2026 Strategy: End Malaria Faster* articulates a vision for how PMI will contribute to the global goals of saving more than four million lives and averting over 1 billion cases by 2025. The Strategy

[15] Early initiation of breastfeeding and exclusive breastfeeding up to six months; appropriate complementary feeding; increased dietary diversity for children 6-24 months; and increased dietary diversity for pregnant women

maintains the broader orienting goal to work with 30 PMI partner countries, including Nigeria to further reduce malaria deaths and substantially decrease malaria morbidity, towards the long-term goal of elimination and includes five core focus areas: reaching the unreached; strengthening community health systems; keeping malaria services resilient; investing locally; and innovating and leading. Achieving the goals and objectives outlined in the End Malaria Strategy will require coordinated and innovative behavioral programming to achieve optimal uptake of current and emerging malaria interventions e.g. malaria vaccines among affected communities and the providers who serve them. This activity will build on lessons from nearly a decade of mission investments in proven and emerging malaria SBC approaches in Nigeria to scale up implementation while continuing to innovate.

HIV/AIDS

The United States Government (USG) is leading other donors and governments to coalesce around its ambitious goal of controlling the HIV epidemic and ending HIV/AIDS as a public threat by 2030. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the U.S. government's initiative to help save the lives of those infected and affected by HIV/AIDS around the world. In Nigeria, PEPFAR seeks to end HIV/AIDS as a public threat by 2030 by furthering the achievement of the 95-95-95 targets through accelerating core interventions for epidemic control, with particular emphasis on impact; efficiency; sustainability; partnership; and human rights. To reach these targets, PEPFAR recognizes and has identified behavioral science as a key component in its 2023-2028 strategy. Achieving the 95-95-95 targets will require effectively addressing related social and behavioral factors affecting demand for biomedical prevention methods such as Pre-Exposure Prophylaxis (PrEP) and voluntary medical male circumcision (VMMC), HIV testing, treatment initiation, and continuity and adherence to HIV treatment. This activity will advance areas of particular interest in Nigeria which include but are not limited to closing inequity gaps (e.g. lower case finding among men and children), addressing last mile and persistent challenges (such as lower adherence to HIV treatment among adolescents and young adults), and supporting the introduction of longer acting treatment and new options for PrEP.

Tuberculosis

USAID leads the US Government's efforts to combat TB in collaboration with stakeholders and partners around the world. The USAID Global TB Strategy (2023 -2030) articulates the " vision, mission, goals, results framework, strategic objectives, and principles to contribute to partners' collaborative efforts to meet upcoming United Nations HighLevel Meeting on TB targets, end the TB pandemic by 2030, and eliminate TB by 2050"[16]. The strategy contributes to the goals of the WHO's End TB Strategy as well as the SDGs. Nigeria is one of the 24 high burden countries that USAID provides bilateral assistance and supports National TB Programs with their TB control efforts. USAID's evidence-based expansion of its reach, cure, prevention and innovative approach is implemented through a mix of Technical Assistance and Direct Service Delivery interventions which are then scaled up by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF ATM). Achieving the UN HLM targets in the complex and under-resourced Nigerian health sector requires an intentional focus on doing-more-with less while seeking to address the social factors that influence the spread of TB and those that affect care seeking for those with symptoms. Programming will focus on improving uptake of services among priority populations, reducing pre-treatment loss to follow-up or refusal of treatment, improving treatment adherence and improving TB preventive practices as well as uptake of TB preventive therapy.

Global Health Security

Around the world, millions of people have lost their lives and livelihoods because the world lacked

[16] USAID Global TB Strategy 2023 - 2030

capacity to prevent, detect, and respond to COVID-19 and other emerging infectious disease threats. USAID's Global Health Security (GHS) Program seeks to prevent and mitigate the increasing occurrence and severity of epidemics, pandemics, and other emerging infectious disease threats. USAID partners with countries, including Nigeria to build and strengthen local partnerships and develop measurable sustainable capacity to adopt evidence-based and innovative solutions to prevent, rapidly detect, effectively respond to, and ultimately recover from emerging infectious disease threats – whether naturally occurring, accidental, or deliberate. USAID/Nigeria advances the implementation of the One Health approach, recognizing the connection between the health of the environment, animals, and people, bolstering the GHS architecture; and building resilience in concert with USAID's broader global health programs.

This activity will support Nigeria to achieve demonstrable increase in capacity in at least one of five 5 key GHS technical areas, risk communication and community engagement (RCCE), in alignment with the relevant priority indicators as defined in the Joint External Evaluation (JEE) 3rd edition. This activity will support Nigeria to continue to use data to identify and address highest priority zoonotic and outbreak diseases, assess risks and gaps; design and implement interventions to mitigate risk, encourage appropriate treatment seeking behavior, promote interactive communication channels, and improve community preparedness. Global guidance such as WHO's Risk Communication and Community Engagement Guidance present a body of knowledge for continued investments in RCCE programming to advance USG's GHS goals.

Cross-Cutting Priorities

Gender Equality and Women's Empowerment

USAID's 2023 Gender Equality and Women's Empowerment Policy and United States Strategy to Prevent and Respond to Gender Based Violence (GBV) cuts across all development sectors, programs, and objectives, including the health areas cited above. Achievement of the policy's objectives -- reduce gender disparities, strive to eliminate gender-based violence and mitigate its harmful effects, increase women's and girls' agency, advance structural changes and promote equitable gender norms – contributes to individual agency, gender-equitable relationships, enabling systems and environments in which women, men, gender diverse individuals, youth, and couples can more easily adopt healthier behaviors and utilize health services. This activity will address these objectives as critical factors within community health and SBC processes across the project life cycle, within the outcomes and impact of programming.

Youth

An enhanced focus on adolescents and youth is vital to USAID/Nigeria's ability to achieve the health and development goals of the Country Development Cooperation Strategy (CDCS) 2020-2025. The continued practice of child, early, and forced marriages and unions and other forms of GBV yields severe and negative consequences for the present and future health and wellbeing of girls, boys, and their children. USAID's Youth in Development Policy's (2022) goals are to: increase the meaningful participation of youth within their communities, schools, organizations, economies, peer groups, and families; enhance their technical and soft skills; provide opportunities to contribute to communities and for workforce development; and foster healthy relationships so they may build on their collective leadership. Recognizing that adolescence and young adulthood are critical periods for establishing both social norms and behavioral patterns which continue into adulthood and influence health outcomes of both individuals and their families, educational attainment, and economic security across the lifespan, this activity will maintain a meaningful focus on young people, including married adolescents and gender

diverse and marginalized youth, as a critical priority audience for community health and SBC interventions.

Health Systems Strengthening

USAID's publication on Social and Behavior Change and Health System Strengthening highlights the use of SBC to strengthen the overall health system. SBC methodologies and approaches can be integrated into health system strengthening (HSS) efforts to address the social and behavioral drivers of key actors that affect health system performance. This integration can help change the behavior of providers, their supervisors or policy makers (e.g. by providing insights into why healthcare workers may not be providing quality care by analyzing and responding to underlying bias or social norms that may be indirectly weakening access to high quality and equitable health care), and increase chances for social change, which go beyond the accumulation of changes at the individual level and transform social norms and structures that influence individual and collective decision-making. This activity will work closely with other mission funded HSS activities and include a focus on the use of SBC approaches to improve the design and uptake of financial protection schemes (Nigeria's growing health insurance program); link households to resources, services and networks (Nigeria's conditional cash transfers and other demand side incentives); mobilize communities and health system actors around uptake and service quality; and strengthen social accountability efforts.

Climate Change

USAID's 2022-2030 Climate Strategy recognizes climate change as a global crisis that threatens progress made through decades of investments in health and development. This strategy emphasizes a "whole-of-Agency" approach and underscores the negative effects of climate change on physical and mental health, mortality, food security, and access to essential services, such as health care; water, sanitation and hygiene; and the exacerbated impact of climatic shocks in worsening health outcomes during disease outbreaks. To strengthen climate resilience of populations vulnerable to climate impacts, the strategy highlights the role of SBC programming to foster the adoption of new climate-friendly behaviors by a range of actors; shift social and gender norms to provide greater voice for marginalized and underrepresented groups in climate action; and address the structural barriers impeding access to products, services, and financing as part of larger climate change initiatives. This activity will contribute to addressing the complexity of climate change in Nigeria, with a focus on applying insights and evidence on behavior change to inform the design and integration of climate and health interventions.

Localization

Localization at USAID is defined as intentional changes to policies, processes, staffing, and funding decisions to support partnerships and programs that equitably empower local actors, strengthen local systems, and facilitate local leadership so that development and humanitarian assistance are more effective and sustainable. USAID/Nigeria's health office is deepening its commitment to being transparent, inclusive, and responsive to and supportive of local actors in leading their own development. To achieve this, this activity will fully consider, and integrate relevant aspects of localization objectives and best practices, and contribute to measurable results as outlined in USAID's locally-led development, local systems, local capacity strengthening and local capacity strengthening policy.

Disability, Indigenous Rights, and Racial and Ethnic Equity

As detailed in USAID's Disability Policy, USAID is committed to the inclusion of people who have physical and cognitive disabilities and those who advocate and offer services on behalf of persons with disabilities. The policy promotes nondiscrimination against and equal opportunity for persons with

disabilities. As of December 2023, this policy is undergoing updates. USAID's Policy on Promoting the Rights of Indigenous Peoples (PRO-IP) guides development practitioners to strengthen the design and management of programs that affect Indigenous Peoples. Finally, new in 2023, USAID's Racial and Ethnic Equity Initiative builds on USAID's long-standing efforts to ensure development programming is fully inclusive of historically marginalized racial, ethnic, and Indigenous communities, including people of African descent, and further incorporates equity into USAID operations, programming, and learning. Implementation of this CH and SBC activity will align with the priorities laid out in these policies and initiatives.

In addition to the above outlined policies, strategies and initiatives, this activity will also advance other priority plans including FP High Impact Practices; the Global Health Security Strategy; USAID Resilience Policy and the USAID's Climate Strategy 2022-2030.

A.5.4 Alignment to Nigeria Health Priorities and Strategies

This Activity will advance the goals of key GoN health policies and initiatives, specifically, those related to demand generation or advocacy, communication, and social mobilization These will include but not limited to the 2024-2026 NHSRII and its associated Sector Wide Approach (SWAp); 2019 National Health Promotion Policy and its 2020-2024 strategic plan for health promotion; NPHCDA's strategic blueprint (2024-2026); the national community health worker program; One Health Strategic plan and National Action Plan for Health Security (currently in revision); the 2021-2025 Nigeria Malaria Strategic Plan (NMSP) and its related National Malaria Advocacy Communication and Social Mobilization Strategy and Implementation Guide; the National TB Strategic Plan (2021-2025); National Family Planning Blueprint; National Reproductive Maternal Child and Adolescent Health and Nutrition Strategy (currently in revision); National FP2030 commitments; and all other relevant GON strategies, policies, and initiatives outlined. Beyond health specific policies, this Activity will advance the objectives of relevant national youth, women empowerment, gender, and environmental health policies. All of these strategies, policies, and initiatives will shape the context in which this Activity will prioritize investments.

PART D: USAID/Nigeria Historical Investments – Scope and Key Achievements

USAID/Nigeria's health investments are focused on ending preventable child and maternal deaths; malaria prevention, control, and elimination; increasing and sustaining access to safe, voluntary, high-quality family planning and reproductive health services; and combating infectious diseases and pandemic threats through global health security. This Activity will build on the gains of USAID/Nigeria's historical investments in community health programming, SBC research and interventions, most recently through the USAID Integrated Health Program, and the Breakthrough Research and Breakthrough Action mechanisms to contribute to improvements in reproductive, maternal, newborn, child and adolescent health, nutrition, malaria, and TB (RMNCAH-NM and TB) care seeking behaviors and shift cultural and social norms including those related to gender equity, that are antithetical to improving the health status of Nigerians.

USAID/Nigeria Social Behavior Change Investments – scope and Key Achievements

SBC programming has long been an area of strategic priority for USAID/Nigeria ("the Mission"), and USAID remains one of Nigeria's leading funders of SBC research and programming for health. The mission has invested significantly in social, and behavior change communication, an important SBC approach, for more than a decade. In the last seven years, the Mission began to invest in SBC approaches that incorporate practices from other BC fields, such as behavioral economics, and human-centered design into supported SBC research and programming. This sustained investment in SBC has supported the growth of communities of practice, and of SBC professionals in the public sector at national and subnational levels, allowing for focused attention to - and progress against - priority health behavioral challenges.

Much of the Mission's investment in SBC to date has focused on improving accelerator health behaviors pertaining to FP/RH, MNCH, malaria, nutrition, and TB. SBC investments have also included those to combat pandemic threats such as COVID-19 and Ebola through focused RCCE, preparedness, and post-epidemic recovery programming. Cross-cutting areas such as gender and youth have also been a focus across the health sector, including SBC programming. The mission has largely funded SBC programming through buy-ins into global awards under the Bureau for Global Health's portfolio and these have varied in size and scope. These activities include Communication for Change (C-Change) (2007-2012), the Health Communication Capacity Collaborative (HC3) (2012-2017), Breakthrough-RESEARCH (BR) (2017-2023) and Breakthrough-ACTION (BA) (2017-2025).

Specifically for C-Change[17] USAID/Nigeria funded the creation of tools and sustainable channels for SBCC training, including creating certificate and Masters degree programs through centers of excellence in Universities University of Calabar (UNICAL) and Cross River State University of Technology (CRUTECH). Both Universities incorporated SBCC theory and practice into their communication and/or public health curricula to strengthen institutional capacity and to build and sustain a new cadre of SBCC professionals through graduate-level SBCC courses supported and supervised by Ohio University partners. C-Change also supported the development of the Strategic Framework for Malaria Communication in Nigeria. With Health Communication Capacity Collaborative (HC3), USAID/Nigeria extended support to include 1) direct implementation of SBC interventions, primarily focused on malaria behaviors and expanding to include FP behaviors in the second year (2015) and in two states and 2) increasing public sector capacity for the design, implementation and monitoring of quality SBC programming at national and subnational levels. HC3 Nigeria also supported SBC policy development and implementation as well as the establishment of in-country SBC knowledge management and communities of practice.

[17] Full report here

Mid-and-end-evaluation reports documented lessons learned, the premise upon which the mission built subsequent SBC investments in Breakthrough Action (BA) and Breakthrough Research (BR) mechanisms.

USAID/Nigeria SBC investments in BR contributed to expanding the evidence-base on cost, program and cost-effectiveness of an integrated, multi-component Social Behavior Change (SBC) program and addressed priority programmatic research questions. Results provided actionable feedback for the adaptation of implementation approaches (led by BA) as well as evidence on what works in SBC programming, for whom and in what context. The thrust of the buy-in was the design and conduct of three-waves of a Behavioral Sentinel Survey (BSS) which assessed year-on-year shifts in ideational or behavioral determinants of a range of priority behaviors (to inform adaptive implementation), and contributed data points for the impact evaluation which assessed program and cost effectiveness of integrated SBC viz malaria-only SBC programs. In addition, BR completed three qualitative studies to assess effectiveness of specific SBC approaches such as efforts to influence gender norms through coalitions of religious leaders in Advocacy Core Groups, SBC capacity strengthening efforts in the public sector and sustainability of capacity strengthening efforts directed at ward development committees (WDCs).

USAID Nigeria's investment in BA is the single largest buy-in from a mission. It heralds the health offices investments in a complex integrated RMNCH, malaria, nutrition and TB SBC program with complementary malaria and or TB only SBC investments across twelve states and the FCT. BA Nigeria supports direct implementation using coordinated communication and non-communication based approaches. Communication approaches combine mass and social media; community-level programming; and interpersonal communication, and incorporates insights from non-communication-based approaches such as behavioral economics and human centered design to refine and enhance relevance and impact of SBC interventions. SBC investments have also leveraged the widespread access to mobile phones and social media to expand access to SBC messages and accelerate the spread of new ideas and norms as well as address misinformation/disinformation. All approaches are grounded in behavioral theory; informed by research and programmatic experience; and designed and implemented following a systematic and proven process.[18] Attention to social norms, including gender, audience engagement, participation and segmentation is integrated across all stages of intervention design and implementation.

USAID/Nigeria has made investments in applied behavioral sciences to address behavioral determinants of provider adherence to malaria diagnosis and case management guidelines, with considerable success and results. Efforts involved SBC partners leading the diagnosis, development and testing of prototypes or solutions and service delivery partners leading scaled implementation of successful solutions.

A critical component of SBC investments through BA focused on an intentional, systematic capacity strengthening approach for ward development committees (WDCs). WDCs are established by the National Primary Health Care Development Agency as part of the Ward Health Structure (WHS) in 2000, constituted by communities and responsible for the organization and management of development activities, including for health, in a ward (Nigeria's lowest level electoral unit). Using a structured capacity assessment tool, USAID/Nigeria supported the reactivation and capacity building across domains of leadership (governance), participatory planning, collaboration and coordination, resource mobilization and monitoring and evaluation. USAID supported the implementation of a performance-based capacity

[18] Such processes include JHU-CCP's P-Process, FHI360's C-Cycle, and PSI's DELTA, among many others.

strengthening approach[19] with "stages or tiers of capacity" phased in over time complemented with implementation of an adapted Community Action Cycle[20] a proven community mobilization approach that fostered community-led processes through which supported WDCs organized, set priorities (guided by frequently updated community health information boards), developed community health action and resource plans, mobilized resources, tracked progress, and acted collectively for improved health. A summary of capacity gains across six hundred and fifty nine (659) WDCs that USAID supported across five states can be gleaned from the sustainability evaluation report. USAID supported WDCs voluntarily[21] meet regularly to discuss health and development issues, encourage community participation in health and drive local accountability for primary health care.

In addition to work across multiple health areas, the mission funded a robust RCCE response to COVID-19 pandemic including introduction and deployment of the COVID-19 vaccine in Nigeria. Lessons from these efforts have since expanded to support the risk communication goals of GoN's one-health strategy and five-year GHSA roadmap. Support is continually shaped by data on localized disease outbreaks or epidemics, and closely coordinated with all relevant national and state level ministries and agencies as in close collaboration with other USAID and CDC funded GHSA implementing partners supporting other streams of the GHSA one-health strategy.

Finally, investments through BA has yielded two important knowledge management resources: Springboard, an online networking and sharing resource that supports and nurtures global-, regional-, and country-level SBC communities of practice, and the Compass, a curated, interactive online materials repository. Further information on BA is available publicly on the project website, as well as from the project's midterm evaluation report.

USAID/NIgeria Community Health Investments – Scope and Key Achievements

Nigeria's CHIPS program, established by the NPHCDA in 2018, was designed to bridge the gaps in access to health care, improve the continuum of care, link households to the healthcare systems, complement national data systems, improve health outcomes, and strengthen the community component of PHC, critical to attaining Universal Health Coverage (UHC). The program is structured to stimulate and support households in communities to seek PHC services through various delivery platforms, enabling clients to obtain essential promotive, preventive and treatment services by bringing these services closer to households through home visits, especially in rural/underserved communities. The program sought to harmonize existing community-based programs into one category of community-based health workers, served by one training curriculum and one monitoring and evaluation (M&E) framework.

Since 2018, USAID/Nigeria has supported GoN efforts at national and across selected states to operationalize the CHIPS program, established by the NPHCDA in 2018 to bridge the gaps in access to health care, improve the continuum of care, link households to the healthcare systems, complement national data systems, improve health outcomes, and strengthen the community component of PHC, critical to attaining Universal Health Coverage (UHC). Critical to the success of the program is the availability of a functional PHC center in the ward (one PHC per ward) that will serve as the site for referral, CHIPS personnel management, supervision, commodity, and data collation and reporting within

[19] Starting in the first tier with smaller, achievable community actions guided by USAID/BA to a second tier of more involved engagement and increased self-determination. Each tier is designed to build on the successes achieved by the community. Communities were required to meet performance-based selection criteria at each tier to be eligible for continued support from USAID/BA in the next tier.

[20] https://mcld.org/2016/04/15/methodology-of-save-the-children/

[21] Received no payments, acted using self-mobilized resources, often from member contributions, local philanthropists and private sector donations.

the ward. USAID's investments focused on enhancing service readiness in at least one PHC per ward across five states, and the national-level design and pilot implementation of the Community Health Management Information system (CHMIS) in Sokoto state. The mission has funded community health systems strengthening through several bilateral mechanisms including Integrated Health Program (IHP) (2017-2024); Health Workforce Management (2020-2025); Presidential Malaria Initiative for States (2018-2025) as well as through buy-ins into global mechanisms including Breakthrough Action Nigeria (BA-N) (2017-2025) and Local Health System Strengthening (2022-2024).

USAID/Nigeria GHS Investments – Scope and Key Achievements

Risk Communication and Community Engagement is also a core area of USAID/Nigeria GHS support. USAID programming advances real-time exchange of information, expert advice and opinions during unusual and unexpected events or emergencies. USAID programs disseminate information using a mix of communication and community engagement strategies, such as media and social media communications, mass awareness campaigns, health promotion, social mobilization, stakeholder engagement. Capacity building and infodemic management are also at the core of USAID GHS RCCE investments. Support is aligned with the JEE core indicators and relevant critical path elements.

Specific to strengthening RCCE systems for emergencies, USAID provided technical assistance and support for the development, validation, printing and launching of several strategic documents including but not limited to the Multi-hazard Risk Communication guideline, Infodemic Management guideline, Social Media Strategy and National Strategic Plan for the Elimination of Rabies; provided secretariat and funding support to the National Risk Communication and Community Engagement Technical Working Group (NRCTWG) providing technical assistance across nine disease-specific areas (Lassa fever, mpox, EVHD, yellow fever, rabies, diphtheria, COVID-19, anthrax, HPAI); support for the development of the RCCE capacity assessment tool, funded RCCE capacity assessments in two states (Bauchi and Plateau) and provided technical assistance for the assessment in three additional states (Ebonyi, Kebbi and Benue).

For risk communication with an assessment score moving from 2 (JEE 2017) to 3 (JEE 2023), USAID/Nigeria adopts a One Health approach to the development of messages and material across several disease areas, including Lassa fever, anthrax, Mpox and diphtheria. Key achievements include support for the development of a One Health RCCE Training Package for Public Health and Media Practitioners (facilitator's manual and annex); support for the deployment of a multichannel approach to message dissemination, including print, radio, TV, digital, social media channels; cultivated media partnership with over a hundred radio stations across 13 implementation states; enhanced the COVID-19 microsite and development of a website to harness multi-country research on select zoonotic diseases with an emphasis on risk and prevention behaviors, individual and sociocultural drivers, and the policy and communication environment that influences those behaviors; provision of dedicated technical assistance and support for the national infodemic management team; support for several national perception surveys e.g., for COVID, Lassa fever, mpox to inform evidence-based message development; development of a Social Media and Infodemic Management National training module.

On the community engagement indicator with an assessment score moving from 2 (JEE 2017) to 3 (JEE 2023), USAID investments supported the establishment and enhanced functionality of coordinating mechanisms such as social mobilization committees, public health EOC, One Health teams and infodemic management teams at subnational level, supported the development of a Community Engagement Strategy for Risk Communication and an advocacy toolkit; refinement and finalization of a rapid

assessment tool for Lassa fever and diphtheria as well as capacity building in data analysis, visualization, dissemination, and utilization guidance for key stakeholders in the public sector.