Independent Evaluation of the United Nations–Government Joint Programme to Accelerate the Sustainable Development Goals in Nigeria 2020–2022:

Institutionalizing social protection for accelerated Sustainable Development Goals' implementation in Nigeria

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ILO

UNDP

unicef
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WFP
wfp.org

World Health Organization

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FOREWORD

On behalf of the Federal Ministry of Finance, Budget and National Planning (MFBNP) and the United Nations (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 the Sustainable Development Goals (SDGs) in Nigeria 2020–2022: Institutionalizing social protection for accelerated SDG implementation in Nigeria (JP). It was funded by the UN Joint SDG Fund from its headquarters in New York and the Government of the Federal Republic of Nigeria as part of their commitment to achieving the 2030 Agenda for Sustainable Development and leaving no one behind on the path to universal peace and prosperity.

The Nigeria-based JP was a two-year project – running from January 2020 to June 2022 – with the aim of institutionalizing social protection for accelerated SDG implementation. Four UN organizations drew on their different areas of expertise to implement the project: (i) the 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


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(UNDP). Through a pilot project in Sokoto State in North West Nigeria, these organizations combined an institutional approach (policy and capacity strengthening) with the implementation of tangible interventions (cash transfers) to enhance access of Nigerian citizens to social protection.

To ascertain the extent to which the JP achieved its aims, an independent evaluation, coordinated by UNICEF, was commissioned by the UN System in Nigeria. The evaluation assessed the relevance, effectiveness, efficiency, coherence, impact, sustainability and performance of the JP in achieving the expected results. The evaluation also examined what worked well for whom, what did not work, why and made recommendations for improvement. 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 followed strictly. 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 individuals, from beneficiaries to high-level stakeholders, were consulted to procure insights and primary data for the evaluation.

The findings and recommendations are clearly defined in the body of the report. It is important to mention that the relevance of the JP is not in doubt, as evidence clearly shows the extent of deprivations and the resulting need for a social protection system to address poverty and vulnerabilities throughout the country. The JP had a direct impact on 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 the country. However, the duration of implementation was short at just two years, compared to the long-term systemic transformation needed for establishing social protection programmes in Nigeria. This needs to be factored into the development of further programmes by the UN in Nigeria.

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

We implore all stakeholders, including the government, to make use of the findings and recommendations from the evaluation and to consider them when planning future programmes.

Prince Clem Ikanade Agba
Minister of State for Finance, Budget
and National Planning

Matthias Schmale
UN Resident Coordinator in Nigeria

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The evaluation team is grateful for the leadership and facilitation of the Minister of Finance, Budget and National Planning, Dr Zainab Shamsuna Ahmed, and Minister of Humanitarian Affairs, Disaster Management and Social Development, Hajia Sadiya Umar Farouq. The leadership coordination role of the Acting National Coordinator of the National Social Safety-Nets Coordinating Office (NASSCO), Kabir Abdullahi, is also recognized.

A key role was played by participating UN organizations in both obtaining and using the funding provided by the UN Secretary-General's Office in 2020–2022 to implement this JP. Peter Hawkins, former UNICEF Country Representative (UNICEF being the lead agency coordinating this UN Joint SDGs project with the Resident Coordinator's Office); Paul Howe, former Country Representative of WFP; Dennis Zulu, Country Representative of ILO; and Mohamed Yahya, Country Representative of UNDP, played essential roles and have successfully driven this joint project at both federal and state levels.

The evaluation team would like to express thanks and appreciation to the UNICEF Nigeria Country Team for their trust, guidance, support, valuable insights, contributions and quality assurance for the commissioning and management of the evaluation of the JP. Special appreciation goes to Peter Hawkins, former UNICEF Country Representative in Nigeria and Cristian Munduante, the new UNICEF Country Representative in Nigeria; UNICEF Deputy Representative, Rushnan Murtaza; Dr Robert Ndamobissi, Evaluation Manager (for his technical leadership role on this evaluation); Dr Hamidou Poufon, Chief of Social Policy; Temi Esteri Fet'era, Social Policy Specialist; Faizat Badmus-Busari, Social Protection Consultant; Isah Ibrahim, UNICEF Social Policy Specialist at the Sokoto field office; and Dr Danjuma, UNICEF Monitoring and Evaluation (M&E) Specialist at the Sokoto field office.

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Input and reviews by social protection experts at federal and state level were provided by Abiola Akanni at WFP Nigeria; Segun Tekun, Programme Officer at ILO Nigeria; Clare Henshaw, National Programme Specialist at UNDP; Grace Arinze Ononwu, Economic Research Associate at UNDP Nigeria; and Dr Francis Ukwuije, Health Specialist at the World Health Organization.

Key stakeholders throughout this evaluation included members of government institutions, the UN, academia and the National Bureau of Statistics (NBS).

ABBREVIATIONS AND ACRONYMS

CBT	community-based transfer
CWG	cash working group
FGD	focus group discussion
HoH	head of household
ILO	International Labour Organization
JP	Joint Programme (in this document, refers to the United Nations–Government Joint Programme to Accelerate the Sustainable Development Goals in Nigeria 2020–2022)
KII	key informant interview
LGA	local government area
M&E	monitoring and evaluation
MEAL	monitoring, evaluation, accountability and learning
MFBNP	Federal Ministry of Finance, Budget and National Planning
MHDSD	Ministry of Humanitarian Affairs, Disaster Management and Social Development
MLE	Ministry of Labour and Employment
₦	naira
NASSCO	National Social Safety-Nets Coordinating Office
NBS	National Bureau of Statistics
NPC	National Population Commission
NSPP	National Social Protection Policy
OECD DAC	Organisation for Economic Cooperation and Development's Development Assistance Committee
OSSAP-SDGs	Office of the Senior Special Assistant to the President on the Sustainable Development Goals
SDG	Sustainable Development Goal
SOCHEMA	Sokoto State Contributory Health Management Agency
SOCU	State Operations Coordinating Unit
TWG	technical working group
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNSDPF	United Nations Sustainable Development Partnership Framework
US$	United States dollars
WFP	World Food Programme

EXECUTIVE SUMMARY

Methodology and objectives

From January 2020, four UN agencies, UNICEF, WFP, ILO and UNDP, implemented the two-year UN–Government Joint Programme to Accelerate the Sustainable Development Goals in Nigeria 2020–2022: Institutionalizing social protection for accelerated SDG implementation in Nigeria (referred to in this document as the Joint Programme, or JP). This two-year US$2-million project aimed to enhance social protection at the federal and state levels in Nigeria (SDG target 1.3) and thereby support the achievement of SDG targets 1.3, 2.2, 3.8, 4.1, 5.1, 10.4, 16.9 and 17.1. The JP used a combined intervention approach, which is outlined below:

- The *operational component* provided health insurance coverage for a year to 6,000 recipients from vulnerable groups in four local government areas (LGAs) in Sokoto State, namely Bodinga, Wamakko, Tambuwal and Wurno. Of these recipients, 658 pregnant and/or

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lactating women and caregivers of children under 2 years were eligible to receive cash transfers in Bodinga, Wamakko and Wurno.
- The *institutional component* supported Nigeria's national social protection legal framework by developing a social protection bill and building the capacity of government ministries, departments and institutions working on social protection at federal and state levels.

UNICEF commissioned consultants Samuel Hall on behalf of the four participating UN agencies to:

- conduct an external and gender-responsive endline evaluation of the JP at the federal level and in Sokoto State using the Organisation for Economic Cooperation and Development's Development Assistance Committee (OECD DAC) criteria; and
- identify good practices and lessons learned for future implementation.

The evaluation of the JP is based on primary and secondary data. The primary data collection approaches served to obtain diverse perspectives from individuals connected at various levels with the programme, from beneficiaries to high-level stakeholders. Data were collected from 20 key informant interviews (KIIs), 10 focus group discussions (FGDs) with beneficiaries and three community observations in Tambuwal, Bodinga and Wurno, and a quantitative phone and in-person survey with 261 cash-transfer beneficiaries and 471 non-beneficiaries (the control group) of cash transfers.

The JP 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 (National Development Plan 2021–2025, Nigerian Economic Sustainability Plan and National Social Protection Policy (NSPP) 2021). Moreover, while the operationalization of social protection focused on Sokoto State, the result of this pilot is expected to be scalable and replicable across other states in Nigeria based on their individual contexts. To that effect, the theory of change model (see Annex B) for the JP emphasises the development of a blueprint for successful implementation and expansion of cash transfers and universal health insurance to all state governments in Nigeria, using the lessons from the programme's implementation in Sokoto State.

It is important to note that the conclusions of the JP are based on the two-year experimental nature of the pilot. A two-year pilot may not be sufficient to meet objectives that require long-term systemic transformation; however, it can provide guidance on strategies and capacity requirements, and offer innovative resource ideas for achieving universal social protection. Based on this understanding, all the UN and government partners interviewed referred to the short implementation period. Therefore, while it is possible to learn from the successes and challenges of the pilot programme, additional time should be given when rolling out the JP in the future to effectively assure its long-term impact.

Key findings and lessons learned: Five key messages

An analysis following OECD DAC evaluation criteria is developed in this study, particularly in Sections 4 (Findings) and 5 (Lessons learned). The evaluation team adopted an innovative approach to present the strategic findings and lessons learned by considering (i) the presentation of five key strategic messages and (ii) the presentation of key findings by each evaluation criterion to ensure compliance with the global standards of evaluation of United Nations Evaluation Group, which provides guidelines for establishing the institutional framework, management and use of evaluations.

Key findings by five strategic messages

1. The UN SDG project alleviated recipients' financial burdens and encouraged them to seek professional health care

Beneficiaries emphasized the positive impact of cash transfers and health insurance on their well-being. Several women's testimonies indicate that they felt empowered to take their sick infants and children to the health centre or hospital without waiting for, or consulting with, their husbands who manage the household finances. At the same time, husbands said they spent less money on health care and no longer had enormous financial pressure which usually led to prioritizing food over health care.

Government and UN agencies applied evidence-based planning by using data from the capacity needs assessment undertaken by the Federal Ministry of Finance, Budget and National Planning (MFBNP);[1] the health needs assessment undertaken by UNICEF in 2021 – using an independent consultant – that focused on the capacity of the Sokoto State Government to provide health services and Sokoto State residents' capacity to afford health care services; and the Nigeria Demographic and Health Survey 2018 (NPC and ICF International, 2018), which revealed the challenges related to nutritional diets and access to health care for children nd pregnant women.

The evaluation team used a quasi-experimental approach to compare findings between the treatment group (beneficiaries) and the control group (non-beneficiaries) during the endline evaluation. However, the lack of up-to-date baseline data for household livelihood expenditure, health insurance and cash transfers in Sokoto State limited the measurement of the impact of the JP. There is no doubt that the JP had positive impacts on its beneficiaries in terms of access to professional health care services and meeting immediate needs, but it is recommended that a baseline assessment is carried out for future social protection programming.

2. The cash transfers contributed to meeting immediate needs

Only ₦5,200 was allocated to pregnant and/or lactating women under the cash transfer component of the project with ₦5,000 being the actual cash transfer and ₦200 being available to cover bank charges and transportation costs. The recipients' perceived main strength of the cash transfers is that it facilitated access to basic needs, such as meeting immediate food requirements and improved health-seeking behaviours of mothers and caregivers. A few women reported that they succeeded in saving money, which they used to start small businesses, thus reducing the financial barriers that prevent poor families from accessing basic social services.

The most commonly mentioned weakness of the JP was the short-term duration of the aid. Moreover, the project did not have a sustainability plan for the beneficiaries. As a result, when the SDG project ended, there was no mechanism in place to ensure that the beneficiaries, who are among the poorest in north-west Nigeria, would continue to benefit from health care insurance or cash transfers.

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 were aimed at facilitating access to health care and reducing out-of-pocket expenditure on health. The perceived impact of the health insurance intervention is that it increased the demand for primary health care services, including antenatal and postnatal care.

1 Report on the status of the social protection policy and programme in Sokoto State (MFBNP, 2019).

Despite sensitization and awareness, some beneficiaries shared their health insurance cards with neighbours and members of their extended family, in accordance with the African cultural values of love and solidarity in sharing of resources. A deeper understanding of the sociocultural 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 chronic food insecurity. The newly amended Health Insurance Act 2022 has expanded coverage to ensure large-scale access of poor families to primary health care in Nigeria through the establishment of the Vulnerable Group Fund.

4. The SDG project fostered collaboration and coordination among key government social protection stakeholders to strengthen the foundation of a nationally owned system

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

The JP supported strengthening government institutions to create an environment where relevant ministries, departments and agencies are empowered to take the NSPP forward through the establishment of relevant social protection coordination platforms. All UN agencies involved have noted the positive externalities in coordination, mainly through the establishment of the Social Protection Technical Working Group (TWG) at the national level. At the state level, the Sokoto State Cash Working Group (CWG) was established as a subset of the Sokoto State Social Protection TWG. Each participating UN agency, as well as the national body, delivered as one to achieve a common objective. This would not have been possible had these institutions been operating separately.

The JP created an environment that helped improve capacity and coordination between state agencies – namely the MFBNP, Ministry of Labour and Employment (MLE) and MHDSD – and UN agencies. This is clearly a solid foundation that the JP can build on to enhance social protection at the federal and state levels in Nigeria.

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

The UN Joint SDG Fund project has its relevance as a strategy for addressing the high poverty rate in Nigeria with over 89 million people living below the poverty line (40 per cent). The findings of the recently published 2020 Multidimensional Poverty Index report, reveals that over 113 million (63 per cent) people in Nigeria, and 91 per cent of Sokoto State's population, are multidimensionally poor (UNDP and Oxford Poverty and Development Initiative, 2020).

The two-year duration of the JP was too short to have maximum impact on the beneficiaries. Additionally, the challenging COVID-19 pandemic, which led to movement restrictions imposed by government, had an impact on project operations such as travelling in the field. The project, however, succeeded in simultaneously implementing both institutional and operational activities at both national and subnational levels. While this approach saved time, a more efficient approach would be to first strengthen the institutional base (capacity building, establishing coordination platforms, policy development and implementation) and then leverage the enabling environment to ensure an efficient and effective system for operationalizing the guiding policies and strategies. Strengthening government's institutional framework would need to include the regular updating of a single, consolidated state and national government social register, thus ensuring that beneficiaries of all

social protection interventions are mined from a single source. This would help address the targeting, monitoring, evaluation and accountability issues that accompany social protection interventions.

While the project made tremendous efforts to build capacity, some concerns remain around stakeholders' understanding of what social protection entails and how to consolidate partnerships to ensure coordinated delivery of social protection programmes in Nigeria.

While the JP was conceptualized as a pilot in building social protection systems and providing cost-intensive direct interventions, the evaluation found that there was no sustainability plan or strategy in place. As a result, the project's impact on beneficiaries might not be sustained once it has ended unless the state government fully buys into it and has the technical and financial capacity to continue the interventions.

Given the funds spent on identifying recipients, setting up systems for the distribution of health insurance coverage and cash transfers, and strengthening the capacity of government stakeholders, it is necessary to ensure that resources invested do not go to waste. Government therefore needs to put mechanisms in place to ensure that social protection interventions are incorporated into its plans via clear and costed implementation frameworks.

Key findings by evaluation criteria

This section summarizes the report's findings by OECD DAC evaluation criteria (relevance, coherence, effectiveness, efficiency, impact and sustainability). In particular, it aims to respond to the following two main, broader expectations of the overall purpose of the evaluation:

- Analyse whether the JP in Nigeria met its high-level objectives.
- Analyse the extent to which the JP strengthened the capacity of government and the ecosystem for the scale-up and sustainability of the social protection system in Nigeria.

In assessing the project the evaluation team adopted the rating criteria and colour coding in Table 1.

Table 1: Colour coding for OECD DAC evaluation ratings

CATEGORY OF MERIT RATING	DESCRIPTION	COLOUR
High	High level of satisfaction – more than 80% of expectations achieved and a reassuring outlook for the future (80–100%)	
Positive	Average level of satisfaction – more than 50% of expectations achieved and a reassuring outlook for the future	
Insufficient	Not satisfactory – less than 50% of expectations achieved and a concerning outlook for the future	
Not achieved	Expectations not met (shortfall)	

Relevance: Is the 2020–2022 JP doing the right things?

The JP is **HIGHLY RELEVANT**

The evaluation team concluded that the JP is highly relevant to the needs of the poor and vulnerable populations of Nigeria. This is based on the evidence of multidimensional poverty and the negative effects of COVID-19, and the fact that Sokoto State, with primarily rural communities and an economy that is dependent on agriculture, has some of the highest levels of poverty and insecurity in north-west Nigeria. Many people in the state live in such dire conditions that immediate assistance is needed.

The design of the JP is based on key evidence generated from relevant national and local surveys, assessments and studies, namely the (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 assessment of Sokoto State. In addition, the JP is well aligned to the national and state development plans, the NSPP and the National Health Act 2014.

Due to funding limitations, universal social protection coverage was not adopted for the JP. Populations were targeted by category associated with multidimensional poverty; the elderly, children, pregnant women and persons living with disabilities were given priority in the selection of JP beneficiaries.

From qualitative FGDs with Sokoto beneficiaries at the community level, the evaluation found that there are some errors of exclusion and inclusion of relevant beneficiaries. The lack of a single, consolidated and harmonized state registry of the poor and vulnerable negatively affected the targeting of beneficiaries. The implementing agency, the Sokoto State Operations Coordinating Unit (SOCU), faced challenges of outdated, obsolete data from multiple sources. These included its own data and those of the Ministry of Women and Children Affairs, Sokoto State's Zakat and Endowment Commission and the state government's SDG Office. There was also a conflict of interest among ministries, departments and agencies at the state level.

Coherence: Is the 2020–2022 JP well aligned with the global framework and national priorities?

The JP is **POSITIVELY ALIGNED** with SDGs 1 and 10, the National Development Plan, NSPP and state development priorities.

The assessment of the coherence of the JP was based on the following questions:

- 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?
- What are the strengths of the JP in comparison to other social protection programmes?
- What are the comparative strengths of the coordination and convening roles of the JP? To what extent did the JP enhance UN agency coherence?

Based on the evidence of a desk review of available documents, KIIs and FGDs, the evaluation team concludes that the JP is positively aligned with global and national priorities, and that it takes into consideration issues of gender equality, equity and rights of persons with disabilities.

It also aligns with existing social protection programmes at the federal and state levels, including the national cash transfer programmes, the basic health care provision fund programme on health insurance, Zakat and Endowment Commission's cash and food assistance programme, Ministry of Social Welfare cash transfers for persons with disability, Ministry of Women and Children Affairs cash transfers for selected vulnerable populations (widows, orphans and survivors of sexual and gender-based violence survivors) and the State Cash Transfer Office cash transfer programme for vulnerable populations.

The JP promotes gender equality and the rights of persons with disability through a focus on assisting pregnant women and lactating mothers, the formulation of a rights-based social protection bill, and input into the National Health Insurance Act 2022 that makes health insurance mandatory for all Nigerians.

However, from the review of relevant documents and collection of field data it was found that due to the lack of disaggregated data to clearly indicate the number of persons on the state social register living with disability, the JP was unable to ascertain the number or proportion of beneficiaries of either health insurance or cash transfers in Sokoto State, who are living with a disability.

There were also allegations of fraud in the distribution and selection of beneficiaries, which could 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 subnational policies.

The JP strengthened coordination amongst partners through knowledge sharing, active participation and involvement in the Development Partners Group, as well as institutionalization of quarterly meetings between partners and relevant implementing ministries, departments and agencies and a joint approach to awareness-creation, communication and outreach. This has enhanced the government's common understanding of the social protection landscape and national coordination systems. The JP also leveraged existing programmes implemented by other partners (Save the Children International, Action Against Hunger, Plan International and the European Union, etc).

Effectiveness: Has the 2020–2022 JP achieved expected results?

The JP is **HIGHLY EFFECTIVE** in achieving expected results.

The independent evaluation of the effectiveness of the JP was guided by the following questions in the terms of reference (see Annex I for full terms of reference):

- To what extent has the JP contributed to accelerating the SDGs at the national and state levels, as well as contributed to UN Sustainable Development Partnership Framework (UNSDPF) Outcome 6?
- 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 because of the implementation of the JP?

Based on strong evidence, the evaluation team concluded that the JP successfully achieved expected results as committed within the results framework regarding its two outcomes and outputs. The evaluation team's review of relevant documents, KIIs and FGDs revealed 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 social protection policy was approved by the Federal Executive Council. During the same period, 2020–2022, the budget allocation for social protection increased by over 100 per cent.

The JP provided capacity and institutional strengthening that contributed to an increase in health insurance coverage from 3 per cent to over 5 per cent of 200 million citizens of Nigeria (10 million beneficiaries).

Regarding social protection activities at state level, over 600 pregnant and/or lactating women and caregivers of under-fives benefited from mixed cash transfers (unconditional and conditional) with over ₦5,200 received monthly for a period of six months. Six thousand health insurance beneficiaries (70 per cent female and 30 per cent male) were registered in primary health-care facilities across

four LGAs. Beneficiaries were able to access free health care services when they visited their designated centres.

Efficiency: Has the 2020–2022 JP achieved adequate economy?

The JP is **POSITIVE** in value for money.

Three specific evaluation questions were considered for the assessment of value for money of the JP:

- 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?
- Are activities low in cost and affordable, yet of adequate quality to improve the situation of vulnerable households?
- Is the current organizational set-up, collaboration and contribution of concerned ministries and others working effectively to help ensure accountability? What more can be done?

Regarding the promotion of a culture of value for money to optimize interventions and inter-agency synergies to achieve results, the evaluation team found that the JP positively achieved adequate value for money. The unit cost of intervention was about US$68.90 (₦30,314) for the delivery of access to free health services with multiple visits to a health care facility and medication that benefited 6,000 women and children, as implemented by the UNICEF field office in Sokoto. The unit cost was around US$112.65 (₦49,566) for 658 pregnant and/or lactating women and caregivers of children under 2 years of age who benefited from digital cash disbursements as delivered by WFP in Sokoto State.

Despite the limitations that were identified, such as knowledge gaps, the JP'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 NSPP will ensure the extension of the coverage to previously excluded populations.

However, there remains a need for improved inter-agency collaboration in terms of pooling resources or costs between agencies or actors. Also, the focus remains results oriented (delivering the expected numbers versus 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 analyse the real value of its operational contribution to the population. Simple avenues can be identified, such as: (i) favouring longitudinal analyses to capture improvements in value for money over time; (ii) systematizing comparative analyses with similar contexts and programmes; (iii) producing disaggregated cost analyses, to better understand how and where the JP spends most of its money; and (iv) a focus on the broader context to understand how JP contributes to improving people's lives and well-being.

Impact: Has the 2020–2022 JP achieved the expected impact on lives?

The JP had a **POSITIVE** impact.

The following evaluation questions served as reference for the assessment of the impact of the JP:

- To what extent has the social assistance (cash transfers) provided to vulnerable populations in Sokoto generated positive effects in income and social transformation to households and communities vis-à-vis SDG 1 (ending poverty) and SDG 10 (reducing inequality)?
- What lessons can be documented or challenges observed from the implementation of the model in reaching vulnerable populations and providing services?

- What are the negative externalities of the JP, with a focus on ethical (fraud) and societal (tensions) issues?

The evaluation team measured the impact of the social protection interventions in Sokoto State using a quasi-experimental design, comparing treatment group (beneficiaries) findings with findings from non-beneficiaries. Quantitative data and qualitative opinions revealed that the JP has made a positive difference in the lives and livelihoods of beneficiaries (over 600 pregnant and/or lactating women and caregivers of children under 2 years of age) who received assistance in the form of health insurance and cash transfers, in comparison to non-beneficiaries.

Regarding health insurance, the JP has alleviated beneficiaries' financial burdens and encouraged recipients to seek health care. Beneficiaries were able to access professional health care when needed and women recipients were more likely to have received services from qualified health personnel 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 confirm that 59 per cent of surveyed beneficiaries were assisted by qualified health personnel for any health problem in the past year compared to 47 per cent of surveyed non-beneficiaries.

Concerning the cash transfer, which benefited 658 pregnant women and caregivers of children under 2 years, the evaluation team concludes that there is a positive impact on health expenditure indicators and the effects and usage of cash transfers related to SDG 1 (ending poverty) and SDG 10 (reducing inequality).

When focusing on health expenditure that is relevant to the JP activities, namely preventive health services and maternal and child health expenditures, the differences are more striking. The JP focused more on bridging the gap in preventive health through cash transfers and health insurance coverage, which led to improved behaviour in seeking health care amongst beneficiaries.

Many of the beneficiaries expressed the view that the health insurance coverage, specifically, had a more significant positive impact on their lives than cash transfers in isolation or immunization for specific diseases, which were provided by other programmes in the past. Lastly, there was a clear gender focus as the target beneficiaries were women and children, who as a result were able to get the medical attention they needed without putting an additional financial or psychological burden on the household.

Sustainability: Has the 2020–2022 JP achieved adequate sustainability?

The JP is **UNSUCCESSFUL** in sustainability.

The specific evaluation questions are as follows:

- To what extent has the strategy adopted by the JP contributed to the sustainability of results, especially in terms of the SDG principle of 'leave no one behind' and the social protection system?
- To what extent has the JP supported 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 JP through the action of the government and other stakeholders and/or UN agencies?
- What are the lessons learned about the provision of integrated social protection services?
- In what ways should the current JP approach be revised or modified to improve the sustainability of the programme services?

The evaluation team has concluded that the JP falls short of ensuring the sustainability of gains.

Learning from crises and uncertainty: The COVID-19 pandemic led to significant delays of about one year in JP implementation; consequently, the JP had to be extended following a missed launch date in March 2020, when the pandemic spread across the world. The JP did not have a coordinator who could serve as an intermediary between implementing partners and ensure that the programme was moving forward until late 2020. 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 for strengthening and streamlining social protection in Nigeria. The government provided cash transfers and food throughout the country and may have been more inclined to take the social protection bill forward because of the effects of the pandemic on citizens.

In terms of access to health care during the various peaks of the pandemic, FGD participants believed that COVID-19 did not prevent them from receiving medical care, either under the JP or in general. A participant in Dogon Daji, for instance, said that the hospital helped people cope with COVID-19 early on by raising awareness on protective methods, such as face masks and handwashing, and on symptoms of the disease (FGD 5).

In the current context, where uncertainty and multidimensional crises have become the norm, it is important for a larger-scale or longer-term social protection programme 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 long term and predictable in nature compared to the short-term cycles of humanitarian aid (European Commission, 2015). This means it needs long-term funding, objectives and programming. While the JP was conceptualized as a pilot in Sokoto State, building a social protection system with policies and direct interventions is cost-intensive; not having a strategy to continue the programme carries the risk that the funds spent will have no sustainable impact. For continued funding and implementation beyond the pilot, and to ensure that investments made in setting up systems and processes for distributing health insurance coverage and cash transfers do not go to waste, a sustainability plan should be put in place. Furthermore, as a NASSCO representative put it, Nigeria has several success stories associated with pilot projects, but replicating and scaling up those projects to continue beyond the pilot stage has proven to be a challenge.

As elaborated in Sections 4.5.1 and 4.5.2, there was no strategy in place to ensure that the beneficiaries, who are among the poorest in north-west Nigeria, would continue to benefit from health care 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 (i) an exit strategy for the JP's partners; and (ii) the gradual assumption of responsibility by government (technical and financial).

Recommendations

Recommendation 1: Promote 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 and universal protection) in contexts of almost widespread socioeconomic destitution and chronic multidimensional crises.

Recommendation 2: Start with an informed, realistic, flexible and contextualized theory of change. Any expansion or follow-up of the JP will require a much more pragmatic, realistic and contextualized theory of change to translate the abstract goals of the SDGs and the multi-country ambition of the JP into effective and sustainable actions and interventions.

Recommendation 3: Promote a real monitoring, evaluation, accountability and learning (MEAL) approach for better adjustment or revision of the pilot. Significant learning dividends from the pandemic crisis and 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: Put 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 programmes and dedicated indicators. It is necessary to go further, not by simply conceiving women as 'the most vulnerable population' and therefore natural beneficiaries, but by understanding that they are agents of change in rural areas, particularly in terms of community decisions, allocation of household resources, diversification of income through migration decisions (e.g., of husbands and sons), etc.

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

Recommendation 6: Promote a culture of value for money to optimize intervention and inter-agency synergies. It is imperative that the JP strengthen its capacity to analyse the real value of its strategic and operational contribution. Simple avenues worth mentioning are: (i) favouring longitudinal analyses, to capture improvements in value for money over time; (ii) systematizing comparative analyses with similar contexts and programmes; (iii) disaggregating cost analyses; and (iv) focusing on the broader context to understand how the JP contributes to improving people's lives and well-being.

Recommendation 7: Shed 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, analyse, respond to and eliminate any perception of fraud or unfairness from the population. A fit-for-purpose complaints response mechanism should be put in place to foster voice and accountability down to the granular level.

Recommendation 8: Make 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 programme, with no "social and societal solidarity agenda" (KII with UNICEF, July 2022). 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: Promote 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: (i) an exit strategy for the JP partners; and (ii) the gradual ramping up of government partners' involvement (technical and financial).

1. BACKGROUND

1.1 Introduction

From January 2020, four UN agencies, UNICEF, WFP, ILO and UNDP, implemented the two-year JP. This US$2-million project aimed to enhance social protection at the federal and state levels in Nigeria through diverse, targeted intervention strategies. The JP supported accelerating the implementation of the SDGs in Nigeria by focusing on eight specific SDGs (1, 2, 3, 4, 5, 10, 16 and 17) and eight specific indicators (1.3, 2.2, 3.8, 4.1, 5.1, 10.4, 16.9 and 17.1). Each of the SDGs is intricately linked and interdependent.

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

UNICEF commissioned consultants Samuel Hall on behalf of the four participating UN agencies to conduct an external and gender-responsive endline evaluation of the JP at the federal level and in Sokoto State, and to identify good practices and lessons for future implementation.

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 NSPP, using the OECD DAC evaluation criteria (OECD DAC Network on Development Evaluation, 2019). The key objectives were to:

- 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;

UNICEF (2016) 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: (i) progressive realization of universal coverage; (ii) national systems and leadership; and (iii) inclusive social protection (UNICEF, 2016).

- assess the performance of the JP in achieving expected results (outcomes and outputs) as committed within the results framework (see Annex C) and theory of change (see Annex B); and
- determine the programme's effective and/or intended or unintended benefits (impacts) and higher-level effects of social protection interventions of the pilot in Sokoto State on marginalized populations regarding household income generation and social coverage.

In addition, the evaluation examined strengths and weaknesses for activity replication and UN accountability to the government and relevant partners on the following aspects: what worked well for who, what did not work and why, and what can be better done in the future? While the operationalization of social protection was focused on Sokoto State, the initial assumption is that the results and learning of this pilot should be scalable and replicable across other states.

1.1.2 Evaluation scope

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

It covers the implementation of the JP from January 2020 until the end of June 2022 and pays particular attention to the policy framework and outcomes in relation to gender, including gender equality and the empowerment of women 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 the survey 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 programme's policy and capacity-building components. They helped contextualize beneficiaries' perceptions surrounding the successes and shortcomings of the health insurance and cash transfers that had been provided. 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.

This evaluation is intended for use by a wide variety of stakeholders and for different purposes, including the promotion of accountability, documentation and learning, as summarized in Table 2.

1.2 Programme background

1.2.1 Programme rationale

It was anticipated that the JP would contribute to strengthening access to social protection in Nigeria (SDG target 1.3) and thereby support the achievement of SDG targets 1.3, 2.2, 2.8, 4.1 and 10.4.[2] It is

2 SDG 1 (no poverty), target 1.3: 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 (no hunger), target 2.2: 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/or lactating women and older persons. SDG 3 (good health and well-being), target 3.8: 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 (reduced inequalities), target 10.4: Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality.

Table 2: Evaluation users and intended uses

EVALUATION USERS	INTENDED USES OF FINDINGS AND RECOMMENDATIONS
UN Resident Coordinator's Office	• Ensure accountability to the UN Secretary-General's coordination of the Joint UN SDG Fund • Coordinate UN agencies' future policy advocacy • Leverage partnerships and evidence-informed decision-making for UN joint programming
UN funds, programmes and specialized agencies in Nigeria	• Review and refine intervention strategies • Inform expansion of the JP in other states, by articulating the cash transfer and universal health insurance scheme for greater impact on access to social protection and improved health, education and nutrition, especially among vulnerable groups • Develop a communications strategy for greater engagement of national actors in social protection
Departments and agencies working on social protection programmes	• Inform the NSPP for the expansion and replication of integrated social protection programmes throughout the country
Civil society organizations and non-governmental organizations	• Familiarize organizations with successful approaches so that they can build on the lessons learned during the evaluation to strengthen advocacy and intervention approaches
Development partners, donors, private actors and individuals	• Encourage additional humanitarian and development support for Nigeria by increasing the visibility of UN support in the country

noteworthy that there was a strong emphasis on institutional strengthening in the programme – the aim was to have the government take the lead in project implementation. While the operationalization of social protection was focused on Sokoto State, the results of this pilot programme should be scalable and replicable across other states. To that effect, the theory of change model (see Annex B) for the JP emphasizes the development of a blueprint for successful implementation, the expansion of cash transfer programmes and the attainment of universal health coverage for all state governments in Nigeria, using the lessons from the programme's implementation in Sokoto.

The JP aimed to support a social contract between the state and its constituents through sustainable, equitable and quality social protection benefits and services ensured by the development and implementation of national and state social protection policies. The targeted recipients included the most vulnerable groups (women; children; girls; youth; persons living with HIV/AIDS, tuberculosis or leprosy; persons with disabilities; older people; migrants; etc.) who have relatively limited access to social protection services compared to the general population. The institutional component of the JP aimed to strengthen the capacity of state institutions to effectively deliver social intervention programmes and state consultations throughout the country and set up SDG accelerators through the:

- communal engagement of women and adolescent girls in social behavioural change communication activities to strengthen efforts made in the reduction of infant and child mortality due to malnutrition (SDG 2.2);
- expansion of existing cash transfer programmes promoting girls' education to help increase the proportion of children who complete primary education, achieving at least a minimum proficiency level in literacy and numeracy (SDG 4.1); and

- improved participation of women and adolescent girls in decision-making processes through their inclusion in the establishment of communal project management committees to help create conditions that advance rather than undermine gender equality and women's empowerment (SDG 5).

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 to achieve universal social protection for all 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 in social protection (in both social insurance and social assistance) in Nigeria to implement social protection programmes, with a particular focus on cash transfers and improving access to health and the health situation of vulnerable groups, such as women; children; girls; youth; persons living with HIV/AIDS, tuberculosis or leprosy; persons with disabilities; older people and migrants.

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 for 658 pregnant and/or lactating women and caregivers of children under 2 years[3] to cover visits, including for vaccinations and immunizations for pregnant women, to the designated eight primary health care centres within the three LGAs of Bodinga, Wamakko and Wurno in Sokoto State. 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 the Sokoto State Contributory Health Management Agency (SOCHEMA), beneficiaries received a card displaying their name, which they could present at the closest affiliated health centre to receive free medical care. Beneficiaries selected were:

- The elderly
- Pregnant and lactating women
- Caregivers of children under 5 years
- Persons living with a disability
- Teenage girls.

The 658 cash transfer beneficiaries in the 'pregnant and/or lactating women' and 'caregivers of children under 2 years' categories were expected to access health services at the primary health care centres where they were registered. At the end of each month, these care centres shared attendance lists with SOCHEMA, which was a member of the CWG, who then sent the names to WFP. The CWG processed the cash transfers for eligible beneficiaries with guided technical support from WFP. Recipients were thus expected to go to the primary health care centres for the required services, such as antenatal care, skilled delivery, postnatal care, vaccination and 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 health care services more frequently.

3 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.

1.2.2 Results framework

The results framework (see Annex C) was adjusted from its initial version by participating UN agencies following the JP's close-out in August 2022 to account for delays and modifications linked to the COVID-19 pandemic. The main transformative results for this impact evaluation were introduced by the Joint SDG Fund Secretariat in June 2021 and are based on the JP's desired impact and objectives. The results framework contributes to the JP's performance evaluation regarding its impact and effectiveness. The main transformative results identified by implementing agencies were as follows:

- Implement a legally and financially strengthened social protection system (SDG 1.3). The JP was expected to support government in the development of a draft social protection bill, which would include financial provisions on social protection expenditure by 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 for health care through a state-financed health insurance scheme for the poorest and most vulnerable (SDG 3.8). Six thousand members of the poorest and most vulnerable groups were identified to be enrolled in a selected state's health insurance scheme, of which 2,100 pregnant women and caregivers of children under 2 years were to be provided with transportation stipends through innovative digital cash transfer mechanisms and standard operating procedures. The conditions attached to this cash transfer programme were to be laid down in the selected state. In particular, the state cash transfer institutions would be provided with a foundation to adopt a shock-responsive social protection approach through cash transfer mechanisms.
- Establish and build the capacity of six state SDG offices to serve as innovation hubs for other states' SDG offices. The six pilot states were intended to provide a platform to share feasible and innovative solutions that would use social protection to overcome bottlenecks and expand financing to accelerate SDG achievement. The JP was to ensure that the achievement of SDGs related to social protection was accelerated and that learning and sharing across states was improved.

Table 3 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.

1.2.3 Leading agencies and implementing partners

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

Figure 1 (page 27) shows how the different actors were involved in the key results.

1.3 Programme timeline

The US$2 million JP was initially set to finish in January 2022 but was extended until June 2022. Table 3 presents the various milestones of the JP.

Table 3: List of outputs and corresponding deliverables

OUTPUTS	DETAILS
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 1.1a: Percentage of key stakeholders with increased capacity/ knowledge of social protection system development (gender-disaggregated). Output 1.1b: Existence of social protection bill is technically validated by stakeholders.	**Main deliverables (2021)** • Training covering policy drafting, financing and legal frameworks for social protection, engaging federal ministries, departments and agencies • Outreach to state actors, civil society organizations, groups representing persons with disabilities, workers and employers • Draft revised NSPP • Draft harmonized national social protection bill The JP completed a legal mapping report, which preceded the attorney-general's appointment of legal experts to draft the harmonized national social protection bill. ILO delivered training to build the legal team's understanding of social protection, 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: (i) discuss and validate findings; and (ii) present recommendations for the drafting of the revised national social protection bill. The process involved consultations with legal advisers from MFBNP, MLE and MHDSD to ensure that the bill is in line with the existing legal framework and to secure the buy-in of relevant political stakeholders. The NSPP includes a shock-responsive approach to social protection and a costed work plan and captures inputs from the private sector, civil society organizations, groups representing persons with disabilities, workers and employers. At the end of 2022, the JP supported the MFBNP in convening a high-level stakeholder forum to introduce the revised NSPP and the draft bill to secure its pre-approval. The JP supported the development of the Sokoto State Social Protection Policy (awaiting governor sign-off), including a costed action plan (multisectoral M&E framework and costing of the policy). The policy and MEAL framework will act as a blueprint for a sound social protection programme. The final version of the Sokoto State Social Protection Policy was introduced to the Sokoto State Executive Council for its approval. Participating UN agencies also recruited two consultants to work closely with the MFBNP in drafting an implementation plan and M&E framework to strengthen the revised NSPP.
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 1.2a: Fiscal space determined for social protection. Output 1.2b: National priorities in social protection costed. Output 1.2c: New strategy designed and signed by the government.	**Main deliverables (2021–2022)** • Fiscal space assessment • Social protection costing, prioritization and fiscal space report *2021:* The JP completed a fiscal space study reviewing the government's revenue and budgetary allocation to social protection, including regional and global comparisons. The study served to shape the social protection policy's financial component and was used to advocate the government to create a budget line dedicated to social protection. The JP further encouraged the government to establish a social protection trust fund. *2022:* The JP produced a report on costing, prioritization and fiscal space for social protection, using regulatory accounting principles, to evaluate the cost of 19 social protection policies. The report also identified innovative ways to fund social protection by 2026 through increasing taxes and contributory revenues.[4] The JP further built the MFBNP's capacity to use the regulatory accounting principle model and develop social protection cost scenarios.

4 Double-digit inflation will, however, pose significant challenges for social protection budgeting.

OUTPUTS	DETAILS
Output 1.3: SDG innovation and accelerator states identified and established with proven innovative solutions and financing towards achieving social protection. Output 1.3a: Number of quick wins identified for immediate implementation at the subnational level. Output 1.3b: Number of financing methods for SDG acceleration identified, recommended and utilized.	**Main deliverables (2020–2022)** • Six zonal consultations • 21 quick wins • Nine financing methods for SDG acceleration *2020–2021:* The JP organized six zonal consultations, one in each of the country's geopolitical zones. The consultations identified nine financing solutions for social protection,[5] and 21 potential quick wins[6] for states to take forward and implement. Through these consultations, the JP carried out training for the establishment of SDG innovation hubs and advocated with private-sector stakeholders, including the Private Sector Advisory Group, 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. *2022:* The JP supported the SDG hubs with information technology equipment (laptops) and carried out capacity-building activities. The JP also built the capacity of government stakeholders to strengthen the capacity of institutions in charge of social protection.
Output 2.1: The existing cash transfer scheme is expanded and the basis for universal cash to pregnant women and newborn children in Sokoto is laid down.	**Main deliverables (2020–2022)** • Sokoto State social protection CWG established and its members capacitated through training workshops and a handholding process to transfer cash to pregnant and/or lactating women and caregivers of children under 2 years • Paper-based cash transfers in the state transformed to digital cash transfers using a management information system enable for community-based transfers (CBTs). • Set up a complaints feedback mechanism structure • Train the Sokoto State CWG on digital CBT processes *2021:* The JP carried out a capacity needs assessment, which resulted in the establishment of the Sokoto State Social Protection CWG, whose members received training to implement and transform paper-based cash transfers to digital cash transfers. The impact of the training was measured through 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 document, identifying the most effective and feasible cash transfer approach in Sokoto, which was endorsed and approved by the state's TWG members. The JP further reviewed the CWG's terms of reference and supported it in developing standard operating procedures to adopt a shock-responsive approach. The CWG's key roles were enrolling beneficiaries through capturing required information; distribution of payment instruments; preparing a payment list that met conditionality criteria for the cash transfer programme; monitoring; and managing complaints and feedback. The CWG did not operate the digital payment platform, as the tool to carry out cash transfers was not available in the state. *2022:* Following a financial landscape analysis, the JP linked the CWG with a financial service provider to implement Sokoto's first digital cash transfer project, targeting pregnant and/or lactating women and children under 2 years of age. The project relied on a CBT-enabled management information system that consisted of six rounds of monthly transfers. As part of the cash transfer project, the JP supported the CWG to establish a complaints and feedback mechanism.

5 Some of these innovative solutions include allocating 1 per cent of internally generated revenue to social protection and using endowment funds for health care service delivery through public–private initiatives.

6 Possible quick wins included the use of a single state registry for all social protection activities; the review of existing social protection policies every three years to ensure that they respond to emerging issues and to address challenges identified during the M&E process; and the establishment and training of state TWG and CWG members from relevant ministries, departments and agencies on social protection.

OUTPUTS	DETAILS
Output 2.2: Universal health coverage at the state level accelerated using the Basic Health Care Provision Fund and community-based insurance mechanisms.	**Main deliverables (2020–2022)** • Developed 15 training manuals for SOCHEMA • Supported actuarial valuation of the National Health Insurance Authority • Raised awareness on World Universal Health Coverage Day • Held eight training sessions with the National Health Insurance Authority • Provided health care coverage to 6,000 beneficiaries • Conducted a study on health needs of pregnant women and children in Sokoto State *2021:* The JP assessed SOCHEMA's ability to implement health insurance activities and developed 15 training manuals intended for SOCHEMA's staff, which were approved by the National Health Insurance Authority. 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 health care. At the federal level, the JP held eight training sessions with National Health Insurance Authority, focusing on actuarial valuation, data collection and data quality requirements and delivered a study on the National Health Insurance Scheme. These steps paved the way for Nigeria's president to turn the National Health Insurance Authority bill into a law, which makes health insurance mandatory. The Vulnerable Group Fund was also established. *2021–2022:* With SOCHEMA, Sokoto State's Zakat and Endowment Commission and the Ministry of Women and Children Affairs, the JC identified 6,000 beneficiaries to whom they distributed identity cards in 2021 and who received health insurance coverage for a year.


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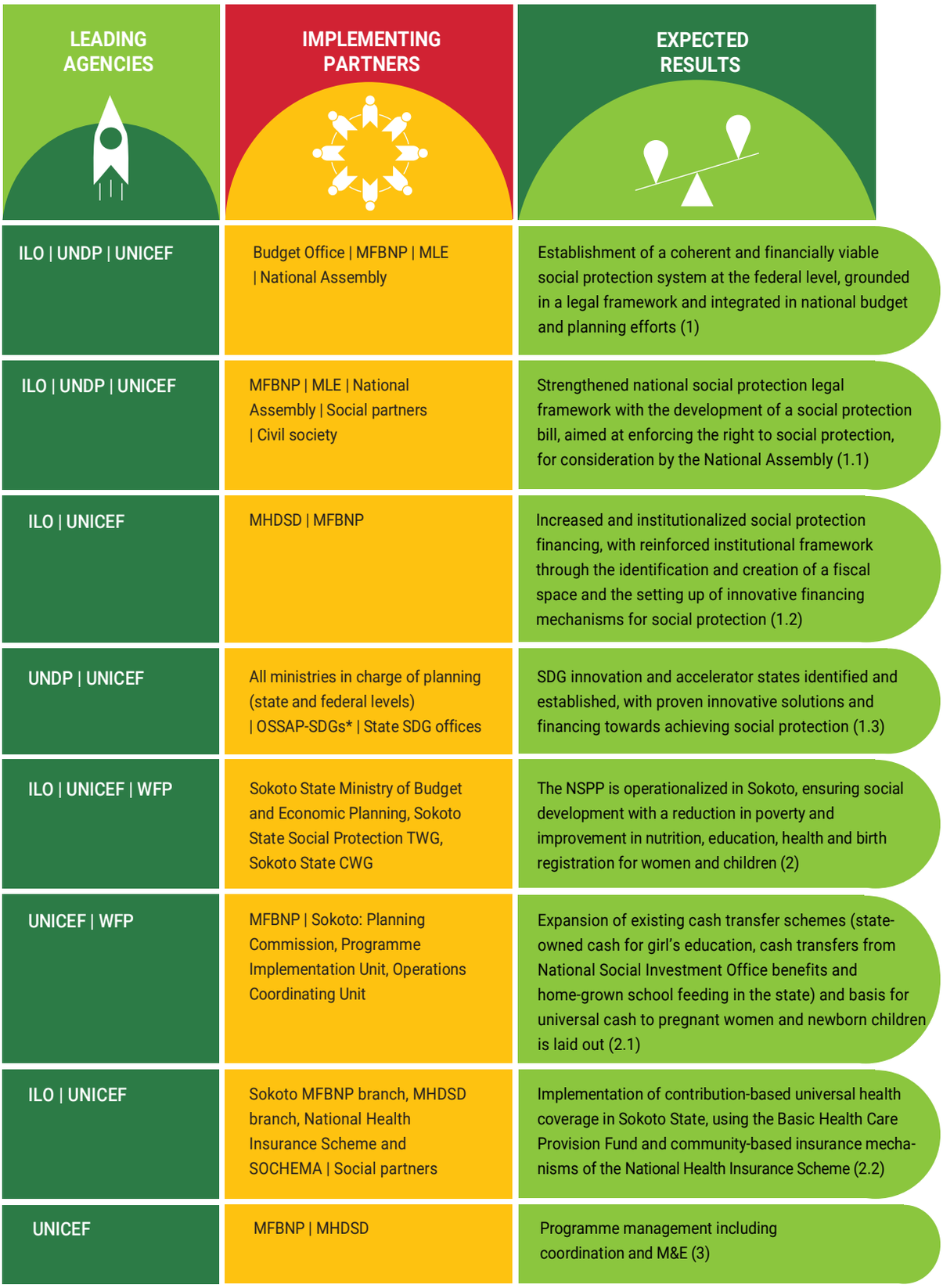
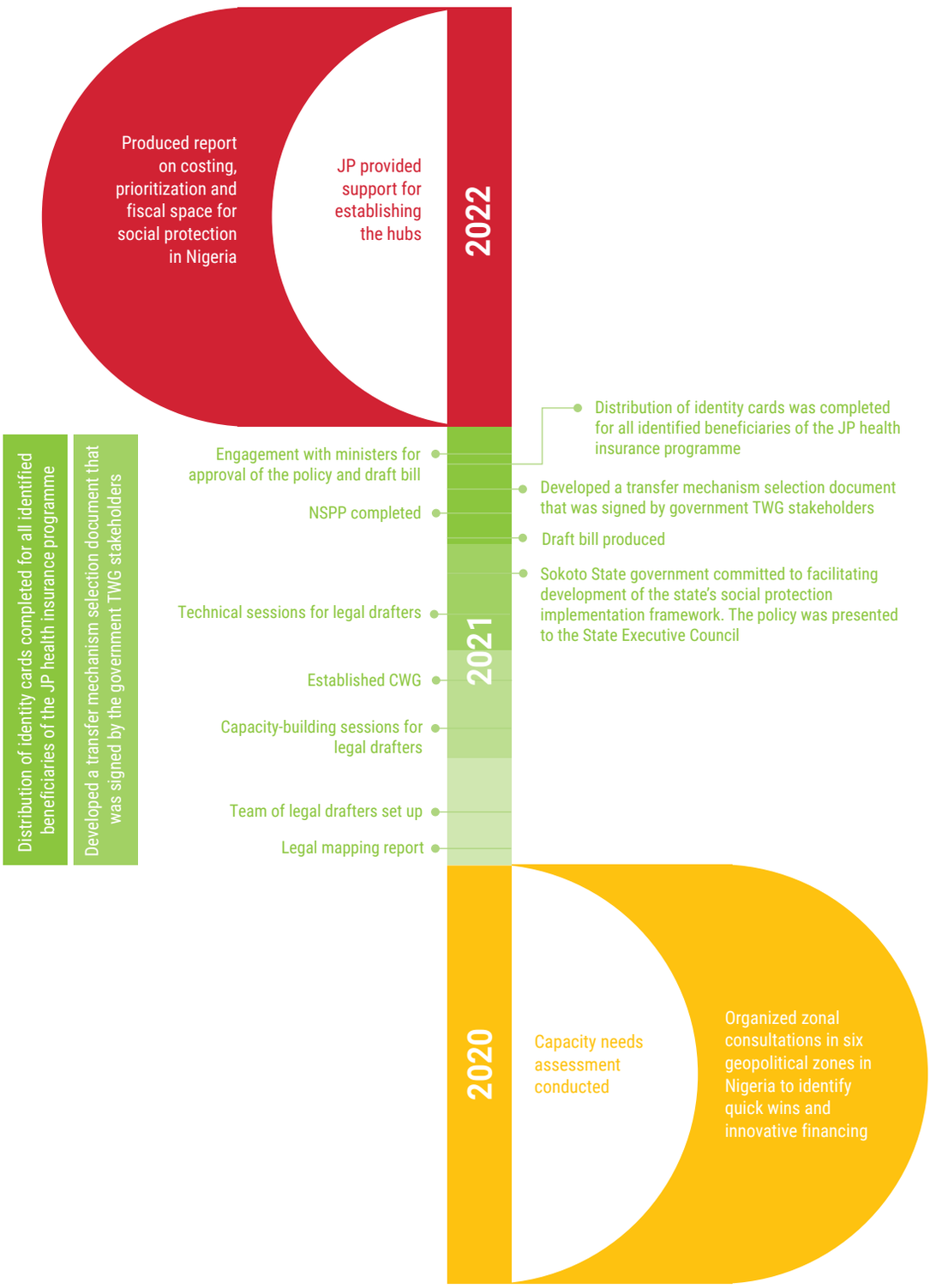
Figure 1: Stakeholder per result



* OSSAP-SDGs = Office of the Senior Special Assistant to the President on the Sustainable Development Goals

Figure 2: Programme timeline



2. METHODOLOGY

This section presents the methodology used for the final evaluation of the JP on institutionalizing social protection in Nigeria. The evaluation was conducted between July and September 2022. The following sections summarize 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 according to the OECD DAC criteria:[7]

- *Relevance:* How relevant are the integrated social protection services to priorities and policies at the national and state levels?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7 The full list of evaluation questions and sub-questions is available in the Annexes.

- *Coherence:* How coherent has the programme been with international commitments, including gender equality, equity for children and the human-rights-based approach?
- *Effectiveness:* How effective has the programme been in achieving its set objectives and its results, including any unintended and differential results?
- *Efficiency:* How efficiently has the JP been managed, given the human and financial resources available? What have the costs been, including funding and in-kind support, and how efficient has the UN Country Team been at reducing transaction costs?
- *Sustainability:* How has the JP been conducive to sustainable results in terms of social protection and buy-in from key stakeholders?
- *Impact:* What has the impact of cash transfers in Sokoto State been?

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. These lenses are not used in addition to the evaluation questions but overlap and continue to address the OECD DAC criteria. Table 4 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 to the macro level	SDGs, triple nexus (which utilizes a combination of sustainable development, peace-building and conflict mitigation), regional priorities, best practices	Impacts of COVID-19, sustainability of programming

The inclusion lens considers gender, disability and other factors of marginalization. The ecosystems lens 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, more broadly, other socioeconomic factors.

2.2 Research methods

A mix of primary qualitative and quantitative data, as well as secondary data, were collected. The tools developed to address the evaluation questions directly are further summarized in the evaluation matrix in Annex 1.

- *Key informant interviews:* Phone and in-person interviews with key stakeholders were conducted to understand the interrelations between relevant actors and assess how their coordination or competition can be leveraged for the development of social protection, as well as the potential for replication and scale-up of integrated social protection programmes across Nigeria. The KIIs were conducted with JP partners and key stakeholders in the intervention areas in Sokoto, Enugu, Nasarawa, Delta, Lagos, Gombe and Abuja. See Annex E for a list of interviewees.
- *Focus group discussions:* The FGDs covered recipients that benefited from health insurance coverage only and those that received both cash transfers and health insurance. These

discussions allowed for meaningful participation of the recipients. The FGDs were accompanied by three community observations to gather feedback and insight from communities with beneficiaries of the health insurance coverage programme in Sokoto State. See Annex E for more details on participants and sites visited for the FGDs and community observations.

- *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 but 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. See Annex E for more details.
- *Secondary research:* Two secondary research elements were integrated, namely a literature review and an analysis of programme material, including activity and progress reports, for evaluation criteria that could not be assessed through primary data collection.

For the evaluation, consultants Samuel Hall partnered with Mindset, an international social research organization with an office in Nigeria, to undertake the data collection from the FGDs, community observations and phone survey. Samuel Hall trained Mindset's field teams on their data collection methods and 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 the FGDs and the survey were selected based on a list of primary health care centres and discussions with UNICEF during the inception phase. Given the scope of the evaluation, the research team was unable to cover all target areas. A decision was therefore taken to focus on some areas covered only by health insurance and other areas covered by the additional cash transfers.

Primary health care centres 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 and other costs associated with ante- and postnatal visits and immunization at primary health care centres of 658 pregnant and/or lactating women and caregivers of children aged under 2 years. The beneficiary groups for the cash transfers were chosen because of the state's poor maternal and health indicators for women and children.

The research team conducted in-person fieldwork in three LGAs in Sokoto, namely Bodinga, Wurno and Tambuwal. The specific communities in those LGAs were chosen by prioritizing areas with a high number of beneficiaries. Ultimately, FGDs and in-person surveys were administered in the following communities:

- Achida, Wurno
- Bodinga, Bodinga
- 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 mobilization of identified participants. The KIIs were conducted with key stakeholders from a comprehensive list 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 community observations were met in all locations, the target number of KIIs was not completed due to limited available time as well as the reasons outlined in Section 2.5 on challenges and limitations.

Table 5: Qualitative sampling

TOOL	TARGET		ACTUAL	
KIIs	20		15	
FGDs	10	4 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) recipients of health insurance coverage in the three communities that have the highest number of beneficiaries who provided a phone number (two per community)		2 in Bodinga, Bodinga (cash and health) 2 in Achida, Wurno (cash and health) 2 in Dogon Daji, Tambuwal (only health)
Community observations	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 randomized, but due to limitations in the beneficiary lists provided by SOCHEMA and SOCU, which is further elaborated on in Section 2.5 below, the initial target of a phone survey with 800 households (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-two-year-olds' caregivers, adolescents, the 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. This is further discussed in Section 2.5.

The control group helped capture what the 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. No baseline evaluation, which would have provided a list of non-beneficiaries, was performed at the onset of the JP's implementation. Initially, the consultants planned to ask selected beneficiaries, at the end of the survey, if they could provide the phone numbers of one or two persons living in their community who they knew did not benefit from the programme. As most 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, 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 health care centres in Wurno, Bodinga and Tumbawal.

Figure 3: Face-to-face respondents' beneficiary profile

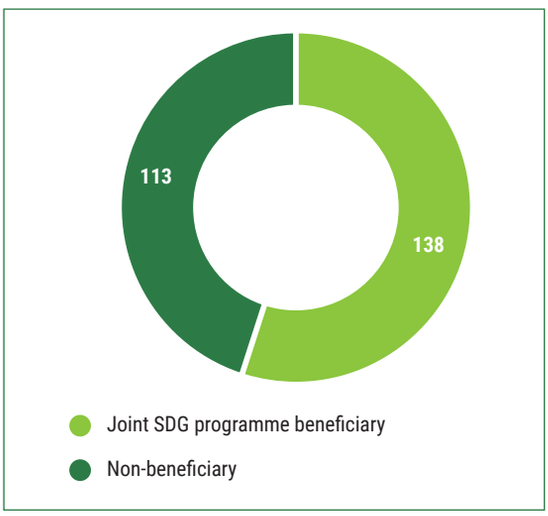

Figure 4: Phone respondents' beneficiary profile

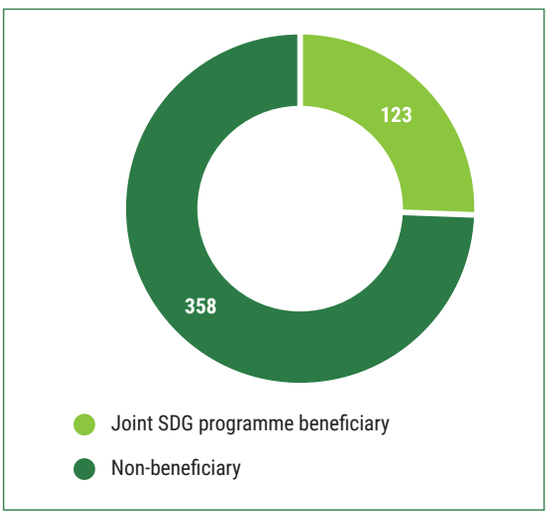

Table 6: Quantitative sampling

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 per cent) face-to-face respondents reported being beneficiaries of the JP (see Figure 3), and 123 of 481 (26 per cent) of phone respondents reported the same (see Figure 4). Ninety-seven per cent of face-to-face respondents were women and 82 per cent of phone respondents were male. Table 6 provides a summary of the beneficiaries and non-beneficiaries sampled.

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

2.4 Analysis

After the data collection phase was completed, the team performed qualitative and quantitative data analysis and financial analysis of the primary and secondary data collected. Qualitative analysis was performed utilizing an inductive qualitative analysis approach to draw findings from the collected data, drawing on the research questions and guided by the evaluation matrix. For the quantitative data analysis, the statistical teams went through each variable in the dataset to identify any anomalies. Then

the analysts calculated simple frequencies of all the variables of interest and disaggregated analyses of all key indicators by the community. Furthermore, a brief financial analysis of the JP was provided, focused on the effectiveness of the programme with regard to the budget that was allocated and to the programme's modus operandi – as one UN fund as opposed to agencies operating in a siloed approach – through reviewing relevant documentation provided by the participating UN agencies.

2.5 Challenges and limitations

The JP is a large and complex programme operating in a similarly complex environment and, 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, comprehensive baseline data 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 of and access to professional health care services by the target population in Sokoto State. Moreover, while MEAL plan was developed, it was not followed through to the end and therefore provides limited data for the 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 for fine detail at all levels and the results are, therefore, indicative. The quantitative data are not representative of the beneficiaries for the reasons outlined below. The qualitative component highlights trends, experiences and individual perceptions and is, by its nature, not representative.

The main challenge in collecting primary data from the direct beneficiaries and control group was that the choice of participants was based on the information contained in the beneficiary lists from SOCU. While the cash transfer recipients were also part of the health insurance coverage group, a comprehensive list of all beneficiaries and whether they were part of both was not provided. It should be noted that the JP 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 1,342 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 that had 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 per cent, were recipients; 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.

The low success rate of the phone survey could be related to the low rates of phone connectivity and ownership in the target areas in Nigeria, and particularly among the target groups. The lack of success might also point to limited depth monitoring throughout the implementation of the health insurance

component, which was managed by SOCHEMA, and the cash transfers, which were managed by the CWG. It should be noted 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 is analysed in Section 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 that resulted 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 on 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 to carry out the phone survey led to a prolonged data collection phase.
- After contacting and following up with the potential KII respondents from the list provided, only 15 were eventually successfully interviewed, either individually or in a group. The challenges concerning reaching the stakeholders on the list provided included lack of response, invalid email addresses and refusal to participate.

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

3. CONTEXT ANALYSIS

The following sections summarize the JP's context at the national level and in the pilot state, Sokoto. 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 in the towns of Bodinga in Bodinga LGA, Achida in Wurno LGA and Dogon Daji in Tambuwal LGA.

3.1 Nigeria

Nigeria has an estimated population of 216.7 million (UNFPA, 2022) that has faced a volatile security situation for decades, particularly in the north-east and north-west, along with huge socioeconomic disparities. It is a multi-ethnic and culturally diverse country with stark geographic differences in terms of economic growth and well-being (World Bank, 2021). Residents in the lowest wealth quintiles are concentrated in the north-east and north-


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west, while those in the highest wealth quintiles are concentrated in the south and south-west (NPC and ICF International, 2019).

In the past decade, the Nigerian economy experienced challenges of various kinds which, aside from the economic consequences of the COVID-19 pandemic, include various violent conflicts across the country, zero economic growth rates, poor management of economic and financial affairs and high unemployment rates, especially of the youth. According to the World Bank (n.d.), the gross domestic product went from US$3,100 per capita in 2014 to US$2,085 per capita in 2021. Large proportions of the Nigerian population are both monetarily and multidimensionally poor[8] and in 2020 an estimated 39,1 per cent of Nigerians lived below the international poverty line (NBS, 2020).

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 (Afolabi, 2017; Yenle, 2017). These cuts occurred in a context of high infant mortality rates of 67 deaths per 1,000 births. According to the 2018 National Demographic Health Survey, only 2.6 per cent of women and 3.4 per cent of men have subscribed to any health insurance scheme (NPC and ICF International, 2019). In terms of education, the enrolment rate in primary education is 92.8 per cent for girls and 94.5 per cent for boys.

This context has compelled the government to adopt concentrated social protection measures to address the country's challenges to alleviate the scourge of instability and promote the general well-being of all Nigerians. The NSPP, launched in 2019, was a milestone for the country's social policy. It 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 socioeconomic shocks by promoting and enhancing livelihoods and a life of dignity" (MFBNP, 2021).

While the NSPP is ambitious, its roll-out is still nascent, with only a small percentage of the vulnerable population being covered currently and a lack of clear policy direction at the national and federal levels. Social protection programmes vary between states, because state governments are encouraged to develop and implement social protection interventions best suited to the state's particular context. 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 social protection programmes in the country and supported the state in capacity-building and policymaking.

The development of the National Social Registry was essential for the roll-out of the NSPP; it is "a repository of information about potential beneficiaries for multiple social assistance programmes that share a common population of interest, but not necessarily the same eligibility approach" (Community and Social Development Authority, 2022). The initiative to develop the registry, led by the NASSCO and the World Bank, was designed and developed concomitantly to, but independently from, the JP. To build the registry, NASSCO used CBTs, which relies on community members to identify households they deem poor and vulnerable within their area of residence. UNICEF representatives emphasized the role played by the JP in operationalizing the National Social Registry by using data mined from the registery to identify Sokoto beneficiaries in partnership with SOCU, and enhancing collaboration with NASSCO at the federal level.

8 According to 2018 estimates, 46.4 per cent of Nigerians are multidimensionally poor (UNDP and Oxford Poverty and Human Development Initiative, 2020).

3.2 Sokoto State

The state of Sokoto in the country's north-west was selected as a pilot area for the social protection operationalization component of the JP. Disparities in terms of access to social services and socioeconomic status are large 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 has high levels of poverty and insecurity and an economy dependent on agriculture in primarily rural communities.

Gender disparities in political representation, access to and control over property, credit facilities, technologies, education and health are ubiquitous in Sokoto State. Fifty-two per cent of residents are in the lowest wealth quintile, with health, nutrition and education indicators being particularly low, making it one of the country's most economically disadvantaged regions. Over 80 per cent of the population is engaged in agriculture. Unemployment and inflation rates are higher than the national average and women and youth are particularly disadvantaged in the economy. Just 5 per cent of women have completed secondary education or more – the lowest rate in the country (NPC and ICF International, 2019). The state experiences insecurity with incidents of bandit attacks leading to deteriorating living conditions and human displacement. Many people in the state live in such dire conditions that immediate assistance is needed to avoid a major humanitarian crisis.

The JP health insurance component 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 mapped ministries, departments and agencies engaged in cash transfers in the state to become members of the CWG. They then conducted a capacity needs assessment to identify capacity gaps requiring strengthening for sustainability and assessed different cash transfer modalities. This was done by comparing different means of cash transfer and identifying the capacities and capabilities of implementing institutions to deliver the cash transfers, as well as 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 and how they need immediate and coordinated efforts to mitigate these.

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

In terms of the capacity of institutions to implement social protection interventions, the government of Sokoto State has shown the political will and financial commitment to institutionalize the social protection policy. It is important to note that prior to the JP there was no platform for ministries, departments and agencies implementing social protection interventions to meet, plan and share ideas. It was through the JP that the social protection TWG was established, and formally inaugurated by the State Commissioner of Budget and Economic Planning. Effective collaboration concerning social protection programmes among agencies in the state was facilitated by the JP and most notable was the establishment of the TWG. The JP developed terms of reference for the TWG, got approval from the government and supported its establishment, and also gave support to monthly TWG meetings.

3.3 Community observations in Bodinga, Wurno and Tambuwal

While the selected LGAs in Sokoto have similar poverty levels and education characteristics, the levels of insecurity and access to health care services vary slightly, as observed in the community observations, which allowed the evaluation team to focus on three towns:

- Bodinga town's geographic location is an advantage for its economy. Due to its closeness to the state capital and a highway linking it to other LGAs and states, the town has experienced consistent development. The town is the capital of Bodinga LGA and is culturally homogeneous. Respondents interviewed said that the city is relatively safe, but insecurity is still considerable in a few villages in the LGA.
- Achida in Wurno is seriously affected by increasing rates of crime and insecurity. One informant said that 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 for widows, orphans and the elderly, and a health worker complained that such people are not included in the health insurance coverage. The economy depends on agriculture, similarly to the rest of Sokoto State. Luckily, the land is suitable for supporting agrarian activities.
- Farming is reportedly the primary occupation for people in Dogon Daji town of Tambuwal LGA, and there is a limited number of businesses, and only a few shops in the town. There is little cultural diversity in the population, which numbers roughly 90,000. The town has a dense forest where criminal activities such as kidnapping and robberies frequently occur. Some respondents said that the security situation is improving due to government and community mobilization efforts.

In the communities, the state of health facilities and people's inability to cover medical costs are significant hindrances in accessing adequate health care, particularly for pregnant women and people with disabilities. Residents interviewed in Dogon Daji gave the most positive responses when asked about the state of their primary health care centre, as it was built recently and provides services that are accessible to the disabled 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 do not take into account the needs of people with disabilities or of 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 primary health care centres was reported in all locations, the majority of respondents spoke highly of the health care workers' commitment to helping their communities.

Regarding the state of education in Sokoto, the main barrier to children continuing school after the primary or secondary level is that parents cannot afford their education. Boys often emulate their parents and work on family farms, and girls marry young, when they leave school. While it was said 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 versus non-beneficiaries

The following section provides a brief comparison of key socioeconomic and health indicators for beneficiaries and non-beneficiaries of the JP to better contextualize the findings presented in the subsequent chapter. Section 2.5 (see page 34) highlights the limitations of the sampling.

3.4.1 Household characteristics

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

Most respondents, in both the face-to-face and phone samples, reported having small children. Seventy-four per cent of non-beneficiaries and 64 per cent of the beneficiaries interviewed via phone reported having children under 2 years of age. The share of such households was smaller among the face-to-face respondents, of whom 46 per cent of non-beneficiaries and 54 per cent of beneficiaries had children of this age. Similar tendencies were observed when respondents were asked about having children who were under 5 years of age in 2020/21.

Table 7 shows that while differences between non-beneficiaries and beneficiaries were not significant when asked about health care conditions during the birth of children under 2 years of age, they were significant when asked about assistance of qualified health personnel for any health issues in children under 5 years of age.

Table 7: Health assistance received according to respondents' survey answers

QUESTIONS	PHONE RESPONDENTS (%)		FACE-TO-FACE RESPONDENTS (%)	
	NON-BENEFICIARIES	BENEFICIARIES	NON-BENEFICIARIES	BENEFICIARIES
Have children under 2 years of age	74	64	46	54
% of children under 2 years born in a health facility or clinic	41	44	52	51
Have children who were under 5 years of age in 2020/21	72	73	45	60
% of children under 5 years 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 often reported pregnant women among household members (22 per cent of the face-to-face interviewees and 44 per cent of the phone interviewees), as well as chronically ill persons (7 per cent of the face-to-face interviewees and 20 per cent of the phone interviewees). Additionally, 3 per cent of face-to-face respondents and 11 per cent of phone interviewees reported that they live with physically disabled household members.

When asked about the type of home they live in, phone interviewees most frequently reported separate 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 versus non-beneficiaries (see Figure 5).

Figure 5: Type of homes in which respondents live

Table 8: Main sources of drinking water reported

WATER SOURCE	PHONE RESPONDENTS (%)		FACE-TO-FACE RESPONDENTS (%)	
	NON-BENEFICIARIES	BENEFICIARIES	NON-BENEFICIARIES	BENEFICIARIES
Dug well – unprotected	30	28	29	38
Tube well or borehole	29	27	29	22
Dug well – protected	26	25	12	21
Piped water (public tap or standpipe)	11	8	21	16

Within both samples and among both beneficiaries and non-beneficiaries, about 3 in 10 respondents reported unprotected dug wells as their main sources of drinking water. Other most frequently reported main sources of drinking water were protected dug wells, tube wells or boreholes and public piped water (see Table 8).

3.4.2 Income and household expenditure

The top three main sources of income identified by respondents in both face-to-face and phone interviews were agriculture, trade (retail) and livestock. In addition, 17 respondents interviewed via phone identified their job in the 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 (see Figures 6 and 7).

Figure 6: Main sources of income, phone interviewees

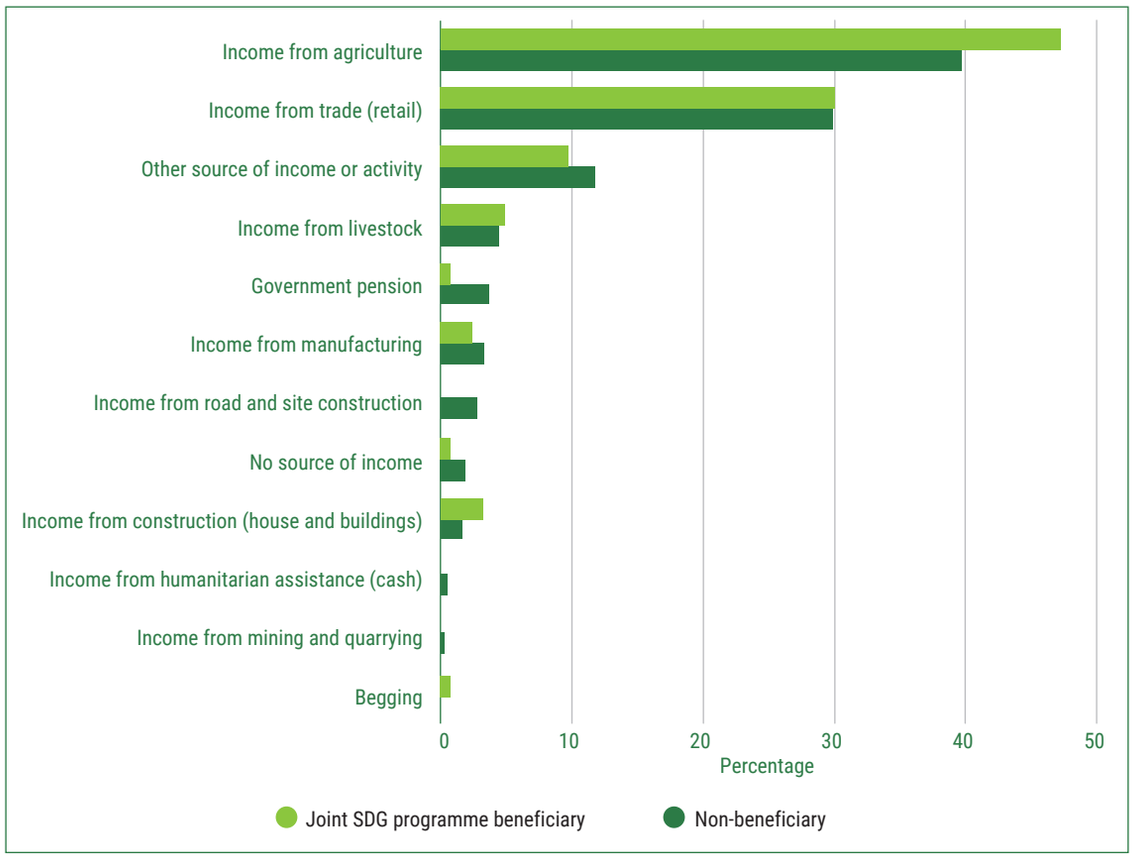


Figure 7: Main sources of income, face-to-face interviewees

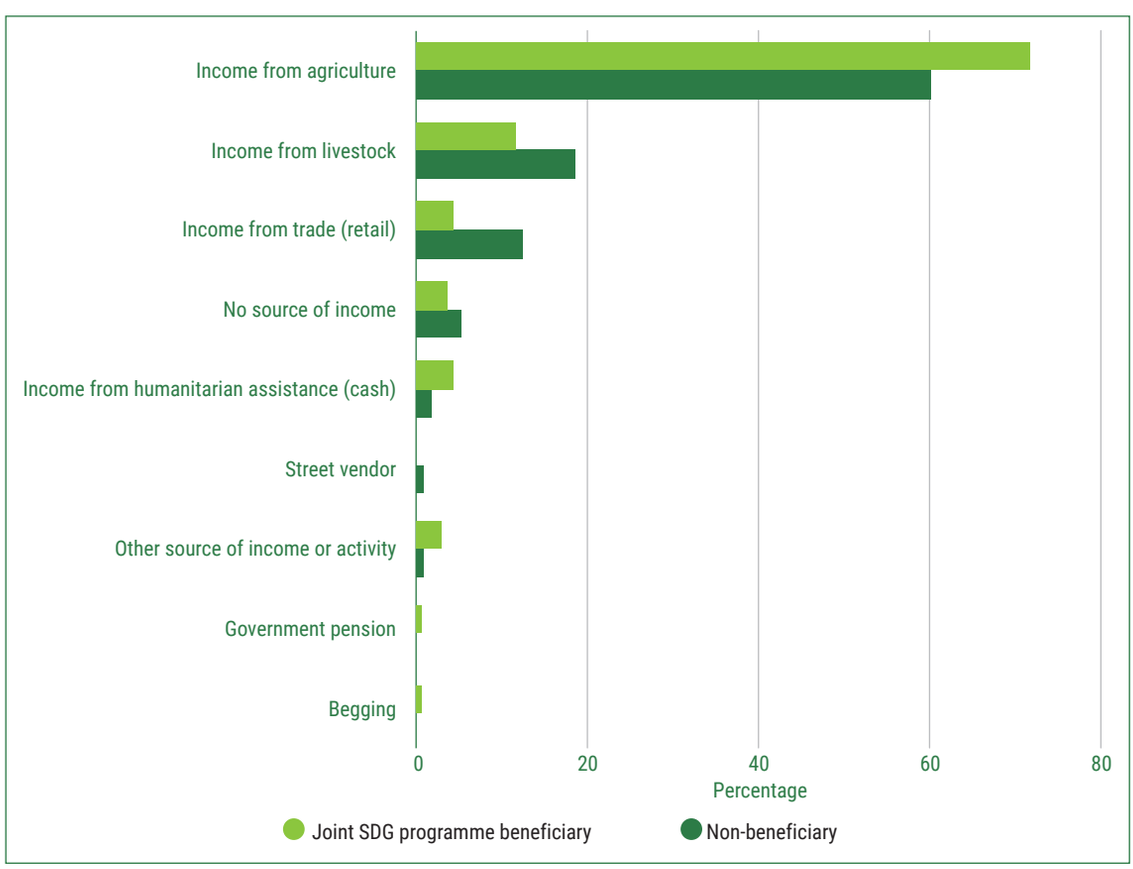
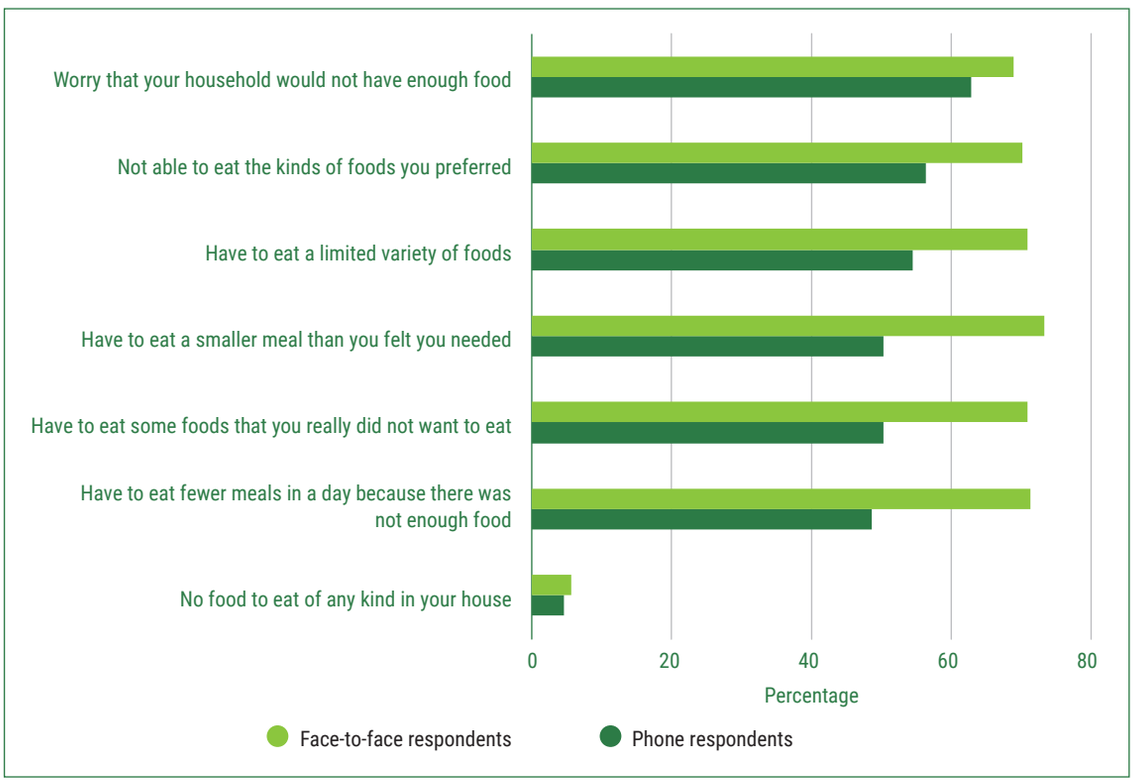


Figure 8: Food insecurity coping strategies



When asked about spending on basic items and services, most phone respondents (53 per cent) reported that between 70 per cent and 100 per cent of household expenditure is on food.[9] Only 8 per cent of face-to-face non-beneficiary respondents and 17 per cent of face-to-face beneficiaries spent this much on food.

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

3.4.3 Household expenditure on health

Most respondents in both surveys reported that up to 10 per cent of their expenditure was on health. When asked about how much of it was spent on maternal and child health specifically, JP beneficiary interviewees reported lower maternal and child health expenditure for both phone and face-to-face surveys compared to non-beneficiaries in each of the surveys. Of phone respondents, most beneficiaries (40 per cent) reported spending less than 25 per cent, in comparison to only 22 per cent of non-beneficiaries. Similarly, the face-to-face interviewees reported spending of 21 per cent by non-beneficiaries and 33 per cent by beneficiaries.

Beneficiary respondents who were interviewed via phone also reported lower expenditure on preventive health services when compared to their non-beneficiary counterparts: 40 per cent of phone non-beneficiaries spent less than 25 per cent, in comparison to 55 per cent of phone beneficiaries. The difference between the two groups was, however, not significant within the face-to-face sample.

9 Beneficiary and non-beneficiary differences were not statistically significant.

4. EVALUATION FINDINGS

The evaluation findings presented in the following sections are based on a range of primary and secondary data. The findings are categorized according to the OECD DAC evaluation criteria (see Figure 9 and Table 9) and the corresponding evaluation questions and sub-questions outlined in the methodology. The evaluation team defined three categories of assessment of the JP's merit or inadequacy in relation to the six evaluation criteria, keeping in mind the status of the project and the level of requirement in a pandemic and post-pandemic context. It must be recognized that the evaluation grid imposed by UNICEF for this evaluation (OECD DAC) does not work in the programme's favour 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 programme that was developed in a very short period of time and carried out in situations of emergency and endemic crisis, which undoubtedly call for a different evaluation approach. These dimensions, which appear to be the weakest, would be more accurately evaluated in a few years' time, if the programme were renewed.

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

Table 9: Colour coding for OECD DAC evaluation ratings

CATEGORY OF MERIT RATING	DESCRIPTION	COLOUR
High	All expectations of OECD DAC criteria are fully achieved by the project given a realistic operational and strategic calendar	
Positive	Average level of satisfaction – more than 50% of expectations are achieved and a reassuring outlook for the future	
Insufficient	Not satisfactory – less than 50% of expectations are achieved and concerning outlook for the future	
Not achieved	Expectations not met (shortfall)	

4.1 Relevance

The JP is **HIGHLY RELEVANT**

To assess the relevance of the JP, the evaluation team looked at whether the project did 'the right thing' in terms of how its interventions responded to the needs of the most vulnerable households, including people with disabilities.

Synthesis

The question of the relevance of the JP is not in doubt, as according to respondents the need for a social protection system is clear throughout the country. In this regard, the institutional component of the JP helped identify gaps and strengthened existing systems based on a needs assessment and feasibility study carried out prior to the implementation of the programme. 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 of the JP.

The evaluation team has concluded that the JP is highly relevant to the need of the poor and vulnerable population of Nigeria. This is based on the evidence of multidimensional poverty and the negative effects of COVID-19, because Sokoto State, with primarily rural communities and an economy that is dependent on agriculture, has some of the highest levels of poverty and insecurity in north-west Nigeria. Most people in the state live in such dire circumstances that immediate assistance is needed. The design of the JP is based on key evidence generated from relevant national and local surveys, assessments and studies, namely the: (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, the JP is well aligned with the national and state development plans and NSPP, as well as the National Health Act 2014. However, due to funding limitations the universal social protection coverage approach was not adopted for the JP. As such, targeting by category associated with multidimensional poverty (the elderly, children, pregnant women, persons living with disability) was given priority in the selection of the JP beneficiaries.

EVALUATION QUESTIONS		RATING
4.1.1	Are the activities and outputs of the JP consistent with the national social protection strategy and the attainment of its objectives?	
4.1.2	Have contextual factors (specific to each of the programme sites) been considered in the design and implementation and adaptation of integrated social protection services?	
4.1.3	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?	
Relevance (given the limited time and pandemic context)		

4.1.1 National Social Protection Policy

JP stakeholders supported the MFBNP in the development of a harmonized national social protection bill and the revision of a NSPP that would take into consideration emerging issues such as COVID-19, and worked with Sokoto institutions to draft a state-level social protection policy (MFBNP, 2021). Nigeria's first NSPP was endorsed in 2017. The revised version developed under the JP's mandate delineated the roles and responsibilities of social protection implementers (KII 9, World Bank). In addition to drafting the NSPP, the federal government approved the National Health Insurance Act in May 2022. According to the ILO representative, ILO 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.

The JP supported Nigeria's strengthened investment in social protection. Although there was a previous version of the NSPP, which expired in 2020, there was no implementation plan and it had not been costed. The JP supported the revision of the policy to include a costed implementation plan and M&E framework. As the NASSCO representative pointed out, social protection, as a concept that is new and not necessarily well understood by all political bodies, remains fragmented; the federal government and state authorities do not share a common vision and strategy and there is no expenditure tracking mechanism in place. A focal point for ILO further noted that the social protection policy drafting process highlighted coordination issues between government agencies. To address this, the JP supported the TWG in establishing a legal and harmonization committee comprising legal advisers from key ministries to support the drafting of the social protection bill. The bill identifies social protection as a human right and focuses on increasing and improving coordination between state institutions, which have implemented various social protection programmes but failed to "speak to each other" (KII 4, ILO). If the policy is taken forward, state institutions will establish a national social protection 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 feasibility study, which were critical to identifying and understanding opportunities and challenges related to social protection. As the OSSAP-SDGs representative put it, "a blanket approach will not work in Nigeria due to the country's diversity and differences between states" (KII 9, World Bank). The Ministry of Education delegate noted that various aspects were considered in the JP's design phase, ranging from security to access to health care. A representative for the UN Resident

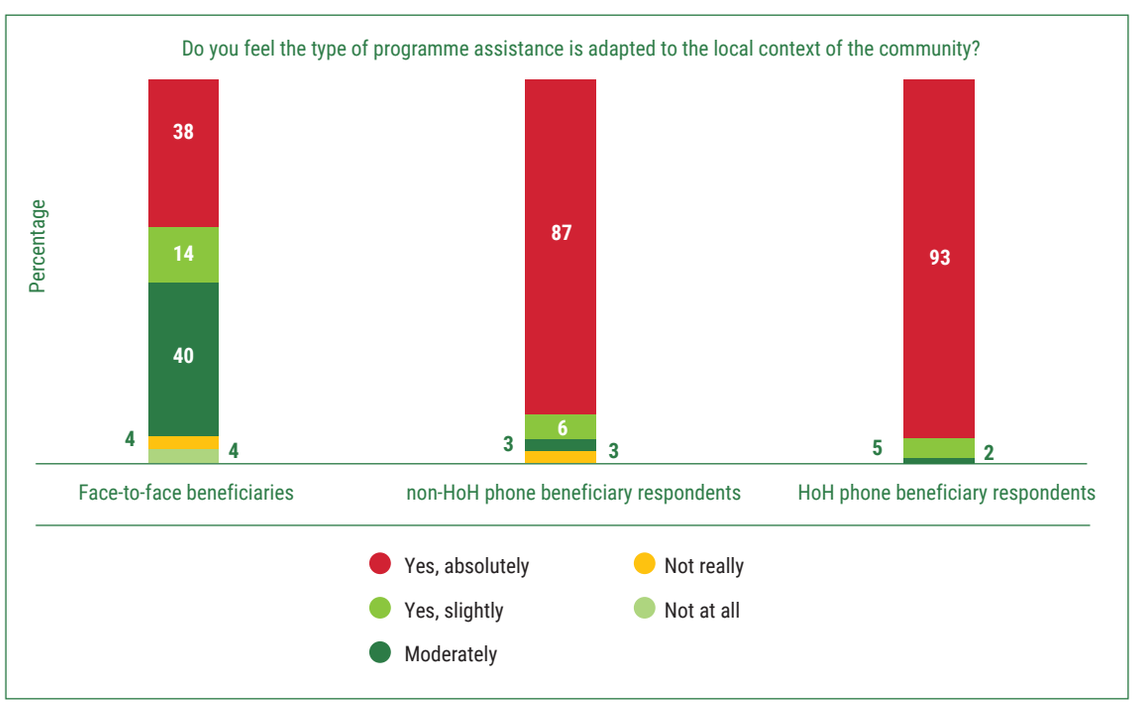
Coordinator's Office, however, pointed out that assumptions surrounding Nigeria's institutional capacity with regard to social protection had not been verified prior to implementation. According to this informant, these inaccurate assumptions affected the roll-out of the pilot component in Sokoto, with beneficiary identification being more challenging and time-consuming than anticipated.

4.1.3 Relevance of integrated social protection services to the most vulnerable households

Most survey respondents agreed that the programme assistance was adapted to the local context of the community, but face-to-face respondents were much less likely to report that they absolutely agree with this statement (39 per cent) compared to phone respondents (90 per cent). Ninety-three per cent 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. Eighty-seven per cent of phone respondents reported that this was absolutely the case compared to 44 per cent of face-to-face respondents. As the majority of those interviewed face-to-face were women, this 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 of the JP. Sixteen per cent of face-to-face beneficiary respondents reported having any challenges compared to 24 per cent of phone head-of-household (HoH) respondents and 22 per cent of non-HoH phone respondents.

The interview with the Sokoto Ministry of Education representative suggests that despite the explicit target of including people with disabilities in the JP, this group was not purposely reached out to during the implementation phase, nor were their specific needs taken into consideration. This was apparent in the cash distribution modalities the programme opted for, which beneficiaries themselves identified as inadequate. In Achida, several participants indeed mentioned 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 (FGD 1, women, Wurno). Similarly, people with disabilities may be unable to go to health centres to receive care.

Figure 10: Programme assistance's relevance to local context



> When we go for registration and meet them in the field, we involve everybody. But to target those with disabilities, no. The health programme 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.
> KII 14, SOKOTO 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.
> FGD 3, MIXED, BODINGA

While the aims of the programme seemed to be clear to the majority of respondents, they might not all have been aware that people with disabilities were explicitly targeted (97 per cent of face-to-face respondents and 80 per cent 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 programme awareness sessions, as 76 per cent of face-to-face beneficiaries responded that someone from their community was likely to have attended an awareness-raising session compared to 68 per cent 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 noted that politicians who were tasked with coordinating beneficiary identification only selected those who were affiliated with their party: "if you don't do their politics, they wouldn't include you in this support" (FGD 3, mixed, Bodinga, Bodinga). 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" (FGD 2, 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].
> FGD 3, MIXED, BODINGA, BODINGA

This was not the case in Dogon Daji (FGD 5, mixed, Tambuwal), 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 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

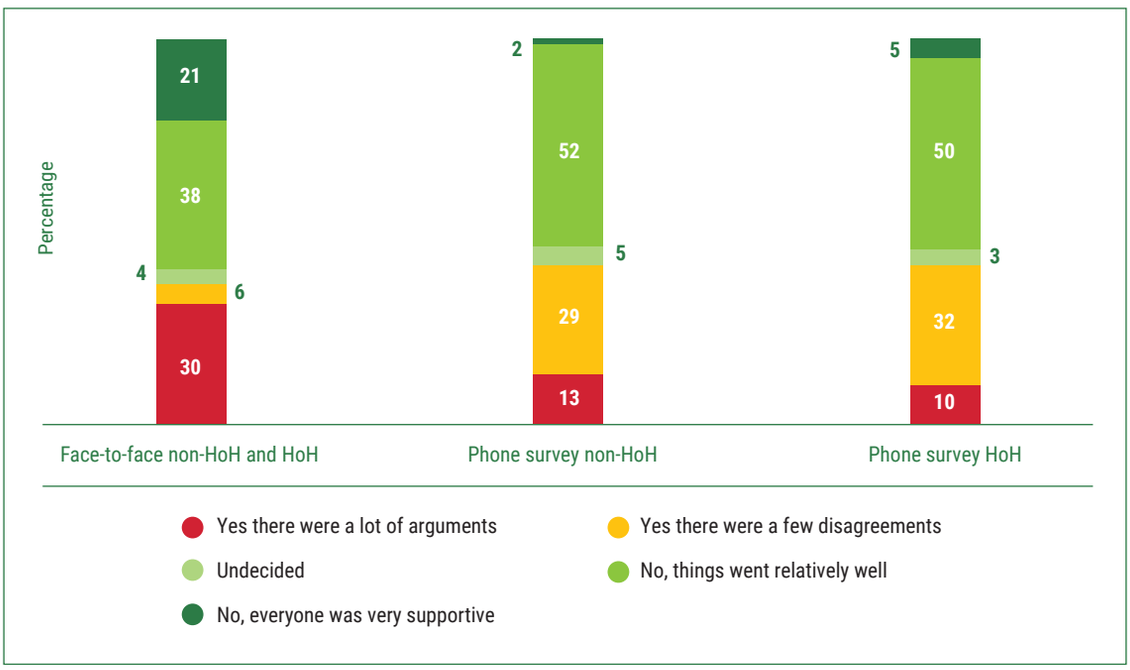
Beneficiaries in Bodinga and Achida seemed to be vague about the selection criteria. Several discussion participants appeared unaware of the selection criteria. This suggests that communication surrounding the assistance that community members could apply for may have been insufficient. In this regard, a participant in Bodinga said that the onset of the selection and distribution activities was confusing and poorly organized. In Achida, participants said they did not know when to go to collect the cash transfers; one of them said, "if you heard [that someone] collected theirs, you go to the [collection point] with yours" (FGD 1, women, Wurno). 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 noted, "we were not given [the cash transfer] even though we heard that neighbouring towns received it" (FGD 5, mixed, Tambuwal, Dogon Daji).

> At the time they came for our names, there were the elderly who didn't know about the programme 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.
> FGD 8, WOMEN, BODINGA, BODINGA

The SOCHEMA representative 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 transfer resulted in 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 seems to have played a key role in incentivizing 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 programme 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 benefiting from the programme and are very happy. […] She told me before the programme, she used to beg for medical and financial support from the rich houses and the politicians. But now they can easily use the slip to seek medical care in the hospital.
> FGD 5, MIXED, TAMBUWAL, DOGON DAJI

Figure 11: Challenges or problems with receiving programme assistance



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

Thirty-six per cent of face-to-face respondents and 42 per cent of phone respondents reported that at least a few disagreements had arisen as a result of the programme, with 30 per cent of face-to-face respondents reporting that there had been many disagreements (see Figure 11). However, these arguments seemed to be confined to intercommunity dynamics. Few respondents who received cash transfers reported that any conflict had arisen within the household itself (89 per cent of face-to-face and 87 per cent of phone respondents reported that conflicts either never or rarely arose within the household).

4.2 Coherence

The JP is **POSITIVELY ALIGNED** with global, national and subnational priorities.

To evaluate the coherence of the JP, 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 social protection interventions.

Synthesis

In terms of coherence, the JP has certainly succeeded in initiating or strengthening collaboration 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 CWG. Each implementing UN agency and national body was able to bring a different skill set to the table to achieve a common objective. This would not have been possible had these institutions been operating separately. In terms of the JP's uniqueness in comparison to other programmes, it was able to address pressing needs that had not been tackled before.

Based on the evidence of a desk review of available documents, KIIs and FGDs, the evaluation team concludes that the JP is positively aligned 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 social protection programmes at the federal and state level, which include the national cash transfer programmes, Basic Health Care 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 populations (widows, orphans and survivors of sexual and gender-based violence) and the State Cash Transfer Office cash transfer programme to vulnerable populations.

The JP promotes gender equality and the rights of persons with a disability through its focus on interventions with pregnant women and lactating mothers, the formulation of a rights-based social protection bill and the provision of input into the National Health Insurance Act 2022 that makes health insurance mandatory for all Nigerians.

EVALUATION QUESTIONS		RATING
4.2.1	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?	
4.2.2	What are the strengths of the JP in comparison to other social protection programmes?	
4.2.3	What are the strengths of the coordination and convening roles of the JP, and to what extent did the JP contribute to enhancing UN Country Team coherence?	
Coherence (given the limited time and pandemic context)		

4.2.1 Gender and equity focus

While the JP sought to involve the state Ministry of Women and Children Affairs in its implementation phase, a ministry representative said the ministry was seldom involved in the roll-out of the Sokoto pilot, despite being a member of the TWG. The 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 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 social protection discussions in Sokoto. The SOCHEMA representative further pointed out that SOCHEMA carried out gender-sensitive training with enumerators in charge of identifying beneficiaries. The WFP provided training on the prevention of sexual exploitation and abuse, and protection to all desk officers of the complaints feedback mechanism, CWG members and SOCHEMA call centre contact personnel. Similarly, and as discussed above, the JP sought to include persons with 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, distinguishes the programme from 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.
> FGD 8, WOMEN, BODINGA

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

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

4.2.2 Strengths of the JP compared to other social protection programming

Interestingly, many discussion participants believed that health insurance coverage provides more adequate assistance than cash transfers on their own. Another strength of the JP is the fact that most participants were able to reflect on the type of assistance they received, i.e., health insurance coverage and the JP was able to respond to concrete needs and alleviate beneficiaries' anxiety with regard to health care.

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 and emphasized that its regularity was a considerable advantage. In terms of other aid received, the quantitative data showed that 27 per cent of JP beneficiaries reported having received aid outside of this programme compared to 7 per cent of non-JP beneficiaries. The most commonly reported aid received from other organizations was 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" (FGD 3, mixed, Bodinga).

One of the participants in Dogon Daji explained that the JP's assistance was timely because "things are very hard now" (FGD 6, mixed, Tambuwal). In July 2022, after the cessation of the JP and shortly before data collection, Nigeria experienced an inflation rate of 19.6 per cent, the highest since 2005 (Aanu, 2022), with immediate consequences:

> The only medical intervention we benefited from in the past was immunization for some diseases like measles, polio, etc. It was hardly likely to receive free prescription drugs in the

hospital in the past. They would only prescribe it for you to buy outside of the hospital.
FGD 5, MIXED, TAMBUWA.

Most discussion participants did not have a clear understanding of who was behind the JP; this could be related to the low literacy levels, but also implies that this information should have been more strongly emphasized during the beneficiary identification and assistance distribution processes. Several participants in Dogon Daji believed that the government had provided the health insurance coverage and cash transfers (FGD 6, mixed, Tambuwal), while some participants in Achida identified a doctor, OC Saadu, as the source of the assistance. In Achida, a participant believed that the hospital was behind the provision of her health care coverage:

I received ₦5,000 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.
FGD 4, MIXED, WURNO

4.2.3 Strengths of the UN Country Team's contribution to the JP's coherence

In the interviews, JP stakeholders emphasized the critical role played by the UN Country Team, which had capitalized on implementing agencies and stakeholders' unique skill sets. The ILO representative, for instance, felt that the UN Country Team provided a platform to "come together and deliver on a common objective" (KII 4, ILO) while the Save the Children International delegate noted that "the programme played a unifying [role]... the Development Partners Group was strengthened and membership broadened" (KII 7, Save the Children International). The NASSCO delegate further said that "there is [a] huge complementarity in bringing different skill sets towards [the] implementation of the programme", which was apparent in the way NASSCO worked with UN bodies to expand the registry to Sokoto State through the Zakat list (KII 8, NASSCO).

These statements echo the testimony shared by the representative from the UN Resident Coordinator's Office, who believed that, despite challenges, coordination between the various implementing agencies worked well and that the Sokoto pilot yielded encouraging results. This was, in part, due to the complementary roles and expertise of leading agencies – policy development for ILO; children, women and nutrition for UNICEF; social protection and cash transfers for WFP; and institutional capacity-building and the creation of innovation hubs for UNDP. This informant further emphasized that the JP could not have achieved these results if implementing agencies had been working separately:

The JP changed the way the government perceives social protection and encourages states, even the poorest ones, to look for ways to generate revenue.
KII 10, UN RESIDENT COORDINATOR'S OFFICE

4.3 Effectiveness

The JP 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 the SDGs.

Synthesis

Despite the absence of a baseline, which made it difficult to capture the effectiveness of health insurance coverage for the JP recipients, great strides have been made on the institutional side, most notably the drafting of a revised NSPP and harmonized national 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 concluded that the SDG project has successfully achieved the expected results as committed in the results framework regarding its two outcomes and outputs. The evaluation team's review of relevant documents, KIIs and FGDs revealed 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. In addition, the draft NSPP was approved by the Federal Executive Council and during the same period, 2020–2022, the budget allocation for social protection increased by over 100 per cent.

The JP provided capacity and institutional strengthening that led to an increase in health insurance coverage from 3 per cent to over 5 per cent of 200 million citizens (10 million beneficiaries).

Regarding the social protection activities at the state level, over 600 pregnant and/or lactating women and caregivers of children under 2 years benefited from the mixed (unconditional and conditional) cash transfer, with over ₦5,200 received monthly for a period of six months. Six thousand health insurance beneficiaries (70 per cent female and 30 per cent male), were registered in primary health care facilities across four LGAs. Beneficiaries were able to access free health care services whenever they visited their designated centres.

EVALUATION QUESTIONS		RATING
4.3.1	To what extent has the JP contributed to accelerating the SDGs at the national and state levels, as well as contributed to UNSDPF Outcome 6?	
4.3.2	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 JP?	
Effectiveness (given the limited time and pandemic context)		

4.3.1 Performance evaluation of the JP's effectiveness vis-à-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 10, reveals that the JP was successful overall in meeting expectations. Given the operational time frame (two and a half 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: (i) institutional capacity-building and implementation of the strategies developed; and (ii) 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 Resident Coordinator's Office to the SDG Secretariat at headquarters, as well as the FGDs and KIIs with stakeholders, are the reference sources for the evaluation of programme effectiveness. It naturally has some limitations, as the data were 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 a 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 NSPP was 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 JP 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 (versus 2,000 expected) received a numerical cash transfer allocation of about ₦20,000 and about 6,000 pregnant women and girls were provided with free access to health services under the health insurance programme. In addition, under the Basic Health Care Provision Fund programme funded by the government and World Bank, about 59,615 women were enrolled in the health insurance programme 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,[10] 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 logical framework 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 indicators and results.

Table 10: Assessment of achievement of expected results of the JP 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

10 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, 2015).

EXPECTED RESULTS	INDICATORS	BASELINE	EXPECTED RESULTS 2021	RESULTS ACHIEVED IN 2022 (FINAL RESULT)	ANALYTICAL ASSESSMENT
Output 1.1: Strengthened national social protection legal framework with the development of a social protection bill, aimed at realizing rights to social protection for consideration by the National Assembly	Output indicator 1.1a: Percentage of key stakeholders with increased capacity/knowledge on social protection system development (gender disaggregated)	To be determined	90%	80%	Achieved with significant caveats: (i) efforts to be made in terms of gender parity; (ii) qualitative interviews contradict 2022 data
	Output indicator 1.1b: Existence of social protection bill technically validated by stakeholders	No	Yes	Yes	Achieved
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 government KII)
	Output indicator 1.2b: National priorities in social protection costed	No	Yes	Yes	Achieved
	Output indicator 1.2c: New strategy designed and signed by government	No	Not available	Not available	Not achieved
Output 1.3: SDG 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 subnational 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	Not available	8	10	Achieved with limited evidence communicated to the research team

EXPECTED RESULTS	INDICATORS	BASELINE	EXPECTED RESULTS 2021	RESULTS ACHIEVED IN 2022 (FINAL RESULT)	ANALYTICAL ASSESSMENT
Outcome 2: By 2021, the NSPP is operationalized in 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 2a: Percentage 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 2b: Percentage of poor with access to health care (disaggregated by gender)	31,362 enrolled beneficiaries (male 27.7%; female 72.2%)	50,000 enrolled beneficiaries with access to state health care (male 40%; female 60%)	59,615 enrolled beneficiaries	Achieved
	Outcome indicator 2c: Percentage of poor/vulnerable girls covered by cash transfer programme (disaggregated by gender)	Not available	2,000 pregnant and/or 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 and community-based insurance mechanisms	Output indicator 2.1a: Percentage of girls and women covered by health insurance (disaggregated by gender)	31,362 enrolled beneficiaries (male 27.7%; female 72.2%)	5,000 enrolled beneficiaries (male 35%; female 65%)	6,000 enrolled beneficiaries (male 30.1%; female 69.9%)	Achieved with a positive trend in the last few months of implementation

4.3.2 Assessment of beneficiaries' opinions/satisfaction vis-à-vis 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.

Overall, stakeholders believed that the JP's focus on capacity-building of government institutions played a key role in creating an environment where these institutions were empowered to take the social protection policy forward. The JP, primarily through the TWG that was created with support from UNICEF, informed WFP of the creation of a CWG (KII 10, UN Resident Coordinator's Office). In turn, WFP organized a series of training sessions for the CWG members to develop payment strategies and monitoring tools for cash transfers (KII 14, Sokoto Ministry of Education). The CWG, with UNICEF, subsequently engaged in other projects, including a cash transfer programme, to encourage school enrolment, and also trained ministries, departments and agencies on how to locate beneficiaries and transfer cash effectively (KII 14, Sokoto Ministry of Education).

According to the UN Resident Coordinator's Office representative, the JP also sought to change the paradigm around social protection: across the country, social protection was considered a federal responsibility and the JP attempted to engage states in adopting their own social protection policies. This echoes the input of the SOCHEMA representative, who recalled that ILO carried out a capacity assessment to identify SOCHEMA's needs and delivered training on social protection and health insurance, and WFP updated SOCHEMA's management information system. Similarly, the OSSAP-SDGs 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 ad hoc capacity-building on social protection 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 design and implementation of social protection programmes. In addition to the policy, implementation and MEAL activities, the JP has supported the development of the Sokoto State social protection costed implementation plan to ensure the inclusion of social protection cost estimates in the annual budget. A Save the Children International representative, however, said that the JP should have put 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 raise resources other than those provided by the project. The ILO is working with the government to identify an innovative way to generate revenue for social protection, and the JP asked the government to contribute additional financial resources to social protection.

> 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.
>
> KII 7, SAVE THE CHILDREN INTERNATIONAL

It must be noted that increased budget allocation to social protection has been achieved both at the federal and state levels and the JP's fiscal space assessment identified innovative funding mechanisms

for social protection 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.

4.4 Efficiency

The JP is **POSITIVE** in value for money.

With regard to the JP's efficiency, the evaluation team looked at the resources (financial, human and timing) of the project to assess if they had been adequately used to achieve the expected results.

Synthesis

It is worth mentioning that important efforts have been made in terms of coordination among the relevant entities of the JP, such as signing of a memorandum of understanding to ensure that interventions implemented under the Basic Health Care Provision 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 JP. Nonetheless, concerns have been raised about tensions between the different social protection entities that could limit these coordination efforts.

Regarding value for money, the unit cost of intervention was about US$68.9 (₦30,314) for the delivery of multiple times access to free health services and medication that benefited 6,000 women and children as implemented by the UNICEF field office in Sokoto. The unit cost was US$112.65 (₦49,566) for 658 pregnant and/or lactating women and children under 2 years of age who benefited from 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 NSPP will ensure the extension of the coverage to previously excluded populations.

The evaluation team has concluded that the JP ensured adequate value for money.

EVALUATION QUESTIONS		RATING
4.4.1	Have the integrated social protection services been implemented in an effective and efficient way in terms of both human and financial resources, compared to other alternatives?	
4.4.2	Are activities low in cost and affordable, yet of adequate quality to improve the situation of vulnerable households?	
4.4.3	Is the current organizational set-up, collaboration and contribution of concerned ministries and others working effectively to help ensure accountability? What more can be done?	
Efficiency (given the limited time and pandemic context)		

4.4.1 Assessment of the organizational set-up, collaboration and contribution of ministries and others towards ensuring accountability

The JP sought to strengthen coordination mechanisms for social protection. According to the ILO representative, the organization worked with the National Health Insurance Scheme, NASSCO and the World Health Organization to sign a memorandum of understanding with SOCU and ensure that all health insurance interventions implemented under the Basic Health 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 at the end of the project in June 2022. However, key informants interviewed during this evaluation raised concerns about state institutions' ability to coordinate to

take the social protection policy forward and develop a legal framework around its implementation. Key informants also discussed underlying issues. One of them (KII 15, National Cash Transfer Office) noted that there are political disagreements and tensions between NASSCO and the National Cash Transfer Office that translate into limited sharing of information, as well as a lack of coordination and communication between social protection entities and the government. This informant noted that a key government stakeholder working on social protection in Sokoto was not aware of the JP. Another informant, representing one of the implementing agencies, raised concerns about the government's ability to deliver on social protection due to critical capacity gaps (KII 3, WFP). While the JP and some of its leading stakeholders worked with the Nigerian government to streamline and integrate social protection, the government remains ill-equipped to implement social protection.

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

4.4.2 Financial analysis

The tables in this section provide a breakdown of expenses over the period 2020–2021, based on documents shared with the evaluation team by UNICEF, WFP, ILO and UNDP. As previously indicated in Section 2.5 (page 34), a comprehensive financial analysis cannot be performed due to the lack of relevant and related financial documentation.

As shown in Table 11, the UN agencies utilized almost their entire allocation of funds, except for ILO, which used around 88 per cent. The total utilization rate of the JP was 96 per cent. In terms of share of the total US$1.951 million that was allocated, UNICEF had the highest share (36 per cent), followed by ILO (26 per cent), then UNDP (21 per cent) and lastly WFP with the lowest share (18 per cent).

Table 11: Status of JP funds

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

The main limitation regarding the analysis of the amounts spent by expenditure category is that ILO's expenditures are not included because they were categorized by project outputs, unlike the rest of the agencies (Table 12). Therefore, the analysis is restricted to the amount spent by UNDP, UNICEF and WFP. It is noteworthy that the categories that had the highest share of total spending for the three agencies were cash disbursements (around 43 per cent) and services (32 per cent). Travel accounted for 8 per cent of total expenditure and the rest of the categories for between 3 and 5 per cent.

When taking a closer look at the category with the highest expenditure (cash disbursement) we find that UNICEF used 67 per cent of this category while WFP used the rest (UNDP had no cash disbursements). UNDP and UNICEF spent almost equal amounts on services (48 per cent and 52 per cent, respectively) while WFP did not spend on this category at all. Lastly, in terms of total travel

spending, UNDP's expenditure was the highest (64 per cent of the category's total), followed by UNICEF (21 per cent) and WFP (15 per cent).

Table 12: Total amount spent by UN agency and by category of expenditure (in US$)

TYPE	UNDP	UNICEF	WFP	ILO	TOTAL
Salaries	10,954.40	1,869.00	40,000.00	Data missing	52,823.40
Cash disbursements	–	413,380.00	204,487.80	Data missing	617,867.80
Services	221,893.10	239,130.80	–	Data missing	461,023.90
Supplies	–	16,676.50	56,390.40	Data missing	73,066.90
Travel	71,495.00	24,004.90	16,603.00	Data missing	112,102.90
Direct charge head cost	67,323.40	0.80	11,157.30	Data missing	78,481.50
Programme support costs	25,924.50	–	21,361.50	Data missing	47,286.00
Total	**397,590.38**	**695,062.00**	**350,000.00**	**Data missing**	**1,442,652.38**

4.4.3 Value for money: Cost-effectiveness analysis

Despite the challenging constraints to obtaining adequate financial data related to the operationalization of the JP to beneficiaries in Sokoto State, the evaluation team has tried to perform a cost-effectiveness analysis using two approaches: (i) estimation of a unit cost of service delivery of health insurance and digital cash transfer; and (ii) cost analysis by the three categories of outcome (examples of ILO's interventions) using specific financial data per outcome provided by ILO.

Cost-effectiveness analysis of delivery of health insurance and digital cash transfers

According to UN staff, there was positive value for money for cash transfer assistance in the JP, but the SDG project is considered to be only partially cost-effective, in view of the limited result achieved for the digital cash transfer aspect: only 32.4 per cent of the expected target beneficiaries were reached.[11] Table 13 shows the unit cost was about US$112.65 (₦49,566) for 658 pregnant and/or lactating women and children under 2 years of age who benefited from digital cash disbursements delivered by WFP in Sokoto State. The unit cost of intervention was about US$68.9 (₦30,314) for the delivery of multiple access to free health services and medication that benefited 6,000 women and children as implemented by the UNICEF field office in Sokoto.

While these results confirm the achievement of the first of the following objectives and the shortcomings of the second, it should be noted that the focus remains: (i) outputs and results-oriented (i.e., reaching the expected number of beneficiaries) without sufficiently considering the real (and evolving) needs of a population exposed to chronic crises; and (ii) limited in terms of the analysis of value for money, as there is no comparative evidence to draw conclusions from (e.g., other similar implementation contexts for UNICEF or WFP, or other programmes in Sokoto implemented by other humanitarian actors).

11 This section and the analysis of value for money was shared by UN staff between the draft and final iterations of this report. These calculations are their responsibility.

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

EXPECTED RESULT	PLANNED NUMBER OF BENEFICIARIES	BENEFICIARIES REACHED (RESULT ACHIEVED)	% ACHIEVED (COVERAGE)	TOTAL EXPENDITURE	ESTIMATED AVERAGE UNIT COST
Provision of health care coverage to 6,000 beneficiaries	6,000	6,000 women and children	100	US$413,380	US$68.90 (₦30,314)
Digital cash transfer provided to pregnant and/or lactating women and children under 2 years of age	2,030	658 women	32.4	US$74,124	US$112.65 (₦49,566)

This important caveat naturally leads to some simple recommendations for strengthening future JP value-for-money calculations: (i) favouring longitudinal analyses to capture improvements in value for money over time; (ii) systematizing comparative analyses with similar contexts and programmes; (iii) disaggregated cost analyses, to better understand how and where the JP spends most of its money; and (iv) 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 value for money to a more dynamic and qualitative approach, which would help capture the actual *value* and *effectiveness* of the programme for the populations in need, i.e., the extent to which the JP contributes to improving beneficiaries' lives in a given context.

Analysis of cost-effectiveness of the JP by outcome

Financial analysis by outcome was only feasible for ILO spending, as ILO is the only agency that had categorized spending according to the project outcomes (see Table 14). Moreover, given that ILO did not engage in Outcome 3, there are no expenditures to show for that outcome in the table. The bulk of ILO spending went to Outcome 1, which constituted around 63 per cent of the agency's total funding, while Outcome 2 made up around 37 per cent. It is noteworthy that ILO spent nothing on Outcome 2 in 2022.

Table 14: ILO fund utilization/distribution per outcome

OUTCOME	PREVIOUS YEAR (US$)	CURRENT YEAR (%)	TOTAL (US$)	% SHARE OF FUNDING PER OUTCOME
Outcome 1 Implement a legally and financially strengthened social protection system (SDG 1.3). The JP is expected to have a draft social protection 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	PREVIOUS YEAR (US$)	CURRENT YEAR (%)	TOTAL (US$)	% SHARE OF FUNDING PER OUTCOME
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 from the poorest and most vulnerable groups have been identified to be enrolled in a selected state's health insurance scheme, of 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 six 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
Grand total	**207,864**	**51,808**	**259,672**	**100.00**

4.5 Sustainability

The JP is **UNSUCCESSFUL** in sustainability.

To evaluate the JP's 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 JP, as well as through identifying good practices and lessons learned.

Synthesis

The evaluation team has concluded that the JP did not ensure the sustainability of gains. There was no strategy in place to ensure that the beneficiaries, who are among the poorest in north-west Nigeria, would continue to benefit from health care coverage after the JP ended. In addition to 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: (i) an exit strategy for the JP's partners; and (ii) the gradual ramping up of government partners' involvement (technical and financial).

The JP helped improve capacity and coordination among state agencies (MFBNP, 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 government authorities is not guaranteed. According to agencies such as ILO or UNDP, the lack of understanding, capacity, training and resources of government and institutional partners could jeopardize the interventions implemented over the period of the JP. Moreover, the difficulties of implementation in Sokoto and the fact that the specifics of social protection (as opposed to a cash-based assistance programme) were only marginally understood, seem to condemn the intervention. However, when it comes to social protection, the 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, communities and the people. Besides the necessary improvements to be made to the design and implementation of the programme, and in addition to the questions of scale-up or replicability, this calls for a reflection on the modalities of follow-up of the assistance provided since the beginning of the intervention in Sokoto.

EVALUATION QUESTIONS		RATING
4.5.1	To what extent has the strategy adopted by the JP contributed to the sustainability of results, especially in terms of the SDG principle of 'leave no one behind' and the social protection system?	
4.5.2	To what extent has the JP 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 JP through the action of the government and other stakeholders and/or UN country teams?	
4.5.3	What lessons were learned about the provision of integrated social protection services?	
4.5.4	In what ways should the current JP approach be revised or modified to improve the sustainability of the programme's services?	
Sustainability (given the limited time and pandemic context)		

4.5.1 The JP fostered coordination among state agencies and with organizations/associations

Interviews with JP implementing agencies highlighted that the JP brought together several ministries, including the MFBNP, MLE and MHDSD. Following the implementation of the JP and notably the state consultations, other states appear to have expressed interest in adopting a social protection policy – this is the case in Kaduna (KII 4, ILO) and Zamfara (KII 10, UN Resident Coordinator's Office). Another encouraging step towards the strengthening of social protection includes the signing of memoranda of understanding between SOCHEMA and three associations in Sokoto State – the All Farmers Association of Nigeria, 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 per person (KII 5, SOCHEMA). The All Farmers Association of Nigeria representatives notably said that the association secured a loan of ₦1 billion for their 1.5 million members, who agreed to a one-year period of deduction from wages for health insurance. The success of their enrolment process, however, remains to be seen. Other stakeholders mentioned the role played by the TWG in harmonizing social protection programming carried out by Sokoto ministries, departments and agencies. According to one of them, the TWG encouraged entities responsible for social protection implementation to coordinate for the first time, notably due to UNICEF developing a social protection policy that encourages state ministries to abide by it (KII 13, Sokoto Ministry of Budget and Economic Planning).

4.5.2 Continuity and takeover by government authorities is not guaranteed

Despite coordination efforts led by government authorities, some concerns remain around these authorities' understanding of what social protection entails and how to deliver it. According to the ILO representative, certain institutional personnel believe that social protection is about handing out cash, as opposed to providing health insurance (KII 4, ILO; KII 6, MHDSD). This misunderstanding negatively affects operational coordination between institutions tasked with implementing the social protection policy. Several stakeholders also pointed out that it would remain challenging to ensure continuity when there was a change of administration, which was scheduled for February 2023. Notably, the World Bank representative explained that a social protection 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 social protection is a "vector of poverty reduction". In addition, some key informants called for the government to identify funding sources for social protection, as opposed to simply advocating for and promising to dedicate more budget to it (KII 11, Foreign, Commonwealth and Development Office; KII 4, ILO).

> 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 enough scale. What we need from the private sector is collaboration to innovate solutions geared towards the vulnerable we are trying to serve.
> KII 11, FOREIGN, COMMONWEALTH AND DEVELOPMENT OFFICE

Similarly, the Save the Children International representative noted that most of the governors who had committed to social protection reform in their state, including the governor of Sokoto, were 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] social protection 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 social protection in our political discourse so that whoever emerges already understands the need for these programmes.

Similarly, a Sokoto Ministry of Education representative said that while the MBEP set aside ₦225 million for social protection in 2021 – an outcome sought by the JP – the release of the funds had yet to take place and JP were continuing their advocacy work on that matter.

4.5.3 Lessons learned and revisions to the programme approach

Stakeholders emphasized the critical need for continual capacity-building of state agencies, as well as for the involvement of more permanent structures such as civil society organizations, which could act as reliable relay systems when administrations change and political mandates end (KII 7, Save the Children International; KII 8, NASSCO). As a NASSCO representative put it, a number of success stories are associated with pilot projects in Nigeria, but replicating and scaling up those projects to continue beyond the pilot stage has proven to be a challenge.

> If there is another phase of the programme, there is a need to build structures for sustainability at the very onset. To me, those structures involve civil society organizations alongside government; [...] they can be part of the design and implementation of the programme so that when partners are gone, the civil society organizations are still in place.
> KII 7, SAVE THE CHILDREN INTERNATIONAL

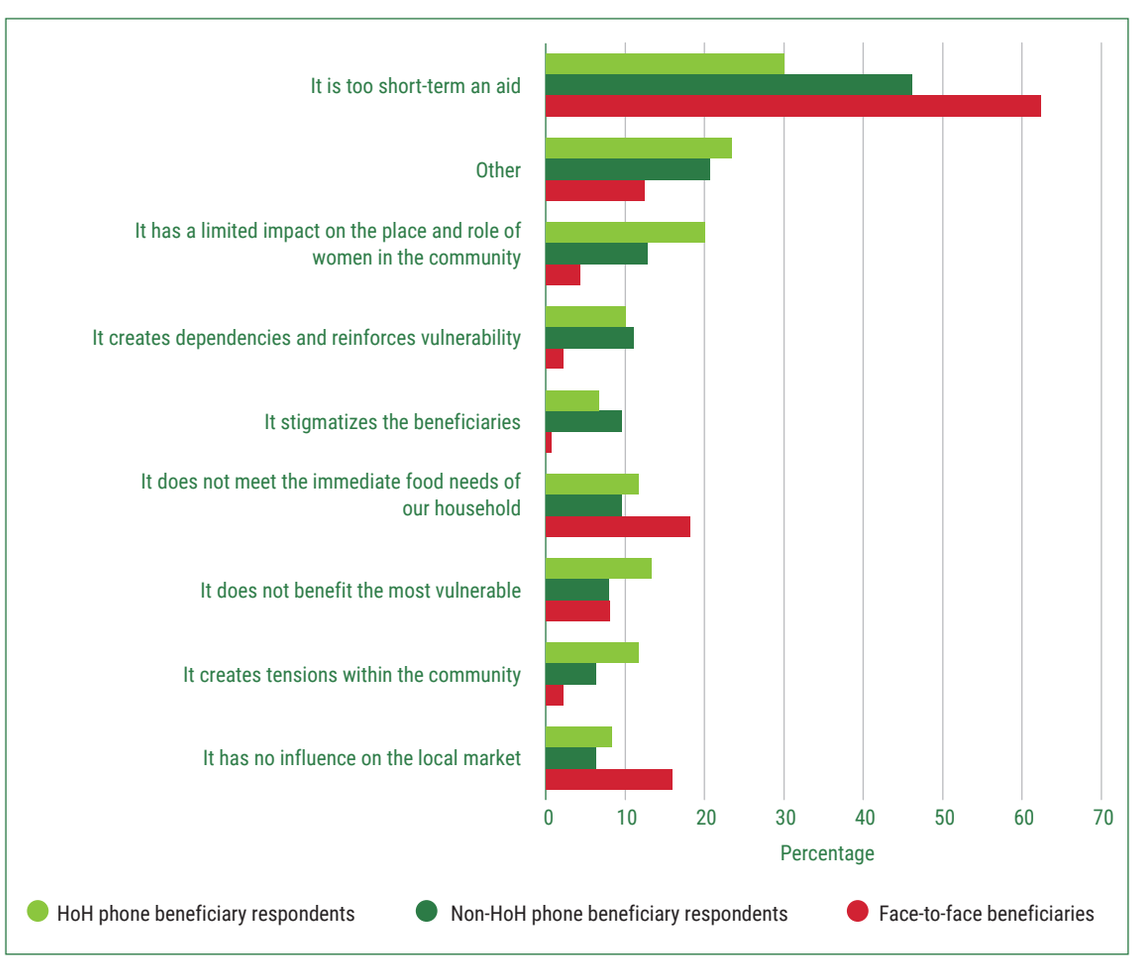
> We are trying to ensure there is legislation backing social protection programmes on the ground. With [a] lack of legislation, once there is a change in government, there is a risk of abandonment. Institutionalizing the social protection programmes requires legislation backing the operations. Once that is put in place, if this can be achieved before the expiration of the current administration, it will be difficult to undo it.
> KII 6, MHDSD

Furthermore, one of the main weaknesses of the social protection approach set up by the JP is that its beneficiaries could not afford to pay for health insurance through a contributory mechanism (KII 4, ILO). When the JP ended, there was no mechanism in place to ensure that the beneficiaries, who are among the poorest in north-west Nigeria, would continue to benefit from health care coverage. It must be noted that the JP was designed as a pilot with the intention of building the capacity of government regarding instituting social protection policies and sourcing funding to contribute to the sustainability of the programme. While there are other solutions, such as relying on wealthier community members to pay for health insurance through Zakat or using the government's Basic Health Care Provision Fund, these are yet to be explored. This is particularly concerning for households whose main source of income comes from the informal economy. World Bank data indicate that, in 2018, 20 per cent of the Nigerian population was covered by social protection and labour programmes (World Bank, 2023). An ILO representative stated that most of these are workers in the formal economy and their contributions are legally framed. However, most of Nigeria's workers are in the informal sector and while the National Health Insurance Scheme has a programme especially for such workers, funding is limited and those who cannot afford to contribute are excluded from the scheme.

4.5.4 Perceived main strengths and weaknesses

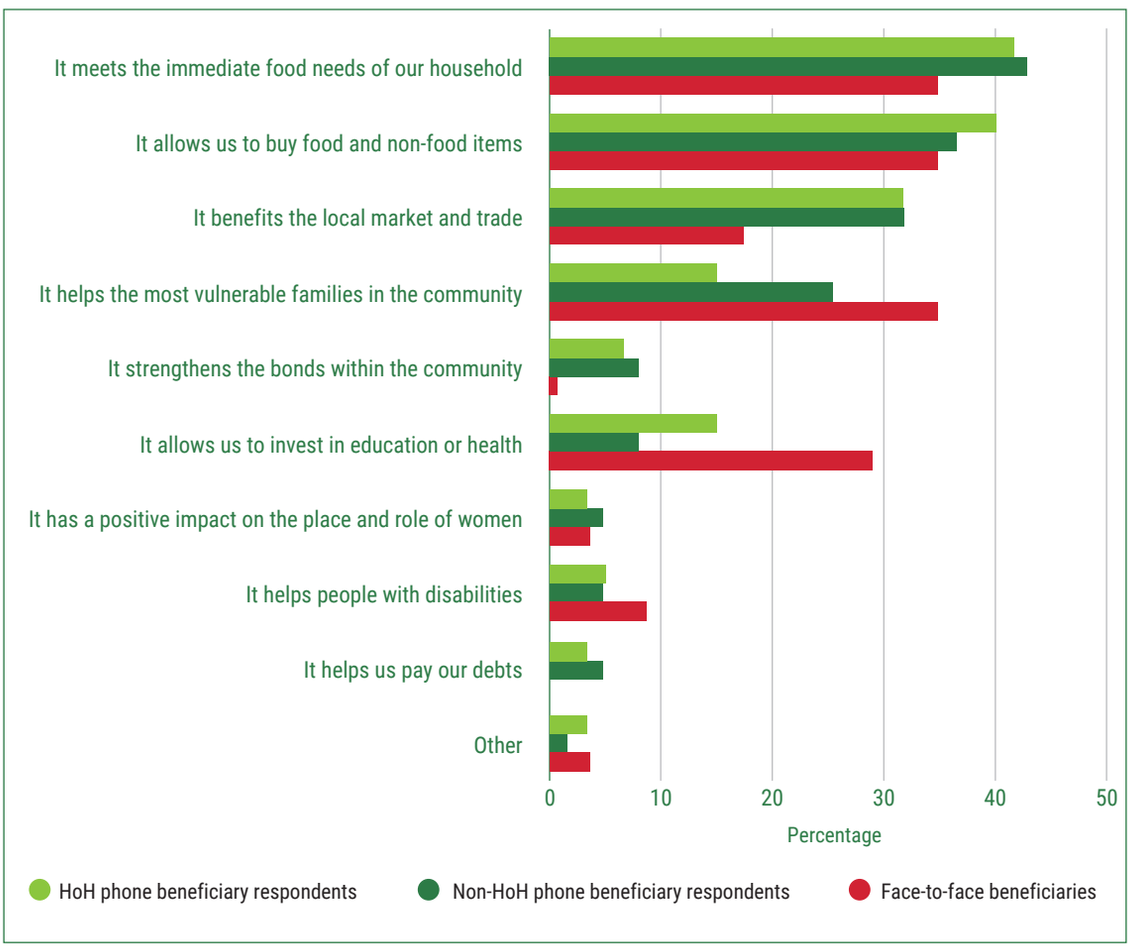
By far the most commonly chosen weakness of the JP was that the period over which aid was provided was too short term (Figure 12). Survey respondents considered the main strength of the programme to be that it covered basic needs. Of those who selected 'other', many reported that no significant weaknesses could be attributed to the programme.

Figure 12: Main weaknesses of the JP



Generally, the most often reported strengths were related to positive food security and livelihood outcomes (Figure 13). However, face-to-face respondents also reported that the programme was beneficial in helping the most vulnerable families in the community (35 per cent of face-to-face respondents) and that it allowed them to invest in health or education (29 per cent of face-to-face respondents).

Figure 13: Main strengths of the JP



4.6 Impact

The JP has a **POSITIVE** impact.

To evaluate the JP's impact, the evaluation team sought to understand what difference the JP made by looking at the intended and unintended consequences of the programme and measuring their impact on beneficiaries and their households.

Synthesis

In order to provide answers to the question related to impact, beyond simple short-term outputs, measurement of the contribution of the JP is necessary with regard to: (i) the institutional and collaborative capacity of Nigerian counterparts on social protection issues; and (ii) 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 dialogue 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 such efforts are often not seen immediately but rather in the long-term policy and operational work of the relevant actors. Also, 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 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 measured the impact of the social protection interventions implemented in Sokoto State using a quasi-experimental design that compares findings about the treatment group (beneficiaries) with those about non-beneficiaries. Evidence from statistical quantitative data and qualitative opinions revealed that the JP made a positive difference in the lives and livelihoods of beneficiaries (658 pregnant and/or lactating women and caregivers of children under two years of age) who received assistance for health insurance and cash transfers in comparison to non-beneficiaries.

Many of the beneficiaries expressed the view that the health insurance coverage specifically had a more significant positive impact on their lives than cash transfers in isolation or immunization for specific diseases by other programmes in the past. Lastly, while the 6,000 beneficiaries who benefited from health insurance coverage were selected from all vulnerable groups, the project can be seen as gender-sensitive – beneficiaries included 658 pregnant and/or lactating women, and caregivers of children under 2 years. As a result, beneficiaries where able to receive the medical attention they needed without financial or psychological burden on the household.

EVALUATION QUESTIONS

4.6.1	To what extent has the social assistance in the form of cash transfers provided to vulnerable populations in the pilot state of Sokoto generated positive effects in income and social transformation to households and communities vis-à-vis SDG 1 (ending poverty) and SDG 10 (reducing inequality)?
4.6.2	What lessons can be documented or challenges observed from the implementation of the model in reaching vulnerable populations and providing services?
4.6.3	What are the negative externalities of the JP, with a focus on ethical and societal issues, e.g., fraud and societal tensions?

4.6.1 JP alleviated beneficiaries' financial burdens and encouraged recipients to seek health care

Across the board, beneficiaries who took part in the discussions and survey emphasized the positive impact of the JP on themselves and their households. The JP notably contributed to alleviating the financial burden that families typically face when one of their members is ill. The qualitative data show that beneficiaries, in particular women, were able to access professional health care when needed, 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 that follows further presents the positive impact on health expenditure indicators and the effects and usage of the cash transfers related to SDGs 1 and 10.

> 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.
> FGD 4, MIXED, WURNO, ACHIDA

> The benefit of this programme cannot be overemphasized. 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.
> FGD 4, MIXED, WURNO, ACHIDA

Effects on health expenditure 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 confirm that 59 per cent of surveyed beneficiaries were assisted by a qualified health personnel for any health problem in the past year compared to 47 per cent 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 (FGD 8, women, Bodinga, Bodinga).

Similarly, the quantitative data confirm the positive effects on health expenditure and access to professional health care, as well as preventive health services. While the differences in health expenditure are minimal, as shown in Figure 14, programme beneficiaries reported spending relatively less on health care compared to non-beneficiaries. When focusing on health expenditure that is relevant to the JP activities, namely preventive health services and maternal and child health expenditure, the differences are more striking. The difference in spending patterns on maternal and child health expenditure is even more accentuated than preventive health, which points to the programme's impact as it paid special attention to that domain.

Impact and usage of cash transfers: After verifying primary health-care centre attendance lists, the JP provided a lump sum of ₦5,200 per month (₦5,000 being the actual cash transfer and ₦200 to cover point-of-sale withdrawal charges and transport) to the beneficiaries. Most survey respondents reported receiving their last assistance in 2022 (88 per cent of face-to-face respondents and 70 per cent 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 per cent) followed by June (25 per cent) and February (27 per cent) and phone respondents in August (29 per cent) followed by June (17 per cent) and July (15 per cent). On average, face-to-face respondents reported receiving ₦28,140 in the last distribution and phone respondents reported receiving ₦29,011. While 25 per cent of face-to-face respondents and 8 per cent 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, such costs appear to be considerably lower – a reality known and understood by JP stakeholders. The cash transfers therefore provided beneficiaries with extra financial resources that they could spend or save as they wished. To contextualize this amount and what it means, a participant in Achida said that people in this area typically pay around ₦100 for a round trip to the nearest primary health care centre using a tricycle (*keke napep*) (FGD 1, women, Wurno, Achida).

Figure 14: Household health expenditure

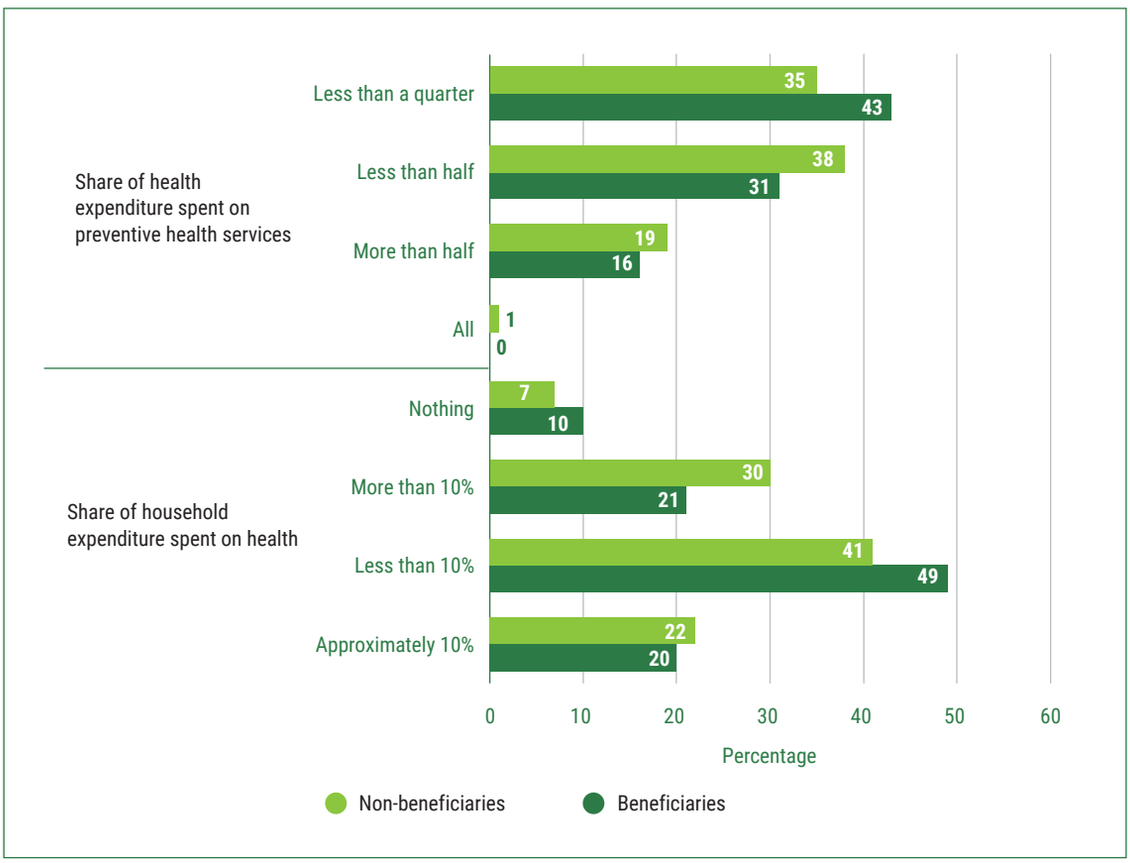
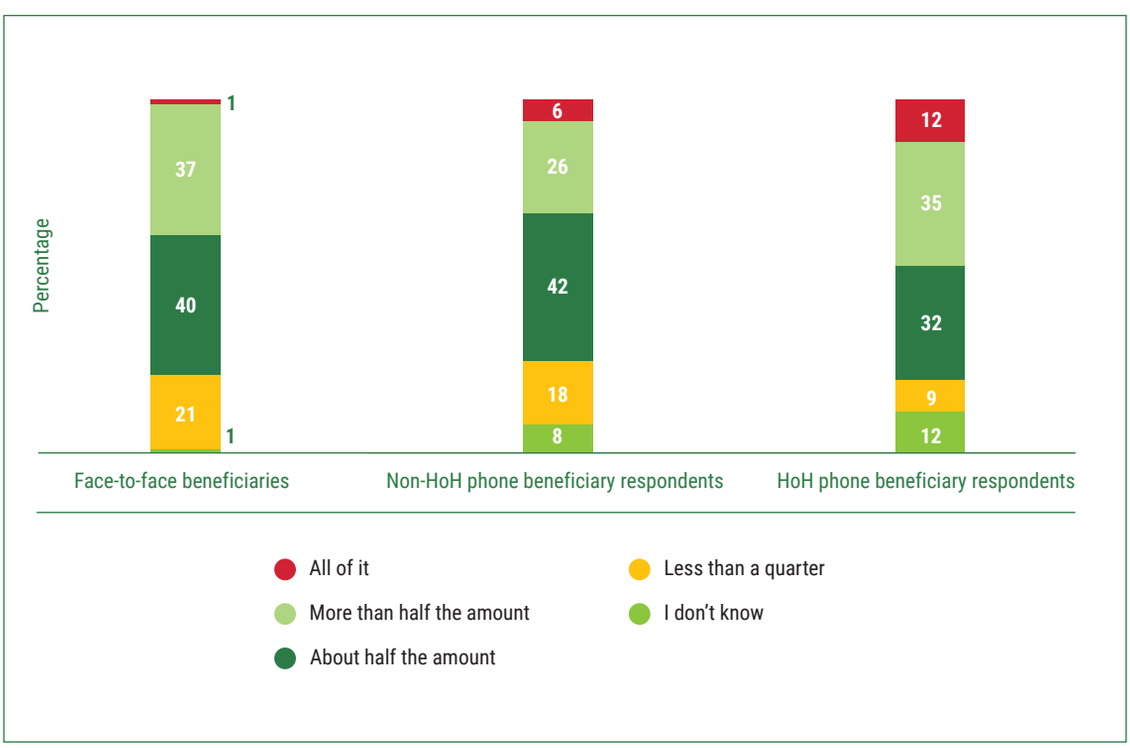


Figure 15: Proportion of the cash transfer used to buy food



The quantitative data confirm that a high proportion of the cash transfers was spent on food (Figure 15). Seventy-eight per cent of face-to-face respondents and 76 per cent of phone respondents reported spending at least half of the cash transfers on food. After food, the most common use of cash transfers was to start a business (76 per cent face-to-face respondents and 52 per cent of phone respondents), followed by hospital and medical fees (22 per cent of face-to-face respondents and 24 per cent of phone respondents). Typically, women decide on how money should be spent. Eighty-seven per cent of face-to-face respondents, of which 97 per cent were women, reported deciding on household expenditure. Alternatively, 67 per cent of phone respondents, of which 82 per cent were men, reported that their spouse directed cash transfer funds.

A representative of the Sokoto 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, the second and third cash transfers were released together. This gave some beneficiaries the opportunity to invest in small businesses, such as livestock, poultry, or small trade operations. 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.
> FGD 2, 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.
> FGD 8, WOMEN, BODINGA, BODINGA

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

4.6.2 Lessons learned in reaching vulnerable populations and providing services

There were 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 feelings of anxiety that negatively impacted them. Several men said that they felt less financial pressure because they no longer had to prioritize food over health care, 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 for or consulting with their husbands if they managed the household finances. A male participant in Achida said,

> With [...] this programme, 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.
> FGD 4, MIXED, WURNO, ACHIDA.

Several participants felt that, besides children, women 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.

> 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.
> FGD 8, WOMEN, BODINGA, BODINGA

Impact on pregnant or lactating women: In all the discussions, participants who were pregnant or knew a woman who was pregnant during the programme's time frame 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 cost around ₦70,000 in a public hospital and could be as much as ₦200,000 in private institutions.

> 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 breeched. 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.
> FGD 8, WOMEN, BODINGA, BODINGA

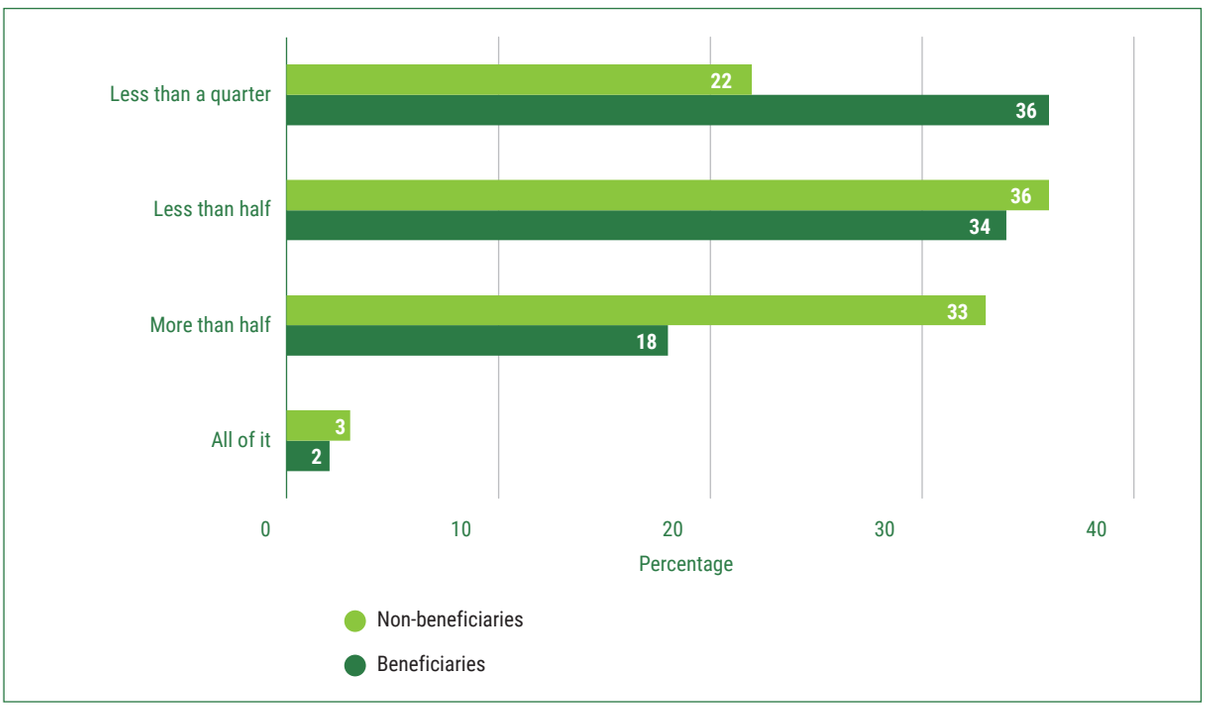
> What I like the most is when I was pregnant, I went to the hospital and confirmed my pregnancy. I started from the first month and I always go there because I know I will be taken care of when I have a problem, or I'm feeling sick. I just go to the hospital and complain and I will be given drugs or advice 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.
> FGD 8, 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 2 years receive vaccines. A woman in Bodinga said that she had not received any prenatal care for her previous pregnancies and only 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 in the hospital (FGD 8, women, Bodinga, Bodinga).

While the quantitative data do not show a significant impact on children being born in a health facility or a clinic, it shows positive results on the recipients' reduced health expenditures 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 to the percentage of non-beneficiaries (28 per cent versus 29 per cent). Figure 16 clearly shows how the JP health insurance coverage contributed to recipient households spending less on maternal and child health.

Figure 16: Share of health expenditure spent on maternal and child health

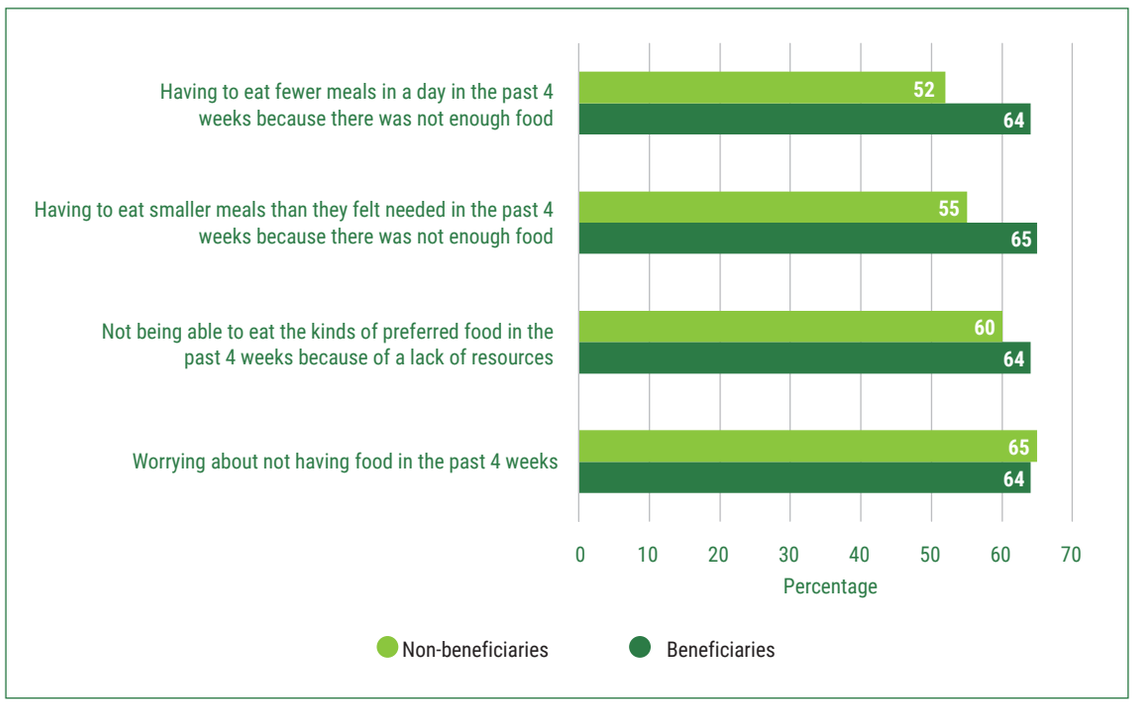


Impact on education and nutrition: While JP stakeholders assumed that beneficiaries would allocate part of the cash to their children's education and improved nutrition, the evidence gathered thus far does not indicate that this happened in most cases. There also does not appear to have been a survey at the beginning of the project to explore how beneficiaries intended to spend the cash transfers. The differences between 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 for 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" (FGD 3, mixed, Bodinga, Bodinga).

> Our father died, leaving behind younger siblings. In the past, for example, I used to generate ₦15,000 per month and the health issues of my siblings cost ₦5,000–7,000 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.
>
> FGD 6, 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 was 92 per cent of beneficiaries compared to 90 per cent of non-beneficiaries.

Figure 17: Impact on nutrition indicators



The programme seems to have had no effect in terms of nutritious well-being (see Figure 17). This could be explained by the high poverty levels prevalent in the target areas and is indicated by the fact that there was a higher percentage of beneficiaries than non-beneficiaries who reported having fewer/smaller meals because there was not enough food. This was also the case for those reporting on not being able to eat preferred food in the past four 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 four weeks was lower than of non-beneficiaries who reported the same, the difference was minimal. Lastly, the reported percentages between beneficiaries and non-beneficiaries on the number of meals eaten per day is inconclusive.

4.6.3 Negative externalities of the JP

While much can be learned from the pilot, primarily from design and implementation errors that will be discussed in the following sections, 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 they 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 would 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" (FGD 8, women, Bodinga, Bodinga).

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 programme before they started and people were told to come out and register and we even went to our neighbours and told them about the programme 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 [as] there was bias in the selection of beneficiaries, that we are related to the programme coordinators/ organizers [and] that was why we were selected.

FGD 5, MIXED, TAMBUWAL, DOGON DAJI

Alleged cases of fraud: Across areas where discussions took place, there appear to have been serious mishaps in cash assistance distribution modalities. Testimonies from beneficiaries raise concerns about cases of fraud. These cases include those given in Table 15.

Table 15: Testimonies of alleged fraud

THEME	EXAMPLE(S) FROM FGDS
1. Multiple cases of wrongly labelled health insurance cards led to non-beneficiaries receiving them.	In Bodinga, a participant said that she witnessed someone taking another person's card, while two other participants recalled receiving three cards bearing their personal information (FGD 8, women, Bodinga, Bodinga).
2. Beneficiaries lent their health insurance cards to family members and seemed unaware that they were not allowed to do so.	In Achida, 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 (FGD 4, mixed, Wurno, Achida). In Dogon Daji, a participant said, "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," while another participant said, "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" (FGD 6, mixed, Tambuwal, Dogon Daji). Similar statements were made during a discussion in Bodinga, where participants said they lent their cards to their siblings so that they could receive health care free of charge, with one of them explaining, "we benefit from the programme 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 [she's] without the card we will have to give her money for going to the hospital" (FGD 8, women, Bodinga, Bodinga). "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" (FGD 8, women, Bodinga, Bodinga).
3. Beneficiaries stopped receiving cash assistance without being informed of why.	In Bodinga, a participant said that he was given a slip with which he received ₦5,000 and was informed, as JP stakeholders were distributing ₦20,000, 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 (FGD 8, women, Bodinga, Bodinga).[12]

12 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

These reflections on the programme are intended to provide lessons that extend beyond the current project assessment. The main aspects of knowledge or understanding gained – positive or negative – are summarized here in eight key lessons.

5.1 Assessment

Start with an informed, realistic, flexible and contextualized theory of change at the national and state 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, and capacity) and operational realities (targeting, needs assessments, implementation and MEAL). A *first lesson* of the programme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is therefore certainly not to consider multi-country strategies or frameworks as sufficient theories of change at the scale of a state (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 time frame for implementation was too limited, especially in the contexts of the pandemic and universal and chronic poverty. It is understood that the multi-country nature of the JP pilot did not allow for a long-term approach, but this 'short-termism' is incompatible with obtaining truly significant results, because mentalities (of the government and communities) and operational modalities (of the UN, non-governmental organizations and implementing partners) have not had the time necessary to evolve. The *second lesson* is that to allow the development of effective and impactful social protection programmes, only a long-term approach should prevail (over a decade or more).

Finally, it is necessary to take the measure of the change required of the various actors (government, UN agencies and non-governmental organizations) in terms of social protection, in a context of extreme precariousness (e.g., in Sokoto) and structural weakness (institutional and government), where the actors consulted were clearly more skilled and used to responding to emergency situations than to implementing social protection programmes. 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 and implement and monitor programmes that go beyond emergency logic. This applies to all stakeholders and undoubtedly points to a lack of upstream analysis of the JP to obtain better results. Several years would have been necessary to allow for a shift from emergency approaches to resilience and social protection logics.

5.2 Design

Focus 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 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; social protection and cash transfers for WFP; and 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 where institutions such as the CWG or TWG are empowered to take the social protection policy forward. The environment created by the JP also helped improve capacity and coordination among state agencies (MFBNP, MLE and MHDSD) and with UN organizations/associations.

Despite these positive results, a *fourth lesson* is that only a phased approach, where the implementation dimension (e.g., in Sokoto) builds on the institutional dividends (in central government and at state level, as well as between international agencies), can create real impact through 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.

Consider the gender perspective as central in strategic and operational terms

The programme has taken into account the gender dimension in the implementation of its activities. However, by limiting this approach to a conception of gender as (i) a cross-cutting issue; and (ii) a criterion of vulnerability, it seems that the programme 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, there are notable differences 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 programme, 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 communities that are often different, where the roles and functions of men and women are also different.

5.3 Implementation

Expand beyond health insurance and limited financial inclusion

The JP's assistance gave beneficiaries an incentive to seek health care when they are ill by providing them with health insurance and thereby tackling a prominent issue that affects access to health care, but there are other critical factors that cannot be mitigated by the provision of health insurance. While a SOCHEMA representative emphasized 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 other factors as critical issues. These include 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.[13] 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 (through assistance) or indirectly (though 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 of the assistance (protection) actors and an understanding of the real needs are therefore essential. This will allow the programme to generate a multiplier effect in terms of impact and sustainability by coupling cash assistance with other actions currently envisaged in, for example, health, hygiene, livelihoods, irrigation, food diversification, animal vaccination and fertilizers.

13 This is particularly challenging for pregnant women who go 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 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 a.m. and 3 p.m.; 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.

Understand redistribution phenomena

Testimonies from beneficiaries and survey data showed that the health insurance coverage was not only used for the beneficiaries but also for extended 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 besides Zakat are common in communities and therefore the provision of health insurance coverage and cash transfers might have had a wider positive impact on communities, beyond the direct beneficiaries. These informal redistribution and sharing arrangements are an indirect positive externality of JP and social protection intervention. In this regard, the *seventh lesson* is that a deeper understanding of the sociocultural 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.

5.4 Ethics and accountability

Minimize the risk of fraud (perceived or real) by promoting transparency and accountability

It should be noted that targeting problems, 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 was often shared in 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. The *eighth lesson* is that, in programmes of this magnitude and implemented in relative urgency, it is essential to identify a framework of accountability and transparency to avoid rumours and suspicions of fraud.

6. FINAL REFLECTIVE CONCLUSIONS AND DISCUSSIONS

The JP aimed to support a social contract through 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 social protection was focused on Sokoto State, the results of this pilot project should be scalable and replicable across other states. To that effect, the theory of change model (in Annex B) for the JP emphasizes the development of a blueprint for successful implementation and expansion of cash transfers and universal health insurance that can be used by all state governments in Nigeria using the lessons of the programme's implementation in Sokoto.

This concluding section summarizes 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:

- Analyse whether the JP in Nigeria met its high-level objectives;

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- Analyse the extent to which the JP laid a foundation for the future sustainability of social protection in Nigeria.

An important caveat to these conclusions is of course the experimental dimension of the programme, 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, to achieve the impact desired, more time should have been given to the project.

6.1 Relevance

Rethinking vulnerability and targeting: Sokoto State, with primarily rural communities and an economy that is dependent on agriculture, has some of the highest levels of poverty and insecurity in north-west Nigeria. Many people in the state live 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 people 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 effectiveness of a social protection programme 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, non-governmental organizations, governments and donors. The 'poor' or 'vulnerable' are not fixed groups but rather fluid, particularly in contexts like that of 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" (Barrientos and DeJong, 2006). Generally, poverty targeting generates errors of exclusion and inclusion, and static surveys or assessments to identify the 'poor' do not account for the dynamic and pervasive nature of vulnerability. This debate has not yet taken place, but should before scaling up or replicating the programme in another context. This should be one of the issues of the JP – not in a polemical, but in a constructive, way through a pilot and a conceptual discussion that includes all stakeholders.

6.2 Coherence

Continuing the effort of operational coherence between UN agencies and other parties: While the UN agencies interviewed emphasized the improvement in relations with the government (towards more information and coordination) as well as between partners (UN and non-governmental organizations), it must also be emphasized that these effects are still limited after two and a half years, as capacities appear limited at the government and state levels, and institutional habits are still marked by a form of inertia and 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 moved 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 (see Sections 4.5.1 and 4.5.2) 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 could 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.

6.3 Effectiveness

Promoting a necessary debate between stakeholders, towards more equitable social protection mechanisms: The following questions need to be clarified: "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 per cent), 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 (a 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.

6.4 Efficiency

Promoting a culture of value for money to optimize intervention and inter-agency synergies: The efficiency analysis section reveals a lack of knowledge of value for money per intervention and a clear absence of inter-agency collaboration, which is not only detrimental to the accountability of the programme but also to its optimization and generation of possible multiplier effects (through the pooling of resources or costs between agencies or actors). As it stands, the focus remains results-oriented (i.e., delivering the expected numbers) 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 analyse the real value of its operational contribution to the population. Simple avenues can be identified, such as: (i) favouring longitudinal analyses to capture improvements in value for money over time; (ii) systematizing comparative analyses with similar contexts/programmes; (iii) disaggregated cost analyses, to better understand how and where the JP spends most of its money; and (iv) a focus on the broader context to understand how the JP contributes to improving people's lives and well-being.

6.5 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 for strengthening and streamlining social protection in Nigeria. The government provided cash transfers and food throughout the country and may have been more inclined to take the social protection bill forward.

In terms of access to health care during the various peaks of the pandemic, discussion participants believed that COVID-19 did not prevent them from receiving medical care, either under the JP or in general. A participant in Dogon Daji, for instance, said that the hospital helped people cope with COVID-19 early on by raising awareness of protective methods such as the use of face masks and handwashing and, of symptoms of the disease (FGD 5).

In the current context, where uncertainty and multidimensional crises have become the norm, it is important for a larger-scale or longer-term social protection programme 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 long-term and predictable in nature compared to the short-term cycles of humanitarian aid (European Commission, 2015). This means it needs long-term funding, objectives and programming. While the JP was conceptualized 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 carries the risk that the funds spent will have no sustainable impact. So that the funds spent on identifying beneficiaries and setting up processes for distributing health insurance coverage and cash transfers do not go to waste, a plan is needed for continued funding and implementation beyond the pilot. Furthermore, as a NASSCO representative put it, a number of success stories are associated with pilot projects in Nigeria but replicating and scaling up those projects to continue beyond the pilot stage has proven to be a challenge.

As mentioned in Sections 4.5.1 and 4.5.2, there was no strategy in place to ensure that the beneficiaries, who are among the poorest in north-west Nigeria, would continue to benefit from health care 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: (i) an exit strategy for the JP's partners; and (ii) the gradual ramping up of government partners' involvement (technical and financial).

6.6 Impact

Building on the initial promising outputs to generate longer-term impact: During the feedback exchanges of this evaluation with 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 great 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 programme or its ability to achieve the objectives of a logical framework – 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 Food and Agriculture Organization of the UN 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; and 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' time (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 programme, which is supposed to constitute a common base and 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 (Devereaux et al., 2017). Targeting beneficiaries for social protection interventions should be transparent and easily understood.

7. RECOMMENDATIONS

All the recommendations listed in Table 16 are based on the findings and conclusions of this study. They are addressed to partner agencies in Nigeria as well as those in 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 programme; and 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: Promote 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

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Table 16: Synoptic table of recommendations and players

RECOMMENDATIONS	SHORT-TERM	MEDIUM-TERM	LONG-TERM
Key conceptual recommendations: Theory of change, contextualized logical framework and MEAL approach			
1: Promote a necessary debate towards more equitable social protection mechanisms, which involves rethinking vulnerability and targeting	All UN agencies involved plus government and other stakeholders		
2: Start with an informed, realistic, flexible and contextualized theory of change	All UN agencies involved		
3: Promote a real MEAL approach for better adjustment or revision of the pilot	All UN agencies involved, implementing partners and government counterparts		
Key programmatic recommendations: A gender-transformative approach paired with contextual knowledge and accountability			
4: Put gender analysis at the heart of both the strategy and the social protection system	All UN agencies involved plus government		
5: Understand redistribution phenomena		UNICEF, WFP	
6: Promote a culture of value for money to optimize intervention and inter-agency synergies	All UN agencies involved, implementing partners and government counterparts		
7: Shed light in a transparent manner on every allegation of fraud (real or perceived)		All UN agencies	
Towards a realistic roadmap: Build an inclusive social contract and ensure sustainability			
8: Make social protection a national cause through awareness, advocacy and communications		All UN agencies involved plus government and other stakeholders	
9: Promote sustainability and ensure follow-up (including a proper exit strategy)			All UN agencies involved plus government

Note: 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.

social protection system (social contract, universal protection) in contexts of almost widespread socioeconomic destitution and chronic multidimensional crises. Because of the political message sent to the population this requires a real debate between agencies, as well as with the government, and also reflect thoroughly on the issues of 'vulnerability criteria' and 'targeting'.

Recommendation 2: Start with an informed, realistic, flexible and contextualized theory of change

A social protection programme in a context as volatile as that of Nigeria and Sokoto State requires a very clear and detailed theory of change in order to anticipate changes and not be subject to short-termism or be unprepared for crises. Any expansion or follow-up of the JP will require a pragmatic, realistic and contextualized theory of change to translate the abstract goals of the SDGs and the multi-country ambition of the JP into effective and sustainable actions and interventions.

Recommendation 3: Promote 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 DAC or baseline approach, is not systematized.

7.2 Key programmatic recommendations: A gender-transformative approach paired with contextual knowledge and accountability

Recommendation 4: Put 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 programmes and dedicated indicators. It is necessary to go further by not simply conceiving women as 'the most vulnerable population' 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 (e.g., of husbands and sons), etc. They must therefore be at the heart of the programme in a way that is not only 'passive' (= vulnerable) but 'active' (= transforming agents). This implies a better knowledge of the sociocultural contexts as well as specific empowerment interventions for women and the promotion of equality.

Recommendation 5: Understand redistribution phenomena

A better understanding of the redistributive phenomenon, which is common in Sokoto, can contribute to better reduction of poverty and vulnerability factors by promoting the percolation of assistance, reducing targeting errors and contributing to better social cohesion. Redistribution and solidarity must not only be analysed but encouraged, according to 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, and from citizens to citizens through redistribution.

Recommendation 6: Promote a culture of value for money to optimize intervention and inter-agency synergies

As mentioned in the findings and conclusions of this document, the absence of an analysis of real value for money is highly problematic – especially if the objectives of the past two to three years were possible replication, duplication and scaling up of the intervention. So, it is imperative that the JP strengthen its capacity to analyse the real value of its strategic and operational contribution. Simple avenues are worth mentioning again: (i) favouring longitudinal analyses, to capture improvements in value for money over time; (ii) systematizing comparative analyses with similar contexts/programmes; (iii) disaggregating cost analyses; and (iv) focusing on the broader context to understand how the JP contributes to improving people's lives and well-being.

Recommendation 7: Shed 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, there is no targeting method that fits every context. Mechanisms have to be contextualized and local capacities need to be built to support the process of identification and ensure safeguarding. In this respect, beyond the debate on choices in the approach (pro-poor targeting, vulnerability criteria, universal coverage), it is important to be aware of, analyse, 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: Make 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, as well as the lack of any real ambition to communicate with the government (nationally and at 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 proper reflection must be conducted so that the communities do not perceive the initiative as another humanitarian assistance programme, with no "social and societal solidarity agenda" (KII with UNICEF, July 2022). Similarly, the strong link between institutional efforts and the implementation of concrete interventions should be further emphasized in Nigerian opinion and among all stakeholders.

Recommendation 9: Promote sustainability and ensure 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: (i) an exit strategy for the JP's partners; and (ii) the gradual ramping up of the government partners' involvement (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 that of 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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ANNEXES

The following annexes are provided under 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.*

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Annex E: List of respondents and sites visited

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Annex F: Qualitative tool guidelines

Key informant interview guidelines

Focus group discussion guidelines

Community observation guidelines

Annex G: Quantitative tool guidelines

Annex H: Informed consent protocol

Annex I: TOR for service contracting