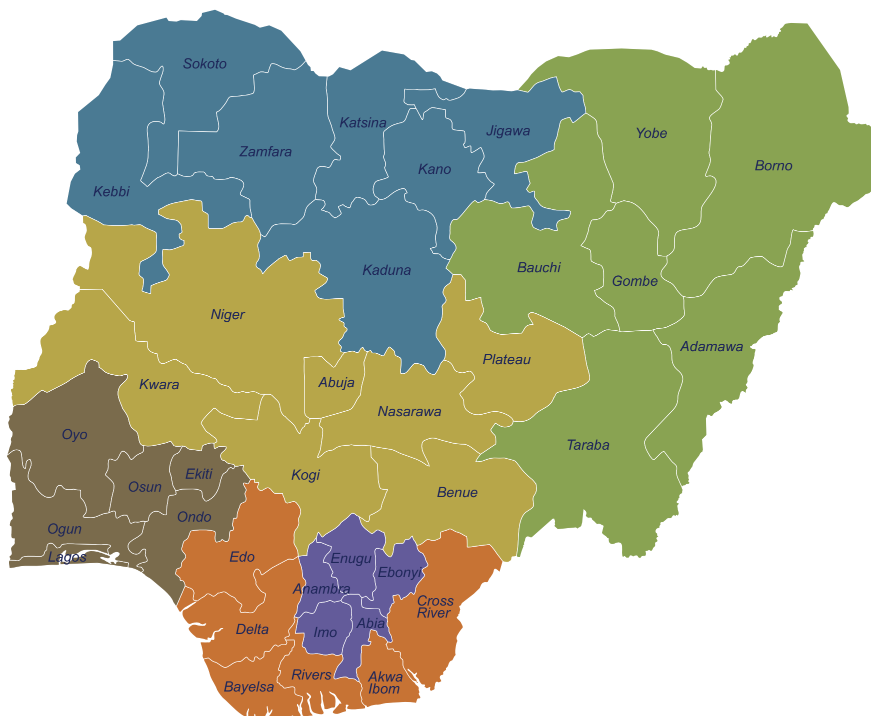
SpeakUpAfrica.

STAKEHOLDER & LANDSCAPE ANALYSIS

Prepared for the Bill & Melinda Gates Foundation

Description of key partners and activities of integrated community care management in Nigeria



Mandate

According to the Results Framework associated with Speak Up Africa's BMGF grant award, and in order to "Gain insight into the understanding among influencers and the general public in Nigeria and Ethiopia of both the causes of pneumonia and the necessary prevention and treatment, Speak Up Africa" is:

1. Conducting a 2-3 month landscape analysis in each country; and
2. Conducting a survey in each country to determine the baseline level of "understanding" of pneumonia, its causes, prevention and treatment among influencers and the general public in Nigeria and Ethiopia. These surveys will include the names of the most important influencers and the most important distribution pathways in Nigeria and Ethiopia.

This Stakeholder & Landscape Analysis was conducted to satisfy Objective 1 above.

Methodology

This Nigerian Landscape Assessment was conducted through a series of qualitative interviews with partners, and reinforced with secondary data and government reports. The research was designed to outline the landscape of child health in Nigeria, including a general understanding of pneumonia and to identify the opportunities and the gaps in children's health in Nigeria – with a particular focus on communications and awareness. Working closely with as many of the principal partners and NGOs that we could identify in Nigeria, Speak Up Africa conducted over 30 interviews to identify the key players in child health, including those influencing access to commodities (or supply), those influencing demand creation and overall child health communications, and those who are playing any kind of national awareness or advocacy role. The interviews were designed to garner a comprehensive understanding of the political climate in which partners are working: the social context of different geographic and thematic areas; gaps in advocacy and communications interventions; perceptions of child health information; access to services and understanding the pathways to engage government in a meaningful manner.

Below is a selected example of the questions that were asked to each partner:

- Where are national, regional and state level government priorities when it comes to maternal and child health?
- What should be our collective advocacy priorities in order to see sustained reductions in child mortality?
- What are the key implementation and resource gaps in implementing successful child health programs in Nigeria?
- What do you believe to be the most important advocacy priority in advancing our collective child health agenda? (i.e. community access, financial resources, skilled providers, health provider training, commodity availability, etc.)
- At what level of government do you think advocacy efforts would be most effective? (i.e national vs. states)
- If at the state level, which states should be prioritized and why? (i.e. burden, population, public health investment, etc.)
- Who should be the target of advocacy efforts?

Country Background

Nigeria is the largest country in Africa, in terms of both size of the economy and size of the population. The country has an estimated GDP of US $1 trillion and a population of roughly 180 million people[1]. Nigeria is a federal republic comprised 36 States and the Federal Capital Territory. It is a growing economy with oil as a dominant source of government revenue and foreign exchange receipts for the past four decades. As oil prices have declined in recent years, much of the current economic growth has been driven by agriculture, telecommunications and services.

1- Central Intelligence Agency, Country Profiles.

Demographics[2]	Figure
Population	181,562,056
Annual Population Growth Rate (percent)	2.45%
Median Age (years)	18.2 years
Population under 14 years old (percent)	43.01%
Urban Population	47.8% of total population
Rate of Urbanization	4.66% annual rate of change (2010-15 est.)

Nigeria's gross domestic product (GDP) grew at an average of 6% in the last 8 years. However, the benefits of growth have been slow to reach many Nigerians. Despite the modest growth, there have not been significant socioeconomic improvements.

Although progress was made in reducing absolute poverty, these gains have been outstripped by population growth. Accordingly, Nigeria did not meet Millennium Development Goal 4. By 2015, child mortality was still at 58 deaths per 1000 live births, compared to the target of 30 deaths per 1000 live births[3]. Nearly 600,000 children under the age of five die annually in Nigeria due to pneumonia, diarrhea, and malaria, which together represents 72% of Nigeria's under-five mortality[4].

Health Information[5]	Figure
Health expenditures	3.9% of GDP (2013)
Infant mortality rate	72.7 deaths/1,000 live births
Total number of under-five deaths	804,429 (2013)
Under-five population	30,546,274 (2013)
Cause of death: Diarrhea	15% (2013)
Cause of death: Malaria	31% (2013)
Cause of death: HIV/AIDS	4% (2013)
Cause of death: Pneumonia	26% (2013)

The 2013 Nigeria Demographic and Health Survey report provides evidence of the health status of mothers and children in Nigeria and the utilization of services.

Key Findings NDHS 2013

- One in every four children age 12-23 months (25 percent) were fully vaccinated at the time of the survey
- Two percent of children under age 5 showed symptoms of acute respiratory infection in the two weeks before the survey; for 35 percent of these children, advice or treatment was sought from a health care facility or provider.
- Thirteen percent of children under age 5 had a fever in the two weeks before the survey; for 32 percent of these children, advice or treatment was sought from a health care facility or provider.
- Ten percent of children under age 5 had diarrhea, and 2 percent had diarrhea with blood, in the two weeks before the survey.

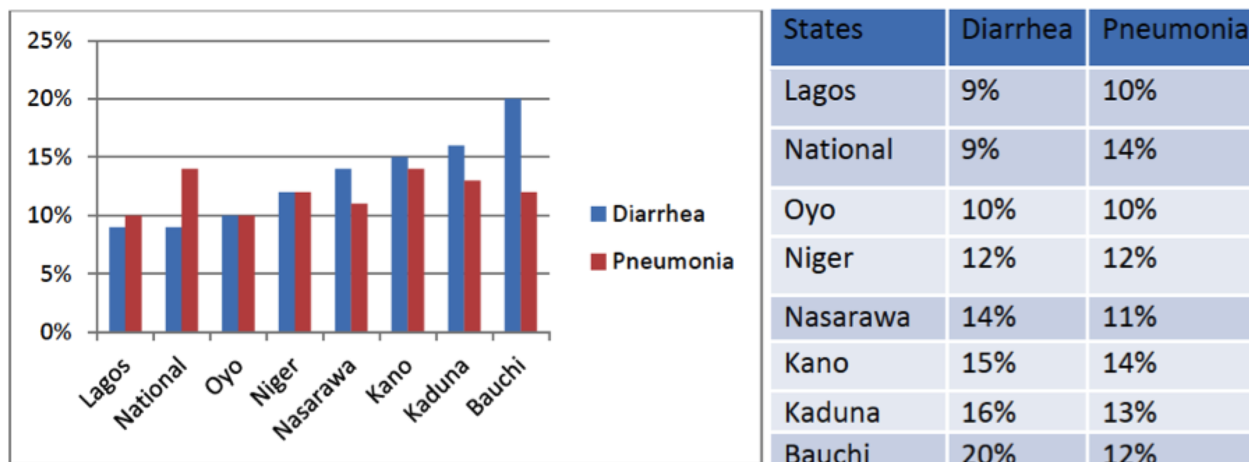
2- Central Intelligence Agency. https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html

3- Nigeria 2015: Millennium Development Goals, End-Point Report

4- Nigerian Federal Ministry of Health, Child Health Policy 2015 (Revised)

5- World Health Organization, Neonatal and Child Health Profile: Nigeria 2013. http://www.who.int/maternal_child_adolescent/epidemiology/profiles/neonatal_child/nga.pdf

Childhood mortality rates differ substantially among geo-political zones, as well as between urban and rural areas. The under-five mortality rate is 121 deaths per 1,000 births in the urban areas, compared with 191 deaths per 1,000 births in rural areas.



States	Diarrhea	Pneumonia
Lagos	9%	10%
National	9%	14%
Oyo	10%	10%
Niger	12%	12%
Nasarawa	14%	11%
Kano	15%	14%
Kaduna	16%	13%
Bauchi	20%	12%

Graph and Table : Diarrhea and Pneumonia death rate in the PACFaH project pilot States and National level

Even though under-five mortality dropped 49% between 1990 and 2015, approximately 750,000 Nigerian children still die every year from largely preventable causes[6]. Pneumonia and diarrhea remain the top killers of children in Nigeria. From the year 2000 to 2013, the number of under-five deaths from pneumonia remains unchanged. In contrast, deaths from malaria and measles declined by 34% and 97% respectively.

A key challenge for the implementation of health services has been the delay in the 2016 budget approval. The National Assembly should approve the budget by the end of each calendar year. However, 2015 has experienced unprecedented delays in the approval process, which have led to crippling challenges for the State to implement any federal or state activities. The federal government has continued to pay salaries for the states but has not released any other funds. The 2016 national budget proposal totaled to approximately 6.07 trillion Naira, which increased the country's expenditures nearly threefold, with a particular focus on education: 396 billion naira allocated to education. Health had 296 billion naira allocated and a similar amount for the defense budget. The contentious budget would double Nigeria's deficit to about 2.2 trillion naira (11 billion USD), further exasperating the already struggling economy due to falling oil revenues. Working in this context, one must be aware of the Ministry of Health's financial constraints. That being said, it is essential to make a strong economic case for public health investment. Currently, the emphasis is nearly entirely on education as means for potential economic growth.

Policy Environment

The National Health Committee recently approved a policy that calls for States and the Ministry of Health to scale up of the implementation of the National Guideline on ICCM in order reduce under-5 mortality. The challenge for states is access to funding to scale up ICCM.

In regards to disease specific policy guidelines, the Pediatric Association of Nigeria (PAN) has adopted and published, "Clinical Practice Guidelines on Community Acquired Pneumonia in Children" wherein they recommended that antibiotics (Amoxicillin in particular) should be used as first line drug in the treatment of childhood pneumonia[7]. In May 2016, the National Health Committee approved Amoxicillin as the first-line treatment for pneumonia and has included it on the national essential medicines list (EML). It is now the responsibility of each state to approve Amoxicillin to the state EML. Even with Amoxicillin not on the state EML, Amoxicillin suspension is widely available. Nigeria has begun local production of Amoxicillin DT.

6- Pneumonia and Diarrhea Progress Report (2015), p 25 John Hopkins, IVAC

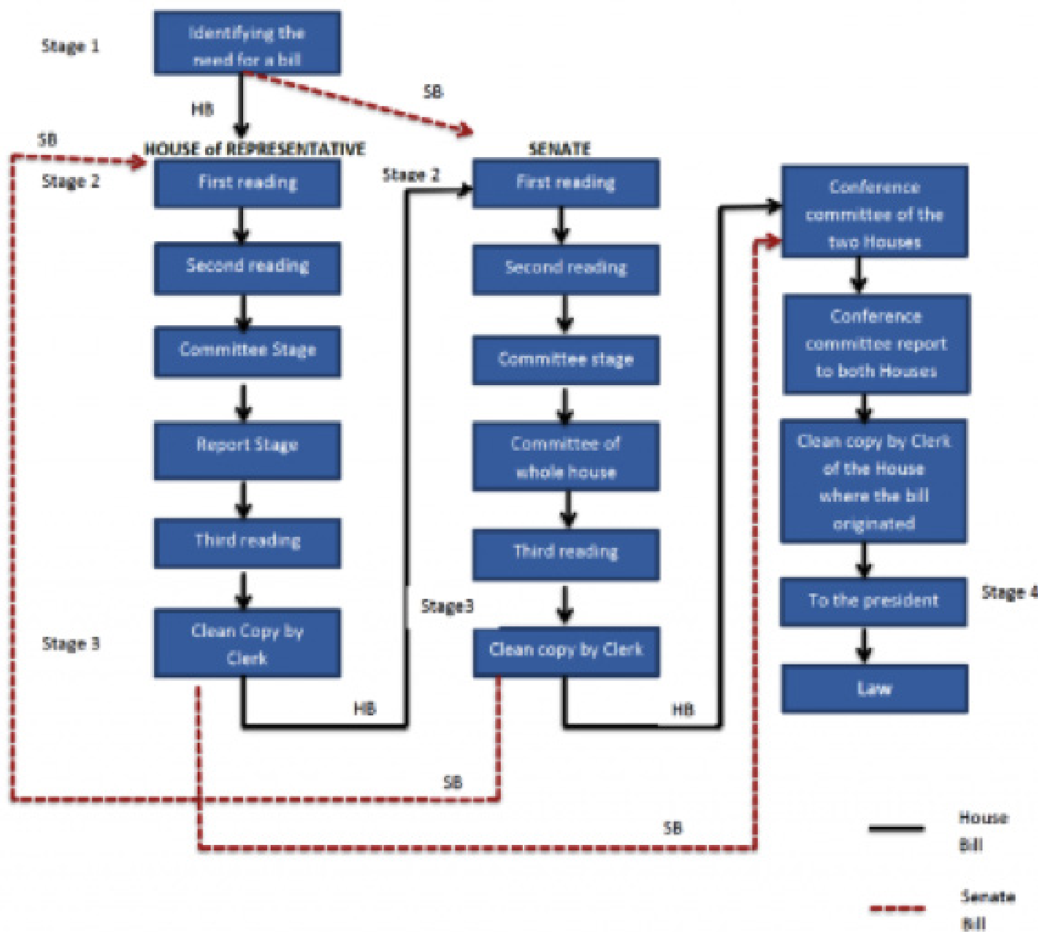
7- Paediatric Association of Nigeria (PAN) August 2014: Clinical Practice Guidelines on Community Acquired Pneumonia in Children page 23

Legislative Process

A key part of political advocacy work depends on understanding how the Nigerian legislative process works. Nigeria operates a bicameral system, which consists of a lower and upper House whose members are elected. Before a bill of legislation becomes a law, it exists as a bill proposed to the National Assembly. While a bill can be initiated by anybody, only a Member of the House or a Senator can introduce it on the floor of the House or the Senate. The bill must pass four stages and receive three readings before it can be passed into law. These stages take place in both the Lower House (known as the House of Representatives) and Upper House (known as the Senate). The bill is introduced to either the upper/lower House of Assembly without debate for first reading. Thereafter, a second reading is carried out at an announced date where the purpose or reason of the proposed bill is explained, followed by a general debate on the bill by the House. After the introduction of the bill, a Committee of the House meets to have a detailed examination and debate on the bill, after which amendments are made. The bill is then read for a third time, after which, the House is asked to vote on the Bill. Once the House passes the bill, a clean printed copy of it containing the various amendments is signed by the Clerk and endorsed by the Speaker/Senate President. The copy is then forwarded to the Clerk of the other House (Rep/Senate) for consideration.

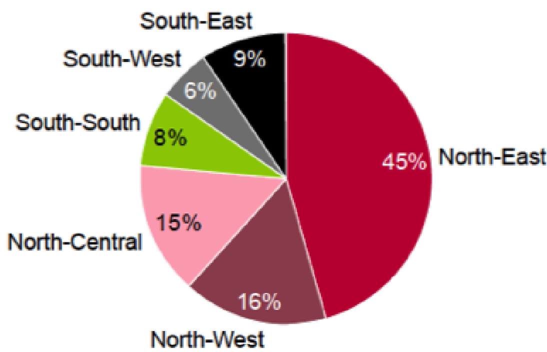
Afterwards, Conference committee report is sent to both Houses for consideration. If both Houses approve the bill, all the original papers of the bill are sent to the clerk of the House where the Bill originated. The clerk then puts together all the amendments and produces a clean copy of the Bill, which is sent to the President for his signature. The President then assents the bill into a new law by giving the President's seal of approval. Once it's a law, the Bill becomes an "Act".

The National Assembly is empowered by the Constitution to overrule the veto of the President. If, after 30 days, the President refuses to sign the bill the two Chambers can recall the bill and re-pass it. If the Bill is passed in the form it was sent to the President by two thirds (majority) in both Chambers, the Bill automatically becomes law even without the signature of the President[8].
The Association for Progressive Communications summarizes the process through this chart :



8- Association for Progressive Communications, Intermediary Liability: The Process of Law Making in Nigeria, 2104

UNICEF and WHO developed an integrated Global Action Plan for Pneumonia and Diarrhea (GAPPD), which highlights a comprehensive strategy through three prongs to end preventable child deaths by 2025: Protect, Prevent, and Treat. The framework is designed to protect children by establishing and promoting good health practices; prevent children from becoming ill from pneumonia and diarrhea by ensuring universal coverage of immunization, HIV prevention and healthy environments; treat children who are ill from pneumonia and diarrhea with appropriate treatment.



In order to address this, the Nigerian government has taken concrete steps to mitigate preventable child deaths. For all three of the major childhood illnesses (diarrhea, malaria, and pneumonia), effective treatments exist that can prevent the majority of the remaining deaths. However, these treatments are not reaching the children who need them. In order to address the inadequacy of access to treatment and services, the Federal Ministry of Health designed a strategy to ensure essential medicines are available across Nigeria. Through the Essential Childhood Medicines Scale-up Plan, the FMoH focused on four priority areas: Generate Demand for Appropriate Treatment and Promote Care-Seeking; Improve Availability and Use in the Public Sector; Improve Affordability; and Transform Private Sector Treatment Provision.

Furthermore, Nigeria launched the flagship Saving One Million Lives Initiative (SOML) which is now funded by the World Bank and expected to run until 2019. This initiative aims to rapidly increase access to proven interventions across six maternal newborn and child health program areas. The SOML focuses on health outcomes rather than outputs or inputs. The core strategy is to employ performance management to drive accountability and action, in order to achieve targets on coverage of interventions and number of lives saved.

In 2012, the Government of Canada awarded a grant to the WHO Global Malaria Programme to support the scale-up of integrated community case management of childhood diseases (ICCM) in sub-Saharan Africa. Through the Rapid Access Expansion Programme (RAcE), WHO has awarded funding of up to US$ 3 million annually to nongovernmental organizations for ICCM. The strategy is in the pilot stage in selected states: Abia and Niger. The program's objective, beyond contributing to the reduction of child mortality due to the three major illnesses, is to generate evidence to inform WHO policy recommendations and programmatic guidance on ICCM. Lessons learned will be reviewed to share experiences and identify the best practices for the scale-up of ICCM programs across sub-Saharan Africa. The project will also serve as a foundation for a comprehensive policy review on case management in the 5 target countries, and a review of WHO's policy guidance on ICCM.

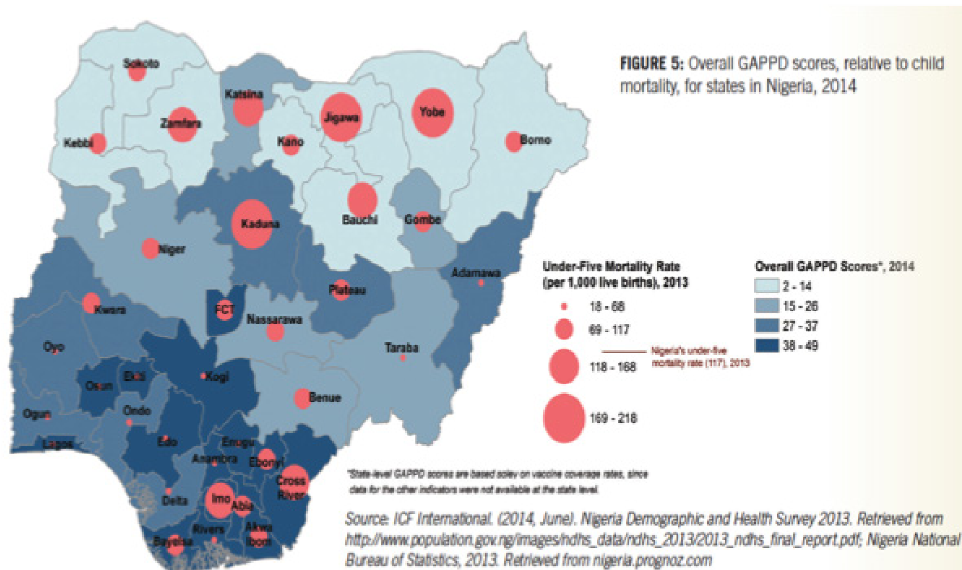


FIGURE 5: Overall GAPPD scores, relative to child mortality, for states in Nigeria, 2014

*State-level GAPPD scores are based solely on vaccine coverage rates, since data for the other indicators were not available at the state level.

Source: ICF International. (2014, June). Nigeria Demographic and Health Survey 2013. Retrieved from http://www.population.gov.ng/images/ndhs_data/ndhs_2013/2013_ndhs_final_report.pdf; Nigeria National Bureau of Statistics, 2013. Retrieved from nigeria.prognoz.com

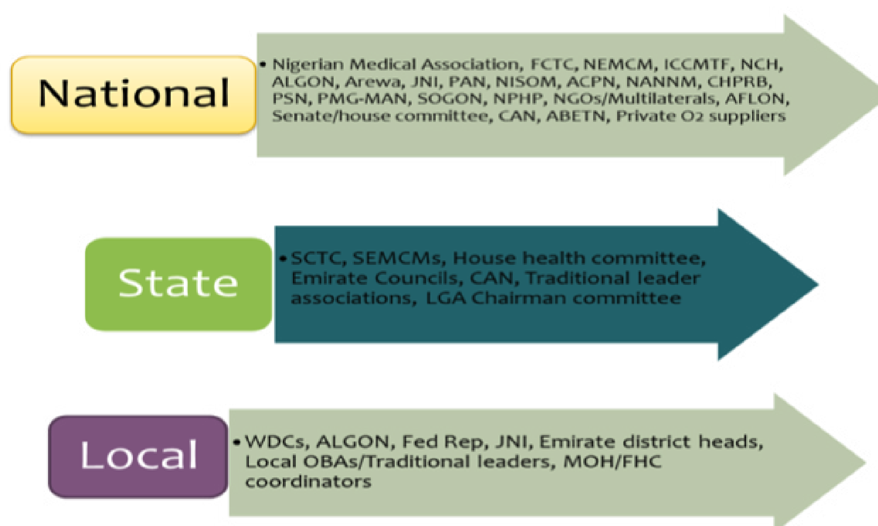
Government Health Structure

Nigeria's public health care system is weak and fragmented. It is divided into three tiers, each associated with one of the administrative levels of government: federal, state, and local government. All three tiers of government share responsibilities for providing health services and programs in Nigeria. The Federal Government is largely responsible for providing policy guidance, planning and technical assistance, coordinating state-level implementation of the National Health Policy, and establishing health management information systems. The federal government is also responsible for disease surveillance, drug regulation, vaccine management, training health professionals, the management of teaching, psychiatric and orthopedic hospitals, and also runs some medical centers.

The State Ministries of Health, State Hospital Management Boards, and the Local Government Areas (LGAs) share the responsibility for management of health facilities and programs. The states operate the secondary health facilities, and in some cases tertiary hospitals, as well as some primary health care facilities. State authorities are responsible for the training of nurses, midwives, health technicians and the provision of technical assistance to local government health programs and facilities.

The 774 local governments oversee the operations of primary health care facilities within their geographic areas. This includes the provision of basic health services, community health hygiene and sanitation. There are 34,000 health facilities in the country[9]. The inadequate public health system has given rise to a robust private health sector, as well as to traditional and spiritual healers.

Key Policy Influencers



The federal budget covers tertiary care and disease control programs, the states' budgets pay for secondary care, and the local governments' budgets cover primary care. In addition to the Federal Ministry of Health, another centrally funded agency, the National Primary Health Care Development Agency, has the mandate to support the promotion and implementation of primary health care.

During a BMGF meeting in June 2016, the Minister of Health and BMGF highlighted the importance of counterpart funding to ensure ownership and accountability.

9- http://nmis.mdgs.gov.ng/

Ministry of Health : Niger state

As the Ministry of Health is focusing its implementation efforts at the state level, and in order to comprehensively understand the health system, SUA visited Niger state in consultation with CHAI. Niger state is notable because several existing intervention efforts are currently underway, including a pilot of ICCM in 6 LGAs in collaboration with Malaria Consortium and the state MoH. Furthermore, partners such as CHAI have worked extensively in the state. (See CHAI section for more information.) Niger state provides with a good example of how interventions are implemented and how partners engage with the government.
Niger is the largest (land mass) state in Nigeria, comprising of are 25 Local Government Areas in Niger state :

Agaie / Agwara / Bida / Borgu / Bosso / Chanchaga / Edati / Gbako / Gurara
Katcha / Kontagora / Lapai / Lavun / Magama / Mariga / Mashegu / Mokwa / Munya
Paikoro / Rafi / Rijau / Shiroro / Suleja / Tafa / Wushishi

This equates to 274 wards in the state. The FMoH of health has rolled out the Pneumococcal vaccine in three phases targeting cohorts of states at a time.. The third and final stage will include Niger state and is expected to be available July2016.

As SUA and the MoH toured a local health center, there were very few posters that were designed for the consumption by the caregiver. Even the posters in the local languages were too complicated for the average “market woman” to understand their meaning. The MoH expressed a strong desire for campaign assets to be designed for the caregivers – not the health care providers. Most posters depicted too much technical information and lacked descriptive pictures. Unprompted, the MoH asked about the recently launched Every Breath Counts job aids (designed for health care workers) that were created by CHAI.

Furthermore, the state has its own initiative to upgrade 75 health centers to provide 24/7 service. State officials are currently assessing the facilities that are eligible for upgrade. While there are nearly 1,300 health facilities in Niger, it is unclear how many health posts, health clinics, and health centers there actually are. At the time of SUA’s visit to Niger (April 2016), it was not known how many of the health centers are actually functioning. A common problem is the lack of commodities or staff for many health posts. Concluded in May 2016, HSDF conducted an assessment to identify and classify functional health facilities into Type A (PHC center), Type B (PHC clinic) or Type C (health post/dispensary) based on the minimum service package and standards.

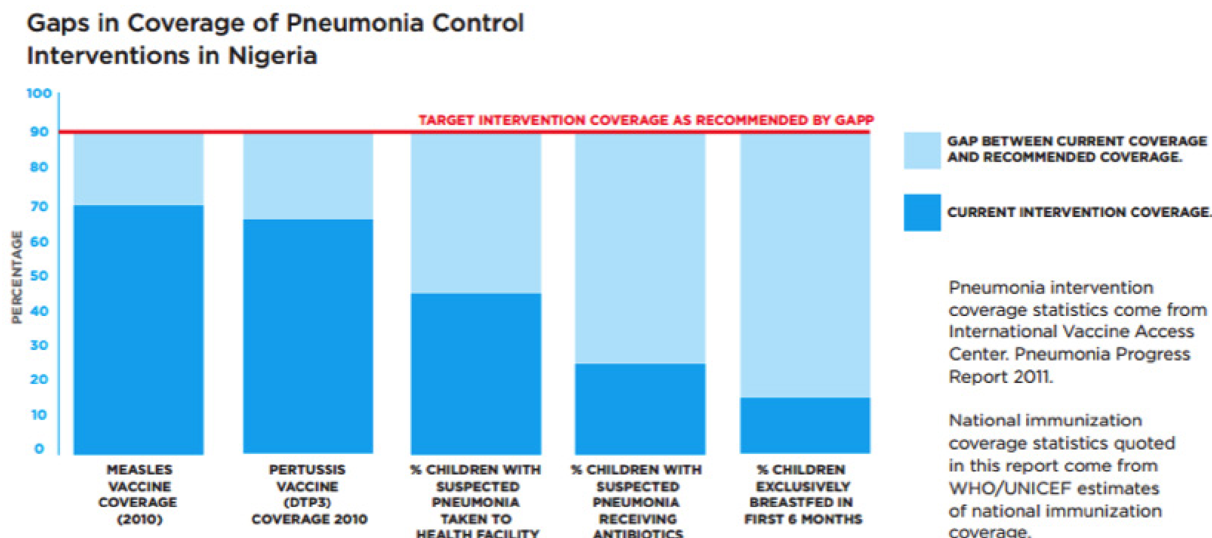
SUA met with the Permanent Secretary and the Director of the Primary Health Care Unit. They have recently developed a health committee for each political ward. This is a strategy shift from the health educators that were previously identified by the state (who too often had political ambitions or were too politically driven to be effective). The new committee is comprised mostly of women, particularly leaders from women’s organizations.

Pneumonia in Nigeria

The 2013 Demographic Health Survey highlights acute respiratory infection (ARI) among the leading causes of childhood morbidity and mortality in Nigeria. Although Nigeria lags behind in key Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD) and child mortality indicators, progress in combatting pneumonia has begun under the leadership of the Nigerian government. The FMoH has drafted a National Action Plan for the Prevention and Control of Pneumonia in Nigeria (NAPP) with the objective of ensuring that every child is protected against pneumonia, and has access to preventive and treatment measures. In line with GAPPD, the interventions laid out follow the same three strategic components:

1. Protection from pneumonia : Focus on exclusive breastfeeding, adequate nutrition, reducing indoor air pollution, and promotion of hand washing.
2. Prevention of pneumonia : Increase vaccination coverage against measles and pertussis, and to introduce vaccination against pneumococcus (April 2013) and Haemophilus Influenza (April 2012). This includes targeted communication and IEC and other interventions.
3. Treatment of pneumonia : Simple and effective case management of clinical pneumonia at household and community levels, health center level, and hospital level. Under Integrated Management of Childhood Illness (imci), most pneumonia case management would occur at the Primary Health Centre (PHC) level and rely on trained Community Health Extension Workers (CHEW), while community case management is addressed by current plans to roll out Integrated Community Case Management (ICCM). Both of these programs are slated for scale-up.

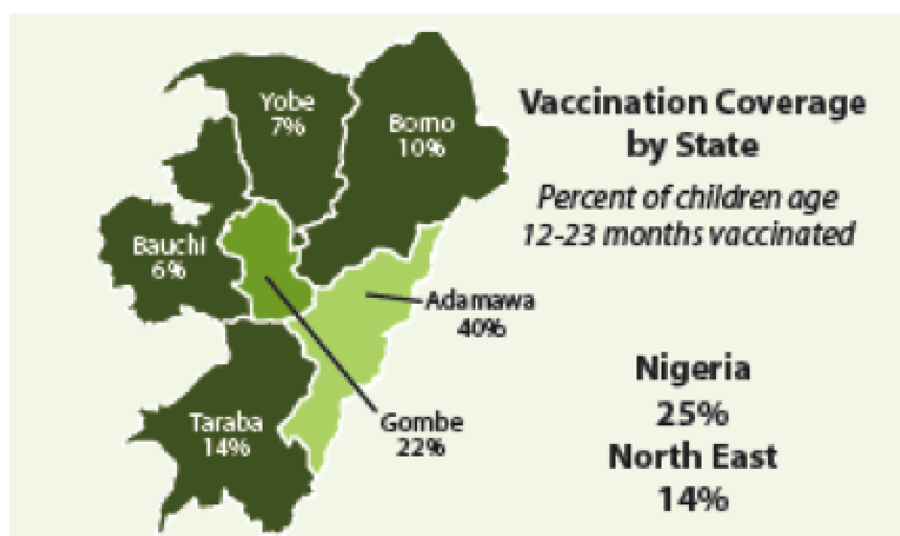
As this National Action Plan is still in draft form, many of these efforts have not yet been rolled out. There are on-going discussions on how to best fold these pneumonia-targeted interventions into the wider ICCM strategy. There is limited access to diagnostic technologies (X-ray machines and pulse oximeters) and to oxygen for treatment. The diagnosis of pneumonia is primarily done symptomatically by public and private primary providers and retailers. It is presumed that diagnosis is generally weak due to conflation of fever with malaria. Correct diagnosis is further lessened by low awareness on the part of caregivers, with fewer than a quarter of caregivers recognizing symptoms of pneumonia (MICS, 2007)



Vaccinations in Nigeria

Vaccine-preventable diseases like pneumonia, diarrhea, meningitis, and measles cause a significant proportion of deaths of children in Nigeria. Despite the burden of disease, Nigeria has made extraordinary progress in improving access to vaccination in recent years. Coverage for all vaccines increased substantially over the 2000-2010 decade. According to WHO/UNICEF estimates, DTP3 coverage more than doubled from 29% to 69% during this time period. Nigeria conducted an important mass campaign in late 2011 to deliver a new meningitis vaccine.

Increasing coverage of routine vaccines and introducing new vaccines against the two leading causes of fatal pneumonia — Haemophilus influenza type b (Hib) and pneumococcus — are high priorities for Nigeria. In 2012, Nigeria began a three-year phase rollout of the pentavalent vaccine, which protects against diphtheria, tetanus, pertussis, hepatitis B, and Haemophilus influenza b. Introduction of the pneumococcal and rotavirus vaccines are expected to begin in 2017. Pneumococcal vaccines are in its last roll out stage and will be available through the country by July 2016.



Furthermore, Nigeria has been delisted from WHO's polio-endemic countries. However, rising vaccine program costs and the financial implications caused by impending transition out of Gavi support are real challenges.

Availability of Services and Commodities

Access to appropriate treatment for diseases affecting children under-five is constrained by limited care seeking, poor diagnosis, and the failure to provide appropriate treatment even when the diagnosis is made correctly.

Overall, care seeking for childhood illnesses in Nigeria remains low. The 2013 Nigeria Demographics Health Survey (NDHS) shows that only 35% of caregivers sought advice or treatment from a health facility or provider for of children with ARI symptoms. Similar rates exist for fever and diarrhea, 32% and 29% respectively. Care seeking for ARI's has only marginally improved since the last NDHS in 2008, which was 32% care seeking. Conversely, care seeking has actually decreased for fever and diarrhea since 2008, which were 36% and 32% respectively.

According to partner interviews, low care seeking is likely due a combination of several factors, including cultural perceptions of childhood illnesses, the cost of treatment, an inability to recognize the danger signs of common childhood illnesses, and a lack of geographic access to appropriate sources of care. Most caregivers in Nigeria fail to recognize pneumonia as a disease that needs prompt and serious medical attention. In fact, fewer than a quarter of caregivers are aware of the two danger signs of pneumonia: fast breathing and difficult breathing[10]. In fact, when caregivers did seek care for a child with symptoms of pneumonia, the majority indicated that they did so because of the child's fever and not because of the child's respiratory symptoms. As pneumonia can kill a child in as few as three days, poor recognition of the danger signs is a critical barrier to overcome[11].

If we distill the data a bit further, we can see that the caregivers are nearly twice as likely to seek services from the private sector (42%) compared to 26% from the public sector. This distinction is notable because the private sector is not as regulated as the public sector[12]. This is a major concern, because anyone without any training, certification, licensing, or registration, can become a private provider or PPMV. Essentially they are street side 'chemists' who are not monitored by the government. PPMVs are not licensed to legally prescribe antibiotics, including Amoxicillin. Legally, PPMVs must refer caregivers to health facilities. Because of this clear conflict of interest, PPMVs may be incentivized to prescribe treatment other than Amoxicillin to illegally procure antibiotics. This is particularly dangerous for caregivers who may seek care from PPMVs and receive inappropriate treatment, which could ultimately be fatal. In the case of diarrhea, fewer than 40% of children who received care for diarrhea from these outlets received ORS while nearly half received antibiotics[13].

PPMVs also often miss opportunities to recommend and promote appropriate treatments to caregivers. One study found that nearly 80% of caregivers patronizing PPMVs request specific medications, but PPMVs ask for clarifications or a history from the customer in fewer than 19% of transactions. They simply sell the requested medication 69% of the time[14].

Of the small number of caregivers that seek care, only 45 percent of under-five children with suspected pneumonia received antibiotics. The percentage is considerably higher in the urban areas (53 %) than rural (43 %). About 11% of women knew the two danger signs of pneumonia[15].

Another significant barrier is poor availability of essential medicines in healthcare facilities. Nearly one-quarter of public health facilities do not stock first-line ACTs or antibiotics for pneumonia. Only about one third of public facilities stock ORS. Average stock-out durations at public facilities stand at ninety days (WHO/FMoH, 2010). Moreover, availability of commodities at public-sector institutions is often worse in northern states where mortality burdens are highest. Malaria treatment (ACTs) have been reported to be available in as few as 50% of public facilities.

Amoxicillin suspension (125 mg/5mL) is the most commonly available drug in both public and private facilities. There are 25 different importers of the antibiotic in Nigeria. GlaxoSmithKline (GSK) is in the lead with the highest volumes of suspension formulations (125 mg/5mL). GSK's product is most commonly found in private facilities. Furthermore, there are over a dozen Nigerian manufacturers

10- NBS/UNICEF, 2007

11- (Reyes, Perez-Cuevas, Salmeron, Tome, Guiscafre, & Gutierrez, 1997)

12- USAID, 2011

13- Nigeria Demographics Health Survey 2008.

14- Brieger, Osamor, Salami, Oladepo, & SA, 2004.

15- UNICEF Multiple Indicators Cluster Survey Nigeria: 2011 Main Report

who produce amoxicillin suspension, but only one (Daily Need Group) who is approved to manufacture Amoxicillin Dispersible Tablets (Amoxicillin DT). This is significant because Amoxicillin DT is significantly more cost effective than suspension. The price for suspension is roughly $2.1 USD while dispersible tablets cost only is $.7 USD.

FMoH is in the process of updating guidelines and policies, emphasizing the preference for dispersible tablets (DT) rather than suspension, highlighting the economic benefits of advocating Amoxicillin DT over suspension, and highlighting amoxicillin's higher efficacy than cortimoxazole. It is encouraging that many state health budgets already have Amoxicillin suspension as a budget line. A switch to the more appropriate and cheaper Amoxicillin DT will thereby imply budgetary savings for these states. This is particularly important especially in the context of a lower FMoH budget.

Another key barrier to treatment is insufficient awareness, skills, and diagnostic tools among Community Health Extension Workers (CHEWs) to properly diagnose and treat childhood illnesses. Training materials on essential childhood diseases—including pneumonia, diarrhea, and malaria—have not yet been properly integrated into a comprehensive training module that is appropriate for Integrated Community Case Management (ICCM) implementation.

Contributing to this lack of knowledge at the public provider level is the challenge of recruiting and retaining qualified staff at healthcare facilities. Studies in both northern and southern Nigeria report high levels of client dissatisfaction in primary health facilities as a result[16]. This is partly the result of a lack of sufficient and usable job aids and trainings. Providers are often not trained on how to properly diagnose pneumonia and may not have the proper equipment to measure a respiratory rate (using a simple respiratory rate timer). An additional complication is the prevalence of diagnostic overlap: pneumonia often presents with fever—which is equated with malaria—and therefore may result in a child being prescribed an antimalarial. Even if the child has pneumonia, co-morbidity diagnosis remains limited.

Non-Governmental Organizations

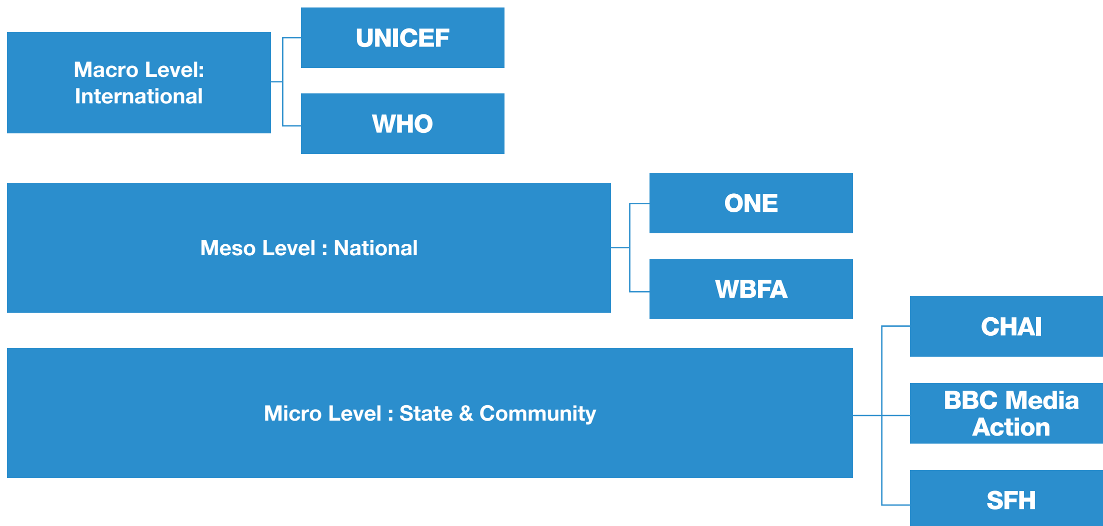
The partners that support the Nigerian government in reducing child mortality are comprised of government agencies, foreign governments (e.g. the Canadian Government's grant to WHO for RaCE project) and local and international NGOs. All development partners working in child health in Nigeria have adopted the Federal Ministry of Health's integrated child health policy into their interventions.

Local organizations operate at various levels throughout the country, work in consultation and assist with the implementation of the international organizations. As Speak Up Africa is not intending to do a deep dive for social behavior change, this landscape analysis has not attempted to include the operations or activities for the local organization. Therefore the focus of this landscape analysis has been on the international NGOs that work on several aspects of child health. However, it is clear that international organizations such as Pact and CHAI depend on the local organizations for their community network and implementation assistance. For example, as part of their projects, CHAI and Pact utilized an influencer map that was strategized and coordinated by local organizations.
The following matrix breaks down activities & interventions of key stakeholders :

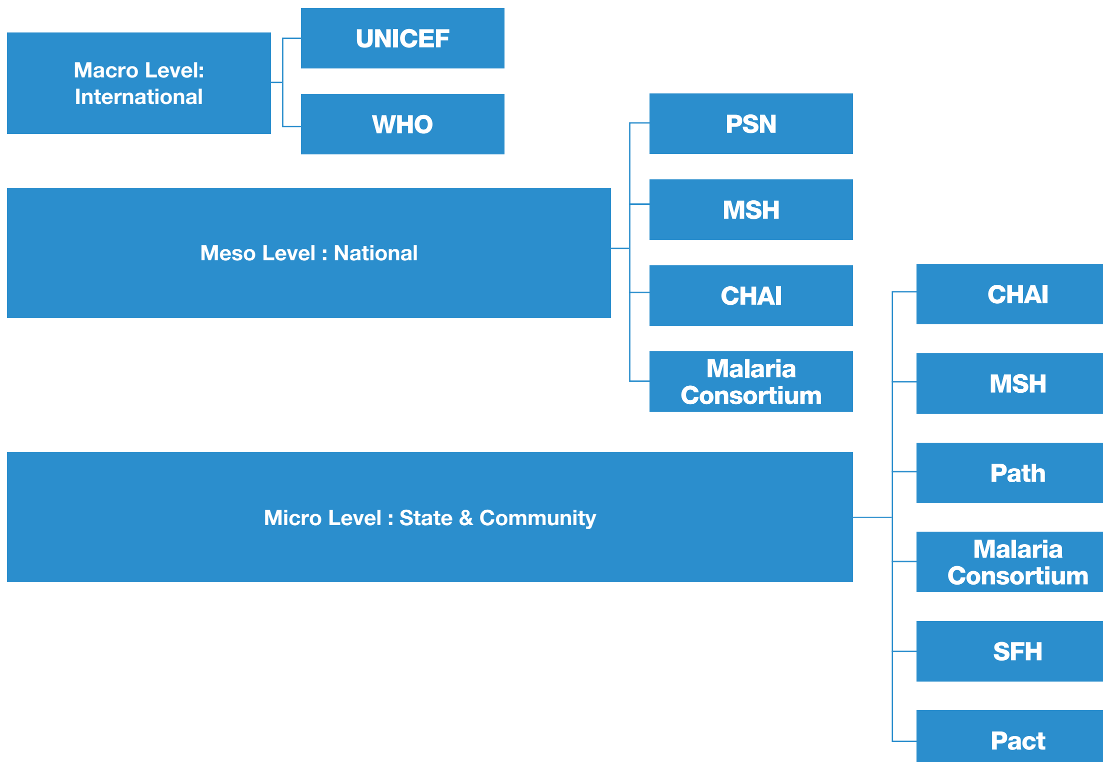
16- Sambo, 2010 & Ehiri JE, 2005

Partners Matrix:

Demand



Supply



National Essential Medicines Coordinating Mechanism (NEMCM)

Contact Person(s): Dr. Nnenna Ihebuzor, Director, Primary Health Care Systems Development

Under the leadership of the National Primary Health Care Development Agency (NPHCDA), the National Essential Medicines Coordinating Mechanism (NEMCM) continues to make strong advances to support the scale-up of essential childhood medicines in the country. To date, all NEMCM stakeholders are currently implementing activities in 13 fully covered and 24 partially covered states of the country. In 2014, all stakeholders convened on a quarterly basis while the Subgroups – M&E and Demand Generation – hold regular meetings separately and report to the NEMCM. A new subgroup - Procurement and Supply Management – was created to coordinate, and oversee procurement and distribution of essential childhood medicines. State and Local Governments and Development Partners in Nigeria mandate the subgroup to support and track the procurement and distribution of these commodities.
Additionally, States Essential Medicines Coordinating Mechanisms (SEMCMs) were established in 9 states to ensure that a coordinated approach is employed in the utilization of resources at state-level by states and partners. These new coordinating mechanisms will also help to ensure that local activities follow the national framework and leverage lessons from the NEMCM and partners efforts. Within the NEMCM there are partners whose work focus on pneumonia specifically, ranging from advocacy, demand generation, and educating PPMVs and health care providers. Speak Up Africa is a recent member of NEMCM and attends quarterly meetings.

Pharmaceutical Society of Nigeria Partnership for Advocacy in Child and Family Health (PSN-PACFaH)

Contact Person: Dr. Remi Adesun, Strategy Program Director

PSN-PACFaH is a BMGF grantee with an objective to ensure that the first line treatment for childhood pneumonia is Amoxicillin DT (as opposed to suspension) through policy advocacy. While their work has a national focus, they also work with three priority states: Lagos, Kano, and Kaduna. Each of these states has Gates grantees working on child health. Lagos State arguably has one of the most advanced health systems in Nigeria, with a significant number of trained health workers, two teaching hospitals, as well as long term international donor support. The Lagos State MoH is extremely responsive and the health budget, while still low, is used to a large extent appropriately. The state was also recognized globally for its response to Ebola in 2015. Kano is a high burden state in the North West geo-political zones of Nigeria. Kano accounts for 16% of the pneumonia burden, the second highest in Nigeria. Kaduna State has the third largest population in Nigeria and is situated in the geo-political zone with the second highest burden of pneumonia. From a policy standpoint a key challenge is getting adequate attention from government stakeholders to ensure actionable engagement. PSN-PACFaH recommends that additional demand creation support to catalyze policy dialogue is an area in which SUA could productively engage. The development of strategic communication specifically focused on the legislative arm of the government would help to catalyze MoH and MoF to provide necessary support and resources. This national advocacy support could include assistance in forecasting the estimated return on investment in child health resources. While MoH has updated its policies, but the political will for implementation is not yet there. Potential advocacy messaging would be to show the importance of child health infrastructure, not just on health, but as a part of the country's overall success, including economic growth. Currently, the government is investing a disproportionate amount of domestic resources as means to grow the Nigerian economy, however, it is discounting the importance of access to quality public health care as an important compounding factor.

Beyond the national advocacy, PSN-PACFaH advocated for Amoxicillin DT to be included on the revised National Standard Treatment policy document and Essential Medicine List, thus removing cotrimoxazole as the first line treatment for pneumonia. This enabled states to adopt revised EML at a state level, ensuring the availability of Amoxicillin DT in all health facilities. (Amoxicillin DT is available in states that are piloting ICCM including Niger, Kebbi, Abia, and Adamwa states. This is only during the pilot state, which is expected to end at the in Q3/Q4 2016.)

In March 2016, the National Council approved the roll out of ICCM nationally. However, Remi Adeseun, PSN Strategy Program Director stated "due to the lack of available resources, fewer than 10% of the states are able to implement the policies approved by the National Council". Despite Nigeria's previous commitment to allocate 15% of its expenditures to health in accordance with the Abuja Declaration signed 15 years ago, Nigeria only spends 4.3% on public health. Furthermore, most states do not allocate enough funds to public health expenses. Only the Bauchi state spends 15% of its budget on public health.

Mr. Adeseun also highlighted the lack of partnership and coordination amongst health partners during the budgeting process at state and national levels. "At the state level, partners can support the development of annual health operational plans and play a key role towards advocating for inclusion of budget lines for child health commodities. It would be critical to develop a shadow budget and monitor how allocated domestic resources are being released, disbursed and used to meet the health needs of the Nigerian child". The support from international donors to ensure that routine immunization remains a key priority needs to be further strengthened with Federal and State Governments commitment to fund.

Clinton Access Health Initiative (CHAI)

Contact Person(s): Tiwadayo Braimoh & Obinna Ajeroh

CHAI is a Gates grantee, implementing projects focused on reducing childhood mortality from malaria, diarrhea and, more recently, pneumonia. Their programmatic objectives are to ensure a policy change for the inclusion of Amoxicillin DT on the revised EML at the Federal and State levels. Furthermore, CHAI is working with local manufacturers/importers of Amoxicillin DT to ensure adequate supply and demand for Amoxicillin DT.

CHAI is making sure health care providers have the right tools to correctly diagnose and treat pneumonia (including severe pneumonia). CHAI's priority is to change the prescribing practices of various providers. As most caregivers seek care from PPMVs, CHAI has devoted significant effort to training care providers, which includes recognizing pneumonia and diarrhea danger signs. CHAI has reached 23,000 PPMVs with their training. The training empowers PPMVs to identify the signs and symptoms of ICCM diseases, with a focus on diarrhea and pneumonia. However, due to the legislative policies, PPMVs are not allowed to treat pneumonia because there is no regulation or supervision for the PPMVs. Therefore, these PPMVs are trained to identify the symptoms of pneumonia yet expected to refer the patients to seek care at a nearby facility. However, in an exception to this rule, PPMVs working in LGAs that are piloting the ICCM, are allowed to prescribe Amoxicillin. As ICCM has been recently passed at the national level, all states are expected to roll out ICCM (pending available funding). This is a clear example of how the policies are not aligned with the practices in the communities.

This discrepancy is a clear advocacy priority for CHAI. Not only are advocacy efforts are needed to align the providers with the new policy changes, bur further efforts are needed to move toward the larger picture of improving community access of services and commodities. As also mentioned by PSN, continual resistance from medical professionals and associations has blocked community providers, such as PPMVs to distribute basic antibiotics, such as Amoxicillin. Jason Houdek, Associate Director, Essential Medicines at CHAI, noted the disconnection between the doctors providing care and influencing policy from the communities in need of care. Mr Houdek also notes that while PSN works closely amongst the medical community, PSN's professional association is strongest amongst pharmacists (and not with doctors). He emphasized the resistance amongst doctors regarding community treatment due to the lack of doctors in rural areas. He believes that this is a task-shifting resistance in which doctors are trying to protect their professions. The majority of the "resistance for community access stems from doctors' refusal to task shift". In other words, doctors are uncomfortable with the idea of shifting some tasks and responsibilities from their jurisdiction to providers with less formal education or training.

As Amoxicillin as been added to the EML and approved as the first line treatment, health care providers will need to be oriented and aware of this policy change. The first step is to print the revised the National Standard to include Amoxicillin with the funds that expire in June 2016. The printing of the Standard further solidifies its legitimacy and likelihood in implementation. Mr. Houdek states, "initial advocacy efforts need to ensure that providers throughout the country are familiar with the new policy change for consistent implementation as well as have the states adopt and implement national level policies". CHAI believes the PPMVs in Niger state can identify pneumonia better then the providers in the health facilities. Visiting a health center outside of Minna (the capital of Niger), the health center report showed that the facility diagnosed over 300 patients with malaria and only 2 with pneumonia in the past 5 months. When asked about co-morbidity, only malaria is ever diagnosed or treated. This indicates a serious under diagnosis of pneumonia.

CHAI has a three year pneumonia plan to work on a joint investment plan with the state to forecast the equipment budgets, train health care providers, create quality improvement teams, support the supervision, and ensure there is enough pneumonia commodities (oxygen, Amoxicillin DT). CHAI is also advocating for oxygen treatment to be on the national and state essential equipment list.

In Lagos State, demand generation interventions have been carried out in support of health care workers' capacity to diagnose and treat diarrhea and pneumonia. The focal states for the project are Kano, Kaduna, and Niger, where they have reached 5,000 PPMVs through demand creation interventions focused on recognizing the symptoms of pneumonia.

The recurring challenge and barrier to their work is the delayed revision of the EML, which hampers availability of Amoxicillin DT to health facilities in all states and the weak supply and demand value chain for the manufacturing, supply and uptake of the Amoxicillin DT.

Political advocacy can be highlighted into two main issues: financing and access to services & treatment. In regards to financing, Nigeria is struggling with an ailing economy that lost nearly 45% of its revenue due to depreciating oil prices. Many states in Nigeria are oil dependent and are struggling to maintain the existing costs. "State governments are months late in paying the salaries," Jason Houdek. Therefore, CHAI stresses the need for advocacy efforts to focus on the effectiveness, transparency, and accountability of the government to procure commodities and implement programs, rather than focus on the increase of resource allocation to the Federal or States Ministries of Health. This type of advocacy needs to be state-specific in order to recognize the nuance that exists

in each state. Mr. Houdek cites the following example, in Kaduna, the commodities are available in nearly two thirds of all functioning public health facilities for a small fee. However, in neighboring Katsina, the commodities are free of charge yet the public health facilities constantly struggle with stock out issues. Therefore, CHAI asserts that it would be more effective to ensure commodities are consistently available at a low cost. This strategy would also build consumer confidence in the health facilities and therefore be less likely to seek treatment through informal channels.

CHAI further distinguishes the assumption that the cost of the commodities is the main proportion of the total care seeking or treatment process. CHAI points out that the percentage a caregiver pays to receive care varies greatly dependent on their location. Further asserting that financial schemes need to account for the ability of certain states to pay a bit more for commodities while it needing to subsidize in others. This is an important point of advocacy as the recently passed national Health Bill is strongly promoting the health insurance schemes and is an active strategy of the FMoH.

As part of the National Health Bill, the FMoH will allocate 1% of its total revenue to the primary health care unit. Furthermore, for all States that a meet certain requirements, the FMoH will match funding. The timing of the National Health bill provides an opportunity to leverage federal funding.

CHAI also highlighted the resource intensive process of community-based messaging as an important gap in interventions. Most partners focus their activities on providers; there is a lack of demand creation activities and materials focused on caregivers.

Society For Family Health (SFH)

Contact Person: Ogechi Onuoha, Maternal & Child Health Manager, Expanded Social Marketing Project in Nigeria (ESMPIN) & Boladale Akin-Kolapo, Deputy Chief of Party

SFH with support from USAID is currently wrapping up the Expanded Social Marketing Project in Nigeria (ESMPIN). The five-year social marketing project is nationwide and focuses on 22 priority states – 11 states in the north and 11 states in the south. SFH focuses on improving demand and supply chain of RMNCH commodities in the private sector. SFH also partners with local manufacturers of ORS/zinc. SFH partners with Association for Family and Reproductive Health, BBC World Service Trust and Population Services International to implement ESMPIN.

SFH works with community based development agents (CBDAs) in Ebonyi where ICCM is currently being piloted. While SFH's focus is primarily on diarrhea and ORS/zinc uptake, there is an overall focus on child health and pneumonia. Working in 4 LGAs, (2 test and 2 control), SFH trains, mentors, and supervises CBDAs to ensure quality control. SFH also provides commodities (including Amoxicillin DT). The ICCM pilot study will end in July 2016 and has reached a total of 45,000 children under five.

The CBDAs make an income from the selling commodities. They are responsible for going house to house to do demand creation activities. CBDAs serve as a step below PPMVs; SFH hopes to graduate the CBDAs to PPMVs. A point of difference between CBDAs and PPMVs are that CBDAs are registered with the government.

As previously mentioned, policy limits the distribution of antibiotics such as Amoxicillin DT. A key advocacy gap, as identified by Boladale Akin-Kolapo, Deputy Chief of Party, is the need for an "enabling policy environment for improved access for private sector vendors", such as CBDAs to prescribe Amoxicillin. In accordance with the pilot ICCM project, SFH cites success of CBDA's ability to diagnose pneumonia correctly and administer treatment effectively. With supervision of the vendors, SFH considers this to be a good model for the rest of the country to follow.

As such, SFH believes there is a need for advocacy efforts to empower PPMVs and community health workers to dispense Amoxicillin. Aside from this policy change, SFH is also calling on funders to purchase treatment from local manufacturers and support local pharmaceutical companies to set up factories.

SFH have found the same cross cutting issues to seeking treatment for pneumonia :

Care seeking barriers	Supply barriers
Knowledge and beliefs about childhood illness	Inconsistent availability of services at health posts
Ignorance and distrust of health caregivers	Drug stock outs
Distance and lack of transportation	Functionality of health facilities
Cost of care-seeking	
Cultural limitations	

BBC Media Action

Contact Person: Rachael Borlase, Head of Country Programs & Genevieve Hutchinson, Senior Projects Manager

BBC Media Action has conducted Gates-funded research on diarrhea and pneumonia. The project was recently scaled down and pneumonia was ultimately removed their remit. Accordingly, BBC Media Action has not analyzed the results of the pneumonia research. The research was conducted in Kebbi and Benue, which are both located in the south.

BBC Media Action also conducted a KAP on immunizations in 2 states: Kano and Kaduna. Although it was not pneumonia specific, the information was designed to capture perceptions on child health in a more general sense.

As previously mentioned, BBC Media Action has been commissioned to produce the demand generation component for SFH and Association for Reproductive and Family Health. This work encompasses community and local radio stations as well as interpersonal communication strategies. This project has reached caregivers through existing community-based structures from town criers to market women associations and health facilities. Although their strength is in mass media, BBC Media Action also designed dark kits to reach people who are unable to access radio and tv.

BBC Media Action has also conducted research on identifying community leaders. The research was conducted for a project to engage community members for routine immunizations. One of their key insights was the role that Grandmothers play in society. For example, in the north, elder women are looked upon as having wisdom in childrearing and hence might be key child health "influencers".

A few years ago, BBC Media Action also worked on a project, Panda, which involved 10 states and had pneumonia specific information on Kaduna and Niger states. This project was funded by WHO.

Wellbeing Foundation Africa (WBFA)

Contact person: Mrs. Toyin Saraki, Founder & Dr. Luther-King Fasehun, Director

Since inception, the Wellbeing Foundation has been focused on maternal and child health. WBFA's work in the pneumonia space has centered at the national level with a focus on advocacy. Wellbeing's principal focus has been on maternal health, midwifery, nutrition and increased access to client-held, integrated maternal and child personal health record (PHR) booklets. They implement projects nationwide, with a particular focus in Kwara State, primary beneficiaries being caregivers, especially mothers.

H.E. Mrs. Toyin Saraki, Founder of WFA, has given several call-to-action speeches for improved access to preventive and treatment options for childhood diseases. In fact, she is a strong advocate for the Every Breath Counts campaign, which was launched in January 2016 at the African Union summit. On behalf of the Wife of the President of Nigeria, Mrs. Toyin Saraki addressed the Organisation of the African First Ladies against HIV/AIDS to urge fellow First Ladies to become engaged in the campaign. Mrs. Toyin Saraki then represented Mrs. Buhari again at the Women Deliver Conference in Denmark in May to launch the Every Breath Counts Coalition. Her tireless efforts continue with her ambition to film every wife of the governor's from each state. SUA has a close and productive working relationship with her and the Wellbeing Foundation, and are well positioned to facilitate Governors' wives filming.

Pact

Contact person: Dr. Shobo Olukolade George & Dr. Amina Ahmad–Shehu

Pact is currently implementing a project, ICARE, which is a five-year program which partners with Abt Associates (supply) and BBC media action (demand). The project aims to reduce mortality due to diarrhea. Abt Associates works on ensuring the PPMVs have access to ORS zinc commodities. BBC media Action designed the dark kits to be used for the listening groups. While the Pact project does not focus specifically on pneumonia, their 4-pronged approach may be a useful best practice:

1. Listening groups: There are 6 sessions in which a group listens to radio dramas followed by discussions by facilitators. Each session has a different focus and all lead toward the same goal: to increase the uptake of ORS/zinc as a treatment for diarrhea. There are 20 caregivers in the listening groups. The target audience is specific to caregivers of children under five years old. Listening groups didn't work as well in Kebbi, but worked well in Benue. Adjustments had to be made for Kebbi to hold group sessions in households instead of in public spaces.
2. Community Meetings: Engage community members during existing community structures, such as town halls. This ensures that different participants (i.e. men, elders, etc.) will also be engaged in understanding the danger signs of diarrhea and the importance of seeking treatment.
3. Household visits: Community based organizations are contracted by Pact to go out to the communities and have household discussions about diarrhea. The Community based organizations already have thorough networks in which they can disseminate their workers. Pact works with 14 CBOs in each state.
4. Key influencers: Pact engages key influencers at higher level (state government and community elders) to ensure the permission to work in these communities. Similar approach as CHAI and their 'tier 1 influencers".

USAID- MSH

Contact Person(s): Nkeiru Onuekwusi & Faleke Olumide, Child Health Team Leader

USAID supports an integrated maternal and child health program in Nigeria. The current focus in the pneumonia space is advocacy and supply of Amoxicillin DT. Working through the Maternal Childhood Survival Programme, a dedicated resource has been identified to ensure (over the next 18 months) that a policy change occurs at the Ministry of Health to include Amoxicillin DT as an over-the-counter drug, similar to ACTs for the treatment of malaria. This project started in Q4 2015. On the supply end, working with The U.S. Pharmacopeia Convention (USP), this project is focused on supporting local manufacturers of Amoxicillin DT to ensure quality control of products.

MSH believes that a critical advocacy need is the inclusion of Amoxicillin DT as an OTC, which in turn enables PPMVS to immediately provide treatment options for primary care givers with children who have pneumonia. However, there are some concerns regarding misuse. The intention of making Amoxicillin OTC is geared towards PPMV being able to legally prescribe Amoxicillin. It is likely that a supervisory mechanism will need to be established for PPMV's before there is a policy change.

MSH said they could use the help to mobilize key influencers (like the Wife of the President) to provide air cover to their advocacy work as they continue a dialogue with policy makers on the issue of availability of Amoxicillin DT and its inclusion on the EML at all levels in the country.

MSH cites another key advocacy issue, which has been particularly prominent this year: financial resources. MSH highlights the problematic structure of the current system, which does not allow for finances to be deliberately sourced, allocated, and disbursed in a timely fashion. Faleke Olumide, Child Health Team Leader, states, "delays in access to finances impede access to quality child health services. Since the key to providing quality child health services is sustainability, strong sustainable financing channels are needed on a continuous basis."

MSH also highlights the need to advocate for better coordination, planning, and monitoring of child health advocacy activities, particularly in the states. This coordination will ensure a stronger and comprehensive child health advocacy strategic plan at the national and state level.

Faleke Olumide believes concerted advocacy efforts are often too focused at National level. In regards to advocacy efforts, MSH believes "more effort should be given to the states as they are independent of the federal government with diverse peculiarities, needs, resources and challenges. Ensuring alignment with policymakers at the state level will help facilitate the implementation of the interventions, which happen at the state level." In regards to investing in certain states, MSH prioritizes the high burden areas to ensure high impact.

Faleke Olumide notes "health interventions have implications and thus requiring proper management and regulation for good health outcome/impact. Therefore while considering caregivers and providers, it is important to target policy makers especially at the state level. The policy makers make and enforce policies for enabling environment as well as regulatory and monitoring elements in the interest of the end users of the intervention/services." In general, MSH sees the state policymakers as the priority target for advocacy efforts.

ONE Campaign

Contact Person(s): Mwambu Wanendeya, Africa Executive Director

ONE launched an accountability campaign, Make Naija Stronger, designed to pressure the FMoH to keep its promise to spend 15% of its federal budget on public health. In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support. When the Abuja Declaration was signed Nigeria's spending was only marginally lower then it is now; Nigeria currently spends 4.3% on public health, which is a similar percentage to its expenditures as before it made the commitment 15 years ago.

ONE is hoping to raise public awareness of the campaign through a short video that interviews (including one in which a man lost his wife in a Lagos hospital). This powerful video received 100,000 views within the first week. However, the views and comments via social media did not translate into petition signatures. ONE aims hand over a petition to the government in July/August, when the Ministry of Health is expected to begin to write its annual budget. ONE also hopes to engage citizens to write letters to their state representatives. However, since the campaign is focused on demanding more expenditure without making any specific asks, popular engagement is limited as they are unsure how to help. ONE is interested in partnering with SUA to engage political leaders such as the governors.

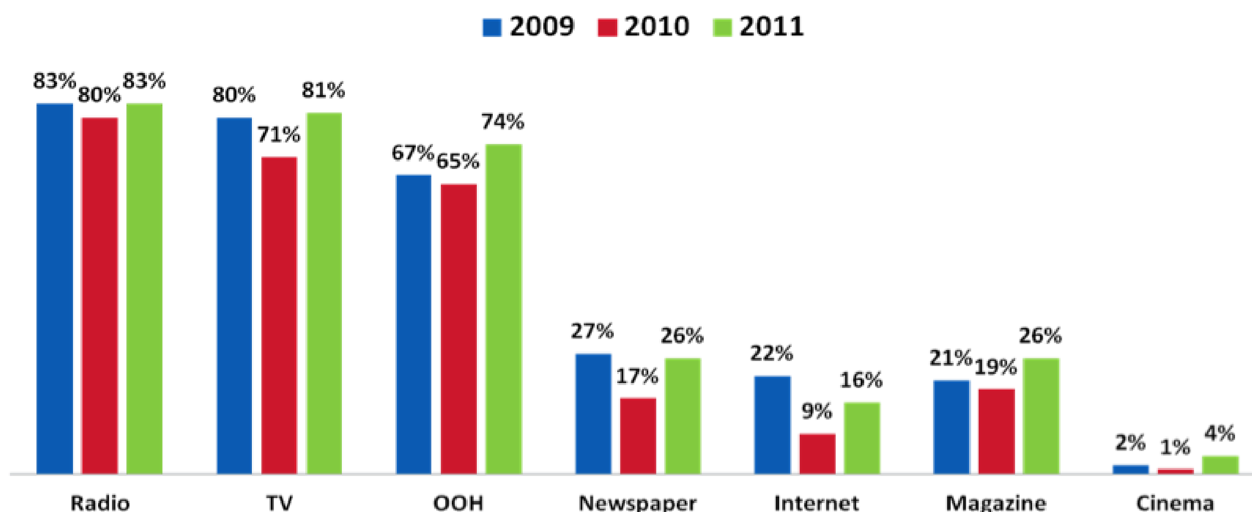
ONE sees the two key advocacy priorities: increased public health allocation and transparency of funds. Currently, ONE is advocating for increased investment in public health generally through the Make Naija Stronger campaign. Therefore, establishing a partnership would enable the two campaigns to work together and reinforce their goals. Including a child health aspect is a useful platform for ONE because it would demonstrate specific impacts from increased resource allocation. ONE has a strong public following in Nigeria, accounting for two million Nigerian subscribers. ONE would also be an ideal partner to further disseminate campaign materials.

Media Landscape

Nigeria's media is largely privately owned. The 1992 deregulation of broadcasting ended the government monopoly of the broadcast media helping to make one of Africa's most vibrant, free media landscapes. While Nigeria has a multitude of media platforms at its disposal, radio, television and "out of house" platforms have the best penetration. Out of house platforms refers to billboards, posters, placards, etc.

Radio and TV are the lead media platforms with very high reach, cutting across demographic and geographic groups in Nigeria[17]. Radio due its affordability and its battery or solar powered access has a much higher in rural areas. Radio is the medium that is able to address the peculiarities of language through local adaptations thus is best placed to reach the grassroots in rural Nigeria. However, as indicated in the table below, "out of house" (OOH) or billboards have significantly high penetration throughout the country.

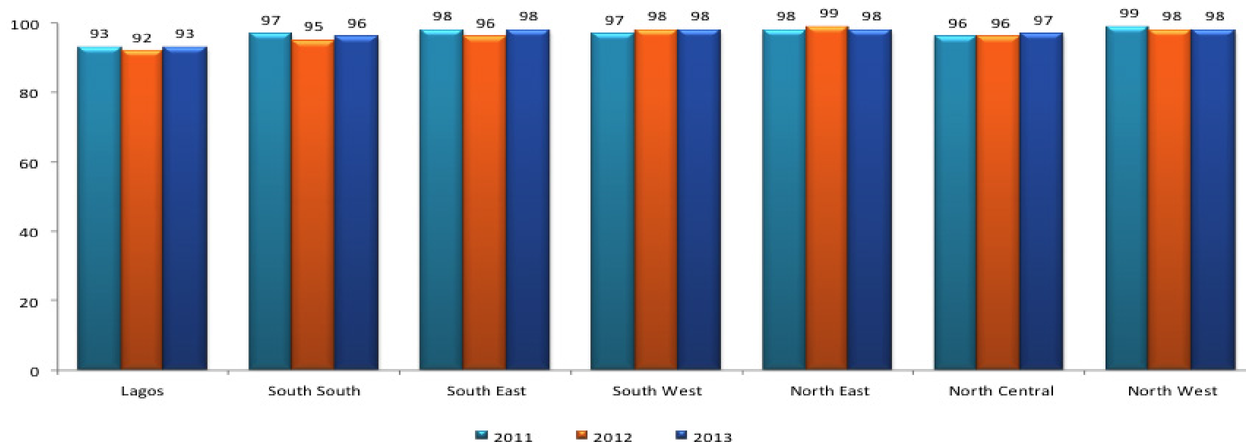
17- Nigeria Media Scene, OMD, 2012



Penetration of various mediums in Nigeria

Radio Landscape

There are 137 radio stations, 41 of which are government owned. Campus radio has had a historical presence in universities across the country. The 25 private radio stations (60% of which are based in Lagos) have developed a 'cult' following of on air personalities that have phone programs with large listenership and followership on social media. International radio stations have had a presence in Nigeria since the 1940's with VOA and BBC having versions of the Hausa speaking world service. With a weekly reach of 23.5 million adults the BBC Hausa Service has around four times the size of the audience for the English service in Nigeria. The BBC Hausa Service reaches 13% of Nigerians weekly. It is generally perceived a credible and reliable source of news[18].



Radio Listenership by Region. Source: AMPS 2011-2013

Television Landscape

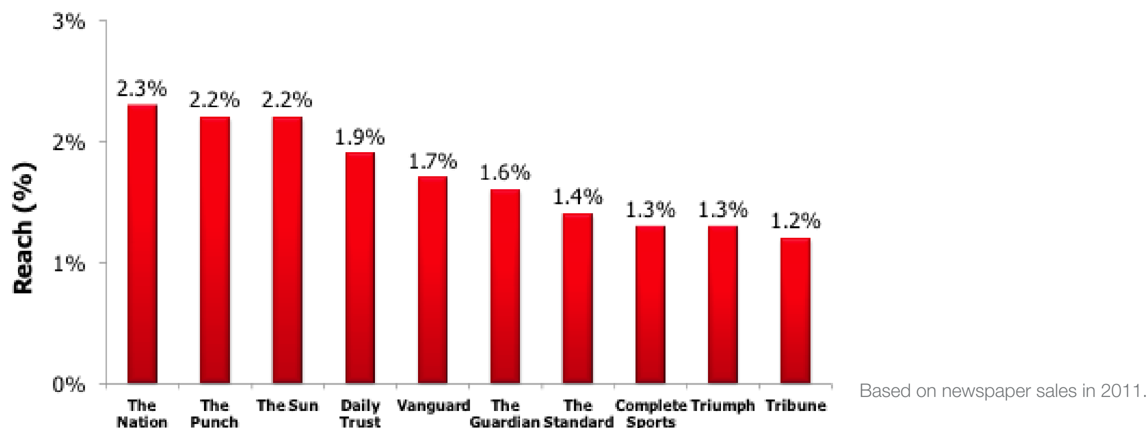
While it does not have the same reach as radio, television is starting to make inroads into urban audiences. Overall, a quarter of the population in Nigeria has access to cable or satellite television. Among audiences with television, radio still tends to be consumed in the mornings, but television becomes dominant in the evenings.

Nigeria has over 105 terrestrial TV stations and 137 satellite TV stations, and an additional 33 wireless cable service providers. The National Television Station (NTA) has by the largest reach with 95 TV stations and 30-40 million Nigerians tuning in to the nine o'clock news every night. State TV is also popular; every state in the country has its on TV and radio stations.

18- BBC World Service Reviews, Qualitative research on the BBC Hausa Service Prepared (2010)

Print Landscape

Newspaper circulation in Nigeria is fairly low, with the Sun Newspaper having a circulation of 200,000 nationwide. Many of the leading newspapers have adopted a strong online presence. There are over 78 sector specific newspapers covering business, sports, entertainment and general interest. Readership of specific titles is usually localized, with regionally skewed reach. Daily newspapers are the dominant players, pricing is just over $1; cost is a significant barrier to increasing circulation



Based on newspaper sales in 2011.

Telecommunications & Social Media Landscape

Nigeria has the largest mobile market in the region with roughly 60% of households possessing mobile telephones. These are predominately "Feature phones". As with many African countries, Nigeria has leap frogged landlines with mobile line subscribers, reaching an estimated 151,357,769 million active mobile subscriptions as of January 2016[19]. An estimated 10.5 million people have access to 3G services (roughly 6.2% of the population), and over 15% purchase dual SIM devices to cut costs for outgoing calls. Nigeria has over 43 million Internet users and more than more than 45 million Internet connected devices - Internet World Stats. Nigeria is the largest telecommunication market in Africa with upwards of 151 million users and a growing subscription level since 2001. Internet penetration recorded 76% year on year growth between 2010 and 2011, in the process surpassing the reach of newspaper by 27%. 64% of Nigerian Internet users fall within the 18 – 34 age band. 90% of Internet users, between ages 18 – 27, use their mobile phones to access the Internet. Social media, emailing and games are some of the most predominant online habits among Nigerians. There are over 4.3 million Nigerians on Facebook and 1.6 million on Twitter. The use of social media is more suited for the middle income earners and with its limited reach, it is best suited for specific communications to this target audience.

In understanding the various markets and trying to rationalize the over 250 ethnic groups in Nigeria, there is a natural segmentation that is commonly adopted, which groups Nigeria into three distinct markets: North, East, and West. The table below provides a high-level summary of these three regions and their respective media habits.

Factors	North	East	West
Dominate Religion	Islam	Christianity	Christianity
Dominate Language	Hausa	Igbo, Pidgin	Yoruba, Pidgin, English
Dress	White	Colorful	Colorful
Occupation	Agriculture	Trading	Professionals
Lifestyle	Conservative	Flashy	Modern & Hip
Lead Media	Radio	TV	TV
Media Habits	- Radio is major medium due to the nomadic nature of the Hausas then followed by Outdoor and TV - TV is strong due to watching Indian Movies - Communal viewing & listening - High emphasis on religious festivals	- Listen to radio during AM - Tend to listen to news/business shows - TV viewing in afternoon is increasing as most of them have TV sets in their shops - Social activities are high, but usually don't last late into the night	- TV radio and outdoor are the most effective mediums in this region - More educationally inclined - More sophisticated audience - Very active social life (24 hrs)

Source: MediaCom

19- http://www.ncc.gov.ng/index.php? option=com_content&view=article&id=125:art-statistics-subscriber-data&catid=65:cat-web-statistics&Itemid=73

Communication Gaps

In light of the partner interviews, literature review, and research, it is clear that dedicated communications could improve outcomes with respect to two key constituents: policy makers and primary caregivers.

Caregiver Advocacy Gaps

As described earlier, existing partner interventions are largely focused on healthcare providers (through trainings, job aids, and access to commodities). When SUA visited a health center in the company of Ministry of Health representatives, the gaps in caregiver-focused materials were starkly evident.

While there were many posters and materials on the walls, all of these materials used copious amounts of jargon and all were directed to the health providers. This information was sometimes too technical and with images that were too confusing even for health providers. The MoH representative was not confident that health workers would be able to grasp the intention of these materials. The MoH representative insisted that the materials hanging on the wall were designed to be reference materials that should be found in health workers' offices, not in the waiting room of a health center. He stressed the need for caregiver focused materials with very simple and to the point messages.

The MoH representative stressed the importance of capturing caregivers as they visit the health center. While visiting the health center, caregivers are a "captive audience". In the Representative's view, the health center is a "low hanging fruit" opportunity – by reaching mothers who are already seeking care at a health facility. The representative clearly understood the value of creating nuanced messages for target audiences and emphasized the need for creative content that could be understood by the "average market woman".

Policy Advocacy Gaps

A recurring theme that was presented was the need to provide communication materials directed for policymakers to empower them to make informed decisions. PSN and NEMCM highlighted their challenges of advocating child health amidst a myriad of competing health priorities. In their view, diseases such as pneumonia are not given the priority they merit (based on disease/mortality burdens). Therefore, communication materials could include basic, awareness materials, which would make the general case for investment in pneumonia prevention and community access to treatment. Advocacy materials could also include technical materials (including easily digestible fact sheets) outlining the economic and social impact of improved child health services.

NGOs working on the implementation side, such as CHAI, SFH, and Malaria Consortium struggle to implement their activities efficiently due to a lack of an enabling policy environment that is focused on community access. Although ICCM has been officially approved and Amoxicillin listed as a first-line treatment for pneumonia, there are still significant barriers and bottlenecks caregivers to seek care, especially in rural areas. For example, caregivers tend to seek care from PPMVs, particularly in the north, yet theses PPMVs do not have the authority to dispense Amoxicillin.

Another policy gap, as highlighted by CHAI, ONE, and PSN, are the financial constraints to implementing the existing policies. The federal and state ministries have not allocated sufficient resources to public health and fall short of the Abuja Declaration commitment of fifteen percent. ,There is a need for advocacy to raise public awareness of the government's commitment to the 15% investment and to ICCM and of the need for to transparency in resource allocation.

Overwhelming consensus of the key advocacy gaps revolves around two key themes: finances & community access to treatment. The following table is an overview of identified advocacy gaps.

Overview of Advocacy Gaps

Gap	Target Audience	National vs. State	Impact vs. Effort
Community access to Amoxicillin	Policymakers	National & State	High Impact & medium effort
Alignment of providers to revised policy (i.e. inclusion of Amoxicillin as the first line treatment & EML)	Medical association (i.e. doctors)	National	High Impact & low effort
Lack of domestic resources geared to public health (i.e.: Abuja Declaration)	Policymakers	National & State	High impact & high effort
Transparency and accountability of resource allocation (i.e. shadow budgets)	Policymakers	National & State	High impact & high effort
Lack of public awareness of the prevalence and burden of pneumonia	General public	National & State	High impact & Medium effort
Counterpart Funding	Policymakers	National & State	High impact
Consistent financial channels	Policymakers	National & State	Medium impact & High effort

Conclusion & Preliminary Recommendations

Based on extensive interviews and research, partners have identified several overlapping child health advocacy needs to push the needle on reducing child deaths. There are several key policy 'wins' that have demonstrated Nigeria's progress and political will: nationwide rollout of ICCM; inclusion of Amoxicillin on the national EML; approval of Amoxicillin as the first line treatment for pneumonia. In light of this progress, it is recommended that a national advocacy campaign around child health and pneumonia, which would target thought leaders, influencers and policymakers to create an enabling policy environment and solidify political will to push a strong child health agenda.

The proposed campaign would be led by a group of credible influencers across different sectors. By capturing influencers across various arenas, the campaign would saturate its target audiences with directed messages. The campaign would recruit iconic Nigerians across different sectors (i.e. policymakers, thought leaders, celebrities, etc.) as public health champions and influencers across multiple communication platforms: TV, radio, billboard, SMS, and social media.

This campaign would reinforce the fact that there are clear actions that the government can take in order to make progress on child health and pneumonia in particular. These actions relate to fully funding health generally (up to the 15% Abuja Declaration target), to fully fund ICCM, to ensure that Amoxicillin is finally firmly placed on the EML, and enable community access to treatment. The campaign would be designed to create political pressure and accountability for the government to channel sufficient domestic resources to effectively prevent and treat pneumonia at the community level and thereby reduce child pneumonia related deaths.

In order to garner political support, the campaign should work closely with H.E. Toyin Saraki who is already engaged in the Every Breath Counts campaign and Coalition. She has proposed to engage the wives of the governors for every state in Nigeria to participate in raising awareness around the importance of prevention, diagnosis and treatment for child health diseases. Building this platform would enable each state to take on a different child health issue. Having the wives' engagement would strengthen the political commitment and ownership across the nation.

A pertinent entry point for engagement is the Governors' Wives Forum. In 2016, it was restructured from a singular national forum into the Northern Governors Wives Forum (NGWF) chaired by Zamfara State Governor's wife Asma'u Abdul'aziz Yari and the Southern Governors' Wives Forum chaired by Imo State governor's wife Nneoma Nkechi Okorocha. Recently, the Southern Governors' Wives Forum converged in Lagos and was hosted by the wife of the Lagos State Governor, Mrs. Bolanle Ambode. Through the assistance of H.E. Toyin Saraki, the campaign could use these opportunities to engage the wives.

Given the recent advocacy success of the national approval of ICCM, now is an opportune time to make the case for continued engagement at the community level. It is essential to work within Nigeria's legislative and budgetary timelines.

Overview of Proposed Advocacy Campaign Activities/Scenarios

High Engagement & High Impact :

- Film of all governors' wives to appear in a public health service announcement.
- Host events during the newly reformed Governors Wives Forums. All of the PSAs would appear in a conglomeration of the PSA and shown at the high-level Governors' Wives Forums and as a key feature around Pneumonia Month advocacy. By filming all of the governors' wives, it creates momentum on a national scale that can be use as a model at the regional level as proof of political engagement and active political will. It may serve as a great catalyst for other countries in Africa as a model to amplify child health and pneumonia efforts.
- Film two popular cultural celebrities to be showcased and featured during "Pneumonia Month"
- The campaign would be launched as part of 'Pneumonia Month' in November of the campaign year.
- The campaign would be displayed and featured at various high-level activities and stakeholder engagements in partnership with the Federal Government and other development partners.
- Public services announcements would be aired on TV and radio in the 3 local languages as well English.
- Given the high Internet penetration in Nigeria, a robust social media campaign will also be developed and implemented throughout the life of the campaign. Below are a few key events around which campaign assets can be disseminated and promoted.
- Work alongside the ONE's campaign to hold the government accountable to its commitment to spend 15% of its expenditures on public health. Currently, ONE has not focused on any clear asks from the government beyond the general expectation to allocate 15% on public health and has not engaged the public in a meaningful way. Low petition turnout is due to the fact that the public is largely unaware of the commitment and its importance. By creating a campaign that highlights the importance of child health investment, pneumonia specifically, Nigerians will be more likely to get involved with the movement.

Key Advocacy Moments/ Events	Activities
African Union Summit	January & June/July
State budget planning	July
National budget planning	September
Independence Day	October 1
International Day of the Girl Child	October 11
Universal Children's Day	November 20
Pneumonia Month	November
Budget approval	December

Medium Engagement :

- Film the five governor's wives and 2 celebrities. In regards to recruiting strong influential champions the Chairs for the Governors' Wives Forums, specifically the Chair of the Northern Governors' Wives Forum (NGWF): Zamfara State Governor's wife Asma'u Abdul'aziz Yari, and the Chair of the Southern Governors' Wives Forums (SGWF): Imo State governor's wife Nneoma Nkechi Okorocha. Amongst the Southern Governors' Wives, the wife of the Ogun State Governor, Mrs. Funso Amosun, is known to be quite influential and has a good personal and professional relationship with the wife of the President.

Low Engagement :

- Film only two of the governors wives: specifically the Chair of the Northern Governors' Wives Forum (NGWF): Zamfara State Governor's wife Asma'u Abdul'aziz Yari, and the Chair of the Southern Governors' Wives Forums (SGWF): Imo State governor's wife Nneoma Nkechi Okorocha.

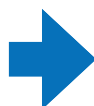
Intervention Logic

Every Ministry is required to present its respective budget to the National Council and the Ministry of Finance for approval. A Ministry of Finance representative highlighted the importance of framing public health priorities through an economic lens. Keeping this in mind, the FMoH must present a compelling economic case on why further investment and resources are necessary for the overall wellbeing of Nigeria as a country.

Nigerians have lost confidence in the government's ability to provide public services. The 'government is looking for an easy success story' to build Nigerians' confidence in the government. Studies have shown positive correlation between economic impact and investment in women and children's health. Funded by BMGF, Alive and Thrive conducted research that analyzed how to articulate investment in women and children's health to policymakers. A key takeaway was the fact that human rights-based arguments and messaging were not as effective as economic arguments with respect to government investment and ownership. (More highlights are listed in the chart below.) Therefore, the ideal campaign would highlight the economic loss due to preventable illnesses. By crafting messages, which make the case for the government to make smart and efficient investments in child health. The campaign would help allay Nigeria's development and budgetary concerns.

General learnings from discussions with stakeholders:

- The **economic argument for investment is more compelling** for policy makers than the rights-based or inequality argument
- **Family planning** and **adolescents** are both seen as integral components of the women's and children's health agenda
- **Nutrition** is synonymous with this health agenda
- **Gender inequality** and **women's empowerment** (or the lack of) are seen as **major obstacles to progress** and are an integral part of the women's and children's health agenda
- **Education is inherently linked to women's and children's health** - viewed as cyclical multiplier for progress.



Messaging content should:

- Be explicit about the **direct linkages between investment and impacts for the economy** and broader society
- Emphasize the importance of **helping people reach their full potential**, (rather than just survival), with positive examples
- State how women and children's health aligns with issues across the **broader developmental agenda**
- Link women's health to the **gender equality** and **women's empowerment**
- A powerful argument is **educating girls will help contribute to economic growth**. But this requires explanation for most audiences.

Source : Every Woman Every Child

Priority Advocacy Audiences

Campaign targets would be broken into 2 segments: 1) policymakers & thought leaders and 2) the general public. The campaign would raise the profile of pneumonia at the national and state level. Keeping in mind political situation and budgetary timelines, the first priority audience should be the national and state policymakers. An important distinction to make is that the ideal campaign should engage policymakers beyond the Ministry of Health. A significant part of the challenge for Nigeria is to allocate enough funds for child health among all of the competing priorities in other ministries. As such, the campaign aims to target policymakers from Ministry of Finance with an economic case for investment in child health.

A secondary, yet complementary audience, for the campaign is the general public. Raising public awareness of the burden and severity of childhood diseases, such as pneumonia, would create bottom up pressure for government action. Through a surround sound message of empowerment, the campaign would catalyze the public to demand adequate resources directed to child health infrastructure and systems.

Influencer Engagement

The campaign would engage a variety of key influencers in different sectors. Each influencer's role would vary depending on his ability and willingness to engage. The campaign would provide tailored levels of engagement with the champions and does not anticipate a one-size fits all approach. It is recommended to engage each champion based on his or her comparative advantage.

For example, Mrs. Toyin Saraki, as the wife of the Senate President, has unique social and political capital to ensure the wives of governors participate in the campaign. Accordingly, Mrs. Saraki would likely be used as much for her behind the scenes advocacy as for her on air messages.

The comparative advantage of celebrities, artists and athletes on the other hand would likely be in public-facing messages. The campaign would develop a menu of child health issues and each celebrity influencer could pick from this menu in order to find an overlap between his/her own interests and the needs of the campaign. This menu of issues would largely follow the GAPPD integrated approach. The champions would be filmed to produce a cadre of health messages to be disseminated on television, radio, and key events. With each celebrity influencer, the campaign would film thought leader/national advocacy messages as well as caregiver/"-mother in the market" awareness messages. A social media toolkit would be designed specifically for champion as means for further public engagement.

The campaign should to embrace each recruited celebrity influencer across different subjects and time. Initial engagement would involve influencer education, subject matter decision making, radio and TV footage capture, social media and event planning. Over time, and across a serious of planned in advance touch-points, the campaign would continue to engage each influencer. It is critical that each influence receives regular (monthly) updates on the campaign progress and on the on-going recruitment of new campaign champions.
SUA suggests the following potential influencers :

Potential	**Advocacy Influencers**
Political & Thought Leaders	**Titles**
H.E. Mrs. Aisha Muhammadu Buhari	Wife of the President of Nigeria
Mrs. Toyin Saraki	President of the Wellbeing Foundation
Dr. Obiageli Ezekeli	International Advocate
Abike Dabiri Arewa	Public Figure
Dayo Israel	Public Figure
Asma'u Abdul'aziz Yari	Zamfara State Governor's wife & Chair of the Northern Governors' Wives Forum
Nneoma Nkechi	Imo State governor's wife & Chair of the Southern Governors' Wives Forum
Wives of the Governors	All states
Musicians & Actors	**Titles**
P-Square	Singers
Femi Kuti	Singer
Omoni Oboli	Nollywood actress
Desmond Elliot	Nollywood actor
Kalu Ikeagwu	Nollywood actor
Waje	Singer
Omawumi	Singer
Olu Jacobs	Nollywood actor
Joke Silva	Nollywood actress
Athletes	**Titles**
John Obi Mikel	Captain, Nigeria National Soccer player
Ahmed Mussa	National Soccer player
Alex Iwobi	National Soccer Player
Ahmed Musa	National Soccer Player
Victor Moses	National Soccer Player
Blessing Okagbare	National Athlete

For more influencer biographies, please see Appendix 1: Influencer Biographies

Appendix 1:
Potential Influencer Biographies

POLITICAL & THOUGHT LEADERS

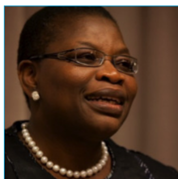
Name: H.E. Aisha Muhammadu Buhari
Sector: Politics - Nigeria's First Lady
Why chosen: Public Figure and Pneumonia Champion
Previous work in health: Every Breath Counts Campaign, & Donations to Orphanages
Areas of concerns/controversies: None
Twitter: 70,400 followers

Aisha Muhammadu Buhari is the wife of Muhammadu Buhari, the President of Nigeria, who assumed office on May 29, 2015. She is a pneumonia ambassador for the Every Breath Counts campaign. She is a women's rights activist and child right advocate. She has, on several occasions, emphasized the need for young girls to get primary and secondary school education before getting married, saying that she believes no girl should get married before the age of 17. She founded Future Assured to continue her advocacy work for the health and wellbeing of women and children through community mobilization and health promotion. She is a Cosmetologist, Beauty Therapist and Author.

Name: Mrs. Toyin Saraki
Sector: Politics - Charity and Philanthropy
Why chosen: International advocate for maternal and child health
Previous work in health: On going work in the child health space
Areas of concerns/controversies: Her husband is the Senate President, in court over some allegations around his asset declaration
Twitter: 29,300 followers

As Founder-President of Wellbeing Foundation Africa (WBFA), Mrs Toyin Saraki is a Nigerian philanthropist with two decades of advocacy covering maternal, newborn, and child health, gender-based discrimination and violence, improving education, socio-economic empowerment and community livelihoods in Africa. She has worked closely with Speak Up Africa to promote and advocate for the Every Breath Counts campaign. She is very interested in working with Speak Up Africa to engage all of the 36 governors' wives to participate in the campaign by filming them in a PSA to raise awareness to various health issues.

She also launched a successful social media campaign through Wellbeing Foundation Africa in 2012 called #MaternalMonday to raise awareness on key issues in maternal, newborn and child health in Africa. She contributed largely to the establishment of the Lifestream Charity in 1993 and is a global advocate of the UN's Every Woman Every Child campaign. Toyin is on the board of the Global Foundation for the Elimination of Domestic Violence and the board of the Africa Justice Foundation. Toyin Saraki is the Newborn Champion for Save the Children Nigeria and was the inaugural Global Goodwill Ambassador to the International Confederation of Midwives in 2014.



Name: Obiageli Ezekwesili
Sector: International Advocate/National Thought Leader
Why chosen: Held various ministerial roles in government/World Bank, co-founder Transparency International
Previous work in health: Leadership in Bring Back Our Girls Campaign for the Chibok girls
Areas of concerns/controversies: None
Twitter: 479,000 followers

Obiageli Ezekwesili is a Nigerian chartered accountant. She was a co-founder of Transparency International, serving as one of the pioneer directors of the global anti-corruption body based in Berlin, Germany. She served as Federal Minister of Solid Minerals and then as Federal Minister of Education during the second-term presidency of Olusegun Obasanjo. Since then, she served as the Vice-President of the World Bank's Africa division from May 2007 to May 2012.

Name: Abike Dabiri-Erewa
Sector: Politics / Charity and Philanthropy
Why chosen: Credible public figure with extensive media and publicity experience
Previous work in health: None
Areas of concerns/controversies: None
Twitter: 292,000 followers

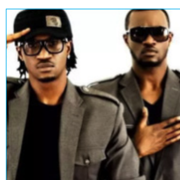
Abike Kafayat Oluwatoyin Dabiri-Erewa, is a Nigerian politician and former member of the Nigeria Federal House of Representatives representing Ikorodu Constituency in Lagos State. She was the Chairman of the House Committee on Media & Publicity. She was also the former Chair of the House Committee on Diaspora Affairs. She was elected for the first time in 2003, and re-elected in 2007 and 2011.

Name: Dayo Israel
Sector: Politics & Charity and Philanthropy
Why chosen: Credible public figure with extensive media and publicity experience
Previous work in health: Save the Children UK, UNICEF, YGA
Areas of concerns/controversies: None
Twitter: 6,000 followers

Dayo Israel (LLB (Hons), MA International Relations) is an astute motivational speaker and advisor to many world leaders, business executive, politicians, young entrepreneur and sports professionals. He is also an internationally recognized personality with over 12years of professional experience in international development having worked with organisations such as The United Nations, British Council, Save the Children UK, UNICEF, in various capacities and has appeared on countless television interviews, commercials, talk shows, radio programs, and was even selected by the United Nations to represent all the young delegates to the UN General Assembly Special Session on Children on a special CNN Live Interview. Recently, He was specially invited by Queen Elizabeth II and the Duke of Edinburgh to a private reception at Buckingham palace.

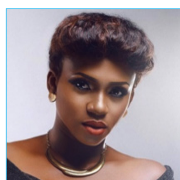
Appendix 1:
Potential Influencer Biographies

CELEBRITIES



Name: P-Square
Sector: Music
Why chosen: Wide followership Across Africa
Previous work in health: None
Areas of concerns/controversies: Accused of sampling western songs and alleged rift between the duo
Twitter: Combined followership of 1.6 million

P-Square are a Nigerian R&B duo of identical twin brothers Peter Okoye and Paul Okoye. They produce and release their albums through Square Records. In December 2011, they signed a record deal with Akon's Konvict Muzik label. In May 2012, they signed a record distribution deal with Universal Music South Africa. They are ambassadors for Nigeria's Telecommunication'



Name: Waje Iruobe
Sector: Music
Why chosen: Wide followership Across Africa
Previous work in health: Malaria Free Nigeria Campaign
Areas of concerns/controversies: Some level of explicit content in one of her music videos
Twitter: 360,000 followers

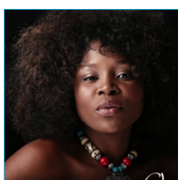
Waje is female Nigerian musician who came into spotlight in 2008 after being featured in a couple hit singles which includes Psquare-Do Me and others. She is an award winning singer who has multiple hit singles to her name also. Waje is currently working with the youths of her community through an organization she calls WajeSafeHouse, where she teams up with other NGOs quarterly to help fight for their cause. She was also a Malaria No More ambassador in the Malaria Free Nigeria campaign. Waje has a daughter, Emerald, who was born when Waje was 17 years old. The name of Emerald's biological father remains unknown. No scandal, but she was accused to be too explicit in one of her music videos.

Name: Femi Kuti
Sector: Music
Why chosen: Wide followership Across the World, Afro Music Legend
Previous work in health: Malaria Free Nigeria Campaign and UNICEF Associate
Areas of concerns/controversies: None
Twitter: 70,000 followers

Olufela Olufemi Anikulapo Kuti, popularly known as Femi Kuti, is a Nigerian musician born in London and raised in Lagos. He is the eldest son of afrobeat pioneer Fela Kuti and a grandchild of a political campaigner, women's rights activist and traditional aristocrat Funmilayo Ransome Kuti. In 2012 he was both inducted into the Headies Hall of Fame (the most prestigious music awards in Nigeria), was the opening act on the Red Hot Chili Peppers' European arena tour and became an Ambassador for Amnesty International. Kuti has been a vocal advocate of HIV/AIDS prevention since 1997, when his father, Fela Anikulapo-Kuti, founder of Afro-beat music, died of the disease. Femi Kuti first became associated with UNICEF when he contributed an essay to The Progress of Nations, a UNICEF publication describing what becomes possible when nations invest in children's well-being and protect their rights.

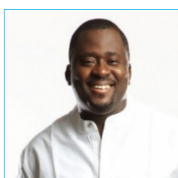
Name: Omoni Oboli
Sector: Nollywood Actress
Why chosen: Wide followership Across the World
Previous work in health: Brand Ambassador for Nunu milk
Areas of concerns/controversies: None
Twitter: 83,000 followers

Omoni Oboli is a Nigerian actress and producer. In 2010 she won the award for Best Actress - Narrative Feature at the Los Angeles Movie Awards, and the award for Best Actress at the Harlem International Film Festival. She was nominated for the Best Actress in a Leading Role award at the 2011 Africa Movie Academy Awards. In 2014, Omoni won Big Screen Actress of the Year award, at the 2014 ELOY Awards, for her movie Being Mrs Elliot. She is an ambassador of the Nunu Brand, PZ Cussons Nigeria. There is no scandal around Omoni Oboli.



Name: Omawumi Megbele
Sector: Music
Why chosen: Wide followership Across Africa
Previous work in health: None
Areas of concerns/controversies: None
Twitter: 522,000 followers

Omawumi Megbele, known by her stage name Omawumi, is a Nigerian singer-songwriter and actress of Itsekiri ethnicity. She is a brand ambassador for Globacom, Konga.com, and Malta Guinness. She's also part of the campaign called «Rise with the Energy of Africa».
Omawumi has been involved in charity works such as Project Alert Pink Pearl Foundation, Notes2Notes, and "Maga No Need Pay" campaign, a behavioral change campaign against cyber-crimes. She is chosen because she has massive followership that extends beyond Africa given that her rise to stardom was from a competition that cuts across Africa. No political affiliation and no scandal.

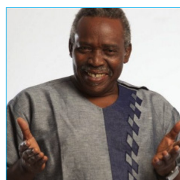


Name: Desmond Elliot
Sector: Nollywood Actor & Politics
Why chosen: Popularity & Wide Followership
Previous work in health: Staunch Advocate against Cancer
Areas of concerns/controversies: None
Twitter: 264,000 followers

Desmond Elliot is a Nigerian actor, director, and politician who has starred in over two hundred films and a number of television shows and soap operas. He won best supporting actor in a drama at the 2nd Africa Magic Viewers' Choice Awards and was nominated for best supporting actor at the 10th Africa Movie Academy Awards. He was elected as a lawmaker of the Lagos State House of Assembly, Surulere Constituency, in the April 11, 2015 Nigerian General Elections. He is a politician under the All Progressive Congress party. He throws his weight behind the fight against cancer through awareness creation. No known scandal around him.

Name: Kalu Ikeagwu
Sector: Nollywood Actor
Why chosen: Popularity
Previous work in health: Youth Development
Areas of concerns/controversies: None
Twitter: 24,000 followers

Kalu Egbui Ikeagwu is a British-Nigerian actor and writer. As an actor, he has received several awards and nominations for his performances on screen. He runs a youth empowerment scheme called Excellence in Entertainment workshop, targeted at training a minimum of 2000 youth in Lagos state on various aspects of film making. There is no scandal around him.



Name: Olu Jacobs
Sector: Nollywood Actor
Why chosen: Movie Veteran in Nigeria
Previous work in child health: Supports lots of Children Cause in Nigeria
Areas of concerns/controversies: None
Twitter following: No Verified Account

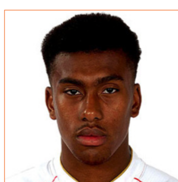
Oludotun Jacobs popularly known as Olu Jacobs, is a Nigerian actor. He has starred in several British television series and international films. In 2007 he won the African Movie Academy Award for Best Actor in a Leading Role. He trained at The Royal Academy of Dramatic Arts in London. He has starred in various British television shows and series in the 1970s (e.g. The Goodies, Till Death Us Do Part, Barlow at Large, and The Venturers. Olu Jacobs was honoured with the Industry Merit Award for outstanding achievements in acting at the 2013 Africa Magic Viewers Choice Awards.

Name: Joke Silva
Sector: Nollywood Actor
Why chosen: Movie Veteran in Nigeria
Previous work in child health: Supports Gender Inequality Causes she is a United Nations Goodwill Ambassador
Political affiliation: None
Areas of concerns/controversies: None
Twitter following: 23,000

Joke Silva is a Nigerian actress and director. She has received several awards and nominations for her work as an actress including the awards for Best Actress in a Leading Role at the 2nd Africa Movie Academy Awards in 2006, and Best Actress in a Supporting Role at the 4th Africa Movie Academy Awards in 2008. She has starred in several films and television series of both English and Yoruba languages. Joke Silva is involved in charity with the United Nations, as she is their goodwill ambassador and she gives seminars to young women in tertiary institutions. She is focused on championing women's issues. She is a mentor to many upcoming actor and actresses.

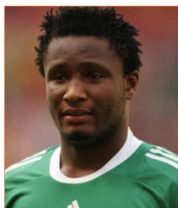
Appendix 1: Potential Influencer Biographies

ATHLETES



Name: Alex Iwobi
Sector: Sports
Why chosen: Popularity & Plays for one of the Big Four Clubs
Previous work in health: None
Areas of concerns/controversies: None
Twitter: 84,300 followers

Alex Iwobi is a Nigerian professional footballer that plays as a winger and a striker for Premier League club Arsenal. He is also the nephew of the legendary Austin J.J. Okocha. Alex initially played junior team football for England but opted to play for the Nigerian National team in 2015. He has become a sensation in the English league and is one of the players to look out for in the next season. There is no scandal around him.

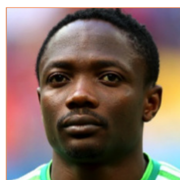


Name: John Obi Mikel
Sector: Sports
Why chosen: Popularity & Plays for one of the Big Four Clubs
Previous work in health: Malaria Free Nigeria Campaign
Areas of concerns/controversies: Had a controversy at the beginning of his international career (Manchester United and Chelsea) had a dragged court case.
Twitter: Official Twitter Account has been suspended

Mikel John Obi, is a Nigerian professional footballer who plays as a midfielder for English club Chelsea and the Nigeria national team. Mikel represented the Nigeria under-20 team at the 2005 FIFA World Youth Championship and won the Silver Ball for the second-best player at the tournament (behind Lionel Messi) as the Africans finished runner-up to Argentina. On March 24, 2016, Mikel was named captain of the Nigeria national football team, replacing Ahmed Musa. He was an ambassador of the Malaria Free Nigeria campaign

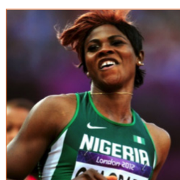
Name: Victor Moses
Sector: Sports
Why chosen: Popularity & Plays for one of the Big Four Clubs
Previous work in health: Malaria Free Nigeria Campaign
Areas of concerns/controversies: None
Twitter: 730,000 followers

Victor Moses is a Nigerian professional footballer who plays as a winger for Premier League club Chelsea. Born in Nigeria, Moses represented England at under-16, under-17, under-19 and under-21 levels, but opted to play for Nigeria as opposed to being fully capped for England. He has gained over 20 caps for Nigeria since his debut in 2012, and played in their winning campaign at the 2013 Africa Cup of Nations, as well as the 2014 FIFA World Cup. He is a part of the sports for hope campaign and was an ambassador of the Malaria Free Nigeria campaign



Name: Ahmed Musa
Sector: Sports
Why chosen: Popularity & one of Nigeria's best strikers
Previous work in health: None
Areas of concerns/controversies: None
Twitter: 8,000 followers

Ahmed Musa is a Nigerian professional footballer that plays forward for Russian club CSKA Moscow and the Nigeria national team. He is known for his pace, dribbling, composure, versatility and defensive effort. He has been compared to Jesus Navas and Arjen Robben for his pace and his ability to cut inside and cause havoc, he is a good creator as well as corner specialist, scorer of many great balls in to the net. Musa is the first Nigerian to score more than once in a FIFA World Cup match after scoring twice against Argentina in the 2014 FIFA World Cup.



Name: Blessing Okagbare-Ighoteguonor
Sector: Sports
Why chosen: One of the most celebrated Nigerian Athletes
Previous work in health: None
Areas of concerns/controversies: None
Twitter: 5,024 followers

Blessing Okagbare-Ighoteguonor is a Nigerian track and field athlete who specializes in long jumping and short sprints. She is an Olympic and World Championships medallist in the long jump, and a world medallist in the 200 metres. She also holds the Women's 100 metres Commonwealth Games record for the fastest time at 10.85 seconds. Her 100 m best of 10.79 makes her the African record holder for the event. Okagbare was born in Sapele Delta State. Given her athletic physique, teachers and family members encouraged her to take up sports. Initially she played football as a teenager at her high school and later, in 2004, she began to take an interest in track and field. She participated in a number of disciplines early on, competing in the long jump, triple jump and high jump events at the Nigerian school championships and winning a medal in each. As a 19-year-old, she won a bronze medal in the women's long jump event at the 2008 Summer Olympics in Beijing.