

From Evidence to Practice

How Evidence Action and J-PAL are collaborating to adapt the research into a pilot across two Nigerian states



The problem

Millions of people die or suffer from conditions we **already know how to prevent.**

1,000+ children under 5 die every day from preventable waterborne illness

880M+ children are at risk of parasitic worms that impair nutrition and learning

200K+ babies die each year from congenital syphilis

The opportunity

The **solutions already exist** – and
cost almost nothing to deliver.

<\$2/yr

Safe water access via dispensers

Chlorination reduces under-five child mortality from all causes by around 20%

\$0.50

Deworming treatment

Protects nutrition, school attendance, lifetime earnings

\$0.84

Syphilis test

Added to existing prenatal care to prevent stillbirths

What's missing is the
capacity to deliver them.

Real expertise.

Government partnerships.

Investment to deliver at scale.



We use **evidence** to improve health and economic outcomes for **entire generations**.

We identify and scale the world's most cost-effective health solutions through government partnerships across Africa and Asia.

6

interventions scaled

11

countries

530M+

people reached

Why Nigeria?

Tope Ogunbi
Country Director, Nigeria

Our Impact in Nigeria

Evidence Action has worked alongside the Nigerian government and partners since 2016.

10

Years operating
in Nigeria

44M+

Deworming treatments
delivered

40%

States (15)
supported

32K+

Health workers and teachers
trained annually

Programs

- School-Based Deworming (6M+ children/year)
- Nutrition (MMS & SQ-LNS)
- Malaria Prevention in Schools (IPTsc)
- Additional programs in scoping (IV iron, water pilots, HPV)

Government Partnerships

- Federal & State Ministries of Health
- National Primary Health Care Development Agency
- Ministries of Education (UBEC, SUBEB)
- Nutrition, Malaria, NTD & WASH technical working groups

Why Nigeria?

evidence
action

01

SCALE

Scale of Disease Burden

2.1M

zero-dose children

8.7M

undervaccinated

15% of the global burden
(highest of any country) creates
unmatched opportunity for
cost-effective impact.

Source: UNICEF

02

DEMAND-SIDE GAP

Awareness & Motivation Barriers

50%

of those who miss doses cite awareness gaps

Vaccines are available. Parents
aren't opposed. The barriers are
informational and motivational
— and therefore addressable.

Source: UNICEF MICS

03

EVIDENCE OF IMPACT

Proven Interventions

83%

of healthcare workers consider SMS effective

Nigeria-specific trials and
partner pilots confirm these
approaches **move the
needle locally.**

Source: Evidence Action formative
research, MMS Nigeria pilot

Why Evidence Action?

evidence
action

01 SCALE

Scale of Operation

Proven infrastructure and deep government partnerships position Evidence Action to scale intervention from pilot to **more than 1 million children** across Nigerian states.

02 DEMAND-SIDE GAP

Integrated Model Bridges the Gap

 Digital Reminders

 Community Ambassadors

 Targeted Incentives

One **unified, cost-effective** package – not fragmented across separate programs.

03 EVIDENCE OF IMPACT

Designed for Sustained Impact

Pilot will generate rigorous evidence to **support government adoption and replication** across regional contexts.

Pilot Overview

evidence
action

~60K

Children
enrolled

~150

Health
facilities

15 mo

Pilot
duration

2

States with
regional diversity



Nigeria scoping trip, April 2025

Left: Nasarawa Ministry of Health

Above: LGA Immunization Officer FCT

Operationalizing the evidence

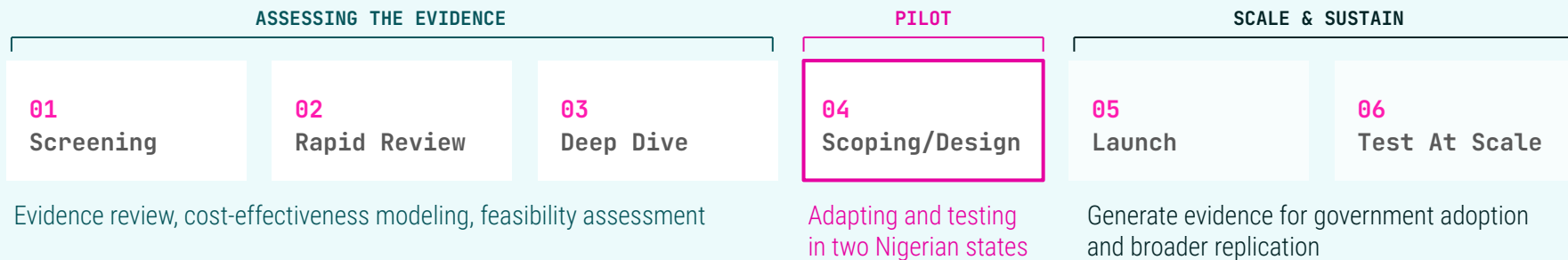


Colin Richardson
Associate Director, New Program Development

ABOUT THE ACCELERATOR

Our six-stage process for vetting, stress-testing, and scaling programs

Collaborating with J-PAL to run immunization demand generation through our new program development engine



evidence
action



+



J-PAL

ABDUL LATIF JAMEEL POVERTY ACTION LAB

1

Local Literature

2

Formative Research

3

Treatment Variations

4

Incentive Models

5

Government Ownership

Incorporating lessons from other evidence generated in Nigeria

• **BMJ GLOBAL HEALTH**
Automated phone call and text reminders for childhood immunisations (PRIMM): a randomised controlled trial in Nigeria
Eze et al. · Ondo State, Nigeria · 2019
SMS REMINDERS

• **J. COMMUNITY HEALTH**
Effects of Community Health Nurse-Led Intervention on Childhood Routine Immunization Completion in Ibadan, Nigeria
Oyo State, Nigeria · 2015
COMMUNITY ENGAGEMENT

• **VACCINE**
Impact of mobile phone-based reminders on routine childhood immunization coverage and timeliness
Kawakatsu et al. · Lagos, Nigeria · 2020
SMS REMINDERS

• **JOURNAL OF PEDIATRIC NURSING**
SMS text messaging improves uptake of childhood immunization in a rural community in Nigeria
Oladepo et al. · 6 states / FCT, Nigeria · 2021
SMS REMINDERS

• **BMJ GLOBAL HEALTH**
Short message service (SMS) reminders for childhood immunisation in low-income middle-income countries: a systematic review and meta-analysis
Eze et al. · 18 studies, 11 LMICs · 2021
SYSTEMATIC REVIEW

• **BMC HEALTH SERVICES RESEARCH**
A multi-stakeholder engagement approach for increasing childhood immunization in Oyo State, Nigeria
Oyo State, Nigeria · 2021
COMMUNITY ENGAGEMENT




Community promotion



Transport vouchers



SMS reminders



Cash transfers

1

Local
Literature

2

**Formative
Research**

3

Treatment
Variations

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Incentive
Models

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Government
Ownership

Learning how
caregivers
actually receive
and engage with
health reminders.

Surveys & Focus Groups



Messaging

Language, tone, length, salutation preferences



Channel/Platform

SMS vs. WhatsApp vs. voice messages



Credibility

What time/frequency/sender makes the message trustworthy rather than considered spam

1
Local
Literature

2
Formative
Research

3
**Treatment
Variations**

4
Incentive
Models

5
Government
Ownership

Randomizing
small variations
to optimize the
intervention

Pilot Population

Ambassador
Density

HIGH DENSITY



VS

LOW DENSITY



Ambassador
Profile

CAREGIVER NOMINATION



VS

RELIGIOUS LEADER



Message
Framing

HEALTH BENEFIT

"Protect your child..."

VS

SOCIAL NORM

"Most mothers..."

VS

INCENTIVE

"Free transport..."

1

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Variations

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**Incentive
Models**

5

Government
Ownership

Testing a menu of
incentives that
fit the local
context



Nutrition Supplement

Does a tangible health
product (SQ-LNS) feel
valuable to caregivers?

VS



Transport Offsets

Is the cost of travel a
binding constraint for
caregivers?

1

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Variations

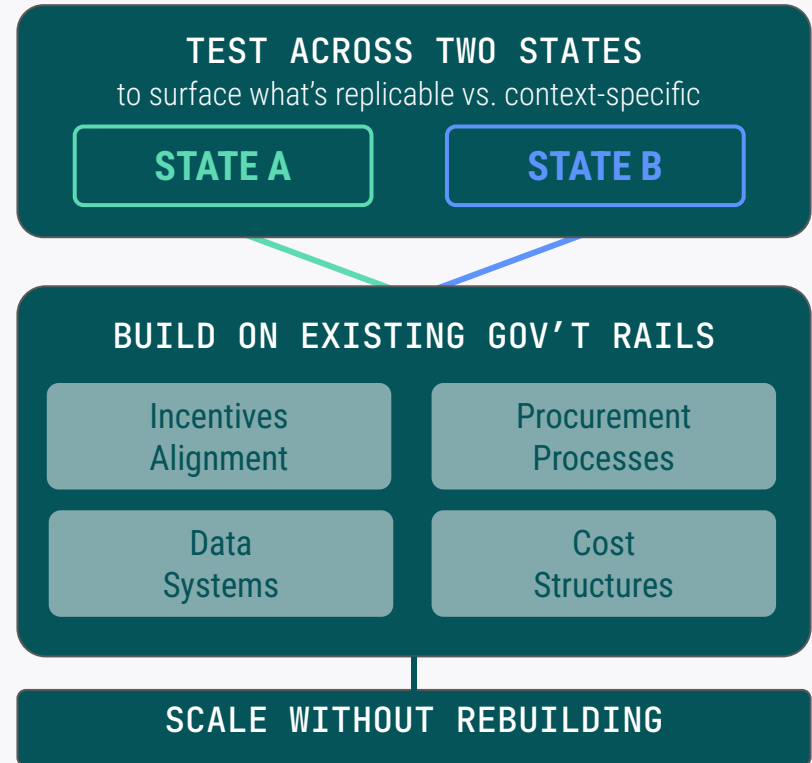
4

Incentive
Models

5

Government
Ownership

Adapt the design
for **integration**
into government
systems for
scalability across
geographies



What's Next

NOW Formative Research

Q3 Design Finalization

Q4 Pilot Launch

