USAID/Nigeria

MCH/Reproductive Health Program Mid-term Evaluation

Prepared by
Dr. Dan Blumhagen (Team Leader)
Dr. Carol Barker:
Dr. Muyiwa Oladosu:
Dr. Olubunmi Olufunke Asa
Dr. Jack Reynolds.

July 2009

EXECUTIVE SUMMARY

The United States Agency for International Development Mission to Nigeria contracted with GHTech to provide a team of five experts to examine three of the Family Planning/Reproductive health projects that they have been supporting in Nigeria. This is one of a series of evaluations that are being conducted to provide guidance to the Mission as it implements new projects and develops its 2009-2014 strategy. In this summary, we will not focus so much on our assessments of the individual projects—which provide many comments and recommendations—but rather on the major issues that must be addressed in the next five years.

The team was charged with doing a late mid-term evaluation of: ACCESS/MCHIP, Acquire/Fistula Care, and Improving Reproductive Health in Nigeria (IRHIN). The evaluation was to outline opportunities, challenges and critical areas to address and make recommendations on the most effective and efficient path forward.

The health, and particularly the maternal mortality rates in the Northern States of Nigeria are among the highest in the world, and infant and child mortality rates are extremely high. The team does not believe that Nigeria has any possibility of attaining the Millennium Development Goals without massive donor and government commitment.

Program Description

The **ACCESS** (Access to Clinical Community and Maternal, Neonatal and Women's Health Services) Nigeria Program has the following goal: "To accelerate the reduction of maternal and newborn mortality and the attainment of the MDGs in Nigeria". This 3- year program has been running since January 2006, and is due to end in September 2009 but has been extended to 2010 under another project. It now operates in 18 Local Government Authorities in Kano, Katsina and Zamfara states.

Overall, the ACCESS program shows healthy progress. The number of deliveries with a skilled birth attendant in rose steadily over 2007-8 as did the number of antenatal care visits and postpartum visits, all of which surpassed their targets with a roughly three-fold annual increase. Couple-years of protection increased more slowly, but this was related to stock-outs of contraceptive supplies in some facilities, a matter out of the hands of the project.

The purpose of the ACQUIRE project, which began in September 2006, is to increase access to quality comprehensive fistula repair, prevention and reintegration services. It has: (1) been raising community awareness, (2) has established a set of five, soon to be seven, fistula repair centers where surgical techniques and post-operation care are practiced; (3) and it works to increase the use of contraceptives by promoting the use of FP services.

Fistula, which is caused by prolonged or obstructed labour, has high prevalence in Nigeria, with an estimated 800,000 women currently needing repair and the number rising as development of relevant services fails to keep up with population growth. Over the life of the project, Acquire has been able to correct fistulas on some 4,000 women.

ACQUIRE currently works at five sites in the North, three of which are service sites (including one at Sokoto) and two training sites. Two new service sites being developed include one Southern site and Bauchi state in the north.

ACQUIRE is creating much goodwill for USAID, but careful design of the project for the future is needed if there is to be a strategic approach to making the work sustainable.

Improved Reproductive Health In Nigeria (IRHIN) has the long-term objective to support Nigeria in achieving a more transparent and participatory democracy with a healthier and better educated population. The purpose of the project is to improve the understanding of, access to, and correct use of contraceptives to reduce unintended or mistimed pregnancies.

IRHIN is national in scope, but also has some work, done by its Pathfinder International, that is concentrated in Kaduna, Cross River and Abia. SFH was awarded funding over 5 years (June 2005 – June 2010) to improve Family Planning utilisation rates, measured by national surveys measuring Contraceptive Prevalence Rates, and service statistics measuring Couple Years of Protection.

Key activities to increase awareness and use of family planning include provider training, social marketing, radio and TV campaigns, community involvement, demand creation, expansion of the PPMV outlets, addition of new contraceptives, and targeting religious and other leaders.

SFH has partnered with Pathfinder to draw on the expertise of the latter in provision of clinic-based services and community mobilisation in the three focus states. Pathfinder works with NGOs in each state, each of which works with clinics to support their efforts.

Pathfinder improved the quality of FP/RH services by (1) rehabilitating clinic buildings, (2) Providing equipment for contraceptive services, and (3) training in family planning. However, inability to retain trained staff was a major problem.

Programmatic Issues:

The evaluation team found the following major issues affected nearly all of the projects, and will need to be addressed in the next phase of USAID Assistance:

- Geographic Distribution: The project activities were spread so thinly across Nigeria that there was little synergy between even different project sites of the same agency. If, for example, there are 350 km between different project sites in the same State, the project team will spend more time on the road than they will providing support and mentoring to the project site staff.
- Health Impact on Family Planning/Reproductive Health: Because the activities are spread so widely and have so few intervention sites, they cannot have an effect on population based statistics. The IRHIN Social Marketing program is the one exception to this, but even this project barely distributes sufficient commodities to make a nationwide impact.
- Synergy: There is very coordination between the projects, which, in part, is a function of project design, since tasks are being carried out in different states that usually do not overlap.
- Gender Equality: The team was pleased at the way women and men had been incorporated into all aspects of the project: 30% of Pharmaceutical Vendors are women, and, in the north, the number of male community outreach workers is nearly as large as the number of women.
- Inadequate Resources: USAID and the Implementing Partners do not have enough resources in terms of funding or Mission staff to manage the number of activities. Joyce Holfeld recommends six staff: we agree.
- Poor Data Quality: Most of the service statistics presented by the partners are suspect. Acquire is the exception. IRHIN does a better job since it has a number of National and Sub-national surveys, but we were not able to track service statistics from the provider to Abuja where reports were written.
- Logistics: Every project had significant problems with stock-outs, which frequently put the project on hold.

- Staff Mobility: In almost any location, staff are extremely transient. As soon as one person is trained, they leave for greener pastures. Both of the most senior trainers in the Acquire project have been promoted to higher government posts, so much of the future of the project has been taken away. This is also true with the private sector, as staff come and go.
- Lack of Basic Facilities: In most places we visited, there is a lack of electricity, drugs, water, ability to sterilize instruments, transport or adequate facilities. This must be dealt with in some manner.

Future USAID Programming:

- Focus and concentrate program efforts to achieve program results.
- Logistics, Logistics, Logistics. This should be the principal focus of new efforts. If there are no supplies, there is no program.
- Establish ways of working with all three levels of government to build commitment to the work being done.
- Consider ways of reaching out to where people are, rather than requiring them to come to a fixed facility.

Conclusions:

USAID and its Implementing Partners have done a very good job given the constraints of the environment, staffing and funding.

The ground may be softening, but there's a lot of work ahead that requires dynamite and pick-axes.

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The Evaluation Team wishes to express its gratitude to the management and staff of the Society for Family Health. Their cooperation, openness and logistical support were very much appreciated. The team also wishes to thank our two Research/Logistic Assistants, Mr. Charles Asa and Ms. Ezedwueme Chinene of Mira Monitor who accompanied us throughout the evaluation.

Disclaimer

This work was funded through contract # xxx.yyy with the Global Health Technical Assistance

project (GTech). The views expressed in this report are those of the team members and do not necessarily reflect the views of GTech or USAID.

Abbreviations

ACCESS	Access to Clinical Community and Maternal, Neonatal and Women's Health Services
ACQUIRE	Acquire.Fistula Care
AIDS	Acquired inmuodeficiency syndrome
AMTSL	Active Management of third Stage of Labor
ANC	Antenatal Care
APCON	Advertising Practitioners Council of Nigeria
BCC	behavior change communications
BSS	Behavioral Surveillance Survey
CBD	community-based distribution
CBO	community-based organization
CHEW	Community Health Extension Worker
COMPASS	Community Participation for Action in the Social Sector
COP	Chief of Party
CSO	civil society organization
CYP	Couple-year of protection
DFID	Department for International Development
DHS	Demographic Health Survey
ECP	emergency contraception pill
EH	Engender Health
EmONC	Emergency Obstetric and Newborn Care
ENHANSE	Enabling HIV/AIDS and TB in the Social Sector Environment
EU	European Union
FCT	Federal Capital Terrority
FHS	Family Health Services
FMOH	Federal Ministry of Health
FP	family planning
GHAIN	Global HIV/AIDS Initiative Nigeria
GON	Government of Nigeria
HHCC	Household-to-Hospital Continum of Care
HIV	Human inmunodeficiency virus
IHRIN	Improved Reproductive Health in Nigeria project
IIP	Investing in people
IP	Implementing partner
IPT	Intermittent Preventive Treatment
IR	Intermediate Result
IUCD	intrauterine contraceptive device
LAM	Lactational Amenorrhea
LGA	Local Government Area
LOE	Level of Effort
LOP	Life of project
LQAS	lot quality assurance sampling
MAP	Measuring Access and Performance survey
MAP	Men As Partners
MAQ	Maximizing Access and Quality
MAWCH	Maryam Abacha Women and Children's Hospital
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goals
MDS	Manufacturers Delivery Service
MNCH	Maternal, Newborn and ChildHealth

MOH	Ministry of Health
NACA	National Action Committee on AIDS
NARHS	National HIV/AIDS and Reproductive Health Survey
NBC	Nigeria Broadcasting Commission
NDHS	Nigerian Demographic and Health Survey
NGO	Non-governmental Organization
NYSC	National Youth Service Corps
OC	Oral contraceptive
PATH	Partnership for Transforming Health Systems
PCN	Pharmacists Council of Nigeria
PE	Peer educator
PHC	Primary Health Center
PLWHA	people living with HIV/AIDS
PMTCT	Prevention of Mother-to Child treatment
POP	point-of-purchase
PPFN	Planned Parenthood Federation of Nigeria
PPMV	Proprietary Patent Medicine Vendor
PPT	pre-packaged treatment for malaria
PSRHH	Promoting Sexual and Reproductive Health for HIV/AIDS Reduction
RCO	regional communications officer
RH	Reproductive Health
SBM-R	Standards- Based Management and Recognition
SFH	Society for Family Health
SO	Strategic Objective
SPARHCS	Strategic Pathway to Reproductive Health Contraceptive Security
STTA	Short-term Technical Assistance
TFR	total fertility rate
USAID	United States Agency for International Development
USG	United States Government
WCWC	Women and Children Welfare Clinic
WDC	Ward Development Committee
WRA	women of reproductive age

I. INTRODUCTION

A. Objective

USAID/Nigeria requested GHTech to assemble a team of five internationally recognized family planning and reproductive health (FP/RH) experts to do a mid-term evaluation of three of USAID's FP/RH programs: ACCESS/MCHIP, Acquire/Fistula Care, and Improving Reproductive Health in Nigeria (IRHIN). The review is intended to make comments on how the program could be improved over the year remaining in the agreements, but more importantly, to make recommendations on how the lessons learned here can improve the design of the 2009-2014 USAID Health strategy.

The purpose of this mid-term evaluation is to provide the USAID/Nigeria Investing in People (IIP)/Health, Population and Nutrition (HPN) Team with sufficient information to make programmatic and budgetary decisions regarding future directions. The evaluation was to outline opportunities, challenges and critical areas to address and make recommendations on the most effective and efficient path forward. The evaluation was to look at the performance of each project through June 2009

B. Reproductive Health Situation in Nigeria

About one million children die each year before their fifth birthday, and infant and child mortality rates are extremely high, even when compared to other sub-Saharan countries. Maternal mortality rates are among the highest in the world, particularly in the northern states, and completed fertility remains over 7 in the northern states, where childbearing starts very early and births are very closely spaced. This document does not need to repeat the grim statistics, which can be found in almost every other recent report on FP/RH in Nigeria.[1][2][3] Given that the Millennium Development Goals (MDGs) require a 75% reduction in the Maternal Mortality ratio, and universal access to reproductive health services, including antenatal care, peri-partum care, and family planning,[4] the team does not believe that Nigeria has any possibility of attaining the goals without massive donor and government commitment.

C. Government and Donor Commitment

The Federal Government and its partners have recently developed an "Integrated Maternal, Newborn, and Child Health (IMNCH) strategy," which lays out a collaborative strategic approach to accelerating progress in reducing child and maternal mortality (including the role of family planning). This IMNCH strategy has been approved by the National Council for Health, and plans are being made to implement it through advocacy and analytical support, initially in twelve states. Donors have worked closely with the Government in all stages of this process.

There are, however, several areas of concern: "In the first place, government interventions happen on three levels: national, state, and local. The federal level is responsible for setting policies, providing overall guidance, managing and funding tertiary facilities and key research and development programs. The state level funds and manages state hospitals and maternities, teaching

[1] Holfeld & MacDonald: The Ground is Strengthening, 2007
[2] Holfeld et.al.: An Evaluation Of The USAID/Nigeria Social Sector Projects: Enhanse And Compass, 2009
[3] Maternal Child Health, Family Planning and Reproductive Health Strategic Approach, USAID/Nigeria, December 2008
[4] www.un.org/millenniumgoals/index.shtm

colleges, and provides higher technical staff for the State Ministry of Health …The local government authorities (LGAs), with little technical expertise and insufficient funds, are responsible for basic staffing, managing and financing of…primary health clinics within their jurisdiction."[5] One of the biggest problems we encountered during this evaluation is that local governments, for cost reasons, want to hire the lowest paid staff, the Community Health Extension Workers (CHEWs), to perform many clinical level functions in hospitals and clinics under their purview.

As a team, we were also concerned that the officials we met with at the state and local levels[6] seemed relatively unconcerned about the needs for family planning, even when presented as birth spacing. This interpretation is also supported by the observation that, while in 2002 there was an entire booklet on the Federal Strategy on family planning, by 2007 family planning had been reduced to a half page in the overall strategy on reproductive health.

Secondly, there are multiple levels of multilateral, bilateral and private donors that support a variety of activities in a variety of places, sometimes scattered broadly across the face of the map. While it is possible for the major players to have a seat at the table for planning and overall implementation, on the ground it is much more difficult. As will be described below, even different USAID supported programs rarely collaborate, even if they are operating in the same states.

Finally, partly because the public sector has proven so unreliable in the past, a host of private sector providers, from traditional healers and birth attendants to pharmaceutical vendors to tertiary hospitals have grown in the private sector to meet these needs. While we support and applaud the work done by the private sector, the fact that an individual often has many facilities to choose from means that it is difficult to determine how to measure service impact. A woman, for example, may be motivated towards family planning[7] by a private sector community-based distribution agent, be additionally motivated by a radio drama, and may ultimately get commodities from an unlicensed vendor. This means that data cannot be easily captured by service statistics, and can lead to marked over- and under-reporting.

D. USAID Strategic Plan

The work done by USAID over the past several years has been guided by two strategic plans, the January, 2006 Country Strategy Statement, and the December, 2008 Maternal Child Health, Family Planning, and Reproductive Health Strategic Approach. The earlier strategy outlined activities in some nine states and the Federal Capital Territory (Abuja), and was directed at: (a) preventing and controlling infectious diseases; (b) improving child survival, health and nutrition; (c) improving maternal health and nutrition; and (d) supporting family planning. The targets for this were ambitious, including an increase of the contraceptive prevalence rate (CPR) from 9 to 11 percent, and providing quality RH/FP services to 4.2 million women.

The 2008 revised strategic framework set the USAID Mission on a course of concentrating on two states, Sokoto and Bauchi, both of them in Hausa-speaking areas in the north. Northern Nigeria has worse health statistics and poorer levels of health care than much of the rest of the country. One telling statistic is that in Kano State, available health facilities, operating at capacity, could only handle 20% of births in their catchment areas. The strategic framework includes a full package of RH and Emergency Obstetrical and Newborn Care (EmONC), including antenatal care, immunizations of mothers and children and presumptive malaria treatment. The team was

[5] Holfeld et. al. 2008
[6] Because of scheduling problems, the team was unable to meet with any Federal Level officials.
[7] This, of course, applies to all social service delivery and not solely to family planning.

concerned, however, that the mission believes that "All of the interventions…can be delivered at the community level by a range of community-based and facility-based public and private sector workers with relatively low levels of training." Given the very low level of basic education that we saw—discussed below, under 'ACCESS'—we feel that is approach is overly optimistic.

USAID correctly identified the need to intervene at both state and local government levels to improve capacity to plan and manage health care. While this is unlikely to yield results in the short or even medium term, it is an investment that is crucial to developing a sustainable public health sector in Nigeria.

Responses to a Request for Applications (RFA) are currently being reviewed by the mission and is expected to be awarded some time before this report is finalized. This will then become the operational plan for intervention in the public sector. Since it is still in the procurement process, the GHTech team cannot make any comments on the strategies being proposed by the applicants.

It is troublesome that the 2008 USAID strategy does not include working with private providers as a source for FP/RH as well as EmONC services in selected facilities. The only possibilities suggested include expanding the social marketing program with Society for Family Health (itself an NGO, and nearly totally supported by donor funds) and developing a single Public-Private Partnership with a major employer

E. Mid-Term Evaluation Scope of Work

The USAID Mission to Nigeria asked the GHTech to address the current situation of each of the three projects (ACCESS, Acquire, and the IRHIN) but to particularly focus on the implications of the team's findings to the further development of the Mission's health strategy for 2009-2010.

Program Questions

* Are the projects on the right track and are benchmarks/results being met? What changes, if any, need to be made? What are the gaps?
- Are the interventions adequate for a significant health impact on RH/MCH?
* Are the interventions adequate for improving access to quality services?
* Discuss how the interventions are implemented. What were trends? Results achieved? Successes?
* What were the major obstacles/difficulties confronting RH/maternal health? How are these issues being addressed by the project? What were the results/achievements towards SO 13 objectives? Discuss missed opportunities, if any, for linkages with HIV/AIDS PEPFAR funded activities.
* Recommend strategies for addressing and improving linkages in the future.
* Recommend future strategic areas that need to be addressed.

Geographic Coverage

- Are the current project geographic areas rational?
- If new areas are selected in the future, what geographic coverage would make sense, considering the Mission's/health team strategic priorities, other USG programs and the FMOH's plan for strengthening the health sector?

Local Capacity Building and Local ownership

- To what extent have the projects succeeded in gaining the buy-in and participation of government institutions at state and LGA levels? What approaches were used and what challenges did the projects face in obtaining buy-in and participation if any?

- Discuss project efforts at capacity building (institutional, management, programmatic and technical) among grantees (NGOs including local), central government, state government, local health department, community and private sectors and where relevant.
- Is the project strengthening county (state/LGA) capacity to deliver health services?
- What are the major obstacles?
- How are they addressed at the various levels?
- What were the major break-through and accomplishments? Give evidence and site examples.

Compatibility, Synergy, Sustainability

- Do the current projects respond to the FMOH's desired directions for Nigeria? How do projects work (coordinate, collaborate and seek synergy) with the FMOH/State/LGA? How can this relationship be further strengthened? How does the program complement other RH/MCH services in the country?

* To what extent have projects sought to coordinate activities and seek synergies with USAID/Nigeria's other health projects, SOs, donors and local partners (NGOs, private sector)? Describe approaches used.

* To what extent have the projects improved the enabling environment for MCH/RH?

* Are the projects working towards sustainability? How and what else could be done?

- To what extent have the projects achieved gender equity and what approaches where used? Any challenges and gaps?

Future USAID/Nigeria Health Programming

* What are the lessons learned that should be expanded in the remaining life of the project, or follow-on project? What else could/should we be doing?

* What activities would have the greatest impact?

- What should be the balance between service and health capacity/systems work?

* What are recommendations for future strategic directions in strengthening Federal, state, LGA, NGO/private sector?

* What are the strengths and innovative activities being undertaken that should be continued, scaled-up and emphasized?

F. Methodology

The team used a combination of document review, key informant interviews and site visits to conduct this evaluation.

Beginning on June 29, 2009, the first week was spent in team formation, document reviews, and meetings with the USAID Mission staff and representatives from the Abuja offices of the partners being evaluated. These provided a wide array of documents to add to our understanding of the project.

The next two weeks were spent in site visits. The Public Sector team (ACCESS, Acquire) visited sites in Kano, Katsina, Zamfora and Sokoto States before returning to Abuja. The private sector team (IRHIN) visited Kaduna, Kano, Lagos, and Cross River States. The team leader divided his time between the two teams.

The final ten days were spent in meetings with the Abuja offices to get further clarifications on issues we had seen, and to get as many different sets of statistics and monitoring and evaluation reports as were readily available. There were extensive discussions within the team to come to conclusions that spread across all three projects and into the future programming needs of USAID that finally resulted in a draft of the report that was presented to the Mission on July 27.

G. Team Composition

Dr. Dan Blumhagen (Team Leader): Consultant in Public Health and strategic planning, monitoring and evaluation with 25 years of international experience, including 20 years as a USAID Population, Health and Nutrition specialist and Program Officer.

Team A: Public sector

Dr. Olubunmi Olufunke Asa: Public Health Physician with 12 years of experience as a specialist in promotion of maternal and child health at national and community levels.

Dr. Carol Barker: Specialist in health planning and policy in the context of international health, with 35 years of experience full- time in this field.

Team B: Private sector

Dr. Muyiwa Oladosu: International expert in research, monitoring, and evaluation of development projects around the world. He has over 23 years experience, conducting evidence-based monitoring and evaluation of development projects in several countries of Asia, Africa, Europe, North America, and South America.

Dr. Jack Reynolds: Specialist in health planning and policy in the context of international health, with 35 years of experience in this field. For over 40 years, he has applied these skills to find ways to improve the delivery of health services in domestic and international programs.

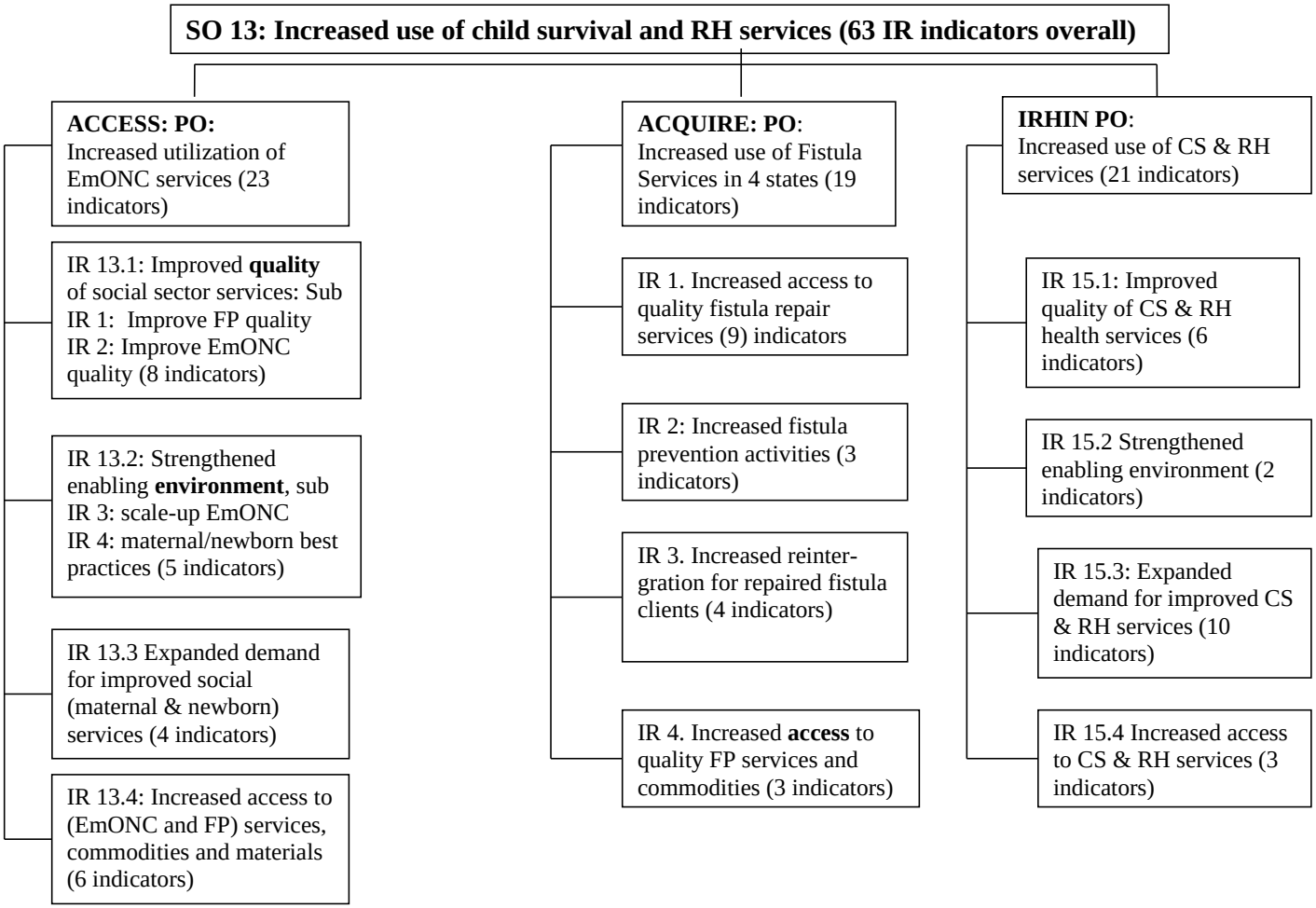
II. PROJECT COMPONENTS

II. A. OVERVIEW

As noted above, there are three projects being evaluated. Each project has the same Strategic Objective: Increased use of child survival and RH services. The three have similar project objectives, to increase utilization of health services. They also have similar Intermediate Results. For example, all have improving access as an IR. Each one also has improved quality as an IR. Two have strengthening of the enabling environment and increasing demand as IRs. However, they are not equal. ACCESS is focused on EmONC; ACQUIRE is concerned with Fistula services; and IRHIN has improvement of child spacing and RH as it's objective. See Figure 1 for a graphic display of each project's POs and IRs.

The projects also work in various states. Pathfinder (a subcontracter to SFH) works exclusively in three states: Kaduna, Cross River and Abia. But SFH's Community program is in 18 states. Its social marketing program is nationwide. Access works in three states: Kano, Katsina, and Zamfara. ACQUIRE works in seven states: Sokoto, Zamfara, Kano, Kebbi, Katsina, Bauchi and Eboni.

USAID divided the evaluation into a public component (ACCESS and ACQUIRE) and a private component (IRHIN). One team was assigned to evaluate the public components and a second team assessed the private components.


SO 13: Increased use of child survival and RH services (63 IR indicators overall)
ACCESS: PO: Increased utilization of EmONC services (23 indicators)
IR 13.1: Improved quality of social sector services: Sub IR 1: Improve FP quality IR 2: Improve EmONC quality (8 indicators)
IR 13.2: Strengthened enabling environment, sub IR 3: scale-up EmONC IR 4: maternal/newborn best practices (5 indicators)
IR 13.3 Expanded demand for improved social (maternal & newborn) services (4 indicators)
IR 13.4: Increased access to (EmONC and FP) services, commodities and materials (6 indicators)
ACQUIRE: PO: Increased use of Fistula Services in 4 states (19 indicators)
IR 1. Increased access to quality fistula repair services (9) indicators
IR 2: Increased fistula prevention activities (3 indicators)
IR 3. Increased reinter-gration for repaired fistula clients (4 indicators)
IR 4. Increased access to quality FP services and commodities (3 indicators)
IRHIN PO: Increased use of CS & RH services (21 indicators)
IR 15.1: Improved quality of CS & RH health services (6 indicators)
IR 15.2 Strengthened enabling environment (2 indicators)
IR 15.3: Expanded demand for improved CS & RH services (10 indicators)
IR 15.4 Increased access to CS & RH services (3 indicators)

II. B. ACCESS

Introduction

The ultimate health goal of the ACCESS Nigeria Program is: "To accelerate the reduction of maternal and newborn mortality and the attainment of the MDGs in Nigeria".

This is similar to FMOH's national Reproductive Health Policy, which is to "reduce maternal and neonatal mortality in Nigeria", as well as FMOH's goal "to accelerate the reduction of maternal and newborn mortality and the attainment of the MDGs in Nigeria".

The need to increase use (and by implication, access to) emergency obstetric care services is of great importance in Nigeria but more especially in the Northern States. In the North West Zone, infant mortality overall is 114 per 1,000 births, of which 55 are neonatal[8].Maternal mortality is also known to be high. The Federal Ministry of Health quotes a figure of 800 per 100,000 live births for Nigeria as a whole, but it is well known that rates are much higher in the North. ACCESS documentation uses a figure of 1,025 for the North West Zone[9]. Some authors however put this even higher. A 2003 estimate was 2,420 deaths per 100,000 live births[10]. On top of this, after childbirth as many as 17,000 per 100,000 women are left with serious disabilities such as fistula, uterine prolapse, damage to bladder or urethra, pelvic or urinary tract infections, anaemia and infertility.

Maternal mortality has complex causality. (a) Mortality is reduced when births are spaced so that the mother remains healthy and her baby well fed, and (b) that high risk of an emergency situation developing during childbirth cannot be foreseen. The priorities in achieving safe childbirth for mother and baby are to ensure that skilled birth attendants are available to deliver babies, and that emergency obstetric care is available and can be reached if things start to go wrong.

In this situation, like that obtaining in North West Nigeria, the challenge is to encourage women to avail themselves of services provided. The baseline survey for ACCESS found that in Kano and Zamfara, 80% of women surveyed had delivered their last child at home, and out of the total sample surveyed, only 8.3% said they would have preferred that someone else assist with the birth instead of the person who actually did. There are other reports that women consider three days to be a normal labor.

The three- year ACCESS program has been running since January 2006, and is due to end in September 2009 but has been extended to 2010 under another project. It was initiated in 4 selected LGAs in two Northern states (Kano and Zamfara). It is now in 18 LGAs in 3 states (Kano, Katsina and Zamfara).

The key program approach is the implementation of an integrated programme along the Household-to-Hospital Continuum of Care (HHCC). This includes community and facility-based essential maternal and newborn care (EMNC) interventions focusing on ANC, emergency obstetric and

[9] ACCESS Nigeria Country Program Brief, June 2009, quoting FMOH and UNICEF.

[10] Adamu Y.M. *et al* , 'Maternal Mortality in Northern Nigeria: a Population-based Study' European Journal of Obstetrics & Gynaecology, Volume 109, no. 2, 15 August 2003

newborn care and postpartum care including FP. The program is being implemented in a range of facilities as set out below. In Katsina, the programme was formally started in March 2008 so there has been only one year of implementation. As the number of facilities being covered in each state has expanded over time, it is difficult to review progress against targets that may have been set at an early stage when less capacity was available.

Table 1: Facilities currently covered by ACCESS

	Specialist hospital	General Hospital	CHC[11]	WCWC[12]	PHC[13]
Zamfara		6 (of which 1 for women & children)		2	9
Kano	1	6	1		10
Katsina		5	4		4

It should be noted that of course this is only partial coverage of the facilities in each state. Zamfara has 17 general hospitals and around 502 PHC facilities, for instance.

Table 2: Proportions of population currently covered by ACCESS

	Total Population of State (millions)	Population of LGAs where ACCESS is working (millions)	Percentage of State Population in ACCESS supported LGAs
Zamfara	3.260	1.502	46%
Kano	9.384	1.944	21%
Katsina	5.793	1.533	26%

However, this may over-represent the proportion of the state populations covered as one would need to look at figures ward by ward within the selected ACCESS LGAs

Life of Project Objective

Overall, the program shows healthy progress. The number of deliveries with a skilled birth attendant in rose steadily over 2007-8 as did the number of antenatal care visits and postpartum visits made, Targets were exceeded for all of these indicators. It is regrettable that the indicators could not be expressed as a percentage of all deliveries / pregnancies. One area where performance is below target is that of increasing couple-years of protection (CYP), despite the efforts of the project to make birth spacing counselling user-friendly by working to ensure that all project PHCs have some female staff. However, as stock-outs can be a major problem for contraceptives (see below) it is not possible to measure performance against this indicator

[11] Comprehensive Health Center

[12] Women and Children Welfare Clinic

[13] Primary Health Centre

ACCESS Program Results Framework

SO15: Increased use of child survival and reproductive health services
Program Objective: Increased utilization of EmONC services by pregnant women, mothers, and newborns at selected LGAs in two states
Key Indicators:

- % of births attended by skilled health personnel [C 33.1]
- % of caretakers seeking care from skilled care providers for sick newborns
- % of pregnant women who received at least 4 antenatal care visits [C 33.2]
- Couple-years of protection (CYP) [C 34.1]
- # /% of postpartum women using contraception (including LAM) 6 weeks postpartum

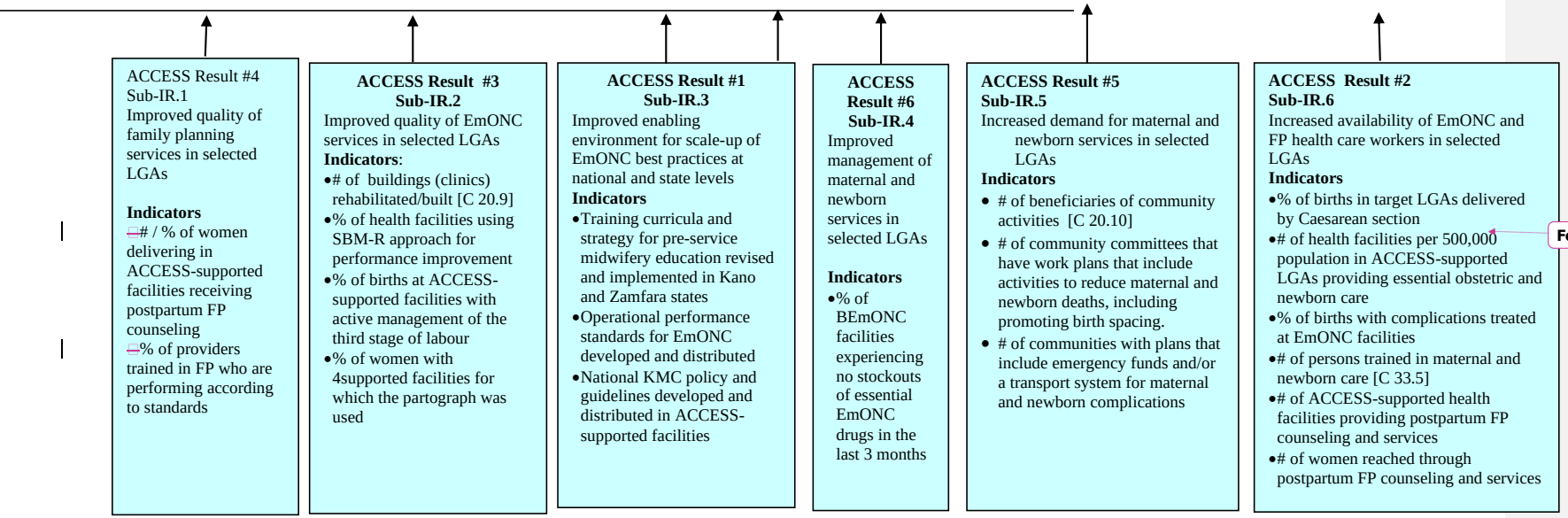


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Table 3: Progress on Access Project Objective Indicators

Indicators	FY07	FY08
# deliveries with a Skilled Birth Attendant	7,685	22,092
# Antenatal Care visits by skilled providers from USG-assisted facilities	33,333	115,678
# Postpartum/newborn visits within 3 days of birth in USG – assisted programmes	7,534	26,842
Couple – years of protection in USG – assisted programmes	6,492	11,516

IR 13.1: Improved Quality of Social Sector Services

There are two aspects to quality of care, family planning services and Emergency Obstetric and Neonatal Care (EmONC) services.

Family planning services

Concerning family planning (FP), progress overall is good. The provision of USG assisted service delivery points providing FP counselling or services is on target with CHEWs providing services at PHCs. The number of staff trained in FP/RH is, if anything, slightly ahead of target. The reports do not contain training statistics disaggregated by gender. Many respondents among facility staff clearly rated family planning activities as a major area of success. This is due in part to the extra training provided, in part to the efforts to raise demand for contraceptives in local communities (see below). In the current PMP, no indicator is used to reflect the volume of contraceptive devices actually distributed. In Zamfara and Katsina there shortage of contraceptive supplies, but in Kano there was a mysterious shortage at Murtala Mohammed Specialist Hospital, which was made family planning services almost non-existent.

The number of counselling sessions being held was significantly below target. The explanation offered was that health workers are not entering records for non-acceptors. The most likely explanation is that "the target for this indicator was set bearing in mind the introduction of household counsellors program in Katsina state. This activity is yet to take place because of the long process of involving stakeholders in the selection of household counsellors." (Quarterly report April 09).

Health workers rated acceptance rates among those counselled as generally very high, and denied there was under-reporting. While high acceptance rates are to be welcomed, it must be remembered that these are the acceptance rates for the (still small) proportion of the female population now seeking services for ANC and delivery, and do not mirror an equally high potential rate for the population at large.

When ACCESS began its activities in Nigeria, it was seen as having an important focus on post-partum birth spacing activity. However, there is no indicator for acceptors of family planning methods among post-partum women counselled. Doubtless, this relates to the fact that all women are being counselled to use LAM – the lactational amenorrhea method of birth control whereby exclusive breast-feeding for the first six months of the baby's life offers protection against conception. The team considered this to be a concern. While exclusive breast-feeding for the first six months is good practice for the baby, failure to counsel the new mothers on birth spacing methods in the immediate post partum period seems to be a lost opportunity: busy mothers may well not return after six months in order to accept contraception at that point.

Emergency Obstetric and Neonatal Care

The performance in improving quality of EmONC services has been somewhat more patchy; in part because there have been delays in infrastructural improvements. This has been due to, among other problems, slow release of funds. The effect of slow work to rehabilitate health facilities is that equipment deliveries (which procedurally follow only after rehabilitation is completed) have also been slow. This in turn has slowed down the pace at which skills in using equipment can be imparted to staff. In the case of Katsina State, the delays are particularly damaging, as it seems likely that the rehabilitation work will only be complete shortly before the presently foreseen date for project closure. The review team were reassured that, following discussion around this point, equipment would be issued ahead of the usual schedule. Concerns remain however that it is now late to retrieve this situation.

Training for performance improvement in delivery services using the Standards-Based Management and Recognition (SBM-R) Approach has been undertaken quite widely and is generally on track, although the Katsina facilities need to catch up. Training on basic Emergency Obstetric and Neonatal Care (BEmONC) and the posting of NYSC Doctors to ACCESS supported PHCs are both leading to increase in the number of women receiving Active Management of the third stage of labour and the performance in this area is overall, up to target.

Progress on improving management of pre-eclampsia and eclampsia has been somewhat slower; though reporting is incomplete in this area. One cause of delay is that there have been major shortages of magnesium sulphate. This is however now being made locally so the problems should be over. However, it may also be that training has not yet covered eclampsia treatment adequately. Another consideration is that staff may not be able to give enough time (or consider it enough of a priority) to keep the patient under as regular observation as would be desirable.

Incorporation of the partograph into standard delivery practice has been particularly slow. One reason given is that if women turn up too late into labour, there is little point in starting a partograph. Other reasons offered are that proper training in use of partographs has yet to take place (at least for CHEWs, who are being offered a simplified modular form of the BEmONC training); that production of the actual stationary was delayed and getting partographs into circulation has taken time. Furthermore, staff claim they don't have time to use this instrument.

IR 13.2. Strengthened Enabling Environment

The environment in which ACCESS must operate cannot be said to be enabling. In many cases external factors have posed problems. One example is with contraceptive stock-outs (see below). Other problems largely stem from staff being transferred to other parts of the state, and also from delays in production of materials and standards where these must receive approval from an outside body.

The development of performance standards for EmONC for use in hospitals and PHCs has been significantly delayed. Though these are now approved, the performance standards for family planning services are delayed even longer. The national guidelines being developed by ACCESS for Kangaroo Mother Care await approval by external reviewers. One wonders if the contribution would be taken more seriously if ACCESS had a presence state-wide rather than in selected facilities. In some instances during this review, senior SMOH officials seemed unaware of ACCESS and its current and potential contribution. This may exacerbate such problems.

Other environmental problems are around the fact that working with LGAs is not always easy and the LGAs themselves are poorly resourced and lacking in technical support.

In terms of donor support, the review team concurred with the earlier findings of Holfeld and McDonald[14] that the work of USAID in this sector receives relatively small amounts of funding when viewed in relation to the problems to be addressed, and that the USAID office is lacking in capacity to support the ACCESS programme adequately.

It is also important to mention the physical environment in which services must be offered. All facilities visited have major problems with electricity supply and spend a large proportion of their meagre recurrent budget on diesel for generators. Furthermore, the sterilising equipment provided by USAID cannot be operated without a power supply, and in all three states, sterilisation was being done with chemicals; an unsatisfactory and unreliable method. Water is also a problem. The most popular single request made for extra support was, time after time, for a bore hole. However, a bore hole requires a pump, so it would be useless unless the electricity can be made available.

The Integrated MNCH Strategy of the Federal Ministry of Health (2007) specifies that each state should invest in ensuring a power supply for all its secondary level facilities, while providing at primary level standby generators, solar lanterns, kerosene or gas fridges for blood storage (p60). That services are being provided in these inauspicious circumstances is a tribute to determination and almost, mind over matter.

The impact of the dispersion of the project is shown in the table below:

[Note to Editors: This table is not yet listed in the table of tables at the beginning of this document]

ACCESS Supported Health Facilities as a proportion of Health Facilities in the State.

State	No of general hospitals in the State*	No. of ACCESS-supported hospitals	% hospitals supported by ACCESS Program	No of PHCs in the State**	No of ACCESS supported PHCs	% PHCs supported
Kano	32	8	25.00	163	10	6.13
Katsina	23	5	21.74	378	8	2.12
Zamfara	19	6	31.58	110	11	10.00

*Source: Ministries of Health -verbal info-June2009

***Source: WHO (2002) RH Resources and Services Survey*

As can be seen here, ACCESS only provided services in about a quarter of the hospitals in each State, which diluted its impact. More importantly, it provided support to a minimal number of the Primary Health Centers across the three states. Had, for example, ACCESS concentrated its efforts on Zamfara, they could have supported all the hospital, but would still have only supported less than a third of all the PHCs in the State. They may not have had the problems experienced with staff transfers, and could have had a real impact where they were working

[14] "The Ground Is Softening" For The Usaid/Nigeria Health Portfolio Considerations For The Present And The Future

By Joyce M. Holfeld, Patricia Macdonald Submitted To Akua Kwateng-Addo And The Usaid/Nigeria Health Team

January 2007

IR 13.3. Expanded Demand for Improved Social Services

The data available in the project quarterly reports seems to paint a lacklustre picture of work in the area of increasing demand, but the field visits gave the review team a much more dynamic view. The reported numbers of beneficiaries from community activities is not as high as hoped, but it is there has probably been under-reporting in this area.

The communities visited by the team showed a great deal of energy and enthusiasm. Mobilizers are typically men, though in some communities a few women had also been selected. It is more difficult for women to obtain permission to go out and about than it is for men, and also that women are generally less educated. Men are probably good at persuading other men to take a more liberal view on issues such as birth spacing and use of maternity services than has been the case in the past. The baseline survey for ACCESS indicated a high level of male control over decision making about the conduct of pregnancy and birth, so this is probably an important aspect of the work. The work of mobilizers is now going beyond advocacy, and schemes such as ones for emergency transport are being developed

One particularly impressive community level activity is that of the volunteer saving clubs for women - *Tallafis* (self-help in Hausa). These clubs are similar to Gramin banks, and enable women to have access to credit and resources they can access. The team saw a gathering of women from several clubs in Mada, Zamfara State, which was, indeed, an impressive sight, bringing together perhaps 200 women who are participating in this activity. There are now 13 savings clubs in 5 communities. Across the clubs in this local area alone, it was said that women have raised around N1 500,000 in funds that can be called upon by members, both for entrepreneurial activity or for emergencies in childbirth.

IR 13.4. Increased Access to Services, Commodities and Materials

The main indicators for this result are measures of drug stock-outs for BEmONC. This seems to be a questionable measure of management capacity in the selected LGAs, because the project has no control over drug supplies. Stock-outs of the designated tracer drugs are frequent and efforts to reduce this have been unsuccessful. In 2008, no BEmONC facilities were without a stock-out of some essential at some point in the year. ACCESS is doing all it can to advocate for improvements in the drug supply. This is another area where, if ACCESS had a presence in support of state-wide activity, it would stand more chance of being influential in bringing about improvements.

The other indicator for improved management of services is related to the provision of newborn essential care: this has not been consistently measured over the project lifetime.

The more directly relevant indicators for this result are related to actual provision of services and of staff. Caesarian section rates are one indicator that is important here, though the reporting on this indicator shows discrepancies in various documents. However, taking the data from the report for Quarter 2 2009, the rate is estimated at 5%, still well below the 15% target. The reasons give are the infrastructural challenges, staff shortage and continuing high prevalence of home deliveries.

The other indicator of availability of services and staff is number of people trained in maternal / newborn health through USG-supported programmes. Generally, the project has kept pace with its targets in this area, though it would be useful if reporting were more consistently disaggregated to show numbers of female and male workers trained. However, there is a problem in looking only at volume of training, because achievements in training are being undermined by the high rate of staff transfers.

A further problem is that in the view of the review team, the Community Health Extension Workers

(CHEWs) who form the backbone of maternity care capacity for PHCs, are inadequately prepared in terms of basic education (possibly even literacy) and improving their professional skills is difficult if not impossible. An example of the low level of ability that obtains is that of weighing babies. It seems the CHEWs were often not recording birth weight or recording it inaccurately. The project has recognised this by creating a training programme based on short, simple modules of 2-3 days each, offered at intervals in the hope that the new learning can be digested before moving on. The review team are of the view that a better approach would be on-the-job, highly practical training in which an experienced instructor works alongside the CHEWs in a health facility for perhaps one month, helping them to incorporate good practices into their daily work – learning by doing.

The evaluators doubt whether the CHEWs can ever form the basis for a para-midwifery cadre. It would seem more promising to explore the possibility of the new midwifery school in Zamfara training a new cadre of community midwives, if standards can be established such that these are skilled birth attendants in line with the WHO definition and professional specifications.

Project Management

Project management is not monitored via specific indicators for ACCESS. The activities witnessed by the review team and the interviews conducted, to major concerns about the way the project is being run. Indeed on the contrary, the project team is probably forced to work extremely hard to achieve results despite an environment that seems actively hostile to their efforts. The impression was one of considerable energy and commitment. The only concerns were around monitoring and record – keeping and these are mentioned below.

Monitoring and Evaluation

Although data collection is taken seriously in the project, there are a number of flaws that were noticed in the course of the field visits. Some data appeared to be seriously suspect – for example an instance noted in Daura General Hospital in which 156 entries included records of only two low birth weight babies and three complicated deliveries; an observation that seems incredible. Quite often also, actions taken were recorded with a just a check-mark, and provided no, detailed information as to treatment given.

One explanation is that staff are struggling with the difficult situation that they must record data in at least three places – the Government records system, the project recording system and the individual patient notes. This is tough for anyone but especially so for staff some of whom would seem to be only barely literate, and often are also overworked. For example, in one busy little maternity ward, the lack of basic recording was noted. The explanation offered was that at any one time, there was only one nurse-midwife to cover that ward. How, then, can good record – keeping be expected?

Other issues that almost certainly compound with this are:

- Lack of ownership of the project record – keeping system and a feeling that this is impinging on available time for patient care
- Lack of appreciation of the importance of the information to be recorded
- Need for more training in record keeping

Links to other USAID programmes

USAID requested information on the extent to there is collaboration between the three programmes

that are the subject of this evaluation.

In visiting ACCESS and its facilities, respondents were questioned about their contact or collaboration, if any, with ACQUIRE and IRHIN. The answer was consistently that there was little interchange, although of course the lead project officers all know each other and do meet in certain situations.

There was even some suggestion that a degree of competitiveness exists between the programmes. This was specifically mentioned in the case of ACCESS and ACQUIRE. The issue seems to be rooted in the fact that these two projects have in some instances performance indicators that are similar, and this leads to the danger of double counting on the one hand, and distrust about who should claim the praise for positive results on the other.

It is probably quite possible to review the indicators and reorganise them to eliminate this problem. However if more active collaboration is viewed as important, it may be necessary to take more radical action. It may be that a lead is needed from USAID in convening meetings of senior staff from the programmes. Another option to consider would be that of creating some kind of organisational link that effectively brings the present projects under one organisational umbrella.

Analysis and Conclusions

Immediate considerations (to December 2010. The whole ACCESS team are to be congratulated at doing a good job in difficult circumstances and in the absence of an enabling environment. Health workers in facilities visited are grateful for what ACCESS has done.

However, the late start and the delays described above have prejudiced the work in Katsina. In the view of the review team, this is unlikely to be able to bear fruit within the program time available. While in no way wishing to denigrate the efforts that have been made to further the work of ACCESS and extend it to three states, the review team considers that USAID should consider ending the work begun in Katsina State immediately and redirecting resources (including possibly staff) to the other two states.

It is noteworthy that Katsina is one of the states selected for support in the field of MNCH work under the new DfID- Norwegian programme in the Northern States. The possibility of the work that ACCESS has initiated should be brought to the attention of the DfID managers in the hope that some degree of continuity might be achieved or at least some lessons learned may prove useful.

The team recommends that ACCESS continue in Kano and Zamfara until the end of the MCHIP period.

Long term. Following this period, it is recommended that USAID reconsider how they do MNCH / RH work in the public sector. As long as work is focused on only a few facilities in selected LGAs, it is difficult for a State Ministry of Health to give much attention to the important and evidence-based work being supported by USAID. It is further difficult for the Ministry of Local Government to appreciate the importance of this work or to relate to it. It is proposed that rather than spreading work thin over several states, it would be preferable to work in one (or if funding permitted, more than one), entire states, rather than at the facility / LGA level alone. The same point was made by Holfeld and MacDonald[15]. This approach would make it possible to work with the State Ministry to

[15] "The Ground Is Softening" For The Usaid / Nigeria Health Portfolio Considerations For The Present And The Future by Joyce M. Holfeld, Patricia Macdonald Submitted To Akua Kwateng-Addo And The Usaid/Nigeria Health Team January 2007

support the development of a human resources strategy, to tackle the problems of logistics management, input to an improved approach to quality assurance and open up the possibility of creating a unified and simplified approach to data collection and monitoring. An alternate view within the team is that starting with a few contiguous LGAs and expanding services to the whole state over a two to three year period might be more practical.

Working state-wide would allow an ACCESS type project to really make a difference in a way that work in selected LGAs simply cannot. It would also provide a show-case for USAID's work that would create the possibility of methods being adopted on a national basis. ACCESS has much to offer. Already, it has developed the operational performance standards for EmONC in hospitals and PHCs, in collaboration with the FMOH, WHO, UNICEF and PATH. The training manual for Kangaroo Mother Care is also available for all States. ACCESS and FMOH have jointly produced a Situation Analysis and Action Plan for Newborn Health in Nigeria. However, there remains a good deal of learning that is not being fully utilised in development of national standards and guidelines, and , if ACCESS were better positioned, more opportunities would be available.

USAID has decided to focus its work on just two states, Bauchi and Sokoto. This implies the end of ACCESS work in Zamfara and Kano as well as Katsina. In the course of field visits, the team repeatedly asked health workers how they would feel if ACCESS work came to an end. On the whole, the responses were along the lines that ACCESS had done a good job; they would appreciate continued support, but as and when it did come to an end, they would continue within the framework and approaches developed with ACCESS and keep the work going forward. DfID and the EU are both active in one or another of these States and may be willing to take up the projects that USAID started

Bauchi has 4.7 million people; Sokoto has 3.7 million people. The resources of ACCESS are currently financing work that is claimed to reach 5 million people. These resources would be adequate to finance work in one state including a greater emphasis on improving state systems. Increased resources would make it possible to operate in both states.

Recommendations

1. USAID should consider ending the work begun in Katsina State forthwith and redirecting resources (including possibly staff) to the other two states.
2. ACCESS should continue in Kano and Zamfara until the end of the MCHIP period.
3. Under T-SHIP, ACCESS should relocate its work to one or both of the selected priority states, Bauchi and Sokoto.
4. Work should be undertaken in future on a state-wide basis, rather than in selected LGAs only.
5. USAID should consider the organizational modalities possible for an improved link between the work of ACCESS and ACQUIRE, in order to maximize the synergies between the complementary efforts to improve maternal and neonatal health ongoing through these programs.

II. C. ACQUIRE

II. C. 1. Objectives

The purpose of the Acquire project is to increase access to quality comprehensive fistula repair, prevention and reintegration services by: 1) raising community awareness through outreach programs addressing the needs and concerns of women, men and community and religious leader. This outreach also seeks to reintegrate women back into their homes and communities once their fistulas have been repaired by reducing stigma, providing psychosocial support and teaching them work skills such as sewing; 2) It also builds on work of other donors to establish and maintain a set of five, soon to be seven, fistula repair centers where excellent and relatively simple surgical techniques and post-operation care is practiced; 3) As an integrated reproductive health project ACQUIRE also works to increase the use of contraceptives by promoting the use of FP services. USAID support for fistula services began in September 2006 with funding to Engender Health (EH) under the ACQUIRE project.

There are no accurate figures on the number of women requiring fistula repair in Nigeria. The best guess is that there are around 800,000 women currently needing repair[16]. The long term prognosis is even worse. Fistulas are largely caused by prolonged labor, and can be prevented by rapidly available skilled midwifery care. Unfortunately, since many women in Nigeria believe that three days is normal for labor, it is difficult to get them to come to a hospital or comprehensive health center in time. Because of this, the number of women with fistulas is projected to continue to rise into the foreseeable future, since the number of deliveries already exceeds health care system capacity, and are accelerating at a pace that exceeds growth in facilities and trained personnel.

The team notes, with dismay, that fistula prevention and repair is neither included in the USAID draft strategy nor in the TSHIP Program Description. We hope that this is an oversight and not a conscious decision.

Recommendation: USAID should review its existing strategy and contract mechanisms to ensure that there is continued funding for Fistula Prevention and Repair.

The five year Nigerian prevention, repair and reintegration of women with fistulas began in May 2007 at the five sites listed below. Each received a series of activities including direct support for repairs, refurbishing of facilities, training of staff and supporting networking opportunities for surgeons to share experiences. The first three are primarily service sites and the last two training sites:

- Kebbi State: Specialist Fistula Center Birnin Kebbi
- Sokoto State: Maryam Abacha Women and Children's Hospital (MAWCH)
- Zamfara State: Faridat Yakubu General Hospital
- Kano State: Laure Fistula Center at the Murtala Mohammed Specialist Hospital
- Katsina State: Babbar Ruga Hospital

The project has also recently expanded to include two new states (Eboyin to meet the demand for fistula services in the south and Bauchi in the North East). The project sites in Sokoto and Bauchi fit directly into the USAID planned focus on these states, and should offer greater opportunities for collaboration than has heretofore been the case.

[16] Harrison KA (1985) Child-bearing, health, and social priorities: A survey of 22,774 consecutive deliveries in Zaria, northern Nigeria. Brit J Obstet Gynecol 92: Suppl 51–119.

Intermediate Results: The higher order goal to which the project contributes equates to USAID/Nigeria's Strategic Objective (SO) 13, Increased Use of Child Survival and Reproductive Health Services in Targeted Areas.

There are four Intermediate Results (IRs), each of which will be discussed in turn.

IR1: Increased access to quality fistula repair services.
IR2: Increased fistula prevention activities
IR3: Increased reintegration opportunities for repaired fistula clients
IR4: Increased access to quality family planning services and commodities

II. C. 2. Increased access to quality fistula repair services

By the end of the 2008 fiscal year, the project staff had repaired a total of some 4000 women had been treated by the project. The 2008 total, 1437, represents a 3.7% increase above target for FY08 and 32% above the total repairs of 1081 conducted in FY07. These results are due to the 'pooled effort' campaigns conducted at least once every quarter. This strategy brings trained surgeons from several sites to a single hospital, where they 'Pool' their work to help reduce the backlog of fistula cases and maximize the use of hospital facilities. The majority of women who had surgery had a closed and dry fistula upon discharge (93%) with reports of complications very low overall.

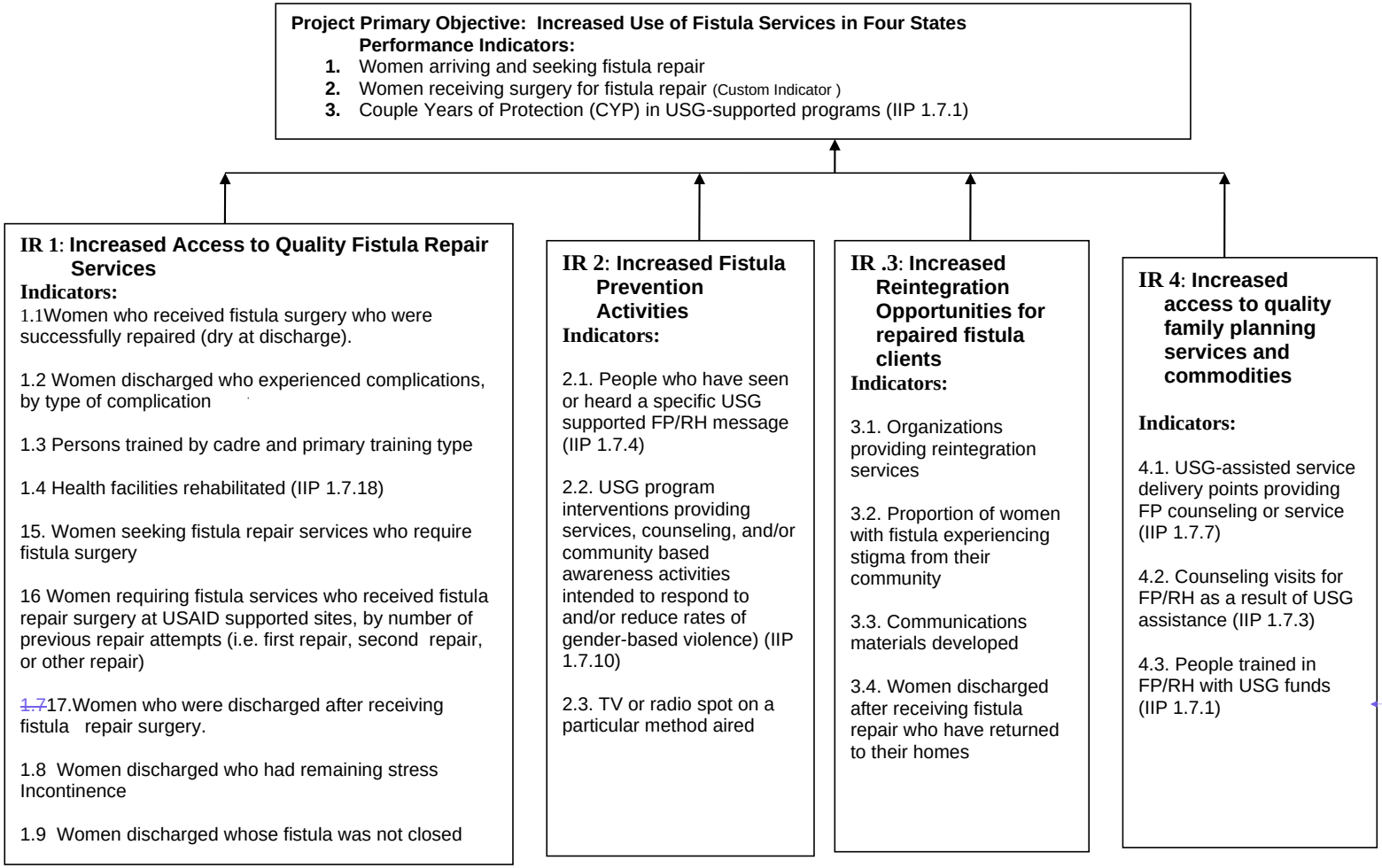
Training: Training in fistula surgery is conducted in collaboration with the State Ministries of Health. As noted above, there were two training sites. Training is provided both for surgeons and nurses, who focus on post operative management including infection control, and counseling on both fistulas and on family planning. One nurse trainer was sent to Tanzania for higher level curriculum development.

A total of twenty-seven doctors (all male) and eighty-two nurses have been trained with two doctors reaching the advanced trainer status. Only nine doctors were still offering services in the AQCUIRE supported facilities, and even then, one of the two advanced trainers has been transferred to the State Ministry of Health. Many of the trained surgeons have found their way to the teaching hospitals and peripheral sites not offering fistula repair. This results in a loss of the resources used to train these surgeons. Since women need a particularly long hospital stay—2-4 weeks—they use up constrained general hospital beds, so fistula repair is usually only done in specialized hospitals.

One of the big gaps is that the appropriate technology fistula repairs are not being taught in either medical school or in OB/Gyn residencies. Part of this is due to a stand-off between the current project director and the Nigerian Society of Obstetricians and Gynecologists (SOGON). The most important result is that this science and surgical techniques are not being made widely available in the mainstream of Nigerian medicine. The next phase of USAID support should work to ensure a reconciliation between the two groups, and introduction of the subject into both medical school and residency curricula.

Recommendations: USAID should work with specialist Obstetricians and Gynecologists to introduce appropriate technology fistula repair into medical school and specialist training.

To ensure that all fistula team members kept up to date with new ideas, Acquire arranged regular 'Fistula Retreats'. These have been successful both to acquire new knowledge and to encourage each other.



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The team observed that the theater and fistula wards of both the Faridat Yakubu hospital Gusau and Mariam Abacha women and children's hospital Sokoto have been refurbished with new wards and rehabilitation centers built. The team also saw the operating tables, autoclaves, air conditioners and TV/VCRs the project has provided to these facilities to enable them function optimally.

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II. C. 3. Increased fistula prevention activities

Fistula prevention has both a primary and a secondary aspect. Primary prevention requires training women and traditional birth attendants to recognize prolonged labor and arrange immediate transfer to a facility that can intervene before damage is done. There are enormous roadblocks to prevention, given the state of roads, transport, and CHC and secondary hospital deficiencies. Secondary prevention requires early recognition that a fistula is starting to form (the woman is leaking two days after delivery) and treatment with a catheter into the bladder for two weeks. Nearly all women who start treatment within four weeks of delivery will be prevented from developing a permanent fistula. It is striking that the ACCESS EmONC package does NOT include secondary fistula prevention. (www.jhpiego.org)

Recommendation: ACCESS should immediately add secondary fistula prevention to its Nigeria EmONC services.

The project has undertaken several initiatives to raise awareness about fistula treatment services and prevention. These include:

- Mobilizing religious leaders as advocacy champions for fistula: These leaders were trained and educated on the causes of fistula, the short and long term impact on the client, family and community and also met with affected women so they could appreciate firsthand the devastating effect of fistula on a woman's life. They now include discussion of fistulas as part of Friday fiadu prayers, and are reported to have reached over 75,000 people during the 2008 fiscal year. In the words of one religious leaders we spoke to: "When I first heard about this project I was against it! But after being enlightened by them I realize these American people mean well for us."

- Partnering with community based organizations- A total of six organizations (two from each of the three primary States of intervention) have been engaged to create awareness about fistula in the communities. The evaluation team met with them in Sokoto where they were undergoing update training on family planning/advocacy. There is anecdotal evidence that community mobilization has led to women regaining hope for a normal life, and coming to hospital for treatment.

- Development of behavior change communication strategies/materials- In collaboration with key stakeholders, the project reviewed existing materials and developed new culturally appropriate messages in languages specific to the targeted audiences in the three primary States the project works in (Sokoto, Zamfara and Kebbi). At the end of the 2008 fiscal year, the project had produced a total of 25,000 client educational materials such as posters and brochures in English, Hausa and Ajimi (the Arabic lettering for the Hausa language). Many of these materials were visibly displayed in the sites visited.

- Use of the media: The project has partnered with the media in the three primary states and at the national level to air programs on fistula treatment and primary prevention. The Hausa service of the Voice of America features live discussions with fistula clients, project staff and religious leaders. The project also sponsors a national radio program (health watch) with reach of over 14 million listeners to discuss fistula. This has yielded several success

stories for the project and has exposed the fact that the problem of fistula is nationwide, judging by the number of women from the south who call in to find out more about fistula and how they can get help in form of treatment.

- Secondary Prevention- Acquire is strongly committed to actively find women who have started leaking urine immediately postpartum and refer them for catheter placement. They estimate that 30-40% of their fistula patients can be managed without surgery since they arrive shortly after delivery

II. C. 4. Increased reintegration opportunities for repaired fistula clients

If women are diagnosed and treated quickly enough that they are not shunned by their home and communities, rehabilitation is not needed. For the others, Acquire works in collaboration with the State governments, especially the offices of the First Ladies and the Ministry of Women, advocating construction of rehabilitation centers where clients learn sewing, sewing, cooking and knitting during the 4-6 week post operation. In Zamfara, the State government has constructed and equipped a rehabilitation center for skills building attached to the fistula center. The fistula center in Sokoto is soon to commission a new rehabilitation center and has gone a step further to give knitting and sewing machines to the fistula patients when leaving the rehabilitation center. The project has also partnered with the private sector (Syngenta) to support fistula care and reintegration activities. The organization was said to have donated the long lasting insecticide treated bed nets seen to the fistula wards in Zamfara and Sokoto and sewing machines to the rehabilitation center in Zamfara.

II. C.5 Increased access to quality family planning services and commodities

Acquire provides counseling and referral of treated patients for family planning. It is important to note that Acquire does NOT provide contraceptive goods and services at any of its facilities. Instead, a woman is referred to a Government Family Planning center which is usually co-located with the hospital. Since these centers also provide contraceptives to women in the community, plus any referral from other programs like ACCESS, It is impossible to say which commodities are attributable to which source. Double counting is inevitable, and has led to squabbles between organizations as to who can claim which CYP. Given that there are 1-2,000 women who are treated each year, this is unlikely to have an effect on overall population statistics.

Recommendation. Acquire should be relieved of the responsibility to report CYP.

II. C. 6. Project Management

ACQUIRE's team has built productive partnerships with all stakeholders, including the State Ministry of health, Ministry of Women's Affairs and the Office of the First Lady. The project leadership was praised and valued by all health sector partners interviewed by the team. Activities are coordinated from the main Abuja office by the country director.

There is one field office in Sokoto where the deputy country director resides. Sokoto is strategic in that the other two focus States of Zamfara and Kebbi are close to it. The program officers work directly with the staff at the facilities. There is a monitoring and evaluation advisor who operates from Abuja and visits each site quarterly. The team believes that an M&E officer should be resident in the Sokoto field office.

Commented [D1]: Bunmi—why do you recommend this? The statistics at the Acquire sites are fairly good, so I'm not sure what impact adding M&E to Sokoto would have.

Data Quality: Through an examination of quarterly reports and a records review, we believe that, with the exception of CYP, the data on services provided is accurate.

Lessons Learned from the project's work to date are:

- The problem of fistula is nationwide and is likely going to continue to rise
- The project is creating an immense amount of good will for the United States in these areas.
- The development of stable human capital by equipping health providers with the relevant skills and expertise to manage fistula will help ensure an effective and sustained national response, but this may be undermined by Nigerian staff transfer policies
- Advocacy and awareness raising are necessary for sensitizing communities and mobilizing political/social support for fistula activities as the culture of silence and shame surrounds the condition.

Conclusions. While the fistula repair activities of the ACQUIRE project represent a small fraction of the backlog of an estimated 800,000 cases, it has provided a strategic opportunity to raise awareness and mobilize to action the political local and religious leaders on the need to increase efforts to prevent and treat fistula. The project has helped to strengthen long term capacity to provide fistula treatment services both in terms of infrastructure and human resources though more needs to be done in this direction. From the view point of the women who have benefited, years of stigma, shame and isolation were ended. By providing fistula treatment in such a visible manner the condition can be highlighted, demystified and recognized as curable and preventable. If funding is continued and preferably increased, the project can expand its activities into more states across the country to be positioned to address the menace of fistula and contribute to improving maternal/reproductive health of the Nigerian woman.

Recommendations.

- USAID should continue to support fistula primary and secondary prevention and treatment, possibly in collaboration with other donors. Having a strong donor such as USAID behind the program will make its incorporation into the standard practice of Nigerian medicine more feasible.
- The national VVF task force should be up and running. This will ensure a coordinated response at addressing the problem of fistula, avoid duplication of effort and ensure efficient use of already scarce resources
- The project does not directly provide contraceptive services and should not be reporting on CYP
- The mission's monitoring system that places a premium on numbers should be discouraged. In the words of one program staff "we don't ask why these targets are set we ask how we can meet them". The project is encouraged to continue as an independent activity rather than under the T-SHIP plan
- There should be an increased focus on secondary prevention in other programs such as ACCESS.
- The integration of fistula prevention/care into ongoing country programs and initiatives should be promoted, such as the integrated maternal newborn and child health strategy
- Acquire should develop a compact guide on effective approaches to actively engage fistula survivors at the facility and community levels

II. D. IMPROVED REPRODUCTIVE HEALTH IN NIGERIA (IRHIN)

II. D. 1. IRHIN Project Objectives

USAID's long-term objective is to support Nigeria in achieving a more transparent and participatory democracy with a healthier and better educated population. SFH and its partners were awarded the IHRIN project as a vehicle for achieving that objective. The **goal** of IRHIN is to support Nigeria in achieving a more transparent and participatory democracy with a healthier and better educated population in a growing and diversified economy. The **purpose** of the project is to improve the understanding of, access to, and correct use of contraceptives to reduce unintended or mistimed pregnancies. The SFH team set out to accomplish this by achieving the following four **outputs** (see Figure 2 for a summary of the IRs and their indicators):

- Improved **quality** of reproductive health services
- A strengthened **enabling environment**
- Expanded **demand** for improved reproductive health products and services, and
- Increased **access** to reproductive products, services and materials.

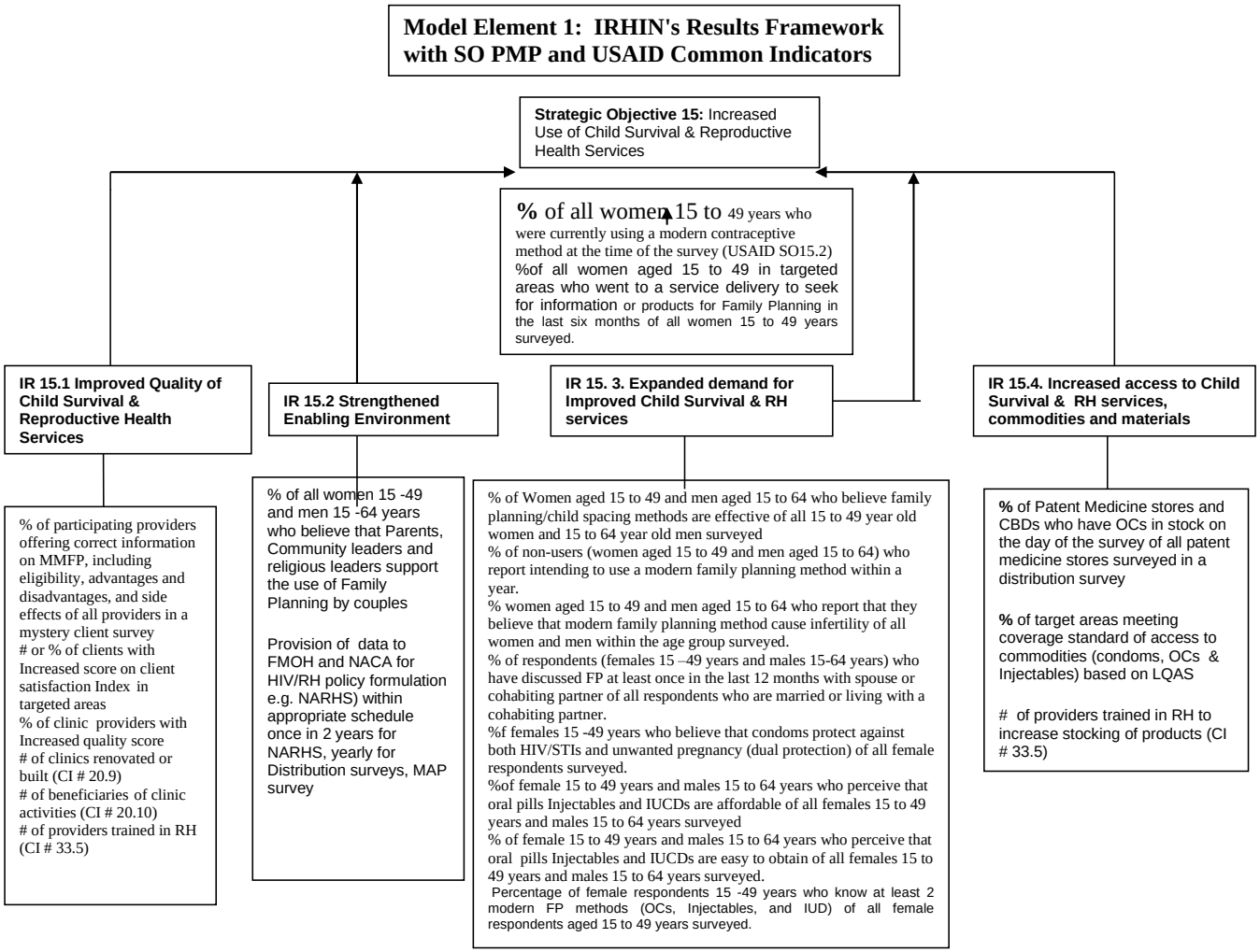
The project expected to contribute to an increase in modern contraceptive prevalence for all women of reproductive age (WRA) (ages 15-49) from 9 percent for modern methods to 11 percent by the end of the project. The 2008 NDHS indicates that Nigeria has not yet met that target. The percent achieved at mid-term was 9.7 percent.[17] However, this was an increase over the 2003 figure of 8 percent. Use of any method also increased from 12.6 in 2003 to 14.6 in 2008. Nevertheless, the principal conclusion is that contraceptive prevalence in Nigeria remains very low and is growing only slightly.

If the CYP provided by the CSM program is viewed in light of Nigerian population growth, a different picture emerges. Project records show that distribution grew by about 300,000 CYP per year. Nigeria's growth rate is conservatively estimated at 3% [18]per year, if we then estimate that .25% of Nigeria's population (140 million) is women of reproductive age, we can roughly calculate that, every year, there are an additional 1,000,000 women of reproductive age in Nigeria. Clearly, the growth in CYP provided is falling behind the growth in population. This estimate is partially confirmed by 2003/2008 DHS figures, which only show a growth in CPR from 9.0 to 9.7 over the five year period.

Although the IRHIN project is national in scope, a portion of it concentrated on three states: Kaduna, Cross River and Abia. Contraceptive prevalence in one of those states was below the national average (Kaduna at 8.4 percent use of modern methods). It was significantly above the national average in the other two (16.3 % in Cross River and 15.6% in Abia). The CPR varied significantly by region (from 2.5% in the North West to 21% in the South West) by state (from 0.2% in Jigawa to 49.6% in Legos) and by density (6.2% in rural areas and 17.1% in urban).

[17] Table 4, p. 13, 2008 DHS.

[18] The Chairman of the Population Commission estimates the growth rate at 3.2% per year (personal communication)



USAID provided

The second SO indicator was employed to determine if women in the three targeted states went to service facilities to seek family planning information or services.[19] The 2005 baseline was 26 % for Kaduna, 29 % for Abia, and 44% for Cross River.[20] The TRAC Nigerbus survey showed that the figures for 2007 were 60 % for Kaduna, 34% for Abia and 22 % for Cross River. Other IR indicators show that significant changes were expected on such performance indicators as CYPs (13.4 million) and coverage (90% for condoms, 75% for pills, and 60% for injectables). See Table 1 in Annex X for the baselines, targets and mid-term achievements for all of the IR indicators.

USAID provided $13.5 million to SFH to achieve these objectives over a five-year period (June 2005 – June 2010).[21] Key interventions selected to reach the objectives include provider training, social marketing, radio and TV campaigns, community involvement, demand creation, expansion of the PPMV outlets, addition of new contraceptives, and targeting religious and other leaders.

[19] Percent of all women aged 15-49 in targeted areas who went to a service delivery to seek for information or products for Family Planning in the last six months of all women 15-49 years surveyed. See Nijerbus 2007.

[20] Improved Reproductive Health in Nigeria, Performance Management Plan, July 2006, p. 7.

[21] An additional $1.725 million was provided in FY 2008.

II. D. THE PATHFINDER PROJECT

II. D. 1 Objectives.

SFH's partnership with Pathfinder planned to address issues of RH service quality through training of private sector and other NGO providers. The aim of the training was to increase provider knowledge and counseling skills, address attitudinal barriers toward the provision of contraceptives, and build a practical understanding of behavior change communications techniques.

Pathfinder is a component of the IRHIN project that attempts to support networks of private practices run by either existing Community Service Organizations (CSO) or physicians and nurse/midwives. These are to be developed into significant providers of Family Planning/Reproductive Health providers of goods and services. An outreach component is built into the project, with Community Mobilizers urging women and men to accept birth spacing, and go to the clinics to get clinical services. As is stated in the project agreement:

SFH draws on Pathfinder's considerable expertise in the provision of clinic-based services and in community mobilization to conduct intensive activities to strengthen the quality of services in selected areas of three focus states — Kaduna, Cross River, and Abia. Over the period of the project, Pathfinder has worked with the following nine non-governmental organizations (NGO):

Kaduna state:
- Federation of Muslim Women Association in Nigeria (FOMWAN) Saminaka, Lere LGA
- Evangelical Church of West Africa (ECWA) Kafanchan zone
- Nigerian Medical Association (NMA) Kafanchan zone

Cross-River state
- We Women Network
- Medical Women Association
- Association of General Medical Practitioners of Nigeria (AGMPN)

Abia state
- Medical Women Association
- OSUSU 1 Catchment Area for Community Participation (OSUSU CAPA 1)
- Abia State University Teaching Hospital Catchment Area for Community Participation (ABSUTH CAPA)

For the first two years, there were up to five clinics per organization, but more were added in 2008. Some dropped out of the program for a variety of reasons. Of the original total of 21 clinics in 2006, two dropped out and five were added in 2008. Another two are on the verge of dropping out, largely because of poor performance in distributing family planning commodities. We were able to visit seven clinics.

The team was able to visit representative clinics of all NGOs in Kaduna and Cross River States. We were not able to visit Abia because of an episode of violence the week before our site visits began. The clinics in Kaduna state were predominantly rural, and there was a mix of urban and rural sites visited in Cross River.

Pathfinder used the Centers of Excellence at the Teaching Hospitals to provide the clinical training. Internal resources and the Network Trainers conducted non-clinical and FP service delivery management training. The plan called for 45 nurse/midwives and 21 physicians to be trained.

Skill training for doctors. In 2007 some 22 doctors from CSO partner clinics received competency-based training on FP methods. The training included updates on all FP methods and skill-building for insertion of IUCDs and implants. The FP division also conducted training for the doctors on the SDM using the CycleBeads. Job aids were produced and given to doctors to aid them in client counseling.

Skill training for nurses and doctors. In 2008 a total of 17 nurses and six doctors from the IRHIN-supported clinics were given competency-based training on all FP methods. Three were trained on Jadelle and 18 had update sessions on contraceptive technology. These and other training that the providers have received since the inception of the IRHIN project in July 2005, have had a tremendous effect on the quality of service provision, especially on counseling activities. In FY08 a total of 37, 250 clients received one- on-one-counseling and another 85, 620 persons were reached through group health talks.

II. D. 2. Improved Quality of Social Sector Services

Pathfinder improved the quality of FP/RH services by (1) rehabilitating clinic buildings, (2) Providing necessary equipment for clinical contraceptive services, (3) training the director of each clinic and designated staff providing family planning services. In return, the clinics were to provide designated space for family planning counseling and service provision, staff to provide counseling and services, and subsidized services to clients. i.e., they were not to charge the standard clinic visit fee of N 1,000-1,500.

We observed all of these in every facility we visited, although one NGO had not taken their instruments out of their plastic bags during the entire three year life of the project. In many instances, the staff originally trained had left the clinic to seek greener pastures. Indeed, the inability to retain trained staff was the primary complaint of all clinic directors.

Initially, it was very difficult to convince private practitioners to provide these essentially free services since they did not see FP as increasing their revenue. Project directors spoke about indirect benefits, such as improving the visibility of the clinic, and increasing the pool of potential patients who would then come to them after seeing that they were treated politely in clean, high quality settings. The providers we discussed this with were convinced that it was true, but had no way of quantifying the effect. Nonetheless, by the end of the three years, most of the members of the AGMPN in Cross River were providing some level of FP services, as partially confirmed through a visit with one clinic not associated with the project that was providing similar levels of FP services.

When visiting the clinics, the rehabilitation work was very evident. Each clinic had a separate section for provision of family planning counseling and provision of services. We noted some lack of electricity, and the use of chemical sterilization, which is less desirable. We were not able to observe the techniques used to insert implants, give injections or insert IUDs to ensure that good practices were being followed.

II. D. 3. Strengthening the Enabling Environment

Enabling Environment: The environment that Pathfinder worked in was relatively good, in that there were few of the problems that plagued other programs. Most of the practitioners had back-up generators, so electricity and water were much less of an issue. There were no governmental or social hinderances to their work. One major obstacle is that most people tended to believe that they were more expensive than the government or PPMV sources. The biggest hinderances came from the problems of having such a far-flung program, a lack of a program coordinator in the South South, and not building a critical mass of providers who could mutually support each other.

Pathfinder worked with private practitioners to try to build support for FP/RH activities in the private sector.

II.D.4. Expanded Demand for Improved Social Services

Pathfinder assisted the clinics in developing networks of Community Mobilizers, Peer Educators, and Community Based Distributors among both men and women in the communities near the clinics. It is difficult, however, to actually measure the impact this had, since FP acceptors typically did NOT go to the clinic facilities. There were always a variety of FP providers, including other NGOs (CEDPA, for one), the Government health centers and hospitals, and PPMVs and others. In one situation, for example, the community was 28 km. away from the clinic site, which cost 1,000 N round trip for travel. Essentially none of these women and men went to the clinic, but chose to attend the Government health centers. While Pathfinder staff recently introduced referral cards to try to track this flow outside the system, it is not yet working well enough to provide accurate estimates. In one community, we learned of school aged girls going to their local PPMVs to get oral contraceptives to keep from becoming pregnant, and rarely were referred to clinics for basic health screening.

We would like to single out the FOMWAN group for particularly hard work and enthusiasm. They actively took on the Muslim Imams and Islamyya schools, and got these religious leaders to agree that family planning was part of Islam, and should be addressed in Friday prayers, and were able to introduce reproductive health training in the madrassas. While further field work would be necessary to confirm their impact, theirs is a model to be replicated across Muslim Nigeria. Since it is a nationwide organization, it should not be difficult to include them in any follow-on project. There was also outreach to churches, particularly by ECWA and by the providers in the South. We were not struck by the enthusiasm that we would like to have seen in some of the other women's groups. This may be a sampling artifact.

Unfortunately, this effort did not result in the provision of a large amount of contraceptives, as measured by CYP. The table below shows the annual results for each NGO. Of course, since the figures reported by Pathfinder only represent services provided by the clinics in the program, the total impact of the program is likely to be much greater than shown in the reporting tables. Extrapolating through the end of 2009, we see that all providers together only provided some 12,500 CYP over four years, or an average of less than 400 CYP per partner per year.

Table 4: IRHIN Project Partners CYP Contributions 2006-2009

State	Partners	Annual CYP for all Methods				
		2006	2007	2008	2009*	Total
Abia	ABSNON	**298.1**	424.6	453.4	69.6	1,245.7
	CAPA**	280.0	400.0	354.6	488.5	1,523.1
Abia total		**578.1**	**824.6**	**808.0**	**558.1**	**2,768.8**
Cross River State	AGPMPN	439.8	654.5	962.2	484.9	2,541.4
	MWAN	35.8	22.8	122.8	170.5	351.9
	WWN	0.0	70.0	506.5	281.3	857.8
Cross River State total		**475.6**	**747.3**	**1,591.5**	**936.7**	**3,751.1**
Kaduna	ECWA	57.6	159.3	131.5	70.5	418.9
	FOMWAN	127.2	486.3	347.5	239.8	1,200.8
	NMA	190.4	644.6	705.2	460.8	2,001.0
Kaduna total		**375.2**	**1,290.2**	**1,184.2**	**771.1**	**3,620.7**

Project total		**1,428.9**	**2,862.1**	**3,583.7**	**2,265.9**	**10,140.6**

Note:

* 2009 data is for 1st Quarter for ABSNON and 1st and 2nd Quarters for other Partners

** The data from CAPA is being verified and has not yet been accepted for 1st quarter 2009

The Pathfinder project was managed out of Abuja for the first two years. While this is acceptable for Kaduna State sites, it did not work very well for Cross River and Abia States. In addition, the project leadership in the two southern states was given to the two top officials in the AGMPN. In this setting, the project responsibilities were added on to their existing organizational responsibilities, and their need to attend their clinics. We met all three of the initial project leaders, and found them to be enthusiastic about the project, and report having worked very hard to convince their colleagues that quality of clinical care—not merely FP/RH—was critical to maintaining good relationships with their patients. Nonetheless, when a local project coordinator was added in 2008, things ran more smoothly. She could spend much more time with each practice, teaching, mentoring, motivating people in their work. The increases in provision of services in Cross River State that is seen in 2008 and the first half of 2009 is largely due to her efforts. Unfortunately, as the project is structured, she is dependent on public transport for the hundreds of kilometers she must travel each week to supervise the clinics. One of her clinics is 250 kilometers north of Calabar, and the work in Abia state is another 130 km in another direction. If this work is to be continued in the future, there should be some arrangements made for a project vehicle to be stationed in Calabar.

Monitoring and Evaluation. Monitoring is carried out on an at least quarterly basis, although in Cross River and Abia it is done more frequently. We reviewed clinic records and compared them with the reports submitted to the home office and did not find any significant discrepancies. We have already noted that the reporting system underestimates the accomplishments of this program.

II.D.5. Increased Access to Services, Commodities and Materials

All of these efforts were intended to increase the provision of FP goods and services. In some situations, this happened and we can measure the results. One clinic near Calabar was located in a tight-knit community very near to a market, and the physician had done the necessary outreach, and trained ALL of his staff (including the health aides who were on duty at night) to give family planning counseling and appropriate commodities 24 hours a day. Proximity to a market is important, since women can go to the market and slip away privately to get contraception without the whole village (or particularly their husbands) knowing about it. Late hours are important because most women are farmers, and need to work their fields during the day, and only have time for group meetings or clinic attendance in the evening after their work for the day is done. This particular provider had the highest rate of contraceptive acceptors in the entire sample of 26.

II. E. Society of Family Health IRHIN Projects

II E. 1.Improved Quality of Child Survival and RH Services

When building private sector support, IRHIN paid a great deal of attention to quality care. Part of this, of course, is 'perceived quality' where the customer is greeted in a friendly manner, and the facility is recently painted, uses colorful posters, and has knowledgeable staff. They also work to improve quality of care, by providing clinical training for health practitioners so they can actually perform the procedures safely.

II. E.1.a. Training of Proprietary Patent Medicine Vendors

Selection. A major responsibility of the detailers is the training of PPMV. Detailers work with the PPMV associations, the Pharmacists Council of Nigeria (PCN), hospitals, and attend the monthly state MOH meetings to identify PPMV for training. Based on its successful curriculum and model developed under the VISION project and previous training in collaboration with Pathfinder, each of SFH's 16 detailers conduct five PPMV staff trainings per year. With 50 participants per training, SFH would reach approximately 4,000 PPMV per year, or 20,000 over the life of the project. Although this is a lot, there are over 200,000 PPMV. At this rate it will take 50 years to train all of the PPMV.

Turnover is a significant problem with private providers and community workers. Once they are trained they leave for better-paying jobs. Retention is higher among those who have their own business (a shop, private practice) or are members of the target community.

PPMV Profile. A training session usually takes 6-8 hours. Each session needs to be tailored to the language and educational level of the PPMV. Some trainees are barely literate, others are new to private sector selling. Some are retired nurses. The majority are traders who have their own medicinal shops and are registered as PPMVs.

Training Content. The training covers each contraceptive method, including the characteristics of the method, potential side effects, prescription requirements, and legal restrictions on what the PPMV can and cannot do, such as providing injections. The trainers stress the importance of obeying the law when it comes to medical procedures and prescriptions. Clients should be referred to a licensed provider or hospital for initial OC screening and prescriptions, insertions of implants, injections and insertions of IUDs.

Just as important is the emphasis on the benefits of spacing to the client, the parents, the children, the community and the country. The trainers are sensitive to religious views, including Catholic and Moslem dogma but do not make an issue of this. For controversial issues the trainers open the discussion, encourage debate and strive to reach consensus. Training is supposed to be informal with lots of trainee participation. As an incentive, the PPMVs are given a modest transportation allowance as well as snacks and drinks during the training. A simple pre-post test is administered and the results summarized for the participants. Low scores identify individuals who need special attention.

Achievements. Roughly 13,600 PPMV (30% women) have been trained in the past three fiscal years (2006-2008). The training has also had a direct effect on OC and condom sales and a broadened range of coverage. Consumer confidence in PPMVs has risen as a direct result of the training. The vendors have also seen an increase in their status as knowledgeable and trustworthy salespersons. Participating PPMVs have been linked to clinics and hospitals where they could refer clients for services or information that they could not provide.

Factors affecting performance. Stock outs have a significant effect on PPMV sales and customer confidence in the reliability of supplies. Dropouts is another problem. Some PPMV drop out because of poor sales, lack of interest, or relocation. To replace these dropouts the detailer has to provide on-the-job training (OJT) unless a training session is scheduled. Membership in a PPMV association has a number of benefits, including being a forum for discussion of new contraceptive products, dealing with stock outs, and so forth. All of the PPVM have to pay cash for the supplies they order. This has not had a significant effect on sales, but the absence of credit makes it difficult for the PPMV to expand their operations. The legalization of PPMV rights to sell and be trained about OCs and condoms has enabled the program to expand to any and all parts of the country.

Conclusions. Overall, the training seems to be useful and practical. All of the PPMVs interviewed were very positive about the training and wanted more. So far there doesn't seem that there has been much, if any, update training. SFH suggested this could be done for people who were initially trained in 2000. Through the addition of the detailing teams about five percent of gross RH commodity sales were redistributed from the wholesalers to retail outlets, thereby boosting placement levels in towns outside wholesaler bases.

Recommendations are to continue the PPVM program and to expand it to cover unserved areas, including rural or remote areas where unmet need is high. Refresher or upgrade training is needed to keep PPMV current as to advances in FP and contraceptive technology. More detailers are needed if the program is to expand.

II. E.1.b. Training of Private Sector and NGO Providers

Objectives. SFH's partnership with Pathfinder planned to address issues of RH service quality through the training of private sector and NGO providers. The aim of the training was to increase provider knowledge and counseling skills, address attitudinal barriers toward the provision of contraceptives, and build a practical understanding of behavior change communications techniques.

Pathfinder used the Centers of Excellence at the Teaching Hospitals to provide the clinical training. Internal resources and the Network Trainers conducted non-clinical and FP service delivery management training. The plan called for 45 nurse/midwives and 21 physicians to be trained. Both initial and update training were planned.

Update training. In 2006, the IRHIN team conducted update training for 424 doctors and nurses on injectables and IUCDs. Participants learned to use provider checklists to screen patients for appropriate FP methods. Technical support visits were made to designated FP sites in the area. Responses to the IPC activities at the FP sites were positive. Women who attended the IPC sessions collected referral cards so that they could access FP services at designated service delivery points within the communities.

Skill training for doctors. In 2007 some 22 doctors from CSO partner clinics received competency-based training on FP methods. The training included updates on all FP methods and skill-building for insertion of IUCDs and implants. The FP division also conducted training for the doctors on the SDM using the CycleBeads. Job aids were produced and given to doctors to aid them in client counseling.

Skill training for nurses and doctors. In 2008 a total of 17 nurses and six doctors from the IRHIN-supported clinics were given competency-based training on all FP methods. Three were trained on Jadelle and 18 had update sessions on contraceptive technology. These and other training that the providers have received since the inception of the IRHIN project in July 2005, have had a tremendous effect on the quality of service provision, especially on counseling

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activities. In FY08 a total of 37, 250 clients received one- on-one-counseling and another 85, 620 persons were reached through group health talks.

Update training on IUCD. The six-day provider training was a huge success. There were 109 participants (F: 91; M: 18) from 18 states where unmet need was high. The training took place at five teaching hospitals from around the country: Zaria, Jos, Enugu, Lagos and Calabar.

Update Workshop for FP providers. The FP division, in collaboration with PPFN, conducted a contraceptive update training course for 896 (F=702, M=194) participants, who came from the 18 states with the highest unmet need for Family Planning. In addition to updates on all FP products, three new contraceptives were introduced: Jadelle, Norigynon and Pregnon. These quality upgrade training sessions are expected to affect provider skills, which will lead to better counseling and expansion of demand for all FP methods.

Conclusions. IRHIN efforts to improve the quality of child survival and RH services had mixed results. On the one hand, work with the PPMVs and the drug detailers seems to have been very successful in creating a cadre of people who had accurate, up to date information that they could share with their clients. It is particularly impressive that detailers conduct five trainings per year to ensure that PPMVs and others are kept current on the commodities that are available in the market.

On the other hand, work with private providers such as physicians, nurses and midwives has yet to provide many visible results. Whether referring to the Pathfinder NGOs, whose clinics do not provide a significant amount of contraceptives, or the larger training sessions for providers from across the country, whose impact has not yet been studied, the results have been disappointing. In our opinion, both Pathfinder and the broader training should have been focused better and monitored more closely. In one instance, work with the AGMPN, Pathfinder might have been wiser to accept all willing providers with assistance, rather than focusing solely on those who were willing to have "family planning provider" posted on a sign posted outside their clinics. Providers may have become more willing to advertise once they had some idea of demand and acceptance, and they would have been able to support each other better at their monthly meeting.

Recommendations. Pathfinder should spend the remaining time under its contract doing what it can to ensure that the trained providers will be able to continue providing services. However, they should not anticipate continuing the program in its current form.

SFH should continue to provide training in clinical methods of family planning to providers that come from all parts of Nigeria, but they should monitor the effects of the training to determine whether what has been taught is incorporated into the provider's clinical practice.

The new project should work to build a cadre of private providers in the two focus states of Bauchi and Sokoto, with outreach to all providers willing to offer FP services, regardless of whether they advertise or not.

II. E.1.c: Enhancing Clinical Service Delivery

In addition to the Pathfinder interventions, SFH conducted nationwide training programs for many more physicians. Unfortunately, the team was not able to interview the people who had been trained, and they do not appear to have been studied in a systematic way to determine the impact of the training.

In 2006, the IRHIN team conducted update training for 424 doctors and nurses on injectables and IUCDs. Participants learned to use provider checklists to screen patients for appropriate FP methods. Technical support visits [by SFH] were made to designated FP sites in the area.

Responses to the IPC activities at the FP sites were positive. Women who attended the IPC sessions collected referral cards so that they could access FP services at designated service delivery points within the communities.

In 2008, two rounds of training were held:

- A two-day update training session was held to cover all modern methods of child spacing. This included the Standard Days Method using the CycleBeads, counseling and infection prevention procedures. There were 900 participants made up mainly of nurses, CHEWS, doctors and pharmacists. They came from the 18 states with the highest unmet need for family planning. These states are Abia, Bauchi, Bayelsa, Borno, Cross River, Ebonyi, Edo, Delta, Gombe, Kaduna, Katsina, Kwara, Lagos, Ogun, Ondo, Plateau, Rivers and Zamfara.

- A six-day detailed update training on all modern FP methods was held for 100 providers from the 18 states mentioned above. The emphasis was on IUCD insertion and management. The training was to be conducted at ABU Teaching Hospital Zaria, University of Jos Teaching Hospital, Uni-cal Teaching Hospital, UNTH Enugu and University of Lagos Teaching Hospital.

In addition, working with ABT Associates, IRHIN supported a training program for HMOs providers from the Managed Care and Family Wellness Programs (MCFWP). The training covered FP, nutrition, immunization and malaria control. There were many other provider training programs conducted under the auspices of other USAID project, such as PSP, but these are beyond the scope of the evaluation.

II. E.1.d. Provide Support through Enhanced Medical Detailing

Detailers. In 2003, SFH hired and trained eight new medical detailers, all pharmacists, to promote and help distribute SFH ethical products, including hormonal contraceptives, IUCDs, and Prepackaged Treatment for Malaria (PPT). In 2007-2008 eight more detailers were hired so that there was one per region. Unfortunately, turnover is high. Three detailers resigned in the past year. Thus, retaining trained detailers is a significant challenge.

Activities. The detailers were trained by Pathfinder. Their role is multi-faceted and combines the promotion of specific branded products, monitoring stock levels at sales outlets, distributing products to remote outlets not covered by wholesalers, ensuring favorable placement of products and point of purchase promotional materials, and providing support supervision to providers. The detailers also monitor the quality of coverage and mass media. They watch pricing among the wholesalers to make sure they don't go over the recommended price for contraceptives. They can't monitor the PPMV because there are too many of them. This is a formidable job. SFH is planning to hire sales agents (1/region) to take over product sales and deliveries. One detailer noted that she now has a Community Focal Person for 5-6 CBDs. This will free up more time for the detailers to spend on PPMV training and demand creation.

II. E.1.e: Provision of provider support materials

Providers were given support materials appropriate to their needs. PPMVs need the basic stock of commodities, and they need pamphlets, posters, and other training materials to be able to properly educate their clients. These were found in the PPMV shops that the team visited.

Clinical service providers need the basic educational materials for client education, and we found these at the family planning site in every clinic. These include posters, including anatomical posters

and models, desk sized flip charts for patient instruction, and examples of the different methods available. The family planning areas of each clinic had also been renovated, and were welcoming. In addition, providers need a basic set of equipment, including exam tables, sterilizers, lights and the specific tools for each method. The one deficiency we observed was that there were no trocars for inserting injectables. We were told that the manufacturer had ceased production of reusable trocars, and had not begun distributing single use models. Otherwise all support materials were available.

II. E. 2. Strengthened Enabling Environment (IR 2)

II. E. 2. a. Project objectives

The environment for reproductive health in Nigeria poses numerous challenges. Under IRHIN, SFH and Pathfinder planned to expand their roles in improving the enabling environment for RH. Project activities on the ground were to be supported by and linked to mass media communications and advocacy on a variety of issues that are critical to the increased use of reproductive health services, including the use of media, gender issues, cultural and religious barriers, policies restricting provision of services, and policies discouraging private sector investment in the delivery of reproductive health products and services. Areas of focus were to include advocacy to increase support by the pharmaceutical regulatory agency to allow dispensation of oral contraceptives by PPMVs; partnerships with private sector manufacturers to facilitate market entry and increase the supply of commercially sustainable contraceptive products; advocacy and outreach with community leaders and male partners to garner support for use of reproductive health services; and advocacy with media regulatory agencies to ease restrictions on reproductive health messages in mass communications.

II. E. 2.b. Socio-Cultural opposition

Religious opposition to family planning is relatively low, except among some Catholics and Moslems. Conservative religious leaders cite Church and Koran dogma as justification of their opposition. Some individuals are so traumatized by this opposition that they hide their use of contraceptives. The introduction of CycleBeads has generated a lot of interest – and acceptance – among these individuals.

Moslem religious leaders in some states consulted the Koran and found a statement that said mothers should breastfeed for two years. There were two interpretations: 1) this refers only to breastfeeding; and 2) indirectly, this acknowledges that FP is allowed so that women can delay/space pregnancies. Most agree with this latter interpretation, but not all. As a result, these leaders have become openly supportive of FP/Child Spacing.

Male opposition seems to be waning as more and more men are brought into the discussion about FP and RH. They have become vocal advocates of FP and act as formal or informal peer educators. The shift of terminology to "child spacing" and the message that spacing has financial and other benefits for the husband as well as for the mother, the children, and the community have convinced many men that FP/CS is a very good thing.

Misconceptions are still common, especially in rural areas where education levels are quite low. Some women and men believe that contraceptives make one fat, that it's a scam to make money, that it's a form of genocide, that IUDs migrate to the brain, that injectables make you ill – all these and other misconceptions are being addressed by community health workers, PPMV, and providers.

Women's groups have also played an important role in overcoming resistance and misconceptions.

II. E. 2.c. Media Environment

The use of **mass media**, especially the radio dramas, have also helped to bring such issues to the forefront for discussion.

Journalists. In 2006 IRHIN, in collaboration with ENHANSE and Internews, organized a five-day workshop for 14 print media journalists. A second workshop for 14 electronic media journalists was held in 2007. The objectives were to get the journalists to correct misconceptions about FP/RH, to strengthen their advocacy and communication skills, and to bring RH back into national discussion. The journalists developed, produced and recorded stories for their media. The team found one print journalist who was still working at her paper on the health beat and still published articles on FP/RH. Time was too short to seek out the other trainees. However, it would seem useful to determine whether or not more journalists should be trained.

II. E. 2.d Government Regulations

PPMV. All ethical drugs have to be registered with the government. Distributors also have to be registered. IRHIN was successful in getting the Pharmacists Council of Nigeria (PCN) to approve training of PPMV who are registered with the Council in dispensing oral contraceptives.

New products. When IRHIN wants to introduce a new product, the government wants it to be free to the public. The government doesn't seem to understand that the social marketing objective is to break even, not lose money. It hopes to recover the cost of bringing a new product to market. Without donor subsidies, social marketing organizations like SFH would go out of business.

USAID's procurement regulations are often a problem for SFH and its partners. Both waivers of the buy America policy or approval for construction can take six months, which delays or slows down some project activities.

Stockout borrowing is commonplace in the marketplace. When SFH or the government runs out of a certain contraceptive it borrows or buys the contraceptive from the other provider. The alternative is to deny FP to its clients. However, USAID has a strict policy against its contraceptives being sold or loaned to public clinics. This causes tension on both sides, but the policy is frequently ignored.

II. E. 2.e. Costs

Contraceptive costs. Some potential acceptors of FP/RH believe that the services and contraceptives should be free. They won't take a method that they have to pay for, or they search for the cheapest provider. This seems to be a cultural norm. Some PE and IPC "volunteers" expect to be paid. Some women expect to be paid for attending a group discussion. While many women are willing to pay something for FP methods, and most believe that the prices are low and reasonable, the importance of cost affects acceptance, continued use, and drop outs. Small profit margins cause some PPMP to drop out, also. When campaigns gave IUDs away for free, the number of new acceptors increased sharply.

Price fluctuations also affect use. While IRHIN social marketing prices are regulated and generally stable and reasonable, even they have fluctuations, especially when supplies are limited or unavailable due to stock outs at government facilities. There are seasonal variations, as well. Sales tend to go up toward the end of the year.

Monitoring prices is feasible at the wholesale level. The IRHIN detailers monitor prices by looking at invoices regularly. However, sales at the retail level, especially among PPMV cannot be

verified. The PPMV do not record sales and do not make out invoices. And there are just too many PPMV for a distributor to monitor more than a handful. The detailers try to make the case for keeping prices low and consistent so as to make money via volume of sales, not just prices. Whether this works is unknown. Pathfinder tried to get retailers to keep sales records, but that didn't work and it was dropped.

II. E.2. f. Advocacy

Forum. IRHIN also was instrumental in organizing a Religious Leader's Forum in 2006 on maternal mortality reduction. This led to the formation of a national consultative interfaith forum that meets twice a year.

HMO. SFH collaborated with PSP-One and Total Health Trust (THT) to train providers working with the THT Health Maintenance Organization (HMO) on its Managed Care and Family Wellness Programs (MCFWP), which includes family planning as a key component. Providers from Abuja, Lagos, Nasarawa, Bauchi, and Kano were trained on FP in 2007.

Women's Groups. Advocacy visits were paid to faith-based women's groups (NASFAT and CHAN) in 2006. In 2008 a workshop for female religious workers on maternal and child mortality was held in Kaduna. Some 41 women leaders from Christian and Islamic faiths attended.

Conclusions

There are only two indicators for this IR, neither of which is particularly reflective of the IR objective to strengthen the enabling environment:

- Percent of all women 15-49 and men 15-64 who believe that parents, community leaders and religious leaders support the use of FP by couples
- Provision of data to FMOH and NACA for HIV/RH policy formulation

The qualitative conclusions, based on IRHIN reports and field interviews, are that some improvements have been made in reducing opposition to family planning and increasing government support, but that much more needs to be done before the government will take the lead in providing FP services and commodities throughout the country.

Recommendations

Social marketing should continue its advocacy efforts at both the state and national levels. Particular attention is needed to bring FP services and contraceptives to people in rural areas where unmet need is high. Relevant indicators for this IR need to be developed and tracked.

II. D. 3. Expanded Demand for Reproductive Health Services and Products

Demand creation is a major aspect of the IRHIN projects using a strategy borrowed largely from social marketing concepts. The two components of demand creation outlined in the project cooperative agreement are mass media and interpersonal communication. The team added IEC as a third component. The need for the mass media, interpersonal approaches and IEC materials is based on the need to reduce misperceptions, overcome resistance and increase demand for family planning in the country. The evaluation examined strategies used to improve knowledge about family planning, methods availability and affordability.

II. D. 3. a. Mass Media

The mass media strategy that was used in demand creation since the inception of the IRHIN project is a combination of radio and TV slots and outdoor messaging using billboards. SFH capitalized on, and expanded the radio drama series titled, "One Thing at a Time" that had been in existence even before the IRHIN project started. The radio drama aired in 40 stations nationally was programmed into 26 spots, one per week for six months, and then repeated for the second half of the year. The radio drama is currently been aired nationally in Hausa, Igbo, and Yoruba, the three major languages spoken in Nigeria. Aside from the radio drama series, which integrates family planning and HIV/AIDS messaging, reports from key informant interviews showed that SFH have four spots on radio addressing child spacing benefits.

TV spots aired nationally in Pidgin English highlights the health benefits of child spacing to the mother, the husband, and the family. The typical scenario is of two poor families, one spacing their children while the other does not. The outdoor messaging was not being used at the time of this evaluation. However, reports suggest that about 100 billboards were strategically located throughout the country for about two years. They were not continued due to a lack of funding.

One of the PMP indicators is exposure to radio and TV campaigns. Specifically, the indicator is number of people who have seen or heard a spedcific USG-supported FP/RH message. There are no baseline, target or mid-term data for that indicator. However, there are relevant data from a Nigerbus survey that was carried out in February 2008.

Three media campaigns were carried out during the Nigerbus. One was a campaign called Radio Drama. The other two were campaigns on child spacing, one on the radio and the other on TV. The results show that all three campaigns attracted similar, large audiences.

Table 5: Mass Media Campaign Exposure

Campaign	Male	Female	Male	Female	Total Number Exposed
Radio Drama	26.8 %	26.5 %	9,947,038	10,009.250	19,956,288
TV Child Spacing	20.6 %	23.4 %	7,254,038	7,378,549	14,632,587
Radio Child Spacing	22.0 %	20.0 %	7,747,031	6,306,452	14,053,483
Total					48,642,358

SFH held one mass marketing campaign for family planning during this project, in 2008. Unfortunately, they have not had sufficient funds to continue the outreach. This should be corrected in the next project.

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II. D. 3. b. Inter-personal Communications

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SFH and Pathfinder have used "intensive community outreach" to create demand. SFH implements the community outreach approach by identifying and adopting communities where there is a considerable level of misinformation. The adoption of communities is localized through the involvement of SFH field offices and CSOs in the locality. There are 18 of these sites throughout the country. The outreach approach used interpersonal communicators (IPCs) and peer educators (PEs) to intensively engage people about the benefits of child spacing and to make referrals to FP providers for those people who wish to adopt a method. SFH supported each site for one year, which was thought to be enough for the communities to continue the program by themselves. Results of field visits of the MTE team and from the NARHS suggest that this community approach is yielding positive results. Whether they can be sustained without outside funding is a question that needs to be explored.

II. D. 3. c. IEC Materials

IEC materials include pamphlets, flyers, posters, flip charts and other visual aids that help outreach workers use to convey messages to target audiences. IEC materials were difficult to find in most sites that were visited by the team. More clients need to be exposed to IEC materials on continuous bases at the health facilities and at PPMV shops. There is a need to tap into missed opportunities on outdoor advertising, which was virtually non-existent as of the time of this evaluation.

Conclusions

There are 12 indicators for the Demand IR. All but two of these show a decline from the baseline to the mid-term assessment. The intention to use FP in the next 12 months rose from 8 % to 20 % for men and from 8% to 13% for women. The belief that FP can lead to infertility declined from 36% to 23% for men and from 33% to 22% for women. The remaining four belief indicators all declined: the belief that FP/CS is effective; the belief in the efficacy of condoms; the belief that contraceptives are easy to obtain – all declined, and for all methods. These data indicate that demand creation is low and declining.

Surprisingly, the indicators of distribution of contraceptives all show modest increases. Condoms exceeded the baseline by 37 million. OCs were 2.3 million over the baseline, so were injectables. Even IUDs exceeded the baseline by 32,000.

It is tempting to say that interpersonal communication through community outreach seems to have more immediate effects on changing misconceptions about family planning than the mass media. Evidence from the beneficiaries that were interviewed attest to this assertion. However, both are required. Mass media are effective in reaching a large proportion of the target audience, but IPC is effective in bringing about behavioral change.

Recommendations

More effort is needed in both mass media and IPC, as they are complementary. Both will be needed in the two states that are going to be the focus of the follow-on project. In addition, more IEC materials are needed to complement key messages conveyed by mass media and IPC. Materials are especially needed for PPMV and the intensive community outreach sites.

The team also strongly recommends that, in the follow-on project, that there be a nationwide multi/mass media family planning campaign on an annual basis.

II. D. 4. Increasing Access to Reproductive Products, Services, and Materials

SFH has an impressive commodities distribution architecture based on long standing work and experience with transport companies like the Manufacturers Delivery Service (MDS). This section discusses efforts put into increasing access to modern family planning methods.

II. D. 4. a. Addressing Coverage Gaps through MAP Analysis

There are five indicators for this IR. Four of them address coverage, as measured by the MAP surveys. Baselines ranged from 45% to 85% while targets ranged from 60% to 90%. Actual coverage at mid-term ranged from 49 % to 68% for the established contraceptives (OCs, Gold Circle, and Depo-provera). See Table 1 in Annex X for more details.

Table 6: Coverage of Selected Contraceptives: 2008

	Duo Fem	Post-inor 2	Noris-terat	Depo Provera	Cop-per T	Gold Circle	Life Style	Norig-ynon	Preg non
Coverage	75%	50	41	49	NA	68	18	7	11
Quality 1	17%	4	5	8	NA	20	2	1	3
Quality 2	71%	49	39	47	NA	68	18	6	10
Quality 3	24%	33	11	17	NA	29	20	<20	<20

Coverage = product sold within a walking distance of 20 minutes in an urban locality and 30 minutes in rural; Quality 1 = Outlets display promotional materials; Quality 2 = product available at time of visit; and Quality 3 = product sold at recommended retail price.

The MAP surveys, which have been conducted since 2006, provide valuable information to wholesalers, detailers, and management, in particular. The surveys have included specific recommendations that SFH has not always acted upon. The latest survey (2008) strongly recommended that SFH "improve on coverage and quality of coverage for all products." The report also said that "both urban and rural communities will have to be strategically reached with intensified coverage…[22]"

II. D. 4. b. Distribution and Detailing Strategy

Product distribution starts from the SFH warehouse in Lagos. The warehouse in Lagos does packaging of products ranging from condoms to injectables, and copper T. This is a massive endeavor, involving hundreds of workers. Trucks are assigned at the warehouse to deliver products to MDS locations in states all around the country. From these locations, selected wholesalers, who are registered with SFH, buy products which are then either distributed to or picked up by the PPMV outlets, hospitals, maternities, pharmacies and others. Recent efforts by SFH to bring packaging of products closer to the distribution chain is seen as a positive step that should reduce time and costs.

SFH has 16 detailers spread around the country. They are the key to supply and demand for contraceptives. One detailer said that his mornings are spent with nurses, midwives and physicians creating demand and taking orders. Afternoons are spent delivering supplies. The detailers enlist whoever is available to help with distribution, which helps to keep costs down. The detailers check invoices to make sure that sales are within the recommended price. They are also responsible for finding and training PPMVs.

The major problem is stock outs. Noriygon was out of stock since May. Noristerat was under-ordered, causing shortages everywhere. Sometimes products get stuck at the docks, which also affects delays in distribution.

The success of the distribution system is evident from the increase in CYPs from 2.06 million in FY06 to 2.33 million in FY07, and 2.7 million in FY08.

The table shows actual sales compared to projected sales from 2006 through 2008. The table shows a steady increase of sales each year. Measured by CYPs, there was an increase of 300,000 CYP each year over the previous year. Condoms accounted for the largest contribution, just over 60 percent of all sales. They were followed by Duofem (14%), Depo Provera (10%), IUDs (7%) and Noristerat (6%). Those five contraceptives accounted for 98% of the CYPs

[22] MAP 2008, p. 15.

Table 7: Actual CYP, 2006-2008

Product	FY06 CYPs Achieved	FY07 CYP Achieved	FY08 CYP Achieved	Total CYP	Percent CYP
Depo Provera	179,375	239,875	307,925	727,175	10.2%
Duofem	302,310	321,720	372,440	996,470	14.0%
IUCD	139,158	195,930	190,050	525,138	7.4%
Condoms	1,342,339	1,414,735	1,564,841	4,321,914	60.9%
Noristerat	104,867	149,333.00	183,017	437,216	6.2%
Postinor2			51,920	51,920	0.7%
CycleBeads	1,740	10,000	18,800	30,540	0.4%
Norigynon			3,730	3,730	0.1%
Jadelle			1,785	1,785	0.0%
Pregnon			3,323	3,323	0.0%
Total CYP	**2,069,788**	**2,331,593**	**2,697,831**	**7,099,212**	**100.0%**

*Note: The projected figures are from the Cooperative Agreement on Contraceptive Social Marketing in Nigeria signed in June, 2005. See Table X in Annex Y for details.

There was a problem setting targets. The PMP targets were: 1,025 million units for condoms; 29 million for OCs; 3.5 million for Noristerat; 4 million for Depo; 271 thousand for IUDs; and 13.4 million CYPs. Most of these targets are so high that they must be in error.

II. D. 4. c. Sustaining Access to Products and Services

As mentioned previously, the detailers are the key to both distribution of supplies as well as demand creation. While it is possible to check regularly with large clients, such as hospitals and pharmacies, it is more difficult to meet regularly with PPMV to make sure they are receiving their supplies quickly. Attendance at PPMV meetings is one avenue for maintaining contact, but those meetings could have 700 PPMVs in attendance. It seems imperative to expand the number of detailers and sales agents to make sure that client contact is maintained.

Another marketing strategy underway is the introduction of a mid-priced pill. SFH is partnering with PSI in this exercise. Together with market segmentation, this approach could lead to significant cost recovery, thus reducing the need for large subsidies.

II. D. 4. d. Increasing Access through Community Outreach

PR and IPC. Evidence from the MAP surveys and the field visits by the evaluation team suggest that increased access to family planning may have been achieved through community outreach activities. Considerable numbers of trained IPCs and PEs have engaged their respective communities on family planning benefits and sources of methods. Beneficiaries interviewed during the course of this evaluation corroborated this fact. Most of the beneficiaries interviewed during the field trip reported been referred by the IPCs, and PEs to either a public or a private facility. These community intensive sites are typically led by a CSOs located in or near the site. As such they have the advantage of being familiar with the local population and can work easily with community and religious leaders in the area.

Sustainability. The biggest problem with this model is that it only receives IRHIN support for one year. This is enough time to recruit and train PEs and IPCs and, perhaps, a provider from the area. But after a year, program support ends. Most of the sites visited acknowledged that they would not be able to carry on for more than a few months without technical and financial support. They point

out that staff leave or look for work elsewhere when the support comes to a close. SFH argues that a sustainability structure is put in place before the exit date and that should be enough for the sites to continue working. This seems unlikely and SFH will need to assess this approach as soon as possible, since a number of sites have already been affected.

II. D. 4. e. Increasing Private Sector Presence

The social marketing concepts of commodities distribution has been gaining acceptance in the health sectors in the country. As of June 2009, 51 wholesalers are registered with SFH nationwide. The numbers of PPMV that have received training from SFH has been on the increase since the inception of the IRHIN project. Reports suggest that over 4,000 PPMVs have been trained each year. Also, more private clinics and hospitals are likely to participate in the project because of its cost recovery approach. However, it is difficult to identify private manufacturers to partner with due to low margins, limited product lines, and investment requirements. Nevertheless, SFH has been able to introduce several new contraceptives, including Jadelle, Lacon F, Misoprotol, CycleBeads, and Lifestyle.

Conclusions

There are differences in the coverage levels of family planning products/services across the country. The coverage level of established products like Duofem and Gold Circle is quite good. Noristerat, Depo Provera, and Prostenol 2, are in a fairly adequate range. Increasing coverage of these, and the lower-rated methods like Lifestyle, Norigynon and Prenon should be a priority for FHS. Of even more concern is the low quality of coverage of products/services in delivery points across the country.

Recommendations

- Linkages between wholesalers/detailers and retailers (such as PPMVs and CSOs/CBOs) should be strengthened to ensure that adequate stocks are readily available in rural as well as urban areas.

- IEC and point-of-sale materials should be more readily available at the retail level. These materials are critical to outreach workers, such as PEs, IPCs and providers, so that they can reinforce messages about the benefits of FP as well as the range of contraceptives available.

- SFH should examine ways to reduce or eliminate stock outs. For example, by establishing "buffer stocks" or emergency supplies at warehouses that can be tapped to fill unexpected gaps. USAID should relax its distribution policy so that public and private stocks can be loaned to each other in cases of emergency.

- SFH should also explore new ways to monitor prices to eliminate artificial increases in prices at retail levels. For example, mystery shoppers can be useful in identifying vendors who jack up prices.

II. D. 5. Project Management (JR)

Organization. It is important to keep in mind that SFH is a large, complex organization and IRHIN is a relatively small part of that organization. SFH's primary interventions span the nation in family planning, HIV/STI prevention, malaria prevention and treatment, and waterborne illnesses. SFH has an annual budget of over $80 million, over 200 employees and 16 regional offices, in

addition to its headquarters in Abuja.

As such, SFH brings a good deal of management experience to the project at both the national and state levels. Its two principal partners – Pathfinder and PSI – also bring a lot of experience and expertise. SFH is the prime recipient and takes responsibility for social marketing and community organization. SI is the prime for international consultants who provide financial and technical support. Pathfinder is the lead partner for provider training and clinic-based support.

Planning and Reviewing receives a lot of attention, in part because of the large number of organizations involved and the need for coordination. There are annual partner meetings to review progress against key performance indicators and to develop detailed plans for the next quarter and year. Pathfinder has quarterly meetings where the participants discuss what each group is doing and develop action plans for the next quarter.

Staff Training/Capacity Building is so important to SFH that it could be seen as part of the corporate culture. Training is not only to build project-level skills but also to help its employees advance in their careers and in life. One detailer noted that she has attended six training events in the past two years, all sponsored by SFH. Staff who come from the private sector need training in how the public sector works and how FP, RH, HIV and malaria interventions work. There is also a lot of turnover in these projects and training is needed for replacement staff, as well.

Linkages and Coordination SFH purposely establishes linkages with local and international organizations, both public and private. Examples include SACA (HIV), GHAINS (HIV referral), CHSORESS (local CSO, Pathfinder, PSI, WHP, the state MOH, general and teaching hospitals. This is another corporate culture characteristic of SFH. The linkages expand SFH's ability to do more than it would be able to do alone, and enables them to build capacity among local organizations.

Sustainability is an important issue for SFH. Many of the CSO projects do not have the funds to continue projects started under IRHIN. Even SFH staff concede that the projects will "die" once donor funding ends. People who have been trained under the project (physicians, nurse-midwives, and outreach workers) are already seeking "greener pastures." There is concern that both the clinics built up by Pathfinder and the outreach programs developed by SFH and its partners will not last long after their support ends.

Expansion/Scaling up is under discussion among staff. Both Pathfinder and the SFJ models were designed to be easily replicated. Several of the staff noted that if there were more money they would go to other states where the need is greater and private sector activities are limited. If they had to work with the public sector they would select sites where there were no other donors. The current system fosters duplication, overlap and "cherry-picking." Some staff suggested working in places like Ebonyi where the need is very high and there are few services. A second priority would be to conduct more IUD campaigns. The ones they have sponsored have produced 50-100 new IUD acceptors in a single day. A third priority would be to extend the intensive phase of the CSO projects to 24 months, and/or to provide more TA.

Private Sector Involvement. Getting more private sector providers (both doctors and nurses) is difficult. They are in businesses and are profit-oriented. There is not much profit in FP. As noted above, experience to date seems to indicate that once trained, they tend to leave for better-paying jobs. Sending providers to rural areas would be very problematic unless the providers were from those remote areas. MOH nurses tend to be transferred to other sites and/or specialties (e.g., emergency, infectious diseases, etc.). The MOH believes that nurses should be able to work in all departments, not specializing in any, such as FP.

Conclusions. The IRHIN project seems to be very well organized and managed. SFH has just undergone a major restructuring, so it will be important to monitor performance over the next year. SFH's capacity building philosophy also seems to work well for the benefit of staff as well as the organization. The numerous linkages to other organizations and projects also seems to work well. This allows SFH to carry out more than it would be able to do alone. Sustainability of project services is a serious issue that needs to be addressed right away. There is a good chance that all of the clinical and outreach interventions that they have undertaken will end when donor funding ends. Until that is done, expansion would be risky.

Recommendations. Continue to carry out the good management practices, including capacity development and linkages with other organizations. Sustainability needs to be given immediate attention. There is no point in continuing to establish new service delivery sites if they are going to end as soon as SFH support ends. In the meantime, consider extending these sites for another 6-12 months while a sustainability strategy is worked out.

II. D. 6. Research, Monitoring and Evaluation

The team was impressed with the quality and utility of research and M&E activities. The data and reports are definitely useful and "actionable." The IRHIN project incorporated key data sources for performance management of the project throughout its life cycle. The Nigeria Demographic and Health Surveys (NDHS), the NARHS, Nigerbus surveys, MAP/distribution surveys, and quality assurance surveys are the key population-based surveys employed to monitor and evaluate the project. Other methods used include qualitative research, process monitoring indicators, and equity measurement.

The NDHS and the NARHS were not designed to cover all of the core IRHIN activities. However, aspects of the NARHS on misconceptions about family planning, and exposure to targeted mass media social marketing are highly relevant and have been used to track changes of some indicators. Complementing these surveys are more specialized surveys. The Nigerbus data focus on exposure to the media, while the MAP is relevant to understanding progress on coverage and quality of access to family planning and reproductive health. Qualitative data have been used to corroborate or tease out issues in the implementation process that were not addressed by population-based data. Routine MIS information has been collected each quarter to measure contacts, referrals, visits and sales data.

Evidence from team visits to the states showed that much of M&E activity were initiated by and controlled from SFH headquarters in Abuja. This is understandable given that the social marketing component is national and the CSO intensive community sites are found in 18 states. However, there have been occasions where local research and M&E are needed. The three Pathfinder states are an example.

Apparently, no dedicated M&E officers have been stationed in the states or regions. SFH is now recruiting for such positions. This should be especially useful in the two states that will be the focal point of the new project.

Conclusions

Research, monitoring and evaluation are impressive in IRHIN. However, there are numerous gaps in the PMP, in particular. Not all of these can be filled by the various surveys and M&E requirements. In addition, the lack of M&E officers in the field limits the collection and analysis of indicators measuring the accomplishment of key interventions.

Recommendations

- There is the need for the population-based surveys to reflect more of the IRHIN project indicators. The delay in distribution/MAP survey information feeding into programming on coverage and quality can be reduced by using rapid appraisal techniques instead or combine with the MAP surveys.
- Having a dedicated M&E officer in the field will enhance quality and timeliness of the information collected for programming.

E. CROSS-CUTTING ISSUES:

There are a number of issues that apply to all projects. First, there are several questions that the team was asked to address directly that have not been dealt with in the document so far:

- **Are the interventions adequate for a significant health impact on RH/MCH?**

  This is a difficult question. The answer is clearly yes if one only looks at the individuals whose lives have been saved or changed by the intervention. However, being able to measure a project's success on a population basis is much more dismal.

  Acquire has provided services to 1500 women to date over the life of the project so far: 800,000 women need fistula repair and the number of women nationwide who develop fistulas nationwide are far greater than the number of women who have been healed.

  ACCESS: A relatively small percent of deliveries in their local catchment areas come to hospital for complicated deliveries, partially because of cultural practices, partially because of lack of transport in an emergency, partly because most women's experience with government hospitals has not been helpful. In addition, few TBAs bring their patients to even project hospitals for fear of losing their fee or of being berated by the hospital staff. We do not have sufficiently fine data to pick up changes at the LGA level in maternal and neonatal mortality and morbidity.

  IRHIN: An increase of 300,000 CYP per year does not keep up with population growth. The DHS shows a modest growth in CPR from 8.2 in 2003 to 9.7 in 2008. Other surveys are inconsistent and generally show a lower growth rate. Actually getting to the point where fertility and population growth rate begin to fall will take a great deal of effort.

- **Are the current project geographic areas rational?**

  Acquire: Initially, it was believed that fistulas were a problem that applied mostly to the North of Nigeria. The decision to support five existing fistula hospitals in northern states was appropriate. Fistula repair—as opposed to secondary prevention—is a highly refined surgical technique, and it is appropriate to concentrate these services in specialist facilities. With the growing recognition that additional clinics are need in the south one new facility is being opened. However, the south may need two three more facilities to be able to use the 'pool' technique.

  ACCESS: Distribution across widely separated LGAs means that it is difficult to provide proper support. It is difficult for the small staff to do effective monitoring and on-site training if they have to spend hours on the road to get to the scattered clinics. This is most notable in Katsina. While ACCESS is doing better in in Kano and Zamfara, we believe that either clustering LGAs or operating at the State Level providing services to all LGAs will be more geographically realistic.

  IRHIN: The Social Marketing program operates appropriately nationwide, and has synergies with GHAIN and the Malaria Initiative. However, the numbers of PPMVs and Detailers is too small to cover the entire program. In the future, at least the focus states need to have deeper coverage.

  Pathfinder is spread too broadly to have an impact. The program should spend the rest

of the time remaining in the current project to improve successful clinic sites, and then spend time working with local providers to create a new intervention model for Bauchi and Sokoto.

We were not able to see any of the other trained providers from eighteen states to determine whether this is a geographically sound approach. They should be surveyed to determine the extent to which they have become effective providers of goods and services.

- **Compatibility, Synergy, Sustainability:** Do the current projects respond to the FMOH's desired directions for Nigeria? How do projects work (coordinate, collaborate and seek synergy) with the FMOH/State/LGA? How can this relationship be further strengthened? How does the program complement other RH/MCH services in the country?

  Compatibility: The team has reviewed FGoN policy documents, and has spoken with a few northern State health officials, but, for scheduling reasons, we were unable to meet with any officials at the Federal Level. ACCESS, to take one example, was reportedly very effective working at that level to help design policies and curricula regarding EmONC.

Synergy: We spoke with many people in the projects about synergy. Unfortunately, what we found was little coordination at best, and outright competition at worst. To take a single example, the IRHIN's PPMVs and private practitioners were competitors for clients in Cross River State, and both competed with the local government health centers. Other situations we learned about were worse: According to Acquire, they asked ACCESS to help with training of their outreach workers. ACCESS reportedly refused unless they were to be able to count all the CYP generated by Acquire's staff against ACCESS's targets. This is absurd. In some ways, we fault the Mission for allowing the number counting to get ahead of project implementation.

There was very little coordination with DfID—confirmed by our meetings with DfID—even though both donors had similar activities in the North. There was more coordination with State Government, and efforts to reach out to local governments.

Sustainability: We discussed this with staff from each of the projects. We believe that, at this point, none of these three activities are sustainable without continued donor support. The one most likely to continue would be the fistula hospitals, but they have no succession plans, and their current master trainer is in his 70s. The only reason why they are sustainable is that they represent a 'feel good' project, and other private and public sector donors are likely to step in and fill the gap. To be realistic, three years of effort is not sufficient for almost any activity to become self-supporting. At this point, we estimate that it will take major donor—and government commitment—to continue for at least 10-20 years.

Gender Equality: One of the most striking things about Nigeria's work is that all projects have made good progress in incorporating men and community/religious leaders in their outreach efforts.

Other Significant Issues:

- Poor Data Quality: This is a problem that the Mission needs to address immediately. We did not see PMPs either for the Health office of the Mission, or for any implementing partner

except IRHIN—and even that did not include targets for the Pathfinder program. We found the following problems:

- Access registers are not filled in sufficiently to know whether EmONC procedures are actually being carried out
- CHEWs don't understand/are not able to follow need for documentation—the Partograph not being used, registers suggest that the CHEWs do not know how to use the scales to weigh newborns, and that they grossly underestimate the number of complicated deliveries. Bluntly put, we do not believe any of the service statistics presented by ACCESS. We have no reason to doubt their non-service statistics, trainings, equipment furnished, buildings rehabilitated, etc. We also do not believe their CYP estimates, since in many sites FP services are actually provided by a government facility instead of ACCESS.
- Acquire provides no contraceptives but continues to report CYP. They do, however, counsel women who have had surgery on contraception, but they refer the women elsewhere for service and commodities.
- Pathfinder project design does not recognize contraceptive seeking behavior in Nigeria and therefore consistently underestimates the program's accomplishments.

Inadequate Funding: The Team believes that, for the projects to date, USAID has not had sufficient resources to begin to meet needs: $13.5 million is absurd to try to do social marketing across the country. Indeed, the only reason why they have succeeded so well is that some management and logistical activities have been costed under other USAID projects. In addition, the USAID staff numbers are grossly inadequate to monitor and manage the projects: Joyce Holfeld recommends at least six staff headed by two direct hires, and we agree with that assessment. While we have not costed out a new private sector project, we feel that it should be equally as large as the TSHIP award.

Project Staff Mobility: this has been adequately discussed under each of the projects, but it is worth repeating: As soon as public sector staff begin to be trained, they are transferred elsewhere, leaving a vacuum behind. This is even true of the two most experienced trainers in the fistula project. Unfortunately, the private sector has same problems with staff leaving to seek better employment elsewhere

Lack of basic facilities: These have also been discussed in depth: Lack of Electricity, Lack of Water, Lack of Ability to Sterilize Instruments, Lack of Transport, and Run-down hospitals and clinics

Future USAID/Nigeria Health Programming

The Mission requested that we look at specific issues concerning future Health work in Nigeria:

- Lessons Learned: These have been adequately addressed above.

- Greatest Impact:
  - We agree with the Mission's decision to focus on two states for most public and private sector efforts.
  - We feel that there is an enormous unmet need for FP across the Nation: This means that the Mission needs to increase CSM efforts with an emphasis on increased supply/logistics and frequent Mass/Multi Media Campaigns.

  - We feel that Fistula Training should be incorporated into core and specialist medical training.
  - We feel that there should be an effort to offer a full range of services away from fixed clinical facilities: The PPMVs are one good effort, but they need to be markedly expanded. We feel that there should be FP outreach, with skilled providers in all methods at places where people congregate regularly, such as market days.

- Balance between Service and System Strengthening
  - At this point, the project should focus on service srovision with enough system strengthening to address immediate obstacles, i.e., frequent staff transfers, preference of LGAs for cheaper, poorly skilled CHEWs at health facilities. As we have learned over the past 40 years, there is no upper limit to the demand for 'system strengthening', and there is almost no lower limit to the impact that most efforts have. It will take years of relatively low level efforts to bring most LGAs—and even states—to the point where they can manage all parts of their local programs.

- Future Directions in supporting the Three Levels:
  The work to date has been good, but it depends more on the interests of the individuals individuals in top positions rather than any structural improvements. Extremist attacks, such as those we saw on the last day the team was in country, can easily wipe out a decade of careful work. That they occurred in one of USAID's intended Focus States, Bauchi, is ominous.
  - We feel that USAID and its implementation partners need to work at all levels to increase the recognition that Family Planning/birth spacing is critical to achieving ANY health objectives
  -
- Strengths:
  - The Society for Family Health is an extremely experienced CSM organization. We believe that it has the capacity to move to scale
  -
- Innovative Programs:
  - Innovative Fistula Repair Program
  - Innovative outreach to Men, Community and Religious Leaders
  - Innovative approaches to women's credit for support for peri-natal care
  - Little innovation in other programs: Seem to be replicating work done elsewhere without considering Nigeria's unique needs

Conclusion:
There is no need to reiterate what has been said above. Each member of the team believes that the USAID/Nigeria Mission and its Implementing Partners did a very good job given the constraints of the environment, staffing and funding.

To paraphrase Joyce Holfeld: The ground may be softening, but there's a lot of work ahead that requires dynamite and pick-axes.

IV. ANNEXES

A. Scope of Work

USAID/NIGERIA MCH/REPRODUCTIVE HEALTH PROGRAM

Mid-term Evaluation

Scope of Work

(Revised: 05-19-09)

I. Purpose

The purpose of this mid-term evaluation is to provide USAID/Nigeria Investing in People (IIP)/Health, Population and Nutrition (HPN) Team with sufficient information to make programmatic and budgetary decisions regarding future directions. The evaluation will focus on USAID/Nigeria's public sector projects, "ACCESS/MCHIP and "Acquire/Fistula Care," both implemented through field support mechanisms, and the bilateral private sector project "Improving Reproductive Health in Nigeria" (IRHIN) implemented by the Society for Family Health. The evaluation will outline opportunities, challenges and critical areas to address and make recommendations on the most effective and efficient (i.e., operating within the implementation cost) path forward under the follow on period. The evaluation will look at the performance of each project through June 2009.

II. Background

Nigeria has among the worst health indicators in the world. Maternal and under five mortality is estimated at 1,100/100,000 and 201/1,000 deaths respectively. Total fertility is 5.7 births per woman with only 3 percent of women using modern contraceptive. USAID's has a long history of activities in the health sector, including MCH, family planning and reproductive health implemented both in the public and private sector. Under the Mission's current (2004-2009) strategic plan, USAID aims "*to increase use of social sector services"* under its Strategic Objective (SO) 13 and meet its four intermediate results: *1) IR 13:1 Improved quality of social sector services; 2) IR 13:2 Strengthened enabling environment; 3) IR13:3 Expanded demand for improved social sector services and 4) IR 13:4 Increased access to services, commodities and materials* to assist the Government of Nigeria to improve the quality, access and use of social sector services. USAID has various mechanisms in place to attain its health SO including bilateral programs and field support/central mechanisms; the focus of this midterm evaluation will be on the following three projects:

ACCESS/MCHIP: (1/06 to 12/09): ACCESS/MCHIP supports the utilization of quality Emergency Obstetric and Newborn Care services (EmONC) including birth spacing/reproductive health and family planning) by pregnant women, mothers and their newborns in three states: Kano, Katsina and Zamfara. The project is implemented in Nigeria by JHPIEGO.

Acquire/Fistula Care (10/06-10/11): This project supports comprehensive fistula prevention, repair and community based integration and family planning activities in five states: Kebbi, Sokoto, Zamfara, Kano and Katsina and is currently expanding to two additional states: Bauchi and Ebonyi. The project is implemented in Nigeria by ENGENDERHEALTH.

IRHIN: (2005-2010): IRHIN is a national reproductive health social marketing project

implemented by the Society for Family Health (SFH), a Nigerian NGO. The project also has a small service delivery component working with private facilities in Kaduna, Abia and Cross River States.

These three projects have similar goals but different activities; therefore they are being evaluated as a "program package".

III. Scope of work

The following **illustrative questions** should be used as a guideline for the evaluation team:

Program Questions

- Are the projects on the right track and are benchmarks/results being met? What changes, if any, need to be made? What are the gaps?
- Are the interventions adequate for a significant health impact on RH/MCH?
- Discuss how the interventions are implemented. What were trends? Results achieved? Successes?
- What were the major obstacles/difficulties confronting RH/maternal health? How are these issues being addressed by the project? What were the results/achievements towards SO 13 objectives? Discuss missed opportunities, if any, for linkages with HIV/AIDS PEPFAR funded activities.
- Recommend strategies for addressing and improving linkages in the future.
- Recommend future strategic areas that need to be addressed.

Geographic Coverage

- Are the current project geographic areas rational?
- If new areas are selected in the future, what geographic coverage would make sense, considering the Mission's/health team strategic priorities, other USG programs and the FMOH's plan for strengthening the health sector?
    a.

Local Capacity Building and Local ownership

To what extent have the projects succeeded in **gaining the buy-in** and participation of government institutions at state and LGA levels? What approaches were used and what challenges did the projects face in obtaining buy-in and participation if any?

- Discuss projects efforts at capacity building (**institutional, management**, **programmatic and technical**) among grantees (NGOs including local), central government, state government, local health department, community and private sectors and where relevant. Is the project strengthening county (state/LGA) capacity to deliver health services? What are the major obstacles? How are they addressed at the various levels? What were the major break-through and accomplishments? Give evidence and site examples.

Compatibility, Synergy, Sustainability

- Do the current projects respond to the FMOH's desired directions for Nigeria? How do projects work (coordinate, collaborate and seek synergy) with the FMOH/State/LGA? How can this relationship be further strengthened? How does the program complement other RH/MCH services in the country?
- To what extent have projects sought to **coordinate** activities and seek synergies with USAID/Nigeria's other health projects, SOs, donors and local partners (NGOs, private sector)? Describe approaches used.

- To what extent the have projects improved the **enabling environment** for MCH/RH. Are the projects working towards sustainability? How and what else could be done?
- To what extent have the projects achieved **gender equity** and what approaches where used? Any challenges and gaps?

Future USAID/Nigeria Health Programming

- What are the lessons learned that should be expanded in the remaining life of the project, or follow-on project? What else could/should we be doing?
- What activities would have the greatest impact?
- What should be the balance between service and health capacity/systems work?
- What are recommendations for future strategic directions in strengthening Federal, state, LGA, NGO/private sector?
- What are the strengths and innovative activities being undertaken that should be continued, scaled-up and emphasized?

IV. Methodology

The evaluation team will be divided into two sub-teams. One sub-team will examine the public sector projects (ACCESS, ACQUIRE), and the other will focus on the private sector project (IRHIN). The sub-teams will travel separately to their respective geographical locations, and then, upon return will work together to produce a single evaluation report that discusses not only the specifics of the individual projects but also analyzes how the projects are collaborating and what are the synergies. In order to address the comparability issues due to use of two separate teams for project review, a common questionnaire/interview guide will be developed and used to collect information and guide the analysis.

The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information required to assess the evaluation questions. The methodology will be discussed and finalized with the USAID/Nigeria HPN Team once the evaluation team has arrived in Nigeria. The methodology will include but not limited to: document review, team planning meeting, key informant interviews, site visits and observation.

Team Planning Meeting

The full team will have a two-day team planning meeting upon arrival in Nigeria. The team planning meeting is an essential step in organizing the team's efforts. During this meeting, the team will produce a workplan, timeline, interview instruments, and preliminary draft outline of the report. Roles and responsibilities will be agreed upon, and the team will have an initial briefing from USAID.

This meeting will allow USAID (and the partners) to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:

- clarify team members' roles and responsibilities,
- review and develop final assessment questions
- review and finalize the assignment timeline and share with USAID,
- develop data collection methods, instruments, tools, guidelines and analysis,
- review and clarify any logistical and administrative procedures for the assignment,
- establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion,
- develop a preliminary draft outline of the team's report, and
- assign drafting responsibilities for the final report.

Document Review

USAID/Nigeria will provide the evaluation team with key documents prior to the start of in-country work for their review (many of these are located on the USAID/Nigeria web site). These will include, but are not limited to:

- USAID/Nigeria Health Strategic objective SO13 (2004-2009)
- USAID/Nigeria health result framework and standard indicators
- Draft new health strategy (2009-2014)
- IRHIN Cooperative Agreement
- Projects workplan and monitoring plans
- Projects quarterly/annual reports
- Baselines surveys
- Trip reports
- Government health strategies, policies, guidelines, and protocols

Interviews

Key informant interviews will include but not limited to:

- USAID/Nigeria HPN Team
- GON staff at federal, state, LGA level
- Projects (ACCESS/MCHIP, Acquire/Fistula Care and IRHIN) staff in Nigeria and in Washington, DC
- Health facilities staff and beneficiaries at targeted sites
- Targeted Community groups and NGOs
- Other implementers, international donors, private sector group working in partnership with each projects

Site Visits and observations

The evaluation team is expected to conduct site visits of targeted states. It should be noted that the IRHIN social marketing project is implemented nationwide, with limited service delivery aspect in select states, while the public sector projects (ACCESS/MCHIP and Acquire/Fistula care) are implemented in selected states. The evaluation team is expected to travel to sites in Kano and Sokoto.

Note about Security: The in country and actual site visit travel plan will be reviewed and cleared by the Regional Security Office (RSO) prior to any team in country travel.

V. Team Composition

USAID is looking to conduct one comprehensive evaluation of the three projects covering all the geographic zones with some geographic overlaps (they are not covering all the zones?). The evaluation team will consist of:

International

The 5 international consultants will possess the following qualifications:

- ***Team leader (responsibility for overall evaluation coordination and final report, will travel with sub-team A: public sector focus)***: a senior level consultant with extensive experience designing, managing and evaluating large and comprehensive health programs. He/She will have strong skills in assessment and analysis of USAID population and health projects and extensive experience working in Africa. The team leader will have expertise in FP/RH, excellent leadership and management skills, strong writing skills, demonstrated ability to manage a team of professionals.

- ***MCH/evaluation expert (will travel with sub-team A)***: a senior consultant with extensive knowledge and experience in evaluating public health programs with a particular focus on maternal, newborn and child health care.
- ***FP/RH expert (will travel with sub-team A)***: a senior consultant with extensive knowledge and experience in public health programs with a particular focus on public sector FP/RH programs.
- ***Private sector/evaluation expert (will travel with sub-team B: private sector focus)***: a senior level consultant with extensive knowledge and experience in evaluating public health programs with a particular focus on the private sector. He/She must have experience in evaluation and Maternal and Child Health programming.
- ***FP/RH expert (will travel with sub-team B)***: a senior consultant with extensive knowledge and experience in public health programs with a particular focus on private sector FP/RH programs.

The team leader will:

- Finalize and negotiate with USAID/Nigeria the evaluation work plan;
- Establish evaluation teams, roles, responsibilities and tasks;
- Coordinate different teams;
- Lead the discussion on site visit selection;
- Ensure the logistics arrangements in the field are complete;
- Coordinate the process of assembling input/findings for the evaluation report and finalizing the evaluation report;
- Coordinate schedules to ensure timely production of deliverables;
- Lead the oral and written preparation and presentation of key evaluation findings and recommendations to USAID/Nigeria, Government counterpart and other audiences as appropriate.

The Team Leader will be responsible for the overall planning, design and implementation of the evaluation and work coordination among team members. It will be the Team Leader's responsibility to submit a satisfactory report to USAID within the agreed timelines. The Team Leader is responsible for report writing and the organization of the debriefing presentations. Program schedules for field visits shall be discussed and prepared prior to the team's arrival in Nigeria. This plan will be finalized during the TPM.

The team members: Duties will be determined in consultation with the Team leader and may include the following:

- Assist the team with instrument development and data collection;
- Participate in data analysis and report writing;
- Assisting the Team leader as directed in all aspects of completing evaluation deliverables

Domestic

Research/Logistics Assistants (2): The team will be supported by 2 local Research/ Logistics Assistants who will provide logistical and admin support during the team work in country. The logistics assistant will work directly with and report to the team leader

Responsibilities will include:

- Arrange for copying/compiling reading materials, field visits, local travel reservations, hotel reservations, appointments with stakeholders, arranging for vehicles for appointments and on site visits, and other tasks as requested by the team.
- Participate in the development of interviews and FGD guides/training in their use;
- Conduct interviews and FGDs where needed;
- Serve as note takers and organizers during interviews and FGD;
- Participate in daily field debriefing;

- Write, revise and submit hard and electronic copies of interviews field notes to the TL.

USAID/Washington GH office *(2).* (To be confirmed by the Mission***)***

USAID/Nigeria health team

USAID/Nigeria staff will **not** accompany the consultant team to the field visits or interviews rather they will provide program support and guidance if they happen to be at the same site/state the team is visiting.

The government (at state and LGA level*)*

It is anticipated that government officials such as Ministry of Health and National Planning Commission personnel will accompany the consultant team on field visits. This will be an opportunity for government officials to learn about progress made in USG supported RH/FP interventions.

VI. Logistic Support

GH Tech will be responsible for providing logistics support for this assignment. Two Research Assistants/Logistics Coordinators will be hired to assist the team (refer to section V. above for details). USAID/Nigeria guidance on hotels and methods of in-country travel is essential and appreciated.

VII. Oversight and Management

The evaluation team will report to USAID/Nigeria HPN Team Leader.

VIII. Level of Effort and Timing

The evaluation will begin o/a late June and will require a total of eight weeks of effort on a six day work week. One/two week(s) for preparation, document review and drafting interview and FGD guidelines/questions, four week(s) of data collection and two week(s) of analysis and writing

Task/Deliverable	**Duration/LOE**							
	Team Leader	FP/RH (Team A)	FP/RH (Team B)	MCH Eval Expert	Private Sector Eval Expert	Research/ Logistics Assistants (Team A)	Research/ Logistics Assistants (Team B)	*MOH/ GON Officials
Review background documents & offshore preparation work.	5	3	3	3	3	2	2	0
Phone interviews and meetings with ACCESS/MCHIP	3	2	2	2	2	0	0	0

Task/Deliverable	**Duration/LOE**							
	Team Leader	FP/RH (Team A)	FP/RH (Team B)	MCH Eval Expert	Private Sector Eval Expert	Research/ Logistics Assistants (Team A)	Research/ Logistics Assistants (Team B)	*MOH/ GON Officials
& ACQUIRE staff								
Travel to Nigeria	2	2	2	2	2	0	0	0
Team Planning Meeting and meeting with USAID/Nigeria	2	2	2	2	2	2	2	
Meetings and interviews with key informants (stakeholders, USAID staff) in Abuja	5	5	5	5	5	2	2	
Information and data collection Kano, and Sokoto (maybe another site).	12	12	12	12	12	12	12	
Discussion, analysis and draft evaluation report preparation in country.	6	6	6	6	6	4	4	
Debrief meetings with USAID and key stakeholders (**preliminary draft report due to USAID**)	2	2	2	2	2	2	2	
Depart Nigeria /Travel to US	2	2	2	2	2	0	0	

Task/Deliverable	**Duration/LOE**							
	Team Leader	FP/RH (Team A)	FP/RH (Team B)	MCH Eval Expert	Private Sector Eval Expert	Research/ Logistics Assistants (Team A)	Research/ Logistics Assistants (Team B)	*MOH/ GON Officials
USAID & partners provide comments on draft report (out of country) – 10 working days								
Team revises draft report and submits in final to USAID (out of country)	5	4	4	4	4	0	0	
USAID completes final review								
GH Tech edits/formats report (one month)								
Total Estimated LOE	44	40	40	40	40	24	24	

A six day work week is approved when team is working in country.

IX. Cost

The cost will be determined once the team composition is finalized

VIII. Deliverables

The following deliverables will be submitted to USAID/Nigeria HPN Team Leader. The timeline for submission of deliverables will be finalized and agreed upon during the team planning meeting:

- A work plan specifying the deliverables, draft interview and FG instruments, and a timeline upon the completion of the team planning meeting.
- In and out briefings with key mission personnel including the MD and a PowerPoint presentation of findings and recommendations to USAID. The Team will consider USAID comments and revise the draft report accordingly, as appropriate.
- Draft report in both hard and electronic formats - A draft report of the findings and recommendations should be submitted to USAID/Nigeria prior to the Team Leader's departure from Nigeria. The written report should clearly describe findings, conclusions and recommendations. USAID will provide comment on the draft report within two weeks of submission.
- Final report in both hard (xx hard copies) and electronic format.
  GH Tech will be responsible for editing and formatting the final report, which takes

approximately 30 days after the final unedited content is approved by USAID. GH Tech makes its evaluation reports publicly available on its website and through the Development Experience Clearinghouse unless there is a compelling reason to keep the report internal (such as procurement-sensitive information).

Note: USAID is looking for one consolidated report containing findings on the three projects.

B. Persons Contacted

ACCESS, Abuja

Professor Emmanuel Otolorin	Country Director
Dr. Tunde Segun	Senior Programme Manager
Dr. Gbenga Ishola	Senior M&E Officer
Ms. Awele Ekpubeni	Senior Finance & Admin Officer
Deji Adeyi	Senior Program Assistant

ACCESS, Kano

Hannatu Abdullahi	MCH/RH Coordinator
Samaila Yusuf	Community Mobilization Officer
Aminu Idris	Finance & Admin Assistant

Kano State & Hospital Officials

Hajiya Aisha Isyaku Kiru	Commissioner for Health
Hajiya Sa'adatu Nataalah	National Coordinator FP
Hajiya Asmau Ahmed	Safemotherhood Coordinator
Dr. Garba Tella	Medical Officer I/C Gezawa General Hospital
Bashir Magaji	Community Health Officer in Charge Babawa PHC
Yahaya Jogana	Babawa Community Mobilization Team Leader
Pat Okonkwo	Nurse/Midwife
Haladu Mohammed	Ward Focal Person

ACCESS, Katsina

Amina Sule	MCH/RH Coordinator
Sogiji Ibrahim	Community Mobilization Officer

ACCESS, Zamfara

Dr. Shittu Abdu-Aguye	Program Officer
Zaynab Nyako	Community Mobilization Officer
Salamatu Bako	Clinical Officer
Aliyu Adamu Tsafe	Strategic Information Officer

Zamfara State & Hospital Officials

Hajiya Zainab Haliu Anka	Commissioner for Women & Children's Affairs
Dr. Muhammed Bello Buzu	Executive Chairman, Hospital Services Management Board
Mohammed Mustapha	Secretary, Hospital Services Management Board
Ibrahim Nahushe	Director, Nursing Service
Mr. Zurumi	Deputy Director Finance
Engr. Haliru Garba	Director Services
Dr. Ibrahim	Medical Director, King Fahd Women & Children Hospital
Hajiya Ladi Dawa	Matron, King Fahd Women & Children Hospital
Sanni Mada	Deputy Director Health, Mada PHC/Community Mobilization Officer
Hajiya Ladi Gusua	CHEW, Mada PHC
Dr. T.M. Moriki	Principal Medical Officer, Zurmi General Hospital
Ramatu Usman	Matron, Zurmi General Hospital
Ajuji M. Rector	FP Clinic, Zurmi General Hospital

ACQUIRE, Abuja

Iyeme Efem	Country Project Manager

Kano State & Hospital Officials

Hajiya Aisha Isyaku Kiru	Commissioner for Health
Hajiya Sa'adatu Nataalah	National Coordinator FP
Hajiya Asmau Ahmed	Safemotherhood Coordinator
Dr. Amir Yola	Surgeon, Murtala Mohammed Specialist VVF Hospital
Dr. Kabir	Surgeon, Murtala Mohammed Specialist VVF Hospital
Hajiya Mariam	Matron in charge, Murtala Mohammed Specialist Hospital
Binta Musa	Nurse, Murtala Mohammed Specialist VVF Hospital

ACQUIRE, Katsina

Ireti Sutton	M&E Advisor

Zamfara State & Hospital Officials

Hajiya Saratu Shinkafi	First Lady
Hussaina Salami	Matron/VVF Coordinator, Farida Fistula Hospital
Hadiza Musa	FP Provider
Adamu Kaura	Theatre Nurse

ACQUIRE, Sokoto

Dr. Adamu Isah	Deputy Project Manager
Ms. Tessy Effa	Policy & Advocacy Advisor
Aishatu Umar Bello	FP/RH Advisor
Yusuf M. Alkali	Finance/Admin Officer

Society for Family Health (SFH) Abuja

Dr. Bright Ekwerenmadu	Chief of Party/Managing Director
Dr. Jennifer Anyati	Director Research
Obi Oluibgo	Director of Programs
Dr. Samson Adebayo	Assistant Director, Research
Fatima Muhammad	Senior Manager FP
Ineala O. Theophilus	FP/RH Cordinator
Rakiya Idris	Assistant Manager/FP/RHQA
Joe Odogwu	COO
Alex Kamalu	Assistant Director Finance
Shokoya Adebukola	Corps Member FP
Modupe Williams	Corps Member FP

Pathfinder, Abuja

Chinwe Onumonu	DPO
Daniel Yerima	Grants Officer
Lawrence Kwaghga	M&E Specialist
Mathew Onoja	IRHIN Project officer

Society for Family Health (SFH) Kaduna

Ibrahim Gwalla	Regional Manager
Olugbenga Peter	Detailer
Habiba Lawan	CSO
Hayiya Aisha Suleiman	CSO

Kaduna State & Hospital Officials

Dr. Emmanuel Ozumba	Deputy Director, New Era Clinic

Mary Chikeizie	Senior Midwife/Nurse, New Era Clinic
Patricia .N. Oti	Senior Midwife/Nurse, New Era Clinic
Mr. Andrew Matawa	Project Manager, ECWA Comprehensive Health Centre
Mrs. Rafikatu	Nurse, ECWA Comprehensive Health Centre

Society for Family Health (SFH) Kano

Yusuf Dayyabu	Regional Manager
Aizobu Dennis	Area Sales Manager North
Amal Shelley	HIV Focal Person
Balkisu Abubakar	Malaria Focal Person
Hadiza Alhamdu	FP Focal Person
Ibrahim Garba Kiri	Motor Vehicle Operation
Yakubu Joshua Duoma	Motor Vehicle Operation
Musa Ali	Motor Vehicle Operation
Emmanuel Ede	Detailer

Isyaku Usman Ahmed	Store keeper, MDS warehouse, Kano
Safiye Yusuf	Peer Educator
Hajida Kende Yusuf	IPC Conductor
Shehu Usman Abdullahi	Deputy Director Commercial, Radio Corporation, Kano

Wholesalers, Kano

Auwalu Sani Ibrahim	General Manager
J.O. Ajaebgu	Executive Manager

PPMVs, Kano

Blessed Jaco
Samuel Asua

Beneficiaries (Gwagwarwa Ward), Kano

Mario Danuti
Amarya Sani
Hajara Aminu
Bilkisu Basale
Rabi Isah
Yarinya Mohel
Inna Sarki

Religious Leaders, Kano

Malam Maruf Gwagwarwa
Malam Danjumai Warizam

Society for Family Health (SFH) Lagos

Ikejide Sebestian	Area Sales Manager
Okeke Uzoamaka	Assistant Manager FP/WHP
Ayodele Wunmi	Logistics Manager
Dr.Goodman Olayinka	Regional Manager
Ojajeni Solomon .S.	AD, Lagos Operations

Mr. J.O. Olutayo	Technician, Ministry of Health
Mrs. O.O. Emmanuel	Scientific Officer, Ministry of Health
Mrs. Dinatu Sani Kantiyok	Manager, MDS Warehouse, Lagos

Mrs. Owolabi Morenikeji	IPC Conductor
Akinpelumi Ayo	IPC Conductor
Bukunola Olawoani	Peer Educator
Olufowobi Seun	Peer Educator

Wholesalers, Lagos
Mr. Pauly Anowai
Ugochukwu Ibeh

PPMVs, Lagos
Mr. Wilfred Obiora
Solomon Okoro

CSO
Shodiya Damola Femi
Chukwulobe Obianuju
Bolanle L. Dare

Beneficiaries
Mrs. Mosumola Ogunsade
Bola Ajayi

Society for Family Health (SFH) Cross River

Dr. Odio Batholomy	Regional Manager
Mrs. Affiong L. Umanah	IRHIN Project officer
Kalu Uka	Health Communication Manager
Kenneth Oboh	BCC Southern Operations Manager
Mrs. Ini Abasi Nglass	Detailer
Mrs. Hannah Edet	Central Sales Manager, MDS Warehouse
Mercy Udoewah	M&E Officer, Immanuel Infrimary Clinic, Calabar
Iduak Albert Ekong	M&E Officer, CSO
Uduak Paulicap Ekop	M&E Officer, Pathfinder
Egom Joseph Egon	IPC Conductor

PPMVs, Cross River
Horobong Akpan
Bassey Tom

Wholesaler
Ime .J. Bassey

Beneficiaries, Cross River
Roselyn Inyang
Chukwu Antonia
Felicia Sebastian
Patricia Albert
Vivian Moshe

Peer Educator
Cosmos Ita

Immanuel Infirmary Clinic Calabar

Dr. E. Mkponam	Project Director
Dr. A. Udoh	Medical Director
Mercy Udoewah	MW/FP Service Provider
Glory Kin – George	MW/FP Service Provider

Medical Women Association Nigeria Clinic

Dr. Patience Odusolu	Project Director/Chairman MWAN
Dr. Ani N. E	Project Coordinator
Janet Etteng	MW/FP Service Provider
Eveh Egwu	MW/FP Service Provider
Glory Ibanga	MW/FP Provider, Mount Zion Medical Clinic
Udak Ekpo	M&E Officer, AGAMPN Secretariat
Dr. Usang Ekanem	Medical Director, USY Medicals

PHC Department, UGEP ("WE WOMEN")

Mrs. Awuken Obaji	Project Coordinator
Mrs. Nkoyo Oka	CBD Supervisor
Obal Ujong U.Ina	Traditional Ruler, Ugep

Ugep Community (CBD WOMEN)

Patience Ujong Ina	Coordinator
Dr. Dan Abubakar	MD/Former Project Coordinator AGPMPN
Grace	MW/FP Service Provider
Patience E. Etimita	Beneficiary
Margaret Domini	Teacher /CBD, Nko Community
Dr. E. Mkpanam	Project Director AGPMPN, Mission Hill Clinic
Dr (Mrs.) Archibong	Medical Director/Member MWAN, Faith Foundation
Edith Bassey	MW/FP Service Provider

C. References

D. Tables

F. Map of Project States

G. Power Point Presentation