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USAID/NIGERIA MATERNAL, CHILD, AND REPRODUCTIVE HEALTH PROGRAM MID-TERM EVALUATION

November 2009

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ABBREVIATIONS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services
ACQUIRE	Access, Quality, and Use in Reproductive Health Project
ADS	Automated Directives System
AGMPN	Association of General Medical Practitioners of Nigeria
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
BCC	Behavior Change Communications
BEmONC	Basic Emergency Obstetric and Newborn Care
CBD	Community-based distribution program
CBO	Community-based organization
CHC	Comprehensive health center
CHEW	Community Health Extension Worker
CPR	Contraceptive prevalence rate
CSO	Civil society organization
CYP	Couple-years of protection
DHS	Demographic and Health Survey
ECWA	Evangelical Church of West Africa
EH	EngenderHealth
EmONC	Emergency Obstetric and Newborn Care
ENHANSE	Enabling HIV/AIDS, TB, and Social Sector Environment
FMOH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women’s Associations in Nigeria
FP	Family planning
GHAIN	Global HIV/AIDS Initiative Nigeria
GH Tech	Global Health Technical Assistance Project
GON	Government of Nigeria
HIV	Human immunodeficiency virus
HMO	Health maintenance organization
HPN	Health, Population, and Nutrition
IEC	Information, education, and communication
IHRIN	Improved Reproductive Health in Nigeria project
IMNCH	Integrated Maternal, Newborn, and Child Health
IIP	Investing in people
IP	Implementing partner
IPC	Interpersonal communicator
IR	Intermediate result
IUD	Intrauterine device
LAM	Lactational amenorrhea method

LGA	Local Government Area
LOE	Level of effort
LQAS	Lot quality assurance sampling
MAP	Measuring Access and Performance survey
MAQ	Maximizing Access and Quality
MAWCH	Maryam Abacha Women and Children's Hospital
MCFWP	Managed Care and Family Wellness Programs
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MDS	Manufacturers Delivery Service
M&E	Monitoring and evaluation
MNCH	Maternal, Newborn, and Child Health
MOH	Ministry of Health
NACA	National Action Committee on AIDS
NARHS	National HIV/AIDS and Reproductive Health Survey
NDHS	Nigerian Demographic and Health Survey
NMA	Nigerian Medical Association
NGO	Nongovernmental organization
OC	Oral contraceptive
PCN	Pharmacists Council of Nigeria
PE	Peer educator
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health center
PMP	Performance Monitoring Plan
PO	Program objective
PPMV	Proprietary Patent Medicine Vendor
PSI	Population Services International
RH	Reproductive health
SBM-R	Standards-Based Management and Recognition
SFH	Society for Family Health
SMO	State Ministry of Health
SO	Strategic objective
THT	Total Health Trust
TFR	Total fertility rate
TSHIP	Targeted States High Impact Project
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) Mission to Nigeria contracted with the Global Health Technical Assistance Project (GH Tech) to provide a team of five experts to examine three of the family planning/reproductive health (FP/RH) projects that they have been supporting in Nigeria. This is one of a series of evaluations that is being conducted to provide guidance to the Mission as it implements new projects and develops its 2009–2014 strategy. This summary does not focus on assessments of the individual projects—although the full evaluation contains many comments and recommendations on these—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 to Clinical and Community Maternal, Neonatal, and Women’s Health Services (ACCESS)/Maternal and Child Health Integrated Program (MCHIP), ACQUIRE/Fistula Care (ACQUIRE), and Improving Reproductive Health in Nigeria (IRHIN). The evaluation outlines opportunities, challenges, and critical areas for the Mission to address, and makes recommendations on the most effective and efficient path forward.

Health statistics, and particularly the maternal mortality rates, in the northern states of Nigeria, are among the worst in the world. Infant and child mortality rates are also extremely high. The team does not believe there is any possibility that Nigeria will attain the Millennium Development Goals (MDGs) without massive donor and government commitment.

PROGRAM DESCRIPTION

The ACCESS Nigeria Program has the following goal: “To accelerate the reduction of maternal and newborn mortality and the attainment of the MDGs in Nigeria.” This three-year program has been running since January 2006, and was due to end in September 2009. It has been extended to 2010 under the Maternal and Child Health Integrated Program (MCHIP) project. It now operates in 18 Local Government Areas (LGAs) in Kano, Katsina, and Zamfara states.

Overall, the ACCESS program shows healthy progress. The number of deliveries assisted by a skilled birth attendant rose steadily over 2007–2008 as did the number of antenatal care (ANC) visits and postpartum visits, all of which surpassed their targets with a roughly three-fold annual increase. Couple-years of protection (CYP) increased more slowly, but this was partly 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 vesico-vaginal fistula repair, prevention, and reintegration services. It has three interventions: (1) raising community awareness; (2) establishing a set of five, soon to be seven, fistula repair centers where surgical techniques and post-operation care are practiced; and (3) increasing the use of contraceptives by promoting the use of family planning (FP) services.

Fistula, which is caused by prolonged or obstructed labor, is highly prevalent in Nigeria. There are approximately 800,000 women currently needing repair and the number continues to rise as the growth of good obstetrical care 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 are training sites. Two new service sites being developed: one in a southern state and another in Bauchi state in the north.

ACQUIRE is creating much goodwill for USAID, but to ensure that demand is met and services are sustained requires a more ambitious strategy. That strategy needs to be developed and activated as soon as possible.

Improved Reproductive Health in Nigeria (IRHIN) has the long-term objective of supporting 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 includes interventions carried out by Pathfinder International in Kaduna, Cross River, and Abia States. Society for Family Health (SFH) has a five-year timeframe (June 2005–June 2010). The key strategies are to improve use of FP, as measured by national surveys of contraceptive prevalence rates (CPR), and social marketing of contraceptives measured by sales of contraceptives and calculations of CYP.

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 Proprietary Patent Medicine Vendor (PPMV) outlets, addition of new contraceptives, and generating of support from religious and other leaders.

SFH has partnered with Pathfinder to draw on the expertise of the latter in providing clinic-based services and community mobilization in its three focus states. Pathfinder works with nongovernmental organizations (NGOs) in each state, each of which works with local clinics to support their efforts.

Pathfinder has improved the quality of FP/RH services by: (1) rehabilitating clinic facilities, (2) providing equipment for contraceptive services, and (3) training of providers and field workers in family planning. Although improvements are being made, it has been a challenge to retain trained staff.

PROGRAMMATIC ISSUES

The evaluation team found that 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 in providing support and mentoring to the project site staff.
- **Health Impact**: The impact of FP/RH on CPR and CYP has been limited. That is because activities are spread over large areas and there are few intervention sites. The IRHIN Social Marketing program is the one exception to this, but even this project barely distributes sufficient commodities to have a measurable nationwide impact.
- **Synergy**: There is very little coordination among the projects, which, in part, is a function of project design. Projects generally take place in sites that do not overlap with one another.
- **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 female outreach workers.
- **Inadequate resources**: USAID and the implementing partners (IPs) do not have enough funds or staff to manage the large number of activities in the various sites. Joyce Holfeld, who conducted an

evaluation of the USAID-financed ENHANSE and COMPASS projects, recommended six USAID staff.¹ The evaluation team agrees.

- Poor data quality: Some of the service statistics presented by the partners are suspect. ACQUIRE is the exception. IRHIN does a better job because it has a number of national and sub-national surveys, but the team was not able to track service statistics from the provider to Abuja where reports were written. In addition, since clients seek contraceptives from multiple sources, three of the activities (ACQUIRE, ACCESS, and Pathfinder) do not have enough data that enables them to link project activities with contraceptive use.
- Logistics: Every project had significant problems with stock-outs, which frequently caused activities and contraceptive sales to drop.
- Staff mobility: In almost any location, staff is extremely transient. After workers get trained, they tend to leave for “greener pastures.” Both of the most senior trainers in the ACQUIRE project have been promoted to higher government posts. Others look for more secure jobs, since some positions only receive support for 12 months. This is also true in the private sector, as staff come and go nearly as quickly as in public facilities.
- Lack of basic facilities: In most places visited, there was a lack of electricity, drugs, water, transport, and/or adequate facilities. USAID and its partners need to find ways to address these issues.

FUTURE USAID PROGRAMMING

The projects under review will continue under one or more programs. Thus, it will be important to address the most critical issues right away. Here are the most important suggestions:

- Focus and concentrate program efforts to achieve program results.
- Logistics 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.
- Consider ways of reaching out to where people are, rather than requiring them to come to a fixed facility.

CONCLUSIONS:

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

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

¹ Holfeld, et al. *An Evaluation of the USAID/Nigeria Social Sector Projects: ENHANSE and COMPASS*, 2009.

RECOMMENDATIONS

GENERAL RECOMMENDATIONS

1. Funding should be increased as currently planned, and the USAID Health Office should be increased to six direct hire equivalents. In future work in this area, efforts should be made to work with communities to advocate use of family planning/birth spacing.
2. SFH, civil society organizations (CSOs), and government agencies need to identify ways to reduce turnover of key personnel, especially providers.
3. Retention indicators should be developed and used in recruiting for these positions, for example, tracking candidate ties to his/her home state or town.
4. An awards system needs to be developed to encourage key staff and providers to continue working for the program.

ACCESS

5. ACCESS should review its lactational amenorrhea method (LAM)-only contraceptive policy for postpartum family planning, and consider whether it makes more sense to start women on a contraceptive regimen immediately.
6. USAID should discuss the future of work begun in Katsina State with all stakeholders and consider redirecting resources, possibly including staff, to the other two states.
7. ACCESS should continue in Kano and Zamfara until the end of the MCHIP period, and then consider whether to continue them or to arrange for transfer to another donor.
8. Work should be undertaken in the future on a state-wide basis, rather than only in selected LGAs.
9. The Mission should explore the possibility of the new midwifery school in Zamfara to train a new cadre of community midwives.
10. ACCESS should immediately add secondary fistula prevention to its Nigeria outreach and clinical Emergency Obstetrics and Newborn Care (EmONC) services.
11. ACCESS should develop more robust measures to link family planning motivation and support to government clinics with actual contraceptive use.

ACQUIRE

12. USAID should review its existing strategy and contract mechanisms to ensure that there is continued funding for fistula prevention and repair.
13. USAID should work with specialist obstetricians and gynecologists to introduce appropriate fistula repair technology into medical school and specialist training.
14. Because the ACQUIRE project does not provide contraceptive services directly, it must develop effective ways of measuring contraceptive use that is directly related to clinical and outreach services.
15. 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."

16. The integration of fistula prevention and care into ongoing country programs and initiatives should be promoted. It should be integrated into the maternal newborn and child health strategy.
17. ACQUIRE should develop a compact guide on effective approaches to involving fistula survivors at the facility and community levels.

IRHIN

18. Continue the PPMV program and expand it to cover underserved areas, including rural or remote areas where unmet need is high.
19. Refresher or upgrade training should be introduced to keep PPMV updated on advances in FP and contraceptive technology.
20. More detailers should be hired and trained if the program is to expand.
21. Social marketing should continue its advocacy efforts at both the state and national levels.
22. More effort is needed in both mass media and interpersonal communication, since they are complementary. Both will be needed in the two states that are going to be the focus of the follow-on project.
23. More information, education, and communication (IEC) materials are needed to complement key messages conveyed by mass media and interpersonal communicators (IPCs). These materials are especially needed for PPMV and the intensive community outreach sites. Linkages between wholesalers/detailers and retailers, such as PPMVs and CSOs/community-based organizations (CBOs) should be strengthened to ensure that adequate stocks are readily available in rural as well as urban areas.
24. IEC and point-of-sale materials should be more readily available at the retail level. These materials are critical to outreach workers, such as peer educators (PEs), IPCs, and providers, so that they can reinforce messages about the benefits of FP as well as the range of contraceptives available.
25. SFH should examine ways to reduce or eliminate stock-outs. For example, it could establish “buffer stocks” or emergency supplies at warehouses that can be tapped to fill unexpected gaps.
26. USAID should relax its distribution policy so that public and private stocks can be loaned in cases of emergency.
27. SFH should also explore new ways to monitor prices to eliminate artificial increases at retail levels. For example, mystery shoppers can be useful in identifying vendors who jack up prices.
28. SFH should continue to carry out its good management practices, including capacity development and linkages with other organizations.
29. 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.
30. In the meantime, consider extending these sites for another 6–12 months while a sustainability strategy is worked out.
31. Population-based surveys must reflect more of the IHRIN project indicators.
32. Periodic upgrade/refresher training is needed for staff and providers.
33. An assessment of PPMVs is needed to identify ways to improve performance.

34. Examine expansion of product lines to include maternal and child health (MCH) products. This would help PPMVs, in particular, as it would boost sales and profits.
35. Develop a strategy for increasing acceptance of long-term methods, especially intrauterine contraceptive devices (IUDs).
36. Develop 26 or more Radio Drama segments and other mass media series on health issues.
37. Produce and distribute new and standard IEC and point-of-service material.
38. Conduct an in-depth assessment of the Pathfinder and CSO programs to find ways to make them more effective.
39. Expand the existing “Contraceptives for Catholics” campaign.
40. Take action to implement the Measuring Access and Performance (MAP) survey recommendations on coverage and quality of coverage.
41. Revise the project targets to be more reasonable and attainable.
42. Develop contingency plans for various scaling-up scenarios.

1. INTRODUCTION

1.1. OBJECTIVE

USAID/Nigeria requested that the Global Health Technical Assistance Project (GH Tech) assemble a team of five internationally recognized family planning and reproductive health (FP/RH) experts prepare 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 show how the program could be improved over its remaining year, and, more importantly, to make recommendations that use the lessons learned to improve the design and execution 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 in the future. The evaluation outlines opportunities, challenges and critical areas to address and makes recommendations on the most effective and efficient path forward. The evaluation reviews the performance of each project through June 2009.

1.2. REPRODUCTIVE HEALTH SITUATION IN NIGERIA

Each year about one million Nigerian children die before their fifth birthday. These 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, where completed fertility remains over seven, 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.²³⁴ 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,⁵ the team does not believe that Nigeria has any possibility of attaining the goals without massive donor and government commitment.

1.3. GOVERNMENT AND DONOR COMMITMENT

The Nigerian federal government and its partners have recently developed an Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy. It lays out a collaborative approach to accelerating progress in reducing child and maternal mortality through targeted interventions, including family planning. The IMNCH strategy has been approved by the National Council for Health, and plans are underway to implement it through advocacy and analytical support, initially in 12 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 colleges, and provides higher technical staff for the State Ministry of Health (SMOH). The local government authorities (LGAs), with little technical expertise and insufficient funds, are responsible for basic staffing, managing and financing

² Holfeld & MacDonald: *The Ground is Softening*, 2007

³ Holfeld et.al.: *An Evaluation Of The USAID/Nigeria Social Sector Projects: ENHANSE and COMPASS*, 2009

⁴ *Maternal Child Health, Family Planning and Reproductive Health Strategic Approach*, USAID/Nigeria, December 2008

⁵ www.un.org/millenniumgoals/index.shtml

of primary health clinics within their jurisdiction.”⁶ One of the biggest problems encountered during this evaluation was that local governments, for cost reasons, want to hire the lowest paid staff, the Community Health Extension Workers (CHEWs), to perform many clinical functions in hospitals and clinics under their purview.

It was also troubling that the officials at the state and local levels⁷ seemed relatively unconcerned about the need for family planning, even when presented as birth spacing. While in 2002 there was an entire booklet covering 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 supporting a variety of activities, sometimes scattered broadly. While it is possible for the major players to participate in planning and overall implementation, on the ground it is much more difficult. As will be described below, even different USAID supported programs operating in the same states rarely collaborate.

Finally, partly because the public sector has proven so unreliable, a host of private sector providers—from traditional healers and birth attendants to pharmaceutical vendors to tertiary hospitals—have emerged. While the team support and applaud the work done by the private sector, the fact that an individual often can choose between multiple facilities means that it is difficult to measure service impact. A woman, for example, may be motivated to seek family planning⁸ by a private sector community-based distribution agent and then by or a radio drama, and may ultimately get commodities from a local vendor. This means that data cannot be easily captured by service statistics, leading to marked over- and under-reporting.

1.4. 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 nine states and the Federal Capital Territory (Abuja), and was directed at: (1) preventing and controlling infectious diseases, (2) improving child survival, health, and nutrition, (3) improving maternal health and nutrition, and (4) supporting family planning. Given the Nigerian population size and the relatively low level of USAID funding, the targets for this were ambitious, including projecting increase of the CPR from 9% to 11%, and providing quality RH/FP services to 4.2 million women.

The 2008 revised strategic framework directed the USAID Mission to concentrate on two states, Sokoto and Bauchi, both of them in Hausa-speaking areas in the north. The health statistics and levels of health care in northern Nigeria are among the worst in 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 proposed 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 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 observed—discussed below, under ‘ACCESS’—this 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 unlikely to yield results in the short or even medium term, this is an investment that is crucial to developing a sustainable public health sector in Nigeria.

⁶ Holfeld et al. 2008

⁷ Because of scheduling problems, the team was unable to meet with any federal-level officials.

⁸ This, of course, applies to all social service delivery and not solely to family planning.

Responses to a request for applications are currently being reviewed by the mission and are expected to be awarded before this report is finalized. The report will then become the operational plan for intervention in the public sector. Since it is still in the procurement process, the GH Tech team could not make any comments on the strategies being proposed by the applicants.

It is troublesome that the 2008 USAID strategy does not include partnerships 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 SFH (itself an NGO, and nearly totally supported by donor funds) and developing a single public-private partnership with a major employer.

1.5. MID-TERM EVALUATION SCOPE OF WORK

The USAID Mission to Nigeria asked GH Tech to address the current situation of each of the three projects (ACCESS, ACQUIRE, and IRHIN) with a focus on the implications of the team's findings for the further development of the Mission's health strategy for 2009–2010.

1.5.1. Program Questions

The Mission posed a number of questions to the evaluation team. These were organized by topic: program, geographic coverage, local capacity and ownership, compatibility, synergy and sustainability, and future USAID health programming.

- 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 Strategic Objective (SO) 13 objectives? Discuss missed opportunities, if any, for linkages with PEPFAR-funded HIV/AIDS activities.
- Recommend strategies for addressing and improving linkages in the future.
- Recommend future strategic areas that need to be addressed.

1.5.2. 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 and health team's strategic priorities, other United States Government (USG) programs, and the Federal Ministry of Health's (FMOH) plan for strengthening the health sector?

1.5.3. Local Capacity Building and Local ownership

- To what extent have government institutions at the state and LGA levels bought into and participated in the projects? What approaches were used and what challenges did the projects face in obtaining buy-in and participation?

- 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.
- 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 breakthroughs and accomplishments? Give evidence and cite examples.

1.5.4. Compatibility, Synergy, Sustainability

- Do the current projects respond to the FMOH's desired directions for Nigeria? How do projects coordinate, collaborate, and seek synergy with the FMOH/State/LGA? How can this relationship be strengthened further? 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 were used to do so? Any challenges and gaps?

1.5.5. 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 be done?
- 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?

1.6. METHODOLOGY

The evaluation was conducted using a combination of document review, key informant interviews, and site visits. USAID divided it 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.

The first week, beginning June 29, 2009, was spent on team formation, document reviews, and meetings with the USAID Mission staff and representatives from the Abuja offices of the partners being evaluated. These activities 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, Zamfara, and Sokoto States before returning to Abuja. The private sector team (IRHIN) visited Kaduna, Kano, Lagos, and the Cross River States. The team leader divided his time between the two teams.

The final 10 days were spent in meetings with the Abuja offices to get further clarifications and as many statistics and monitoring and evaluation reports as were readily available. After extensive discussions, the team arrived at conclusions that spread across all three projects and into the future programming needs of USAID. On July 27 a briefing on the evaluation was held for USAID and its implementing partners (IPs). A draft report was distributed on July 28. USAID/Nigeria submitted its comments to the team on August 20. A final report was sent back to USAID for approval and to GH Tech for editing and production.

1.7. 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.

1.7.1. Team A: Public sector

Dr. Olunmi 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. In recent years, she has worked extensively in the area of maternal and neonatal health and in northern Nigeria in the field of strategic health planning.

1.7.2. 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 of experience conducting evidence-based monitoring and evaluating development projects in Asia, Africa, Europe, North America, and South America.

Dr. Jack Reynolds: Specialist in health planning and policy in the context of international health. For over 40 years, he worked to improve the delivery of health services in domestic and international programs.

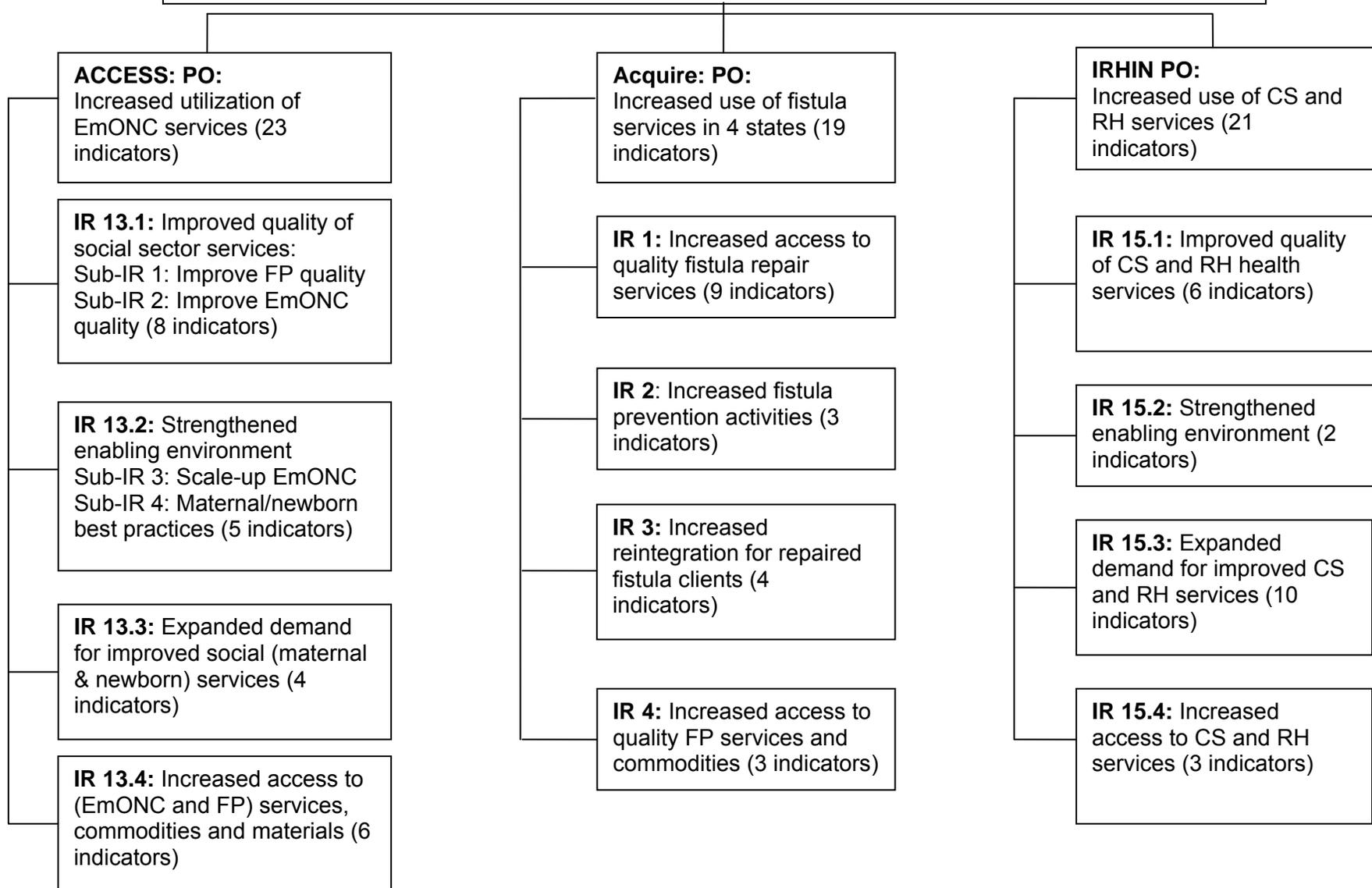
2. PROJECT COMPONENTS

2.1. OVERVIEW

As noted above, there are three projects being evaluated. Each project has the same SO: 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 (IRs). For example, all have improving access and quality as an IR. Two have strengthening of the enabling environment and increasing demand as IRs. However, they are not identical. ACCESS is focused on EmONC, ACQUIRE on fistula services, and IRHIN on the improving child spacing and RH. See Figure 1 for a graphic display of each project's program objectives (POs) and IRs.

The projects also work in various states. Pathfinder (a subcontractor to SFH) works exclusively in three states: Kaduna, Cross River, and Abia. SFH's community program is in 18 states and 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 Ebonyi.

Figure 1: SO 13: Increased use of child survival and RH services (63 IR indicators overall)



2.2. ACCESS

2.2.1. 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 access to emergency obstetric care services is crucial in Nigeria, especially in the northern states. In the North West Zone, infant mortality overall is 114 per 1,000 births, of which 55 are neonatal.⁹ 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 uses a figure of 1,025 for the North West Zone.¹⁰ Some authors however put this even higher. A 2003 estimate was 2,420 deaths per 100,000 live births.¹¹ Furthermore, as many as 17,000 per 100,000 women are left after childbirth with serious disabilities such as fistula, uterine prolapse, damage to bladder or urethra, pelvic or urinary tract infections, anemia, and infertility.

Maternal mortality has complex causality. Mortality is reduced when births are spaced so that the mother remains healthy and her baby well fed. 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 quickly—within a few hours—if things start to go wrong.

In this situation, 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, while originally scheduled to end in September 2009, it has been extended to 2010 under the MCHIP project. It was initiated in four selected LGAs in two northern states (Kano and Zamfara). It is now in 18 LGAs in three states (Kano, Katsina and Zamfara).

The key program approach is the implementation of an integrated program along the Household-to-Hospital Continuum of Care. This includes community and facility-based essential maternal and newborn care interventions focusing on ANC, emergency obstetric and newborn care, and postpartum care including FP. The program is being implemented in a range of facilities as set out below. The program in Katsina, launched in March 2008, has been implemented for only one year. As the number of facilities being covered in each state has expanded, it is difficult to review progress against targets that may have been set earlier, when less capacity was available. In the follow-on project, targets should be revised when there is a significant change in program capacity. This is permitted by the USAID Automated Directives System (ADS), as long as the changes in indicators are documented in the annual report. In addition, the mission and project should develop project and possibly site-specific indicators that will help

¹⁰ ACCESS Nigeria Country Program Brief, June 2009, quoting FMOH and UNICEF.

¹¹ 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.

clarify project developments, even if these are not the overall USAID project indicators. Situation-specific indicators are also permitted by the ADS.

TABLE 1: FACILITIES CURRENTLY COVERED BY ACCESS					
	Specialist hospital	General Hospital	CHC ¹²	WCWC ¹³	PHC ¹⁴
Zamfara		6 (of which 1 for women & children)		2	9
Kano	1	6	1		10
Katsina		5	4		4

It should be noted that this is only partial coverage of the facilities in each state. Zamfara has 17 general hospitals and around 502 primary health centers (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.

2.2.2. Life of Project Objective

Overall, the program shows healthy progress. The number of deliveries with a skilled birth attendant in rose steadily over 2007–2008 as did the number of ANC and postpartum visits. Targets were exceeded for all of these indicators. It is unfortunate that the indicators could not be expressed as a percentage of all deliveries or pregnancies. One area where performance is below target is that of increasing couple-years of protection (CYP). Part of this may be due to the fact that it is very difficult to link women receiving prenatal and perinatal care to contraceptive use, and even more difficult to link motivational efforts in the community to women’s use of birth spacing techniques. This is complicated by frequent stock-outs, which have the effect of requiring women to seek contraceptives in other outlets.

¹² Comprehensive Health Center

¹³ Women and Children Welfare Clinic

¹⁴ Primary Health Center

Figure 2: ACCESS Program Results Framework

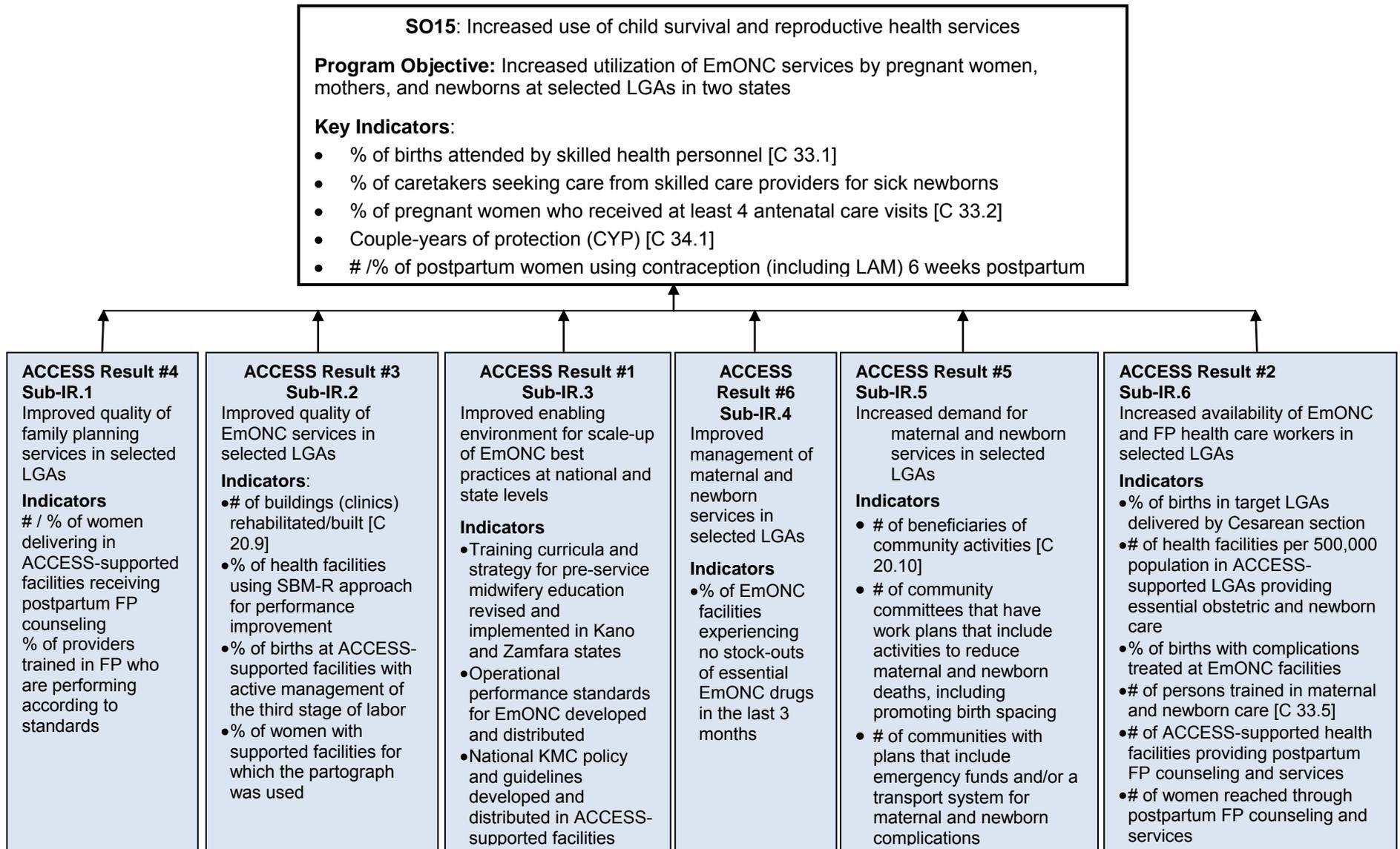


TABLE 3: PROGRESS ON ACCESS PROJECT OBJECTIVE INDICATORS		
Indicators	FY07	FY08
# Deliveries with a skilled birth attendant	7,685	22,092
# Antenatal care visits by skilled providers from USG-assisted facilities	33,333	115,678
# Postpartum/newborn visits within 3 days of birth in USG-assisted program	7,534	26,842
Couple-years of protection in USG-assisted programs	6,492	11,516

2.2.3. IR 13.1: Improved Quality of Social Sector Services

There are two aspects to quality of care: FP and EmONC services.

Family planning services

Family planning (FP) progress overall is good. The provision of USG-assisted service delivery points providing FP counseling 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 performance monitoring plan (PMP), no indicator is used to reflect the volume of contraceptive devices actually distributed. In Zamfara and Katsina there was no shortage of contraceptive supplies, but in Kano there was a mysterious shortage at Murtala Mohammed Specialist Hospital, which was made family planning services almost nonexistent.

The number of counseling 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 counselors program in Katsina state. This activity is yet to take place because of the long process of involving stakeholders in the selection of household counselors.” (Quarterly report April 2009).

In addition to the extension work that is done by the community mobilization teams, ACCESS works with the local family planning providers to upgrade their skills. For example, in FY 2008, ACCESS reports:

- “ACCESS Nigeria recognizes family planning (FP) as a key component in the efforts to reduce maternal and newborn mortality in the country. ACCESS Nigeria has, therefore, been actively involved in FP activities in its program states of Kano, Katsina and Zamfara. Activities carried out by ACCESS in these states include training of providers and their supervisors, development of FP performance standards, development of supervisory checklists, establishment of FP services and supervision of these services.
- “During the past year, ACCESS trained 14 Community Health Extension Workers (CHEWs) and 18 midwives on postpartum FP (PPFP). Trainees were provided with technical assistance to commence or improve PPFP services at their various facilities. This has contributed to the increased access to FP services during the postpartum period. ACCESS also trained 17 midwives to provide long-acting contraceptives, specifically IUD and Jadelle, in order to increase the method mix at their various facilities. In order to increase demand for, and uptake of FP services, ACCESS trained 22 male motivator trainers who will be training other men to raise awareness of FP and reproductive health issues and services among men in their communities. Twenty-eight supervisors from State Ministries

of Health (SMOH) and Local Government Areas (LGAs) were also trained on supportive supervision to ensure that FP services including patient and service records are of high quality.

- “ACCESS Nigeria also coordinated the development of FP performance standards for Nigeria in collaboration with the Federal Ministry of Health (FMOH). The process of developing these standards involved relevant stakeholders from the FMOH, National Primary Health Care Development Agency, Teaching Hospitals, Society of Gynaecology and Obstetrics of Nigeria, Nursing and Midwifery Council of Nigeria, and development partners working in the field of FP. The FP performance standards will help to improve the quality of FP services in the country. (The standards are currently ready for production.) Similarly, ACCESS has also developed a supervision manual for use by FP services supervisors that will help to ensure that FP services meet the required standards.” (emphasis in original)

Because of the extensive support that ACCESS provides to Government of Nigeria (GON) facilities, the team believes that all contraceptives provided by their FP clinics can be used to assess ACCESS project impact, as measured by CYP. If there are two or more programs supporting the same GON facility, the Mission and IPs should develop a methodology to allocate CYP to each partner. Clearly, this will be somewhat artificial, but is more likely to be useful without the expenses of developing a complicated monitoring scheme that will be difficult to implement.

Health workers rated acceptance rates among those counseled as generally very high, and felt that there was no 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.

Family planning statistics continue to show the magnitude of the problem facing ACCESS as it attempts to encourage use of birth spacing methods in northern Nigeria. For example, in 2008, ACCESS reported some 22,000 deliveries, 116,000 antenatal visits, and 26,800 postpartum visits to program facilities.¹⁵ There were nearly 31,000 FP/birth spacing counseling visits. Despite this activity, ACCESS was only able to provide 11,500 CYP during that year. As discussed elsewhere, ACCESS, ACQUIRE and Pathfinder all have difficulty in linking services and counseling with actual contraceptive use, partly because clients have many options for purchasing contraceptives that are not under the purview of the project. In light of this, the team believes that there is significant under-reporting. The work continues to be very difficult, but ACCESS is aware of the problem and is seeking solutions.

When ACCESS began its activities in Nigeria, an important area of focus was postpartum birth spacing activity. As the PMP developed, there was no indicator to measure the number of acceptors of FP methods among postpartum women counseled. One of the main reasons for this is that all women are being counseled to use the lactational amenorrhea method (LAM) of birth control whereby breastfeeding for the first six months of the baby's life offers protection against conception. Women are therefore counseled to use LAM for the first six months postpartum, and then advised to come back for FP/birth spacing methods. The team considered this to be of concern. While exclusive breastfeeding for the first six months is good practice for the baby, a delay in starting contraception for the following six months seems to be a lost opportunity. After the six-month gap, mothers may have forgotten the advice they received, may simply be too busy or too far distant from care providers, or may have become pregnant. If mothers are not counseled to begin contraception immediately, the successor project may wish to build a six-month outreach modality to recruit birth spacing acceptors among former patients.

Recommendation: ACCESS should review its LAM only contraceptive policy for postpartum FP, and consider whether it makes more sense to start women on a contraceptive regimen immediately.

¹⁵ ACCESS: USAID/Nigeria FY08 Quarter 4 and Annual Report, November 19, 2008.

Emergency Obstetric and Neonatal Care

Improving the quality of EmONC services has been more problematic. This is partly because there have been delays in infrastructural improvements, which is exacerbated by the lengthy process of getting construction approvals and release of funds. This results in slow releases of needed equipment, which procedurally follow only after rehabilitation is completed. This in turn has impeded teaching staff how to how to use equipment. 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 was 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 widely undertaken and is generally on track, although the Katsina facilities need to catch up. Training on basic BEmONC) and the posting of the National Youth Service Corps doctors to ACCESS supported PHCs are leading to an increase in the number of women receiving active management of the third stage of labor. 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 sulfate. This is now being manufactured in Nigeria, so the problems should be reduced. 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 is that if women turn up too late into labor, there is little point in starting a partograph. Other reasons 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); and that production of the actual stationary was delayed and getting partographs into circulation has taken time. Furthermore, staff claim they do not have time to use this instrument.

2.2.4. IR 13.2. Strengthened Enabling Environment

ACCESS does not operate in an enabling environment. 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 be approved by 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 FP services continue to be delayed. 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 solely in selected facilities. In some instances, senior SMOH officials seemed unaware of ACCESS and its current and potential contribution.

Other environmental problems arise from the fact that working with LGAs is not always easy and the LGAs themselves have scant resources and lack technical support.

In terms of donor support, the review team concurred with the earlier findings of Holfeld and MacDonald¹⁶ that the work of USAID in this sector receives relatively small amounts of funding compared with the problems to be addressed, and that the USAID office lacks both funding and staff to support the ACCESS program 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 meager recurrent budget on diesel for generators. Furthermore, because the sterilizing equipment provided by USAID cannot be operated without a power supply, in all three states, sterilization was being done with chemicals—an unsatisfactory and unreliable method. Water is also a problem. The most frequent single request made for extra support was, time after time, for a bore hole. However, a bore hole requires a pump, so it is useless unless electricity can be made available.

The IMNCH 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, and kerosene or gas fridges for blood storage (p60). That services are being provided in these inauspicious circumstances is a tribute to determination.

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

TABLE 4: ACCESS SUPPORTED HEALTH FACILITIES AS A PROPORTION OF HEALTH FACILITIES IN THE STATE						
State	Number of general hospitals in the state*	Number of ACCESS-supported hospitals	Percent of hospitals supported by ACCESS Program	Number of PHCs in the state**	Number 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 information), June 2009

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

This table shows how thinly ACCESS services were spread over northern Nigeria. Only about a quarter of the hospitals within each state have received ACCESS support. More importantly, it only provided support to about 6% of the PHCs in each of the three states. It is extremely difficult to have an impact on a population basis with as few facilities as were available. As a counter-example, ACCESS could have focused the same amount of services to all the hospitals in Zamfara and could have been more effective in that state. In this example, it would still have only provided about one third of the ZAMFARA PHCs. This concentration of effort could have had synergistic effects between hospitals and PHCs, and could have built a stronger public outreach effort, reducing problems with staff training, material logistics, and project staff movement.

¹⁶ Holfeld, Joyce M. and Patricia MacDonald. “The Ground Is Softening,” for the USAID/Nigeria Health Portfolio: Considerations for the Present and the Future. Submitted To Akua Kwateng-Addo and the USAID/Nigeria Health Team, January 2007.

2.2.5. IR 13.3. EXPANDED DEMAND FOR IMPROVED SOCIAL SERVICES

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 travel than it is for men, and also women are generally less educated. Men are probably better 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. Despite this, although the reported numbers of beneficiaries recruited by community activities is not as high as hoped, they have probably been under-reporting because women are free to choose which provider to use.

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 an impressive sight, bringing together perhaps 200 women who are participating in this activity. There are now 13 savings clubs in five 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.

2.2.6. 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 an unreliable measure of management capacity in the selected LGAs, because the project has no control over drug supplies. There are frequent stock-outs of the designated tracer drugs and efforts to reduce this have been unsuccessful. In 2008, every EmONC facility had a stock-out of some essential drug. 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 state-wide activity, it could be more influential in bringing about improvements.

The other indicator for improved access to services measures the provision of newborn essential care: this information has not been consistently collected and reported over the project lifetime, and therefore cannot be assessed.

The more directly relevant indicators for this result are related to actual provision of services and trained staff. Cesarean 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%, well below the 15% target. The reasons given are infrastructural challenges, staff shortages, and the continuing high prevalence of home deliveries.

The other indicator of availability of services and staff is the number of people trained in maternal/newborn health through USG-supported programs. The project has generally 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 are two problems in looking only at volume of training. First, achievements in training are undermined by the high rate of staff transfers, which leads to a lack of trained staff at the various sites. Second, simple training does not necessarily result in changed behavior in a clinical setting.

A further problem is that the 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. An example of this problem is seen in weighing of babies: often, CHEWs were not recording birth weight, or recording it inaccurately. The project has recognized the lack of

education by creating a training program 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 feels 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. This would work if standards can be established such that the trainees become skilled birth attendants in line with the World Health Organization (WHO) definition and professional specifications.

2.2.7. Project Management

Project activities began in Kano and Zamfara states in 2006. The Katsina activities were started in early 2008, and thus have had far less time to mature. There is a central office in Abuja to manage coordination and policy dialogue with the central government and other stakeholders, including USAID. There is a regional office in each state, which supports the project sites. At least once a month each site receives a supervisory visit—and more often as needed to support the hospitals and PHCs. There is no specific project management indicator. It might be useful for the follow-on project to track frequency of supervisory, training, and monitoring visits and compare them to how quickly sites reach their goals. Based on interviews and document reviews, there do not appear to be significant management issues other than those discussed above, which are principally due to the challenging environment. Because of this, the project team works extremely hard to achieve results, displaying considerable energy and commitment. The only concerns were around monitoring and record-keeping. These are mentioned below.

2.2.8. 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. One example, noted in Daura General Hospital, involved 156 entries for June 2009 which included records of only two low birth weight babies and three complicated deliveries—an observation that seems incredible. Also, actions taken were often recorded with a just a check-mark, with no detailed information provided 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 that are sometimes only barely literate, and often 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 related issues are:

- Lack of ownership of the project record—feeling that keeping a system is an unwarranted intrusion on the time available for patient care,
- Lack of appreciation of the importance of the information to be recorded and used to improve quality of care, and
- Need for more training in record-keeping.

The focus on service facilities and on the numbers of users of these facilities does not show the level of impact that the ACCESS program could have. At some point in the project cycle of the follow-on activity, the Mission and IPs should make some estimates of the number of deliveries, and their expected impact. In the original PMP, population-based surveys were projected, but these have not been done. An alternative is to use relatively simple calculations of the annual incidence of pregnancy among women of reproductive age (WRA). When combined with population figures, this can lead to a rough estimate of the impact of any particular program. However, at this point it is more important for ACCESS to ensure that the service statistics are accurate, and that records are collected in one place instead of being spread across a variety of patient records and clinic/hospital logs. It is also important to understand that higher-level indicators—such as an increasing proportion of the population using services—will not be useful in the first few years of small projects.

2.2.9. Links to other USAID programs

USAID requested information on the collaboration between the three programs that are the subject of this evaluation.

During visits to 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 the lead project officers said they all knew each other and meet in certain situations.

There was even some suggestion that the programs compete with each other. This was specifically mentioned in the case of ACCESS and ACQUIRE. The issue seems to be that these two projects have some similar performance indicators and data sources. This leads to the possibility of double counting and distrust about who should claim credit for positive results.

It may be possible to review the indicators and reorganize them to eliminate this problem. However, if more active collaboration is viewed as important, USAID may need to take the lead in convening meetings of senior staff from the programs. Another option to consider would be creating a formal organizational link that effectively brings the present projects under one umbrella.

2.2.10. Analysis and Conclusions

Immediate considerations (to December 2010): The whole ACCESS team is to be congratulated at doing a good job in difficult circumstances and in the absence of an enabling environment. Health workers in the 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, it is unlikely to be able to bear fruit within the program time available, and will, at best, become a ‘turn-key’ activity with little chance of success unless it is picked up by another donor, presumably the Department for International Development (DFID). The team understands the political desires of both of the state government and the National Planning Commission to spread benefits of donor activity widely across the region. Nonetheless, the team feels that USAID and ACCESS/MCHIP should be in a position to negotiate the location of service sites to ensure their greatest effectiveness. While in no

way wishing to denigrate the efforts that have been made to further the work of ACCESS and to extend it to three states, the review team urges USAID to immediately discuss the future of the work already begun in Katsina State with stakeholders and consider 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 program in the northern states. The work that ACCESS has initiated should be discussed with DFID managers so that some degree of continuity might be achieved.

Long term: As ACCESS is winding down, and the Targeted States High Impact Project (TSHIP) is starting, USAID should reconsider how it does 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 SMOH to give much attention to the important and evidence-based work being supported by USAID. It is also difficult for the Ministry of Local Government to appreciate the importance of this work or to relate to it. Rather than spreading work thinly over several states, it may be preferable to work in one (or if funding permitted, more than one) entire state, rather than at individual facility/LGA levels. The same point was made by Holfeld and MacDonald.¹⁷ This approach would make it possible to work with the State Ministry to support the development of a human resources strategy, to tackle the problems of logistics management, to improve quality assurance, and to open up the possibility of creating a unified and simplified approach to data collection and monitoring. Alternatively, a more practical approach might be to start with a few contiguous LGAs and expand services to the whole state over a two to three-year period.

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 so that methods could be 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 Partnership for Transforming Health Systems. 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 utilized 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, Kano, and 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 that ACCESS had done a good job and that they would appreciate continued support. However, if ACCESS did end, they said that they would continue within the framework and approaches developed with ACCESS. DFID and the European Union are both active in these states and may be willing to take up the projects that USAID has started.

Bauchi has 4.7 million people; Sokoto has 3.7 million people. The current resources of ACCESS are 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 discuss the future of work begun in Katsina State with all stakeholders and consider redirecting resources (including possibly staff) to the other two states.

¹⁷ Holfeld, Joyce M. and Patricia MacDonald. "The Ground Is Softening," for the USAID/Nigeria Health Portfolio: Considerations for the Present and the Future. Submitted To Akua Kwateng-Addo and the USAID/Nigeria Health Team, January 2007.

2. ACCESS should continue in Kano and Zamfara until the end of the MCHIP period.
3. Future work should be undertaken on a state-wide basis, rather than in selected LGAs only.
4. USAID should consider how to improve links between the work of ACCESS and ACQUIRE to develop the synergies that are possible in the programs' efforts to improve maternal and neonatal health.
5. The Mission should explore the possibility of using the new midwifery school in Zamfara to train a new cadre of community midwives.
6. ACCESS should immediately add secondary fistula prevention to its Nigeria outreach and clinical EmONC services.
7. ACCESS should develop more robust measures to link family planning motivation and support to government clinics to actual contraceptive use.

2.3. ACQUIRE

2.3.1. Objectives

The purpose of the ACQUIRE project is to increase access to quality comprehensive fistula repair, prevention, and reintegration services in three ways. First, ACQUIRE raises community awareness through outreach programs addressing the needs and concerns of women, men, and community and religious leaders. 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. Second, ACQUIRE 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. Third, as an integrated reproductive health project, ACQUIRE 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 EngenderHealth (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 approximately 800,000 women currently need repair.¹⁸ 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 rise, since the number of deliveries already exceeds health care system capacity, and is accelerating at a pace that exceeds the growth of facilities and trained personnel.

The five year Nigerian plan for 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, although repairs are done at all the centers:

- Kebbi State: Specialist Fistula Center Birnin Kebbi

¹⁸ 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.

- 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: Ebonyi to meet the demand for fistula services in the south and Bauchi in the northeast). 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 previously been the case.

Intermediate Results: The higher order goal to which the project contributes equates to USAID/Nigeria’s 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

2.3.2. Increased access to quality fistula repair services

By the end of the 2008 fiscal year, the project staff had provided fistula repairs to a total of about 4000 women. The 2008 total, 1437, represents a 3.7% increase above target for FY 2008 and 32% above the 1081 total repairs conducted in FY 2007. 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%). Reports of complications were very low overall.

Training: Training in fistula surgery is conducted in collaboration with the SMOHs. 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.

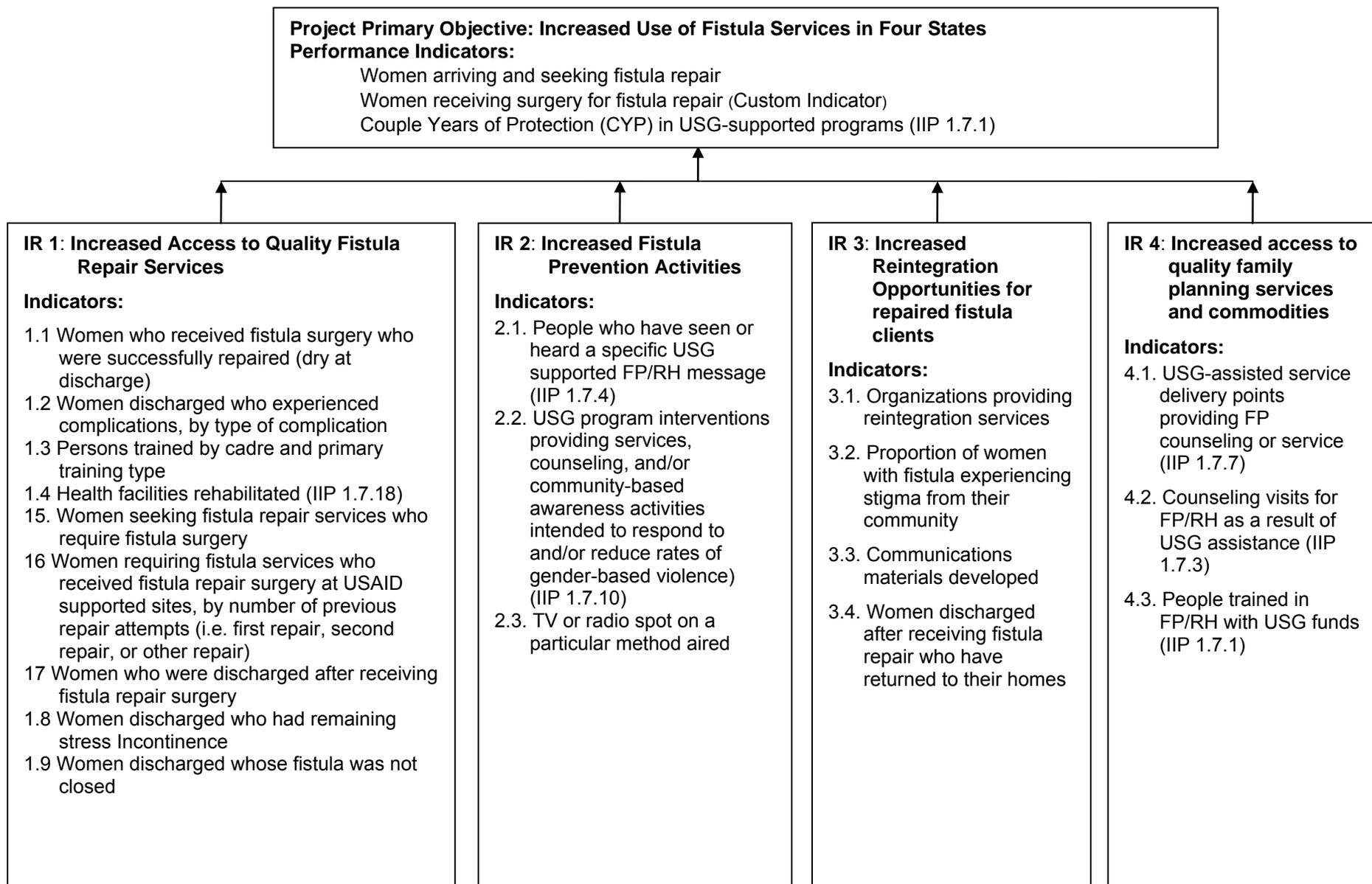
A total of 27 doctors (all male) and 82 nurses have been trained, with two doctors reaching the advanced trainer status. Only nine doctors were still offering services in the ACQUIRE supported facilities, and even then, one of the two advanced trainers has been transferred to the SMOH. Many of the trained 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—two to four weeks—they use up constrained general hospital beds, so fistula repair is usually only done in specialized hospitals.

One of the major issues of the ACQUIRE project is how to disseminate the research and techniques into widespread practice in Nigeria. The master trainer has arguably performed more fistula repairs than anyone else in the world—17,000—and has developed simplified techniques that achieve good results. He is an instructor in German medical schools, and is internationally recognized for his work. The techniques taught in academic and tertiary hospitals are said to be much more complicated and probably

not as effective. Furthermore, medical students and residents in obstetrics and gynecology have few opportunities to perform fistula surgery, since most patients are poor and cannot afford tertiary care, especially when secondary hospital procedures are free. Unfortunately, there is a stand-off between the master trainer and the Nigerian Society of Obstetricians and Gynecologists—with fault probably on both sides—which has hindered the dissemination of appropriate techniques. The next phase of USAID support should expand its work to reconcile these two groups, and to ensure that general physicians, surgeons, and specialists in obstetrics and gynecology are trained effectively and are providing these services.

Recommendations: USAID should work with specialist obstetricians and gynecologists to ensure that appropriate technology fistula repair is successfully being taught and practiced in medical school and specialist training.

Figure 3: ACQUIRE Program Results Framework



The team observed that the theater and fistula wards of both the Faridat Yakubu General Hospital in Gusau and Mariam Abacha Women and Children’s Hospital in Sokoto State 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.

2.3.3. 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 if the woman is leaking two days after delivery. It then requires 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). While ACCESS standard procedures call for catheter use following difficult deliveries, it is not clear that this is carried out. ACCESS’s successful outreach program should also be used to mobilize women who are leaking after home delivery.

Recommendation: ACCESS should ensure that secondary fistula prevention is actually provided through the Nigeria EmONC and outreach 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, including the short and long-term impact on the client, family, and community. They also met with affected women so they could appreciate firsthand the devastating effect of fistula on a woman’s life. The leaders 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 leader: “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 these organizations 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 hospitals 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 Sokoto, Zamfara and Kebbi, the three primary states where the project works. 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), which reaches over 14 million listeners to discuss fistula. This has yielded several success stories for the project and has exposed the

nationwide scope of the problem, judging by the number of women from the south who call in to find out more about fistula and how they can get treatment.

- Secondary Prevention: ACQUIRE is strongly committed to actively finding women who have started leaking urine immediately after delivery and referring them for catheter placement. They estimate that 30–40% of their fistula patients can be managed without surgery because they arrive shortly after delivery.

2.3.4. Increased reintegration opportunities for repaired fistula clients

If women are diagnosed and treated quickly enough, they are not shunned by their home and communities, and 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 four to six week post operation period. 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 provide knitting and sewing machines to the fistula patients when they leave the rehabilitation center. The project has also partnered with the private sector (Syngenta) to support fistula care and reintegration activities. The organization has donated long lasting insecticide treated bed nets to the fistula wards in Zamfara and Sokoto. It has also given sewing machines to the rehabilitation center in Zamfara.

2.3.5. Increased access to quality family planning services and commodities

ACQUIRE provides treated fistula patients with FP counseling and referral. It supports co-located GON FP clinics by training staff and providing basic IEC materials, and has worked with state governments to open new clinics in their catchment areas. This work is just beginning to bear fruit. In 2008, ACQUIRE only provided 1643 CYP¹⁹, a level that will not have an impact on population statistics. As noted elsewhere for ACCESS and Pathfinder, it is difficult for ACQUIRE to estimate the level of contraceptives delivered to people who were successfully motivated by the program. It has not been possible to estimate the extent to which FP messages are incorporated in Community Mobilization activities.

It is still important to note that ACQUIRE does not provide contraceptive goods and services at any of its own facilities. Instead, a woman is referred to a government family planning center which is usually co-located with the hospital, which does receive some support from ACQUIRE. 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 which group can claim which CYP.

Recommendation: The ACQUIRE project does not provide contraceptive services directly, so it needs to develop effective ways of measuring contraceptive use that is directly related to clinical and outreach services.

2.3.6. Project Management

ACQUIRE's team has built productive partnerships with all stakeholders, including the SMOH, 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.

¹⁹ Acquire: Nigeria: Prevention, Repair, and Reintegration of Fistula Project. Annual Report. October 01, 2007 – September 30, 2008.

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 (M&E) advisor who operates from Abuja and visits each site quarterly. It may be helpful to have an M&E officer resident in the Sokoto field office to be able to work more frequently with hospital and clinic staff in recording and using data, both for reporting but also for supervision and improvement of clinical care.

Data Quality: Through an examination of quarterly reports and a records review, it has been determined 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 worsen.
- The project is creating an immense amount of good will for the United States.
- 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 raising awareness are necessary in order to sensitize communities and mobilize political/social support for fistula activities given the culture of silence and shame that 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 to convince local political 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. But more needs to be done. For the women who have benefited, years of stigma, shame, and isolation have 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. In this way it can be positioned to address the menace of fistula and contribute to improving the maternal and reproductive health of Nigerian women.

Recommendations:

- USAID should continue to support fistula primary and secondary prevention and treatment, possibly in collaboration with other donors. With a strong donor such as USAID behind the program, its incorporation into the standard practice of Nigerian medicine will be more likely.
- 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 member: "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 TSHIP plan.
- There should be an increased focus on secondary prevention in other programs such as ACCESS.
- The integration of fistula prevention and 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.

2.4. IMPROVED REPRODUCTIVE HEALTH IN NIGERIA (IRHIN)

2.4.1. 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 4 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
- Increased **access** to reproductive products, services and materials

The project expected to contribute to an increase in modern contraceptive prevalence for all WRA, ages 15–49, from 9% to 11% for modern methods by the end of the project. The 2008 Nigerian Demographic and Health Survey (NDHS) indicates that Nigeria has not yet met that target. The percent achieved at mid-term was 9.7%.²⁰ However, this was an increase over the 2003 figure of 8%. 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.

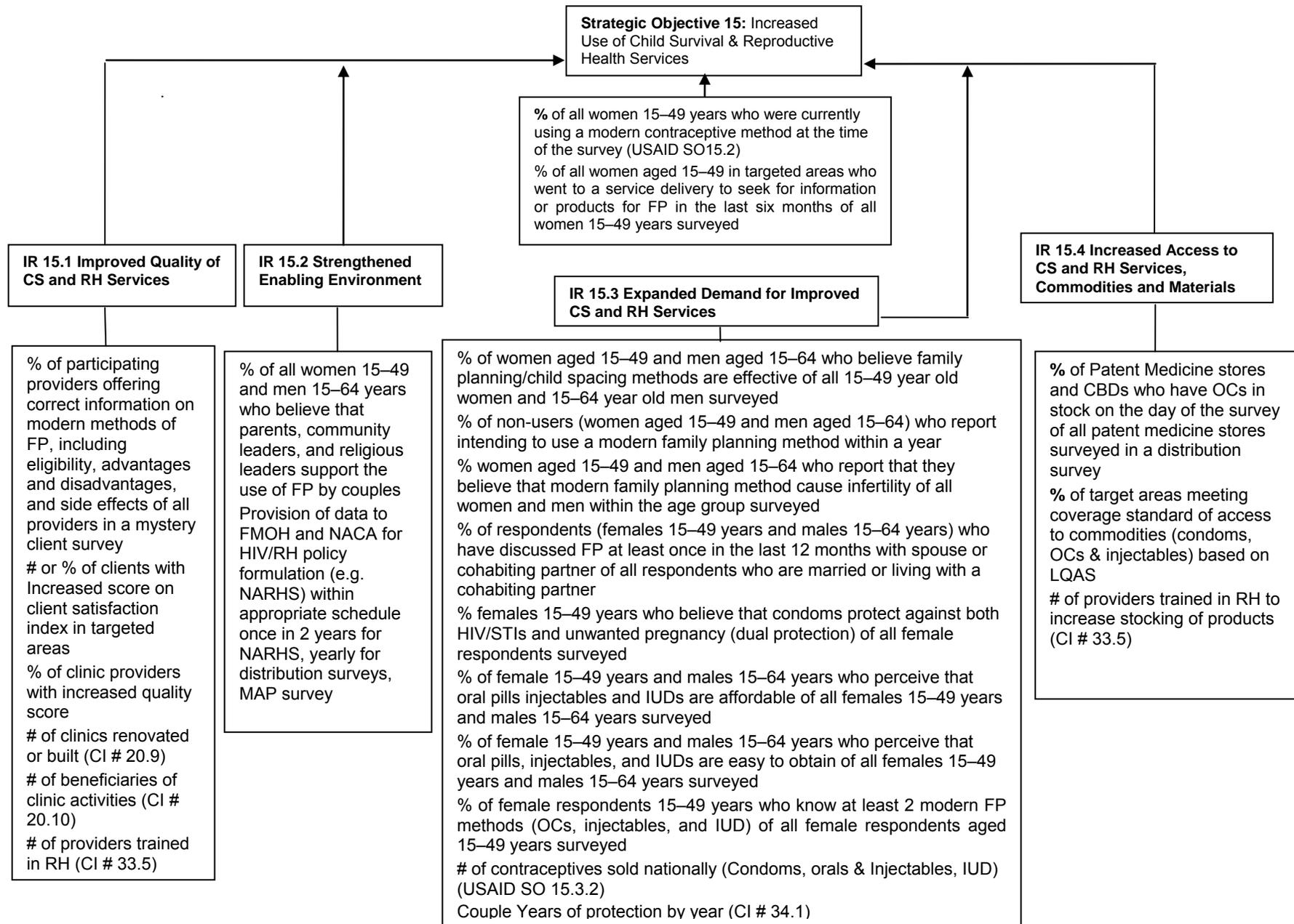
If the CYP provided by the CSM program is viewed in light of Nigerian population growth, an even more dire picture emerges. Project records show that distribution grew by about 300,000 CYP per year. Nigeria's growth rate is conservatively estimated at 3%²¹ per year. If it is assumed that 0.25% of Nigeria's population (140 million) is WRA, every year there are an additional 1,000,000 of these women in Nigeria. Clearly, the growth in CYP provided is falling behind the growth in population.

Although the IRHIN project is national in scope, a portion of it concentrated on three states: Kaduna, Cross River, and Abia. In one of those states contraceptive prevalence was below the national average, with Kaduna at 8.4% in use of modern methods. However, it was significantly above the national average in the other two, with 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 Lagos), and by density (6.2% in rural areas and 17.1% in urban areas).

²⁰ Table 4, p. 13, 2008 DHS.

²¹ The Chairman of the Population Commission estimates the growth rate at 3.2% per year (personal communication).

Figure 4: Model Element 1: IRHIN's Results Framework with SO PMP and USAID Common Indicators



The second SO indicator was used to determine if women in the three targeted states went to service facilities for FP information or services.²² The 2005 baseline was 26% for Kaduna, 29% for Abia, and 44% for Cross River.²³ The Tracking Results Continuously (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 CYP (13.4 million) and coverage (90% percent for condoms, 75% for pills, and 60% for injectables). See Table 5–9 in Annex C for the baselines, targets, and mid-term achievements for all of the IR indicators.

USAID provided \$16.3 million to SFH to achieve these objectives over a five-year period (June 2005–June 2010).²⁴ 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.

When the IRHIN project expires in 2010, the Mission plans to follow up with a new project that will employ the same interventions without a break in service delivery. Like IRHIN, this will consist of a social marketing program and private sector support initiatives. Recognizing that the new project will be designed shortly, the team focused its recommendations on the follow-on project as well as the remaining tenure of IRHIN. This supplements the TSHIP project mentioned above, which will focus on public sector RH and FP services that will begin in 2009.

2.4.2. The Pathfinder Project

Objectives

SFH’s partnership with Pathfinder was designed to address issues of RH service availability by focusing on private practitioners and NGOs. Appropriate levels of quality of service were attained by training private sector and other NGO providers.

SFH draws on Pathfinder’s considerable expertise in providing clinic-based services and mobilizing communities to strengthen the quality of services in three focus states: Kaduna, Cross River, and Abia. Since the project began, Pathfinder has worked with the following nine NGOs:

Kaduna:

- 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:

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

²² Percent of all women aged 15–49 in targeted areas who went to a service delivery to seek for information or products for FP in the last six months of all women 15–49 years surveyed. See Nigerbus 2007.

²³ Improved Reproductive Health in Nigeria, Performance Monitoring Plan, July 2006, p. 7.

²⁴ An additional \$1.725 million was provided in FY 2008.

Abia:

- 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, up to five clinics were established per organization, but more were added in 2008. Some dropped out of the program. Of the original 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.

The team was able to visit seven NGO clinics in Kaduna and Cross River. Abia could not be visited because of an episode of violence the week before site visits began. The clinics visited 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 project resources and the network trainers conducted non-clinical and FP service delivery management training. The plan called for training 45 nurse-midwives and 21 physicians.

Skill training for doctors: In 2007, 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 IUDs and implants. The FP division also conducted training for the doctors on the Standard Days Method using 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. Training that the providers have received since the IRHIN project began in July 2005 has had a tremendous effect on service quality especially counseling activities. In FY 2008, the program reached a total of 37,250 clients through one-on-one-counseling and another 85,620 through group health talks.

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, and (3) training the director of each clinic and designated staff to provide family planning services. In return, the clinics offered space and staff for family planning counseling and service. They also subsidized services for clients by not charging the standard clinic visit fee of N 1,000–1,500.

These improvements were observed in every facility visited, although one NGO had not taken its instruments out of their plastic bags during the entire three-year life of the project. In many instances, the staff that was originally trained left the clinic to seek greener pastures. Indeed, the primary complaint of all clinic directors was their inability to retain trained staff— not unlike the situation in public facilities.

Initially, it was very difficult to convince private practitioners to provide free services because 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 were convinced that it was true, but had no way of quantifying the effect. Nonetheless, by the end of the three years, most AGMPN members in Cross River, for example, were providing some level of FP services. This was 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 family planning counseling and services. However, the lack of electricity was noted, as was the use of chemical sterilization, which is less desirable. Because the techniques used to insert implants or intrauterine devices (IUDs), or give injections were not observed, it could not be determined if good practices were being followed.

Strengthening the Enabling Environment

Enabling Environment: The environment that Pathfinder worked in was relatively good, in that it displayed 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 hindrances to their work. However, one major obstacle was that most people tended to believe that these private clinics were more expensive than the government or PPMV sources. The biggest hindrances came from having a far-flung program, from the lack of a program coordinator in the south and from the absence of a critical mass of providers who could mutually support one another.

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 nearby communities. It is difficult, however, to actually measure the effect this had on behavior, since FP acceptors typically did not go to the clinic facilities. There was always a variety of FP providers, including other NGOs (CEDPA, for one), the government health centers and hospitals, and PPMVs. In one situation, for example, the community was 28 kilometers from the clinic site and it cost 1,000 N for round trip travel. Because of this, none of the community's women and men went to the clinic, choosing instead to attend the government health centers. Pathfinder staff recently introduced a system of referral cards to track this flow outside the system, though it is not yet working well enough to provide accurate estimates. In one community, school-aged girls went to their local PPMVs to get oral contraceptives to keep from becoming pregnant, and were rarely referred to clinics for basic health screening.

The FOMWAN group provides a particularly good example of hard work and enthusiasm. It actively took on the Muslim Imams and Islamiyya schools, and got these religious leaders to agree that family planning was part of Islam. It persuaded the imams to discuss FP at Friday prayers and was able to introduce RH training in the madrassas. While further field work would be necessary to confirm FOMWAN's impact, it is a model to be replicated across Muslim Nigeria. Since it is a nationwide organization, it should not be difficult to include it in any follow-on project. There was also outreach to churches, particularly by ECWA and by the providers in the south. However, some of the women's groups did not seem as enthusiastic. This may be a sampling artifact.

Unfortunately, all this effort did not result in large amounts of contraceptives being delivered, as measured by CYP. The table below shows the annual results for each NGO. 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, all providers together only provided about 12,500 CYP over four years, or an average of less than 400 CYP per partner per year.

The reasons for this are not completely clear. It has already been noted that people may well have been motivated by the community organizers, yet chose another type of provider in order to obtain FP commodities. In some cases, it appeared that the physician was heavily occupied by his/her clinical practice and did not have time to build a large FP practice. In several instances, the clinics did not have sufficiently trained staff to provide any methods other than condoms or CycleBeads. In some instances, the physicians did not seem to be motivated to provide services. Whatever the reason, the follow-on project will need to consider its approach to providing FP services through the private sector before committing to an approach.

TABLE 5: 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	AGMPN	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.

For the first two years, the Pathfinder project was managed out of Abuja. While this was acceptable for Kaduna sites, it did not work very well for Cross River and Abia. 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 to their clinics. All three of the initial project leaders were enthusiastic about the project, and reported that they worked 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, and motivating people in their work. Increases in services in Cross River State during 2008 and the first half of 2009 are largely due to her efforts.

Unfortunately, given the way 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 is another 130 km in another direction. If this work is to be continued in the future, a project vehicle should be stationed in Calabar.

Monitoring and Evaluation: Monitoring is carried out on an at least quarterly basis, although in Cross River and Abia it occurs more frequently. Comparing clinic records with the reports submitted to the home office did not reveal any significant discrepancies. It has already been noted that the reporting system underestimates the accomplishments of this program.

Recommendation: Conduct an in-depth assessment of the Pathfinder and CSO programs to find ways to make them more effective.

Increased Access to Services, Commodities and Materials

All of these efforts were intended to increase the availability of FP goods and services. One example where results could be measured is a clinic near Calabar, located in a tight-knit community near a market. The physician had done the necessary outreach, and trained all of his staff, including the health aides who were on duty at night, to provide family planning counseling and appropriate commodities at all hours. Proximity to a market is important, because it allows women to slip away privately and get contraception without the whole village—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. This provider had the highest rate of contraceptive acceptors in the entire sample of 26.

2.5. SOCIETY FOR FAMILY HEALTH: IRHIN PROJECTS

2.5.1. Improved Quality of CS and RH Services

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

Training of Proprietary Patent Medicine Vendors

Selection: A major responsibility of the detailers is training PPMVs. Detailers work with the PPMV associations, the Pharmacists Council of Nigeria (PCN), hospitals, and attend the monthly state MOH meetings to identify PPMVs 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 PPMVs per year, or 20,000 over the life of the project. However, there are over 200,000 PPMVs. At this rate it will take 50 years to train all of them.

Turnover is a significant problem with PPMVs as well as with private providers and community workers. After receiving training, they leave for better-paying jobs. Retention is higher among those who have their own business— a shop or a 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, and 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 laws pertaining to medical procedures and prescriptions. Clients are to be referred to a licensed provider or hospital for initial oral contraceptive (OC) screening and prescriptions, insertions of implants, injections, and insertions of IUDs.

Training also emphasizes 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. When controversial issues are raised, the trainers open the discussion, encourage debate, and strive to reach consensus. Training is supposed to be informal with a strong emphasis on 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 PPMVs (30% women) have been trained in the past three fiscal years (2006–2008). The training has affected sales of contraceptives and broadened the range of coverage. Consumer confidence in PPMVs has probably increased as a result of their increased knowledge of a range of methods. As a result of this increased knowledge, PPMVs have become more confident in their work

Factors affecting performance: Stock-outs have a significant effect on PPMV sales and customer confidence in the reliability of supplies. The team observed two types of stock-outs in the delivery system: temporary stock-outs and artificial stock-outs. The temporary stock-out may be caused by delays caused by the lag between when orders were taken at SFH warehouse in Lagos and when the products reached the Manufacturers Delivery Service (MDS) that made the request. Also, temporary stock-out may be due to failure of the manufacturing company to keep producing commodities so that supply meets demand. Artificial stock-out is mainly due to a lack of communication between wholesalers and PPMVs, or between wholesalers and MDS, or between SFH detailer and PPMVs. It could also result from a wholesaler or PPMV lacking the funds needed to obtain commodities in a cash-and-carry system. Both wholesalers and PPMVs repeatedly expressed concerns about the lack of a credit facility. Stock-outs may result in substantial unmet need for commodities at the sales outlets in the supply chain.

PPMVs continue to drop out of the program. Some do so because of poor sales, lack of interest, or relocation. To replace these dropouts the detailer has to provide on-the-job training 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, and dealing with stock-outs. All of the PPMVs 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 operations. The legalization of PPMV rights to sell and be trained about OCs and condoms has enabled the program to expand throughout the country. When the issue of credit was discussed with PPMVs, they strongly recommended that USAID/SFH not extend credit. One of the main reasons for this is that there is no legal way to enforce repayment because of poor implementation of contract laws. A more appropriate channel for credit may be the PPMV association, and SFH and USAID might wish to provide technical support to the association to establish a revolving credit fund.

Recommendation: An assessment of PPMV knowledge and practice would be useful to identify ways to improve their performance.

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 it does not seem that there has been much, if any, update training. SFH suggested this could be done for people initially trained in 2000. Through the addition of the detailing teams about 5% 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 with advances in FP and contraceptive technology. More detailers are needed in order for the program to expand.

Additional Training of Private Sector and NGO Providers

Objectives: Training similar to that provided to the Pathfinder NGOs was made more broadly available to private practitioners throughout the country.

Update training on IUD: The six-day provider training was a huge success. There were 109 participants (91 female and 18 male) from 18 states with high unmet need. The training took place at five teaching hospitals throughout the country: Zaria, Jos, Enugu, Lagos, and Calabar.

Update Workshop for FP providers: The FP division, in collaboration with Planned Parenthood Federation of Nigeria, conducted a contraceptive update training course for 896 participants (702 female and 194 male) participants, who came from the 18 states with the highest unmet need for FP. 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 the expansion of demand for all FP methods.

Conclusions: IRHIN efforts to improve the quality of child spacing 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 to share with their clients. It is particularly impressive that detailers conduct five trainings per year to keep PPMVs and others 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 much visible result. The clinics of the Pathfinder NGOs do not provide a significant amount of contraceptives, and the results of the larger training sessions for providers from across the country, whose impact has not yet been studied, have been disappointing. Both Pathfinder and the broader training should have been better focused and monitored more closely. For example, in working 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 outside their clinics. Providers may have become more willing to advertise once they had some idea of demand and acceptance. They also 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, it should not anticipate continuing the program in its current form.

SFH should continue to provide training in FP clinical methods to providers that come from all parts of Nigeria. However, training should also be monitored to determine whether it has been 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.

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 those who had been trained, and they do not appear to have been studied in a systematic way to determine the impact of their training.

In 2006, the IRHIN team conducted update training for 424 doctors and nurses on injectables and IUDs. Participants learned to use provider checklists to screen patients for appropriate FP methods. SFH made technical support visits to designated FP sites. 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 covered all modern methods of child spacing. This included the Standard Days Method using the CycleBeads, counseling, and infection prevention procedures. There were 900 participants, mainly nurses, CHEWS, doctors, and pharmacists. They came from the 18 states with the highest unmet need for family planning: 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 covering all modern FP methods was held for 100 providers from the 18 states mentioned above. IUD insertion and management was emphasized. The training was conducted at ABU Teaching Hospital Zaria, University of Jos Teaching Hospital, University of Calabar Teaching Hospital, UNTH Enugu, and University of Lagos Teaching Hospital.

In addition, working with Abt Associates, IRHIN supported a training program for health maintenance organization (HMO) 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 projects, such as Private Sector Partnerships, but these are beyond the scope of the evaluation.

Recommendations:

- Refresher or upgrade training should be expanded to ensure that all PPMVs are current as to advances in FP and contraceptive technology.
- More detailers should be hired and trained to support expansion of the program.

Provision of provider support materials

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

Clinical service providers need the basic educational materials for client education, and these were found at the family planning site in every clinic. They included 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 observed was the lack of trocars for inserting injectables. It was explained that the manufacturer had ceased production of reusable trocars, and had not begun distributing single-use models. Otherwise all support materials were available.

2.5.2. Strengthened Enabling Environment (IR 2)

Project objectives

The environment for reproductive health in Nigeria poses numerous challenges. Under IRHIN, SFH and Pathfinder planned to expand its 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 involving a variety of issues critical to the increased use of RH services. These issues include: the use of media, gender issues, cultural and religious barriers, and policies restricting the provision of services including discouraging private sector investment in the delivery of RH products and services. Areas of focus were: advocacy to increase support from the pharmaceutical regulatory agency to allow dispensation of oral contraceptives by PPMVs and partnerships with private sector manufacturers to facilitate market entry and increase the supply of commercially sustainable contraceptive products. Outreach to community leaders and male partners to gain support for the use of reproductive health services was also a focus, as was advocacy with media regulatory agencies to ease restrictions on RH messages in mass communications.

Socio-cultural opposition

Religious opposition to family planning is relatively low, except among some Catholics and Muslims. Conservative religious leaders cite dogma as justification of their opposition. Some individuals are so intimidated by this opposition that they hide their use of contraceptives. The introduction of CycleBeads has generated much interest—and acceptance—among these individuals. A great deal of work has been done with imams on Qur’anic teachings. Many have agreed that the Qur’an tacitly permits birth spacing and have begun teaching it in Friday prayers.

One Catholic diocese has been open to a program called “Contraception for Catholics,” which teaches about all methods while focusing attention to the methods approved by church hierarchy.

Recommendation: Expand the existing “Contraceptives for Catholics” campaign.

Muslim religious leaders in some states consulted the Qur’an 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 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 family planning/child spacing 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 they are a scam to make money or are a form of genocide; that IUDs migrate to the brain; and that injectables make you ill. All these and other misconceptions are being addressed by community health workers, PPMVs, and providers.

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

Media Environment

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

Journalists: In 2006 IRHIN, in collaboration with Enabling HIV/AIDS, TB, and Social Sector Environment (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. It would seem useful to determine whether more journalists should be trained.

Government Regulations

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

New products: When IRHIN plans to introduce a new product, the government wants it to be free to the public. The government does not seem to understand that the social marketing objective is to break even, not lose money, by recovering 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. It can take six months to obtain waivers of the “Buy America” policy or to get approval for construction. This delays or slows down some project activities.

Stock-out borrowing is commonplace in the marketplace. When SFH or the government runs out of a certain contraceptive it borrows or buys it from another 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.

Recommendation: USAID should find a way to relax its distribution policy so that public and private stocks can be “loaned” to each other in the case of stock-outs.

Costs

Contraceptive costs: Some potential acceptors of FP/RH believe that the services and contraceptives should be free. They will not take a method if they have to pay— or they search for the cheapest provider. This seems to be a cultural norm. Some PEs and IPC “volunteers” expect to be paid, as do some women who attend a group discussion. While many women are willing to pay something for FP methods, and most believe that the prices are low and reasonable, cost affects acceptance, continued use, and dropouts. Also, small profit margins cause some PPMVs to drop out. 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, they do fluctuate, especially when supplies are limited or unavailable due to stock-outs at government facilities. There are seasonal variations, as well. Toward the end of the year, sales tend to increase.

Monitoring prices is feasible at the wholesale level. The IRHIN detailers can do this by examining invoices regularly. However, sales at the retail level, especially among PPMV cannot be verified. The PPMV do not record sales or make out invoices. Also 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 sales volume, not just prices. Whether this works is unknown. Pathfinder tried to get retailers to keep sales records, but that did not work and was dropped.

Advocacy

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

HMO: SFH collaborated with Private Sector Partnerships (PSP-One) and Total Health Trust (THT) to train providers working with the THT HMO on its 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 (Nasrul-Lahi-il Fathi Society and Christian Health Association of Nigeria) in 2006. In 2008 a workshop for female religious workers on maternal and child mortality was held in Kaduna. Forty one 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

- Data to FMOH and National Action Committee on AIDS (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. However, much more must 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 should be developed and tracked.

2.5.3. 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. Outlined in the project cooperative agreement, the two components of demand creation 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. The evaluation examined strategies used to improve knowledge about FP, methods availability, and affordability.

Mass Media

Since the inception of the IRHIN, the mass media strategy used in demand creation project has been 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,” which had been in existence 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. “One Thing at a Time” is currently being 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 SFH has four spots on radio addressing child spacing benefits, according to informant interviews.

TV spots aired nationally in pidgin English highlight 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. Reports suggest that about 100 billboards were strategically located throughout the country for about two years, but were discontinued due to a lack of funding. There is a need to tap into missed opportunities in outdoor advertising, which was virtually non-existent at the time of the evaluation.

Recommendation: Develop another year’s worth (26 segments) of the radio drama and other mass media series on health issues.

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 specific USG-supported FP/RH message. While there are no baseline, target, or mid-term data for that indicator, it was tracked by the Nigerbus survey that was carried out in February 2008.

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

TABLE 6: 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

In 2008, SFH held one mass marketing campaign for FP during this project. Unfortunately, it has not had sufficient funds to continue the outreach. This should be corrected in the next project.

Interpersonal Communications

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 these communities—there are currently 18 throughout the country—is localized through the involvement of SFH field offices and CSOs in the locality. 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 themselves. Field visits of the mid-term evaluation team and from the National HIV/AIDS and Reproductive Health Survey (NARHS) suggest that this community approach is yielding positive results. Whether it can be sustained without outside funding is a question that needs to be explored.

IEC Materials

IEC materials include pamphlets, flyers, posters, flip charts, and other visual aids that help outreach workers 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 continually exposed to these materials at the health facilities and at PPMV shops.

Conclusions: There are 12 indicators for the Demand IR. Four of these show an improvement from the baseline to the mid-term assessment. The percentage of men intending to use FP in the next 12 months rose from 8% to 20%, while for women it rose from 8% to 13%. The belief that FP can lead to infertility declined from 36% to 23% for men and from 33% to 22% for women. The remaining belief indicators all declined: the belief that family planning/child spacing is effective; the belief in the efficacy of condoms; the belief that contraceptives are easy to obtain – all declined, and for all methods. These issues should be directly addressed through existing and future outreach techniques.

The indicators of distribution of contraceptives all show modest increases. Condoms exceeded the baseline by 37 million, OCs by 2.3 million, and injectables by 1.2 million. Even IUDs exceeded the baseline by 32,000.

It is tempting to say that interpersonal communication through community outreach has a more immediate effect on changing FP misconceptions than does mass media. Evidence from the beneficiaries that were interviewed attest to this assertion. However, both approaches are required. Mass media are more effective in reaching a large target audience, while interpersonal communication—at a much higher cost on a per-person contacted basis—is more effective in bringing about behavioral change.

Recommendations: More effort is needed in both mass media and interpersonal communication, 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 interpersonal communication. Materials are especially needed for PPMV and the intensive community outreach sites.

Based on experience in other African countries, the team also strongly recommends that, in the follow-on project, there be a nationwide multi/mass media FP campaign on an annual basis.

2.5.4. 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 MDS. This section discusses efforts put into increasing access to modern family planning methods.

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 the tables in Annex C for more details.

	Duo Fem	Postinor 2	Noristerat	Depo Provera	Copper T	Gold Circle	Life Style	Norigynon	Pregnon
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. They have included specific recommendations that SFH has not always acted upon. The latest survey, in 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...”²⁵

Recommendation: Take action to implement the MAP recommendations on coverage and quality of coverage.

Distribution and Detailing Strategy

Product distribution starts from the SFH warehouse in Lagos. It packages products ranging from condoms to injectables, to the 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 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, and pharmacies. SFH’s recent efforts to bring the packaging of products closer to the distribution chain are seen as a positive step that should reduce time and costs.

²⁵ MAP 2008, p. 15.

Provide Support through Enhanced Medical Detailing

Detailers: Drug detailers, who are advertising, information and distribution agents, are a key part of the SFH strategy.

Activities: The detailers were trained by Pathfinder. Their role is multifaceted and combines promoting 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 that they do not exceed the recommended price for contraceptives. However, the detailers cannot monitor PPMVs because there are too many of them. SFH is planning to hire sales agents (one per region) to take over product sales and deliveries. One detailer noted that she now has a Community Focal Person for 5–6 community-based distribution programs (CBDs). This will free up more time for the detailers to spend on PPMV training and demand creation.

In 2003, SFH hired and trained eight new medical detailers, all pharmacists, to promote and help distribute SFH ethical products, including hormonal contraceptives, IUDs, and prepackaged treatment for malaria. In 2007–2008 eight more detailers were hired so that there was one per region. SFH currently has 16 detailers spread around the country. They are the key to supply and demand for contraceptives. Unfortunately, turnover is high: three detailers resigned in the past year. Retaining trained detailers is a significant challenge. One detailer said that his mornings are spent with nurses, midwives and physicians creating demand and taking orders. Afternoons are spent delivering supplies. Detailers enlist whoever is available to help with distribution, which helps to keep costs down. They check invoices to make sure that sales are within the recommended price and are also responsible for finding and training PPMVs.

The major problem is stock-outs. Norigynon was out of stock from May until the site visits in June. 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 CYP from 2.06 million in FY 2006 to 2.33 million in FY 2007 and to 2.7 million in FY 2008.

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

Product	FY06 CYP 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%
IUD	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%

TABLE 8: ACTUAL CYP, 2006-2008

Product	FY06 CYP Achieved	FY07 CYP Achieved	FY08 CYP Achieved	Total CYP	Percent CYP
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 the tables in Annex C 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 Provera, 271 thousand for IUDs, and 13.4 million CYP. Most of these targets are so high that they must be in error.

Recommendation: Revise the project targets to be more reasonable and attainable.

Sustaining Access to Products and Services

As mentioned previously, the detailers are the key to both the distribution of supplies and 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 way to maintain 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 Population Services International (PSI) in this exercise. Together with market segmentation, this approach could lead to significant cost recovery, thus reducing the need for large subsidies.

One issue is the relatively low access to long-term methods, specifically injectables and IUDs. Many PPMVs are not permitted to stock any longer-term method than condoms oral contraceptives and CycleBeads, and even some of the CSOs described above only provide these products. As described above, the current model of engaging CSOs and private practitioners has not worked well. There are tantalizing hints from some of the outreach campaigns that have brought services closer to the community rather than expecting the community to come to the services delivery sites.

Recommendation: Develop a strategy for increasing acceptance of long-term methods, especially IUDs.

Many trained IPCs and PEs have worked in their communities, advocating FP benefits and providing information on sources of methods. Beneficiaries interviewed during the course of this evaluation corroborated this fact, reporting that they had been referred by IPCs and PEs to either a public or a private facility. These community-intensive sites are typically led by a CSO 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.

Recommendation: In future work in this sector, efforts should be made to work with communities to advocate use of family planning/birth spacing.

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 seek work elsewhere when support ends. 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, because a number of sites have already been affected.

Increasing Private Sector Presence

The social marketing of commodities distribution has been gaining acceptance. As of June 2009, 51 wholesalers are registered with SFH nationwide. The numbers of PPMV that have received training from SFH has increased 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, Misoprostol, CycleBeads, and Lifestyle.

Conclusions: There are differences in the coverage levels of FP products and services across the country. The coverage level of established products like Duofem and Gold Circle is quite good. Increasing the coverage of Noristerat, Depo Provera, and Prostenol 2—currently fairly adequate—and that of lower-rated methods like Lifestyle, Norigynon, and Prenon should be a priority for the Family Health Service. Of even more concern is the low quality of coverage of products and services in delivery points across the country.

Recommendations:

- 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, helping them to 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, it could establish “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.

2.5.5. Project Management

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. IRHIN’s five-year budget of \$16.3 million is a very small part of SFH’s overall budget.

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 considerable experience and expertise. SFH is the prime recipient and takes responsibility for social marketing and community organization. PSI is the prime recipient for international consultants who provide financial and technical support. Pathfinder is the lead partner for provider training and clinic-based support.

Planning and Reviewing receive considerable 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 and Capacity Building is so important to SFH that it could be seen as part of the corporate culture. Training not only builds project-level skills but it also helps 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 much 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), Global HIV/AIDS Initiative Nigeria (GHAIN) (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 it 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 SFH models were designed to be easily replicated. Several of the staff noted that if there was 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 technical assistance.

Recommendation: the Mission and SFH should develop contingency plans for various scaling-up scenarios.

Private Sector Involvement: Getting more private sector providers (both doctors and nurses) is difficult. They are in businesses and are profit-oriented and 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 have a professional or personal tie to area. 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. Its capacity-building philosophy as well as the numerous linkages to other organizations and projects also seems to work well for the benefit of staff and the organization. This allows SFH to carry out more than it would be able to do alone. However, the 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 SFH has undertaken will end when donor funding ends. Until sustainability is resolved, 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.

2.5.6. 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. 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, information provided by NARHS on misconceptions about family planning, and exposure to targeted mass media social marketing is highly relevant and has 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 analyzes progress on coverage and quality of access to FP/RH. Qualitative data have been used to corroborate or tease out issues in the implementation process that were not addressed by population-based data. Routine management information system (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 was 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, which 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 (see Annex C for details). Not all of these can be filled by the various surveys and M&E requirements. The lack of M&E officers in the field also limits the collection and analysis of indicators measuring the accomplishment of key interventions.

2.6. CROSS-CUTTING ISSUES:

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

2.6.1. 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, when measured on a population basis, the project’s success is minimal.

ACQUIRE has provided services to around 5,000 women to date over the life of the project so far. However, 800,000 women need fistula repair and the number of women nationwide who develop fistulas nationwide is 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. This is the case because of cultural practices, lack of transport in an emergency, and because most women's experience with government hospitals has not been helpful. In addition, few traditional birth attendants bring their patients to even project hospitals for fear of losing their fee or of being berated by the hospital staff. There is not 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 Demographic and Health Survey (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.

2.6.2. 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 needed 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 it must spend hours on the road to reach scattered clinics. This is most notable in Katsina. While ACCESS is doing better in Kano and Zamfara, 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.

The team was 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.

2.6.3. 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, it was 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: The team spoke with many people in the projects about synergy. Unfortunately, it found 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 were worse. According to ACQUIRE, when it asked ACCESS to help with training of outreach workers, ACCESS reportedly refused unless it could count all the CYP generated by ACQUIRE’s staff against ACCESS’s targets. This is absurd. In some ways, the team faults the Mission for allowing the number counting to get ahead of project implementation.

Coordination: There was very little coordination with the DFID. This was confirmed by meetings with this organization, 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: This was discussed with staff from each of the projects. The team believes 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. They are only sustainable because 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, 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.

2.6.4. Other Significant Issues

Poor data quality: This is a problem that the Mission needs to address immediately. The team did not see PMPs either for the health office of the Mission, or for any IP except IRHIN—and even that did not include targets for the Pathfinder program. The team found the following problems:

- ACCESS registers are not filled in sufficiently to know whether EmONC procedures are actually being carried out.
- CHEWs do not understand or are not able to follow the 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, the team does not believe any of the service statistics presented by ACCESS. However, there is no reason to doubt their non-service statistics, trainings, equipment furnished, buildings rehabilitated, etc. The team also does 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: it is absurd to try to do social marketing across the country with \$13.5 million. Indeed, the only reason why USAID has 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 the team agrees with that assessment. While the team has not costed out a new private sector project, it feels that it should be as large as the TSHIP award.

Recommendation: Funding should be increased as currently planned, and the USAID Health Office should be increased to six direct hire equivalent positions.

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

Recommendations:

- SFH, CSOs, and government agencies need to identify ways to reduce turnover of key personnel, especially providers.
- Retention indicators should be developed and used in recruiting for positions.
- An awards system needs to be developed to encourage key staff and providers to continue working for the program.

Lack of basic facilities: These issues have also been discussed in depth: lack of electricity, lack of water, lack of the resources to sterilize instruments, lack of transport, and run-down hospitals and clinics.

2.6.5. Future USAID/Nigeria Health Programming

The Mission requested that the team look at specific issues concerning future health work in Nigeria.

Greatest impact:

- The team agrees with the Mission’s decision to focus on two states for most public and private sector efforts.
- There is an enormous unmet need for FP across Nigeria. This means that the Mission should increase CSM efforts with an emphasis on increased supply and logistics and frequent mass/multi media campaigns.
- Fistula training should be incorporated into core and specialist medical training.
- 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. The team feels 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 supervision with enough system strengthening to address immediate obstacles, i.e., frequent staff transfers, preference of LGAs for cheaper and poorly skilled CHEWs at health facilities. As has been 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 has depended more on the interests of the individuals in top positions than any structural improvements. Extremist attacks, such as those seen 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.
- The team believes 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: SFM is an extremely experienced CSM organization. It has the capacity to move to scale under the new private sector/social marketing program.

Innovative programs:

- Innovative fistula repair program
- Innovative outreach to men, community, and religious leaders
- Innovative approaches to women's credit for support for perinatal care
- Little innovation in other programs: they seem to be replicating work done elsewhere without considering Nigeria's unique needs.

Conclusion: Each member of the team believes that the USAID/Nigeria Mission and its IPs 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.

ANNEX A: SCOPE OF WORK

USAID/Nigeria MCH/Reproductive Health Program
Mid-term Evaluation
(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 (SFH). 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% of women using a modern contraceptive. USAID 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?

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 cite 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 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 were 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 be done?
- 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
- 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, D.C.
- 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. The evaluation team will consist of:

International

The five 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, and 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 MCH 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 two local Research/ Logistics Assistants who will provide logistical and administrative 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 team leader.

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 of background documents & offshore preparation work	5	3	3	3	3	2	2	0
Phone interviews and meetings with ACCESS/MCHIP & ACQUIRE staff	3	2	2	2	2	0	0	0
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	2	2	2	2	2	2	2	

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
(preliminary draft report due to USAID)								
Depart Nigeria /Travel to US	2	2	2	2	2	0	0	
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 focus group instruments, and a timeline upon the completion of the team planning meeting.
- In and out briefings with key mission personnel, including the Mission Director, 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 comments on the draft report within two weeks of submission.

- Final report in both hard copy 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.

ANNEX B: CIVIL SOCIETY ORGANIZATIONS

SFH developed partnerships with 18 CSOs to set up community outreach/referral projects in 18 states with high unmet need. The following is a listing of these CSOs and the states where they are working.

S/N	State	Civil Society Organization
1.	Rivers	Support for Mankind Development Initiative
2.	Cross River	Centre for Health Works, Development and Research
3.	Bayelsa	Center for Development Support initiatives
4.	Plateau	FOMWAN
5.	Gombe	Community Oriented Health Providers Association
6.	Abia	Eziukwu 1 Community Partners for Health
7.	Delta	Hope Health Organization
8.	Ebonyi	Safe Motherhood Ladies Association
9.	Bauchi	Rahama
10.	Borno	Community Development and Reproductive Health Initiative
11.	Zamfara	Future Hope
12.	Katsina	Association for Reproductive Family Health and Youth Development
13.	Kaduna	Women Development Organization
14.	Lagos	Human Development Initiative
15.	Ogun	Positive Outreach Foundation
16.	Kwara	Royal Covenant Heritage Foundation
17.	Edo	Centre for Research and Preventive Health Care
18.	Ondo	Knowledge and Care Organization

ANNEX C. TABLES

CONTRACEPTIVE TARGETS AND ACHIEVEMENTS

SFH and USAID plot monthly, quarterly and annual sales of contraceptives. It is important to report and analyze CYP as well as unit sales. It is also important to look at the contributions of each method.

In the text CYP sales are summarized by method and fiscal year in table 10. This annex provides more detail on CYP sales. For example, Table 9 shows that almost three million Depo Provera injections were sold during the FY 2006–2008 period, and close to 15 million packets of Duofem were sold.

However, that does not necessarily mean that Duofem outsold Depo Provera, since one is an injectable that is good for three months and the other only lasts one month. To standardize sales the project computes “Couple Years of Protection,” known as CYP. The table shows the conversion factors that are used to calculate CYP for each method. For example, four injections equal one CYP and 15 packets of Duofem equal one CYP. These factors take into account such behavioral issues as missing an injection or pill.

The table shows that condoms are by far the most common contraceptives sold. In terms of CYP, condom sales account for almost two-thirds of all contraceptives sold. Three brands of contraceptives (Gold Circle, Depo Provera, and Duofem) dominate the market, accounting for almost 90% of all sales. Almost two-thirds of CYP are attributable to condoms, which is generally of limited effectiveness. The most effective and cost-effective method listed in the chart is IUD, which accounts for less than 4% of all CYP. Clearly, the emphasis on methods is the reverse of what it should be. Long-term methods should be dominant. Condoms and CycleBeads should be at the bottom of the list of effective methods.

Product	Type	CYP factor	Total Sales	Total CYP	Per-cent
Depo Provera	Injectable	N / 4	2,908,700	727,175	10.7%
Duofem	Oral	N / 15	14,947,050	996,470	14.6%
IUD	IUD	N * 1.68	149,940	251,899	3.7%
Condoms*	Condom	N / 120	518,633,686	4,321,947	63.3%
Noristerat	Injectable	N / 6	2,623,300	437,217	6.4%
Postinor 2	Emergency oral	N / 15	778,800	51,920	0.8%
CycleBeads	Standard days	N * 2	15,270	30,540	0.4%
Norigynon	Monthly injectable	N / 12	44,760	3,730	0.1%
Jadelle	2-rod implant	N * 3.5	510	1,785	0.0%
Pregnon	Emergency oral	N / 15	49,850	3,323	0.0%
Total				6,826,006	100.0%

*Gold Circle. Another brand (Lifestyle) has just been introduced.

If enough short-term methods were sold, then the program would not need to concentrate on long-term methods. These data show that this is not the case. The relative distribution of CYP by method shows little change year by year. IUDs, for example, increased in 2007 but declined in 2008. Almost all other methods showed modest increases each year. But overall, total CYP gained 12.6% between 2006–2007 and 15.7% between 2007 and 2008. Again, most of that increase was in condom sales. The program needs to put more effort into the promotion of long-term methods if it is going to have any effect on CPR and total fertility rate (TFR).

TABLE 10: CYP ACHIEVEMENT FY 2006–FY 2008					
Product	FY06 Actual CYP	FY07 Actual CYP	FY08 Actual CYP	Total Actual CYP	Percent
Depo Provera	179,375	239,875	307,925	727,175	10.2%
Duofem	302,310	321,720	372,440	996,470	14.0%
IUD	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	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%

Table 11 shows the CYP targets by year. What stands out is a significant increase in targets for Depo Provera and condoms. Targets for IUDs remain low and flat at less than 1% increase over the three years. Condom targets, on the other hand, more than doubled in 2007. Postinor 2 had an unattainable target of 480,000 CYP in 2006. That dropped to 53–58,000 CYP in 2007 and 2008. It appears that the project set unrealistic targets for some key methods and put its emphasis on condoms, one of the least effective contraceptives.

TABLE 11: CYP TARGETS, FY 2006–FY 2008					
Product	FY 06 CYP Target	FY 07 Target CYP	FY 08 Target CYP	Total Target CYP	Percent
Depo Provera	3,000,000	3,300,000	3,630,000	9,930,000	61.0%
Duofem	308,000	385,000	423,500	1,116,500	6.9%
IUD	31,250	32,035	32,832	96,117	0.6%
Condoms	700,000	1,648,333	1,771,958	4,120,292	25.3%
Noristerat	100,000	110,000	121,000	331,000	2.0%
Postinor2	480,000	52,800	58,080	590,880	3.6%
CycleBeads	20,000	30,000	50,000	100,000	0.6%
Total CYP	4,639,250	5,558,168	6,087,370	16,284,789	100.0%

Excludes new contraceptives (Norigynon, Jadelle and Pregnon), for which targets had not been set.

Table 4 shows that by the end of 2008 the project had significantly overestimated sales of Depo Provera (9 million CYP) and Postinor 2 (close to 540,000 CYP). Although condom sales did well, this is still the dominant market method.

TABLE 12: CYP TARGETS VS. ACHIEVEMENTS, FY 2006–FY 2008					
Product	FY 06 Actual - Target CYP	FY 07 Actual - Target CYP	FY 08 Actual - Target	Total Actual - Target CYP	Percent
Depo Provera	-2,820,625	-3,060,125	-3,322,075	-9,202,825	100.1%
Duofem	-5,690	-63,280	-51,060	-120,030	1.3%
IUD	107,908	163,895	157,218	429,021	-4.7%
Condoms	642,339	-233,598	-207,118	201,623	-2.2%
Noristerat	4,867	39,333	62,017	106,216	-1.2%
Postinor2	-480,000	-52,800	-6,160	-538,960	5.9%
CycleBeads	-18,260	-20,000	-31,200	-69,460	0.8%
Total CYP	-2,569,462	-3,226,575	-3,398,378	-9,194,415	100.0%

Excludes new contraceptives (Norigynon, Jadelle, and Pregnon), for which targets had not been set.

The main conclusion from this analysis is that the program is relying too much on condoms and will have a very difficult time increasing CPR and decreasing TFR through this strategy. Much more emphasis will be needed on longer-term methods (IUDs, implants, voluntary surgical contraception) and mid-range methods (orals and injections).

PROJECT MONITORING INDICATORS

It is especially important that all of the key stakeholders (SFH, Pathfinder, USAID, government agencies, et al.) have access to all of the project monitoring indicators. This includes baseline, mid-term, and final performance data. These data are crucial for determining how well the projects are doing in carrying out their planned activities. Mid-term data are especially important for USAID/HPN's planning process. After all, HPN will continue IRHIN through mid-2010 and thereafter in new projects in social marketing and private sector. It will be important for the current Performance Monitoring Plan (PMP) to be examined and decisions made as to what changes, if any, will be made for the next phase of support.

The following table summarizes the status of all of the 32 PMP indicators selected for the IRHIN project. The evaluation team did not have the time needed to do the same for ACCESS and ACQUIRE. USAID should make sure that those PMPs are completed, analyzed and revised as needed.

The IRHIN PMP is organized by IR. The number of indicators selected for the SO and IRs is summarized below:

SO 15: Increased use of CS & RH services	2 indicators
IR 15.1: Improved quality of CS & RH services	6 indicators
IR 15.2: Strengthened enabling environment	2 indicators
IR 15.3: Expanded demand for improved CS & RH services	12 indicators
IR 15.4: Increased access to CS & RH services, commodities and materials	5 indicators
Other indicators	4 indicators

There are two SO indicators. As noted already, the project has not done well with respect to the most significant indicator—use of modern contraceptive methods. In the future much more emphasis and support will be needed to go well beyond the miniscule CPR target. Data on the second indicator have not been collected, much less analyzed. This is a key behavioral indicator that should be activated so that program managers can identify interventions that lead to increased use of services.

TABLE 13: SO DATA TABLE					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid - Target
SO 15: Increased Use of Child Survival & Reproductive Health Services					
1. CPR (modern methods)	NARHS	9%	11%	9.7%	- 1.3
2. Increased percentage of women seeking FP counseling and information in targeted areas	TRAC Nigerbus survey	Kaduna 26% Abia 29% Cross River 44%			

The six quality indicators are not especially enlightening because the first two, which are positive, are very limited. If Pathfinder developed and administered a quality score the team could not find it. The indicator on clinics rehabilitators is a simple count that does not indicate much about quality. The last two indicators are also broad estimates, which may not even be accurate.

Overall, quality of care is an important contributor to program success and deserves to be carefully monitored. USAID should make sure that better indicators are selected and data on quality are collected, analyzed, and acted upon.

TABLE 14: QUALITY DATA INDICATORS					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid - Target
IR 15.1 Improved Quality of Child Survival & Reproductive Health Services					
1.1 Provision of correct information on FP	Mystery Client Survey	See Table 18			
1.2 Score on client satisfaction	Exit surveys	See Table 19			
1.3 Quality score of clinic providers	Pathfinder Quality Assurance system				
20.9 Clinics Rehabilitated /built (homes, schools, clinics, markets)	Program reports	0	21	21	0
20.10 Beneficiaries of Clinic Activities	Program reports	0	1.2 million		
33.5 Number of people trained in FP/RH with USG funds	Program reports	0	63	1,474	+1,411

The indicators for enabling environment do not reflect the very significant contributions that FSH has made in gaining support for new contraceptives and licensing of PPMV. Both indicators should be dropped and replaced by more qualitative measures.

TABLE 15: ENABLING ENVIRONMENT DATA TABLE					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid -Target
IR 15.2 Strengthened Enabling Environment					
2.1 Belief that parents, community leaders or religious leaders support the use of FP by couples	NARHS	M: 30% F: 29%	M: 35% F: 34%	Religious leaders only Kaduna 52.2% Abia 17.8% Cross River 34.4%	
2.2 Accurate and timely RH research disseminated to GON/MIH to make appropriate policy decisions	IRHIN reports	Not available			

The 12 demand indicators are, in general, much more informative and useful. The first seven of these indicators are from the NARHS and reflect national and state performance. The data are broken down by gender, which is very important for planners. They also show that mid-term performance is below target

for all but one of these indicators (intention to use FP in next 12 months). These figures should encourage USAID, the government, and partners to put more emphasis on specific demand creation activities.

Our assumption is that the NARHS indicators reflect local conditions and values: for example, “belief in the effectiveness of FP.” If not, the indicators should be revised to do so. In addition, some consideration should be given to adding key service indicators to the NARHS, such as “women seeking FP counseling and information.” Some indicators need to be standardized. For example, the NARHS asks women if they know at least two FP methods. The PMP asks if they know at least one FP method. Thus the NARHS data cannot be used for the PMP on this indicator.

The indicators on contraceptive distribution are collected regularly and are essential to the social marketing part of the program. These data on unit sales and CYP were examined in the tables below.

TABLE 16: DEMAND DATA TABLE					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid - Target
IR 15.3 Expanded demand for improved Child Survival & RH Services					
3.1 Belief that FP/CS methods are effective	NARHS	M: 63% F: 55%	M: 67% F: 60%	M: 51.5 F: 47.2	M: -15.5 F: -12.8
3.2 Intention to use FP in the next 12 months	NARHS	M: 8% F: 8%	M: 12% F: 12%	M: 19.8 F: 13.4	M: +7.8 F: +1.4
3.3 Belief that use of FP can lead to infertility	NARHS	M: 36% F: 33%	M: 31% F: 28%	M: 22.5 F: 21.8	M: -8.5 F: -6.2
3.4 Discussion of FP with a partner (at least once) in the last 12 months	NARHS	M: 34% F: 30%	M: 38% F: 34%	M: 16.8 F: 14.5	M: -21.2 F: -19.5
3.5 Belief in the efficacy of condoms	NARHS	F: 42%	F: 52%	M: 54.0 F: 44.9	M F: -7.1
3.7 Belief that contraceptives are easy to obtain (daily pill)	NARHS	Oral pills: M: 30 F:33 Injectable M: 26 F: 31 IUD M: 12 F: 16	Oral pills M: 36 F:39 Injectable M: 32 F: 38 IUD M: 15 F: 20	M: 20.9 F: 25.5 M: 20.6 F: 22.4 M: 6.4 F: 10.2	M: -15.1 F: -13.5 M: -11.4 F: -15.6 M: -8.6 F: +9.8
3.8 Knowledge of (at least 2) FP methods (PMP is at least 1)	NARHS	M:30 F:37	M: 35 F:42	NA	
3.9.1 Distribution of Condoms	MIS monthly report	150 million	1,025 million	187,780,896	-838,780,896
3.9.2 Distribution of contraceptives (OCs) (Duofem and Postinor2)	MIS monthly report	4 million	29 million	6,365,400	-23,365,400

TABLE 16: DEMAND DATA TABLE					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid - Target
IR 15.3 Expanded demand for improved Child Survival & RH Services					
3.9.3 Distribution of contraceptives (injectables)	MIS monthly report	Noristerat 490,700	Noristerat 3,464 million	1,098,100	- 2,365,900+
		Depo Provera 571,500	Depo 4,329 million	1,231,700	-3,115,300
3.9.3 Distribution of contraceptives (IUD)	MIS monthly report	25,000	271,982	54,300	-217,682
34.1 Couple years of Protection	MIS reports	1,984,413	13,391,649	2,697,831	-10,693,818

The five access indicators focus on distribution and coverage of contraceptives. There are no indicators of access to services. The commodity data come from annual MAP surveys that provide detailed information about the presence of each type of contraceptive. This is valuable information that is used to adjust social marketing strategies. One indicator (number trained in RH) was not reported and should probably be put in an activity category rather than a performance category.

USAID should consider including access to services in its revised PMP.

TABLE 17 A: ACCESS DATA TABLE					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid - Target
IR 15.4 Increased Access to Child Survival & RH Services, Commodities and Materials					
4.1 Distribution of OCs by PPMA & CBD (outlets with OCs in stock)	Distribution survey or MAP survey	65%	75%	68%	- 7
4.2.1 Coverage standard met for condoms	MAP survey	85%	90%	Gold = 68% Life =18%	- 22 +18
4.2.1 Coverage standard met for OCs	MAP survey	65%	75%	68%	- 7
4.2.1 Coverage standard met for Injectables	MAP survey	45%	60%	Noris = 41% Depo = 49% Norig = 7%	- 19 +49 +7
33.5 Maternal Capacity Building Number trained in RH	Program reports	0	20,000		

*Annual sales

A new set of seven indicators was added in FY 2007. No data were collected on three of the indicators. This is unfortunate as the indicators identify specific behaviors that are crucial to program performance: counseling visits, provision of counseling and services, and stock-outs. The fourth indicator is important to determine if mass media messages are being heard. This indicator fell some five million listeners below its target.

TABLE 17 B: ADDITIONAL ACCESS DATA INDICATOR TABLE					
Indicator	Source	Baseline	Target	Mid-term	Difference Mid - Target
New Number of counseling visits for FP/RH as a result of USG assistance	Project reports	NA			
New: Number of people who have seen or heard a specific USG-supported FP/RH message (Radio Drama)	Nigerbus		25 Million	19,956,288	- 5 Million
New Number of USG-assisted service delivery points providing FP counseling or services			21		
New Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP			2		

The overall conclusion is that an enormous amount of time and effort went into setting up a comprehensive PMP that is not being fully carried out as planned. The principal result is that some important PMP data are being collected and used (contraception distribution and NARHS data, in particular). However, much of the remaining PMP data are either being collected and not used or not even collected.

USAID will need to review its PMP for IHRIN to make sure that key indicator data are routinely collected, tabulated, analyzed, and acted upon. This recommendation applies to ACCESS and ACQUIRE, as well.

Mystery Client Survey Results

The data on the PMP indicator for *Provision of Correct Information on Family Planning* was to be collected through a Mystery Client Survey. That survey was conducted in early 2008. However, the survey does not include a specific, single question on provision of correct information. The following findings list a number of relevant questions that give a broad picture of provision of correct information. There are no baseline or target data.

TABLE 18: MYSTERY CLIENT RESULTS	
Information was clear and simple	95 %
Provider took concerns seriously	91 %
Had private talk with provider	88 %
Satisfied with the service	88 %
Obtained resupply of pill	84 %
Counseling time spent with provider was adequate	77 %
Good facility environment	77 %
Dissatisfied with pills and referred to hospital	51 %
First time users referred to clinic or MD	45 %
Informed of different FP methods	39 %
First time users prescribed daily pill	39 %
Information was not clear about how to take the pill	37 %
Told what to do if missed taking a pill	22 %
First time users sold pills	17 %
Stock-out	15 %
Informed about side effect of pill	14 %
Asked method preferred	8 %

This information and the qualitative section of the report conclude that the vendor was aware of situations requiring referral to a clinic, hospital or physician. However, many vendors did not refer new clients to health facility, largely because they were afraid of losing a customer.

Exit Interview Results

One of the PMP indicators is “Score on client satisfaction.” However, there are no data on that specific score. There are some data on client satisfaction, however. Exit interviews were conducted with 126 women in Abia, Cross River, and Kaduna states as part of Nigerbus. The data were analyzed in May 2009 and are summarized here. There are no baseline or target figures.

TABLE 19: CLIENT SATISFACTION WITH FP SERVICE	
Satisfied with FP service	97 %
Cost is expensive	7 %
Cost is affordable	82 %
Cost is cheap	11 %
Spent too much time in the clinic	25 %
Satisfied with services provided and will recommend to friends	99 %

The data show that clients are very satisfied, believe prices are affordable, and would recommend the service to their friends.

ANNEX D: PERSONS CONTACTED

ACCESS, ABUJA

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

ACCESS, KANO

Hannatu Abdullahi	MCH/RH Coordinator
Samaila Yusuf	Community Mobilization Officer
Aminu Idris	Finance and Administrative Assistant

KANO STATE & HOSPITAL OFFICIALS

Hajiya Aisha Isyaku Kiru	Commissioner for Health
Hajiya Sa'adatu Nataalah	National Coordinator FP
Hajiya Asmau Ahmed	Safe Motherhood 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
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Dr. (Mrs.) Archibong	Medical Director/Member MWAN, Faith Foundation
Edith Bassey	MW/FP Service Provider

ANNEX E: DOCUMENTS REVIEWED

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ANNEX F: RECOMMENDATIONS MATRIX

The following table summarizes the key findings and their related recommendations. The recommendations are organized by project (ACCESS, ACQUIRE, IRHIN) and topic.

Findings	Recommendations
General	
The EmONC sector receives relatively small amounts of funding when viewed in relation to the problems to be addressed, and that the USAID office lacks both funding and staff to support the ACCESS program adequately. (p. 14)	Funding should be increased as currently planned, and the USAID health office should be increased to six direct-hire equivalents.
Officials met at the state and local levels seemed relatively unconcerned about the need for family planning. (p. 2)	In future work in this area, efforts should be made to work with communities to advocate use of family planning/birth spacing.
The PMP targets were: 1.025 million units for condoms; 29 million for OCs; 3.5 million for Noristerat; 4 million for Depo; 271,000 for IUDs; and 13.4 million CYP. Most of these targets are so high that they must be in error. (p. 43)	Revise the project targets to be more reasonable and attainable.
Staff and Training	
Multiple places in document: all activities are hampered by staff turn-over. (e.g. p. 45)	<p>SFH, CSOs and government agencies need to identify ways to reduce turnover of key personnel, especially providers.</p> <p>Retention indicators should be developed and used in recruiting for these positions. Examples are: the candidate has ties to his/her home state or town.</p> <p>An award system needs to be developed to encourage key staff and providers to continue working for the program.</p>
CHEWs may not have adequate basic education to serve as trained birth attendants. (p. 16)	The Mission should explore the possibility of the new midwifery school in Zamfara training a new cadre of community midwives.
There has been little, if any, update training. (p. 35)	Refresher or upgrade training should be introduced to keep PPMV current as to advances in FP and contraceptive technology.
A total of 16 detailers have been trained to cover all of Nigeria. (p. 37)	More detailers should be hired and trained if the program is to expand.
Only 100 of 900 trained providers have received updates. (p. 36)	Periodic upgrade/refresher training is needed for staff and providers.

Findings	Recommendations
Commodities and Logistics	
Stock-outs have a significant effect on PPMV sales and customer confidence in the reliability of supplies. (p. 35)	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. SFH should examine ways to reduce or eliminate stock-outs. For example, it could establish “buffer stocks” or emergency supplies at warehouses that can be tapped to fill unexpected gaps.
There is frequent “borrowing” between the private and public sectors, despite USAID prohibitions. (p. 39)	USAID should relax its distribution policy so that public and private stocks can be loaned to each other in cases of emergency.
Frequent staff transfers have made training facilities’ maternity staff difficult. (p. 18)	Work should be undertaken in the future on a state-wide basis, rather than only in selected LGAs.
Communication and Media	
Mass media campaigns are limited, and community IPC initiatives are limited to a year’s support. (p. 41)	More effort is needed in both mass media and interpersonal communication, since 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.
IEC materials were difficult to find in most sites that were visited by the team. (p. 41)	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.
The radio drama, “One Thing at a Time” has been an effective mode to reach selected markets. (p. 39)	Develop 26 or more Radio Drama segments and other mass media series on health issues.
IEC materials were difficult to find in most community outreach sites that were visited by the team. (p. 40)	Produce and distribute new and standard IEC and point of service material.
One Catholic diocese has been open to a program called “Contraception for Catholics,” which teaches all methods, while focusing attention on the methods approved by church hierarchy.	Expand the existing “Contraceptives for Catholics” campaign.

Findings	Recommendations
ACCESS	
Exclusive use of LAM for postpartum FP may be a missed opportunity for women to use longer-term methods. (p. 12)	ACCESS should review its LAM-only contraceptive policy for postpartum FP, and consider whether it makes more sense to start women on a contraceptive regimen immediately.
Only a few months remain in the ACCESS project in Katsina State. Very little has been accomplished because of staff turnover and construction procurement delays. (p. 13)	USAID should discuss the future of work begun in Katsina State with all stakeholders and consider redirecting resources (including possibly staff) to the other two states.
Future support for MNCH/FP is unclear in strategy statements.	ACCESS should continue in Kano and Zamfara until the end of the MCHIP period. ACCESS should relocate its work under TSHIP to one or both of the selected priority states.
There is little or no synergy between the three projects evaluated. (p. 17)	USAID should link ACCESS and ACQUIRE interventions in the future to ensure that maternal and neonatal services are provided.
There are poor relations between the ACQUIRE fistula repair project and the professional training at basic medical and specialty levels. (p. 21)	USAID should work with specialist obstetricians and gynecologists to introduce appropriate fistula repair technology into medical school and specialist training.
The ACCESS EmONC package does not include secondary fistula prevention. (p. 23) 80% of women in the north deliver at home. (p. 8)	ACCESS should immediately add secondary fistula prevention to its Nigeria outreach and clinical EmONC services.
It is very difficult to link women receiving pre- and perinatal care to contraceptive use, and even more difficult to link motivational efforts in the community to women's use of birth spacing techniques. This is complicated by frequent stock-outs, which have the effect of requiring women to seek contraceptives in other outlets. (p. 9)	ACCESS should develop more robust measures to link family planning motivation and support to government clinics to actual contraceptive use.
ACQUIRE does not provide contraceptive goods or services directly, but refers patients to another center, often co-located with ACQUIRE. (p. 24)	The ACQUIRE project does not provide contraceptive services directly, so it needs to develop effective ways of measuring contraceptive use that are directly related to clinical and outreach services.
The Mission has not adequately negotiated the reason for data collection and reporting with ACCESS and ACQUIRE. (p. 24)	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."
Other programs do not have specific secondary fistula prevention programs. (p. 23)	The integration of fistula prevention/care into ongoing country programs and initiatives should be promoted. It should be integrated into the maternal newborn and child health strategy. ACQUIRE should develop a compact guide on effective approaches to involving fistula survivors at the facility and community levels.

Findings	Recommendations
IRHIN	
All providers together only provided some 12,500 CYP over four years, or an average of less than 400 CYP per partner per year. (p. 32)	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 redesign the approach in any subsequent program.
Only scattered advocacy events have been scheduled. (p. 39–40)	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.
Contraceptive prices fluctuate according to availability, which affects use and continued use. (p. 39)	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.
SFH purposely establishes linkages with local and international organizations, both public and private. (p. 46)	SFH should continue to carry out its good management practices, including capacity development and linkages with other organizations.
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. (p. 46)	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.
Factors affecting PPMV performance are poorly understood. (p. 36)	An assessment of PPMVs is needed to identify ways to improve performance.
Some IUD campaigns [SFH] has sponsored have produced 50–100 new IUD acceptors in a single day. (p. 45)	Develop a strategy for increasing acceptance of long-term methods, especially IUDs.
Pathfinder CSOs did not become effective providers of FP goods and services. (p. 32)	Conduct an in-depth assessment of the Pathfinder and CSO programs to find ways to make them more effective.
The latest [MAP] 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...”	Take action to implement the MAP recommendations on coverage and quality of coverage.
Expansion/scaling up is under discussion among [SFH] staff. (p. 45)	Develop contingency plans for various scaling- up scenarios.

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