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ACCESS TO CLINICAL AND COMMUNITY MATERNAL, NEONATAL AND WOMEN'S HEALTH (ACCESS) / MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM (MCHIP)

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ACRONYMS AND ABBREVIATIONS

ACE	Alliance for Credible Elections
ACCESS	Access to Clinical and Community Maternal, Neonatal & Women's Health
AMTSL	Active Management of Third Stage Labor
ANC	Antenatal Care
AR	Annual Report
CCG	Community Core Group
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHEW	Community Health Extension Worker
CMT	Community Mobilization Team
CPR	Contraceptive Prevalence Rate
CYP	Couple Year of Protection
DFID	British Department for International Development
DQA	Data Quality Assurance
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
ESMPIN	Expanded Social Marketing Project in Nigeria
ETS	Emergency Transport System
FANC	Focused Antenatal Care
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FP	Family Planning
GH	General Hospital
GHI	Global Health Initiative
GON	Government of Nigeria
HBB	Helping Babies Breathe
HHC	Household Counselor
HHCC	Household to Hospital Continuum of Care
HMIS	Health Management Information System
HPN	Health, Population and Nutrition
IEC	Information, Education and Communication
IPC	Interpersonal Communication
IR	Intermediate Result
ISS	Integrated Supervisory System
IUD	Intrauterine Contraceptive Device
JHPIEGO	An Affiliate of Johns Hopkins University
KMC	Kangaroo Mother Care
LAM	Lactational Amenorrhea Method
LGA	Local Government Area
LOP	Life of Project
LSS	Life Saving Skills
MBSM	Male Birth Spacing Motivator
MCHIP	Maternal and Child Health Integrated Program
M&E	Monitoring and Evaluation
MgSO ₄	Magnesium Sulfate
MMR	Maternal Mortality Ratio
MMSH	Murtala Mohammed Specialist Hospital (Kano)
MNB	Maternal and Newborn
MNBC	Maternal and Newborn Care

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MSS	Midwives Service Scheme
NDHS	Nigeria Demographic and Health Survey
NHMIS	National Health Management Information System
NMEMS	Nigeria Monitoring and Evaluation Management Services
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Center
PMP	Performance Management Plan
PMV	Private Medicine Vendor
PO	Project Objective
PP	Postpartum
PPH	Postpartum Hemorrhage
PRRINN	Partnership for Reviving Routine Immunization in Northern Nigeria
RH	Reproductive Health
SBA	Skilled Birth Attendant
SBM-R	Standards Based Management -- Recognition
SMOH	State Ministry of Health
SO	Strategic Objective
SOW	Scope of Work
TFR	Total Fertility Rate
TMMD	Women's Savings and Loan Group
TPM	Team Planning Meeting
TSHIP	Targeted States high Impact Project
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USAID/N	United States Agency for International Development/Nigeria
USG	United States Government
VDC	Village Development Committee
WCWC	Women and Children Welfare Clinic
WDC	Ward Development Committee

EXECUTIVE SUMMARY

BACKGROUND

The United States Agency for International Development (USAID)/Nigeria transferred field support funding annually, over the period January 2006 through February 2012, to two consecutive USAID/Washington centrally-funded projects, first, to the Access to Clinical and Community Maternal, Neonatal and Women's Health Project (ACCESS) and subsequently, when ACCESS ended, to the Maternal and Child Health Integrated Program (MCHIP). The purpose of this final external evaluation is to assess achievements under the ACCESS/MCHIP Project relative to their objectives and indicators. Specifically, the evaluation will assess:

- ACCESS/MCHIP's performance achievements against project indicators encompassing issues of population coverage, couple years of protection (CYPs), contraceptive prevalence, impact on mortality and effectiveness of key innovations implemented;
- ACCESS/MCHIP's performance of in-service facilities and communities on improving the quality of care in Emergency Obstetric and Newborn Care (EmONC), antenatal and postnatal care, Family Planning (FP) and safe maternity services for normal births; and
- Sustainability of achievements under the ACCESS/MCHIP Project at the national, state and local areas and service delivery sites, including the impact on policy at the federal and state levels.

Several constraints were experienced during the conduct of this evaluation due to the deteriorating security situation in the Northern states. As a result of travel restrictions and delays encountered in getting to the field, only eight facilities in two states were visited over a five-day period instead of the originally planned 14-16 facilities in all three states over 10 days. However, the team was able to bring State Ministry of Health (SMOH) and Local Government Area (LGA) officials from all three states to Abuja for in-depth interviews, and this provided rich supplemental data to the facility and community feedback obtained during the field visits to the two states. Thus, the evaluation team feels that more than sufficient and complementary data were collected to ensure an informed and valid final evaluation of the ACCESS/MCHIP Project.

KEY FINDINGS

Increased Utilization of FP and EmONC Services

The ACCESS/MCHIP Project increased utilization of FP and EmONC services in selected LGAs in Zamfara, Kano and Katsina states from January 2006 to February 2012 through implementation of the Household to Hospital Continuum of Care (HHCC) approach that created awareness and increased demand at the community level, linked communities to facilities where providers had received skills training and improved,

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standards-based management was being practiced. Over the Life of Project (LOP), the number of deliveries with a Skilled Birth Attendant (SBA) increased fairly steadily against annual targets, as did the number of Antenatal Care (ANC) visits, the number of Postpartum (PP)/newborn visits within three days of birth, and the number of newborns receiving essential care. The number of counseling visits for FP/Reproductive Health (RH) and Couple Year Protection (CYP) attributable to the project's activities lagged over the first three years, but eventually caught up to and exceeded their targets during the final two reporting years of the project. Data and feedback from the field confirm that targets were exceeded as a result of the increase in the number of LGAs and facilities over the LOP, as well as an increase in the utilization of services at the individual facility level.

The greatest increase in utilization of FP and EmONC services took place at the hospitals, which is to be expected due to their larger client load and number of staff. However, it was also clear that FP and ANC visits had increased as well at the four Primary Health Centers (PHCs) visited. Three of the four PHCs visited more than doubled their number of annual ANC visits over the Life of the Project (LOP). Utilization trends observed in the eight facilities visited are generally consistent with utilization of services in the remaining program-supported facilities. Significant increases and decreases in utilization figures generally tracked skills training for providers and the availability of Skilled Birth Attendants (SBAs) and other staff. The community mobilization effort was overwhelmingly cited for its critical role in informing, motivating and linking the community to facility-based services. All FP and Maternal and Newborn Care (MNBC) services were facility-based; only awareness raising, counseling and the establishment of Emergency Transport Systems (ETs) were community based.

Improved Quality of FP Services

The quality of FP counseling and services were improved under the ACCESS/MCHIP Project through skills training for providers, the use of Standards Based Management-Recognition (SBM-R), supportive supervision and the provision of equipment. Over the LOP, over 600 doctors, midwives and Community Health Extension Workers (CHEWs) were trained in FP counseling skills, contraceptive technology updates, postpartum family planning, including Lactational Amenorrhea Method (LAM) and the provision of two long term methods, Intrauterine Contraceptive Devices (IUDs) and Jadelle implants. The quality of FP services was measured by three indicators, all reasonably good proxies for quality of care: number of service delivery points providing FP counseling or services; number of persons trained; and the number of FP counseling visits as a result of program assistance. Annual targets were met or exceeded each year with the exception of counseling visits, but the number of visits eventually surpassed the annual targets and then doubled the FY 2011 target.

Feedback from field visits and interviews with key SMOH and LGA stakeholders confirmed that the facilities' staff had benefited from skills training and were now better able to counsel clients and provide services, including IUDs and Jadelle, which they had not been doing previously. Printed posters and flip charts were observed in the facilities

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and reportedly being used. The 56 FP standards of care developed in 2009 as part of the SBM-R approach were not being fully adhered to due to the lack of sufficient staff and equipment. However, many of the stakeholders cited the FP standards as being useful job aids to the providers to remind them of important steps to follow. Staff at the high volume, better staffed Murtala Mohammed Specialist Hospital (MMSH) in Kano were trained in SBM-R and, following the first external follow-up visit, increased compliance against FP standards from 63.2% to 82.5%. The quality of FP service delivery was impaired by frequent staff turnover that required re-training, insufficient staff, lack of necessary equipment such as IUD and Jadelle insertion kits, and inadequate private space for FP counseling.

Improved Quality of EmONC Services

Progress against targets for the quality of EmONC services was strong for five of the seven indicators, particularly for providers trained in EmONC, use of Active Management of Third Stage Labor (AMTSL) and eclampsia management. Training of service providers in EmONC, implementation of best practice innovations in EmONC, establishment of standards for EmONC, provision of equipment and renovation of facilities were the key inputs for increasing the quality of EmONC care.

Feedback from the field facility visits and interviews with the SMOH and LGA stakeholders confirmed a significant improvement in provider skills: Life Saving Skills (LSS); Focused ANC (FANC); AMTSL; management of Postpartum Hemorrhage (PPH) and eclampsia; Helping Babies Breathe (HBB); and management of neonatal sepsis. The perception was that, following infection prevention training and skills training for providers, the management of labor and delivery is now cleaner and safer even at the PHC level.

The SBM-R approach to improving the quality of services was introduced into 30 facilities, but never fully implemented owing to the large number of standards involved, insufficient staff and equipment. In the 11 facilities where baseline and two external assessments were carried out, compliance with EmONC standards significantly increased in hospitals through a mean score of 11.8% at baseline compared to a mean score of 83.9% after the second external assessment; and in PHCs from a mean score of 1% at baseline to 61.9% after the second assessment.

Three facilities, out of the 19 renovated under the project, were visited and it was observed that two were already in disrepair and the other had already been re-renovated by another donor. The quality of the renovation work appeared to have been sub-standard, nonetheless, the facility's staff were appreciative of the renovation assistance, as well as the basic obstetric care equipment that had been provided.

Improved Enabling Environment for Scale-up of Successful Project Activities at State and National Levels

All three process indicators for improving the enabling environment were achieved in a timely manner, but were poor indicators that failed to capture the scope and intent of this important Intermediate Result (IR). The ACCESS/MCHIP Project contributed

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significantly at the national, state and LGA levels to an improved enabling environment through:

- Participation in national-level advocacy groups that formulated strategy, increased funding for and inclusion of FP commodities as a line item in the national budget, contribution to the design of the Midwives Service Scheme (MSS), establishment of national standards for FP and EmONC, etc.;
- Assistance to Zamfara state in setting up a state Health Management Information System (HMIS) and harmonizing data collection registers for all three states, active participation in state stakeholder groups that developed an integrated supervisory system;
- Community mobilization efforts at the LGA level that increased awareness and acceptance of birth spacing and ANC, the establishment of an Emergency Transportation System (ETS) and a community financing mechanism for birth preparedness and emergency transport needs (Women's Savings and Loan Groups).

Many of the achievements mentioned above have a relatively good chance of being sustained and possibly scaled-up: policies and standards, new HMIS systems and improved data collection and use of data, establishment of the ETS and financing mechanisms, etc. This was supported by stakeholder feedback from all three levels. Women's Savings and Loan Groups have already multiplied and are thriving well beyond project areas. The Kano SMOH expressed interest in scaling up community mobilization throughout the state, and stakeholders from all three states felt that some community mobilization efforts would continue due to the communities' feeling of empowerment.

Improved Management of Maternal and Newborn Care Services

The three indicators used by the project to measure improved management reflected neither the scope nor the intent of the Intermediate Result (IR). Two indicators were eventually dropped and the indicator that measured utilization of Essential Newborn Care (ENC) exceeded the targets annually. Nonetheless, significant achievements took place that contributed to improved management of MNBC services:

- Improved record keeping and data management at the facility and state level;
- Development and use of 14 management standards for hospitals and PHCs; and
- Improved capacity for and use of supportive supervision of service providers.

Feedback from SMOH and LGA stakeholders confirmed that improved record keeping, training in data management, use of standards and a joint supervision effort increased the effectiveness and focus of data reporting and use of data for management decision making, improved quarterly supervision and the state's capacity to carry this supervision out on its own.

Increased Demand for Maternal and Newborn Care Services

Achievement against all three indicators for increased demand was slow at the beginning of the project, but right on target over the last several years. Demand creation for MNBC services under the ACCESS/MCHIP Project focused on community mobilization efforts and relied largely on Interpersonal Communication (IPC) utilizing community leaders,

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male motivators and women who went house to house to reach pregnant women in their homes. Community Mobilization Teams (CMTs) and Community Core Groups (CCGs) were established to lead community engagement activities. Once these community groups understood the importance of birth spacing, ANC and facility based delivery with SBAs, they became engaged in leveraging materials and financial support from individuals and community organizations to address identified gaps such as renovation of a dispensary, curtains for privacy at a PHC, funds for procurement of essential drugs, mosquito nets, an ambulance, water tank, toilets for facilities, and benches for waiting areas.

Household Counselors (HHCs), recruited and trained to educate pregnant women on a one-to-one basis in their homes about the danger signs of pregnancy, labor, delivery and during the postpartum period, especially with their newborns, proved to be an effective mechanism for increasing awareness and demand for MNBC services in an appropriate manner. Male Birth Spacing Motivators (MBSMs) educated men alone or in groups about the benefits of birth spacing, the danger signs of pregnancy and delivery and the importance of encouraging women to attend nearby facilities for ANC and delivery with a SBA, effectively lowering barriers for women to seek services outside the home. Over the LOP, HHCs reached 32,926 women and referred 12,481 for a variety of MNBC services and improved their ability to recognize danger signs in pregnancy, labor and in their newborns. The MBSMs counseled and referred over 11,000 men for FP.

Feedback from the field visits and from SMOH and LGA officials confirmed that community mobilization, as carried out under the ACCESS/MCHIP Project utilizing CMTs, CCGs, HHCs and MBSM working together, was highly successful in creating demand for maternal and newborn services in project-supported areas. It was also noted that once communities became aware that certain facilities had been renovated and providers trained, they were more inclined to seek services from these nearby facilities.

Effectiveness of Project Design and Management in contributing to Project Achievements

The design of the ACCESS/MCHIP Project for Nigeria worked well overall. USAID/Nigeria was one of the few Missions to choose to implement the entire HHCC approach, thus addressing all three delays that women experience in reaching appropriate EmONC services and maximizing the synergy and impact of all HHCC components. USAID/Nigeria also chose to focus heavily on integrating birth spacing with MNBC services and was one of the few Missions to design and carry out a baseline and endline population-based survey, although only for the ACCESS phase. By focusing on 28 LGAs scattered over three states and only 57 facilities out of thousands, the project stretched limited resources over too large and scattered geographic area, achieving broader, but shallower coverage.

The implementing partner, an affiliate of Johns Hopkins University (JHPIEGO), provided good continuity of technical and management leadership at both headquarters and within Nigeria. JHPIEGO headquarters and partners provided frequent TA visits during the first year to facilitate start-up. Best practice interventions, skills training and provision of the

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equipment needed to implement them were generally successful, but not all. Those interventions that were introduced in a manner that was overly staff intensive and/or requiring long checklists or data tracking, or were simply not mother-friendly, were less successful in being incorporated and used by facility-based providers. While the ACCESS/MCHIP Project's leadership was strong and gender diverse, it was heavily physician based. While this ensured good access to the medical community, it is probable that a more diverse leadership, that included increased midwifery, community mobilization skills and experience, might have increased integration of interventions closer to the community and household in a more mother-friendly manner.

USAID/W provided good continuity of oversight of the ACCESS and MCHIP projects. The USAID/Nigeria Project Activities Manager changed twice during the project period, but received sufficient briefing to maintain management oversight. The frequency and intensity of field level oversight declined over the LOP from quarterly to annually or less. However, good management relationships with the ACCESS/MCHIP Project staff and quarterly portfolio reviews appear to have compensated for the limited field oversight.

Project monitoring and evaluation (M&E) over the LOP was quite good. JHPIEGO project staff reported regularly against IR indicators and USAID maintained an updated Performance Management Plan (PMP) that reflected LOP achievements. The majority of the ACCESS/MCHIP Project's indicators reported against matched the scope and intent of the IRs, but not always. Many indicators were expressed as numbers rather than percentages so there was little understanding of the denominator for each indicator. Unfortunately, there is little data on utilization for the newborn interventions: HHB, Kangaroo Mother Care (KMC) and neonatal management of sepsis as there were no indicators covering them. In addition to data collection and reporting against USAID indicators, ACCESS collected baseline and endline data through population-based surveys and facility audits which supplement the IR indicators and document important additional accomplishments and trends over the three years of ACCESS in the four original LGAs. Strong data quality assurance (DQA) appears to have been maintained by USAID under this project, so that weaknesses were detected early and satisfactorily addressed over the LOP.

Effectiveness of Facility and Community Level Activities in Promoting Access and Utilization of Services

Community and facility level interventions, as components of the HHCC approach effectively created awareness and leveled barriers to access, linked the community with the facilities, and improved the quality of service delivery at the facility level through skills training, management improvements and in some cases through renovation of facilities and provision of equipment. Each component intervention played an essential role that, when combined under the HHCC approach, resulted in increased utilization of MNBC services. Substantial linkages between communities and facilities were built into the HHCC model, primarily through the CMTs, CCGs, HHCs and MBSMs. Among the eight facilities visited, linkages were evident and observed at six. Feedback from the field visits, LGA and SMOH officials and other stakeholders both within and outside the ACCESS/MCHIP Project was overwhelmingly positive about the effectiveness of these

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various community mobilization and linkage interventions and their impact on improved health outcomes for mothers and newborns.

Of the numerous EmONC interventions supported through skills training for providers, eclampsia management with magnesium sulfate (MgSO₄) and AMTSL appear to have been most successfully incorporated and utilized in the facilities. The partograph was not widely used, primarily due to lack of partographs and late presentation of laboring women at the facilities. Three major newborn interventions were also piloted: KMC, HBB and management of neonatal sepsis. None of the three interventions were tracked through project indicators, nor was sufficient data available to determine actual use of these interventions. Nonetheless, feedback from providers and community level stakeholders was positive and sufficient to determine that of the three newborn interventions, HBB appears to have been most frequently utilized at facilities. While HBB was only implemented in the final year of the project, providers mentioned using the intervention successfully in the context of ENC. KMC appears to have been introduced in a manner that providers found to be time and space intensive, and mothers found it to be unfriendly.

From FY 2007 through FY 2010, data from ten hospitals within the project areas reflect that total deliveries by SBAs rose fairly steadily from 7,685 in FY 07 to 22,681 in FY 11, while the number of maternal deaths fell significantly from 283 to 163 from FY 07 to FY 10, or from 3.68% to .74% of all SBA deliveries. This is strong confirmation of the effectiveness of the multiple components of HHCC including community mobilization for demand creation, skills training for providers, implementation of best practice interventions and the use of performance standards for improved quality and utilization of EmONC services.

CONCLUSIONS

Community mobilization, as implemented through the ACCESS/MCHIP Project, is an effective tool for improving awareness, acceptability and demand for FP and maternal and newborn services. Placed within the HHCC approach, which linked demand for services from the community to facilities that had received a variety of quality-enhancing interventions, there was an increased uptake in FP and EmONC service utilization in project-supported areas. Much of this increased uptake in service utilization can be attributed to the ACCESS/MCHIP Project, based on data analysis of utilization trends and feedback from field visits to the facilities, state and LGA stakeholder interviews.

The quality of service delivery improved due to skills training for providers in effective interventions, and improved management of services and standards, which served as job aids for providers and as measures of quality improvement in service delivery. However, the high turnover and insufficient number of providers, as well as chronic shortages of equipment, infrastructure and commodities at the facility level, negatively impacted the project's ability to more fully improve access to and utilization of quality FP, maternal and newborn care. SBM-R is an appropriate approach for improving the quality of service delivery, but fell short of its potential by failing to fully take into account and

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modify the approach to take into consideration the low-resource setting (shortage of providers, commodities and equipment, capacity to track data) of project areas.

The ACCESS/MCHIP Project also contributed effectively to strengthening the enabling environment at the national, state and community levels, and this will have a long-term impact, well beyond the close of the ACCESS/MCHIP Project in February 2012. The sustainability of these improvements in the enabling environment are more likely to live on than those brought about by skills and management training because no supportive capacity was built or funding ensured for their continuation after the LOP. Continuation of some community mobilization efforts and the Women's Savings and Loan Groups is highly likely where commitment progressed to empowerment.

The ACCESS/MCHIP Project made a substantial contribution to USAID/Nigeria's Health, Population and Nutrition (HPN) Assistance Objective and the six intermediate results described earlier. Clearly, the project increased the quality and utilization of FP and EmONC services for pregnant women, mothers and newborns in selected LGAs in the three states in support of the original project objective.

The ACCESS/MCHIP Project leaves a wealth of lessons learned for consideration by on-going and future USAID HPN projects.

RECOMMENDATIONS

1. Experience with highly successful the ACCESS/MCHIP Project components, (HHCC, community mobilization, Women's Savings and Loan Groups, EmONC interventions, skills training etc.) as well as less successful or inadequately documented newborn care interventions, should be fully shared with and taken into consideration by TSHIP and other FP/MNBC projects and programs as soon as possible.
2. Although a MCHIP endline population-based survey similar to the one carried out at the completion of ACCESS (2009) was never carried out, USAID should consider repeating a similar survey using the same baseline facilities and LGAs in late 2012. This would help to better understand the achievements over five years in those first 4 ACCESS LGAs, as well as to ascertain the extent to which community mobilization activities were actually sustained after the project ended. This would also provide valuable additional information for the design of future projects, particularly those with community mobilization components.
3. New interventions (best practices or otherwise) should be introduced as early as possible in a project or program and should be tracked against established indicators. They should take into consideration low resource setting handicaps (shortage of providers, commodities and equipment, capacity to track data) and be focused as close to the community/household level as possible.
4. Project indicators should match the scope and intent of the project's IRs and should increasingly be denominator-based. When new activities and interventions are added

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mid-project, new indicators should be added to the results framework in order to track them properly. Several indicators on sustainability should be incorporated early to focus attention on designing and implementing activities in a manner more likely to be sustained.

5. Renovation of facilities should be used to leverage community or LGA support and contributions. It is more likely that the community will maintain and continue support for facilities they have built or renovated.

6. Master training capacity should be established at the state level for provider skills, as well as management strengthening training, would improve the chances for sustaining key capacity building interventions.

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INTRODUCTION

PURPOSE

USAID/Nigeria transferred field support funding annually, over the period January 2006 through February 2012, to two consecutive AID/Washington centrally-funded projects, first, to ACCESS and subsequently, when ACCESS ended, to MCHIP. The purpose of this final external evaluation is to assess achievements under the ACCESS/MCHIP Project relative to their objectives and indicators.

The main objectives of this evaluation are to assess:

- ACCESS/MCHIP Project's performance achievements against project indicators encompassing issues of population coverage, CYPs, contraceptive prevalence, impact on mortality and effectiveness of key innovations implemented;
- ACCESS/MCHIP Project's performance in facilities and communities in improving the quality of care in EmONC, antenatal and postnatal care, FP and safe maternity services for normal births in service facilities; and
- Sustainability of achievements under ACCESS/MCHIP Project at the national, state and local areas and service delivery sites, including the impact on policy at the federal and state levels.

BACKGROUND

The ACCESS/Nigeria Project was implemented January 2006--March 2009 before transitioning, relatively smoothly, to the MCHIP/Nigeria Project (April 2009-February 2012). The goal of the three-year ACCESS Project was to contribute to the reduction of maternal and neonatal mortality by achieving its LOP objective: increased utilization of quality EmONC services and birth spacing by pregnant women, mothers and their newborns at selected LGAs in Kano and Zamfara.

The ACCESS Project commenced implementation in 2006 in four LGAs: Kaura Namoda and Gusau in Zamfara and Gezawa and Dawakin Tofa in Kano. In 2008, at the request of the State Government, Katsina was included in the project as well. When the ACCESS/Nigeria Project transitioned into the MCHIP/Nigeria Project in 2009, coverage expanded to 22 LGAs in three states.

The transition from ACCESS/Nigeria to MCHIP/Nigeria was facilitated by the fact that the latter project was designed to build on the successes achieved and lessons learned under the ACCESS/Nigeria project and to continue support to the Government of Nigeria (GON) to increase and improve maternal and newborn care services in project sites. The ACCESS/MCHIP Project continued activities implemented under ACCESS and further expanded coverage from 16 facilities in four LGAs in two states to a total of 58 facilities in 28 LGAs in the three states of Zamfara, Kano and Katsina.

The ACCESS/Nigeria Project approach integrated FP with maternal and newborn care MNBC services using a Household to Hospital Continuum of Care framework. The

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ACCESS/Nigeria approach focused on increasing the supply, demand and quality of FP and MNBC interventions through community mobilization, competency based skills training for providers, strengthened service delivery management and improved quality of care at the facility level.

In addition to the continuity of goal, objective and project activities, the following six intermediate results remained constant over the LOP for the ACCESS/MCHIP Project:

- Improved enabling environment for and scale-up of best practices for EmONC at national and state level
- Improved availability of EmONC trained health care workers in selected LGAs
- Improved quality of EmONC services in selected LGAs
- Improved quality of FP services in selected LGAs
- Increased demand for maternal and newborn services, including FP in selected LGAs
- Improved management of maternal and newborn services in selected LGAs

Total funds obligated and transferred from the field to Washington for ACCESS/Nigeria were \$6,073,000; total funds transferred for MCHIP/Nigeria was \$6,250,000 for a total LOP funding of \$12,323,000.

MATERNAL AND NEWBORN HEALTH IN NORTHERN NIGERIA

The Northwest region of Nigeria, where Zamfara, Kano and Katsina are located have some of the worst FP/RH statistics, generally much poorer than the national average.

Table 1: Comparison of Key FP/RH Indicators for Nigeria and the Northwest Region		
INDICATOR	NW REGION	NATIONAL AVERAGE
MMR	1025	545
TFR	7.3	5.7
CPR (all methods)	2.8	15.4
Neonatal Mortality	47	40
% receiving ANC from skilled provider	31.1	57.7
% delivering at health facility	8.4	35
% attended at delivery by SBA	9.8	38.9

The 2008 Nigeria Demographic and Health Survey (NDHS), the first NDHS to measure MMR, estimates nationwide MMR in Nigeria at 545. While no breakout by region was done in this survey, the United Nations Children's Fund (UNICEF) has estimated MMR in the Northwest to be 1025, almost double the national average. While use of all methods of contraception is low nationwide (15.4%), it is still lower in the Northwest (2.8%). Similarly the percent of women who had a live birth in the five years preceding the survey who

received ANC from a skilled provider was 57% for Nigeria; only 31.1% for the Northwest. Table 1 compares additional key indicators for maternal and newborn health

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between the Northwest and the National average for Nigeria. The high levels of MMR and total fertility rate (TFR) and the low contraceptive prevalence rate (CPR) reflect the low utilization rates of MNBC services including FP, as well as inadequate availability and accessibility of services and skilled service providers.

METHODOLOGY

The evaluation was conducted in Nigeria in January-February 2012 by a two-person team with both national and international experience. The Evaluation Team used both quantitative and qualitative approaches to gain insight on accomplishments under the ACCESS/MCHIP Project's activities and the processes that led to those results. A variety of methods and approaches were used to collect and analyze information relevant to the evaluation's objectives, and questions outlined in the Scope of Work (SOW) for the USAID/Nigeria ACCESS/MCHIP Project are in Annex A. The following methods and approaches were used:

1. Review and Analysis of Background Materials. Documents relevant to the Nigeria ACCESS/MCHIP Project were identified and assembled for review and analysis. These included ACCESS and MCHIP Program Descriptions, Quarterly and Annual Reports (ARs), ACCESS/MCHIP PMPs, annual project work plans, technical and training material, past program evaluations and assessments, project data base data on service utilization and facilities, USAID/Nigeria's Global Health Initiative (GHI) Strategy 2010-2015 and other documents related to the project. A complete list of documents consulted is in Annex B.

2. Team Planning Meeting. The Evaluation Team conducted a two-day Team-Planning Meeting (TPM) upon arrival in Nigeria and before starting the in-country portion of the evaluation. During the TPM, the team reviewed and clarified questions on the evaluation SOW, clarified USAID's expectations about the evaluation and the Evaluation Team, determined details of the methodology, drafted an initial work plan, determined how data was going to be collected and what data collection tools would be used, finalized the major evaluation questions for key informant interviews in Abuja and the field, as well as for focus group discussions (FGDs), developed the evaluation report table of contents, clarified team members' roles and assigned drafting responsibilities for the evaluation draft report. The TPM outcomes were shared with and approved by USAID/Nigeria.

3. Key Informant Interviews. The team conducted interviews with key informants from USAID/Nigeria, USAID/W, USAID implementing partners, the Federal Ministry of Health (FMOH), SMOHs and LGA officials from Kano, Zamfara and Katsina states, facility staff and community groups and workers. A complete list of persons contacted during the evaluation is in Annex C; question matrices, facility checklists, FGD discussion guides are in Annex D.

4. Site visits. The Team had originally planned to conduct field visits to 14-16 selected ACCESS/MCHIP Project service delivery points and health facilities in the project's selected LGAs in all three focus states of Kano, Katsina and Zamfara, including visits with the corresponding communities in which the project operates to observe activities. However, due to unrest in the state of Kano and an indefinite US Embassy travel

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restriction to the Northern area, the team was unable to follow this original plan. Despite the travel restriction, the Sr. OB/GYN Specialist team member, who is a resident in the North, and the Nigeria Monitoring and Evaluation Management Services' (NMEMS) Sr. M&E specialist visited eight health facilities in two states —Katsina and Zamfara. Community groups such as village Development Committees (VDCs), Ward Development Committees (WDCs), Women's Savings Groups, HHCs, MBSMs, and transport workers for ETS were called to several facilities for targeted FGDs with the Sr. OB/GYN Physician. A total of 15 state-based ACCESS/MCHIP Project staff, SMOH and LGA officials from all three states were invited to travel to Abuja for interviews with the Team Leader. Daily contact was maintained between the Team Leader and the Sr. OB/GYN physician via cell phone and e-mail.

While USAID, NMEMS and the Evaluation Team realized that this plan was not ideal, the Team was able to adequately supplement data obtained from the field visits using this revised plan. The Evaluation Team chose a sample of eight facilities to ensure a good representation of different facility types, size, client volume, institutional commitment and project activities as presented below in Table 2. Although field visit time was reduced and Kano state could not be visited at all, the Team felt that the sample selection was adequate to allow generalization to the greater facility population. A map of the three ACCESS/MCHIP Project states and LGAs is in Annex E.

TABLE 2: Facilities Visited by Activity and Characteristics

Facility and Location (LGA)	Year Activities Started	Service Volume	Assessment of Institutional Commitment*	Activities
ZAMFARA STATE				
General Hospital, Gusau	2006	High	High	Renovated, SBM-R, KMC
Women and Children Welfare Clinic (WCWC) Mada, Gusau	2006	Low	Medium	Renovated,
General Hospital, Kaura Namoda	2006	High	High	Renovated, SBM-R,
Primary Health Center (PHC) Kurya, Kaura Namoda	2006	Low	Low	SBM-R, MSS
KATSINA STATE				
General Hospital, Funtua	2008	High	High	SBM-R, MSS
PHC Abukur, Rimi	2009	Low	Low	
PHC Malunfachi	2009	Low	Low	MSS
MCH Hospital Turai Yar Adua, Katsina	2010	High	High	

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* Assessment of Institutional Commitment was assigned subjectively by project field staff based on the level of management cooperation received over the LOP.

5. Data Analysis and Report Writing. The team shared and analyzed data collected from all sources, focusing particularly on annual and incremental achievement in utilization of services against project indicators and facility level trends. The Team identified and addressed gaps in data, discussed and reached agreement on findings, conclusions and recommendations that were presented during a debriefing session with USAID's Health Team. A draft report was prepared and submitted to USAID/Nigeria before the team departed from Abuja. The Team finalized the report taking into consideration comments and suggestions from USAID/Nigeria, as well as NMEMS.

6. Limitations and Unanticipated Benefits of the Revised Evaluation Methodology.

As noted earlier, as a result of the security situation in the Northern states, field visits were curtailed and limited to two of the three states originally intended to be visited. While it is unlikely that confidence and validity were adversely affected by not visiting the third state, the overall evaluation would certainly have been stronger and more complete had the team been able to include Kano in the itinerary as originally planned. Due to delays necessitated by the security situation, only five days could be spent in the field rather than ten as originally planned. Thus only eight facilities were visited instead of 14-16 as originally envisioned. By bringing officials from the three SMOHs and LGAs, as well as field staff from the ACCESS/MCHIP Project into Abuja for interviews with the Abuja-based Evaluation Team member, more time was available for discussion and the amount of information and project-based experience shared ended up being much greater than would have been achieved through shorter courtesy visits carried out in the course of a field visit. This wealth of field level feedback provided a rich addition to the facility and community-based activity feedback received by the second Evaluation Team member during field visits. The Evaluation Team feels that the sample selection of facilities was sufficiently representative and that sufficient information and data was collected to ensure an informed and valid final evaluation of the ACCESS/MCHIP Project.

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FINDINGS

Most of the indicators tracked in USAID/Nigeria's annual PMPs have been met or exceeded for the ACCESS/MCHIP Project. Achievement measured by these indicators will be discussed in the appropriate sections below, within the context of the other numerous achievements and shortcomings not necessarily captured by the PMP and AR indicators.

1. INCREASED UTILIZATION OF FP AND EMONC SERVICES

The ACCESS/MCHIP Project promoted use of FP and EmONC services in selected LGAs in Zamfara, Kano and Katsina states from January 2006 to February 2012 through the Household to Hospital Continuum of Care (HHCC) approach that created awareness and increased demand at the community level, linked communities to facilities where providers had received skills training and improved management was being practiced. Achievement measured by the six Project Objective (PO) indicators listed below in Table 3 shows a fairly steady annual increase toward achieving targets mutually agreed upon between USAID/N and the ACCESS/MCHIP Project management. CYP achievements fell short of their annual targets for the first three years (2006-2009), but improved considerably over the final two years (2010-2011) of the project. Although CYPs did not increase in line with targets during the first three years, they do translate into a considerable increase in CPR between 2006 to 2009, as reflected in the baseline and endline population-based surveys carried out under ACCESS. A complete list of all project indicators with footnotes is in ANNEX F.

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Table 3: Project Objective Indicators: Increased Utilization of Quality EmONC Services, Including Birth Spacing, by Pregnant Mothers and Their Newborns at Selected LGAs in Kano , Zamfara and Katsina

Indicators	2006 Base-line	FY 07 (Targets) Achieved	FY 08 (Targets) Achieved	FY 09 (Targets) Achieved	FY 10 (Targets) Achieved	FY 11 (Targets) Achieved
Key Indicator 1: # of deliveries with a SBA		(2,000) 7,685	(20,000) 22,092	(22,000) 39,677	(50,000) 49,006	(55,000) 57,755
Key Indicator 2: # of ANC visits by skilled providers from United States Government (USG)-assisted facilities		(10,000) 33,333	(100,000) 115,678	(120,000) 218,267	(220,000) 245,841	(250,000) 265,266
Key Indicator 3: # of postpartum/newborn visits within 3 days of birth in USG-assisted programs		(1,500) 7,534	(20,000) 26,842	(25,000) 33,533	(35,000) 51,221	(40,000) 56,659
Key Indicator 4: CYPs in USG-supported programs		(10,000) 6,492	(20,000) 11,516	(20,000) 11,354	(17,000) 27,041	(18,500) 27,509
Key Indicator 5: # of counseling visits for FP/RH as a result of USG assistance		(12,000) 11,924	(50,000) 30,894	(60,000) 42,387	(55,000) 74,044 72,236F/1808M	(60,000) 134,278
Key Indicator 6: % of postpartum women using contraception (including LAM) at one year postpartum	5.0%			15.0%	No Baseline / Endline surveys done for MCHIP	

In 2006, the ACCESS/MCHIP Project covered the population surrounding 16 facilities in four LGAs in two states, Zamfara and Kano. By 2010, population coverage had expanded to 58 facilities in 28 LGAs in three states, including Katsina. Roughly 35% of the population of these three states was covered under the ACCESS/MCHIP Project. A complete list of the 58 project facilities by LGA, state and population coverage is in Annex G. In order to assess how much of the increased utilization of services has resulted from the increased number of facilities included under the ACCESS/MCHIP Project, the Team looked at utilization trends for the eight facilities visited. Table 4 below shows that service utilization trends for the eight facilities visited support the overall conclusion that increased utilization occurred at the facility level at the same time the number of facilities covered by the project was also increasing.

Clearly the greatest increase in service utilization took place at the four hospitals visited, and this is to be expected given their larger staffs and heavier client loads. However, trends in increased utilization were also seen at the four PHCs, particularly for ANC and ENC. The weakest increases in service utilization at the PHC level appear to be for deliveries by SBAs and PP/NB visits within three days of birth. Since the

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ACCESS/MCHIP Project did not include CHEWs as SBA, deliveries by CHEWs are not captured under the number of deliveries by SBAs, which significantly undercounts the deliveries at the PHC level. Significant increases and decreases generally track SBA transfers in or out of a facility, and are more pronounced at the PHC level. For example, the sudden appearance of SBA deliveries in FY11 at Kurya PHC coincides with the FY10 deployment of two midwives under the Government's MSS. The number of newborns receiving essential care has increased consistently at all eight facilities in Table 4. Increased utilization of FP is reflected by increased CYPs at each facility. The decrease in three facilities in 2011 is attributed to contraceptive stock-outs, particularly for Depo-Provera.

Increased utilization of FP and MNBC services at the eight facilities visited is fairly consistent with the service utilization patterns documented by available project data for all 58 facilities. Service utilization trends for ENC at all facilities indicate that 15 of the 23 PHCs (65%) reflect steadily increasing utilization through FY 11, while 27 of the 34 hospitals (79%) reflect the same. CYP trends at all facilities over the LOP support similar fairly steady increases. Twenty one of the 23 PHCs (91%) show fairly steady increase in CYPs through FY10 and 10 of the 23 PHCs (43%) show steady increase through FY11, despite the stock-out of FP commodities mentioned earlier; 26 of the 34 hospitals (76%) show steady increase in CYPs through FY10, and 18 (53%) show steady increases in CYPs through FY11. It would appear that the hospitals were slightly less affected by the stock-outs than the PHCs.

Feedback from the facility staff visited and SMOH and LGA officials interviewed further supports the fact that utilization of key FP and MNBC services increased at the facility level over the LOP. All four PHCs visited in Zamfara and Katsina reported that FP and ANC clients had increased significantly under the ACCESS/MCHIP Project, due largely to referrals from the HHCs and MBSMs. Similarly the King Fahad General Hospital (GH) in Zamfara and the Kaura Namoda GH attributed their increased FP and ANC clients to community mobilization efforts and the supporting referral slips from HHCs were in evidence at these hospitals. SMOH officials from Kano spoke of tremendous increases in FP and ANC clients and said that only recently have husbands and wives been seen visiting the facilities together for FP. They attributed this increased engagement of men in FP discussion to community mobilization efforts of the CCGs, HHC and MBSMs. LGA officials from Katsina said that although women still prefer to deliver at home, in the privacy and comfort of their homes, they will sometimes go to a facility for delivery, especially in the event of complications. They also credited increased male involvement under the ACCESS/MCHIP Project with greater utilization of facility-based services. Previously they did not understand the importance of birth spacing and ANC visits with skilled providers.

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Table 4: LOP Utilization Trends for Key FP/MNBC Services in 8 Facilities Visited

Facility	FY07	FY08	FY09	FY10	FY11
# of Deliveries with a Skilled Birth Attendant (SBA)					
Kurya PHC	0	0	0	0	85
Kaura Namoda GH	426	446	577	547	790
Mada PHC	0	0	0	0	0
Gusau King Fahad GH	496	813	734	546	1121
Funtua GH			137	595	479
Abukur PHC			87	37	81
Malunfachi PHC			78	86	388
Turai Yar Adua MCH				1654	2320
CYPs in USG-Assisted Programs					
Kurya PHC	14	51	60	96	69
Kaura Namoda GH	41	137	347	259	657
Mada PHC	5	23	44	88	76
Gusau King Fahad GH	69	335	472	1304	1126
Funtua GH		292	724	709	924
Abukur PHC			32	48	54
Malunfachi PHC			105	134	200
Turai Yar Adua MCH				674	907
# of ANC Visits by Skilled Providers from USG-Assisted Programs					
Kurya PHC	271	425	771	757	691
Kaura Namoda GH	3147	4204	4695	4773	4193
Mada PHC	356	582	1248	1911	1032
Gusau King Fahad GH	4390	9398	9907	12166	11991
Funtua GH		13507	15744	13371	11294
Abukur PHC			552	859	1327
Malunfachi PHC			5238	5613	3124
Turai Yar Adua MCH				4622	6642
# of Newborns Receiving Essential Care in USG-Supported Facilities					
Kurya PHC	56	89	78	103	119
Kaura Namoda GH	180	283	445	299	577
Mada PHC	15	70	147	203	127
Gusau King Fahad GH	236	662	621	467	996
Funtua GH		1419	2744	1729	2287
Abukur PHC			83	189	218
Malunfachi PHC				174	933
Turai Yar Adua MCH				1673	2085
# of PP/NB visits within 3 days of birth in USG-Assisted Programs					
Kurya PHC	6	40	24	19	40
Kaura Namoda GH	140	454	437	500	607
Mada PHC		21	40	2	33
Gusau King Fahad GH	173	221	662	542	913
Funtua GH		1689	3038	2699	3576
Abukur PHC			48	34	60
Malunfachi PHC			62	193	177
Turai Yar Adua MCH				3886	2349

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2. IMPROVED QUALITY OF FP SERVICES

Achievement against the three IR indicators for improved quality of FP services tracked throughout the LOP are fairly consistent with or exceed the targets (Table 5). The number of counseling visits was below target for the first three years but gained momentum over the last two years. By FY 2011, all 58 USG-assisted facilities were providing FP counseling and services.

Table 5. IR-1 Indicators: Improved Quality of FP Services in Selected LGAs

Indicator	FY 07 (Targets) Achiev.	FY 08 (Targets) Achiev.	FY 09 (Targets) Achiev.	FY 10 (Targets) Achiev.	FY 11 (Targets) Achiev.
# of USG-assisted service delivery points providing FP counseling or services	(10) 15	(36) 37	(40) 48	(54) 57	(60) 58
# of persons trained in FP/RH with USG funds (disaggregated by gender)	(60) 33	(500) 517 280F/23M	(500) 583	(500) 567 378F/189M	(550) 683 381F/302M
# of persons that have seen or heard a specific USG-supported FP/RH message	(12,500) 54,010	(75,000) 59,888	Dropped by USAID due to ambiguity in defining what constitutes a message		
# of counseling visits for FP/RH as a result of USG assistance	(12,000) 11,924	(50,000) 30,894	(60,000) 42,387	(55,000) 74,044 72,236F/ 1808M	(60,000) 134,278

The quality of FP counseling and services was improved under the ACCESS/MCHIP Project through skills training for providers, the use of SBM-R, supportive supervision and the provision of equipment. Over the LOP, over 600 health care providers (doctors, midwives and CHEWs) were trained in FP counseling skills, contraceptive technology updates, postpartum family planning (including LAM) and provision of long term methods (IUDs and Jadelle implants).

Feedback from the field visits and interviews with key SMOH and LGA stakeholders confirmed that facility staff had benefited from skills training and were now better able to counsel clients and provide services, including IUDs and Jadelle, which they had not been doing previously. Job aids and FP information, education and communication (IEC)

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materials were developed and provided by the project. Printed posters and flip charts were observed in facilities and reportedly being used.

Under the project, 56 FP standards were developed in 2009 and utilized as part of the SBM-R approach used by the ACCESS/MCHIP Project for quality improvement in service delivery. FP standards as observed and discussed during the field visits were not being fully adhered to, often because there was a lack of equipment and insufficient staff, situations that forced providers to take short cuts. Heavy staff turnover of 10-20% each year also made it necessary to repeatedly train staff in proper use the SBM-R approach. Many of the staff reported that they used the standards as job aids, to ensure that they provided services correctly. At several facilities the providers felt the standards had been set too high. Staff at the high volume, better staffed MMSH facility in Kano were trained in SBM-R and following their first external follow-up visit, had increased compliance against FP standards from 63.2% to 82.5%. Recently, the TSHIP project, with ACCESS/MCHIP Project assistance, has reduced the number of FP standards to just nine in an effort to improve their use.

SMOH officials interviewed felt that the use of standards-based checklists during their quarterly supervision made them more aware of the importance of tracking service quality and gave them the means to do so. Based on client exit interviews carried out by one SMOH FP coordinator during her quarterly supervisory visits, FP clients increasingly mentioned that the providers “knew better what they are doing and gave us more information about FP methods”. The clients also told her that they appreciated being able to receive FP services at the PHCs, closer to home.

Staff at the four PHCs visited mentioned a shortage of IUD and Jadelle kits and their resulting inability to provide this service, despite having been trained. They also expressed concern that their skills in IUD and Jadelle insertion would decline over time if they didn't have the necessary insertion kits. In all the PHCs visited, there was obvious lack of space for counseling. The FP counseling and ANC consultations were usually carried out in the same location, without adequate privacy. The inclusion of CHEWs in capacity building for counseling and the provision of information about pills and injectables has improved the FP skills of this cadre of staff who provide most of the FP services at the PHC level.

Several providers interviewed during field visits said that the ACCESS/MCHIP Project had also improved their record keeping and data management skills, which had improved their awareness of the importance of improving the quality of services at their facilities.

3. IMPROVED QUALITY OF EMONC SERVICES

Progress against targets for five of the seven indicators for improved quality of EmONC services in selected LGAs was quite strong, only two fell short of targets, the number of facilities renovated and use of the partograph for labor management.

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Table 6. IR-2 Indicators: Improved Quality of EmONC Services in Selected LGAs

Indicator	FY 07 (Targets) & Achiev.	FY 08 (Targets) & Achiev.	FY 09 (Targets) & Achiev.	FY 10 (Targets) & Achiev.	FY 11 (Targets) & Achiev.
# of health facilities rehabilitated	(6) 0	(12) 7	(6) 6	(12) 6	(0) 0
# of persons trained in maternal/newborn health through USG-supported programs	(30) 261	(500) 522	(600) 356	(600) 760 428F/332M	(600) 784 550F/234M
# of health facilities using SBM-R approach for performance improvement	(8) 10	(20) 29	(30) 30	(30) 30	(0) 0
# of women receiving AMTSL through USG-supported programs	(2,000) 6,835	(20,000) 21,778	(22,000) 30,467	(35,000) 45,138	(40,000) 50,574
% of women receiving AMTSL through USG-supported programs (no targets set)	87.2%	99.6%	81.1%	97.6%	98.2%
# / % of women with eclampsia managed according to protocol in ACCESS-supported facilities *	(160) 155	(60%) N/A	(75%) 100%	(100%) 100%	(100%) N/A
# of births at ACCESS-supported facilities for which the partograph was used	(2,000) 4,409	(20,000) 10,400	(22,000) 30,467	(30,000) 23,200	(33,000) 23,744

*USAID PMP switched indicator from # to % based in 2008

Training of service providers in EmONC, establishment of standards for EmONC, implementation of best practice innovations in EmONC, provision of equipment and renovation of facilities were the key inputs for increasing the quality of EmONC care. The ACCESS/MCHIP Project trained 2,678 providers, including doctors, midwives and CHEWs in maternal and newborn health care over the LOP. Training was repeated frequently due to high staff turnover at most facilities. Feedback from the field facility visits and interviews with SMOH and LGA stakeholders confirm a significant improvement in provider skills in LSS, FANC, AMTSL, management of PPH and eclampsia, HBB and management of neonatal sepsis. It was felt that management of labor and delivery was now cleaner and safer even at the PHC level following infection

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prevention training and skills training for providers. Available records and provider responses from all eight facilities visited indicate that following training, management of eclampsia with MgSO₄ had remarkably improved the survival of patients with eclampsia. At Turai Yar'adua Hospital, of the seven maternal deaths recorded in 2011, only one was due to eclampsia. Prior to training in eclampsia management with MgSO₄, eclampsia had been the leading cause of maternal deaths.

Given the fact that ability to provide Caesarean section is a key component in comprehensive emergency obstetric and newborn care (CEmONC), the ACCESS/MCHIP Project adapted the Anaesthesia for Emergency and Neonatal Care Learning Resource Package for use in Nigeria and implemented a three weeks training program to upgrade the knowledge and skills of practising nurse anaesthetists from all three project states. Caesarean sections as a percentage of all births in project-supported facilities remained low throughout the project, ranging from 1% to 5 % against a target of 15%.

Use of MgSO₄ for eclampsia and HHB were well received by the providers and considered to be effective interventions. In most of the health facilities visited, FANC was being practiced. AMTSL is now a standard practice in health facilities and providers interviewed were able to describe the procedure correctly in all eight health facilities visited. The partograph was being used in only one facility of the eight visited. Reasons cited for failure to use the partograph included the shortage of partographs, failure to understand how to use them, staff intensive to use and the fact that women usually arrive at the facility too late in labor to make it worthwhile.

The ACCESS/MCHIP Project renovated 19 facilities and provided basic obstetric equipment (delivery kits, episiotomy repair kits, Caesarean section kits, IUD insertion kits and adult/newborn resuscitation equipment) to those facilities renovated, as well as others according to facility needs. Three facilities visited had been renovated and two were already in disrepair. The other had been re-renovated by DfID. The quality of the renovation work appeared to have been sub-standard. Nonetheless, the staff at the facilities were appreciative of the renovation assistance.

The ACCESS/MCHIP Project introduced JHPIEGO's SBM-R approach to quality improvement of EmONC services at 30 health facilities and trained health care providers and supervisors in its use. National performance standards were established with the FMOH for EmONC for both hospitals and PHCs. The large number of standards involved (199 for hospitals and 173 for PHCs) and the substantial staff time required to implement the process properly were challenges in most facilities where it was introduced. In those 11 facilities where baseline and two external assessments were carried out, compliance with EmONC performance standards was significantly increased in hospitals from a mean of 11.8% at baseline to 83.9% after the second external assessment; and in PHCs from a mean of 1% at baseline to 61.9% after the second assessment. More importantly, there was an inverse relationship between compliance with set standards and declining maternal mortality between 2007-2009 at MMSH in Kano State.

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4. IMPROVED ENABLING ENVIRONMENT FOR SCALE-UP OF SUCCESSFUL PROJECT ACTIVITIES AT STATE AND NATIONAL LEVELS

All three of the indicators for measuring achievement under an improved enabling environment focused on the one-time development of training curricula, performance standards or training manuals and their distribution. While all three indicators were achieved in a timely manner, the process indicators failed to capture the scope and intent of the IR including many other significant achievements in this area under the ACCESS/MCHIP Project.

Table 7. IR-3 Indicators: Improved Enabling Environment for Scale-up of FP and EmONC Best Practices at National and State Levels

Indicator	FY 07 (Targets) & Achiev.	FY 08 (Targets) & Achiev.	FY 09 (Targets) & Achiev.	FY 10 (Targets) & Achiev.	FY 11 (Targets) & Achiev.
Training curricula and strategy for pre-service midwifery education revised and implemented in Kano and Zamfara states	(1) 0	(1) 1	(2) 2	Completed in FY 09	
Operational performance standards for EmONC developed and distributed in ACCESS-supported facilities	EmONC standards for hospitals and PHCs developed	(400) 750	(600) 627	(0) 0	Distribution completed
National KMC training manuals distributed in ACCESS-supported facilities	(1) 0	(200) 0	(300) 486	Activity completed FY 09	

The ACCESS/MCHIP Project contributed significantly at the national policy level to an improved enabling environment for FP and MNBC through their participation in numerous advocacy groups, and accomplishments that included:

- Formulation of the *National IMNCH Strategy Document*, through the Core Technical Committee of the IMNCH Secretariat;
- Compilation and publication of *A Situational Analysis and Action Plan for Newborn Health in Nigeria* in collaboration with Save the Children US, which formed the framework upon which the new IMNHC policy was developed;
- Collaboration with Stakeholders' Group at the national level to successfully advocate for FMOH funding for inclusion of FP commodities as a budget line

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- item in 2011, as well as the inclusion of MCH as part of the Government of Nigeria's (GON's) Transformation Agenda;
- Collaboration with the National Primary Health Care Development Agency (NPHCDA) on training for master trainers for HBB for nationwide scale-up through all PHCs; and
 - Contribution to the design and advocacy for the National Midwife Service Scheme launched by the FMOH in 2008 in an effort to ensure 24/7 coverage by SBAs at PHCs.

Accomplishments under ACCESS/MCHIP Project that effectively expanded the enabling environment for FP and MNBC at the state level included:

- Assistance to Zamfara state in setting up a state HMIS unit, which has significantly improved HMIS systems and data management for the state. The SMOH is confident that they can maintain the system after 2012 and has started including private facilities into the HMIS;
- Assistance in all three states in harmonizing data collection registers;
- Participation in state Stakeholder Group Meetings that resulted in the development of an Integrated Supervisory System (ISS), blending multiple donor and state supervisory checklists and methods into one common supportive-supervision system in all three states. In Katsina, group advocacy resulted in the SMOH deciding in 2010 to increase salaries of health workers in the state.

Despite advocacy efforts with the Stakeholders' Group to influence additional resource allocation, particularly for increased staff and commodities, efforts were not productive.

At the LGA/community level, the three most significant achievements under the ACCESS/MCHIP Project for improving the enabling environment were:

- the community mobilization efforts in selected LGA areas that increased awareness and acceptance of birth spacing and ANC among community leaders and men;
- the establishment of a community financing mechanism for birth preparedness and emergency transportation and RH needs, i.e., the Women's Savings and Loan Groups., and
- the establishment of Emergency Transport Systems that trained volunteer drivers on why and how pregnant women in labor or those experiencing life threatening complications can be assisted to reach a health facility as quickly as possible.

Sustainability of Achievements under the ACCESS/MCHIP Project

Policy and strategies developed at the national level, and the HMIS and ISS at the state level, should be self-sustaining in the future. At the LGA/community level, community mobilization, ETSs and the Women's Savings and Loan Groups are also likely to be sustained, based on interview feedback from the SMOH and LGA officials. In Katsina and Zamfara, Women's Savings and Loan Groups have already spread well beyond the project areas. In Zamfara over 200 groups have been established throughout the state. In Kano, the SMOH has developed a proposal to scale up the community mobilization component to additional LGAs in the state, possibly with DFID or another donor's

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assistance. At the state as well as LGA levels there was considerable optimism that community groups (CCGs, CMTs), skills training and supportive supervision against standards (particularly in Katsina where state master trainers were trained), use of standards as job aids, and some HHCs and MBSMs would continue functioning well after the project's close-out.

Scale-up of interventions and Linkage with Other Projects

Scale-up of specific interventions beyond the project areas appears to be limited to the further expansion of Women's Savings and Loan Groups beyond the project areas and replication of condensed performance standards for FP and EmONC, supportive supervision, KMC and HBB under the TSHIP project. Good linkage appears to have taken place with Save the Children UK's project, Partnership for Reviving Routine Immunization in Northern Nigeria (PRRINN), in Zamfara and Katsina. Some of the ACCESS/MCHIP Project's activities are to be continued under PRRINN, e.g., Neonatal Sepsis Management. However, the Team found that despite shared staff between the ACCESS/MCHIP Project and TSHIP, TSHIP leadership was unaware of the difficulties encountered with KMC, as well as the overwhelming success of the Women's Savings and Loan Groups.

5. IMPROVED MANAGEMENT OF MATERNAL AND NEWBORN SERVICES

The three indicators used by USAID and the ACCESS/MCHIP Project to measure IR-4, "Improved management of maternal and newborn services", (Table 5 below) failed to capture the intent or scope of the project's activities. The first and third indicators measured stock-outs, despite the fact that the procurement of drugs/commodities and commodity management were not part of the project. Consequently, both indicators were eventually dropped by USAID. The second indicator measured increased utilization of newborn essential care and has already been discussed with the PO indicators that measured increased utilization of FP and MNBC services.

Table 8: IR 4 Indicators: Improved Management of Maternal and Newborn Services in Selected LGAs

Indicator	FY 07 (Targets) & Achievmt	FY08 (Targets) & Achievmt	FY09 (Targets) & Achievmt	FY10 (Targets) & Achievmt	FY 11 (Targets) & Achievmt
# of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs***	(14) 14	(28) 26	(48) 30	(24) 31	Dropped
# of newborns receiving essential care in USG supported facilities (drying of NB, keeping NB warm and putting NB to breast within one hour of delivery)	(2,000) 5,675	(18,000) 18,037	(20,000) 29,033	(30,000) 46,041	(35,000) 55,012

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% of CEmONC facilities experiencing no stock-outs of essential EmONC drugs in the last 3 months	(50%) 0%	Indicator dropped—project has no responsibility for drugs procurement or management
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Although not captured by PMP indicators, the ACCESS/MCHIP Project actually contributed significantly to improved management of MNB services through:

- Improved record keeping and data management at the facility and state level;
- Development and use of 14 management standards for hospitals and PHCs; and
- Improved capacity for and use of supportive supervision of service providers.

1.	Job descriptions for key EmONC functions
2.	Establishment of client flow system
3.	Appropriate signage to identify EmONC services
4.	Use of appropriate patient history filing system
5.	EmONC data recorded daily, consolidated and sent to PHC Dept. in LGA
6.	Selected maternal care outcome indicators monitored
7.	Selected newborn outcome indicators monitored
8.	Information analyzed for decision-making
9.	Analysis of maternal and NB deaths and decisions taken based on analysis
10.	Teamwork among EmONC providers
11.	Periodic evaluation of client satisfaction
12.	System in place to respond to referrals
13.	System in place to ensure timely transportation for obstetric emergencies
14.	Hospital has surgical management available 24 hours a day

Early baseline facility audits carried out in 2006 by the ACCESS Project revealed that record-keeping systems at many of the 16 original facilities were weak and not very functional. Working at the national level, the ACCESS/MCHIP Project worked with the FMOH to modify the National Health Management Information System (NHMIS) data collection tools for the three states to better accommodate standard MNBC services such as birth planning and complications readiness; essential newborn care; counseling for FP and AMTSL. The ACCESS/MCHIP Project also developed maternal and newborn record booklets, initiated and supported monthly data review meetings and trained 150 in record keeping. Training was also provided to 77 facility managers, state and LGA officials in the use of data for decision-making. Stakeholders from both the Katsina and Zamfara SMOH credited the project for giving them improved tools and skills that have greatly improved their record keeping and use of data for decision making. In Katsina, the project also assisted in setting up a much-needed HMIS Unit at the state level.

As part of the SBM-R process, 14 management standards were developed and incorporated into the National Standards for EmONC for Hospitals and PHCs (Table 9). These standards were introduced at 30 facilities and tracked through two external reviews

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at 11 core SBM-R facilities. Five of these 11 core facilities achieved a score above 70% during the second external review. Unfortunately, the management standards for PHCs were simply cut and pasted from the hospital management standards and were not revised to reflect differences in setting.

The ACCESS/MCHIP Project worked in all three states with other donors and implementing partners, through the Stakeholder Groups, to develop an integrated supervisory system so that all projects in the state would agree to one standard supportive supervision system. The project provided training in supportive supervision to 87 SMOH, LGA and facility managers using standards-based checklists. ACCESS/MCHIP state program officers carried out joint quarterly supervisory visits with SMOH managers. Feedback from SMOH and LGA stakeholders confirmed that this training and joint supervision increased the effectiveness and focus of supervision and improved the states' capacity to carry out this supervision on its own. Unfortunately, only one of the three states, Katsina, had sufficient funds allocated to cover the transportation costs associated with continuing ISS without donor assistance.

Finally, the ACCESS/MCHIP Project partnered with the DELIVER Project on logistics management training for SMOHs and facilities with DELIVER providing the technical support and the ACCESS/MCHIP Project providing the venue and travel costs for participants. Improvement in commodity management along with allocation of sufficient resources at the national and state levels for drugs and commodities are still needed to prevent frequent shortages of drugs, equipment and commodities that continue to act as barriers restricting access to quality MNBC services.

6. INCREASED DEMAND FOR MATERNAL AND NEWBORN SERVICES

Achievement against all three indicators for increased demand for maternal and newborn care in selected LGAs (Table 10) was slow at the beginning, but right on target over the last several years. The first indicator, number of beneficiaries of community activities, is a simple count of all those who participated in any community-based intervention and is also intended, according to the PMP, as an indirect measure of improvement in quality of life for participants. This indicator failed to reach the targeted numbers during the first several years, because it takes time to build-up momentum with community mobilization activities, but it reached 46,770 during the final year of the project.

Table 10. IR-5 Indicators: Increased Demand for Maternal and Newborn Services in Selected LGAs

Indicator	FY 07 (Targets) & Achievmt	FY08 (Targets) & Achievmt	FY09 (Targets) & Achievmt	FY10 (Targets) & Achievmt	FY 11 (Targets) & Achievmt
# of beneficiaries of community activities	(12,500) 1,842	(20,000) 15,890	(30,000) 21,674	(42,000) 28,132	(44,000) 46,770

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# of community committees that have work plans that include activities to reduce MNB deaths, including birth spacing	(8) 6	(24) 27	(24) 27	(51) 51	(51) Nothing reported
# of communities that have plans that include emergency funds and/or a transport system for maternal and newborn complications	(8) 6	(24) 27	(24) 27	(51) 51	Nothing reported

Demand creation for maternal and newborn services under the ACCESS/MCHIP Project was based on community mobilization efforts and relied largely on Interpersonal Communication (IPC) utilizing community leaders, male motivators and women who went house to house to reach pregnant women in their homes. IPC was conducted one-on-one, in small groups or at larger community gatherings, weddings and naming ceremonies.

The establishment of 19 Community Mobilization Teams (CMT) and 52 Community Core Groups (CCGs) within the three states effectively led communities to take responsibility, through the involvement of community leaders, and their on-going advocacy for the community, for identifying infrastructure needs and obtaining the resources for them. Once these community groups understood the importance of birth spacing, ANC and facility-based delivery with SBAs, they engaged in leveraging materials and financial support from individuals and community organizations to address gaps such as renovation of a dispensary, curtains for privacy at a PHC, funds for procurement of essential drugs, mosquito nets, an ambulance, water tank, toilets for facilities, benches for waiting areas, etc.

The ACCESS/MCHIP Project identified and trained 477 volunteer HHCs to educate pregnant women on a one-to-one basis in their homes about the danger signs of pregnancy, labor, delivery and during the postpartum period, especially with their newborns. This proved to be an effective mechanism for increasing awareness and demand for maternal and newborn services among women in an appropriate manner. Four hundred and forty nine MBSMs were trained to educate men alone or in groups about the benefits of birth spacing, the danger signs of pregnancy and delivery and the importance of encouraging women to attend nearby facilities for ANC and delivery with a SBA. Over the LOP, HHCs reached 32,926 women and referred 12,481 for a variety of services including focused antenatal care, institutional deliveries with SBAs, recognition of danger signs in their newborns, and family planning services. The MBSMs counseled and referred over 11,000 men for family planning. It is not hard to find the women and men who were referred in the service utilization achieved and reflected in Table 3, and as discussed earlier under the PO service utilization indicators.

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Feedback from the field visits and from SMOH and LGA officials confirmed that community mobilization as carried out under the ACCESS/MCHIP Project, utilizing CMTs, CCGs, HHCs and MBSM working together, was highly successful in creating demand for maternal and newborn services in project-supported areas. It was also noted that once communities were aware that certain facilities had been renovated and providers trained, this was an important factor in increasing demand for services from the nearby facilities.

7. EFFECTIVENESS OF PROJECT DESIGN AND MANAGEMENT IN CONTRIBUTING TO PROJECT ACHIEVEMENTS

ACCESS/MCHIP Design

USAID/Nigeria was one of the few countries that chose to implement the full HHCC model, the core technical approach introduced under USAID/W's global ACCESS Project. This HHCC approach worked well in the ACCESS/MCHIP Project for a number of reasons. It comprehensively addressed all three delays that women experience in reaching appropriate EmONC services and the mix of interventions was heavily weighted toward the community and household. The Mission also chose to place increased emphasis on FP, especially during the post partum period, using MNBC as the entry point, and using the terminology of birth spacing rather than FP. These approaches worked well in the highly conservative Northern states of Zambara, Kano and Katsina. When the ACCESS project transitioned into MCHIP, the Mission added emphasis on engaging men through MBSMs, but minimized expansion into broader child health topics, maintaining a tight focus on maternal and newborn service delivery.

ACCESS was launched in January 2006 through a National Stakeholders' Meeting. State selection took place in this context and was based on the highest burden of MNB mortality, as well as donor gaps in the Northern area, which was a USAID strategic priority area. Zamfara and Kano states were eventually agreed upon. In 2007, Katsina state approached USAID for inclusion in the project and this was agreed to, primarily for political reasons, but this further stretched an already small project budget. LGA selection took place in the context of State Stakeholder Meetings that included the SMOH, Hospital Management Board and Directorate for Primary Health Care and gave the project good state ownership. Criteria was again needs-based, but also focused on LGAs with the greatest population coverage. Facilities were selected within LGAs according to needs, population coverage and the presence of a working minimum of staff and infrastructure. Generally speaking, the various selection processes favored and resulted in geographically scattered coverage within each state, i.e., more LGAs but fewer facilities within each LGA. Only 58 facilities were eventually covered, but they were scattered over 28 LGAs in three states and represented a fraction of the total number of facilities in the three states. Katsina alone has 1006 facilities. Three ACCESS state-level project offices were also required to support activities. Thus, the ACCESS/MCHIP Project coverage was sprinkled across isolated, non-contiguous LGAs in three states, allowing for broader, but shallower coverage. This was perhaps the Project's most serious design flaw.

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Finally, USAID/N's ACCESS project was one of the few within USAID's worldwide program to design and carry-out baseline and endline population-based surveys and facility audits, which enabled ACCESS to show population-based impact in the original four LGAs. Unfortunately, there were no similar baseline/endline surveys carried out for MCHIP, not even a second endline of the original four LGAs. This would have shown a five year impact, albeit over a small area, relative to that covered by the LOP. Cost was cited as the reason for not carrying out this additional survey, but it is not clear that USAID and JHPIEGO ever discussed this as an important project activity, or worth searching for additional funding to carry it out.

Implementation, Technical Support and Management by JHPIEGO

JHPIEGO provided good continuity of technical and management leadership at both headquarters and at the country level. JHPIEGO/W and partners provided frequent TA visits during the first year to facilitate start-up. Save the Children provided support and oversight of community mobilization activities. The Futures Group supported the Women's Savings Groups. JHPIEGO provided initial training to ACCESS/Nigeria staff in clinical skills for EmONC, contraceptive technology, counseling skills, supportive supervision and record keeping. Feedback from all stakeholders from the national to the community and facility levels was overwhelmingly positive and generally confirmed the very professional, supportive and facilitative approach taken by project staff over the LOP.

Best practice interventions were implemented with skills training for providers who often went on to provide step-down training to others and, with respect to data collection, to support effectiveness in impacting health outcomes. Many of these interventions were highly successful insofar as they were incorporated and utilized in the facilities. Feedback from the field and project data confirmed that increased provider skills and improved availability of MNBC services at the facility level resulted in increased utilization of services. However, not all best practice interventions worked in the context in which they were introduced. Those interventions that were introduced in a manner that was overly staff intensive, required long checklists or data tracking, or were simply not mother-friendly were less successful in being incorporated and used by facility-based providers. While the ACCESS/MCHIP Project's leadership was strong and gender diverse, it was heavily physician-based. While this ensured good access to the medical community, it is probable that a more diverse leadership that included increased midwifery, community mobilization skills and experience might have increased the integration of interventions closer to the community and household in a more mother-friendly manner.

USAID Management

USAID/W provided good continuity of oversight of the ACCESS and MCHIP projects. The USAID/N Project Activities manager changed twice during the project period, but sufficient briefing was provided to the new managers. The frequency and intensity of field level oversight declined over the LOP from quarterly to annually or less, however, good management relationships with the ACCESS/MCHIP Project staff and quarterly portfolio reviews appear to have compensated for the limited field oversight.

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The Mid-term Evaluation of the ACCESS/MCHIP Project carried out in November 2009 made seven key recommendations for follow-up action. Where action was deemed necessary by USAID or the ACCESS/MCHIP Project, all recommendations were adequately addressed with the possible exception of one. It was recommended that the Mission should explore the possibility of the new midwifery school in Zamfara to train a new cadre of community midwives. Action on this recommendation was passed by USAID to the ACCESS/MCHIP Project, which approached Zamfara SMOH and found that there was more interest in increasing the number of students admitted each year, than there was in training a new cadre of community midwives. Through advocacy with the Nursing/Midwifery Council, agreement was reached to increase the annual admissions limit to 100 from 50. While this is also a useful outcome for increasing trained midwives, it fails to address the need for community midwives at a time when there is an increasing interest at the national level for an additional cadre of midwives who could attend deliveries at PHCs and in the home, thereby expanding the options for delivery by SBAs. A complete list of Mid-Term Evaluation recommendations and the subsequent actions taken is found in ANNEX H.

Project M&E approach.

The ACCESS/MCHIP Project collected and reported data against project indicators agreed to with USAID in quarterly and annual progress reports. Based upon the data provided, USAID updated and maintained annual PMPs. It is clear that data provided to USAID was considered and analyzed as some figures were revised before being reflected in the PMP, and notations made in the comments section. The 2010 ACCESS/MCHIP PMP, the most recent PMP made available to the Evaluation Team reflected full information on the indicator and its numerator, as well as denominator, if the indicator was percentage based. In many cases the comments reflect reasons for exceeding or falling short of targets. Clearly the 2010 PMP is a working document that has been updated to track trends and progress over time. Earlier versions of the PMP included several instances where percentage-based indicators were replaced later by numbers-based indicators, presumably because the denominator information could not be readily obtained from data collected by the project. Several percentage based indicators were added to the PMP over the LOP without ever being reported against, e.g., percent of providers trained in FP/RH who are performing according to standards. USAID was constantly improving the indicators, possibly to stay aligned with the new USAID/N GHI Strategy 2010-15, even though the project did not report against them.

The majority of the ACCESS/MCHIP Project's indicators reported against matched the scope and intent of the IRs, but not all. The indicators for IR-3, enabling environment, and IR-4, improved management of FP/MNS services, did not adequately meet the intended scope or intent of the IRs and this has already been discussed. New indicators included in the GHI strategy indicate that the Mission has already taken steps to improve indicators. Thus the indicator, "% of facilities supported by the USG that are reporting consistently to the national HMIS", that appears in the GHI Strategy for USAID/N 2010-15, is a good example of an indicator that would have better measured accomplishments against intent under IR-4, improved management of FP/MNB services under the

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ACCESS/MCHIP Project. Unfortunately, there is little data on utilization for the newborn interventions: HHB, KMC and neonatal management of sepsis. While the latter intervention was only begun in August 2011, the other two interventions were implemented early enough in the project so that, if there had been indicators in the ACCESS/MCHIP Project's results framework, there would have been utilization trends for those services as well.

In addition to data collection and reporting against USAID/N indicators, ACCESS collected baseline and endline data through population-based surveys and facility audits which supplemented the IR indicators and documented important additional accomplishments and trends over the three years of ACCESS in the four original LGAs.

Strong DQA appears to have been maintained by USAID under this project. The overall weakness in project data was detected early in 2007 and enabled the ACCESS/MCHIP Project to make timely and meaningful interventions to strengthen data management at the state, LGA and facility levels. By 2011 most of the project indicators were showing improved and acceptable results in routine USAID/N DQA exercises.

8. EFFECTIVENESS OF FACILITY AND COMMUNITY LEVEL ACTIVITIES IN PROMOTING ACCESS AND UTILIZATION OF SERVICES

The effectiveness of the community and facility level interventions stems largely from their incorporation into the holistic Household to Hospital Continuum of Care intervention approach that created awareness and leveled barriers to access; linked the community with the facilities; and improved the quality of service delivery at the facility level through skills training, management improvements and in some cases through renovation of facilities and provision of commodities. Each component intervention played an essential role so that, when combined under HHCC, they resulted in increased utilization of maternal and newborn services. Simply stated, it was a winning equation for the ACCESS/MCHIP Project.

Increased Demand + Decreased Barriers to Access + Increased Quality of Services = Increased Service Utilization / Improved MNB Health Outcomes

Within this HHCC model, a number of best practice interventions were introduced at both the community and facility level. Because these interventions were already considered "best practices" by international experts, this evaluation seeks only to assess how effectively each intervention worked in the HHCC model to increase demand, improve access and/or increase utilization of maternal and newborn services. Community interventions include: CMTs, CCGs, HHCs, MBSMs, ETS and Women's Savings and Loan Groups. Facility interventions include: integration of FP into MNBC services, ANC, AMTSL, MgSO₄ for eclampsia management, partograph use for labor management, postpartum systematic screening, HBB, KMC, and management of neonatal sepsis.

Community Interventions

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The community mobilization effort began with the very effective CMTs and CCGs, established by the ACCESS/MCHIP Project, and comprised of community leaders. Through participatory approaches, they identified causes of maternal and newborn health problems in the communities, identified gaps in knowledge and access to services and set about addressing these gaps. As one interviewed CCG member so eloquently expressed himself, “the community has become empowered and will continue acting long after the ACCESS/MCHIP Project ends to prevent our women and newborns from dying. It is our responsibility”.

Once the community leaders had established a foothold of awareness within the communities, the trained HHCs and MBSMs took their respective messages to pregnant women in the homes and men outside the homes. One of the greatest barriers to women accessing services was identified early on as the men’s reluctance to permit their wives to use FP or to attend health facilities. The MBSMs were able to address attitudes causing those barriers directly and with surprisingly good results. About 28% of the 11,371 men counseled by the MBSMs eventually accepted a FP method for themselves or for their spouses.

Emergency Transport Systems, established in all three states, played an effective role in ensuring women could access EmONC services, if needed, and served as a very visible linkage between the communities and the facilities. The volunteer drivers were trained on why and how to transport women quickly when experiencing delivery complications. A total of 141 women benefited from this service.

Finally, the establishment of 109 Women’s Savings and Loan Groups provided women with an alternative financing mechanism for costs related to maternal and newborn care, as well as broader health care needs. While only about 5% of the money collected was used to access emergency obstetric or newborn care, many women took loans for small business start-ups which had the benefit of providing them with the means to cover health and medical care through their own earnings. Awareness raising discussions at the weekly meetings focused on the need to plan for and save some small amount of money for emergency transport services in the event of obstetric or newborn complications. Financial empowerment of women was seen as a major unanticipated benefit of these groups. Husbands and community leaders have been very supportive of these groups. They have taken on a life of their own and are multiplying throughout all three states beyond the ACCESS/MCHIP Project-supported LGAs.

Most importantly, all of the above community networks (CMTs, CCGs, HHCs, MBSMs, and Women’s Savings and Loan Groups) worked together synergistically to produce and support very effective community mobilization. Table 11, below, further supports the extent of increased awareness and utilization of services attributable to community mobilization and other HHCC activities under the ACCESS portion of the project, as measured under the Baseline and Endline surveys. There was a significant increase between 2006 and 2009 in the percentage of women who had both heard about the importance of birth preparedness (46.5% to 83.6%) and reported having made any birth preparedness arrangements for their last birth (31.8% to 68%). Current use of FP among

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non-pregnant women increased dramatically from 1% to 15%. Although there was virtually no difference in the percentage of women who delivered their last baby at home (80.1% to 80.2%), there was a small increase in the percentage of those women who delivered their last baby with a SBA (22% to 24.6%). When SBA is broadened to include CHEWs, the increase is greater, from 22.8% at baseline to 30.4% at endline. These figures would suggest that even though women continue to prefer to deliver in their homes, they are increasingly using SBAs and/or CHEWs at the delivery; and more deliveries with SBAs are likely taking place at home.

Table 11. Effectiveness of HHCC Approach under ACCESS in 4 LGAs

Indicator	Baseline Results 2006	Endline Results 2009
Women who had heard about birth preparedness	46.5%	83.6%
Women who reported making any birth preparedness arrangements	31.8%	68%
Women who received 4 or more ANV visits	34.3%	53%
Women who reported that someone checked on their health after they gave birth	22%	51%
Women receiving PP care who selected a FP method	5.8%	23%
Current use of FP among non-pregnant women	1%	15%
Respondents who knew about a committee or group in the community working toward improving the health of pregnant women and their babies.	N/A	58%
Women who delivered most recent birth at home	80.1%	80.2
Women who delivered last birth with SBA (doctor, nurse/midwife)	22.0%	24.6%

Source: ACCESS Baseline and Endline Population –Based Surveys; sample sizes -- 396 and 444 respectively.

Feedback from the field visits, LGA and SMOH officials and other stakeholders both within and outside the ACCESS/MCHIP Project was overwhelmingly positive about the effectiveness of these various community mobilization and linkage interventions, and their impact on improved health outcomes for mothers and newborns. Most felt that the community mobilization efforts were key to increasing demand and utilization of services. In Zamfara, one CCG member remarked that even before the MBSMs were established, the CCGs had begun to change attitudes within the community so that men were not only allowing their wives to go to the facilities for FP and ANC, but were encouraging them to go. Many felt that communities, and especially HHCs and MBSMs, would continue their work beyond the EOP. In Katsina, three LGAs have picked up the small stipends for HHCs to enable them to continue their community mobilization efforts. Several LGA officials credited the increased utilization of services with decreased maternal and newborn deaths in their areas, although there was no data to support this statement.

Linkage between the Communities and Facilities

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Substantial linkages between communities and facilities were built into the HHCC model, primarily through the CMTs, CCGs, HHCs and MBSMs. Among the eight facilities visited, linkages were evident and observed at six. The two facilities without visible linkage with the communities they serve were both high volume hospitals. Linkages were strongest at the PHC level and referral slips given to clients by the HHCs and MBSMs were the most evident form of linkage observed. Other examples of linkages included: monthly meetings between the CMT and PHC staff, midwife or CHEW from the PHC works with the HHCs during training and may attend their meetings; HHCs may accompany women to the facilities for services.

Facility Level Interventions

Integration of FP into MNBC services worked well, due largely to the fact that FP was presented in terms of birth spacing and ANC was used as the entry point. As community awareness and acceptance for FP grew, so did utilization of FP services. Between 2006 and 2009, the percent of women counseled for FP during PP visits and who used contraception, including LAM, increased from 5.8% to 23% (ACCESS Baseline/Endline Survey). FP counseling and services were limited to the facility level under the ACCESS/MCHIP Project and no efforts were made to establish community-based distribution channels, or to link women to private medical vendors (PMVs) supported under the Expanded Social Marketing Project in Nigeria (ESMPIN) project. In fact, all services were limited to the facility level, and this would have unduly limited access for some women unable or unwilling to leave their homes.

Of the numerous EmONC interventions supported through skills training for providers, eclampsia management with MgSO₄ and AMTSL appear to have been most successfully incorporated and utilized in the facilities. The improvements in utilization trends at facilities have already been discussed. In addition, Table 12 shows increased access to these two interventions and others at facilities included under the ACCESS Baseline and Endline Facility Audits.

Table 12. Increased Access to EmONC and FP Services under ACCESS in facilities in 4 LGAs

Indicator	Baseline Results 2006	Endline Results 2009
Staff available 24/7	38.9%	46.7%
AMTSL practiced	29.4%	64.3%
Use of partograph	6.3%	6.7%
Management of eclampsia with MgSO ₄	6.3%	42.9%
Management of PPH with oxytocin	62.5%	71.4%
IUD insertion	18.8%	50%
Natural FP	37.5%	71.4%
LAM	43.8%	84.6%

Source: ACCESS Baseline and Endline Facility Audits; samples sizes—18 and 15 facilities respectively.

The partograph was not widely used and thus less effective than other interventions for reasons already elaborated upon earlier. Postpartum Systematic Screening, an innovative

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intervention to increase opportunities for providers to counsel for FP, was piloted in two hospitals in 2009, but discontinued after several months due to its time-intensive nature and failure to produce significantly increased use of FP services. While an increased number of FP referrals were made by providers using this screening technique, most referrals were not acted upon.

Three major newborn interventions were also piloted: Kangaroo Mother Care, Helping Babies Breathe and management of neonatal sepsis. While none of the three interventions were tracked through project indicators, nor is there sufficient data available to determine actual use, feedback from providers and community level stakeholders was positive and sufficient to determine that of the three NB interventions, HBB appears to have been the most utilized at facilities. While HBB was implemented later in the project, providers mentioned using the intervention successfully in the context of ENC.

KMC appears to have been introduced in a manner that providers found to be time and space intensive, and less than mother-friendly. Providers felt the procedure was too time consuming and paperwork intensive. State and LGA officials from both Kano and Zamfara said that women felt stigmatized by their segregation in the KMC wards and that the intervention should not have been facility based, but home based. It was felt that mothers of low birth weight babies would have preferred to use the technique in the privacy, familiarity and comfort of their own homes. The KMC ward in the King Fahad Hospital was closed when visited and records indicated that the last baby and mother to use the KMC ward was in 2010. All babies who were cared for in the KMC wards went home alive according to project data, but the intervention has essentially been discontinued due to poor utilization. Introducing this intervention closer to the community and home may have resulted in better utilization and effectiveness under the ACCESS/MCHIP Project as the technology is simple and appropriate for low-resource settings.

Finally, the intervention for Management of Neonatal Sepsis was not introduced until August 2011. While data show that 195 sick newborns were managed under this intervention, there is not sufficient data to determine utilization and effect on health outcomes within the project areas. However, 208 health care providers have been trained to strengthen the identification, treatment and referral of sick newborns with neonatal sepsis at the PHCs using this intervention.

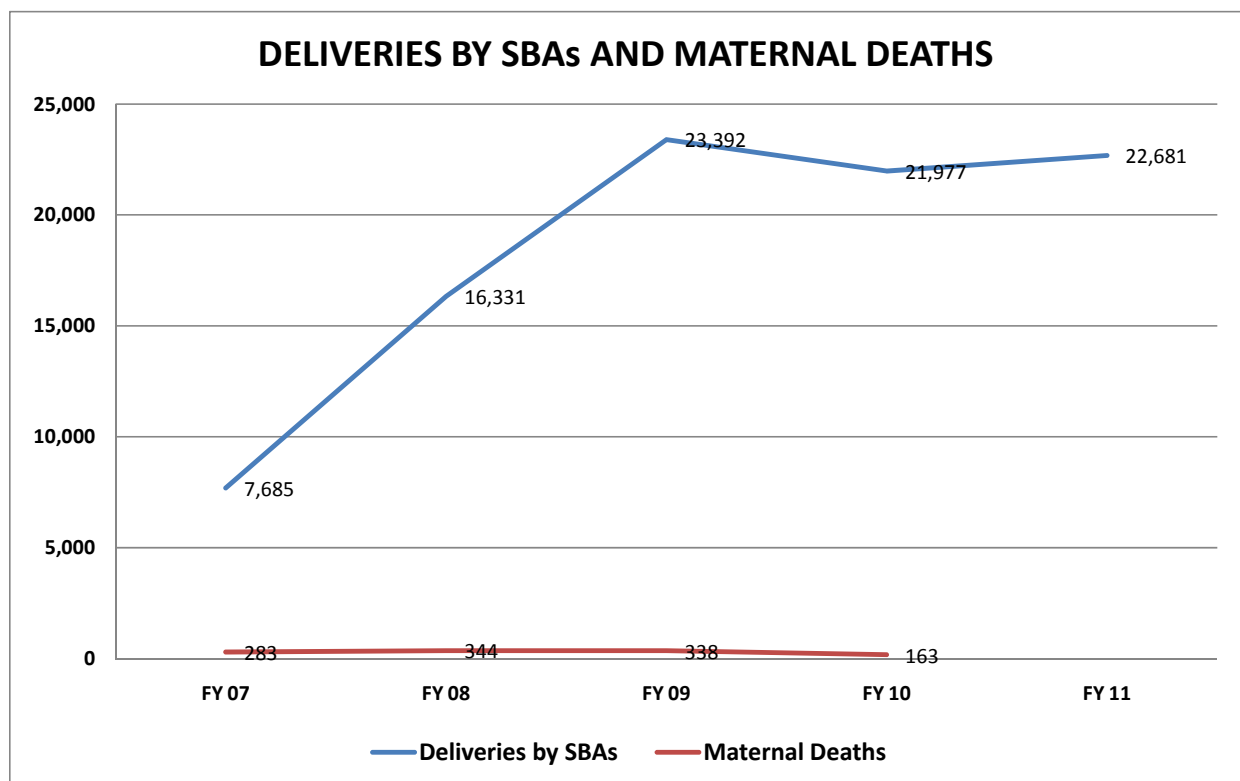
The goal of the ACCESS/MCHIP Project was to *contribute to the reduction of maternal and neonatal mortality by achieving increased utilization of quality EmONC services in Kano and Zamfara*. While little impact data was collected or is available for maternal and neonatal mortality, Table 13 illustrates the effect of the various activities that worked synergistically through the HHCC approach in the ACCESS/MCHIP Project areas. From FY 2007 through FY 2010 data from 10 hospitals within project areas reflect that total deliveries by SBAs rose fairly steadily from 7,685 in FY 07 to 22,681 in FY11 while the number of maternal deaths fell significantly from 283 to 163, or from 3.68% to .74% of all SBA deliveries. This is dramatic confirmation of the effectiveness of the multiple components of HHCC including community mobilization for demand creation, skills

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training for providers, implementation of best practice interventions and use of performance standards for improved quality of EmONC services under the ACCESS/MCHIP Project.

Table 13: Increased Deliveries by SBAs and Decreased Maternal Deaths at 10 Facilities in Kano and Zamfara

Facility	FY 07	FY 08	FY 09	FY 10	FY 11
Deliveries by SBAs	7,685	16,331	23,392	21,977	22,681
Maternal Deaths	283	344	338	163	N/A
Maternal Deaths as % of SBA deliveries	3.68%	2.11%	1.44%	.74%	N/A



CONCLUSIONS

Community mobilization as implemented under the ACCESS/MCHIP Project was an effective tool for improving awareness, acceptability and demand for FP and maternal and newborn services. Placed within the HHCC approach, which linked demand for services from the community to facilities that had received a variety of quality-enhancing interventions, there was an increased uptake in FP and EmONC service utilization in project-supported areas. Much of the increased uptake in service utilization can be attributed to the ACCESS/MCHIP Project, based on data analysis of utilization trends and feedback from field visits to facilities, state and LGA stakeholder interviews.

The quality of service delivery improved due to skills training for providers in effective interventions, improved management of services and standards, which served as much as job aids for providers as measures of quality improvement in service delivery. However, the high turnover and insufficient number of providers, as well as chronic shortages of equipment, infrastructure and commodities at the facility level, negatively impacted the project's ability to more fully improve access to and utilization of quality of FP, maternal and newborn care. SBM-R is an appropriate, best practice approach for improving the quality of service delivery, but fell short of its potential by failing to fully take into account and modify the approach to the low-resource setting involved in project areas.

The ACCESS/MCHIP Project contributed effectively to strengthening the enabling environment at the national, state and community levels, and this will have a long-term impact, well beyond the close of the ACCESS/MCHIP Project in February 2012. The sustainability of these improvements in the enabling environment are more likely to live on than those brought about by skills and management training because no supportive capacity was built, or funding ensured for their continuation after the LOP. Continuation of some community mobilization efforts and the Women's Savings and Loan Groups are highly likely to continue where commitment progressed to empowerment.

The ACCESS/MCHIP Project made a substantial contribution to USAID/N's HPN Assistance Objective and the six intermediate results described earlier. Without a doubt, the project increased utilization of FP and EmONC services by pregnant women, mothers and newborns in selected LGAs in three states in support of the original project objective.

The ACCESS/MCHIP Project leaves a wealth of lessons learned for consideration by on-going and future USAID HPN projects.

CONSTRAINTS AND CHALLENGES

Challenges and constraints that were beyond the control of the ACCESS/MCHIP Project to remedy were well documented in the Mid-Term Evaluation and these pretty much continued through the LOP. Rapid turn-over of SMOH and facility staff, as well as insufficient numbers of skilled birth attendants continued to plague the project. The FMOH's MSS scheme and continued single-year posting of newly graduated medical doctors (NYSC) provided some additional staff, but placement and deployment of staff remained outside the influence of the project. Continual turn-over required continuous skills and SBM-R training. Insufficient basic infrastructure (facilities, electricity and water), constant shortages of equipment and stock-outs of commodities, drugs and contraceptives, particularly the IUD and Jadelle, continued to constrain achievement of project objectives.

Several challenges and constraints were partially addressed through the project with some success. The project was able to make impressive inroads in creating awareness, acceptance and demand for FP and EmONC services in the very conservative Northern area of the country. Faced with poor record keeping and non-existent data management systems in most of the project-supported areas, the ACCESS/MCHIP Project was also able to put into place procedures and tools for improved record keeping and data management at the state level in all three project states.

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LESSONS LEARNED

1. Community mobilization that incorporates community leaders and men is an effective tool for increasing awareness, acceptance and demand for FP and maternal and newborn services, especially in the more conservative, Northern states of Nigeria.
2. Integrating FP, in the context of birth spacing, into maternal and newborn care services using ANC as the entry point improves acceptance and FP utilization, even in conservative Northern states.
3. It is difficult to implement quality standards at the facility level without the commodities, equipment and sufficient staff to meet the standards. While hundreds of standards may be the optimal way to ensure quality, beginning with a more condensed set of standards is probably a better starting point. Put another way, improving skills of providers and putting standards into place is not sufficient in and of itself for improved quality of services without the equipment and commodities to properly practice the skills.
4. Keeping innovative interventions as close to the community/household level as possible results in better acceptance and use. Given the continuing strong preference of women for delivering at home and the marginal increases in women delivering in facilities with SBAs, looking at modified approaches to get SBAs closer to the woman will likely be necessary to improve attendance by SBAs at delivery.
5. Empowerment is a powerful tool and one likely to fuel sustainability of activities even when it was not planned or foreseen, as in the case of community empowerment and financial empowerment of women through the Women's Savings and Loan Groups.
6. It is better to focus on one state as opposed to small parts of three. Aside from the ability to show impact at the state level instead of only the facility level, there are also cost-savings in only supporting one state project office. There is also a level of expectation built for increased support when pilot activities are begun in a few locations in a state. One SMOH was pleased with the ACCESS/MCHIP Project's activities, but complained that the project had only covered 11 of the state's 44 LGAs. They conveyed the sense that they felt cheated by the project. Pilot activities in scattered areas in three states gave rise to unfulfilled expectations for further expansion throughout the states.
7. Inclusion of CHEWs in skills training increased the pool of trained providers. Where skilled providers are insufficient to meet demand for services, all potential staff need to be appropriately and fully trained and used.
8. A lesson learned is only useful if it is passed on and taken into consideration in on-going and follow-on projects with similar objectives.

RECOMMENDATIONS

1. Experience with highly successful ACCESS/MCHIP Project's components (HHCC approach, community mobilization, Women's Savings and Loan Groups, EmONC interventions), as well as less successful or inadequately documented newborn care interventions, should be fully shared with and taken into consideration by TSHIP and other FP/MNBC projects as soon as possible, both the positive and the negative.
2. Although a MCHIP endline population-based survey similar to the one carried out at the completion of ACCESS (2009) was never carried out, USAID should consider repeating the survey using the same baseline facilities and LGAs, in late 2012. This would help to better understand the achievements over five years in those first 4 ACCESS LGA, as well as to ascertain the extent to which community mobilization activities were actually sustained after the project ended. This would provide valuable additional information for the design of future projects, particularly those with community mobilization components.
3. Introduction of new interventions (best practices or otherwise) should take place as early as possible in a project and should be tracked against established indicators; new interventions should take into consideration low resource setting handicaps (shortage of providers, commodities and equipment, capacity to track data); and should be focused as close to the community/household level as possible.
4. Project indicators should match the scope and intent of the project and IRs, and should increasingly be denominator based. When new activities and interventions are added mid-project, new indicators should be added to the results framework in order to track them properly. The incorporation of several indicators on sustainability would focus attention early on toward designing and implementing activities in a manner more likely to be sustained.
5. Renovation of facilities should be leveraged as community or LGA support and contribution, as it is more likely that the community will maintain and continue support for the facilities they have built or renovated.
6. Establishment of master training capacity at the state level for provider skills, as well as management strengthening training, would improve the chance for sustaining key capacity building interventions.

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ANNEXES

ANNEX A. EVALUATION SCOPE OF WORK

I. EVALUATION TITLE

Activity:

End-of-Project Evaluation of the “Access to Clinical and Community Maternal, Neonatal & Women’s Health - Nigeria” (ACCESS) and follow-on “Maternal and Child Health Integrated Program (MCHIP) - Nigeria” Project, or ACCESS/MCHIP Nigeria Project

Contract:

Nigeria Monitoring and Evaluation Management Services (MEMS-II)/ The Mitchell Group, Inc.

II. PERFORMANCE PERIOD

It is anticipated that the period of performance of this end-of-project evaluation will be o/a January 9 to March 15, 2011 depending upon consultants’ availability. Total approximate time will be 38 working days.

III. FUNDING SOURCE

The Mission will use Indefinite Quantity Contract (IQC) support funds through the Monitoring and Evaluation Management Services II (MEMS) project.

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

USAID-Nigeria transferred field support funding annually, over the period January 2006 through February 2012, to two consecutive, AID/Washington centrally-funded projects, first, to ACCESS and subsequently, when ACCESS ended, to MCHIP. USAID/Nigeria has commissioned MEMS II to help organize this *final external evaluation* of the ACCESS/MCHIP Nigeria project. The evaluation will concentrate on the ACCESS/MCHIP Nigeria Project as designed and implemented to achieve stated results for Nigeria over the above-mentioned period.

The last external evaluation of the project was conducted in 2009. Maternal, neonatal and child health, reproductive health and family planning (MNCH/RH/FP) results under three USAID-funded projects –ACCESS/MCHIP, Fistula Care and Improved Reproductive Health in Nigeria (IRHIN) - were evaluated by an external evaluation team. The main issues identified by the evaluation team and included in the final evaluation report were stockouts of commodities, high staff turnover, poor data quality, lack of basic facilities and inadequate resources.

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Given that the ACCESS/MCHIP Nigeria project supported MNCH/RH/FP interventions in communities located in states with some of the worst indicators in Nigeria, USAID/Nigeria is commissioning this end-of-project external evaluation **to assess the difference the project has been able to make to the health of women and newborns in Kano, Katsina and Zamfara States relative to the project objectives and its MNCH/RH/FP indicators (with attention to how those changed over time).**

The main objectives of the evaluation are to assess:

- ACCESS/MCHIP's *performance achievements in Nigeria in sequential project periods, with reference to the MNCH/RH/FP indicators* agreed upon by ACCESS/MCHIP and USAID/Nigeria, encompassing issues of coverage, cost-effectiveness, couple years of protection, contraceptive prevalence and measures of impact on mortality;
- ACCESS/MCHIP's *performance in facilities and communities in improving the quality of care* in emergency obstetrics and newborn care (EmONC) services; antenatal and postnatal services; safe maternity services for normal births in service facilities; and FP.
- *Sustainability of achievements* at the level of the states, local government areas (LGAs) and service delivery sites, and impact on health policies at federal and state levels of government.

The evaluation team should *assess how the choices of the selected service facilities in selected LGAs in selected states were made, and the effect on pursuit of project objectives and achievement of results.*

During the 6 year period in which the ACCESS/MCHIP Nigeria project was implemented, the leadership and overall governance structure of ACCESS and MCHIP themselves, AID/Washington support and USAID/Nigeria underwent significant changes: to cite some examples, the adoption of a new Mission Strategy for 2010-2015; changes in Mission, HPN Team leadership; changes in HPN Team Activity Managers; changes in AID/Washington Cognizant Technical Officers/Agreement Officer Technical Representatives (CTOs/AOTRs); and changes in project staffing in Nigeria. The evaluation team – to the extent possible – should assess how the changes at all levels may have affected achievements of the project.

The evaluation team is also asked to *highlight the strategic policy, program and technical recommendations on MNCH/RH/FP that has resulted from the project*, with particular reference to the project's relationships with federal, state and LGA authorities; other development partners; the USAID/Nigeria-funded Targeted States High Impact Project (TSHIP) in Bauchi and Sokoto; and service providers in facilities in the three ACCESS/MCHIP states. Given the "pilot" nature of USAID/Nigeria's assistance under ACCESS/MCHIP (that is, activities were funded and implemented in selected states, selected LGAs in those states, and in only selected service delivery points and communities in those LGAs – and did not target the entire population of the states), recommendations and transfer of experience were nevertheless expected by

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USAID/Nigeria from project areas, influencing decisions and performance in other service delivery points, other LGAs and at the level of the three state governments. The evaluation team is asked to assess *whether and to what extent that occurred and to itself make recommendations* that can be considered by Government authorities at all levels, other public and private sector development partners, USAID/Nigeria and other service facilities and providers.

Finally, *performance and innovations that exceeded or fell short of project requirements should be described and highlighted.*

V. BACKGROUND

The ACCESS/Nigeria project was implemented for approximately three years (January 2006-March 2009) before transitioning to the MCHIP/Nigeria project in April 2009; the latter will run through end of February 2012. Total funds obligated and transferred from the field to Washington for ACCESS/Nigeria were \$6,073,000, while MCHIP/Nigeria received about \$6,250,000 (total will be calculated at the end of February 2012).

The goal of the ACCESS/Nigeria Project was the same as that stated in the Federal Ministry of Health's (FMOH) National Reproductive Health Policy – “to reduce maternal and neonatal mortality in Nigeria” - and “to accelerate the reduction of maternal and newborn mortality and the attainment of the Millennium Development Goals in Nigeria.”

The ACCESS/Nigeria project approach for achieving this goal was through implementation of integrated community and facility-based maternity and EmONC interventions including antenatal and postnatal care and FP, while ensuring a “household-to-hospital continuum of care” (HHCC). The ACCESS/Nigeria approach focused on increasing both the supply of and the demand for quality interventions.

ACCESS was to work collaboratively with the federal and State governments and focus its interventions in two states: Kano and Zamfara, based on the particularly high maternal mortality rates (MMR) in those states. Kano and Zamfara states are predominantly rural and poor, bearing the greatest burden of maternal and newborn mortality.

Over three years, ACCESS/Nigeria was to contribute to the reduction of maternal and neonatal mortality by achieving its life-of-project (LOP) objective:

Increased utilization of quality EmONC services (including birth spacing) by pregnant women, mothers and their newborns at selected LGAs in two states, Kano and Zamfara.

The overall objective of the MCHIP/Nigeria follow-on project is:

Increased utilization of quality EmONC services (including birth spacing) by pregnant women, mothers and their newborns at selected LGAs in three states, Kano, Katsina and Zamfara.

The MCHIP/Nigeria project was designed to build on the successes achieved and lessons learned under the ACCESS/Nigeria project and support the Government of Nigeria (GON) to increase and improve social sector services, particularly MNCH, for its

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citizens. The project was also expanded to 6 additional LGAs and 12 additional health facilities in the state of Katsina, and carried on its ACCESS activities in Kano and Zamfara.

Similar to ACCESS/Nigeria, MCHIP/Nigeria also implemented interventions both at the facility and community levels and MCHIP/Nigeria also applied the HHCC approach. The HHCC approach recognizes the importance of a successful maternal and newborn care program to systematically address maternal and newborn issues of the community and facility together using evidence-based interventions and best practices.

Over its LOP through February 2012, MCHIP/Nigeria is expected to achieve the following six intermediate results:

- Improved enabling environment for and scale-up of best practices for EmONC at national and state level
- Improved availability of EmONC trained health care workers in selected LGAs
- Improved quality of EmONC services in selected LGAs
- Improved quality of FP services in selected LGAs
- Increased demand for maternal and newborn services, including FP in selected LGAs
- Improved management of maternal and newborn services in selected LGAs

At the end of the project therefore, USAID expects key policies and standards in place; improved enabling environment for and scale-up of best practices for EmONC at national and state level; improved quality of EmONC services, antenatal and postnatal services and FP in selected facilities in selected LGAs; increased births attended by skilled attendants; and increased demand for maternal and newborn services including FP.

VI. SCOPE OF WORK

In addition to the main evaluation objectives above, other specific evaluation objectives are:

- Assess the extent to which the ACCESS/MCHIP Nigeria project has contributed towards the USAID/HPN Assistance Objective and Intermediate Results during the period of its implementation.
- Appraise the extent to which ACCESS/MCHIP Nigeria met its Operational Plan and performance targets set each year during the Performance Planning and Reporting (PPR) process.
- Describe specific changes in the enabling environment for EmONC and FP/RH that could be linked to the contributions of the ACCESS/MCHIP Nigeria Project from 2006 through February 2012 at national, state, LGA and community levels.
- Describe outcomes of health system strengthening activities implemented by the project.

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- Document best practices, lessons learned and innovations applied under the project, including (but not limited to) integration of FP into MNCH interventions at the facility and community levels: were proven “best practices” in some centers applied in other sites under the project, and were those best practices also applied in other facilities/sites that were not part of the project, in the same or other LGAs and states?
- Review the level of implementation of key recommendations from the November 2009 mid-term evaluation of ACCESS/MCHIP Nigeria commissioned by USAID/Nigeria.
- Assess the choice of project design and its effect on attainment of stated objectives in ACCESS/MCHIP Nigeria, including the effectiveness of the ACCESS/MCHIP Nigeria project design in achieving project objectives - especially with respect to site selection and population coverage - based on what was agreed with USAID/Nigeria at project inception and at subsequent intervals during implementation. Describe the factors considered in selecting facilities and communities for intervention. Explain the effectiveness of the project in expanding access to services and increasing population coverage of key interventions in the target communities.
- Describe the implementation of the HHCC approach under the project as the vehicle for the implementation of integrated community- and facility-based essential maternal and newborn care interventions. How well has this approach helped in improving access to basic essential maternity care and EmONC? What other beneficial outcomes were attributable to the application of this approach?
- Review the effectiveness of the key interventions implemented under the project relative to the level of effort that went into producing the results. Identify specific approaches that produced outcomes effectively and the conditions precedent to such accomplishments.
- Disaggregate and assess improvements in key maternal, neonatal and FP outputs *at peripheral health facilities and major urban-based large facilities respectively* that are attributable to the project. Describe the magnitude and type of resources required to achieve the results (especially improved rates of antenatal care and Skilled Birth Attendants [SBAs]) in the peripheral facilities and identify the critical factors that appear to facilitate or impede these improvements in service delivery outputs at the peripheral facilities.
- Assess the effectiveness of community level activities to promote access to maternal, neonatal and FP services under ACCESS/MCHIP Nigeria, and assess linkages with national and state efforts to improve MCH outcomes.
- Assess the *Monitoring and Evaluation approach* applied by the project: how effectively has this approach helped in tracking progress and making decision over the life-of-project; assessing results against targets; reporting performance to USAID/Nigeria, the GON at all levels, staff in project facilities and other stakeholders; and in helping to improve project management?

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- Determine the effectiveness of project management approaches applied under the project.
- Determine the effectiveness of implementation/management and technical support provided by JHPIEGO – the prime implementing partner for ACCESS and MCHIP – and other organizations in the JHPIEGO consortia, respectively awarded under each of the centrally-funded projects, to ACCESS/MCHIP Nigeria: did JHPIEGO and other consortia organizations provide the right kind and quality of assistance to enable ACCESS/MCHIP Nigeria to attain its objectives to the fullest possible extent?

VII. METHODOLOGY

The evaluation team will use a mixture of quantitative and qualitative approaches to gain insight into the impact of ACCESS/MCHIP Nigeria activities and the processes that lead to those impacts. The team will identify and conduct focus group interviews, key informant interviews (KII) and in-depth interviews with various stakeholders under the project. The team will also review performance records available through routine health reporting, project records, past evaluations and USAID/Nigeria performance records for quantitative information and other relevant sources. Interviews and data gathering will be conducted through field trips in Nigeria; and either through visits to JHPIEGO in Baltimore or conference calls from Nigeria with JHPIEGO staff.

1. **Background Materials Review:** Prior to conducting field work, the evaluation team will review background materials such as ACCESS and MCHIP Program Descriptions (for the centrally-funded projects and for ACCESS Nigeria and MCHIP Nigeria respectively), annual work plans, technical and training materials, past program evaluations reports and other documents related to the project. The Mission will provide these to the team as soon as possible and if possible, prior to the team's arrival to Abuja.
2. **Team Planning Meeting:** The team will conduct a 2-day team planning meeting (TPM) upon arrival in Abuja and before starting the field site visits portion of the evaluation. The TPM will review and clarify any questions on the evaluation SOW, agree on team member roles and responsibilities, clarify USAID's expectations of the evaluation and evaluation team, decide on the details of methodology, draft an initial work plan, develop a data collection plan, develop tools/interview guides that will be used by the team for key informant interviews and focus group discussions (FGDs), finalize the evaluation questions, develop the evaluation report table of contents, clarify team members' roles, and assign drafting responsibilities for the Evaluation report. The TPM outcomes will be shared with USAID/Nigeria, which will participate in sections of the TPM.
3. **Field Visits:** Conduct field visits to the project's selected service delivery points (SDPs)/health facilities in the project's selected LGAs in all 3 focus states, and to selected communities in which the project operated to observe the activities of collaborating community partners: the team may also select other non-project

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SDPs/facilities and LGAs to visit, and should interact with appropriate state-level health decision-makers to determine their knowledge of the project.

4. **Interviews:** Conduct interviews with key informants from other selected USAID Implementing Partners (but including TSHIP), USAID/Nigeria, the FMOH, SMOHs, LGA authorities as well as – as time permits - other development partners including U.N. agencies, community organizations (including women’s groups) and other relevant stakeholders identified in project documentation and interviews.
5. **FGDs:** Conduct FGDs with MCHIP community partners and relevant health providers.
6. **Debrief:** Prepare a presentation and debrief for USAID/Nigeria with main findings and recommendations.
7. **Draft Report:** Prepare a draft report for USAID/Nigeria before departing Abuja.
8. **Final Report:** Prepare a final report with an executive summary that includes main findings, conclusions, and recommendations for program improvements.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

An Illustrative Table of Level of Effort (LOE)

Tasks (All team members unless otherwise noted)	Team Leader B. Spaid	CCN Consultant Randawa
Travel Return Trip to/from Nigeria	4	
Preparations and review documents (to be provided by USAID), to occur before team arrives Abuja and prior to beginning the evaluation. (Evaluation Team in USA and Nigeria, assisted by MEMS II and USAID/HPN)	4	4
Team planning meetings (TPMs); develop evaluation work plan and timeline; develop interview/ FGD questions including list of people to be interviewed, draft and review of tools, develop report outline.(Evaluation Team/MEMS II in Abuja)	2	2
Conduct key informant interviews in MCHIP office with staff, USAID/HPN Team, the FMOH and other development partners. (Evaluation Team, Abuja)	4	4
Field visit for interviews/FGDs with State Ministries of Health, selected LGA authorities, communities and facilities.(Evaluation Team and administrative support assistant in Kano, Katsina and Zamfara, assisted by MEMS II from Abuja)	10	10
Team analysis of findings/consensus on conclusions and recommendations, and report outline as well as development of a PowerPoint presentation; would like an additional day or two in	4	4

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Abuja to meet/discuss with USAID and JHPIEGO upon return from field to clarify and confirm data and findings as the team consolidates and agrees upon findings and recommendations. (Evaluation Team, in states and Abuja, assisted as needed by MEMS II in Abuja)		
Conduct debriefing for USAID/Nigeria.(Evaluation Team, Abuja)	1	1
Prepare draft report --first draft submission prior to evaluation team departing country (incorporating comments from briefings).(Evaluation Team in Abuja assisted as needed by MEMS II)	4	4
USAID comments on draft (10 working days in addition to total days for the evaluation team)		
Report finalization, taking USAID/Nigeria comments into consideration, this takes place at home location of Team Leader but with constant consultation with other evaluation team member based in Nigeria. (Evaluation Team Leader in USA and CCN in Nigeria, with MEMS II assistance as needed)	5	3
Total	38	32

*Please note that actual travel time will depend upon the individual consultants' home locations.

The evaluation team will consist of two members including a Team Leader (international) and one local team member. The team members should represent a balance of technical expertise related to evaluation, MCH-FP service delivery, health services planning and programming, as well as community approaches to health. In addition to evaluation team members, the team will have a host country national hired by MEMS II, who will provide administrative and logistics support to the team.

The evaluation team members must have significant national/international health program experience. They should have some Nigeria country or African regional experience, along with comparative experience in MCH/FP and maternity/EmONC service delivery in developing countries. At least one member of the team must have Nigeria clinical experience and be familiar with the MCH/FP service delivery structure in the public sector. In addition, at least one member of the team must also be familiar with cultural issues and have relevant experience with community interventions in northern Nigeria.

Substantial experience in conducting evaluations, reviews or assessments is expected of the members, and experience in developing MNCH/FP strategies would be useful. All team members must be computer literate and have fluent professional-level English speaking writing and presentation skills.

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A general idea of the responsibilities and necessary skills/experience of the Team Leader and Team Member is described below. Each evaluation team member is expected to have an advanced degree in health management, health finance, public health or a closely related field. Demonstrable expertise in monitoring and evaluation; FP services, community mobilization, behavior change communications; and service delivery research are highly recommended.

Team Leader: The Team Leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other member of the team. The Team Leader will develop tools for the evaluation and share it with USAID/Nigeria. The Team Leader will develop the outline for the draft report, present the report and after incorporating USAID/Nigeria comments, submit the final report to MEMS II within the prescribed timeline. MEMS II will edit and print ample copies of the report in consultation with USAID/HPN.

Skills/Experience: The Team Leader should have:

1. Advanced degree in health management, health finance, public health or related field;
2. At least 10 years working experience in the field of international health;
3. Knowledge of health systems and health issues in developing countries;
4. A good understanding of USAID procedures and project administration;
5. Program design and evaluation experience;
6. Experience leading a multi-cultural team for international health program evaluations or related assignments; and
7. Excellent writing, communication, and presentation skills.

In addition to the technical responsibilities outlined in the scope of work for the assignment, Team Leader responsibilities include:

Preparations:

8. Finalize and negotiate the team work plan with client;
9. Establish roles, responsibilities, and tasks for each team member ;
10. Task and manage the administrative/clerical/logistics assistant, and ensure that the logistics arrangements are complete.

Management:

11. Facilitate preparations and agenda for the Team Planning Meeting (TPM);
12. Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report;
13. Manage the process of report writing;
14. Manage team coordination meetings in the field;
15. Coordinate the workflow and tasks and ensure that team members are working to schedule;
16. In communication with MEMS II, ensure that team field logistics are arranged (e.g., administrative/clerical/logistics support is engaged, ensuring that payment

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is made for services, car/driver hire or other travel and transport is arranged, etc.)

Communications:

17. Handle conflict within the team;
18. Serve as primary interface with the client and serve as the spokesperson for the team, as required;
19. In collaboration with MEMS II, debrief the client as the assignment progresses and organize a final debriefing;
20. Keep MEMSII staff apprised of challenges to progress, work changes, team travel plans in the field, and report preparation via phone conversation or email at least once a week;
21. Serve as primary interface with NMEMSII for the submission of draft and final reports/deliverables to MEMSII;
22. Make decisions about the safety and security of the team, in consultation with USAID/Nigeria and MEMSII.

Direction:

23. Assume technical direction lead as required, in order to ensure quality and appropriateness of assignment and report content.

Specific start and end dates, travel dates, and due dates for deliverables will be determined in collaboration with MEMS II and USAID/Nigeria and, based on the availability of the consultants, a detailed timeline will be review enduring the TPM.

Team Member: The second member of the team – working in close collaboration with the Team Leader - will provide clinical and other technical content as well as field experience in delivering services in Nigeria to the evaluation exercise.

Skills/Experience:

1. A senior physician or midwife, with experience delivering MNCH/RH/FP services at primary health care and EmONC referral levels in Nigeria;
2. Advanced degree in health management, health finance, public health or related field;
3. At least 10 years working experience in the field of international health;
4. Knowledge of health systems and health issues in developing countries, including community-based or extension services;
5. Program design and evaluation experience; and
6. Excellent writing, communication, and presentation skills

Duties/Responsibilities: Working closely with the Team Leader:

7. Assess *clinical and technical quality and value* of MNCH/RH/FP activities carried out under ACCESS/MCHIP Nigeria project;
8. Review and assess *content and effectiveness of clinical/technical and community-level materials* developed under the project, including policies, standards, guidelines, instructional materials,

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information/education/communications and behavior change communications materials, etc.

9. Assess *clinical/technical and community-level or extension worker training and subsequent changes in worker performance*;
10. Review and assess *physical improvements to facilities* (including availability of contraceptives, drugs, supplies and equipment), *facility operations and worker performance*;
11. Assess whether clinic-based and community-based or extension worker performance *improved, fell short or exceeded project objectives*;
12. Assess and *highlight clinical/technical best practices, lessons learned and/or innovations*;
13. Assess the project's *clinical/technical/operational recommendations and actual improvements* made by the project at primary health care centers and referral facilities, *in terms of client satisfaction* as well as *appropriateness and contributions to improvements in MNCH/RH/FP outcomes*; and
14. Assess whether improvements and project accomplishments are *sustainable in terms of client access and use, worker performance, quality of care*, etc. at the project's selected facilities
15. Assess support provided or not by the LGAs to the facilities and assess *whether the project contributed to the relationships between facilities and LGAs*.

IX. LOGISTICS

MEMSII will provide technical and administrative support, including identification and fielding appropriate consultants in consultation with USAID/Nigeria. In addition, MEMSII will provide all logistical arrangements such as flight reservations to/from Nigeria, country clearances from USAID/Nigeria, in-country travel, airport pick-up/drops, lodging and interpreters (if needed).

The administrative/logistics assistant will be hired locally by MEMS II to – under the direction of the Team Leader and MEMS II - arrange field visits, local travel, hotels, key informant interviews and meetings, and appointments with stakeholders.

A six-day work week, if required, is authorized by USAID/Nigeria.

In the first instance, the Team Leader will communicate with MEMS II on arrangements and direction of the evaluation. If needed, however, the Team Leader will contact USAID/HPN directly.

X. DELIVERABLES AND PRODUCTS

1. An evaluation work plan and timeline- prepared during the TPM.
2. A detailed report outline- prepared during the TPM.

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3. Questionnaire/guideline for conducting key informant interview and FGDs- prepared during the TPM, submitted to USAID/HPN for review and approval prior to initiating key informant interview and site visits.
4. Debriefings - the two-member team will debrief MEMS II and USAID/Nigeria on findings, conclusions and recommendations before leaving Nigeria. Up to two PowerPoint presentations for debriefing and summarizing findings, conclusions and recommendations will be prepared and distributed at intervals. USAID/Nigeria will provide feedback during the briefing meeting and debriefing(s).
5. Draft Evaluation Report - a synthesized draft report will include, at a minimum, the following: scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for USAID/Nigeria management based on the conclusions); lessons learned (documented and highlighted); and future directions (implications for future designs and for others to incorporate into similar programs).

The evaluation team will provide USAID/Nigeria with a draft report that includes all the components of the final evaluation report prior to their departure from Nigeria.

USAID/Nigeria will provide written comments on the draft report to the Evaluation Team within 10 working days of receiving the draft report.

6. Final Evaluation Report - the final report will address the comments provided by USAID/Nigeria on the draft report. The Team Leader will revise the draft report and deliver an electronic copy of the final revised version to MEMS II and USAID/Nigeria within three weeks of receiving USAID feedback. This report will be a public document.

Any procurement sensitive pieces, comments and recommendations that need to be treated as confidential in the judgment of the Team Leader, will be separated by the Team Leader from the final report and included in an internal memorandum to USAID/Nigeria. The memorandum will be internal to USAID/Nigeria.

Discussions and recommendations related to SOW can be made publicly available.

MEMSII will provide the edited and formatted final document approximately 30 days after USAID/Nigeria provides final approval of the report. The report will not be longer than 40 pages total, excluding annexes. MEMSII will provide 10 printed copies and an electronic file. MEMSII will make the results of the evaluations public on the USAID Development Experience Clearinghouse and on its project website.

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PROPOSED OUTLINE FOR EVALUATION REPORT (TO BE FINALIZED DURING THE TPM)

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ACKNOWLEDGEMENTS		
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CONCLUSIONS (as well as any limitations in the inferences)		
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Evaluation Scope of Work		
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XI. RELATIONSHIPS AND RESPONSIBILITIES

The Evaluation Team will work under the technical direction of USAID/Nigeria, the client.

USAID/Nigeria will:

On being provided with same by MEMS II, approve country clearances for travel – this is particularly important given security issues;

Provide the team with a general list of suggested organizations and contact information;
Arrange for initial communications with appropriate contacts with ACCESS/MCHIP Nigeria, the GON and other organizations at the outset of the process.

Client Roles and Responsibilities (in consultation and collaboration with MEMS II):

Before In-Country Work:

Documents. Identify and prioritize background materials for the consultants and provide them, preferably in electronic form.

USAID-Supplied Evaluation Participants. Provide guidance regarding participation in the assignment by Mission staff (i.e. who will participate, how long, source of funding for their participation).

During In-Country Work:

Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Mission Point of Contact person(s), **Joseph Monehin and/or John Quinley**, and provide technical leadership and direction for the team's work.

Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.

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Facilitate Contacts with Partners. Introduce the team to project partners, local government officials and other stakeholders and, where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-Country Work:

Timely Reviews. Provide timely review of draft/final reports and approval of the deliverables.

MEMSII Roles and Responsibilities (in collaboration with Team Leader and USAID/Nigeria):

Local Consultants. Assist with identification of potential local consultants and provide contact information.

Logistics: Coordinate all assignment related expenses for their consultants incurred in carrying out this review including travel, transportation, lodging, and communication costs, etc.

Organizing meetings: Assist team in expanding the list of organizations and persons to contact, and for arranging key meetings and appointments with federal, state and LGA officials, and accompany the team on these introductory interviews (especially important in high-level meetings).

NOTE: The Team Leader is given the final decision as to who will accompany the team members to meetings and on field visits. This means that the Team Leader can decide to exclude both MEMS II and USAID/Nigeria staff from meetings and field trips, except in the case of security concerns in the judgment of USAID/HPN.

XII. NMEMS II AND MISSION CONTACT PEOPLE/PERSON

NMEMS II:

Dr. Carlos Torres, MEMS II Project Director

Zakariya Zakari, Deputy Chief of Party

USAID/Nigeria:

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Sharon Epstein

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XIII. COST ESTIMATE: TBD

Provided separately as an Evaluation Budget accompanying this report.

XIV. REFERENCES (Project and Relevant Country Documents)

ANNEX A. List of Pertinent Documents

ACCESS and MCHIP global award documents

ACCESS and MCHIP Nigeria concept notes/program descriptions

Annual work plans

Annual and quarterly reports

ACCESS/MCHIP Monitoring and Evaluation Plans/PMP

USAID-commissioned Data Quality Assessment Reports for ACCESS/MCHIP

USAID/Nigeria Maternal, Child and Reproductive Health Program Mid-term Evaluation Report, Nov 2009

USAID Nigeria Strategic Plan 2010-2013

USAID Operational Plan and other planning documents

All ACCESS/MCHIP-commissioned internal reviews/evaluations conducted in Nigeria since project onset

Nigerian Demographic and Health Survey (NDHS) 2008

National Strategic Health Development Plan (NSHDP) 2010-2015

National RH Policy

Checklist for assessing USAID Evaluation Reports

USG Global Health Initiative Country Strategy

BEST Strategy

Any other ACCESS/MCHIP materials will be provided on the evaluation team's request

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ANNEX B. DOCUMENTS REVIEWED

ACCESS, Nigeria (2010). Postpartum Systematic Screening in Northern Nigeria: A Practical Application of Family Planning and Maternal Newborn and Child Health Integration.

ACCESS, Nigeria (2010). Safe Motherhood in Northern Nigeria: Results from an Evaluation of the ACCESS Program in Kano and Zamfara States.

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ACCESS/MCHIP Evaluation USAID/Nigeria

United States Agency for International Development, Nigeria (2010). USAID/Nigeria Strategy 2010-2013.

ANNEX C. PERSONS CONTACTED

JHPIEGO, Abuja

Prof Emmanuel Otolorin, Contry Director
Adetiloye Oniyere, HIV Project Officer
Lydia Airede, Senior Technical Officer
Gbenga Ishola, Sr M&E officer
Anche Ekpubeni, Sr Finance & Admin officer
Beatrice Nwanokwu, HR officer

USAID Abuja

Sharon Epstein, HPN Team Leader USAID
John Quinley, Sr Health Advisor
Joyce Elele, Program Officer/ M&E
Tara O'day, Health Officer
Barbara Dickson, Program Office Dir.
Kayode Morenikeji, Activities Manager, ACCESS/MCHIP
Ekanem Bassy, CSO Specialist (PDG)
Ugo Oguejiofor, OAA Specialist
Joseph Monehin, HPN MCH Prog Manager
Maiwada J Abdullahi, SPM (RH)
Rose Chinedum-Udumukwu, Prog & Exchange Visitor Asst
Folake Olayinka, MCH Prog Manager

NMEMS Abuja

Carlos Terres, COP
Zakari Zakariya, DCOP
Tayo Olugbemi, Sr. M&E Specialist
Nura Nasir, M&E officer

JHPIEGO, Washington

Koki Agarwal, ACCESS & MCHIP Project Director for JHPIEGO

USAID, Washington

Nahed Matta, USAID CTO/AOTR for ACCESS and MCHIP

FMOH, Abuja

Dr B, Okoguale, HOD Family Health
Dr Bose Adeniran, Head-RH
Dabiri O.M (Mrs), Head-HP
Akinsanmi, CM RH
Dr James OI, MO/CH
Dr Chris Isokpunwu, H/Nutr

Other Implementing Partners, Abuja

Dr. Mojisola Odeku, Project Director NURHI

Mohammad J Abdullahi, Director PHC SD NPHCDA

Dr. Abimbola Williams, Sr. Newborn & Child survival Advisor Save The Children

TSHIP

Marc A. Okunnu, COP

Habib Sadauki, DCOP Bauchi

William Sambisa, Director M&E

A M Maishanu, DCOP Sokoto

Kano State Officials

Dr Ashiru Rajab, Deputy Dir. PHC and DC SMOH

Ahmad Abubakar Dawakin Tofa LGA

Ladi Ibrahim, Dawakin Tofa LGA

Dr Nasir Bashir, ACCESS/MCHIP Kano Program officer

Hajia Sa'a Nata'ala, Coordinator for PH/FP

Zamfara State Officials

Mr Lawali Umar Bungudu, Director PHC (Retired) SMOH

Mr Aliyu Bello Kura, Information Officer for Kauran Namoda LGA and Chairman of the CCG

Mr Isah Mikhailu, Planning Officer International Agricultural Development (IFAD) and Sec CCG

Mrs Hafsat Halilu Anka, Asst MCH Coordinator for SMOH

Gen Hospital Kauran Namoda, Zamfara

Dr Kelechi Otuonye Medical officer Gen Hosp K/Namoda

Esther Bako CNO i/c Maternity Gen Hosp K/Namoda

King Fahd WCWC, Zamfara

Dr Ibrahim Nazaradden, Medical Officer i/c

Abubakar Mohd, Director Admin

Umar Suleman, CNO

Nana Ahmed, CNO

Risikat Sola, FP Midwife

Ladi Dawa, FP Midwife

Mary Saleh, CNO L/Ward

Kurya PHC, Zamfara

Usman Abdulwahab, Officer I/C

Mairo Isyaku, Midwife i/c

Sanusi Lawal, i/c Immunization

Ogbuagu Chinwe, MSS Midwife

Adeniyi Mariam, MSS Midwife

Halima Umar, CHEW

Mada PHC/Community, Zamfara

Sani Mohd Mada, CMT Chairman

Nafisat Aminu, CHEW

Nasiru Dan-Alkali, CCG

Audu Musa, CCG

Yahaya Sani, CCG

Muas Mamman, CCG

Ibrahim Musa, CCG

Garba Ibrahim, CCG

Suwaiba Aliyu, HHC

Hajara Ma'azu, HHC

Hafsat Idris, HHC

Fadimatu Sale, HHC

Murjanatu Abdullahi, HHC

Mustafa Lawal, CCG

A Aliyu, CCG

Abubakar Ibrahim, CCG

Sani Mada II, CCG

MBSM Shagari, Zamfara

Murtala Sani, MBSM

Hassan Nasiru, MBSM

Aminu Bello Danamu, MBSM

Bashir Abubakar, MBSB

Abdullahi Aliyu, MBSM

Sanusi Nasiru, MBSM

Sani Labaran, MBSM

Lawal Nuhu, MBSM

Katsina state

Hajia Amina Sule, ACCESS/MCHIP Program Officer for Katsina state

Hajia Fati Garba, State Primary Health Care Development Agency, State RH/FP
Coordinato

Abukur PHC, Katsina

Amina Sule, i/c PHC Abukur

Suleman Sada, Chairman CMT

Tijjani Sa'idu, MBSM

Bello Sama'ila, MBSM

Suleman Bala, MBSM

Sani Aliyu, CCG Leader

Uwani Abdullahi, HHC

Hafsat Kamilu, HHC

Zainab Yusuf, HHC

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Asma'u Lawal, TMMD
Binta Mohammad, TMMD

Gen Hospital Funtua, Katsina

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Lawal Danbai, M&E officer
Maryam Jimoh, CNO

PHC Malumfashi, Katsina

Maryam Mudi, CHEW
Hannatu Maiwada, CHEW

Turai 'Yar'adua MCH Katsina

Safiya Labaran Ibr, CNO
Raliya Umar , CNO
Maryam Mohd, CNO

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ANNEX D. DATA COLLECTION MATRICES AND TOOL

ANNEX D.1. MATRIX: ABUJA Contacts and Key Interviews

Evaluation source	Question/Feedback	USAID Sharon Epstein 08036650832 Kayode 08033177096 Joseph Monehin 08055690004	JHPIEGO Dr. Otolorin Lydia Regina 08036830860	FMOH & NPHCDA Mrs. Osuntogun, Director FH Dept Mrs. Ogunmayin Dr. Olumuyiwa Oyinbo	UN & other donor Agencies
		Project Team			
1. How has the ACCESS/MCHIP Project increased utilization of FP and EmONC services in selected LGAs			What were the most effective strategies for increasing utilization of services under ACCESS/MCHIP?		
1.a population covered by each separate LGAs (denominator)			Does project have this information?		
1.b utilization breakdown by facility			Does the project have data for utilization by facility (58) for key indicators 1 & 4		
2. How has the ACCESS/MCHIP Project improved quality of FP services in Project areas?			To what extent has the project been able to make available trained FP counselors; improvement in the logistics system and provision of standards and protocols in all 58 facilities?		
2.a taking into consideration the different settings			How do you ensure Q in different settings? GET COPIES OF STANDARDS-BASED CHECK LISTS		
3. How has the ACCESS/MCHIP Project improved the quality of EmONC services in the project area?			To what extent has the project been able to make available trained midwives and/ or doctors ; and how and to what extent did they incorporate the CHEWs?		
3.a			# of trained providers that can provide EmONC at different settings?		
3.b			How were they able to achieve supply of functional equipment, drugs and supplies		
			To what extent did the project make available standards and protocols, partographs for EmONC?		
3.d Use of SBM-R			Out of 58 facilities, why was SBM-R used in only 30 facilities? Data by facility for improvement against SBM scorecard? Was PDQ used with the community to identify gaps in care quality and if so how successful?		
4. How has ACCESS/MCHIP contributed to improving the enabling environment (EE) for scale-up of FP and EmONC successful activities at the state and national levels			What are the major gaps JHPIEGO has identified in MNC/FP policies and what support did the project give in addressing them?	What are the identified gaps and deficiencies that impede the FMOH in addressing FP and maternal/newborn health needs at the national level? How has ACCESS/MCHIP succeeded	

ACCESS/MCHIP Evaluation USAID/Nigeria

Evaluation source	Question/Feedback	USAID Sharon Epstein 08036650832 Kayode 08033177096 Joseph Monehin 08055690004	JHPIEGO Dr. Otolorin Lydia Regina 08036830860	FMOH & NPHCDA Mrs. Osuntogun, Director FH Dept Mrs. Ogunmayin Dr. Olumuyiwa Oyinbo	UN & other donor Agencies
				<p>in supporting the FMOH in addressing these needs?</p> <p>What more can be done and how?</p> <p>Can you cite any examples or provide data to show improvement in FP/maternal and newborn care or health?</p>	
			How many and what policies were developed or adapted in order to improve EmONC/FP?		
			How has the project been able to increase funding for EmONC/FP at the local, state and national levels?		
			How many and what type of organizations, sub-grantees was the project able to improve capacity to deliver services? How did they do it?		
			How did the project help in scaling up successful activities outside the LGAs at the state or national level?		
			What linkages were established were other USAID or other donor projects?		What do you see as the major challenges in improving utilization and quality of FP/maternal and newborn care services, particularly in the North?
			To what extent have attitudes changed among men and community leaders for supporting FP and EmONC? DATA!		
	5. How has ACCESS/MCHIP improved management of maternal and newborn services in selected program sites?		How has ACCESS/MCHIP improved management of maternal and newborn services in selected program sites?		
	5.a training (DQA, finances, grant proposals,		Specific Inputs by training topic?		
	5.b supportive supervision		How effective has supportive supervision been in improving service delivery?		
	6. How has ACCESS/MCHIP improved mgmt of maternal and		6. Looking at different settings—PHC, Hospitals, etc what are the appropriate communications		

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Evaluation source	Question/Feedback	USAID Sharon Epstein 08036650832 Kayode 08033177096 Joseph Monehin 08055690004	JHPIEGO Dr. Otolorin Lydia Regina 08036830860	FMOH & NPHCDA Mrs. Osuntogun, Director FH Dept Mrs. Ogunmayin Dr. Olumuyiwa Oyinbo	UN & other donor Agencies
	newborn services in selected LGAs		strategies used?		
	6.1 What types of mass media?		6.a what types of mass media were used and how effective were they?		
	6.2		6.b what types of IPC materials used by setting? Was there formative research on these materials?		
	6.3 community mobilization		6.c Did the project utilize a framework that supports formation of community mobilization networks? Did they link with VDCs and the states? # of WDCs and VDCs utilized? Were PDQs used?		
	7. How effectively has project design and management contributed to ACCESS/MCHIP achievements?	How did design contribute to accomplishments or detract? --pilot nature —broad rather than deep To what extent was the design “generic” or “Nigerian”? In absence of signed MOUs with LGAs, how supportive were the states and LGAs? What was the assumption on who would provide commodities and contraceptives?	7. What effect did morphing ACCESS into MCHIP have on project achievement? Staff turn-over within the project, AID/W, USAID?	How well has ACCESS/MCHIP staff collaborated and kept FMOH apprised of project activities?	What project activities do you have in common with the ACCESS/MCHIP project in 3 states? How well did the ACCESS/MCHIP project collaborate coordinate with your agency? Examples?
		M&E—discussion and use of quarterly and annual reports? Frequency of field visits and actions taken? Indicators: Why a difference between PMP and Annual reporting? Where is baseline data? Where are LOP Targets? STILL NEED: USAID Operational Plan and Performance targets set during annual Performance Planning and Reporting process.	M&E—merging AID/W and Mission indicators? What happened to denominators/% indicators? Where is baseline data?		
		DATA—quality; reports from NMEMS? How good is data?	DATA—quality and flow?		
	7.d	How did USAID use the Mid-Term Evaluation to make changes in the ACCESS/MCHIP project? What actions did USAID take/discuss with ACCESS against mid-term evaluation recommendations? Based on the evaluation and ARs, did the Mission ever propose additional funding or	Actions taken against the Mid-Term Evaluation—status. SEE CHART		

ACCESS/MCHIP Evaluation USAID/Nigeria

Evaluation source	Question/Feedback	USAID Sharon Epstein 08036650832 Kayode 08033177096 Joseph Monehin 08055690004	JHPIEGO Dr. Otolorin Lydia Regina 08036830860	FMOH & NPHCDA Mrs. Osuntogun, Director FH Dept Mrs. Ogunmayin Dr. Olumuyiwa Oyinbo	UN & other donor Agencies
	LOP? Were there changes in program implementation or reporting that have changed over time with the consent of USAID? E.G. Dropping indicators with a denomination?				
	Effectiveness of JHPIEGO management?		Effectiveness of USAID management?		
8. How effective were various community level activities in promoting access to FP and EmONC?			Which community level activities were most effective in promoting access to services? DATA! Male motivators, HHCC, emergency transport schemes, women's savings groups? MSS? Work with CBOs FBOs and women's groups?		
9. What were the strengths and weaknesses of the ACCESS/MCHIP project?	9. What were the strengths and weaknesses of the ACCESS/MCHIP project? What should USAID have done differently in hindsight? What were the most important achievements under the project?		9. What were the strengths and weaknesses of the ACCESS/MCHIP project?	What were the major contributions made by the project?	
10. What lessons were learned under ACCESS/MCHIP? What worked well and what didn't?			What worked well and what didn't? LESSONS LEARNED? Which activities were more cost-effective than others? How effective are the male motivators? CHEWs? What data supports this?		

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ANNEX D.2. MATRIX: State and LGA Key Interviews

Evaluation Question/Feedback source	SMOH	State ACCESS/MCHIP staff	LPA staff
1. How has the ACCESS/MCHIP Project increased utilization of FP and EmONC services in selected LGAs?	<p>Project Team</p> <p>1. What are the identified gaps and deficiencies that impede the SMOH in addressing FP and maternal/newborn health needs in your state at this stage?</p> <p>1.a. Has ACCESS/MCHIP succeeded in supporting the SMOH in addressing these needs?</p> <p>1.b. What more can be done and how?</p> <p>1.c. Can you cite any examples or provide data to show improvement in FP/maternal and newborn care or health?</p> <p>FOR KANO ONLY: IN WHAT YEAR DID ALL SECONDARY FACILITY CARE BECOME FREE AND HOW MUCH OF THE INCREASE IN FACILITY DELIVERIES CAN BE ATTRIBUTED TO THIS RATHER THAN TO ACCESS/MCHIP INTERVENTIONS?</p>	<p>1. What were the most effective strategies for increasing utilization of services under ACCESS/MCHIP?</p> <p>For which services did utilization increase the most?</p>	<p>1. What are the identified gaps and deficiencies that impede the LGA in addressing FP and maternal/newborn health needs in your state at this stage?</p> <p>1.a. Has ACCESS/MCHIP succeeded in supporting the LGA in addressing these needs?</p> <p>1.b. What more can be done and how?</p> <p>1.c. Can you cite any examples or provide data to show improvement in FP/maternal and newborn care or health?</p>
2. How has the ACCESS/MCHIP Project improved quality of FP services in Project areas?	<p>2. Has the ACCESS/MCHIP Project improved quality of FP services in your state?</p> <p>2.a. How have they done so? (standards, FP counselors, commodities--PPFP, LT methods)</p> <p>2.b. How well did STBM work? Is this something the state plans to continue?</p>	<p>2. To what extent has the project been able to make available trained FP counselors; improvement in the logistics system and provision of standards and protocols in your state?</p>	<p>2. Has the ACCESS/MCHIP Project improved quality of FP services in your LGA?</p> <p>2.a. How have they done so? (standards, FP counselors, commodities--PPFP, LT methods)</p> <p>2.b. How well did STBM work? Is this something the state plans to continue?</p>
3. How has the ACCESS/MCHIP Project improved the quality of EmONC services in the project area?	<p>3. Has the ACCESS/MCHIP Project improved the quality of EmONC services your state?</p> <p>3.a. How have they done this?</p> <p>--standards, --trained HC providers including midwives who can provide services for focused ANC, provide clean and safe delivery and manage complications, such as eclamsia, PPH, NB complication management, --availability of functional equipment and operating theatre --sufficient # of facilities? --SBM-R</p>	<p>3. To what extent has the project been able to make available trained midwives and/ or doctors; and how and to what extent did they incorporate the CHEWs?</p> <p>3.a. # of trained providers that can provide EmONC at different settings?</p>	<p>3. Has the ACCESS/MCHIP Project improved the quality of EmONC services in your LGA?</p> <p>3.a. How have they done this?</p> <p>--standards, --trained HC providers including midwives who can provide services for focused ANC, provide clean and safe delivery and manage complications, such as eclamsia, PPH, NB complication management,</p>
		3.b. How were they able to achieve supply of functional equipment, drugs and supplies	
		3.c. To what extent did the project make available	

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Evaluation Question/Feedback source	SMOH	State ACCESS/MCHIP staff	LPA staff
		standards and protocols, partographs for EmONC?	
		3.d. How many facilities in state used SBM and how successful was it? [Zamfara—13; Kano—6; Katsina—1] CROSSCHECK!	
4. How has ACCESS/MCHIP contributed to improving the enabling environment (EE) for scale-up of FP and EmONC successful activities at the state and national levels	What aspects of the project will the state continue? SBM? 4.a. To what extent have attitudes changed among men and community leaders for supporting FP and EmONC in your state? DATA!	4. To what extent has the ACCESS/MCHIP project left a lasting influence on the state? [policies, standards, guidelines, training, etc] 4.a. To what extent have attitudes changed among men and community leaders for supporting FP and EmONC in your state? DATA!	What aspects of the project will the LGA continue? SBM? 4.a. To what extent have attitudes changed among men and community leaders for supporting FP and EmONC in your LGA? DATA!
	4.b. Did the state scale up any successful ACCESS/MCHIP activities at the state level outside the project LGAs? Is the SMOH planning to scale up any of the successful activities under ACCESS-MCHIP? What activities does the state plan to continue? SBM etc	4.b. How did the project help in scaling up successful activities outside the LGAs at the state level? How has the project been able to increase funding for EmONC/FP at the local and state levels?	What activities does the LGA plan to continue? SBM etc
	4.c. How well did ACCESS/MCHIP collaborate/link with other state organizations, projects efforts?	4.c. What linkages were established were other USAID or other donor projects?	
5. How has ACCESS/MCHIP improved management of maternal and newborn services in the state?	5. Has the project assisted the SMOH in improved resource allocation in any way? (funding, staff, commodities) Or other improvements in managing maternal and newborn services, (data collection, etc.)	5. How has ACCESS/MCHIP improved management of maternal and newborn services in selected program sites? (record keeping and reporting? Supportive supervision?) 5.a. How many and what type of organizations, sub-grantees was the project able to improve capacity to deliver services? How has the project improved management of services at the LGA and state levels?	5. How has ACCESS/MCHIP improved management of maternal and newborn services in the state?
5.b supportive supervision	Did any SMOH officials participate in any project-run training? (supportive supervision?) How effective has SS been? record keeping? In improving management of services?	5.b. How effective has supportive supervision been in improving service delivery? EXAMPLES! 5.c. How has management of facilities improved?	Did any LGA officials participate in any project-run training? (supportive supervision?) How effective has SS been? record keeping? In improving management of services?
6. How has ACCESS/MCHIP increased demand for maternal and newborn services in selected LGAs?	6. Has ACCESS/MCHIP increased demand for maternal and newborn services in selected LGAs in the state?	6. Looking at different settings—PHC, Hospitals, etc what are the appropriate communications strategies used?	6. Has ACCESS/MCHIP increased demand for maternal and newborn services in your LGA?
6.1 What types of mass media?	Mass media? BCC, Job Aids,	6.a what types of mass media were used and how effective were they?	Mass media? BCC, Job Aids,
6.2	IPC—counseling, MBSMs, HHC,	6.b what types of IPC materials used by setting? Was there formative research on these materials?	IPC—counseling, MBSMs, HHC,
6.3 community mobilization	Community Mobilization— CMYs, CCGs, VDCs, WDCs,	6.c Did the project utilize a framework that supports	Community Mobilization— CMYs, CCGs,

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Evaluation Question/Feedback source	SMOH	State ACCESS/MCHIP staff	LPA staff
	women's savings groups, CBOs? How effective was community mobilization in increasing demand for services?	formation of community mobilization networks? Did they link with VDCs and the states? # of WDCs and VDCs utilized? Were PDQs used?	VDCs, WDCs, women's savings groups, CBOs? How effective was community mobilization in increasing demand for services?
7. How effectively has project design and management contributed to ACCESS/MCHIP achievements?	7. In your opinion, how well was the project managed? 7a. Did ACCESS/MCHIP adequately involve the SMOHs in planning, implementing and monitoring activities? 7b. How was additional ACCESS/MCHIP data collection useful? 7c. Degree of interaction and collaboration with Project staff and USAID staff? Examples.	7. Was project management support from Abuja sufficient? How often visited? What support from Project staff in US? Data—quality and flow? Record keeping Effectiveness of USAID management? How often did someone visit from Abuja HPN office (DQA and Not DQA-related)? Were visits helpful? How?	7. In your opinion, how well was the project managed? 7a. Did ACCESS/MCHIP adequately involve the SMOHs in planning, implementing and monitoring activities? 7b. How was additional ACCESS/MCHIP data collection useful? 7c. Degree of interaction and collaboration with Project staff and USAID staff? Examples.
8. How effective were various community level activities in promoting access to FP and EmONC?	Which community level activities were most effective in promoting access to services in your state? DATA! Male motivators, HHCC, emergency transport schemes, women's savings groups? MSS? Work with CBOs FBOs and women's groups?	Which community level activities were most effective in promoting access to services? DATA! Male motivators, HHCC, emergency transport schemes, women's savings groups? MSS? Work with CBOs FBOs and women's groups? How effective were CMTs and CCGs in mobilizing the communities? EXAMPLES!	Which community level activities were most effective in promoting access to services in your LGA? DATA! Male motivators, HHCC, emergency transport schemes, women's savings groups? MSS? Work with CBOs FBOs and women's groups?
9. What were the strengths and weaknesses of the ACCESS/MCHIP project?	9. What were the strengths and weaknesses of the ACCESS/MCHIP project? What were the most important achievements under the project?	9. What were the strengths and weaknesses of the ACCESS/MCHIP project?	9. What were the strengths and weaknesses of the ACCESS/MCHIP project? What were the most important achievements under the project?
10. What lessons were learned under ACCESS/MCHIP? What worked well and what didn't?	10. What lessons were learned under ACCESS/MCHIP? What worked well and what didn't?	10. What worked well and what didn't? LESSONS LEARNED? 10.a. Which activities were more cost-effective than others? How effective are the male motivators? HHCs? What data supports this?	10. What lessons were learned under ACCESS/MCHIP? What worked well and what didn't?

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ANNEX D.3 MATRIX: Key Interview Questions for those residing outside Abuja and field visit areas

Evaluation source	Question/Feedback	Nahid Mata USAID/W CTO for ACCESS & MCHIP 202-712-4564 703-625-8791 (cell) nmatta@usaid.gov	Koki Agarwal ACCESS & MCHIP Project Director JHPIEGO Washington D.C. 202-835-3102 410-294-3077 (cell) kagarwal@jhpiego.net	Marc Okunnu TSHIP COP 07037197441 (cell) mokunnu@tshipnigeria.org
Project Team				
1. How has the ACCESS/MCHIP Project increased utilization of FP and EmONC services in selected LGAs	<p>How long have you been the ACCESS/MCHIP AOTR?</p> <p>Did you participate in the team that came to Nigeria in Jan 2006 to participate in the stakeholders' meeting to better understand Nigeria's EmONC situation? If so, how did it facilitate the "launch" of the activity?</p> <p>How satisfied were you with the Nigeria project in terms of overall project achievement in increased utilization of EmONC and FP services?</p>	<p>How long have you been the ACCESS/MCHIP Director?</p> <p>Did you participate in the team that came to Nigeria in Jan 2006 to participate in the stakeholders' meeting to better understand Nigeria's EmONC situation? ? If so, how did it facilitate the "launch" of the activity?</p> <p>How satisfied were you with the Nigeria project in terms of overall project achievement in increased utilization of EmONC and FP services?</p>		
2. How has the ACCESS/MCHIP Project improved quality of FP services in Project areas?			<p>The original global project description includes PQI for QA—How did this become SBM-R in the Nigeria project?</p> <p>The Nigeria project found the SBM-R process to be overly time consuming and staff intensive and only achieved baseline assessment in 30 for 57 facilities and multiple follow-up assessments in only 11. Was this typical of other country programs? Should this process have been streamlined?</p>	
3. How has the ACCESS/MCHIP Project improved the quality of EmONC services in the project area?				
4. How has ACCESS/MCHIP contributed to improving the enabling environment (EE) for scale-up of FP and EmONC successful activities at the state and national levels	Improving the enabling environment for scaling up was an important component from the beginning under the global program. Compared to other countries, how did the Nigeria program do?	Improving the enabling environment for scaling up was an important component from the beginning under the global program. Compared to other countries, how did the Nigeria program do?		<p>What successful components from ACCESS/MCHIP is TSHIP scaling up in Sokoto and Bauchi?</p> <p>How did TSHIP design and implementation benefit from ACCESS/MCHIP experience? (state-wide, data population based %-wise, etc.)</p>
5. How has ACCESS/MCHIP improved management of maternal and newborn services in selected program sites?				
6. How has ACCESS/MCHIP improved Demand for maternal and newborn services in selected LGAs?				
7. How effectively has project	How well did USAID/Nigeria manage this program?		Design—was Nigeria the only program that incorporated a	

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Evaluation source	Question/Feedback	Nahid Mata USAID/W CTO for ACCESS & MCHIP 202-712-4564 703-625-8791 (cell) nmatta@usaid.gov	Koki Agarwal ACCESS & MCHIP Project Director JHPIEGO Washington D.C. 202-835-3102 410-294-3077 (cell) kagarwal@jhpiego.net	Marc Okunnu TSHIP COP 07037197441 (cell) mokunnu@tshipnigeria.org
design and management contributed to ACCESS/MCHIP achievements?	<p>Did they require more or less of your time and effort than other programs?</p> <p>Was reporting complete and timely?</p> <p>Were there any management difficulties you remember?</p> <p>M&E: Did you feel M&E was rigorous enough? MCHIP had no baseline and endline as did ACCESS.</p> <p>DQA problems</p>	<p>substantial FP component?</p> <p>How well did USAID/Nigeria manage the project?</p> <p>How well did the local JHPIEGO/project staff manage the project? Did they require more or less of your time and effort than other programs? Was reporting complete and timely? Were there any management difficulties you remember?</p> <p>M&E: Did you feel M&E was rigorous enough? MCHIP had no baseline and endline as did ACCESS.</p> <p>DQA problems</p>		
8. How effective were various community level activities in promoting access to FP and EmONC?				
9. What were the strengths and weaknesses of the ACCESS/MCHIP project?				
10. What lessons were learned under ACCESS/MCHIP? What worked well and what didn't?	What Lessons Learned and/or INNOVATIONS did the Nigeria project contribute to the global project?	What Lessons Learned and/or INNOVATIONS did the Nigeria project contribute to the global project?		

ANNEX D.4. Health Facility Interview Guide for ACCESS/MCHIP Evaluation

Intervention	Key questions and areas of interest	Targeted Stakeholders
<p>Program Achievements Increase utilization of FP and EmONC Improve Quality of FP and EmONC services Improve Management of Maternal and Newborn services Increase Demand for Maternal and Newborn services Infrastructure development and equipment Commodity security</p>	<p>1) What has been identified by in-charges as institutional capacity gaps and deficiencies that impede the ability of health facility to address maternal and newborn health needs at the facility and community level? 2) Has the project been successful in its support to health facility in addressing those needs? 3) What more can be done and how? 4) Ask for training reports/register or any other supporting documents. Probe : Areas of interest: ACCESS/MCHIP support in 1) use of SBM-R approach; supportive supervision; HBB, KMC 2) FP; 3) Renovations of health facility; 4) training of providers, clinical instructors/preceptors (relevance to training needs, training topics; appropriateness and quality of training materials; cadre of trainees); provision of Equipments and drugs for maternal and newborn health services.</p>	<p>In charges of PHC centre (BEOC) and HOD, O&G Dept of essential referral centre (CEOC) Matron i/c ANC clinic, Labour ward, FP clinic</p>
	<p>What has been identified by in charges as needs, gaps and weakest links in addressing the issue of focused antenatal care/clean & safe delivery/EmONC and FP in the facility? Has the project been assisting in the above efforts and in what ways? What more can be done and how? Ask for relevant registers or any other supporting health statistics or documents. Probe :Areas of interest FANC - Prevention of complications of pregnancy and childbirth, early detection and treatment of complications, birth planning and complication readiness; malaria prevention and management in pregnancy (prevention, diagnosis, treatment, referrals), procurement and distribution of SP, iron and folate; BCC to improve SP and ITN use among pregnant women; availability of malaria treatment guidelines(ANC Register) Clean & safe delivery - Facility delivery, Use of Partograph, Active Management of Third Stage of Labour, Postpartum monitoring, , emergency</p>	

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	<p>trolleys(L/Ward Register) Essential newborn care; Rx of Neonatal sepsis, Care of low birth weight and preterm babies(KMC), Helping Babies Breath (HBB) FP:-No of counselors, Linkage with HHC and MBSM; Commodities available//Logistics (Check FP Registers for No of clients/method-PPFP, Long Acting and other methods</p>	
<p>Program Effectiveness</p> <p>Social mobilization Community participation BCC/IEC NGO/CBO participation</p>	<p>How effective were the various facility and community level activities in promoting access to maternal, neonatal and FP services(MBSM, HHC, ETS, MSS ?</p> <p>Social mobilization - Are there links at health facility level that work with local mobilization networks, change champions Ask for statistics of local service delivery networks, linkages with other sector groups in the state, HHCC?</p> <p>Community participation - Are there links at health facility level with WDCs, VDCs, Community coalitions. Ask for existence of WDCs, VDCs, and Health Facility Management Committee.</p> <p>BCC/IEC - Are there units at health facility level that use BCC/IEC for EmONC/FP activities?</p> <p>NGO/CBO participation - Are there links at health facility level with any NGOs/CBOs working for Maternal and Newborn Health in the area?</p>	

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<p>Policy Program management Resource allocation</p>	<p>Relevant needs gaps and weak links identified by the in charge in the Maternal and Newborn health policy and whether the project has been supportive in addressing them and in what ways? What more can be done and how? Probe: Policy - Number of policies (plans, guideline, manuals, protocols or job aides available to improve MNCH/FP at health facility level Program management - Whether trainings on Logistic planning; record keeping and supportive supervision has been attended by the staff of the health facility Resource allocation – Monthly grants to the facility by the SMOH or LG office, SPHCDA etc, and whether this is sufficient or not.</p>	
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ANNEX D.5. COMMUNITY LEVEL INTERVIEW GUIDE

Program Achievements	Stakeholders
<p>#8 How effective were the various facility and community level activities in promoting access to maternal, neonatal and FP services (MBSM, HHC, ETS, MSS)?</p> <p>How effective was the project in expanding access to services and increasing population coverage of key interventions in the target communities?</p> <p>Do you think the project had succeeded in increasing access to maternal and newborn health services to many more people than before?</p> <p>If YES; What evidence do you have to support this?</p> <p><i>Probe: evidence of community awareness on MNCH services; evidence of community involvement/participation in conduct of MNCH services at the Health facility; More people patronizing the health facility</i></p>	<p>VDCs, CMTs, CCGs WDCs, ETC drivers, HHC, MBSM, Women Groups</p>
<p>How effective was the HHCC approach for integrated community and facility based essential maternal and newborn care interventions?</p> <p>How did your community/group collaborate in any way with the HF to increase people's awareness of MNCH services?</p> <p>Is your community/group active in sharing community information with HFs and vice versa? And how did this help in improving access to services?</p> <p><i>Probe (if they are involved with health education, messages, announcements, etc.)</i></p> <p><i>Probe : evidence of increased demand by the community for MNCH services</i></p> <p><i>Evidence of attitudinal changes towards FP</i></p>	
<p>What are the most effective community key interventions that promote access to maternal, newborn and FP services under the project?</p> <p>What are the various types of community activities that your groups do and what are most effective among them that create demand and promote access to maternal, newborn and FP services?</p> <p>Probe: List of activities (types)- MBSM, Women Loans scheme, ETS, HHC, etc</p>	
<p>Sustainability</p> <p>What are some ways that the project has contributed to capacity building/training for your community/group to continue your efforts beyond the project period??</p> <p>What is your group/community doing for sustainability of these efforts/ services now that the project is over?</p>	

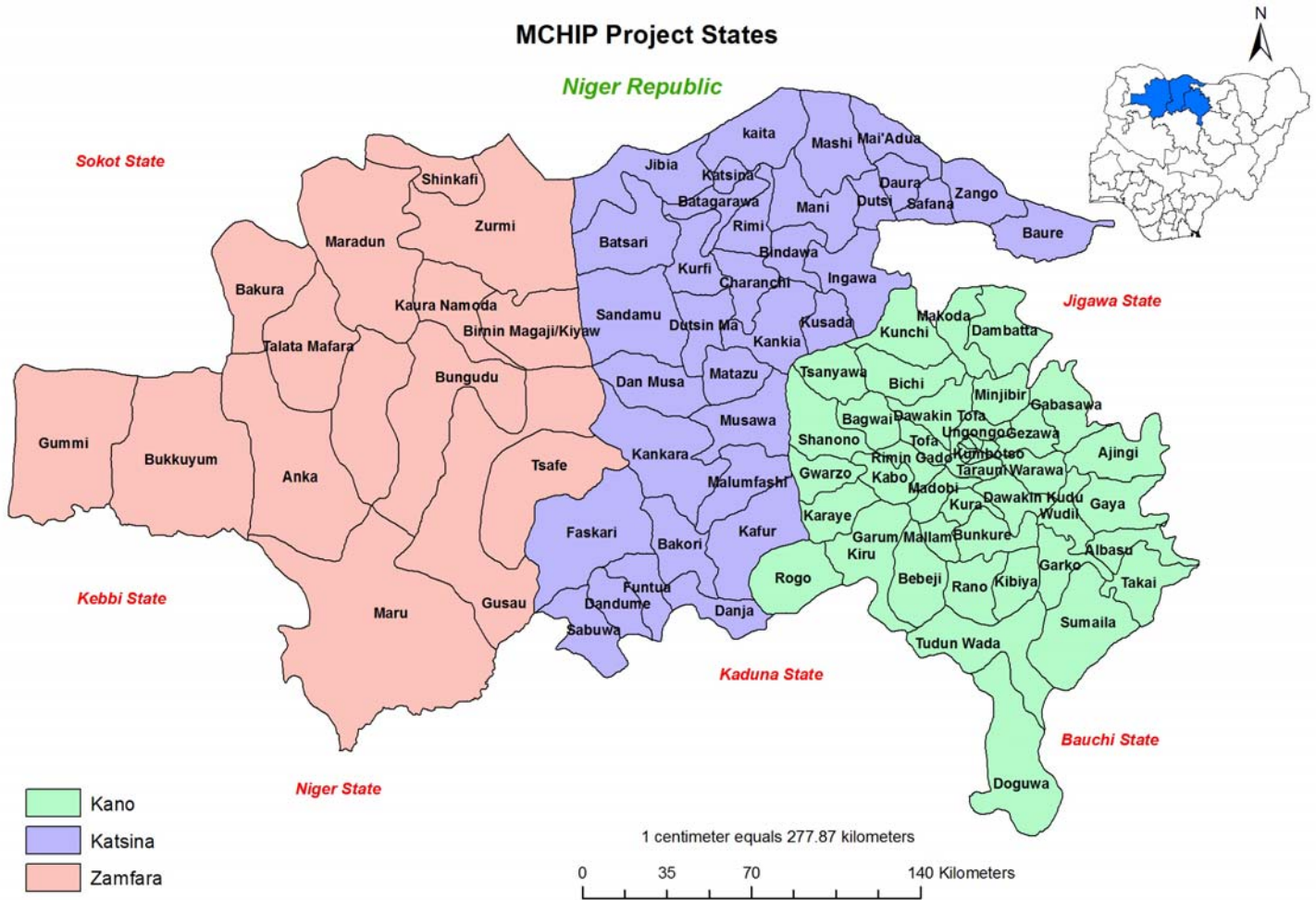
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ANNEX D.6. Client Interview Guide for ACCESS/MCHIP Evaluation

Intervention	Key questions and areas of interest	Targeted Stakeholders
<p>Program Achievements</p> <p>Increase utilization of FP and EmONC</p> <p>Improve Quality of FP and EmONC services</p> <p>Improve Management of Maternal and Newborn services</p> <p>Increase Demand for Maternal and Newborn services</p> <p>Infrastructure development and equipment</p> <p>Commodity availability</p>	<p>1) What type of services have you received at the facility? What else you wanted to have but was not available?</p> <p>2) Do you think that the services at the facility have improved in the last one year or two? And to what extent?</p> <p>3) What additional services or attentions would you like to receive?</p> <p>Probe: Areas of interest</p> <p>ACCESS/MCHIP support in 1) More qualified and dedicated staff to handle ANC, Labor and Delivery and FP services; 2) Available drugs and supplies; 3) Clean and Renovated health facility; 4) Type 3 DELAY drastically reduced; 5) More women patronizing the health facility</p>	<p>1 FP Client</p> <p>1 ANC Attendee</p> <p>1 Mother of sick neonate</p>

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ANNEX E: MAP OF ACCESS/MCHIP STATES AND LGAs



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ANNEX F: ACCESS/MCHIP OBJECTIVES, INDICATORS, BASELINE, ANNUAL TARGETS AND ACHIEVEMENTS

Indicators	Baseline	FY 07 (Targets) & Achievement	FY 08 (Targets) & Achievement	FY 09 (Targets) & Achievement	FY 10 (Targets) & Achievement	FY 11 (Targets) & Achievement
Project Objective: Increased utilization of quality EmONC services including birth spacing) by pregnant mothers and their newborns at selected LGAs in Kano , Zamfara and Katsina						
Key Indicator* 1: # of deliveries with a SBA		(2,000) 7,685	(20,000) 22,092	(22,000) 39,677	(50,000) 49,006	(55,000) 57,755
Key Indicator 2: # of ANC visits by skilled providers from USG-assisted facilities		(10,000) 33,333	(100,000) 115,678	(120,000) 218,267	(220,000) 245,841	(250,000) 265,266
Key Indicator 3: # of postpartum/newborn visits within 3 days of birth in USG-assisted programs		(1,500) 7,534	(20,000) 26,842	(25,000) 33,533	(35,000) 51,221	(40,000) 56,659
Key Indicator 4: CYPs in USG-supported programs		(10,000) 6,492	(20,000) 11,516	(20,000) 11,354	(17,000) 27,041	(18,500) 27,509
Key Indicator 5: % of postpartum women using contraception (including LAM) at one year postpartum [derived by USAID from ACCESS baseline/endline surveys]	5.0%			15.0%	No Baseline / Endline surveys done for MCHIP	
Key Indicator 6: # of counseling visits for FP/RH as a result of USG assistance		(12,000) 11,924	(50,000) 30,894	(60,000) 42,387	(55,000) 74,044 72,236F/1808M	(60,000) 134,278
Program Indicator**: % of births attended by SBAs	22.2%			25.3%		
Program Indicator: % of pregnant women who received at least 4 ante-natal care visits	34.3%			53%		

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Program Indicator: % of caretakers seeking care from sick care providers for sick newborns	22%			Indicator dropped from endline survey		
CPR (from ACCESS baseline/endline)	1.2%			15.0%		
Sub-IR 1: Improved quality of family planning services in selected LGAs						
# of USG-assisted service delivery points providing FP counseling or services		(10) 15	(36) 37	(40) 48	(54) 57	(60) 58
# of persons trained in FP/RH with USG funds (disaggregated by gender)		(60) 33	(500) 517 280F/237M	(500) 583	(500) 567 378F/189M	(550) 683 381F/302M
# of persons that have seen or heard a specific USG-supported FP/RH message		(12,500) 54,010	75,000 59,888	Dropped by USAID due to ambiguity in defining what constitutes a message		
# of counseling visits for FP/RH as a result of USG assistance		(12,000) 11,924	(50,000) 30,894	(60,000) 42,387	(55,000) 74,044 72,236F/1808M	(60,000) 134,278
% of women delivering in USG-supported facilities receiving PFP counseling**	57.5%	N/A	N/A	63.2%	N/A	N/A
Sub-IR 2: Improved quality of EmONC services in selected LGAs						
# of health facilities rehabilitated		(6) 0	(12) 7	(6) 6	(12) 6	(0) 0
# of health facilities using SBM-R approach for performance improvement		(8) 10	(20) 29	(30) 30	(30) 30	(0) 0
# of women receiving AMTSL through USG-supported programs		(2,000) 6,835	(20,000) 21,778	(22,000) 30,467	(35,000) 45,138	(40,000) 50,574
% of women receiving AMTSL through USG-supported programs		87.2%	99.6%	81.1%	97.6%	98.2%
# of women with eclampsia managed according to protocol in ACCESS-supported facilities / % of women with		(160) 155	(60%) N/A	(75%) 100%	(100%) 100%	(100%) N/A

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eclampsia managed according to protocol in MCHIP-supported facilities						
# of births at ACCESS-supported facilities for which the partograph was used		(2,000) 4,409	(20,000) 10,400	(22,000) 30,467	(30,000) 23,200	(33,000) 23,744
% of births at ACCESS-supported facilities for which the partograph was used	6%	(40%) 49.4%	(75%) 41.7%	(100%) 42.4%	(100%) 46.2%	(100%) N/A
Sub-IR 3: Improved enabling environment for scale-up of EmONC best practices at national and state levels						
Training curricula and strategy for pre-service midwifery education revised and implemented in Kano and Zamfara states		(1) 0	(1) 1	(2) 2	Activity completed in FY09	
Operational performance standards for EmONC developed and distributed in ACCESS-supported facilities		EmONC standards for hospitals and PHCs developed	(400) 750	(600) 627	Distribution Completed FY10	
National KMC training manuals distributed in ACCESS-supported facilities		(1) 0	(200) 0	(300) 300	Activity completed FY09	
Sub-IR 4: Improved management of maternal and newborn services in selected LGAs						
# of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs***	14	(14) 14	(28) 26	(48) 30	(24) 31	DROPPED
# of newborns receiving essential care in USG supported facilities (drying of NB, keeping NB warm and putting NB to breast within one hour of delivery)		(2,000) 5,675	(18,000) 18,037	(20,000) 29,033	(30,000) 46,041	(35,000) 55,012

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% of CEmONC facilities experiencing no stock-outs of essential EmONC drugs in the last 3 months		(50%) 0%	DROPPED—project has no responsibility for drugs procurement of logistics			
Sub-IR 5: Increased demand for maternal and newborn services in selected LGAs						
# of beneficiaries of community activities		(10,000) 1,842	(20,000) 15,890	(30,000) 21,674	(42,000) 28,132	(30,000) 46,770
# of community committees that have work plans that include activities to reduce maternal and newborn deaths		(8) 6	(24) 27	(24) 27	(51) 51	Nothing reported
# of communities that have plans that include emergency funds and/or a transport system for maternal and newborn complications		(8) 6	(24) 27	(24) 27	(51) 51	Nothing reported
Sub-IR 6: Improved availability of EmONC health workers in target/selected LGAs						
# of persons trained in maternal/newborn health through USG-supported programs		(30-22F/8M) 261	(500) 522	(600) 356	(600) 760 428F/332M	(600) 784 550F/234M
C-sections as a percentage of all births in USG-supported facilities		(1%) 1%	(3%) 5%	(5%) 1%	(15%) 1.5%	(15%) 4.1%

Sources of data: USAID PMPs; ACCESS/MCHIP Annual Reports FYs 07-11; ACCESS baseline and endline surveys

*Indicators designated as “Key Indicators” and IR indicators were established by USAID and JHPIEGO and reported against annually in the ACCESS/MCHIP Annual Project Reports. Where discrepancies exist, the PMP figures have been used.

**Indicators designated as “Program Indicators” were established for use in the baseline and endline surveys carried out in 2006 and 2009 under ACCESS.

***Tracer drugs selected were: Oxytocin, Hydrallazine, Diazepan, Ampiclox, Gentamicin, Metronidazole, Sulphadozine-pyrimethamine, Iron/Folate tabs.

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ANNEX G: ACCESS/MCHIP FACILITIES BY LGA AND STATE WITH POPULATION COVERAGE

#	Name of Facility	State	LGA	Location	Year Intervention Started	Service volume (high, medium or low)	Assessment of Institutional Commitment (high, medium or low)	MSS health facility (Yes, No)	Renovated? SBMR? KMC?	Estimated Population of LGA
1	Kasuwar Daji PHC	Zamfara	Kaura Namoda	Kasuwar Daji	2006	Low	Low	Yes		352,818
2	Kurya PHC		Kaura Namoda	Kurya Madaro	2006	Low	Low	Yes	SBMR-1	
3	Yankaba PHC		Kaura Namoda	Yankaba	2006	Low	Low	Yes		
4	General Hospital Kaura Namoda		Kaura Namoda	Kaura Namoda	2006	High	High	No	Ren, SBMR-1	
5	WCWC Mada		Gusau	Mada	2006	Low	Medium	No	Ren,	449,014
6	WCWC Magami		Gusau	Magami	2006	Medium	Low	No		
7	Shagari PHC		Gusau	Gusau	2006	Low	Low	No	SBMR-1	
8	Dr. Karima WCWC, Tudun Wada		Gusau	Tudun Wada Area	2006	Medium	High	No	Ren, SBMR-1	
9	WCH General Hospital, Gusau (KF)		Gusau	Gusau	2006	High	High	No	Ren, SBMR-1, KMC	
10	General Hospital Zurmi		Zurmi	Zurmi	2007	Medium	Medium	No	Ren, SBMR-1	360,594
11	General Hospital Tsafe		Tsafe	Tsafe	2008	High	High	No	Ren, SBMR-2	324,924
12	General Hospital Shinkafi		Shinkafi	Shinkafi	2008	Medium	Low	No	SBMR-2	154,811

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#	Name of Facility	State	LGA	Location	Year Intervention Started	Service volume (high, medium or low)	Assessment of Institutional Commitment (high, medium or low)	MSS health facility (Yes, No)	Renovated ? SBMR? KMC?	Estimated Population of LGA
13	General Hospital Anka		Anka	Anka	2008	Medium	Low	No	SBMR-2	188,605
14	WCWC Shinkafi		Shinkafi	Shinkafi	2008	Low	Low	No	SBMR-2	
15	PHC Dauran		Zurmi	Dauran	2008	Low	Low	Yes	SBMR-2	
16	PHC Bilbis		Tsafe	Bilbis	2008	Low	Medium	Yes	Ren, SBMR-2	
17	Bagega PHC		Anka	Bagega	2008	Low	Low	Yes	SBMR-2	
18	General Hospital Gummi		Gummi	Gummi	2010	High	Low	No		229,039
19	General Hospital Maradun		Maradun	Maradun	2010	Medium	Low	No		249,329
20	General Hospital Bakura		Bakura	Bakura	2010	Medium	Low	No		
										2,309,134
1	Babawa PHC	Kano	Gezawa	Babawa	2006	Low	Low	Yes	Ren, SBMR-1	359,454
2	Abasawa PHC		Gezawa	Abasawa	2006	Low	Low	Yes		
3	Gezawa General Hospital		Gezawa	Gezawa	2006	High	High	No	Ren, SBMR-1	
4	Dawanau PHC		Dawakin Tofa	Dawanau	2006	Low	Medium	Yes	Ren, SBMR-1	295,313
5	Ganduje PHC		Dawakin Tofa	Ganduje	2006	Low				
6	Tatarawa PHC		Dawakin Tofa	Tatarawa	2006	Low	Low	Yes	SBMR-2	

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#	Name of Facility	State	LGA	Location	Year Intervention Started	Service volume (high, medium or low)	Assessment of Institutional Commitment (high, medium or low)	MSS health facility (Yes, No)	Renovated ? SBMR? KMC?	Estimated Population of LGA
7	Dawakin Tofa General Hospital		Dawakin Tofa	Dawakin Tofa	2006	Medium	Medium	No	Ren, SBMR-1	
8	Murtala Mohammed Specialist Hospital		Kano Municipal	Kano	2006	High	High	No	Ren, SBMR-1, KMC	421,354
9	Sheik Mohd' Jidda General Hospital		Fagge	Kano	2008	High	Low	No	Ren,	220,915
10	Rano General Hospital		Rano	Rano	2008	High	High	No		182,064
11	Kiru Compr Health Center (Hospital)		Kiru	Kiru	2008	Medium	High	No	Ren,	331,031
12	Rurum PHC		Rano	Rurum	2008	Low	Medium	Yes		
13	Yako PHC		Kiru	Yako	2008	Low	Low	No		
14	Rejiyar Lemo PHC_T/Bojuwa PHC		Fagge	Rejiyar Lemon Area, Kano	2008	Low	Medium	No		
15	Dambatta General Hospital		Dambatta	Dambatta	2008	High	Medium	No		244,907
16	Fagwalawa Cottage Hospital		Dambatta	Fagwalawa	2008	Low	Medium	No		
17	Tudun Wada General Hospital		Tudun Wada	Tudun Wada	2008	Medium	Low	No		277,372
18	Burum-burum PHC		Tudun Wada	Burum-burum	2008	Low	Medium	Yes		
19	Sir Muhammad Sanusi Specialist Hospital		Nassarawa	Nassarawa	2010	High	High	No		733,799

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#	Name of Facility	State	LGA	Location	Year Intervention Started	Service volume (high, medium or low)	Assessment of Institutional Commitment (high, medium or low)	MSS health facility (Yes, No)	Renovated ? SBMR? KMC?	Estimated Population of LGA
20	Gwarzo General Hospital		Gwarzo	Gwarzo	2010	High	High	No		218,689
21	Waziri Gidado Hospital		Ungoggo	Ungoggo	2010	High	Low	No		499,251
22	Mariya Sanusi Maternity Hospital		Ungoggo	Ungoggo	2010	High	Low	No		
23	Gawagwarwa PHC		Nassarawa	Gwagwarwa	2010	High	Medium	No	Ren,	
24	Fagwalawa Comprehensive health center (???)								Ren,	
										3,784,149
1	General Hospital, Dutsinma	Katsina	Dutsinma	Dutsen-ma	2008	High	High	Yes		198,035
2	General Hospital, Daura		Daura	Daura	2008	High	Medium	Yes		339,563
3	General Hospital, Funtua		Funtua	Funtua	2008	High	High	Yes	SBMR-2	256,390
4	PHC, Faskari		Faskari	Faskari	2008	Low	Low	Yes		231,943
5	Zakka PHC		Safana	Zakka	2008	Low	Low	No		238,229
6	CHC, Mai'adua		Mai 'adua	Mai'adua	2008	Low	Low	No	Ren,	235,050

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#	Name of Facility	State	LGA	Location	Year Intervention Started	Service volume (high, medium or low)	Assessment of Institutional Commitment (high, medium or low)	MSS health facility (Yes, No)	Renovated ? SBMR? KMC?	Estimated Population of LGA	
7	PHC, Abukur		Rimi	Abukur	2009	Low	Low	No		174,241	
8	General Hospital, Rimi		Rimi	Rimi	2009	Medium	Medium	No	Ren,		
9	General Hospital, Malunfachi		Malunfachi	Malunfachi	2009	Medium	High	Yes		193,780	
10	PHC, Malunfachi		Malunfachi	Malunfachi	2009	Low	Low	Yes			
11	CHC, Daura		Daura	Daura	2009	Low	Low	yes			
12	CHC, Funtua		Dutsinma	Dutsinma	2009	Medium	Medium	No			
13	CHC, Dutsinma		Dutsinma	Dutsinma	2009	Low	Low	No			
14	Turai Yar adua MCH		Katsina	Katsina	2010	High	High	No		366,442	
15	Specialist Hospital, Katsina		Katsina	Katsina	2010	High	High	No			
										2,233,673	
TOTAL # OF FACILITIES=58			ESTIMATED POPULATION SERVED							8,326,956	

*Source: National Population Commission, estimates for 2011 based on 2006 census figures

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ANNEX H: ACTIONS TAKEN AGAINST ACCESS/MCHIP MID-TERM EVALUATION KEY Recommendations

Key Recommendations	Actions Taken
1. ACCESS should review its LAM-only contraceptive policy for PFP and consider whether it makes more sense to start women on a contraceptive regiment immediately.	No action was necessary; as the recommendation was incorrect. This was pointed out to the Evaluators who chose not to make any correction. ACCESS never used a LAM-only contraceptive policy for PFP. LAM is one of twelve methods discussed with women during postpartum visits as documented in the 2009 Endline Survey under ACCESS (page 42).
2. USAID should discuss the future work begun in Katsina State with all stakeholders and consider redirecting resources, possibly including staff, to the other states.	USAID and ACCESS discussed this and decided to continue with Zamfara as the third state. USAID had been approached early on in the project to add Katsina and it was added for political reasons. Thus to discontinue the work entirely was not possible for fear of adversely affecting the first two states. Activities in Katsina were never scaled up to the extent seen in Zamfara and Kano for this reason. Of the 15 facilities in Katsina, only two were renovated, one received SBM-R training/assistance, and no KMC center was established.
3. ACCESS should continue in Kano and Zamfara until the end of the MCHIP period and then consider whether to continue or to arrange for transfer to another donor.	USAID and ACCESS/MCHIP discussed this. USAID decided and informed ACCESS/MCHIP July 2010 that the project would end in January 2012.
4. Work should be undertaken in the future on a state-wide basis, rather than only in selected LGAs.	The TSHIP project has been developed on a state-wide basis to provide integrated MNCH activities using high impact and low cost interventions to reduce maternal, neonatal and child deaths in Bauchi and Sokoto.
5. The Mission should explore the possibility of the new midwifery school in Zamfara to train a new cadre of community midwives.	The Mission left this action to MCHIP. In response, MCHIP reports that three states were more interested in expanding the number of students admitted each year to midwifery schools from 50-100. Through advocacy with the states and the Nursing/Midwifery Council, the latter agreed to increase annual limit on students admitted to 100. There is reportedly interest at the national level to train community midwives, but this discussion has not been advanced under the project.
6. ACCESS should immediately add secondary fistula prevention to its Nigeria outreach and clinical EmONC services.	No action required. This has always been included in EmONC training carried out by ACCESS/MCHIP and is included in the Standards for EmONC developed by the project.
7. Access should develop more robust measures to link FP motivation and support to government clinics with actual contraceptive use.	ACCESS/MCHIP has maintained data linking HHCs and MBSMs to service utilization and contraceptive use.