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END-OF-PROJECT EVALUATION OF THE NIGERIA FAMILY HEALTH (FH+) PROJECT

September 2017

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Cover Photo: Mrs. Hadiza Karo interviewing a nurse provider at the Wushishi Maternal and Child Health Clinic in Niger State. Photo credit: Sa'adatu Sule.

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ABSTRACT

The USAID/Nigeria-funded Family Health Plus (FH+) project implemented a three-pronged approach to increase the long-acting reversible contraceptives (LARCs) contraceptive prevalence rate (CPR). Managed by Marie Stopes International of Nigeria with partners Palladium Group (formerly Futures Group International) and Marie Stopes International, the three-year project ended in March 2017. It focused on training public health providers on LARC service delivery, advocacy to create an enabling environment, and demand and public awareness of LARC, and worked in 20 states in all geopolitical regions of Nigeria, training 2,124 providers in LARC and certifying more than 1,549 providers in LARC. The evaluation team visited public health facilities in three to four Local Government Areas in five states to observe LARC service delivery and to interview clients and providers. Stakeholders at the federal and state levels were also interviewed.

Overall increase of LARC CPR during the project's period of performance was 1.5 percent. FH+ conducted the LARC training, but the quality of performance in facilities was found to be sub-par. The assessment focused on sustainability, cost effectiveness, quality of the training activities, and the value of the mobile District Health Information Software (DHIS) data collection system. Although the project's Advocacy component organized Advocacy Working Groups, it did not focus on creating an enabling environment to support LARC acceptance. Furthermore, demand creation was seldom conducted, nor did it occur regularly. Most of the budget was spent on training advocates in the working groups and LARC providers. Training activities had exceedingly high budgets and, compounded with the low quality of the LARC providers and Advocacy Working Groups, their effectiveness and the return on investment was low and not sustainable.

ACKNOWLEDGMENTS

The evaluation team would like to thank the Family Health Plus (FH+) Project's staff and its partner organizations, Marie Stopes International of Nigeria, Palladium Group, and Marie Stopes International, for their time and insights into the project design and functions. We would also like to thank the government of Nigeria's federal and state Ministries of Health, community leaders, and family planning coordinators in the government and civil society. As the evaluation team visited communities and public health facilities, many women and their families, family health care providers, and LARC trainers answered questions and candidly discussed their experiences and thoughts about family planning, specifically LARC. None of these interviews could have happened without the support of USAID/Nigeria's Office of Health, Population, and Nutrition and GH Pro, which handled logistics and technical issues seamlessly and effortlessly. We appreciate and acknowledge all of their work.

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ACRONYMS

AWG	Advocacy Working Group
CEI	Client exit interviews
CHEW	Community health extension worker
CPI-U	Consumer price index-urban
CPR	Contraceptive prevalence rate
DHIS	District Health Information Software
ESMPIN	Expanded Social Marketing Program in Nigeria
FGD	Focus group discussion
FH+ Project	Family Health Plus Project
FP	Family planning
GH Pro	Global Health Program Cycle Improvement Project
GIS	lobal information system
GON	Government of Nigeria
HF	Health facility
HISP	Health Information Systems Program
HMIS	Health Management Information System
IR	Intermediate results
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
LGA	Local Government Area
M&E	Monitoring and evaluation
MEMS II	Monitoring and Evaluation Management Services II
MIS	Management Information System
MSI	Marie Stopes International
MSION	Marie Stopes International Organization of Nigeria
NDHS	Nigeria Demographic and Health Survey
NGO	non-governmental organization
NPV	Net Present Value
OPHN	Office of Health, Population, and Nutrition
PMTCT	Prevention of Mother-to-Child Transmission
PRS	Performance Reporting Systems

PRS	Performance Reporting System
QTA	Quality Technical Assistance
SMART	Specific, Measurable, Achievable, Relevant, and Timely
SSV	Supportive supervision visit
TBA	Traditional birth attendant
TOT	Training-of-trainers
USAID	United States Agency for International Development
USG	United States Government
VHW	Village Health Worker
WDC	Ward Development Committee

EXECUTIVE SUMMARY

BACKGROUND

USAID/Nigeria's Office of Health, Population, and Nutrition (OPHN) commissioned an evaluation of its Family Health Plus (FH+) project, which was managed by Marie Stopes International of Nigeria (MSION) with sub-awardees Palladium Group (formerly Futures Group International) and Marie Stopes International (MSI). FH+ was implemented from March 4, 2014, to March 3, 2017, its overarching goal to increase use of the long-acting reversible contraceptive (LARC) among women in Nigeria. This was to be done using a three-pronged approach: LARC capacity building of service providers in the public sector (Intermediate Result [IR]1); advocacy to create an enabling environment (IR2); and demand and public awareness of LARC services (IR3).

An evaluation team consisting of reproductive health and family planning (FP) specialists, a monitoring and evaluation (M&E) specialist, an advocacy and demand creation specialist, and logicians visited five states—Benue, Cross River, Lagos, Niger, and Ondo—in July 2017. The team interviewed more than 750 people and visited public health facilities in three to four Local Government Areas (LGAs) in each state. The evaluation team also observed service delivery of implants and intrauterine devices (IUDs); conducted exit interviews with clients; interviewed providers and master trainers; and conducted key informant interviews with community, state, and federal government officials and representatives from non-governmental organizations (NGOs) and civil society.

USAID/Nigeria, FH+, and government representatives agreed that project startup and commencement of activities took longer than expected due to a series of "fits and starts." One reason was that state governments did not take the lead in the activities, as was expected from the project design. There also was turnover among FH+ senior staff. Another important factor in understanding FH+'s performance was that MSION had not been a primary contractor for USAID/Nigeria. There are considerable requirements (and expectations) for managing a USAID-funded cooperative agreement which MSION and MSI, both service delivery organizations, did not have.

FH+ ACTIVITIES

More than 2,100 providers were trained in LARC service delivery in 20 states. Of these, 1,549 were certified, meaning they received three supervision visits to observe their work. The evaluation team found issues in service delivery with many the providers. One observation team reported a reluctance to perform service delivery of IUDs because the providers felt they had not had enough practice or were not confident in their abilities.

The Palladium Group (formerly Futures Group International) managed the Advocacy component (IR2) and the mobile District Health Information Software (DHIS) pilot. The aim of IR2 was to create an enabling environment in each state to contribute to LARC service delivery. FH+ advocacy activities focused on forming Advocacy Working Groups (AWGs), which they did in 11 states (nine new groups and two were carry-overs from other programs), and working with stakeholders to include an FP line item in state budgets. A few of the AWGs have continued after FH+ ended; however, only a few states added FP line items in their budgets. The AWGs did not focus on creating an enabling environment through advocacy activities and, because of a dearth of human and financial resources, such advocacy was delegated to local civil society organizations. Because these organizations did not receive funding,

they had to create their own FH+ advocacy messages, communication materials, and strategic goals, as did individual states.

Demand creation and public awareness were done on a very limited scale. Activities that did occur were carried out in conjunction with demand campaigns implemented by USAID's Expanded Social Marketing Program in Nigeria (ESMPIN). However, ESMPIN and FH+ did not operate simultaneously in many of the same communities or states, which limited the number of demand creation activities. When the projects did work together, FH+ felt it was successful in increasing LARC acceptance; in communities where ESMPIN was not present, FH+ did not have strategic demand and public awareness plans.

Another FH+ activity was designed to introduce mobile DHIS for data collection in public health facilities. It was impressive to see this being tested, though the federal and state government have yet to include it as part of their routine data collection process. There were a series of issues with the mobile DHIS, which is a free and open source software, including that some states and the Federal Ministry of Health still require paper copies of all reporting in addition to electronic data, and general problems with lost passwords, lost phones, and poor internet service. However, as one government official said, it was "exciting" that it was even tried. The overall sense by government users and officials is that, though it was a good experiment, results were mixed and would benefit from an evaluation.

Under FH+, LARC contraceptive prevalence rate (CPR increased 1.5 percent, a projection consistent with previous years of LARC. Because advocacy, demand, and public awareness were underfunded and the quality of service delivery was determined to be below standard, the expected increase in LARC CPR as a result of FH+ efforts was more muted than expected.

The question of LARC sustainability underlies the FH+ Project. Some believe that training providers in LARC service delivery is enough. Many government officials, Mission technical staff, and NGOs thought the training component, despite any weaknesses, put the skills and capabilities into the government no matter where providers live or work. However, without stronger health systems, a network of trained providers is not enough to increase LARC CPR in Nigeria.

FINDINGS

FH+ was designed on the understanding that LARC uptake would increase if more providers were trained on LARC service delivery, and an enabling environment and demand were created.

The evaluation team found the providers trained under the project were not confident in conducting the service delivery, or the training they received was not adequate to make them proficient in LARC service delivery. Retraining and recertification are needed to reach standards acceptable to USAID.

Training costs for AWGs and LARC providers were exceptionally high considering how many people/groups were actually trained.

Because we are talking about FP and the majority of providers are women as are the primary beneficiaries it would be logical to assume that the project would address gender. This was not the case, however, and gender requires a strategic plan to support women in their choices and decision-making.

Master trainers should be experienced trainers (e.g., teachers and trainers from schools or teaching hospitals) and be familiar with LARC service delivery. Providers and facilities should be equally weighted

in conducting facility assessments to assure the longevity, aptitude, and capability of LARC provider trainees.

The research under FH+ was inadequate to design and monitor the project. Only research on training (IR1) was conducted. IR2 and IR3 did not have strategic methodologies to design the demand creation and advocacy or to measure their impact.

Messages, counseling, materials, interpersonal communication, and peer-to-peer education were underserved in FH+. Only a few counseling and communication materials were developed under FH+. The providers, community health extension workers (CHEWs), and traditional birth attendants (TBAs) needed low- or no-literacy materials that addressed side-effects, and pre- and post-counseling. Correct information on LARC should be provided to peer and provider support groups, male involvement groups, and social influencers to address rumors and reassure women about their decision to use LARC.

The project technical team felt that the different components completed (e.g., training, forming AWGs, and mobile DHIS) were successful. FH+ did not seem to realize that these components alone would not be sustainable or increase LARC CPR.

For LARC service delivery to be sustainable, elements other than provider training need to be functioning. The current public health services are uneven and underserved in many of these key areas, including demand support, unbroken supply chain, financial costs, and incorrect information among providers and women.

I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this evaluation was to determine if the USAID-funded Family Health Plus (FH+) Project achieved its goals and its three Intermediate Results (IRs), and if it was overall a cost-effective investment by USAID. The findings will contribute to the design and focus of future projects funded by USAID/Nigeria.

EVALUATION QUESTIONS

1. To what extent were FH+'s training methodologies effective in strengthening the capacity of family planning (FP) service providers providing long-acting reversible contraceptives (LARC) in supported states?
2. To what extent were FH+ strategies and activities cost-effective? Were there unexplored innovative and cost-effective implementation strategies that were not employed that could/should be utilized?
3. To what extent were FH+'s strategies and activities (including demand creation) sustainable and effective in increasing the use of LARC in supported states?
4. What gender-focused strategies and activities were applied by FH+ during implementation?
5. What vacuum in facility/state government Health Management Information System (HMIS) is being filled by the introduction of the mobile DHIS 2.0?

II. PROJECT BACKGROUND

Nigeria's estimated population of 174 million includes about 39.2 million women of reproductive age (15-49). The total fertility rate remains high, at 5.5, and 23.2 percent of births have an interval of less than two years (Nigeria Demographic and Health Survey [NDHS] 2013). The health status of women is extremely poor: In the 2015 Mothers' Index Ranking, Nigeria was 166 of 179 of Tier II (less developed) countries. Nigeria also has one of the highest maternal mortality ratios in the world, at 576 per 100,00 live births (NDHS 2013). An estimated 50,000 women die from preventable pregnancy-related causes every year in Nigeria, and two-thirds of all births are high-risk due to the woman's age, parity, or spacing of births.

In addition to enabling men and women to realize their reproductive intentions, voluntary FP is one of the most cost-effective interventions in public health and has the potential to reduce poverty and avert up to 30 percent of maternal deaths and 10 percent of child deaths. Yet the CPR is low, at 10 percent (NDHS 2013), and only 31.3 percent of demand for FP is satisfied by modern methods, well below the recommended benchmark of 75 percent. The government of Nigeria (GON) is invested in the adoption of favorable policies and improved coordination of national activities. Opportunities in improving uptake still exist, such as: (i) high unmet need of FP across Nigeria's six geopolitical zones and (ii) available data on population and service statistics reveal that more short-term methods are visited at service delivery points, but service providers would prefer to provide longer methods. This is corroborated with the increase in uptake of LARCs in years following training of providers at service delivery points.

With support from USAID, the Family Health Plus Project, led by Marie Stopes International Organization Nigeria (MSION), was launched in 2014 to strengthen competency of service providers in 20 states in Nigeria across the six geopolitical zones.

The goal of FH+ is to strengthen Nigeria's overall health system, build provider capacity to deliver high-quality LARC FP services, and empower users to demand high-quality FP and improve their access to long-acting FP.

The Family Health Plus Project has three IRs:

- IR1: Strengthened capacity of healthcare providers and service delivery points to offer quality long-acting FP services
- IR2: Improved policy, governance, and community environment for long-acting FP
- IR3: Increased awareness of and demand for long-acting methods

The FH+ Project consortium will contribute to USAID's objective to increase access to long-acting methods of contraception by:

- Filling gaps and improving skills and capacity of public sector providers at high-volume sites to deliver LARC.
- Focusing on high-volume sites and achieving service integration across health areas through linkage with other ongoing programs (e.g., the Subsidy Reinvestment and Empowerment Program (SURE-P) and the Midwives Services Scheme (MSS)) and prevention of mother-to-child transmission (PMTCT) sites.

- Supporting discrete demand generation activities to launch implants and IUDs in FH+ target communities, which will complement overall FP demand-generation programs funded by USAID.
- Addressing supply chain and logistics management issues in collaboration with other USAID-funded programs, such as the DELIVER Project.
- Addressing information management and policy barriers that inhibit access to comprehensive FP choice.

FH+ is implemented by a consortium led by Marie Stopes International Organization of Nigeria under a cooperative agreement with the United States Agency for International Development (USAID. The project was rolled out in two phases focused in 10 states (Kaduna, Kano, Benue, Nasarawa, Plateau, Ogun, Oyo, Cross River, Edo, and Ondo) from March 2014 to September 2015. Implementation was expanded to 10 additional states in September 2015: Lagos, Rivers, Delta, Bayelsa, Imo, Katsina, Kogi, Niger, Gombe, and Taraba. Other consortium members are Palladium (formerly Futures Group International) and MSION.

FH+ contributes to USAID's development objective of improving the health of women primarily by contributing to building FP providers' capacity to deliver high-quality LARC FP services, as well as by empowering users to demand high-quality FP, thus improving their access to long-acting FP.

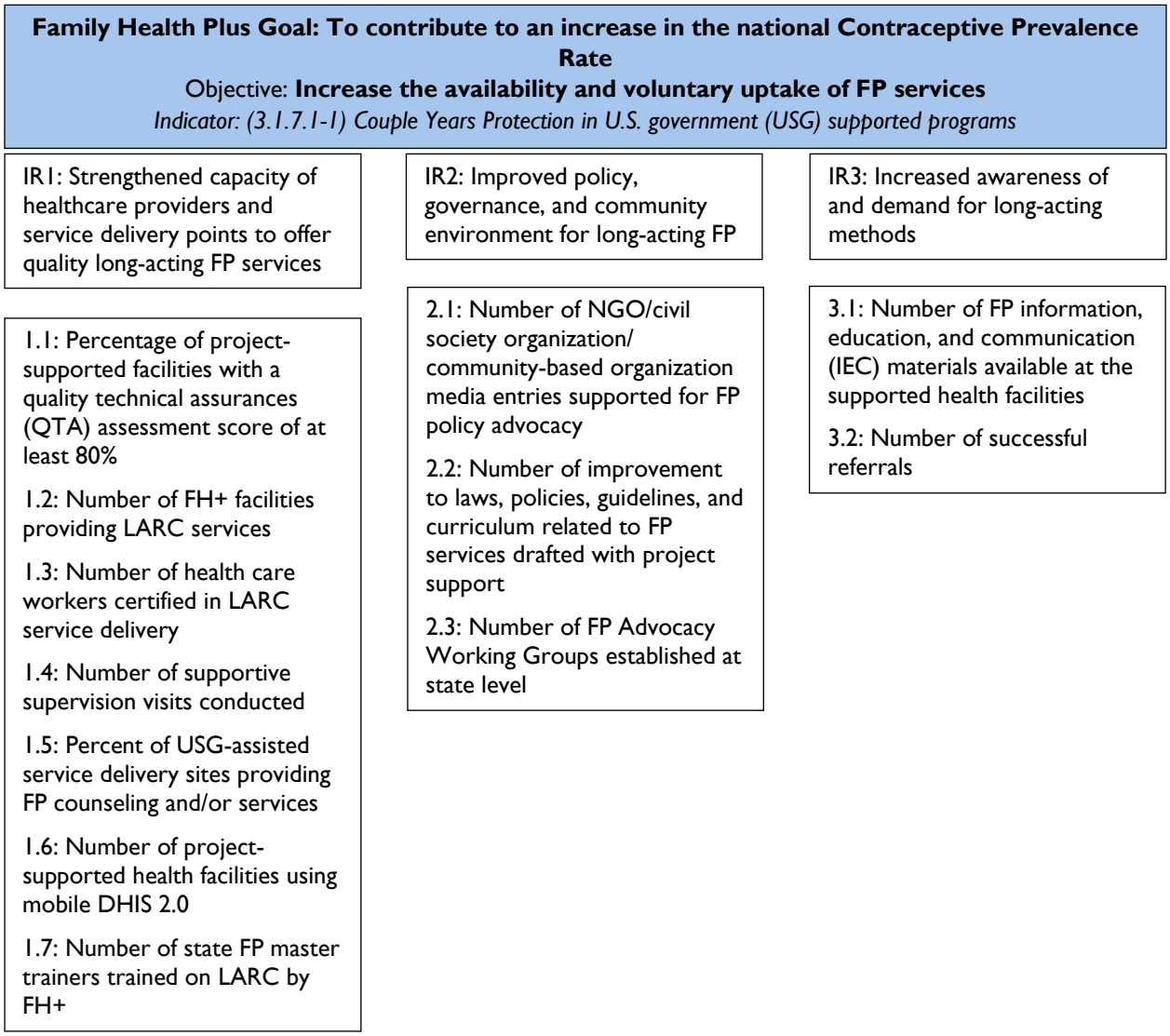
The evaluation team observed that uptake of LARC services is low, mainly due to the limited capacity of providers to offer the services the project was designed to address. FH+ assumes that access to high-quality FP services will be broadened—and this will positively affect the uptake of services—if service providers' confidence to provide safe, high-quality FP services, including LARC methods, is strengthened across all states; the government ensures the enabling environment; and demand is created by providing correct and accurate information to communities.

The project's three IRs work in synergy in delivering FH+'s overall goal. The first works to build the capacity of health workers to provide safe, high-quality FP services with a focus on LARC. This is expected to bridge the gap in knowledge and skills of providers to provide FP services, especially LARC. The second IR focuses on working with government at the state level to create an enabling environment for provision of FP services. The focus here is on providing FP commodities, piloting the HMIS tool at facilities, supporting training of government staff on provision of LARC services, and increasing funding of FP activities at the state and local government levels. FH+ has no provision for the purchase of FP commodities and printing of HMIS at the facility level. The project was also designed to work with government at all levels to make these available at facilities; it relied on other USAID projects (e.g., DELIVER) to manage FP commodity logistics and distribution to health facilities.

The third IR aims to increase demand at the facility level to generate demand for FP services, especially LARC. The projectFH+ was also to benefit from other USAID community mobilization and demand creation projects (e.g., the Sustaining Health Outcomes through the Private Sector (SHOPS) and ESMPIN) to drive demand to its training centers. Because as it was assumed FH+ would be linked with other projects, it did not allocate funds for demand creation.

Figure 1 on the next page shows the FH+ Project results framework, including the three IRs and their sub-IRs.

Figure 1. FH+ Results Framework



III. EVALUATION METHODS AND LIMITATIONS

The evaluation team developed a work plan and methodology to answer the evaluation questions.

METHODOLOGY

The evaluation process started about 10 days before a three-day in-country team planning meeting to prepare the protocol and develop the data collection instruments. At the meeting, held June 28-30, the team reviewed the FH+ scope of work (SOW) and finalized data collection instruments. The evaluation team used a mixed (qualitative and quantitative) approach to determine if FH+ achieved its objectives at end line and analyze the cost-effectiveness and sustainability of its approaches, interventions, and innovations. The methodology consisted of interviews and focus group discussions (FGDs) with FH+ staff members; key government officials at the national, state, and local levels; beneficiaries in the community; other donor organizations; and USAID/Nigeria's technical team.

The evaluation team developed 10 data collection tools/guides for use in the field. These included structured and semi-structured discussion guides for client exit interviews; service provider interviews; health facility (HF) assessments; FGDs; and key informant interviews (KIIs). The team conducted a thorough desk study of primary and secondary sources, including relevant documents and analyzed performance indicators as well as financial data. The team interviewed a total of 264 people in Lagos, Ondo, Benue, Niger, Cross River, and the Federal Capital Territory (FCT), observed 76 LARC counselling sessions and procedures, and conducted 69 facility assessments. The team reviewed annual and quarterly reports, annual and quarterly work plans, training materials, and financial records. (See Annex III for persons interviewed and Annex IV for a bibliography of documents reviewed.) The team conducted 50 FGDs: nine in Lagos, 12 in Ondo, 11 in Benue, 11 in Niger, and seven in Cross Rivers with a total of 149 participants. Each FGD lasted an average of 45 minutes, with an average of four participants per group.

The key approaches that were used to collect and analyze data for the evaluation were:

Review of Background Materials and Other Relevant Documentation: Project documents relevant to the evaluation were collected for review and analysis. These included the project design, SOW, annual and quarterly reports, annual work plans, technical and training materials, financial reports, and technical and research documents. The team also reviewed materials and reports from other USAID-funded projects and donor agencies in FP.

Interviews and Field Visits

Sampling: For the evaluation, USAID/Nigeria pre-selected five states—Lagos, Ondo, Benue, Cross River, and Delta—from the 20 FH+ states to measure the project performance. However, during the in-brief meeting with USAID, it was determined that the team should include states in the northern part of the country, apart from the north central region, and include one of the states where FH+ is currently being implemented. After due consideration of security and logistics, Niger State was selected to replace Delta State. For spread and geographical representation in the selected states, one Local Government Area (LGA) was randomly selected from each state in the three senatorial zones—except in Lagos State, where four LGAs were selected to give the evaluation team more time for pre-testing tools.

Observations were conducted based on clients' consent, and exit interviews were conducted with clients who received LARC services on the day of assessment. In all, the team visited 16 LGAs for the field work. Table 1 (next page) shows the states and LGAs used in the evaluation.

Table 1. States and LGAs Used in the Evaluation

S/N	State	LGAs
1	Lagos	Lagos Mainland, Ikorodu, Mushin (Ifako Ijaiye was replaced because the providers were not available on day of assessment. The team did not visit Surulere because it could not get a letter of authorization to conduct the evaluation in HFs on time, which resulted in the loss of one day for field work.)
2	Ondo	Owo, Ile Oluji, Akure North, and Akure South were used to compensate for the LGA not visited in Lagos.
3	Niger	Wushishi, Bida (replaced Chachanga LGA because most of the providers were either not available or on leave), Paikoro (replaced Lapai because there were only two HFs in the LGA)
4	Benue	Katsina-Ala (three HFs rendered LARC services), Tarka (one HF replaced another in Katsina-Ala), Otukpo (three HFs rendered LARC services), Makurdi (three HFs rendered LARC services), and Gboko (three HFs to make up for shortfalls in Katsina-Ala, Otukpo, and Makurdi LGAs).
5	Cross Rivers	Ikom LGA (four HFs), Calabar South (four HFs), Ogoja (two HFs), and two additional HFs in Calabar municipal (selected to make up for two shortfalls in Cross Rivers North)

In each LGA, the team planned to visit four project-supported HFs (a total of 64 facilities). The team visited and conducted the evaluation in 69 HFs (18 in Benue, 14 in Cross River, 12 in Lagos, 11 in Niger, and 14 in Ondo). FH+ provided a list of supported facilities in the LGAs; of these, four LGAs were purposefully selected from those which had only four supported facilities; for other LGAs with more than four supported HFs, the facilities were selected based on their client volume (high and low) and, for logistical purposes, their proximity to each other.

Study Instruments: The team developed 10 data collection tools/guides, one for each key informant group. The instruments generated both quantitative and qualitative data. The key informants were representatives of the federal and state governments; FH+ staff; USAID/Nigeria technical staff; public health care workers; community mobilizers; master trainers; and District Health Information Software (DHIS) consultants. FGD guides for women using LARC and for the Ward Development Committee (WDC) were developed, as were a client exit interview survey and service delivery observation guide. A facility assessment checklist was also prepared. However, because FH+ did not work with community mobilizers and WDC, the two audiences were not interviewed.

Procedure: The team conducted individual interviews and FGDs. The field work began in Lagos State July 3-7, 2017, with travel to Ondo and Benue from July 10-14, ending in Niger and Cross River from July 17-21. Joint and individual meetings and interviews were held with the previously identified informants, and community-level FGDs were held with LARC women beneficiaries. FP counselling and insertion procedures were observed for IUD, Implanon, and Jadelle, and exit interviews were conducted with clients to whom LARC was provided on the date of visit. A survey was conducted in 69 HFs to assess the availability and capability of human and material in high-quality LARC services delivery. To complete these interviews in each state, the team recruited and trained six data collectors to conduct

interviews with the different survey populations. The data collectors were local residents who spoke the local language and knew local customs, and were experienced in data collection methods.

Cost Analysis: Cost data was collected retrospectively by interviewing key informants (i.e., health workers in charge of HFs in both rural and urban areas) and review of available cost and expenditure data. A cost inventory was then created based on this available data.

Overall cost was divided into fixed costs (those that do not vary with the level of output in the short run) and variable costs (those that vary with the level of output). For capital items, MSION provided estimates of the scrap value, and straight-line depreciation was used to calculate the annual cost over the duration of the intervention. Assumptions were made concerning the useful life of these items; for example, the useful life of vehicles and laptops was considered to be four years, and furniture was five years. The average annual foreign exchange rate MSION used was adopted for conversion of cost variables.

The average duration of LARC service provision was determined through on-site observation and consultations with FP specialists. For implants, including pre- and post-counseling, the average was estimated at 40 minutes per procedure. For IUDs, it was 60 minutes.

The team assumed nurses at HFs worked 40 hours per week (160 per month). The average monthly salary, including allowances, was calculated and applied to get the hourly rate for LARC providers. The total number of clients who received LARC services through FH+ was then used to calculate the total hours devoted to service provision. The team also estimated personnel costs.

Cost data was corrected for inflation to base year using the whole consumer price index for "All item Urban Consumers (CPI-U) 1982-84=100 (Unadjusted)."

Incomplete cost data made it difficult to correct for the time effect of money. Ideally, a discount rate of 3 percent should have been applied to both the cost and outcomes of the intervention.

Data Analysis: The qualitative and quantitative data collected through FGDs and KIIs and cost data were analyzed and synthesized using Microsoft Excel. Themes and patterns were also identified from the responses. Excel was also used to generate frequency tables and graphs from the data. Trends in performance on indicators were also analyzed. (See Annex VI for a summary of analyses of the evaluation's qualitative and quantitative data.)

LIMITATIONS

FH+ Project Primary Research: There was inadequate qualitative and quantitative data available for program design, and monitoring and evaluation (M&E) data.

Project Close-Out: The evaluation team's work in some states slowed down because FH+ had ended and staff were not available. Generally, took the evaluation team more time to receive the necessary approval from the state governments to conduct interviews and visit facilities. The field team spent a considerable amount of time locating HFs that received training from the project. To address these limitations, the evaluation team adopted the successful approval process used in Lagos State, requesting that FH+ send letters to the remaining four states well in advance to inform LGAs about the evaluation activity and to ask for their approval to conduct the evaluation. This helped minimize the time required for approval. The evaluation team had LGA staff lead and direct them to the HFs. Because the evaluation was conducted after close-out, there were no FH+ staff to help to facilitate the approvals and

introductions, though MSION regional staff did write letters and introduce the field teams to appropriate state officials.

Retirement of Trained LARC Providers: It was difficult to observe LARC procedures in some states because some Marie Stopes-trained nurses/midwives had retired from service. As such, the evaluation team observed only a few procedures. In some instances, retired nurses/midwives were recalled/invited to HFs to conduct LARC procedure—at a cost.

Difficult Terrain: Some of the locations originally selected were inaccessible due to difficult terrain. To compensate for this, the team redirected its work to other LGAs that fit the required profile. The alternative LGAs were within the same senatorial district.

Time Constraints*:* To maximize time at data collection sites, the evaluation team travelled on weekends. In a few communities, HFs could not be assessed because the providers were not available on the date of visit. In some instances, LGA FP coordinators did not communicate information about their schedules to the providers in time or at all. Other times, though they were informed, providers were not available due to other activities.

Rainy Season: It rained throughout the week the team was in Lagos, which hampered the movement of the evaluation team and clients.

Farming Season: The evaluation team could not get enough clients for the FGDs because it was farming season and clients had gone to their farms. The FGDs were held with available clients (i.e., those the provider could reach).

Competing Programs in the State: The period of the evaluation fell within state programs, such as Maternal, Newborn, and Child Health Week and World Population Day. This meant some key stakeholders were unavailable for interviews. To accommodate stakeholders, the evaluation team sometimes had to conduct interviews in the evenings and weekends.

Incomplete Documentation of Financial and M&E Data, Reporting, and Project Records: Overall, the project's recordkeeping for financials, M&E, research, and general statistics was inadequate. For example, financials were not calculated or recorded to evaluate the project's cost-effectiveness, which necessitated the use of estimates in some cases. Summaries and totals of CPRs and service delivery were sometimes inconsistent from report to report, as well as with the Nigeria Family Planning Dashboard.

ETHICAL CONSIDERATIONS

All respondents provided verbal informed consent before taking part in the evaluation. No children or youth were included in interviews or FGDs, all of which were conducted in safe, private environments. Information that could reveal the identity of respondents was excluded, and the team collected information only on the category of respondent. Participants gave permission for taking photos during interviews and FGDs, and were informed that photos may be used for evaluation reports.

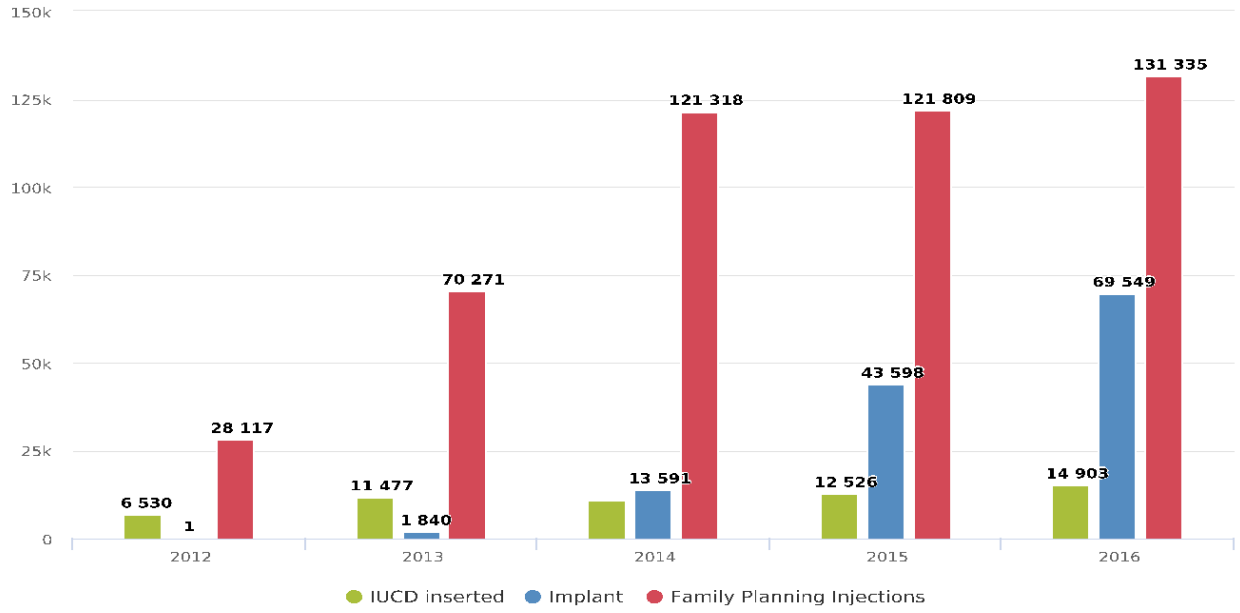
IV. FINDINGS

Evaluation Question 1: To what extent were FH+'s training methodologies effective in strengthening capacity of FP service providers providing LARC in supported states?

STRENGTHS

Overall, FH+ trained 2,124 providers, of which 73 percent (1,549) were certified to provide LARC services. These providers came from widespread facilities (1,725), which increased access to LARC, as shown by the increased uptake of LARC services in Figure 2.

Figure 2. Uptake of LARC Services in FH+ Facilities



Source: Nigeria DHIS, FH+ Dashboard.

Information collected from the field (i.e., through provider interviews) also supports the DHIS data, as 83 percent of the HFs visited commenced LARC services after FH+ had trained their staff. All HFs were providing copper T IUDs, Jadelle, and Implanon; 16.1 percent were also offering progesterone IUDs.

FH+ used government staff as trainers and supervisors, which made it possible to cover many HFs. One interviewee, a member of the Ondo State Primary Health Care Board, described the FH+ intervention as "simple … but high-impact."

Both master trainers and providers were satisfied with training they received: In interviews, none rated the training as "poor" or "very poor."

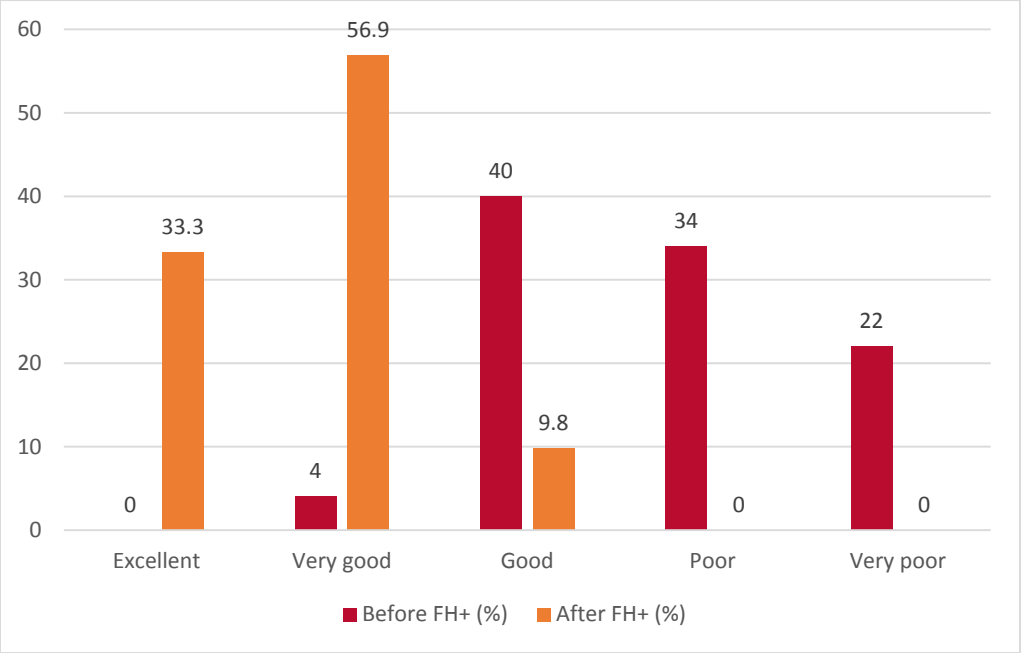
The providers said that the training improved their skills and resulted in increased uptake of LARC services. Data obtained from the field shows that 83.3 percent of the LARC providers interviewed started offering LARC services after project training.

The master trainers were provided with training kits, job aids (e.g., posters, counseling cards, and medical eligibility criteria wheels), manuals, and, in one case, a multimedia projector. One was provided with anatomical models. The master trainers were involved in LARC training sessions during implementation; all said they had supervision visits from FH+ during the sessions, which they found useful because they helped improve their performance. All the master trainers had also conducted supervision visits to trained providers, which they felt highlighted the need for regular supervision to maintain the quality of services. All the providers who had received supportive supervision found the visits useful in helping them to improve the quality of their services by addressing challenges and motivating them to do their best.

The providers interviewed observed a positive change after FH+ interventions began, with the majority reporting an increase in uptake of LARC services (71.4 percent), a decrease in complications (21.4 percent), a decrease in the rate of FP commodity stockouts (17.9 percent), and improved quality of services (12.5 percent). The increased uptake of LARC is thought to be due to increased access to

LARC, especially implants, following training. Figure 3 shows how providers rated the uptake of LARC services before and after FH+ interventions.

Figure 3. Providers' Rating of Uptake of LARC Services before and after FH+ Interventions



Providers also reported satisfactory management of LARC side effects and complications. The majority provided the correct treatment, and only a few mentioned that they had to remove the IUD or implant (1.8 percent for each).

As the list below illustrates, clients were very satisfied with the services they received at the HFs. However, it should be noted that feedback, garnered during exit interviews, might be so positive because most respondents lived in the same community as their health providers and did not want to say anything negative.

- Almost 98 percent said they had been treated well by the provider.
- Almost 98 percent said they had received good care from the provider.
- Almost 96 percent said they had been treated well by other staff at the facilities.
- Almost 94 percent said they had enough privacy.

Similarly, FGDs with former LARC clients showed that most (93.8 percent) were satisfied with services received. The remaining clients were unsatisfied due to side effects.

WEAKNESSES

Selection of Participants for Training

Master trainers were identified and selected by FH+ in collaboration with the state Ministry of Health based on information obtained from project annual reports and using predetermined criteria. The state FP coordinator was mandatorily the lead master trainer.

The LARC Master Trainers' Profile document obtained from FH+ indicates that almost all the master trainers trained were experienced LARC providers and facilitators. However, FH+ reports of the training-of-trainers (TOT) seemed to suggest that the master trainers were in fact *not* experienced LARC providers. Specifically, the expected outcomes of the training as indicated in the TOT reports were:

1. To acquire skills to be a good trainer
2. To acquire skills to provide LARC services
3. To be proficient in the provision of LARC

That participants were expected achieve these outcomes is in contrast to TOT participants' eligibility criteria in the MSI Master Trainer Guide v3.1, which states the first criterion as the "consistent ability to perform the service or procedure(s) to be trained in according to published clinical policies and guidelines"'

In cases where there were no providers that met the criteria for being LARC trainers, selected providers first had to undergo a six-day LARC training and then return to their HFs to practice their newly acquired skills before being trained as LARC trainers.

The challenges noted in the TOT reports indicated that some participants had never provided FP services or LARC, as detailed in the excerpts below:

"Having participants who have never provided FP service before was also a challenge. This was evidenced by the handling of syringes, wearing of gloves, and injection-giving techniques, thereby making performance on the field slow." (November 29 to December 6, 2015 TOT report). The same report acknowledged that some participants had no prior experience with LARC.

As one of the training successes, the November 22 to 29, 2015 TOT report mentioned that only five of 20 participants had previous knowledge of modern FP methods (of which four were familiar with pills and injectables). Participants' comments in the same report also provide additional evidence of:

- "Never inserted an IUD before, but can do it now. Thanks to FH+/MSION."
- "I have never seen Jadelle and Implanon before. I now know better."
- "This is my first time … attending any FP training."

Similarly, end-of-course evaluations in the Phase 1 TOT reports showed that only a small proportion of participants were confident about providing FP (LARC) services. (See Table 2, next page.) Reports from the other TOTs did not include details about the end-of-course evaluation findings.

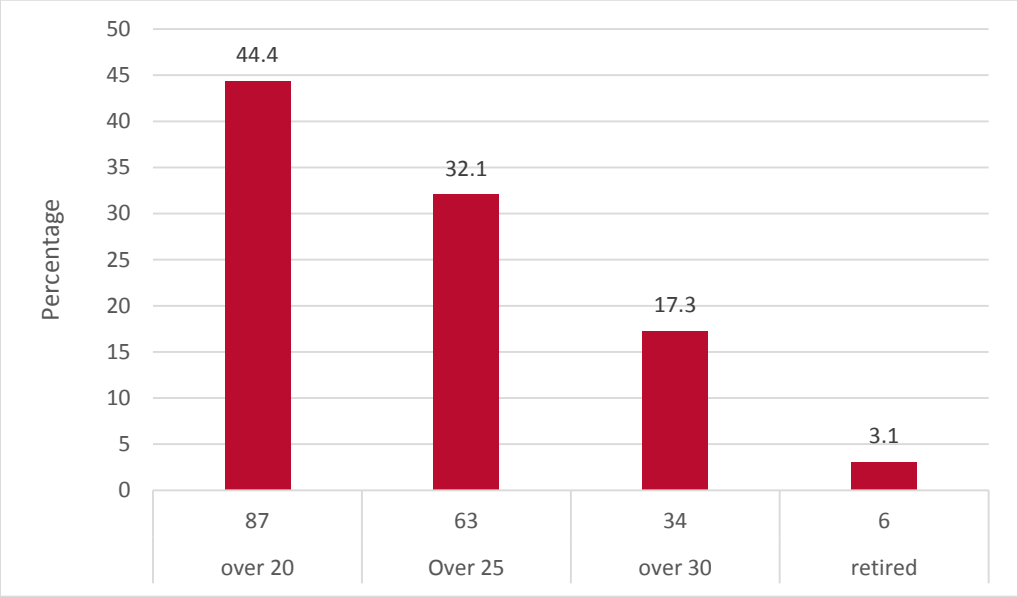
Table 2. End-of-Course Evaluation: TOT Participants' Responses about Their Confidence in Providing FP (LARC) Services

TOT Date	Strongly Agree	Agree	Neutral, Disagree & Strongly Disagree
August 11-16, 2014	23%	7%	70%
August 18-23, 2014	16%	4%	80%

The majority of the master trainers interviewed (66.7 percent) became FP trainers only after the training. They said the benefits of the training included acquisition of clinical and training skills, as well as increased demand for LARC, suggesting that they may also have had limited LARC experience.

Furthermore, participants did not consistently meet other criteria to be selected for TOT. For example, only providers with at least five years before retirement were supposed to participate, but some were closer to retirement when they were trained, as was observed in Cross River and Benue states during the field evaluation exercise. This was supported by the FH+ LARC Master Trainers' Profile document, which showed that only about one-third of the master trainers had 25 years or more work experience (Figure 4).

Figure 4. Master Trainers' Years of Experience



A quotation from the August 11-16, 2014, TOT report also supports this: "Most of the service providers are [older] and a lot of time and efforts will be needed for them to cope with the stress they will be facing during training and supportive supervision."

Greater engagement of state officials would improve the chances of success, as they can also help to identify other potential trainers to engage outside the government system (e.g., Planned Parenthood

Federation of Nigeria). The participant selection for the cascade training courses was satisfactory as the project trained FP providers. The project did not train CHEWs.

Conducting aptitude tests or qualitative studies among current providers is a standard method to identify the best candidates for training. Long-term institutionalizing the LARC service delivery training in the medical school curriculum increases the provider field with confident, trained providers in service delivery.

Training Approach

The TOT for master trainers focused more on clinical service delivery than training skills, as evidenced by the time allocated to the latter. Based on information in the TOT reports, the TOT had an eight-hour daily program that ran for six days (a total of 48 hours). Of this, 13 hours and 20 minutes (27.9 percent of the total time) were allocated to training skills, and one hour (2.1 percent) was allocated to supervision skills.

Among master trainers interviewed, 44.4 percent mentioned anatomical models as the training material that was not provided by FH+. In the project's Phase Two Providers Training Summary Report, participants also made comments along the lines of, "more models should be distributed for effective learning." Additionally, providers said there was insufficient time for skills practice on both models and clients during cascade training, particularly for IUDs. Based on the Phase Two Providers Training Summary Report, providers at that cascade training felt that the time for skills practice was insufficient, with one commenting that "more time and days should be given for practical, period of training to be extended." Similarly, as noted in the TOT reports, participants observed:

- "Since the training needs more practical, time for practical should be extended from two to three days or make the training two weeks instead of one week." (August 11 to 16, 2014 TOT report)
- "There is a need to increase the days for the training for better quality services; to understand very well. Thank you for your concern shown to us." (August 18 to 23, 2014 TOT report)
- "The training was very skillful and knowledgeable, but adequate length of time for the course to be extended to 10 to 14 days."
- "The course content was very rich, but was downloaded in a rush though not bad, will need further refresher training from time to time." (November 29 to December 6, 2015 TOT report)

The end-of-course evaluation from the TOT reports also shows that only a small proportion of the participants felt there was sufficient time for practicing skills at the clinical site (Table 3). The reports of the other training courses did not give details about the end-of-course evaluation findings.

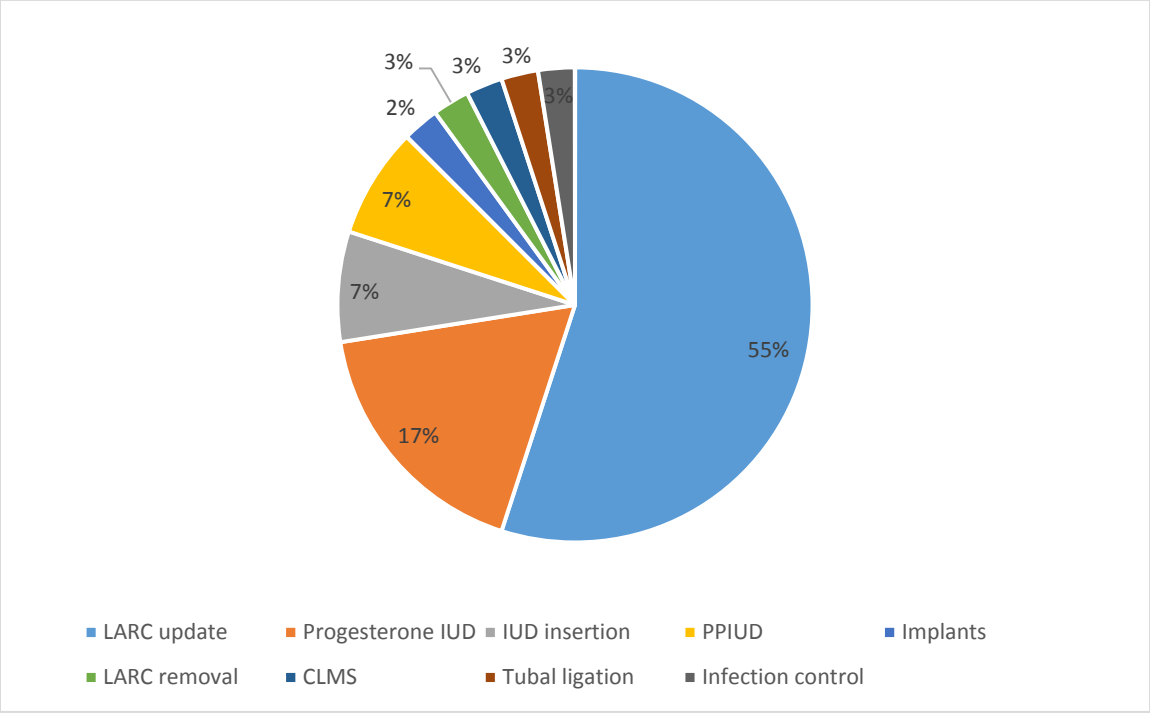
Table 3. End-of-Course Evaluation: TOT Participants' Response on Adequacy of Time for Clinical Practice

TOT Date	Strongly Agree	Agree	Neutral, Disagree & Strongly Disagree
August 11 to 16, 2014	4%	20%	76%
August 18 to 23, 2014	2%	15%	83%

Interviews revealed that both master trainers and providers would like additional training on clinical service delivery. Master trainers requested LARC updates/refresher (50 percent), postpartum IUD

insertion (25 percent), interpersonal communication (12.5 percent), and contraceptive logistics management system (12.5 percent). Similarly, providers also requested additional training on LARC updates (55 percent), progesterone IUD insertion (17.5 percent), IUD insertion (7.5 percent), postpartum IUD insertion, (7.5 percent), and other aspects of FP (Figure 5, next page). Initial scheduling and clustering of facilities for Quality Technical Assistance (QTA) should be done with more input from the FP coordinator.

Figure 5. Additional FP Training Desired by Providers (from Interviews)



Supportive Supervision

All the TOT reports reviewed included the recommendation that regular supervision is required to ensure high-quality training and service delivery. Master trainers conducted supportive supervision visits in collaboration with state government officials (e.g., Ministry of Health or Primary Health Care Board) using a checklist to assess services and provide on-the-job training as required. However, supportive supervision was not consistent or very effective: Some providers reported that they never received supportive supervision visits, others said they received them only once or twice over the life of the project. Table 4 shows the frequency of supervision visits as reported by providers.

Table 4. Frequency of Supportive Supervision Visits as Reported by Providers

Frequency of Visits	No. of Providers	%
Every month	14	28.6
Every 6 months	9	18.4
Every 3 months	8	16.3
None	4	8.2
3 times during project period	3	6.1

Frequency of Visits	No. of Providers	%
Every 2 months	3	6.1
Once during the project period	3	6.1
Every 2 weeks	2	4.1
Weekly	2	4.1
Every 4 months	1	2.0

The QTA FH+ Performance Report (October 2016) also noted that there was a "varying degree of supportive supervision visits by the master trainers owing to varying states' peculiarities." Although this report showed satisfactory performance at a majority of the HFs, with on overall score of 73.8 percent (the minimum for satisfactory services is 70 percent), it noted that one of the key challenges to the QTA exercise was low client turnout for proper assessment of technical competence. This indicates that the quality of the supportive supervision visits was not satisfactory.

In addition, as observed earlier, some of the supervisors who were also the trained trainers were not experienced enough to spot technical lapses by their supervisees. Improvement in the selection and training of TOT would resolve this problem.

Even experienced supervisors sometimes overlook or under-emphasize their supervisees' technical incompetence, as they are too familiar with one another. External supervisors should be engaged to conduct supervisory visits, perhaps on a quarterly basis. This could be done by the national trainers of LARC.

Although most of the providers interviewed reported positive changes after FH+ interventions, some (3.6 percent) observed increased FP commodity stockouts due to increased demand. Eighteen percent of providers reported stockouts of LARC commodities in the preceding three months; of these, 81.8 percent were stockouts of Implanon and 18.2 percent were Jadelle. This suggests poor commodity logistics management and inadequate/poor quality supportive supervision at these HFs.

Similarly, although a majority of HFs reported an increase in uptake of LARC services, one reported a decrease after FH+ interventions resulting from clients discontinuing implants due to side effects. The same facility reported that one client who had removed an implant was observed publicly discouraging women from using implants. These issues probably result from poor counseling, which could also be addressed by regular high-quality supportive supervision.

The evaluation team observed basic errors that a supervisor would have corrected, including poor counseling, inadequate infection prevention, incorrect xylocaine injection technique, incorrect placement of implants, and incorrect treatment of side effects/complications (vitamin K–1.8 percent and ergometrine–1.8 percent for bleeding). In addition, most of the HFs the evaluation team visited did not have communication materials, such as counselling flipcharts and client information posters. Details of the observation findings are below.

General Observations

The evaluation team observed LARC services only when clients consented. Observations were carried out using the checklists in Annex V. As the majority of LARC clients wanted implants, only one IUD insertion was observed. No LARC removals were observed. Most of the counseling sessions (70.6 percent) and implant insertions (61.1 percent) observed were unsatisfactory, defined as the provider not

performing two or more key steps satisfactorily (using the standard observation checklists). A majority of the unsatisfactory services involved four or more tasks, as detailed in Figure 6 on the next page.

Counselling Observations

The evaluation team observed 34 counselling sessions, 24 (70.6 percent) of which were unsatisfactory. Table 5 (next page) presents details of these counselling tasks that were not performed satisfactorily.

The QTA FH+ Performance Report (October 2016) noted other counselling challenges, such as a lack of sexually transmitted infection integration in counselling, inadequate post-insertion counselling, and lack of counselling aids, such as flipcharts, balanced counseling strategy cards, medical eligibility criteria wheels, and models for demonstration.

Figure 6. Proportion of Providers with Unsatisfactory Performance of Tasks Based on Evaluation Team Observations

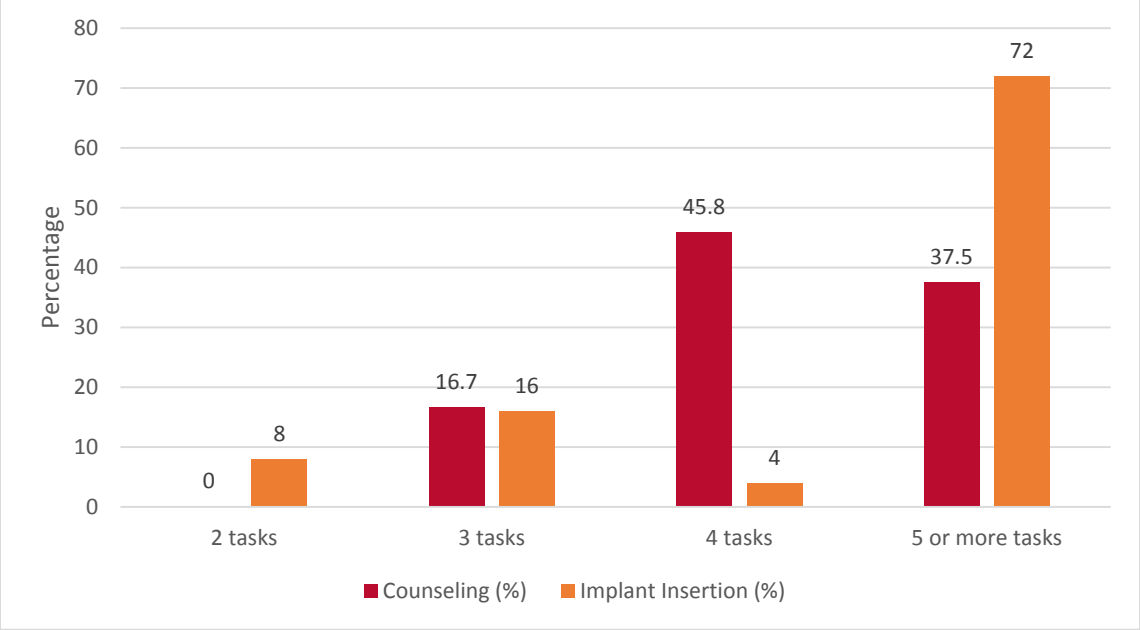


Table 5. Unsatisfactory Counselling Tasks

Unsatisfactory Tasks	No.	% of Total Observed
Did not ensure visual privacy	20	58.8
Did not ensure auditory privacy	19	55.9
Did not discuss side effects and other possible health problems of available methods	18	52.9
Did not screen client for medical eligibility	15	44.1
Did not explore client's attitudes and beliefs that favor or rule out one or more methods	13	38.2
Did not ask client to repeat instructions to ensure understanding	13	38.2
Did not address client's needs and concerns	8	23.5
Did not discuss potential side effects of chosen method	8	23.5
Did not explain how each method works and its effectiveness	6	17.7
Did not help client choose a method	4	11.8

Unsatisfactory Tasks	No.	% of Total Observed
No follow-up instructions given to the client	4	11.8
Did not explain where and how each method is used	3	8.8
No general FP information provided to the client	3	8.8
No further evaluation of client carried out (e.g., best practices)	3	8.8
No information provided in what client should do if she has side effects	3	8.8
Did not assure client that she can return any time	2	5.9
Did not answer client's questions	1	2.9

IUD Observations

The evaluation team observed only one IUD insertion, and it was unsatisfactory due to many errors in the procedure. In addition, there was no privacy in room where the procedure took place—people kept coming into the room even though the client was fully exposed. Also, it was possible to see and hear through the open windows.

Implant Insertion Observations

The evaluation team observed 41 implant insertions, 25 (61 percent) of which were unsatisfactory. Tables 6 and 7 present the team's observations about these procedures.

Table 6. Unsatisfactory Implant Insertion Tasks

Unsatisfactory Tasks	No.	% of Total Observations
Did not ask the woman about her reproductive goals and need for protection against STIs	20	48.8
Did not screen the client for eligibility to use the implant	21	51.2
Did not observe the client before discharge	19	46.3
Did not perform appropriate post-procedure infection prevention tasks	17	41.5
Did not insert implants using correct sterile technique and local anesthesia	16	39.0
Did not discuss what to do if client experiences any side effects or problems	14	34.1
Did not assure the client that she can have the implants removed at any time	14	34.1
Did not describe insertion procedure and what to expect	12	29.3
Did not tell the client what is going to be done or encourage her to ask questions	12	29.3
Did not assess the client's knowledge about the implant's major side effects	11	26.8
Did not provide follow-up visit instructions	7	17.1
Did not wash hands	6	14.6
Did not obtain or review brief reproductive health history	4	9.7
Did not position the client's arm correctly—raised it on a pillow	2	4.9
Did not instruct client about wound care	2	4.9
Did not assure the client that the implants can be removed whenever she wants	1	2.4
Was not responsive to the client's needs and concerns about the implants	1	2.4
Did not confirm the client's method choice	1	2.4

Table 7. Other Comments on Implant Observations

Comments	No.	% out of 25 Unsatisfactory Procedures
Poor infection prevention practices, used gloved hands to open cupboards and touch other unsterile surfaces	14	56
Very dirty FP room	8	32
Posterior position of implant	9	36

Comments	No.	% out of 25 Unsatisfactory Procedures
Did not withdraw to check whether the needle was in a blood vessel before injecting xylocaine	8	32
Jadelle position not accurate—one was straight and the other angulated instead of the "V" shape	7	28
Poor counselling	5	20
Client was very apprehensive about the procedure as it was not explained to her—she thought her arm would be cut open for the insertion and then stitched afterwards	4	16
Did not infiltrate needle insertion point, just advanced needle completely and injected	3	12
No visual or auditory privacy at the facility as door and windows were wide open	3	12
Post-insertion counselling needs improvement (e.g., what to avoid, wound care)	3	12
Client was not screened for medical eligibility	3	12
Local anesthetic was inadequate and client was in pain during insertion of Implanon NXT	2	8
Poor positioning of arm—client's arm and head placed on a pillow	2	8
Used digging movement instead of smooth, steady motion to pierce skin and insert the implants (claimed that clients take traditional medicine that makes their skin tough, preventing metal from piercing)	2	8
Jadelle rods placed widely apart	2	8

Proper xylocaine injection technique is important to prevent injection into a blood vessel, which may have dangerous consequences. Incorrect placement of implants may result in difficulty in removal. Both issues may result in dissatisfaction among clients and discourage uptake of the implants.

The poor infection prevention practices observed during the field visits are in keeping with the FH+ Phase One Providers Training Summary Report, which detailed that most trainees lacked awareness of infection prevention procedures and aseptic techniques. This observation during the training should have prompted regular and close supportive supervision of the trained providers.

Exit interviews at HFs revealed that most clients chose a facility due to proximity to their homes rather than for the quality of services as detailed (Table 8).

Table 8. Clients' Reasons for Choosing an HF

Reason (Multiple Responses Allowed)	No.	%
Proximity to residence	17	47.2
Familiar with facility, had services there previously (e.g., antenatal care, delivery)	8	22.2
Referred by friend	5	13.9
Free services	3	8.3
Friendly and efficient providers	3	8.3

Other Approaches with Potential to Significantly Increase Uptake of FP

Master trainers should be trained in LARC—preferably after being deemed proficient—before being trained as trainers. The TOT should include supervision and training skills to ensure high-quality service

delivery. Supervision should also be improved by providing anatomical models to LGA FP coordinators to use during supportive supervision visits.

Counselling should be emphasized as a vital part of the training content to improve uptake of LARC services, reduce discontinuation rates, and dispel myths and misconceptions. To make counselling more effective, communication materials such as brochures, leaflets, counselling charts/flipcharts, appropriate posters, and other job aids, should be provided.

Training should also include development and maintenance of quality improvement strategies and tools, including service delivery protocols and service uptake charts to show the LARC performance at each facility.

To enable ample hands-on practice, the ratio of participants to training models should not be too high.

LARC training in nursing, midwifery, and teaching hospitals should be institutionalized to increase access to LARC services.

FH+ training resulted in increased access to LARC services by increasing the number of trained providers in HFs; however, there were challenges with selecting master trainers, who are also supervisors, and the approach to training them. Because these challenges have a direct effect on the quality of services being provided, they need to be addressed appropriately.

Implementing partners can work with state authorities to identify master trainers who meet both criteria – being a skilled and experienced trainer and having experience in FP service delivery – and then train them on LARC TOT alone. Those who do not meet the criteria can be trained first as LARC providers, followed by the TOT as detailed above.

Because of their limited experience in performing service delivery, some providers felt less confident about IUD service delivery. There was also high absenteeism, and trained providers did not regularly show up at the HFs. As in all professions, to be successful and effective, practitioners need more than training in technical skills—they need to be committed to the work. That commitment and motivation are not captured in a quantitative assessment or checklist.

The training material is adequate, but requires updating. For example, the balanced counseling strategy needs to be updated to the 2015 version. The training manual also needs to be reviewed so it is appropriate for providers trained under the project. One instructor at a nursing/midwife school said she had adopted the manual to train her students.

Evaluation Question 2: To what extent were FH+ strategies and activities cost-effective; were there unexplored innovative cost-effective implementation strategies that were not employed that could/should be utilized?

Overall, training costs were high; costs for advocacy and LARC, including three supportive supervision visits (SSVs), were extremely high. Members of the FH+ team said they did attempt to keep costs down by using government facilities for training and limiting travel. For the mobile DHIS activity, the technical consultants said the software could be downloaded on any Android device and information could be sent as text messages or emails. The project did not need to purchase new phones for providers for this

activity. Other innovative cost strategies for the mobile DHIS would be to form partnerships with local mobile carriers for lower rates and providing promotional messages via texting or calls.

As Table 9 (next page) shows, approximately $13.9 million (undiscounted) was spent during implementation of the FH+ Project, from April 2014 to April 2017.[1] The cost was divided into fixed, variable, and semi-variable. The fixed cost came to just over $3.5 million, which included salaries, rents, utilities, and vehicles. The training fees payable to LARC trainers were estimated and deducted from the salaries and allowances to prevent double counting and reported under variable cost. The project bought nine vehicles and received five used vehicles from another USAID project, one of which was unusable. The overall vehicle cost after deduction of scrap value came to about $70,500.

The total variable cost was approximately $8 million, which included the estimated personnel cost for both training and SSV. Each LARC training session (batch) had 25 trainees, lasted six days, and was facilitated by five or six MSION staff. There were 80 batches total, four in each of the 20 project states. The SSV team comprised the state clinical officer for Marie Stopes and two state government officials. A total of 1,549 health providers who received at least three visits were considered to have received SSVs and completed the LARC training.

The training was divided into two components, theory and clinical, and SSV. The average cost estimate for the theory and clinical component for 2,283 (masters trainers and LARC providers) was $684.69, and the average cost for the 1,549 LARC providers who received SSV was $487.58 (393.84+93.74), giving an overall direct training cost estimate of $1,172.27.

Other variable costs, such as drugs and supplies, including consumables, were calculated based on total number of patients seen during implementation.

Table 9. Cost of FH+ LARC Service Provision

Resources	Quantity (A)	Cost/Unit (B) $	Total Cost (AxB) $
Fixed Cost			
Staff salary, fringes & allowances (local, international & contract)	N/A	1,742,888.21	1,742,888.21
Rent for Marie Stopes	36 months	1,567.78	56,440.00
Utilities (Marie Stopes)	36 months	535.61	19,282.00
Rent and maintenance estimates (government facilities)	36months	21,380.54	769,699.35
Utilities estimates (government)	36 months	15,002.86	536,892.51
Equipment and furniture	36 months	10,565.43	380,355.63
Vehicles	13	5,419.09	70,448.17
Subtotal			**3,576,005.87**
Variable Cost			
Personnel time (government facilities) 8 hours/week	35,6930.2 hours	2.77	988,334.90
Total travel and transport (minus travel for SSVs)	36 months	13,732.56	494,371.26
Training (theory & clinical)	228 (master trainers & LARC providers)	600.70	1,371,392.28

[1] As the actual annual expenditure was unavailable, estimates and average cost were used for this evaluation. Cost data was based on available data at the end of February 2017 and may vary over time.

Resources	Quantity (A)	Cost/Unit (B) $	Total Cost (AxB) $
Personnel time (estimated trainers' fees for theory & clinical)	2,283 (master trainers & LARC providers)	83.99	191,745.60
SSVs (travel)	1,549 LARC providers	93.74	145,197.71
Personnel time (estimated trainers fee for 3 SSVs)	1,549 LARC providers	393.84	610,058.16
Research/Information, education & communication	N/A	284,217.47	284,217.47
Other direct cost	N/A	420,626.15	420,626.15
Drug cost FP	507,254 clients	4.17	2,113,877.53
Supplies (consumable, insertion kit, pregnancy test)	507,254 clients	2.77	1,405,136.00
Subtotal			**8,024,957.06**
Semi-variable Cost			
Other project partners			
Sub-awards, U.S. organization/firm: Palladium			1,716,114.46
Sub-awards/subcontracts, non-U.S. organization/firm: MSI			565,320.00
Subtotal			**2,281,434.46**
GRAND TOTAL			**13,882,397.39**

Palladium, which was responsible for the training and introduction of the mobile DHIS, and MSI spent roughly $2.2 million. The actual cost was also not available, so the evaluation used estimates from the proposed budgets.

In the absence of actual yearly expenditure, it was assumed that most of the project budget would have been expended by the end of 2016, and the entire amount was corrected for inflation up to June 2017 using the whole consumer price index for "All item Urban Consumers (CPI-U) 1982-84=100 (Unadjusted).[2] This gave a total cost expenditure of 13,882,397.39. The present value, as well as a sensitivity analysis, could not be estimated due to incomplete cost data.

Cost-Effectiveness

A comparison of the cost and the outcome was conducted using the unadjusted cost. Results include:

- Average cost per LARC service provided: $27.37 ($13,882,397.39/$507,254)
- Average cost per LARC provider (master trainers and LARC, training only, no SSV): $684.69
- Average cost per LARC provider who received three SSVs: $487.58
- Average cost per LARC provider and three SSVs: $1,172.27
- Average cost per couple years of protection[2]: $11.60
- Average cost per person for e-Health training: $170.21 ($320,000 / $1,880)
- Average cost per AWG formed/strengthened: $9,272.73
- Average cost of introduction of mobile DHIS at 1,380 health facilities (based on assumption that Palladium worked on only the mobile DHIS project): $1,169.65

[2] USAID defines couple years of protection as the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. See https://www.usaid.gov/what-we-do/global-health/family-planning/couple-years-protection-cyp.

The average cost per LARC service provided ($27.37) looks effective, but the cost to train a provider was very high ($1,172.27) and is less effective in the short term. However, the team observed some issues that may have negatively affected the outcome, most notably the quality of LARC services provided to women.

Generally, the start-up costs for LARC training and services are acknowledged to be high, and there is presently not an existing baseline LARC training cost for comparison in Nigeria. In building on an existing government program, FH+ has used available resources efficiently. However, the health provider's interest in LARC, retention of the health workers trained, and the health focus or priorities of the various state governments may also have affected the outcome. The same health provider in charge of other programs, such as immunization and antenatal care, is also expected to provide LARC services at the HFs. The ability to improve the quality of services and retain providers will in the long run make the cost versus outcome effective.

The effectiveness of the e-Health training was a good case study upon which to build. The results were mixed, but some state governments are interested in adopting it. The concept of AWGs was good, but cost versus outcome was high.

Using the Impact 2 model Version 4, the health and economic impact of FH+ using the service lifespan was determined to be as follows:

- In 2015, a total of 157,110 pregnancies, 77,102 live births, 56,560 abortions, 888 maternal deaths, and 419,578 DALYs (disability-adjusted life years were averted. Direct health care cost saved was £6,051,358 (2015 GBP).
- In 2016, a total of 241,983 pregnancies, 118,754 live births, 87,114 abortions, 1,350 maternal deaths, and 645,139 DALYs were averted. Direct health care cost saved was £9,320,387 (2015 GBP).

Other cost-effective interventions that could have been used on FH+ include:

- Have DHIS apps installed on personal phones rather than provide mobile phones.
- Partner with state government to form LARC mobile outreach to serve hard-to-reach areas.
- Integrate demand creation into other health activities at the facilities and make use of "missed opportunities" to educate women on LARC (e.g., immunization and antenatal clinics).
- Work with CHEWs, village health workers (VHWs), TBAs, and WDCs that interact regularly with women in the communities for demand creation.

Evaluation Question 3: To what extent were FH+'s strategies and activities (including demand creation) sustainable and effective in increasing the use of LARC in supported states?

For sustainability of LARC services, many elements need to be put in place and continue after a project or investment ends. Several studies, including one editorial funded by USAID, *Effective LARC Providers: Moving Beyond Training* by James Shelton and Anne Burke, and *Long-Acting Reversible Contraceptive Use among Ethiopian Youth* by Ndola Prata and Divya Vohra (University of California, Berkley), show that in addition to high-quality and sound training, there needs to be a strong mentoring system, no breakdown in supply chain, and demand-side support. A study by George Washington University's Jacobs Institute of Women's Health conducted among U.S. women and providers cites relevant issues of self-efficacy, provider bias, costs of LARC, and lack of correct knowledge by both providers and women as barriers

to LARC sustainability. Several of these issues are currently ingrained in the Nigerian public health system; however, FH+ was tasked to resolve them, which would have contributed to sustainability for LARC service delivery. FH+ focused on three areas—training, advocacy, and demand creation—and this evaluation found that the quality or performance of all three was inadequate. The training quality is addressed in Question 1; Question 3 focuses on the advocacy and demand creation components.

The primary hypothesis of FH+ was that if there were more trained providers, LARC CPR would increase. Of the 2,124 providers in the public health sector that the project trained, 1,549 (73 percent) were certified. LARC CPR has had an uptake, but it has not shown the significant increase expected (5 percent LARC, DHIS 2017 Nigeria Family Planning Dashboard) considering the investment made in training and capacity building.

FH+'s IR3 (demand and public awareness) was the least supported of the program's technical components. Originally, FH+ intended to coordinate its trained providers with USAID's ESMPIN, an FP social marketing and demand creation project managed by Society for Family Health. However, the two projects did not overlap in enough states or communities to make a significant difference. MSI's global demand creation approach has providers also serving as client mobilizers in their communities. FH+ adapted this practice, but that additional task on underpaid and overworked providers was not effective. FH+ did not have a significant demand or public awareness strategy, or a budget for these strategies, because it was relying on ESMPIN. When the coordination with ESMPIN did not work out, FH+ did not have an alternative plan.

As noted above, the FH+ budget for demand and public awareness was very small, and the majority was used to print and produce LARC and FP posters and brochures for project-supported clinics. Messages, low-literacy materials, community outreach, special family health events, and counseling sessions were not developed or incorporated specifically for FH+ and LARC. Because CHEWs, TBAs, and non-LARC providers were not trained, it left a vacuum, and the correct information and counseling advice that women and families needed and were requesting was not provided. The CHEWs and providers will continue to work in their communities after FH+ leaves, and having FP advocates in the government system contributes to sustainability. FP is still a controversial subject in Nigeria, and messages and campaigns over the past several years have not effectively removed its stigma, corrected misconceptions and rumors, or addressed women's fears and concerns.

Advocacy pursued under IR2 was designed to assure an FP line item in states' budgets. Few states adapted an FP line item, and because the advocacy team was spread over 20 states, it did not have the resources to focus on state-specific issues that were preventing acceptance of LARC or barriers that prevented an enabling environment. FH+ did form nine new AWGs and introduced two that already existed in other projects. FH+ did garner lessons learned about forming the AWGs, primarily whether to include government officials (the answer is not to) and how the groups needed to be reconfigured with representatives from civil society, media, and academia. Still, the AWGs are continuing in some states. In a few states, the team was told, the AWGs did increase awareness about FP as they were recognized as the FP group.

One AWG was working with state and community stakeholders that often did not understand how FP affected them or did not have an interest in it. The AWG did not have adequate information to help tailor its advocacy messages to show how FP could help address each state's concerns (e.g., economic development, food security, and overall security). Several AWG members commented that stakeholders sat up and listened when the talk about FP related to economic growth. They also observed that members of the AWG were not familiar with or adept in discussing state issues and the impact of FP on

those issues. FH+ did conduct advocacy training for its members, but although participants thought it was important, they were less appreciative of the training modules, including Specific, Measurable, Achievable, Relevant, and Timely (SMART) and Impact Now. A less intense and more practical training module would have been beneficial in helping AWG members plan and implement advocacy campaigns. AWGs would have been invaluable in supporting and helping to organize programs and groups for male involvement, peer counseling and support groups, and creating stakeholder advocates.

Mobile DHIS is exciting on different levels, primarily as a pilot test using new technology for data collection, but government, FH+, and Mission staff reported mixed results. (See further details in Question 5) Mobile DHIS is another example of an FH+ activity that, as implemented and designed, was not sustainable because it did not connect to a larger operations system and the government still requires paper forms for reporting. One state is interested in continuing to use mobile DHIS after FH+ ends, but the other states are not using it consistently.

If FH+ had improved correct information among women and providers, created a supportive community, implemented demand creation to support LARC, and identified LARC advocates and formed peer and support groups, the training and capacity building would have been closer to sustainability. Relying on one health provider serving one patient at a time will take a very long time to improve LARC CPR. Systems need to shift to be both sustainable and increase LARC CPR.

Observations

FH+ focused on one issue in its advocacy work: increasing or adding FP money in state and community budgets. It did not advocate for LARCs or specific methods, and it did not tailor FP issues to each state's interests or needs. Its advocacy approach was myopic—one size fits all. Overall, FH+ did not conduct adequate research, including among key stakeholders at the state and community levels, nor did it systematically monitor its advocacy work. It did not develop advocacy messages (not even for the core push of budget increase); instead, it relied on the AWGs' media representatives to talk to the media and decide what to tell them. The project did not develop data visualization and advocacy materials, and outreach centered on budgets for FP, not specific FP methods, including LARCs.

Palladium, which managed the advocacy IR, conducted extensive training to create AWGs. It conducted five-day training events and applied its SMART approach, as the consortium's proposal indicated it would do, but these were expensive. The training focused on how to do advocacy instead of how to advocate for FP and LARCs. (See Question 2 about cost effectiveness).

Without adequate research and because LARCs were not the primary advocacy issue, neither the evaluation nor FH+ can show a correlation between the project's advocacy work and an increase in LARCs.

The evaluation cannot stress enough that FH+ dramatically underserved advocacy and demand creation. The project had a naive attitude toward these two critical components. Inadequate research and preparation, and reliance on a sophisticated advocacy module and another USAID-funded project's demand creation activities contributed to the misfires and underperformance of these two IRs.

USAID's project scope of work followed a proven three-pronged model that recognized the importance and need for each component to increase acceptance and self-efficacy. The implementing partners' lack of understanding and experience in designing and managing a results-oriented, integrated program undermined success. Considering the history and experience the FH+ consortium brought in FP, it is

astounding that it did not demonstrate an understanding of advocacy and demand creation in the success of increasing LARC CPR.

Evaluation Question 4: What gender-focused strategies and activities were applied by FH+ during the project implementation?

The program did not have an articulated gender strategy, which would have provided guidance on interventions for positive transformation of gender norms related to FP. Based on the FH+ annual reports, the following activities were carried out for gender equality and female empowerment:

- Conducted a gender and youth assessment, a key result being disaggregation of the different segments of the female population in the intervention states.
- MSION revised its management information system (MIS) to include young people and adolescents.
- Project materials for awareness raising, demand creation, and communication were tailored to empower boys and girls as well as women and men to make informed choices about reproduction.
- Distributed information, education, and communications materials in Hausa, Igbo, and Yoruba that were tailored to empower men and women to make informed choices regarding their reproductive health.

The annual reports did not include information about how the project utilized these activities to improve gender issues.

Of FH+, USAID, and partner technical staff interviewed, 50 percent said that the project had a positive influence on gender. They cited the following as project activities that influenced gender and social inclusion:

- Reaching men through religious leaders, gatekeepers, and monthly health meetings.
- Gender balance in the AWGs.
- Messaging in communication for both males and females.
- Provision of access to FP empowers women.
- Women prefer female providers, and most trainees were female.

These respondents (technical staff) felt gender activities were not sufficient, as there was not a budget line, but they did not provide any suggestions for other activities to improve gender issues.

Most government staff who were interviewed (66.7 percent) could not give examples of how FH+ addressed gender issues. Others gave the following responses:

- The project did not consider gender; the focus was on women, and the influence of men in FP uptake was not considered (16.7 percent).
- Male involvement was a lost opportunity (11.1 percent).
- There were no gender activities, and most participants were female by default (5.6 percent).
- Both sexes were involved in training and service delivery (5.6 percent)
- During training, providers were advised to encourage clients to seek their husband's consent where possible (5.6 percent).

As respondents noted, the majority of providers and trainers were women. The TOT reports indicate that 92.8 percent of the trained master trainers were female and 7.2 percent were male. Similarly,

information obtained in the field shows that 98.7 percent of providers trained at the visited HFs were female and 1.3 percent were male. The AWGs also include men and women, and advocate for FP uptake among women's and men's groups.

Among client exit interview respondents, 77.1 percent indicated that providers encouraged them to discuss FP with their husbands/partners, although only 44.9 percent said that providers encouraged them to come to the clinic with their husbands/partners. The exit interviews also revealed that many women did not know whether men are involved in FP, as detailed in Table 10.

Table 10. Client's Knowledge of Involvement of Men in FP Services at HFs

Question	Yes	No	Don't Know
Do men visit the facility for FP information and services?	22.2%	13.4%	64.4%
Do men accompany their wives/partners to the facility for FP services?	34.8%	28.2%	37%

Of these clients, only 29.8 percent had ever been accompanied to the FP clinic by their husbands/spouses and 70.2 percent had not. This limited understanding of the role men play in FP presents a missed opportunity to involve men in FP, as satisfied clients and their spouses could serve as promoters of the services.

The FGDs with former LARC clients revealed that providers encouraged them to discuss FP with their husbands/partners and that a majority did so. However, some did not have discussions because:

- Discussing FP is forbidden in their tribe because, once the bride price is paid, the husband owns the woman.
- The boyfriend will suspect her of infidelity and will not consent to FP.
- The husband/partner is against FP because he believes it makes people fat.

The role of husbands/partners in the uptake and continuation of FP cannot be overemphasized. A focused gender strategy would have addressed these issues in a manner acceptable to both men and

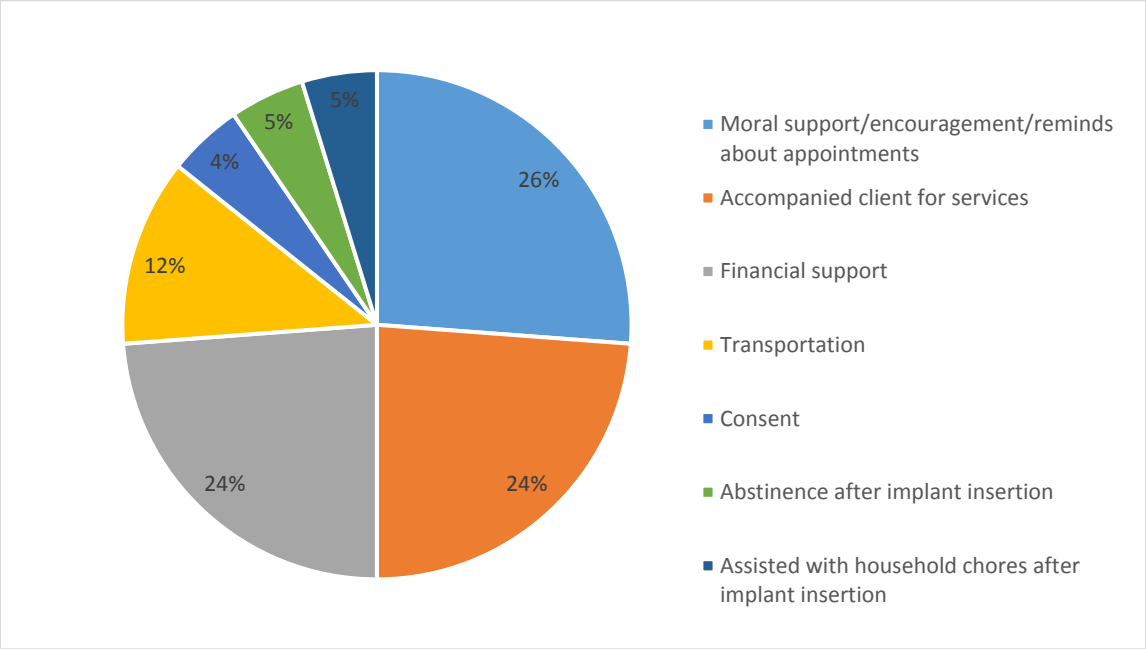
their wives/partners. This information also highlights the need for more research on the gender and social issues surrounding FP generally, and LARC in particular.

Among FGD participants who discussed FP with their husbands/partners, all said their male partners were supportive. Figure 7 (next page) illustrates the types of support women received.

Conclusion

FH+ did not have an articulated gender strategy. Having a strategy would have resulted in a more focused approach to interventions aimed at positively transforming gender relations for FP.

Figure 7. Types of Support Provided by Husbands/Partners of FGD Respondents



Evaluation Question 5: What vacuum in facility/state government HMIS is being filled by the introduction of the mobile DHIS 2.0?

The DHIS, a free and open source software (FOSS) currently running on version 2, is used for capturing, storing, analyzing, and reporting routine data. It was developed by the Department of Informatics, University of Oslo, Norway, under a global research and development initiative called the Health Information Systems Project (HISP). The Nigerian government has adopted DHIS as the national platform for its health information system.[3]

FH+ planned to develop a stand-alone database for FP electronic data collection from HFs. However, based on interactions and discussions with the Federal Ministry of Health's Department of Planning Research and Statistics, which is the custodian of the national health database, the database was suspended in favor of the DHIS in the spirit of having one national health management information database. With guidance from the ministry, the project engaged Management Information System (MIS)

[3] Monitoring and Evaluation Management Services (MEMS II) project, DHIS training PowerPoint presentation for HIV/AIDS implementing partners.

consulting firm (HISP), which worked with the Nigerian government to develop the national DHIS 2.0 platform and managed the system.

In 2014, the project engaged HISP to reconfigure the national DHIS to include access on Android phones that enabled data entry directly from HFs. This approach helped FH+ to support the Federal Ministry of Health to achieve its priority plan of migrating from a Java-based platform to an Android application. The new system also supported the monthly collection of all health data from the HFs, not only FP data. The database was also configured to host the FP training data, which assisted FH+ to migrate from a Microsoft Excel/paper-based training database to a fully electronic system that could be accessed remotely. The DHIS was also enhanced with the activation of the global information system (GIS) data representation component with geo-tagging of all project-supported facilities. This helped in the disaggregation of project data and reporting directly from the DHIS 2.0 platform.[4]

To achieve this result, FH+ in 2016 trained a total of 1,880 facility staff, HMIS data recorders, and M&E officers on how to use the mobile DHIS mobile (1,439 facility staff and 441 state and LGA staff). These trained staff were provided with Android phones with the DHIS application pre-installed. Table 11 shows the number of people trained in each project state.

Table 11. Number of People Trained on Mobile DHIS

State	No. of Facility Staff Trained	Others Trained (State and LGA staff)	Total Trained
Oyo	46	15	61
Ogun	62	14	76
Plateau	85	18	103
Benue	49	23	72
Cross River	76	21	97
Nasarawa	56	15	71
Edo	84	14	98
Ondo	67	22	89
Kano	49	47	96
Kaduna	78	25	103
Imo	119	30	149
Lagos	90	22	112
Rivers	70	27	97
Bayelsa	44	9	53
Delta	113	27	140
Taraba	52	25	77
Katsina	82	37	119
Gombe	53	10	63
Niger	69	19	88
Kogi	95	21	116
TOTAL	**1,439**	**441**	**1,880**

Source: FH+ spreadsheet on number of people trained on Mobile DHIS.

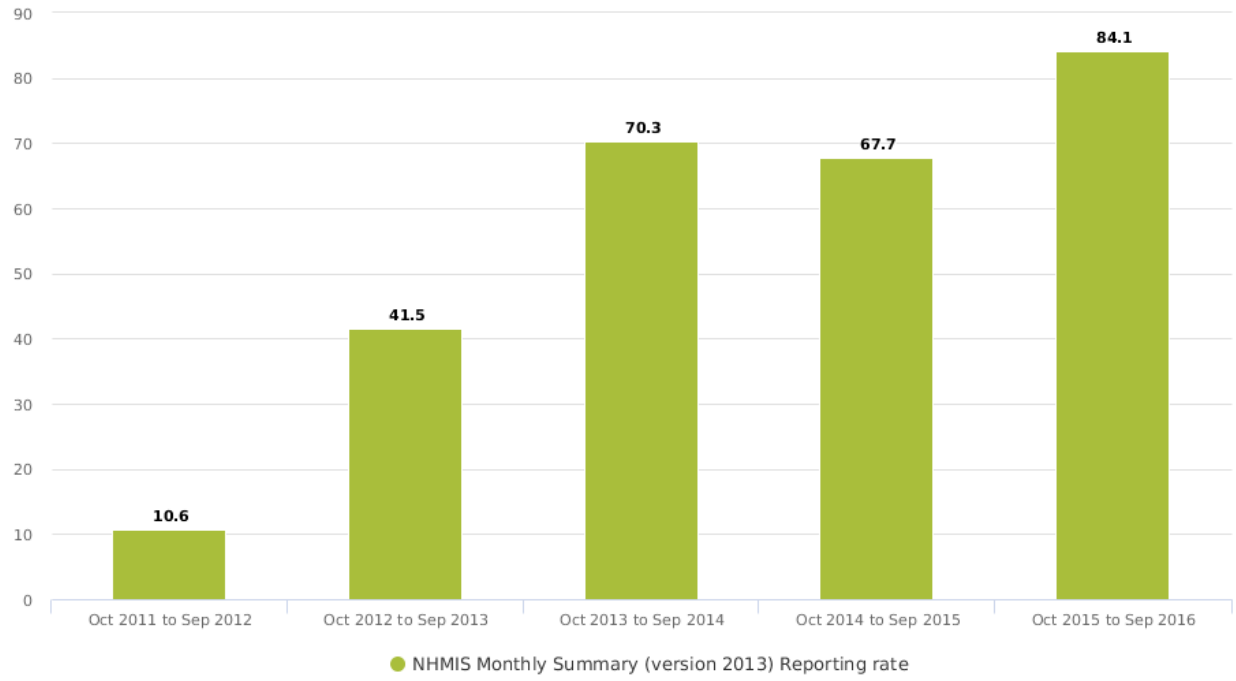
The rollout of the mobile DHIS to HFs did not commence until 2016—two years into implementation—because the activity needed government buy-in. During the evaluation, government, FH+, Palladium, and USAID respondents were asked about the effectiveness and efficiency of the mobile DHIS in data reporting. Respondents said the platform was effective only up to a certain point, including because HFs stopped using it (33.8 percent of HFs currently use it, 66.2 percent do not). LARC providers,

[4] FH+ Year 2 Annual Report.

government staff, and FH+ said problems affecting performance included data disappearing after entry, network failure, internet down time, lack of funds to buy data, no electricity to charge phones, staff attrition, and lost phones that were not replaced.

Respondents did consider the mobile DHIS efficient in providing real-time data for use by different tiers of government and other stakeholders. They also said it was cost-efficient because it enabled them to spend less time traveling to submit data. Furthermore, it improved completeness and timely submission of data: As Figure 8 shows, the data reporting rate increased 16.4 percent between the periods of October 2014 to September 2015 and October 2015 to September 2016.

Figure 8. FH+ Facility Reporting Rate: October 2011 to September 2016



Source: FH+ Dashboard on National DHIS.

FH+ would have recorded much greater success in the rollout and implementation of the mobile DHIS if it had addressed the following:

Coverage: It was implemented in only about 10 percent of the HFs supported by MSION, which made its contribution insignificant.

Government Buy-In: Although a majority of the state governments showed interest in the mobile DHIS when it was rolled out, they did not adopt it as the sole means for reporting data. HF staff trained on the system and who had the mobile DHIS app were still required to submit their reports manually (i.e., hard copy). When asked about the mode of transmitting their data to the next level, 57 percent of HF staff at project-supported facilities reported using hard copies, only 12 percent reported using mobile DHIS, and 31 percent said they used both methods (manual and electronic). For these staff, the use of the mobile DHIS added another task to their workload without additional remuneration; this discouraged them from using it. Also, interviews with stakeholders did not show that the government had any plans to sustain the use of mobile DHIS because none of the states visited had a plan in place to

continue and maintain its use after FH+ ended. In Ondo State, where Marie Stopes is no longer present, a majority of HFs are not using the mobile DHIS to report data, whereas in Niger State, where Marie Stopes has a new project, HFs are still using it to send their data. This was also corroborated by HISP, the DHIS consultant, which reported that the government relies on partners (contractors) for overall use and management of the mobile DHIS system.

Quality of Data Entered: Inadequate supervision and validation of the quality of data entered through the mobile DHIS was an important drawback, as only HISP does central validation of data. Although state Departments of Planning Research and Statistics and LGAs were expected to supervise data collection, they often did not.

Maintenance and Technical Support: Although FH+ had a technical support component for the rollout of DHIS, the evaluation team found it to be ineffective. One government respondent in Ondo State said that HF staff reported that the person employed by FH+ to provide DHIS technical support was not responsive to their needs, even after several calls. This respondent said some HF staff had stopped using the phone because they did not receive technical support.

Respondents said use of the mobile DHIS would have been more effective and efficient if FH+ had done the following:

- Provided good maintenance support and technical assistance
- Provided funds to buy data
- Included training on how to use smartphones and the Android platform
- Worked with the Nigerian government to have a sustainability plan for the use of mobile DHIS

CONCLUSION

The mobile DHIS is an innovative, exciting idea. As one of the respondent noted, "MSI surprised the government by having the guts to test mobile DHIS, even if it didn't work—now [we] know it can be done." Still, the mobile DHIS had advantages and disadvantages; the evaluation team noted that it had great potential if it had been properly rolled out, which should have included having government buy-in, monitoring, and provision of proper technical support.

RECOMMENDATIONS

1. The mobile DHIS pilot should be evaluated to measure its strengthens and weaknesses before the system is scaled up.
2. The mobile DHIS component should be continued under a well-financed health systems strengthening award that includes operations and financial technical assistance. It should be launched on a pilot basis.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The conclusions from the research findings can be categorized into research, communication, gender, and capacity building. The evaluation team's conclusions are presented below.

CONCLUSIONS	USAID	FH+ PROGRAM
1. FH+ completed training of 2,124 providers and master trainers of which 1,549 were certified (having three SSVs). This means 575 providers were trained but are not qualified to conduct LARC service delivery.		More thorough HF and provider analysis and assessment. More providers trained is not an assurance of better quality of service. Advocacy efforts with state governments to conduct supervision visits.
2. The challenge for the 1,549 certified providers (three supervised visits) is the quality of their LARC service delivery.		Supervision is a part of the quality assurance package, along with the selection criteria for providers to be trained. (See conclusion 6, about a lack of qualified providers.) Though they may have met the number of years of experience and geographic location, there was no evaluation of their confidence with LARCs, motivation, or interest in performing these services.
3. Before moving ahead with future training, master trainers with experience as trainers and in LARC should be retrained and recertified. Counseling and interpersonal communication should also be emphasized.	USAID, as the donor, will be responsible for selecting a new implementing partner and providing strong technical oversight. The Nigerian government must also be involved.	
4. The $9 million contract resulted in a 1.5% increase in CPR (DHIS FH+ Dashboard 2017).	Require FH+ to have a more strategic design, realistic innovations, and results monitoring. The project should work in fewer but more targeted geographic areas, and have more funding.	Funding and emphasis was primarily about service delivery training (with weak counseling and support). Program innovation, M&E, supply chain, demand creation, and an enabling environment are needed to increase LARC CPR.

CONCLUSIONS	USAID	FH+ PROGRAM
5. Public HFs are supposed to provide free FP services; however, it is reported that clinics are charging for consumables, service delivery, or other tangible products. These costs are barriers to women having access to FP methods and services.		"Paying for free family planning" is an appropriate issue for state-level advocacy and the AWGs to address.
6. There were challenges with selecting the master trainers, who are also supervisors, and the approach to training them. These have a direct effect on the quality of services being provided, and need to be addressed to ensure client satisfaction with LARC.		FH+'s clinic and provider assessment needed to be more than a checklist equally weighted between HFs' and providers' capabilities and motivation/interest.
7. Appropriate research to design FH+ for sustainability and effectiveness and to conduct project M&E were inadequate.	Reassert the need for primary research, especially formative research among beneficiaries, stakeholders, and providers.	Inadequate research throughout the whole project created gaps and holes in the design, implementation, and M&E.
8. FH+ did not conduct any research among women to understand their behaviors, fears, and motivations related to FP.	Approval of overall project design and implementation plan should have been evidence-based.	Primary research was inadequate, especially among beneficiaries and their environment.
9. Poor counseling by health providers, and lack of a cohesive communication outreach activity (e.g., interpersonal communication, peer education, demand creation) allowed rumors and misinformation about FP and LARC to continue to spread and deterred women and their partners from accepting LARC.		More data and evidence were needed to design a strategic project that went beyond service delivery training to supporting services (e.g., counseling, demand creation, enabling environment).
10. During the life of FH+, implant delivery increased in public HFs, but acceptance of IUDs has gone down relative to uptake of implants.		Overall project design: Training should include counseling and support; advocacy to create an enabling environment; and demand creation with correct information, support, and marketing.
11. The Nigerian government is decentralized, and each state has its own issues and is influenced by different social and cultural norms (e.g., CHEWs receiving LARC training and task shifting policy). The FH+ advocacy component did not tailor the AWGs' efforts to state-specific issues, which did not help to increase LARC service delivery.	FH+'s RFP references budget line items as an advocacy issue.	Advocacy must be tailored to state stakeholders' issues and concerns that need to be enhanced, and to removing barriers through a strategic advocacy effort.
12. The Federal Ministry of Health passed a law endorsing a task shift of LARC for CHEWs. Not every state is adopting this federal policy.		Advocacy must occur among state stakeholders to encourage policy change at the state level.

CONCLUSIONS	USAID	FH+ PROGRAM
13. Training providers in LARC service delivery is an important step, but there are other components that need to be in place for LARC service delivery to be sustainable and increase LARC CPR.		The training curriculum must be stronger in the interpersonal component of service delivery (e.g., in counseling). Demand and counseling training should also be given to other providers, TBAs, CHEWs, and general practitioners.
14. Mobile DHIS results were mixed. Because data on its application are inconclusive, before moving forward, there should be an evaluation of the pilot to measure its effectiveness, strengthens, and weaknesses.	Mobile DHIS should not be in this procurement.	
15. Mobile DHIS is an innovative initiative, but should be included in a well-designed health system strengthening activity that integrates into a whole-of-government IT system	Mobile DHIS should not be in this procurement.	
16. There were interruptions in service delivery because some state governments did not pay health workers' salaries regularly or replace retiring staff with new employees. There were also strikes and community crises (no pay). Clinics without workers undermines the goal of LARC access.		Innovative an advocacy approach with local and state ministries to reduce breaks in service delivery (i.e., help prevent community crises, strikes, or staff not being paid).
17. Federal and state ministries of health were aware of the FH+ Project but did not appear to be very engaged with it; they acted as observers more than partners. Project staff had a different view than government officials, especially in the states that felt FH+ was not inclusive.		Project management and strategic advocacy campaigns are mandatory to effectively engage with federal, state, and local gatekeepers.
18. The Federal Ministry of Health would like to have LARC services in every HF. How realistic or strategic this is should be looked at realistically.	Discuss quality and quantity with the ministry.	
19. FH+ training and advocacy appear to be "off-the-shelf" activities that MSION and Palladium have done in Nigeria and other countries, without tailoring approaches to fit the cooperative agreement's scope of work. This broad approach led to uneven and low-quality project performance.	The proposal submitted by the winning consortium did explain its design and the materials it would use.	Program design and management require evidence to tailor training and develop communications materials to reflect the needs and situations in Nigeria.

RECOMMENDATIONS

Training, Capacity Building, and Supervision: The criteria for LARC master trainers should be experience in being an FP trainer and/or a LARC service provider. The selection criteria for master

trainers need to be followed consistently to ensure that providers who are close to retirement do not form a large proportion of people trained.

When selected master trainers are not experienced in LARC, the training module for trainers needs to be modified to have six days for LARC and five days for effective reproductive health training skills and supportive supervision. These should be conducted as two training sessions; LARC should be first, to be followed by the TOT after an interval to allow trainees to practice skills in their HFs.

Training without the necessary tools and equipment is inadequate. Adequate numbers of LARC training models and kits should be provided so that the ideal ratio of (i.e., not more than four trainees to one model) can be maintained. Models should also be made available for supervisors to use during SSVs.

The project should engage trained trainers who have retired but are still available to work.

One step to assure sustainability would have been to institutionalize LARC in all nursing and midwifery schools and teaching hospitals. This is happening in a few schools. Forming long-term partnerships through memoranda of understanding or technology transfer would expand all health care providers' LARC capacity and standardize LARC service delivery with future midwives, nurses, and doctors. Each graduating class would be well-trained in classroom and practicum under strong supervision. It would have also assured LARC training had been given to pre-qualified providers who wanted it.

Counseling training needs to be emphasized for LARC providers, CHEWS, other HF providers, TBAs, and other community providers so everyone has correct information about methods, side effects, and benefits. The TBAs and other community health workers can also serve as demand creation agents.

Supervision and refresher training needs to be held on a regular basis.

Facility upgrades to improve the infrastructure at FP clinics and provide equipment and supplies will help improve quality of care. Equipment and supplies required include consumables, insertion and removal kits, blood pressure machines, scales, autoclaves, and screens. It should be stressed to providers that equipment and supplies provided should remain in the HFs.

Research and M&E: FH+ accomplishments could have been more effective and sustainable had it had at its core evidence and data to inform the project design and to monitor progress. Future projects' research methodology should include mapping to identify FP hot spots; analysis of social and cultural norms that influence FP behaviors; and qualitative and quantitative research among primary audiences, (e.g., women and implementing partners) and secondary audiences (e.g., stakeholders, providers, religious leaders, in-laws, and friends) to identify fears, beliefs, and motivations for FP practices. Messages and materials used in advocacy and community engagement, media relations, provider counseling, and peer education should be pre-tested and developed based on the primary research. Midterm evaluations, "mystery patients," and spot visits should be conducted randomly to gauge the quality of service delivery and to see if HFs have providers on site. IR2 and IR3 did not have M&E plans; there were indicators, but the volume of materials printed and number of meetings are not adequate indicators of FH+'s overall objectives.

FP still carries a stigma in Nigeria. Misconceptions and rumors are still barriers to women's acceptance of any FP method. Proper research would assist in designing communication, advocacy, and counseling activities that would reduce stigma, ease misconceptions, and dispel rumors.

Program Management: MSION had not been a primary implementing partner for USAID/Nigeria before FH+. The positive move of selecting a new partner meant a new perspective on the situation and

Nigeria's public health issues. It also meant a steep learning curve for understanding USAID's requirements and expectations (i.e., financial and technical), and learning how to successfully manage a multi-tiered contract or a cooperative agreement. During three years of implementation, MSION did not demonstrate that it came to understand these requirements and expectations. Subsequently, entire components of FH+ were not completed, and others were not conducted effectively. This should not discourage USAID from selecting new implementing partners; instead, it should recognize that markers must be put in place, especially for local organizations, to measure how the program management is performing. This may lie in requiring experienced compliance and procurement officers to be part of the project team, ensuring there is technical leadership that understands the requirements and magnitude of managing an agreement, and connecting implanting partners with USAID's mentoring program or Office of Small Business. Several of the mistakes made under FH+ could have been avoided with experienced management.

Adequate Resources: Each IR—training, advocacy for an enabling environment, demand and public awareness, and gender—was a necessary component for FH+ to reach its goal of increasing Nigeria's CPR. All of these technical areas must have an adequate budget, appropriate technical staff, and evidence to develop and implement for maximum results. These activities, if integrated, will contribute to increases in LARC.

Gender: Gender is more than the number of women in a project or the recognition that women are the primary beneficiaries. Social and cultural norms prohibit women making their own decisions and having easy access to health care. Likewise, male involvement is more than a man saying a woman can practice FP. There must be a gender plan/strategy that effectively changes norms and contributes to an increase in CPRs. Teams must conduct research the gender issues and social norms influencing FP uptake in intervention communities. In collaboration with stakeholders in the community, they must also develop, implement, and monitor a gender strategy based on evidence obtained from research.

Cost: A costing template should be designed and used from Day 1. This will appreciably reduce the loss of information about cost and enable the economic evaluation to be more robust.

Innovation: Innovations in several areas would have enhanced FH+, such as research, GPS, and application of mobile technology for demand creation. Teams should remember that innovation does not have to be grand, elaborate, or expensive.

Mobile DHIS: The use of mobile DHIS in submitting data was a strong innovation, but the component should be continued under a well-financed health systems strengthening award that includes operations and financial technical assistance. This component should begin on a pilot basis.

ANNEX I. SCOPE OF WORK

Assignment #: 401 [*assigned by GH Pro*]

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

TITLE: End of Project Evaluation of the Family Health Project (FH+)

I. Requester / Client

■ USAID Country or Regional Mission

Mission/Division: USAID/Nigeria / Health Population & Nutrition (HPN)

II. Performance Period

Expected Start Date (on or about): June 2017

Anticipated End Date (on or about): November 2017

III. Location(s) of Assignment: (Indicate where work will be performed)

The evaluation will be conducted in Nigeria (priority sites in red).

Family Health Plus focused states in Nigeria – in all the six geopolitical zones

Ogun, **Lagos**, Oyo, Edo, Imo, **Cross River**, Kaduna, Kano, Gombe, Nasarawa, **Benue**, Taraba, Niger, **Ondo**, **Delta**, Beyelsa, Plateau, Kogi, Katsina and Rivers

IV. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (*Check timing of data collection*)

☐ Midterm ■ Endline ☐ Other (specify): ____

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and

operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

■ Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

V. Background

If an evaluation, Project/Program being evaluated:

Project Title	Family Health Plus (FH+)
Award	AID-620-A-14-00001
Award Dates	March 4, 2014 - March 3, 2017
Project Funding	$9,000,000
Implementing Organization(s)	Marie Stopes International Organization Nigeria. Sub-awardees: Palladium and Marie Stopes International
Project AOR	Moriam Olaide Jagun

Background of project/program/intervention

Nigeria estimated 174 million has about 39.2 million women within the reproductive age group, 15-49. The total fertility rate remains high at 5.5, and 23.2% of births have an interval of less than 2 years (DHS 2013). The health status of women is extremely poor: the 2011 Report on the State of the World's Mothers ranked Nigeria as one of the worst places in the world to be a mother, and the country has one of the highest maternal mortality ratios in the world at 576 per 100,00 live births (DHS 2013). An estimated 50,000 women die from preventable pregnancy-related causes each year in Nigeria, and two thirds of all births are high risk due to the woman's age, parity or spacing of births.

In addition to enabling men and women to realize their reproductive intentions, voluntary FP is one of the most cost effective interventions in public health and has the potential to reduce poverty and avert up to 30% of maternal deaths and 10% of child deaths. Yet the contraceptive prevalence rate is low, 10% (NDHS 2013) and only 31.3% of demand for FP is satisfied by modern methods; well below the recommended benchmark of 75%. Government has investments in adoption of favorable policies and improved coordination of national activities. Opportunities in improving uptake still exists with; (i) high unmet need of family planning across the six geopolitical zones in Nigeria; (ii) Data available (Population and service statistics data) point to the fact that more short term methods are patronized at the service delivery points but service providers are desirous in providing longer methods. This is corroborated with the increase in uptake of long-acting reversible contraceptives (LARCs) over the years following training of providers at service delivery points.

With support from USAID, the Family Health plus led by Marie Stopes International Organization Nigeria was launched in year 2014 to strengthen competency of service providers in 20 states in Nigeria across the six geopolitical zones.

The specific FH+ project result areas are as follows:

- Result 1: Strengthened capacity of healthcare providers and service delivery points to offer quality long acting family planning services

- Result 2: Improved policy, governance and community environment for long acting family planning.
- Result 3: Increased awareness of and demand for long acting methods

Through the aforementioned, The FH+ project consortium will contribute to USAID's objective to increase access to long-acting methods of contraception by:

- Filling gaps and improving skills and capacity of public sector providers at high-volume sites to deliverLARC;
- Focusing on high-volume sites and achieving service integration across health areas through linkage with other on-going programs such as the Subsidy Reinvestment and Empowerment Program (SURE-P), Midwives Services Scheme (MSS), and prevention of mother-to-child transmission (PMTCT) sites;
- Supporting **discreet** demand generation activities to launch implants and IUDs in FH+ target communities which will complement overall FP demand-generation programs funded by USAID;
- Addressing supply chain and logistics management issues in collaboration with other USAID-funded programs such as DELIVER; and
- Addressing information management and policy barriers that inhibit access to comprehensive FP choice

Describe the theory of change of the project/program/intervention

The Family Health Plus Project (FH+) is implemented by a Consortium led by Marie Stopes International Organization Nigeria (MSION) under Cooperative Agreement with United States Agency for International Development (USAID). The project was rolled out in two phases with phases one focused in ten states: Kaduna, Kano, Benue, Nasarawa, Plateau, Ogun, Oyo, Cross River, Edo and Ondo, from March 2014 to September 2015. The project implementation was expanded to ten additional states in September 2015 to date: Lagos, Rivers, Delta, Bayelsa, Imo, Katsina, Kogi, Niger, Gombe and Taraba. Other members of the project consortium are Palladium (former Futures Group) and Marie Stopes International (MSI).

FH+ Project contributes to USAID's development objective of improving the health of women, primarily by contributing to building Family Planning Providers' capacity to deliver quality Long Acting Reversible Contraceptive Family Planning services, and secondarily by empowering users to demand quality FP, thus improving their access to long-acting FP.

From an analysis done, it was observed that uptake of LARC services is low. The main reason identified was limited capacity of providers to offer LARC services which the project was designed address. The overall assumption of the project is that if the competence of service providers is strengthened across all states to provide quality and safe FP services to include long acting reversible contraceptive methods, enabling environment ensured by government, demand created by providing correct and accurate information to communities, access to quality family planning services will be broadened and this will impact positively on the uptake of services.

The goal of the FH+ project is to strengthen the overall health system, build provider capacity to deliver quality Long Acting Reversible contraceptive Family Planning services, and empower users to demand quality FP and improve their access to long-acting FP.

The FH+ has three Sub-IRs:

- Strengthened capacity of healthcare providers and service delivery points to offer quality long acting family planning services
- Improved policy, governance and community environment for long acting family planning.
- Increased awareness of and demand for long acting methods

The three intermediate results of FH+ work in synergy in delivering the project overall goal. The first works to build the capacity of Health Workers to provide quality and safe Family Planning services with focus on LARC. This is expected to bridge the gap in knowledge and skills of providers to provider Family Planning services especially LARC.

The second focuses on working with government at the state level to create enabling environment for provision of Family Planning services. Focus here is on provision of FP commodities, HMIS tool at the facility, supporting training of government employed staff to be trained on provision of LARC services and increasing funding of FP activities at the state and local government level. The FH+ project has no provision for purchase of FP commodities and printing of HMIS at the facility level. The project was also designed to work with government at all levels to make these available at the facility. The project relied on other USAID projects like DELIVER to manage FP commodity logistics and distribution to health facilities.

The third intermediate results aim to increase demand at the facility level to generate demand for FP services especially LARC. The project was also to benefit from other USAID community mobilization and demand creation projects to drive demand to FH+ trained centers. Funds were not allocated to this as it was assumed it will be done by other USAID funded projects and FH+ linked with them.

Strategic or Results Framework for the project/program/intervention

Family Health Plus FH+ Goal: To contribute to an increase in the national CPR
Objective: **Increase the availability and voluntary uptake of FP services**
Indicator: (3.1.7.1-1) Couple Years Protection in U.S. government-supported programs

IR1: Strengthened capacity of healthcare providers and service delivery points to offer quality long-acting FP services

1.1: Percentage of project-supported facilities with a quality technical assurances (QTA) assessment score of at least 80%

1.2: Number of FH+ facilities providing LARC services

1.3: Number of health care workers certified in LARC service delivery

1.4: Number of supportive supervision visits conducted

1.5: Percent of U.S. government-assisted service delivery sites providing FP counseling and/or services

1.6: Number of project-supported health facilities using mobile DHIS 2.0

1.7: Number of state FP master trainers trained on LARC by FH+

IR2: Improved policy, governance, and community environment for long-acting FP

2.1: Number of NGO/civil society organization/ community-based organization media entries supported for FP policy advocacy

2.2: Number of improvement to laws, policies, guidelines, and curriculum related to FP services drafted with project support

2.3: Number of FP Advocacy Working Groups established at state level

IR3: Increased awareness of and demand for long-acting methods

3.1: Number of FP information, education, and communication materials available at the supported health facilities

3.2: Number of successful referrals

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

FH+ Project focus states in Nigeria: The activities were conducted in two phases.

1. **Capacity building of Provider on Services Provision and DHIS2 mobile:** Kano, Kaduna, Plateau, Benue, Nasarawa, Edo, Ondo, Cross River, Ogun, Oyo, Lagos, Rivers, Delta, Bayelsa, Imo, Kogi, Niger, Gombe, Taraba and Katsina
2. **Family Planning Advocacy Working Group:** Rivers, Imo, Niger, Katsina, Kogi, Ogun, Oyo, Benue, Cross River, Kaduna and Plateau.

VI. Scope of Work

The purpose of this endline evaluation is to evaluate the performance of the Family Health Plus (FH+) project; this evaluation will seek to determine to what extent the project achieved its objectives at endline and will also determine the cost effectiveness and sustainability of FH+'s approaches, interventions and innovations as it pertains to improving access to family planning services especially LARCs in the selected states. The findings of the evaluation will be utilized as learning experience to inform subsequent and similar project designs, implementation and performance.

A. Audience

The findings of the evaluation will primarily benefit USAID/Nigeria as they prepare to utilize the findings as a learning experience to a new project design.

Secondary users will include:

- USAID Washington – who will support the Nigeria Mission and utilize the data for improving FH+ project and designing new programs of a similar nature
- The Government of Nigeria (Federal Ministry of Health) – who will better understand the lessons learned from public sector involvement in supporting the provision of FP services in Nigeria;
- FH+ focus states – who will have more information on best practices and lessons learned and what will work best in their local context; and how best to use and leverage existing resources to increase the provision of FP services;
- Other donors and partners working in FH+ focus states – who will better understand the context within which they work; and this may inform reprogramming and possibly, change in their project(s) focus.
- Other countries who will be interested in using similar strategy in improving uptake of family planning services.

B. Applications and Use

The evaluation findings will provide information to USAID Nigeria's HPN office on how to design projects with a similar design that will potentially have an improved performance. The findings will also give key stakeholders' insights into best practices and where current gaps exist in family planning programming, thus stimulating appropriate government response and engagement with key FP key stakeholders. With dissemination through the DEC, other countries could benefit from the results.

C. Evaluation/Analytic Questions & Matrix

	Evaluation Question	Research Methods	Application or Data Use
I	To what extent were FH plus's training methodologies effective in strengthening capacity of FP service providers providing LARC in supported states? - Please analyze strengths and weaknesses, both internal and external	- Qualitative research methods with health facilities service providers at in focus states as respondents - Mystery client surveys with FP clients to determine service provider competencies	- Needed for new project design - Needed to improve future project implementation and performance

	Evaluation Question	Research Methods	Application or Data Use
	- Consider other approaches with potentials to significantly increase uptake of FP services.		
2	To what extent were FH+ strategies and activities cost effective; were there unexplored innovative cost effective implementation strategies that were not employed that could/should be utilized?	- Cost effective analysis of the project expenditure	- Needed for new project design - Needed to improve cost effectiveness of future project implementation
3	To what extent were FH+'s strategies and activities (including demand creation) sustainable and effective in increasing the use of LARC in supported states? - Note evidence demonstrating supported state governments now being responsive in owning their FP activities after FH+ interventions exists	- Qualitative research methods (In-depth interviews, FGD, Key informant interviews) with key stakeholders (staff of the state Ministry of Health, State FP coordinator) at the national and focus states as respondents.	- Needed for new project design - Needed to improve cost effectiveness of future project implementation - Needed to improve future project implementation and performance
4	What gender focused strategies and activities were applied by FH+ during the project implementation? Were - Note if they were sufficient and/or effective	- Qualitative research methods (In-depth interviews, FGD, Key informant interviews) with health facilities service providers at in focus states as respondents - Mystery client surveys to determine service provider competencies	- Needed for new project design
5	What vacuum in facility/state government HMIS that is being filled by the introduction of the Mobile DHIS 2.0? - Note what can be done to scale this up and ensure its sustainability if it was noted as a successful strategy	- Qualitative research methods (In-depth interviews, FGD, Key informant interviews) with key stakeholders at the national and focus states as respondents. - Review of the national DHIS 2.0	- Needed for new project design - Needed to improve cost effectiveness of future project implementation - Needed to improve future project implementation and performance

■ **Document and Data Review** (*list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

1. FH+ cooperative agreement and/or program description
2. FH+ Annual Work plans
3. FH+ TSS approach evaluation report
4. FH+ quarterly and annual performance reports
5. PMP/Results Framework and existing indicator data
6. Nigeria DHIS
7. Population based surveys and routine data.
8. Report of program activities.
9. Other relevant document not listed

■ **Secondary analysis of existing data** (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

USAID will arrange access to PRS and FH+ datasets, as needed.

Data Source (*existing dataset*)	**Description of Data**	**Recommended Analysis**
FH+ Internal database	This is housed in FH+ and documents all data beyond USAID expectations	Routine statistics documenting uptake of services
USAID Performance Reporting Systems (PRS)	USAID Database: It's the data reporting platform where USAID implementing partners report quarterly data to the mission.	Uptake of family planning services after FH+ projects began.
The national DHIS 2.0 database	This database has all the national FP data from all public health facilities	
Project reports	This will describe project, strategies, activities throughout the life of the project	

■ **Key Informant Interviews** (*list categories of key informants and purpose of inquiry*)

Key informants will be purposively selected to be interviewed. USAID/Nigeria and the FH+ project will provide a list of key informants and their contact information, as well as facilitate formal introductions as appropriate. Among those to be interviewed some will include:

1. USAID/Nigeria Staff
2. FH+ project staff
3. Other Family Planning focused USAID Implementing Partners such as SHOPS and ESMPIN projects
4. Other development partners.
5. Federal Ministry of Health, State Ministries of Health (SMOH) Officials
6. Service Providers from FH+ supported facilities and project beneficiaries.
7. Members of Family Planning Advocacy Working Groups

The key informants constitute stakeholders who have active contacts with the FH+ project. The purpose of this data collection method is to obtain these key stakeholders perspectives and views of

the FH+ project and their performance. It will provide the evaluation team an opportunity to state the strengths and weakness of the project and their views on what can be focused on during the design of future private sector focus FP projects.

■ **Focus Group Discussions** (*list categories of groups and purpose of inquiry*)

The purpose of this method would be to inquire if FP clients perceive gaps in FH+'s support to health facilities and if they can propose solutions that can improve the quality of service delivery for future follow on projects. If men and women participate in FGDs, the group discussion will be conducted separately for men and women, to adjust for the potential power differential between men and women, and to assure women's voice is heard equally to men. We are proposing that four groups be selected for the FGDs;

1. Master Trainers
2. Providers in selected facilities
3. Those trained on use of mobile DHIS2
4. Family planning clients to facilities

■ **Group Interviews** (*list categories of groups and purpose of inquiry*)

Optional: Key informants can be grouped and interviewed together, as long as the respondents feel free to express their opinions openly.

■ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

- Family planning clients to facilities

■ **Facility or Service Assessment/Survey** (*list type of facility or service of interest, and purpose of inquiry*)

This will involve review of FP data at the facility. Review will cover periods before and after the interventions (introduction of the project to the selected facilities) took place. A facility checklist will be used for the collection of the data. Data will be sourced from the facility FP summary forms, FP daily register, Daily consumption record form or any form that the facility and state use for reporting routing FP services at the facility level.

■ **Cost Analysis** (*list costing factors of interest, and type of costing assessment, if known*)

Project expenditure data and related information to determine cost effectiveness of FH+ activities

■ **Observations** (*list types of sites or activities to be observed, and purpose of inquiry*)

The Team will observe at select FH+ supported facilities and observe actual service provision. Before the visit, community mobilization will be done to generate some demand for FP services in the facility.

VIII. Analytic Plan

The Evaluation Team will develop an analysis plan and review with USAID/Nigeria for inputs. It is expected that the analysis plan will include analysis of qualitative data derived from **Key Informant Interviews**, **Focus Group Discussions** and **Facility assessment using the facility checklist.**

For quantitative data basic descriptive statistics and minimal level inferential statistics are expected.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. Quantitative data will be analyzed primarily using descriptive statistics.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data etc.) will allow the Team to triangulate findings to produce more robust evaluation results. The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation if any is used

VIII. Activities

Background Materials Review: Prior to conducting field work, the evaluation team will review background materials such as FH+ Program Descriptions, annual work plans, Performance Management Plan, technical and training materials, past program evaluation reports quarterly and annual performance 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. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – Upon arrival in Abuja, a team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Clarify USAID's expectations of the evaluation and evaluation team
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Decide on details of the evaluation methodology
- Develop data collection methods, instruments, tools and guidelines used by the team for KIIs and FGDs
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's evaluation report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief will include all the Evaluation Team members, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.

- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools in addition to presenting formally an evaluation protocol that will detail the items mentioned above. Also, the format and content of the Evaluation report(s) will be discussed. During the review briefing.

- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email or by phone whichever is feasible.

- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (***Note**: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)

- **IP & Stakeholders' debrief/workshop** will be held with the FH+ staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID. USAID may request debriefs with the States. This will be discussed during the TPM.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits for data collection to the proposed states of **Ogun, Lagos, Benue, Kogi and Imo, Cross River, Nasarawa and Kaduna.**

The evaluation team will outline and schedule key meetings and site visits prior to departing to the field, with the support of USAID and the project staff in identifying key actors. USAID/Nigeria staff will randomly select facilities to be visited. The team will jointly conduct field visits to the selected service delivery points (SDPs)/health facilities in the project's selected LGAs in focus states to observe the activities of the project: the team may also select appropriate state-level health decision-makers to determine their knowledge of the project. Selection of states and SDPs will be by purposive sampling excluding states with security concerns for safety reasons. The evaluation team will conduct interviews with key informants from other selected USAID Implementing Partners (including SHOPS and ESMPIN, USAID/Nigeria, State Ministry of Health's, Local Government Areas authorities and other relevant stakeholders identified in project documentation and interviews.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. The Team Lead will submit a draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and re-submit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

Internal Procurement Memo - The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

Data Submission – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

IX. Team Composition, Skills and Level of Effort (LOE)

Evaluation team:

Team Qualifications: Please list technical areas of expertise required for this activity

The evaluation team will consist of 1) FP Specialist 2) Evaluation Specialist/Health System strengthening specialist 3) Costing Specialist. Additionally, 2 Logistics/Admin who will also serve as research assistants. The Team Leaders should be selected from the team, the team members should also be a mix of international or qualified local, with relevant skills and capacity, and no link to the FH+ project). The team members should represent a balance of expertise in conducting rigorous evaluations, technical expertise related to FP service delivery in general and in the public sector in particular including, health services planning and programming, as well as public sector approaches to health service delivery.

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 FP service delivery in developing countries.

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

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.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations (6) Writing and submitting the evaluation report is accordance with USAID standards

Qualifications:

- Minimum of 10 years of experience in public health, which included experience in implementation of health and family planning activities in developing countries
- Demonstrated experience leading health sector project/program evaluations utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in Africa, with Nigeria and/or West Africa regional experience is desirable
- Experience working with government on FP and/or MCH service delivery in developing countries will be an advantage.
- Experience working on gender integration and/or transformation is desirable
- Familiarity with USAID health programs
- Familiarity with USAID policies and practices
    - Evaluation policy
    - Performance monitoring plans

Key Staff 1 Title: FP/RH Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in FP/RH. She will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations. There is preference for local females with experience working managing state programs

Qualifications:

- At least 8 years' experience with FP/RH projects; USAID project implementation experience preferred

- Expertise in supply and demand for FP services
- Experience working on gender integration and/or transformation is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 2 Title: Evaluation Specialist: He/she should have qualifications and demonstrated experience in M&E and evaluation methodological designs and implementation.

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring the highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Advanced degree in health management, health finance, public health or a closely related field
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Proficient in English
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID M&E policies and practices
    - Evaluation policies
    - Results frameworks
    - Performance monitoring plans

    Number of consultants with this expertise needed:____1____

Key Staff 3 Title: Health Economist (Costing Expert)

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate the cost efficiency, as part of the evaluation. S/he will provide technical expertise for the

expenditure and value for money analysis. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- At least 5 years of experience working with cost analysis in developing country settings context
- Experience should include in depth in understanding of evaluating programs from a cost efficiency perspective
- Experience working with projects to extracted expenditure data, including categorizing these expenditures into useful categories of project implementation
- Experience assessing value for money on health and development projects
- Experience assessing areas for priority investment, and whether money is being spent where it should be in order to maximize desired results
- Experience with USAID health programs
- Experience working with formal and non-formal private sector networks, including NGOs regarding commodity sales and distribution, is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, with experience producing evaluation and/or technical report

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local Evaluation Logistics /Program Assistant (2 consultants) will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. They will also assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with FP/RH programs and services, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts to, as needed. The Logistics/Program Assistant will have a good command of English and local language(s). S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:

■ Significant Involvement anticipated – If yes, specify who: **Ikenyei Uche** and **Celeste Carr**, USAID/Nigeria, is expected to have substantial involvement throughout the evaluation, including TPM and field data collection

☐ No

Staffing Level of Effort (LOE) Matrix (Optional):

Level of Effort in **days** for each Evaluation/Analytic Team member

Activity / Deliverable		Evaluation Team			
		FP/RH Spec & Team Leader	Evaluation Specialist	Costing Specialist	Logistics / Local Eval
Number of persons →		1	1	1	4
1	Launch Briefing	0.5			
2	HTSOS	1	1		
3	Desk review	5	5	5	
4	Preparation for Team convening in-country	0.5			3
5	Travel to country	2	2		
6	In-brief with Mission	0.5	0.5	0.5	0.5
	Meet with RSO	0.5			
7	Team Planning Meeting	4	4	4	4
8	Workplan and methodology review briefing	0.5	0.5	0.5	0.5
9	Eval planning deliverables: 1) workplan with timeline analytic protocol (methods, sampling & analytic plan); 2) data collection tools				
10	In-brief with FH+	0.5	0.5	0.5	0.5
11	Data Collection DQA Workshop (protocol orientation/training for all data collectors	2	2	2	1
12	Prep / Logistics for Site Visits	1	0.5	2	2
13	Data collection / Site Visits (including travel to sites)	15	15	15	15
14	Data analysis	5	5	5	2
15	Debrief with Mission with prep	1	1	1	1
16	IP & Stakeholder debrief workshop with prep	1	1	1	1
17	Depart country	2	2		
18	Draft report(s)	8	7	7	1
19	GH Pro Report QC Review & Formatting				
20	Submission of draft report(s) to Mission				
21	USAID Report Review				
22	Revise report(s) per USAID comments	3	2	2	
23	Finalize and submit report to USAID	0.5			
24	508 Compliance Review				
25	Upload Eval Report(s) to the DEC				
	Total LOE per person	**53**	**49**	**46**	**32**
	Total LOE	**53**	**49**	**46**	**128**

If overseas, is a 6-day workweek permitted ■ Yes ☐ No

Travel anticipated: List international and local travel anticipated by what team members.

It is anticipated that the evaluation will take place in 5 of the twenty FH+ states which will be purposively selected in consultation with USAID Nigeria. The 5 States are likely to be Lagos, Cross River, Benue, Ondo, and Delta, but selection will be finalized during the TPM. Exclusion criteria would be states that have security concerns

X. Logistics

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
Nigeria	☐ Tourist	■ Business	☐ No preference

XI. Analytic Report

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*)

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy). a. The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes). b. The structure of the report should follow the Evaluation Report template, including branding found here or here. c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID. d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here. **Reporting Guidelines:** The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.*** The preliminary findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format: ● Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 2 pages); ● Table of Contents (1 page);

- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations (17-20 pp total for FCR)
- Issues (1-2pp)
- Future Direction (2-3pp)
- Annexes
    - Annex I: Evaluation/Analytic Statement of Work
    - Annex II: Evaluation/Analytic Methods and Limitations
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviews
        - Bibliography of Documents Reviewed
        - Databases
        - [etc]
            - Annex V: Disclosure of Any Conflicts of Interest
            - Annex VI: Statement of Differences [if applicable]

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

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The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

ANNEX II. EVALUATION/ ANALYTIC METHODS AND LIMITATIONS

Design: The evaluation used a mixed-methods design using quantitative and qualitative approaches. For the quantitative approach, primary data collection was done through client exit interviews (CEI) complemented by secondary data collection and analysis of project data (FH+ database and Performance Reporting System), DHIS data at the state level, and facility uptake data on long acting reversible contraception (LARC) was undertaken. The qualitative component included focus group discussion sessions (FGDs) with women using LARCs and key informant interviews with government, FH+ staff, LARC providers and master trainers, Palladium staff, advocacy working group (AWG) members, the DHIS consultant (HISP), USAID, and other identified stakeholders. In addition, observations of LARC counselling and procedures were conducted.

Sampling: The evaluation data collection was conducted in five of the 20 FH+ Project intervention states. USAID purposively selected four of these states, and one was selected based on the need to include states in the northern part of the country and one state where FH+ is currently being implemented. One LGA was randomly selected in each senatorial district in Benue, Cross River, Ondo, and Niger States, and four LGAs were randomly selected in Lagos State to provide the evaluation team more time for pre-testing of tools. Observations were conducted with clients' consent; and CEIs were conducted with clients who received LARC services on the day of the assessment. Facilities were purposely selected for LGAs that had only four project-supported facilities and randomly selected for LGAs that had more than four facilities. The table below provides sample sizes and numbers reached by the evaluation for both qualitative and quantitative data collection methods.

Sample Sizes and Numbers Reached for Qualitative and Quantitative Data Collection Methods

Method	Category	Target Sample Size	Number reached	% Reached
Key Informant Interviews	Government, master trainers, USAID, FH+ Project staff, AWG, UN Population Fund, DHIS, and others	75	68	91%
	LARC provider	64	56	88%
Exit Interviews	LARC clients	128	51	40%
Observations	LARC providers	128	76	59%
HF Assessments	FH+ supported facilities	64	69	108%
FGDs	**LARC clients** Number conducted	64	50	78%
	Number of participants	256	149	58%

METHODS

Desk Review: Project documents relevant to the evaluation were collected for review and analysis. These included the project design, the scope of work, annual and quarterly reports, annual work plans, technical and training materials, financial reports, and technical and research documents such as the baseline report, the midterm report, the facility audit report, and the exit interviews report. The evaluation team also reviewed materials and reports from other USAID-funded projects and other donor agencies in FP.

The evaluation team conducted key informant interviews with FH+ management, technical, financial, and M&E unit staff, government staff in the states, LARC es visited providers and master trainers, the DHIS consultant, the United Nations Population Fund, the Clinton Health Access Initiative, and USAID.

Quantitative Data Collection: In addition to CEIs, the evaluation team collected secondary data from the FH+ project database, the c), DHIS data at the state level, and facility LARC uptake data.

The evaluation team also observed counselling and LARC procedures to ensure the quality of service provision and conducted facility assessments to assess the availability of materials, equipment, and consumables for provision of LARC services.

Data Management and Analysis: Qualitative data/notes from all locations were transcribed and organized for content and thematic analysis. Quantitative analysis was primarily conducted using graphs and trends in a Microsoft Excel template.

LIMITATIONS

FH+ Project Primary Research: Qualitative and quantitative data for program design and monitoring and evaluation data was inadequate.

Project Close-Out: In states where FH+ was not operating, the evaluation team's work was slowed. It took the evaluation team more time than expected to get the approval of the state governments to

conduct the evaluation in LGAs and facilities. Also, it took the team more time to locate facilities in some states than others.

Retirement of Trained LARC Providers: In some states, some of MSI-trained nurses/midwives had retired, making it difficult to observe LARC procedures. In some instances, retired nurses/midwives were being recalled/invited to the health facility to conduct LARC procedure at a cost.

Difficult Terrain: Some of the locations originally selected were inaccessible due to difficult terrain. To compensate for this, the team redirected its work to other LGAs that fit the required profile. The alternative LGAs were within the same senatorial district.

Time Constraints: To maximize time on the road, the evaluation team travelled on weekends. In a few communities, HFs could not be assessed because the providers were not available when the team visited.

Rainy Season: It rained throughout the week the team was in Lagos, which hampered the movement of the evaluation team and clients.

Farming Season: The evaluation team could not get enough clients for the FGDs because it was farming season and clients had gone to their farms.

Competing Programs in the State: The period of the evaluation fell within state programs, such as Maternal, Newborn, and Child Health Week and World Population Day. This meant some key stakeholders were unavailable for interviews.

Incomplete Documentation of Financial and M&E Data, Reporting, and Project Records: The project did not provide all required financial data needed to calculate its cost effectiveness, so the evaluation team had to use estimates in some cases. Also, the facility data the evaluation team received from FH+ was incomplete.

ETHICAL CONSIDERATIONS

All respondents provided verbal informed consent before taking part in the evaluation. No children or youth were included in interviews or FGDs, all of which were conducted in safe, private environments. Information that could reveal the identity of respondents was excluded, and the team collected information only on the category of respondent. Participants gave permission for taking photos during FGDs and KIIs, and were informed that photos may be used for evaluation reports.

ANNEX III. INTERVIEW SCHEDULE

DAY/DATE	TIME	PERSON & ORGANIZATION	COMMENTS/NOTES
28 June	9:00 a.m.	USAID Technical Team	Debrief
29 June	4:00 p.m.	Aluka Terpase & Team DHIS contractor	Intro to mobile DHIS, software, partner debrief
30 June	10:00 a.m.	FH+ Technical team. at Marie Stopes	Project debrief
30 June	1:00 p.m.	Onoride Ezire, former chief of party for FH+	Former FH+ chief of party; now with Palladium
3 July	10:00 a.m.	Bimbo Fayole, FH+ regional director Evelyn Kutelu, FH+ clinical trainer MSI, Lagos	Lagos State
4 July	10:00 a.m.	Dr. F.F. Oludara, director Dr. Okaga S.A. Adeoti, deputy director, Directorate of Family Health and Nutrition Dr. Atobatele	SMOH, Lagos
5 July	3:00 p.m.	Moriam Jagun, FH+ agreement officer's representative	Former USAID agreement officer's representative (FH+)
7 July	9:00 a.m.	Dr. A.O. Folarin-Williams, M&E, SMOH, Lagos	Meet @ cold storage SMOH, Ikeja, Lagos
7 July	11:00 a.m.	Mrs. M.O. Olybode, master trainer, LASUTH	Master trainer in Lagos, trained by MSI under FP+
9 July	12.00 p.m.	Mrs. Tohila Victoria, FP coordinator, SMOH, Benue State	08035940800, SMOH, Benue State
9 July	7:00 p.m.	Osunmakinwa Olusegun, executive secretary, PHCDB, Ondo State	Retired from position 1 week before interview; 08033903219
10 July	9:00 a.m.	Rosemary Adegbulu, RH coordinator, PHCDB, Ondo State	08033619829
10 July	12:30 p.m.	Mrs. Omoleranis Oke, FP coordinator, Akure North, Ondo State	08160434444
10 July	1:00 p.m.	Jermial Oke, director, PHCDB, Ondo State	09065949945
10 July		Victoria Ogundana, PHCDB, Ondo State	08034705923
10 July	10:00 a.m.	Ebere Ubah, M&E, FH+, MSI	Meeting at MSI, Abuja
10 July	11:30 a.m.	Yeminis Omekeh, supply chain	Meeting at MSI, Abuja
10 July	1:00 p.m.	Damola Olajide, e-health, FP+, MSI	Skype
11 July	9:00 a.m.	Elizabeth Tondu, FP+ state clinical	Phone call, 07069205372
11 July	10:00 a.m.	Kingsley Odogwu, chief of party, FH+, MSI	Acting FH+ chief of party; formerly clinical expert
11 July	1:00 p.m.	Bello Bisalla, FP+ policy	Meeting at Palladium office
11 July	9:45 a.m.	Mrs. Dare Samuel, FP coordinator, Akure South	08034742374

DAY/DATE	TIME	PERSON & ORGANIZATION	COMMENTS/NOTES
11 July	10:15 a.m.	Mrs. Adeniji Ojo, PHCDB, Ondo State	07037830138
12 July	TBD a.m. 8:30-10:30 a.m.	USAID Technical Pam Foster Kayode Morenikeji	Individual meetings w/FH+ technical staff at Mission
12 July	3:00 p.m.	Dauda Suleiman, country director, Palladium	Meeting at Palladium office, Abuja
12 July	1:00 p.m.	Jumoke Olafadeha, SCTO MSION, Ondo State	Currently residing in Osun; 08033923248
13 July	11:00 a.m.	Zainab Saidu, country rep., Clinton Health Access Initiative	At the Initiative's office, 7B Ganges Street, off Alvan Ikoku Way, Maitama, Abuja; 234.803.714.8272
13 July	3:30-5:30 p.m.	USAID Technical Joseph Monehin	USAID
13 July	12.00 p.m.	Mom Lazarus A., Lawyers Alert, Makurdi, Benue State	08063895571, Justice Hall, NUJ House 79 Ankpa Road, Makurdi, Benue State
13 July	12.00 p.m.	Doki Samuel T., MSION, Benue State Office, Makurdi, Benue State	07035745411. Interviewed on FH+
13 July	3:00 p.m.	Mrs. Dorcas Johnson, HMIS, SMOH, Ondo State	09094567737
14 July	10:00 a.m.	Bridget Oladele, nurse tutor	08060221090
14 July	1:00 p.m.	Jerome Shaguy, FP+, HISP, Palladium consultant	Skype call to Lao
14 July	11:00 a.m.	Dr. Joseph Kumba, permanent secretary SMOH, Benue State	08065947928, SMOH, Makurdi, Benue State
14 July	11:00 a.m.	Dr. Terver Chieshe, director, SMOH, Makurdi, Benue State	07035542896, SMOH, Makurdi, Benue State
17 July	11:00 a.m.	Amaka Anene, UNFPA	07034173553
14 July	1:00 p.m.	Jimin Simon Terver, Makurdi, Benue state.	08036323237, SMOH, Makurdi, Benue state.
17 July	3-4:00 p.m.	Uche Ikenyei, USAID	At MSI
17 July	4:00 p.m.	Emmanual Ajah, operations, MSION, Abuja	Marie Stopes 8034353190
17 July	10.00 a.m.	Barr. Lucy Enakirehi, FP Coordinator, SMOH, Cross River State	08036000672, SMOH, Cross River state
17 July	1:00 p.m.	Mrs. Dorcas Abu, FP coordinator, SMOH, Niger State	08063682968
17 July	11:00 a.m.	Kayode Afolabi, FMOH, family health	08069365667
19 July	12:00 p.m.	Emeka Nwachukwu, HSS, FH+, Palladium	Hilton call & mt Ex Lounge 009 1 832 526 7623
19 July	1:30 p.m.	Elizabeth Oluyomi, FMOH, reproductive health	07030980095
20 July	5:00 p.m.	Leonard Viashima, regional team leader, FP+	Skype call

DAY/DATE	TIME	PERSON & ORGANIZATION	COMMENTS/NOTES
21 July	11:00 a.m.	Chinweoke Onumonu, Association for the Advancement of FP in Nigeria (AAFP)	8033810975 #3 Cross River Street Area 3, Garki, Abuja
21 July	1:00 p.m.	Mrs. Grace Ifene, SCTO, MSION	8033011038
21 July	4:00 p.m.	Comfort Okpe, state advocacy, Palladium	Phone/skype call
20 July	12:00 p.m.	Moses Egom, DHIS2 Coordinator, SMOH, Cross River State	08062883109, SMOH, Cross River State

ANNEX IV. BIBLIOGRAPHY

Family Health Plus Project Reports and Documents

1. Advocacy Capacity Building Workshop (SMART Training) PowerPoint, 2016.
2. Balanced Counseling Strategy Plus Toolkit, USAID's Frontiers Project.
3. Dashboard of Public Sector Health Facilities: Client Exit Interviews, 2016.
4. FH+ Advocacy Family Planning Strategy Framework and Plan of Action for Benue, Cross River, Kaduna, Oyo, Ogun, Plateau States, 2015-2016.
5. FH+ Annual Reports 2015, 2016.
6. FH+ Annual Work Plans, 2015, 2014, 2016.
7. FH+ Budget to USAID, 2014.
8. FH+ Communication and Counseling Materials (IEC): Family Planning Choices and SOP for IUC Insertion and Removal, SOP for IUD Insertion and Removal Poster, Family Planning brochure.
9. FH+ Daily Consumption Reports, April 2016, December 2016, January 2017.
10. FH+ Database for e Health/mobile DHIS Training Workshop, November 2015.
11. FH+ End-of-Project Report, July 2017.
12. FH+ End-of-Project PowerPoint.
13. FH+ Facility Audit Report, 2014.
14. FH+ Financial Report.
15. FH+ Fully executed award.
16. FH+ IMPACT, Scaling Up Impact of FH+ in Phase 2 States: Opportunities and Options.
17. FH+ Midline Evaluation Report, Impact of Providers' Capacity Building on Improving Access to Voluntary Family Planning Services.
18. FH+ Performance Monitoring Plan, 2014.
19. FH+ Project Description, 2014.
20. FH+ Quarterly Reports, March 2014, December 2014, March 2015, June 2015, December 2015, March 2016.
21. FH+ Report on Training-of-Trainers on LARC, November 2015.
22. Impact Now Manual, Palladium/Health Policy Project, August 2015.
23. Miscellaneous media articles on advocacy events.
24. Mobile DHIS Reporting Rates, July-December 2015 and July-December 2016.
25. MSION Youth Strategy, 2015.
26. PSS 2016 Client Exit Interview Results Nigeria, April 2017.
27. FH+ Spreadsheet on number of people trained on Mobile DHIS.

National Studies and Strategies

1. FMOH Task Shifting Letter, 2014.
2. Measurement and Access Program Survey (MAPS) 2014, 2015, 2016 reports and data.
3. Nigeria Demographic and Health Survey (NDHS), 2013.
4. Government of Nigeria, Federal Ministry of Health's "Scale Up Plan" 2014.
5. Multiple Indicator Cluster Survey (MICS) Report, 2011.
6. Government of Nigeria, Family Planning Blueprint 2020.
7. Government of Nigeria's Manual for Training Doctors and Nurses on LARC, 2015.
8. Nigeria Family Planning Dashboard.
9. Nigeria DHIS FH+ Dashboard.
10. USAID Performance Reporting System.

Other Reports and Studies

1. Kapadia-Kundu, Nandita, Understanding Program Implementation Processes & Behavior Trails of FP users in ESPMIN Cycle 3, JHU/CC/HC3, January to July 2013.
2. Kapadia-Kundu, Nandita and Boulay, Marc, The ESMPIN Family Planning Assessment Report, JHU/CCP/HC3, August 2014.
3. MEMS II DHIS training PowerPoint Presentation HIV/AIDS) Implementing partners.
4. Mooney, Andrea, A Sustainable Way to Expand Access to LARC, Population Services International, IMPACT, Global Health News and Commentary, 2016.
5. Prata, Ndola and Vohra, Divya, Long-Acting Reversible Contraceptive Use among Ethiopian Youth: Potential Demand and Strategies for Promotion, University of California, Berkeley, Bixby Center for Population, Health and Sustainability.
6. Shelton, James D. and Burke, Anne E., Effective LARC Providers: Moving Beyond Training. Global Health: Science and Practice, August 2016, 4.

ANNEX V. DATA COLLECTION INSTRUMENTS

FH+ Evaluation Questionnaires

INDEPTH INTERVIEW: LARC PROVIDERS

Date: _____ **Name of respondent:** _____

State: _____ **Facility/LGA:** _____

Name of Interviewer:_____ **Tel No**:_____ ____

Type of facility: Rural ☐ **Urban** ☐

Good morning. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus (FH+) project. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

1. Can you tell me what type of health provider you are? [Probe]:

   Doctor, ……1
   Nurse/midwife……..2
   Nurse…….3
   Midwife…….4
   Senior Community Health Extension Worker……..5
   Junior Community Health Extension Worker……...6
   Community Health Officer……7
   Others specify……
   _____

2. How long have you been working in this facility (*In years)*? _____
3. How long have you been offering LARC services? _____
4. How long has the facility been offering LARC services?_____
5. What LARC services do you provide at the clinic? [Probe: Copper T IUD, LNG IUS (Progesterone IUD), Jadelle, Implanon) _____

6. Are you familiar with FH+ (Marie Stopes)? If so, what do you know about them and their services?

_____

_____

_____

7. Has your facility received any support from FH+? Yes……1 No……2

   If yes, what specifically has it done?

_____

_____

_____

8. Have you or any of your colleagues participated in any training organized by FH+? Yes…1 No…..
   If yes, what type of training did you or they receive *(LARC, TOT, DHIS mobile)?*

_____

_____

_____

   How did you use the training received in your work?_____ ___

a. How do you rate the training you received? With 1 being the poorest and 5 being excellent

Item	(5) Excellent	(4) Very Good	(3) Good	(2) Poor	(1) Very Poor	Comments
Content (Counselling, Procedures, Infection control, HMIS etc.)						
Duration						
Participant selection (Appropriate or inappropriate)						
Methodology Probe (audio visual aids, role play, demonstrations/return demonstrations, clinical practice, HMIS practice?)						
Training materials Probe (Handouts, models etc.)						
Others Specify						

9. Name other areas of training (if any) you would like to receive in the future that is relevant to your work in LARC? _____

10. Have you noticed a difference in your work and your facility since FH+ has been associated with your facility? If so, what specifically has changed? *[Probe: good or bad] Increased LARC client, Less complications, availability HMIS forms, timely submission of data, less stockout, appropriate referral etc.*

_____

_____

_____

11. Where do you get supplies of LARC commodities? _____

12. Have you experienced stock-outs in the last three months for LARC Product? Yes…..1, No…..2

    If yes, which products? _____

    Why do you think this happened?_____

13. How many times a week does family planning services hold at your facility?_____

14. Time of family planning services is ___ AM to _____ PM

15. On the average, how many clients do you see at the clinic daily? _____

16. Where do you counsel your clients for FP? _____

    Is there a separate area for this? Yes…...1, No„„.…„„2
    Is there visual privacy? Yes……1, No……2
    Is there auditory privacy? Yes……1, No……2

17. How do your clients select long-term family planning methods (LARC)?

    _____

18. Have you ever had any supportive supervision visits to your facility for LARC? Yes...1, No…….2.

    If yes, by whom?_____ _____

    How often? _____

    Do you find these visits useful? Yes….1, No…..2. Please explain

    _____

    _____

19. What kinds of data do you collect? _____

    _____

    Do you report this data to any authorities? Yes……1, No……..2

    If yes, which authorities? _____

    How often? _____

    How do you transmit this data? Manual… 1 Electronic (DHIS Mobile)..2 Others_____

    When did you start using DHIS Mobile?_____

If through DHIS Mobile what challenges did you encounter in the use of the device?

_____

Was the issue resolved? Yes…1 No…2 How?_____

If not resolved why:_____

How could the use of mobile DHIS be promoted among health providers?

_____

20. On a scale of 1-5 with 1 being Very poor and 5 being Very good, how will you rate the uptake of LARC services in your facility before and after the commencement of the FH+ project?

Uptake of LARC Services	(5) Excellent	(4) Very Good	(3) Good	(2) Poor	(1) Very Poor
Before FH+					
After FH+					

What is/are your reason(s) for this score?

_____

_____

21. Do clients return to the clinic with complaints or side effects of the LARC methods? Yes or No. If so what are the issues:

Copper T:_____ _____
LNG IUS:_____
Jadelle:_____
Implanon:_____

How do you address these issues or the side effects?

_____
_____

Do you feel confident about your ability (skills) to address the complaints and side effects?

_____
_____

22. Is there anything that you would have liked the FH+ project to do that was not done? Please explain.

_____

_____

_____

_____

Thank you for your time and cooperation.

In-depth Interviews: MASTER TRAINERS

Date: _____ **Name of respondent:** _____

State: _____ **LGA/Facility:** _____

Name of Interviewer:_____ **Tel No**:_____

Good morning. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus (FH+) project. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour. Do I have your permission to begin?

1. Can you tell me what type of health provider you are? [Probe: Doctor, Nurse/midwife, Nurse, Midwife, Community Health Extension Worker, others]

   _____

2. Where do you work? [Probe: Midwifery school, health facility, teaching hospital, etc.]_____

3. How long have you been working as an FP trainer (*In years)*? _____

4. How long have you been conducting LARC trainings? _____

5. Are you familiar with FH+ (Marie Stopes)? If so, what do you know about them and their services?

   _____

   _____

6. Have you ever participated in any training organized by FH+?

   If yes, what type of training? _____

   How has the training affected your performance as a LARC master trainer?

   _____

   _____

   How do you rate the training you received? With 1 being the Poorest and 5 being excellent

Item	(5) Excellent	(4) Very Good	(3) Good	(2) Poor	(1) Very Poor	Comments
Content *(Adult learning principles, use of audio visual aids, use of anatomical models, SOPs etc.)*						
Duration						

Item	(5) Excellent	(4) Very Good	(3) Good	(2) Poor	(1) Very Poor	Comments
Participant selection *(Appropriate or inappropriate)*						
Methodology *Probe (audio visual aids, role play, demonstrations/ return demonstrations?)*						
Training materials Probe *(Handouts, models etc)*						
Others Specify						

7. What training materials and equipment were provided to you or your institution by FH+? *[Probe: training manuals, mannequins (anatomical models), LARC instruments]*

   _____

   _____

   Are these sufficient for your training needs? Yes---1, No----2 If no, please explain what is lacking

   _____

   _____

8. Name other areas of training (if any) you would like to receive in the future that is relevant to your work as a LARC master trainer? _____
9. How often do you conduct LARC trainings? _____
10. Do you provide reports of these trainings to the authorities? Yes----1, No----2

    If yes, which authorities? _____
11. Have you ever had any supportive supervision visits during LARC training? Yes--1, No--2

    If yes, by who?_____ _____

    If no why?_____

    Do you find these visits useful? Yes….1, No…..2. Please explain

    _____

    _____

12. Have you ever provided supportive supervision? Yes--------1 No--------2

    Can you describe your experience while providing the supportive supervision?

    _____

    _____

13. Is there anything that you would have liked the project to do that was not done? Please explain.

    _____

    _____

Thank you for your time and cooperation.

FOCUS GROUP DISCUSSION: LARC/FP CLIENTS

Date: _____ **Name of respondent:**_____

State: _____ **LGA/Facility:** _____

Name of Interviewer:_____ **Tel No**:_____ _____

Good morning/afternoon. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus (FH+) project. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as key persons to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our discussion will take about one hour.

Do I have your permission to begin?

1. How many of you have children? [raise hands]
   Record number out of total number of respondents _____
2. How many of you have gave birth in the last one year? [raise hands]
   Record number out of total number of respondents _____
3. Age of participants:

Age Range	Number of Participants
18-24	
25-34	
35-44	
45+	

4. How did you hear about the long-acting family planning methods (LARCs)? *[Probe: family, friends, health provider, Community Mobilizers, posters, radio, TV, etc]*_____
5. How many of you visit this facility *(name public facility in the locality)* for a long acting family planning method like IUD or implant?
   Record number out of total number of respondents _____
6. Why do you go to this facility for LARC? *[Probe: location, Proximity, referral, promotion, affordability]*
   _____
   _____
7. How Long have you been using LARC? *(Not the reinsertion period. The first use)*

Age Range	Number of Participants
18-24	
25-34	
35-44	
45+	

8. What did you think the benefits were for the long acting family planning method before you started using it? _____

   _____

9. And what were your reservations (fears) about the LARC methods before you started using it?_____

   _____

Now that you are using it, what has been your experience_____

_____

10. Was the health care provider able to answer your questions about your health or about the LARC method you chose? Probe for type of questions and providers response and what was omitted

    _____

    _____

11. What type of side effects have you been experiencing? Probe – Let them mention the type of side effects and record the number of respondents that mentioned the specific side effect?_____

    Copper T (10 Yrs):_____
    IUD (5 Year):_____
    Jadelle 5 Years):_____
    Implanon (3 years):_____

    For those that had side effects what did you do about the side effect?
    Copper T (10 Yrs):_____
    IUD (5 Years):_____
    Jadelle (5 Years):_____
    Implanon (3 years):_____

12. When was the last time you visited the clinic for LARC? What was the reason you went to the clinic? [Probe: follow-up, side effects, method discontinuation]?

    _____

Are you satisfied with the LARC services you receive at the facility? Ask them to explain their reasons. If yes, please explain why

_____

If no, please explain why

_____

In the future, if you need LARC services will you come back to this clinic again? Why *(Assuming you had a child and you want to continue with LARC){Ask them to explain their reasons}*_____

_____

13. Do the health workers encourage you to discuss FP with your husband/partner? Number, Let them explain?_____

_____

14. How many of you discussed your decision to use LARC with your husband/partner?

Record number out of total number of respondents _____

Why did you not discuss the use of LARC with your husband/partner?_____

_____

If you discuss with your husband/partners how did it affect your decision to use LARC?

_____

Do you feel your husband/partner is supportive of your decision to use LARC? probe for what type of support he provides?_____

_____

If no what do you think are his reasons for not supporting your decisions?_____

15. Does someone go with you to the FP clinic? [Probe: your husband/partner, friend, relative]?_____

16. Do you know the any organization that support the provision of LARC services in your community?

Mention name of organization:_____
What support have they provided in your community:_____

17. Have you heard of Family Health Plus (FH+) in your community?
Record the number_____

18. What did you hear about FH+?_____

19. Are you familiar with FH+ activities? _____

20. How did you hear about FH+? [Probe: radio, posters, word of mouth, social media).

_____

21. What are your suggestions for the improvement of LARC services offered in this facility?

_____

22. What would you suggest for increasing the uptake of LARC services?

_____

Thank you for your time and cooperation.

End-of-Project Evaluation of FH+ Project July 2017

Exit Interview for Clients

Introduction: *My name is (**Name of the interviewer**); I am working for GH Pro, a USAID contractor on Monitoring and Evaluation. We are evaluating the USAID/FH+ project in order to find out its impact, therefore we are interviewing individuals who directly or indirectly benefit or are involved in the project's activities.*

Confidentiality and consent: *I am going to ask you questions some of which may be personal, and will also use an audio recorder. Your answers will be kept strictly confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place in other health facilities that are involved in the project in 4 other states as well. I will greatly appreciate your help in responding to this survey. May I continue? Yes ( ) No ( )*

A. Identification

1. State:_____ LGA:_____
2. Facility name:_____
3. Name of the interviewer:_____
4. Date of interview: _____

B. Background characteristics

1. **Age as at last birthday**:_____
2. **Sex:** Male …….1 Female ……2
3. **Marital status**: Single: --1, Married: --2, Separated: --3, Divorced: --4, widowed: --5, Living with a partner……. 6
4. **Highest education completed**

No education--1. Quranic --2, Primary --3, Secondary--4, Post-secondary--5, Graduate---6

5. **Occupation**:

Schooling--1, Unemployed--2, House wife--3, Trading--4, Professional--5, Farming---6

6. **Parity**: Number of children you have:_____; Age of last child (in months):_____

C. Effects of FH+ activities

1. (a) What LARC services have you been receiving in this facility? (***Circle as many as appropriate***)

   10-year IUD……...1, 5-year IUD……..2, 5-year implant (Jadelle)……..3, 3-year implant (Implanon)…….4

   Other (specify)_____

   (b) What service(s) were offered to you today? _____

2. How has LARC affected the wellbeing of your family members? Give examples

   _____

   _____

3. How many years have you been using FP? _____

4. Have you used another FP method in the past? Yes ----1, No-----2
   If yes, which method(s)_____

   Why did you change to the current FP method you are using?

   _____

5. Were you told about the benefits and possible side effects of the method you are using?
   Yes-----1, No-----2

   What informed your judgment regarding the utilization of this facility?

   _____

6. Were you given any information about STI/HIV prevention and condoms at this facility? Yes ----------1, No---------2
7. Were you given any pamphlets or brochures with information on different FP methods to read (or have someone read for you) at home? Yes---------1, No---------2
8. Do you feel your FP method choice was respected by the provider? Yes---1, No----2
9. For women: was your husband's permission required as a condition for providing you with a LARC method? Yes----------1, No----------2

If yes, was it: Written consent----------1, Verbal consent----------2

10. Were you offered any incentives based on your decision to accept LARC method? Yes-------1, No-------2 Comments (if any)_____ _____

D. Client Satisfaction

1. Do you feel that the waiting time was?
   Too Long: Yes--1 No--2
   Comment:_____

   Too Short: Yes--1 No--2
   Comment:_____

   Okay: Yes--1 No--2 Comment:_____

   Others Specify ----------
   Comment:_____
2. Do you feel that the provider welcomed you politely? Yes--1 No—2
   Comment:_____
3. Did you clearly understand all the information given to you by the provider? Yes--1 No--2
   Comment:_____
4. Did you feel comfortable asking questions during the consultation? Yes--1 No--2
   Comment:_____
5. Do you feel that the time you spent with the provider during consultation was?
   Too Long: Yes--1 No--2
   Comment:_____

   Too Short: Yes--1 No--2
   Comment:_____

Okay: Yes--1 No--2 Comment:_____

Others Specify ----------
Comment:_____

6. Do you feel that you were treated well by the provider? Yes---------1 No—-----2
   Comment:_____
7. Do you believe you received good care *(actual Service*) from your provider? Yes…1 No….2
   Comment:_____
8. Do you feel that you were treated well by the staff? Yes----------1 No--------—2
   Comment:_____
9. In your own opinion did you have enough privacy during the consultation? Yes---1 No--2
   Comment:_____
10. How much did you pay for LARC services?_____ _____
11. Are you satisfied with the price paid? Yes---------1 No—------2
    Comment:_____
12. Were you satisfied with the service that you received today?
    Very satisfied----1, Satisfied-------2, Dissatisfied------3, Very dissatisfied--------4

    Comment:_____
    _____

10. Would you willing come back to this service provider that attended to you? Yes-----1 No-—2

    Comment:_____
    _____

13. Would you recommend this health provider to your family and friends? Yes------1 No-----—2

    Comment:_____
    _____

E. Gender

1. Do the FP providers encourage you to discuss FP with your spouse/partner?
   a. Yes---------1, No----------2
2. Do the FP providers encourage you to come to the clinic with your spouse/partner?
   a. Yes---------1, No----------2
3. Do men come to this facility for FP information and services?
   a. Yes----------1, No---------2 Don't Know-------3
4. Do men come to this FP clinic with their wives/partners?
   a. Yes----------1, No---------2 Don't Know-------3
5. Has your husband/partner ever visited the FP clinic with you?
   a. Yes---------1, No----------2

Comment:_____

6. Sex of Provider that provided FP services today? Male ---------1, Female ----------2

F. Recommendations

What are your suggestions for the improvement of LARC services offered in this facility?

_____

What would you suggest for increasing the uptake of LARC services?

_____

Thank you for your time and attention

FH+ PROJECT FACILITY ASSESSMENT

Please administer this assessment to the Staff in-charge of the health facility. Respond to each question as completely as possible and add all comments in the space provided at the end of the assessment. Please read the following paragraph to the respondent before beginning the interview:

I am here today on behalf of GH Pro to conduct an assessment of your facility to enable us assess the impact of the FH+ Project. Your participation in this process is very important. Your responses will be kept confidential. No institution or individual will be identified by name in the final report.

We ask you to respond to each question to the best of your ability. If you have questions at any moment during the interview, do not hesitate to ask. Do you agree to participate in this assessment?

If the respondent agrees to participate in the assessment, place an « X » in the following box.

☐ **The respondent agreed to participate in the assessment.**

Interviewer's name: _____Date:_____

State: _____ LGA _____

Name of facility: _____

Type of facility:

Primary Health center……..…..……1

General hospital……..……...…….2

Other (specify) ……..4

Affiliation of facility:

LGA……1

State…….2

Federal……..……3

Other (Specify) ……...…….4

RESPONDENT'S BACKGROUND

1. Title of the respondent: _____
2. Number of years of service in the facility: [ ] Years
3. Professional cadre of the respondent:

Doctor……...1

Nurse……...…… …….2

Midwife…… ..…… … …3

Nurse/Midwife…… ……4

SCHEW……..……5

JCHEW……..……...……6

Community Health Officer……..…….. ……7

Other (specify) _____

4. Can you give me the salary range per month for JCHEWs (junior CHEW) at your facility?_____

5. Can you give me the salary range per month for S CHEWs (senior CHEW) at your facility?_____

6. Can you give me the salary range per month for nurses/midwife at your facility?

_____

GENERAL OBSERVATION

S/N	Things to Observe	Yes	No	Comment
1	Are the facility grounds well maintained? (vegetation, stagnant water, Trash, debris)	1	2	
2	Is the facility clean and tidy? (floor, walls, ceiling)	1	2	
3	Is the facility well ventilated?	1	2	
4	Are health workers neat and tidy? (uniforms, shoes)	1	2	
5	Are there toilets for clients?	1	2	
6	Are there toilets for staff?	1	2	
7	Is there a private area for FP counseling?	1	2	
8	Is there a procedure area for IUD and implants?	1	2	
9	Availability of water supply/back up	1	2	
10	Availability of electricity supply/back-up	1	2	
11	Availability of waste disposal system – incinerator, burying	1	2	
12	Availability of communication materials/posters	1	2	
13	PMTCT services	1	2	
14	ANC services	1	2	
15	Delivery services	1	2	
16	Postnatal services	1	2	

FACILITY STAFFING

Does the facility have the following staff?	FEMALES				MALES			
	Total No.	No. Trained on FP	No. Trained on LARC		Total No.	No. Trained on FP	No. Trained on LARC	
			FH+ Training	Other Training			FH+ Training	Other Training
CHEWs								
Nurses								
Midwives								
Nurse/Midwives								
Doctors (General Medical Officers)								
Gynaecologist								
Others Specify								
Total								

SCHEDULES

1. How many days per week does this facility offer FP services? [ ]

Please, specify which days……

What time does the FP clinic open?_____

What time does the FP clinic close? _____

Do you have group counselling on FP? Yes _____1, No _____2

2. How often do you have the FP group Counselling?.....
3. Where do you usually have your FP group counselling sessions?.....
4. How often does the facility get new supplies of FP commodities?

Twice in a Month _____ (__)
Monthly _____ (__)
Bi monthly _____ (__)
Quarterly _____ (__)
Every 6 months _____ (__)
Others Specify ----------

6. Have you had stock outs of FP commodities in the last three (3) months? Yes __1 No __2

If yes, which one(s)? _____

And why? _____

Are the following equipment and supplies available, accessible and in working order? (ASK TO SEE AND CHECK)

Equipment/Supplies	Available Today?		Readily Accessible?		Working Correctly?	
	Yes	No	Yes	No	Yes	No
Client record forms and files	1	2	1	2	1	2
Thermometer	1	2	1	2	1	2
Xylocaine injection	1	2	1	2	1	2
Communication materials for FP, LARC e.g. posters, counseling flip charts, brochures, job aids, counseling cards, etc	1	2	1	2	1	2
Light source	1	2	1	2	1	2
Weighing Scale	1	2	1	2	1	2
Sphygmomanometer	1	2	1	2	1	2
Scissors	1	2	1	2	1	2
Sterile needles and syringes	1	2	1	2	1	2
Sterile gloves	1	2	1	2	1	2
FP – cycle beads	1	2	1	2	1	2
FP - Male condoms	1	2	1	2	1	2
FP- Female Condom						
FP – Pills	1	2	1	2	1	2
FP – Depo Provera	1	2	1	2	1	2
FP – Noristherat						
FP – IUD (copper)	1	2	1	2	1	2
FP – LNG IUS (progesterone IUD)	1	2	1	2	1	2

Equipment/Supplies	Available Today?		Readily Accessible?		Working Correctly?	
	Yes	No	Yes	No	Yes	No
FP – Jadelle	1	2	1	2	1	2
FP – Implanon	1	2	1	2	1	2
FP – permanent methods	1	2	1	2	1	2
Appropriate storage facilities for FP commodities (free from rain, products off floor and on shelves)	1	2	1	2	1	2
Equipment for LARCs – specula, insertion and removal kits for IUDs and implants	1	2	1	2	1	2
Infection prevention equipment/supplies (cotton wool, antiseptics, disinfectants, soap, detergent, autoclave, etc)	1	2	1	2	1	2
Infection prevention: waste containers – sharps boxes, pedal bins	1	2	1	2	1	2

HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) AND RECORDKEEPING

A. Which documentation are available at the facility for FP?

Register	Yes	No
NHMIS FP Register	1	2
NHMIS Summary Report/sheet	1	2
Daily Consumption Record	1	2
Others Specify	1	2

B. Reporting

i. Do you use the Mobile DHIS2 to transmit your data Yes……..1, No……..2

ii. If yes, when did you start using the mobile application? ……

iii. What is the frequency of reporting using the mobile application?.....

iv. What challenges did you encountered while using the mobile DHIS 2?.....

v. Were you able to resolve the issue? Yes ……..1 No…….2

vi. How did you resolve the issue?.....

vi. Why were you not able to resolve the challenge?.....

vii. How could the use of the mobile DHIS2 be improved in health facilities?.....

For the services in the following tables, check all that apply and include the actual figure for 2013 to 2017.

C. Number of Clients Counseled on FP in the Facility from 2013 to Date

FP Counseling	2013	2014	2015	2016	2017 to June	Total
Female						
Male						
TOTAL						

D. Facility FP Uptake/Service Data 2013 to Date

FP Methods	2013	2014	2015	2016	2017 to June	Total
IUD (copper)						
levonorgestrel intrauterine system (LNG IUS)						
Jadelle						
Implanon						
Cycle beads						
Pills						
Depo						
Noristerat						
Male Condoms						
Female Condom						
Female sterilization						
Vasectomy						

Interviewers Comments: (Please note any additional observations here):

……
……

Cost, Utility & Maintenance

1. How much does your facility pay for electricity?_____
2. In this area how much does it cost to rent a generator per day?_____
3. In this area how much does it cost to buy a bucket of water?_____
4. How much does it cost to rent a room per month in this area?_____
5. How much do you spend on maintenance at this facility on a monthly basis?
6. How much did you spend monthly on internet services to send data to DHIS? _____
7. If you don't have the DHIS phones how much did you spend monthly on transport to send in your data to the Local Government Authorities?

Checklist for Family Planning Counseling Skills
(To be completed by Observer)

State:_____ **LGA**_____

Name of Facility_____

Type of Provider _____

Name of Observer _____

Date of Visit _____

Tick the appropriate box as follows:

Satisfactory: Performs the step or task according to standard procedure or guidelines

Unsatisfactory: Does not perform the step or task according to standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
Initial Interview			
1. Greets woman respectfully and with kindness.			
2a. Assures necessary auditory privacy.			
2b. Assures necessary visual privacy.			
3. Obtains biographic information (name, address).			
4. Provides general information about family planning.			
5. Explores any attitudes or religious beliefs that either favor or rule out one or more methods.			
6. Gives the woman information about the contraceptive choices available and the risks and benefits for each. 6a. Shows where and how each is used 6b. Explains how the method works and its effectiveness 6c. Explains possible side effects and other health problems ● Explains the common side effects			
7. Discusses client's needs, concerns and fears in a thorough and sympathetic manner.			
8. Helps client begin to choose an appropriate method using the BCS+ tools if available.			
Client Screening			
1. Screens client carefully to make sure there is no medical condition that would be a problem (uses Medical Eligibility Criteria).			
2. Explains potential side effects and make sure that each is fully understood.			

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
3. Performs further evaluation (physical examination), if indicated. (Non-medical counselors must refer client for further evaluation.)			
4. Discusses what to do if the client experiences any side effects or problems.			
5. Provides follow-up visit instructions.			
6. Assures client she can return to the same clinic at any time to receive advice or medical attention.			
7. Asks the client to repeat instructions.			
8. Answers client questions.			

- Provision of services: ☐ Satisfactory ☐ Unsatisfactory
- Duration of counseling? _____

Comments:

_____

Observer's Signature_____ Date_____

Checklist for IUD Counseling and Clinical Skills
(To be completed by Observer)

Instructions: Ask and receive consent for observations. If in the same room with client during observations, then get consent from both provider and client.

[Give instructions for where the observer should be in the room, especially in the exam room. These observations may be considered intrusive, and observer needs to handle them carefully and use discretion. Consider not observing the IUD insertions/removals, and only ask the provider about what was done]

Name of Provider _____

Name of Facility _____

Name of Observer _____

Date of Visit _____

Tick the appropriate box as follows:

Satisfactory: Performs the step or task according to standard procedure or guidelines

Unsatisfactory: Does not perform the step or task according to standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
IUD Insertion			
1. Greets client respectfully and with kindness.			
2. Asks woman about her reproductive goals and need for protection against STDs.			
3. If IUD counseling not done, arranges for counseling prior to performing procedure.			
4. Determines that the woman's contraceptive choice is the IUD.			
5. Reviews Client Screening Checklist to determine if the IUD is an appropriate choice for the client.			
6. Assesses woman's knowledge about the IUD's major side effects.			
7. Is responsive to client's needs and concerns about the IUD.			
8. Describes insertion procedure and what to expect.			
9. Obtains or reviews brief reproductive health history.			

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
10. Checks that client has recently emptied her bladder and washed and rinsed her genital area if necessary.			
11. Tells client what is going to be done and encourages her to ask questions.			
12. Washes hands thoroughly and dries them.			
13. Palpates abdomen and checks for lower abdominal, especially suprapubic, tenderness and masses or other abnormalities.			
14. Puts new examination or sterile surgical gloves on both hands.			
15. Arranges instruments and supplies on high-level disinfected or sterile tray.			
16. Performs speculum examination.			
17. Collects vaginal and cervical (urethral) specimens if indicated.			
18. Removes speculum and either sets aside on instrument tray or places in 0.5% chlorine solution for 10 minutes for decontamination if another high-level disinfected speculum is available for use.			
19. Performs bimanual examination.			
20. Performs rectovaginal examination if indicated. ● Immerses both gloved hands in 0.5% chlorine solution. ● Removes gloves by turning inside out and disposes of gloves in leakproof container or plastic bag.			
21. If **not** performing rectovaginal examination, immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out then disposes in leakproof container or plastic bag.			
22. Washes hands thoroughly and dries them.			
23. Loads Copper T 380A in sterile package.			
24. Puts new examination or sterile surgical gloves on both hands.			
25. Inserts vaginal speculum to see cervix.			
26. Applies antiseptic solution two times to cervix, especially the os, and vagina.			
27. Gently grasps cervix with tenaculum.			
28. Sounds uterus using no-touch technique.			
29. Inserts the Copper IUD using the **withdrawal** technique.			

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
30. Cuts IUD strings to 3-4 cm in length or does not cut depending on local protocol			
31. Gently removes tenaculum and speculum and places in 0.5% chlorine solution for 10 minutes for decontamination.			
32. Before removing gloves, places all instruments in 0.5% chlorine solution for 10 minutes for decontamination.			
33. Disposes of waste materials in leak-proof container or plastic bag.			
34. Immerses both gloved hands in 0.5% chlorine solution and removes gloves by turning inside out then disposes in leak-proof container or plastic bag.			
35. Washes hands thoroughly and dries them.			
36. Completes client record.			
37. Teaches client how and when to check for strings.			
38. Discusses what to do if client experiences any side effects or problems.			
39. Provides follow-up visit instructions and answers any questions.			
40. Assures client that she can have the IUD removed at any time.			
41. Observes client for at least 15 to 20 minutes before sending her home.			

Step/task	Satisfactory	Unsatisfactory	Not Observed/ Comments
IUD Removal			
1. Greets client respectfully and with kindness.			
2. Asks client her reason for removal and answers any questions.			
3. Reviews client's reproductive goals and need for protection against STDs.			
4. Describes the removal procedure and what to expect.			
5. Checks to be sure client has emptied her bladder and washed and rinsed her genital area if necessary.			
6. Tells client what is going to be done and encourages her to ask questions.			
7. Washes hands thoroughly and dries them.			
8. Puts new examination or sterile surgical gloves on both hands.			

Step/task	Satisfactory	Unsatisfactory	Not Observed/ Comments
9. Performs bimanual exam.			
10. Inserts vaginal speculum to see cervix and IUD strings.			
11. Applies antiseptic solution two times to the cervix, especially the os, and vagina.			
12. Grasps strings close to cervix and pulls slowly but firmly to remove IUD.			
13. Shows IUD to client.			
14. Immerses IUD in 0.5% chlorine solution and disposes of in leakproof container or plastic bag.			
15. Gently removes speculum and places in 0.5% chlorine solution for 10 minutes for decontamination.			
16. Before removing gloves, places all instruments in 0.5% chlorine solution for 10 minutes for decontamination.			
17. Disposes of waste materials in leakproof container or plastic bag.			
18. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out then disposes in leakproof container or plastic bag.			
19. Washes hands thoroughly and dries them.			
20. Records IUD removal in client record.			
21. Discusses what to do if client experiences any problems and answers any questions.			
22. Counsels client regarding new contraceptive method, if desired.			
23. Helps client obtain new contraceptive method or provides temporary (barrier) method until method of choice can be started if in need of contraception.			

- Provision of services: ☐ Satisfactory ☐ Unsatisfactory
- Duration for IUCD insertion: Start time____ to End time_____

Observer's Signature_____ Date_____

Checklist for Contraceptive Implants
(To be completed by Observer)

Instructions: Ask and receive consent for observations. If in the same room with client during observations, then get consent from both provider and client.

[Give instructions for where the observer should be in the room, especially in the exam room. These observations may be considered intrusive, and observer needs to handle them carefully and use discretion.]

Name of Provider _____

Name of Facility _____

Name of Observer _____

Date of Visit _____

Tick the appropriate box as follows:

Satisfactory: Performs the step or task according to standard procedure or guidelines

Unsatisfactory: Does not perform the step or task according to standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
Implant Insertion			
1. Greets client respectfully and with kindness.			
2. Asks woman about her reproductive goals and need for protection against STDs.			
3. If Implant counseling not done, arranges for counseling prior to performing procedure.			
4. Determines that the woman's contraceptive choice is the Implant.			
5. Reviews Client Screening Checklist to determine if the Implant is an appropriate choice for the client.			
6. Assesses woman's knowledge about the Implant's major side effects.			
7. Is responsive to client's needs and concerns about the Implants.			
8. Assures client that the Implants can be removed whenever she wants.			
9. Obtains or reviews brief reproductive health history.			
10. Describes insertion procedure and what to expect.			

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
11. Tells client what is going to be done and encourages her to ask questions.			
12. Checks to be sure that client has thoroughly washed and rinsed her entire arm (optional)			
13. Tells client what is going to be done and encourages her to ask questions			
14. Positions client's arm on a clean, dry cloth			
15. Washes hands thoroughly and dries them.			
16. Puts new examination or sterile surgical gloves on both hands.			
17. Inserts Implants using correct sterile technique and local anaesthetic.			
18. Performs appropriate post-procedure infection prevention tasks.			
19. Instructs client about wound care. Tells client there may be bruising and slight bleeding at the insertion site during the first few days; this is normal.			
20. Completes client record and clinic register.			
21. Discusses what to do if client experiences any side effects or problems.			
22. Provides follow-up visit instructions and answers any questions.			
23. Assures client that she can have the Implants removed at any time.			
24. Observes client for at least 15 to 20 minutes before sending her home.			

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
Implant Removal			
1. Greets client respectfully and with kindness.			
2. Asks client her reason for removal and answers any questions.			
3. Reviews client's reproductive goals and need for protection against STDs.			
4. Describes the removal procedure and what to expect.			
5. Checks to be sure client has thoroughly washed and rinsed her entire arm.			
6. Tells client what is going to be done and encourages her to ask questions.			
7. Determines that the required sterile or high-level disinfected instruments are present.			

Step/Task	Satisfactory	Unsatisfactory	Not Observed/ Comments
8. Washes hands thoroughly and dries them.			
9. Puts new examination or sterile surgical gloves on both hands.			
10. Removes the Implants using the correct sterile technique.			
11. Performs appropriate post-procedure infection prevention tasks.			
12. Instructs client regarding wound care and makes return visit appointment, if necessary			
13. Discusses what to do if any problems occur and answers any questions			
14. Counsels client regarding new contraceptive method, if desired			
15. Helps client obtain new contraceptive method or provides temporary (barrier) method until method of choice can be started			
16. Records removal and new method chosen (if appropriate) in client record and clinic register.			
17. Observes client for at least 15 to 20 minutes before discharging.			

- Provision of services: ☐ Satisfactory ☐ Unsatisfactory
- Duration for Implant insertion: Start time____ to End time_____

Observer's Signature_____ Date_____

FH+ EVALUATION QUESTIONNAIRES

Date: _____ **Name of respondent:** _____

State: _____ **Location:** _____

Name of Interviewer: _____ **Tel No**: _____

KEY INFORMANT INTERVIEW: FH+ TECHNICAL STAFF AND PARTNERS

Good morning. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus Project. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour.

Do I have your permission to begin?

1. What was your role at FH+? And, how long were you with the project?

_____

_____

[If a subcontractor: What was your organization's role under FH+?]

2. From your experience with the FH+ Project what would you identify as its major accomplishment in improving LAC services in Nigeria?

_____

_____

3. What are examples of project activities that you feel worked well?

   _____

4. What are examples that you feel did not work well?

_____

5. Are there any special policies or issues in the implementation of LAC activities that hampered FH+'s work? Yes or No If so, can you give examples?

   _____

   How did you deal with these?

6. [Policy] Did you apply the SMART approach to your advocacy work? Yes No

   What was the profile of the people that implemented the SMART approach?

   _____

   How effective was it in affecting the change you wanted to see in your state?

   _____

   What parts of SMART worked for you? _____

   How would you revise it, if you could? _____

8. Did it improve efficiency in data collection? Explain

   _____

9. Will the government of Nigeria be able to continue and expand the use of mobile DHIS in public facilities at the end of FH* project? Explain

   _____

   _____

10. FH+ is working in 20 states. Based on what you have seen do you believe that the program has been cost effective. Can you give examples if Yes, or No. _____

11. What type of demand creation and public awareness activities were done under FH+ to reach Result #3?

    _____

    Do you feel these activities were effective? If so, can you give examples:

    _____

12. How did you measure the impact of the demand creation and awareness activities?

    _____

14. Do you think the project has had a positive influence in gender issues?

_____

    Can you give an example of what FH+ did that influenced gender issues and social inclusion?

_____

_____

15. Has this program been collaborative in working with all members of the program? Has it been collaborative with the government? Other projects?

_____

_____

16. For a future program, what would you recommend be done differently?

    _____

    _____

17. With Nigeria's official CPR and CYP's for FP especially LARC are very low, how do you explain HP+s LARC impact?

18. Were there unexplored innovative cost-effective strategies that could have been used under this project? Explain

19. For a future program, what would you recommend be done differently?

    _____
    _____
    _____

That is the end of our interview. Do you have any questions for us?

Thank you again for your time.

Date: _____ **Name of respondent:** _____

State: _____ **Location:** _____

Name of Interviewer: _____ **Tel No**: _____

KEY INFORMANT INTERVIEW: USAID/Nigeria – Technical Officers

Good morning. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour. Do I have your permission to begin?

1. How long have you been at USAID/Nigeria? _____
2. Were you involved with the FH+ project and if so, in what capacity?

_____

3. In your opinion, what were the successes of FH+?

_____

Why do you think these were successful?

_____

4. What were the areas that you think FH+ did not excel?

_____

Why do you think these were not successful or did not reach the objectives?

_____

5. From your observations how well did FH+ work with the government at the federal and at the state levels? Give examples of activities?

_____

6. How well did they work with the other USAID-funded projects? SHOPS? ESMPIN? Policy? Give examples

_____

_____

7. Are you familiar with the SMART approach used by Palladium for the advocacy and policy Results #2?

_____

8. From your observation was the approach effective? Or asked another way, did you see policy shifts or changes take place?

_____

9. What do you know about the program's public awareness and demand creation plan? Give examples

_____

_____

10. What do you know about the use of Mobile DHIS to collect and report data on the National DHIS system?

_____

_____

11. From your observation was the use of mobile DHIS effective? Explain

_____

_____

12. Did it improve efficiency in data collection? Explain

_____

_____

13. What were the advantages and disadvantages experienced with the use of the mobile DHIS?

_____

_____

14. What could FH+ have done differently as regards to the deployment and use of the mobile DHIS?

_____

_____

15. Will the government of Nigeria be able to continue and expand the use of mobile DHIS in public facilities at the end of FH* project? Explain

_____

_____

16. From your experience with FH+ do you believe what it has accomplished is sustainable? Will the government of Nigeria be able to continue and expand the LARC services in the public facilities?

_____

_____

17. Can you site gender activities that were part of FH+?

_____

What accomplishments has FH+ made in gender?

_____

18. Without looking at budgets do you believe FH+ has been cost effective? Has it had a good return on investment?

_____

19. Overall do you think they accomplished the FH+ objectives?

_____

20. If you were to redesign the project or do it again, what would you change?

_____

What would you keep the same?

_____

This is the end of my questions. Is there anything you want to ask or say that we didn't raise?

Thank you.

KEY INFORMANT INTERVIEW:

GOVERNMENT OF NIGERIA, MINISTRY OF HEALTH OFFICIALS

(FEDERAL AND STATE)

Date: _____ **Name of respondent:** _____

State: _____ **Location:** _____

Name of Interviewer: _____ **Tel No**: _____

Good morning. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus Project in Nigeria. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

Our interview will take about one hour. Do I have your permission to begin?

1. Are you aware of USAID-funded Family Health Plus Program? Yes …. 1 No….2

2. Has your office worked with FH+? Yes …. 1 No….2

   If so, how did you or your office work with them?

_____

_____

_____

3. Can you describe what you think FH+'s accomplishments have been in Nigeria *[or state]?*

_____

_____

_____

   a. Specifically, do you believe that FH+ has contributed to improved family planning services at the public health clinics in the communities and states where it has worked?

_____

_____

b. Do you believe because of its work that FH+ has contributed to any increases in family planning (LARC) and uses of health services in Nigeria [*the state*]?

_____

_____

4. One of the goals of USAID under the FH+ Project was to establish a sustainable model in family planning services. Do you believe FH+ has accomplished its sustainability goal?

_____

_____

a. Can you provide examples of what you see as long-lasting or sustainable outputs from the program? [Probe: products, community based distribution, access to affordable products]

_____

_____

b. What plans did the government have to continue the training and provision of LARC services after the end of FP+ Project?

_____

_____

5. What do you know about the use of Mobile DHIS to collect and report data on the National DHIS system?

   _____

   _____

6. What role did FH+ played in the use of mobile DHIS for reporting?_____

   _____

7. From your observation was the use of mobile DHIS effective? Explain

   _____

   _____

8. From your observation did it improve efficiency in data collection? Explain

   _____

   _____

9. How many HFs were using the Mobile DHIS to send their report in 2014? _____

10. How many are currently using the Mobile DHIS to send their report in 2017?_____

11. What challenges were experienced in the use of the mobile DHIS and how were they addressed?

_____

_____

12. What were the advantages and disadvantages of using the mobile DHIS?

_____

_____

13. What could FH+ have done differently as regards to the deployment and use of the mobile DHIS?

_____

_____

14. What plans are put in place to continue and expand the use of mobile DHIS in public facilities after FH+ project? Explain

_____

_____

15. Can you give examples of how you think FH+ addressed or did not address gender issues in its activities?

_____

_____

16. How did the FH+ project support the government to implement the task shifting policy?

_____

_____

17. What would you identify as lost opportunities under FH+?

_____

_____

That is the end of our interview. Do you have any questions or comments for us?

Thank you again for your time.

KEY INFORMANT INTERVIEW:

Mobile DHIS Consultant

Date: _____ **Name of respondent:** _____

State/Federal: _____ **Location:** _____

Name of Interviewer: _____ **Tel No**: _____

Good morning. Thank you for meeting with us. I am ____, (title) for an evaluation of the Family Health Plus Project in Nigeria. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

*Our interview will take about one hour. Do I have your permission to begin****? Yes….1 No…2***

1. How familiar are you with the USAID-funded Family Health Plus Program?

_____

_____

2. In which capacity did you work with them?

_____

_____

3. The DHIS instance used for the mobile devices is it a new instance or an existing instance?
Yes…..1 No……..

4. If an old instance who owns the instance and what addons were put on the instance?

_____

_____

5. From your observation was the use of mobile DHIS effective in reporting and analysis? Explain

_____

_____

6. From your observation did it improve efficiency in data collection and reporting? Explain

_____

_____

7. What challenges were experienced in the use of the mobile DHIS and how were they addressed?

_____

_____

8. What were the advantages and disadvantages of using the mobile DHIS?

_____

_____

9. What could FH+ have done differently as regards to the deployment and use of the mobile DHIS?

_____

_____

10. What plans are put in place to continue and expand the use of mobile DHIS in public facilities after FH+ project? Explain

_____

_____

11. As the group managing the national DHIS instance, what are the gaps that still exist which should be addressed to make the system effective and efficient?

_____

_____

12. What should be done by stakeholders to improve the use of mobile DHIS in the country?

_____

_____

13: Other Comments and Recommendations:

_____

_____

Thank you for your time

ANNEX VI. STATEMENT OF DIFFERENCES

FH+ evaluation report – Statement of Difference

We are grateful to USAID Nigeria for this opportunity to submit a Statement of Difference to be annexed to the FH+ Project Evaluation Report. Below is a summary of the principal issues raised in the report and our responses. We found numerous issues with the report's methodology, basis for findings and evaluative framework of reference.

As mentioned in our initial response, we would like the opportunity to participate in the design of future evaluations of our USAID-funded public-sector support activities to ensure a stronger evaluation product which can be used for programmatic improvement and learning, as well as understanding the dynamics with which the public-sector intervention operates.

1. **Clinical quality of counselling and voluntary LARC service provision by observed public sector providers**

The evaluation report outlines serious issues with provider competence in voluntary LARC provision. Clinical quality is at the heart of Marie Stopes International Organisation Nigeria (MSION)'s work, and we are concerned by these findings. However, the methodology used by the evaluation to select providers for observation makes it difficult for us to draw clear conclusions from these findings.

Under the FH+ project, 72% of trained providers were certified as competent to provide voluntary LARC services. As is common in the public health sector, many of the providers trained under FH+ have been moved to different facilities since the end of the project. Instead of seeking out and observing providers based on a list of those certified by the FH+ project, the evaluators visited facilities where trained providers had been present for part or all of the project. The evaluators did not request names of the providers who were observed and did not confirm whether they had been certified under FH+. It is therefore not possible to know whether observed providers had been certified by FH+, trained but not certified, or not trained but simply present in a facility where another provider had been trained under FH+. This makes it difficult to draw meaningful conclusions regarding the quality of provision by providers certified under FH+.

Similarly, it is difficult to ascertain from the evaluation report whether supportive supervision requirements were met or otherwise for the observed providers. All certified providers (1,549) received at least three supportive supervision visits under the FH+ project. However, those who were not trained under FH+ (but are now working in facilities supported under FH+) would not have received supportive supervision, and 28% of those who were trained did not proceed to certification and may not therefore have received 3 supportive supervision visits. The majority of those who did not proceed to certification were in Lagos State, where the state Ministry of Health did not permit MSION to conduct post training supportive supervision visits, and therefore no providers in Lagos were certified. The evaluators were made aware of this but still undertook provider observations in Lagos State.

The report also notes that providers trained under the project 'were not confident in conducting the service delivery'. We are unclear on the grounds for this finding, as elsewhere the report notes that 83% of providers commenced voluntary LARC services after training by FH+ and that all were satisfied by the training received, noting that the training improved their voluntary FP skills and resulted in increased LARC uptake.

There are also several instances in the report where broad conclusions relating to the impact of clinical quality on client outcomes and perspectives seem to be drawn from single instances and over-extrapolated. For example, the possibility of poor provider counselling leading to implant side effects

was cited by only one facility, but is credited with 'allowing rumours and misinformation about FP and LARC to continue to spread [serving as] deterrents to women and their partners accepting LARC'. Additional evidence is needed to substantiate this conclusion. It is also important to note that over the life of the FH+ project, a total of 329,610 implants, 34,824 IUCDs and 71 LNG-IUS (Levonorgestrel Intrauterine System) were delivered by the trained providers. All MSI country programs take part in annual clinical quality audits to ensure that clinical services are of the highest quality, safeguard client wellbeing, and exceed client expectations. MSION already uses learnings from these annual audits of all service delivery channels, including certified public sector providers, to regularly evolve and strengthen its provider training and support packages.

Although MSION is committed to strengthening the quality of voluntary FP counselling and provision, including LARC provision in the public sector, and would welcome the opportunity to learn from these evaluation findings to continue to strengthen our training and support approach, these evaluation-related methodological issues make it challenging for us to identify where changes are required.

2. Approach to selection of Master Trainers under the project

The report notes, based on comments from two training reports, that Master Trainers were not sufficiently proficient in voluntary LARC provision before being taken on and trained as Master Trainers. The evaluators extrapolate from two training reports to suggest that this was the case for the majority of the Master Trainers.

MSION took a health systems strengthening approach to Master Trainer selection under FH+, seeking to build the capacity of government FP focal points in each state by supporting them through the Master Trainer process. Although the majority of those selected as Master Trainers were experienced LARC providers, in a few states, the lack of previous LARC availability in the state meant that there was an absence of experienced providers. For this reason, MSION adopted a two-phase training strategy, with a three month period of observation after the initial training to monitor voluntary LARC proficiency. Only after certification in voluntary LARC provision would the individuals then start their role as Master Trainers.

MSION recognises that, whilst advantageous for health systems strengthening, this approach occasionally resulted in less experienced Master Trainers operating in a minority of states. MSION has therefore adapted our approach for the current project and will be using our own staff and carefully selected expert consultants for the Master Training role moving forward.

3. Issues with evaluation methodology

It is unclear whether this assessment, which included clinical observations and interviews with clients, underwent IRB review. Second, the FH+ partners consider that limiting the selection of evaluation participants to observe by asking for client consent and client exit interviews a missed opportunity. Selection of participants should have factored in whether clients had received services from both certified and non- certified providers. Third, the FH+ partners are concerned about the conflict of interest of having a former MSION employee (who left under unpleasant circumstances) as part of the evaluation team.

4. Cost-effectiveness of the FH+ public provider training approach

The FH+ partners find the costing analysis on p. 22-23 of the report unclear. Table 9 reports total costs of FH+ voluntary LARC service provision of $13,882,397. The entire FH+ budget totalled $9 million, so we are unsure of how the evaluation team came to this significantly higher total. It is also unclear which cost effectiveness criteria or comparator public sector training costings the evaluation team have applied to assess the costs of training a provider as 'exceedingly high'. MSION was committed

throughout FH+ to carrying out project activities as efficiently as possible, mindful of the limited budget and expansive project scope, and we believe that actual project expenditure costs represents good value for money.

5. Requirement for holistic approach to ensure sustainability of voluntary LARC delivery

The report notes that '*In order for LARC service delivery to be sustainable, other elements than provider training need to be functioning. The current public health services are uneven and underserved in many of these key areas, i.e., demand support, unbroken supply chain, financial costs, and incorrect information among providers and women.*'

We agree that strengthening the health system for sustained LARC service delivery is a holistic process. The Mission's approach to the challenge of limited public sector LARC provision rightly involved multiple implementing partners, working in coordination but focused on specific aspects.

At the same time, the conceptual basis for the assertion that without health stronger systems, a network of trained providers is not enough to increase LARC CPRs in Nigeria was not established. While this statement is correct, it does not reflect an understanding of the project's scope. The focus of the FH+ project was to set up a sustainable model for building public sector provider capacity, while other implementing partners focused on other aspects of strengthening the Nigerian health system. This said, there are limits to the level of sustained change achievable in a focused, 3-year project. MSION welcomes the opportunity to re-engage with public sector providers and communities supported under FH+ in the current SIFPO 2 buy-in to further embed health system capacity and provider skills in voluntary FP provision including LARCs, further expanding FP access and choice for these communities.

Lastly, the FH+ evaluation report would benefit from more consideration about what was within and what was outside the project's locus of control. Project, environment, systemic factors are all intermingled in the discussion, as if the project is responsible and in control of all these factors.

6. Lack of focus on demand generation/awareness raising activities

Specifically, the report makes reference to a lack of focus on **demand generation** activities under the FH+ project: '*demand creation and public awareness were done on a very limited scale. What was done was carried out in conjunction with USAID's Expanded Social Marketing Program in Nigeria (ESMPIN) demand campaigns. However, ESMPIN and FH+ did not operate at the same time in many of the same communities or states, which limited the number of demand creation activities. When they did work together, FH+ felt it was successful in increasing LARC acceptance. In communities that did not have ESMPIN, the project (FH+) did not have strategic demand and public awareness plans.*'

The FH+ partners agree that demand generation was not sufficiently emphasised or resourced under the FH+ Project, yet that was how the project was designed. Instead, it was observed that satisfied clients were a major source of client referrals and were used to fill the gap of community mobilisation activities conducted as part of demand generation.
A significant demand generation component was included in the project proposal but was removed at the Mission's request due to ongoing demand generation work by other implementing partners in Nigeria. MSION regularly raised the issue of inadequate synergies between ESMPIN and FH+ with the Mission during the project and proposed alternative approaches. The project was designed to be as low cost as possible to ensure that interventions would be sustainable beyond the life scope of the project.

7. Issues with evaluation of advocacy activities

The report is critical of the advocacy activities undertaken under FH+ and claims that the FH+ project lacked understanding of the value of advocacy. However, the report does not include a well substantiated discussion of results against the project's results framework for advocacy. It also does not effectively or systematically address basic evaluative questions for the advocacy component. The advocacy training curriculum adapted for FH+ is best practice and has been used worldwide. The report would need to include examples to substantiate these claims.

At the same time, the evaluators seem to be conflating policy advocacy with social and behavior change communication--which are quite different in their objectives, approaches, and results gain.

According to the evaluation report *...a few of the AWGs have continued after the program ended; however, only a few states added FP line items in their budgets. Efforts to create an enabling environment through advocacy activities was not a focus of the AWGs and, because of low human and financial resources, the advocacy to create enabling environment was detailed to local civil society organizations. These organizations were not funded and FH+ advocacy messages, communication materials, and strategic goals were not created and it was left to individual organization and states to create their own.*

The project supported FPAWGs to produce state-specific strategies and costed plans, which their respective SMOHs signed off on. The evaluators do not appear to have reviewed the state-level advocacy strategies, which summarized strategic goals, messaging, and tactics.

According to the report, *...messages, counseling, materials, interpersonal communication, and peer-to-peer education were underserved in FH+. The providers, community health extension workers (CHEWs), and traditional birth attendants (TBAs) needed low- or no- literacy materials that addressed side-effects, and pre- and post-counseling.* Please note that the FH+ project did not train CHEWs or TBAs, and did not have developing messages and materials for them as part of its mandate.

8. Inadequate research

According to the evaluation report, *the research under FH+ was inadequate to design and monitor the project. The only research that was conducted was on training (IR1). IR2 and IR3 did not have strategic methodologies to design the demand creation and advocacy or to measure their impac*t.

Impact is typically a long-term effect often at the population level and therefore could not have been measured at the project level. The advocacy strategies produced with project support at the state level were used as a basis for the project's advocacy efforts.

Also, advocacy and demand creation appear to not be understood; they are coupled together in different parts of the report when they are quite distinct approaches.

Third, the evaluation report states that *there was inadequate qualitative and quantitative data available for program design and monitoring and evaluation data*. This statement is surprising, as data quality assessments (DQAs) were conducted twice a year and reports written. Client exit interviews took place twice and reports were written afterwards as well.

9. Ability to meet Cooperative Agreement manager requirements and expectations

The evaluation report notes that *'MSION did not demonstrate during the three-year period that it came to understand the requirements and expectations of being a successful Cooperative Agreement manager. Subsequently, there were whole components of FH+ not completed and others done less than effectively.'* MSION would like to better understand the rationale for this conclusion. Whist managing FH+ was a learning process, MSION has built sound and effective project management and USAID compliance systems through an extensive training process for key staff and with technical assistance from Marie Stopes International (MSI), drawing upon significant expertise in USAID Cooperative Agreement management across the MSI Partnership. Examples used by the evaluators as

evidence of this conclusion do not reflect USAID or specific project requirements. For example, the report notes inadequate record-keeping and incomplete documentation on the basis that *'the project's financials were not calculated or recorded to evaluate the cost-effectiveness of the project'*; this was not a reporting requirement under the project and is not a typical requirement for USAID Cooperative Agreements.

The evaluation report also states that *"There are considerable expectations and requirements that come with managing a USAID cooperative agreement which MSION and MSI did not have"*, despite there being no indication in this report that MSI was evaluated as a subawardee.

10. Achievement of project goals

The report notes that *'FH+'s increase of LARC Contraceptive Prevalence Rate (CPR) was 1.5%, which was a consistent projection based on previous years of LARC. Because advocacy and demand and public awareness were underfunded and the quality of service delivery was determined to be below standard, the expected increase in LARC as a result of FH+'s efforts CPR increase were more muted than expected'*. Elsewhere the report states 'the team observed that uptake of LARC services is low'.

The basis for these conclusions are not clear, and are contradicted elsewhere in the report where the significant increase in LARC uptake under FH+ is noted. There was no CPR goal in the FH+ project, so we are unclear what comparator the evaluators used when they assessed the 1.5% point CPR increase as more muted than expected. Whilst meeting Nigeria's national CPR goals cannot be achieved through a single project, we are proud of the scale-up in LARC access and resulting impact on FP choice and contribution to CPR achieved under this project in a relatively short timeframe, with over 350,000 women taking up a LARC service from providers who in most cases had not been able to provide this service prior to the project, meeting the overall FH+ Program objective of increasing the availability and voluntary uptake of voluntary FP services and exceeding the project CYP expectations.

Lucky Palmer

Digitally signed by Lucky Palmer
DN: cn=Lucky Palmer, o=Marie Stopes International Organisation Nigeria, ou=Programmes, email=lucky.palmer@mariestopes.org.ng, c=NG
Date: 2017.11.02 09:07:18 +01'00'

Year 2014 - 2017 USAID Performance Reporting System for FH+ Project

ANNEX VII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Page 113 of 131

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Dee Bennett	26 May 2017
Signature	Date
Dee Bennett	Managing Partner
Name	Title Anothus Options LLC

401 Nigeria

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature		Date	15/05/17
Name	ADENIJI FOLUKE	Title	DR

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature	Date
Falaye	15/05/2017
Name	**Title**
AWOLEYE Joshua Olatunji	15/05/2017

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

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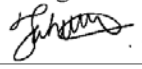

Signature	Date
	05/13/2017
Tahirah Ikharo	Ms.
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature — Date: 30/04/2017

Name: Ayodeji Omotayo Olugbemi — Title — Date: 30/04/2017.

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

OMOBOLA ODUTOLU

Signature	Date
Odutolu	5/6/17
Name	**Title**
OMOBOLA TITILAYO ODUTOLU	MRS

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

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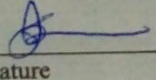	3-5-17
Signature	Date
SA'ADATU SULE	DR
Name	Title

ANNEX VIII. SUMMARY BIOS OF EVALUATION TEAM

Dee Bennett, Team Leader: Dee Bennett is a seasoned social and behavior change professional with more than 25 years of experience in strategic planning and design of donor-funded health programs, including family planning/reproductive health, infectious diseases, maternal and child health, and emergency/pandemic diseases. She is the founder and managing partner of Another Option LLC, a woman-owned small business company with a specialty in social and behavior change and strategic planning in international development. Prior to establishing Another Option LLC she was a Vice-President at AED and a senior technical expert in social behavior change.

Foluke Adenjii, Costing Expert, Dr. Foluke Adeniji is a lecturer and public health physician. A fellow of the West African College of Physicians, she holds an MB. CH.B from Obafemi Awolowo University Ile-Ife and Msc in Health Systems Management from the University of London. She teaches biostatistics, health economics and financing, health systems and reproductive health. Her research interests include health systems, HIV, and epidemiology of infectious diseases.

Joshua Olatunji Awoleye, Research Assistant: Joshua Olatunji Awoleye is an evaluation professional with more than 10 years of experience conducting qualitative and quantitative research to access project/program and stakeholders capacity in Nigeria and other West African countries through key informant interviews, focus group discussions, direct observation, and surveys. He obtained his Master's in Public Health from the Royal Tropical Institute at the University of Amsterdam; Postgraduate Diploma in Project Management from Anglia Ruskin University United Kingdom, as well as an M.Sc. in Social Work at LAUTECH Nigeria and a post-graduate diploma in Development Administration, focused on monitoring and evaluation.

Omobola Odutolu, Family Planning/Reproductive Health Specialist: Omobola Odutolu is a trained nurse with a B.SC Nursing and Masters in Guidance and Counselling, and a trained family planning provider. She is a reproductive health specialist with more than 20 years in the development field having worked with local national and international organization in Nigeria. Mrs. Odutolu is currently a free-lance consultant and has consulted for various organizations on reproductive health issues including HIV/AIDS, maternal and child health, gender, family planning, and adolescent sexual and reproductive health.

Omotayo Olugbemi, Evaluation Specialist: A demographer with more than 30 years' experience in monitoring and evaluation (M&E), Omotayo Olugbemi has experience in the areas of population, reproductive health, maternal and child health, child survival, malaria, orphans and vulnerable children, HIV/AIDS, management information system, and training and education. She is a seasoned evaluator and has led or taken part in research and evaluation activities, and has worked in various USAID-supported projects as an M&E expert.

Rose Mary Romano, Another Option Technical Support, is a skilled public health professional with more than 30 years of experience in managing social and behavior change communication projects for USAID, the Centers for Disease Control and Prevention, The World Bank, and other donors on maternal and child health, water and sanitation, HIV and AIDS, infectious diseases and nutrition. Ms. Romano's communication expertise includes strategic planning, research, design and implementation of

national media and community interventions, public relations, advocacy and monitoring and evaluation. Ms. Romano holds a Master's Degree in Community Health Education and is a Managing Partner of Another Option.

Dr. Sa'adatu Talatu Sule has more than 25 years of work experience in reproductive health in Nigeria. A medical doctor with postgraduate certifications in public health and obstetrics and gynaecology, Dr. Sule began her career working as a lecturer, clinician, and researcher at Ahmadu Bello University Zaria before moving to development work. She has been working full time in development for the past 13 years and has served as a full-time staff with various organizations. She has been working as an independent reproductive/maternal/newborn/child/adolescent health consultant for more than one year. As a consultant, Dr Sule has been involved in various reproductive health assignments including training, curriculum development, operations research, and project evaluation for various organizations.

For more information, please visit

http://ghpro.dexisonline.com/reports-publications

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