

FINAL REPORT

Evaluation of the Maternal, Newborn and Child Health Week in Nigeria



NOVEMBER 2016

UNICEF NIGERIA COUNTRY OFFICE



Evaluation of the Maternal, Newborn and Child Health Week in Nigeria. Final Report

© United Nations Children’s Fund, Nigeria, 2016.
United Nations Children’s Fund
Plot 617/618, UN House,
Diplomatic Zone, Central Area District
Abuja, Nigeria

UNICEF’s Nigeria Country Office manage evaluation and evaluative studies on a wide range of topics for the purpose of contributing to learning about what makes for effective development, as well as supporting accountability for results in Nigeria. These evaluations aim at identify what works and what does not in terms of achieving sustainable and equitable development results, and to throw light on how and why interventions succeed or not under various circumstances. In assessing UNICEF support to Nigeria government at Federal and State level and other development partners, these evaluations consider where, how and why progress is being made and the difference it is making in the lives of children, women in Nigeria.

By publishing evaluation reports, the UNICEF Nigeria Country Office makes evaluation findings, lessons and conclusion available to a wide audience. Lessons learned from evaluation are expected to inform operational improvements and, ultimately, to support the achievement of better results. The publication of evaluation reports also supports accountability, by providing all interested parties with independently determined evidence relating to UNICEF’s performance. This provides a basis for informed dialogue and discussion, and helps to assure all stakeholders that the organization operates in an open and transparent manner.

The content of this report do not necessarily reflect the policies or views of UNICEF. The text has not been edited to official publication standards and UNICEF accepts responsibility for error.

The designations in this publication do not imply an opinion on the legal status of any country or territory, or of its authorities, or the delimitation of frontiers.

The copyright for this report is held by the United Nations Children’s Fund – Nigeria Office. Permission is required to reprint/reproduce/photocopy or in any other way to cite or quote from this report in written form. UNICEF has a formal permission policy that requires a written request to be submitted. For non-commercial uses, the permission will normally be granted free of charge. Please write to the UNICEF Nigeria Country Office at the address below to initiate a permission request.

For further information, please contact:
UNICEF Nigeria Country Office
United Nations Children’s Fund
Plot 617/618, UN House,
Diplomatic Zone, Central Area District
Abuja, Nigeria
djobin@unicef.org

Foreword

This Impact Evaluation of the Maternal and Newborn Child Health Weeks (MNCHWs) was commissioned by UNICEF to Liverpool School of Tropical Medicine, Centre for Maternal and Newborn Health through a competitive process late 2014 in order to assess the extent to which MNCH Weeks has been adapted to meet the needs of the targeted clientele, and partners, and determine the extent to which the MNCH Weeks have been implemented as intended and to determine whether the intended outcomes were achieved, and whether there were any unintended outcomes and lessons learned.

The evaluation identify several challenges that will need to be address, should the government continue with the MNCH Week. Such challenges are for instance:

Despite the MNCH weeks were designed to reach the marginalised groups, the coverage to groups in rural areas/hard to reach areas is limited. Nevertheless, the evaluation team notes that MNCH weeks use in some instance mobile and fixed sites, compromise routine PHC services and few outreach or community based implementation sites. There is however evidence of use of non-clinical staff for clinical procedures as a results of under staffing at some PHC units during the MNCHWs.

With respect of implementation, what evaluation observed is that no state has implemented expected MNCH week interventions at any round since 2010. For instance the weeks were systematically implemented outside of the recommended national dates. Also, key steps in planning, implementation and reviewing of MNCWs are largely out of sync and not consistent with MNCHW guidelines at both national and state levels.

On the outcome level, the evaluation team has found no evidence that the MNCHW has significantly contributed to coverage of essential MNCHW interventions in Nigeria. And based on analysis of DHS data, there is limited evidence that the MNCHWs has contributed to improved maternal, new-born and child health outcomes.

With respect of the value for money, there is limited data available for a comprehensive cost description of the MNCHWs; funding by Government has been on the decrease since 2013 while funding from UNICEF has been on the increase side, questioning the relevance of the week.

On the brighter side, the evaluation has demonstrated a strong odds ratio between awareness of and participation in the MNCHWs. Therefore, if the MNCHWs has a robust social mobilization strategy, significant awareness and participation can be assured.

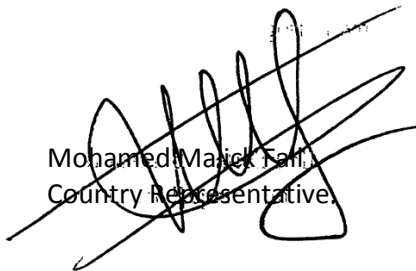
The evaluation found that there is a solid partnership base to support MNCHW and a significant investment in technical assistance from key stakeholders. There is a large body of regulating documentation developed and available for MNCHW in Nigeria. In addition, the programme has potential of significantly increasing coverage of key Maternal and Newborn Child Health (MNCH) interventions through efficient social mobilisation that creates awareness and participation. However, these can only be possible through effective partnership, adequate supplies, utilization of guiding documents, timely release of funds and commitment by State government. Also, observations were documented in terms the dire need of increasing evidence generations, ensuring transparent and comprehensive information on budget and expenditure limits the capacity of partners to plan and implement MNCHW.

From the methodological view point, the Theory Based Approach, focusing on Contribution Analysis and including a survey of more than 5000 household was instrumental for generating the evidences for this evaluation, especially on the impact of the coverage.

The MNCHW is organised to deliver an integrated package of highly cost-effective MNCH services/interventions. The evaluation team was able to engage with partners and communities in spite of a challenging context and should be commended.

I wish to express my personal thanks to the Health, Nutrition, HIV and AIDS, Communication for Development, Monitoring and Evaluation teams of UNICEF Nigeria, the government partners, especially NPHCDA who co-chair the Evaluation Steering committee with Unicef, the Community Leaders for their efforts in participating and contributing to this evaluation. We also thank, Implementing partners such as Save the Children, Vitamin Angels (VA), Helen Keller International (HKI), Micronutrient Initiative (MI) and Department for International Development (DFID) for the significant technical and financial support.

The results of this Impact Evaluation will be useful in informing the way forward, and agreed on an exit strategy, to ensure sustainability and ownership. It also shows us how, together, we can more effectively make a reality the dream of a Nigerian where all children and women are provided with quality MNCH services.



Mohammed Malik Fah
Country Representative

CONTENTS

CONTENTS.....	- 4 -
LIST OF TABLES.....	- 6 -
LIST OF FIGURES.....	- 6 -
ACKNOWLEDGEMENTS.....	- 7 -
ABBREVIATIONS.....	- 8 -
Executive summary.....	- 10 -
Overview of MNCHW evaluation.....	- 10 -
Evaluation objectives and intended audience.....	- 10 -
SCOPE of the evaluation.....	- 10 -
Evaluation methodology.....	- 10 -
KEY FINDINGS BY EVALUATION OBJECTIVES.....	- 11 -
Main conclusions by mnchw THEORY OF CHANGE.....	- 12 -
OVERALL CONCLUSION.....	- 13 -
recommendations.....	- 14 -
INTRODUCTION.....	- 16 -
This report is structured in to six chapters; a brief description of the content of each chapter is presented below.....	- 16 -
Background Of The Nigeria Maternal Newborn And Child Health Weeks.....	- 17 -
1.1. Geographical context of MNCHW.....	- 17 -
1.2. CONTEXT OF THE MNCHW.....	- 17 -
Table 1: The MNCHW program: key features.....	- 18 -
2.3. The MNCH weeks logical model.....	- 20 -
2.4. stakeholders involved in the MNCH weeks.....	- 22 -
2.5. MNCHW IMPLEMENTATION STATUS.....	- 25 -
Evaluation Purpose, Objectives And Scope.....	- 26 -
purpose.....	- 26 -
Objectives of the evaluation and main evaluation question.....	- 26 -
SCOPE of the evaluation.....	- 26 -
EVALUATION CRITERIA AND QUESTIONS.....	- 27 -
APPROACH.....	- 28 -
Evaluation Methodology.....	- 30 -
Design.....	- 30 -
METHODS OF DATA COLLECTION.....	- 31 -
SAMPLING.....	36
DATA ANALYSIS.....	38
STAKEHOLDER CONSULTATIONS.....	39
LIMITATIONS.....	39
Findings.....	44
FINDINGS RELATED TO MNCHWS INPUTS.....	44
FINDING RELATED TO MNCHW ACTIVITIES.....	49
FINDINGS RELATED TO MNCHW OUTPUTS.....	62
FINDING RELATED TO MNCHW OUTCOMES.....	69
Conclusions and Lessons Learned.....	75
APPRAISAL OF FINDINGS.....	75
Summary of conclusions.....	77
LESSONS LEARNT.....	78

OVERALL CONCLUSION	80
RECOMMENDATIONS	81
Policy recommendations	82
Operational recommendations.....	83
List of Annexes	85
Annex 1: Terms of Reference.....	86
Annex 2: List of Persons Interviewed, Affiliated Institutions and Sites Visited	101
Annex 3: List of Documents Consulted and reviewed	103
Annex 4: Data Collection Tools	107
Annex 5: Evaluators Biodata and Team Composition.....	110

LIST OF TABLES

Table 1: The MNCHW program: key features.....	- 18 -
Table 2: MNCHW Implementation partners.....	- 22 -
Table 3: MNCHW IE, evaluation criteria and key evaluation questions	- 27 -
Table 4: Evaluation criteria, questions, indicators, data collection methods and sources	32
Table 5: Data sources, numbers sampled, locations of data collection, key limitations and mitigation measures.....	40
Table 6: Assessment of MNCHW indicators against the MNCHW Intervention Logic	58
Table 7: Children reached with MNCHW intervention (10 rounds, 2010-2014)	63
Table 8: Women reached with MNCHW interventions (10 rounds, 2010-2014)	64
Table 9: Intervention coverage and attendance of MNCHW: Odds Ratio	68
Table 10: Coverage of selected MNCH interventions attributable to the MNCHW	74
Table 11: Summary of conclusions along the MNCHW programme Theory of Change.....	77

LIST OF FIGURES

.....	- 21 -
Figure 2: Revised MNCH week Theory of Change.....	46
Figure 3: Average allocation to MNCHW per State, 2013-2015 (Source: NPHCDA, 2016)	47
Figure 4: Awareness of MNCHW by Zones	55
Figure 5: Rapid SMS dashboard (http://rapidsmsnigeria.org).....	61
Figure 6: MNCHW interventions reach: average, min and max no. of beneficiaries (2010-2014)	65
Figure 7: Implementation of MNCHW interventions in two States	65
Figure 8: Percentage of total recommended MNCH interventions delivered in each state between 2010 and 2014	66
Figure 9: Percentage Omission of each MNCHW intervention between 2010 and 2014	66
Figure 10: Coverage of essential interventions in Nigeria (Source: NDHS 2013)	70
Figure 11: Progress in coverage of essential interventions in Nigeria (NDHS 2008 and 2013)	70
Figure 12: Under five mortality rate by socio-economic characteristic of the population (NDHS 2013)	71

ACKNOWLEDGEMENTS

The Impact Evaluation team acknowledges the immense support of UNICEF, the National Primary Health Care Development Agency (PHCDA), State PHCDA, Maternal and Child Health Weeks stakeholders at national, state and local government levels as well as community stakeholders for their participation throughout this evaluation.

We are particularly grateful to the Chair and Co-Chair of MNCHWs Evaluation Steering Committee (ESC), Dr Emmanuel Odu-Acting Executive Director NPHCDA and Denis Jobin Chief Monitoring and Evaluation UNICEF Nigeria, for their guidance and support.

We acknowledge the support State Ministry of Health, State PHCDA, local government health authorities and members of communities who participated in this IE in Abia, Adamawa, Anambra, Bauchi, Bayelsa, Edo, Katsina, Kebbi, Kwara, Niger, Ogun, Osun), and FCT Abuja.

Finally, we are grateful to all the data collection teams for their dedication and commitment throughout the data collection period.

The evaluation team
Liverpool, 3rd November 2016

ABBREVIATIONS

ANC	Antenatal Care
BCG	Bacillus Calmette-Guerin Vaccine
BR	Birth Registration
CBO	Community Based Organisation
CHAN	Christian Health Association of Nigeria
CHD	Child Health Day
CSO	Civil Society Organisations
DAC	Development Assistance Committee
DFID	Department for International Development
DPT	Diphtheria, Pertussis and Tetanus Vaccine
EA	Evaluability Assessment
EU	European Union
FBO	Faith Based Organisation
FCT	Federal Capital Territory
FGD	Focus Group Discussions
FMOH	Federal Ministry of Health
GAVA	Global Alliance for Vitamin A
GNI	Gross National Index
HCP	Health care provider
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
ITN	Insecticide Treated nets
KHP	Key Household Practices
KII	Key Informant Interviews
LGA	Local Government Area
LLIN	Long-Lasting Insecticide-Treated Bed Nets
Low-ORS	Low-osmolality Oral Rehydration Salt
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MI	Micronutrient Initiative
MN	Powder Micronutrients Powder
MNCH	Maternal, Newborn and Child Health
MNCHW	Maternal, Newborn and Child Health Week
MNH	Material and Newborn Health
MUAC	Mid Upper Arm Circumference
NGO	Non-governmental Organisation
NPHCDA	National Primary Health Care Development Agency
OECD	The Organisation for Economic Co-operation and Development
OPV	Oral Polio Vaccine
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
SC	Save the Children
SMOH	State Ministry of Health

SMS	Short Message Service
SNO	State Nutrition Officer
SPHCMB	State Primary Health Management Board
ToC	Theory of Change
TOR	Terms of reference
UN	United Nations
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VA	Vitamin Angels
WB	World Bank
WHO	World Health Organization
WRA	Women of reproductive age

EXECUTIVE SUMMARY

OVERVIEW OF MNCHW EVALUATION

UNICEF and the National Primary Health Care Development Agency through the Maternal Newborn and Child Health weeks (MNCHW) Evaluation Steering Committee (ESC) requested for an independent impact evaluation of the MNCHWs. ESC comprises key stakeholders who provide input into the MNCHW (Funding, Technical assistance, Coordination, Partnership and Leadership).

EVALUATION OBJECTIVES AND INTENDED AUDIENCE

The primary beneficiaries of the MNCHW evaluation are therefore represented on the ESC. The objectives of the impact evaluation are as follows:

1. Assess the extent to which MNCH weeks has been adapted to meet the needs of the targeted clientele, and partners.
2. Assess the extent to which the MNCH weeks have been implemented as intended
3. Assess whether the intended outcomes were achieved, and whether there were any unintended outcomes
4. Provide a descriptive cost analysis for the intervention
5. Identify lessons learned, exploring what has worked well, what has not worked as well and make recommendations to strengthen the MNCH Weeks

SCOPE OF THE EVALUATION

Geographical scope and Time period – the evaluation was designed to cover the period 2010-2015. The proposed approach entailed evaluating the intervention nationwide. The sample for both quantitative and qualitative data collection in this evaluation are *Abia, Adamawa, Anambra, Bauchi, Bayelsa, Edo, Katsina, Kebbi, Kwara, Niger, Ogun, Osun*), and *FCT Abuja*

EVALUATION METHODOLOGY

An evaluability report was produced following a scoping visit (Important background information about the programme was collected), this report paved the way for a full independent evaluation based on a theory based approach in the absence of a baseline and challenges using an experimental evaluation design.

The inception phase resulted in detailed evaluation plan, revised evaluation questions (EQs), identification of sources of data, determination of resources required to complete the evaluation, clarity of roles and responsibilities. During the inception phase LSTM ensured that ESC had a shared understanding of how the evaluation will proceed.

The Theory based approach used contribution analysis for the evaluation. The **main evaluation question** used to guide the impact evaluation was “Has the MNCHW contributed to improve the health status of women and children in Nigeria, by increasing coverage of key maternal, newborn and child health interventions?” additional evaluation questions linked to the revised Theory of

Change were formulated.

A mixed data collection approach was used, primary data was collected from a household survey, key informant interviews and focus group discussions. Secondary data was analysed from relevant reports, data sets and publications. A household survey involving 5,389 households in 320 clusters with 5,139 children under 24 months of age, 2,531 children between 24 and 59 months, and 5,180 women of reproductive age. The survey was conducted in 12 states and FCT Abuja. The main objective was to determine the contribution to coverage of MNCHW intervention at the 2nd round of 2015 MNCHW.

Key informant interviews were at national (FCT) and 12 states. While FGDs were collected from Ogun, FCT Abuja, Katsina, Abia and Katsina states only. Twenty-two key informant interviews were conducted in Abia, Katsina, Kwara, Niger, and Ogun states with key MNCHW stakeholders, 14 focus group discussions with community members, and 15 FGDs with health care providers and health managers. Key informants from 24 institutions/organisations who are key MNCHW partners/stakeholders were interviewed at National level.

Secondary data was reviewed, planning of the 2nd round of the 2015 MNCHW at National level and FCT were observed and a case study of one state was under taken.

KEY FINDINGS BY EVALUATION OBJECTIVES

- 1. Assess the extent to which MNCH weeks has been adapted to meet the needs of the targeted clientele and partners:** MNCHW was designed to reach marginalised groups, providing a one stop opportunity twice a year to boost coverage of key MNCHW interventions. The evidence if of limited coverage to groups in rural areas/hard to reach areas.
 - a. The approach of mobile and fixed sites, compromise routine PHC services and few outreach or community based implementation sites are evident.
 - b. There is also evidence of use of non-clinical staff for clinical procedures as a results of under staffing at some PHC units during the MNCHWs.
 - c. One state (Case study) deliberately adopted the approach of concentrating of fewer interventions of low coverage rather than all recommended MNCHW interventions, partly to improve efficiency in implementation

- 2. Assess the extent to which the MNCH weeks has been implemented as intended:**
 - a. No state has implemented expected MNCH week interventions at any round since 2010
 - b. States frequently implement the MNCHWs outside the recommended national dates
 - c. Key steps in planning, implementation and review of MNCWs are largely out of sync and not consistent with MNCHW guidelines at both national and state levels

- 3. Assess whether the intended outcomes were achieved and whether there were unintended outcomes**
 - a. No evidence is found that the MNCHW has significantly contributed to coverage of essential MNCHW interventions in Nigeria.

- b. Based on analysis of DHS data, there is limited evidence that the MNCHWs has contributed to improved maternal, newborn and child health outcomes.

4. Provide a descriptive cost analysis for the intervention

- a. There is limited data to provide a comprehensive cost description of the MNCHWs
- b. Funding by Government has been on the decrease since 2013 while funding from UNICEF has been on the increase
- c. The lack of transparency around budgets and actual expenditure by UNICEF and key stakeholders supporting MNCHW raises a lot of concern about accountability. This is also a missed opportunity to improve efficiency.

5. Identify lessons learnt, exploring what has worked well, what has not worked well and make recommendations to strengthen the MNCH weeks

- a. Several lessons learnt from evaluation of the MNCHWs are on political commitment and funding, implementation approach, dependency of PHC on MNCHWs, Weak MNCHW implementation monitoring system, Discrepancy about the source of Vitamin A, social mobilization strategy, effect of immune plus days on MNCHWs and training of health care workers.
- b. Recommendations are provided below

MAIN CONCLUSIONS BY MNCHW THEORY OF CHANGE

MNCHW logic (ToC)	Evaluation conclusion
Outcome	<p><u>Finding 4.1:</u> The objectives and related outcomes of the MNCHW are consistent with the priorities of Nigeria, and still relevant</p> <p><u>Finding 4.2:</u> The design of the MNCHW activities is partially consistent with its intended effects and impacts</p> <p><u>Finding 4.3:</u> No evidence is found that the MNCHW has significantly contributed to coverage of essential MNCHW interventions in Nigeria</p>
Outputs	<p><u>Finding 3.1:</u> MNCHW achieves a significant population reach, at least for selected interventions</p> <p><u>Finding 3.2:</u> MNCHW is not implemented consistently across States and over time</p> <p><u>Finding 3.3:</u> Attendance to MNCHW is suboptimal</p> <p><u>Finding 3.4:</u> The current model of the MNCHW is not fit to reach the most marginalized</p>
Activities	<p><u>Finding 2.1:</u> The allocation and the timely disbursement of funds for the MNCHW is a key bottleneck to implementation</p>

MNCHW logic (ToC)	Evaluation conclusion
	<p>Finding 2.2: There is a large body of regulating documentation developed and available for MNCHW in Nigeria, but this is not widely used</p> <p>Finding 2.3: The quality, inclusiveness and timeliness of the coordination and planning functions needs substantial improvement</p> <p>Finding 2.4: Equipment, supplies and medical items are inconsistently available across States and across different MNCHW rounds</p> <p>Finding 2.5: The effectiveness of the current training and deployment model is unclear</p> <p>Finding 2.6: Social mobilization does not reach targets groups sufficiently</p> <p>Finding 2.7: The MNCHWs are perceived as a one stop shop for valuable health care for women and children, as well as promoting the use of routine health care services.</p> <p>Finding 2.8: The M&E framework of the MNCHW presents design issues</p> <p>Finding 2.9: There are strong monitoring tools in place, but their actual use for real time analysis and decision making could be improved</p> <p>Finding 2.10: Reporting and documentation are inadequate and information is not accessible</p>

OVERALL CONCLUSION

The evaluation concludes that despite its lack of impact on MNCH (no significant contribution to coverage or improved health outcomes), the programme has potential of significantly increasing coverage of key MNCH interventions through efficient social mobilisation that creates awareness and participation. This can only be possible through effective partnership, adequate and timely release of funds and complete commitment by state government.

RECOMMENDATIONS

The recommendations at the end of this evaluation are derived from the evidence generated, discussed in the findings and conclusion chapters of this report. Consultations with NPHCDA, UNICEF and MNCHW ESC have contributed to the development of the recommendations. The stakeholders have recommended presentation of this report to National Council on Health and the National Council of State. Thirteen recommendations at policy and operational levels which can be All 13 can be implemented in the short to medium term are as follows:

Policy

1. **NPHCDA** should develop an accountability framework in collaboration with partners and state governments at central and state levels to monitor, input, activities and outputs. This is also to improve coordination.
2. **NPHCDA** should constitute a national steering committee with clear ToR developed in collaboration with UNICEF and other partners. This committee
 - will provide strategic over sight, drive the implementation of the accountability frame work
 - develop an exit strategy for the MNCHW
 - Recognises and recommends states, partners and institutions for recognition to the Minister for Health and National Council of state for national recognition and awards. This is a means of stimulating quality
 - suggest policy direction to NPHCDA, NCOH and FMOH,
 - updates MNCHW materials and guidance documents
 - Develop, track and report on key Performance Indicators (KPIs) at national and state levels...for example state with that meet all mile stones according to guidelines-regular implementation committee meetings (documented minutes and actions), microplanning meetings, quality of costed micro plans, attendance of national planning and review meetings
3. **SPHCDA/SMOH should constitute MNCHW** coordination committees with clear ToR and KPIs, Committee at state and local government levels
 - drives implementation according to guidelines,
 - drives accountability and transparency,
 - develops and reviews implementation strategy,
4. **NPHCDA** in collaboration with the states and partners, should redesign social mobilization strategy for MNCHW
 - Rebranding of MNCHW to improve accountability and awareness
5. **NPHCDA and SPHCDA** should consider designing context specific MNCH weeks
 - In order to reduce inequity of coverage, consider context specific approach. A core set of interventions can be implemented, but a minimum additional set, implemented specifically at health care facility and via outreach should be developed and agreed.
 - Modify the fixed/mobile post approach: In order to improve coverage, implement the MNCHWs at all PHCs, this will reduce cost of deploying health care workers to mobile or fixed posts. Savings from this can be used to fund social mobilization

- Set of core interventions delivered at HCF, at community or specific interventions for all and others based on local needs
6. **FMOH, NPHCDA and UNICEF should streamline MNCHW approach** with other adhoc activities (IPDs, measles campaign etc) to improve coverage.
 7. **NPHCDA in collaboration with UNICEF and other partners should develop an exit strategy for MNCHW, to compliment the policy direction of PHC in Nigeria (implementation at scale of the national strategy of 1-PHC per ward)**

Operational recommendations

1. **NPHCDA** in collaboration with implementing partners should consider central funding mechanism (matching funds from partners) through a single funder manager
2. Improved transparency about funding by all partners, timely reports, reconciliation available as open access documents
3. **NPHCDA** should explore innovative approaches to health care worker training, use of relevant job aids including availability of MNCHW guidelines and training manual
4. **SPHCDA** should consider implementing MNCHWs at all PHCs rather than using the fixed and mobile site approach as a means of increasing coverage
5. **NPHCDA, SPHCDA and partners** should strengthen the monitoring of MNCW implementation. Additional indicators for monitoring every level in the ToC is needed.
6. **NPHCDA** should
 - Improve quality of training, special team to monitor the quality of this, set standards to achieve this.
 - Consider reducing frequency of training and savings can be used to improve social mobilization
 - Consider the use of innovative approaches to training, mobile technology platforms-training videos, MNCHW guidelines and training manuals.

INTRODUCTION

This is a report on the Impact Evaluation of the Nigeria Maternal Newborn and Child Health Weeks (MNCHWs) carried out by the Liverpool School of Tropical Medicine (LSTM) and commissioned by UNICEF Nigeria through the MNCHWs Evaluation Steering Committee (ESC). Data collection was collected from June 2015 to March 2016, the results were disseminated to stakeholders in September 2016 at Abuja Nigeria.

THIS REPORT IS STRUCTURED IN TO SIX CHAPTERS; A BRIEF DESCRIPTION OF THE CONTENT OF EACH CHAPTER IS PRESENTED BELOW

Background of the MNCHWs: the context of key social, political, economic, demographic and institutional factors that have a direct bearing on the MNCHWs. Overview of scope of implementation of MNCHWs, key stakeholders involved and their roles and the implementation status of the MNCHWs
Evaluation purpose, objectives and scope: The rationale for the evaluation, specific objectives, scope, main evaluation question and limitations of evaluation.

Evaluation methodology: This chapter provides a description of the methodology applied to the evaluation, including a description of the design used address all evaluation questions linked to the evaluation criteria. A description of quality assurance measures to ensure reliable and valid data is collected is provided as well as ethical considerations.

Findings: Findings that respond directly to the evaluation criteria and questions, consistent with the scope and objectives of the evaluation (based on data collection methods and analysis) described in chapter 3 above are presented. Gaps, limitations of the findings are also described and discussed.

Conclusions and lessons learned: Conclusions based on the analysis and directly responding to the evaluation objectives and findings. The strengths and weaknesses of the MNCHWs based on the evidence presented in chapter 4. Lessons learned about improving the MNCHWs and the Primary Health Care (PHC) in Nigeria are discussed.

Recommendations: Recommendations developed in consultation with key stakeholders from the findings and consistent with the objective of the evaluation are presented.

BACKGROUND OF THE NIGERIA MATERNAL NEWBORN AND CHILD HEALTH WEEKS

1.1. GEOGRAPHICAL CONTEXT OF MNCHW

Located in West Africa, the Federal Republic of Nigeria comprises 36 States and the Federal Capital Territory of Abuja. According to the latest projections, Nigeria has a population of approximately 169 million (UN, 2012), of which 29 million are children under the age of five. It is estimated that every year more than 7 million babies are born in Nigeria.

Nigeria is the largest economy in Africa, and yet the country still ranks 152 of 187 in terms of Human Development Index¹. According to the World Bank², “despite a strong economic track record, poverty in Nigeria is significant, and reducing it will require strong non-oil growth and a focus on human development. Constraints to growth, such as the investment climate; infrastructure, incentives and policies affecting agricultural productivity as well as quality, and relevance of tertiary education have been identified”.

1.2. CONTEXT OF THE MNCHW

Over the past decades, Nigeria has achieved good progress in improving maternal and child health outcomes, although insufficient to achieve its Millennium Development Goals targets. According to recent estimates, the under-five mortality rate has declined from 213 per 1,000 live births in 1990³ to 128 per 1,000 live births in 2013⁴; the MDG 4 target of reducing under-five mortality to 71 per 1,000 live births by 2015 remains far from reach. Trends in neonatal mortality also show good progress: the neonatal mortality rate has reduced from 52 per 1,000 live births to 37 per 1,000 live births during the period 1990-2013.

The country has also successfully reduced the maternal mortality ratio (MMR): in Nigeria, the MMR was estimated at 1,200 per 100,000 live births in 1990⁵ and at 576 per 100,000 live births in 2013. The MMR has more than halved during the period, although Demographic and Health Survey (DHS) data indicate that no progress has been achieved during the period 2008-2013, and further investments are still needed to achieve the MDG 5 target for MMR, set at 300 per 100,000 live births.

1.2.1. Rational for MNCHWs

This slow progress in MDG 4 and 5 was recognised by the Government of Nigeria at the 53rd National Council on Health in March 2010, and therefore the Maternal and Child Health Week (MNCHW) was introduced-amongst other measures, as a priority and strategic action to accelerate the reduction of

¹ Human Development Report 2014 – United Nations Development Program

² <http://www.worldbank.org/en/country/nigeria/overview>

³ Levels and Trends in Child Mortality, Report 2014 – UN Inter-Agency Group for Child Mortality Estimates

⁴ Nigeria Demographic and Health Survey 2013

⁵ Trends in Maternal Mortality: 1990 to 2013 – Estimates by WHO, UNICEF, UNFPA, the World Bank, and the United Nations Population Division

child mortality and improvement of maternal health. This intervention was primarily intended to improve access to essential, quality MNCH services, consistently with the objectives of the 2007 Integrated MNCH Strategy. The key features of the MNCHWs are presented in **Table 1**

The MNCHW is organised to deliver an integrated package of highly cost-effective MNCH services/interventions. These services are primarily delivered to strengthen the routine PHC services, the NPHCDA⁶ describes the week as ‘a simple one-time delivery mechanism that consolidates services that are likely to immediately demonstrate impact in terms of significantly increasing coverage levels of core preventive and curative interventions that can improve the health of mothers and children’.

MNCHWs are not unique to Nigeria, they are implemented in other countries. They started as Child Health Days (CHD) introduced by the United Nations Children’s Fund (UNICEF) and the World Health Organisation (WHO) in 1999⁷.

TABLE 1: THE MNCHW PROGRAM: KEY FEATURES

Program duration	Since 2010
Lead Partners	National Primary Health Care Development Agency Federal Ministry of Health
Estimated annual expenditure	USD 86.5M ⁸
Main Donors/Partners	DFID; Micronutrient Initiative, Helen Keller International, World Bank, Save the Children, Vitamin Angels, WHO, UNFPA and UNICEF
Geographic Focus	Nationwide
Target groups	Pregnant, lactating women and children under the age of five years
Goal	To improve the health status of women and children by increasing the coverage of key MNCH interventions.
Objectives	<ul style="list-style-type: none"> ▪ To improve the utilisation of routine services ▪ To contribute to health systems strengthening ▪ To increase uptake of Antenatal care (ANC)/Prevention of mother to child transmission (PMTCT) services and retention in care ▪ To improve key healthy household practices ▪ To improve the capacity of health workers to deliver Maternal, Newborn and Child Health interventions. ▪ To improve utilisation of health information management systems

⁶ National Primary Health Care Development Agency: Guidelines for Implementing Maternal Newborn and Child Health Weeks in Nigeria, Second Edition April 2014

⁷ Centre for Maternal and Newborn Health LSTM: Literature Review on Maternal Newborn and Child Health Weeks. August 2015. Annex 4 Inception Report of the Evaluation of Nigeria MNCH weeks

⁸ Nigeria MNCHW impact evaluation terms of reference

Following a successful pilot of the MNCHWs in two states Nigeria in 2009, the National Council on Health recommended the biannual implementation of the MNCHWs in all states of Nigeria.

A set of MNCH interventions were approved for delivery during the MNCHWs. The week is held twice annually usually in May and November every year using a facility based delivery approach (fixed or mobile health care posts are used, this means that the week may be delivered completely from a few health care facilities throughout the week -fixed post in a local government area and implemented for a few days in a few facilities-mobile posts). Temporary posts can also be set up targeting hard-to-reach communities.

2.2.1. MNCH weeks interventions

The MNCH weeks guidelines⁶ recommends **19 different interventions to be delivered during the MNCHWs**, a brief description of each intervention and the primary targets I described in the MNCHW impact evaluation companion report.

2.2.2. Policy framework

The MNCHWs implementation was further driven by a policy to accelerate progress towards the achievement of the health MDGs. The Federal Ministry of Health (FMOH) of Nigeria developed a *Harmonized Country Plan of Priority Interventions for 2014-2015*, this policy identifies six key focus areas for action, prioritizing key interventions that are already underway for rapid scale up or improvements in programming, to accelerate impact.

The Focus area 1 identified through the above mentioned plan is maximizing RMNCH Weeks and other existing campaigns⁹. In particular, the plan identifies the following objectives to maximize the RMNCH weeks:

1. Improve the quality of RMNCH weeks (and frequency)
2. Increase the coverage of RMNCH weeks
3. Increase the number of essential commodities provided through the RMNCH weeks
4. Improve data collection and analysis through the RMNCH weeks

2.2.3. MNCHW Governance and management structure

The National Primary Health Care Development Agency (NPHCDA) is the public institution with primary responsibility of implementing the MNCHW. The agency provides guidance for implementation of the weeks. The implementation of the weeks at state level is by the State PHCDA with funding predominantly from the State Ministry of Health and development partners.

The NPHCDA has developed a number of guiding documents that support the implementation of the MNCHWs. The implementation guidelines in its second edition. The MNCHW guidelines contains the conceptual framework for the MNCHWs. These are closely related to the Theory of Change for the programme.

Two of the key documents guiding implementation of the MNCHWs are as follows:

⁹ Harmonized Country Plan of Priority Interventions for 2014-2015, Federal Ministry of Health, Nigeria (page 18)

- Guidelines for Implementing the MNHCW in Nigeria (NPHCDA, 2014)
- Training Manual for Implementing the MNHCW in Nigeria (NPHCDA, 2014)

The date for the particular week is set by NPHCDA (occurs in the months of May and November each year) but each state will work towards this date or another week as close as possible to the nationally prescribed date.

The NPHCDA facilitates microplanning at National level. The agency also monitors the implementation of the week.

State Ministries of Health and state primary health care development agencies implement the MNCHWs at state level. Training of health care workers for the week occurs at state and LGA levels.

The Federal Ministry of Health provides technical input and policy direction while several other stakeholders provide input (funding, technical assistance, coordination and partnership) to key activities towards implementing the MNCHWs.

2.3. THE MNCH WEEKS LOGICAL MODEL

2.3.1. MNCHW implementation strategy

The NPHCDA also set out **four main strategies** that are expected to lay the road map for the success of the MNCHWs they are

- 1) progressively increase the number of private and public health facilities implementing the MNCH weeks,
- 2) creating demand for routine MNCH services through MNCHW activities,
- 3) building partnerships with other sectors such as the Ministry of Local Government and Chieftaincy Services/Education, Agriculture, Women Affairs, Information, Civil Society Organisations (CSOs), People Living with HIV and AIDs networks, Development Partners and relevant community structures such as Ward Development Committees (WDC),
- 4) community mobilization by involving other relevant sectors, town announcers, individuals, individuals, households and communities¹⁰.

Resources are mobilised from various sources for the implementation of the MNCHWs, SMOH, development partners such as Micronutrient Initiative, Helen Keller International, World Bank, Save the Children, Vitamin Angels, WHO, UNFPA and UNICEF. Funding for some of the partners are from multilateral and bilateral agencies such as the United Kingdom Department for International Development (DFID), USAID CIDA and the European Union (EU). There are various degrees of coordination of resource mobilisation within the states, ranging from development of a joint budget and direct financial contribution to the State Government, to funding for the implementation of specific interventions, in specific local government areas of a state.

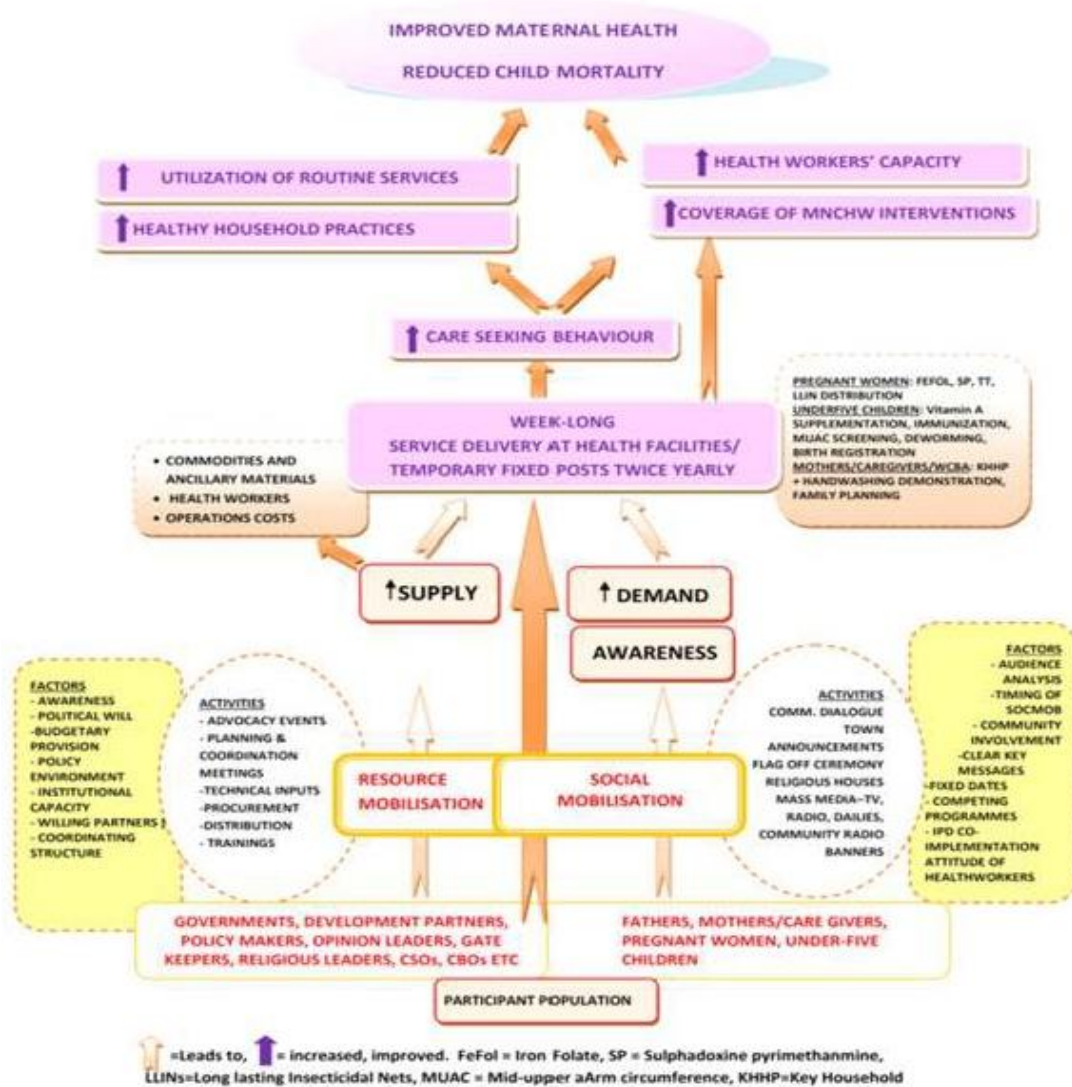
¹⁰ Guidelines for implementing Maternal Newborn and Child Health Weeks in Nigeria. National Primary Development Agency Second Edition April 2014

2.3.2. Logical framework

A **conceptual framework of the MNCHW** is described in detail in the guidelines for the MNHCW (NPHCDA, 2014) and underpins the whole approach, strategy and tools developed through such guidelines.

This is presented in **Figure**

Figure 1: MNCHW conceptual framework



2.4. STAKEHOLDERS INVOLVED IN THE MNCH WEEKS

Various implementing partners (Error! Reference source not found.) were involved in the planning, implementing and monitoring of the MNCHWs. These include, but were not limited to the partners indicated below:



a. Federal Ministry of Health (FMOH)

The FMOH provides technical assistance to the National Primary Health Care Development Agency and the State Ministry of Health

(SMOH) for the implementation of the MNCHWs. Specifically, FMOH technical staff provide supervision during implementation of the MNCHWs, facilitate training of health care providers and support monitoring and data analysis.

b. National Primary Health Care Development Agency (NPHCDA)

The NPHCDA has ownership of and provides overall leadership for the MNCHW programme. It is responsible for national planning and coordination of MNCHW, setting of implementation dates, coordination of partners, development of the guidelines for implementation and a Monitoring & Evaluation framework for the MNCHW. Monitoring of the MNCHW is conducted by deploying monitors and supervisors to the states. The NPHCDA also provides some funding for the MNCHWs (specifically for national level orientation and review meetings and monitoring). NPHCDA co-chairs the MNCHW Evaluation Steering Committee (ESC), with UNICEF.

c. State Ministry of Health, State/FCT Primary Health Care development Agency (SPHCDA)

The MNCHW is coordinated by the Executive Secretary of the State Primary Health Care Development Agency (SPHCDA) who oversees all the planning and implementation and supervises a focal person that coordinates all the SMOH programme officers involved. These officers collaborate with partners such as UNICEF and World Health Organization (WHO). There is also a committee which usually meets and source funds from State Ministry of Health (SMOH) & SPHCDA. The committee also carries out monitoring and supervision. The states specifically fund procurement of most commodities, review meetings, training of health care workers and monitoring.

Table 2: MNCHW Implementation partners

Partner	Role within MNCHW
National Primary Health Care Development Agency	Implementation and training guidelines, monitoring, overall coordination, social mobilization, resource mobilization

Federal Ministry of Health	Technical support, training, monitoring
State level authorities	Procurement of drugs, supplies, training, social mobilization, monitoring
Donors	Resource mobilization
UNICEF	Resource mobilization, technical support, social mobilization, procurement of drugs, suppliers and equipment
Implementing partners	Procurement of drugs, supplies, training, monitoring. Contribute to development/review of guidelines and technical documents

a. UNICEF

Prior to MNCHWs, Child Health Weeks (CHWs) were solely implemented by UNICEF. Since approval of the MNCHWs for implementation twice annually, the funding base and number of partners supporting the MNCHWs has grown. UNICEF plays a role in mobilizing resources to support the MNCHWs from multiple donors. UNICEF provides support through three sections; Health, Nutrition and HIV/AIDs. Health section provides support to 17 states, this includes demand and supply side activities. Supply side activities include procurement of essential medicines and equipment including Vitamin A distributed through MoH systems. HIV/AIDs provides support to all states,

UNICEF Nutrition section, provides direct support to 19 of the 36 states and FCT, specifically inputs are funding, technical support, monitoring and support for coordination. Specific activities funded include technical support and orientation for the development of microplans at local government level, coordination meetings at state level (LGA, state and partners), training for health care workers, advocacy (community leaders), social mobilization (MNCHW promotion through town announcers), mobilization of funding from donors and support for monitoring via SMART surveys.

UNICEF is a strong advocate for independent evaluation of the MNCHWs and co-chairs the MNCHW Evaluation Steering Committee (ESC) with NPHCDA.

d. Department for International Development (DFID)

The DFID nutrition programme contributes to MNCHWs through funding of specific interventions in specific states through UNICEF and Save the Children. UNICEF (Kebbi, Katsina, Jigawa, Yobe, Zamfara): Micro nutrients, Zn, Iron, folic, vitamin A, CMA malnutrition programme. These funds go directly to the states where there are DFID funded programmes.

There is also some DFID funding which supports for supportive supervision and procurement of drugs and supplies for MNCHWs.

e. [Save the Children \(SC\)](#)

Save the Children (SC) provides support mainly for the nutrition activities during the MNCHW, working through the WINNN (Working to Improve Nutrition in Northern Nigeria) project which is funded by DFID. The WINNN states are Jigawa, Katsina, Kebbi, Yobe, and Zamfara. The project provides Albendazole, Zinc/ORS, vitamin A, and iron-folate. SC is also involved in social mobilisation, pre- and post- MNCH week planning.

Save the Children is also involved in MNCHW data quality assessment and provides technical support for newborn care activities at national level only.

f. [Vitamin Angels \(VA\)](#)

Vitamin Angels provides support mainly for the nutrition activities during the MNCHW, working through community based organisations (CBOs). VA implements in 26 states with expected expansion to all states.

VA provides Albendazole and vitamin A while partner CBOs distribute the commodities. VA does not provide funds to partners; they use their own logistics systems.

Major partners are Christian Health Association of Nigeria (CHAN) and Association of Civil Society Organisations for Malaria, Immunisation and Nutrition (ACOMIN). They also work with Save the Children in Lagos state only.

VA conducts training of NGOs/CBOs on vitamin A and deworming service delivery. They are also involved in monitoring and supervision during the MNCHW. VA has not conducted any research or evaluation on the MNCHW.

g. [Helen Keller International \(HKI\)](#)

Helen Keller International is funded by the Canadian Government and their focus is on vitamin A supplementation, and to a lesser extent, deworming.

Vitamin A is procured through UNICEF. Its focus states are Katsina, Benue, Adamawa, Ekiti, FCT, Jigawa, Ebonyi and Akwa Ibom.

HKI supports planning, social mobilisation, health care worker training, and review meetings in their focus states and supports national review meetings through NPHCDA. HKI is trying to standardise the training and offer it online and offline, producing training videos. They also conduct post-event evaluation surveys; approximately 900 households per state, randomly selected.

h. [Micronutrient Initiative \(MI\)](#)

Micronutrient Initiative (MI) is funded by the Canadian Government and started supporting the MNCHW right from its inception in 2008/9, in collaboration with NPHCDA. The pilot (child health weeks) was conducted in Osun, Ogun and Benue states. MI started providing support to states in 2013.

Focus states include Bauchi, Gombe, Kano, Kogi, Sokoto, Niger, Nassarawa, Plateau, Bayelsa, Edo, Delta, Cross River, Enugu and Imo.

MI supports microplanning, training (on MNCHW integrated approach at state and LGA level), supervision, social mobilisation (community dialogue, town announcers, training), guideline development, and review meetings (national and state level).

They also participate in smart surveys and engage FMOH and NPHCDA for policy development, training and monitoring.

MI supports provision of vitamin A to all 36 states and FCT using UNICEF procurement and distribution systems.

MI activities are harmonised with those of other organisations offering similar services through the Global Alliance for Vitamin A (GAVA) which includes MI, HKI, UNICEF and Johns Hopkins University.

2.5. MNCHW IMPLEMENTATION STATUS

The MNCHWs have been implemented twice a year since 2010 and implementation should be guided by guidelines provided by the NPHCDA. The extent to which implementation has been carried out based on the guidelines, adaptations to implementation modalities over time has not been investigated prior to this impact evaluation.



EVALUATION PURPOSE, OBJECTIVES AND SCOPE

PURPOSE

Since implementation of the MNCHWs in 2010 in Nigeria, an impact evaluation has not been performed. The MNCHWs was a short term strategy by the Federal Government of Nigeria, to improve the coverage of evidence based MNCH interventions in order to reduce maternal, newborn and under 5 mortality. The **purpose** of the evaluation is to assess to what extent the MNCHW strategies, approaches and the overall intervention logic have contributed to improved maternal, newborn and child health outcomes in Nigeria, to explain how change was achieved and make recommendations to strengthen it.

The conclusions and recommendations from the evidence generated during the evaluation will be used by Federal Government of Nigeria to inform primary health care policies linked to strategies for attaining global health targets, used by National and state PHCDA to improve implementation of the MNCHWs and used by UNICEF/partners to contribute to efficient implementation of MNCH weeks. The ultimate beneficiaries of this impact evaluation are the women of reproductive age, under 5-year-old children, who will have improved access to evidence based preventive and curative services that reduce the risk of mortality and morbidity.

OBJECTIVES OF THE EVALUATION AND MAIN EVALUATION QUESTION

The **objectives** of the proposed evaluation are:

- Assess the extent to which the MNCHWs have been implemented as intended;
- Evaluate the extent to which the MNCHW has been adapted to the needs of intended target groups;
- Assess whether the intended outcomes of the MNCHW were achieved, and whether there were unintended outcomes;
- Identify lessons learned, exploring what has worked well, what has not worked well and why;
- Make recommendations to strengthen the MNCHWs

The **main evaluation question** used to guide the impact evaluation was “Has the MNCHW contributed to improve the health status of women and children in Nigeria, by increasing coverage of key maternal, newborn and child health interventions?”

SCOPE OF THE EVALUATION

Geographical scope and Time period – the evaluation was designed to cover the period 2010-2015. The proposed approach entailed evaluating the intervention nationwide. The sample for both quantitative and qualitative data collection in this evaluation are *Abia, Adamawa, Anambra, Bauchi, Bayelsa, Edo, Katsina, Kebbi, Kwara, Niger, Ogun, Osun*), and *FCT Abuja*.

Sampling approach and the limitations of the proposed design are presented in the companion report.

Evaluation Criteria - In line with the OECD/DAC criteria for international development evaluations¹¹, and as detailed in the terms of reference, the proposed evaluation will provide an independent assessment of the MNCHWs in Nigeria against the following criteria: relevance, impact, effectiveness, efficiency and sustainability (including partnership).

During the inception phase of this impact evaluation, evaluation questions presented through the IE ToR were further refined based on the evaluability report.

EVALUATION CRITERIA AND QUESTIONS

The final set of evaluation questions (EQ) addressed via this evaluation is presented below.

Table 3: MNCHW IE, evaluation criteria and key evaluation questions

Evaluation Criteria	Key Evaluation Questions
Relevance	<ul style="list-style-type: none"> ▪ To what extent are the objectives of the programme still valid? ▪ Are the activities and outputs of the programme consistent with the intended impact? ▪ To what extent does the intervention reach its targeted clientele addressing its needs and priorities? ▪ To what extent is UNICEF support relevant?
Effectiveness and efficiency	<ul style="list-style-type: none"> ▪ To which extent has the MNCHW contributed to improve coverage of PHC interventions? ▪ To what extent has UNICEF and her partners support being effective and efficient? ▪ What are the intervention costs? ▪ Are there areas along the MNCHW delivery chain where operational efficiency improvements can be achieved? If so, what are they and how can they be implemented?
Impact	<ul style="list-style-type: none"> ▪ What is the consistency of the MCHW impact with the anticipated theory of change? ▪ What is the contribution of the MNCHW to sustain maternal, newborn and child health outcomes? ▪ What is the contribution of the MNCHW to strengthen the primary health care system?
Partnership	<ul style="list-style-type: none"> ▪ To what extent is the partnership between UNICEF and NPHCDA effective and coordinated? ▪ Are there clear roles and responsibilities of MNCH week partners?
Sustainability	<ul style="list-style-type: none"> ▪ How sustainable is the MNCHW? ▪ Is there an exit strategy in place? ▪ What are the roles of partners, and what is the level of ownership and accountability?

¹¹ Guidelines developed by the OECD/DAC Network for Development Evaluation (OECD/DAC 2010)

APPROACH

A variety of approaches were used to systematically address the complex and comprehensive set of questions of this evaluation. The value of the intervention was determined by an assessment of the quality of the systems (institutional-national, state, partners and community- cultural, social, etc.) and their inter-relationships from inputs, activities to implementing the MNCHWs. A community participatory approach was also used to explore the immediate outputs of the MNCHWs while quantifying the extent of coverage of MNCHW interventions was determined via a household survey. The evaluation design approved and used is based on the Standards for Evaluation as defined by the United Nations Evaluation Group¹².

Gender equality and human rights

A 12-member multidisciplinary team of evaluators with five males and eight female members (See Annex 4 for Evaluation team composition and biodata). The team was guided by LSTM and Nigeria Code of Practice for Research Conduct, in conducting this evaluation (principles are presented in Box 5 below).

Box 5: Ethical code of conduct and principles guiding evaluation

- Being open, honest and fair, including properly attributing the contribution made by others
- Providing leadership and co-operation in research, including the appropriate supervision and mentoring of young researchers
- Appropriately recording and reporting research, allowing ready verification of the quality and integrity of the research data
- Appropriate dissemination, application and exploitation of the results of research;
- Compliance with relevant regulations or policies, whether legal, institutional or other, which govern particular aspects of research
- Professional participation only in work which conforms to accepted ethical standards and which ensures the safety of all those associated with the research
- Participation only in work which the researcher is competent to perform
- Avoidance of real or apparent conflicts of interest
- Strict maintenance of the confidentiality of all those involved

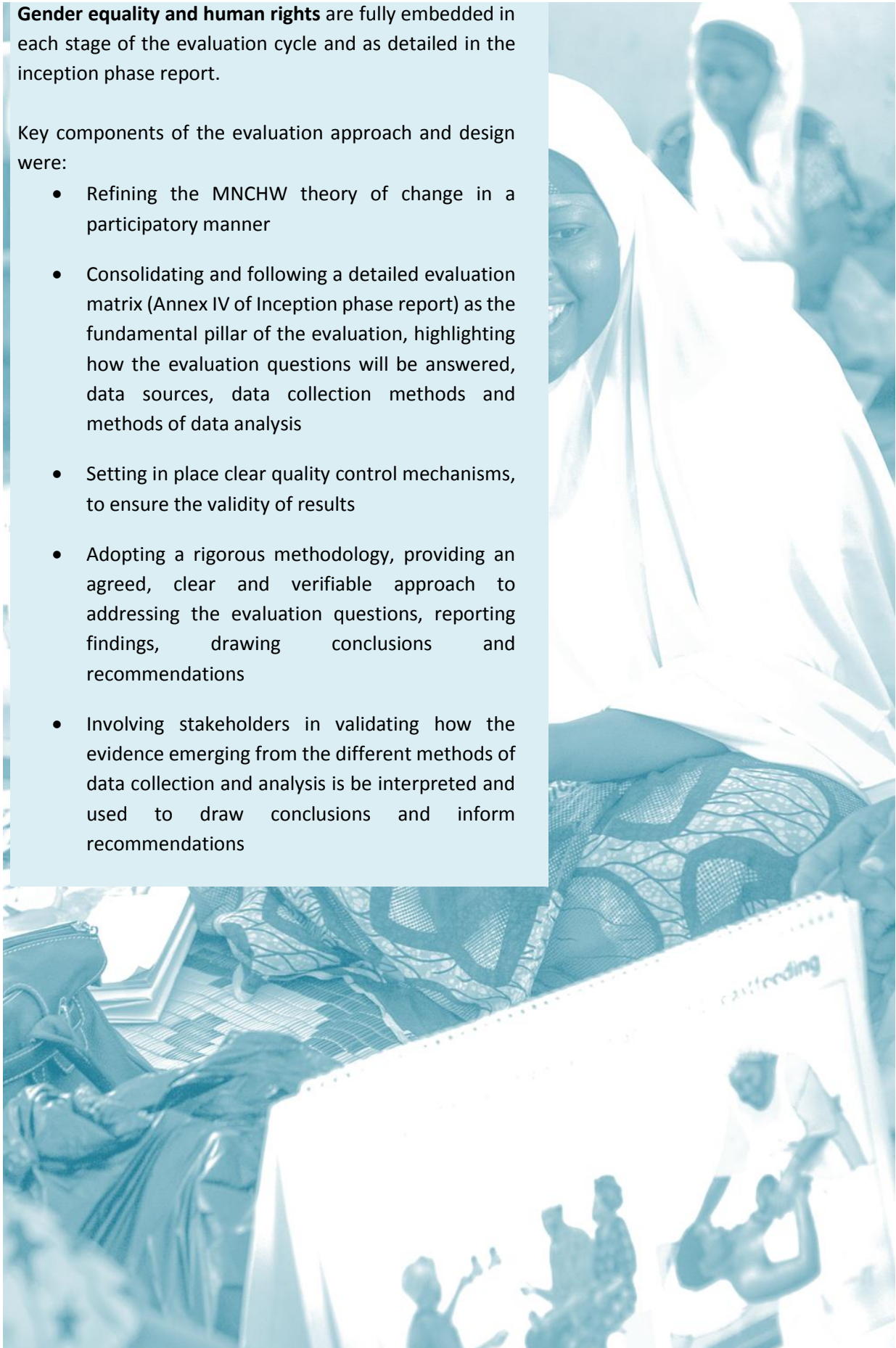
These principles are fully aligned with key United Nations Evaluation Group (UNEG) standards, and in particular: integrity, independence and impartiality (UNEG 2.5.); participation of stakeholders throughout the evaluation process (UNEG 3.11); respect and honesty (UNEG 3.10); anonymity and confidentiality of individual information (UNEG 2.7.).

¹² United National Evaluation Group (UNEG): Standards for the Evaluation in the UN System. April 2005.

Gender equality and human rights are fully embedded in each stage of the evaluation cycle and as detailed in the inception phase report.

Key components of the evaluation approach and design were:

- Refining the MNCHW theory of change in a participatory manner
- Consolidating and following a detailed evaluation matrix (Annex IV of Inception phase report) as the fundamental pillar of the evaluation, highlighting how the evaluation questions will be answered, data sources, data collection methods and methods of data analysis
- Setting in place clear quality control mechanisms, to ensure the validity of results
- Adopting a rigorous methodology, providing an agreed, clear and verifiable approach to addressing the evaluation questions, reporting findings, drawing conclusions and recommendations
- Involving stakeholders in validating how the evidence emerging from the different methods of data collection and analysis is be interpreted and used to draw conclusions and inform recommendations



EVALUATION METHODOLOGY

DESIGN

Based on the comprehensive evaluability assessment a non-experimental design was used for this impact evaluation to determine what contribution the MNCHWs has made to coverage of the interventions implemented (outputs) and the outcomes (reduced under 5 and maternal mortality), a theory based approach, specifically contribution analysis was used. The lack of a baseline or control group, leaves the option to build a case for reasonably inferring causality, that is the extent to which the intervention can be said to have contributed to a set of observed outcomes (negative or positive).

Contribution Analysis

Contribution analysis¹³ is an analytical approach suited for studies that examine **whether a programme or policy contributed to achieving certain results and impacts.**

As suggested by Mayne, contribution analysis is useful in instances where it is impractical, inappropriate, or impossible to address the attribution question through an experimental evaluation design, the evaluation question must be readdressed by focusing on the extent to which the evaluator can “build a case for reasonably inferring causality,” that is, the extent to which the intervention can be said to have contributed to a set of observed (positive or negative) outcomes.

The basic assumption underlying contribution analysis is that causality (plausible attribution) can be derived from addressing the following:

- That a programme is based on a plausible and doable theory of change,
- That the activities in the theory of change are implemented accordingly,
- That the theory of change can be validated by existing evidence.
- Additionally, evidence should demonstrate that the chain of expected results has occurred and that other factors, including influencing factors and alternative explanations for achievements that influenced the programme were assessed and their relative influence recognised.

Multiple lines of evidence were used to confirm and validate the contribution story. A detailed description of the contribution analysis design used for this impact evaluation is presented in the companion report and inception report.

¹³ Mayne, J. 2001. Addressing attribution through contribution analysis: using performance measures sensibly. Canadian Journal of Program Evaluation 16: 1-24

METHODS OF DATA COLLECTION

Primary data (quantitative via household survey and qualitative through key informant interviews and focus group discussions) and secondary data analysis were used to answer the evaluation questions. A detailed description of the methods used and procedures are provided in the companion and inception reports. Error! Reference source not found. Table 4 overleaf provides a summary of the methods and data sources used to address the evaluation questions.

Household survey

A household survey was conducted to estimate the current coverage of key interventions which are included in the campaign and to estimate the proportion of the coverage which is attributable to the campaign. The survey captured data from eligible households which included at least one child who was reportedly below two years of age at the time of the most recent MNCHW campaign which took place in or soon after November 2015. For eligible households, details concerning the numbers of women of reproductive age, children under two years of age and other children under five years of age and mosquito bed nets were collected. Ages were measured at the time of the most recent MNCHW campaign. Details concerning activities covered in the MNCHW campaigns were collected from at least one available member who was a woman of reproductive age, all children under two years of age and all other children aged between two and five years of age.

Data collection tools, ethical approval and piloting of tools

The data collection procedure and data collection tools have been approved by ethical committees at LSTM and FMOH. Also, details of training and piloting of the tools and protocols are provided in separate reports (**Annex 10, 11**). A detailed report of data collection in two phases is also provided as (**Annex 12 and 14**).

Gender equality and human rights considerations

Several measures were taken at input, process, output and outcomes.

Evaluation input and process level

- Fair composition of teams of consultants and field workers involved in data collection;
- Equal voice to different groups assessed/involved in data collection at management, facility or community level;

Evaluation output and outcomes

- Disaggregation of quantitative data by socio-economic characteristics of the population;
- Disaggregation of data by gender (where available);
- Analysis of qualitative research coded relevant emerging themes according to gender and socio economic characteristics of the population;
- The findings of the evaluation – when this was possible - have highlighted relevant aspects of gender equality and human rights, exploring barriers/bottlenecks to equal access to care for different groups of the population.

Table 4: Evaluation criteria, questions, indicators, data collection methods and sources

Evaluation Criteria	Key Evaluation Questions	Operational evaluation questions	Indicator/Descriptor	Data collection method and Primary data sources	Data collection methods: and Secondary data sources	
Relevance	To what extent are the objectives of the programme still valid?	Are MNCHW a priority delivery platform in Nigeria? Are its objectives consistent with national priorities for the health sector?	Assessment by policy and key stakeholders of relevance of MNCHW objectives	Qualitative data: Key Informant Interviews	Policy Documents; MNCHW reports	
		Are there budgetary commitments for the MNCHWs?	Proportion of States with MNCHWs budgets developed/approved	n/a	MNCHW reports and State budgets	
	Are the activities and outputs of the programme consistent with the intended impacts and effects?	Is the bundle of interventions offered consistent with the objective of MM and IM reduction?	Proportion of States with MNHCW funded	n/a	MNCHW reports and State budgets	
		Are all recommended interventions delivered through the MNCHW?	Assessment by simulation of impact of MNHCW interventions on MM and IM reduction	Document review: MNCHW reports from the States and NPHCDA	Lancet series; LSTM literature review on CHDs	
		Do all states deliver the MNCHW?	Proportion of MNHCW interventions offered, per state and per year	-	-	
		Do women and children attend the MNCHW?	Number of states offering MNCHW per year	Map number of states offering MNCHW, per year	MNCHW reports from the States and NPHCDA	
		To what extent does the intervention reach its targeted clientele addressing its needs and priorities?	Are communities aware of the MNCHW?	Proportion of women with children U2 attending the last MNCHW preceding the survey	LSTM Survey 2016 survey	MNCHW reports from the States and NPHCDA
			Are all target groups of the MNCHW reached through the intended interventions?	Proportion of women aware of MNCHWs (stratified by geographical area and educational level)	LSTM Survey 2016 survey	Other survey reports (e.g. ORIE baseline survey for DFID program)
		No. of women of reproductive age and n. of PLW reached by year, by intervention, stratified by urban/rural	-	MNCHW reports from the States and NPHCDA		

Evaluation Criteria	Key Evaluation Questions	Operational evaluation questions	Indicator/Descriptor	Data collection method and Primary data sources	Data collection methods: and Secondary data sources
	To what extent is UNICEF support relevant?	<p>To what extent MNCHWs are a means to reach the most underserved populations?</p> <p>To what extent the MNCHW is useful and valuable, in women's perspectives? What additional services would they like to receive through the MNCHW? What services are not essential?</p> <p>In what aspects (design; planning; funding; logistics and supply; delivery; measurement) is the contribution of UNICEF perceived as of added value at central level?</p> <p>In what aspects is the contribution of UNICEF perceived of added value at states level?</p>	<p>Proportion of women attending MNCHW, by geographical area and educational level</p> <p>Assessment by end users of relevance of the intervention package and delivery strategy</p> <p>Assessment by key stakeholders at national level</p> <p>Assessment by key stakeholders at States level</p>	<p>LSTM Survey 2016 survey</p> <p>Focus group discussions</p> <p>Key Informant Interviews</p> <p>Key Informant Interviews</p>	<p>Other survey reports (e.g. ORIE baseline survey for DFID program)</p> <p>Other relevant research (e.g. ORIE report on barriers to MNCHW)</p> <p>-</p> <p>-</p>
Effectiveness and efficiency:	<p>To which extent has the MNCHW contributed to improve coverage of PHC interventions?</p> <p>To what extent has UNICEF and her partners support being effective and efficient?</p>	<p>Was there an increase in coverage of selected interventions before and after the introduction of MNCHW?</p> <p>Has the coverage of selected interventions increased over time, after the introduction of the MNCHW?</p> <p>What proportion of women and children reached with essential interventions did access those interventions via MNCHW (compared to routine)?</p> <p>Are funding levels at central and states level sufficient to deliver the MNCHWs?</p>	<p>Annual rate of change in interventions coverage (2003-2013)</p> <p>Observe trends in interventions coverage from 2010 to 2014, by intervention/by state</p> <p>Proportion of women and children that accessed selected interventions via MNCHW</p> <p>Attributable fraction (as above, disaggregated by key population characteristics: sex; mother literacy; rural/urban/state)</p> <p>Proportion of States reporting shortage of funding during MNCHWs</p>	<p>-</p> <p>-</p> <p>LSTM Survey 2016</p> <p>LSTM Survey 2016</p> <p>-</p>	<p>DHS 2003; DHS 2010; DHS 2013</p> <p>SMART SURVEY data sets, 2010 to 2015</p> <p>-</p> <p>-</p> <p>Operation Room reports; Annual reviews; Donor funding mapping</p>

Evaluation Criteria	Key Evaluation Questions	Operational evaluation questions	Indicator/Descriptor	Data collection method and Primary data sources	Data collection methods: and Secondary data sources
	<p>What are the intervention costs?</p> <p>Are there areas along the MNCHW delivery chain where operational efficiency improvements can be achieved? If so, what are they and how can they be implemented?</p>	<p>Is there availability of supplies at implementation level, during the MNCHW?</p> <p>Is there availability of personnel and means during MNCHW?</p> <p>What are the incremental costs of the MNCHW?</p> <p>What activities of the MNCHW could be planned and implemented better?</p>	<p>Proportion of States reporting shortage of supplies during MNCHWs</p> <p>Number of personnel trained and deployed to MNCHWs, per State</p> <p>Cost Description</p> <p>Assessment of areas of efficiency gains</p>	<p>Key Informant Interviews with States and FGDs with HCWs</p> <p>-</p> <p>-</p> <p>Case Study</p> <p>Observation of November 2015 MNCHW planning and monitoring</p>	<p>Microplans; Operation Room reports; Annual reviews</p> <p>Microplans; Operation Room reports; Annual reviews</p> <p>Microplans; donor's reports; state reports</p> <p>-</p>
Impact	<p>What is the consistency of the MCHW impact with the anticipated theory of change?</p> <p>What is the contribution of the MNCHW to sustain maternal, newborn and child health outcomes?</p> <p>What is the impact that the MNCHW has had on the primary health care system?</p>	<p>Is the MNCHW contributing to change as expected from the ToC?</p> <p><i>As above</i></p> <p>Is the MNCHW contributing to reinforce the health systems in management; human resources; quality of care; supplies; health information?</p>	<p>Contribution Analysis (contribution story)</p> <p><i>As above</i></p> <p>Stakeholders assessment</p>	<p>All</p> <p><i>As above</i></p> <p>Key informant interviews</p>	<p>All</p> <p><i>As above</i></p> <p>MNCHW reports</p>
Partnership	<p>To what extent does the partnership between UNICEF and NPHCDA effective and coordinated?</p>	<p>What are stakeholder's perceptions on MNCHW partnership effectiveness and efficiency?</p>	<p>Stakeholders assessment</p>	<p>Key informant interviews</p>	<p>-</p>

Evaluation Criteria	Key Evaluation Questions	Operational evaluation questions	Indicator/Descriptor	Data collection method and Primary data sources	Data collection methods: and Secondary data sources
	Are there clear roles and responsibilities of MNCH week partners?	What are roles and responsibilities against the MNCHW conceptual accountability framework?	Review of responsibilities along the ToC	Assess accountability framework (par 3.7 of guidelines) against real life implementation	Key informant interviews; Direct observation of Nov 2015 round
Sustainability:	How sustainable is the MNCHW are? Is there an exit strategy in place? What are the roles of partners, and what is the level of ownership and accountability?	<p>To explore long term plans re the MNCHW in Nigeria</p> <p>To identify opportunities to enhance human, social and financial sustainability of the MNCHW</p>	Does the government have a vision and a long term plan for the MNCHWs in Nigeria? What are the stakeholder's perceptions re such plans?	-	National policy documents; KIIs

Data collection period

Data collection for household survey, key informants, beneficiaries and non-beneficiaries were conducted independently. All qualitative data was collected between October 2015 and February 2016

Household survey data was collected within two time periods: 1st to 17th February 2016 (Phase 1) and 29th February to 21st March 2016 (Phase 2). The survey obtained quantitative data on the usage of services which were provided during the MNCHWs. Since these services are also available directly throughout the year via the national primary health care services, data collection also captured recalled information regarding the timing and sources of services.

SAMPLING

Sampling was necessary for the household survey, qualitative data collection and case studies

Household survey

Estimates were planned for the nation and for each sampled state, both settings (urban and rural), each of the six zones and the FCT. A stratified cluster sampling approach was planned. Within each zone two states were purposively selected. The intention in purposive selection was to use the 'best' and 'worst' states within each Zone. States were ranked in terms of their performance as measured by five relevant coverage indicators [Birth registration, Tetanus toxoid, Vitamin A, DPT3 and ITN coverage] which were measured in the Nigeria DHS of 2013.

When field work commenced some states had not delivered the 2nd round of the 2015 MNCHW which had been scheduled to take place by mid-February 2016. They were therefore ineligible for estimation of the impact of the campaign. Such states were replaced with the most similar eligible State within the respective Zone. North Eastern (Borno state was the worse ranked state but was classified as a high security risk area, so was replaced with Bauchi state which was ranked 5th in the zone) and North Central Zones (Best ranked state was Kwara and the worse ranked state was Niger) had no dates for the implementation of the 2nd round of 2015 MNCHW as, at mid-February 2016, they were replaced by Benue state-ranked 5th and Plateau state ranked 4th. Kogi and Nassarawa states ranked 2nd and 3rd respectively were not implementing or had no fixed dates) were affected.

Within each stratum (Zone and Setting combination) enumeration areas (EAs) were sampled using systematic probability proportional to size. Within selected EAs 16 households were to be selected. Four enumerators were each expected to collect data from 4 households within the EA. Where the EA contained more than the required number of households they were selected using a further one or two stages in which each enumerator randomly selected two streets and then two dwelling structures from the selected street. If the household was not eligible, a new household was selected. Where the eligible woman was not present, a recall on the same day was attempted. When the target respondent was still not available the household was replaced. When consent was not given in a household, that household was replaced but the incomplete data was captured.

The survey involved 5,389 households (105% of planned sample) 9,320 clusters (41% urban and 59% rural), 5,139 children aged 0-23 months (54% Male, 46% Female); 2,531 children aged 24-59 months (52% Male, 48% Female) and 5,180 women of reproductive age (15-49 years)-

Detailed sampling methodology, allocation of EAs is presented in the inception report.

Qualitative data sources

Key Informant Interviews (KIIs) and Focus Groups Discussions (FGDs). A qualitative approach was viewed as most appropriate for collecting information concerning the background (contextual data), as well as perceptions and views relating to the MNCHWs. These were from the two main types of respondents via KIIs (i.e. with those involved in overseeing, management or other implementation of the MNCHWs) and FGDs with members of the beneficiary communities (potential and actual recipients).



Two case studies on two states, one adjudged to provide exemplary implementation of the MNCHWs (Kaduna state) and one that has missed several round of MNCHWs (Kogi state).

Also LSTM observed the planning of the November 2015 MNCHWs at National level and in FCT Abuja, and the monitoring of its implementation at National level.

Key informant interviews

KIIs were to be undertaken at both state and national level, targeting national policy makers (FMOH, NPHCDA) and stakeholders (UNICEF, SPHCDA, WHO, Vitamin Angles, USAID, DFID etc.). Other stakeholders were identified in the inception period (see state and National consultative reports in Annex 2 and 3) directors and managers of health services at State and Local Government Area (LGA) level, community leaders and health workers. These provided insights into the organisation, implementation, elements of evaluation and recommendations for MNCHWs from a variety of perspectives of those involved directly or indirectly in the initiative. Key informant interviewees were conducted in all 12 states and FCT Abuja were the household survey was conducted

Focus group discussions

FGDs were conducted in four purposively selected states and FCT Abuja. The included states were Katsina (North west) and Niger (North central) in the North, and Ogun (South west) and Abia (South east) in the South of the country. These were selected as two relatively well performing (Ogun and FCT Abuja) and three poorly performing states (Abia, Katsina and Niger) on maternal and child health indicators (evaluation of state performance done as part of the evaluation planning). At the time of data collection all states included had conducted the second round of 2015 MNCHWs except Niger state. In each state, one rural and one urban location was selected. The locations for FGDs was the same for the beneficiaries and healthcare providers.

FGDs were conducted at two levels:

1. **With health care workers**, to explore their views on bottlenecks to MNCHW implementation and to test key assumptions regarding training of health care workers pre-MNCHWs role and capacity of health volunteers during MNCHWs; perceptions of areas of potential efficiency gains.
2. **At community level**, to explore perceptions regarding quality and usefulness of the MNCHW priority needs, barriers to access and influence of MNCHW on behaviour and practices. This will complement the review of reports from the states on social mobilisation input and activities.

Case studies

Two states were purposefully selected for case studies on recommendation of key stakeholders based on a judgement of the level of success or challenges encountered in the implementation of the MNCHWs so far. Of the two states (Kaduna and Kogi state), data collection was only possible in Kaduna state. The political instability at the time of data collection prevented a visit to the state by the evaluation team.

Data analysis

DATA ANALYSIS

To build a contribution story which is based on a solid and objective approach to **drawing conclusions** based on available data, various methods of **triangulation** were used.

Data triangulation: various approaches to data triangulation will be adopted.

Data from the LSTM household survey will be triangulated with data sets of large scale surveys regularly performed by UNICEF in country. Findings at selected States level will be also triangulated with evidence available through secondary data of outputs achieved during the MNCHWs and of availability of inputs (Operation room reports; birth registration data sets; immunisation records).

Methodological triangulation: through the proposed mixed methods approach, evidence from both qualitative and quantitative data will be used to assess each of the hypotheses being tested. Multiple lines of quantitative data will be used to inform reasoning around hypotheses testing, whereas emerging themes from qualitative data will be used to validate the credibility of hypotheses and to construct plausible explanations of findings.

Investigator triangulation: both qualitative and quantitative data will be analysed independently by LSTM researchers assigned to the evaluation. In addition, researchers will also independently interpret data; different interpretations will then be used by the LSTM team for collective analysis and brainstorming.

An in-depth description of the data analysis for both qualitative and quantitative data is presented in the companion report.

STAKEHOLDER CONSULTATIONS

Stakeholder consultations engagement throughout the evaluation, was important to develop a robust methodology, tools and strengthen the contribution story that emerged. LSTM consulted the MNCHWs evaluation steering committee (ESC) during each phase of the evaluation (inception phase¹⁴ and pre-data collection phase). All tools and evaluation protocol were approved by the MNCHW ESC the 20th of January 2016. The meeting was chaired by the NPHCDA and was attended by 28 individuals representing 14 different stakeholders^{15,16}. The last consultation was held on the 21st of September 2016 to discuss the findings/results and recommendation of the evaluation.

LIMITATIONS

A number of limitations related to this evaluation were identified with a description of how dealt and are outlined in Table 5 overleaf. (A full description of limitations are presented in the companion report). These have been taken into account by the evaluation team, when documenting findings and drawing conclusions.



¹⁴ MNCHWS Evaluation Steering Committee inception phase meeting June 2015. Minutes

¹⁵ MNCHWs Evaluation Steering Committee 20th January 2016. Minutes

¹⁶ MNCHWs evaluation, LSTM January 2016 Mission report.

Table 5: Data sources, numbers sampled, locations of data collection, key limitations and mitigation measures

Data type		Source of data	Number	States included	Use in the evaluation	Limitations and ways of mitigating
Primary	Qualitative	Key informant interviews at national level	24	NA	Key informant interviews helped to establish details of the MNCHW campaigns concerning roles and responsibilities of different stakeholders, identify main barriers and enablers, but also focus on specific points relevant for the individual respondents relating to MNCHW. Data generated in through the interviews were triangulated against other KIIs, but also against official documents and data.	<p>Availability of target participants: Not all stakeholders identified as potential respondents were able to take part in the interviews, thus limiting the pool of information available for evaluation – steps were taken to allow for the breath of responses to be represented, but the limited timeframe for fieldwork simply made it impossible to accommodate everyone’s availability. Representatives of a wide range of MNCHW stakeholders were interviewed</p> <p>Validity and relevance of responses: Views of stakeholders included represent their personal opinions and beliefs which may not tally with those of organizations they represented or necessarily be based on robust evidence, but rather may be anecdotal and influenced by particular circumstances – this is a general risk of all types of qualitative research and the researchers tried to mitigate it by asking questions in a way that would encourage elaboration and using examples which would help with identifying the strength and direction of data collected. Wherever possible, other data sources, including secondary official documents and statistics were used as part of triangulation of the data for the evaluation.</p> <p>Perception of disclosure of sensitive institutional information: There is a risk of not wanting to disclose information which may portray the institution the respondents represented in negative light or disclose issues which may reflect negatively on the respondent themselves – the way this was mitigated was by using questions in a non-threatening way which would not put respondent under unnecessary pressure to feel they needed to reveal things with which they were uncomfortable, while at the same time underlining the</p>

Data type		Source of data	Number	States included	Use in the evaluation	Limitations and ways of mitigating
						importance of providing both positive and negative perceptions, so as to aid the programme overall.
	Qualitative	Key informant interviews at state level	22	Abia, Katsina, Kwara, Niger, and Ogun	As above, with more specific focus on individual states, especially with relation to comparing well and poorly performing areas.	As above
	Qualitative	Focus group discussion with healthcare providers (healthcare providers, managers and other senior members of staff at facility level, volunteers) in urban and rural settings	15 (including 11 with healthcare providers, two with managers, two with volunteers)	FCT Abuja, Abia, Benue, Katsina, Kwara, Niger and Ogun	<p>Themes were derived from the topic guides and the initial analysis of the data and captured in a code frame subsequently applied to individual transcripts. Due to the three different types of respondents, views and ideas expressed by the representatives of the different groups were compared, alongside other FGD characteristics including state and location (urban/rural). The data were then triangulated against points raised by community members in the potential beneficiaries FGDs. No direct triangulation against official statistics was done, though themes identified were incorporated in the broader analysis.</p> <p>Key areas for data generation covered the organisation of the MNCHWs, issues around training of staff, stock management, running of the intervention (including outreach services) and perceived results wrt volume of patients, effects of the campaign on services and health outcomes, key challenges and suggestions for improvements.</p>	<p>As above, plus:</p> <p>Sensitive issues: Because of the group discussion setting, not wanting to share information which may negatively affect the relations with others present in the room – respondents were informed at the start of the discussion that they should only share whatever they felt comfortable within the group, but if there were any other points they wished to raise, they were welcome to speak to the moderators and the research team outside the FGD.</p> <p>Quality assurance during data collection: FGDs covered a lot of material and within the available time, not all issues were covered to the same degree and therefore there is a risk that not all issues were covered in sufficient depth across all FGDs – the research team held debriefing sessions and reviewed the notes following each FGD to identify such gaps and discussed ways of addressing any missing points in subsequent groups.</p>
		Focus group discussions	28 (14 with beneficiaries)	FCT Abuja, Abia, Benue,	Key themes from the individual groups were used to develop a coding frame initially	<ul style="list-style-type: none"> MNCHW terminology: The degree of confusion around MNCHW branding meant that the

Data type		Source of data	Number	States included	Use in the evaluation	Limitations and ways of mitigating
	Qualitative	with beneficiaries and non-beneficiaries (male and female) in urban and rural settings	, 10 with non-beneficiaries , four with respondents of mixed usage backgrounds)	Katsina, Kwara and Ogun	<p>developed on the topic guide and all individual transcripts was coded. The individual points raised were then use to develop a narrative on particular points with all different types of views covered by respondents within and across the groups. Analysis by states, locations (rural/urban), genders and users/non-users was performed to compare views expressed by representatives of the various groups. Points raised by community members were triangulated against themes from the GDs with HCPs. No direct comparison with actual statistics or official reports was done, but points raised were incorporated in the broader analysis.</p> <p>Key areas for data generation covered ways of learning about the campaign (including social mobilisation means and evaluation of the publicity), access to services as part of MNCHW and outside, main advantage of the MNCHWs (where relevant), main challenges and suggestions for improvement</p>	<p>recruitment for some of the groups was not as expected and included a mix of beneficiaries and non-beneficiaries, thus potentially affecting the outcome of the discussion – moderators tried to steer the discussion in such a way as to accommodate the experiences of the different types of respondents without making either group feel uncomfortable.</p> <ul style="list-style-type: none"> • Generalisability of qualitative results: Qualitative data collected from 4 states only. The opinion of other beneficiaries, health care workers, health care managers in other states may be different. Appropriately sampled participants, representing, gender, urban, rural, beneficiaries, non-beneficiaries, health managers and health care providers. Data collected till saturation. Triangulation (Data, methodological, investigator) was used to improve reliability of the results.
	Quantitative	Household survey with data collected on under-2, under-5, women of reproductive age	5, 389 households in 320 clusters with 5, 139 children under 24 months of age, 2, 531 children aged 24-59 months and 5, 180	<p>Two states sampled from each of the 6 geopolitical zone, with precision of estimates at National and Zonal level.</p> <p>FCT Abuja, Abia Anambra, Kwa-Ibom,</p>	Coverage data contributed by MNCHW as well as awareness of MNCHW	<ul style="list-style-type: none"> • Generalisability of Household Survey results: HHS conducted in 12 states and FCT Abuja only. So estimates for each of the 36 states and FCT cannot be determined. Precision of results at Zonal and national level only based on sampling methodology used. • Primary respondents not available: WRA who are employed were likely away to work in the afternoon and mid-afternoon during week days. Repeat visits late afternoon or during the weekend was used to mitigate this. If necessary, the house hold was replaced.

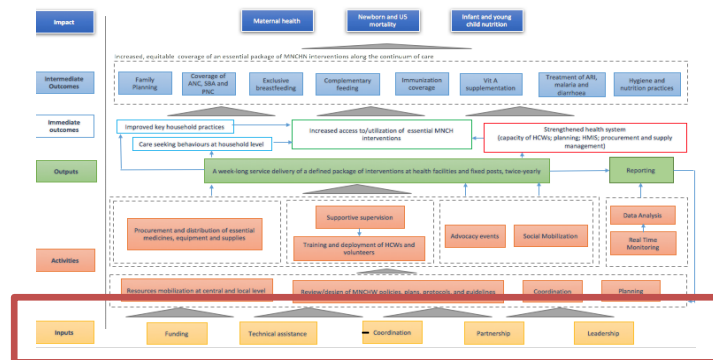
Data type		Source of data	Number	States included	Use in the evaluation	Limitations and ways of mitigating
				Edo, Ogun, Osun, Benue Plateau, Katsina, Kebbi, Adamawa and Bauchi states.		<ul style="list-style-type: none"> • MNCHW terminology: MNCHW is not a term recognised by community members or health care workers. The training of data collectors included comprehensive description of MNCHWs and ways of differentiating it from IPDs • Limited access to some communities included in the sampling frame: Physical access to some clusters were difficult, the team of data collectors used means of transport appropriate for the areas and set out very early for data collection. • Cultural sensitive issues: Clusters were culture restricted the use of men to interview women, we had predominantly female data collectors in such areas. • Data quality assurance during field work: There was robust supervision of data collectors by LSTM, UNICEF, FMOH and NPHCDA. Feedback to improve the quality of data collection was carried out daily.
Secondary data collection		Reports, monitoring data sets, Operation Room reports; Annual reviews; Donor funding mapping. Microplans; Operation Room reports; Annual reviews		All states	To address some evaluation questions	<ul style="list-style-type: none"> • Lack of financial informant on costs of MNCHW: In order to provide a description of the costs of MNCHW, budget/reconciled expenses from stakeholders is required. Appealing for information through the MNCHW Evaluation steering committee and UNICEF. • Lack of comprehensive MNCHW reports: Key stakeholders were approached for documents during MNCHW ESC meetings, visit to states, key informant interviews and visits to NPHCDA

FINDINGS

The methodology utilized for this evaluation entails assessing the program ToC, and the strength of assumption along the causal chain linking inputs to activities; activities to outputs; and outputs to outcomes and impacts. The revised ToC is presented in the next page. The key findings emerged from our research are presented according to such approach.

FINDINGS RELATED TO MNCHWS INPUTS

Key inputs of the MNCHW are identified as follows: Funding; Technical Assistance; Coordination; Partnership; and Leadership.



Finding 1.1 Lack of transparent and comprehensive information on budget and expenditure limits the capacity of partners to plan and implement MNCHW

- No evidence was found during the evaluation of the availability of a comprehensive quantification and budgeting process, that allows to estimate the resources needed to plan and implement the MNCHWs at national level. This issue hinders the ability to predict and then assess allocations against a costed macro-plan for the initiative.
- NPHCDA has recently initiated to track allocations of resources from donors and partners, NPHCDA, and States. At its current state, the tracking dashboard does only capture the value of financial allocation, whereas in kind support (procurement, logistics, technical assistance) is not quantified nor monetized. This tracking tool is an encouraging start, but needs improvement in its conceptualization, design and implementation.
- At the moment, the data available indicate that – depending on various rounds of the MNCHW – data on allocations are available for 30-60% of implementing States. And that data on allocations from LGA are available inconsistently (6% of LGAs allocation available in 2015; 51% in 2013). Full cost description of available financial information on MNCHWs is presented in the companion report.
- Data on allocations from NPHCDA are of limited usefulness for analysis. No information is available on the methods and on accuracy of the exercise, and the lack of quantification of non-financial allocations limits considerably the possibility to make any conclusive assessment.
With this premise in mind, it is worth considering that the available data show a trend of decrease in allocation of funds from States, as well as from other donors and partners. This is

partially offset by the increased funding earmarked by UNICEF for the MNCHW. For round 1 2015, the contribution from UNICEF alone accounted for approximately 50% of the total reported allocations for that round **(Figure 3)**.

Figure 2: Revised MNCH week Theory of Change

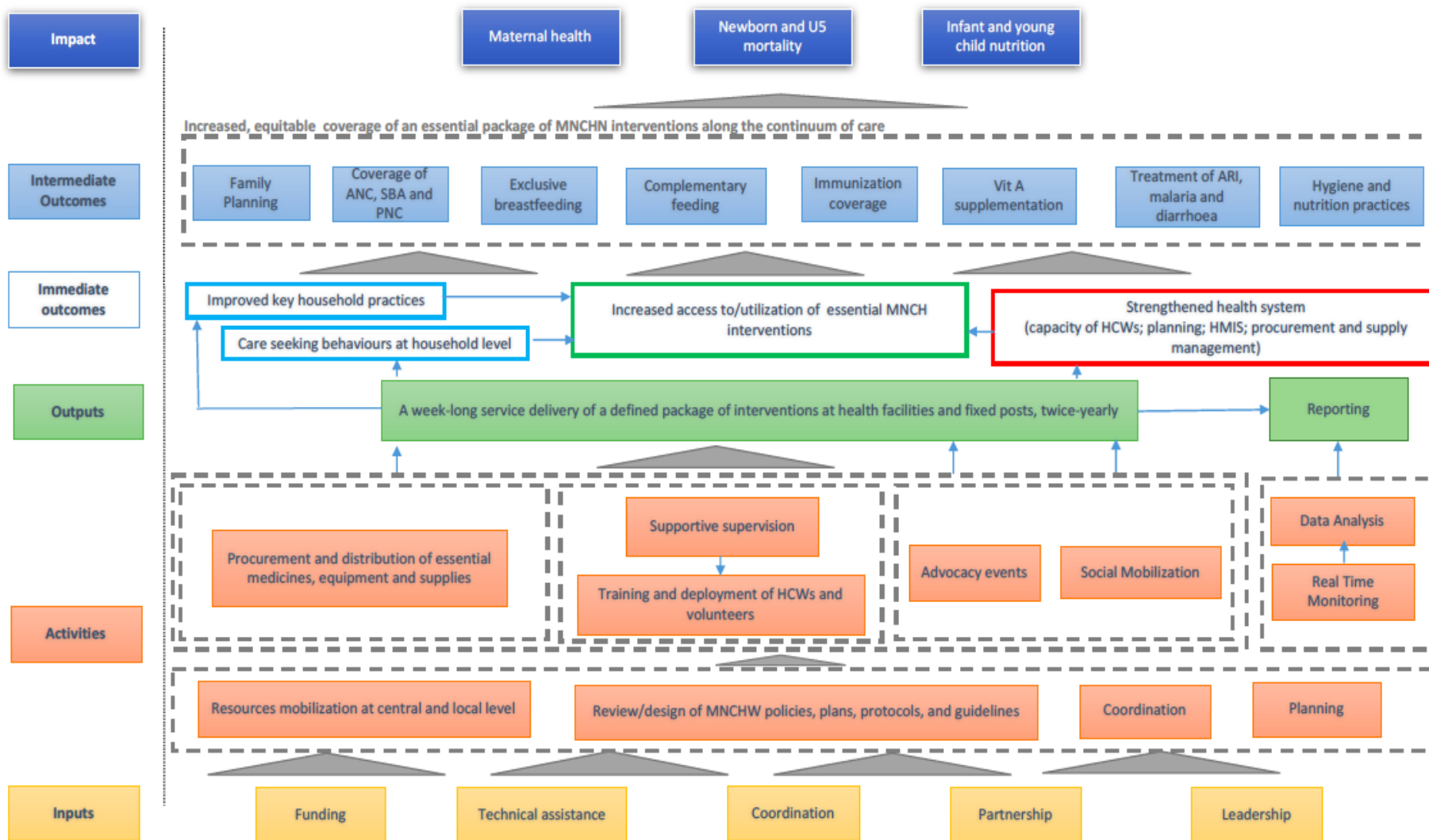
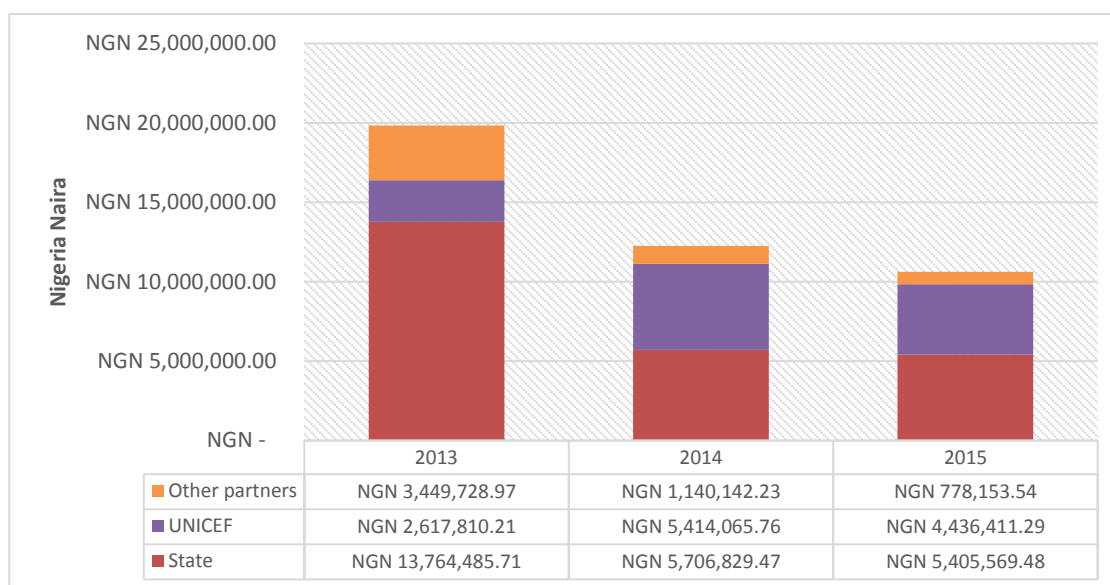


Figure 3: Average allocation to MNCHW per State, 2013-2015 (Source: NPHCDA, 2016)



- No data were accessible to the evaluation on the actual expenditure incurred at various levels of the system. Lack of information on actual spend hinders the capacity of NPHCDA and partners to advocate for increased and timely investments; to document under-expenditure; and to assess value for money (efficiency).

Finding 1.2 There is a solid partnership base to support MNCHW, at least at national level and with stakeholders operating within the health sector

- The NPHCDA has ownership and overall leadership of the MNCHW programme. It is responsible for national planning and coordination of MNCHW, setting of implementation dates, coordination of partners, development of the guidelines for implementation and a Monitoring & Evaluation framework for the MNCHW. The FMOH provides technical assistance to the National Primary Health Care Development Agency and the State Ministry of Health (SMOH) for the implementation of the MNCHWs.
- A core group of partners have historically supported the MNCHW. These include, but not limited to: UNICEF; UNFPA; WHO; DFID; World Bank; Vitamin Angels; HKI; Micronutrient Initiative; Save the Children.
- The key stakeholders who drive the MNCHW are perceived to be the NPHCDA, FMOH and UNICEF Nigeria, while for planning and implementation at state level the SMOH and State Primary Health Care Management Board (SPHCMB) drive the campaigns.

→ In general terms the roles and responsibilities of different stakeholders are clear and that these are broadly outlined in the MNCHW guidelines. However, the roles for development partners are only described in general terms for the group as a whole and **division of roles and responsibilities between different partners needs more clarification**. Before each MNCHW round there are stakeholder planning meetings, where different partners agree on who does what. After each round there are review meetings, but a few interviewees mentioned they were not always invited. However, communication of information through e-mail was reported as good.

“The partners have not even up till now been able to harmonise their work. That lack of harmonisation of strategy, approach, of mandate has led to a lot of fragmentation of what seems to be an integrated approach.” (KII at national level; T1 - 11.11.15 - 01)

→ No evidence is found at neither States nor national level about systematic, large scale **partnerships beyond the health sector**, and including for instance other line ministries; media; private sector; grassroots organizations.

“How do we sell public health as really MNCH? How do we convince the private sector and make this look like they are not just giving, but they are getting in return? There are ways to do this.”

→ UNICEF provides significant support to the MNCHW in its current formant and this support is relevant to delivery of the MNCHWs. Based on literature review, UNICEF implemented the CHDs in Nigeria prior to its transformation into the MNCHWs. UNICEF provides funding that supports procurement, planning, monitoring and the impact evaluation of the MNCH weeks at National level and in all states of Nigeria. UNICEF also provides technical assistance through its Health, Nutrition, HIV and monitoring & evaluation teams. NPHCDA and UNICEF are co-chairs of the MNCH weeks evaluation steering committee.

Finding 1.3 There is a significant investment in technical assistance from key stakeholders, but this is often limited by limited resources and agendas

→ A desk review and interviews with stakeholders at various levels of the MNCHW delivery chain suggest that substantial resources have been invested over time in the provision of technical assistance to the MNCHW.

→ Besides and beyond financial and logistic support provided by partners, examples of technical assistance include: the set-up of a real time monitoring system for the campaign (Rapid SMS); the support to the design of comprehensive guidelines, protocols and tools for the campaign; the design of training packages for managers, health care workers and monitors; the introduction of micro-planning processes and tools. In many instances, UNICEF has been catalytic in setting the agenda for technical assistance at design stage; at implementation stage, a lot of technical assistance on the field has come from NGOs.

- Evidence from our primary research suggest that the ‘fit’ of partners’ support is often constrained by limitations in terms of selected geographical and/or intervention areas; by the availability of resources over time. And by internal/individual prioritization processes and agenda.

Finding 1.4 Political leadership is high, but translation of political commitments into action is limited

- Political will is key to the realization of MNCHW at scale, and with regularity. Underlying reasons are lack of political will and commitment, which leads to inadequate funding and late release of funds, as well as weak and late planning.

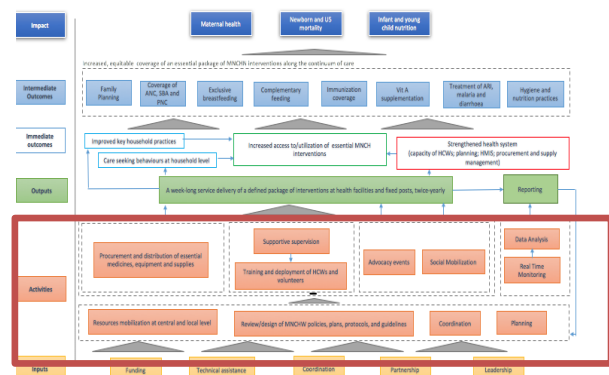
- It is observed that political will is often limited to public statements and communications, but not always followed by concrete action (funding and support). Political will and commitment is required, not only verbal, but it should be translated into increased allocation of financial and human resources to routine PHC services.

“It is political will. If there is no political will there will really be no money. Because you can’t say in Nigeria there is no money. Nigeria is a rich country, you know, and no partner should be investing any money in Nigeria, by the way. Nigeria can fund its own health system. If they don’t want to do it, they don’t want to do it. Let’s not beat around the bush. If they don’t want to fund it... If states will have health high on their priority agenda, the money is there.”
(KII at national level; T1 – 12.11.15 – 01)

- Evidence from qualitative research provides examples of the importance of political will in the realization of MNCHWs. An example of political will was given of a state which is committed to funding of the MNCHW because the Governor is a medical doctor. Some states are committed despite not being wealthy, while other states, with plenty of resources, are not interested in funding health care. Therefore, advocacy directed at governors and LGA chairmen is seen as very important.

FINDING RELATED TO MNCHW ACTIVITIES

Key inputs of the MNCHW are identified as follows: Resource mobilization; Design of policies, manuals and protocols; Planning and coordination; Procurement and distribution of essential supplies and medical items; training and deployment of health care workers; supportive supervision; advocacy and social mobilization; monitoring and reporting;



Finding 2.1 The allocation and the timely disbursement of funds for the MNCHW is a key bottle neck to implementation

- There is no data available to produce an analysis of funding trends and gaps, for the MNCHW. Yet, at all levels of the system involved in the evaluation via qualitative research, stakeholders report that inadequate funding is a key challenge of the campaign; this particularly relevant with regard to Government funding at state and LGA level, both for the MNCHW and for PHC in general.
- Evidence suggests that funding for the MNCHWs and funding systems are not adequate and that **inadequate funding or late release of funds negatively** affect the MNCHWs in different ways, such as:
 - Inadequate planning because there are no funds for planning and coordination meetings and planning is late and ad hoc because of late release of funds;
 - Delayed or even non-implementation of MNCHWs;
 - Inadequate social mobilisation, leading to low uptake of MNCHW interventions and low coverage;
 - Inadequate training of health care providers;
 - Shortage or non-availability of MNCHW commodities, such as deworming tablets, ferrous & folic acid tablets, LLITNs;
 - Inability to reach hard-to-reach communities contributing to low coverage
- **Key bottlenecks** to the capacity of the system to leverage funds include:
 - Inconsistent Government ownership at various level of the system.
 - Existence of different funding mechanisms; Some development partners provide funding for the MNCHW directly to the FMOH/NPHCDA or their partner states, while others, such as CIDA, DFID and the European Union (EU), channel their funds for the MNCHW through UNICEF or Save the Children, which is done by DFID. Others provide commodities to the MNCHW programme. Such de-facto condition creates a hard-to-manage scenario;
- Commitment from Government is inadequate, particularly at state and LGA level. Even if there is funding, funds are often released too late, which particularly affects pre-implementation activities at state and LGA level, such as purchasing commodities, training of health workers and social mobilisation.
- Bureaucracy and processes are also bottlenecks to timely access to funds. Examples are included below.

Delays in funding due to internal bureaucracy - Kaduna state had only implemented 8 of the 11 rounds of MNCHW at the time of the visit, the 2nd round of the 2015 MNCHWs was planned for the week after the visit. The main reason for non-implementation of 2 rounds and delay implementation of the November 2015 round was lack of funds and delay in release of funds. The new funding arrangements in government (TSA-Treasury single account) was cited as a

significant factor in the release of funds (this is similar to what was reported by the FCT PHCDA, during their planning meeting for November 2015, observed by LSTM).

Delays in funding due to partner's bureaucracy - Partners and NGOs that fund the MNCHWs may do so by providing funds directly to the PHCDA. This involves writing a proposal, which has to be processed and approved via government system, prior to submission to the partner.

Key informants at state level identified this process as another source of delay in the release of funding and they suggested advanced planning to overcome this

“States get funds by writing proposals and this may be delayed by bureaucracy, for example, the person that should sign and forward the proposal may be unavailable sometimes for up to a week”. **KII state level**

problem. A typical quote illustrating this point is presented in the box above.

Finding 2.2 There is a large body of regulating documentation developed and available for MNCHW in Nigeria, but this is not widely used

- A number of regulatory documents are available for MNCHW. These include: Guidelines for Implementing the MNCHW in Nigeria (NPHCDA, 2014); Training Manual for Implementing the MNCHW in Nigeria (NPHCDA, 2014); reporting tools, IEC material, protocols, M&E forms etc.
- Policies, protocols and guidelines for MNCHW are **internally consistent and updated**.
- The MNCHW guidelines produced by the NPHCDA is in its second edition and key stakeholders at both National and State levels are aware of them. They are usually not readily available as hard copies. Health care workers and facility managers are unfamiliar with the MNCHW guidelines.

Finding 2.3 The quality, inclusiveness and timeliness of the coordination and planning functions needs substantial improvement

- According to the MNCHW guidelines, a national MNCHW committee, also referred to as steering committee or planning committee, plans and coordinates the MNCHWs at federal level. Key stakeholders involved in this evaluation via KIIs were not aware of its existence. However, there is evidence that there are general stakeholders' meetings before each MNCHW round, which are coordinated and chaired by the NPHCDA. This is considered to be the planning platform where representatives from relevant departments of government ministries and other government agencies meet with those from multilateral development agencies, notably UNICEF, and international and national development partners and NGOs.

- TORs for NMCHW committee or for any other planning meeting could not be found during the course of the evaluation. It appears there is no implementation plan for the MNCHWs or other document which clarifies more in detail the roles and responsibilities of different individuals, departments and organisations, and who does what, when and where.

- At state level there is a focal person responsible for planning and coordination of activities of the MNCHW in the state. It was reported that this was usually the state nutrition officer (SNO) or the state immunisation officer, reflecting the initial focus of child health campaigns. There is also supposed to be a MNCHW coordinating committee at state level.
The extent of planning and coordination at state and LGA level varies but improvement is needed in weak states and LGAs, which can be identified during post MNCHW reviews. There are some states which are doing well, while other states are unable to synchronise the MNCHW with the recommended national dates or only manage to organise one week per year instead of two.

- One common reported issue is ‘late planning’, that occurs despite that the MNCHW guidelines are clear and everybody knows that the weeks will be held every year in May and November and that the uniform exact dates will be later communicated by the NPHCDA.
Although SMOHs are quite autonomous in the decentralised governance system in Nigeria, instead of starting the MNCHW planning process several months in advance, it seems planning at state level starts only after a formal official letter has been received from the NPHCDA about the next round of the MNCHW, indicating the exact dates. Reportedly this letter arrives rather late resulting in inadequate resource mobilisation, inadequate social mobilisation and poor planning, coordination and implementation of the weeks.

- After each MNCHW there is supposed to be a post implementation review meeting at national level with the same stakeholder group, but this is not always held. Additionally, not all Non-Governmental Organisations (NGOs) are invited, further limiting the strength of the committee.

- Key to a bottom up approach to planning is the exercise of **micro-planning**, which is in theory the driving force determining outputs, activities and inputs required to implement MNCHW from HF level above. Micro-planning is an approach widely promoted by WHO and UNICEF, for which standard tools, SOPs and guidelines have been developed and widely implemented. Nigeria has microplanning embedded in its MNCHW guidelines.
The evaluation performed a desk review of microplans available for 2014. We reviewed an excel data set, shared by NPHCDA, designed to aggregate all micro-plans for the May 2014 MNCHW round. We found that:
 - In May 2014, 32 of 37 States (including FCT) implemented the MNCHW.
 - The data set made available to LSTM provides detailed work plans and/or micro plans for only 20 of the 32 implementing states (62%).
 - However, only 17 of the 20 reporting states had micro plans (85%).

- In summary, the micro plans collected and available at central level for the round under analysis were available in 17 out of 32 implementing states (53%)
- The templates used to produce micro plans were not consistent, according to the data set. States used a wide range of tools.
- The consistency in using the micro-plans to estimate the relevant resources needed was sub-optimal. For the reporting States (53% of the sample):
 - 70% of the micro plans quantify the resources for man power.
 - 50% of the micro plans quantify the resources for logistics.
 - 60% of the micro plans quantify the resources for BCC.
 - 50% of the micro plans quantify the resources for management.

Finding 2.4 Equipment, supplies and medical items are inconsistently available across States and across different MNCHW rounds

- The procurement process for MNCHW is **highly fragmented**. By definition, part of the items is procured at national level, other at States level. And this mix varies over time depending on various factors, partners' commitment being a leading one.
- The quantification process is unclear because of the issues related to poor microplanning reported above. Also, the quantification is subject to different processes and metrics depending on individual MNCHW interventions, and different partners will engage with different quantification and procurement processes.
- As a result, health care workers, health facility managers, community members commonly report **insufficient supplies and commodities during the MNCHWs**. This has a negative effect on demand for MNCH interventions and participation in the MNCHWs. Several key informants and health care workers compared the MNCHWs to other campaigns, pointing out that the MNCHWs usually ran out of commodities and supplies compared to the Immunisation Plus Days (IPDs). This may suggest a better coordinating mechanism with the IPDs, probably because a single institution is responsible for procurement and distribution of the commodities/supplies required and few interventions are involved. Typical responses from key informants and interviewees are presented in the box below

“Availability of commodities varies from place to place. Stock outs are experienced in areas with high turn up of peoples like this facility. We hardly have enough commodities.” (Beneficiary, husband, SW, Rural)

“Many pregnant females turn up until our stock runs out by Tuesday. It is embarrassing to tell them to buy routine malaria drugs after promising to issue them free of charge.” (HCP, Abuja, Urban)

“Commodities like vitamin A and the Albendazole are always missing. You keep on visiting a specified centre to search for the missing item. Logistics make some things difficult.” (HCP, Abuja, Urban)

→ **Logistics around timely distribution of drugs, supplies and commodities can also be improved.** Based on key informant interviews, FGDs with HCWs, there was a lot of concern over late arrival of necessary commodities, which made the delivery of the MNCHWs difficult. During the MNCHWs, when there are stock outs or delays in the arrival of commodities and supplies, facilities cope by asking patients to purchase the commodities or they lend stock from nearby health care facilities. A typical response is presented in the adjacent box.

“The days for implementation are okay. The problem is that commodities arrive very late. Supplies should arrive before the implementation date.” (HCP, Male Volunteer, Abuja Rural)

“You can borrow from nearby facilities or you call the LGA they will bring more.” (HCP, SE, Rural)

“I inform the head office then they provide what is required. It does not take long to access the commodities when available in the store.” (HCP, Abia, Urban)

Finding 2.5 The effectiveness of the current training and deployment model is unclear

- The training provided via MNCHW is an opportunity to contribute to capacity building of healthcare workers, at least for those interventions which are part of the MNCHW package and participate in the training for the MNCHWs.
- Comprehensive data on the training of HCWs are not available. And to the best of our knowledge, no evaluation of the MNCHW training package has been conducted to date, to assess its effects on improved competencies and skills.
- Qualitative research performed via evaluation provides some tracer indicators of **bottlenecks and of areas of improvement for the training.**
 - **Target HCWs:** the training package may be offered to health care workers who will be deploy to deliver MNCH services during the week, but who regularly perform different duties at health care facilities. This potentially undermines the investment in training since new skills and competencies are not used/practiced after MNCHWs;
 - **Quality:** The content of the training was generally perceived positively, though its organisation and length were subject to negative opinions. It appears that the quality of the training and materials varies depending on the body responsible for the training on the ground as well as level of training (state, LGA, ward).
 - There is lack of **consistency in the content** of training provided pre-MNCHWs. This is based on KIIs and case study. Some KIIs report that focus of training is on improving clinical

skills required to implement MNCHW interventions, others reported that the focus is on data collection. Relevant section of the case study is provided below

Kaduna state case study (full transcript and report in Annex 10)

Training is supported by development partners, officers at state level support ward development officers to cascade the 2-day training.

Focus of training is on data collection rather than clinical procedures

UNICEF is concerned about the use of volunteers for clinical procedures. These volunteers are not primarily trained to perform such function however the SPHCDA argue that they have been trained.

Use of non-clinical personnel for clinical duties may put MNCHWs beneficiaries at increased risk of harm. Similar concerns were raised by senior PHCDA staff at FCT Abuja. Two cases of adverse reactions to some of the vaccines and likely due to wrong dosing were given as examples in November 2015.

- **Effectiveness of the training:** there is no evidence about the quality and effectiveness of the rather short MNCHW trainings. Several informants reported that during MNCHW supervision visits they had observed inadequate performance of health workers despite the MNCHW training.

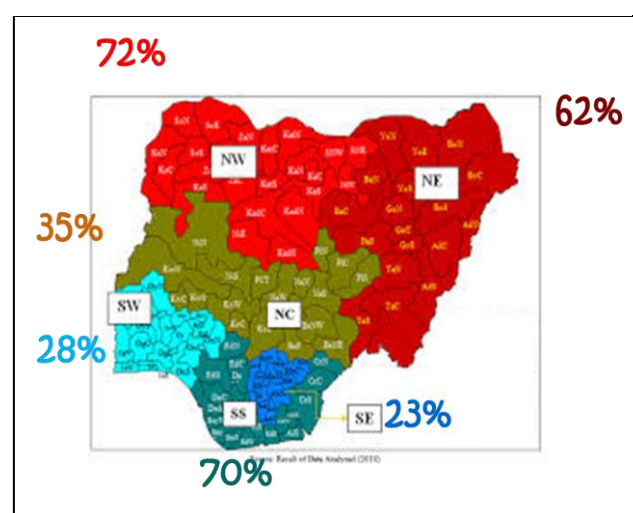
Finding 2.6 Social mobilization does not reach targets groups sufficiently

→ Social mobilization is a key activity of the MNCHW, implemented to generate awareness on the campaign and hence to stimulate participation to it.

The LSTM survey data indicate that **48.6% of respondents surveyed** reported to be aware of MNCHW. Results varied according to geographical areas; more women were aware of the campaign in rural areas (57%) compared to urban areas (33%); awareness also varied by Zones, as shown in Figure 4.

These results are highly concordant with the survey performed by UNICEF in October 2016, via U-Report¹⁷. Such survey in fact indicates that 21% of respondents are aware of MNCHW.

Figure 4: Awareness of MNCHW by Zones (LSTM survey, 2015)



¹⁷ <https://nigeria.ureport.in/poll/1555/>

Such survey received most of its responses from the South West Zone, where our survey suggests a similar level of awareness (28%).

- A study implemented by ORIE in 2013 within the evaluation of the Working to Improve Nutrition in Northern Nigeria (WINNN) Programme interventions in Northern Nigeria presents additional, interesting findings. The survey concludes that although ca. 545 of communities are aware of MNCHW, only **12% of mothers are aware of it**. This evidence points towards inadequate targeting of social mobilization activities, which do not seem to reach the most appropriate target group for MNCHW.
- Strategies used for social mobilization commonly used include the use of town criers/announcers as well as religious institutions; radio messages; IEC material. No evidence is available on the existence of a social mobilization strategy for the campaign. Community mobilization can improve awareness about the MNCHW but the participation of WRA may depend on decision makers at household level. Key informants at state level, WRA who participated in FGDs reported that the decisions of their husbands was very important determinant of their participation during the MNCHWs. MNCHWs social mobilization strategy should include ways of increasing husbands (and other senior household members who act as gate-keepers for services) understanding of the benefits of the MNCHWs. Interestingly, FGDs with (potential) beneficiaries highlighted the need to involve men more so they can embrace the MNCHWs. Some typical relevant quotes from qualitative data sources are presented in the box below:

“Many people are unaware of the health campaign due to limited awareness about it. Even if information is disseminated through churches and on the streets, not everyone goes to such places. I have never seen such information disseminated at the market square and yet many business people are found there.” **(Non Beneficiary, Man, B Urban)**

“Information about MNCHW was announced by the town crier. He informed us that health service providers were to come to our church to immunize children.” **(Beneficiary, Man, A Rural)**

A banner was developed which indicated the date and venue of the campaign. But the commonest method is the use of vehicle and speaker to announce in the community.” **(Beneficiary, Man, SW, Urban)**

“Sometimes we [HCPs] announce in churches, mosques and use town crier. If we inform the chief, he in turn informs the town crier to make the advertisement.” **(HCP, NC, Urban)**

“Your husband can prevent you from accessing medical services during the MNCHW if he wants your services at home.” **(Non Beneficiary, Woman, A Rural)**

“When it comes to ante natal care, how to involve the head of the household directly, so that he will do something that will make them to be aware or to be part of the program”. **(HCP, N Rural)**

Finding 2.7 The MNCHWs are perceived as a one stop shop for valuable health care for women and children, as well as promoting the use of routine health care services.

- Based on FGDs, amongst women and communities aware of the MNCHWs, there is a perception that it is valuable, provides a wide variety of services free of charge for women and children.
- MNCHWs beneficiaries appreciated family planning and ANC services MNCH activities the most, others appreciated were mosquito nets distribution, malaria prevention, and finally immunization. They also will like to see essential laboratory tests performed during the MNCHWs.

“They [MNCHW] are all essential because they address different aspects of our bodies. When our children receive preventive medication to lead healthy lives, then us mothers and the entire family become happy.” (Beneficiary, Woman, SW, Rural)

“It is because a pregnant woman receives holistic treatment. The drugs recommended will help you build your blood levels and clear your malaria.” (Beneficiary, Woman, NC, Rural)

“The programme is good because some people did not know the importance of [visiting] the hospital. But now, such people enjoy going there to obtain treatment. In the village people visit hospitals in the event of any health challenge unlike before this campaign. Also, pregnant women visit clinics for check-up to ensure safe delivery.” (Beneficiary, Woman, NC, Urban)

- Generally, MNCHW were perceived as valuable because they help to improve awareness of health issues and increase the update of services at primary level. This was noted by recipients and health providers alike.

Finding 2.8 The M&E framework of the MNCHW presents design issues

- The MNCHW guidelines present an articulated M&E framework designed to monitor progress in achieving objectives of the intervention. These include:
 - 15 Process indicators
 - 39 Output Indicators
 - 8 Outcome Indicators

The evaluation has assessed whether these indicators are ‘tailored’ to the intervention logic and hence to the theory of change of the MNCHW.

The results of the assessment are presented in **Table 6**, and discussed overleaf.

Table 6: Assessment of MNHCW indicators against the MNCHW Intervention Logic

<i>Intervention Logic (as per Theory of Change)</i>		<i>Number of Indicators (As per MNHCW guidelines)</i>	<i>Description</i>
Inputs	Funding	2	Process indicators 3 and 4
	Technical Assistance	-	
	Human Resources	-	
Activities	Planning and coordination	2	Process indicators 1 and 2 Process indicators 5, 10, 11 Process indicator 6 Process indicators 12, 13, 14, 15 Process indicators 8 and 9
	Advocacy/social mobilization	3	
	Training	1	
	Logistics and supply	4	
	Monitoring	2	
Output	Delivery of one-week campaign	1	Process indicator 7
Immediate Outcome	Improved care seeking behaviours	-	All process indicators but 10, 12, 13, 14, 34, 38
	Increased coverage of MNCHW interventions	35	
	Improved household practices	-	
	Increased utilization of health services	-	
	Enhanced health workers' capacity	-	
Intermediate Outcome	Reduction of the incidence of childhood malnutrition and illnesses	7	4 outcome indicators and process indicators 10, 12, 13, 14
	Reduction of the incidence of pregnancy related complications	-	
	Reduction of anaemia and malaria in pregnancy	-	
		-	

<i>Intervention Logic (as per Theory of Change)</i>		<i>Number of Indicators (As per MNHCW guidelines)</i>	<i>Description</i>
	Increased government budgeting for MNCH at all levels		
Impact	Reduced child mortality	3	3 impact indicators 1 impact indicator and process indicators 34 and 38
	Improved maternal health	3	

The above presented analysis poses some issues:

- **Input level indicators**

At input level, the set of indicators defined to monitor the MNHCW does not capture information on two critical factors for the implementation of the campaign, i.e. technical assistance and human resources. In addition, the indicators defined to monitor the availability of funding are purely quantitative. They do not capture important dimensions such as a) timeliness of funding availability; b) equity of funding allocations (per capita distribution)

- **Activity level indicators**

There are indicators in place to monitor all the key activities implemented through the MNHCW. Again, all the envisaged indicators are quantitative and there is no qualitative measure defined to assess the extent to which activities are performed as per guidelines and at required standards.

- **Output level indicator**

The defined output level indicators correctly aim at monitoring the implementation of MNCHWs by States and LGAs. As previously highlighted in the evaluability report (see section on *Testability*), one key assumption underlying the MNHCW strategy is that in addition to providing services at health facilities, the program sets in place temporary health posts and/or performs door to door activities in communities. This strategy is meant to overcome access barriers for hard to reach segments of the population.

This critical aspect is not captured via the defined indicator.

- **Immediate outcome level indicators**

There is a substantial discrepancy between the program intervention logic (defined objectives and immediate outcomes) and the MNHCW defined indicators at outcome level. All the outcome level indicators identified focus exclusively on the dimension of **interventions coverage**. No indicators are set in place to measure progress in achieving the other outcomes that are defined by the program conceptual framework.

- **Intermediate outcome level indicators**

Intermediate outcomes are meant to capture the improvement in the health status of the population (prevalence of disease), for those conditions that are addressed through the MNCHW. The MNHCW defined intermediate outcome indicators are: stunting; wasting; vitamin A deficiency rate. These indicators do only partially mirror the intermediate outcomes envisaged through the program theory of change. In fact, no indicator is identified to measure: childhood illness (disease prevalence); reduced malaria in pregnancy; reduced anaemia in pregnancy.

- **Impact level indicators**

Impact level indicators refer to: maternal mortality ratio; newborn mortality rate; infant mortality rate; under-five mortality rate. These set of indicators capture the ultimate impact that the MNHCW intends to achieve, defined as reduced child mortality and improved maternal health.

In addition to the above listed inconsistencies, the EA also notes that the **definition of MNHCW indicators lacks some critical features:**

- Definition of the indicators (numerator and denominator)
- Frequency of data collection
- Source of information and Responsibility for data collection

This poses potential problems in ensuring the consistency and quality of data.

→ Not all indicators of the M&E framework are collected as per MNCHW Implementation Guidelines

Process level indicators

The MNHCW defined process level indicators are designed to measure the availability of inputs and the implementation of critical activities.

Although various tools/sources are available to collect most of these indicators (Micro Plans; Rapid SMS; Operations Rooms; States reports), the way in which the information on the identified 15 process indicators is collected and reported is incomplete, and inconsistent over time and across states.

No summary dashboard has been found by the EA reporting against all the process indicators.

Output level indicators

The MNHCW defined output level indicators essentially measure the coverage achieved through the program. The National Primary Health Care Development Agency manages an excel based dashboard that collects and reports data on all the interventions proposed through the MNHCW. This dashboard is regularly updated based on information produced at state level through an equivalent spreadsheet; in turn, each of the State level reports provide disaggregated information by LGA and by ward.

Data are disaggregated by age groups, consistent with the age groups defined through the MNHCW guidelines and related indicators.

Impact level

Impact level indicators are not routinely collected. It is assumed that these indicators will be monitored through national demographic health surveys (NDHS).

In particular, such surveys do periodically estimate some of the defined indicators, at national level and at States level, namely: newborn mortality rate; infant mortality rate; under five mortality rate; maternal mortality ratio (National level only); stunting; wasting.

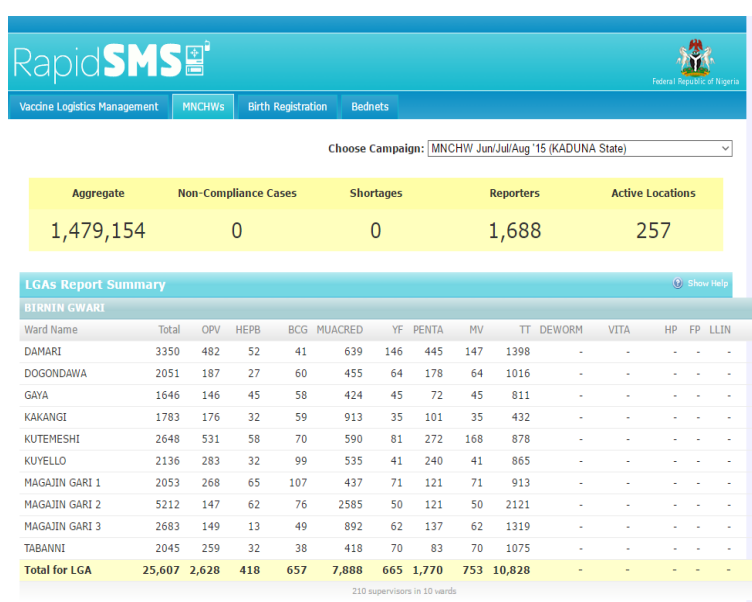
There is no clarity on how the indicators on vitamin A deficiency rate and on HIV MTCT will be collected, since these are not usually measured through the NDHS.

Finding 2.9 There are a strong monitoring tools in place, but their actual use for real time analysis and decision making could be improved

→ Despite of the above considerations, the MNCHW benefits of a good base of tools and practices to monitor the MNCHWs outputs, i.e. intervention reach achieved during each round. In particular, the Rapid SMS function, introduced with support from UNICEF, allows the collection of data via cell phones, and its analysis in real time.

→ Rapid SMS collects information about reach of campaign interventions at LGA and ward level per each State, and per each round of the MNCHW. Such data are open and accessible online.

Figure 5: Rapid SMS dashboard
(<http://rapidsmsnigeria.org>)



→ An Operation Room (OR) has been established as a good practice; the OR is active during the campaign and allows to take action to address operational issues faced during implementation.

→ The extent to which the OR and more in general the data collected through Rapid SMS and through other routine tools are actually used to inform planning, decision making, and actions is not documented.

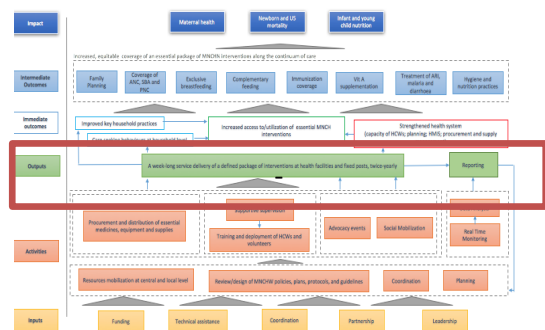
Finding 2.10. Reporting and documentation are inadequate and information is not accessible

- According to the MNCHW guidelines, each State will produce a comprehensive report at the end of each campaign round. Reporting of MNCHWs is a key output for adequate documentation and records that may become useful for future planning and for accountability. The evaluation team could only identify a set of comprehensive state MNCHW reports available and accessible via a shared location at central level
- In addition, reports accessed via States presented inadequate features, including: lack of consistency in formats; lack of completeness and accuracy of information and difference in the type of information included in various reports. Also, in most States a complete set of reports for MNCHW was not available or accessible.

FINDINGS RELATED TO MNCHW OUTPUTS

The primary output of the MNCHW is defined as follows: a week-long service delivery of a defined package of interventions at health facilities and fixed posts, twice a year.

This is by policy and guidelines expected to happen in all States of the country during time periods defined at national level. In each State, only a limited number of LGAs is selected for implementation.



Finding 3.1 MNCHW achieves a significant population reach, at least for selected interventions

By definition, the MNCHW is designed and conceived as a platform for enhanced service delivery of routine interventions. Therefore, target groups are clearly defined, **in line with national protocols**, and indicated in the Guidelines for Implementing the Maternal, Newborn and Child Health Week.

The MNCHW interventions and related target groups are identified as follows:

<p>Pregnant women</p> <ul style="list-style-type: none"> i. Ante-natal care ii. Tetanus toxoid iii. Health promotion iv. Long Lasting Insecticidal Treated Nets Intermittent Preventive Treatment (IPT) vi. Iron Folate vii. HIV Counseling and Testing (HCT) viii. PMTCT and referrals 	<p>Children 0 – 5 months</p> <ul style="list-style-type: none"> i. Birth registration ii. Essential Newborn care iii. Immunization iv. Long Lasting Insecticidal Treated Nets (LLINs) v. EID (optional)
<p>Children 6-59 months</p>	<p>Nursing mothers</p>

Immunization ii. Vitamin A supplementation iii. De-worming iv. Nutrition screening v. LLINs vi. Low Osmolarity ORS and Zinc vii. Health promotion viii Treatment of common ailments and referral ix. Distribution of micronutrient powder X Birth registration xi. HCT (optional)	i. Health promotion ii. Family planning, Birth spacing and Birth registration Counseling iii HIV Counseling and Testing (HCT) viii. Prevention of Mother-to-Child Transmission (PMTCT) and Referrals/Linkages
---	---

All the interventions are aimed at **every woman and child** in the country.

Considerations regarding reach require assessing the issue along three key dimensions: time; geography/location; and interventions.

The hypothesis defining a good MNCHW implementation is that all individual interventions are delivered in every State, and in every round of the event.

Table 7 and

Table 8 below indicate the population reached via various interventions from 2010 to 2014, cumulatively.

Table 7: Children reached with MNCHW intervention (10 rounds, 2010-2014)

YEAR/ MONTH	Children < 59 months						
	Vitamin A	Deworming	BR	OPV (0-59mths)	Measles(0-11)	DPT/PENT A	MUAC Screening
mag-10	26.225.768	4.901.783		18.024.646	386.544	507.544	7.889.399
nov-10	4.419.233	289.830	47.194	7.934.358	53.262	63.794	836.836
mag-11	17.401.670	7.050.195	527.914	5.625.032			803.286
nov-11	19.747.872	4.711.996	334.400	3.265.019	129.984	445.777	9.975.111
mag-12	23.348.736	7.499.374	404.452	1.643.947	305.328	687.563	12.750.763
nov-12	18.635.823	6.399.457	378.309	1.395.744	568.305	885.617	12.135.145
mag-13	17.963.805	7.941.083	581.373	2.079.694	475.216	926.878	14.507.144
nov-13	24.074.864	8.769.883	348.534	1.918.507	942.556	862.718	16.797.646
mag-14	26.431.304	10.944.795	375.213	1.334.958	413.650	852.314	19.030.264
nov-14	25.860.875	11.286.022	259.473	1.404.487	395.721	805.278	18.571.526
Average Total in 10 rounds	20.410.995	6.979.442	325.686	4.462.639	367.057	603.748	11.329.712

Table 8: Women reached with MNHCW interventions (10 rounds, 2010-2014)

YEAR/ MONTH	Pregnant women			WRA
	LLIN	SP	Iron Folate	FP
mag-10	4,005,823	730,996	3,600,561	
nov-10	14,940	38,899	51,878	
mag-11	90,701	644,722	1,776,894	
nov-11	148,707	441,449	2,407,911	2,870,204
mag-12	107,367	708,862	2,117,240	305,531
nov-12	171,515	621,264	1,857,937	338,496
mag-13	99,025	647,135	2,427,560	293,220
nov-13	140,678	849,006	12,752,388	277,811
mag-14	280,499	662,658	3,029,158	272,574
nov-14	219,309	548,302	2,378,872	274,150
Average Total in 10 rounds	527,856	589,329	3,240,040	463,199

Nigeria has an estimate number of 31.1 million children under the age of five (Countdown 2015) and of 7.1 million births per year.

With these proxy denominators in mind, some interventions such as Vitamin A, deworming and MUACC screening achieve a significant coverage and hence the MNCHW provides on average a substantial contribution to reaching target populations.

This is particularly the case for Vitamin A, which is reported by NPHCDA as primarily implemented via MNCHW.

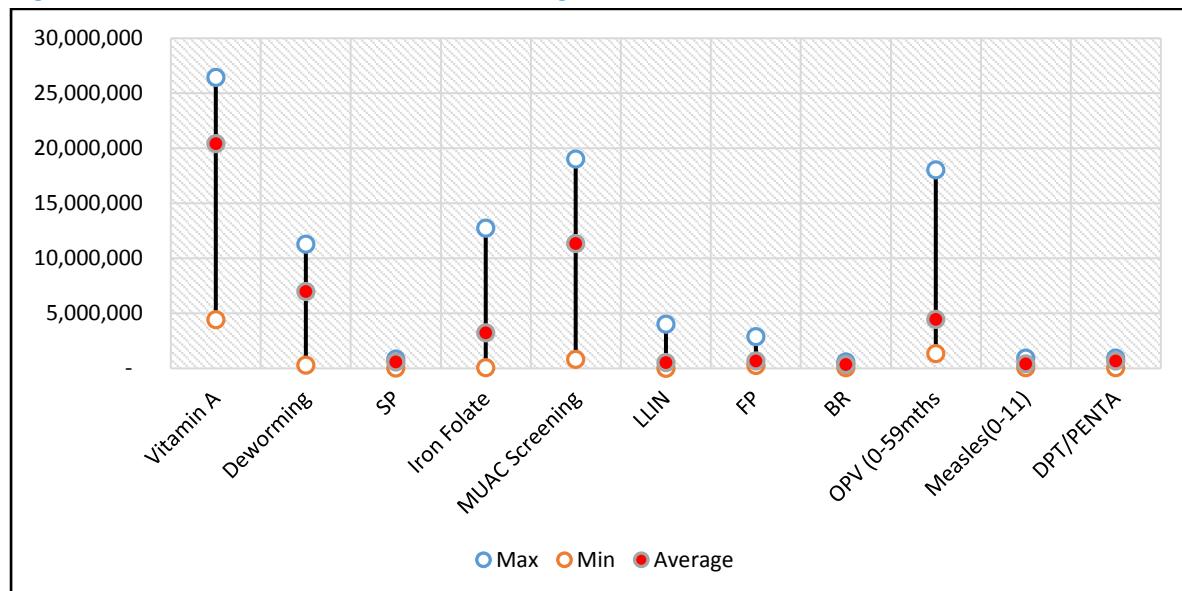
Finding 3.2 MNCHW is not implemented consistently across States and over time

As a complement to the above considerations, it is important to flag that the ‘average’ reach suffers of drastic variations over time and across States, and this undermines the campaign effectiveness.

Figure 6 shows the same data presented above, plotting the average reach, as well as the minimum and maximum number of beneficiaries reached during any round of MNCHW from 2010 to 2014, for

selected interventions. As it is clearly visible, the average is heavily affected by significant variations across various rounds, especially for those interventions that achieve a larger scale of implementation.

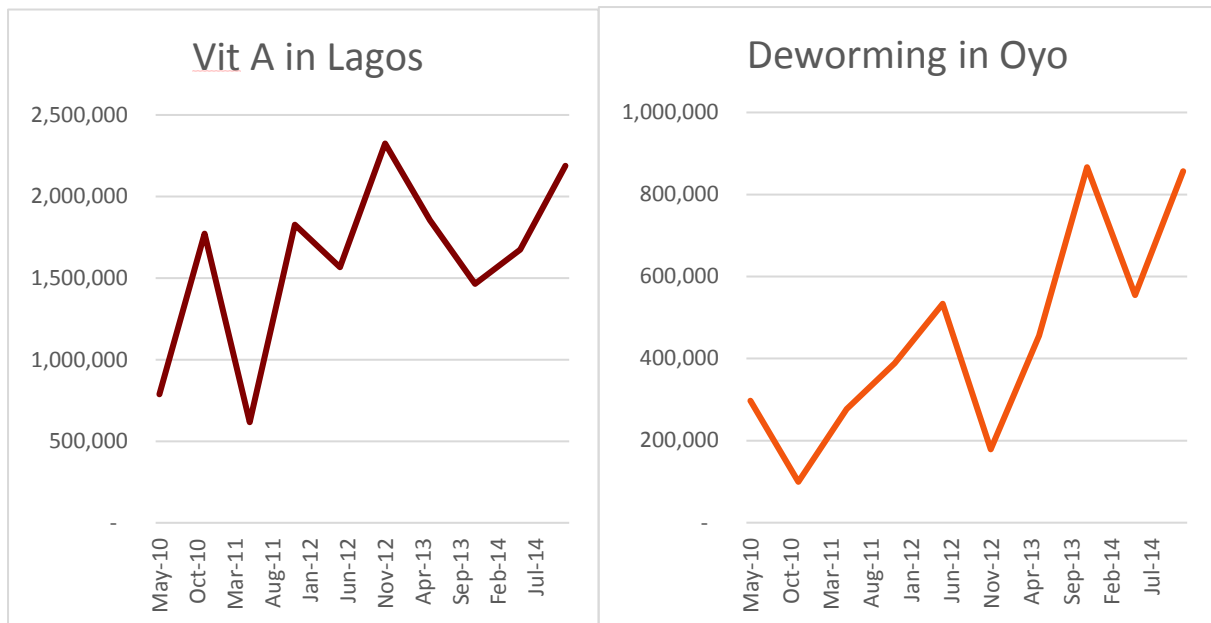
Figure 6: MNCHW interventions reach: average, min and max no. of beneficiaries (2010-2014)



In the Figure above wide variations suggest significant inconsistency in coverage and therefore implementation. The smallest variations are seen with Sulphadoxine-Pyrimethine (SP) for pregnant women, family planning (FP), birth registration (BR), measles and Diphtheria-Pertussis and Tetanus (DPT) interventions, this may be because there is consistent implementation or very states implement to the same level but the graph does not present information on proportion of target population reached. Such variation is not only observed at national level, but also across States.

This is shown in **Figure 7** below, where intervention reach for two particular MNCHW interventions is shown for two different States, demonstrating the varying and inconsistent levels of implementation even at individual State level.

Figure 7: Implementation of MNCHW interventions in two States



In essence, the analysis of MNCHW secondary data available via NPHCDA shows that **in none of the 10 campaign rounds implemented from 2010 to 2014 all the MNCHW interventions were ever delivered as a complete package, in any of the States of Nigeria.**

In other words, from 2010 to 2014:

None of the States has ever succeeded in delivering all the MNCHWs interventions in any of the rounds implemented since 2010 (

Figure 8 and Figure 9);

In no occasion since 2010, has the MNCHW been implemented in all States

No State has succeeded to implement all the MNCHW rounds scheduled since 2010

Figure 8: Percentage of total recommended MNCH interventions delivered in each state between 2010 and 2014

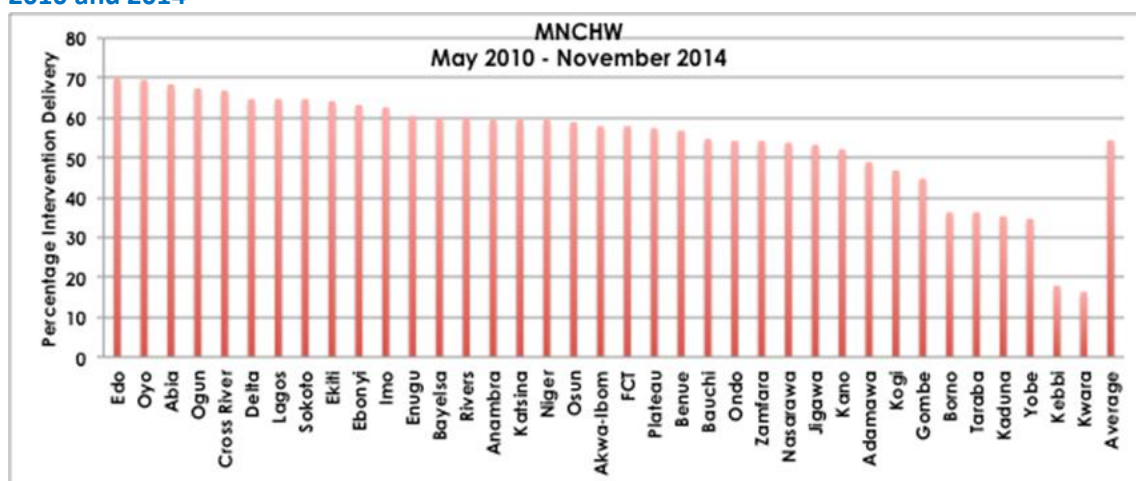
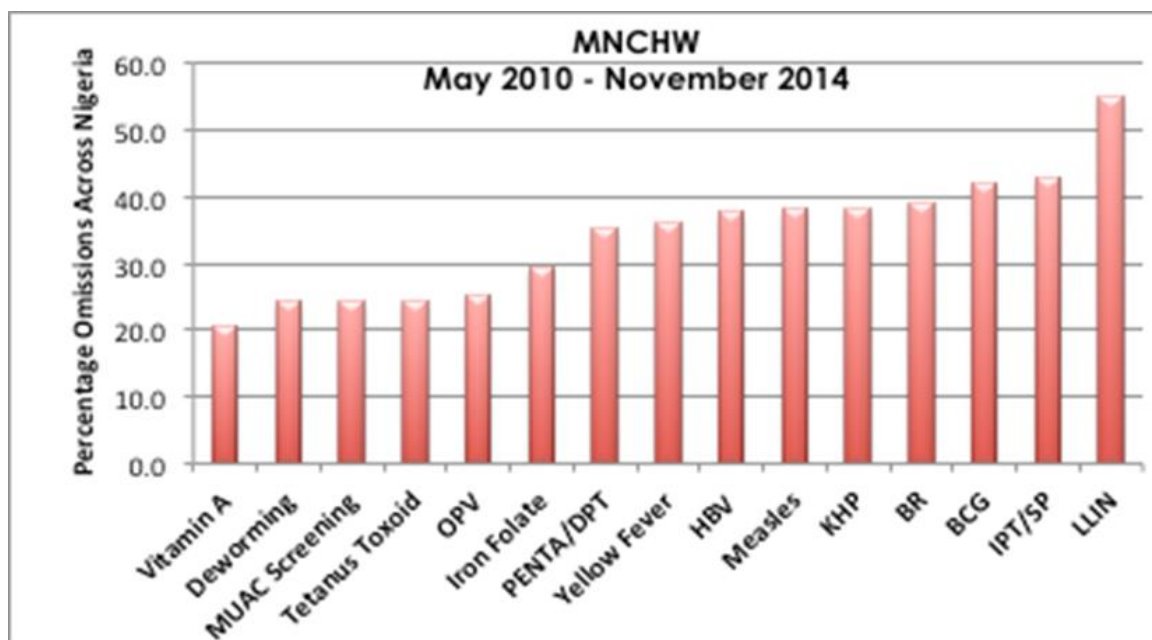


Figure 9: Percentage Omission of each MNCHW intervention between 2010 and 2014



Finding 3.3 Attendance to MNCHW is suboptimal

- Part of the equation determining the effectiveness of a health intervention is the demand for and utilization of such intervention.
- Data from the LSTM survey show that in 2015, only 27.8% of surveyed respondents reported to have attended the MNCHW preceding the survey (Round 2, 2015). Survey data also show that attendance was higher in rural areas (35%) than in urban areas (18%).
- Our analysis also suggests that one major determinant of the attendance of MNCHW is awareness. In fact, according to our survey results the odds that a woman who is aware of MNCHW attends it is nearly 50 times higher than one who is not aware of it (OR 47,3, CI 34,6; 64,4).
- Suboptimal attendance to MNCHW clearly undermines the investment that goes into this intervention and its effects. Also, it presents **missed opportunities in terms of enhancing interventions coverage**. As shown in **Table 9** below, the attendance of MNCHW is a positive determinant of coverage. The probability that a woman or child who attends the MNCHW has a higher chance to receive an intervention is presented below, most interventions except OPV3 and ANC interventions.

Table 9: Intervention coverage and attendance of MNCHW: Odds Ratio

<i>Intervention</i>	<i>Odds Ratio (OR)</i>	<i>Confidence Interval (CI)</i>
DTP 3	1.69	(1.30, 2.18)
BCG	2.69	(1.69, 4.30)
OPV 3	1.25	(0.99, 1.57)
Measles	1.52	(1.09, 2.11)
Vitamin A	3.24	2.70, 3.89)
Deworming	1.66	(1.37, 2.02)
ANC 1	1.43	(0.75, 2.75)
Contraception	1.29	(1.05, 1.59)
Birth registration	1.88	(1.52, 2.33)

Finding 3.4 The current model of the MNCHW is not fit to reach the most marginalized

The evaluation notes that a major determinant of the MNCHW effectiveness is also the model of service delivery adopted in Nigeria.

In fact, the MNCHW presents some unique features that in the opinion of the evaluator undermine its potential:

A very **large bundle of interventions**, targeting a variety of different population segments (Children U5, WRA, pregnant women (PW), household in general).

A facility based approach. Whilst CHDs were conceived primarily as an outreach intervention aimed specifically to reach the most marginalized by bringing simple interventions to them in the community, the MNCHW is designed as a package of services which is delivered in facilities. Such concept, per se, does not address access barriers related to distance, opportunity costs and security in an active manner.

Limited scale. MNCHW are not consistently implemented in all LGAs, nor they are implemented in all the primary health care facilities within the LGA. Only some are selected.

Decentralization. Much of the financial, logistic and management responsibility of delivering MNCHWs is left to States, in respect of the model of administrative decentralization adopted in Nigeria. Such approach entails that the barriers faced by individual States in delivering routine PHC services are mirrored in the implementation of MNCHW. As a consequence, the intervention loses its unique feature to be 'incremental' and 'supplemental' to normal services.

FINDING RELATED TO MNCHW OUTCOMES

MNCHW goals and objectives are clearly described across various regulating documents as follows¹⁸:

The MNCHW goals and objectives are clearly described across various regulating document as follows:

Goal: To improve the health status of women and children by increasing coverage of key maternal, newborn and child health interventions.

Specific Objectives:

To improve the utilization of routine services.

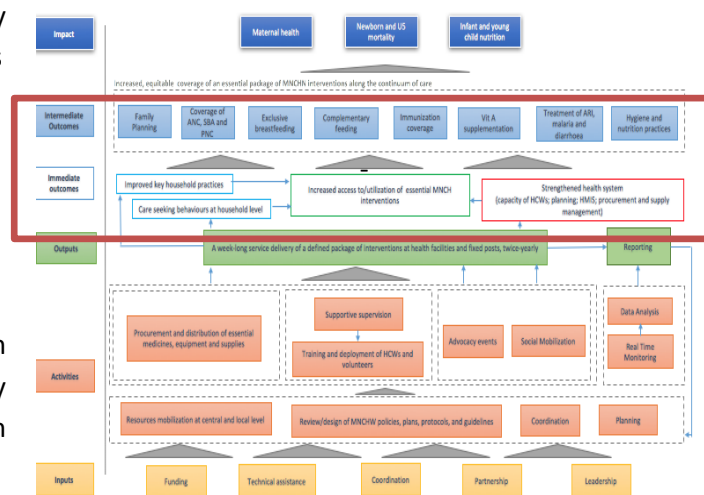
To increase the coverage of MNCHW interventions.

To improve key healthy household practices.

To improve the capacity of health workers to deliver maternal and child interventions.

To improve health and care seeking behaviour of care givers.

To improve utilization of health information management system.



Finding 4.1 The objectives and related outcomes of the MNCHW are consistent with the priorities of Nigeria, and still relevant

MNCHW objectives can be conceptually structured around three main areas of focus: ‘demand side’ objectives (Objectives 3 and 5); ‘supply side’ objectives (Objectives 4 and 6); and ‘services utilization’ related objectives (Objectives 1 and 2).

The objectives remain valid to the context of Nigeria. In fact, available data on maternal and child mortality in Nigeria, as well as on coverage of essential MNCHN interventions show that the progress in improving maternal and child mortality in the country has been limited in the past decade, and insufficient to achieve the MDGs 4 and 5 targets in Nigeria.

Under this scenario, three main arguments support the relevance of the MNCHW to the priorities and needs of Nigeria:

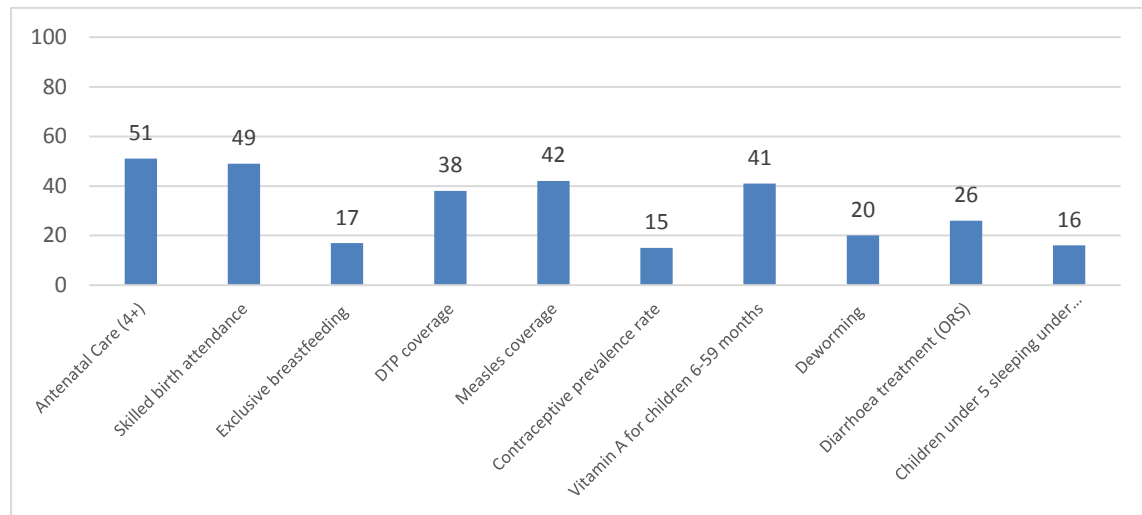
- **Insufficient coverage of essential interventions promoted through the MNCHW**

As shown in **Error! Reference source not found.** below, in Nigeria the most recent data available through national surveys (NDHS 2013) show that coverage with essential maternal and child health

¹⁸ Source: Guidelines for the Implementation of the MNCHW in Nigeria - NPHCDA, 2014

interventions is still low. This per se supports the argument that promoting the uptake of these interventions – all proven to be effective in reducing mortality – is highly relevant for the health needs of the population.

Figure 10: Coverage of essential interventions in Nigeria (Source: NDHS 2013)

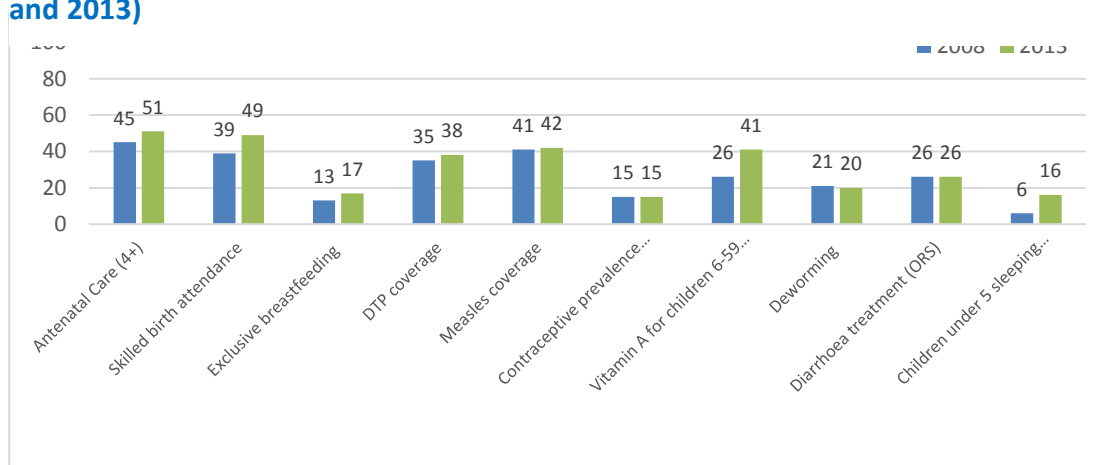


- **Insufficient progress in enhancing coverage of essential interventions**

Besides the low levels of coverage measured in 2013, available NDHS data also indicate that the progress achieved during the period 2008-2013 has been poor, and inconsistent amongst the various interventions (**Figure 11**).

Such low progress suggests that investing in additional interventions that may accelerate coverage is relevant to the needs of the population of Nigeria.

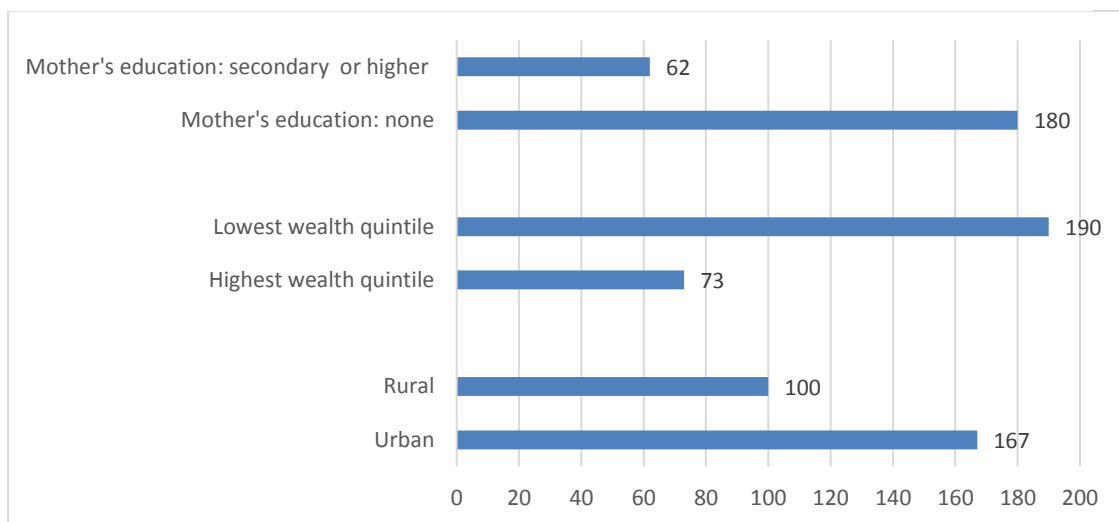
Figure 11: Progress in coverage of essential interventions in Nigeria (NDHS 2008 and 2013)



- **Inequities in maternal and child health outcomes**

The most recent estimates available (NDHS 2013) on under-5 mortality reveal that there are substantial equity gaps in the distribution of child mortality according to key socio-economic characteristics of the population (**Figure 12**). These suggest that a strategy that is aimed at ‘reaching the unreached’, by scaling up a package of key maternal, neonatal and child survival interventions in hard to reach areas, is crucial to enhance a concrete equity agenda in the country and relevant to the needs of the population.

Figure 12: Under five mortality rate by socio-economic characteristic of the population (NDHS 2013)



Data

from our qualitative research (KIIs) confirm this analysis; the objectives of the MNCHW are perceived as fully valid and relevant at both central and local level in Nigeria. Yet the relevance of such objectives is undermined by the current lack of clarity on an exit strategy and a renewed effort to strength the PHC system. Therefore, the MNCHW objectives are still valid but in order to produce the desired results, it needs to be redesigned integrated in to the PHC, so that it complements and strengthens the PHC rather than prop up the PHC.

Finding 4.2 The design of the MNCHW activities is partially consistent with its intended effects and impacts

The MNCHW conceptual framework sets clearly the causal chain of events that transforms inputs (funding, technical assistance) into activities (social mobilization; supply and logistics; training; planning and coordination) and activities into the envisaged outputs (a week long service delivery of a bundle of defined MNHCN interventions at health facilities and at temporary fixed posts) and then into outcomes.

The **plausibility of the expected outcomes** of the MNCHW– as defined by the program conceptual framework - is analyzed below.

According to Taplin et al¹⁹, *Plausibility refers to the logic of the outcomes pathway. Does it make sense? Are the outcomes in the right order? Are there gaps in the logic?*

- **Increased Coverage of MNCHW interventions**

The underlying rationale of the MNCHW is to '**complement the weak routine services of the PHC system in Nigeria thereby bridging gaps that poor coverage of facilities and services may have created**'²⁰

Hence, the key assumption determining the expected outcome of the MNCHW is that ad hoc, regular campaigns will contribute to **increase coverage of a selected package of interventions**.

The high plausibility of this expected outcome is documented in the literature, and there is extensive evidence that child health campaigns have a positive effect on selected interventions coverage, as documented by Palmer et al: '*There is a general consensus in the literature that CHDs and other integrated events have improved coverage of key interventions such as vitamin A supplementation, deworming, insecticide-treated bednets, and measles vaccine. Pre- and post-event coverage surveys have also highlighted improvements in coverage equity, leading the World Bank to rank integrated events, including CHDs, as pro-poor*'²¹. The extent to which the investment (inputs) in MNCHWs determines an increase in coverage (effect) of the interventions proposed during the weeks is as a key evaluation question to be addressed in Nigeria.

- Improved household practices and care seeking behaviors

A second, critical outcome that is expected as a result of MNCHWs is that the investment in health education—embedded in the program design—contributes to **behavior change and to an increased adoption of key family practices**.

In particular, the focus of health promotion activities as described through the MNCHW Training Manual envisages that during the campaign messages are delivered on 4 key areas: growth promotion and development; disease prevention; home management; care seeking and compliance.

As pointed by Fox and Obregon²² '*We know that improving child survival requires promotion of healthy behaviors as well as efforts to addressing social exclusion, discrimination and a range of social and behavioral determinants that cut across the life cycle. These determinants are complex. They include **structural barriers, financial barriers, individual and collective motivations, social and community norms, policy environments, and cultural systems that can enable or impede individuals and communities to adopt, change, or maintain healthy behavior.***'

¹⁹ Theory of Change TECHNICAL PAPERS, A Series of Papers to Support Development of Theories of Change Based on Practice in the Field. By Dr. Dana H. Taplin, Dr. Heléne Clark, Eoin Collins, and David C. Colby , April 2013

²⁰ Report of the Stakeholders' Consensus Meeting on Maternal Newborn and Child Health Week, August 2014

²¹ Food Nutr Bull. 2013 Dec;34(4):412-9. Evolution of the child health day strategy for the integrated delivery of child health and nutrition services. Palmer

²² Fox E, Obregón R. Population-Level Behavior Change to Enhance Child Survival and Development in Low- and Middle-Income Countries. *Journal of Health Communication*. 2014;19(sup1):3-9. doi:10.1080/10810730.2014.934937.

The continuum from change in knowledge to change in attitudes and consequently in healthy behaviours entails overcoming barriers at individual, household and community level and this requires the adoption of multiple strategies.

The evaluation team could not find evidence in the international literature of the impact of behaviour change interventions delivered through campaign activities.

In their review, Palmer et al report that *'services such as nutrition screening, birth registration, growth monitoring, and **behavioral change communication** have been included in only about one-quarter of all events. This may be due to their highly discretionary nature, requiring providers to have specific and often unique information for each client.*

Such interventions may be more effectively delivered on an individual level or through group-based strategies (e.g., women's groups), as opposed to high-volume events like CHDs.'

The possible effects of MNCHW in enhancing the adoption of key family practices at household level are not clear, nor supported by evidence and the plausibility of such envisaged outcomes will require further assessment.

Utilization of routine services

A third expected outcome of the MNCHW is the increased uptake of routine services, which is a positive externality supposedly generated through the program, by improving the interaction between communities and primary health care services.

A review of child health days in Africa²³ suggests that an unintended impact of CHDs is *'that there has possibly been the neglect of other key child survival interventions'*, i.e. that the efforts and focus in delivering integrated campaigns has diverted the focus from strengthening routine services to focused investments in campaign activities.

The possible effects of MNCHW in increasing the uptake of routine services is **not supported by evidence** and the plausibility of such envisaged outcomes will require further assessment.

- **Increased Health workers' capacity**

Through their review, Doherty et al identify and document some major limitations of the capacity of CHDs to enhance health workers' capacity.

These include: over burden of health workers during the preparation and implementation of the campaigns; diversion of critical staff from routine services at facilities during the activity; possible distortions/economic disincentives related to the payment of ad hoc per diems during the implementation of the health weeks.

In addition, the review notes that despite the investment in HCWs training associated with CHDs, *'Problems with quality of care were identified during field observations in several countries, notably in the administration of vitamin A capsules and de worming tablets, in the method of weighing children and plotting of weight on the road to health cards and in safe disposal of syringes'*.

²³ Doherty T, Chopra M, Tomlinson M, Oliphant N, Nsiband D, Mason J. Moving from vertical to integrated child health programmes: experiences from a multi- country assessment of the Child Health Days approach in Africa. Trop Med Int Health 2010;15:296–305.

The possible effects of MNCHW in increasing the capacity of health workers is **not supported by evidence** and the plausibility of such envisaged outcomes will require further assessment.

Finding 4.3 No evidence is found that the MNCHW has significantly contributed to coverage of essential MNCHW interventions in Nigeria

According to available DHS data, maternal and child mortality have not improved at a faster average rate during the period that follows the introduction of MNCHW, compared to the period preceding it. Change in mortality and interventions coverage depends from many factors, never from a single event, policy or program and therefore progress in MNCH cannot be attributed (or not) to the MNCHW.

This impact evaluation was not designed to measure attribution.

Yet, as a conclusive statement, the evaluation team observes that according to statistical analysis of our survey data, **no evidence was found that the MNCHW significantly contributes to national coverage.**

Table 10: Coverage of selected MNCH interventions attributable to the MNCHW

	<i>Coverage (LSTM HHS)</i>	<i>% of coverage from MNCHW (LSTM HHS)</i>	<i>MNCHW contribution to coverage (%)</i>	<i>95% CI to</i>
BCG	68.3	8.2	1	(-7.8, -9.8)
Measles	52.2	12.5	1.7	(-.65, -10.1)
Birth Registration	53.2	18.8	8.1	(-2.0, 18.1)
Vitamin A	55.1	22.9	4.6	(-4.8, 14)
MUAC	23.7	21	1.7	(-5, 8.5)
Deworming	36.8	15.7	2	(-5.9, 9.9)
CPR	11.2	3.9	0.3	(-4.9, 5.4)

As shown in **Table 10** above, the contribution of the MNCHW to interventions coverage is modest for most interventions. And it is not statistically significant.

CONCLUSIONS AND LESSONS LEARNED

APPRAISAL OF FINDINGS

Evaluation design

The MNCHW impact evaluation was conducted under constraints of a lack of baseline and lack of a control group. The evaluation was designed using a Theory based approach specifically using a contribution analysis. The first deliverable was an evaluability assessment that resulted in a revised Theory of Change. The evaluation was designed to test the linkages in the ToC and answer the key evaluation question “Has the MNCHW contributed to improve the health status of women and children in Nigeria, by increasing coverage of key maternal, newborn and child health interventions?”

Quality assurance

The evaluation used mixed research methods to answer the questions, and triangulated the results to generate the conclusions. Data was collected by different teams, trained and overseen by senior evaluation team members. Similarly, analysis was conducted by independent team members and reviewed by senior team members before inclusion in the final report.

The evaluation team constantly engaged with the MNCHW Evaluation Steering Committee, to discuss the methodology, tools and provide updates and discussed the findings and recommendations with an expanded group of MNCH stakeholders. During field work a robust system of monitoring and quality assurance was also implemented. Training of data collectors and actual data collection was done in phases, with data checks taking place in real time, allowing for repeat data collection to take place if necessary (See [Annex 11, 12, 13, 15](#), for training and pilot reports, data collection reports and monitoring/action reports).

The results from the HHS are largely comparable with data obtained from larger household surveys (Multicenter Indicator survey, DHD), in terms of coverage.

The confusion between the IPDs and MNCHWs created a problem with clear identification of what programme intended targets participated in. Related questions were subjected to back checks during field work by dedicated quality assurance officers, up to 15% of households with discordant responses were replaced. This gives a reasonable margin of confidence on the results.

Relevance of MNCHWs

The objectives of the MNCHWs are still valid. At the time the MNCHWs were approved for implementation, there was a need to accelerate the progress towards achieving global targets for maternal, newborn and child health (MDG 4 and 5) in 2010. However, at the end of the MDGs, and after 10 rounds of MNCHW implementation there is no evidence that the MNCHWs has contributed to improving these health outcomes.

There is currently a national strategic focus on high priority interventions such as the integrated maternal newborn and child health interventions with a target to reduce MMR, IMR and U5 mortality and morbidity in Nigeria. One of the strategies put forward by the Hon Minister for Health is ‘Aggressive prioritization of the MNCHWs and immunization campaigns. Also as part of the one-PHC

per ward policy, primary health care will be strengthened, potentially making the MNCHWs irrelevant after some time. If the MNCHWs improve coverage of MNCHW interventions, reduce maternal and child health mortality and increase utilization of PHC services, it should become irrelevant after some time as the PHC functions optimally. The findings and recommendations from this evaluation will be useful in strengthening the MNCHWs, as FMOH, NPHCDA and partners agree an exit strategy for the MNCHWs.

Awareness of MNCHWs

The findings of lack of awareness and the reasons for this are similar to that reported in a 2014 operational research in 3 northern states, they investigated the low awareness of the MNCHW. In that evaluation, similar to this, women who participated in the MNCHW were aware of the benefits, but were confused by IPDs. The reasons for non-attendance of MNCH weeks were lack of husband's support (permission, transport cost), traditional and religious beliefs, stock outs and negative experiences on visiting health care facilities.²⁴

Implementation and coordination

The literature review performed under this evaluation, showed that similar CHD/MNCHW implemented in other countries (Ethiopia, Uganda, Tanzania) had similar problems identified in this evaluation such as disruption of PHC services and poor coordination. However, health care providers and the community perceived that it was of benefit in improving child survival. Where the approach was more community based and with fewer interventions, high coverage was achieved. The number of interventions implemented were smaller with a focus on interventions that required less medical knowledge and skills to implement, they were predominantly centrally coordinated but district level planning was strong and were integrated within the health system (Doherty T., 2009). One 2015 systematic review concluded that adding complex interventions to the package of interventions (family planning and HIV counselling) made field implementation time consuming and counterproductive (Wallace D., 2012).

This evaluation found out that there is a plausible link to MMR reduction but this is mainly through family planning, there is limited evidence that ANC will contribute much. However, ANC is more likely to contribute to reduced IMR and potentially improve the likelihood of skilled attendance at birth. Family planning as a primary prevention approach for maternal mortality reduction can be effectively promoted via outreach services. At the moment this is the MNCHW intervention with the least coverage (except for Micro nutrient supplementation). The evaluation found 11.2% CPR-any method (DHS 2013 reported 9.8%).

²⁴ ORIE 2014: What are the barriers to attendance to the MNCHW and how can these be reduced.

SUMMARY OF CONCLUSIONS

The evaluation team used a participatory approach embedded in both the formative and summative aspects of this evaluation. The evaluation was to support and enhance the MNCHWs programme desired outputs/outcomes.

The findings and conclusions represent a holistic view with the focus on logic of delivering the MNCH weeks based on the ToC

The table below presents a summary of conclusions against the ToC.

Table 11: Summary of conclusions along the MNCHW programme Theory of Change

MNCHW logic (ToC)	Evaluation conclusion
Outcome	<p>Finding 4.1: The objectives and related outcomes of the MNCHW are consistent with the priorities of Nigeria, and still relevant</p> <p>Finding 4.2: The design of the MNCHW activities is partially consistent with its intended effects and impacts</p> <p>Finding 4.3: No evidence is found that the MNCHW has significantly contributed to coverage of essential MNCHW interventions in Nigeria</p>
Outputs	<p>Finding 3.1: MNCHW achieves a significant population reach, at least for selected interventions</p> <p>Finding 3.2: MNCHW is not implemented consistently across States and over time</p> <p>Finding 3.3: Attendance to MNCHW is suboptimal</p> <p>Finding 3.4: The current model of the MNCHW is not fit to reach the most marginalized</p>
Activities	<p>Finding 2.1: The allocation and the timely disbursement of funds for the MNCHW is a key bottleneck to implementation</p> <p>Finding 2.2: There is a large body of regulating documentation developed and available for MNCHW in Nigeria, but this is not widely used</p> <p>Finding 2.3: The quality, inclusiveness and timeliness of the coordination and planning functions needs substantial improvement</p> <p>Finding 2.4: Equipment, supplies and medical items are inconsistently available across States and across different MNCHW rounds</p> <p>Finding 2.5: The effectiveness of the current training and deployment model is unclear</p>

MNCHW logic (ToC)	Evaluation conclusion
	<p>Finding 2.6: Social mobilization does not reach target groups sufficiently</p> <p>Finding 2.7: The MNCHWs are perceived as a one stop shop for valuable health care for women and children, as well as promoting the use of routine health care services.</p> <p>Finding 2.8: The M&E framework of the MNCHW presents design issues</p> <p>Finding 2.9: There are strong monitoring tools in place, but their actual use for real time analysis and decision making could be improved</p> <p>Finding 2.10: Reporting and documentation are inadequate and information is not accessible</p>

LESSONS LEARNT

The evidence suggests that MNCH weeks provides increased awareness for PHC services however it is not efficiently run. Implementation is not as per guidelines, poor planning, weak monitoring and lack of a clear exit plan are key problems with the current implementation approach.

Political commitment and funding: A functional **primary health care** system is a function of the federal and state governments. Strategies to support the PHCs therefore should be fully supported by both levels with NPHCDA providing policy, strategic and technical directions, most of the funding should be from state level. Based on data available for this evaluation from NPHCDA, increasingly most of the funding for the MNCHWs comes from non-governmental sources such as UNICEF. Delays in funding or lack of funding put the objectives of the MNCHWs at risk.

Implementation not as intended: Successful implementation depends on good planning and the MNCHW guidelines has provided directions for planning, coordination, training, monitoring and review of the MNCHWs. Observation of the planning for November 2015 showed that there is poor adherence to the guidelines. Improved tools for microplanning, improved indicators for monitoring all levels in the MNCHW logic, from inputs to outcome is needed. A strong coordination mechanism is likely to drive implementation based on the guidelines in order to meet the programme objectives.

Primary Health Care system heavily dependent on MNCHWs: The evaluation found out that various partners procure equipment, drugs and supplies for the PHC facilities as well and the MNCHWs. Specifically, UNICEF supports a number of health care facilities in several states. Community members and health care providers reported lack of drugs and supplies after MNCHW in some PHC facilities. This leaves a lot of doubt the strategy to invest heavily in the MNCHWs rather on directly strengthening the PHC system. This underscores the urgent need for more discussion at appropriate levels on how the MNCHWs fit to the medium and long term PHC strategy in the country.

Lack of detailed reports and documentation: The main challenge encountered in the course of secondary data analysis during this evaluation was the lack of detailed reports from states. Another major challenge is the lack of details and consistency in the few available state reports, micro plans and work plans. This limited the depth of analysis that could be conducted during this evaluation. Critically missing was detailed cost information for the MNCHWs, this information is not available from any single source, so it was not possible to provide a detailed cost description. Comprehensive documentation and reporting will improve accountability, provide enough data for future evaluations and monitoring. Kaduna State's report for the May 2010 implementation of MNCHW is an exemplary report that could be used as a basis for the design of a consistent reporting framework for all the states in future MNCHWs ([Annex 21](#)).

Disaggregated coverage data: The intervention coverage data would also have a more detailed picture if it were stratified by age groups and other demographic parameters, such as economic and social parameters. This is not currently the case from the data we have for the previous MNCHWs. The use of RapidSMS for data collation limits the amount of details that can be shared, this platform can be updated to improve its robustness and functionality.

Source of vitamin A: While it is widely reported by key stakeholders at national that vitamin A is available only during MNCHWs, the evaluation could not confirm this through key informants at state level or documentation on immunisation cards seen during the household survey. Of the 5367 children under the age of 2 included in the HHS, 2061 (or 38.4%) of them had vaccination cards inspected by data collectors. Only 7% (363) of these cards had vitamin A recorded and only 26 (0.5%) had vitamin A administration recorded within the period of any MNCHW. Based on the evidence collected during this evaluation, Vitamin A is not exclusively provided during the MNCHWs in Nigeria.

Reduced number of interventions and implementation in all PHCs: The evaluation found a unique approach to implementation of MNCHWs from the Kaduna state case study. A smaller number of interventions are implemented based on state coverage numbers and rather than implementing in a few PHCs, implementation is in all PHCs. This strategy is to ensure equity in access by the target population, preventing the need for added transportation cost to the family, in order to participate in the MNCHWs.

Effect of IPDs: This is a confounding factor in terms of evaluation, it also negatively affects planning and implementation of MNCHWs. While key lessons can be drawn on the success in planning and implementing the IPDs, its implementation should be better coordinated with that of the MNCHWs if the objectives of the MNCHWs are to be realised.

Social mobilisation strategy: This evaluation has demonstrated a strong odds ratio between awareness of and participation in the MNCHWs. Therefore, if the MNCHWs has a robust social mobilization strategy, significant awareness and participation can be assured. A revised social mobilization strategy can draw some input from the approach in Kaduna state. Also in the case study from Kaduna state, town announcers have been attached to each PHC for social mobilization, this is to improve awareness within each catchment area. This relatively new strategy (2015), should be evaluated in future to determine the effectiveness on awareness and participation during the weeks.

Renewed branding of MNCHWs as part of a new social mobilization strategy will facilitate future evaluations. This is important to differentiate other health campaigns from MNCHWs, some of which have one or more of the MNCHW interventions. Such rebranding in regional or cultural specific blocks will be most appropriate.

Training of health care workers: The evaluation concludes that the training for health care workers prior to each MNCHW so far is not consistent in content, duration of training and there are doubts to its benefit amongst key stakeholders. Better quality assurance of the training is needed, more innovative m-health training linked to continuous professional development may be more beneficial. Mandatory less frequent training is likely to free up funds that can be invested in social mobilization to increase awareness for MNCHWs.

OVERALL CONCLUSION

The **purpose** of this evaluation is to assess to what extent the MNCHW strategies, approaches and the overall intervention logic have contributed to improved maternal, newborn and child health outcomes in Nigeria, to explain how change was achieved and make recommendations to improve it. In other to do so, the evaluation set out to address the question of the contribution of the MNCHWs to improved health status of women and children under 5 years of age.

The evaluation concludes that despite its lack of impact on MNCH (no significant contribution to coverage or improved health outcomes), the programme has potential of significantly increased coverage of key MNCH interventions through efficient social mobilisation that creates awareness and participation. This can only be possible through effective partnership, adequate and timely release of funds and complete commitment by state governments.



RECOMMENDATIONS

The recommendations at the end of this evaluation are derived from the evidence generated, discussed in the findings and conclusion chapters of this report. The findings and conclusions relate directly to the objectives of this impact evaluation:

- 1. Assess the extent to which MNCH weeks has been adapted to meet the needs of the targeted clientele and partners:** MNCHW was designed to reach marginalised groups, providing a one stop opportunity twice a year to boost coverage of key MNCHW interventions. The evidence is of limited coverage to groups in rural areas/hard to reach areas.
 - a. The approach of mobile and fixed sites, compromise routine PHC services and few outreach or community based implementation sites are evident.
 - b. There is also evidence of use of non-clinical staff for clinical procedures as a result of under staffing at some PHC units during the MNCHWs.
 - c. One state (Case study) deliberately adopted the approach of concentrating of fewer interventions of low coverage rather than all recommended MNCHW interventions, partly to improve efficiency in implementation

- 2. Assess the extent to which the MNCH weeks has been implemented as intended:**
 - a. No state has implemented expected MNCH week interventions at any round since 2010
 - b. States frequently implement the MNCHWs outside the recommended national dates
 - c. Key steps in planning, implementation and review of MNCHWs are largely out of sync and not consistent with MNCHW guidelines at both national and state levels

- 3. Assess whether the intended outcomes were achieved and whether there were unintended outcomes**
 - a. No evidence is found that the MNCHW has significantly contributed to coverage of essential MNCHW interventions in Nigeria.
 - b. Based on analysis of DHS data, there is limited evidence that the MNCHWs has contributed to improved maternal, newborn and child health outcomes.

- 4. Provide a descriptive cost analysis for the intervention**
 - a. There is limited data to provide a comprehensive cost description of the MNCHWs
 - b. Funding by Government has been on the decrease since 2013 while funding from UNICEF has been on the increase
 - c. The lack of transparency around budgets and actual expenditure by UNICEF and key stakeholders supporting MNCHW raises a lot of concern about accountability. This is also a missed opportunity to improve efficiency.

- 5. Identify lessons learnt, exploring what has worked well, what has not worked well and make recommendations to strengthen the MNCH weeks**
 - a. Comprehensive section on lessons learnt is provided in the previous chapter
 - b. Recommendations are provided below

These recommendations have been presented to and discussed with stakeholders (expanded MNCHW ESC meeting in October 2016) and to the community health department of the National Primary Care Development Agency Abuja, Nigeria. Finally, several consultations have been made with UNICEF technical teams on the findings and recommendations.

The recommendations made are at policy and operational levels, some of the recommendations can be acted on immediately, while others are medium to long term.

The last consultations on the findings and recommendations held in October 2016, recommended that the evaluation report should be presented to the National Council of State for Health and the National Council of State. This is because the MNCHWs was recommended for implementation through NCSH (commissioners for Health and the Federal Minister for Health) while state governors and the federal executive council interact at the National Council of States. This way recommendations for states and discussions about an exit strategy can gain effective traction.

All 13 recommendations can be implemented in the short to medium term.

POLICY RECOMMENDATIONS

1. **NPHCDA** should develop an accountability framework in collaboration with **UNICEF**, state governments and partners at central and state levels to monitor, input, activities and outputs. This is also to improve coordination.
2. **NPHCDA** should constitute a national steering committee with clear ToR developed in collaboration with **UNICEF** and other partners.
 - This committee will provide strategic over sight, drive the implementation of the accountability frame work
 - develop an exit strategy
 - Recognises and recommends states, partners and institutions for recognition to the Minister for Health and National Council of state for national recognition and awards. This is a means of stimulating quality
 - suggest policy direction to NPHCDA, NCOH and FMOH,
 - updates MNCHW materials and guidance documents
 - develop, track and report on key Performance Indicators (KPIs) at national and state level, for example, states that meet all mile stones according to guidelines- i.e. regular implementation committee meetings (documented minutes and actions), microplanning meetings, quality of costed micro plans, attendance of national planning and review meetings
3. **SPHCDA/SMOH should constitute** coordination committees with clear ToR and KPIs, Committee at state and local government levels
 - drives implementation according to guidelines,
 - drives accountability and transparency,
 - develops and reviews implementation strategy,

4. **NPHCDA** in collaboration with the states and partners, should redesign social mobilization strategy for MNCHW
 - Rebranding of MNCHW to improve accountability and awareness
5. **NPHCDA and SPHCDA** should consider designing context specific MNCH weeks
 - In order to reduce inequity of coverage, consider context specific approach. A core set of interventions can be implemented, but a minimum additional set, implemented specifically at health care facility and via outreach should be developed and agreed.
 - Modify the fixed/mobile post approach: In order to improve coverage, implement the MNCHWs at all PHCs, this will reduce cost of deploying health care workers to mobile or fixed posts. Savings from this can be used to fund social mobilization
6. **UNICEF, NPHCDA and FMOH should streamline MNCHW approach** with other adhoc activities (IPDs, measles campaign etc) to improve planning, implementation and coverage.
7. **UNICEF in collaboration with NPHCDA and other partners should develop an exit strategy for MNCHW, this to compliment the policy direction of PHC in Nigeria (implementation at scale of the national strategy of 1-PHC per ward)**
 - **UNICEF** should rethink its strategic support for the MNCHWs and consider long term investment towards the 1-PHC per ward national policy

OPERATIONAL RECOMMENDATIONS

1. **NPHCDA** in collaboration with implementing partners should consider central funding mechanism (matching funds from partners) through a single fund manager for the MNCHWs.
2. **UNICEF, NPHCDA** and all partners supporting MNCHWs should improve transparency about funding by providing timely reports and budgetary reconciliation available as open access documents. This way the true financial cost of inputs and activities of the MNCHWs can be determined. Such information should be made available during MNCHW review meetings at all levels.
3. **NPHCDA** should explore innovative approaches to health care worker training, use of relevant job aids including availability of MNCHW guidelines and training manual
4. **SPHCDA** should consider implementing MNCHWs at all PHCs rather than using the fixed and mobile site approach as a means of increasing coverage and improving efficiency.
5. **NPHCDA, SPHCDA and partners** should strengthen the monitoring of MNCW implementation. **UNICEF** should support NPHCDA in developing additional indicators for monitoring every level in the ToC is needed.
6. **NPHCDA** should

- Improve quality of training, special team to monitor the quality of this, set standards to achieve this.
- Consider reducing frequency of training and savings can be used to improve social mobilization
- Consider the use of innovative approaches to training, mobile technology platforms-training videos, MNCHW guidelines and training manuals.

LIST OF ANNEXES

Annex 1-5 are part of this report, 6-21 are attached as separate documents

Annex 1: Terms of Reference

Annex 2: List of Persons Interviewed, Affiliated Institutions and Sites Visited

Annex 3: List of Documents Consulted and reviewed

Annex 4: Data collection tools

Annex 5: Evaluators Biodata and Team Composition

Annex 6: Report on the Stakeholders Workshop on the Theory of Change of the MNCHW in Nigeria

Annex 7: Evaluation of MNCHWs Programme in Nigeria Report on the Key Informant Interviews at National Level

Annex 8: Evaluation of MNCHWs Programme in Nigeria Report on the Key Informant Interviews at State Level

Annex 9: Report on Observation of November 2015 MNCHWs Planning at National and FCT Level

Annex 10: Kaduna state case study and transcripts

Annex 11: Report on Training of Data Collectors and Pilot of Tools for Household Survey Phase 1 January 2016

Annex 12: Report on Training of Data Collectors and Pilot of Tools for Household Survey Phase 2 March 2016

Annex 13: Field Report on Household Survey Data Collection Phase 1

Annex 14: Qualitative Data Collection Tools

Annex 15: Field Report on Household Data Collection Phase 2

Annex 16A: Summary of quantitative monitor reports and actions by LSTM

Annex 16B: Field Report on Qualitative Data Collection

Annex 17: MNCHW Evaluation: Report on Secondary Data Analysis

Annex 18: Qualitative (FGDs) analysis report

Annex 19: Household Survey result tables

Annex 20: Household Survey database

Annex 21: Kaduna State MNCHW final report June 2010

ANNEX 1: TERMS OF REFERENCE

ToR for the Evaluation of the Maternal Neonatal and Child Health Week in Nigeria, from 2010 to 2013:

Introduction/ Background

Easily preventable and/or treatable infectious diseases account for 71% of the more than 1 million under-five deaths estimated in Nigeria every year with deaths being attributable to malaria (24%), pneumonia (20%), diarrhoea (16%), measles (6%) and HIV/AIDS (5%); with a wide variation across the geopolitical zones/States. The coverage of preventive interventions is still low and often skewed towards implementation of vertical programmes that are often donor driven. The Primary Health Care system are generally weak and thereby unable to support and/or deliver integrated services which necessitates the use of vertical approaches that do not necessarily strengthen the health system even though often successful interventions. Vertical interventions often create competition for human resources and many a times are duplicative of ongoing intervention. While almost every intervention has some health benefits, the implementation of numerous almost unending programmes-one week it is Polio Eradication campaigns, next week malaria control using LLINs and measles campaign etc may result in beneficiary fatigue and a risk of backlash in terms of acceptability and community cooperation for uptake of services.

The Accelerated Child Survival and Development (ACSD) concept that is embedded into the existing national Integrated Maternal and Neonatal and Child Health Strategy is a vehicle that is aimed at scaling up a package of key maternal, neonatal and child survival interventions. This package contains high impact interventions that have been proven to reduce neonatal and child mortality. The national Child Health Policy clearly outlines the need to implement an integrated approach, such as the MNCH week which packages a number of proven high impact interventions targeting as many clients as possible in a week.

Consistent with the national Integrated Maternal and Neonatal and Child Health Strategy, which aims to scale up a package of key maternal, neonatal and child survival interventions, the MNCH Week is a package of high impact interventions delivered twice a year (May and November) targeting maximum coverage. The strategy, being integrated, provides a one-stop shop for clients to access key life-saving services in a short time and possibly bringing them into the fold of clients who might develop the habit of seeking such services consistently from the routine outlets in the future.

The strategy is co-funded by the government at different levels UNICEF and other Partners. The planning, implementation, monitoring and reviewing of the results of the Week are also done jointly thereby strengthening partnerships and institutional capacity through training health workers and learning lessons from successive rounds as well as applying some of them to the routine services. The MNCH Week is a complementary package that is meant to augment the routine services and not to replace them.

The MNCH week is a service delivery activity comprising of the following interventions:

- i. Immunization– Measles, Yellow Fever, Oral Polio, DTP, Tetanus Toxoid
- ii. Malaria - LLINs
- iii. Nutrition - Vitamin A, MUAC screening, Deworming,
- iv. ANC -TT, Fe/Folate, and SP for IPT

- v. IEC - Exclusive and Complementary feeding, Hand washing with soap by mother
- vi. Birth registration
- vii. And now HIV Counselling and Testing (HCT) as a new recommended intervention in the package.

Prior to the implementation of the MNCH Week, a micro planning exercise is undertaken covering the aspects of :

- Injection safety
- Cold chain: requirements and availability,
- Logistics: need for transportation and communication
- Staff training and
- Community participation
- Data management and real time reporting (RapidSMS)

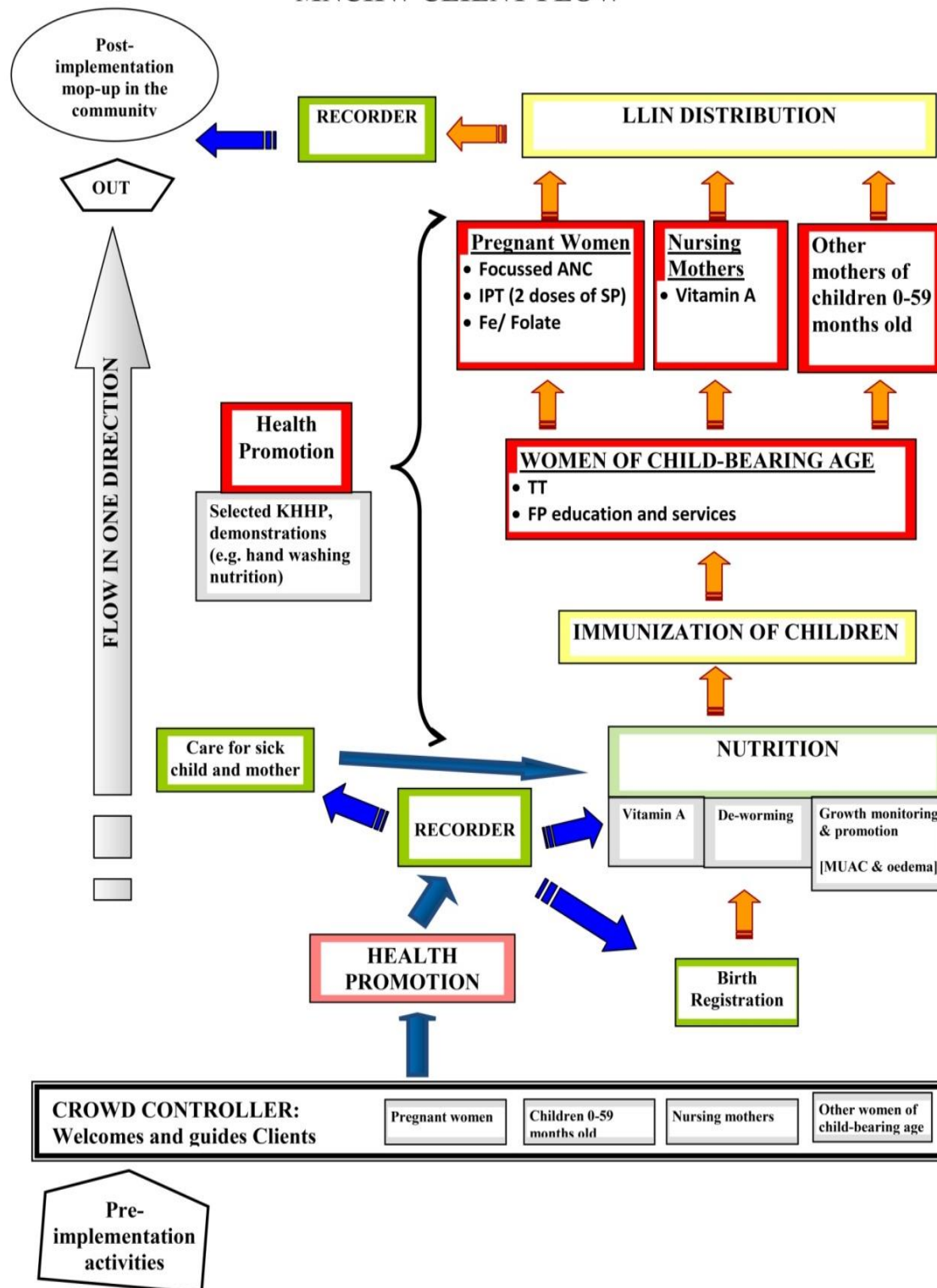
MNCHW History and Strategies Used in achieving Results

In year 2009, the Federal Ministry of Health (FMOH), in partnership with UNICEF, and Roll Back Malaria Program (RBM), piloted an integrated Child Health Week package in 2 northern States of Nigeria. This was highly successful; following which the lessons learnt was documented and disseminated. This led the national government in collaboration with other health sector stakeholders, to institute the Maternal, New-born and Child Health Week (MNCHW) Strategy in 2010. It has been implemented in all the 36 States and the Federal Capital Territory in Nigeria since then. This has consistently led to coverage of over 70%, while UNICEF's post-VAS coverage survey report (UNICEF 2010) put the national coverage at 83.4%²⁵.

Tally sheet coverage reports for year 2011 indicate that 73% of eligible children were reached during Round 1 and 82% during Round 2 (representing 21.6 million and 24.2 million children respectively). Figure 1 below is a summary of coverage by Round of Vitamin A supplementation since inception of mass distribution in year 2000, while figure 2 shows State specific VAS coverage in 2011 as revealed by MICS4 report (2011).

The MNCHW Implementation Framework

MNCHW CLIENT FLOW



Goals and objectives of the MNCH week:

The goal of the MNCHW is to deliver a package integrated "high-impact, low-cost child survival interventions" aimed at

-
- Achieving the highest possible coverage of children;
 - Promote Multi-intervention programming;
 - Delivering an integrated package of high impact interventions at low cost;
 - Effective preventive services for improving MNCH that are run in conjunction with routine services at health facilities
-

The Specific Objectives:

- 1. To improve the utilization of routine services.**
- 2. To increase the coverage of MNCHW interventions.**
- 3. To improve key healthy household practices.**
- 4. To improve the capacity of health workers to deliver maternal and child interventions.**
- 5. To improve health and care seeking behaviour of care givers.**
- 6. To improve utilization of health information management system.**

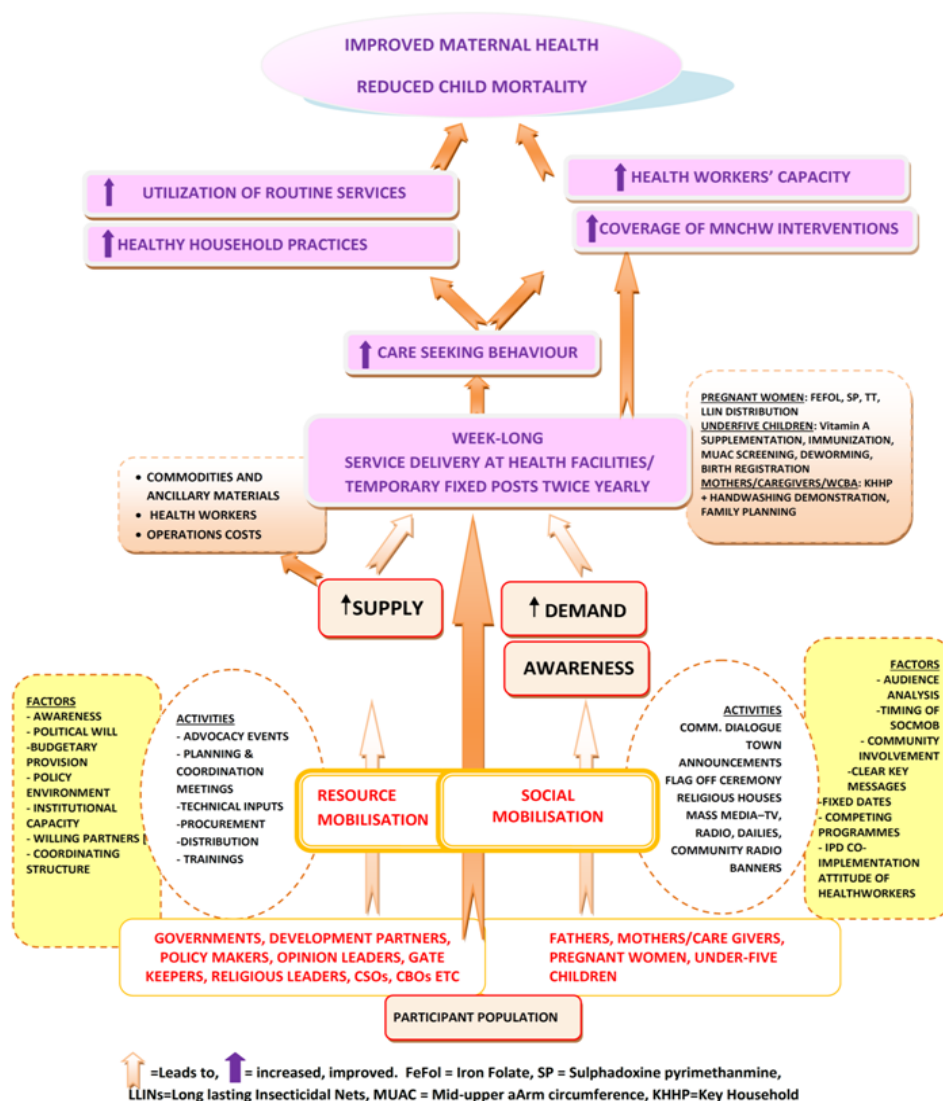
When did the MNCH week start and plans to end?

The MNCH Week started in 2010 and is meant to continue until the Primary Healthcare system in Nigeria is strong enough to run adequate routine services to meet the needs of the population, thereby making it unnecessary to undertake any special interventions on a regular basis. At the present time, the performance of both the routine PHC services and the MNCH Week are widely varied between zones and States making it very difficult to predict how far in the future the strategy will remain operational.

Area of operation and target population:

The MNCH Week is a countrywide intervention that takes place twice a year (May and November) and targets under-five children, pregnant and women of child-bearing age.

Conceptual framework:



The MNCH log frame/ Theory of Change

With effective community mobilization and dialogue, the implementation of the key interventions during IMNCH week is expected to result in high degree of service uptake by both mothers and children. Increased service uptake during the week linked with continuous routine utilization is expected to result in improved health of children and mothers. Many of the interventions supported during IMNCH week if sustained are known to save lives and thereby reducing the burden of maternal and child mortality.

Program: MNCH Weeks Evaluation - Logic Model

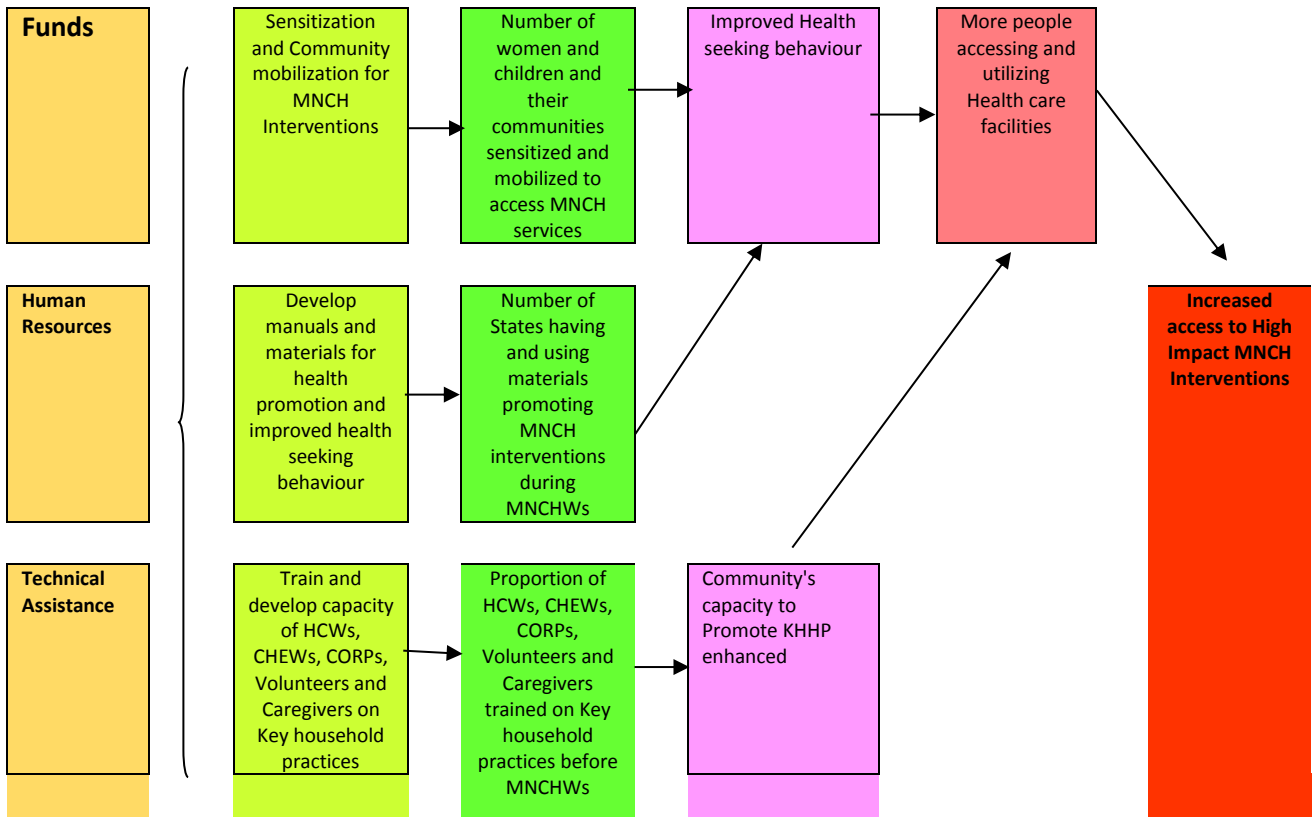
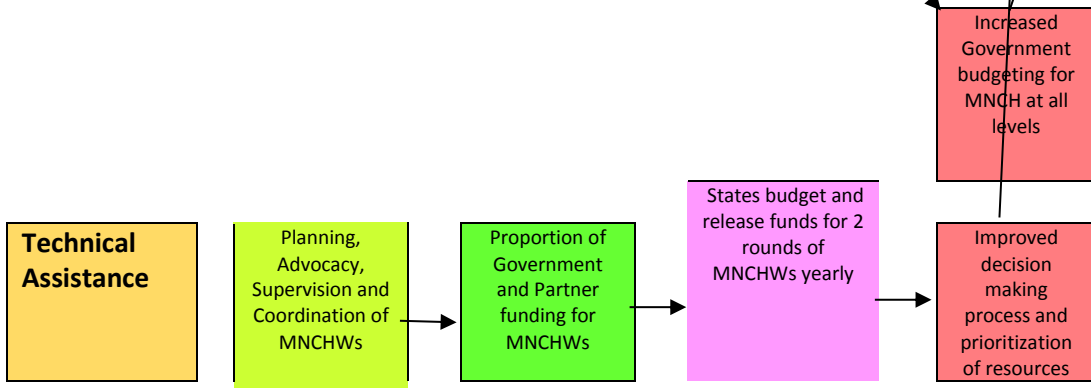
Situation: Evaluation of bi-annually MNCH Weeks which started in 2010 and still on-going. The goal of the MNCHW is to deliver a package integrated "high-impact, low-cost child survival interventions"

Aimed at § Achieving the highest possible coverage of children § Promote Multi-intervention programming § Delivering an integrated package of high impact interventions at low cost

§ Effective preventive services for improving MNCH that are run in conjunction with routine services at health facilities. The conduct of regular MNCH weeks is expected to achieve the following objectives

- Ensure access by mothers and children 0-59 months to the following key maternal/child survival interventions in the targeted States:
- Social mobilizations for routine immunization as scheduled, and for missed opportunities.
- At least 80% of children 6-59 months in the targeted LGAs given vitamin A every 6 months.
- 12-59 months old children in target LGAs de-wormed every 6 months.
- 6-59 months old children screened for acute malnutrition and appropriately referred if malnourished.
- ANC for iron and folate supplementation, TT and SP
- LLIN promotion and distribution for under five children and pregnant and lactating women
- Health Education on key household practices





Assumptions: Adequate funding of MNCHWs by government and partners; Continued provision of Services at Service delivery points; Adequate HRH available for MNCHWs implementation; Stability in politics especially at LGA level; Adequate Security is ensured

External Factors; Knowledge, attitudes, beliefs, myths and taboos on MNCH interventions pose a serious threat to adoption of high impact MNCH interventions

Purpose of the evaluation

The MNCHW was conceived to complement the weak routine services of the PHC system in Nigeria thereby bridging gaps that poor coverage of facilities and services may have created.

The purpose of this evaluation is to build our knowledge based on effective strategies, and thus determine what worked well, where, why and under what circumstance? The evaluation findings shall be used for advocacy activities with the intention of influencing State and Federal government to support, scale up and increase budget as relevant.

In addition, the evaluation will examine whether MNCH week appropriately designed, implemented, and achieving the expected results; whether is it in line with the needs of the clients and how has it affected the PHC system to date and what are the likely long term outcome and impact on both the clients, institutions and the health system? The evaluation will also look at the extend of which UNICEF/Donors support was effective, identify lessons learned and relevant.

The findings of the evaluation will be of great value in future discussions with governments who, being the primary duty bearers, are the principal partners in the intervention. Whatever the findings, the evidence will help guide dialogue within the partnership. The hope is that this evidence based engagement will elicit commitment for better implementation or if already being well done, to sustain the thrust. With already three years of MNCHW implementation, it is not healthy to continue only being guided by States' monitoring reports without probing further to ask deeper questions as will be done in an evaluation. Thus, the time is due for the MNCH week to be subjected to an evaluation.

Scope and focus of the evaluation

The scope of the evaluation covers the period January 2010-July 2014. However, baseline data will be sought from the immediate previous year(s) to help in assessing the level of progress made over the period relying on national surveys as well as State and zonal review reports.

The evaluation will focus on the following questions:

Evaluability

- Are the long-term impact and outcomes clearly identified and are the proposed steps towards achieving these clearly defined?
- Is the MNCH Week objectives clearly relevant to the needs of the target group, as identified by any form of situation analysis, baseline study, or other evidence and argument?
- Is a complete set of documents available with respect of MNCH Week activities and results?
- Is data being collected for all the indicators as they relate to the Theory of Change? Is gender disaggregated data available?
- Do existing M&E systems have the capacity to deliver?
- Are goals, objectives, results and performance indicators meet standards for Results-Based Management?
- Resources and services designed to effectively respond to conditions (including risks), needs and problems identified?

Relevance

- What is the value added by the implementation of MNCH weeks in relation to its primary results in immunisation, nutrition, ANC and KHHPs?
- What extend the MNCH week reached the targeted clientele, met their needs, especially the most deprived?

- To what extent has the implementation of MNCH weeks boosted PHC services (quality and coverage) and strengthened key PHC systems e.g. governance of PHC HMIS, funding for PHC service delivery, etc?
- Did the intervention is relevant given the government priorities (Federal and States) and plans?
- To what extent does UNICEF support is relevant?
- The choice of delivery channel is based on an assessment of options and a sound evidence base from the target population needs, especially the most worst-off?

Effectiveness and efficiency

- Are all MNCH Week interventions achieving satisfactory results in relation to stated objectives in the short term?
- How likely are they to continue to do so in the long term?
- Can the cost of delivery of the packages during the MNCH week be considered good value for money?
- To what extent UNICEF support is effective and efficient?

Impact

- What are the impact achieved by the MNCH Week interventions as identified on the theory of change? And what are the impact of the most deprived? Especially women and children?
- What are the impacts of the respective key results in the lives of beneficiaries with respect of health wellbeing of under-five children, pregnant and women of child-bearing age?
- What impact has the implementation of the MNCHW had on the PHC system now and possibly in the future?
- What is the impact of UNICEF within PHC system and UNICEF contribution to the reduction of IMR and MMR?

Partnership

- To what extent does the partnership between UNICEF and PHC is effective and well-coordinated? Is there shared and clear responsibility and accountability for results?
- IS there an active participation of state partners? and beneficiaries (especially women and most worst off beneficiaries) in implementation and MNCH Week activities?
- Is there clear definition, understanding and acceptance of roles and responsibilities of MNCH week partners?
- Do partners in management have the appropriate authority and tools they need to make decisions and take action?

Sustainability

- How sustainable is the intervention, given the level of government's commitments, ownership at federal and state level?
- What is the disposition of the communities towards the MNCHW and their resultant attitude to the routine services?
- What is the pattern of the state's contributions in the MNCHW?
- The proportion of states that have budget line for MNCHW?
- To what extent does UNICEF specific support is sustainable?

Sources of information

The sources of information that will be used in the course of the evaluation are as follows:

- National surveys (MICS and NDHS)
- Reports of the Joint Annual Reviews of the Health Sector
- Report of States (SMOH) annual health sector reviews
- State MNCHW monitoring reports
- Reports of Zonal MNCHW reviews
- Trip reports of personnel participating in the MNCHW activities
- Interviews with government partners, NGOs and community members

Tasks to be accomplished

The key tasks to be undertaken by the engaged evaluator include, among others, the following:

- To undertake an evaluability assessment of the MNCH Week intervention;
- To refine the theory of change and scope of the intervention;
- Develop an inception report containing a detailed Evaluation Plan and design that address the specific evaluation questions proposed here, relevant indicators, data collection methods and present evaluation design options to meet the quality expectation for approval by the Project Authority (UNICEF);
- Undertake a comprehensive desk review of the MNCHW and similar approaches in Nigeria and other countries in the sub-region to establish a rich knowledge base to facilitate comparisons and proffering of solutions to identified shortcomings;
- Consult and work with stakeholders at the national, State, LGA and Ward levels through all available means (email, teleconference, in-person meetings, etc) to gather primary information/data and corroborate other information provided by stakeholders at other levels;
- Periodically review the evaluation plan and provide updates to ensure timely and transparent delivery.
- In good time, inform the Project Authority of any significant modifications to the intervention/project that could affect the evaluation and any difficulties that may arise in implementing the approved evaluation design;
- Provide at least one progress report and prepare the evaluation report described in the agreed Deliverables.
- Undertake any reasonable task associated with the evaluation within the period of engagement.

Quality expectation

It is expected that the evaluation design will deal with the four dimensions of quality of impact evaluation and the proposal will demonstrate how it will successfully address the following: statistical conclusion validity; construct validity; external and internal validity.

Statistical conclusion validity is concerned with whether the presumed cause of the MNCHW intervention and the presumed effect (the impacts as per the Logic model) are related. Measures of effect size and their associated confidence intervals should be calculated. Statistical significance (the probability of obtaining the observed effect size if the null hypothesis of no relationship were true) should also be calculated.

Construct validity refers to the adequacy of the operational definition and measurement of the

theoretical constructs that underlie the MNCHW outcomes and impact. We need to ensure that we indeed measure what we had intended to change.

External validity refers to the generalizability of causal relationships across different persons, places, times, and operational definitions of interventions, outcomes and impacts.

Finally the internal validity refers to the correctness of the key question about whether the MNCHW intervention really did cause a change in the outcome and impact expected. Essentially is the evaluation design appropriate and deal with a counterfactual e.g. what would have happened to the MNCHW clients (experimental units) if the intervention had not been applied to them?

Stakeholder Participation and Specific Responsibilities:

The evaluation will be steered by a Committee composed of the relevant stakeholders (FMOH, NPHCDA, WHO, UNICEF, UNFPA, NBS and other partners). The committee will be chair by UNICEF and the main goal is oversee and manage the overall evaluation process. The TORs include, among others, the following responsibilities:

- Review and approve the RFP, and the proposals bided against
- Review and approve key deliverables of the evaluation, including the inception report, evaluation plan and final reports.
- Review plans for the data collection, instruments and tools as required and if needed.
- Provide timely feedback on draft reports, including comments from peer reviewers to the service provider or through any appropriate means as mutually agreed.
- Approval of the final report based on the fulfilment of quality standards/criteria agreed the inception report.
- Recommend approval/rejection of specific recommendations emerging from the report, and provide management response.
- Develop minutes of the meeting including all relevant decisions.

Accountabilities:

i. Field Office:

The Zonal Offices of NPHCDA and the Field Office PME Specialists and the CSD Managers/Health Specialist will serve as the primary contact persons with the evaluation team. They will provide the necessary technical guidance and logistic support and serve as a link with NCO.

ii. NCO:

A steering committee will be established to oversee the evaluation process. The draft TORs and key deliverables will be review by the steering committee. The committee will be chair by UNICEF.

iii Regional Office

The Regional Office will also be invited to comment on the draft deliverables.

iv Peer reviewers

UNICEF, as part of its quality assurance process, will ensure that the TORs and deliverables are peer reviewed by an independent and paid evaluators. The budget will factor in this QA process.

Evaluation team roles/responsibilities and qualifications:

Roles/responsibilities

The evaluation team should be composed of a team leader international or national and a team of national evaluators to assist him/her. The team leader will be responsible for the overall oversight of evaluation and quality issues while the team of evaluator shall assist the team leader in carrying out the assignment, including but not limited to facilitating logistics, meetings, interviews with stakeholders and identifying/accessing relevant data sources. Based on detailed roles and responsibilities, as will be mutually agreed and approved by the Approving Authority, detailed responsibilities of both parties will be further elucidated once selection is made.

The proposal should demonstrate a team composition with a solid and relevant experience in both Impact evaluation studies and related sector (Health, Immunization and nutrition)

Qualifications

The selected firm/consultant must possess the following qualifications, abilities and qualities:

- ✓ At least a Master's degree or equivalent in the field of public health, epidemiology, biostatistics or social sciences from a recognized institution
- ✓ Demonstrated experience in sound impact evaluation design
- ✓ Excellent report writing and analytical skills
- ✓ Previous experience in carrying out impact evaluations for MNCHW or similar public health interventions;
- ✓ Sound capacity and experience in planning and organizing evaluation logistics;
- ✓ Strong capacity in data management and statistics;
- ✓ Adequate background in microeconomics, statistics and econometrics;
- ✓ Excellent track record in partnering with African survey or equivalent firm(s) to conduct field work or research;
- ✓ Excellent track record of working with Sub-Saharan African clients, including Governments;
- ✓ Good will be an added advantage

Additional requirements:

- Experience of working in and understanding of the Nigerian health care architecture and systems will be an added advantage
- Ability to work in a multicultural environment and teamwork are also desirable

Risks and Risk Mitigation

It is impossible to predict all the problems and risks that might arise. Those that are considered most likely to appear are the following:

a) Perceptions that the evaluation is threatening the support provided both financially and technical.

Having a steering committee that manage the evaluation and own the findings; An effort will be made from the beginning to communicate the evaluation's objectives, purpose and scope, and to highlight the need to improve and scale up.

b) Timing presents a major risk for this evaluation. Time for data collection will be tight.

Country office including Field offices support will be necessary to ensure that time spent in country is well used and documentation sharing happens well before arrival, so that consultants can quickly begin with data collection and logistical issues resolved prior to arrival. In addition, bidders are encouraged to be forthright about whether they recommend a longer period, or the compromises they project emerging if that duration is maintained.

c) Data availability, quality and consistency are to a degree unknown. The mitigation factors will be to perform an evaluability assessment to feed the choice of approaches and methods. It is also expected that the creativity and skill of the consultants in identifying appropriate data source.

Ethical Considerations:

The Evaluation will follow Government of Nigeria and UNICEF guidelines on the ethical participation of children. In addition, all participants in the study will be fully informed about the nature and purpose of the research and their requested involvement. Only participants who have given their written or verbal consent (documented) will be included in the research. Specific mechanisms for feeding back results of the evaluation to stakeholders will be included in the elaborated methodology.

All the documents, including data collection, entry and analysis tools, and all the data developed or collected for this study/consultancy are the intellectual property of the government of Nigeria and the UNICEF. The Evaluation team members may not publish or disseminate the Evaluation Report, data collection tools, collected data or any other documents produced from this consultancy without the express permission of, and acknowledgement of GoN and UNICEF..

Procedures and logistics:

The evaluator/evaluation firm will determine the logistics support required to execute the assignment. The requirements should be briefly outlined in the inception report and agreed to by the approving authority for inclusion in entitlements payable.

Deliverables:

- An inception report, detailing the evaluation design and detailed work plan and cost.
- Periodic updates and a final Evaluation Report, which should include
 - Executive summary
 - Methodology: description of sampling and evaluation methodology used, assessment of methodology and its limitation, data collection instruments, and data processing (analysis methodology, and quality assurance)
 - Findings
 - Conclusions
 - Recommendations
 - Lessons learned
 - Annexes: List of indicators, questionnaires, and if survey, table of sample size and sample site as appropriate
- The report should be provided in both hard copy and electronic version in English in the required UNICEF format.
- Completed data sets (filled out questionnaires, records of individual interviews and focus group discussion, etc.)
- The evaluation report will be required to follow and will be rated in accordance with GoN policy and “UNICEF Evaluation Report Standards” and UNICEF Evaluation Technical Notes

Schedule

Weeks	Description of activities	Expected Duration
Inception phase		
1-3	Inception mission and evaluability assessment	3 weeks
3-4	Inception report the results of evaluability assessment and proposed approaches and methods	2 weeks
5	Review of the study plan, protocol, analytical framework and indicators by steering committee	1 week
6	Feedback and revision; acceptance of the inception report	1 week
Data collection phase		
7-10	Data collection phase: preparation (conception of household survey, pilot the survey, training of enumerators, etc.) and execution. In the field.	4 weeks
Data analysis		
11-12	Preparation and submission of draft report	2 weeks
13-14	UNICEF feedback on draft report	1 weeks
15	Preparation and submission of final report	1 week

Payment schedule:

This should be in instalment payments, based on deliverable, the last being made upon satisfaction of the last deliverables.

Payment schedule	Payment proportion
Deliverable 1: Inception report	50% of total cost
Deliverable 2: Draft report	30% of total cost
Deliverable 3: final report	20% of total cost

Resource requirements:

- Estimate the cost and prepare a detailed budget. Note the source of funds. Link the budget to the key activities or phases in the work plan. Cost estimates may cover items including:
 - Travel: international and in-country
 - Team member cost: salaries, per diem, and expenses
 - Payments for translators, interviewers, data processors, and secretarial services.
 - Training cost and printing of material if relevant
- Estimate separately any expectations in terms of time costs for:
 - Staff (before, during, after)
 - Other stakeholders, including primary stakeholders.

UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete, not delivered or for failure to meet deadlines.

All materials developed will remain the copyright of UNICEF and that UNICEF will be free to adapt and modify them in the future

Prepared by: _____
Chief of Health Signature _____
Date

Reviewed by: _____
Chief of PME Signature _____
and FC Date

Approved by: _____
Deputy Rep. Signature _____
Date

ANNEX 2: LIST OF PERSONS INTERVIEWED, AFFILIATED INSTITUTIONS AND SITES VISITED

UNICEF: Unicef Nigeria Country Office, UN House, Plot 617/618, Diplomatic Drive Central Business District, PMB 2851, Garki, Abuja, Nigeria			
1	15/06/15	Aboubacar Kampo	Chief Health
2	15/06/15	Arjan de Wagt	Chief Nutrition
3	15/06/15	Caroline Barebwoha	U-report Project Officer
4	15/06/15	Jonathan Addo	Security Advisor
5	15/06/15	Denis Jobin	Chief Planning Monitoring & Evaluation and Field Coordination
6	18/06/15	John Egbe Agbor	Immunisation Manager
7	18/06/15	Assaye Bulti	Nutrition Officer (Data)
UNFPA: United Nations Population Fund, Abuja			
1	16/06/15	Ratidzai Ndhlovu	Representative
2	16/06/15	Olanike Adedeji	NPO RHCS Analyst
3	16/06/15	Adegoke Dawodu	National Family Planning Analyst
4	16/06/15	Osaretin Adonri	Assistant Representative
DFID			
1	16/06/15	Melkamnesh Alemu	Health Adviser, Human Development Team
2	16/06/15	Kemi Williams	Human Development Team Leader
RH DIVISION FMOH			
1	16/06/15	Dr. Kayode Afolabi	Head Reproductive Health Division
2	16/06/15	Dr. Musa H. Hadiza	RH/Safe Motherhood
3	16/06/15	Osuntogun A.O	Head Safe Motherhood
FAMILY HEALTH DEPARTMENT FMOH: Federal Ministry of Health			
1	18/06/15	Dr. A.R Adeniran	Head, Child Health
2	18/06/15	Dr. C.C Ugboko	Head GASHE
3	18/06/15	Omoru A. E	Deputy Director MNCH
4	18/06/15	Dr. Musa H. Hadiza	RH/Safe Motherhood
5	18/06/15	Madu Ezioma P	ACEHO/Health Promotion
6	18/06/15	Dr. H.S Idris	Assistant Director MNCH
7	18/06/15	Oyibo F.U	ACNO/Nutrition
8	18/06/15	Saadatu Sule	Technical Advisor
9	18/06/15	Luigi Dáguino	Senior Technical Officer
10	18/06/15	Adama Abdul	PNO 2
11	18/06/15	Helen Y. Akhigbe	ACNO
NATIONAL BUREAU OF STATISTICS			

1	18/06/15	Mr Isiaka Olarewaju	National Bureau of Statistics
MNCHW EVALUATION STEERING COMMITTEE			
1	19/06/15	Pharm Amaka Nwoha	PHSCD NPHCDA
2	19/06/15	Dr. Mayowa Alade	Focal person World Bank
3	19/06/15	Adanna Opara	Programme Officer Helen Keller International
4	19/06/15	Omoru Alex	Desk Officer MNCHW FMOH
5	19/06/15	Oluyemisi Akinwande	UNAIDS Consultant
6	19/06/15	Suleiman Yakubu	Vitamin Angels
NATIONAL POPULATION COMMISSION			
1	19/06/15	Mr Usman Kolapo	Census Department, National Population Commission
2	29/06/2015	Hajiya Zainab Mahmud	Vital Registration Department, National Population Commission
ORIE (NUTRITION RESEARCH IN NORTHERN NIGERIA)			
1	22/06/2015	Dr Vincent Ahonsi	National Team Leader
NIGER STATE			
1	25/06/2015	Dr Usman Tiffin	Permanent Secretary, Niger State Ministry of Health
2	25/06/2015	Dr Shehu Yabagi	Executive Secretary, Niger State Primary Health Care Development Agency
3	25/06/2015	Mrs Anna Simon	Niger State Safe Motherhood Coordinator
4	25/06/2015	Dr Amina M. Baloni	Health Specialist, UNICEF Kaduna Office
SAVE THE CHILDREN			
1	26/06/2015	Karina Lopez	Senior Nutrition Adviser
2	26/06/2015	Oluwatoyin Oyekenu	
EUROPEAN UNION			
1	29/06/2015	Dr Anthony Ayeke	International Aid/Cooperation Officer, Health, EU Nigeria
WORLD BANK			
1	1/07/2015	N'Della Njie	Operations Officer, Health, World Bank
2	1/07/2015	Noel Chisaka	World Bank
3	1/07/2015	Mayowa Alade	World Bank
HELEN KELLER INTERNATIONAL			
1	1/07/2015	Babajide Adebisi	Chief of Party
MICRONUTRIENT INITIATIVE			
1	2/07/2015	Dr Abiodun Oladipo	Country Director
2	2/07/2015	Ms Folake Anjorin	Officer i/c MNCHW

ANNEX 3: LIST OF DOCUMENTS CONSULTED AND REVIEWED

Source: National and State Key Informants

State/Zone	MNCHW Reports	Other MNCHW documents
Kebbi	2009 State report-executive report	2009 Stock balance report
	2009 CHW report drafts 1 & 2	Number of people reached with different MNCHW interventions in Kebbi state in June 2011- raw unaggregated data in excel sheets
		Number of people reached with different MNCHW interventions in Kebbi state in June 2011
Katsina		Number of people reached with different MNCHW interventions in Katsina State in July 2011
FCT		Number of people reached with different MNCHW interventions in FCT in November 2012
Ebonyi	June 2010 report (PowerPoint presentation)	
Katsina	June 2011 Report	Katsina June 2011 MNCHW/IPDs State Debriefing-PowerPoint presentation detailing people reached, interventions, etc. during the MNCHW, and trends in vaccinations, etc. from Jan to June 2011
Abia		Number of people reached with different MNCHW interventions in Abia State in May/June 2010
Bayelsa		Bayelsa State Call-in Data for May 2010 MNCHW (i.e. targets and coverage for MNCHW)- Excel sheet
		M&E checklist used during MNCHW
		Bayelsa State targets and coverage for MNCHW for May 2011
Niger		Number of people reached with different MNCHW interventions in Niger state in June 2011
Sokoto	Illela Local Government Report	Number of people reached with different MNCHW interventions in Sokoto State in June 2011
	December 2009 State Report	
Zamfara		Number of people reached with different MNCHW interventions in Zamfara State in June 2011
Kaduna	June 2010 State Report	Number of people reached with different MNCHW interventions in Kaduna State in June 2010
Delta		Number of people reached with different MNCHW interventions in Nov 2011 (Excel sheet)
Ebonyi		Number of people reached with different MNCHW interventions in Ebonyi state in June 2010
		Number of people reached with different MNCHW interventions in Ebonyi state in June 2011
Jigawa	May 2011 report (PowerPoint presentation)	

Kano		Number of people reached with different MNCHW interventions in Kano state in 2011 (?month)
		Number of people reached with different MNCHW interventions in Kano state in May 2011- raw unaggregated data in excel sheets
		Number of people reached with different MNCHW interventions in Kano state in Nov 2011- raw unaggregated data in excel sheets
Plateau	May 2011 report (PowerPoint presentation)	
Yobe	June 2011 report (PowerPoint presentation)	
Nasarawa	July 2011 report (PowerPoint presentation)	
Gombe	May 2011 report (PowerPoint presentation)	
Ondo	May 2011 Report	
Rivers	MNCHW target and coverage for Rivers state in June 2011 (Excel sheet)	
Borno	Number of people reached with different MNCHW interventions in Borno state in June 2011- raw unaggregated data in excel sheets	
Lagos	Number of people reached with different MNCHW interventions in Lagos state (?Month and Date)	
	May 2011 MNCHW vaccine usage summary	
BFO states (Ogun, Osun, Edo, Delta, Ekiti, Lagos, Ondo and Oyo)	Number of people reached with different MNCHW interventions in BFO states in May/June 2010	
		Number of people reached with different MNCHW interventions in BFO states in Nov 2010
		Number of people reached with different MNCHW interventions in BFO states in May 2011
		Number of people reached with different MNCHW interventions in BFO states in Nov 2011
		Number of people reached with different MNCHW interventions in BFO states in May 2012
CFO states (Katsina, Kebbi, FCT, Kwara, Niger, Kaduna, Kogi, Sokoto, Zamfara)	Number of people reached with some MNCHW interventions in CFO states in June 2011	
DFO states (Adamawa, Bauchi, Borno, Gombe, Jigawa, Kano, Nasarawa, Plateau & Yobe)	Number of people reached with different MNCHW interventions in BFO states in June 2011	

Selected states		December 2009 Routine immunisation coverage for measles and TT
	Report of November 2013 MNCHW implementation conducted in 9 UNICEF focal states	
	Report of May/June 2014 MNCHW implementation conducted in 14 UNICEF focal states	
	Report of November 2014 MNCHW implementation conducted in 29 states including UNICEF	
South-West Zone	November 2012 Report	
All States	Update on May/June 2010 MNCHW in 36 states/FCT (PowerPoint presentation)	MNCHW target and coverage for all states in May 2010 (Excel sheet)
	Report of May 2011 MNCHW (PowerPoint presentation)	MNCHW target and coverage for all states in May 2011 (Excel sheet)
		MNCHW_2010-2011_ Sept Review Meeting: providing a review of MNCHW in 2010 till 2011 (PowerPoint presentation)
	May 2014 Report	Dates of MNCHW in May/June 2011
		Immunisation coverage for DPT3 in all states (both routine and MNCHW) from January to June 2011
		MNCHW target and coverage for all states in Nov 2010 (Excel sheet)
		MNCHW target and coverage for all states in Nov 2011 (Excel sheet)
		May 2014 Monitoring Report
		MNCHW Data summary May 2010 to November 2014
		MNCHW NPHCDA national workplans for 2014 and 2015
		MNCHW state workplans for November 2014
June 2015 MNCHW micro plan		

Source: National Primary Health Care Development Agency Documents

S/No	Document labelled as	Date	Title
1.	First round 2015 state WP and MP	2015	June 2015 maternal newborn and child health week (state micro planning template for vaccines)
2.	Funding support from partners	2014	May 2013 MNCHW - 33 states implemented - Borno, Adamawa, Niger and Kebbi did not implement
3.	List of key stakeholders supporting states		Key stakeholders supporting maternal newborn and child health week in states
4.	Mapping of campaign implementation may and November 2014	May & Nov 2014	May 2014 MNCHW state implementation
5.	May 2014 MNCHW Report	May-14	MNCHW report may 2014
6.	May 2014 Monitoring report – UNICEF focal states	May-14	Report of May 2014 maternal newborn and child health week (MNCHW) implementation conducted in 13 UNICEF focal states
7.	MNCHW Guidelines - 06-15	2nd Edition April 2014	Guidelines for implementing maternal newborn and health week in Nigeria
8.	MNCHW Training Manual 06-15	2014	Training manual for implementing maternal newborn and health week in Nigeria
9.	MNCHW 2010-2011 Review- August2011-Zonal-presentation_updated	2010/2011	Nigeria Maternal and Child Health Weeks 2010-2011 - Achievements, Challenges and Ways Forward
10.	MNCHW data 10 rounds	May 2010 - Nov 2014	Maternal newborn and child health week data summary may 2010 - Nov 2014 round
11.	National work plans 2014 and 2015	2014/2015	Maternal Newborn and Child Health Week (MNCHW) National work plans 2014 and 2015
12.	Nov 2013 Monitoring report - UNICEF focal states	Nov-13	Report of November 2013 maternal newborn and child health week (MNCHW) implementation conducted in 9 UNICEF focal states
13.	Nov 2014 State WP and MP	Nov-14	State MNCHW planning template
14.	Nov 2014 Monitoring report - UNICEF focal state	Nov-14	Comprehensive summary of the May/June, 2014 MNCHW implementation in mi/UNICEF 14 states
15.	Nov2014MNCHWReport	Nov-14	Report of November 2014 maternal newborn and child health (MNCH) week implementation conducted in 29 states including FCT
16.	Report of Nov 2014 review meeting	Jun-15	Report of the November 2014 Maternal Newborn and Child Health Review and Planning Meeting for June 2015 Implementation

ANNEX 4: DATA COLLECTION TOOLS

Qualitative Data

Key informant interview guide questions

- Review of participant information sheet (discussed via telephone and copy sent via email 1 week prior to interview)
- Obtain content for interview verbal/written
- Interview time 45-60 minutes
- views audio recorded with respondent's permission

1. Interviewee details

- Name of institution
- Position in institution
- How long in position
- How long been involved in MNCHW and in what capacity(ies)

2. How is the MNCHW funded?

- What is the split of funding?
- What is the risk if various partners do not meet their funding obligations?

3. What role does your institution play in the design, planning, funding of the MNCHWs?

- How effective is the partnership between your institution and UNICEF?
- Does your institution have any role in the M/E of the MNCHW? Please describe this role?
- What is your opinion of about the effectiveness of this monitoring/evaluation?
 - Discuss any challenges, limitations/factors responsible for success or sub-optimal performance
 - What are the key lessons from your opinion on monitoring/evaluation of the week by your institution?

4. What is the level of accountability of your institution for the deliverables of the MNCHWs

5. Regarding the MNCHWs, what is your opinion about

- Planning, microplans development
- Logistics
- Training
- Monitoring
- Reporting

6. What has worked well in the overall implementation?

- Any examples of what have worked well at National, State and Local government levels?
- Describe the factors that were responsible for success?

7. What are the barriers to implementing MNCHWs based on the current implementation guidelines?

8. In your opinion, how can the MNCHWs be improved?

9. In your opinion, how can the MNCHWs be sustained?

- What is your opinion about the capacity (systems) of the NPHCDA to sustain the approach?
- How can FMOH contribute to sustaining the approach?

10. How can the PHC system be improved based on the experience of the MNCHWs?

Additional specific questions for state and local government key informants

1. How will you rate the performance of your state/LGA for the last two MNCHWs in terms of

- Planning, microplans development
- Logistics
- Training
- Monitoring
- Reporting

Focus Group Discussion Guide

Community:

1. Use of health care services within the community

- a. What are the services available in your community for health care for children / women of reproductive age?
 - [Prompts: Routine/emergency; public/private]
- b. Where do you go for care during pregnancy, for preventive services for under 5s such as immunisation, growth monitoring etc.?
 - [Probe: What informs your choice?]
- c. Where do you go when your under 5-year-old children are ill?
 - [Probe: What informs your choice?]

Support questions: All services available on an ongoing basis? Some gaps? if gaps, what are they and how much of an inconvenience do they cause?

2. MNCHWs:

a. Awareness

Prior to today, have you heard about Maternal, Newborn and Child Health Weeks?

If so, what do you know about the initiative? When was the first time you heard about it?

[Expected inputs: twice a year campaigns; outside of normal health service delivery; services for children: immunisation, vitamin supplementation, de-worming; services for mothers/women of reproductive age; bed nets]

Support questions: How do people in your community learn about the Week taking place? How much in advance would the information be available? Who informs about the Week coming to the area? What services are offered as part of the campaign?

- [Prompts: word of mouth; leaflets; community meetings, radio, community leader, TV etc.]

b. Experience

Have you participated in any MNCHWs?

- [Probe for specificity i.e. when?]

For those who have experience/knowledge of MCHWs:

What were the factors that encouraged you to use the services under MNCHWs?

- [Prompts: encouragement from community leaders; other families taking part; health provider's advice; free care; extra events accompanying MCHWs, including promo materials, MCHWs increases opportunity for normal services for women and children in the community]

On the week of the campaign, what was your experience of using the services?

- [Prompt: It met your expectations or not and why?]

What worked well? [share specific examples]

What did not work well? [share specific examples]

For those who have not used MCHWs:

What were the factors that prevented/discouraged you from using the services under MCHWs?

- [Prompts: no information; inability to access services due to overcrowding; opinions of others' dissuading from use of initiative; ill health]

c. Evaluation

Are there particular aspects of the MCHWs which are more / less useful compared to others? Please provide reasons for your choices

Do you think MCHWs add value to the health services offered to a. women, b. children? If yes, what is the added value? If not, what are the reasons you don't think the initiative is working?

3. Recommendations:

a. If at all, what would you change in the campaign to improve it?

- [Prompts: contents (e.g. types of services provided); format (e.g. frequency; organisation); communication (e.g. information on MCHWs); how women can be encouraged/motivated to participate in the MNCHWs]

b. If you could pass on a message to the organisers of the MCHWs, what would you like to tell them?

ANNEX 5: EVALUATORS BIODATA AND TEAM COMPOSITION

The LSTM MNCHW evaluation team is made up of 12 members and one adviser (five males and eight females). The team is led by Dr Charles Ameh with technical supervision from Professor van den Broek. The team has four sub units: In-country technical coordination, programme management, Research and Monitoring & Evaluation (M&E) statistics units (Figure 4).

Most key team members have had specific tasks and responsibilities, at specified times during the life time of the evaluation.

A weekly meeting (senior management team) of all unit leaders and the team leader reviewed and signed off all operational, technical and administrative plans related to the evaluation. All standard operations procedures, data quality checks, team performance check procedures were developed, reviewed, signed off and monitored by the senior management team.

Five of the team members were based in Nigeria, four of them were responsible for supervising the household survey and conducting key informant interviews at National, State and Local Government levels government levels. The in-country team leader had overall operational responsibility for activities carried out in Nigeria during the evaluation and reported to the Team leader based in Liverpool.

The head of monitoring and evaluation was responsible for monitoring all data collection in real time (HHS via iPad with GPRS capability and real time uploading of data and qualitative data collection via LSTM field supervisors, telephone calls and text messaging).

During the inception phase we appointed three additional team members. We replaced one of our international team members on the research unit (Dr Joseph Onwude) with Dr Jan Hofman. Dr Hofman's extensive experience in Public Health, M&E and in Nigeria strengthened the team. We also added two National consultants (Drs Ijaya and Adewole) to reinforce our National team during the inception and data collection phases of the evaluation. See table for summary of LSTM evaluation team expertise, specific roles and responsibilities during this evaluation.

Figure 4: LSTM MNCHW evaluation team structure

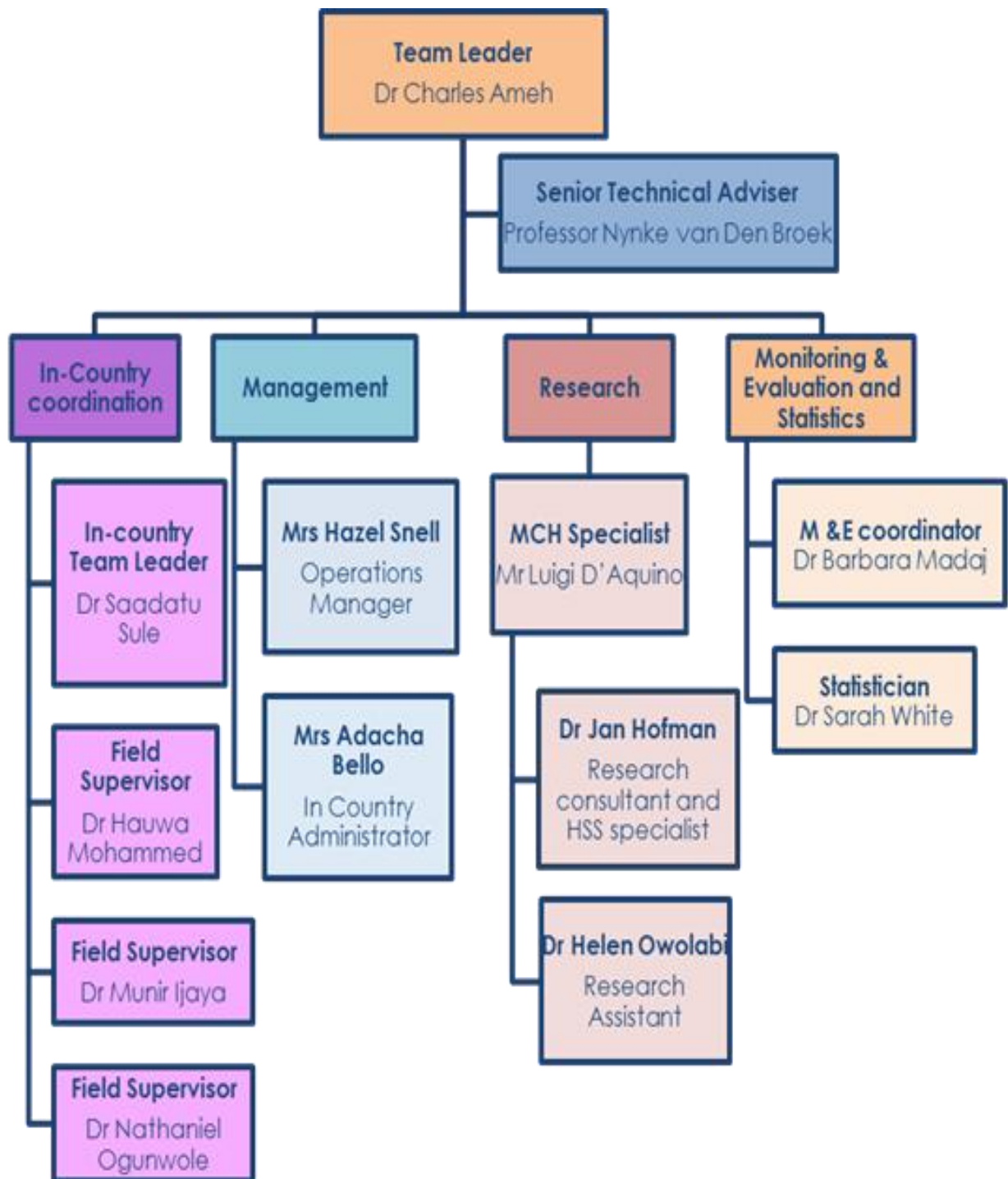


Table 12: LSTM MNCHW Evaluation Team Biodata

Name, designation	Location	Years, expertise and countries of experience	Role and Responsibilities under this assignment
<p>Dr. Charles Ameh Deputy Health CMNH, LSTM</p>	UK	<p>Over 15 years of experience Reproductive health, Maternal and newborn health, quality of care, Emergency Obstetrics & Newborn Care, research, monitoring & evaluation, data management, supply chain management, project management</p> <p>Kenya, Nigeria, Tanzania, Ghana, Malawi, Ethiopia, South Africa, Sierra Leone Zimbabwe</p>	<p>Team Leader Strategic and technical input. Evaluation design; Evaluability assessment Team management; External relations Report writing Approval of final reports</p>
<p>Prof. Nynke van den Broek Head of CMNH, LSTM</p>	UK	<p>Over 25 years of experience Reproductive health, maternal and newborn health, quality of care, Emergency Obstetric & Newborn Care, operational research, monitoring and evaluation.</p> <p>Kenya, Malawi, Nigeria, Zimbabwe, South Africa, Somaliland, Swaziland, Tunisia, Indonesia, Pakistan, Sri Lanka.</p>	<p>Technical supervision Strategic and technical oversight Relations with client Approval of final reports</p>
<p>Mr. Luigi D’Aquino, Senior Technical Officer CMNH, LSTM</p>	UK	<p>Over 15 years of experience Technical assistance; policy analysis and program evaluations. Maternal and child health, health systems strengthening, health policy and planning, and community based health care.</p> <p>Angola, Cambodia, Sudan, Mozambique, Ethiopia, Malawi, Zimbabwe, Middle East.</p>	<p>MCH specialist Evaluation design Evaluability assessment Policy analysis Impact assessment and cost-benefit analysis Report writing</p>
<p>Dr. Barbara Madaj Lead Monitoring and Evaluation, CMNH, LSTM</p>	UK	<p>Over 12 years of experience Research both qualitative and quantitative, mixed methods on small and large scale studies, data management, monitoring and evaluation.</p> <p>Algeria, Bangladesh, China, India, Kenya, Iraq, Czech Republic, Poland, Latvia, Tanzania, Zimbabwe, Sierra Leone</p> <p>Coordination/Oversight Russia, United Arab Emirates, Ghana, Morocco, Somaliland, Tunisia, Turkey, Bulgara, Pakistan, RSA, Malawi, Nigeria.</p>	<p>M&E coordinator Training of field teams for primary data collection Oversight of data collection, quality assurance and analysis Design of qualitative research</p>
<p>Dr. Sarah White Statistician</p>	Malawi	<p>Over 25 years of experience in application of a broad range of statistical methods, of relevance to the design and analysis of biomedical research using different software’s: Stata, SPSS, Epi Info and R. Extensive experience and incisive skills in the review of the research methods content of research proposals using quantitative methods. Malawi, UK</p>	<p>Statistician Design of survey (sampling methods) Statistical analysis of survey data</p>

FINAL REPORT