



USAID
FROM THE AMERICAN PEOPLE



END OF PROJECT EVALUATION OF THE EXPANDED SOCIAL MARKETING PROJECT (ESMPIN) IN NIGERIA

March 2017

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Dee Bennett, Foluke Adeniji, Omotayo Olugbemi, Joshua Olatunji, Sa'adatu Sule, and Augustine Yusuf Longjo.

Cover photo: Mother holds her four-month old son as a nurse prepares for their maternal-child health session at a rural clinic in Nigeria. Credit: © 2013 Adrian Brooks, Courtesy of Photoshare

END OF PROJECT EVALUATION OF THE EXPANDED SOCIAL MARKETING PROJECT (ESMPIN) IN NIGERIA

March 2017

USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment Number: 246

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

This document is available online at <http://ghpro.dexisonline.com/reports-publications>. Documents are also available through the Development Experience Clearinghouse (<http://dec.usaid.gov>). Additional information can be obtained from:

Global Health Project Cycle Improvement Project (GH Pro)

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20006

Phone: +1 (202) 625-9444

Fax: +1 (202) 517-9181

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

This document was submitted by GH Pro to the United States Agency for International Development under Contract No. AID-OAA-C-14-00067.

ABSTRACT

The Expanded Social Marketing Project in Nigeria (ESMPIN) is a five-year social marketing project funded by USAID/Nigeria to reduce maternal, and child morbidity and mortality and increase affordable family planning modern methods to Nigeria couples. The evaluation focuses on five questions: effectiveness of strategies, sustainability of strategies, evaluation of results, cost analysis, and gender conducted under the program. ESMPIN is managed by The Society for Family Health (SFH), a Nigerian non-governmental organization that has implemented social marketing programs in Nigeria since the 1990s. Its partners for this award are Population Services International (PSI), British Broadcasting Corporation Media Action, and the Association of Reproductive and Family Health (ARFH), and the project worked in 22 states in Nigeria. ESMPIN was successful in building commodity-security, showing a reduction in stock-out rate from 30% to 15%. Although the program invested heavily in independent detailing and distribution networks, these are not sustainable operations without heavy funding from donors or outside sources. Cost analysis and primary research show the return on investment for the interpersonal communication agents in the South to be very low at about 2%, costing \$3.321 million per Cycle (180 communities). ESMPIN conducted several pilot programs, including one with chemists, Proprietary Patent Medicine Vendors, and a public-private partnership with the Chi Pharmaceutical Ltd., manufacturer of an oral rehydration solution and Zinc. After \$57 million and almost six years of implementation, Couple Years of Protection (CYPs) in 2011 for medium- and long-acting reversible contraceptive methods, (e.g., implants injectables, and IUDs) were 28.2% of the baseline CYP while over the five-year time frame by the end of ESMPIN (2016) the CYPs for these same products had increased only 0.1% to 28.3% CYPs.

ACKNOWLEDGMENTS

Evaluations can be disruptive and intrusive as projects and people are trying to continue to work while they are regaled with questions and seemingly endless requests. The evaluation team recognizes this and acknowledges the willingness of everyone to quickly respond. The Society for Family Health (SFH) and the Expanded Social Marketing Project in Nigeria staff as well as its partners British Broadcasting Corporation Media Action, Association of Reproductive and Family Health (ARFH), and Population Services International (PSI) were generous with their information and time, as were the health facilities, federal and state ministries of health, the Local Government Association and Ward Development Committees, and Chi Pharmaceutical Ltd. staff that we interviewed, visited, and met with. We recognize the thought and preparation that went into the planning and support of this assignment by USAID/Nigeria, Office of Health, Population, and Nutrition, and to GH Pro, which made it run so smoothly. We also acknowledge the dedication and pride that everyone involved in ESMPIN feels about their work and shows in their commitment.

CONTENTS

Abstract.....	iii
Acknowledgments	iv
Acronyms.....	vii
Executive Summary	ix
I. Introduction.....	I
Evaluation Purpose.....	I
Evaluation Questions.....	I
II. Project Background	3
III. Evaluation methods and limitations	5
Methodology.....	5
Limitations.....	7
IV. Findings.....	8
V. Conclusions and Recommendations	32
Conclusions	32
Recommendations.....	34
Annex I. Scope of Work.....	36
Annex II. Evaluation Methods and Limitations.....	67
Annex III. Data Collection Instruments	85
Annex IV-A. Sources of Information: List of persons Interviewed.....	120
Annex IV-B. Bibliography of Documents Reviewed.....	122
Annex V. Site Visit Schedule	125
Annex VI. Summary of Data Collected	138
Annex VII. Disclosure of Any Conflicts of Interest.....	166
Annex VIII. Statement of Differences	174

TABLES

Table 1. States and LGAs for the Evaluation.....	6
Table 2. Percentage of USG-assisted Service Delivery Points that Experienced Stock-outs of Contraceptive Methods (ESMPIN Presentation to Evaluation Team, SPARCS and MAP Survey reports).....	17
Table 3. Percentage of Communities That Had At Least One Outlet Where Chi Co-packaged ORS + Zinc Product Could Be Obtained (MAP Survey 2016)	18
Table 4. CBDA and IPCA Performance in Increasing Access to FP and MCH Services (ESMPIN MIS data and reports)	20
Table 5. Comparison of Price List of Products by Different Organization (Source: From field study).....	22
Table 6. Total Fixed and Variable Costs for the ESMPIN Project.....	23
Table 7. Family planning Cost-effectiveness for ESMPIN (3% Discount Applied).....	24
Table 8. Outcome Measures of IPCA and CBD Strategies	25
Table 9. Cost-effectiveness of Strategies (in US\$).....	25
Table 10. Chi Pharmaceuticals Ltd, Guide for Pricing Costs, November 2016	27
Table 11. Age Distribution of Exit Interview Clients Who Utilized FP Services	29

FIGURES

Figure 1. CYP Method Mix: Baseline data. LOP Target Compared with LOP Achieved.....	16
Figure 2 Percentage CYP for Short-Acting Contraceptive Methods (Condoms Contraceptive Pills, Cycle Beads): Baseline Compared with LOP Target and LOP Achieved	16
Figure 3. Percentage CYP for Medium and Long-Acting Reversible Contraceptive Methods: Baseline Compared with LOP Target and LOP Achieved	17
Figure 4. WDC FGDs: Type of Support Given by Men to their Wives for FP	30

ACRONYMS

ACT	Artemisinin-based combination therapy
ARFH	Association of Reproductive and Family Health
BBC MA	British Broadcasting Corporation Media Action
BCC	Behavior change communication
CBD	Community-based distribution
CBDA	Community-based distribution agent
CBN	Central Bank of Nigeria
CBO	Community-based organization
CHEW	Community health extension worker
CPI-U	Consumer Price Index for All Urban Consumers
CPR	Contraceptive prevalence rate
CYP	Couple years of protection
DFID	Department for International Development
DHIS	District Health Information System
ESMPIN	Expanded Social Marketing Project in Nigeria
FCT	Federal Capital Territory
FGD	Focus group discussion
FMOH	Federal Ministry of Health
FP	Family planning
GON	Government of Nigeria
GON	Government of Nigeria
HC3	Health Communication Capacity Collaborative
HCC	Health Communication Coordinator
HF	Health facility
IEC	Information, education, and communication
IPC	Interpersonal communication
IPCA	Interpersonal Communication Agents
IR	Intermediate Results
IRHIN	Improving Reproductive Health in Nigeria
ITN	Insecticide-treated bed net
IUD	Intrauterine Device
KII	Key informant interview

LARC	Long-acting reversible contraceptives
LARM	Long-Acting Reversible Methods
LGA	Local Government Area
LLIN	Long-lasting insecticidal net
LOP	Life of project
M&E	Monitoring and evaluation
MAPS	Measurement and Performance Surveys
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MCH	Maternal and Child Health
MOU	Memorandum of Understanding
NDHS	Nigeria Demographic and Health Survey
NGO	Non-governmental organization
NURHI	Nigerian Urban Reproductive Health Initiative
ORS	Oral Rehydration Solution
POU	Point-of-Use
PPMV	Proprietary Patent Medicine Vendor
PRS	Performance Reporting System
PSI	Population Services International
RH	Reproductive health
SDP	Service delivery point
SES	Socio-economic status
SFH	Society for Family Health
SHOPS	Strengthening Health Outcomes through the Private Sector
SMOH	State Ministry of Health
SPSS	Statistical Package for the Social Science
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TPM	Team Planning Meeting
USAID	United States Agency for International Development
USG	U.S. Government
WDC	Ward Development Committee
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

Nigeria is on track to be the third largest country in population in the world by 2050 (UN “World Population Prospects: The 2015 Revisions”). Though Nigeria is seen as an emerging market because of its oil reserves, the 2009 global recession and economic forecasts for 2017 have diminished the prospects of a booming economy. In regard to family planning (FP) and maternal, and child health (MCH), Nigeria has stalled in stemming its efforts to reduce morbidity and mortality and increasing family planning. To address these health issues, the government proposed an ambitious blueprint (Government of Nigeria, Federal Ministry of Health’s “Scale Up Plan” 2014) that included the goal of reaching 36% Contraceptive Prevalence Rate (CPR) by 2018. In 2013, the CPR for modern methods was 9.8% (UNDP 2013) and all methods was 15.1%. (World Bank and NDHS) and in 2016, the CPR for modern methods was 14% for all women (Performance Monitoring and Accountability, November 2016).

United States Agency for International Development/Nigeria (USAID/Nigeria) has worked with the Government of Nigeria (GON) for over 20 years to implement its FP and MCH plan. Among USAID/Nigeria’s health portfolio was the five-year Expanding Social Marketing Project in Nigeria (ESMPIN). Building on the government’s FP goals, ESMPIN was to increase Couple Year of Protection (CYP) of Long-Acting Reversible Methods (LARM) by 40.8% over the life of the project, engage and strengthen Nigerian manufacturers and companies, and change behaviors in target audiences toward family planning and maternal and child health.

ESMPIN

USAID/Nigeria awarded ESMPIN in 2011 to the Nigerian non-governmental organization (NGO) Society for Family Health (SFH) as prime, with international companies, Population Services International, British Broadcasting Corporation Media Action, and the Nigerian NGO, Association of Reproductive and Family Health (ARFH) as subcontractors. SFH has conducted social marketing of family planning products in Nigeria since 1990 and most recently managed a USAID/Nigeria project—Improving Reproductive Health in Nigeria (IRHIN)—that socially marketed family planning products and provided training to service providers. Simultaneously, SFH has received grants from other donors, the Bill and Melinda Gates Foundation, the Global Fund, and the United Kingdom’s Department for International Development (DFID) to market and promote family planning and MCH products.

SFH has in its product line 14 FP-branded products; for USAID-funded ESMPIN, the focus was on five FP products, four of which were LARC methods, while also leveraging SFH’s other products that were supported by DFID and the Bill and Melinda Gates Foundation. The four USAID FP products were: Combination3 (an oral contraceptive), Depo-Provera (an injectable), implants, and an intrauterine device (IUD). MCH products were an Artemisinin-based Combination Therapy (ACT) for malaria, two point-of-use water products (PUR, a Procter & Gamble water purification product, and Water Guard, which was subsequently replaced by Water Guard Plus), and a combination Oral Rehydration Solution and Zinc (ORS + Zinc).

The distinctions between what products were funded by which donors would have been less important if the program’s end results were more dynamic. To complete this assignment, the evaluation team had

to untangle several program management issues: budget allocations by donor; management, marketing and promotion; and detailing—detailers are trained personnel who visit pharmacies, chemists, and health facilities to introduce new pharmaceutical products or fill orders for existing products. In Nigeria detailers must be pharmacists or a health professional, and interpersonal communication [IPC]) levels of effort; returns on investment by methods and products; and quantifying program goals by products and activities.

EVALUATION METHODOLOGY

The evaluation team used primary and secondary research to conduct this assignment. ESMPIN's research had critical data gaps of primary and secondary audiences and social and ecological factors that impact decision-making and behaviors. To fill these gaps the team used secondary research from the Johns Hopkins University's HC3 Program (Health Communication Capacity Collaboration); BBC Media Action (BBC MA) research on its ESMPIN mass media component; Measurement and Performance Surveys (MAPS) Multiple Indicator Cluster Survey (MICS); the Nigeria Demographic and Health Surveys (NDHS); and sales and financial data. The evaluation team also designed and conducted its own research, including focus group discussions (FGDs) with multiple primary and secondary audiences; exit interviews at public and private health facilities; observation checklist of facilities; and key informant interviews (KII) with stakeholders and audiences. In total, the evaluation team visited 32 facilities and interviewed 698 people in the Federal Capital Territory (FCT) and six states: Lagos, Oyo, Ogun, Zamfara, Kebbi, and Sokoto.

FINDINGS: GENERAL CATEGORIES

As in all multi-faceted programs, there were many informative findings that are documented in the report; all of the “why’s” and “how’s” of the findings fall into three categories. These are:

- Limited data to guide program design, monitoring and evaluation (M&E) strategies' performance, and to make program corrections as needed.
- Use of a social marketing model that is better equipped for countries at the extreme end of the development spectrum where private and commercial markets are nascent, not for a country like Nigeria with a strong commercial sector.
- Program management and operations that broadly tracked and captured the program's activities but lacked the accuracy and specificity to measure results and performance.

KEY FINDINGS

The data and findings show many activities but no change in CYPs for medium- and LARC methods (injectables, implants, and IUDs) over the six years of the project. Question 3 goes into further detail on the stagnation of CYPs between the years of 2011 to 2016. CYP during the span of ESMPIN from baseline of 28.2% CYPs for medium and LARMs in 2011 and 28.3% achieved CYP for medium and LARM in 2016. The ESMPIN team proposed in 2011 in the program description a change in contraceptive method mix from 28.2% CYP for medium- and long-acting contraceptive methods, i.e., IUDs, implants, and injections, to 40.8% CYP by 2015. By the end of the project, it generated 28.3% CYP for medium- and long-acting methods which represented a 0.1% increase over the baseline of 28.2% CYP in 2010.). It shows product sales plateauing after a mini-peak in 2013. CYPs are heavily dependent on condoms

(48%) to meet an under-performing 14,717,588 million CYPs. If condoms were removed from the equation, CYPs would drop to 7 million. Awareness is high for modern methods—around 70% for men—but misinformation about the side effects, i.e., fear of methods being irreversible, are still barriers to women accepting a product and even for staying on methods. For one out of four women, according to HC3's research, even when they did use a modern method like pills or injectables, they were not willing to tell their partners that they were using a method or willing to talk to other women about it. Cultural and social norms are critical barriers to couples adopting a long-acting method. Those factors were not a surprise and were reiterated in the BBC Media Action research and in the evaluation team's FGDs with SFH's community-based distribution agents (CBDA) and interpersonal communication agents (IPCA).

The social marketing model used by PSI and SFH for ESMPIN was commonly used in the 1990s and early 2000s. This older model takes on all aspects of social marketing (i.e., distribution, promotion, detailing, warehousing, and marketing) while private companies and manufacturers brand the product. In a country like Nigeria this model runs counter to its busy commercial sector. Nigeria has local manufacturers and distributors that can take the lead on most of the social marketing tasks with technical assistance from a project because it is further along the development spectrum. In early 2000, as desired public health impact and results were plateauing or stagnating, the actors responsible for designing and implementing social marketing programs began to retool and reorient the social marketing model to shift the marketing to be done by local and regional manufacturers and local companies, i.e., distributors, warehouses, and suppliers, with social marketing projects providing technical assistance in business and financial management, forecasting, and mapping and targeting.

Malaria and maternal and child health products sales are a blip on the charts. Even breaking down the populations to specific states and communities where the project worked, for five years SFH sold 858,000 sachets of PUR and approximately 4 million units of Water Guard Plus; SFH did not provide sales data for ACTs. Under the Global Fund, Malaria ACTs were distributed for free to PPMVs that were trained in malaria prevention (ESMPIN Annual Report 2013-2014). During the life of the project, according to interviews with USAID technical staff, an initial funding of \$1 million was allocated to ESMPIN; in the second year of ESMPIN it was reduced to \$500,000, and then the following year dropped from ESMPIN and redirected from ESMPIN to a different funding mechanism.

In an environment such as Nigeria, where there are social and culture factors that influence gender issues. Gender requires a commitment of resources and strategies to create change at the federal level among key stakeholders and down to the household level. ESMPIN's approach to gender was through a male involvement strategy that consisted of workshops targeted to individual change. There was engagement and positive comments from the men that participated in these workshops, but to be sustainable and effective there need to be institutional changes.

And finally, without ongoing financial support from donors or outside investors, as ESMPIN is currently constituted its primary strategies and interventions would not be sustainable or be able to continue—even in a reduced state

CONCLUSION

According to the numbers of all its activities and efforts ESMPIN did not increase CYP for medium and LARM and ended in the same place it started at 28.3% CYP achieved for medium- and long-acting reversible methods, i.e., implants, injectables, IUDs. But the argument could reasonably be made that it

lost positioning of LARMs because of its over-emphasis on condoms (the only money-maker of all the ESMPIN methods). Service delivery is not easily accessible for these long-term products and public health facilities are giving the same or similar products away for free.

How SFH and its partners addressed these barriers is a better reflection of the overall management and innovation under ESMPIN than the sub-par sales numbers. After six years (and even more years considering SFH's presence in Nigeria) SFH proudly declared that it was a Nigerian company and had managed social marketing in Nigeria since 1990. There are still the same barriers, cultural and social factors, and misunderstandings about modern methods that have existed since the introduction of social marketing activities and the longer acting modern methods, i.e., injectable and implants, and have not been effectively reduced through detailing, interpersonal communication, mass media, and other social marketing interventions. Specifically, under ESMPIN's social marketing, there has not been the acceptable shift to improve maternal and child health or to change behavior.

Service delivery for injectables, IUDs, and implants was not part of ESMPIN's statement of work. Other USAID-funded programs, such as Strengthening Health Outcomes through the Private Sector (SHOPS), were tasked to conduct service delivery training and support private health facilities. A repeated barrier to sales of long-term methods was the low availability and access to service delivery of these methods, especially in rural areas. This was a substantial barrier and one that USAID had addressed in designing the two health initiatives. However, in interviews with the two programs it appears, in the early days of the two programs there were slow starts and poor communication between the two projects, but there were improvements over the life of the project. How much the poor working relationship between the projects had on the acceptance of methods, improvements in maternal health, and increasing CPRs was not to be determined from this evaluation or other data gathered but professional experience shows it does not work to the advantage of beneficiaries.

ESMPIN strategies were not the wrong choices but how they were designed and executed resulted in sub-par performance of sales, CPRs, and unmet needs among primary target audiences, and subsequently, negligible behavior change.

Finally, the findings show a large portion of the overall program budget was spent on distribution, stand-alone or independent IPC and detailing, and warehousing. Without ongoing financial support from donors or outside investors, as currently constituted ESMPIN's primary interventions would not be sustainable.

RECOMMENDATIONS

A future program to increase acceptance of LARM should be a component of a larger service delivery program in the public and private sectors. The behavior change model should understand the Nigerian landscape and use evidence-based strategies that can create the enabling environment that supports FP and MCH. This would include a participatory approach that is inclusive, working with religious and traditional stakeholders, multisectoral government officials, and the private sector. Change must be made within institutions in order to be successful with individual behavior change. Innovative approaches which are not that innovative now can be more effective, cost-efficient, and reliable to implement behavior change strategies. For example, introduce technologies such as digital and social media for communication, IPC, M&E, micro-targeting mapping, sales and distribution tracking (there are apps to help Community Health Extension Worker [CHEWs] do better IPC); social franchises to brand Proprietary Patent Medicine Vendor or Community-based Distribution Agent; and social investments

instead of loans to kickstart local manufacturers and distributors. Instead of operating independent distribution and detailing teams, invest the funds in private companies to institutionalize these capabilities and build the capacity of public and private sector health workers by strengthening the federal and state ministries of health (F/SMOH) health education units.

Successful Activities for Future Projects

Under ESMPIN there were five distinct activities that were successful and could be expanded under a new award.

These are interrelated and could result in improved maternal and child health:

1. **Commodity-security.** Under ESMPIN, the commodity stock-out dropped from around 36% to 16%. The evaluation survey covered the 22 ESMPIN priority states as well as two non-priority ESMPIN states, Benue and Nassarawa. Moving into underserved areas using alternative distribution systems (i.e., CBDAs) and existing networks (i.e., PPMVs) may reduce commodity stock-outs.
2. **Informal Distribution Systems.** The community-based distribution agents show a good chance of being sustainable and they have the capability (and willingness) to go into remote and underserved communities. This expansion and making CBDAs sustainable would increase commodity-security while contributing to improved maternal and child health.
3. **PPMV Network.** Whether through social franchise or independents, the role of the PPMVs are the backbone of health services among lower-income families. Ensuring products are in shops and PPMVs are competently trained would guarantee wider outlets of modern methods, increase sources of correct information, and improve service delivery.
4. **Private Sector Manufacturers.** PSI and SFH's assessment of the private sector manufacturers is an excellent source to engage with the private sector manufacturers. Written in 2013 the market assessment looked at 14 Nigerian companies that were likely manufacturing partners. The 14 companies were pending final approval by the World Health Organization to locally manufacture public health products. Between 2013 and 2016 SFH did not revisit these companies to form partnerships or to institute mentoring relationships that could contribute to a sustainable solution to make maternal and child health and family planning products available in Nigeria.
5. **Participatory Approach.** The participatory approach used in the North and practiced by the CBDAs under ARHF was successful in engaging with and creating credibility among key stakeholders. This was done by conducting town hall meetings, engaging with men and women, and having advocates from religion, government, and private sector.

But most important of all the recommendation is to keep evaluating and questioning what is working and what is not working. Behavior change in human beings always involves adjusting and shifting—because we are human.

I. INTRODUCTION

EVALUATION PURPOSE

The purpose of this end of project evaluation was to evaluate the Expanded Social Marketing Project in Nigeria (ESMPIN). The evaluation further sought to determine the cost-effectiveness and sustainability of ESMPIN's approaches, interventions, and innovations in promoting behavioral changes among women of reproductive age, and to assess their ability to stimulate greater private sector involvement in demand generation for family planning services and maternal and child health services. The evaluation findings will be used for learning and in the development of future private sector-focused FP/MCH follow-on project designs.

The findings of the evaluation primarily benefit United States Agency for International Development in Nigeria as they prepare to design a follow-on private sector family planning and maternal and child health projects. The findings will be disseminated and significantly benefit the respective *ESMPIN focus state governments, other focal donors and civil society organizations* that have interest and investments in these states. Secondary users will include:

EVALUATION QUESTIONS

- USAID Washington – that will support the Nigerian Mission and utilize the data for designing new programs of a similar nature
- The Government of Nigeria (GON), Federal Ministry of Health (FMOH) – that will better understand the lessons learned from private sector involvement in supporting the provision of FP/MCH services in Nigeria
- ESMPIN focus states – that will have more information on best practices and lessons learned and what will work best in their local context, and how best to use and leverage existing resources to increase the provision of FP/MCH services
- Other donors and partners working in ESMPIN focus states – that will better understand the context within which they work; this may inform reprogramming and possibly, change in the focus of their project(s)
- ESMPIN Project and other private sector health improvement projects – other private sector health improvement projects would use results disseminated for mid-course changes in their projects

There were five guiding evaluation questions for this assignment:

1. To what extent were ESMPIN project's Social Marketing, IPC, and CBD interventions sustainable?
2. To what extent were ESMPIN's activities effective in ensuring that socially marketed commodities filled the affordability, accessibility, and availability gaps in their focused communities and markets, as opposed to competing with or replacing independently viable private sector commodities?

3. To what extent were ESMPIN strategies cost effective; and are there more innovative cost effective strategies that could potential increase uptake of FP services within the private sector that could have been explored by ESMPIN?
4. To what extent did the ESMPIN's project activities incorporate gender programming during the life of the project and what effects did it have in increased uptake of FP services in ESMPIN supported sites?
5. To what extent are ESMPIN's strategies effective in increasing the use of modern contraceptives in Nigeria (disaggregated by type of contraceptive provided)?

II. PROJECT BACKGROUND

About two-thirds of Nigeria's estimated population of 180 million lives in the rural areas, often lacking the basic modern social amenities and infrastructure, with enormous implications on the quality of life of majority of the populace. Nigeria has some of the highest maternal and child morbidity and mortality rates in the world; of approximately 8.8 million children that die in the world each year, one million are in Nigeria, and the maternal mortality ratio of 576 per 100,000 live births according to the 2013 Nigeria Demographic and Health Survey



Community mobilizers and FGD participants in Ibadan, South East LGA, Oyo State. Photo credit: Sa'adatu Sule

(NDHS), which also paints a gloomy picture of the poor state of the Nigerian health indices. In Nigeria, the total fertility rate has not dropped significantly between 2003 and 2013 with only a 0.2 drop—from 5.7 to 5.5 children per woman. Fertility rates are highest in rural areas in the North, whereas unmet need for family planning is highest in the South South and North West.

Despite the relatively high level of awareness of FP in Nigeria and decades of donor and government-funded program efforts, the level of utilization still remains dismally low. The Contraceptive Prevalence Rate (CPR) among currently married women in 2003 was 8.1% for modern methods (NDHS 2003) and rose to 15% in the 2013 NDHS. However, the Multiple Indicator Cluster Survey (MICS) 2011 shows CPR to be 17.5% for women currently married or in union. The level of contraception among sexually active young women is particularly low, contributing to the high level of unwanted pregnancy, unsafe abortions, and ultimately, high maternal mortality. Disparities in these indices are most apparent between the north and south, but there are differences even between states within the same region.

The health-seeking behavior of Nigerian women regarding pregnancy-related care remains poor and poses one of the greatest challenges to maternal mortality reduction in the country. Nigeria presents a challenge for health programmers due to its large population, with wide-ranging cultural, religious, and political contexts. A majority of Nigerian women's health-seeking behavior is largely controlled by men. While more than half of the population resides in the north, it is much less densely populated than the south and poses a challenging environment for increasing access to health products and services.

With support from USAID, the Society for Family Health is the prime implementing partner for the ESMPIN project. The six-year social marketing project has a nationwide focus on 22 priority states in Nigeria (11 in the north and 11 in the south) where the much-needed community-level demand creation activities takes place. The project was designed as a follow-on to the Improving Reproductive Health in Nigeria (IRHIN) Project, with the goal of expanding the achievements attained under the IRHIN Project, especially the Life of Project Couple Years of Protection (CYP).

ESMPIN contributes to USAID's strategic objective of improving the health of women and children in Nigeria, primarily by increasing the use of modern FP methods and, secondarily, by increasing access to

child health products in Nigeria, utilizing social marketing techniques and behavior change communication (BCC).

The overall goal of ESMPIN will be achieved through the following four Intermediate Results (IR):

Sub-objective (IR) 1: Expansion of access and availability of varying affordable, high-quality modern contraceptive methods, diarrhea, and malaria management products widely, through private sector channels

Sub-objective (IR) 2: Improve knowledge, attitudes, perceptions, and practices regarding FP/reproductive health (RH), malaria, MCH issues at individual, household, and community levels, among vendors and private sector health providers through appropriate BCC information, education, and communication (IEC) activities

Sub-objective (IR) 3: Collaborative partnerships with private health providers. Expanded to include implementing partners, government agencies, and other relevant stakeholders so that FP/RH, malaria, and MCH social marketing and behavior change communication are widely understood and enthusiastically supported

Sub-objective (IR) 4: Capability of commercial/private sector in Nigeria to manufacture FP/RH, malaria, and MCH products for social marketing in Nigeria assessed and new product registration or production facilitated

III. EVALUATION METHODS AND LIMITATIONS

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

METHODOLOGY

The process started with a five-day Team Planning Meeting (TPM) to better define the scope of work and develop data collection tools. The evaluation team used a mixed (qualitative and quantitative) approach to determine if ESMPIN strategies were effective, sustainable, and cost-effective. The methodology consisted of interviews and focus group discussions (FGDs) with ESMPIN staff members; key government officials at the national, state, local, and community levels; beneficiaries in the community and members of civil society organizations; proprietary patent medicine vendors, community-based distribution agents (CBDA); interpersonal communication agents (IPCA), other donor organizations; and the USAID/Nigeria technical team.



Community-based distribution agent talking to a potential customer.
Photo credit: Longjo Yusuf

The evaluation team developed 12 data collection tools/guides for use in the field. These included both structured and semi-structured discussion guides for client exit interviews; service provider interviews; health facility assessments; FGDs; and Key Informant Interviews (KIIs). The team conducted a thorough desk study of relevant documents and analysis of performance indicators as well as financial data. The reports and data were both primary and secondary. The team interviewed a total of 698 people in Lagos, Oyo, Ogun, Kebbi, Sokoto, and Zamfara, States, and the Federal Capital Territory (FCT). The team reviewed communication materials, annual and quarterly reports, training materials, and promotion and sales guides. See Annex IV-A for persons interviewed and Annex IV-B for bibliography of documents reviewed for further information. The team conducted 71 FGDs: six in Lagos, 15 in Oyo, 15 in Ogun, 11 in Kebbi, 12 in Sokoto, and 12 in Zamfara. Each FGD lasted for an average of 45 minutes, with an average of four to 12 participants per group. A detailed methodology matrix is provided in Annex II.

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

Review of background materials, and other relevant documentation: Project documents relevant to the evaluation were collected for review and analysis. These included project design, scope of work, annual and quarterly reports, annual work plans, technical and training materials, financial reports, ESMPIN gender materials, and technical and research documents relevant to the evaluation. The team also reviewed materials and reports from other USAID-funded projects in family planning and maternal and child health, including malaria.

Interviews and field visits

Sampling: For the evaluation, USAID/Nigeria pre-selected six states—Lagos, Oyo, Ogun, Sokoto, and Zamfara—from the 22 priority states to measure IPC implementation by ESMPIN IPCAs and four states in the north to measure the IPC by CBDAs. For spread and geographical representation in the selected states, one Local Government Area (LGA) was randomly selected from each state in the three senatorial zones giving a total of 18 LGAs visited for the field work. Table 1 gives the LGA breakdown.

Table 1. States and LGAs for the Evaluation

S/N	State	LGAs
1	Lagos	Somolu, Alimosho, and Epe
2.	Oyo	Ibadan South East, Ibadan South West, and Akinyele
3.	Ogun	Abeokuta North, Ado-Odo Ota and Sagamu (replaced Ifo that was originally selected because of poor road network)
4.	Sokoto	Sokoto South, Tambuwal, and Wamako
5	Kebbi	Argungu, Jega, and Miyama (replaced Shaga that was originally selected because of distance and difficult terrain)
6.	Zamfara	Bungudu, Kaura Namoda, and Anka

In each LGA the team visited two intervention communities representing IPCA Cycles 1 through 10 for total of 36 visits in the IPC communities. ESMPIN divided its interpersonal communication agents' activities in the South into Cycles. A Cycle lasts for six months and covered a designated geographic area. At the end of six months, the IPCAs would move to the next geographic region. There were 10 IPCA Cycles under ESMPIN. Two referral health facilities were also selected per LGA, giving a total of 36 health facilities. The team was able to visit only 32 of the 36 health facilities because facilities are closed on Saturday and the travel schedule did not accommodate weekend closures. ESMPIN provided a list of Proprietary Patent Medicine Vendors (PPMVs) in the 36 communities and PPMVs were randomly selected for visits. The IPCAs and CBDAs that participated in the implementation of the project were selected and included in the sample for the evaluation.

Study Instruments: The team developed 12 data collection tools/guides, one for each key informant group. The instruments generated both quantitative and qualitative data. The key informants were: representatives of the federal and state governments, ESMPIN staff, USAID/Nigeria technical staff, public and private health care workers, ESMPIN detailers, distributors, PPMVs and community-based distributors, community mobilizers, manufacturers, and warehouse managers. FGD guides for men and women and for the Ward Development Committee (WDC) were developed along with a client exit interview survey. A facility assessment checklist was prepared.

Procedure: The team conducted individual interviews and focus group discussions. The field work began in Lagos state October 31 through November 2, 2016, with travel to Oyo from November 3-5, then to Ogun and Sokoto from November 7-9, and ended in Kebbi and Zamfara between November 10-12. Joint and individual meetings and interviews were held with the previously named informants, and community-level FGDs with men and women beneficiaries and WDC members. A health facility survey was conducted in 32 facilities in the six states to assess the human resources capability and availability of materials and supplies related to family planning and maternal and child health services. To complete these interviews from each state, the team recruited and trained six experienced data collectors to

conduct interviews with the different survey populations. The data collectors were local, and spoke the local language and knew local customs.

Cost Analysis: An inventory of all costs was made based on available data on a yearly basis. Costs for all donated and free products were estimated and total intervention costs calculated. Estimates of the main strategies employed in the program were also carried out and compared. Costs were divided into fixed, variable, and semi-variable. Fixed costs were those that in the short-term do not vary with level of output, variable cost increases with level of output; and semi-variable costs have a fixed and variable component. Capital costs (such as furniture, vehicle, and equipment) were annuitized using straight line depreciation and outcomes and costs were discounted at 3%. Assumptions were made concerning their useful life: the useful life of vehicles was four years, of laptops three years, and of furniture five years.

Scrap value for majority of the vehicles was provided by SFH, while a scrap value of zero was assumed for furniture and equipment. The total costs, annual costs, average costs, and an overall average cost effective ratio were calculated. The monthly Central Bank of Nigeria (CBN) average exchange rates for each year were used for the conversion of Nigerian Naira to US dollars.

The evaluation adopted mixed methods approach based on the primary data collected during fieldwork for cost analysis, observations, service data and secondary data analyzed. Costs were not strictly recorded in the early stages of the project, making it difficult to fully estimate some of the costs. Cost data were sometimes incomplete and difficult to disaggregate. The baseline program was assumed to be “no program,” i.e., no method of contraception for the purpose of comparison.

Data Analysis: The qualitative data collected through FGDs and KIIs and cost data were analyzed and synthesized using Microsoft Excel, while themes and patterns were identified from the responses. The quantitative data collected from health facilities were analyzed using Statistical Package for the Social Science (SPSS) software. Frequency tables and graphs were produced from the data using Excel software. Trends in performance on indicators were analyzed. See Annex VI for a summary of analyses of both qualitative and quantitative data collected during the evaluation.

LIMITATIONS

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

Time Constraints: To maximize time on the road the evaluation team traveled on Fridays and weekends. In a few communities, health facilities could not be assessed because they had closed for the day or were not open on the day of assessment.

Incomplete documentation of financial and monitoring and evaluation data, reporting, and project records: The evaluation team found SFH co-mingled its different projects' documentation, product sales data, and resource tracking, which made it difficult to properly assess the project for cost effectiveness. For example, numbers of people trained were not consistent with ESMPIN's budget line items. Data from the Performance Reporting System (PRS)—a reporting system that enables USAID/Nigeria Implementing Partners to report their performance data and USAID/Nigeria staff to view and analyze the reported data—and from the ESMPIN District Health Information System (DHIS) database were incomplete. Also, sales and commodity tracking at the distributor level was paper-based, which made it susceptible to irregularities.

IV. FINDINGS

Evaluation Question 1. To what extent were ESMPIN's strategies effective in increasing the use of modern contraceptives (disaggregated by type of contraceptive provided), ORS/Zinc and point of use water products for the management and prevention of childhood diarrhea in supported sites?

ESMPIN's behavior change goal is the adoption of modern contraceptive methods among underserved women and men in Nigeria, and preventative (water purification (ORS/Zinc) for maternal and child health. To reach this goal, ESMPIN designed an integrated program that used several strategies targeted primary audiences of men and women of reproductive age. The strategies were interpersonal communication implemented by detailers, IPCAs, and CBDAs; product promotion through



Facilitator and FGD participants in Alimosho LGA, Lagos.
Photo credit: Sa'adatu Sule

community activities including demonstrations; mass media, specifically print and broadcast (radio) advertisements and generic radio programming; messages and material development; and product social marketing targeted to individuals. In a few settings, an advocacy strategy was used stakeholders.

The key finding related to the ESMPIN strategies effectiveness is not that the strategies were the wrong choices but that how they were designed and executed resulted in sub-par performance of sales CPRs, and unmet needs among primary target audiences and, subsequently, negligible behavior change. As discussed later in this report, the research conducted under ESMPIN was among the primary audience of men and women of reproductive age. In-depth interviews were not conducted by ESMPIN among secondary audiences such as religious leaders, family and friends, and traditional health workers who are influential on couples' decision-making. Without this data, it is difficult to identify barriers or motivations to change behaviors, to design messages and outreach activities that are effective, and to monitor behavior change.

For any strategy to be effective, i.e., reach desired results, the strategy must be based on evidence. To have the best evidence or data they must come from a mix of methodologies, i.e., qualitative, quantitative, and socio-ecological. In addition to designing effective programs and interventions, data are used to monitor and evaluate a program's impact and results and to fine-tune and adjust strategies for better results over the life of a program.

Johns Hopkins University's HC3 Project conducted an assessment of the IPC activities and many of its findings were similar to those in this report: engagement with family and close friends (inclusion of socio-behavior for family planning), targeted geographic IPCA, and an integrated approach including mass media and interpersonal communication.

Research and Evidence-based. The project used its subcontractor, PSI's research models—PERForM and FOQUS—for its program research. These models focused on primary audiences, men and women.

Research was not conducted among key secondary audiences, including influentials, e.g., family, friends, federal and community stakeholders. Small studies were conducted with a few secondary audiences, such as vendors, health care workers related to ORS + Zinc. ESMPIN did conduct a series of annual evaluations (see Methodologies) it did not conduct an inclusive mid-term evaluation that captured all components of ESMPIN.

The evaluation team used the primary research and a number of secondary research studies, product sales, financial records, and CPR data. ESMPIN's primary research among primary audiences had information gaps and holes of information that are needed to design an effective behavior change program. As stated above, missing were in-depth interviews with primary and secondary audiences that moved beyond knowledge and attitudes into motivations and aspirations. Because people's motivations and beliefs constantly are changing, such data need to be regularly updated to document shifts in behavior among key audiences changes in the socio-ecological landscape, and adjust the program to reflect those changes. As outlined later in this report, key messages used for all audiences (e.g., couples, men-to-men, influentials, social norms, emphasize birth spacing. Birth-spacing reinforces the fears men and women have about the family planning methods being irreversible instead of eliminating them. Messages for advocacy and among influential stakeholders were similar to or the same as the messages (birth spacing) targeting men and women.

There are three secondary research reports that evaluated several of the BCC strategies. The first was conducted by HC3; the second by BCC Media Action, which studied its mass media campaign conducted in the north under ESMPIN; and the third was Measurement and Performance Survey(s) (MAPS) (2013, 2014, 2015, and 2016 respectively), a health omnibus-like study. In addition to this secondary research, the evaluation team measured the effectiveness of the different strategies in its FGDs and exit interviews, and also reviewed the most recent NDHS data.

Audience Segmentation. The PSI research models create archetypes of its primary audiences: men and women of reproductive health age. Segmentation was primarily gender and there were several archetypes that highlighted religion. In the "Report of the ESMPIN Delta Workshop of Injectables" held in December 2011 there is an archetype of a couple. It is unclear if they are urban or peri-urban or a specific religion. The archetype models were not updated during the six-year project and as indicated above behaviors and landscape change and archetypes should reflect those changes. Also, archetypes were not created for audiences related to maternal and child health nor for secondary audiences, including public and private health workers, LGA and Ward Development Committee (WDC) members, and FMOH and state ministries of health (SMOH). Another key secondary audience that was not included in the segmentation or research were the family (i.e., in-laws) and friends of couples of reproductive age. The HC3 research highlighted the need for including the family and friends in future interpersonal communication to increase impact. The influence of family and friends on decision-making is very important and can be even more influential than health care workers and providers. Socio-ecological research was also not conducted.

Messaging. Research is used to design strategies and as a guide to message development. Each audience (e.g., couples, stakeholders, family, and friends) needs specific messages that would resonate with them. Messages were developed for each audience category, (i.e., men, women, stakeholders, address social norms); however, the message is only birth-spacing (Delta Report and FoQuS, ESMPIN Projects 2012). There continues to be fear and misunderstanding among Nigerian men and women that modern methods are irreversible. According to HC3's research, one out of four women in their study chose to

stop using a modern method because of that fear. The role of messaging and communication—whether mass media or IPC—is to eliminate those fears that the ESMPIN messages reinforced. In the Delta Workshop referenced above there was a message developed for specific audiences: husbands-to-wives, men-to-men, social norms, and influentials (community leaders) and the message that was developed for each of these audiences is that birth spacing contributes to a healthy family.

Mass Media. Many years of research continue to show that mass media—e.g., radio, television, print, alone—does not change behavior; it is an effective strategy to increase awareness and when applied with other strategies, policy change, IPC, it can make a difference. In Nigeria, awareness of family planning methods among women is at 70% (BBC Media Action Evaluation). Awareness is not the issue. Moving from awareness, or knowledge, to doing or accepting a new behavior is the hurdle.

For ESMPIN, the mass media were shared between SFH and British Broadcasting Corporation Measurement and Performance Surveys Media Action. BBC Media Action developed generic (not brand- or method-specific) radio programs on health and lifestyle; SFH developed brand- and method-specific radio and print ads. BBC Media Action conducted a study of its mass media and training in the north and its results show that the highest reach to target audiences was 27%. A separate study conducted throughout the country by HC3 showed that, in the south, 80% of women heard at least one FP message on the radio; radio listenership was lowest in the north but was still relatively high at 59 to 69%. However, despite the mass media, sales in the north continued to be low at around 17% (HC3 Study 2016).

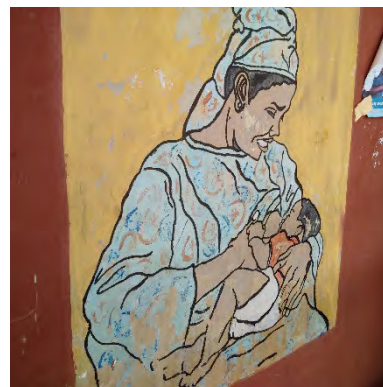
Eighty percent of the women in ESMPIN's target audience have cell phones (HC3 research). However, only 6.3% were contacted with FP messages on their phones and 7.1% received a family planning SMS. Social and digital media and web-based technologies were not key strategies under ESMPIN. SMS was used by detailers, but the radio programs and radio advertisements were not converted to apps so they could not be listened to on mobiles, tablets, or web-based computers.

Interpersonal Communication. IPC is continually proven to be one of the strongest strategies to effect behavior change when conducted by a trusted source, e.g., a family, friend, health worker. ESMPIN created or expanded its independent distribution network to include CBDAs, IPCAs, detailers, and merchandisers. Their effectiveness is discussed in more detail in Questions 2 and 3. The data on their sales and impact are remarkably low: an HC3 study shows 5% for IPCAs and 17% for CBDAs and the costs analysis per person for uptake of a modern method under an IPCA cycle was calculated at \$30.88 by the evaluation team (see Evaluation Question 4).

When distribution and sales are combined with IPC it may lose credibility and trust; instead of an impartial counseling and discussion, the IPC becomes a promotion and a sales spiel. Based on ESMPIN's budget allocations and personnel hours, the IPC through alternative distribution sources had the highest investment. (IPCAAs provided counseling and gave each person they talked to a reference card. Unlike CBDAs in the North, they did not distribute or sell products. The number of targeted people that talked to IPCAs and were given a reference card to visit a facility was estimated to be 21 million. Out of the 14.2 million that were given a reference card by the IPCAs, 338,169 did visit a clinic. This is a 2% uptake. The uptake by IPCAs calculated by the evaluation team based on ESMPIN's data and discussed later in this evaluation was low. The IPCAs were very positive about their efforts and their work as were the CBDAs but the enthusiasm and interest did not translate to acceptance of modern methods or increase in sales.

Training and Capacity Building. USAID recommended a pilot with PPMVs for social marketing, IPC, and product distribution that has been implemented under other social marketing programs. The training modules used for detailers and PPMVs focused on the components needed to organize an IPC event, methods, and side effects. The Health Communication Coordinator (HCC) training module did not contain training on the social science of IPC skills. The downside of this was first, that those conducting IPC were not fully-trained in how to conduct effective IPC and second, an effective IPC training has built-in indicators that can be used to measure IPC's effectiveness and how it is contributing to behavior change. The evaluation team could find no mention of IPC training being conducted with Traditional Birth Attendants (TBAs), that are private sector or private health facility workers. ESMPIN did train unemployed Community Health Extension Workers or CHEWs in IPC and the CBDAs as part of its distribution plan. The training module for IPCAs and CBDAs was an IPC flipchart that is comprehensive of all methods and relates to the concept of “Healthy Family My Pride and Joy.” The evaluation team reviewed the BCC strategy but not the malaria training module.

Social Marketing. Social marketing is both a strategy and a key component of ESMPIN. Social marketing is a complex strategy that draws from numerous tools to create behavior change. Reviewing the sales data and ESMPIN reporting showed that product sales plateaued around 2013. By 2016, the CYPs were lower and sales show the majority to be male condoms (close to 50%). The second and third choices were injectables (18.3%) and oral contraceptives (15.6%). There was not an apparent change in ESMPIN's strategies to increase acceptance of long-acting reproductive methods or to address behaviors related to family planning.



Wall mural on breastfeeding at health facility. Photo credit: Dee Bennett

There are numerous tactics under these strategies that ESMPIN could have used to improve sales and behavior results. ESMPIN's social marketing approach has not captured the energy of Nigeria's private sector. They employed a social marketing strategy used in the 1990s and early 2000s. A more robust social marketing strategy that fits Nigeria should have been adopted. Also, the sub-purposes 3 and 4 are very explicit about engaging with the private sector to build its capacity and to expand the private sector market. In addition to partnerships to develop and distribute products, it could include social franchising of PPMVs and social investment of manufacturers and distributors like Chi Pharmaceutical Ltd (Chi) or other local companies. PSI, a partner on this project, is known for its social franchise model and social investment, and yet they did not employ these strategies.

Community Engagement and Advocacy. There are strong social and cultural norms (factors) that influence couples' opinions and decisions to use any modern method. BBC and HC3's research shows that ESMPIN's activities in the north—led by AFRH did engage with the religious and community elders through the CBDA's activities, such as one-on-one meetings town hall meetings. In the south, the inclusion of religious leaders and government officials was less prevalent. Several community leaders and health officials in the south said that they were not included in planning activities with ESMPIN and therefore were not engaged in the mobilization and outreach. When asked about ESMPIN's plan to address social and cultural factors, the project officials said they did so “when they needed to but it was not part of the overall plan” and “there was not a strategy for working with Ward Development Committees. In a discussion with a senior official from PSI he said that “it was not part of PSI's approach

to engage with the government.” Again, HC3’s report recommended two IPC models that are socio-behavioral models that move outside of the individual to engage with inner influentials (family and friends), external influentials, and community stakeholders.

Behavior Change. The models used to design ESMPIN focus on individual behaviors and, judging from the reports and data the team reviewed, ESMPIN did not delve into the social and ecological landscape of Nigeria. Over the last several years, in some regions, cultures, and ethnic groups (Christian, Muslim, and traditional), Nigeria has become more conservative and inclusive while other areas and peoples are looking outside the country and are influenced by the West and other areas of Africa. To be successful in changing individual behavior, research has shown that socio-ecological issues must be addressed to create an enabling environment that removes barriers to FP and MCH, allowing communities and segments to make FP acceptable. Though SFH did design advocacy strategies and IPC promotion plans, they are targeted to individual behavior. Neither the models nor the SFH research look at the social and cultural norms or policy and regulations that affect (directly or indirectly) people’s actions, behaviors, and choices.

Evaluation Question 2. To what extent were ESMPIN’s Social Marketing, IPC, and CBD interventions sustainable?

Finding: Without ongoing financial support from donors or outside investors as currently constituted ESMPIN’s primary interventions would not be sustainable.

In an interview with the FMOH, one counterpart observed that the program was not designed with sustainability built in it. There were four major interventions in ESMPIN’s social marketing (see Evaluation Question 1) and none of these have been designed to be sustainable outside of donor funding and will end or be dramatically reduced in scope and effectiveness without outside funding.

The most costly and expensive intervention is the development and maintenance of four promotion and detailing teams, i.e., IPCAs, CBDA, detailing and merchandizers. The costing analysis conducted by the evaluation team, and a second costing analysis prepared by HC3, found the projected cost of implementing the IPCA model in 180 communities during one Cycle (six-month timeframe) to be \$3,321,101 and cost per method uptake is between \$34.89 and \$38.35. The evaluation team found the cost per uptake on a modern method to be \$30.88 using a different analysis model (See Evaluation Question 4). A cost analysis was not done for the CBDAs in the north. The HC3 cost analysis was of ESMPIN IPCAs operating in the south following a six-month cycle in a specific geographic location. ESMPIN conducted 10 Cycles during the life of the project; if each cycle cost \$3.321 million the IPCA implementation in the South alone would have been 50% of ESMPIN’s budget. Measured against the impact of these interventions to accept and use a modern method, the investment and sustainability have a low return. Note: HC3 in its report sees this investment as a good return-on-investment. (See Evaluation Question 4 for cost analysis.)

ESMPIN’s CBDAs have been effective in helping to create an enabling environment through their integration in their communities, being on the ground for a long time (as opposed to a six-month Cycle that was used by the IPCAs in the South). CBDAs have been proactive and formed an association, pay dues, and are looking for ways to continue to work in this field after ESMPIN closes. While some CBDAs are asking for higher profits to extend their distribution reach (i.e., gas, transportation), higher profits would require an increase in profit margin and that would raise the costs of the commodities. A few ESMPIN products are already equal to or more expensive than others on the market, e.g., ORS +

Zinc, oral contraceptives. DKT which is entering the Nigeria market is underpricing its products in direct competition with SFH products.

For the IPC interventions to be sustainable, the project should have trained and established CBDAs, IPCAs, and detailers within existing institutions such as F/SMOHs, private manufacturers, or civil society instead of setting up separate operations under ESMPIN. CBDAs could do the same detailing under the auspices of health or pharmaceutical companies; health providers, CHEWs, and health volunteers trained in IPC would work within the government framework, and TBAs and PPMVs in the private sector. The CBDAs lived and worked within a community for years, where IPCAs rotated through communities on a six-month rotation. HC3's behavioral research measured the impact of IPC under a cycle model and it showed that 25% of the men and women who chose a method discontinued use of that method after 12-14 months, primarily due to concerns that methods are irreversible; the same research did not show a measurable increase of new users after the IPCA Cycle stopped.

A representative from FMOH talked about the value of forming partnerships and Memoranda of Understanding (MOU) with ESMPIN to ensure longer-term results. Representatives from the ministry of health at the federal and state levels said that MOUs with the government and working together to develop work plans were very important for the family planning work to move forward.

The FMOH's Office of Health Education staff informed the evaluation team that it was not familiar with what ESMPIN was doing for promotion or communication; they had not been included or consulted. HC3 does work closely with the office and provides technical assistance to the staff. HC3 along with ESMPIN are members of the National Reproductive Health Technical Group.

SFH, under another USAID award, did a pilot with a selection of the more than 300,000 PPMVs. PPMVs are the go-to source for health care by many Socio-Economic Status (SES) D and E populations. (The middle and low D and high E socio-economic status are the target populations for a social marketing program, A being the highest. The low E are the poorest of the poor where high E have limited disposable income for health care and products.) One of PSI's signature models is social franchising, which has the capability to be a sustainable entity; as discussed with PSI, PPMVs are a good candidate for that model.

Social Marketing. Social and commercial marketing of family planning products is a niche market. There is a finite number of people at a given time that can or would use the products; because of contraindications and pharmaceutical composition, certain products can only be used by certain people, and products are now available for free at health clinics. Of all the products in the portfolio, the condom is the most profitable. Ethical drug, is a drug that requires a written prescription by a medical practitioner and is sold by a pharmacist. Long-term reversible methods, such as implants or injectables are ethical drugs. These drugs are more expensive to package and market and require a trained provider to administer. A barrier to the acceptance of long-term methods such as implants and injectables is that there are not enough trained providers in several of the states to administer the device. Without the service delivery then the method is of no worth. This is another example of sustainability. ESMPIN did work with the Strengthening Health Outcomes through the Private Sector (SHOPS) program to train more health care workers, but the programs were not working in the same locations, which caused a service gap.

Private Sector. Nigeria has a robust commercial tradition and there are new commercial manufacturers that could be strong partners in the sale and distribution of these commodities. To be

sustainable after the project ends, the transfer of products and distribution should be made to the private sector about mid-way through ESMPIN; this assumes the distribution, warehousing, detailing, and marketing should be assumed by the commercial partners. A good example of a good partner to do social marketing is Chi Manufacturing. Though the connection between Chi and ESMPIN originated at the recommendation of USAID, the partnership has worked with ESMPIN and SHOPS. In discussions with different actors from SMOH and Chi they did not appear to clearly distinguish between SHOPS and ESMPIN. Chi is still enthusiastic about continuing to partner with USAID on other projects. Chi is now producing an Artemisinin-based Combination therapy (ACT) for malaria and next year plans to launch an antiviral for HIV and AIDS. Sales of ORS + Zinc have been low and the Chi product is priced in the middle of the product range, which is a positive. Globally, ORS + Zinc sales have been mixed and the Nigeria sales figures are also low. The Chi representative, however, continues to be optimistic about working with USAID specifically in technical assistance in technical forecasting and business planning. He felt the private-sector model would be sustainable. Also, there are potentially new commercial partners: 14 Nigerian companies were to achieve World Health Organization (WHO) pre-qualification by 2014 (SFH 2013 *Assessment of Pharmaceutical Manufacturers for Social Marketing Commodities in Nigeria*).

The team visited several warehouses that are partners to ESMPIN large ESMPIN warehouse in Ogun and three wholesalers at the King's Market on Lagos Island. The team observed the overall set-up of the facilities and there were several findings that should be more closely examined by an impartial supply chain and commodities expert. There were questions about whether the fulfillment team should wear protective clothing (e.g., gloves, hair nets, masks) when working at the Ogun warehouse. Two of the three wholesalers' sites visited were cluttered, dark with products, and had boxes scattered throughout the space. The disorder within the space, combined with fetid water and waste outside the facility, raised concerns about the quality and care of these products. These warehouses track sales and distribution through a paper trail and do not use electronics or digital technologies. SFH does use digital tracking up to the warehouse because that is up to the point that it tracks its sales.

Service Delivery and Health Care. Service delivery has been a barrier to the success of the social marketing under ESMPIN. One trusted private sector provider in Nigeria are the TBAs. Similar to PPMVs, TBAs are often the first point of care for women in the communities. Their identified roles include the provision of maternal and child health services, conducting normal deliveries, and dispensing of short-term contraceptives, especially in the rural communities where they often play a key role in health care. Involving them in a project of this magnitude would aid efficiency and sustainability of such a program.

For sustainability and consistency in service delivery, the IPC capability should have been institutionalized within the public and private sector facilities among health workers, CHEWs, and health volunteers—not operated by a separate, independent IPC team. A good example of this is that CBDAs reported that they answered many questions from potential users about side effects and contraindications of FP methods, but the users would go to the clinic and receive free products. If the health workers and CHEWS working in the health clinic had been trained in IPC, a level of exchange would have removed.

Evaluation Question 3. To what extent were ESMPIN's activities effective in ensuring that socially marketed commodities filled the affordability, accessibility, and availability gaps in their focused communities and markets, as opposed to competing with or replacing independently viable private sector commodities?

ESMPIN Intermediate Results (IR) I “Methods and Products Available. Accessible and Affordable” focuses primarily on the sale of contraceptives/commodities through social marketing and health care providers’ engagement in the private sector in Nigeria and also training of service providers at referral health facilities and social marketing networks.

ESMPIN proposed that through the activities conducted under this sub-IR they would be able to generate 23,136,742 CYP at the end of the project (with permission from USAID this was reduced to 17,157,928); achieve a shift in emphasis from sales of short-acting methods toward medium- and long acting reversible methods, which they projected would increase from 28.3% CYP to 40.8% CYP; increase coverage for areas that meet standards for FP from 36% to 80%; and ensure that only 15% of supported service delivery outlets will experience stock-outs of products. It is expected that through this there would be a decrease in morbidity and mortality among mothers and children.

To answer Evaluation Question 3, the evaluation team reviewed ESMPIN activities, the results under IR I also used the results from the field visits, to determine the effectiveness of the project in filling the affordability, accessibility, and availability gaps in the implemented states.

General findings show that ESMPIN had limited achievement in filling the gaps in the area of availability, accessibility, and affordability, as follows.

Availability of Products: ESMPIN conducted various activities such as commodity distribution, medical detailing, mass detailing, Service Delivery Point (SDP) recruitment, clinical presentations to healthcare providers, and engagement of professional groups through their professional bodies. They conducted regular meetings/advocacy visits with relevant stakeholders i.e., government, religious, and traditional leaders in the north, but this was less consistent in the south. The evaluation team noted that the messages to community leaders found in the advocacy plan were the same messages used to convince couples and men and women to practice birth-spacing and how to manage side effects, which was not adequate for the stakeholder. In addition, they partnered with the commercial sector, represented by SFH wholesalers and distributors who were used for distribution of FP commodities and service provision. ESMPIN also has in place commodity sales and a distribution team that drive the social marketing component of the project and focuses on continuing to increase the supply of family planning and child survival products and services across the country through the private and public sectors.

In the six years of project implementation, the project managed a basket of commodities (reproductive health and child survival) comprising six USAID-funded products and other leveraged products. The products are: Cycle beads, oral pills (Duofem, Combination 3, Norigynon), male and female condoms, implants, intrauterine devices (IUDs), injectable, emergency contraceptive pills, Water Guard, Water Guard Plus, PUR, and ORS + Zinc. The leveraged products were from DFID (Gold Circle, male condom; Noristerat (two-month injectable); and Pregnon (emergency contraceptive); Global Fund Malaria, ACT; and SFH Enterprise Fund (Water Guard, PUR, Pregnon).

The findings of producing availability, the evaluation team found:

- The major achievement of the project was commodity security: where they ensure that there is enough buffer stock of the commodities at each level of the commodity chain. Stock-outs were fewer and when they did occur, they were corrected in shorter periods of time.

Figure 1. CYP Method Mix: Baseline data. LOP Target Compared with LOP Achieved

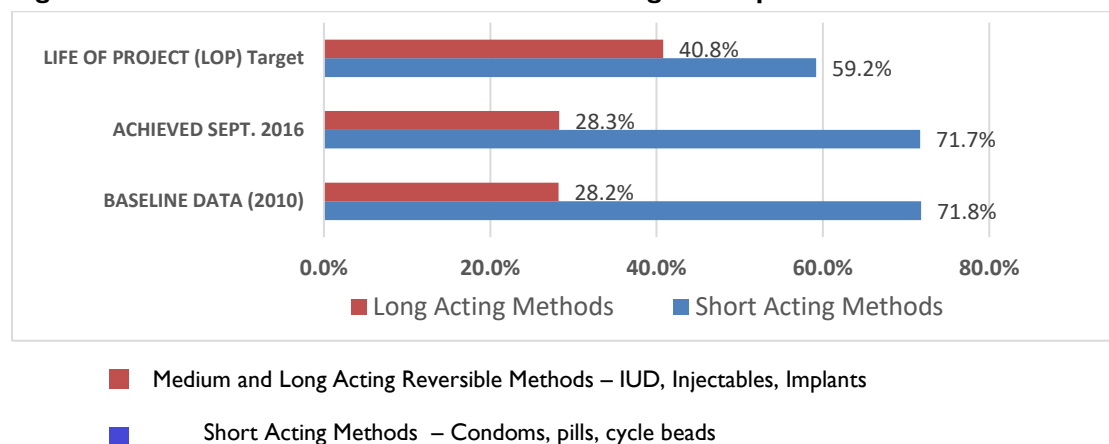
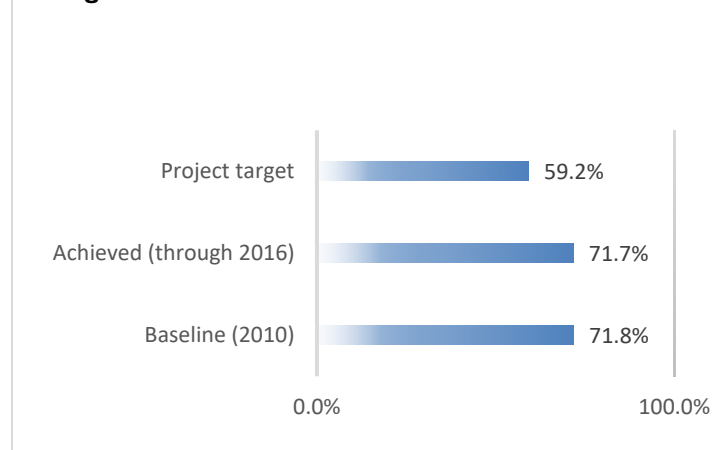
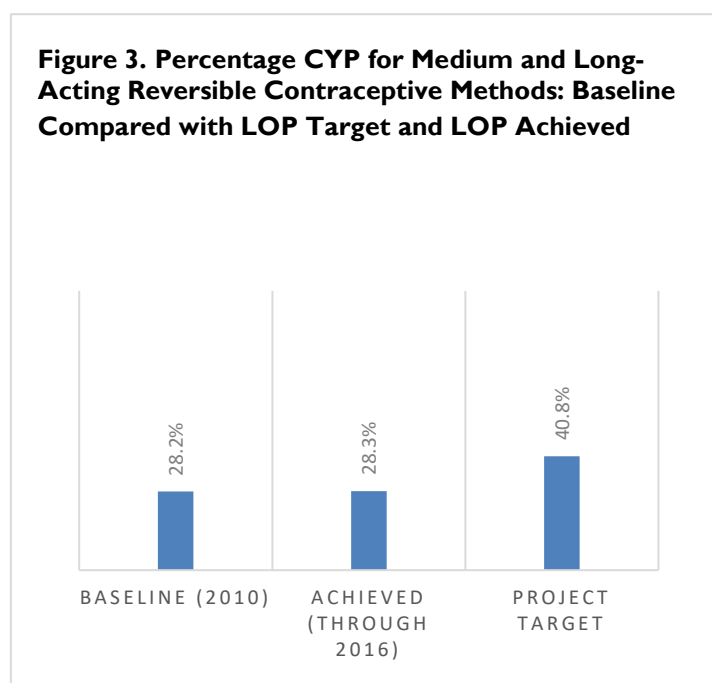


Figure 2 Percentage CYP for Short-Acting Contraceptive Methods (Condoms Contraceptive Pills, Cycle Beads): Baseline Compared with LOP Target and LOP Achieved



Note: Short-Acting Methods = condoms, pills, and cycle beads

Figure 3. Percentage CYP for Medium and Long-Acting Reversible Contraceptive Methods: Baseline Compared with LOP Target and LOP Achieved



Note: Medium and Long Acting Reversible Contraceptive Methods = Injectable, IUCD and Implant

- The project achieved 86% of the expected CYP (see Annex VI for data on CYP life-of-project (LOP) compared with actual CYP achieved), but was unable to move the sales of contraceptives from short-acting to long-acting methods. ESMPIN achieved 28.3% CYP against the projected 40.8% CYP method shift.
- In terms of stock-out of contraceptive, the project was able to reduce contraceptive stock-outs from 36% to 15.5% (see 2).

Table 2. Percentage of USG-assisted Service Delivery Points that Experienced Stock-outs of Contraceptive Methods (ESMPIN Presentation to Evaluation Team, SPARCS and MAP Survey reports)

Variable	Baseline	Project Achievement	LOP Target
Percentage of USG-Assisted Service Delivery Points that Experience a Stock-Out at Any Time during the Reporting Period of a Contraceptive Method that the SDPs is Expected to Provide	36% (SPARCS Survey)	15.5% (MAP Survey)	15%

The table shows that most of the SDPs, for the purpose of this evaluation the SDPs are: public and private hospitals and clinics, PPMVs, pharmacies, and non-traditional outlets, such as hotels, and shops had contraceptives throughout the period of implementation. This was attributed to prompt supply of

products and adequate buffer stocks available at different levels of the supply chain network. This was corroborated by the findings during the field visits, which showed that ESMPIN FP products were available in PPMV stores and Private Health Facilities also sold by CBDAs and IPCAs. When asked about stock-out of contraceptives, only 24% of the PPMVs and CBDs interviewed stated that they have ever experienced stock-outs of FP products and the products stocked out include the oral contraceptive, Combination 3. The major reasons given by the PPMVs for the stock-outs were increased patronage and lack of funds to restock commodities. Also, 15% of the healthcare workers interviewed stated that they experienced stock-outs in the last six months before the evaluation and the commodities usually stocked-out include injectables (Depo Provera and Noristerat) and condoms (female and male). However, the opposite was the case for child survival products as field visits revealed that Water Guard Plus and PUR were not available in most outlets PPMVs and CBDs visited during the evaluation. (Refer to Annex V for details of SDPs.)

Table 3. Percentage of Communities That Had At Least One Outlet Where Chi Co-packaged ORS + Zinc Product Could Be Obtained (MAP Survey 2016)

Variable	Baseline	Project Achievement	LOP Target
Percentage of communities that have at least one outlet where Chi co-packed ORS + Zinc can be obtained	73.9% (ORS) 2.9% (Zinc)	44% (ORS + Zinc) (MAP Survey 2016)	No target

The project introduced the co-packaged ORS + Zinc within partnership with Chi, but the product was not readily available in some of the communities, only 44% of the communities where ESMPIN implemented the project had at least one outlet in the community where Chi co-packed ORS + Zinc could be obtained (MAP Survey 2016).

ESMPIN distributed Water Guard and PUR, which are water purification products. They also replaced the Water Guard with Water Guard Plus. From the results of the IPC evaluation conducted in 2016 and presentation of ESMPIN to the evaluation team, the project was able to increase knowledge from a 20% baseline to 73.6% among caregivers that proper storage of water and use of point-of-use water purification technologies are effective means of preventing diarrhea among children less than five years as against a target of 60%. When this was compared with actual usage, it did not translate into increase in actual use of the products as the project could treat only 2,628,791,700 liters of water, which amounts to 41.6% of their expected target of 6,312,033,750 liters (PRS data and ESMPIN Report to Evaluation Team). The field visits conducted by the evaluation team showed that Water Guard Plus and PUR were not available in most outlets visited (by PPMVs and CBDs) and only 41% of the PPMVs and CBDs interviewed sold the products—which they said was not one of the most popular methods they sold.

The project could have achieved more in the area of making products available if they had included partnerships to develop and distribute products with several pharmaceutical and manufacturing companies and creating a social franchise of PPMVs and possibly the CBDAs and introducing social enterprise or investments to increase funding of manufacturers, distributors, warehouses, and promotion. According to the 2013 ESMPIN report, there were 14 Nigerian companies on track to achieve WHO pre-qualification in 2014 (SFH 2013 *Assessment of Pharmaceutical Manufacturers for Social Marketing Commodities in Nigeria*). The project did establish a partnership with Chi which was one of the 14 Nigerian companies identified in the assessment, but there is no evidence the project used this MOU

with Chi to leverage partnership with other Nigerian companies and form multiple public private partnerships.

Accessibility of Services. In order to make services available to beneficiaries, ESMPIN implemented different activities, including training of non-traditional health providers (i.e., PPMVs, TBAs, CBDAs, IPCAs,) to provide FP and MCH information and knowledge to community members. Activities conducted by PPMVs and CBDAs included town hall meetings, specialized group sessions during antenatal care (ANC) visits, child welfare clinics, male involvement sessions, and provision of door-to-door services, referral, and counselling.

The CBDAs, as part of their basic tasks, distribute over-the-counter products, mainly Cycle beads, condoms, and Combination 3 pills. They also carry water purification products to reach the rural areas of communities. During Cycle I-0 the IPCA Model there were no service provision but this was adjusted in Cycle I0 to be a service provision model engaging with CHEWS as IPCAs.

ESMPIN measured the effectiveness of providing accessibility to FP and MCH services and products through the number of PPMVs, CBDs, and health workers trained; coverage in family planning and MCH service provision; number of referrals to health facilities; and service uptake.

The findings of the evaluation team on accessibility of service are as follows:

- According to a MAP survey, the project was able to achieve its target for FP coverage (81%), which was 1.25% over the LOP target of 80% but field visits showed that most respondents interviewed felt that geographical coverage of activities (promotion, sales of products) was limited in range because the project did not cover the breadth and length of the states where project implementation took place. Some of their comments included: “Scale up/increase geographical coverage” (ESMPIN staff); “Increase awareness to hard-to-reach areas” (WDC members); and “Extend project duration/increase coverage” (Government officials).
- The project was able to identify and recruit 7,256 SDPs (*data collated from ESMPIN’s Annual Report and Document on new SDPs opened*), which included both traditional and non-traditional outlets like PPMVs and Kiosks), to increase availability and access to FP and MCH products and services. (See list of SDPs by type in Annex V.)
- The project used the IPC Cycle model, which involves implementation of activities for six months in a community, after which they exit from the community and then repeat the process somewhere else. The project also used the CBD model of employing community-based organizations (CBOs) to coordinate the activities of CBDs, and the CBDs that worked throughout the LOP. The IPC model was modified during Cycle I0 implementation to become the service provision model using trained CHEWs to provide services in addition to other activities during the six-month implementation period. Out of the three models, the CBD is more sustainable because they take contraceptive products into women’s homes, businesses, and markets. This reduces the cumbersome burden of travelling long distances to obtain FP products and services, increases the acceptability, and is friendly to low-income women. They also worked throughout the life of the project and have formed associations, and opened bank accounts to which they are contributing money that they hope to use to procure commodities to continue service provision after the end of ESMPIN project. The CHEW model would have been sustainable, but because they are employed and paid salaries by ESMPIN it is not likely they will continue service provision after the end of the ESMPIN Project.

- In terms of capacity building, the project trained 55,747 PPMVs, 2,208 CBDAs, and 7,291 IPCAs (*ESMPIN database*) in the 22 priority states on counselling skills, how to display and dispense products, referral, and documentation of activities. During the field visits, 71% of the PPMVs/CBDs said that they were trained on FP, 17% said on diarrhea prevention and treatment, 3% said on malaria while 1% on water treatment. All 27 community mobilizers interviewed stated that they participated in ESMPIN trainings and were trained on administration of products (93%), referrals, and IPC (8%). Also, 43% of the health care workers interviewed stated that they participated in ESMPIN trainings (likely they were confusing this with other SFH or SHOPS training) and over 82% of those trained received training on family planning, 29% on diarrhea prevention and treatment, 18% on malaria prevention and treatment, while 12% stated they were trained on exclusive breastfeeding. The trained personnel generated FP and MCH demands in the community, provided non-prescriptive contraceptives, and conducted referrals to health facilities. The project also leveraged trainings conducted by SHOPS and Nigerian Urban Reproductive Health Initiative (NURHI) projects to train referral facility health care providers on contraceptive technology updates.
- The IPCAs and CBDAs through their efforts, reached 21,584,316 community members (IPCAs 14,209,051 and CBDAs 7,375,265) with FP and MCH information (*ESMPIN MIS data*). However, the Nigerbus survey of 2016 shows that the project could not achieve much in sustaining the mass media and IPC activities as only 22.1% of audience interviewed could recall hearing or seeing a specific U.S. Government (USG)-supported FP/RH message, which was only 29% of their expected end of project target of 75%. The CBD survey conducted by ESMPIN in 2016 shows only “32% of respondents in CBD communities credited CBDAs as providing them with information on FP/CS.” (*CBD Evaluation Report 2016*).

FP service uptake, especially for the medium- and long-acting methods, did not increase significantly as only 2% of the IPCAs contacts actually accepted an FP method from the referral health facilities (HFs). When compared with those who were actually referred and picked up service, this rose to only 15% of referred clients picking up FP methods at the HFs. The analysis is presented in Table 4 below:

Table 4. CBDA and IPCA Performance in Increasing Access to FP and MCH Services (*ESMPIN MIS data and reports*)

Outlet	Number of people contacted by IPCAs and CBDAs	Number of referral cards issued	Number of referral cards redeemed	Number of uptake individuals service	Contact to uptake of service	Referrals to redeemed	Referrals to uptake	Redeemed to uptake
IPCA	14,209,051	2,295,187	576,321	338,169	2%	25%	15%	59%
CBDA	7,375,265	104,420	50,610	Not tracked by project	Uptake not tracked	48%	Not tracked by project	Not tracked by project
Total	21,584,316	2,399,607	626,931			26%		

- There were gaps in provision of long-acting reversible methods services as a result of untrained providers at some of the supported referral HFs, especially in the northern region. It was found that the majority of the public health facilities were manned by CHEWs. This was corroborated

by findings in the field, which showed that 55% of HCWs interviewed were CHEWs, 25% nurse midwives, 13% nurses, 5% health educators, and only 1% doctors. It is suspected that this might have accounted for why the project was not able to move users from short-acting methods to medium- and long-acting methods as projected in the project document. ESMPIN as a project could not intervene in this area because of the nature of the project design, as they were requested to leverage trainings conducted by other projects like SHOPS to train health providers in their supported referral health facilities. Unfortunately, the SHOPS project worked in only five out of the project 22 priority states.

- CBDAs and IPCAs both provided the same service but the IPCA Cycle (six months per community) was too short to have sustained impact while CBDAs stayed longer on the project and were able to form associations. Respondents during KIIs and FGDs said the period of implementation should be extended to between one and five years.
- CBDAs and IPCAs want to carry other products like long-last insecticide treated nets (LLINs) and antimalarial drugs, which ESMPIN did not distribute. This limited their ability to provide access to malaria products.

The project had missed opportunities to increase access to FP and MCH products which they did not utilize, including:

- Use of trained CHEWs from the inception of the project, i.e., implementation of the service provision model, as they can also provide services at the community level.
- Use of TBAs, who are also a source of reference for health services by community members.
- Increased inclusion of WDCs in the implementation of the project as they serve as gatekeepers in the community.

Service delivery was also an issue with increasing accessibility because of the design of the project, which did not allow ESMPIN to train health care workers but rather asked them to leverage other USAID-supported projects.

Affordability of ESMPIN Products. ESMPIN used DFID's total market approach to make products available to community members. The approach identified segments of society to be reached with high quality products and services according to their ability to pay, but this was not applied in the implementation of the project. It is known that in a balanced market, the poorest access products and services through free distribution; those who are somewhat better off have access through subsidized products and services; and those with greater ability to pay use the commercial sector (*ESMPIN Program Description*).

The private sector's role in the health sector has grown dramatically over the past decade. Currently, health expenditures in private facilities account for 75% of health expenditures. In Nigeria, 60% of all FP services are delivered through the private sector, which is the most frequently reported source of contraceptive supply in Nigeria, providing modern contraception to approximately 2.5 times as many women as the public sector (*USAID SBCC/Private Sector Bilateral Redesign Assessment Abuja, Nigeria*).

The government introduced free distribution of FP commodities in public health facilities, which attracted all social economic groups to go to the government HFs to receive FP and MCH services, including the target group for social marketing (i.e., the lower social economic group). Despite this free

distribution, the project complemented the government efforts by reaching areas in dire need and with limited access to these commodities as well as the commercial market. Also in 2013, the FMOH, with support from donors and implementing partners, scheduled free distribution of over 58 million male condoms through the public sector; this clearly contributed to low commercial sales performance of the project during the year.

Across public health facilities (which get free FP commodities from the government) and private health facilities (which source their commodities through commercial or social marketing), the cost of FP services remain a challenge to ready access. The public facilities charge fees¹ for the service under the assertion that they do not receive free consumables. To address this, ESMPIN provided consumables to some of the referral health facilities, especially public health facilities, to help drive down the cost of providing FP and child spacing services (*ESMPIN FY15 Annual Report*). ESMPIN staff and reports state they conduct monitoring visits in these facilities, at which time they can also observe if fees are being charged. Also, at one facility a health care provider reported they used to charge N2500 for FP services, but now with ESMPIN-subsidized products they now charge N1000 for FP services.

Feedback from the field indicated that willingness of wholesalers and retailers to invest money into the contraceptive market has dropped significantly, mainly as a result of the economic recession in Nigeria. Three PPMVs interviewed stated that they were unable to restock because of lack of funds. ESMPIN also witnessed the activities of competitors like DKT group that sell the daily oral pill (Levofem) and the emergency pill (Postpill), which are direct competitors of the project's Combination 3 and Postinor 2. The wholesale Combination 3 and Postinor 2 pills. Wholesale prices were N47 and N50 respectively, which has a price advantage over ESMPIN brands (*ESMPIN FY15 Annual Report*). They stated that this also affected their product sales. This was also corroborated with the evaluation findings on the field as presented in Table 5 below.

Table 5. Comparison of Price List of Products by Different Organization (Source: From field study)

Product Type	ESMPIN Price	DKT Price	Government Price
Condom (Basic)	N650/24 packs (Gold Cycle)	N600 / 36 packs (Kiss)	Free
Oral Pills	Between N20 and N50 / Sachet (Combination 3)	N47 / sachet for Levofem	Free
Pills (Emergency)	N155 / Sachet (Postinor 2)	N50 for post pill	Free

Our field research, however, shows that despite the lower prices of competitor's products, some community members still finds ESMPIN products affordable. Thirty-eight percent (38%) of women FGD participants stated that ESMPIN FP and MCH products are affordable and reasonable while 58% said it was free (most probably referring to the government's free FP products and 10% said it was not affordable. Also, 23% of the community mobilizers (IPCAs) stated that apart from referring clients to the HFs they also referred them to clinics because of service affordability and accessibility. On the part of government officials 28% stated that methods were available and affordable because ESMPIN products

¹ These are informal fees, but most government facilities charge these fees to provide services to clients because government is not meeting its obligation to provide the finances to purchase the consumables. Sometimes in government health facilities they ask clients to bring consumables, like gloves, cotton wool etc. before services are provided. These are not standardized across the health facilities. Standard fees are not posted in the health facilities.

are cheaper than other products in the market. This was, however, at variance with field findings, which showed that some of ESMPIN products are indeed more expensive than other brands. For instance, in FY2015, ESMPIN reported that they could not meet the target for ORS + Zinc sales because of “the presence of more affordable brands in the market.” The response of the government officials shows that they might not be aware of which products are ESMPIN products and the cost of the products.

In order to make products more affordable to clients, some of the respondents made the following suggestions:

- Reduce cost of commodities (5% of PPMVs).
- Make products available at reasonable price (three WDC groups).
- Provide the commodities to CBDAs and IPCAs free of charge and allow them to add a small margin on the price for their own profit.

Evaluation Question 4. To what extent were ESMPIN’s strategies cost effective; could ESMPIN have explored and utilized alternative and innovative cost effective strategies that have potentials of increase uptake of family planning and childhood products and services within the private sector?

Perspective. The perspective of the program fund provider was adopted for this evaluation and only program costs were evaluated.

Time Frame. The time frame for this study was from July 2011 to September 2016. The analytic horizon is the entire reproductive life of the women who received family planning products.

Intervention unit. The outcome measures used were Couple Year of Protection (cost per CYP) and number of births averted (cost per birth averted).

Results. The costs expenditure of all the 22 ESMPIN states were reviewed. Table 6 below shows the annual fixed costs based on available data. Further breakdown of cost is available in the annexes.

Table 6. Total Fixed and Variable Costs for the ESMPIN Project

Resource	Year 1 Jul 2011-Dec 2012	Year 2 Jan- Dec 2013	Year 3 Jan-Dec 2014	Year 4 Jan-Dec 2015	Year 5 Jan-Sept 2016	Total Amount Spent (\$)
Fixed Cost						
Staff salary and allowances (local, international, and contract)	4,896,961	2,935,962	3,176,761	3,681,032	2,717,594	18,847,245
Rent (Facilities/Warehouses)	110,713	33,632	90,266	48,344	52,816	335,771
Office/warehouse Repairs and Maintenance	46,204	16,241	36,378	62,625	33,199	194,647
Utilities	23,662	14,844	10,251	23,335	11,529	83,620
Equipment and Furniture	79,226	67,792	69,368	96,582	81,607	394,574
Vehicles	190,409	213,324	213,324	213,324	213,324	1,043,704
Subtotal	5,347,175	3,281,794	3,596,348	4,125,242	3,110,068	20,899,561

Resource	Year 1 Jul 2011-Dec 2012	Year 2 Jan- Dec 2013	Year 3 Jan-Dec 2014	Year 4 Jan-Dec 2015	Year 5 Jan-Sept 2016	Total Amount Spent (\$)
Variable cost						
Total travel and Transport (including airfare)	442,512	451,991	543,557	790,736	307,965	2,536,761
Communication programs, events, and advocacy	847,684	96,004	112,781	399,256	146,469	1,602,194
Mass Media*	1,725,489	2,214,415	2,864,890	2,831,108	685,580	10,321,482
Trainings and Meetings	1,791,486	974,442	1,373,169	1,390,917	1,168,460	6,698,473
Research	1,167,347	386,469	149,751	337,504	115,616	2,156,688
Other Project Partners**	1,641,826	1,377,099	2,289,553	2,084,733	817,890	8,211,102
Other Direct Costs	376,109	114,735	220,752	227,950	101,180	1,040,725
Drug Costs (FP)	15,465,062	8,922,840	10,035,804	6,591,330	3,427,942	44,442,978
Subtotal	23,457,515	14,537,995	17,590,257	14,653,534	6,771,102	77,010,403
GRAND TOTAL	28,804,690	17,819,790	21,186,605	18,778,776	9,881,171	97,909,964

* semi-variable cost

** PSI & ARFH

Table 6 shows the fixed, semi-variable, and variable costs on an annual basis. The scrap value of the 42 project vehicles was estimated to approximately \$202,251.17. This was deducted from the overall cost of the project vehicle. Yearly Central Bank of Nigeria (CBN) rates used for conversion were 157.43 for 2012, 157.31 for 2013, 158.55 for 2014, and 197 and 305 for 2015 and 2016 respectively. The economic costs of the drugs were estimated to give an estimate of the total cost of the drugs on an annual basis. All costs were presented in US dollars.

The total intervention cost for family planning program inclusive of donated products and services was \$97,909,963.3 million; this was calculated as direct program cost. The annual cost for the family planning program ranged between \$18 to \$21 million.

Table 7. Family planning Cost-effectiveness for ESMPIN (3% Discount Applied)

Discounted Total Cost	Discounted CYP	Discounted total number of births averted	Cost per birth averted (\$)	Cost per CYP (\$)
90,694,285.56	13,644,146.28	907,961,046.79	0.10	6.65

Outcome measures. The first cost effectiveness ratio as shown above in Table 7 was a measure of the discounted total program cost divided by the total outcome (discounted) as measured by the total birth or pregnancies averted. This was \$0.10.

The second cost effectiveness ratio was a measure of the cost per CYP. The CYP is calculated by dividing the time period provided by one unit of contraceptive cover by 365 days. The net CYP was not adjusted for failure rates of the individual devices, but the same discount rate applied to the cost was also used. The cost per CYP, i.e., total cost divided by total CYP, was \$6.65.

Evaluation of Strategies. The strategies evaluated were the use of PPMVs, CBDAs, IPCAs and mass media of family planning services. The basic ESMPIN model from the HC3 Cost Evaluation Report, 2016 was used to project costs of IPCA in 533 communities and adjust them from 2013 to 2016 using annual average of US dollars whole consumer price index for All Item Urban Consumers (CPI-U) 1982-84-100 (Unadjusted). Cost per IPCA trained was not available, while cost per CBDA trained was \$65.28. This was estimated based on the total amount spent during training (\$144,140.80) and the number of persons trained (2,208) The total amount spent in training 53,749 PPMV was \$2,240,833.71 giving a rate of \$41.69 per PPMV trained.

Table 8. Outcome Measures of IPCA and CBD Strategies

Strategies	# of people trained	# of Contacts	# of referrals	# of redeemed referrals (%)
IPC	7,291	14,209,051	2,295,187	576,321
CBD	2,208	7,375,265	104,420	50,610

Table 9. Cost-effectiveness of Strategies (in US\$)

Strategies	Cost of Activities (\$)	Cost/ activity (\$)	Cost/ contact (\$)	Cost/ referral (\$)	Cost/ redeemed referral (\$)	Cost/ FP uptake (\$)
IPC	10,441,248.98	1,432.07	0.73	4.55	18.12	30.88
CBD	4,065,702.17	1,841.35	0.55	38.94	80.33	NA

The cost per activity based on projected cost for IPCA was \$1,432.07 and CBD \$1,841.35. Average cost per contact (calculated as the total activity cost divided by total number of contacts) was \$0.73 for IPCA and \$0.55 for CBDA. The average cost per referral (calculated as total activity cost divided by total number of referrals) was \$4.55 and \$38.94 for IPCA and CBDA respectively. Average cost per referral card redeemed similarly measured was \$18.12 for IPCA and \$80.33 for CBDA. Cost per family planning method uptake was \$30.88 for IPCA. Data for CBDA were not available.

In this study, the IPC estimate, such as average cost per contact, was lower than the \$0.90 reported by the HC3 study. Likewise, the average cost per referral card redeemed and average cost per method uptake were lower in the index study than the \$23.90 and \$42.76 reported by the HC3 study. This may not be unconnected to the fact that the fixed costs do not change much and allow for economies of scale.

Cost effectiveness methods. Family planning programs generally are considered as cost effective strategies that help save lives, particularly in resource-poor countries when compared to a base of no program. Limitations of this study include the outcome measures, which were based on assumption of contraceptive use measured by sales; the perspective employed in this study did not take into account other financial cost implications to the users and may not reflect the actual cost burden.

Cost effective innovations that could have been used include the use of social media—such as Twitter, Facebook, and WhatsApp—to communicate with potential users and for healthcare workers to access current information about side effects, contraindications, or misinformation. These social media Apps are common tools used by health workers, including CHEWs, for IPC. These media are affordable, 80% of our target audience of women have mobile phones, and they reach quite a large audience base.

SFH's Total Marketing. SFH's Total Marketing is a marketing model where a heavily subsidized product is underwritten by a more expensive line extension product. ESMPIN used Total Marketing for male condoms and emergency contraceptives primarily funded by DFID. For its heavily subsidized male condom that costs 30 Naira it will require 55 to 60 Naira to cover its marketing and distribution costs or to break even. This is about 50% or double its selling price; and to be safe and because of the environment where ESMPIN and SFH are working "make it three times" the selling price was the recommendation of SFH's social business specialist.

Of the three SFH condoms, the most expensive may cost the consumer 250 Naira, the program would require 110 Naira or 150 Naira to show a comfortable profit of about 90 Naira. This profit would be redirected into the heavily-subsidized product and a profit to the company. ESMPIN does not have to handle the product import costs, since the products are donated and delivery to Nigeria are covered directly by USAID.

The following matrix is from Chi Pharma and it is a guide to how Chi calculates costs and overhead. There are many variables that need to be considered, according to an email from Mr. Ikenna Orakwue, Head of Public Health, Chi Pharma, Ltd.

Table 10. Chi Pharmaceuticals Ltd, Guide for Pricing Costs, November 2016

Description	Basis	Variables
FOB Price to DB of Importing Country	US Dollar	
Air Freight	Largely depends on volume size and it is high for liquid cargo.	5%
Total CFR (USD)	US Dollar	
Total CFR (NAIRA)	Conversion rate of Local currency in compare to USD (Subject to Change)	To be determined
Insurance		0.50%
CIF - Naira	Local Currency – Naira	
Import Duties:		
Import Duty		20%
7% Surcharge		
0% VAT		
1% CISS		
0.5% TLS		
Total Import Duty		
Clearing Charges	Depends Largely on Chargeable Weight	5-10%
NAFDAC	Subject to change - New NAFDAC Guidelines	2.5%
Landed Cost- Lagos	Local Currency – Naira	To be determined
Finance Cost for Import		To be determined
LC - 4 months	@18% pa for 4 months at least on CIF Price	6.0%
Stock Holding - 4 months	@18% pa for 4 month at least on Landed cost to Lagos	6.0%
Selling & Distribution Overheads	@5% for selling and distribution costs	8.0%
Other Overheads - Admin & Warehousing	@5% for other overheads	5.0%
Total Cost		
Distributors' Margin		To be determined
Selling Price- at DB's point		

Question 5. To what extent did the ESMPIN's project activities incorporate gender programming during the life of the project and what effects did it have in increasing uptake of Family Planning and MCH services in ESMPIN supported sites?

The program description contains the ESMPIN gender strategy, which details the various approaches for ensuring gender integration for the various program interventions. For family planning, diarrhea, and

malaria prevention and treatment, the gender strategy focused on messages targeted at women in their traditional role as mothers and men in their traditional role as protectors and decision-makers of their families. In addition, for FP the program also specifically targeted women CBDAs and PPMVs in the north and IPCAs in the south. Women detailers were better positioned to reach more women with FP messages. The FP gender strategy also mentions that “peer educators will form groups among members of their same sex to encourage open and comfortable discussion while also seeking opportunities for mixed sex discussions given the importance of spousal discussion as a determinant for use of FP.” However, the document did not give details of how to identify and utilize such opportunities for mixed-sex discussions and it is not clear whether such information was available to program staff, although 75% of program staff that were interviewed felt that the program had a positive influence on gender.

Examples of gender interventions provided by program staff include:

- Separate meetings with men in workplace or at association meetings, e.g., for commercial motorcyclists in Oyo State.
- Specific messages for men (e.g., social support) and women (e.g., side effects of FP) in Ogun State.
- Having both female and male CBDAs, though there are more females in Zamfara State.
- Men supporting their wives to use FP methods, e.g., Cycle beads, in Kebbi State.
- Women encouraged to make inputs into issues that affect them during town hall meetings with both men and women in Sokoto State.

Although the majority of the examples given are of interventions that are gender-accommodating, the last two reflect some transformation of gender relations in the target communities. In addition, 37.5% of ESMPIN staff that were interviewed mentioned male involvement as an example of program activities that worked well, while 12.5% felt that male involvement was the biggest contribution of ESMPIN to the communities. However, one of the men’s groups interviewed in Sokoto mentioned that they would have liked to have more FP sensitization activities for men at relaxation areas. Similarly, some of the recommendations for improvement of the program mentioned by the community mobilizers in Sokoto State included more involvement of men (3.7%) and more involvement of traditional rulers (3.7%).

Among the women’s groups, 33.3% said that they had utilized the health facilities for FP while 11.1% of men said they had utilized the facilities for FP. Both men and women who utilized FP services were satisfied with the services they had received at the facilities and felt that there was no difference between men and women in how they were treated.

The majority of clients that had exit interviews at the facilities were married women (83.9%) and all but one (98.2%) were satisfied with how they were treated, while the rest (1.8%) said they were dissatisfied. Only one client (1.8%) felt that a male health worker would not have shown her much care and would have referred her to a female provider (Sokoto, 30 years old with Quranic education). Among the clients, 44.6% utilized FP services on the day of the exit interview and almost all of them were women (96%). There was only one man (Sokoto, 43 years old with secondary school education) who had utilized FP services on behalf of his wife following interaction with community mobilizers. All the FP clients were married except for one (Oyo, 23 years old with post-secondary education). The ages of the FP clients ranged from 17 to 45 years and age distribution is shown in the table below.

Table 11. Age Distribution of Exit Interview Clients Who Utilized FP Services

Age range	Number	Percentage
15 – 19 years	1	4%
20 – 24 years	4	16%
25 – 29 years	6	24%
30 – 34 years	5	20%
35 – 39 years	3	12%
40 – 44 years	2	8%
45 – 49 years	2	8%
No response	2	8%

All the family planning clients were satisfied with the services they had received at the facilities.

Findings from the interviews with women's groups in the communities also suggest that there is some transformation of gender relations, as 69.2% of women who said that they had utilized the health facility for family planning said that they were accompanied by their husbands for the services while 7.7% went alone but with their husband's consent. Of those who utilized the facilities for family planning services, 53.8% said they got information about FP from mobilizers and all of these women attended the facilities with their husbands. For all services (FP and MCH, 64.1% attended the facilities with their husbands while 5.1% went alone but with their husband's consent. Similarly, a majority (90.5%) of WDCs interviewed reported that following the interventions, men now support their wives to use ANC and family planning.

Community mobilizers, include the IPCAs and CBDAs, were comprised of women and men at a ratio of 2:1. Almost all community mobilisers (96.3%) mentioned that they refer more women than men to the health facilities. The reasons given for referring more women included:

- The products are mostly for women (50%).
- Women are more accessible (usually around while the men are at work) and approachable than men (38.5%).
- Women bear the burden of childbirth and child care; the impact is on them and their children (7.7%).
- Most mobilizers are women (3.9%).

Only 3.7% of the community mobilizers said that they refer more men than women to the facilities and the reason given was because the men are the heads of the household (in Sokoto State).

Among the challenges reported by the community mobilizers, 14.8% mentioned harassment by men; this occurred mainly in the south (in Lagos, Ogun, and Oyo States) where the mobilizers were mostly women and would approach both men and women for FP mobilization. Another gender-related challenge mentioned by community mobilizers was resistance to FP by men (11.1%); this occurred both in the north and the south (in Kebbi, Ogun, and Oyo States).

All PPMVs that were interviewed agreed that both men and women have preferred FP methods. They felt that men prefer condoms because they are cheap and easy to use and also protect against sexually transmitted infections (STIs) while women prefer pills because they are easy to use and have less side effects compared to injectables.

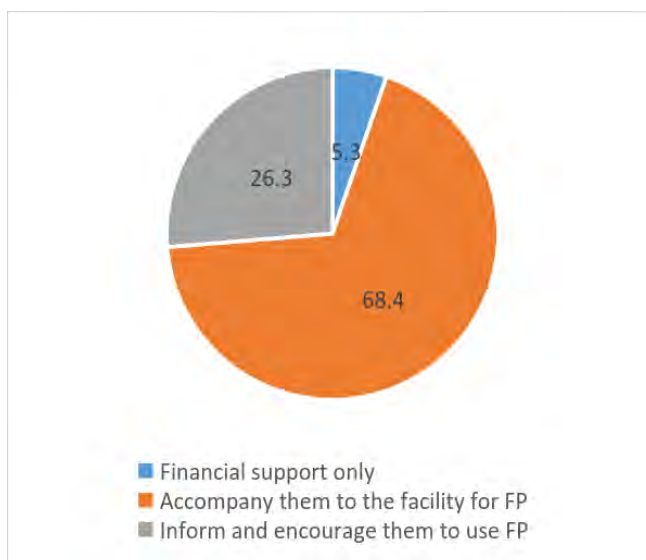
Majority of PPMVs that were interviewed (57.6%) reported that 50% or more of their FP clients are women and a large proportion (42.4%) reported that 70% or more of their FP clients are women. Conversely, a large proportion (42.4%) reported that 30% or less of their FP clients are men. The PPMVs suggested various reasons for having more women FP clients and these include:

- Women are more involved in sensitization/the project than men (7.6%).
- Women are the ones who use the products (7.6%).
- Men are shy to buy the commodities (3%).
- Men feel FP is a woman's thing (1.5%).
- Men marry many wives so the women are the ones who protect themselves (1.5%).

Although ESMPIN has a gender strategy, this was not well communicated to or well-known among government officials collaborating with the program. Though there are a mix of men and women, 60% of government officials interviewed had no idea whether the program addressed gender or not, 15% felt that the program did not address gender, and 5% felt that men were not well involved because there are no male IPCAs. Only 20% of government officials were of the opinion that the program addressed gender and examples of gender activities that they gave were male involvement sessions, women enlightening husbands about FP, and women attending town hall meetings where they are given equal opportunities as men to air their views on FP and other health issues.

The gender strategy in the program description also includes the disaggregation of monitoring and evaluation (M&E) data by sex in order to provide information on gender-based differences in health-seeking behaviors and health determinants. Such information was used to inform the development of appropriate messages for men and women. Disaggregating the data by sex was also used to determine whether the program was making the desired impact on the sexes and provide a basis for corrective

Figure 4. WDC FGDs: Type of Support Given by Men to their Wives for FP



actions to improve the impact. For example, the BBC End of Project Evaluation estimated that men constituted 52% of the listeners reached by the BBC Media Action radio program “Ya Take Ne Arewa and these included fathers (23.1%) and husbands of pregnant women (28.9%) though this media reach had minimal impact on the health-seeking practices of the people (only 14% for malaria, 4% for diarrhea, and 0% for FP).

As part of the gender strategy, the training modules for PPMVs also listed “gender issues” as part of the agenda.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

SFH and its subcontractor PSI are using a social marketing approach that was very popular in the 1990s and early 2000s. This model assumes that many of the responsibilities and roles that are normally performed by a manufacturer or commercial company. For example, the program creates detailing and distribution units, manages warehouses and product fulfillment, designs and implements marketing and outreach, and brands products.



Fulfilment at SFH Warehouse. Photo credit: Omotayo Olugbemi

Over the years, as countries have begun to have stronger commercial sectors and small and medium-sized manufacturing concerns, the need for a different approach has evolved to better fit the advancement of countries such as Brazil, Jordan, and South Africa that are further along the development spectrum. The revised social marketing model is not to do the role of the private sector but to work to strengthen their manufacturing capabilities, distribution and detailing units, and warehousing and storage. Projects like ESMPIN should provide technical assistance in financial management and business forecasting, operations, and on a limited basis, marketing, not do the commercial sector's job. The project, in conjunction with the companies, also would liaise with the government and health services to assure all actors are in agreement about specific public health issues. A newer component to the revised social marketing model has been the introduction of social investment by a countries' diaspora or other philanthropic individuals and organizations that want to invest in social projects. Social investment ventures are being encouraged by USAID.

One indicator of the effectiveness of the social marketing strategy is the data. In 2011, ESMPIN proposed it would achieve 40.8% CYP of medium and long-term methods and its baseline was 28.2%; at the end of 2016 and with funding of \$57 million from USAID in addition to other funding of FP products, CYPs are almost the same at 28.3%. It is also important to remember that these FP products are not new to Nigeria—most have been on the market for at least eight years—and that SFH has been working in family planning social marketing since 1990.

The second social marketing model was implemented throughout Africa (including in Nigeria), under NetMark, the USAID-funded malaria prevention project, where it met with good success. It ended when the US Government and the Government of Nigeria chose to distribute ITNs for free, which essentially killed the commercial market. (Another lesson learned for family planning products that are now provided for free in government facilities.

Even though Nigeria has felt the 2009 recession hard and there are predictions that 2017 will continue to show an economic downturn, the application of USAID funds along with other donors' funding may be better served by adapting the revised social marketing model and putting emphasis on strengthening local manufacturers and companies (sub-purposes 3 and 4) with technical assistance, social franchising, and social investment.

ESMPIN's important contribution is to commodity-security. There are still stock-outs but they are less frequent and do not last as long. The project has seen a drop from 30% to 15% of stock-outs in supported facilities.

SFH's financials, record-keeping, and documentation are not always in agreement, making it difficult to exactly determine project outcomes and allocation. As the recipient of similar awards from different donors, the less-than-exact record-keeping made it difficult to identify where one program stopped and another began and who worked on which projects.

ESMPIN's research should have included: 1) a comprehensive socio-ecological study, 2) qualitative research among all the primary and secondary audiences, and 3) M&E indicators for behavior change and monitor shifts in social and cultural norms. These data would have been important in designing effective messages and strategies by audience that would contribute to behavior change. For example, the FP message was birth spacing, which reinforced the fear couples had that modern methods are irreversible. ESMPIN gender activities were mostly male involvement workshops. For those that attended it had a positive impact; however, to make a significant difference in gender, there need to be changes in social and cultural norms among institutions and that did not happen.

Male condoms are a very profitable commodity; income or profits from condom sales can be applied to SFH's operations and overhead, and underwrite subsidized products, distribution, and detailing. Long-acting reversible methods and maternal and child health products, including malaria, are not profitable, especially when compared to condoms. SFH uses a Total Marketing model being funded by DFID for its condoms and emergency contraceptives and has had good returns on investment but it is hard to determine how many were for family planning and how many for HIV and AIDS.

Maternal and child health products and malaria were overall underserved by this program. USAID redirected its malaria funding from the project because it had another mechanism that was more strategic in malaria prevention and management. There is little information on what was done related to MCH and malaria (there are plans), and sales are so low (835,000 PUR) that this component is inconsequential. ESMPIN budgets are not tracked in detail by funding streams—e.g., by population, MCH—making it difficult to break down activities cost efficiency and impact by activities.

SFH's management of commodities is incomplete. SFH does not track commodities to the end user; instead, how SFH counts "sales" when the product leaves its warehouse and is delivered to the wholesaler's warehouse and a payment is made. There is no way to know if a product has been sold if it is in another warehouse or on shelves in stores or shops. Reporting sales gives an impression that sales are to consumers or users and are higher than they are.

In regard to measuring sales by delivery to warehouses, because that is when money is transferred between the two entities, SFH will not market products on consignment. Because of the 2009 recession, many vendors are not able to buy products to stock their shelves, which closed off access of products to consumers. This raises the question of whether a temporary reversal of that policy would have been a better marketing decision.

ESMPIN did mapping to identify chemists and pharmacies to work with; however, in our spot visits, the majority of the shops either did not carry ESMPIN products or, in those that did, the items were not the least expensive. It was difficult to identify which shops carried ESMPIN products or had received training about FP and MCH products. Increasing outlets results in increased access and organizing the pharmacies and chemists under one franchise model is a good way to do that. Under a social franchise

model, the shops would have received training, marketing, and no stock-outs, which would have benefited them over their competitors.

Technology in this project is underserved. HC3 research shows that 80% of ESMPIN's target audience have mobile phone while only 9% received mobile calls or SMS on FP. BBC Media Action's radio programs and ESMPIN ads were not made available on digital media, such as social media (apps) or web-based technology. IPC apps for healthcare workers developed by USAID projects were not introduced in ESMPIN, and micro-targeting mapping for better marketing of products does not appear to have been used. There are also technologies that can be used to track sales and product movement from wholesalers to shops to consumers that were not used. The project's liaison with Chi talked about the need for Chi to learn about better mapping techniques to know where to place their products. This is a common technique used in HIV and AIDS condom mapping. The ESMPIN technology stops once the commodities went to the wholesalers' warehouse, which makes it difficult to track how long a product is on the retailers' shelves and where it was sold. Because SFH measures its sales from its warehouse to the distribution center, this also explains why its high number of "sales" do not correspond to CYPs or CPR.

ESMPIN has a gender strategy which was implemented, and data collected by the project were disaggregated by sex as described in the program description, but there were no gender-based indicators that would have provided better guidance on the program performance as it relates to gender. In addition, the training modules for PPMVs listed "Gender Issues" as part of the agenda but there was no slide with details of what this means and what is expected of the PPMVs regarding gender.

Overall program recording-keeping, documentation, and financials did not always agree, which made it difficult to track what the program did and its funding.

RECOMMENDATIONS

1. Good research is vital. Before moving ahead with further social marketing interventions, there is a need to conduct several independently led assessments and studies to guide these new interventions. Either prior to awarding the new project, or as an initial phase of the project, consider conducting independently or under the next project three studies: 1) qualitative research among ALL audiences, primary and secondary, stakeholders and individuals; 2) a socio-ecological survey of Nigeria looking closely at social and cultural norms that influence decision-making and acceptance of health systems, including FP and MCH and policies and regulations that are barriers or incentives; and 3) infrastructure and distribution assessment of manufacturers or organization that could be part of social investment or partnership under a new award.
2. The evidence and data from these studies should be the base for the design of all aspects of the new award and future social marketing interventions. Without good data then it is guess work.
3. Social marketing should be designed to be a support to public and private health system strengthening. Without readily available services, the majority of the USAID commodities portfolio cannot be implemented; demand creation (IPC and detailing) should be part of the institutions' capacity and not independent of it to strengthen the overall health system.
4. PPMVs, TBAs, private clinics, and health providers from both public and private sectors are the backbone of a successful behavior change program. Train them, reward them, incentivize them, and support them. They are a trusted source of information and are rooted in the community.

5. PPMCs are prime candidates for social franchising, as are local manufacturers to be recipients of social investment. SHOPS was issuing loans to private companies; loans are a bad cycle to get into. However, investment in local entities is a way to reduce USAID's funding load while building the private sector. One of the goals of the manufacturers' assessment is to identify potential partners and what investment funding would address, such as technologies in warehouses for tracking products, infrastructure improvements, generators, or better equipment.
6. An objective to improving maternal and child health is not the responsibility of one sector or one agency. This is a multisectoral commitment and, as one LGA told the evaluation team, bring in the ministries of education, agriculture, and water. Everyone must be committed to improve health, teach children to read, or raise people and families out of poverty.
7. Establish benchmarks and indicators for gender integration and inclusion to be measured and reported over its lifespan. It would also be useful to have periodic external assessments of gender activities and strategies.

ANNEX I. SCOPE OF WORK

Assignment #: 246 [assigned by GH Pro]

Global Health Program Cycle Improvement Project -- GH Pro

Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 5-26-16

Last update: 9/30/16

I. TITLE: END OF PROJECT EVALUATION OF THE EXPANDED SOCIAL MARKETING PROJECT IN NIGERIA (ESMPIN)

II. REQUESTER / CLIENT

☒ USAID Country or Regional Mission

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

III. FUNDING ACCOUNT SOURCE(S): (CLICK ON BOX(ES) TO INDICATE SOURCE OF PAYMENT FOR THIS ASSIGNMENT)

☐ 3.1.1 HIV

☐ 3.1.4 PIOET

☒ 3.1.7 FP/RH

☐ 3.1.2 TB

☐ 3.1.5 Other public health threats

☐ 3.1.8 WSSH

☐ 3.1.3 Malaria

☒ 3.1.6 MCH

☐ 3.1.9 Nutrition

☐ 3.2.0 Other (specify):

IV. COST ESTIMATE: APPROX. _____ (NOTE: GH PRO WILL PROVIDE A FINAL BUDGET BASED ON THIS SOW)

V. PERFORMANCE PERIOD

Expected Start Date (on or about): September 28, 2016

Anticipated End Date (on or about): April 14, 2017

VI. LOCATION(S) OF ASSIGNMENT: (INDICATE WHERE WORK WILL BE PERFORMED)

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

ESMPIN focused states in Nigeria

- I. **Interpersonal Communication (IPC) Agents:** Lagos, Ogun, Oyo, Cross River, Rivers, Kogi, Ebonyi, Kaduna, Edo, Delta, Enugu, Sokoto, Bauchi, FCT, Imo, Adamawa, Akwa Ibom State;

2. **CBD:** Jigawa, Katsina, **Kebbi** and **Zamfara**.
3. **Social Marketing:** Nationwide

VII. TYPE OF ANALYTIC ACTIVITY (CHECK THE BOX TO INDICATE THE TYPE OF ANALYTIC ACTIVITY)

EVALUATION:

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

☐ Midterm ☒ Endline ☐ Other (specify): _____

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify): _____

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ **Assessment**

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ **Costing and/or Economic Analysis**

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

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

☐ **Process Evaluation** (Check timing of data collection)

☐ Midterm ☐ Endline ☐ Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline

☐ Midterm

☐ Endline

☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Project Title:	Expanded Social Marketing Project in Nigeria (ESMPIN)
Award:	AID 620-A-11-00001
Award Dates:	April 5, 2011- April 4, 2017 (one year no-additional-cost-extension)
Project Funding:	\$57,899,979
Implementing Organization(s):	Society for Family Health (SFH) Prime. Sub awardees: Association for Reproductive and Family Health (ARFH), Population Services International (PSI) and BBC Media Action (BBCMA)
Project AOR:	Kayode Morenikeji

Background of project/program/intervention:

About two-thirds of Nigeria's estimated population of 180 million lives in the rural areas, often lacking the basic modern social amenities and infrastructure, with enormous implications on the quality of life

of majority of the populace. Nigeria has some of the highest maternal and child morbidity and mortality rates in the world; of approximately 8.8 million children that die in the world each year, one million are in Nigeria, and the maternal mortality ratio of 576 per 100,000 live births, according to the 2013 NDHS, also paints a gloomy picture of the poor state of the Nigerian health indices. In Nigeria, the total fertility rate has not dropped significantly between the 2003 and 2013 with only a 0.2 drop from 5.7 to 5.5 children per woman. Fertility rates are highest in rural areas in the North, whereas unmet need for family planning (FP) is highest in the South South and North West.

Despite the relatively high level of awareness of family planning in Nigeria and decades of donor and government funded program efforts, the level of utilization still remains dismally very low. The contraceptive prevalence rate (CPR) among currently married women in 2003 was 8.1% for modern methods (NDHS 2003) and rose to 15% in the 2013 NDHS. However, the MICS 2011 shows CPR to be 17.5% for women currently married or in union. The level of contraception among sexually active young women is particularly low, contributing to the high level of unwanted pregnancy, unsafe abortions and ultimately the high maternal mortality. Disparities in these indices are most apparent between the north and south, but there are differences even between states within the same region.

The health seeking behavior of Nigerian women regarding pregnancy related care remains poor and poses one of the greatest challenges to maternal mortality reduction in the country. Nigeria presents a challenge for health programmers due to its large population, with wide ranging cultural, religious and political contexts. Their health seeking behavior is largely controlled by men. While more than half of the population resides in the north, it is much less densely populated than the south and poses a challenging environment for increasing access to health products and services.

With support from USAID, the Society for Family Health is the prime implementing partner for the ESMPIN project. The six years social marketing project has a nationwide focus on 22 priority states in Nigeria (eleven in the North and eleven in the South) where the much needed community level demand creation activities takes place. The project was designed as follow-on to the Improving Reproductive Health in Nigeria (IRHIN) Project with the goal of expanding the achievements attained under the IRHIN Project, especially the Life of Project CYP.

The overall goal of ESMPIN will be achieved through the following four intermediate result (IR) areas:

- *Sub-objective (IR) 1: Expansion of Access and Availability of varying affordable, high quality modern contraceptive methods, diarrhea and malaria management products widely, through private sector channels.*
- *Sub-objective (IR) 2: Improve knowledge, attitudes, perceptions and practices regarding FP/RH, malaria, MNCH issues at individual, household and community levels, among vendors and private sector health providers through appropriate behavior change communication (BCC) information, education communication (IEC) activities.*
- *Sub-objective (IR) 3: Collaborative partnerships with private health providers. Expanded to include implementing partners, government agencies other relevant stakeholders so that FP/RH, malaria and MNCH social marketing and behavior change communication are widely understood and enthusiastically supported.*
- *Sub-objective (IR) 4: Capability of commercial/private sector in Nigeria to manufacture FP/RH, malaria and MNCH products for social marketing in Nigeria assessed and new product registration or production facilitated.*

ESMPIN contributes to USAID's strategic objective of improving the health of women and children in Nigeria, primarily by increasing the use of modern family planning methods and secondarily, by

increasing use of child health products in Nigeria, utilizing social marketing techniques and behavior change communication (BCC).

Project website: <http://sfhnigeria.org/projects/expanded-social-marketing-project-in-nigeria-esmpin>

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

The Expanded Social Marketing Project in Nigeria (ESMPIN) is implemented by the Society for Family Health (SFH) Nigeria under Cooperative Agreement with United States Agency for International Development (USAID). The social-marketing project is implemented nationwide but focuses on 22 priority states in Nigeria (eleven in the North and eleven in the South). SFH implements ESMPIN in partnership with the Association for Reproductive and Family Health (ARFH), BBC Media Action (BBC MA) and Population Services International (PSI).

ESMPIN contributes to USAID's development objective of improving the health of women and children in Nigeria, primarily by increasing the access and utilization of use of modern family planning methods and secondarily, by increasing use of child health products in Nigeria. ESMPIN's success is measured directly by its Intermediate Result (IR), which is to achieve sustained use of family planning, maternal, neonatal and child health methods and products.

The ESMPIN IR is further divided into four Sub-IRs:

1. Methods and products available, accessible and affordable;
2. Knowledge, attitude, perception and practices of healthy behavior improved;
3. Collaborative partnerships with private health providers sustained; and
4. Capability of the commercial/private sector to locally manufacture health products improved.

ESMPIN is a dual track project which focuses on the social marketing of effective family planning and child survival commodities to improve the health of women and children, while also carrying out interventions to improve the sustainability of the production and availability of these commodities.

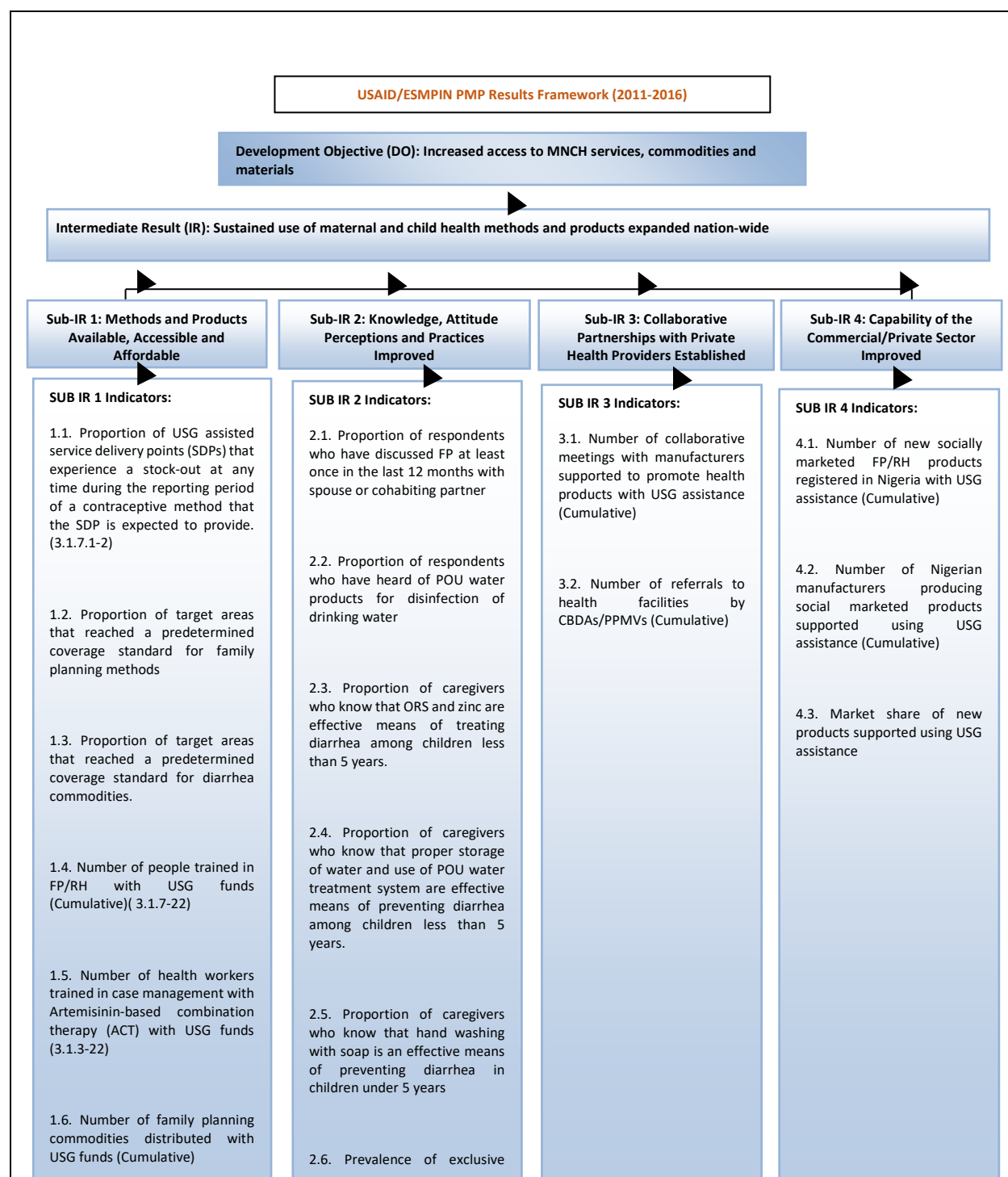
The four intermediate results of ESMPIN's work in synergy in delivering the program outcome. The first works to improve access to affordability of essential health products that either prevent disease or effectively treat primary health care ailments. In so doing, the use of these products reduces both child and maternal mortality and improves the quality of life of persons that use them. ***The strategy is based on the Theory of planned Behavior. It is expected that this strategy will improve the self-efficacy to carry out known actions through the improved access to required commodities.***

The second focuses on demand creation directly. It recognizes that health-related information, motivation to change, and behavioral skills are important determinants of whether or not a healthy behavior is performed. Based this, it focuses on ensuring that appropriate information is conveyed to the people who require these commodities to improve their health status. Methods used include both mass media and community level interpersonal communications. ***It is expected that the twin interventions of (1) improving access and (2) increasing demand will lead to better adoption of health behavior.*** Targets for these two interventions include increasing family planning

utilization and increasing the adoption of recommended child health practices (e.g. exclusive breastfeeding, sanitary practices and the appropriate treatment of diarrhea using of ORS/Zinc)

The third and fourth intermediate results aim to ensure that the private sector contributes to the health of the citizens. Through this the private health sector is targeted initially by ensuring that the pharmaceutical production industry is able to produce required health commodities and later, by ensuring that the lower retail aspect of the pharmaceutical industry is able to meaningfully contribute to provision of appropriate health care in the hard-to-reach areas of the country.

Strategic or Results Framework for the project/program/intervention



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

ESMPIN focus states in Nigeria:

1. **BCC: Lagos, Ogun, Oyo**, Cross River, Rivers, Kogi, Ebonyi, Kaduna, Adamawa, Edo, Delta, Enugu, Bauchi, **Sokoto**, FCT, Imo & Akwa Ibom State
2. **CBD: Jigawa, Katsina Kebbi and Zamfara.**
3. **Social Marketing: Nationwide.**

IX. SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this endline evaluation is to evaluate the Expanded Social Marketing Project in Nigeria (ESMPIN) project; the evaluation will further seek to determine the cost effectiveness and sustainability of ESMPIN's approaches, interventions and innovations in promoting behavioral changes amongst women of reproductive age, and assess their ability in stimulate greater private sector involvement in demand generation for family planning services and MCH services. The evaluation will utilize the findings as learning and in the development of future private sector focused FP/MCH follow on project designs.

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The findings of the evaluation will primarily benefit USAID/Nigeria as they prepare to design a follow on private sector FP/MCH project. The findings will be disseminated and significantly benefit the respective ESMPIN focus state governments, other focal donors and civil society organizations that have interest and investments in these states. Secondary users will include:

- USAID Washington – who will support the Nigeria Mission and utilize the data for designing new programs of a similar nature
- The Government of Nigeria (Federal Ministry of Health) – who will better understand the lessons learned from private sector involvement in supporting the provision of FP/MCH services in Nigeria;
- ESMPIN focus states – who will have more information on best practices and lessons learned and what will work best in their local context; and how best to use and leverage existing resources to increase the provision of FP/MCH services;
- Other donors and partners working in ESMPIN focus states – who will better understand the context within which they work; and this may inform reprogramming and possibly, change in their project(s) focus;
- ESMPIN Project and other private sector health improvement projects – Other private sector health improvement projects would use results disseminated for mid-courses changes in their projects

C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

The evaluation findings will provide information to USAID Nigeria's HPN office in facilitating advocacy for future Public Private Partnerships (PPP) and greater private sector focused engagement by the

Government of Nigeria. The findings will also give the national and state governments insights into where current gaps exist in Family Planning programming, thus stimulating appropriate government response and engagement with key stakeholders.

D. Evaluation/Analytic Questions & Matrix:

- a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**
- b) List the recommended methods that will be used to collect data to be used to answer each question.
- c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

	Evaluation Question	Research Methods	Application or Data Use
1	To what extent were ESMPIN's strategies effective in increasing the use of modern contraceptives (disaggregated by type of contraceptive provided) ORS/Zinc and point-of-use water products for the management and prevention of childhood diarrhea in supported sites?		
2	To what extent were ESMPIN's Social Marketing, IPC, and CBD interventions sustainable? NOTE: The mission defines sustainability as the ability of SFH to maintain the services that have been offered under the USAID grant without donor support, at the level provided under that grant		
3	To what extent were ESMPIN's activities effective in ensuring that socially marketed commodities filled the affordability, accessibility, and		

	Evaluation Question	Research Methods	Application or Data Use
	availability gaps in their focused communities and markets, as opposed to competing with or replacing independently viable private sector commodities?		
4	To what extent were ESMPIN's strategies cost effective; could ESMPIN have explored and utilized alternative and innovative cost effective strategies that have potentials of increase uptake of Family planning and childhood products and services within the private sector?		
5	To what extent did the ESMPIN's project activities incorporate gender programming during the life of the project and what effects did it have in increasing uptake of Family Planning and MNCH services in ESMPIN supported sites?		

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions lead to an ineffective evaluation.)

- E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods:

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

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

1. ESMPIN cooperative agreement and/or program description
2. ESMPIN Baseline reports
3. ESMPIN Annual Work plans
4. Past program evaluation reports
5. ESMPIN quarterly and annual performance reports
6. PMP/Results Framework and existing indicator data
7. Gender analyses report (GH Pro 102)
8. Nigeria DHS, MIS (http://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=30&c=Nigeria&Country=Nigeria&cn=&r=1) and Nigeria MICS (https://mics-surveys-prod.s3.amazonaws.com/MICS4/West%20and%20Central%20Africa/Nigeria/2011/Final/Nigeria%202011%20MICS_English.pdf)
9. Nigeria SBCC Private Sector report (GH Pro 151)
10. Nigeria SBCC multi sector report (GH Pro 137)
11. Other relevant document not listed

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

USAID will arrange access to DHIS-2, PRS and ESMPIN datasets, as needed.		
Data Source (existing dataset)	Description of data	Recommended analysis
District Health Information System (DHIS-2)	Service statistics being reported through the national Health Management Information System (HMIS)	Uptake of family planning and maternal and Child health services after ESMPIN project began.
ESMPIN Internal database	This is housed in ESMPIN and documents all data beyond USAID expectations	Routine statistics documenting uptake of services
USAID Performance Reporting Systems (PRS)	USAID Database: It's the data reporting platform where USAID implementing partners report quarterly data to the mission.	Uptake of family planning and maternal and Child health services after ESMPIN projects began.

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

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

1. USAID/Nigeria Staff
2. ESMPIN project staff
3. Other Family Planning focused USAID Implementing Partners such as SHOPS and FH+ projects
4. Federal Ministry of Health, State Ministries of Health (SMOH) Officials
5. Service Providers from ESMPIN-supported facilities, including Wholesalers, retailers, PPMVs, CBDs, and Private Health Facilities.

6. LGA authorities and other relevant stakeholders identified in project documentation and interviews
7. Nigerian GH Pro consultants who worked on SBCC and Gender assessments/analyses

The key informants constitute stakeholders who have active contacts with the SHOPS project. The purpose of this data collection method is to obtain these key stakeholders perspectives and views of the SHOPS project and their performance. It will provide the evaluation team an opportunity to state the strengths and weakness of the project and their views on what can be focused on during the design of future private sector focus FP/MCH projects.

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

The purpose of this method would be to inquire if FP and MCH clients perceive gaps in ESMPIN's support to health facilities and if they can propose solutions that can improve the quality of service delivery for future follow on projects. If men and women participate in FGDs, the group discussion will be conducted separately for men and women, to adjust for the potential power differential between men and women, and to assure women's voice is heard equally to men. We are proposing that 2 groups be selected for the FGDs, those that attend and those that do not attend ESMPIN supported sites, this will give insights why they attend and don't prefer to attend ESMPIN sites.

1. Family Planning Clients
2. Maternal & Child Health Clients

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

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

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

Selected clients from ESMPIN supported health facilities and CBDs

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

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

Project expenditure data and related information to determine cost, and areas of project implementation where ESMPIN has expended funds.

☐ **Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

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

The Team will observe at select ESMPIN supported services and activities, including FP IPC and CBD. Observations and selected sites will be determined during the TPM.

☐ **Data Abstraction** *(list and describe files or documents that contain information of interest, and purpose of inquiry)*

☐ **Case Study** *(describe the case, and issue of interest to be explored)*

☐ **Verbal Autopsy** *(list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)*

☐ **Rapid Appraisal Methods** *(ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)*

☐ **Other** *(list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)*

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ☐ No

List or describe case and counterfactual”

Case	Counterfactual

X. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interviews data, or a descriptive analysis of quantitative survey data.

The Evaluation Team will develop an analysis plan and review with USAID/Nigeria for inputs. It is expected that the analysis plan will include analysis of qualitative data derived from **Key Informant Interviews, Focus Group Discussions** and **Client/Participant Satisfaction or Exit Interviews**. **For quantitative data basic descriptive statistics and minimal level inferential statistics are expected.**

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run if appropriate.

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

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

XII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background Materials Review: Prior to conducting field work, the evaluation team will review background materials such as ESMPIN Program Descriptions, annual work plans, Performance Management Plan, technical and training materials, past program evaluation reports quarterly and annual performance reports and other documents related to the project. The Mission will provide these to the team as soon as possible and if possible, prior to the team's arrival to Abuja. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

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

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

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

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting, a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (*Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **Stakeholders' debrief/workshop** will be held with the ESMPIN staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID. USAID may request debriefs with the States. This will be discussed during the TPM.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits for data collection to the proposed states of Lagos, Oyo, Ondo, Zamfara, Kebbi, and Sokoto. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field, with the support of USAID and the project staff in identifying key actors. GH Pro evaluation team and USAID/Nigeria staff will jointly randomly select the BCC, PPMVs and referral SDPs states to be visited during the Team Planning meeting and jointly conduct field visits to the selected service delivery points (SDPs)/health facilities in the project's selected LGAs in focus states, and to selected communities in which the project operated to observe the activities of collaborating private sector partners: the team may also select appropriate state-level health decision-makers to determine their knowledge of the project. Selection of states and SDPs will be by simple random sampling excluding states with security concerns for safety reasons. The evaluation team will conduct interviews with key informants from other selected USAID Implementing Partners (including SHOPS and FH+, USAID/Nigeria, State Ministry of Health's, Local Government Areas authorities and other relevant stakeholders identified in project documentation and interviews.

Internal Procurement Memo – The Evaluation Team will develop an internal memo to capture the procurement sensitive and SBU information developed during the evaluation team. It will be submitted to the USAID management team with the first draft evaluation report. Procurement sensitive information from the evaluation will be removed and included in the internal memo for USAID's use. The documented will not be edited or formatted.

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

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

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

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

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

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	October 4, 2016
■ In-brief with USAID	October 24, 2016
■ Workplan and methodology briefing	October 26, 2016
■ Workplan with timeline	October 28, 2016
■ Analytic protocol with data collection tools	October 2016
■ In-brief with target project	October 31, 2016
■ Routine briefings	Weekly
■ Out-brief with USAID with Power Point presentation	November 23, 2016
■ Findings review workshop ESMPIN with Power Point presentation (TBD during TPM)	November 25, 2016
■ Draft report	Submitted to GH Pro: January 3, 2017 GH Pro submits to USAID: January 6, 2017
■ Internal Memo	Submitted to GH Pro: January 3, 2017 GH Pro submits to USAID: January 6, 2017
■ Final Draft report	Submitted to GH Pro: February 1, 2017 GH Pro submits to USAID: February 6, 2016
■ Final report	March 6, 2017

■ Raw data (cleaned datasets in CSV or XML with data dictionary)	February 1, 2017 (with Final Draft Report)
■ Report Posted to the DEC	March 22, 2017

Estimated USAID review time

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

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the subject are focus
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

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

The evaluation team will consist of 1) FP/MCH Specialist 2) Evaluation Specialist 3) SBCC/Social Marketing and 4) Costing Specialist. Additionally, 2 Logistics/Admin who will also serve as research assistants. The Team Leaders should be selected from the team, the team members should also be a mix of international or qualified local, with relevant skills and capacity, and no link to the ESMPIN project) The team members should represent a balance of expertise in conducting rigorous evaluations, technical expertise related to FP-MCH service delivery in general and in the private sector in particular including, health services planning and programming, as well as private sector approaches to health service delivery.

The evaluation team members must have significant national/international health program experience. They should have some Nigeria country or African regional experience, along with comparative experience in FP-MCH service delivery in developing countries. At least one member of the team must have demonstrable **expertise in social marketing, private sector and sales; family planning services, additional /complementary expertise in social behavioral change communication and media are highly recommended.**

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

Each evaluation team member is expected to have an advanced degree in health management, health finance, public health or a closely related field. Demonstrable expertise in monitoring and evaluation; FP services, community mobilization, behavior change communications; and service delivery research are highly recommended.

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

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

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

Qualifications:

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

Key Staff I Title: FP/RH + MCH Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in FP/RH. She will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 8 years' experience with FP/RH and MCH projects; USAID project implementation experience preferred
- Expertise in supply and demand for FP and MCH services
- Experience working on gender integration and/or transformation is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 2 Title: Evaluation Specialist: It will either be the International Team Leader or one of the two local team members, depending on qualifications and demonstrated experience in M&E and methodological design.

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

Qualifications:

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

Number of consultants with this expertise needed: _____ | _____

Key Staff 3 Title: Social Marketing & SBCC Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate BCC demand generation activities. S/he will provide technical expertise on behavior change and demand generation for FP/RH and MCH services. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- At least 10 years of experience working with social marketing and BCC programs in developing country settings
- Experience should include mass media, community-based interventions, and interpersonal communications (IPC)
- Experience working with formal and non-formal private sector networks, including NGOs regarding commodity sales and distribution
- Experience in social marketing and demand generation for FP/RH and MCH commodities, including long acting and reversible contraceptives and ORS, as well as other products and services (e.g., TB control, WASH, and MNCH and other health programs)
- Knowledgeable about the business side of social marketing
- Experience and knowledgeable on evaluation methodologies related to social marketing and BCC
- Experience working in private sector health service delivery project preferred
- Experience in implementing and/or evaluating capacity-strengthening activities within social marketing programs is desirable
- Good writing skills, with experience producing evaluation and/or technical reports

Key Staff 4 Title: Health Economist (Costing Expert)

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate the cost efficiency, as part of the evaluation. S/he will provide technical expertise for the expenditure and value for money analysis. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- At least 5 years of experience working with cost analysis in developing country settings context
- Experience should include in depth in understanding of evaluating programs from a cost efficiency perspective
- Experience working with projects to extracted expenditure data, including categorizing these expenditures into useful categories of project implementation
- Experience assessing value for money on health and development projects
- Experience assessing areas for priority investment, and whether money is being spent where it should be in order to maximize desired results
- Experience with USAID health programs
- Experience working with formal and non-formal private sector networks, including NGOs regarding commodity sales and distribution, is desirable

- Experience in social marketing and demand generation for FP/RH and MCH commodities, including long acting and reversible contraceptives and ORS, as well as other products and services (e.g., TB control, WASH, and MNCH and other health programs), is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, with experience producing evaluation and/or technical report

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

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

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

☐ Yes – If yes, specify who:

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

☐ No

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

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

- e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

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

Activity / Deliverable		Evaluation Team				
		SBCC Specialist /Team Leader	Evaluation Specialist	FP/ MCH Specialist	Costing Specialist	Logistics / Program Assist
Number of persons →		1	1	1	1	2
1	Launch Briefing	0.5				
2	Desk review	5	5	5	5	2
3	Preparation for Team convening in-country	0.5				3
4	Travel to country	2				
5	Team Planning Meeting	3	3	3	3	3
6	In-brief with Mission	0.5	0.5	0.5	0.5	0.5
7	Workplan and methodology review briefing	0.5	0.5	0.5	0.5	0.5
8	In-brief with ESMPIN	0.5	0.5	0.5	0.5	0.5
9	Data Collection DQA Workshop (protocol orientation for all involved in data collection)	3	3	3	3	3
10	Prep/Logistics for Site Visits	1	0.5	0.5	0.5	2
11	Data collection / Site Visits (including travel to sites)	15	15	15	15	15
12	Data analysis	5	5	5	5	3
13	Debrief with Mission with prep	1	1	1	1	1
14	Depart country	1		1		
15	Draft report(s)	8	6	6	6	1
16	GH Pro Report QC Review & Formatting					
17	Submission of draft report(s) to Mission					
18	USAID Report Review					
19	Revise report(s) per USAID comments	3	2	2	2	

20	Finalize and submit report to USAID	0.5				
21	508 Compliance Review					
	Upload Eval Report(s) to the DEC					
	Total LOE per person	50	42	42	42	34.5
	Total LOE	50	42	42	42	69

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

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

It is anticipated that the evaluation will take place in 4 of the twenty-two ESMPIN states which will be randomly selected by the team leader. Exclusion criteria would be states that have security concerns

XV. LOGISTICS

Visa Requirements

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

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

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

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it.

GH Pro does not provide Security Clearances, but can request **Facility Access**. Please note that Facility Access (FA) requests processed by USAID/GH (Washington, DC) can take 4-6 months to be granted. If you are in a Mission and the RSO can grant a temporary FA, this can expedite the process. If FA is granted through Washington, DC, the consultant must pick up his/her FA badge in person in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant must complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (must register approximately 3-4 months in advance). Additionally, there will be the cost for one week's lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- ☐ USAID Facility Access (FA)
Specify who will require Facility Access: _____
- ☐ Electronic County Clearance (ECC) (International travelers only)
☐ High Threat Security Overseas Seminar (HTSOS) (required with ECC)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)
- ☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____
- ☒ Travel -other than posting (specify): _____
- ☐ Other (specify): ECC is not required, but travel itineraries should be shared with Mission

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
 - o Develop SOW.
 - o Peer Review SOW
 - o Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

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

XVIII. ANALYTIC REPORT

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

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- a. The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).

- b. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The preliminary findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 2 pages);
- Table of Contents (1 page);
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions (1-2 pages)
- Project [or Program] Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings
- Conclusions
- Recommendations (17-20 pp total for FCR)
- Issues (1-2pp)
- Future Direction (2-3pp)
- Annexes
 - Annex I: Evaluation/Analytic Statement of Work
 - Annex II: Evaluation/Analytic Methods and Limitations
 - Annex III: Data Collection Instruments
 - Annex IV: Sources of Information
 - o List of Persons Interviews
 - o Bibliography of Documents Reviewed
 - o Databases, [etc.]
 - Annex V: Disclosure of Any Conflicts of Interest
 - Annex VI: Statement of Differences [if applicable]

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

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

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

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

XIX. USAID CONTACTS

	Primary Contact	Alternate Contact
Name:	Ikenyei Uche Chukwuka	Kayode Morenikeji
Title:	M&E Specialist	AOR ESMPIN
USAID Office/Mission	USAID/Nigeria HPN Unit	USAID/Nigeria
Email:	uikenyei@usaid.gov	kmorenikeji@usaid.gov
Telephone:	+23494619397	+23494619383
Cell Phone (optional)	+2348102484508	+2348033177096

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report [OPTIONAL]

	Technical Support Contact 1	Technical Support Contact 2
Name:	Gertrude Odezugo	Celeste Carr
Title:	Maternal and Child Health Manager	Private Sector Lead
USAID Office/Mission	HPN/Nigeria	HPN/Nigeria
Email:	godezugo@usaid.gov	ccarr@usaid.gov
Telephone:	+2348102484364	
Cell Phone (optional)		

XX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, those are not listed above

--

EVALUATION DESIGN MATRIX

This design matrix may be helpful for connecting your evaluation methods to questions. Often more than one method can be employed in analytic activity to obtain evidence to address more than one question. A method should be listed by question when it will include specific inquiries and/or result in evidence needed to address this specific question.

Evaluation Matrix

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
To what extent were ESMPIN's strategies effective in increasing the use of modern contraceptives (disaggregated by type of contraceptive provided) ORS/Zinc and point-of-use water products for the management and prevention of childhood diarrhea in supported sites?	• Modern method Contraceptive Rate • CYP • Number of commodities (FP, ORS and Zinc) distributed with USG funds • Number of new/revisit acceptors • Number of people trained in FP/RH with USG funds • Number of referrals to health facilities by CBDAs/PPMVs •	1. Key Informant Interviews 2. Focused Group Discussion 3. Review of Program documents 4. HMIS data/DHIS & USAID PRS		1. Qualitative analytical approaches 2. Descriptive Statistics
To what extent were ESMPIN's Social Marketing, IPC, and CBD interventions sustainable? NOTE: The mission defines sustainability as the ability of SFH to maintain the services that have been offered under	• Proportion of audience who recall hearing or seeing a specific USG-supported FP/RH message • Proportion of respondents who have discussed FP at	1. Key Informant Interviews 2. Focused Group Discussion 3. Review of Program documents 4.		1. Qualitative analytical approaches 2. Descriptive Statistics

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
the USAID grant without donor support, at the level provided under that grant	least once in the last 12 months with spouse or cohabiting partner			
To what extent were ESMPIN's activities effective in ensuring that socially marketed commodities filled the affordability, accessibility, and availability gaps in their focused communities and markets, as opposed to competing with or replacing independently viable private sector commodities?	- Percentage of USG-assisted service delivery points (SDP) that experience a stock out at any time during the reporting period of a contraceptive method that the SDS is expected to provide - Number of commodities (FP, ORS and Zinc) distributed with USG funds - Proportion of target areas that reached a predetermined coverage standard for family planning method, and diarrhea commodities - Market share of new products supported using USG assistance - Number of Nigerian manufacturers	- Key Informant Interviews - Focused Group Discussion - Review of Program documents		I. Qualitative analytical approaches.

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis Method
	producing social marketed products supported using USG assistance			
To what extent were ESMPIN's strategies cost effective; could ESMPIN have explored and utilized alternative and innovative cost effective strategies that have potentials of increase uptake of Family planning and childhood products and services within the private sector?	• Review IPs document for gender related strategies • Number of service providers trained by gender • Number of women (new Acceptors) receiving a method of FP from participating private Providers	4. Key Informant Interviews 5. Focused Group Discussion 6. Review of Program documents 7. HMIS data/DHIS & USAID PRS		1. Qualitative analytical approaches 2. Descriptive Statistics

ANNEX II. EVALUATION METHODS AND LIMITATIONS

GH PRO Evaluation Workplan

Date: 26 October 2016

Title: 246 – Nigeria ESMPIN Evaluation

Dates of Evaluation Implementation: October 24, 2016 – March 6, 2017

Purpose

1. To determine the cost effectiveness and sustainability of ESMPIN's approaches, interventions, innovations in promoting behavioral changes among women of reproductive age
2. Assess their ability in stimulate greater private sector involvement in demand generation for family planning services and MCH services
3. To use findings in the development of future private sector focused FP and/or MCH projects

Evaluation Questions

1. To what extent were ESMPIN's strategies effective in increasing the use of modern contraceptives (disaggregated by type of contraceptive provided) ORS/Zinc and point-of-use water products for the management and prevention of childhood diarrhea in supported sites?
2. To what extent were ESMPIN's Social Marketing, IPC, and CBD interventions sustainable? [**NOTE:** USAID/Nigeria defines sustainability as the ability of Society for Family Health to maintain the services that have been offered under the USAID grant without donor support, at the level provided under that grant.]
3. To what extent were ESMPIN's activities effective in ensuring that socially marketed commodities filled the affordability, accessibility, and availability gaps in their focused communities and markets, as opposed to competing with or replacing independently viable private sector commodities?
4. To what extent were ESMPIN's strategies cost effective; could ESMPIN have explored and utilized alternative and innovative cost effective strategies that have potentials of increase uptake of Family planning and childhood products and services within the private sector?
5. To what extent did the ESMPIN's project activities incorporate gender programming during the life of the project and what effects did it have in increasing uptake of Family Planning and MNCH services in ESMPIN supported sites?

Target audience(s) for this evaluation

1. USAID/Nigeria – Global Health Nutrition and Population technical and management team of ESMPIN and that will design future Maternal and Child Health projects
2. USAID/Washington – Global Health, Nutrition and Population will support USAID/Nigeria and utilize the data and evaluation findings in designing new RHFP MCH awards.
3. The Government of Nigeria (Federal Ministry of Health) will understand and support the involvement of the private sector in sustainability of FP and MCH services in Nigeria

4. Donor community in informing collaborative programming and strategy in similar public health focus
5. Contractors and civil society that specialize in public health service delivery with a private sector component

Team Members:

Name	Role	Responsibilities
Dee Bennett	Team Leader SBCC and Social Marketing	• Provide team leadership • Managing team's activities • Ensuring that all deliverables are met in a timely manner, • Serve as a liaison between USAID and the evaluation/analytic team • Lead briefings and presentations • Provide technical expertise on social and behavior change, demand generation and social marketing for FP/RH and MCH services.
Sa'adatu Talatu Sule	FP-MCH Specialist	• Provide expertise in FP/RH. • Participate in: • planning and briefing meetings • data collection • data analysis • development of evaluation presentations • writing of the Evaluation Report.
Ayodeji Omotayo Olugbemi	Evaluation Specialist	• Provide quality assurance on evaluation issues • Train data collectors • Participate in: ○ planning and briefing meetings ○ development of data collection tools and protocols ○ data collection ○ data analysis ○ development of evaluation presentations ○ Writing of the Evaluation Report.
Awolaye Joshua Olatunji	Program Assistant/Logistics	Conduct all logistics and administrative activities needed on the evaluation. • Participate in: ○ planning and briefing meetings ○ data collection ○ Data analysis and interpretation ○ development of evaluation presentations
Augustine Yusuf Longjo	Program Assistant/Logistics	Conduct all logistics and administrative activities needed on the evaluation. • Participate in: ○ planning and briefing meetings ○ data collection ○ Data analysis and interpretation ○ development of evaluation presentations

Methodology (provide list with brief descriptions):

Methods:

Literary Audit of Secondary Research and Documentation. ESMPIN documents that include, program description, Performance Monitoring Plan (PMP), annual workplans, quarterly and annual reports, study reports and program evaluations. This audit will provide information on the program's activities, rationale, and approach as well as data for analysis that can be used for the evaluation.

Secondary Analysis of Existing Data. Secondary data includes District Health Information System (DHIS-2), ESMPIN internal database and USAID Performance Reporting Systems (PRS), and Nigeria Demographic and Health Survey (DHS) will be reviewed to provide data on uptake of family planning and maternal and child health services before and during ESMPIN.

Key Informant Interviews (KIIs). Discussion guides will be developed and administered to key stakeholders (USAID/Nigeria, Government of Nigeria Officials in the Ministry of Health, and ESMPIN technical and operations staff. Interviews will be held with program partners and implementers including PPMVs, Community Based Distributors (CBDs), detailers, distributors, health care workers, and wholesalers) involved in the implementation of the ESMPIN Project to obtain their perspectives and views of the ESMPIN project and its performance. The method will provide information that will enable the evaluation team to state the strengths and weakness of the project and focus and direction for future projects in FP/MCH.

Focus Group Discussions (FGDs). FGD guides will be developed and administered to men and women of reproductive age to determine FP and/or MCH clients use and allegiance to ESMPIN health facilities and from these discussions identify gaps to be addressed or successes that can be enhanced to overall improve the quality of service. Separate FGD will be conducted for men and women. The respondents will be separated into those that attend ESMPIN-supported clinics and those that do not. this will determine if there is a preference for or an identified difference between EXMPIN and non-ESMPIN sites.

Exit Interviews. Structured questionnaire will be developed and administered to clients after they receive service at ESMPIN supported facilities and CBD. This is for insights into whether there is a quality of FP/MCH services received and the client's satisfaction with the services.

Cost Analysis. ESMPIN project budget, additional outside funding, and available expenditure data will be reviewed to determine the cost effectiveness of project implementation

Observations. Structured questionnaires will be developed and used to observe FP and MCH service provision in selected ESMPIN supported facilities and CBD sites

Evaluation Matrix

	Evaluation Question	Information Required and Source(s)	Methodology	Sample	Limitations	Data Analysis	What will this evaluation allow the evaluator to say
	<i>What questions is the team trying to answer?</i>	<i>What information is needed to address each question? Where will they get this information?</i>	<i>How will the team answer each evaluation question?</i>	<i>What is the criteria for site sample selection? From who and in what locations?</i>	<i>What are the design's limitations and how will it affect the evaluation?</i>	<i>How will the data be managed and analyzed?</i>	<i>What are the expected results of the work?</i>
I	To what extent were ESMPIN's strategies effective in increasing the use of modern contraceptives (disaggregated by type of contraceptive provided) ORS/Zinc and point-of-use water products for the management and prevention of childhood diarrhea in supported sites?	Information Needed <i>Normative</i> Source: - Project strategy implementation reports - Routine Service data - DHS and MICS report	1. Key Informant Interviews 2. Focused Group Discussion 3. Review of Program documents 4. HMIS data/DHIS & USAID PRS 5. Review of secondary data	South and North differences For LGA selection, used criteria of senatorial district Locations where activities took place. For IPC, included 1st and 10th cycles purposefully to show if the tempo of result was sustained after the 1st cycle.	Time Constraint None Availability of key informants, documents and data How: Not getting enough information that could support the findings	- Quantitative and Qualitative analytical approaches - Trend Analysis	- Effectiveness of services - Quality of services provided - Whether there was an increase in the uptake of services

	Evaluation Question	Information Required and Source(s)	Methodology	Sample	Limitations	Data Analysis	What will this evaluation allow the evaluator to say
				Proximity			
2	To what extent were ESMPIN's Social Marketing, IPC, and CBD interventions sustainable? NOTE: The mission defines sustainability as the ability of SFH to maintain the services that have been offered under the USAID grant without donor support, at the level provided under that grant	Information Needed: <i>Descriptive</i> Source: Project strategy implementation reports Cost analysis for profit margin or break-even status Product graduation Expansion of market and engagement of private sector via MOUs, Ltrs of Agreement, partnerships	Cost analysis of OH, marketing and distribution costs, and returns Sustainability Plan Key informant interviews	Same as above	Same as above	- Quantitative and Qualitative analytical approaches Cost analysis	The overall sustainability of this social marketing approach and whether the returns justify the cost and other resources
3	To what extent were ESMPIN's activities effective in ensuring that socially marketed commodities filled the affordability,	Information Needed Normative Source: - Project strategy	- Willingness to pay and ability to pay surveys - Focused Group Discussion	Same as Above	Same as above	- Quantitative and Qualitative analytical approaches - Descriptive Statistics	Pricing viability of ESMPIN products for affordability and sustainability

	Evaluation Question	Information Required and Source(s)	Methodology	Sample	Limitations	Data Analysis	What will this evaluation allow the evaluator to say
	accessibility, and availability gaps in their focused communities and markets, as opposed to competing with or replacing independently viable private sector commodities?	implementation reports - Routine Service data - DHS and MICS report	with male and females - Exit interviews Review of Program documents - HMIS data/DHIS & USAID PRS - Review of secondary data			- Market reports	
4	To what extent were ESMPIN's strategies cost effective; could ESMPIN have explored and utilized alternative and innovative cost effective strategies that have potentials of increase uptake of Family planning and childhood products and services within the private sector?	Information Needed Descriptive ESMPIN budget and expenditure reports on each strategy Routine service data project implementation reports	- Cost Analysis - Key Informant Interviews - Focused Group Discussion - Review of Program documents	Same as above	Same as above	Qualitative and quantitative analytical approaches Descriptive Statistics Program approach	M&E of the innovations for effectiveness (memorable, sustainable, doable) and cost Return on investment

	Evaluation Question	Information Required and Source(s)	Methodology	Sample	Limitations	Data Analysis	What will this evaluation allow the evaluator to say
5	To what extent did the ESMPIN's project activities incorporate gender programming during the life of the project and what effects did it have in increasing uptake of Family Planning and MNCH services in ESMPIN supported sites?	Information Needed Descriptive Source: Review IPs document for gender related strategies SBCC strategies, messages, and design on gender Project strategy implementation reports Routine Service data	1. Key Informant Interviews 2. Focused Group Discussion 3. Review of Program documents 4. Mass media and SBCC activities	Same as above		Qualitative analytical approaches Descriptive Statistics	Use of gender in non-traditional roles in advertising and community outreach Gender a major component in IPC training and detail training A gender component in ESMPIN design ESMPIN staff – gender equity

Main data sources and evaluation questions

To adequately address the five evaluation questions and generate reliable evidence for this evaluation, eight major sources of secondary and primary data have been identified and would be consulted and explored. Table 2 present a matrix that link the different data sources with the evaluation questions. The information that will be obtained from these sources would help to highlight and present the outcomes of the project. Information from the evaluation will give insights into ESMPIN that should be considered in the design of future funding. These sources of information consist of the following:

1. ESMPIN project design, work plans and quarterly and annual reports
2. Research Studies
 - a. Nigeria Gender Assessment Report
 - b. Nigeria BCC Strategy across USAID's Health Portfolio
 - c. Nigeria SBCC Private Sector Assessment
 - d. ESMPIN Baseline Report
 - e. Barriers and Drivers of Modern Contraceptives Report
3. Population-based surveys
 - a. NDHS 2013
 - b. MICS report
4. Routine data
 - a. DHIS2 data
 - b. USAID Performance Reporting System (PRS)
 - c. ESMPIN PMP targets and Achievements
5. National, state and local key informant interviews with
 - a. ESMPIN Technical and Financial Staff and Partners
 - i. PSI
 - ii. ARFH
 - iii. BBC Media
 - b. FMOH staff – DPRS, Reproductive Health Division (Family Planning), Child Health, Health Promotion
 - c. HC3
 - d. USAID technical staff
 - e. NURHI
 - f. SHOPS
 - g. Detailers
 - h. Health Providers
 - i. Patent and Proprietary Medicine Vendors (PPMV)
 - j. Distributors
 - k. Community-based Distributors (CBD)
6. Exit Interviews with patients
7. Focus group discussions
 - a. Women of reproductive age and care givers who use ESMPIN supported facilities
 - b. Men who use ESMPIN supported facilities
 - c. Women of reproductive age and care givers not using ESMPIN supported facilities
 - d. Men not using ESMPIN supported facilities
8. Facility Assessment

9. ESMPIN Financial Reports and Budgets

Matrix of data sources and evaluation questions

Evaluation Approach

The endline evaluation will utilize mixed methods approach to address all the questions in this study as mentioned earlier. These will include literary review and desk audit of ESMPIN's overall approach, M&E reports, government of Nigeria's Family Planning and Maternal and Child Health (FP/MCH) policies and regulations. Also reviewed will be national surveys such as NDHS, MIS, MICS, cooperative documents

S/N	Data Sources	Evaluation Questions				
		Q1: Uptake of service (FP, ORS, Zinc)	Q2: Sustainability of Social Marketing Strategy	Q3: Affordability, Accessibility, and Availability of commodities	Q4: Cost effectiveness	Q5: Gender
1.	Project docs-Work plans & reports	x	X	x	x	x
2.	Research Studies	x	x	x		x
3.	Surveys	x		x		
4.	Routine data	x		x		x
5.	Key informant interviews	x	x	x	x	x
6.	Exit Interviews	x	X	x	x	x
7.	Focus group discussions	x	X	x	x	x
8.	HF assessment	x		x		
9.	Financial Record				x	

and DQA reports and any other relevant reports and documents. In addition, there would be analysis of existing DHIS and Performance Reporting System (PRS) data, key informant in-depth interviews (KII) with ESMPIN staff, partners, government and beneficiaries of the ESMPIN project. There would also be focus group discussion sessions among groups of men and women from men and women who use ESMPIN supported facilities and those that did not use ESMPIN supported facility other methods would involve health facility assessment and exit interviews at selected communities among beneficiaries in the states. The above table presents project objectives, evaluation questions and proposed methodology that would be utilized to evaluate each project objective.

Evaluation methodology

Evaluation design

The evaluation will be mixed method design using both quantitative and qualitative methodologies. For the quantitative study, a facility assessment will be undertaken in health facilities in selected Local Government Authorities (LGA) while the qualitative component will employ focus group discussion sessions (FGDs) among men and women in various communities, as well as key in-depth interviews

(KIs) with project implementers, partners and identified stakeholders. Health personnel also will be interviewed, and exit interviews will be conducted among clients after they have received services

Study location

The evaluation would be conducted in six out of the 22 priority intervention states. The states are Lagos, Oyo, Ogun, Sokoto, Zamfara and Kebbi that represent three in the north and three in the south. The states were purposively selected by USAID/Nigeria based on close proximity among selected states in these geographic regions, the perceived difference between results in the two regions and the fact that the CBD strategy was only implemented in the northern region. To achieve spread and geographical representation in the selected states, one LGA was randomly selected from each of the three Senatorial Zones in the four states (Oyo, Lagos, Ogun and Sokoto) implementing Interpersonal Communication (IPC) and social marketing activities. This yielded 12 LGAs (21% out of a total number of 56 LGAs in four states). For the two states, Kebbi and Zamfara implementing CBD and social marketing six LGAs were randomly selected which represents 20% of the LGAs in the two state. At the LGA level two communities were identified based on where the intervention took place. One referral supported health facility would be selected per community for the assessment; two PPMVs, two CBDs, two detailers and two other sites in each community where commodities are distributed to clients would be identified and included in the survey (Table 4).

Table 4 Number of intervention, evaluation LGAs and exposure to MAP intervention.

S/N	States	Number of LGA	Evaluation LGA	Number of communities	Evaluation communities
1.	Lagos	15	3	42	6
2.	Oyo	20	3	43	6
3.	Ogun	13	3	31	6
4.	Sokoto	8	3	32	6
5.	Kebbi	17	3	TBC	6
6.	Zamfara	13	3	TBC	6
	Total	86	18		36

The final selected communities for the evaluation for the IPC and Social marketing strategies are presented in the table below:

State	LGA	IPC Cycle	# Communities where ESMPIN Implemented	# of Selected communities	Names of selected communities	Senatorial District
Lagos	Alimosho	Cycle 7	3	1	Oke-Odo	West
		Cycle 9	2	1	Santos	
	Epe	Cycle 10	3	2	Bado papa and Odomola	East
	Somolu	Cycle 1	2	2	Ijebutedo and Ibuowo	Central
Ogun	Abeokuta North	Cycle 1	1	1	Iberekodo	Central
		Cycle 10	1	1	Iberekodo	
	Ifo	Cycle 4	2	1	Ifo	East
		Cycle 8	3	1	Oke-Aro	
	Ado Odo Ota	Cycle 3	3	2	Ota & Sango Ota	West
Oyo	Ibadan South East	Cycle 10	2	2	Orita Aperin and Molete/Odo Oba	South
	Ibadan South West	Cycle 1	2	1	Molete Oke Ado	South
	Akinyele	Cycle 6	2	2	Moniya and Opo Sasa	Central
Sokoto	Sokoto South	Cycle 1	1	1	Tundu Wada	North
		Cycle 8	2	1	Nakasari	
	Tambwal	Cycle 10	3	2	Samyinna and Shiyyar Makera	South
	Wamako	Cycle 1	2	1	Gwiwa	North
		Cycle 4	1	1	Sabon Gari/Bado/Gumbi/ Kammata	

The final selected communities for the evaluation for the CBD and Social marketing strategies are presented in the table below:

State	LGA	Number of communities	Senatorial District
Zamfara	Bungudu	2	Zamfara central
	Kaura Namoda	2	Zamfara north
	Anka	2	Zamfara west
Kebbi	Argungu	2	Kebbi north
	Jega	2	Kebbi central
	Shaga	2	Kebbi south

Study population

Study population include men and women in study communities, Head of health facility personnel in supported facilities, project implementers from ESMPIN and their partners, key stakeholders such as detailers, PPMVs, CBDs, personnel of LGAs, and state FMOH.

Sample size

The number of FGD and KII sessions are presented in Table. This was determined purposively based on relevance, appropriateness for addressing evaluation questions and available time frame for the evaluation. A total of 74 KII sessions would be conducted at both state and National levels with different target audience while 24 FGD sessions would be conducted among women and men in the states. This would translate to a total of 177 persons for the qualitative study.

Most of the quantitative data for the evaluation would be derived from secondary analysis of data from project documents as well as secondary data from national surveys and databases. Thirty-six health facilities (HFs) would be selected for assessment in the evaluation; two HFs would be selected from each LGA. The number of facilities to be assessed was based on convenience and time constraint in the evaluation.

Interactions will be held with 554 persons or more.

Table 5. Number of Health Facilities (HFs), Key In-depth Interviews (KIIs), Focus Group Discussions (FGDs) in the evaluation.

S/N	States	# of LGA	Evaluation LGA	Qualitative Component										Quant Component
				KII Sessions							FGD Sessions		Exit Interview	
				USAID FMOH SMOH LGA SFH AFRH HC3 PSI ARFH SHOP	PPMV	CBD	Detailers	Community Mobilizer	Distributor	Health Provider	Men	Women	Clients at HF	HF Assessment
1.	Lagos	15	3	12	12	N/A	12	12	12	6	2	2	12	6
2.	Oyo	20	3	10	12	N/A	12	12	12	6	2	2	12	6
3.	Ogun	13	3	10	12	N/A	12	12	12	6	2	2	12	6
4.	Sokoto	8	3	9	12	N/A	12	12	12	6	2	2	12	6
5.	Kebbi		3	9	12	12	12	12	12	6	2	2	12	6
6	Zamfara		3	9	12	12	12	12	12	6	2	2	12	6
	FCT			15										
Total			18	74	72	24	72	72	72	36	12	12	72	36

Sampling technique

The basic sampling unit in the facility survey is the health facility where ESMPIN intervened and used as referral center. A sampling frame of these facilities would be drawn and the facilities that falls within the selected states and communities would be purposefully included in the evaluation. A total of two health facilities, would be selected for assessment in each LGA. FGD sessions would be conducted among men and women beneficiaries and none beneficiaries in those communities.

Instruments and measures

Ten discussion and interview guides was developed to guide the discussions for the qualitative component of the survey. The guides focus on the five evaluation questions that the evaluation is expected to answer. The guides developed are:

KIIs for:

- Government of Nigeria officials
- ESMPIN Technical and Financial Staff
- Health Care Workers
- Detailers
- Distributors
- PPMV
- CBDs
- Community Mobilizers
- Exit Interview

FGDs

- FGD guide for men
- FGD guide for women

Also, a tool will be developed and used for cost analysis.

Quantitative data collection: A structured standardized and approved data collection template was designed for the health facility assessment.

Data quality assurance

When needed, data collection instrument will be transcribed for use on the field during data collection activities. Experienced moderators and data collectors with good working knowledge of local languages would be engaged to assist with facilitation of KII and FGD sessions in all study locations. In all, it is planned that 6 data collectors will be engaged per state. Those engaged would also be provided re-fresher training on facilitation and how to avoid leading questions and how to document and interpret cues.

Data management plan

Text data from all locations would be transcribed and organized in Excel software. The text data would be managed, coded and analyzed with the use of the software. Findings from qualitative information

would provide contextual understanding of observed evidences from quantitative components of the survey. The health facility data would be entered on IBM SPSS 20.0 and analyzed in excel spreadsheet.

Data analysis and synthesis plan

The evidences from the project documents and reports desk audit will be synthesized along with the primary evidences from health facility assessment, qualitative studies and analysis of secondary data in a manner that will provide a reliable end line situation of the Project Areas (PAs).

Report writing plan

The information from all the data sources would be triangulated and reported in a succinct report. The format would be in line with USAID guidelines and would be revised in response to comments from GH Pro and USAID before a final copy would be produced.

Work plan

The work plan for field implementation, data analysis, report writing and debrief of USAID and MAP is presented in Table 6.

Table 6 Work plan for field implementation and debrief to Key Stakeholders

Description of activities	October and November 2016				
	Week 24 th – 29 th Oct.	Week 30 st Oct - 5 th Nov.	Week 7 th – 12 Nov.	Week 13 th – 19 Nov.	Week 20 th – 26 Nov.
Abuja					
In Brief with USAID					
IN Brief with ESMPIN					
Team Planning Meeting					
Development of field protocol, tools and schedule of visits					
Travel to Lagos					
In brief with ESMPIN Lagos Team					
KIIs with state government officers					
KII with SHOPS, CHI< P&G					
Conduct FGD with Beneficiaries					
Conduct KIIs with PPMVs, Detailers and Mobilizers					
Conduct Exit interviews					
Conduct Facility assessment					
Debrief ESMPIN and State Government					

Description of activities	October and November 2016				
	Week 24 th – 29 th Oct.	Week 30 th Oct - 5 th Nov.	Week 7 th – 12 Nov.	Week 13 th – 19 Nov.	Week 20 th – 26 Nov.
Travel to Oyo					
In brief with ESMPIN Oyo Team					
KIIs with state government officers					
KII with ARFH					
Conduct FGD with Beneficiaries					
Conduct KIIs with PPMVs, Detailers and Mobilizers					
Conduct Exit interviews					
Conduct Facility assessment					
Debrief ESMPIN and State Government					
Travel to Ogun State					
In brief with ESMPIN Ogun Team					
KIIs with state government officers					
KII and observation at warehouse					
Conduct FGD with Beneficiaries					
Conduct KIIs with PPMVs, Detailers and Mobilizers					
Conduct Exit interviews					
Conduct Facility assessment					
Debrief ESMPIN and State Government					
Travel to Sokoto					
In brief with ESMPIN Sokoto Team					
KIIs with state government officers					
Conduct FGD with Beneficiaries					
Conduct KIIs with PPMVs, Detailers and Mobilizers					

Description of activities	October and November 2016				
	Week 24 th – 29 th Oct.	Week 30 th Oct - 5 th Nov.	Week 7 th – 12 Nov.	Week 13 th – 19 Nov.	Week 20 th – 26 Nov.
Conduct Exit interviews					
Conduct Facility assessment					
Debrief ESMPIN and State Government					
Travel to Zamfara					
In brief with ESMPIN Zamfara Team					
KIs with state government officers					
Conduct FGD with Beneficiaries					
Conduct KIs with CBDs, Detailers and Mobilizers					
Conduct Exit interviews					
Conduct Facility assessment					
Debrief ESMPIN and State Government					
Travel to Kebbi					
In brief with ESMPIN Kebbi Team					
KIs with state government officers					
Conduct FGD with Beneficiaries					
Conduct KIs with CBDs, Detailers and Mobilizers					
Conduct Exit interviews					
Conduct Facility assessment					
Debrief ESMPIN and State Government					
Travel to Abuja					
Follow up meeting with ESMPIN					
Meetings with USAID					
Data analysis and reporting					
First draft report ready					

Description of activities	October and November 2016				
	Week 24 th – 29 th Oct.	Week 30 th Oct - 5 th Nov.	Week 7 th – 12 Nov.	Week 13 th – 19 Nov.	Week 20 th – 26 Nov.
Preparation of initial key findings					
Debrief ESMPIN					
Debrief USAID					
Departure of Lead Consultant					

Ethical considerations

Ethical clearance will not be required for the evaluation since the study will not be requiring any human samples and discussions would not be intrusive. In addition to the confidentiality clause each FGD discussant would however give an informed consent before they can be included in the study. All discussants would have the right to discontinue in an FGD session at any time. Facility assessments would be conducted after obtaining permission from all appropriate authorities in the states.

Risks and Assumptions

It is assumed that the evaluation team will receive maximum cooperation from ESMPIN and all stakeholders at all levels including USAID/Nigeria. It is also the hope of the evaluation team that selected states would be safe and peaceful throughout the evaluation period to enable the team visit all locations of interest without any form of hindrance. The team lead will maintain close contact with USAID/Nigeria and receive regular security briefing concerning the states of interest. Should the team receive any report(s) of pending threats to safety, activities would be suspended pending when the situation would be resolved or another location selected.

ANNEX III. DATA COLLECTION INSTRUMENTS

ESMPIN EVALUATION QUESTIONNAIRES

Date: _____ Name of respondent: _____

State: _____ Location: _____

Name of Interviewer: _____ Tel No: _____

KEY INFORMANT INTERVIEW: GOVERNMENT OF NIGERIA, MINISTRY OF HEALTH OFFICIALS (FEDERAL AND STATE)

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. How familiar are you with the Expanded Social Marketing Program in Nigeria, or ESMPIN?

2. How has your office worked with ESMPIN?

3. Can you describe what you believe ESMPIN has done in Nigeria [or state]?

- a. Specifically, from your experience do you believe that ESMPIN has contributed to improved family planning and maternal and child health services, availability of contraceptives, ORS + Zinc, water purification, malaria prevention, in Nigeria or the states where it has worked?

- b. Do you believe ESMPIN has contributed to any increases in family planning and maternal and child health services in Nigeria or the state?

4. One of the goals of ESMPIN is to establish a sustainable model for family planning and maternal and child health services and products. Do you believe it has accomplished its sustainability goal?

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

5. Another goal of ESMPIN was to make available a selection of contraceptive methods such as injectables and implants in the private sector that were affordable and accessible. Do you believe this has been accomplished?

6. ESMPIN is a national program and serves in 22 states. Without seeing budgets or data related to expenditure but would your impress be that EXSMPIN has been cost effective. Can you give examples if Yes, or No.

7. Can you give example of how you saw ESMPIN address or not address gender issues in its outreach and activities?

8. In your experience with ESMPIN, what would you name as its most lasting accomplishment?

9. What would name as lost opportunities from ESMPIN.

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

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

KEY INFORMANT INTERVIEW: ESMPIN STAFF AND PARTNERS

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. What is your role at ESMPIN? And, how long have you been with the project?

2. From your experience with ESMPIN what would you identify as its biggest contribution to improving family planning and maternal and child health services in Nigeria?

3. As an insider, what do you think are good example of project activities that worked well and led to desired results?

a. What contributed to this success?

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

a. What factors contributed to this?

5. What were the biggest challenges you encountered in the implementation of the project?

6. Are there any special policies and issues in the implementation of FP/MCH program that hamper EMSPIN's project? Can you give examples? And how did you deal with these?

7. What interventions do you think would be sustainable after ESMPIN? Why?

8. Do you think the project has had a positive influence in gender issues? Can you give an example of what ESMPIN had done?

9. Has this program been collaborative in working with members of the consortium? With the government? Other projects?

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

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

Date: _____ Name of respondent: _____

State: _____ Location: _____

Name of Interviewer: _____ Tel No: _____

FOCUS GROUP DISCUSSION FOR WOMEN OF REPRODUCTIVE AGE

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. How many of you have children? [raise hands] how many have children under five years old?
[raise hands]

Total number of participants _____

Number that have children under five years of age _____

2. What day is the market day? _____

3. Where do you go for your family planning and services products? [Probe: public, private or community, CBD, PPMVs, midwife)

4. Why do you go to that facility? [Probe: location, referral, promotion, affordability]

5. When was the last time you visited the clinic? What was the reason you went to the clinic?
[Probe: your health, your child's health, antenatal care, buy products]?

6. Do you remember what treatment or care you received at the facility on your last visit?

7. Could you tell us about your general experiences at the health facility during your visits?
Comments

4. What did you buy at the clinic or shop? [Probe: ORS + Zinc, PUR, a contraceptive]
Did you find their costs reasonable and affordable?

5. Was the health care provider able to answer your questions about your health or about the products you bought?

6. Will you return to this health facility if you need health care services again?

7. Did someone go with you to the clinic? [Probe: your husband, friend, relative]?

8. Have you heard of ESMPIN in your community? Are you familiar with what it is? How did you hear about it? [Probe: radio, posters, word of mouth, social media].

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

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

FOCUS GROUP DISCUSSION FOR MEN OF REPRODUCTIVE AGE

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. How many of you have children [show of hands]? How many have children are under the age of five [show of hands]?

Total number of participants _____

Number that have children under five years of age _____

2. What day is the market day? _____

3. Think back to the last time you visited the health clinic. Did someone go with you to the clinic? [Probe: your wife, friend, relative]? Or did you accompany someone to the clinic? [Probe: wife, mother, friend]

4. Why did you go to that specific clinic? Was it referred by someone or did you hear about it through an ad or promotion?

5. Have you heard of ESMPIN in your community? Are you familiar with what it is? How did you hear about it? [Probe: radio, posters, word of mouth, social media). Can you name anything that ESMPIN has brought to your community?

6. How did the staff treat you or your family at the facility? Was there any difference in the way you were treated compared to the women in the HF (male involvement, women-friendly environment etc.)? Please explain.

7. Is it likely that you or your family members will return to the health facility should you need health care services?

8. Have you heard of ESMPIN in your community? Are you familiar with what it is? How did you hear about it? [Probe: radio, posters, word of mouth, social media). Can you name anything that ESMPIN has brought to your community?

9. Have you and your community benefitted from ESMPIN project? How? Give examples.

10. What benefits did you wish you would have gotten from ESMPIN that you didn't get? (give examples). How can FP/MCH services be made more acceptable to people in your community?

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

EXIT INTERVIEW FOR CLIENTS

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

Confidentiality and consent: I am going to ask you questions some of which may be personal, and will also use an audio recorder. Your answers will be kept strictly confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is taking place in other health facilities that are involved in the project in 5 other states as well. I will greatly appreciate your help in responding to this survey. May I continue?

A. Identification

1. Questionnaire number: _____ (*Skip*)
2. State: _____ LGA: _____
3. Ward: _____ Community: _____
4. Location: Rural ----- 1, Urban-----2
5. Name of the interviewer: _____ Date: _____

B. Background characteristics

1. **Age as at last birthday:** _____
2. **Sex** _____
3. **Marital status:** Single: -----1, Married: -----2, Separated: -----3, Divorced: ---4, widowed: ----
-5
4. **Highest education completed**
No education-----1. Quranic -----2, Primary -----3, Secondary-----4, post-secondary-----5,
Graduate-----6
5. **Occupation:** Schooling-----1, Unemployed-----2, Housewife-----3, Trading-----4,
Professional-----5, Farming-----6
6. **Parity:** Number of children you have: _____; Age of last child (in
months): _____
7. **Monthly Income (N) :** _____

C. Effects of ESMPIN activities

1. (a) What kind of services have you been receiving in this facility? (*Circle as many as appropriate*)
FP-----1, Malaria-----2, Diarrhoea-----3, Nutrition-----4
(b) What service(s) were offered to you today?
FP-----1, Malaria-----2, Diarrhoea-----3, Nutrition-----4

2. How have these services affected the wellbeing of your family members? Give examples

3. Which intervention is the most (and least) utilized?

	Intervention	Most utilized	Less utilized	Not utilized
1.	Family Planning			
2.	Nutrition (Exclusive breastfeeding)			
3.	Malaria prevention/treatment			
4.	Treatment of childhood diarrhea			

4. What informed your judgment regarding the utilization of services?

D. Clients Satisfaction

1. How would you describe the services you received in the facility?

Very satisfied----1, Satisfied-----2, Dissatisfied-----3, Very dissatisfied-----4

2. Were you given any pamphlets or brochures with information on different FP/MCH/WASH interventions to read (or have someone read for you) at home? Yes_____, No_____

3. Were you offered any incentives to accept FP? Yes....., No.....

If yes, what incentive_____

4. Were you denied any benefits or services based on your decision not to accept a family planning method? Yes_____, No_____ Comments (if any)

5. How long did you spend at this health facility today to receive care?_____

6. What time did you arrive?..... (interviewer to note exit time.....)

7. If not working, ask client what else they could have been doing if they did not come to the health facility today?

8. How much will this activity (in 7 above generate for the client)

E. Gender

Has there been any change in the way you are treated as a woman in this HF (male involvement, women-friendly environment etc.)? Please explain

I. Recommendations

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

Thank you for your time and attention

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

KEY INFORMANT INTERVIEW: DETAILER

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. I understand you are a detailer for ESMPIN. Did you receive any training before assuming the position of detailer? Yes..... I, No.....2

If yes, what type of training? _____

For how many days? _____

Have you participated in any refresher training or are you updated on new information related to the products? Yes.....I No.....2

2. On the average, how many visits to the retailers do you make in a week? _____

How large is the area you cover? _____

3. What types of retailers do you visit? _____

4. What do you do during a normal detailing visit? _____

5. On average, how much time do you spend with each retailer? _____

6. What ESMPIN products do you detail? _____

Do you only detail the pharmaceuticals? Yes.....I, No.....2

From your experience, which products are more popular? _____

Why do you think so? _____

7. Have any of the retailers experienced stock out of commodities at any point in time? Yes.....I, No.....2

Which ones? _____

8. Have you experienced any challenges in your detailing work? Yes.....1, No.....2

If so, what were they? _____

How did you overcome them? _____

9. Do you have male and female retailers? Yes,,,,,1, No,,,,,,,2

Who has more sales if there is a difference? _____

10. How are you compensated for your work?

11. Is the detailing model under ESMPIN an effective model to continue? Yes....1, No,,,,,2

Is it cost effective? _____

12. Are there things that you would recommend the project do differently? *[Please explain what and things that you would have love to be addressed]*

Thank you for your time and attention

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

KEY INFORMANT INTERVIEW: DISTRIBUTORS

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. What has been your role with the ESMPIN project? _____

- a. Do you see any impact ESMPIN has made in growing the market? Please explain yes or no
[Probe: any effect on sales of commodities, wider audience, awareness]

2. What ESMPIN commodities do you distribute? [Probe: ethical; non-ethical]. What are the most popular products?

3. How often do you receive commodities – it on a regular basis or do you place orders?

4. Have you ever experienced stock out of any commodities? Yes....I, No.....2

Which ones? _____

Do you know what the reason was for the stock out?

5. Apart from stock out, are there other challenges you have experienced under this program?
Yes.....I, No.....2

If yes what are they? _____

How did you overcome the challenges?

6. If the project close, would you be able to continue to do your job? Yes....I, No....2

If yes why and how?

7. What are the things that you would have liked for the project to do that were not addressed [*Please explain what and things that you would have love to be addressed*]? _____

Thank you for your time and attention

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

KEY INFORMANT INTERVIEW: PPMVs/CBDs

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. [For PPMV] Are you familiar with the ESMPIN project? In what way? Please explain?

a. From your experience do you see an impact on the work ESMPIN is doing?

b. Has there been a positive or negative effect on sales of commodities since the project started?

2. Did you receive any training under this project? Yes....I, No.....2

If yes, what type of training did you receive? _____

Do you feel it has made a difference on your work and providing services? Could you give examples.

3. What are your ESMPIN commodities? _____

How often do you receive a supply? _____

Which organization supplies you with the commodities? _____

4. Of the family planning products you sell, which is the most popular method? _____

Do men have a preferred method? Yes 1, No.....2

Do women have a preference? Yes.....1, No.....2

What do you think is the reason for the popularity? _____

5. What percentage of your customers are male? Female?

Why do you think there are more [men than women/women than men based on previous answer]?

6. Have you ever experienced stock out of any commodities? Yes.....1, No.....2

What specifically? _____

Do you know the reasons for the stock out? Yes.....1, No.....2

What are the reasons for the stock out? _____

Do you think this had an impact on your sales?

7. Apart from stock out, have you experienced any other challenges? Yes.....1, No,,,,,2

If yes what are they? _____

How did you overcome the challenges?

8. What is the geographic coverage you serve? _____
_____How
are you compensated? _____

9. If the project closed out, will you still be distributing the commodities? Yes.....I No...2
If yes why and how? _____

10. What are the things that you would have love the project to do that were not addressed [*Please explain what and things that you would have love to be addressed*]?

Thank you for your time and attention

Date: _____ Name of respondent: _____

State: _____ Location: _____

Name of Interviewer: _____ Tel No: _____

KEY INFORMANT INTERVIEW: HEALTH CARE WORKERS

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

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

2. How long have you been working in this facility (In years)? _____

3. Are you familiar with ESMPIN (SFH)? If so, what do you know about them and their services?

4. Has your facility received any support from ESMPIN? Yes.....1, No.....2

If yes, what specifically did they do to support your facility? _____

5. Have you or any of your colleagues participated in any training organized by ESMPIN? Yes....1, No.....2

If yes, why type of training did you or your colleagues received. _____

6. Are there areas of training you would like to receive in the future that is relevant to your work in health care? Yes.....1, No,,,,2, Please specify?

Have you noticed a difference in your work and your facility since ESMPIN has been associated with your facility? Yes.....1, No.....2

If so, what specifically has changed? [Probe: good or bad]

7. Which products do you dispense at the clinic? [Probe: types of contraceptives, PUR, malaria treatment, ORS + Zinc] _____

8. Do you provide recommendations or counseling for your patients? Yes.....1, No....2. If yes, please explain?

9. Where do you get supplies of products you dispense? _____

10. Have you experienced stock-outs in the last three months? Yes.....1, No.....2

If yes, which products? _____

Why do you think this happened? _____

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

Is there a separate area for this? Yes.....1, No.....2

Is there visual and auditory privacy? Yes.....1, No.....2

12. How do your clients select an FP method? _____

Is it voluntary.....1, Are they offered any incentives for taking FP.....2

Are they denied service for not accepting FP? Yes.....1, No.....2

13. Have you ever had any supportive supervision visits to your facility? Yes...1, No.....2.

If yes, by who? _____

How often? _____

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

14. What kinds of data do you collect? _____

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

If yes, which one? _____

How often? _____

How do you transmit this data? _____

15. On a scale of 1-5 with 1 being Very poor and 5 being Very good, how will you rate the uptake of FP/MCH services in your facility before and after the commencement of the ESMPIN project?

Very Poor 1

Poor 2 Fair.....3

Good.....4

Very Good.....5

11. What are the things that you would have love the project to do that were not addressed [*Please explain what and things that you would have love to be addressed*]?

Thank you for your time and attention

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

FOCUS GROUP DISCUSSION: WARD DEVELOPMENT COMMITTEE

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

You were suggested as part of the FGD to provide information about this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned from your field experience.

Before we begin, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the report, or otherwise attributed to you.

The FGD will take about one hour.

Do I have your permission to begin?

1. Do you know the ESMPIN project? Yes.....1, No.....2

If yes what is the role of your committee on the project _____

2. With the presence of ESMPIN project in your community for the past years, do you believe that they have made a difference among families in the community? Explain

3. Do you think you and your community have benefitted from ESMPIN? Yes.....1, No.....2

Can you give an example how? [**Prompt: how has community utilization of FP and MCH services changed and impact on community's general health**]

4. Has your group participated in any training or sensitization by ESMPIN? Yes.....1, No.....2

If so, how have you used this training? _____

5. Were you able to apply the training to your work? Yes 1, No.....2.

If so, has using it changed anything? Yes.....1, No.....2.

What do you do differently? Explain

6. How does your community/group collaborate with the IPC Team and Health Facility? [**Prompt: to increase public awareness and utilization of FP and MCH services**].

7. How do you think the health facility benefited from your contributions? Please give examples.

8. Have you noticed a change in the way husbands support their wives in utilizing health facilities?

What recommendations do you have to improve your community's/group's capacity in supporting FP and MCH services?

Thank you for your time and attention

ESMPIN PROJECT FACILITY ASSESSMENT CHECKLIST

Assessor's name: _____

Today's Date: ____/____/____

Day Month Year

Name of facility: _____

Type of facility:[]

Primary health center

General hospital (secondary facility)

Other (specify) _____

Affiliation of facility:

Private

LGA

State

Federal

Other (Specify) _____

State: _____ LGA _____

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

I am here today on behalf of GH Pro to conduct an assessment of your facility to enable us to assess the impact of the ESMPIN Project. I would like to ask you several questions about the types of service you provide and other issues relating to number of staff trained to provide such services. The information gathered will be used to identify the type/s of intervention needed to improve the quality of the services you provide in the facility. Your participation in this process is very important. Your responses will be kept confidential. No institution or individual will be identified by name in the final report.

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

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

☐ The respondent agreed to participate in the assessment.

RESPONDENT'S BACKGROUND

1. Title of the respondent: _____

2. Number of years of service in the facility:[] years

3. Professional cadre of the respondent:

Doctor

Nurse

Midwife

Other: (specify) _____

GENERAL OBSERVATION (Tick appropriate response)

		Yes	No	Comments
1	Are the facility grounds well maintained? (vegetation, stagnant water, etc.)			
2	Is the facility clean and tidy? (floor, walls, ceiling, etc.)			
3	Is the facility well ventilated? (check for cross ventilation)			
4	Are there nets on the windows? (are the nets intact?)			
5	Are health workers neat and tidy? (uniforms, shoes, etc.)			

FACILITY STAFFING

Does the facility have the following staff?	FEMALES				MALES			
	Total no.	No. trained on FP	No. trained on malaria	No. trained on diarrhea	Total no.	No. trained on FP	No. trained on malaria	No. trained on diarrhea
CHEWs								
Nurses without midwifery training								
Midwives								
Doctors (General Medical Officers, Obstetrician)								
Total								

Instruction: Place an "X" in the YES column if the item/service is available and functions correctly. Place an "X" in the NO column if the item/service is not available or does not function correctly. Record your comments in the COMMENTS column, as necessary.

AVAILABLE SERVICES/INFRASTRUCTURE

DOES THE FACILITY HAVE THE FOLLOWING SERVICES/INFRASTRUCTURE?	YES	NO	COMMENTS
Services available 24 hours a day, 7 days a week			
ANC			
Delivery			
Family Planning			
Nutrition – Exclusive Breastfeeding (EBF)			
Malaria prevention and treatment			
Diarrhea prevention and treatment			
ORT corner			
Private area for FP counseling			
Procedure area for IUD, injectables or implants			
Toilets for clients			
Toilets for staff			
Water supply/back up			
Electricity supply/back-up			
Waste disposal system – incinerator, burying, etc.			

SCHEDULES

1. How often does the facility get new supplies of drugs and FP commodities? _____

2. Have you had stock outs of FP/MCH supplies/commodities in the last 3 months?

Yes ___ 1, No ___ 2

If yes, which one(s)? _____

And why? _____

3. How many days per week does this facility offer ANC services?[] Please, specify which days and how many hours a day _____

What is the opening time for this clinic _____

4. How many days per week does this facility offer FP services?[] Please, specify which days and how many hours a day _____

What is the opening time for this clinic _____

5. How many days per week does this facility offer child welfare (U5) services? [] Please, specify which days and how many hours a day _____

What is the opening time for this clinic _____

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

Equipment/Supplies	Available Today?		Readily accessible?		Working correctly?	
	Yes	No	Yes	No	Yes	No
Client record forms and files						
Refrigerator/cold chain system						
Thermometer						
Malaria tests						
ORS/Zinc						
Intravenous fluids – normal saline, paediatric saline, Ringer’s lactate, Darrow’s solution						
Antibiotics – oral, parenteral						
ACT						
Sulphadoxine Pyrimethamine for IPT						
Xylocaine injection						
LLINs						
Communication materials for malaria, EBF, FP, diarrhea e.g. posters, counseling flip charts, brochures, job aids, counseling cards, etc.						
Light source						
Weighing Scale						
Sphygmomanometer						
Scissors						
Sterile needles and syringes						
Sterile gloves						
FP – cycle beads						
FP – condoms (male)						
FP – condoms (female)						
FP – pills						
FP – injectables						
FP – implants						
FP – IUDs						
FP – permanent methods						
Appropriate storage facilities for drugs and FP commodities (free from rain, products off floor and on shelves)						
Equipment for LARCs – specula, insertion and removal kits for IUDs and implants						
Infection prevention equipment/supplies (cotton wool, antiseptics, disinfectants, soap, detergent, autoclave, etc.)						
Infection prevention: waste containers – sharps boxes, pedal bins						

HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) AND RECORDKEEPING

A. Which registers are available at the facility?

Register	Available		If yes, is it used routinely?		Register	Available		If yes, is it used routinely?	
	Yes	No	Yes	No		Yes	No	Yes	No
ANC					FP				
Delivery					Child welfare (under 5) clinic				
PNC					Drug inventory				
Nutrition clinic					FP supplies				

B. What reports do you submit routinely to the State Ministry of Health?

Name of Report	Frequency of Preparation	Sent/given to whom?

For the services in the following tables Check all that apply and include the actual figure for the last **SIX YEARS** for which data are available

C. MCH services provided in the last 6 Years:

ACTIVITY	2011	2012	2013	2014	2015	2016 (Sept)	Total
Malaria treatment							
EBF counseling							
Diarrhea treatment (ORS/Zinc)							

D. Number of Clients counseled on FP in the facility in the last 6 yrs:

FP Counseling	2011	2012	2013	2014	2015	2016 (Sept)	Total
Female							
Male							
TOTAL							

E. Number of FP Clients by methods received in the last 6 yrs:

FP METHODS	2011	2012	2013	2014	2015	2016 (Sept)	Total
Cycle beads							
Pills							
Depo							
Noristerat							
IUDs							
Implants							
Condoms							
Female sterilization							
Vasectomy							
Others (Specify):							
Total							

F. Quantity of FP Commodities dispensed to Clients in the last 6 yrs:

FP METHODS	2011	2012	2013	2014	2015	2016 (Sept)	Total
Cycle beads							
Pills							
Depo							
Noristerat							
IUDs							
Condoms							
Implants							
Others (Specify):							

COST

How much do clients pay for consultation at FP clinic? _____

How much do clients pay for consultation at general clinic? _____

Cost of products

FP METHODS	Cost
Cycle beads	
Pills	
Depo	
Noristerat	
IUDs	
Implants	
Condoms	
Female sterilization	
Vasectomy	
ORS/Zn	
Water Guard	
Others (Specify):	

ASSESSOR COMMENTS: (Please note any additional observations here):

Date: _____

Name of respondent: _____

State: _____

Location: _____

Name of Interviewer: _____

Tel No: _____

KEY INFORMANT INTERVIEW: COMMUNITY MOBILIZERS

Good morning. Thank you for meeting with us. I am _____, (title) for an evaluation of the Expanded Social Marketing Program in Nigeria, or ESMPIN. On behalf of USAID I am part of a team talking with stakeholders from different sectors about the program and its overall accomplishments and lessons learned from your standpoint.

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

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

Our interview will take about one hour.

Do I have your permission to begin?

1. Are you familiar with the ESMPIN project? Yes.....1, No.....2

In what way? Please explain?

a. What impact do you think they have made?

b. Has the project had any effect on sales of commodities?

2. Did you participate in any training under ESMPIN? Yes....1, No.....2

If yes, what type of training? _____

Do you feel the training has had an impact on your work in service delivery? Explain

3. What is the most popular reason for referring clients to the HF?

4. Do you refer more males or females for services? More males....1, More females.....2

What do you think is the reason(s) for [more males; more females]?

Explain _____

5. How many days in a week do you go out to mobilize people? _____

6. Do you know how many of the people you refer actually access services?

Yes....1, No....2. If yes explain and give number.

7. What are the challenges you face as a community mobilizer? Explain

How have you addressed these challenges?

8. What would you recommend to increase the demand for FP and MCH services?

9. What are the things that you would have love the project to do that were not addressed [*Please explain what and things that you would have love to be addressed*]?

Thank you for your time and attention

ANNEX IV-A. SOURCES OF INFORMATION: LIST OF PERSONS INTERVIEWED

Name	Organization	Email	Telephone
Oheme Benson	SFH	boheme@sfnigeria.org	08129940493
Jennifer Anyato	ESMPIN	jayato@sfnigeria.org	08023289518
Ogechi Onuaha	ESMPIN/SFH	oonuha@sfnigeria.org	08037922489
Abdulsamad Salihu	SFH/EEP	asaliu@sfnigeria.org	08030644746
Isaac Omonoju	ESMPIN	iomonaju@sfnigeria.org	08036469300
Wale Adedeji	SFH	wadedeji@sfnigeria.org	08023003412
Shekoni Omolara	SFH	oshekoni@sfnigeria.org	08023191449
Johnson Ekele	SFH	jekele@sfnigeria.org	08036335594
Bright Ekweremadu	SFH	bekweremadu@sfnigeria.org	08036540807
Omokhodu Idogho	SFH	oidogho@sfnigeria.com	08023006631
Wole Fajemisin	SFH	wfajemisin@sfnigeria.com	08068039009
Aliyu Jibrin Guraguri	ARFH	ajguraguri@gmail.com	08037051313
Michael Alagbile	SFH	malagbile@sfnigeria.com	08129940572
Abosede Olowoyeye	BBC Media Action	Abosede.olowoyeye@ng.bbcmediaaction.org	07081901869
Genevieve Hutchinson	BBC Media Action	Genevieve.hutchinson@ng.bbcmediaaction.org	08090462453
Omoriegie Godpower	SFH	gomoriegie@sfnigeria.org	08033280457
Emmanuel Meribole	FMoH, Research and Statistics	meribole@yahoo.com	08023071624
Bisong John O	FMoH, Research and Statistics	bisongnabe@yahoo.com	08028063220

Name	Organization	Email	Telephone
Toba Adeogo	FMoH, Research and Statistics	lsaring.health@gmail.com	08063846479
Haruna Aminu	FMoH, Research and Statistics	aaharuna@rockmail.com	08035742277
Dr Kayode Afolabi	FMoH	kayodeakinofolabi@gmail.com	08069365667
Onyedikachi Ewe	SFH Lagos		08030523557
Awosika Oluseyi	SFH Lagos	oawosika@sfnigeria.org	08060486232
Mahiuyaku Efe Williams	SFH Lagos		08022563086
Alowode Oluwatosin	SFH Lagos		08169898407
Onabanjo Temitope	SFH Lagos		08033431291
Ajetunmobi Sekinot	SFH Lagos	sajetunmobi@sfnigeria.org	07031393926
Osarumwense Olajide	SFH Lagos		08035837724
Adewoyin Olufunke	SFH Lagos		08037007790

ANNEX IV-B. BIBLIOGRAPHY OF DOCUMENTS REVIEWED

Research and Studies

1. Gold MR, Siegel JE, Russel LB, Weinstein MC. Cost-effectiveness in Health and Medicine. New York: Oxford University Press, 1996.
2. Haddix AC, Teutsch SM, Corso PS, Prevention Effectiveness, A Guide to Decision Analysis and Economic Evaluation. New York: Oxford University Press, 2003.
3. Central Bank of Nigeria. Exchange rates. Available at www.cbn.gov.ng accessed on Nov 15th, 2016
4. Hughes. D and McGuire A. The cost-effectiveness of family planning service provision. Journal of Public Health Medicine: 1996 (18) 2; 189-196.
5. Kapadia-Kundu, N., Understanding Program Implementation Process and Behavior Trails of Family Planning Users in ESMPIN Cycle 3, JHU/CCP/H3, January to July 2013
6. Kapadia-Kundu, N and Boulay, M., The ESMPIN Assessment Report, JHU/CCP/H3 August 20, 2014
7. Trussella J B, Lallac AM., Doanc QV., Reyesc E, Pintoc L, and Gricard J. Cost Effectiveness of Contraceptives in the United States. Contraception, 2009 January; 79(1): 5–14
8. Prata N, Sreenivas A, Vahidnia F, Potts M. Saving maternal lives in resource-poor settings: facing reality. Health Policy. 2008; doi:10.1016
9. Oshonwoh F E, Nwakwuo G C, Ekiyor C. Traditional birth attendants and women’s health practices: A case study of Patani in Southern Nigeria Journal of Public Health and Epidemiology 2014 Vol. 6(8), pp. 252-261.
10. Imogie AO, Agwubike EO and Aluko K Assessing the role of Traditional Birth Attendants (TBAs) in health care delivery in Edo State, Nigeria. African Journal of Reproductive Health, 2002 Vol. 6, No. 2, pp. 94–100
11. Ngo T, Pinchoff J. Building innovation and family planning programs for the next generation. Available at <http://www.poverty-action.org/blog/building-innovative-and-evidence-based-family-planning-programs-next-generations> accessed 18th Dec 2016
12. Zulliger, Rose, PhD, MPH. Cost Evaluation of the implementation and Scale Up of the Expanded Social Marketing Project in Nigeria, JHU/CCP/H3
13. UN “World Population Prospects: The 2015 Revisions
14. IRHIN, Evaluation of Community Level Family Planning Interventions: Qualitative Study, 2008, SFH
15. USAID/Nigeria Maternal, Child, and Reproductive Health Program Mid-Term Evaluation, 2009
16. Nigeria Gender Assessment (Final Report) for USAID, 2016
17. USAID Social and Behavior Change Communication/Private Sector Bilateral Redesign Assessment, Nigeria, 2016
18. SBCC Strategy Across USAID’s Nigeria Health Portfolio for USAID (Draft) 2016

National Studies and Strategies

19. Measuring Access and Performance (MAP) studies 2014, 2015, 2016 reports and data
20. Nigeria Demographic and Health Survey (NDHS), 2013

21. Government of Nigeria, Federal Ministry of Health's "Scale Up Plan" 2014
22. Multiple Indicator Cluster Survey (MICS) Report, 2011

ESMPIN Reports and Research

23. ESMPIN Annual Performance Report FY 2011 – 2012
24. ESMPIN Annual Performance Report FY 2012 – 2013
25. ESMPIN Annual Performance Report FY 2013 – 2014
26. ESMPIN Annual Performance Report FY 2014 – 2015
27. ESMPIN Quarterly Reports, 2011-2016
28. ESMPIN Performance Monitoring Plan (PMP) Final, SFH, 2011-2016
29. ESMPIN Baseline survey data on family planning, diarrhea, malaria and nutrition in fifteen Nigerian States, 2011
30. ESMPIN Revised Technical Proposal, November 24, 2010
31. E-Mail trail for change of PMP Indicators
32. BCC Media Action ESMPIN End line Project Research Report, 2016
33. ESMPIN Behavior Change Communication Strategy 2012 – 2015
34. ESMPIN Advocacy Plan, 2013
35. Assessment of Pharmaceutical Manufacturers for Social Marketing Commodities in Nigeria, ESMPIN, 2013
36. Abstract - Findings of an assessment of the effectiveness of a Community-Based Distribution intervention on family planning uptake in hard-to-reach, rural populations in Northern Nigeria
37. Abstract - An assessment of the coverage and effectiveness of a ESMPIN's Interpersonal Communication Strategy in Selected States of Nigeria
38. Performance of Key Indicators of Society for Family Health Programs on Malaria, Diarrhea, and Family Planning from NARHS 2012 and Nigerbus 2013
39. ESMPIN PowerPoint Presentation to the Evaluation Team
40. SBCC Strategy Across USAID's Nigeria Health Portfolio Draft Report, June 2016
41. Review of ESMPIN data in the USAID Performance Reporting System
42. Review of ESMPIN sales figure for 2011 – 2016
43. Approved Action Memo for No-cost Extension for Cooperative Agreement No AID-620-A-00-10-00016-00 Expanded Social Marketing Project in Nigeria
44. Report of the ESMPIN Delta Workshop on Injectables SFH, 2011
45. ESMPIN IPC Flipchart (North)
46. ESMPIN IPC Flipchart (South)
47. ESMPIN Marketing Plan for ORS and Zinc 2012
48. ESMPIN Marketing Plan (PPT) 2012-2013
49. ESMPIN Utilizing the Framework for Qualitative Studies in Social Marketing (FoQuS) for Insights into Family Planning Program in Nigeria 2013

50. Society for Family Health and merchants of medicine: Supporting patent and proprietary medicine vendors to deliver high quality health services in Nigeria, 2013
51. PPMV Sensitization Workshop – Training (PPT)
52. SFH Detailing Strategy, 2011
53. SFH Sales and Distribution Strategy, 2011
54. ESMPIN Workplans 2011-2015
55. Qualitative Study on ORS/Zinc among Healthcare Providers, PPMVs and Caregivers (PPT), ESMPIN
56. Ephemera for PPMV– Quality Improvement within Social Franchise Networks Incorporating the Health Network Quality Improvement System (HNQIS), SFH
57. ESMPIN Health Communication Coordinator Toolkit, 2013
58. Assessing the Effectiveness of “Storming the Nightingale” as a Strategy for Family Planning Awareness Creation among Health Providers in Nigeria, SFH, 2012
59. FoQus for Marketing Planning Study Design Nigeria, 2012
60. Nigeria (2012): Barriers and Drivers of Modern Contraceptives Use in Nigeria, PSI for ESMPIN
61. FoQuS Dashboard for Nigeria, PSI, ESMPIN
62. SFH Strategic Plan (2013-2017) Confidential
63. Society for Family Health: Success in Nigerian Health Sector
64. Supply Chain Management, Innovation, Integration and Leveraging, 2013
65. ESMPIN Price Card, 2016
66. ESMPIN, BBC Media Action Results and Review, 2016
67. ESMPIN BBC Media Action Final Report, 2016
68. Ya Take Ne Arena Radio Stations Donations in Kind, ESMPIN for BBC Media Action
69. BBC Media Action Strategy, 2012
70. PMI BCC Planning Tools (Malaria) under ESMPIN
71. ESMPIN BCC Strategy (PPT) 2014
72. ESMPIN Demand Creation Activities – PMI
73. Malaria Operational Plan FY 2016, BCC Activities, ESMPIN
74. Communication Materials: Radio Programs, Radio PSAs, Radio Product Ads (ORS/Zinc, water guard and PUR)

ANNEX V. SITE VISIT SCHEDULE

FIELD WORK ACTIVITY SCHEDULE - Lagos

Time	Lagos State Schedule		
	Monday - 31/10/2016	Tuesday - 1/11/2016	Wednesday - 2/11/2016
08:00 AM	Travel to ESMPIN Office	Travel to Epe	Travel to Alimosho
09:00 AM	Inbrief with ESMPIN Team (all evaluation Team member)	KII with CHI - (DB & LY)	LY travel to Ibadan
10:00 AM		EPE LGA KII - HOD Health/Coordinator (SS, AO, data collectors)	Alimosho LGA KII - HOD Health/Coordinator (SS, AO, DB, data collectors)
11:00 AM	KII SMOH – PS and Director Public Health/PHC All Evaluation Team Members) KII SMOH – Director PRS (DB & LY)	KII with Private Health Facility Regulatory Body ((DB & LY) Epe LGA Community A – FGD with women that attend ESMPIN HF (AO & JO) Epe LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Epe LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)	Alimosho LGA Community A – FGD with women that attend ESMPIN HF (AO, DB JO) Alimosho LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Alimosho LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)
12:00 PM	KII SMOH –State RH/MCH coordinator (DB & LY) Somolu LGA - HOD Health/Coordinator (SS) Somolu LGA Community A – FGD with women that attend ESMPIN HF (AO & JO) Somolu LGA Community A & B- Client Exit Interviews (Data Collectors) Somolu LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)	Epe LGA Community A – FGD with men that attend ESMPIN HF (AO & JO) Epe LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Epe LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Alimosho LGA Community A – FGD with men that attend ESMPIN HF (AO, DB, JO) Alimosho LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Epe LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)
01:00 PM	Lunch	Lunch	Lunch

Time	Lagos State Schedule		
	Monday - 31/10/2016	Tuesday - 1/11/2016	Wednesday - 2/11/2016
02:00 PM	KII SMOH –Health Education Unit (DB & LY) Somolu LGA Community A – FGD with men that attend ESMMPIN HF (AO & JO) Somolu LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Somolu LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)	KII with Private Pharmaceutical Council Body ((DB & LY) Epe LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & JO) Epe LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Epe LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),	Alimosho LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & JO) Alimosho LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS, DB & data collectors) Alimosho LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),
03:00 PM	KII _ SHOPS Project (DB & LY) Somolu LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & JO) Somolu LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Somolu LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors)	KII _ with P&G (DB & LY) Epe LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & JO) Epe LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Epe LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data	Alimosho LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & JO) Alimosho LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS, DB & data collectors) Alimosho LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data
04:00 PM	Somolu LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & JO) Somolu LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Somolu LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data	Travel back to Hotel	Travel back to Hotel
05:00 PM	Travel back to hotel		

FIELD WORK ACTIVITY SCHEDULE - Oyo

Time	Oyo State Schedule		
	Thursday - 3/11/2016	Friday - 4/11/2016	Saturday - 5/11/2016
08:00 AM	Travel to Ibadan	Travel to Akinyele LY travel to Sokoto Jo travel to Ogun state	Travel to Ibadan South East
09:00 AM		KII with Private Health Facility Regulatory Body ((DB)	
10:00 AM	Inbrief with ESMPIN Team (all evaluation Team member}	Akinyele LGA KII - HOD Health/Coordinator (SS, AO, data collectors)	Ibadan South East LGA KII - HOD Health/Coordinator (SS, AO, DB, data collectors)
11:00 AM	KII SMOH – PS and Director Public Health/PHC (All Evaluation Team Members) KII SMOH – Director PRS (DB & LY)	Akinyele LGA Community A – FGD with women that attend ESMPIN HF (AO & data collectors) Akinyele LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Akinyele LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)	Ibadan South East LGA Community A – FGD with women that attend ESMPIN HF (AO, DB & data collector) Ibadan South East LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Ibadan South East LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)
12:00 PM	KII SMOH –State RH/MCH coordinator (DB & LY) Ibadan South West LGA - HOD Health/Coordinator (SS) Ibadan South West LGA Community A – FGD with women that attend ESMPIN HF (AO & JO) Ibadan South West LGA Community A & B- Client Exit Interviews (Data Collectors) - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Akinyele LGA Community A – FGD with men that attend ESMPIN HF (AO & data collectors) Akinyele LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Akinyele LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Ibadan South East LGA Community A – FGD with men that attend ESMPIN HF (AO, DB & data collectors) Ibadan South East LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Ibadan South East LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)

Time	Oyo State Schedule		
	Thursday - 3/11/2016	Friday - 4/11/2016	Saturday - 5/11/2016
01:00 PM	Lunch	Lunch	Lunch
02:00 PM	KII SMOH –Health Education Unit (DB & LY) Ibadan South West LGA Community A – FGD with men that attend ESMMPIN HF (AO & JO) - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) - KII with detailers, PPMVs, Mobilizers (Data Collectors)	KII with Private Pharmaceutical Council Body (DB) Akinyele LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & data collectors) Akinyele LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Akinyele LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),	Ibadan South East LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & data collector) Ibadan South East to LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS, DB & data collectors) Ibadan South East LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),
03:00 PM	KII _ ARFH Project (DB & LY) Ibadan South West LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & JO) - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Ibadan South West LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors) LY travel back to Lagos	Akinyele LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & data collectors) Akinyele LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Akinyele LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data collectors)	Ibadan South East LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & JO) Ibadan South East LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Ibadan South East LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data SS Travel to Lagos
04:00 PM	Ibadan South West LGA Community B – -FGD with men that did not attend ESMMPIN HF (AO & JO) Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Ibadan South West LGA Community A&B - KII with	Travel back to Hotel	Travel back to Hotel

Time	Oyo State Schedule		
	Thursday - 3/11/2016	Friday - 4/11/2016	Saturday - 5/11/2016
	detailers, PPMVs, Mobilizers (Data collectors)		
05:00 PM	Travel back to hotel		Sunday 6/11/2016 - 10am travel to Ogun/Sokoto for SS

FIELD WORK ACTIVITY SCHEDULE - Ogun

Time	Ogun State Schedule		
	Monday - 7/11/2016	Tuesday - 8/11/2016	Wednesday - 9/11/2016
08:00 AM		Jo travel to Kebbi via Sokoto	Travel to Ado Odo/Ota
09:00 AM	Inbrief with ESMPIN Team (all evaluation Team member}	KII with Private Health Facility Regulatory Body ((DB & AO) KII with Private Pharmaceutical Council Body (DB AO)	KII at Warehouse (DB & AO)
10:00 AM		Travel to Ifo	KII at Warehouse (DB & AO)
11:00 AM	KII SMOH – PS and Director Public Health/PHC (All Evaluation Team Members) KII SMOH – Director PRS (DB & JO)	Ifo LGA KII - HOD Health/Coordinator (DB, AO, data collectors)	Ado Odo Ota LGA KII - HOD Health/Coordinator (AO, DB, data collectors)
12:00 PM	KII SMOH –State RH/MCH coordinator (DB & JO) Abeokuta North LGA - HOD Health/Coordinator (AO) Abeokuta North LGA Community A – FGD with women that attend ESMPIN HF (Data Collectors) Abeokuta North LGA Community A & B- Client Exit Interviews (Data Collectors)	Ifo LGA Community A – FGD with women that attend ESMPIN HF (AO & data collectors) Ifo LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (data collectors) Ifo LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)	Ado Odo Ota LGA Community A – FGD with women that attend ESMPIN HF (AO & data collector) Ado Odo Ota LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Ado Odo Ota LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)

Time	Ogun State Schedule		
	Monday - 7/11/2016	Tuesday -8 /11/2016	Wednesday -9/11/2016
	- KII with detailers, PPMVs, Mobilizers (Data Collectors)		
01:00 PM	Lunch	Lunch	Lunch
02:00 PM	KII SMOH –Health Education Unit (DB & JO) Abeokuta North LGA Community A – FGD with men that attend ESMMPIN HF (AO & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (data collectors) - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Ifo LGA Community A – FGD with men that attend ESMMPIN HF (AO & data collectors) Ifo LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Ifo LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Ado Odo Ota LGA Community A – FGD with men that attend ESMMPIN HF (AO, & data collectors) Ado Odo Ota LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Ado Odo Ota LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)
03:00 PM	Abeokuta North LGA Community B – FGD with women that did not attend ESMMPIN HF (AO, & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Abeokuta North LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors) JO travel to Lagos	Ifo LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & data collectors) Ifo LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Ifo LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),	Ado Odo Ota LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & data collector) Ado Odo Ota LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Ado Odo Ota LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),
04:00 PM	Abeokuta North LGA Community B – -FGD with men that did not attend ESMMPIN HF (AO & data collectors) Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors) Abeokuta North LGA Community A&B - KII with	Ifo LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & data collectors) Ifo LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors)	Ado Odo Ota LGA Community B – FGD with men that did not attend ESMMPIN HF (AO & data collectors) Ado Odo Ota LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (DB & data collectors)

Time	Ogun State Schedule		
	Monday - 7/11/2016	Tuesday -8 /11/2016	Wednesday -9/11/2016
	detailers, PPMVs, Mobilizers (Data collectors)	Ifo LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data collectors)	Ado Odo Ota LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data collectors)
05:00 PM	Travel back to hotel	Travel to Lagos	Travel back to Lagos

FIELD WORK ACTIVITY SCHEDULE - Sokoto

Time	Sokoto State Schedule		
	Monday - 7/11/2016	Tuesday -8 /11/2016	Wednesday -9/11/2016
08:00 AM			Travel to Tambuwal
09:00 AM	Inbrief with ESMPIN Team (all evaluation Team member}	KII with Private Health Facility Regulatory Body ((SS & LY) KII with Private Pharmaceutical Council Body (SS & LY)	
10:00 AM		Travel to Wamako	Tambuwal LGA KII - HOD Health/Coordinator (SS & data collectors)
11:00 AM	KII SMOH – PS and Director Public Health/PHC (All Evaluation Team Members) KII SMOH – Director PRS (SS& LY)	Wamako LGA KII - HOD Health/Coordinator (SS & LY)	Tambuwal LGA Community A – FGD with women that attend ESMPIN HF (data collector) Tambuwal LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Tambuwal LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)
12:00 PM	KII SMOH –State RH/MCH coordinator (SS& LY) Sokoto South LGA - HOD Health/Coordinator (SS)	Wamako LGA Community A – FGD with women that attend ESMPIN HF (SS & data collectors)	Tambuwal LGA Community A – FGD with men that attend ESMPIN HF (data collectors) Tambuwal LGA Community A - Health Facility Assessment+

Time	Sokoto State Schedule		
	Monday - 7/11/2016	Tuesday -8 /11/2016	Wednesday -9/11/2016
	Sokoto South LGA Community A – FGD (with women that attend ESMMPIN HF (LY & Data Collectors) Sokoto South LGA Community A & B- Client Exit Interviews (Data Collectors) - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Wamako LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (LY & data collectors) Wamako LGA Community A & B- KII with detailers, PPMVs, Mobilizers (Data Collectors)	HWs+ Client Exit interviews (SS & data collectors) Tambuwal LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)
01:00 PM	Lunch	Lunch	Lunch
02:00 PM	KII SMOH –Health Education Unit (SS) Sokoto South LGA Community A – FGD with men that attend ESMMPIN HF (LY & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (data collectors) - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Wamako LGA Community A – FGD with men that attend ESMMPIN HF (LY & data collectors) Wamako LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Wamako LGA Community A - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Tambuwal LGA Community B – FGD with women that did not attend ESMMPIN HF (data collector) Tambuwal LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Tambuwal LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors),
03:00 PM	Sokoto South LGA Community B – FGD with women that did not attend ESMMPIN HF (LY, & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Sokoto South LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors)	Wamako LGA Community B – FGD with women that did not attend ESMMPIN HF (SS & data collectors) Wamako LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (data collectors) Wamako LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data Collectors), LY travel to Zamfara	Tambuwal LGA Community B – FGD with men that did not attend ESMMPIN HF (data collectors) Tambuwal LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Tambuwal LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data collectors)

Time	Sokoto State Schedule		
	Monday - 7/11/2016	Tuesday -8 /11/2016	Wednesday -9/11/2016
04:00 PM	Sokoto South LGA Community B – -FGD with men that did not attend ESMMPIN HF (LY & data collectors) Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Sokoto South LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data collectors)	Wamako LGA Community B – FGD with men that did not attend ESMMPIN HF (data collectors) Wamako LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Wamako LGA Community A&B - KII with detailers, PPMVs, Mobilizers (Data collectors)	Travel to Hotel
05:00 PM	Travel back to hotel	Travel to hotel	

FIELD WORK ACTIVITY SCHEDULE - Zamfara

Time	Zamfara State Schedule		
	Thursday - 10/11/2016	Friday 11 /11/2016	Saturday -12/11/2016
08:00 AM	Travel to Zamfara		Travel to Bugundu
09:00 AM		KII with Private Health Facility Regulatory Body ((SS & LY) KII with Private Pharmaceutical Council Body ((SS & LY)	
10:00 AM	Inbrief with ESMPIN Team (all evaluation Team member}	Travel to Anka	Bugundu LGA KII - HOD Health/Coordinator (SS & data collectors)
11:00 AM	KII SMOH – PS and Director Public Health/PHC (All Evaluation Team Members) KII SMOH – Director PRS (SS& LY)	Anka LGA KII - HOD Health/Coordinator (SS & LY)	Bugundu LGA Community A – FGD with women that attend ESMMPIN HF (SS & data collector) Bugundu I LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (LY &data collectors)

Time	Zamfara State Schedule		
	Thursday - 10/11/2016	Friday 11 /11/2016	Saturday -12/11/2016
			Bugundu LGA Community A & B- KII with CBDs, detailers Mobilizers (Data Collectors)
12:00 PM	KII SMOH –State RH/MCH coordinator (SS& LY) Kaura Namoda LGA - HOD Health/Coordinator (SS) Kaura Namoda LGA Community A – FGD (with women that attend ESMMPIN HF (LY & Data Collectors) Kaura Namoda LGA Community A & B- Client Exit Interviews (Data Collectors) - KII with CBDs, detailers Mobilizers (Data Collectors)	Anka LGA Community A – FGD with women that attend ESMMPIN HF (SS & data collectors) Anka LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (LY & data collectors) Anka LGA Community A & B- KII with CBDs, detailers Mobilizers (Data Collectors)	Bugundu LGA Community A – FGD with men that attend ESMMPIN HF (LY& data collectors) Bugundu LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Bugundu LGA Community A - KII with CBDs, detailers Mobilizers (Data Collectors)
01:00 PM	Lunch	Lunch	Lunch
02:00 PM	KII SMOH –Health Education Unit (SS) Kaura Namoda LGA Community A – FGD with men that attend ESMMPIN HF (LY & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (data collectors) - KII with CBDs, detailers Mobilizers (Data Collectors)	Anka Wamako LGA Community A – FGD with men that attend ESMMPIN HF (LY & data collectors) Anka LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Anka LGA Community A KII with CBDs, detailers Mobilizers (Data Collectors)	Bugundu LGA Community B – FGD with women that did not attend ESMMPIN HF (SS & data collector) Bugundu LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (LY & data collectors) Bugundu LGA Community A&B - KII with CBDs, detailers Mobilizers (Data Collectors)
03:00 PM	Kaura Namoda LGA Community B – FGD with women that did not attend ESMMPIN HF (LY & data collectors)	Anka LGA Community B – FGD with women that did not attend ESMMPIN HF (SS & data collectors) Anka LGA Community B - Health Facility Assessment+	Bugundu LGA Community B – FGD with men that did not attend ESMMPIN HF (LY & data collectors) Bugundu LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews

Zamfara State Schedule			
Time	Thursday - 10/11/2016	Friday 11 /11/2016	Saturday -12/11/2016
	- Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Kaura Namoda LGA Community A&B KII with CBDs, detailers Mobilizers (Data Collectors)	HWs+ Client Exit interviews data collectors) Anka LGA Community A&B KII with CBDs, detailers Mobilizers (Data Collectors)	(SS & data collectors) Tambuwal LGA Community A&B - KII with CBDs, detailers Mobilizers (Data Collectors) Travel to Sokoto
04:00 PM	Kaura Namoda LGA Community B – -FGD with men that did not attend ESMMPIN HF (LY & data collectors) Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Kaura Namoda LGA Community A&B KII with CBDs, detailers Mobilizers (Data Collectors)	Anka LGA Community B – FGD with men that did not attend ESMMPIN HF (LY & data collectors) Anka LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews (SS & data collectors) Anka LGA Community A&B - KII with CBDs, detailers Mobilizers (Data Collectors)	
05:00 PM	Travel back to hotel	Travel to hotel	Sunday 13 th November 2016 Travel to Abuja

FIELD WORK ACTIVITY SCHEDULE - Kebbi

Kebbi State Schedule			
Time	Thursday - 10/11/2016	Friday 11 /11/2016	Saturday -12/11/2016
08:00 AM	Travel to Kebbi via Sokoto		Travel to Argugu
09:00 AM		KII with Private Health Facility Regulatory Body (SS & LY) KII with Private Pharmaceutical Council Body ((SS & LY)	
10:00 AM		Travel to Shaga	Argugu LGA KII - HOD Health/Coordinator (DB & JO, AO)
11:00 AM		Shaga LGA KII - HOD Health/Coordinator (SS & LY)	Argugu LGA Community A – FGD with women that attend ESMMPIN HF (AO & data collector)

Time	Kebbi State Schedule		
	Thursday - 10/11/2016	Friday 11 /11/2016	Saturday -12/11/2016
			Argugu I LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews ((DB, JO & data collectors) Argugu LGA Community A & B- KII with CBDs, detailers Mobilizers (Data Collectors)
12:00 PM	Inbrief with ESMPIN Team (all evaluation Team member} KII SMOH – PS and Director Public Health/PHC (All Evaluation Team Members) KII SMOH – Director PRS (DB, AO & JO)	Shaga LGA Community A – FGD with women that attend ESMPIN HF (AO & data collectors) Shaga LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews ((DB, JO & data collectors) Shaga LGA Community A & B- KII with CBDs, detailers Mobilizers (Data Collectors)	Argugu LGA Community A – FGD with men that attend ESMPIN HF (JO & data collectors) Argugu LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews ((DB, AO & data collectors) Argugu LGA Community A - KII with CBDs, detailers Mobilizers (Data Collectors)
01:00 PM	Lunch	Lunch	Lunch
02:00 PM	KII SMOH –State RH/MCH coordinator (DB & JO) Jega LGA - HOD Health/Coordinator (DB & JO) Jega LGA Community A – FGD (with women that attend ESMPIN HF (AO & Data Collectors) Jega LGA Community A & B- Client Exit Interviews (Data Collectors) - KII with CBDs, detailers Mobilizers (Data Collectors)	Shaga Wamako LGA Community A – FGD with men that attend ESMPIN HF (JO & data collectors) Shaga Anka LGA Community A - Health Facility Assessment+ HWs+ Client Exit interviews ((DB, AO & data collectors) Shaga LGA Community A KII with CBDs, detailers Mobilizers (Data Collectors)	Argugu LGA Community B – FGD with women that did not attend ESMPIN HF (AO & data collector) Argugu LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews ((DB, JO & data collectors) Argugu LGA Community A&B - KII with CBDs, detailers Mobilizers (Data Collectors)
03:00 PM	KII SMOH –Health Education Unit (DB) Jega LGA Community A	Shaga LGA Community B – FGD with women that did not attend ESMPIN HF (AO & data collectors) Shaga LGA Community B - Health Facility Assessment+	Argugu LGA Community B – FGD with men that did not attend ESMPIN HF (JO & data collectors) Argugu LGA Community B - Health Facility Assessment+

Kebbi State Schedule			
Time	Thursday - 10/11/2016	Friday 11 /11/2016	Saturday -12/11/2016
	– FGD with men that attend ESMMPIN HF (Jo & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (AO & data collectors) - KII with CBDs, detailers Mobilizers (Data Collectors)	HWs+ Client Exit interviews (DB, JO & data collectors) Shaga LGA Community A&B KII with CBDs, detailers Mobilizers (Data Collectors)	HWs+ Client Exit interviews (DB, AO & data collectors) Argugu LGA Community A&B - KII with CBDs, detailers Mobilizers (Data Collectors) Travel to Sokoto
04:00 PM	Jega LGA Community B – FGD with women that did not attend ESMMPIN HF (AO & data collectors) - Health Facility Assessment+ HWs+ Client Exit interviews (DB, JO & data collectors) Jega LGA Community A&B KII with CBDs, detailers Mobilizers (Data Collectors)	Shaga LGA Community B – FGD with men that did not attend ESMMPIN HF (JO & data collectors) Shaga LGA Community B - Health Facility Assessment+ HWs+ Client Exit interviews ((DB, AO & data collectors) Shaga LGA Community A&B - KII with CBDs, detailers Mobilizers (Data Collectors)	
05:00 PM	Jega LGA Community B – -FGD with men that did not attend ESMMPIN HF (JO & data collectors) Health Facility Assessment+ HWs+ Client Exit interviews ((DB, AO & data collectors) Jega LGA Community A&B KII with CBDs, detailers Mobilizers (Data Collectors) Travel back to hotel	Travel to hotel	Sunday 13th November 2016 Travel to Abuja

ANNEX VI. SUMMARY OF DATA COLLECTED

SUMMARY OF QUALITATIVE AND QUANTITATIVE DATA COLLECTED DURING THE EVALUATION

Table VI.1: Key Informant Interviews (KII) Respondents

Type of respondents	Lagos	Oyo	Ogun	Sokoto	Zamfara	Kebbi	Abuja	Total
Govt. Officials	4	2	5	3	2	2	7	25
Health Care Worker	9	5	10	5	6	6	N/A	41
Community Mobilizers	6	5	6	5	9	5	N/A	27
Exit Interviews	13	4	9	11	9	10	N/A	56
WDC Members	4	2	2	5	3	5	N/A	20
Distributors	1	0	0	1	0	0	N/A	2
PPMVS	9	18	13	10	3	13	N/A	66
Detailers	2	1	1	1	0	0	N/A	5
HFAs Assessed	5	5	6	5	6	5	N/A	32
USAID Staff	N/A	N/A	N/A	N/A	N/A	N/A	11	11
ESMPIN Staff & Partners	8	4	2	2	1	5	25	47
Others (SHOP)	1	N/A	N/A	N/A	N/A	N/A	N/A	1
Others (Gender Consultant)	N/A	N/A	N/A	N/A	N/A	N/A	1	1
Total	62	46	54	48	39	51	44	344

Table VI.2: FGD Conducted and Number of Respondents

Type of respondents	Lagos	Oyo	Ogun	Sokoto	Zamfara	Kebbi	Total
FGD conducted - Men	3	6	8	6	6	6	35
FGD Respondents - Men	16	41	23	24	24	26	154
FGD conducted - Women	3	9	7	6	6	5	36
FGD Respondents – Women	23	79	29	25	24	20	200
Total FGDs conducted	6	15	15	12	12	11	71
Total FGDs Respondents	39	120	52	49	48	46	354

Table VI.3: Total PPMVs Trained per Year.

Year	Target	ACHIEVEMENT 2011-2016		
		Female	Male	ALL
2011		941	2,029	2,970
2012	15,500	5,054	8,125	13,179
2013	15,000	5,926	8,284	14,210
2014	15,000	6,081	8,976	15,057
2015	15,000	1,802	2,319	4,121
2016		1,776	2,434	4,210
Total	60,000	21,580	32,167	53,747

Table VI.4: CYP for Family Planning Products on ESMPIN

	CYP	CYP	CYP	CYP	CYP	Total
Family planning Products	Year 1 (July 2011 - Dec 2012)	Year 2 (Jan-Dec 2013)	Year 3 (Jan-Dec 2014)	Year 4 (Jan-Dec 2015)	Year 5 (Jan-Dec 2016)	CYP Jul 2011-Sept 2016
Gold Circle	2,598,619	1,477,037	1,605,984	1,095,216	807,494	7,584,350
Duofem	128,340	0	0	0	0	128,340
Depo Provera	472,525	261,750	299,725	297,575	255,500	1,587,075
Combination 3	531,150	427,980	514,656	443,040	350,340	2,267,166
Noristerat	275,900	160,750	169,917	168,683	116,950	892,200
Copper T	483,000	244,260	446,936	138,276	185,748	1,498,220
Postinor-2	60,276	32,256	49,649	59,424	62,350	263,954
Jadelle	30,400	38,152	41,268	32,619	38,000	180,439
LifeStyles	9,023	6,993	5,940	3,969	3,559	29,484
CycleBeads	65,550	36,300	48,300	27,450	14,250	191,850
Pregnon EC	3,780	18	4,320	648	0	8,766
Norigynon	4,431	1,069	0	0	0	5,500
Elegance	14,501	2,348	4,610	6,575	2,177	30,211
Gold Circle Flex	0	0	0	25,402	24,631	50,033

Total	4,677,495	2,688,913	3,191,305	2,298,877	1,860,998	14,717,588
-------	-----------	-----------	-----------	-----------	-----------	------------

Table VI.5: CYP Method Mix

CYP Method Mix					
Method	CYP Short Acting Methods		Method	CYP Medium & Long Acting Methods	
	Project Actuals	Life of Project target		Project Actuals	Life of Project target
Condoms	7,694,078	2,473,396	IUCD	1,498,220	697,263
Orals	2,673,726	1,012,753	Implant	180,439	67,865
Cycle Beads	191,850	41,976	Injectables 2 mths	892,200	416,530
			Injectables 3 mths	1,587,075	1,249,544
Total	10,559,654	3,528,125		4,157,934	2,431,202
	Total Project actual	Total LOP Target			
CYP	14,717,588	5,959,327			
% Method Mix	71.7%	59.2%		28.3%	40.8%

Table VI.6: Calculation of Change in Method Mix

Methods	CYP Baseline %	CYP Achievement 2011-2016 %	CYP Life of Project Target %
Short Acting Methods	71.8%	71.7%	59.2%
Medium and Long Acting Methods	28.2%	28.3%	40.8%
Total	100%	100%	100%

ESMPIN Project did not achieve the desired change in CYP method mix as at LOP. The method mix remained the same as baseline.

Table VI.7: Performance of CBDAs and IPCAs

ITEM	CBDA	IPCA CYCLES 1-10	Total
Contacts	7,375,265	14,209,051	21,584,316
Referrals	104,420	2,295,187	2,399,607
Redeemed referrals	50,610	576,321	626,931
Method uptake	Not tracked by project	338,169	338,169 (IPCA only)
Referrals to redeemed	48%	25%	26%
Referral to uptake		15%	14% (IPCA only)
Redeemed to uptake		59%	54% (IPCA Only)

Table VI.8: Service Delivery Points (SDPS) Available

TYPE OF SDPs	FY11	FY12	FY13	FY14	FY15	FY16	TOTAL
Clinics	454	265	302	127	123	105	1,376
Proprietary patent medicine vendors (PPMVs)	1,019	156	522	385	409	502	2,993
Pharmacies	518	380	386	193	232	378	2,087
Non-traditional outlets (NTOs)	124	616	22	2	-	36	800
Total	2,115	1,417	1,232	707	764	1,021	7,256

Table VI.9: Detailing Calls by Detailers to SDPS

SDP OUTLETS	FY15	FY16	TOTAL
Hospital & clinics	4,038	3,531	7,569
pharmacies	5,482	5,615	11,097
PPMVs	4,125	2,757	6,882
Others (NTOs)	292	597	889
TOTAL	13,937	12,500	26,437

TABLE VI.10: CENTRAL BANK OF NIGERIA EXCHANGE RATE

Year	1\$
2011	151.79
2012	157.43
2013	157.31
2014	158.55
2015	197.00
2016	305.00

TABLE VI.11: FAMILY PLANNING AND CHILD SURVIVAL STRATEGY OUTCOMES FOR ESMPIN

Outcome measures	Year 1 (July 2011 - Dec2012)	Year 2 (Jan - Dec 2013)	Year 3 (Jan- Dec 2014)	Year 4 (Jan- Dec 2015)	Year 5 (Jan -Sept 2016)	Total Outcome Measure
Number of births averted	329,590,402	187,543,304	205,141,950	145,845,752	108,828,968	976,950,376
CYPs	4,677,494	2,688,913	3,191,305	2,298,877	1,860,998	14,717,588
No of cases of diarrhoea prevented	2,193,656	1,507,824	1,362,720	4,659,960	7,990,464	17,714,624
No of cases of diarrhoea treated	-	1,200	428,316	311,900	493,700	1,235,116

TABLE VI.12: TOTAL INTERVENTION COST FOR ESMPIN

Program cost	Items	Year 1 - (From Inception to Dec 2012)	Year 2 (Jan -Dec 2013)	Year 3 (Jan-Dec 2014)	Year 4 (Jan-Dec 2015)	Year 5 (Jan - Sept 2016)	Total Amount Spent from Inception to Sept 2016
Personnel cost	Personnel cost						
	Local Staff						
	Direct program staff (local)	2,306,662.00	1,510,467.00	1,671,753.00	1,951,565.00	1,469,995.00	8,910,442.00
	Support / Admin Staff / Volunteer	875,829.00	451,507.00	470,111.00	697,926.00	574,525.00	3,069,898.00
	Warehouse staff	71,642.00	73,454.00	65,229.00	61,282.00	51,802.00	323,409.00
	Benefits, allowances, pension contribution	823,632.00	485,920.00	577,249.00	659,197.00	517,426.00	3,063,424.00
	International staff						
	Direct Salary Expats	372,670.00	204,056.00	219,530.00	148,089.00	22,379.00	966,724.00
	Allowances (housing, shipping, storage, danger pay and other allowances)	446,525.76	210,557.52	172,889.07	162,973.27	81,466.52	1,074,412.14
	Outside Consultant services (legal, finance, security, IT etc.)	502,673.00	254,572.00	165,192.00	385,745.00	130,754.00	1,438,936.00
	Total	5,399,633.76	3,190,533.52	3,341,953.07	4,066,777.27	2,848,347.52	18,847,245.14
Facilities	Facilities						
	Rent (Facilities/ Warehouse)	110,712.69	33,632.34	90,265.94	48,344.28	52,816.00	335,771.24
	Office Repairs & Maint	40,322.17	16,129.80	31,777.58	59,924.49	32,088.00	180,242.04
	Warehouse Repairs & Maint	5,882.15	110.66	4,600.06	2,701.25	1,111.30	14,405.43
	Utilities	23,661.58	14,843.90	10,251.16	23,335.09	11,528.69	83,620.43
	Total	180,578.59	64,716.70	136,894.74	134,305.12	97,543.99	614,039.14
Equipment & Furniture							
	(Computers & Laptop)	12,344.76	15,778.00	16,523.67	38,938.16	38,938.16	122,522.75
	Copier	8,340.24	0.00	0.00	0.00	-	8,340.24

Program cost	Items	Year 1 - (From Inception to Dec 2012)	Year 2 (Jan -Dec 2013)	Year 3 (Jan-Dec 2014)	Year 4 (Jan-Dec 2015)	Year 5 (Jan - Sept 2016)	Total Amount Spent from Inception to Sept 2016
	Equipment repairs & maintenance	48,884.21	42,357.49	43,188.27	47,987.01	33,012.00	215,428.98
	Office furniture	9,656.42	9,656.42	9,656.42	9,656.42	9,656.42	48,282.08
	Total	79,225.62	67,791.91	69,368.36	96,581.59	81,606.58	394,574.05
Travel & Transport	Travel & Transport						
Vehicles	Vehicles						
	Vans, Ford Rangers	190,409.34	190,409.34	190,409.34	190,409.34	190,409.34	952,046.71
	4x4 four-wheel drive	0.00	22,914.42	22,914.42	22,914.42	22,914.42	91,657.68
	Vehicle Insurance	59,693.44	23,576.03	102,959.27	46,162.69	-	232,391.43
	Vehicle repair & maintenance	62,070.70	53,107.04	72,469.26	94,614.02	77,539.48	359,800.50
	Cost of fuel	21,460.19	108,123.91	107,363.51	133,686.21	89,154.45	459,788.27
	Intl Airfares and per diem for Conference & Training	9,951.70	0.00	5,445.04	34,807.97	2,751.32	52,956.04
	Visas/Travel Fees/Baggage	10,226.38	8,746.42	5,272.33	3,699.06	-	27,944.18
	Local Airfares and per diem for Conferences, Training & retreat	221,283.94	184,099.52	242,085.44	469,489.22	134,589.39	1,251,547.52
	Other Airfares: relocation, home leave	29,980.67	11,223.53	2,077.30	1,365.42	-	44,646.92
	Local transport	11,517.06	63,114.53	5,885.29	6,911.00	3,929.90	91,357.79
	Shipping & handling	12,508.23	0.00	0.00	0.00		12,508.23
	Medical Evacuation Insurance	88.00		0.00	0.00	-	88.00
	Workers Compensation (FWC)	282.00		0.00	0.00	-	282.00
	Workers Compensation (DBA)	3,449.58		0.00	0.00	-	3,449.58
	Total	632,921.23	665,314.74	756,881.21	1,004,059.36	521,288.31	3,580,464.85

Program cost	Items	Year 1 - (From Inception to Dec 2012)	Year 2 (Jan -Dec 2013)	Year 3 (Jan-Dec 2014)	Year 4 (Jan-Dec 2015)	Year 5 (Jan - Sept 2016)	Total Amount Spent from Inception to Sept 2016
Educational materials	Communication						
	IEC Production Other Media (2 providers, 1 pregnancy women, youth, low literacy, child survival caregivers, and referral cards)	330,046.00	18,435.00	81,396.00	329,452.00	109,358.81	868,687.81
	IEC Educational Events (Intervention through SMS messages to providers)	0.00	897.00	0.00	6,342.00	3,840.00	11,079.00
	IEC Educational Events (16 Launch for 3 products at Cluster and national levels)	392,006.00	13,162.00	3,940.00	39,898.00	28,858.00	477,864.00
	IEC Educational Events (Storming the Nightingale)	125,632.00	53,205.00	27,445.00	23,564.00	4,412.00	234,258.00
	National Level Advocacy		10,305.00	0.00	0.00	-	10,305.00
	Total	847,684.00	96,004.00	112,781.00	399,256.00	146,468.81	1,602,193.81
	Media Expenses						
Media Expenses	BBC-Content Development, production, training, endline survey	759,576.74	1,210,465.07	1,287,113.30	1,389,935.08	365,072.13	5,012,162.31
	Free Air time and Space	351,887.03	550,153.67	568,487.00	548,611.74	81,515.65	2,100,655.07
	Additional media expense by SFH (Radio jingles, drama, and adverts)	614,025.00	453,796.00	1,009,290.00	892,561.00	238,992.32	3,208,664.32
	Total	1,725,488.77	2,214,414.73	2,864,890.30	2,831,107.81	685,580.09	10,321,481.71
Training cost	Training cost						
	PPMV Training	804,410.72	389,843.08	444,174.23	296,354.15	306,051.53	2,240,833.71
	Detailers meeting	54,877.73	60,681.53	32,303.58	64,827.28	99.53	212,789.65
	IPC, total training cost including materials and remuneration	626,705.93	432,115.59	636,514.66	807,861.75	718,571.40	3,221,769.32
	Program Meetings & Retreats	237,220.36	78,385.59	218,426.51	160,687.33	108,350.00	803,069.79

Program cost	Items	Year 1 - (From Inception to Dec 2012)	Year 2 (Jan -Dec 2013)	Year 3 (Jan-Dec 2014)	Year 4 (Jan-Dec 2015)	Year 5 (Jan - Sept 2016)	Total Amount Spent from Inception to Sept 2016
	<i>Conferences Collaboration</i>	68,270.88	13,416.36	41,749.51	61,186.28	35,387.14	220,010.17
	Total	1,791,485.62	974,442.14	1,373,168.50	1,390,916.80	1,168,459.59	6,698,472.64
Research & Evaluation Cost	Research & Evaluation Cost						
	<i>Total project expenditure on research: surveys, cost benefit analysis, qualitative surveys</i>	1,167,347.00	386,468.78	149,751.24	337,504.33	115,616.40	2,156,687.75
Other Project Partners	Other Project Partners						
	<i>PSI</i>	555,348.21	280,816.65	250,289.78	349,432.34	113,236.10	1,549,123.08
	<i>ARFH</i>	1,086,477.25	1,096,282.79	2,039,263.50	1,735,300.87	704,654.00	6,661,978.41
	Total	1,641,825.46	1,377,099.44	2,289,553.28	2,084,733.21	817,890.10	8,211,101.49
Other direct cost	Other direct cost						
	<i>Business Insurance</i>	18,656.32	6,266.44	49,526.91	53.16	7,608.81	82,111.63
	<i>Office Supplies</i>	76,989.47	26.41	0.00	9,789.56	4,817.37	91,622.81
	<i>Communications</i>	216,814.89	40,426.80	82,146.96	152,544.90	59,984.58	551,918.13
	<i>Postage and Delivery</i>	8,567.10	6,468.85	4,441.27	3,855.51	1,755.24	25,087.98
	<i>Reproduction & Printing</i>	12,614.59	46,645.34	45,593.69	17,782.14	6,414.62	129,050.39
	<i>Professional Development</i>	1,150.09	952.15	20,178.40	16,875.38	6,988.25	46,144.28
	<i>Non-Program Meeting Expenses</i>	0.00	934.42	0.00	3,004.35	-	3,938.77
	<i>Dues, Fees, Subscriptions</i>	3,548.78	1,382.22	1,201.30	1,640.41	138.01	7,910.72
	<i>Bank Charges/Fees</i>	33,040.07	11,632.06	17,663.05	22,404.10	13,472.89	98,212.17
	<i>Miscellaneous/Others</i>	1,816.77		0.00	0.00	-	1,816.77

Program cost	Items	Year 1 - (From Inception to Dec 2012)	Year 2 (Jan -Dec 2013)	Year 3 (Jan-Dec 2014)	Year 4 (Jan-Dec 2015)	Year 5 (Jan - Sept 2016)	Total Amount Spent from Inception to Sept 2016
	Packaging of drugs	2,911.00					2,911.00
	Total	376,109.09	114,734.70	220,751.58	227,949.51	101,179.77	1,040,724.65
	Drug cost (Family planning)	15,465,062.01	8,922,840	10,035,803.90	6,591,330	3,427,942.16	44,442,978.07
	Grand Total	29,307,361.15	18,074,360.65	21,351,797.18	19,164,520.99	10,011,923.32	97,909,963.29
	Drug cost (Child survival)	857,050.41	344,216.97	361,887.82	401,402.7	481,516.8	2,446,074.70
	Grand Total	30,164,411.56	18,418,577.62	21,713,685.00	19,565,923.69	10,493,440.12	100,356,037.99

TABLE VI.13 FGD RESPONSES _ MEN GROUP

Table VI 13:1 – Benefits that FGD participants Received from ESMPIN Project

Variables	Number	%
Provision of Products	5	19%
Awareness about FP, malaria, ORS, etc.	8	31%
Free Drugs - ORS, Zinc, Malaria & FP products	2	8%
Reduction in unwanted Pregnancy	2	8%
Reduction of maternal & child death	3	12%
Improvement in MCH	1	4%
Free Health care services	2	8%
Quality Health Care Services	3	12%
Total Respondent	26	

Table VI 13:2 – Benefits that FGD participants expected from ESMPIN Project

Variables	Number	%
Full program on malaria Control	1	5%
Establishment of emergency centre	1	5%
Increase in quantity of drugs supplied	3	16%
Free FP drugs/services	4	21%
More sensitization/awareness creation	6	32%
More FP units in HFs	3	16%
Provision of bed nets	1	5%
Total Respondent	19	

Table VI 13:3 – How can ESMPIN make their services more acceptable

Variables	Number	%
TBAs to be fully integrated into healthcare system	1	8%
Provision of treated bed net	1	8%
Provision of malaria injection	1	8%
Increase awareness	6	50%
Provision of free FP products	2	17%
More posters	1	8%
Total Respondent	12	

TABLE VI.14 -FGD RESPONDENTS: WOMEN

Table VI.14:1 Type of treatment /care received at Health Facilities

Variables	N	%
FP	19	34%
Child Treatment - Diarrhoea, Immunization	15	27%
Malaria Treatment	15	27%
Post Natal Care	1	2%
General care, stomach upset, body weakness	6	11%
Total Respondent	56	100%

Table VI.14:2 Type of Products brought from Health Facilities

Variables	N	%
FP Methods	7	30%
Zinc/ORS	8	35%
PUR/Water Guard	2	9%
Malaria Drugs	2	9%
antibiotics	1	4%
Others _ antibiotics, BP Drugs, Analgesic	3	13%
Total Respondent	23	100%

Table VI 14:3 Are Cost reasonable and Affordable

Variables	N	%
Yes	11	38%
No	3	10%
Free	15	52%
Total Respondent	29	100%

Table VII 14:4 How do you get to know about ESMPIN Project

Variable	N	%
Community Mobilizers	15	28%
BBC Materials	10	19%
Word of Mouth	10	19%
Home to Home visits	7	13%
Mass Media	12	22%
Total Respondent	54	100%

Table VI 15 - PPMVS/CBDS RESPONDENTS**Table VI 15:1 Did you receive training under the project**

Variable	N	%
Yes	53	80%
No	12	18%
No Response	1	2%
Total	66	100%

Table VI 15:2 Type of training received

Variable	N	%
FP	41	71%
Malaria	2	3%
Diarrhoea	10	17%
Water Treatment	1	2%
Others (IPC training, Basic Training)	4	7%
Total	58	100%

Table VI 15:3 How did ESMPIN make a Difference in your work

Variable	N	%
Increase Income/ sales	7	23%
Increase Knowledge/ Able to better educate clients	22	71%
Able to save lives	2	6%
Total	31	100%

Table VI 15:4 What type of ESMPIN commodities you sell**Multiple Response _ N=66**

Variable	N	%
FP Products – Combination 3, Postinor, Condoms, Injectables	64	97%
Zinc, ORS	50	76%
Water guard, PUR	27	41%

Table VI 15:5 What type of ESMPIN commodities do you sell

Multiple Response _ N=66

Variable	N	%
SFH/ESMPIN	42	64%
Pharmacies	12	18%
Buy from Market		0%
Others (CHI, PPFN, ICARE, Community Excellence)	4	6%

Table VI 15:6 Most Popular Methods sold by PPMVs

Multiple Response _ N=66

Variable	N	%
Oral (Combination 3)	43	65%
Condom	26	39%
Injectables	1	2%
Postinor	1	2%
No response	2	3%

Table VI 15.7 Ever experienced stock out of commodities

Multiple Response _ N=66

Ever experienced stock out of commodities	N	%
Yes	16	24%
No	47	71%
No Response	3	5%
Total	66	100%

Table VI 15.8 Type of Product usually stocked out

Combination 3

Table VI 15.9 How often do you receive Products**Multiple Response _ N=66**

Variable	N	%
Once a week -Monthly	20	30%
2 Months plus	5	8%
Constantly/ Regularly	20	30%
Not regular	1	2%
On request	5	8%

Table VI 15.10 Have you experience other challenges

Variable	N	%
Yes	16	24%
No	44	67%
No response	6	9%
Total	66	100%

Table VI 15.11 Type of Challenges experienced**Multiple Response _ No=16**

Variable	N	%
NPF & PCN Harassment	4	25%
Bleeding from use of orals	2	13%
Product expiry date	1	6%
Increase in price of commodities	1	6%
Out of stock from company	1	6%

Table VI 15.12 Will you be able to sell the products after ESMPIN Close out

Variable	N	%
Yes	56	85%
No	8	12%
No Response	2	3%
Total	66	100%

Table VI 15.13 If Yes Why?**Multiple Response_ N=56**

Variable	N	%
Increased Income	7	13%
Because of its patronage	5	9%
Already buying the products from open market	13	23%
Availability of products	20	36%
Others - to mentor my customers	1	2%

Table VI 15:13 How?

Variable	N	%
I am already buying it from the open market/ where to get products	37	66%

Table VI 15:14 Things that will like the Project to do**Multiple Response_ N=66**

Things want project to do	N	%
Product Availability	15	23%
Provide more training	18	27%
Cost of commodities to be reduced	5	8%
Commodities like ORS/ZINC, ACT, to be available and affordable	2	3%
Sensitization of NPF to stop harassing PPMVs	1	2%
Vendors to be licensed to sell FP injections	1	2%

Table VI 16: Detailers Responses**Distribute commodities - FP products, Water guard, ORS/ZINC****Table VI 16.1 Do retailers experience stock out?**

Variable	No	%
Yes	3	100%
No	0	0%

Table VI 16.2 Commodities stock out

Variable	No	%
Water guard	2	67%
Depo Provera	2	67%
Noristerat	1	33%
Combination 3	1	33%

Table VI 16.3 Detailing cost effective?

Variable	No	%
Yes because it help to increase uptake of service	3	100%

Table VI 16.4 Do you experience challenges?

Variable	No	%
Yes	3	100%
No	0	0%

Table VI 16.5 Type of challenges experienced

Responses
Competitors - DKT
Insecurity
Harassment of PPMVs
Economic conditions
Training of PPMVs
Providers not wanting to listen

Table VI 16.6 Recommendations

Responses
Employ more providers
Provide training to PPMVs
Cost of products to be competitive with those in the market

Table VI. 17 GOVERNMENT OFFICIALS RESPONSES

Table VI 17.1 Methods Available & Affordable

Variable	No	%
Methods Available & Affordable	5	28%
Others	2	11%
No Idea	5	28%
No Response	6	33%
Total	18	100%

Table VI 17.2 Cost effectiveness

Variable	No	%
ESMPIN Products cheaper than other FP products (Use cheaper approach to achieve more)	4	33%
Good Value for Money "Project empowers the community and leave community with health knowledge useful to them" "No amount is too much to secure the health and future generation"	2	17%
Not Cost Effective Free Service in government not free in private hospital & expensive Use more to achieve less	2	17%
Don't Know	4	33%
Total	12	100%

Table VI 17.3 Recommendations

Extend project duration/increase coverage	2
Provide adequate remuneration for mobilizers	1
Re-training of health workers	1
Involve WDC from inception of project	1
To incorporate both demand creation and service provision in future projects	1

Table VI 18 COMMUNITY MOBILIZERS RESPONSES

Table VI 18.1 Impact of the project

Variable	N0	%
Increase awareness about FP, malaria, water sanitation & environment	15	58%
increased acceptability because services are rendered at homes	1	4%
Improved attitude and uptake of FP and Malaria services	6	23%
Decreased morbidity and mortality among pregnant Women and children	1	4%
Decreased unwanted pregnancies and abortion rates and better water purification	2	8%
Child spacing in practice	1	4%
Total	26	100%

Table VI 18.2 Did you participate in any ESMPIN Training

Variable	No	%
Yes	27	100%
No	0	0%
Total	27	100%

Table VI 18.3 Types of training received

Variable	No	%
How to administer products - FP. ORS/ZINC. Water purification drugs	25	83%
Community mobilization	1	3%
Referrals	2	7%
IPC	2	7%
Total	30	100%

Table VI 18.4 Reasons for referring clients

Variable	No	%
Affordable service	3	10%
Accessibility	4	13%
Have professionals in HFs	3	10%
Staff Hospitality	1	3%
FP services	19	61%
Counselling	1	3%
Total	31	100%

Table VI 18.5 Do you refer more males or females

Variable	No	%
More Female	26	96%
More Male	1	4%
Total	27	100%

Table VI 18.5 Do people referred assess service

Variable	No	%
Yes	8	36%
No	14	64%
Total	22	100%

Table VI 18.6 Reasons for referring more females than male

Reasons for referring more females than male	No	%
Most products are for women	14	52%
Women are usually around	2	7%
Women are more accessible and approachable	7	26%
Impact on them and their children	1	4%
Main beneficiaries of FP	1	4%
Women bear the burden of child birth	1	4%
Husband is head of family	1	4%
Total	27	100%

Table VI 19 WARD DEVELOPMENT COMMITTEE RESPONSES**Table VI 19.1 Role of WDCs on ESMPIN Project**

CBDs Selection
Sensitization
Education of People on FP
Link Beneficiaries to HF

Table VI 19.2 What difference experienced in Communities as a result of ESMPIN Intervention

Multiple response: Number =20

Variable	No	%
Increase in use of FP	8	40%
Increase in utilization of HFs	1	5%
Water purification	2	10%
Reduction in unwanted Pregnancies and abortion	3	15%
Reduction in incidence of Diarrhoea	4	20%
Husbands now adopt FP & CS services	1	5%

Table VI 19.3 Did communities benefited from ESMPIN Program

Variable	No	%
Yes	20	100%
No	0	0%
Total	20	100%

Table VI 19.4 Type of Benefits. Multiple Response: N=20

Variable	No	Total
FP accepted and practiced	10	50%
Reduction in infant and maternal mortality	3	15%
Reduction in abortion rate and unwanted pregnancy	3	15%
Increased patronage at HFs	5	25%

Table VI 19. 5 Participation in ESMPIN Training

Variable	No	%
Yes	14	70%
No	5	25%
No Response	1	5%
Total	20	100%

Table VI 19.6 Type of Training Received**Multiple Response Number = 14**

Variable	No	%
FP, immunization	6	43%
Use of water guards	2	14%
Diarrhoea Treatment	1	7%
Malaria Prevention and Treatment	4	29%
Sensitization	4	29%

Table VI 19.7 Benefits Health Facilities Received from WDC participation in ESMPIN Project

Variable
More people referred for FP
Increase in uptake of FP service
Increase in client flow

Table VII 19.8 Recommendations

Variable
Increase awareness to hard to reach areas 3 WDC groups
Make products available at affordable price (3 WDC groups)
Require more trainings
To create more awareness and motivate the communities

Table VII 20 HEALTH CARE WORKER RESPONSES**Table VII 20.1 Type of Health Care Worker**

Variable	No	%
CHEWs	22	55%
Nurse/Midwives	10	25%
Nurse	5	13%
Doctor	1	3%
Health Educator	2	5%
Total	40	100%

Table VI 20.2 Did you Participate in ESMPIN Training

Variable	No	Total
Yes	17	43%
No	19	48%
No Response	4	10%
Total	40	100%

Table VII 20.3 Type of Training Received**Multiple Response _ Number=17**

Variable	No	Total
Family Planning	14	82%
Malaria Prevention and Treatment	3	18%
Diarrhoea Prevention and Treatment	5	29%
Exclusive Breast Feeding	2	12%

Table VI 20.4 Would you like to receive training in Future

Variable	No	%
Yes	36	90%
No	4	10%
Total	40	100%

Table VI 20.4 Type of Trainings Desired

Variable	No	%
FP	28	78%
Malaria	1	3%
Diarrhea	1	3%
HIV/AIDS	1	3%
No Response	5	14%
Total	36	100%

Table VI 20.5 Types of Products Dispensed**Multiple Response – Number = 40**

Variable	No	%
FP	35	88%
ORS/ZINC	28	70%
Anti-Malaria	21	53%
Water Purification drugs	2	5%

Table VI 20.5 Experienced Stock out in last 3 Months

Variable	No	%
Yes	6	15%
No	34	85%
Total	40	100%

Table VI 20.6 Types of commodities stocked out

Variable
Injectables - Depo and Norristerat
Female and Male condom
Antibiotics

Table VI 20.7 Source of Product

Variable	No	%
DDIC	2	5%
MAP	3	8%
State Ministry of Health	15	38%
SFH	5	13%
ESMPIN	4	10%
HIVN	1	3%
UNICEF	3	8%
WHO	1	3%
SHOPS	2	5%
Pharmacy	3	8%
Maria Stope	1	3%
Total	40	100%

Table VI 20.8 Uptake of service after EMPIN Intervention

Variable	No	%
Good/Very Good	35	88%
Poor	2	5%
No Change	2	5%
Don't Know	1	3%
Total	40	100%

Table VI 21 ESMPIN STAFF RESPONSES**Table VI 21.1 Biggest contribution of ESMPIN Project****Multiple Response - Number=8**

Variable	No	%
Provision of affordable products	2	25%
Capacity Building	3	38%
Increase access to the unreached areas	5	63%
Increase FP & MCH knowledge	3	38%
Demand Creation	4	50%
Product Availability	2	25%
Task shifting using CHEWs	2	25%

Table VI 21.2 Project Activities that worked well

Variable	Number	%
Town Hall Meeting	3	38%
Male involvement	3	38%
Use of IPC	3	38%
Use of IEC	1	13%
Product Distribution	1	13%
Monthly Review Meeting	2	25%
Monitoring and Supervision of IPCAs	1	13%
Integration of FP and child survival products	1	13%
Use of Drama	2	25%
CBD strategy	2	25%
Use of CHEWS	2	25%
Secure buy in of stakeholders	1	13%

Table VI 21.3 What contribute to the success

Variable
Leveraging on existing projects
Buy in of Government
Availability of funds
Dedication of project staff
Proper communication
Engagement of stakeholders
Engagement of drama troupes
Task shifting policy

Table VI 22.4 Project Activities that did not work well

Not using task shifting from inception of project
Short duration of IPC cycle "too short to see impact" ESMPIN Staff Oyo
Lack of service provision component in cycles 1-9
Pricing of FP products
Inadequate number of CBDs per ward
Counselling at HFs

Table VI 22.5 Reasons for not working well

Policy on task shifting not approved until later in implementation of project
Project design
Government gives commodities while CBDs sell
Inadequate funding
Issues discussed at HF too generic and not detailed

Table VI 22.6 Are there Policies that hampered implementation?

Variable	No	%	Types of Policy
Yes	4	50%	Free distribution of FP products at Government Facilities CHEWs not able to provide LARC service
No	2	25%	
No response	2	25%	
Total	8	100%	

Table VI 22.7 Challenges Encountered

Late disbursement of funds/inadequate funding
Insecurity
Hard to reach terrain
Clients not getting to HFs/poor turnout of clients
Short duration of cycles
Strike Action in public Health Facilities
Relocation of IPC members from community
High cost of FP services in some HF
Poor attitude of HCWs to referred clients
Free distribution of FP products
Not able to provide other products like LLITNs and ACT

Table VI 22.8 Sustainable Interventions**Multiple Response – Number=8**

Variable	No	%
Facility service provision	2	25%
Product Distribution to PPMVs	2	25%
Use of CHEWs in IPC	3	38%
CBD Model	4	50%

Table VI 22.8 Reasons for sustainability

Variable	No	%
Ability of PPMVs to sell products without help	3	38%
Task shifting policy	3	38%
Sustained service of Awareness creation	1	13%
CBD organized, registered, have account and already meeting on their own	3	38%

Table VI 22.9 Gender Interventions

Variable
Working with Okada Riders
Have separate meetings with men in work place and association meeting
Message targeted at men
25% CBD Men, 75% women
80% referrals women and 20% are men
Men now supporting their wives to use FP products
Women now encouraged to make inputs into issues that affect them

Table VI 22.10 Collaboration

Consortium Members	Government	Other Projects
Produce IPC Flip Charts _ PSI	Participate in joint review meeting	FHH+ - trained HCWs on LARC
Supplies the commodities - SFH	conduct joint monitoring visits	NURHI - Training of providers
Involve in demand Creation - ARFH	Participation in Technical Working group meetings	MAP - give malaria drugs
Demand creation through mass media - BBC	Support of various stakeholders like community leaders etc.	Global Fund - provide both FP and Malaria products
Relationship is good, mutual and cordial	Quote "WDCs are like Senior friends to CBDs" Kebbi staff	PPFN - provide RDTs, nets & drugs for CBDs
		Participate in partners quarterly review meetings

Table VI 22.11 Recommendations

Scale up/increase geographical coverage	3
Continue capacity building for providers	3
Task shifting policy to be sustained	1
Increase IPC cycle period to 1 year	1
Have program for youths	1
Include service provision in project design	1
Supply free commodities to CBD for them to sell at token price	1
Integrate other products like nets, ACT in CBD commodities distributed	2
Provide motorcycles to CBDs for ease of movement	1
Increase transport allowance to CBDAs	1
To have sustainability plan from inception of project	1
Have sufficient budget to cover hard to reach areas	1
Have office space, equipment's, etc. for NGOs, CBDs	1
Increase margins given to CBD agents	1
Use of CBDAs instead of IPCAs because it is more sustainable	1

ANNEX VII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

USAID Non-Disclosure and Conflicts Agreement- GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT

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

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

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine

of up to \$5,000, or both. In particular, U.S. criminal law (18 USC 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my contract or other relationship with the Department or Agency that last ted me access to

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

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Signature

Date 4 Oct 2016



Name

Title Manufacturing Pen

Ar

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

08/25/16

Name

ADENIJI FOLUKE OLUKENI

Title

DR

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	
Signature	Date 10-06-2016
Augustine	
Name	Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

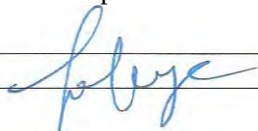
Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

12/08/2016

Name

AWOLETE JOSHUA OLATUNJI

Title

Mr.

Page 114 of 131

PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.	
9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.	
ACCEPTANCE The undersigned accepts the terms and conditions of this Agreement.	
Signature	Date
<u>Ayodeji Omotayo Ohugbemi</u>	<u>28/7/2016</u>
Name	Title
<u>AYODEJI OMOTAYO OHUGBEMI</u>	<u>MRS</u>

Page 114 of 131

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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

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

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	1-9-16
Signature	Date
SA'ADATU T. SULE	DA
Name	Title

ANNEX VIII. STATEMENT OF DIFFERENCES

ESMPIN's Response to Endline Evaluation Report

General Comments on the Evaluation Report

Thank you for the opportunity to provide comments for this review report. While we appreciate the perceptions made clear by the reviewers, it seems that the evaluators were not able to fully understand what the ESMPIN project was set up to achieve by USAID, how the program went about achieving it and the challenges (both identified risks and emerging issues) that affected the outcome of the program.

1. The Expanded Social Marketing Project in Nigeria (ESMPIN) was designed and mandated to operate within the private sector. It was not expected to work in the public sector. The association with the public-sector health facilities was mainly due to the evidence that within the locations that ESMPIN implemented the Interpersonal Communication (IPC) and Community Based Distribution (CBD) strategies, that there were limited numbers of private health facilities and where they existed, at most times lacked trained family planning providers. This scenario predicated the need to operate within certain facilities in the public sector for referral. This was clearly not evident in the report, which continually faulted our inability to engage with the public sector as pertains to using publicly engaged CHEWs.
2. The program was unable to increase long term and medium term methods in the public sector as though the IPC work done referred clients to the public sector clinics (as referral facilities available in most communities were from the public sector) and due to the commodity logistics systems in Nigeria, ESMPIN is not allowed to sell or distribute products to public sector facilities.
3. The continued faulting of ESMPIN not seizing the opportunity to work with local manufacturers centered on the restrictions associated with the purchase of goods using USG funds from manufactures that have not met certain specifications. Despite this, SFH as an organization through its social business worked with a number of local manufacturers, including Daily Need Industries and CHI Pharmaceuticals.

Research

A lot was alluded to inadequate conduct of formative research to guide development of the profiles of the secondary audiences. The evaluators assumed that some research work were not carried out that they believed was necessary: this mainly borders on secondary audiences.

It is obvious, and has been pointed out at many times and shared with the team, that a great deal of research was carried out, influencers including the barriers to SBCC were identified, and strategies to either seize the opportunities that they offered or overcome the barriers that they were identified. Messages developed were usually pre-tested to determine their response to these; meetings were held in the communities with such influencers; and post evaluation exercises usually reflected on if the work done had helped overcome the obstacles identified or presumed.

It must be appreciated that the research work of the project was a continuous exercise, and the knowledge that in Nigeria customs vary across zones and even within states and localities must be

noted. The barriers identified in locations were regularly discussed during the monthly review IPCA and CBDA meetings. The ESMPIN Health Communication Coordinator (HCC) and the team of IPCAs (who were from the communities) then developed approaches to overcome the barriers. These approaches commonly included meeting with the male partners, meeting both religious and traditional heads, developing strong relationships with the health workers in the referral health facilities.

Sales

A statement was made of ESMPIN' commitment to improve the sales of the Long and medium term methods. The statement looks at the method mix rather than if ESMPIN increased the sales of the various products. The sales of various medium and long-term methods increased in the period of ESMPIN. This increase was **significant and is on target in ESMPIN** (though less than the target stated in the evaluation).

This was despite the major strategy of distributing the commodities to private sector health facilities in the IPC communities was eroded because of the lack of private health facilities with trained providers in most locations where the poor and vulnerable work, which was where ESMPIN was expected to work. The sales generated because of this was therefore not reflected in the sales made by the Sales team.

It is clear that the IPC strategy led to a significant change in the method mix in locations where it worked, which is also reflective in the states at large. This is reflected in the method mix seen in the IPC evaluation 2016; SHARCHS 2016 and the NBS smart survey 2015.

Cost effectiveness

The aim of looking at the cost-effectiveness of the strategies seem to be carried out in a logical manner. Some areas of efficiency are however not reflective of the work done. The use of a IPC contacts-to-FP uptake may not be the best method of developing a measure of efficiency.

The IPC contacts do not imply reached persons as the strategy expects that all persons would have been reached at least twice during a cycle and persons who have opted for referrals were visited more than twice to provoke their redeeming the referrals.

While operating within an environment that does not give targets, our expectations was to obtain about 35 referrals per IPC working per month. It was on this basis that IPCAs were assessed. Our data shows that the average IPC generated about 27 referrals a month which was 80% of our expected reach.

Below are the specific comments for statements that have been written in the draft report. We apologize for repeating comments but as in the report statements were repeated for emphasis, ESMPIN did repeat its comments and clarifications also.

Section	Page	Evaluator's Comment	ESMPIN's Response
Abstract	Page iii Paragraph 1	ESMPIN was successful in building commodity-security, showing a reduction in stock-outs from 30% to 15%. Though the program invested heavily in independent detailing and distribution networks, these are not sustainable operations without heavy funding from donors. Cost analysis and primary research show the return on investment for the interpersonal communication agents (IPCA) in the South to be very low at about 2%, costing \$3.321 million per Cycle (180 communities).	The figure \$3.3M per cycle seems to be an exaggeration or may include other things beyond the IPC strategy. We would strongly recommend that this be reviewed to be more realistic. ESMPIN implemented 10 cycles throughout LOP. An average of \$3.3M per cycle would amount to \$33.3M. Nevertheless, the extrapolation contradicts the total cost for IPC on table 9 of page 40 at \$10, 441.248.98 which covered the total of 10 IPC Cycles. The 2% persons contacted to uptake efficiency does not take into consideration the fact that multiple contacts are made per person to convince people to take up services.
	Page iii Paragraph 1	After \$57 million and almost six years of implementation Couples Years of Protection (CYPs) in 2011 for short and long acting methods were 28.2% and at the end of the program had increased only 0.1% to 28.3% CYPs.	While ESMPIN' proposal to grow the medium & long-acting methods of modern contraceptives to contribute 40.8% of the total CYP by end of project was not met, the project successfully grew the medium & long-acting methods from the 2010 baseline of 25% to 35% by the end of 2016, a 42% increase. <i>(Please note that 28.2% for 2010 baseline mentioned in the proposal was a projection as proposal was submitted before end of 2010).</i> This performance is more exciting particularly when reviewed on a commodity-by-commodity basis. For example, within same period ESMPIN significantly reduced the CYP contribution of Male Condom from the baseline 57% to 41% by end 2016, grew oral pill from the baseline 15% to 19% for obvious reason of

			critical role of oral contraceptives to the unmet need situation in Nigeria. ESMPIN also grew 3-monthly Injectables contribution from 6% to 14% at end of 2016.  LARC Contribution to CYP This performance is bearing in mind the operating environment during the period of ESMPIN project characterized by significant improvement in the access and availability of modern contraceptives products and services in the public sector, with a significant contribution from the evidence informed IPC work done by ESMPIN in IPC communities. In project locations the method mix obtained range from 40%-50% for medium and long term methods (IPC Evaluation 2016; CBD Evaluation 2016; SHARCHS 2016) - See annex
Executive Summary Background	Page 1 Paragraph 2	ESMPIN was to increase Couple Year of Protection (CYP) of Long Acting Reversible Methods (LARM) to 40.8% over the life of the project	Same as above. While ESMPIN proposal to grow the medium & long-acting methods of modern contraceptives to contribute 40.8% of the total CYP by end of project was not met, the project successfully grew the medium & long-acting methods from the 2010 baseline of 25% to 35% by the end of 2016, a 42% increase. <i>(Please note that 28.2% for 2010 baseline mentioned in the proposal was a projection as proposal was submitted before end of 2010).</i> This performance is more exciting when you review this on commodity by commodity basis, for example,

			within same period ESMPIN significantly reduced the CYP contribution of Male Condom from the baseline 57% to 41% by end 2016, grew oral pill from the baseline 15% to 19% for obvious reason of critical role of oral contraceptives to the unmet need situation in Nigeria. ESMPIN also grew 3-monthly Injectables contribution from 6% to 14% at end of 2016.
Executive Summary Evaluation Methodology	Page 1 Paragraph 1	The evaluation team used primary and secondary research to conduct this assignment. ESMPIN's research had critical data gaps of primary and secondary audiences and social and ecological factors that impact decision-making and behaviors.	ESMPIN research provided data to measure all indicators that were stated in the PMP. Beyond this, it provided data for determining the various archetypes for which mass media and IPC messages were developed. Prior to entry into any community, a Rapid Assessment was carried out to determine the profile of the community and the barriers that did exist in these communities and this was shared with the team.
Key Findings	Page 2 Paragraph 1	The data and findings show many activities but no change in CYPs for medium and LARMs over the six years of the project (28.2% CYPs in 2011 and 28.3% CYPs in 2016).	While ESMPIN proposal to grow the medium & long-acting methods of modern contraceptives to contribute 40.8% of the total CYP by end of project was not met, the project successfully grew the medium & long-acting methods from the 2010 baseline of 25% to 35% by the end of 2016, a 42% increase. <i>(Please note that 28.2% for 2010 baseline mentioned in the proposal was a projection and proposal was submitted before end of 2010).</i> This performance is more exciting when you reviewed on a commodity-by-commodity basis. For example, within same period ESMPIN significantly reduced the CYP contribution of Male Condom from the baseline 57% to 41% by end 2016, grew oral pill from the baseline 15% to 19% for obvious reason of critical role

			of oral contraceptives to the unmet need situation in Nigeria. ESMPIN also grew 3-monthly Injectables contribution from 6% to 14% at end of 2016.
Key Findings	Page 2 Paragraph 2	Nigeria has local manufacturers and distributors that can take the lead on most of the social marketing tasks with technical assistance from a project because it is further along the development spectrum.	While this recommendation is succinct, Nigeria has not gone that far along the chain. Nonetheless, we started collaboration with CHI only after their ORS/Zinc passed the USP Pharmacopeia. We also collaborated through SFH with other local manufacturers including Daily Need Industries. It will be interesting to know the source of this information and the local manufacturers that can take a lead on most of the social marketing tasks as our extensive research in this does not appear to show this.
Conclusion	Page 3 Paragraph 1	According to the numbers of all its activities and efforts, ESMPIN did not increase CYP for LARM and after five years wound up in the same place it started at 28.3% CYP for LARM. But the argument could reasonably be made that it lost positioning of LARM because of its over-emphasis on condoms (the only money-maker of all the methods). Service delivery is not easily accessible for these products and public health facilities are giving the same or similar products away for free.	While ESMPIN proposal to grow the medium & long-acting methods of modern contraceptives to contribute 40.8% of the total CYP by end of project was not met, the project successfully grew the medium & long-acting methods from the 2010 baseline of 25% to 35% by the end of 2016, a 42% increase. (<i>Please note that 28.2% for 2010 baseline mentioned in the proposal was a projection as proposal was submitted before end of 2010</i>). This performance is more exciting when reviewed on commodity by commodity basis, for example, within same period ESMPIN significantly reduced the CYP contribution of Male Condom from the baseline 57% to 41% by end 2016, grew oral pill from the baseline 15% to 19% for obvious reason of critical role of oral contraceptives to the unmet need situation in Nigeria. ESMPIN also grew 3-monthly Injectables contribution from 6% to 14% at end of 2016.

Conclusion	Page 3 Paragraph 2 Paragraph 3	Other USAID-funded programs, such as Sustaining Health Outcomes through the Private Sector (SHOPS), were conducting service delivery training and supporting private health facilities but there is little evidence to show a compatible working relationship between the two projects. ESMPIN strategies were not the wrong choices but how they were designed and executed resulted in sub-par performance of sales, CPRs, and unmet needs among primary target audiences and subsequently negligible behavior change.	ESMPIN worked in 22 states of which SHOPS was present in 4 of these states. In these four states, both ESMPIN and SHOPS collaborated in the area of creating demand around HF with SHOP trained healthcare providers. ESMPIN also provided FP commodities to SHOPS at USAID' request. This is emphasized by the evaluator's comment on page 35. There are documented evidence to show improved behavior change (increased client flow and product uptake) at service delivery points in all ESMPIN intervention communities and this includes human interest as well as success stories. These can be seen from the independent HC3 evaluation report, and routine MIS report, among others. In addition, there was evidence of increased access as shown by successive MAP surveys.
Evaluation Methods and Limitations Cost Analysis	Page 11 Paragraph 4	The evaluation adopted mixed methods based on the primary data collected during fieldwork for cost analysis, observations, service data plus secondary data analyzed. Costs were not strictly recorded in the early stages of the project, making it difficult to fully estimate some of the costs.	All costs were recorded as agreed with the donor from Inception to Date (ITD).
Recommendation Successful Activities for Future Projects	Page 4	Under ESMPIN there were four distinct activities that were successful and could be expanded under a new award.	A fifth successful approach for consideration: Through this evaluation, it is obvious that IPC strategy is cost effective when compared to other strategies and should be considered as a strategy that can be adopted in future programs but with an in-built sustainability component as the CHEW approach.

Recommendation Successful Activities for Future Projects	Page 4 Bullet 5	Participatory. The participatory approach used in the North and practiced by the CBDAs under ARHF was successful in engaging with and creating credibility among key stakeholders. This was done by conducting town hall meetings, engaging with men and women, and having advocates from religion, government, and private sector.	This participatory approach was employed across all ESMPIN locations (both in the North and South). Both independent (JHU, HC3) and internally conducted evaluations are available to substantiate. Differences noted in the North and South were based on evidence of what would be effective and local peculiarities, which would be expected in a programme that used research to inform decisions.
Interviews and Field Visits	Page 10 Paragraph 2	In each LGA the team visited two intervention communities representing Interpersonal Communication (IPC) Cycles 1 through 10 for total of 36 visits in the IPC communities. ESMPIN divided its interpersonal communication agents' activities in the South into Cycles. A Cycle lasts for six months and covered a designated geographic area. At the end of six months the IPCAs move to the next geographic region	The IPCAs do not move at the end of a cycle but rather remain in the community as Community Oriented Resource Persons and therefore act as a sustainable resource for health. Implementation in the new cycle is implemented by new sets of IPCAs resident in the new community.
Cost Analysis	Page 11 Paragraph 3	The evaluation adopted mixed methods based on the primary data collected during fieldwork for cost analysis, observations, service data plus secondary data analyzed. Costs were not strictly recorded in the early stages of the project, making it difficult to fully estimate some of the costs. Cost data were sometimes incomplete and difficult to disaggregate. The baseline program was assumed to be "no program," i.e., no method of contraception for the purpose of comparison.	All costs were recorded according to the approved budget as agreed with the donor from inception to date (ITD). All costing data were complete and accurate from ITD and that can be collaborated using the signed, audited financial statements by our independent auditors and further approved by the regional inspector general (IUG) of USAID If cost were incomplete, liquidation and expenses to USAID would not have balanced.

Limitations	Page 11 Paragraph 3	Incomplete documentation of financial and Monitoring and Evaluation data, reporting, and project records: The evaluation team found SFH co-mingled its different projects' documentation, products' sales, and resource tracking, which made it difficult to properly assess the project for cost effectiveness. For example, numbers of people trained were not consistent with ESMPIN's budget line items. Data on Performance Reporting System and ESMPIN DHIS database were incomplete. Also, sales and commodity tracking at the distributor level was paper-based, which made it susceptible to irregularities.	Sales 'co-mingling' as claimed by the evaluators is unfortunately incorrect as monies sent to support sales under ESMPIN is tracked as well as the retirements. Please note that the retirement made by sales is done using the internal orders as provided in the ESMPIN budget. At the time of the evaluation, program activities were still ongoing. However, the database reflected completely, activities that have been carried out prior to the quarter in which the evaluation was carried out.
Findings Evaluation Question 1	Page 12 Paragraph 1	ESMPIN's behavior change goal is the adoption of modern contraceptive methods among underserved women and men in Nigeria, and preventative (water) and treatment (ORS/Zinc) for maternal and child health. To reach this goal, ESMPIN designed an integrated program that used several strategies targeted at primary audiences of men and women of reproductive age. The strategies were interpersonal communication implemented by detailers, IPCAs, and CBDAs; product promotion through community activities including demonstrations; mass media, specifically print and broadcast (radio) advertisements and generic radio programming; messages and material development; and product social marketing targeted to individuals. In a few settings an advocacy strategy was used targeting stakeholders.	In ALL settings, advocacy to gain active participation of all stakeholders was a priority.
	Page 12	As discussed later in this report, the research that was conducted under ESMPIN was among the	Efforts were made to better understand the secondary audience and persons who may influence over our

	Paragraph 2	primary audience of men and women of reproductive age. In-depth interviews were not conducted by ESMPIN among secondary audiences such as religious leaders, family and friends, and traditional health workers who are influential on couples' decision-making. Without this data, it is difficult to identify barriers or motivations to change behaviors, to design messages and outreach activities that are effective and to monitor behavior change.	primary audience. These include secondary analysis of existing data, pre-testing of messages and materials, and the engagement of them during various community meetings.
Audience Segmentation	Page 13 Paragraph 1	The PSI research models create archetypes of its primary audiences: men and women of reproductive health age. Segmentation was primarily gender and there were several archetypes that highlighted religion. <i>In the Report of the ESMPIN Delta Workshop of Injectables</i> held in December 2011 there is an archetype of a couple. It is unclear if they are urban or peri-urban or a specific religion. The archetype models were not updated during the six-year project and as indicated above behaviors and landscape change and archetypes should reflect those changes. Also, archetypes were not created for audiences related to maternal and child health nor for secondary audiences, including public and private health workers, LGA and Ward Development Committee members, and FMOH and state ministries of health (SMOH). Another key secondary audience that was not included in the segmentation or research were the family (in-laws) and friends of couples of reproductive age. The HC3 research highlighted the need for including the family and friends in future	ESMPIN DELTA was behavior specific. Other DELTA archetypes focused on MCH related behaviours e.g. treating children with diarrhea with ORS/Zinc, Purifying drinking water with Water Guard Plus, mothers of new born exclusively breastfeeding, etc. We had primary audience archetypes across all maternal and child health areas. Following findings from the HC3 evaluation report, ESMPIN strengthened her approach towards engaging

		interpersonal communication to increase impact. The influence of family and friends on decision-making is very important and can be even more influential than health care workers and providers. Socio-ecological research was also not conducted.	family and friends of primary targets using satisfied users
Messaging	Page 13 Paragraph 1	Research is used to design strategies and as a guide to message development. Each audience, e.g., couples, stakeholders, family and friends, needs specific messages that would resonate with them, and tailored messages. Messages were developed for each audience category, i.e., men, women, stakeholders, address social norms; however, the message is only birth-spacing (Delta Report and FoQuS, ESMPIN Projects 2012). There continues to be fear and misunderstanding among Nigerian men and women that modern methods are irreversible. According to HC3's research, one out of four women in their study chose to stop using a modern method because of that fear. The role of messaging and communication whether mass media or IPC is to eliminate those fears which the ESMPIN messages re-enforced. In the Delta Workshop referenced above there was a message developed for specific audiences: husbands to wives, men to men, address social norms, and influentials (community leaders) and the message that was developed for each of these audiences is that birth spacing contributes to a healthy family.	The description of the primary archetypes by the ESMPIN DELTA further describes the secondary audiences that influence each of the primary target. ESMPIN activities and messages were then designed to address the behavioural needs of both primary and secondary targets. For instance, the Town hall meetings, advocacy to community leaders, providers, policy makers, etc. were designed with these needs in view
Mass Media	Page 14 Paragraph 2	For ESMPIN, the mass media were shared between SFH and BBC Media Action. BBC Media Action developed generic (not brand- or method-specific) radio programs on health and lifestyle; SFH developed brand- and method-specific radio and print ads. BBC Media Action conducted a study of its mass media and training in the north and its	All ESMPIN print and media messages were non-branded. Nevertheless, the SFH messages that were branded were not USAID funded. Phone numbers were collected during the field implementation in IPC locations. However, <u>only those who gave consent received SMS</u> across all ESMPIN

		results show that the highest reach to target audiences was 27%. A separate study conducted throughout the country by HC3 showed that in the south 80% of women heard at least one FP message on the radio; radio listenership was lowest in the north but was still relatively high at 59 to 69%. However, despite the mass media, sales in the north continued to be low around 17% (HC3 Study 2016). Eighty percent of the women in ESMPIN's target audience have cell phones (HC3 research). However, only 6.3% were contacted with FP messages on their phones and 7.1% received FP SMS. Social and digital media and web-based technologies were not key strategies under ESMPIN. SMS was used by detailers, but the radio programs and radio advertisements were not converted to apps so they could be listened to on mobiles, tablets, or web-based computers.	health areas, as this is challenging to certain person due to multiplicity of messages and women who used FP methods without their spouses consent. ESMPIN leveraged on SFH's presence on social media (Twitter, Facebook, Instagram) to promote its objective. Nevertheless, most of the mobile phones owned by the ESMPIN priority target audience are not android phones, and therefore SMS was a more effective means of reaching them.
Interpersonal Communication	Page 14 Paragraph 2	When distribution and sales are combined with IPC, it may lose credibility and trust; instead of an impartial counseling and discussion, the IPC becomes a promotion and sales spiel. Based on ESMPIN's budget allocations and personnel hours, the IPC through alternative distribution sources had the highest investment. (IPCAs provided counseling and gave each person they talked to with a reference card. Unlike CBDAs in the North, they did not distribute or sell products. The number of targeted people that talked to IPCA and given a reference card to visit a facility was estimated to be 21 million. Out of 14.2 million that were given a reference card by the IPCAs, 338,169 did visit a clinic. This is a 2% uptake. The uptake by IPCAs calculated by the	The CBDA strategy was designed and implemented to combine IPC and sales and this has been commended by the evaluator as effective in this report. The credibility and trust challenge raised in this statement seems to be a contradiction. In addition, the report did not mention in this area the Cycle 10 CHEW method, in which trained CHEWS provided both IPC and service delivery at community level. The figure reflected here corresponds to the number of persons who took up an FP method. The number of those who visited the clinic (redeemed referral) is 576,321.

		evaluation team based on ESMPIN's data and discussed later in this evaluation was low. The IPCAs were very positive about their efforts and their works as were the CBDAs but the enthusiasm and interest did not translate to acceptance of modern methods or increase in sales.	
Training and Capacity Building	Page 14 Paragraph 1	USAID recommended a pilot with PPMVs for social marketing, IPC, and product distribution that has been implemented under other social marketing programs. The training modules used for detailers and PPMVs focused on the components needed to organize an IPC event, methods, and side effects. The Health Communication Coordinator (HCC) training module did not contain training on the social science of interpersonal communication skills. The downside of this is first, that those conducting IPC are not fully-trained in how to conduct effective IPC and second, an effective IPC training has built-in indicators that can be used to measure IPC's effectiveness and how it is contributing to behavior change. The evaluation team could find no mention of IPC training being conducted with Traditional Birth Attendants (TBAs), that are private sector or private health facility workers. ESMPIN did train unemployed Community Extension Workers (CHEWS) in IPC and the CBDAs as part of its distribution plan. The training module for IPCAs and CBDAs is an IPC flip chart that is comprehensive of all methods and relates to the concept of "Healthy Family My Pride and Joy". The evaluation team reviewed the BCC strategy but not the malaria training module.	iCCM is the only recommended pilot from USAID that comes to mind. ESMPIN is unaware of any other pilots recommended. ESMPIN trains PPMVs as a component of the program and has also trained private sector trainers to train PPMVs which engenders sustainability even after the project ends. The training for HCCs and IPCAs is heavily focused on priority IPC skills which include probing skills, rapport-building skills, listening and responding skills, and summarizing skills TBAs are not recognized by the Government to offer Family Planning, Malaria, Diarrhea, EBF services as promoted by ESMPIN. Nonetheless, ESMPIN's advocacy events included TBAs as influencers in intervention communities where they are prominent. In such cases, they were encouraged to refer their clients to access services promoted by ESMPIN at health facilities. Furthermore, ESMPIN engaged some TBAs as IPCAs where they meet the IPC selection criteria. ESMPIN has a comprehensive training curriculum for both IPCAs and CBDAs, which was shared with the

			evaluation tool. This training curriculum contains the malaria training module and other ESMPIN health themes. The flip chart is only a tool used to conduct IPC sessions and not a training module.
Social Marketing	Page 15 Paragraph 1	Social marketing is both a strategy and a key component of ESMPIN. Social marketing is a complex strategy that draws from numerous tools to create behavior change. Reviewing the sales data and ESMPIN reporting showed that product sales plateaued around 2013. By 2016, the CYPs were lower and sales show the majority to be male condoms (close to 50%). The second and third choices are injectables at 18.3%, and oral contraceptives at 15.6%. There was not an apparent change in ESMPIN's strategies to increase acceptance of long-acting reproductive methods (LARM) or to address behaviors related to family planning. There are numerous tactics under these strategies that ESMPIN could have used to improve sales and behavior results. ESMPIN's social marketing approach has not captured the energy of Nigeria's private sector.	It is important to note that to achieve a significant shift from short-term to long-term method, it will require that providers are trained on LARC. However, since ESMPIN did not have the <u>mandate to train</u> any health providers beyond PPMVs, the project was constrained to leverage on the presence of other IPs such as SHOPS, and FH+, offering training services in only a few of ESMPIN intervention states/communities. ESMPIN strategies to increase acceptance of long acting methods were myriad, including working to engage with the providers encouraging method mix changes, including through detailing and provider BCCC. This entailed encouraging providers to upskill in methods as well as providing consumables often lacking in public sector locations. ESMPIN also proactively worked with IPs and SFH projects that trained providers to train/upskill providers in community facilities where IPC was being implemented. While important to address method choice (many women prefer short term methods) ESMPIN worked on building trust and trained IPCs on counselling techniques across all methods,
Community Engagement and Advocacy	Page 15 Paragraph 1	There are strong social and cultural norms (factors) that influence couples' opinion and decisions to use any modern method. BBC and HC3's research shows that. ESMPIN's activities in the north led by AFRH did engage with the religious and community elders through the CBDA's activities such as one-on-one meetings, town hall meeting. In the south,	Engagement with relevant stakeholders (community leaders, religious leaders, government officials, etc.) was prioritized under the ESMPIN project. Before intervention commences, ESMPIN gains the support of these stakeholders and they play a vital role

		the inclusion of religious leaders and government officials was less prevalent. Several community leaders and health officials in the south said that they were not included in planning activities with ESMPIN and therefore were not engaged in the mobilization and outreach. When asked about ESMPIN's plan to address social and cultural factors, the project officials said they did so "when they needed to but it was not part of the overall plan" and "there was not a strategy for working with Ward Development Committees". In a discussion with a senior official from PSI he indicated that "it was not part of PSI's approach to engage with the government." Again, HC3's report recommended two IPC models that are socio-behavioral models that move outside of the individual to engage with inner influentials (family and friends), external influentials, and community stakeholders.	in community selection, IPCA selection and training, and also support supervision of activities. Besides this one-on-one advocacy engagement, ESMPIN has evidence to show that advocacy events in the form of Town hall meetings were conducted across all locations in the North and South. The project has quite extensive evidence that it worked outside of the individual to engage with significant others and community stakeholders through its advocacy and male involvement approaches.
Behavior Change	Page 15 Paragraph 1	The models used to design ESMPIN focus on individual behaviors and, judging from the reports and data the team reviewed, ESMPIN did not delve into the social and ecological landscape of Nigeria. Over the last several years, in some regions, cultures, and ethnic groups (Christian, Muslim, and traditional), Nigeria has become more conservative and inclusive while other areas and peoples are looking outside the country and are influenced by the West and other areas of Africa. To be successful in changing individual behavior, research has shown that socio-ecological issues must be addressed to create an enabling environment that removes barriers to FP and MCH, allowing communities and segments to make FP acceptable. Though SFH did design advocacy strategies and IPC promotion plans, they are targeted to individual behavior. Neither the models nor the SFH research look at the	The FOQUS conducted early in the project provided information to better identify the sociocultural norms and the policy and regulations that affect (directly or indirectly) people's actions, behaviour and choices as regards ESMPIN's targeted BCC objectives. The FOQUS reports and other reports have been provided to the team. In addition the DELTA process while looking at behaviour change at the individual level does take a sociological approach to looking at how social and cultural norms affect behaviour in the situational analysis component.

		social and cultural norms or policy and regulations that affect (directly or indirectly) people's actions, behaviors, and choices.	
Evaluation Question 2.	Page 16 Paragraph 1	To what extent were ESMPIN's Social Marketing, IPC, and CBD interventions sustainable? In an interview with FMOH, one counterpart observed that the program was not designed with sustainability built in it	The highlighted comment is more of a perception than a fact as there is no documented evidence to support this. ESMPIN's sustainability strategy includes: 1. ESMPIN is leaving behind a pool of trained IPCAs whom are being engaged by states government and partners to promote ESMPIN related and other health themes. In some cases, these IPCAs independently formed themselves into CBOs where they continue promoting ESMPIN healthy behaviours. The IPCAs who are left behind in all ESMPIN intervention communities continue to serve as community resource persons. 2. The use of ORS/Zinc even after project exit shows potential of being sustained and increased as CHI and other local manufacturers/partners would continue to promote it. A result of ESMPIN intervention. 3. The ESMPIN project leveraged on the FG task-shifting policy to train and engage CHEWs who create demand through IPC as well as offer short/medium-term FP methods. With incentives from the commodities that they sell, these CHEWs will continue demand creation and service provision, even after project exit. 4. A pool of trained PPMVs on all ESMPIN health areas which the evaluation report

	Page 16 Paragraph 2 Page 16 Paragraph 4	The most costly and expensive intervention is the development and maintenance of four promotion and detailing teams, i.e., IPCAs, CBDA, detailing, and merchandizers. The costing analysis conducted by the evaluation team, and a second costing analysis prepared by HC3, found the projected cost of implementing the IPCA model in 180 communities during one Cycle (six-month timeframe) to be \$3,321,101.00 and cost per method uptake is between \$34.89 and \$38.35. The CBDAs lived and worked within a community for years where IPCAs rotated through communities on a six-month rotation called Cycles.	indicates have continued to stock on products remain a sustainable approach. 5. A pool of PPMVs who are trained to implement iCCM have shown to continue to offer quality service. This also is a sustainability approach to improve child survival. 6. Improved stocking practices implies that service delivery points will continue to purchase child spacing and child survival products. 7. CBDAs has already been highlighted as having potential for sustainability. These comments portray some level of misunderstanding of the ESMPIN interventions. It presumes that IPCAs, CBDAs a merchandising and detailing is under one strategy. Presently the ESMPIN IPC strategy is being engaged in 22 locations with a maximum of 66 communities the cost on page Although the ESMPIN IPC cycles only lasted 6 months within a location, the IPCAs lived in the intervention communities and did not move. The IPC strategy however, was also designed based on evidence to strengthen the available structures within the community (health facilities, PPMVs, and other SDPs) predominantly in the South and a few northern states. This was done by creating demand around these outlets such that after exit, community members will continue to access services at these outlets as a major sustainability approach.
--	---	--	--

	Page 17 Paragraph 2	HC3's behavioral research measured the impact of IPC under a cycle model and it showed that 25% of the men and women who did chose a method discontinued use after 12-14 months, primarily due to concerns that methods are irreversible; the same research did not show a measurable increase of new users after the IPCA Cycle stopped. A representative from FMOH talked about the value of forming partnerships and Memoranda of Understanding (MOUs) with ESMPIN to assure longer-term results; and representatives from the ministry of health at the federal and state levels said that MOUs with the government and development of work plans were very important for the family planning work to move forward, as they believed USAID support would be ongoing. The FMOH's Office of Health Education staff informed the evaluation team it was not familiar with what ESMPIN was doing for promotion or communication; they had not been included or consulted. HC3 does work closely with the office and provides technical assistance to the staff. HC3 along with ESMPIN are members of the National Reproductive Health Technical Group.	A 25% discontinuation is actually lower than what is seen in most sub-Saharan FP programs (Contraceptive Discontinuation: Reasons, Challenges and Solutions, Dec. 2015). <u>The major finding of the JHU HC3 evaluation was a substantial increase in new FP users over a 6-month period after exit which informed USAID scale up across six states.</u> The CBD approach was designed based on evidence to bridge the gap on low presence of PPMVs in the North by engaging agents to create demand and sell non-ethical FP and MCH products. 35 (table 9) is a more realistic IPC cost It would have been important to mention comments from the Family Health Division of the Federal Ministry of Health as they are our primary contact. Unfortunately, the evaluator seems to have gone to the wrong department as ESMPIN worked more closely with Family Health Division of FMOH which includes the Family Planning and Child Health Departments. ESMPIN also works with the departments at state levels and this was not mentioned also.
--	--------------------------------	---	---

Private Sector	Page 17 Paragraph 1	Nigeria has a robust commercial tradition and there are new commercial manufacturers that could be strong partners in the sale and distribution of these commodities. To be sustainable after the project ends, the transfer of products and distribution should be made to the private sector about mid-way through ESMPIN; this assumes the distribution, warehousing, detailing, and marketing should be assumed by the commercial partners. A good example of a good partner to do social marketing is Chi Manufacturing.	It would be interesting to know why the evaluators believe the commercial sector can take over the sales and distribution of these FP commodities. It has been our experience that the commercial sector would be most unlikely to distribute their products to hard-to-reach locations such as is done by ESMPIN throughout the LOP. This is due to the high cost involved. Besides unfavourable prices envisaged to be offered by the commercial sector, they most likely would not take their intervention to hard-to-reach communities, just as the evaluators found it difficult to visit some hard-to-reach areas where ESMPIN worked.
	Page 17 Paragraph 1	Though the connection between Chi and ESMPIN originated at the recommendation of USAID, the partnership has worked with ESMPIN and the Strengthening Health Outcomes through the Private Sector (SHOPS) project. In discussions with different actors from SMOH and Chi they did not appear to clearly distinguish between SHOPS and ESMPIN. Chi is still enthusiastic about continuing to partner with USAID on other projects. Chi is now producing an Artemisinin-Based Combination Therapy (ACT) for malaria and next year plans to launch an antiviral for HIV and AIDS. Sales for ORS/Zinc have been low and the Chi product is priced in the middle of the product range which is a positive. Globally, ORS/Zinc sales have been mixed and the Nigeria sales figures are also low. Chi representative however continues to be optimistic about working with USAID specifically in technical	The relationship between ESMPIN & CHI pharmaceuticals is as a result of ESMPIN's exploration. Although sales of ORS/Zinc is considered to be relatively low, the combined sales was non-existent at the beginning of ESMPIN. The current sales volume is attributed to the effort of ESMPIN intervention.

	Page 18 Paragraph 1	assistance in technical forecasting and business planning. He felt the private-sector model would be sustainable. Also, there are potentially new commercial partners: 14 Nigerian companies were to achieve World Health Organization (WHO) pre-qualifications by 2014 (SFH 2013 <i>Assessment of Pharmaceutical Manufacturers for Social Marketing Commodities in Nigeria</i>). There were questions about whether the fulfilment team should wear protective clothing, i.e., gloves, hair nets, masks when working at the Ogun warehouse. At the wholesalers, two of three sites visited were cluttered, dark with products and boxes scattered throughout the space. The disorder within the space and fetid water and waste outside raised concerns about the quality and care of these products. These warehouses track sales and distribution through a paper trail and do not use electronics or digital technologies. SFH does use digital tracking up to the warehouse because that is up to the point that it tracks its sales	Warehousing activities for which protective clothing's and gadgets are compulsory are those involving primary packaging. SFH warehousing nonetheless only involves secondary re-packaging of commodities which do not require such protection. SFH/ESMPIN regularly conducts audit inspection of their facilities and regularly bring to their attention issues that may impact the work that we do. However, occasionally lapses may occur in between inspections.
Service Delivery and Health Care	Page 18 Paragraph 1	Service delivery has been a barrier to the success of the social marketing under ESMPIN. One trusted private sector provider in Nigeria are the Traditional Birth Attendants (TBAs). Similar to PPMVs TBAs are often the first point of care for women in the communities. Their identified roles include the provision of maternal and child health services, conducting normal deliveries and dispensing of short-term contraceptives, especially in the rural	Official government policies are unknown to permit TBAs to offer FP services in Nigeria, but allows Village Health Workers and CBDAs based on the task shifting policy to allow a particular range of services. TBAs are not trained providers, unlike VHWs who are part of the health system.

		communities where they often play a key role in health care. ^{7, 8} Involving them in a project of this magnitude would aid efficiency and sustainability of such a program.	
Evaluation Question 3	Page 19 Paragraph 2	General findings show that ESMPIN had limited achievement in filling the gaps in the area of availability, accessibility, and affordability, as follows:	This conclusion does not seem to align with the evaluator’s main finding as stated below: ‘The major achievements of the project is commodity security where they ensure that there is enough buffer stock of the commodities at each level of the commodity chain. Stock outs were fewer and when they did occur, they were corrected in shorter periods of time.’
Availability of Products	Page 19 Paragraph 1	ESMPIN conducted various activities such as commodity distribution, medical detailing, mass detailing, Service Delivery Point (SDP) recruitment, clinical presentations to healthcare providers and engagement of professional groups through their professional bodies. They conducted regular meetings/advocacy visits with relevant stakeholders—i.e., government, religious, and traditional leaders in the north—but this was less consistent in the south.	There is evidence to show that the same strategy being implemented in the North is also implemented in the South and with results to show.
	Page 19 Bullet point 1	The major achievement of the project is commodity security where they ensure that there is enough buffer stock of the commodities at each level of the commodity chain. Stock-outs were fewer and when they did occur, they were corrected in shorter periods of time.	This is noted. However, the evaluation team’s general findings seems to refute this important assertion. It is suggested that the general findings be changed to reflect this.
	Page 20 Bullet point 2	The project achieved 86% of the expected CYP (See Annex VII for data on CYP life-of-project (LOP) compared with actual CYP achieved), but was unable to move the sales of contraceptives from short- acting to long- acting methods. ESMPIN	While ESMPIN proposal to grow the medium & long-acting methods of modern contraceptives to contribute 40.8% of the total CYP by end of project was not met, the project successfully grew the medium & long-acting methods from the 2010 baseline of 25% to 35%

		achieved 28.3% CYP against the projected 40.8% CYP method shift.	by the end of 2016, a 42% increase. <i>(Please note that 28.2% for 2010 baseline mentioned in the proposal was a projection as proposal was submitted before end of 2010).</i> This performance is more exciting when reviewed on commodity-by-commodity basis. For example, within same period ESMPIN significantly reduced the CYP contribution of Male Condom from the baseline 57% to 41% by end 2016, grew oral pill from the baseline 15% to 19% for obvious reason of critical role of oral contraceptives to the unmet need situation in Nigeria. ESMPIN also grew 3-monthly Injectables contribution from 6% to 14% at end of 2016. This performance is baring the operating environment during the period of ESMPIN project characterized by significant improvement in the access and availability of modern contraceptives products and services in the public sector, also noting the significant contribution of ESMPIN to this.
	Page 21 Bullet point under Table 2	The project introduced the co-packaged ORS/ZINC with partnership with Chi Manufacturing but product was not readily available in some of the communities, only 44% of the communities where ESMPIN implemented the project had at least one outlet in the community where Chi co-packed ORS/Zinc could be obtained (MAP 2016 survey).	ESMPIN's mandate was to manage and drive the key ESMPIN deliverable related to MCH, with particular emphasis on ORS/Zinc strategy and implementation of and scaling up ORS/Zinc as treatment of diarrhea in Nigeria. Therefore, ESMPIN did not only promote CHI ORS/Zinc, but ORS/Zinc use generally. It should be stated here that ESMPIN major reasons for developing co-packed ORS and zinc was to increase the availability of Zinc tablets. The innovation led to an increase in availability from 2.9% in 2013 to at least 44% in 2016. This is "laudable" and not "limited".

			An SDP that stocks another brand of ORS/Zinc may likely not stock CHI ORS/Zinc.
	Page 22 Paragraph 2	According to the 2013 ESMPIN report, there were 14 Nigerian companies on track that would achieve WHO pre-qualifications in 2014 (SFH 2013 <i>Assessment of Pharmaceutical Manufacturers for Social Marketing Commodities in Nigeria</i>) which the project did not explore the possibilities of bringing them on board.	This was NOT an ESMPIN mandate as findings from the assessment was to guide USAID into taking a decision on the way forward.
Accessibili ty of Services	Page 21 Paragraph 1	In order to make services available to beneficiaries, ESMPIN implemented different activities, including training of non-traditional health providers, i.e., PPMVs, CBDAs and IPCAs to provide FP and MCH information and knowledge to community members. Activities conducted by PPMVs and CBDAs include town hall meetings, specialized group sessions during antenatal care (ANC), child welfare clinics, male involvement sessions, and provision of door-to-door services, referral, and counselling.	These special sessions are conducted and led by ESMPIN' HCCs and SPOs. IPCAs and CBDAs only lead door-to-door services.
	Page 21 Paragraph 2	The CBDAs, as part of their basic tasks, distribute over-the-counter products, mainly Cycle beads, condoms, and Combination 3 pills. They also carry water purification products to reach the rural parts of the communities. During Cycle 1-9 of the IPC Model, there was no service provision but this was adjusted in Cycle 10 to be a service provision model engaging CHEWS as IPCAs. ESMPIN measures the effectiveness of providing accessibility to FP and MCH services and products through the number of PPMVs, CBDs, and health workers trained, coverage covered in FP and	Based on program design as approved by USAID, the IPC strategy was only designed to create demand. The Cycle 10 approach with a service provision component involving CHEWs was a pilot to advise future programming, leveraging on the task-shifting policy following approval in 2015. Hence, the CHEW approach could not have been implemented prior to 2015 as the task shifting policy had not been approved prior to 2015.

	Page 22 Bullet point 1	MCH service provision, number of referrals to health facilities, and service uptake. The findings of the evaluation team on accessibility of service are: According to a MAP survey, the project was able to achieve its target for FP coverage (81%), which was 1.25% over the LOP target of 80% but field visits shows that most respondents interviewed felt that geographical coverage of activities (promotion, sales of products) was limited in range because the project did not cover the breadth and length of the states where project implementation took place.	Sales/social marketing was done nationwide and across the length and breadth of each states. However, community level interventions were conducted in selected prioritized communities with the belief that demand created within would diffuse across. The MAP survey which was evidence of ESMPIN' impact should be of considerable significance, as perceptions by community members could be affected by many issues.
	Page 22 Bullet point 3	The CHEW model would have been sustainable, but because they are employed and paid salaries by ESMPIN it is not likely they will continue service provision after the end of the ESMPIN Project.	The ESMPIN project pilot the CHEW strategy with unemployed CHEWs in order to avoid conflict of interest. CHEWs employed at the PHCs are usually fully occupied with facility services and have little or no time for community level intervention. The CHEW strategy was designed to be sustainable through the incentives the CHEWs gets from the markup on product in addition they would continue to gain access through SFH sales team, which includes; detailers and local wholesalers within the community. In the post Cycle 10 period ESMPIN is looking at sustainability approaches and determining how these CHEWs will continue activities within their communities as the mark up could be a veritable source of income for them.
	Page 23 Bullet point 1	The IPCAs and CBDAs, through their efforts, reached 21,584,316 community members (IPCAs-14,209,051 and CBDA, -7,375,265) with FP and MCH information (<i>ESMPIN MIS data</i>). However, the Nigerbus survey of 2016 shows that the project could not achieve much in sustaining the mass	Nigerbus surveys measure spontaneous recall of messages and does not include prompted responses. This feature led to lower figures that are normal for most campaigns. A learning from this is that in future

	Page 23 Paragraph 2	media and IPC activities as only 22.1% of audience interviewed could recall hearing or seeing a specific U.S. Government (USG)-supported FP/RH message, which was only 29% of their expected end of project target of 75%. The CBD survey conducted by ESMPIN in 2016 shows only “32% of respondents in CBD communities credited CBDAs as providing them with information on FP/CS” (<i>CBD Evaluation Report</i> 2016). The FP service uptake, especially for the medium- and long-acting methods, did not increase significantly as only 2% of the IPCAs contacts actually accepted an FP method from the referral health facilities (HFs). When compared with those who were actually referred and picked up service this rose to only 15% of referred clients picking up FP methods at the HFs.	emphasis should be on not measuring just spontaneous but also prompted recall. It would be important to also state that the exposure to IPCA averaged 55% and was as high as 72% in locations that were just existed. Number of IPC contacts does not translate to the number of persons reached as our strategy recommends at least two visits per person and even more for persons who received referrals. ESMPIN in implementing its IPC strategy developed targets per IPC agents. This included 35 redeemed referrals per agent per cycle. Our data reveals that these targets were about 80% met. Referral cards issued and percentage redeemed is a better indicator of ESMPIN IPC efficiency
	Page 23	Table 1. IPCA and CBDAs performance in increasing access to FP and MCH services (<i>ESMPIN MIS data and reports</i>) <i>*See table inserted at bottom of this table</i>	ESMPIN in implementing its IPC strategy developed targets per IPC agents. This included 35 redeemed referrals per agent per cycle. Our data reveals that these targets were 80% met. It must be understood that individual IPC contacts does not imply number of persons as persons would have been reached at least twice, based on the IPC strategy. Number of referral cards issued and redeemed referrals may be a better indicator of ESMPIN IPC efficiency.
	Page 23	CBDs and IPCs both provided the same service but IPCs cycle (six months per community) was too short to have sustained impact while CBDs stayed	Contrary to the evaluators report, the JHU HC3 evaluation showed data indicating that the impact of the IPC strategy was sustained 6 months after

	Bullet point 3	longer on the project and have been able to form associations. Respondents during KIIs and FGDs said the period of implementation should be extended to between one and five years. CBDAs and IPCs want to carry other products like long-last insecticide nets (LLINs), antimalarial drugs which ESMPIN did not distribute and this limited their ability to provide access to malaria products. The project had missed opportunities to increase access to FP and MCH products which they did not utilize, including:	intervention. In addition, the IPCAs were selected from within the communities and did not ‘leave’ the communities. So they would still be available within the communities as a resource for FP within those communities, even if they were not actively conducting IPC sessions for the ESMPIN project. Evidence suggest a number become PPMVs within their communities. The CHEW strategy, which was piloted in the last Cycle, aimed at improving the sustainability of the approach. This was reinforced in the findings from the IPC evaluation. ESMPIN at the inception was designed as a private sector and social marketing focus with on demand creation as a major tool. The demand creation is still centered around the private sector environment. Recall the first and second cycles of IPC focused on using private health facilities as referral points. From lessons learnt of unavailability of the private facilities in the communities, unavailability of providers at these facilities, distance from health facilities, this led the project to seek approval from USAID to extend referrals to public facilities. Based on the above, the use of CHEWs at this point would have been near impossible because the FG task-shifting policy (which ESMPIN strongly facilitated) had not been signed. Additionally, FMoH and NPHCDA recognizes CORPs as qualified to offer certain level of healthcare, which do not include TBAs.
--	-----------------------	--	---

			Finally, the ESPMIN project worked with WDCs for communities. It should be noted therefore that the WDCs are only viable when funded. For instance, the ESMPIN IPC program worked closely with the WDCs in Sokoto and Bauchi who were being funded by the TSHIP project implemented in these states.
Affordability of ESMPIN Products	Page 25	Table 2. Comparison of price list of products by different organization (Source: From field study)	DKT is a new entrant into social marketing environment in Nigeria that is less than 24 months old, therefore it actively used underpricing as an entry strategy. To buttress this point, as at January 2017, the same DKT condom is now 29% higher.
Evaluation of Strategies	Page 28	Table 3. Cost effectiveness of strategies	This analysis does not recognize the fact that CBDAs had limited contact because they worked in the same location for the LOP.
Question 5.	Page 30 Paragraph 2	To what extent did the ESMPIN's project activities incorporate gender programming during the life of the project and what effects did it have in increasing uptake of Family Planning and MNCH services in ESMPIN supported sites? Although ESMPIN has a gender strategy, this was not well communicated to or well-known among government officials collaborating with the program. Though there are a mix of men and women, 60% of government officials interviewed had no idea whether the program addressed gender or not, 15% felt that the program did not address gender and 5% felt that men were not well involved because there are no male IPCAs.	The program has a gender strategy and it is unfortunate that the government persons interviewed did not know this, probably as gender had been strongly mainstreamed into the program. For example IPCAs that were trained were both male and female. (Male=1,668; female=3,044), and the project had strategies aimed at reaching both male and female community members. In addition, the project keeps a close watch on gender mix when training PPMVs, employing HCCs and other staffing arrangements.

Conclusion	Page 36	Their technology stops once the commodities went to the wholesalers' warehouse, which makes it difficult to track how long a product is on the retailers' shelves and where it was sold. Because SFH measures its sales from its warehouse to the distribution center, this also explains why its high number of "sales" do not correspond to CYPs or CPR.	ESMPIN is developing an app that will be used to track sales from the wholesaler to the retail end through the demand creation reps. (Nkiru please confirm) Sales of FP translates into measures of CYPs as only when a sale is recorded is it measured as a CYP. In addition, the latest SmartSurvey shows an increase in CPR to 21% (SmartSurvey 2015). In this issue therefore, this non-correlation is therefore unclear.
-------------------	---------	---	---

* Inserted table:

Outlet	Number of people contacted by IPCAs and CBDs	Number of referral cards issued	Number of referral cards redeemed	Number of uptake of service	Contact to uptake of service	Referrals to redeemed	Referrals to uptake	Redeemed to uptake
IPC	14,209,051	2,295,187	576,321	338,169	2%	25%	15%	59%
CBD	7,375,265	104,420	50,610	Not tracked by Project	Uptake not tracked	48%	Not Tracked by Project	Not Tracked by Project
Total	21,584,316	2,399,607	626,931			26%		

For more information, please visit
<http://ghpro.dexisonline.com/reports-publications>

Global Health Project Cycle Improvement Project

1331 Pennsylvania Avenue NW, Suite 300

Washington, DC 20006

Phone: (202) 625-9444

Fax: (202) 517-9181

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