EnCompass LLC

John D. and Catherine T. MacArthur Foundation Maternal Health Accountability Grants in Nigeria

Endline Evaluation Report

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ACRONYMS

AMHiN	Accountability for Maternal, Newborn, and Child Health in Nigeria
BASAM	Bauchi State Accountability Mechanism
CHR	Community Health and Research Initiative
CISLAC	Civil Society Legislative Advocacy Centre
CSO	Civil society organization
DevComs	Development Communications Network
FCT	Federal Capital Territory
FMCH	Free Maternal and Child Health Partnership
JOBETH	Journalists for Better Health
MDSR	Maternal Death Surveillance and Response
MNCH	Maternal, Newborn, and Child Health
MNCH2	Maternal, Newborn, and Child Health Programme
MPDSR	Maternal and Perinatal Death Surveillance Review
NGO	Nongovernmental organization
NMA	Nigerian Medical Association
PHC	Primary health care
SERVICOM	Service Compact with All Nigerians
SOGON	Society of Gynaecology and Obstetrics of Nigeria
WARDC	Women Advocates Research and Development Centre
WHARC	Women's Health Action Research Centre

Executive Summary

In 2013, the John D. and Catherine T. MacArthur Foundation created a portfolio of seven grants to work collaboratively to increase government accountability for maternal health in Nigeria. Over the past 3 years, the portfolio worked in four accountability areas—budget analysis, community mobilization, legal approaches, and maternal death audits—at federal, state, and local levels in 12 Nigerian states and the Federal Capital Territory (FCT). In 2016, an endline evaluation was conducted to understand which accountability strategies, and which interventions within each strategy, were most promising for building government accountability for maternal health.

Methodology

The questions framing this endline evaluation were developed collaboratively with the Foundation in January 2016 and refined and finalized with grantee organizations during a July 2016 Design Meeting. The overarching question of this evaluation was, "*What do we need to know to do more of what is promising?"* Specific evaluation questions were tailored to capture the particular changes in behavior of each stakeholder group or boundary partner[1] that grantees were seeking to influence through their grant-funded actions: media consumers and producers, lawyers, civil society organizations (CSOs), maternal death surveillance and response (MDSR) committees, government officials, and legislative committees. The evaluation used a mixed-methods design, collecting qualitative data through individual and group interviews and focus group discussions, triangulated with grantee monitoring data, a desk review, and findings from the 2013 baseline and 2015 midline evaluation.

During a 2-day Data Consultation meeting in Abuja in May 2017, the evaluation team, grantees, and key actors in Nigeria's maternal health community came together to validate findings, refine conclusions and develop recommendations on where grantees and the broader maternal health community should focus their efforts moving forward.

Endline Evaluation Findings

Media: Since midline, how has the use of maternal evidence changed and how have grantee activities influenced the quantity and quality of maternal health reports?

Grantees: Advocacy Nigeria, Civil Society Legislative Advocacy Centre (CISLAC), and Development Communications Network (DevComs)

[1] In outcome mapping, "boundary partner" refers to an individual, group, or organization with which the project interacts and which it anticipates opportunities to influence. The project's goals focus on changing the behavior, relationships, activities, and actions of boundary partners. The ideal behavioral change for each type of boundary partner contributes to the ultimate goals of the project. (See http://www.betterevaluation.org/en/plan/approach/outcome_mapping.)

Grantee-supported activities including capacity building for journalists, investigative journalism field trips, and CSO–media partnerships, were reported as successful in strengthening media's role in holding government more accountable for maternal health. Journalists' knowledge and use of maternal health data sources increased since midline, although access to budget information remained a challenge. Key media producers (journalists, editors, and media executives) and consumers (policymakers, development partners, and CSOs), reported grantee engagement as having an important influence on the overall increase in quantity and quality of reporting on maternal health.

Lawyers: What are the most promising alternative means used to seek redress (judicial or otherwise) in cases of maternal death or injury? What are the enablers and constraints of these means?

Grantee: Women Advocates Research and Development Centre (WARDC)

The number of litigation cases for maternal death and injury was lower than anticipated during the 3-year grant period. Respondent's emphasized that constitutional barriers, lack of financial incentives for lawyers, and limited expertise litigating maternal health cases all hindered maternal health litigation. In order to further maternal health litigation moving forward, respondents reported that increased awareness of patient rights, among the general public and in the legal profession, was necessary. WARDC's procedural knowledge and connections were reported as important influences in supporting maternal health litigation cases.

Lack of knowledge, religious and cultural beliefs, illiteracy, pressure by family members, fear of retribution, and perceived costs have all been constraints to seeking redress, both judicial and non-judicial, for maternal injury and death, and these constraints have remained consistent since the baseline. However, respondents where WARDC worked reported being aware of several non-judicial means of redress being used in their communities. Multipronged approaches, such as using the media to prompt government action and using community-based paralegals, were perceived to be effective means of redress. Respondents described community-based paralegals and local traditional and religious institutions as best positioned to assist women and those close to them (e.g., family, friends, and church leaders) in seeking redress through judicial and non-judicial means.

CSO Advocacy and Collaboration: What have been the most important contributions of grantees to maternal health accountability advocacy initiatives and what have been the outcomes of these initiatives?

Grantees: Advocacy Nigeria, CISLAC, Community Health and Research Initiative (CHR), DevComs, and WARDC

Grantees' work included building capacity of other CSOs as well as working directly with government officials and media stakeholders. Government officials reported that technical assistance and use of grantees' maternal health scorecards to provide evidence to inform budget planning were among the most important grantee contributions advocacy initiatives. Government stakeholders also recognized

the important role of CSOs in voicing citizens' input during the decision-making process. Grantee-supported CSOs reported that that support was critical to breaking down barriers between CSOs and state government officials, assisted in forging new relationships with the media, and boosting CSO-CSO coalitions.

MDSR Committees: To what extent are MDSR committees functioning effectively?

Grantees: WARDC and the Society of Gynaecology and Obstetrics of Nigeria (SOGON)

Respondents reported that MDSR committees were functioning effectively, as evidenced by the fact that most committees convened meetings on a regular basis, almost all recorded maternal deaths were reviewed, and MDSR recommendations were submitted to facility and state officials. Community members and facility staff reported that community members participated effectively on SOGON-supported MDSR committees.[2] In facilities with high maternity rates relative to staff size, some MDSR committees struggled to carry out their tasks and review deaths in a timely manner.

Health facility staff and state-level government representatives reported that MDSR committees were perceived as useful for measuring quality of care and holding facilities accountable for maternal health. Most grantee-supported MDSR committee members at facility and state levels considered the MDSR model to be sustainable, as evidenced by the government's adoption of the model into national policy.[3]

Health facilities have implemented 36 percent of MDSR committee recommendations, including improvements in service delivery, commodity availability, and infrastructure. Respondents attributed the implementation of recommendations at the facility to state oversight, facility leadership commitments, availability of resources, and interdepartmental cooperation. In addition to providing funds for the MDSR committees, some states have also provided resources for key maternal health commodities and issued guidelines stipulating care for patients regardless of their ability to pay. The key constraints to implementing MDSR committee recommendations at the facility level, according to respondents, were lack of adequate resources and insufficient support from leadership.

Political will has been the main factor facilitating state-level implementation of MDSR committee recommendations. Sound evidence supporting recommendations improved state government buy-in. The main factors constraining implementation of MDSR committee recommendations at the state level were reported to be limited funds for maternal health, which were allocated with insufficient specificity and released too slowly.

[2] WARDC does not currently engage community members.
[3] For consistency's sake, this report refers to "MDSR committees," while acknowledging that the Federal Ministry of Health has expanded the concept to include perinatal death surveillance and response (MPDSR committees).

Government Budgeting: At what stage in the budget cycle are grantee-supported CSOs intervening most effectively and most strategically? What factors enable effective CSO intervention in the budget cycle?

Grantees: CHR and Advocacy Nigeria

Grantee-supported CSOs intervened most effectively in budget planning (budget drafting and approval) by working closely with different levels of government to bring community voices into the budget-planning process and advocating for increased budget allocations for maternal health. Similar enablers were reported for successful participation in the budget planning and tracking process. In budget planning, technical expertise and constructive relationships with community members, government officials, and CSO coalitions enabled effective CSO engagement. In budget tracking, technical skills and use of scorecards, in combination with collaborative relationships with government officials, brought the best results. Constraints reported for effective CSO participation in budget planning involved competing health priorities and governmental mistrust of CSOs. In budget tracking, effective CSO intervention was hindered by gaps in CSO skills, inconsistent use of scorecards, government turnover, and lack of transparency.

Stakeholders differed (individually and by region) in assigning the most strategic stage of the budget cycle for CSO engagement. There was no consistency about which stage was best for CSO intervention. Respondents reported that future opportunities for CSO engagement included deepening links between the community and government and increasing the use of evidence in budget decisions by engaging throughout all stages in the budget cycle.

Legislative Committees: What supports state legislators to translate executive policy pronouncements related to maternal health into implementable bills and laws at state level?

Grantee: CISLAC

Respondents reported that CISLAC's continuous advocacy and capacity building helped ensure that legislators were knowledgeable about maternal health issues and their role in translating executive policy pronouncements into bills and laws. Respondents pointed to high turnover of government officials from the previous administration and the slow nature of the country's legislative process as the key barriers for translating federal policy pronouncements into implementable bills and laws.

Conclusions

Although findings show that some accountability areas had quicker progress than others, all four areas proved to be mutually reinforcing influences in holding the government accountable for maternal health. Relatively speaking, **maternal death audits** has shown the most concrete evidence of progress in holding government accountable for maternal health. At baseline, MDSR committees were nonexistent; by endline, they were not only established, but also showing evidence that

SOGON- and WARDC-supported MDSR committees were functioning effectively, with committee recommendations being used to improve quality of care for pregnant women and mothers.

Findings related to **budget analysis** show that although this area has been slower to show concrete progress in increasing budgets, respondents felt that progress was meaningful and crucial to long-term gains in maternal health improvement. In particular, expanding grantees' personal relationships and use of accountability mechanism tools helped government boundary partners recognize the importance of prioritizing maternal health among all issues in the state health budgets.

Legal approaches experienced a needed shift over the 3-year grant period, as litigation was not making sufficient progress. WARDC capitalized on community members' increasing use of alternative means of redress by using locally based paralegals and supporting community members to seek redress.

CSO mobilization proved to be another successful and promising strategy for maternal health accountability, through increased grantee engagement with and support for the creation of CSO coalitions, grantees' actions to influence the quality and quantity of maternal health reporting with media boundary partners, and the formation of close relationships with legislative committees.

Recommendations

These recommendations were developed collaboratively by grantees and other key maternal health stakeholders and are grounded in evaluation findings. A key overarching recommendation is to continue capitalizing on successful actions across the package of accountability areas and strengthening promising actions taken under each boundary partner's sphere of influence. For this reason, the recommendations are presented by boundary partner.

Media

1. Expand education of media stakeholders in maternal health
2. Expand collaboration within media and between media and other advocacy areas
3. Continue to use multiple media streams to bring greater attention to maternal health

Lawyers

1. Expand education on how to effectively litigate on maternal health
2. Continue to identify and communicate alternative means of redress for maternal mortality and injury

CSO Advocacy and Collaboration

1. Expand and strengthen CSO coalitions and networking and collaboration among CSOs
2. Expand CSO partnerships with specific sectoral partners (e.g., CSO–media coalitions, CSO–government partnerships)

MDSR Committees

1. Increased advocacy to government stakeholders for institutionalization of MDSR committees
2. Scale up MDSR committees throughout Nigeria
3. Increase dissemination of MDSR best practices and successes

Government Budgeting

1. Continue to expand government–CSO relationship in order to increase CSO influence with government stakeholders
2. Build on and expand CSO influence in budget cycle, specifically in budget planning
3. Build on and expand use of accountability mechanisms to provide evidence on maternal health budget tracking
4. Work with the media to expand understanding of budget process

Legislative Committees

1. Continued capacity building for legislatures on maternal health issues and improving their capacity on the lawmaking process
2. Scale up promising practices in working with state houses of assembly

INTRODUCTION

Background

In 2013, the John D. and Catherine T. MacArthur Foundation funded a seven-grant portfolio focused on increasing government accountability for maternal health in Nigeria. The portfolio focuses on four accountability areas: budget analysis, community mobilization, legal redress, and maternal death audits. The portfolio spans 3 government levels (federal, state, and local), 12 states and the Federal Capital Territory (FCT), and 5 geopolitical zones. Conceiving funding at a portfolio level, instead of just as individual grants, was a new approach for the Foundation. The purpose of funding a portfolio was to decrease competition and increase collaboration among civil society organizations (CSOs) working in different sectors to more effectively address government accountability.

To demonstrate pathways for increasing government accountability to maternal health, the Foundation commissioned EnCompass to articulate the portfolio-level theory of change; conduct a baseline study, as well as midline and endline portfolio-level evaluations; and provide technical support to build grantees' capacity to monitor their grants. (These monitoring data were also used for the midline and endline evaluations.)

Evaluation Purpose, Users, and Uses

The purpose of this endline evaluation is to deepen understanding of which interventions have been the most promising for increasing maternal health accountability in Nigeria. The Foundation made its final 3-year grants in January 2017,[4] intending to consolidate gains achieved through this portfolio. The Foundation is using findings from this evaluation for two purposes:

- To provide evidence, for its activities and for the broader maternal health community, on which accountability areas—and which interventions in each area—have shown to be most promising opportunities for building government accountability for maternal health
- To enhance the sustainability of its grantees by providing information that identifies promising areas on which individual grant activities should continue to focus.

Since 2013, when the grants were awarded, grantee activities have evolved in response to changes in the context and lessons learned. The endline evaluation documents successes and challenges in each key accountability area, paying special attention to the effect of changes in the broader Nigerian context on the portfolio's original intended outcomes. Some evaluation questions look back over the entire portfolio to describe cumulative change. In other instances, the evaluation purposes are better served by examining activities related to recent shifts in programming to understand their potential for improved effectiveness.

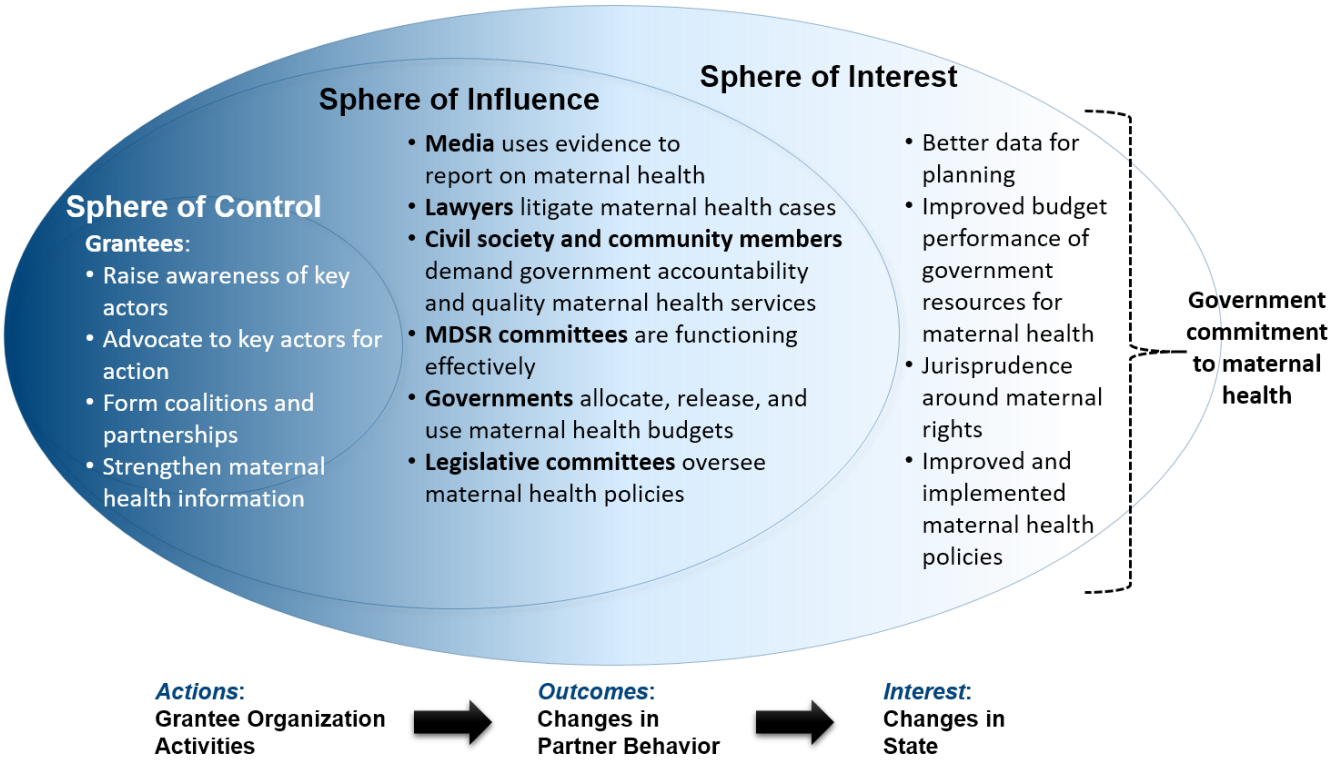
[4] CHR's grant was awarded in September 2016.

Theory of Change

The literature acknowledges that the accountability landscape is filled with a broad array of actors with multiple connections, creating layered webs of accountability with varying degrees of autonomy and sources of control or oversight. Recognizing the complexity of the multiple pathways to intended outcomes and the geopolitical diversity of this portfolio, EnCompass used a modified outcome-mapping framework to develop an explicit, portfolio-level theory of change and guide the evaluation design and methodology. Outcome mapping focuses on grantee organizations' direct actions ("sphere of control"), the resulting changes (actions) desired among the key actors (stakeholders or boundary partners) with which the grantee organizations interact ("sphere of influence"), and the resulting changes by federal, state, and local governments that are sought ("sphere of interest").[5]

At the midline evaluation design meeting in February 2015, grantees adjusted the portfolio theory of change to reflect changes since implementation of their grants.[6] During the endline evaluation design meeting in July 2016, grantee organizations revisited the theory of change, but did not make substantial modifications. They agreed that the endline evaluation should focus on the sphere of influence (the desired changes in boundary partners' actions). The updated portfolio theory of change is presented in Exhibit 1.

Exhibit 1: Theory of Change to Achieve Government Accountability to Maternal Health



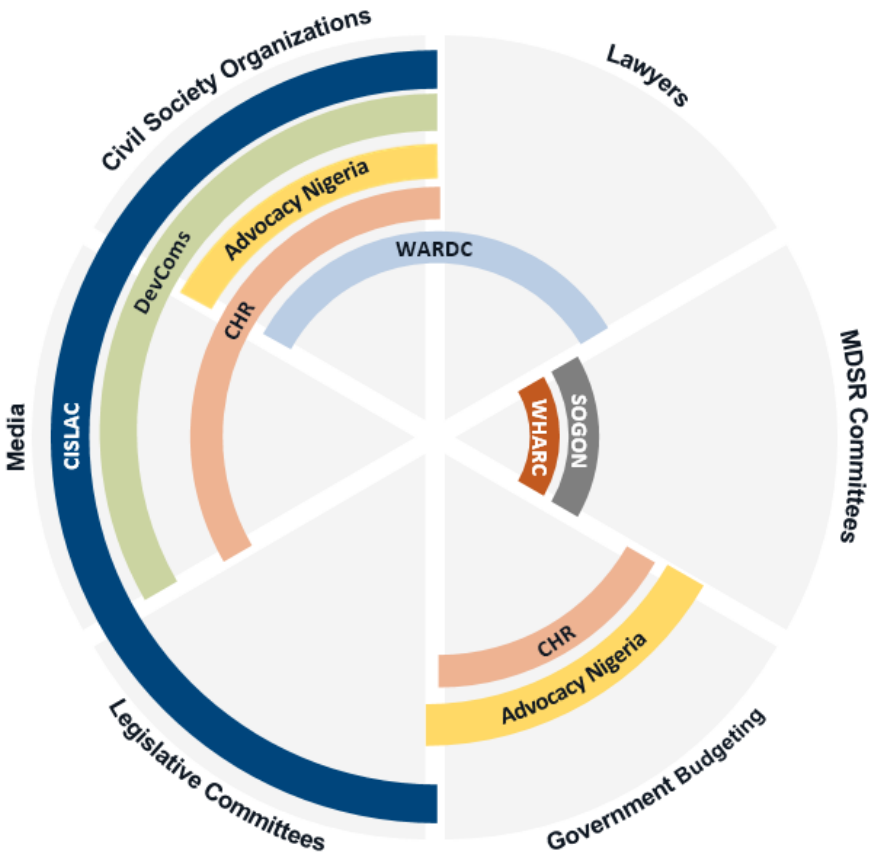
[5] Earl, S., F. Carden, and T. Smutylo. 2001. *Outcome Mapping. Building Learning and Reflection into Development Programs*. Ottawa: International Development Research Center.

[6] Changes include several refinements and clearer language in the sphere of control and the sphere of influence.

Grantee Organization Activities

This portfolio comprised seven grantee organizations working directly or indirectly with multiple boundary partners through a range of activities, as described in Annex 1. Exhibit 2 illustrates which organizations worked with which boundary partners (see the sphere of influence in Exhibit 1).

Exhibit 2: Grantee Organizations' Relationship with Boundary Partners



Evaluation Questions

The overall question guiding the endline evaluation is, "*What do we need to know to do more of what is promising?*" In other words, the evaluation seeks to understand what has been learned from this portfolio of grants about how to continue making progress in maternal health accountability. In June 2016, EnCompass and the Foundation drafted evaluation questions based on the Foundation's intended uses of the endline evaluation findings. These questions were refined with grantee organizations at the July 2016 design meeting (see box, next page). Exhibit 3 (also on the next page) presents the final questions and details the data analysis plan.

To ensure that the endline evaluation remains grounded in grantees' work, on July 21, 2017, EnCompass facilitated a 1-day evaluation design meeting with grantee and MacArthur Foundation representatives in Abuja. The objectives were to:

- Reach a shared understanding of the endline evaluation purpose and use
- Revisit and refine, if needed, the portfolio theory of change
- Design evaluation questions (to answer the overall question, "What do we need to know in order to do more of what is promising?")
- Share understanding of how monitoring data would be used in the endline
- Agree on the sample states and list of stakeholders
- Clarify grantees' roles during the evaluation.

The endline evaluation questions were tailored to capture the specific changes in behavior of each stakeholder group or boundary partner in the sphere of influence: media consumers and producers, lawyers, CSOs working in advocacy, maternal death surveillance and response (MDSR) committees, government officials, and legislative committees. As appropriate, evaluation questions capture portfolio-level impact, explore emerging outcomes, measure the state of the accountability at the national level, and build on midline findings to better understand what is showing promise and should be continued.

Exhibit 3: Endline Evaluation Questions

Sphere of Influence	Evaluation Questions
Media uses evidence to report on maternal health	1. How has use of maternal health evidence changed since midline? 2. How have grantee activities influenced the quantity and quality of maternal health reports since midline?
Lawyers litigate maternal health cases	3. What are the most promising alternative means used to seek redress in cases of maternal death or injury? 4. What are the enablers and constraints of the identified alternative means? 5. What supports or hinders lawyers trained by the Women Advocates Research and Documentation Centre (WARDC) to litigate cases involving maternal health and death brought to them?
Civil society and community members demand government accountability and quality maternal health services	6. What have been the most important contributions of grantees to maternal health accountability advocacy initiatives? 7. What outcomes have been achieved by maternal health accountability advocacy initiatives conducted by grantees and grantee-supported CSOs?

Sphere of Influence	Evaluation Questions
MDSR committees are functioning effectively	8. To what extent are MDSR committees functioning effectively? 9. To what extent are MDSR committee recommendations implemented by facilities? 10. What factors enable and constrain implementation of MDSR committee recommendations by facilities? 11. To what extent do MDSR recommendations influence practice and budget allocation at the state level? 12. What factors enable and constrain implementation of MDSR committee recommendations at the state level?
Governments allocate, release, and use maternal health budgets	13. At what stage in the budget cycle are grantee-supported CSOs intervening most effectively? 14. What factors enable effective CSO intervention in the budget cycle? 15. What stages in the budget cycle are the most strategic for CSO intervention?
Legislative committees oversee maternal health policies	16. What supports state legislators to translate executive policy pronouncements related to maternal health into implementable bills and laws at the state level?

Design, Sample, Methods, and Limitations

Design

The evaluation design is the product of multiple consultations with the Foundation, grantee organizations, and EnCompass' local data collection team. The evaluation questions are both summative and formative. For summative questions, the evaluation team (Annex 2) compared endline data with midline data; for formative questions, the team collected data in August and September 2016 on observations and perceptions.

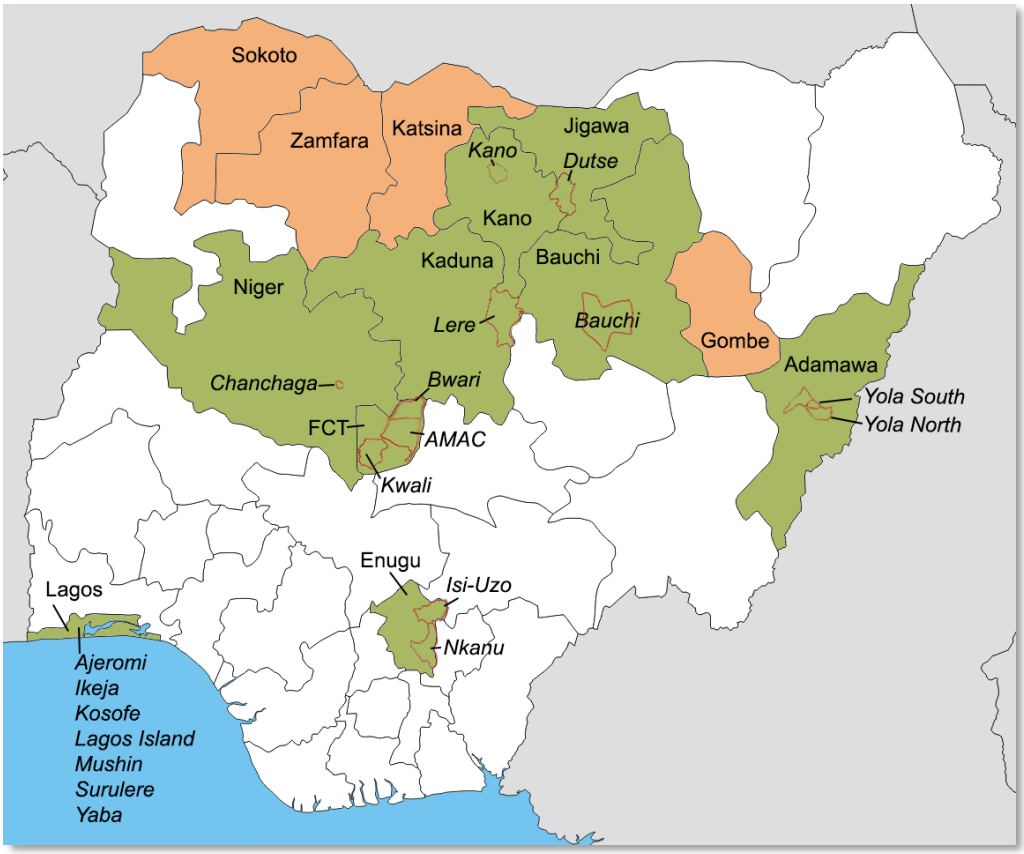
The evaluation design uses mixed methods and incorporates qualitative data collected through individual and group interviews and focus group discussions with stakeholders, triangulated with grantee monitoring data and desk review. In addition, the EnCompass team collected data from the grantees on the contextual factors influencing their work. Please see Annex 3 for the data sources for each evaluation question.

Sample

As grantees worked across a range of states (see Annex 1), the first level of sampling selected states for data collection. State selection was based on grantees' activities under the MacArthur Foundation grant, feedback from the Foundation, and feedback from grantees during the July 2016 Endline Evaluation meeting. In Exhibit 4 (next page), the states in green are the sample visited for data collection, with local government authorities in italics. States in orange are where grantees worked but were not visited for data collection. The sample for the endline evaluation was the same as the baseline and midline sample, with one exception: The team visited Adamawa State instead of Gombe

State, due to Advocacy Nigeria's reported successes in Adamawa State and the unique learning opportunity visiting this state presented. Within the states, the sample was designed to capture changes in the sphere of influence (i.e., changes in behavior among those with whom the grantees have been working directly or indirectly). Key informants for semi-structured interviews included media houses, health desk correspondents, editors, MDSR committee members, community members engaging with MDSR committees, CSOs, government officials (federal, state, and local), professional associations, development partners, and health facility and hospital staff. Grantees identified key informants based on the focus of their work in a given state, and the sample was finalized in consultation with the data collection teams. (See Annex 4 for a full list of stakeholders interviewed.)

Exhibit 4: Endline Evaluation Sampled States and Local Government Authorities for Data Collection



Sample visited for data collection *where grantees work, but not visited for data collection*

Methods

Primary Qualitative Data Collection: Three data collection teams, each comprising one regional coordinator and two data collectors, traveled to three states each, spending 3 to 5 days in each of the nine sample states. The teams used semi-structured interviews and focus group discussions to collect data from key informants. Interview and focus group discussion guides are included in Annex 5. The teams obtained informed consent from respondents before proceeding with data collection. Respondent data are confidential and stored on a secure, password-protected computer.

Document Review: The evaluation team reviewed grantee annual reports, WARDC case studies, newspaper articles on maternal health issues in Nigeria, and other relevant documents to gain a deeper understanding of the grantees' work and context.

Qualitative Data from Grantees as a Group: During the endline evaluation design meeting in July 2016, EnCompass facilitated participatory exercises with grantees to collect information on the effect of the Nigerian context on project implementation and achievement of outcomes; enablers and constraints to their work in the current Nigerian context; and any changes to their grant activities or focus since the midline evaluation. This information was used to frame the evaluation findings and is presented throughout the report.

Grantee Monitoring Data: Grantees submitted monitoring data to EnCompass for the period of October 2015 to July 2016 on outputs and outcomes since the midline evaluation. All data in the report that were analyzed fall within this period, with the exception of two indicators:

- *Implementation of MDSR committee recommendations* was extended to the start of the grant (December 2013) in order to adequately capture the facilities' process of reviewing and implementing recommendations.
- *Executive policy pronouncements leading to implementable bills and laws* was extended to the start of the grant (December 2013) in order to accommodate the time needed for a pronouncement to turn into a bill and law.

Grantee data from the earlier period was already available from the midline data collection.

Data Analysis

The EnCompass evaluation team coded and analyzed all data collected through interviews and focus group discussions using Dedoose, a cross-platform application,[7] for both content and thematic analysis. All data were disaggregated by sex, state, local government authority, and stakeholder group and triangulated across sources and stakeholders. The qualitative codebook was piloted and finalized with three data analysts. All findings in this report emerged from a series of virtual EnCompass team internal data analysis and interpretation sessions to discuss data discrepancies and analysis across the four key evaluators.

In May 2017, EnCompass convened a data consultation meeting with grantees, the Foundation, and key stakeholders from the maternal health community, including government officials, doctors, journalists, donors, and other nongovernmental organizations (NGOs). During the 2-day meeting, stakeholders and grantees worked collaboratively to validate findings, refine conclusions, and develop recommendations on where grantees and the broader maternal health community should focus their efforts. The conclusions and recommendations in this report reflect these inputs.

[7] See www.Dedoose.com.

Limitations

The evaluation team encountered a number of limitations during the endline evaluation.

Grantee Monitoring Data: The EnCompass team provided a range of technical support to increase grantee organizations' capacity to collect, collate, and store monitoring data related to their work. Their data quality improved, but the monitoring data submitted for this evaluation had limitations:

- *Ambiguity and inconsistency.* Some grantee indicators had unclear or undocumented definitions and inconsistent data compilation methods, compromising the validity of the data and ability to roll up and compare results across the portfolio.
- *Limited standardization across organizations.* There were subtle but important differences in the way grantee organizations defined, collected, compiled, and analyzed data for the same indicators. This made it difficult to analyze at the portfolio level, especially for the outcome-level indicators that were added at endline.
- *Outcome-level indicators.* Before the midline evaluation, grantee organizations collected output-level indicators almost exclusively. Due to the organizations' increased capacity, EnCompass added outcome-level indicators to the monitoring plans. These indicators were more challenging for the organizations to collect, but provided better information on the portfolio's progress. This endline evaluation reports on many new outcome-level indicators, but there are limited data available in previous periods on these indicators.
- *Midline-endline period:* The time between the midline and endline evaluations was a shorter period of grant implementation: 9 months for endline (October 2015 to July 2016) versus 22 months for midline (December 2013 to October 2015). In addition, some grants had already ended during this period, and the grantee organizations had not collected data on some or all indicators when their grant or funding ended or changed during the endline evaluation period. The baseline had no grantee data, as this was before grantees had started monitoring, so there is limited ability to compare quantitative data across baseline, midline, and endline.

Respondents' Knowledge of Specific Grantee Actions: Data collectors reported difficulty attributing results for grantee organizations working as a coalition. Respondents often recognized and reported the results of coalitions, but were unfamiliar with specific grantee organizations' roles.

Data on Legislation: Data collectors found it challenging to schedule interviews with state legislators, so those data are limited and based primarily on grantee and CSO perceptions.

Sample from Midline to Endline: The endline evaluation sample included one change, replacing Gombe State with Adamawa State. This change was made to capture learning cited by Advocacy Nigeria on successes in Adamawa State that would be useful for this learning-focused evaluation. However, this meant that endline data from Adamawa State had no midline or baseline for comparison. Similarly, qualitative midline data from Gombe State had no endline comparison.

The Nigerian Context

Many contextual factors unique to Nigeria affected the grant portfolio over the past 3 years. Grantees identified four main categories that affected the entire portfolio: the change in government, changes in policies, resource scarcity, and insecurity. Specific contextual factors relating to each sphere of influence are reported in the introduction to each subsection in the findings.

Change in Government: In April 2015, Nigerians elected the country's first presidential opposition candidate, General Muhammad Buhari. The handover of power resulted in a turnover of officials in key positions at national and state levels, with positive and negative effects on grantees throughout the endline evaluation. Some grantees that had made progress with previous state-level officials had to restart their advocacy efforts with the new cadre. Grantees reported that the new government's anticorruption focus had a positive impact on their work by putting into position many government officials at the state level who wanted to see more efficient progress. Grantees also reported that since many new governors were more receptive to the issue of maternal health, grantees subsequently had more access to the governors than in the past.

Changes in Policy: The new government's policies presented new opportunities and challenges for grantees. Grantees welcomed the increased policy focus on health, with a specific focus on HIV/AIDS, immunization, contraceptive commodities, and primary health care (PHC). Grantees pointed to the National Health Policy, developed in April 2016 and passed in February 2017, as beneficial in bringing maternal health to the fore.[8] However, grantees also reported that the government has fallen short in implementing the National Health Act (2014). As at midline, grantees mentioned that some of their work in clinical settings was interrupted because the Subsidy Reinvestment and Empowerment Program had stopped funding for midwives employed by the Midwives Service Scheme.

Increasing Financial Constraints: Recently, Nigeria has endured economic instability and threats to its security. Its economy relies on oil, which accounts for approximately 90 percent of export revenues and roughly 75 percent of the country's consolidated budgetary revenues. Due to the global decline in oil prices,[9] Nigeria is experiencing a foreign exchange crisis and has fallen into recession. With decreased revenue, the federal government has struggled to release the expected funds to states. This delay has had a negative impact on grantees working in budget tracking as they try to ensure that maternal health is properly funded. Fuel scarcities have constrained the ability of grantees and those they work with to travel to carry out their work.

Insecurity: Nigeria's security situation has remained unstable due to Boko Haram's terrorist activities. Many northern CSOs have fled, including those partnering with MacArthur grantees. Grantee travel to northern states was also been restricted due to security concerns. Thus, grantee activities in the north were delayed or interrupted.

[8] More information available at: http://www.afro.who.int/en/nigeria/press-materials/item/8750-nigeria-develops-new-national-health-policy-to-accommodate-emerging-trends.html.
[9] World Bank Overview, available at: https://www.worldbank.org/en/country/nigeria/overview.

FINDINGS

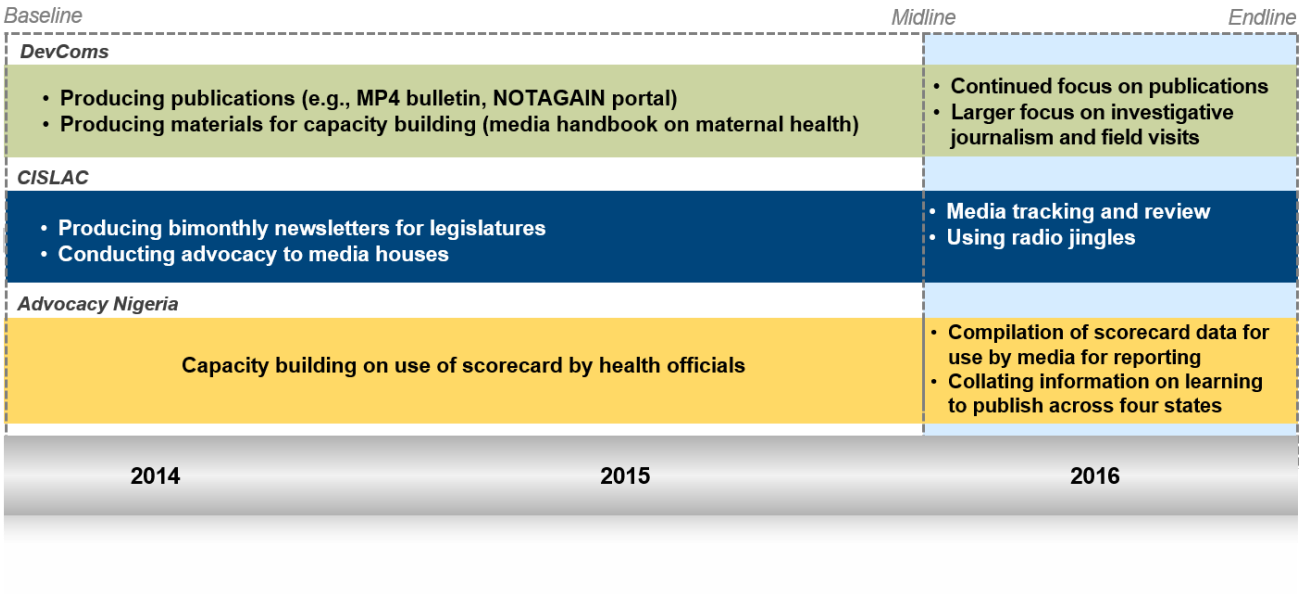
Due to the nature of this portfolio, many grantee organizations' work sought to influence a variety of boundary partners. This section presents endline findings, organized by boundary partner. Subsections on context and background summarize grantee organizations' work in the sphere of control, if or how their activities changed between midline and endline, and what contextual factors helped or hindered their goals.

Media

Context and Background

Three grantee organizations worked to enhance the visibility of maternal health issued in the media, as illustrated in Exhibit 5.

Exhibit 5: Changes in Grantee Activities Influencing Media across Life of Portfolio



Advocacy Nigeria, the Civil Society Legislative Advocacy Centre (CISLAC), and Development Communications Network (DevComs) focused on different stages of evidence generation and use. CISLAC generated and published data for journalists, policymakers, and legislators. DevComs, which produces information for the national NOTAGAIN campaign,[10] supported journalists to undertake investigative journalism on maternal health. Advocacy Nigeria used a scorecard to assess facility readiness for maternal health in three areas: human resources, essential maternal health commodities, and the enabling environment (basic utilities, water, and electricity). Advocacy Nigeria

[10] Funded by the MacArthur Foundation and implemented by a number of CSOs, the NOTAGAIN campaign includes advocacy events, meetings, training, and an online portal. Its goal is to create awareness about the maternal health situation in Nigeria by facilitating communications among media professionals, CSOs, and the public to collectively demand accountability in maternal health service delivery.

maintained a database of scorecard findings and provided these data for the media to use for evidence-based advocacy.

Grantee Scorecards

Advocacy Nigeria, CHR, and CISLAC all used scorecards for different purposes, mentioned throughout the report.

- With media partners, Advocacy Nigeria used scorecard data to provide evidence for media reporting.
- With government budgeting partners, Advocacy Nigeria and CHR used scorecards to track budget expenditure and release, and to advocate for increased budget allocations to government officials.
- For CSO advocacy and collaboration, CHR and CISLAC trained CSOs and health workers on how to use the scorecards and how to train others to use them.

The production of high-quality information on maternal health was a core activity for Advocacy Nigeria, CISLAC, and DevComs from beginning of the grant (see Exhibit 6). DevComs and CISLAC were consistent, averaging one article per month throughout the life of the portfolio. Advocacy Nigeria did not report any maternal health evidence products at midline or endline, because its scorecard database did not fit into the portfolio-level indicator definition of published products.

Exhibit 6: Number of Maternal Health Evidence Products Delivered by Grantees

Organization	**Midline** *Grant inception (Dec. 2013) to Midline (September 2015):* ***22 months***		**Endline** *Midline (October 2015) to Endline (August 2016):* ***10 Months***	
Unit of Analysis	**Average/Month**	**Total Midline**	**Average/Month**	**Total Endline**
Advocacy Nigeria	0	0	0	0
CISLAC	0.80	17 (November 2013)	0.90	9
DevComs	0.91	20 (December 2013)	0.80	8

Between midline and endline, DevComs produced eight evidence-based products, including newsletters, press releases for international health days (e.g., World Population Day, World AIDS Day, and International Day to End Obstetric fistula), factsheets, and opinion pieces for media stakeholders.

CISLAC published nine editions of its monthly newsletter, "Gender and Maternal Health," for boundary partners, including journalists, policymakers, and legislators during the 10-month endline period. CISLAC also conducted an audit of the maternal health situation in Kano, Katsina, Kaduna, and Jigawa states; the report was published in 2016.

Evaluation Q1: How has use of maternal health *evidence* changed since midline?

No grantee monitoring data were available to answer this question as it was framed: CISLAC does not track whether materials they produce and distribute are used, and DevComs could not obtain the information to measure "*Percent increase in web hits on information websites developed by DevComs,*" because the NOTAGAIN campaign portal was being reconstructed from February through August of 2016. However, information from interviews and focus groups provides qualitative information in response to this question.

1 Journalists' knowledge and use of maternal health data sources have increased since midline. Access to budget information was still challenging.

Journalists, CSOs, and development partners reported that use of maternal health evidence has improved since midline. Journalists demonstrated better knowledge of maternal health data sources, including grantee sources. Whereas midline evaluation respondents reported that most maternal health data were from non-grantee sources, at endline there was more mention of grantee data as sources of information. Respondents referred to grantee sources, such as workshop materials by CHR, CISLAC and DevComs scorecards, press briefings, media–CSO forums, and specific grantee-generated publications.

Media respondents cited using the following secondary data sources: the Nigeria Demographic and Health Survey, hospital records, the State PHC Development Agency, Google search results, and the World Health Organization website. They also reported using primary sources, including the technical experts referred to them by grantees, grantee resource persons, and data gathered during field trips facilitated by DevComs.

> *The information of maternal health is playing an important role in my reporting. The scorecard, records at the facility and NDHS [Nigerian Demographic Health Survey] are some of the information I used in writing my reports. (Media respondent, Bauchi State)*

Media and CSO respondents reported that data availability has improved overall. Journalists described their ability to request data from government sources, such as the State PHC Development Agency and the State Hospital Management Board. However, ease of access to data from government sources appears to depend on the quality of a journalist's contacts in the agency that houses the information.

> *The information is always available depending on your relationship with the source of information. Sometimes, I go to the commissioner, permanent secretary, other directors, local government PHC coordinators, facility managers, the workers, community, and religious leaders, and the women. And the availability of the information keep[s] on improving day by day. (Media respondent, Jigawa State)*

Media respondents pointed to grantees' efforts to improve access to information, particularly their role in helping to establishing the State PHC Development Agency.

> *In 2014, partly due to advocacy by CISLAC and other NGOs, the state government established [the State PHC Development Agency]. Since its establishment, access to information has increased. You can approach the executive director and he's ever willing to speak to journalists. (Media respondent, Kano State)*

There was consensus that budget data remained difficult to access. Respondents attributed this to poor government transparency and a budget process that did not lend itself to stakeholder participation.

> *It is very easy to get maternal health information but very difficult to get MNCH [maternal, newborn, and child health] budget information. There is no participatory budget. As it is now, awareness has increased, government has no [other] option than to make it participatory. (Media respondent, Bauchi State)*

2 Key media producers and consumers[11] reported an overall increase in *quantity* of reporting and pointed to grantee engagements as having an important influence on this increase.

Key media producers and consumers alike reported an increase in maternal health reporting since the start of the grant portfolio. At baseline, respondents described reporting on maternal health as "generally infrequent." At midline, this had increased to "1 to 3 reports per week." At endline, some journalists described the number reports as "uncountable."

> *It has increased. There are lots of program[s] now in the media. Freedom Radio and Express Radio run programs every day except Saturday and Sunday. They invite experts in that field to speak generally on health issues. (CSO respondent, Kano State)*

Grantee influence in increasing maternal health reporting was also more evident than at midline. Several journalists gave concrete examples of maternal health articles they wrote after field visits or capacity building provided by grantees. Journalists also reported being more aware of maternal health following their field visits.

> *If not for the constant workshop[s] we always have with DevComs, I doubt if I will dabble into maternal issue. I will probably be writing on hepatitis, tuberculosis, and HIV/AIDS and the others. (Media respondent, Lagos State)*

3 Key media consumers and producers perceived the *quality* of maternal health reporting as improved. Journalists' efforts to improve their skills in this area suggested this trend might continue.

[11] "Key media producers" refers to journalists and editors working in print, online, radio, and Internet outlets in Nigeria. "Key media consumers" includes policymakers, development partners, and CSOs working in maternal health.

Although it is difficult to determine the degree to which the quality of maternal health reporting can improve in a 10-month period, the perception among grantees was that quality improved between midline and endline. Respondents said that the quality of maternal health reporting had improved, particularly in being more regularly based on primary or secondary evidence. At midline, "use of expert information" in maternal health reportage was mentioned as an improvement over baseline. Endline responses continue this trend.

> *The evidence and information on maternal health is becoming more reliable than before. (Media respondent, Bauchi State)*

Some journalists are beginning to specialize in health reporting, bringing increasingly sophisticated skills to bear in assessing the quality of data. For example, media correspondents mentioned their participation in the Bauchi State Accountability Mechanism for MNCH (BASAM),[12] a coalition of CSOs, government, media, and other stakeholders that strengthens advocacy and coverage of maternal health issues.

> *The quality has improved and it is evidence-based … BASAM has an advocacy group, evidence-based group, and knowledge management committee … I belong to the knowledge management committee, which [comprises] the media and some NGOs. We have the technical people who belong to the evidence group who bring out data, which we sit down to look at it, and when it is accepted as evidence-based, then we use it as back-up. From there, the advocacy group will go out to the government to advocate for issues identified. (Media respondent, Bauchi State)*

Journalists for Better Health (JOBETH) in Kaduna Sate is another example of journalists organizing to build skills in health reporting. JOBETH is an offshoot of the Free Maternal and Child Health Partnership (FMCH), the primary group working on maternal and child health in the state. JOBETH trains journalists to deepen their knowledge of health and provides them with resources to ensure accurate reporting.[13] CISLAC and DevComs have both supported FMCH, which has benefited members of JOBETH in turn.

Although grantee contributions to BASAM and JOBETH may have been indirect, these organizations are promising signs that the gains in maternal health reporting will take root and be sustained by journalists' efforts.

Evaluation Q2: How have grantees' activities influenced the quantity and quality of maternal health reports since midline?

4 Grantee-supported activities, including capacity building, field trips, and partnerships with media, have contributed to improvements in maternal health reporting.

[12] More information available at http://www.mamaye.org/en/blog/mamaye-advocacy-team-sets-health-agenda-new-bauchi-government.
[13] More information available at https://jobethblog.wordpress.com/about/.

Grantee engagement with the media occurred through a variety of modalities, including training, press conferences, and other strategies. DevComs' strategy for influencing the media focuses on building the capacity of editors and journalists through training in maternal health, and providing investigative journalism grants for journalists to go into the field to report.

Between the midline and endline evaluations, DevComs trained 54 journalists (see Exhibit 7), who went on to publish 85 articles on maternal health accountability. DevComs also reported that in the 6 months following the training, 32 percent of the 54 journalists trained produced at least two reports on maternal health, 14 percent produced three reports, and 7 percent produced four reports. Two grantee organizations working in this area, CHR and CISLAC, did not train journalists during this period because of gaps in funding.[14] However, the seven journalists CHR trained earlier in the life of the portfolio published 34 articles between midline and endline, suggesting a persistent effect of this training.[15]

Exhibit 7: Results of Grantee Activities in Training Journalists[16]

Organization	Number of journalists trained in maternal health *Dec. 2013–Sept. 2015 (grant inception to midline)*	Number of journalists trained in maternal health *Oct. 2015–Aug. 2016 (midline to endline)*	Total number of journalists trained in maternal health
CHR	7	0	**7**
CISLAC	102	0	**102**
DevComs	132	54	**186**
Total	**241**	**54**	**295**

WARDC increased its influence on the production of media material. Between midline and endline, WARDC began to hold press conferences on the maternal death cases it had investigated. The press conferences, in combination with WARDC's work on the NOTAGAIN campaign and other advocacy initiatives, brought the issue to the attention of journalists, who reported on 13 maternal mortality and morbidity reports between the midline and endline evaluations.

The midline evaluation identified the following key enablers to increasing maternal health reporting: capacity building for media staff; partnerships between CSOs and the media; personal interest of media staff; and use of public outcry. Grantees leveraged these enablers to increase reporting on maternal health.

[14] CHR's grant ended in December 2014. As of June 2016, CISLAC had not received the last tranche of its grant from the Foundation. The number of articles published is from journalists trained prior to the end of the grant.
[15] Source: Midline evaluation report data.
[16] These data were recorded by name of each journalist attending the training to avoid double counting across or within organizations across multiple training courses. The data are also disaggregated by sex.

DevComs continued to build the capacity of journalists through training, field trips, facility visits, and awareness-building activities with positive results.

Media respondents pointed to training and field trips organized by CISLAC and DevComs as the key to promoting use of maternal health data and increased reporting on the topic. DevComs-organized field trips brought journalists face-to-face with maternal health. They visited the local PHC facility and interviewed community members to get a better understanding of maternal health facing the community. These field trips provided journalists and editors with primary information and firsthand experience of the state of maternal health in Nigeria.

> *What contributed to the success was access, because I have never been to those communities and it was through DevComs, when we went for a field trip in Katampe Community. (Media respondent, FCT)*

CHR, CISLAC, and DevComs also trained journalists on how to use primary data to inform their stories. Journalists reported the importance of this training for strengthening the evidence base of their reporting, especially during a time in Nigeria when key media producers and consumers increasingly consider primary evidence more credible.

> *It's not a third-party thing any more. We use primary data because the writer is involved in looking for the information. (Media respondent, FCT)*

CSO-sponsored field trips were also an effective means for building personal interest of media staff in maternal health. Journalists pointed to their experiences during the field trips and their knowledge of the rate of maternal deaths as the reasons they now feel it is their duty to pay keen attention and make the issues visible. Some respondents said that the number of journalists reporting on maternal health has increased as the subject gains more attention.

> *The training we received from DevComs in the past has built our capacity to report more and better on maternal health. It started from the duties assigned to us, and now it is a passionate and interesting part of the journalist life. (Media respondent, Jigawa State)*

The midline evaluation recommended that grantees broaden the cadre of media stakeholders with which they work. Building on this, grantees increased their efforts to influence editors through advocacy, in the form of a news bulletin for health and awareness-raising visits. Grantees were encouraged by initial responses to these activities and respondents reported that some editors had taken an interest in maternal health and were bringing up the topic at editorial meetings.

Also following midline evaluation recommendations, grantees built partnerships with the media, primarily by convening regular forums that brought together members of the media and CSO representatives to build knowledge and share experiences on advocating for and reporting on maternal health. Sometimes, when there is an issue particularly relevant to maternal health, grantees conducted a press briefing to highlight the issue and stimulate journalists' interest in reporting on it. These forums helped open lines of communication and dispel the mutual suspicion that had previously characterized relationships between CSOs and the media.

> *We have a CSO–media forum in Lagos every quarter to address the issues of maternal health. In the past year, we had a forum on maternal health budgeting, and look at what government has done, especially with the 15 percent commitment on health budget. (CSO respondent, Lagos State)*

Stronger partnerships between CSOs and the media are important levers in holding government accountable for budgets (see Government Budgeting) and turning executive policy pronouncements into implementable bills and laws (see Legislation).

Aside from WARDC's work on the NOTAGAIN campaign and press briefings, there was no evidence that grantees deliberately pursued "public outcry." However, media respondents agreed that public interest is a strong influencer in the type of articles that get written and published. In other words, when maternal health is in the public spotlight, journalists are more likely to feature the topic.

> *Another reason is public outcry, even though only the NGOs can do that because the government sometimes does not want you to give a negative report and may frown at you. For example, when it was reported that there was malnutrition resulting from a poor child-feeding program, the government frowned until UNICEF [the United Nations Children's Fund] intervened by providing statistical evidence. (Media respondent, Kaduna State)*

Lawyers

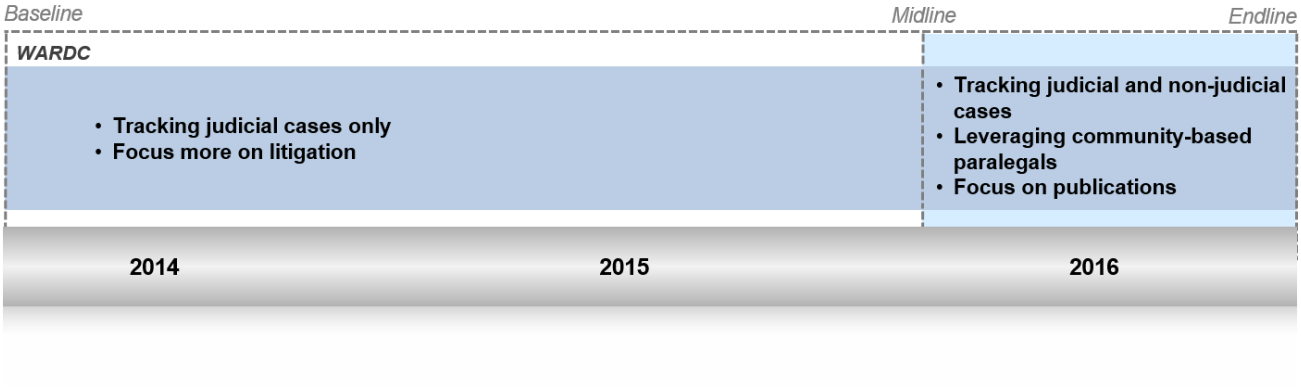
Context and Background

In Nigeria, litigation on maternal death and injury remains limited. Few cases are brought to lawyers, and the litigation process can be lengthy and difficult. Women and their families are reluctant to take cases of maternal injury and death to court. Women are often unaware of their right to seek redress and uninformed about how to report a case when they do not receive adequate health care. In addition to cultural and religious norms that play a part in this reluctance, women and their families believe litigation is an expensive and lengthy process. Grantees reported that court cases are prolonged due to the number of national holidays the court observes, amongst other reasons for delay limiting the time for litigation.

As Exhibit 8 illustrates (next page), WARDC is the only grantee in the portfolio using legal and social advocacy to hold the government accountable for advancing maternal health and reducing maternal death and injury. WARDC works in Enugu, Kaduna, and Lagos states on policy implementation and jurisprudence for maternal death and injury, and on maternal rights. As reported at midline, lawyers and legal professionals in these three states stated that the WARDC training gave them insight into maternal health and the possibility of litigating on maternal death and injury. Yet, bringing cases to litigation has been slow. At midline, WARDC reported that it was following and supporting three

cases involving maternal death or injury. Between midline and endline, three new cases, including two judicial cases,[17] were brought to WARDC.

Exhibit 8: Changes in Grantee Activities Influencing Lawyers across Life of Portfolio



The midline evaluation described constraints WARDC faced in bringing maternal death and injury cases to court and recommended that the organization expand its activities to include non-judicial means of redress for victims and their families. Between midline and endline, WARDC began supporting one non-judicial case and started working with CSOs that train community-based paralegals, volunteers who identify cases at the community level. WARDC has leveraged these paralegals to bring maternal death and injury cases to its attention for litigation or redress. WARDC also conducted community-based awareness-raising activities to create demand for maternal and child health services.

Because only one non-judicial case had been added to the WARDC's roster, the endline evaluation relied on key informants with knowledge of the case, as well as other non-judicial cases brought to other organizations and actors. Therefore, there is little data to answer the evaluation questions, and findings reported below are based on respondents' limited experience in litigating maternal death and injury cases over the entire 3-year grant period, not only the period between midline and endline.

Evaluation Q3: What are the most promising alternative means used to seek redress in cases of maternal death or injury?

5 Patients and families were unlikely to seek redress in cases of maternal death and injury. However, respondents where WARDC works were aware of several non-judicial means of redress.

Similar to midline findings, respondents continued to report that in cases of maternal death or injury, most Nigerians in rural and urban settings prefer to "leave it in God's hands." Respondents were more aware of options for redress, in comparison with the baseline and midline evaluations, and described a variety of avenues at the community, state, and national levels. At the community level, victims' relatives report the cases to community elders, village or ward heads, and village or facility

[17] Data reported at midline were not disaggregated by judicial and non-judicial.

health committees. According to respondents from Kaduna State, people also brought maternal death and injury cases to the *zumunta mata* (women's wings of churches).

> *People are getting more aware. Relatives and relations are helping them to seek redress. Sometimes the churches also play a part and intervene in cases when it concerns their members. (State government respondent, Enugu State)*

Familiarity with legal proceedings and connections might play a role in who pursues cases through judicial and non-judicial means. In Lagos and Kaduna states, several families have brought cases to CSOs and community-based paralegals, trained by WARDC, who wrote petitions to the government or had discussions with facilities involved. Some CSOs have organized press conferences and rallies to protest ill treatment and negligence that has led to maternal death.

Alternative Means of Redress in Nigeria

- Taking cases to community leaders, village elders, or the church
- Bringing cases to WARDC-trained paralegals, who petition government and discuss with health facilities
- Organizing press conferences and rallies to protest ill treatment
- Bringing malpractice cases to the NMA and SERVICOM
- Having police file reports of cases

Respondents also reported using state and national institutions to seek redress. Respondents from Enugu and Kaduna states reported that state-level law enforcement file reports on the situation in case it was required in the future to seek redress, through alternative means or otherwise. Respondents also pointed to Service Compact with All Nigerians (SERVICOM) and the Nigerian Medical Association (NMA), both of which can penalize hospitals and doctors if malpractice is identified, as a promising path to seek alternative means of redress. Respondents in Enugu and Lagos states said that some cases reached the higher echelons of the state government (i.e., civil servants at the director level and higher, to those responsible for decision-making in the state) or the State House of Assembly, if people had personal connections with these key stakeholders.

6 Multipronged approaches that include the media in prompting government action were perceived to be effective means of redress.

Respondents described involving several different actors, particularly the media, to prompt action by the government or health officials in response to a maternal death or injury case. The combination of petitioning the government and engaging the media in cases was reported as having the greatest likelihood of leading to positive results. CSOs used rallies and campaigns to get media attention.

> *When the [maternal death and injury] case came to our notice, we did a petition to the Lagos state government because the woman was up to term and the death was avoidable. We compelled the Lagos state government to set up a committee and to look at what happened. We used a lot of media and were called to appear before the committee. We were also invited to a higher panel with the Head of Service. (CSO respondent, Lagos State)*

As reported at midline, the NOTAGAIN campaign continued to stand out as a multipronged approach to bring awareness of maternal health rights. The campaign, launched on June 9, 2014, in Lagos, used a national platform to draw media attention, advocate to government, use connections in government, and raise awareness among the general population on the importance of maternal health and options for redress. Families who brought their maternal death and injury cases to WARDC reported hearing of the organization through NOTAGAIN. The campaign engaged with journalists willing to report on maternal death and injury cases, and was seen as an effective means of encouraging authorities to take action, even if the cases did not always result in favorable rulings.

Respondents also recommended alternative means of redress for future use. They suggested engaging government institutions, such as the State Ministry of Women Affairs, which deals with cases of negligence, and the National Human Rights Commission, which deals with domestic violence cases. Both institutions' pronouncements are now taken as High Court pronouncements, which could be enforced and were therefore seen as showing promise for those seeking redress.

> *[I suggest] partnership with government institutions whose work and services affect women, (e.g., the National Human Rights Commission). This is one of the best government institutions you can use for non-judicial redress. They have rules and procedures, and if they decide on a matter and endorse it, you can go and enforce it. (Lawyer, Enugu State)*

7 Community-based paralegals appear well positioned to assist women and those close to them (e.g., family, friends, church leaders, etc.) to seek redress through judicial and non-judicial means.

Between midline and endline, WARDC leveraged a network of community-based paralegals[18] to assist women and their families to bring their cases for judicial or non-judicial redress. Using funds from other sources, WARDC trained paralegals or worked with paralegals trained by other CSOs. For example, in Enugu State WARDC worked with paralegals trained by the Civil Resource Development and Documentation Centre. Paralegals received training in basic human rights and the law, investigation skills, and proper procedures for reporting violations. Their role is to identify human rights violations in their communities, inform citizens of their rights, provide assistance, and report cases.

Community-based paralegals seemed to be an effective means for encouraging patients to exercise their rights to seek redress. Through their regular presence in the health facilities, these advocates kept abreast of facility conditions and learned of maternal death and injury cases. When a paralegal heard of a case, the paralegal sought out the patient or her family to offer assistance. The advocates also reported cases to CSOs and media outlets, when necessary. Respondents in Lagos and Kaduna states said that more women would be likely to report their cases when supported by community-based paralegals.

[18] WARDC has been working with community-based organizations in Enugu, Kaduna, and Lagos states. The paralegals are either community-based organizations' staff or individuals WARDC has found through community engagement.

We worked with traditional birth attendants and went house-to-house. We entered a house, met a pregnant woman lying down [and] vomiting, and we took her to the PHC. The nurse in charge and all other staff were not around. The nurse in charge came back later and complained that we were disturbing her. I mentioned that we had legal backing. I reported this incidence to the counselor for health. Last year, all the staff of that facility were sent away. (Women respondent trained by WARDC, Kaduna State)

Women do not know where to go, but now we know about the [community-based paralegals] and we can now report to them, but that is recent. (Women respondent trained by WARDC, Lagos State)

Evaluation Q4: What are the enablers and constraints of the identified alternative means?

8 Support by a local organization was critical for enabling women to seek redress.

Women mentioned the backing of a group, such as a CSO or church, as critical to their seeking redress. One respondent noted, "You cannot do this alone." Petitions often require numerous trips to official offices and, depending on the socioeconomic status of those seeking redress, the time and transportation costs could be daunting and sometimes prohibitive.

It is cost-intensive to pursue this kind of case. We can even go on several occasions without seeing the person in charge. A lot of effort is required. And yes, it also requires special connections. If you are very active, those connections will help a lot. (Woman respondent, Kaduna State)

CSOs, including WARDC, use their knowledge and connections to navigate the system on behalf of victims' families. For example, WARDC staff know which lawyers may be willing to take a case, which government authority should receive a petition, and which journalists would consider publicizing a case.

9 Consistent with baseline and midline findings, lack of knowledge, religious and cultural beliefs, illiteracy, pressure by family members, fear of retribution, and perceived costs have all been constraints to seeking alternative means of redress.

Women and their families have been constrained by several factors from seeking alternative means of redress in maternal health cases. Consistent with baseline and midline findings, respondents in Enugu, Kaduna, and Lagos states reported that many cases went unreported because most women did not know where to take their cases and felt they had nobody to fight for them.

We like to do something, but because we are in the village, we do not know where to go. If you people want to help us, tell us where to go and who[m] to talk with. If we go to the police, we do not know what they will tell us. (Woman trained by WARDC, Enugu state)

Consistent with baseline and midline findings, respondents from Enugu and Kaduna states reported illiteracy and religious and cultural values as the major constraints to seeking redress through judicial or non-judicial means. In Enugu, Kaduna, and Lagos states, women said they were also constrained by pressure from family members not to take up cases and misconceptions that seeking redress is costly. For example, a respondent in Lagos State reported that a mother working with a paralegal was pressured by family members to drop a case:

> *I went to the hospital when I went into labor, but the matron told me I was only 2 [centimeters] dilated and I should go back home. But the labor was strong and on my way home, I [got on] a bike and fell down. About an hour later, I started bleeding and called my husband, who rushed me back to the hospital. The matron said there was nothing she could do. We were advised to go to a private hospital and as we got there, I fainted. When I woke up, I was told that the baby died 3 days after delivery. When I tried to take up the case, my father-in-law asked us to stop … because it could be the devil using the hospital staff. The pressure from my family members made me drop the case. (Woman respondent, Lagos State)*

Similar to baseline and midline, respondents in Enugu State spoke of women's fear of victimization resulting from pursuing redress for maternal death and injury-related cases. Some respondents reported incidents of health clinic staff and community-based paralegals' sharing details of reported cases with each other. This lack of confidentiality became known among survivors, and respondents said they did not speak up due to their concerns with lack of confidentiality among service providers.

> *Fear of the fact that after telling the person, they may tell the person you are reporting. (Woman respondent, Enugu State)*

Evaluation Q5: What supports or hinders lawyers trained by WARDC to litigate cases involving maternal death and injury brought to them?

10 Increased awareness of patient rights among both the general public and the legal profession was seen as necessary for furthering maternal health litigation. WARDC's procedural knowledge and connections supported cases moving forward.

Even though litigating on maternal death and injury is still rare, respondents reported that there were important factors that encouraged litigation of maternal health cases. At midline, female patients and their families lacked awareness of their rights. This was reported again during the endline evaluation. Creating greater awareness of women's reproductive health rights among the public and legal professionals was reported as a key enabler to litigating cases. Respondents reported that some lawyers were also unaware of the specifics of maternal health rights. WARDC's close relationship with lawyers and ability to provide technical guidance on legal procedures was reported as another enabler in litigating maternal health cases. WARDC's connection with the proper government authorities enabled cases to be pushed forward and was reported as yet another enabler to maternal death and injury litigation.

The first thing is enlightenment, not just for the victims [clients], but the lawyers as well. If victims [clients] do not know their rights, there is no way it will get to the court; and if lawyers also are not looking in the direction of litigation, there is no way they will make an attempt to go there. (Lawyer, Enugu State)

11 Constitutional barriers, lack of financial incentives for lawyers, and limited expertise have hindered maternal health litigation.

Lawyers reported that a major barrier in litigating maternal death and injury cases concerned the status of reproductive rights in the Nigerian Constitution. The reproductive and socioeconomic rights of citizens, enshrined in Chapter 2 of the Constitution, are "non-justiciable," meaning that no court of law may try a case specifically in disregard to the infringement of these rights.[19] Lawyers can sue based on health staff's negligence, but not based on infringement of patients' rights to health services.

One of the challenges of litigation is that health care is in Chapter 2 of the Constitution and it … cannot be litigated upon and this is a big legal barrier, so there is need to adjust the constitution. (Lawyer, Enugu State)

Maternal health litigation is a relatively new and low-paying area of legal practice in Nigeria. With limited financial incentives, lawyers do not generally seek out cases; instead, CSOs, such as WARDC, or the media bring cases to lawyers.

Because litigating in maternal death and injury is still new, lawyers lack expertise in maternal health litigation. Those who take on cases might have to spend more time studying the topic or consulting their peers, which can slow the process.

There is need for training because maternal health is a new area for lawyers and it has gender issues involved. There is need to strengthen their capacity in this area. (CSO respondent, Lagos State)

Respondents noted that cultural and religious beliefs that discourage litigation might make it especially difficult for women to discuss such issues with male lawyers.

Another challenge is that there are no female lawyers. Men are always biased and not interested. Women don't like discussing such things with male lawyers. (Woman respondent, Kaduna State)

[19] Section 6(6)(c) of the Constitution.

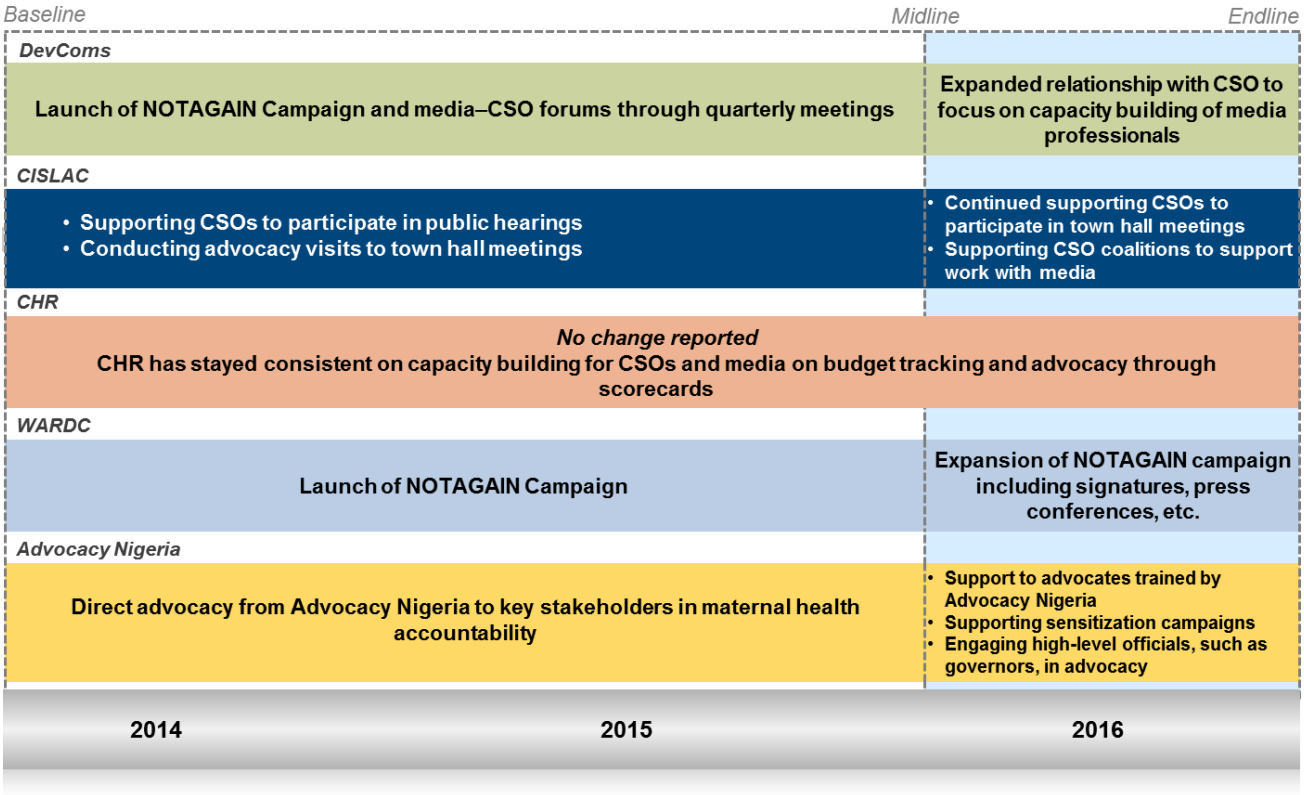
CSO Advocacy and Collaboration

Context and Background

CSO advocacy work has been strongly affected by changes in government and shifts in policy. Before the election, some grantees and the CSOs they supported had made progress with officials, and were forced to restart advocacy efforts with the new cadre of officials. Some new government representatives have been more receptive to CSO engagement and supportive of maternal health.

As illustrated in Exhibit 9, five grantees conducted advocacy initiatives and built the capacity of CSOs and CSO coalitions to do the same: Advocacy Nigeria, CHR, CISLAC, DevComs, and WARDC.

Exhibit 9: Changes in Grantee Activities Influencing CSO Advocacy and Collaboration across Life of Portfolio



Grantees' work focused on formation of the Accountability Mechanism for MNCH in Kano State and provided support to the following coalitions: BASAM, Coalition for Maternal Health in Niger State, FMCH, Jigawa Maternal Accountability Framework, and the Partnership for Promotion of Maternal and Child Health.

Grantees continued to focus on CSO mobilization during the endline evaluation period. Training delivery remained steady over the life of the portfolio, with an average of 52 participants trained

monthly by all grantees at midline and 50 at endline. Since the midline evaluation, four grantees[20] provided training and capacity building to 501 members of CSOs and CSO coalitions. Advocacy Nigeria and CHR have trained the most participants since midline: 242 and 157 CSO members, respectively. At midline, grantees reported training 1,055 CSO members in a little less than 2 years.

The training and activities varied depending on the objectives of each grantee. For example, CHR trained CSOs to track state government budgets and conduct advocacy activities with policymakers. Advocacy Nigeria provided maternal health awareness and advocacy skills to community-level organizations.

Exhibit 10: CSO Members Reached across Life of Portfolio

Time of grant	Number of CSO members attending grantee actions or activities	Average number of CSO members trained monthly
Grant inception to midline (Dec. 2013–Sept. 2015): **22 months** [21]	1,055	52
Midline to endline (Oct. 2015–Aug. 2016): **10 Months)**	501	50
Total (grant inception to endline)**: 32 months**	1,556	51

Evaluation Q6: What have been the most important contributions of grantees to maternal health accountability advocacy initiatives?

12 State government officials reported that technical assistance and scorecards were among the most important contributions of grantees. CSOs reported that grantee support was critical to breaking down barriers between CSOs and state government, and forging new relationships with the media.

In support of government accountability for maternal health, grantees undertook advocacy activities and built the capacity of CSOs and CSO coalitions to do the same.

Grantee advocacy efforts targeted state government officials directly. State government respondents in Bauchi, Jigawa, Kaduna, and Kano states valued the training and technical assistance grantees provided. Grantees supported government officials to develop key agendas and use evidence from their maternal health scorecards to inform budget planning. The use of scorecards is discussed further in the sections on Government, Legislation, and Media.

[20] Since midline, WARDC has not conducted any CSO mobilization events.
[21] This is an average time. CHR, DevComs, and WARDC reported activities from April 2014; Advocacy Nigeria reported from September 2013; and CISLAC reported from December 2013.

We get capacity building support from CSOs—not just workshops but also meetings, which are eye-opening for us. The meetings are usually very productive. People generate ideas for us. In line with the training received, we follow the eight standard steps, which include calling a stakeholder meeting to share the vision of maternal mortality reduction and the importance of integrated supportive supervision and so on. (Government respondent, Niger State)

Capacity building for CSOs. CSO respondents in Adamawa, Bauchi, Jigawa, and Kano states reported that grantee training and coaching enabled them to participate in public hearings at the state assemblies. Grantees coached participants on how to gain access to the State House of Assembly, the public hearing process, and how to make presentations to defend maternal health during public hearings.

Apart from the logistic support we had from the CHR and Evidence for Action, we had a barrier between us and [the] government. They helped us in breaking this barrier. (CSO respondent, Bauchi State)

Prior to the training, many CSO members were skeptical of going into a government building to present their demands and discuss issues with officials. Following the training, respondents reported they were able to hold successful meetings with government representatives. At the time of data collection, CSOs reported conducting similar training for community members.

CSOs also reported that DevComs-sponsored field trips and the CSO-media fora were very important to their advocacy initiatives. More information is provided in the Media section.

DevComs also supports a media–CSO forum where the Ministry of Health gives updates on maternal mortality reduction activities. It avails CSOs and journalists the opportunity to see or hear what government is doing so they can take appropriate action. (CSO respondent, Kaduna State)

13 Government has continued to recognize the role of CSOs in supporting decisions by voicing citizen's input and providing information.

As at midline, respondents from government, CSOs, development partners, and women's groups reported increased government openness to CSO participation in the development process. They explained that CSO networks and coalitions have played an intermediary role by serving as a formal pathway through which citizens' concerns can reach the government. Government, women, and CSO respondents in Adamawa and Bauchi states reported that CSOs have helped raise public awareness of maternal health issues and enabled community members to voice their demands of government on maternal health.

With our advocacy facilitated by the CSOs, the feeling of embarrassment on the part of the people has changed. Most of the people get embarrassed when they are asked to go and talk to government because they think they don't know anyone. This has changed and has become a thing of the past. (Local government official, Adamawa)

CSOs have become a critical factor in our feedback mechanism. Because of them, government has been able to get a huge portal of access to information in addition to our own traditional methods of getting feedback. (Government respondent, Enugu State)

Evaluation Q7: What outcomes have been achieved by maternal health accountability advocacy initiatives conducted by grantees and grantee-supported CSOs?

14 Grantee-supported CSOs and CSO coalitions have contributed to increased government commitments and mobilized other stakeholders on behalf of maternal health.

Although grantees attempted to track advocacy actions taken by the CSOs they trained and supported, all did not measure this in the same way, partially due to the varied nature of their engagement with CSOs.[22] CSOs supported by Advocacy Nigeria undertook advocacy visits to government partners and conducted community sensitization activities. Those supported by DevComs engaged other CSOs, government officials, and media on the importance of maternal health. CSOs supported by CHR developed action plans with CSOs and government officials to implement maternal health initiatives, and used the Health Management Information Systems scorecard to track government expenditure.

Exhibit 11: CSO Capacity Building and Actions to Influence Government Commitment

Organization	CSO members attending grantee actions or activities *(Midline)*	CSO members attending grantee actions or activities *(Endline)*	CSO actions taken as a result of grantee support *(Midline)*	CSO actions taken as a result of grantee support *(Endline)*
Advocacy Nigeria	170	157	15	4
CHR	105	242	6	14
CISLAC	367	19	16	Not collected
DevComs	81	83	9	3
WARDC	332	0	8	0
Total across grantees	**1,055**	**501**	**54**	**21**
Total across grantees: life of portfolio	**1,556**		**75**	

[22] This outcome indicator was introduced after the midline evaluation and suffers some challenges to validity, because grantees interpreted "CSO actions" differently. In some cases, grantees may have reported the actions they intended CSOs to undertake as a result of training, rather than actions they actually carried out. CISLAC did not collect these data.

Other sources provided examples of actions taken by grantee-supported CSOs and CSO coalitions. The CSO coalitions tailored their advocacy efforts to maternal health needs in their states. For example, in Kaduna and Kano states, the coalitions worked to ensure that government had a legal framework for FMCH, conducted facility assessments and present findings to the government, demanded improved PHC services, and demanded increased budgetary allocations and a distinct budget line for maternal health. In Kaduna State, the MNCH Coalition advocated to the governor by holding a press conference to encourage passage of the "PHC Under One Roof" bill.

> *They [Kano coalition] advocate for the health budget to be more open, and this gave way to a pre-budget hearing. (CSO respondent, Kano State)*

CSO and government respondents alike reported increased government commitment to maternal health since midline. According to CSO respondents, the government has moved beyond pronouncements and has begun to take action.

> *Because of the feedback from CSOs, we have been able to access information that may not have been available. … We act on their information and reach out to the facilities. (Government respondent, Enugu State)*

> *We met with the commissioner last year in Abuja and he gave us his phone number … so when we arrived we wrote a petition to him on maternal deaths and he presented it to the State Council, and came with a reply that the governor promised to re-employ about 300 retired nurses and midwives, renovate health facilities, one PHC per ward making 255 PHCs … that [is] because of WARDC and other CSOs, they are now aware of what happens at the local government areas. (Woman representative, Kaduna State)*

Development partners in Kaduna State reported a gradual increase in budget allocation to maternal health in the state. Other respondents from Kaduna State attributed improvements in maternal health services, such as antenatal care, to the advocacy efforts of CSOs. This increased budget commitment to maternal health is covered more substantially in Government Budgeting.

CSO respondents reported that increased media involvement has boosted the success of their advocacy efforts, leading to increased resources for maternal health.

> *The fact that the media has been reporting matters on maternal health is one of the things that spurred the government to increase the budget in Lagos State. Bringing the CSOs and the media together has helped to project the issues CSOs advocate for through the journalists working with them. (CSO respondent, Lagos State)*

CSOs also mobilized stakeholders that had not been involved in maternal health services.

> *In Gombe, we worked to enhance the community's awareness and ownership by inviting the NURTW [Nigerian Union of Road Transport Workers] and Keke NAPEP [tricycle riders] to participate in the delivery and implementation of maternal health services. There was a rally, and the NURTW talked about how they have committed themselves to transporting*

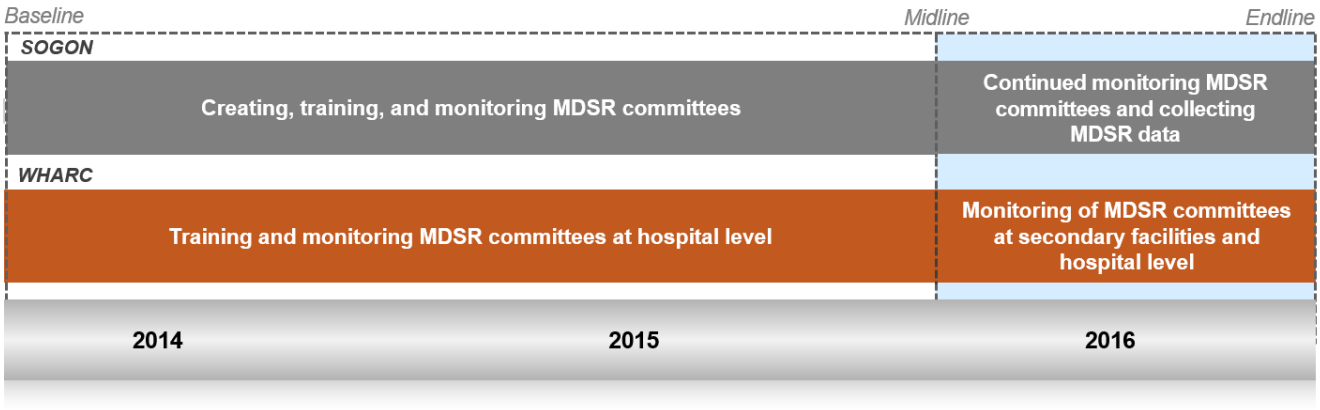
pregnant women to health facilities, and they also wait for them to deliver. (CSO respondent, Kaduna State)

MDSR Committees

Context and Background

Several contextual barriers should be considered when measuring grantee progress of the MDSR committees since midline (see Exhibit 12). The new government has centralized funding in a Treasury Single Account, making it more difficult for facilities to access funds to implement MDSR committee recommendations. Additionally, frequent strikes by health workers, particularly in 2016, have continued to delay the MDSR committees' ability to meet and collect the data from health workers as required for each maternal death review. In the current environment, health workers are often transferred from one facility to another, causing turnover in committee membership and an ongoing need for orientation and training. The FCT MDSR committee was disbanded in February 2016, but restarted in August 2016. These committees have continued to face reluctance by families and communities to share information about maternal deaths.

Exhibit 12: Changes in Grantee Activities Influencing MDSR Committees across Life of Portfolio



In 2012, the Society of Gynaecology and Obstetrics of Nigeria (SOGON) partnered with the International Federation of Gynecology and Obstetrics to introduce maternal death review to Nigeria. "The MDSR model is based on the principles of continuum of care, from the family, community, Primary Health Center, through to the Secondary Health Center (general hospitals). This broad-based approach offers the best opportunity to capture every maternal death in a community, whether they occurred within a health care facility or elsewhere."[23]

SOGON and Women's Health Action Research Centre (WHARC) were originally funded by the Foundation to pilot the establishment of MDR committees in the FCT and Lagos State. In 2014, the maternal death review committees transformed into MDSR committees, whose purpose is to track

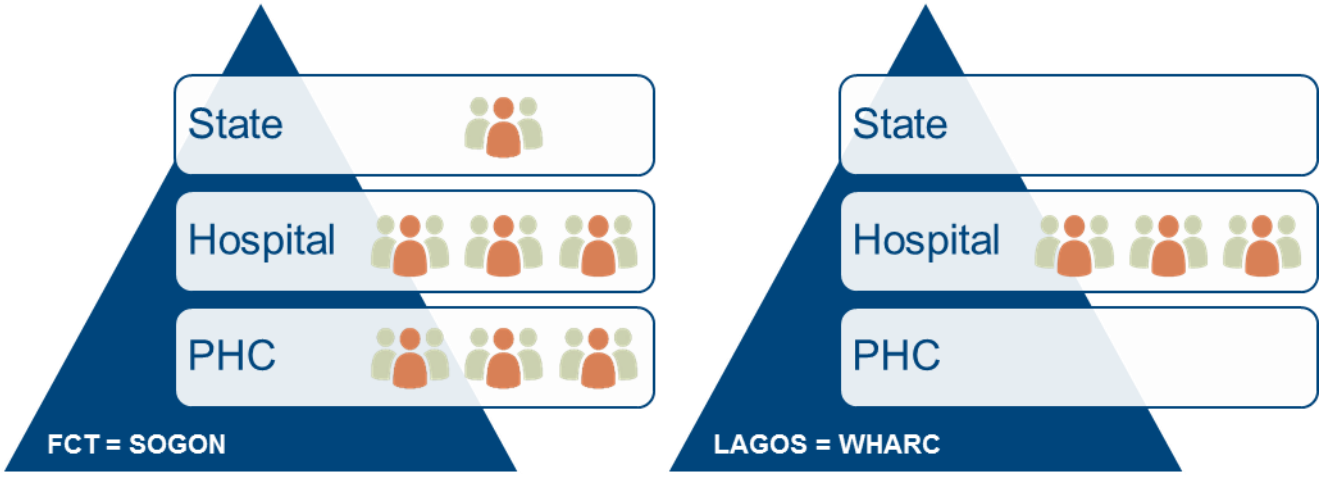
[23] Shittu, O., and S. Adeoye. 2014. Report on Sensitization of Stakeholders Meeting: The FCT-SOGON Maternal Death Review (June 25).

maternal deaths and conduct review meetings (including verbal autopsies in the case of the FCT committees) to determine the causes of maternal deaths and make recommendations to the facilities and the State Department of Health on what to do to prevent future maternal deaths. Since midline, the Federal Ministry of Health has expanded the MDSR concept to include perinatal death surveillance and response, making these the Maternal and Perinatal Death Surveillance and Response (MPDSR) committees. This development introduced a shift from analyzing only every maternal death to including every maternal, stillbirth and newborn death. This policy was informed by the Sustainable Development Goal 3, which targets "ending preventable maternal deaths by 2030"[24] and "ending stillbirths and newborn deaths (perinatal deaths) by 2035."[25]

A recent but yet to be published national assessment on the extent of nationwide institutionalization of MPDSR suggest that more than two-thirds of Nigerian states have adopted MPDSR and commenced implementation, to varying extents, at state, health facility, and community levels. The assessment also revealed that the broad embrace of the scheme is influenced by the deep state-level involvement of members of SOGON. For consistency's sake, this report refers to all grantee-supported committees as MDSR.

Exhibit 13 illustrates how SOGON and WHARC work in two locations, FCT and Lagos State, with different levels of MDSR committees. SOGON works with MDSR committees based at the general hospital, PHC facility, and state level, and WHARC works only with MDSR committees based in general hospitals.

Exhibit 13: SOGON and WHARC Support to MDSR Committees



SOGON worked in the FCT with several MDSR committees based in a general hospital, three committees based in community PHC facilities, and one state-level committee that oversaw all

[24] WHO. 2015. Strategies toward ending preventable maternal mortality (EPMM). Available at: http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/.

[25] UNICEF and WHO. 2014. Every newborn: an action plan to end preventable deaths. Available at: www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/.

MDSR work in the FCT. WHARC worked with three general hospital-based MDSR committees in Lagos State.

WHARC and SOGON had different approaches to community engagement with MDSR committees. Influential community members sat on SOGON-supported MDSR committees operating in PHC facilities in the FCT. Community members performed surveillance duties, tracked maternal deaths in their communities, and reported to the disease surveillance notification officers.

In community-based PHC facilities, because of their smaller size and catchment area, the number of births is generally lower, and complicated births should be referred to the nearest general hospital. SOGON and the FCT-level committee members paid supervisory visits to PHC facilities and general hospitals and provided on-the-spot capacity building where necessary. WHARC monitored committee meetings and provided support to ensure meetings were held regularly.

Exhibit 14 below shows the number of deliveries and maternal deaths reviewed in facilities with a grantee-supported MDSR committee from October 2015 to May 2016.

Exhibit 14: Number of Deliveries and Maternal Deaths Reviewed in Facilities with Grantee-Supported MDSR Committees (October 2015–May 2016) [26]

Facility	Grantee providing support	Number of deliveries	Number of maternal deaths
Bwari General Hospital	SOGON	1,246	1
Kwali General Hospital	SOGON	603	1
Nyanyan General Hospital	SOGON	1,667	0
Kogo Community PHC	SOGON	89	0
Kwali Community PHC	SOGON	43	0
Gbagalape Community PHC	SOGON	119	0
Ajeromi General Hospital	WHARC	548	7
Gbagada General Hospital	WHARC	1,224	17
Lagos Island Maternity Hospital	WHARC	1,433	37

[26] WHARC reported its data excluding January, February, and April 2016. March, May, and October through December 2016 are represented. The data are generated from hospitals records of the number of deaths compared with deaths reported to the MDSR committee for review.

Evaluation Q8: To what extent are MDSR committees functioning effectively?

15 MDSR committees have been functioning effectively. Most committees convened meetings on a regular basis, almost all maternal deaths were reviewed, and MDSR recommendations were submitted to facility and state officials.

For this evaluation, effective functioning was defined as a committee's timely review of a maternal death and submission of recommendations to the appropriate level, facility, and/or state.

Prior to the midline evaluation, much grantee activity focused on the formation of MDSR committees; therefore, data are not always comparable to midline. Grantee-supported MDSR committees met regularly from October 2015 to May 2016. Frequency of meetings varied depending on the type of facility and the grantee providing support. SOGON-supported community-based MDSR committees reported meeting quarterly, regardless of the occurrence of a maternal death, while the hospital-based and FCT-level committees only convened in response to a maternal death. In contrast, all three hospital-based MDSR committees supported by WHARC met at least once a quarter, regardless of whether a death had occurred. Three WHARC-supported committees convened for a total of 23 meetings from midline to endline, while six of SOGON-supported committees met 18 times. All SOGON-supported MDSR meetings were highly attended: The organization's monitoring data reported 85 percent attendance at hospital MDSR meetings and 86 percent at community meetings. WHARC did not keep attendance records.

Exhibit 15: Regularity of Grantee-Supported MDSR Committee Meetings (October 2015–May 2016)

Grantee	Number of MDSR committees		MDSR committees meeting at least once per quarter	Total MDSR meetings
	Facility and state level	*Community level*		
SOGON	4	3	3	18
WHARC	3	0	3	23

According to grantee monitoring data, WHARC-supported MDSR committees reviewed 60 of the 61 maternal deaths (98 percent) that occurred from October 2015 to May 2016, and SOGON-supported committees reviewed both of the two maternal deaths in their facilities.[27] Both grantees showed improvement in reviewing maternal deaths in comparison with midline evaluation findings, as Exhibit 16 shows. Key informants corroborated this improvement and stated that MDSR committees were effectively carrying out their mandate to review maternal deaths.

[27] Facility-level data on the number of deaths and death reviews are available upon request.

Exhibit 16: Percentage of Maternal Deaths Reviewed during Life of Portfolio

Grantee	Percentage of maternal deaths reviewed by MDSR committees	
	Midline	*Endline*
SOGON	79% (11/14)	100% (2/2)
WHARC	42% (16/38)	98% (60/61)

> *We meet regularly every month and do our review, make recommendations, etc. We even have a surveillance officer whose ears are always on the ground in the communities. (PHC facility respondent, FCT)*
>
> *The state-level committee does not meet monthly, but we visit facilities every month for supervision in collaboration with SOGON to see what they are doing and encourage them. (State government respondent, FCT)*

MDSR committees responded quickly when a maternal death occurred in their facility. According to data compiled by SOGON, since the establishment of the MDSR committees in March 2015, the average time between a maternal death and review by committee was 14 days.[28]

Exhibit 17: Number of Days between Death and Review by SOGON-Supported MDSR Committees (March 2015–May 2016)[29]

Name of facility	Date of death	Date of review	Days between death and review
Nyanya General Hospital	14/03/2015	23/03/2015	9
Gbagalape PHC	22/03/2015	23/04/2015	23
Kwali General Hospital	15/04/2015	30/04/2015	15
Nyanya General Hospital	24/04/2015	27/04/2015	3
Gbagalape PHC	12/05/2015	13/05/2015	1
Kwali General Hospital	08/06/2015	30/07/2015	52*
Bwari General Hospital	25/06/2015	01/07/2015	6
Nyanya General Hospital	23/08/2015	27/08/2015	4
Bwari General Hospital	28/09/2015	30/09/2015	2
Bwari General Hospital	11/04/2016	13/04/2016	2

[28] One committee reviewed two maternal deaths that had occurred before the committee was established. These data are excluded from the calculations of average time between death and review.
[29] The exhibit contains all of the data provided by SOGON throughout the life of the portfolio.

Name of facility	Date of death	Date of review	Days between death and review
Kwali General Hospital	Unknown	24/03/2015	Unknown

** The delay in reviewing this maternal death occurred because the MDSR committee leader was transferred and the position remained vacant for some time.*

16 Health facility staff and state-level government representatives perceived the MDSR committees as useful.

Health facility staff and state-level representatives perceived MDSR committees as useful. Health facility staff reported that the committees drew membership from various departments in each health facility, including Medical Records, Laboratory, Nursing, Health Education, Engineering, and Disease Surveillance. Respondents reported that staff's willingness to collaborate across departments was a sign that they considered it useful.

Perinatal death has recently been integrated into some MDSR committees' review processes. Pediatricians were recruited into committees in Lagos State, adding another department to the committees' structure.[30]

> *The members of staff here have a better perspective of the committee, and I think they appreciate it a lot … the head of laboratory is involved; the health educator is also there, the apex nurse, head of engineering and other departments. We all have an idea of how enormous the task ahead is. (Facility respondent, Lagos State)*

State-level government representatives also reported that they perceived MDSR committees as useful. To support this statement, these respondents pointed to the adoption of MDSR by the state government, subsequent establishment and inauguration of state-level MDSR committees, inclusion of MDSR in current government budgets, and recognition of MDSR as a core strategy in achieving the federal government's "Saving One Million Lives Initiative Program-for-Results."[31] Since the incorporation of perinatal deaths into the committees' mandate, the government has trained health workers in Lagos State on how to include those deaths in their review; respondents interpreted this as an indication of support for future expansion of MDSR committees.

> *At the government level, they are even taking it much more serious[ly] at the state level … Government trained us when the composition of pediatric was introduced. (Facility respondent, Lagos State)*

[30] Although the FCT has changed the committee name from MDSR to MPDSR, perinatal issues have not been integrated into committee functions.
[31] More information available at: http://projects.worldbank.org/P146583?lang=en

17 SOGON was the only grantee engaging community members in MDSR committees. Community members and facility staff reported that community members participate effectively on SOGON-supported MDSR committees.

Community members and facility staff members reported that community members participated effectively on the SOGON-supported committees and that they perceived MDSR committees as useful.

In Lagos State, the WHARC's MDSR project design included engagement at the community level (verbal autopsies). However, when the endline evaluation was conducted, WHARC had not yet begun its engagement with communities. WHARC also did not engage any PHC-based MDSR committees in its work. Although WHARC has reported some community-level engagement, no community members in Lagos State were interviewed in this sample, and there was no concrete evidence that communities were engaged.

> *We relate very well at the three levels, and the Government, SOGON, facility staffs, and the community perceive it as good. (Facility respondents, FCT)*

18 Most grantee-supported MDSR committee members at the facility and state level considered the MDSR committee model sustainable.

Respondents pointed to the states' adoption of MDSR committees as proof of sustainability. In March 2016, the 58th National Council on Health, held in Sokoto State, affirmed the government's support for MDSR and "the inclusion of Perinatal Death Review into the already approved Maternal Deaths Review."[32] In May 2016, the Federal Ministry of Health issued a directive to all states to adopt the MDSR model. Subsequently, all states have dedicated funds to support MDSR committees. Most respondents pointed to these factors as strong predictors that the committees would continue to operate after the end of this 3-year grant period.

> *It is sustainable because the state wants it and I represent the state as the MPDSR chairman; apart from this, it is compulsory, the state wants it. (Facility respondent, FCT)*

> *To a large extent, it is a sustainable model and in our budget preparation at the FCT level, money has been budgeted for MPDSR and it's now like a statutory thing that every state government must adopt and with increased advocacy it will be sustainable. (State government respondent, FCT)*

There are some concerns about the continued effectiveness of committees after the grantees stop supporting them. Grantees have been providing logistical support for convening MDSR meetings, including approximately 5,000 naira (about $15) for refreshments and secretarial services.[33] At

[32] Communiqué issued at the Federal Ministry of Health's 58th National Council on Health meeting at Giginya Coral Hotel, Sokoto, Sokoto State, March 7–11, 2016. Available at: http://www.health.gov.ng/doc/58th%20NCH%20Communique.pdf [accessed November 22, 2016].
[33] Reported and verified by SOGON.

endline, some respondents expressed concern that without this support, MDSR committees might not be motivated to meet as often. Some MDSR committees were convening meetings without grantee support, however, and many committee members were reported to be motivated to continue MDSR work. A few participants reported that the recent inclusion of perinatal surveillance may have put a strain on the committees and threatened the sustainability of the model.

> *I cannot comment effectively on [sustainability] yet. The only constraint is when we have to call meetings where we discuss O&G [obstetrics and gynecology] and pediatric cases together at the same time. The MD[S]R used to be a maximum of two cases per sitting at a 2-week interval. We have shortage of manpower here. We cannot have the presence of a pediatrician all the time because of cumbersome schedule. (Facility respondent, Lagos State)*

19 In facilities with a high maternity rate, relative to staff size, some MDSR committees struggled to carry out their tasks and review deaths in a timely manner.

MDSR committees operating in hospitals that carry a high maternity patient load, such as in Lagos State, seemed to be struggling. With a high maternity rate, limited staffing, and high staff turnover, some medical personnel struggled to provide patient services and carry out MDSR committee duties.

> *Sometimes, it is a bit challenging because we are overwhelmed. Every 2 to 3 months, we hold the review and send the report. This was the norm last year, but since we changed to MPDSR this year, we have been able to send our reports monthly. Sometimes, we do not complete the review of all the mortalities for a month within the stipulated time because of the high mortality rate here. (Facility respondent, Lagos State)*

Respondents noted that the increased maternity rate at hospitals may be related to increased referrals from lower-level hospitals. Respondents reported that more women from the communities with difficult or dangerous maternal health issues are being referred to hospitals from the community PHC facilities. However, respondents also reported that without increasing staff and resources to tend to those patients, the result is an increased burden on hospital staff and resources.

> *The challenge actually is overwhelming because of the high mortality rate. We receive a lot of referrals, a lot of bad cases, and that is why we have high mortality rate. There was a time we lost 9, another one 13 patients in a month. It is a bit difficult to keep up with that. The workload has increased and our staff size is shrinking, and we have other burdens of administrative and clinical work. This distracts us from being able to sit down and do the meeting[s] like we should do them. We have time constraints in giving enough time to each case. (Facility respondent, Lagos State)*

Evaluation Q9: To what extent are MDSR committee recommendations implemented by facilities?

20 Thirty-six percent of MDSR recommendations have been implemented by health facilities, including improvements in service delivery, commodity availability, and infrastructure.

When an MDSR committee meets to review a maternal death, it conducts a verbal autopsy to determine the immediate and long-term causes of death, completes all required forms, and drafts recommendations and an action plan to address the cause of death. Recommendations not within the purview of the facility are submitted to state-level entities, including the State Ministry of Health and State PHC Development Agency.[34]

WHARC did not collect data on the implementation of recommendations. However, staff reported anecdotally that some facility-level recommendations were implemented. Only one SOGON-supported MDSR committee reported implementing a recommendation since the midline. One of the committees reported that none of the seven recommendations submitted had been implemented by the hospital between midline and endline.[35] Due to the slow nature of MDSR committee recommendations' being included and implemented, the evaluation team expanded to look at grantee monitoring data to the start of the grant in 2013.

Over the life of the grant portfolio, health facilities where SOGON-supported MDSR committees operated implemented 18 recommendations, or 36 percent of all recommendations submitted by the committees.[36] Examples of implementation include the following:

- **Changes in Practice:** More effective referrals between the community-based PHC facilities and general hospitals; adjustments in call duty time (ensuring that doctors do not leave until they have properly handed over the patient to the next doctor); and more efficient release and transfer of laboratory results to the ward, even in cases where a client is yet to pay.[37]
- **Improvement in Utilities and Infrastructure:** Since the midline, two SOGON-supported facilities implemented significant recommendations. Kogo PHC in Bwari has had improved access to electricity and water supplies. Kwali General Hospital has set up a "second call" duty room[38] to accommodate another doctor on call, thereby providing better medical coverage.
- **Purchases of Additional Equipment:** Facility purchased a sphygmomanometer (for blood pressure measurement) in Lagos Island Hospital.

[34] SOGON Annual Report 2016.
[35] Data on the number of recommendations made at each facility are available upon request.
[36] SOGON Monitoring Data, August 2015.
[37] Most facilities charged user fees for laboratory tests. In the past, many facilities would refuse to begin procedures until fees were fully paid. There is anecdotal evidence that some clients have died because of this.
[38] A room for doctors who need to stay overnight or sleep during the day because of fatigue from call duty.

- **Improved Availability of Essential Commodities for Maternal Health:** In Lagos State, emergency caesarian section kits were provided to prevent maternal death from complicated labor (even when the client was unable to pay for these services).

Respondents pointed to the influence of the MDSR committees in contributing to these positive changes in the health facilities.

> *Implementation of recommendations by facilities is very impressive. There have been a lot of structural changes as well as infrastructure. There have also been operational changes. For example, in Bwari General Hospital, a person died there because there was a window period when the patient was not attended to due to delays in handing over. In response, there is now [an] order that no patient can be left unattended to. (CSO respondent, FCT)*

> *The implementation is good and our theater has been duplicated; two emergencies can be handled at the same time; our CCTV [closed-circuit TV] has made everyone to be up and doing, we have about 28 cameras and intercoms have been installed, too! (Facility respondent, FCT)*

Respondents cited several factors that influenced the 36 percent implementation rate: Adoption of recommendations often takes up to 6 months; elections meant that many tasks were on hold until the newly elected officials took office; and late release of budget funds in 2016 meant that funding amounts were unclear. It should be noted that there is no standard for the level of uptake of MDSR committee recommendations, nor for the time frame for implementing them.

Evaluation Q10: What factors enable and constrain implementation of MDSR committee recommendations by facilities?

21 Respondents attributed the implementation of recommendations at the facility to state oversight, facility leadership commitments, availability of resources, and interdepartmental cooperation.

Respondents reported that a key factor affecting implementation of MDSR committee recommendations was increased oversight by the state-level MDSR committee and facility management. Facility leadership reported that facilities where the MDSR recommendations were being implemented were under the constant watch of the state-level MDSR committees. State-level committees and implementing partners paid supervisory visits to the facilities and checked whether recommendations had been implemented. At select facilities, supervisory teams even provided supportive guidance and training during their visits to improve the quality of MDSR implementation.

At other facilities, management began conducting internal oversight of MDSR recommendations. For example, one respondent recalled a hospital where management installed cameras in all departments to enable effective monitoring. The knowledge that the MDSR committee would review every maternal death meant that health workers felt more accountable for a death that occurred during their shift.

MDSR has made people accountable. Once there is oversight, people become more accountable. (Facility respondent, FCT)

Respondents also reported that the level of awareness and commitment from facility leadership promoted implementation of recommendations. One participant mentioned that implementation tended to be faster where the facility head was an obstetrician/gynecologist.

Leadership is playing a key role here. The doctors have also learnt to document properly in the folder. (Facility respondent, Lagos State)

Interdepartmental cooperation on the committee laid the foundation for the collaboration necessary to implement recommendations at the facility level.

There is interdepartmental cooperation. The improvement in the issues of referrals is because we had to address the issue of delays. Initially, things kept repeating themselves, but now referral is much better. (Facility respondent, FCT)

22 The key constraints to implementation of MDSR committee recommendations included lack of adequate resources and insufficient support by facility leadership.

The constraint reported most often was inadequate resources to support implementation of recommendations.

There is nothing they can do if the issue is beyond their budget. (CSO respondent, FCT)

Respondents reported that weak support from the head of the health facility negatively affected implementation of recommendations. If facility directors were not passionate about reducing maternal mortality, they were unlikely to take prompt action to address MDSR committee recommendations.

Evaluation Q11: To what extent do MDSR recommendations influence practice and budget allocation at the state level?

23 In addition to state funds for the MDSR committees, some states have provided resources for key maternal health commodities and issued guidelines stipulating care for patients, regardless of their ability to pay.

MDSR reviews included recommendations for the facilities in which they operated and for state-level entities, such as the Ministry of Health and State PHC Development Agency. Recommendations for the state included changes in guidelines or budget. However, the line between facility and state was sometimes unclear. This evaluation relied on informant statements and did not independently verify whether specific recommendations fell under the state's mandate.

In Lagos State, facility respondents mentioned various examples of how MDSR committee recommendations had been implemented at the state level. In response to recommendations, the

state has begun to put more resources to key maternal health commodities, such as essential drugs, improved blood banking systems, and ambulances.

> *Light, water, and the equipment we needed. The FCT Development Agency provided light [i.e., electricity]. (Facility respondent, FCT)*

> *I can say that implementation is done partially in the sense that recommendations at the state level [go] back to the facilities, for instance, provision of call duty room. Also, when Kwali General Hospital didn't have an effective blood banking system due to poor power supply, we advocated for constant supply of diesel to power [the] generator. (State government respondent, FCT)*

Respondents in Abuja credited MDSR recommendations for the recent change in FCT guidelines for admitting patients. The guidelines stipulate that once a client arrives at a health facility, she must be seen promptly, regardless of her ability to pay for services.

In Abuja, during the transition period following the 2015 election, the FCT-level MDSR committee was disbanded. This committee had served as liaison between facilities and the state's Department of Health. A new committee was recently inaugurated, and respondents from government and CSOs in Abuja and Lagos reported a new commitment to allocate resources for MPDSR.

Evaluation Q12: What factors enable and constrain implementation of MDSR committee recommendations at state level?

24 Political will has been the main factor facilitating implementation of MDSR committee recommendations at the state level. Sound evidence supporting recommendations improved state government buy-in.

Respondents in Lagos State and the FCT pointed to political will as the main enabling factor supporting implementation of MDSR committee recommendations at the state level.

> *The state has zero tolerance for maternal death and we are working with all stakeholders, head of departments, and relevant directors in the ministry to see how the unit will be helped to continue with the MDSR committee. (Facility respondent, Lagos State)*

One facility respondent underlined the importance of evidence and the role of MDSR committees in providing the data for government. With many competing priorities, including health priorities, the MDSR committee data have given the government tangible evidence on which to base budget allocations. This has helped government prioritize maternal health in its policies and budgetary allocations to support this commitment.

> *Because of competing challenges and scarce resources, Lagos State [will pay attention] when confronted with data about well-thought interventions concerning maternal and child lives. If we provide data, like we showed in Island Maternity Hospital, we showed data that*

we needed ambulances and recently the government gave us 27 ambulances for our services. (Facility respondent, Lagos State)

25 The main factors constraining implementation of MDSR committee recommendations at the state level were limited funds for maternal health, allocated with insufficient specificity and released too slowly.

Nigeria's economic situation has limited the government's ability to implement many MDSR recommendations at the state level. Funds for maternal health were limited and, as reported at baseline, state health budgets do not have a line item for maternal health. (See the Government Budgeting section on the next page for further details.) Release of allocated funds is often delayed. These factors negatively affected efforts to implement recommendations.

Not all have been implemented because of the economic crisis and poor financial backing. This is August and [a] budget has not been signed yet. (Facility respondent, FCT)

The challenge we always have is that there are some challenges that keep coming up, which are not from the hospital angle—it is at the state and local government levels. Sometimes, we do not get feedback on how those challenges are being tackled. It is always frustrating … when we have to repeat the same recommendations. That is our major challenge. (Facility respondent, Lagos State)

Respondents remarked that the when recommendations are not implemented, committee members might lose their motivation to participate in the MDSR process.

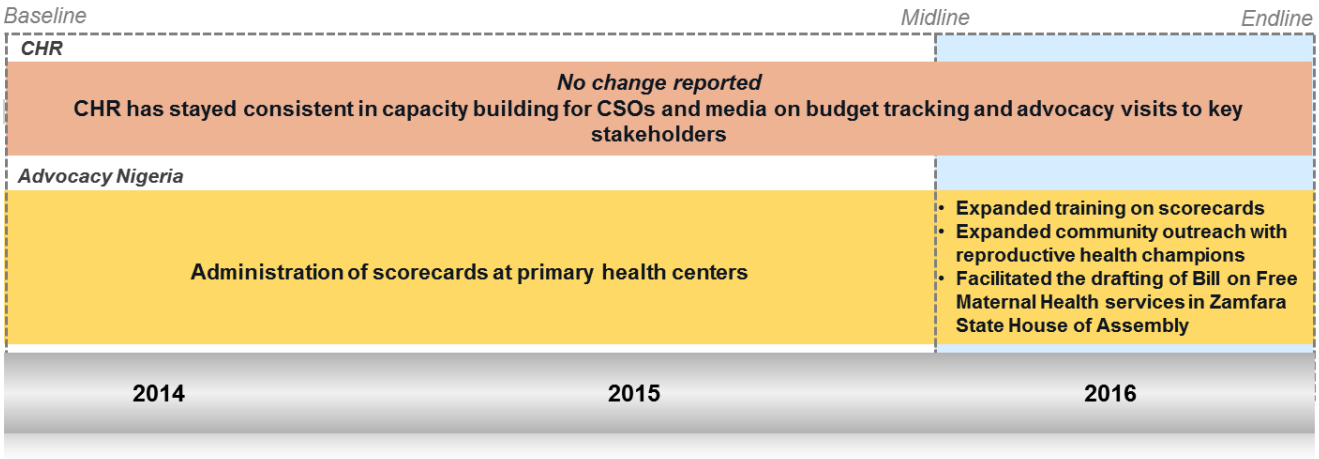
MDSR manages to implement the little recommendations that can be implemented within the facility, but when it gets to the state, they are barely implemented. They give recommendations over and over, and I think it is challenging and it might weigh the committee members down conducting meetings. (CSO respondent, Lagos State)

Government Budgeting

Context and Background

Nigeria's recession has added to the government's difficulty in releasing allocated funds to the states. This has had devastating effects, especially on the health system. Grantees (Exhibit 18) worked to ensure that maternal health was represented in the state budget. However, this often did not translate into improved health services at the facility level. Key stakeholders reported that health facilities were understaffed and under-resourced.

Exhibit 18: Changes in Grantee Activities Supporting Government Budgeting across Life of Portfolio



In July 2016, the federal government announced an increase in the health budget for the 2017 fiscal year to address some of the challenges facing the sector. Several states also announced increased investments in PHC that have the potential to reduce maternal and child mortality. In October 2016, for example, Jigawa State reported that it had built 27 PHC centers and quarters for 27 midwives and was moving forward to equip and furnish the facilities. In August 2016, Niger State made public its plans to build 70 PHC centers, the first phase of a plan to open 274 centers offering comprehensive, 24-hour medical service in each of the state's wards. The Kaduna State government has awarded contracts for the refurbishing and renovation of one PHC per ward, making a total of 255 PHCs.

Grantees and CSOs worked with the government throughout the budget cycle to ensure that maternal health funds were allocated, released, and expended. Nigeria's budget cycle varies in practice from state to state, though it generally follows a four-stage process, described below.[39]

Budget Planning

- *Stage 1 – Budget Drafting:* The executive branch prepares the budget. Each ministry, such as the Ministry of Health, drafts a budget for inclusion in the statewide budget.
- *Stage 2 – Budget Approval:* The state assembly debates and revises the budget. The final allocations are agreed upon and approved.

Budget Tracking

- *Stage 3 – Implementation:* Funds are released and procurements made based on approved allocations.
- *Stage 4 – Auditing and Evaluation:* Actual budget expenditures are accounted for and assessed for their effectiveness.

[39] Dickerson, D., and A. A. Ahmed. 2013. *Advocacy for Family Planning: Understanding the Budget Process in Two Nigerian States—Cross River and Zamfara*. Washington, D.C.: USAID Health Policy Project, Futures Group. Available at: https://www.healthpolicyproject.com/pubs/104_AAHPPNigeriaStatesBudgetAdvocacyFINAL.pdf

Throughout the portfolio, grantee and grantee-supported CSOs carried out advocacy activities at each stage of the budget cycle. During Stage 1, CSOs worked with members of state ministries, such as the Ministry of Health, to ensure that maternal health priorities were represented in the draft budget. CSOs also presented evidence (e.g., scorecard data) during budget preparation and review meetings organized by the state ministries. During Stage 2, CSOs participated in the defense of the budget in the State House of Assembly. Following budget approval, CSOs monitored funds to ensure they were obligated and released in a timely manner (Stage 3). They also tracked state-level budget expenditures by using Advocacy Nigeria and CHR scorecards to document and record availability of equipment, staff, and essential drugs in facilities (Stage 4). The scorecards enabled grantees to hold the government accountable for releasing funds and provided evidence to use in advocating to the Ministry of Health and state legislatures during the budget drafting and approval phases.

Advocacy Nigeria and CHR[40] engaged directly with key stakeholders in the budget cycle and built the capacity of CSOs and CSO coalitions to carry out this work. In budget planning, Advocacy Nigeria and CHR conducted advocacy visits to key state-level policymakers. In budget tracking, Advocacy Nigeria documented improved budgeting allocations for maternal health and CHR liaised with national agencies to ensure that budget allocations were expended. Both organizations also supported CSOs in advocacy visits to state and local policymakers. Advocacy Nigeria trained health care workers and CSOs on the use of scorecards for budget tracking and advocacy, and CHR supported CSOs and media in carrying out budget tracking and advocacy.

CISLAC trained CSOs to present at state public hearings, and worked with legislatures during the budget approval process.

Evaluation Q13: At what stage in the budget cycle are grantee-supported CSOs intervening most effectively?

26 Grantee-supported CSOs intervened most effectively in budget planning (budget drafting and approval) by working closely with different levels of government.

Government and CSO respondents in Bauchi, Jigawa, Niger, and Kano states said that grantees had intervened effectively in all the budget stages. According to respondents, grantees intervened from the budget preparation and planning stage up to budget approval, implementation, monitoring, and the budget tracking stage.

> *Since last year, things have changed at different times. NGOs are involved in all the budget stages till the final stage. (Government respondent, Niger State)*

CSOs, development partners, and State government respondents in Adamawa, Bauchi, Jigawa, Kaduna, Kano, and Niger states reported that grantee-supported CSOs participated throughout the

[40] Because of a gap in funding (CHR's grant ended in December 2015), CHR activities were limited after the midline evaluation. Nevertheless, respondent descriptions of grantee influence on CSO capacity and government commitments included CHR contributions that continued to influence government budgeting.

budget process. However, they were most effective during the budget-planning stage. For example, Advocacy Nigeria reported that the women's groups and traditional leaders it supported had visited state assembly members, women's affairs commissioners, and health commissioners to advocate for increased funding for maternal health. CSOs supported by CHR worked with government officials to develop annual operational plans detailing planned expenditures. The CSOs intended to monitor expenditures against these plans to ensure funds set aside for maternal health were spent as allocated. At the federal level, as part of the accountability for Maternal, Newborn, and Child Health in Nigeria (AMHiN) coalition, CHR met with the Transition Committee before the inauguration of the new administration's cabinet. At this meeting, AMHiN coalition members pressed the government to allocate 15 percent of the national health budget to maternal health.

27 Grantee-supported CSOs have had success in bringing community voices into the budget-planning process, contributing to increased budget allocations for maternal health.

CSO and state government respondents (including policymakers) in Bauchi, Jigawa, Kano, and Niger states reported successes in the budget-planning stage. CSOs and government representatives in Bauchi State attributed the increased budgetary allocations for the health sector (from 6 to 16 percent) to CSO advocacy in the state budget-planning process.[41]

Respondents in Jigawa and Kaduna states reported that CSO coalitions were bringing community-level perspectives to the government planning process by conducting community needs assessments. The coalitions worked alongside state government officials to incorporate community needs assessment findings into sector plans and the medium-term sector strategy.[42] As all state ministries, departments, and agencies developed annual budget proposals as part of their medium-term sector strategies, CSO participation and input into this strategy process was considered an essential achievement by many stakeholders.

> *They [CSOs] made needs assessment for all the communities in Jigawa State. They mobilize the communities and come up with the pressing needs of the communities. They gather it, document, and present it to the various ministries, departments, and agencies during budget preparation. (Government respondent, Jigawa State)*

[41] As reported by CHR to the evaluation team.

[42] The medium-term sector strategy is a process for linking ministries, departments, and agencies' policies, budgets, and monitoring and evaluation, and a tool for improving development outputs and outcomes. Following the development of the Medium Term Expenditure Framework in 2006 and the passage of the Fiscal Responsibility Act of 2007, the governments of Nigeria adopted the strategy as the most reliable and practical mechanism for ensuring effective public expenditure management and pro-poor service delivery.

Evaluation Q14: What factors enable effective CSO intervention in the budget cycle?

Budget Planning

28 Technical expertise and constructive relationships with community members, government officials, and CSO coalitions enabled effective CSO engagement in the budget-planning process.

CSO and government respondents both said that constructive relationships enabled effective CSO intervention in the budget-planning process. Development partners pointed to CSOs' technical expertise and collaborative relationships with government as a key enabler in the budget-planning process. CSOs credited the training they received from grantees for their ability to provide technical assistance to their government counterparts. Respondents underlined the importance of further training for CSOs and state assembly members, especially following the election of new legislators.

> *What helped most was the series of trainings by CHR. Our individual connection helped. Like one of us has a link with the Permanent Secretary of Ministry of Health [for] Kano. (CSO respondent, Kano State)*

Respondents also pointed to the importance of collaboration with community influencers (e.g., religious leaders) as an enabler. These people were seen as credible spokespersons for their communities and "had the ears" of government officials. CSOs recruited community influencers as allies in advocating for government accountability to maternal health during budget planning; for example, to take findings from CSOs' community needs assessment to the state government.

> *We use the religious leaders as well as some community influencers. Also, we use the parties to go through the executive and policymakers. So, we use those strategies. The parties, the community influencers (those that are not on a certain political seat), you talk to him, [and they] can definitely pave a way for you. (CSO respondent, Adamawa State)*

CSO coalitions were also identified as a key factor in effective intervention. Coalitions brought a number of benefits, including better information exchange, reduced advocacy costs, and the elimination of redundant activities.

> *For me, one of the ways we use the networking among CSOs is to work together. Nowadays, CSOs are formed into networks and coalitions to advocate for issues. (CSO respondent, Adamawa State)*

29 Effective CSO engagement in budget planning was constrained by government mistrust of CSOs and competing health priorities.

CSO respondents listed government mistrust of CSOs, the slow nature of bureaucracy, and the weak economy as key constraints to budget planning. They reported that new government officials did not

understand the work CSOs do. Consistent with baseline and midline findings, some new government officials did not consider CSOs as partners in progress and viewed them as meddling. For these reasons, CSOs reported difficulty in engaging government officials in pre-budget planning meetings.

> *The understanding of our work. When we started this, we were completely misunderstood. We felt that challenge. (CSO respondent, Adamawa State)*

Government respondents in Jigawa State pointed out that government officials must balance multiple demands from CSOs, each advocating for a different priority. This is consistent with baseline and midline findings, which reported that in an environment of limited resources, maternal health needs were forced to compete with other health needs.

> *[CSO] requests are enormous and the state resources cannot cater for the requests. If they list their demand[s], they expect … the state to address all and all at a time. The state is faced with resource and technical constraint[s] that will not enable us to implement our plans, let alone that of the CSOs. (Government respondent, Jigawa State)*

Budget Tracking

30 Technical skills and scorecards, in combination with collaborative relationships with government officials, brought the best results in budget tracking.

As in the budget-planning stages, respondents reported that the technical skills of grantee-supported CSOs were key to their effectiveness in budget tracking. CSOs provided tools and assistance to their government counterparts. For example, in Niger state, CSO and government respondents participated in a joint workshop to develop a workplan to track the budget.

> *CHR also called the agency and other indigenous CSOs to a workshop to draw a work plan on budget tracking. (Government respondent, Niger State)*

CHR introduced scorecards to monitor state health sector performance in Bauchi, Jigawa, Kano, and Niger states. Respondents reported that grantee-developed scorecards were an effective budget tracking tool, because they enabled government stakeholders to see data on maternal health in a clear, simple format.

Equipped with expertise and scorecards, CSOs leveraged collaborative relationships to advance maternal health in the budget-tracking process. Respondents in Bauchi and Jigawa states reported that engagement in tracking helped foster collaborative relationships among key players in the health sector, including CSOs, ward development councils, community leaders, and government agencies. As a result of this collaboration, the stakeholders developed a common brief for future advocacy efforts.

CSO respondents in Bauchi State reported an example of a successful budget-tracking initiative carried out by the Bauchi network of CSOs. The network established a best practice committee, which analyzed budget expenditures and determined that the government had failed to honor its

commitment to spend 16 percent of the budget on health. It used this information to advocate to the Ministry of Health and ensure that the government released the full amount.

> *If there are capital projects, we go there and confirm it. Sometimes, we collaborate with the State House of Assembly during their oversight function. If not for the tracking, we would not know what is happening. For instance, the work on a hospital in Birnin Kudu had work stopped. We discovered what happened through the tracking. (CSO respondent, Jigawa State)*

31 Effective CSO intervention in the budget-tracking process was constrained by gaps in CSO skills, inconsistent use of scorecards, government turnover, and lack of transparency.

According to reports by CSOs and development partners in Bauchi and Niger states, some CSOs lacked capacity for budget tracking. CSOs reported they were more knowledgeable about budget planning, and requested further training to improve their effectiveness in tracking.

> *Budget tracking is very important. No matter how well you plan the budget, if it is not tracked and monitored, it will be a waste of resource[s] and energy. We lack the required capacity, skills, and expertise in budget tracking. That is why we are not deeply into it. You will be given a budget document, but you will not be able to figure out where the maternal health section is and you cannot even understand the terms used. (CSO respondent, Bauchi State)*

CSOs in Adamawa State reported gaps in their understanding of how to use and report on the scorecard. They attempted to use the Advocacy Nigeria scorecard, which was replicated from a CHR scorecard for supportive supervision and budget expenditure, but did not receive proper guidance, so they were unable to use the scorecard as intended.

> *I asked the national headquarters to provide me with a kind of template to record that scorecard. And that scorecard is for only facilities and women groups. So, when those scorecards were administered and hence I cannot get any template to record it, it was dumped. Like I was saying, due to inconsistency in reporting, these things happened. (CSO respondent, Adamawa State)*

CSO respondents reported that insufficient data analysis skills held them back at times in translating their data into easily digestible evidence for government counterparts. Development partners in Niger State noted that even when CSOs analyzed budget data, the government did not use the data for planning due to this constraint.

> *Sometimes, it is the need for skills more especially in data analysis that is hindering our success … Data will be collected, but when we come to the analysis, we face challenges. (CSO respondent, Jigawa State)*

Respondents also reported turnover among government officials and lack of government transparency as constraints. Changes in state government personnel occurred as a result of the elections, when posts for political appointees were filled by the incoming government, and due to civil service regulations, which require staff to rotate their posts. In both cases, turnover made it difficult to build constructive relationships between CSOs and the government.

> *Presently, the main hindrance to the success is the issue of membership of the assembly, where only 3 out of the 30 members were reelected to return … all the trained and experience members who were working seriously for the course of the maternal health were voted out by their constituencies, and the new members did not understand the process well. (Government respondent, Jigawa State)*

Evaluation Q15: What stages in the budget cycle are the most strategic for CSO intervention?

32 The most strategic stage of the budget cycle for CSOs to engage differed per stakeholder response and per region. There was no consistency in which stage CSOs should intervene.

Stakeholders were divided on which stage of the budget process offers the most strategic opportunities for CSO intervention. CSOs and development partners in Adamawa, Jigawa, and Kaduna states believed the planning stage was more strategic. Respondents said the reasoning for prioritizing this stage was that if health funding is not allocated from the start, then there will be no funds to track. Additionally, respondents noted, involvement in this stage was strategic for CSOs because it gave them a chance to bring information from the grassroots level into the government planning process. Respondents recommended that CSO interventions start when the call circular is released, and noted the importance of CSOs' engagement at the budget-drafting stage, so the head of department would include maternal health in revenue estimates.

> *At the planning [stage], it should be an all-inclusive budget process. Even we are engaging with the grassroots, going down [to] meet the ward development committees in our localities to know what government is doing. Because different people voice different priorities. We need to hear from the different sectors on how to improve on our budgets. So, it is during planning that the CSOs should be involved. (Government respondent, Bauchi State)*

Some respondents in Kaduna State made a strong case for the budget-approval stage's being the most strategic for CSO intervention, more important than the planning stage.

> *I see them playing more [of a] role at the approval stage in the legislature. CSOs need to build the capacity of legislators … even on the executive side there is need for continuous capacity building. This is because there is [a] high attrition rate. (CSO respondent, Kaduna State)*

Several CSO and state government respondents in Adamawa, Bauchi, Jigawa, and Kano states said CSOs should engage throughout the budget cycle, because every stage is equally important. These respondents warned against eliminating the role of CSOs in any stage.

> *Well, at whatever stage of the budget process, CSOs' involvement is very important. Remember, we involve them in the planning stage [but] they are also needed during the budget defense to ensure that all the line budgets are properly captioned and the implementation stage—CSOs can also play an important role in that. So, as far as I am concern[ed], CSOs are needed at all stages of [the] budget process. (Government respondent, Adamawa State)*

33 Future opportunities for CSO engagement included deepening links between the community and government and increasing the use of evidence in budget decisions by engaging throughout the budget cycle.

CSO respondents in Jigawa and Kano states noted that CSOs should continue to serve as watchdogs and increase their monitoring of budgetary allocation, release, and expenditure. Government and CSO respondents reported an important role for CSOs in linking citizens to government: They bring community input to the government and facilitate community engagement in important government processes, such as the budget cycle. CSOs can deepen citizen engagement by training community members on the procedural rules of the state assemblies.

> *CSOs can create awareness on the rules of legislation … in the communities they go to so that communities can hold their representatives accountable. (Government respondent, Kaduna State)*

Government respondents in Bauchi and Jigawa states reported that CSO coalitions were a major opportunity for CSOs to deepen engagement in the budgeting process. With further capacity, these coalitions would be well-positioned to expand their involvement and take on new activities, such as budget discussions in House of Assembly. This should be coupled with further development of advocacy tools for budget tracking, including scorecards.

> *Participation of the CSOs at the committee-level budget discussion in the House of Assembly, where the budget is taken line by line, is another untapped opportunity. (CSO respondent, Jigawa State)*

Legislative Committees

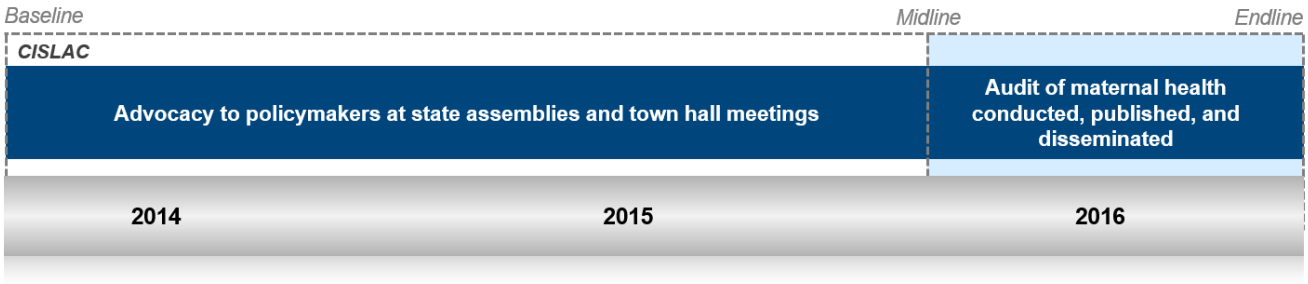
Context and Background

The Nigerian government signed the Abuja Declaration in 2001, committing to allocate 15 percent of its total budget to health.[43] Since signing the declaration, federal government allocations have not met the promised target. In 2015, only 6 percent of the national budget was allocated to health.[44]

The legal framework upon which Nigeria operates outlines the powers and responsibilities of each tier of government (federal, state, and local) but is silent about the specific health care responsibilities of each tier. In general, the federal government formulates policies, sets standards and guidelines, coordinates and monitors implementation of policies, provides technical assistance, and mobilizes resources. Some federal policies are binding for the nation, while others must be approved by the state legislatures before they become law.

The state legislative process has two steps. First, bills are drafted when state legislatures either translate federal policies into bills or write new bills unconnected to existing policies. Then, the bills are introduced into the state assembly and legislators vote on whether to pass them into law. CSOs can play a role in both steps. CSOs train legislators to ensure that they understand their role in translating policy pronouncements into bills and provide policy briefs on the merits and shortcoming of proposed bills. They also advocate for the passage of key bills in public hearings.

Exhibit 19: Changes in Grantee Activities Influencing Legislation across Life of Portfolio



CISLAC is the only grantee that worked directly with state legislatures and relevant committees in the state assembly to ensure that executive policy pronouncements were translated into implementable bills and laws. It carried out the following activities in four states (Jigawa, Kaduna, Kano, and Katsina):

- Conducting "state of maternal health" audits to assess the content of the existing policies and identify gaps for the executives and legislatures
- Conducting advocacy visits to legislatures and relevant committees in the state assemblies

[43] Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases. 2001 (April). Available at: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.
[44] Nigeria Health Watch, 2016. Available at: http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1171_2016_HEALTH_BUDGET_COMPARISON_1223.pdf.

- Conducting town hall meetings with legislatures to further understanding of legislative oversight on maternal health
- Disseminating policy briefs on maternal health to policymakers and legislators
- Producing bimonthly newsletters to enhance public and legislative awareness of key health issues.

Due to the slow nature of policy work and minimal change in policy since the baseline evaluation, the data to support this question relied heavily on grantees' annual reports and key informant interviews. The evaluation team conducted fewer interviews than anticipated, due to the busy legislative schedule and the annual Hajj.

CISLAC reported that seven health policies had been implemented and five maternal health bills passed during the 3-year grant. During the endline evaluation, CISLAC pointed to the passage of two bills as particularly important, the National Health Bill and State PHC Agency bills in Jigawa, Kaduna, Kano, and Katsina states. There had been no new policy pronouncements in the past year. However, CISLAC pointed to the following progress in three of the four states:

- In **Kano State**, the Health Contributory Fund for Family Health and Immunization was established to provide free essential drugs for child and maternal health. Implementation varies across the state and there is no policy to sustain the fund.
- In **Katsina State**, the PHC Development Agency provided free antenatal service, neonatal care, and immunization for children under 5 years and operated a vesicovaginal fistula treatment center.
- In **Kaduna State**, the Free Health Care for Maternal Health bill was under consideration in the state assembly, and "Primary Health Care Under One Roof," a policy to reduce fragmentation in the delivery of PHC services by integrating all of them under one authority, has been passed. CISLAC provided technical support during consideration of the bill.

Evaluation Q16: What supports state legislators to translate executive policy pronouncements related to maternal health into implementable bills and laws at state level?

34 CISLAC's continuous advocacy and capacity building helped ensure that legislators were knowledgeable about maternal health issues and about their role in translating executive policy pronouncements into bills and laws.

CISLAC worked with other CSOs and government officials to advocate for maternal health. Respondents reported that CISLAC's consistent presence and ability to build relationships with government officials were key to progress, particularly during the 2015 government transition. Many new legislators were unfamiliar with maternal health. Respondents noted that all of CISLAC's engagements helped build maternal health champions in the legislature, who have continued to facilitate the passage of maternal health bills.

CSO and government officials reported that CISLAC's policy briefs were important sources of information on maternal health. Respondents noted that they benefited from two main types of information provided by CISLAC's training: key maternal health issues affecting Nigeria and the role state legislatures can play in passing bills promoting maternal health into law.

Looking forward, one respondent suggested that CISLAC translate its policy briefs into local languages in the north, because state assembly members sometimes deliberate only in the local language. This points to the potential importance of reader-friendly policy briefs as an advocacy tool for state legislators.

> *We've held several meetings with CSOs and we [had the opportunity] to get first-hand reports from them, especially on areas that we knew nothing about. CSOs, including CISLAC, have increased our awareness and built our capacity on maternal health. (Federal government respondent, Kaduna State)*

35 The high turnover of government officials and the slow nature of the legislative process have been barriers to translating federal policy pronouncements into implementable bills and laws.

Respondents noted constraints involved in supporting state legislatures to translate policy pronouncements into implementable bills and laws. Grantee staff working with state legislatures reported that the high turnover rate of legislators made it difficult to build the relationships necessary to advance advocacy objectives. The 2015 election resulted in a 70 percent turnover rate of state government officials, and many legislatures that CISLAC had worked with for the previous 2 years left the government.[45] CISLAC invested considerable time and resources in building relationships with new legislators. Furthermore, many of the committees were slow to begin functioning after the election, meaning CISLAC could not complete its planned advocacy visits. Legislators' busy schedules and limited availability continued to be a challenge for CISLAC and CSOs seeking to engage with them.

> *Many of them [legislators] lost their elections and didn't return to office. So, there are new legislators on [the] ground. It affected their effectiveness because some of them are new house members. Also, certain officers are not knowledgeable at all about maternal health, so it is like starting all over again. (CSO respondent, FCT)*

[45] CISLAC. 2016. Annual Report to MacArthur Foundation.

CONCLUSIONS

The purpose of the endline evaluation was to gain deeper understanding of which accountability areas, and which grantee actions within each accountability area, have shown the most promise in increasing maternal health accountability. The theory of change developed at the beginning of this portfolio of grants hypothesized that the ultimate result of increased government commitment to maternal health—as demonstrated by bigger budgets, more jurisprudence, better health policies and better planning—depended on actions taken by specific actors or boundary partners, which grantees would try to influence through their specific actions.

Conclusions are organized in two ways, first by examining the Foundation's four accountability areas, and then by examining what has changed in boundary partner behavior.

Conclusions by Accountability Area

Although findings show that some accountability areas have had quicker progress than others, all four accountability areas proved to be mutually reinforcing influences on holding government accountable for maternal health. Findings show that one of the most influential changes throughout the past 3 years was the shift among grantees to collaborate and coordinate with each other, and with boundary partners in the sphere of influence, across multiple accountability areas.

The findings indicate that **maternal death audits** have the most concrete evidence of progress in holding government accountable for maternal health. This accountability area shows great promise for the future, as it has produced clear evidence on the quality of maternal health services in facilities and has led to improvements in health facility infrastructure and services. MDSR committees have been institutionalized in state-level government policies.

Findings related to **budget analysis** show that, although this area is slower to show concrete progress in increasing budgets, it is an important pathway for continued focus. This pathway faces several hurdles related to slow bureaucratic processes, competing priorities for health allocations, and the impact on overall government budgets in times of economic fragility. However, there has been progress in government stakeholders' understanding of the importance of maternal health issues and beginning to prioritize maternal health in their budget-planning processes. Government stakeholders at federal, state, and local levels are using evidence produced by CSOs to make decisions about funding related to maternal health. Coalitions of government stakeholders and CSOs such as Accountability Mechanism for MNCH in Kano State (AMKASS) and Maternal, Newborn, and Child Health Programme (MNCH2), also provide a promising model of government–CSO collaboration that should be expanded in the future.

Legal approaches findings indicate that this pathway, as originally envisioned, was not as successful as hoped; the number of maternal death or injury cases has not increased substantially over the 3-year grant period. The barriers to litigation (including religious and cultural factors that hinder community members from bringing cases to court, slow litigation processes, constitutional barriers, and lack of expertise and financial incentives for lawyers to take on these types cases) were too great

to make progress. As a result, grantees sought other pathways to advance government accountability for maternal health through non-judicial means of redress. By acknowledging these limitations, paralegals and other community-based stakeholders are providing citizens with an alternative to seek redress and, therefore, a path forward in working under legal approaches.

Findings related to **CSO mobilization** indicate that this has proven to be an important strategy for holding the government accountable for maternal health over the 3-year grant portfolio. CSOs have increased collaboration and formed more CSO coalitions since baseline, expanding the platform for raising awareness and progress on maternal health and government accountability for maternal health.

Conclusions by Boundary Partner

Boundary partner actions and behavior, in some cases, cut across multiple accountability areas, as **Exhibit 20** illustrates.

Exhibit 20: Accountability Areas

Conclusions Related to Those in the Media

Findings show that grantees' actions to influence media boundary partners (journalists, editors, and other media executives) to increase the quality and use of evidence in reporting on maternal health have resulted in new areas and innovations in maternal health reporting. For example, the media have expanded collaboration with advocacy organizations to strengthen the use of evidence for reporting and use new media streams to raise Nigerians' attention on the state of maternal health.

Findings show that grantee activities have contributed to increasing the quality and quantity of maternal health reporting by journalists and editors. Grantees' activities that had the most influence

on media boundary partners were reported to be production and dissemination of evidence on maternal health issues, advocacy for better data access to government stakeholders, engagement of editors in understanding and reporting on maternal health, increasing CSO–media partnerships, training of media staff to understand how to report on maternal health issues, and cultivating the interest in reporting on maternal health by conducting investigative journalist trips.

Although the media face financial and institutional constraints, key media producers and consumers have increasingly adopted the value of evidence-based reporting as a result of grantees' actions, and have begun using more primary data for reporting in comparison with baseline. For example, findings show that journalists have embraced CSO-supported investigative reporting approaches and increased the overall amount of primary and secondary data in their coverage of maternal health.

Journalists' efforts to organize and promote health reporting through consortia, such as BASAM and JOBETH, have also been successful. Findings show that grantees' actions across the portfolio, in combination with journalists' efforts, have catalyzed a nascent paradigm shift for the media in support of more evidence-based reporting and increased the media's role in promoting government accountability for maternal health.

Conclusions Related to Lawyers

Findings show that grantees' efforts to increase the number of lawyers litigating maternal health cases was one of the more challenging approaches to increasing maternal health accountability. Several factors constrained work with this boundary partner. Findings indicate that cultural norms and beliefs identified at baseline, regarding keeping maternal health issues as a family and religious issue, continue to prevent women and their families from seeking redress in cases of maternal death and injury and lead to misconceptions and barriers related to the perceived high costs of seeking redress. In addition, constitutional barriers, lack of incentives for lawyers, and the limited number of lawyers trained to litigate maternal health cases continue to hinder progress.

Over the 3-year grant period, few cases were brought to court in the three states where WARDC worked (Enugu, Kaduna, and Lagos) and, due to the long timelines for litigation, WARDC litigated only six cases. In these six cases, WARDC worked with lawyers to increase their knowledge of maternal health and maternal death and injury litigation, and used personal connections with lawyers and litigators to help advance cases.

Although working through judicial channels has not shown progress, findings indicate that community members are increasingly using alternative means of redress, which WARDC capitalized on to be as effective as possible in maternal redress. Grantees' actions, such as engaging the media to bring attention to maternal death and injury cases and using community-based paralegals to report cases, were reported as successful approaches for increasing opportunities for redress. Support by local partners, including religious institutions, CSOs, and community members, was reported to encourage people to seek alternative means of redress; this is an area for more exploration in future projects.

Conclusions Related to CSOs

Findings show that grantees' engagement with CSOs over the past 3-years has contributed to increasing CSO capacity to advocate with government stakeholders for maternal health in budgeting and policy implementation, and to advocate with media stakeholders on reporting. Findings show that grantees' engagement with and support in the creation of CSO coalitions was a successful strategy for increasing collaboration and coordination among CSOs and between CSOs and boundary partners (such as the media).

Grantees' technical assistance to government—specifically, training on government budgeting and maternal health—played a key role in improving the evidence base, both in voicing community members' concerns to government and in using facility scorecard data to present clear arguments for gaps in maternal health.

Conclusions Related to MDSR Committees

Findings show that grantees' engagement with the MDSR committees has helped hold facility staff more accountable for high-quality maternal health care and hold government stakeholders more accountable for funding maternal health. At baseline, MDSR committees were nonexistent. By endline, MDSR committees were not only established; findings show that they are now functioning at state and local levels in Lagos State and the FCT, and that committee recommendations are being used to improve quality of care for mothers and pregnant women.

Endline findings show that most committees convened regularly, reviewed almost all maternal deaths in their facilities, and submitted recommendations to facility and state officials. SOGON-supported MDSR committees expanded to the community level, establishing community MDSR committees to conduct verbal autopsies. Facility-level implementation of MDSR recommendations was limited to 36 percent over the life of WHARC and SOGON's grants, but facility leadership demonstrated commitment and interdepartmental cooperation increased.

Evidence of state-level oversight and funding of MDSR committees supported findings regarding the sustainability of the MDSR committees once grantee support ends. Findings related to state-level implementation of MDSR recommendations are weaker, but include examples of key maternal health commodities and guidelines stipulating care for patients regardless of their ability to pay. Funding has constrained implementation of recommendations at facility and state levels.

Conclusions Related to Government Budgeting

Findings show that CSOs have made progress in holding government officials more accountable for allocating, expending, and releasing funds for maternal health. Grantees' personal relationships and use of accountability mechanism tools helped government boundary partners recognize the importance of prioritizing maternal health among all issues in the state health budgets.

Grantees and grantee-supported CSOs worked together and with community members to use scorecards and other budget analysis tools to created evidence around allocation, release, and

expenditure of funds per the approved budget; brought this evidence to government decision-makers; and leveraged technical expertise and collegial relationships to participate in budget planning in the states where they worked. Due to the cyclical nature of the budget process, CSOs' engagement at every stage of the budget cycle was identified as important; at endline, however, the most progress was seen in the budget-planning stage. Future opportunities for CSO engagement were reported as deepening links between the community and government and increasing the use of evidence in budget decisions by engaging throughout the budget cycle.

Conclusions Related to Legislative Committees

Findings show that CISLAC's policy brief and other advocacy efforts with legislatures influenced the implementation of seven health policies and the passage of five maternal health bills between baseline endline in the four states where CISLAC worked (Kano, Kaduna, Katsina, and Jigawa). CISLAC built legislators' capacity and knowledge on maternal health and their role in translating executive policy pronouncements into bills and laws, leading to increased interest among legislators to collaborate more with CSOs on maternal health in the future.

These recommendations were first generated during a 2-day Data Consultation Meeting of grantee staff and executive directors, MacArthur Foundation staff, and stakeholders from Nigeria's broader maternal health community, including government officials, journalists, editors, doctors, lawyers, and NGOs. During the meeting, stakeholders processed and discussed findings, refined conclusions, and co-created recommendations based on where they saw the greatest need for progress in maternal health accountability. The recommendations are organized by accountability area and boundary partner, supported by the endline evaluation findings and conclusions.

Recommendations by Accountability Area

The Foundation's 3-year portfolio investment sought to demonstrate pathways for increasing government commitment to maternal health. The findings of this evaluation have elucidated what is working, what could work better, and what alternative pathways should be considered. Overall, the key recommendations are to continue capitalizing on successful actions across the package of accountability areas and to continue strengthening actions that have shown particular promise.

As the Foundation shifts its investment focus to other areas of need in Nigeria, these recommendations focus on how to build on what has been learned in these accountability areas. Funders are encouraged to support continued efforts that influence boundary partners to change behaviors and actions in order to move Nigeria closer to the sphere of interest and the ultimate goal of federal, state, and local government accountability for maternal health. In recognition of the mutually reinforcing influence of the accountability areas, funders are encouraged to engage simultaneously with multiple accountability areas. Many opportunities for collaboration exist, and government, donors, and civil society should focus on synergy in their efforts.

Recommendations by Boundary Partner

Referring to the theory of change and the key boundary partners in the sphere of influence, whose behaviors are key to improving government accountability for maternal health, specific recommendations are presented here, organized around achieving changes among specific boundary partners.

Media

Overall areas for future work: Those working through the media to influence maternal health accountability highlighted three key areas for stakeholders to prioritize:

1. **Expand and institutionalize maternal health education in media institutions that train journalists**
2. **Expand collaboration within and between media and other advocacy areas**
3. **Continue to use multiple media streams to bring greater attention to maternal health**

High-Level Recommendation	Action	Who is the action targeting?	Who can carry out the action?
1. Expand and institutionalize maternal health education in media institutions that train journalists	Integrate maternal health into the curricula of schools of communication so journalists are more knowledgeable about and comfortable reporting on maternal health issues.	• Universities and other tertiary institutions that train journalists • Journalism students • Journalists and editors	• Advocacy for curriculum: CSOs working in media, such as DevComs, CISLAC, and CHR • Creating, training, and institutionalizing the curriculum: Nigerian Universities Commission, Nigerian Union of Journalists, Nigerian Association of Women Journalists
	Continue to train and educate journalists and editors on current and emerging areas in maternal health to improve the quality and quantity of maternal health reports.	• Journalists and editors	• CSOs working in media (e.g., DevComs, CISLAC, and CHR) • NGOs • Media organizations • Development partners • Government
2. Expand collaboration within and between media and other advocacy areas	Strengthen state-level media-health coalitions and expand coalitions to more states to continue strengthening these partnerships.	• Existing media coalitions (e.g., JOBETH, BASAM) • Journalists and editors	• Media CSOs • Other community-based organizations
	Continue to expand CSO–media partnerships to increase opportunities for investigative journalism, capacity building of media stakeholders, and knowledge sharing.	• CSOs and media organizations working through any of the maternal health reporting streams (e.g., budgeting tracking, legislation, MDSR)	• DevComs (which holds a CSO–media forum and supports partnerships between these groups) • Other CSOs working in media (e.g., CHR and CISLAC)
3. Continue to use multiple media streams to bring greater attention to maternal health	Continue using investigative journalism and new media to sensitize communities and government agencies on maternal health issues.	• Nigerians at all levels of the system, from government officials to rural community stakeholders	• CSOs working in media (e.g., DevComs, CHR, and CISLAC) • Government and media organizations

Lawyers

Overall areas for future work: Those working with lawyers on judicial and non-judicial means of influencing maternal health accountability highlighted two key areas:

1. **Expand education on judicial and non-judicial resolutions to maternal mortality and injury**
2. **Continue to sensitize communities to reduce existing barriers to maternal health litigation and educate them on how to seek alternative means of redress.**

High-Level Recommendation	Action	Who is the action targeting?	Who can carry out the action?
1. Expand education on judicial and non-judicial resolutions to maternal mortality and injury	Continue training lawyers on how to use human rights laws to prosecute against maternal death and injury, given the restrictions of Chapter 2 of the Constitution.	• National Judicial Institute • Female Judges Forum • Lawyers	• CSOs working in litigation (e.g., WARDC)
	Support the institutionalization and use of effective sexual and reproductive rights and health in training curriculum for law students and lawyers, building on the Women's Aid Collective and Legal Research and Resource Development Center's sexual and reproductive health curriculum in law school curricula.	• **Collaborate with** Women's Aid Collective and Legal Research and Resource Development Center • **Integrate curricula at** Council of Legal Education; Nigerian Institute of Advanced Legal Studies	• CSOs working in litigation (e.g., WARDC and the International Federation of Women Lawyers-Nigeria)
	Conduct new and refresher training courses on effective ways to support non-judicial means of redress, focusing on knowledge of the code of ethics to encourage greater use of alternative means of redress.	• Paralegals • Facility health committees • Local health committees • Hospital friends	• CSOs working in litigation (e.g., WARDC and Civil Research and Resource Documentation Centre)
2. Continue to sensitize communities to reduce existing barriers to maternal health litigation and educate them on how to seek alternative means of redress	CSOs should continue to partner with the media to increase reporting on judicial and non-judicial maternal health cases, to increase awareness of sexual and reproductive rights and health as a human rights issue. CSOs should use evidence from lawyers, paralegals, health facilities, and community institutions to build community awareness of the ways to seek redress against maternal health via judicial and non-judicial means.	• Media houses, Paralegals and community members.	• CSOs working in media (e.g., DevComs) • CSOs working in litigation (e.g., WARDC) • Media houses
	CSOs should continue to collaborate with faith-based organizations and religious and traditional leaders to encourage alternative means of redress in their communities and work toward reducing cultural barriers.	• Religious and traditional and community leaders	• CSOs working with paralegals (e.g., WARDC)

CSOs

Overall areas for future work: Those working with CSOs to increase advocacy and collaboration pointed to CSO coalitions, networking, and collaboration and as the most important areas to continue expanding. CSO partnerships with specific sectoral partners are covered in the relevant sections (e.g., CSO–media partnership is covered under Media).

High-Level Recommendation	Action	Who is the action targeting?	Who can carry out the action?
Continue to strengthen CSO coalitions and networks	Build on existing CSO coalitions and continue supporting platforms for CSOs to partner, and create a common goal in increasing maternal health accountability to strengthen the efficiency and effectiveness of their individual efforts.	• CSO coalitions working in maternal health accountability	• CSOs (e.g., Advocacy Nigeria, CHR, and CISLAC) that already work with CSO coalitions

MDSR Committees

Overall areas for future work: Those working with MDSR committees to increase maternal health accountability highlighted three key areas for stakeholders to prioritize:

1. **Increase advocacy for MDSR committees**
2. **Scale up MDSR Committees throughout Nigeria**
3. **Increase dissemination of MDSR best practices and successes**

High-level Recommendation	Action	Who is the action targeting?	Who can carry out the action?
1. Increase advocacy for MDSR committees	Continue to advocate to government stakeholders for effective functioning of MDSR committees, including encouraging greater implementation of recommendations at facilities.	• Federal, state, and local government	• CSOs working with MDSR committees (e.g., SOGON and WHARC)
	Increase advocacy for building political will from state governments and partners to translate MDSR committees from policy into law (which requires funding allocation).	• Federal, state, and local government	• CSOs working with MDSR committees (e.g., SOGON and WHARC)
2. Scale up MDSR Committees throughout Nigeria	Scale up MDSR committees to federal owned tertiary hospitals in order to expand utilization of this successful quality of care approach. (Currently, the model operates only at state and local levels.)	• Federal, state, and local government	• CSOs working with MDSR committees (e.g., SOGON and WHARC) • CSOs working in government advocacy
	Develop strategies for involving the private health sector in the MDSR model. (The private sector makes up 70% of health care delivery; it is critical to engage them in this successful model.)	• Private sector health facilities	• CSOs working with MDSR committees (e.g., SOGON and WHARC) • CSOs with connections to the private sector
	Scale up use of community-level verbal autopsies in MDSR committees for increased evidence of maternal death and injury at local levels. This process has started and should be expanded.	• Community-level stakeholders conducting verbal autopsies	• CSOs working with MDSR committees (e.g., SOGON and WHARC)
3. Increase dissemination of MDSR best practices and successes	Expand dissemination of Nigeria's success in MDSR committees, nationally and internationally, to expand learning and adoption of the practice more broadly.	• MPDSR committees • State governments • State ministries of health • Federal Ministry of Health	• WHARC • SOGON

Government Budgeting

Overall areas for future work: Those working with stakeholders on increasing government commitment to allocate, release, and spend funds on maternal health highlighted four key areas for stakeholders to prioritize:

1. **Continue to expand government-CSO relationship to increase CSO influence with government stakeholders**
2. **Continue to build on CSO influence in budget cycle, specifically in budget planning**
3. **Build on and expand use accountability mechanisms to provide evidence on maternal health budget tracking**
4. **Work with media to expand understanding of budget process**

High-level Recommendation	Action	Who is the action targeting?	Who can carry out the action?
1. Continue to expand government-CSO relationship to increase CSO influence with government stakeholders	Continue to foster CSO–government collaboration and partnership for mutually reinforcing and beneficial relationship. Encourage CSOs to convene government stakeholders, sit in on budget briefings, and use any opportunity to build relationships with the appropriate ministries to increase influence on budgeting for maternal health.	• State Ministry of Health • State PHC Development Agency • National PHC Development Agency • Federal Ministry of Health • Health Management Board • Ministry of Budget and Planning	• CSOs working in government budgeting (e.g., CHR and CISLAC)
2. Continue to build on CSO influence in budget cycle, specifically in budget planning	Continue to strengthen the process and collaboration with Government Ministries, Departments and Agencies (MDAs) and CSO collaboration as well as collaboration among CSOs in influencing the budget cycle. Target the budget-planning process, as this is where grantees have had the greatest success in the past.	• Ministry of Health, State PHC Development Agency, National PHC Development Agency, Federal Ministry of Health, Health Management Board, Ministry of Budget and Planning	• CSOs working in government budgeting (e.g., CHR and CISLAC)
3. Build on and expand use accountability mechanisms to provide evidence on maternal health budget tracking	Continue to use budget tracking tools, scorecards, and other accountability mechanisms to hold government accountable for releasing funds for maternal health. Use evidence from MDSR and other advocacy areas to advocate for budget lines related to maternal health.	• Ministry of Health • State PHC Development Agency • National PHC Development Agency • Federal Ministry of Health • Health Management Board • Ministry of Budget and Planning	• CSOs working in government budgeting (e.g., CHR and CISLAC) • CSOs working in MDSR committees (e.g., SOGON and WHARC)
4. Work with media to expand understanding of budget process	Increase public knowledge on budget provisions using simplified information formats (e.g., infographics and jingles) to provide easily understandable information and have the public hold the government more accountable for maternal health.	• Media houses • Other communication organizations	• CSOs working with media (e.g., DevComs and CISLAC) • CSOs working with government budgeting (e.g., CHR and CISLAC)

Legislative Committees

Overall areas for future work: Those working with legislative committees to turn executive policy pronouncements into implementable bills and laws highlighted two key areas for stakeholders to prioritize:

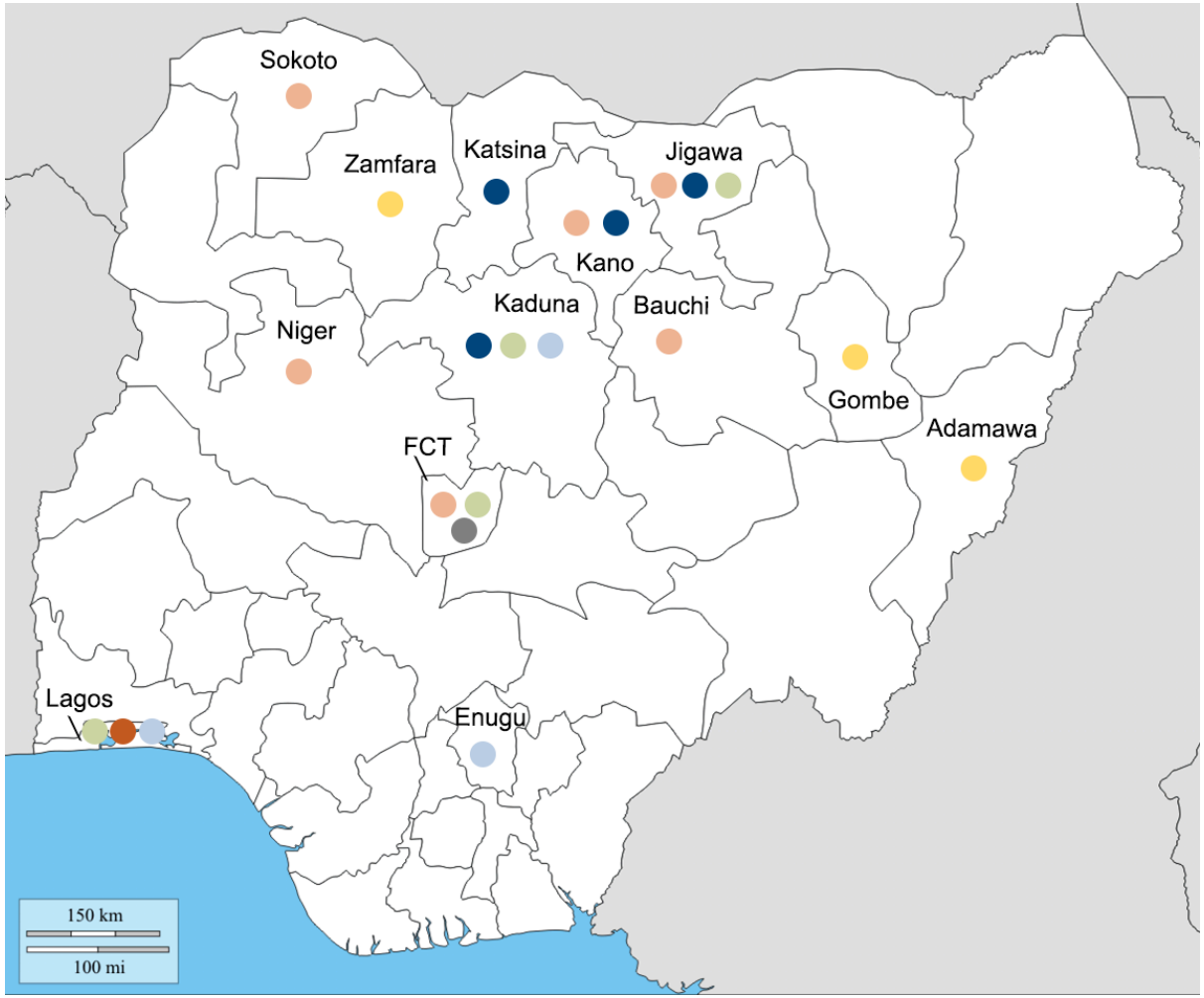
1. **Continue building the capacity of legislators on maternal health issues and the lawmaking process**
2. **Scale up promising practices in working with state houses of assembly**

High-level Recommendation	Action	Who is the action targeting?	Who can carry out the action?
1. Continue building the capacity of legislatures to understand the importance of maternal health and the process of transforming policies into implementable bills and laws	Continue grantee efforts of advocating to independent legislators and state house assemblies to encourage oversight on maternal health and ensure implementation of bills and laws. Encourage CSOs to advocate for an implementation strategy, at all levels, for every law passed.	• Legislators	• CSOs working in this area (e.g., CISLAC)
	Strengthen capacity of relevant legislative committees in maternal health. This could include advocacy and capacity building of the House Committee on Women and the Sustainable Development Goal on maternal health issues and oversight.	• Legislators	• CSOs working in this area (e.g., CISLAC)
2. Scale up promising practices in working with state houses of assembly	Scale up the standing committee on government–CSOs to build stronger relations in state houses of assembly.	• Legislators	• CSOs working in this area (e.g., CISLAC)

Annex 1: Grantee Activities by Location

Exhibit 21: Grantee Activity by State

CISLAC *DevComs* *Advocacy Nigeria* *CHR* *WARDC* *SOGON* *WHARC*



Activities listed below are based on 2015 grantee annual reports, as validated by grantees during the May 2017 data consultation session.

Grantee (accountability area)	Activities	State/ FCT
Advocacy Nigeria *Community mobilization (policy advocacy)*	• Advocacy visit by women's group, religious, and traditional leaders to selected government officials on the state of maternal health issues, including political parties • Meeting of trained stakeholders with Health Care Facility workers • Network meetings with other collaborators and partners • Community outreach with reproductive health champions in local government authorities • Feedback to stakeholders (women and religious/community leaders, policymakers) on how to advocate to government counterparts • Facilitated drafting Bill in Zamfara State	Adamawa, Gombe, Zamfara
Community Health Research Initiative (CHR) *Community mobilization (policy advocacy), budget tracking and analysis*	• Support the AMHiN coalition meeting and advocacy group • Support the activities of the MNCH accountability mechanisms at state level • Develop scorecard on key maternal health indicators • Develop annual shadow report in line with the Commission of Information Accountability • Capacity building for CSOs and media on budget tracking and advocacy • Support the implementation of quarterly integrated supportive supervision • Conducted advocacy to high level lawmakers (governors, ministers)	Bauchi, FCT, Jigawa, Kano, Niger, Sokoto
Civil Society Legislative Advocacy Centre (CISLAC) *Community mobilization (policy advocacy)*	• Audit of the state of maternal health in four states: Jigawa, Kaduna, Kano, and Katsina states • Advocacy visits to relevant committees in the state assemblies in Jigawa, Kaduna, Kano, and Katsina states • Media engagement (media parley) and advocacy to CEOs of media houses in the four states • CSO participation in public hearing • Public hearing on the state of maternal health • Advocacy visits to legislators in the four states. This was a year 1 activity that, owing to political atmosphere (elections, constitution of committees) could not be carried out. Two states, Jigawa and Kano, have been visited so far. • Production of bimonthly newsletters to enhance public and legislature awareness of key health issues	Jigawa, Kaduna, Kano, Katsina

Grantee (accountability area)	Activities	State/ FCT
Development Communications Network (DevComs) *Community mobilization (media, policy advocacy, legal experts, civil society) partners)*	• Capacity-building workshops (quarterly CSO–media forum) for media professionals • Visited 10 media organizations in Lagos State to seek the buy-in from their management, editors, and staff toward prioritizing MNCH issues in their reporting • Medical experts, legal experts, civil society partners were engaged as trainers at workshops and during media appearances on radio • Weekly content update on the NOTAGAIN campaign portal • Four CSO–media roundtable meetings were held each in Kaduna and Lagos states to discuss emerging issues in maternal health • Two bloggers' meetings were held to brainstorm on emerging maternal health issues and disseminate them on the existing social media platforms • Media support for partners by providing media practitioners to cover their events and produce media reports, which inform the public about issues raised at the event • Media appearances were facilitated on radio in all the project sites (FCT Abuja, Jigawa, Kaduna, and Lagos states) • Two field visits were facilitated each in FCT Abuja, Jigawa, Kaduna and Lagos states to provide journalists with firsthand information on what is happening in underserved communities and health facilities	FCT, Jigawa, Kaduna, Lagos
Society of Gynaecology and Obstetrics in Nigeria (SOGON) *Maternal death audits*	• Support to monthly supervisory visits to the three primary and three secondary medical facilities. • Support to monthly facility MDSR committee meetings—train organizations in MDSR committee role and function • Communication support between SOGON program team and facility personnel • Transportation support for supportive supervision and MDSR surveillance • Support to MDSR presentation during SOGON's annual conference • Sensitize on importance of functional MDSR committees across Nigeria • Maternal death reviews and response tracking data from communities, PHC centers, general hospitals, and states • Write report on result findings and best practices	FCT
Women Advocates Research and Documentation Centre (WARDC) *Legal approaches, community mobilization (policy advocacy)*	• NOTAGAIN campaign/community mobilization: advocacy with health institutions in the project states, two press conferences, national launch in Abuja, presentation of the three million signatures, national open-air rally • Public interest litigation on maternal mortality and legal advocacy • Engagement with human rights treaty bodies • Engagement with Nigerian Bar Association • Writing report on outcomes of court cases	Enugu, Kaduna, Lagos

Grantee (accountability area)	Activities	State/ FCT
Women's Health Action Research Centre (WHARC) *Maternal death audits*	• Continue to support the reviews of maternal deaths in the three project health facilities: Ajeromi General Hospital, Gbagada General Hospital, Lagos Island Maternity Hospital • Supervisory visits to the project sites for project monitoring • Conducted key informant interviews at Odun Ward in Lagos Island and Ojora ward in Ajeromi Local Government Area in Lagos State • Data transcription and documentation of the results of the baseline study on the current status, reporting and documenting of maternal deaths within two communities in Lagos State • WHARC Executive Director; Dr. Wilson Imongan and Program Officer; Miss Chioma Ekwo paid an advocacy visit to the council executives of Ifelodun Local Council to solicit their support in implementing the community verbal autopsy • Organized a sensitization workshop on maternal death verbal autopsy at Ajeromi-Ifelodun Local Government Authority • Drafting report on outcomes and MDSR process in three facilities	Lagos

Annex 2: Evaluation Team Members

Lynne Franco, Team Leader, Vice President of Technical Assistance and Evaluation

Kelsey Simmons, Evaluation Specialist

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Aminu Muhammad Mustapha, Data Collector

Blessing Olutoyin Williams, Data Collector

Loveth Metiboba, Data Collector

Mabinu Olasumbo Oladipo, Data Collector

Sabine Topolansky, Project Coordinator

Annex 3: Data Analysis Plan

This plan was used for data collection and preliminary data analysis. During secondary data analysis, evaluation questions were refined based on updated information about grantee activities.

Sphere of Influence	Endline Evaluation Questions	Evaluation Sub-questions	Portfolio-Level Indicators	Indicator Data Limitations
Media uses evidence to report on maternal health	1. How has use of maternal health evidence changed since midline? *Evidence = data on maternal health, grantee-produced materials*	1.1 Has the quality of evidence increased? 1.2 Has the availability of evidence increased?	*A. Number of maternal mortality and health cases instigated by WARDC that are reported by journalists* *B. Output: Number of maternal health evidence products delivered by Advocacy Nigeria, CISLAC, and DevComs* *C. Percent increase in web hits on information websites developed by DevComs*	
	2. How have grantee activities influenced the quantity and quality of maternal health reports since midline? *Engagement = training, CSO–media forums, outreach, field trips*	2.1 How has grantee engagement with journalists and editors (print and electronic) influenced use of maternal health evidence by journalists and editors? 2.2 How do media producers and key media consumers perceive the quantity of reporting on maternal health? *Key media consumers: Policymakers, development partners, CSOs working in maternal health* 2.3 How do media and key media consumers perceive the quality of reporting on maternal health? *Quality = supported by evidence, including data on maternal health, cases, grantee-produced materials*	*D. Percent of media staff trained by CHR, CISLAC, and DevComs who produce at least two reports on maternal health/maternal mortality within 6 months of the training* *E. Output: Number of journalists trained by CHR, CISLAC and DevComs in maternal health reporting*	D. Aggregate data are vulnerable to reliability challenges – grantees may use different measurement procedures. E. Data may be vulnerable to double-counting journalists who participate in multiple grantee activities.

Sphere of Influence	Endline Evaluation Questions	Evaluation Sub-questions	Portfolio-Level Indicators	Indicator Data Limitations
Lawyers litigate maternal death and injury cases	3. What are the most promising alternative means used to seek redress in cases of maternal death or injury?	3.1 Which of the alternatives means of redress is more likely to yield more positive results? (criteria for positive results to be determined by informants) 3.2 Which alternative means of redress are the most efficient? 3.3 Who is most likely to seek redress using alternative means?	*F. Number of non-judicial maternal death and injury cases that have come to WARDC as a result of WARDC activities*	
	4. What are the enablers and constraints of the identified alternative means?	4.1 What are the enablers of alternative means? 4.2 What are the constraints to alternative means?		
	5. What supports or hinders lawyers trained by WARDC to litigate cases involving maternal health and death brought to them?	5.1 What supports lawyers trained by WARDC to litigate cases in maternal health and death brought to them? 5.2 What hinders lawyers trained by WARDC to litigate cases brought to them?	*F. Number of non-judicial maternal health cases that have come to WARDC as a result of WARDC activities* *G. Number of judicial maternal health cases that have come to WARDC as a result of WARDC activities*	
Civil society and community members demand government accountability and quality maternal health services	6. What have been the most important contributions of grantees to these maternal health accountability advocacy initiatives?			
	7. What outcomes have been achieved by maternal health accountability advocacy	7.1 What is the significance of the outcomes achieved by advocacy initiatives conducted by grantee-supported CSOs?	*H. Number and type of CSO actions undertaken as a result of grantee support to influence*	

Sphere of Influence	Endline Evaluation Questions	Evaluation Sub-questions	Portfolio-Level Indicators	Indicator Data Limitations
	initiatives conducted by grantees and grantee-supported CSOs? *Outcomes = steps towards greater government accountability to maternal health (budgets, policy, media, or improved services)*		*or change government commitment to maternal health* *I. Number and type of community-level actions undertaken as a result of WARDC community mobilization to influence or change government commitment to maternal health*	
MDSR committees are functioning effectively	8. To what extent are MDSR committees functioning effectively? *Effective = Committee reviews all maternal deaths in a timely manner and submits recommendations to facility and state.*	8.1 To what extent do key stakeholders perceive MDSR committees as useful? (Key stakeholders= facility staff, community members, state-level representatives) 8.2 To what extent is the effectiveness of MDSR committees sustainable?	*J. Number of MDSR committees supported by WHARC/SOGON that meet at least once a quarter* *K. Average time between maternal deaths reported and review at MDSR meeting* *L. Percent of maternal deaths reviewed by SOGON-supported MDSR committees* *M. Percent of MDSR committee recommendations that are implemented by facility* *N. Number of MDSR committee recommendations that are implemented by state*	M. Percentage indicator is vulnerable to reliability challenges – grantees may use different measurement procedures for calculating percentage of recommendations implemented. N. Grantees currently do not track their recommendations at the state level.
	9. To what extent are MDSR committee recommendations implemented by facilities?		*M. Percent of MDSR committee recommendations that are implemented by facility*	

Sphere of Influence	Endline Evaluation Questions	Evaluation Sub-questions	Portfolio-Level Indicators	Indicator Data Limitations
	10. What factors enable and constrain implementation of MDSR committee recommendations by facilities?	10.1 What factors enable implementation of MDSR committee recommendations by facilities? 10.2 What factors constrain implementation of MDSR committee recommendations by facilities?	*M. Percent of MDSR committee recommendations that are implemented by facility*	
	11. To what extent do MDSR recommendations influence practice and budget allocation at state level?		*N. Number of MDSR committee recommendations that are implemented by state*	
	12. What factors enable and constrain implementation of MDSR committee recommendations at state level?	12.1 What factors enable MDSR committee recommendations at state level? 12.2 What factors constrain MDSR committee recommendations at state level?	*N. Number of MDSR committee recommendations that are implemented by state*	
Governments allocate, release, and use maternal health budgets	13. At what stage in the budget cycle are grantee-supported CSOs intervening most effectively?	13.1 What successes have grantee-supported CSOs experienced in intervening in the budget planning process? 13.2 What successes have grantee-supported CSOs experienced in intervening in the budget tracking process?	*O. Percent of CSOs trained by CHR advocating for improved budget performance for maternal health to local and state governments*	
	14. What factors enable effective CSO intervention in the budget cycle	14.1 What factors enable effective CSO intervention in the budget planning process? 14.2 What factors constrain effective CSO intervention in the budget planning process? 14.3 What factors enable effective CSO intervention in the budget tracking process?	*O. Percent of CSOs trained by CHR advocating for improved budget performance for maternal health to local and state governments*	

Sphere of Influence	Endline Evaluation Questions	Evaluation Sub-questions	Portfolio-Level Indicators	Indicator Data Limitations
		14.4 What factors constrain effective CSO intervention in the budget tracking process?		
	15. What stages in the budget cycle are the most strategic for CSO intervention?	15.1 What additional opportunities are there for greater CSO involvement in the budget cycle?		
Legislative committees oversee maternal health policies	16. What supports states legislators to translate executive policy pronouncements related to maternal health into implementable bills and laws at state level?	16.1 What enables legislatures to translate executive policy pronouncements into implementable bills at state level? 16.2 What constrains legislatures to translate executive policy pronouncements into implementable bills at state level?		

Annex 4: Key Informants Interviewed

Stakeholder	State
Civil Society Organizations	
• Fahimta Women Youth Development Association	Bauchi
• Health Management Board	Bauchi
• NAWAJ/NTA	Bauchi
• Federation of Muslim Women's Associations in Nigeria (FOMWAN)	Bauchi
• Community Health and Research Initiative (CHR)	Bauchi
• Community Rescue Initiative (CRI)	Bauchi
• Community Initiative for the Promotion of Health and Education Sectors	Bauchi
• Development Exchange Center (DEC)	Bauchi
• Rariyan Goro Youth	Bauchi
• Zango Women Empowerment – Treasurer	Bauchi
• Young Leaders Network	Bauchi
• Fawoydi	Bauchi
• Bauchi State Network of Civil Society Organizations	Bauchi
• Heal Disability	Bauchi
• Search Results Bauchi State Accountability Mechanism for MNCH (BASAM)	Bauchi
• Community Health and International Research Organization	Enugu
• Maternal and Child Health Advocacy Partners	Enugu
• Global Missions Intl. (GLOMINT)	Enugu
• Civil Society Action Coalition on Education for All (CSACEFA)	Enugu
• GoldMark Services Nig.	Enugu
• Global Health Awareness Research Foundation (GHARF)	Enugu
• SOPAT/CENGOS	Enugu
• CIRDDOC	Enugu
• African Law Foundation	Enugu

Stakeholder	State
• Community Mobiliser, Naara	Enugu
• MCH-CS Partnership	Kaduna
• PACA/St John's Catholic Church	Kaduna
• RHAN-MCH-CS	Kaduna
• Gender Awareness Trust	Kaduna
• Centre for Development and Advocacy	Kaduna
• KNOW 'UR' BUDGET	Kaduna
• Pharmaceutical Sales/Medical Association	Kaduna
• Secretary, Accountability Mechanism on MNCH in Kano State (AMMKAS)	Kano
• Snr Prog Manager, Youth Society for the Prevention of Infectious diseases and Social Vices (YOSPIS)	Kano
• Taurarume Awareness and Development Association	Kano
• Partnership for Promotion of Maternal and Child Health	Kano
• AMMKAS	Kano
• GHON	Kano
• Budget Tracking Group (BTG)	Kano
• Mufarka Youth Development Initiative	Kano
• Centre for Research and Documentation/Voice Accountability Project (VAP)	Kano
• Centre for Advocacy in Gender and Social Inclusion (CAGSI)	Kano
• Executive Director, YOSPIS; Reagan-Fascell Democracy Fellow, National Endowment for Democracy	Kano
• State Coordinator, Transparency and Development Information Initiative (TDII)	Kano
• Secretary, Kano Civil Society; Affiliate Kano Partners (State Coordinator)	Kano
• Disability Awareness and Development initiative	Lagos
• Humanity Family Foundation for Peace and Development (HUFFPED)	Lagos
• Youth Empowerment Foundation (YEF)	Lagos
• Executive Director, Centre For Mmadu On Human Rights	Lagos
• Planned Parenthood Federation of Nigeria (PPFN)	Niger

Stakeholder	State
Grantees	
• Advocacy Nigeria (AN)	Adamawa, Kaduna
• Society of Gynaecology and Obstetrics of Nigeria (SOGON)	FCT
• Community Health and Research Initiative (CHR)	Kano, Niger, Bauchi, Jigawa
• Development Communications Network (DevComs)	Lagos, Jigawa, Lagos, Kaduna
• Women Advocates and Research Documentation Centre (WARDC)	Lagos, Kaduna
• Women's Health Action Research Centre (WHARC)	Lagos
Professional Health Associations	
• International Federation of Women Lawyers (FIDA) Enugu State Branch	Enugu
• Member, Steering Committee, Lacsop; Chairman, Lagos Advocacy Working Group, supported by Pathfinder and Nuri; Co-Chair, Lagos State Accountability Mechanism, supported by Mama Ye On Maternal and New Born Health	Jigawa
• Nigerian Nurses and Midwives	Kaduna
• Chairperson, National Association of Women Journalists, Kano State Branch	Kano
State Government	
• Adamawa Primary Health Care Development Agency (PHCDA), Yola North, Adamawa State	Adamawa
• Primary Health Care Authority Yola South	Adamawa
• Lamido Aliyu Musdafa Clinic, Damare, Yola South	Adamawa
• Ministry of Health Yola, Adamawa State	Adamawa
• WDC Damare Inji Uku	Adamawa
• Ministry of Health, Bauchi State	Bauchi
• Bauchi State Primary Health Care Development Agency (PHCDA)	Bauchi
• Secretary, Enugu State Health Board	Enugu
• Asokoro General Hospital/SOGON	FCT
• FCT- PHCB/SOGON	FCT
• Coordination and Monitoring in the Directorate of Budget and Economic Planning, Jigawa State	Jigawa

Stakeholder	State
• House Committee on Education Jigawa State House of Assembly, Dutse	Jigawa
• Ministry of Health, Kano	Kano
• Centre for Communication and Reproductive Health Services (CCRHS)	Niger
• State PHC Development Agency	Niger
• State Ministry of Health	Niger
International Projects	
• Evidence 4 Action (E4A)	Bauchi
• Strategic Planning Coordinator, MNCH2	Kano
• State Midwife Mentor, MNCH2	Kano
• Evidence and Advocacy Coordinator, MNCH2	Kano
Media	
• Nigeria Television Authority (NTA) Bauchi	Bauchi
• Radio Nigeria (Globe FM)	Bauchi
• Government House Media/Daily Trust	Bauchi
• News Agency of Nigeria (NAN)	Bauchi
• Daily Times Newspaper Health Reporters (State Correspondence)	Bauchi
• British Broadcasting Corporation (BBC) Reporter	Bauchi
• State Correspondent - Daily Champion	Bauchi
• Alheri Newspapers / Dandalkura Radio International Reporter	Bauchi
• BATV – Reporter	Bauchi
• FRCN/Armed Forces Radio, Presenter	FCT, Kaduna
• The Nation, Reporter	FCT
• Independent Television, Reporter	FCT
• Daily Trust, Reporter	FCT, Kaduna
• Guardian, Reporter	FCT
• National Television Authority, Producer	FCT
• IITV, Staff	FCT

Stakeholder	State
• Radio Nigeria	FCT
• Daily Sun Newspaper – Reporter	Jigawa
• Radio Jigawa – Reporter	Jigawa
• Leadership Newspaper, Dutse, Jigawa State	Jigawa
• Health Issues, Radio Jigawa	Jigawa
• News Agency of Nigeria, Jigawa Office	Jigawa
• Freedom Radio Jigawa	Jigawa
• Jigawa Maternal and Newborn Child Advocacy Partners (MNCH-AP)	Jigawa
• Jigawa Maternal Accountability Forum, (JIMAF)	Jigawa
• Gender and Social Inclusion, Dutse, Jigawa	Jigawa
• National Association of Nigerian Nursing and Midwives, NANNM, Jigawa State	Jigawa
• VOA	Kaduna
• Nigerian Pilot/Africa Prime News	Kaduna
• Africa Prime News	Kaduna
• People's Daily	Kaduna
• Nagarta Radio	Kaduna
• DITV	Kaduna
• Daily Independent	Kaduna
• Newswatch	Kaduna
• Citysourceng.com	Kaduna
• Talkwifenans.com	Kaduna
• Abubakar Rimi TV	Kano
• News Editor/Health Reporter and Producer	Kano
• Cool Wazobia/Arewa FM Kano	Kano
• African Newspage	Kano
• Freedom Radio, Kano	Kano
• Reporter, Daily Trust	Kano

Stakeholder	State
• EKO FM/Radio Lagos	Lagos
• Radio One, 103.5 FM	Lagos
• Guardian Newspapers	Lagos
• Leadership Newspapers	Lagos
• Federal Radio Corporation of Nigeria (FRCN)	Lagos
• Health Reporter/Editor, Daily Independent Newspaper	Lagos
• TV Continental	Lagos
• Thisday Newspaper	Lagos
• Daily Times Newspaper	Lagos
• Vanguard Newspapers	Lagos, Jigawa
• National Mirror	Lagos
Facilities	
• Uwani Health Centre	Enugu
• Poly S D Hospital, Asata	Enugu
• Ministry of Health, Ifelodun LCDA In Ajeromi Local Government Authority	Lagos
• Island Maternity Hospital	Lagos
• Ajeromi General Hospital	Lagos
• Gbagada General Hospital	Lagos

Annex 5: Data Collection Matrix and Tools

Exhibit 22 presents the data collection matrix that was used in the design of data collection tools. Interview questions were designed to answer each evaluation question within each sphere of influence. Interview questions were then mapped to key informants in each state who worked within one or multiple spheres of influence. Interview guides were then developed based on key informants. Illustrative questions for each sphere of influence can be found below.

Exhibit 22: Sphere of Influence Mapped to Key Informants

Sphere of Influence	Evaluation Questions	Key Informants
Media	1-2	Media (all) Grantees (all) Professional Associations (only Q1-2) CSOs (Only Q1) Policymakers (Only Q2)
Layers	3-5	WARD-C Women (Q4-6) CSOs (Q4-6) Grantee ((All) Professional Association (FIDA) (Q4-6) Lawyers trained by WARDC (Q4-5, Q7)
CSO Advocacy and Collaboration	6-7	CSOs (all) Grantee (all) Government (all) Development Partners (all) Professional Association (Q9)
MDSR Committees	8-12	MDSR Committee Members (all) Health Facility Staff (all) Grantees (all) Community Members (all) Government (state level) (Q10, 13-14)
Government Budgeting	13-15	Grantee (all) CSOs supported by Grantees (all) Policymakers (all) Grantees (all) Development Partners (Q15 &Q17)
Legislative Committees	16	Legislatures (all) Grantees (CISLAC) (all)

Illustrative Interview Questions by Sphere of Influence

Background

1. What improvements in maternal health accountability is your organization working towards? We mean "accountability" in the following three ways:
    a. *increasing government commitments*
    b. *ensuring government compliance with commitments already made*
    c. *ensuring higher quality maternal health services.*
2. What groups/stakeholders did you work with on maternal health accountability, or other areas related to maternal health or maternal mortality in the past year?

3. How have these partnerships or individual organizations facilitated change in maternal health accountability?

Media

4. Where did you get maternal health and maternal mortality evidence/information in the past year to inform your work? (*Probe whether they ever use information from media*)
5. How easy or hard it is to find this information? *(Probe: Is the information readily available? Is it easy to find the information you need?)*
6. What suggestions do you have for improving the accessibility of information on maternal health?
    a. More information?
    b. Different forms of distribution*?*
7. How would you describe the quality of the evidence/information on maternal health and maternal mortality that you have used within the past year? (*Probe: Has it improved in the past year? Stayed the same?)*
8. How would you describe the availability of the evidence/information on maternal health and maternal mortality that you have used within the past year? (*Probe: Has it improved in the past year? Stayed the same?)*
9. How would you rate the quality of media reports on maternal health in the last year on a scale from 1 to 5, with 1 being extremely poor quality, supported by little to no evidence, and 5 being extremely good quality based on evidence from case studies, grantee-produced material, and other scientific sources? Please explain your rating. *(Probe: Has this changed in the past year?)*
10. How would you describe the volume of media reports on maternal health published in the last year in comparison to previous years? (*Probe: Has it increased? Decreased? Stayed the same? Has the number of journalists/publications reporting on maternal health increased/decreased?)*
11. Thinking back to your best example of reporting on maternal health – a report you are proud of – what role, if any, did [grantees named in previous question] contribute to that report?
12. How else have CSOs supported you in your reporting efforts in the past year? (*Probe: building an evidence base, capacity building/training, building off of media staff personal interest, etc.)*
    a. **If training**: What was the most important learning point for you from the training(s)?
13. What other factors enabled you to report on maternal health in the past year?
14. What particular challenges did you face in the past year when researching and reporting on maternal health?
15. In what ways might CSOs help you to overcome those challenges in the future?

Editors Only:

16. In the past year, how often have you approved publication of stories about maternal health or maternal mortality issues*? (Probe: Has the amount increased or decreased in comparison to previous years?)*

17. What is the process for choosing/assigning staff to research and write an article?
18. What is the process for choosing articles for publication? *(Probe: What factors do you consider?)*
19. Please tell me about a time in the past year, you assigned staff to write about maternal health issues. *(Probe: What factors led to this decision, what was the story about, what made you assign this piece of work?)*
    a. Was this work published? Why or why not?

Litigation

20. Please describe your involvement in any maternal death and injury-related court cases this year.
    *Probes: Please describe the case. How did you come to be involved (understand role of WARDC and other means that support cases being brought to lawyers)? What was your role and involvement? What was the outcome of the case? (**Note**: Really try to capture the story of the case)*
21. What factors supported you in litigating this case?
22. What barriers did you face when litigating this case?
23. Do you know of any examples of people seeking redress for maternal death and injury issues outside the courts?
    (Probe: What are the different ways to seek alternative of redress?)
24. Do you know of any examples in which an alternative means of redress led to a positive result?
    (Probe: What happened? Who was involved? When did this take place? What was the outcome?)
    (If "No," ask: Which alternative means of redress are the most promising for seeking positive results in the future?
    a. Why do you consider the result positive? Did the family of the woman consider it a positive outcome?
    b. What supported the success of this case?
    c. What resources were required to ensure its success?
    d. What were the major barriers encountered?
    e. How accessible would you consider this means of redress to people experiencing maternal death or injury issues?

CSO Advocacy and Collaboration

25. Please describe the advocacy activities supported by *(insert appropriate grantee name here)* undertaken by your organization in support of maternal health improvements in <u>the past year</u>?
26. What outcomes have been achieved by these activities? We are interested in outcomes whether they are:
    - Planned or unplanned. They don't have to be predicted on the work plan.

- Related to indicators or not. They don't have to be counted in an indicator.
- Positive or negative.

27. Description of outcome: Please summarize the observable change in the behavior, relationships, activities, or actions of community members or organizations influenced by the above activities and outputs of your grantee-supported activities.

    Be specific about:

    - Who changed?
    - What changed?
    - When did the change occur?
    - Where did the change occur?
    - How did the change influence or change government commitment to maternal health?

28. Contribution to the outcome: In one or two sentences, what was your organization's role in influencing the outcome?
29. Significance: Why is this outcome important? How would you explain its importance to someone not familiar with Nigeria?
30. What supporting information do you have about the outcome? (newspaper articles, documents, observations, conversations, evaluations, photos)
31. Who, outside of your organization, has working knowledge of this outcome? Please recommend one to three knowledgeable, independent, and credible sources of information.
    a. What type of support has been the most beneficial for your work?

MDSR Committees

32. How timely do MDSR committees meet following a maternal death?
33. Has the MDSR process changed in the past year? If so, how?
34. In the MDSR process, what has worked well in the past year? What needs improvement?
35. In the past year, what has enabled the MDSR committee to do its job? What has hindered it?
36. To what extent are MDSR committees functioning effectively? *Effective = Committee reviews all maternal deaths in a timely manner and submits recommendations to facility and state.*
37. In your opinion, how accurate is the maternal death reporting in your facility and/or community?
38. In your opinion, how do key stakeholders perceive the effectiveness of MDSR committees?
    a. Health facility staff:
    b. Community members:
    c. Government officials:
39. To what extent are MDSR committee recommendations implemented by facilities? Can you provide an example of a time a facility implemented recommendations provided by MDSR committees?

    If Yes:

    i. What factors enabled this implementation?
    ii. What factors hindered implementation?

If No:

iii. What factors have hindered implementation of MDSR committee recommendations by facilities?

iv. What would need to happen to enable facilities to implement the MDSR committee recommendations?

40. To what extent are MDSR committee recommendations used at the state level? Can you provide an example of a time a facility implemented recommendations provided by MDSR committees?

If Yes:

v. What factors enabled this use?

vi. What factors hindered this use?

If No:

vii. What factors have hindered implementation of MDSR committee recommendations by facilities?

viii. What would need to happen to implement these MDSR committee recommendations by facilities?

Government Budgeting

41. Thinking about the past few years, please give me an example of a time when CSOs (or your organization, if grantee) have helped to influence the budget planning process for maternal health?

    Please be specific about:

    a. What did your organization do?
    b. When?
    c. Where?
    d. Who was involved?
    e. How CSO activities influence government budget planning for maternal health?

42. What factors contributed to this success?

43. What factors hindered the success achieved by (CSO named in the question above)?

44. Please describe the most important success achieved by your organization in influencing government budget tracking for maternal health (ensuring projects and procurements are carried out after approval). *Probe for activities including scorecards, documenting budgetary allocations, capacity building for CSO and media on budget tracking, etc.*

    Please be specific about

    f. What did your organization do?
    g. When?
    h. Where?
    i. Who was involved?
    j. How CSO activities influence government budget planning for maternal health?

45. What factors contributed to this success?

46. What factors hindered this success?

47. At what phase of the budget cycle do you see CSOs having the greatest opportunity to influence the budget? *(Probe for budget planning/drafting, budget legislation, or budget implementation)*
48. Looking to the future, what are some untapped opportunities for greater engagement that your organization could take advantage of in influencing the government budget cycle?

Legislation

49. Have there been any executive policy pronouncements related to maternal health over the past year that have been translated into bills?
    a. *If no, probe: When was the last executive policy pronouncement related to maternal health?*
    b. *If yes, can you explain the process involved?*
        i. What was your role in this process?
        ii. Who are the key players in this process?
        iii. Are there any other legislators in support of this bill? If yes, who?
        iv. Did you engage with them directly? If so, how?
        v. What support did you provide to these supporting legislators?

50. What factors were the most effective in supporting this process?
51. What were the barriers faced throughout this process?
52. Throughout this process, how, if at all did CSOs support your efforts?
53. How can CSOs support your efforts more strategically in the future?
54. Did this executive policy pronouncement turn into an implementable state law?
    c. If Yes:
        i. What factors were the most effective in supporting this process?
        ii. What were the barriers faced throughout this process?
    b. If No:
        i. Why hasn't this policy pronouncement turned into an implementable law?
        ii. What needs to happen to ensure it is translated into an implementable law?

Concluding Questions

1. To successfully affect government accountability for maternal health in the current context, what needs to be done more of, less of, differently?
   What else would you like to tell me/us, but didn't because I/we didn't ask the right question?
2. Do you have any questions for me?