

Joint Strategy for Monitoring and Evaluation

**Nigerian Urban Reproductive Health Initiative (NURHI)
Project**

Measurement, Learning & Evaluation Project

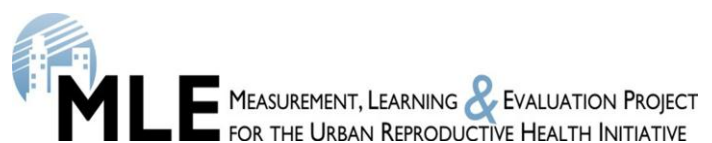


Table of Contents

1.0	Introduction	6
1.1	Urban Reproductive Health Initiative.....	7
1.2	Key Players.....	7
1.3	Monitoring and Evaluation Team	10
1.4	Overview of M&E Plan	10
1.5	Principles of the Monitoring and Evaluation Plan	12
2.0	Program Description and Frameworks	12
2.1	NURHI Program Goals and Objectives	12
2.2	Program Strategies and Activities.....	13
2.3	Logic Model	16
3.0	Program Implementation Plan.....	18
4.0	Key Questions	18
5.0	Indicators and Data Sources	20
5.1	Indicator Table/Matrix.....	20
5.2	Data sources.....	21
6.0	Monitoring Plan	26
7.0	Evaluation Plan/Design	26
8.0	Data Quality Plan	29
9.0	Information Dissemination and Utilization.....	30
9.1	Key Audiences & Dissemination Strategies	31
9.2	Dissemination and Utilization of Results	33
10.0	Roles and Responsibilities.....	34
10.1	Project implementers	34
10.2	Implementing partners	35
10.3	MLE	36
11.0	Timeline.....	36

Acronyms Reference List

ANC-Antenatal Care

APHRC-African Population and Health Research Center

ARDA-African Radio Drama Association

ARFH-Association for Reproductive and Family Health

ARO-Asia Regional Office

BCC-Behavior Change Communication

CBO-Community-Based Organization

CCPN-Center for Communication Programs Nigeria

CLMS-Contraceptive Logistic Management System

CPC-Carolina Population Center

CPR-Contraceptive Prevalence Rate

CTU-Contraceptive Technology Update

DevComs-Development Communications Network

DQA-Data Quality Assessment

DHS-Demographic and Health Survey

FGD-Focus Group Discussion

FMOH-Federal Ministry of Health

FP-Family Planning

FPE-Family Planning Effort

FPPN-Family Planning Provider Networks

GPS-Global Positioning System

HERFON-Health Reform Foundation of Nigeria

HIV/AIDS-Human Immunodeficiency Virus /Acquired Immunodeficiency Syndrome

HMIS-Health Management Information System

HSS-Health Systems Strengthening

IBP-Implementing Best Practices

IDI-In-Depth Interviews

ICRW-International Center for Research on Women

JHU-CCP-Johns Hopkins University Centre for Communications Program

JSI-John Snow, Inc.

K4Health-Knowledge for Health Project

KM-Knowledge Management

LAPM-Long-Acting and Permanent Methods

LGA-Local Government Area

M&E-Monitoring and Evaluation

MEASURE-Monitoring and Evaluation to ASsess and Use REsults

MLE-Measurement, Learning & Evaluation Project

NDHS-Nigeria Demographic and Health Survey

NGO-Non-Governmental Organization

NHMIS-National Health Management Information System

NURHI-Nigeria Urban Reproductive Health Initiative Project

OBA-Output-Based Aid

OR-Operations Research

PAC-Post Abortion Care

PMV-Patent Medicine Vendors

PPFN-Planned Parenthood Federation of Nigeria

QI-Quality Improvement

RH-Reproductive Health

SDP-Service Delivery Point

SMOH-State Ministry of Health

SRH-Sexual and Reproductive Health

SSA-Sub-Saharan Africa

UAC-United Africa Company

UN-United Nations

UNC-University of North Carolina at Chapel Hill

UNICEF-United Nations Children's Fund

Urban RH Initiative-Urban Reproductive Health Initiative

USAID-United States Agency for International Development

Joint Strategy for Monitoring and Evaluation – NURHI/MLE

1.0 Introduction

Guided by the idea that all people should have the opportunity to have healthy and productive lives, the Bill and Melinda Gates Foundation has been bringing together better technology, improved knowledge and practices, and partnerships with local stakeholders to improve health and save lives in low-income countries. Currently, the Gates Foundation is supporting an innovative, multi-country effort to improve reproductive health (RH) in urban populations. The Nigeria Urban Reproductive Health Initiative (NURHI) is the Nigeria-based arm of the Gates Foundation-funded Urban Reproductive Health Initiative (Urban RH Initiative), which is also present in India, Kenya, and Senegal. In order to achieve the NURHI objectives, a comprehensive monitoring and evaluation approach needs to be used across the entire lifecycle of the project. The NURHI and the Measurement, Learning & Evaluation (MLE) projects have come together to develop this Joint Strategy for Monitoring and Evaluation.

This document is meant to serve as a framework for the multiple monitoring and evaluation activities that are being undertaken to support the NURHI project. This strategy will provide a comprehensive and systematic presentation of the monitoring and evaluation plans to inform the NURHI program planning and review process. In addition, this strategy is designed to assure that the NURHI and MLE projects are able to answer the key programmatic learning and evaluation questions through collaborative data collection and analysis activities. We outline the various approaches used by the multiple partners to inform program design, program improvements, and overall program impact evaluation.

The document is organized in multiple parts including:

- a) Introduction that summarizes the key players and their collaborative partners;
- b) Program description and frameworks to clarify program goals, objectives, and activities;
- c) Program implementation plan that provides insights into how the NURHI program is being rolled out;
- d) Key questions to clarify the objectives of the monitoring and evaluation data collection strategies;
- e) Key indicators and data sources used to monitor and evaluate the program;
- f) Monitoring plan that lays out the approach to regular program monitoring of activities and costs;
- g) Evaluation plan that clarifies the overall MLE evaluation design as well as the operations research projects;
- h) Data quality plan to clarify how monitoring and evaluation data will be reviewed to assure high quality;
- i) Data use and dissemination plan to present activities to strengthen the use of the data by NURHI and government partners;
- j) Roles and responsibilities of key partners; and
- k) Timeline for the overall program and monitoring and evaluation activities.

In the section on Evaluation plan, we provide a summary of the activities underway in Nigeria and how these relate to the cross-country impact evaluation of the Urban Reproductive Health Initiative in Uttar Pradesh, India; Kenya, Senegal, and Nigeria.

The overall objective of the monitoring and evaluation plan is to provide evidence on the implementation and success of NURHI's approach, including that of specific interventions being tested under the Initiative, as well as to track progress and inform decision-making throughout the project's lifecycle.

1.1 Urban Reproductive Health Initiative

The Urban Reproductive Health Initiative (Urban RH Initiative) is the core country investment of the Foundation's Family Planning Strategy, which was launched in 2009. The goal of the Urban RH Initiative is to significantly increase modern contraceptive prevalence rates (CPR) in select urban areas in Uttar Pradesh India, Kenya, Nigeria and Senegal. This is to be accomplished through the implementation of robust supply and demand interventions that improve the quality of family planning (FP) services; integrate family planning into maternal and child health and HIV/AIDS services; increase contraceptive demand; increase the role of the private sector in the provision of contraceptives; and increase government commitment to FP. The Urban RH Initiative focuses particular attention on the urban poor. The Nigerian Urban Reproductive Health Initiative (NURHI) in six cities in Nigeria is being implemented by a consortium of partners being led by Johns Hopkins University Center for Communication Programs (JHU/CCP).

1.2 Key Players

Nigerian Urban Reproductive Health Initiative

NURHI is a consortium of four core partners supported by collaborating local partners and led by the Johns Hopkins University Center for Communication Programs (JHU/CCP). The other core partners are John Snow Inc., the Association for Reproductive and Family Health (ARFH), and the Center for Communication Programs Nigeria. Collaborating partners include the African Radio Drama Association (ARDA), Development Communications Network, IPAS, Health Reform Foundation of Nigeria (HERFON), and Advocacy Nigeria. In addition to serving as lead organization, JHU/CCP also leads the demand generation and advocacy agendas, while JSI leads the service delivery components in partnership with ARFH.

Center for Communication Programs: JHU/CCP envisions a world in which communication saves lives, improves health and enhances well-being. The Johns Hopkins Bloomberg School of Public Health, the oldest and top-ranked school of public health in the United States, established JHU/CCP in 1988 to focus attention on the central role of communication in health behavior change. JHU/CCP has a staff of approximately 400 professionals and active, large-scale programs in more than 30 countries. JHU/CCP manages numerous programs and grants in collaboration with a wide range of donors including USAID and other bi-lateral donors, UN agencies, private foundations, corporations, and non-governmental organizations such as UNICEF.

Association for Reproductive and Family Health: ARFH is a Nigerian non-governmental organization, established in 1989. Its vision of enhanced sexual and reproductive health and the rights of individuals and couples in Nigeria and elsewhere in Africa is the driving force behind ARFH's developmental and health programs. ARFH's philosophy rests on meeting the sexual and reproductive health needs of disadvantaged rural and urban communities through innovative, low cost quality interventions and efficient management. ARFH's mission is to initiate, promote, and implement in partnership with other organizations, developmental, HIV and AIDS, SRH and family planning programs and interventions for young people and adults. Through capacity building, technical assistance, operations research, and evaluation, ARFH works to improve the quality of life in Nigeria and elsewhere in Africa.

John Snow, Inc. (JSI) is a public health agency dedicated to providing high quality technical and managerial assistance to public health programs throughout the world. JSI is a recognized leader in a range of public health areas including family planning clinical service delivery, public-private partnerships, logistics support and contraceptive management. In Nigeria, JSI's DELIVER project works to establish effective and efficient supply chains for public health and family planning programs. Under the Enterprise Program, JSI worked closely with the commercial section of the US Embassy and developed a large portfolio of private sector partners in Nigeria, including several multinational firms, such as Lever Brothers, United Africa Company (UAC) and national and multinational oil companies. The Enterprise Program also worked with labor unions and in expanding the vision of Planned Parenthood Federation of Nigeria (PPFN) (the local International Planned Parenthood Federation affiliate) to include public-private partnerships.

Center for Communication Programs Nigeria (CCPN) focuses on the central role of communication to impact health behavior, providing leadership and technical guidance in the field of strategic health communication. With offices in Abuja and Kano, CCPN has robust institutional capacity and human resources to effectively improve public health in Nigeria. CCPN is well positioned in Nigeria to implement strategic communication programs with the government of Nigeria, international donors, funders and non-governmental organizations focusing on the central role of communication in health behavior change in relevant health areas.

Measurement, Learning & Evaluation project

The **Measurement, Learning and Evaluation (MLE) project** is implemented by the University of North Carolina's Carolina Population Center (CPC), in collaboration with the African Population and Health Research Center (APHRC) and the International Center for Research on Women (ICRW). This MLE Consortium includes experts in impact evaluation, urban population and health measurement and evaluation, capacity building, and knowledge translation.

The **Carolina Population Center** at the University of North Carolina at Chapel Hill is a premier research institution that has carried out numerous projects in the fields of population, FP, and health. CPC faculty, many of whom have appointments at the UNC School of Public Health, include noted experts in FP, RH, HIV and other infectious diseases, nutrition, maternal and child health, adolescent health, gender, health economics, and epidemiology. Through its leadership of the USAID-funded Evaluation project and

the MEASURE Evaluation I, II, and III projects, CPC/UNC has demonstrated its ability to develop, manage, and implement complex, multi-country projects to produce evaluation research findings that contribute to the global FP and RH fields (see www.cpc.unc.edu/measure for examples of this work). In these and other projects, CPC/UNC has collaborated with cooperating agencies and host country partners to develop evaluation methodologies and tools, collect and analyze data, build the capacity of host country institutions and individuals, develop and implement M&E systems, and disseminate and use evaluation results.

The **African Population and Health Research Center** is an international non-governmental, non-profit organization whose mission is to promote the well-being of Africans through policy-relevant research on key population and health issues affecting SSA. It brings together a multidisciplinary team of African scholars to take the lead in developing and implementing priority research programs and enhancing the use of research findings for policy formulation and program improvement in the region. APHRC's research focuses on four themes: 1) population dynamics and RH; 2) urbanization and well-being; 3) health challenges and systems; and 4) education. APHRC has a rich skills base and experience in designing and implementing large- and small-scale cross-sectional surveys, longitudinal studies, and qualitative studies in various African settings. APHRC's ground-breaking research related to urbanization and well-being as well as population dynamics and RH has played an important role in enhancing international awareness of the unique vulnerabilities faced by the rapidly growing poor population in African cities.

The **International Center for Research on Women (ICRW)** is a recognized leader in gender and development research and is uniquely qualified to provide technical assistance to the University of North Carolina and other partners in the implementation of this project in India. ICRW's mission is to empower women, advance gender equality and fight poverty in the developing world. ICRW is known for leveraging its research into policy recommendations for governments, international organizations and donor agencies. Additionally, the key group involved in this project is the Asia Regional Office (ARO) in New Delhi; this team is responsible for the research and evaluation activities in India. The ARO focuses their work on the needs of women in the region, works collaboratively with local and regional partners to conduct empirical research, build capacity and advocate for evidence-based, practical ways to change policies and programs.

The **Knowledge for Health Project (K4Health)** is managed by the Center for Communication Programs (CCP) at the Bloomberg School of Public Health at Johns Hopkins University. CCP has more than 30 years of proven knowledge management (KM) experience and is a recognized leader in the field of health communication, with extensive technical expertise and program experience in various communication areas. K4Health is a KM project that launched various pioneering Internet and mobile technology innovations and manages the IBP Knowledge Gateway. K4Health was asked to join the MLE project to collaborate on knowledge management and knowledge sharing efforts. Specific MLE activities for K4Health include establishing mechanisms to exchange information among country consortia, in-country M&E partners and MLE Team; identifying appropriate approaches to distribute MLE findings and methodologies that can be implemented through the MLE website, related listservs and through other technologies; developing products on relevant topics and using findings from MLE and others for

distribution at the national, regional, and global levels; creating a repository of knowledge about urban RH programs, lessons learned, and best practices that is easily accessible to the global community; and working with stakeholders at the regional and global levels to encourage use of data for decision-making including, but not limited to, using the MLE findings.

1.3 Monitoring and Evaluation Team

The core monitoring and evaluation team that will support the work under this Joint M&E Strategy includes key players from Nigeria Urban Reproductive Health Initiative (Moji Odeku, Project Director; Bola Kusemiju, Deputy Project Director; Saad Abdulmunin, M&E Advisor; Marc Boulay, Baltimore-based Research Advisor) and from the MLE project (Ilene Speizer, MLE Technical Deputy Director/co-Principal Investigator; Gwen Morgan, Research Scientist; Meghan Corroon, MLE Technical Officer; Akin Akiode, Country Manager).

1.4 Overview of M&E Plan

This Joint Monitoring and Evaluation Strategy provides a framework for measuring NURHI's progress towards the goals and objectives of the overall project. This plan details the various types and sources of data that will be collected and then used to evaluate measurable indicators that indicate progress towards the project's objectives and strategies. This Strategy is important for key decision making throughout project implementation and periodic review of project activities.

Throughout the process, data will be collected at multiple levels to inform program design, program improvements, and overall program impact. Figure 1, below, illustrates the multiple types of data that will be obtained throughout the project and illustrates a **Global Framework for NURHI Monitoring and Evaluation**. This figure depicts how the standardized periodic data collection and analysis for evaluation builds on, but differs from the local, ongoing program monitoring that all partners engage in, and will continue to engage in. The two activities serve fundamentally different but inter-connected purposes:

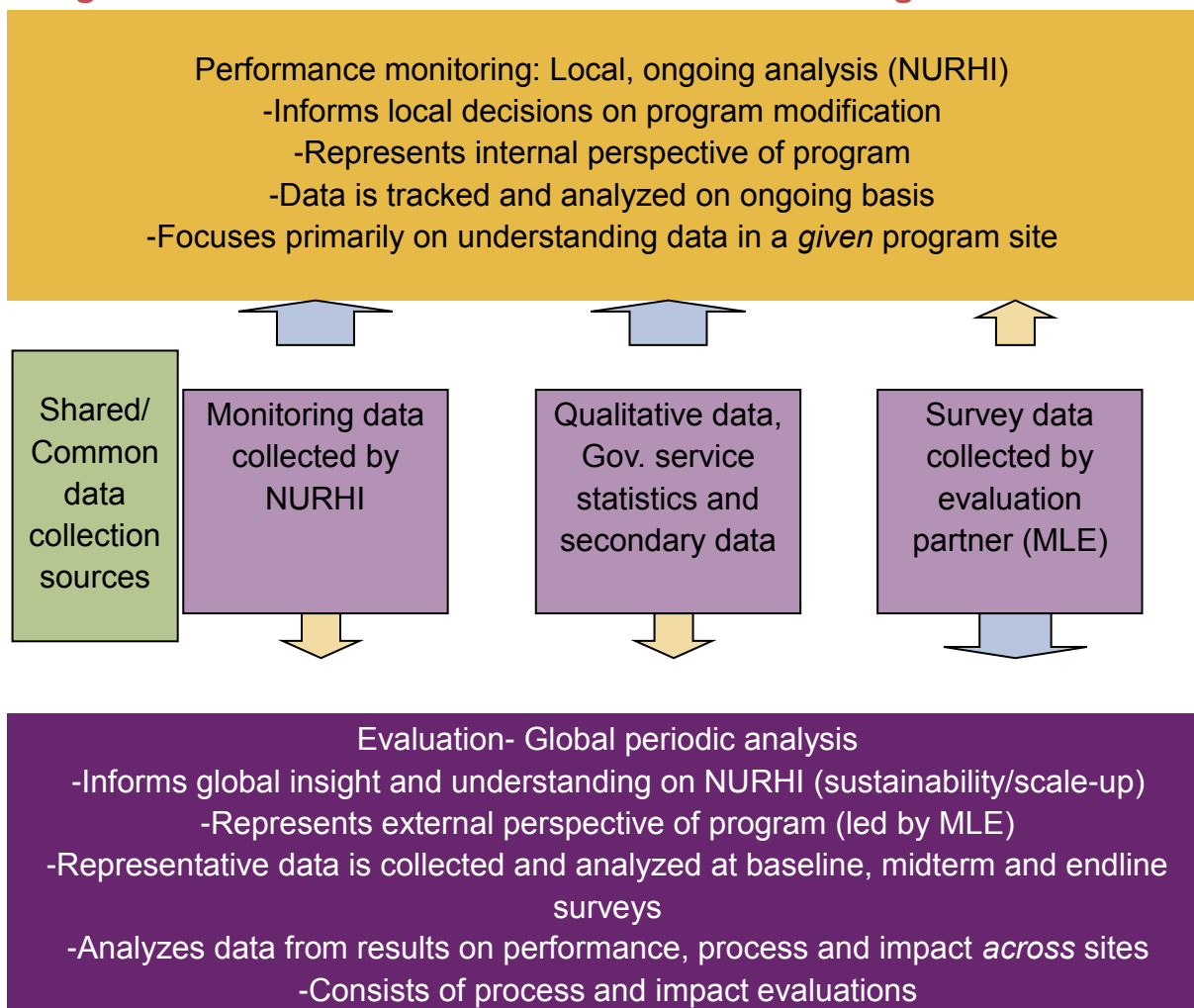
- The monitoring at the local level is to ensure that implementing partners—who know the program implementation best—can make adjustments and improvements on an ongoing and timely basis so as to ensure the delivery of high quality, effective interventions.
- The periodic outcome and impact evaluation, on the other hand, pulls key pieces of information from both the monitoring and evaluation processes, and includes a more detached and comprehensive review to ascertain emerging patterns in program delivery and results on a periodic basis. It answers the fundamental questions of whether the NURHI endeavor and its sub-parts are meeting the desired results.

The figure also emphasizes that rather than duplicating efforts, the global monitoring and evaluation process draws from all existing data formats and collection mechanisms:

- Performance monitoring is primarily informed by monitoring data collected by the implementing partner and the secondary data sources, supplemented by some data collected by the evaluation partner;
- Program evaluation is primarily informed by quantitative, representative survey data, supplemented by monitoring data, qualitative data, and secondary data sources.

Figure 1 also lays the foundation for an inclusive evaluation process that relies on **partnerships** in data generation and data use. It emphasizes the development of measures of program “success” that are relevant to all partners, relying on data that is most useful in the NURHI settings and across all partners. It emphasizes program evaluation as a practical and ongoing process that involves implementing partner program staff, vendor personnel, as well as evaluation experts. The roles of the partners in the collection and use of the various data sources are presented in Figure 1 and signified by the different sized arrows in the figure below (larger arrows indicate primary responsibility; smaller arrows indicate secondary roles).

Figure 1. Global Framework for NURHI Monitoring and Evaluation



1.5 Principles of the Monitoring and Evaluation Plan

The following principles will guide the implementation of this Joint M&E Strategy:

- 1) Participatory Approaches – Stakeholder participation is key to ensuring ownership of the monitoring and evaluation data and information. Consequently, NURHI and MLE will adopt approaches and tools that will allow for effective participation of stakeholders including beneficiaries in collection and review of monitoring data and information.
- 2) Timeliness and Relevance – NURHI and MLE will seek to provide and use relevant information about project progress, challenges, problems and lessons learned when it is most needed. Timeliness in receipt of data and information, as well as focusing on the most relevant information available, will be key to success of the strategy.
- 3) Feedback – NURHI will seek objective feedback from all stakeholders, gain perspectives on the interventions being carried out, put in place and operationalize mechanisms for learning lessons and applying them to improve project effectiveness and quality.
- 4) Simplicity- monitoring and evaluation data collection tools and processes will be made simple to minimize burden of reporting.
- 5) Use of available tools – As much as possible NURHI and MLE will seek to leverage on what is available and adapt these to suit the needs of the project. Thus existing government service statistics will form the basis of data collection tools where appropriate to avoid creating new systems and structures.

2.0 Program Description and Frameworks

2.1 NURHI Program Goals and Objectives

As part of the Bill and Melinda Gate Foundation Urban Reproductive Health Initiative, the overall goal of NURHI is to significantly increase the use of modern contraceptives among women and men in urban areas of Nigeria, particularly among the urban poor. Below, the specific project goal and objectives are presented.

Project Goal: Increase modern CPR in selected urban areas (by at least 20 percentage points).

Objectives:

1. Develop cost-effective interventions for integrating quality family planning with maternal and newborn health, HIV and AIDS, postpartum and post-abortion care programs.
2. Improve the quality of FP services for the urban poor with emphasis on high volume clinical settings.
3. Test novel public-private partnerships and innovative private-sector approaches to increase access to and use of family planning by the urban poor.

4. Develop interventions for creating demand for and sustaining use of contraceptives among marginalized urban populations
5. Increase funding and financial mechanisms and a supportive policy environment for ensuring access to family planning supplies and services for the urban poor.

2.2 Program Strategies and Activities

Strategic Approach

Our strategic approach to the project is based on the Gates Foundation hypothesis that, “if a choice of modern contraceptives is consistently available in urban settings to population groups...and if a social environment is created that supports and lowers barriers to contraceptive use, then contraceptive prevalence will increase and knowledge and practice will diffuse to rural areas.” **We further believe that as we create demand, demand will drive supply, ultimately leading to long-term sustainability that is market-driven.**

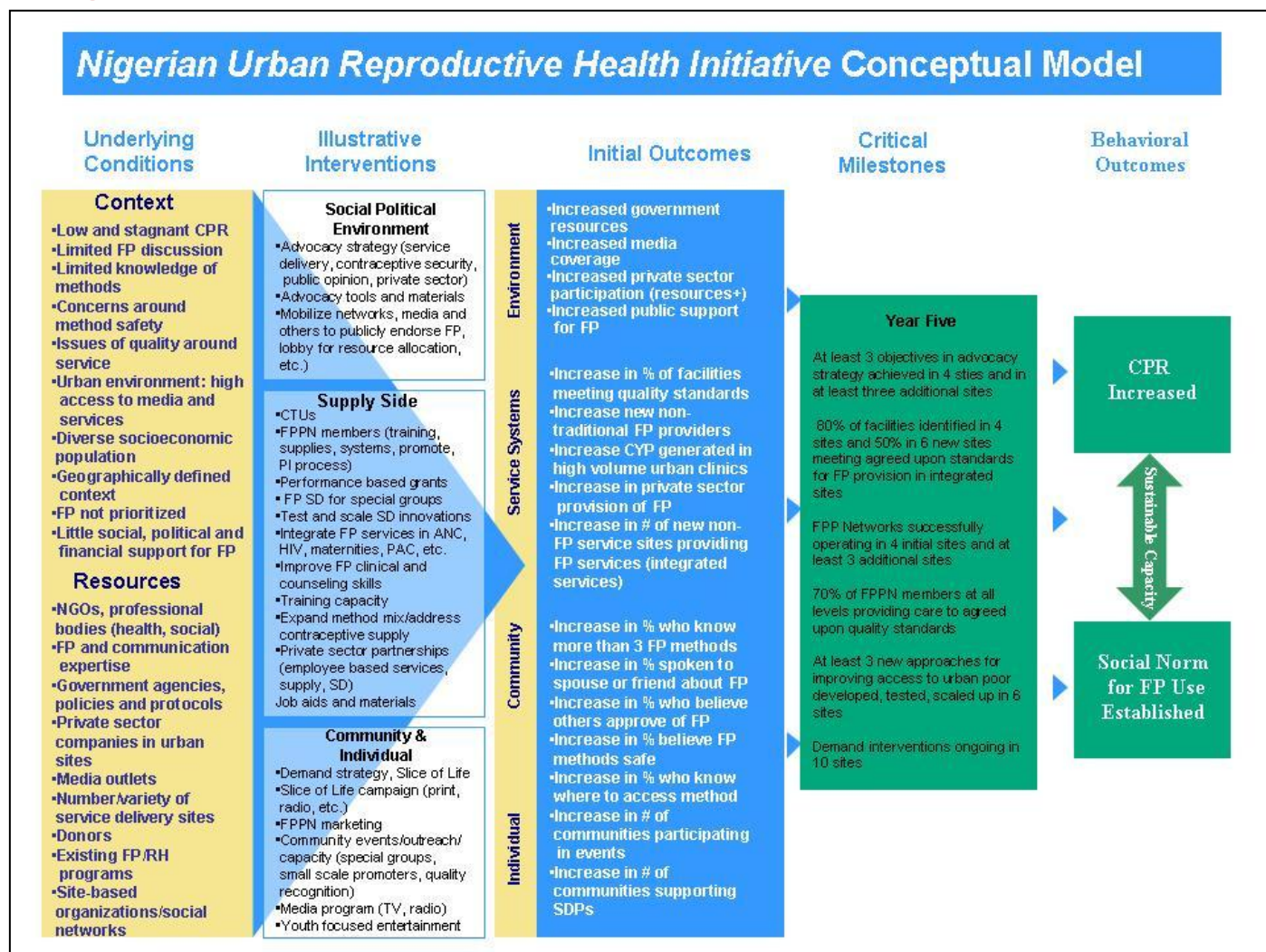
We will achieve this by:

- Creating demand through innovative, consumer-first campaigns and activities based on a socio-ecological approach and a focus on those in the 3rd, 4th and 5th socioeconomic status (SES) quintiles in urban areas
- Incentivizing the supply side, particularly the private sector, to improve quality and meet the demands of the urban poor by providing training, resources, and marketing support
- Linking supply and demand through a network approach
- Implementing advocacy efforts to increase commitment and sociopolitical support for family planning, particularly at the state and local government area (LGA) levels, and
- Testing, validating documenting, and replicating models for family planning integration, quality improvement and demand that effectively reach and respond to the needs of the urban poor.

Conceptual Model

Individuals do not live in a social vacuum—they live within and are deeply affected by (and in turn influence) a complex system of family and community dynamics, norms, and social structures that can act as barriers to, or facilitators of, healthy action. The environmental and structural characteristics facilitating or hindering FP use call for a strategically integrated response where interventions at one level (individual, community, service, or institutional) affect drivers at other levels. This response is described in the conceptual model (see Figure 2, next page). The model provides an overview of how context drives our approaches and activities. These interventions will result in initial outcomes, which in turn will contribute to achievement of our indicators of success. These indicators of success represent key points of progression towards our mutually reinforcing behavioral outcomes of favorable social norms towards family planning use and increased CPR, leading ultimately to improved health outcomes (decreased maternal, infant and child mortality).

Figure 2. NURHI Conceptual Model



Objective-Specific Activities

The project framework is centered on several specific activities under each objective. Over the course of five years NUHRI’s project strategy will focus around several key activities:

Objective 1: Develop cost-effective interventions for integrating quality family planning with maternal and newborn health, HIV and AIDS, postpartum and post-abortion care programs.

Objective 2: Improve the quality of FP services for the urban poor with emphasis on high volume clinical settings.

Activities 1 & 2

- Activity 1/2.1: Establish building blocks for quality improvement and integration (*Review quality standards, Identify High Volume Sites, Conduct Contraceptive Technology Updates*)

- Activity 1/2.2: Increase access to and delivery of FP methods and services in new clinical settings through provision of integrated services (*Clinical Capacity Assessments and Training of providers in the integration of services*)
- Activity 1/2.3: Strengthen systems and provider competence to deliver quality FP services (*Training of providers, performance-based grants*)
- Activity 1/2.4: Improve the availability of family planning products to ensure that contraceptive supplies meet growing demand (*performance improvement assessments*)

Objective 3:

Test novel public-private partnerships and innovative private-sector approaches to increase access to and use of family planning by the urban poor

Activities:

- Activity 3.1: Create, support and promote Family Planning Provider Networks (FPPN)(*Private sector branding strategy, Provider in-depth interviews, Development of FPPN organizational structure*)
- Activity 3.2: Optimize Planned Parenthood Foundation of Nigeria’s unique niche in supporting family planning outreach and services (*Branding and marketing of FPPN members to attract clients*)

Objective 4:

Develop interventions for creating demand for and sustaining use of contraceptives among marginalized urban populations.

Activities:

- Activity 4.1: Develop a powerful demand side communication strategy that reflects the web of relationships, networks, services, and businesses that impact family planning decision-making, to overcome individual and social barriers to use (*Secondary analysis of 2008 NDHS, FGDs and community mapping studies, Strategy Development*)
- Activity 4.2: Implement an integrated demand strategy using a combination of channels and media (*FP Ambassadors, Inventory of FP/RH BCC materials*)
- Activity 4.3: Develop engaging and interactive youth-focused activities to catalyze information exchange and dialogue around reproductive health choices and norms (*Develop youth-focused materials and activities with Youth Toolkit and Caravans*)
- Activity 4.4: Test Output-Based Aid (OBA) and other approaches to improve access and use by the very poor (*FGDs and community mapping among the very poor*)

Objective 5: Increase funding and financial mechanisms and a supportive policy environment for ensuring access to family planning supplies and services for the urban poor

Activities:

- Activity 5.1: Develop advocacy strategies to guide advocacy implementation at the national and local (site) levels (*Interviews with policymakers and stakeholders, Develop policy and advocacy strategy with Core Advocacy Groups*)
- Activity 5.2: Mobilize additional resources (budgetary and other) and policy support to improve family planning program quality and access for the urban poor (*Resource tracking for contraceptive security, Participate in policy meetings, training of state/LGA staff on budgeting*)
- Activity 5.3: Catalyze high level and visible support for family planning (Healthy Timing and Spacing of Pregnancy) in selected urban sites (*Mobilization of FP Champions, Build capacity among partners to conduct advocacy activities and develop advocacy tools*)

Intervention Sites

NURHI is being implemented in four first phase cities (Kaduna, Abuja, Ibadan and Ilorin) and two second phase cities (Zaria and Benin City). Cities were selected during the first year using an evidence-driven participatory process with staff and stakeholders. In these cities, NURHI is targeting the bottom three wealth quintiles, which all live on less than \$2 a day. To ensure access for the poorest of the poor, NURHI has a robust social mobilization initiative and will test interventions that reduce barriers to service access, such as cost, transportation, or knowledge.

2.3 Logic Model

Figure 3 presents the overall logic model of the NURHI program. This logic model is more specific to program implementation plans than the conceptual framework that also includes the context within which the programs will be implemented. Logic models are a useful tool for both program planning but also for designing monitoring, evaluation, and costing assessments. The logic model provides a clear picture of what the program will be doing and the expected outputs and outcomes from these various activities. The logic model is organized by the NURHI objectives, thus Objectives 1 and 2 are presented jointly.

Figure 3. Nigeria Urban Reproductive Health Initiative Logic Model

OBJECTIVES	ACTIVITIES		OUTPUTS	SHORT-TERM OUTCOMES	INTERMEDIATE-TERM OUTCOMES	LONG-TERM OUTCOMES
	DEVELOPMENT	IMPLEMENTATION				
1. Integrate FP into other health services	Review Quality Standards	Contraceptive Technology Updates	Increased support for FP services and service integration within the health system	Increased number of sites providing integrated services	<p><u>Coverage</u> Increased use of modern FP</p> <p><u>Quality</u> Increase in the percent of women using a modern method continuously for at least one year</p> <p><u>Private Sector</u> Increased use of private sector for modern FP, especially among the urban poor</p> <p><u>Demand</u> Increase in the percent of women reporting a stated need for FP</p> <p><u>Equity</u> Increased level of modern contraceptive use among the urban poor</p>	<p><u>Health</u> Reduced Total Fertility Rate</p> <p>Reduced Maternal Mortality</p> <p>Reduced Infant Mortality</p> <p>Reduced under-5 mortality</p> <p>Reduced child stunting and wasting</p>
2. Improve the quality of FP services	Identify High Volume Sites	Training of clinical and non-clinical providers in provision of modern FP including LAPM	Increased provider motivation and skills to provide FP counseling to clients seeking a variety of services	Increased couples-year protection based on improved method mix		
	Clinical Capacity Assessments	Provide performance-based grants to support innovative approaches to improve	Increased use of performance improvement approaches for FP service quality	Reduced number of facilities with stock outs		
	Training of Trainers					
	Performance Improvement Assessments					
3. Test novel public-private partnerships and innovative public sector approaches	Private Sector Strategy Branding plan	Development of Family Planning Provider Network (FPPN) organizational structure	Increased capacity of private-sector FP providers to provide appropriate modern FP methods	Increased number of methods available in private sector		
	Provider In-depth interviews	Branding and Marketing of FPPN members to attract clients	Increased linkage between public and private sector FP providers			
4. Create demand for, and sustain use of, contraceptives	Secondary Analysis of 2008 NDHS Baseline Survey FGD / Community mapping study Inventory of FP/RH BCC materials Strategy Development	Develop communication strategy with Media spots (print, TV, radio), Radio drama, FP Ambassadors and Community-based activities	Increased availability of messages promoting the use of modern contraceptives	Increased numbers of women and men exposed to messages from community and media sources		
		Develop youth-focused materials and activities with Youth Toolkit and Caravans	Increased access to FP messages among youth and urban poor	Increased numbers of youth exposed to FP messages		
5. Foster a supportive policy environment	Interviews with policy makers and stakeholders	Develop policy and advocacy strategy with Core Advocacy Groups, participation in policy meetings, development of policy briefs, training of State/LGA staff on budgeting, and mobilization of FP Champions	Increased visibility of family planning as a topic on national and local agenda	Increased number of FP supportive policies adopted in LGAs		
	Advocacy Strategy and Design Workshops	Build capacity among partners to conduct advocacy activities and develop advocacy tools	Increased support for FP programs among state and local leaders	Increased funding by LGAs for FP programs including modern and LAPM methods commodities and services		
	Resource tracking for contraceptive security					

3.0 Program Implementation Plan

NURHI is currently implementing in four cities: Kaduna, Abuja, Ibadan, and Ilorin. The project is led by the Project Director and Deputy Director based in Abuja, supported by a team of technical advisors responsible for strategic direction and technical guidance to site-based teams. The urban site-based teams fall into two categories: anchor sites and satellite sites. Anchor sites have a fuller complement of staff and office support, while the related satellite site have a lower staffing level, with technical staff in anchor sites supporting the needs of the anchor and satellite sites, drawing on consultants to complement their efforts. Expansion to the two new sites, Zaria and Benin City, in Year 4 will follow a similar pattern and will likely include at least one additional anchor office (to be determined).

The baseline phase of the project focused on data gathering, learning and developing program implementation networks. Following this preliminary phase, NURHI began program implementation during year 2 in its initial four implementing cities. Initial program implementation focuses on provider skills building, quality improvement, contraceptive supply and security, advocacy activities and an intensive demand generation campaign. NURHI collaborates with public and private sector providers in all its implementing cities. The final phase of the NURHI program will include accelerated scale-up of activities in the two expansion cities, focused support at service delivery points based on data and demand, and greater attention to promoting services for younger adults.

Collaborating partners and local NGOs/CBOs, based on their areas of expertise and strength, are tasked with implementation of specific activities at the city level, such as local advocacy, media engagement, logistics for the revolving drug fund, and social mobilization.

4.0 Key Questions

The Evaluation Team together developed key questions that influence the overall objectives of the monitoring and evaluation strategy for the NURHI Program. These key questions relate directly to the program's goals and objectives. They provide a perspective on the need for routine monitoring data as well as the baseline, midterm, and end-line evaluation data. The key questions are as follows:

1. ***Contraceptive prevalence rate - Has prevalence of modern family planning method use increased? Has there been a change in the modern method mix since the program began? Has prevalence increased among the urban poor?***

This question captures the effect of the NURHI program on the overall program goal, to increase modern contraceptive use. In Nigeria, at baseline, there is wide variability in prevalence of contraception and method mix across the program cities. These variations may reflect differences in demand (e.g., a lack of interest in long-term and permanent methods in more Muslim cities) or may

reflect access to methods (e.g., stock outs of injections and other methods in some or all cities). The program intends to address these city-specific differences by expanding method options (through improved contraceptive security as well as improved quality of services) in all cities and increasing demand for modern family planning. With improved access to and quality of family planning services, the expectation is that there will be increased modern method use and that this may also change the method mix. This question will examine these changes in use and method mix by city and among the urban poor.

2. ***Program exposure—What proportion of women (poor and non-poor) report exposure to the varying program strategies (e.g., FPPN members, media and radio and television spots, FP ambassadors, community-based activities)?***

It is pertinent to understand at midterm (and subsequently at end-line) the extent of program exposure in the intervention cities. If a large proportion of women and men report that they were exposed to media and community-based activities, it is expected that there will be a greater uptake of modern family planning use. Alternatively, if exposure (or memory of exposure) to media and other demand creation activities is low, this will indicate to the program that they need to modify their demand creation activities to increase outreach. Furthermore, the midterm evaluation will help to understand the extent of participation of Patent Medicine Vendors (PMV) in the Family Planning Provider Network (FPPN) including their training and distribution of program-related methods. This information is important for the NURHI program to know for identifying gaps in program implementation that can be addressed in the remaining program implementation years. Information on the FPPN will come from both the NURHI monitoring data as well as from the PMV survey that is led by MLE at midterm.

3. ***Public-private sector contribution - Is there an increase in the private sector share of FP distribution and what role is the FPPN playing in contraceptive provision for the urban poor?***

As with program exposure, this key question addresses the role of the private sector and the contribution of the FPPN in increasing exposure to family planning methods in the private sector. Currently, many women (and men) report that they receive their condoms and pills from PMV. Over time, with increased branding and training of FPPN members, the project will be able to determine if use of private sector FP methods increases. This will be assessed through both the household surveys (women and men) as well as the PMV audits at midterm and end-line.

4. ***Have the quality of services in high volume and integrated facilities improved?***

A key objective of the program is to improve the quality of services and to integrate family planning into the high volume service delivery sites. The program will be affecting service quality through various mechanisms including quality improvement standards, integration of long-term and permanent methods into existing health services, and improved access to a wide variety of methods to meet women's (and men's) family planning needs. At midterm, the facility audit, exit interviews in high volume facilities, and provider interviews will provide information on whether the service delivery

environment has changed and if the program is meeting its goals of improved quality of service delivery. In addition, monitoring data will provide information on program improvements including the extent of providers trained, use of job aids, and access and use of quality standards.

5. Effect of program exposure – What is the effect of exposure to program components or strategies on contraceptive attitudes, intentions, budgetary allocation, acceptance and use? To what extent do program elements have a combined effect on contraceptive use?

Using the end-line data, the project will examine the overall effect of exposure to the multiple program activities (including demand generation and supply-side) on overall contraceptive attitudes, intentions, acceptance, and use in the target cities. **The underlying hypothesis of the NURHI program is that demand will stimulate improved supply and quality of services.** This will be examined through observing changes in demand and the supply environment simultaneously and assessing how these changes are related to overall use. Monitoring data from the NURHI team will be used to identify differences in program implementation across the intervention sites; this information can be included in the analyses to identify distinctions by combination of efforts as well (e.g., if some sites put more emphasis on long-term and permanent methods, this can be accounted for in analyses). Moreover, using monitoring data from the NURHI team, it will be possible to determine if budget allocations at the state and national levels have changed because of the increased focus on these urban reproductive health initiatives in target cities.

6. Cost-effectiveness of program- Which project component(s) or strategies were more cost effective to achieving the project goal?

Using extensive costing information collected by the MLE and NURHI teams to determine the cost of the various program activities, the MLE team will undertake a cost-effectiveness analysis of program strategies. Notably, the analysis will only be done at the lowest level for which program costs can be disaggregated (and impacts can be measured). At a minimum, it is expected that cost effectiveness can be assessed for the varying demand generation activities (e.g., mass media separate from interpersonal communication), as well as for the Family Planning Provider Network and other supply side activities (e.g., improved quality of programs in high volume facilities). Costs for these activities will be related to the outcomes of the activities at the individual-level (particularly increases in modern contraceptive use).

5.0 Indicators and Data Sources

5.1 Indicator Table/Matrix

The indicator matrix (see Appendix 1) captures all activities, outputs, and outcomes from the logic model, organized by NURHI objective. The indicator matrix is organized by objective and logic model component. Details are provided in the indicator matrix on the data source (e.g., NURHI monitoring or MLE data) that will be used to measure each of the indicators presented. In addition, as appropriate, details are provided on when indicators will be disaggregated for better presentation of implementation differences across cities.

5.2 Data sources

The Nigerian Urban Reproductive Health Initiative is using six broad categories of data sources for program planning, program improvements, and program evaluation. These data sources include secondary data, Family Planning Effort Score and stakeholder engagement, formative data, operations research data, monitoring data and the MLE evaluation data. All of these data sources play a role in informing the NURHI strategy and/or measuring NURHI's progress towards the goals and objectives of the overall project. These data sources are described in more detail below.

Description of Secondary Data Sources

At the start of the project, the 2008 Demographic and Health Survey (DHS) was the main existing source of information related to contraceptive use and the determinants of use in Nigeria. Members of the NURHI research team conducted a secondary analysis of the urban subsample from these data to examine factors associated with both a stated need for family planning among all women and a met need for family planning among women with a desire to space or limit their childbearing. Three factors were associated with a desire to space or limit childbearing: having a smaller ideal family size; a woman's participation in household decisions; and greater knowledge of contraceptive methods. Two of these factors – having a smaller ideal family size and knowledge of contraceptive methods – were also associated with current use of a modern contraceptive method among women with a stated need for family planning. Women's participation in household decision-making was not associated with current method use among women with a stated need for family planning, while a preference for either sons or daughters was not associated with either a need for family planning or current use of a contraceptive method. These factors (having a smaller ideal family size; a woman's participation in household decisions; and greater knowledge of contraceptive methods) appeared to mediate the relationship between wealth quintiles, religion, and North-South residence. Women in upper two wealth quintiles were more likely to have smaller ideal family sizes, to participate in household decision-making, and to know more contraceptive methods. Muslim women living in northern Nigeria tended to have larger ideal family sizes, less participation in household decisions, and less knowledge of contraceptive methods than other women. Interestingly, Muslim women living in southern Nigeria were more like Christian women with respect to ideal family size, decision-making, and contraceptive knowledge.

Description of Futures Institute Family Planning Effort Score and Stakeholder Engagement

Government commitment to family planning will be measured using two methodologies, the Family Planning Effort (FPE) score and In-Depth Interviews. The FPE is a tool that is used to measure levels of government commitment to family planning. It has been used internationally in six rounds with 80 to 100 countries since 1982 with the results being used to establish family planning priorities, measure progress, identify program strengths and weaknesses, and strategically direct advocacy activities. In Nigeria the FPE was modified for city level use and implemented in the four initial project cities (Abuja, Ibadan, Ilorin, and Kaduna) in 2010. The respondents were experts in family planning who scored the government family planning program along seven main components: policies, services, record-keeping and evaluation, access and availability of family planning commodities, positive/negative influences on the family planning program, current justifications for the program, and program emphasis on population subgroups. In the four cities a total of 72 experts completed the questionnaire during the baseline survey. The FPE will be repeated in the middle of year 3 and the end of year 4 to assess changes. Stakeholder in-depth interviews will be used as supplemental qualitative information to assess changes in government support during the project. The first round of interviews was completed in 2010 with a total of 65 stakeholders from government ministries/agencies, NGOs, religious leaders, and community and market women were interviewed about their level of awareness about current government policies and priorities, opinions on links between family planning and development, preferences related to information and data sharing, and views on specific issues related to family planning. The survey will be repeated during the final year of the project to assess change.

Formative research studies

To help inform project activities, three interrelated qualitative studies were conducted during the first year of the project. First, a series of focus group discussions were held with women and men recruited from middle-class, poor, and very poor neighborhoods of Ibadan and Kaduna. These discussions used a variety of projective techniques including photo elicitation story completion methods. The project explored perceptions associated with desired family size, spousal communication and household decision-making related to fertility and contraception, and specific contraceptive methods. Key findings arising from these focus groups include:

- A strong association between perceived ability to support one's family and appropriate family size, although participants were more apt to recommend that others base family size decisions on their ability to support their family than to apply this criteria to their own household.
- Recognition among both women and men that husbands, while the ultimate decision-maker regarding contraceptive use, are reluctant to engage in conversations about contraception and wives are reluctant to initiate these conversations.
- A strong perception among all participants that many contraceptive methods have strong negative consequences for the health of the mother. While closely timed births were recognized as harmful, little harm was associated with having many children.

A second study used community mapping techniques to have men and women draw their community and identify the sources of family planning methods available in their community. As with the focus groups, these community maps were drawn by participants recruited from middle-class, poor, and very poor neighborhoods of Ibadan and Kaduna. Findings from the community mapping exercise include:

- The observation that men tended to have a more expansive and more detailed view of their community than women, possibly indicating that men are more mobile in their community
- Both men and women were aware of multiple sources of family planning methods in their community
- People in Kaduna were able to identify more sources of family planning than people in Ibadan.

A third study revisited the same neighborhoods included in the community mapping exercise to interview a sample of health providers identified in the community maps. The purpose of these interviews was to assess the availability and quality of services provided by these sources. Key findings include:

- Providers are quite knowledgeable about the health benefits of contraceptive methods
- However, these providers are reluctant to serve youth and unmarried adults and many require spousal consent before they will provide a method
- They also see promotion, awareness creation and education as an exclusively governmental function.

Operations Research

Two operations research activities are currently planned. One study will focus on the Family Planning Provider Networks (FPPN) in each city. This study will seek to interview all members of the FPPN at their annual meetings to assess improvements in their knowledge, attitudes, and practices over time. In addition, we will measure the personal and professional linkages among these members to assess whether participation in the FPPN strengthens these linkages and whether these linkages facilitate the diffusion of favorable information related to family planning throughout the network. The first wave of this study will be implemented in early year 3, with subsequent waves in successive years.

The second planned operations research activity, planned for the spring of 2012, intends to map out the socio-metric networks of men and women living in a small number of communities in the project cities. By measuring the direct and indirect linkages among community residents, this study will provide detailed information on the extent to which family planning messages diffuse through these communities and the role that program activities may play in fostering this diffusion.

Additional operations research studies will be developed through joint discussions among study partners.

Description of Monitoring Databases

Data collection tools

The existing National Health Management Information System (NHMIS) data collection tools, for example, registers and summary forms tools were extensively reviewed and modified to incorporate some important data collection needs, especially on family planning (FP) integration, an aspect not captured by the NHMIS tools. The modified tools include health facility daily FP register, health facility daily Ante Natal Care (ANC) register and clinical referral form. Additionally, new tools were developed including Reproductive Health/Family Planning (RH/FP) integration summary form, non-clinical service utilization tally form, non-clinical referral forms, and health facility daily Post Abortion Care –Family Planning (PAC-FP) integration register and commodities logistic data tool. The tools are deployed to the service delivery points to collect service utilization data. All the modified and newly developed tools were presented to and approved by the Federal Ministry Health, HMIS Unit. The service providers, LGA M&E officers, record officers, and state M&E and HMIS officers, were trained by NURHI in all the NURHI supported cities (except Abuja) in June and July 2011 on the use of the tools. The service providers and the record officers will be responsible for completing these tools at the facility level monthly, while the LGA, State M&E and HMIS officers, as well as the NURHI state M&E and HSS/QI officers, will support and mentor the service providers on the data collection. To promote best practices and uphold data quality, NURHI team in collaboration with Government officials will conduct a quarterly data quality assurance visit.

The activity report form, milestone report forms and training form (attendance register) were developed to capture all NURHI supported activities such as trainings, workshops, meetings and other related activities. These forms are to be completed once an activity is conducted by the NURHI state team anchoring the activity and reviewed by the technical advisor responsible for the activity.

Databases

To store and keep track of all activities in the project, a number of excel-based databases were developed. The city level M&E officers will aggregate data for review monthly with support from the M&E Advisor at the respective cities, while the M&E advisor will aggregate data at the central level.

Service Delivery Database - The database was tailored to keep track of the number of clients reached with family planning services such as counseling, referrals, new acceptors and revisits for each method from the high volume sites disaggregated by service delivery point (FP clinic and integration points).

Activity Database – Participant related information (qualification, profession, contact details) by type of activity such as training, workshop or meetings is captured in the database. Other relevant information including objective of the event, venue, number of days and date of the event are recorded. The information is collected at the city level by the NURHI program assistant and passed to the city level M&E office for entry into the database.

Media Database - The database was designed to monitor all family planning related publications/broadcast in the country, with emphasis on NURHI supported media activities. The NURHI

M&E officers populate the database with information provided to them by the NURHI BCC officers, collaborators and independent media monitors on a monthly basis. Overall, the database keeps track of date of report, topic, media type, source, page number/time of broadcast, author/reporter, author/reporter's phone and email, person interviewed and designation of person interviewed.

Contraceptive Logistic Management System (CLMS) Database - Data that will ensure consistent commodity availability at all times will be tracked in this database. The database captures data on beginning balance, quantities of commodities received during the month, consumption, losses/adjustments and stock on hand, lead time for requisition made, stock-outs, and minimum and maximum quantities available in a facility. The QI/HSS Officers will submit the data electronically on a monthly basis from the NURHI supported high volume site, while the logistics officer maintains the database.

Description of MLE Data Sources

1. **Individual-Level Household Surveys:** The MLE project conducted confidential survey interviews with women and men of reproductive age from October, 2010 – March, 2011. A representative sample of households, women, and men provided their basic demographic characteristics (such as age, ethnicity, family structure, and migration practices), their experience with family planning methods, their awareness of family planning messages, and their fertility desires. In addition, respondents reported on their current health care experiences, including how they pay for health care and when and where they seek care for themselves and their children. At baseline, the women's survey also collected information on how to locate these women at midterm and end-line for follow-up surveys. This will permit an examination of how fertility desires and family planning behaviors change over time with increasing program activities and exposure.
2. **Service Delivery Point Surveys:** In 2011, MLE researchers collected data at a wide range of public and private service delivery points (SDP), including hospitals, health centers, clinics, and doctor's offices. In each facility, we undertook a facility audit and provider interview(s). Facility audits obtained information on the services that are provided at each location and the availability of family planning methods and prescription requirements. Interviews with health care providers in study facilities identified providers' training, standard operating procedures with clients, and referral mechanisms. In those facilities that were of higher volume, as identified by the NURHI program, client exit interviews were undertaken to identify women's reasons for their family planning or maternal or child health visit, the types of services received, counseling practices, and general perceptions of quality of care. In addition, a pharmacy audit was undertaken in about 100 pharmacies in each study city and a brief audit was undertaken with about 100 patent medicine vendors (PMV) in each city.

6.0 Monitoring Plan

The central project office in Abuja will serve as the primary repository for the monitoring data collected in the sources listed above. Activity level monitoring at the regional level will be reported electronically to the central level on a monthly basis, while service statistic data will be reported quarterly. The M&E Advisor based in Abuja will maintain the central database for tracking and reporting on all monitoring indicators.

The M&E advisor will provide a monthly update on activity-level indicators and a quarterly update on service indicators to project leadership to inform timely management decision-making. Data on these indicators will be reported to the foundation on an annual basis.

7.0 Evaluation Plan/Design

In order to evaluate the impact of the Urban RH Initiative interventions, the Gates Foundation concurrently initiated the Measurement, Learning & Evaluation (MLE) Project, an independent evaluation team that will conduct an impact assessment of the four country Urban RH Initiative programs. A key objective of the MLE project is to undertake a rigorous impact evaluation of the country programs, identifying the most effective and cost-efficient programmatic approaches to improving contraceptive use among the urban poor. Specifically, the MLE project will evaluate the success of both *demand-side* Urban RH Initiative interventions (those that increase the desire for family planning services) and *supply-side* interventions (those that increase the quality of and access to family planning services) through data collection at both the individual level and from service delivery points. The MLE project will also undertake a cost-effectiveness analysis of specific programmatic approaches, where feasible.

The MLE project evaluation comprises three design elements that allow researchers to measure programmatic impact across cities, over time, and among the urban poor and non-poor.

Impact Across Cities. The MLE project will take advantage of the delayed implementation of programmatic activities in some cities to develop a *quasi-experimental* design. Researchers will evaluate four NURHI-targeted cities (Abuja, Ilorin, Ibadan, Kaduna) that will receive immediate interventions and two cities (Benin City and Zaria) that will serve as comparison cities, as they will be delayed in receiving NURHI interventions. An assessment of these cities with the original set of intervention cities will add variation that will provide more precise measures of program impact.

The project will use a quasi-experimental design in which data collection will commence simultaneously in four intervention and two comparison cities. Two types of data will be collected in all cities: individual-level household data on women and men, and service delivery point data. A standard set of instruments and indicators have been developed for use at the individual, household, and facility levels

which were reviewed by the NURHI country team and adapted to the local context. We also describe our hybrid study design that has both longitudinal and cross sectional components. In this section, we focus on the longitudinal survey and describe tracking procedures designed to minimize sample attrition.

Impact Over Time. The MLE project will use a combination of repeated cross-sectional data (surveying a new representative sample of respondents at multiple points in time) and longitudinal data (surveying the same respondents at multiple points in time) in a *hybrid study design*. This hybrid approach maximizes the strengths of both types of data; rigorous cross-sectional surveys provide the attitudes and behaviors of a representative sample of the cities' population at a given point in time, while longitudinal data measure the causal impact of program components on outcomes of interest. In particular, by including the same women over time, we can examine women's exposure to the program and how this relates to changes in her actual contraceptive use behaviors, controlling for her baseline fertility and family planning experiences. The project will also collect longitudinal data from a sample of health and family planning facilities that provide services to women and men – service delivery points (SDPs) – and examine access to and quality of family planning services at these facilities over the study period.

Impact Among the Urban Poor. To identify the impact of NURHI interventions among the urban poor, the MLE project will structure the sampling of respondents to identify programmatic outcomes among both slum and non-slum populations. In Nigeria, the sample frame was based on the recent census sampling units. A representative sample of sampling units from each city was selected to permit an examination of the fertility and family planning characteristics at the city level. Information on household assets as well as information on household consumption will be used to classify residents of the cities as poor (e.g., lowest two wealth quintiles or having less than two-dollars a day consumption) and non-poor.

Hybrid Study Design

Cross-Sectional Data. The MLE project will conduct cross-sectional surveys with women at two points in time – at baseline prior to the implementation of the NURHI programs and at end-line of the interventions, four years later. These data will allow the MLE team to determine if the overall contraceptive prevalence rate changes significantly in cities during this period. The MLE team will also collect cross-sectional surveys with men in intervention cities at baseline and end-line of the project to measure men's contraceptive attitudes and behaviors, gender attitudes, and identify any changes in men's perspectives over time. Because these surveys are cross-sectional, baseline and end-line respondents will differ and it will not be possible to attribute changes in knowledge, attitudes, and behaviors directly to program exposure at the individual level.

Cross-sectional data collection requires that researchers use an updated sampling frame to randomly select respondents at each survey round. A sampling frame is a snapshot of the entire population of a study area, in this case, each city, at a given point in time. With an accurate sampling frame, every adult in each city has the same chance of random selection into the study. Because urban populations are

quite dynamic – urban migration can change the characteristics of cities quite rapidly – MLE researchers will identify, to the extent possible, updated sampling frames for use at end-line. By randomly selecting respondents from these sampling frames, each cross-sectional survey will represent the entire population of men or women living in each city at the time of the survey. Thus, the MLE team will assess men’s family planning attitudes and behaviors at two points in time and the contraceptive prevalence rate of each city (calculated from the women’s cross-sectional surveys) at baseline and end-line of the study.

Longitudinal Data. The MLE project will also collect longitudinal data from the same women and SDPs over time. Field workers collected baseline data in 2010/2011 with women and SDPs; follow-up data with the same women and SDPs will be collected at midterm and endline. Because longitudinal data permit researchers to measure change over time, this study component will allow the MLE project to identify the causal impact of the NURHI family planning interventions on women’s family planning attitudes and behaviors and also determine if NURHI intervention activities improve the quality of family planning services in urban areas.

To maximize the significant resources required to collect both cross-sectional and longitudinal data, the women who are randomly selected as respondents to the baseline cross-sectional survey will become the participants in the longitudinal study. These women will receive follow-up surveys at midterm and end-line. Dovetailing the cross-sectional and longitudinal data collection conserves project resources and ensures that the longitudinal surveys with women represent the larger population of study cities at baseline (as researchers will randomly select these women from a current sampling frame).

One of the challenges of collecting longitudinal data is respondent attrition. Over time, individuals may move households or migrate to other cities or regions, limiting the ability of researchers to conduct follow-up surveys. To mitigate this, MLE researchers collected detailed tracking information for each woman in the longitudinal survey. This information included addresses and cell phone numbers for the respondent, as well as the names and contact information for her household members, community leaders, landlords, and friends. If a respondent changes residence before a follow-up survey, the MLE team will use this detailed tracking information to locate the respondent and determine the feasibility of conducting follow-up surveys at her new location.

The longitudinal component of the hybrid study design also includes data collection from a wide range of public and private SDPs. At baseline, MLE researchers will randomly select health care providers offering family planning services, pharmacies, and patent medicine vendors (PMV) that offer contraceptives within each study city. Additionally, the sample will include SDPs that respondents identify in the baseline survey as their preferred location for family planning services. Field workers will conduct follow-up surveys with the same SDPs at midterm and end-line. To track the location of the facilities, researchers will note the GPS coordinate of each SDP during the baseline survey and use this information to easily identify the same facilities upon return visits.

Program Cost Analysis. Impact evaluations also provide an opportunity to determine the cost-effectiveness of different programmatic approaches to ensure that scarce resources are used most efficiently. To conduct these cost analyses, the MLE project will collect detailed information on program costs (including financial contributions and in-kind expenses) over the course of the project. Where possible, this information will contribute to an impact analysis that captures the cost of individual interventions.

8.0 Data Quality Plan

High quality data is paramount in providing progress reports that will offer program managers and decision makers a concise and accurate reflection of whether NURHI programs are 'succeeding.' Attention to data quality ensures that target setting and results reporting are informed by valid and sensitive information. In this way, attention to data quality leads to improved program performance and to more efficient resource management. The NURHI M&E team led by the M&E Advisor will be conducting routine data quality assessment and data verification exercises in all NURHI supported high volume sites to reconcile records in the NURHI service delivery database. The exercise will be carried out in collaboration with Government officials quarterly. The aim of the exercise is to verify data reported in the areas of family planning service provision in order to ascertain its consistency with the source documents at the facilities. The exercise would be conducted using a structured checklist that assesses data availability, consistency and validity.

- *Data Availability*– Availability is the most fundamental data quality issue, and refers primarily to gaps in data. If fields are missing or records cannot be located, then it is difficult to ascertain whether required services have or have not been delivered, gaps in data limit the ability to conduct analysis, can result in client and commodity mismanagement and under-reporting of results.
- *Data Consistency* – Consistency deals with a higher level of error - the transference of data from one record or data collection tool to another. For all service delivery point activities, there is a flow of patient/client data between service points and data collection tools, either for aggregation or patient/client management purposes. This requires careful attention on behalf of health care providers or medical records staff in the transcription of data from one form to another. During a rapid assessment it is not possible to review all possible sources of inconsistency. Therefore, a random selection of a specified number of client Identification Numbers from the respective register(s) will be reviewed to give some insight into quality standards at each facility.
- *Data Validity* –Validity in this context deals with simple calculation errors, or failing to correctly sum data from registers and lower-level data entry tools into monthly summary forms and the reports sent to the next level on the dataflow. The monthly summary forms are the main source

of data used to assess progress in service provision, and feed into NURHI databases and reports. It is not feasible to assess all possible errors, so emphasis will be focused on verifying a selection of the most important indicators.

Updates following the Data verification exercises will be entered into the database system. Issues, recommendations and feedback arising from data verification exercises will be discussed with the NURHI city level team, facility managers, LGA and State M&E officers and other technical staff.

NURHI city level M&E officers will conduct monthly/bimonthly routine monitoring/mentoring visits to high volume sites to provide on-site technical assistance and supportive supervision of service providers and record officers. The objective of the visits is to further strengthen the understanding of the service providers on the use of M&E data collection and reporting tools. During the visits, registers and other records will be reviewed; problems encountered by the facility staff will be identified and addressed in a participatory manner.

To promote data use at the facility level, NURHI will run quarterly M&E meetings in all NURHI supported cities. These meetings will be chaired by the state government agencies (State M&E officer and FP coordinator). The meetings will serve as a forum where all representatives from the high volume sites will converge to discuss progress and challenges in a participatory manner. During these meetings the city-level M&E officers will present aggregated data showing the cumulative totals and trends on the key indicators from the previous quarter data, which will allow for feedback and follow-up on performance issues.

9.0 Information Dissemination and Utilization

NURHI believes information dissemination and utilization is critical to the success of the project as well as the sustainability of the project interventions. **NURHI expects that data and information generated from the various M&E activities will contribute towards the enhancement and strengthening of FP service delivery at all levels (facility, local government, Federal MOH (FMOH), State MOH (SMOH) and other ministries).** Likewise, improvements in quality of service delivery will reinforce the need for appropriate policy changes at the national levels. To facilitate the realization of this objective, NURHI will support multiple information dissemination and utilization strategies targeting various audiences at state and city levels as well as at the national level.

9.1 Key Audiences & Dissemination Strategies

Audience	Data to be disseminated and utilized	Dissemination strategies
Facility and Community Level Audience		
FPPN Members	<ul style="list-style-type: none"> • Feedback on their reports • FPPN Study • Project achievements • Highlights of city and national surveys 	<ul style="list-style-type: none"> • Quarterly meetings
Public and Private Sector Service Delivery Points	<ul style="list-style-type: none"> • Routine Data- FP Acceptors, FP integration, Quality of FP/RH Service; FP Referrals • Stock data – Stock outs, Consumption and forecasting • Highlights of city and national surveys • Lessons Learned and Best Practices in FP 	<ul style="list-style-type: none"> • Quarterly review meetings with SDP Teams • Data Quality Meetings
City Level Audiences		
SMOH, Ministry of Local Government / Local Government Health Management teams / Religious & Traditional Leaders	<ul style="list-style-type: none"> • Baseline, Midterm and End of Project Evaluation Findings • Routine Data- FP Acceptors, FP integration, Quality of FP/RH Service; FP Referrals • Stock data – Stock outs, Consumption and forecasting • FPPN Study • Community Network Study • Highlights of city and national surveys • Lessons Learned and Best Practices 	<ul style="list-style-type: none"> • Quarterly Review Meetings • NURHI Website • Ad hoc problem solving meetings
FP/RH stakeholders at City levels	<ul style="list-style-type: none"> • Highlights of city and national surveys • FPPN Study • Community Network Study • Summary trends from routine reports • Lessons Learned and Best practices on FP 	<ul style="list-style-type: none"> • Quarterly Stakeholder forums • Project update meetings • NURHI Website • Advocacy forums

National Level Audiences		
NURHI consortium	<ul style="list-style-type: none"> • Formative, Baseline, Midterm and End of Project Evaluation Findings • FPPN Study & Community Network Study • Routine Data- FP Acceptors, FP integration, Quality of FP/RH Service; FP Referrals • Stock data – Stock outs, Consumption and forecasting • Project updates 	<ul style="list-style-type: none"> • NURHI website • Routine Partner meetings • Technical Working Group meetings • Project review meetings • Annual planning meetings
FMOH- Reproductive Health Division (Family Health Department), Department of Planning and Research	<ul style="list-style-type: none"> • Baseline Findings on FP/RH • Routine Data- FP Acceptors, FP integration, Quality of FP/RH Service; FP referrals • Lessons Learned and Best Practices on FP • Stock data – Stock outs, Consumption and forecasting • Proof of concept results 	<ul style="list-style-type: none"> • Technical Working Group meetings on FP/RH
National Bureau of Statistics; Office of the President; Ministry of Planning, National Primary Health Care Development Agency, National Health Insurance Scheme (NHIS)	<ul style="list-style-type: none"> • Baseline Findings on FP/RH • Project updates • National policies that have been updated to include FP provisions for the urban poor 	<ul style="list-style-type: none"> • Meetings with the Ministries • Advocacy tools- pamphlets, brochures etc. • Advocacy meetings with targeted policy makers
Donor Agencies supporting FP/RH activities	<ul style="list-style-type: none"> • Baseline Findings on FP/RH • Routine Data- FP Acceptors, FP integration, Quality of FP/RH Service; FP Referrals • Stock data – Stock outs, Consumption and forecasting 	<ul style="list-style-type: none"> • Annual bilateral meetings between NURHI and targeted donors. • Donor Round table meetings • Internet (NURHI website, email)
Other International organizations involved in FP/RH activities	<ul style="list-style-type: none"> • Lessons Learnt and Best Practices on FP • Proof of concept results 	<ul style="list-style-type: none"> • Interagency review meetings • Internet (NURHI website, email)
External Audience/Out of Country		
Gates Foundation	<ul style="list-style-type: none"> • Project updates 	<ul style="list-style-type: none"> • Periodic project review meetings
MLE	<ul style="list-style-type: none"> • Project updates • Selected monitoring data 	<ul style="list-style-type: none"> • Periodic project review meetings
International Community	<ul style="list-style-type: none"> • All study reports from project data 	<ul style="list-style-type: none"> • International conferences • NURHI Website

9.2 Dissemination and Utilization of Results

To ensure maximum comprehension and use of data in project programming and communication, NURHI will host data use workshops following the baseline and formative research and midterm surveys. These workshops will contain a presentation of the findings, followed by group discussions on the implications of the findings. The output of these discussions will be 1) recommendations for programs and 2) questions for further exploration. NURHI teams will explore data by city and by program component. NURHI will document the recommendations and questions identified and use them to direct future programming and dissemination to a wider audience.

Local level information dissemination and utilization interventions will mainly relate to feedback of local survey data and service statistics to influence appropriate changes at the local government to support access to FP services and within the health facility to improve service delivery. These activities will be undertaken by NURHI partners implementing health facility-related interventions. State and national level dissemination efforts will be integrated within a broader advocacy strategy that will be spearheaded by the FMOH RH division, but with the participation of all NURHI partners. Under this approach, advocacy forums will disseminate the results of project evaluations (surveys, cost effective studies and proof of concept studies) as well as trends in FP acceptance that can be attributed to project activities. NURHI will support translating information into target specific advocacy products on behalf of all RH partners that can be disseminated on a routine basis. Ultimately, this activity will also contribute towards enhanced visibility of NURHI.

10.0 Roles and Responsibilities

This M&E plan involves the participation of personnel from within NURHI, the collaboration of various national stakeholders and support from the broader Urban RH Initiative consortium, including MLE and the Futures Institute as well as other Urban RH Initiative country implementing teams.

10.1 Project implementers

NURHI national office and city-based technical personnel will play a critical role in the execution of this M&E plan. The table below gives highlights of the specific roles envisaged for each category of personnel:

Project Implementer	Roles and Responsibilities
City Based Technical Personnel: Service delivery officers; Quality Assurance officers; Communication officers; etc.	<ol style="list-style-type: none"> 1. Organize and coordinate the project/periodic review meetings with facilities, FPPN members and other city level stakeholders 2. Organize feedback meetings on data and other information generated by NURHI with stakeholders at facility, district and city levels 3. Review data collection tools 4. Provide inputs on project reports (case studies, best practices, lessons learned) 5. Collection of data at facility and community levels
NURHI State Team Leaders	<ol style="list-style-type: none"> 1. Overall coordination of the city level project review activities and consultative meetings with various stakeholders to share NURHI data 2. Ensure data entry and editing of routine NURHI data 3. Monitor city level achievements
NURHI Monitoring and Evaluation Team	<ol style="list-style-type: none"> 1. Design of the M&E system 2. Design, adapt and finalize of data collection tools and guidelines 3. Establish and manage databases 4. Facilitate data interpretation and use workshops 5. Coordinate support for monitoring visits, DQAs, data review meetings, provision of equipment 6. Coordinate NURHI input to MLE evaluation surveys and studies 7. Lead design of proof of concept studies and assist as requested in study activities 8. Provide M&E input for all NURHI reports

Project Implementer	Roles and Responsibilities
NURHI Technical Advisors – Service Delivery, Quality Assurance, Private Sector, Logistics, Advocacy and Communication	<ol style="list-style-type: none"> 1. Technical inputs on the M&E system and data collection tools 2. Review and interpretation of M&E data 3. Ensure dissemination and utilization of data findings 4. Technical support to field teams in conducting project and periodic review meetings on M&E data 5. Technical inputs in the design of OR activities

10.2 Implementing partners

Partner	Roles
JHU/CCP	<ol style="list-style-type: none"> 1. Overall coordination and technical support in the execution of the M&E plan 2. Lead/Participate in project review meetings with FMOH and SMOH 3. Manage all NURHI databases 4. Provide M&E input on all reports and dissemination of results 5. Prepare audience specific advocacy products 6. Provide guidance on proof of concept studies and other operations research 7. Lead coordination with MLE on Baseline, Midterm and End-line evaluation surveys 8. Monitor all NURHI achievements
JSI	<ol style="list-style-type: none"> 1. Supervise collection, review data, and ensure entry of routine data from service delivery points 2. Supervise collection, review data, and ensure entry of CLMS data 3. Prepare reports on results for dissemination 4. Monitor achievements of JSI activities
ARFH	<ol style="list-style-type: none"> 1. Supervise collection, review data, and ensure entry of quality assurance data from service delivery points 2. Supervise collection, review data, and ensure entry of training data 3. Prepare reports on results for dissemination 4. Monitor achievements of ARFH activities
CCPN	<ol style="list-style-type: none"> 1. Supervise collection, review data, and ensure entry of routine data from communication activities 2. Coordinate monitoring and evaluation of mass media and community campaigns 3. Prepare reports on communication activities and results for dissemination 4. Monitor achievements of CCPN activities

10.3 MLE

MLE will play a substantial role in the execution of the M&E strategy. More specifically, MLE will be responsible for the overall technical backstopping of the NURHI Baseline Surveys. For the midterm and end-line evaluations, it will assume full responsibility as an external party contracted to assess the impact of the Urban RH Initiative globally. In addition, MLE will provide technical support for the design and execution of the proof of concept and diffusion studies, as and when requested by NURHI.

11.0 Timeline

Activity/Data source	2009				2010				2011				2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PMP											PMP																	
Program implementation*									Program implementation → Scale - up												Close out							
MLE data collection							Baseline								Midterm								Endline					
Analysis of DHS data																												
Formative Studies																												
FPPN Study											OR	OR			OR	OR							OR	OR				
Community Network Study															OR	OR												
Additional OR studies																			OR	OR								
Monitoring data - databases***																												
Service delivery									X				X				X				X							
Activity									X				X				X				X							
Media									X				X				X				X							
CLMS									X				X				X				X							

*The timeline for program implementation and close-out assumes that NURHI is granted a 15 month extension

***Monitoring data collection is ongoing, though consolidation of data occurs once annually and is indicated by an "X"

Appendix 1. Nigeria Urban Reproductive Health Initiative Indicator Matrix

Objective	Logic Model Component	Indicator	Data Source	Frequency	Target (for those indicators with targets)	Comments
<i>Objectives 1 and 2 –Integrate FP into other Health Services and Improve the quality of FP Services</i>						
		<i>Outputs:</i>				
	Increased support for FP services and service integration within the health system	Number of CTUs conducted, by audience	Training database	Annually		Audiences include: stakeholders, clinical providers and non-clinical providers
	Increased provider motivation and skills to provide FP counseling to clients seeking a variety of services	Number of providers trained, by type of training and type of provider	Training database	Annually		Training types include: IPCC skills, integrating FP into other MCH services, LAMP, and On-the-Job (OJT) training approaches.
	Increased use of performance improvement approaches for FP service quality	Number of performance-based grants awarded	Facility database	Annually		

		<i>Short-term Outcomes</i>				
	Increased number of sites providing integrated services	Percent of targeted high volume clinics that provide integrated family planning services	MLE data	Biennial Baseline, mid-term, end-line		
	Increased couples-year protection based on improved method mix	Couples-year protection	Service registers at High Volume Sites	Annual		
	Reduced number of facilities with stock outs	Percent of project supported high volume facilities with stock-outs of contraceptive method	MLE data	Biennial Baseline, mid-term, end-line		
<i>Objectives 3 –Test novel public-private partnerships and innovative public sector approaches</i>						
		<i>Outputs</i>				
	Increased capacity of private-sector providers to provide appropriate modern FP methods	Number of private sector clinical providers trained in FP service provision	Training database	Annual		

	Increased linkage between public and private sector FP providers	Number of service providers enrolled in FPPN	FPPN Records	Annual		data will be disaggregated by public/private service providers
		<i>Short-term Outcomes</i>				
	Increased number of methods available in private sector	Percent of private sector facilities (including FPPN members) that offer two or more modern family planning methods	MLE data	Biennial Baseline, mid-term, end-line		Can measure this two ways – as whether they generally sell, and if they currently have the method in stock.
<i>Objectives 4 – Create demand for and sustain use of contraception</i>						
		<i>Outputs</i>				
	Increased availability of messages promoting the use of modern contraceptives	Number of materials developed and produced to stimulate demand for FP, by type of material	Materials Inventory	Annual		
	Increased access to FP messages among youth and urban poor	Number of youth-oriented materials developed and produced	Materials Inventory	Annual		

		<i>Short-term outcomes</i>				
	Increased number of women and men exposed to messages from community and media sources	Percent of men and women exposed to FP messages, by source	MLE data	Biennial Baseline, mid-term, end-line		Source will be disaggregated by mass media and community level sources and will be reported separately by wealth quintile
	Increased number of young people exposed to messages from community sources	Percent of adolescents aged 15-24 participating in community-level activities promoting FP	MLE data	Biennial Baseline, mid-term, end-line		
<i>Objectives 5 –Foster a supportive policy environment</i>						
		<i>Outputs</i>				
	Increased visibility of family planning as a topic on national and local agenda	Number of positive news items about RH/FP in sentinel radio, television and print news sources	Media monitoring	Annual		
	Increased support for FP programs among state and local officials	Number of state and local officials that publicly state their support for FP	Media monitoring	Annual		

		<i>Short-term Outcomes</i>				
	Increased number of FP supportive policies adopted in LGAs	Number of LGAs in project areas that adopt at least one new supportive FP policy	Media monitoring	Annual		
	Increased funding by LGAs for FP programs including modern and LAPM methods, commodities	Amount of funding for FP programs in LGA budgets				

Intermediate Outcomes across Objectives 1-5

	<u>Coverage</u> Increased use of modern family planning methods	Contraceptive Prevalence Rate (CPR)	MLE data	MLE baseline, midterm, end-line	Target = 20% point increase	Goal Indicator
	<u>Quality</u> Increase in the percent of women using a modern contraceptive method continuously for at least one year	Percent of current users of a modern contraceptive method who report using that method continuously for at least one year	MLE data	MLE baseline, midterm, end-line		

	<u>Demand</u> Increase in the percent of women reporting a stated need for FP	Percent of women with a desire to delay the birth of their next child by at least two years or stop childbearing altogether	MLE data	MLE baseline, midterm, end-line		
	<u>Private Sector</u> Increased use of private sector sources for modern FP, especially among the urban poor	Percent of contraceptive users reporting that they last received their current method at a private facility	MLE data	MLE Baseline, mid-term, end-line		Overall and Among lower three lowest wealth quintiles (i.e. the urban poor)
	<u>Equity</u> Increased level of modern contraceptive use among the urban poor	CPR (disaggregated by wealth)	MLE data	MLE baseline, midterm, end-line	Target = 50% increase attributable to lowest quintiles	Goal Indicator
<i>Impact Indicators across Objectives 1-4</i>						
	Fertility	Total fertility rate	MLE data	Baseline, mid-term; end-line		Note – can disaggregate by poor/non-poor
		Age specific fertility rates	MLE data	Baseline, mid-term; end-line		Note – can disaggregate by poor/non-poor
	Unplanned pregnancy	Percentage of pregnancies in the last year that are reported to be unintended	MLE data	Baseline, mid-term; end-line		Note – this is not an explicit performance indicator

	Infant mortality	Infant mortality rate (under one year)	MLE data	Baseline, mid-term; end-line		Note – this is not an explicit performance indicator
	Newborn mortality	Newborn mortality rate (under one month)	MLE data	Baseline, mid-term; end-line		Note – this is not an explicit performance indicator
	Maternal mortality	Maternal mortality rate				Note – the MLE data does not have a large enough sample size to measure MMR