FP CAPE
Family Planning
Country Action Process Evaluation

FINDINGS REPORT:

NURHI 2 Midterm Learning Evaluation

This report presents key findings from the midterm learning evaluation of the Nigerian Urban Reproductive Health Initiative, Phase 2 (NURHI 2) project. The evaluation is designed and conducted by the Family Planning Country Action Process Evaluation (FP CAPE) project.

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Disclaimer

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Contents

Acronyms

ACG	Advocacy Core Group
BMGF	Bill & Melinda Gates Foundation
CCP	Center for Communication Programs
CHEW	Community health extension worker
CIP	Costed implementation plan
CSO	Civil society organization
DHS	Demographic and Health Survey
FGD	Focus group discussion
FP	Family planning
FP CAPE	Family Planning Country Action Process Evaluation
FMOH	Federal Ministry of Health
HC3	The Health Communication Capacity Collaborative
HMIS	Health Management Information System
IP	Implementing partner
JHU	Johns Hopkins University
KII	Key informant interview
LAPMs	Long-acting and permanent methods
LARC	Long-acting reversible contraception
LGAs	Local Government Areas
LPAY	Life Planning for Adolescents and Youth
mCPR	Modern contraceptive prevalence rate
M&E	Monitoring and evaluation
MLE	Measurement and Learning Evaluation
NURHI	Nigerian Urban Reproductive Health Initiative
NYSC	Nigeria Youth Service Corp
PMA2020	Performance Monitoring and Accountability 2020
PPFP	Post-partum family planning
PPMV	Patent and proprietary medicine vendor
SMOH	State Ministry of Health
SPHCB	State Primary Health Care Board
TCI	The Challenge Initiative
TWG	Technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UNC-CH	University of North Carolina at Chapel Hill

Executive Summary

The Nigerian Urban Reproductive Health Initiative (NURHI) is one of the longest running and largest scale investments of the Bill & Melinda Gates Foundation (BMGF) in family planning (FP). Phase 1 of NURHI, from 2009 to mid-2015, focused on increasing access to FP and use of modern contraceptives in six urban areas in Nigeria. Starting in late 2015, NURHI Phase 2 aimed to scale up the success of NURHI 1. NURHI 2 focused on sustainability to achieve a "positive shift in family planning social norms at the structural, service, and community levels that drives increases in mCPR" (NURHI 2 proposal narrative). It was implemented in Kaduna, Lagos, and Oyo states. This report summarizes results of a participatory midterm learning evaluation designed and conducted by Family Planning Country Action Process Evaluation (FP CAPE) to generate evidence on NURHI 2's progress against project objectives and capture learning from their scale up experience. FP CAPE is a project that generates evidence on how and why specified BMGF FP investments are or are not driving change in key reproductive health outcomes across the Democratic Republic of the Congo and Nigeria.

Evaluation objectives

The overall objectives of the evaluation are to: (1) provide NURHI 2 with information to correct program implementation mid-course and planning moving forward, including areas to change, strengthen or reduce; (2) provide the BMGF with information to assess how well NURHI 2 is achieving intended results; and (3) support a larger learning agenda around scale and sustainability to inform BMGF's Accelerate Country Action Initiative and its grants, including The Challenge Initiative (TCI).

Evaluation questions

The evaluation focuses on three overarching research questions:

1. How has the model that emerged from NURHI 1 been adapted and evolved within NURHI 2?
2. Has NURHI 2 achieved its intended results? What have been its strengths and weaknesses, and why have these occurred?
3. Where, how, and with what results has NURHI 2 contributed to replication, scale-up, and systems improvements/sustainability?

Methods

To address the evaluation questions, this evaluation used a mixed methods approach that triangulated three data sources: document review; secondary analysis of existing quantitative data (PMA2020, DHS, MLE Study, and NURHI 2's monitoring data); and primary collection and analysis of 157 key informant interviews (KIIs) and 30 focus group discussions (FGDs) with government staff, Advocacy Core Group (ACG) members, scale-up partners, health facility staff, community health extension workers (CHEWs), social mobilizers, women of reproductive ages, and NURHI 2 staff.

Summary of findings

Evidence from the evaluation suggests that NURHI 2 program activities positively influenced the attitudes and behaviors of women and health providers, and supported institutional changes in FP programs, policies and implementation. Deliberate attention to early and frequent stakeholder engagement, embedding practices within existing structures, and transferring ownership of NURHI practices to other institutions and systems are important foundations for sustainable change.

Questions	*Findings*
How has the model that emerged from NURHI 1 been adapted and evolved within NURHI 2?	▸ The main substantive changes in NURHI 2 compared to NURHI 1 were an increased emphasis on institutionalization and sustainability, and the addition of Life Planning for Adolescents and Youth (LPAY) activities for youth. ▸ Other changes were adaptations or modifications in implementation rather than fundamental shifts in program components. ▸ All changes were driven by data, implementation experience, and the shift in focus of NURHI 2 toward scale-up compared to NURHI 1.
Has NURHI 2 achieved its intended results? What have been its strengths and weaknesses, and why have these occurred?	▸ NURHI 2's advocacy efforts contributed to elevating and advancing understanding of and commitment to FP at Federal, state and LGA levels ▸ Qualitative data yielded positive reports from women on their experiences with quality of care in NURHI 2-supported health facilities. Quantitative findings suggested increases in quality of FP care indicators in Kaduna and Oyo, while findings for Lagos were mixed. ▸ Overall, NURHI 2 program activities contributed to positive changes in several FP beliefs and social norms at community and service levels in the three project states. ▸ Both quantitative and qualitative data suggested that NURHI 2's FP messaging through various media channels has positively influenced women's beliefs in FP and contributed to increased use of FP and intention to use. ▸ Different data sources provide a different picture of mCPR trends in each of the three NURHI 2 states but overall we did not see the significant, rapid increase in mCPR found for NURHI 1. ▸ Majority of key informants shared positive impressions about NURHI 2's performance. NURHI 2's strengths included its "exceptional" leadership, "committed" staff, and a "secret sauce" featuring flexible design, active use of data for implementation and monitoring, and effort to

Questions	Findings
	apply a "sustainability lens" within every program component. There were some mixed opinions about NURHI 2's engagement with government. Some key informants pointed out gaps in NURHI 2's programs, including costs of some interventions, such as the airing of media and the 72-hour clinic makeover.
Where, how, and with what results has NURHI 2 contributed to replication, scale-up, and systems improvements/ sustainability?	▸ NURHI 2 placed an increased emphasis on institutionalization, scale-up, and system sustainability by following the "engage – embed – evolve" strategy. ▸ NURHI 2 has institutionalized a variety of its program components at both government and health facility levels through training, tool sharing, and providing technical support to the institutions and FP services. ▸ There were a number of examples of scale-up of components of NURHI 2 programming by other partners, particularly those within the Center for Communication Programs (CCP) portfolio, including The Challenge Initiative (TCI). ▸ Findings from this evaluation and the NURHI 1 Sustainability Study suggest that changes in norms and individual practices, improvements in capacity of staff, and institutionalized policies and guidelines are likely to be sustained. However, interventions that are resource intensive, that are vulnerable to weaknesses within other system components, or are external to existing systems, are not likely to be sustained.

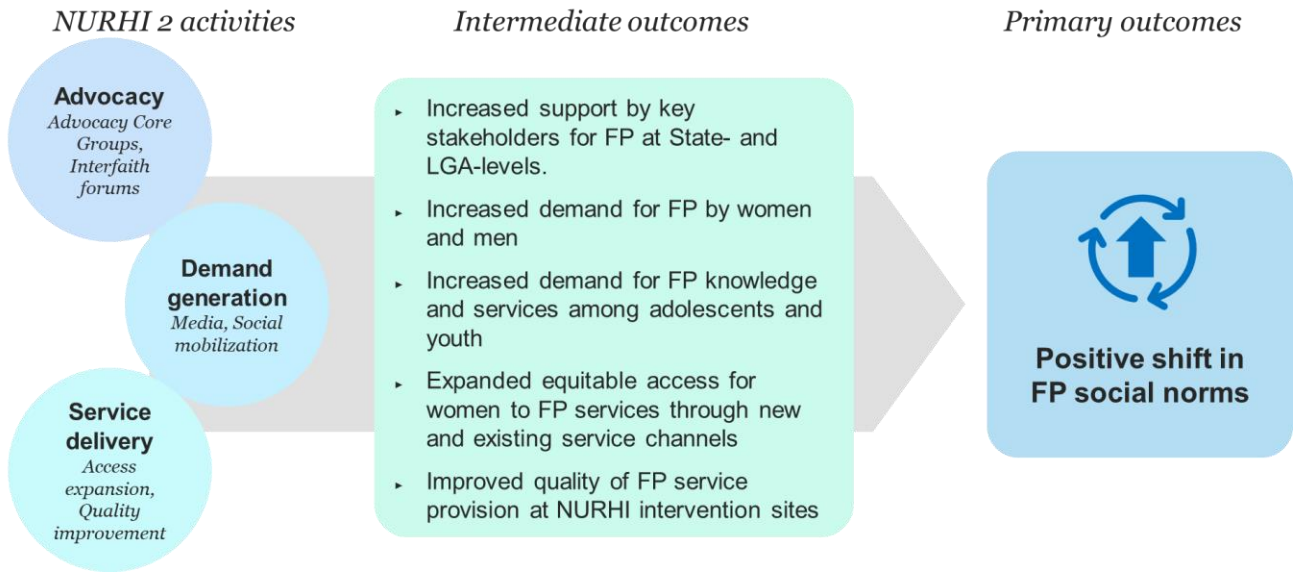
Key lessons learned

- There was evidence that NURHI 2 activities positively influenced the attitudes and behaviors of women and health providers, and supported institutional change in FP programs, policies and implementation.
- Our findings support the value of NURHI's three-pronged approach addressing advocacy, demand generation, and service delivery and the underlying assumption that social norm change at all levels builds a foundation for sustainable change in FP behavior.
- Deliberate attention to early and frequent stakeholder engagement, embedding practices within existing structures, and transferring ownership of NURHI practices to other institutions are important foundations for sustainable change.
- A realistic resource plan needs to be part of preparing for sustainability. There also needs to be sufficient time to fully establish nascent practices and to diversify the resource base to support activities.
- There are trade-offs between implementing to achieve rapid mCPR change and implementing to achieve sustainable system change, which takes time.

01 Introduction

The Nigerian Urban Reproductive Health Initiative (NURHI) is one of the longest running and largest scale investments of the Bill & Melinda Gates Foundation (BMGF) in family planning (FP). NURHI Phase 1, which began in 2009 and ran until mid-2015, sought to increase access to and use of modern contraception in six cities in the north and the south of Nigeria. The NURHI approach, as documented by the Measurement, Learning and Evaluation (MLE) Project, had a significant impact on modern contraceptive use.[1,2,3] Phase 2 of NURHI (NURHI 2) began in October 2015, and has focused on scale-up in Kaduna, Lagos, and Oyo states to achieve a "positive shift in family planning social norms at the structural, service, and community levels that drives increases in mCPR" (NURHI 2 proposal narrative). *Figure 1* depicts a summary of the theory of change for the NURHI 2 program strategy. Specifically, NURHI 2 uses theory-led, data-driven approaches in advocacy, demand generation and service delivery activities together to achieve its intermediate and primary outcomes.

***Figure 1**: Theory of change for NURHI 2 program strategy*



Evaluation objectives

The NURHI 2 Midterm Learning Evaluation was put in place to understand performance and progress against project objectives and to learn from the largest BMGF FP investment in Nigeria. Its objectives are to:

1. Provide NURHI 2 with information to mid-course correct program implementation and planning moving forward including areas to change, strengthen or reduce;
2. Provide the BMGF with information to assess how well NURHI 2 is achieving intended results; and
3. Support a larger learning agenda around scale and sustainability to inform BMGF's Accelerate Country Action Initiative and its grants, including The Challenge Initiative (TCI).

Evaluation questions

This evaluation was designed to understand the adjustments in the approaches tested and proven in NURHI 1, the results achieved within NURHI 2 thus far, and the scale-up progress within NURHI 2 program activities. It focuses on three overarching evaluation questions:

1. How has the model that emerged from NURHI 1 been adapted and evolved within NURHI 2?
2. Has NURHI 2 achieved its intended results? What have been its strengths and weaknesses, and why have these occurred?
3. Where, how, and with what results has NURHI 2 contributed to replication, scale-up, and systems improvements/ sustainability?

To create a learning agenda, a more specific set of evaluation questions was developed under these overarching questions through a participatory process involving BMGF, NURHI 2, and other evaluation stakeholders (e.g., TCI, Nigeria Federal Ministry of Health, and a private donor). These questions evolved further during the course of the evaluation to reflect emerging interests and the feasibility of addressing the questions with available data. The final list of sub-questions is presented in *Annex 1*. These sub-questions guided data collection and analysis.

02 Methods

Study design and methods

The NURH 2 Midterm Learning Evaluation design included document review, secondary analysis of existing quantitative data, and primary collection and analysis of key informant interviews (KIIs) and focus group discussions (FGDs). To address the wide range of evaluation questions, findings from quantitative and qualitative analysis and systematic document review were triangulated.

Document review

The evaluation team systematically reviewed, derived, and analyzed content from a full range of NURHI documents. These included seminal documents (e.g., project proposals, annual reports, results framework, and results tracker), external, reflective papers and articles (e.g., MLE Project's peer-reviewed publications, the NURHI 1 Sustainability Study, and presentations) and internal documents such as frameworks, charts and diagrams produced for and during periodic meetings between FP CAPE and NURHI 2.

Quantitative study

The evaluation used existing data sources for all quantitative analyses. These data sources included PMA2020 surveys, the Measurement and Learning Evaluation (MLE) study data, NURHI 2-funded Omnibus survey data, NURHI 2's monitoring data, and the Nigeria Demographic and Health Surveys (DHS). *Table 1* summarizes all secondary data sources. We used all the data sources, except the MLE study data, for analyses for Kaduna and Lagos. For Oyo, we combined two data sources to examine change over time: specifically, the 2015 cross-sectional women's sample from the MLE study (i.e., NURHI 1 evaluation data) and the only available PMA2020 Oyo sample from 2017. See *Annex 2* for sample sizes of surveyed women of reproductive age (WRA) in Kaduna, Lagos, and Oyo. Quantitative data were analyzed in Stata 16.0 (StataCorp, College Station, TX).

***Table 1**: Secondary data sources used for quantitative analyses*

Data source	*Wave*	*Coverage*
PMA2020	2015, 2018	Kaduna, Lagos
PMA2020	2017	Oyo
Measurement and Learning Evaluation (MLE) study	2015	Oyo
NURHI 2' Omnibus data	2017, 2018	Kaduna, Lagos, Oyo
Demographic and Health Surveys (DHS)	2013, 2018	Kaduna, Lagos, Oyo
NURHI 2's monitoring data	2015–2019	Kaduna, Lagos, Oyo

Qualitative study

Qualitative data from multiple stakeholders enhanced quantitative findings and filled in data gaps. For qualitative data collection, six open-ended, in-depth interview questionnaires and two FGD guides were developed, one for each participant group (See *Table 2* below). The FGD guide with women of reproductive ages was translated from English into Hausa and Yoruba. All the interview tools were pilot tested in the field and revised with local consultants and the evaluation team before being finalized for actual data collection. All interviewers and notetakers for the data collection received two-day or two-and-a-half day trainings which featured in-class presentations, role play or pilot KIIs and FGDs with actual health facility staff, CHEWs, social mobilizers, and women of reproductive ages.

A total of 157 KIIs and 30 FGDs were conducted in person, in a quiet, confidential setting between February and May 2019.[i] The one interview that did not take place in person was conducted over Zoom with an implementing partner in Kaduna. *Table 2* shows the qualitative sample breakdown. Verbal informed consent for study participation, which included being digitally recorded, was obtained by the research team at the beginning of each interview. Each interview was conducted in English, Hausa, Yoruba, or a combination of English and Hausa or English and Yoruba, and lasted between 45 and 90 minutes. Interviews were digitally recorded, and fully transcribed within 3–7 days after the interview. All interviews were transcribed and, where needed, translated from Hausa or Yoruba into English. Transcriptions were checked by the FP CAPE research team for quality assurance.

The qualitative data were analyzed using ATLAS.ti v.8.4.20. The research team collaboratively developed a codebook using a set of deductive codes to start, which were aligned to evaluation questions. These were refined and added to through an inductive process while reading through the initial set of interviews. The interviews were coded by a team of five coders who were trained to have a shared understanding of the meaning and application of the codes, as well as the coding process. Once all interviews were coded, thematic content analysis was conducted to identify patterns in the data that emerged as key themes. Illustrative quotes were included as evidence to describe how these key themes come together. See *Annex 9* for a tabulation of emergent themes and the number of quotes associated with each theme.

[i] The study was classified as non-human subjects research, and exempted from IRB review by the University of North Carolina at Chapel Hill, U.S., and received IRB approval by the National Health Research Ethics Committee, Nigeria (NHREC Protocol Number NHREC/01/01/2007–31/12/2018 and NHREC Approval Number NHREC/01/01/2007–29/01/2019).

***Table 2**: Study participants interviewed, by participant group*

Participant	*Sample size*
NURHI 2 staff	24 KIIs*
Government staff	24 KIIs
Advocacy Core Group (ACG) members	14 KIIs
Scale-up partners	26 KIIs**
Health facility staff	47 KIIs
CHEWs	22 KIIs
Social mobilizers	12 FGDs
Women	18 FGDs***
TOTAL	**187 KIIs and FGDs**

Notes:

* Included 7 interviews conducted by Lisa Cobb (NURHI 2/JHU)

** Included 2 interviews conducted by Lisa Cobb (NURHI 2/JHU)

*** Women of reproductive age (both married and unmarried) were recruited through both referral from health facilities that NURHI has been working with and snowball sampling.

Strengths and limitations

The evaluation was designed to use secondary quantitative data only. This approach maximizes the use of existing data and reduces costs by eliminating resources and time needed for primary data collection. PMA2020 provided population-level data to examine some outcomes NURHI 2 was expected to influence. However, PMA2020 was not specifically designed to evaluate NURHI 2; it was not sampled or powered for that purpose and did not include specific questions on exposure to NURHI 2 interventions. The data were particularly limited for Oyo where there was only one round of PMA2020 data available for 2017. We used the 2015 MLE endline data for Oyo as a baseline to compare with the 2017 PMA2020 data. However, the samples are not fully comparable. The Omnibus survey data collection supported by NURHI 2 provided more specific data on NURHI 2 interventions and on family planning attitudes and norms. However, we found some data quality issues with some of those data and they are only available for 2017 and 2018. The DHS data are useful but, like PMA2020 data, do not collect data on exposure to NURHI 2 interventions and the samples were not powered for state-level analysis so have relatively small sample sizes at the state level. Such limitations in the quantitative data meant that we were unable to fully address some specific evaluation sub-questions. As a result, we had to rely more on the qualitative data for those questions or focus more on the overarching question.

Although the qualitative data are rich and specific to NURHI 2, they reflect the perspectives and opinions of those interviewed, many of whom by necessity were closely associated with the implementation of the program and consequently have varying degrees of interest in the evaluation findings. As such for some specific evaluation questions, these data may not be readily comparable to or complemented by the objective quantitative data.

The application of mixed methods for the evaluation enabled us to gain more in-depth and wide-ranging understanding of the NURHI 2 program. Particularly, interviewing a variety of informants, including government partners, health providers, and women recruited through NURHI 2-supported facilities (not necessarily FP clients), allowed us to introduce broader, somewhat external perspectives into the evaluation. However, the volume of data generated by the wide range of evaluation questions and types of informants extended the time needed for analysis. This made it challenging to synthesize evaluation findings into a manageable volume of results. In addition, starting the evaluation after NURHI 2 had formulated its Year 4 work plan, together with the time required for IRB approval, qualitative data collection and analysis meant that the results were not available in time to inform mid-course correction for NURHI 2 (Objective 1 of the evaluation). *Table 3* summarizes the strengths and limitations of the evaluation's data sources and methods.

***Table 3**: Summary of strengths and limitations of the evaluation*

Strengths	*Limitations*
▸ The utilization of secondary data was maximized by combining available sources for all quantitative data analyses	▸ Unable to fully address some specific evaluation questions due to lack of quantitative data that either are specific to NURHI 2 or are of appropriate quality
▸ Qualitative data were rich and specific to NURHI 2	▸ Challenge to triangulate qualitative with quantitative data for some specific questions because qualitative data reflected opinions of informants only, and there were inherent differences between random selection for objective quantitative data collection versus purposive selection of qualitative data collection participants
▸ Application of mixed methods provided a more in-depth understanding of the NURHI 2 program	▸ Unable to inform mid-course correction for NURHI 2 program due to timing of the start of the evaluation, time required for IRB approval, fielding of qualitative data collection, and analysis and harmonization of distinct data sets.

03 Results

Question 1: *How has the model that emerged from NURHI 1 been adapted and evolved within NURHI 2?*

A significant shift between NURHI 1 and NURHI 2 was an increased emphasis on institutionalization and sustainability. This was driven by the scale-up mandate and lower funding of NURHI 2 compared to NURHI 1. Rather than direct implementation, project staff increasingly engaged with government partners as technical advisors and provided government counterparts with technical and organizational assistance. This shift in mandate and emphasis is discussed further below in relation to the third overarching evaluation question.

Why was NURHI 2 adapted?

NURHI 2's intent was entirely different from NURHI 1's aim. NURHI 1 was designed to test out new and innovative program interventions to increase voluntary family planning use. However, NURHI 2 was intended to scale-up effective program components that had been proven in NURHI 1 and sustain those programs by handing them over to government and implementing partners.

In addition, NURHI 2 received less funds based on the expectation that, compared to NURHI 1, NURHI 2 would implement fewer, proven interventions, and it would more intentionally focus on sustainable scale-up and institutionalization – both of which were assumed to cost less. The funding for NURHI 2 that came from the BMGF and a private donor was $18 million over five years compared to $47 million over 5.5 years for NURHI 1.

> *"NURHI 2 was purposely designed for scale-up, for institutionalization of NURHI 1's best practices and models… So, it's about two projects that were designed [so] that the first one established the best practices while the second one is about scaling up and sustainability."* – NURHI 2 staff, Headquarters

Data and lessons learned from NURHI 1 guided adjustments made in NURHI 2. Specifically, decisions based on learning from NURHI 1 included: adding the Life Planning for Adolescents and Youth (LPAY) component into NURHI 2; shifting its social mobilization strategy from visibility campaigns to community canvassing, and reducing expensive media activities.

What did NURHI 2 adapt or adjust from NURHI 1?

Along with lessons learned from NURHI 1, changes in scope and resources led NURHI 2 to increase target populations, add new geographical contexts, and drop some geographies. The activity areas were broadly kept the same from NURHI 1 to NURHI 2. However, implementation adaptations were made in response to evidence and experience working in new contexts.

Geographies and contextual differences

Phase 1 of NURHI was implemented in six cities across Nigeria from 2009–2015: Kaduna City (Kaduna State), Zaria (Kaduna), Abuja FCT, Ilorin (Kwara), Ibadan (Oyo), and Benin City (Edo). All implementation sites were urban, densely-populated areas with a somewhat adequate access to family planning supplies. NURHI 1 focused on eliminating barriers to contraceptive use and creating a supportive environment where family planning could advance as a social norm, specifically for urban poor populations.

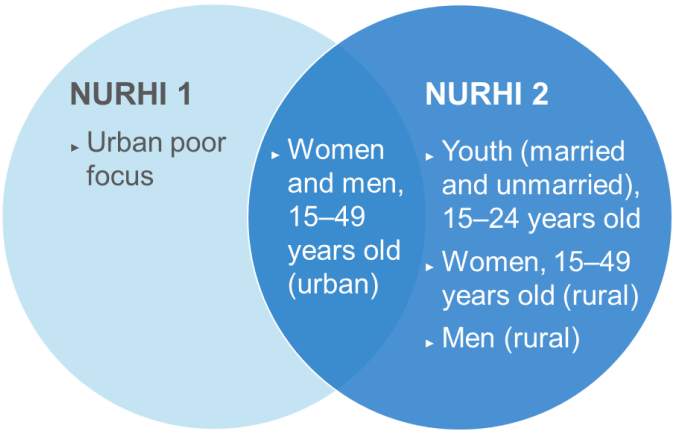
NURHI Phase 2 began in late 2015 and runs through 2020. NURHI 2 shifted toward "statewide" implementation in three of Nigeria's most populous states: Kaduna, Lagos, and Oyo. Statewide interventions include advocacy efforts and media programming; however, facility and community-level interventions were also implemented in select local government areas (LGAs). Community-level interventions in Kaduna took place in 15 LGAs, covering approximately 75% of Kaduna's women of reproductive age. In Lagos, the 10 LGAs selected for implementation covered approximately 66% of the state's women of reproductive age. In Oyo, NURHI 2 program activities were implemented in 15 out of 33 LGAs. *Annex 3* presents maps of implementation geographies and investments for NURHI 1 and NURHI 2.

Building on the success of NURHI 1, NURHI 2 continues to address barriers to family planning and to create demand for services. NURHI 2 also aims to strengthen systems so that the positive shift in family planning social norms can be sustained.

Target population

In phase 2 of the project, NURHI continues using data to inform its program implementation. Specifically, NURHI 1 evidence from MLE and other studies showed that youth are an important under-served demographic. This led to integrating Life Planning for Adolescents and Youth (LPAY) into all program components of the NURHI 2 model. The youth component add-on to NURHI 2 represents a holistic approach to increase family planning use among 15–24-year olds through advocacy, demand generation, and service delivery interventions. One of the most notable achievements of youth-focused programming has been the integration of LPAY into the National Youth Service Corp (NYSC). Hundreds of NYSC members were trained in LPAY education materials and have subsequently taught LPAY curriculum alongside HIV prevention programming.

***Figure 2**: Differences in target population between NURHI 1 and NURHI 2*



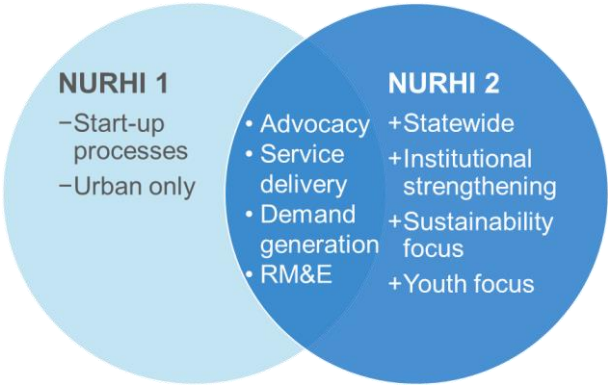
Lessons learned from NURHI 1, along with research evidence that male partners pose a barrier to FP use for many women, contributed to another distinct expansion in target population after the first year of phase 2 of the project.[4,5] While men were included in NURHI 1 to some degree, NURHI 2 created activities intentionally and specifically targeting men through demand generation activities, such as radio programming and social mobilization strategies. The radio program *Go Men Go* highlights NURHI 2's incorporation of both male and youth populations into

the NURHI model. *Go Men Go* was the product of NURHI 2 and the NYSC collaboration. The radio program focused on discussions of reproductive health and family planning and used young men from the NYSC as hosts and family planning champions. The radio program created awareness of family planning for its younger audience, while inviting men into the family planning conversation.

Program activity areas: Advocacy, demand generation, and service delivery

A defining feature of the NURHI model is the "comprehensive package." To shift social norms and enable increased use of family planning, the NURHI model simultaneously addresses advocacy, demand generation, and service access and quality. This overarching model was maintained in NURHI 2 (*Figure 3*). Also continued was the focus on continual use of data to inform and refine program implementation. Although many of the specific interventions from phase 1 did not change significantly in phase 2, there were some notable adaptations in implementation in response to evidence and experience working in new contexts. Such implementation tweaks were not always fully described in documents or interviews, however.

***Figure 3**: Differences in scope and program activities between NURHI 1 and NURHI 2*



Some examples of program adaptations for each area of program activities are identified below:

- **Advocacy** interventions generally stayed the same during NURHI 2. These included media advocacy trainings, religious leader engagements, community-based advocacy, advocacy for family planning budgets, and budget tracking. Due to capacity built during NURHI 1, many advocacy interventions required less funding support during NURHI 2. For example, several of the Advocacy Core Groups (ACGs) established in NURHI 1 are now self-sustaining NGOs that no longer require NURHI funding support. In addition, responding to evidence of the importance of religious leaders as influencers of family planning attitudes and behaviors, NURHI 2 expanded work with religious leaders, including Christian as well as Muslim leaders.

- **Service delivery** interventions that remained consistent from NURHI 1 to NURHI 2 included using distance learning for training, integration of family planning into other clinical services, clinical outreach, and 72-hour clinic makeovers. During NURHI 2, additional focus was given to decreasing provider bias in family planning services and to overall health system strengthening. To address provider bias, NURHI 2 conducted values clarification exercises and human centered design interventions such as client-provider dialogues. Overall health system strengthening during NURHI 2 involved: on-the-job training and supportive supervision to healthcare professionals, LARC training for CHEWs, and whole-site orientation training for clinics. However, NURHI 2 dropped the family planning provider referral network that was implemented in the latter part of NURHI 1. This decision was based on mixed experience with it in NURHI 1.

- **Demand generation** activities had the most significant changes from NURHI 1 to NURHI 2 due to a reduction in the number of activities and adjustments to continued interventions. NURHI 2 undertook formative research to adapt FP media messages for the new contexts, particularly in Lagos. Mass media was expensive in Lagos; therefore, NURHI 2 scaled back mass media efforts in favor of increased emphasis on social mobilizers. Specifically, television programming such as *Newman Street* was not funded by NURHI 2, and the number of radio dramas decreased during NURHI 2 in favor of more cost-effective radio spots. Social mobilization activities in NURHI 2 shifted from visibility parades and mass community gatherings to a structure of neighborhood, door-to-door campaigning. Demand generation interventions that carried over from NURHI 1 included *Get It Together* media campaigns, some continued entertainment-education radio programming, and social mobilization.

How was NURHI 2 adapted?

NURHI took into account the increased focus on sustainability in adapting from phase 1 to phase 2. This included addressing political and socio-cultural differences between phase 1 and phase 2 geographies, engaging FP partners and stakeholders at every level, and shifting implementation responsibilities from NURHI to government and other implementing partners.

***Figure 4**: NURHI 2's adaptation strategy*

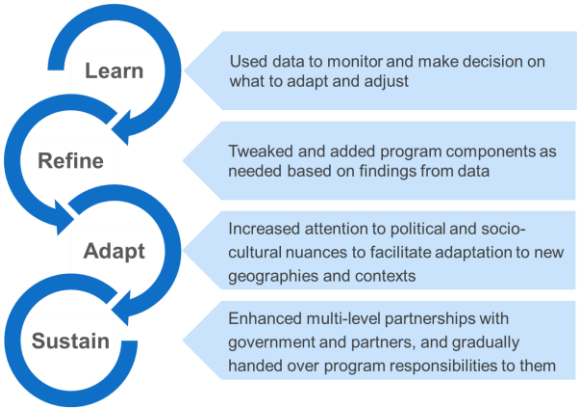


Figure 4 describes the adaption strategy which aligns with NURHI 2's scale-up approach. Specifically, NURHI 2 used different sources of data (e.g., landscaping, stakeholder mapping, Omnibus survey data, and MLE data) to inform the decision-making process on what strategies or interventions to adapt, which program components to adjust, and which population groups to prioritize. Based on the data, NURHI 2 tweaked, dropped, and added program components and target populations, as described above, to make the program fit with its new scope, including the focus on sustainability.

One of the key factors facilitating the adaptation was the ability to maintain flexibility. This was accomplished by increased attention to local political environments, and socio-cultural nuances within the new implementing geographies and contexts.

To sustain effective NURHI program components after the project ends, NURHI 2 worked to ensure that all approaches are embedded within existing local structures – government, social and civil society – in each implementation state. Rather than creating new structures, NURHI enhanced partnerships with government agencies and other implementing partners at all levels. It gradually handed over program responsibilities by taking a supportive role, assisting government and FP partners with technical and organizational support when needed. For instance, the Contraceptive Technology Update

> *"…they were using the Islamic perspective [on family planning], and in NURHI 2, we found out the Christians will say, 'You have Islamic perspective, what about us? We have our questions too.' So, in NURHI 2, we now developed the Christian perspectives."* – NURHI 2 staff, Headquarters

meetings brought multiple partners together and enhanced engagement from organizations such as the Association of Private Practice in Nigeria, the Nurse Midwives Association of Nigeria, and the Nigerian Medical Association. Service delivery interventions also extended beyond high-volume sites to include type-II facilities[ii], smaller clinics, and even patent and proprietary medicine vendors (PPMVs). Sustainability is discussed further under Question 3.

Question 2: *Has NURHI 2 achieved its intended results? What have been its strengths and weaknesses, and why have these occurred?*

NURHI 2 continued using theory-led, data driven approaches in advocacy, demand generation and service delivery activities to achieve its intermediate outcomes. Its intermediate outcomes include increased support from stakeholders for FP at all levels, increased demand for FP knowledge and services, particularly among youth, and improved access to and quality of FP services for women. These intermediate outcomes are expected to contribute to a "positive shift in family planning social norms at the structural, service, and community levels that drives increases in mCPR" (NURHI 2 proposal narrative).

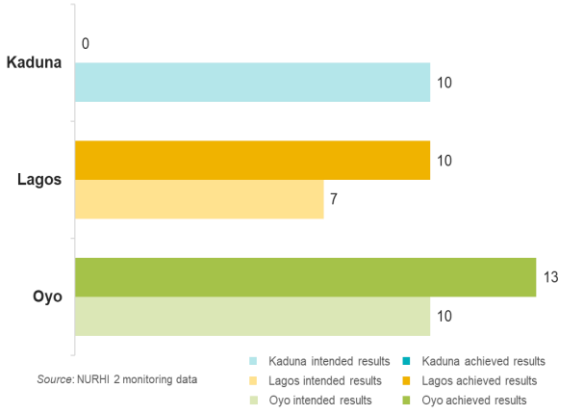
Has NURHI 2 achieved its intermediate outcome results?

The triangulation of document review, qualitative data, and existing quantitative data allow us to address evaluation questions related to NURHI 2's achievement of some intermediate outcomes from its program activities.

Advocacy

NURHI 2's monitoring data and key informant interviews indicated that its advocacy efforts contributed to increased state and LGA-level stakeholders' support of family planning. *Figure 5* describes NUHRI 2's intended versus achieved results for creation of budget lines for family planning by state. The graph shows that in Lagos and Oyo, the target number of LGAs that created budget lines for FP was exceeded, while no LGAs created FP budget line items in Kaduna.

***Figure 5**: Number of LGAs that funded family planning with regular budget lines (2015 – 2019)*

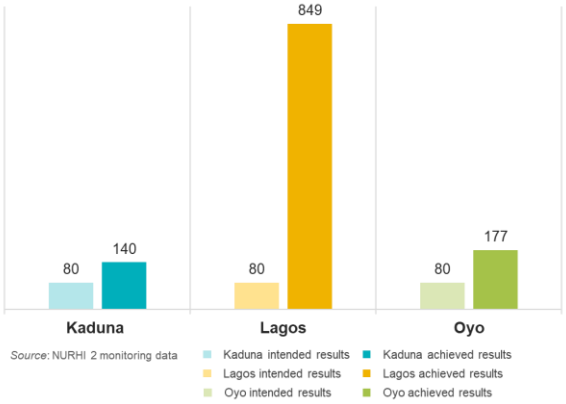


At the Federal level, key informants described how Nigerian officials are more motivated than ever to discuss and accommodate family planning. Advocacy has positively influenced national-level social norms among policy makers and stakeholders

[ii] A type-II health facility is defined as a primary health care clinic that serves a group of communities with about 2,000 people.

regarding the importance of family planning for Nigeria. The change was reflected with the establishment of Federal budget lines for family planning and the National Family Planning Blueprints.

***Figure 6**: Number of public statements supporting FP by religious, community, and traditional leaders (2015 – 2019)*



NURHI 2's monitoring data and key informant interviews indicated that advocacy also contributed to increased state and LGA-level stakeholder support of family planning. In all three implementation states, NURHI 2's expanded work with religious leaders led to increased public statements supporting family planning by religious, community and traditional leaders. Increased support from these trusted leaders is in turn expected to influence large scale social norms surrounding the acceptance of family planning in Nigerian communities. *Figure 6* shows NURHI 2 greatly exceeded the targeted number of public statements by religious, community, and traditional leaders, particularly in Lagos state.

> *"I feel it [NURHI 2] has been quite effective in a way that it's been able to raise the profile of FP in the country. [This is] not only for NURHI but [also] for across the board [of FP community]. Some of the tools they've developed – [including] 72-hour makeover – have been quite useful."* – Scale-up partner, Federal

Overall, NURHI has elevated and expanded the conversation around family planning on Federal, state and LGA levels through advocacy work with religious, community and traditional leaders. Advocacy outcomes contribute to increases in domestic funding for family planning as well as visibility of family planning across the country.

Demand generation

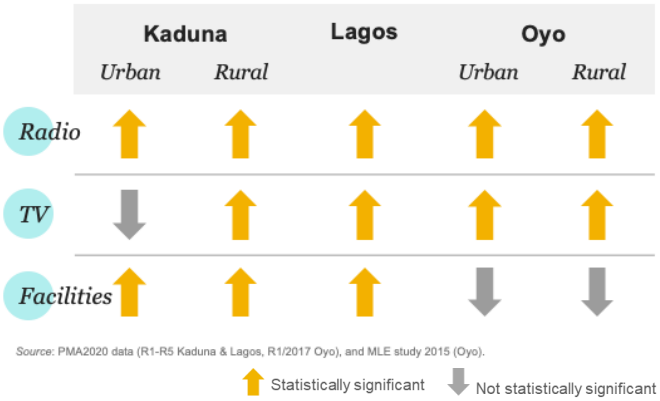
Figure 7 describes changes in exposure to FP messages through radio, TV, and health facilities from the beginning of NURHI 2 through the midpoint of the program. The data come from PMA2020 and reflects exposure of women to FP messages generally, but not specifically to NURHI's FP messages. Exposure to FP messages through radio, TV and health facilities has generally increased across both rural and urban geographies during the NURHI 2 period.

Qualitative data collected from women and health providers provide more personalized specific information on the influence of NURHI 2 activities. Women frequently discussed how exposure to FP messages through NURHI 2 activities influenced their beliefs about FP, allayed concerns, and encouraged them to adopt FP. Different women were influenced by different messaging channels: some women discussed the influence of radio programs and messages while others emphasized the personal role of social mobilizers in their decision-making.

> *"It benefits me… especially the radio jingles [on FP programs]. I do listen to it several times. If I pick up my phone and tune to the station, I will hear about it. Then I also hear about it in the hospital. And even in my area where I stay, they always ring into my hearing. People do talk about it a lot. When we are discussing amongst ourselves, we also talk about it."* – Woman, rural Oyo

Family planning exposure through various media have interacting effects. Exposure through TV and radio has a widespread audience, while exposure through health facilities allows women to ask questions and have personal interaction with authority figures on health. Qualitative interviews with women in NURHI 2 states show that these channels were able to reach women on multiple levels. Encouraging family planning in community conversations influenced FP social norms and intention to use in local environments. Specifically, women in focus group discussions said that listening to programs on the radio helped to change *"minds towards family planning positively,"* while for some, these messages assured that *"[family planning] was not going to make me stop having children… it is just to space between this and that child."*

***Figure 7**: Exposure to FP messages, 2015 – 2017/18*



Key informants highlighted the influence that health facility staff (including CHEWs) have on the community. Facility staff discuss family planning during various health events, including antenatal visits and child vaccination events to create awareness about FP and generate demand among women. Facility staff sing songs to clients about FP, helping to increase awareness and knowledge about family planning. One focus group participant said that the songs *"made us curious about what was happening, and we concluded it would be nice for us to do [family planning]."*

> *"**M**: Did you notice anyone that started using family planning after… community activities?*
> ***R1**: We've seen many like that when they [social mobilizers] came to the community, they explained to them. They [women] later went again to the hospital to get more information about it. They started using immediately they got there.*
> ***R2**: … when I saw the mobilizers during community activities, I wanted to know more about other [FP] methods"*
>
> – Women, Lagos

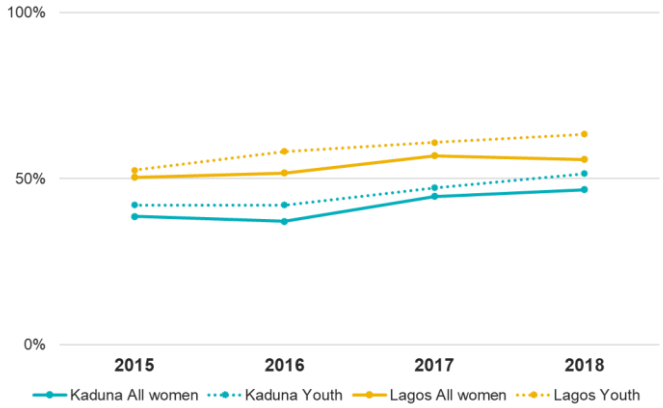
Numerous studies have demonstrated the importance of social mobilization for social and behavioral change communication and generating demand for FP services.[6,7] Although the available quantitative data sources did not include questions about NURHI 2's social mobilization, qualitative data from interviews with women, health facility staff, and stakeholders yielded pertinent data. These interviews suggest that NURHI 2's social mobilization activities helped change awareness and acceptance of family planning, including FP referrals, and ultimately contributed to increasing women's intention to use FP in all three states.

Social mobilizers were able to reach harder to access, more rural clients with FP messaging. They provided opportunity for both women and men to ask questions about family planning and encouraged women to visit facilities by assuring them that prices for services were low or free. A woman in a focus group discussion shared that the social mobilizers *"are not the ones who administer [family planning] to us, so they give us referrals to the hospital. But we learn everything about it from them before we go to the hospital."* This finding also corresponds with the document review and NURHI 2's monitoring data that social mobilization was a crucial component of NURHI 2 programming. The number of social mobilization events has greatly increased since NURHI 2 started in 2015, with each state adapting the social mobilization

approach and material to suit their context. For example, in some places social mobilization for FP was integrated into other health education or social mobilization for other health issues, while in others, local artisans, youth groups, and CHEWs led and/or participated in the community-based social mobilization activities.

Data from PMA2020 indicate that intention to use family planning among non-users in Kaduna and Lagos has increased somewhat since the start of NURHI 2 (*Figure 8*). Many key informants and focus group participants expressed the opinion that the demand for FP was increasing in the community, including among youth. This is somewhat substantiated by quantitative data from the NURHI 2's Omnibus surveys which also shows generally positive change in the intention to use FP among youth and all women of reproductive age (data not shown).

***Figure 8**: Intention to use FP among non-users age 15-49 and among youth age 15-24, 2015–2018*



Source: PMA2020 data (R1-R5) Kaduna and Lagos
Note: Quantitative trend data on intention to use was not available for Oyo state.

Service delivery

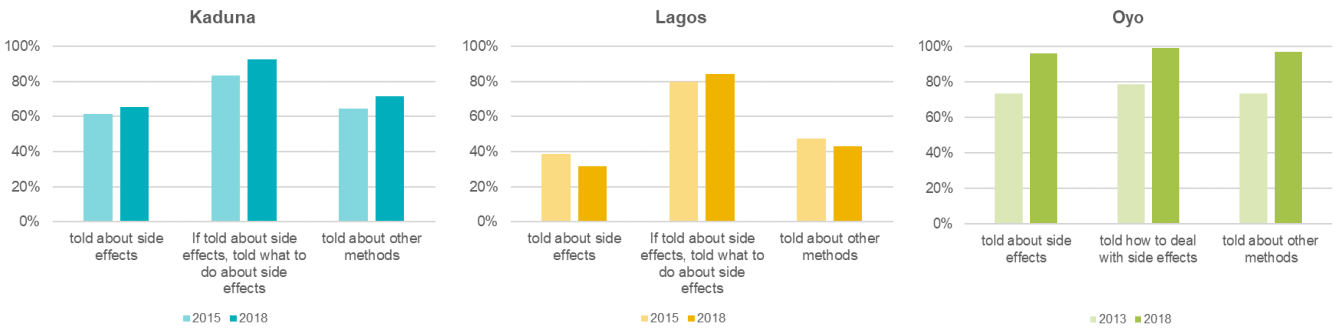
Both quantitative and qualitative data point to the importance of side effects of methods, including personal experiences as well as experiences of friends, in influencing norms and behaviors. Quality of care plays a role by increasing women's confidence in the services and methods they use. For example, women expressed that they were reassured by the readiness of a facility to provide FP, including tests for drug sensitivity before a method was administered, resolution of extra-fee payments for services, and appropriate management of side effects.

There were several examples in the qualitative data of women reporting positive experiences with the quality of care in NURHI 2-supported facilities. Focus group discussions and key informant interviews pointed to positive effects of NURHI's 72-hour clinic makeover. These makeovers created separate spaces for counseling and service provision, and ensured better client privacy. The change in aesthetic, giving clinics a cleaner, more welcoming feel, encouraged clients to seek FP services there. However, we do not know if the new clients who seek services at the renovated clinics are new FP users or clients who were obtaining contraceptive methods from other sources previously.

> *"**R1**: [The health facility] has been renovated; it is not like it was before…*
> ***M**: Do you think these renovations have encouraged people to go or discourage them?*
> ***R2**: It has made more people come, there are better changes than before."*
>
> – Women, Kaduna

Three quantitative population-level indicators of quality of care are displayed in *Figure 9*. Women currently using a modern contraceptive method were asked (1) was she told about side effects when she obtained her current method; (2) if she was informed about side effects, was she told what to do about the side effects; and (3) was she counseled about other FP method options?

***Figure 9**: Quality of care indicators among women using modern contraceptive methods in three NURHI 2 states*



Source: PMA2020/2015 – 2018 for Kaduna and Lagos; and DHS 2013 and 2018 for Oyo[iii]

Data for Kaduna and Lagos from PMA2020 data for 2015 and 2018 align with the period of NURHI 2 implementation. All three of the quality of family planning care indicators increased from the beginning of NURHI 2 in 2015 to 2018 in Kaduna state. The picture is more mixed in Lagos state with two of the three indicators showing a slight decline while one indicator shows a slight increase. This may be related to high levels of condom use in Lagos, which are often obtained from pharmacies. Data for Oyo come from the DHS and represent change over a longer period (2013–2018) than in the other two states[iv]. The DHS data show notable increases in all three of the quality of family planning care indicators in Oyo state over this five-year period. Overall, these quality of care data attest to relatively good and improving quality of care practices in the three states. The sample sizes on which these indicators are based are relatively small, however, so these results should be interpreted with some caution.

Has NURHI 2 achieved its ultimate outcome results?

The ultimate outcome that NURHI 2 aims to achieve is positive change in family planning social norms at the structural, service, and community levels.[v] Findings presented above indicate that NURHI 2's advocacy work positively influenced policy makers and community leaders in support of family planning. Provider norms are discussed below under Question 3. Here, we focus on changes in community norms around family planning.

[iii] Sample sizes for these indicators vary depending on the survey year, state, and the indicator. The sample sizes are of the order of 460 to 540 for Kaduna, from 330 to 380 for Lagos, and from 110 to 130 for Oyo.

[iv] The questions in DHS were similar to those in PMA2020 but there are some differences in the skip patterns for the quality of care questions, so the questions are asked of slightly different groups of modern method users.

[v] Kincaid D.L. Social networks, ideation, and contraceptive behavior in Bangladesh: A longitudinal analysis. Soc Sci Med. 50 (2): 2000; 215–231

Omnibus survey data from the three NURHI 2 states for 2017 and 2018 show positive change in some beliefs about family planning. The percentage of women who did not believe that contraceptives are dangerous to your health increased from 70.9% in 2017 to 84.3% in 2018 in Kaduna, from 57.5% to 71.5% in Lagos, and from 68.3% to 73.8% in Oyo (*Figure 10*). The percentage of women who did not believe that women who use FP may become promiscuous shows similar trends (*Figure 11*). In Kaduna, this indicator increased from 79.4% in 2017 to 86.8% in 2018, while in Lagos it increased from 73.5% to 76.3%, and in Oyo from 64.1% to 66.5%. Trends in perceived self-efficacy for FP use among women, ages 18–49,varied by state. The percentage of women who believe that "they would need someone's permission to use FP" decreased from 71.4% to 69.1% in Kaduna, and from 75.5% to 72.1% in Oyo, but increased in Lagos from 55.2% in 2017 to 63.2% in 2018 (*Figure 12*).

Key definition

Contraceptive ideation: is defined as "new ways of thinking and the diffusion of those ways of thinking by means of social interactions in local, culturally homogeneous communities." [iv]

To capture ideation, NURHI 2 uses a model with three components, each of which includes several elements:

- **Cognitive**: Knowledge, attitudes, perceived risk, subjective norms, and self-image;
- **Emotional**: Emotional response, empathy, and self-efficacy; and
- **Social interaction**: Social support and influence, spousal communication, and personal advocacy.

***Figure 10**: Percentage of women who did not believe that "contraceptives are dangerous to your health"*

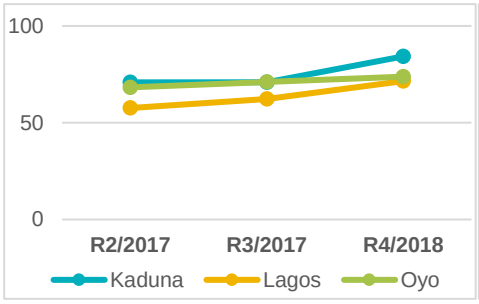


***Figure 11**: Percentage of women who did not believe that "women who use FP may become promiscuous"*

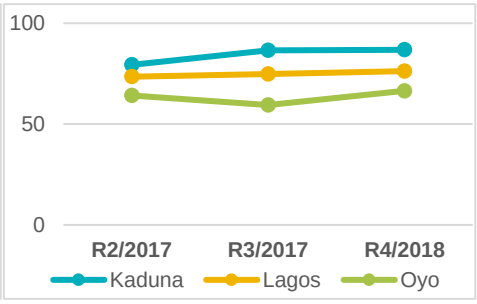
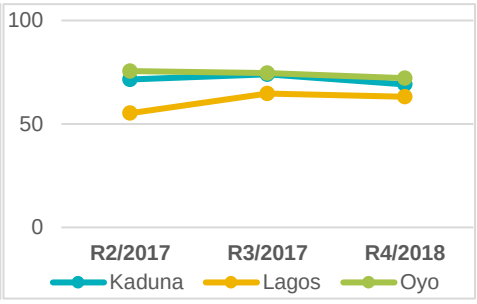


***Figure 12**: Percentage of women who believed that "they would need someone's permission to use FP"*



Source: Omnibus data (R2-R4 Kaduna, Lagos and Oyo)

> *"You see when family planning service arrived, like we youth, I first felt is not necessary because we are still young. We felt it might cause damage to our body. But when we started using it, and we saw it was successful, and it will also help us whenever we are ready to use it."* – Woman, Oyo

Synthesis results from qualitative data provide similar evidence of positive change in beliefs and norms around FP. Specific questions about the general acceptance and awareness of FP in the community were asked of FP service providers, social mobilizers and women of reproductive ages. Most key informant interviews and focus group discussions mentioned improvements in the acceptance and awareness of family planning among people in the community, including adolescents and youth (*Table 4*). Many women, including youth, acknowledged that family planning is "*very good*" and "*important*" to their life because it helps them to prevent "*unwanted*

pregnancy," "*to have the number of children that they are able to care for*," to have time to "*nurture [their children] well*," as well as "*to plan the near future*" for themselves.

However, some informants and focus group participants also noted that negative norms around family planning persist. Challenges to sustainable changes in FP social norms that respondents pointed out include taboos against FP users, and lack of support from spouse and family for contraception use.

See *Annex 4* for a more detailed discussion of the factors that influence women's beliefs and behaviors around family planning that emerged from the qualitative data and of how the various NURHI 2's program components come together to address and influence them.

***Table 4**: Positive changes in people's FP awareness mentioned by respondents*

Participant	# of KIIs and FGDs
Health facility staff	43/47 KIIs
CHEWs	17/21 KIIs
Social mobilizers	11/12 FGDs
Women	16/18 FGDs

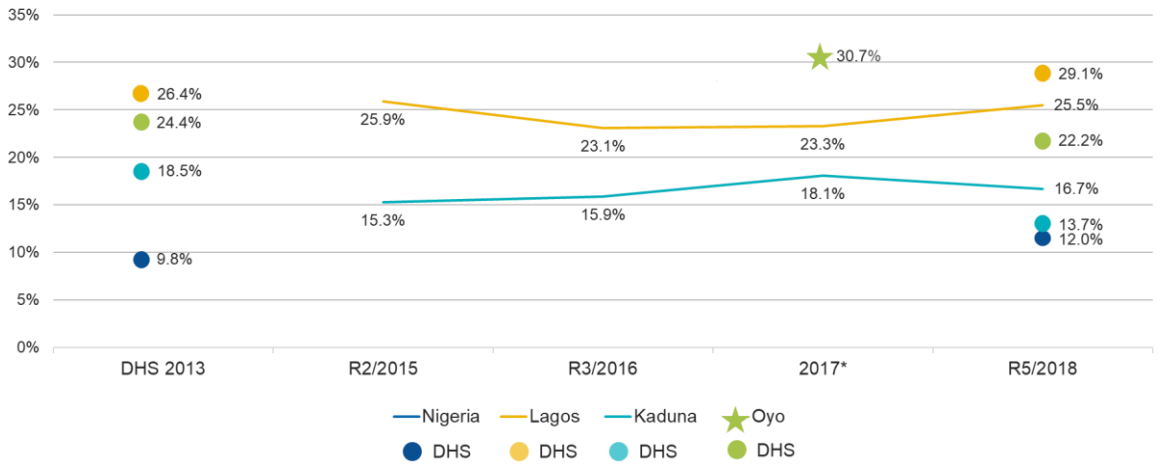
KII: Key informant interview
FGD: Focus group discussion

Mentioned Not mentioned

Has mCPR changed throughout the lifespan of NURHI 2?

Although modern contraceptive prevalence rate (mCPR) is not the primary outcome of NURHI 2, it is the outcome that Nigeria aims to increase in its national plan and in FP2020 goals and NURHI 2 aims to contribute to those goals. Trends in mCPR among married women in PMA2020 data show a fluctuating but relatively flat trend overall in Kaduna and Lagos over the 2015–2018 period. The DHS data, however, show an increase in mCPR among married women in Lagos from 2013 to 2018 but a decrease in Kaduna. The mCPR among married women in Oyo fluctuates depending on the source but shows a lower level of mCPR in 2018 compared to earlier surveys (*Figure 13*).

***Figure 13**: mCPR trends for married women in three NURHI 2 states*

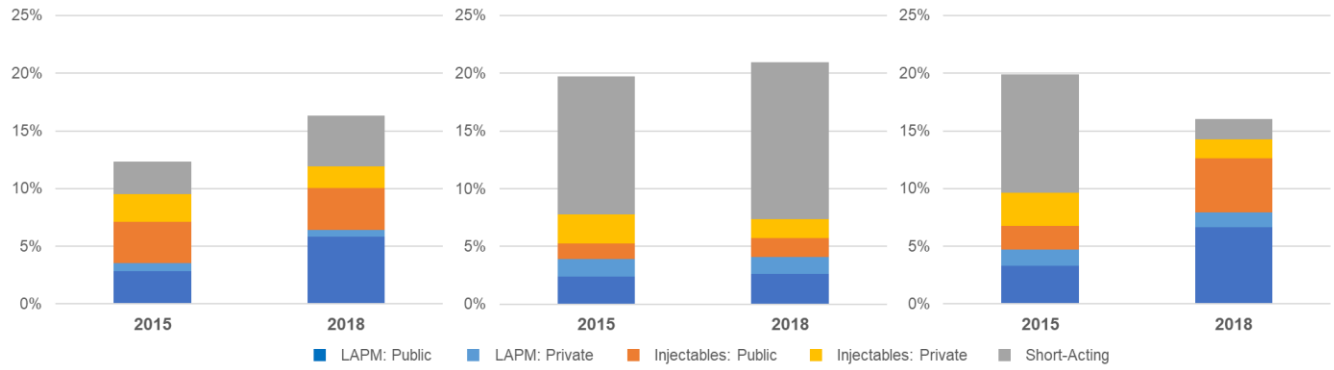


Source: PMA2020 data (R2-R5 Kaduna & Lagos *R4/2017 Kaduna & Lagos, R1/2017 Oyo)
DHS 2013, 2018

Which service channels have been most effective for expanding access to injectables and long acting and reversible methods of contraception?

Descriptive analysis of PMA2020 and DHS data can provide some insights into which service channels are most important for access to injectables and long acting reversible and permanent methods (LAPM). *Figure 14* shows the prevalence of modern methods among all women of reproductive age by method type and source over time in the three NURHI 2 states. In Kaduna, use of LAPM has increased notably, primarily reflecting increases in use of implants, and that increase is primarily driven by the public sector. Injectable use has not changed much but there has been a shift toward obtaining injectables in the public sector. Oyo has also seen a notable increase in use of LAPM, again largely reflecting increased use of implants obtained in the public sector. Injectable use has also increased in Oyo also driven by the public sector. In Lagos there has been little change in use of LAPM and a slight decrease in use of injectables. Users of these methods in Lagos tend to use the public and private sectors to a similar degree in 2018.

***Figure 14**: Modern contraceptive use among all women age 15-49 by method and source in three NURHI 2 states*



Source: PMA2020/2015 – 2018 for Kaduna and Lagos; and DHS 2013 and 2018 for Oyo

There are several sub-questions for overarching question 2 related to the impact of NURHI 2 programs. However, we were unable to address impact fully in a statistical sense due to lack of suitable existing quantitative data for impact analysis. Multivariate regression analyses of existing surveys show several positive impacts of general FP messaging through radio, television, and health facilities on modern contraceptive use midway through NURHI 2 (*Figure 15*)[vi]. The findings are consistent with results for the same outcome for NURHI 1.

***Figure 15**: Marginal effects of general FP messaging on mCPR at midpoint NURHI 2*

	Kaduna		Lagos	Oyo	
	Urban	*Rural*		*Urban*	*Rural*
Radio	—	—	✓ + 5.5%	—	✓ + 8.4%
TV	—	✓ + 12%	—	✓ + 9.7%	—
Facility	✓ + 10%	✓ + 5.6%	✓ + 5.9%	—	—

Source: PMA2020 data (R1-R5 Kaduna & Lagos, R1/2017 Oyo), and MLE study 2015 (Oyo).

[vi] We examined differences across geographies in terms of the probability of using FP between those exposed to different channels of FP messaging. We looked at these differences at roughly the outset of NURHI 2 (the "baseline") and in the most recent PMA2020 round (midline). Standard errors of the marginal effects were adjusted for the clustered sample design.

What have been NURHI 2's strengths and challenges, and why have these occurred?

In key informant interviews, we asked the government staff, ACG members, implementing partners and health facility staff: "How has NURHI 2 performed?" and "What are their strengths and their challenges?"

Most interviewed informants shared positive impressions about NURHI 2's performance (*Table 5*). While CHEWs and social mobilizers were not specifically asked about NURHI 2's performance, some key informants and focus group participants brought up the subject and expressed positive impressions of NURHI 2's FP programs.

***Table 5**: Positive impression of NURHI 2's performance mentioned in KIIs & FGDs*

Participant	# of KIIs and FGDs
Government staff	23/24 KIIs
ACG members	13/14 KIIs
Scale-up partners	25/26 KIIs
Health facility staff	35/47 KIIs

KII: Key informant interview
FGD: Focus group discussion

Mentioned Not mentioned

Key informants provided insights into NURHI 2's strengths as keys to its success. Many informants felt that NURHI 2's *"exceptional"* leadership and its *"passionate," "strategic"* and *"committed"* staff enabled the project to perform well. They also cited NURHI 2's three-pronged approach, which intertwines advocacy, demand generation, and service delivery activities as a strength. NURHI 2's program approach benefitted from their use of data to design, adapt, keep track of, and tweak program activities. In addition to applying a "*sustainability lens*" within every program component, NURHI 2's adaptive approach enabled the project to adjust program activities for different geographic and cultural nuances: one-size did not fit all. Also, NURHI 2's use of multiple communication platforms, such as WhatsApp, allowed it to engage with various implementation partners and groups.

Key informants had mixed opinions about NURHI 2's engagement with the government. Some expressed concerns about gaps in NURHI 2's engagement, citing that it was *"not government driven,"* and *"rushing in handing NURHI 2 over to [the] government,"* and that NURHI 2 had not involved the government in some of its programs. Others were satisfied with NURH 2's level of government engagement stating that *"NURHI is doing well in terms of ensuring the state is very involved in their activities."* Even with mixed results on NURHI 2's engagement, informants from the government and scale-up organizations expressed interest in NURHI 2's expansion to additional states and LGAs, particularly in more rural and hard-to-reach areas.

Key informants pointed out some shortcomings. They indicated that the cost of some of NURHI's interventions, including those involving the airing of media and the 72-hour clinic makeovers, could have negative implications for sustainability. Additionally, some informants thought that the nature of NURHI 2 *"being an implementation program"* with a short timeline, might constrain impact and sustainability within the government system, particularly in new geographic areas added in NURHI 2, such as Lagos, and rural Kaduna and Oyo.

"They do a lot on demand generation, and that actually manifested greatly in Kaduna state when at the time, they were able to contribute to the modern CPR doubling within a short period of time… They also focus on adolescents in that, and even as part of their demand generation activity, they engage in advocacy. They also do a lot of social and behavioral change activities. Then, they also work with us at the federal level to support some system strengthening" – Government staff, Federal

"…because the leadership of NURHI itself… [she] knows where the bottlenecks are, and she will [be] – is – was able to diagnose effectively and manage these different problematic areas. That can give us a good mileage and a lot of strategic programming. You have an objective and you give targets…, with empirical evidence, you are able to plan, strategize, and implement your programs… You adapt to the local peculiarities." – Government staff, Federal

"Deficiencies of NURHI as a program], I think the timeline is short. For a system that wasn't even well organized like family planning, now they're trying to hand it over but coming about like a bit of a rush. And I'm concerned about sustainability... Their ability to see those things through is another problem that can be envisaged in engaging too." – Government staff, Lagos

Question 3: *Where, how, and with what results has NURHI 2 contributed to replication, scale-up, and systems improvements and sustainability?*

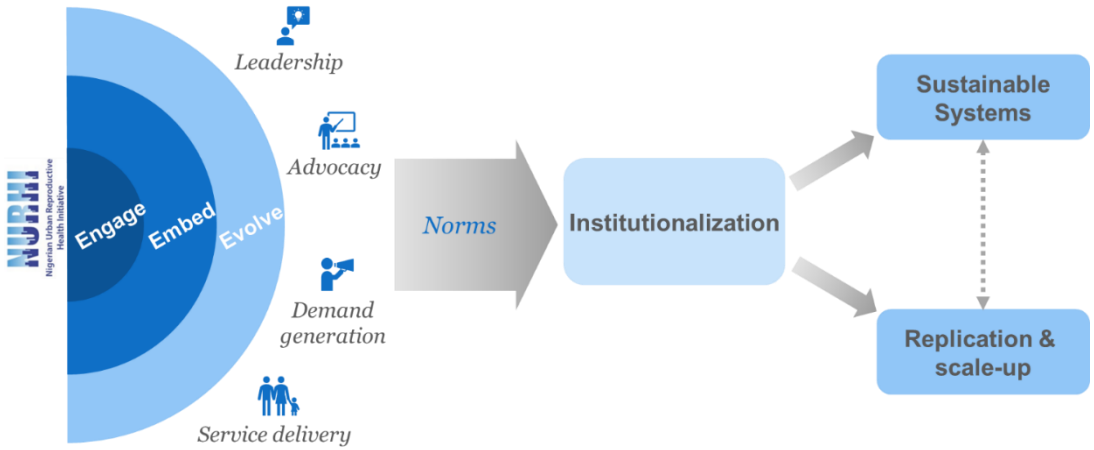
As NURHI entered phase 2, its focus shifted from testing whether the NURHI programming model worked or not, to institutionalizing, replicating, and scaling-up the proven model for sustainability. Therefore, NURHI 2 has placed an increased emphasis on institutionalization, scale-up, and system sustainability.

Figure 16 summarizes the overall "**engage** – **embed** – **evolve**" approach NURHI 2 has been taking to increase institutionalization and scale-up which in turn promote sustainability. Specifically, NURHI 2 envisioned a sustainable FP system as one that "cannot be reliant on transient resources." To accomplish this, NURHI 2 developed a three-step strategy. It starts with **engaging** leaders, stakeholders, and FP practitioners through collaboration and partnership. As the partnership is established, NURHI 2 works with stakeholders and partners to **embed** NURHI practices (e.g., advocacy, demand generation, and service delivery) in institutions by incorporating the practices into their mandate, approaches, tools, or activities. To **evolve** FP systems and structures, NURHI 2 focuses on transferring full ownership of its practices to the institutions, where the institutions become the main drivers of those practices or activities and NURHI 2 acts as a technical advisor to those institutions.

Key definitions

- **Institutionalization:** The process of adopting family planning practices or activities, incorporating them into a system, and establishing them as routine or the standard practice of the system *within the existing NURHI sites at the government level.*
- **Scale-up/ replication:** The process in which *implementing partners or government* conduct a large-scale application of NURHI practices, *beyond NURHI 2's original scope or states.*
- **Sustainability:** The ability for program components or interventions to continue without support from NURHI 2 *within the existing NURHI sites and through national policies*.

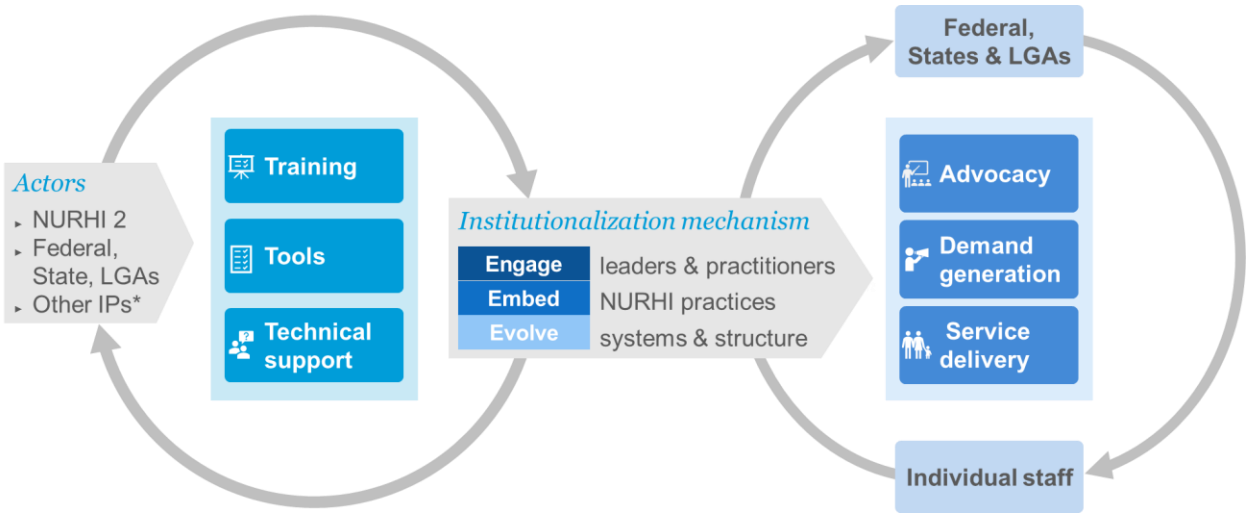
***Figure 16**: NURHI 2's strategy for institutionalization and scale-up to achieve sustainability*



Has NURHI 2 contributed to institutionalization?

One of the keys to sustainability is institutionalization. Key informant interviews with government, health providers and NURHI 2 staff together with document reviews indicated that NURHI 2 has institutionalized a variety of its program components at both government and health facility levels using the "engage – embed – evolve" strategy.

***Figure 17**: Institutionalization process of NURHI 2 programming*



***** Implementing partners (IPs) include community-based organizations, NGOs, etc.

Institutionalization in government agencies

At the government level, NURHI 2 engaged stakeholders, leaders, and staff at Federal, state, and LGA levels in discussions related to family planning and NURHI 2's program activities and practices (*Figure 17*). To gain trust and buy-in from the stakeholders and government staff, these engagements were initiated under rubrics like "we work together" and "what would you like to see happen?" As part of the process, NURHI 2 acted as technical advisor (instead of implementer). It helped set up a platform to prepare for importing proven activities that aim to improve the government's FP programs, and embed NURHI practices into implementing activities within government structures. NURHI 2's attitude is that *"this is your program, and we are here to help/support,"* with NURHI 2 gradually transferring ownership of those activities and practices to these agencies.

In its role as technical advisor, NURHI 2 focused on capacity building for government officials and staff, M&E officers, members of ACGs, technical working group (TWG) subcommittees, and media houses. The capacity of individual staff was strengthened through continuous training, tool sharing, and technical support activities; strengthened individual capacity in turn strengthens the

> *"So, one of the lenses that we use for sustainability is engage, embed, evolve. From the beginning… we engage them. [They] learn by doing all of that, embedding into their structures so that, you know, if you leave, it is in there and for them to actually evolve from all the engagement. All the training… for them to evolve and begin to do these things themselves."*
> – NURHI 2 staff, Headquarters

capacity of the governmental institutions and system they work in. *Annex 5–A* summarizes core capacity building activities that NURHI 2 provided to government staff.

Government staff and ACG members produced examples of NURHI 2's practices that have been institutionalized in systems at Federal, state and LGA levels (see *Annex 5–C, D, E*). These examples include:

- Budget Tracking Teams established to monitor budget allocation and release for FP using NURHI 2's budget tracking checklist;
- Advocacy Core Groups became independent CSOs and operate as coalitions of FP advocates;
- M&E officers use data for tracking program progress;
- Components of NURHI 2's demand generation program adopted for the National FP Communication Plan;
- Social mobilization activities follow NURHI 2's operational components; and
- FP coordinators use NURHI 2's practices and tools for their commodity logistics management work.

"Majorly, we work with NURHI… We were trained in advocacy messages, advocacy methods… [What] we've been doing is to make sure policymakers buy into FP because before NURHI came, people were not accepting FP." – ACG member, Oyo

"…the Post-Partum Family Planning Manual and Guideline have been approved. NURHI played a key part in the successful development, piloting, and finalization." – Government staff, Federal

"…[NURHI] made us realize that look, whether big or small we have to start somewhere. So, we started outreaches. We started our own in the form of town hall meetings, and we are still keeping up with it… It has been helping." – State government staff

Key informants, including government staff, ACG members and NURHI staff, identified both facilitators and barriers that they thought impacted the results of institutionalization processes in government agencies. Along with positive results of the NURHI program and strong partnerships with government and stakeholders, NURHI 2's "engage – embed – evolve" strategy was highlighted as a key factor facilitating the institutionalization process.

Barriers cited included strong cultural resistance to family planning among certain stakeholders during engagement, lack of coordination among implementation partners, high cost of some components of NURHI 2 program, and government's lack of relevant resources to sustain institutionalized skills and activities. *Annex 5–B* presents facilitating factors and challenges to the institutionalization process at government agencies

Institutionalization at health facility level

At the facility level NURHI 2 engaged health providers, nurses, CHEWs and others in conversations on how to improve access to and quality of FP service, and embedded NURHI practices in the facility through training, tool sharing, and technical support. Gradually the structures evolved by transferring full ownership of practices to the facility. Specifically, NURHI 2 trained, engaged and involved every member of the health facility to act as an FP advocate. It also used various communication platforms (e.g., WhatsApp) to gather and engage health providers in FP-related conversations. In particular, NURHI 2's 72-hour makeover intervention

utilized local artisans and resources, and involved facility staff and community members to promote interaction, enhance ownership, and assume responsibility. *Annex 5–F* presents the most significant capacity building and support activities that NURHI 2 provided to health providers, nurses, CHEWs, and other staff in their approach to institutionalization at the health facility level.

NURHI 2's 'step-down' training approach, a form of training to transfer knowledge and technical skills to colleagues within the same institution, was identified by informants as a key factor facilitating institutionalization of practices at the health facility level because it helped diffuse knowledge and skills to FP providers, nurses, and CHEWs who would otherwise not receive NURHI 2 trainings. Key informants also identified NURHI 2's human-centered design interventions focusing on provider biases, government adoption of training on LARC methods for FP providers, and support from healthcare providers as factors supporting institutionalization of practices at the facility level.

Key informants also discussed barriers to institutionalization. Changing mindsets and long-standing behaviors takes time, which affects the pace of institutionalization. The ability of CHEWs to provide a full range of contraceptive methods with high quality of care varies among clinics and geographies. Key informants also raised concerns about the future availability of consumables and commodities to sustain provision of a full range of contraceptive methods (*Annex 5–G*).

"…the NURHI people, they used to come for…on-site training. So, the gardener, the security, all the departments are involved. So, anybody that comes, even if they don't know the clinic could ask anybody, and anybody that is working here will bring the client to FP clinic." – Health facility staff, Oyo

"…during NURHI training…my thinking has really change… that is everybody agrees to accept family planning at anytime, you are free to access it to them without any complain or any query to them." – CHEW, Lagos

"… there's a thing that said, 'teach a child how to fish, not how to eat the fish,' so I will be able to do it on my own. I've been taught how to fish. So even though they are…not there, I will keep fishing." – Health facility staff, Kaduna

Has NURHI 2 contributed to replication and scale-up?

NURHI 2 appeared to create a ripple effect beyond the project's original scope as implementing partners and government replicated and scaled-up many NURHI practices within their own programs.

Key informants identified a number of examples of scale-up of components of NURHI activities by other partners (see *Annex 6–A, B, C*). There were more specific examples of scale-up within the Center for Communication Programs (CCP) portfolio – including within The Challenge Initiative (TCI), Post-Pregnancy Family Planning (PPFP), the USAID-funded HC3 project, and Breakthrough Action – than from projects and organizations that were not affiliated with CCP. This is not surprising because there are more structures and incentives in place to support replication and scale-up within an institution than among more distantly related organizations (*Figure 18*).

Opinions also differed sometimes about whether a particular activity is actually a scale-up of a NURHI approach or not. Some activities, like the 72-hour clinic makeover and Advocacy Core Groups, are well defined NURHI-developed activities, and are clear instances of scale-up. Other activities, such as social mobilizers and provider training are widely used within family planning, and are not readily attributable to one particular program. Though NURHI has evolved its own approaches to social mobilizers and provider training, attribution as scale-up promoted by NURHI 2 is sometimes less clear. Nevertheless, key informants were able to identify some examples of NURHI 2 scale-ups via other partners such as UNFPA, World Bank, Planned Parenthood Federation of Nigeria, and private philanthropists.

***Figure 18**: Levels of NURHI 2 scale-up*

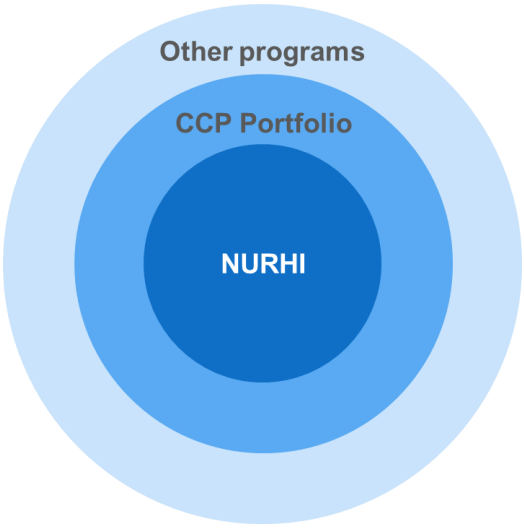
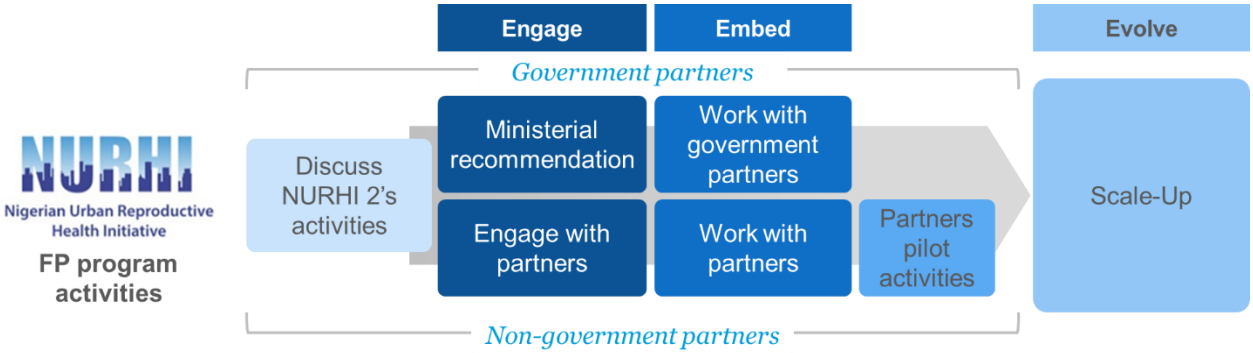


Figure 19 describes the scale-up process of NURHI 2 programming that emerged from the key informant interviews. This process also follows the engage–embed–evolve strategy. NURHI 2's practices and program activities in advocacy, demand generation, and service were introduced broadly to both government and non-government partners through various formats. These formats include technical working group meetings, national and international FP conferences, engagement activities, community-based activities, and peer-reviewed publications. NURHI 2 program practices of interest to government partners were then recommended to Ministers for scale-up approval. With non-government partners, NURHI 2 engaged to have stakeholders and policymakers buy into the idea for scale-up. Once a scale-up was agreed to, NURHI 2 worked with partners to review and adjust the program practices to fit within a different organizational structure, program context, geography and/or health focus. NURHI 2 also provided technical support to initiate and sometimes to advance the scale-up process. In many cases, non-government partners piloted particular NURHI practices or program activities before implementing them on a larger scale. After scale-up was underway, NURHI 2 continued to provide technical support to partners to monitor, review, adjust and improve the practices, as well as handover the activities to Federal and state governments.

> *"The 72-hour [clinic makeover] is going beyond even us, yes even TCI, even CCP to stay. It's already been borrowed by a lot of people, NSHIP has taken it up in Bauchi State and they are trying to replicate it."* – TCI staff

***Figure 19**: Scale-up process of NURHI 2 programming*



What steps has NURHI 2 taken to position for scale-up?

Most interviewed partners shared that engagement strategies, as well as the technical support provided by NURHI 2 before, during and after scale-up, were stepping stones in the process. In its role as technical advisor, NURHI 2 held learning sessions with government staff and implementing partners to increase their understanding of how NURHI approaches work and how they can be adapted. In addition, by promoting knowledge management – sharing resources, materials and tools with scale-up partners – NURHI 2's project states became learning labs where partners could visit, observe and learn from the experience. NURHI 2's efforts to design flexible and adjustable program activities and tools also enabled partners to adjust the adopted interventions as needed.

Key informants identified a number of factors that they felt contributed to scaling-up NURHI 2 activities. These included evidence of the success of NURHI program practices, strong partnerships with government and implementing partners, the ability to adapt the NURHI model, advocacy efforts, technical support and resources provided by NURHI 2 to support scale-up, and the availability of data such as PMA2020 to inform planning for scale-up. Identified barriers to scale-up included limited human and financial resources, weak M&E and data systems to support the evidence-based decision-making promoted in the NURHI model, disagreement among partners about which elements of the NURHI model to scale up, lack of transparency and accountability among some government partners at the LGA level, and policy barriers (e.g., FP for youth). See

"Through the advocacy and engagements with government officials at the state level, they [NURHI] have made difference to the states where they are operating in… to buy into FP…and take ownership… Not just buying into it, [but] they see the program as… they own it." – Government staff, Federal

"There are a lot of their [NURHI's] materials. We adapted a lot. We had to develop some, but we use their materials, we just reprinted, or they gave us free… and we did print… those ones that are specific to our clients." – Scale-up partner, Lagos

"In our human resource structure, we really wanted to be very lean. But we discovered that – [even] we said that in being lean – we would have only two consultants in the states, one person would handle advocacy and demand generation, another person will do service delivery and research monitoring and evaluation, which is contrary to…the NURHI structure." – Scale-up partner, Federal

Annex 6–D for more detail on the facilitating factors and challenges to the scale-up of NURHI 2 programming.

Has NURHI 2 contributed to sustainability?

We cannot yet assess the extent to which FP practices introduced by NURHI 2 and associated FP behavior change at the population level will be sustained after the project ends because NURHI 2 was still ongoing at the time of this evaluation. However, the institutionalization process described above is expected to contribute to sustainability. In addition, findings presented for Question 2, which evince some social norm advances and increases in intention to use FP among women and youth in NURHI 2 program areas, are expected to contribute to sustained FP behavior change. Evidence from the recent sustainability study conducted by the MLE project suggests that changes in norms and behaviors around FP among providers and women were sustained after NURHI 1 ended (See *Annex 7*).

"Now, Federal Government is talking family planning. Even Buhari is talking family planning. You would never have heard that from any of the presidents or vice-presidents or any of the ministers in time past… Funding… Federal Government has done everything from Blueprint development to CIPs." – ACG member, Federal

"Well before if I see a youth that comes in for family planning, I won't do family planning for youth. For a newly[-wed] couple, before, I'm asking for partner consent. But this has been changed after the training at NURHI that a youth that walks in for family planning that means she knows the best for herself." – Health facility staff, Oyo

*"**R1**: Anyone that goes for family planning treatment there is thoroughly tested before having any treatment administered.*
***R2**: They always attend to us if we have any complains afterwards.*
***R3**: The reason why I patronize the general hospital is that the health workers there are considerate and friendly.*
***R4**: They are very friendly and welcoming to the extent that even the head of facility attends to patients with calmness and ensures that they get the right treatment and method for their body system."*

– Women, Oyo

At the systems level, government's commitment and political will to support family planning have increased at both Federal and state levels, as evidenced by positive shifts in FP funding, policy, and coordination. Specifically, NURHI approaches are embedded in several national FP policies and guidelines, including the Task-Shifting and Task-Sharing policy (TSP), Costed Implementation Plans (CIPs), and the National Family Planning Communication Plan (2017–2020). There have been increases in FP allocations in State budgets in Kaduna, Lagos, and Oyo; however, funding releases have been more limited (See *Annex 8–A*).

Qualitative data suggest that there have been positive shifts in health provider norms and behaviors related to FP in NURHI 2 program areas. In key informant interviews, health providers and CHEWs indicated how their attitude toward providing FP services, in particular FP for adolescent and youth, have changed thanks to NURHI 2's training in FP counseling and provision. This also reflected in the establishment of youth-friendly reproductive health services where young people can receive comprehensive, client-centered family planning counseling. See *Annex 10* for additional illustrative quotes for this and other emergent themes.

In the key informant interviews, we asked government stakeholders, ACG members and implementing partners (IPs) for their opinions on what would be sustained if the project ends. Key informants had diverse opinions about what elements of NURHI 2 would be sustainable after the end of the project, and there was no strong consensus. Elements that were more commonly mentioned as likely to be sustainable included the advocacy efforts through the Advocacy Core Groups and interfaith forums, dedicated FP messaging and outreaches to adolescents and youth through the National Youth Service Core (NYSC), improved quality of care by providers, and the capacities built and technical resources developed through the span of NURHI 2. Respondents identified the strengthened capacity of local systems as a result of NURHI's efforts to embed their knowledge, strategies, materials, and interventions with government and implementing partners as a facilitator of sustainability. Through its interventions, NURHI has established a "*solid foundation*" from which government and other partners can build upon. In addition, continued support from government and other donors was cited as a facilitator to sustainability (See *Annex 8–B* for more details).

Key informants evinced somewhat more consensus on what elements are less likely to be sustainable. Program elements that have significant cost implications or demand on staff's time were felt to be the least likely to be sustainable. These included the 72-hour clinic makeover, activities requiring high levels of government staff time (e.g., regular supportive supervision), some demand generation components (e.g., TV/radio spots, Green Dot campaign, and *Get It Together*), and M&E and data collection and use. By far the most commonly cited barrier to sustainability was funding constraints. Other barriers noted included lack of time for government to prepare to take over program components, lack of clarity in responsibilities for some program components, lack of good quality data to inform decision-making, and continued high reliance on partners to implement activities (See *Annex 8–C* for more details).

These findings represent informants' opinions of what will and will not be sustainable after NURHI 2 and why, but they are broadly consistent with the findings of the NURHI 1 Sustainability Study. Specifically, awareness of and demand for FP services from clients were found to be sustained after NURHI 1 as was availability of commodities due to continued support from government and international donors. Meanwhile, activities like social mobilization and provider competency-based training were found to be less sustained due to lack of funding and lack of a sustainability plan in place for provider trainings once NURHI 1 exited.

"I think the area of advocacy, involvement of religious leaders [will continue]. Once you get them involved, it becomes part of them so beyond the life of the project. I feel this is something that will continue because it's part of them, probably they've even incorporated it into some of the activities in the community,… maybe in their religious groups." – Scale-up partners, Lagos

"…beyond the life of the project, the two keys that arouse everything… we've talked about the human resource within the state, there's the materials... And we know we have this human resource there and it's the opportunity to keep this, the strategies, the skills they gain from NURHI. And since we are using the same pull it's an avenue for us to perpetuate the legacy of NURHI." – Scale-up partner, Federal

"[NURHI] have done so much that for government to take over all those things overnight… is a big challenge… So, if NURHI exits today, government need to do a lot of budgeting to take over that and fund that project. So, it's not an easy task." – Government staff, Kaduna

"For the [72-hour clinic] makeover, government will tell you they don't have the capacity to do that, you know… even our own facilities we've not renovated them and all that. I feel that might not be able to [continue]." – Scale-up partner, Lagos

04 Discussion and Recommendations

Key Lessons Learned

- There was evidence that NURHI 2 activities positively influenced the attitudes and behaviors of women and health providers, and supported institutional change in FP programs, policies and implementation.
- Our findings support the value of NURHI's three-pronged approach addressing advocacy, demand generation, and service delivery and the underlying assumption that social norm change at all levels builds a foundation for sustainable change in FP behavior.
- Deliberate attention to early and frequent stakeholder engagement, embedding practices within existing structures, and transferring ownership of NURHI practices to other institutions are important foundations for sustainable change.
- A realistic resource plan needs to be part of preparing for sustainability. There also needs to be sufficient time to fully establish nascent practices and to diversify the resource base to support activities.
- There are trade-offs between implementing in a way to achieve rapid mCPR change and implementing in a way to achieve sustainable system change, which takes time.

The main substantive changes in NURHI 2 compared to NURHI 1 were an increased emphasis on institutionalization and sustainability, and the addition of Life Planning for Adolescents and Youth (LPAY) activities for youth. Other changes were more adaptations to implementation than fundamental shifts in program components. Changes were driven by data and implementation experience and the shift in focus of NURHI 2 toward scale-up, compared to NURHI 1.

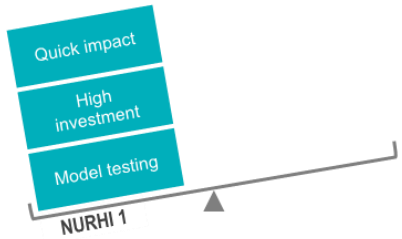
Qualitative findings pointed to many examples of how NURHI 2 activities positively influenced the attitudes and behaviors of women and health providers, and supported institutional change in FP programs, policies and implementation. Quantitative data indicate that there has been a positive change in intention to use family planning among women and youth, and in several beliefs and social norms at the community level. Focus group discussions with FP service clients reflect notable decrease in provider bias, contributing to improved quality of FP services, and quantitative data suggest some improvements in quality of care in Kaduna and Oyo, although findings were more mixed in Lagos.

Modern contraceptive prevalence rate (mCPR), while not the ultimate outcome that NURHI 2 programming focuses on, is a longer-term goal of the Nigeria FP strategy and FP2020. Different data sources provide a different picture of mCPR trends in each of the three NURHI 2 states but

overall we did not see the significant, rapid increase in mCPR that was observed in the MLE evaluation for NURHI 1[vii].

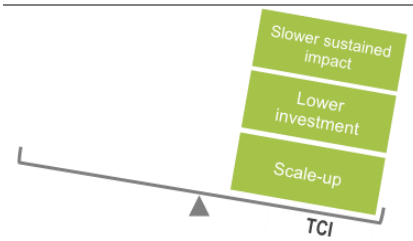
How might we interpret this finding? NURHI 1 aimed to test the NURHI model so was intensively focused on achieving relatively quick impacts on mCPR with high resource levels. In contrast, NURHI 2 was designed to test scale-up of the successful NURHI model. As such, it aimed to address sustainability and institutionalization in addition to a "positive shift in family planning social norms at the structural, service, and community levels" to eventually increase mCPR. It also had a lower resource level, consistent with sustainability objectives. One potential consequence of this shift in focus is that trade-offs have to be made between implementing in a way to achieve rapid mCPR change versus implementing in a way to achieve sustainable system change (*Figure 20*). System change takes time as there are often entrenched, systemic barriers that are not easily changed by an external project. In addition, resources are spread more thinly in scale-up. It is also possible that, compared to the original NURHI 1 urban sites, there was less latent demand for FP to tap into in Lagos and rural areas of Kaduna and Oyo. The TCI project aims to catalyze scale up of the NURHI model with an even greater emphasis on working within existing systems for sustainability. It will be interesting to learn from that experience how these potential trade-offs play out under that model.

***Figure 20**: Sustainability programming trade-off*



- NURHI 1 was a high intensity project with large resource investment.
- NURHI 1 contributed to significant increases in mCPR in the six cities where it was implemented.
- However, several components of the program were unsustainable without continued funding.

- NURHI 2 aimed to scale up the success of NURHI 1, while focusing on sustainability
- NURHI 2 achieved progress in several precursors to increased contraceptive use and sustainability, but did not attain the rapid gains in mCPR observed in NURHI 1.



- TCI catalyzes scale up of NURHI models to boost awareness, access, and acceptability of FP in order to increase mCPR.
- TCI relies on existing government systems to fund and oversee these FP projects.

[vii] On a methodological level, the results for NURHI 1 were obtained from a large evaluation that was specifically designed to evaluate the impact of NURHI 1. The mCPR estimates for NURHI 2 are obtained from surveys that were designed to provide state-wide data and are not designed to provide specific information on NURHI 2 interventions and geographies.

The results of this evaluation, along with the results of the NURHI 1 Sustainability Study, provide some lessons on which aspects of NURHI 2 are likely to be sustainable and which are not. Changes in norms and individual practices, improvements in capacity of staff, and institutionalized policies and guidelines are likely to be sustained. Interventions that are resource intensive, are vulnerable to weaknesses in other system components, or are external to existing systems are not likely to be sustained. Deliberate attention to stakeholder engagement, embedding practices within existing structures, and evolving practices by transfer of ownership of NURHI practices to other institutions have been important in laying the foundations for sustainable change. However, while resource constraints are not the whole story, they are a significant barrier to sustainability. A realistic resource plan needs to be part of preparing for sustainability. There also needs to be sufficient time to fully establish nascent practices and to diversify the resource base to support activities.

Annexes

Annex 1: Specific research questions

The evaluation focused on a number of specific sub-questions to answer the three overarching questions. Findings decks of sub-questions can be accessed here.

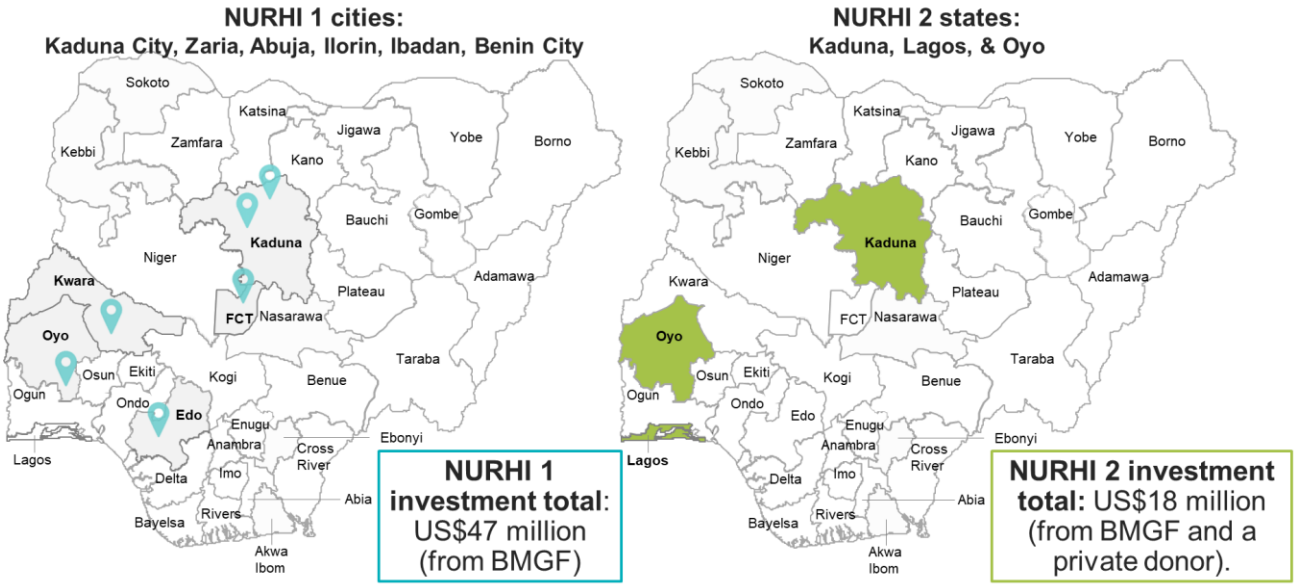
No.	*Questions*
1. *How has the model that emerged from NURHI 1 been adapted and evolved within NURHI 2?*	
1.a	How and why was the design and implementation of NURHI 1 adapted in NURHI 2, by activity area, context, population?
2. *Has NURHI 2 achieved its intended results? What have been its strengths and weaknesses, and why have these occurred?*	
2.a	How has NURHI 2 strengthened approaches to better reach women/population segments who were previously not reached?
2.b	Did NURHI 2 produce different results (in terms of intermediate outcome level and mCPR) by activity area compared to NURHI 1? What further adaptation is needed?
2.c	How do NURHI 2 intervention components (demand, service delivery, and advocacy) impact mCPR and ideation changes?
2.d	Which program components are the most critical for increasing modern family planning use for different demographics?
2.e	Which service channels have been most effective for expanding access to injectables and long acting and reversible methods of contraception?
2.f	Has the project contributed to normative change at the community level? If so, how? If not, why not?
3. *Where, how and with what results has NURHI 2 contributed to replication, scale-up, and systems improvements/ sustainability?*	
3.a	Has the project contributed to normative change at the provider level? If so, how? If not, why not?
3.b	What influence has NURHI 2 had on institutionalizing capacity for implementation and management of FP programs as reflected in proximate and ultimate outcomes, to adapt to evolving circumstances such that work is sustained without their existence/support?
3.c	Which aspects of NURHI 1 and/or NURHI 2 have been adopted and replicated in the public or private sector's FP programming environment at scale as a result of X years of investment? What factors contributed to these instances of scale-up?
3.d	What has been the experience with adaptation of NURHI 2 program components in terms of what seems to have gone well and what challenges were experienced? What were the adaptations to interventions that were made and why?
3.e	What steps has NURHI 2 taken to position for scale-up in other sites at the federal and state government, and other system/institutional levels?
3.f	What has been the influence NURHI has had on the Nigeria national FP program, agenda and discourse?

Annex 2: Sample size of surveyed women of reproductive age in Kaduna, Lagos and Oyo states

State and Survey	*Number of WRA surveyed*
Kaduna	
DHS 2013	1243
DHS 2018	1610
PMA2020 2015	2934
PMA2020 2018	2766
Omnibus 2017a	1187
Omnibus 2017b	1134
Omnibus 2018	1525
Lagos	
DHS 2013	1482
DHS 2018	1445
PMA2020 2015	1429
PMA2020 2018	1590
Omnibus 2017a	1196
Omnibus 2017b	1195
Omnibus 2018	1600
Oyo	
DHS 2013	915
DHS 2018	918
MLE survey 2015	1844
PMA2020 2017	1842

Annex 3: NURHI 1 vs. NURHI 2: Geography and resources

Differences in geography and resources between NURHI 1 and NURHI 2

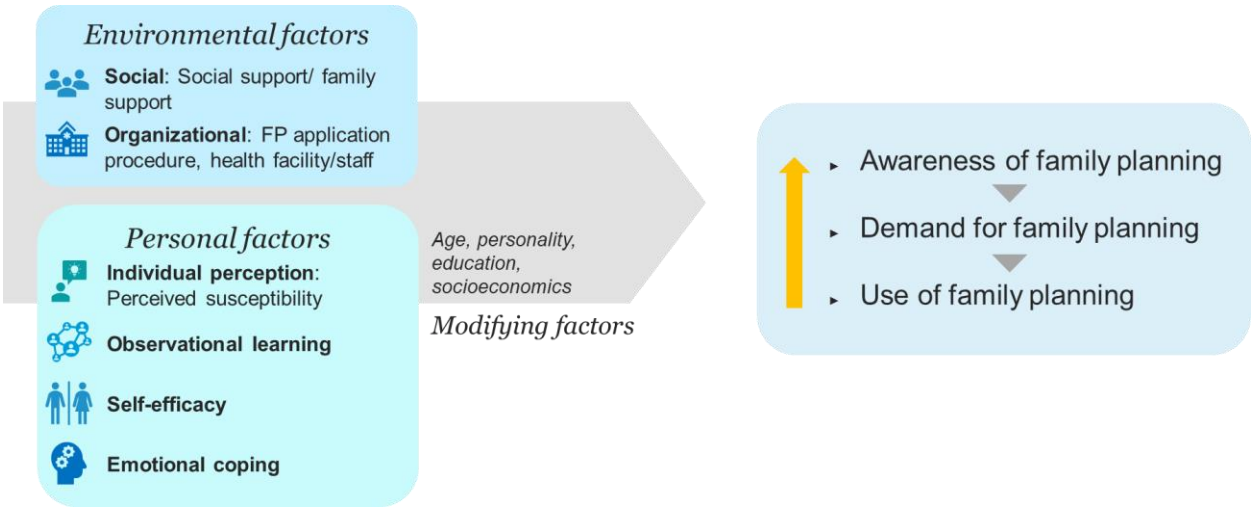


Source: Document review, qualitative interviews

Annex 4: How has NURHI 2's overall approach influenced FP social norms and behaviors?

To better understand the impact of NURHI 2's program components on FP social norms, it is useful to look into the underlying factors that influence the awareness, demand, and use of family planning, especially in a culture where women still need someone's permission to obtain a FP method. *Figure 16* presents a conceptual framework for the determinants of FP awareness, demand, and use that is derived from the qualitative data. The data indicate that awareness, demand and use of FP by women in the community are influenced by their interactions with environmental and personal factors.

***Figure A4**: Determinants of awareness, demand, and use of family planning*



Social and organizational, influences can affect women's attitudes toward and decisions to use FP. These include communication that women have with family and friends, as well as support and influence she receives from her broader social network (e.g., neighbors, community members, religious and community leaders, FP messaging on radio and TV, health talks, outreach or social mobilization events). The organizational factors encompass characteristics of FP services and of health care providers. Some factors related to FP services may encourage FP use. These include free access to FP service and availability of various FP methods that allow greater choice. Some examples of FP services conducive to FP use are *"friendly and attentive attitudes"* of health facility staff and CHEWs; improved quality of FP services (e.g., no stock-outs, clean clinic rooms, privacy, short wait times); and accessibility of FP services (e.g., availability of FP services at more easily accessed locations).

> *"Some people took the information [about child spacing] the wrong way, but with the help of our religious leaders who came out and explained to the people that child spacing has existed since the time of our prophets. This enlightened women and thank God they have embraced it... In my own case, now it's about seven years since I gave birth. I understand that there is a lot of benefits in child spacing, you will feel better and healthy."* – Woman, Kaduna

"[I chose to do FP at the facility I'm using now] because… they will run test. Not that when we get there, they will just force a method on you. They will run test to know which method can suit our body system." – Woman, Oyo

"Family planning is a good thing… because at least you would have [time to] train your child to extent that you know that 'Fine, I can have another child apart from this.' You will concentrate on one than [more than] one. So, I think FP is good for you to be spacing your child and giving them a good moral." – Woman, Lagos

Personal factors refer to personal cognitive, affective and physical events that can influence a woman's attitude and decision to use, including individual's perception, observational learning or expectation of outcomes, self-efficacy, and emotional coping. Individual perception denotes a woman's belief regarding the benefits and importance of FP. This includes the chance of having a better life and health condition by using contraception. As women in our focus groups stated they may now be able to prevent *"unwanted pregnancy"*, have more energy to *"take better care of my children,"* having time to *"go back to school"* for better career, or *"not giving birth to children more than my strength."* Additionally, what a woman perceives and decides about FP is also influenced by observing others' experiences with FP. A woman may become interested in and decide to use FP service because her friend or neighbor *"had done it," "does not have a problem,"* and *"is happy"* with the outcome. Self-efficacy translates to confidence to access FP service and maintain contraceptive use without experiencing restriction or fear. Barriers a woman may experience to access or use of FP may include a bad experience with certain FP methods, lack of time and transportation, fear of *"going against God's wish," "being judged by community members,"* or experiencing negative impacts on marriage if she uses FP, or fear of dealing with side effects of contraception. Emotional coping encompasses the desire or rationality that helps motivate a woman to overcome barriers and access FP services, such as desire to have fewer number of children, or fear of *"being pregnant again soon"* after the previous pregnancies.

Annex 5: Results: NURHI 2 institutionalization

***Annex 5–A*: Summary of NURHI 2's capacity building activities at government level**

Capacity building	*Activity*
Training	▸ Training on leadership in FP strategy development, and FP program development, implementation and management ▸ Workshops on FP, contraceptive technology, advocacy skills, FP budgeting and budget tracking, and data collection and analysis ▸ Training on using quality data for decision making for HMIS and LGA M&E officers at the SMOH and SPHCB ▸ Training for LPAY Ambassadors
Tools	▸ Tools on FP budget development and budget tracking ▸ Documents supporting FP advocacy to policymakers, religious leaders, and media (e.g., Christian and Islamic perspectives on FP) ▸ Materials supporting FP demand generation and service delivery (e.g., billboards, flyers, and reporting tool on service quality) ▸ FP training manual and service protocol for health facilities
Technical support	▸ Developing the National FP Blueprint and CIPs, FP program implementation and management in states and LGAs ▸ Setting up platform to strengthen ACGs that facilitated the evolving of local civil society organizations (CSOs) ▸ Data use in TWG meetings ▸ Development of FP supportive supervision checklist

***Annex 5–B*: Facilitating factors and challenges to NURHI 2's institutionalization at government level**

Facilitators	*Challenges*
▸ Positive results of NURHI 1 and 2 drew policymakers' interest in adopting NURHI programs	▸ Strong resistance on part of stakeholders during engagement process (e.g., religious and traditional leaders)
▸ NURHI's "engage – embed – evolve" strategy enabled government's buy-in and transformation of FP activities	▸ High cost of programs (e.g., 72-hour makeover), and government's uncertainty around FP funding and procurement protocol may limit adoption of FP activities
▸ Strong partnership with government, religious leaders and partners enabled the engagement process	▸ Lack of coordination among the implementation partners in institutionalization process
▸ NURHI's consistent efforts to strengthen capacity and provide TA to government staff/activities	▸ Government's lack of relevant resources (e.g., financial and human resources) to sustain the institutionalized skills and FP activities
▸ Setup of information about NURHI's interventions as an open resource make it more accessible	▸ Technical support provided to government agencies sometimes was not perceived to be aligned with government's agenda

Annex 5–C: Evidence of institutionalized capacity to sustain advocacy for FP over time

	Federal	*State*	*LGA*
Budget Tracking Teams were established, using budget tracking checklist to monitor budget allocation and spending for FP	●	●	●
ACGs were transformed into civil society organizations (CSOs), and operate as independent coalition of FP advocates in Nigeria	●	●	●
M&E officers received training on data reporting, collection and analysis, used data for monitoring and evaluation, and drafted M&E reports	●	●	●
TWGs were established for frequent meetings to discuss solutions for various issues related to FP program implementation and management	●	●	
FP social behavior change communication strategy for Reproductive, Maternal, Newborn and Child Health was developed and promoted	●	●	

● Evidence ◌ No evidence

Annex 5–D: Evidence of institutionalized capacity to sustain FP demand generation over time

	Federal	*State*	*LGA*
National FP Communication Plan was designed and developed, adopting components of NURHI 2's demand generation program	●	●	
Social mobilization activities were implemented, featuring training curriculum and operational components from NURHI 2's program	●	●	
NURHI's *Go Men Go* radio show was handed over to MOH, including training on program content writing and production to government staff	●	●	
Outreach programs to generate FP demand were implemented in various formats with the support from NURHI 2		●	●
Training curriculums and materials supporting FP demand generation were adopted from NURHI 2's		●	●

Annex 5–E: Evidence of institutionalized capacity to sustain FP service delivery over time

	Federal	*State*	*LGA*
Government's training on FP counseling and methods provided to health providers and CHEWs, used NURHI 2's curriculum and materials	●	●	●
FP coordinators practiced NURHI's commodity logistics management skills and tools to manage the contraceptive supply and distribution	●	●	●
National Guideline on Access Government Commodities by Private Health Practitioners was developed based on outcomes of NURHI's commodity management with private sector	●		
Outreach programs to enhance FP services delivery were implemented in various formats with the support from NURHI 2		●	●
Supportive supervision activity was adopted and implemented, using NURHI format and FP supportive supervision checklist		●	●

***Annex 5–F*: Summary of NURHI 2's capacity building activities at health facility level**

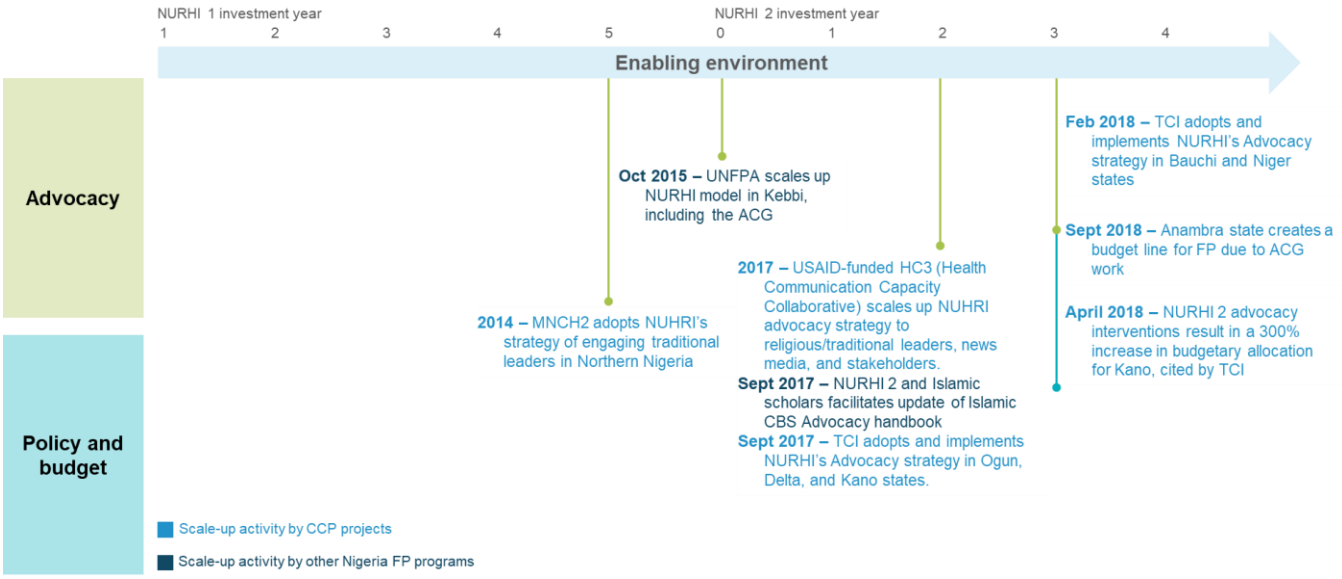
Capacity building	*Activity*
Training	▸ Training on interpersonal communication to decrease provider bias and strengthen provider-client relationships ▸ Whole site orientation that trained every personnel at the facility, from the "gateman" to the lead provider on the importance of FP ▸ Training and re-training to keep FP providers updated on new and most current methods and LARCs, specifically implants and IUDs ▸ Step-down trainings
Tools/ Equipment	▸ Providing support on commodities, consumables, and proper equipment for LARC insertion ▸ Clean and furnished health facility (e.g., 72-hour makeover) ▸ Job aids such as the Medical Eligibility Criteria (MEC) wheel, flow charts, and educational material for counseling
Technical support	▸ Supportive supervision which includes: – Correcting LARC insertion technique – Building confidence of the providers – Ensuring job aids are being utilized – Confirming that data is being tracked at the facility – Ensuring cleanliness and quality of services are being upheld at the facility

***Annex 5–G*: Facilitating factors and challenges to NURHI 2's institutionalization at health facilities**

Facilitators	*Challenges*
▸ 'Step-down trainings' diffuse knowledge and skills to providers who would otherwise not receive NURHI trainings	▸ Changing mindsets and long-standing behaviors takes time
▸ Human-centered design and values clarification interventions help decrease provider biases for youth and unmarried individuals	▸ CHEWs ability to provide a full range of contraceptive methods is highly variable based on geography and needs of the local clinic
▸ Government has taken up provider trainings for LARC methods	▸ Concerns about sustainability of the ability to provide a full range of contraceptive methods based on future lack of free consumables and commodities available
▸ Healthcare providers buy-in and appreciate supportive supervision and trainings	

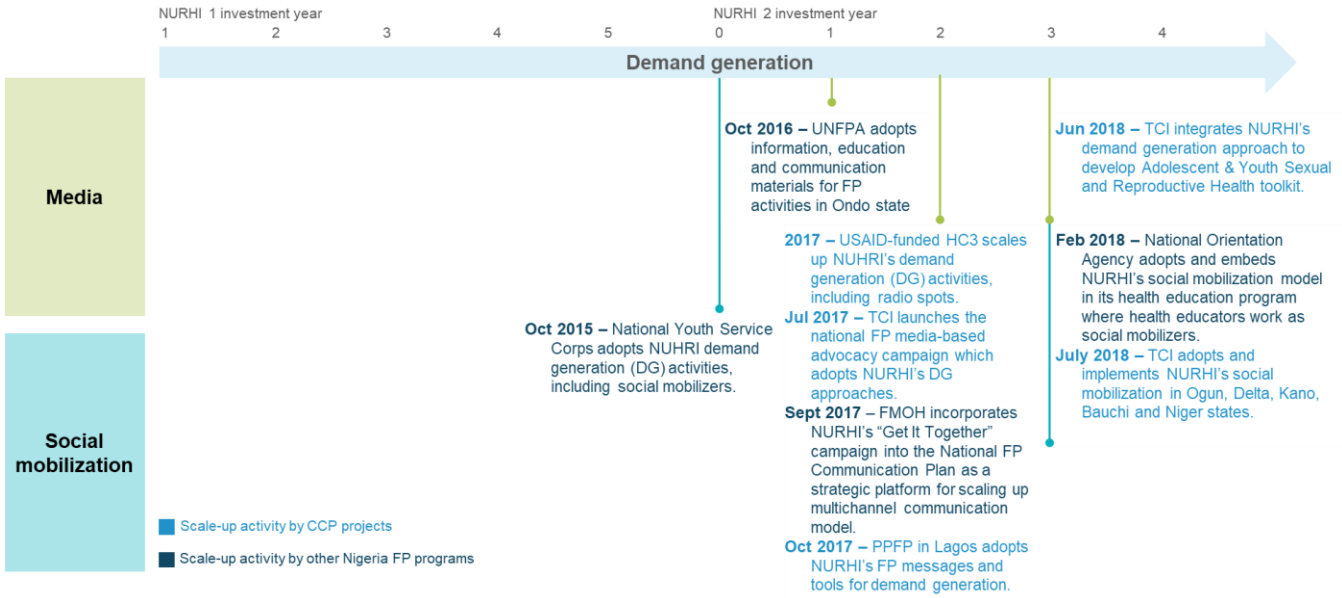
Annex 6: Results: Scale-up of NURHI 2 programming

Annex 6–A: Evidence of scale-up of NURHI 2's advocacy practices



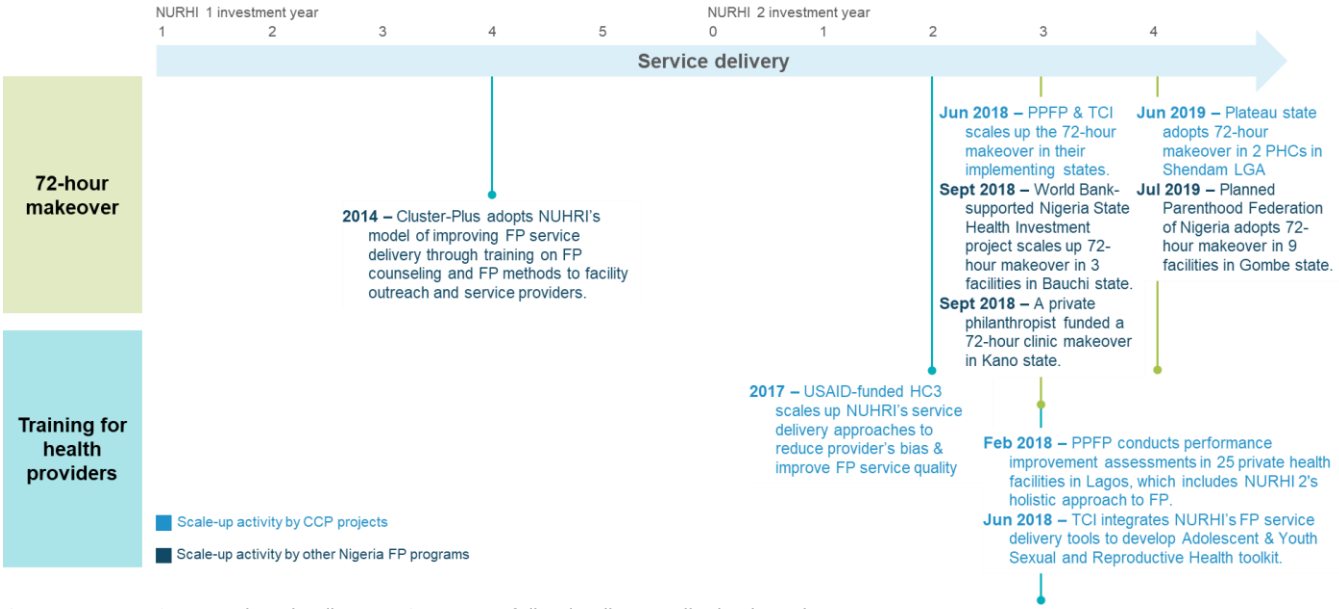
Source: NURHI 2 Interactive Timeline, BMGF FP Portfolio Timeline, qualitative interviews

Annex 6–B: Evidence of scale-up of NURHI 2's demand generation practices



Source: NURHI 2 Interactive Timeline, BMGF FP Portfolio Timeline, qualitative interviews

Annex 6–C: Evidence of scale-up of service delivery practices and program activities



Source: NURHI 2 Interactive Timeline, BMGF FP Portfolio Timeline, qualitative interviews

Annex 6–D: Facilitating factors and challenges to the scale-up of NURHI 2 programming

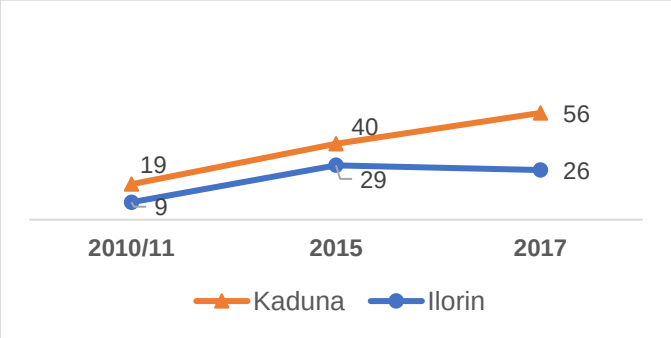
Facilitators	*Challenges*
▸ Positive outcomes of NURHI programs drew partners' interest in scale-up	▸ Limited funding and human resources to implement the scale-up
▸ Strong partnership with government and partners enabled the engagement process	▸ Weak M&E and reporting system that limited the planning and monitoring among scale-up partners
▸ Flexibility of NURHI models enabled the adjustment for scale-up	▸ Disagreement in selecting programs for scale-up among policymakers and stakeholders
▸ Advocacy effort, technical support, and resources provided by NURHI and partners	▸ Lack of transparency and accountability of government partners in scale-up process at LGA level
▸ Availability of data for planning and making decision about scale-up (e.g., PMA2020)	▸ Policy hindrance that limited the scale-up (e.g., FP for adolescents)

Annex 7: Summary of NURHI 1 Sustainability Study

The recent NURHI 1 Sustainability Study examined what has been sustained two years after NURHI 1 activities formally concluded.[8, 9,10] The study design compared three urban sites: Ilorin, where program activities concluded, Kaduna where they continued under NURHI 2, and Jos where no NURHI program activities took place.

Findings from the study demonstrated that mCPR continued to increase among all women in Ilorin (from 22.9% in 2015 to 27.0% in 2017) and Kaduna (from 14.9% to 21.7% respectively). Despite ending the program in Ilorin, respondents reported continued exposure to different aspects of NURHI's FP messages on the radio and television but at a lower level compared with 2015. In contrast, exposure was lower in Kaduna compared to Ilorin in 2015, but continued to rise by 2017.

***Figure A7.1**: Percentage of women who reported that they would be praised, encouraged, or talked favorably about if people in the community knew they were using FP/ contraception*

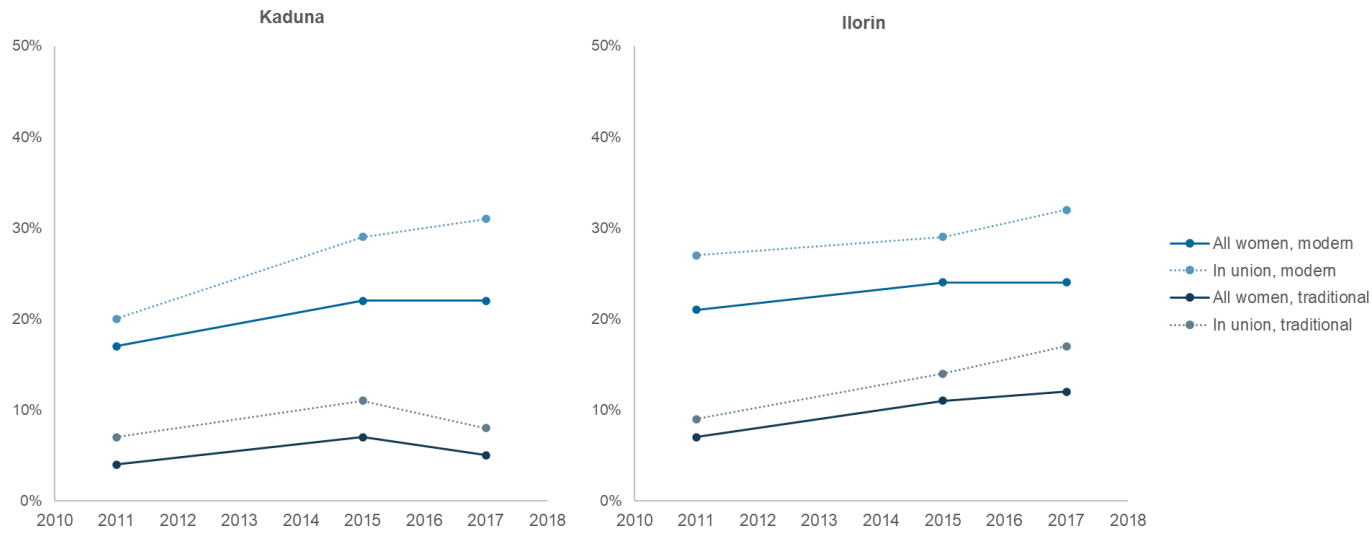


Source: NURHI 1 Sustainability Study

> *"Yes, it has changed. Why do I say so? Because if she does that [use contraceptives], people would see her as someone who is taking care of her children and they are in good health, and so she is taking care of them as she should and that would attract them to what she is doing."* – Woman, Kaduna

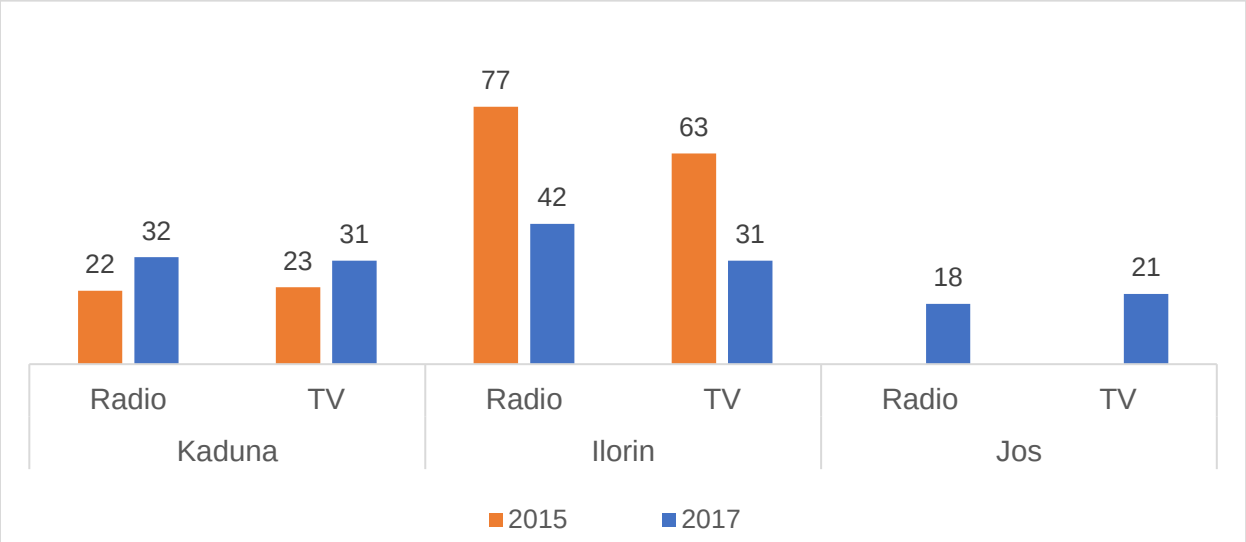
NURHI-supported facilities had better quality and higher service use than non-supported ones. However, in Ilorin, quality of service did not continue a strong upward trend after NURHI 1 ended. Improvements made during phase 1 – such as training of providers, assuring consumables availability, offering a full range of methods, and availability of job aids and education materials – were not necessarily maintained. In Kaduna, quality of service continued to increase as the program extended to the second phase. In 2014, there was no difference in service utilization between the two states, but in 2017, Kaduna had significantly more new FP users than Ilorin. Notably, social norms around contraceptive use and high-quality services were sustained in Ilorin, even after NURHI 1 ended. However, improvements were greater in Kaduna where the program continued (*Figure A7.1*).

Figure A7.2: NURHI 1 Sustainability Study: *Current use of contraception among all women and women in union*



Source: NURHI 1 Sustainability Study

Figure A7.3: NURHI 1 Sustainability Study: *Percentage of women who report exposure to radio and television spots with couple talking about FP in 2015 and 2017*



Source: NURHI 1 Sustainability Study

Annex 8: Results: Sustainability of NURHI 2 program activities

***Annex 8–A*: Budget allocation and release for family planning in NURHI 2 states**

	2016	2017	2018	2019
Kaduna	$**0** allocated $**0** released	$**308,500** allocated $**138,800** released	$**304,800** allocated $**304,800** released	$**411,700** allocated $**0** released
Lagos	$**94,000** allocated $**0** released	$**267,600** allocated $**86,700** released	$**659,900** allocated* $**134,200** released	$**256,200** allocated $**200** released
Oyo	$**25,400** allocated $**0** released	$**18,500** allocated $**50,900** released	$**109,000** allocated $**33,600** released	$**101,000** allocated $**0** released

Source: Pathfinder AFP data
Note: Currency conversion using average annual rate. Numbers rounded to nearest hundred.
*Lagos 2018 allocated amount also includes Saving One Million Lives FP allocations.
The Nigeria 2019 Appropriation Bill cut FP allocations by 90%, from 2.9billion NGN in 2018 to 300 million NGN in 2019

***Annex 8–B*: NURHI 2 program components that government and IPs think will be <u>sustainable</u>, and why**

Sustainable	*Facilitators to sustainability*
▸ Advocacy efforts through the ACGs, and Interfaith forums	▸ NURHI building the capacity of local systems by embedding the knowledge, strategies, and materials, and interventions established over the course of NURHI 1 and NURHI 2 to government and implementing partners.
▸ Dedicated FP messaging and outreaches to adolescents and youth through the NYSC	▸ Continued funding from both outside sources and government.
▸ The high quality of services from healthcare providers	▸ NURHI established a "solid foundation" from which government and other partners can build upon.
▸ The capacities built and resources developed over the span of NURHI 2	

***Annex 8–C*: NURHI 2 program components that government and IPs think will be <u>unsustainable</u>, and why**

Unsustainable	*Barriers to unsustainability*
▸ The 72-hour clinic makeover	▸ Lack of funding – *this was by far the most common theme when government and scale-up partners were asked about sustainability*
▸ Proactive government approaches to improve the FP landscape	▸ Not enough time for the government to prepare to take over program components.
▸ Certain demand generation components such as: TV/radio spots, Green Dot campaign, and Get It Together	▸ Lack of clarity and accountability for who should be responsible for certain program components.
▸ M&E and data collection and use	▸ Lack of reliable, high quality data for decision making.
	▸ Government still relies heavily on implementing partners to carry out programs.

Annex 9: Number of quotes associated with emergent themes

Q	Theme	# of quote
Question 1	**Adjustment between NURHI 1 and NURHI 2**	
	Geography	33
	Target population	31
	Program activities (advocacy, demand generation, service delivery)	130
	Impacting factors to the adjustment between NURHI 1 and NURHI 2	
	Facilitating factors	42
	Challenges	17
Question 2	**Exposure to FP message: *Channels***	
	Radio and TV	158
	Social mobilizers	254
	Health providers and CHEWs	238
	Exposure to FP message: *Impacting factors*	
	Facilitating factors	152
	Challenges	191
	LARC use: *Access channels*	
	Health facility	114
	CHEWs	50
	Other channels	7
	LARC use: *Impacting factors*	
	Facilitating factors	215
	Challenges	244
	Impact of NURHI 2 program activities: *Advocacy*	
	FP funding and FP policy	68
	Leaders' and media's support to FP	82
	Collaboration in FP among government staff and stakeholders	74
	Impact of NURHI 2 program activities: *Demand generation*	
	Radio and TV	51
	Social mobilizers	182
	Health providers and CHEWs	95
	Impact of NURHI 2 program activities: *Service delivery*	
	Quality and access to FP service	360
	FP social norms: *Changes in community and reasons for changes*	
	FP view	472
	FP demand	227
	FP service	272
	Other changes	44
	Opinions: *NURHI 2's performance, strengths and challenges*	
	NURHI 2's performance	386
	NURHI 2's strengths	197
	NURHI 2's challenges	74
	Opinions: *NURHI 2's influence to changes in FP*	
	FP landscape at Federal, State and LGA levels	193
	FP view at Federal, State and LGA levels	119
	FP capacity at Federal, State and LGA levels	151
	Institutionalization – Government level: *Capacity building*	

Q	Theme	# of quote
Question 3	*Training*	192
	Tool	97
	Other strategy (e.g., technical support, financial support)	290
	Institutionalization – Government level: *Evidence*	
	Advocacy at Federal, State and LGA levels	278
	Demand generation at Federal, State and LGA levels	120
	Service delivery at Federal, State and LGA levels	182
	Institutionalization – Government level: *Impacting factors*	
	Facilitating factors	126
	Challenges	149
	Institutionalization – Facility level: *Capacity building to providers/ CHEWs*	
	Training on FP methods	227
	Training on FP counseling	139
	Supportive supervision	134
	Institutionalization – Facility level: *Impact on providers/ CHEWs*	
	Provider/ CHEW bias	125
	FP method administering skill	106
	FP counseling	136
	Service satisfaction	72
	Scale-up: *Process*	
	Advocacy	59
	Demand generation	85
	Service delivery	58
	Scale-up: *NURHI 2's steps to position for scale-up*	
	Technical support	195
	Other support	99
	Scale-up: *Evidence*	
	Advocacy	73
	Demand generation	99
	Service delivery	100
	Scale-up: *Impacting factors*	
	Facilitating factors	122
	Challenges	128
	Sustainability: *If NURHI 2 ends*	
	Government level	218
	Facility level	102
	Community level	79

Annex 10: Emergent themes with illustrative quotes

Main emergent themes, sub-themes, and a selection of illustrative verbatim quotes and narrative data that were used to answer the evaluation questions are presented here.

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