FP CAPE
Family Planning
Country Action Process Evaluation

SUMMARY REPORT:

NURHI 2 Midterm Learning Evaluation

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This report presents a summary of some 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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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). 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. The NURHI approach, as documented by the Measurement, Learning and Evaluation (MLE) Project, had a significant impact on modern contraceptive use.[1,2] Starting in late 2015, NURHI Phase 2 aimed to scale up the success of NURHI 1 in Kaduna, Lagos, and Oyo states to achieve a "positive shift in FP social norms at the structural, service, and community levels that drives increases in mCPR" (NURHI 2 proposal narrative). This evaluation was put in place to understand performance and progress against project objectives and to learn from the largest BMGF FP investment in Nigeria.

Evaluation objectives and questions

The NURHI 2 Midterm Learning Evaluation objectives are to:

1. Provide NURHI 2 with information to 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).

The evaluation has 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. Results for the overarching questions are summarized here. A more detailed full report is also available.

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[1] Measurement, Learning & Evaluation (MLE) Project Nigeria Team. Evaluation of the Nigerian Urban Reproductive Health Initiative (NURHI) Program. Stud. Fam. Plann. 2017; 448: 253–268. https://doi.org/doi:10.1111/sifp.12027

[2] Winston, J., Calhoun, L.M., Corroon, M. et al. Impact of the Urban Reproductive Health Initiative on family planning uptake at facilities in Kenya, Nigeria, and Senegal. BMC Women's Health 18, 9 (2018). https://doi.org/10.1186/s12905-017-0504-x

Evaluation design and methods

The evaluation design included systematic 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. The data sources and study samples are summarized in *Annexes 2.a* and *2.b*. Quantitative data was analyzed in Stata 16.0. For qualitative data collection, eight open-ended, in-depth interview and FGD guides were developed for the different participant groups. A total of 157 KIIs and 30 FGDs were conducted between February and May 2019. All interviews were transcribed and, where needed, translated from Hausa or Yoruba into English. The 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, and were refined and added to through an inductive process while reading the first set of interviews. Once interviews were coded, thematic content analysis was conducted to identify patterns in the data that come together as key themes. The quantitative and qualitative results and document review were triangulated to answer evaluation questions.

Findings

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.

NURHI 1 focused on six densely-populated urban areas with relatively established health service environments. NURHI 2 was developed as a scale-up of the NURHI 1 approach. It continued to work in Kaduna City but expanded to rural areas of Kaduna and to Lagos, a new urban site. As such it represents a test of the replication of the NURHI model in two new contexts; a rural area and a mega-city. NURHI 2 also continued to work in Ibadan and expanded to rural areas of Oyo state with funding from a private donor. NURHI 2 worked in 15 of 22 local government areas (LGAs) in Kaduna, in 10 of 19 LGAs in Lagos, and in 15 of 33 LGAs in Oyo as well as at the system level with the State government in each state. The BMGF funding for NURHI 2 was $18 million over 5 years compared to $47 million over 5.5 years for NURHI 1. The reduced funds were based on the expectation that, compared to NURHI 1, NURHI 2 would implement fewer evidence-based interventions, and that it would be more intentionally focused on sustainable scale-up – both of which were assumed to cost less.

> *"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

A defining feature of the NURHI model is the “comprehensive package” that simultaneously addresses advocacy, demand generation, and service access and quality to shift social norms and enable increased use of family planning. This overarching model was maintained in NURHI 2, as was their focus on continual use of data to inform and refine program implementation. NURHI considered 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.

NURHI 2 made a few significant changes to the original NURHI model. Evidence from the analysis of the MLE data for NURHI 1 and other studies showed that youth are an important demographic that is under-served for FP which led to the integration of Life Planning for Adolescents and Youth (LPAY) to all three components of the NURHI 2 model. There were also a number of adaptations in implementation in response to evidence and experience working in new contexts. Many of these tweaks were in implementation details that were not fully described in documents or interviews. Some of the significant examples identified include:

- NURHI 2 expanded work with religious leaders, including adding work with Christian as well as Muslim leaders in response to evidence of the importance of religious leaders as influencers of FP attitudes and behaviors.
- NURHI 2 worked more closely with men’s groups after the first year because male partners posed a barrier to FP use for many women (this was a theme that also emerged in our qualitative analysis).
- NURHI 2 undertook formative research to adapt FP media messages for the new contexts, particularly in Lagos. Mass media was expensive in Lagos, so NURHI 2 scaled back mass media efforts in favor of increased emphasis on social mobilizers. Levels of exposure to FP messages on radio and TV were also already relatively high in Lagos when NURHI 2 began.
- NURHI 2 dropped the FP 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.

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 FP social norms at the structural, service, and community levels that drives increases in mCPR” (NURHI 2 proposal narrative).

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 KIIs indicated that its advocacy efforts contributed to increased state and LGA-level stakeholders’ support of FP. At the Federal level, key informants described how Nigerian officials are more motivated than ever to discuss and accommodate FP. Advocacy

has positively influenced national-level social norms among policy makers and stakeholders regarding the importance of FP for Nigeria. The change was reflected with the establishment of Federal budget lines for FP and the National Family Planning Blueprints. In all three implementation states, NURHI 2's expanded work with religious leaders led to increased public statements supporting FP 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 FP in Nigerian communities.

> *"I feel it [NURHI 2] has been quite effective in a way that it's been able to raise the talk [about family planning], the profile of family planning 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 – 72-hour makeover and some materials – have been quite useful."* – Scale-up partner, Federal

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

Demand generation

PMA2020 data on exposure of women to FP messages indicated that 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 found that 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.

> *"**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."* – Woman, Lagos

FP exposure through various media have interacting effects. TV and radio messages reach a wide 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 showed that these channels were able to reach women on multiple levels. Encouraging FP in community conversations influenced FP social norms and intention to use in local environments. Specifically, women in FGDs said that listening to programs on the radio helped to change *"minds towards family planning positively,"* while for some, songs that health facility staff (including community health extension workers (CHEWs) sang during various health events *"made us curious about what was happening, and we concluded it would be nice for us to do [FP]."* Social mobilizers were able to reach harder to access, more rural clients with FP messaging. A woman in a FGD shared that the social mobilizers *"are not the ones who administer [FP] to us… but we learn everything about it from them before we go to the hospital."*

Data from PMA2020 indicate that intention to use FP among non-users in Kaduna and Lagos has increased somewhat since the start of NURHI 2. For example, in Kaduna, the percentage of

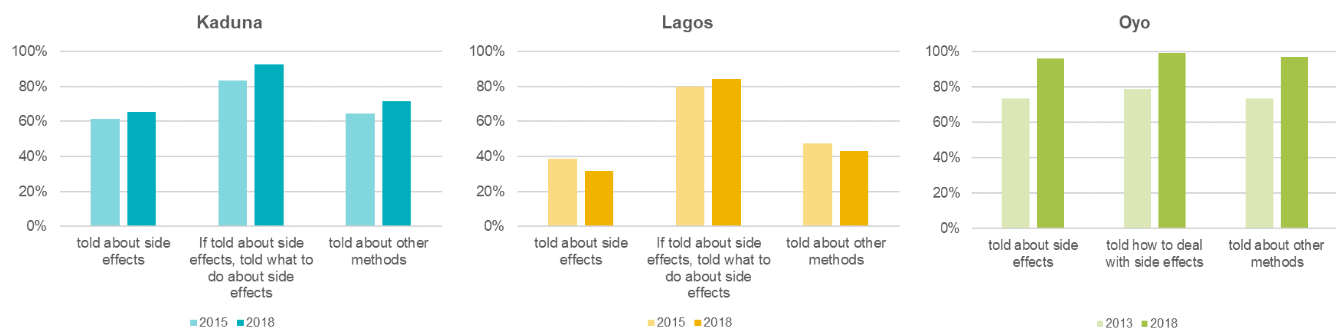
non-users age 15–49 who intend to use a contraceptive method in the future increased from 38.5% in 2015 to 45.6% and in 2018, and in Lagos, it increased from 50.4% in 2015 to 55.8% in 2018. Quantitative data on intention to use FP were not available for Oyo.

Service delivery

Both quantitative and qualitative data pointed 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.

FGDs and KIIs 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. Quantitative population-level data indicated that quality of care indicators improved from the beginning of NURHI 2 in 2015 to 2018 in Kaduna state, while the picture is more mixed in Lagos state (This may be related to high levels of condom use in Lagos, which are often obtained from pharmacies) (*Figure 1*). Data for Oyo came from the DHS, and showed notable increases in all three of the quality of FP 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.

Figure 1*: 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[3]

FP social norms

The ultimate outcome that NURHI 2 aims to achieve is positive change in FP social norms at the structural, service, and community levels.4 Findings presented above indicate that NURHI

[3] 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.

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

2's advocacy work positively influenced policy makers and community leaders in support of FP. Provider norms are discussed below under Question 3. Here, we focus on changes in community norms around family planning.

Omnibus survey data from the three NURHI 2 states for 2017 and 2018 show positive change in some beliefs about FP. 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. The percentage of women who did not believe that women who use FP may become promiscuous shows similar trends. 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.

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."

To capture ideation, NURHI 2 uses a model with three components:

- **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.

"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 KIIs and FGDs mentioned improvements in the acceptance and awareness of FP among people in the community, including adolescents and youth. Many women, including youth, acknowledged that FP is "*very good*" and "*important*" to their life because it helps them to prevent "*unwanted pregnancy*," 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 FP 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.

Modern contraceptive use

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. While different data sources show different trends, overall, we did not see the significant, rapid increase in mCPR found for NURHI 1.

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

As described above, NURHI 2 placed an increased emphasis on institutionalization and sustainability. The overall approach NURHI 2 took to increase institutionalization and scale-up which in turn promote sustainability can be summarized as:

- **Engage** leaders and practitioners through collaboration and partnership
- **Embed** NURHI practices in institutions by incorporating the practices into their mandate, approaches, tools, or activities
- **Evolve** systems and structures by transferring full ownership of NURHI practices to the institutions.

Institutionalization of NURHI 2 programming

One of the keys to sustainability is institutionalization. KIIs 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.

NURHI 2 engaged stakeholders, leaders, and staff at Federal, state, and LGA levels in discussions related to FP and NURHI 2's program activities and practices. To build 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) focusing on capacity building for government staff, monitoring and evaluation (M&E) officers, members of Advocacy Core Groups (ACGs), technical working group subcommittee, media houses, and health providers, nurses, and CHEWs. It helped set up a platform to prepare for importing proven activities that aim to improve the government's FP programs, and to embed NURHI practices into implementing activities within government and facility 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 activities and practices to these agencies and health facilities.

Key definitions

- **Institutionalization:** The process of adopting FP 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*.

Some examples of NURHI practices that have been incorporated into government and civil society FP activities include ACGs becoming civil society organizations (CSOs) and operating as coalitions of FP advocates, the Budget Tracking tool, the National FP Communication Plan, social mobilization activities, and commodity logistic management tools. At health facility level,

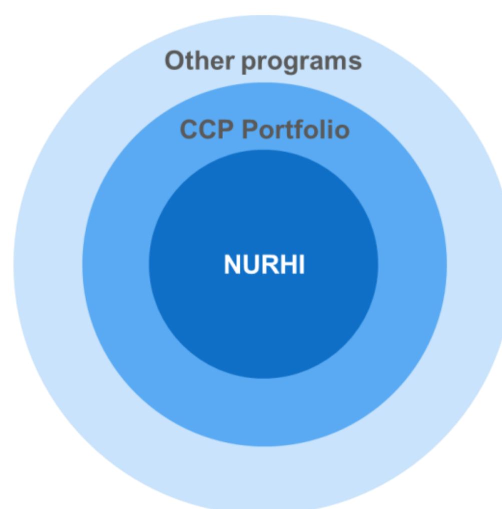
NURHI 2 embedded its practices to improve access to and quality of FP service in facility through training, tool sharing and technical support. In particular, NURHI 2's 72-hour makeover intervention utilized local artisans and resources, and involved facility staff and community members to promote interaction, enhance ownership, and assume responsibility.

Scale-up of NURHI 2 programming

NURHI 2 created a ripple effect beyond the project's original scope as implementing partners and government agencies replicated 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. 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 2*). Opinions also differed sometimes about whether a particular activity is a scale-up of a NURHI approach or not. Some activities, like the 72-hour clinic makeover and ACGs, 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 FP interventions, and are not readily attributable to one particular program. Although 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 2*: Levels of NURHI 2 scale-up*



Key informants identified a number of factors that they felt contributed to the ability to scale-up NURHI activities. These included evidence of the success of the approach, strong partnerships, the ability to adapt the NURHI model, advocacy, technical support and resources provided by NURHI to support scale-up, and the availability of data such as PMA2020 to inform planning for scale-up. Barriers to scale-up identified included lack of 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 what 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).

NURHI 2's contribution 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.

At the systems level, government's commitment and political will to support FP 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).

At the health facility level, there have been positive shifts in health provider norms and behaviors related to FP in NURHI 2 program areas. In KIIs, health providers and CHEWs indicated how their attitude toward providing FP services, in particular FP for adolescents 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 FP counseling.

"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

"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

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 ACGs and interfaith forums, dedicated messaging to adolescents and youth through the National Youth Service Core (NYSC), improved quality of care by providers, and the capacities and technical resources developed through NURHI 2. These are all examples of things that have been institutionalized in some way and for which NURHI 2 has established a solid foundation to build from.

Key informants evinced somewhat more consensus on what elements are less likely to be sustainable. Program elements that have significant cost implications or place high demands 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. While these findings represent informants' opinions of what will and won't be sustainable after NURHI 2 and why, they are broadly consistent with the findings of the MLE sustainability study which examined what components of NURHI 1 were and were not sustainable and why after NURHI 1.

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 FP attitudes and norms. However, we found some data quality issues with those data, and they are only available for 2017 and 2018.

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.

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 and 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).

Discussion and recommendations

The main substantive changes in NURHI 2 compared to NURHI 1 were an increased emphasis on institutionalization and sustainability, and the addition of 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 FP among women and youth, and in several beliefs and social norms at the community level. FGDs 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.[5]

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 FP 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. 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.

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.

[5] 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.

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

Annexes

Annex 1: *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: *Data sources*

Annex 2a: *Quantitative data*

The majority of secondary quantitative analysis was conducted using the following sources:

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

Notes:
**For Oyo, we combined two data sources:

- For "baseline", we used the endline cross-sectional women's sample from the MLE study (i.e. NURHI 1 evaluation data);
- For "endline", we used the only available PMA2020 Oyo sample from 2017.

The baseline and endline data are therefore less comparable for Oyo than for Kaduna and Lagos due to differing sampling for these two surveys, which should be considered in interpreting results for Oyo.

Annex 2b: *Qualitative data*

Key informant interviews (KIIs) and focus group discussions (FGDs) were conducted at Federal and state levels:

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.