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THE LEADERSHIP DEVELOPMENT FOR FAMILY PLANNING / REPRODUCTIVE HEALTH FOR POLITICAL OFFICE HOLDERS, TRADITIONAL AND RELIGIOUS LEADERS PROJECT

END-OF-PROJECT PERFORMANCE EVALUATION FINAL REPORT

February 12, 2014

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Front Cover Photo Caption:
Nigerian Religious Scholars in Mali for Study Tour
ASDAP Office, Bamako, Mali, July 20, 2010
Co-organized by MSH Nigeria Office and dRPC, Nigeria

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Prepared By:
USAID/Nigeria's Monitoring and Evaluation Project II (MEMS II)
Contract No. 620-M-00-11-00001-00
The Mitchell Group, Inc. (TMG)

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The Evaluation Team

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ACRONYMS

ANC	Antenatal Care
CHEW	Community Health Extension Worker
CSR	Corporate Social Responsibility
dRPC	development Research Projects Center
ESD	Extended Service Delivery
FAAN	Fulbright Alumni Association of Nigeria
FANC	Focus Ante-Natal Care
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women Association of Nigeria
FP/RH	Family Planning/Reproductive Health
GAP	Group Action Plan
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPN	Health, Population and Nutrition
HSPs	Health Service Providers
HTSP	Healthy Timing and Spacing of Pregnancy
IAP	Individual Action Plan
ICT	Information and Communication Technology
IEC	Information, Education and Communication
IP	Implementing Partner
ITN	Insecticide Treated Nets
IUCDs	Intra-Uterine Contraceptive Devices
KII	Key Informant Interview
LDF	Leadership Development Forum
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies

MLSS	Modified Life Savings Skills
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry Of Health
MSP	Minimum Standards Package
NDHS	Nigeria Demographic Health Survey
NGO	Non-Governmental Organization
NIPSS	National Institute for Policy and Strategic Studies
PHC	Primary Health Care
PL	Political Leader
PPH	Post-Partum Hemorrhage
RH	Reproductive Health
SBCC	Social and Behavior Change Communications
SOW	Statement of Work
STI	Sexually Transmitted Infection
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
TL	Team Leader
TM	Team Member
TRL	Traditional and Religious Leader
TT	Tetanus Toxoid
USAID	United States Agency for International Development
WCWC	Women and Children Welfare Center
WDCs	Ward Development Committees
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

This is an end-of-project performance evaluation of a USAID-supported activity to develop leadership and improve the enabling environment for Family Planning and Reproductive Health (FP/RH) in northern Nigeria.[1] The project was a behavioral change communications and advocacy activity. It was designed to develop messages about FP/RH that were more acceptable within the communities where the project operated (in the states of Niger, Sokoto and Zamfara), and then deliver those messages through traditional and religious leaders.[2] It also developed a consensus among political leaders on the importance of FP/RH issues, and these trained leaders then built human capacity, renovated health facilities, and advocated for more adequate funding.

The purpose of the evaluation was to assess the dRPC project's achievements; document its best practices, the challenges it faced and how they were dealt with; and make recommendations for future USAID activities to further improve the FP/RH enabling environment in northern Nigeria. The evaluation's findings and recommendations will contribute to the USAID/Nigeria's Health, Population and Nutrition (HPN) Team's design of a new, broader health communications and advocacy activity, and also help the dRPC, and other stakeholders, to improve their programming of future FP/RH activities in northern Nigeria.

PROJECT BACKGROUND

The development Research and Projects Center (dRPC) an indigenous non-profit organization, implemented the "dRPC Project" in the states of Sokoto, Zamfara and Niger in northern Nigeria, from 2009 to 2012, under a USAID Cooperative Agreement. The project was conceived in response to alarming health statistics in Nigeria, particularly in the northern states.[3] The overall goal of the project was to create a cadre of FP/RH "Champions" from among the religious, traditional and political leaders in the project's communities who would influence positive changes in FP/RH behavior and practices. Specifically, the dRPC Project was designed to expand commitment among key stakeholders to increase demand for FP/RH services, and to reduce barriers to demand for FP/RH services deriving from weak leadership and misconceptions about those services.

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[1] For brevity and easier reading, this report refers to the Leadership Development for Family Planning / Reproductive Health for Political Office Holders, Traditional and Religious Leaders Project as the "dRPC Project," following the name of the development Research Projects Center (dRPC), which implemented the project.

[2] The messages, derived in significant part from Quranic scholarship, emphasized the importance and acceptability within Islam of 'birth spacing' to enhance the health of both mother and child, rather than the more contentious concept of 'family planning.'

[3] For example, mortality of children under age five in Nigeria is estimated to be 157 per 1,000 live births; maternal mortality is 545 per 100,000 live births; and the prevalence of modern contraceptive methods is only 9.7%. The severity of these FP/RH statistics is much more pronounced in northern Nigeria.

The project identified two influential groups to which messages about FP/RH would be targeted: traditional and religious leaders (TRLs) and political leaders (PLs). The religious leaders, by virtue of their scholarship and tradition, build and shape the mindset of individuals in the communities. The traditional leaders influence community members through their social standing and traditional positions in society. dRPC empowered the TRLs to propagate messages that would help community members to better understand, accept and practice RH and Birth Spacing principles. The PLs, on the other hand, are comprised of State and Local Government Area (LGA) executives, members of the judiciary, legislators, health policy makers and Health Service Providers (HSPs). The project equipped them with RH and Birth Spacing information and leadership capacity so they could create and improve the political environment for accessing better RH and Birth Spacing services in the public sector (see Annex IX for full description of their composition and role in the dRPC project).

Some of the key strategies that the dRPC Project undertook included organizing leadership forums for TRLs and PLs; developing RH mentors through a formal mentoring program with the TRLs that participated in the leadership forums; and creating alumni networks and conducting advocacy visits to secure budgetary and political support for local level programming on RH and Birth Spacing.

EVALUATION QUESTIONS, DESIGN, METHODS AND LIMITATIONS

The Evaluation Team undertook a qualitative assessment as directed by the Statement of Work (SOW) for the assignment, and designed a data collection and analysis approach to answer the following four evaluation questions:

1. To what extent has the project achieved its objective of improving the enabling environment for FP/RH in the three target states?
2. Which advocacy activities were successful and had a positive impact and which ones had no or limited impact, and why?
3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states, and how has dRPC contributed to this? How were these roles different for traditional/religious and political leaders in terms of effectiveness?
4. What effect did the project's activities have on women and men from the community differently?

In keeping with the guidance given in the SOW, the Evaluation Team carried out document reviews and then selected Sokoto and Zamfara states for field visits. In each state, three communities were selected for the Focus Group Discussion (FGDs), Key Informant Interviews (KIIs) and health facility visits. Adopting a purposive sampling strategy that was suggested in the SOW, the Team selected within these two states those communities that were in close proximity of a TRL who was trained by the dRPC Project. The Team utilized 8 semi-structured guides to allow for open ended discussions. The 4 FGD guides, 3 guides for KIIs and 1 guide-checklist featured very similarly focused questions, to allow for triangulation of the findings. The FGD guides were translated into Hausa, the language spoken in the two states where the Team conducted the discussions and interviews.

The Evaluation Team conducted 59 KIIs with TRLs and PLs; 16 FGDs with community men, women, adolescent males and females, and visited 7 health facilities in the two selected states. There were data limitations imposed by the fact that there was no baseline survey containing data useful for the evaluation. There was also the potential of recall bias on the part of some respondents. Since the project had terminated more than a year previously, some respondents had difficulty recalling details about project activities. Some respondents had been included in other donor-funded non-government organization (NGO) projects, and found it somewhat confusing to recall specifics only about the dRPC project. To compensate for these potential sources of recall bias, the Evaluation Team triangulated its findings wherever possible by comparing answers from different groups to validate the responses. Also, the Team was cognizant of possible social desirability bias, and used follow-up "probing questions" where appropriate to elicit true responses.

FINDINGS AND CONCLUSIONS

The Evaluation Team's findings and conclusions are organized by the four evaluation questions and summarized as follows:

Question 1: To what extent has the project achieved its objective of improving enabling environment for FP/RH in the three target states?

In meeting its objectives, the dRPC Project trained TRLs and PLs, facilitated overseas study tours in Egypt and Mali, and organized training for HSPs. The targets for the numbers of (i) leadership forums organized, (ii) individuals trained with USG fund; (iii) number of alumni networks formed were met or exceeded. Two output indicators were not met: (i) public proclamations in support of RH/Births Spacing by TRLs and PLs; and (ii) mentoring of the participants.

The Evaluation Team's findings in respect to achievement of an improved enabling environment for FP/RH in the three target states is presented below with thematic analysis of specific indicators:

Enabling Environment for Reproductive Health

Both men and women in the communities where the project operated appeared to prefer a slightly older age for marriage of women (18 years), and for giving birth to the first child (18 to 21 years), as compared to the ages preferred for these events even a few years ago. This pre- and post-intervention comparison was possible by asking about the prevalent practices and beliefs in the communities before the dRPC Project began. From the FGD responses it appeared that most women go to health facilities for Antenatal Care (ANC) visits, and they receive at least two doses of the Tetanus Toxoid (TT) vaccine during pregnancy. Most women preferred to deliver at health facilities, although financial and social factors may prevent facility-based deliveries.

Enabling Environment for Birth Spacing:

In the FGDs, the Team was told that women are having fewer children now as compared to even a few years ago. It appears from the Team's interviews and discussions that couples in the communities assisted by the project are increasingly making joint decisions about Birth Spacing. Women in the FGDs told the Team that four years ago (before the dRPC Project began) they

did not believe in Birth Spacing; today they recognize the benefits.[4] Community members get messages about Birth Spacing from multiple sources: radio, television, home, peers and TRLs. We found the community members quite knowledgeable about the modern methods of Birth Spacing. Injectables are the most preferred Birth Spacing method.

Largely as a result of dRPC's behavioral change communications and advocacy activities in communities where the project was active, community members now seem to understand that Islam encourages Birth Spacing to improve the health of infants and their mothers; and further, that contraceptive methods, except for permanent methods, may be utilized for that purpose. Nonetheless, there continued to be a near consensus that contraceptives should not be used only for the purpose of limiting the number of children. Parents also said they continued trying to have children after the birth of several girls, in the hope of eventually having a boy.

The Evaluation Team concluded that, in a relatively short period, the dRPC Project to a large extent has succeeded in initiating a positive mind shift about Birth Spacing within the communities where the project was active in northern Nigeria, which is a substantial and significant achievement.

Evaluation Question 2. Which advocacy activities were successful and had a positive impact and which ones had no or limited impact and why?

The TRLs mentioned that a study tour to Egypt was highly effective because it allowed them to interact with Islamic scholars and leaders who showed them how Islam supports the spacing of births, to improve the health of both the infant and the mother. The trips to Mali and in-country workshops were valuable as well. These helped the participants to learn about different Birth Spacing methods promoted in another African country, consider the fact that Islam encourages the spacing of children, and also gain leadership skills.

The Alumni Association was the least effective, and the Individual Activity Plans (IAPs) and Group Activity Plans (GAPs) were also relatively ineffective. The reason was that the TRLs had anticipated continued support from the dRPC Project for implementing their IAPs and GAPs. With the project's termination, their expectations remained unfulfilled, as did their activity plans.

The PLs identified the Ghana tour as the most effective, since it gave them the opportunity to see for themselves how another African country had improved health services for its population. Follow-up workshops within Nigeria were also beneficial. For the HSPs, training to build technical skills was most effective. The least effective activities for the PLs were the Alumni Association, and the advocacy visits sponsored by the project. They said that lack of interest and support from the government following the termination of the dRPC Project was the main reason for this.

[4] Several respondents also mentioned that, when the dRPC project began operations four years previously, NGOs which entered these communities to promote 'family planning' would not be welcomed.

The Evaluation Team's conclusion is that there was need for a clear exit strategy, with the TRLs and PLs having been prepared to conduct their planned tasks without having to depend on continued project support. The project did not adequately plan and allocate its resources to prepare these leaders to develop and conduct these initiatives on their own.

Evaluation Question 3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states and how has the dRPC Project contributed to this? How were these roles different for traditional/religious and political leaders in terms of effectiveness?

Based on numerous KIIs and FGDs, the Evaluation Team found that the Traditional and Religious Leaders seemed to have effectively influenced the belief system relating to RH and Birth Spacing in the communities where they functioned. They gave RH- and Birth Spacing-related messages through their sermons, counselling and pronouncements. They preached in mosques, Ramadan sermons, wedding and naming ceremonies and Islamic schools and centers. Most religious leaders relied on the Quran and Hadith to support their Reproductive Health and Birth Spacing messages.

The dRPC Project appears to have equipped the TRLs to deliver key RH and Birth Spacing-related messages; the Evaluation Team was told that their sermons, counseling and pronouncements did not focus on these topics before the dRPC Project began. By organizing overseas study tours and in-country training opportunities, the dRPC Project contributed to building the TRLs' knowledge of, and commitment to improve the enabling environment for RH and Birth Spacing.

The Project also contributed to the PLs' understanding of RH and Birth Spacing, and prepared them to carry out RH and Birth Spacing advocacy activities within the political and bureaucratic spheres. And the Project helped the PLs to develop their IAPs and GAPs, and invested in their mentoring, as well as in advocacy visits. But the support provided to the PLs was found to be significantly less effective than that to the TRLs.

The reason is that TRLs are placed closer to their communities relative to the PLs; they have significant influence on individual and family belief systems and decision-making. They have a stable presence in the communities and thereby offer continuity in their teaching and counseling. The PLs, on the other hand, are more distant from the communities they serve, and they have very little direct influence on the prevailing belief systems within those communities. They are subject to frequent replacement or transfer, making them an unstable source of information and support; and they operate under bureaucratic and funding constraints that tend to threaten the institutional sustainability of those results they are able to accomplish (see Annex IX for full description of their composition and role in the dRPC project).

Evaluation Question 4. What effect did the project activities have on women and men from the community differently?

The single most important impact of the dRPC Project was that it assisted communities' change in perceptions and beliefs about RH and Birth Spacing. This change seemed to be taking root generally within the communities, impacting men, women and adolescents equally. There were also some added benefits brought about by this change, particularly for women and young girls.

Men expressed more willingness to allow their wives to visit health facilities for ANC sessions. Before the dRPC Project this tended not to be the case. Both men and women mentioned their preference presently for facility-based delivery. According to interviews with the Team, the communities value female children and the investment in their education.[5] Joint decisions are reportedly increasingly being made about Birth Spacing, which only the men would make even a few years ago.

RECOMMENDATIONS

Based on its findings and conclusions, the Evaluation Team developed several recommendations for the design and implementation of future FP/RH communications and advocacy activities to be implemented by USAID/Nigeria, including:

- USAID should explore expanding activities in two phases:
  - First, to consolidate gains that have been made and extend to additional LGAs in the three focus states.
  - Second, to scale up activities in additional states in northern Nigeria and include additional interventions such as messaging through media and collaboration with the government of Nigeria.

- The development hypothesis / logical framework for any future activity should be clearly articulated to target social and behavior change aspects.

- The new activity should expand work with TRLs to ensure results sustainability, and support selected sub-groups of the PLs with those activities that proved to be effective.

- Scaling up should ensure stronger project staffing structure and office set up in all focus states.

- USAID should require a robust Monitoring and Evaluation system with baseline, mid-term and end-of-project evaluation surveys.

- Future activities should document all training and other materials developed and used, and disseminate them as appropriate.

- All training and Social and Behavior Change Communications (SBCC) materials, messages and methods should conform to international standards and evidence-based strategies.

- Future FP/RH activities in northern Nigeria should emphasize the more acceptable terminology of 'Birth Spacing,' rather than the more contentious 'Family Planning.'

[5] One of the messages conveyed from Quranic scholarship was the injunction to both men and women to acquire education.

EVALUATION PURPOSE & EVALUATION QUESTIONS

EVALUATION PURPOSE

As described in the evaluation Statement of Work (Annex I), this is an end-of-project evaluation of the USAID-supported dRPC Project for leadership development to improve the enabling environment for Family Planning/Reproductive Health (FP/RH) by working with traditional and religious leaders, as well as political office holders, in three selected states (Niger, Sokoto and Zamfara) in northern Nigeria. The purpose of the evaluation was to determine the level of achievement toward expected results and to document best practices and lessons learned during the project's implementation. The evaluation was designed to also suggest directions for future USAID activities to improve the enabling environment for FP/RH in northern Nigeria.

Specifically, the evaluation:

1. Documents the project's objectives and measures the outputs
2. Identifies and measures core outcomes related to policy change and attitudes towards FP/RH
3. Documents changes in the opinion of FP/RH in communities where the project worked
4. Documents the project implementation process, including details on how the leadership forums, advocacy activities and materials were designed, and their impact on changes in attitudes and behavior towards FP/RH (as a concept and as an essential social service).

The primary user of the evaluation's findings is USAID's HPN technical team, which will apply the findings and recommendations to the design of a new, broader health advocacy activity. The evaluation's findings will also document the results achieved, successes, challenges and lessons learned. The dRPC, as an organization, will also apply the findings to improve its activities in northern Nigeria. Other stakeholders will use the findings to strengthen coordination and collaboration with government and other donor programs to ensure achievement of sustainable results in the FP/RH arena. See Annex I for the detailed SOW.

EVALUATION QUESTIONS

The key evaluation questions as listed in the SOW are:

1. To what extent has the project achieved its objective of improving the enabling environment for FP/RH in the three target states?
2. Which advocacy activities were successful and had a positive impact, and which ones had no or limited impact and why?
3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states and how has the dRPC contributed to this? How were these roles different for traditional/religious and political leaders in terms of effectiveness?
4. What effect did the project activities have on women and men from the community differently?

PROJECT BACKGROUND

The development Research and Projects Center (dRPC) is an indigenous non-profit organization that was established in 1994 and based in Kano State, with a focus on participatory development efforts in northern Nigeria. Under the Cooperative Agreement GSM No 043 and No. 044, administered by World Learning, dRPC implemented The Leadership Development for Family Planning/Reproductive Health for Political Office Holders, Traditional and Religious Leaders Project. For brevity and ease of reading, this project is referred to as the "dRPC Project" throughout this report. The dRPC Project operated in three northern states of Nigeria—Sokoto, Zamfara and Niger, from February 2009-September 2012 (See Annex VI).

Preliminary statistics from the Nigeria Demographic and Health Survey (NDHS) 2013 indicate that, in 2013, Nigeria's Total Fertility Rate (TFR) was 5.5 births per woman. Although the national TFR demonstrates a downward trend since1990, the indicator has remained almost static over the last decade. Contraceptive use rate appears to be the same over the last 5 years. The northeast and the northwest regions have the lowest contraceptive use rate. Between 2008 and 2013 the rate of Antenatal Care (ANC) accessed from a skilled service provider seems to have improved; the rate of protection of the last live birth against neonatal tetanus has increased; and the rate of facility-based delivery appears to have slightly improved. Over these last five years the rate of ownership and use of insecticide treated nets (ITNs) have seen a dramatic increase; particularly noteworthy is the three-fold increase of the number of pregnant women who slept under an ITN (the night before the survey). This increased rate demonstrates that Social and Behavior Change Communication (SBCC) Campaigns and availability of pertinent products can result in spectacular gains even in a short period of time. Selected slides showing these preliminary data from the NDHS 2013 are included in Annex VII.

In an effort to further improve Nigeria's generally poor Reproductive Health (RH) and Birth Spacing indicators, particularly in its northern region, USAID/Nigeria designed The Leadership Development for Family Planning/Reproductive Health (FP/RH) for Political Office Holders, Traditional and Religious Leaders Project and the dRPC, through a Cooperative Agreement, implemented it with the aim to develop and empower a group of leaders (political, traditional and religious) in society who would influence positive changes in FP/RH behavior and practice.

Project goal

The overall goal of the dRPC project was to create a cadre of FP/RH transformative religious and traditional leaders, as well as political office holders, in the three focal states of Zamfara, Sokoto and Niger. The project intended to achieve the following results:

1. Strengthened enabling environment so that FP/RH could be discussed and implemented
2. Expanded demand for improved social sector services

Project objectives

The objectives of the project were as follows:

1. Increase awareness of maternal mortality and morbidity as a public policy problem and expand commitment among key stakeholders to address this problem by increasing demand for FP/RH services.

2. Strengthen the enabling environment for FP/RH information and service delivery and reduce barriers of weak leadership, misconceptions and incorrect information.

Development hypothesis and results framework

Although a development hypothesis was never clearly articulated at its inception, the dRPC project was a behavioral change communications and advocacy activity designed to develop leadership and improve the enabling environment for FP/RH in northern Nigeria. The project developed FP/RH messages that were more acceptable within the communities where the project operated – which tended to be negatively disposed toward the concept of 'family planning' – and then delivered those messages through traditional and religious leaders. The messages, derived in significant part from Quranic scholarship, emphasized the importance and acceptability within Islam of 'birth spacing' to enhance the health of both mother and child. The project also worked to develop a consensus among political leaders on the importance of FP/RH issues, build human capacity, renovate health facilities, and advocate for more adequate funding.

The dRPC project's results framework may be found in Annex I. It includes the project's outputs, objectives, goals, intermediate results and strategic objectives showing causal relationships. Although it lists output indicators, the results framework does not include outcomes or outcome indicators.

Project implementation strategies and activities

The following are the project's principal implementation strategies and activities:

1. Advocating and building capacity through leadership forums with religious and traditional leaders and political office holders
2. Developing RH mentors through a formal mentoring program with the traditional, religious leaders and political office holders that participated in the leadership forums
3. Establishing an alumni network for RH/Birth Spacing champions aimed at creating a collective responsibility for sustaining RH/Birth Spacing, and encouraging the continued accomplishment of results such as positive public pronouncements and support to RH/Birth Spacing activities
4. Conducting advocacy visits for budgeting for RH/Birth Spacing to selected political office holders and developing and distributing advocacy materials to be used during advocacy visits in order to encourage decision makers in government to increase resources for RH/Birth Spacing programs

Project monitoring and evaluation approach

A dedicated Monitoring and Evaluation (M&E) Officer was appointed during the second phase of the project. The project had no baseline assessment report with indicators with which the Evaluation Team could compare their findings, but there was a mid-term report and an end-of-project report.

Project target groups

The dRPC Project focused on two separate arenas: leadership development for political leaders and leadership development for traditional leaders and Islamic scholars, in an effort to create a cadre of transformative political leaders, traditional leaders, and Islamic scholars for improving

RH/Birth Spacing environment. These leaders were expected to inspire change; communicate accurate information; and support the government's new policies on RH/Birth Spacing services in the target states of Niger, Sokoto and Zamfara. It is important to discuss the characteristics and functions of these different groups of leaders for a better appreciation of the project, and to understand the contributions of these groups to the project objectives and goal.

1. Although the information in this report is about the Traditional and Religious Leaders (TRLs) together, the Team recognizes that in fact, they are two different types of leaders, and they exert two closely linked, but different kinds of influences. The religious leaders are knowledgeable about Islamic scriptures and use their understanding of the scriptures to build and shape the communities' belief system. The traditional leaders, on the contrary, have no mandate to teach or preach using the religious scriptures, although they may be quite knowledgeable on religious matters and scriptures, but they have great influence on their community members through their social standing and traditional position in society. Thus, ideally the training for these two groups of leaders should be different and targeted to produce two different sets of responses. Consequently, the expectations for these two groups within the TRLs in terms of their performance should be different. The dRPC selected the TRLs through a process of 'snowballing,' which entailed selecting one individual and using this person to identify others around him or her.

2. Again, although this report refers to all leaders in political positions as Political Leaders (PLs) they are in fact, not a homogeneous group. This group comprises of State and Local Government Area (LGA) executives, legislators, judiciary, health policy makers and health service providers (HSPs).

    a. Politically appointed or elected leaders (elected legislators, members of the house committee on health, and state executives) are often in their positions temporarily and may not be in their offices long enough to effect change. And while in office they often experience competing interest and demands. But they hold the power to make budgetary decisions and other resource allocations.

    b. The health policy makers/technocrats are career civil servants who have risen to management positions in the state ministries. These political leaders are more stable; give technical and programmatic information to the leaders described above, and the Implementing Partners (IPs) that work with them. This category of PLs develop budgets, work plans, policy drafts, etc. They do not, however, make decisions on funding allocations, or secure other types of resources, and they need to advocate for resources.

    c. Within this larger group of PLs there is another sub-group, the HSPs, who work at health facilities and provide health care directly to the community members. The dRPC Project also included them for training. This group of leaders benefits the most from technical training. The HSPs can influence quality of health services if they receive adequate training and resources. But they have only limited decision-making power or responsibility (see Annex IX for more details).

EVALUATION METHODS & LIMITATIONS

In response to the USAID SOW the Evaluation Team undertook several steps:

Desk Research
The Team Leader (TL) and Team Member (TM) reviewed program documents that USAID | Nigeria and dRPC furnished to MEMS II. These included the project proposal, work plans, quarterly and annual reports, mid-term, end-of-project evaluation report, and training materials, among other resources. These documents are listed in Annex IV.

Team Planning Meeting
Following arrival of TL in Abuja, MEMS II organized the first Team Planning Meeting at its office on Monday, October 21, 3013. The evaluation work plan appears in Annex VIII. Team members discussed the SOW and their roles and also developed a draft evaluation work plan for USAID's approval.

In-brief with USAID | Nigeria
The MEMS II Chief of Party (COP) and the TL met with the Health, Population and Nutrition (HPN) and Program Team members to discuss and review the SOW and work plan.

Project Presentation by dRPC Senior Staff Members
Senior staff members of the dRPC presented the highlights of the project, answered questions and provided many details for the Evaluation Team members.

Evaluation instruments
The TL, TM and the Senior Monitoring and Evaluation Specialist from MEMS II developed eight instruments for use in the field. These were semi structured discussion guides for use with Focus Group Discussion (FGD), Key Informant Interviews (KIIs) and a guide for reviewing health facility statistics. We used 4 FGD guides, 3 KII guides and 1 health facility guide-checklist The FGD guidelines were translated into Hausa, the language mainly used in the states where the field work was to be done. MEMS II submitted these instruments, along with a report outline and the draft work plan, to USAID for approval. See Annex III for these instruments.

Selection of Sites for Field Work
In keeping with the SOW instructions, the Evaluation Team selected Sokoto and Zamfara for our field work. The dRPC operated the project in three states: Sokoto, Zamfara and Niger. The SOW instructed the Team to select Sokoto and one of the remaining two states. For logistical reasons, the Team selected Zamfara. For each state the Team planned to visit three communities. These communities were the ones where the dRPC Project has trained at least one TRL. Therefore, the selection of the communities was purposive. We distributed the FGDs and KIIs across the state capital and two other communities in each state. The KIIs with the TRL, the FGDs and health facility visits took place in the catchment area (within 3 to 5 kilometers) of a religious leader who was trained by dRPC.

Sampling and Method of Data Collection

The SOW Methodology Matrix recommended a qualitative evaluation with purposive sampling of TRLs. The Team spent 6 days in each state conducting 59 KIIs with TRLs and PLs; 16 FGDs with community men, women, adolescent males and females; and visited 7 health facilities in the two selected states. The Evaluation Team was careful in selecting the appropriate age range for the FGD participants, e.g., women of 15 to 45 years of age, and adolescents 14 to 19 years of age. We conducted each FGD with 8 to 12 participants. The former dRPC Project Focal Person in each state identified the TRLs and the PLs who were trained by the project, and made appointments for the meetings. The Focal Persons did not participate in the discussions or interviews; their role was to facilitate the KII appointments and the FGDs, as well as guiding us to the local health facilities. One local data collector was hired in each state to provide additional support to the Team for data collection, and to ensure that the local dialect was used during the FGDs. The TL oriented the local data collectors and the evaluation team on the evaluation guides. We conducted the KIIs and FGDs in these communities, and visited the local health facilities. A list of all the communities visited; field visits made by the Team; and the KII and the FGD participants are listed, along with their contact information, in Annex IV.

Data Analysis

The TL recorded the notes on to a simple set of data analysis tools. These analysis tools were the same as the guides the Team used to conduct interviews, discussions and facility visits in all six communities of the two states. To keep track of the different communities, the responses (text) were colored differently. Color-coded analysis tools for each guide provided the Team with an easy way to group together the answers to each question in each guide, and also allowed for each response to be linked to the community from which it was collected. The Team completed data collection and transcription in each state and, upon return to Abuja, all the responses from all the interviewees and participants were ready for analysis. The TL, TM with inputs from MEMS II Senior M&E Specialist completed analyzing the data and prepared the preliminary findings. The Team performed thematic analysis to identify initial themes by reviewing the transcripts from field notes from the KIIs and FGDs. The Team then categorized each participant's response into one of the identified overarching themes. The health facility statistics is presented in the form of summary tables and notes. The analysis tool used is in Annex III.

Discussions with dRPC and Activity Manager/USAID on Key Preliminary Findings

The TL and TM, along with MEMS II staff, discussed the preliminary findings with the dRPC senior staff in Abuja. This gave the Team an opportunity to collect additional information about the project, clarify certain points and correct a few details in the findings. We also met with the USAID Activity Manager for the project, shared the preliminary data with him and received his feedback.

Presentation of Findings and Conclusions to USAID

The TL gave a PowerPoint presentation of the preliminary findings, conclusions and recommendations to USAID | Nigeria HPN, Program and Education team members. Three others from the Evaluation Team joined the TL in discussing the findings with the USAID staff at the presentation.

Draft Report

The TL, TM, with support from MEMS II staff, developed the draft report and TL then submitted the draft to MEMS II COP, DCOP and Senior M&E Specialist for feedback. Besides responding to the four key evaluation questions, the draft report also provided additional findings and observations on a few related areas. After incorporating the feedback received, the TL in consultation with other team members prepared the final draft report before his departure from Nigeria.

Data Limitations

The project ended more than a year ago. The respondents sometimes had difficulties recalling details about project activities. Also, the fact that some respondents have been and/or are currently included in other donor funded non-government organizations (NGO) projects, including USAID funded projects, made it somewhat confusing and difficult for them to remember specifics about the dRPC Project. These respondents were very few in number.

The Evaluation Team also recognized the fact that social desirability bias can be a factor where participants tend to project a favorable image. The Team used follow up questions as "probes" where appropriate to elicit honest responses. As an example, when in men's FGDs the opening question about whether the participants should give importance to women's Reproductive Health and Birth Spacing resulted in a positive response, the follow up question, *"Why do you feel it is important?"* was asked in order to understand the genuineness of the response. These types of follow-up, indirect questions were used multiple times throughout the FGDs and KIIs.

One target group, the members of the judiciary in Zamfara, refused to grant the Evaluation Team interviews, although they had agreed to the appointments. The reason was they had failed to secure legal clearances from higher authorities for the interviews.

The Evaluation Team did not find a project baseline with indicators that are comparable to the indicators used in this end-of-project performance evaluation. But the Team collected from the respondents as much information as possible about the RH/Birth Spacing status, beliefs, and practices in their communities that prevailed four years ago (before the dRPC Project began). This allowed the Team to make comparisons in these areas before and after the dRPC Project.

Triangulation

The Evaluation Team designed all the data collection instruments with similarly focused themes to allow triangulation of responses from several sources to ensure the validity of the data. As an illustration, the information from the dRPC on the TRLs preaching and teaching about Birth Spacing was verified through KIIs with the TRLs, which again we discussed and verified during FGDs with men, women and the young adolescents.

This approach to information validation is depicted in this diagram from the slides the Team presented to USAID during de-briefing. Finally, we cross-checked major findings with the dRPC for elaboration and correction of information.

FINDINGS, CONCLUSIONS & RECOMMENDATIONS

FINDINGS

In this section the findings from our document review and field assessments are discussed, and the results organized in response to the four evaluation questions. The Evaluation Team has also included additional findings not covered specifically by the four questions.

Question 1: To what extent has the project achieved its objective of improving the enabling environment for FP/RH in the three target states?

The dRPC Project trained 106 religious leaders, both male and female in Leadership Development Forums; 50 traditional and religious leaders attended the Islam and Maternal Health study tour in Egypt; 16 influential female scholars attended the Maternal and Child health study tour in Mali coordinated by Management Sciences for Health, Mali; 295 members of the Executive, legislature, judiciary and local government chairmen were trained in leadership development, many for the first time; and 151 health providers at primary health care centers in Niger, Sokoto and Zamfara were trained.

From The Evaluation Team's review of the project's results framework (see SOW in Annex I), the outputs (measured by a set of output indicators) was expected to directly contribute to the two project objectives: (1) to create capacity of the TRLs and PLs to communicate accurate information to people on RH and Birth Spacing, and (2) to increase capacity of the TRLs and PLs to improve the enabling environment in RH and Birth Spacing. These two objectives would work together to achieve the project goal, which was to create a cadre of RH/Birth Spacing transformative religious and traditional leaders, as well as political office holders in the three focal states of Zamfara, Sokoto and Niger.

The Team found all the output indicators have been achieved except for two, i.e., public proclamations in support of RH/Birth Spacing by the PLs and TRLs (700 proclamations recorded out of a targeted 900), and mentoring (167 out of a targeted 171). The shortfall in the number of proclamations may be explained by several factors: the dRPC lacked sufficient staffing in the focal states to effectively monitor proclamations made by the TRLs and PLs. Some of the TRLs were reluctant to openly and regularly record their speeches for onward transmission to an external entity, because this could be easily misinterpreted by their congregations as sponsoring or serving the purposes of outside interests. Even though hesitant in *recording* their sermons or speeches these TRLs nevertheless, preached and counselled effectively within their communities on RH and Birth Spacing issues. Other contributing factors may include unfamiliarity on the part of the TRLs with writing and following work plans, and also, as a number of TRLs pointed out, *"listing our speeches appears to be like bragging about our achievements, which is not something that we wish to do."*

The End-of-Project Report that dRPC submitted to USAID | Nigeria indicates that all other targets for (i) number of leadership forums organized, (ii) number of individuals trained with USG fund; and (iii) number of alumni networks formed have been met or exceeded. These outputs were designed to contribute to the achievement of the project's objectives. Although the results framework did not include *outcome* indicators key outcome level achievements are as follows: (i) TRLs and PLs have increased their knowledge, skills and confidence in advocating for an improved environment for RH and Birth Spacing; (ii) Some TRLs and PLs have implemented their Individual Activity Plans (IAPs) and Group Activity Plans (GAPs) partly or completely; (iii) HSPs have increased their knowledge and skills as a result of technical training; (iv) community members appear to have a heightened level of awareness and positive practices in the areas of RH and Birth Spacing. These and other findings are described below. The Evaluation Team analyzed the responses from the FGDs with women, men and adolescent females and males, as well as the KII responses from the TRLs and PLs to evaluate the dRPC Project's achievements.

Focus Group Discussion with Women

Since there was no baseline benchmark with indicators that we could utilize for comparing achievements, the Evaluation Team members asked the participants about their perception and experience *four years ago*, before the dRPC Project began in 2009. This allowed for before-after comparisons on a number of topics. The Team was aware of the possible effects of two factors when analyzing the findings: first, there is the possibility of recall bias on the part of the respondents, and secondly, there are influences external to the project, e.g., radio, television, other health projects operating in the area, which may have contributed to the apparent positive change in society over the past four years. In the absence of an experimental or research study with a case-comparison design, it is difficult to attribute positive changes solely to dRPC. Nevertheless, the discussion questions relating to situations or perceptions that existed "four years ago," helped with comparing the indicators at the time of the evaluation to those at the time before dRPC began its project.

The Project's achievement and its objective in creating an enabling environment for RH and Birth Spacing are separately described under these two intervention areas.

Enabling Environment for Reproductive Health

<u>Women's age at marriage and at birth of the first child</u>

From the FGDs with women's groups, the Team learned that currently it is acceptable for young women in the communities to get married at or around the age of 18 years. Even a few years ago it was the norm for girls to be married at an average age of 14 or 15 years. It appears that some positive changes in the mindset of the project's communities toward the age of marriage of women have taken root. We also learned from these FGDs that the current preference of mothers having their first child is between the age of 18 and 21 years.

A few years ago this was between age 16 and 18. In the FGDs with men we found very similar responses. Very few men preferred that women should get married before 18 years of age, and have their first child before 19 or 20. Both male and female respondents mentioned that delaying the age of marriage for girls *"..allow for these girls to be adequately mature before marriage."* And also because *"this delay will enable girls to complete basic schooling."* When asked what was their preference four years ago, most men said the ages at which girls got married and had their first baby was much lower. In one FGD at Gagi, Sokoto the evaluation team was told, *"…. there is a big change in age of marriage and giving birth within Gagi community between now and four years ago. Because 4 or more years ago, none of the community members would have listened or spoken to you (about these issues). We used to marry off our female children between 9–12 years of age and they started bearing children at the ages of 10–12 years."*

Antenatal Care

From FGDs with both men and women the Team learned that the women go for ANC *"to access health services,"* and they know it is beneficial to the mother and the baby. The young adolescent males also believe that ANC visits are good for the mother and her baby, as one respondent described, *"Because health workers are specialists that can attend to any medical problems that may arise during delivery or ANC."* Only a few women stated during their FGDs that they have not gone for ANC visits during their last pregnancy; and only a few did not receive TT2 vaccine. We noted however, that there is unclear understanding in the community about the recommended number of ANC visits, and currently the practice is to go generally about 4 to 8 times. This is likely the legacy from a previous system, which advocated for more ANC visits than the 4 visits that World Health Organization (WHO) recommends. More recently, the Federal Ministry of Health (FMOH) has introduced the Focused Antenatal Care (FANC) protocol, which is attempting to align ANC visit frequency and activities with the WHO recommendations.

Place of Delivery

More women prefer to deliver in the health facilities at present than a few years ago. The men in the community also tend to believe that facility-based delivery is better than home-based delivery, *"…because in the event that any complications should arise involving either the mother or her child, then it will be easier to intervene and save their lives within a health facility."* A few men voiced their dissent pointing out that delivering in the hospital is costly, staff lack respectful attitude toward patients, and that there is still a stigma associated with facility-based delivery, i.e., delivering in the hospital is often considered appropriate only for those with labor and delivery related complications. These men would prefer to have home deliveries for their women with a skilled birth attendant. The adolescent males had mixed views about the ideal place for delivery, while the adolescent females unanimously stated facility-based delivery is the best. Four years ago, the community members preferred most deliveries to take place at home, *"…because there was not so much knowledge and exposure on the importance of going to the hospital and that's why four years ago more women delivered their children at home,"* explained one young teenage girl.

Obstetric fistula and genital mutilation

From the responses, the number of women with obstetric fistula is low and declining, compared to a few years ago when there were more such cases. All the respondents stated that genital mutilation of young girls has never been practiced in the project area.

Enabling Environment for Birth Spacing

Number of Children, Gender Preference

The number of children born to a woman in the communities generally now varies between 3 and 12. Even a few years ago the number of children per women was higher, according to the women FGD respondents. Men tend to prefer more children, often stating during their FGDs that families should have as many children as God gives them. When asked if couples continue to have children after having several daughters, in the hope of having a son, nearly all the women participants said "yes." The couples continue having children with the hope that God will give them a son. The men in their FGDs seemed to have a mixed pattern of response, with those who opted to continue for a boy pointing out that this was because of the need to carry on the family name, and help support the father economically with his occupation. Interestingly, most adolescent males stated that they would not continue to seek a male child, because in the words of one FGD participant, *"I prefer girls and there is no difference between boys and girls even though in our society, boys are preferred because they can help in economic activities."* The adolescent females, however, opted to continue to have children in the hope of having a male child. A possible explanation for the women and young girls to feel this way may have to do with the implicit pressure and expectation the society has on them for giving birth to *male* children. The TRLs during their KIIs repeatedly pointed out that there is no Islamic basis for gender preference for children.

Decision Making for Birth Spacing

In the communities the Team visited, while solely the man in the family used to decide whether a couple should continue to have children, currently this is changing and both men and women are making joint decisions about spacing births. In the FGDs with women, when the Team probed to learn how this has changed over the last few years, we were told, *"Some women now are able to raise and discuss the issues of birth spacing with their husbands." And again, "Men are now involved in providing information to their wives in the community on FP services. Men now support and encourage FP in their homes."*

Sources of Information about Birth Spacing

In the FGDs the Team conducted with men and women, as well as the adolescent males and females, we learned that community members get information on Birth Spacing. Women receive information from the health facilities and medical staff, and also through radio programs, discussion with other women in the communities and also from the TRLs. The sources of information for men mainly are the health workers in the facilities and TRLs in their communities, the radio, town announcers (individuals who go around the communities announcing important messages), posters and NGOs. The adolescent males reported their sources are similar to those of the men; additionally, they mentioned the TRLs, mosques, local dramas and college. For the adolescent females, the sources were married women in the homes and their communities.

Importance of Birth Spacing

In the communities the Team visited, the women in their FGDs unanimously stated that they believe spacing births of their children is good for their own health and the health of their children. When asked if they believed this four years ago, nearly all of the women participants said, *"No! We did not believe in birth spacing at all."* Some also added that there were fewer types of contraceptives available for them to access. The men also were in agreement on the need for Birth Spacing. Some of them said having children frequently caused mainly an economic problem, but many also pointed out Birth Spacing is essential to protect the health of the mother and her baby: *"Yes, because we will like to prevent 'rurutsa' (frequent births) in our families because it can harm the health of our wives and the breastfed baby."* The adolescent males and females also believe spacing of births is good for the mother and her children.

Interval Between Births

Most women in the FGDs stated there should be 3 years interval between child births, while some believe the interval should be 4 to 5 years. Four years ago they believed the ideal interval between births should be lower, even one year or 1.5 years. Men also believe there should be adequate spacing of births. Most of them preferred an interval of 2 to 3 years, although their responses ranged between 1.5 to 6 years. When asked what they believed four years ago, they said, *"We did not think about the birth spacing interval and our wives gave birth mostly within 1 – 2 years after the last delivery."*

Birth Spacing Methods

In the communities we visited women are now more aware of modern methods of contraception. Four years ago this knowledge was mainly limited to oral contraceptive pills and condoms. The women participants in the FGDs knew that implants, pills, condoms and injectables can be used for spacing births. The injectable contraceptive is the most utilized commodity. Most women stated both husband and wife jointly make decisions about birth spacing. All participants unanimously stated that Islam permits birth spacing. Nearly all women believe Islam does not prohibit the use of contraceptives for spacing births. Some felt Islam does not allow the use of contraceptives for *limiting* the number of children, and does not permit permanent methods. Men are also aware of the different methods and commodities that are available in the communities. Four years ago their knowledge was limited to only the oral pills and condoms. Men also believe Islam permits all contraception methods with the exception of permanent methods, which are only permitted if the life of the mother is threatened; and they believe that Islam does not permit the use of permanent contraception methods to limit the number of children.[6]

To summarize the response to the evaluation question # 1, it appears that the dRPC Project has been instrumental in shaping and shifting community mindset positively toward adopting RH and Birth Spacing behavior and practices in the communities where it was implemented.

[6] None of the respondents quoted any Quranic verse to support their beliefs about permanent methods of contraception.

Despite the fact that there was no baseline data to compare to, the Evaluation Team attempted to gauge from its interactions with the community members about what was the RH and Births Spacing environment four years ago, before the dRPC Project began. We believe that compared to the scenario four years ago, the project communities to a large extent have witnessed an improved enabling environment in RH and Birth Spacing. Although dRPC may not claim full attribution for this improvement, it nevertheless gets credit for contributing toward this change. The Team also recognized the fact that the dRPC, through this project, undertook a bold initiative for enhancing RH and Birth Spacing programming in a strongly conservative society. It is rare to have a local NGO take such a bold stand for RH and Birth Spacing in northern Nigeria.

Evaluation Question 2. Which advocacy activities were successful and had positive impact and which ones had no or limited impact and why?

The dRPC Project had two primary target groups—the TRLs and PLs—who received the project's direct inputs. The project aimed to train, empower and equip these two groups to influence positive changes in the RH and Birth Spacing environment. The Evaluation Team presents its findings on successful and not-so-successful advocacy activities as they relate to these two categories of primary project participants.

Traditional and Religious Leaders

The project planned its strategies and activities for the TRLs to provide a central message to the community members, i.e. Islam is not opposed to Birth Spacing, and the Quran and the Hadith provide a strong basis for Birth Spacing and women's right to RH. The project organized a range of activities involving the TRLs. These are detailed above in the Background section. Some of these activities were quite effective and beneficial to the TRLs, while others were not very effective.

<u>Most Effective Activity</u>

Through Key Informant Interviews with the TRLs, the Evaluation Team learned that they regarded their study tour in Egypt as the most effective activity of the project. The participants met with respected Islamic scholars and leaders who helped them learn new things from the religious scriptures and tradition in support of RH and Births Spacing. The TRLs who were against Birth Spacing were convinced after interacting with the renowned Egyptian teachers and scholars, and this visit was an eye-opener for them. As one respondent put it, *"the Egypt visit allowed us to interact with renowned and respected Islamic scholars who used facts to convince us without forcing their opinion on us."* The visiting TRLs also learned, for the first time, how to preach on Birth Spacing in a confident and compelling manner.

Interviewer Using Focus Group Discussion Guide

Also effective were the training workshops/Leadership Development Forums (LDFs) in Kano, Sokoto and Abuja and a study tour for some female TRLs to Mali. These activities provided opportunities to interact with respected religious teachers and scholars and with peers, allowing the TRLs to acquire new knowledge in RH and Birth Spacing in light of Islamic teachings, and also giving them the opportunity to share their experience and constraints.

Least Effective Activity

The TRLs identified the Alumni Association as the least effective activity. The project expected the Alumni Association to evolve as a sustainable network of the "Champions", who were the participants in the overseas study tour and at the in-country workshops. In principle, this was a novel idea for paving the way for the trained TRLs to share experience with each other, nurture and inspire one another and address challenges and emerging needs together. In practice however, the Association failed to thrive following the project's planned termination. In the Team's estimation the intent was quite good, but the preparation of the foundation for this type of network to take root was not established. For instance, the project did not effectively communicate to the TRLs that following the project's termination they were on their own, and they would be expected to continue the Association's activities with their own initiative and resources. The TRLs expressed their disappointment with the fact that the dRPC Project support had stopped, and so their Alumni Association could not move forward with their planned activities. Perhaps better communication, along with a longer period of mentoring on dRPC's part, would have helped in managing expectations, and prepared the Alumni Association to be sustainable.

Another activity that did not continue following project termination was the follow-up of Individual and Group Activity Plans. The TRLs were expected to develop and implement IAPs and GAPs. In reality, the TRLs often are not used to crafting their own work plans. And keeping detailed logs of each activity, e.g., sermons, individual or group counseling, visitations, etc. are not within the TRLs' tradition for reasons pointed out earlier. So, the TRLs explained to us during the KIIs that, while they preached sermons where they included messages on Birth Spacing and counseled the members of their congregations on RH matters, they did not keep consistent records of these activities, contents of their messages or frequency or place of their pronouncements.

The dRPC did attempt to collect audio recordings of the sermons, publications of messages, etc. during the life of the project, but these did not continue following project termination. And even during the project, the monitoring of these TRL activities was difficult to undertake mainly due to lack of staffing and funding.

The Evaluation Team noted that in each state there was only one part time staff responsible for coordinating, supporting, monitoring, and reporting on project activities. In the Team's estimation the lack of adequate staffing in the project states contributed to the sub-optimal performance for some of the project's activities, such as the continuation of the Alumni Association, the IAPs and GAPs.

Political Leaders

The political leaders also informed the Evaluation Team about activities that they considered to be most effective and those that were less beneficial.

Most Effective Activity

Most political leaders interviewed stated that out of all of the project's activities the visit to Ghana was extremely beneficial to them. They learned about the successes that the Ghana health system had achieved. *"The most effective activity for me was the study tour to Ghana, because it enabled me to see the health system in Ghana..."* commented one PL. During this tour the participants learned firsthand how Ghana lowered its measles rate; introduced the use of misoprostol and chlorhexidine at the community level; and Magnesium Sulphate at the facility level. They were inspired by the Ghana Health Minister, First Lady and many doctors and health workers with whom they had opportunities to interact.

Follow-up training workshops and seminars in Abuja and Gusau were also mentioned as being effective because these provided an opportunity for interaction with peers or colleagues from other project focal states, as well as networking and information sharing opportunities.

Least Effective Activity

From these KII with the PLs, it appears that the least effective activity of the project was the continuation of the Alumni Association and the Advocacy Visits. As in the case of the TRLs, the Alumni Association was formed with the intent to encourage the Champions to network with each other, share experiences and together address issues related to RH and Birth Spacing in their constituencies. The PLs cited several reasons for the demise of their Association; poor attendance at meetings and the lack of continued support from the dRPC or the government being the most important among them. One respondent explained that the Association was formed toward the end of the dRPC Project and *"…there was little or no support (for this activity)."*

Likewise, the advocacy visits were also viewed as least effective by the PLs because *"interagency collaboration was missing."* These advocacy visits were aimed at government stakeholders with influence on health policy and funding in the respective focus states. These visits were planned on a quarterly basis by a mixed team from the project. The intent was for the Alumni Associations to continue this practice in their respective states. However, advocacy visits by the Alumni Association was conducted only rarely. Advocacy on the part of the PLs did not result in the expected budget allocation or political support from the state government to the LGA authorities. Consequently, the PLs felt there was little incentive to continue these advocacy visits.

The Evaluation Team feels that the underlying reasons as to why these initiatives became ineffective with both the TRLs and the PLs had to do mainly with the lack of adequate planning, staffing and time that were needed to make these efforts worthwhile and sustainable.

Although categorized under PLs by the dRPC, the HSPs included in the project were different type of leaders in that they were mostly *health facility service providers and managers.* Their training was mostly focused on Leadership Development and selected topics from the Modified Life Savings Skills (MLSS) training, as well as training on the Minimum Standards Package (MSP). These abridged versions of the two trainings were tailored for the HSPs, and conducted by an external consultant. This group of service providers felt that the effectiveness of the project's training helped them to gain technical and programmatic knowledge on the delays that contribute to high Maternal Mortality Ratio (MMR) and their mitigation, management of Post-Partum Hemorrhage (PPH) and improving communication skills, to name a few. The Kano and Gusau workshops were mentioned by a couple of the HSPs as being quite useful to them.

Evaluation Question 3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states and how has dRPC contributed to this? How were these roles different for traditional/religious and political leaders in terms of effectiveness?

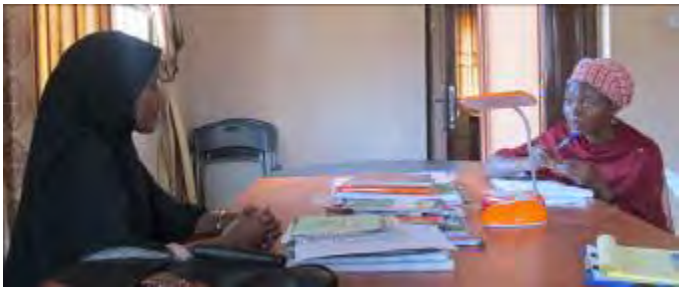
As in the case of Question 2, the Team responds to this question as it relates to the project's primary target groups.

Traditional and Religious Leaders

The TRLs in the dRPC Project promoted and improved RH and Birth Spacing environment through a variety of ways.

<u>Modes of Message Delivery</u>

All the TRLs interviewed by the Team stated that they give messages related to RH and Birth Spacing to their congregations during lectures, sermons and preaching. Often the RH and Birth Spacing information is discussed explicitly, while sometimes the information is embedded in the larger context of their sermons, counseling and pronouncements.



Key Informant Interview with a Female Religious Leader

Messages cover topics related to birth spacing, maternal health, ANC and deliveries. A few TRLs recorded their messages on audio tapes for wider dissemination, and practiced what they preached, as one individual put it, "*I produced a lecture on tape specifically on ANC visit, and demonstrated (the teaching) by sending my own wife for ANC visits."* Female religious scholars trained by the dRPC told the Team they too provided RH and Birth Spacing messages to their audience, and are now more confident in doing so. "*With the knowledge I gained, I can now stand in front of women to address them on health-related issues,"* said one female religious leader who had been to Mali on a study tour organized by the dRPC. The TRLs listed a range of messages they preach and teach, which include the dangers of 'rurutsa', the practice of Birth Spacing, importance of ANC visits, and a large number of topics that directly or indirectly touch on RH and Birth Spacing.

Place of Message Delivery

The TRLs listed a variety of places and events where they have disseminated key messages on RH and Birth Spacing: Friday 'Khutbah' (sermons) at mosques and smaller gatherings seemed to be the most utilized conduit for the TRLs to talk to their communities about a wide range of issues, which included RH and Birth Spacing. Also mentioned were the events at the Islamic schools and the Federation Of Muslim Women Association of Nigeria (FOWMAN) center, naming ceremonies (Walima), weddings, local government events, and Ramadan 'tafsir' sermons.

Use of Scriptures to Support RH and Birth Spacing

Concerning RH and Birth Spacing the central message that the TRLs gave to their congregation was that Islam does not prohibit Birth Spacing, but in fact, encourages this and also supports RH measures. To do this effectively, most religious leaders mentioned during their KIIs that they have used the Quran and Hadith in support of their views.

The dRPC's Contribution to TRLs' Effectiveness

Based on the responses the Team received from the TRLs, it is apparent that the dRPC Project equipped and empowered them to confidently inform their congregation about RH and Birth Spacing. When asked to describe the difference in their messages before and after the dRPC Project, one leader said, *"I used to discuss about maternal health issues even before the coming of dRPC, but I only started to include Birth Spacing in my messages after my interaction with dRPC."* And another leader said, *"...before (dRPC Project) my messages were on family relationships and general health, but now (they are) more specifically on child spacing."*

The Team learned from the KIIs that in both congregational messages and individual or group counseling, the TRLs provided specific information on the need for spacing children, ways in which this could be done, and the importance of ANC visits and health facility-based delivery. Before the dRPC Project, they said they did not have such focused and informed messages for counseling their community members. Now they do. When asked about the difference in their counseling messages and methods (compared to four years ago) one leader stated, "*The difference includes counseling for men on child spacing and care for their family health; there is now additional information on RH, and advice for child spacing."*

An indication that there is a shift in the project community mindset is exemplified in the quote from another religious leader, *"I speak about birth spacing, responsibilities of married couples, ANC, deliveries. I used to give these messages even in the past because I preach to, and teach a lot of married women in my school. The only difference now is that I don't face as much opposition and attacks from the community as I used to in the past."* This and many other similar testimonies shared with the Team during our interviews and discussions indicate that the dRPC's investment among the TRLs have been instrumental in starting to effect a change in the community mindset.

Contributions of Female Religious Leaders

The female religious leaders made significant contributions in improving the enabling environment in RH/Birth Spacing. Based on the responses from the FGDs with the

community members and the KIIs with the *female* religious leaders the Evaluation Team learned that:

1. The female religious leaders now have more knowledge, skills and drive in advocating for RH and Birth Spacing during outreach sessions with women in their communities.
2. Couples trust the female TRLs often, and seek their counsel on RH/Birth Spacing matters.
3. Female TRLs seem to have a strong sense of gender understanding and other contextual factors when referring couples to appropriate resources for RH/Birth Spacing services.
4. Some female religious leaders have utilized their leadership training on RH/Birth Spacing to improve their teaching skills at Islamic schools (e.g. giving public lectures for women at events organized by the Muslim Students Society) where they are able to influence students, and through these young students influence also their families and communities.
5. Some female religious leaders have been empowered by the project to the extent that they reportedly debated with their male counterparts during the RH/Birth Spacing Leadership project training on issues of women's and children's health.

Key Informant Interview with a Female Religious Scholar

Political Leaders

Most PLs who met with the Evaluation Team for the KIIs stated that they had developed activity plans with support from the dRPC. These were individual, as well as group activity plans. A wide range of activities had been planned by the PLs. These activities can be grouped under (i) education of girls and women so they can be trained as health workers; (ii) community mobilization and sensitization for better health; (iii) renovation and construction of health facilities; (iv) advocacy visits to the state Ministry of Health for budget allocation; and (v) others. Some activities, as described by the PLs, clearly contributed to the improvement of RH and Birth Spacing. Here are a few direct quotes from our KIIs as examples of these activities: "P*urchasing RH and child health related drugs for free distribution and CHEW training at School of Health Tech with assurance of job following graduation" "Sensitization about RH issues for a specified community; developed an IAP which focused on strengthening ANC activities as well as effective management of labor cases." "I was able to use TBAs to identify and link pregnant women to their local health facility, as well as providing constant supply of routine ANC drugs to those selected health facilities;" "I included (in my IAP) outreach activities like training, and women's group discussion on child spacing, advocacy to the Ministry of Health on women's reproductive health."*

Key Informant Interview with a Political Leader

Some activities were not so directly associated with RH and Birth Spacing, but nevertheless the PLs felt these made indirect contributions to these two areas. A few quotes from the PLs: "O*rganizing social clubs, self-help projects such as digging water wells, renovating schools and other community needs;" "Construction of health facilities, getting equipment for facilities, advocacy steps to get budget allocated for these tasks and for health workers' salary increases;" "Renovated two hospitals and equipped them during my tenure;" "Included in IAP the renovation of three clinics for improvement of MCH."*

The dRPC's Contribution to the PLs' Effectiveness

Many PLs told the Evaluation Team that before the dRPC Project began four years ago they did not develop activity plans. As in the case of the TRLs whom the dRPC Project empowered with new knowledge and confidence, we found that the PLs also received support from the dRPC for their own leadership development. Training through overseas study tours and workshops, formation of Alumni Association, developing IAPs and GAPs, mentoring, and advocacy were some of the areas where the project had focused its attention with the PLs.

Most PLs demonstrated to the Evaluation Team their deep understanding and commitment to improving the RH and Birth Spacing environment. They voiced their support for ANC, hospital deliveries, spacing births using contraception methods available in the communities. Most seemed to know the benefits for spacing births. When asked about the reasons they said, *"Yes; after a woman delivers it takes a while for her to recover, so for the sake of the mother's and child's health (the) spacing of birth is absolutely important." And again, "Yes, it is beneficial because a family that practices birth spacing is likely to be healthy, be content, have improved economic status and fewer hospital visits due to illness."* There was little or no preference for a boy over a girl child.

Several PLs expressed their gratitude to USAID for helping in the development of their communities and states. One individual stated, *"USAID has done a lot of community development activities for this community."* He was alluding to not just one but several projects funded by USAID in his state.

PLs that were not trained by the dRPC are unlikely to possess the basic knowledge of, and favorable attitude to RH and Birth Spacing principles and practices. This was highlighted when we had a chance encounter with a couple of PLs in high positions that had not received any input from the dRPC Project. An LGA Commissioner for instance, told us he prefers to have a boy child since the boy will grow up to help with the family income. He said the best way to space children and give a mother enough rest after delivery is for the husband to take another wife. His Deputy Commissioner and several

Traditional Leader at a Key Informant Interview

others at the Director level in this LGA were present during this discussion and they agreed with the Commissioner. None of them were associated with the dRPC Project.

The Evaluation Team feels this heightened awareness and commitment among dRPC project beneficiaries were a result of the project's investment in the PL's training and other related activities.

Although the project made substantial investments in the PLs, the return was not very significant. While several PLs told the Evaluation Team they were successful in accomplishing most, if not all of their IAPs and GAPs, there were many other PLs who admitted being unable to accomplish their planned activities, or as in some cases, accomplished only part of what they had planned. They cited as major obstacles funding constraints; transfers of individuals or completion of their office tenure; lack of support from the state government, from the Alumni Association and the dRPC.

Difference in the Effectiveness of TRLs and PLs

The fact that the dRPC utilized very similar approaches to inform and empower different groups of their primary target audience allowed the Evaluation Team to understand that there are uneven results in the different groups.

The PLs trained by the dRPC did not appear to be as effective as the TRLs. This is because first, the PLs are not a homogeneous group of stakeholders. So, the agenda for those who are elected or appointed to office is not the same as the agenda of the members of the judiciary, or the priorities for the health technocrats and facility managers. Secondly, unlike the TRLs who reside and function within their communities, the PLs are not placed in close proximity to the communities and had very little direct influence on shaping the belief system in the society. Thirdly, their sphere of influence and effectiveness is also limited by the fact that they are not necessarily in positions to individually change policies and budgeting processes for RH and Birth Spacing. They have to depend on a hierarchical system of decision-making and function within bureaucratic structures over which they have limited or no control. Many PLs deplored the fact that they were unable to implement many of their planned activities. This is consistent with the Mid-Term Evaluation findings of July 2011, in which only a few PLs had implemented more than two activities from their action plans, and fewer had stated their interest in continuing to work with RH after the end of the dRPC Project.

On the contrary, the effectiveness of the TRLs' roles in improving the RH and Birth Spacing environment is borne out by the fact that men, women and young adolescents recognize their authority and accept their teachings. All of the women who participated in the FGDs stated they personally heard their TRL preach or counsel about birth spacing. A majority of these women said the Religious Leaders in their communities used verses from the Quran and Hadith in discussing spacing of birth. In most communities where we held FGDs, the women and men informed us that four years ago they did not hear any TRL speak openly on these topics. A participant remarked, *"In the past TRLs only discussed…topics on religion, but they have now included topics on birth spacing."*

TRLs demonstrate a much higher level of stability, commitment and competence in positively influencing the communities' RH and birth spacing attitudes and practices. The TRLs also have faced constraints at times, as did their political counterparts. Some of them did not want to be seen openly supporting birth spacing, and on many occasions they realized "embedding" these messages in the context of larger, general preaching and teaching made their congregation more receptive to their messages on reproductive health and birth spacing.

Evaluation Question 4. What effect did the project's activities have on women and men from the community differently?

The change in the perception of RH and Birth Spacing in the communities we visited is the single most important effect that the dRPC Project achieved. Men and women, as well as the adolescents, in the project communities who took part in the FGDs described to the Evaluation Team how within a few years their views have improved regarding RH and Birth Spacing. When we asked what was the source of information about RH and Birth Spacing four years ago we were told, "… *four years ago, our major source of RH/Birth Spacing messages was the radio but we did not trust these messages that were broadcast over the radio by someone we did not know, and we did not believe those messages because it is usually government-sponsored."* The project succeeded in re-inforcing knowledge on RH and Birth Spacing from other sources with the preaching, teaching and counseling by the TRLs in the community.

Focus Group Discussion with Men

The effects of the project on men and women were not remarkably different when we consider their shared beliefs and views. But there are some added benefits of the project that related directly to the women and young girls. In the communities, which the Team visited, men have expressed more willingness to allow their wives to go for ANC visits and hospital deliveries compared to four years ago. They recognize the value of the girl child and investment in their education. Community leaders told us they have specifically sponsored *girls* to get education so they can become skilled in providing RH services. As one of them mentioned, *"I sponsored some girls in the villages within my LGA to go to the School of Health Technology; now they have graduated and work in the Primary Health Care (PHC) in their villages."*

As reported during the FGDs with men and women, decisions for birth spacing are being made jointly by husbands and wives, unlike the past. Both men and women are more willing to accept contraception for Birth Spacing compared to four years ago. Women mentioned during their FGDs that they receive RH and Birth Spacing information and messages from female TRLs, who were trained by the dRPC Project. This was not the case even a few years ago. Men seem to accept the principle and practices of Birth Spacing, which they did not do a few years ago.

From the FGDs the Evaluation Team found that the adolescent *males* are aware of the need for ANC visits, facility-based delivery and Birth Spacing; they believe Islam permits Birth Spacing; they hear these messages from their local TRLs. Adolescent *females* told us that they get Birth Spacing and RH information from home, hospitals, radio, television and local TRLs; they believe spacing births is good for the mother and her children; most believe there should be 3 to 4 years interval between births; and they know about modern contraceptives.

The Evaluation Team learned about a number of unintended benefits that occurred in the communities, apparently resulting from the dRPC Project activities. Here are a few of these success stories. Following his activity plan that he developed with support from the project, a TRL used his own funds to *"renovate clinics and constructed benches for women coming to (the health) facility for ANC visits."* During a KII with a PL we learned about how his group initiated water, sanitation and hygiene activities in his community, which they had included in their GAP, with little funding: *"Yes, …we included sanitation, water, hygiene, maternal health and they were all accomplished because they did not require much funding."* Other spinoffs from the project included self-help projects in the communities such as digging of water wells to provide better source of water; renovation of schools; advocacy to different ministries for securing funds to train staff and improve RH and Birth Spacing activities, as well as youth related activities for HIV/AIDS prevention. In an interview with a PL we learned that, *"the health sector was strengthened as a result of the involvement of TRLs, we (health professionals) shared views with them. This has never been done before dRPC."*

As we have pointed out in an earlier section, although all the benefits in the communities cannot be attributed solely to the dRPC Project, it appears the project has improved the mindset of the community men, women and adolescents by having a positive impact on the enabling environment for RH and Birth Spacing. Apart from the added value for women and girls as discussed above, the effect of the project appears to have equally impacted the belief system for men, women and adolescents.

ADDITIONAL FINDINGS

Health Facility Statistics Review

The Evaluation Team visited 7 health facilities at several levels ranging from PHC to General Hospitals. These are: (i) PHC Gagi, Sokoto, (ii) PHC Gandi, Rabah LGA, Sokoto; (iii) General Hospital Bodinga, Sokoto; (iv) Women and Children Welfare Center (WCWC) Gusau, Zamfara; (v) WCWC Anka, Zamfara; (vi) General Hospital, Talata Mafara, Zamfara; and (vii) Orphans & Less Privileged Clinic, Talata Mafara, Zamfara.

Health Facility Visited By Evaluation Team

The Team found gaps in the availability and quality of RH and Birth Spacing data in most of the facilities visited. Some facilities did not have log books and registers for the Team to

review at the time of the visit. The Team was told the log books were with individual staff members who were not present at that time of the visit; or the officer-in-charge could not locate registers. At other facilities the documentation was incomplete, i.e., the data were missing for several months in a given year or for an entire year. Two facilities can be commended for producing fairly a useful set of data for the Team. These were the General Hospital in Bodinga, Sokoto and the WCWC Gusau, Zamfara. In the table below we present selected data in RH and Birth Spacing from these two facilities.

Summary of Selected RH/FP Indicators at the General Hospital Bodinga, Sokoto and the WCWC Gusau, Zamfara visited during the evaluation:

Indicator	Sokoto		Zamfara	
	Past 12 months (Nov 2012 to Oct 2013)	Previous 12 months (Nov 2011 to Oct 2012)	Past 12 months (Nov 2012 to Oct 2013)	Previous 12 months (Nov 2011 to Oct 2012)
Number of pregnant women attended by skilled personnel in this facility at least once during pregnancy	1632	Not available	1077	1192
Number of pregnant women that were attended by skilled personnel in this facility a minimum of four times during pregnancy	1387	816	947	1192
Number of pregnant women who received two doses of TT	1061	365	692	501
Number of live births that took place in the facility	672	576	773	725
Number of women of reproductive age who received a contraceptive method	954	767	191	165
Number of women of reproductive age accepted for the first time in their lives any contraceptive method	540	660	131	72

Compared to the figures in the most recent 12 months (November 2012 to October 2013) with those of the previous 12 months (Nov 2011 to Oct 2012), the Team observed, as shown in the table above, that there was an increase in the number of pregnant women who were attended by skilled service providers at least four times during pregnancy for ANC in the Sokoto facility. In the Zamfara facility, however, there seems to be an actual decrease in the number of 4th ANC visits. The number of pregnant women who received two doses of

TT vaccine during their last pregnancy increased in both facilities in the most recent 12 months compared to the previous 12 months. The increase in the Sokoto facility is much higher than that of the Zamfara facility. The recent NDHS 2013 preliminary data shows an apparent national level increase in TT protection of the last pregnancy as compared to the data of NDHS 2008 (see PowerPoint slide handout in Annex VII). There is a slight increase in the number of live births over these two time frames as documented by both facilities. The NDHS 2013 report shows a slight increase at the national level in the rate of facility-based delivery as compared to the data from NDHS 2008. Total number of contraceptive acceptors from these two facilities has increased. The number of first time acceptors somewhat decreased in the Sokoto facility, while it increased notably in Zamfara.

The Evaluation Team examined the NDHS preliminary report released in October 2013 to view these findings from the two facilities against the backdrop of *state* level performance. This preliminary report from NDHS 2013 shows 17.4 percent of women 15 to 49 years of age received antenatal care for the last live birth from a skilled provider in the state of Sokoto. In Zamfara State this rate is 22.4 percent. From this report it appears 13.9 percent of the last live births have been protected against neonatal tetanus in Sokoto State. In Zamfara State the neonatal tetanus protection rate is at 17.5 percent. The state level rates for facility-based delivery are 4.7 percent and 5.0 percent in Sokoto and Zamfara respectively. In Sokoto State 0.7 percent women 15-49 years of age currently use a modern method of contraceptive. This rate is 1.3 percent in Zamfara State.

Reviewing Statistics in Health Facility

While this was not an in-depth health facility survey, the Team's review of the available data from these two facilities nevertheless gives a snapshot of selected indicators in RH and Birth Spacing in the communities. These two facilities are located in populated urban or semi-urban areas, are well-staffed and are able to manage obstetric cases without having to refer the patients to another facility, with the exception of obstetric fistula.

In contrast to these two facilities that had relatively good records, the health facilities located in rural areas generally demonstrated more gaps in the documentation of their RH/Birth Spacing statistics. Contraceptive oral pills, condoms and injectables were available in all the facilities the Team visited during the evaluation. The Team found injectables and implants were the most utilized, while condoms and Intra-Uterine Contraceptive Devices (IUCDs) were the least preferred. This is consistent with the FGD responses from the communities we visited. Stock outs of Birth Spacing commodities were generally rare in most of the facilities visited, i.e., contraceptive pills in one case and the stock of implants in the other.

At our request the statistics department of the Zamfara State Ministry of Health provided their state level data for selected RH indicators. According to these official government statistics, the number of women registered for ANC first visits and women who had facility-based deliveries showed progressive increases from 2009 to 2012. The ANC fourth visit and TT2 vaccine indicators declined somewhat over the years. For all indicators there is an increase in 2010 followed by a decrease in 2011, most prominently for the ANC fourth visit.

Zamfara State RH statistics for selected indicators 2009 -2013

Selected RH Indicators	2009	2010	2011	2012	2013
ANC First Visit	21201	43492	41775	84002	N/A
ANC Four Visits	46084	50330	25618	38522	N/A
TT2 **Vaccines**	24578	43585	14691	36669	N/A
Deliveries (Live Birth)	13813	17295	13417	18948	N/A

Project Staffing

The dRPC headquarters is based in Kano and operated the project in three states (Niger, Sokoto and Zamfara), but did not establish project offices in these states. The project recruited a part time State Focal Person in each state to manage all project activities, including monitoring and reporting on project activities. The Evaluation Team feels this was not an effective staffing arrangement, given the work load and the requirements for tracking project progress. The Team consulted with the former dRPC Project Focal Persons in Sokoto and Zamfara for understanding the ground level details about project operations. They informed the Team about the turnover of Focal Persons and the lack of resources to set up project offices to adequately monitor the project's activities. Despite these constraints, the State Focal Persons have tried their best to submit their quarterly and other reports to the dRPC's headquarters in Kano.

Project Materials and Training

The project developed training materials and Information, Education and Communication (IEC) materials. The Team found copies of several such materials during their document review and field work. The Team reviewed a training manual/facilitator guide that the dRPC used for its 3-day leadership training for the PLs. The manual was detailed and the material was presented in modules and sessions covering key areas of leadership in RH. In the Team's judgment a three-day training session to cover all the areas planned in this manual is ambitious. Also, it was unclear to the Team if the different categories of PLs received separate type of inputs during this short training session. The Team thinks it would be more effective for concept retention and practical application to have periodic short training sessions, such as the three-day workshop

Training DVD Used During Forums

that would span several months or even a year. The short training sessions would be designed for the same cohort of participants receiving sequentially arranged lessons on leadership and RH/Birth Spacing.

Project Monitoring and Evaluation
Fulbright Alumni Association of Nigeria (FAAN) was under an agreement with the dRPC to conduct M&E activities for the project. However, from the Team's document review and field visit, it appears the M&E system remained weak, at least in the first phase of the project.

Key Challenges and Constraints in Project Implementation
- The project experienced significant challenges in monitoring and documenting pronouncements. This was due in part to the absence of a field office in the programming states
- The project invested in strategic government officials who were frequently reassigned and were later moved out of public health offices and departments
- Political insecurity in the three states at times led to activities being rescheduled, which hampered the effectiveness of some community based activities
- Political office holders were unable to make the time to participate in follow-up mentoring activities
- Identifying staff, who would be acceptable to the conservative target groups of this project and competent at technical tasks such as report writing, proved to be difficult
- Finding trainers with experience in participatory training methods constituted a challenge for the project

CONCLUSIONS

The Evaluation Team recognizes that the results presented in this report may not be fully attributable to the dRPC Project. This is because the communities, the TRLs and the PLs receive inputs from a variety of sources from outside the dRPC project, which may influence their perceptions and practices. Nevertheless, the results seem to indicate that the project has initiated a shift in the mindset of members of the communities where the project operated.

Below is a synopsis of the results of the responses to the four evaluation questions:

Evaluation Question 1: To what extent has the project achieved its objective of improving enabling environment for FP/RH in the three target states?

In reference to the results framework we found the project met or exceeded all of its planned *output* targets with the exception of two areas: pronouncements and mentoring.

Reproductive Health:
- It appears that men and women in those communities where the project operated have positive perceptions toward the age of marriage of women and the age when a woman gives birth to her first child.

- From the FGDs it appears most pregnant women go to facilities for ANC visits. They know it is beneficial for them and their baby.
- There is a misconception in the community about the recommended number of ANC visits.
- More women prefer to deliver at a health facility, although financial and social factors may prevent them from doing so.

Birth spacing:

- In FGDs, community members stated that women have fewer children now compared to even a few years ago.
- It appears from the Team's interviews and discussions that couples in the project communities are beginning to make joint decisions about Birth Spacing.
- Couples continue to have children after the birth of several daughters in the hope that they will have a son.
- Community members get messages about Birth Spacing from sources that range from radio, television, home, peers, and TRLs.
- During FGDs women mentioned they believe Birth Spacing is good for their health and the health of their children. Four years ago they did not believe in Birth Spacing.
- Community members during the Team's visits appeared quite knowledgeable about modern methods of Birth Spacing. Injectables are the most preferred Birth Spacing commodity in the communities visited.
- The Team learned from discussions that community members believe Islam permits Birth Spacing, with the exception of permanent methods, and for the purpose of limiting the number of children.

To a large extent, the dRPC Project succeeded in initiating a positive shift in the perception of community members where it operated. A few years ago this change was not so apparent. Even if the Project does not get full attribution for such an important change, the dRPC can claim credit for taking a bold step for RH and Birth Spacing in the three states of northern Nigeria, and improving the enabling environment in these areas.

Evaluation Question 2. Which advocacy activities were successful and had a positive impact and which ones had no or limited impact and why?

For the TRLs, the study tour to Egypt was the most effective. They learned from religious scholars and teachers that Islam does not prohibit spacing of births, and found support for this view from the Quran and Hadith, which the TRLs found to be quite beneficial. The trip to Mali and workshops in various places of Nigeria were also of considerable value.

The TRLs felt the Alumni Association was the least effective. The IAPs and GAPs also were of limited value to the TRLs. The Team learned from our interviews that the TRLs had expected the dRPC Project to continue supporting and collaborating with the Alumni Association's activities. They also expected the project would offer resources to implement their IAPs and GAPs. When the project ended as planned, there were no further inputs for the TRLs. Consequently, they were unable to continue with their Alumni Association and IAP/GAP activities.

It seems there was need for a clearer understanding about the extent to which the project would support the TRLs with their associations and plans. Also, there should have been an exit strategy that would have prepared the TRLs to carry out these tasks with their own limited resources.

In the case of PLs, the Ghana tour was the most effective. Witnessing health care improvement in another African country was inspiring for the PLs. Follow-up workshops in several places within Nigeria were also quite beneficial. For the HSPs, who were grouped with the PLs, the abridged MLSS and MSP training sessions were the most effective. This type of training helped them acquire new knowledge, which they have been able to apply in their health care work.

The least effective activity for the PLs was the Alumni Association, and the advocacy visits were also relatively ineffective. Lack of interest, little support from the government and the termination of the dRPC Project were cited as the main reasons for ineffectiveness of the Association. The advocacy visits were not very productive because they did not result in the desired budget allocation and political support from the state government. Most of the PLs, therefore, became disappointed and lost interest in these advocacy activities.

The Evaluation Team feels adequate planning, staffing and investing sufficient time to prepare the PLs and the TRLs to establish and conduct these initiatives on their own would have made them more sustainable and effective.

Evaluation Question 3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states and how has the dRPC contributed to this? How were these roles different for traditional/religious and political leaders in terms of effectiveness?

The Traditional and Religious Leaders

The Team found in the KIIs with the TRLs and during the FGDs with community members that the TRLs trained by the dRPC Project seemed to have influenced the belief system in the communities quite effectively through RH and Birth Spacing related messages, preaching, counseling and pronouncements. Messages included information about RH, ANC and Birth Spacing. Often the TRLs spoke openly, but sometimes the RH/Birth Spacing information was conveyed within the wider context of their messages.

- They preached and taught at the Friday "Khutba" sermons at mosques, Ramadan 'tafsir' sermons, wedding and naming ceremonies and Islamic schools and centers such as the FOWMAN.
- Most religious leaders used the Quran and Hadith to support their RH and Birth Spacing messages.

The dRPC Project's Contributions to TRLs' Effectiveness

- The dRPC Project successfully equipped the TRLs to preach and teach RH/Birth Spacing related messages and support these messages with Scripture.
- TRLs informed the Team that before the dRPC Project they did not include in their messages women's reproductive health matters or the need for spacing children.

- The Project was successful in building the TRLs' capacity and commitment toward improving RH and Birth Spacing through the overseas study tours and teaching through in-country workshops

Political Leaders

The PLs also improved their capability to develop individual and group plans for carrying out RH/Birth Spacing activities utilizing their political influence.

- PLs developed their IAPs and GAPs, which included a wide variety of activities that directly and indirectly supported RH and Birth Spacing.
- Some of the activities the PLs planned in their IAP and GAP included: training for girls to get higher education, especially in the health field; community mobilization and sensitization for better health; and renovation of health facilities and providing them with equipment.

The dRPC Project's Contributions to PLs' Effectiveness

- The Project gave the PLs a new understanding about RH and Birth Spacing.
- The dRPC helped the PLs to develop their IAPs and GAPs.
- Training through an overseas study tour and workshops; formation of the Alumni Association, although this produced little result; developing IAPs and GAPs; mentoring, and advocacy (with mixed results) were some of the areas focused on the PLs.

Difference in the Effectiveness of the TRLs and PLs

In the Team's estimation, the TRLs appear to have been relatively more effective in improving the enabling environment for RH and Birth Spacing.

The following factors seem to be the main reasons for this difference:

- TRLs are placed more intimately within their communities relative to the PLs.
- TRLs command respect and have a significant influence on individual and family belief systems and practices, including those related to RH and Birth Spacing.
- TRLs live in the communities and there is continuity of their presence, teaching and counseling.
- PLs on the other hand, are not so close to their communities and have little direct influence on the prevailing belief system in the society.
- PLs function within bureaucratic institutions and funding constraints over which they have very little control.
- PLs are sometimes transferred or voted out of their offices and, consequently, are unable to complete what they started.

Evaluation Question 4. What effect did the project activities have on women and men from the community differently?

The dRPC Project's most important impact was the change of perception and belief among the men, women and adolescents in the project communities, as these relate to RH and Birth Spacing. Although this change in their view that has begun to take root in the communities are very similar among men, women and adolescents, there are some added benefits, especially for women and young girls:

- Men are more willing to allow their wives to go for ANC visits compared to four years ago.
- Men and women would prefer facility-based deliveries.
- The communities value the girl child and commit more investments in their education.
- The husband and wife are making Birth Spacing decisions jointly, which only the husband used to make even a few years ago.
- Both men and women are now willing to accept contraception compared to four years ago.
- TRLs give RH and Birth Spacing messages and counseling to men and women, which was not the case a few years ago.
- Adolescents are aware of Birth Spacing principles and contraception methods. Like the adults, they too believe that Islam permits Birth Spacing.

The Evaluation Team learned about some unintended benefits that resulted from the dRPC Project.

- A TRL used his personal funds to help with health facility renovations and provided benches for pregnant women who come to the facility for ANC visits.
- Inspired by the dRPC Project, a PL (with little funding) was able to implement a water, sanitation and hygiene project, as well as elements of MCH activities in his community, which were in his GAP.
- Self-help projects for youth and youth related activities for preventing HIV/AIDS started in the project communities.
- School renovation and staff training took place.

These success stories are spinoffs from the dRPC Project that added value to improving the enabling environment for RH and Birth Spacing, either directly or indirectly. Although all the benefits and achievements in the communities are not attributable to the dRPC Project, the Team believes that it has been quite successful in shaping the perceptions and belief system of men, women and adolescents.

Additional Findings

In this report the Team also provides additional findings and observations outside the four evaluation questions.

Health Facility Statistics Review

The Team visited 7 health facilities in Sokoto and Zamfara states. Apart from two facilities (one in each state) none had a good system for documenting activities, or preserving registers and log books, particularly for ANC visits, deliveries and FP/RH services. The team mainly analyzed the available records from these two health facilities in the two states. The analysis showed that in both facilities in Zamfara and Sokoto states the number of live births slightly increased, while the total number of contraceptive users generally increased over the past two years. Other observations were that injectables and implants were the most utilized commodities, while condoms and IUCDs were the least preferred. Stock-outs of Birth Spacing commodities were rare.

Interviews with HSPs and review of available data at all the seven facilities indicated:

- Contraceptive oral pills, condoms and injectables were available in all the seven facilities.
- Injectables and implants were the most utilized commodities, which is consistent with the community FGD responses the Team gathered.
- Condoms and IUCDs were the least preferred contraceptives.
- Stock-outs of Birth Spacing commodities were rare.

Project Staffing

The Evaluation Team feels the project's staffing was inadequate. From its headquarters in Kano, the dRPC operated this project in three focal states. There was only one part-time focal person in each state, and there have been several turnovers among the focal persons. Given the workload, it would be ideal to have more staff members with a functional project office in each state.

Project Materials

The training tools and IEC materials that were made available to the Evaluation Team for review could be further improved by including internationally accepted and evidence based information and training methodologies. The training curriculum and manual used for short training sessions for the PLs can be improved by a more effective training plan.

Project Monitoring and Evaluation

The M&E system was not very effective, and remained weak until about the second phase of the project. The lack of adequate staffing and office structure in the project operation areas contributed to the weakness in monitoring the project's progress. A robust M&E plan with well-articulated logframe and appropriate indicators can be useful.

RECOMMENDATIONS

Two-phase Approach and Timeframe for Scaling Up

The Team recommends that USAID | Nigeria consider designing a new, broader advocacy activity under two phases: A Preparatory Phase (Phase I) for the duration of 2 to 3 years; followed by a 5 year Scale Up Phase (Phase II). The two-phased approach will give the implementing partners sufficient time to consolidate the gains made by the dRPC Project. There will be opportunities to test and refine the project's interventions and management processes, and to understand better the lessons learned during this first Preparatory Phase. Drawing upon the lessons learned from this initial phase, the second phase can then expand the best practices to cover a wider geographical area and target groups with a focused set of interventions.

The HPN Unit within USAID | Nigeria has funded only one other local NGO besides the dRPC, and that was also under a partnership with a U.S. based implementing organization. So, the Health team has had a little more than 3 years of experience in partnering directly with a local agency (dRPC). The recommended two-phase approach will allow USAID to build on its initial relationship with local agencies in northern Nigeria for the first 2 to 3 years, before embarking on a full scale up programming for 5 years.

Project Location

The dRPC Project operated in three focal states (Sokoto, Niger and Zamfara) where selected TRLs and PLs received program inputs. There are still other TRLs and PLs who have not been targeted by the project in these three states and who would benefit from the new project's interventions. In Phase I, the project will map out the new TRLs and PLs in those LGAs and Wards where the dRPC Project has not operated, and who can expand the project's sphere of influence within the three focal states. These new TRLs and PLs would join the cadre of leaders already trained by the dRPC Project to learn about and participate in improving RH and Birth Spacing environment.

Phase II should be planned to expand the project beyond the three focal states. A variety of factors will need to be considered within the health, political, economic and other related sectors in the potential new project states. At the outset of this second phase formative research should be undertaken, which will inform the selection of the new states. The selection of specific states would depend upon the resources available for programming, USAID's strategy in northern Nigeria, the security situation and other factors.

Target Groups

As was the case with the dRPC Project, the new project should target both TRLs and PLs. The PLs, however, should be carefully selected so as to re-focus only on those categories that proved to be effective and have the potential for yielding strong results.

During Phase I, the TRLs in the three focal states that have not been part of the previous dRPC Project will join the existing group of TRLs in the new project. The PLs should be from the following two categories: (i) politically appointed/elected leaders and "King Makers." These King Makers are powerful, charismatic individuals with followings and connections, and they exert considerable influence over the political environment of their communities, LGAs and the States; and (ii) health and health related technocrats who are the management staff in health and related ministries, departments and agencies (MDAs). This re-grouping of the PLs ensures that only those categories of PLs who have been effective in the dRPC Project are retained in the new project. Thus, the new project will not include the leaders from the judiciary branch; and will not target the HSPs.

In Phase II, the project will select these same target groups – TRLs and the re-categorized PLs – in the new states where the project expands.

Interventions

The new project should continue to implement only the proven interventions and strategies from the previous project, while incrementally adding new strategies, some as part of operations research. Since the Team recommends a two-phase approach for scaling up, the project should initiate these new approaches in Phase I, and carefully study the lessons learned from their implementation. And based on the experience acquired in this first phase, the project should then roll out the best practices in Phase II to cover wider geographical areas as it expands to add more individuals in its target groups.

Utilizing Existing TRLs as Resource Persons

Since the previous project has already prepared a group of selected TRLs, particularly through organizing study tours in Egypt and Mali, we recommend that the new project invest in this trained group of TRLs to prepare them as resource persons for the new TRLs who will join the project in both Phases I and II. These former 'champions' or graduates will serve as the teachers and role models for the newly recruited TRLs, thus avoiding the need for expensive study tours abroad. The existing TRLs, who would serve as teachers and mentors, will need special training to equip them in their new role, besides giving them the content and context of their messages. Adult learning principles would be an important area to consider in the "training of trainers" for the TRLs.

Continuing with the Leadership Development Forum

The new project should design an appropriate curriculum with specific modules to equip the PLs to understand and adopt their roles as policy and decision makers, budget and work plan developers. The curriculum with specific modules will inform and prepare the PLs to adequately support RH and Birth Spacing in their work. The curriculum and training will need to be specific for the specific sub-groups of the PLs, i.e., those that are politically appointed and elected, and the others who serve as civil servants (health and health-related technocrats).

Using Internationally Accepted Messages and Training Methodology

In designing the LDF and the training for the TRLs (see the two recommendations above), the new project should adapt RH and Birth Spacing messages that are evidence based and have been tested in a similar country and cultural context. There are several training resources that have been developed and field tested in Muslim populations in developing countries. The new project should consider these resources for adapting and creating its own tools for training the TRLs. One excellent training resource is the "Mobilizing Muslim Religious Leaders for Reproductive Health and Family Planning at the Community Level: A Training Manual." It was developed by the Extended Service Delivery (ESD) Project with USAID funding, and is freely downloadable from the Internet: http://www.intrahealth.org/files/media/mobilizing-muslim-religious-leaders-for-reproductive-health-and-family-planning-at-the-community-level-a-training-manual/best_practices_religious_leaders.pdf. And also from http://www.esdproj.org/site/DocServer/1_RLs_Trng_Mnl_Final_5_8.pdf?docID=1981 It is organized into 16 sessions and takes the participants incrementally from basic to more complex contents ranging from RH/FP and Islam to Safe Motherhood, Sexually Transmitted Infection (STI) and HIV/AIDS and leadership skills development. It comes with participants' handouts and a facilitator's guide. This specific training manual was piloted in Yemen, Kenya and Nigeria. The Team highly recommends this resource for organizing the new project's training methodology.

Another resource material that the project can consider is the "Muslim Khutba Guide: A toolkit for religious leaders" published in May 2009 by IMA World Health with USAID support under the ACCESS Project. It can be downloaded freely from the website, http://www.imaworldhealth.org/dev/images/stories/technical-publications/Muslim_Khutbah_Sermon_Guide.pdf .

This resource material gives the Islamic basis for a number of very pertinent MNCH/RH and Birth Spacing beliefs and practices with direct quotes and references from the Quran. It can serve as an excellent tool for developing systematic lesson plans for TRL training, as well as reference materials for the TRL training participants.

Adapting Evidence Based Intervention Strategies

The Healthy Timing and Spacing of Pregnancy (HTSP) is an approach to Birth Spacing that encompasses a broader concept of the reproductive cycle. USAID funded the development of the HTSP strategy, which is a comprehensive approach covering important aspects of RH and Birth Spacing, starting from the healthiest age of the women for her first pregnancy to spacing subsequent pregnancies following a live birth, still birth, miscarriage or abortion – capturing all pregnancy-related intervals in a woman's reproductive life. A quick overview of the HTSP strategy is available at http://www.who.int/pmnch/topics/maternal/htsp101.pdf. More detailed information can be downloaded from http://www.k4health.org/toolkits/HTSP that will help the new project to explore the appropriateness for adapting the HTSP strategy. The project's staff members responsible for organizing and training at the Leadership Development Forum (LDF) will benefit from an online course, which methodically covers the principles and practices of HTSP, and is freely available at http://www.globalhealthlearning.org/course/healthy-timing-and-spacing-pregnancy.

Mentoring of the TRLs and PLs

The target groups should receive mentoring from appropriate individuals and organizations that the new project will identify and facilitate. As an example, the PLs would be linked to the National Institute for Policy and Strategic Studies (NIPSS) for receiving mentoring support. The NIPSS's faculty includes well respected senior level political figures.

Establishing and Strengthening the Leadership Network

Based on the lessons learned from the previous dRPC Project initiative about the Alumni Association, the new project should establish a Leadership Network. This network of project leaders will be strengthened by receiving and managing sub-grants, organizing periodic forums for knowledge sharing, undertaking advocacy activities and developing and implementing GAPs. Unlike the Alumni Association supported by the previous project, the Leadership Network initiative should receive adequate attention from the new project with a streamlined structure, curriculum and sustainable plan of action. There should be two such Leadership Networks for the TRLs and PLs functioning with their own GAPs. Periodic interactions between the two Leadership Networks through an annual conference, for example, will foster better understanding and appreciation of each other's roles in the communities. The success of any activities related to these networks will depend on implementing a well-conceived plan, laying out clear expectations, adequate project support and good monitoring.

Engaging Public and Private Media Channels

The Evaluation Team learned from the FGDs that radio and television play important roles in the community for information dissemination. On a number of occasions the community members identified radio and TV as their primary source for information on RH and Birth Spacing. Some mentioned a phone-in radio program, which provided them with an

interactive platform to discuss RH and Birth Spacing matters with dRPC trained leaders. The Team feels that a concerted effort to engage the public and private sector media channels can contribute to positive changes in attitudes about RH and Birth Spacing in the project communities. The new project should consider starting this media-based initiative in Phase I in selected project areas, and then scale up the approach to cover other areas in Phase II.

Establishing Information and Communication Technology Resource Center

The project should consider establishing an Information and Communication Technology (ICT) resource center, especially given the fact that in this new project (unlike the previous one) the Team does not recommend overseas study tours. The TRLs can communicate through this ICT Center with the Islamic scholars and teachers in Egypt and other places during periodic conference calls, webinars and other distance learning approaches. The contact with respected teachers in Egypt gives the TRLs the opportunity to discuss new and emerging lessons and to discuss their experiences and challenges. Since the utilization of an ICT Center removes the need for undertaking expensive study tours, the Team feels this would be a cost-effective and worthwhile investment. This new ICT strategy should be adopted in a *phased* manner, with initially a small-scale set up for a limited number of users in Phase I. Utilizing the lessons learned from this first phase, during Phase II the project's implementation can then expand the user base and access to the ICT Center to cover a wider geographical area and include more individuals in its LDF target groups.

Introducing Mobile Health Strategies for Operations Research

The ubiquitous presence of mobile phones even in the remote rural areas of northern Nigeria offers an interesting opportunity to the new project. For a number of years USAID has supported the use of mobile phones for frontline health worker training, their supervision, text messaging to targeted audiences for improving health knowledge and practices in several health projects. As an operations research initiative, the new project might consider utilizing this mHealth technology for (i) systematically giving specific knowledge and information to the TRLs about RH and Birth Spacing to complement their learning from the LDF; (ii) reporting and monitoring their activities such as sermons and pronouncements; (iii) community members can also benefit from text and voice messages designed to disseminate appropriate RH related information in general, and targeted reminders for ANC visits, contraceptive follow up etc. for registered users. The new project might explore the possibilities of leveraging Corporate Social Responsibility (CSR) funding from private sector phone companies who may offer discounted rates for text and voice messaging. We recommend exploring the feasibility and laying the ground work for this strategy in Phase I, and then gearing up the mHealth initiative in Phase II.

Integration and Collaboration

The dRPC Project was designed to improve the enabling environment for RH and Birth Spacing. Although an attitudinal change has taken root in the communities as a result of this project, the Team feels there is still a great need to strengthen the project's strategies, but it is too early at this point to integrate these strategies with other intervention areas. RH and Birth Spacing interventions are closely interrelated, and the previous project's objectives combined these two areas together. It would be prudent to continue to focus on these two areas, consolidating the gains and acquiring further experience in RH and Birth

Spacing, instead of integrating RH and Birth Spacing with other interventions during the life of the next project.

The new project should collaborate with the Government of Nigeria and, to the extent possible, be closely coordinated with the State Ministries of Health and Social Services, and other appropriate ministries. Areas of cooperation with these ministries (both health and non-health) will be critical for introducing mHealth and the ICT Center initiatives, as well as utilizing state radio and television for information and message dissemination.

The Evaluation Team learned from dRPC Project that it had attempted collaboration with other projects in the focus states. However, because of differences in work plans, project priorities and management decisions, viable collaboration was not possible. Recognizing the challenges with integration, the Team recommends a mixed model. While vertical structure for different projects will likely continue to exist centrally, at the project *site* level coordination should be explored. For instance, in Sokoto state the new project can investigate possible coordination with the USAID funded TSHIP Project at the ward level by involving the Ward Development Committees (WDCs). From the mid-term evaluation report of the TSHIP Project (November 2012), the Team understands that the project successfully created and strengthened the WDCs, which are effective community platforms for expanding community-based delivery of the targeted interventions. The report commends the high degree of initiative, personal and financial commitment of the WDCs. This ward level platform may offer the new project an opportunity to collaborate and integrate with the USAID funded TSHIP Project.

Another area of collaboration would be to link the *TRLs* to other USAID funded projects such as the TSHIP. This will add synergy to the social and behavior change efforts that projects are making in the communities.

Resource Materials

The new project should include in its work plan the development and appropriate dissemination of the project's learning materials and resources. Carefully documenting the lessons learned and best practices from both phases will allow the new project to develop training and educational materials, which can lead to the crafting of training toolkits, for instance, that can be appropriately disseminated for the benefit of other partners and stakeholders. The project should include line item budget for developing such a toolkit and incorporate this in its work plan. This will likely be accomplished in Phase II, although the documentation of the training and education materials, as well as tracking their usefulness, should begin in Phase I.

Adequate Staffing and Office Set Up

It is essential for the new project to have a strong presence in all of the project's states. There should be well qualified staff for both management and technical functions. The staff will need an adequate office, communications and logistical support in order to carry out their activities. The technical staff should be well versed on the RH and Birth Spacing principles and programming. They should be linked to specific individuals in the target groups (TRLs and PLs) and will be responsible for supporting them, monitoring their

performance, and solving problems. Additional staff members and office arrangements should be planned in advance, even as the interventions and expansion of the geographical presence of the project in Phase II are rolled out.

Development Hypothesis and Theory of Change

The development hypothesis / logical framework for any future activity should be clearly articulated to link social and behavior changes with project outputs, outcomes and objectives. The scaled up project should be based on an appropriate theory of change.

Monitoring and Evaluation Strategy

The design for the new project should include a robust M&E plan, with appropriate indicators to track and evaluate the project's progress. There should be a formative research with baseline benchmarks at the beginning of Phase I (Preparatory Phase). At the end of this phase a detailed assessment of the project activities will inform the design of Phase II (Scale up phase). Plans and a budget should be developed for a mid-term evaluation and a final evaluation for Phase II. The project should also have a clearly articulated logframe, demonstrating the relationships between inputs, outputs, objectives, Intermediate Results, Goal(s) and Strategic Objective. Timely submission of PMP should be a priority.

Acceptable Terminology

Future FP/RH activities in northern Nigeria should emphasize the more acceptable terminology of 'Birth Spacing,' rather than the more contentious 'Family Planning.' The Evaluation Team found that in Hausa the concept of spacing births of children and the term 'Birth Spacing' were readily understood and accepted.

ANNEXES

ANNEX I: EVALUATION STATEMENT OF WORK

End-Of-Project Evaluation Scope of Work for Leadership Development for Family Planning and Reproductive Health (FP/RH) for Political Office Holders, Traditional and Religious Leaders

I. BACKGROUND INFORMATION

A. Project Identification Data

Development Objective	Project Title
Increase Use of High Impact Interventions	Leadership Development for FP/RH for Political Office Holders, Traditional and Religious Leaders
Award Number	**Award Date**
A-00-04-00021-00	February 13, 2009 to June 30, 2012
Funding	**Implementing Partners**
A two-year, $2.338 million project, extended for additional 15 months	development Research and Project Centre (dRPC)
Activity Manager **Alternate Activity Manager**	Joseph Monehin Kayode Morenikeji

II. EVALUATION RATIONALE

A. Evaluation Purpose

This is an end-of-project evaluation of the USAID-supported dRPC activity on leadership development to improve the enabling environment for FP/RH by working with traditional and religious leaders as well as political office holders in 3 selected states (Niger, Sokoto and Zamfara) in northern Nigeria. The purpose of the evaluation is to determine the level of achievements towards expected results and to document best practices and lessons learned during the project implementation. The evaluation will also assess the challenges faced during project implementation and suggest directions for future USAID activities to improve the enabling environment for FP/RH in northern Nigeria.

Specifically, the evaluation will:

a) Document the project objectives and measure the outputs

b) Identify and measure core outcome areas related to policy change and attitudes towards FP/RH
c) Document the changes in the opinion of FP/RH in communities where the project worked
d) Document project implementation process, including details on how the leadership forums, advocacy activities and materials were designed, and their impact on changes in attitudes and behavior towards FP/RH (as a concept and as an essential social service)

It is important to distinguish whether there are different perspective on specifically family planning issues as opposed to reproductive health issues in general. Some of the respondents may have significantly different positions on both issues, which though may be closely related, may elicit different passions

B. Audience and Intended Users

The primary user of the evaluation findings is the USAID/HPN Team, which will apply the findings and recommendations to the design of a new, broader health advocacy activity. Findings of the evaluation will also document results achieved, successes, challenges and lessons learned. The dRPC as an organization will also apply the findings to improve its programming activities in northern Nigeria. Other stakeholders and partners will use the findings to strengthen coordination and collaboration with government and other donor programs to ensure achievement of sustainable optimum results in the FP/RH arena.

C. Evaluation Questions

The key evaluation questions are:

1. To what extent has the project achieved its objective of improving enabling environment for FP/RH in the three target states?

2. Which advocacy activities were successful and had positive impact and which ones had no or limited impact and why?

3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states and how has dRPC contributed to this? How were these roles different for traditional/religious and political leaders in terms of effectiveness?

4. What effect did the project activities have on women and men from the community differently?

D. Development Context

Nigeria is the largest country in Africa with a population of approximately 167 million people. Nigeria ranked 153 out of 186 countries in the 2012 United Nations Development Program (UNDP) Human Development Index. The health care system has been neglected for the past two decades resulting in devastating statistics, as noted in the 2008 Nigeria Demographic and Health Survey (NDHS). Under-five mortality is estimated at 157 per 1,000 live births, with deaths caused primarily by malaria, vaccine preventable diseases, diarrheal disease and acute respiratory infections. Infant mortality accounts for about half of all deaths among children under-five years of age. Maternal mortality is at 545 per 100,000 live births, with the rate being at much higher than that in the northern states. Total fertility remains the same for almost a decade - 5.7 children per woman, varying widely between north and south, urban and rural; and the prevalence of modern contraceptive methods is a mere 9.7%.

Delivery and use of child survival and reproductive health services in Nigeria is poor. High child and maternal morbidity and mortality and high fertility translate into rapid and unsustainable population growth with annual population growth rate estimated at 3.2%. Availability and use of affordable child survival and maternal health services is appallingly low. At least 20 percent of Nigerian children will die before their fifth birthday. Fertility is high, birth intervals are short, and contraceptive prevalence is low. Health indicators are much worse in the predominantly Muslim north than in the rest of the country, demonstrating regional imbalance and inequity.

E. Project Goal and Results

The overall goal of the project is to create a cadre of FP/RH transformative religious (also called here Islamic scholars, both men and women) and traditional leaders (mainly men), as well as political office holders (men and women) in the three focal states of Zamfara, Sokoto and Niger. It is intended to achieve the following results:

a) Strengthened enabling environment so that FP/RH could be discussed and implemented
b) Expanded demand for improved social sector services

The result framework is attached in appendix 1.

F. Approach and Implementation

These results were intended to be achieved by implementing the following key activities:

a) Advocating and building capacity of key political leaders through conducting leadership forums with religious and traditional leaders and political office holders

b) Developing FP/RH mentors through a formal mentoring program with the traditional, religious leaders and political office holders that participated in leadership forums

c) Establishing an alumni network for FP/RH champions aimed at creating a collective responsibility for sustaining FP/RH and encouraging the continued accomplishment of results such as positive public pronouncements and support to FP/RH activities, especially in the north

d) Conducting advocacy visits on budgeting for FP/RH to selected political office holders and developing and distributing advocacy materials to be used during advocacy visits in order to encourage decision makers in government to increase resources for FP/RH programs

The project focused on two separate arenas: leadership development for political leaders and leadership development for traditional leaders and Islamic scholars, and an effort to create a cadre of transformative political leaders, traditional leaders, and Islamic scholars on FP/RH. These leaders were expected to inspire change; communicate accurate information; and support the government's new policies on FP/RH services in the target states of Niger, Sokoto and Zamfara.

Data Limitations

- No baseline data.

III. EVALUATION DESIGN AND METHODOLOGY

A. Evaluation Design

This evaluation will use a non-experimental design. Qualitative data collection methods will be used to gain insight into the questions above applying a variety of methods including review of key and relevant documents; focus group discussions; in-depth interviews with key informants; and site visits. The evaluation will be conducted by a team of both internal and external evaluators to be identified by Nigeria Monitoring and Evaluation Management Services (NMEMS II) in consultation with USAID/Nigeria.
The Evaluation Team should examine Family Planning issues differently from broad Reproductive Health issues and distinguish respondents' perspectives on both.

B. Data Collection Methods

Data will be collected using primary and secondary sources. A sample methodology matrix is provided in Table 1. The winner of the bid is expected to provide details on: Data Collection Methods; Methodology Matrix; Data Analysis Methods; Methodological strength and weaknesses and Evaluation Products. The key approaches that will be used to collect and analyze data for the evaluation are as follows:

C. Background Materials Review

Prior to conducting field work, the team will review background materials such as project description and grant agreement, annual and quarterly reports, indicators, past project evaluations and other public documents related to the project. The dRPC will provide a list of contacts from each state and the attendance sheets and contact information for those that participated in the leadership fora and advocacy activities. The Mission will provide these documents to the team in advance of the evaluation start date and will provide a letter of introduction for the evaluation team

D. Team Planning Meeting

The team will conduct a 2-day team planning meeting (TPM) in Abuja before starting the evaluation. The TPM will review and clarify any questions on the evaluation SOW, draft an initial work plan, develop a data collection plan, finalize the evaluation questions, develop the evaluation report table of contents, clarify team roles, and assign drafting responsibilities for the evaluation report. The TPM outcomes will be shared with USAID/Nigeria and the health team will participate in sections of the TPM.

E. Key Evaluation Steps

a) Review program documents, including the technical proposal, annual work plans and annual reports, technical, training, advocacy materials, and the evaluation reports (list and documents to be provided by the Mission).

b) Engage in a two-day Team Planning Meeting (TPM) to discuss the evaluation SOW; agree on team member roles and responsibilities; clarify the evaluation expectations of USAID; draft an evaluation work plan; decide on methodology; develop tools/interview guides that will be used by the team for key informant interviews and focus group discussions (FGDs); and draft a report outline.

c) Conduct field visits to project implementation areas to review the project activities, meet with key stakeholders (including individuals that participated in the leadership trainings and those that have heard the messages of religious, traditional and political leaders).

d) Conduct interviews with key informants from USAID implementing partners, USAID, government counterparts, donor organizations, and others, as necessary.

e) Conduct FGDs with religious, traditional and political leaders, both male and female.

f) Conduct FGDs with community members (including men that are congregation members; women; youth).

g) Review Family Planning service statistics in selected public health facilities within the project focus communities.

h) Prepare a presentation and debrief for USAID/Nigeria with main findings and recommendations.

i) Prepare a draft report for the Mission after field visits.

j) Prepare a final report with an executive summary that includes main findings, conclusions, and recommendations for program improvements.

Table 1: Sample Methodology Matrix

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
1. To what extent has the project achieved its objective of improving enabling environment for FP/RH in the 3 target states?	Descriptive Comparative	Focus Group Discussion, Key Informant Interview,	Interviews	Purposive sample of Religious and Traditional Leaders	Qualitative data analysis
2. Which advocacy activities were successful and had positive impact and which ones had no or limited impact and why?	Descriptive Comparative	Focus Group Discussion, Key Informant Interview, Semi-structured questionnaires	Interviews, data reviews	Purposive sample	Qualitative data analysis
3. What roles did traditional, religious and political leaders play in improving the enabling environment for FP/RH in the target states and how has dRPC contributed to this?	Descriptive	Focus Group Discussion, Key Informant Interview, Desk reviews	Interviews of religious and political leaders. Review of government policies and legislations	Purposive sampling of religious and political leaders	Qualitative data analysis
4. What effect did the project activities	Descriptive, comparative	Desk reviews,	Project documents		Qualitative data analysis

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
have on women and men differently?		Focus Group Discussion, Key Informant Interview	and interviews of project beneficiaries		

F. Data Analysis Methods

The amount of analysis required will vary depending on the kinds of respondents, the samples to be taken and the number of other stakeholders to be interviewed and the extent to which conclusions can be reached easily based on simple analyses.

Family Planning Service statistics in selected facilities within the focus areas will be reviewed for utilization trends, method mix and commodities stock-outs.

G. Methodological Strengths and Limitations

The methodological strengths lay on the variety of data collection techniques to be used and targeted respondents. A semi-structured questionnaire will therefore be used.

*Baseline data are not available nor are data on existing numbers of political, traditional and religious leaders.

H. Dissemination Plan:

The final report will be published in hard and electronic copies and distributed to development partners with activities in Family Planning and in northern Nigeria. Four hard copies are to be delivered to the mission. Academic institutions, research organizations, government ministries and agencies as well as local NGOs and CBOs will also be provided with hard copies of the final report. The final report will also be posted on the USAID Development Experience Clearinghouse (DEC) website: dec.usaid.gov

I. Evaluation Deliverables

The following deliverables will be submitted to USAID/Nigeria. The timeline for submission of deliverables will be finalized and agreed upon during the team planning meeting:

1. An evaluation work plan and timeline: The work plan and timeline will be prepared during the team planning meeting, in consultation with Nigeria Monitoring and Evaluation Management Services (NMEMS II) and USAID/Nigeria.

2. A detailed report outline: This will be agreed upon during the team planning meeting.

3. Questionnaire/guideline for conducting key informant interviews and FGDs: These documents will be prepared during the team planning meeting and submitted to the Mission for review and approval prior to the initiation of key informant interview and site visits.

4. Debriefing(s): The Team Leader will regularly debrief the Mission AOR for the activity on progress being made with the evaluation during field work. At the end of field work, a debriefing meeting will be organized to be attended by the full evaluation team. The debriefing will occur with USAID/Nigeria (HPN and possibly other teams) and include the evaluation team's findings, conclusions and recommendations, before they leave Nigeria. Power-point presentations for the debriefing will summarize findings, conclusions and recommendations and will be distributed during the meeting. USAID will provide feedback during the both the in-briefing and debriefing(s).

5. Draft evaluation report: A synthesized draft report will include, at a minimum, the following: scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs).

   The evaluation team will provide USAID/Nigeria with a draft report that includes all the components of the final evaluation report prior to their departure from Nigeria. USAID/Nigeria will provide written comments on the draft report to the evaluation team within 10 working days of receiving the draft report.

6. Final evaluation report: The final report will address the comments provided by USAID/Nigeria on the draft report. The team leader will revise the draft report and deliver an electronic copy of the final revised version to USAID/Nigeria within three weeks of receiving USAID feedback.

J. Reporting Guidelines

The format for the evaluation report is as follows (number of pages is illustrative):

- Executive Summary (2 pp.)
- Table of Contents (1 pp.)
- Introduction (1 pp.)
- Background (2-3 pp.)
- Methodology (1 pp.)
- Findings and Conclusions (17- 20 pp.)
- Issues and Challenges (5 pp.)
- Recommendations/Future Directions (10 pp.)
    - Recommendations on project approaches and activities from within the project that could be scaled-up or replicated, how and why?
    - Recommendations on other approaches and strategies to use for a broader health advocacy activity
- References
- Annexes
- Data set

K. TEAM COMPOSTITION

The Evaluation Team will consist of up to 5 members, including a Team Leader, Team Member, and a Logistics Assistant and 2 data collectors. The team members should represent a balance of several types of knowledge related to FP/RH service delivery in Nigeria and advocacy and behavior change (if possible, FP in Islamic contexts or in Muslim countries).

The technical team members must all have significant national/international health program experience. They should have some Nigeria or African regional experience, along with comparative experience in advocacy and working with religious leaders. At least one member of the team must have Nigeria experience and be familiar with the intricacies of the workings among political office holders, religious and traditional leaders.

Experience in conducting evaluations and/or assessments is expected of all members, and experience in developing strategies would be useful. All team members must have professional-level English speaking and writing skills.

Team Member: Objectively understands the complex and dynamic social systems in Nigeria, including traditional and religious influences, leadership, and systems. Ability to speak Hausa is compulsory while ability to understand Arabic will be an advantage. The individual must be familiar with the FP/RH service delivery structure in the public sector in Nigeria.

In the interviews, the team will be exploring issues that lie at the core of traditional/religious beliefs. The interviewers must be very knowledgeable about the various issues, and be very sensitive to how they will be perceived. The majority of the interviewers to be used for data collection should be practicing Muslims, since people being interviewed may perceive them as being more understanding.

Logistics Assistant: The logistics assistant will be hired locally to arrange field visits, key informant interviews and meetings, local travel, hotel and appointments with stakeholders.

Data Collectors: Will **s**upport in data collection, note taking, and conducting FGDs and interviews. Experience working with the target audience; one male and one female suggested.

Team Leader: The team leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with other members of the team. The team leader will develop tools for the evaluation in collaboration with the team member and NMEMS II and share it with USAID/Nigeria. The team leader will develop the outline for the draft report, present the report and after incorporating USAID/Nigeria staff comments if necessary, submit the final report to USAID/Nigeria within the prescribed timeline.

Skills/Experience:

The Team Leader should have:

1. Advanced degree in public health, sociology or related field
2. At least 10 years working experience the international arena
3. Must have experience with Muslim issues in FP/RH. Must have Muslim Africa experience.
4. Experience and expertise communication and advocacy campaigns. preferably including monitoring and evaluating
5. Experience leading a team for international health program evaluations or related assignments
6. Program planning, evaluation, and design experience; program management and evaluation
7. Excellent writing, communication, and presentation skills

In addition to the technical responsibilities outlined in the scope of work for the assignment, other responsibilities of the team leader include:

Preparations

1. Finalize and negotiate with client for the team work plan for the assignment
2. Establish assignment roles, responsibilities, and tasks for each team member
3. Ensure that the logistics arrangements in the field are complete

Management

1. Facilitate the team planning meeting (TPM) to set the agenda and other elements of the TPM
2. Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report
3. Manage the process of report writing
4. Manage team coordination meetings in the field
5. Coordinate the workflow and tasks and ensure that team members are working to schedule
6. Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.)

Communications

1. Handle conflict within the team
2. Serve as primary interface with the client and serve as the spokesperson for the team, as required
3. Debrief the client as the assignment progresses, and organize a final debriefing
4. Keep the USAID/Nigeria appraised of progress challenges, work changes, team travel plans in the field, and report preparation via phone conversation or email at least once a week
5. Serve as primary interface with USAID/Nigeria for the submission of draft and final reports and deliverables to USAID/Nigeria
6. Make decisions in conjunction with USAID/Nigeria about the safety and security of the team, in consultation with the client.

Direction

Assume technical direction lead, as required, in order to ensure quality and appropriateness of assignment and report content

L. LEVEL OF EFFORT AND DURATION

The expected in-country timeframe for this task is approximately August-September, 2013. Specific start and end dates, travel dates, and due dates for deliverables will be determined in collaboration with USAID and based on the availability of the consultants, and a detailed timeline will be produced during the team planning meeting.

The level of effort (LOE) for the international consultant, the local consultant and data collectors is indicated in Table 2.

Table 2: Level of Effort (LOE) (Work days)

Tasks	Team Leader	Team Member	Logistics Assistant	Data Collectors (2)
Travel time for international consultant team leader	4			
Review of project documents and consultation with USAID/Nigeria	3	3		
Hold team planning meetings; develop evaluation work plan and timeline; develop data collection instruments and list of people to be interviewed; letter of introduction; data analysis methods; report outline; and finalize logistical/administrative arrangements	3	3	3	3
Conduct field visit for data collection and interviews (TL, TM, LC and 2 data collectors)	12	12	12	12
Review data collected, analyze and prepare a presentation, and debrief for USAID/Nigeria	5	5		
Draft report	3	3		
Finalize report	5	3		
Total	**35**	**29**	**15**	**15**

M. EVALUATION MANAGEMENT

A. Logistics

The evaluation team will work under the technical direction of USAID/Nigeria, the client. A six day work week is authorized for the evaluation team while in Nigeria. USAID/Nigeria will provide overall direction to the team, provide key documents and background materials for reading and help arrange the in-briefing and debriefing.

USAID/Nigeria will:

- Provide names and contact information for possible evaluation to team members. The to consult with USAID's Evaluation Officer on final selection - approve final team composition and members;
- Approve final evaluation scope of work and final evaluation report;
- On being provided by NMEMS II with names and arrival dates of selected evaluation team members, approve country clearances for team members and approve all subsequent internal travel by road and air by team members – this is particularly important given security concerns – also, keep NMEMS II and team leader informed regarding security or other travel concerns;
- Through NMEMS II, provide the evaluation team with USAID and other essential contacts and contact information, and facilitate initial and subsequent communications and letters of introductions;
- Through NMEMS II, provide the evaluation team with background documents and project documentation; and

- If travel by USAID and NMEMS II staff to the north is permitted, provide guidance regarding their participation in the evaluation.

NMEMS II Roles and Responsibilities (in collaboration with USAID/Nigeria) will:

- Submit list of suitable evaluation team members to USAID;
- Contract with the team members, including data collectors and logistics assistant;
- Logistics: Coordinate and pay all assignment-related expenses incurred by the consultants including travel, transportation, lodging, and communication costs, etc.;
- Brief the team on external evaluation requirements and work with USAID to answer any questions;
- Work with USAID to assist the evaluation team in organizing key meetings and arranging appointments;
- Ensure team leader and members meet the requirements of the external evaluation scope of work and their contracts, including timely submissions of draft and final evaluations; and
- Consult USAID and approve any necessary changes to the evaluation team's work plan and travel and consultations schedules.

B. Scheduling

The illustrative schedule for the evaluation will involve three categories of tasks, as outlined in Table 3: [7]

Task	Schedule
Pre-field Travel Tasks (1 week)	
Review project documents and reports	August 2013
Design evaluation framework	August 2013
Develop data collection tools	August 2013
Identify sample to be interviewed	August 2013
Develop a schedule for data collection	August 2013
Field Tasks (3 weeks)	
Review additional project documents and reports; meetings in Abuja	August 2013
Visit field sites and interview beneficiaries and other key stakeholders	August 2013
Review data collected and draft report	August 2013
Send out first draft of report	August 2013
Presentation/debrief to USAID/NMEMS II	August 2013
Presentation/debrief to other key stakeholders	August 2013
Post-field Travel Tasks (5 weeks)	
Review report and address comments	September 2013
Draft report	September 2013
USAID/Nigeria review comments due	September 2013
Finalize report and submit (3 weeks)	October 2013

[7] Some activities may overlap

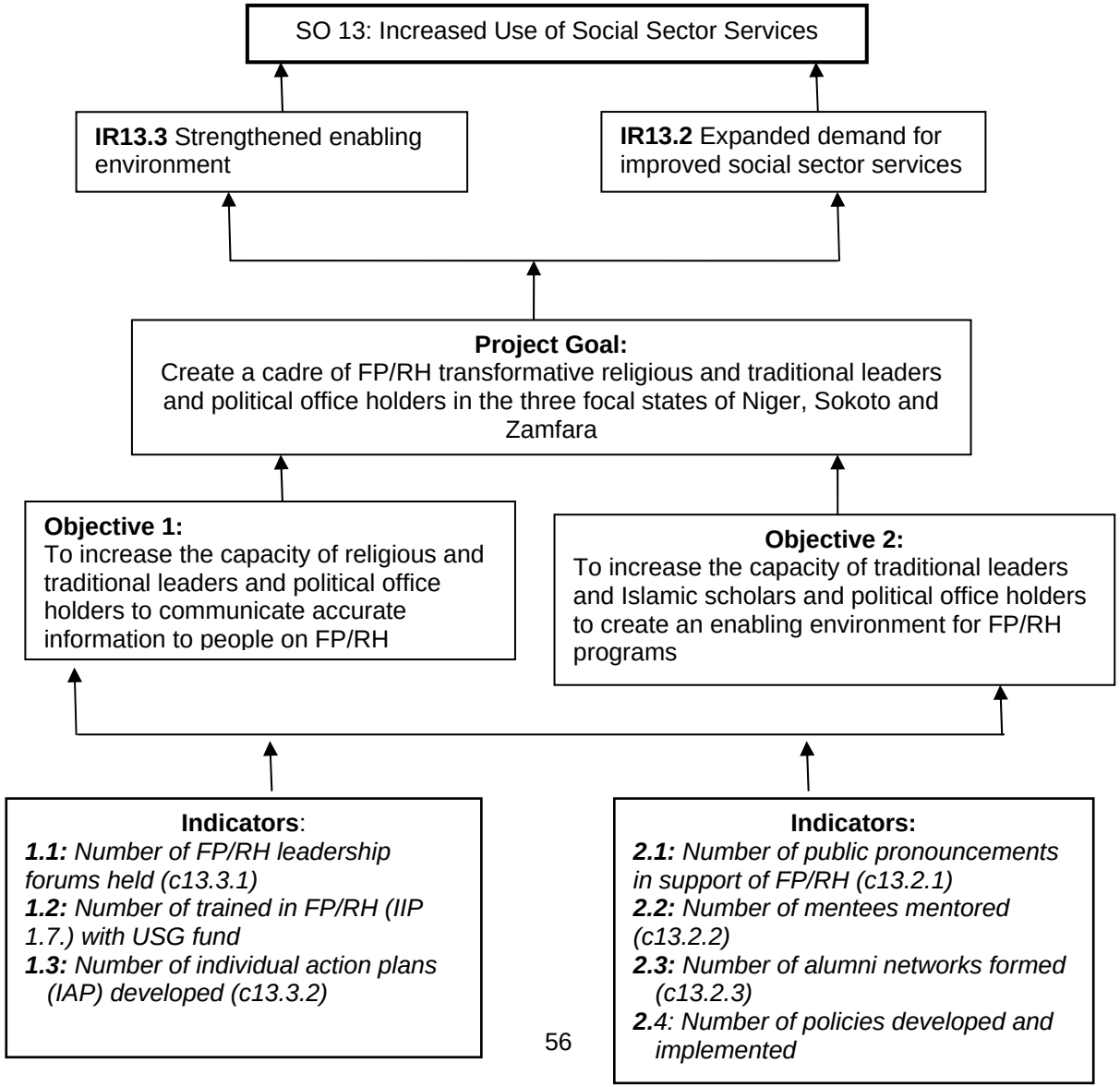
C. Existing Data

The evaluation team will have access to vital documents relevant to the evaluation. These documents will include the following:

- USAID/Nigeria Strategic Plan through 2009
- USAID/Nigeria Strategic Plan 2010-2013
- 2008 Nigeria Demographic and Health Survey (NDHS)
- 2009 National HIV/AIDS and Reproductive Health Survey (NARHS)
- Request for Application (RFA)
- Technical proposal and Scope of Work for the dRPC LDT/LDP Project
- Initial agreement and amendments
- Annual work plans
- Financial documents
- Progress reports (quarterly and annual)
- Reports from an internal evaluation conducted in July 2011 by dRPC
- Official USAID correspondence and feedback (e.g. from portfolio reviews) and
- Any other relevant materials documenting the management, implementation process and results
- Nigeria's National Reproductive Health Policy
- Nigeria's National Integrated Maternal, Newborn and Child Health Strategy
- USAID Evaluation Policy
- A Review of Literature on Islam and Family Planning and of Family Planning Activities in Northern Nigeria
- Evidence-Based Child Spacing Intervention Development for Northern Nigeria among Young Married Men and Women (15-30**)**
- dRPC End-of-Project Report

Appendix 1 ***LEADERSHIP DEVELOPMENT FOR TRADITIONAL, RELIGIOUS LEADERS AND POLITICAL OFFICE HOLDERS ON FP/RH***

RESULT FRAMEWORK



ANNEX II: EVALUATION METHODS AND LIMITATIONS

The evaluation methodology followed the guidance given in the Methodology Matrix in the SOW. The sampling was purposive, the approach was a non-experimental qualitative one utilizing semi-structured instruments to guide the FGDs, KIIs and health facility statistics review, as prescribed in the Matrix.

ANNEX III: DATA COLLECTION INSTRUMENTS

The evaluation team used seven semi-structured guides for conducting Focus Group Discussions and Key Informant Interviews, and one mini checklist/guide for recording health facility statistics. These eight data collection instruments are furnished below.

GUIDE FOR KEY INFORMANT INTERVIEW WITH TRADITIONAL AND RELIGIOUS LEADERS (TRLs)

State_____ LGA_____ Ward_____

Venue _____

Interviewed by_____

Date_____

Introduction; overview of survey; consent

Greet the interviewee(s): I am (write name)_____, I represent USAID a donor organization, which partners with the FMOH.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: I am meeting with you today to conduct a discussion to understand your views and beliefs about women's health (reproductive health) and birth spacing (family planning).
Get permission: I welcome you to this discussion on these issues of women's health and child spacing with us, since I believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, I would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after the respondent gives verbal permission proceed with questions.
- Tell the respondent that at any time s/he may leave the discussion.
- Begin discussion by thanking the respondent for agreeing to meet and giving time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the TRLs believe about women's reproductive health?
A kasar Najeriya a 'yan shekarun nan ana yawan magana a kan halin da mata ke ciki, musammman mata masu juna-biyu, da yara kanana a cikin al'umma – bukatar da su ke da ita ta abinci mai gina jiki domin su girma yadda ya kamata. In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. *Ko kana ganin kula da lafiyar mata (abun da ya shafi daukan ciki zuwa haihuwa) da kuma bada tazarar haihuwa abubuwa ne masu mahimmanci? Me ye dalilin da ya sa ka ke ganin hakan na da mahimmanci? Menene dalilin da ya sa ka ke ganin hakan ba shi da mahimmanci?* Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Why do you feel this is important? And why do you feel it is not important (if a respondent does not see this as important).
2. *A ina ya kamata mace ta haihu? [a gida] [a karamin asibiti] [a babban asibiti] Me ye dalili?* Where should a pregnant woman have her delivery? [home/health center/hospital] Why?

3. *Wa ya fi cancanta ya karbi haihuwar mace? Me ye dalili?* Who is the ideal person to deliver her baby? Why?
4. *Kwatankwacin tsawon wanne lokaci ya kamata likita ya duba macen da ta haihu?* How soon after delivery should the mother and her baby be examined by a trained health worker?
5. *Misalin 'ya'ya nawa a so-samu ya dace mace ta haifa a tsawon rayuwar ta?* How many children should a woman have in her lifetime?
6. *A ra'ayin ka kana ganin ya kamata a fifita 'ya'ya maza fiye da 'ya'ya mata? Me ye dalili?* Do you believe there should be preference for boys over girls? Why or why not?
What do the TRLs believe about birth spacing?
7. *Menene koyarwar addinin Musulunci game da bada tazarar haihuwa?* What does Islam teach about spacing birth of children? [If the answer is positive, then ask the following questions on birth spacing; if not, then skip to Question no. 17]
8. *Watanni ko shekaru nawa ya kamata mace ta bada tazara tsakanin kowacce haihuwa. Shekara hudu da suka wuce menene ra'ayin ka game da wannan?* What should be the interval (months or years) between child births? What did you believe four years ago?
9. *Ta wadanne hanyoyi za a iya bada tazarar haihuwa? Kimanin shekara hudu da suka wuce ka san wadannan hanyoyin?* What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]** Did you know about these contraceptives four years ago?
10. *Wadanne hanyoyin bada tazarar haihuwa Musulunci ya yarda da su? Akwai hanyoyin da Musulunci bai yarda da su ba? Wadanne ne?* Which contraceptive methods are permitted by Islam? Are there specific contraceptive methods that are *not* permitted by Islam? Which are these?
How do the TRLs promote and teach about women's reproductive health and child spacing?
12. *Cikin shekara daya da ta wuce, ka taba yi wa jama'a fadakarwa game da bada tazarar haihuwa? A wanne wuri ne? Kamar sau nawa?* Did you preach about birth spacing in the year preceding the survey? Where did you preach? How many times in the past year?
13. *Wadanne sakonni ko fadakarwa ka ke yi wa jama'a game da bada tazarar haihuwa da kula da lafiyar mata? Kafin zuwan dRPC kana yin wadannan jawabai, a wancan lokacin jawabin da ka ke yi sun bambanta da yanzu?* What messages did you give to your congregation about birth spacing and women's health? Did you give these types of messages before the dRPC Project began, and were your messages different at that time?
14. *Ka kan kawo ayoyin Kur'ani da Hadisi wajen fadakar da jama'a? Kafin zuwan dRPC kana yin hakan? Sau nawa ka yi haka daga bara zuwa yanzu?* Did you use the Quran, Hadith and other religious sources in your preaching or counseling? Did you do this before the dRPC Project began? How many times in the past year?
15. *Kamar wadanne irin batutuwa ka ke magana a kan su wajen fadakar da jama'a? Kana samun nutsuwa/kwanciyar hankali wajen yi wa jama'a fadakarwa a kan bada tazarar haihuwa? Kafin zuwan dRPC kana fadakarwa a kan bada tazarar haihuwa? Idan haka ne, akwai bambanci tsakanin da da yanzu?* What type of topics did you address during counseling? Are you comfortable in counseling community members on birth spacing? Did you counsel on birth spacing before the dRPC Project? If so, is there a difference in the content or approach of your counseling now? What are these differences?
16. *Da maza da mata da kuma matasa suna jin wadannan batutuwan daga gare ka? Kafin zuwan dRPC suna jin batutuwan daga gare ka? Idan haka ne, akwai bambanci a da da yanzu game da batutuwan? Menene bambacin?* Do the men, women and youth hear about these topics from you? Before the dRPC Project began did they hear about these topics from you? If so, are there differences in the topic contents? What are these differences?
What specific roles did the dRPC Project have in equipping the TRLs?

17. *Shin dRPC sun taba gudanar da wani shiri don yi muku bita game da lafiyar matar da kuma mahimmancin bada tazarar haihuwa da hanyoyin da za a bada tazarar? Wadanne tsare-tsaren dRPC ka taba halarta? Kamar sau nawa?* Did the dRPC Project conduct activities to give you information on women's health, birth/child spacing and contraceptives? What activities (if any) did you participate in? How often? *[Probe for LDF/Retreat, Study Tour, Alumni Association/Network]*
18. *Yaya tasirin wadannan tsare-tsaren? A cikinsu wanne tsari ne ya fi kowanne tasiri? Wanne ne bai yi tasiri ba sosai? Menene dalili?* How effective were these activities? Which activity was most effective? Why? Which one was the least effective? Why?
19. *Aiki da RPC ya taimaka maka wajen tsara yadda za ka gudanar da ayyukan ka na fadakar da jama'a? Ta yaya?* Did the dRPC Project help you to develop a plan of activities? In what ways? *[Probe for Individual Action Plan, Group Action Plan, Monitoring Plan, Sub-grants for supporting action plans]*
20. *Ka taba fitar da wani tsari na gudanar da ayyukan fadakar da jama'a? Da-me da-me tsarin ya kunsa? Ya za ka iya kwatanta nasarar da ka samu wajen gudanar da tsare-tsaren? A cikin tsare-tsare da ka yi, wanne da wanne ka aiwatar?* Did you develop an action plan? What did you include in it? How much of your plan did you accomplish? Which activities?
21. *dRPC sun taimaka maka a kan yadda za ka bi diddigin ayyukan da ka tsara?* Did the project help you to develop a monitoring plan? *[Explain what is a monitoring plan, if necessary]*
22. *Kafin zuwan dRPC ka na yin duk ayyukan da ka ambata? A yanzu an sami ci gaba a ayyukan da ka ke yi din?* Before the dRPC Project started working with you four years ago, were you doing the things you mentioned above? Are you doing them now better/ in greater volume or frequency?
23. *Kana ganin dRPC sun kara maka sani da kwazo a matsayin ka na uban kasa/malami ta fannin fadakar da jama'a a game da lafiyar mata da bada tazarar haihuwa? Za ka iya kawo misali?* Do you feel the dRPC Project has increased your understanding and performance as TRLs in teaching your congregations/communities about women's reproductive health and birth spacing? Why or Why not?

At end of session ask:
Is there anything else you would like to tell us or ask us?
Thank the participant(s) for giving time and responses before closing session.

GUIDE FOR KEY INFORMANT INTERVIEW WITH POLITICAL LEADERS (PLs)

State_____ LGA_____

Venue _____

Interviewed by_____

Date_____

Introduction; overview of survey; consent

Greet the interviewee(s): I am (write name)_____, I represent USAID a donor organization, which partners with the FMOH.

Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.

State purpose of the visit: I am meeting with you today to conduct a discussion to understand your views and beliefs about women's health (reproductive health) and birth spacing (family planning).

Get permission: I welcome you to this interview on these issues of women's health and child spacing with us, since I believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, I would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after the respondent gives verbal permission proceed with questions.
- Tell the respondent that at any time s/he may leave the discussion.
- Begin discussion by thanking the respondent for agreeing to meet and giving time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the PLs believe about women's reproductive health and birth/child spacing?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Why do you feel this is important? And why do you feel it is not important (if a respondent does not see this as important).
2. Do you believe there should be preference for boys over girls? Why or why not?
3. Do you think spacing births/children in a family is beneficial for the health of mothers and children? Why? or Why not? [If response is negative skip to Question no. 5]
4. What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]** Did you know about these contraceptives four years ago?
What specific roles did the dRPC Project have in equipping the PLs?
24. Did you participate in any dRPC Project activities for building leadership capacity on women's health, birth spacing and contraceptives? What activities (if any) did you participate in? How often?*[Probe for LDF/Retreat, Study Tour, Mentoring Visits, Advocacy Visits, Alumni Associations]*
25. How effective were these activities? Which activity was most effective? Why? Which one was the least effective? Why?

26. Did the dRPC Project support you to develop a plan of activities? In what ways? If answer is negative, skip to Question no. 9. *[Probe for Individual Action Plan (IAP), Group Action Plan, Monitoring Plan, Sub-grants for carrying out Action Plans]*
27. Did you develop an action plan? What did you include in it? How much of your plan did you accomplish? Which activities?
28. Before the dRPC Project started working with you four years ago, were you developing IAPs? Are you doing them now?
29. Do you feel the dRPC Project has increased your understanding and performance in the field of women's reproductive health and birth spacing in your State/LGA? Why or Why not? *[Probe for number of RH/FP policies, RH/FP budget lines, RH/FP parliamentary bills, RH/FP Advocacy Visits]*

At end of session ask:

Is there anything else you would like to tell me or ask me?

Thank the participant(s) for giving time and responses before closing session.

GUIDE FOR FOCUS GROUP DISCUSSION WITH MEN IN THE COMMUNITY

State_____ **LGA**_____ **Ward**_____

Venue _____

Interviewed by_____

Date_____

Introduction; overview of survey; consent

Greet the interviewee(s) : We are (write names)_____, we represent an organization based in Abuja, which partners with the FMOH, and is responsible for assessing the improvements of different projects.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: We are meeting with you today to conduct a discussion to understand your views and beliefs about women's health (reproductive health) and birth spacing (family planning).
Get permission: We welcome you to this discussion on these issues of women's health and child spacing with us, since we believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, we would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after all the respondents give their verbal permission proceed with questions.
- Tell the group that at any time a person may leave the discussion.
- Begin discussion by thanking the participants for agreeing to meet and giving their time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the men in the communities believe about women's reproductive health?
A kasar Najeriya a 'yan shekarun nan ana yawan magana a kan halin da mata ke ciki, musammman mata masu juna-biyu, da yara kanana a cikin al'umma – bukatar da su ke da ita ta abinci mai gina jiki domin su girma yadda ya kamata. In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. *Ko kuna ganin kula da lafiyar mata (abun da ya shafi daukan ciki zuwa haihuwa) da kuma bada tazarar haihuwa da kuma kula da lafiyar kananan yara abubuwa ne masu mahimmanci?* Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* 2. *Me ye dalilin da ya sa ku ke ganin hakan na da mahimmanci? Menene dalilin da ya sa ku ke ganin hakan ba shi da mahimmanci?* Why do you feel this is important? And why do you feel it is not important (if there are those who do not see this as important). *Make a note of the numbers of respondents with the different views. Do this with as many questions as possible. Only numbers not names needed.*
3. A shekara nawa ya dace a yi wa budurwa aure? Idan so samu ne, a shekara nawa ya kamata mace ta yi kafin tayi haihuwar fari? Shekaru hudu da sukawuce, menene tunanin ka a kan wadannan tambayoyi? What is an ideal age for a woman to get married? In your opinion at what age should she have her first

baby? Four years ago what did you believe about these two questions?
4. *A lokacin da mace ke da juna-biyu shin ya kamata ta je awon ciki wajen ma'aikacin lafiya?* During pregnancy should a woman consult a doctor/health worker/midwife for ANC? Y/N/Do not know/Refuse to answer*[Record the numbers of responses for each option] [Probe to find out reasons for the answers]*
5. *Kamar sau nawa ya kamata mace mai juna-biyu taje awon ciki?* How many times should a pregnant mother consult a doctor/health worker/midwife?
6. *A ina ya kamata mace ta haihu? [a gida] [a karamin asibiti] [a babban asibiti] Me ye dalili?* Where should a pregnant mother have the delivery of her child: at home or at a health facility? Why?
7. *Misalin 'ya'ya nawa a so-samu ya dace mace ta haifa a tsawon rayuwar ta?* How many children should a woman have in her life time?
8. *Idan ma'aurata suka haifi 'ya'ya da yawa duk mata, a ra'ayinku kuna ganin sa ci gaba da neman haihuwa ne har lokacin da suka samu da namiji ko 'ya'ya maza?* If several daughters are born to a couple but no son, should the couple continue to have children until they have one or more sons? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option] [Probe to find out reasons for the answers]* Four years ago what did you believe about this question?
9. *Wa ke yanke hukucin ci gaba da haihuwa tsakanin ma'aurata?* Who decides in the family about whether or not a couple should continue to have more children?
10. *Ko akwai mata a cikin wannan al'umma wadanda ke fama da cutar yoyon-fitsari?* Do women in this community suffer from obstetric fistula? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* *Shin adadin mata masu cutar yoyon-fitsari yana karuwa ne, ko raguwa ya yi, ko kuma yana nan yadda ya ke?* Has the number of women who have such fistula increased, decreased or remained the same through the last four years?
11. *Ko a cikin wannan al'umma ana yi wa mata kaciya?* Is female genital cutting widely practiced in the community? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* *Ko kaciyar da ake yi wa mata na yi masu illa? Menene dalili? Shin wannan al'adar ta karu ne ko raguwa tayi, ko kuma tana nan yadda take a shekara hudu da suka wuce?* Is female genital cutting harmful for girls/women? Why? Why not? Has this practice increased, decreased or remained the same through the last four years?
What do the men believe about birth/child spacing?
12. *Shin ko kuna da masaniya a kan bada tazarar haihuwa da hanyoyin da a ke bi a yi hakannan? Ta wace hanya ku ke samun wadannan bayanai? Shekaru hudu da suka wuce waccce ce babbar hanyar ku ta samun wadannan bayanan?* Do you get information or hear messages about birth/child spacing and contraceptives? What is the primary source of your information on these matters?Four years ago what was your primary source?
13. *Shin bada tazarar haihuwa abu ne mai kyau, kayyade iyali fa? Menene dalili? Shekara hudu da suka wuce menene ra'ayinku game da wannan?* Is it a good thing to space child births and/or limit the number of children in a family? Why or why not? What did you believe four years ago?
14. *Watanni ko shekaru nawa ya kamata mace ta bada tazara tsakanin kowacce haihuwa. Shekara hudu da suka wuce menene ra'ayin ku game da wannan?* What should be the interval (months or years) between child births? What did you believe four years ago?
15. *Wa ke yanke hukucin bada tazarar haihuwa tsakanin ma'aurata? Shekara hudu da suka wuce wa ke zartar da hukuncin?* Who makes the decisions about birth/child spacing in your families? Who made the decisions about birth/child spacing four years ago?
16. *Ta wadanne hanyoyi za a iya bada tazarar haihuwa? Kun san wadannan hanyoyin shekara hudu da suka wuce?* What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]** Did you know about these

contraceptives four years ago?
17. Wadanne hanyoyin bada tazarar haihuwa a ka fi amfani da su a wannan garin? Shekara hudu da suka wuce wadanne hanyoyin a ka fi amfani da su? **[If modern contraceptives are mentioned above, then ask:]**Which contraceptive methods are available in the community? Which ones are mostly used? Four years ago which ones were available and mostly used?
What do the men believe about Islam's teaching on birth spacing?
18. Musulunci ya yarda da bada tazarar haihuwa? Shekara hudu da suka wuce kun yarda da hakan? Does Islam permit a couple to space births? If so, did you believe this four years ago?
19. Wadanne hanyoyin bada tazarar haihuwa Musulunci ya yarda da su? Akwai wadanda Musulunci bai yarda da suba? Which contraceptive methods are permitted by Islam? Are there specific contraceptive methods that are not permitted by Islam? What are these?Why are these not permitted?
What specific roles did TRLs have in informing, encouraging and counseling men RH/FP?
20. Su wanene uwayen kasa da malamai a wannan garin? Akwai mata a cikinsu? Who are the local TRLs in your area? Are they males or females?
21. Shin uwayen kasa da malamai suna fadakar da al'ummarsu a kan harkar lafiyar mata da yara da hanyoyin bada tazarar haihuwa? A ina suke bada fadakarwar? Shekara hudu da suka wuce wadanne sakonni su ke badawa? Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives? How do they give these teachings/messages? Has there been a difference in the content of their messages over the lastfour years?
22. Kun taba jin uban kasa ko malami ya yi magana a kan bada tazarar haihuwa a masallaci ko wajen taro (misali wajen saukar Kur'ani, zanen suna…)? Kimanin sau nawa daga bara zuwa yanzu? Shekara hudu da suka wuce suna haka? Shekara hudu da suka wuce wadanne sakonni su ke badawa? Did you hear the local TRLs preach about birth spacing in formal settings (e.g. mosques)? How many times in the past year? Did they do this four years ago? If so, has there been a difference in the content of their messages over these four years?
23. Shin uwayen kasa ko malamai sun taba yi wa dayanku magana game da tazarar haihuwa ko cikin iyalenku ko wani sashe daga cikinku daga bara zuwa yanzu? Kimanin sau nawa? Did you or anyone in your family discuss with the TRLsabout birth spacing matters individually, as a family, or in a small group in the last one year? How many times?
24. Shin malamai ko uwayen kasa na kawo ayoyin Kur'ani da Hadisai domin bada fatawa game da bada tazarar haihuwa a wajen tarurruka? Shekara hudu da suka wuce suna yin hakanan?Akwai bambanci a fadakarwar da suke yi shekara hudu da suka wuce? Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth spacing during their speeches or counseling sessions or other meetings? Did they do this four years ago? If so, has there been a difference in the content or the way they used these verses in their messages over these four years?

At end of session ask:
Is there anything else you would like to tell us or ask us?

Thank the participant(s) for giving time and responses before closing session.

GUIDE FOR FOCUS GROUP DISCUSSION WITH WOMEN IN THE COMMUNITY

State_____ **LGA**_____ **Ward**_____
Venue _____
Interviewed by_____
Date_____

Introduction; overview of survey; consent
Greet the interviewee(s) : We are (write names)_____, we represent USAID a donor organization,which partners with the FMOH.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: We are meeting with you today to conduct a discussion to understand your beliefs and practices about women's health (reproductive health) and birth spacing (family planning).
Get permission: We welcome you to this discussion on these issues of women's health and birth spacing with us, since we believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, we would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after all the respondents give their verbal permission proceed with questions.
- Tell the group that at any time a person may leave the discussion.
- Begin discussion by thanking the participants for agreeing to meet and giving their time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the women in this community practice about reproductive health?
A kasar Najeriya a 'yan shekarun nan ana yawan magana a kan halin da mata ke ciki, musammman mata masu juna-biyu, da yara kanana a cikin al'umma – bukatar da su ke da ita ta abinci mai gina jiki domin su girma yadda ya kamata. In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. *Ko kuna ganin kula da lafiyar mata (abun da ya shafi daukan ciki zuwa haihuwa) da kuma bada tazarar haihuwa da kuma kula da lafiyar kananan yara abubuwa ne masu mahimmanci?* Do you feel importance should be given to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* *Me ye dalilin da ya sa ku ke ganin hakan na da mahimmanci? Menene dalilin da ya sa ku ke ganin hakan ba shi da mahimmanci?* Why do you feel this is important? And why do you feel it is not important (if there are those who do not see this as important). *Make a note of the numbers of respondents with the different views. Do this with as many questions as possible. Only numbers not names needed.*
2. *Budurwa na shekara nawa ake yi mata aure a garinnan? Mace na shekara nawa ta ke haihuwar fari? Shekaru hudu da sukawuce, a shekara nawa ake yi wa budurwa aure? A shekara nawa mata ke haihuwar fari?* At what age do women get married in this community? At what age does a woman usually have her first baby? Four years ago what was the age at which women got married, and at which age did women have their first child?

3. *A lokacin da mace ke da juna-biyu shin ya kamata ta je awon ciki wajen ma'aikacin lafiya? Menene dalili?* During pregnancy should a woman consult a doctor/health worker/midwife? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Why? Why not?
4. *Kamar sau nawa ya kamata mace mai juna-biyu taje awon ciki?* How many times should a pregnant mother consult a doctor/health worker/midwife?
5. Sau nawa kuka taba zuwa awon ciki a haihuwar da kuka yi ta karshe? For those who have been pregnant, ask: how many times did you consult a skilled medical person (doctor/health worker/midwife) during your last pregnancy?
6. *Lokacin da ku ke zuwa awon ciki na haihuwar da kuka yi ta karshe an yi muku allurar da a ke yi wa mata masu juna-biyu?* Did you get TT (use Hausa term) vaccines during your last pregnancy? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
7. *A ina mata ke haihuwa? [a gida] [a karamin asibiti] [a babban asibiti] Me ye dalili? Shekara hudu da suka wuce a ina suke haihuwa?* Where does a pregnant mother have the delivery of her child: at home or at a health facility? Why? What was the practice four years ago?
8. *Misalin 'ya'ya nawa yawancin mata suke da su a garinnan? Shekara hudu da suka wuce ya'ya nawa yawancin mata suke da su?* How many children do most women in this community have? How many children did most women have in this community four years ago? *[PROBE if necessary to find out how many children the participants had]*
9. *Idan ma'aurata suka haifi 'ya'ya da yawa duk mata, su kan ci gaba da neman haihuwa ne har lokacin da suka samu da namiji? Shekara hudu da suka wuce yaya abun yake?* If several daughters are born to a couple but no son, does the couple continue to have children until a son is born? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Why and why not? Four years ago what was the practice in this community?
10. *Wa ke yanke hukucin ci gaba da haihuwa tsakanin ma'aurata? Daga shekara hudu zuwa yanzu hakan ya canja? Menene canjin?* Who decides in the family about whether or not a couple should continue to have more children? Has this changed in the last four years? If yes, what is the change?
11. *Ko akwai mata a cikin wannan al'umma wadanda ke fama da cutar yoyon-fitsari? Shin adadin mata masu cutar yoyon-fitsarin yana karuwa ne, ko raguwa ya yi, ko kuma yana nan yadda ya ke (daga shekara hudu zuwa yanzu)?* Do women in this community suffer from obstetric fistula [Use local language to describe fistula]? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Has the number of women who have such fistula increased, decreased or remained the same through the last four years?
12. *Ko a cikin wannan al'umma ana yi wa mata kaciya? Shin wannan al'adar ta karu ne ko raguwa tayi, ko kuma tana nan yadda take a shekara hudu da suka wuce?* Is female genital cutting widely practiced in the community? [Use local language to describe FGC]? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Has this practice increased, decreased or remained the same through the last four years?
What do the women believe andpractice about birth spacing?
13. *Shin ko kuna da masaniya a kan bada tazarar haihuwa da hanyoyin da a ke bi a yi hakannan? Ta wace hanya ku ke samun wadannan bayanai? Shekaru hudu da suka wuce waccce ce babbar hanyar ku ta samun wadannan bayanan?* Do you get information or hear messages about birth spacing and contraceptives? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* What is the primary source of your information on these matters? Four years ago what was your primary source?*[PROBE to ascertain if TRLs were the primary source]*

14. *Shin bada tazarar haihuwa abu ne mai kyau? Menene dalili? Shekara hudu da suka wuce menene ra'ayinku game da wannan?* Is it a good thing to space child births in a family? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Why or why not? What did you believe four years ago?
15. *Watanni ko shekaru nawa ya kamata mace ta bada tazara tsakanin kowacce haihuwa. Shekara hudu da suka wuce menene ra'ayin ku game da wannan?* What should be the interval (months or years) between child births? What did you believe four years ago?
16. *Ta wadanne hanyoyi za a iya bada tazarar haihuwa? Kun san wadannan hanyoyin shekara hudu da suka wuce?* What can be done to space childbirth?**[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]** Did you know about these contraceptives four years ago?
17. *Wadanne hanyoyin bada tazarar haihuwa a ka fi amfani da su a wannan garin? Shekara hudu da suka wuce wadanne hanyoyin a ka fi amfani da su?* **[If modern contraceptives are mentioned above, then ask:]** Which contraceptive methods are available in the community? Which ones are mostly used? Four years ago which ones were available and mostly used?
18. *Wa ke yanke hukucin bada tazarar haihuwa tsakanin ma'aurata? Shekara hudu da suka wuce wa ke zartar da hukuncin?* Who makes the decisions about birth spacing in your families? Who made the decisions about birth spacing four years ago?
What do the women believe about Islam's teaching on birth spacing?
19. *Musulunci ya yarda da bada tazarar haihuwa? Shekara hudu da suka wuce kun yarda da hakan?* Does Islam permit a couple to space births? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* If so, did you believe this four years ago?
20. *Musulunci ya yarda da amfani da hanyoyin bada tazarar haihuwa?* Does Islam permit the use of contraceptives for child spacing? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
21. *Wadanne hanyoyin bada tazarar haihuwa Musulunci ya yarda da su?* Which contraceptive methods are permitted by Islam? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
22. *Akwai wadanda Musulunci bai yarda da suba? Wadanne ne? Menene dalili?* Are there specific contraceptive methods that are not permitted by Islam? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Ask those who answered "Yes": What are these contraceptives? Why are these not permitted?
What specific roles did TRLs have in informing, encouraging and counseling women?
23. *Su wanene uwayen kasa da malamai a wannan garin? Akwai mata a cikinsu?* Who are the local TRLs in your area? Are they males or females?
24. *Shin uwayen kasa da malamai suna fadakar da al'ummarsu a kan harkar lafiyar mata da yara da hanyoyin bada tazarar haihuwa? A ina suke bada fadakarwar? Shekara hudu da suka wuce wadanne sakonni su ke badawa?* Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* How do they give these teachings/messages? Has there been a difference in the content of their messages over the last four years?

25. *Kun taba jin uban kasa ko malami ya yi magana a kan bada tazarar haihuwa? Kimanin sau nawa daga bara zuwa yanzu? Shekara hudu da suka wuce suna haka? Shekara hudu da suka wuce wadanne sakonni su ke badawa?* Did you hear the local TRLs preach about birth/child spacing? Y/N/Do not know/Refuse to answer *[Record the <u>numbers</u> of responses for each option]* How many times in the past year did you hear them preach about birth/child spacing? Did they do this four years ago? If so, has there been a difference in the content of their messages over these four years?
26. *Shin uwayen kasa ko malamai sun taba yi wa dayarku magana game da tazarar haihuwa ko cikin iyalenku ko wani sashe daga cikinku daga bara zuwa yanzu? Kimanin sau nawa?* Did the TRL speak to you or anyone in your family about birth spacing matters individually, as a family, or in a small group in the last year? Y/N/Do not know/Refuse to answer *[Record the <u>numbers</u> of responses for each option]* How many times?
27. *Shin malamai ko uwayen kasa na kawo ayoyin Kur'ani da Hadisai domin bada fatawa game da bada tazarar haihuwa a wajen tarurruka? Shekara hudu da suka wuce suna yin hakanan?Akwai bambanci a fadakarwar da suke yi shekara hudu da suka wuce?* Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth spacing? Y/N/Do not know/Refuse to answer *[Record the <u>numbers</u> of responses for each option]* Did they do this four years ago? If so, has there been a difference in the content or the way they used these verses in their messages over these four years?

<u>At end of session ask</u>:
Is there anything else you would like to tell us or ask us?

Thank the participant(s) for giving time and responses before closing session

GUIDE FOR FOCUS GROUP DISCUSSION WITH MALE YOUTHS IN THE COMMUNITY

State_____ **LGA**_____ **Ward**_____

Venue _____

Interviewed by_____

Date_____

Introduction; overview of survey; consent

Greet the interviewee(s) : Weare (write names)_____, we representUSAID a donor organization,which partners with the FMOH.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: We are meeting with you today to conduct a discussion to understand your views and beliefs about women's health (reproductive health) and birth spacing (family planning).
Get permission: We welcome you to this discussion on these issues of women's health and child spacing with us, since we believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, we would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after all the respondents give their verbal permission proceed with questions.
- Tell the group that at any time a person may leave the discussion.
- Begin discussion by thanking the participants for agreeing to meet and giving their time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the youths in the communities believe about women's reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should know about women's reproductive health issues and the frequency of child birth, and the wellbeing of the young children and their mothers? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why do you feel this is important to know? And why do you feel it is not important (if there are those who do not see this as important). *Make a note of the numbers of respondents with the different views. Do this with as many questions as possible. Only numbers not names needed.*
2. What is an ideal age for a woman to get married? At what age should she have her first baby? Four years ago what did you believe about these two questions?
3. During pregnancy should a woman consult a doctor/health worker/midwife? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why? Why not?
4. How many times should a pregnant mother consult a doctor/health worker/midwife?
5. Where should a pregnant mother have the delivery of her child: at home or at a health facility? Why?
6. How many children should a woman have in her life time?
7. If several daughters are born to a couple but no son, should the couple continue to have children until they have one or more sons? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*

Why and why not? Four years ago what did you believe about this question?
8. DELETED
9. Do women in this community suffer from obstetric fistula [Use local language to describe fistula]? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Has the number of women who have such fistula increased, decreased or remained the same through the last four years?
10. Is female genital cutting widely practiced in the community [Use local language to describe FGC]? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]* Has this practice increased, decreased or remained the same through the last four years?
What do the male youths believe about birth/child spacing?
11. Do you get information or hear messages about birth/child spacing and contraceptives? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* What is the primary source of your information on these matters? Four years ago what was your primary source?
12. Is it a good thing to space child births and/or limit the number of children in a family? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why or why not? What did you believe four years ago?
13. What should be the interval (months or years) between child births and why? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* What did you believe four years ago?
14. DELETED
15. Is it possible to space children? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
16. What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
17. **[If modern contraceptives are mentioned above, then ask:]**Which birth spacing methods are available in the community? Which ones are mostly used?
What do the male youths believe about Islam's teaching on birth spacing?
18. Do you have any knowledge on Islam permitting a couple to space births?
19. Do you have knowledge of birth spacing methods that are permitted by Islam? Are there specific contraceptive methods that are not permitted by Islam? What are these? Why do you think they are not permitted?
What specific roles did TRLs have in informing, encouraging and counseling male youths RH/FP?
20. Who are the local TRLs in your area? Are they males or females?
21. Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* How do they give these teachings/messages? Has there been a difference in the content of their messages over the last four years?
22. Did you hear the local TRLs preach about birth spacing in formal settings (e.g. mosques)? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
23. Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth spacing during their speeches or counseling sessions or other meetings? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*

At end of session ask:
Is there anything else you would like to tell us or ask us?

Thank the participant(s) for giving time and responses before closing session.

GUIDE FOR FOCUS GROUP DISCUSSION WITH FEMALE YOUTHS IN THE COMMUNITY

State_____ LGA_____ Ward_____

Venue _____

Interviewed by_____

Date_____

Introduction; overview of survey; consent

Greet the interviewee(s) : We are (write names)_____, we represent USAID a donor organization, which partners with the FMOH.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: We are meeting with you today to conduct a discussion to understand your beliefs and practices about women's health (reproductive health) and birth spacing (family planning).
Get permission: We welcome you to this discussion on these issues of women's health and birth spacing with us, since we believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, we would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after all the respondents give their verbal permission proceed with questions.
- Tell the group that at any time a person may leave the discussion.
- Begin discussion by thanking the participants for agreeing to meet and giving their time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the female youths in this community believe and practice in the area of reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel importance should be given to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why do you feel this is important? And why do you feel it is not important (if there are those who do not see this as important). *Make a note of the numbers of respondents with the different views. Do this with as many questions as possible. Only numbers not names needed.*
2. At what age do women get married in this community? At what age does a woman usually have her first baby? Four years ago what was the age at which women got married, and at which age did women have their first child?
3. During pregnancy should a woman consult a doctor/health worker/midwife? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why? Why not?
4. How many times should a pregnant mother consult a doctor/health worker/midwife?
5. For those who have been pregnant, ask: how many times did you consult a skilled medical person (doctor/health worker/midwife) during your last pregnancy?

6. DELETE
7. Where do most pregnant mothers have the delivery of her child: at home or at a health facility? Why? What was the practice four years ago?
8. How many children do most women in this community have?
9. If several daughters are born to a couple but no son, should the couple continue to have children until a son is born? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why? Why not? Four years ago what was the practice in this community?
10. Who decides in the family about whether or not a couple should continue to have more children? Has this changed in the last four years? If yes, what is the change?
11. Do women in this community suffer from obstetric fistula [Use local language to describe fistula]? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Has the number of women who have such fistula increased, decreased or remained the same through the last four years?
12. Is female genital cutting widely practiced in the community[Use local language to describe FGC]? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Has this practice increased, decreased or remained the same through the last four years?
What do the female youths believe and practice about birth spacing?
13. Do you get information or hear messages about birth spacing and contraceptives? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* What is the primary source of your information on these matters? Four years ago what was your primary source?*[PROBE to ascertain if TRLs were the primary source]*
14. Is it a good thing to space child births in a family? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why or why not? What did you believe four years ago?
15. What should be the interval (months or years) between child births? What did you believe four years ago?
16. Is it possible to space children? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
17. What methods can be used to space childbirth?**[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
18. **[If modern contraceptives are mentioned above, then ask:]**Which contraceptive methods are available in the community? Which ones are mostly used?
19. DELETED
What do the female youths believe about Islam's teaching on birth spacing?
20. Do you have any knowledge on Islam permitting a couple to space births? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* If so, did you believe this four years ago?
21. Do you have knowledge of birth spacing methods permitted by Islam? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Are there specific contraceptive methods that are not permitted by Islam? What are these? Why do you think they are not permitted?
What specific roles did TRLs have in informing, encouraging and counseling female youths?
22. Who are the local TRLs in your area? Are they males or females?
23. Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* How do they give these teachings/messages?

24. Did you hear the local TRLs preach about birth spacing? Y/N/Do not know/Refused to answer *[Record the <u>numbers</u> of responses for each option]* How many times in the past year?
25. Did the TRL speak to you or anyone in your family about birth spacing matters individually, as a family, or in a small group in the last year? Y/N/Do not know/Refused to answer *[Record the <u>numbers</u> of responses for each option]*
26. Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth/child spacing? Y/N/Do not know/Refused to answer *[Record the <u>numbers</u> of responses for each option]*

<u>At end of session ask</u>:
Is there anything else you would like to tell us or ask us?

Thank the participant(s) for giving time and responses before closing session

GUIDE FOR KEY INFORMANT INTERVIEW WITH HEALTH SERVICE PROVIDERS (HSPs)

State_____ **LGA**_____ **Ward**_____

Venue _____

Interviewed by_____

Date_____

Introduction; overview of survey; consent
Greet the interviewee(s): I am (write name)_____, I represent USAID a donor organization, which partners with the FMOH.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: I am meeting with you today to conduct a discussion to understand your views and practices about women's health (reproductive health) and birth spacing (family planning).
Get permission: I welcome you to this interview on these issues of women's health and child spacing with us, since I believe you have important views that will help us to understand the performance of the dRPC Project. If you permit, I would like to ask you a few questions to start our discussion. Any information you provide will remain confidential and your names or addresses will not be revealed.

- ONLY after the respondent gives verbal permission proceed with questions.
- Tell the respondent that at any time s/he may leave the discussion.
- Begin discussion by thanking the respondent for agreeing to meet and giving time.
- First ask a few general questions, and then specific ones as follows.

Note: Attempt to assess differences that may have taken place in last four years in areas of knowledge, attitude & practice.

What do the HSPs believe about women's reproductive health and birth/child spacing?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Why do you feel this is important? Why do you feel it is not important (if a respondent does not see this as important)?
2. In your judgment how many times should a pregnant mother visit a doctor/nurse/midwife during her pregnancy?
3. Where should she have her delivery? [home/health center/hospital] Why?
4. Who is the ideal person to deliver her baby? Why?
5. How soon after delivery should the mother and her baby be examined by a trained health worker?
6. How many children should a woman have in her lifetime?
7. Do you think spacing children in a family is beneficial for the health of mothers and children? 8. Why? or Why not? [If response is negative skip to Question no. 5]
9. What can be done to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]** Did you know about these contraceptives four years ago?
What specific roles did the dRPC Project have in equipping the HSPs?
30. Did you participate in any dRPC Project activities for building leadership capacity on women's health, birth spacing and contraceptives? What activities (if any) did you participate in? How often?*[Probe for LDF/Retreat, Study Tour, Training on MLSS and MSP, Alumni Associations/Networks]*

31. How effective were these activities? Which activity was most effective? Why? Which one was the least effective? Why?
32. Did the dRPC Project support you to develop a plan of activities? In what ways? If answer is negative, skip to Question no. 14. *[Probe for Individual Action Plan (IAP), Group Action Plan, Monitoring Plan, Sub-grants for carrying out Action Plans]*
33. Did you develop an action plan? What did you include in it? How much of your plan did you accomplish? Which activities?
34. Before the dRPC Project started working with you four years ago, were you developing IAPs? Are you doing them now?
35. Do you feel the dRPC Project has increased your understanding and performance in the field of women's reproductive health and birth spacing in your health facility? Why or Why not? *[Probe for number of ANC visits, facility based deliveries, PNC visits]*

At end of session ask:

Is there anything else you would like to tell me or ask me?

Thank the participant(s) for giving time and responses before closing session.

Guideline for Collecting Selected Reproductive Health and Family Planning Service Statistics

From Health Facility

This simple guide is to be used for collecting only selected RH and FP related data from the health facilities that operate in the specific communities where traditional and religious leaders and local government leaders who have been trained by the dRPC Project are still active or have been recently active.

Greet the interviewee(s): My name is _____, I am here on behalf of USAID, which is a Donor organization, and which partners with the FMOH.
Give background: dRPC Project has worked with Traditional and Religious Leaders (TRLs) and Political Leaders (PLs) to improve women's health in this community.
State purpose of the visit: We are meeting with you today to learn about your services for women's health (reproductive health) and birth spacing (family planning).
Get permission: We would like to have your permission for discussing with you, and looking at your facility records. Any information you provide will remain confidential and your name, designation or facility name will not be identified in the reports.

ONLY after the respondent has given verbal permission proceed with questions.

Begin discussion by thanking the respondent for agreeing to meet and giving time.

Respondent's Name_____

Respondent's Designation_____

Health Center Level/Type _____

Health Center Location_____

Catchment Area Total Population_____

Catchment Area Population of Women of Reproductive Age (15 to 45 yrs.)_____

Interviewer_____

Date of visit_____

Reproductive Health
1. How many pregnant women were attended by skilled personnel in this facility at least once during pregnancy in the last 12 months for reasons related to the pregnancy? What was the number of such women four years ago?*[See records reflecting ANC visits]*
2. How many pregnant women were attended by skilled personnel in this facility a minimum of four times during pregnancy in the last 12 months for reasons related to the pregnancy? What was the number of such women four years ago?*[See records reflecting ANC visits]*
3. Number of pregnant women who received two doses of TT in the last 12 months. Number four years ago? [See ANC records]

4.	Number of live births took place in the facility in the last 12 months. Number of live births four years ago?*[See delivery records]*
5.	Does this facility refer complicated delivery cases? If so, where are they referred to? In the last 12 months how many cases did this facility refer?*[See referral records]*
Birth Spacing	
6.	How many women of reproductive age are using (or whose partners are using) a contraceptive method from this facility? What was this number four years ago?
7.	How many women of reproductive age accepted for the first time in their lives any contraceptive method in the last 12 months from this facility? What was this number four years ago?*[See contraceptive dispensing records]*
8.	Which contraceptive methods are offered in this facility? Which ones are most utilized? Which ones are utilized the least? *[See contraceptive utilization records and note any trend over the last 12 months for each method]*
9.	Have there been stock-outs of contraceptives in the last 12 months? If so, which ones were stocked out? For how long?*[See CLMS records]*

At end of session: Thank the participant(s) for giving time and responses before closing session.

Data analysis tool

The evaluation team used a simple analysis tool, which comprised of the eight data collection guides (in Annex III above) on which the TL transcribed the responses in different colors to indicate the communities from where the team collected the responses. Following are the eight color coded analysis tool showing responses from each community.

ANALYSIS OF KEY INFORMANT INTERIVEWS WITH TRADITIONAL AND RELIGIOUS LEADERS (TRLs)

State

Sokoto Gandi, Sokoto town and Bodinga, South Sokoto Gagi, Magajin Gari B

Zamfara Gusau, Anka, Talata Mafara

What do the TRLs believe about women's reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? 1) Yes, very much. 2) Yes, very much. 3) Yes 4) Yes, very, very important 5) Yes. 6) Yes, the importance of women's and children's health can never be overemphasized. Sensitization has not in fact reached some remote communities, so we still have a lot of work to do. 7) Yes 8) Yes 9) Yes 10) Yes 11) Yes, very much. 12) Yes 13) Yes 14) Yes 15) Yes 16) Yes, I strongly believe so. 17) Yes, very strongly. 18) Yes 19) Yes 20) Yes, indeed

21) Yes it is very important.
22) Yes
23) Yes
24) Yes, these are very important issues
25) Yes
26) Yes

Why do you feel this is important?

1) "Women are our mothers."
2) "Women are our mothers."
3) I feel women's health is the overall concern for the community
4) Need to provide better health for women and children. From Islamic perspective women are not to be subjected to too much stress. And multiple children and rapid succession creates great stress on women's health.
5) As a woman, I feel this is very important
6) Because that's how we can save their life. Without proper care, even minor ailments like malaria and anemia can lead to death. 90% of mothers now go for ANC.
7) It will help reduce maternal and child mortality.
8) They should be given high priority because women and children in urban or rural areas have a higher rate of illness
9) Yes, I believe that the health of women and children, as well as the issue of birth spacing is important. For instance, birth spacing allows children to grow up strong and healthy, otherwise they will be unhealthy in childhood and possibly even in adulthood. Islam is not against taking any lawful step to prevent any health difficulties amongst women, and in fact when a woman is not well, even her husband cannot have any peace of mind. And I also believe that a healthy and vigorous child gladdens ("sweetens") the heart of the parents.
10) It should be given great importance because mothers are "iyayen al-umma" i.e. the parents of mankind or of the nation while children are "manyan gobe" i.e. the "adults of tomorrow" (adults of the future)
11) It saves the life of the mother and the child, and even the father (if the mother gets VVF for example, the father is also affected).
12) Birth spacing is even approved by the Quran in certain conditions: e.g. Mother is ill. During breastfeeding if a woman gets pregnant then both mother and child will suffer.
13) Women also human beings and deserve to be taken care of esp. so that they can take care of own children, husbands and families.
14) It is important for both women and child; Islam permits child spacing to enable healthy family
15) Because women are more prone to suffer and die from pregnancy & delivery related problems than men & therefore need more attention. While birth spacing is important because it enables couples to train, educate & feed their children better
16) The Quran has in several places stressed the importance of women eg in his last sermon, Muhammad peace be upon him (PBUH) repeated thrice "take care of your women's rights or responsibilities" while in another verse of the Quran is an injunction to "take care of your parents especially your mother" because of the ordeal she went through in bearing and raising you until you became independent. In addition, the health & wellbeing of the woman and her child is the foundation is the basis of a happy home and contentment of the husband. Islam strongly supports birth spacing "tanzimul nasli" as prescribed in the Quran but it is against "tahdidul nasli" i.e. limiting the birth of children because it promotesupports life & continuity of societies
17) "Women and children are like a seed of each generation, they need very good care to

develop."

18) As a result of the importance attached to it, now 90% of pregnant women go for ANC, there is about 70% reduction in maternal mortality. *{Note that these are estimates}*
19) To reduce maternal mortality.
20) "Especially in the Muslim North, our current health condition is due to neglecting women's and children's health care. Serious health problems can bankrupt a family."
21) The health of mothers and their children is what brings contentment of the husband
22) Yes, I strongly feel that importance should be given to these issues because if a mother & her child are well, then there will be contentment in the home & heart of the husband, which will also reflect in the society where they live. Besides children are the future adults. Birth spacing is permitted in Islam because it allows a woman to adequately take care of herself, her children & her home
23) because they affect one another and can lead to each other. For, instance lack of birth spacing can lead to frequent births which in turn can result in poor health for mother & child and the husband will subsequently be stressed out from running around looking for money to treat his family
24) Many women go for FP and we are seeing an encouraging trend
25) Yes because the lives of women is the foundation of any society. There were a lot of misconceptions regarding birth spacing in the past but that is improving now
26) Giving priority to the health of mothers & children is compulsory under Islamic Law. Because health is essential before anything can be done either physically or spiritually. While birth spacing can be justified for women that suffer from frequent un-spaced births or on medical grounds, therefore permanent contraceptive methods are not permissible in Islam
27) "They are all important, especially pregnant mothers' health. There is still high maternal mortality rate at the rural areas."

And why do you feel it is not important (if a respondent does not see this as important).

2.Where should a pregnant woman have her delivery? [home/health center/hospital]

1) At the hospital.
2) At the hospital.
3) Health facility
4) Hospital
5) Hospital
6) Hosp
7) At the hospital under the care of professional health worker.
8) Hosp
9) Hosp
10) Hosp
11) At the hospital under the care of professionals.
12) Hosp
13) Hosp
14) Hosp
15) Hosp
16) Health facility is a best place to deliver
17) The health facility is best
18) Hosp
19) At the hospital under the care of professionals.
20) Hosp
21) Hosp

22) The best place for her is the health facility
23) The best place is the health facility
24) Health facility
25) Hosp
26) At the health facility
27) The health facility is the best place but due to illiteracy or financial factors, most births take place at home
28) At the hospital (in my own opinion).

Why?

1) That's where she will get good care.
2) Health workers are trained to handle complications.
3) There are professionals who can identify complications, if any.
4) Because of the medical assistance they can get in the hospital by the skilled health service providers.
5) It is safer in the hospital.
6) That's where she will get good care, and only professionals can handle complications (when they occur).
7) At the hospital.
8) At the hospital under the care of professional health worker.
9) She will get professional care, and so will have rest of mind.
10) The proper place will be in the health facility because of the care they will receive but we cannot blame does that deliver at home without understanding their reasons for delivering at home
11) That's where she will get good care, and when there is complication, it would be properly handled.
12) I encourage (since last year) women to deliver in our health facility because it has enough staffing & drugs following the sustained efforts by our traditional leader. I believe it is best to deliver in the health facility because of the care they will receive in the health facility e.g. they will have access to "miso" (misoprostol) and useful advice. However, traditionally, they prefer their wives to deliver at home because that way, they don't have to spend money on hospital fees and no male health worker will examine their wives.
13) Women should deliver in the health facility so that if she has any complications, she will be quickly attended to. And so that health will be properly taken care of.
14) The mother and her new born baby are prone to various types of diseases if not adequately taken care of.
15) Hosp. to avoid birth complications
16) To make delivery easy
17) To get docs care and attention; avoid complication or rescue from complications that may affect mother and baby
18) There are qualified professional doctors and nurses; govt. hosp accessible with little money.
19) because a woman can get qualified professional attention there.
20) because a lot of harmful practices occur during deliveries conducted at home. A woman should be taken to the hospital on the first sign of labor
21) That's where complications can be properly handled if they occur.
22) Babies and mothers can get infected with diseases at home delivery.
23) To save the mother's and the baby's life (protect them from infections), stop excess bleeding if it occurs, and assist during prolonged labor.
24) Some problems (complications) cannot be handled at home. Also prolonged labor causes a lot of problems. Moreover, the hospitals have the required equipments to conduct delivery.
25) because it is equipped to handle births

26) Facility, where she can rest (up to 6 hours), be cleaned up & be adequately taken care
27) because she can be quickly attended to in the event of any complication
28) so as to have acess to skilled personnel
29) because possible complications can be easily treated
30) That's where you will rest assured (your wife will deliver safely). But due to some cultural barriers (preference for a female health worker to conduct delivery), inadequate manpower, and sometimes the harassment by some of the health workers discourage women from delivering at the hospital.

3.Who is the ideal person to deliver her baby?

1) Preferably a female health worker.
2) Preferably a female health worker.
3) Doctor or health professional.
4) Female health service provider
5) Female doctor
6) Preferably a qualified female health worker
7) Anybody that is deployed to the labor room
8) I believe that a trained midwife is the best person to take deliveries
9) Preferably a trained female health worker
10) We generally prefer females to attend to our wives during labour & delivery, therefore a trained female midwife is the best person to take delivery
11) A hospital midwife should ideally take deliveries because they are the trained professionals in that field
12) Nurses and midwives.
13) Doctor or midwife;
14) Doctor supported by a nurse
15) Female nurse, doc, midwife
16) Health practitioner (skilled)
17) Midwives
18) This should be a trained health worker but the husband should be around to shoulder his responsibilities
19) Preferably a trained midwife
20) Preferably a female nurse.
21) Qualified midwife/nurse.
22) Doctor
23) The midwives or trained traditional birth attendants (TBAs) are the best people to take deliveries
24) Trained female health workers
25) A trained female health worker
26) Trained midwife
27) By a trained birth attendant
28) Female Muslim health worker is the best but if not available, even a male is permitted to attend to a woman in labor
29) Preferably a trained female nurse/midwife

Why?

1) Women feel more comfortable being attended to by female folks.
2) Women feel more comfortable being attended to by female folks.
3) The proper place will be in the health facility because of the care they will receive but we cannot blame does that deliver at home without understanding their resons for delivering at

home
4) Women will be more free with another female staff.
5) Doctor can take care of any complications.
6) Women are more comfortable being attended to by female folks.
7) Anybody deployed to the labor room is presumably qualified.
8) Because she has the appropriate knowledge and skills to do this
9) Naturally women feel more comfortable being attended to by fellow females.
10) Because she is a trained health professional who can detect and manage complications such as abnormal positions of the baby etc
11) They are knowledgeable. "My wife had a breach during one of her deliveries, she would have died if she wasn't taken to the hospital."
12) To ensure safe delivery
13) To avoid complications; in case of need for surgery; to ensure success of multiple deliveries
14) Will encourage more women to be more educated and specialized in the areas of RH
15) It is a sensitive issue: life being born out of life; safety and health reasons
16) because they are trained in that field
17) On the same day to ensure that there are no problems with the mother or the baby
18) In case of any primary or secondary complication, a trained midwife will be able to handle.
19) Because she's knowledgeable.
20) Midwives and nurses are qualified in the area of delivery.
21) Doc; at times nurses can only help to some extent.
22) because they have been trained to do so
23) because they have the knowledge & skills
24) because she has the skills and knowledge
25) To bo able to acess good health service
26) because the person will know what action to take in the event of a complication
27) To mitigate the cultural barrier preventing some women from delivering at hospital.

4. How soon after delivery should the mother and her baby be examined by a trained health worker?
1) If a woman delivers safely, a trained health worker should examine her within the first one week.
2) Immediately a woman delivers, but if the delivery was safely, there's no problem even if it takes up to a week.
3) Immediately; next visit after a month or as directed by the health service provider.
4) After one week.
5) Immediately, as soon as possible.
6) If a woman delivers at home, a trained health worker should be called immediately.
7) If the delivery is at home, she should be examined within 24 hours. This will also ensure that the baby is immunized.
8) I believe that a trained midwife is the best person to take deliveries because she has the appropriate knowledge and skills to do this
9) I was made to understand by the health workers that if a woman has a normal delivery, she does not need to be seen by health worker, but if in the assessment of a health worker, she needs to be examined then that is also fine
10) Within 1 week.
11) We generally only take our wives to be examined by a health worker after delivery if there is any evident health problem in the mother or infant after delivery, otherwise the woman who has a "normal" delivery is not taken to the health worker to be examined.
12) A health worker should examine a mother and her baby immediately after delivery, and this can either be at home or in a health facility

13) Immediately after home delivery. If it's in the hospital, she should be retained for some hours before being discharged.
14) 2-3 months
15) 12 hours after birth; days of vaccination should the following visit day.
16) Immediately
17) After one week
18) Immediately after delivery, not more than 5 – 30 minutes
19) If the delivery is at home, a trained health worker should be called immediately to check the condition of the mother (make sure she's not having excess bleeding) and ensure the baby is breathing normally and not having jaundice.
20) At most 3 hours. If the delivery is at home, it should be immediately - to make sure the baby and the mother are not infected with any disease.
21) Qualified midwife/nurse.
22) Immediately
23) As soon as possible after delivery so as to rule out any problem in the mother or baby
24) After 24 hours unless the husband is against it
25) Immediately in my opinion
26) Immediately
27) As soon as possible after birth
28) Immediately is best because of my personal experience with my wife
29) If the delivery is at home, a trained health worker should be called immediately, if a trained health worker is not available, she should be taken to the hospital immediately.

5. How many children should a woman have in her lifetime?
1) Number of birth is not restricted in Islam (it is in fact encouraged to have more children).
2) Maximum of 12
3) If a child can be taken care of, then there should not be a number.
4) Maximum 5
5) As many as 7; as Islamic scholar I don't believe that there should be a specific number of children that we need. We learn from health specialists that having more than 7 children might be detrimental to mother's health
6) Depends on the time she gets married, but 9 or 10 is okay.
7) Not more than 6 or 7.
8) I don't have a fixed number but I think her health and the number of children she already has should be the major factors that determine the overall number of children that she should bear
9) Like 3 or 4, maximum of 6
10) In my views which is based on Shariah (Islamic Jurispudence), there cannot be a cut off for the number of children a woman should have in her lifetime because this is already pre-destined by Allah, unless on grounds of the health of the mother or her children
11) A woman should ideally have between 7 to 8 children in my opinion in her lifetime
12) 3 to 5.
13) Max 5
14) Has two children; people are entitled to their own decision
15) 3-5
16) 4-5
17) 5 -6 children
18) Only Allah can decide the number and this should not be the focus for birth spacing
19) At most 6 or 7, ideal is 5.
20) At most 7, it should not exceed 10.

21) 3 are enough, at most 4.
22) 4-6
23) Between 8 – 10 children
24) 5 (2 males) & (3 females)
25) Only Allah can decide
26) Max 5
27) As Allah wishes
28) As many as Allah gives me if they are good kids & I am capable of catering from them
29) Up to 9.

6. Do you believe there should be preference for boys over girls?

1) Boys and girls are all a blessing (but people prefer boys)
2) Boys and girls are all a blessing.
3) No, not at all.
4) No
5) No, I even prefer daughters.
6) No
7) No
8) No
9) No
10) I do not think there are any difference between boys and girls
11) No
12) No
13) No
14) No
15) No
16) No
17) No there shouldn't be
18) Yes
19) No
20) No
21) No
22) No, Islam actually has preference for girls over boys
23) No there isn't & she personally prefers girls because they are more caring of parents than boys
24) No,
25) No
26) No
27) No there is the basis for such preference under Islamic Law for such a preference
28) No

Why?

1) Boys help you in your endeavors
2) Boys are our natural successors
3) It's a natural thing in men.

Why not?

1) Every child is equal
2) Society needs both boys and girls; girls are usually more sympathetic toward their parents and care for them—more than boys.

3) Religion never stated it is better to have a boy than a girl. They are equal, only have different roles to play when they grow up. They are all equal in God's sight.
4) Naturally men prefer boys, but the most important thing is to have a blessed child. Girl-child can equally benefit the society.
5) As one of the articles of faith, one should embrace whatever comes as a destiny.
6) In my opinion (& the shariah), any child that Allah gives a couple is good. But in the community, the tendency is that if a couple have mostly boys, then they will yearn for girls and vice versa. However, not having any boys in the family is likely to be more worrisome for a couple in our society
7) I know some female children that help their parents more than the males.
8) I prefer both, and there is no Islamic basis for any preference for boys over girls. The best thing is to have good children that have "albarka"/ "barakat" (i.e. useful or blessed or fruitful). In my experience girls are even more caring and loving than boys!
9) I do not think there are any difference between boys and girls, and I will accept any that Allah gives to me. I also feel that the important thing is for children to have "albarka" (i.e. be good or fruitful). However, the general feeling in the community is that husbands (males) prefer to have boys while wives (females) prefer to have girls but the latter will also be very worried if they don't have any boy
10) It has happened several times, where daughters became more helpful to their parents than the sons.
11) Even Quran does not teach preference for boys. Hadith is clear: if need be more attention should be given to the girls.
12) Any child is useful if well trained
13) Should be treated equally; what a boy u do a girl can also do it, and depends on upbringing
14) Female children perform functions of male children
15) Because what is important is that children should turn out to be hardworking and blessed irrespective of gender
16) because only Allah knows who is best and Islam enjoins justice between male and female children
17) Both boys and girls can help you in life.
18) It is wrong in Islam
19) It's un-Islamic
20) because only Allah knows which child will do their best by you
21) God is Almighty he can bestow knowledge to both male and female children
22) There is no Islamic support for preference for boys over girls
23) What's important is a blessed child.

What do the TRLs believe about birth spacing?

7. What does Islam teach about spacing birth of children?
1) Islam recommends 30 months of pregnancy and breastfeeding (implicitly a form of birth spacing).
2) Islam permits birth spacing, when it's necessary.
3) In Islam child spacing is allowed, but birth is not 'controlled' because that would be *limiting* the number, but spacing is allowed.
4) Islam supports birth spacing. In fact, Islam even encourages birth spacing. I did my own research, and before I was against birth spacing myself, but not anymore.
5) Islam allows for birth spacing
6) Islam is flexible. There is no categorical statement on this. However, if a (health) condition warrants child spacing then it is permissible.
7) Islam does not prohibit child spacing.

8) Islam generally supports birth spacing as agreed by the consensus ("maslaha") of Islamic scholars in the interest of the health of the mother & child. In specific contexts too eg medical problems in the mother
9) Islam always promotes the wellbeing of women and children, and since child spacing ensures their wellbeing then Islam supports it.
10) My recent understanding is that Islam supports birth spacing for the purpose of preserving the health of mothers and to prevent "rurutsa" (frequent births that follow each other too closely). Islam actually makes it compulsory to space births if there is medical evidence (by health professionals) that shows harm will be done to the mother if it is not done.
11) I know that Islam is not against child spacing because Islam say that a woman be allowed after delivery to breastfeed her child for up to about 2 years so that the mother and child attain or regain their health
12) It's permissible. Whenever a woman conceives, the baby feeds from what she eats. Without adequate provision of nutritional food, she will suffer. The Quran says "Do not throw yourselves with your own hands into destruction" therefore if the mother doesn't get adequate food and allowed to conceive, she is thrown into destruction.
13) Islam: spacing should be allowed to ensure good health, support and even strengthen the family by providing help to the mother
14) 30 months pregnancy plus breastfeeding
15) Islam allows birth spacing only when couples agree, or when there's health problems.
16) Islam advocates breastfeeding for 2 yrs. so child spacing is allowed by Islam
17) Islam is not against birth spacing but it is against limiting children out of fear of becoming poor. Therefore Islam is against abortion
18) Islam prescribes birth spacing for a couple so that the baby gets adequate breastfeeding for a suitable length of time i.e. 2 years
19) There's child spacing in Islam. Islam says you should acquire what you can control.
20) It's permissible. Islam teaches how to space births.
21) Yes, there's provision for birth spacing in Islam, so long as there is consensus among the couples.
22) Islam does not permit permanent sterilization without a cogent reason.
23) Islam supports birth spacing as stated in the Quran in the verse that prescribes a weaning interval
24) It is permitted by Islam e.g. withdrawal method
25) Yes
26) Islam gives priority health and so is birthspacing
27) Islam supports birth spacing as narrated in the Quran
28) Yes
29) There's withdrawal method, which is permissible in Islam (if the couples reach consensus).

[If the answer is positive, then ask the following questions on birth spacing; if not, then skip to Question no. 17]

8. What should be the interval (months or years) between child births? What did you believe four years ago?

1) 17 months.
2) 24 months of breastfeeding if a baby is sick.
3) 3 years is ideal
4) At least 3 years. This includes 2 years for breastfeeding, and then pregnancy. Natural method (?)
5) 3 years. Health wise and also from Islam's point of view this is a good interval between births.
6) Ideally 2 ½ years, but this is just a recommendation - not compulsory.

7) At least 2 or 3 years.
8) This is not fixed but there is an Islamic model "isharat" based on verses from the Quran that can be used, the model advises an interval of 30 months before getting pregnant after the last child birth. However, in my personal opinion 3 years should be the minimum between births but this should be handled on a case by case basis based on contextual factors so as to safeguard the quality of life of a woman
9) Minimum of 2 years.
10) I believe it should be 2 years
11) I think it should be three years apart
12) At least 3 years.
13) 3 to 4 years
14) 30 months
15) 2-4
16) 3 yrs
17) 3 – 4 years.
18) In my opinion 3 years
19) In Islam, 2 years is the ideal
20) At least 5 years (in my opinion), but ideally 3 years for everyone.
21) 3 yrs
22) 2 years
23) Islam prescribes 3 years approximately & she feels that 4 years is also fine because the child will be old enough to be independent
24) 24 months minimum, I knew this 10 years ago
25) Minimum 2years
26) 2 yrs
27) 2years.
28) 5 – 6 years.
29) 2 yrs.

What did you believe four years ago?

1) The same thing.
2) Yes, same.
3) I believed birth spacing was intended to kill children. This was based on a wrong interpretation of a Koranic verse, which states, "don't kill your children." After undertaking research in this area I understood that although Allah swt. says not to kill children I'm actually not killing my child by using contraceptives. I'm only preventing the formation of embryo that has not yet formed.
4) I believed birth spacing was not allowed by Islam.
5) I believed child spacing was not permissible by Islam.
6) I did not have this understanding 4 years ago, however I remember that even during my childhood (a long time ago), "rurutsa" (too frequent births) was considered an unwanted and troubling condition for a woman to have.
7) Same
8) I had the same opinion.
9) Four yrs ago the knowledge of religion was there for me, but not on health. dRPC is now in the area of awareness, budgeting, LGA advocacy on health and the house of assembly.
10) 2 years
11) Thought FP was prohibited, and would not even have this discussion with you.
12) I had the same opinion 4 years ago
13) I have always had this belief
14) Same: 2 years of interval

15) Didn't believe in it
16) I didn't believe in it.
17) I didn't believe in it.
18) 2 years—same
19) 24 months minimum, I knew this 10 years ago
20) yes at least 2 years minimum, and I knew this because I worked at the health facility
21) I believed the same 2years ago
22) I believed in this 4 years ago
23) Same opinion

9.What method(s) can be used for spacing births?

1) The withdrawal method; modern contraceptives
2) Withdrawal
3) Condoms, IUDs, injectables, implants and also breastfeeding and withdrawal method. All three wives have received implants.
4) Pills, injectables, maintaining safe period (*check IRH/Georgetown website for correct term*)
5) As advised by professionals. This could include modern contraceptives, barrier methods and withdrawal.
6) Traditional and modern contraceptives (like injectables, barrier and oral pills)
7) I have heard of pills, injectables and IUCDs.
8) Modern contraceptives and permanent sterilization.
9) I know that birth spacing can be achieved through modern means such as using contraceptive injectable & pills (which I have heard of but do not know about deeply). I also know other traditional methods such as amulets worn around the waist have been used with varying success in past as well as presently.
10) Child spacing can be achieved through the use of modern contraceptives e.g. implants, injectables & pills
11) Traditional and modern contraceptives (like injectables, and oral pills)
12) Injections, pills and tablets, vasectomy, cervical cap, diaphragm, loop, withdrawal, safe days (rhythm) method
13) Note: published a song about this topic of child spacing.
14) Injectables, condoms, implants, pills
15) Condoms, pills, IUCD, injectables.
16) Pills, IUDs, injectables, implants, loops (Copper T?), traditional method (withdrawal)
17) Pills, injectables, implants, cycle beads, condoms. Yes I knew about them 4 years ago
18) Modern contraceptives prescribed by health workers such as injectables, implants, condoms
19) Withdrawal and calendar methods (which are the recommended in Islam), then there is the use of (male) condom and modern contraceptives (oral pills and injectables).
20) Natural methods (calendar) and modern contraceptives (oral pills).
21) Modern contraceptives (oral pills, implant, IUCD, condom), natural methods (calendar) and withdrawal.
22) Natural methods (calendar), withdrawal, modern contraceptives (oral pills, injectables, implant).
23) Pills, implants, condoms.
24) Couples can use the withdrawal method, cycle beads which they heard of from the Mali tour, female condoms, pills, and implant.
25) Pills, injectables, condom.
26) Withdrawal method , pills , injectibles, implants, condom use.
27) Pills, injectable, condoms. I knew them 4 years ago
28) Pills, injectables, withdrawal method, calendar method
29) Withdrawal, modern contraceptives (oral pills, injectables, implant).

[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]

Did you know about these contraceptives four years ago?

1) No.
2) Yes; modern contraceptives ok if not used for limiting no. of children.
3) No
4) Yes; I knew about them, but didn't know if it was permissible so dRPC encouraged me to go do more research, and provided justification for what I'm working on.
5) Yes
6) Yes, I knew about them 4 years ago but not in details
7) Yes
8) I was not aware of these modern methods four years ago
9) I only knew about injectables & pills 3 years ago. I only recently came to know about implants
10) No
11) Only few methods like pills.
12) 4 yrs. ago I did not know this much. I had some misconceptions about child spacing, but now I know better. I thought 1 1/2 yrs was OK.
13) Yes.
14) Yes
15) Pills
16) Yes I knew about them 4 years ago
17) Yes
18) No
19) Yes
20) Yes
21) Yes, I knew about them 4 years ago
22) She only knew about condoms & pills in the past (4 years)
23) Knew this long ago because I had training on FP by UNFPA
24) yes I knew about all these
25) I knew all the methods mentioned above except the calendar method
26) Yes

10.Which contraceptive methods are permitted by Islam? Which are these?

1) Any type.
2) Any type.
3) Islam permits the use of all contraceptives as long as it is not done in fear of poverty.
4) Islam permits any method that will not harm mother or child.
5) Withdrawal method.
6) Any method.
7) I know that Islam permits the use of drugs and devices for birth spacing as long as they are not harmful to the woman.
8) Any method.
9) All the types of contraceptives I mentioned earlier are permissible in Islam.
10) Any method
11) All methods

12) Withdrawal
13) No method is restricted
14) All methods permitted
15) All are permissible if they are used with the intent of birth spacing and are harmless
16) Any method
17) Any method
18) Any method
19) They are all permitted unless if they are found to be harmful
20) None are forbidden if they do not cause harm
21) All are permitted because some Companions of the Prophet (PBUH) practiced it
22) All ; withdrawal , pills , injectibles, implants , condom use
23) It depends on the side effect of the drug.
24) All are permitted unless if they are permanent methods
25) Any method

Are there specific contraceptive methods that are *not* permitted by Islam?

1) None.
2) None
3) Methods that change/confuse women's menstrual cycle. Because irregular bleeding will affect her prayer times, as she cannot predict mens. She used a contraceptive pill in the past and has first hand experience about this problem.
4) Permanent sterilization
5) None
6) However, I have heard that some of these methods can cause distortions in menstrual patterns and even infertility, these will affect how such methods are viewed by Islam and they need to be studied more closely
7) None, but abortion is prohibited.
8) I know that all drugs ("that are harmless") can be used for birth spacing, even (irreversible) methods can be used if it is recommended by a doctor based on medical grounds and in the interest of the patient
9) I don't know of any other type of contraceptive that is not permitted by Islam
10) None
11) Permanent methods that will prevent one to ever have a child again is not permitted by Islam. E.g.Vasectomy.
12) Yes; anyone that has health problems for women.
13) No
14) None
15) None are forbidden if they do not cause harm although I believe the rhythm method is preferred
16) Use of charms
17) None (except permanent sterilization).
18) None
19) None (except permanent sterilization)
20) Abortion; Islam prohibits abortion , its only allowed on health reasons
21) No it depends on what I said earlier
22) None (except if they pose health risk).

How do the TRLs promote and teach about women's reproductive health and child spacing?

12. Did you preach about birth spacing in the year preceding the survey?

1) Produced a lecture on tape specifically on ANC visit (demonstrated by sending my own wife for ANC), also talked about avoiding prolonged labor, and enrolment of girl-child into school. *{Note that birth spacing did not seem to be clearly pronounced in the lecture – perhaps the need to get a copy from dRPC and verify}.*
2) Yes.
3) Yes. Embedded this topics or child spacing in discussing nutrition, health and diet.
4) Yes
5) Yes
6) Yes
7) Yes
8) Yes
9) Yes
10) Yes,
11) I used to preach about birth spacing generally within the context of maternal health in the past year at the.
12) We talked to ward heads about importance of ANC attendance, RI, hospital deliveries etc.
13) No
14) Yes
15) Yes
16) Yes
17) Yes
18) Yes
19) Yes
20) Yes, More than 20 times.
21) Yes
22) Yes
23) Yes
24) Yes
25) Yes.
26) Yes
27) Yes,
28) Yes,
29) No; but I spoke generally on maternal health. We usually allow the female scholars to speak more on birth spacing
30) Yes.
31) Yes

Where did you preach?

1) After Friday prayers
2) After daily Islamic lessons at school.
3) FOMWAN center, naming ceremonies, large gatherings, and lectures organized by hosp. E.g. lecture on breast cancer.
4) On Fridays during prayer, and Mondays during meetings. Radio and taped messages. Over 5 million listeners.
5) Local govt. events in Sokoto town, naming ceremonies.
6) At wedding and naming ceremonies (Walima)

7) At the community in collaboration with ward development committee members.
8) Yes, I did but we RLs can only preach "general principles because we are not health workers". I preach during Friday sermons, through out the Ramadan "tafsir" and after "tarawiyy prayers during Ramadan.
9) At the mosque and small gatherings. Also produced a lecture on tape on birth spacing
10) Friday Prayers (Khutbah) sermon as well as Thursdays interactions with pupils at his home, and the sermons he gives through out the month of Ramadhan (fasting)
11) At the palace of the Yarin Gandi
12) At lectures organized by Muslim Students Society, and at the school where I teach.
13) The Islamic School
14) Mosque, govt. gatherings involving traditional leaders to preach where necessary, specific places for preachers.
15) Islamic religious gatherings; book publications (Morality and Ethics in Islam; Status of Women in Islam)
16) Friday weekly preaching forums; Muslim Students Association of Nigeria alumni association forum; wedding gathering (walima)
17) In health facilities, in prisons, rural areas etc. more than 20 times
18) At several forums such as public gatherings, mosques, Islamic schools.
19) At community gatherings (including the rural areas), and at schools.
20) At comm. Gatherings
21) At lectures organized by Muslim Students Society, and public lectures organized by Muslim Sisters Organization.
22) At mosque, at school, at public lectures
23) Mainly in Islamic schools, during outreaches to rural areas.
24) To women groups in our village outreach that we do thrice a week except when our car broke down. Other venues include weddings, our Islamic schools, naming ceremonies etc
25) during public speeches in Islamic schools and health talks in the clinic in my village that was built with MDG funds but I was very instrumental in building it.
26) at gatherings
27) At mosques
28) Mostly during the Ramadan tafsir (sermons) or during Friday prayer preachings during the questions & answer sessions.
29) At lectures, daily Islamic lessons, before Friday prayer sermon.

How many times in the past year?

1) Several times.
2) Several times (can't remember precisely).
3) Four times in the whole year.
4) Many times
5) 15-20 times
6) 3 times
7) Twice, at gatherings. Also counsel individuals (including colleagues) several times (can't remember how many times).
8) About 6 or 7 times.
9) I don't keep count (approx 20 – 25)
10) Three times.
11) These sessions are held more than 30 times in a year.
12) 4 times
13) About 15 times.
14) More than 100 times
15) More than 20 times e.g. wedding feast

16) More than 10 times
17) 4 times
18) 4 times
19) Over 30 times.
20) More a 50 times last year
21) At different forums approximately more than 30 times/year.
22) About 5 times
23) Many times
24) 5-10 times

13.What messages did you give to your congregation about birth spacing and women's health?

1) Mostly on ANC and hospital delivery; effects of un-spaced child birth.
2) On ANC and effects of un-spaced child birth.
3) Importance of attending ANC; facility based deliveries; importance of allowing a child to be healthy and strong before having another child. Show disapproval to mothers who bears many children
4) Messages on life skills, marriage, and having many wives.
5) Infant's health, hospital visiting for ANC.
6) Encourage women to go for ANC, because it's the entry point, then professionals would give further advises.
7) Women's right (to go for ANC), provision of nutritional food for them, and the disadvantages of non-spaced children.
8) I gave general messages related to maternal &child health focusing on the responsibilities of husbands to their wives and vice versa.
9) Parents' responsibility of taking care of the children and women (especially when they are pregnant)
10) The messages I delivered was about the dangers and problems associated with "rurutsa" and the need for birth spacing (which was targeted at community members) but I also included other social issues (which was targeted at the government) such as bad road networks that can cause delays in bring a pregnant woman to the hospital, thus contributing to maternal mortality.
11) Responsibilities of husbands to take care of their wives, whether they are pregnant or not, to always try alleviate their sufferings, which birth spacing is one way to do that.
12) Women's health, child spacing, need to visit facility health centers for ANC, girl child education (so many more girls will be educated and become female HSP).
13) RH, child spacing and ANC
14) Messages on health and all aspects of life; messgs on women's health and birth spacing
15) Mainly on maternal health, sanitation, birth spacing.
16) Mainly speak about birth spacing, responsibilities of married couples, ANC, deliveries. I used to give these messages even in the past because I preach & teach a lot of married women in my school. The only difference now is that I don't face as much opposition and attacks from the community as I used to in the past
17) On birth spacing specifically and women's and children's health generally.
18) About the effect of frequent child birth and the wellbeing of mothers and children.
19) Generally on women's and children's wellbeing.
20) On women's and children's health generally; number of children one should ideally have vis-à-vis the economic situation.
21) On birth spacing & women's health.
22) We discussed about benefits of spacing births, referrals, attending ANC during pregnancy and delivering in health facility.
23) Messages on birth spacing, maternal health, ANC, deliveries etc.

24) Economic Education (implication) for both men and women , Health of women and children education
25) I spoke generally on women's health matters related to pregnancy, ANC etc.
26) On the Islamic perspective on birth spacing & its relationship to the health of women. Yes, but not with the same depth and clarity
27) I begin by talking about the responsibility of both the husband and wife on one another. The husband is responsible for the wife's general wellbeing, then I bring-in the issue/need for birth spacing.

Did you give these types of messages before the dRPC Project began, and were your messages different at that time?

1) Messages remain the same.
2) Messages remain the same.
3) Yes, same messages. After dRPC project we became more deliberate on messages with birth spacing.
4) Yes; but with dRPC I know more because their advice encouraged me to get into research.
5) No; I didn't know all this, but dRPC helped me to understand.
6) Yes
7) Yes
8) I did not use to do these contents in detail in the past before the coming of dRPC
9) Yes
10) I did not talk about these issues in the past
11) No
12) No. B4 messages were on family relationships and general health, but now more specifically on child spacing.
13) No. only on family and child health
14) No
15) Yes
16) Yes but without birth spacing.
17) No
18) No
19) Yes, previously I focused on ANC visit and hospital delivery.
20) Yes
21) No
22) Yes, but lesser emphasis on birth spacing. Spoke mainly about ANC attendance, deliveries, sanitation & nutrition
23) I used to discuss about maternal health issues even before the coming of dRPC but I only started to include birth spacing in my messages after my interaction with dRPC
24) No
25) Yes; No big difference; it is all the same but improved to now include messages on family health and child spacing.
26) They are unchanged
27) Yes.
28) No

14 Did you use the Quran, Hadith and other religious sources in your preaching or counseling?

1) Yes.
2) Yes.
3) Yes. We did but very carefully because it was very sensitive issue.

4) Yes
5) Yes
6) Yes.
7) Yes
8) Yes, I quote from Suratul Baqarah in the Quran as well as the teachings of Yusuf Qadawiyy
9) Yes
10) Yes; and I used to quote verses also in the past.
11) Yes
12) Yes
13) Yes
14) Yes
15) Yes
16) Yes.
17) Yes, at present and in the past.
18) Yes
19) Yes
20) Yes
21) Yes
22) Yes.
23) Yes, I used to quote from relevant verses when preaching now and even in the past before the coming of dRPC.
24) Yes, but did not include birth spacing in the past
25) Yes
26) Yes.
27)
28) Yes
29) Yes
30) Yes

Did you do this before the dRPC Project began?

1) No.
2) No.
3) Yes; because we gave dRPC our commitment, and we are more knowledgeable.
4) Yes
5) No.
6) No
7) No
8) Yes
9) Past sermons was not on birth spacing or women's health.
10) No
11) Yes
12) Yes
13) No
14) No I didn't.
15) On birth spacing specifically and women's and children's health generally.
16) No
17) Yes
18) No
19) Yes, but not necessarily in support of birth spacing.
20) Yes we used it in the past before dRPC project commenced

21) Yes.
22) Yes; that is the standard practice when conducting any sermon.
23) No
24) No

How many times in the past year?

1) Several times (can't remember precisely). {Tracking/monitoring progress has been identified as a bit of a challenge by dRPC during the debrief}.
2) Several times (can't remember precisely).
3) Still 4 times.
4) 15 – 20 times.
5) 3 times
6) Several times (can't remember how many times).
7) 6-7
8) 3
9) more than 30 times
10) About 15 times
11) More than 20 times
12) Many time
13) About 100 times
14) Yes; more than 100 times
15) More than 20 times
16) About 20 times or more
17) More than 10 times
18) 4 times
19) 4 times
20) Over 30 times
21) More than 30 times
22) More than 30 times last year because we conduct outreaches to villages, Islamic schools and social gatherings
23) Many times
24) More than 20 times
25) 1 -2 times
26) 5-10 times

15.What type of topics did you address during counseling?

1) ANC and hospital delivery; effects of not spacing birth
2) ANC and hospital delivery; effects of not spacing birth
3) Random, not as planned activity: self-reliance (life skills for women), discussion on diet issues.
4) Women's health, nutrition, training for caregivers
5) Urge men to allow women to go for ANC
6) The importance of ANC visit and child spacing.
7) Yes
8) No
9) I spoke about responsibilities of a couple to each other in marriage especially focusing on the rights of the woman and child. Yes, I have always been involved in couple counseling (either intentionally or accidentally)
10) Urge husbands to allow their wives to go for ANC.
11) I usually speak about maternal health/menstrual problems, ANC & hospital delivery &

frequent births.

12) Maternal and child health. Also encourage young females to study health-related courses.
13) Women reproductive health; child health
14) Solving problems between families; solving problems among women and their husbands; helping women in taking RH, health decisions
15) Pre-marital counseling; baby or birth counseling
16) Changes in menstrual pattern when taking pills, birth spacing generally, ANC visits etc.
17) Birth spacing, responsibilities of married couples, menstrual patterns, ANC, and hospital deliveries. Yes, within the limits of my knowledge. Yes, but not as much as now. The difference is I now do more with the additional knowledge I gained
18) Girl-child education and birth spacing.
19) Birth spacing and ANC visit.
20) Wellbeing of mothers and children including birth spacing and ANC visit.
21) Women's and children's health, birth spacing.
22) Menstrual pattern disorders, birth spacing, ANC, immunization.
23) I spoke mainly on ANC, child nutrition, sanitation, birth spacing, menstrual hygiene & patterns etc.
24) Topics related to birth spacing, maternal health, ANC, deliveries, menstrual problems associated with contraceptives but mainly to friends and relatives.
25) No I did not
26) Marital counseling , family counseling
27) Maternal health matters generally.
28) Birth spacing and frequent births in relationship to the health of women.
29) Husband's and wife's responsibility on one another.

Are you comfortable in counseling community members on birth spacing?

1) Yes.
2) Yes.
3) Yes
4) Yes.
5) Yes
6) Yes
7) I am comfortable discussing these issues with individuals or couples that approach me.
8) Yes
9) Yes
10) Yes
11) Yes
12) Yes.
13) Yes.
14) Yes, "some people are now opting for 3 years birth interval, not even 2 years."
15) Yes
16) Yes
17) Yes
18) Yes.
19) Yes, I now discuss birth spacing more often and confidently
20) Yes
21) No.
22) Yes
23) Yes

Did you counsel on birth spacing before the dRPC Project?

1) No.
2) No.
3) Yes, counseling done in our own discrete way, without being too open. Now it's much more in-depth and more targeted.
4) No.
5) No.
6) No
7) Yes, even in the past before dRPC but the content of what I do now has been influenced by the exposure I got through dRPC
8) No
9) I used to do this in the past but the focus was different then
10) No
11) Yes
12) Yes
13) Yes
14) No
15) Yes, but not as much as now.
16) No
17) No
18) No
19) No
20) No
21) Yes, although I have no deep technical knowledge
22) Yes;
23) No
24) Yes.
25) Yes

If so, is there a difference in the content or approach of your counseling now? What are these differences?

1) Yes
2) Yes
3) Yes; use of Islamic perspectives (to promote birth spacing?)
4) B4 messages were on family relationships and general health, but now more specifically on child spacing.
5) Yes
6) Now counseling freely and knowledgeably
7) The difference is I now do more with the additional knowledge I gained
8) mainly on children and maternal health generally
9) The difference includes counselling for men on child spacing and care for their family health; There is now additional information on health and RH; Medical advice to men on options for child spacing
10) The difference is there is better acceptance and awareness about birth spacing now when compared to the past. My understanding and speeches on birth spacing are more advanced now.
11) No

16. Do the men, women and youth hear about these topics from you?

1) Yes.
2) Yes.
3) Yes, only women
4) Yes
5) Yes
6) Yes. I discuss this with young girls at the school where I teach.
7) Yes. Women are reached by house-to-house mobilizers that I participated in training.
8) Yes,
9) Yes
10) Yes, they do.
11) Yes
12) Yes
13) Yes
14) Yes
15) Yes.
16) The difference is I now do more with the additional knowledge I gained
17) Yes, but not as much as now.
18) Yes
19) Yes; Yes, (I pass my messages to women in the community through female mobilizers).
20) Yes (only by women).
21) Yes
22) Yes.
23) Yes, they do, particularly rural women.
24) Yes.
25) Yes. Topics RH, Childspacing and maternal health
26) Yes.
27) Yes.
28) Yes

Before the dRPC Project began did they hear about these topics from you?

1) No.
2) No.
3) There were projects that hit the rocks because they used the term “family planning”
4) No.
5) No
6) No
7) The people used to listen to me even before the dRPC project began
8) No
9) No; only family health messages
10) Yes
11) Yes
12) No.
13) Yes.
14) No
15) No
16) No
17) No
18) Yes, they did

19) No they did not
20) No. I now include birth spacing issues from time to time
21) Yes
22) Yes.
23) Yes.
24) Yes

If so, are there differences in the topic contents? What are these differences?

1) Yes
2) Now we include in the messages topics for care givers and about RH to women.
3) But in the past before the coming of dRPC it was just a little and people usually turned to family members for information on these topics. The difference is that I now discuss issues related to maternal health and birth spacing
4) Previously did not talk about child spacing.
5) Difference with now is that my messages have a focus on health of children and mothers as well as discouraging the use of traditional methods for preventing "rurutsa"
6) Additional discussion of RH and counseling for couples are not added.
7) Inclusion of men and women's role in RH; counseling and guidance on good health and birth spacing
8) We now include birth spacing in our discussions
9) The difference is I now do more with the additional knowledge I gained
10) but we did not dwell too much on the topic of birth spacing in the past when compared to now
11) But after dRPC there is more data on RH and more detailed topics on RH
12) No
13) Yes, the differences are that there is better acceptance, awareness and understanding of birth spacing now when compared to the past. Maternal health, ANC, hospital delivery in the past but birth spacing, referrals to health workers for advice on birth spacing, ANC visits, etc.
14) No

What specific roles did the dRPC Project have in equipping the TRLs?

17.Did the dRPC Project conduct activities to give you information on women's health, birth/child spacing and contraceptives?

1) Attended 3 seminars (2 in Sokoto, 1 in Kano)
2) Attended 3 seminars (2 in Sokoto, 1 in Kano)
3) Yes
4) Yes
5) Yes
6) Yes, almost at all forums.
7) Yes
8) Yes
9) Yes
10) Yes,
11) Yes
12) Yes
13) Yes;
14) Yes
15) Yes
16) Yes
17) Yes

18) Yes
19) Yes
20) Yes
21) Yes
22) Yes
23) Yes,
24) Yes,
25) Yes.
26) Yes
27) Yes
28) Yes

What activities (if any) did you participate in?

1) Leadership Development Forum.
2) Leadership Development Forum.
3) Rigorous session on issues of pegging marriage age, which we discovered were possible. Pre-marital counseling, travel to Cairo. Information of alumni assoc. with Ghana, Cairo participants
4) Advocacy visits, training for himself, health worker meetings, Cairo study tour.
5) Visit to Mali, visit to Cairo, follow up activities
6) Workshops in Sokoto and Kano (Leadership Development Forum). Also participate in the alumni.
7) Sokoto workshop, Egypt study tour (x1), Stakeholders meeting in Sokoto (x4), HSP meeting in Abuja (x1), Meeting in Gusau (x1)
8) Workshops in Sokoto and Kano (Leadership Development Forum) about 4 times.
9) We had the following trainings with dRPC
10) Meeting (? LDF retreat) in Kano (once)
11) Meetings in Sokoto (4 times)
12) But no alumni association was set up for them
13) I participated in seminars/retreats in Kano, Abuja, Zamfara and Sokoto
14) I am a member of the Sokoto alumni association but I have not attended any of the meetings
15) Training and capacity building in Cairo study tour
16) Study tour in Cairo, workshops in CANO, Abuja, Niger
17) MMR reduction workshop; trainings
18) Alumni association; Cairo study tour
19) we attended meetings in Zamfara organized by dRPC
20) Meetings at Gusau, Zamfara (x6); Meeting at Kano (x1); Alumni association was formed 2years ago (met thrice) (they are a mixed bunch)
21) Participated in advocacy visit to Emir of Anka
22) Tour to Egypt, Ghana and Mali. Almost all dRPC activities.
23) LDF
24) The debriefing by TRLs who visited Egypt.
25) Tour to Egypt, Ghana and Mali. Almost all dRPC activities.
26) Meetings (x3) at Gusau. Did not go to Egypt or Mali, but I heard about it
27) I went on the Mali tour and Kano (once) also, plus a couple of meetings in Gusau
28) Meetings in Kano (x1); Meetings in Gusau (x6); Meeting in Abuja (x1); Part of alumni advocacy team to Anka
29) Egypt tour; Workshops in Abuja, Kano and Gusau
    a. Meeting in Gusau (x2); Heard of travel tour to Egypt

30) Egypt tour(x1), Meetings in Gusau (x5), Meetings in Kano (x2-3), Meeting in Abuja (x1)
    a. Alumni association was formed in 2010 but they do not meet frequently. They went on advocacy visit to Emir of Anka
31) Tour to Egypt, workshops in Zamfara, Kano and Abuja.

How often?

1) Rarely
2) Once
3) About 4 times
4) One Kano and 4 Sokoto mtng
5) Workshops in Sokoto, Zamfara and Kano.
6) About 4 times step down training to my peers, and dRPC helped me to build my knowledge and capacity
7) Three times: 2 in Zamfara, 1 in Kano (LDF)
8) LDF (2) in Zamfara.
9) About 10 times

[Probe for LDF/Retreat, Study Tour, Alumni Association/Network]

18. How effective were these activities?

1) All activities have been effective.
2) All activities have been effective.
3) The trainings (LDFs?), Cairo tour.
4) All were effective
5) Very effective.
6) Quite effective
7) Very effective.
8) Very effective
9) Very effective
10) Very effective
11) Very effective
12) Very effective
13) All were effective
14) All the activities with dRPC were effective
15) Very effective
16) Very effective
17) Very effective
18) Very effective
19) All the activities were effective in my opinion
20) Quite effective
21) Quite effective because the Mali tour was an eye opener for me in terms of birth spacing methods in use in another Muslim (francophone) country
22) All were effective
23) All were effective
24) Very effective

Which activity was most effective?

1) Mobilization for ANC.
2) Mobilization for ANC visits.
3) Trip to Cairo

4) Cairo tour
5) Cairo trip was most effective.
6) Brainstorming sessions and reaching consensus on controversial issues like birth spacing.
7) Study tour to Egypt
8) The Egypt study tour was the best
9) The forum at Kano
10) The Kano meeting was the best for me
11) The most effective and memorable was the retreat held in Kano for the TRLs which I attended as the representative of the Yarin Gandi. The least effective was the alumni meetings because little was done
12) Workshop in Kano
13) The action plan and trip to Egypt
14) Study tour to Egypt
15) MMR reduction training
16) Cairo trip; follow up visits to ensure continuity (monitoring)
17) The training workshop on effective management was the best for me
18) The meeting at Kano was the most effective
19) Tour to Egypt,
20) Kano tour
21) Debriefing by TRLs who visited Egypt.
22) Workshop in Kano; debriefing by TRLs who visited Egypt; and a workshop bringing together doctors and TRLs.
23) The meetings at Abuja & Kano were the most effective for me because I met with other scholars but the other activities were also effective
24) Egypt tour; Workshops in Abuja, Kano and Gusau
25) The most effective was the Egypt tour
26) Tour to Egypt

Why?

1) "The involvement of prominent Islamic scholars made the whole course more credible."
2) There's change in attitude in the community regarding ANC.
3) Felt more encouraged to study and research in the RH area. Met well known religious scholars with more knowledge that made me go into research on RH.
4) Because there was a heated debate and subsequently a consensus.
5) Sharing of experience with other TRLs, when they came back.
6) Because it involved interacting with renowned and respected scholars who used facts to convince them without forcing their opinion on them. In addition, the dRPC engagement strategy (respecting them, creating rapport with them & winning their confidence) with TRLs was a very brilliant move
7) There was a debate between pro- and anti-birth spacing Islamic scholars.
8) because it allowed for questions & answers as well as interactions with each other and with notable knowledgeable religious leaders.
9) The retreat was effective for me because I met with high ranking
10) The pragmatic approach used in conducting the session.
11) Able to learn new things in RH issues, share ideas as regards to preaching on birth spacing.
12) Helps to enlighten in RH
13) Hosp and Univ. we visited were very good and we learned a lot.
14) Least effective – none. All were very effective
15) Continuity and sustainability—she is continuing to train her peers.
16) Because I got the chance to network with teams from Sokoto and Niger
17) Because of the networking opportunity & relationships that were formed. Met with old

friends, respected Islamic scholars & traditional rulers etc.

18) "because I've seen a lot and learnt a lot, religious leaders who were formerly against birth spacing where convinced there and then."
19) I've learnt a lot.
20) The Mali tour was an eye opener for me in terms of birth spacing methods in use in another Muslim (francophone) country
21) Involved people that I knew directly , people I could learn from and also have immediate impact on . It also involved other professional leaders
22) Egypt tour opened my eyes to leadership role of Islamic teachers in health of their communities. I was also impressed by the good health system in Alexandria.
23) Egypt tour: "I've gained a lot"

Which one was the least effective?

1) Alumni has not been fully instituted and sustained, only implemented informally.
2) Individual action plan because we needed follow up; not being able to air messages on radio
3) None
4) Alumni Assoc.
5) None were least effective, all were useful.
6) Alumni association
7) Don't know.
8) Don't know
9) An association of TRLs was formed with support of dRPC but it has not taken off effectively but they have used their initiative to form a local TRLs NGO 2 years ago based on their dRPC experiences
10) Don't know
11) And the least effective was a local meeting in a primary school within the community on creating awareness within the community which was organized by the ?LGA
12) The least effective was the alumni meetings because little was done
13) Don't know
14) Meetings scheduled to be held in Gusau: locations far apart and expensive to attend
15) Mali Tour
16) Don't know
17) Don't know
18) Formation of alumni assoc.
19) Abuja workshop
20) None of the dRPC activities were ineffective
21) Cannot say

Why?

1) Don't know.
2) I don't know, but maybe because of lack of merging the three leadership of each of the alumni (Ghana, Mali and Cairo)
3) Mali tour-- Due to security concerns in the country (Mali).
4) Alumni assoc. was not sustained.
5) I feel it was too far , people and their needs should be met in their immediate environment

19.Did the dRPC Project help you to develop a plan of activities? In what ways?

1) No.
2) No.
3) Yes.

4) Yes.
5) Yes.
6) Yes
7) No
8) Yes, we developed a GAP after the Egypt tour
9) It wasn't very effective as dRPC did not continue to provide support.
10) Developed a group action plan on health of women of reproductive age and ANC
11) No
12) Yes, they did and it was a document of some sorts (?IAP)
13) Partly yes,
14) dRPC gave time frame for completion and an outline.
15) Mentorship by dRPC officials.
16) I was asked during the Sokoto meeting to give a verbal presentation of their activities in the Gandi traditional council in Gandi town but was not outlined or written on paper
17) No
18) Yes, by drawing up the action plan; by helping to facilitate topics of discussions on RH and Child Spacing
19) Yes; developed messages for ANC, renovated clinics (e.g. construction of benches for women coming to facility for ANC)
20) Yes; preparation of workplan; how to organize workshop and people
21) IAP; dRPC helped develop IAP by drafting schedules and IAP formats; planned to conduct advocacy visits
22) Yes, an IAP
23) Yes, they supported us to develop a GAP
24) Yes; through providing grant and mentoring.
25) Yes; through mentoring
26) Yes; through mentoring
27) Yes (a group plan of activities); through mentoring
28) Yes, through developing IAP
29) Yes, GAP
30) Yes; In supporting the committee of the palace to draw up program activity schedule
31) No
32) Yes, IAP & GAP
33) Yes; mentoring

[Probe for Individual Action Plan, Group Action Plan, Monitoring Plan, Sub-grants for supporting action plans]

20 Did you develop an action plan?

1) No.
2) No.
3) Yes, we did
4) No
5) Yes
6) Yes, a small group action plan
7) Yes
8) Yes (assisted by other orgs)
9) Yes, we did a GAP
10) No
11) Yes
12) Yes

13) No
14) No
15) Yes
16) Yes
17) Yes
18) Yes
19) Yes,
20) Yes we developed a GAP
21) Yes
22) No
23) No
24) No
25) No
26) Yes, I developed my IAP based on my rural teaching and preaching activities.
27) Yes, we had a GAP.
28) Yes
29) No
30) Yes
31) No

What did you include in it?

1) We tried to replicate what we learned in Cairo
2) Advocacy to ministry, joint program activities with the government.
3) Sensitization of female students to study health-related courses.
4) Monthly review meeting with community based health volunteers; monitoring of new deliveries;
5) Community mobilization, meeting with other traditional rulers & the public) and IAP (public preaching – this is ongoing, advocacy – this was not done
6) I included preaching on the health of women and children based on the Islamic perspective.
7) Plan for messaging; plan for
8) Messgs for community on RH
9) Awareness building on RH; sensitization at community level on FP; advocacy visits to stakeholders on RH
10) I included a water sanitation program, preaching on MCH issues to rural women, income generating activities
11) On preaching in rural areas, produced IEC/ 20 cassette recordings on birth spacing for use in rural areas, media enlightenment on maternal mortality.
12) Sustainability plan (involvement of religious leaders in community sensitization).
13) We have started venturing into local income generating activities that we can teach rural women
14) They include preaching in rural areas, making cassettes for training & distribution. Most of the activities were accomplished
15) Plan on how to work with the community on health sanitation, women health.
16) Yes. Preaching in Friday mosque, female Islamic schools, Ramadan preaching & production of cassettes was my IAP (I accomplished all). But the GAP was advocacy visits to identified stakeholders eg Emir of Anka (not all GAP was accomplished)

How much of your plan did you accomplish?

1) 20%

2) To a large extent.
3) Nothing was implemented from the action plan because it needed involvement of others
4) About 70%
5) I accomplished most of these activities especially the part related to the preachings
6) N/A
7) 78%
8) 80%
9) 80%
10) All accomplished
11) 88.8%
12) Most of the activities were accomplished
13) About 90percent.

Which activities?

1) Assisted a student to secure admission to study medicine.
2) House-to-house mobilization
3) ANC visits; use of mosquito nets; counseling on preparedness for birth; and immunization of children under the age of five years.
4) Trainings/seminars on child spacing; sensitization of women and communities on RH
5) Yes
6) N/A
7) Involvement of religious leaders.
8) health sanitation, women health

21. Did the project help you to develop a monitoring plan? *[Explain what is a monitoring plan, if necessary]*

1) No.
2) No.
3) Yes. We developed a Mon. plan. Lot of things intended but didn't happen.
4) No
5) No
6) Yes
7) No
8) Not really, but IAPs were reviewed during one of the meetings at Sokoto and the state dRPC focal persons were asked to use tape recorders to record preaching by TRLs
9) No
10) No, but sometimes, the dRPC staff used to come and record my speeches during a sermon
11) No
12) No
13) Yes
14) Yes; now able to use my experience to work with state govt. in sharing experiences of all I learned in Cairo; I can now influence government to fund seminars on RH in the State.
15) Yes; by drafting a workplan and following up
16) Yes
17) No
18) No
19) No
20) Yes

21) No
22) No
23) No
24) No
25) No
26) Yes
27) No
28) No
29) No

22. Before the dRPC Project started working with you four years ago, were you doing the things mentioned above?

1) No
2) No
3) No
4) Yes
5) No
6) No
7) No
8) No
9) Yes, but like I said earlier we were not doing these dialogues within the traditional leaders 4 years ago
10) No
11) Not all of them, only a few
12) No
13) Yes
14) Yes, some but there was not much focus on RH and birth spacing
15) Yes but there was no discussion on birth spacing
16) Yes, I was but I have better understanding of the issues now
17) No
18) No
19) No
20) No
21) Yes.
22) No
23) Yes.
24) Yes; but only a few; because I was alone
25) Yes
26) No

Are you doing them now better/ in greater volume or frequency?

1) But now we are doing them more and better
2) Yes
3) I am doing them now in greater focus and frequency
4) We are doing these IEC activities & discussions better now
5) No
6) Yes, a lot better, the difference is clear, esp. in the areas of improved messages on child spacing
7) Yes; yes

8) Yes; doing a lot better now; included activities and mssgs. of child spacing and RH
9) I am doing the work better now
10) No
11) We are doing some aspect of our work better especially related to information on birth spacing
12) No, but I am now including more birth spacing issues in my preaching
13) Yes, doing them better now especially the inclusion of birth spacing in some health or sponsored talks
14) dRPC came and helped to identify and trained people within my community and empowered my committee on health to be able to participate on all RH, Family counselling, and health matters. So they have involved the entire Emirate now .
15) Yes. In better quality
16) Yes. I am doing sermons, counseling & speeches better, and there is better health facility attendance and utilization of birth spacing now compared to the past
17) No

23. Do you feel the dRPC Project has increased your understanding and performance as TRLs in teaching your congregations/communities about women's reproductive health and birth spacing?

1) Yes, absolutely.
2) Yes.
3) Yes.
4) Yes
5) Yes
6) Yes
7) Yes.
8) Yes, very much; particularly the trips to Mali and Cairo
9) Yes.
10) Yes
11) Yes, absolutely
12) Yes
13) Yes
14) Very well
15) Yes
16) Yes
17) Yes, absolutely
18) Yes
19) Yes indeed.
20) Yes
21) Yes indeed.
22) Yes
23) Absolutely Yes,
24) Yes,
25) Yes, in many ways
26) Yes,
27) Yes, absolutely.
28) Yes

Why

1) "Equipped us with the necessary knowledge to address people's concern."
2) "We have been sensitized and trained, we can now address people's concern better."
3) The training and experience during the training by dRPC has helped a lot. Only now I am

able to do more since I have more knowledge and justification to speak to people.

4) "Even dRPC's approach changed in the course of implementation (after cultural/religious considerations - with the involvement of TRLs."
5) The Egypt experience gave us more confidence to reach the community.
6) Yes, because of the opportunities I was exposed to by dRPC I now understood women's health, child health & birth spacing and my role as a TRL in helping our communities to understand. I used to think it was the responsibility of government alone to create this understanding
7) "Now there is more demand for health care services by the community."
8) Because in the past I was not in support of birth spacing and delivery in the hospital although I was in support of ANC but I know better now
9) Yes, because in the past there were little dialogue with other traditional leaders as well as fewer ANC attendances, RI, and health facility utilization by the populace in our rural areas but these have all changed now and all these have improved significantly in Gandi town & surrounding villages
10) Now I address the community more confidently.
11) Now we have several methods that we adapted for teaching our women on RH, and child spacing
12) Gave me experience, invited me on advocacy events to neighboring states
13) I now discuss RH issues and challenge and even advise women from an informed position. Built my counseling and guidance skills to talk to women more adequately on birth spacing
14) Now comfortably can discuss FP, use of contraceptives with women and even encourage husbands/men to support spouses on FP.
15) We are able to utilize male scholars to reach community men on key areas of RH.
16) I have a better understanding of birth spacing and MCH issues now
17) Because the dRPC gave me additional knowledge and also stimulated me to do additional research that expanded my understanding of RH/birth spacing
18) "I was made to understand that we should not rely only on government in carrying out developmental activities."
19) "dRPC has become a model - a success story that we share with other development projects."
20) "With the knowledge I gained, I can now stand in front of women to address them on health-related issues."
21) "I got first-hand information and was convinced by famous religious leaders on issues regarding birth spacing."
22) because we benefitted from a better understanding about discussions around birth spacing through our interaction with dRPC
23) Because the Mali trip helped me to have clearer picture of birth spacing in Islam and I now use this knowledge to explain better to critics
24) "because our understanding of birth spacing issues and our roles regarding it were elementary, & dRPC opened our eyes to this and we are now at a more advanced stage in this regard"
25) More women now acess RH , Child spacing services
26) by increasing my RH knowledge
27) Because I have a better understanding of my role in health and the issue of birth spacing than before

Or Why not?

<u>At end of session ask</u>:
Is there anything else you would like to tell us or ask us?

1. There is the need for the provision of means of transportation and megaphone to be used for community mobilization.
2. Was dRPC funded by USAID?
3. Entry point in community should be non birth-spacing initiative, e.g. skill acquisition centers to cope with immediate needs, e.g. water, employment, hunger. These will build rapport through which we can later introduce messages around birth spacing.
4. There is the need to educate people more. Sensitization/mobilization is most effective in a literate society.

5. dRPC should continue. Most projects winded up without fully implementing their plan, hence did not achieve the desired result.
6. Also new projects should enter into partnership with state and local governments to get their commitments to sustain the developmental activities.
7. There is the need to sustain the dRPC initiatives of bringing together TRLs to champion a common course.
8. There is the need for the provision of means of transportation for community mobilization.
9. How do I respond to those that accuse me of being a government sponsored preacher?
10. Can dRPC continue its activities because these have ebbed in the last 1year and possibly extend it to rural areas
11. dRPC should continue its activities in Sokoto state. From the closing-out of dRPC, mobilization activities became low. Now we begin to witness maternal mortality, 7 cases recently within my locality.
12. dRPC project should continue to help sustain all that has taken place in the community
13. I encourage development progs. To target more religious leaders in subsequent health programs.
14. Pl. include education in the dRPC project components—will help to address issues on early marriage and tackle some RH issues that women face.
15. Advocacy to local philanthropists and politicians to fund small scale outreaches; extend this dRPC efforts to rural areas because that is where the bulk of the problem is at the moment
16. There is the need for a follow-on project for continuity of the good initiative.
17. There is the need to take TRLs to developed countries to see how their systems work.
18. Development workers/projects should endure and exercise patience in implementing activities.
19. There is the need for follow-on project, with close supervision and evaluation of success.
20. There is the need to follow-up on Group Action Plan and Individual Action Plans to identify gaps and challenges.
21. It is important to attach or link a health worker with technical knowledge on birth spacing methods to groups of preachers that go on outreach to rural areas so as to give appropriate support and advise in such places because this is a common challenge faced by preachers
22. Expand dRPC activities to rural areas, reach out to religious leaders who are closer to the rural people.

ANALYSIS FOR KEY INFORMANT INTERIVEWS WITH POLITICAL LEADERS (PLs)

State

Sokoto LGA___Gandi, Rabah, Sokoto town & Bodinga, South Sokoto and Gagi

Zamfara Gusau, Anka, Talata Mafara

What do the PLs believe about women's reproductive health and birth/child spacing?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Why do you feel this is important? And why do you feel it is not important (if a respondent does not see this as important). 1) I feel strongly that the reproductive health of women and the frequency of child birth is very important so as to prevent maternal deaths and because frequent pregnancies and births by a mother is a burden to the health of the mother 2) Yes; important to take care of the health of the mother and children. In the past community interpretation of Islam would not allow birth spacing except for certain medical condition where it was necessary. 3) Yes I feel that it is important to give priority to maternal deaths because they are related to poverty, illiteracy and lateness or delay by mothers in attending health facilities when they are ill. On the other hand, it is important to consider the health of children too because they are not as strong as adults and are more susceptible to various illness 4) Yes; it involves women/children's health. According to religion we are supposed to protect women. In this area women population density is high. 5) Yes; there is a need to give emphasis on RH and birth spacing. Stats are not good 6) Yes; so as to reduce maternal/child mortality 7) Yes; there is low ANC, high home delivery, religious and traditional barriers, low education level for girls, and poverty 8) Yes, because they are our mothers and it is important to protect the lives of our children too 9) Yes; women's health is essential for bringing up a healthy baby 10) Yes (strongly), Maternal health is very important because it is the same as the health of the society while the health of children is important because they are the adults of tomorrow. On the other hand, birth spacing is important 4 preventing "RURRUTSA". And it became widely accepted in the state when religious leaders were now made aware that the aim of birth spacing is not to limit family size. 11) Yes; During his tenure took part in dRPC retreat meetings; 12) Yes; Zamfara has high MMR, which is a great concern. Ghana trip taught us that the lessons we learned there can be adapted here. Several years ago people believed child spacing was against religion. This has now changed. 13) Yes; Women's reproductive health is very important since they produce women leaders of tomorrow. For healthy mothers and children 14) Yes; To reduce problems associated with maternal mortality. 15) Yes, because maternal deaths is a big problem in Zamfara state and birth spacing has a role to play in the health of the mother and child. While healthy children will grow to become the healthy adult of future society. 16) Yes. Birth spacing is very important especially in our context where there is high rates of poverty and large extended families in our communities. Birth spacing also enables mothers to regain their strength & health after every pregnancy. The health of children is very important to consider because they are vulnerable & easily fall sick 17) Yes; pregnant mothers have difficulty in childbirth, esp. in rural areas. Communities not interested in ANC; Child spacing gives both husband and wife time to get ready for next child, giving them adequate time to prepare. Religion does not prohibit child spacing. Govt. making efforts to increase awareness.

18) Yes, they are very important because a man can only be content if his family are fine
19) Yes; the importance of MCH cannot be overemphasized in Northern Nigeria, particularly Zamfara state, which was once classified as 'danger zone'. The involvement of TRLs (study tour etc.) who sensitized the communities (including rural areas) by making pronouncements on the importance of MCH has made a difference. Today, we are beginning to see some positive results (from the service statistics available).

2. Do you believe there should be preference for boys over girls? Why or why not?

1) There is no preference for boys over girls at the policy and program level at the LGA, and in fact, girls can be said to be preferred because there are more intervention programs targeting girls than boys in the LGA such as the girl-child initiative (UNICEF), the "Budurwa" project by the Life Helpers Initiative for preventing early marriage and which also provides grants to economically empower girls.
2) "Budurwa" is the Hausa word for a pubertal adolescent girl
3) No preference; humans don't have a control over gender of the child; pray that both boys and girls would do well
4) No, there I do not have any preference for boys over girls, and neither does the policy of the govt. As a parent, I actually prefer girls to boys because they take better care of their elderly parents than boys. When boys marry, they tend to forget about taking care of their parents and concentrate on their families only. While even within the wider community, the preference for boys over girls has being declining over time
5) No; they should be equal because God has provided for both, and children are a blessing from God.
6) No preference; every child should get equal education
7) No; there should be preference for both boys and girls because both need attention and care to become responsible people
8) No
9) No; because what I wish for in my children is "albarka" (blessing). However, in our community, boys are generally preferred because it is expected that they will in turn take care of the father during old age. That is why the announcement of the birth of a male child is more forcefully announced at gatherings in my belief
10) No preference; because if you train both well, they will make good citizens.
11) Personally I have no preference towards having girls or boy because I believe children are given by Allah. In addition the focus of the government is in favor of the female eg more funding is giving to ANC and nutrition programs
12) No preference. God gives you what He wants and you don't know how they will turn out in the future
13) No preference. They all are my children, and need equal education.
14) No; Both the male and female children can be responsible people if well trained and well brought up.
15) No; They are both children with equal rights
16) No, in fact it is the other way round in this LGA because after recognizing the need for female health manpower, Gusau LGA is enrolling and training girls from different communities at the school of midwifery who will on graduation be employed in their communities of origin to reduce the problem of maternal deaths.
17) However at the community level there is some boy preference but dRPC had done some work in improving girl child education in the LGA
18) No. Because they are the same, girls are more caring. However, in our culture boys maybe preferred for reasons of carrying on the family name. The policy of government may favor girl child education so as to help in achieving the MDGs in the state
19) Historically Arabs preferred but there should be no preference. Girls often give more attention to parents. Girls more sharp than boys.
20) No, because both are equal. In fact, programs in the LGA favor pregnant women
21) No, they should be treated equally.

3.Do you think spacing births/children in a family is beneficial for the health of mothers and children? Why? or Why not? [If response is negative skip to Question no. 5]

1) Spacing births is good for the mother because it helps to prevent maternal deaths from frequent pregnancies and births. It also allows the children that have been born to get adequate nutrition
2) Seen benefits in my own family; mother and child remain healthy with spacing of birth

3) Yes, it is beneficial because “rurutsa” (frequent births) does not allow a mother and her child to be healthy
4) Yes; it is. Economic problems can be avoided if children are spaced.
5) Yes; beneficial for even the father; mother does not get good nutrition, can lead to maternal deaths and child’s health is jeopardized if there is frequent child birth
6) Yes; to make both mother and child healthy
7) Yes; spacing children is beneficially for all aspects of life
8) Yes, I believe so because if you compare between children whose mothers adequately or inadequately space their births, it will be noticed that the latter are less healthier
9) Yes; after a woman delivers it takes a while for her to recover, so for the sake of the mother’s and child’s health spacing of birth is absolutely important.
10) Yes, it is beneficial because a family that practices birth spacing is likely to be healthy, be content, and have improved economic status and fewer hospital visit due to illness.
11) Yes; mother to take care of the child she’s breastfeeding.
12) Yes
13) Yes; To enable the women to live long and healthy; To ensure that the children are all healthy
14) Yes; For health reason, economic reasons ,with more children comes with more needs for support and more work to earn more.
15) Yes, because it helps to keep mother & child healthy through allowing them to gain optimal growth before conceiving again
16) Yes, because it allows the mother & child to grow optimally and regain their nutritional states before another pregnancy
17) Yes; Many/frequent births prevent taking good care of children.
18) Yes because it allows a couple to prevent frequent births
19) Yes “Imagine a nursing mother conceiving another pregnancy within a short period after delivery. It’s devastating. Her system is weakened with every birth she has, and when the uterus gets ruptured, that’s the end.”

4. What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
1) Birth spacing can be achieved through the use of modern contraceptives such as injectables e.g. “jedel”, “implanon” or pills e.g. “microlut”, “microgynon” or male/female condoms. They have IUCDs but only the General Hospital (and none of the 5 PHCs in the LGA) has the manpower capacity to do IUCD insertions and IUCDs are generally not popular with women in the communities of the LGA. Women in the communities of the LGA prefer injectables and recently implants are becoming popular following community mobilization (done 3 times a week) for implants. All the 5 PHCs in the LGA have the capacity to insert implants
2) Pills, injections, IUDs
3) I know of local methods eg withdrawal method and the use of modern contraceptives such as pills, injectables, IUCDs.
4) Mobilizing communities, starting from grass-root level, so that everyone can be aware. They should know the importance of health policy; and that contraceptives or OK and are available. Any method women / men can use for child spacing: modern method such as condoms, and also traditional methods.
5) Pills, injectables,
6) Pills, injectables, implants
7) Breast feeding, implants, injectables, pills, condoms (not popular)
8) I believe that the man can practice abstinence after child birth or they can use pills, male/female condoms or injectable because abstinence may not always be possible
9) Any method which is not harmful to the mother. There is an Islamic method, and there are pills and injectables.
10) Modern contraceptives such as contraceptive pills, injectables and implants can be used to space birth. Traditional contraceptives such as amulets are also used for birth spacing in the community.
11) IUDs, injectables, pills, safe days, condoms
12) Inj., IUCDs, pills, withdrawal, vaginal spermicidals, condoms (male and female)
13) Use of contraceptives like pills, injectibles , IUCD, Condoms.
14) Pills, IUCD, loops, natural withdrawal methods

15) Calendar method, injectables, pills, IUCDs but these are no longer popular.
16) Condoms, pills, injectables & implants.
17) Pills
18) condoms, pills, injectable (preferred), IUCD, implants.
19) Oral pills, injectables, implant, IUCD; traditional (charm)

Did you know about these contraceptives four years ago?

1) Yes.
2) Only knew these superficially 4 years ago, the dRPC meeting gave me better understanding about these modern contraceptive methods
3) Yes; but dRPC gave strategies for increasing birth spacing
4) Yes, only IUCDs and Copper T
5) I have known about the modern contraceptive methods for more than four years now
6) I did believe these things, but the dRPC project was a confirmation of what I already knew and made it even more convincing and acceptable to me.
7) I have known about modern contraceptives for more than 4 years now (sine my days in school of health technology)
8) Yes; pills
9) Yes, but IUCDs were more used in the past 4 years
10) He knew all these 4 years ago
11) Yes; pills
12) I knew them all except implants which were introduced 2 years ago
13) Yes

What specific roles did the dRPC Project have in equipping the PLs?

5. Did you participate in any dRPC Project activities for building leadership capacity on women's health, birth spacing and contraceptives?

1) Yes
2) Yes
3) Yes
4) Yes
5) Yes
6) Yes
7) Yes
8) Yes
9) Yes
10) dRPC invited to Sokoto and Katsina for workshop
11) Yes; see # 7
12) Yes
13) Yes; Activities : Capacity building sessions on maternal mortality reduction
14) Yes
15) Yes
16) Yes

What activities (if any) did you participate in? How often? *[Probe for LDF/Retreat, Study Tour, Mentoring Visits, Advocacy Visits, Alumni Associations]*

1) I participated in some dRPC activities and I am aware that my LGA chairman & Director, PHC also participated in some dRPC activities, however the latter has been transferred to another LGA. She has heard of the Ghana tour because those that went on that tour facilitated / shared their experiences during the meeting at Sokoto. The following are the dRPC activities I participated in and they were very popular with health workers
2) HSP training in Sokoto in 2012
3) Review meeting (focusing on gaps & challenges following the HSP training)- 2012
4) Supervisory follow-up visit with dRPC team to LGA Chairman & Director PHC – 2012
5) One seminar at Gusau, Zamfara on RH-FP. It was a two-day seminar
6) I attended a 2 day meeting in Abuja (in 2009 or 2010), after which we were supported to form an

association of technocrats (did not have TRLs in the association), which I was made the chairman for Sokoto state. We organized 3 meetings on a monthly basis but the attendance was very poor (3 out of 18 members attended) and we got discouraged. We also made attempts to see the chairman (Hon Goronyo) for the 3 states and he gave us appointments twice but he failed to turn up

7) Ghana tour and alumni association headed by Dr. Gandi
8) Study tour in Ghana; Alumni Network; Action Plan with advocacy initiatives to increase govt. budget for RH and FP
9) Training on FP; effectively distribute methods of FP among women; so many trainings from other orgs
10) Ghana trip; Alumni association,
11) I have attended a 1 day workshop on maternal mortality in Abuja organized by dRPC (in 2011 or 2012) after the meeting, an alumni association was set up with a chair, secretary & PRO. The association was slated to continue meeting. He thinks he also attended another meeting at Sokoto with TRLs but he can't remember precisely
12) Seminars/workshops on RH/MCH for NGOs and ….for policy makers; designing individual plan of action, collective plan of action, workshop in Abuja (for overall assessment on individual w/plan and it implementation), workshop in Kano
13) Several meetings at Sokoto Guest inn Sokoto, a retreat at Kano, a study tour to Ghana, two Alumni association meetings and 1 monitoring/ advocacy visits to LGA PHCs.
14) Ghana trip, alumni association, IAP, advocacy
15) Workshop on maternal mortality Reduction (MMR); Training on how to conduct community mobilization , advocacy on Reproductive health and child spacing in the communities and community sensitization on ANC and child spacing; Monthly
16) LDF in Sokoto (x1); LDF in Gusau (x1); Heard of Ghana Study Tour; Part of network
17) Study tour to Niger State (to study how they set up the SPHCDA bill in Niger state)
    a. Part of the team that paid advocacy visit to Zamfara State House of Assembly
    b. The SPHCDA bill in Zamfara state was mainly supported by PRRINN-MNCH but with some support through the efforts of dRPC
18) Meeting at Abuja &? Sokoto (couldn't make it)
19) Ghana study tour for 10 days. 2011 topics: effective communications MCH progs in Ghana. Using that knowledge in the current role in the Min. of Cultural Affairs and Tourism.
20) LDF at Sokoto (x1); Meeting at Gusau (x2); Heard of Ghana tour
21) Workshops in Zamfara and Kano.

6. How effective were these activities? Which activity was most effective? Why?

1) The HSP training was the most effective for me because they went all over FP, ANC & delivery knowledge and skills including the minimum service package
2) Effective; we contributed a lot; discussed LGA constraints; advocated for increased funding for health—building hosp/clinics: also organizing renovations and equipment; provided all services related to birth complications free of charge; facilitated training of birth attendants. The Gusau seminar helped him to understand and take initiative in his LGA
3) All the activities were effective
4) Ghana trip exposed us to ways that other countries have adopted for improving their population's health, particularly RH/FP. The Ghana trip and alumni association interventions were equally important.
5) "Ghana study tour was most effective as it increased knowledge and experience; it made me more aware of maternal and child health"
6) Does not remember
7) Ghana visit-very useful. Many changes made as a result. Met with Health Minister, First Lady, Doctors and learned how they improved health in Ghana. Started measles IMZ campaign, lowered measles rate, use of misoprostol and chlorhexidine at community level, and Magnesium Sulphate in hosp. introduced.
8) I was impressed most by the maternal mortality focus of the meeting because it involved pregnant women which directly or indirectly affects everybody, however all the activities were useful to me
9) Workshop (retreat) in Abuja, on assessment, evaluation and experience sharing was most effective,

because it allowed a lot of sharing from dRPC project participants from other states. There was cross-learning.

10) The most effective activity for me was the study tour to Ghana, because it enabled me to see the health system in Ghana, the minister of health in Ghana and also Nigerian Ambassador to Ghana.
11) Retreat.
12) All were very effective. The most effective was the training of HSPs. He facilitated the trainings.
13) Very effective; Most effective was the community Sensitization on ANC and child spacing
14) Very effective; Most effective--the training and capacity building sessions
15) The LDF was most effective
16) The most effective was the study tour to Niger State
17) The most effective was the Gusau meeting
18) Most effective: Kano meeting

Why?

1) It helped build and shaped our knowledge or reproductive health
2) Because many people were reached with the message on child spacing and importance of ANC;
3) because of the caliber of senior & influential people that attended
4) because they interacted with their peers i.e. the Niger State legislators especially the Niger State House Committee on Health and the Commissioner of Health
5) Ghana trip was successful because it allowed us to share new knowledge to MOH staff.
6) Gusau mtng. here I met with senior health stakeholders in the state and networked with them, but the LDF meeting also opened his eyes to what is expected from a leader
7) There was no distraction, there was good interaction with various intellectuals.

Which one was the least effective? Why?

1) The alumni association which did not progress because of poor attendance at meetings. However, I was very galvanized by the maternal health statistics presented at the meeting and I was able to network or share experiences with colleagues from other states at the Abuja meeting
2) The advocacy visits; interagency collaboration was missing. It included budget preparation and interaction between agencies.
3) Does not remember
4) Alumni Assoc. was least important
5) Alumni association, since it did not receive government support and so was unsustainable.
6) None was ineffective, they all were quite effective.
7) The least effective activity for me is the Alumni association because the association was formed towards the end of the dRPC project when there was little or no support for the alumni meetings. The chairman of the alumni association was Dr Gandi and the association met only twice.
8) All were effective
9) Advocacy; because policies were not changed, activities not implemented and policy makers were not supportive to the plan, despite advocacy efforts.
10) None was least effective all were effective
11) None

7.Did the dRPC Project support you to develop a plan of activities? In what ways?

If answer is negative, skip to Question no. 9.

[Probe for Individual Action Plan (IAP), Group Action Plan, Monitoring Plan, Sub-grants for carrying out Action Plans]

1) No; the LGA chairman & Director, PHC had an IAP but the latter have been transferred
2) Yes; developed IAP; but plan was not fully implemented.
3) Yes, I developed a plan of activities with support of dRPC
4) Yes; they supported me in developing a state plan with line ministry input. dRPC played a role of bringing everyone together to give inputs in the plan.
5) Yes; supported me to develop an individual action plan.
6) No
7) Yes; contributed to strategic budget line development, as a result of IAP implementation.
8) Yes, they designed a GAP

9) Yes; dRPC helped me develop a program plan of action that was achievable. Both individual and collective plans of action
10) Yes, they supported me in developing my IAP.
11) Yes;
12) Yes; developed plan;
13) Yes; They helped to draw up a guideline and template for my work plan
14) Yes; Ways: dRPC helped me to plan activities
15) Yes, GAP
16) No
17) Group plan of action—dRPC helped to develop
18) Yes, GAP for his LGA
19) No

1. Did you develop an action plan? What did you include in it? How much of your plan did you accomplish? Which activities?

1) Educating TBAs; purchasing RH and child health related drugs for free distribution and CHEW training at School of Health Tech with assurance of job following graduation; decentralizing staff in LGA. Priorities changed with emergence of polio, with focus and resources diverted to polio eradication. Only 40% of the IAP was achieved
2) Yes, my plan included sensitization about RH issues for a specified community. It was not implemented because of the attitude of the alumni association
3) Yes; Included in my plan: capacity building for youth, esp for rural areas—social clubs, self help projects such as digging wells, renovating schools and other community needs.
4) Yes; developed a plan for initiating a CHEW certification training program for RH and FP.
5) No
6) Yes; construction of health facilities, getting equipment for facilities, advocacy steps to get budget allocated for these tasks and for health worker salary increases. Achieved about 90% of the state action plan. Increased budget lines, constructed 230 PHCs and equipped 66 of these facilities.
7) Yes, they designed a GAP but he can't remember but it was on maternal mortality. They did not do anything
8) Yes; included and implemented—sponsored some girls in the villages within my LGA to go to the School of Health Technology; now they have graduated and have work in the PCH in their villages. Also conducted guidance and counseling sessions for career building. I implemented about 80% of my plan.
9) Yes, I developed an IAP which focused on strengthening ANC activities as well as effective management of labour cases. I was able to use TBAs to identify and link pregnant women to their local health facility, as well as providing constant supply of routine ANC drugs to those selected health facilities. However, only part of this activities were accomplished because of lack of funds.
10) Yes; water supply, health and education because here in Zamfara we are left behind in health. Renovated two hospitals and equipped them during my tenure. Included in IAP 3 clinics for improvement of MCH, and involved men to reduce maternal mortality.
11) Advocated to diff. ministries for staff training; identified RH-FP problems and planned ways to address them; met with house members to advocate for RH-FP. 90% plan accomplished.
12) Yes; developed state strategic plan and included in it training of midwives, EOC training.
13) Yes; I included outreach activities like training and women group discussion on child spacing, advocacy to the ministry of health on women reproductive health; 80% accomplished: training and women group discussion on child spacing, advocacy to the ministry of health on women's reproductive health
14) Yes; activities for TBAs and support child spacing awareness programs in the community.
15) Accomplishment = 70 to 80 percent
16) Yes, GAP & we included sanitation, water hygiene, maternal health and they were all accomplished

because they did not require much funding

17) Cannot recall elements of action plan
18) Yes, trainings for LGA health staff. None was followed up or accomplished.
19) No

9. Before the dRPC Project started working with you four years ago, were you developing IAPs?

1) No
2) No; there was no guidance
3) No
4) Annual budget was the same as the action plan.
5) Yes; but dRPC helped us to develop costed plans (budget?)
6) No
7) Strategic Plan was made 9 years ago. But it remained shelved. dRPC Project helped them to update the plan and implement it.
8) Not now or in the past
9) No; dRPC actually helped me develop action plans, although I was already conducting activities related to women and children, but without a formal plan of action.
10) Yes, I started developing IAPs more than four yes ago with PMM.
11) No; I was not developing any plans at all.
12) No; It was as a result we had in katsina that I was able to develop my skills in workplan development
13) Yes, because other Partners had taught us how to do it.
14) No
15) No
16) Yes.
17) No

Are you doing them now?

1) Yes; I develop annual action plans and budget (government plans and budgets are equated to 'action plan.'
2) N/A
3) No, except for the normal state action plan and budget.
4) Yes; we develop and implement action plans and are currently implementing them now.
5) I have no IAPs at the moment
6) No. And because of dRPC retreat there was lot of encouragement
7) Yes; each year state strat plan is developed.
8) Yes I am now able to develop work plans and even share with other colleagues so as to have their inputs and secure their participation in some of my programs
9) Yes, we are still doing it especially for routine immunization
10) No
11) No.
12) Yes for RI & IPDs

10. Do you feel the dRPC Project has increased your understanding and performance in the field of women's reproductive health and birth spacing in your State/LGA? Why or Why not?

[Probe for number of RH/FP policies, RH/FP budget lines, RH/FP parliamentary bills, RH/FP Advocacy Visits]

1) Yes, through the trainings (MLSS, MSP) that they received. She uses these experiences in her day to day job. There is also another scheme by TSHIP in the LGA called the "community based health volunteer" which has helped in uptake of maternal & FP services in the LGA
2) Yes; I learned a lot. I learned with little resources a lot can be done. Communities showing positive health behavior now.
3) Yes, because it made me aware that I have a role in promoting health
4) dRPC assisted me in getting exposure to international scenario in RH/FP even though I am an 'old timer.' I have increased the annual budget for youth related RH/FP/HIV activities.
5) Yes; Ghana experience was very helpful in inspiring me to introduce the CHEW training program. Also, the advocacy visits to government officials for budget allocation for RH-FP
6) Yes; helped me to retrain our staffs on issues of birth spacing

7) dRPC brought policy changes/improvements in RH-FP. They had a simple but effective policy—they brought TRLs and PLs, organized tours and workshops and discussions to increase knowledge and commitment.
8) Yes, especially on women's health
9) Yes; dRPC increased my understanding especially in the area of individual/government/state responsibility; and helping me to develop action plans over which I have ownership. We developed IAPs annually alongside with others, e.g. member of House of Assembly of Sokoto State.
10) Yes, I have learnt a lot of new stuff that I ought to have known from dRPC trainings as well as about what kind of health system we ought to be using in Nigeria. I am unaware new policies or guidelines for RH/FP but I am aware that several advocacy visits were made by my senior colleagues together with the dRPC team
11) Yes; In Ghana learned: all pregnant mothers brought under a health insurance scheme, which can be adopted here. In Ghana there is '0'tolerance for maternal deaths.
12) Yes; Because I can now assist and even take part in activities of health service providers, especially in the areas of community dialogue with women to encourage them to access family planning services.
13) Yes; because now I can plan and implement community /state level RH activities eg sensitization of women on FP and child spacing , effectively and also report my successes .
14) Yes, because they facilitated a linkage between traditional rulers and the LGA through which we get a lot of things done
15) Yes but very slightly because the dRPC interaction with him wasn't consistent or sustained
16) dRPC made me enlightened and committed in RH and child spacing plus other health issues.
17) Yes, dRPC opened my eyes to the leadership role I should be playing in RH/FP
18) Yes; "The health sector was strengthened as a result of the involvement of TRLs, we (health professionals) shared views with them. This has never been done before dRPC."

<u>At end of session ask</u>:

Is there anything else you would like to tell me or ask me?

1. Why has she not heard from dRPC for some time now?
   I told her the project has ended last year
2. She sent her thanks to dRPC and eval team
3. Do not allow LGA to go alone in making changes in the community. Work with the State Ministry so special funds are allocated to LGA.
4. I wish dRPC would continue to meet with me to give me encouragement and continue their work in northern Nigeria.
5. Intervention didn't last long enough. Re-starting dRPC interventions and scaling up will reach more people with RH-FP benefits. VVF is important resulting from early marriage, low levels of formal education, and frequent pregnancies
6. "USAID has done a lot of community development activities for this community." USAID supported the communities with commodities, capacity building and even some renovations of health facilities
7. Transfer of political leaders and decision makers is not a total defeat. In new locations where they are placed, they introduce new health policies and initiatives thanks to the training dRPC gave them. Case in point the Dir. of PHC in Sokoto State Govt. who was trained by dRPC but was transferred to be the Dir. of School of Health Technology started a new training program there for the CHEWS which he included in his activity plan.
8. Advice—there is need for developing sustainable capacity for implementing activities even without foreign assistance.
9. dRPC was able to bring out together Ulemas and traditional leaders to advocate for reproductive health rights. dRPC should be given another chance to replicate their work in Sokoto State. Even though they were not based in Sokoto State they have made a lot of impact here.
10. Are there any plans for the return of the dRPC project because I like to be part of it?
11. Issue of health important, because indicators are going backward. Projects should go to the grass-roots level and not be focused at state level.
12. TRLs are permanent and the training is sustainable. But political leaders are also important because they can secure funds.

13. Following Ghana trip learnings were shared widely among state and LGA staff, so transfer of staff doesn't hamper the training outcomes, since the other staff in the dept. become aware of the disseminated learning and policies. Appreciated dRPC efforts.
14. dRPC in future programming should please include more funding that will boost the morale of TBAs in the community of magazu not far from Tsafe LGA.
15. We should ensure mothers don't die in the course of giving birth to children.
16. I want dRPC to continue supporting the state, we still have high maternal mortality at the rural areas. dRPC should involve other influential people at the community apart from TRLs (e.g. leaders of CBOs)

ANALYSIS FOR FOCUS GROUP DISCUSSION WITH MEN IN THE COMMUNITY

Sokoto **Gandi, Rabah, Sokoto Town & Bodinga, Sokoto Gagi**

Zamfara **Gusau, Anka, Talata Mafara**

What do the men in the communities believe about women's reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? 1) Yes, it's very important (unanimously) 2) Yes 3) All the men at the FGD regarded as important the reproductive health of women and the frequency of child birth, and the wellbeing of the young children and their mothers. They said their community is very advanced in issues of RH/FP. They proudly said that their TL i.e. the Sarkin Yakin Gagi (SYG) is a renowned dRPC champion in the state and he was part of the tour to Egypt. The SYG said he learnt a lot about FP/RH which greatly influenced his participation with women's health (e.g. community based use of misoprostol/chlorhexidine). 4) Yes =10, No response =2 5) Yes, women's and children's health is important (unanimously); birth spacing is also important (11/12 participants). 6) Yes=10 2. Why do you feel this is important? 1) "Women are our mothers and children are the leaders of tomorrow." It is important to encourage pregnant women to go for ANC and deliver at the hospital and children to go for immunization. To demonstrate how important it is, the community provided housing accommodation for the health work in-charge of the health facility and also secured a vehicle from the MDGs office. 2) I believe that it is important to maintain the health of our women because they "hold together" our homes while children are not very "strong and they are vulnerable", so they should be taken care of because they are the "adults of tomorrow". 3) Another pointed out that children that well cared for are healthy and have vitality, while another said "it is important to take care of our women in the rural areas because they don't have ready access to health facilities" and they usually need more support 4) One respondent said that women are the "mothers of society", so if they are healthy & educated, then the whole society is healthy, and vice versa. Other participants generally agreed with him 5) Women are important members of society and the stress they undergo during pregnancy makes them vulnerable, so they need special priority. Children on the other hand are susceptible to illness and are the future adults of any society and need to be taken care of 6) "Women suffer childbearing. When they are in labor, sometimes getting the transportation to take them to the hospital becomes a challenge, and this makes them suffer more. Therefore we need to put-in our best to take care of women." 7) "What I heard from religious leaders about the importance of women's and children's health changed my attitude. Whenever one of my family members is sick I take them to the hospital." 8) "A pregnant woman is in a critical condition that requires utmost care, so also the children, if they are not properly taken care of at infancy, some diseases could have a permanent effect on their lives."
3. What is an ideal age for a woman to get married? 1) From 15 to 20 years (unanimously). 2) 21 years (while 2 respondents felt that their recommended ages will allow for these girls to be adequately

mature before marriage), 14 – 15 years (4 said this is the best age because of my religious convictions), 18 years, 13 years (1 respondent said I married my wife at the same age)

3) Some said 18 years (x2), 20 -25 years if the girl wants to finish her schooling but 18 years if she is not attending any school, 16 – 17 years i.e. if the husband can adequately cater for her health and her other responsibilities
4) 18 yrs (2), 14yrs (x1), 13 (x2), 15 (x2), 6 – 8 yrs.
5) At least 22 years; 13 to 15 years; 18 to 20 years; 18 to 20 years; 18 to 20 years; 18 to 20 years; 21 to 22 years; 20 years; 17 to 20 years; 16 to 17 years; 18 to 20 years; 18 to 20 years; 22 to 25 years.
6) 12 years; 12; 12; depends on the maturity level (physical development) of the girl; 18; 20; 18; 12; 12; 12; 15; 18; 12

At what age should she have her first baby?

1) From 24 to 26 years (when she becomes fully mature)
2) She should start bearing children at the age of 20years (x4), 22 years (x2) & 17 years (x2)
3) 20 years (x2), 22 years (x2), 21 years,19 years (x3)
4) Anytime that Allah wills, 19yrs, 20yrs, 16yrs, 15 – 16 yrs, 18 -19yrs
5) At 18 years; at 19 years; at 19 years; at 22 years; at 25 years.
6) 15; 19; 20; 21; 19; 19; 14; 19; 14.

Four years ago what did you believe about these two questions?

1) From 10 years and first have a child almost immediately.
2) Four years ago we all would have told you that the girls should be married off at the ages of between 12 - 13years and should start bearing children between 16 – 17 years.
3) We know that there is a big change in age at marriage and giving birth within Gagi community between now and four years ago. Because 4 years ago, none of the community members would have listened or spoken to you. We used to marry off our female children from between 9 – 12 years of age and they started bearing children at the ages of 10 – 12 years
4) Had same opinion
5) The same opinion (unanimously).
6) 12; 12; 12 (getting married); 14; 13; 15 (first baby).

4. During pregnancy should a woman consult a doctor/health worker/midwife?

1) Yes (unanimously), the moment she's around 4 months pregnant.
2) Yes (if there is a pregnancy related problem, all =8), but if no pregnancy related problems (Yes= x6, because she will receive health talks and check up during ANC visits) (No = x2 , because it will be cheaper for me)
3) Yes – 9, No =0. One respondent said that it was now regarded as compulsory within the Gagi community for all women to attend ANC. This was generally agreed with and they attributed it to the community awareness and mobilization efforts of their TL "the SYG has really stood up & intensified community mobilization efforts". Community members even know & practice the community based use of misoprostol for PPH & chlorhexidine for cord care after delivery because of the efforts of SYG and TSHIP.
4) Yes = All
5) Yes = 12. To check the fetal wellbeing; if a pregnant woman doesn't go for ANC, a problem could be discovered when it's too late.
6) Yes=All

5. How many times should a pregnant mother consult a doctor/health worker/midwife?

1) From 4 months until delivery; 10+ times; as advised by the health workers.
2) I think she should start when she is 6 months pregnant & go weekly until she delivers (12 visits), while another respondent said my wife should go weekly or as instructed or needed throughout pregnancy i.e. between 20 – 32 visits approximately
3) A participant said I believe a pregnant woman should start consulting a doctor once her pregnancy is 4 months old, so that she initially visits the health facility monthly and fortnightly in the latter stage of her pregnancy until she gives birth to the baby. Another said that a minimum of 3 visits is required while

another said up to 8 visits in a pregnancy is ok
4) 6-7 times, 8 times, 7 times, more than 10 times
5) From 4 to 6 visits; at least 12 times.
6) About 4 or 5 times; as prescribed by the health workers; about 6 or 7; 7; 4; 6 to 7 times; 7; 7; 7 or more; 4 times.

6. Where should a pregnant mother have the delivery of her child: at home or at a health facility?
1) At the hospital (unanimously)
2) I believe that deliveries should take place in the health facility
3) A respondent said the health facility is the best place, but in practice most deliveries occur at home but in the presence of a midwife who is invited from the health facility because the local health facility runs shift duty system and there is always a staff/midwife available. Another respondent said, a number of deliveries don't take place in the health facility because the women deliver normally at home during the follow up interval prescribed by the health workers.
4) Hospital: Yes = 8, because she will get good care; No= 1, because I will have to pay for services and because of negligence & attitude of health workers
5) At the hospital (9 respondents); at home if there's no complication (3 respondents)
6) At home (3 participants; at hospital (8 participants)

Why?
1) To avoid complications.
2) Because the health worker will check my wife well and will handle medical problems that may arise (this was generally agreed by all except for 1) And that respondent now said that, all the deliveries that my wives have ever had were normal and took place at home except for 1 of my wives who has medical problem and because of that she only delivers in the health facility and not at home.
3) It is better to deliver in the health facility because in the event that any complications should arise involving either the mother or her child, then it will be easier to intervene and save their lives within a health facility
4) To ensure complications are properly handled when they occur.
5) "That's where she'll get proper care;"
6) "If a woman is taken to the hospital, the impression is that she had complication, but if she delivers at home, it signifies there's no problem;"
7) "My wife had prolonged labor at home, but the moment we took her to the hospital, she delivered within 5 minutes"
8) "Sometimes the health workers harass the women in labor"

7. How many children should a woman have in her life time?
1) 3; 5; 4; 7
2) 6 (x1), As Allah wishes (x1), 8 (x2), 10 (x2), 11 (x1) & 5 (x1)
3) 3, 10, 8 (x2), 5, 7, 9, 6, 4 were mentioned by different respondents, while one of the respondent said that any number of children without limit as long as they have access to quality care & if they are born at 5 yearly intervals
4) 12 (x3), 10 (x3), 11, 5 - 6, what Allah decides
5) Any number; 10; 15; 10; 6 or 7
6) 7; 8; as much as possible; 5, 12; 10; 10; as much as possible.

8. If several daughters are born to a couple but no son, should the couple continue to have children until they have one or more sons?
Y/N/Do not know/Refuse to answer*[Record the numbers of responses for each option] [Probe to find out reasons for the answers]*Four years ago what did you believe about this question?
1) Yes (unanimously), because a male child serves as a successor; the male child is easier to train. Same response 4 years ago
2) No (all =8) because it is not a big issue now, but in the past, our community had preference for buys and most will continue trying to get a male to bear the family name while the female child will eventually marry into another family

3) Yes = 6, No =2
4) The respondents that generally said "yes" explained that they will continue seeking for a boy because they have opted for a small family size in the first place and boys are generally preferred, And one said that girls are "like the shadow of a palm tree that provides its shade to other trees rather than to itself". On the other hand, the respondents that said no to the questions said that they will be content with having only girls
5) Yes = 5, because I need to have a boy who will help me in my occupation
6) No = 7, because there is no difference between boys and girls, in fact girls are more loving and caring to their parents
7) No; same response 4 yrs. ago.
8) No "what's important is a blessed child, girls sometimes proved to be more helpful to their parents"
9) Yes "I will marry another wife"
10) No "both boys and girls are a blessing"
11) No "if I exceed the number (of children) I target (10), my wife may have problem"
12) Same thing four years ago

9. Who decides in the family about whether or not a couple should continue to have more children?
1) The husband (unanimously)
2) The husband usually make this decision in the family (this was unanimous)
3) The couple decides was chosen by 6 participants and they believed that this position was favored by Islam. The other 3 respondents felt that the husband is responsible for taking that decision
4) Couple's decision = 7, because raising a family is a joint project and this is recommended by Islam
5) Husband's decision = 5, because he is the breadwinner of the family
6) It's a joint decision (unanimously)
7) It's a joint decision (unanimously).

10. Do women in this community suffer from obstetric fistula?
Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
1) Very rare (one in Maradi, now recovered/ healed).
2) No (x7), but 1 respondent said he heard of a case in the surrounding village who was taken to Sokoto. However, all the respondents generally agreed that it was on the decline
3) No = 9
4) Yes=All,
5) Yes
6) Yes=All

Has the number of women who have such fistula increased, decreased or remained the same through the last four years?
1) Incidence has been largely controlled.
2) VVF is not common now compared to 4 years ago said one of the respondents
3) But is declining rapidly
4) Incidence decreasing
5) Incidence decreased

11. Is female genital cutting widely practiced in the community?
Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
1) No (unanimously)
2) No (x8), FGC is not part of our traditions
3) No = 9. It is not done in Sokoto state said all the respondents
4) No = All.
5) No=All
6) No=All

Is female genital cutting harmful for girls/women? Why? Why not? Has this practice increased, decreased or remained the same through the last four years?
1) Yes FGC is harmful, but there are isolated instances of removal of the clitoris for " female illness or libido" by traditional barbers but this has also declined

What do the men believe about birth/child spacing?

12. Do you get information or hear messages about birth/child spacing and contraceptives? What is the primary source of your information on these matters?
    1) Yes; From health workers and intensified preaching by religious leaders.
    2) We have heard of birth spacing mostly from health workers in the health facility, or through our wives or through our ward development committee. But 4 years ago, it was through radio
    3) Yes (was said by everyone), The primary & effective source of RH/FP in our community is our TL. But other available sources in the community are public announcements by Town announcers sponsored by NGOs including distribution of condoms & posters. This is in addition to radio programs but these are generally not trusted by the community.
    4) Yes, from the radio, some sermons of our teachers & health workers at health facility.
    5) Radio; at the hospital from health workers; from NGOs.
    6) Yes; Radio; from religious leaders.

    Four years ago what was your primary source?
    1) None.
    2) However, four years ago, our major source of RH/FP messages was the radio but we did not trust these messages that were broadcast over the radio by someone we did not know, and we did not believe those messages because it is usually government sponsored
    3) These were the same sources minus sermons of our Islamic teachers about 4 years ago
    4) Same: radio, hosp., health workers, NGOs
    5) Radio

13. Is it a good thing to space child births and/or limit the number of children in a family?
    1) It's very important, especially considering the economic realities.
    2) Yes, because we will like to prevent (frequent births) "rurutsa" in our families because it can harm the health of our wives and the breastfeeding baby
    3) Yes (was said by all),
    4) Yes
    5) It's important (11/12 participants).
    6) It's important (11/12 participants).

    Why
    1) ensures the wellbeing of the child and the mother or why not?
    2) it is good to space children, because that is the way to allow the mother to regain her health & vitality, and the baby to become healthy and robust. It is not good to have frequent births ("rurutsa") and this has always being recognized even in the past
    3) Because birth spacing is permitted in Islam but limiting the number of children in a family because of fear of poverty is not permitted in Islam.
    4) To ensure the wellbeing of the children and the mothers
    5) Mothers need to have some rest. The pain they go through during delivery is inexplicable.

    What did you believe four years ago?
    1) Aware of it but no strong belief.
    2) We did not believe in birth spacing even for "rurutsa" 4 years ago
    3) Well, four years ago we did not believe in birth spacing, and we will have responded to your question by saying that "Allah Ke Tishe Su" i.e. Allah will take care/provide for these children no matter their quantity. But our TL has over the years enlightened our community on RH/FP and our community is very aware of these issues now
    4) But 4yrs ago, we were not interested in listening to anyone discussing about birth spacing
    5) Did not believe in birth spacing
    6) The same thing (4 participants). Did not believe in it (8 participants).

14. What should be the interval (months or years) between child births?
    1) 2 years; 3 years; 21 months; 6 years.
    2) 1.5 years (x1), 2 years (x2), 2.5 years (x3) & 3years (x1). Four years ago,
    3) 5 years, 3-4 years (x2), 3 years (x2), 4 years (x3), 2.5 years
    4) 3yrs (x2), 2-3yrs, 4 yrs (x3), 2 - 4yrs (x3).
    5) 3 or 4 years; 3 years; 3 years; 2 years; 2 years; 3 years; 1 year 5 months; 3 years; 3 years.
    6) 3 years; 2;2;2;2;3;3; don't need, so long as there is no problem.

    What did you believe four years ago?
    1) A minimum of 1 year 9 months (unanimously).
    2) We did not think about the birth spacing interval and our wives gave birth mostly within 1 – 2years after the last delivery
    3) However, 4 years ago, we did not think about specific intervals and short intervals were very common
    4) Did not have any birth spacing interval in mind 4 yrs ago (all)
    5) Did not believe in it.
    6) 1 year 7 months (4 participants). Did not believe in it (8 participants).

15. Who makes the decisions about birth/child spacing in your families?
    1) The husband.
    2) It is mostly the men in our community and sometimes in consultation with their wives, but it is mostly the men that make these decisions even four years ago
    3) This depends in my opinion whether it is in a polygamous or monogamous situation, in a polygamous setting, there is competition between wives to have the highest number of children. Therefore, the husband & wives must take a shared decision, otherwise spacing will be difficult. There should also be shared decision making regarding spacing among monogamous couples in my opinion. This view was shared by 6 participants, while the other respondents (4) strongly felt that it was mainly the decision of the man
    4) It is the decision that should be made by the couples (x6), by the husband (x1), wife's decision if the husband refuses to cooperate (x1).
    5) It's a joint decision (unanimously).
    6) It's a joint decision (unanimously).

    Who made the decisions about birth/child spacing four years ago?

    1) The husband.
    2) However, four years ago, there was general agreement that it was mainly the decision of the husband
    3) Four years ago, we all had these positions.
    4) Did not believe in it.
    5) The same opinion (6 participants). It was a unilateral decision made by the husband (2 participants)

16. What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
    1) Use of oral pills; injectables (subject to appropriateness); IUD
    2) We have heard that contraceptive pills and injectables can be used. Other local methods such as herbs or "rubutu"are also used.
    3) Through the use of modern contraceptives such as implants, vasectomy, implants, oral contraceptives, IUCDs, Noristerat. But other traditional/"Islamic" methods such as abstinence for 10 days after the end of menstruation, use of herbs & amulets are also used in the community.
    4) Injectables, pills, implants, withdrawal method, condoms.
    5) Use of oral pills; injectables, implant; traditional (charm)
    6) Use of oral pills; natural (calendar); injectables, traditional (charm); condom

    Did you know about these contraceptives four years ago?

1) Not aware (unanimously).
2) However, the use of local methods was commoner in the past
3) The community only knew about oral contraceptives four years ago
4) These methods with the exception of implants were known 4 years ago
5) Use of oral pills; injectables, implant; traditional (charm)
6) We knew some, but not all.

17. **[If modern contraceptives are mentioned above, then ask:]**Which contraceptive methods are available in the community?
1) Oral pills; injectables
2) The contraceptive pills and injectables are widely available, and contraceptive injectables are the most widely used in our community. The contraceptive pills were the most widely available and used four years ago
3) All the modern contraceptives such as implants, vasectomy, implants, oral contraceptives, IUCDs, Noristerat are all available here
4) Oral pills; injectables
5) Oral pills (some mothers send their kids to buy for them).

Which ones are mostly used?
1) people now prefer implants
2) Depo-provera is the least preferred now because it is perceived as causing delayed return of fertility after cessation of use or even outright infertility
3) Injectables are widely available and mostly used.
4) Traditional methods

Four years ago which ones were available and mostly used?
1) Oral pills.
2) oral pills were frequently used
3) This was the same situation, 4 years ago
4) Oral pills.

What do the men believe about Islam's teaching on birth spacing?

18. Does Islam permit a couple to space births?

1) Islam permits 2 years interval using natural methods; Islam does not restrict number of birth (it is in fact encouraged to have more children)
2) Yes (x8), especially for "rurutsa".
3) Yes, if it is not done with the intention of being afraid that plenty of children will result in poverty for the parents but it is done with the intention of maintaining or protecting the health of the mother and her children
4) Yes.
5) Yes, withdrawal has been discussed in Islam.
6) It's permissible

If so, did you believe this four years ago?
1) No, we didn't know this information 4 years ago
2) We did not have this understanding four years ago
3) Yes; but not as widely and unreservedly as I do now
4) The same thing
5) The same thing, but mostly traditional methods were used then.

19. Which contraceptive methods are permitted by Islam?
1) Any one.
2) All are permitted

3) All contraceptive methods that are not permanent are accepted (vasectomy is not accepted) because what if you change your mind and want to have more children or if your children die for any reason?
4) All methods that do not cause harm are permitted
5) Any method
6) Any method. But this depends on one's intention. It has to be for the wellbeing of the mother, not due to economic considerations.

Are there specific contraceptive methods that are not permitted by Islam?
1) None (unanimously)
2) The only exception to the use of permanent contraceptive method in Islam is when the doctors prescribe it based on medical grounds, then it is ok to do it
3) None
4) None (unanimously)

What specific roles did TRLs have in informing, encouraging and counseling men RH/FP?

20. Who are the local TRLs in your area?
1) Yarin Gandi, Chiroma, and 4 prominent Imams
2) We have both male traditional & (male & female) religious leaders in Bodinga, bo
3) Yes, TLs, chief Imam etc. The TRLs are synonymous with each other in most instances or are even blood relatives
4) They are mostly our Islamic teachers and preachers plus the district or ward heads of Tudun Wada.
5) Emir of Anka, Marafa, Sarkin Baura; Mal. Hussaini, Mal. Danbaba, Mal. Sha'aibu;
6) Mal. Hamza Abubakar, Mal. Aliyu Musa, Mal. Sunusi Sarkin Malamai; Malama Suwaiba, Malama Asma'u, Malama Balkisu.

Are they males or females?
1) There's a female – Hauwa Alhaji Bello
2) We have male and female religious scholars in our community
3) And we have both males and females in our locality
4) Female TRLs: Malama Rabi, Malama Fati, Malama Ba'u

21. Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives?
1) Yes
2) Yes, the District head of Bodinga through the Turaki of Bodinga speak during locally held public meetings, town hall & local traditional council meeting etc
3) Yes,
4) Yes, mainly during sermons by our Islamic teachers. Yes, the content of their messages address birth spacing especially during questions & answers sessions unlike 4 years ago
5) Yes
6) Yes especially the female religious leaders.

How do they give these teachings/messages?
1) During congregation of the village head, chaired by the district head where village heads are asked to sensitize their Imams.
2) Yes, the content of the messages have changed from RI/Polio related messages in the past to messages on "miso"/ maternal health currently
3) Through face to face encounters, khutbah, weddings, naming ceremonies etc
4) During wedding parties (walima), at schools
5) In the community, during wedding parties (walima), weekly lectures

Has there been a difference in the content of their messages over the last four years?

1) Not practiced (at least not in the mosque).
2) Yes, in the past they did not use to speak about RH/FP in their speeches
3) Yes, now they are being more elaborate.
4) Yes

22. Did you hear the local TRLs preach about birth spacing in formal settings (e.g. mosques)?
1) Yes
2) Yes; during the early "subh" morning prayers, Friday prayers
3) Yes
4) Yes,.
5) Yes, but during lectures for women (certainly not at the mosque)
6) Yes, I've heard Mal. Aliyu Musa talking about it.

How many times in the past year?
1) At times during Friday or daily prayers.
2) The imam especially (Mallam Bala) does that every Friday (>20 times last year),
3) At several forums (5times, 4, 3-4, more than 20 times in the last year)
4) more than 10 times
5) Can't remember the number of times.
6) About 3 times; about 10 times; about 7 times.

Did they do this four years ago?
1) No
2) No, in the past they did not speak about RH/FP in their speeches
3) No
4) No

If so, has there been a difference in the content of their messages over these four years?
1) Yes
2) There is a difference because the focus before was on polio but now it has changed to maternal health
3) No, they did not 4 yrs ago. The message dwells on birth spacing relatively more often than in the past

23. Did you or anyone in your family discuss with the TRLs matters related to birth spacing in the last one year?
1) People sometimes consult Imam Zakari on health related issues (because he's considered knowledgeable)
2) Yes, on several occasions to me, on no occasion (x5), once (x2)
3) Yes, individually or in groups, and on several occasions individuals go to them to seek clarification on RH/FP issues even from within and surrounding communities. This is generally more frequent in Ramadan
4) Yes
5) Yes
6) Yes

How many times?
1) As the need arises.
2) (3 times, 8 times, 15 times, once)
3) more than 5 times (as a family or individual)
4) 5 times
5) Cannot say precisely.

24. Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth spacing during their speeches or counseling sessions or other meetings?
1) Yes on several occasions.
2) Yes,

3) Yes, from Suratul Nisa'a, Nahl and from Hadiths and other religious texts etc
4) Yes, they do.
5) Yes during lectures for women.
6) Yes

Did they do this four years ago? If so, has there been a difference in the content or the way they used these verses in their messages over these four years?

1) Never discussed.
2) They did not do this in the past 4 years because the focus is now on maternal health, while it was on polio in the past
3) No, they didn't do this in the past. But they now do this in their speeches to support RH/FP
4) Yes, but not so frequently in the past. They are more supportive of birth spacing now
5) Yes; no difference.
6) No

<u>At end of session ask</u>:
Is there anything else you would like to tell us or ask us?

1) Need for provision of more health facilities especially at remote villages to ease access.
2) Why did the questions focus only on health & not female education because I think they are both important for women?
3) What about other health issues that are important such as malaria?

ANALYSIS FOR FOCUS GROUP DISCUSSIONS WITH WOMEN IN THE COMMUNITY

Sokoto Rabah 8 participants, Bodinga 9 participants, South Sokoto Gagi

Zamfara Gusau N=12, Anka N=11, Talata Mafara

What do the women in this communities practice about reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel importance should be given to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Y/N/Do not know/Refuse to answer *[Record the <u>numbers</u> of responses for each option]* 1) Y=3 (n=8) 2) Y=9 (n=9) 3) Y=8 (n=9) 4) Y=12 (n=12) 5) Y=11 6) Y=11 7) Yes= 12 Why do you feel this is important? 1) Because medicines are now available (1); Attendance in ANC (3); Refused to answer (3) 2) Women & children are the heart of the home: children are future hope, and difficulties in pregnancies. 3) Mother's health and child's health 4) So women can take care of own children; to build strong healthy nation by having healthy mothers 5) For good health of mother and baby 6) Only healthy women are able to educate and bring up their children responsibly And why do you feel it is not important (if there are those who do not see this as important). *Make a note of the <u>numbers</u> of respondents with the different views. Do this with as many questions as possible. Only numbers not names needed.*
2. At what age do women get married in this community? 1) Until she completes secondary school (8) 20yrs 2) 18 yrs (8); 17 (1) n=9 3) 18-19 (9) 4) 16 (5); 18(6) 1 (no response) 5) 18 to 30 yrs = 11; 6) 18 yrs = 3 At what age does a woman usually have her first baby? 1) Age 21 (8) 2) Age 18 (8); 17 (1) 3) Age 19 (9) 4) 17 (5) 18 (7) 5) First baby = 19 to 31 years = 11 6) First baby = 19 to 21 years = 12 Four years ago what was the age at which women got married, and at which age did women have their first child? 1) 15 yrs (8), 17 yrs (8) 2) 14 yrs. (9), 15 yrs. (9) 3) 18 (9); 18 (9) 4) 15 (4); 17 (8); first child 16-18 yrs (12).

5) 22 (11); 24 (11)
6) marriage was 15 yrs = 6; First baby 16yrs= 6

3. During pregnancy should a woman consult a doctor/health worker/midwife?
1) Y= 8 /N = 2/
2) Y=9
3) Y=9
4) Y=12
5) Y=11
6) Yes= 12;

Do not know/Refuse to answer *[Record the numbers of responses for each option]*

Why?
1) To receive care and support on health area; to avoid delivery complications
2) Access good health service
3) Adequate healthcare and support for mother and child
4) To access good health for mother and child
5) To access health services and treatment

4. How many times should a pregnant mother consult a doctor/health worker/midwife?
1) 8 times (8)
2) 7 times (9)
3) 10 times (9)
4) 4 times (12)
5) 6 times (11)
6) 4 times (12)

5. For those who have been pregnant, ask: how many times did you consult a skilled medical person (doctor/health worker/midwife) during your last pregnancy?
1) 8 times (2); others (NO consultation) = 2
2) 4-5 times (1); 6 (1); 7 (1); others no response (N=9)
3) 5 times (1); 6 (3); 8 (4); 7 (1)
4) 5 (2); 7 (4); 8 (6)
5) Once = 1; 4=5; 5=1; 6=1; 10=1; Never visited hospital=2
6) 2 times=1; 4=8; 7= 2; Never visited hospital=1

6. Did you get TT (use Hausa term) vaccines during your last pregnancy?
1) Y = 4 /N = 4/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
2) Y=9
3) Y=9
4) Y=12
5) Yes=9; No = 2
6) Yes= 11; No = 1

7.Where does a pregnant mother prefer to have the delivery of her child: at home or at a health facility?
1) Facility (6);
2) Home (9)

3) Home (9)
4) Home (5); hosp (7)
5) Home (11); hosp (11)
6) Hospital = 12

Why?
1) High hospital bills; easier at home
2) For getting good health care services; there is good post partum care
3) House – easier and more accessible (12); Hosp – to avoid complications for mother and child (8); no response (4)
4) Hospital cares and supports mother and child during delivery; To avoid complications of birth

What was the practice four years ago?
1) Same
2) Same
3) Home delivery
4) Home (10) Hosp (2)
5) Same: Hosp and home (11 each)
6) House = 12

8.How many children do most women in this community have ?
1) 12 (5)
2) 7 (9)
3) 10 (9)
4) 7-8 (2); 10-12 (10)
5) 3=2; 6=3; 4 or5 = 6
6) 5 to 6 = 10; 10= 2

How many children did most women have in this community four years ago? *[PROBE if necessary to find out how many children the participants had]*
1) Between 10 and 20
2) It's what God has given
3) At least 12 (12)
4) 10-12 = 11
5) 12 children = 10; 13 to 15 children = 2

9.If several daughters are born to a couple but no son, does the couple continue to have children until a son is born?
1) Y= 7/N/Do not know/ Refuse to answer =1 *[Record the <u>numbers</u> of responses for each option]*
2) Y=9
3) Y=8; N=1
4) Y=12
5) Y=11
6) Continue =3; Stop = 9

Why
1) If they continue God will give them a male child
2) Because God may now give a son
3) God will give them a boy
4) So as to have a male child
5) God may bless the couple with a male child

and why not?

1) Because I prefer to take care of the ones I already have
2) God will bless the existing daughters to be responsible citizens , perhaps the couple are not destined to have a boy child

Four years ago what was the practice in this community?

1) Same
2) They will continue
3) Same
4) So as to have a male child
5) continue =12; Why; to birth the heir of the family.

10.Who decides in the family about whether or not a couple should continue to have more children?

1) Men (3); Women (3)
2) Men (9)
3) Both (12)
4) Men and women= 1; Men Only = 11

Has this changed in the last four years? If yes, what is the change?

1) Men=8
2) Men=9
3) Women (1) Men (2) Both (9)
4) Men are now involved in providing information to their wives in the community on FP services. Men now support /encourage FP in their homes by giving supports to their wives . *[Does not directly address the question]*
5) Men only =12; Some women now are able to raise and discuss the issues of birth spacing with their husbands.

11.Do women in this community suffer from obstetric fistula [Use local language to describe fistula]? Y/

1) N=7/
2) Do not know/
3) Refuse to answer =1
4) N=9
5) N=9
6) Y=12
7) Yes= 10; I don't know =1
8) Yes= 12; I don't know =1

Has the number of women who have such fistula increased, decreased or remained the same through the last four years?

1) Women now know the measures to take to prevent pregnancy, and the stress of childbirth.
2) Reducing =12
3) Numbers of women with fistula as at 4yrs ago were more than now, so the difference is that it has decreased.
4) Decreasing = 11; No response = 1

12.Is female genital cutting widely practiced in the community [Use local language to describe FGC]?

1) N=8/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
2) N=9
3) N=9
4) N=12
5) No=11
6) No=12

Has this practice increased, decreased or remained the same through the last four years?
Same

What do the women believe and practice about birth spacing?

13.Do you get information or hear messages about birth spacing and contraceptives?

1) Y=8/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
2) Y=9
3) Y=9
4) Y=12
5) Y=11
6) Yes=12

What is the primary source of your information on these matters?

1) Doctors & Hospitals
2) Hosp., messages from sensitization, from peer group messages
3) Hosp (9); Husband (1); Peers (9); Gatherings (9)
4) Radio
5) Health workers at the hospital; Radio; Discussion among peers
6) Hospital = 12; Radio = 12; Religious leaders =12

Four years ago what was your primary source? *[PROBE to ascertain if TRLs were the primary source]*

1) Hosp (6) Peer information (6)
2) Not much information available, but contraceptives were available through some type of CBD
3) Peers
4) Health workers
5) 4yrs ago; only on the radio = 12

14.Is it a good thing to space child births in a family?

1) Y=6/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
2) Y=9
3) Y=9
4) Y=12
5) Y=11
6) Yes= 12

Why or why not? What did you believe four years ago?

1) Didn't have awareness or support 4 years ago
2) Good health for women; space enables good care for children; happy family
3) For good health of the woman; as child delivery is stressful; four years ago contraceptives were not popular.
4) To raise healthy children and have good health for mother. 4 years ago, believed but had no access to contraceptives.
5) To produce healthy baby; to help the mother in staying healthy; we do not like or welcome discussion on

FP as at then; we do not discuss FP as a topic anywhere
   a. to produce healthy baby; b. to help the mother in staying healthy; (c) for women's healthy reproductive health;
6) Four years ago: No! we did not believe at in birth spacing at all =12

15. What should be the interval (months or years) between child births? 3 yrs.=7;
1) 3 yrs = 7
2) 3 yrs = 9
3) 3 to 4 yrs = (9)
4) 3 yrs (12)
5) 4-5 yrs (11)
6) 3yrs = 12;

What did you believe four years ago?
1) Same; in practice the gap is 1.5 yrs to 2 yrs, even though it's not really what they want (unmet need?)
2) 3 – 4 yrs
   a. to 2 yrs (12)
3) 1-2 yrs. (11)
4) 4yrs ago; We believed in 1 or 1.5yrs =12

16. What methods can be used to space child birth? **[PROBE: Are there any other methods?**
1) Injection=7; Medicines=7; condoms=7; IUDs=7
2) Pills, injectables and IUD
3) Injection, pills, IUDs
4) Pills, injectables, implants, condoms, sterilization (female)
5) Injectables, pills , implants =12

If any modern contraceptives are mentioned by the respondents, then ask:] Did you know about these contraceptives four years ago?
1) Only pills =7
2) Only few pills & injectables.
3) Injection, pills, IUDs
4) No
5) Use of condoms, injectable, implants; 4yrs ago= traditional method or beads =11
6) None; only traditional methods =12

17. **[If modern contraceptives are mentioned above, then ask:]** Which contraceptive methods are available in the community?
1) All 4 above
2) IUDs, injectables
3) Injectables, pills
4) Pills
5) Implants, pills, condoms , injectibles are available and mostly used
6) Implants, pills, condoms , injectibles are available and mostly used

Which ones are mostly used?
1) Injectables.
1) Pills, inj, IUDs
2) Pills (12)
3) Pills only (11)

Four years ago which ones were available and mostly used?

1) Only pills and inj.
2) Injectables, pills
3) Pills (12)
4) None

18. Who makes the decisions about birth spacing in your families?

1) Women = 5; Men=1; Refused=2
2) Men=9
3) Men & women = 9
4) Both=12
5) Men=11
6) Men =9; Women=3

Who made the decisions about birth spacing four years ago?

1) Same
2) Men=9
3) Men & women = 9
4) Women alone = 2; couple = 10
5) Women (using contraceptives secretly) =11
6) Only men = 12 .

What do the women believe about Islam's teaching on birth spacing?

19. Does Islam permit a couple to space births?

1) Y=8/N/Do not know/Refuse to answer *[Record the <u>numbers</u> of responses for each option]*
2) Y=9
3) Y=9
4) Y=12
5) Y=11
6) Y=12

If so, did you believe this four years ago?

1) Yes=8
2) Y=9
3) Y=9
4) Y=12 only on mother's health grounds
5) Y=11
6) Y=12

20. Does Islam permit the use of contraceptives for child spacing?

1) Do not know=7
1) Y=9 (if it is for women's health, but not for limiting children to have own convenience)
2) Y=9
3) Y=12
4) Y=11; did not know this 4 yrs ago; women did not believe in FP 4yrs ago because there was the rumor that a women may not conceive again after using any birth spacing method.
5) Y=12

21. Which contraceptive methods are permitted by Islam?
    1) Periodic abstinence
    2) Period count (rhythm method) Note: 4 to 5 days after period is safe period
    3) Rhythm (safe days) method=9; withdrawal method = 9
    4) Withdrawal = 12; safe period method
    5) Traditional method =11
    6) All the methods (injectibles, pills, implants) are permitted for use in Islam, except the methods that will be permanent =12

22. Are there specific contraceptive methods that are <u>not</u> permitted by Islam?
    1) Do not know=8/
    2) FP involving modern contraceptives that exceeds 6 years, or couple living away from each other for long periods
       Reasons: because Prophet said good to have many children, and you don't know which one will turn out to be responsible.
    3) No
    4) No
    5) Yes
    6) Yes

    Ask those who answered "Yes": What are these contraceptives? Why are these not permitted?

    1) Implant, condoms
    2) The ones that cannot be reversed , that is, Islam does not permit any family planning method that will make one not ever bear children again =12; FP should only be for a while, so as to recover and fully recuperate from any birth complications / health wise. The holy prophet said we should marry and multiply

What specific roles did TRLs have in informing, encouraging and counseling women?

23. Who are the local TRLs in your area? Are they males or females?
    1) T leaders, R leaders, chairman, dist. heads
    2) T leaders, Mullahs, R leader, Elders
    3) Males = 12
    4) Traditional leaders, Imams, political leaders; Males= 11
    5) Traditional leaders, Imams, political leaders; All males =12

24. Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives?
    1) Y=8/N/Do not know/Refuse to answer *[Record the <u>numbers</u> of responses for each option]*
    2) Y=9
    3) Y=9
    4) Y=12
    5) Y = 11
    6) Y=12

    How do they give these teachings/messages?
    1) Town Announcers (individuals who goes through community making imp. Announcements (8); hospitals (3)
    2) During palace gatherings, clinic health talks, hosp. (9)
    3) Delivery, care for infants, women RH. At hosp, homes, T/L house, school premises
    4) During questions and answers sessions; during mosque programs; phone-in progs on radio
    5) Islamic gatherings ,public gatherings ,
    6) Religious gatherings, during preaching = 12

Has there been a difference in the content of their messages over the last four years?

1) NO
2) NO
3) It was the same
4) Yes
5) 4yrs ago ; yes, but people always insult them
6) 4yrs ago ; There was usually no discussion on FP

25. Did you hear the local TRLs preach about birth/child spacing?

1) Y=8
2) Y=9
3) Y=9
4) Y=12
5) Y=11
6) Yes=12

How many times in the past year did you hear them preach about birth/child spacing?

1) >5 times=7
2) 7 times = 6
3) >10 times=9
4) About 10 times
5) Over 30 times; At Islamic gatherings , on the radio
6) 4 times =12

Did they do this four years ago?

1) Y=8.
2) Y=7
3) Y=9
4) Now more preaching to attend ANC, bringing children for IMZ
5) N=12 there was no talk about contraceptives; the difference is that they included ANC
6) yes but not often and people would usually not listen .
7) No! we did not hear TLs talk about birth spacing.

26. Did the you or anyone in your family speak with your TRL about birth spacing matters individually, as a family, or in a small group in the last year?

1) Family=No; small group=Y
2) 7 times (9)
3) Small groups = 9
4) Individually and groups=9
5) Y=1; N=11; three times
6) Y= 11; Only in a small group gathering and not individually
7) Yes = 12; Only in a small groups = 12

How many times?

1) Over 20 times
2) 4 times

27. Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth spacing?
    1) N=7/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
    2) N=9
    3) Y=9
    4) Y=12
    5) Y=11
    6) Yes = 12

    Did they do this four years ago?
    1) N=7
    2) N=9
    3) N=12
    4) Y=11
    5) No =12. In the past TLs only discussed only on Islamic verses and topics on religion , but they have now included topics on FP.=12

    If so, has there been a difference in the content or the way they used these verses in their messages over these four years?
    1) TRLs now support FP with scripture verses and encourages families to pay more attention to the wellbeing of their homes.
    2) More enlightenment and programs aimed at women to attend ANC,
    3) Women now come for FP and delivery even from villages.

At end of session ask:
Is there anything else you would like to tell us or ask us?
1) Why are you scaling up sensitization on FP?
2) Please I'd like to have more children even though I am old?
3) Malaria still killing our children and pregnant women. Pl. what is your plan toward this in future programming?
4) An elderly woman that has not given birth in a long time, what advice will you give us?

ANALYSIS FOR FOCUS GROUP DISCUSSION WITH MALE YOUTHS IN THE COMMUNITY

Sokoto **Gagi**

Zamfara **Gusau**

What do the youths in the communities believe about women's reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should know about women's reproductive health issues and the frequency of child birth, and the wellbeing of the young children and their mothers? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why do you feel this is important? And why do you feel it is not important (if there are those who do not see this as important). *Make a note of the numbers of respondents with the different views. Do this with as many questions as possible. Only numbers not names needed.* 1) Yes= 9 a. I agree that their health is important, but it appears that most of the attention is focused mainly on females with very few or none for males & that is unfair (a 50:30 focus will be fairer) b. I think their health is more important because they are the ones that get pregnant, conduct breast feeding and menstruate on a regular basis so they need more care. Moreover, they do not have the freedom or permission go out like the males and this is a disadvantage to them in terms of getting health information and advice 2) Yes = All. Because children are the future of any society and the health of mothers is essential for the development of any society. Some believed that maternal health should have priority over child health. Birth spacing is permitted in Islam & it allows the child, its mother & father to have some respite before another baby arrives
2. What is an ideal age for a woman to get married? At what age should she have her first baby? Four years ago what did you believe about these two questions? 1) 13 years ("which I am basing on what I think is the Islamic prescription), 15 -16 years, 17 – 18, 18 – 19. One of the respondent said " it think it will depend on the physical maturity of the girl") 16 years, 14 years, 16 – 17 years, 18 -19 years. Once again, one of the respondent said " it think it will depend on the physical maturity of the girl") 2) Marriage - 14 – 16 years, 15yrs, 20yrs, 18 yrs. (x2), age is not a pre-requisite for marriage in Islam First baby – 20 yrs, 21yrs, 18yrs,
3. During pregnancy should a woman consult a doctor/health worker/midwife? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* Why? Why not? 1) Yes, because it is an opportunity to check the health of the mother and her unborn child. In the past our women used to drink herbal concoctions during pregnancy 2) Yes = All Because health workers are specialists that can attend to any medical problems that may arise during delivery or ANC
4. How many times should a pregnant mother consult a doctor/health worker/midwife? 1) (I think it depends on the state of health of the mother), weekly, monthly, at 3 monthly intervals, fortnightly, 3 weekly intervals 2) Monthly from 4th month of pregnancy (at least 5 times), Weekly (> 10 times), it depends on the health workers, it depends on the next appointment given to her
5. Where should a pregnant mother have the delivery of her child: at home or at a health facility? Why? 1) I think the health facility is the best place for a woman to deliver because she will get better attention or care but if the delivery occurs at before she can reach the hospital, then a health worker should be called to assist her at home (x6) 2) I do not agree with them, I think it is better if she delivers at home because I will not have to spend any

money on hospital bills (3)

1) The health facility is the best place for a pregnant woman to deliver because she will get adequate care and avoid VVF, prolonged labor etc. but most health facility staff are rude or unhelpful

6. How many children should a woman have in her life time?
   1) 3-4, 4-5, 5 (3), 4 (2), 3, 6, 2-3
   2) 4, 10 (x4), 6(x2), 4 (x4), 3, 5

7. If several daughters are born to a couple but no son, should the couple continue to have children until they have one or more sons?
   Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
   Why and why not? Four years ago what did you believe about this question?
   1) Y=6, N-3
   2) I will not continue seeking for boys if all my children are girls as long as they "albarka" (good or upright children) because what wealth you will get through your children is already destined by Allah eg she can become rich or even marry a rich husband
   3) I will not stop searching for a boy because it is males that can inherit and continue the family tree
   4) No = All. I prefer girls and there is no difference between boys and girls even though in our society, boys are preferred because they can help in economic activities

8. DELETE

9. Do women in this community suffer from obstetric fistula [Use local language to describe fistula]? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
   Has the number of women who have such fistula increased, decreased or remained the same through the last four years?
   1) No=9
   2) Yes, but it has declined considerably and it is generally restricted to rural areas

10. Is female genital cutting widely practiced in the community [Use local language to describe FGC]? Y/N/Do not know/Refuse to answer *[Record the numbers of responses for each option]*
    Has this practice increased, decreased or remained the same through the last four years?
    1) No=9
    2) No - All

What do the male youths believe about birth/child spacing?

11. Do you get information or hear messages about birth/child spacing and contraceptives?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    What is the primary source of your information on these matters? Four years ago what was your primary source?
    1) Y=9, mainly through our TRLs and the NGOs they invite to talk to us but other sources include TV/radio, posters, health facility, college of education. In the past the main source was the health facility
    2) Yes=all. BBC service, local media, Mosques, Islamic preachers, local dramas

12. Is it a good thing to space child births and/or limit the number of children in a family?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    Why or why not? What did you believe four years ago?
    1) I do not think it is a good thing if it prevents you from having your required number of children
    2) I think it is a good thing so that you can take good care of your child within your resources
    3) Yes =All. Because it allows the mother and her child to obtain optimal health before she embarks on another pregnancy

13. What should be the interval (months or years) between child births and why?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    What did you believe four years ago?
    1) 2 years, 2-3,3 (x3), 4 (x2), 3-4
    2) 2yrs, 3-4yrs (x2), 5yrs (x2), 2 – 4yrs

14. DELETE

15. Is it possible to space children?
Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
1) Y =9
2) Yes=all

16. What methods can be used to space child birth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
1) We have heard of "family planning" such as condoms, pills, injectables but other methods include abstinence, cough syrup, cold water, salt licks, paracetamol, herbs
2) In the past, abstinence was the only option but we now have pills & injectables, loop, implants, withdrawal, calendar method

17. **[If modern contraceptives are mentioned above, then ask:]** Which contraceptive methods are available in the community? Which ones are mostly used? Four years ago which ones were available and mostly used?
1) Pills and injectables are the most available &widely used in my opinion
2) Pills are the commonest

What do the male youths believe about Islam's teaching on birth spacing?

18. Do you have any knowledge on Islam permitting a couple to space births?
1) Yes, by consensus of Islamic scholars ("maslaha")
2) Yes =All. A verse in the Quran prescribe 2yrs

19. Do you have knowledge of birth spacing methods permitted by Islam? Are there specific contraceptive methods that are not permitted by Islam? What are these? Why do you think they are not permitted?
1) I don't think birth spacing methods are not forbidden by Islam unless they are permanent like tying up the womb or taking intoxicants to space births. But even tying up the womb can be permitted on medical grounds
2) Yes. None are forbidden as long as the intention is to space births and not limit births

What specific roles did TRLs have in informing, encouraging and counseling male youths RH/FP?

20. Who are the local TRLs in your area? Are they males or females?
1) Yes, we have senior TLs, male and female RLs but the female RLs are not very prominent
2) Yes, we have males and females religious leaders but the traditional leaders are not very active in health matters in the community except on invitation

21. Do the TRLs discuss with the community members about women's (reproductive) health, spacing of children and contraceptives?
Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
How do they give these teachings/messages? Has there been a difference in the content of their messages over the last four years?
1) Yes = 9. They usually communicate with us through the TL (Sarkin Yaki Gagi), who then convenes the targeted group and then they can discuss with them
2) Yes = All. In mosques, discussions, sermons, in radio stations. Birth spacing is mentioned more often now than in the past

22. Did you hear the local TRLs preach about birth spacing in formal settings (e.g. mosques)?
Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
1) Yes=8, N=1
2) Yes = all

23. Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth spacing during their speeches or counseling sessions or other meetings?
Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
1) Y=2, Do Not Know =5, N=2 (because he spoke on verses supporting polio & not birth spacing)
2) Yes=All

At end of session ask:
Is there anything else you would like to tell us or ask us?
1) Is it true that "family planning" drugs have side effects eg can disrupt menses and make menstrual blood accumulate in the womb?
2) What are the birth spacing intervals associated with each of the "family planning" drugs

ANALYSIS FOR FOCUS GROUP DISCUSSIONS WITH FEMALE YOUTHS IN THE COMMUNITY

Sokoto South Gagi

Zamfara Gusau

What do the female youths in this community believe and practice in the area of reproductive health?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel importance should be given to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? 1) Yes=10 2) Yes=12 Why do you feel this is important? 1) To give births to healthy babies; safe delivery of children 2) A woman is in charge of the home and as such needs to stay healthy And why do you feel it is not important (if there are those who do not see this as important).
2. At what age do women get married in this community? 1) 18 (10) 2) Marriage age 15years =1; 18years = 9; 20 years = 2 At what age does a woman usually have her first baby? 1) 19=(10) 2) First baby ; 16years = 1; 20 years = 9; 21years = 2 Four years ago what was the age at which women got married, and at which age did women have their first child? 1) Marriage 12 to 14years = 12 2) First Baby 13 to 15years =12
3. During pregnancy should a woman consult a doctor/health worker/midwife? 1) Y=10 2) Yes = 12 Why? 1) To access good health care from Doctors and other health professionals
4. How many times should a pregnant mother consult a doctor/health worker/midwife? 1) At early stage of preg; 10 times (10) 2) 9times = 12
5. DELETE
6. DELETE
7. Where do most pregnant mothers have the delivery of her child: at home or at a health facility? Why? 1) Hospital = 10 2) Hospital =12; To avoid complications like VVF and PPH; To avoid exposing the child to any kind of infection What was the practice four years ago? 1) No! Not many women went the hospital for deliveries because there was not so much knowledge and exposure on the importance of going to the hospital and that's why as at 4years ago more women delivered

their children at home. = 12

8. How many children do most women in this community have?
   1) 7 or 8 =10
   2) 8 to 10 children = 12

9. If several daughters are born to a couple but no son, should the couple continue to have children until a son is born?
   1) Continue = 8; Stop = 2
   2) Continue = 12

   Four years ago what was the practice in this community?
   1) Continue =12

10. Who decides in the family about whether or not a couple should continue to have more children? Has this changed in the last four years? If yes, what is the change?
   1) Men = 10
   2) Women = 2

   4years ago:
   1) Only men = 12

11. Do women in this community suffer from obstetric fistula [Use local language to describe fistula]?
   1) NO=10
   2) Yes =12

   Has the number of women who have such fistula increased, decreased or remained the same through the last four years?

12. Is female genital cutting widely practiced in the community [Use local language to describe FGC]?
   Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
   Has this practice increased, decreased or remained the same through the last four years?
   1) No=10
   2) No =12

What do the female youths believe and practice about birth spacing?

13. Do you get information or hear messages about birth spacing and contraceptives?
   Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
   What is the primary source of your information on these matters? Four years ago what was your primary source? *[PROBE to ascertain if TRLs were the primary source]*
   1) Yes=10
   2) Yes= 12

   Sources :
   1) Within the home and also in the hosp =10
   2) Married women in our homes and community =12

14. Is it a good thing to space child births in a family?
   Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
   Why or why not? What did you believe four years ago?
   1) Y=10; 4 years ago = in order to have a healthy baby; and to promote love between couples
   2) Yes=12

   Why?
   For the good health of women and their children.

15. What should be the interval (months or years) between child births?
    1) 3-4 years = 10
    What did you believe four years ago?
    1) Same = 2; Did not know = 8
    2) SKIPPED

16. Is it possible to space children?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    1) Y=10; once both couples agree
    2) SKIPPED

17. What methods can be used to space child birth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
    1) Pills, ineactables, implants, IUD, Traditional methods
    2) SKIPPED
    Did you know about these contraceptives four years ago?
    1) Y=8, N=2

18. **[If modern contraceptives are mentioned above, then ask:]** Which contraceptive methods are available in the community? Which ones are mostly used? Four years ago which ones were available and mostly used?
    1) Injectables and oral pills = 8; do not know=2; 4 yrs. ago only traditional methods (amulets and beads) = 10
    2) SKIPPED

19. DELETE

What do the female youths believe about Islam's teaching on birth spacing?

20. Do you have any knowledge on Islam permitting a couple to space births?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    If so, did you believe this four years ago?
    1) Do Not Know=10;
    2) Yes= 12

21. DELETE

What specific roles did TRLs have in informing, encouraging and counseling female youths?

22. Who are the local TRLs in your area? Are they males or females?
    1) T Leaders, Imams, head of religious leaders; males
    2) They are the TLs , RLs , Imams , local government chairmen .Males =12

23. Do the community members discuss with the TRLs about women's (reproductive) health, spacing of children and contraceptives?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    How do they give these teachings/messages?
    1) Y=10 ; mosques, during meetings with TLs, and gatherings at the Imam's palace
    2) Yes= 12; Through the Radio and Television

24. Did you hear the local TRLs preach about birth spacing?
    Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]*
    How many times in the past year?
    1) N=10
    2) Yes; Many times

25. Did you or anyone in your family speak to the TRL about birth spacing matters individually, as a family, or in a small group in the last year? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* 1) N=10 2) No
26. Did the TRLs use verses from the Quran, Hadith or other religious sources to teach about birth/child spacing? Y/N/Do not know/Refused to answer *[Record the numbers of responses for each option]* 1) No=10 2) Yes

ANALYSIS FOR KEY INFORMANT INTERIVEWS WITH HEALTH SERVICE PROVIDERS (HSPs)

Sokoto Gandi PHC (not trained by dRPC), Bodinga

Zamfara Gusau, Anka, Talata Mafara

What do the HSPs believe about women's reproductive health and birth/child spacing?
In recent years there have been much discussion in Nigeria about the health conditions of women, especially when they are pregnant, and about the young children in the communities—their need for nutrition and proper growth. 1. Do you feel you should give importance to women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers? Why do you feel this is important? Why do you feel it is not important (if a respondent does not see this as important)? 1) Yes; mothers need to be healthy to take care of babies 2) Yes, she thinks that maternal health is very important because it affect the health of the whole family. It also affects the fetus as well as the child that is being breastfed. On the other hand the health of the child is also very important because an unhealthy child affects the state of mind of the child's parent. 3) There is an increase in acceptance of modern contraceptives by clients that use to reject them in the past because they now know the benefits of birth spacing. 4) Yes, I strongly believe that importance should be given women's reproductive health and the frequency of child birth, and the wellbeing of the young children and their mothers because women are the bedrock of any society i.e. "without women, there is no society". And no husband will feel alright if his wife is sick. On the other hand birth spacing is important in preserving the health of the mother by preventing "rurutsa" (very frequent child births which they described as getting pregnant while still breastfeeding another child which can result in poor health for mother & child). And frequent child bearing (i.e. rurutsa) would prevent the mother from adequately taking care of her children, which could result in the child becoming malnourished "tamowa" 5) Yes; but unsure of the views of the other stakeholder. I have seen from my own experience the advantage of child spacing 6) Yes; To ensure that both child and mother are not malnourished 7) Yes; Reduces MMR, IMR; allows growth of children and adequate spacing; there is financial benefit for the family as well with spaced child birth. 8) Yes; frequent pregnancies prevent women from taking care of children, husband and family.
2. In your judgment how many times should a pregnant mother visit a doctor/nurse/midwife during her pregnancy? 1) 4 2) I believe a pregnant woman should visit a health care worker at least 14 times to get her health checked. 3) at least five times during pregnancy 4) 5 times 5) 4 times 6) 4 times 7) 4 times

3. Where should she have her delivery? [home/health center/hospital] Why?
   1) I believe she should have all her delivery in the health facility so that potential complications e.g. bleeding during labour can be addressed by a trained professional in the health facility..
   2) Hospital
   3) I believe that a pregnant woman should deliver only in a health facility of course!
   4) This allows her to relax away from prying eyes (e.g. of co-wives) and to be in the company of fellow women undergoing the same experience. It also allows you to shout out when you have labor pangs (which is against the local cultural norms), without being regarded as "weak" within the community. I know that it is also safer for the mother & unborn baby to be born in the health facility because they will be adequately taken care of especially when any complication arises.
   5) At the health facility
   6) Hospital or health facility
   7) Facility; maternal complications avoided; safe delivery possible; immunization of newborn—BCG, OPV-1
   8) Hosp. Complications during delivery can be averted.

4. Who is the ideal person to deliver her baby? Why?
   1) The ideal person to deliver a baby is a midwife, because she is a trained professional.
   2) Trained qualified Health Service Provider; because the person would be trained to give good care.
   3) Midwives, female community health workers & trained TBAs. The latter in the absence of the former, because they trained on taking deliveries safely and know how to handle safe neonatal and cord care practices
   4) Minimum: trained CHEW
   5) Mid wife or CHEW; They are the skilled persons who are able to take deliveries successfully
   6) Midwife
   7) Midwife; she knows how to safely deliver child.

5. How soon after delivery should the mother and her baby be examined by a trained health worker?
   1) Within 60 minutes after if delivery takes place in the hosp.
   2) I think the mother and her baby should be examined by a health worker at least 30 mins after delivery.
   3) I strongly believe that a woman should be taken immediately taken to the hospital after delivery at home even before the umbilical cord is cut!
   4) After 24 hours
   5) Immediately
   6) Within 1 hour
   7) 2 weeks after delivery for PNC

6. How many children should a woman have in her lifetime?
   1) I believe 5 to 6 children are okay for a woman during her life time. However, some women in our community have up to 12 children but most women on the average have 6 to 8 children.
   2) 5
   3) 2 – 4 children max!
   4) 6 is OK
   5) Children
   6) 3-4
   7) 6 children. The decision should be the husband's and wife's.

7. Do you think spacing children in a family is beneficial for the health of mothers and children?
   1) Yes;
   2) I believe 5 to 6 children are okay for a woman during her life time. However, some women in our community have up to 12 children but most women on the average have 6 to 8 children.
   3) Yes
   4) Yes, very much
   5) Yes it is beneficial;
   6) Yes; beneficial for mother
   7) Yes; At least 2 year interval

8. Why? or Why not? [If response is negative skip to Question no. 5]
   1) keeps mothers healthy; children also grow up healthy
   2) yes it is beneficial because it allows the infant to be adequately breastfed, and it also allows the mother to regain the blood and other nutrients she lost during pregnancy and labour.
   3) It helps the mother and her children to have good health
   4) So mother can take care of her child
   5) To ensure that mother and child are healthy
   6) Finance, medical care, education
   7) Because the older child can help in taking care of the younger child (e.g. fetching water or food for the younger sibling)

9. What methods can be used to space childbirth? **[PROBE: Are there any other methods? If any modern contraceptives are mentioned by the respondents, then ask:]**
   1) Pills, condoms, injections.
   2) Contraceptives injectables and pills can be used for birth spacing.
   3) I know about the following methods of spacing births, contraceptive injectables or pills, IUCDs, Implant, Jedel & BTL (bilateral tubal ligation).
   4) Injectables, pills, IUCD, Copper T, Jadel, vasectomy and female sterilization
   5) Use of family planning pills, injectibles , condoms, IUCD
   6) Implants, IUCD, condoms, pills, injectables
   7) Pills, inj, IUCDs, implants, condoms (male and female), calendar method (Standard Day Method)

   Did you know about these contraceptives four years ago?
   1) I have known about contraceptives injectables and pills for more than 4 years now. However, more and more clients are accepting them now than before.
   2) I knew about these 4 years ago from several trainings I received in school
   3) Yes
   4) Yes; but didn't know about implants
   5) Knew about pills, calendar method, but not implants (introduced one year ago); dRPC helped in increasing my knowledge through the Gusau workshop.

What specific roles did the dRPC Project have in equipping the HSPs?

10. Did you participate in any dRPC Project activities for building leadership capacity on women's health, birth spacing and contraceptives? What activities (if any) did you participate in? How often? *[Probe for LDF/Retreat, Study Tour, Training on MLSS and MSP, Alumni Associations/Networks]*
    1) No
    2) Yes, I have attended a training for HSP organized by dRPC in Gusau, Zamfara state (2011). This training lasted for 5 days and the topics discoursed during the training are management of labour, birth/FP, ANC and PPH.
    3) Yes, I participated in 2 trainings conducted by dRPC which took place at Sokoto Guest Inn, Sokoto but I cannot remember the specific dates now. Some of the topics discussed during the training that I can remember include FANC, Delays that cause maternal mortality, poor communication skills of health workers & MSP
    4) Ghana study tour
    5) Yes; Training activities on maternal and child health care; 8 danger signs of pregnancy (training for community women); Dialogue and community meeting on RH, Maternal child health - Monthly , weekly
    6) Facility checklist use; Ghana study tour; Kano workshop; distribution of posters
    7) Gusau workshop

11. How effective were these activities? Which activity was most effective? Why? Which one was the least effective? Why?

    1) All the topics discoursed during the training were effective, however in my opinion the session on management of PPH was the most effective for me because of its important of reducing maternal mortality. In addition we were provided with dettol, hand gloves, forceps and delivery kits after the training by dRPC.
    2) All the topics/activities were effective and relevant for me
    3) Very effective; I learned a lot and shared with colleagues the lessons learned.
    4) Kano trip was the most effective. In-charges (of facilities) were trained by dRPC and they are using these knowledge and skills in their facilities. Ghana trip was also effective.
    5) Least effective: checklist. No equipment supplied for facility upgrading.
    6) Gusau workshop was the most useful since we mobilized women for discussing ANC, danger signs of pregnancy and the delays that leads to maternal deaths. Men now allow their wives to come to the hosp. child spacing.
    7) Very effective
    8) Most effective – A. Dialogue with community on RH
       B. Training of the community volunteers
    9) These are community based activities who ended up training and empowering others in the areas of RH and child health

    Least effective ;
    1) Training of the TBAs
    2) Because TBAs still use traditional methods and require more training to be very successful in taking part in health activities

12. Did the dRPC Project support you to develop a plan of activities? In what ways?
    If answer is negative, skip to Question no. 14.
    1) No, but I was visited by a team from dRPC once after the HSP training in Gusau. The visiting team came and interacted with my clients to find out what their family planning preferences were.
    2) No
    3) Yes
    4) Yes; Training on how to plan activities /workshops on RH , Child spacing family health education
    5) No
    6) Yes; dRPC trained us to develop IAPs.

13. Did you develop an action plan? What did you include in it? How much of your plan did you accomplish? Which activities?
    1) Not applicable.
    2) N/A
    3) Yes; awareness and outreach messages on child spacing and RH to women; 85%
    4) Yes; Included;
        a- counting of the population size of women children in the community and settlement
        b – Number of children under 3/ 5 and encouraging their parents to come to the facility for the required vaccinations; Accomplished: 75 to 90 percent for all the activities mentioned
    5) Yes; plan included immunization and surveillance activities including HIV/AIDS program activities
    6) Yes; 90% accomplished

14. Before the dRPC Project started working with you four years ago, were you developing IAPs? Are you doing them now?
    1) No
    2) N/A
    3) No; after dRPC initiated a women's dev. assoc. targeting women and RH topics; dRPC empowered me to develop activities even though we no longer work with them.
    4) No; But after the dRPC we are now developing IAPs .
    5) Yes; Yes, doing now--HIV activities: sensitization of TRLs on HIV prevention
    6) No; developing such plans now. I have given my phone # to pregnant women so they can call me if they have a need.

15. Do you feel the dRPC Project has increased your understanding and performance in the field of women's reproductive health and birth spacing in your health facility? Why or Why not?
    1) Yes, because the HSP training has increased my capacity of removal of retained placenta, management of complicated labour as well as first aid for sick children.
    2) Absolutely Yes! As a result of the dRPC training that I attended, I have a better understanding of FANC, and I do not harass or discriminate against dirty clients. And we now have very high client attendance at our health facility
    3) Very well. Started out as junior staff, and did not know much about RH, but dRPC has now trained me a lot and built my capacity in RH areas.
    4) Yes; we have been able to effectively reduce the number o infant death /mortality rate , this includes also the maternal mortality rate as our women are now informed to take better reproductive health decisions
    5) Yes; thru Kano training learned about implants; improving midwives 'skills on labor and delivery; using delivery kits.
    6) Yes; earlier services were limited to the hosp. but dRPC trained us on community based service delivery.

    [Probe for number of ANC visits, facility based deliveries, PNC visits]

At end of session ask:

Is there anything else you would like to tell me or ask me?

1) Request to USAID: Give us hospital equipment and drugs so we can better treat our patients.
2) dRPC should continue because they are impacting well in the lives of the community members.
3) When will dRPC come back to Zamfara.
4) The Emir of Anka has been very supportive he called all health personnel to organize training activities in collaboration with the NGOs on RH , Child spacing and Malaria.
5) We learned a lot at the 5-day Gusau workshop. We need more such training. dRPC did not have any follow up with the workshop participants except for a few contacts during the first few months after the w. shop.

Guideline for Collecting
Selected Reproductive Health and Family Planning Service Statistics
From Health Facility

Sokoto: Gandi, Bodinga town (Gen Hosp), South Sokoto and Gagi
Zamfara: Gusau, Anka, Talata Mafara

Health Center Level/Type ____

Primary Health Center
Gen hosp
PHC
WCWC—PHC
WCWC—PHC
General Hosp
PHC—Orphans and Less Privileged Children

Health Center Location
Gandi, Sokoto state
Bodinga
South Sokoto, Gagi
Gusau, Zamfara State
Anka, Zamfara State
Talata Mafara
T. Mafara

Catchment Area Total Population
18,000 people in 21 villages
7,825
Not available
24 Settlements with population 7,548
15,000

Catchment Area Population of Women of Reproductive Age (15 to 45 yrs.)
8,000
1,723
Not available
Not Available
3,500

Interviewer
Dr. Paul Robinson
Dr. Sanusi Abubakar
Paul R.
Sanusi A.
Paul R.
Paul R.

Date of visit
10-28-13
10-31-13
10-31-13
11-16-13

Reproductive Health
1. How many pregnant women were attended by skilled personnel in this facility at least once during pregnancy in the last 12 months for reasons related to the pregnancy (ANC visits)? 1) Not available 2) 1632 ANC visits (2013) 3) Not available i. November 2011 – 111 ii. December 2011 – 72 iii. January 2012 – 87 iv. February 2012 – 196 v. March 2012 – 151 vi. April 2012 – 62 vii. May 2012 – 94 viii. June 2012 – 98 ix. July 2012 – 98 x. August 2012 – 65 xi. September 2012 – 86 xii. October 2012 – 72 xiii. November 2012 – 106 xiv. December 2012 – 82 xv. January 2013 – 109 xvi. February 2013 – 85 xvii. March 2013 – 78 xviii. April 2013 – 87 xix. May 2013 – 102 xx. June 2013 – 88 xxi. July 2013 – 61 xxii. August 2013 – 87 xxiii. September 2013 – 85 xxiv. October 2013 – 107 ANC New 1) April 2013 – 9 2) May 2013 – 9 3) June 2013 – 4 4) July 2013 – 10 5) Aug 2013 – 5 6) Sep 2013 – 9

7) Oct 2013 – 4
8) No other data for 2013 or previous years available
9) Trend is increasing according to the In Charge

What was the number of such women four years ago? *[See records reflecting ANC visits]*

1) Fewer
2) 960 ANC visits (2011)
3) Fewer
4) No data for previous years available
5) Trend is increasing according to the In-Charge
6) 4 years ago (2009); ANC 4th visit –15/month

2. How many pregnant women were attended by skilled personnel in this facility a minimum of four times during pregnancy in the last 12 months for reasons related to the pregnancy?

1) 620
2) 1387 ANC visits (2013) and 816 ANC visits (2011) Most of their clients that voluntarily book for ANC in the health facility (and not necessarily came to consult them because they had medical problem in pregnancy) tend to continue coming back for subsequent visits. Please note that they do not practice focused ANC (FANC)
3) 108

i. November 2011 – 57
ii. December 2011 – 56
iii. January 2012 – 70
iv. February 2012 – 93
v. March 2012 – 99
vi. April 2012 – 123
vii. May 2012 – 137
viii. June 2012 – 118
ix. July 2012 – 121
x. August 2012 – 96
xi. September 2012 – 108
xii. October 2012 – 114
xiii. November 2012 – 90
xiv. December 2012 – 55
xv. January 2013 – 87
xvi. February 2013 – 79
xvii. March 2013 – 88
xviii. April 2013 – 85
xix. May 2013 – 63
xx. June 2013 – 71
xxi. July 2013 – 81

xxii. August 2013 – 106
xxiii. September 2013 – 72
October 2013 – 70

4th ANC visit is not recorded in the register.

Register does not show column for 4th ANC visit. Only New/Re-visits are recorded.

Orphans and Less Privileged Clinic--PHC
Nov 12 – 14
Dec 12 – 14
Jan 13 – 5
Feb 13 – 8
Mar 13 – 12
Apr 13 – 5
May 13 – 9
June 13 – 27
July 13 – 26
Aug 13 – 30
Sep 13 – 40
Oct 13 – 27
Total – 196

ANC 4th visit – 25/month

What was the number of such women four years ago? *[See records reflecting ANC visits]*

1) Fewer (exact figures not available)
2) 816 ANC visits (2011)
3) Fewer (exact figures not available)
4) ANC 4th visit = 15/month

3. Number of pregnant women who received two doses of TT in the last 12 months. Number four years ago? [See ANC records]
   1) 1066; Increasing trend.
   2) 1061 (2013) and 365 (2011)
   3) 154; fewer 4 yrs ago. Increasing trend
   i. November 2011 – 42
   ii. December 2011 – 39
   iii. January 2012 – 78
   iv. February 2012 – 55
   v. March 2012 – 52

vi. April 2012 – 90
vii. May 2012 – 69
viii. June 2012 – 50
ix. July 2012 – 20
x. August 2012 – 0
xi. September 2012 – 0
xii. October 2012 – 7
xiii. November 2012 – 81
xiv. December 2012 – 41
xv. January 2013 – 77
xvi. February 2013 – 65
xvii. March 2013 – 64
xviii. April 2013 – 41
xix. May 2013 – 50
xx. June 2013 – 43
xxi. July 2013 – 75
xxii. August 2013 – 30
xxiii. September 2013 – 60
October 2013 – 65

Records not available

Oct 12 – 75
Nov 12—67
Dec 12 – 81
Jan 13 – 70
Feb 13 – 94
Mar 13 – 97
Apr 13 – 147
May 13 – 120
Jun 13 – 151
July 13 – 139
Aug 13 – 182
Sep 13 -- 165

Orphans and Less Privileged Clinic
Nov 12 – 2
Dec 12 – 3
Jan 13 – 4
Feb 13 – 6
Mar 13 – 5
April 13 – 7
May 13 – 5
Jun 13 – 45
July 13 – 43
Aug 13 – 15

Sep 13 – 5
Oct 13—Out of Stock
Total 140

4 years ago: TT2 = 10/month

4. Number of live births took place in the facility in the last 12 months. Number of live births four years ago? *[See delivery records]*
   1) 256; increasing trend
   2) 672 deliveries (2013) and they are mostly booked cases, 576 (2011) and they are mostly un-booked cases Show Chart 2013 is an incomplete year; is 2011 also incomplete?
   3) 99; increasing trend for facility delivery

i. November 2011 – 54
ii. December 2011 – 70
iii. January 2012 – 61
iv. February 2012 – 55
v. March 2012 – 64
vi. April 2012 – 58
vii. May 2012 – 73
viii. June 2012 – 56
ix. July 2012 – 67
x. August 2012 – 65
xi. September 2012 – 69
xii. October 2012 – 73
xiii. November 2012 – 58
xiv. December 2012 – 50
xv. January 2013 – 47
xvi. February 2013 – 48
xvii. March 2013 – 83
xviii. April 2013 – 93
xix. May 2013 – 63
xx. June 2013 – 62
xxi. July 2013 – 67
xxii. August 2013 – 65
xxiii. September 2013 – 57
xxiv. October 2013 – 80

May – 6
June – 6
July – 7
Aug – 5
Sept – 8
Oct – 4

No. of live births 4 years ago – not available. The trend for deliveries in this facility is

increasing according to the In-Charge

No. of live births 4 years ago is missing.

No. of live births 4 years ago 168 (Orphans and Less Privileged Clinic)

5. Does this facility refer complicated delivery cases? If so, where are they referred to? In the last 12 months how many cases did this facility refer? *[See referral records]*
    1) Sokoto; 18
    2) They are a referral centre (with capacity to do C/S, they have 1 doctor & 7 midwives) for the LGA, and commonly see obstetric conditions such as anemia in pregnancy, postpartum anemia, prolonged/obstructed labor, postpartum hemorrhage, retained placenta which they can readily handle. They rarely have the need to refer obstetric cases elsewhere. They only refer cases of VVF (they referred 1 case of VVF in the last 12 months to the VVF Centre, Maryam Abacha Hospital, Sokoto)
    3) General hosp 3
    4) 29 referrals approximately
    5) No referral out
    6) Less than 5; referred to General Hosp.

Birth Spacing

6. How many women of reproductive age are using (or whose partners are using) a contraceptive method from this facility?
    1) 353
    2) 68 (2011), 165 (2012) & 191 (2013)
    3) 200
    i. November 2011 – 54
    ii. December 2011 – 69
    iii. January 2012 – 0
    iv. February 2012 – 97
    v. March 2012 – 65
    vi. April 2012 – 54
    vii. May 2012 – 72
    viii. June 2012 – 124
    ix. July 2012 – 42
    x. August 2012 – 16
    xi. September 2012 – 110
    xii. October 2012 – 64
    xiii. November 2012 – 65
    xiv. December 2012 – 81
    xv. January 2013 – 64
    xvi. February 2013 – 109
    xvii. March 2013 – 163
    xviii. April 2013 – 91

xix. May 2013 – 83
xx. June 2013 – 74
xxi. July 2013 – 78
xxii. August 2013 – 67
xxiii. September 2013 – 46
October 2013 – 33

5) As of Oct 13, there were 56 total clients on contraceptives

6) 10 per month.

What was this number four years ago?

1) See above
2) Fewer

7. How many women of reproductive age accepted <u>for the first time in their lives</u> any contraceptive method in the last 12 months from this facility?
1) 162
2) 64 (2011), 72 (2012) & 131 (2013)
3) 80
i. November 2011 – 52
ii. December 2011 – 50
iii. January 2012 – 57
iv. February 2012 – 87
v. March 2012 – 57
vi. April 2012 – 41
vii. May 2012 – 54
viii. June 2012 – 70
ix. July 2012 – 41
x. August 2012 – 16
xi. September 2012 – 72
xii. October 2012 – 63
xiii. November 2012 – 50
xiv. December 2012 – 60
xv. January 2013 – 63
xvi. February 2013 – 72
xvii. March 2013 – 75
xviii. April 2013 – 70
xix. May 2013 – 65
xx. June 2013 – 31
xxi. July 2013 – 22
xxii. August 2013 – 4
xxiii. September 2013 – 17
xxiv. October 2013 - 11

5) 25 new acceptors

6) 8 New acceptors

What was this number four years ago? *[See contraceptive dispensing records]*
Increasing trend

8. Which contraceptive methods are offered in this facility?
   1) Condoms, pills, injectables, implants.
   2) Noristerat, male/female condoms, Implants & Contraceptive pills are available
   3) Condoms, pills, injectables
   i. November 2011 – (Oral contraceptives = 22, injectables =45, IUCDs = 2)
   ii. December 2011 – (Oral contraceptives = 14, injectables =39, IUCDs = 1)
   iii. January 2012 – (Oral contraceptives = 0, injectables =0, IUCDs = 0)
   iv. February 2012 – (Oral contraceptives = 20, injectables =77, IUCDs = 0)
   v. March 2012 – (Oral contraceptives = 20, injectables =45, IUCDs = 0)
   vi. April 2012 – (Oral contraceptives = 16, injectables =38, IUCDs = 0)
   vii. May 2012 – (Oral contraceptives = 21, injectables =51, IUCDs = 0)
   viii. June 2012 – (Oral contraceptives = 59, injectables =65, IUCDs = 0)
   ix. July 2012 – (Oral contraceptives = 2, injectables =40, IUCDs = 0)
   x. August 2012 – (Oral contraceptives = 0, injectables =16, IUCDs = 0)
   xi. September 2012 – (Oral contraceptives =49, injectables =61, IUCDs = 0)
   xii. October 2012 – (Oral contraceptives = 2, injectables =62, IUCDs = 0)
   xiii. November 2012 – (Oral contraceptives = 19, injectables =46, IUCDs = 0)
   xiv. December 2012 – (Oral contraceptives = 29, injectables =52, IUCDs = 0)
   xv. January 2013 – (Oral contraceptives = 2, injectables =62, IUCDs = 0)
   xvi. February 2013 – (Oral contraceptives = 50, injectables =56, IUCDs = 3)
   xvii. March 2013 – (Oral contraceptives = 97, injectables =66, IUCDs = 0)
   xviii. April 2013 – (Oral contraceptives = 31, injectables =60, IUCDs = 0)
   xix. May 2013 – (Oral contraceptives = 24, injectables =57, IUCDs = 2)
   xx. June 2013 – (Oral contraceptives = 4, injectables =70, IUCDs =)
   xxi. July 2013 – (Oral contraceptives = 11, injectables =67, IUCDs =)
   xxii. August 2013 – (Oral contraceptives = 13, injectables =58, IUCDs =)
   xxiii. September 2013 – (Oral contraceptives = 2, injectables =43, IUCDs =)
   October 2013 - (Oral contraceptives = 14, injectables =39, IUCDs = 1)

   5) Condoms, pills and injectables

   6) Injectables, implants and pills.

   7) Pills, injectables

   Which ones are most utilized?
   1) Injectables
   2) Noristerat & implants are preferred in 2013. Contraceptive pills were

preferred in 2011.
3) Injectables

Which ones are utilized the least?

1) Condoms
2) The least preferred is female condoms
3) Condoms

9. Have there been stock-outs of contraceptives in the last 12 months? If so, which ones were stocked out? For how long? *[See CLMS records]*
   1) No
   2) Only experienced stock out of implants once this year but it was replenished within a month. No stockouts of the other FP commodities was experienced
   3) No
   4) Yes, there was a stock out of FP commodities (?pills) in June 2013
   5) No stock outs
   6) No
   7) No; only pills are out of stock for 2 months.

ANNEX IV: SOURCES OF INFORMATION

List of Persons Interviewed

Note: KII=Key Informant Interview; HSP=Health Service Provider; PL=Political Leader; TRL=Traditional and Religious leader; RL=Religious Leader; FGD=Focus Group Discussion

DAILY ACTIVITY RECORD SOKOTO					
S/N	**NAME**	**PHONE NUMBER**	**DESIGNATION**	**LOCATION**	**ACTIVITY TYPE**
DAY 1 SOKOTO (October 28, 2013)					
1	Zuwaira Muhammad Moyi		LGA MCH Coordinator	Rabbah LGA	KII-HSP
2	Alhaji Lawali Abdullahi	7054564910	Incharge Gandi PHC	Gandi , Rabbah LGA	KII-HSP
3	Alhaji Abdulhamid		Project Associate Leadership development training (LDT) Drpc	Sokoto	KII-dRPC
4	Zaiyyanu Bello Gandi		LGA Chairman Rabbah	Rabbah LGA	KII-PL
5	Abdulrahman Gandi		Traditional ruler (Ciroma, Rep of Yarin Gandi)	Gandi , Rabbah LGA	KII-TRL
6	Ladan Zakariyya	8071280963	Liman Rabbah	Rabbah LGA	KII - TRL
7	Liman Shuaibu	8157931799	Liman Kurya Rabbah	Rabbah LGA	KII-TRL
8	Focus Group discussion - Women			Rabbah LGA	FGD - Women
9	Focus Group discussion - Men			Rabbah LGA	FGD -Men
DAY 2 SOKOTO (October 29, 2013)					
1	Junaidu Muhammad Sokoto	8032418681, 08031101600	Director Local government matters	Umar farouk state secretariate	KII -PL
2	Bello Alkali	8036063908	Director Youth Development	Shehu Kan giwa secretatriate	KII- PL
3	Rahamatu A Salleh	8036784879	Amira FOMWAN Sokoto		KII -TRL (female RL)

S/N	NAME	PHONE NUMBER	DESIGNATION	LOCATION	ACTIVITY TYPE
			jurisdiction sokoto 23 LGA Activity centre sokoto		
4	Alhaji Shehu Mohammed sokoto	7037640279	deputy director planning, ministry of & science technical education	Shehu Kan giwa secretatriate	KII- PL
5	Zakari Mohammed Sangare	8039611612	sokoto state teachers service board	Shehu Kan giwa secretatriate	KII- PL
6	FGD		Women	Bodinga	FGD (women)
7	FGD		Men	Bodinga	FGD (Men)
8	Dr. Abdulrazak Gandi	8036354439	Former director PHC SPHCDA,Sokoto		KII- PL
DAY 3 SOKOTO (October 30, 2013)					
1	Sheik Mustapha Sidi Attahiru	803504963	Sheik (Islamic Scholar)	Ali Akilu Road Jummat Mosque	KII- TRL
2	Dr. Balbasatu Ibrahim	7037425013	Secretary sokoto state Fomwan	FOMWAN Sokoto	KII-TRL (female RL)
2	FGD Men		Gagi Community Sokoto	Sokoto	FGD-(MEN)
3	FGD Women		Gagi Community Sokoto	Sokoto	FGD-(WOMEN)
4	Mal Aminu Labbo	80164278688	Imam of Gagi town / Religious leader	Gagi Community	KII-TRL
5	Ibrahim M. Liman	8035049400	Chief Imam/Director of Alhassan Schools, Sifawa, Bodinga	Alhassan schools sifawa , Bodinga	KII- TRL
6	Imamu Sayyadi Ibrahim		Chief Imam/Sarkin	Gagi	KII-TRL

S/N	NAME	PHONE NUMBER	DESIGNATION	LOCATION	ACTIVITY TYPE
			Mallamai, Gagi/Religious leader		
7	Hadiza Bello	8032830594	CHEW Private Hospital worker	Sifawa, Bodinga	KII- HSP
DAY 4 SOKOTO (October 31, 2013)					
1	Aisha Musa Baba	8067980960	Mid wife	General Hospital Bodinga	Health Facility visit
2	Bello Maigandi Durbawa	8078042521	PHC Coordinator	Kebbe L.G (Fomerly at Bodinga LGA)	KII -PL
3	Nana M. Bello	8065077306	Aliyu Joda sokoto (Formerly at BHC Gagi)	Sokoto south	KII - HSP
4	Alhaji Bawa Sani	8069032945	Traditional leader (turakin Bodinga)	Bodinga	KII - TRL
5	Hajiya Mairo Bello Sheriff		Family planing state coordinator	Sokoto	KII - PL
6	Hajiya Kuluwa A. Nuhu	08025082531, 08053617609	Hon. Commissioner Min of women affairs	Sokoto	KII - PL
7	Hajiya Fatima Mohammed		Incharge BHC Gagi	Gagi BHC Sokoto North	Health Facility visit
DAY 5 SOKOTO (November 1, 2013)					
1	Mal. Sani Kwani	8022675061	Islamic Scholar	Bypass Sokoto	KII - TRL
2	Hajiya Aishatu Abubakar		MCH Coordinator, Sokoto South LGA & Deputy Director, Sokoto South LGA	Sokoto South Secretariat	KII-PLs
3	Magajin Gari				KII-TRL
DAY 6 SOKOTO (November 2, 2013)					
1	Male adolescent youths at Gagi		Unmarried adolescents		FGD - Youths

S/N	NAME	PHONE NUMBER	DESIGNATION	LOCATION	ACTIVITY TYPE
					Male
2	Female adolescent youths at Gagi		Unmarried adolescents		FGD - Youths Female
3	Ibrahim Muhammad Rabah		Former Chairman, Rabah LGA, Sokoto		KII-PL

NOTES:

KII	Key Informant Interviews
FGD	Focus Group Discussion
TRL	Traditional / Religious Leaders
PL	Political Leaders
HSP	Health Service Providers
RL	Religious Leaders

PARTICIPANT'S LIST IN FOCUS GROUP DISCUSSION (FGD)

ACTIVITY TYPE	LOCATION	LIST OF PARTICIPANTS
FGD Women Group	Bodinga LGA	Sa'adatu Bala
		Hassana Alhaji Bawa
		Abu Alhaji Bawa
		Hauwa'u Alhaji Bawa
		Yaya Arbuga Alh Bawa
		Inna gado Alhaji
		Gado Mohammadu
		Nana Late Danbase
		Ummu Late Ahmed
		Kulu Yar Gajara
		Hadi Jekada
		Kulu Lawali
		Balkisu Danbaja
		Hadiza Bala
FGD Women Group	Gandi	Halima Sani
		Rukayya Aminu
		Aisha Muazu
		Fatima Sani
		Hafsa Sabu'u
		Maryam Basiru
		Ummu Bashir
		Abu Sani
		Saudatu Abdullahi
FGD Men Group	Bodinga	Idris Hassan Bodinga
		Alhaji Umaru Dabago
		Abdullahi Labbo Jekada
		Mallam sabo Danchadi
		Alhaji Shehu Sifawa
		Alhaji Liman Mani Dingydadi
		Alhaji Sala Danchadi
		Alhaji Aliyu Danchadi Chairman
FGD Men Group	Rabbah LGA	Alh. Bunu Umar
		Marafa Gandi
		Labbo Baura
		Umaru Ubandoma

ACTIVITY TYPE	LOCATION	LIST OF PARTICIPANTS
		Abdulkadir Bunu
		Engr. Tukur Gandi
		Aminu Kofa
		Mallam Bello G.
FGD Women Group	Rabbah LGA	Lantana Abubakar
		Jamila Mohammed Sani
		Fatima Abubakar
		Rashida Mohammed Sani
		Asma'u Umar
		Zalihatu Abbas
		Rukayya Abbas
		Maryam Aliyu
FGD Female Youths	Gagi	Zuliha Umar Gagi
		Asma'u Malami Gagi
		Khadijah Mohammed Gagi
		Harruna Balkisu
		Aisha Bello
		Asma'u Bello
		Summayya Yusuf
		Maryam Ibrahim
		Asma'u Mohammad
		Aisha Malami
FGD Male Youths	Gagi	Abdullahi Harunna
		Jaffaru Ahmad
		Anas Umar Gagi
		Abdullahi Muhammad
		Bashir Umar
		Isma'il Maidammu
		Faruku Mohammed
		Mubarak Gidado
		Aliyu Umar
		Murtala Sahabi Gagi
		Aliyu Umar Ahmed

DAILY ACTIVITY RECORD ZAMFARA					
S/N	**NAME**	**PHONE NUMBER**	**DESIGNATION**	**LOCATION**	**ACTIVITY TYPE**
DAY 1 ZAMFARA(November 4, 2013)					
1	Fadimatu Salihu	8182040602		Organization for Muslim women on health and Education	KII RL
2	Rabiatu Abdul kadir	8063839770	Member	MSS ACCADEMY	KII RL
3	Mohammed Habib Aliyu	8069832226	Director, social welfare	Abdullahi fodio Islamic Foundation	KII PL
4	Alhaji Yahaya Kanoma	8063075385	District head of Kanoma	Maru Emirate Council Zamfara	KII TRL
5	Alhaji Iliyasu Muhammad		District head	Tudun wada	KII TRL
6	Zulaiha Adamu D Kwangiila	7035166486	Teacher	MSS ACCADEMY	KII RL
7	Mallam Rabiu Na ibi		scholar	Darul arzam sch	KII RL
DAY 2 ZAMFARA (November 5, 2013)					
1	Ismaila Ibrahim	8068715777	DPHC		KII
2	FGD Men			Gusau Zamfara	FGD Men
3	FGD Women			Gusau Zamfara	FGD Women
DAY 3 ZAMFARA(November 6, 2013)					
1	Shittu Mohammad Mohammed	Anka Emirate	Chief Imam Anka Emirate		KII TRL
2	Bala Audu Gusau	Anka LGA	DPHC		HSP
2	FGD Women			Anka LGA	FGD Men
3	FGD Men			Anka LGA	FGD Women
DAY 4 ZAMFARA(November 7, 2013)					
1	Akilu Yahaya	8069815044	HOD Arabic, ZACAS		KII RL
2	Aliyu Musa Mafara		Teacher	Madrasatul Tarbiyyatul Islamiyya	KII RL
3	Muktar Hamza		Director studies		

S/N	NAME	PHONE NUMBER	DESIGNATION	LOCATION	ACTIVITY TYPE
4	Alh. Salihu Abubakar Anka		Permanent secretatry , culture and tourism Gusau		KII PL
5	Yusuf Musa Mafara		DPHC SMOH		
6	Buhari Abdullahi Anka		CHEW/WCWC PHC Anka LGA		HSP
7	Hadiza salihu Mafara		MCH Cordinator GH Talata mafara		
8	Lawal Mohammed Mafara		D .PHCC Talata mafara		
7	Rilwanu Ibrahim		Manager orphans and less privileged clininc		
	FGD Women			Talata Mafara	FGD Female Group
	FGD Men			Talata Mafara	FGD Male Group
DAY 5 ZAMFARA(November 8, 2013)					
1	Mukhtar Hamisu	08032848666	DDPRS	State Ministry of Health	KII
DAY 6 ZAMFARA (November 9, 2013)					
1	FGD Female Youths Group			Gusau Zamfara	FGD Female Youths Group
2	FGD Male Youths Group			Gusau Zamfara	FGD Male Youths Group

NOTES:

KII	Key Informant Interviews
FGD	Focus Group Discussion
TRL	Traditional / Religious Leaders
PL	Political Leaders
HSP	Health Service Providers

RL	Religious Leaders

PARTICIPANT'S LIST IN FOCUS GROUP DISCUSSION (FGD)		
ACTIVITY TYPE	**LOCATION**	**LIST OF PARTICIPANTS**
FGD Women Group	Anka LGA	Hauwa Abdullahi
		Hauwa Adamu
		Jamila Mohammad
		Asiya Isah
		Balkisu Malam Dan Dare
		Binta Abdullahi
		Halima Sani
		Binta Musa
		Hadiza Musa
		Sa'adatu M Zamfara
		Hadiza Aminu
FGD Women Group	Gusau Zamfara State	Ramatu Abubakar T.
		Saratu Garba Kanoma
		Aisha Salihu Ahmad
		Safiya Malam Yahuza
		Daharatu Abbas Ahmad
		Zainab Salihu Muhtar
		Aminatu Abubakar Abubakar
		Binta Abdullahi Gusau
		Aminatu Mohammed Khalil
		Sadiya Abdullhamid Masud
		Rashidat Abdullahi
FGD Women Group	Gusau , Zamfara state	Shamsatu Anwar A. Tahir
		Asiya Abubakar
		Hajara Jimada Musa
		Saratu Umar Faruk
		Halima Abdullahi
		Halima Bala Wakili
		Hadiza Jimada Musa
		Hadiza Ahmad
		Hafiza Abdurrazak
		Hadiza Ahdam
		Fatima Al- Mustapha
		Faiza Abubakar

FGD Men Group	Anka LGA	Salisu Abdu
		Basiru Abdullahi
		Ummaru Suleiman
		Abubakar Mohammed
		Mohammed
		Nura Ibrahim
		Hussaini Salihu
		Shehu Saadu
		Tasiu Abubakar
		Sanusi Lawoli
		Tasiru Isah
		Kabiru Lawal
FGD Women Group	Talata Mafara LGA	Faizah Ibrahim
		Asma'u Bashiru
		Aishatu Usman
		Suwaiba Yusuf
		Halimatu Usman
		Zainabu Bello
		Safiyatu Mohammad
		Hadiza Aliyu
		Aisha Adamu
		Razika Idris
		Sakinatu Bello
		Ralia Akilu
FGD Men Group	Talata Mafara LGA	Bashiru Aliyu
		Armayau Shehu
		Rilwanu Umar
		Mustapha Abubakar
		Abubakar Aliyu
		Suhailu Abdullahi
		Muhammad Kabir
		Aliyu Abukar
		Samaila Musa
		Saidu Ahmad
		Anas Sanusi
		Mal. Hamza Abubakar
FGD Male Group	Gusau Zamfara	Abdulrahman Sayyadi
		Almustspha sani Bawa

		Kamaludeen Bala
		Beeliyaminu Mohd
		Bello Abbas
		Sanusi Aliyu
		Khalid Nasiru
		Nafi'u Hamza
		Aliyu Bello
		Jamilu Musa Barade Anka
		Nasiru Musa
		Sahid Sani Anka
FGD Male Group	Gusau Zamfara	Abubakar Salihu
		Ismaila Adullahi Muhd
		Hassan Adamu
		Aminallah Riduwanu
		Aliyu Ibn Abbas
		Musa Ibn Abbas
		Abubakar Ibrahim
		Abubakar Maigari
		Ibrahim Hamza
		Munir Aliyu
		Ibrahim Zauri
		Rabiu Salihu Moriki

List of documents reviewed

	Title of publication/report	Commission body/author	Date	Remarks
1.	Creating Champions ISOLs & Leadership in Reproductive Health/ Family Planning a proposal by dRPC submitted in Response to the RFA issued by World Learning on behalf of USAID.	dRPC, Yahaya Hashim	January 4th 2009 – January 3rd 2011	Technical Proposal
2.	Creating Champions for FP/RH amongst senior office holders in the Executive, Legislative, and Judicial arms of government and in the Local Government Areas of Sokoto, Zamfara and Niger State a Nigerian Response.	dRPC		Proposal Submitted by dRPC
3.	Technical Application; Advancing Change Champions Leadership and Initiatives in Maternal Health (ACCLAIM) Extension Project (A Community level approach for political, traditional and religious leaders) in Niger, Sokoto and Zamfara States.	dRPC	February 2011	Technical Report
4.	Leadership Development Forum for Political leaders on Family Planning/Reproductive Health (FP/RH) Extension Phase II, The Advancing Change Champions Leadership Initiatives for Maternal (ACCLAIM)	dRPC	July 2011	dRPC Performance Management Plan (PMP)
5.	The Role of Islamic Religious Leaders in Maternal Health Programmes: Sociological perspective	T.A Muhammad Baba (dRPC)	June 13th 2013	Paper presentation at two days' workshop held in Zamfara State
6.	LEADERSHIP Development Forum On FP/RH, Project Timeline Phase 1&2	dRPC	September 16th 2013	PowerPoint Presentation
7.	LEADERSHIP Development for Reproductive Health (Activities 1& 2)			PowerPoint Presentation
8.	External Report by Voluntary Services Oversees (VSO) Population and RH Evaluation Volunteer assigned in Calabar and requested by VSO to evaluate dRPC project	dRPC, Mrs. Sarah Mukisa	March 2012	Report
9.	Mid Term Assessment Report,	dRPC	July 2011	Mid -term

	Title of publication/report	Commission body/author	Date	Remarks
	FP/RH Leadership development project in Niger, Sokoto and Zamfara States, Activity 1 for political office Holders & Activity II for Traditional and Religious Leaders			Assessment Report
10	Leadership Development Forum for Political, Religious and Traditional Leaders on Family Planning /Reproductive Health (FP/RH) Activity 1 and 11, Grant Activity Completion Report Submitted to World Learning	dRPC	November 2012	Report
11	LEADERSHIP Development for Reproductive Health Retreat Facilitation Manual for Sate Political Executives, Legislators, the e Judiciary and Senior Local Government Functionaries as well as Islamic Scholars & Traditional Leaders, Discover yourself – Discover change	dRPC	June 2009	
12	Mid Term Assessment Report, FP/RH Leadership development project in Niger, Sokoto and Zamfara States, Activity 1 for political office Holders & Activity II for Traditional and Religious Leaders	dRPC	July 2011 (Finalized 2012)	Mid -term Assessment Report
13	LEADERSHIP Development for FP/RH, AN Assessment of the Strategy of Providing Technical Health Information to Traditional and Religious Leaders in the Leadership Development for FP/RH project 2009 – 2012, Project peer Review Series No 2 of 7	Sul Abdullahi Gaya (FWACS)/ Sagir Saleh (dRPC)	June 18th 2012	Report
14	LEADERSHIP Development for FP/RH, , Project peer Review Series No 3 of 7	dRPC , Muslim and Christian Religious Leaders	2009 –2012	
15	LEADERSHIP Development for FP/RH, , Project peer Review Series No 1 of 7, National Institute for Policy and Strategic Studies , Kuru Issues paper Challenges and Possibilities of engaging Senior Civil Servants	dRPC / NIPSS, Prof M.O. Madugu and Musa E. Umar	2009 - 2012	Paper Presentation

	Title of publication/report	Commission body/author	Date	Remarks
	in Leadership Development Programs			
16	LEADERSHIP Development for FP/RH, , Project peer Review Series No 4 of 7, The experience of Muslim Women and their Associations in Leadership Development for Reproductive Health	Halima Aisha Hassan Amina FOMWAN North West Zone (dRPC)		
17	LEADERSHIP Development for FP/RH, , Project peer Review Series No 6 of 7 Strengthening State Primary Health Care Development Agencies to take leadership in FP/RH	Alhaji Balarabe Hamzah (dRPC)	2009 - 2012	
18	Management Systems Challenges Strategies and Opportunities in the leadership Development for FP/RH Implemented by DRPC Lessons learnt and Best practices for Nigerian NGOs	The Centre for Management Development Nigeria (dRPC)		
19	Leadership Development for Traditional and Religious Leaders on Family Planning and Reproductive Health	dRPC	2009	LDT Annual Report
20	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional Leaders & Islamic scholars LDT	dRPC	January – March 2012	Quarterly Report
21	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional Leaders & Islamic scholars LDT	dRPC	April – June 2012	Quarterly Report
22	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional and Religious Leaders in FP/RH Cooperative Agreement #:GPO-A-00-04-00021-00	dRPC	January – March 2011	Quarterly Report
23	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional and Religious Leaders in FP/RH	dRPC	April – June 2011	Quarterly Progress Report

	Title of publication/report	Commission body/author	Date	Remarks
	Project 2			
24	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional and Religious Leaders in FP/RH Project 1, Quarterly Progress Report Exchange on FP/RH in Egypt	dRPC	July – September 2011 Submitted November 2nd 2011	Quarterly Progress Report
25	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional Leaders & Islamic Scholars in FP/RH LDT	dRPC	October – December 2011	Quarterly Progress Report
26	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Traditional and Religious Leaders in FP/RH	dRPC	January – March 2010	Quarterly Progress Report
27	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH	dRPC	April – June 2010	Quarterly Progress Report
28	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH dRPC Female Islamic Scholars (FIS)	dRPC	July _ September 2010 Dated October 2010	Quarterly Progress Report
29	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH, Ms Sharon Epstein Head HPN USAID Nigeria declaring the workshop open	dRPC	October – December 2010 Dated January 2011	Quarterly Progress Report
30	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH	dRPC	January – March 2009	Quarterly Progress Report
31	FP/RH Leadership	dRPC	April – June	Quarterly Progress

	Title of publication/report	Commission body/author	Date	Remarks
	Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH		2009	Report
32	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH	dRPC	July – September 2009	Quarterly Progress Report
33	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Activity 2 Leadership Development Forum for Traditional and Religious Leaders in FP/RH The District Head of Tudun wada, Gusau Bashir etc.	dRPC	October – December 2009	Quarterly Progress Report
34	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Political Leaders in FP/RH LDP	dRPC	January – March 2012	Quarterly Progress Report
35	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara Leadership Development Forum for Political Leaders in FP/RH LDP	dRPC	April – June 2012	Quarterly Progress Report
36	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Project 1: Leadership Development Forum for Political Leaders in FP/RH LDP	dRPC	January – March 2011	Quarterly Progress Report
37	LDP QUATERLY PROGRESS REPORT FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH Cooperative Agreement #: GPO –A-00-01-00021-00,	dRPC	April – June 2011	Dissemination in Niger and Sokoto State
38	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Project 1: Leadership Development Forum for	dRPC	July – September 2011 Submitted: 2nd November	Quarterly Progress Report

	Title of publication/report	Commission body/author	Date	Remarks
	Political Leaders in FP/RH		2011	
39	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Project 1: Leadership Development Forum for Political Leaders in FP/RH LDP	dRPC	October – December 2011	Quarterly Progress Report
40	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH	dRPC	January – March 2010	Quarterly Progress Report
41	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH	dRPC	April – June 2010	Quarterly Progress Report
42	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH dRPC LDT and LDP Champions and members	dRPC	July – September 2010	Quarterly Progress Report
43	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH Researchers carrying out a role play exercise in preparation for the midterm review	dRPC	October – December 2010	Quarterly Progress Report
44	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH	dRPC	January – March 2009	Quarterly Progress Report
45	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH	dRPC	April – June 2009	Quarterly Progress Report
46	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership	dRPC	July – September 2009	Quarterly Progress Report

	Title of publication/report	Commission body/author	Date	Remarks
	Development Forum for Political Leaders in FP/RH			
47	FP/RH Leadership Development Project in Niger, Sokoto and Zamfara State Activity 1: Leadership Development Forum for Political Leaders in FP/RH Women being counselled at rural site of maternal health outreach project	dRPC	October – December 2009	Quarterly Progress Report
48	Leadership Development for FP/RH project No 1 of 6 project summary & Achievements	dRPC	2009 - 2012	
49	Project Document No 2 of 6 Leadership Development for FP/RH Resolutions of Islamic Opinion Leaders at open Space Forum	dRPC	8th May 2010	
50	Leadership Development for FP/RH project No 1 of 6 project Document No 3 of 6 Reflections of the experiences of Political office Holders	dRPC		
51	Project Document No 4 of 6 Political Pronouncement in Support of FP/RH	dRPC	December 2010	Training Evaluation report
52	Leadership Development for FP/RH project No 1 of 6 project Document No 5of 6	dRPC		
53	Project Document No 4 of 6, Advocacy & Budgetary Allocation to Health in the LDP/ LDT Project	dRPC		Bulletin
54	Leadership Development for FP/RH Success Story 1 of 8	dRPC	7th March 2010	
55	Leadership Development for FP/RH Success Story 2 of 8	dRPC	August 2009	
56	Success Story 3 of 8 Sarkin Yakin Gagi a true RH champion	Alhaji Sani Umar Jabbi		
57	Leadership Development for FP/RH Success Story 4 of 8 Success Story 3 of 8	Hajiya Sa'adatu F. Audu	22nd June 2010	
58	Success Story 5 of 8	Mallam Ibrahim Liman Sifawa		
59	Success Story 6 of 8	Honorable Zainab Nasko	December 2009	
60	Success Story 7 of 8	Honorable Abubakar Umar Mamako	November 2009	
61	Leadership Development for FP/RH Success Story 4 of 8	dRPC		

	Title of publication/report	Commission body/author	Date	Remarks
	Success Story 8 of 8			
62	End-of-Project evaluation in Depth Interview Guide for Islamic Opinion Leader trained LDT Project	dRPC		
63	Monthly Public Pronouncement Tracking Form for Islamic Opinion Leaders	dRPC		
64	Leadership Development Forum for Political, Religious and Traditional Leaders in FP/RH	dRPC	September 2012	End-of-Project Report
65	Fulbright Alumni Association Of Nigeria (FAAN) in collaboration with dRPC Sokoto State	dRPC		
66	Fulbright Alumni Association Of Nigeria (FAAN) in collaboration with dRPC Zamfara State	dRPC		
67	Leadership Development for RH/FP(State Political office Holders and Traditional and Religious Leaders	Dr.Judith – Ann Walker/ Dr. Yahya Hashim	October 19 2011	Assessment
68	Portfolio Review Leadership Development for RH/FP	dRPC	1st November 2011	Response to USAID Assessment
69	Leadership Development for RH/FP Portfolio Review	dRPC	5th November 2010	Implementation Challenges
70	Memorandum of Understanding between dRPC/FAAN to Create sustainable network of Alumni Amongst RH leaders in Northern Nigeria	dRPC	3rd December 2009	Alumni Network
71	National Institute for policy and Strategic Studies Kuru - Nigeria	dRPC	5th March 2010	
72	Literature review: Islam and Family Planning with a Special emphasis on northern Nigeria	Merrill Wolf and Aisha Abubaka		Final Report
73	Appendix 1: Key information interviews on family planning conducted for this desk review	dRPC		Final report
74	Appendix 2: current and recent donor supported family planning interventions in Northern Nigeria	dRPC		Final report
75	Formative Research: Child Spacing and family Planning Attitudes of Young married men and women in Selected Area of North-western Nigeria	Sharon Tsui and Nancy Williamson (dRPC)		Final report
76	Engaging Islamic Opinion	Yahaya Hashim	1990 - 2000	

	Title of publication/report	Commission body/author	Date	Remarks
	Leaders and associations in public health intervention in Northern Nigeria – Best and promising practices from a macro level review of project	and Judith – Ann Walker (dRPC)		
77	Mid-Term Evaluation of Target States High Impact Project (TSHIP)	Elvira Beracochea	November 2012	Mid-Term Evaluation Report
78	Nigeria Demographic and Health Survey -- 2008	Commission Federal Republic of Nigeria and ICF Macro	2008	Survey Report
79	Nigeria Demographic and Health Survey – 2013 Preliminary Results	Commission Federal Republic of Nigeria and ICF Macro	November 2013	Power Point Presentation

ANNEX V: DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Dr. Paul Robinson
Title	Global Health Consultant
Organization	The Mitchell Group
Evaluation Position?	X Team Leader ☐ Team member
Evaluation Award Number *(contract or other instrument)*	A-00-04-00021-00 (Project Number)
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Leadership Development for Family Planning / Reproductive Health for Political Office Holders, Traditional and Religious Leaders Project; implemented by development Research Project Center;
I have real or potential conflicts of interest to disclose.	☐ Yes X No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

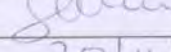
Signature	
Date	November 20, 2013

ANNEX:DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

Name	DR SANUSI ABUBAKAR
Title	TEAM MEMBER (DR)
Organization	BAYERO UNIVERSITY KANO
Evaluation Position?	☐ Team Leader ☑ Team member
Evaluation Award Number(*contract or other instrument*)	A-00-04-00021-00
USAID Project(s) Evaluated(*Include project name(s), implementer name(s) and award number(s), if applicable*)	Leadership Development for Family Planning / Reproductive Health for Political Office Holders, Traditional and Religious Leaders Project; implemented by development Research Project Center;
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	20/11/2013

ANNEX:DISCLOSURE OF ANY CONFLICTS OF INTEREST

[The Evaluation Policy requires that evaluation reports include a signed statement by each evaluation team member regarding any conflicts of interest. A suggested format is provided below.]

Name	Habibu Makanjuola
Title	MS Logistics Asst. & Data Collector
Organization	Centre for Research & Conflict Mgt.
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(contract or other instrument)*	A-00-04-00021-00
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Leadership Development for Family Planning / Reproductive Health for Political Office Holders, Traditional and Religious Leaders Project; implemented by development Research Project Center;
I have real or potential conflicts of interest to disclose.	☐ Yes X No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

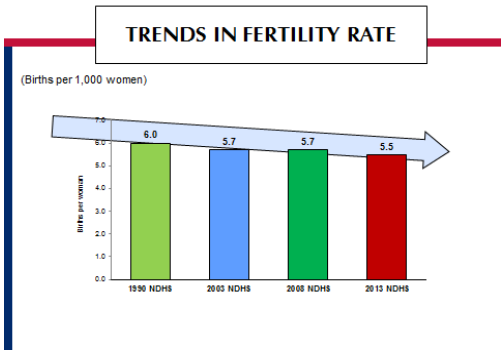
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

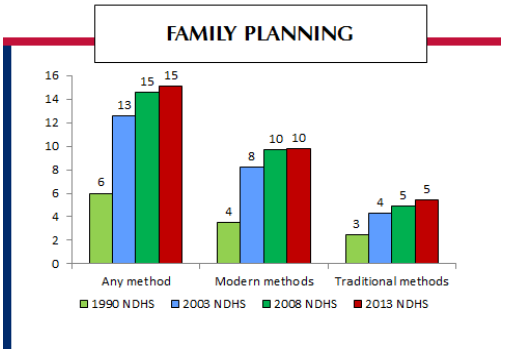
Signature	
Date	20th November 2013

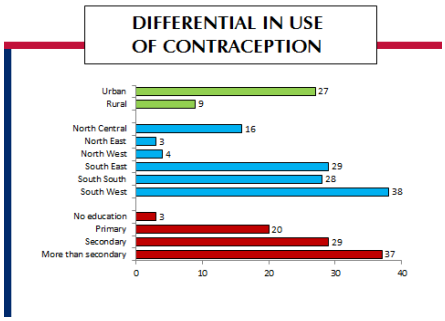
ANNEX VI: MAP OF NIGERIA SHOWING PROJECT FOCAL STATES

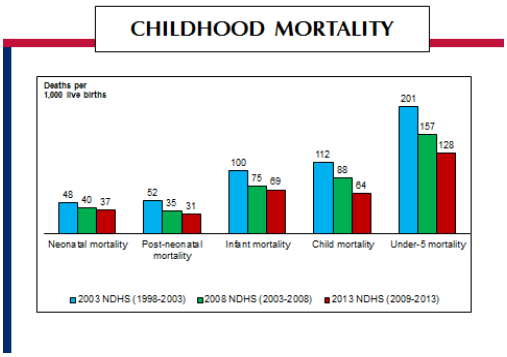
ANNEX VII: SELECTED SLIDES FROM NDHS 2013 PRESENTATION

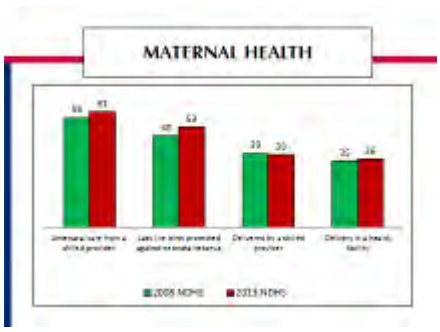
(Obtained from USAID| Nigeria)

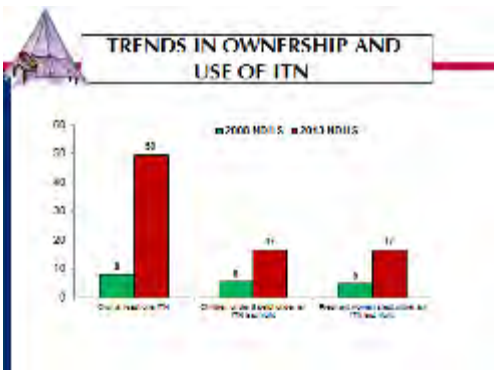












ANNEX VIII: EVALUATION WORK PLAN

WORK PLAN FOR ACTIVITIES IN USA—*PRE* TRAVEL TO NIGERA

TL = Team Leader (Dr. Paul Robinson); TM = Team Member (Dr. Sanusi Abubakar); MS = MS (Nura Nasir); LA = Logistics Assistant (Habiba Makanjuola);
DC-S = Data Collector in Sokoto (Zainab Aliyu); DC-Z = Data Collector in Zamfara (Husseina Abdussalam)

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Monday 10-14-13 Day 1 To Wednesday 10-16-13 Day 3	TL = 3	Preparatory work	• Review of USAID Scope of Work • Review of Work Order • Research and review relevant publications, project reports and journal articles • Develop proposed work plan • Develop draft evaluation tools • Develop draft team planning meeting agenda • Consult with MEMS II • Make travel arrangements	TL	
Thursday 10-17-13 Day 4 To Friday 10-18-13 Day 5	TL = 2	Travel to Nigeria	Fly from Washington, DC to Abuja, Nigeria	TL	
Total LOE	**TL = 5**				

TENTATIVE WORK PLAN FOR ACTIVITIES IN ABUJA—*PRE* FIELD VISIT

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Saturday 10-19-13 Day 1		Initial planning	• Initial discussion with Chief of Party and Deputy Chief of Party, MEMS II on field plans for the dRPC project evaluation • Review of project documents • Drafting of agenda for Team Planning	COP, Deputy COP, TL	
Monday 10-21-13 Day 2	TL = 1 TM = 1	Meetings with MEMS II Staff, and evaluation team members	• Introductions to MEMS II staff • Office set up • Orientation • Review of dRPC Project documents • Review of draft work plan	MEMS II staff, TL, TM	
Tuesday 10-22-13 Day 3	TL = 1 TM = 1	• USAID In-briefing • dRPC presentation • Team planning	• Discussion with USAID • Discussion with dRPC senior staff • Meeting with evaluation team members • Review of dRPC Project documents	USAID and dRPC staff, TL, TM	
Wednesday 10-23-13 Day 4	TL = 1 TM = 1 LA = 1	• Team planning • Work plan development • Eval tools design	• Review of dRPC Project documents • Start drafting work plan • Begin drafting guidelines for FGDs, KIIs, facility checklist • Start making arrangements for field contacts and activities	TL, TM, MS, LA	
Thursday 10-24-13 Day 5	TL = 1 TM = 1 LA = 1	• Team planning • Work plan development (cont.) • Eval tool design (cont.) • Submit draft work plan, eval tools and report outline	• Develop logistics plan for field activities • Develop detailed work plan for remaining assignments • Review of dRPC Project documents • Continue drafting guidelines for FGDs, KIIs, facility checklist • Continue field contacts and arrange field activities • Complete work plan, evaluation tools and report outline, and submit to USAID	TL, TM, MS, LA	• Work plan • Evaluation tools and • Report outline
Friday 10-25-13 Day 6	TL = 1 TM = 1 LA = 1	• Team planning • Finalize work plan, evaluatio	• Incorporate USAID feedback on draft documents (work plan, eval tools and report outline) • Review dRPC and other materials • Finalize logistics plan and travel arrangements	TL, TM, MS, LA	

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
		n tools and report outline			
Saturday 10-26-13 Day 7	TL = 1 TM = 1	• Continue desk review • Finalization of evaluation tools and logistics	• Review dRPC and other materials • Finalize guidelines and checklist • Print out guidelines and checklist for field use	TL, TM	
Total LOE	**TL = 6 TM = 6 LA = 3**				
Sunday, Oct 27 to Sunday, Nov 10: Field Work					

TENTATIVE WORK PLAN FOR FIELD ACTIVITIES FROM OCT 27 THROUGH NOV 10

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Sunday 10-27-13 Day 1		• Travel to Sokoto • Orientation and mock interviews • Consultation with dRPC Focal Person in Sokoto	• Orient data collector on eval tools • Conduct mock interview trials • Consultation with dRPC Proj. Focal Person (Sokoto)	Eval Team (TL, TM, MS, LA, DC-S,)	
Monday 10-28-13 Day 2	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) KIIs with Traditional & Religious Leaders (TRLs)	<u>State Level Interviews</u> State Execs State Assembly (Health Comm.) Members <u>Community A—(Two vehicles—two teams)</u> Local Govt. Execs Local government council members Health Service Providers Health Facility Visit Emirs, Dist. heads, Village heads, & Ward heads Imams, preachers and teachers of adult Islamic schools	Eval Team TM, LA TL, MS, DC-S,	

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Tuesday **10-29-13** **Day 3**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) FGD with community *men* FGD with community *women*	<u>State (cont.) (Two vehicles)</u> State and Local Govt. Execs State Assembly (Health Comm.) Members <u>Community A</u> Adult men Women of reproductive age (15-45 yrs)	TM TL, MS LA, DC-S	
Wednesday **10-30-13** **Day 4**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) FGD with community *men* FGD with community *women* KIIs with Traditional & Religious Leaders (TRLs)	<u>Community B (Two vehicles)</u> Local Govt. Execs Local government council members Health Service Providers Adult men Women of reproductive age (15-45 yrs) Emirs, Dist. heads, Village heads, & Ward heads Imams, preachers and teachers of adult Islamic schools	TM TL, MS LA, DC-S TM	
Thursday **10-31-13** **Day 5**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) FGD with community *men* FGD with community *women*	<u>Community B (cont.)</u> Health Service Providers Health Facility Visit <u>Community C (Two vehicles)</u> Local Govt. Execs Local government council members Health Service Providers Health Facility Visit Adult men Women of reproductive age (15-45 yrs)	TM TL, MS LA, DC-S	

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Friday **11-1-13** **Day 6**	TL = 1 TM = 1 LA = 1 DC-S = 1	KIIs with Traditional & Religious Leaders (TRLs) Data transcription & analysis	Community C (cont.) Emirs, Dist. heads, Village heads, & Ward heads Imams, preachers and teachers of adult Islamic schools Begin transcribing findings and consolidating field notes	TM Eval Team	
Saturday **11-2-13** **Day 7**	TL = 1 TM = 1 LA = 1 DC-S = 1	• FGD with youths • Data transcription & analysis (cont.)	FGD with youths —Male group --Female group Collating, consolidating field notes and transcribing findings	TL, TM, MS LA, DC-Z Eval Team	
Sunday **11-3-13** **Day 8**		• Travel by road to Zamfara • Orientation and mock interviews • Consultation with dRPC Focal Person in Zamfara	• Orient data collector (Zamfara State) on eval tools • Conduct mock interview trials • Consultation with dRPC Project Focal Person (Zamfara)	Eval Team (TL, TM, MS, LA, DC –Z)	
Monday **11-4-13** **Day 9**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) KIIs with Traditional & Religious Leaders (TRLs)	<u>State Level Interviews</u> State Execs State Assembly (Health Comm.) Members <u>Community A—(Two vehicles—two teams)</u> Local Govt. Execs Local government council members Health Service Providers Health Facility Visit Emirs, Dist. heads, Village heads, & Ward heads Imams, preachers and teachers of adult Islamic schools	Eval Team TM, LA TL, MS, DC-S,	

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Tuesday **11-5-13** **Day 10**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) FGD with community *men* FGD with community *women*	State (cont.) (Two vehicles) State and Local Govt. Execs State Assembly (Health Comm.) Members Community A Adult men Women of reproductive age (15-45 yrs)	TM TL, MS LA, DC-S	
Wednesday **11-6-13** **Day 11**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) FGD with community *men* FGD with community *women* KIIs with Traditional & Religious Leaders (TRLs)	Community B (Two vehicles) Local Govt. Execs Local government council members Health Service Providers Adult men Women of reproductive age (15-45 yrs) Emirs, Dist. heads, Village heads, & Ward heads Imams, preachers and teachers of adult Islamic schools	TM TL, MS LA, DC-S TM	
Thursday **11-7-13** **Day 12**	TL = 1 TM = 1 LA = 1 DC-S = 1	Key Informant Interviews with Political Leaders (PLs) FGD with community *men* FGD with community *women*	Community B (cont.) Health Service Providers Health Facility Visit Community C (Two vehicles) Local Govt. Execs Local government council members Health Service Providers Health Facility Visit Adult men Women of reproductive age (15-45 yrs)	TM TL, MS LA, DC-S	

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Friday **11-8-13** **Day 13**	TL = 1 TM = 1 LA = 1 DC-S = 1	KIIs with Traditional & Religious Leaders (TRLs) Data transcription & analysis	Community C (cont.) Emirs, Dist. heads, Village heads, & Ward heads Imams, preachers and teachers of adult Islamic schools Begin transcribing findings and consolidating field notes	TM Eval Team	
Saturday **11-9-13** **Day 14**	TL = 1 TM = 1 LA = 1 DC-S = 1	• FGD with youths • Return to Sokoto • Data transcription & analysis (cont.)	FGD with youths —Male group --Female group Collating, consolidating field notes and transcribing findings (cont.)	TL, TM, MS LA, DC-Z Eval Team Eval Team	
Sunday **11-10-13** **Day 15**		Return to Abuja		TL, TM, LA, MS	
Total LOE	**TL = 12** **TM = 12** **LA = 12** **DC-S = 6** **DC-Z = 6**				

TENTATIVE PLAN FOR ACTIVITIES IN ABUJA—*POST* FIELD VISIT

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Monday **11-11-13** **Day 1**	TL = 1 TM = 1	Prepare findings and conclusions	Consult and consolidate field notes and synthesize findings	TL, TM	
Tuesday **11-12-13** **Day 2**	TL = 1 TM = 1	Prepare findings and conclusions (cont.)	Consult and consolidate field notes and synthesize findings (cont.)	TL, TM	
Wednesday **11-13-13** **Day 3**	TL = 1 TM = 1	Prepare findings and conclusions (cont.)	Consult and consolidate field notes and synthesize findings (cont.)	TL, TM	
Thursday **11-14-13** **Day 4**	TL = 1	Finalize findings and conclusions	• Finalize findings and conclusions • Discuss these with dRPC • Prepare PowerPoint presentation • Print out handouts	TL	

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Friday 11-15-13 Day 5	TL = 1 TM = 1	Debrief USAID|Nigeria	Present findings and conclusions to USAID through PowerPoint presentation	TL, TM, MEMS II Senior Staff USAID Staff	Presentation of findings and conclusions to USAID
Saturday 11-16-13 Day 6	TL = 1 TM = 1	Draft report development	Begin drafting evaluation report using feedback from USAID	TL, TM	
Monday 11-18-13 Day 7	TL = 1 TM = 1	Draft report development (cont.)	Continue writing draft report	TL, TM	
Tuesday 11-19-13 Day 8	TL = 1 TM = 1	Draft report development (cont.)	Continue writing draft report	TL, TM	
Wednesday 11-20-13 Day 9	TL = 1 TM = 1	Draft report development (cont.)	Continue writing draft report	TL, TM	
Thursday 11-21-13 Day 10	TL = 1	Finalize draft report	Finalize writing draft report	TL	
Friday 11-22-13 Day 11	TL = 1	Draft report submission to MEMS II	Submit draft report to MEMS II	TL	Draft report submitted to USAID and MEMS II
Tuesday 11-26-13 Day ?	TL = 1	• Draft report submission to USAID • TL travels to USA	• Incorporate feedback from MEMS II and submit to USAID • TL leaves Abuja and returns to USA	TL	Draft report to USAID
Total LOE	**TL = 12 TM = 8**				

TENTATIVE WORK PLAN FOR ACTIVITIES IN THE U.S. – *FOLLOWING* TL's RETURN FROM NIGERIA

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Monday 11-25-13 To Wednesday 12-11-13		USAID review of draft report		USAID	
Thursday 12-12-13		USAID comments to TL		USAID	
Monday 12-16-13 To Friday 12-20-13	TL = 5 TM = 3	• Report finalization • Final report submission	• Utilize feedback from USAID to complete evaluation report. • Submit electronic version of the final report to USAID and MEMS II	TL, TM	Final report of evaluation

Date	LOE	Activity	Detailed Task	Responsibility	Deliverable
Total LOE	TL = 5 TM = 3				

TIME LINE FOR EVALUATION ACTIVITIES

Activity	Oct 14-19	Oct 21-24	Oct 28-Nov 9	Nov 11-15	Nov 16-26	Nov 26	Nov 25-Dec 13	Dec 16-20	Deliverable
• **Document review, consultation with MEMS, preparation of draft work plan and evaluation tools** • **TL travel to Nigeria** • **Initial meetings with MEMS II COP and Deputy COP**	X								
• **In-briefing with USAID** • **Meeting with dRPC** • **Team planning & work plan development** • **Evaluation tools design** • **Submission of work plan and tools to USAID**		X							• Work plan • Evaluation tools • Detailed report outline
• **Field work: interviews and discussions in two States**			X						
• **Preparation of findings and conclusions** • **Presentation to USAID**				X					PowerPoint presentation of findings & conclusions
• **Draft report preparation** • **Draft report presentation to USAID**					X				Draft report
• **TL return to U.S.A.**						X			
• **USAID review of draft report** • **USAID feedback to TL**							X		
• **Final report preparation and submission to USAID**								X	Final Evaluation Report

ANNEX IX: Composition and Role of Political Leaders involved in the dRPC project

The sub-groups under the Political Leaders Target group (PLs) along with their intervention results and our recommendations are discussed below.

1. Politically elected and/or nominated officials:
   a. Generally have a high turnover rates in their various official positions because they only serve for specified terms in office.
   b. Also, they generally have widely varied competing interests, health being only one of them.
   c. The Alumni Association established by the dRPC Project quite late in the project life remained weak and largely unproductive.
   d. The leadership training and orientation on RH/Birth Spacing thus yielded limited benefits because of the high turnover rates, competing priorities and a weak Alumni Association as described in section 1 a, b, and c, above.
   e. The Evaluation Team has recommended that in the new scaled up project this group should receive targeted intervention. With adequate support and new approach to training (discussed in the Recommendation section) this group of PLs can be an asset to the project. Their political support and clear understanding of RH/Birth Spacing will be quite useful.
2. Health technocrats or career civil servants at state or LGA level, such as directors of PHC at the state ministry of health or LGA PHC department. The dRPC training was moderately effective for these health technocrats and senior career civil servants at state & LGA levels. The effectiveness was limited because of a number of reasons:
   a. Most technocrats or civil servants are constrained by the bureaucratic norms or working environment of the state or LGA within the parameters of which they are expected to perform and behave.
   b. Some health technocrats were transferred or retired from service during the life of project.
   c. Lack of a strong Alumni Association within the PL group also was a contributing factor for the moderate effectiveness of the health technocrats and civil servants.
   d. We have recommended that this group be included in the new project because of their important role in developing budget and work plan for the health sector, besides conducting many other critical administrative functions. The strategies for training interventions and networking that we have recommended in the evaluation report can substantially improve the performance of this group.
3. Health service providers (HSPs), e.g. health facility managers, within the PL group:
   a. comprised of individuals with health backgrounds, so they already were experienced and skilled in the area of RH/Birth Spacing
   b. Most HSPs are already FP advocates and the dRPC training further empowered them in this endeavor.

c. We recommended (in the draft report) that this group be included in the new project in those areas where there are no implementing partners providing them with technical training. If the technical training for HSPs is not under the purview of this type of project, as mentioned in comments below (comment 'b' and MJ24), then this group can be removed from the recommended list of PLs. *This group is now deleted from the Final Report.*

4. Members of the judiciary:
   a. Did not cooperate with dRPC in a significant way, and were later excluded from much of the project activities.
   b. Appeared to us as being very cautious about making statements in connection with the evaluation, without first examining all legal ramifications and securing official clearance.

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