Leadership Development Forum for Political, Religious and Traditional Leaders
On
Family planning/Reproductive Health (FP/RH)

End of Project Report

Submitted to

USAID Nigeria
by
development Research and Projects Centre (dRPC) KANO Nigeria

September 2012

A participant is learning how to use a hand globe without contamination. LSS, practical session

Zamfara State Head of Service Alhaji Bello Muhammad Umar urging the participants to make best use of what they learn from the forum to curb maternal dealth in the state

The Emir of Anka Alhaji Attahiru Muhammad Ahamd delivering his speech during the opening ceremony of one of the leadership FP/RH forum in Gusau Zamfara state. 26 November 2011

Hajia Safiyyah Haidar and Sarkin Kanoma Alhaji Yahaya sharing their Egypt professional exchange visit experience with forum participants

1.0 Background

Nigeria is the largest country in Africa with population of approximately 145 Million people, Nigeria ranked 158 out of 177 countries in 2005 United 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 2003 Demographic and Health Survey (DHS). Under – five mortality is estimated at 200 per 1000 live births, with death caused primarily by malaria, vaccine preventable disease, diarrheal disease and acute respiratory infections. Infant mortality accounts for about half of all death among children under five years of age. Maternal mortality hovers at a shocking 800 per 100,000 live births, with the rate being at least three times that in the northern states. Total fertility is 5.7 children per woman and the prevalence of modern contraceptive method is 8.9%.

Delivery and use of child survival and reproductive health services in Nigeria is weak. High child and child mobility and mortality and high fertility translate into rapid and unsustainable population growth. 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 contraceptives prevalence is low, Health indicators are much worse in the predominantly Muslim North than in the rest of the country, demonstrating regional imbalance and inequality. The lack of access to basic health services, particularly in the North, is encapsulating successive generations of the poor deeper and deeper into poverty, further marginalizing communities and fuelling the potential of the unrest.

The development Research and Projects Centre (dRPC) is an indigenous non-profit formed in 1994 in Kano State. Since its formation, the dRPC's mission has been to facilitate participatory development by creating champions for change in the North of Nigeria. To do so the Centre has targeted key stakeholders - political office holders, health administrators and providers, as well as traditional and religious leaders as the most strategic actors capable of influencing change in health seeking behaviours of men and women in the community. Leadership development capacity building through training, study tours and mentoring were the mechanism used by the

dRPC to create a new cadre of champions for FP/RH (Family Planning/Reproductive health) in the late 1990s and early 2000s. The dRPC's early efforts to create champions for FP/RH through leadership development were recognized by development partners such as the Institute for International Education (IIE), West Coast Centre, in 2002 when the Centre was supported to anchor the Leadership Development for the Mobilization of FP/RH. The LDM project ran from 2002 to 2011. By the mid-2000 David and Lucile Packard Foundation and Family Health International began to support the dRPC's work building capacity for leadership development.

In 2008 the dRPC responded to United States Agency for International Development (USAID) Nigeria RFA calling for applications for the Leadership Development for FP/RH project. The dRPC's application was successful and the Centre was awarded the grant to implement the twin-projects through Cooperative Agreement GSM No.043 and No.044 administered by World Learning. The twin-projects Activity I, Leadership development for Political office holders and Activity II, Leadership development for Traditional and Religious leaders commenced January 2009 and are scheduled to end on 30th June 2012.

1.2 Project Goal:

Create a cadre of transformative leaders from amongst traditional, religious and political leaders to inspire change, communicate accurate information and support emerging trends in favour of accessing family planning and reproductive health (FP/RH) services.

1.3 Objectives of the projects GSM No.043 and N.044

i. Increase awareness of maternal mortality and morbidity as a public policy problem and expand commitment amongst key stakeholders (Religious Opinion Leaders, Political Office Holders, health administrators with responsibility for maternal health at community level and providers at service delivery points) to transform this problem by increasing demand for FP/RH services

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

1.3.1 LDT results framework

Objectives: To expand the capacity of male and female religious opinion leaders (ROLs) and their associations to champion FP/RH in their communities by creating awareness, by making pronouncements, advocating to decision makers and modeling responsible FP/RH leadership

Results I: Participation of Female ROLs in FP/RH Increased

Result II: ROLs Capacity on FP/RH Built

Result III: A Cadre of FP/RH Transformative ROLs Created

Result IV: Enabling Environment Strengthened

1.3.2 LDP results framework

Objectives: To increase the capacity of decision makers in strategic institutions with responsibility for FP/RH at LGA level to design and implement minimum standards and best practices in LGAs health administrative units, build capacity for improved service delivery and convene broad based policy dialogues around FP/RH.

Results I: Participation of Female Health Decision Makers in FP/RH Increased

Result II: Health Decision Makers and Service Providers' Capacity on FP/RH Built

Result III: Enabling Environment Strengthened

1.4 Focal States

The project worked in the 3 focal states identified by the RFA:

- **Niger State (North Central, Nigeria)**

Niger state was created in 1976 out of the defunct North Western state. It consists of 25 local Government Areas. It has an estimated population of 4, 082, 5558 (NPC 2006). The state is made up of the old Nupe and Kontagora Kingdoms, Suleja and Zazzau Emirates. The 3 major cultural/ ethnic groups are the Nupes, Hausas and Gwaris. The state is located in the Middle West central Nigeria and is bordered by Kaduna, Kebbi, Kwara, Kogi, and Zamfara states. It shares a border with the Federal capital Territory and an international border with the republic of Benin. While majority of the population is Muslim, it has a significant indigenous Christian population.

The state has 1, 323 primary health care facilities, 18 secondary facilities and 2 tertiary facilities all public owned. In addition there are 446 registered private health facilities which include hospitals, clinics, maternity homes, and diagnostic laboratories. In addition, there are 1200 licensed patent medicine vendors in the state.

Table 1: Key Health Indicators in Niger State

INDICATOR	**CURRENT STATUS**
Women of child bearing age (15-49 yrs)	925,143 (NPC 2006)
Under 5 yrs	786,009 (NPC 2006)
Adolescents (10-24)	1, 185,681 (NPC 2006)
Total fertility rate	7.5 % (NDHS 2008)
Use of FP modern method by married women (15-49yrs)	4 % (NDHS 2008)
Antenatal care provided by skilled health worker	37 % (NDHS 2008)
Skilled attendant at birth	17 % (NDHS 2008)
Delivery in health facility	16 % (NDHS 2008)

A situation analysis conducted in 2009 by the state as part of the process of development of the state's 5 year Strategic Health Development plan, indicated that uptake of FP and RH services have been undermined by negative cultural and traditional beliefs and practices, while lack of human resources in both quantity and quality have further undermined access to these services especially in rural and hard to reach communities.

- **Sokoto State (North West, Nigeria)**

Sokoto was among the first set of states to be created in the year 1967 out of the then regions in the country. “The Seat of the Caliphate” as it is known is the spiritual seat of the Islamic leadership in country since the days of the Usman Dan Fodio Jihad.

Geographically, Sokoto State is located in the North-western part of Nigeria. It borders Niger Republic to the North and Benin Republic to the North West, Kebbi State to South and Zamfara State to the East. It has a land mass area of about 32,000 square kilometers, 23 LGAs, 120 health districts and 244 political wards. A greater proportion of the inhabitants are rural dwellers (80%) with only 20% dwelling in the urban settlements. The predominant tribes are Hausa and Fulani while Islam is the main religion.

The state has a total population of 4.2 million according to the 2006 census. The neonates, children under one year, Children under-5, Children under 15 years, women of child-bearing age (15-49), and pregnant mothers constitute 2% (80,514), 4% (161,028), 20% (805,142), 40% (1,610,283), 20% (805,142), and 4% (161,028) respectively. Current health indices are poor in the state as indicated by MICS 2007 and NDHS 2008 among other studies. Crude Birth Rate is 41.7 per 1000, Infant Mortality Rate is 100 per 1,000 live births, Under Five Mortality Rate is 166/1000 live births and Maternal Mortality Rate 850/100,000. Current use of contraception, any method is 2.1%, with any modern method as 1.9%. Other maternal health indicators in the State include 13.8% receiving ANC from a health professional, 6.8% Percentage of pregnant women whose last live birth was protected against NNT, Percentage delivered by a health professional is 5.1%; and Percentage delivered in a health facility is 4.4%.

Childhood Immunization indicators are 4.5% BCG coverage, 2.0% DPT3, 10.9% OPV3, 3.5% Measles with fully immunized children standing at 1.0% and zero dose of 64.7%. Other indications of poor utilization of health services are illustrated by the fact that 30.4% of children with fever received treatment from a health facility/provider, 33.8% of children with diarrhoea were treated in a health facility/provider and 12% of children with diarrhoea were given, any ORT.

The factors responsible for high infant, child and maternal deaths in Sokoto State are not different from that obtainable elsewhere in Northern Nigeria. They include low utilization of

existing health services, dearth of health personnel, early marriage and early child bearing, high frequency of childbearing, low literacy rates, especially among the female gender, gender discrimination and other harmful traditional/ cultural practices. The other underlying factors that contribute to the dismal picture in the state include poverty and low community awareness of the health services existence as well as poor attitude of the personnel delivering the services. In addition, inadequate and inequitable distribution of human resource for health, inadequate and poorly maintained health care infrastructures, poor state of health management information and disease surveillance systems, inadequate funding and weak governance systems remain major challenges to effective planning, implementation and evaluation of the State's health system

- **Zamfara State (North West, Nigeria)**

Created in 1996 out of the old Sokoto state, Zamfara state in North West Nigeria is a culturally and religiously homogenous state. With an estimated population of 3,278,873 (NPC 2006), and 15 Local Government Areas, it is bordered by Sokoto, Kebbi, Katsina, Kaduna and Niger states, in addition to an international border with Niger Republic. There are many ethnic groups but the major ones are Fulani and the many Hausa sub-groups and dialects. These groups share a common culture and religion which is Islam. Zamfara state was the first state to introduce the Shari'a Islamic criminal law in Nigeria in 2000. While the state is overwhelmingly Muslim, there are small numbers of Christians (mostly settler groups from other Nigerian states) and indigenous animists.

Table 2: Demographic and Health Profile of Zamfara State

Total population	**3,278,873**
Female	1,637,250
Male	1,641,623
Under 5 years (20% of Total Pop)	662,736
Adolescents (10-24 years)	948,089
Women of child bearing age (15-49 years)	766,233
Child Mortality rate	66 (PRRINN report 2009)
Percentage of women receiving antenatal care from trained health workers (current and last pregnancies	8% (PRRINN annual report 2009)
Percentage of women attended by skilled health worker at last delivery	25% (PRRINN annual report 2009)

Barriers to access for FP/RH services from the demand side in Zamfara include cultural, traditional and religious influences, lack of knowledge of danger signs, concerns about costs, and lack of physical access due to remoteness of facilities or inaccessibility. While on the supply side challenges include inadequate facilities, inadequate skilled manpower and ill-equipped facilities.

1.5 Target Groups: Leadership Groups

The target groups of this project were the recognised leadership groups and institutions in the 3 target states. These are groups with either due to constitutional mandates, custodianship of societal traditional and moral values, have great proven influences on health seeking behaviour and practices in the 3 focal states. These are:

- **Religious Opinion Leaders (ROLs)**

Religion plays a significant role in the lives of nearly all Nigerians. In recent years, there has been a growing recognition that religious leaders and communities of faith play an important role in shaping health – seeking behaviour. Religious leaders and clergy of varying levels of capacity and training are often arbiters of morality and ethics, defining what is prescribed or proscribed by a faith. This is particularly relevant with respect to maternal and child health, reproductive health, and family planning as they are at juncture where science, religion, culture, and morality intersect. Consequently, maternal and child health, reproductive health and family planning information and practices that are supported by religious leaders and religious institutions are more likely to be accepted by the community.

- **Political Office Holders (POHs)**

In Nigeria, the government is largely decentralized. State Governors, State Commissioners of Health and Legislative leaders play important roles in public health care including establishing healthcare budgets and determining investments in social sector services. LGA Chairmen and Councillors play important roles in operational implementation. Therefore, engaging with State Governors and other State-level political leaders is an important part of creating a supportive environment for family planning/reproductive health services among Nigerians.

- **Health administrators with responsibility for maternal health at community level.**
- **Providers at service delivery points.**
- **Traditional leaders**

Nigerian traditional rulers often derive their titles from the rulers of independent states or communities that existed before the formation of modern Nigeria. Although they do not have formal political power, in many cases they continue to command respect from their people and have considerable influence.

Since 1999, Nigerian has been under democratic rule, with an elected President, House of Assembly, Senate and a Federal system characterized by States and Local Governments. Despite this, a significant parallel system exists of 'traditional rulers', unelected individuals whose roots sometimes stretch back to the authority systems of the pre-colonial era. Many, however, do not, but are relatively recent creations. Even those with older roots, such as the Shehus of Borno and the larger Northern Emirates, have found the nature of their authority significantly reconstructed in recent times. Despite predictions in the 1960s that this type of traditional ruler would disappear, they have persisted and flourished in Nigeria.

1.6 Institutional Collaborations

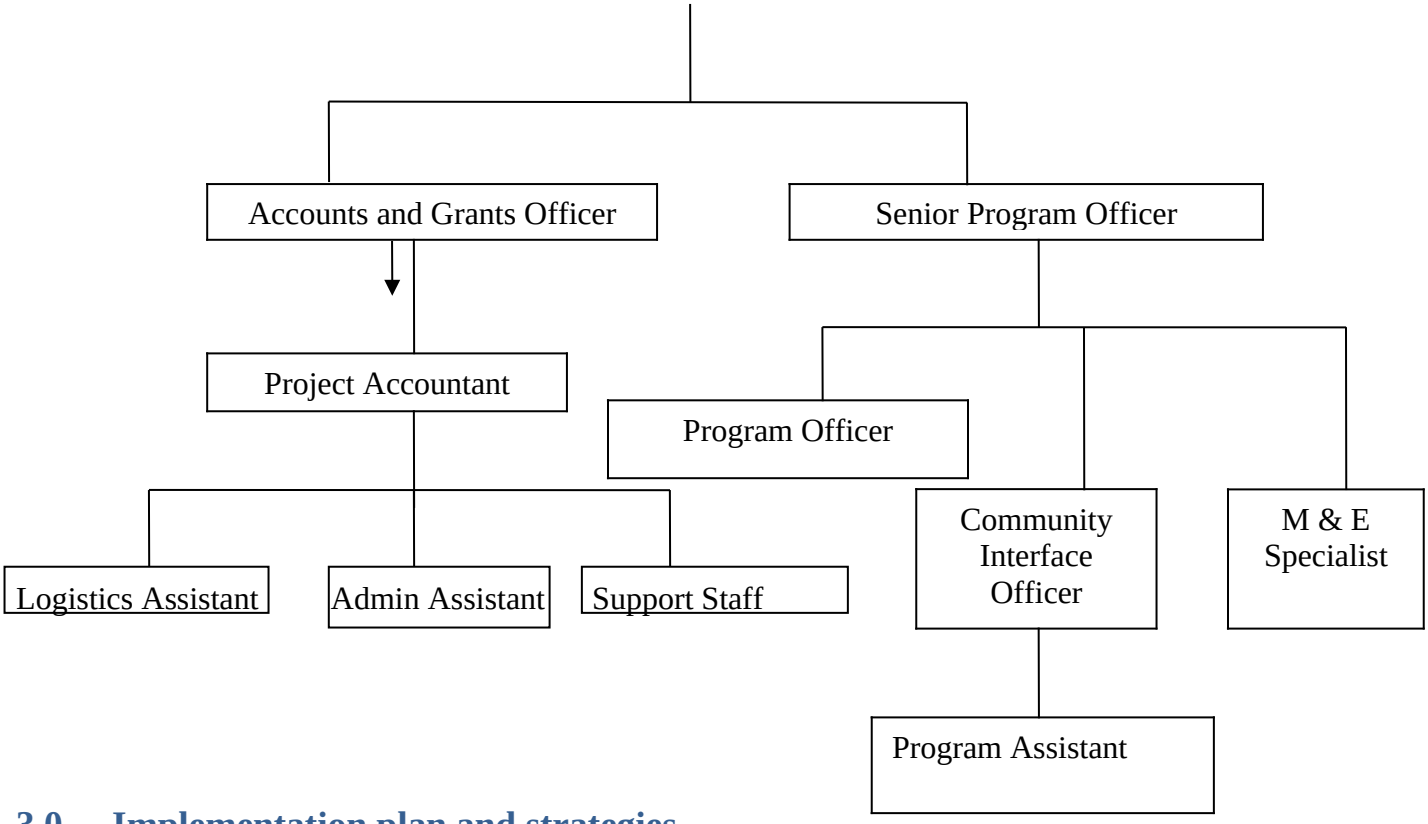
2.0 Project Management, Project Team and Organogram

The management structure of project was based on the dRPC's decentralized project management structure. Key coordination functions such as work plan development and review, scheduling and supervision were carried out by dRPC core project team at the Kano office while key implementation functions were carried out at the state level with major partners and state focal persons. The core project team based in the Kano head office of dRPC coordinated functions such as implementation of work plan and review; supervision and monitoring of different project activities to achieve the project objective.

In assigning relevant responsibilities, the program officer is responsible for implementing all project activities with supervision and guidance from the project manager. While the monitoring and evaluation specialist tracks data to ensure project targets were achieved. All the schedules of the project manager, program officer and M&E specialist were supported by resident consultants who routinely liaised with the project director and project management team.

A project accountant was responsible for administering project expenditure, budget management, financial records keeping, financial reporting and reconciliations in accordance with USAID financial policies and guidelines.

PROJECT MANGER (LDP) **PROJECT MANAGER (LDT)**



3.0 Implementation plan and strategies

Four key strategies were adopted in project implementation. These strategies which comprised the following were anchored by sub-project teams made of core project teams, independent consultants and institutional partners:

3.1 Sub-team for Strategic Activity I. – Curriculum Development

The curriculum development sub-team was lead by Dr. Judith-Ann Walker, and consisted of dRPC staff, Dr. Tahir Gwarzo and Hadiza Abdullahi and backstopped by dRPC expert Dr. S. Yusuf. The curriculum development sub-team of the dRPC coordinated and supervised the curriculum development process which adapted the UN-LDP curriculum by integrating RH into the LDP program. This process will be led by Chief UN Leadership expert Dr. Berhanu Tadesse Taye and will include experts from the Ahfad University for Women, RH program in Sudan for FP technical inputs as well as the training institute NIPSS. The chief in-country facilitator, Alhaji Abubakar Mohammed Sokoto from NIPSS will also support this team.

3.2 Strategic Activity II – Training

The RFA of the USAID leadership development project called for leadership development forums (LDFs) to be convened as a start-up activity to catalyze transformation amongst political office holders as well as traditional and religious leaders. The dRPC convened. LDFs of. participants in the first phase of the project 2009-2011 and … LDFs of … participants in the second phase of the project 2011-2012.

The dRPC developed a compelling curriculum in February 2009 in which groups with experience engaging senior policy makers as well as traditional leaders in the North were invited to make inputs. Experts making inputs into the curriculum development workshop was Dr. Kole Shetimma, MacArthur Foundation Regional Director; Awal Rafsanjani, Executive Director CISLAG, Professor Denis Ityivia, Director Inter-Gender; Hajiya Bilkisu Yusuf, FOMWAN. Umar Kawu, British Council Certified Leadership Development trainer facilitated the process. The curriculum was underpinned by participatory approaches and sessions were designed to guide office holders as well as traditional leaders to into playing with blocks, following a leader while being blindfolded and role playing reproductive health issues and problems in practical and natural terms.

3.3 Strategic Activity III – Mentoring and Alumni development

To further increase champion’s skills in plan implementation, communications skills, problem solving skills, and application of innovative approaches to overcoming challenges in

communities, a mentoring program was organized for the level 1 and 2 champions. In the LDP project Mentoring was designed as an activity to support the project's target groups who had developed action plans at the end of LDFs or at the end of study tours. Action plans could be individual action plans or indeed state action plans as in the case of the second phase of the project. The target groups who developed action plans in the project were state political office holders who attended the LDFs in 2009, health administrator at primary health care level who attended the Ghana study tour in 2011 and traditional and religious leaders who attended the Egypt study tour in 2009 and again in 2011.

The purpose of the mentoring exercise was to provide the target groups with strategies, techniques and encouragement to achieve the goals set in their action plans. During the first phase of the project where the project's target groups developed individual action plans, the dRPC carried out mentoring as a one-one-one activity. The dRPC staff and consultants met with the target groups separately in their offices, their homes at hotel venues to monitor action plan progress and to support target groups on how to achieve goals. During the first phase of the project the staff of the National Institute for Policy and Strategic Studies, NIPSS, were co-opted into the dRPC's mentoring team. The NIPSS team conducted their mentoring through telephone calls and letters of encouragement to the political office holders who attended the LDFs. In the second phase of the project mentoring took the form of group mentoring in response to action plans being group plans implemented by the Alumni of health administrators who attended the Ghana study tour. Group mentoring exercises were more productive mechanism for encouraging the target group to meet goals as the group sessions had a positive dynamic with other participants being as supportive as the dRPC team.

While individual mentoring worked well for political office holders in the first phase of the project this was not the case for the traditional and religious leaders target group. Mentoring of traditional and religious leaders who attended the Egypt study tour in both 2009 and 2011 was conducted through group mentoring events. Traditional and religious leaders preferred to meet their mentors in groups and preferred to discuss challenges faced to implementing individual and state action plans in groups rather than alone.

Qualified and experience consultants were identified and recruited locally. The consultants were supported by the dRPC project staff. As part of the mentorship, Champions were regularly met one-one to review their plans, implementation status, challenges and opportunities. The program lasted throughout the project life.

3.3.1 Creation of Alumni Networks

To encourage sustainability beyond project life, champions were supported and facilitated to set up a state champion's alumni association, and a network for states alumni associations (comprising associations from the 3 project states).

The primary goal of the alumni associations is to ensure the presence in each state of a vibrant, well informed and well motivated critical mass of highly respected community leaders that not only believe in the importance of MCH and FP/RH, but also that which continues to remain engaged, to promote MCH and FP/RH access and uptake, and also recruit others to the cause for greater access.

The network that brings the 3 alumni together was aimed at encouraging cross fertilization of ideas, and experiences amongst the states. By the end of the project, all 3 states associations have been duly formed and registered with the relevant regulatory authorities. In addition, they have all developed annual plans to guide their activities.

3.4 Strategic Activity IV – Monitoring and Evaluation (M&E)

3.4.1 Monitoring and evaluation approach

The M& E approach focussed on the output and outcome evaluation to establish the extent of changes in knowledge, attitudes and practice. It also focussed on system change of the environment on FP/RH services in the three states.

The monitoring and evaluation mechanism provided the key inputs for capturing experiences, lessons learnt and best practices of the program. The main source of data collection under the M&E system was primary.

The dRPC, as coordinator of the program has documented and disseminated learning from the various components of the leadership interventions with development partners, key stakeholders, researchers, and leadership training institutions. The dissemination was part of the shared learning strategy and covered issues such as the management of study tours, trainings for senior level leaders as well as storytelling, monitoring and evaluation of leadership development programs. Also consultants, partners were consulted to capture the experiences and lessons learnt from the activities. It is hoped that this will generate dialogue among stakeholders and other development partners on not only sustaining the success achieved, learning from challenges encountered but also widening the scope and scale of the interventions.

4.0 Project Targets and Indicators

Table 3: Activities, Targets and Indicators of LDP LDT project 2009 – 2012

Activities	Indicators	Target	Actual
Advocacies for increase political commitment and increase budgetary allocation for FP/RH services by LDTs & LDPs	Number of advocacy visits conducted to state assemblies and members of states executive council.	12 advocacy visits over LoP (4 per state)	12 advocacies
Public Pronouncements in Support of FP/RH by LDTs & LDPs	Number of public pronouncements made by LDTs & LDPs	900	> 700
Conduct Mentoring exercise (LDPs & LDTs)	Number of Mentees Mentored	171	167
Creation of Alumni associations and networks in states. (LDP & LDT)	Number of Alumni associations and Networks formed	17 (5 each per state and 2 umbrellas)	17 alumni
LDFs capacity training in FP/RH promotion and management (LDP)	Number of LDPs trained	270	264 (M) 31 (F)
LDFs –Leadership Development forums on FP/RH held for LDPs. (LDP)	Number of FP/RH Leadership Forums held	9	10

Development of IAPs by LDP participating at the leadership development forums.	Number of IAPs Developed	270	295
In-country leadership development forums on FP/RH for LDTs in states.	Number of LDTs from states participating in leadership development forums.	90	106 (M) 0 (F)
Leadership development forums for states LDTs held.	Number of FP/RH Leadership Development Forums for states LDTs held.	5	5
Development of IAPs by LDTs attending leadership development Forums.	Number of IAPs Developed	81	106
Study tour to Ghana by states health decision makers to understudy best practices in FP/RH interventions and services delivery.	Number and Sex of Delegates Participating study tour to Ghana	15 (M) 15 (F)	21(M) 9 (F)
Step-down training on leadership in FP/RH for Health decision makers in states.	Number and Sex of Health Decision Makers Participating in step-down training.	30 (M) 30 (F)	43 (M) 18 (F)
Development of states action plans by trained health decision makers.	Number of State Action Plans Developed	3	3
Capacity building workshop for health service providers at PHCs on Leadership in FP/RH and Evidence-Based Clinical Guidelines.	Number of Health Service Providers from PHCs trained per state.	150 (50 per state)	44 (M) 107 (F)
Sub-grant awards to alumni network	Number of Sub-grants Awarded to States Alumni associations	3	3
Distribution of materials	Number of Minimum Standard	260	1,375

on MH,MLSS and minimum. Standard of care Package.	Guidelines Distributed		
State Stakeholders policy dialogue on reviewing critical challenges to increase uptake and efficient delivery of FP/RH services.	Number of Maternal Health Policy Dialogue Held	3	3
New initiatives to help SPHCDAs	Number of Strengthening Initiatives for SPHCDAs	5	5
Study tour (LDT) to Egypt for male and female Religious, and Traditional leaders. Study tour (LDT) to Mali for female religious leaders.	Number of Males and Females Religious and traditional leaders participating in study tour to Egypt. Number of female religious leaders attended the study tour	36 (M) 15 (F) 0 (M) 16 (M)	35 (M) 15 (F) 0 (M) 16 (M)
LDT post Egypt step-down training on leadership for FP/RH.	Number of Males and Females Trained in FP/RH leadership.	60 (M) 60 (F)	79 (M) 60 (F)
Capacity building workshop of FBOs on strategies for reaching vulnerable populations with FP/RH services.	Number of Males and Females FBOs participating in Capacity Building workshop.	15 (M) 15 (F)	19 (M) 18 (F)
Development of state actions plans by state LDT alumni associations.	Number of State Action Plans Developed	6	6
Media re-broadcast of Public pronouncements by LDTs in states.	Number of People reached with pronouncements by LDTs through re-broadcasts on media.	1 Million	5.75 million

5.0 Project Achievements

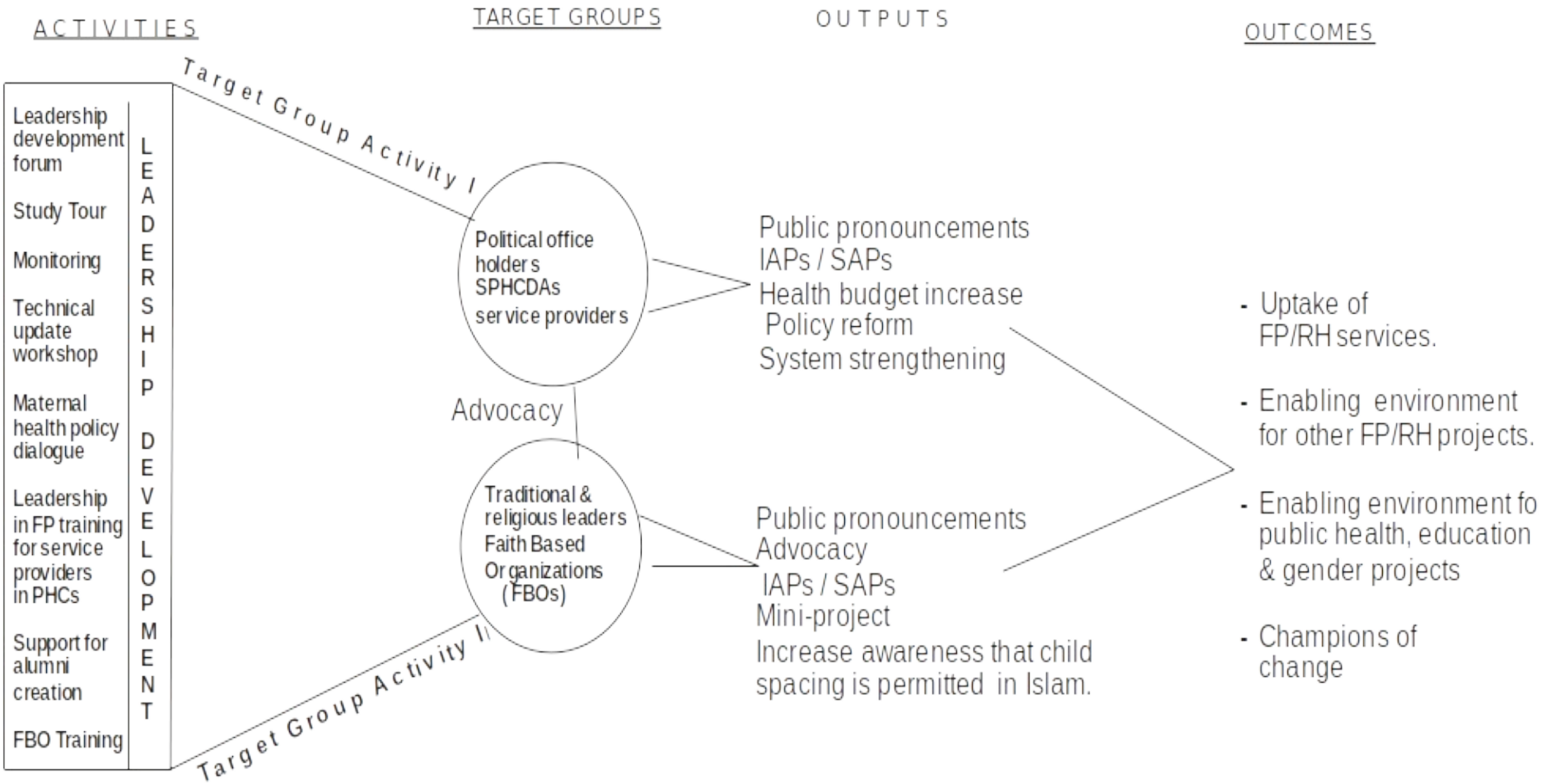


Table 4: FP/RH Leadership Development Project in Niger, Sokoto and Zamfara States (LDP)

Table 1: Main activities of the project

Activity	Date/period	Frequency / Number	Participants			Type of participants
			Male	Female	Total	
Leadership Development Forum on FP/RH	July 2009	3	87	2	89	Local government Chairmen and Councilors for Health
	July – August 2009	4	68	6	74	State Legislators and the Judiciary
	August 2009 – March 2010	3	109	23	132	State Executives Leaders
Mentoring Program/exercise	Throughout the period of the project	Continues	-	-	-	State and Local Government Executive, Legislators and the Judiciary
Creation of State Alumni Association	March 2010, June 2010	3		31	295	State and Local Government Executive, Legislators and the Judiciary
Regional Alumni Network Forum: Umbrella Network	July 2010	1	13	5	18	Delegates from State and Local Government Executive, Legislators and the Judiciary

Table 2: Other supporting activities of the project

Activity	Team composition /responsible	Frequency /Number	Year	Audience/stakeholders visited
Sensitization visits to the project state governments	Project staff, formative research consultants, religious & traditional leaders	3	2009	Community leaders, policy makers , state executives and senior civil servants
Advocacy visits for budgetary increase	Project staff, members of alumni associations from community	3 3	2009 2010	SHOA, Ministry of health, budget and planning, Local government, women

	and religious leaders			affairs and so on
Mentoring and Monitoring visits to the 3 focal States	Project staff and consultants	3 6	2009 2010	Political leaders who participated in the project activities
Mid-term evaluation supervision visits	Project staff and consultants	1	2011	Political leaders who participated in the project activities were evaluated
Dissemination visit	Project staff and consultants	3	2011	Political leaders, and senior civil servant and other state government officials
Helped participants to develop action plans	Forum facilitators and project consultants	282	2009	

Table 3: Training and Workshops

Activity	**Date/period**	**Frequency / Number**	**Participants**			**Type of participants**
			Male	**Female**	**Total**	
Exchange visit to Ghana (Study tour)	September 2011	1	21	9	30	Health policy makers and health service providers
Step down leadership training on FP/RH	November - December 2011	3	43	18	61	Health policy makers and health service providers
Workshop on MLSS and minimum standard package for maternal health	December - 2011	3	44	107	151	Health service providers at local government facilities
Policy Dialogues	February - 2012	3	38	10	48	Health policy makers and health service providers

Table 2: Other supporting activities

Activity	**Team composition /responsible**	**Frequency /Number**	**Year**	**Audience/Stakeholders visited/Beneficiaries**
Creation of state alumni associations	Male and female health policy makers and services providers	3	2011	-
Developing of state action plans	Male and female health policy makers and services providers	3	2011	-

Advocacy visit	Project staff , consultants and state alumni association members	3	2012	SHOA, Ministry of health, budget and planning, Local government, women affairs and so on
Mentoring and monitoring visits/exercise	Project staff and consultants	12	2011-2012	States alumni association members
Sub-grant awarded to State Alumni Association	-	3	2012	Member of states alumni association
Field visit to PHCs	Consultants and members of state alumni association	3	2012	Health services providers at local facilities
Distribution of Minimum Standard Guidelines for Maternal Health	-	1,375	2012	Health facilities, Alumni associations of health personnel, USAID IPs, Line ministries and SHOA

Table 5: FP/RH Leadership Development Project in Niger, Sokoto and Zamfara States (LDT)

Table 1: Main activities of the project

Activity	**Date/period**	**Frequency / Number**	**Participants**			**Type of participants**
			Male	**Female**	**Total**	
International Exchange to Egypt (Study Tour)	July –August 2009	1	20	0	20	Traditional and religious leaders (first class emir, district heads and Friday mosque imams)
Leadership Development Forum on FP/RH	November 2009 – May 2010	7	106	0	106	Traditional and religious leaders (first class emir, district heads and Friday mosque imams)
Mentoring Program/exercise	Throughout the period of the project	Continues	-	-	-	Traditional and religious leaders (first class emir, district heads and Friday mosque imams)
Creation of State Alumni Association	February – March 2010	3	106	0	106	Traditional and religious leaders (first class emir, district heads and Friday mosque imams)

Regional Alumni Network Forum: Umbrella Network	May 2010	1	92	0	92	Traditional and religious leaders (first class emir, district heads and Friday mosque imams)
Update workshop	November 2010	1	28	11	39	Male and female religious leaders; community leaders

Table 2: Other supporting activities of the project

Activity	Team composition /responsible	Frequency /Number	Year	Audience/stakeholders visited
Sensitization visits to the project state governments	Project staff, formative research consultants, religious & traditional leaders	3	2009	Community leaders, policy makers , state executives and senior civil servants
Advocacy visits for budgetary increase	Project staff, members of alumni associations from community and religious leaders	3 3	2009 2010	SHOA, Ministry of health, budget and planning, Local government, women affairs and so on
Mentoring and Monitoring visits to the 3 focal States	Project staff and consultants	3 6	2009 2010	Political leaders who participated in the project activities
Mid-term evaluation supervision visits	Project staff and consultants	1	2011	Political leaders who participated in the project activities were evaluated
Dissemination visit	Project staff and consultants	3	2011	Traditional and religious leaders, Political leaders, and senior civil servant and other state government officials
Helped participants to develop action plans	Forum facilitators and project consultants	92	2009-2010	

Table 3: Training and Workshops

Activity	Date/period	Frequency/ Number	Participants			Type of participants
			Male	Female	Total	
International Exchange to Egypt (Study tour)	September 2011	1	15	15	30	Male and female religious leader; community leaders
Step down leadership	November - December	3	79	60	139	Male and female religious leader;

training on FP/RH	2011					community leaders
Capacity building for FBOs on how to run NGOs	February-2011	3	19	18	37	Members of Faith-Based Organizations (FBOs)

Table 2: Other supporting activities

Activity	**Team composition /responsible**	**Frequency /Number**	**Year**	**Audience/Stakeholders visited/Beneficiaries**
Advocacy visit	Project staff , consultants and state alumni association members	3	2012	SHOA, Ministry of health, budget and planning, Local government, women affairs and so on
Mentoring and monitoring visits/exercise	Project staff and consultants	12	2011-2012	States alumni association members
Dissemination of FP/RH Public Pronouncements on TV	-	3(1 show in each project state)	2012	5.75 million people estimated to watch and hear the message in the three project states
Creation of State Alumni Associations	Male and female religious and traditional leaders	6	2011	-
Developing of state action plans	Male and female health policy makers and services providers	6	2011	-

The dRPC's Study Tours in FP/RH

The dRPC conducted 4 study tours involving 96 participants (56 males and 40 females) over the life of the project 2009 -2012. The summary of the study tour experience under the leadership development project is below:

Table 6: Summary of all LDP/LDT study tour

Study Tours	Target group	Delegates		Expected Results
		Male	**Female**	
Islam and FP/RH tour to Egypt, 2009	Influential traditional and religious leaders with large following in Zamfara, Niger and Sokoto	20	0	New knowledge gained, attitude change on child spacing within Islam and new behaviours to take leadership by making pronouncements and carrying out mini-projects in FP/RH
Maternal and child health study tour to Mali, 2010	Influential female Islamic scholars in Bauchi, Zamfara, Niger and Sokoto	0	16	Knowledge gained, change of attitude and new behaviours to support gender responsive integrated Maternal and child health interventions
Islam and FP/RH tour to Egypt, 2011	Influential traditional and religious leaders with large following in Zamfara, Niger and Sokoto	15	15	New knowledge gained, attitude change on child spacing within Islam and new behaviours to take leadership by making pronouncements and carrying out mini-projects in FP/RH
Best practices in maternal health program management at Community level in Ghana, 2011	Senior health administrators with responsibility for maternal health at community level	21	9	New knowledge and skills on community based maternal health gained, commitment to adapting new knowledge, attitude and behavior change
Total		**46**	**40**	**96**

Assessment of the outcomes of study tours

The dRPC assessed the impact of the outcomes of study tours by carrying out pre-study tour interviews of knowledge, attitude and behaviour during orientation meetings; daily monitoring of sessions; end of study tour interviews during debriefings; and impact assessments 3 months to 1 year after the study tour. We drew on the reports from these assessments to examine the question of interest – how effective are study tours as a mechanism for developing leaders in FP/RH.

(11. Impact – unanticipated and sustainable achievements

12. Lessons Learnt

13. Challenges and Recommendations (this section should include management challenges also)

14. Conclusion and path to scale

15. Appendices:

(A) Summary of PMP 1

(B) Summary of PMP 2

(C) Summary of portfolio reviews and responses

(D) Success stories

(E) Budget reconciliation